REFERENCES

Babken V. Babajanian. (2005). *Bottom Up and Top Down? Community Development in Post-Soviet Armenia: The Social Fund Model. Social Policy and Administration,* 39,4 (August 2005)

Bent D. Jorgensen, Cecilia Bergstedt, Nguyen Quang Dung, Do Thi Phuong Thao (2001), *An Uphill Voyage The Village Development Budget and Decentralization in Phu Tho Province, Northern Viet Nam,* Vietnam Sweden Mountain Rural Development Programme (MRDP), Ministry of Agriculture and Rural Development

Bent D. Jorgensen and Pham thi Phuong Thao. (2007). *Assessment of PRAP implementation in localities covered by the Community Based Health Development.* Viet Nam and Sweden Health Cooperation Minstry of Health

Bob Baulch, Truong thi Kim Chuyen, Dominique Haughton, Jonathan Haughton (2001), *Ethnic Minority Development in Vietnam: A Socio-Economic Perspective*

Bracht and Tsouros (1990) *Principles and strategies of effective community participation, Health Promotion International.* 5, 3, 199-208 (1990)

Chambers Robert, (1992), *Participatory Rural Appraisal (PRA): Challenges, Potentials and Paradigm*, World Development, 22,10, 1437-1454, (1994)

Chambers Robert, (1997), *Whose Reality Counts?* London; Intermediate Technology Publications, (1997)

Cohen and Uphoff (1980), *Participation's place in rural development: Seeking clarity through specificity*, http://www.sciencedirect.com/science/article

David Everatt and Lulu Gwagwa (2005) *Community Driven Development in South Africa, 1990-2004*, Africa Region Working Paper Series No. 92. World Bank.

Drake, E (2003), *Good Governance and the World Bank,* Bretton Woods Project, London.

Esman, M.J. and N.T. Uphoff, (1982), *Local Organization and Rural Development: The State of the Art*, Ithaca, NY: Cornell.

Frank K. Nyonator, J. Koku Awoonor-Williams, James F. Phillips,Tanya C. Jones, Robert A. Mller (2003), *The Ghana Community-based Health Planning and Services Initiative: Fostering Evidence-based Organizational Change and Development in a Resource-constrained Setting*, Policy Research Division, Population Council, working paper No.180- (2003)

Gaby Jacobs (2004) *Professionals in Health Promotion: stuck between top-down policies and bottom-up approaches1* Paper presented at the International Conference on Professionals between People and Policy Workshop: Empowerment of Professionals, Amsterdam/Utrecht (October 7-8 2004)

Godfrey M. Mubyazi and Guy Hutton (2003), *Understanding mechanisms for integrating community priorities in health planning, resource allocation and service delivery*, Southern African regional network on equity in health (EQUINET) support from IDRC, Canada

Guijt, I (1996), *Participation in Natural Resource Management: Blemished Past and Hopeful Future*, IDS, Sussex.

J. David L Zakus and Cathrine L Lysack. (1998) *Revisiting Community Participation*, Health Policy and Planning Oxford University Press (1998)

Judith L. Ladinsky; Ruth E. Levine(1985) *The organization and health services in Viet Nam*, Journal of Public health policy Vol. 6 No.2

Jonathan Conning and Michael Kevane (2000), *Community Based Targeting Mechanisms for Social Safety Nets*, prepared paper for Third International Conference on Conditional Cash Transfers, Istanbul, Turkey (2006)

Kahssay H.M & Oakley P., (1999) eds. *Community involvement in health development: a review of the concept and practice.* Geneva, World Health Organization, (Public Health in Action, No. 5).

Lincoln C. Chen and Linda G. Hiebert (1994), *From Socialism to Private market: Viet Nam health in rapid transition.* Harvard School of Public Health

Lise Rakner, Alina Rocha Menocal, Verena Fritz,(2007) *Democratisation's Third wave and the Challenges of Democratic Deepening: Assessing International Democracy Assistance and Lessons Learned*, Working paper 1, Oversea Development Institute, United Kingdom

Meuwissen L.E.M.,(2002) *Problems of cost recovery implementation in district health care: case study of Niger*. Health Policy and Planning

Monica Das Gupta, Helene Grandvoinnet, Mattia Romani (2003), *Fostering community-driven development: What role for the state?* World Bank Policy Research Working Paper 2969 (January 2003)

Oakley P. (1989), Community *involvement in health care development*. World Health Organisation, Geneva.

Olico-Okui (No date), *Community participation: An abused concept?* Institute of Public Health, Uganda.

Reid G, Kasale H. (2000), Strategic Alliances, The role of society in Health, *http://www.who.int/civilsociety/documents/en/*

Rene Loewenson (1998) *Public participation in health; Making People matter* - IDS WORKING PAPER 84 - The Institute of Development Studies at the University of Sussex, Brighton England

Riftkin Susan B (1985), *Lesson from community participation in Health programs*, HEALTH POLICY AND PLANNING,1(3):240-9 (1986 Sep)

Riftkin Susan B (2001), Ten *Best Readings on Community Participation and Health*, African Health Sciences Vol 1,1 (August 2001)

Rifkin Susan B (2003), *A Framework Linking Community Empowerment, and Health Equity: It Is a Matter of CHOICE,* Centre for Health and Population Research ISSN 1606-0997

Román Vega-Romero & Mauricio Torres Tovar (2007), *The Role of Civil Society in Building an Equitable Health System,* WHO Commission on the Social Determinants of Health and the Health Systems Knowledge Network

Sarah Atkinson, Luci Lia Fernandes, Andrea, Caprara and Jasmine Gideon (2005), *Prevention and promotion in decentralized rural health systems: a comparative study from northeast Brazil* - Health Policy and Planning 20(2)- Oxford University Press, United Kingdom

Somesh Kumar (2002), *Methods for Community Participation: A complete Guide for Practitioners*, ITDG Publishing, London, WCIB4HL, UK

Susan J.Adams (2005) *Vietnam's Health Care System: A Macroeconomic Perspective.* Paper Prepared for the International Symposium on Health Care Systems in Asia Hitotsubashi University, Tokyo (January 21-22, 2005)

UNDP Vietnam (2006), *Deepening Democracy and Increasing Popular Participation in Viet Nam*, Policy dialogue Paper - Hanoi, Vietnam

United Nations (2004), *Community-driven Development as an Integrated Social Policy at the Local Level*, ECONOMIC AND SOCIAL COMMISSION FOR WESTERN ASIA, New York

USAIDS (2006), *Rural Expansion of Afghanistan's Community-based Healthcare Program,* MSH- Management Science fo Health, Cambridge,MA 02139-4613 USA

Vietnam-Sweden Health Cooperation, Ministry of Health (1998), *Project document of Support for Disadvantaged Areas 1999-2002 (SDA)*, Hanoi, Vietnam

Vietnam-Sweden Health Cooperation, Ministry of Health (2002), *Project Document of Community-Based Health Development 2003-2006 (CBHD)*, Hanoi, Vietnam

Vietnam-Sweden Health Cooperation, Ministry of Health (2002), *Result Analysis Report of Support for Disadvantaged Areas 1999-2002 (SDA)*, Hanoi, Vietnam

Vietnam-Sweden Health Cooperation, Ministry of Health (2006), *Result Analysis Report - Community-Based Health Development* 2003-2006 *(CBHD)*, Hanoi, Vietnam

WHO (2003), *Health and Ethnic Minorities in Viet Nam*, Technical Series No 1 World Health Organization in Viet Nam

WHO/UNICEF Alma Ata (1978). Primary Health Care, *Report of the International Conference on Primary Health Care, Alma Ata*, USSR 6-12 September 1978. Geneva, World Health Organization, (1978)

Wiseman, V., Mooney, G., Berry, G & Tang, K.C, Social Science and Medicine (56: p. 1001-1012. 2003).

Woelk, G B (1992). *Cultural and structural influences in the creation of and community participation in health programs*. Social Science and Medicine 35

World Bank (2003), *Poverty and Health*, OECD Publications Service, Paris, France.

World Bank (2005) *Local Governance, Transparency and Anti-Corruption in Community-Driven Development in Vietnam,* Community-Based Rural Infrastructure Project (CBRIP), Ministry of Investment and Planning, Vietnam

APPENDICES

Appendix A

RANKING SCALE FOR MEASURING COMMUNITY PARTICIPATION DIMENSIONS OF COMMUNITY-BASED HEALTH CARE

Level:	Minimal	Restricted	Fair	Open	Maximal
Score:	1	2	3	4	5
Needs assessment	Outside expert solely projects possible problems or conducts survey	Outside expert viewpoint dominates but community interests are considered, often through input of community based leadership	Community-based leadership assessment of community views and needs dominates	Community-based leadership is actively involved in seeking out community members' viewpoint, and in analysis of needs	Community members involved in research and analysis of needs under active community based leadership direction
Leadership	Community-based leadership represents only the wealthy minority and acts only in their interest	No collaboration among Community-based leadership for community health; A health leader/ worker appointed by outside expert works independent of social interest groups	There is some collaborating community-based leadership functioning under an outside expert - appointed health leader/worker	Community-based leadership represents different groups in the community, is active and takes initiative in community health activities	Community-based leadership represents the variety of interests in the community and has ownership/control of community health activities
Management	Activities induced by outside expert. Only outside expert conducts supervision of activities	An outside expert - appointed health leader/worker manages independently, under supervision of outside expert	Community-based leadership involved to some extent in management of activities but without control of activities	Community-based leadership is self-managed and involved in supervisor of activities	The activities and supervision of the activities are the responsibility of the community-based leadership
Organization	Outside expert does not use a community-based organization, or imposes one for project, which then remains inactive	Outside expert imposes a community-based organization or committee, but this organization develops some activities	Outside expert imposes a community-based organization, but this organization becomes fully active	Existing community organizations actively cooperate in community health activities	Existing community organizations, representing a broad constituency, incorporation create their own mechanisms for introducing community Health activities.
Resource mobilization	Token amount contributed by community. Community based leadership does not decide on any resources allocation	Mechanism established for resource generation, but community-based leadership has no control over use of resources	Continuing contribution of local resources, but no or limited community-based leadership control of resources	Continuing contribution of local resources, and community-based leadership controls use of funds	Considerable resources contributed by community or obtained otherwise by Community-based leadership. Community- based leadership allocates available resources

Appendix B

INSTRUCTIONS FOR USING THE COMMUNITY PARTICIPATION ASSESSMENT TOOL

Name of Community Health Initiative being assessed:

What best describes your role in this initiative? (Please check all that apply)

___ Staff member of this initiative
___ Leader in a community-based service agency or organization
___ Involved Citizen
___ Advisory Board/Steering Committee member for this initiative
___ Client or Recipient of Services from this initiative
___ University partner
___ State or Local government health or human services agency officer
___ Other role (Please describe :) _____

How long have you been involved in this initiative? _____

Definitions of terms used in this tool:

Community-based leadership: The formal and/or informal power-holders or authorities in the community. In some communities, leaders may only be those with wealth or political power who work only in behalf of their own self-interest. In the most progressive communities, the varieties of constituencies in the community have leadership representation and voice, and community leadership effectively acts on behalf of community concerns and priorities.

Outside Expert: Someone who comes from outside the community, perhaps a government health or human service agency official or a university researcher, who comes to the community with a pre-existing agenda of what issue needs to addressed and how it should be addressed. This is not to say that communities cannot benefit from outside experts; the issue is whether an outside expert is *imposed* on the community, or whether the community seeks an outside expert as a consultant or partner.

RANKING:

Please use the attached matrix to rank this initiative on its level of community participation. For each dimension of the community health initiative (leadership, organization, needs assessment, management and resource mobilization), please choose the corresponding general description that comes closest to describing this local initiative. Score each dimension by writing down the column number (number I through 5) that corresponds to the description you chose.

DIMENSION SCORE

Leadership: _____
Organization: _____
Needs Assessment: _____
Management: _____
Resource Mobilization: _____
TOTAL SCORE: _____ (out of a maximum score of 25)

Appendix C

GROUP DISCUSSION PLAN

1. **Place:** Commune Health Station
2. **Participants**: Criteria for selecting participant will be: people have been taking part in the CBHD project, leaders and health professional those are in charge of health development in local areas. So that, the members will be as follow: one District Health Planners, Chairman of Commune People Committee. Head of Commune Health Station, 4 representative of Mass-Organizations, Head of Villager, 2 Village healths Worker of selected villages. Total of 11 people
3. **Time**: 1h – 1h30
4. **Facilitators**: Nguyen Xuan Son, Nguyen Huu Thang, Bach Anh Tuan, Vu Van Ninh
5. **Contents of the discussion**: Assessment of community participation in CBHD project around the following indicators: Needs Assessment. Leadership, Organization, Management, Resource Mobilization, and the other assumption of factors related to the process of community based health care such as Culture/Historical, Political, Health System, and Community Capacities.

5.1. Community participation in health indicators

Needs assessment of health with PRA

- How are needs identified?
- Does identification relate only to health service needs?
- Is the affected community involved in needs identification and assessment?
- Does the assessment strengthen the role of a broad range of affected community members?

Leadership

- In your community, which groups does the leadership represent and how does it do so?
- Is the leadership paternalistic and/or dictatorial, limiting the prospects of wider participation for various groups in the affected community?
- How does the leadership respond to the needs of poor and marginalized people?
- Do most decisions by the leadership result in improvements for the majority of the people, for elites only, or for the poor only?

Management

- Are decisions solely in the hands of professionals, or are they made jointly with affected community members?
- Are the decision-making structures changing in favor of certain groups, and if so, which groups?

- Are management structures expanding to broaden decision-making groups?
- Is it possible to integrate non-health needs?

Organization
- Are new organizations being created to meet defined needs, or are the existing ones being used?
- Are the organizations flexible and able to respond to change, or are they rigid, fearing a change in control? Emergency responses, and do changes benefit professionals or affected community members?
- What changes have taken place in the organizations since the introduction of emergency responses, and do changes benefit professionals or affected community members?

Resources mobilization
- What is the affected community contributing, and what percentage is this of the total response costs?
- Are resources from the affected community being allocated for the support of parts of the response that would otherwise be covered by government allocations?
- Whose interests are served by the mobilization and allocation of resources?

5.2. Assumption of other indicators

5.2.1. Cultural
- Do you think culture can be affected or influence to the participation of the community in health care? What are they for example?
  Notes: The concept of culture is normally very broad in term of linguistic, traditional life style of ethnic minority groups; working style of local staff; attitude and behavior of people in seeking for health care etc. Please state more related concept
- Did the community really want to improve the health care and health status? For example on health promotion; nutrition; health education; disease eradication etc.
- Your experience on the mobilizing ethnic minorities group in implementing the project? What were the advantages and disadvantages?
- Does the diversity of language challenge in communicate during the process of the project?

5.2.2. Community capacity
- Do the institutions within district administration units know about the community based in planning method?
- How many percent, approximately, of them know and done the "bottom up" planning?
- The CBHD project has been introduced by open course for the facilitators in the preparation period. However, do you think that was enough for implement the project? Are there some obstacles? And what are they?
- How many of your colleges have been taking part in the project?

- Do you think their capacity has been improved? Please specify the actual capacity or skills they have gained?
- If the skills of staff were not sufficient what should be providing more?
- Do you think health staff should also have some knowledge on anthropology when working with ethnic minority?
- Do the other means like facilities, finance resource etc, have been needed for the application of the community based in health care? What were lacking for a better run?

5.2.3. Local political regime

- Do you know the political regime of the State and Communist party on decentralization and financial autonomy? What are they? Is it easy to implement?
- Do the lower levels receive the emergency supports from upper levels on this regime?
- Have the monitoring and supervision activities done regularly?
- What is the instruction of CBHD to do the community participation approach?
- Do you think the CBHD method on participatory planning can be contribute to the future changing of the country regime on autonomy and self responses within state system? Take example?

5.2.4. Health system

- What are the understandings and experiences of health institutions and professionals in community based approach of CBHD?
- The readiness of health system to change ways of management in term of organization, human resources, funding?
- It is flexible, supportive to respond to the needs of community?

6. Summing up and analyzing results:

7. Writing report

Appendix D

INTERVIEW QUESTIONS FOR HOUSEHOLD

Name of household.....
Address.....
Date of interview.....
Revenue.....

1. **The understanding and willing to participate of people**
- Did you know the CBHD project?
- Did you know your right in participating of health care activities?
- Did you see the guideline how to do intervention of hygiene and sanitation of the project?

2. **Actual participation of community:**
- Did you or your family members participate in the project activities? How was it? When was it? Specify the activities?
- Which of the activity do you think was the best? Which was not so good?
- Did you attend some of health education activity (ITC) that conducted by commune or village health workers? What were the contents?
- This activity has been done regularly?
- Do you think the participation of community in health care has been affected to the health service or it was just a token only?

3. **The contribution and benefit from the project**

- Did you know the concept of mobilizing resources of the project? What way?
- What have you contributed to the project? In which activity? How much? (Including the labor forces counted in money)
- What did you get from the project? Did you receive a good service for health care? Or well consulted in disease preventions?

4. **The changing in quality improvement after the intervention of the project**
- Do you see some changing in health care in your community in good manner compare to the time before the project has been implemented?
- Commune health services change or not change? Do you satisfy these services? Or the performance of Commune health worker and Village health workers?
- If we could do it better, what should be taking into account? Please giving some suggestion for CHW and VHW?

Appendix E

INTERVIEW QUESTIONS FOR COMMUNE HEALTH STAFF

Name of Interviewee.....
Name of Health Unit.....
Date of interview.....
Place.....

1. **Needs assessment of health with PRA**
- How are needs identified?
- Does identification relate only to health service needs?
- Is the affected community involved in needs identification and assessment?
- Does the assessment strengthen the role of a broad range of affected community members?

2. **Leadership**
- In your community, which groups does the leadership represent and how does it do so?
- Is the leadership paternalistic and/or dictatorial, limiting the prospects of wider participation for various groups in the affected community?
- How does the leadership respond to the needs of poor and marginalized people?
- Do most decisions by the leadership result in improvements for the majority of the people, for elites only, or for the poor only?

3. **Management**

- Are decisions solely in the hands of professionals, or are they made jointly with affected community members?
- Are the decision-making structures changing in favor of certain groups, and if so, which groups?
- Are management structures expanding to broaden decision-making groups?
- Is it possible to integrate non-health needs?

4. **Organization**

- Are new organizations being created to meet defined needs, or are the existing ones being used?
- Are the organizations flexible and able to respond to change, or are they rigid, fearing a change in control? Emergency responses, and do changes benefit professionals or affected community members?
- What changes have taken place in the organizations since the introduction of emergency responses, and do changes benefit professionals or affected community members?

5. Resources mobilization

- What is the affected community contributing, and what percentage is this of the total response costs?

- Are resources from the affected community being allocated for the support of parts of the response that would otherwise be covered by government allocations?
- Whose interests are served by the mobilization and allocation of resources?

6. Cultural and ethnic minority

- Do you think culture can be affected or influence to the participation of the community in health care? What are they for example?
  Notes: The concept of culture is normally very broad in term of linguistic, traditional life style of ethnic minority groups; working style of local staff; attitude and behavior of people in seeking for health care etc. Please state more related concept
- Did the community really want to improve the health care and health status? For example on health promotion; nutrition; health education; disease eradication etc.
- Your experience on the mobilizing ethnic minorities group in implementing the project? What were the advantages and disadvantages?
- Does the diversity of language challenge in communicate during the process of the project?

7. Community capacity

- Do the institutions within district administration units know about the community based in planning method?
- How many percent, approximately, of them know and done the "bottom up" planning?
- The CBHD project has been introduced by open course for the facilitators in the preparation period. However, do you think that was enough for implement the project? Are there some obstacles? And what are they?
- How many of your colleges have been taking part in the project?
- Do you think their capacity has been improved? Please specify the actual capacity or skills they have gained?
- If the skills of staff were not sufficient what should be providing more?
- Do you think health staff should also have some knowledge on anthropology when working with ethnic minority?
- Do the other means like facilities, finance resource etc, have been needed for the application of the community based in health care? What were lacking for a better run?

8. Local political advocacy

- Do you know the political regime of the State and Communist party on decentralization and financial autonomy? What are they? Is it easy to implement?

- Do the lower levels receive the emergency supports from upper levels on this regime?
- Have the monitoring and supervision activities done regularly?
- What is the instruction of CBHD to do the community participation approach?
- Do you think the CBHD method on participatory planning can be contribute to the future changing of the country regime on autonomy and self responses within state system? Take example?

9. Health system

- What are the understandings and experiences of health institutions and professionals in community based approach of CBHD?
- The readiness of health system to change ways of management in term of organization, human resources, funding?
- It is flexible, supportive to respond to the needs of community?

Appendix F

INTERVIEW QUESTIONS
FOR CHAIRMAN PEOPLE COMMITTEE

Name.....
Address.....
Date of interview.....
Revenue.....

1. **The understanding and willing to participate of people**

- Did you know the CBHD project? What is the goal of this project?
- Did you know the right of citizen in participating socio-economy development especially in health care activities?
- What is the participation level of citizen in your areas? If not high, what were the main reasons?

2. **Actual participation of community:**

- Did your commune participate in the project activities? How was it? When was it? Specify the activities?
- Which of the activity do you think was the best? Which was not so good?
- Did your commune conduct some of health campaigns or health education activity (ITC) that introduced by commune or village health workers? What were the contents?
- These activities have been done regularly?
- Do you think the participation of community in health care has been affected to the health service or it was just a token only?

3. **The contribution and benefit from the project**

- Did you know the concept of mobilizing resources of the project? Which way?
- What have you contributed to the success of the project? Which activity? How much money? (Including the labor forces counted in money)
- What did your commune get from the project? Did your citizen receive a good service for health care? Or well consulted in disease preventions by commune or village health workers?

4. **The changing in quality improvement after the intervention of the project**

- Do you see some changing in health care in your community in good manner compare to the time before the project implemented?
- Do the commune health services change or not change? Do people satisfy these services? Or the performance of Commune and Village health workers?
- If we could do it better, what should be taking into account? Please giving some suggestion for CHW and VHW' improvement?

Appendix G

INTERVIEW QUESTION FOR DISTRICT HEALTH PLANNERS

Name of staff.....
Name of Health Unit.....
Date.....
Place.....

1. Community participation in health

1.1. Needs assessment of health with PRA

- How are needs identified?
- Does identification relate only to health service needs?
- Is the affected community involved in needs identification and assessment?
- Does the assessment strengthen the role of a broad range of affected community members?

1.2. Leadership

- In your community, which groups does the leadership represent and how does it do so?
- Is the leadership paternalistic and/or dictatorial, limiting the prospects of wider participation for various groups in the affected community?
- How does the leadership respond to the needs of poor and marginalized people?
- Do most decisions by the leadership result in improvements for the majority of the people, for elites only, or for the poor only?

1.3. Management

- Are decisions solely in the hands of professionals, or are they made jointly with affected community members?
- Are the decision-making structures changing in favor of certain groups, and if so, which groups?
- Are management structures expanding to broaden decision-making groups?
- Is it possible to integrate non-health needs?

1.4. Organization

- Are new organizations being created to meet defined needs, or are the existing ones being used?
- Are the organizations flexible and able to respond to change, or are they rigid, fearing a change in control? Emergency responses, and do changes benefit professionals or affected community members?
- What changes have taken place in the organizations since the introduction of emergency responses, and do changes benefit professionals or affected community members?

1.5. Resources mobilization

- What is the affected community contributing, and what percentage is this of the total response costs?
- Are resources from the affected community being allocated for the support of parts of the response that would otherwise be covered by government allocations?
- Whose interests are served by the mobilization and allocation of resources?

2. Assumption factors affect to the community participation

2.1 Cultural

- Do you think culture can be affected or influence to the participation of the community in health care? What are they for example?
  Notes: The concept of culture is normally very broad in term of linguistic, traditional life style of ethnic minority groups; working style of local staff; attitude and behavior of people in seeking for health care etc. Please state more related concept
- Did the community really want to improve the health care and health status? For example on health promotion; nutrition; health education; disease eradication etc.
- Your experience on the mobilizing ethnic minorities group in implementing the project? What were the advantages and disadvantages?
- Does the diversity of language challenge in communicate during the process of the project?

2.2. Community capacity

- Do the institutions within district administration units know about the community based in planning method?
- How many percent, approximately, of them know and done the "bottom up" planning?
- The CBHD project has been introduced by open course for the facilitators in the preparation period. However, do you think that was enough for implement the project? Are there some obstacles? And what are they?
- How many of your colleges have been taking part in the project?
- Do you think their capacity has been improved? Please specify the actual capacity or skills they have gained?
- If the skills of staff were not sufficient what should be providing more?
- Do you think health staff should also have some knowledge on anthropology when working with ethnic minority?
- Do the other means like facilities, finance resource etc, have been needed for the application of the community based in health care? What were lacking for a better run?

2.3. Local political regime

- Do you know the political regime of the State and Communist party on decentralization and financial autonomy? What are they? Is it easy to implement?

- Do the lower levels receive the emergency supports from upper levels on this regime?
- Have the monitoring and supervision activities done regularly?
- What is the instruction of CBHD to do the community participation approach?
- Do you think the CBHD method on participatory planning can be contribute to the future changing of the country regime on autonomy and self responses within state system? Take example?

2.4. Health system

- What are the understandings and experiences of health institutions and professionals in community based approach of CBHD?
- The readiness of health system to change ways of management in term of organization, human resources, funding?
- It is flexible, supportive to respond to the needs of community?

APPENDIX H

HEALTH RESULTS IN TREATMENT AND NATIONAL HEALTH PROGRAMS

Dong Khe Commune - Van Chan District. 2003-2006

STT	Indicators	2003	2004	2005	2006	(+) (-)
I	**General Information**					
1	Total population	5326	5281	5339	5230	-96
2	Numbers of woman from 15-49 of age	1355	1366	1455	1500	145
3	Numbers of children < 1 year old	78	83	94	87	9
4	Numbers of children < 2 years old	133	145	155	148	15
5	Numbers of children < 5 years old	354	349	391	393	39
II	**Curative services**					
1	***Numbers of examinations***	7188	7356	7483	8561	1373
	In which: + At CHS	3747	3987	4261	5035	1288
	+ Health care card for the Poor	133	356	331	761	628
	+ At the households	156	167	180	191	35
2	***Numbers of Treatment Patients***	181	210	236	257	76
	In which: + At CHS	152	170	195	225	73
	+ Patient with health card for the poor	95	120	157	186	91
	+ At households	78	84	88	92	14
3	***Numbers of referring***	123	105	96	87	-36
III	**Woman health care**					
A	***Maternal health***					
1	**Numbers of pregnancy**	93	87	84	86	-7
2	Numbers of maternal health checks	93	87	84	86	-7
	In which: At CHS	93	87	84	86	-7
	At households	0	0	0	0	0
3	Numbers of pregnancies who have third-times of health checking during the pregnancy period	88	83	81	84	-4
4	Numbers of maternal health checking	264	249	243	252	-12
5	Numbers of pregnancy who received consultant	93	87	84	86	-7
6	Numbers of delivery	93	87	84	86	-7
	In which At CHS and others health spot	63	65	70	85	22
	At home	8	7	3	1	-7
	Assistance by health staff	8	7	3	1	-7
	Without assistance of health staff	0	0	0	0	0
7	Numbers of obstetrical calamity – cases	0	0	0	0	0
	- Numbers of referred cases	0	0	0	0	0
	- Numbers of deaths	0	0	0	0	0
	In which : Calamity at CHS (Cases/Deaths)	0	0	0	0	0
	Calamity at home (Cases/Deaths)	0	0	0	0	0
8	Numbers of mother did health check after delivery	93	87	84	86	-7

B	***Woman health care***					
1	Numbers of gynecology health check	345	365	386	398	53
2	Numbers of people having vaginitis and vulvitis etc.	175	160	130	39	-136
3	Numbers of people success in treatment	155	135	124	25	-130
4	Numbers of abortions	34	32	25	19	-15
5	Number of women receiving consultancy on STD and HIV/AIDS	345	365	386	398	53
IV	**Children health care**					
1	Numbers of pneumonia children < 5 years old	99	76	68	52	-47
	In which: Check and treatment at CHS	99	76	68	52	-47
	Referring	13	13	11	9	-4
	Death	0	0	0	0	0
	Numbers of mothers having consulted on pneumonia and rational use of drugs	99	76	68	52	-47
2	Numbers of diarrhea of children <5 years old	35	30	24	20	-15
	In which: Numbers of checked and treated at CHS	21	18	14	11	-10
	At home (include VHWs)	14	12	10	9	-5
	Death	0	0	0	0	0
	Numbers of mother receiving the consultancy on diarrhea prevention and rational use of drugs	35	30	24	20	-15
3	No. of malnutrition children< 24 month of ages (level I, II, III)	49	42	39	33	-16
	No. of Children < 2 of age follow the wage and growth chart	133	145	155	160	27
	No. of Mother having children < 2 of age having consultancy on nutrition	133	145	155	160	27
4	No. of Children from 9 -24 month of age fully immunized	65	78	81	90	25
V	**Diseases prevention at community**					
1	No. of malaria clinical cases	23	17	11	9	-14
	In which examined and treatment at CHS	23	17	11	9	-14
	No. of referring	0	0	0	0	0
	No. of Death	0	0	0	0	0
	No. of health education on Malaria Prevention	15	19	25	28	13
2	Total numbers of Tuberculosis mobility	6	4	1	2	-4
	In which: No. of AFB (+)					0
	No of patients to be controlled and treated	6	4	1	2	-4
	No. of death caused by TB	0	0	0	0	0
VI	**Fatality situation**					
1	No. of mortality	22	27	25	23	1
2	No. mortality of children < 1 year old	1	0	0	0	-1
3	No. mortality of children < 5 years old	1	0	0	0	-1
4	No. mortality of pregnancy women	0	0	0	0	0
						0

Note: Ordinary numbers (+) are for increase and minus (-) are for decline

APPENDIX I

HEALTH RESULTS IN TREATMENT AND NATIONAL HEALTH PROGRAMS

Nam Lanh Commune - Van Chan District. 2003-2006.

No	Indicators	2003	2004	2005	2006	(+) (-)
I	**General Information**					
1	Total population	2795	2852	2987	3044	249
2	Numbers of woman from 15-49 of age	584	590	658	671	87
3	Numbers of children < 1 year old	57	62	66	75	18
4	Numbers of children < 2 years old	100	116	136	133	33
5	Numbers of children < 5 years old	325	318	330	356	31
II	**Curative services**					
1	***Numbers of examinations***	3478	3523	3754	3870	392
	In which: + At CHS	2257	2468	2591	2689	432
	+ Health care card for the Poor	2257	2468	2591	2689	432
	+ At the households	1221	1055	1163	1181	-40
2	***Numbers of Treatment Patients***	256	274	295	326	70
	In which: + At CHS	156	189	197	210	54
	+ Patient with health card for the poor	156	189	197	210	54
	+ At households	100	85	98	116	16
3	***Numbers of referring***	47	42	36	21	-26
III	**Woman health care**					
A	***Maternal health***					
1	**Numbers of pregnancy**	57	59	67	57	0
2	Numbers of maternal health checks	57	59	67	57	0
	In which: At CHS	45	46	58	55	10
	At households	12	13	9	2	-10
3	Numbers of pregnancies who have third-times of health checking during the pregnancy period	30	36	48	52	22
4	Numbers of maternal health checking	102	121	153	158	56
5	Numbers of pregnancy who received consultant	57	59	67	57	0
6	Numbers of delivery	57	59	67	57	0
	In which At CHS and others health spot	26	30	42	51	25
	At home	31	29	25	6	-25
	Assistance by health staff	20	22	21	4	-16
	Without assistance of health staff	11	7	4	2	-9
7	Numbers of obstetrical calamity – cases	0	0	0	0	0
	- Numbers of referred cases	4	3	1	1	-3
	- Numbers of deaths	0	0	0	0	0
	In which : Calamity at CHS (Cases/Deaths)	0	0	0	0	0
	Calamity at home (Cases/Deaths)	0	0	0	0	0
8	Numbers of mother did health check after delivery	49	56	66	57	8

B	***Woman health care***					
1	Numbers of gynecology health check	277	280	344	352	75
2	Numbers of people having vaginitis and vulvitis	244	200	196	120	-124
3	Numbers of people success in treatment	244	200	196	120	-124
4	Numbers of abortions	4	2	2	1	-3
5	Number of women receiving consultancy on STD and HIV/AIDS	277	280	344	352	75
IV	**Children health care**					
1	Numbers of pneumonia children < 5 years old	50	40	33	32	-18
	In which: Check and treatment at CHS	40	32	27	20	-20
	Referring	10	8	5	3	-7
	Death	0	0	0	0	0
	Numbers of mothers having consulted on pneumonia and rational use of drugs	50	40	33	32	-18
2	Numbers of diarrhea of children <5 years old	21	16	14	11	-10
	In which: Numbers of checked and treated at CHS	16	12	10	10	-6
	At home (include Village Health Workers)	5	4	4	1	-4
	Death	0	0	0	0	0
	Numbers of mother receiving the consultancy on diarrhea prevention and rational use of drugs	21	16	14	11	-10
3	No. of malnutrition children< 24 month of ages (level I, II, III)	42	39	36	31	-11
	No. of Children < 2 of age follow the wage and growth chart	100	116	136	140	40
	No. of Mother having children < 2 of age having consultancy on nutrition	100	116	136	140	40
4	No. of Children from 9 -24 month of age fully immunized	51	55	57	59	8
V	**Diseases prevention at community**					
1	No. of malaria clinical cases	25	14	12	2	-23
	In which examined and treatment at CHS	25	14	12	2	-23
	No. of referring	3	2	0	0	-3
	No. of Death	0	0	0	0	0
	No. of health education on Malaria Prevention	6	15	18	24	18
2	Total numbers of Tuberculosis mobility	0	1	1	1	1
	In which: No. of AFB (+)	0	1	1	1	1
	No of patients to be controlled and treated	0	1	1	1	1
	No. of death caused by TB	0	0	0	0	0
VI	**Fatality situation**					
1	No. of mortality	3	4	3	3	0
2	No. mortality of children < 1 year old	0	0	0	0	0
3	No. mortality of children < 5 years old	0	0	0	0	0
4	No. mortality of pregnancy women	0	0	0	0	0

Note: Ordinary numbers (+) are for increase and minus (-) are for decline

BIOGRAPHY

Nguyen Xuan Son was born in Hanoi the capital of Vietnam on April 1st, 1962. He got his Bachelor of Public Administration in 1998 and Bachelor of English in 1997 in Hanoi. He has been working for Ministry of Health over 8 years in the position of expert on health care system development of organization and manpower. In 2007, he received a scholarship from Siam Cement Group to do his Master Degree in International Development at Political Science Faculty, Chulalongkorn University, Bangkok, Thailand.