'Health system stewardship and regulation in Vietnam, India and China' (HESVIC) was a multidisciplinary and multi-partner project implemented over three years (July 2009 – December 2012) with the financial support from the European Commission FP7. It investigated regulation as it relates to wider governance in policy and practice of health systems in maternal health for Vietnam, India and China. HESVIC used maternal health as a particular critical case study to investigate health regulation and to support policy decisions that would improve accessibility, affordability, equity and quality coverage of health care in the three countries.

Specific research-related objectives were:

1. To examine the application of international standards in governance and regulation of maternal health activities – to the extent that such standards exist;
2. To develop a typology of private and public practitioners involved in maternal health in the three study countries;
3. To outline national standards for governance and regulation of maternal health activities in the three study countries;
4. To explore the effects of governance and regulation of maternal health care, services and systems on equitable access to quality maternal health care, within and across each study country;
5. To disseminate the results and recommendations widely to the government and other key health sector stakeholders in the three study countries and to the professional/scientific community.

Other objectives:

6. To enhance the capacity of the partner research institutions in health systems research;
7. To increase sustainable collaboration between the Consortium partners.

The HESVIC achievements in terms of research process and research findings were:

a. We identified an overarching framework to conceptualize and critically analyze health regulation and governance;
b. We improved our understanding of regulation processes, and through them of determinants for governance;
c. We developed an integrated approach for the assessment of regulation, with room for variation in evaluation strategy and instruments;
d. We compared situations between contexts, case studies and countries;
e. We developed motivated support for policy decisions.

Overall, in the wider health policy field, HESVIC research suggests that regulatory control is constrained under current conditions in LMIC settings, with the possible exception of services that are centrally planned. In the three countries, regulation of private outlets is met with reluctance, leading to public authorities generally not being able to list private practitioners operating in their area. We found that regulation-hampering mechanisms are related to historical, socio-political and administrative conditions in LMIC. This confirms that to date there is a lack of field evidence on whether mechanisms exist in LMIC to intervene and control health markets and, ultimately, redistribute wealth and disease. It is believed

that this perpetuates the inequitable delivery and financing of care interventions and control mechanisms.

HESVIC project engaged particularly with national and regional policy makers dealing with health governance and (maternal) health regulation of Vietnam India and China.

Our results, as we summarised to policy makers, were that regulations should be nested in larger health policies because:

- Regulations are not very effective on their own, certainly under LMIC conditions;
- Regulations can yield undesirable effects. For instance, in Vietnam, combined with the common perception that the quality of services is better at the provincial level than at district level, the EmOC regulation resulted in the over-burdening of provincial hospitals;
- Health professionals cannot merely be motivated and deterred by material incentives and punishments but also need symbolic incentives in addition.
- Governments commonly are reluctant to ensure regulation for the private sector but the private sector should be more involved in regulatory processes.
- Designing regulation in Vietnam, India and China was dominantly carried out in a closed way by bureaucrats, politicians and government external advisers. Granting non-state actors, like health facility users and other socio-economic groups, a voice may help regulations work better for them.

These messages were communicated to policy makers through numerous channels during and at the end of the project through consultation meetings and dissemination workshops; conferences; policy briefs; short courses; project web-sites and development of peer reviewed journal articles for publication in national and international journals.