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THE MINISTRY OF HEALTH/ UNICEF

ASSESSMENT ON SOCIALIZATION AND PARTICIPATION OF THE COMMUNITY IN THE PRIMARY HEALTH CARE IN DONGTHAP, GIALAI, HAIPHONG, QUANGTRI AND THAINGUYEN

HaNoi - March.2000

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1. INTRODUCTION

Different people in general, and in primary health care in particular, perceive the participation of the community in health care differently. In developed countries, the concept of socialization is understood that State plays the main role in providing all health services. In many developed countries, due to the shortage of state budgets from taxes for public health, they try to solve this problem by appealing to the community, so the expression "socialization" is replaced by "community involvement" and " community participation". These two conceptions seem to be very different because one is the State's responsibility, and the other is the people's themselves.

In our country, in the past, during the subsidized period, our State monopolized in providing people with health services based on the budgets gained from taxes and on international aid. According to the first look, even at this time, Vietnam already socialized health activities at high levels. Regardless of the limit of high quality in health service (due to the lack of finance), it is a very good model guaranteeing the justice in enjoying health services at high level without much difference among people of different communities. Later, along with the transformation into market economy aiming at socialism, during the first period of the health reform, our State's subsidy for health services reduced considerably. Meanwhile, our public health tried its best to maintain its activities at the normal space, but it didn't work. The degrading/ deterioration in the whole health system was unavoidable. At this time, many international organizations offering aid brought the concepts of community involvement and community participation in health care. At the same time, hospital fees were allowed, subsidy at provincial level ended, and private pharmacist services appeared. All this helped the State to share its financial burden with its people. The results brought about had both positive and negative characteristics. People had to pay for health service and had to spend their own money on medicine. This enabled clinics at all levels to be active and operate again, but this also caused trouble to poor people because they couldn't afford the fees and had no money to buy medicine. Many of them were deeply in debt due to their illnesses, or limited their health utilities. Being aware of the advantages and disadvantages of involving the community's participation, Vietnam Public Health, under the leadership of the Party, has found out the methods to increase the advantages and decrease the

disadvantages mentioned above. Since the National Representatives Conference, our country has undergone many changes. Our Party, our people try their best to fulfill their aims to make our people rich and our country prosperous, our society just and cultivated. Under the leadership of our Party, the potential in the people has been mobilized in a series of big campaigns including the campaign of mobilizing people to participate in the health care and protection. In the documents of our Party and State, this mobilization is called "Socialization".

In fact, the idea of socialization is a result of the process of mobilizing people to struggle for the revolution under the leadership of the Party. Today, looking back at the course of the development of our Party, the above idea has been a principle in carrying out our socialist revolution. At the 8th Conference, our Party confirmed: " All the social policies are solved according to the spirit of socialization, The State plays a decisive role and at the same time mobilizes all people, all enterprises, all mass organizations, all foreign individuals and organizations to take part in solving these social problems".

In the field of health care and protection for people, we have to be sure that the idea "socialization" prevails throughout our programs, organizations, and leadership. To follow the spirit of socialization, all the activities of health care and protection must aim at the followings.

First, this work must be done by our health industry as the decisive force. On the other hand, it must be combined with the participation and cooperation of the other organizations such as education, training, culture, informative, physics, population, family planning etc. Thanks to this, all the strengths in our people have been mobilized and the qualities in our heath services have bee improved. The cooperation of different branches is not temporary, but it is fixed in our long-term programs with the contracts signed by two or more parties.

Together with the cooperation of different branches, health care and protection for our people has been supported by the participation of the organizations in the community, especially Women union, HCM Youth union, Red-cross Association, Farmers' Association as well as other non-government organizations functioning as health care, health education, and charity.

Health care and protection should get various forms of investments from different sources. Our former slogan " State and people work together" is only one of these forms.

At last, health care and protection in the spirit of socialization was put under the direct leadership of our Party Committees at all levels and close management of our State and local authorities.

This is the fact that although the socialization of health activities has been put into practice for many years, State institutions and mass organizations, under the leadership of the Party committee at all levels or under the direction of the PHC committee, here really taken part in the activities and management of health, but they still lack the harmony in the operation process. In different localities, health care sections aid health sector differently and at different degrees. One of the causes of the above problems is that the local health sector has not done well their advisory role, has not fully pointed out all the difficulties and shortenings of the health activities, except the shortage of workforce resources - which is endless and available everywhere. Hence, everything got stuck. To reduce little practical proposals, the Ministry of Health together with UNICEF have applied the method of curve already used in many African countries to help health units to identify the "bottle neck" in their health management process and as a technical tool to illustrate and persuade in settling down the problems of these "bottle neck". This is the method to strengthen/reinforce and concretizes the activities of the health at grass-root levels and is called the method of control based on community (CBM). In fact, CBM can be a very effective method of consolidating the socialization of health care at grass-root levels.

It's time we summed up all our experience lessons from the mobilization of the people at different periods, so that we can systematize all the theories and practices in the socialization of PHC in Vietnam.

This study is carried out with the objectives:

1. ***Assessing the activities of socialization and involvement of the community to participate in PHC at grass-root level and in contributing their workforce to the health activity.***

2. ***Assessing the role of the CBM in the provision of essential health services and in the socialization of health activities at grass-root levels.***

2. SUBJECTS AND METHODS

2.1. Subjects

2.1.1. At district level

- Interview the participations who were the representatives of the authorities, social organizations, and district health centers including vice president of the provincial people's committee, representatives of different mass organizations, director and vice - director of health centers, the head of the general planning, and the head of finance and accounting department of the provincial health centers.

- Examine documents and decrees of the local Party committee instructing on primary health care and socialization of health activities in the area.

2.1.2. At commune level

- Interview the members of the primary health care committee or the health care committees in the communes.

- Interview the representatives of the community including the heads of the villages.

- Interview the mothers having children under five, young men of labour age, and schoolteachers.

- Interview the commune and village health officers.

- Examine documents, decrees and resolutions of the commune party committee instructing, primary health care activities and socialization of heath.

2.2. Method of selecting areas to study:

Stage 1: Selecting towns / cities

We have selected 6 cities - representing those cities that have got aid from UNICEF and other different areas by random. The results we have found are:

- Two Northern cities: ThaiNguyen and HaiPhong
- Two Middle - part cities: QuangTri and GiaLai

- Two Southern cities: LongAn and DongThap

Stage 2: Selecting districts:

From the provinces above, the districts for the study were selected by using stratified method random. They are those districts that got aid from UNICEF and those who didn't have any aid at all. Listing the names of all the districts belonging to the city, and then 2 districts for each city were selected by random. UNICEF - aided districts are called " Intervention Districts" (ID), the rest are " Control Districts" (CD). Therefore, from 6 selected cities, we have chosen 12 districts, of which 6 are interviewed and 6 are controlled districts belonging 3 different geographical areas. (See table 1).

Tables 1. Districts involved in study

Provinces	Districts with UNICEF intervention	Controlled Districts
DongThap	TamNong	TanHong
GiaLai	Chuse	Chuprong
HaiPhong	VinhBao	TienLang
LongAn	CanDuoc	BenLuc
QuangTri	CamLo	GioLinh
ThaiNguyen	DaiTu	DongHy

Stage 3. Selecting communes.

From selected districts, 2 communes as representatives of each district were chosen by random. Hence out of 12 districts we have chosen 24 communes to conduct a survey and assessment on the community's participation in primary health care of which there are 12 intervened and 12 non - intervened communes (table 2)

Table 2. Communes involved in study

Districts	District name	Communes
With UNICEF aid group	VinhBao	Hoabinh, Lyhoc
	DaiTu	Khoi ky, Dai tu
	CamLo	Cam hieu, Cam thuy
	Chuse	Hbong, Ia Blang
	CanDuoc	Tantrach, PhuocDong
	TamNong	Phucuong, Phuduc
Controlled group	TienLang	Bachdang, Tienthanh
	DongHy	Hoptien, Linhson
	GioLinh	Giolinh, Linhhai
	Chuprong	Iaphin, Thanghung
	BenLuc	Phuocloi, Longhiep
	TanHong	Anphuoc, Tancongtrai

2.3. Research methodology

Deep interviews, group discussions and document, reports and statistics available data analysis were used in this study.

Techniques used quantitative study:

- Deep interviews: interviewing the above objects based on the samples suggested (see appendix 1).

- Group discussion: The number of the participants in each group is from 6-14 including officers from districts, communes, and community. We discussed together by face in face on the participation of the community in primary health care.

- Analysis of available figures/desk study. There were two forms used to collect documents available on written documents issued by the state ,the science and

education board concerning the primary health care and socialization of primary health care. We formatted the checklist on the functions and duties of the different sectors in the socialization of primary health care.

2.4. Writing the questionnaire

The sets of these questions were designed with the aim and necessary indices to answer the questions put forward in the study.

After being designed, these questions and checklists were protested before they were printed to serve as official sets of questions for the study. This was carried out to edit / correct the shortcomings during the process of designing these sets of questions and check - tables and make them understandable to people so that everyone can answer them easily. (see appendix 2).

2.5. Investigators

Investigator chosen are teachers of the Public Health Department, Hanoi Medical University. The reason to choose these people as investigators is that they are teachers, so their communicative skill is good. They have good knowledge on their specialization and good skill in group discussions, deep interviews and observations, so that the information obtained from them must be much more accurate, free of errors especially in leading group discussions.

2.6. Training of investigators

The contents of investigators training course covers:

- Contents of the questions sets for deep interviews and group discussions

- Techniques of contact and interviews

The study started when these trained investigators understood well, each of these questions and mastered the techniques of interviewing and leading group discussions. With this aim, the duration of the training course was 3 days and covered the following:

- Introducing, discussing and answering all the questions concerning the "questions sets" and questions for group discussions

- Introducing, directing and exercising all these interview techniques

- Role - plays

- Asking questions based on localities and drawing experience conclusions. Only those who absorbed and mastered all these techniques, and had good responsibility could be chosen as investigators for the study.

2.7. Organizing and conducting the assessment on the community participation in primary health care

There are 3 stages:

- Stage 1: Preparation (From Sep, 20th to Sep, 30th 1999)

Selecting provinces, districts and communes to conduct the study. Informing time-schedule of this study to locals

- Stage 2: Collecting the data (From Oct 1st to Nov. 15th 1999).

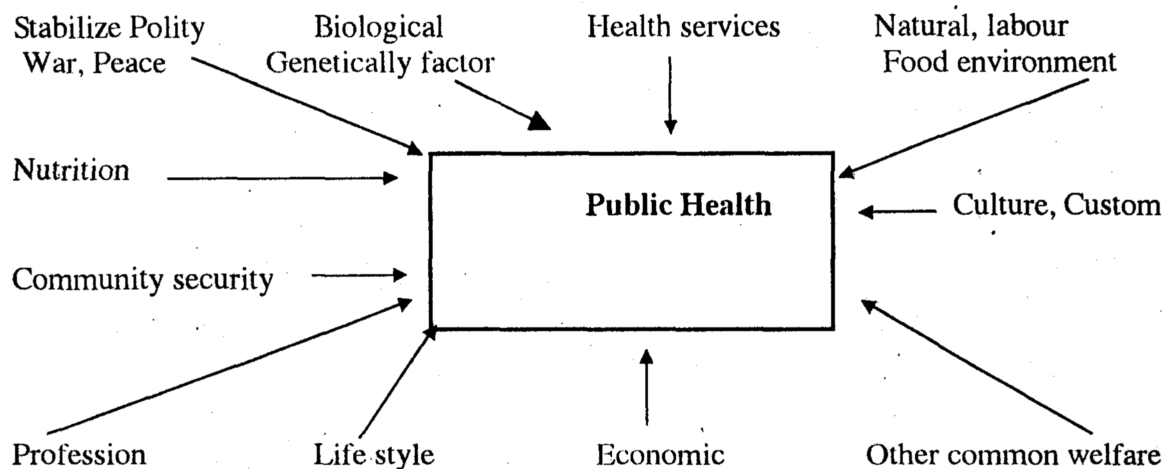
- Stage 3: Processing, analyzing the data and writing reports (From Nov.16th to Dec. 30th 1999)

This stage started after all the interviews were conducted, the minutes of group discussions were finished. All these data were looked through again, their qualities were checked, and data were classified and coded. All these data were discussed, analyzed, and reported by a group of experts.

3. RESULTS OF THE STUDY AND DISCUSSIONS

3.1. Socialization in Vietnam

The health of the community is under the influence of many factors, of which biological factor and health services and nutrition are the three factors that people tend to pay most attention to.



Looking at this diagram we can see that to improve the community health, we can't only rely on health services. On the other hand, health service itself can't be separated from economic, cultural, and social conditions, with which it is concerned and by which it is influenced. Other factors affecting the community's health are also closely linked and have become a combination of various relationships, i.e., if one of these factors changes, other factors also have to change forming a vicious circle to the health service, to people's health and vice versa.

With the above analysis, people's health care has theoretically a high social characteristic. If we rely solely on medical techniques, we can only diagnose and treat individual patients. If we can make use of economic, cultural, social factors as well as the participation of all sectors and organizations, we can change/improve the whole community's health. Therefore, socializing people's health care is essential. However, as above mentions, today many people still abused meaning of socialization, even socialization is used with different meaning as its natural. They consider "Socialization is

the mobilization of individual contribution to health service as a requirement each is responsible for his/ her health". If we understand socialization like that we privatize and reduce the social characteristics of health activities, if not saying that we create favorable conditions for health privatization and individualization.

To better understand the urgent necessity of socializing the people's health care in our country, we represent here the data on diseases caused by poverty, ignorance, unhealthy lifestyle, and stress.

3.2. Characteristics of the socialization of the people's health care in Vietnam

The period of 1960 - 1975 was the period of the preparation for the southern liberation war. At this time, economy did not develop well, but health and educations were already highly socialized. The community's health units spread even in different labour teams, plants / workshops, districts. Our state provided free service of prevention and treatment. During this period, the different between the rich and the poor was small, so this free provision had good influence and contributed a lot to the stabilization of our northern people's life, who were both back front and the front for our resistance against the French.

1975 - 1986 were post - war 10 years, there was nothing changed in the aim and methods, solutions of the health sector. Subsidy was maintained. Socialization of health care was still high while our health escort met with many difficulties; for example, the state investment in health was too low to keep different health units operating. The demand for the community's health care still increased, forming sharp contract/conflict between demand and supply/provision. This period was said to be a crisis after the war, in which our economy could not find a way - out yet. The community did not change yet the forms of participation in health services, still did not give any direct support (fees for diagnosis and treatment), to health sector and our economy was still slow and passive. The deterioration of health units during this period showed slow change in our health sector, shortage of resources, and lack of knowledge to exploit the resources from the community. The lesson we can draw here is that socialization must always associate with the mobilization if not only workforce, spiritual support, but also finance from the community. This has been more clearly seen since economic reforms.

1987 - 1994 is the period when health services were less and less used for diagnosis and treatment. During this period, health sector wanted to retain the decisive role of the community, but also wanted to encourage the development of health privatization. The attitude and demand of the community towards health services had changed and caused conflicts difficult to settle down. The degradation of the local health units, the collapse of the communal health systems due to the lack of finance from labour teams and farms, the privilege of the public community's health disappeared and basis of socialization decreased. Meanwhile, the development of private health services partly met the needs of the community for diagnosis and treatment. Naturally, health service tended to be privatized.

When economic reforms shifted to market policy, the links within the community were social, spiritual and emotional but also economic ones. There was a competition between the state health and the private health. The capacity of providing health services decreased. This decrease affected the health prevention and health education of the communal health. People tended to seek health services for individuals rather than for the entire community, so the capacity of mobilizing the community to participate in the community's health care decreased? Loosely organized while the decree 15/CP (1975) had become out of date and a new decree to replace the old one was not available. Mass organizations got confused in changing their activity course. Health activities were marketed naturally, reducing the capacity of mobilizing people of the community's health system. The only one possibility to mobilize the community's participation was left. It was the fact that patients were still willing to pay for hospital fees. This fact was maintained and developed. The decision 45/HDBT 1989 allowed a partial hospital fee and the resolution 299/HDBT on health insurance (1992) contributed to the increase of the workforce resources from the community for diagnosis and treatment activities, leading health operation to get out the previous difficult situations. The initial success in the mobilizing of the community to participate by paying directly and by buying health insurance was undeniable during this period. For this reason, people tended to too much appreciate this method - the method of getting more financial resources for health sector with the claim " Everyone is responsible for his health", forgetting that the contributions by the community could exhibit the socialization much more than self responsibility for the health of individuals, and of people in the community. The above analysis shoes that

the socialization of health activities of this period was slow confusing, passive and tended to exploit the community's contributions. From 1994 up to now: this is the period the community's health system has regained its reputation. Health services at communal level have been used much more; prevention actions have been improved considerably. Agriculture stably developed. The capacity, possibility to pay for service fees or medicine also increased. The leading ability to control health activities of the local authorities improved owing to a series of health and educational programs, which require them to participate more often and more actively, more effectively. During the operation of health and education aid programs, many training courses were held for leaders of the community and organizations. The resolution N^0 4 of our Party pointed out that health activities had entered people's life. Following this resolution were a system series of documents at government level, inter - ministry circulars. The officers of communal level throughout the community have been paid since the day the Resolution 58/TTg and the Resolution of the VII Assembly confirmed the socialization, varieties of education and health. Together with the development in economy and education, increased our people's literacy. Party committees at all levels and local authorities have paid more attention to the movements "Build a cultural, green and clean village". Many organizations have taken an active part in these movements, too. In addition, many foreign organizations, government, and non-government ones also highly appreciate the programs of community development, considering women's ability et, of which the community's health care and health education have greatly contributed to the restoration of the socialization of health care activities more effectively, more scientifically and more widely. Leaders of the community, and of the organizations gradually participate in planning health activities, inspecting, and assessing health services. In fact, it is not easy to do this, besides it depends a lot on the capacity of the local health units. Once their management capacity is weak, they cannot function advisors to the leaders of the community. In some places, people's health care committees are called Primary health care committees, and these committees at district and commune levels were founded almost everywhere. Their duties were assigned clearly but their activities did not work well yet. Since 1994, socializing health care in our country has had a scientific theoretical basis. At central level theoretical system has confirmed the leading principles during the socialization of people's health care based on politics and laws as follows:

1. Mobilize and educate all people living in their own condition to be aware that they must be responsible for creating, protecting and improving their own health.

2. Impact factors deciding or affecting health of individuals and the community, both internal and external factors.

3. Help them understand the techniques of identifying and solving their health problems.

4. In crease the decisive role of the health sector in cooperating and integrating people's health care into other social activities

5. Apply and integrate technical methods measures properly.

6. Increase the role of responsibility of all level community's leaders.

Party leaders, leaders of authorities, organizations, government bodies, and people with high reputation in the community area important and decisive factors. Socializing people's health care according to the above-mentioned orientation changed the way to access to the development of people's health in which people have an active role in deciding to take care, protect, and improve their own health, and the health of their community, so that this operation will surely be successful. They will not be passively waiting for decisions sent to them, which sometimes might be not practical and cannot satisfy the health needs.

There fore, socialization of people's health care is a shift from the old access to the new one. Health care, protection and improvement should really be the responsibility/duty of the people and for the people.

3.3. Realization of socialization and community involvement in Primary Health Care in areas sponsored by UNICEF

(1) ***Realization of socialization in 6 studied provinces in 1999***

Table 3. Some general figures

Some general figures	Camlo	Canduoc	Chuse	Daitu	Tamnóng	Vinhbao
N^0 of communes	9	17	14	30	12	30
N^0 of commune with CBM	9	17	13	30	12	30
Population	42589	158473	108675	158610	88058	184680
Natural birth rate	2.13	1.75	3.74	1.67	2.08	1.32
N^0 of 15 - 49 years old women	-	37371	23491	44042	17782	49651
N^0 of children under 1	-	2773	3886	2661	1831	2256
N^0 of children under 5	-	14511	33821	13036	6538	14894
N^0 of babies born under 2500g	-	86	10	53	78	-
N^0 of malnourished children under 3	39,5	568	445	1.702	-	-
N^0 of children died under 1	21/1000	12 4.3/1000	12 3.1/1000	24 9/1000	40 21.8/1000	10.9/1000
N^0 of children under 5	30/1000	15 1.0/1000	30 0.9/1000	41 15/1000	-	3.5/1000
N^0 of women died due to pregnancy and birth	0	1 3.6/1000	0	1 3.8/1000	0	

Table 3 shows that of 6 districts sponsored by UNICEF, TamNong and CamLo have the highest rate of children died under 1 year old. Chuse, CanDuoc have the lowest rate. DaiTu and CanDuoc still have the rate of mothers' death.

Table 4. Some figures of finance

General figures	Cam Lo	Can duoc	Chu se	Dai tu	Tam nong	Vinh bao
Average expenditure/ health service		14,908đ	7,175đ	7,765đ	4,281đ	9,209đ
Average cost/health service		10,594đ	429đ	2,910đ	1,507đ	4,908đ
Service fee		12,446đ	3,556đ	6,546đ	4,155đ	6,632đ
Average cost/prescript		7,818đ	2,976đ	-	3,227đ	4,883đ
Average cost/time		-	4,426đ	-	-	5,441đ
Restoring capital		1,12	0,99	1,03	1,01	1,09
Rate of returned capital during the time of report		3,66 times	0,32 times	1,27 times	1,06 times	1,27 times
Rate of medicine profit		120%	54%	118%	110%	109%

In 6 districts sponsored by UNICEF, average expenditure per one health service is highest in CanDuoc and lowest in TamNong. Average fees for diagnosis and treatment service, average service fees and average prescription costs are different in the areas with different incomes. This indicates that the possibility to mobilize the community to make financial contributions is very different in different areas, so that an assistance (balance) is needed to help public health services in poorer areas. In fact, assistance takes place, for example. Chuse is a mountainous area with very low financial indices, so people here do not have to pay for their diagnosis, treatment or medicine when they are ill. This is a form of subsidy maintained to help minority people in mountainous area. This form helps to reduce the injustice between mountainous and urban areas, between the rich and the poor.

Through this form of assistance we can see that our State policy in using the contributions of the people with high incomes to help people with low incomes is right and flexible in the socialization of our people's health care. Some remote places in river deltas like Tamnong, Dongthap are also poor, but unfortunately, this assistance from our State has not reached them yet. The maintenance of this subsidy like this, however, has some unreasonableness, because in poor areas there are poor people and rich people. The rich people in poor areas can get help from the State, whereas rich people in rich areas cannot. Hence, we have to work out a better solution to this problem, so that help can reach the right person.

(2) ***Opinions got from group discussions and thorough interviews about Primary Health Care in the locality.***

12 group discussions at district level, 24 group discussions at communal level, and 209 direct interviews in the community, we can comment on the Primary Health Care activities in the recent years as follows.

At intervened districts. They almost answered that there was very much progressions in their primary health care at the district, communes in the recent years, concentrated to following aspects

* Power of management

The leaders' perception was changed. They has clearly known the importance of primary health care, socialization of health activities as well as the community participation on health care. There is integration on health care.

The activities were done more scientifically. The health care was made up out a plan annually, setting priorities program planning

* Mother and children health care was better

* The immunization rate attains to very high

* The rate of pregnancy check is high

* The rate of malnourished children reduces

However, there are some limitations as:

* The direction of activities was still not thoroughly

* The rate of people coming to health station to examine and treating their diseases is still not high

Some opinions of study districts are following presentation:

- In **VinhBao**, HaiPhong, Primary Health Care is very successful. It has changed the attitude of many leaders. It also has made the community understand that prevention is better than cure, and that taking care of mothers' and their children's health is very necessary, especially in the first stage of socializing health service. The results of CBM have provided the Primary Health Care board at district level with more scientific methods to operate and raise the awareness of Primary Health Care of the district health center officers. All operations have been assessed, and each health center has a group of 12 inspectors. Different branches and sectors have cooperated and integrated in Primary Health Care. The greatest success gained by VinhBao is the integration of different branches in Primary Health Care. Through the talks with the local people, we often hear: The difficulty for this work is the limit of popularization due to " the budget shortage" and the leaders here do not really appreciate spiritual contributions of the people. Some of the leaders still keep their own opinion. Especially, many of the representatives of the local authorities think that health care is the responsibility of the health sectors itself, because it is the matter of specialty. The investments as well as workforce and financial aid from the community to realize this program is still too low to meet the budget needs.

- In **CamLo**, QuangTri, district health centre has reported that health care is one of activities planned annually. Children's health care is done well, different branches have co-operated in their operations and extensive immunization reaches 100%. The rate of pregnancy check - up is 100%, but the rate of 3-month pregnancy check - up is still slow, however, it tends to grow. In this district, the participation of the local authorities is rather good. This work is done well here owing to the decisive and advisory of the local health sector in the health care board. We have been told that the director of the district health centre is very influential person in the area. We cannot deny the individual role of the leader in the mobilizing the community to participate in health care.

The greatest shortcoming in this area is that the rate of people using health services is still low because of the poor knowledge of the health officers' specialty:" only 45% communes have doctors, and medicine is too little: This also shows that the number of people using communal clinics is low without knowing that their using communal clinics is their contribution to health care activities of the people in the area.

- **DaiTu**, ThaiNguyen: What we know about this area is that health care in DaiTu and ThaiNguyen is successful, the rate of malnourished children reduces, extensive immunization is very fruitful, no accidents and no death due to pregnancy and birth. People's awareness of health care is raised. But the rate of women who have their pregnancy checked 3 times is not high yet partly they are not very cautions, and partly because the clinic has no tools to test Albumin.

We can say the general comments like those above are popular not only in DaiTu. Having such general comments, we have nothing else to do. To do away with this situation, we ought to use CBM much more. So that when commenting on health care, health management officers and the community's leaders have to give concrete figures " bottle - necks" and propose the solutions to express their role, duty as well as their future activity plans.

- **CanDuoc**, LongAn: let us know that health care in the past years has made great achievement, starting to socialize health service in the area. This activity ha created opportunity for other organizations to participate. Thanks to this, many diseases have been swept such as malaria, bleeding, and typhoid fever. The knowledge of the health staff is bettered. Local clinics are provided with more health equipment.

- Women's health care used to be weak, but now it bettered a lot.

- New - born babies' heath care: 90% of local clinics have aseptic rooms with enough staff that is regularly trained. About 70% of mothers come to the clinics to give births, much higher than before. However, the rate of pregnancy - check is still not high.

- Post - birth mothers' health care: due to the lack of time and health officers, only serious cases can get " this care".

CBM program has helped a lot health officers were to make plans and to identify " bottle necks". The officers here have started their work more and more smoothly and display more initiative in their work.

- However, all the opinions show:
- Health staff is not enough and weak: there are no doctors with high qualifications, communal health officers are not bettered including those in primary health care board. Co-coordinator network lacks finance so it cannot work well enough.
- Material basis: health basis is degrading because of the shortage of finance.
- People's awareness of children's health care is not high.
- The access to this area is difficult, so it's not easy to take care of women and children, especially of after - giving - birth women. It is not easy either, to check the babies' weight regularly.
- There are many private heath units, so people can get diagnosis from various sources. They may be the force that can be mobilized to participate in the pregnancy management during the first 3 months.

- **TamNong**, DongThap: primary health care activities in TamNong in the recent years have been well co-operated with other districts and communes.

- Children's health care: The rate of direct contact/ access is satisfactory, the rate of use is 100%, and the coverage rate is also 100%, but the effective coverage rate is only 92,9% due to a number of inadequate measures.

- Pregnant women's health care: The rate of use is 72,7%, the coverage rate is 61,3% and effective coverage rate is 45,7% because 3 - time - pregnancy - check - ups are not highly popular, and mothers' awareness is low, so they come to check their pregnancy when it is 4 month old. During the first 3 months of their pregnancy, they come to private health clinics. To cope with this situation, 8/12 health officers come to check/ examine pregnancy at home.

- After - birth women's care: the coverage and effective coverage rates are still low (34,4%)

- Diagnosis and treatment: the rate of access is 92,9%, but the use rate, the coverage (26,1%) and the effective coverage rate are only 24,9%. The rate of diagnosis and treatment has lowered for the 2 reasons: firstly, doctors sent to work at these clinics must be diagnosis - treatment doctors, but not management doctors. Secondly, people tend to believe that private doctors have better medical equipment. What is the good gained by health officers and leaders here is that it is the community who realized the priorities to plan, to deal with, and to popularize so that people were more able to protect their health. All the members have said that what they had got that is their people begin to understand that they have the rights to make comments on the health management and that their clinics have been formed and had s management system, which has been running well.

TamNong still has many difficulties. It is a remote place, people's knowledge is low, and so their work and their knowledge shift are slow. During the dry season, they go to their fields, during the wet one, they moves to other places so it is very difficult to manage health, especially pregnancies and babies' weight. The team of co-coordinators is very poor, so they cannot devote all their time to the community's primary health care.

- **Chuse** - GiaLai: it is said that all the health programs have started, reaching the their targets. What is still not good lure is that they don not speak common language. Many people cannot speak Kinh language, their knowledge is low, their specialty is limited, and there are not enough officers, not enough equipment for clinics, and no detailed plans.

At the controlled districts

They almost answered that there district, communes has Primary Health Care board but its activities are not regularly and not have detail activity plans

There are not yet in co-operating multi- sectors with each other in health care mainly is responsibility by health sector.

The situation in some districts is following showed:

- **BenLuc** - LongAn: People in primary health care board have told us that in 1989, the districts started training primary health care officials from 3 to 10 and 15 communes. Being the only province in the south that realizes these programs (P03, P04 - mothers' and children's health care) and finished in 1997. Now children's health care has been started

through out the districts under the leadership of the local authority and the tight / close integration between branches and social organizations. The public health network in the entire district is about 300 peoples. 15/15 communes have 4 assistants doctor of obstetrical pediatric specialist, 6/15 communes have local doctors working on the place.

- Problems remained: " Financial basis is poor, though improved, all the clinics are unable to meet the requirements of the ministry of health. Clinics on road - sides are polluted with dust, poor-water-waste disposal systems. Health networks are poor, some clinics have no pharmacists, and Investments in children's nutrition are not available. There are no financial sources for health units (1999)".

"Provinces are poor, provincial hospitals accommodate 80 beds, the area of the hospital is small infections department is located in the people's committee's hall, so hygiene is not guaranteed".

From the above comments, we can deduce that the health management of districted health canters regards health activities as the duties of the health units only. They have not seen the urgency of calling on the participation of the community's or social organizations' leaders in carrying out these programs. The problems mentioned too generally without pointing out " the bottle - necks" to deal with.

- **Tan Hong** - Dong Thap: like in other districts, there are complaints about the lack of equipment and workforce for health lines: " Only 2/9 communes have doctors. Community's health official is not enough in quantity and poor in quality, so their management is limited. Especially, there is a lack of means for transporting patients, for officers to visit different villages. During the rainy season, transportation is extremely difficult, so health care activities are considerably limited. People's basic knowledge is low. They still have many backward customers. They put forward very pessimistic run arks and believe that everything here is limited due to lack of workforce. We have not heard anyone say that these difficulties can be overcome or reduced with the participation of the community. Then, where is the advisory role of the health sector for the local authority? Why are not there any solutions to improve the weak community health officials system?

- **Chu prong** - Daklak: Districted health center has informed: " health care activities here still have many difficulties, the propaganda and mobilization are limited due to the languages, to road-systems, to the lack of health officers and their worries about their work. Financial sources for medicine supplied to the clinics are not enough. The commune has primary health care board but it nearly does not work. It has never held any meetings since its establishment".

- The problem pointed out about Chu prong is not the fact that it's a mountainous district. Primary health care board was established but have not concrete duties. When health bodies cannot persuade the deputy president of the people's committee, who directs the people's health care program in a district, socialization can be carried out only on paper. The leaders of the committee have many other things more urgent to do and so they often ignore their responsibility.

- Dong Hy - Thai Nguyen: leaders of health centre have shown that in the recent years health activities in the area have gained great achievements, raising people's knowledge. The community has realized that health care is the responsibility of not only health sector, but also of all people, all branches, and organizations. Extensive immunization is very high, nearly 100%, children and mothers' health care is fairly good, there are no cases of death due to birth, and volunteers are active. However, there are difficulties such equipment shortage, lack of medicine, low people's knowledge, poverty of village health officers".

Generally, through discussions, we have noticed that districts health center has been aware of the role of the community's participation and the role of the local authorities in Cupertino with other branches and organizations to get aid for health care activities.

The role and prestige of the local leader of the districted health canters are well expressed. If the local health leaders have good knowledge and persuasive voice, they can involve people in the participation.

3.4. Basis of socialization of regarding its organization

3.4.1. *The role of the local authority*

All the people, who have been asked about the importance of the People Committee at district level, answered that the district people Committee plays a very important role in health - care activities. The district people Committee make decision in the following fields:

- Directly instruct other department to co-ordinate with the medical and heath care department in health care activities.

- Pass/ approve cost estimation, finance support plans, which are not included in the given budget, for health care campaign to priority objects.

- Instruct the Commune People Committee to establish Primary Health Care Board in the commune to start health care activities.

- Make decision and policies regarding the health care activities.

- Supervise activities of health care centers

- Manage private health care systems

- Evaluate the instructions to health care activities implementation

As for districts beyond the project, the answer on the importance of the People's Committee focuses on the following three points:

- With the decision by People's Committee, the socialization could get more favorable conditions.

- Provide additional funds for disease - preventing activities

- Mobilize other organizations, departments, branches to take part in the Primary Health Care activities together with medical and heath care department.

The research in all districts has confirmed that local authority plays an important role, as well as has impact on the results of Primary Health Care activities.

Table 7. Opinions of role of the People's Committee

Role of the People's Committee	Intervened communes		Controlled Communes		p
	n	%	n	%	
Direction of health station	39	35.5	47	47.5	>0.05
Direction sector participation	36	32.7	29	29.3	>0.05
Supervise	20	18.2	2	2.0	<0.001

For the role of instruction of diagnosis and treatment activities and direction different sectors participated, both groups had the same the remarks. For the role of supervision, people' perception in intervened group is higher than that of controlled group. The role of the people's committee in supervision of their commune heath care activities were awarded clearly

All the people being asked in the commune also answered that over the past few years the People's Committee has included the heath care plan in the general plan of the commune, which is subject to the approval of the commune People Council. To the questions on what issues are usually raised in the health care plan. Most answers are focused on health care activities for the children and women. Thus, regarding the organization, the People's Committee has played an important role in the socialization of Primary Health Care of the people during the past and present years.

3.4.2. ***The Department of Primary Health Care activities and its role in instructing other departments, and branches, and in mobilizing the community to participate in Primary Health Care.***

Regarding the Primary Health Care board, 100% people answered that their district has established this board. However, the composition of the board in different localities in different. The members are about from 4 to 13 participants, 8-10 members for almost districts, of which someone from People 's Committee, some from Health care center, Women union, Youth union, Mother-Children protection committee, population

commission, represented of accountant, local Party 'committee, Red cross society, National Front, Education, Communication unit, Farmers' society

Checking people in the communes whether they know that the Board of Primary Health Care activities is available in their commune, 102/110 people (92,7%) in intervened communes answered "yes", only 8/110 answered "don't know". In controlled communes, 11/99 people (11%) answered they didn't know, 8/99 (8%) the questioned people said that there have had not primary health care board in their communes.

Almost of people know that the head of the dept. is the deputy chairman of the commune People Committee. This fact shows that in the communes, which have UNICEF program/project, local people and leaders pay more attention to this department than in other communes without UNICEF projects.

3.4.3. ***Documents regulations by the Government and the Ministry of health concerning the mobilization of the community to participate and contribute to the Primary Health Care activities (socializing health) started by different localities.***

At districted level

Table 6. Documents concerning the socialization and participation of the community in Primary Health Care at districted level.

Documents	Intervened		Checked	
	Yes	No	Yes	No
1. Law of health protecting	x		x	
2. Decision 37/CP on oriented strategy of people's health protection and care from 2000 - 2020 and national strategy		x		x
3. Decree 90/CP by the Government on socializing health and education	x		x	
4. Decree 01/CP by the Government on setting up the local health network systems	x		x	

5. Decree 02/CP by the Government on setting up the local health network systems	x		x	
6. Circular 07/BYT--TT on guiding how and what the Primary Health Care must be done	x		x	
7. Decision 58/TTG by the Prime - Minister on health policy at grass -root level	x		x	
8. Resolution by the Provincial Party Committee on starting the TW resolution 4 on Health care and Family planning	x			x
9. The Central Department of Science and Education - Ministry of health. Carrying out the socialization of the people's health care at health grass- root level.		x		x

The results in the table above show that the intervened districts still keep most of the documents by the Government and the Ministry of Health concerning socialization and participation of the community in Primary Health Care. However, the documents by the central Science and Education board are not kept in many places even though they were trained on the contents of these documents. There are some districts like Vinh Bao has had even 2 Resolutions concerning people's health care and family planning.

Contrary, in checked districts, of the documents and decrees by the Government and the Ministry of health, only 2 documents are still kept. They are decree 37/CP, and documents by the Science - Education Board - Ministry of health about socialization.

At the communal level

Table 7. Documents concerning the socialization and participation of the community in Primary Health Care kept in commune lines.

Documents	Intervened communes		Checked communes	
	Yes	No	Yes	No
1. Health protecting law	x			x

2. Decision 37/CP on oriented strategy of people's health protection and care from 2000 - 2020 and national strategy		x		x
3. Decree 90/CP by the Government on socializing health and education		x		x
4. Decree 01/CP by the Government on organizing local health network		x	x	
5. Decree 02/CP by the Government on organization of grassroots health service network		x		x
6. Circular 07/BYT-TT on guiding the operation of Primary Health Care	x			x
7. Decision 58/TTG by the Prime - minister on health service policies at grassroots level	x		x	
8. Resolution of district's Party committee on the implementing of the 4th Governmental be solution in Health care and Family planning		x		x
9. Special subject on health care according to people committee's resolution		x		x
10. The Central Department of Science and Education - Health care Ministry, socializing health care of people in the grassroots medical service level		x		x

The results in table 7 show that a lot of documents, acts, decrees connected with the socialization and participation of the community in health care in all communes of intervened districts and communes of investigated districts, are missing, only some circulars and decrees are kept. Therefore, inadequate store of documents of the Government and Health Ministry on health care socialization and participation of the community in Primary Health Care in a commune, an implementing unit, is a difficult problem against the application of these documents. In some communes, although they

keep these documents, the documents are put in cabinet tightly; it takes hours to find out them. This issue needs examining and correcting.

3.4.4. ***The transference of information from the legal documents and decrees of the Government and the Health Ministry and the implementation of these documents in localities.***

Official dispatches and documents are mailed to the communal People Committee or health station, but training documents, and sometimes, resolutions, decrees are sent to the People Committee and health station through meetings. But how are these documents publicized in communities? Here is an answer from a head of a hamlet:

"The legal documents and resolutions are publicized at the People Committee's meetings by the chairman of the committee or the secretary of the Party executive committee after their training course".

The Resolutions of the Party and the Government related to health care socialization, and the resolutions, circulars of the People Committee district reaching the localities, are first studied by relevant officials and then publicized to all members of the Party and people. However, these documents (if reaching people) only popularize the mobilization of the people to contribute their effort and property. The community does not completely understand the content of these documents.

An up - cropping problem is the fact that documents after being used for training or publicizing are usually stored up too carefully so it is very hard to find them to read later. The publicizing in an area is carried out as follows.

"Monthly our quarter gathers to discuss our labour work. In such meeting we read and publicize all documents and circulars if any, so that people can know and implement"

In some opinions, to publicize and implement circulars or other legal documents related not only to health service but also other matters, necessary to multiply these documents and send them directly to the heads of quarters who are required to publicize them. Only in this condition, can the people understand their rights and obligations to protect their health not only for themselves but also for their family and neighbors. This is s wish of the people that we have to study and find direction to satisfy.

3.4.5. ***Existing issues of legal document systems connected with guidance of health care socialization.***

The result mentioned above shows that: general assessments about legal document system guiding health care socialization, passed by health care committee or Primary Health Care committee in many areas until now, are inadequate, and not publicized sufficiently to implement. Except the documents on socialization guidance of the central department of Sciences and Education, and circular 07/BYT-TT of Health Ministry, instructing the Primary health Care which are rather in details. (These two documents are compiled with the support of UNICEF and SIDA).

To implement the policies of socializing health service and education of the Party and the Government (Decree 90/CP), all the localities should actually activate by issuing Revolutions of the local Party. Therefore, if the local Party (commonly in district level does not promulgate any resolutions, the communal line will have difficulties in implementing them. We do not intend to criticize the bureaucratic style of work in many localities, but we want to mention about the tardiness or the passiveness of the communal level. Until now, in communes, legal documents from the central front are not used directly, but wait for instructions from above, direct higher level. To hand over the instructions quickly, it is needed to regulate fully in compiling documents detailed enough so that every areas can implement immediately without explanation and there should be principles for localities to apply suitably with their own condition. On the way legal documents are sent in turns from the central Government to provincial administrative committee and then to districts from provinces and at last to communes there will be other documents. This makes the implementation of these government policies slow and divergent at times, or being interrupted in provincial level or district level. Perhaps, this is an issue needed to study in our administrative reforms at present.

Another problem we want to mention here is in many legal documents they only point out targets but not the way how to organize and the resources, especially financial sources. In the case without financial source, the legal documents did not often show "fun dings for implementation from budget for regular activity " or "from culture the funds of the locality". There have not been any province level legal documents regulating or guiding localities to recover their health funds.

As a result, some areas have funs, some have not, and each locality has different contributions and collections. In the coming time, the medical service funds of communes are needed to examine suitably. This form should be encouraged, as this is a specific form to socialize medical services, not only depending on collecting medical services fees. (Cure is going to be prevention).

3.5. The activities of Primary Health Care Committees at all levels

Through the investigations on the field in the localities with and without UNICEF projects, we have the following results:

3.5.1. *The functions and responsibilities of Primary Health Care Committee (PHCC).*

Tables 8. The functions and responsibilities of Primary Health Care Committee (According to the answers of the community's representatives in implementing - project and checked communes).

The functions and responsibilities of PHCC (according to the Central Department of Sciences and Education).	Intervened communes (with UNICEF project)	Checked communes (without UNICEF project)
3 functions	2%	0,0%
2 functions	15%	16,7%
1 function	75,8%	4,2%
Wrong answer	24,2%	70,8%

With this table, once more we can see that the knowledge and concern of the communities in intervened areas are better than in checked ones. In the intervened areas, 78,5% of the answerers get one - right - function, 15% get two - right - function - answers, however, the proportion of people having right answers (3 functions) about the functions and responsibilities of PHCC in intervened areas is low, only 2% and 24% have wrong answers. But in checked areas, the proportion of answerers who misunderstood the responsibilities of PHCC account for 70,8%. They thought the responsibility of PHCC is

to examine health, distribute medicine, prevent diseases and propagandize birth control. These thoughts prove that policy publicizing in localities is not good enough.

The members of PHCC from districts to communes (villages) have little knowledge about their major responsibility completely, even medical service staff assistants of the local authorities also do not understand the function of the committee thoroughly. However, in the intervened communes (villages), the proportion of people having right answers is a little bit higher than in the others.

3.5.2. ***Documents guiding the establishment and operation of the Primary Health Care Committee for communes of 12 districts investigated, all have issued guidance on the establishment of PHCC in communes***. Thanks to this 100% of the communes have Primary Health Care.

*** Operations of Department**

Over the past 2 years, in intervened districts, PHC has had from 3 to 9 meetings, including quarterly and sudden when there are epidemic campaigns. These meetings are often about:

- General comments on what have been done and undone.
- Activity - plan making and supervision in the area
- Looking for funds and their sponsors
- Criticizing their diagnosis and treatment
- Criticizing women's children's health care
- Criticizing the implementation of AIDS prevention
- Criticizing health education
- Criticizing the implementation of those programs such as extensive immunization, mother and children's health care, epidemic and environmental hygiene.

In checked districts, the answers are very different, Primary Health Care Committee has never held any meetings (Chuprong - GiaLai) whereas some other places like GioLinh - QuangTri has had 17 - 18 meetings. In general, meetings are held once a quarter, or together with epidemic campaigns with the aims to reinforce local health, start

immunization/ vaccination campaigns, appointing people in charge of the operation of PHC.

When asked about their schedule and duties, all districts have detail activity plans by Primary Health Care Board. The duties of branches and organizations taking part in Primary Health Care include: Communicating and educating their members to carry out successfully the task of primary health care, co-operating with health sector. However, when they was asked about the contents what they communicated to, how many times a year they have to do this, how many times a year the members have to involve in these activities, and how much they have achieved, none of the organizations could give the concrete answers except several heads of Women's Associations.

- Activities of Primary health Care Board in control communes: it was informed that the board organizes/ holds a meeting only when there is an epidemic, but not according to the schedule, or to order of the higher body. In intervened communes, VinhBao for example, 5 out of 8 people (60,2%) said that there is meeting schedule every month, and 3 out of 8 people said there is no meeting schedule. In Chuse, 6/11 people said that they had schedule for their activities. The answer in CanDuoc was no. In DaiTu: 4/14 has said "yes". They even reported that there are a meeting every 6 months, meeting about mothers' post- natal health care once a month, but 7/14 people said "no meetings", and the rest answered they didn't know. In CamLo district, the number of people said "yes" is rather high (10/14 people), but when schedules are asked and be checked, no one can give any detailed schedules.

Plan - making in communes: we have noticed that all these communes operate/ work depending on epidemics and on the plans made for a month (intervened and checked). PhuocLoi commune in TamNong district has made very good plans.

At periodic meetings or based on the higher bodies' requirement Primary Health Care Board holds a meeting, discussing their monthly plans, assigning each of the members concrete duties to closely watch. As usually there are 3 main ingredients of this operation. They are authority, health sector and women.

The branch - integrations here is like the one at districted level. It takes place when clinics invite them to attend there joint - meeting. The other branches invite health staff to have a talk to their organizations when they do need to do it.

Generally speaking, the operation of the Primary Health Care Board in particular and of other boards concerning with health in general, has not got specific schedules monthly, quarterly, and yearly.

The meetings are held, depending on epidemic campaigns are not the operations of communes are not regular, without the same guidance to prove this, we are going to quote what was said by the Head of Thai Nguyen Women organization.

"The number of boards organizations concerning with health in a commune is the same as in a district. The operation of this Board depends on epidemic campaigns. Before starting to implement a campaign, the Boards calls for a meeting and assigns duties to each of the members in the Board. After the campaign finishes, they sum up and draw lesions and wait for other tasks...:These Boards have no weekly or monthly schedule".

3.5.3. ***The role of branches organizations***

** Documents instructing the Cupertino of branches in the district to participate in Primary Health Care with the Health sector.*

Table 9. Stored documents about multi-sectional integrations and reasons for unavailability of these documents.

Documents	Intervened districts (n = 21)	Checked districts (n = 25)
Yes	7	0
No	14	25
Reasons why not issued combined documents		
- No ad vocation		17

- No feasibility, depending on local areas	6	2
- Villages' poverty	8	3
- Not know		3

When being asked about district guiding documents on co-working together with health service center in Primary Health Care, most districts answered "District did not issue any implementation at vertical and horizontal integration documents in Primary Health Care but the issues had been dealt with in Party executive committee or local Government's intercept meetings, and all the committees and organizations have actively participated" (In fact, there were a ad vocation from Communist Party and guidance from People's committee)

When asked about the reasons why implementation at vertical and horizontal integration documents were not issued: for the intervened districts: there are two main reasons: poverty and depend on local areas. For controlled districts, 17 out of 25 ideas suggested that they have not got that motor, 3 out of 25 ideas said that residents are poor and 3 out of 25 people didn't know the reasons. The remainders have said that if there are such documents, it is impossible to implement them. Those said that the main reason was the poverty, just because they think that having implementation at vertical and horizontal integration documents means the mobilization of contributions and so if these documents are issued, the poor communes will not have the ability to implement them.

* *Districted Health centers guide the Primary Health Care activities in their areas*:

When being asked about the guidance of districted health center on the primary health care activities management, for intervened districts, the answers were: there were a particle guidance on these activities for at least 2 recent years in:

- ***Plan - making***:

    - Districted health centers teach the way to the communes how to make plans, detailed plans to propose to districted health centers and from districted health centers to health sector CanDuoc- LongAn, VinhBao- HaiPhong, CamLo-QuangTri, DaiTu- ThaiNguyen...)

- Health care supporter teams guide to the villages' leaders to work out a medical plan and choose the issues for them. At present, 70-80 percent of villages have their own plans (CamLo- QuangTri, Can Duoc- LongAn).

- ***Plan implementing***: after having detail planning, specific tasks will be assigned to each individual, each area (CanDuoc, TamNong) they also ask other organizations to join them in particular task, suitable to their junctions and ability.

- ***Supervising activities***: Supervising activities are periodically done, having monthly reports by health service centers quarterly and annually (CanDuoc, TamNong, VinhBao).

For controlled districts

Planning making: When they were asked about the guidance of districted health center on the primary health care activities management, their answers "Having no guideline" (Chumprong- GiaLai), "District medical center helped communal health service center to map out their plans in accordance with their tasks that Health Sector had assigned to the districts" (BenLuc, DongHy, Tan Hong), "District medical center supplied concrete guidance on diagnosis and treatment activities and major health care program" (DongHy, ThaiNguyen) or "District medical center helped communes in working out diagnosis and treatment, expenditures and management in the local areas (GioLinh, Tien Lang).

- The other organizations were invited to mobilize their members to participate. Their activities assessments are usually conducted quarterly or yearly.

In general, we think "District medical center had more management and methodical guidance in intervened districts than in controlled districts. Here, activities were more actively implemented".

* *Districted organizations and branches participate in primary health care management and guidance activities.*

When asked about different organizations' participation in health service activities management, most districts said "In general, committees had no contributions in management activities. They mainly participated in meetings except two Women's Union and culture and Information association who actively took part in".

"Only when talks about health care service we needed, or when the Youth union held meetings, health service centers we invited to talk about birth control measures. Like that for the Women's Union, they only asked the health service center to talk about the way to breed/ raise and take care of their children when they had meeting".

It has been clear that "implementation at vertical and horizontal integration depends on the nature and requirement of each organization. These integrated activities showed that: In intervened districts as well as checked districts, all the committees implemented their tasks at vertical line. All the communes had a Cupertino with health care service centers in conducting health programs once there were resolutions or Instructions by the Party or the Authority these instructions were given out only when health service centers asked for.

* *The role of the districted and organizations in health service activities and in the relationship with the local health service center.*

Table 10: People's awareness about the role of committees in primary Health care activities.

Committees, Organizations	Intervened communes (n = 110)		Checked communes (n = 99)	
	n	%	n	%
Youth	44	40.0	38	38.4
Women's Union	86	78.2	81	81.8
Farmers' Association	15	13.6	5	5.0
Veteran Association	16	14.5	17	17.2
Red Cross Organization	25	22.7	12	12.1
Old people's Organization	8	7.2	3	3.0
Communal Health care clinics	26	23.6	22	22.2
Communal population committee	16	14.5		
Communal homeland front	16	14.5		

Interviewing 209 (110 in intervened communes, and 99 in checked communes) about which committees or organizations have actively participated in primary health care activities, 78.2 percent of the interviewed people in intervened communes and 81.8 percent in checked communes said: Women's Union had the greatest contributions, following were the youth Union and the communal health care clinics.

In all group discussions, many suggestions showed that "If all the district committees' participating in primary health care activities the Women's Union is one of the most active organizations. It has the closest relationship with the health activities because it is women's interest; following it is the Youth Union, the Red Cross Organization est.,

Table 11: Youth Union's Participation in Primary health care activities.

The way of participation	Intervened communes (n = 110) %	Checked communes (n = 99) %
Mobilizing people in cleaning up their villages	38.8	39.4
Mobilizing family planning a birth control	35.5	29.3
Mobilizing mothers in having their children vaccinated	19.1	14.1
Mobilizing pregnant women in pregnancy check - up and AT injection	6.3	2.0
Mobilizing people in using clean water and environmental protection	29.1	19.2
No participating/ involvement	5.4	11.1

This table shows that: nearly 40 percent of the answer said the Youth Union's mobilize its members to take part in the operation of cleaning up villages. There had not difference between intervened and controlled communes. The interviewed people have said that the Youth Union's mobilized people in using birth control methods and

mobilized mothers to bring their children to go to health station to examine or get vaccination in intervened groups was higher than that in controlled groups.

This means that in intervened communes the Youth Union take more active part in health care than in other communes.

Table 12: Women's Participation in the Primary Health Care.

Forms of participation	Intervened communes (n = 110) %	Controlled communes (n = 99) %
Mobilizing people to clean up their villages	15.4	19.2
Mobilizing people to use birth control measures	76.9	75.8
Mobilizing people to have their children vaccinated	61.8	72.7
Mobilizing pregnant women to have their pregnancy check - up and AT injections	53.6	57.6
Mobilizing people to use clean water and protect environment	37.3	25.3
Mobilizing people to have their babies weighed and raise them healthy	16.4	4.0

Table 12 shows that 76.9% of the interviewed people in intervened communes and 75.8% of the controlled groups confirmed the role of the women's participation to mobilize their people in using birth control measures and having vaccinations (61.8% comparing with 72.7%).

The above results illustrate that in controlled communes, women also take a very active part in all health movements.

Table 13. Farmers' Organization's participation in primary health care.

Forms of participation	Intervened communes (n = 110) %	Controlled communes (n = 99) %
Mobilizing people to clean up their villages	42.4	26.8
Mobilizing people to use birth control measures	16.7	14.6
Mobilizing people to have their children vaccinated	9.1	11.1
Mobilizing pregnant women to have their pregnancy check - up and AT injections	6.1	2.4
Mobilizing people to use clean water and protect environment	27.3	24.3
Mobilizing people to implement the pattern of VAC and raise children healthy	16.4	24.2

The participation of the Farmers' organization in mobilizing people to clean up their villages 42.5% of intervened communes, 26.8% of controlled ones, this form of participation was also seen in the VAC pattern. The community's participation in people's health care.

Table 14. Community's participation in primary health care activities.

Forms of participation	Intervened communes (n = 110) %	Controlled communes (n = 99) %
Cleaning up villages	51.5	36.6
Using birth control measures and having family planning	28.8	19.5
Having children vaccinated	28.8	19.5

Using clean water and protecting the environment	34.8	22.0
Having pregnancy checked - up and AT injection	31.8	7.3
Feeding babies on breast milk	21.2	12.2
No participation	3.0	34.1

When asked what they have done for primary health care themselves, the table above shows that: the number of people participating in these activities in interviewed communes was higher than that in controlled communes. For example in intervened communes the number of people taking part in cleaning up their villages is 51.1% comparing with 36.6%, in taking part in mobilizing pregnant women to have their pregnancy checked and at injections is 31.8% comparing with 7.3% in controlled communes. In other activities such as mobilizing people to use clean water and protect the environment, mobilizing pregnant women to have their pregnancy checked, or to feed their babies on breast milk etc, the number of the people taking part in intervened communes is also greater than in controlled ones. The number of people no taking part at all in these activities is very low in intervened communes (3% comparing with 34.1%).

3.6 Work force aid from the people's committees at all levels and from different organizations as well as the participation of the community in primary health care.

3.6.1. ***Documents regulating and guiding the localities in mobilizing people to contribute primary health care.***

When being asked about the documents guiding people to make contributions to health funds or to the operations of the clinic, nearly all communal officers, when interviewed, answered "no documents". The lack of these documents leads to free activities.

"Now the districted people committee has no special documents guiding people to make contributions to health activities. The committee only has documents regulating people to make annual contributions to social funds, 5 kg of rice per capita"

The use of social fund was not clearly defined including the fact that how much could be used for health activities. Hence, these funds were used without plans at communal level, whereas the amount of money from rice sales was not small. Here, the responsibility is the financial sector, and health sector at higher level gives no instruction/ advice.

3.6.2. ***People's attitude towards participation in raising social funds.***

Through group discussions and communal interviews about the contributions of the community, we have noticed that all people are ready to contribute if they know how these funds will be used to serve health purposes. Their main ideas are: "We are willing, but let us know where and how out money will be used". Many people to make force/ about contributions is easy, but financial contributions is very difficult because they are, generally, very poor. So if we mobilize them to contribute rice, they are ready to do it". They're some families who are too poor to make any contributions. Some others have low awareness but they are ready if they are explained to".

Therefore, the human resources from the community are still an abundant and people are always ready to participate if the local authority knows how to mobilize these resources in addition to the primary health care activities in the area.

3.6.3. ***The forms of the community's contributions***

Table 15. Forms of contributions.

Forms of contributions	Communes sponsored UNICEF	Non - sponsored communes
* Money	0.0 đ	0.0 đ
* Wage pay/ person/ year	2	1.5
* Rice	Not yet	Not yet

This table shows that the main form of the community's contribution to primary health care activities is wage pay but not money. Psychologically, farmers do not want to use their money to contribute, so they are ready to contribute what is available at their homes, mainly rice. The main form of the farmers' contribution in wage pay is to

participate in the environmental protection or in the mobilization of the people to carry out health programs such as extensive immunizations, birth control and family planning.

3.6.4. ***Health sector's and people committee's financial aid to establishing the material basis and equipment supply.***

Table 16. Financial aid /subsidy from health sector and districted people's committee in sponsored UNICEF areas (1VN đ/per head- 1998).

Places	Health sector	Districts	Programs
Cam lo	30,5265	2,1134	-
Can Duoc	21,7980	1,1180	1,2660
Chuse	25,0000	138	44,373
Dai Tu	-	-	-
Tam Nong	37,207	-	4,445
Vinh Bao	11,175	84	4,561

The results in table 16 show that in UNICEF sponsored districts besides the financial source from the health sector, the districted people committee has provided districted health centers with subsidy to operate. The committee provides subsidy according to per capita. CamLo has the highest (2,113VNd/capita); VinhBao gets the lowest (84VNd/per capita). Hence, depending on the concrete condition/ situation and the consideration of the local authorities as well as the consultation of the health service, the subsidy is various to help the health sector reduce its financial difficulties in operating primary health care for the people.

Table 17. Subsidy from health sector, districted people committee in Non- sponsored districts (average VND/ head- 1998).

Places	Health sector	Districts	Programs
Ben Luc	7,6658 đ/h	542.7 đ/h	-
Chu prong	-	-	-
Dong Hy	21306 đ/h	7,008 đ/h	2,674 đ/h

Gio Linh	21528 đ/h	111.6 đ/h	4,602 đ/h
Tan Hong	45,264 đ/h	-	-
Tien Lang	13,371 đ/h	-	-

The results in table 17 show that like in UNICEF sponsored areas, the financial source from districts to health centers' operation is various according to the concrete local situations. In DongHy, the committee gives the Health centers and health clinics 7,008d/head to train local health people because DongHy is a remote, mountainous place, whereas ChuProng, TanHong, TienLang get no money from the committee for their people's health care activities.

3.6.5. People's committee's financial aid for the establishment of material basis and equipment supply.

Table 18. Financial aid from health centers communal people committees in UNICEF sponsored areas (average VN D/head - 1998).

Districts	Communes	Health center	Communal committee	Programs
Cam lo	Cam Hieu	3,5730	391	-
	Cam Thuy	-	1,181	-
Can Duoc	Tan Trach	-	-	-
	Phuoc Dong	1575	121	241.3
Chuse	Hbong	-	-	-
	Ja blang	8,5856	4,510	2,337
Dai Tu	Khoi ky	8,440	-	-
	Thi tran	-	-	-
Tam nong	Phu duc	3,079	-	-
	Phu cuong	8,539	266	350
Vinh bao	Hoa binh	10,720	5,360	9455
	Ly hoc	-	-	-

Table 18 shows that in communes belonging to UNICEF sponsored districts, besides the financial sources provided at vertical line of the health centers and from health programs, the communal people committee gives additional aid to the health center to operate. The financial aid to the clinics to work mainly is to subsidy the communal health officials and village health center, during the immunization days or the micronutrients days. Of 12 investigated communes, 2 communes can get financial aid from the people's committee which is 4,510d and 5,360d per head (JaBlang, HoaBinh), some other communes cannot get any aid (LyHoc, Phuduc, DaiTu, KhoiKy, HBong and TanTrach). The communal people committee from social funds contributed by people every year extracts this financial aid.

Table 19. Financial aid from health centers, communal people committees in non-sponsored UNICEF areas (average per head- VND, 1998).

Districts	Communes	Health center	Communal committee	Programs
Ben luc	Phuoc loi	2,6175	396.2	297.2
	Long hiep	-	-	364.4
Chu prong	Japin	4910	-	-
	Thang hung	-	-	9690
Dong hy	Linh son	8,1920	861	1,3087
	Hop tien	10,5440	125.8	-
Gio linh	Linh hai	7,4090	-	-
	Thi tran	3,6540	6440	3625
Tan hong	Tan cong tri	-	785.5	-
	An phuoc	1,6825	-	1,3750
Tien lang	Tien thanh	8220	8010	672.5
	Bach dang	-	4,6700	-

Table 19 shows that communes belonging to the districts without UNICEF sponsorship can get financial aid from districted health centers and programs (like UNICEF sponsored districts). This money is also used on the health workers, coordinators est. during the days of health campaigns. Tien Thanh, Vinh Bao can get aid of 4,670d/head to assist its communal clinics to build up and upgrade the rooms, drilled-wells ect. There are some communes, which cannot get any aid.

General assessments on the role of the party's and local authority's committees as well as of other organizations in the composition of the health care board.

In our country, the communist Party is the body that directly leads our people. The People's committees have to carry out the aims and resolutions set up by our communist Party committee. The people's councils are one part of our local authorities. The process of socialization depends on the resolutions by our communist Party committee, and on the decisions by the local people's council and people committee. In the composition of the Party committee in a district, there are representatives of the people's committee and Heads of different organizations. This is the basis of health and education socialization, which carries judicial, party and public characteristics. This is also our Party's Strength in the propaganda with the people in the field of health care, especially in preserving the directions and power to fulfill the targets already set out.

In the studied localities as well as in the other ones throughout the country, we have noticed, "where there is no attention of the communist leadership, there health care can't run effectively and always copes with a lot of difficulties. If we automatically compare the theories in management which consists of planning realizing, and controlling with the results of the discussions with several leaders of the community, we can see that only 2/6 of local people's committees involving in the planning, none of the local authorities takes part in assessing. We would make a mistake if we conclude that the community leaders haven't really participated. The reason is that perhaps the questions for discussions are not clear or the discussion participants have different ideas.

In fact, in any area at any level, our Party and Government are engaged in health care plan formulation. This is measured in the conclusion of health care task in the local as well as in social organization's economic development plans and resolutions. Quite a number of health care tasks are given to grass- root health care establishment via the local

authority. Not few localities provide supplementary resources to the state budget, including the assignment of duties to various organizations to assist the health care branch. Finally, the local authorities don't directly assess all the health activities but it is the deputy presidents of the people's committee in charge of the communal culture who know about all health situations and health activities in their area. This is also a form of assessment. The target analysis shows the importance in deciding the directions and methods of supervising the task of health care of the local people and of health sector in particular. The health care or the primary health care committee at district level has had a concentrated and united leadership and participation in health care activities. Few people claim that this committee does not have the same leadership, so some places have ten committees and some have only one called health care committee/ Board sponsored by UNICEF sponsorship. Some remarks above are partly correct and partly incorrect in our present situation, because first, there are one or ten different health care committees, their members are, in fact, only a group of representatives of the People's committee, of organizations, and branches in the area. These organizations are only different in names, which they have according to their activities at different periods of time in order to fulfill a series of activities assigned by senior bodies (e.g. Mother- children protection, malaria-prevention, malnutrition- prevention etc). Leaders of these organizations are the heads of the local authorities. The tasks to realize these programs are given to the lower by the higher-level bodies. These programs may be sponsored, so they have their own aims, budgets, and financial management. It's the development of vertical independent programs that has created independent committees in different localities rather than the localities want to have such separate committees. In fact, programs whose aims are decided by the local communities, methods, are suggested by local authorities, labour sources are provided by communities, have not been developed and not been encouraged to develop in the proper way according to their importance. Here, there are internal and external reasons concerning each locality. All the members of the health care committee have not learnt how to manage community public health, except vice- president of the people's committee and the head of the women association.

Besides, health units at communal level are not strong enough to advise the People's committee in the health care activities. This can be seen clearly trough the contact with the local officers who complain: "In the health care committee only a few