CHAPTER I

INTRODUCTION

This dissertation is based on two studies related to community participation. The first part is a literature review looking at the concept and the use of community participation in development work. The second part is a field study made in a remote mountainous area in the north of Vietnam where a pilot project named Community Based Health Development has been implemented using the community based approach.

Vietnam – general information

Viet Nam occupies a central position in Southeast Asia, bordering China to the north and Laos, Cambodia to the west. The whole to east side is the coast to Chinese Sea. Three-quarters of Viet Nam's territory consists of mountains and hills, much of which is forested. Viet Nam's population is currently over 86 million and growing at a rate of about 1.3 percent per annum. Viet Nam is home to 54 ethnic groups. The majority *(Kinh)* accounts for 87 percent of the population and reside in the lowlands and cities, while the highest concentrations of ethnic minorities are in the mountainous regions.[1]

Viet Nam has made a rapid economic progress since the *doi moi* reform process was launched at the Sixth Congress of the Communist Party in 1986. With the advent of *doi moi*, which translates literally as 'renovation', Viet Nam began the transition from central planned to a market-oriented economy. Economic growth has averaged seven to eight percent per annum over the entire period despite the interruption of the East Asian Financial Crisis from 1997 to 1998.

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1 General Statistics Office. Database of the Vietnam Household Living Standard Survey 2004 [Cơ sở dữ liệu của Khảo sát mức sống dân cư 2004]. 2006.

For the mountainous areas, the Vietnamese government is concerned about the well being of the ethnic minority population. In the constitutions of 1946, 1980 and 1992, Vietnam acknowledged the position, the rights and the obligations of all ethnic groups living in Vietnam. Ethnic minorities participate in the development of appropriate policies, reflected by the relatively high representation at national level (17.3% of the representatives of the National Assembly in 2002 were of ethnic minority origin which was higher than the proportion in the population)[2]. At the provincial and the district levels, the involvement of ethnic minorities in the decision process is less prominent and some ethnic groups are less involved than others. The communist party has called upon the government to create the necessary conditions for all ethnic groups to catch up with the overall general economic growth of the Vietnamese society, with respect for culture, language, customs and beliefs of the different ethnic groups.

Viet Nam – Health care system

> *"Over recent years the thrust of Vietnam's health sector strategy has emphasized active prevention, public service delivery at the "grass roots" level, the need to mobilize the entire society in support of improved health care, the expansion of health insurance cover, the value of traditional medicine, and the active participation of the private sector under the government's leadership."*
>
> *Susan J Adams (2005)*
> *Viet Nam health care system: A Macroeconomic perspective*

The rapid growth of the economy in Viet Nam has also influenced the development of the social sectors including health care. The health sector has also been affected by the transition towards a market economy. How to tackle issues of equity and efficiency in health, unbalancing in development between social and economic sectors, between low-land and highlands/disadvantages areas have been strongly considered in the main development strategies of the country. Moreover, the

[2] World Health Organization, *Health And Ethnic Minorities In Viet Nam* , 2003

health care system itself could no longer develop in a sustainable way if centralized and subsided with a large budget/financing. The problem facing Viet Nam at this moment is how to finance an economically viable system of health care in a country with minor resources, while at the same time remaining true to the principle of equity and efficiency.

The present health care system in Vietnam is hierarchically structured in 4 levels: Central, Province, District and Commune levels. There are 64 provinces and cities and more than 600 districts with hospitals, preventive health centers, and provincial schools of health. In the more than 10 000 there are commune health stations and in the more than 100 000 villages there are village health worker who are funding with a small allowance from the government. The village health worker plays an important role of services provision for the villagers. They provide a very basic diagnosis and treatment as well as health education to the local community.

In addition to this overall structure, there are vertical national health programs for health problems like tuberculosis, leprosy, malaria, family planning, dengue fever, Expanded Program of Immunization (EPI), Control of Diarrhea Disease (CDD), and Acute Respiratory Infection (ARI). Each of them is affiliated with a central institution all working through the same health care structure. However, there is no formal integration or coordination of these vertical programs at the different levels.

The health care system in Viet Nam as a whole has been seen as a complete and comprehensive system in theory. The system is well organized and provides services. However, new challenges have emerged since the transition into a market-oriented economy. This has created a widening gap between the rich and the poor including reduced access to health care. The remote areas are lacking adequate health care facilities and personnel. The financing for health care is declined annually Finance resources to providing training for health professional and giving incentive to keep doctors to work in the rural and mountainous areas have been discussed.

For health care services for ethnic minorities who are living in mountainous and disadvantaged areas, there was still little action taken. Still some initiatives have been considered to help the poor to access the health care services. The Government issued decrees to provide free health care and medical treatment at state medical facilities for communities in difficulties and disadvantaged areas, mostly inhabited by ethnic minority populations. A health insurance system was introduced in 1993 and is compulsory for formal sector workers and civil servants. It covers about 11% of the population of Vietnam but has very little impact on the population of ethnic minorities (WB & ADB, 2002). Therefore the Government launched free health insurance for the poor to be set up by the Provincial People's Committees. (Decision No 139/QD-TTG of October 2002, reinforcing the health care policy of decrees 135/1994).

Besides the health problems covered in the Millennium Development Goals (MDGs), Vietnam faces many health problems caused by environmental pollution, lifestyle changes, unsafe conditions in work and daily life and an aging population. While endemic communicable diseases as dengue fever, malaria, respiratory disease, and digestive tract diseases continue to persist new diseases are emerging, as SARS, avian influenza A(H5N1), and HIV/AIDS. Non-communicable diseases, including cardiovascular disease, cancer, and mental illness, are showing an upward trend. Premature mortality (before 60 years of age) remains high, particularly in males, because of accidents, smoking, alcohol, and illicit drugs.[3]

In the era of globalization, modernization and industrialization, those barriers in health care were not excluding the ethnic minorities. Attention has been directed toward reducing inequity in health between regions, social strata, and ethnic groups. Still great differences persist between the urban, rural and mountainous people. For example, life expectancy at birth for both males and females in the northwest and the central highland regions is much lower than that in urban and lowland regions. The child malnutrition rate and infant mortality rate (IMR) are higher in rural and mountainous areas. Ethnic minorities, a large proportion of whom are poor and living in the rural, highland and mountainous areas, tend to have worse health status than

[3] Ministry of Health (2006), Annual Health Report, Medical Publishing House, 2007

that of the Kinh ethnic majority located in urban and river deltas areas. This could be seen in the table below:

Table 1: Life expectancy at birth, child malnutrition rate, and IMR by region

	Life expectancy at birth (1989-1999)		Child malnutrition rate, 2004 (%)	IMR, 2004 (per 1000)
	Male (year)	Female (year)		
Whole country	66.5	70.1	26.6	17.8
Urban areas	73.1	76.3	21.2	9.7
Rural areas	65.2	68.9	30.8	20.4
Red River Delta	69.8	73.4	22.8	11.5
Northeast	65.2	68.9	29.8	23.9
Northwest	60.2	64.0	32.0	33.9
North Central Coast	66.4	70.1	31.7	24.9
South Central Coast	65.3	69.0	27.7	18.2
Central Highlands	58.6	62.3	35.8	28.8
Southwest	71.0	74.4	19.9	10.6
Mekong River Delta	66.9	70.5	25.1	14.4

Source: Life expectancy at birth 1999[4] – Child malnutrition 2004[5], IMR 2004[6]

Constraints to ethnic minority development and well-being include factors such as isolation, remoteness, low access to credit and productive assets and limited access to quality social services. The overall education level among ethnic minority groups is lower and most ethnic minority groups live in geographical and climatic conditions that are harder than those of the majority one. Together these factors results in different health problems, limited access to health care services and poor

[4] General Statistics Office Monograph on marriage, fertility and mortality in Vietnam: Levels, trends and differentials, Hanoi: Statistical Publishing House; 2001.
[5] National Institute of Nutrition, General Statistics Office. Progress in child and maternal nutrition: Effectiveness of the intervention program in Vietnam 1999-2004, Hanoi: Statistical Publishing House; 2005.
[6] General Statistics Office. Survey of population change and family planning 1/4/2004 [Điều tra biến động dân số và KHHGĐ 1/4/2004]. Hanoi: Statistical Publishing House; 2005.

health status of the ethnic minority groups. Poor health is, in turn, a threat to socio-economic development and leads to the vicious circle of poverty and ill health. In general, the accessibility to the public health services of people living in mountainous areas, mostly ethnic minorities, is a consequence of geographical, culture, languages, structural and financial problems.

Geographical access to health facilities in the mountainous areas has considerably improved during the last decade. The road network in remote and mountainous areas improves continuously and remote villages are strongly encouraged to move towards the roads. The number of Commune Health Centers (CHC) that cannot be reached by cars all year round has decreased drastically the last years. Many patients still need several hours of walking to reach a CHC, especially during the flooding and raining seasons. See table 2[7].

Table 2: Distance from Commune Health Center to Hospitals (km)

Regions	District Hospitals	Provincial hospitals	Central hospitals	Nearest hospitals
Red river delta	6,5	24,0	67,6	5,9
Northeast	16,8	57,0	169,5	16,1
Northwest	21,0	88,5	211,8	18,1
North central coast	12,3	58,1	158,3	9,5
South central coast	12,6	35,3	66,5	11,1
Central highland	15,1	58,5	231,8	14,5
Southeast	9,1	33,6	86,0	9,1
Mekong river delta	10,1	29,8	117,2	9,6

Source: National Health Survey, 2001-02

Cultural differences remain important barriers for access to health services (SDA, 2000; Bui the Cuong, 2002; cited in WHO 2003), in particular for the smaller ethnic groups. The minorities' health seeking behavior is mainly related to self-

[7] National Health Survey 2001-2002, Ministry of Health of Viet Nam 2003

medication. They take care of themselves by their own treatment method. There is several way of doing that. One is by their traditional medicine and another is by buying drug from the drug store. For example, the woman of H'mong (a type of the ethnic minority living in high mountainous) will not accept the help by others during her delivery. Only the husband or a relative is accepted and the delivery is often taking place in a small thatched hut in the forest.

Language is also a problem for providing health care services. Health systems often lack resources, knowledge, or institutional priority to provide staffs who can speak the language of several minorities. Similarly, time pressures on physicians may hamper their ability to accurately assess symptoms of minority patients, especially where cultural or linguistic barriers are present. The limited availability of well-qualified staff who can speak the languages of the local population and who have knowledge of local customs and habits, is a major drawback of the public health facilities in rural and mountainous areas. The experience of the Support to Disadvantaged Areas (SDA) project shows that in remote areas it is hard to find Village Health Worker (VHW) candidates who meet certain minimal requirements for a health worker such as literacy (WB *et al.*, 2001). The trend of the health workers moving to richer areas is very common today. Doctors trained in the district hospital will often stay in the city or open their own private clinic. The risk is that some remote areas will end up with doctors providing lower quality care to poorer patients, while the better staff will take advantage of opportunities to move to richer health facilities with wealthier patients.

The numbers of communes without a commune health station has been decreased annually as investments have been made by the central government and the localities through national projects called Program 135 (The National Poverty and Hungry Eradication Program). However there is still a lack of funding for the running costs of the remote health stations. There was often poor coordination between the national health program and donors who provide support incase of shortage of medical equipments.

The government of Viet Nam has seen these shortcomings for health care services in remote areas and has trying to set up policies and regimes to solve them. Over recent years the Vietnam's health sector strategy has emphasized active prevention, and public health service delivery at the "grass roots" level in the disadvantaged areas. This also includes the need to mobilize the entire society in support of improving the health care services under the government's leadership.[8] Mobilizing resource from the whole society, public and private health, NGOs, donors as well as the citizens themselves have been stated in many policy and strategy of the government.

The initiative by the government to improve the health funds for the poor in general, and for the ethnic minorities in particular, is named health care funds for the poor (HCFP). This fund is allocated 70,000 VND (less than US$5) per poor beneficiary per year. The central budget covers 76% and the rest is covered by other sources such as individual and community contributions. As of 2003, there were 11 million HCFP beneficiaries, representing 84 percent of the target population. Out of this group, one third had been granted health insurance cards and two thirds had been entitled to direct reimbursements of health care costs.[9] After some year of implementation, the ministry of health and donors evaluations showed that the rich use this regime more than the poor. Firstly, administrative work required time and considerable amount of money. A number of beneficiaries do not know how to keep and use the card they have and cards may often be lost or teased. Secondly, the distance and poor transportation in mountainous areas created a lot of difficulties for the distribution of new cards. Thirdly, there is no strong network of inspection on medical protocols and financial practice for a strict supervision in order to ensure the effective use of HCFP. Lastly, the government could not afford to pay for this scheme for a long time since the there is an increasing demand for health care.

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[8] World Bank (2004), Vietnam Public Expenditure Review and Integrated Fiduciary Assessment, October 5, 2004, World Bank.

[9] World Bank (2005), Viet Nam development Report Governance. Prepared for the Vietnam Consultative Group Meeting. (Hanoi: WB, December 1-2. 2004).

Decentralization in the health care delivery has been an ongoing process in Vietnam for several years. This has led to an increasing share of government health spending going to the local level (provincial level, district and commune levels). The new State Budget Law, effective from January 2004, has given increased budget autonomy to provinces by providing recurrent funding on two block grants, one for "wages and salaries" and the other for "all other operations and maintenance". The size of these block grants depends on the provinces' population size, disease patterns and differential resource needs. The aim of the decentralized and autonomous policy is enhancing local government ownership, creating the interaction between health care and the overall development at grassroots levels. But there is still hardly any kind of instruction or any approach to apply this mechanism yet.

Today, there remains little understanding about the methods to be used by provinces to allocate funds internally across districts and communes. Because of this, inequities in the allocation of government health funding at the district and commune levels may effectively offset any apparent improvements in equity in the province. Therefore, the participation in financial reallocation for health at local level will be very important in the new stage of decentralization. People should know what they have in their hands and how much they should spend for improving their own health. But sometime the local governments may not have the capacity to encourage community involvement in local governance, including health services. Further, the poor and marginalized tend to be ill equipped to be mobilized for the participatory opportunities decentralization can offer. When decentralization transfers spending and revenue-raising authority to the local levels, the lack of administrative capacity can lead to financial mismanagement, waste of resources and corruption.

Community Based Health Development Project – CBHD

The Swedish Government, through the Swedish International Development Agency – SIDA, and the Ministry of Health of Vietnam have been collaborating in a pilot project called Community-Based Health Development Project (CBHD) [the former name was Supports for Disadvantaged Areas (SDA)] in the Northern

Provinces and started in the 1990s as a proposal trying to solve the problems of health in disadvantaged areas where ethnic minority people are living. The project has been divided in three phases. In the last phase between 2003 and 2006, the project is implemented in two provinces, Yen Bai in the northern mountainous province and Quang Nam in the Centre Coast of Vietnam. The development of the pilot approach was officially taken on by the provincial health sector.

The overall goal of the CBHD project was to "Complete and apply the approach of community based health development in order to enhance the efficiency of health system and improve the use of health services of people living in disadvantaged areas". The specific objectives were formulated during a workshop with the participation of the two pilot provinces using the Logical Frame Work approach in the year of 2003. The specific objectives were formulated as follows:

- to intensify the awareness, mobilize the participation of community in health care activities at local level;
- to improve management capacity of health profession as well as in health institutions and staff in the health system and
- to formulate a new health policy at grassroots level appropriate to conditions in the remote and disadvantaged areas.

Yen Bai was one of two provinces that were chosen for the implementation of the CBHD. Four districts were selected for intervention - Van Chan, Van Yen, Tran Yen and Luc Yen districts. Those districts are mountainous and disadvantaged based on the criterion of the Government. Van Chan and Van Yen have been selected for this field study. Therefore some introduction of these two districts is necessary.

One of the important approaches used in the CBHD was community participation. This approach was used in many supported areas in the health care development in the CBHD project as in participatory planning, decentralized training and the integration and supervision of the national health programs. The CBHD has studied the situation and assessed the health needs. Then intervening for improving

the health care system was considered in these districts. In the process of needs assessment the Logical Framework Approach – LFA – was used to set up the project document and plans. The main tools used to involve local people at the local levels were Participatory Rapid Appraisal for Planning (PRAP). PRAP was conducted at village and commune levels from the start of the project with the purposes of finding the real needs at the local levels. Then the local communities could get involved or participate in the process of health development. Their health plan should be set up based on the problem identified and solved by themselves with the technical support form the higher levels and some small funding from the CBHD project. The overall results of the CBHD project in Yen Bai and particularly in Van Chan and Van Yen districts will not be discuss in this paper. There are reports available analyzing the specific achievements of the CBHD project at each level. These results are sometimes referred to as secondary resource when looking into community participated in health care.

For the planning sessions the CBHD project used the PRAP tools like wealth ranking, community mapping, season calendars, Venn diagrams, group discussions, deep interviews and collection of secondary data for the health needs identification and health planning. There has been a specific evaluation report conducted in the Viet Nam - Sweden Health Cooperation together with the Ministry of Health where the following remarks have been taken,

> *"....we anticipate good opportunities that the PRAP process can be replicated in other localities and in new phases of the CBHD program and beyond the VSHC"* [10]

In the final analysis report of the CBHD project in Yen Bai some challenges and weaknesses were brought out by the consultants,

> *"... the significant of way and tools used in doing PRAP were actually not very well understood for every member who has taking part in the needs assessment sessions. Therefore some of the activities in the plan could not*

[10] Bent D Jorgensen and Pham thi Phuong Thao, 2007- *Assessment of PRAP implementation in localities covered by the Community Based Health Development.*

meet the real needs and situation of some household and people" ... "... Some of the construction works in the plan like latrine was not appropriate to the needs or to the behavior of using by the people. Some poor households could not contribute with resources like money or material to build the latrine e.g. H'mong household in Hong Ca, Suoi Giang, and Dao people in Nam Lanh communes (Van Chan and Van Yen district). They could not complete the work without support from other wealthier household or local authorities... "[11]

This CBHD pilot project could have been done better if the challenges that may affect the execution have been recognized earlier. What were the main obstacles to the development process? Why did the project not succeed as was expected? What are the perceptions and understandings of the local people to the community based approach?

1.1. Statement of the problems

After the literature review of a numbers international articles as well as synthesizing the experiences from the Community Based health Development Project the following considerations may be considered as a framework for the implementation of the community participation concepts i.e.

- the involvement of the community in health care planning in the culture context;
- the capacity of the local health system and health worker;
- the advocacy of the political/policy authorities
- and the specific challenges in health development in the disadvantaged areas.

1.1.1 Socio-cultural aspects that support individuals and collective groups to take part in the process of community participation

Most ethnic minority people are living in the mountainous and disadvantaged areas of Viet Nam, as in Yen Bai province. The way of living, as related to farming or societal relationship, reflects their traditions and culture, their knowledge and values

[11] Yen Bai Provincial Health Bureau, 2007 - *Final Analysis Report*

forming their identity. To get them involve in community participate related to health is then problematic. Related questions may be:

> *Why are ethnic minority households so poor? They may lack endowments (land, education, other physical and human capital); they may be geographically and culturally remote; they may lack political clout; and they may have low returns on their endowments, perhaps because of discrimination, or for cultural or informational reasons..... To tease out the relative importance of these effects we estimate and decompose a set of expenditure equations. The results of these decompositions suggest that geographic and cultural remoteness is important.*[12]

The culture could be understood in two ways. The health professionals may see the culture as a set of "belief "and "custom" which are potential "obstacles" to the introduction of new health measures and ideas. The social scientists may view the culture in the realm of health as "local knowledge" - indigenous medicine - and "local strategies" for securing health care (Linda Stone, 1992). Both views tend to regard local cultures as fairly static. The understanding of the importance of local cultures is then not deep. The importance to combine modern and traditional medicine is well known today e.g. the link between modern cure and the traditional herbs used by local people for thousands of years. Oakley et al. (1999) agued that "culture is not an obstacle to community participation, but it must be understood before participation can take place. The way of life is one of the culture identities of this community. The relationship of the community describes the characteristic of the people living there.

The inhibition culture feature in mountainous area is language diversity. That was a big barrier to the communication between groups of ethnic minorities and the patient and health professional. Linguistic differences even created the discrimination in proving health services. *"Minorities may experience a range of other barriers to accessing care.....including barriers of language, geography, and cultural familiarity."*[13] Moreover, language barrier in sharing ideas or involvement in the

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[12] Bob Baulch et al. 2001, *Ethnic Minority Development in Vietnam: A Socio-Economic Perspective*
[13] Brian D. Smedley et al. 2003, *Unequal treatments: Confronting racial and ethnic disparities in health care*

discussion on development in general and in health care promotion etc. can be seen when people expressed clearly or can be correctly understood. In the experience of CBHD, in some workshops or group discussions, if the groups speak of the same language then the information are clear and agree can be made. But mixtures of more groups took more time and people seem not happy with the conclusions. In using the research tools of RRA with in-depth interview researcher can not be sure that the translator provided accurate information or not.

1.1.2 Are local health workers prepared to the decentralization mechanism and flexibility in respond truly to meet the demand community participation in health development?

Many of the professional health staffs who have been recruited to work in remote areas are selected from their own communities. Then there is a greater chance that they will come back and work in this area. However, many have been selected even if they do not have the basic education before entering the medical school. This has lead to capacity problems of health staff in mountainous remote areas. If the selection criteria's are set to high few have the chance to enter medical schools.

In addition, after graduation re-training seldom takes place to update their professional skills. When the health system develops, new and higher skills are required from the health staff. One example is the treatment schemes for non-communicable diseases. New diagnostic equipment has been introduced over the last years, also in remote areas. Better trained staff will become increasingly important.

1.1.3 Is there a political context and policy mechanisms that give support to the community participation in health development?

The advocacy of political regimes on enhancing democracy in grassroots level could contribute to the good governance and strengthening the system. But community participation can not be seen as a tools as a purpose of the political purposes of increasing democracy, because in doing so, the nature and value of the rights of people in participation can lead to other means. In principle democracy promotion is aimed for higher demand of electoral and political processes that assist

to the electoral administration, election monitoring and supports for political parties.[14] Therefore, community participation can keep the balance between the development and benefit to the poor people. However, democracies give support mainly to the development of equity in health, education and others public society concerns

> *The aims of membership participation need to be realistic ... there are many different kinds of participation, not all of them relevant or effective for all tasks. It makes no sense to think in terms of achieving maximum participation, since participating in decision-making or implementation, for example, entails costs as well as benefits to individuals*[15]

1.1.4 Other possible threats or challenges toward community participation

Community perceptions and understanding of their rights is another aspect that may have influence to the success and obstacle of the participation. People should know their right to participate in social activities or even in policy development. The United Nation has also stated the need of participation "...participation of the population in all health-related decision-making at the community, national and international levels", (Article 12, United Nation, Right to Health). People might have an interest in archiving a healthier community with healthy lifestyle reducing the burden of diseases.

In 1998, the Vietnamese Government promulgated a Decree on Grassroots Democracy (*dan chu co so*) and put in place a legal framework required to expand direct citizen participation in local government. The decree established new mechanisms to enable citizens to exercise their rights to be informed of government activities affecting them, to discuss and contribute to the formulation of certain policies, to participate in local development activities and to supervise government performance. However, it is sometimes heard that people in Viet Nam are passive and unwilling to participate actively in local governance. There have been little responses

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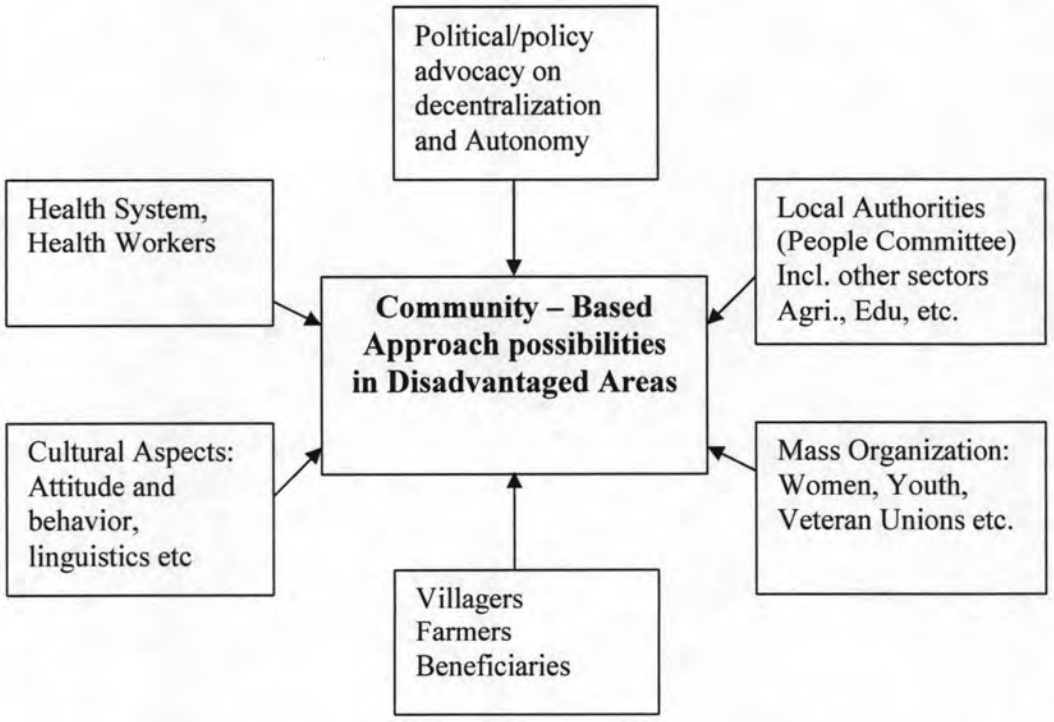
[14] Lise Rakner, Alina Rocha Menocal, Verena Fritz,(2007) Democratisation's Third Wave and the Challenges of Democratic Deepening: Assessing International Democracy Assistance and Lessons Learned, Working paper 1, Oversea Development Institute, United Kingdom

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

from some government sectors trying to raise people's participation. Then participatory grassroots democracy has become more like a slogan only. The health sector is often still waiting for support from the higher levels. The decentralization and autonomy scheme is not well functioning as there is no strong legislation developed and no available guidance how to do.

The participation of ethnic minority groups in public life still remains limited. It is widely considered that ethnic minorities have 'low capacity' to participate in local level activities. These prejudices, often held by higher-level authorities, are a significant obstacle to decentralization and increased participation in minority areas. Actually, community solidarity and participatory actions are often strong within ethnic areas. Many minority communities are close-knit, highly egalitarian, with their long traditions of helping one another and organizing mutual support and networks.

Figure 1: The conceptual issues of community participation in health



1.2 Research Questions

1. How to improve the practice of community based in health care at grassroots level in disadvantaged areas in Vietnam?
2. What will be a lesson-learned for the health sector when community participation approach could contribute to the process of decentralization and autonomy?

1.3 Objectives of Research

1. To review and assess the situation of community participation approach in health care
2. To investigate the perceptions and understanding of the community;
3. To find the facilitating factors for success and obstacles faced in applying; and
4. To make recommendations to improve the practice of this approach.

1.4 Research Methods

Two main studies have been done: One is literature review looking at community participation concepts and experiences using the concept in different development projects and programs. The other part is a field study on a community based health development program in Yen Bai Province in Viet Nam, using community participation approach.

- Selection of study area

For this study four out of twelve CBHD intervened communes in Van Chan and Van Yen districts were selected in each district two communes were selected. (Please see the detail in Chapter III, the informant's profile)

- Data collection methods and tools:

+ Review published literature related both to health and non-health sectors relevant to community participatory approaches in health care.

+ Secondary data from the CBHD project at the district health centers, commune health stations and at the village level mainly from the project's data and partly from the routine data.

+ Group discussion where information was collect from four group discussions in the four selected communes. The participants invited to the group discussion was the chairman of the commune People's Committee as representing the local authorities, the head of Commune Health Station representing the health professional, and representatives from the commune Mass-Organizations as the Fatherland Front, the Woman Union, and the Youth Union representing the political organizations at the commune level. Also districts health planners, head of villages and Village Health Workers were invited. Four group discussions with the numbers of nine to twelve participants in each were held.

The content of group discussion was focused on factors that have influenced the process of community participation as leadership; management; needs assessment, organization, resource mobilization culture, political advocacy and financing regimes. Suggestion on how to better practice community participation approach in health care was then proposed by the groups.

+ Interview some of key informants were also held. District's health planners, the chairman of commune People Committee, commune Health Workers and individual households in the villagers were included in the interviews...

The district health planers answered questions related to needs assessment, management; leadership and decision making as well as resource reallocation of health budget, benefit and obstacles.

The chairman of the commune People' Committees answered questions about the understanding and perception of community based approach and community participation as well as what the local did contributed to and benefited form the process.

The commune health workers responded to questions about the quality of the health services; available resources, as well as benefit and obstacles;

For the household members answered questions focused on the readiness to participate in mobilizing resources for health activities, how to proceed, the positive and negative experiences gained, their contribution and interests in the CBHD project, the abilities and skills of the health worker and their satisfaction of the health services after project finished.

- Tools and methods for analyzing the results

The collected information from the group discussions and interviews was analyzed by using ranking methods judging how and why change has taken place in the CBHD project. The following indicators were used to assess community participation (Rifkin, 1999):

+ needs assessment
+ leadership
+ organization
+ management
+ resource mobilization

However, in this study, some additional factors were also looked at. They are:

+ culture aspect in the community – attitude, behavior, willingness, linguistic
+ perception and understanding of people
+ political advocacy regime
+ local capacities to investigate and use information collected at village level.

For this added indicators, available literature was used together with the information has been collected in the group discussion and from the field interviews. It is important to understand that this assessment views participation as a process rather than an outcome.

1.5 Limitation

Due to time constraint, the study covered a short period of time. It was also conducted late since the CBHD project ended 2006. Therefore, people could not remember clearly the process and the sequence of the project. Other problems faced were that some community members who had been involved in the project had moved for other duties.

The presence of the chairman of the People committee had an influence on the members participating in the study. The study group carefully stated from the beginning that the purpose of the visit was just to learn lesson from the project at commune and village for the next stage of CBHD. Still the study members seemed nervous when asked about the challenges that have influenced the success of the project.

In addition, the budget for the study was insufficient to arrange a proper field preparation, for the meetings and for the guides when going to the villages and households.

1.6 Significance of Research

The area of this research is about community participation in health. The study aims to find the possibilities and readiness of community participation in health development in disadvantaged areas. The complexity of social relations between people dealing with health and the health needs of people living in mountainous and disadvantaged areas became clear by looking at the context of policy advocacy, the local health system and the cultural aspects in willingness to participate in health protection of local people. The result of the research can be a resource for policy makers as well as local health authorities when looking for a reasonable policies to strengthen the of grass roots health system facing conditions of isolation, lack of information, diversity of culture of ethnic minorities, health care management, organizing/re-organizing health structures and human resource development.

Table 3: Summary of Goals and Objectives of the study

Goals/Aims	***Objectives***	***Tools***	***Sample***
To review and assess the situation of the community participation approach and find out the success and obstacle when using it to improve the health services in disadvantaged areas	1. To review and assess the situation of community participation in health care	Group discussion, Interview	Four communes in two districts
	2. To investigate the perceptions and understandings of community;	Group discussion, Interview	Four communes in two districts
	3.To find the facilitating factors for success and obstacles faced by the community and	Group Discussion, Interview	Four communes
	4. To make recommendations to improve the practice of this approach	Interview	Representatives of the villagers