CHAPTER III

RESEARCH FINDINGS

The field study has been conducted in Yen Bai, the Northern Mountainous Province of Viet Nam where the Community Based Health Development Project has just stopped intervention in 2006. Two districts purposively selected were Van Chan and Van Yen base on the criteria of geographical representatives of poverty, mountainous and remoteness with more than a half of population being ethnic minority. A frame of poverty criterion set by the Ministry of Labor, Invalids and Social Affair of Viet Nam – MoLISA was used for the selection. *(The informants profile will be follow in the next item)*

This chapter aims to describe the assessment results of the situation of the community based approach and community participation in health care that been done in four communes in these two districts. The study will use the assessment tool that have been developed and used around more than fifteen countries. This tool has been developed by Rifkin's and Karin A Lehman (1999)[1] to measure the level of participation of people in the health care activities. Experiences have been used to revise the tool adopted for each situation and condition of each country. For the measurement of community participation in health care, the study used the ranking scale looking at five dimensions of community participation: (See detail in Appendix A and B).

- Needs assessment,
- Leadership,
- Management,
- Organization,
- Resource Mobilization

[1] Rifkin's and Karin A Lehman (1999), "An Instrument to Measure the Level of Community Participation in Community-based Health Initiatives: a tool for participatory planning and process monitoring that presented at the Third Annual CCPH National Conference, Leadership for Healthier Communities and Campuses, Seattle WA, March 27-30, 1999

As in the problem statement, the study also assumed other aspects that might have influence to the approach of community participation. They are perception and understanding of community, health system and community capacity, political advocacy and ethnicity culture. Information was collected in the group discussions and interviews focused on certain topic that has been set from the beginning to investigate above dimensions. Questions have been prepared for each variable suitable to the study areas of ethnic minorities and mountainous people along with the dimension below:

- Perception and understanding of community on the approach
- Political Advocacy and Administration,
- Cultural and Ethnicity,
- Health System and Community Capacity.

The study also investigates available secondary health data at commune health stations. This is done to illustrate the changing and the improving utilization of health services at the commune and village levels. Household interview is another resource to find the differential information on people's satisfaction to the health services. In general, both methods used, as group discussion and the interviews are combined to assess the perception and understanding of community participation of people in these areas.

3.1 Community Profile

The study area is in Quang Minh, Tan Hop (Van Yen district), Dong Khe and Nam Lanh (Van Chan district). In each commune group discussions were conducted. In every village interviewed two households were interviewed. Below is the community profile on some information of setting areas on general socio-economic, health facilities and staff for two districts and every commune as well as some features of visited informants.

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Table 4 Community Profile in Research areas

Settings	***Geography***	***Population***	***Income***	***Livelihoods***	***Health facilities &staff***	***Culture***	***Access DHC***
Van Chan District	- 2200 km2 - 3 small town 29 commune, 352 villages	- 145.648 -31,230 households	80USD Per head peryear	Farming, forestation and home craft	-1 district hospital - 6 policlinics - 28 CHSs - 286 health staff - 376 VHWs - poor conditions of facilities and equipment	13 diversity group of ethnic minorities mainly are Dao (Mien) and H'Mong	Mainly by motorbike and on foot
Van Yen District	1890 km2 1 district town 26 communes 319 villages	- 114.100 - 23.532 households	72USD/head/year	Cinnamon forestation, rice and home craft	- 1 district hospital - 2 policlinics - 26 CHSs - 270 health staff and 319 VHWs	11 groups of ethnic minorities mainly are Dao (Mien) and H'Mong	Mainly by motorbike and on foot
Dong Khe Commune	-2.286 ha - 14 villages	-5.134 people -1203 households	????	Cultivation of rice and Tea plant - Exploitations of limestone	- 12 health staff in both policlinic and CHS (1 doctor, 3 asst.doctors, 2 secd. Pharmacist; 3 nurses, 2 midwifes, 1 upgrade be a doctor	66% of population are Tay minority	Mainly by motorbike and on foot

Settings	*Geographical*	*Population*	*Income*	*Livelihoods*	*Health facilities & staff*	*Culture*	*Access DHC*
Nam Lanh Commune	-3,890 ha of land -7 villages	- 3,044 people - 556 households	65,1% are poor households	Cultivation of rice.	-1 doctor, 1 asst.doctor, 2 nurses - 7 VHWs	90% of population are Dzao ethnic	Mainly by on foot
Quang Minh Commune	-4,816 ha of land -6 villages	- 2215 people - 449 households	-1,440.000 VND (90 USD).	Cultivation and forestation	- 5 health staff. (2 asst. doctors, 3 nurses) 2 absent for upgrade study - 6 VHWs - Lacking of equipments	Tay and Dzao (Mien) minority	Mainly by on foot
Tan Hop Commune	-6,179 ha of land -14 villges	- 3,581 people -771 households	25% poor household	Cinnamon forestation	- 4 health staff (2 asst.doctors,2 nurses) -14 VHWs - lacking of staff and capacity - one nurse absent for upgrade study	67% of population are ethnic minority of Dzao	Locate scattered (the most far villages is 8 km form CHS) could not access by motorcycle

The study areas are mainly Dzao (Mien), Tay and some of H'mong families. Most of the communes are poor and did not reach over the poverty standards set by the Ministry of Labor, Invalid and Social Affair (MoLISA). The standard criteria for poverty income is under 22 USD per/month and is far from the world's criteria of incomes under 2 USD per/day. The income of households is low and comes mainly for agriculture and forestation. There is some "trade village" of family handicraft but has not contributed much to the increasing of their income. The health status of people therefore is not good since their living standard is low and their access to the health care services is inadequate to meet the demand of people.

However, since the last two decades, the development of the country has also affected the ethnic minorities even if they still have their own strong sense of community and ethnic cultural identity. The backward rituals of those ethnics are still on restoration in the industrialization and modernization process of Viet Nam. The process of development changes their life style. Income has increased year by year with new techniques of cultivation in fertilizing, land reclamation, double cropping and irrigation. Therefore the behavior of health seeking is also changing. People are coming down to the commune health station to consultant by health workers or have treatment when they are ill instead of calling shamans or spirit healers. They can get free health check-ups and medicines from the Government Program Poverty Eradication Program Nr 135, which give support for disadvantaged areas.

3.2 Advantaged and challenges

The study tools and methods were well prepared as well as field plans and community preparation. There was a good co-ordination supported by the district and provincial teams. The right people had been invited to take part in the group discussions and it has done in a nice atmosphere. At the beginning, there were some nervous participants but later the group discussion had reached a good mood. People were progressively involved in the discussions but some of them did not have any

ideas to contribute. According to our observations, the group of villagers and Village Health Workers almost keep silent during workshop.

Limitation of financial support was an initial problem to the study. There was no financial support for the study. The sampling of the study therefore had to be narrowed down since the researcher had to manage with a small amount of funds for lodging, traveling, photocopy paper, training for interviewer, secretary, guides to the villages, data collection and translation.

Time constrains was also a problem for the study. Only three week was spent in the field. The work has been done rapidly by using group discussion and interview methods. If time had been available others tool like observation, ranking, daily route diagrams could have been used to find more results on health services operation and the ethnics people lifestyle, working status and conditions.

Communication to the ethnic people was another problem. Working in the areas of ethnic minority is not easy even for the local authorities and health staff. For outsiders that is even more difficulty. There were limitations in communication for group discussions and especially for the interview sessions. The language used was *Kinh* since there was no other choice. Therefore, between the interviewer and interviewee there was a gap of understanding. Questions have been developed as simple as possible but had to be revised for the next day in another village. The situation was gradually improved but not as much as expected.

The other purpose of the field visit was also to *collect secondary* data in the commune health stations. In some communes the filed documents was not carefully stored and data was not available not only for the project documentation but also the regular resources for health data statistic. The question is how the commune can analyze the health situation of the population if they could not have a surveillance system and trends of diseases patterns. The better administrative in running health stations could obviously contribute to a better quality of services delivery.

Ultimately, this study should have been conducted earlier or/either some year later. It is still too early to see the effects of the project. On the other hand that is too late to assess the process for the project approaches used since people in the four communes do not remember what has happened after four year of implementation. Certain time was required for them to remember things that had been done. For example, they could not remember how needs has been identified. But later, they could list the activities were done after additional explanations from the facilitators. Finally the results came out but not in the right order. When the results had to be repeated and sorted out the study members were happy. In the village, two of the eight study team members visited and interviewed households. The household members confused the CBHD project with other projects. When discussing about the intervention of the CBHD project on the environment and sanitation by building latrine and water system they then remembered the CBHD project. In the next section more findings will show the perception and the knowledge of the community members related to the content of community based approaches in the field.

3.3 Main findings on assessment of community participation

3.3.1 Ranking made by community

In the group discussion, the content of five dimensions has been discussed. Researcher and facilitators explained carefully about the study using the guideline developed by Rifkin's and Karin A. Lehman[2]. The study team has summarized the ranking made by the community participant's base on the scale to measure the dimensions. It was important to note that the results below will not give the true results as the researchers did not know how members in the study understood the measurement tools. However the results could be a good reference that could be used later in the discussion part. The interesting results below may help readers understand

[2] Rifkin's and Karin A Lehman (1999), "An Instrument to Measure the Level of Community Participation in Community-based Health Initiatives: a tool for participatory planning and process monitoring that presented at the Third Annual CCPH National Conference, Leadership for Healthier Communities and Campuses, Seattle WA, March 27-30, 1999

how people self-expressive their participation in health care CBHD project. In other word what were people thinking on their participation to the process of health development in their own areas:

Table 5 Ranking of Community Participation made by community groups

	Commune 1 (8 people)	Commune 2 (11 people)	Commune 3 (10 people)	Commune 4 (13 people)	Total Average
Needs assessment	5	4.2	4	4.5	4.4
Leadership	5	4.6	4	4.1	4.4
Management	3.8	4.5	3.8	3,8	3,9
Organization	4.5	4.7	3.8	3.8	4.2
Resources Mobilizing	4	4.7	4.1	3.7	4.1

According to the finding from the ranking results made by community members, it seems that the commune and village leaders knew well project purposes since they were involved direct and work with the project but not the people at village level. The results could not say for sure that the knowledge or understanding of the community members were sufficient or adequate. The findings below will show the results of each commune in Yen Bai by looking evidence in the five dimensions both in group discussion and interview resources. The available data form CBHD project management board in these four communes of Van Chan and Van Yen (plan, reports, primary data etc) were used to combining and checking the precise of data collected from the field.

Table 6 Findings base on the dimensions of community participation in health care

	Needs assessment	Leadership	Organization	Management	Resources Mobilize
Commune 1 Tan Hop	- Needs identify has been done long time that not clearly remember process - The problems finding that related not very much in health care activities like treatment, examination instead only focus on hygiene and sanitation	- Leadership was strong in leading community but focus mainly on the implementation not in the mobilization - Respond and support to the poor households by providing labor resource - Represent of mass-organization and other community members	- Using existing organization, not separated for project management board - Tightly in organizing project activities but decision has been made mainly by CHS - Mass Organizations joined to decision making process with indisposed	- Integration health activities in community development activities - Took involvement of Commune Health Committee CHC in management (representative of others members in community) - No changing in decision-making structure since project entered.	- Not strong in mobilizing resources from community especially form other members - Just providing for human resources - 40% resources coming form community but mainly labors and local available materials???
Commune 2 Quang Minh	- Health needs was done but not related to the needs of large population. Only in the 2 selected villages. - Affected by facilitators at districts health planner in needs identifications.	- Leadership was strong in leading community but in impose way - Health care has been concerned by the leaders of commune authorities - Has represented of mass-organization and other community members	- Using existing organization, not separated for project management board - Organization are to stable in direct community in socio-economic development instead of flexible in response to the change	- Integration in development activities of the commune - Took involvement of CHC - No changing in decision-making structure since project entered.	- Not strong in mobilizing resources from community especially form other members - Providing for human resources and materials but in very clear rate: Wealthy households: 50%, Average: 30%; Poor households 20%

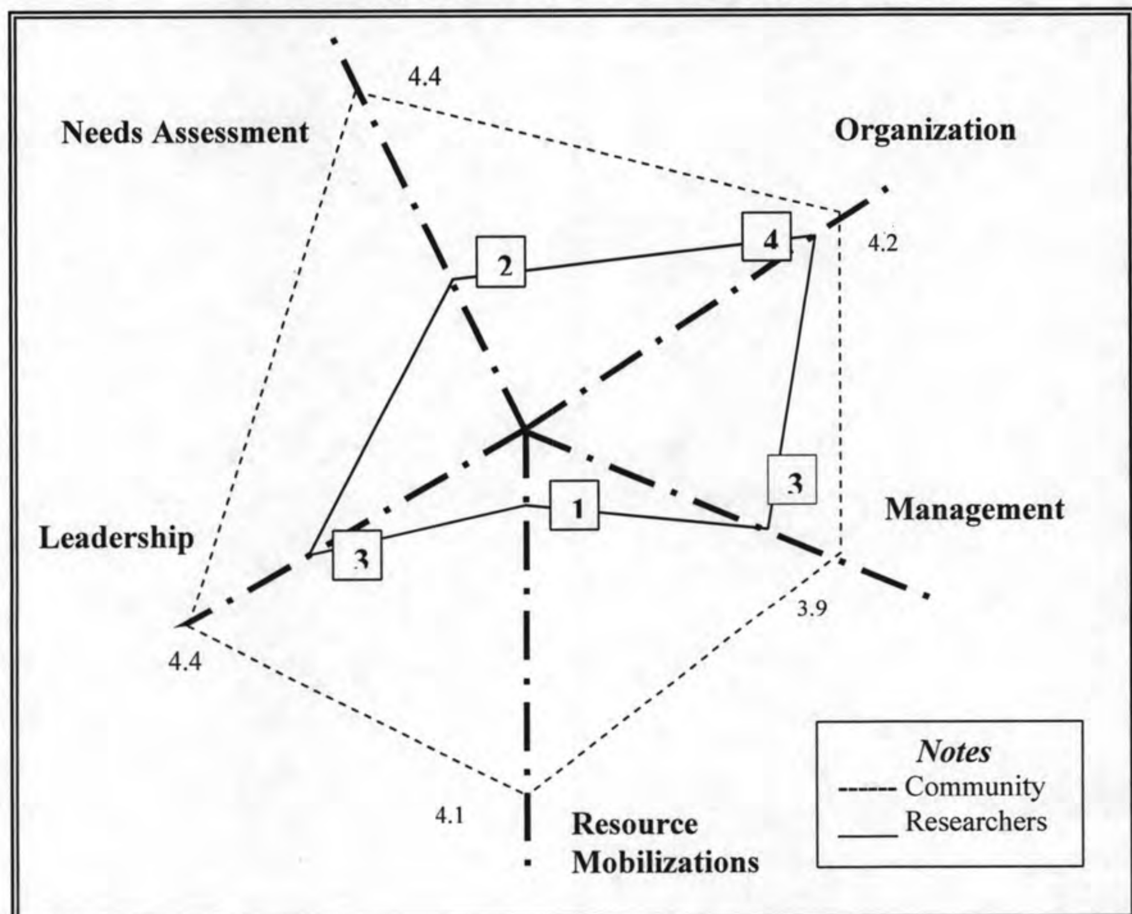
	Needs assessment	Leadership	Organization	Management	Resources Mobilize
Commune 3 Dong Khe	- Needs identify has done in long time but people still remember the steps to do PRA. - The large of community members took part in the process political, authorities, masses.etc - affected by subjective ideas of facilitators at districts health planners	- Leadership was strong in leading community but paternalistic and impose - Support to the poor households has not been focus and response - Has a representative of mass-organization and other community members - Decisions making collectively decided by the community members	- Using existing organization, not separated for project management board - Organization strongly in direct the community in implementation both of socio-economic and project	- Integration in development activities of the commune - Took involvement of CHC - No changing in decision-making structure since project entered.	- Not strong in mobilizing resources from community especially form other members - Just providing for human resources and available facilities from the government budget - Not clear percentage of contribution to the project and not public informed
Commune 4 Nam Lanh	-The committee board did not know how it was done. It was confused during first hour - Fully depend to the guide by facilitators -The role of masses organization have not been strong since their village was not select as the pilot one - Health identification was poor in progress	- Leadership was strong in leading community but paternalistic and impose - Not very much concerned for autonomy, subsidy ideas has represented in broad range. - Did not know clear concept on what was decision-making during the process of needs assessment. In PRAP process	- Using existing organization, not separated for project management board but it was changing some of position of cadres during implementing - Masses joined to decision making process with indisposed	- Integration in development activities of the commune. - Took involvement of CHC but was not strong. - Overload of managerial works since some of duplicated projects running at same time and same purposes	- Not strong in mobilizing resources from community especially form other members - Not clear percentage of contribution to the project, and not public informed

3.3.2 Scoring and summary

After looking into the situation of community participation of CBHD in certain numbers of aspects and dimensions the study has summarized in ways of qualitative method, using measure tools by Susan Rifkin and Karin A Lehman. There is differences results for scoring especially when involve the representative members of community into assessment process. Their view about community participation for sure was different by members, authorities, or level of management and so on. That result could be subjective since we did not know how far the members' understanding on using this tool to measure and what they could take the conclusion of discussion and use it in scoring.

However the study therefore has checked information between different levels to findings above and the differential between clusters of information that collected. That brings the assessment more in line with the real situation of CBHD in those areas as follow:

Figure 4 Spider Diagram on Community Participation



There were differences in ranking between the community and researcher when using the same given tools for measurement. The score that made by community during the group discussion was done so quick with a little information even that was very carefully explained and discussed rounding these dimensions. It has reached only more than hour for both activities. There were some reasons for that. Firstly, the time for member both in discussion and study the instruction using the community participation assessment tools was limited.. Secondly, there were also different members attended with different backgrounds and professionals. Their thinking/perception could be not the same and can be subjective in some ways. Thirdly, the appearances of community leaders in the workshop can be an influence to the results of ranking as well. However, after review other resources of data, the researcher has come to the main finding by stating scoring as bellow:

The "Needs assessment" or health problems identification in CBHD communes was under restrict (score: 2) level because the community just have only see the needs assessment of health problems in turning the interest of building latrine and wells or the water system but not seeing the more risk to the health problem that should identifications and form that they could manage to solve it. The process of needs assessment was not clearly remembered or confusing even from the leaders and response people who have attending in the whole process, especially in the core group at the village who were involved closely to the project. Need assessment of CBHD there for has reached only get people to know just in the community based leadership input. In the process of health needs assessment, there were the involvement of community members as mass-organization but not very much of the marginalized group in the village, the villagers did not know the project purposes and why they should attend this process of health needs identification. Moreover, the health problems were not identified base on the theory of approach. There were no much differences between the four communes but the conditions and situation or diseases pattern of each commune could not be the same as stated in the health plans.

"Leadership" is a fair (score: 3) according to the situation that, the leadership of community participation in mobilizing was not focus very much. However, in the socialist aspects of Viet Nam, the leadership in CBHD could not be recognized so much since the strongly influence of the leading of the communist party in driven any activities in development stage. With this score the study also assured that for the better mobilizing of community, the role of the mass-organization should be more actively since this project is provided the approach to practice to increase the democracy regime of communist party of Viet Nam. However, there might be some reasons for the scoring.

First, the role of Community Health Committee including party, authorities, masses organization to that aspect did not meet the demand of "pull" the others groups to implicate health activities.

Second, there was still a tendency for paternalistic behavior giving directions from the powerful political bodies and limiting the prospects of a broad involvement of others like the poor and vulnerable group in the community. The poor were not prioritized when the intervention was implemented. .

This project was luckily to take the existing administrative system as the "Organization" framework. Then the political bodies strongly advocated the success of the project. The organization was used as it was set up in the community. The good coordination between several sectors can be good evidence showing the well organized work in health care development. Regular meetings, direct monitoring and defined tasks giving to every responsible group are still remaining in the project area today. A weakness in the organization setup is the weak responses to the poor. The CBHD project has also changed the awareness of the administration system to participate in and giving their hands to health care in the community. The result (score of 4) indicates the good organization in applying the community based approach.

The "Management" result is as strong as "Needs assessment" (score: 3) in term of mobilizing the community. Still the capacity, the style of management and the decision making process are all remaining problems. Decisions were not made by the Community Health Committee (CHC) but rather done by health professional (Commune Health Station). However, there was not much change structure by decision making process and lessen the participatory of community to empower in decide what it should be for health care of the community. There was also overlapping in project management and coordination in one of the four study communes.

The weakest of the five dimensions is the "Resource Mobilization" within the community participation's dimensions (score: 1). The reasons of that is the project could not force poor community and poor households to provide budget together with reaching project objectives. Secondly, the contribution of local community was still nothing when it just provided human resources. Question also raised since then: How can the mountainous ethnic people in these areas contribute more than their own labor force since their income has reached only 80USD/per year? Results from Nam Lanh show the same way of mobilizing resource as the CBHD project. They attracted an international organization to intervene with water and sanitation improvement for the rest of household who did not get assistance from the CBHD project. The percentage of resource mobilized was in the proportion of 30 – 40% mainly as labor forces and available local material.

3.3.3 Conclusion

To conclude this part, the study would to stress that, the process of community participation in health care CBHD project has been done in a good way that people could have a chance to involve in health care activities. The awareness of community on health care protection has been increased both in local health, authorities, mass-organization and the villages. However, in some of commune, there was not so strong in mobilizing people and community in health care activities. If yes, it was just strained for the community to take part in the project planning and implementation.

There might be some of reasons but the study will come back in Chapter IV for more analytical of some of aspects.

3.4 Community's perception and understanding to the approach

Community perception was our first main focus and most important factors that might have direct influence to the community participation in health care, especially in the areas of remote and mountainous, more over within the groups of ethnic minorities. People assumed that the ethnic people always have been consider as backward and under-developed because of a variety of difficulties and disadvantaged in economics, education, health, social welfare etc. Thus, they do not know why they should attempt to be involved in health care activities.

As researcher mentioned in previous parts, when asking how the process of health need assessment has been done, people took a while and slowly remembered the steps of it. People could then list all the activities but not in the right order. They said as the time passed so quickly then they could not remember which activity was done first and what was the next. There might be two reason of that, either the time that activities was done so long that they could not remember or since this activities have been done only one time, when CBHD introduced to local people, but they did not have a chance to do it for second time.

> *"...The time is in the raining season in the year of 2003. The core group was trained...health problems and health needs were found by quick questions and answers...the main health problems were woman diseases, eyesore, ailing that call rapid appraisal".*
>
> *Head of villager*
>
> *"...Technical assistant coming to village, ask an 'open question' to people to answer, direct question and also in groups. They ask for the demand of people, what was lacking. After meeting, they come down to mobilized people, setting seasonal calendar, mapping, writing the plan, what should do first and what*

should do later. Prioritize the problems. For example many women have a woman disease that should solve by building clean water..."

Women Union representative

The CBHD project has used the method of Participatory Rapid Appraisal for Planning (PRAP) to identify the health needs to make plans aiming to improve the local health services. This was done in the beginning of the project with the purpose to make people involved in discussions and decisions based on their health problems and priorities. This activity was mainly done at village and commune levels where the community and people have their identity and values. However, the success of this approach can only be achieved if the perception of the community is clear on what participation is, who is going to be involved, which level of community involvement and how the community makes decisions in health care activities as mentioned above. Therefore, to answer these questions the process of participation should be analyzed by looking at the perceptions and understandings of community on the approach of each group

According to Cohen and Uphoff (1980) and Rifkin (1986-1996), the community participation could be recognized only where things are defined. The questions have been raised on the issues of "Who defines a "community"? Local people or outsiders? - Who will decide the priority and solve the problem? Local people or professionals? How is participation occurring, does it really give people opportunity for decision marking and so on? As it was stated in the concept of community participation approach, there were different understanding between different groups of people especially in the areas of study. The study categorized in group representatives of community for investigating their perceptions based on their own diversity of characters. The groups were classified in Health Profession, Local Authorities and Masses and People at the villages. The questions prepared to explore their views on associate health care planning and participation: the time they joined to project; their interest in the project activities; purpose of the approach; their role and their right in participation, statutory or voluntary; the benefits they get etc.

3.4.1 The group of health profession

First, the study found that previously the community participation approach was not present in areas and was first applied in the health sector. Health staff was said that this method was new for them and they could not understand what was mean. Consequently, at the beginning of the process people were confused and have many debates, but later on when this was agreed their participation was very strong.

> *"As a whole, this method is quite new for us, we do not have much more knowledge than villagers beginning of project we were so ambiguous and found it so difficult"*
>
> *Head of Commune Health Station*

Secondly, in term of health profession, normally health problems were identified by using health surveillance and cross-cutting survey to see the health burden or diseases patterns within certain epidemics and little reviewing health physical and within social environment and biomedical science aspect. They focus mainly on the using services for clinical treatment at hospital. Based on our observations, most of the health staff at district and commune level was conservative keeping their ideas on seeing health problems and illness instead of using participation approach to involve community in health care activities. When doing health needs assessment with community based approach, they allow their idea or their professional expertise to lead people to view their health problem from health professional views. One of our finding was that the health problems in four communes look very similar to each other which can be easily recognized in the two communes at same district, there were health problems findings like respiratory, skin diseases, diarrhea, woman disease, and malnutrition and so on. It was not surprisingly to have these results because the district health staff had been providing techniques to assess health needs to these communes.

Thirdly the health planning in Viet Nam it was still using the top down approach by targeting from upper level. Therefore, health staffs at commune get a

little familiar with the approach from bottom up and needs based, not to mention that they never done it before. Thus has made difficulties for the CBHD to apply the bottom up in planning. Health staff did not know how to switch their plan in to meet both mechanisms. The planning mechanism on health care in that area has limited the process of the approach since people are not allow to apply, if yes it just for the project purposes.

> *" .. We followed the guidelines of the project with unclear purposes but still have to complete the targeted health indicators assigned by district and provincial health authorities."*
>
> *Head of Commune Health Station*
>
> *"Bottom-up planning is good in theory but the availability of resource has to be assured...sometime the plan ambition is huge but the capacities in practice are not sufficient..."*
>
> *District Health Staff*

Fourthly, to make health staffs agree to work with the ethnic minorities was one of the most difficulties task. Difficulties have appeared in mobilizing community and in health education. The communication to ethnic has been seen as obstacle to the process of finding needs of ethnic community. They recognized that, if they could speak the language of Dao (Mien) people, things will be easier for them both in performance their job and mobilized them to the health care activities. To this issue we will come back to the next part.

> *"When we conduct group discussion to seek information, the Dao people may not talk or express their ideas when we tried to evoke their imagination, but what we got was not much"*
>
> *Commune Health Staff*
>
> *"If we know their language, we could discuss and live with them in the village we can understand them more and vise versa. Then the discussion will be more sympathetic."*
>
> *District Health Staff*
>
> *"We do not understand their language therefore it was difficult to consult the health issues. Every time when come to the village we have to take VHW to*

come with us, but we were afraid that the translation of VHW may not be accurate...I think it will be better for the communication if every commune health station has at least one ethnic minority staff"

Head of Commune Health Station

3.4.2 The group of local authorities and mass-organizations

Like the other groups, from the beginning of the project the purposes of the project seem unfamiliar to them, but late on the situation has changed. We have begun with the question of why they should be involved in the process of needs assessment identification and why they have to play as an important role in management of project. Then people know that their role is for state management to steer for a healthy live for their citizens but not sure about the integration of their duty into health development stage. In the group discussion, they also could not really remember all the process of PRAP. Below was all their imagination of the process:

"...The time is in the raining season in the year of 2003. The core group was trained...health problems and health needs were found by quick questions and answers...the main health problems were woman diseases, eyesore, etc"

Head of villager

Our first finding was that the awareness of local authorities and mass-organization has improved since the CBHD project intervened in the health sector. They found that using this approach was a good chance for people to take part in the process of co-learning involving system development and local capacity building. The role of members of community has been strengthened. People like to discuss about health problem that they never were asked before. They understand more the purposes of the project

" in the management work, the participation of citizens is our willing: "Dan biet, Dan ban, Dan lam, Dan kiem tra" (People have to know, people have to discuss, people have to do, people have to control – A slogan of democratization concepts in Vietnamese)

Chairman of Commune People Committee

"...Technical assistant coming to village, ask 'open question' to people to answer, direct question and also in groups. They ask for the demand of people, what was lacking. After meeting, they come down to mobilized people, setting seasonal calendar, mapping, writing the plan, what should do first and what should do later prioritize the problems. For example many women have a woman disease that should solve by building clean water system..."

Women Union representative

In group discussion and other activities like in health needs identification, the role of community member was a salient point. Woman, Youth, Veteran, Farmer Unions were strongly involved. They even take responsibility in planning and assigning their organization to take part in health activities like mobilizing people to clean the village roads, take care of malnutrition children. For example the Youth Union was assigned to help the poor household to transport the cement and bricks etc. That means, the process of empowering has been successfully. Participants can increase control over their lives. Anyways, for the long run, researchers are not sure that this approach will be supported by local authorities.

"Local authorities and whole community participated in mobilizing available resources based on the agreement between them: labor force, movement of sanitation and environment, contribution the available material in local like wood, bamboo, sand and other to build the public construction works..."

Analysis Report of CBHD' Yen Bai, 2007

3.4.3 The group of villagers

The villagers have their own and long historical of community-life. Each of the ethnic minority in Viet Nam has a difference of manners and customs. However, the collective living in ethnic society put villagers closer to each other. Most of the villages, the ethnic has their own organization (not admin one) for their inhabitant with strictly rule calling "villager convention" and get well together since ages. It is important to note that the entering of the project to their areas does not mean the

project brings new things. It just looks more or less "fundamentals" and "theoretical" than the activities they have been done every day.

The issue of participation in health care understandings has been raised in the village when we interviewed representatives of household about the knowledge on CBHD project. We also found some difficult in connecting them. The language was used is *Kinh (viet) thus* some of our questions were not really understood by the *Dzao (Mien)* and *H'mong* households. Answers were putting out very short. Therefore researcher was turning it in easy way to stress the questions to get information. Two of eight were confusing and mix the CBHD project to the other projects. But then we ask detail on the construction work that project support of the clean water and sanitation then they know. But sadly to say that they could not understand and remember the purpose of the project: Why the project was coming here, what did project intervene for their village. Did they participate voluntary or statutory etc.

The second issue was investigated on the role and rights of people participating in public activities. But it was not much well known in the village, the informants at village and commune did not know about their rights. Then researcher turned in other question on participation on rights and basic democracy by involve people in social activities. It was reported that people dimly heard that the local government strongly support this but not giving guideline or direction in a specific areas or cases to participate (Decree 29/CP). The CBHD was the first adopted participatory approach and allow people to express their ideas and talk about their health problem, other why, if they are ill they come to have free treatment in the commune health station. Previously, activities related to health care must be covered by health sector and health staff. We revealed on one hand, that people also understand their right but they do not have a chance to take part since there was no announces what it should be, on the other hand why should they do that if their needs for health care still subsidy form the Government. The CBHD constructions work on clean water and latrine looks the same situation to some of villagers instead they should be involve to the process but not much as the project expected. That was the

reason to lessen their confident for involvement in CBHD project activities and passively do what the Government's authorities said.

"District people coming to build latrine for the whole village...they said what we have to do."

Villager

Third finding in our research was that people did not have much time to become involved in the PRAP process since they had to work to earn their livelihood. The name of this approach is "Rapid" but actually it took time for the people to participate. Spending some days for doing the PRAP was a major problem for local people. It was found that even when the CBHD project tried to have meeting and group discussion in the evenings, not many people liked to be involved since they have other thing to do. Therefore time constrain of people especially for the villagers was a limitation of this participatory approach.

"Three days training and two days planning were long time especially during the harvest time."

Villager

Last finding was that their contribution to the project still limited since they are so poor that they could not support the way of the project do. For example with the contribution of 30% in constructions work for clean water tank mainly through the labor forces but still was difficult to some of household. To this issue we have described detail in the analysis part but the community its own has to support for the poor house hold, that concerned by mass-organization and local authorities at commune and village administrative.

"We do not have enough money to contribute to the constructions works, therefore we contribute our labors and do not need to pay cash"

Villager

3.4.4 Conclusion

Above were some of critical findings of the research in the perception and understanding of community and people who were involved in the project. Some of informants did not want to, nor had the time to participate in the project. They might think project was not considered a priority compared with the other problems families

had to deal with. However, in general, the evidence of community interest in achieving healthy life has been shown that people were later concerned very much about their health and involve actively. People take overtime for discussion about health problem identification in their village. Topic was talking around the women disease, nutrition for children and elderly care so on. They known that health is very important, avoiding ill-health is escaped from losing money. The interest and benefits for community participation was clear to everyone in CBHD project when they develop their own health plan and implement it later. All informants was agreed that the project had raised awareness on health issues and services and created a more informed population on health care and protection. But the capacity of community to implement the health plan will be more important to the CBHD project. Do they have sufficient capacity to get on well with the complicated process of this approach? In the next part the study will show some of the findings on this issue.

3.5 Community capacity

The community capacity is very important and can be consider as a main/initial condition to run the approach of community participation especially on planning, implementation and financial management. In the project sites, most of the staff both at local authority and in health care institutions had short formal educations. The better off are often moving down to the big cities to work. A survey carried out to investigate the educational level of members of the Commune People's Councils and People's Committees during 1994 and 1999 showed that around 50% of the members had received primary or junior secondary education and most of them had not received state management and professional training.[3]

In the district and commune levels, the capacity of staff is usually weak as the need for further capacity development for local officials has not been foreseen. After graduation from colleges or universities, staff was appointed to positions in government offices. Further training was seldom planned for. For example, some

[3] A number of problems in training and retraining of cadres and civil servants working in the planning area, To Chuc Nha Nuoc (State Management), no. 9 (1998): 1. cited in Adam Flord, Decentralization in Viet Nam, 2003

health workers had only some short courses after 15 years of working. Moreover, the trained officials and worker's skills were not fully utilized as there is no minimum required facilities and conditions for them to use their knowledge and skills. The capacity of local people then remains low. For example in Nam Lanh commune, the researchers found that only one of sevens Village Health Workers (VHW) has been trained on the officially professional three month curriculum. Six of them did not have any knowledge on health care but they had been chosen to work and performance as health worker for a long time.

"Before, we have seven village health workers but only one of them has been trained. Their duty mainly for health education and health promotion within the village...they mobilize people to prevent disease through the media..."

Vice Chairman of People Committee

3.6 Cultural and Ethnicity

In order to work with ethnic minorities groups the skill of medical anthropology is also important for local health staff when they daily communicate with ethnic minority patients. They must have certain skills and access to special method avoid racial discrimination when providing services. When mobilizing people for health care activities, the task will be even bigger. Yet, in the CBHD project, most of the health staff was not provided with any specific knowledge about cultural issues.

The language used in the process of PRAP needs assessment and planning was mainly the *Kinh* (viet) language. Some of the participants from other groups of minorities could not participate well in conservation and discussion. It was difficult for them when they were not confident to speak out their thinking or actively being involved in the process of sharing opinions. That was one limitation of the participatory approach to the CBHD project.

"We do not understand their language therefore it was difficult to consult the health issues. Every time when coming down to the village we have to take VHW to come with us, but we are afraid that the translation of VHW could not reach our meanings...I think it will be better for the communication if every commune health station have at least one ethnic minority staff"

"For many time when we consulted the Dao people to clean their house, they said that their ancestors had live such a way but we still alive. It is no time to talk and understand about their behavior." But when they understand they can better disseminate our consultation in the whole village..."

Head of Commune Health Station

3.7 Political advocacy

The Grassroots Democracy Decree (Decree No. 29/CP/1998 from the Government) aims to democratize and support the decentralization and give local authorities more decision making powers. The Decree also tries to promote the rights of citizens to be informed, to participate in decision making processes and to supervise the performance of cadres. The other significant advocacy support regime is the National Program of Public Administration Reform that should promote transparency and accountability in state management at all administrative levels.

To date, the Vietnamese policy statements are generally supportive to the concept of fiscal and administrative decentralization as a means of strengthening state effectiveness and meeting some of the aspirations of communities for clean, transparent government. The CBHD project approaches have made many efforts to do this. It is difficult to assess how much the two regimes have been supporting the CBHD project approaches. Most of the interviewee, both in administrative and health sector, did not know the regimes of decentralization and autonomous.

Interviewer:

"Did you know about the autonomous regime at the local level?

Head of the Commune Health Station

"I never heard about."

CBHD has introduced the tools of PRAP with the aims of giving members in the local community the chance to take part in decision-making and to improve local governance. But that aim is difficult to be reached because of the quality of local

governance. The grassroots democratization initiative of the Decree 29 on the democratization has not had much affect in some remote areas even when strongly monitored by the People Council and People Committee and the political bodies from upper levels. The implementation guidelines of these decrees were not well developed to be practices for local governments. How could the provincial governments meet the demand of nearly 600 communes needing full support as their annually income remained low?

Interviewer:

"What are the content of these regimes? (Decentralization and Financing autonomy)

Commune Health Staff:

"The regime of poverty reduction and war sacrificially and invalid soldiers"

Decentralization and giving autonomy in financing for lower level could not be done in every local area. First, the area has to be prepared for the local administrative system regarding the content and purposes of what and how to decentralize and which level that should be decentralized. Secondly, decentralized and autonomous regimes were the right methods to create efficient for state management for local authorities. But what are the needs for improving the quality and accountability of local governance? There are still a numbers of question to the policy makers and researchers in Viet Nam.

To conclude this part, the regimes of decentralization and autonomy could not support to the CBHD project spirits. Later on, if this regime can be implemented in those local areas, people will at least have experienced the approaches that the CBHD project has been advocated.

3.8 The influence of community participation on health services

It was difficult for the study to assess whether the intervention has improved the health status of people or changed the conditions of health care services in project

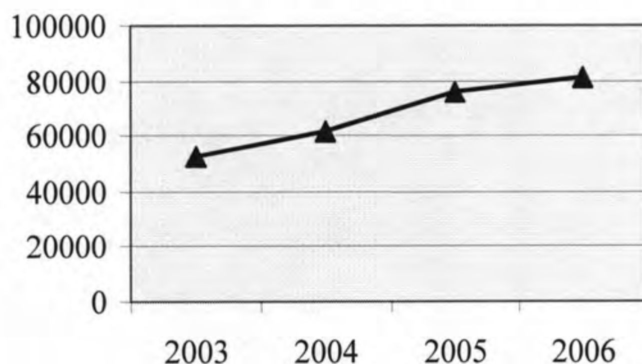
areas. The reason of that is CBHD firstly was not the sole representative who has intervened health development in these areas. There also has been contribution of others national programs and projects taking part in improving health of people. Secondly, with the rapid growth not only in health care but also in socio-economic in Viet Nam today is marvelous that created bias to the assessment of this study. The remains contribution of CBHD was socialization, mobilization of community members in changing the way of management in local health care rather than specifically in certain profession. The researcher has used health indicators that CBHD to measure the fundamentals frequency of health status mainly of women and children groups combining with information from the interviewing at village on people's satisfaction in using health services.

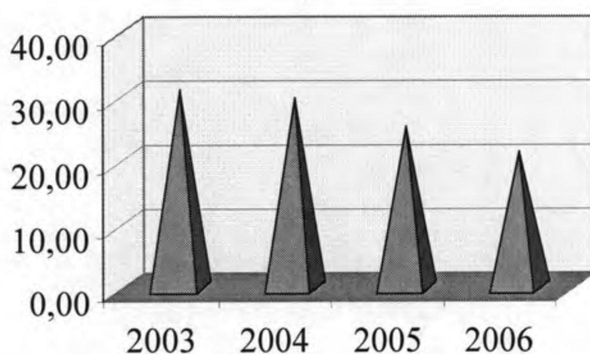
According to the Final Analysis Report of Yen Bai, the situation of health of population in project areas has improved gradually. Change has been meaningfully recorded in the results analysis Final report 2006 of CBHD'sYen Bai :

Table 7 The main indicators of 12 selected communes of project:

Indicators	Years			
	2003	2004	2005	2006
- Total numbers of examinations (times)	52.380	61.714	75.903	81.218
- Average numbers of maternal check (times)	2,44	2,48	2,59	2,95
- Total numbers of delivery at CHS + assisted by CHS' staff (case)	634	661	687	696
- Proportion of malnutrition of children < 2 (%)	30,93	29,53	25,16	21,24

Resources provided by Provincial Health Bureau of Yen Bai and the four communes





In the Nam Lanh, Dong Khe, Tan Hop and Quang Minh communes, similar data have been collected. It will be show as follow:

Table 8 Nam Lanh health indicators:

Indicators	Years			
	2003	**2004**	**2005**	**2006**
- Total numbers of examinations (times)	3478	3523	3754	3870
- Total numbers of maternal check (times)	102	121	153	158
- Total numbers of delivery at CHS + assisted by CHS' staff (case)	26	30	42	51
- Total numbers of malnutrition of children < 2	42	39	36	31

Table 9 Dong Khe health indicators

Indicators	Years			
	2003	**2004**	**2005**	**2006**
- Total numbers of examinations (times)	7188	7356	7483	8561
- Total numbers of maternal check (times)	264	249	243	252
- Total numbers of delivery at CHS + assisted by CHS' staff (case)	63	65	70	85
- Total numbers of malnutrition of children < 2	49	42	39	33

Table 10 Tan Hop health indicators

Indicators	Years			
	2003	**2004**	**2005**	**2006**
- Total numbers of examinations (times)	3660	-	6206	
- Total numbers of maternal check (times)	176	-	156	353
- Total numbers of delivery at CHS + assisted by CHS' staff (case)	28	-	59	52
- Proportion of malnutrition of children < 2 (%)	25,7	-	27,5	-

Table 11 Quang Minh health indicators

Indicators	Years			
	2003	**2004**	**2005**	**2006**
- Total numbers of examinations (times)	1924	3957	6337	3872
- Total numbers of maternal check (times)	324	160	180	276
- Total numbers of delivery at CHS + assisted by CHS' staff (case)	40	31	44	48
- Total numbers of malnutrition of children < 2	60	60	64	64

After reviewing the basic health indicators of the four communes we find that most of the health care for mothers and children has improved significantly. The numbers of maternal health examinations and checking basically increased. Therefore people might be influenced by the consultation and providing health education which the project has given much effort into. Other meaningful resources of information

collected by the interview to investigated *the using of health services and their satisfactions* of people when they come to have treatment in CHS. But some of them also complain about the use of health insurance card that was freely given by the government:

Interviewer:

"What do you think about the health services? How is health of people in your area?

Villager:

"Some people said that is so OK. There is no more illness."

"When we come to CHS, the health staff is available and to take care of the patients"

"We some time have treatment only but do not have prescription for drug. We have to buy ourselves in drug store"

Vice Chairman of Commune People Committee:

"People some time complain about treatment by health insurance card. The health staff does not except people who came for treatment without both insurance cards and identification card or the name in these cards do not correspond. But later on we solve this problem by giving them the temporary identification cards made by Commune People Committee with stamped on their photos"

3.9 Conclusion

The findings to the assessment of Community Based Development Project based on the five dimensions and including other aspects of perception and understanding of community and people, political advocacy, community capacity, ethnicity etc were showing that there is a difference between the different group and the members of community in implementing as well as in the understanding the purpose of this approach into health care development. Therefore, the level of involvement will be also different compared between communes. Some of group can have benefit from the approach but not the others. For example, the poor would not much in taken part in health care activities since they did not know their rights and how to attend to the process.

The study recognized that the contribution of this approach are huge not only for a certain group in community but more than the whole society when the responsibility to health care and protection has to be socialization and considering as apart from community development. The process of participation has to keep balance by taking people involve with the aim of more flexible and not token or rigid, other why the purpose of this method can be driven in other meaning and not get much of result that people expected. Political and administration regime for democratization and decentralization and autonomy, which support to this approach, could only be taken place when it has to be in reality and implementing with the sufficient guideline and regulated.

The purpose of the approach was different in understanding between groups in community can be an obstacle to the process. People may influence their knowledge to driven the means of the approach for another ways. There must be an unique in perception that community participation for health care development has to be focus mainly in health but not separates health as outside component in development stage. The vulnerable and poor group has to be stronger involve since they were lack behind and prejudices.