MCNV Strategic Plan 2012 – 2016

April 2012

Abbreviations

AIDS	Acquired immuno-deficiency syndrome
ART	Anti-retroviral therapy
BCA	Behaviour change activities
BCC	Behaviour change communication
CBR	Community based rehabilitation
CBF	Central Bureau for Fundraising (Dutch seal of approval for fundraising)
CMH(L)D	Community-managed health (livelihoods) development
CWD	Child(ren) with disability
DAC	Development assistance country
DOET	Department of Education and Training
DOLISA	Department of Labour, Invalids and Social Affairs
DPO	Disabled People's Organisation
EBPM	Evidence-based planning and management
ED/EI	Early detection/early intervention (for disability)
EPI	Expanded Program on Immunisation
HIV	Human immunodeficiency virus
IDU	Intravenous drug user
IGA	Income generating activity
IE	Inclusive education
INGO	International non-governmental organisation
ISO	International Standards Organisation
LFA	Logical Framework approach
MCNV	Medical Committee Netherlands-Vietnam
MDG	Millennium Development Goal(s)
M&E	Monitoring and evaluation
MOH	Ministry of Health
MOET	Ministry of Education and Training
NGO	Non-governmental organisation
PACCOM	Vietnamese agency responsible for international NGOs
PARTOS	Dutch organisation representing NGOs
PHC	Primary health care
PhD	Doctor of philosophy
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PSO	Personnel Services Overseas (Dutch development organisation)
PWD	People with disabilities
SEA	South East Asia
STI	Support to training institutes
TEA	Transition in the East Alliance
TB	Tuberculosis
VHDP	Village health development plan
WHO	World Health Organisation
WU	Women's Union

Introduction

The Medical Committee Netherlands – Vietnam (MCNV) started as a solidarity organisation in 1968. In the early years, volunteers and medical students collected medical equipment and medicines for the war-stricken people in Vietnam. The war ended in 1975, and the north and south of Vietnam were reunified; in the following years the country faced the great challenge of reconstruction. As a result of the economic renovation that started in the mid-eighties, Vietnam has seen major economic growth in recent years, which has a positive impact on health and social development in the country.

During this period of development in Vietnam, MCNV has continuously adapted its support to fit the changing context. Today, in 2012, MCNV is a medium-sized development organisation, with paid professional staff in three offices in Vietnam and the head office in Amsterdam. However, MCNV still enjoys the support of more than 8,000 regular private donors in The Netherlands, with an increasing number of donations from families and small foundations. During the past several years, MCNV's budget has tripled, most of the increase coming from project funding by institutional donors.

During this period of time, the field of development cooperation has also been changing. The general public rightfully demands more insight into the use and results of both private donations and government program funding. This demand has consequences for the monitoring and evaluation systems in development organisations, and requires a more transparent culture and the development of indicators for external accountability. The legitimacy of any development organisation must be reviewed and evaluated regularly, and in the context of the rapid economic development in Vietnam, that is especially necessary for MCNV. We perceive that our role, at least in Vietnam, should shift more to an advisory and support function and less of a leading function.

The developments in Vietnam, the Dutch demands for transparency in development cooperation, and the rapid growth of MCNV have led us to reflect on our role and our approaches in the coming years. Who needs our support in Vietnam and in the region? Who are the most vulnerable nowadays and how can these people best be supported? Which strategies do we select to maintain the quality of our internal organisation and the effectiveness of our programmes? How do we ensure continued funding for our programs, considering both institutional donors and our large network of private donors in The Netherlands who give not only financially but also express their solidarity with Vietnam? These and other questions are addressed in this document.

This policy and strategic plan was developed during a long process of meetings and discussions; the documents that formed the basis are listed in Annex 1. Between a strategic plan and the work on the ground, a plan to operationalise the chosen strategies is still needed. This will be a separate plan that is updated annually to take into account the continuing changes in context and possibilities.

Amsterdam, April 2012

1. MCNV Background

1.1 History

Three medical doctors founded the Medical Committee Netherlands-Vietnam (MCNV) in 1968 to provide medical aid to war-torn Vietnam. The Head Office is in Amsterdam and for many years, its main activity was to raise funds and purchase materials for hospitals and disease control programs in Vietnam. A Representative Office was opened in Hanoi in 1996, with two staff to oversee programmes and finances. In 1999, a Project Office was established in Quang Tri Province for the Community Managed Health Development (CMHD) program there and for other projects in Central Vietnam. A second Project Office was opened in Khanh Hoa Province in 2005 to support a new program on Community Managed Health & Livelihood Development in that province. By now, the three offices have grown to house more than 30 staff with a wide range of expertise to implement the programs, and a start has been made on an MCNV presence in Laos.

MCNV's history means that health is traditionally a priority and the entry point to community development and poverty alleviation programs. The concept of health that we use is the broad one described by the World Health Organization (WHO) that stresses the importance of the social determinants of health. The programs therefore also include activities in related sectors that affect health and welfare, such as agriculture, education, nutrition, small enterprise and others, a whole package for socio-cultural development that makes complete health possible. MCNV's partnerships traditionally have been within the government's health sector, from central to peripheral levels, from ministries to households in villages. Activities outside the health sector have led to development of new partnerships with the government in agricultural, education and economic sectors and with the mass organisations such as the Women's Union and the Farmers' Union, which implement many activities at community level. More recently, MCNV has supported civil society organisations at local levels, when there is no government partner to fill the needs, for example, the Disabled People's Organisations. When the programs require expertise outside the field of health, MCNV uses local consultants from other organisations or institutions and/or works with other NGOs to provide a wider range of expertise to the partners.

The priorities of the partners have always been taken into account in MCNV's policies and programming. MCNV has gone through major strategic developments since its start during the Vietnam War, when it sent medical equipment and medicines to Vietnam. In the late 70s and 80s, MCNV supported the rehabilitation of the Vietnamese health sector by strengthening national programs on infectious disease control (malaria, tuberculosis, and dengue) and by improving care in a few selected hospitals. In the 90s, on the request of the partners, MCNV started to reorient its work towards communities and primary health care. From 2000 onwards, most of the programmes have focused on capacity building, empowerment of disadvantaged groups, and community managed activities to create better opportunities for target groups to prioritise their own problems and to participate in the planning, implementation and evaluation of the programmes. In 2005, MCNV's work expanded into the less developed neighbouring country Laos, in Savannakhet province that borders on Quang Tri, a long time partner province in Vietnam. The programme in Laos will continue at least through to 2015 in the context of a new multi-country programme with financial support from the Netherlands government, the Transition in the East Alliance (TEA).

In recent years, MCNV policy has led to an increasing independence of the offices in Vietnam and to a strategy of working towards local funding, including development of social enterprises. MCNV has also continued to build a strong base of research within its programs and in collaboration with research institutions and universities.

MCNV will continue to evolve as the context of our work in Vietnam and other countries in South East Asia (SEA) changes, as new opportunities arise not only in Vietnam but also in Laos, Cambodia and possibly Myanmar, all of which are at the present time considerably less developed than Vietnam and within the scope of MCNV's mandate to provide assistance to the disadvantaged peoples in South East Asia.

1.2 Vision on health and development

We find ourselves in a rapidly changing and globalising world. Economic growth has taken such a spurt in Vietnam that it has reached the status of a Lower Middle Income Country. Other countries in the region such as Laos, Cambodia and Myanmar have also shown increasing economic growth but have not yet reached the status of a Lower Middle income Country[1].

However, the benefits of this transition are not equally distributed among the populations in these countries. Health inequities in South East Asia are a result of a number of other inequities – access to health care, schools, and education, conditions of work and leisure, housing, and development in communities, towns, or cities. This unequal distribution of health is the result of a combination of poor social policies and programmes, unfair economic arrangements, and shortcomings in the political arena. Together, these determinants, the conditions of daily life, constitute the social determinants of health and are responsible for a major part of the health inequities within and between countries. The importance of these features is demonstrated by the setting up of the Commission on Social Determinants of Health by the World Health Organization (WHO) in 2005, to collect evidence on actual conditions and on what can be done to promote health equity by working on the social determinants.

MCNV aims to be an organization whose policies and programmes can influence the social determinants of health for its target groups among the disadvantaged and can contribute to improving health equity. MCNV pays special attention to closing the gap between marginalized and non-marginalized groups in its partner countries and to documenting how it does that and whether it succeeds.

MCNV subscribes to and contributes to the three principles of action that have been formulated by the Commission on Social Determinants of Health:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

MCNV's Vision:

Especially in countries in South East Asia which are in a phase of transition, marginalised groups need to be empowered to obtain equitable access to health care, education, housing and food security, so that they can influence the processes, systems and individuals that presently limit their development.

The marginalised groups that MCNV focuses on are the most vulnerable: the rural poor especially in remote areas, ethnic minorities, adults and children with disabilities, HIV-positive mothers and their children, women and girls in general where they are not able to use their potentials, and the urban poor. The youth have not been a special focus in the past work of MCNV, but they will be responsible for how their society works in the future, so it is essential to ensure that they are included when attention is given to the disadvantaged groups named above.

Promoting the use of participatory approaches is a prominent theme in all the programs funded by MCNV. We do that not only because we recognise that participation is needed for sustainable development, but also because empowerment for real participation forms a strategic challenge in the present South East Asian cultural and political context. While the region goes through a transition phase from top-down planning and hierarchical structures to decentralisation and grass-roots democracy, the people at each level need to be prepared to take up the challenges and responsibilities that will become available for them.

[1] Reference is made to http://data.worldbank.org/about/country-classifications/country-and-lending-groups

1.3 Mission statement

MCNV has historically focused its attention on Vietnam, with occasional support to Laos and Cambodia in the early years. Since 2005, MCNV has also worked in one province in Laos. We now plan to take up activities in other countries in the region when its goals and expertise make that desirable and feasible, with a focus first on the existing programme in Lao DPR and when opportunities arise, in Cambodia and possibly Myanmar, in the next strategic period.

In the mission statement for this strategic planning period, we clarify the contribution that MCNV makes to society in view of the vision formulated above. MCNV assists marginalized people in countries in transition in South East Asia to have more equitable access to social determinants of health such as primary health care, employment, education, housing and food security. At the same time, we believe in the need for evidence-based models that can be disseminated over a wider geographic area, thus increasing our impact and influence in the region. That brings us to the following mission statement.

MCNV Mission Statement:

"*To contribute to the structural improvement of the health of disadvantaged groups in South-east Asia by developing evidence-based participatory models that build capacity and focus on the major determinants of population health.*"

MCNV develops the capacity of existing individuals, groups and institutions in society in such a way that groups of marginalized people who have been experiencing a lack of well being are assisted in improving their life circumstances, with a focus on health at least as an entry point. Health is a multi-facetted and complex concept that cannot be addressed in isolation from other issues. Therefore MCNV aims at programs in which health and well-being are addressed in combination with development issues such as clean water and sanitation, livelihood, access to credit and maintaining or improving the environment. Parallel to programme implementation, MCNV documents and disseminates knowledge about approaches that can be adapted and adopted by individuals, groups and institutions that lie beyond the boundaries of the programmes.

MCNV continuously monitors the balance between achieving improvements in living conditions of the target groups and the strengthening of service for them on the one hand, and allocating sufficient time and resources for learning about effectiveness of approaches and development of skills and attitudes on the other hand. Underlying all of the work is our focus on establishing and maintaining good relationships with and among local stakeholders, who will take the ultimate responsibility for the sustainability of our efforts.

1.4 Core values and working principles

The core values of MCNV are first, the solidarity between the people in the Netherlands and the people in Vietnam and Laos in particular and South East Asia in general, especially the vulnerable groups: the poor, ethnic minorities, the disabled and, in many cases, women and children, and second, the commitment of the donors, the Board, the staff and the Vietnamese counterparts, to improve the position and quality of life of these vulnerable groups.

Besides these core values, a number of 'working principles' guide the policies of MCNV:

- A broad, comprehensive concept of health as described by the WHO Commission on Social Determinants of Health
- Building on existing government and other structures where possible, to avoid creating parallel systems
- Work towards social justice and equity, using a needs-based approach
- Working in partnership, which is characterised by mutual respect
- Transparency and accountability in management practice
- Cultural appropriateness, with consideration for equity and solidarity
- Gender sensitivity
- Focus on development of local expertise in health and human capacity development
- Flexibility and innovation
- Self-reliance of target groups and sustainable programs
- Cost-effectiveness
- Using a participatory approach at all levels
- Self- monitoring, self-evaluation and self-learning, not only for partners but also for MCNV as an organisation
- Shared inputs with partners with a view to handing over the programmes when partners can sustain them on their own

1.5 Legitimacy in changing times

The legitimacy of MCNV is based on three aspects:

1. Approximately 8,000 individual and family donors contributed regularly to support our work in 2011, trusting MCNV to translate their donations into effective assistance for the beneficiaries.
2. Institutional donors such as the Ministry of Foreign Affairs in the Netherlands, the Royal Netherlands Embassy in Hanoi and the European Commission support development in Vietnam, and entrusted MCNV to use their money effectively and efficiently for that purpose.
3. The Vietnamese and Laotian partners want to improve their capacity and the quality of their health systems and ask MCNV to help them do that where gaps are left by their own institutions. New partners ask MCNV to work with them, old partners ask for new programs.

Although several countries in SEA are experiencing economic development, their social development is lagging behind. The authorities and the marginalized communities lack examples of good practice to cope with the growing disparities between social groups that are resulting from rapid and unequal economic growth. MCNV's legitimacy remains in its focus on the vulnerable groups that have not been able to participate in and benefit from the development process.

The legitimacy for MCNV to work in Laos was initially through the Vietnamese partners and the commitment from the Vietnamese government to support Laos. In the MCNV project areas on the border with Laos, communicable diseases such as malaria and cholera cross the border, as do people in the border communities. There was sufficient motivation to expand the work in Laos, which has a much lower level of development than Vietnam. In addition, the administrative and health system structure in Laos is similar to that in Vietnam, as is the culture of the ethnic minority communities which straddle the borders where our programmes are implemented, so that the approaches that have worked well in Vietnam can also work well when adapted for Laos. The first contacts with the province of Savannakhet, next to Quang Tri province in Vietnam, were in 2004; in 2005 pilot projects on community managed health development were established. After that a programme to improve reproductive health care was added. In the new TEA programme, rural development and empowerment of marginalised groups such as ethnic minorities, the elderly and those with mental health problems became the main focus in Savannakhet. The programme in Laos is now an integral part of MCNV's work and the demand for support is still great in Savannakhet and other provinces.

In Vietnam, further evidence for MCNV's legitimacy are the three national medals for MCNV's work given by PACCOM, the agency responsible for international NGOs in Vietnam, the several medals awarded to MCNV staff by the Ministries of Health and Education, the Women's Union, the provinces where we work and national programmes such as the National Tuberculosis Control programme. The interest of other NGOs in Vietnam and from other countries to organise exposure visits to MCNV programs is also an indicator of a general recognition of their quality and our legitimacy.


CHỦ TỊCH
NƯỚC CỘNG HÒA XÃ HỘI CHỦ NGHĨA VIỆT NAM
TẶNG
HUÂN CHƯƠNG HỮU NGHỊ
Ủy ban Y tế Hà Lan-Việt nam


CHỦ TỊCH
NƯỚC CỘNG HÒA XÃ HỘI CHỦ NGHĨA VIỆT NAM
TẶNG
HUÂN CHƯƠNG HỮU NGHỊ
Ủy ban Y tế Hà Lan Việt Nam (MCNV)


LIÊN HIỆP CÁC TỔ CHỨC HỮU NGHỊ VIỆT NAM
THE VIETNAM UNION OF FRIENDSHIP ORGANIZATIONS
GHI NHẬN
ACKNOWLEDGES
MEDISCH COMITE NEDERLAND VIETNAM
Đã có đóng góp tích cực vì giảm nghèo và phát triển tại Việt Nam
For its significant contributions to poverty reduction and development in Vietnam


ĐOÀN CHỦ TỊCH
LIÊN HIỆP CÁC TỔ CHỨC HỮU NGHỊ VIỆT NAM
TẶNG
Bà ELAINE PAMELA WRIGHT
KỶ NIỆM CHƯƠNG
"VÌ HÒA BÌNH, HỮU NGHỊ GIỮA CÁC DÂN TỘC"


BỘ TRƯỞNG BỘ Y TẾ
TẶNG
Bà Pamela Wright
Lương y như từ mẫu


BỘ TRƯỞNG BỘ Y TẾ
TẶNG
KỶ NIỆM CHƯƠNG VÌ SỨC KHỎE NHÂN DÂN
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BAN CHẤP HÀNH TRUNG ƯƠNG
HỘI LIÊN HIỆP PHỤ NỮ VIỆT NAM
TẶNG
Bà Pamela Wright
Trưởng Đại diện tổ chức Y tế Hà Lan tại Việt Nam
KỶ NIỆM CHƯƠNG
"VÌ SỰ PHÁT TRIỂN CỦA PHỤ NỮ VIỆT NAM"


BỘ TRƯỞNG BỘ GIÁO DỤC VÀ ĐÀO TẠO
TẶNG
KỶ NIỆM CHƯƠNG VÌ SỰ NGHIỆP GIÁO DỤC
Bà Anne Marie Alina Maarse


HỘI NGƯỜI MÙ VIỆT NAM
TẶNG
KỶ NIỆM CHƯƠNG
VÌ HẠNH PHÚC NGƯỜI MÙ
Cô Thái Hà Hendrika Johanna Ong


HỘI NGƯỜI MÙ VIỆT NAM
TẶNG
KỶ NIỆM CHƯƠNG
VÌ HẠNH PHÚC NGƯỜI MÙ
Nguyễn Thanh Tùng


HIỆP HỘI THỂ THAO NGƯỜI KHUYẾT TẬT VIỆT NAM
Tặng
BẰNG KHEN
UỶ BAN Y TẾ HÀ LAN - VIỆT NAM TẠI QUẢNG TRỊ


HIỆP HỘI PARALYMPIC VIỆT NAM
BẰNG KHEN


HIỆP HỘI PARALYMPIC VIỆT NAM
BẰNG KHEN


HIỆP HỘI PARALYMPIC VIỆT NAM
BẰNG KHEN
Nguyễn Thanh Tùng


ỦY BAN NHÂN DÂN TỈNH QUẢNG TRỊ
TẶNG
BẰNG KHEN
Pamela Wright


ỦY BAN NHÂN DÂN TỈNH QUẢNG TRỊ
TẶNG
BẰNG KHEN
Mẹ Tý Quảng


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Bà PAULINE OOSTERHOFF


CHỦ TỊCH ỦY BAN NHÂN DÂN TỈNH CAO BẰNG
TẶNG
BẰNG KHEN
Ông PHẠM DŨNG


TRƯỜNG TRUNG HỌC Y TẾ QUẢNG TRỊ
TẶNG
GIẤY KHEN
ÔNG ALBERT EDUARD STOKVIS

1.6 Added Value of MCNV

MCNV's comprehensive, multi-sectoral approach to health is considered a key strength. However, that alone would not distinguish it from other NGOs that may be larger and better resourced.

MCNV's unique strength is derived from its origin as a solidarity organisation and its history of over 40 years in one region. In MCNV, the values of solidarity and basic rights for all are deeply rooted. The idea that MCNV was born out of Dutch civil society, fed by citizens who channelled their feelings of solidarity into voluntary actions like building a hospital for war victims in Quang Tri is in the heart of the organization. Even today, the organization is supported by more than 8,000 Dutch private donors.

History has allowed MCNV to develop an in-depth contextual understanding of Vietnam and perhaps even more importantly, a position of trust with Vietnamese stakeholders that enable it to work more easily in sensitive areas than can other NGOs. Its relatively small size and flexible 'family' style of management also gives it unique advantages to adapt quickly to change and to develop very high quality partnerships.

Last but not least, the academic character of MCNV also distinguishes it from most other INGOs. The emphasis is laid on developing evidence-based approaches and development models rather than trying to reach as many people as possible. MCNV works closely with universities in both Vietnam and the Netherlands; research by master and medical students and PhD candidates helps MCNV to assess and refine its models and approaches and to keep the organization up-to-date and dynamic.

All in all, MCNV provides the development scene with a unique mix of scientifically based working concepts, deeply felt values on solidarity, and hands-on experience with the implementation of a wide range of comprehensive health and development programmes.

1.7 Strategic Alliances

In the past, MCNV has on occasion worked closely with other organizations to implement programmes in Vietnam and to access funding. For example, for many years MCNV collaborated with the Dutch Tuberculosis Society (KNCV) to support the development of the national tuberculosis control programme in Vietnam, and from 2006 to 2009, we implemented the community-managed livelihood and health programme in Khanh Hoa province, funded by the European Union, together with the Italian NGO, UCODEP. The collaboration with the universities, such as the Hanoi and Hue Medical Universities in Vietnam and the Vrije Universiteit's Athena Institute, has strengthened our work.

In 2011, MCNV started working in a new programme in alliance with two other organisations, Global Initiative on Psychiatry (GIP) focusing on mental health around the world, and World Granny, aiming to support the elderly and disadvantaged in developing countries. Together, the three organisations implement the programme called Transition in the East Alliance (TEA), in five countries, funded by the Netherlands Ministry of Foreign Affairs. MCNV is responsible for the overall programme, reporting to the Ministry, but implements the programme directly only in Vietnam and Laos. The programmes in Georgia, Sri Lanka and Tajikistan are implemented by the partners, GIP and WorldGranny, both based in the Netherlands. Working in alliances or coalitions with other organizations is a fruitful way to access new sources of funding and to broaden the expertise available to MCNV in SEA.

2. Context analysis

This chapter provides insight into the contexts of Vietnam, Laos and other countries in South East Asia in which MCNV operates (Vietnam and Laos) or plans to operate (eg Cambodia and Myanmar). Thailand is included in the first paragraph as an example of a more developed country in SEA.

2.1 Poverty and development in South-east Asia

In the past decade, Vietnam has transformed from a low- to a middle-income country, through a combination of enormously increased agricultural production for export and increased industrial production, much of which is a result of foreign companies making use of skilled workers earning low salaries. Both socio-economic indicators and health indicators have shown substantial improvement. Vietnam has already met the first Millennium Development Goal, to eradicate extreme poverty and hunger. However, together with the rise in development levels in both financial and health status, there is an increase in disparities within the country. Although the average numbers for major indicators of health and development show a better overall picture than before, still a great number of people are not better off or are even worse off as compared to the time that Vietnam was a low income country. In 1998, the share of income/expenditure of the poorest 10% of the population was 3.6% and the share of the richest 10% was 29.8%. Growth in economic activity did not lead to a decrease in inequality in the following years: in 2009 these figures were respectively 3.1% and 29.9%.

There are also quite large disparities in health status between regions, living standard quintiles, rural and urban areas and between the ethnic majority and the ethnic minorities. These disparities are revealed by indicators like infant mortality rate, maternal mortality ratio, child malnutrition and child mortality. The Northwest and Central Highlands of Vietnam are the most disadvantaged regions. The differences between these regions and the more socio-economically advantaged regions such as the South East and the Red River Delta are large (MoH/HPG, 2010). For example, in the Central Highlands the child malnutrition rate in 2009 was 28.5% compared to 16.4% in the South East. In the new strategic period, MCNV will continue to pay specific attention to reducing these disparities, by improving the lives of the marginalized groups. MCNV's mission is to contribute to equitable access to social determinants of health such as primary health care, education, housing and food security.

In Laos, where MCNV has been working 2005, it became clear it is possible to apply the development models used in Vietnam in the different context of Laos by adapting them to the different circumstances. MCNV successfully improved the health curricula of the School of Public Health in Savannakhet province, Laos, and successfully carried out a program on reproductive health in villages in that province. Although Laos is less developed than Vietnam and at present ranks among the least developed countries in the world, it has made significant progress in the last years. Literacy has improved and poverty has dropped substantially, but large disparities remain. Poverty is higher in remote and highland areas and the inequalities between income quintiles are huge, with the share of national economy of the lowest and highest quintiles being 7.6% and 45% (WHO-Laos, 2011).

MCNV will explore possibilities to further expand its programs to other neighbouring countries such as Cambodia and Myanmar during the coming years. Myanmar appears to be increasingly open to development assistance, due to recent changes in the country. Both Myanmar and Cambodia are among the countries with the lowest GDP per capita in the world. However, looking at growth rates in GDP, both countries are high on the list. The growth rate in GDP for Cambodia was estimated at 6.7% and for Myanmar at 5.5% in 2011 (CIA, 2011). As is the case in Vietnam and Laos, there are large inequalities in both countries. In Myanmar, people from rural areas (about 70% of the population) are benefiting to a lesser degree from the economic advancement than those in urban areas. There are highly vulnerable populations such as certain ethnic communities and migrant workers (WHO, 2008). In Cambodia, despite economic growth in recent years, in 2007 an estimated 31% of the population still lived below the poverty line (CIA, 2007). First, MCNV will first concentrate on expansion to Laos, which is covered by existing funding. Therefore, the further context analysis below concentrates on Vietnam and Laos, occasionally exploring the conditions in other areas of the SEA region as well.

Table 1: Population & Development

Indicator	Vietnam	Thailand	Laos	Cambodia	Myanmar
Population (est. July 2011)[1]	90,549,390	66,720,153	6,477,211	14,701,717	53,999,804
0-14 (%) (2011 est.)[1]	25.2	19.9	36.7	32.2	27.5
15-64 (%) (2011 est.) [1]	69.3	70.9	59.6	64.1	67.5
65 and over (%) (2011 est.) [1]	5.5	9.2	3.7	3.8	5
Urban population(%)(2010)[1]	30	34	33	20	34
GDP per capita in US $ in PPP terms (2011)[2]	2,682	7,260	2,048	1,739	1,020
HDI (value, rank) (2011)[2]	0.593 (128)	0.682 (103)	0.524(138)	0.523 (139)	0.483 (149)
Adult literacy (%)[1]	94 (2009)[1]	93.5 (2006)[3]	72.7(2005)[3]	77.6 (2008)[3]	91.9 (2008)[3]
Primary school enrolment (net)[3]	M: 96.5 F: 92.4 (2001)	M: 90.7 F: 89.4 (2009)	M: 84.1 F: 80.7 (2008)	M: 90.4 F: 86.7 (2008)	No data available

[1]CIA Factbook [2]UNDP Human Development Index [3]Global Health Observatory Data Repository, WHO

2.2 Social determinants of health

The WHO refers to social determinants of health as the conditions in which people are born, grow, live, work and age, including the health system. These conditions are shaped by the distribution of money, power and resources and all of them influence health status. The social determinants of health are the main sources of health inequities. MCNV recognizes the importance of several social determinants that contribute to better health and pays attention to them in its programmes.

Along with the socio-economic development of Vietnam, the health status of the country's inhabitants has improved significantly. Life expectancy has gone up while indicators such as infant mortality rate, under-5 mortality rate, maternal mortality ratio, and child malnutrition rate have, in general, decreased considerably. Again, there are disparities in the amount of the change between different groups.

These developments are creating an epidemiological transition in Vietnam. Although mortality and morbidity figures for communicable diseases such as tuberculosis and malaria have decreased, diarrhoea is still one of the leading causes of morbidity, while dengue and dengue haemorrhagic fever are increasingly important public health problems (WHO-Vietnam, 2011). At the same time, the figures for non-communicable diseases (NCD) such as diabetes, cardio-vascular diseases, cancer and mental illness are on the rise, creating a double burden of disease. It is estimated that NCD now account for 75% of mortality in Vietnam (WHO-NCD, 2011). On the one hand this shows a positive side of development: more people reach a higher age, which is accompanied by a higher rate of non-communicable diseases. On the other hand it also shows the down side of development: more prosperity comes with a different lifestyle and different nutrition, which affects people's health status. Furthermore, problems related to tobacco, alcohol and drug abuse, injuries due to violence and road accidents and mental disorders are increasingly important health issues (WHO-Vietnam, 2011). Environmental factors also play a role; greater urbanization and industrialization results in increased air and water pollution (MoH/HPG, 2010). As in many countries, HIV/AIDS is also a public health problem. HIV prevalence is still rising in Vietnam even though the incline is becoming less steep.

Although the country is in economic and epidemiological transition, and non communicable diseases are increasing, the most vulnerable groups are still suffering from poverty-related diseases. MCNV's mission is to support these vulnerable groups which are not benefiting from the socio-economic development, with programs targeted at healthy nutrition, malaria, TB, HIV/AIDS and the social determinants that influence health status such as education, water supply and livelihood.

Laos, the other country where MCNV is already working, is far less developed than Vietnam, which is clearly reflected by health indicators such as life expectancy, death rate, maternal mortality rate and infant mortality rate. The difference in development is also visible in the causes of morbidity and mortality. Whereas in Vietnam, NCD account for 75% of mortality, in Laos, they account for only 48% of all deaths (WHO-NCD, 2011). Especially malaria but also dengue and outbreaks of cholera and measles are considered important contributors to morbidity and mortality. Although maternal mortality rates as well as infant and child mortality ratios have fallen considerably during recent years, there are still major differences between Vietnam and Laos especially among ethnic minorities in the highland areas. HIV prevalence remains remarkably low in Laos compared to neighbouring countries.

In Vietnam and Laos the proportion of persons with disabilities is high compared to other countries in the region. In 2006, it was estimated that 8% of the population in Laos and 6.4% of the population in Vietnam was living with a disability (UNESCAP, 2009[1]). Disabled people form one of the vulnerable groups in MCNV's key programs.

Although Myanmar and Cambodia are both heading towards an epidemiological transition as well, communicable diseases still contribute heavily to the burden of disease. The figures on rates of TB and malaria illustrate this situation. In 2009, the prevalence of TB per 100,000 was 525 and 660 for Myanmar and Cambodia respectively. In 2008, the number of deaths due to malaria per 100,000 in Cambodia, 3.7, was comparable with the number in Laos but far higher than in Vietnam. In Myanmar, malaria was the cause of death for 34 of every 100,000 inhabitants in 2008 (WHO-GHODR, 2011).

Table 2: Health Indicators

Indicator	Vietnam		Laos	
Population growth rate (2011, estimated)[1]	1.077		1.684	
Birth rate (2011, estimated)[1]	17.07/1000		26.13/1000	
Death rate (2011, estimated)[1]	5.96/1000		8.13/1000	
Life expectancy at birth (2009)[2]	72		63	
Infant mortality rate per 1000[2]	19 (2010)	27 (2000)	42 (2010)	64 (2000)
Under 5 mortality rate per 1000[2]	23 (2010)	35 (2000)	54 (2010)	88 (2000)
Maternal mortality per 100,000 (est.)[2]	56 (2008)	91 (2000)	580 (2008)	790 (2000)
Prevalence of underweight (under 5) (%)[3]	20 ('03-'09)		37 ('03-'09)	
Prevalence of HIV (adults 15-49) (%)[2]	0.4 (2009)	0.2 (2000)	0.2 (2009)	<0.1 (2000)
Deaths due to malaria per 100,000[2]	0.1 (2008)		2.9 (2008)	
Prevalence of TB per 100,000[2]	333 (2009)	343 (2000)	131 (2009)	152 (2000)

[1]CIA factbook [2]Global Health Observatory Data Repository, WHO [3]Unicef Statistics

2.3 Health systems, staff and structures

In Vietnam, the health system is currently a mixed public-private provider system. It is organized into four different levels: national, provincial, district and commune, each level reporting to the level above. Since the decentralization in health care during the past decade, Vietnam has invested in developing the grassroots healthcare network. The commune level is the basis for primary health care; the health stations in communes provide primary care services. Important public health concerns such as TB and HIV/AIDS are supported in the context of targeted national health programmes (WHO-Vietnam, 2011).

Although the health system has improved, there are still serious problems to be dealt with. The health care services for people in remote areas and poor people remain inadequate (WHO-Vietnam, 2011). People in the most disadvantaged regions, the Northwest and Central Highlands, have to rely primarily on the commune health stations for curative care. However, the proportion of communes reaching national benchmark standards in these two regions is the lowest at 18.3% and 36.9% respectively. There is also an imbalance in the distribution of health workers, with a shortage of staff in rural and disadvantaged regions (MoH/HPG, 2010). The health insurance policy that was developed to protect the poor from catastrophic spending on health did increase their ability to access health services. However, it remains limited. In the past years, payment of health care costs through health insurance cards has declined (MoH/HPG, 2010). In addition, access to medicines is still a problem; the production and supply capacity remains weak and the prices are too high (WHO-Vietnam, 2011). Furthermore, the effectiveness of preventive medicine faces challenges. Knowledge, awareness and skills of the people on how to protect and improve their own health remain low. Education campaigns have not yet had enough impact and access to information, education and communication remains limited, especially in the remote areas (MoH/HPG, 2010). Educating, communicating and informing people are incorporated in most MCNV programmes.

The Lao health system is structured similarly to that of Vietnam. The health system is organized into the same four levels: central/national, provincial, district and village (called *zone* in Laos). The country is facing problems regarding both quantity and quality of human resources for health. Qualified staff is not equally distributed among geographic areas and health system levels, there is a shortage in health staff and underfunding of salaries and wages (WHO-Laos, 2011). There are major differences between urban/rural and rich/poor villages regarding access to health facilities. These and other factors lead to lower health service utilization especially among the rural poor. Rural households in the lowest quintile have an in-patient admission rate of 15.9 per 1.000 people, while this figure for urban households in the lowest and highest quintiles is 24.5 and 38.1, respectively (UNESCAP, 2009[2]).

2.4 Expected future developments

Developments in Vietnam and Laos in the coming years will affect the demand for health care and for related support programs. In Cambodia service provision is still fragmented under many INGOs. Myanmar is just starting to open up for international assistance. Both of these countries are also in transition and may be appropriate for MCNV programs, when suitable partners, programs and funding sources are identified.

2.4.1 Health issues

As noted above, the health issues in the remote areas where many MCNV programmes are implemented are still those related to poverty and underdevelopment. In the more developed urban areas, problems related to tobacco, alcohol and drug abuse, injuries due to violence and road accidents, and mental disorders are becoming increasingly important. Another concern for the future is climate change and environmental health in Vietnam. Development, industrialization and climate change influence each other and at the same time go hand in hand with a change in environmental health, introducing new risks.

Not only the risks that come with a change in lifestyle, but also environmental pollution, caused by rapid industrialization, urbanization and motorization has become a serious health issue in Vietnam (WHO, Representative Office Vietnam). Climate change may be causing a rise in temperature and a change in periodic rainfall, which will have an effect on seasonal drought and seasonal heavy rainfall. This could influence the emergence and development of the vectors of serious communicable diseases such as dengue and malaria (MoH/HPG, 2010). Besides that, climate change on a broader scope could cause a rise in sea level. If there were a one meter rise in sea level, Vietnam would be the most affected country in the world. The Mekong Delta region is at great risk: a rise in water level would displace millions of people from their homes (WHO, Representative Office Vietnam).

Laos has similar concerns for the future. Road accidents, mental health issues, and tobacco and alcohol consumption are also on the rise in Laos, while communicable diseases continue to be a problem. Furthermore, immunization rates are low compared to Vietnam, in the past years a cholera outbreak was reported and a substantial number of measles outbreaks occurred. More outbreaks can occur unless immunization coverage improves. Another concern is food insecurity, which is rated as alarming by international partners like the World Food Programme (WHO-Laos, 2011).

2.4.2 Public-private sector

Since the reform of Vietnam's health sector started in 1989, the private sector has grown steadily. In 2009, 8.9% of all hospitals nationwide were private (WHO-Vietnam, 2011). The development of the private sector has contributed to strengthening the health network of the country. However, once again this development contributes to inequality. Private facilities are primarily located in urban and economically advantaged areas; access to private facilities for the urban poor is difficult since the health insurance card does not cover private care. Furthermore, the economic benefits of working in the private sector have led to a shift of workers from the public to the private sector, resulting in problems with staff coverage in medical facilities (MoH/HPG, 2010).

The private sector is less developed in Laos up to now. The numbers of private pharmacies and clinics (mainly in urban areas) are expanding, however, and the first private hospitals are starting to operate. Similar problems as in Vietnam related to distribution of health care personnel are developing. Most of the senior public health personnel are directly or indirectly involved in private health practice after official working hours. (UNESCAP, 2009[2])

2.4.3 Civil society development

Civil society in Vietnam was limited before the *doi moi* reform period. The reform created a market orientated society which was more open to the private sector, foreign investments and development aid. An increasing number of international NGOs, smaller local NGOs, grass-roots organisations, mass organisations and community-based organisations have developed. On the whole, civil society is an important area of activity for citizens in Vietnam (Nørlund, 2007). Also within the programs of MCNV, groups of individuals have been able to organize themselves when they needed to join forces to fill their needs. However, participation of civil society in health policy making, discussion and health governance is still limited in Vietnam (MoH/HPG, 2010) and the position and acceptance of local organisations is still a sensitive issue.

Until recently civil society in Laos was also very limited. International NGOs and mass organisations have for a long time been the main representation of civil society. In April 2009, the Decree on Associations was signed which allowed central registration of local associations for the first time. More and more organizations are applying for registration but the development of civil society in Laos is still at a very early stage (ADB, 2011).

2.4.4 Other Development Organisations

A directory of development organizations lists 70,000 development organizations globally. A separate directory is available for every country. Among the four countries discussed above, around 500 to 600 organisations work in each country. Cambodia has the highest number, closely followed by Vietnam. In Laos and Myanmar, the number of active organisations is far lower, around 200 and 150, respectively (Directory of Development Organizations, 2011).

The aim of the directory is to promote interaction and active partnerships among key development organisations. Whenever MCNV is interested in initiating a program or considering submitting a project proposal, we check locally whether there is another organisation already involved in that area and whether MCNV can make a useful contribution based on its own special experience and expertise. In Vietnam, there are several thematic working groups that involve both NGOs and other agencies, where information is exchanged about who is working where on what. MCNV participates in the groups relevant for its work, chairing groups and meetings where appropriate. MCNV also collaborates with other organisations when it fits the needs of both partners.

2.5 Development cooperation in The Netherlands

The Government's new aid policy

After general elections in 2010, the new Dutch government announced major policy reforms and austerity measures in the public sector including development cooperation. The reform was partly a result of the public debate in which many doubts were expressed about the effectiveness of development co-operation and about the suitability of that use of Dutch finances in a time of economic hardship. The new Dutch development policy was set out by State Secretary Ben Knapen in a policy paper entitled "More Focus in Development Cooperation", issued in March 2011, which was adopted by Parliament in June 2011.

As the title of the policy paper suggests, the cornerstone of the new policy is to make development cooperation (in particular bilateral aid) more effective and efficient by focusing on fewer policy priorities and on fewer partner countries. In terms of government spending, the aid budget will be reduced from 0.8 to 0.7 percent of the GNP, a cut of 1.9 billion euro in the period 2011 – 2015. This budget cut will be equally shared among the various aid programmes: bilateral aid, multilateral aid and support to the private sector and NGOs.

The most important policy changes and shifts can be summarized as follows:

- A shift from social to economic development: greater emphasis on the importance of economic growth, trade and investment aimed at increasing developing countries' self-reliance, less emphasis on aid. Development efforts must serve as a catalyst for economic growth so that in the end, developing countries can help themselves and become self-reliant. The Dutch corporate sector can also deliver an important contribution to this challenge.
- Greater emphasis on the Dutch national interest, i.e. greater involvement of private business, knowledge centres and NGOs, thereby focusing on those areas where the Netherlands has a competitive advantage or added value and where it can make a real difference in comparison to other donor countries.
- A focus on four key policy priorities where the Netherlands has a clear comparative advantage: food security, water, sexual and reproductive health and rights, and security and the rule of law. These are issues where the Dutch private sector, civil society organisations and knowledge institutions are considered to be experienced and expert and can offer the most in terms of added value.
- Reduced spending on social development, in particular education and health. According to the Government, the Dutch added value in these sectors is limited and does not justify a continuation of investments on the same scale in the future.

- Reducing the number of bilateral partner countries from 33 to 15. The following countries will remain partner countries in the future: Afghanistan, Bangladesh, Benin, Burundi, Ethiopia, Ghana, Indonesia, Yemen, Kenya, Mali, Mozambique, Uganda, the Palestine Authority, Rwanda and Sudan. At present, about a quarter of the Dutch development budget is spent on bilateral aid. However, the Dutch government will continue to spend development funds in other countries through its contributions to multilateral organizations, such as the UN and the EU, through co-financing programmes with NGOs and through special centrally-managed funds. Three former partner countries will be temporarily assisted to make the transition from development cooperation to economic cooperation: Colombia, Vietnam and South-Africa.
- There will be less money available for co-financing organizations. For example, as a result of the general reduction of the aid budget, the funding of the MFS2 programme was cut by 12.5% (50 million Euro). The government intends to further scale down its financial support to NGOs in the future. Private aid organizations will have to increase their own contributions (for example, through donations from other sources) in order to continue to receive financial support from the aid budget. The Government expects that this approach will increase the support for development cooperation in society.

Trends in development funding in the Netherlands

As outlined above, fewer public funds will be available for development aid in the Netherlands in the coming years. Political changes, the financial crisis and budget deficits will put further pressure on the government to cut back public spending, which will also affect the development budget.

From the MCNV perspective, it is important that Vietnam is no longer on the list of partner countries of Dutch bilateral aid, but has been moved to a list of countries in transition, which are expected to become important business partners for the Netherlands. From the start of 2012, there will be no more bilateral funds for development assistance for Vietnam. However, other funds, such as the current MFS2 program, can be applied not only to Vietnam but also to other countries not on the partner list.

Apart from this new situation, it is also clear that social development, in particular through support of education and health programmes, is no longer an overall priority for the Ministry of Foreign Affairs. The Government has chosen for economic development as the cornerstone of its policy and a focus on four key policy priorities, although it does include one specific issue in the field of health, sexual and reproductive health and rights. This implies that support for other specific health (or health-related) issues will be limited.

It was still possible for MCNV to apply for funding through the co-financing programme for NGOs (MFS2) for the period 2011-2016, which has a much broader scope in terms of countries and topics eligible for funding and to receive that grant for the TEA programme. The future of the MFS approach is also uncertain; the next phase of support may take a quite different form, and it is difficult to predict what form that might be and which opportunities might be available to MCNV in the next programme.

Although on the one hand, the government is pulling back from development aid, we can see on the other hand a trend towards the privatization of aid. Private aid through NGOs, philanthropic foundations, charities, the corporate sector and individuals has been growing over the past years, not only in the Netherlands, but in the US and Europe as well. Recent changes in tax incentives have also significantly contributed to the rise of private giving in donor countries. As private actors increasingly contribute to development assistance, this will undoubtedly change the role of the Government.

For MCNV, it is important to have a closer look at theses emerging trends in order to develop pro-active policy responses and to identify potential sources of funding outside the Government programmes.

3. MCNV policy and strategic framework

3.1 Choices made in the past

During the years of the Vietnam War, MCNV staff, volunteers and sympathisers in The Netherlands collected money, medical instruments and medicines to alleviate the burden of suffering among the people of Vietnam. When the war ended in 1975, MCNV's activities shifted from emergency aid to rehabilitation and reconstruction. During the eighties, MCNV mainly provided technical and financial assistance to the developing national disease control programs – tuberculosis, malaria, Vitamin A deficiency and dengue.

In 1989, the Vietnamese government changed key aspects of its health care policy and decentralisation and privatisation were introduced in the health sector. At that time, MCNV started a Primary Health Care program in Quang Tri province in Central Vietnam. This program was set up in consortium with several other Dutch NGOs, each with its own expertise (eg agriculture, forestry, sanitation). After few years, the other NGOs left the program while MCNV continued its collaboration with the health services.

The health partners in Quang Tri asked that the program focus be shifted from the hospital to the community. In the mid-nineties, the PHC program evolved into a community managed health development (CMHD) program. Health was still the entry point, while income generating activities were added as poverty was increasingly identified as a main cause of ill health. The program became a comprehensive health program that contributed to community development, in line with the social determinants of health approach.

During this period MCNV built considerable experience with a participatory approach at different levels involving not only the health service but also other services and local authorities. A focus on gender was added to the program goals; selection of project activities was required to consider gender-related influences, needs and effects as well as health and poverty. Safe motherhood was added to the mix, as was capacity building through support to the training institutions that provide the health care workers in project areas; both were considered essential to improve the quality of health care.

In the late nineties, MCNV also added income generation activities to the Community Based Rehabilitation (CBR) program, again because of the link between the promotion of health and social inclusion for the disabled and their need to escape poverty. In this period the dengue and tuberculosis programs also investigated community-based approaches to prevention and to case-finding and holding, respectively, which were innovative in the national control programs.

A community managed health and livelihood development (CMHLD) program was established in 2004 as it became clearer that it is difficult to address poverty through the priorities set by first identifying health problems. The smaller scale income generation activities that had been introduced in the CBR and CMHD programs now became a main focus of the new program, although health development was still given an important place. This program led to partnerships outside the health sector.

The MCNV programme on infectious diseases, which had supported for decades the national control programmes for tuberculosis, malaria and dengue, was expanded in 2005 to include an HIV programme. This programme focused on prevention of mother-to-child transmission of HIV (PMTCT), and brought in from the disability and CMHD programmes the community based approach, to empower the women living with HIV. Income generation and organisational development were newer additions to the MCNV approach that were included also in this field. At the same time, the increased international and national support for TB, malaria and dengue led to a handing-over of the greater part of those project activities to the national agencies, leaving MCNV more resources to address the new health problems.

3.2 Lessons learnt 2006-2011 and the road ahead

The period 2006-2011 marked a very active period for MCNV with new experiences and experiments and new lessons learnt which are summarized below, as part of the basis of the new strategy.

3.2.1. Need for Comprehensive Approaches

One lesson that has become increasingly clear is that most health problems cannot be solved by a focus only on that health problem. This is comparable to the international recognition in recent years of the Social Determinants of Health, which include issues such as employment, education, and living context. We started with Community-managed Health Development (CMHD) which was an expansion of a primary health care programme to include other social determinants, and then applied the same approach to the Community Managed Health and Livelihood programme, the Community–based Rehabilitation Programme and the HIV Programme. In all of these programmes we could see that the health benefits were maximised when the beneficiaries received support in the areas of education, social inclusion and livelihood and when their empowerment was a key part of the programme.

Implications for the Strategy

We will continue to apply a comprehensive approach in most cases, because health cannot be isolated from the social and economic context.

3.2.2. The pivotal role of learning in the development of sustainable approaches

MCNV has increasingly appreciated the importance of explicit attention to learning as a basis for sustainable development. MCNV recognises that learning should not be an add-on activity in the programs and projects or within MCNV as an organization. Learning needs to be an integral part of the MCNV organization itself, it needs to characterize the relationships between MCNV and stakeholders and it needs to be an integral part of all project and program approaches MCNV develops and implements. We do recognise that local stakeholders will not adopt development approaches developed with MCNV, unless they become accustomed to reflecting on their practices and drawing lessons from their reflections, so they can continuously improve their work once MCNV support is discontinued. MCNV will face difficulties in developing learning relationships and learning oriented approaches with the partners, however, unless it is also a true learning organization.

Over the past several years, MCNV has already taken many steps to become a learning organization. Both in Amsterdam and in Vietnam, meetings and workshops provide a basis for exchange of ideas and experience among staff that contributes to shared learning. Especially with support from and collaboration with the Dutch organisation for NGOs, PSO, provided opportunities for MCNV staff to join workshops and other projects that focus on learning and social change and on how INGOs can improve their way of working.

Implications for the strategy

The objective to pay explicit attention to learning in the programmes and partnerships and in the organization itself will continue in the coming five year period.

3.2.3. Embedding research in MCNV as part of development

Key staff in MCNV have long research experience. Research has always been an explicitly key activity in, for example, the malaria, dengue and HIV programmes, as a way to provide evidence to influence policy and practice in disease control. Since MCNV developed close relationships with Dutch and Vietnamese universities, many studies have been done in collaboration with their staff and students. All of this research has contributed to the planning and evaluation of MCNV's programmes in the field. Since 2003, MCNV has accepted more than 55 students, including undergraduates in medicine and other disciplines and master students, notably from the International Public Health programme of the Athena Institute at the Vrije Universiteit Amsterdam. Two of MCNV's own staff earned PhDs in Amsterdam based on their work, and four more are presently working on the research for their PhD programmes. Both Master and PhD studies have resulted in a number of publications in international journals, sharing the results of our experience with the international scientific community (see MCNV website). All of these studies gave valuable insights into the areas of work of MCNV and in the effectiveness and challenges of approaches MCNV has developed.

Research continues to be important for MCNV, because we need to know how effective the approaches developed in the different programmes are, for different reasons:

- to adapt and change approaches while working so as to continuously improve
- to apply approaches in different contexts[2]
- to disseminate knowledge and contribute to an (inter) national body of knowledge
- to apply for funding for research programmes related to other MCNV activities that may also support interventions as part of the research.

Implications for the strategy
In the next few years, we will embed research more systematically in the organization and in planning. A structural approach towards (action) research will be established and followed for all MCNV programmes, to make sure we contribute to the body of knowledge about our line of work and to provide a strong evidence base for future programmes and proposals.

3.2.4. Changing Planning, Monitoring and Evaluation Practices

In the distant past, most of the MCNV support went to national programmes that had their own monitoring and evaluation systems. Since MCNV has focused more on the programmes in the provinces, we have had to develop planning, monitoring and evaluation systems that fit with each programme. We have used different approaches also in relation to different donors, including a wide application of the Logical Framework Approach (LFA). That was also the main instrument installed to monitor the organisational performance, based on tools and indicators developed in 2007.

Along with many other development organisations, MCNV has experienced deficiencies in the existing LFA-based systems and has started to expand on the type and range of instruments for monitoring and measuring the results of its programmes. In 2010 we recognised that the current planning, monitoring and evaluation (PM&E) system did not provide us sufficiently with the information we needed to lead quickly and efficiently to organisational learning and improvements in programmes. We therefore want to expand on the variety of PM&E approaches in both the MCNV organization itself and in projects and programs that we will maintain and develop in future.

Implications for the strategy
In this new strategic period we will develop a new PM&E system by which we will monitor the effectiveness of the work of MCNV in light of her own vision, strategy and core principles.

3.2.5. Strategic Alliances with other organisations

MCNV has often shared its work closely with other organisations. The support for the National Tuberculosis Control Programme that MCNV provided was closely linked to the technical expertise from the Netherlands Tuberculosis Foundation (KNCV). The CMHLD programme in Khanh Hoa was developed and implemented in collaboration with UCODEP, an Italian NGO. Most recently MCNV has joined with two other Dutch NGOs, World Granny and Global Initiative on Psychiatry to apply for a grant from the Dutch Government, under the MSF2 programme. This grant was awarded from 2011 to 2015, for a programme called Transition in the East, which is implemented in five countries (Georgia, Laos, Sri Lanka, Tajikistan and Vietnam). MCNV is the lead organisation in this alliance.

Implications for the strategy
Joining forces with other organisations can provide new opportunities for funding for existing and new programmes in the coming years. MCNV will invest in the maintenance of alliances we currently have, such as the TEA alliance and will continue to seek new relationships and alliances.

3.2.6. Development of effective and cost-effective approaches

All programmes of MCNV aspire to sustainability. This means that the development of skills and attitudes of local relevant stakeholders and the improvements of relationships between them take centre stage in MCNV programmes. As the less advantaged groups in society often suffer from structural exclusion by local relevant institutions, MCNV brings attention to their specific situations and

[2] (Elements of) MCNV approaches are adapted to the context of Laos, Georgia, Sri Lanka, and Tajikistan in the light of the Dutch funded MSF program (TEA). MCNV's Hanoi-based Knowledge Brokering Unit (KBU) uses approaches developed by MCNV in its own programmes and its consultancy work within Vietnam.

needs, and promotes their inclusion. By establishing local civil society organizations with them that can represent their requirements and specific needs and by linking them to existing institutions, MCNV works to improve chances for these needy and marginalized groups in society.

In all the projects and programs in which MCNV is involved, improving the living conditions of disadvantaged groups is the driving force and main source of inspiration. At the same time, MCNV balances between short-term goals and achievements and longer-term ones. The short-term goals concern the direct improvements in people's life and the longer term goals focus on the need to develop capacities of local stakeholders as well as the need to document and continuously improve on developed approaches and tools. Thus, MCNV does not lay emphasis on 'helping as many marginalized people as possible' in the short term. Rather, we look for the right balance between improving lives of the disadvantaged on the one hand and on the other, the development of approaches that can be adapted and adopted by existing individuals and institutions in society that may lie beyond the boundaries of the MCNV programmes. More recently MCNV has also begun to look into the costs of interventions to help its beneficiaries, in the search for the most efficient way to set up and run effective programmes. This aspect of cost in relation to effect will increasingly be a focus in the coming years.

Implications for the strategy
In the coming five year period, MCNV will pay closer attention to the requirements for the partners to attain independence from MCNV's financial and technical support and to the documentation, description and analysis of the model approaches to promote their replication where it is suitable.

3.2.7. Organizational Changes

The contextual change from Vietnam from a low-income to a middle-income country will have a great effect on the work of MCNV in Vietnam. Funding within Europe for development programmes in SEA is decreasing. MCNV's private donor pool is shrinking and it is difficult to recruit new donors; the young prefer to donate to other countries, especially in Africa, while donations to Asia in general are perceived and less and less necessary. New developments in fundraising both in Vietnam and in the Netherlands are discussed below in Section 4.5.

Every development organisation has as its ultimate goal to make itself redundant, working towards either the resolution of the problems it addresses or to handing over the continued implementation of necessary programmes to the local partners, institutions and services. MCNV also works towards that aim, and has for the past several years been building capacity among the staff and strengthening the structure of the organisation with the aim of making the Vietnam offices more independent. During the period of this strategic plan, we expect that the MCNV offices will be able to operate independently in programme management, and to a great extent in sourcing funding for their work.

There is consensus that MCNV Vietnam is a mature organization that can stand on its own feet, with its own board, its own country and regional strategies and its own diversified funding sources. There is still an important role for the office in Amsterdam, as it will still have added advantage as a bridge between Western donor funding and Vietnam. At present the office in Amsterdam is in a good position to expand the 'MCNV brand' to other countries in the region, starting with Laos and perhaps then Cambodia and/or Myanmar, depending also on potential funding sources.

MCNV Vietnam was started with total support from the donors in the Netherlands, and later partly supported by project funding and now the KBU (see below). It is however not the plan that this route will be taken in other countries. What is planned is to work with the partners and colleagues in each new country to ensure that the local office can generate its own funds and manage its own programmes mostly independently of Amsterdam.

When we consider establishing a new MCNV base in a new country, we will take into account the following aspects:

- We need to have capacity to access diversified funding preferably from within each country or in the region.
- We need to have good partners in each case, both in partner countries and in the Netherlands, including links with professional sources including universities and other training and research institutions.

- We expect to continue to offer services from the MCNV office in the Netherlands to the offices in partner countries (and vice versa) that fit with what the partner organisations need. This can for example focus on access to European and Dutch sources of finances that may not be available to the offices in the partner countries or it could be the coaching to reach the necessary standard of quality in programme and financial management.
- MCNV explores possible new areas based on local analysis.
- New countries: what we do not want is that MCNV offices in new places expect to be supported by MCNV; they will be supported and encouraged to source funding for their programmes themselves, making a start on the 'franchise approach' based on MCNV branding.

This decentralised approach means that MCNV will share its name with a local office/organisation, and agree on quality criteria, instruments, knowledge, and technical assistance. The collaboration should enable gain access to European institutional funding sources, but the local office should be independent, not dependent on funds from MCNV NL to survive. The local office using MCNV's name would only be possible if the new office meets our standards and conditions. This would be a win-win situation. The new structure will determine which services still need to be offered in NL. When we need a presence in each country, we will work out with local staff and partners a local strategic plan and business plan that fits with the local needs and priorities as well as opportunities for financial support. Most likely, extension of ISO certification to local offices will form part of the road map. At the same time we do not want to lose our added value of solidarity and attention to those who are marginalised and need to be empowered to gain access to health and development in their own country. This factor will influence selection of countries, partners and programmes. Ultimately we could see a network of affiliated offices using MCNV frameworks for development programmes with local staff in charge and able to secure sufficient local and international funding.

The first example in the coming years will be in Laos. MCNV wants to be represented in Laos, but does not plan to use Dutch donor funds to start an office there. The TEA program is setting up its programme in Laos and will provide financial security for an office there for the coming few years. We plan to support that office and staff to help them to access diversified funding to reach stability as a local MCNV-Laos office. The concept is that we select staff that is capable of working with us to source additional funding in the coming period, while TEA still supports the office and its programme. For example, we see the need for work on reproductive health in Laos, so we will look for sources for institutional funding on that topic, and add that it to work of the TEA office. Step by step we can build an official MCNV office in Laos, one that is accustomed from the start to find funding to support itself. The same approach would apply in another new country, such as Cambodia or Myanmar.

Implications for the strategy

In the coming five years, we will pave the way to the transformation of MCNV in Vietnam as it is now to an independent organization that relates to MCNV Amsterdam organization as an equal and strategic partner. We will formulate the role of the Amsterdam office in terms of required support the office needs to provide, according to milestones identified in the operational plans. MCNV as the lead organisation is concerned in protecting its name and the quality associated with it, controlling the concept and the quality, securing the know-how, at the same time as it plays the linking role among the decentralised offices. This process will not however eliminate the special relationship between the Dutch donors and the staff and programmes in Vietnam; as long as there are people wishing to contribute to the work in Vietnam, the office in Amsterdam has a role in transferring that support. The Amsterdam office also has a role in obtaining support for and supporting offices in other SEA countries.

3.2.8. Social Enterprise and the KBU

One route to increased self-sufficiency in Vietnam was decided in the last strategic period; that was to embrace opportunities that come with 'social entrepreneurship', that is, with enterprises that earn money while maintaining a social responsibility. Since 2010 we have started to experiment with this approach, starting with the Knowledge Brokering Unit (KBU). Up to the end of 2012 this unit is still a part of MCNV Vietnam; at that time it is expected to become an independent enterprise. The most appropriate legal form will be found to ensure both the independence of the KBU and its link to MCNV.

In this form, it is important both that the KBU continues its close link with MCNV and makes use of our experience and approaches, and that it earns enough money to support itself (including office and related costs) as well as contributing a certain amount to MCNV's project funding. Employees of MCNV can work part-time on KBU assignments without losing their status as MCNV employees, but KBU can also hire consultants outside of MCNV when needed to fulfil the requirements of a mission. Making use of MCNV's networks to form strategic alliances to enable KBU to undertake a wider range of missions is encouraged.

Up to now, the demand for KBU services from a variety of clients (Asian Development Bank, Luxemburg Development, IFAD and the Ministry of Health in Vietnam, among others) shows that there is demand for technical assistance that can at least help to cover office and staff costs, while expanding the application of MCNV approaches in other programmes, and generating income for MCNV. The development during the coming four years of the Asian Centre for Innovative Livelihood and Microfinance, a part of the TEA programme, is expected to parallel the development of the KBU and the two may be linked in one independent enterprise by the end of the TEA programme in 2016. It is also planned that other potential social enterprises, that can serve social ends while generating income for activities of MCNV, will be investigated and developed in the coming years. Part of the investment for such enterprises will come from a fund now being generated by the KBU, while other investors in Vietnam or the Netherlands.

Implications for Strategy

Social enterprises are an appropriate way to combine sustainability and addressing the social determinants of health in the rising economies of SEA. They cannot be the responsibility of the Dutch Board of MCNV, however, since they will fall under the laws of the country they are in. In the near future, when there are independent social enterprises in Vietnam, a new Vietnamese Board will be established, that will include a representative of MCNV but comprise mainly Vietnamese members who represent both the social enterprises that have been established and other stakeholders such as institutional partners. The KBU will continue to receive support to develop and become independent, while maintaining its link with MCNV to ensure both a continued input of expertise from the field and a continued source of income for MCNV from the KBU activities.

4. Framework for 2012 – 2016 and beyond

4.1 Policy and programme themes

The overall goals for MCNV have not changed, but the strategies to achieve them and the organisational structures required to support the strategies are undergoing change.

The programmes that have been running for the few years will be continued in the new period. MCNV is also open to developing new programmes according to the needs and opportunities that arise, as long as they fit with the overall objectives of the organisation.

MCNV recognises the importance of the social determinants of health, as defined by the WHO. This means that we expect all of our programmes to contribute to the aim of influencing those factors, although each programme may make a greater contribution to one or the other of those aims. To repeat those aims:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age;
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – locally and nationally;
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

The main programmes of MCNV are the community managed health development (CMHD), the community managed health and livelihood development (CMHLD) (the two are similar in approach in content, but the second includes a greater emphasis on livelihood), the community-based rehabilitation and inclusive education (CBR/IE) and the community-based HIV programme. The Transition in the East programme contributes to the CMHD, CMHLD and CBR programmes. The HIV programme may expand from its base up to now on prevention of mother-to-child transmission, to address related issues, such as harm reduction among the drug users driving the HIV epidemic. We also plan a broader focus on improving reproductive health (care) for disadvantaged men and women, in Laos as well as the remote areas of Vietnam. The CMHD programme now includes components on rehabilitation and on nutrition, and these continue to be key areas needing attention to improve health in most project areas.

The infectious disease programmes (malaria and tuberculosis) have a larger focus on disease control but we still hope to develop a new community-based tuberculosis control programme in collaboration with KNCV. One of the additional smaller programmes is the Support to Training Institutions (STI), which contributes to better health and social services, and will continue to be a focus also within the TEA programme. Another is the Focus on Women programme, which has been flexible in the past as to topic (ranging from reproductive health to shelters for victims of domestic violence to pilot model microcredit programmes for women) and should continue to be flexible to respond to new needs and opportunities, and to available funding.

4.2 Cross-cutting themes

All of the programmes address the first SDOH issue through a combination of improved health care, improved access to education, and improved economic situation using microfinance instruments. The second SDOH issue is less widely addressed but using our examples of better and more inclusive programmes we can use lobby and advocacy to influence the holders of power to change policy and/or practice to provide better services and situations for our beneficiaries. The third SDOH issue reflects our focus on documentation, research and dissemination of research results.

During the coming years, the cross-cutting themes that were in effect during the previous strategy period continue to be important, such as gender, and using a participatory approach in the programs. However, areas that will receive extra attention are lobby and advocacy and networking within partner countries and outside them, especially within the region of South East Asia.

Within the TEA programme, in effect up to 2015, lobby and advocacy are explicitly planned, but may take different forms in different contexts and countries. Also in the other programmes, we will be

writing up results of documentation of successful models, as evidence for policy documents based on successful field work. As part of advocacy and lobby, we will continue to support exchange visits and study visits to field sites within and between countries to demonstrate successful approaches and models to partners and to policy-makers.

Based not only on our history but also our expertise and experience, health will remain the umbrella that covers other issues among the wider social determinants of health. We will continue to focus on community development, and on self-help groups that are empowered to do more for their own development, while at the same time working with institutional partners to ensure that they can work with and support the self-help groups, always within the local social and legal framework.

Empowerment is the key for the marginalised groups who need to gain access to the economic and other developments that are moving so quickly in the countries of South East Asia. Public health remains our focus, but when opportunities become available for funding, for partnerships or alliances, we will want to expand to include issues we have not yet addressed, such as environmental change. Change in the environment are partly an effect of community activities (consider destruction of forests and development of enterprises) but also have an effect on community health, for example, when climate changes affect vectors of communicable diseases such as cholera and dengue. Environmental pollution that often accompanies development would be an appropriate target for which to seek funding, as would the effects of floods and droughts on the communities that are already lagging behind in development.

4.3 Geographical Focus

Up to now MCNV has worked mainly in Vietnam, and since 2005 also in Laos. Our statutes suggest that we are mandated to work anywhere in South East Asia. As new opportunities arise in other SEA countries such as Cambodia and Myanmar, we can consider efforts to access funding for other countries, perhaps in collaboration with other agencies that complement our strengths. We have already implemented a research project in both Vietnam and Indonesia on HIV. The TEA programme was originally planned to be implemented in Cambodia as well. Technical assistance can be offered anywhere, not only in the other TEA countries (Sri Lanka, Tajikistan and Georgia). The learning from all those experiences can contribute to the programmes in existing project areas.

5. Realisation of policy and strategy

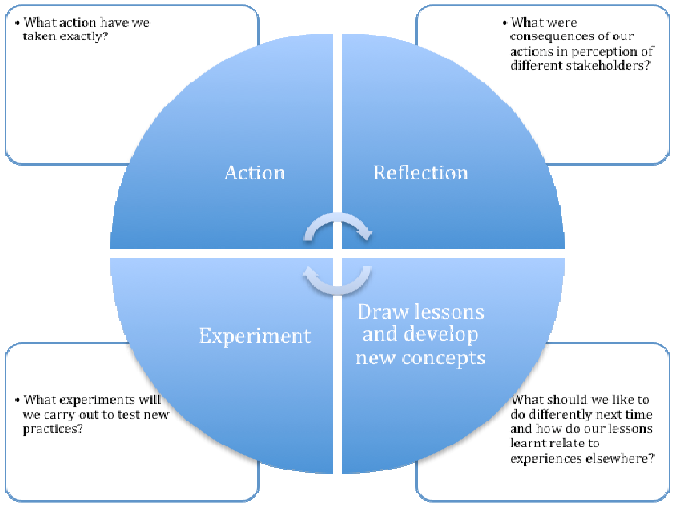
The realisation and implementation of the policy and strategies described in the previous sections will be possible through strengthening of the learning in the organisation (4.1), more attention to research and its role in MCNV's learning and other activities (4.2), continued collaboration with partners in Vietnam and Laos (4.3), improved quality of its internal organisation (Section 4.4) a solid financial base (Section 4.5), and a communication, PR and publicity plan (Section 4.6).

5.1 Learning Organisation

5.1.1 Vision on learning

MCNV fosters a learning culture, in the sense that all staff members are encouraged to take time and feel invited to reflect on program practices, draw lessons and adapt policies and actions accordingly, and to share the results of reflection with each other. A learning culture is the sense that all staff members of MCNV perceive reflection and drawing lessons from it as *'the way we do things around here'*.

Learning in the MCNV organization is practice-oriented and concrete; it should only be called learning if it involves improvement of practice, not only knowledge gained. MCNV follows through the stages of the learning cycle at different levels as pictured in the figure below. At the field level, that means interchange with the local counterparts wherever they are located, village to district to province; we expect interchanges among staff members of different MCNV teams and with relevant stakeholders. At national and international level, interchanges will take place among the different MCNV country offices, ministries, national institutions, other INGOs and international development agencies, and any other appropriate stakeholders.



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5.2. Development of evidence based models and learning

5.2.1 Evidence based models

MCNV tries to bring about major social change by fighting poverty and community and family stigma and discrimination, and by helping people marginalised by AIDS, severe disabilities and/or chronic diseases. That makes MCNV a social innovator. We recognise that we cannot and should not develop models in a mechanistic and static sense, but in the sense of models as approaches and tools that serve as points of reference, that need to be adapted continuously to changing contexts, perspectives and realities. MCNV can only develop such dynamic models if we organise and facilitate systematic reflection and research with a focus on our own practice, continuously adapting the models on the basis of lessons learnt. The approaches and results need to be described and analysed using

recognised methods, including research methods, to assess the strong and weak points of the way we work and propose that others should work.

In the coming strategic period MCNV envisages the further development of at least five models:

- Community Managed Health Development (CMHD),
- Community Managed Health Development and Livelihood (CMHDL),
- Self-help groups to tackle HIV AIDS,
- Community Based Rehabilitation (CBR) including Early Detection & Early Intervention (ED/EI),
- Inclusive Education (IE),
- Capacity development of NGOs and CBOs.

5.2.2 Learning and applied research

As described above, experience is reflected upon and then turned into concepts, which in turn guide new experiments and actions. Working this way within the MCNV programmes together with stakeholders is of great value, but is not enough. To develop innovative and effective models, we have to screen the environment for relevant new ideas, concepts and tools. In MCNV, we broaden our horizons constantly by:

- Facilitating staff and stakeholders' participation in local, national and regional seminars, conferences, workshops and training sessions on newly developed approaches, tools and techniques;
- Organizing exchange visits for staff to visit programs where different approaches are being practiced;
- Creating opportunities for reflection and learning together with partners and groups of partners, from which both MCNV and partners can learn;
- Facilitating students to study our approaches, encouraging them to challenge our assumptions and working practices, and ensuring that conclusions are shared within MCNV at least, and that recommendations are integrated into MCNV practice.
- Encouraging staff to carry out action research while experimenting with new approaches;
- Encouraging monitoring-in-learning approaches and program evaluation as routine practice;
- Promoting staff to learn in formal and informal situations including pursuit of higher degrees in master or PhD programmes.

5.2.3 Research ethics

Research has been a practice within MCNV for many years but in recent years increasing links with universities and international research centres have led us to pay more attention to requirements of international research. One of these issues is ethics. MCNV does try to obtain appropriate ethical approval for the research it does with its partners, in spite of the lack of good structures for such approval in Vietnam. One area to be developed with our research plans is to develop more standardised practices for ethical review and approval, especially when vulnerable people and children are involved. Increasingly, international sponsors of research programmes will require such policies to be in place and publication of our results in international journals will also require it.

5.2.4 Cost-effectiveness

Although many models and strategies are applied by development organisations, rather few of them are assessed from the point of view of the cost in relation to the results. Through the Evidence Based Management and Planning project, MCNV supported several studies on the costs of different components of health care in Vietnam and has a good network among the few specialists in health economics in Vietnam, which includes one MCNV staff member. MCNV has developed several models to address specific development problems, but if we expect these to be replicated by local government or by other organisations, we need to be able to tell them what it costs to prepare and implement the programmes. Through this work, with the assistance of our staff member trained in health economics and our network, we plan to expand the study of costs in our programmes, not only of health interventions but also interventions in capacity building, and relate them to the results of the programmes. The results of the cost and effectiveness analyses will be shared with MCNV's donors both private and institutional, and with other development organisations.

5.3 Partnerships

5.3.1 Partnership Policies

MCNV is not a direct implementer of development programs; we collaborate with implementing partners, who are expected to have ownership over the programs. MCNV provides guidance to these partners for effective implementation, and provides financial assistance. The lessons learned need to be shared throughout the chain of the partners as well as among MCNV staff and other partners.

MCNV often has historical ties with its partners. Since its establishment in 1968, MCNV has worked with the Government of Vietnam, assisting the authorities at different levels to carry out their tasks to improve health and health care. In addition to working with the Ministry of Health, provincial authorities (People's Committees, Departments of Education, Health, and Social Affairs & Invalids) and local authorities at district, commune and village levels, MCNV works with mass organisations such as Women's Unions, Farmers Unions, and Youth Unions to transfer its support to the people. In CMHD and CMHLD program areas, the collaboration extends to local groups of community members who become involved by participating in committees and support groups to plan and implement development activities.

In the past years, MCNV has started working with local NGOs and local civil society organisations, such as the associations for disabled people, associations of village health workers and self-help groups for women living with HIV. The establishment of civil society organisations is new in Vietnam, and MCNV is interested to facilitate that process when it is necessary. In Vietnam, where the government authorities do have and implement pro-poor policies, MCNV will support establishment of civil society organisations to complement the gaps and facilitate activities that are not being done by the local authorities. In Laos and other countries where MCNV is considering working, the situation is similar, with NGOs not yet widely represented, but with openings where international support can promote the strengthening of civil society to address unmet needs of vulnerable people.

5.3.2 International Advisory Committee

Since 2006, MCNV has planned biannual conferences involving advisers from high levels of the different sectors where MCNV is active, in Vietnam and Laos. This International Advisory Committee has met three times in the past six years. The members have been experts in the fields of health, economic and social development from government, non-government and international agencies, who are not directly involved in the work of MCNV and its partners. The experts are working at high levels in their respective agencies, and can share information on relevant changes in the context and in government policies. Together, they form a pool of experts, among whom MCNV makes a selection for each meeting. Up to now, the IAC has met with representatives of the Dutch Board to exchange ideas about the priorities and directions of MCNV's work. The way of working during the coming strategy period may change as the structure of the organisation evolves to meet the changing needs in Vietnam and other countries in SEA. In the TEA programme, each of the five participating countries has a local Advisory Committee, to contribute to the planning and directions of the programme.

The importance of involving local experts in an advisory role for MCNV programmes and planning is recognised, but the optimal way of implementing that function will be reviewed and adjusted in the coming period.

5.4 Quality of the organisation

The quality of the organisation is reflected in three areas: client satisfaction, transparency, and learning. MCNV updates its understanding of 'a quality organisation' and 'quality management' through seminars and workshops organised by PARTOS, PSO and other Dutch agencies relevant for NGO performance. MCNV Amsterdam staff that participate in these training courses ensure that their newly learnt information is shared with the teams in Vietnam.

MCNV is a member of the branch organisation PARTOS in the Netherlands, which represents Dutch NGOs in dialogue with other stakeholders including the Government. Through this membership, MCNV commits itself to the quality criteria and the Code of Conduct formulated by PARTOS. Through membership of PARTOS, MCNV also commits itself to the regulations set by the Commission Wijffels. MCNV has received the CBF certificate since 1998 and ISO certification since 2009. MCNV aims to maintain these quality certificates in the coming years.

The information in the following section provides insight into MCNV's plan to improve the quality of the organisation during the period 2012-2016.

5.4.1 Accountability and client satisfaction

According to MCNV, the quality of the organisation is reflected in the ability to satisfy the needs and demands of our clients. MCNV has four groups of clients:

- final beneficiaries (primary clients),
- partner organisations in Vietnam and Laos,
- private donors,
- institutional donors.

Client satisfaction is achieved through accountability. MCNV wishes to satisfy the needs and demands of all clients, while the first priority goes to satisfying the final beneficiaries.

It is important to MCNV to know how the primary clients value quality of the assistance, and we would like to have primary clients involved in the process of improving quality of our services. To achieve this, MCNV will need to re-assess and adapt its monitoring and evaluation systems. An instrument will be developed by 2013 to assess how our primary clients value our work, perhaps by outsourcing this activity to a local consultant to obtain more objective data. The results of assessments of client satisfaction will be an important input for MCNV and the other partners in the chain to learn how well they are performing and how they can best improve their programs to make the planned contributions to the quality of life of the beneficiaries. Client satisfaction is also part of our ISO certificate, which up to now is based only on the work in the Netherlands but is planned for Vietnam in the coming years.

MCNV values highly the accountability between partners and MCNV. We expect our partners to be transparent and accountable, and likewise we have to endeavour to be transparent and accountable to them. Documents such as the financial manual and the anti-corruption policy help to make this work in practice.

Private donors in The Netherlands are satisfied when they know their money is used well. MCNV writes annual reports, which explain how our funding was used to achieve the objectives of the organisation and its programmes. The annual trips organised for private donors to visit MCNV programs in the field contribute to accountability towards them. Online evaluations are carried out annually as well among private donors, to receive their comments and suggestions for improvements. These assessment tools will continue to be used in the coming years.

MCNV also considers institutional donors as partners in development, with whom MCNV shares common goals. Institutional donors have funding, while MCNV has a network in Vietnam and Laos. MCNV and institutional donors can work together towards their common goals, and aim to see the results and impact of their investments. Timely reporting by MCNV, according to guidelines, with explanations on how the money was used and how it contributed towards achievement of objectives are all part of being accountable, which satisfies donors. Results up to now in this area have been very good and we will strive to maintain that quality in the coming years.

5.4.2. Transparent organisation and structure

Transparency is reflected in clear descriptions of the organisational structure, good governance and openness on policies, narrative and financial results. The organisational structure of MCNV illustrates a gradual transfer of responsibilities from the Amsterdam office to the offices in Vietnam. This fits with the commitment to develop capacity of the Vietnamese-based staff and their partners. The organisational structure will change as MCNV moves to the network or federation style of relation with offices in other countries, as described in Section 3.2.7 above.

MCNV regularly receives consultants and auditors who evaluate the quality of programs and the internal organisation. In the following policy period, MCNV will organise and implement internal audits.

MCNV will update and improve its processes and procedures, described in the MCNV Quality Manual, which needs to be more accessible to the staff. In 2012, MCNV will decide on how regular internal audits will take place, who will be involved in this process, and the methodology to be used. All offices will have access to the supporting documents. MCNV will improve transparency of yearly work plans and short six months progress reports by making them more SMART (specific, measurable, attainable, relevant, time-bound) to facilitate monitoring of working towards results and will continue to work on capacity building of its staff to produce SMARTer plans and progress reports.

The evidence for the efficiency of MCNV's organisational structure comes from the documented descriptions of processes and control mechanisms, regular reflection on functioning of staff, systematic field visits, and the link between policy, work plans and implementation. MCNV will monitor the efficiency of the organisation throughout the policy period. In the Amsterdam office, MCNV staff have worked in a self-steering team, accountable to a Board of volunteers, and that has functioned well in the past years. However, because MCNV has grown significantly and because most of the growth is in Vietnam and Laos, it has become more complicated for the Board to monitor all developments in MCNV. Therefore the Board proposed in 2011 that it should be replaced by a paid managing Director and a voluntary Non-executive Board early in this policy period. This plan will be implemented in the first part of 2012.

The quality of the organisation is also reflected in the highly qualified staff and Board members, the clear description of responsibilities and procedures, the policies regarding promotion of expertise among staff through education and other capacity-building strategies, which are all part of human resource management. The quality of human resource management is reflected by a description of the need for personnel, policies on recruitment of temporary and long term contracted staff, staff performance reviews, personal professional development plans, interns and volunteers, and on prospects for career opportunities and education plans for the staff.

During the policy period, MCNV will continue to improve the quality of its human resource management. Performance reviews and personal development plans for Amsterdam-based personnel will be developed and implemented, as has already been done for Vietnam-based staff. MCNV will further develop its procedures regarding recruitment, including interns and volunteers, as described in the manual. When existing staff cannot carry out special extra tasks, outsourcing is the first solution, before hiring new staff.

5.5 Finances and fundraising

This section focuses on financial administration and management practice, and policies on institutional and private fundraising.

5.5.1 Financial administration and management

The heart of MCNV's financial management is the yearly budget cycle and monitoring of the realisation of the budget, based on financial and narrative progress reports.

All of the basic project administration work takes place in Vietnam. The Amsterdam office consolidates the administration and has a control function; it checks requests for transfer, and carries out post-checks for each project. In Vietnam, an external accountant/auditor verifies the quality of MCNV's project administration through random checks. MCNV adheres to principles of good governance. Annual accounts of MCNV offices in Vietnam and Amsterdam are checked by auditors from internationally recognised firms. For financial security, MCNV has also set aside a continuity fund, to be used in case of serious problems, to pay outstanding commitments to staff and programs.

All criteria and procedures for the financial administration are described in the office manual. Good financial management is reflected in effective integration of the administrative systems of the four offices, efficient design of administration systems that are capable of generating management information, correct procedures for cash management and authorisation of expenditures and money transfers. A long-term budget is updated annually to reflect strategic choices.

MCNV aims to achieve more results with less money from our donors. Partner organisations are facilitated to learn to raise funds for their programs instead of depending only on MCNV financing. Several partners in community development, especially local organisations such as the Women's Union or the Disabled People's Organisations, have established revolving funds for which MCNV provided the seed money. After the first cycle, these revolving funds do not appear in the financial administration of MCNV. The improvements made possible through those funds are a result of MCNV's work with the partners. In the coming years we expect to increase this kind of funding, that share more of the responsibility with the partner, and MCNV will find a way to make these results visible in our reporting.

All of this work has been increasingly transferred to the MCNV offices in Vietnam and we expect that by the end of this policy period, those offices will be able to manage the programmes and a large share of the institutional and private funding (both locally generated and received from outside sources including the Netherlands) by themselves, keeping a relation with the Amsterdam office but not a dependency on it.

5.5.2 Institutional funding

Over the past years, MCNV has enjoyed an increase in the funds available for the programs, because of diverse grants from institutional donors. This has resulted in a higher staffing level in Vietnam, while the number of staff in the Amsterdam office was stable.

Table 3 illustrates that the income from institutional donors has stabilised or decreased since 2010. It also shows the fte of MCNV staff.

Institutional donors often require a certain minimum contribution from the organisation submitting a proposal which is usually in the range of 25%; because of its diversity of funding and especially because of the pool of private donors. MCNV has always been able to satisfy this requirement with no problems. We expect this situation to continue in the coming five years.

Table 3: Overview of financial developments and predictions 2010– 2016

	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	Figures x 1.000 Euro						
Total income							
Income generated by MCNV private donors	826	810	781	743	727	711	700
Income generated by institutional donors	1.510	2.020	1.366	1.200	1.500	1.500	1.200
Income generated by KBU/consulting	100	120	130	140	80	100	100
Overview of institutional donors							
Dutch Ministry of Foreign Affairs (MFS+RNE)	516	1.797	1.266	900	900	900	
Others (PSO and other funds)1	250	173	100				
Number of institutional donors committed	4	3	3	1	1	1	0
Net Income from KBU	20	30	22	30	30	30	
Total staff in fte							
Staff in Amsterdam office	3.9	4.8	5	5	5	5	5
Expatriate staff in Vietnam offices	2.5	2.5	3	3.5	2.5	1.5	1
Local staff in Vietnam offices	34	32	32	30	28	28	25
Local staff in Laos office	0	0	5	5	5	5	5
Local staff in other country offices	0	0	0	2	2	4	4

1: other potential donors include EU, ADB, and research funders including EU; applications are annual

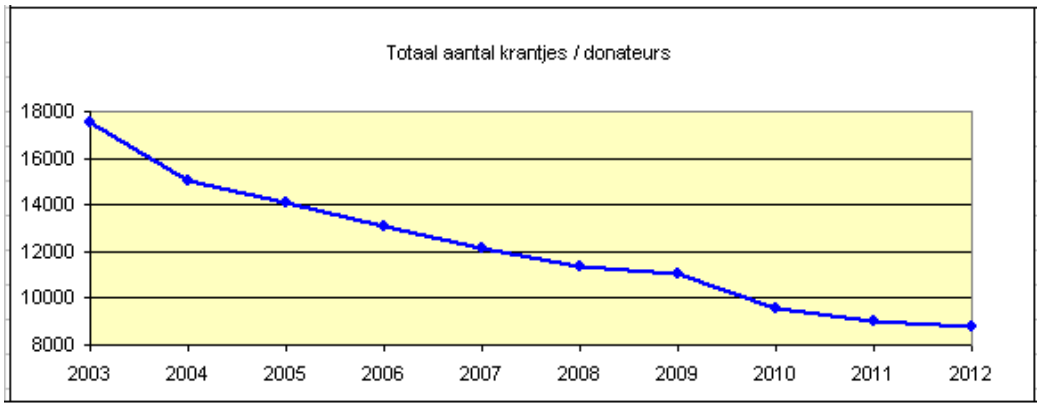
MCNV is prepared for a reduction in funding from its current institutional donors (Dutch Ministry of Foreign Affairs and PSO). MCNV has already started to apply to other sources of income that do not depend on the DAC list. These include the World Bank and Asian Development Bank programs, for which organisations have to tender, and European Union for which organisations have to compete. In Vietnam, MCNV can work with other NGO such as KNCV to access American agencies such as USAID and National Institutes of Health. MCNV expects that new contracts will replace the current portfolio of institutional donor contracts. In the search for institutional donors, MCNV will focus on funds that also grant the MCNV running costs of the proposed programs. MCNV will also pay more attention to helping our partners find funding from (inter)national sources so that they become less dependent on MCNV funding.

An additional source of funding is expected to come from social enterprise development in the coming years, including the already functioning Knowledge Brokering Unit that provides technical assistance to programmes financed by other sources but contributes to MCNV income in Vietnam.

5.5.3 Private funding

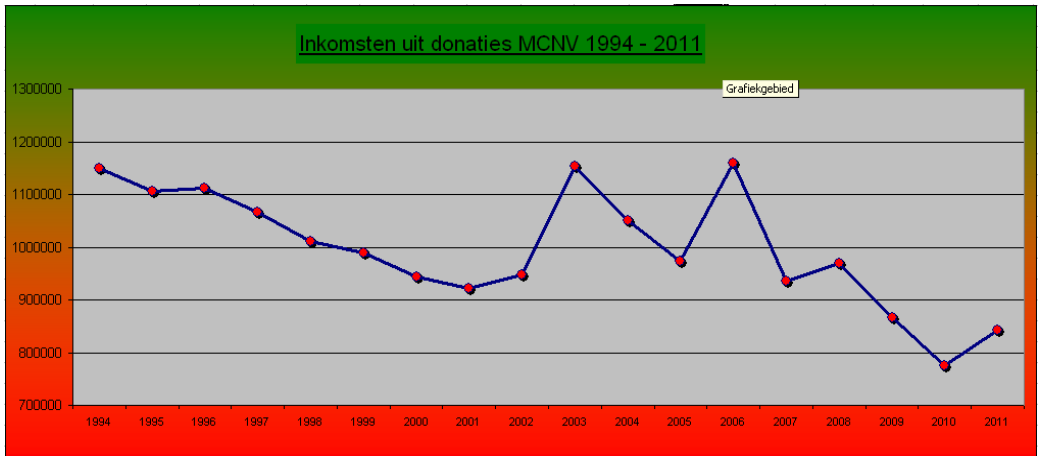
At the end of 2003, 17,500 private donors supported MCNV's activities on regular basis. Most of the private donors have been supporting MCNV since the late sixties or early seventies, when Vietnam was still at war and the peak number of donors was 66,000. These private donors have been very loyal to Vietnam and were committed to its reconstruction after the war. Many of the private donors are now senior citizens, and their number had decreased to about 9,500 by the end of 2010 (Figure 1).

Figure 1: Number of private donors MCNV 2003 – 2010



MCNV's income through private donors is expected to decrease by an average of 5% per year over the coming years, based on recent history (Figure 2), which still leaves several hundred thousand Euro to be spent in an effective, appropriate way in Vietnam and SEA during the coming five years.

Figure 2: Income from private donors, MCNV, 1994 – 2011



In the coming years MCNV will continue to focus on fundraising (FR) activities in the Netherlands, but also more and more in Vietnam. We will reduce time and money spent on FR in the Netherlands and increase the efforts in Vietnam. In 2010, we organized two events in Vietnam, a high tea for business women in Hanoi and gala dinner in Dong Ha, Quang Tri. Both events were successful in the impact of the event: amounts of money raised, numbers of guests, local publicity, awareness and dedication of guests, as well as capacity building of MCNV staff and the partners in Hanoi and Dong Ha. In 2012 we will organize two events in Vietnam, one in Phu Yen province in June and one later in the year in Ben Tre province. In future years we expect to have at least one FR event in Vietnam each year. Once the MCNV office is well established in Laos, we will plan an event in that country.

The declining income from private donors means increased efforts for fundraising in general. As mentioned above, we expect a loss of 5% per year from donors in the Netherlands. In 2010, the decline was 9%, because of the economic crisis and a higher number of donors passing away.

To upgrade private donor income, we have to invest more in fundraising activities in The Netherlands and in Vietnam. MCNV continues to organise trips to Vietnam, and possibly to Laos in the near future, for private donors, which gives them the opportunity to see what MCNV does with their donations, which has been found to increase their loyalty to the organisation (and generates income for MCNV at the same time).

Focus points for communication and private fundraising in 2012-2016

- Image building in Vietnam
- More information about Laos
- Publications and other PR instruments in Vietnam and The Netherlands: articles, research papers, reports and training guides, films, music…
- More initiatives from Vietnam, conducted by Vietnamese staff in different offices
- Strengthen media network in Vietnam
- Upgrade and maintain MCNV donors in the Netherlands
- Major donor approach.

Highlight 2012-2016: Major Donor Approach

In 2011, MCNV started a new approach for private funding in the Netherlands. In this special program that we will develop during the coming years, we focus on private donors or groups of donors who feel close to one of the following activities:

1. Empowerment of children with disability,
2. Mother and child care in Laos,
3. Unique Sunflowers in their struggle against HIV/AIDS.

These activities will be presented to potential major donors with the request to 'adopt' the activity financially for a fixed number of years.

The choice for these three activities emerged from discussions first with a number of staff and Board members, then discussions with ten MCNV donors who feel very close to MCNV, who have been donating already for a long time (some from the start of MCNV in 1968) and who have a wide network. We talked about MCNV's history, their dedication, their interest in specific activities, the things they feel proud of. After summarizing all this information, we came up with three strong activities that could be accepted for long-term support by private donors. In 2012 we will continue to identify potential major donors. This programme is a new approach and needs to be developed carefully over time to 'arrive' at the right persons or groups of persons who are willing and able to promise their dedication for the coming years. Important in this approach is that we make use of all kind of networks, including the network of MCNV Board members and staff. We expect to have the first concrete major donor at the end of 2012.

FR approach in coming years:

- Communication and fundraising staff in Vietnam and Netherlands work more closely together.
- Responsibilities are clear within the team and the Board.
- Describe and plan activities in the strategic plan 2012-2016.

Needed skills:

- Insight and information about activities in different places
- Qualified in communication
- Qualified in fundraising
- Writing skills
- Networking skills
- Event management skills.

5.6 Communication, Public Relations and Publicity

Realisation of MCNV strategies also depends on communication, public relations (PR) and publicity.

External communication is important to MCNV for two main reasons. The first is because the statutes of MCNV ask us to provide information about Vietnam and other South East Asian countries to the public in The Netherlands. Secondly, external communication is essential for fundraising activities, to maintain our good relationships with donors and other stakeholders. Especially for the Major Donor programme described above, we need to be sure of good communication.

Internal communication is also important for MCNV to have a smoothly run organisation, in which staff share the same values, goals and approaches towards health and development. MCNV has made efforts in several ways to improve its internal communication, also in relation to being a learning organisation as described above. Staff meetings, workshops and joint study tours within the South East Asian region and in the Netherlands all help to share information. Reports and other papers are made available to the staff on intranet and regular use is made of Dropbox to share documents among offices and of Skype to communicate across continents. We will continue to pay attention to internal communication and increasingly use the advances in information technology, such as Skype and Dropbox, to facilitate the communication among the different countries and offices.

Public relations and publicity are also used to improve external communication. The purpose of communication is to create support for Vietnam and Laos and for MCNV's work there, among the wider public in The Netherlands. MCNV makes presentations to specific groups such as schools and Rotary Clubs about Vietnam and SEA and how we provide assistance there and continues to publish a quarterly newsletter and distributes this among its private donors. The website will continue to be updated regularly.

To consolidate the PR and publicity functions between the Amsterdam and Vietnam offices, MCNV now has a Public Relations Unit consisting of the Amsterdam PR officer and two Vietnamese staff with specific training in public relations through their local post-graduate studies. This unit works together to prepare a publicity plan each year, and then to implement the plan in cooperation with the staff in all four offices. This collaboration is increasingly important as fundraising in Vietnam and the region becomes more important in the coming years.

In Vietnam, the Hanoi Representative Office regularly represents MCNV at key meetings for INGOs and on themes relevant to MCNV's work, through the local Working Groups and Health Support Group, and at conferences or meetings on specific topics related to MCNV's work and interests.

Dissemination of products from the programmes is an increasingly important publicity tool. Examples include the setting up of the exhibition on the HIV programme for International AIDS Day in December 2011, and the showing of the film on the lives of drug users, also in relation to AIDS Day but on a further two occasions. In the Netherlands, MCNV participated in an HIV Day at DGIS organised around the work of the University of Amsterdam, with whom MCNV had collaborated on HIV research. Presentations at scientific meetings, such as the two HIV meetings in Busan, Korea and in Indonesia in 2011, provide opportunities to present MCNV results to an international audience. Combined with the increased attention to research and documentation, increased material for publicity will become available in the coming years, especially as the four staff complete their PhD programmes and publish their results.

MCNV's 45th anniversary will be celebrated in 2013; this occasion will be used to expand the fundraising activities in Vietnam as well as to showcase MCNV's work in the region up to that time.

Annex 1 Documents

MCNV documents:

Public Report MCNV 2008-2009

Booklet remarks made during symposium on partnership, Quang Tri, 2004

Communication and fundraising plan 2012 – 2016, Amsterdam

MCNV manual, Amsterdam, updated version 2011

Strategy workshop report, Amsterdam, April 2004

Strategy workshop report, Hanoi, April 2006

Strategy workshop report with Amsterdam staff, September 2006

Strategy workshop report with MCNV Board, September 2006

Strategy discussions by Vietnam-based staff in Hanoi, Quang Tri and Khanh Hoa offices, July & August 2011

Staff meeting in Vietnam, Van Chai, November 2007

Staff meeting in Vietnam, Ha Long, November 2009

MT meeting in Hanoi, April 2010

Staff meeting in Vietnam, Hoi An, November 2010

MT meeting in Amsterdam, September 2010

MT meeting in Hanoi, April 2011

Board Workshop in Amsterdam, September 2011

External documents:

Asian development bank, Civil Society Briefs: Lao People's Democratic Republic, October 2011.

Central Intelligence Agency, The World Factbook, 2007: https://www.cia.gov/library/publications/the-world-factbook/geos/cb.html

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Directory of Development Organizations, Volume II, 2011: www.devdir.org

Ministry of Health (MoH) / Health Partnership Group (HPG), Joint Annual Health Review 2010; Vietnam's Health System on the Threshold of the Five-year Plan 2011-2015, Hanoi, December 2010.

Nørlund, I., civil society in Vietnam, 2007.

UNESCAP[1], Disability at a Glance; a profile of 36 Countries and Areas in Asia and the Pacific, 2009.

UNESCAP[2], Promoting Sustainable Strategies to Improve Access to Health Care in the Asian and Pacific Region, 2009.

WHO, Country cooperation strategy Myanmar 2008-2011, February 2008.

WHO, Global Health Observatory Data Repository, 2011.

WHO, Lao PDR Country Health Profile, 2011.

WHO, Non Communicable Disease Country Profiles, 2011.

WHO, Representative Office Vietnam, health sector development: www.wpro.who.int/vietnam/sites/dhs/.

WHO, Viet-Nam Country Health Profile, 2011

PSO manual: M&E of capacity building, policy and instruments, The Hague, March 2004

Quality criteria for PARTOS member organisations, Amsterdam, 2005

Annex 2 Fundraising Matrix of Activities from 2012

The following matrix presents an overview of the fundraising activities, linked to the core values, targets and means to measure them. The information in the matrix shows the added value of each activity and the feasibility off all the planned activities. The matrix is updated annually based on the annual plans.

Special activities					
Activity	**Core Value**	**Objective**	**Target Group**	**Measurement**	**Capacity**
Major Donor Programme	Solidarity, awareness, cooperation, responsibility	fundraising	Potential Major Donor	Result of donations	Fundraising staff member, Consultant, Board members
Fundraising event in Phu Yen, summer/autumn 2012	Solidarity, awareness, cooperation, shared responsibility	Publicity & fundraising, upgrade MCNV reputation	Business men, partners, other NGOs, VN politicians, Dutch Embassy	Amount of guests, result of donations, pr in VN,	PR Staff Vietnam and Amsterdam, CNV staff Vietnam
Party 'MCNV friends', Hue 22 March 2012	Solidarity, friendship	fundraising	MCNV friends, staff members, partners	Amount of guests, result of donations	PR staff Vietnam
Fundraising event for business woman in Ben Tre, autumn 2012	Solidarity, awareness, cooperation, shared responsibility	Publicity & fundraising, upgrade MCNV reputation	Business women, partners, other NGOs, VN politicians, Dutch Embassy	Amount of guests, result of donations, pr in VN,	PR Staff Vietnam and Amsterdam,
Donor meeting in Amsterdam, autumn 2012	Solidarity, friendship	Publicity & fundraising, upgrade MCNV reputation	MCNV friends, donor, MCNV staff, partners	Amount of guests, appreciation of the meeting by (donor)client satisfaction interview	PR Staff Amsterdam
Viewing documentary 'With or Without' April 20th Amsterdam	Transparency, bring activities closer to donor	Publicity, more knowledge about HIV/aids activities in Vietnam	MCNV friends, donor, MCNV staff and board members, partners	Amount of guests, appreciation of the meeting by (donor)client satisfaction interview	PR Staff Amsterdam

Regular activities					
Activity	**Core Value**	**Objective**	**Target Group**	**Measurement**	**Capacity**
keeping & upgrading private donor	Solidarity	Fundraising	Non-active donors	Response in contact and money	Staff Amsterdam, staff Vietnam
Subprojects & sponsoring	Cooperation and solidarity	Fundraising	Special funds, private companies	Estimated budget € 80.000	Staff Amsterdam, Staff Vietnam
Donor tour (April 2012)	Solidarity	strengthen support base for MCNV's work; keep donors' bond to MCNV close	donors	Income from donation, satisfaction, insight and information on how donor money is spent	Staff Amsterdam & Staff Vietnam
Different items in our web shop	Solidarity	Fundraising	Dutch people, donors and others	Income, potential new donor and information	Staff Amsterdam, staff Vietnam
MCNV flyers	Transparency, bring activities closer to donors and potential donors	Communication & fundraising	Donors, private and institutional	Response in contacts and money	PR Staff
MCNV newspaper (quarterly)	Transparency, bring activities closer to donors	Communication & fundraising	Donors	Response, amount of money from direct marketing campaigns	PR Staff Amsterdam, offices in Vietnam
Design item to sell in Vietnam	Solidarity	Communication & fundraising	Donors, partners, others	Income from selling, potential new donors and information	PR staff Vietnam and Amsterdam
Information package online for primary schools	Transfer knowledge	Communication	Children, teachers and parents	Response	Staff Amsterdam
Calendar 2013	Solidarity	Communication & fundraising	Donors & others	Cover costs of production through sales	Staff Amsterdam
Travel brochure, PDF online	Knowledge about Vietnam	Communication and brand awareness	Travellers to Vietnam	Numbers of requests	PR staff Amsterdam
Presentations	Cooperation, knowledge exchange	Brand awareness, fundraising	Secondary schools, students from universities	responses	PR Staff Amsterdam
Advertisements	Solidarity, shared responsibility	Brand awareness, PR & fundraising	MCNV look-a-likes, all others who are interested in VN and MCNV	Responses, income	PR Staff Amsterdam