CHAPTER IV

ANALYSIS AND DISCUSSION

> *"Community participation in health care is an active two way process that may be initiated and sustained by both individuals and communities and by local and health authorities and other organizations. The level of participation and involvement was considered as having benefits for both the communities and professionals, in particular the potential to increase democracy, mobilize resources and energy, develop holistic and integrated approaches, achieve better decisions and more effective services, and ensure the ownership and sustainability of health program."*
>
> *(WHO, 1999)*

In this chapter, the findings of the study will be analysis base on the frame work that has developed in the beginning. The collected information in the field together with available literatures debating on the community participation health care development both in principal and practice will illustrate the findings. The issues discussing in this chapter will be the involvement of community in the process of planning and implementation in the context of political and administrative point of views in Viet Nam because of its possibilities to disseminate and reapplication in the widen range in disadvantaged areas in the country. Therefore, the combination of theoretical of the approach and experiences found in CBHD project can be use as a main framework to analysis features of community based in health care as well as the perception and understanding of community to the approach. They are:

- involvement of community in health needs assessment
- leadership
- organization and its role
- health system management
- contribution of the poor communities
- perception and understanding of community
- ethnicity in community participation.

4.1 The involvement of the community in health needs assessment

The most important in health needs assessment is to gather information on local people's views of their health needs and resources. To mobilize the community will ensure that any health service developed will be based on local needs acceptable to the population. (Kahssay H.M & Oakley P.-1999) In this way local people can understand and increase awareness of the purposes of the health development work. The health problems discussed have to be presented in a simple ways. Then people could be able to describe their health problems and propose solutions. In the CBHD project, Participatory Rapid Appraisal in Planning (PRAP) was the main tool when identifying local health needs. Some of the tools, like mapping, group discussion, season calendar and wealth ranking, were creatively involving people to participate in the planning process. However, the local people should be to choose among the tolls. Then they could select the tools they find appropriate.

> *"The third integral characteristic of Vietnamese medicine is its foundation in community-based medicine, with the people providing their own care. ...this approach has helped to alleviate critical shortages of personnel, particularly in rural areas. In addition, it is consistent with Socialist ideology".*
>
> *Judith L. Ladinsky; Ruth E. Levine(1985)*

Not only the identification of the local community needs but also the priorities set is often coming from upper level targeted in a national agenda. It should be a better connection between local and national priorities including health needs identified by local groups. At the national level, priority on health issues are often made from cross-cutting surveys, in Vietnam mostly related to the National Health Program done by central level health professionals. Each of the programs will target their own plan with its own funds sent down for implementation to the local levels. The national health programs have improved the health during the past years in Vietnam. The programs have also created problems related to health management especially at local levels. As the programs are vertical it becomes difficult to integrate them with each other. Health staff at the commune level has focused their work on national health programs. Other health work as curative care has been a priority.

Sometimes conflicts are created between the national top-down agenda and the health needs identified at local level. The bottom up planning is suffering. Balancing these two approaches is not an easy task for the local level health care.

In the CBHD project, this obstacle was seen already at the outset of the planning sessions. The problem was how to connect the overall plan of community master development plan of the health sector with the national health programs. How could revealed local health problems bee solve by the local authorities? In the beginning the project plan was separated from the ordinary health plan. Some analyzes were done by the project and some concluding were made. First, the context of needs-based planning was not well understood especially at the commune level even by the health planners. Still a top-down approach was used where activities were targeted from the upper levels. Secondly, there was alack of proactive mechanism from the local health authorities. A long period of centrally subsidized planning and financing mechanisms has limited the involvement of the communities in the identification of their health problems. Thirdly, the understanding of the approach on community participation was not well introduced from the beginning of the project. People did not understand what the benefit would be when using community participation. In other word the purposes of community participation in health was not clear to them. The role of community participation was then just to be represented by of the locality authorities receiving project funds to further improve the already defined health situation.

Consequently, some of the community members were confused .They did not know what type of planning method they should be followed, the normal top-down or the new bottom-up introduced by the CBHD project. They did not know what the needs assessment should be used for. Hence they did not participate actively in the process. The analysis report of CBHD in Yen Bai was stating that:

> *"The purpose of PRAP tools used in needs assessment was not clear to every one who participates in the PRAP...then the finding and solutions in the plan were not suitable to the needs and priorities of some householders."*
>
> *Final Analysis Report of CBHD' Yen Bai*

The participation of the local mass-organization in the CBHD project had been significant improved. The CBHD project has strongly made investments into these groups. Training was done on Primary Health Care management, introducing the approach of community based monitoring. The mass-organizations were considered as a key component of mobilizing local people.

In contrast, at the village level, people strongly participated and were highly interested in discussing how to improve their health. They participated very actively in group discussions and the planning sessions. This indicates that the villagers are very concerned about their own health. Women groups at village level were especially active in the discussion as well as in finding solutions to local health problems.

4.2 Leadership

In the PRAP group discussions there was a presence of representatives of community leaders were communist party leader, local authorities, mass-organization and head of villages. At this time the questions "what the leadership represents and how leadership" was used should not be discussed as the answer would surely be the Communist Party Committee. It is better to ask who managed the social and economic development plans in the community. The following are some description of characters of leadership in Viet Nam.

In Viet Nam the concept of leadership is still unknown especially in the rural and mountainous areas. The Communist Party and its political bodies - the mass organization like the Woman, Youth, Veterans and Farmers Unions have always played the role of leaders. Since the first constitution of Vietnam this has been stressed (Constitution 1992, Article 4). Every new direction and policy setting for the development of the country will put forth the resolutions of the party. The resolutions give direction for the whole society from the national to the local level and from the big party committee to the small party cell to implement. It does not mean the Communist Party take over the role of the Government to manage the country. The Party gives direction, in the development with the slogan of "society of equity, democracy and civilization". This issue has been openly known since decades when

Viet Nam has moved to a market-oriented economy. The role and leadership of the Communist Party and the role of the Government has to be clearly distinguished. This trend has moved forward in recent decades since the Decree of democratization and Public Administration Reform has been put into place. However, at the lower levels, the interpretation of resolution coming from the upper levels can be different and depend on the style and strength of local leadership. Despite changes and efforts to clarify the distinction between the Party and the State, the Party does remain central to the policy process, through both formal mechanisms - such as the role of Communist Party of Viet Nam committees - and its role in consultations at all levels.

Leadership at the commune level has been concentrated two main groups, the Party and its bodies (mass-organizations) and the local government. The Party is the main component and plays a very important role in decision-making by giving out the resolutions. The resolutions are often coming form the upper levels and are implemented down at village level (village party cell). The commune local government has the role of administrative management of resolutions together with its specific sections like agriculture, health, education and irrigation. The political and administrative system in Viet Nam is stable.

The leadership is very strong in the studied communes. In one hand that makes it easier to reach the objective of the project but on the other hand that could limit the participation of other group in the community like the poor household and marginalized people. They are not confident to bring out their ideas and seldom join the monitoring activities of the project.

The mass-organizations like Woman, Youth, Veteran and Farmer Unions play a role to propagate and mobilize the whole society to follow the directions of the party and state. They are actively involved in health care development since they are members of the Commune Health Committee[1]. All the problems of the community

[1] Community Health Committee was set up at Commune level to lead the health care at local stipulated by regulations of Viet Nam. The members of this committee are Commune People Committee leader, Head of Commune Health Station, Representative of masses and other member in commune.

have to come solved from upper levels and will be put into the party resolutions accordingly. This seems to be a very top-down approach. It can lead to success in some ways but it dismisses the initiatives at the lower levels and waste of time, money and human resources.

It could be saying that the leadership in our communes did not contribute fully to the prospect of wider community participation for various groups in the community. But this could be also problematic for the ethnic minorities and the poor when they are not encouraged to participate in addressing their opinions on health issues. The leaders were not strong enough to mobilize people in the participatory process. They just told people what to do.

4.3 The use of existing organizations in CBHD

Bracht and Tsouros (1990) in their study have discussed some aspects of organizations which reflect current deficits in organization's capacity to encourage effective participation. Public health professionals and community workers lack both training and creative skills to assist the process of community action. Moreover, they noted a general lack of appreciation of the complex social and political dimensions of effective participation. The problems therefore are mainly on the structures of the organization and its capacity.

CBHD project has from the beginning stated that there is no need to set up a new organization to apply the new approach. Why don't use the existing units in the political and managerial system to take part and respond to the health development at all level? All of the supports of the project in financial or technical terms were integrated with the development goal of the local community. Human and financial resources as well as facilities of the local community government were considered as Vietnamese contributions. At the district, commune and village levels, there was no contribution from the project for extra staff allowances.

Committee leader, Head of Commune Health Station, Representative of masses and other member in commune.

The assessment report of Bent D Jorgensen and Pham thi Phuong Thao, (2007) on *CBHD participatory method* said that the workload of the project had been a burden to the commune leaders and staff since they did not get any allowances. But they did not discussed what would happen with allowances in the future when the project ended if extra allowances would be provided. The project contribution was therefore not only for the goal of project but also related to the sustainability of activities for the future. In addition, at the commune and district levels the Government Administration System has a Commune Health Committee (described below) assisting the integration of activities and human forces with others sectors in the community. Health care in the future will no longer be the duty of health sector alone.

The CBHD project adopted the existing system of political and administrative organizations for the implementation of project. The Commune Health Committee played a main role in the project management. Monthly review meetings were held with the participation of all member of the committee. The chairman of the People's Committee and other mass organizations had been actively involved in the intervention at the village's households. Monitoring was often done by the committee for example on the sanitation construction works. Sanitation and environment campaigns were regularly done by the leaders of all communes visited.

At all level, in the project organization the integration in vertically (health sector) and horizontally (local government) were observed. The CBHD did not set up a for the management and implementation of the project. By doing in such way, people in the Committee will change their perception and understand more about the purpose of project in particular and the health care affairs in general by taking part in the project cycle and get more familiar to the approach of community based. However, the other sectors and members of Health Community have their own duty. Therefore time spending in health care was not much or in other words the participation was limited but in emergency case for example the case like "bird-flu" epidemic disease appeared they should actively take their response to extinguished - has been said by a Chairman of people Committee.

The CBHD project required community participation by using the existing administrative system in a flexible way. This had many advantages. Firstly, there was not a separate management board or regulations for the implementation of the project. By doing so, the project could avoid work overload for the commune' staff when involved. Secondly, the project could then increase the capacity of the system and assured that the result of project could be sustained within the existing system of public management. Thirdly, the CBHD had to assure the sustainability of the approach after the project. The community should be able to manage in their own way in the future.

To sum up, we can say the integration of health to other sector and local authorities will shape the relationship between the health organization and its owners and create a positive impact on accountability of governance at local level.

4.4 Administrative reform in health care system and the CBHD spirits

> *"Some appreciation of the nature of bureaucracy is important in understanding how to ensure effective community participation. Many features of complex modern organizations are themselves obstacles to participation. Bureaucracy has been defined as 'a centrally directed systematically organized and hierarchically structured staff devoted to the regular, routine and efficient carrying out of large scale administrative tasks according to the policies dictated by rulers or directors standing outside and above the bureaucracy' "*
>
> *(Kamenka -1989 pp 157)*

CBHD was though that the Grassroots Democracy Decree 29 and the Public Administration Reform will give support to the CBHD approach as expected. Ideally, the CBHD project should have been a bridge connecting the macro political and policies with the life of people in the local disadvantaged areas. The decentralization process was not well known in the project areas. More involvement of different actors (political, local government, private, non-organizations etc) should have been assured.

Then suitable policies for improving the health care system could have been better formulated. A better balance between central governmental control and local levels institutional autonomy needs to be developed to promote more independent analytic input linking information, analysis, and research to policy decision making. (Lincoln C.Chen, et al. 1994, pp.18)

The CBHD project should not be separate from the development of local community. By integrating the work of project into the local planning system, CBHD succeeded in some respects but not in others. It is important to say that the aim of the project was to stabilize the society by improving the health status of the poor marginalized ethnic groups in disadvantaged and remote areas. It did not have the same objectives as other projects around the world described by Rene Loewenson (1998) in her case study of the health system development in Zimbabwe:

> *"...participation must be seen to affect outcomes and produce visible results; participation should enhance the possibilities for meaningful public input, including from the poorest groups, rather than provide one more bureaucratic structure that distances systems from knowing, understanding and addressing pressing health issues".*

To summarize, the health sector needs the participation of all sectors, as health professional, state managers and policy makers, taking part in the process of reforming public management of health care with the system of administration. Health system is one of the main actors to involve communities in health care. To make people more concerned regarding health care, the health system needs to be more systematic and transparent in how evidence is used in decision making. Therefore health system has to change to become more efficient in management and more community-oriented.

In Viet Nam, at all level the Government has set up the strategy to improve the health system related to different groups of people (ethnic minorities group, women, children, poor and the elderly). This includes the consolidation and development of primary health care/community-based services; strengthening preventive care and

health promotion and improving curative care system. However, some description related to the health system and its managerial functions could be useful to understand especially the health care at grassroots level.

The health system of Viet Nam has been seen as a complete and fully work-out system with the administrative levels from central, province, district and commune. This health system is now facing a number of problems. Structural and economic changes imposed by market reforms have had strong, often negative, influences on the system. It has created inequalities in the access to health care. The investment on health care has been less in rural and disadvantaged areas. Skillful staff has been moving to the big cities since there were no strong incentives to keep them to stay in rural areas. The management capacity both in curative and preventive was weak at the local health care levels. Public health services at commune level are available but they are under utilized. People often by pass the local level going directly to the district and the provincial hospitals to have treatment as the quality of demand did not meet at the local level.

Main activities at commune and village levels are more related to health prevention than to curative care. The national health programs (more than 14 programs in total) are running down from central, provincial and district to commune levels. The local levels are suffered from huge workloads as report writing and doing surveys. Consequently, the quality of services could not be assured. Many patients go directly to the district hospital seeking health care. This creates an overloaded of patients in upper hospitals. There is an urgent need to find out how to manage the works at the commune level.

The aims of the CBHD project was to create better accessibility for the poor people to access public health institutions by investing in facilities, equipments, retraining for health staff on management and upgrading their professional skills. Changing management was a priority in this project. To integration the national health programs to find out the real needs of the community in planning has been introduced and given much attention when identifying health needs the participatory needs

assessment approach have been used. Both health provider and client can then learn from each other. Health staff can have a broad view on health needs looking at the environment and the attitude when looking toward to health care. People should also be aware of how to protect their health and how to keep a healthy life.

The CBHD project supported and mobilized integration both in vertical and horizontal management in health care at commune level: Warnings were made by WB in 1994 *"...there is an abundance of duplication of services between vertically organized programs and horizontal service provision."* The only obstacle was the upper levels (central, province and district levels). In the future, there is a need for further research focused on the local commune and the workload causing by the implementations of many national health programs.

4.5 Contribution of the poor community

A question has to be raised related to the contribution of resources from the local people. It was difficult to find the answers in the CBHD projects areas. The contribution from the local people was what people had in hand as labor forces and available materials. Questions were also raised to local authorities about their contribution to the project. All the responding people answered that the state budget was not enough even for the administrative expenditure. Therefore, the CBHD project accepted the labors and materials contribution from the locals. The aim was more for sustainability and as initiatives towards the community-based approach.

> *"...in terms of public mobilization and the contribution of labor or monetary resources to run various health activities, some of the most successful community-based health initiatives were those that received financial support from external agencies within limited pilot timeframes, which does not give much hope for scaling successful projects up to national level"*
>
> *(Godfrey M. Mubyazi and Guy Hutton -2003 pp2)*

However, for poor areas and poor people the contribution had to be carefully considered. People work hard a whole week just to be able to feed their families. They may not have enough time to participate in the project. The poorest members of a community are often the most vulnerable people. Their opinions could then be very valuable. The CBHD project has the objectives to make special efforts to enable them to participate.

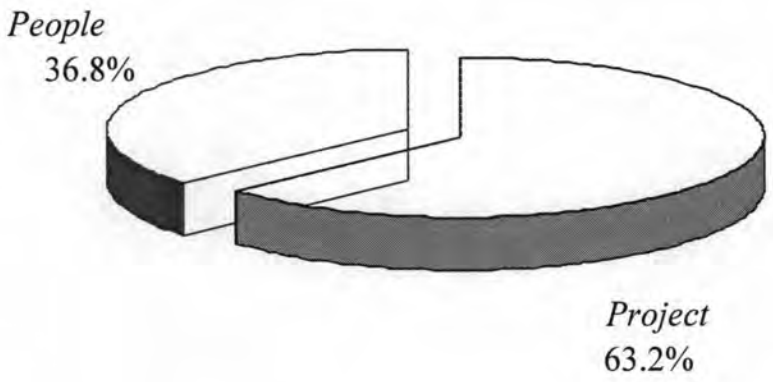
In the report of Bend D Jorgensen and Pham thi Phuong Thao (2007) in the assessment of the Community Based Approach in the project, they stated that the poor household was falling in debt trap when the project intervene to support the building of water systems requesting a high contribution rate. They suggested that the CBHD project should fully subsidize the poor household instead of force them to contribute some funds for project. The contribution that CBHD required was just for labor and available local materials. People did not have to contribute money and other valuable goods. Some communes gave support to the poorest household by mobilizing other resources and labors from Youth Union and Veterans Union. Then the near poor were supported. In some districts, evidence showed the awareness of participation of District People' Committee. They contributed more than 50 millions Vietnamese dong to upgrade Commune Health Stations to reach the National Bench Marking (MoH, 2003)[2].

The contribution was the main dimensions to assess community participation in health care. Contribution of a community can only be assured when the community members themselves feel that they can self-financed with no subsidization from outside. The contribution of the poor always has to be carefully examined. Participation should not put people into risk and in a situation of debts and fear to participate. Below is a figure of the contribution rates of people in the village intervention related to hygiene and sanitation improvement and clean water system construction work in Yen Bai.

---

[2] There are Ten National Bench Marking for Commune Health that has been set and promulgated by the Government in 2003. In which the Commune Health Station should reach the standard of 9 technical rooms for the executing the health services.

Figure 5 *Contribution rate between CBHD project and local people*



Sources: Provincial Community Based Health Development Project of Yen Bai

4.6 The understandings of community on the approach

The findings in Chapter III raised the issues related to each group of community on their perception and understanding to the approach. For sure there were differences thinking because of different gaining or expectations of each member. To analyze this complexity situation, researcher aims to look in two issues: The unique in understanding of every member in the community must be the same and the clearance of role, function identification has to be taking to consideration when apply the approach of community participation in health.

Firstly, "work together" mean that everyone should understand that they are on the same board, go to same direction. The community participation on health care in CBHD found that there were differences in expectation of members in community. The health professions do not take away their view of thinking of health is the absent of diseases as announced by WHO, the view must be more broadly putting improving health as the context of biochemical science and together with the help of techno in health care (Susan Riftkin 1986). Moreover, the participation process brings them to more reality and practice; pull them out of the laboratories and hospitals to learn from community. They perceived health gain on an individual level in terms of knowledge

gained and confidence achieved. Self-confidence and self-esteem was developed through the participation process.

The local authorities have also to change their mind in state management considering that health care is one part of the socio-economic development of their community. To protect their citizens' health by involving them into the process is efficiency ways to improve their awareness in protect themselves from illness. So that, co-learning, co-operation in health care but more with the hope of collective action that community could run the approach without outsiders will be a dream of community. Thus, the unique in understandings of community members on purposes, goals and implementation of community based are very important.

Secondly, the role and function of each members of community has also taking in community participation. This approach can be in practice only when the duties and level of having power clearly defined. The participations then equal to everyone, the benefits and incentives then could balance the relationship of community (Woelk -1992). Therefore, needs of the whole society is more priority than for a small group in the community. The responsibilities of each member can be in practice when the community involved in health planning and implementation that made more explicit for who benefits directly from health services. And the targeted beneficiaries are the poor and ethnic minorities groups. The role of political and executive's administrations and health professions has to be clear identify. That can avoid the overlapping in functioning of the approach and lessen the participation of others community bodies. The rights of people especially the poor and ethnic minority on taking part in thee health care of community is not only for creating the democratization but more for improving their perception of health care and health protection when they attend to the process.

4.7 Cultural and ethnic concepts in mobilizing

Ethnic groups in Viet Nam have been recognized by national classification. Minority ethnic and religious groups can be marginalized within a community. Community health needs assessments may not include the most marginalized and

vulnerable groups. Therefore, there is a need to be aware of the different ethnic and cultural groups within a community. In health care and other services, different groups face different problems and require services that are sensitive to their cultural and linguistic background. As usual, health planners and health project staff considered beliefs and customs (culture) to be potential barriers to initiating new health measures and ideas but actually it was not the case in our areas. We considered culture to be local knowledge (indigenous medicine) and local approaches to assure health care for community members. As some of scholars findings, culture is not very much affected to the community participation in health care, but it has to The only barrier faced is linguistic problem for communication.

In the community, there may be one or many languages in use together with local or regional dialects. Language and literacy are essential for communicating health information and for accessing services and community participation. If literacy is a problem within a community, be sensitive to this and take account of it when deciding on methods of community participation. Knowledge of local minority languages is vital to ensure equity and to enable the whole community to become involved in the community health needs assessment process.

Interviewer:

"Do you have any difficulties when working in health care especially when you do the CBHD project?"

District health staff:

"...many difficulties, affected too much. That's ethnic' language. We did project in three communes but only Hoang Thang Commune because there are haft of "Kinh' people but not in Tan Hop with nearly 70% of them is Dao (Mien) and Tay ethnics."

Interviewer:

"When communicate you need an interpreter? "

District health staff:

"We do not have it but the speed of speech has slow down the progress. Some time we did not receive the right information... There are different ethnic and each of them have a different manners and customs. The Dao and Tay when

communicate they might not speak out and show their opinions. Very difficult to explain to them ....most of them can not read and write..."

Prejudice of major to the minority is trend to make more gap of participation of ethnic minority in taking part to the public activities. People were often saying that ethnic minorities living in mountainous does not have the competence to joint in the society management and referred that they are backward. This is still a challenge for the ethnic minority people participating in development as they are sometimes looked at without respects. The adaptation process may be better today but it had to be keeping in mind that every ethnic minority groups has their identity and traditional background of cultural, life style and ways of seeing the world of nature around. If we wish to help them to improve their health, we must emulate their holistic, preserving their identity, using community based approaches with a better appreciation of the capacity of their culture to utilize their knowledge adapting the complex and changing conditions in health care.

4.8 Conclusion

The conclusion of this analyzing would stressed that community participation in health care could be in practice and success only when it has been put in the context of government propaganda and mechanism supported by the provincial and central authorities with the clearly and unique understandings within the community members on the purposes, instructors for the implementation. Experiences of CBHD project shown that each of the dimensions can be an advantaged or disadvantaged when community members admitted with a virtual view of adjusting and implement the community participation in health care development.

The analytic of problems above also seen the of most crucial aspects that related or have influenced to the approach within the context of political and administration system, health care management in disadvantaged areas of Viet Nam. Because of the time constrain the study has been limited to explore other aspects that might affected to the approach. However, there will be a need for further study in the future.