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Policies on Reproductive Health Care for Ethnic Minority People in Viet Nam



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for Ethnic Minority People
in Viet Nam**

Hanoi, 2010

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PREFACE

In cooperation with the Government of Viet Nam, reproductive health care for ethnic minority groups is one of the key issues supported by the Seventh National Program (2006-2010) of the United Nations Population Fund (UNFPA) within the context of the UN One Plan.

Fifty-four ethnic minority groups live in the upland and relatively remote and mountainous regions of Viet Nam, very often under harsh natural conditions and with limited opportunities for economic development. To address this situation, the Government has introduced a variety of policies to assist ethnic minority groups in catching up with their lowland compatriots.

The Government, Ministry of Health and relevant agencies have developed various intervention strategies to improve health care overall. However, delivery of reproductive health care poses a range of practical challenges. Compared to other regions in Viet Nam, ethnic minority people are exposed to a higher incidence of maternal, infant and child mortality. Abortion rate is also of great concern, suggesting further need to strengthen universal access to quality reproductive health services.

These crucial issues raise questions: how relevant, viable and sustainable are current policies? Is implementation of major policies carried out promptly? Is financial and managerial support provided in a consistent and timely manner at the commune level? Are challenges and setbacks that emerge during implementation relayed back to the central and higher level authorities for their consideration and follow up action? What are the outcomes and measureable results of various RH policies? What adjustments are needed to ensure ethnic minority people have access to high quality RH services?

Between July 2008 and August 2009, UNFPA provided technical and financial assistance to the Ministry of Health for the purpose of conducting a **“Review of Reproductive health Policies and implementation for Ethnic Minority People”**. The Institute of Population and Social Affairs (National Economics University) was commissioned to complete the research. This report presents an abbreviated version of the Review findings.

On behalf of UNFPA, I would like to thank the Institute of Population and Social Affairs (National Economics University) for their commitment and Dr. James Knowles and Dr. Nguyen Thi Thanh Huong for their technical assistance in completing the Review. Our appreciation also goes to UNFPA officers Dr. Duong Van Dat, Dr. Le Thanh Huyen, Ms. Tran Thi Thu Huong and other reproductive health team members, for their support and contribution to the review.

We hope that the findings of this report will be useful to policy makers and program managers at all levels, in developing and implementing more effective reproductive health policies for ethnic minority groups within the context of the 5-year Health Plan, Socio-Economic Development Plan for 2010 - 2015 and the Population and Reproductive Health Strategy for 2010 – 2020.

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EXECUTIVE SUMMARY

This report reflects the outcomes of the “Review of reproductive health (RH) policies for ethnic minority people” conducted by the Institute for Population and Social Affairs (National Economics University) between July 2008 and August 2009. The report aims to highlight strengths and weaknesses in RH policies, particularly those that concern ethnic minority groups. At the close of the report, are recommendations that could be usefully applied in the development of the Population and RH Strategy for 2011-2020.

1. Collection of Review data and information

- Desk studies conducted between 2000 and 2008 that compared 98 RH-related policy documents targeting ethnic minority groups, by content and central issuing authority;
- Interviews with central officials on policy issuance;
- Field studies and face-to-face interviews in the upland provinces of Son La, Dak Lak, Ninh Thuan and lowland control province of Ha Nam;
- Mailing of 1003 questionnaires to health managers, workers and communicators in 37 provinces (300 districts) with significant numbers of ethnic minority dwellers, of which 443 completed the questionnaires (44%).

2. Findings

2.1 RH preference for ethnic minority groups incorporated in policies developed by the central government

In theory, all RH policies include goals for improvement in human, financial and material resources in upland areas. Practical application of these policies however, has resulted in the following setbacks:

- *RH policy references to ethnic minority target groups are inconsistent and vague* with at least 15 different terminologies identified. For example, no clear definition of either “remote, distant, ethnic minority areas” or the minimum population for designation “ethnic minority”.
- *Existence of gaps in policies.* From 2000 to the present, HIV has increasingly become a predominant policy issue, followed by family planning (FP). On the other hand, safe motherhood (SM) has received less attention and infertility, an open-ended question.
- *Lack of feasibility of some indicators.* Based on the ‘inputs’ used in policy making, the set goals or objective indicators have proven too hard to achieve by 2010. This is apparent not only in upland areas but across the whole country. For example, ensuring skilled health worker attendance at 97% of childbirths nationwide, as set out in the National RH Strategy goals for 2001-2010, is a very tall order.
- *Irrationality in human resources policies.* For example, regional on-the-job health workforce training targets are almost identical; support for HIV dedicated workers is based on whether the commune is “critical” or “non-critical” rather than volume of

patients. Allowances for population collaborators (PCs) and village health workers (VHWs) and for communicators are either too low or non-existent.

- *Inconsistencies between policies.* Goals and objective indicators for different strategies implemented over similar periods, are inconsistent. Sometimes, provisions suitable to one policy hinder the goals of another. For example, while promotion of childbirth in health clinics or hospitals is a common goal, implementation guidelines for voluntary health insurance are contradictory.
- *Many indicators are not well explained.* Certain objective indicators set out in the Population Strategy, National RH Strategy, and National Strategy for the Advancement of Women in Viet Nam by 2010, focus only on national targets with no regional reference or specification. Non-discriminatory targets inevitably result in implementation and evaluation difficulties.
- *Overlaps exist between different policies.* Both the Population Strategy and the Reproductive Health (RH) Strategy address RH issues. The National Strategy for the Advancement of Women in Viet Nam by 2010 also refers to RH. About one-third of the indicators in the Population Strategy overlap with indicators of the National RH Strategy. As many as six of seven solutions outlined in the National RH Strategy are similar to those of the Population Strategy.
- *Non-scientific and slow policy-making process.* Some policies are developed without first conducting a needs assessment and desk study of related policies.

2.2 Problems of policies rolled out in sub-national settings

- *At local levels,* long lead-time from policy issuance to implementation of decisions/documents. At provincial levels, lead-time ranges between 6 months to 3 years, with an additional 1 to 6 months at the district level.
- *Lack of customization of provincial and district policies to local specific attributes.* The communes engage in activities in line with written instructions from district authorities, thereby imposing large and tedious workloads.
- *Archiving of policies, except for population/FP policies (in the province, district and commune) in both lowland and upland areas remain poor.*
- *Few staff heed policy detail.* Policies are mainly disseminate to government officials through dissemination workshop; seminars, local newspapers.
- *Community-based RH communication is mainly provided through the public address system, village meetings, leaflets, banners and face-to-face conversation.* Understanding would be more effective if communication materials were translated into local dialects.
- *Of all RH issues in the community FP predominates.* The Kinh people in lowland provinces show better understanding of SM, prevention of STIs and safe abortion practices than their upland ethnic minority compatriots. In both lowland and upland provinces promotion of RH awareness among adolescents is neglected.
- *Relatively low ethnic minority attendance at health clinics especially for birth delivery,* due to distance, lack of transport, poor physical structure of health centers, shortage of

female midwives, poor commitment and attitudes of health workers, financial constraints and traditional preference for “home-based childbirth”. *The five routes to RH care are:* (i) client attendance at health centers; (ii) VHW delivery of home-based care; (iii) district mobile team visits to communes; (iv) CHC healthworker delivery of home-based care; and (v) clients seek care in other facilities/settings. Of the five options, the mobile health care team represents the most practical model, despite various arguments on its efficiency.

- *Challenges in identifying financial and human resources for implementation of policies.* CHC workers visiting the villages and households to deliver RH care are discouraged by inadequate travel allowances and lack of compensation for vehicle fuel costs. Efficiency is hindered by long rotation shifts, lack of staff reliability and negligible salary-based allowances for accommodation and day-to-day needs.
- *Training and in-service training show positive signs, yet challenges remain,* including lack of qualified participants; inadequate funding to sponsor staff on training courses; failure to control ‘output’; location in provincial centers deters attendance by district and commune staff. Inconsistent selection criteria and training approach for village midwives.
- *Gaps in policies regarding commune health infrastructure.* Discriminatory investment of funds for CHC construction between district and province. All too often, the newly built CHC fails to meet the needs of ethnic minority users, not only due to lack of private consultation space but also compounded by inadequate kitchen/food preparation space for patients and care givers.
- *Medical equipment and supplies are insufficient.* Equipment quality in CHCs is usually patchy and need of repair. There is a lack of clean birth kits, transport for mobile health teams. Driver positions are not included in staff quotas nor funds for fuel, and other running expenses. Clean birth packs, drugs for gynecological treatment, contraceptive injectables and implants are all in serious short supply.
- *Serious shortage of communication materials with limited content.* Information on postnatal care and contraceptive instruction is either non-existent or poorly presented with few materials translated into ethnic minority dialects.
- *Survey results show that, CHCs receive support from four income sources, namely: health insurance, the health care fund for the poor, commune budget and earnings from drug sales.* According to regulatory guidelines, a CHC should have access to 8 key income sources and 9 expenditure lines. Compliance with the requirement that each “commune PC must account for recurrent income and expenses of the CHC to guarantee the recurrent budget for the CHC at no less than VND10 million a year” is difficult to achieve particularly at the lower levels where this policy may not have been heard of.
- *Health insurance reimbursement is hindered by registration mistakes or damaged cards.* Health care funds have been extensively established in the provinces. According to the joint reports of the Ministry of Health, fee-for-service payment is required more often than health insurance cards. One disadvantage of the voluntary health insurance scheme is that it only provides cover at district hospitals. Often, the CHC maintains the health insurance cards on behalf of holders, but very few users turn up for medical care due to misunderstanding about eligibility. Emergency care service users are usually required to pay in advance before claiming reimbursements from health insurance. This is due to the fact that CHCs cannot rely on timely refunds from health insurance providers and

therefore find themselves in the position of having to ask service users, even health insurance card holders, to pay upfront for at least part of their childbirth expenses. New Ministry of Health insurance regulations limit the length of inpatient stays at CHCs and inter-commune general clinics to maximum two days, effectively preventing facilities from retaining pregnant women who may be waiting for delivery or requiring postnatal care. Some provinces, with SIDA support, have encouraged ethnic minority women to come to the CHC for childbirth, by providing transport and meal assistance. A weakness of the spontaneous health insurance programme is to request the patients to register health check and treatment at district hospital while there are some patients want to reach the provincial ones.

3. Recommendations

Effective delivery of RH policies concerns both ethnic minority and Kinh people. For the purposes of this report however, recommendations focus specifically on the needs of ethnic minority groups.

3.1 RH policy targeting

- *Policy making process:* prior to enactment policies should: (i) determine overlaps and inconsistencies; (ii) recognise strengths and weaknesses through conducting a baseline survey on policies implementation; and (iii) identify target beneficiaries before promulgating any policy.
- *Types of policies:* The Central Party and National Assembly should provide leadership in determining guidelines to ensure efficient delivery of RH care to ethnic minority groups. Topics should highlight safe motherhood (SM), adolescent RH, STIs, HIV and fertility.
- *Policy goal and responses establishment:* (i) policy goals and responses need to be clearly defined for individual target groups; (ii) when RH and RH care goals and responses are designed, goals and responses specific to the upland areas and ethnic minority groups need to be introduced to correspond to the development level of the sector; (iii) policy goals and responses need to be accompanied with central budget lines to ensure the feasibility of the policy.
- *RH policy goals should be detailed and transparent*
- *Beneficiaries:* policies should identify individual target ethnic minority groups
- *Monitoring and evaluation:* Policies should clearly state lines of responsibility for project monitoring and evaluation. Appropriate funding for this purpose should be clearly stated in the budget.

3.2 Recommendations on policy implementation

Inter-ministerial coordination: there should be (i) cooperation between health insurance and health service providers; (ii) cooperation between project management boards and governments at various levels in supporting financial and human resources; and (iii) more involvement from the Ethnic Minority Committee in the RH communication network.

3.3 Recommendations on RH-related perspectives

- *Salary and allowances:* (i) allowances for health workers in upland and remote areas should be aligned with the education sector; (ii) Decision 75/2009/QĐ-TTg, dated May 11, 2009, of the Prime Minister, providing allowance norms for village health workers, should be implemented as soon as possible; (iii) incentives should be provided to workers involved in promotion of childbirth at health clinics; (iv) funding for translation costs of communication materials into ethnic minority dialects should be increased; and (v) travel allowances and transport costs for CHC workers should be accommodated in budgets.
- *Staff quota:* (i) quotas for the provincial preventive health center, reproductive health center, health education center, HIV center, population administration branch and population/FP centers should be increased; (ii) the RH mobile team should be formalised and; (iii) performance of Project 1816 on staff rotation should be evaluated.
- *Training and in-service training:* (i) training goals should be tailored to the needs of individual ethnic minority groups; (ii) training in connection with specific roles and mandates of individual workers at various levels for better RH performance should be introduced; (iii) training for ethnic minority health workers and female midwives should be generated; (iv) focus on output management in on-the-job training programs for ethnic minority participants, with input from the health and education sectors should be increased; (v) the on-going village midwife training program should be evaluated.
- *Staff rotation:* incentives should be established to encourage well qualified physicians and professionals to participate in health clinics at the community level.
- *Infrastructure, equipment and essential drugs:* (i) CHC infrastructure should take into account ethnic minority client desire for privacy and cooking space; (ii) coordination between resources of medical equipment with consideration of local infrastructure in order to avoid wasteful and inappropriate equipment situation; (iii) there should be sufficient supplies of clean childbirth packs and gynecological drugs; (iv) contraception/FP methods should accommodate ethnic minority preference, (v) Injectables and implants within the standard birth control package; (vi) information and instructions should be translated into local dialects.
- *Recurrent income and expenses of CHCs:* commune PCs should (i) guarantee budgets for CHCs at the standard “no less than VND10 million a year” and increase expenditure caps for electricity, water, telephone and stationery to at least twice current levels; (ii) allow the CHC more autonomy in spending; (iii) repeal the requirement for CHCs in upland and remote provinces to settle payment based on submission of hard copy legal invoices.

3.4 Service provision models

- *Mobile teams providing RH services:* policy regulations should (i) specify staff quotas, travel allowances and staff rotation schemes; (ii) provide appropriate transport means and medical equipment (ultrasound, X-ray, ECG, oxygen tanks etc.), and specify costs for fuel and medical consumables; (iii) notify ethnic minority communities on a regular weekly/monthly basis, of visiting schedules; (iv) ensure the mobile team visits each village and not just the commune.

- *VHW delivery of RH services to households*: there should be (i) further investment in CHC infrastructure, medical equipment, drug supply and human resources to ensure delivery health of services to the villages; (ii) Sub-centers should be established in locations further than 5km from the CHC center; (iii) telephone communication ,especially to facilitate childbirth and emergency calls, should be encouraged; (iv) opportunities for counseling and home-based childbirth support should be promoted.
- *Village midwives*: should be integral to the regular health workforce and receive fair wages after they return to villages at the completion of training.
- *Insurance schemes for RH service delivery*: Health insurance reimbursement standards should be set for all types of services, including FP, to ensure ethnic minority user eligibility at all health facilities, whether public or private.

3.5 Communication models

- *Communication in ethnic minority areas*: (i) national guidelines on RH services should be disseminated to all district and commune health workers involved in RH delivery; (ii) BCC for health workers should address attitudes towards ethnic minority users; (iii) education topics for health workers should include SM for ethnic minority groups and prevention of STIs and HIV.

Methods and means: (i) communication materials should be developed in consultation with the beneficiaries; (ii) design of leaflets should be eye-catching with more pictures and less words; (iii) films/videos should avoid audio explanations unless produced in local dialects; (iv) mobile communication model should be increased, (v) RH communication should be integrated with community-based activities, such as festivals, special market gatherings (love market, spring festival); (vi) advantage should be taken of commune communication broadcast systems; (vii) more ethnic minority people should receive trainings in communication techniques, and; (viii) communication staff should receive more trainings in communication knowledge and skills; and (ix) allowances and travelling means for communication staff should be standardized at more reasonable levels.

CHAPTER I. INTRODUCTION

1.1 Of the total Vietnamese population of 86 million, ethnic minority groups account for 13.7%, of which most inhabit upland and coastal areas. Current data confirm that the socio-economic and health status of ethnic minority groups in Viet Nam is significantly lower than determined in national benchmarks, especially in northern upland and Central Highland locations. In 2003, the Ministry of Health conducted a survey on maternal mortality in Binh Duong confirming a ratio of 45/100,000 live births (approximately equal to that of Ho Chi Minh city). This compares with survey findings of maternal mortality in Quang Tri (Central) of 162 and in Cao Bang (Northern uplands) 411, and the average number in nation wide is 165/100,000 live births. A further study conducted in 2001 also reveals the national prenatal mortality rate at 22.2/1000. These figures confirm an unacceptably high prenatal mortality demographic particularly in the upland areas (including the Central Highland).

1.2 In recent years, in ethnic minority areas, the Government has introduced a poverty reduction program supported by economic and educational reforms. Despite these efforts, reproductive health and policy implementation guidelines for ethnic minority groups hover within a grey area. The reforms take an egalitarian national approach whereby no clear distinction is made between the lowland and upland/ethnic minority areas in delivery and implementation of health care policies, particularly infrastructure, resources and access to services. Whether a commune health center in Ha Giang province (a Northern upland province where 70% of the population are H'mong ethnic minority dwellers) or one located in a low lying area, there is uniformity in policies relating to health facilities, workforce quotas, clinical requirements, technical roles and service provision.

1.3 In effecting improvements in the health status of ethnic minority groups that include the achievement of RH targets envisaged for Viet Nam over the next 10 years, careful review of existing RH policy implementation in upland and ethnic minority areas is required. This report examines RH policies and legislative implementation from several perspectives - geographic, economic and social. The report outlines lessons learned about policy impact and effectiveness, particularly in ethnic minority areas and makes recommendations on how best to modify RH-related policies to meet the specific needs of ethnic minority groups.

CHAPTER II. METHODOLOGY

1. Objectives

This report sets out to:

- 1.1 Identify the implications of service delivery to ethnic minority groups.
- 1.2 Compare similarities and differences found in upland and lowland areas in the implementation of RH-related policies.
- 1.3 Recommend updates and modifications to policies for implementation of RH care for ethnic minority groups that will contribute positively towards the development of new RH and population policies for 2011-2020.

2. Study location

2.1 Comparative studies of RH policy implementation in various ethnic minority communities took account of their (i) diversity; and (ii) location.

Three survey provinces were selected:

- a) Son La, in the North West, a poor province inhabited by many ethnic minority groups such as the Việt, Thái, H'Mong, Mường Dạng, Khang, Kho, Mu, La Ha and Xinh Mun;
- b) Ninh Thuan, in the South East, a province of medium socio-economic development with 28 ethnic minority groups.
- c) Đak Lak, in the Central Highland, inhabited by 44 ethnic minority groups. (RH performance in Dak Lak is rated poorest of all provinces throughout Viet Nam. .

2.2 Field surveys compared RH policy implementation for ethnic minority groups in selected upland and lowland areas. Ha Nam, located in the Red River delta, was identified as the control province.

2.3 The survey settings were selected based on two principles: selection of two districts in each province (one near and one far from the provincial center) and; selection of two communes within each district (one near and one far the district center). In total, 8 districts and 16 communes were selected for the study.

3. Methodology

Research and evaluation of: (i) existing policy systems; (ii) quantitative and; (iii) qualitative data.

3.1 Desk studies of RH-related policy documents targeting ethnic minority groups, either directly or indirectly, at the central, provincial and district levels.

3.2 Quantitative analyses of policy implementation based on data obtained from self-administered questionnaires and direct interviews.

3.3 Clarification of outcomes, causes, setbacks and challenges related to implementation of policy based on qualitative information not readily available through quantitative analysis.

4. Target respondents

4.1 Target respondents included provincial and district staff responsible for implementing RH policies for ethnic minority groups, enacted at the central level.

4.2 Qualitative research was conducted on:

- a) Management staff at the provincial, district and commune levels;
- b) Service providers (provincial, district and commune health workers);
- c) Provincial, district and commune communicators; and
- d) Village health workers (VHWs) and population collaborators (PCs).

4.3 Qualitative research was conducted on:

a) In-depth interviews:

- Planning and administrative staff, RH policy makers (health managers representing the Ministry of Health, provincial and district managers);
- RH service providers (provincial, district and commune levels);
- community clients of RH services;

b) Focus groups: 6-8 participants in each group

- Provincial level: attended by one representative each, from the Party, People's Council, Preventive Health center, Mother and Child Health center, FP center, RH service center, provincial ethnic minority committee and health workers in the border guard military;
- District level: attended by one representative each from the Party, People's Council, Health center, Mother and Child Care and FP center, RH service center, Population/FP center, Finance Office, Economic Planning and Agriculture Development Office; Ethnic Minority and Upland Committee; Government Organization office; health workers in the border guard military, one participant from each entity.
- Commune level: attended by one population and one RH representative (VHW and PC) each from the Women's Union, Farmer's Association, Veteran's Association, the Youth Union and Fatherland Front.

c) A seminar was convened to collect opinions poll for evaluating the existing policy system and to identify improvements for RH implementation for ethnic minority groups. The seminar was attended by representatives from the Ministry of Health, National Assembly Committee for Social Affairs, Central Communication and Education Committee, Population and Family Planning General Department, Population and Development Research Institute and the Sociology Institute.

5. Sample size

5.1 Quantitative study:

a) Information collected in standardized questionnaires and distributed in the four studies provinces. The sample size was included 76 health managers (35 from the provinces, 26 from the districts and 16 from the communes); 136 health workers (37 provincial officers, 50 district officers, 49 commune health workers); 235 communicators (80 from the provinces, 189 from the districts and 103 from the communes) and; 122 VHWs and PCs. The response rate was one hundred per cent.

b) Data collection based on self-administered postal questionnaires involving 1003 respondents, including: (i) representatives of provincial, district and commune management; and (ii) provincial, district and commune communicators in 300 districts and 37 provinces with ethnic minority groups. The response rate for postal questionnaires was 44.0% (443 questionnaires returned)

5.2 Qualitative study

a) In-depth interviews: the study team conducted 104 in-depth interviews (38 health managers, 19 health workers, 38 local residents and 9 senior officials of Ministry of Health Departments).

b) Focus group discussions: The study team conducted 28 focus group discussions among communication staff and representatives of local mass organizations (Women's Union, Population/FP board, Youth Union, Fatherland Front, Farmers' Association). The number of focus group discussions matched respective levels of participation (4 provincial, 8 districts and 16 commune).

6. Data collection methods

6.1 Policy review

a) At the central level, the study team conducted a desk study of RH-related policies archived in official library gazettes.

b) In the studied provinces (provincial, district and commune levels), the study team invited local authorities to provide RH-related policy documents. In addition, the study team visited local libraries.

6.2 Quantitative data collection

a) In each province, the four target groups were issued with self-administered questionnaires. The target groups included: health managers (provincial, district and commune levels); health workers (provincial, district and commune levels); communicators (provincial, district and commune levels); VHWs and PCs.

b) In districts with ethnic minority people located in other provinces, each of the following target groups completed one self-administered questionnaire: health managers (provincial and district PC Vice Chair); leaders of Health Departments/Offices; and communicators (the communication divisions of province and district population/FP Department Branch).

6.3 Qualitative data collection:

- a) Six in-depth interview guidelines specific to each target group were completed by health managers of the Ministry of Health, provincial and district level managers (representatives of provincial and district PC leaders), provincial and district level health workers, commune health center officers, RH service clients and commune health managers (commune people's committee leaders).
- b) Two focus group discussion guidelines were compiled by representatives of mass organizations participating in the provincial, district and commune population/RH communication network.
- c) Interviews and focus group discussions were conducted by experienced and skilled experts. In-depth, individual interviews lasted 60-90 minutes and focus group discussion, 120-150 minutes. Conditions for data collection stipulated quiet venues to encourage open conversation.

6.4 Observations

In the selected districts and communes, consultants observed and photographed clinical facilities and technology related to RH. Data were then compared with the standard checklist.

7. Limitations

While the Review was carefully prepared, some limitations were unavoidable.

2.7.1 High turnover in organizational and human resources had led to the shelving and inaccessibility of some policy documents and information thereby impeding data collection. As a result, access to policies under the jurisdiction of local authorities was limited.

2.7.2 Due to financial and time constraints, evaluation of RH knowledge and practices among ethnic minority groups could not include individual consultations with all relevant community members. Rather, evaluation was mostly based on information and comments from VHWs and PCs.

2.7.3 Due to difficulties involved in interpreting a wide range of RH related regulation practices, the Review was obliged to rely on subjective judgment rather than random sample selection in the observed provinces.

CHAPTER III: FINDINGS

1. Findings on the Review of Reproductive Health Policies for Ethnic Minority Populations

Table 1. Policies dated 2000 onwards:

Issuing agency	Party	NA	Gov	MoH	Joint Ministries	Pop/Family / Children Committee	Total
Number	9	5	36	24	12	12	98

1.1 Strengths of reproductive health policies for ethnic minority populations

a) Preferences

- Resolution 46/NQ-TW, dated Feb. 23, 2005, of the Politburo on protection, care and improvement of public health within the new context, highlights the concept of “effective health care support and improvements for vulnerable groups” (principle 4).
- Article 39, Constitution of 1992 states that: “The State gives priority to the health care program for upland dwellers and ethnic minority populations”.
- Article 42 in the Law on Protection of Public Health of 1989 addresses “Protection of the health of ethnic minority groups”. Paragraph 1 of this Article states clearly that, “the State shall earmark appropriate budget for strengthening and expanding the health care network for ethnic minority groups, particularly in upland and remote areas”. Paragraph 2, Article 42 gives preference to the health workers in these areas: “The State shall offer appropriate compensation to health workers in upland and remote areas”.
- Paragraph 2, Article 11, HIV/AIDS Control Law of 2006 specifies seven groups be given priority access to information, education, communication, including “dwellers of remote, far-flung areas and areas of extreme economic conditions”.
- Article 15 of the Population Ordinance and Article 24 of the Decree 104/2003/NĐ-CP, the implementing document of the Population Ordinance, clearly indicate priority for ethnic minority populations in reproductive health/family planning.
- Principle 2 of the National Strategy on Reproductive Health clearly indicates: “special attention to marginalized groups, the poor, people with contribution to the nation, upland, remote areas and areas of high environmental risk”.
- Principle 2 of the Population Strategy in Vietnam for 2001-2010 also emphasizes: “Concentrated preference for disadvantaged areas with high fertility rates and located in poor and remote areas, to address population problems and upgrade the overall standards of living.”
- Documented evidence confirms consistency of RH policies and service provision in disadvantaged areas with the views of the Party, the National Assembly, the Government and Ministries. As such, these policies incorporate certain allowances for ethnic minority people living in mountainous areas and their health care service providers.

b) Reproductive health policy goals for ethnic minority populations

Reproductive health (RH) policy documents usually specify goals and objectives for each particular stage. For example, Objective 3 of the National Strategy for RH for 2001-2010 stresses: “special attention to disadvantaged areas and vulnerable groups”.

Objective 3 of the National Strategy for RH, 2001-2010

To improve the health status of women and mothers; reduce maternal morbidity and mortality, perinatal and child mortality more equally between different areas and groups, with particular attention to disadvantaged areas and vulnerable groups.

Indicators:

- Pregnant women receiving prenatal care: 90%
- 3 prenatal check-ups: 60%
- Women receiving postnatal care at least once; 60%
- Pregnant women giving birth with skilled birth attendance: 97%
- Mothers giving birth at health facilities: 80%
- Reduction of obstetric complications in total births: 50%

In the population strategy, Objective 1 sets the target for “achieving the replacement fertility rate nationwide by 2005 and in remote and poor areas by 2010”.

c) Comprehensive response system in policy documents

Resolution 46/NQ-TW, dated Feb. 23, 2005, of the Politburo, on protection, care and improvement of public health in the new context requires that: “From now till 2010, the State needs to provide more resources and create a breakthrough in upgrading health services, including preferences for strengthening and streamlining the network of community-based health care, preventive health, provincial and district general hospitals, inter-commune health centers, especially in the Central Highland, Northern uplands, the Central and Mekong River Delta. The State shall guarantee coverage of medical expenses for people who contribute to the revolution cause, for the poor, for children under 6 years of age and for targeted groups of social welfare policies, among others ... Assisting the poor, dwellers in rural, upland, remote areas to participate in appropriate health insurance forms ... Increased on-the-job training of health workers for upland areas and Mekong River delta; ... Encouraging physicians to work in mountainous, remote and disadvantaged areas”.

Such vision has been translated by the State into variety of comprehensive policies, including policies on resources (human, physical, financial) and different areas of operation (communication, services etc.) as follows:

Human resource development for RH

Preference in training

- Directive 06/2006/CT-BYT, dated June 14, 2006, on health workforce training quality assurance;
- Objectives for training the health workforce in disadvantaged areas noted in Decision 1544/QĐ-TTg, dated Nov. 14, 2007, indicating: for 2007-2018, some 11,760 health workers will be trained to work in disadvantaged and mountainous areas in the North, Central, Mekong River delta and Central Highland under the “on-the-job” training regime.

Preference in employment and strengthening human resources

- Directive 06 CT/TW on strengthening and streamlining the community-based health network in section 3 notes: “Increase manpower and technical facilities for the community-based health network; offer appropriate compensation policies to encourage health workers in commune health centers, especially in mountainous and remote areas”.
- Decision 35/2001/QĐ-TTg, dated Mar. 19, 2001 of the Prime Minister, approving the National Strategy for reproductive health care, 2001-2010 states: “attraction of health workers for service delivery in community-based level, disadvantaged and remote areas”.
- Prime Minister’s Decision 1026/QĐ-TTg, dated Aug. 10, 2001, on the approval of the proposal of army – civil health coordination in public health protection and care and for security purposes for 2001-2010, assists improvement of health and particularly RH workforce servicing, for those living in border areas.
- Decision 32/2006/QĐ-BYT, dated Oct. 5, 2006 of the Minister of Health, on the issuance of the “Regulations for recruitment of employees in public services under the Ministry of Health through candidate selection” considers health workers who are members of ethnic minority groups and volunteers in remote, border, island areas as apriority target group, equal to armed forces and worker heroes.

Infrastructure development

- One of the objectives of developing the physical and technical infrastructure for disadvantaged areas, reflected in Decision 950/QĐ-TTg, of the Prime Minister, on development of commune health centers in disadvantaged areas in 2008-2010, indicates: (i) development of health centers, to national standards, in communes in disadvantaged areas; (ii) targeted period from 2008 to 2010; and (iii), all commune health centers qualified for the national standards by 2015.
- For district and regional hospitals, the Prime Minister released Decision 225/2005/QĐ-TTg, dated Sep. 15, 2005, on approval of the proposal for upgrade of district and regional hospitals for 2005-2010, targeting: “facilitating access by the poor and people in mountainous and remote areas to better quality health services ...”

Funding and remuneration arrangements

- The National RH Strategy for 2001-2010 ratifies the cost norms for RH at an average VND 6,000-8,000/person/year.
- Paragraph 3, Section VI of the strategy also specifies that: “RH expenditure from all available sources needs to be used as the first priority for disadvantaged areas, vulnerable groups and the poor, with a 1.5 to 2 multiplier”.
- Decision 170/2007/QĐ-TTg, dated Nov. 8, 2007, approves the national target program for Population and Family Planning, indicating: “The Ministry of Health, Ministry of Planning and Investment, Ministry of Finance are responsible for aligning and estimating the overall resources needed for the program implementation in 2006-2010, and in budget allocation, preferences will be given to rural areas, areas with unstable fertility rates, high fertility rates and areas of disadvantaged and extremely difficult economic conditions”.
- The State also provides exemption and relief regarding costs for transportation of equipment and medicines to upland, island and border areas.

Communication policies

Communication and education are considered instrumental in delivering effective RH/FP. The initial version of the Information, Education, Communication Strategy (1992), notes that “ethnic minority groups have been separated as a special target group for communication”. Principle 3 of the Population, RH/FP Strategy for 2001-2005 also reiterates: “concentration on RH/FP communication and service delivery in various areas ..., particularly remote and poor areas”. Resolution 47/NQ-TW (2005) of the Politburo on continued strengthening of population and family planning policies implementation notes: “renewal of communication and education to create profound changes in reproductive behaviours, mentality and practice of a proportion of the population”. The strategies highlight the important communication role of “village patriarchs and heads”.

Service provision

Under Decision 18/2002/QĐ-TTg, the Government set aside a project on “Strengthening RH/FP services in poor, disadvantaged and remote areas” by 2005 in the national target program for Population and FP. To adapt to the geographical conditions and population distribution in upland areas, Decision 09/2006/QĐ-TTg, dated Jan. 10, 2006 of the Prime Minister emphasized “assembling RH/FP mobile service delivery teams in remote areas ...” specifying a transportation subsidy of VND10,000/person/year for treatment drugs for people living in uplands, islands and ethnic minority areas.

Implementation

- Of the five specialist departments in the District Preventive Health center, two are directly involved in RH: (i) Epidemics, diseases and HIV control, and (ii) RH.
- Collaboration of border military in public health care is backed by the Prime Minister’s Decision 1026/QĐ-TTg, dated Aug. 10, 2001, that approves the proposal for army and civil health coordination in public health care and protection and for security purposes in 2001-2010.

- In regard to an integrative Poverty Reduction Program, the Prime Minister released three decisions on economic – social development strategies for disadvantaged areas: Decision 135/1998/QĐTTg, dated July 31, 1998 for 1,000 communes of extreme conditions in 31 provinces (also known as Program 135); Decision 186/2001/TTg, dated Dec. 7, 2001, for 6 provinces of extreme conditions in the Northern uplands; Decision 168/2001/TTg, dated Dec. 30, 2001, for 4 Central Highland provinces. Program 135 targets infrastructure and social development, including health promotion, facilitating and creating opportunities for people of disadvantaged areas to rise from poverty, become wealthier and improve health. Improvement of socio-economic conditions is a key element in the RH/FP strategy. Decision 170/2007/QĐ-TTg indicates: “Integrating population issues in national socio-economic development programs; taking the lead in coordinating with the Ministry of Health and related agencies; guiding provincial/municipal People’s Committees”.

Consideration by the Party and State regarding RH/FP for ethnic minority population has been consistently enshrined in policy in the form of concepts, objectives and specific responses, to ensure provision of human resources, finances, physical facilities and implementing approaches. This policy system is not, however, without its downside, and will be discussed in the next sections.

1.2 RH policy weaknesses

a) Inconsistencies in defining policy target groups

At least three different terminologies exist, particularly for RH policies associated with ethnic minority target groups: “humanity” (e.g. “members of ethnic minority groups in the Central Highland”); “territorial areas” (e.g. disadvantaged, upland areas); or combination of humanity and territorial areas (e.g. uplands, islands, ethnic minority areas). Conflicting descriptions of beneficiaries noted in a variety of policy documents could lead to incorrect targeting and inadequate policy implementation.

b) Existence of gaps between policies

Gaps exist in national RH policies on fertility, detection of cancer in male reproductive organs or ovarian tumours in young people. FP policies specific to ethnic minority groups lack definition and fail to deal with ethnic minority traditions that encourage children to marry at a younger age than legally permitted, a practice with potential negative impact on ethnic minority quality of life.

c) Infeasibility of some indicators

Safe motherhood (SM) is an important objective in the National RH Strategy for 2001-2010. Some specific indicators for achieving this objective include:

- 97% of women give birth with a skilled birth attendant. As ethnic minority groups account for about 15% of the population, to achieve this indicator, assuming that this rate among the majority Kinh women is 100%, the rate among ethnic minority women will be at least 80%. According to survey results in 2006 on “provision and use of RH services in 7 provinces participating in the 7th National Program funded by UNFPA”, in provinces with substantial ethnic minority populations, the above mentioned rate remains far lower than the minimum threshold, for example, 58.1% in Ha Giang and 43.5% in Kon Tum.

- Abortion rate for every 100 live births is reduced to 25%. According to the Health Statistics Yearbook of the Ministry of Health, however, this rate tends to drop very slowly. The 25% target is obviously too far away to achieve by 2010.

Table 2: Abortion rate per 100 live births

Year	2000	2001	2002	2003	2004	2005
Percentage (%)	44.5	41.22	37.79	38.73	37.51	34.91

Source: Health Statistics Yearbook, Ministry of Health, 2000-2006.

- Maternal mortality ratio is expected to fall to 70/100,000 live births. As reported by the online Vietnamese Communist Party newspaper on Dec. 22, 2008, “the maternal mortality ratio at birth is 165/100,000 according to studies conducted by the Ministry of health in seven provinces representing seven ecological regions in Viet Nam. Maternal mortality ratio significantly vary between the lowlands and uplands, at 81/100,000 and 269/100,000 respectively”. Again, maternal mortality is still a long way from reaching the set target, especially in the uplands.
- By 2010, married couples in the upland and remote areas should, on a voluntary basis, have only two children per family (Directive 13/2007/CT-TTg, dated June 6, 2007). By estimates of Population/FP movement survey in 2006, the total birth rate remains very high: 2.4 in the North West and 2.8 in the Central Highland. Is this a feasible target, particularly given the unsettled fertility rates in recent years?
- Decision 3526/2004/QĐ-BYT, dated Oct. 6, 2004, on approval of the health education action plan for completion by 2010, sets a number of objectives such as: 1005 of commune health centers be equipped with an integrated health education/counseling room with sufficient materials and equipment for operation. By 2006, however, according to estimates of the baseline study on the current state of provision and use of RH services in the seven provinces participating in the Seventh UNFPA Country Program (including five upland provinces), of all commune health centres only 26.7% of reported having education/counseling rooms. In Phu Tho and Kon Tum provinces, where a large number of ethnic minority people reside, zero education rooms exist in compliance with the standard national benchmark.

This statistical evidence strongly indicates the lack of feasibility on national scale of some indicators in the RH/FP policies.

d) Irrationality

- While in theory, policy preference for health workforce training in the Northern uplands, Central, Mekong River delta and Central Highland may appear rational, in practice training indicators ignore regional differences in terms of population size, number of health workers/1000 populations and so on. This conflicts with Decision 1544/QĐ-TTg, dated Nov. 14, 2007, that stipulates on-the-job training indicators for all regions should be equal.

Table 3: Regional on-the-job training indicators

Region	Doctor	Pharmacist	Others
North	840	210	2100
Central	840	210	2100

Central Highland	640	210	2100
Mekong River delta	840	210	2400

Some remuneration schemes for health workers are irrational, for example:

- Joint Ministry of Finance – Health Circular 147/2007, dated Dec. 12, 2007, specifies: the allowance for HIV dedicated staff in “critical communes” is VND200,000 /month, twice the amount of VND100,000/month nominated for “other commune” yet the volume of patients in “critical communes” may be 5-10 times larger.
- Joint Ministry of Finance/Health Circular 147/2007, dated Dec. 12, 2007, specifies that community-based staff (registered) receive VND250,000/person/ month but are not eligible for this allowance if receiving allowances from other funding sources. Surely this lack of incentive can only discourage staff to work closely with HIV patients.

e) Policy inconsistencies

In the Population Strategy, the target year for replacement birth rates in upland and remote areas is set for 2010. Yet, the National RH Strategy for 2001-2010 nominates the same target for achievement by 2005. Such inconsistencies in objectives lead to confusion in implementation, monitoring and evaluation procedures.

f) Insufficient indicators

Certain indicators defined in the Population Strategy, National RH Strategy and National Strategy for the Advancement of Women in Viet Nam by 2010 aim to achieve overall national targets without specific reference to the needs of different regions and areas.

g) Overlaps

The Population Strategy addresses RH and the RH Strategy addresses population. The National Strategy for the Advancement of Women in Viet Nam by 2010 also refers to RH. The target for reducing maternal mortality during pregnancy and birth to 70/100,000 by 2010 is therefore, repeated in at least three strategies. About one-third of indicators in the Population Strategy overlap with those of the National RH Strategy. Further, six of the seven solutions outlined in the National RH Strategy are also identified in the Population Strategy.

h) Policy-making process

Some policies develop without first conducting a needs assessment or desk study. Financial resources required for implementation and successful operation of policies are not adequately reflected. For example, principle 2 in the Population Strategy in Viet Nam for 2001-2010, stresses “... concentration on preferences to areas of high fertility rate, poor and remote areas ...” yet makes no mention of how financial resources might be allocated.

i) Policy detail

It took more than two years from enactment of the Party’s Directive to issuance of the Joint Circular 147/2007/TTLT-BTC-BYT, dated Dec. 12, 2007, that guides the fund management for implementing the national program on prevention and control of some social diseases, dangerous epidemics and HIV from 2006 to 2010. Moreover, although the Joint Circular was supposedly

valid for 5 years (2006-2010), it was not released until the end of December 2007 leaving only three years in practice. Notable is the fact that the issuing of the Joint Circular represents one of the speediest policy implementing processes, compared with the Resolution of the 4th Central Congress (7th term) on Population and FP which, although adopted in 1993, waited another 10 years before the incorporation in the Population Ordinance of 2003.

2. Evaluation RH policy implementation

This section focuses on evaluation of key RH policies still in effect at the sub-national level. The policies chosen for evaluation include:

- The Population Strategy by 2010
- The RH Strategy by 2010

Materials and information used in this evaluation were collected from varied sources: the internet, health and population authorities, libraries located in the survey provinces, in-depth interviews and focus group discussions, and quantitative information collected by the study team.

2.1 Implementation of RH policies

a) Local archiving of policy documents

The study team invited relevant local entities at provincial/district/commune levels to provide legislations pertaining to the Population Strategy for 2001-2010 and the RH Strategy for 2001-2010.

Table 4. Archives of policy documents in the surveyed provinces / districts / communes

Legislations	Ha Nam	Son La	Dak Lak	Ninh Thuan
Province level				
Population strategy	0	X	X	X
RH strategy	X			X
District level				
Pop/FP work plan	1*/2**	½	½	0/2
RH work plan	0/2	0/2	0/2	0/2
Commune level	0***/4****	0/4	0/4	0/4

*: Number of districts maintaining the legislations

** : Number of surveyed districts

***: Number of communes maintaining the legislations

****: Number of surveyed communes

The survey results revealed significantly weak maintenance of policy documents in all provinces, districts and communes in both upland and lowland areas, highlighting a lack of leadership in document management. Legislations, however, remain in effect with implementation underway.

b) Policy lead-time from issue to implementation

“As an upland commune, we don’t issue policy documents but follow district guidelines, which are often slow to come to the commune, sometimes even after the implementing deadline. An existing guideline is still well on-going when the next arrives. Sometimes, the guidelines just seem to overlap all along as one policy has not been fully in effect when the next policy emerges”

(Easol commune officer, Dak Lak).

At the provincial level, it can take from 6 months to 3 years to release implementing documents for national RH policies whereas district lead-time is significantly shorter (2-4 months). The communes do not issue their own policy implementing documents but simply follow the district plans and specified timeline.

In the three mountainous provinces, the situation is similar. The rough terrain and inadequate transport slows down delivery of dispatches from district to the commune (one week up to one month). Sometimes, dispatches arrive at the communes after the district timeline for campaign implementation has passed. Delays can also impact on various interrelated socio-economic activities and work projects already ongoing in the commune, thus adversely affecting their progress and posing overlap challenges.

Among surveyed provinces, only communes in Ha Nam benefit from timely arrival of dispatches, due to their relatively easier access. Depending on budget capacity, as soon as guidelines are received from the higher district level, Ha Nam communes are in a position to begin implementation.

Nonetheless, the time required for RH policy to be translated into practice, following release at the central level, is estimated between 2 and 4 years (3 years from central to provincial level; 3 months from the provincial to district and one month from district to commune). These estimates are based on the assumption that commune staff will commence implementation within 1-2 weeks upon receipt of the district dispatch demanding policy realization.

As part of the 10-year strategy, the three years lost due to slow issuance of documents inhibits efficient and effective implementation.

c) Customization of provincial documents for specific geographic areas and ethnic minority groups

Policy goals and objectives

In respect of implementation, it is usual for provinces to view the goals and objectives of the national Population and RH Strategies as “regulatory indicators” for achievement before, or at least by, 2010. National strategic targets set for 2010, whether for lowland or upland provinces, do not differ significantly. However, as has already been well documented, home-based childbirth particularly among ethnic minority groups in the upland areas often proceeds without a skilled birth helper in attendance with implications of infant and maternal mortality. Despite this well documented situation, determination of goals in the National Strategy does not extend to the lowering the rate of maternal and child mortality in vulnerable areas. This serious omission should be of concern to policy makers in the future.

Solutions

“All local decisions and directives are based on higher level decisions as all the province does is copy the exact document, sign and seal it before forwarding to the community level”

(Focus group discussion between provincial officers in Ninh Thuan).

In general, none of the policy documents issued at the provincial level make specifically individual provision for different ethnic minority groups. Rather, they tend to be almost identical to the national RH and Population Strategies. Particularly, this was found the case in Ha Nam province.

An exception to this practice was found in the recommendations from provincial authorities in Son La and Dak Lak where notably, more attention is paid to the specific needs of ethnic minority people. More appropriate communication messages have been introduced to address different traditional, cultural and language needs. For example, the Rac Lay ethnic minority people in Ninh Thuan endure very difficult economic conditions, limited education, and low literacy rates. These issues require specially designed communication responses. However, solutions to these challenges are non-existent in the provincial policy documents.

The leaders of Ha Nam are of the opinion that all national policies are applicable at the provincial level and therefore suitable for implementation. This means that implementation takes place without adaptation or raising questions. A contrasting view is held by leaders of upland provinces where national RH policy is less relevance within the local ethnic minority context. Following the release of the RH Strategy, financial support for implementation is not only slow to arrive but also excludes funding for the BCC strategy. Despite this unsatisfactory situation, the provincial leaders continue to believe they are not in a position to adapt policy content to accommodate local ethnic minority practices.

d) Irrelevancies in policy documents

- At all three levels, provincial/district/commune, the biggest concerns for implementing RH policies revolve around funding constraints. Policies and implementation plans issued by the districts, more often than not, lack detailed budget lines for each activity. This stems from the fact that in poor districts, especially in upland provinces with large ethnic minority populations, the provincial budget relies entirely on input from the central budget while the district budget depends on provincial allocation. This impasse effectively inhibits policy implementation at the district level.
- A second concern is that policy documents enacted at higher levels often ignore ethnic minority contextual variation thereby encouraging inconsistent and conflicting laws, ordinances and implementing decrees. For example, each of the 4 targeted provincial authorities referred to a policy gap in Article 10 of the Ordinance and other decrees that stipulate married couples may choose, not only how many but when, to have their children depending on their respective personal conditions. Yet, the implementing decree states that each married couple is allowed only 1-2 children. Reconciling these differences poses obvious implications at the provincial level, particularly among the ethnic minority communities. However, the National Assembly has approved amendments to Article 10 of the population ordinance that makes specific provision for certain ethnic minority groups to have more than two children.

- A third concern relates to the lack of detail in provincial and district policy documents. All recommendations in the central guidelines are just copied, sealed and sent to the communes for implementation. The lack of detailed directives causes implementation difficulties for commune staff.
- A fourth concern is that successful pilot models are not replicated. To implement Population/RH policies in the provinces and districts, certain communes are selected for experiment but there is no evaluation of outcomes that might otherwise assist policy implementation.

2.2 Policy dissemination

The quantitative study records a significantly high percentage of responses from local informants on the issue of policy dissemination (100% of managerial staff and 98.6% communication staff). Methods for disseminating RH policies are highly diverse, as follows:

a) RH policy dissemination

In all 4 surveyed provinces, meetings and roundtable talks were found the most popular conduit for policy dissemination. With the exception of Son La, collected data also pointed to the finding that few upland provinces publish RH policies in local newspapers. This communication method should be considered more seriously as a useful way to popularize policies as local staff, especially senior managers, are in the habit of reading the newspaper in the morning and evening, particularly the local Party newspaper.

b) Direct conversation and public address system

Responses from managerial staff to the questionnaire indicate that, of the four surveyed provinces, Ha Nam is the most active in communicating and disseminating RH policies to the public and Dak Lak, the least active. Ranked in percentage order, dissemination of RH policies to the public is highest in the province of Ha Nam, followed by Son La, Ninh Thuan and Dak Lak. In other words, lowland provincial areas have a distinct advantage over upland areas.

Although provincial variation exists, the predominant means of communication are: loud speaker broadcasting, direct conversation and leaflets. Educating the public on RH policies using leaflets is extensively applied among ethnic minority communities in all surveyed provinces (except Ninh Thuan). However, qualitative study confirmed that policy education leaflets are presented in the Kinh language only thus reducing the impact of messages.

In areas with low levels of literacy, leaflets should focus more on pictures and diagrams than words.

Qualitative study results indicate that direct conversation is an effective form of communication. However, this needs to take place within the household and/or in combination with school-based communication programs for children.

“Information channels flow very slowly from higher levels downwards whereas the public can listen and understand the information more quickly from the radio, newspapers and television”
(EaH’Leo commune officer , Cu Kuin, Dak Lak)

The four provinces adopt significantly diverse approaches in disseminating policies to officials and the public. Although the public may learn about policies through mass media the information

tends to lack substance. This highlights the importance of ensuring local governments, through mass organizations, are equipped with appropriate skills to provide education and guidance to the public on implementation of RH policies.

It is difficult to ascertain whether communication facilities and human resources in the Kinh-dominant provinces are better or worse than the ethnic minority. For example, of the four provinces, Son La, although mountainous, confirmed greater diversity in Population/RH communication than found in the more accessible Ha Nam province.

2.3 Implementation of specific policies

a) RH behavioural change communication (BCC)

Communication methodology

Communication methods tend not to build on the intrinsic strengths of traditional cultures. For example, none of the respondents, particularly in ethnic minority areas, referred to promotion of ideas and information by village patriarchs and heads, nor suggested capitalizing on opportunities for RH BCC during festivals. In effect, all four provinces apply similar forms of communication and advocacy namely: direct conversation, leaflets, information integrated with health service provision and activities of mass organizations.

Communication content

- Safe motherhood (SM) information in ethnic minority communities should be able to advise on health workers assisted home-based childbirth, birth at the health facility, drugs and other pharmaceutical products. However, the insufficiency of this information clearly connects to the continuing and common practice among ethnic minority women of home-based childbirth, with or without professional attendance.
- FP information is more commonly available whether in upland or lowland provinces. FP and use of contraceptive methods are regular topics discussed in integrated meetings, club gatherings and face-to-face communication.
- Information on sexually transmitted infections (STIs) and HIV control is less communicated to the public. Only in provinces with a high incidence of STIs and HIV, such as Son La, is attention more focused on this topic. Communicators in Son La disseminate information on different types of diseases how infection occurs, prevention, where to get treatment and how to provide at 200.78/100,000 population in the North West. In comparison, the rate in Ha Nam is only 78.16, in Dak Lak 39.7 and in Ninh Thuan 36.96/100,000 (Health Statistics, 2006). It should be noted that HIV communication is restricted in critical border locations despite high infections rates.
- Information on abortion and post-abortion care is scant. Survey results show lower dissemination of information on unwanted abortions than other identified topics. However, Son La focuses on the topics of abortion FP and contraception marginally more than the other surveyed provinces. For example, survey data show 94.0% of Son La respondents believe that communication on prevention of unwanted pregnancy is provided, followed by 92.9% in Ninh Thuan, 89% in Ha Nam and 83% in Dak Lak. For other topics such as safety and the adverse effects of abortion, Son La is the best communicator, followed by Ninh Thuan. This likely reflects that fact that, of the four north western provinces, Son La records

the highest number of abortions (1,310 abortions in 2006 in Son La, 1,716 in Ninh Thuan, only 199 in Ha Nam and 615 in Dak Lak).

b) Limited RH services

The village health worker (VHW) model for providing home-based services is more apparent in Ha Nam than in other upland provinces. Notable is the fact that home-based VHW service delivery is requested most in Ha Nam and least in Son La and Dak Lak due to two possible causes: first, the population density in Son La (71 people/km²) and Dak Lak (132 people/km²) is more dispersed than in Ha Nam (961 people/km²) and Ninh Thuan (169 people/km²) and, second, VHWs attempting to visit households in Son La and Dak Lak are more challenged by geographic conditions than in the low lying areas of Ha Nam and Ninh Thuan. If more ethnic minority people were to receive midwifery training and subsequent employment as VHWs, the rate of assisted home births in ethnic minority areas would increase. Dissemination of specific information to ethnic minority women would alleviate some of the problems associated with home births and encourage attendance health facilities at least 1-2 days prior to expected commencement of labour, thus avoiding mid-way delivery.

Qualitative interviews with mobile health teams reveal widely different points of view. The Ha Nam team believes that this model matches local conditions well since it allows local clients to benefit from free services associated with the commune health centers. Health staff in Dak Lak and Ninh Thuan take the view that, although appropriate for upland provinces in theory, in practice facility constraints (there is only one car in the district health center) and shortage of skilled manpower, limit the delivery of medical care to remote areas to a maximum 4 times a year. The landing zone for mobile teams is the commune health center, thus making access difficult for some members of the community, particularly ethnic minority groups. When the health teams make field visits, clients are too few during the harvesting season and too many at other, less busy times. In this context, delivery of health services to relatively inaccessible ethnic minority groups is also hindered by limited medical facilities, equipment and supplies, posing significant hygiene risks.

“Ethnic minority people tend to be discrete and avoid crowds. They would refuse to have prenatal checks in a crowded setting, especially the H’ông people”

(in-depth interview with Chiêng Mai CHS manager, Son La)

In general, the range of RH services provided at commune health centers varies little among provinces, whether upland or lowland. Contrary to the interests of SM, ethnic minority women from Son La, Dak Lak and Ninh Thuan are not inclined to travel to the CHC for childbirth, preferring to give birth at home. Most women who visit the local CHC come from poor circumstances whereas the less poor are more likely to attend the district or provincial hospitals. In Ninh Thuan, a richer woman may choose to invite the doctor to attend the birth at home. In the three surveyed upland provinces, major reasons cited for not attending health centers relate to inadequate medical equipment, poor hygiene and importantly, lack of trust in the quality and dedication of commune health staff. Indeed, evidence of these key weaknesses particularly in ethnic minority areas, were identified in all surveyed provinces.

c) Inter-ministerial coordination in implementation of RH policies

RH communication

All four provinces employ a system coordinated by the Party and local governments. The Population department manages the communication network in cooperation with health authorities and other related entities such as the Women's Union, Youth Union, Farmer's Association, Veteran's Association and Fatherland Front. In predominantly ethnic minority provinces the Ethnic Minority Committee is an outsider to this process, an illogical outcome.

The sharing of RH and BCC best practices is less evident in Dak Lak and Ninh Thuan than in Ha Nam and Son La. Respondents from Dak Lak and Ninh Thuan report that, although a Population/RH network has been set up, application is intermittent due largely to disinterest and reluctance of commune leaders in dealing with Population/RH issues.

RH service provision

Service delivery in all 4 provinces is coordinated through integrated communication campaigns reliant on cooperation between health care providers and a number of mass organizations with an interest in population activities.

The lack of efficiency in delivering an integrated communication campaign in upland ethnic minority areas stems from the need to accommodate a variety of local contexts and personal views. On the other hand, health workers in low lying Ha Nam fully endorse the mobile health care model that offers clients the advantage of accessing more convenient and free health services. Prior to the introduction of the integrated communication campaign, residents of Ha Nam had to attend the district hospital and pay for the costs of health care services. Notable is that the high attendance rates previously recorded at the Ha Nam hospital now equal the number of women awaiting visits from commune health care workers under the integrated communication scheme.

In upland provinces, the introduction of integrated communication is poorly supported for the following reasons: (i) ethnic minority people are not required to pay for medical care whether attending the CHC or district hospital. This means that, in terms of finance, the integrated communication campaign fails to impress ethnic minority groups; (ii) the CHC, as designated gathering point, lacks adequate space and capacity to accommodate ethnic minority client needs for privacy and cooking space.

It is precisely for these reasons that both residents and health workers in mountainous provinces did not highly appreciate this model. However, it is the view of the researchers that the integrated communication model should be retained but provides more incentives to health workers to work closely with the local people and involvement of district leaders in policy implementation.

Collaboration between army and civilian health care has no relevance to RH service delivery to small ethnic minority groups in upland provinces. This contrasts with the lowland province of Ha Nam where the army is better integrated with civilian RH health care. Indeed, 44.1% of health worker respondents from Ha Nam reported the practice of army/civilian RH health care cooperation compared with approximately 10% in Dak Lak, Son La and Ninh Thuan. A relatively higher percentage of respondents in Ha Nam also believe that the cooperative model is more effective than in other provinces. However, in all four provinces healthworkers consistently state that the cooperative model is appropriate only for the purpose of delivering general health care. This was found particularly the case in border areas with large ethnic minority populations, where

most army health workers are men. Ethnic minority customs do not condone, under any circumstances, delivery of RH health care services by men.

“Combined army and civil health is only good for common medical care, as RH will not work with the army health settings”

(Focus group among health staff in Ninh Son district, Ninh Thuan province).

Application of combined traditional and western RH medical care for ethnic minority people is limited. However, analysis of interview responses on this topic produced an unexpected outcome, highlighting the stark difference between northern and southern provinces. The proportion of health workers claiming to practice a combination of traditional and western medical services, particularly in regard to RH care, was found higher in the upland north than the lowland south.

d) Surveillance and monitoring of policy implementation

In general, at the provincial level, whether lowland or upland, monitoring and evaluation of RH policies is inadequate. Oversight of health care at the commune level is better monitored by the district than at the provincial level. However, monitoring efficiency varies between provinces and districts. Indeed, where there is an absence of national target programs, international funded projects or NGO support, monitoring and surveillance are almost non-existent. It is worth noting that, during the implementation stage of projects providing funding is available, monitoring is regular and on-going but as soon as the funding phases out, activities slow down and then stop. This strongly suggests that sustained RH intervention is dependent on appropriate budget allocations during the planning stage.

3. Outcomes of RH policies

RH policies and practices implemented among ethnic minority communities play a role in awareness-raising among health workers, other involved staff and families.

3.1 Staff awareness and support for RH policies among ethnic minority groups

a) Management and leadership

In general, policy awareness among leaders in all the three tiers (province, district and commune) is reasonable. However, provincial and district officers are relatively more aware of macro policies than commune staff. Commune managers were conversant only in “business as usual” policies under their daily charge.

b) Health worker awareness of RH national benchmarks

Service providers, particularly health workers, use the “National Guidelines on RH services” as their primary reference. Surprisingly, commune health workers show greater awareness of this handbook than district staff. At the provincial level, lowland health workers are more aware than those in upland regions. Commune health workers are better informed than either district or provincial health staff. Commune health workers in Dak Lak are more conversant with the handbook than those from Ha Nam. These observations are discussed in the next section.

Table 5: Health worker percentage awareness of the National guidelines on RH Services (%)

Level	Ha Nam	combined 3 upland provinces	Son La	Dak Lak	Ninh Thuan
Province	100.0	66.0	87.5	62.5	75.0
District	71.4	50.0	45.5	30.8	69.2
Commune	81.8	71.8	57.1	84.6	75.0

Table 6: Percentage distribution of health worker awareness at all 3 levels of the National guidelines on RH Services

Province/Level	Ha Nam	combined 3 upland provinces	Son La	Dak Lak	Ninh Thuan
Province	25.0	38.9	43.9	20.0	50.0
District	36.4	29.4	20.0	0.0	44.4
Commune	12.5	21.4	25.0	27.3	11.0

Average health worker knowledge at the provincial level is two-thirds (10.3) of the top score (13.6) recorded in Ha Nam. Provincial level health workers in Dak Lak and Ninh Thuan scored 8 and 9 points respectively.

Table 7. Percentage distribution of provincial level health worker awareness of the National Guidelines on RH Services (average score)

	Ha Nam	Combined upland provinces	Son La	Dak Lak	Ninh Thuan
Province	13.6	9.1	10.1	8.4	9.0
District	10.4	6.2	6.2	3.3	9.2
Commune	9.9	7.4	5.1	9.0	8.8

District level health workers barely achieve a median grade (7.4 points out of the maximum 15 points). District level health workers in Ha Nam again show the best understanding and Dak Lak, the least.

Knowledge of the handbook was lowest among commune health staff although close to the district level (7.9 and 7.4, respectively). The provincial level scored highest at 10.4 points.

Quantitative results indicate that training opportunities for health workers represent the most efficient means of raising awareness of the contents of the National Guidelines on Health Services. Analysis of this source by province/district/commune however, shows marked distinction between the lowland province (Ha Nam) and three surveyed upland provinces, likely due to the fact that in Ha Nam, commune health workers receive more training than their district colleagues while in upland provinces, the percentage of trained health workers dips significantly from province to commune.

c) Percentage awareness of communication staff on the BCC strategy for RH/FP

Research data confirm an increase in proportional awareness of communication staff at the provincial level from 84% (2001-2005) to 92% (2006-2010). Ha Nam communication staff record the highest level of awareness of the BCC strategy for RH/FP and Dak Lak, the least.

Although relatively high at the district level, percentage awareness is still lower than the provincial level (79.9% and 88.9% respectively). Unexpectedly, awareness at the provincial level is higher in Dak Lak than Ha Nam while Ninh Thuan is significantly lowest. In Son La, the differences are minimal. It is interesting to note that in Ha Nam, the percentage of district level communicator awareness of the BCC strategy for RH/FP, is lowest of all surveyed provinces.

Analysis of the above data points clearly to the fact that, at the commune level, communicator knowledge of the BCC strategy is significantly highest in Ha Nam province. This observation concurs with results in section 3.2.2 that Ha Nam is the best overall performer of the four studied provinces on implementing communication activities on population.

Awareness of BCC strategy is higher in upland provinces than in Ha Nam. A significant proportion of provincial level communicators are not actively engaged in the implementation of BCC population policies. This unimpressive BCC regional performance pattern is similar for strategies on population, RH and FP.

At the district level, detailed awareness of BCC population strategies remains consistently low, (40% for both phases). Interestingly, the lowest percentage was recorded in Ha Nam and the highest, in Dak Lak.

In upland provinces, the percentage of BCC awareness is higher or at least equal to the district level. The district level is higher than the commune. In Ha Nam, at the provincial level, awareness of BCC strategies is either lower or equal to upland provinces (for example, the rate in Ha Nam is lower than Son La, but approximately equal to Ninh Thuan)

At the commune level, staff familiarity with BCC is higher than in upland provinces. This could be explained by the fact that the surveyed communes in Ha Nam benefit from a JICA project. Communicators in these communes receive more training on RH issues and BCC strategies, through various project channels, than in upland communes. With this advantage, Ha Nam performs significantly better in BCC than other observed provinces.

The percentage of commune communicators with detailed understanding of strategies in both phases remains very low (only 13.7% of the staffs have studied the BCC strategy for 2001-2005 and 17.8% the strategy for 2006-2010). This may be due to lower than expected dissemination of BCC strategies from higher to lower levels, compounded by problems with document delivery to upland communes thus aggravating communication performance on population issues.

Overall, Ha Nam performs better on communication issues than upland provinces. Upland commune health workers blame inadequate performance on poor knowledge, low education levels and lack of materials. Quantitative data endorses these observations.

Public awareness of RH through the evaluation of VHWs/PCs

In this study, RH awareness among the public was measured through quantitative and qualitative studies. Community understanding of RH was quantified through a four-level evaluation of VHWs and PCs applying categories “good”, “indifferent”, “poor” and “hard to define”.

a) Public awareness on SM

Data show that less than 50% of VHWs and PCs rate public awareness of SM (pregnancy care before, during and after delivery) as “good”. Ha Nam, with a majority Kinh population, recorded a higher level of awareness than provinces with ethnic minority dwellers (Son La, Dak Lak and Ninh Thuan). VHWs and PCs in Ninh Thuan rate public awareness as “poor”, with under 10% concluding “moderate” levels of public understanding on SM, significantly less than lowland areas.

Qualitative studies confirm the above findings. Ha Nam respondents are more aware that the pregnant mother should seek three prenatal checkups and ensure adequate diet and rest. This contrasts with relatively limited public understanding of these issues, particularly in provinces with large numbers of ethnic minority dwellers.

“In Cham, Kri villages ... they take the woman to the trees for fear of her dying as she cannot stay home when she dies. There, dead mothers and infants are buried right away without taking them inside the home ... it’s an ancient custom” (in-depth review of male residents in EaSol commune – Dak Lak).

Traditions and customs are among the most decisive factors influencing the incidence of home-based childbirth, with or without a skilled birth attendant. Qualitative results indicate that Kinh knowledge on postnatal care, particularly in Ha Nam, is more detailed than among ethnic minority people, especially the H’mông and Rắc Lây. For example, not only do ethnic minority people tend to believe that the woman is ‘unclean’ during pregnancy but in the event that the infant dies during birth in the forest, H’mông and Rắc Lây customs allow the mother to bury her baby on the spot.

Following childbirth, Kinh women rest for 1-3 months to regain their strength and health whereas H’Mông and Rắc Lây women are more likely to rely on traditional herbal medicines, returning to work immediately after delivery, without postnatal rest or care. This cultural tradition is harmful to the health of both mother and child. More advocacy and education is needed to redress this issue.

b) Public awareness on FP

In general, the public has accepted smaller sized families although female/male sex preferences still exist. In matriarchial societies in the Central Highlands, people prefer daughters, whereas both Kinh and ethnic H’Mông people generally wish for sons. Even among the majority Kinh people in Ha Nam, a lowland province, the son preference dominates.

In upland provinces, understanding of contraceptive methods is modest with under 60% of VHW and PC respondents rating public knowledge of contraceptive methods as “good”. There are clear provincial differences. Ethnic minority people in Ha Nam and Ninh Thuan demonstrate significantly better understanding of contraceptive methods than in Son La and Dak Lak.

In general, public awareness of the adverse effects of abortion varies significantly. In-depth interviews with the residents in the four surveyed provinces indicate that knowledge of the adverse effects of abortion is better in Ha Nam and Son La than Ninh Thuan and Dak Lak. In Son La, ethnic minority people are aware of the need to promote contraception as a means of reducing potential harm to women caused by abortion. In Dak Lak and Ninh Thuan, however, the locals are barely aware of the adverse effects of abortion, some even asking “What is abortion?” or

“Have you heard of abortion?” Indeed, ethnic minority women in these provinces are more likely to opt for full term pregnancies rather than abortion. Only in provinces where ethnic minority people are employed in the public services, is abortion prevalent.

c) STI and HIV/AIDS awareness

Public understanding of STIs and HIV/AIDS is inadequate in Son La and Dak Lak and rated by VHWs and PCs as “poor”. However, STI and HIV/AIDS awareness in Ha Nam and Ninh Thuan is relatively high at 67.6% and 61.8% respectively.

In Ha Nam, Son La and Ninh Thuan, VHWs and PCs awareness of STIs and HIV is rated “good”, falling just above the median level. Dak Lak records the lowest rating at around 20%.

Quantitative data also determines that the residents of Son La, Ha Nam and Ninh Thuan have relatively “good” knowledge on prevention and control of STIs compared to Dak Lak where awareness is rated “poor”. Indeed, many locals interviewed in Dak Lak had either never heard of STIs or HIV or believe that mosquito stings are the main transmitters of these diseases. Prevention knowledge is also very limited. However, where there the national language is spoken or understood, awareness is higher. This highlights the need to translate RH communication policy from national to local languages.

Residents of Son La are better informed than Dak Lak on STIs and HIV. This is likely due to the fact that the infection rate is now higher in Son La than in Dak Lak, and thus provincial leaders have become more focused on delivering BCC on this issue. Nevertheless, in other surveyed provinces, VHWs and PCs rate public awareness of STIs and HIV only as “good” only at 50%. This is of concern and calls for better communication on this topic for both ethnic minority and Kinh people, in upland and lowland provinces.

“Youth understanding is still limited as many know little about adolescent RH”
(in-depth interview with head of Duc Ly CHC, Ha Nam).

d) Adolescent awareness of RH

Understanding of RH and dissemination of knowledge among young people is generally rated “poor”, not only in upland and remote provinces such as Son La but also in the more accessible lowland province of Ha Nam.

e) Adolescent Reproductive Health (ARH)

Public awareness of ARH remains very poor. The provinces are either not interested or lack capacity to manage ARH. Premarital sex among adolescents and young people in the surveyed areas, whether upland or lowland, usually occurs without the benefit of RH knowledge or contraception.

3.2 Community RH practices

a) Safe motherhood (SM)

Evaluation of SM practices among ethnic minority groups is based on comments from VHWs and PCs on how often and where women attend a clinic for pre-natal checkup during pregnancy. Responses confirm that upland provincial women, particularly in Son La, are less likely to request the recommended three pre-natal check-ups.

Quantitative data indicate that pregnancy care practices in the control province Ha Nam are of a higher standard and more readily available than in the other three surveyed provinces, particularly Son La. This unsatisfactory situation persists despite claims of health workers and communication facilitators that ethnic minority women are provided with education sessions on a regular basis. Notably, in Son La, evidence points to minimal awareness among women on the desirability for three pre-natal check-ups.

Survey results highlight the fact that ethnic minority women located in difficult access areas, especially the H'mông in Son La and Rắc Lắy in Ninh Thuan, are likely to seek prenatal examination only if they are experiencing health problems or unusual pregnancy symptoms.

Another concern relates to the timing of the three pre-natal check-ups. In areas with large ethnic minority populations, health workers report prenatal check-up rates as high as 70%. However, in the matter of correctly timing intervals between check-ups, the rate is considerably lower at 30%-40%.

The majority of prenatal check-ups in both lowland and upland provinces take place in health service clinics (95.5%). Increasingly, these include private health facilities particularly in Son La and Ha Nam. This trend suggests that residents of southern provinces are better able to meet the costs of private health care services than their northern compatriots. Reports also show that, in the predominantly ethnic minority provinces of Ninh Thuan and Dak Lak, many women visit private healers/midwives for pre-natal check-ups. This would be of less concern, if more village midwives were trained both in birth practices and counseling thus allowing them to work more closely with pregnant women. As such, more incentives should be provided to attract potential Ninh Thuan and Dak Lak trainees to the village midwifery training programmes.

Evidence of home-based childbirth occurs almost exclusively in upland provinces and only rarely in lowland areas. Ethnic minority people are significantly more likely to give birth at home without the assistance of a skilled birth attendant, a situation that is almost non-existent among Kinh people. Home-based childbirth among the Kinh people occurs predominantly in households that can afford a doctor. This contrasts with ethnic minority groups in Ninh Thuan and Dak Lak where quantitative results reiterate the three key reasons for opting for home birth: (i) commune health center located too far away; (ii) long-standing tradition of giving birth at home or in the forest and; (iii) preference for traditional midwives or healers.

However, costs, transport and distance are even more a barrier to women's attendance at health facilities for childbirth, than cultural factors. While some ethnic minority couples choose a health facility, sometimes at the district level, to have their first child, they are more likely to choose home-based childbirth for the second and subsequent births in the belief that having proved safe once, it will be safe again.

Not only do cultural factors significantly encourage the practice of home-based childbirth but findings show that, during the past two years, some commune health centers in provinces with large numbers of ethnic minority people have not been involved in a single birth due to the simple fact that they are unable to supply female midwifery services.

In addition to the above, there are other significant causes linking the low incidence of visits of ethnic minority women to CHCs. Facilities, medicines and hygiene in commune health centers are notably inadequate compared to district hospitals. For obvious reasons, women tend to choose the latter, particularly if the district hospital is located relatively near to the CHC. All ethnic minority people are entitled to free health insurance cards that can be used at any health service

provider. Thus, they tend to bypass the local CHC, even if offering the designated level of care, and head straight to the regional center or district hospital for prenatal check-ups and birth delivery.

Home-based childbirth is predominant among the Rắc Lắy and Chắm people in Ninh Thuan, the Ê Đê and Gia Rai people in Dak Lak, and the H'Mông, Mường, Thái, Nùng and Dao in Son La. According to VHW and PC respondents, the main reasons these particular ethnic minority communities opt for home-based childbirth, with or without a SBA, are ranked as follows: trusting traditional midwives (43.4%), lack of communication means to call for health worker assistance (35.2%), traditions and customs (34.4%), and lack of medical staff (21.3%).

Postnatal maternal and infant care is notably lacking among ethnic minority groups. For some matriarchal ethnic minority groups such as the Rắc Lắy people in Ninh Thuan, the woman is the key bread winner of the household. This means that, immediately following birth of her child, the new mother seeks traditional herbal therapy to regain physical health and returns to work almost instantly. This particular postnatal trend is predominant in Ninh Thuan, Son La and Dak Lak.

“The first important thing is tetanus immunization but the lack of awareness keeps this immunization rate low. The second should be breastfeeding. Exclusive breastfeeding for 1-6 months infants here is almost non-existent”.

(In-depth interview with head of Phuoc Tien commune health center, Ninh Thuan).

The incidence of postnatal infant care among ethnic minority groups is also less than advisable, especially in terms of breastfeeding and infant immunization.

b) FP practices and the incidence of abortion

VHW and PC interview results show little regional difference in the proportional levels of contraceptive methods and their usage. For example, 97.5% of respondents opt for contraceptive pills, 92.6% for condoms, 72.1% for contraceptive injectables and 95.1% for IUDs. Evidence points to significantly high rates of male sterilization in Ha Nam and Ninh Thuan (55.9% and 50.0% respectively) compared to Son La (5.0%) and Dak Lak (8.8%). Complacency about RH care should not be allowed to prevail over enduring custom in ethnic minority communities that promote large families. Multiple studies point to the fact that, while the fertility rate in Viet Nam may have dropped overall, it is far from stabilized particularly in ethnic minority upland and other less developed regions.

While quantitative results may confirm low abortion rates with virtually no difference between lowland and upland provinces, qualitative study suggest otherwise. Indeed, there are strong indications that abortion is on the rise particularly among the Kinh people in urban and surrounding rural areas. In comparison, ethnic minority people living in remote areas of the same provinces are less inclined to seek abortions.

“Abortion in public hospitals can be complicated ... the staff’s attitude cannot compare to private facilities. People would rather spend more outside than going to the hospital to suffer from the harsh words from the doctors and medical staff” (Focus group discussion of Mai Son district officers, Son La).

Is this statement contradictory to the above comment? According to one VHW, contraceptive practice is as high as 90%. However this opinion does not reflect the community view and suggests that PCs may be inclined to report higher usage of contraceptive methods just to gain

more credibility. High abortion rates, despite significant contraceptive usage, suggest clients may be issued with poor quality contraceptives and/or advised incorrectly on methods of application.

If finances permit, women prefer to seek abortion services from private rather than public providers, to ensure confidentiality, better facilities, skills and kinder staff attitude should complications arise.

Sex-selective abortion exists although more likely practiced in Ha Nam than in provinces with large ethnic minority populations.

c) Gynecological diseases

A summary of qualitative information from surveyed provinces suggests significant incidence of gynecological diseases. The most common disease, according to local estimates, is cervicitis. This infection can be caused through use or contact with unhygienic water sources in the household and workplace. Typically, due to lack of awareness, ethnic minority women tend not seek appropriate medical care in time, or only during integrated communication campaigns. However, health workers believe that such campaigns do not guarantee quality care, confirming yet another gap in RH services and delivery to ethnic minority groups.

d) Increasing HIV incidence

Of the four surveyed provinces, Son La shows the highest HIV infection rate, with the most critical location in the provincial district and town of Mai Son where almost 100% of the communes report infection. However, the actual number of infected people elsewhere is very hard to track and feared to be much higher than reported.

The main cause of HIV infection in the community is believed due to high rates of injectable hard drug use, predicted between 25-30%.

The 2007 Health Statistics report shows (accumulated) HIV infection in Son La as highest of the four surveyed provinces, accounting for 480.29/100,000 population. The rate is significantly lower in Ha Nam, Dak Lak and Ninh Thuan. Ha Nam reports almost double the incidence of HIV than Dak Lak and nearly two and a half times more than Ninh Thuan (105.77/100,000 population in Ha Nam, 60.31/100,000 population in Dak Lak and 41.93/100,000 population in Ninh Thuan). In 2007, compared with 2006, HIV is spreading at an alarming 2.4 times faster pace in Son La. The same comparison shows an almost unchanged rate in Ninh Thuan, 1.5 times higher in Dak Lak and approximately 1.3 times higher in Ha Nam.

4. Review of selected policies associated with RH care for ethnic minority groups

4.1 Human resources policy

The human resources policy covers various issues including staff quotas, salary and allowances, travel allowances, training and incentives in an effort to attract health workers to jobs in upland areas. Public address systems disseminate information. Preference for the specific needs of ethnic minority communities in upland areas is reflected in every legislative document. Enforcement of these policies in practice however is proving rather a daunting task.

a) Salary and allowances for health and population workers

Analysis of field and postal surveys raises questions on the preferential allowance system designed for health workers tasked with providing direct services at various levels. However, when interviewed, a significant proportion of management staff complained that the allowance scheme is unreasonable: 72.2% in Son La, 76.2% in Dak Lak, 77.8% in Ninh Thuan. Across the different regions, the rate is highest in the north east (87.8%) and lowest in the Mekong River delta (73.7%). For health workers delivering direct services to various tiers of the surveyed areas, the percentage is relatively high, especially in the south.

Table 8. Distribution of health workers dissatisfied with the current allowance

Regulation	Son La	Dak Lak	Ninh Thuan	3 upland provinces combined
Allowance level for direct health service providers in district health facilities	63.6	88.9	72.7	75.0
Allowance level for medical staff working at commune health centers	72.7	88.9	84.8	78.6
Allowance level for direct health service providers in provincial/district preventive health centers	72.7	88.9	84.8	72.8
Allowance level for direct health service providers in HIV control centres	72.7	75.0	90.9	77.2

Health worker views on the salary and allowance scheme differ as follows:

- The nature of the job, working conditions: “Sending officially trained doctors to work in the commune level is not relevant to the actual needs, the hardship and difficulty level of the assigned job”. (Head of a CHC in Son La)
- The education sector: “Both are public services sector, teachers working in these areas receive 70% of profession-specific allowance compared to health workers’ allowance of only 35%”, and the question is: “Is it fair?” (Focus group of Ninh Thuan provincial staff)
- Within the sector: “The malaria control program is more simple, yet entitled to 0.2 allowance multiplier, whereas the more difficult and demanding RH is only entitled to 0.1 multiplier. By demanding, we mean that we do not have midwives and thus have to do everything. To be fair, the allowance multiplier should be 0.2 or 0.3.” (Head of a CHC, Ninh Thuan); or “It is low compared to the VND 35,000 paid to doctors and VND 25,000 to nurses on duty in district hospitals”.
- Managerial staff in district health offices on the role of direct health service providers: “The district health office is in charge of management of CHCs and plays a role in the campaigns of preventive health centers; office staff are required to dedicate considerable time in the field and not paying them profession allowance is not reasonable”. (Deputy Manager of a district health office, Dak Lak).
- The allowance at CHCs is VND10,000/person/duty shift but with the manpower quota this amount has to be divided between two people in Ha Nam and Ninh Thuan since, “for safety

reasons, the district health leaders require each duty shift to be staffed by two employees, and to share the VND10,000”.

Population professional staff

The salary level of dedicated population staff in ethnic minority areas is higher than in lowland areas yet, in view of additional challenges, is still relatively low and hardly sufficient to support living and travel related workcosts. This situation prompts some staff to take on other assignments concurrently, to increase their salary and allowances.

Communication staff

In Ha Nam, 54.2% of staff involved in an integrated communication campaign agreed that the VND50,000 per diem allowance for editing a radio script is reasonable, 45.8% that VND10,000 is appropriate for a radio broadcast and 39%, VND25,000 for counseling. In the three provinces with ethnic minority dwellers however, the percentages regarding the adequacy of payments are much lower: respective ratios for Son La are 29.2%, 19.0%, 13.8%; Dak Lak: 29.0%, 17.7% and 17.7%; Ninh Thuan: 21.4%, 19.6% and 8.9%.

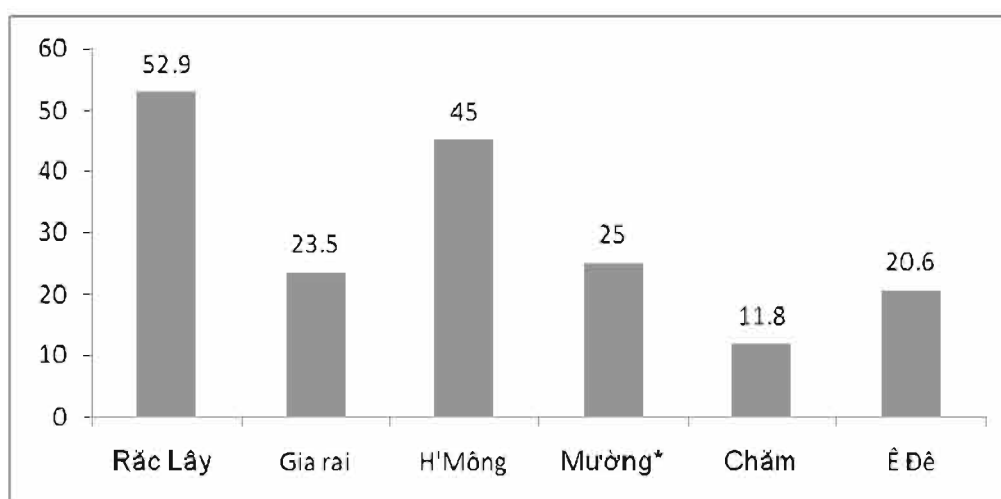


Figure 1: Regional percentages of pay levels for communication activities at commune level

The actual allowances that VHWs and PCs receive vary among areas. Many options have been pursued in efforts to increase the allowance levels for these groups, such as:

- In Dak Lak, “From 2008, the allowance for a VHW has been raised to VND150,000/month compared to the previous VND80,000/month” (Focus group discussion among provincial staff). This level is equal to a lowland province such as Ha Nam: “In February 2008, the provincial People’s Council passed a resolution to raise this allowance to VND130,000 for lowland communes, to VND150,000 for mountainous communes and to permit VHWs to work part-time on other jobs” (Focus group discussion among provincial staff).
- Under Decision 25/2008/QĐ-TTg, dated February 5, 2008, the Ministry of Health decided to increase allowance levels for VHWs in disadvantaged areas, paid from the state budget at 0.5 times the base salary. As a result, this allowance has increased incrementally over time. In Ninh Thuan, “prior to 2007, VHWs received VND210,000/quarter (VND70,000/month). After 2007, this allowance was raised to VND280,000/quarter (in-depth interview with a CHC head). Despite these efforts, pay grades for community-based health staff are still considered too low

to meet current costs of living and transport costs. For example, “Communes in the Central Highlands can be very large. The population of EaH’Leo commune is 22,000 and comprises 24 villages each with about 250-500 households. Travelling over such an extensive area is really challenging for health workers. When asked about this policy, only 40-64% of regional management staff thought the allowances reasonable.

Table 9. Percentages of management staff happy with the new allowance level (0.5 times the base salary) for VHWS, by region

Region	North East	North West	Central	Central Highland	South East	Mekong River delta
Percentage	63.8	63.3	40	54	52.3	55.6

Travel allowances

During field interviews, health managers reported that district health workers must travel more than 15 km to qualify for a travel allowance. Faced with difficult transport conditions and without travel and gasoline allowances, mobile services beyond a 10km radius are limited thus disadvantaging delivery of RH and SM programs and postnatal care to villages and households located in relatively remote areas.

b) Inadequate and poor quality of health workforce in upland areas

Human resources

Staff quota under Joint Circular 08/2007/TTLT-BYT-BNV, dated June 5, 2007, is based on population size and geographic conditions. However, 73.5% of management staff in provincial and regional preventive health centres, responsible for delivering health care to ethnic minority populations, believes this staff restriction is not rational. Similar views were expressed by management staff in the provincial reproductive health center (70.6%), health education centre (73.9%), provincial HIV control center (74.1%), and the provincial population/FP administration branch (70.1%). The 4-strong staff quota applicable to district population/FP centres was also criticized as irrational, particularly in upland and remote areas where high fertility rates prevail among ethnic minority groups.

In practice, the health workforce in the upland areas is inadequate both in quantity and quality. In terms of organizational structure, district health care should be in a position to identify multiple contact points. However, staff restrictions makes human resource arrangements even more difficult to implement.

Regarding communes, the rule is that each CHC has minimum 5 staff members and maximum 10, with regional-specific factors applied. Although not rated very highly, this policy is viewed by most managers as suitable, (Son La: 63.2%, Ninh Thuan: 55.6%, Dak Lak: 66.7%, 3 combined upland provinces: 62.1%). The percentage of managers supporting this staff quota varies by region.

Table 10. Percentage of managers viewing the staff quota for CHCs under Circular 08/2007/TTLT as suitable, by region

Region	North East	North West	Central	Central Highland	South East	Mekong River delta
Percentage (%)	65.3	67.2	59.5	71.9	60.9	76.2

Despite involvement in many programs, at least two of the surveyed provinces (Son La, Dak Lak) have not recruited CHC staff in accordance with the population quota. In Ha Nam, Son La and Ninh Thuan, the CHC midwife was found to be working in several capacities including drug dispenser, accountant, health insurance and reimbursement officer etc. Managers of these CHCs complain that the “quality of the RH program for that reason cannot be guaranteed”.

Staff shortages in CHCs worsen as training and refresher training programs accelerate. CHCs are required to send one staff member to attend the capacity building programs. Young female midwives are often unavailable being either on maternal leave or too busy taking care of their families and small children. Center heads are regularly attending meetings elsewhere.

CHCs with benchmark qualifications are supposed to employ a traditional medicine assistant doctor but study results show that it is very difficult to recruit skilled personnel to work in upland and remote ethnic minority areas. Further, there is a continuing and serious shortage of professional pharmacy staff.

In upland areas, communes are often large in size but, unlike the education sector which has funding to build more schools, few health sub-centers are developed. Often, only one health worker is on duty at any one time to deal with drug dispense, usually confined to malarial drugs. Until skilled health workers are available to deal with prenatal check-ups or obstetric emergencies, there is little likelihood of delivering effective FP and SM services to these areas.

VHWs in both in lowland and upland areas are in short supply. This reflects not only the predominantly senior age group of staff but, more importantly, the fact that allowance levels are too low to attract younger people.

“There is no specific central regulation on the staff quota for mobile health team. Local health leaders may allow for a larger staff if they are inclined to be supportive, other wise, the team may survive but virtually without any staff. Some so-called mobile teams are in fact only teams of one person”

(Focus group among Ninh Thuan provincial staff).

Circular 11/2005/TTLT-BYT-BNV, dated April 12, 2005 and Circular 3/2008/TTLT-BYT-BNV, dated April 25, 2008, ruled out the mobile health team model. Specific regulations for mobile health staff quotas are therefore technically not available but left to local decision makers. The personnel constraint significantly limits the operation of mobile teams. Some travel only to nearby communes and very rarely to the more distant Zone 3 communes, where services are so badly needed.

Regarding the BCC workforce, official regulations require CHCs to have a “communication corner”, to accommodate qualified staff engaged in center-based communication and counseling. In practice, performance in this job category is at best, inadequate. As discussed above, a CHC staff member often assumes multiple positions of which curative care is the first priority. In effect this means that, while technically every CHC is supposed to have a dedicated counselor, this responsibility is inevitably performed poorly.

The network of PCs in upland and remote areas has long been thin on the ground. On average, a facilitator is in charge of 200 households with total 1,000 people, a responsibility more difficult to administer in upland and remote areas given the distances to be covered under difficult conditions. PCs tend to be members of women’s association branches. In provinces with ethnic minority dwellers, a significantly high percentage of communicators delivering RH/FP information are untrained.

Table 11. Percentage of communicators without training on RH/FP communication, by region

Region	North East	North West	Central	Central Highland	South East	Mekong River delta
Percentage (%)	23.8	27.5	29.2	38.2	19.7	31.6

Multiple but weak policies

To attract health workers to remote and disadvantaged areas some policy incentives have been introduced but most are deemed too weak to fulfil their purpose. Very few health workers concur with the suitability of the current compensation scheme.

Table 12. Proportional distribution of health worker acceptance of current compensation as reasonable, by province

Compensation for RH health workers	Son La	Dak Lak	Ninh Thuan	3 upland combined provinces
Salary and profession-specific allowances	30.3	8.3	0.0	12.7
Night duty allowance	21.2	2.8	3.0	8.8
Training, incl. dialects	24.2	11.1	3.0	12.7
Support for female workers	30.3	8.3	21.2	19.6
Housing support	21.2	2.8	12.1	11.8
Means of transport support	27.3	2.8	12.1	13.7
Mobile service delivery allowance	21.2	5.6	15.2	13.7
Others	3.0	0.0	0.0	1.0

“Even with the established staff quota, attracting talent is not easy, especially those with general doctor qualifications and above, even when sizable cash subsidies in the order of dozens of millions of dong is offered to each doctor to to work in remote areas. Initially, we attracted seven people into staff positions, but then they returned the money and left” (Focus group among Son La provincial staff).

In Son La, Ninh Thuan and Dak Lak, other incentives for attracting professional talent are provided, including a cash bonus for those taking jobs in disadvantaged areas, allocation of housing land etc. These inputs, however, pale in significance against the magnet of big urban centers.

Commendation and awards for good performance in RH/FP and BCC activities, offer incentives to communication staff working in various communities. Nevertheless, most PCs in upland and ethnic minority provinces (86.7% in the Mekong River delta, 75.0% in the Central, 72.3% in the North West, 66.7% in the Central Highland, 74.1% in Son La, 66.7% in Dak Lak and 52.9% in Ninh Thuan) believe that these incentives are inadequate.

Concern about staff rotation

On May 26, 2008, the Minister of Health issued Decision 1816/QĐ-BYT approving the project “Rotating medical staff from hospitals of higher levels to lower level hospitals to assist upgrade of quality of care”. Five months later the Decission came into effect. However, three of the surveyed provinces have not yet adopted the policy and only in Son La has implementation recently begun. Despite the positive implications of the policy in terms of commune health staff

rotation, some hitches have emerged. Notably these focus on the unchanged allowance ratio and short rotation periods making it difficult to inspire medical staff to work in the more disadvantaged communities. Accordingly, and in addition to this policy, local managers hope to receive “training and refresher training to improve their capacity for the job and develop a mindset that favours staying in one place for longer periods of time” (Focus group among district staff in Son La). Also they hope to “attract new graduate medical students to work in the upland areas for three years before reassignment to the next step in their career” (Management of a district health center, Ninh Thuan).

Training and in-service training policy

On Nov. 14, 2007, the Prime Minister issued Decision 1544/QĐ-TTg, approving the Project for training the health workforce for disadvantaged and upland areas in the North, Central, Mekong River delta and Central Highlands based on an ‘on-the-job’ system. With the introduction of major policies and projects, training and in-service training offered to the health workforce is robustly underway. Review findings indicate that ‘on-the-job’ training is on-going in most regions and provinces with ethnic minority dwellers. Most managerial staff however, (61.9% managers in Dak Lak, 72.2% in Ninh Thuan and 36.8% in Son La, 65.6%) offered a combined response that the regional allocation of the ‘on-the-job’ training quota, as cited in Project 1544, is not suitable.

Table 13: Percentage of management staff regarding the allocation of training quota outlined in Project 1544 as unreasonable, by region

Region	North East	North West	Central	Central highland	South East	Mekong River delta
Percentage (%)	57.0	58.5	61.9	61.7	69.8	65.0

Field survey results indicate that on-the-job training programs are on-going, funded by either central or local budgets. Ninh Thuan offers an on-the-job training program to CHC staff with higher levels of education (primary level to secondary level, assistant doctor to doctor) funded entirely by the local budget. The provincial training policy clearly states that those working in remote areas should be given priority for the training.

As in Ninh Thuan, Son La has begun to accommodate the on-the-job training program within the local budget. Trainees receive their full salary plus a training allowance. This allowance discriminates in favour of female staff.

Finding the right candidates for on-the-job training is also a problem in the context of low education levels in upland and remote areas. Quantitative results show that 61.1% of management respondents in Son La, 76.1% in Dak Lak, 61.1% in Ninh Thuan and, in combination, 66.6% for the three surveyed upland provinces, find the prospect of committing local staff to on-the-job training, challenging. The regional percentage level for training commitment is also relatively high.

Table 14. Percentage of management that agrees on-the-job staff training is challenging, by region

Region	North East	North West	Central	Central highland	South East	Mekong River delta
Percentage (%)	56.6	48.2	66.7	58.3	53.3	60.0

Typical challenges include:

- High qualifications required: “We are in desperate need of personnel but are sometimes in serious shortage of qualified candidates to send for training. All too often, opportunities go to family members of district or provincial officers with an education advantage”. (Leaders of Son La Health Department).
- In the case of VHWs, “It is very difficult to find the right person to send for training, especially of ethnic minority origin and with secondary school qualification. Those who do qualify are usually not willing to participate due to the inadequate allowance levels, whereas the more enthusiastic are not educationally qualified”. (Focus group among district staff, Ninh Thuan).
- For training of village midwives, qualification expectations are high yet no certification is provided at the completion of the course nor guarantee of a full-time job forthcoming. On the other hand, “those finishing 8th grade can be promoted to commune officials, enjoying both position and salary. We want to send someone with such background to the village midwifery training program but it is very difficult here since there is no prospect of certification.” (Focus group among district staff, Ninh Thuan).
- Gender issue: some training programs are financed by external sources and the training provider gives priority to male trainees for fear that female staff may complete training then marry and relocate to another village/area. The bias towards men makes identifying prospective trainees even more difficult since “men often care more about income and are not keen to participate in the training given the issue of low compensation”. (Head of a CHC, Son La).
- The local health facility is required to cover trainee costs and in many cases, this is a prohibitive factor.
- Training courses often take place in the provincial center. Distance and difficult transport conditions in upland and remote areas seriously hinder potential participation of CHC staff in the training courses.

Further, challenges involved in training, such as pressure to gain a qualification and prohibitive accommodation and transport costs, cause a number of on-the-job trainees to drop out.

The ‘output’ plan for on-the-job trainees is not readily available in many provinces. Trainee liabilities are not clearly defined or strictly complied with, resulting in “non-return” or less than effective work quality. Those sent on upgrade training may decide not to return to their previous positions due to the enormous differences in work conditions between urban areas (district, province or even Ho Chi Minh City) and the more remote areas they have come from. To address this impass, trainees should be offered more incentives to return to their previous workplace. Moreover, if trainees fail to return to their previous positions, punitive schemes could be instigated to ensure trainee repayment of training costs.

4.2 Commune health infrastructure

“The room is so small that we have to take away one of the two delivery tables. Rooms are shared for different uses and often not floor-tiled. Rain leaks through the roof although this is now a little better after some minor repairs. In general, the entire place does not qualified for the benchmark”.

(Representatives of CHC, Son La).

RH infrastructure in upland and remote areas is inadequate. Field surveys reveal that all CHCs built before 2003 (under Program 135, National Health Supportand, Population/Family Health projects) are now in dilapidated condition with cracks in walls and holes in the roof. Hygiene conditions are poor as the walls are not tiled and dotted with fungus.

Policies to supply resources for the reconstruction of CHCs are now in place in all provinces. In the lowland area of Ha Nam, where the living standards are relatively higher, mobilization of community resources has already been introduced with obligatory contributions of VND10,000/person, to be paid over a two year period. This contrasts with upland and remote areas where community leverage is more difficult to introduce and sustain.

In addition to capital resources, another emerging and important issue related to the reconstruction of CHCs, is space. Under the new benchmarks, any new CHCs must provide minimum space of 2000 m². While compliance with this policy may not be such a problem in remote areas, it does pose a challenge in the more densely populated, residential locations. Nonetheless, in upland areas faced with difficult terrain, no policies have been developed for building service delivery sub-centers in response the demands of ethnic minority communities.

In some of the newly constructed CHCs under Decision 950/QĐ-TTg, further improvements are required. Apart from houses and buildings funded from the state budget (VND800 million), other infrastructure such as electricity, water supply, drainage, entrance, fence, etc. are the responsibility of the commune budget (VND200 million). If the commune is under-resourced financially, infrastructure facilities are compromised. Where the CHC structure is not cared for effectively the entire compound is likely to deteriorate quickly.

Typically, in some communes, local health workers report that new CHCs do not meet the needs of ethnic minority groups. All new CHCs are required to set aside one room for integrated service delivery (the consultation room as the briefing and duty room, the warehouse shared with drug dispensary etc.). Service provision, especially RH services, is non-discriminatory, discouraging potential ethnic minority users.

Many ethnic minority groups and local residents are in the habit of carrying firewood and rice to cook their own meals when away from home. This custom has implications for the CHCs where cooking space is not available.

4.3 Essential equipment and drugs

Policy documents on essential equipment and drugs associated with RH issued by the Ministry of Health are currently considered adequate.

a) Essential drugs

The surveyed CHCs are provided with all categories on the essential drug list but supplies are insufficient to meet the health care needs of the community.

A major concern is that in all the surveyed ethnic minority areas, drugs for treatment of gynecological diseases are seriously in short supply and unable to meet the demands of infected ethnic minority women. In lowland areas, private dispensaries sell drugs for the treatment of gynecological diseases. However, even if ethnic minority women in mountainous areas were able to access private drug sources, they cannot afford the cost. Certain drugs offered privately are reportedly not included on the free essential drug list associated with RH/FP programs and therefore not covered by health insurance.

Although condoms and contraceptive pills are available in remote areas, many ethnic minority people prefer contraceptive injectables and implants. Despite this demand, supplies are inadequate thus compromising potential users.

b) Medical equipment

Quantitative data indicates that a large number of RH equipment in higher level health facilities and CHCs is in a state of deterioration and disrepair. In addition, limited infrastructure facilities impact on equipment condition, both in terms of installation and maintenance. One piece of equipment may be used for multiple purposes such as delivery tables substituting for gynecological examination or an operating table used for birth control treatment.

“In recent years, clean birth packs are provided by the population authorities to upland and remote communes but not enough. Each commune receives only 10-15 packs when there are as many as 100 women about to give birth. However, since last year even this limited supply ceased. The commune was informed that supply would be reconnected through the maternal mortality reduction program. The clean delivery kits are very effective but are not currently available”.

(Focus group drawn from district staff, Son La).

Many mobile teams under district management lack critical equipment such as abortion and birth attendance toolkits, or suitable vehicle for mobile missions. Even where a vehicle is available, challenges of remuneration for the driver arise, compounded by lack of funds to meet the costs of gasoline, oil and maintenance. To establish a well-integrated mechanism for delivery of RH care to disadvantaged ethnic minority groups, the district health centres urgently need access to more vehicles and drivers backed by a budget to cover costs.

The SM program for ethnic minority people unwilling or unable to attend a CHC, is supposed to provide clean delivery kits to assist safe home birth delivery. However, there continues to be serious shortage of this item.

Other equipment essential to VHW performance is also in severe shortage. Quantitative survey results indicate that only 25-30% of VHWs are fully equipped with medical kits containing basic drugs and only 25-40% are supplied with first aid kits. Evidence confirms a significant lack of clean delivery kits in Son La, despite the fact that 20% of health managers report VHWs are provided with these kits. In Ninh Thuan and Dak Lak, equipment shortage is even worse with percentages dropping to 5.9% and 2.9% respectively.

Table 15: Distribution of health worker responses on the supply of medical equipment for VHWs, by province

RH equipment provided to VHWs	Son La	Dak Lak	Ninh Thuan	Combined 3upland provinces
Medical bag with common drugs	25.0	23.5	29.4	26.1
Clean delivery kits	20.0	2.9	5.9	8.0
First aid tools (cotton, bandage, splints, thermometer, torch etc.)	40.0	26.5	32.4	31.8

c) Communication equipment and tools

The Review concurs with findings of previous studies that report an even more compromised shortage of communication equipment than medical.

Table 16: Distribution of communication survey results on provision of communication equipment, by province

Communication facilities	Ha Nam	combined 3 upland provinces	Son La	Dak Lak	Ninh Thuan
Leaflets, booklets	52.5	46.6	44.8	50.0	44.6
Books	44.1	26.1	29.3	21.0	28.6
Video players	22.0	15.9	22.4	12.9	12.5
Discs, tapes	23.7	18.2	25.9	14.5	14.3
Video tapes	23.7	17.7	22.4	14.5	16.1
Disc players	20.3	21.6	31.0	24.2	8.9
Communication systems	47.5	25.0	29.3	19.4	26.8

Overall, PC and VHW respondents, (88.2% in Dak Lak, 85.0% in Son La and 76.5% in Ninh Thuan) report multiple challenges in providing effective BCC due to inadequate supplies of communication equipment, tapes and discs. Only one-third believe that the lack of suitable leaflets and booklets contributes to the problem. A high percentage of staff in Dak Lak (70.6%) and Ninh Thuan (61.8%) identified inadequate means of transport means as a key contributing factor.

Table 17. Distribution of survey results on challenges encountered in communication delivery, by province (%)

Challenges	Ha Nam	combined 3 upland provinces	Son La	Dak Lak	Ninh Thuan
Lack of transport means	32.4	57.7	40.0	70.6	61.8
Lack of suitable leaflets, booklets	35.3	36.4	30.0	35.3	44.1
Lack of communication equipment, tapes, discs	47.1	83.4	85.0	88.2	76.5

PC respondents confirm that when equipment is provided it cannot always be put to use in certain remote areas due to lack of electricity supply and/or appropriate space. Provincial health managers advise of efforts to set aside local funds for the purpose of acquiring more

communication equipment. While limited financial resources preclude taking care of the needs of all the communes, delivery of communication programs to remote areas should be considered a priority.

Communication materials are in greater supply than technical equipment. Nonetheless there is concern that materials are only printed in the Kinh language. Local communicators recommend that materials be translated into ethnic minority dialects to ensure messages reach their targets. In recent years, there have been laudable efforts to improve the content of news items and articles on population and development (e.g. the adverse effect of large families on the economic and social well-being of households and society, of population pressure on the environment and so on).

“Tapes and discs in dialects, which would be better tools in communication, are not available. The leaflets should also be printed in dialects, with contents improved and focused more on the adverse implications of having too many children or absence of birth control methods. Currently most leaflets only provide guidance on how to use contraceptive methods”

(focus group among commune staff, Dak Lak.)

4.4 Income and expenditure

The study results indicate multiple gaps in income and expenditure policies implemented in CHCs in upland and remote areas with ethnic minority dwellers, although with provincial variation.

a) Health centers and recurrent budgets

In observed upland and remote ethnic minority communes, CHC revenue comes from four sources: (i) insurance reimbursement for card holders; (ii) earnings from drug sales; (iii) budget allocation from the health care fund for the poor and ethnic minority groups at the norm of VND10,000/person/year; and (iv) commune budget. Of these four, insurance reimbursement and the health care fund for the poor and ethnic minority groups is the largest contributor. In the observed communes, the PC actually finances some of the regular CHC operational costs, usually at an established basic threshold, for electricity, water, telephone and stationery. Earnings from drug sales are minimal as only clients without health insurance pay for the medicines or special drugs not included in the health insurance list. In disadvantaged areas, out-of-pocket expenses on drugs and medical services are negligible.

The regulation calling for the “commune people’s committee to keep stock of recurrent costs of the CHC to guarantee regular funding at no less than VND10 million/year” translates into practice in a variety of ways. In accordance with the Budget Law, the state budget for health care payments to the provinces should be left entirely in the hands of the provincial People’s Council responsible for allocating funds to various sectors according to the priority of items noted on the agenda. In some places, the central budget allocated to health care is remitted directly by line channels (Son La) whereby the Finance Department allocates funds to district health offices, in turn covering CHC expenses. In this way, the budget for CHCs is more secure. The common approach however, is for the central budget to be further distributed horizontally (Dak Lak, Ninh Thuan). The funds go first to the provincial people’s committee for decisions on allocation. Proceeds are then remitted to district PCs and from there, to commune people’s committees. The commune people’s committee considers and then decides what portion of the funds should be channeled to the CHC.

Central regulations tend to restrict local management policies and budget mechanisms. Being unsure themselves, provincial leaders tend not to provide clear policy directives to lower levels officials.

b) Expenditure regulations for health centers

The observed CHCs identify high costs for meeting on-going demand for standard supplies and equipment, as much as VND15 million per year. Funding for procurement however comes from the district health center. When the need arises, CHCs will file their applications to the district center and then wait for approval, a time-consuming practice. This approach means that the CHC is entirely dependent on the jurisdiction of the district health center or commune people's committee.

CHCs complain about another regulation relating to small procurements of equipment and supplies whereby an advance payment is required before settlement by the district health centre on submission of a legitimate invoice. However, legitimate hard copy invoices are not normally available in disadvantaged areas thus hindering the reimbursement process.

“It is very difficult to purchase medical supplies here, unlike in the lowlands. You need to pay in advance with your pocket money then present a legal invoice for reimbursement. But such legal invoices are almost impossible to obtain if you only buying a few spare tools.”

(a CHC head, Son La).

Some CHCs stipulate a cap of VND50,000/ month for electricity, VND50,000/month for telephone charges, VND50,000/month for clean water and VND250,000/quarter for stationery. These expenses are paid for by the commune people's committee. These caps are viewed as too low. As discussed above, following procurement, there may be no cash remaining to pay for electricity rendering advanced technical equipment redundant. Running costs for advanced equipment, in each CHC can be as high as: electricity VND150,000-200,000/month and stationery VND250,000/month. In general, cost norms applicable to CHCs under existing national regulations are not adjusted for inflation thus contributing to the already existing funding challenges.

4.5 Health insurance and health care for the poor

a) Voluntary health insurance

Under Decision 139, all ethnic minority inhabitants of Dak Lak and Son La, are entitled to health care benefits for the poor. In Ninh Thuan, not only the ethnic minority population but also other poor people, regardless of ethnic minority origin, are eligible to receive welfare under Program 135.

Voluntary health insurance is also on-going in other provinces. Ethnic minority people who do not qualify under Program 139 may purchase health insurance on a voluntary basis. This policy does not discriminate between Kinh and ethnic minority people. However, coverage for voluntary health insurance for ethnic minority groups is limited for the following reasons:

- Instant benefits are hard to identify and therefore difficult to justify cost.
- Negative attitudes of service providers with tendency to favour out-of-pocket service users and ignore the health insured. This is very discouraging to those who might otherwise purchase voluntary health insurance.

- Preference to obtain for health care services at the provincial hospital but voluntary health insurance only allows access to district hospitals where needs may not be adequately met.
- In addition to policies on health care and insurance for the poor, under central regulations, some specific local policies have been introduced. In terms of RH, in some provinces such as Dak Lak, the health centers in the more remote districts encourage ethnic minority women to come to CHCs in an effort to avoid traditional home-based childbirth. The policy applied here is either to send district health workers to the communes to attend birth delivery or to provide ethnic minority women with a subsidy of VND20,000 to encourage their attendance at the CHC.
- Ninh Thuan subsidises meal expenses for ethnic minority inpatients from remote areas. In Central Highland provinces, with SIDA input, ethnic minority people used to receive support for travel expenses and exemption from inpatient food and lodging charges. However the SIDA program was phased out in 2009.

b) Setbacks and inconsistencies

Some health insurance regulations on payment of referral fees are viewed by health workers and ethnic minority users as too rigid and inappropriate for upland, remote and difficult access areas. For example, health insurance only covers referral transportation costs for hospital vehicles. If other means of transport are used to reach health facilities, costs are not reimbursed, even on presentation of a legitimate invoice/receipt.

“For referrals, only hospital cars are paid for. A hospital has only 1-2 ambulance vans. As this is a remote province, some districts are as far as 80 km away from the provincial center. The patients may have died waiting for the ambulance to come and take them”

(Head of a district health office, Dak Lak).

The new rules of the Ministry of Health and Health Insurance authority restrict the period of inpatient stay at the CHCs and regional clinics to a maximum two days. This means that CHCs are not inclined to retain patients who require further treatment or await delivery. Rather, patients are referred elsewhere as soon as possible. This regulation is irrational particularly for patients coming from remote and disadvantaged areas. Further, this regulation is not in compliance with criteria set out in the SM strategy whereby the new mother should be allowed to stay for 2-3 days in the CHC following birth delivery, to facilitate postnatal care.

c) Implementing challenges

Issuance of health insurance cards is slow. Sometimes, the validity of a 12-month card is reduced to 6 months by the time it is received by the user. The card must be reissued every year by law but the process is impeded by bureaucratic routines, imposing unsatisfactory delays. Respondents in the observed provinces recommend that card validity be extended to three years.

Multiple factors contribute to delays in card issuance, such as preparation at the service level, mistakes in the register including misspelling of names, wrong date of birth, place of birth and so on. These mistakes occur particularly in regions with low education levels, further compounded by printing and distribution delays. Often cardholders are not advised when the cards are available for collection.

Sometimes a claimant's card is damaged or lost. To bypass this common issue, health insurance cards are sometimes maintained at the CHC. When medical services are provided, the CHC assumes responsibility for dealing with health insurance matters. However, when patients do not have ownership of their cards they are often ignorant of applicable health insurance benefits and often less inclined to attend the CHC for medical services.

Users are required to contribute towards the costs. Sometimes, in the case of emergency care, the user must make the initial payment and seek reimbursement from their health insurer. This requirement not only makes it more difficult for ethnic minority people to access services and but also contradicts prevailing legislation.

Some CHCs (in Dak Lak) report never having received the statutory health insurance reimbursement aligned with Program 139 for birth attendance set at VND150,000/case. Without this reimbursement, CHCs require service users, whether health insured or not, to pay a portion of their childbirth costs. This lack of financial support further discourages attendance of ethnic minority women at the CHC for childbirth.

CHAPTER IV. CONCLUSIONS AND RECOMMENDATIONS

1. Conclusions

1.1 Development of policy system

In general, the Government and related ministries introduce policies with components that specifically targeting ethnic minority groups. Such consistency is apparent among policy makers (Party, National Assembly and Government) and reflected in their efforts to provide training for prospective talent, infrastructure development, resources and community support in reproductive health care. However, policy beneficiaries are not always clearly defined. In addition, some policy components are not appropriate for implementation in the relatively underdeveloped, upland areas. Inadequate attention is paid to specific issues of SM, abortion and adolescent RH in ethnic minority areas. Goals are often impractical and little attention given to lessons learned and recommendations of previous reviews and studies.

1.2 Elaboration and implementation of RH policies

Implementation and archiving of policies issued at the provincial level are unimpressive. Indeed, in all surveyed provinces, document archiving was poorly performed. At lower levels, authorities almost never adapt the policies, disseminated by higher authorities, to fit local conditions and focus only on reducing fertility with scant attention to SM targets.

In provinces with ethnic minority dwellers, the population/RH communication network does not include an Ethnic Minority Committee, thus limiting representation and access to target groups.

In implementing RH service policies, inadequate army and civilian health coordination results in reduced or, in the case of Ninh Thuan Dak Lak, complete lack of efficiency in delivery of RH care. Ironically, the mobile health care system works better in lowland Ha Nam than in the three surveyed upland provinces for which it was designed.

Monitoring and supervision of RH policy implementation remains poorly executed in both lowland and upland provinces.

1.3 Related policies

a) Salary, allowances and other benefits

Under existing policy, salary and professional allowances for health workers and medical staff working with ethnic minority people in disadvantaged areas are rated “low”. Members of mass organizations responsible for communication are not entitled to population/RH communication allowances. Regional differences are not apparent in funding support for commune population/FP communication, other than translation costs of materials into local dialects. Efforts to provide incentives and rewards to talented staff in the form of emulative titles, or in cash and kind are viewed as irrational and ineffective in targeting health workers in ethnic minority areas.

b) Human resources and training

The health workforce quota falls below that defined by the national benchmark. Policies designed to attract prospective talent are either non-existent or inconsistent. In some provinces, and

particularly in upland areas, the offer of cash bonuses or land allocation as a means of attracting human resources, have proved ineffective.

Qualified and dedicated population staff are in short supply in many provinces, particularly following structural changes in the sector. The requirement that each village should assign one PC has also proved impractical in upland and remote areas.

On-the-job training opportunities favour female ethnic minority workers from remote areas. Some challenges have emerged in relation to shortage of 'input' and the inability to keep track of 'output' after training is complete. In addition, RH in-service training and coaching often includes short-term courses with training costs paid by the host location. This system tends to preclude ethnic minority health worker access to courses due to the simple fact that relevant local authorities cannot afford trainee related costs.

c) Infrastructure, equipment and essential drugs

In respect to health, CHC infrastructure development for upland and remote communes sits high on the Government's agenda. Yet, the distribution of development funds from central to local budgets has proven inconsistent particularly for construction of CHCs in disadvantaged ethnic minority communes and many functions remain unrealized. In some cases, even a newly built CHC cannot meet the needs of potential ethnic minority users due to lack of privacy in service delivery and inadequate cooking space.

Equipment and essential drugs in CHCs are patchy and in short supply. Equipment is often accumulated from various sources and programs, exposed to considerable wear and tear and usually in need of repair. Advanced technical equipment is purchased but cannot be put into use due to lack of appropriate infrastructure (electricity) or lack of budget funds. Many mobile teams complain of a shortage of critical equipment such as clean delivery kits and suitable transport. Even when a van or car is available, the local health authority is then confronted with a limited staff quota that does not include a driver nor a budget to cover fuel and other running costs. Clean delivery kits, although rated as vital in SM programs in ethnic minority areas, are in serious short supply. Condoms and contraceptive pills are plentiful but contraceptive injectables and implants, preferred by ethnic minority users, are in constant shortage.

In comparison with medical equipment, shortage of communication equipment is even worse. Incompatibility of technical equipment encourages redundancy and the absence of ethnic minority dialects in RH/FP communication materials is of major concern.

d) Recurrent revenue and expenses

According to guidelines on income and expenditure issued by the Ministry of Health and Ministry of Finance, a CHC is typically required to have 8 key income sources and 9 expenditure lines. Survey results, however, indicate that CHCs in upland and remote areas tend to receive financial support from only 4 income sources of which health insurance and the health care fund for the poor and ethnic minority groups predominate. Contributions from the commune budget or earnings from drug sales are minimal. In the observed communes, the commune PC provides recurrent costs for the CHC, to cover electricity, water, telephone, and stationery. However, the caps are very low.

e) Health insurance and health care for the poor

Under Decision 139/2002/QĐ-TTg and Joint Circular 14/2002/TTLT-BYT-BTC, health insurance beneficiaries must be of ethnic minority background and resident in communes participating in Program 135 and the poor in mountainous areas. Establishment of a health care fund for the poor has been formalized in most provinces. Some provinces, however, define ethnic minority beneficiaries very specifically, whereas others simply call them “the poor”. Currently, and in accordance with the joint report of the Ministry of Health, fee-for-service is more often requested than compliance with the benefits of health insurance cards.

At the sub-national level, ethnic minority users ineligible for coverage under Program 135, may participate in a voluntary health insurance program. However, coverage under this program is limited as short-term interests are not easily addressed, aggravated by the poor attitudes of service providers. A general community preference for provincial hospitals prevails whereas voluntary health insurance limits card holders attendance at district hospitals for medical services.

In addition to policies of health care for the poor and health insurance provided by the central government, local governments have also introduced their own locally-designed policies.

Evidence shows that inconsistencies exist in health care policies and health insurance for the poor. The lists of technical facilities required for efficient service provision are not matched with health insurance cover. There is also a gap between the health insurance policy and the national target program for population/FP services. Contraceptives, currently paid for by the national target program for Population and FP, are not on the health insurance reimbursement list. Although users are exempted from treatment costs, they must pay for the hospital beds and other user fees. Cost norms for allowances and medical consumables under the current health insurance scheme have proven too low and therefore impractical. Consequently, many lower level health facilities without registered budgets have decided to refer their patients to higher levels for care. The rules regarding reimbursement of referral costs contained in some health insurance policies are, according to both health workers and ethnic minority users, too rigid and often irrelevant to local conditions in upland, remote areas. The reimbursement regulations of the Ministry of Health are restrictive, limiting inpatient stays at the CHCs and inter-commune clinics to a maximum two days. No options are included for retaining patients in need of additional services, even for pregnant women awaiting delivery. This has translated into poor SM performance caused by insufficient postnatal care.

Further policy inconsistencies occur in that both high and low income ethnic minority people are entitled to insurance privileges, whereas low income Kinh dwellers residing in the same areas, are not.

The free health insurance cards under Decision 139/2002/QĐ-TTg are reported to reach holders very slowly. In practice, reimbursement of health insurance is challenging due to misinformation on the data base or poor condition of the card. In some places where CHCs retain the cards on behalf of the users, few patients turn up for medical care due to misunderstandings about benefits and entitlements.

While prevailing policies and regulations specify that “the health insured under Program 135 are entirely exempted from any forms of advance payment at admission”, in practice, some health insured patients under emergency care still have to pay medical fees before claiming reimbursement from health insurance. For those giving birth at CHCs, all birth attendance costs are supposed to be covered by health insurance but, as stated in Official Dispatch 9604/BYT-BH on addressing health insurance-related issues, dated Dec. 14, 2007, “regional clinics and commune health centres in upland communes are entitled to health insurance reimbursement for

card users' actual inpatient days but not exceeding two days". For ethnic minority inpatients staying longer than two days, some CHCs charge extra expenses. This further inhibits ethnic minority women with limited economic means, from giving birth at the CHC, despite the relatively low additional cost (only VND40,000 for one week of extra stay as in some CHCs in Ninh Thuan).

1.4 Outcomes of policies

The most urgent RH issue in ethnic minority regions relates to SM. Home-based childbirth is still prevalent in remote areas for reasons that include enduring traditions and customs, distance, cost of living and transport costs. As well, ethnic minority women are reluctant to confront the often negative attitude of CHC medical staff. Postnatal care is of little concern to ethnic minority groups, adding to the gaps in SM education.

Abortion and HIV is a serious problem in Son La but relatively less so in the three other surveyed provinces. Adolescent RH remains an open-ended issue largely due capacity constraints of local health services.

2. Recommendations

2.1 Policy making

a) Policy making process

In developing new policies emphasis should be place on:

- Review and study of existing related policies of the Party, National Assembly, Government and relevant ministries to avoid overlaps or conflict;
- Establishment of feasible goals drawing on relevant survey responses; fine-tuning of existing policies, based on an evaluation of lessons
- Maximum leverage for involvement of scientists and managers;
- Promotion of participation from local services and community;
- Attention to consistency. For provinces with large numbers of ethnic minority dwellers, disadvantaged natural conditions, underdeveloped economy, low education levels, underdeveloped infrastructure, it is not easy to develop an effective stand-alone policy. In practice, without the support of other socio-economic solutions, achievement of health targets and RH goals in particular is unrealistic. As such, long-term policy solutions should be based on inte-connection and consistency.
- Implementation of RH policies in areas with large numbers of ethnic minority dwellers. For the policies to succeed, frequent changes to regulations should be avoided, since they result in unsatisfactory organizational and staff turnover.

b) Different types of policies

In addition to highlighting issues of FP and HIV, the Central Party and National Assembly should develop guidelines that ensure improved leadership performance in all RH issues concerning ethnic minority groups such as SM, adolescent RH, STIs and infertility.

c) Policy goals and responses

RH policy goals and responses should be developed for individual target groups with specific attention to upland areas and ethnic minority groups. Currently, national goals and indicators do not address regional differences. In developing preferential policies for ethnic minority groups, central budget lines should be anticipated. Cost estimates should be attached to submissions to avoid situations whereby, on paper, the policy looks perfect but in practice, provincial and district budgets cannot afford implementation costs thereby resulting at best, in partial performance.

d) Policy beneficiaries

Viet Nam is a country of multiple ethnic minority groups, some residing in the lowlands, others in remote and mountainous areas. There exists a mixture of developed and under developed economies, and high, medium and low education levels. Leverage of resources to facilitate implementation of an RH program, should therefore consider these regional differences. During the policy drafting stage, target beneficiaries should be clearly identified to ensure appropriate development of implementation measures.

2.2 Policy implementation

a) Policy enactment

Upland, poor, ethnic minority provinces face multiple challenges in leveraging local budgets. Therefore, policies that address delivery of RH to poor and ethnic minority areas should ensure early identification of potential funding to support initial implementation and on-going costs.

b) Inter-ministerial coordination

- The Party and Government at all levels should focus on inter-ministerial cooperation in the delivery of RH care and BCC to ethnic minority group at provincial and commune levels. Health insurance authorities and health service providers should cooperate in the implementation of policies concerned with delivery of RH to vulnerable ethnic minority groups.
- Central authorities should develop integrative RH policies for implementation at the district and commune levels. As a starting point, interventions should be relevant to the communities they serve, taking account of local needs. To avoid wastage, the management boards concerned with support projects should work with government at all levels to produce effective aid resource plans.
- The Ethnic Minority Committee should be invited to contribute to the RH communication network.

c) Monitoring and evaluation

Monitoring and evaluation should identify drawbacks in policies, such as infeasible goals, gaps, conflicts etc., to ensure timely correction and amendments as appropriate. As such, when a policy is enacted, clear guidelines should be provided not just on monitoring and evaluation, but also on staff responsibilities and funding sources.

2.3 RH-related perspectives in policies

a) Salary and allowances

- Salaries for health workers in upland and remote areas should be increased in line with inflation, and allowance levels equalized with the education sector.
- Night duty allowances for health workers should be increased from the current VND10,000/person per shift to a more acceptable amount.
- Decision 75/2009/QĐ-TTg, May 11, 2009, of the Prime Minister, providing allowance levels for village health workers (VHW) should be implemented as soon as possible. Under this Decision, from July 1, 2009, the monthly allowance is designated 0.5 and 0.3 times the common minimum salary. More specifically, the 0.5 multiplier is applicable for VHWs in disadvantaged communes under Decision 30/2007/QĐ-TTg, dated Mar. 5, 2007 of the Prime Minister.
- Incentives should be introduced that encourage staff involvement in the promotion of childbirth at health centers in the form of cash bonuses (VND50,000-100,000) for each health worker who successfully persuades women to use the health services. A similar bonus should be applied to sterilization and birth control promoters.
- The budget for translation of communication materials to ethnic minority dialects should be increased. The current VND70,000/day for translation costs associated with a broadcasting session, is inadequate.
- Travel allowances that include remuneration for accommodation and transport costs should be adjusted upwards for CHC staff on missions to the villages, to encourage dedication of village health workers at the community level.
- Incentives should be offered to health workers, especially those of ethnic minority background, to support delivery of health services to ethnic minority groups. In addition to staff training, effective implementation of RH policies for ethnic minority groups depends on VHWs and CHWs returning home to serve their own village people. In this regard, more attention should be paid to financial and other incentives for medical staff responsible for providing services to ethnic minority groups. Not only should training place emphasis on clinical quality and human resource management but also on morals, ethics and attitudes.
- Compensation for PCs, VHWs, village midwives and allowances for community-based health workers should be clearly defined in remuneration schemes relevant to specific assignments. More attention should be paid to raising competence levels during facilitator training, especially in regard to ethnic minority facilitators.

b) Staff quotas

- Official staff quota legislations should take into account region-specific ratio and population size. The number and workload of programs and other tasks should be taken into consideration, particularly in terms of CHC workforce.
- Higher staff quotas should be established for the provincial preventive health centre, reproductive health centre, health education centre, HIV centre, population administration

branch, and district population/FP centre to promote delivery of RH care in remote areas. RH mobile teams located in district and provincial health centres, should be assured of adequate and formalised staff quotas (including a driver).

- Evaluation of Project 1916 on staff rotation is pending, and should include appropriate adjustments to local conditions, particularly in ethnic minority areas.

c) Training and in-service training

- Training programs and strategies should ensure targets are appropriate to different regions.
- In-service training for ethnic minority workers in delivery of RH care should be increased. Training should be upgraded to include more consistent strategies and skills, both in theory and practice. Training topics related to RH performance should be adaptable to the specific role and mandates of health workers at all levels. Additionally, there should be focus on more regular supply and training of ethnic minority health workers and midwives. The two major strengths of ethnic minority participants are familiarity with local customs and ability to communicate in local dialects.
- Current on-the-job training programs should focus more on management issues and avoid meaningless outputs. On-the-job training programs should be based on cooperation between the health and education sectors and ensure secure regular input of ethnic minority trainees. As a starting point relevant RH information should be included in the general education curriculum provided in boarding schools.
- An evaluation should be conducted on the existing village midwife training program to identify areas of expansion and improvement.
- Communicators require training and access to updated materials. Currently, apart from population facilitators, VHWs, members of the general public, village patriarchs and heads are involved in this operation. The skills of these advocates should be promoted to enhance communication outcomes.

d) Staff rotation

Staff rotation should occur not just from lower levels upwards but also from higher levels downwards. Rotation of health workers from commune to district levels, provides only limited opportunities to upgrade professional competence whereas a top-down rotation (district, province) approach exposes service users to experienced professionals.

e) Infrastructure, equipment and essential drugs

- Building of CHCs and development of associated infrastructure should be conducted in tandem, taking into account the needs of ethnic minority groups. In achieving these goals, mobilisation of funds is a key requirement and local governments should identify ways to keep pace with central funding. Where local governments are in difficulty, financial solutions such as access to subsidies and loans should be applied.
- Procurement of medical equipment should be coordinated, with attention to local infrastructure conditions to avoid wastage and equipment incompatibility. Adequate supplies of clean delivery kits and RH drugs should always be available.

- Provision of family planning services should be based on the specific needs of ethnic minority users. Contraceptive injections and implants should be proportionally higher than other contraceptive methods in ethnic minority communities.
- Procurement of population/RH, FP communication equipment should be a coordinated process. Communication materials should be offered in local dialects with more focus on issues of SM, population and development.

f) Recurrent income and CHC expenditure

- Commune PCs should set aside recurrent budgets for the CHC, that guarantee “no less than VND10 million a year”, and increase caps for electricity, water, telephone and stationery to at least twice current levels and thereafter incrementally in line with inflation.
- The CHC should be accorded greater autonomy in matters of expenditure. Use of legal invoices in settlement of payment needs should be rescinded for relatively low cost CHC procurements in upland and remote areas.

2.4 Service provision models

a) Necessity for mobile health care teams in RH delivery to ethnic minority areas

For practical purposes, the regular RH mobile team model for ethnic minority groups should include the following deliverables:

- The size of the team, should ensure capacity to cope with regular service demand as defined by the province. In addition to staff size, other regulations should be instigated to cover travel allowances and staff rotation.
- In terms of equipment, mobile teams should be well equipped with the means of transport, appropriate medical equipment and supplies. Norms should be clearly defined for consumables such as fuel, oil and medicines. With this input, mobile clinics should be well placed to provide good quality home-based services and emergency care.
- Once the mobile team has been set up, work schedules should be disseminated to the community on a regular basis to ensure users are informed when to expect services. The mobile team should be equipped to travel to every village and not only to commune level.

b) CHC model for visiting households to deliver RH care to ethnic minority groups.

If this model is to work, it should ensure:

- Adequate investment in CHC infrastructure, medical equipment, drug supply and human resources.
- In locations more than 5 kms from a CHC, sub-centers should be developed. These sub-centres should be properly equipped and connected to available infrastructure that meets the demands of ethnic minority groups. These sub-centres would replace the existing “empty” houses.

- The two-way staff rotation approach should be adopted to ensure well qualified physicians are in place to delivery health services. Provincial and district health workers should be encouraged to provide hands-on coaching to commune colleagues.
- Telephone communication should be more readily available to facilitate home-based health care for ethnic minority users, especially in case of childbirth and emergency calls.
- Living and transport allowances and medical equipment norms should be clearly defined to facilitate delivery of health services to remote areas.
- Village midwives already visit ethnic minority households, especially in remote areas, to provide prenatal checkups and assist with birth delivery. This successful home-based model should be expanded to include counseling and childbirth support.

c) Village midwife and traditional midwife model

Findings indicate that the village midwife model has proven relatively successful in training VHWs in normal childbirth procedures. This model has proven particularly effective in the three surveyed provinces with large numbers of ethnic minority dwellers. However, at the completion of training when the midwives return to their home villages, they should be guaranteed employment in the health workforce and paid reasonable monthly wages. If not, the trainees will likely forget what they have learnt over time, causing unnecessary waste of human resources.

d) Development of private health care in RH service provision

In the current open door economy, expansion of private health care all over the country is underway. The benefits of this system should include ethnic minority groups by providing more opportunities to choose services appropriate to need. Health insurance reimbursement standards should be set for all types of services, including FP, and legislation enacted to ensure ethnic minority user access to health insurance cover whether attending a public or private facility.

2.5 Communication models

a) What to communicate in ethnic minority areas

Special attention should be given to dissemination of the national guidelines on RH services to all health workers involved in RH delivery in the districts and communes. More BCC training should be offered to health workers at all levels to improve not only skills and service provision generally but also better understanding of and attitudes towards ethnic minority clients. There should be more education opportunities for ethnic minority groups on SM (health care before, during and after delivery), prevention of STIs/HIV and fighting stigma against people with HIV, especially in provinces with large numbers of HIV victims and adolescent RH issues.

b) Communication means and methods

- Developing communication materials should take into account the opinions of prospective beneficiaries. Communication materials should be lively in content focusing on illustrations rather than words to accommodate those ethnic minority people unfamiliar with the Vietnamese language, whether reading, writing or speaking. More RH communication films/videos should be produced. RH communication should be integrated with community activities, such as festivals, special market gatherings (“love

market”, spring festivals etc.). There should be more broadcasts over the commune communication system particularly in concentrated ethnic minority residential areas.

- Communication staff training should focus more on ethnic minority groups, upgrading knowledge and skills. Communication staff should receive salaries and allowances commensurate with their tasks.

2.6 Encouragement of service users

a) Improvement of service quality

- The service quality at health facilities should be improved and upgraded. More specifically, there should be increased investment in infrastructure (health centers, hospitals) and equipment. Staff training should be well planned and based on a formal curriculum. Besides medical services, good management of the communication network also plays a positive role in encouraging the community to use RH services.
- Supply of essential drugs should be adequate and up-to-date, to attract more regular CHC attendance of local ethnic minority residents.
- As part of the training in clinical skills and medical ethics, health workers should develop a more polite attitude towards clients, particularly from ethnic minority backgrounds.

b) More advocacy and promotion

- VHWs play a vital and direct role in RH advocacy and promotion and should encourage ethnic minority residents to use RH services at health centers.
- Some ethnic minority groups maintain the habit of home-based childbirth, a cultural and sometimes adverse trend already highlighted and discussed in previous studies. Making changes to enduring traditions is a daunting task that cannot be achieved overnight. Rather, education program should be adapted to the needs of individual ethnic minority groups in explaining and promoting the wisdom of RH care and BCC.

c) Health insurance and RH services

Ethnic minority respondents voiced concerns about medical referrals and health insurance reimbursements asking how these could be better designed to provide convenient and quality services. Health insurance is available for all ethnic minority groups regardless of economic status. However, not all RH services are covered by health insurance due to the existence of other support programs. Whenever applicable, such programs should be combined with the government health insurance scheme to ensure reimbursement eligibility for all RH services.

d) User fee exemption, relief and support for non-health insurance drug costs

- Ethnic minority users, especially the poor, are often unable to pay for medical costs arising from uninsured RH services. Exemption from the entire range of user fees, or perhaps providing more support to care givers, should help to reduce the incidence of home-based childbirth among ethnic minority groups.

- Meal allowance support for inpatients should be applied at all levels of care. Current discriminatory measures only allow meal allowances to inpatients in district health facilities but not CHCs. This situation encourages users to bypass service levels.
- Financial support for users seeking birth attendance at CHCs should be clarified in official policies, under a separate budget. The current lump sum approach of “leaving it up to the facility’s budget” causes implementation difficulties.
- To attract ethnic minority users to the CHC especially for FP services, financial support should be provided to allow extension of stay as needed. Transport costs for clients coming from remote areas should also be subsidized.

2.7 Inter-ministerial coordination

Different mass organizations, including the Central Ethnic Minority Committee and upland Ethnic Minority Committees should be invited to collaborate in provincial matters regarding the implementation of RH policies for ethnic minority groups.

2.8 Other recommendations

a) Gender of service providers

For ethnic minority people, the gender of the service provider is of particular concern. In matters of obstetrics, gynecology and FP, female health workers are clearly preferred by ethnic minority women. This preference should be taken into consideration when nominating participants for training programmes.

b) Service providers in ethnic minority areas should be have ethnic minority background

Health workers/ RH clinical service providers, in addition to delivery of medical services, should develop counseling skills. The differences in language, traditions and customs of service providers discourage ethnic minority attendance at health clinics. To counter this situation, on-the-spot training should be offered to ethnic minority health workers.

c) Provision of clean birth packs

In remote areas where women are more inclined to choose home-based childbirth, provision of clean delivery kits should be mandatory, supported by instructions on hygiene and safety.

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APPENDIX: REVIEWED LEGISLATIONS

No.	Ref. No.	Date of issuance	Title
I. PARTY			
1	160 – TB/TW	4/6/2008	Notice 160 – TB/TW, dated June 4, 2008, of the Central Executive Committee on the conclusions of the Party Secretariat on the implementation of population/FP policies and some urgent responses
2	54-CT/TW	30/11/2005	Directive of the Secretariat on strengthening leadership in HIV prevention and control in the new context
3	47-NQ/TW	22/3/2005	Resolution 47-NQ/TW, dated Mar. 22, 2005, of the Central Executive Committee on continued strengthening implementation of population/FP policies
4			Implementing guideline for Resolution 47-NQ/TW of the Politburo on continued strengthening implementation of population/FP policies
5	46-NQ/TW	23/02/2005	Politburo’s Resolution on protection, care and improvement of public health in the new context
6	49-CT/TW	21/02/2005	Directive of the Secretariat on family building in the era of industrialization and modernization
7	06-CT/TW	22/01/2002	Directive on consolidation and fine-tuning of the community health network
8	04-NQ/HNTW	14/1/1993	Resolution 04-NQ/HNTW, dated Jan. 14, 1993 of the 4 th meeting of the Central Party Executive Committee, 7 th term, on pressing issues in public health care and protection
9	04-NQ/HNTW	14/1/1993	Resolution 04-NQ/HNTW, dated Jan. 14, 1993, of the 4 th meeting of the Central Party Executive Committee, 7 th term, on population/FP policies
II. NATIONAL ASSEMBLY			
10	64/2006/QH11	12/7/2006	HIV Control Law
11	25/2004/QH11	15/6/2004	Law on protection, care and education of children No. 25/2004/QH11, dated June 15, 2004
12	06/2003/PL-	9/1/2003	Population Ordinance

No.	Ref. No.	Date of issuance	Title
	UBTVQH11		
13	Không số	15/04/ 1992	Constitution of 1992
14	57LCT/HĐNN8	16/08/1991	Law on protection, care and education of children
15	Không số	30/06/1989	Public Health Protection Law
III. GOVERNMENT			
16	38/QĐ-TTg	08/01/2008	Decision 38/QĐ-TTg, on coordination in prevention and control of cross-border HIV infections, of the Prime Minister
17	20-2008/ QĐ-TTg	22/02/2008	Decision 20-2008/ QĐ-TTg, approving the master plan for the development of the medical services network by 2010 and vision by 2020
18	1042/QĐ-TTg	14/11/2007	Decision 1042/QĐ-TTg, dated Nov. 14, 2007, approving the proposal for support in development of district level preventive health centers, 2007-2010.
19	1544/QĐ-TTg	14/11/2007	Decision 1544/QĐ-TTg, dated Nov. 14, 2007, approving the proposal for health workforce training for disadvantaged and upland areas in Northern, Central, Mekong River delta and Central Highland provinces
20	170-2007/QĐ-TTg	8/11/2007	Decision 170-2007/QĐ-TTg, dated Nov. 8, 2007, approving the national target program on population and FP for 2006-2010
21	34-2007/QĐ-TTg	26/09/2007	Decision 34-2007/QĐ-TTg, dated Sep. 26, 2007, approving the national action plan on HIV infection for 2007-2010
22	950/QĐ-TTg	27/07/2007	Decision 950/QĐ-TTg, dated July 27, 2007, on construction of commune health centers in disadvantaged areas for 2008-2010
23	108-2007/QĐ-TTg	17/07/2007	Decision 108-2007/QĐ-TTg, dated July 17, 2007, approving the national target program on prevention and control of social diseases, dangerous epidemics and HIV for 2006-2010
24	96/2007/QĐ-TTg	28/06/2007	Decision 96/2007/QĐ-TTg, dated June 28, 2007, of the Prime Minister on management, care, counselling and treatment of HIV infected people and prevention of HIV infection at educational institutions, correctional schools, curative facilities, social protection facilities, penitentiaries, temporary

No.	Ref. No.	Date of issuance	Title
			custody facilities
25	108/2007/NĐ-CP	26/06/2007	Decree 108/2007/NĐ-CP, dated June 26, 2007 providing details for selected aspects of prevention and control of human immunodeficiency virus (HIV)
26	13/2007/CT-TTG	6/6/2007	Directive 13/2007/CT-TTG, dated June 6, 2007, of the Government's action plan for implementing Decree 47-NQ/TW, dated Mar. 22, 2005, of the Politburo on continued strengthening the implementation of population and family planning policies
27	60/2007/QĐ-TTg	07/05/2007	Decision 60/2007/QĐ-TTg, dated May 7, 2007, of the Prime Minister, on the establishment of the support fund for people with HIV
28	153/2006/QĐ-TTg	30/6/2006	Decision 153/2006/QĐ-TTg, dated June 30, 2006 of the Prime Minister, approving the master plan for the health system in Vietnam by 2010 and vision by 2020
29	240-2006/QĐ-TTg	25/10/2006	Decision 240-2006/QĐ-TTg, on implementation of voluntary health insurance for Population/Family/Children workers in communes and towns
30	34/2006/QĐ-TTg	8/2/2006	Decision 34/2006/QĐ-TTg, dated Feb. 8, 2006, of the Prime Minister, on approval of the proposal for training and refresher training of commune and town state employees of ethnic minority origin
31	09/2006/QĐ-TTg	10/1/2006	Decision 09/2006/QĐ-TTg, dated Jan. 10, 2006 of the Prime Minister, issuing the Government's action plan implementing Resolution 47-NQ/TW, dated Mar. 22, 2005 of the Politburo on continued strengthening the implementation of population and family planning policies
32	313/2005/QĐ-TTg	02/12/2005	Decision 313/2005/QĐ-TTg, dated Dec. 2, 2005, of the Prime Minister on benefits of HIV infected people and those direct in charge of the management, treatment and care of people with HIV in public social protection facilities
33	253/2005/QĐ-TTg	05/10/2005	Prime Minister's Decision 253/2005/QĐ-TTg, dated Oct. 5, 2005, issuing the Government's action plan implementing Resolution 46/NQ-

No.	Ref. No.	Date of issuance	Title
			TW, dated Feb. 23, 2005, of the Politburo on public health protection, care and improvement in the new context
34	225/2005/QĐ-TTg	15/9/2005	Prime Minister's Decision QĐ 225/2005/QĐ-TTg, dated Sep. 15, 2005, on approval of the proposal for upgrade of district hospitals and inter-commune general hospitals for 2005-2010
35	106/2005/QĐ-TTG	16/05/2005	Decision 106/2005/QĐ-TTG, dated May 16, 2005, of the Government on approval of the strategy for family building in Vietnam for 2005 – 2010
36	65/2005/QĐ-TTg	25/03/2005	Decision 65/2005/QĐ-TTg, dated Mar. 25, 2005, of the Prime Minister on approval of the proposal for “Community-based care of unattended orphans, deserted children, seriously disabled children, children who are victims of chemical toxins and children with HIV for 2005-2010”.
37	36/2004/QĐ-TTg	17/3/2004	Prime Minister's Decision 136/2004/QĐ-TTg, dated Mar. 17, 2004, on the approval of the national strategy on HIV control in Vietnam by 2010 and vision by 2020
38	19/2004/QĐ-TTg	12/02/2004	Decision 19/2004/QĐ-TTg, dated Feb. 12, 2004, of the Prime Minister on the approval of the program on prevention and alleviation of homeless, sexually abused children and children in hard, toxic and hazardous labor, 2004-2010
39	265/2003/QĐ-TTg	16/12/2003	Prime Minister's Decision 265/2003/QĐ-TTg, dated Dec. 16, 2003, on benefits for people exposed to HIV or HIV by accident at work
40	104/2003/NĐ-CP	16/09/2003	Decree 104/2003/NĐ-CP, dated Sep. 16, 2003, of the Government, providing implementation details for selected Articles of the Population Ordinance
41	155/2003/QĐ-TTg	30/7/2003	Prime Minister's Decision 155/2003/QĐ-TTg, dated July 30, 2003, amending some special allowances for health workers

No.	Ref. No.	Date of issuance	Title
42	02/2003/CT-TTg	24/02/2003	Prime Minister's Directive 02/2003/CT-TTg, dated Feb. 24, 2003, on strengthening HIV control
43	139/2002/QĐ-TTg	15/10/2002	Prime Minister's Decision 139/2002/QĐ-TTg, dated Oct. 15, 2002, on issuance of the regulations on delivery of medical services to the poor
44	18/2002/QĐ-TTg	21/01/2002	Prime Minister's Decision 18/2002/QĐ-TTg, dated Jan. 21, 2002, approving the national target program on population and family planning by 2005
45	190/2001/QĐ-TTg	13/12/2001	Prime Minister's Decision 190/2001/QĐ-TTg, dated Dec. 13, 2001, on approval of the national target program on prevention and control of some social diseases, dangerous epidemics and HIV, 2001-2005
46	1026//QĐ-TTg	10/8/2001	Prime Minister's Decision 1026/QĐ-TTg, dated Aug. 10, 2001 on approval of the army – civil health coordination in protection and care of public health and for security purposes, 2001-2010
47	10/2001/CT-TTg	04/05/2001	Directive 10/2001/CT-TTg, May 4, 2001, on implementing the population strategy in Vietnam for 2001-2010
48	35/2001/QĐ-TTg	19/03/2001	Prime Minister's Decision 35/2001/QĐ-TTg, Mar. 19, 2001, approving the national strategy on reproductive health for 2001 – 2010
49	147/2000/QĐ-TTg	22/12/2000	Decision 147/2000/QĐ-TTg, Dec. 22, 2000, approving the population strategy for Vietnam, 2001-2010
50	136/2000/QĐ-TTg	28/11/2000	Prime Minister's Decision 136/228, 2000, approving the “National Strategy on Reproductive health, 2001-2010”
51	186/2001/TTg	7/12/2001	Decision 186/2001/TTg, Dec. 7, 2001, for 6 provinces of extreme conditions in the northern uplands
52	168/2001/TTg	30/12/2001	Decision 168/2001/TTg, Dec. 30, 2001, for 4 Central Highland provinces
53	243/2005/QĐ-TTg	05/10/2005	Decision 243/2005/QĐ-TTg, for upland, remote, border, island areas
54	647/QĐ-TTg	12/7/2000	Prime Minister's Decision 647/QĐ-TTg, July

No.	Ref. No.	Date of issuance	Title
			12, 2000, for communes of extreme conditions in upland and remote areas
55	42/2001/QĐ-TTg	26/3/2001	Prime Minister's Decision 42/2001/QĐ-TTg, Mar. 26, 2001, for communes of extreme conditions in upland, border and remote ethnic minority areas
IV. MINISTRY OF HEALTH			
56	05/2008/TT-BYT	14/5/2008	Ministry of Health Circular 05/2008/TT-BYT, May 14, 2008, specifying roles, mandates and organization of the population/FP system at sub-national levels
57	06/CT-BYT	7/12/2006	Ministry of Health Directive 06/CT-BYT, Dec. 7, 2006, on improving the quality of medical services for the community
58	34-2007/QĐ-BYT	29/09/2007	Decision 34-2007/QĐ-BYT, Sep. 29, 2007, on approval of the national action plan for alleviation interventions in HIV infection prevention for 2007-2010
59	06-2007/CT-BYT	07/12/2007	Directive 06-2007/CT-BYT, on improving the quality of medical services for the community
60	16-2007/QĐ-BYT	01/02/2007	Decision 16-2007/QĐ-BYT, Feb. 1, 2007, approving the national action plan on HIV control behavioral information, education and communication by 2010
61	07/QĐ-BYT	19/1/2007	Decision 07/QĐ-BYT, Jan. 19, 2007, on approval of the national program on support and care of people with HIV by 2010
62	08/2007/QĐ-BYT	19/1/2007	Decision 08/2007/QĐ-BYT, Jan. 19, 2007, of the Minister of Health on approval of the action plan for HIV program monitoring and evaluation
63	03/2007/QĐ-BYT	15/1/2007	Decision 03/2007/QĐ-BYT, Jan. 15, 2007, of the Minister of Health on approval of the program for prevention and control of sexually infected diseases by 2010
64	04-2007/QĐ-BYT	15/01/2007	Decision 04-2007/QĐ-BYT, Jan. 15, 2007, of the Minister of Health on approval of the monitoring and evaluation checklist for the national HIV control program
65	34/2006/QĐ-BYT	31/10/2006	Minister of Health's Decision 34/2006/QĐ-BYT, dated Oct. 31, 2006, on issuance of regulations on essential drugs and consumables in FP surgical procedures and

No.	Ref. No.	Date of issuance	Title
			safe abortion
66	20-2006/QĐ-BYT	07/7/2006	Decision 20-2006/QĐ-BYT, July 7, 2006, of the Minister of Health on approval of the national action plan on HIV mother-to-child transmission prevention, 2006-2010
67	06-2006/CT-BYT	14/6/2006	Directive 06-2006/CT-BYT, June 4, 2006, of the Minister of Health on health workforce training quality assurance
68	2010/QĐ-BYT	7/6/2006	Decision 2010/QĐ-BYT, June 7, 2006, of the Minister of Health on issuance of the national comprehensive plan on protection, care and improvement of adolescent and youth health by 2010 and vision by 2020
69	CV 9526/BYT-KH-TC	21/11/2005	Interministerial Official Dispatch CV 9526/BYT-KH-TC, Nov. 21, 2005, addressing provincial/municipal PCs on implementing the proposal for upgrade of the province and district health systems in 2006
70	26/2005/QĐ-BYT	9/9/2005	Decision 26/2005/QĐ-BYT, Sep. 9, 2005, of the Minister of Health on "issuing provisions on the role, authority and organization of district, town, provincial city preventive health centers"
71	25/2005/QĐ-BYT	05/09/2005	Decision 25/2005/QĐ-BYT, dated Sep. 5, 2005 of the Minister of Health on "issuing provisions on the role, mandates, authority and organization of provincial/central municipal HIV control centers"
72	3526/2004/QĐ-BYT	06/10/2004	Minister of Health's Decision 3526/2004/QĐ-BYT, Oct. 6, 2004, approving the action plan on health education by 2010
73	1020/QĐ-BYT	22/3/2004	Decision 1020/QĐ-BYT, dated Mar. 22, 2004, of the Minister of Health, issuing revised provisions on equipment of province and district general hospitals, inter-commune clinics, commune health centers and village health bags, attached to Decision 437/QĐ-BYT
74	3367/QĐ-BYT	12/9/2003	Decision 3367/QĐ-BYT, Sep. 12, 2003, of the Minister of Health on issuance of national guidelines on RH services
75	05/CT-BYT	22/5/2002	Directive 05/CT-BYT, May 22, 2002, of the Minister of Health on implementing the national RH strategy for 2001-2010

No.	Ref. No.	Date of issuance	Title
76	437/QĐ-BYT	20/2/2002	Decision 437/QĐ-BYT, Feb. 20, 2002 of the Minister of Health issuing the medical equipment list for province, district general hospitals, inter-commune clinics, commune health centers and village health bags
77	3519/QĐ-BYT	11/10/2000	Decision 3519/QĐ-BYT, Oct. 11, 2000, of the Minister of Health issuing guidelines on diagnosis and emergency management of 5 obstetric complications
78	370/2002/QĐ-BYT	07/02/2002	Decision 370/2002/QĐ-BYT, Feb. 7, 2002, of the Minister of Health issuing the “National benchmarks for commune health for 2001-2010”
79	32/2006/QĐ-BYT	5/10/2006	Decision 32/2006/QĐ-BYT, of the Minister of Health issuing the regulations on recruitment of state employees in public services attributed to the Ministry of Health by candidate selection
V. POPULATION, FAMILY, CHILDREN COMMITTEE			
80	03/QĐ-DSGĐTE	16/7/07	Decision 03/QĐ-DSGĐTE, July 16, 2007, of the Minister, head of the Committee for Population, Family and children on issuance of the HIV control action plan of the population, family and children sector by 2010
81	351/QĐ-DSGĐTE	13/7/2007	Decision 351/QĐ-DSGĐTE, July 13, 2007, of the Population, Family, Children Committee, approving the action plan for 2007 for implementing the project “Improving the quality of the population through advocacy, promotion for early detection and intervention of fetus and infant disorders and diseases in provinces and cities”
82	624/QĐ-DSGĐTE	28/12/2006	Decision 624/QĐ-DSGĐTE, Dec. 28, 2006, of the Minister, head of the Committee for Population, Family and children on issuance of the proposal on socialization of population, family and children activities by 2010
83	01/2006/QĐUBD SGTĐTE	17/4/2006	Decision 01/2006/QĐUBD SGTĐTE, Apr. 17, 2006, of the Minister, head of the Committee for Population, Family and children issuing the strategy for population/RH/FP behavioural change communication strategy for 2006-2010

No.	Ref. No.	Date of issuance	Title
84	548/QĐ-DSGĐTE	14/10/2004	Decision 548/QĐ-DSGĐTE, Oct. 14, 2004, of the Minister, head of the Committee for Population, Family and children, on development of the premarital check-up and counselling model for 2006-2010
85	03/2001/QĐ-UB	20/7/2001	Decision 03/2001/QĐ-UB, dated July 20, 2001, of the Minister, head of the Committee for Population, Family and children, issuing the strategy for population/RH/FP behavioural change communication strategy for 2001-2005
VI. INTER-MINISTERIAL LEGISLATIONS			
86	32-2008/TTLT-BTC-BYT	17/04/2008	Circular 32-2008/TTLT-BTC-BYT, Apr. 17, 2008, guiding management and use of funding in implementing the national target program on population and FP for 2006-2010
87	147-2007/TTLT-BTC-BYT	12/12/2007	Joint Circular 147-2007/TTLT-BTC-BYT, guiding the management of funding in implementing the national target program for prevention and control of some social diseases, dangerous epidemics and HIV for 2006-2010
88	12 -2007/TTLT-BYT-BTC	19/11/2007	Joint Circular 12 - 2007/TTLT-BYT-BTC, Nov. 19, 2007, guiding financial management for medicines and medical equipment in the US President's emergency aid program (PEPFAR) for HIV control
89	08/2007/TTLT-BYT-BNV	5/6/2007	Joint Circular 08/2007/TTLT-BYT-BNV, June 5, 2007, issuing guidelines on staff quota in public health services
90	02-2006/TTLT-UBDSGĐTE-BYT	26/12/2006	Joint Circular 02-2006/TTLT-UBDSGĐTE-BYT, Dec. 26, 2006, guiding the strengthening of RH/FP integrated advocacy and communication in populous, high fertility and disadvantaged areas
91	88/2005/TTLT-BTC-BYT	11/10/2005	Joint Circular 88/2005/TTLT-BTC-BYT, Oct. 11, 2005, guiding financial management and cost norms for the "HIV control project in Vietnam" using World Bank non-refundable aid
92	10/2005/TTLT-BYT-BTC	30/03/2005	Joint Circular implementing Decision 265/2003/QĐ-TTg, Dec. 16, 2003, of the Prime Minister, on benefits for those exposed to HIV or infected with HIV by accident at

No.	Ref. No.	Date of issuance	Title
			work
93	119/TTLT-BTC-BYT	27/12/2002	Joint Circular 119/TTLT-BTC-BYT, Dec. 27, 2002, issuing guidelines on income, expense and recurrent costs of commune health centers
94	14/2002/TTLT-BYT-BTC	16/12/2002	Circular 14/2003/TTLT-BYT-BTC, Dec. 26, 2002 of the Ministry of Health – Ministry of Finance, issuing guidelines on delivery of medical services and establishment, management, use and settlement filing for the health care fund for the poor under Decision 139/2002/QĐ-TTg
95	105/2002/TTLT-BTC-BYT	20/11/2002	Joint Circular of the Ministry of Finance – Ministry of Health 105/2002/TTLT-BTC-BYT, Nov. 20, 2002, complementing Joint Circular 51/2002/TTLT-BTC-BYT, June 3, 2002, guiding the specifics and cost norms for the national target program for prevention and control of some social diseases, dangerous epidemics and HIV
96	95/2002/TTLT-BTC-UBDSGDTE	22/10/2002	Joint Circular 95/2002/TTLT-BTC-UBDSGDTE, Oct. 22, 2002, of the Ministry of Finance and the Population, Family, Children Committee, guiding the specifics and cost norms of the national target program for population and FP
97	51/2002/TTLT-BTC-BYT	03/06/2002	Joint Circular 51/2002/TTLT-BTC-BYT, June 3, 2002, guiding the specifics and cost norms of the national target program for prevention and control of some social diseases, dangerous epidemics and HIV
98	06/2007/TTLT-BYT-BTC	30/03/2007	Joint Circular 06/2007/TTLT-BYT-BTC, guiding <u>implementation</u> of voluntary health insurance

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