

Building capacity for implementation of the framework convention for tobacco control in Vietnam: lessons for developing countries

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SUMMARY

Effective implementation of the WHO international Framework Convention on Tobacco Control (FCTC) is the key to controlling the tobacco epidemic. Within countries, strong national tobacco control capacity is the primary determinant for successful implementation of the FCTC. This case study of tobacco control policy describes the experience of building national tobacco control capacity in Vietnam under the Reduce Smoking in Vietnam Partnership project within a national capacity-building framework. In the Vietnam experience, four components of tobacco control capacity emerged as especially important

to achieve 'quality' outputs and measurable outcomes at the implementation level: (i) organizational structure/infrastructure; (ii) leadership and expertise; (iii) partnerships and networks and (iv) data and evidence from research. The experience gained in this project helps in adapting our tobacco control capacity-building model, and the lessons that emerged from this country case study can provide guidance to global funders, tobacco control technical assistance providers and nations as governments endeavor to meet their commitment to the FCTC.

Key words: capacity building; tobacco control; Asia; developing countries

INTRODUCTION

Vietnam, a developing country with over 84 million people, carries a heavy burden from tobacco. As more Framework Convention on Tobacco Control (FCTC) guidelines are established by the Conference of Parties, and as the target dates for full compliance to some of these guidelines draw near, it is imperative to critically assess national capacity-building efforts for FCTC implementation. Within countries, strong national tobacco control capacity is one of the primary determinants for the successful implementation of these FCTC measures (Stillman *et al.*, 2003; Wipfli

et al., 2004; Stillman *et al.*, 2006a,b; Lin, 2010). This case study describes the experience of building national tobacco control capacity in Vietnam under the Reduce Smoking in Vietnam Partnership (RSVP) project and provides a real-world model based on a conceptual framework of capacity building.

BACKGROUND

Smoking rates among adult males in Vietnam are considered one of the highest in the world, with a prevalence estimate of 47.4%. (Global

Adult Tobacco Survey (GATS); Vietnam Fact Sheet, 2010) Smoking rates among adult females remain low (1.4%), but increasing globalization and rising incomes bring concerns that smoking uptake among Vietnamese women will increase (Minh *et al.*, 2006). Exposure to secondhand smoke is significant, ranging from 55.3 to 67.7% among youth ages 13–15 years and 49–67.6% among adults [Minh *et al.*, 2006; Global Youth Tobacco Survey (GYTS) Fact Sheet, 2007; Global Adult Tobacco Survey (GATS) Vietnam Fact Sheet, 2010]. The impact of smoking on national health is becoming increasingly evident as the cost to the government is estimated at US\$75 million and includes tobacco-related diseases such as lung cancer, heart disease and chronic obstructive pulmonary disease (Kinh *et al.*, 2006). Moreover, the amount spent on tobacco was equal to 28% of the total expenditure for food in a year (Le TT, 2010).

Like China and Japan, Vietnam has a sizable government-owned local tobacco industry (Pham and Nguyen, 2002). Thus, a key issue in tobacco control in Vietnam is the competing interests within the government to protect national revenues generated by the tobacco industry and to protect the public from the mounting health and economic costs of tobacco-related diseases through policies and programs.

Vietnam's ratification of the international WHO FCTC provided a major opportunity to build on the country's initial tobacco control efforts. In recognition, the Atlantic Philanthropies provided grant funding to the Johns Hopkins Bloomberg School of Public Health (JHSPH) Institute for Global Tobacco Control (IGTC) to partner with the Vietnam Committee for Smoking or Health (VINACOSH) partnership of the Ministry of Health (MOH) for a capacity-building project. The grant supported capacity building for tobacco control policy development and research for relevant ministries and tobacco control agencies (both public and private) within Vietnam. Through VINACOSH, the project coordinated tobacco control projects and training among a wide range of stakeholders, including the ministries of Health, Finance, Trade, Education, Information and Culture, Industry and Transportation, as well as organizations such as the Women's Union, Trade Union, Farmers' Union and health and medical associations.

Capacity building framework

There exists an extensive literature with diverse models of capacity building and development (Honadle, 1981; Goodman, 2000; Elliott, 2002; LaFond *et al.*, 2002; Horton *et al.*, 2003; Germann and Wilson, 2004; Gruen *et al.*, 2008). *Building Blocks for Tobacco Control: A Handbook* (2004) from the World Health Organization (WHO) also contains a comprehensive review of capacity-building components specifically related to tobacco control. The specific tobacco control capacity framework that guided the RSVP project was developed by Wipfli *et al.* (2004). While this framework does not contain any unique characteristics of capacity building, it has been used successfully to help guide and evaluate the implementation of projects in a number of different countries and settings (Stillman *et al.*, 2005, 2006a,b; Stillman, 2010). This framework was developed from a large-scale evaluation project that demonstrated the relationship between capacity measures and lowering of tobacco consumption (Stillman *et al.*, 2003). In this framework, national tobacco control capacity is defined as 'the indigenous capability of countries to develop and deliver comprehensive, multi-sectoral action to reduce tobacco use', reflected in three essential components of the national environment: (i) infrastructure; (ii) expertise and leadership and (iii) empirical

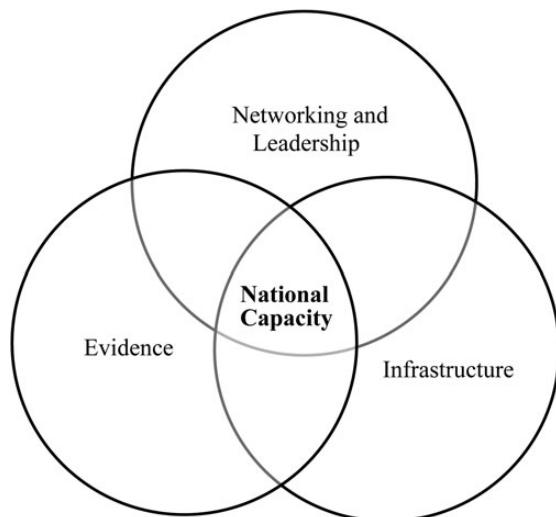


Fig. 1: Original conceptual model for National Tobacco Control Capacity. Source: Wipfli *et al.* (2004).

evidence (Figure 1). This case study explains how experience and evidence helped to expand and adapt this framework to Vietnam, and how the lessons learned can be useful to other countries.

VINACOSH structure and project objectives

VINACOSH is a multi-sectoral agency that provides tobacco control for the country; funding, however, has been obtained from non-government sources. Even before the establishment of the RSVP, VINACOSH was engaged in new regulations and decrees aimed at developing smoke-free public places and implementing tax increase, and warning labels that comply with the obligations set out in the FCTC. Figure 2 highlights the responsibilities and activities under the RSVP project. Since VINACOSH was already engaged in many activities, RSVP focused on (i) expanding the capacity and capability of VINACOSH through increasing the number of staff dedicated to tobacco control; (ii) increasing training to coordinate and facilitate tobacco control more effectively; (iii) strengthening and developing the evidence base in Vietnam and (iv) building the systems and guidelines for consistent monitoring, evaluation and research specifically reporting on FCTC tobacco control policies and interventions. Progress on these objectives was to be assessed by VINACOSH's ability to demonstrate the following outcomes: (i) promote evidence-based policy, legislation and effective interventions, with a special focus on the national tobacco control law; (ii) improve training and education on tobacco control issues and methods; (iii) develop relationships at national and international levels to improve effectiveness and enhance likelihood of sustainability of efforts and (iv) coordinate information-sharing and activities across national and international collaborators.

METHODS

This section describes the data collected for the case study. As this was a capacity-building project, a formative assessment (mid-term) and a summative assessment (final) were conducted. The formative assessment allowed for the process of implementation to be better-understood and corrective actions taken to improve functioning of the project. The summative assessment

provided information to understand what activities were actually implemented at the end of the project.

Data collection

This case study used numerous sources, including both qualitative and quantitative data. Process data were collected throughout the entire project and included plans of action, meeting summaries, agendas of workshops and research reports. In addition, an external consultant conducted formal mid-term and final assessments, consisting of formative (process) and summative (outcome) measures. The formative assessment reviewed program design and implementation, the work process, the dynamics of the partnerships involved and the project's strengths—particularly the 'value-added' component—and weaknesses within the broader context of tobacco control in Vietnam. At the end of the project, in-depth interviews were conducted to document how much RSVP contributed towards enhancing government capacity for tobacco control, addressing the target objectives of the project and increasing the likelihood of political support for a national tobacco control law consistent with the WHO FCTC. This assessment included 22 in-depth interviews with project staff, partners, researchers, WHO representatives in Vietnam and other stakeholders.

Project implementation by year

The focus of the original project was to link research to evidence-based policy development, with policy enforcement as the main strategy for capacity building in Vietnam. Because of the comprehensive nature of the FCTC's policy objectives, year 1 of the project emphasized (i) convening the various stakeholders to formalize VINACOSH and strengthen the relationships with the various Ministries which play key roles in FCTC-related policy development and implementation; (ii) creating a Project Advisory Group composed of Vietnam-based international and bilateral organizations active in tobacco control and (iii) recruiting RSVP project staff for VINACOSH. Workshops were held to help develop a method to track progress in FCTC implementation and to inform local stakeholders about the evidence behind the interventions promoted by the FCTC, especially raising tobacco taxes and mandating effective health

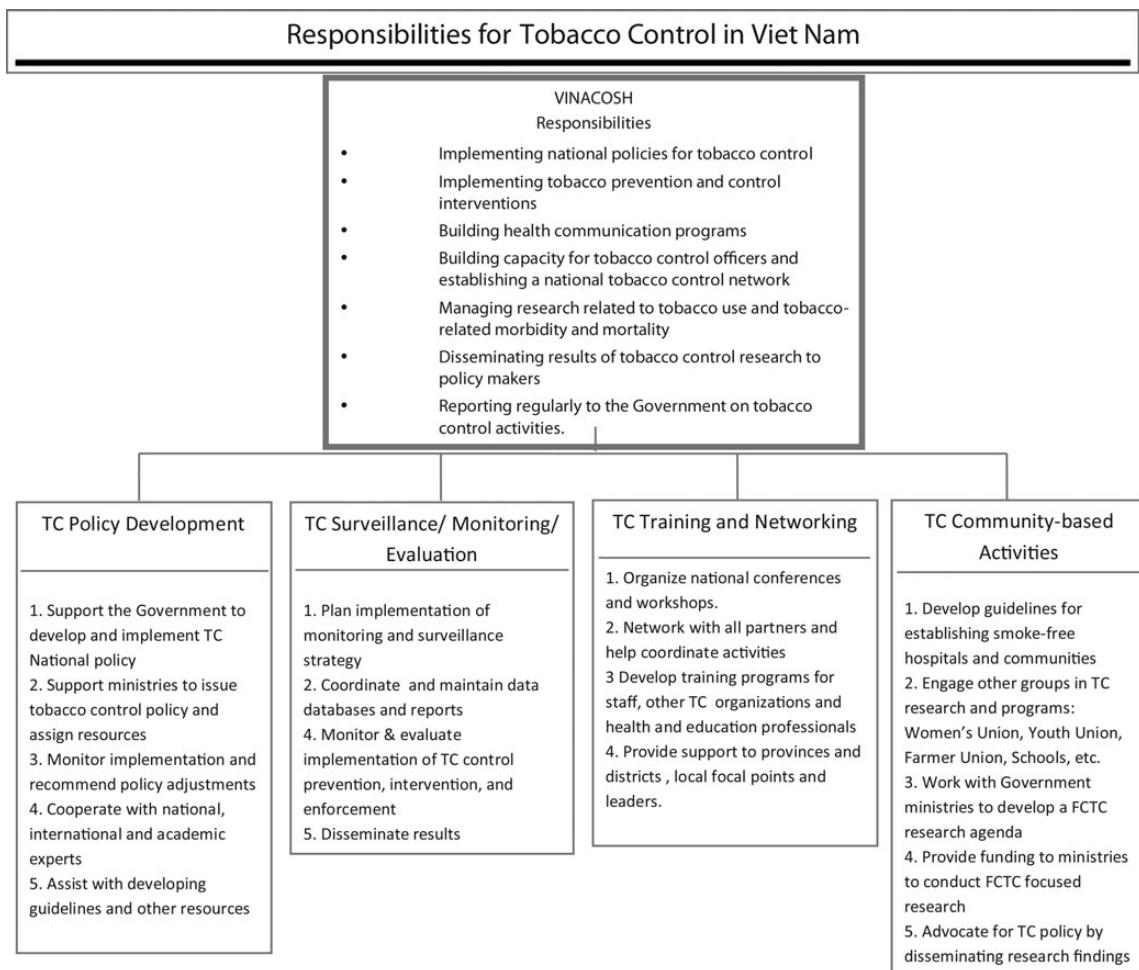


Fig. 2: Responsibilities and activities for tobacco control in Viet Nam.

warnings. Likewise, an advocacy plan to support these measures and an initial proposal outlining a national tobacco control law were drafted with the help of external consultants. The external consultants were selected by VINACOSH and included tobacco control experts from Thailand, WHO representatives from nearby countries and other experts on South-East Asia tobacco control.

In year 2, a plan of work was developed that linked activities and budget lines to the objectives and indicators and defined areas of responsibility for the various stakeholders and partners. The plan outlined a project management structure and method of work that established responsibilities, operating procedures and accountabilities. In the technical arena, a baseline

assessment of the state of national tobacco control policies and implementation gaps was commissioned. In addition, unanticipated opportunities for strong tobacco control were being developed in Vietnam with the beginning of discussions regarding a national tobacco control law. This event necessitated some change of focus within the project to work toward supporting this important policy initiative. The project focused on helping to inform the initial draft of the proposed national tobacco control law by inviting technical assistance from a legal consultant as well as involving other regional partners with the necessary experience to help inform the Vietnamese stakeholders. In the research arena, in anticipation of smoke-free policy development, a situational analysis of hospitals' smoke-

free policies and practices was also conducted. A tobacco control-monitoring tool was developed to assist Vietnam in fulfilling its reporting requirement to the FCTC Secretariat.

In year 3, RSVP, through VINACOSH, started channeling policy development and implementation resources towards the various Ministries, in keeping with the Prime Minister's Directive 12 (2007) (Prime Minister Directive No. 12/2007/ CT-TTg regulates public smoking; retail sale of tobacco products and tobacco advertising, promotion and sponsorship. The Prime Minister Directive also sets forth future plans for increasing the size of health warnings on tobacco product packaging.), which called for the government to intensify tobacco control efforts 'in line with the international convention on anti-smoking.' Workshops were conducted with the various Ministries to educate and inform them of the evidence behind key tobacco control interventions and to train them in strategic planning and implementation. Technical assistance was provided to relevant Ministries for FCTC data collection. Selected potential tobacco control leaders were supported to attend the tobacco control leadership program at JHSPH. Challenges encountered by the VINACOSH in engaging the Ministries at a sufficiently high level to influence each Ministry's likelihood to adopt tobacco-related policies were addressed when the MOH officially designated VINACOSH as a separate office for tobacco control with its own stamp (government seal) and budget. This provided VINACOSH, which was previously perceived as a subordinate entity, with the official mandate and fiscal autonomy to convene its Ministerial partners.

In years 4 and 5, the project extended its training workshops and leadership outreach to members of the National Assembly. Technical assistance focused primarily on (i) expanding smoke-free policy adoption in hospitals by developing implementation guidelines and improving policy compliance through monitoring [A Directive (12/2007/CT_TTg) was signed on 12 May 2007 with the aim of strengthening tobacco control measures to reduce the harm of smoking. In December 2007 the Prime Minister signed a decision to 'intensify the move into line with international convention on anti-smoking'. Smoking is completely banned in educational facilities, government offices, indoor workplaces, public transport where there is a fire risk. A 2008 Directive bans smoking in medical establishments,

including hospitals.]; (ii) assessing research capacity through a systematic mapping exercise and a national tobacco control research conference; (iii) strengthening and advocating to include the draft tobacco control law on the National Assembly agenda and (iv) developing policy enforcement mechanisms within various ministries to guide FCTC implementation. VINACOSH supported those Ministries demonstrating significant progress in implementing tobacco control policies—such as the Ministries of Education and Training (MOET) and Culture, Sports and Tourism (MOCST)—with training workshops and leadership outreach, consistent with Prime Minister's Directive 1315/QD-TTg (2009), which called for the implementation of FCTC guidelines by all government Ministries. (The 2009 Decision No. 1315/QD-TTg on the Ratification of the plan for the Implementation of the FCTC calls for strict implementation of existing regulations and sets forth plans for future action to implement the Framework Convention on Tobacco Control. The Decision requires implementing regulations to bring future plans into effect.)

The project's final year concentrated on (i) evaluating the smoke-free hospitals initiative and implementation of Directive 12; (ii) producing local evidence on the socio-economic impact of the proposed tobacco control law; (iii) assessing the various outputs and accomplishments of the Ministerial partners and (iv) promoting the inclusion of the draft law in the National Assembly agenda for 2011. Figure 3 depicts a timeline of the RSVP project in relation to key tobacco control milestones in Vietnam.

RESULTS

Evolution of the capacity-building model

The experience gained from this project helped in adapting Vietnam's national tobacco control capacity-building model, with a four-component tobacco control capacity model emerging as a more realistic approach. This four-component model slightly expands the concepts in our original model. Based on our experience, we highlighted more of the organizational effort that was a major focus of our capacity building in a developing country. We also felt it necessary to separate and focus more on the leadership and expertise from the networking and partnership development. The four components that were

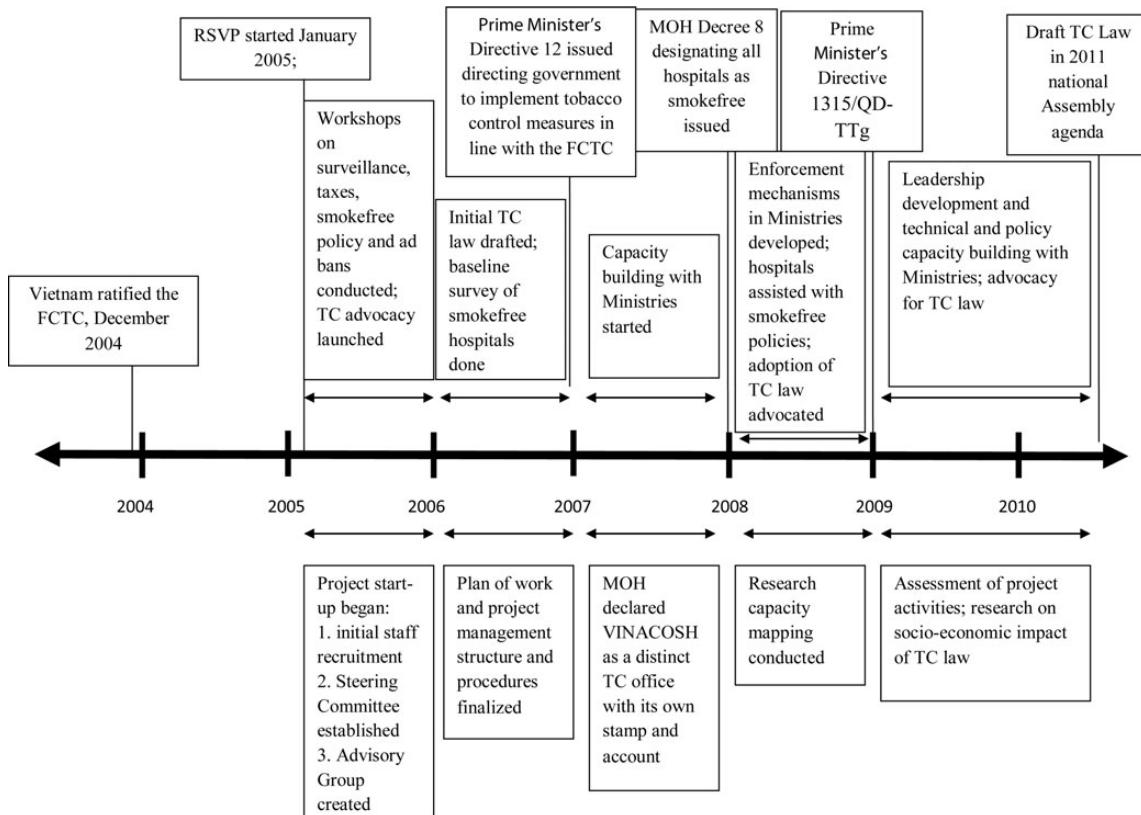


Fig. 3: Timeline of RSVP project and tobacco control milestones in Viet Nam.

especially critical to achieve quality outputs and measurable outcomes were (i) organizational structure/infrastructure; (ii) leadership and expertise; (iii) partnerships and networks and (iv) data and evidence from research. The next sections will discuss the components of the adapted capacity model (Figure 4), as well as the outputs and outcomes from the project (Table 1). The information used to adapt the model resulted from assessments and interviews conducted during the project. We discuss the positive aspects and successes achieved, as well as the challenges that we encountered.

Program management and organizational structure

A major challenge to building and maintaining capacity is establishing the infrastructure needed to maintain the project. This component proved to require considerable time and effort and we expanded the model to reflect this need. The

more difficult issue was learning how to work within a government structure that was not transparent to either of the implementing partners. Better communication from the partners was required, as well as the services of a consultant with greater knowledge of the organizational system and direct relationships with the agency's decision-makers. Feedback concerning the needed processes to achieve goals and specific suggestions to improve implementation, as well as help in linking to other stakeholders who could assist with local implementation, was extremely valuable in improving national and local implementation.

The RSVP project also experienced challenges in maintaining an in-country project mentor, as well as finding and retaining staff within VINACOSH. It was important that the mentor be Vietnamese who spoke the language and understood the culture, and it was unclear whether an individual who was Vietnamese-American would be fully accepted. Some staff

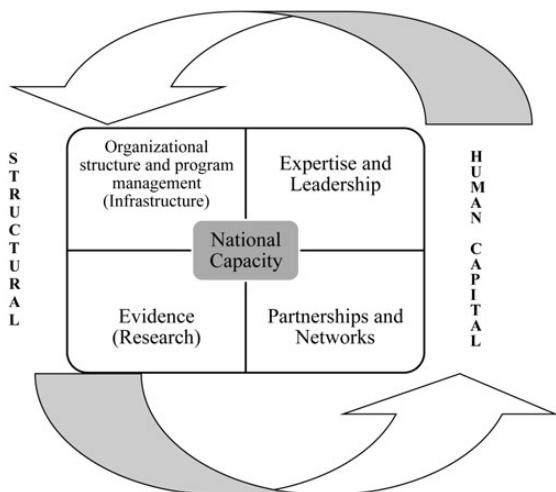


Fig. 4: Modified conceptual model of national capacity for tobacco control.

members were willing to stay within the government structure throughout the project, while others chose to leave for other work opportunities. The project also experienced the death of one of its mentors due to lung cancer. In addition, during the project, substantial development funding for other health-related topics was coming into Vietnam. While external funding was very limited for tobacco control throughout much of the project, the staff had many other, more lucrative opportunities to work with development organizations, resulting in project staffing challenges.

It was evident that for VINACOSH to implement policy at both the national and local levels additional staff with specific skills were required. The funding provided VINACOSH with staff to help carry out the project objectives, but the absence of a clear framework for program management initially delayed project implementation. There were differences between what was determined as necessary by the grant and what the grantee saw as their priorities. In addition, there was also a lack of understanding concerning the barriers and challenges faced by the Vietnamese partners to work within their government

Leadership and expertise

To improve expertise and quality of leadership, staff and stakeholders were provided with additional educational and training opportunities at the Johns Hopkins Bloomberg School of Public Health. Several staff and stakeholders attended

the Johns Hopkins Summer Leadership Program, and others earned academic credit through the Johns Hopkins Certificate Program in Tobacco Control. Still others were mentored and received funding to attend and present RSVP program results at international conferences. These opportunities proved to be invaluable for all of the partners as much was gained from this shared experience.

RSPV served as a bridge project for VINACOSH: the funding and technical assistance allowed VINACOSH to maintain and expand on its activities and to demonstrate to other funders that it had the capacity necessary to apply for and receive additional funding from other donors. At present, however, VINACOSH does not receive any internal funding directly from MOH or other government agencies to support tobacco control in Vietnam, although VINACOSH had been able to obtain funding from numerous external sources to continue its efforts. Maintaining well-qualified staff who would dedicate the leadership skills and experience gained, however, has proved challenging when salaries are fixed in one setting, such as government, but increase greatly in other settings such as international aid agencies. This is especially problematic when funding for other health-related topics becomes a priority for funders.

Partnerships and networks

The relationship between the partner organizations changed over time as a function of VINACOSH's increased capacity, the types of technical assistance needed and the proposed VINACOSH activities to support necessary national and local policy development. In addition, adjustments to work within the governmental structures were necessary. Within Vietnam's centralist hierarchy, political standing is crucial to oversee work across Ministries; this was a limitation that the MOH, and VINACOSH in particular, faced at the project's outset.

VINACOSH is located under a Department of the Ministry of Health, meaning it has less power than the ministry, but its function is inter-ministerial. (Mid-term Assessment, 2007)

The lack of official status also made it difficult for VINACOSH to engage effectively with the other ministries to implement project activities

Table 1: Key outputs and outcomes from the RSVP capacity-building project

	Outputs	Outcomes
Program management and structure (infrastructure)	<ul style="list-style-type: none"> (1) Official MOH memorandum creating mandate for VINACOSH with separate stamp (government seal) and account (2) Clearly delineated program management structure and processes (3) Built stainable program structure and management 	<ul style="list-style-type: none"> (1) Strengthened VINACOSH's official structure empowering it to oversee interministerial/intersectoral tobacco control work (2) Enhanced administrative efficiency and improved ability to manage future tobacco control initiatives (3) VINACOSH secured continued external funding to continue their program activities
Partnerships	<ul style="list-style-type: none"> (1) Various partnership networks created and sustained (Project Steering Committee, Secretariat network, Advisory Group, Stakeholders network) 	<ul style="list-style-type: none"> (1) Established mechanism for formal interaction between VINACOSH and other ministries through officially designated ministerial focal points and project steering committee (2) Established informal network of tobacco control stakeholders
Leadership and expertise	<p>Nationally:</p> <ul style="list-style-type: none"> (1) Advocacy and training for a national tobacco control law consistent with the FCTC (2) Final draft of proposed law created (3) Study tours of potential champions/experts conducted <p>Within Ministries:</p> <ul style="list-style-type: none"> (1) Assessment of MOET's implementation of its smoke-free schools policy (2) Enforcement training for Chief Inspectors of the MOETS (3) Smoke-free hospitals pilot project completed with MOH 	<p>Nationally:</p> <ul style="list-style-type: none"> (1) Greater awareness among National Assembly members and Ministries of the FCTC and evidence to support tobacco control policy action (2) Inclusion of draft law into the 2011 agenda of the National Assembly (3) Growing body of local tobacco control experts and champions <p>Within Ministries:</p> <ul style="list-style-type: none"> (1) Based on the assessment, a stronger, MOET smoke-free school policy promulgated and implemented (2) Enhanced monitoring and oversight for tobacco advertising law; reduced use of smoking images in local films (3) All MOH facilities designated as smoke free
Evidence from research	<ul style="list-style-type: none"> (1) Initiation of data collection system within Ministries (2) Development of standardized FCTC-related tobacco control reporting and monitoring tools for ministries (3) Research capacity mapping completed (4) Local research projects completed 	<ul style="list-style-type: none"> (1) Data collection streamlined, facilitating reporting to FCTC COP (2) Strategic directions for future research capacity-building identified (3) Growing body of local evidence for tobacco control established

in the first 2 years of the project. VINACOSH reported:

In the first months of the project, it was very difficult to work with and get official commitments from the other ministries, because VINACOSH had no official status. Informal talks were easy,

but commitment for official work (under RSVP) needed to be obtained officially. (Mid-term Assessment, 2007)

The interim solution to this challenge was for VINACOSH, through the MOH, to send official letters requesting the other ministries to formally

designate representatives as members of the project Secretariat. It required, however, the issuance of MOH Decision No. 2830/QD-BYT on 30 July 2007, establishing VINACOSH as an official legal entity within the MOH with its own stamp and account to empower VINACOSH to convene other Ministries and establish a mechanism that now permits full and official interaction between VINACOSH and the other Ministries.

The needs to improve communication, specific skills for tobacco control and building capacity for program management were addressed by local project staff:

Training in programme management (for VINACOSH) is needed. We also need a regulatory framework as reference. (Mid-term Assessment, 2007)

Evidence from research

Research is essential to provide local evidence to support FCTC policy recommendations: capacity building created the mechanism to disseminate the evidence to stakeholders, and efforts to develop expertise and leadership provided the champions and spokespersons who advocated for policy action based on the data. VINACOSH had excellent working relationships with many stakeholders in the private sector, as well as other international partners and the RSVP project helped to facilitate these relationships to ensure broader participation in developing tools for monitoring and evaluation. One challenge that was identified concerned the lack of information-sharing and dissemination. Data were not shared between agencies and there was no on-line repository of information. The development of an FCTC reporting and monitoring tool helped facilitate data collection among different agencies. VINACOSH was able to coordinate the acceptance of the monitoring tool as an official government reporting mechanism and to gather and maintain information helpful for the planning and implementation process. Table 1 summarizes the key outputs and outcomes from the final assessment and key informant interviews concerning the capacity-building process in Vietnam based on our expanded four-component model.

Some of the project outcomes are definitive achievements in themselves, such as the creation of a revised and stronger smoke-free schools policy by the MOET and the promulgation of the smoke-free directives. At the national level, the

RSVP project was pivotal in developing an FCTC-consistent tobacco control law—building on earlier work by other stakeholders such as WHO and the Swedish International Development Cooperation Agency—and scheduling the draft on the legislative agenda of the National Assembly.

Other important milestones that the RSVP project likely contributed to include the following: the Prime Minister's Directive 12, Decision No. 1315; national policies and regulations setting the special consumption tax on cigarettes uniform at 55% of the wholesale price of cigarettes and cigars in 2006 (increased it to 65% in 2008); the establishment of cigarette smuggling as a criminal activity in 2009 and the banning of tobacco advertising and smoking in public places in 2010. It should be noted that RSVP started at a time when there was little external investment in tobacco control within Vietnam, but as the project and the FCTC process unfolded, an increasing number of international and bilateral organizations began funneling resources for tobacco control into the country. Thus, any milestones marking progress nationally represent the composite efforts of all external partners and their local counterparts to foster a political and socio-cultural environment conducive to reducing tobacco use. Nevertheless, the role played by the RSVP project was paramount to initiating the necessary capacity for Vietnam to manage the increasing influx of external tobacco control investments and activities and smoothing the way for new partners and initiatives.

LESSONS LEARNED

Given the complex and multi-sectoral nature of tobacco control, numerous components of capacity building are critical for attaining full FCTC implementation. The development of capacity, especially when working within a government agency to build and coordinate working relationships with other government agencies, is a critical challenge, and cannot be achieved by funding alone. The process requires patience and cultural, social and political sensitivity that develops with time, effort and dedication to achieving goals. The following lessons are based on our capacity framework and attempt to synthesize many factors needed in a national capacity-building effort for tobacco control. While this is only a one-country case study, it does provide some general information

that can be useful for other countries building their capacity to implement tobacco control and the honor their commitments to the FCTC.

- (i) Capacity building is indispensable for successful FCTC implementation but it is a comprehensive and ongoing process requiring long-term commitment.

In a developing country where (i) inherent capacity and resources are limited amidst multiple competing health priorities, (ii) conflicts of interest regarding tobacco abound and (iii) political decision-making is centralized, capacity building for tobacco control will likely be a complex and drawn-out process. The four-component model described in this case study provides a conceptual framework that highlights the need for simultaneous capacity building to enhance both organizational structure and human capital. Tobacco control initiatives, regardless of their focus, should deal with enhancing all four components of capacity. This implies that investments in national tobacco control capacity building require long-term commitment; often, this necessitates sustained on-site involvement of the mentoring partner and project staff. However, the investment is essential if countries, especially those from the developing world, are to honor their commitment to fully implement the FCTC.

- (ii) Ensuring an efficient program structure and effective program management is necessary to national tobacco control capacity building.

Tobacco control requires multi-pronged approaches that are often implemented simultaneously with different partners. We recognize that our capacity-building efforts were needed to improve the organizational capacity while also helping to improve its infrastructure. We are now defining capacity as the 'actual or potential ability to perform' and infrastructure as the 'basic underlying framework or features of a system or organization' that contribute to the ability to perform. Infrastructure is generally defined as a component of an organization's capacity. By focusing more on organizational capacity, we provided technical assistance that helped to improve the effectiveness and efficiency of program management. Ideally, a viable management

structure and operating protocols must be established at the outset. Thus, investing in capacity building that addresses infrastructure, organizational structure and program management must, of necessity, happen first.

- (iii) Local champions are a necessary target for capacity building.

Champions play vital roles in getting tobacco control issues on the national policy agenda and in ensuring sound policy formulation and adoption, particularly when the tobacco industry has a strong and official government presence. Identifying and building the capacity of champions is an indispensable component of national tobacco control capacity building.

- (iv) Establishing relationships is as important as establishing the project.

Capacity building is both a process and an outcome. By its nature, a capacity-building project should occur within a partnership context. The strength of the partnership determines the project's impact and sustainability. Thus, establishing good partnerships through a participatory approach is one of the foundations of establishing any capacity-building effort. This is especially relevant when one of the partners is 'from the outside', i.e. from a different socio-cultural and political environment. In this situation, before a partnership project can begin, it is important to go into the target community, establish relationships, build trust, work with the formal and informal leadership and seek commitment from prospective partner organizations and leaders to create the structures and processes for starting the project. When projects are implemented without an initial effort to engage and form effective relationships, they are far less likely to achieve the desired objectives. In contrast, when partnerships are welcomed and encouraged, outcomes exceed expectations.

- (v) While effort- and resource-intensive, tobacco control national capacity building is a sustainability mechanism that is worth the investment.

Capacity gained is capacity sustained. Done appropriately, systematic efforts to build individual and institutional capacity ensure that organizations attain a higher level of readiness for tobacco control. In

Vietnam today, VINACOSH and its partners are handling significantly increased levels of resource infusion and activities in various tobacco control areas. Because of earlier capacity-building projects like RSVP, they are better equipped to handle the rising demand and work load. As the pool of local tobacco control experts and champions grows, technical assistance is increasingly available from within the country, and reliance on external expertise is gradually diminishing. Moreover, VINACOSH's ability to identify and successfully apply for new funding opportunities is ensuring continued support to ongoing tobacco control efforts. Thus, capacity building in and of itself is a mechanism for ensuring sustainability of tobacco control.

CONCLUSIONS

National capacity building for tobacco control is a challenging process, but it is necessary if countries, especially those from the developing world, are to implement the FCTC successfully. The RSVP project was timely and contributed to reinforcing the necessary structural elements and human capital in Vietnam, serving as a bridge that helped transition the country to an enhanced state of readiness for FCTC implementation and ongoing external funding. The four-component model for the RSVP project, which evolved from the original conceptual model in 2004, provides a practical framework to operationalize the capacity-building process. Likewise, the Vietnam experience underscores the value of allocating resources for the process of general capacity building in addition to tobacco control initiatives that focus on specific areas of work. This model, and the lessons that emerged from this country case study, can provide guidance to global funders, tobacco control technical assistance providers and countries as governments' endeavor to meet their commitment to the FCTC.

ACKNOWLEDGEMENTS

The authors would like to thank Mai-Anh Hoang, Huyen Do, Hiep Hoang, Steve Tamplin, Viet Anh and Dr. Ly Ngoc Kinh whose work on behalf of the Reduce Smoking in Vietnam Project contributed to the success of this project.

FUNDING

The Reduce Smoking in Vietnam Project was funded by The Atlantic Philanthropies to The Johns Hopkins Institute for Global Tobacco Control.

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