

Community Disease Control (CDC) and Reproductive Health from a Gender Perspective in Vietnam

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Introduction

This report aims to give an overall assessment of the state of Community Disease Control (CDC) and reproductive health from a gender perspective. It will attempt to draw out issues related to major communicable diseases that are gender-specific, and how the specific difficulties in women's access to the health system in general impact on CDC and reproductive health.

In general, while there are a number of specific issues related to various communicable diseases, the gender issues they have in common are more obvious, related to problems of women's access to the health system overall. These include issues of distance, cost, quality of care at the most convenient level (ie the commune), patriarchal expectations of women etc, alongside many aspects of women's traditional caring role and traditional role of being responsible for children's welfare.

As it is poorer and more disadvantaged women and communities who have the most access problems, there will be a focus on the situation of ethnic minorities, who are overall the poorest sector of Vietnamese society, and who also largely occupy the most difficult and remote mountainous terrain. In addition, these areas are largely regions bordering China, Laos or Cambodia, thus connected to issues of cross-border disease transmission. Given these Vietnamese realities, in many respects 'the poor', 'ethnic minorities', 'people living in remote and mountainous areas' and those 'living in border regions' are largely the same people, which simplifies matters. Throughout the report, where there are no specific ethnic minority indicators, those indicators referring in particular to the Northern Mountains (NM) and the Central Highlands (CH) should be largely interpreted as ethnic minority indicators. To some extent this also applies to parts of the Mekong Delta (MD) where the Khmer minority lives.

At the same time, it is necessary to remember that there are serious pockets of poverty among

sections of the Kinh (ethnic Vietnamese majority) population and the populations of the deltas and plains. For example, parts of the North Central (NC) coastal region suffer from very poor soils, resulting in significant poverty, even though the remoteness and lack of access to services characterising the mountainous regions is largely absent. This is also a region bordering Laos. Parts of the Kinh population of the south Central Coast (CC) and the Mekong are also quite poor, and the border issues in the Mekong affect the Kinh as well as Khmer. In addition, the northernmost strip of coast north of Hai Phong is a major transit to China and is greatly affected by cross-border disease control issues. However, overall the situation in these regions is far better than in the NM and CH (an Appendix at the end of the report summarises background information on the main regions of Vietnam, their poverty levels and ethnic composition, the main ethnic groups, and the mountainous and border regions).

Finally, the report aims to examine government policy in relation to gender specific issues related to CDC and reproductive health and identify strengths and weaknesses according to experts in the field in Vietnam.

Vietnam's Health System

Vietnam has a well-developed health infrastructure with over 10,000 commune health centres (CHC's), each serving 8000 people, and approximately 850 state hospitals employing 27000 doctors and 46000 assistant doctors (WHO, 2003A). Almost all communes have a CHC, with an average of four health workers. Over 30 percent of CHCs are staffed with a medical doctor and 82 percent with at least a mid-wife or an obstetric-pediatric assistant doctor; 52 percent of all villages have a community health worker (NCAW, 2000). According to the Joint Donor Report, "Vietnam's health success is to a large extent based on its wide net of commune health stations. About 96,604 health staff are working in 116,359 villages nationally, and only 1.4 percent of communes lack a medical station" (Joint Donor Report, 2004).

Except in remote areas, health care services for women and children are generally available. Health care workers have been trained in basic health care to serve women's health needs and are able to provide essential obstetric care and safe motherhood services (NCAW, 2000)

The Vietnamese Women's Union (VWU) plays a key role in cooperation with the Ministry of Health (MOH) in taking health and social campaigns and programs to women at all levels, right down to the smallest village level. However, while some VWU staff are paid at higher levels, at the village level it relies on volunteers. Every year, the VWU organises training for officials at provincial and district levels regarding gender issues, and people at these levels then train local officials. The VWU itself plays a very big role in reproductive health and other basic preventative health campaigns.

Access Issues

However, not all regions and social groups benefit equally - poor women, ethnic minority women and women in remote and mountainous areas still face difficulties accessing health services.

Some of the reasons include fees for health service, poor implementation of fee exemption policies, unequal budget allocation between regions, the lower quality of services at the CHC level (the level most accessible by women) due to budget constraints, and deficiencies of qualified staff, equipment and supplies.

Fees impact far more heavily in the poor, and often drive them to purchase drugs without prescription from local outlets, and care provided in the home mainly by women. Not all services cost money. In particular, a wide range of reproductive services, including antenatal examinations,

family planning services, contraception (including dealing with side-effects) and vaccination are free, as are the targeted child immunisations against the seven major infectious diseases, and other treatment for target diseases such as TB.

For services which require payment, the question of how much is not at all clear from the literature. Speaking to people from Ninh Binh and Ha Tay, provinces close to Hanoi with relatively high living standards, we were told it costs "about 2000 VND" (13c) to visit the doctor or even the district hospital just for a general check or "for something small." A report on the impact of Cairo in some poorer North Central coast communes put the figures at 500 VND (3.5c) for a "simple examination" and 1500 VND (10c) for "referral to higher level health facilities," which both appear very low, but 30,000 VND (\$2) for delivery (CIHP et al, 2002, p. 79), somewhat higher. Serious medical problems that require surgery and expensive medicines are a far more serious issue. However, for very poor people not yet covered by any of the exemptions policies or free health cards, even the low amounts may be a factor in seeking health care - a poor resident in Thanh Hoa wondered whether she should have any medical examinations in case a problem was found that meant she had to stay in the CHC: "If we stay in the health station, we have to pay 1000 VND (7c) per night for electricity" (CIHP et al, 2002, p. 79).

There is a wide and expanding range of fee exemptions for various sectors of the population, including most ethnic minorities (up to 13 percent of the population), those targeted as "poor" by the province-level Health Care Funds for the Poor (HCFP), set up in 2002, now covering some 11 million people (some 13 percent of the population, and 84% of the target group) by 2003 (Joint Donor Report, 2004), children under six (some 9 million), while all school children are supposed to be covered by compulsory health insurance, with a parent payment of 15,000 VND (\$1) for the whole year. It is unclear the extent to which the cards for the "poor" and the ethnic minority exemptions cross over or are separate. In any case, MOH is now calling for a doubling in the level of funding for HCFP. Compulsory health insurance also covers all formal sector workers, whether in state, foreign-invested or registered private firms, perhaps some 12-15 percent of the population, but these people are not the poorest, who, if not farmers, tend to work in the informal sector. In the best scenario, health insurance or fee exemption covers perhaps up to half the population, yet many of those excluded are just above the poverty line. Voluntary health insurance is available for 10,000 (66c) VND per month.

WHO field visits observed that initiatives such as fee exemptions, free essential drugs, health insurance and hospital funds for the poor have been launched "on a large scale since 2001" and that this policy has been greeted enthusiastically by both patients and health workers (WHO, 2003). However, they also noted some striking discrepancies in the way such policies were applied. For example, they noted that to receive free treatment in a district hospital, one first needs a referral from a CHC, but some people had reported that fees charged by the CHC itself (whether official or unofficial is unclear) may be higher than at the district hospital without a referral. In addition, it was noted that in the CH the policy of fee exemptions for minorities was enforced, whether they were poor or not, but all Kinh had to pay, again whether poor or not. Overall, however, these policies were assessed by WHO to be sufficient, despite the problems, for basic health cover, but are insufficient in dealing with catastrophic health expenditures, accidents and opportunity costs.

However, one serious problem of growing fee exemption policies is the extent to which the state offsets the cost or not; the Joint Donor Report claims that the central government pays 75 percent of the cost of the HCFP; this still leaves a gap, and there is evidence from many CHCs of the cost not being topped up, and a number of hospitals have complained that the exemption for under-six year olds is not being reimbursed by the government. If not, many CHCs cannot afford the cost, leading either to lower salaries of health staff, who then have to work elsewhere part of the time, or less supplies, or unofficial fees (NCAW, 2000). The WHO team studying ethnic minorities (WHO 2003)

noted that “in some cases, there were no fees, but the stock of free drugs was limited.” While the commune health staff are paid by the district health centre, the low wages may be topped up by the CHC itself, yet the main source of income for the CHCs appears to be either various fees, or from rental of pharmacy space, except for funds for administration and national immunisation campaigns, funded by the Commune People’s Committee (CIHP et al, 2002, p. 460).

According to Dr. Hoa Binh from the Vietnamese Women’s Union (VWU), many of the free campaigns for the poor have been made more effective, avoiding problems like unofficial fees, through activities of the Committee for Population Control and Family Planning and other agencies which announce certain days and times for people to get free health checks and free medicines, and the VWU provides information about the days and times in advance in each local area. Aside from such activities in ethnic minority and particular poor areas, the VWU also gets out information to encourage the buying of voluntary health insurance in other areas, and lobbies the government for free health insurance cards for the poor. However, while the free campaigns may be getting more effective in directly serving the poor, the problem remains of the government not topping up funding for CHC’s relying on fees for much of their work.

According to the NCAW in 2000, budget allocation tends to favour more populated areas and specialised health services, with fewer funds going to rural and remote areas and the primary health services at commune health centres – in 1997, CHCs only received 7 percent of the total public health budget. This results in poor equipment, limited supplies, few qualified service providers and poor benefits for health workers at the commune level. According to Dr. Binh from the VWU, the basis for CHC funding has changed, and both government and donors are providing more to CHC’s. She said that while she does not have exact figures, it is clear that the situation is far better than previously. However, the problems related to low funding remain in many areas, if not so severely. Dr. Bui Thu Ha, head of the Reproductive Health Unit at the Hanoi University of Public Health, reported that the government plans to increase funding to CHCs to 10 million VND each from the central government, a five-fold increase from the current level funded by the Commune government. If so, this would be very significant.

The government’s new strategy for the period to 2010 looks more encouraging, including aiming to ensure greater equality in health services, greater use of the government budget and pre-payment schemes, strengthening the community-based health sector, further developing and integrating traditional medicine and fighting the broad social determinants of bad health (WHO 2002). The Politburo’s resolution on health in early 2005, calling for stepped up state funding and greater use of health insurance to gradually cover the whole population and squeeze out the role of up-front user fees, is very welcome (CPV, 2005). However, until significant extra funding arrives, it will be difficult to assess its impact. WHO believes the new policy direction is positive, but lacking in many specifics regarding, for example, how to ensure things like equality in health care (WHO 2002).

Private practice is spreading rapidly, but quality of practice varies. It is not considered very high in poor areas. However, some private practice is judged to be more user-friendly by patients. WHO (2003) gives a good example the district public hospital in Mai Chau (mostly ethnic Thai) with no user fees, an enthusiastic staff, new techniques and a high quality of health, and so the private sector was unable to compete and has essentially left the area. This appears to be a rare case presently.

Aside from the issues above related to user fees, Dr. Binh from the VWU listed a number of other main issues affecting access of the poor to health facilities. It should be noted that fees are waived for ethnic minorities and many poor people, and most reproductive health services and targeted programs are free for all, yet minorities still have the highest rates of most diseases and the lowest indicators in reproductive health. This indicates that the relatively small user fees are not central to

understanding poor health indicators (fees for curative services are another matter). The following were the main issues:

- remoteness of many regions and thus distance from health facilities – it can still take one to five days in some areas without transport
- lack of access to transport for some of the very poor, especially women
- relatively low funding for local health centres
- in some cases traditional views which keep people away from mainstream views
- lack of awareness among some communities of the existence of services, especially of free services

Health and Gender

Among the poor, women tend to be more disadvantaged than men, for a number of reasons. Firstly, they have more health needs than men, particularly related to pregnancy and child birth. Secondly, they are the primary care givers and so their load at home is increased when access to public health is reduced. Two thirds of those who stop work to care for sick family members are women. Third, in many regions, particularly rural regions, patriarchal values prescribe that in a situation of scarcity, women should sacrifice their personal health needs for the well-being of the family as a whole, and so poor women are less likely than men to access services, especially when there is a cost involved or when distance and time are factors (NCAW, 2000). The relative position of men and women therefore in finalising decisions about spending money has an impact.

Further, emergence of the market economy (doi moi) since 1989 led to a number of changes that have affected women. It has led both to unemployment but also to a greater variety of job opportunities, including for women. Many new jobs were often further afield than traditionally, including migrating from rural areas to cities to find work in new export industries, population transfers inside the country, large-scale trade with neighbouring countries and a small but significant number of people working across the Vietnamese borders. There has also been a very significant rise in sex work.

While some of these opportunities, alongside the rapid economic growth in general and changes in family norms in the past decades, may have increased women's independence, they have also tended to increase women's vulnerability and exposure to various communicable diseases, including HIV/AIDS.

In looking at women's access to CDC services, it is worth first noting that women's access to health services in general are affected by other factors, including women's socio-economic and educational level, levels of political/community participation, and entrenched traditional patriarchal views on women's role in the family and society.

Yet with the growth of market economy, a number of male-female differences which had been reduced under the previous system widened again. Given that under the new system, user fees for health were for the first time introduced, these broader differences have an even more significant impact on women's access to health. Some of the clearest post-Doi Moi differences include [\[1\]](#):

- Average female-operated farms cultivate only half the land area of male-operated farms, and their farm profits are only 62 percent of those of males (pre-Doi Moi, both were equal members of rural cooperatives)

- Female-operated non-farm rural enterprises are on average much smaller, about one-eighth as likely to employ wage workers as male businesses
- Women's waged employment increased by 4 percent between 1993 and 1998, but the increase was 9 percent for men
- The average hourly wage for women is 78 percent that of men, with the biggest differences among those with lowest educational levels (this however should be seen in the context that in most developed countries, the male/female wage gap is wider)
- Doi Moi also introduced user fees for education, and this alongside the greater need for farm labour by each individual household initially led to a high drop-out rate among poorer households, affecting girls more than boys. However, this was reversed by the late 1990s, and both primary and lower secondary enrolments rates are considered high by developing world standards. However, there remains a gap of 4.3 percentage points between female and male enrolment in lower secondary school (89.1% to 84.2%), and a much bigger gap (45.4% to 33.7%) between boys and girls attending school in the 16-20 age group, more pronounced in rural areas (42.2% to 33.7%) (CPFC/PFHP, 2003, p. 13)
- While there was no gender gap for people with no more than primary education among 22-34 year olds in a 2002 report (ie those attending primary school in the 1970's and 1980's), this gap widened markedly among the younger age group after the onset of Doi Moi. However, the state seems to have reversed this, and enrolment by both girls and boys now stands at 96 percent, with even rural areas only reporting a small gap (96.5 male to 95.9 female). Nevertheless, there is a significant group of poor women who were at primary school age between about 1988 and 1998 who did not attend or complete primary school.
- Child malnutrition rates are significantly higher among girls than boys
- Paid maternity leave for state sector workers was cut from 6 months to 4 months at the beginning of the 1990s, and in rural areas most creches collapsed with the end of the cooperatives
- Women's representation in the National Assembly collapsed from 32 percent in 1975 to 17-18 percent over 1987-97, but has increased again to 27 percent since then, the highest in Asia. However, women's representation at Province/District/Commune levels is lower, falling from 28/19/19 percent in the 1980's to 12/12/13 percent in the early 1990's, rising again to 20/18/14 percent in the late 1990's [2]

While the relationship between women's socio-economic situation and health may seem straightforward, the relationship between their educational level and health is also clear. For example:

- When the mother had no education, only 65 percent of girls who were ill accessed health care professionals, but this jumps to 88 percent when the mother had 4 years of education (the father's educational level has little impact on either female or male children)
- The overall percentage of women giving birth without skilled medical professionals is about 12 percent, but only around 30 percent for the poorest women, women with no education and ethnic minority women

In addition, a woman's educational level has a great impact on her ability to decide how to use her earnings. Among women with no education, only 24 percent can make such decisions, while for 41 percent of these women the husband makes the decision (in the remainder of cases, it is made

jointly). However, those with some primary education make the sole decision in 32 percent of cases, which is much the same as for women of all other educational groups. Furthermore, among those women who don't make the decision solely themselves, there is a sharp difference between those for whom the husband makes the decision and those who make the decision jointly with their husbands, corresponding to educational level. Thus for those with only some primary education, 20 percent of husbands made the decision and in 40 percent of cases the decision is made jointly, but these figures change markedly among women who complete higher secondary education (8.5% husband, 55% joint decision) (CPFC/PFHP, 2003, p. 23). Ability to make such decisions impacts on the likelihood of women accessing health care for themselves and their children.

This generally corresponds to figures for regions according to their socio-economic level, and the poorer regions tend to have a higher percentage of ethnic minorities. However, the Central Highlands are a marked exception in this particular case. Whereas the poor, minority dominated Northern Mountains show the lowest percentage of women making their own decisions (20%) and the highest for men making these decisions (29%), the similarly poor, minority dominated Central Highlands has almost the highest percentage of women making these decisions (40%, compared to national average of 30%) and almost the lowest percentage of men (13%, compared to national average of 16%). This may be due to the matrilineal traditions of many CH minorities, compared to the very patriarchal traditions of most NM minorities.

1. State of Communicable Diseases

Overview

The Vietnamese government's Expanded Program of Immunisation (EPI) consists of one dose of BCG (which protects against TB), three doses of DPT (against Diphtheria, Pertussis and Tetanus), three of Polio, and one of Measles vaccine, all within the first 12 months of age. Since 2003, Hepatitis B has been added to this program, and since 1999, vaccination has also been extended to Japanese Encephalitis, Cholera and Typhoid in "designated areas," such as the Mekong. [3] This entire vaccination program is free of charge.

Vietnam's program manages a very high rate of coverage in comparison to many other even wealthier countries in the region, and has been commended by UNICEF. Nevertheless, there are important differences both between regions and the different vaccinations. For example, while across the country, 93 percent of children in practice receive the BCG and the first polio vaccination, only 88 percent receive the first DPT and 83 percent the measles vaccination. The rates for the second and third DPT and polio vaccinations drop. These figures give an overall average rate of 66.7 percent coverage, when taking into account not returning for second and third shots, based on a 2002 survey. It is worth noting, however, that UNICEF's 'State of the World's Children' in 2005 gives overall figures now as high as 98 percent coverage for TB, 99 percent for 3 doses of DPT, 96 percent for 3 doses of polio and 93 percent for measles, an overall rate of 96.5 percent. Some 78 percent of one-year olds are also fully immunised against Hepatitis B. Furthermore, UNICEF was already giving these figures several years earlier, so it is not simply a recent increase, but a statistical discrepancy. Whatever the case may be, the breakdown below is based on the lower figures, and even if too low are of relevance due to the very marked differences they reveal regarding coverage in different regions and educational levels.

The rate of BCG and first polio vaccinations ranges from around 90 to 100 percent, with the lowest in the Northern Mountains of around 90 percent and 100 percent in the Red River Delta. However, there are no figures here for the Central Highlands. The first DPT vaccination was given to only 75

percent of children in the Northern Mountains, but all other regions had rates over 85 percent, up to 98 percent in the RRD. The drop off of the rate by the third vaccination is also much higher in the Northern Mountains than elsewhere, from 75 down to 49 percent. In the case of measles, while the Northern Mountains had a relatively low rate of 79 percent, it was actually much better than the 65 percent vaccinated in the Mekong. In all other regions it was between 80 and 90 percent, except for the 98 percent in the RRD.

There was also a sharp difference regarding educational levels, where children of mothers with no formal education had an average rate of all vaccinations of only 39 percent, figures that rose sharply with each stage of education begun or completed, up to 82 percent among those who complete upper secondary education.

There is very little difference in the vaccination of girls and boys.

Regarding the reasons for the lower rates of coverage in certain regions, it appears that cost is not the issue given the program is free. EPI officer Mr. Hitoshi Murakami from WHO, Hanoi, confirmed that the national program is completely free, but spoke of one case he had observed where women were paying "a couple of thousand dong" for their children to be immunised. He said this was the decision made by the local immunisation point to recover some of the cost, given the low level of funding to CHCs. However, he also indicated that this was "very rare" and everywhere else he had seen no evidence of this.

He outlined two possible reasons for low coverage in certain regions, particularly the NM. Firstly there appears to be an incongruence in many regions between the population figures of the EPI target population and the actual local population figures. He believes this is partly explained by migration, seasonal and longer term. Thus, while some rural areas thus show a "low" coverage", some urban areas show a greater than 100 percent coverage, ie the numbers immunised are greater than the recorded population. Thus in research in slum areas and among squatters in HCMC, it was found that even these people were covered by EPI. However, they would not be recorded as HCMC residents. On the one hand, this shows a very positive commitment on the part of local health authorities to ignore purely bureaucratic definitions of who is a "resident" and thus vaccinate these people. On the other hand, it reveals again some of the problems of the residence system in Vietnam, where it is very difficult to change official residence - local health cadres reported that they often do not know exactly how much vaccine to have available due to uncertainty about population figures.

He reported there were no cultural or religious barriers to immunisation observed among any of the minority populations. However, he had found that some of the minority populations were "weak in terms of social mobilisation," and also that some groups, particularly the H'mong, were very reluctant to approach CHC's even if they knew about the vaccinations. The family of one mother who had died of neonatal tetanus was asked if she had known about the tetanus vaccination. They said they were aware, but were very shy about going to a crowded CHC (presumably where Kinh and others also attended). They said they were still reluctant to go to the village centre even when a mobile team reached their area, and if they actually came to their house they would "consider it." This highlights the particular social isolation of this group and calls for renewed strategies to approach the question.

A very different kind of problem has been noticed regarding Hepatitis B vaccine, which used to incur fees, but now is free. There are still a number of private hospitals, particularly in HCMC, dispensing Hepatitis B vaccine and charging for it. The reason some people go there and buy it is due to a perception, a "myth" according to Murakami, of better quality vaccine and service at private hospitals - a focus group showed some mothers believing that EPI services were likely "lousy" if free. Another particular problem with Hepatitis B vaccine in particular is that it must be

administered straight after birth – the logistics of organising this in remote areas is obviously very difficult, and could well involve hidden costs for transport etc, according to Murakawi.

Local production of most vaccines is sufficient, but according to Associate Professor Dr. Do Si Hien, “the programme lacks the finances to cover the high risk areas in the southern Cuu Long (Mekong) Delta with vaccines against Japanese encephalitis, cholera, typhoid, measles, and rubella,” [4] despite the fact that all of these, except Rubella, are being covered in the Mekong (and measles nationally). Given the low rate of measles coverage in the Mekong, where there is high demand, the availability of vaccine may thus be a problem.

The program has clearly been highly successful. In the 1990s, Vietnam eradicated polio, neo-natal tetanus and leprosy, reduced malaria fatalities by 97 percent, and by 1996, diphtheria and measles fatalities fell 75-80 percent (World Bank, 2002). [5] The World Health Organisation praised Vietnam’s malaria success, calling its “a story to be shared” and claiming the commitment of those in the field was ‘remarkable’ (WHO, 2000). However, malaria remains a serious problem – in 1999, there were 348,000 cases reported, with 190 deaths. In 1997, Vietnam was one of only two countries in the world to meet WHO targets of diagnosing over 70 per cent of TB infections and curing 85 per cent of patients. By 2002, the number of countries was 22, but Vietnam was “the only high-burden country among them” (WHO, 2004). However, TB remains serious, with some 220,000 people estimated to be infected, and 20,000 people dying each year.

Meanwhile, diseases such as Dengue fever, Encephalitis and Rubella also continue to reappear from time to time, particularly in the south, but do not receive the same level of national attention. In addition, new diseases like SARS and Avian Influenza have appeared – while the former was stamped out in a campaign Vietnam was widely commended for, the latter is potentially a much more serious problem throughout the region.

Tuberculosis

In 1997, Vietnam became one of only two countries in the world to meet WHO targets of diagnosing over 70 per cent of TB infections and curing 85 per cent of patients. By 2002, the number of countries was 22, but Vietnam was “the only high-burden country among them” (WHO, 2004), where “high-burden” includes all the populous countries of east, southeast and south Asia. In 2001, Vietnam detected 84% of TB cases and successfully treated 92%.

Nevertheless, there are currently 220,000 people with the disease, and some 20,000 still die per year. The estimated incidence is 179 per 100,000 people. There is also some evidence at the gains are under threat, due to the rise of HIV patients contracting TB or relapsing with TB. At present, 1.4 percent of adult TB cases are HIV positive. The problem is most serious in the Southeast, where HIV is most serious, but the province that has seen the highest recent TB growth is Ninh Thuan, on the south Central Coast, with increases of up to 77 percent. A survey found that in 48 provinces, increases of over 0.6 percent had been recorded. [6]

WHO judges Vietnam to have both a ‘strategic plan’ and a ‘high political commitment’ to fight TB. However, “one challenge is to expand health services, and therefore case detection, to remote areas mainly inhabited by ethnic minorities. To this end, advocacy efforts directed at the National Assembly’s Commission for Social Affairs have helped to bring effective TB control to those living in some mountainous and remote areas, to prisoners, and to homeless people, via community-managed health development projects in 51 of 71 districts. TB education has been provided to ethnic minority groups. Health care workers at all levels have received training for TB to ensure consistent delivery of DOTS.”

“A challenge, and an opportunity, will be to maintain and develop high-quality TB control services within the context of health sector reform, taking advantage of Vietnam’s sophisticated social organization and highly effective TB program. Other challenges are to modernise and rehabilitate the health infrastructure in the remaining 20 districts, regulate the fast-developing private sector, control the influx of non-standard TB drugs, and address the threats of HIV/AIDS and MDR-TB” (WHO, 2003A).

According to WHO, the main challenges include too few qualified intermediate-level staff in some provinces, poor access to DOTS services in remote, mountainous and border regions, and among the homeless, prisoners and illegal residents, rapidly developing private sector service provision without adequate training in DOTS, and an unregulated drug market and use of non-standard TB drugs.

The remedy these problems requires strengthening of management capacity through training, operational research and use of Total Quality Management practices, education through primary health care units and community outreach, involving the People’s Committees and the Women’s Union, private sector training and development of regulations to ensure adherence to DOTS, and legislation on drug inspection to ensure use of WHO-recommended drugs (WHO, 2003A).

Gender Aspects:

(Most of the following from Long, 2000, and NCAW, 2004)

The number of men diagnosed with TB has been consistently close to double that of women throughout the 1990s. In 1999, the number of men stood at around 36,000 and the number of women at about 18,000. This is consistent with international figures – of 3,368,8879 cases notified in 1997, two thirds were men.

However, there are a number of issues which suggest this is due to under-diagnosis of women. Firstly, a greater proportion of men than women present with the ‘classic’ symptoms of TB – cough and sputum expectoration – resulting in increased delays in detection of TB in women.

Secondly, of those who do present with prolonged cough, 35.5% of men are given a sputum test, whereas only 13.6% of women are. The sputum tests requires giving a sample and returning twice, but women are far less likely to return the second and third times, due to factors including “that women are busy with children, housework and dependent on the husband and in-laws in terms of their ability to return to the health care facility” (NCAW, 2004, p. 54).

Finally, as spitting is less socially acceptable for women in Vietnam, this may lead to women producing sputum specimen of lower quality, and hence reduce the ability to diagnose TB.

Regarding other factors, while both men and women believed equally that TB was a contagious disease transmitted through the respiratory track, there is a strong belief that men are more likely to get it due to ‘male-risk factors’ such as the greater amount of smoking, eating out, heavy work etc, that males tend to be involved in. Such beliefs can result in a longer delay in seeking treatment (as symptoms are less likely to be perceived as TB), and also delays in diagnosis by the health worker if he/she shares these beliefs. In the meantime, this can result in an increased risk of transmission within the family.

However, data in Vietnam suggests the first problem does not occur, as among people with a cough lasting three weeks, 90.7 percent of women and 88.3% of men sought health care, and there was no difference in the length of time between first appearance of symptom and seeking health care.

In terms of health care actions as a whole, twice the number of women (15.8%) than men (8.5%)

reported three or more health care actions, but many more women (25.7%) than men (17.5%) practiced self-medication as the first action. More women than men (69% to 60%) chose less qualified providers overall as their first health care action (self-medication, drug-sellers or private practitioners) (Long, 2000, p. 40). "Time and economic constraints seemed to steer the health-seeking behaviour of women to a greater extent than men. Convenience and close proximity to home were reported by 60.7% of women for choosing the first health care action (NCAW, 2004, p. 55).

Regarding difficulties in women's access to health facilities for TB, there was a difference in the travel time between men (30 minutes) and women (37 minutes) to the nearest district hospital (as opposed to CHC), mainly due to women's lower access to motorbike transport. Female patients' families were significantly poorer than males' (7,964,000 VND to 9,349,000 per annum in a 1996 study). Women patients had significantly lower educational levels than men - 56% of men and 44% of women had studied over 9 years (Long, 2000, p. 36-37).

Patients said TB strongly affected the economic situation of the household and increased their poverty. Because men often generated the major income of the family, when they were sick, the burden was considered worse, due to then having to stop work. Though TB drugs were free, treatment cost was still a major concern, due to things like cost of travel from home to hospital, daily expenses in hospitals, especially for food, and financial loss from time off work (Long, p. 46, 864). At home, they could eat cheap food, but in the hospital, they have to eat more expensive food. There is no compensation for such losses, and these costs sometimes result in patients discontinuing treatment (Long, 865). Thus overall, despite free treatment, women spend VND70,465 and men VND127,935 per health care action taken. The difference may be explained by the quality of health care taken and in lower economic access among women (NCAW), though it could also relate to differing official and unofficial fee levels charged based on differing incomes.

There does appear to be a delay in the diagnosis of women with TB, which was much longer for women (5.4 weeks) than men (3.8 weeks) on average.

However, after 2 months of treatment, recovery from cough and sputum expectoration was much quicker among women, and women tended to comply with treatment better. Common reasons for male non-compliance included lack of understanding the risks of non-compliance and choosing to work rather than comply with treatment due to feeling responsible for looking after their families, while among women it tended to stem more often from cases of poor interaction with medical staff or social stigma.

Social isolation of TB victims occurred both within the family and the wider community, and was more severe among women than men (Long 2000). It was particularly severe for women who are not bread-winners, who cannot earn money or who live with the husband's family (Long et al, p. 5). Also, women tended to self-isolate more, to protect family members from the disease. One of the worst things was that when a young unmarried person, particularly a girl, got TB, it could cause difficulty in getting married. Even when the parents had TB, it could affect their unmarried children, especially in rural areas and among less educated people. Some people believed that TB was hereditary and could be passed on to future generations. Some husbands also believed that TB could cause sterility in their wives (Long et al, p. 6, 7).

In terms of progression from TB infection to developing the disease (which only occurs in 10% of infected people), generally the rate is higher for women of reproductive age, whereas the rate of progression in men continues to rise with age. Other than biological or general socio-economic factors, other factors suggested for this include the higher utilisation of health services by women during their reproductive years, the weakness of women after giving birth could lead to greater risk, and the higher alcohol abuse by men which may depress immune function (Long, 2000, p. 11, 34).

Globally, TB infection rates are similar for younger males and females, but from the time of early adulthood, it is higher in men than women. It is supposed that from adolescence onwards, males have more contact with the wider world than females. Among 15-25 year olds, male notification rate only slightly higher than female, after age 25 male rate shoots up far more rapidly than female rate, eg at age 45 the male notification rate is 2.5 times the female rate; however, among older people, the female rate begins to close the gap – for both sexes, rates of TB notification continually rise with age.

Among the recommendations by the NCAW are reducing misconceptions, action to reduce both patient and doctor delays in diagnosis, giving sputum tests to all TB suspects, especially females, expanding case detection activity (eg sputum tests) training to all health staff, including private providers and CHC staff, not just the public hospitals and the direct TB control network, and encouraging more tests to be carried out at CHC's.

Malaria

The World Health Organisation praised Vietnam's malaria success, calling its "a story to be shared" and claiming the commitment of those in the field was 'remarkable' (WHO, 2000). The following is largely based on this report.

Between 1991 and 1999, malaria deaths fell by 97% and cases by 59%; the number of epidemic outbreaks fell by 92%. However, at the end of 1999, the country still reported 348,500 cases of malaria, including roughly 1,350 severe cases, and 190 deaths.

In 1991, the country changed its strategy from mass treatment and DDT spraying to distributing drugs and mosquito nets, intensive twice-yearly residual home insecticide spraying (with pyrethroid group insecticides as DDT use ended in 1991) and intensive ad-hoc health education starting with village heads, Women's Union cadres and commune health staff, and community mobilization.

From 1991 to 1996, the National Program distributed free nets in high endemic areas; the rest of the exposed population was encouraged to buy them and the Program impregnated the nets for them free of charge. A 1995 study showed that a large proportion of the population correctly understood the causes of malaria and that sleeping under bed nets can prevent it, but many said they could not afford them. From 1996 on, the Government freely distributed further nets in the poorest areas, while the NIMPE collaborated with UNICEF and the VWU to encourage others to buy nets at half price. On average, one net is used for 3 people at a cost of around US\$5. The twice-yearly re-impregnation with permethrin is carried out at no cost by staff of the district mobile teams and commune health stations for a cluster of villages at a time in a twice-yearly campaign. By 1999, over 11 million people were using impregnated nets in endemic areas – almost reaching the target for coverage of vector control activities (bed nets plus house spraying combined) of 12 million.

In the 84 priority regions, some 70 percent of patients suffering from malaria seek treatment within 24 hours of onset of symptoms. All inter-communal polyclinics and hospitals do microscopic blood examinations (approximately 2.5 million slides are examined each year). When a slide comes back positive for a patient, all remaining members in her/his household are treated. In these same districts, at least 70 percent of the population uses treated bed nets and 10-20 percent of the population (often the most remote) is protected by residual house spraying.

From 1990 on Vietnam began local production artemisinin and its derivatives for the treatment of falciparum malaria. At least 80 percent of the increased production of antimalarials has been borne by the Government. A range of antimalarial drugs are now easily available free of charge.

Early treatment is now mostly carried out at the commune and village levels (close to 80 percent of all treatments are carried out at this level, around 10 percent are treated by mobile teams while only around another 10-15 percent are treated in hospitals). A working group on border malaria was set up in 1998 comprising five provinces. Military health personnel have for long now been engaged as a partner in malaria control activities in border areas. 400 mobile teams in the high endemic districts and hundreds of village health workers have been taught to recognize malaria and take blood samples for examination; they are retrained about once a year.

Mobile teams are quickly mobilized in cases of outbreaks, reinforcing house spraying and net dipping, carrying out house-to-house information and education campaigns, displaying and distributing posters and brochures all the way to remote villages, and supplying drugs and insecticides. Printed materials are produced especially for minorities and for schools, and videos have also been produced.

The experts and field staff attributed Vietnam's success to factors such as the high level political and financial commitment, its effective use, the active mobilization for malaria control from the central to the village level, the provision of free drugs and insecticides (for house spraying) to the affected population, having an initial vertical structure that followed WHO's guidelines, incorporating village health workers in malaria work in the field, and having achieved a high level of understanding and practice regarding malaria among the population. "The organizational aspects of any national program, they contend, are also crucial. Money alone is not enough."

Ethnic Minority and Migration Issues:

Fifteen million people still live in high endemic areas. One third of all cases and two thirds of deaths occur in 84 districts in 15 provinces where 7.2 million people live, in areas most affected by *P. falciparum*. These are largely in mountainous regions and thus affect ethnic minorities in particular. The living standards and educational level of ethnic minorities plus their migration habits are still problems. Especially during crop failure years, people migrate in search of food and income, sometimes to the forest, and this puts them in a situation of increased risk and of decreased protection.

At least one species of *Anopheles* changed its habitat from indoors to outdoors and there is thus a small risk that neither impregnated nets nor spraying will be effective in certain central regions and the vector primarily bites outside homes, and minority people spend much time in the forest.

However, the high endemic regions also include the Mekong Delta, in areas where shrimp farming is practiced, where the incidence of malaria has remained constant since 1993 mostly due to the surrounding stagnant brackish water that fosters *Anopheles* mosquitoes. In addition, this region borders Cambodia where the same problems occur along the Mekong and there is considerable population contact and movement.

One problem noted among poor people in general is that some families with torn nets are ashamed, and so do not bring them for re-impregnation; it is estimated that 10 percent of households do not bring their nets for dipping on the twice-yearly schedule.

While minorities are a clear target group, it is very often people migrating to endemic areas, who have never been exposed to malaria, that are more at risk than the local minorities. Part of this migration is seasonal (e.g. at coffee harvest time). In 1999, when new land became available in the CH for new coffee plantations, there was an increased wave of migration there, in addition to rising numbers of seasonal workers from the north at harvest time, resulting in a slight increase in the number of new cases of malaria there.

The northern province district visited by WHO for this study contributes an estimated 10,000 seasonal workers to malaria endemic areas of the country. This results in over 50% of malaria cases in that province being 'imported'. In 1999, 1.3 percent of the total population of Nghe An, a poor North Central coast, largely Kinh, province, were mobile, mostly going to mountainous malaria endemic areas in the CH, or to Laos and Cambodia. To cover just this mobile population requires 20,000 doses of anti-malarial drugs (Regional Malaria Control Program, 2000).

Gender Issues:

The WHO team assessed that the program had reached the point "where the remaining problem requires the targeting of special high risk groups," above all adult men who contract malaria when away from their usual home. "In some areas, malaria practically is an occupational disease, affecting young adults who spend the night in the forest," but they add, "however, children and pregnant women are still vulnerable."

Adult men working far from home, both minorities and migrant workers, constitute a clear risk group, as they do with other diseases, and need to be focused on. However, the problem with only focusing on these men is that, as in the case of TB, the perception that it is largely a 'male' disease due to their more risky behaviour, work further from home, being out later at night etc, can have the effect of women being less likely to see the symptoms as malaria and thus take longer to contact a medical practitioner. While we have not come across such extensive gender-specific research on malaria in Vietnam as with TB, it is obvious that this perception of a 'male' disease is quite similar. In addition, many of the other aspects described in the TB would also apply, for example, that of seeing men's health as more important, problems in decision-making, and women's lower incomes and lower access to transport and time.

Moreover, while "young adults who spend the night in the forest" may involve men working far from home in some areas, it is also a particular problem for pregnant women in some areas, especially in parts of the Central Highlands where women traditionally go into the forest to give birth in specially made huts, thus risking contracting malaria while pregnant. There does seem to be evidence that pregnant women are quite vulnerable to malaria. According to Ms ... Ha, Head of Reproductive Health at the University of Public Health in Hanoi. She explained the government provides skilled birth attendants to go to the forest and deliver in their forest huts, and provides clean delivery kits for this purpose. However, these aids in safe delivery may not help in preventing malaria, though the presence of health experts may help women be conscious of the danger.

According to Dr. Binh from the VWU, though anti-malarial medicines are given out free, many women in some highland areas don't know where to get them or that they are free, and it is generally women's responsibility to obtain medicines for their families. The VWU goes to the local level to give women this information, as well as other information on prevention, and information about when the next free dipping of nets in chemicals is to take place. The VWU also runs a "circular credit" program with no interest to allow poor women to buy mosquito nets, and when the loan is returned it goes to another person to do the same (meanwhile families targeted as poor are provided the nets free).

Finally, as women constitute approximately 54 per cent of the labour force in agriculture, [7] "outdoor" work should not be thought of as a male pursuit as it often is. Males perhaps go further afield, but this only adds to myths that women are less vulnerable. In particular, in the shrimp producing areas in the Mekong where malaria remains a severe problem, large numbers of women, including quite young women, work in the shrimp fields and are highly exposed to malaria.

Dengue Fever [8] and Japanese Encephalitis

Dengue and encephalitis appear to be hitting mainly in the Mekong and HCMC region, and like malaria, this is also connected to the large regions of standing brackish water in parts of the Mekong.

Between the 1960's and 1980's, Vietnam was one of the eight countries in South East Asia having highest number of people who died from Dengue Hemorrhagic Fever (DHF). Until the late 1990's, killing *A. aegypti* mosquitoes with chemicals was the main method to prevent dengue fever.

Research about the knowledge, attitudes and practices of mothers in urban areas of HCM City regarding the control of DHF for their children under 10 years of age in the period 1995-97 showed that only 49% of sample mothers, who had children with the disease, and 52% of other mothers, knew that mosquitoes transmitted virus resulting in DHF. Information about the disease and how to control it was gained through the media (e.g. television 26-29%, newspapers 12-16%), healthcare workers (12-16%), and from relatives and friends (21-29%).

By the late 1990s, the methods to control Dengue mostly consisted of ways to reduce contact with mosquitoes, such as encouraging sleeping under mosquito nets or ways of keeping mosquitoes away, rather than methods to reduce the places where mosquitoes often breed, such as open water bodies, open water tanks etc. This could explain why the numbers of people who got DHF were much higher in District 8, where residents contained water in open tanks in their houses due to the lack of water from the public water system, than in any other studied districts. This underlines the connection between the issue of developing clean water sources for the population and the potential spread of mosquito-borne diseases such as Dengue, encephalitis and malaria.

Japanese Encephalitis can kill within a day or two if not detected, and has recently shown growth particularly in the Mekong. As with Dengue, the importance of keeping water bodies covered to deny breeding areas for mosquitoes which may carry the disease is of central importance. However, there is a vaccine for this disease, which since 1999 has been part of the free national EPI program in designated areas, one of which is the Mekong. However, there appear to be problems of extending full coverage in parts of the Mekong, as with other vaccines for serious diseases in this region, such as measles, for reasons that are unclear, but that clearly needs some focus. In addition, it appears that local production of this vaccine is inadequate to cover demand. [9]

The VWU plays an important role in information dissemination to women regarding Dengue, including the importance of covering open water tanks, and encouraging women to get to the CHC early when symptoms appear.

Rubella [10]

Rubella has broken out in a number of communities since November 2004, mostly in HCM City, Dong Nai and Ben Tre in the Southeast, but also at the same time in Lao Cai and Lai Chau in the NM. This disease has a particular impact on pregnant women, as it may pass through the bloodstream to infect a fetus and cause congenital rubella syndrome in developing babies.

In HCM City to now 798 people have contracted the disease. Almost all of them (781 people, or 97%) are in Cu Chi district, where many industrial enterprises are located. The disease has spread fast and concentrated on female workers, for example, female workers in Sam Yang, Natural and Hansae enterprises. Of 320 pregnant workers working in industrial zones in the district, 59 have contracted the disease.

Rubella has spread fast and focused on female workers, because

- They work in crowded environment without wearing masks

- They live in living quarters or low rent houses, with a very low hygienic environment (e.g. several people live in a narrow room without air circulation)

Workers, who get the disease, are requested by doctors to be separated or allowed to take off work for 10 days. However, in some enterprises, affected workers still have to go to work. This appears to be a trade union issue and a violation of the Labour Law.

Vaccination is the most effective prevention, but workers, especially females, cannot afford to pay (the cost of an injection is 100,000-120,000 VND, or \$6-8), as Rubella is not part of the national program. Adults need to have one injection but children need to have two injections. This makes it even more difficult for workers with young families in terms of affordability.

The outbreak in Lai Cai and Lai Chau in the north has hit hundreds of people, concentrated in certain districts. The exact numbers are not clear, nor the ethnic breakdown, but the Health Ministry has put the number up to 1,100 cases in the north, including now in Hanoi. In one district, of 175 cases of fever, some 50 were found to be regular measles, and 125 Rubella. This underlines both the problem of the relatively low rate of measles vaccination in some parts of the Northern Mountains, and also the lack of a Rubella vaccination in the national program.

According to Murakawi, WHO is currently engaged in a dialogue regarding when and how to introduce the vaccine. One issue is that, while rubella is mostly a mild disease for children, which is manageable given generally good health conditions and procedures, it can be devastating to pregnant women. One concern is thus if a vaccine is given to children, the germ will tend to migrate to a greater extent to an older age group and thus hit more pregnant women now.

The other issue is vaccine production – the cost of importing the vaccine is high for Vietnam and supplies are currently running low due to rising demand. [11] Vietnam is about to begin producing measles vaccine, and it would thus be logical to combine this with rubella in something like the MMR vaccine

ARI and Diarrhea

Acute Respiratory Infection (ARI) and Diarrhea are both leading causes of child mortality. Male children are somewhat more likely than girls to have both. In two weeks preceding a survey in 2002 (CPFC/PFHP), some 20 percent of children had had the main symptom of ARI, cough and rapid breathing. However, this was much higher in the Northern Highlands (27%) than elsewhere, and much lower in the Southeast (13 percent). People in the NM were also less likely to seek treatment from health facilities (60%) compared with the Red River Delta (75%).

Diarrhea was almost twice prevalent in the Northern Highlands, Central Highlands and south Central Coast (15-18% in two weeks before the survey) than elsewhere, and twice as prevalent among children whose mothers had had no formal education (19%) than those who completed lower secondary school (10%).

The Health Ministry emphasises educational programs and use of oral rehydration programs, such as the prepared packets of oral rehydration salts (ORS), for diarrhea. However, while 82 percent of mothers in the RRD were aware of ORS, the numbers ranged between 65 and 75 percent in most other regions, but was lower in the Northern Mountains (60%) and very low in the Central Highlands (45%). Only 38 percent of mothers with no formal education were aware of ORS, which sharply rises with even some primary education (59%), up to 89 percent among mothers who complete upper secondary education.

Issues of procuring ORS, as well as those of worms, food safety, handling food etc, all tend to be

linked to women's traditional roles. School-based de-worming is very important in control of diarrhea.

Emerging CDCs

(Based on discussion with Dr. Peter Horby, Communicable Disease Surveillance and Response, WHO)

As both SARS and Avian Influenza (AI) are relatively new CDCs, there is little in the way of concrete gender studies on them, and there is little among the statistics to show any gender bias. However, some important aspects can be borne in mind for follow-up.

Firstly, regarding the much more serious AI situation, in almost all cases, those affected have had direct contact with live poultry and in its slaughter, except for cases such as where raw duck blood 'pudding' was eaten. No cases have been clearly established resulting merely from the eating of cooked poultry.

Therefore, those who have the most contact with poultry, those involved in the killing and preparation of poultry, are most at risk, and this largely means women. In addition, many of the casualties have been children, so again it is important to focus on women given their larger role, especially in rural areas, in taking care of children and thus in educating them in avoiding high-risk behaviour. In addition, given women's role as carers, they may be more likely to contract the disease from a male who already has it than vice versa, for example two sisters who recently got sick after looking after their sick brother. These issues will need a particularly strong gender focus.

SARS was contained much more rapidly in Vietnam (the first country to do so) and since the initial outbreak there has not been another. The main particular gender aspect here would appear to be the large proportion of women who are health workers, given that contracting the disease by health workers from patients accounted for a large number of the victims. The first health worker to have caught Avian Influenza from a patient has also just occurred in late March 2005. The issue here is health workers training, which appears to have been carried out very successfully in the case of SARS.

However, it would be wise to remain vigilant about the possibility of SARS returning. In the discussion about TB above, it appeared that there was no difference between men and women in terms of making a first health action following the appearance of a prolonged cough, so this is a good sign also in terms of the main symptoms of SARS. However, it was seen that it was far more likely for women to first seek out health workers of a lower standard or to apply self-medication than for men, due to factors such as time, convenience and economic constraints. Thus the possibility of a return of SARS adds importance to this issue.

2. HIV/AIDS

The rapid economic growth, population shifts, new work opportunities far from home and changes in family norms in the past decades have also made women more vulnerable and exposed to HIV/AIDS.

Overview of HIV/AIDS situation and its spread among special population groups

The first HIV case was detected in Ho Chi Minh city in December 1990. By 1993, it had become an epidemic in Vietnam but mainly concentrated in the group of injecting drug users. The number of HIV infections increased gradually and by 1998, evidence showed that HIV had spread from the high

risk groups of injecting drug users and sex workers to the general population. "Women who are faithful with their husbands or partners are more and more vulnerable to infection, even though they are engaged in extremely low-risk behaviour." [12] Many women got HIV infection from their husbands or partners who had been involved with sex workers, injecting drug use or who had sex with other men. Currently, HIV infections have been detected in all 64 provinces of Vietnam and by Mid October 2004, there had been 86,018 HIV infections, 13,612 AIDS cases and 7,834 deaths, among which 14.23% of the HIV infected cases are women. [13]

1. HIV/AIDS among pregnant and young women

According to U.N and Vietnamese government officials, pregnant women are one of Vietnam's largest growing risk groups and increasingly vulnerable for HIV/AIDS due to a lack of information about safe sex and limited access to reproductive health services. Documents have shown that the HIV prevalence among pregnant women attending antenatal clinics rose more than 10 times in seven years, from 0.03% in 1995 to 0.39% in 2002, and reached up to 1% among pregnant women attending antenatal services in An Giang and Hai Phong [14] and 1.4% among similar group of pregnant women in Tay Ninh. [15] The infected mothers then may transfer HIV to their babies during delivery or breastfeeding period.

Being involved in high-risk behaviours, young people are more at risk for HIV infection. HIV epidemic has infected many young people who are the important and major source of the labour work force. According to the statistics from the Preventive Medicine and HIV/AIDS Prevention and Control Department, Vietnam MOH, most of the HIV/AIDS infected cases falls under young age groups with people from 13 to 19 and 20 to 29 years of age consist of 9.38% and 53.83% of the total HIV infected cases, respectively. Of the infected youths, an increasing proportion is female. In September 1996, the United Nation Development Program reported that more than half of the HIV cases in Vietnam are people aged from 15 to 24 years old. Young women are the most affected and in several areas, data shows that among the group of 15 to 19 years old youths, two women to one man are infected with HIV. This is an alarming situation that needs urgent solutions so that HIV infection and spread can be controlled.

2. HIV/AIDS among sex workers, women living in communities along the borders between Vietnam, Lao and Cambodia and ethnic minority women.

The opening of Vietnam onto the world brought about a rapid economic development, however, commercial sex trade is expanding alongside with population migration and urbanization. The number of entertainment establishments that link with commercial sex work has increased significantly and more men are visiting sex workers. The number of HIV cases continues to increase in parallel with HIV prevalence among female sex workers. For instance, the rates of HIV infection among female sex workers in Hanoi in three consecutive years of 2001, 2002 and 2003 were 11.5%, 14.5% and 15% while these rates are 7.95%, 11% and 16.5% among female sex workers in Can Tho province in the same years. [16] In Ho Chi Minh city, this rate is even higher, according to Mr. Shigeru Omi, WHO regional director for the Western Pacific.

Even though the HIV endemic in Vietnam is still in the concentrated period as per the WHO assessment, it is a serious endemic in regard to its scope and incidence. In 1999, it was reported that HIV/AIDS cases had been detected in all areas where minority people reside. In addition, it has been noted that the number of HIV cases has increased at a worrying rate among the high-risk groups living along the border of Vietnam with Laos, Cambodia and China. "Prostitution in the border area between Cambodia and Vietnam is considered as one of the main causes of HIV introduction in southern Vietnam." (7) The Southern provinces have received a large flow of Vietnamese immigrant sex workers coming back from Cambodia, a region for HIV epidemic in South

East Asia, and a high proportion of these sex workers are HIV positive. There is conflicting information about the number of Vietnamese sex workers in Cambodia. Data from Ho Chi Minh City Women's Union showed that 40% of the total 30,000 female sex workers in Cambodia were Vietnamese while another report done in 2000 suggested the much lower number of 5,000 Vietnamese female sex workers in Cambodia, chiefly in Phnom Penh and are young girls. Also, according to this report, 80% of these female sex workers come from a southern province bordering to Cambodia - An Giang (7). Beside An Giang, Kien Giang, Tay Ninh and some other surrounding provinces are also major originating provinces in Vietnam, however, accurate information about concentration areas is not yet available. The migration and mobile movement of HIV infected sex workers have initiated the HIV epidemic among this group in these bordering areas. Take An Giang as an example, the rate of HIV infection among female sex workers in An Giang province rapidly increased from 5% in 1997 to 15% in 1998 and..... in 2004, according to the national epidemiological sentinel surveillance. Some other available statistics showed that 65.3% of female sex workers in Vietnam suffer from sexually transmitted diseases which make them more vulnerable to HIV infection (8).

The situation of HIV endemic is somehow different in the Northern provinces of Vietnam. Evidence has shown that the outbreaks of injecting drug use in Vietnam is associated with heroin trafficking routes from Burma, Laos to northern Vietnam and provinces bordering China. These provinces have suffered from the quick increase of HIV infection cases among injecting drug users. For instance, the HIV incidence in Quang Ninh province rose from 163/100,000 (1998) to 215/100,000 in 1999(9). These HIV-infected injecting drug users then continue to transmit HIV virus to their sexual partners, mainly women. In addition to that, thousands of girls and women from Northern provinces like Lang Son, Quang Ninh, Lao Cai and some other Red River Delta provinces have gone to the neighbouring provinces of China. Some of them have become wives, servants and laborers in some remote mountainous areas of China while several others have worked as sex and entertainment workers in the border towns of Mong Cai, Lao Cai and Lang Son. According to the national epidemiological sentinel surveillance, the rates of HIV infection among female sex workers in Quang Ninh and Lang Son rose fromto and from ... to ... respectively.

A survey conducted by MoLISA in 2000 suggested that about 75% of all drug users have used injecting heroin, followed by 33% who used opium. In the highlands of north and central Vietnam and in adjoining Provinces, opium smoking or inhaling was practiced among hill tribes and ethnic minorities for generations. Due to government and UN sanctioned suppression of opium production, its supply has been significantly reduced and therefore, some of these opium users have switched to heroin or other injections and this is a great danger for the rapid spread of HIV/AIDS among young people. However, the statistics about HIV infection among different genders in ethnic minority group is not yet available and it may need further assessment.

Trafficking in women and especially children is a growing problem in Vietnam. A nationwide survey done by the Human Rights Committee in Cambodia found 14,725 sex workers of which 2,291 were children and 78% of them were Vietnamese. It was mentioned that the situation is even worse in China although no precise statistics about this situation and about HIV infection among this most vulnerable children group are available.

Factors that may affect accessibility of women with HIV/AIDS to health services and information

There are many factors that may affect women's accessibility to health services and information especially when they are infected with HIV/AIDS. These factors may include women's educational level and awareness about HIV/AIDS, their income level, the cost of health services provided, the way services are organized to make women feel comfortable, being respected and safe, the support

and care from their husbands or family, the leisure time available for them to go and seek for services and other socio-cultural factors.

1. Socio-cultural environment in Vietnam

Vietnam is the country where the thought and behavior of its people have been influenced by many years of Confucian teachings under the Chinese occupation. According to the Confucianism, women at every level suppose to have a lower position than men in the society structure. Under the lead and guidance of the Communist Party, socialist policy supports gender equity and the position of Vietnamese women in the society has been improved significantly in the past few decades. However, women, especially those stigmatized by HIV infection, are still at a disadvantaged position compared to men. This is even more obvious when it comes to women's accessibility to health services and information when they are sick.

2. Women's educational levels and awareness in relation to HIV/AIDS and its link to socio-cultural factors

Vietnam has gained significant achievements in the fight against illiteracy in order to raise its people's intellect. Compared to other neighbouring countries in Southeast Asia, Vietnam is one of the countries where the illiteracy rate among women is lowest, considering its level of economic development. However, illiteracy among young women and girls still remains a serious problem in Vietnam that needs an urgent solution. The illiteracy rate of Vietnamese women was 13.1%, much higher than the illiteracy rate of Vietnamese men which was only 6%, according to the National Population and Housing Census done most recently in 1999(10). This means that among every 8 women and young girls, there was one illiterate. In 1999, of 5.3 million illiterate people all over the country, around 69% were female. The rate of illiteracy is often higher in women and girls living in rural areas compared to their urban counterparts and the illiteracy situation is even more serious among ethnic minority female. As per another source of data, 88.7% of illiterate women and girls reside in highland and midland rural areas, especially remote areas with socio-economic loss. In particular, these rates were 93.2%, 91.6%, 86.7%, 82.6%, and 82.3% among H'Mong, Nhi Ha, Dao, Gia Rai and Ba Na young women and girls, respectively.

Illiteracy among women and girls has further push them in a more disadvantaged situation and further increased their inequality in getting the socio-economic and health benefits, particularly in access to health care when being infected with HIV. In fact, women and girls have to take "double role" as they make up of about 76% of the labor force in the agricultural sector while still carry the reproduction role and are responsible for taking care of the children in their families (11). With this double workload, women in rural areas often spend 12.5 hours per day working, and in the north, north-central and mountainous areas, rural women have to work 14 hours per day, on average (UNDP). According to the 1997-1998 Vietnam Living Standards Survey, "women of all age groups worked nearly twice as long as men to do housework. They represent the majority of all the people who work 51 to 60 hours per week, and over 61 hours per week. However, this does not mean that women spend less time on income-generating activities." The same survey also showed that women aged 11 to 64 had spent more time in income-generating activities as compared to men (UNDP). This gives women very limited time to relax and even care for their own health. The extra-long working hours and the old thinking wide spreading among ethnic minority group about giving the preference of education to boys have resulted in the high school drop-out rate among young women and girls. Data has shown that in every 100 female children entering the first grade, only half of them finish the fifth grade, and in certain mountainous and remote areas, the number is even much lower - only 10 to 20 female children (11). Female children who drop out of school after one or two years will not have mastered reading and writing. Most of them will become female illiterates. Providing information and teaching them about how to protect themselves from HIV/AIDS is therefore more

challenging. It is also reported that women with lower level of education, especially those illiterate, have very limited access to basic health information and health services for themselves and their children.

A study done in 2000 on “Gender-related impacts of HIV/AIDS epidemic in Quang Ninh and An Giang” showed that low level of education and living in rural areas are influencing factors to the knowledge and behavior of people, including women with HIV/AIDS (12). Also according to this study, the proportion of women who have access to mass media, know about HIV transmission and prevention is lower than that of men. With the double workload, women are often too busy and have little time to watch tivi, listen to radio or read newspaper to improve their knowledge or even care for their own health. Available statistics suggested that urban women and women with higher educational level have heard more about HIV/AIDS in comparison to their rural and lower level of education counterparts. For instance, 97% of urban women compared to 89% of rural women in this study have heard of AIDS. 97% of women with secondary education or higher were aware of AIDS while the rate was 84% and 54% among women with some primary education and women with no education, respectively. Another study carried out in a group of women residing in Hanoi showed that many women believed that they will never contract HIV if they are faithful. In an informal interview, a young woman from Tay Ninh province told us that HIV is the disease of sex workers. She also said that she is faithful to her husband so she is totally safe from HIV infection. Very few women thought that their husbands may transmit the virus to them. This belief was reflected in women’s precautions against HIV/AIDS: Women from 25 to 29 years old didn’t use any precaution method against HIV while women aged 30-34 used condoms more frequently as a contraceptive method. In the meantime, women from 35 to 39 years of age had a high rate of intra-uterine device use but very few used condom to protect themselves from HIV. Married women in the age group of 40-49, however, confessed they had used condom to protect themselves from HIV. Overall, 34.8% of the interviewees did not take any precaution against HIV, did not have any idea about this problem, or did not concern by this problem or felt out of danger.

Women’s low level of education and limited understanding and awareness about HIV impede them from being active in seeking health services and information about HIV/AIDS. This makes women to be more exposed to HIV infection. Helping young women and girls to be literate and improve their awareness about HIV/AIDS are some of the ways to empower them to take control over their lives, contribute to their development and HIV prevention.

3. Women’s income poverty in relation to access

While the renovation process in late 80’s boosted Vietnam’s economy, provided new opportunities for both women and men, there are also some negative impacts on women.

The rise of the market economy in Vietnam has resulted in the shift of women from more secure wage and salary employment into less secure household and informal sector work. Loss of employment for women in these sectors has resulted in a loss of benefits, such as maternity leave allowance and childcare provisions (UNDP). Despite government’s efforts to increase employment opportunities for women and men in Vietnam, many women has lost their jobs and the unemployment rate for women has increased from 5.38% in 1996 to 7.42% in 1999, due to the impact of the regional economic crisis (UNDP). However, due to the positive trend of economic development in Vietnam in the past few years, more jobs have been created and the average unemployment rate among women during the last 6 years is down to 6.29%, lower than that among men (13). Very often, women work predominantly in hotels, restaurants, tourism, banking, schools, hospitals and health care centers, and in textile and garment manufacturing, where they run about 80% of the business (UNDP). Women often have to work harder both domestic household duty and other income-generated work in order to cope with the lack of basic social services such as

education and health care for them. Even though working harder than their male counterparts, women receive less remuneration for their work in compared to men. They earn, on average, 14% per month less than men. They earn an average of US\$32 per month, while men earn an average of US\$41 (US State Department).

In the past years, Vietnam has strived very hard and made impressive achievement in meeting the target of reducing the proportion of people living below the poverty line to approximately 35% in 2000. However, 70% of people living under poverty line are women, particularly rural and ethnic minority women (UNDP). Low level of income has contributed to women's limited access to education and health care, especially when there have been less free of charge education and health care services for the poor and women.

Attitudes to HIV/AIDS sufferers

In discussion with Dr. Binh from the Vietnam Women's Union, she told us that discrimination against women with STD's, particularly HIV, remained a serious issue that the Union, in coordination with the government, is now launching a campaign around. The Vietnam Youth Federation, the youth "mass organization" equivalent to the VWU, has also highlighted campaigning against prejudice and discrimination against HIV/AIDS sufferers at its recent Congress in February 2005. As the following experiences of Mr. Michael DeGregorio of the Ford Foundation show, much remains to be done.

A young woman in the northern mountain province of Thai Nguyen gave birth, and only as she gave birth did the doctor discover she was HIV-positive. Instead of first informing her, he called her husband and family to the hospital. There, in front of all, he announced that she was HIV-positive, the first she knew of it herself. He gave the mother information about what she should do to look after her health, nor even informing her, he called her husband and family to the hospital. There, in front of all, he announced that she was HIV-positive, the first she knew of it herself. He gave the mother information about what she should do to look after her health, nor even informed her that her condition meant her baby was also likely infected. The husband regularly goes away and works in Quang Ninh on the far north coast near the Chinese border, a region well-known for cross-border trade, injecting drug use and sex work, with a significant proportion of HIV-infection. However, the family blamed the woman. The husband till then did not know he was HIV-infected, but he died soon afterwards.

The discussant telling this story also met a woman from Thai Binh in the Red River Delta who had had a very similar experience. She claimed some a large number of women in her village were HIV-positive, only two of whom were sex-workers. Most of the men in that village travel away from the village to work.

3. Maternal and Child Mortality and Reproductive Health

(Many of the detailed figures with breakdowns within this section from CPFC/PFHP, 2003, unless otherwise indicated)

To outline the issues of maternal and child mortality in Vietnam, it is necessary to look at the state of reproductive health overall, as all factors impact on the mortality rates. Current government objectives include reducing the maternal mortality rate, obstetric complications and abortions, and an increase in Reproductive Tract Infection (RTI) treatments, and increased access to basic RH/FP services. The government provides a wide range of reproductive health services at no cost, including antenatal examinations, contraceptives and tetanus-toxoid shots.

Women and Men in Reproductive Health

One thing that comes out clearly in many of the sections below is the issue of encouraging male responsibility in these areas. Dr. Binh from the VWU identified the problem that many services providing advice and education about these issues are provided extensively to women but not to men, including where they are directly involved, such as contraception, Reproductive Tract Infection (RTI) and the spread of STDs. The VWU in some areas has begun to raise awareness among both men and women, and is now campaigning to get men to share responsibility for reproductive health. However, work with men is somewhat beyond the VWUs brief and resources and the problem requires a greater commitment from all levels. Binh also identified a lack of friendly services for teenage women as a major problem.

Binh noted some positive initiatives in this area being carried out by the VWU. Since last year, 'Safe Motherhood Clubs' organised by the VWU have been inviting men as well as women to discuss issues. For example, it becomes a joint community question of why a woman died in childbirth. It is looked at from various aspects, from the community aspect, economic aspect, gender aspect etc. Men reportedly find these meetings useful and "learn things they didn't know." For example, questions such as building their own safety net for things like transport were raised at these meetings. Binh reported that men in a club in Hai Phong put forward the idea of transportation being collectively organised in the community ready in case someone is about to give birth. Men in these clubs also raised the idea of micro-credit for these purposes.

Access to Reproductive Health Facilities and Services

A very high proportion of women live in communities serviced by a community-based distribution (CBD) worker (93-97%), a family planning field worker (94-98%), and a mobile family planning clinic (60-77%). The differences in the figures are between "project provinces" and "non-project provinces." [17] These workers provide free contraceptives, including pills and condoms, to women. Over 90 percent (89% and 95% respectively) of women live in areas where a family planning campaign was conducted in the year prior to the 2002 survey. Unfortunately there is no breakdown for region.

Overall, 59-67 percent of women live within one kilometre of a private doctor, pharmacy, CHC or hospital where they could obtain family planning supplies, and another 32-27 percent from one to four kilometres, ie 91-94 percent reside within 4 kilometres. Virtually all other women in the country, except 1.2 percent, are within 9 kilometres.

Some 40 percent of women live within one kilometre from a facility providing maternal and child health services, mostly a CHC, and another 46 percent from one to four kilometres. Overall, some 80-85 percent of women live within four kilometres of a facility providing antenatal care and delivery, but a substantially greater proportion of urban women live within one kilometre and some 20 percent of rural women live more than five kilometres away, all except about 3 percent within ten kilometres. The proximity of specific children's services (immunisation, oral re-hydration salts, cough treatment etc) tends to fall within the same range.

Fertility Rate:

Vietnam's fertility rate has declined precipitously from 4.0 children per woman in 1987 to 2.7 in 1997 to 1.9 in 2002, a rate regarded to be unprecedented (CPFC/PFHP, 2003, p. 29). In 1999, Vietnam won the Population award from the UN for its achievements in family planning due to a grass roots based campaign run by the Women's Union.

The highest fertility rate was among women with no education (2.82), compared to an average of about 2 percent for women with average educational levels, dropping to 1.39 among women who have completed higher secondary education. It was also highest in the strongly ethnic minority populated Central Highlands (2.9), but also the largely Kinh south central coast (2.37), whereas the strongly ethnic minority populated northern mountains was closer to average (2.01) (p. 30)

The percentage of adolescent pregnancies is also far higher among women who have only had some primary education (10%), lower among those completing primary school (4.5%) and much lower among those completing lower secondary (1.9%).

Reproductive Tract Infections

RTIs are a common problem, one survey reported RTIs in over 70 percent of women in 10 communes in 5 provinces (NCAW, 2000). Women have little knowledge of how to prevent and cure them and they often do not receive appropriate treatment at CHCs, whose capacity to diagnose and treat them is low. The role of men in the spread of RTIs is not addressed, and as a result, their rate remains high despite years of campaigns among women by the VWU (Binh, VWU). RTI's facilitate the spread of STD's to women and can cause complications with pregnancies.

Contraceptive Use:

An extensive family planning program provides free contraceptive services throughout the country (NCAW 2000).

Current contraceptive use among married women is among the highest rates in the developing world, at 78.5 percent, with almost no difference in rural areas (78%), and current use of modern methods stands at 56.7 percent, with actually slightly more rural women using modern methods than urban women. The figures are much higher for those who have ever used contraception (90%, and 79% modern methods). Further, the group with the lowest use are younger women aged 15-24, which is logical as they are the group mostly wanting to become pregnant – among non-users of contraceptives, the under-30 year olds were by far the largest group who gave as a reason wanting more children (52%), and this was by far the biggest reason for this age group (CPFC/PFHP, 2003, p. 40, 41, 49). It is significant that the reasons “access/availability” and “cost” were given for discontinuation by only 0.2 and 0.3 percent respectively, and in both cases this was mainly for condoms. For current non-use, cost was not listed at all, and lack of access was given as a reason by only 0.3 percent of women over 30, and none under 30 (p. 47, 49)

However, there was a markedly lower percentage of women in the Central Highlands using contraception (66.3%), whereas the Northern Mountains was similar to the rest of the country. There was also a markedly lower score for women with no education (65.7%), whereas even those with some primary education came close to average. This correlates with exposure to family planning messages on radio or television – in the CH, only 79% of women had heard such a message, compared to 98% in the RRD. There is also a strong north-south difference, with very high rates in the north (even in the poor, ethnic minority dominated northern mountains such messages had been heard by 91%) and lower rates throughout the south (even in the wealthy southeast, the rate was only 83%). Only 68 percent of women with no education had heard such messages, 78 percent of those with some primary education, rising to 96 percent of women with higher secondary education. Also far fewer couples in the Central Highlands (84%) approve of family planning than average (91%), and again the other southern regions are lower than all northern regions (p. 56), and likewise, couples with no education are less likely to approve (79%) than those with some primary education (84.8%) and all others (well over 90%).

The main form of contraception is still overwhelmingly the IUD which are provided, fitted and removed free of charge, but there are now significant minorities of around 6 percent currently using the pill or condoms, and of 17-18 percent who have used these methods.

Contraceptive services and education have traditionally concentrated on married couples, particularly women, and both married men and unmarried young people have received less attention.

However, there has been some progress in encouraging men to take more responsibility for contraception, according to Dr. Binh from VWU, and male rates of contraception are now higher than before. Men now use more condoms than before, as they are freely available. However, there is a limited number of health workers, not enough to talk to men about how to use them. In addition to the free condoms provided by MOH, the VWU also sells the 'Hello' brand of condom (it must buy them so sells them to survive), but unlike the MOH, the VWU is in more of a position to monitor and educate about their use, thus there is a slight incongruence - the free condoms come with little advice, those that cost a little come with better advice.

The rate of unwanted pregnancies remains high, perhaps partly as a result of this lack of education regarding condom use, but also more generally the still high percentage of men not taking responsibility for contraception. The rate of abortion is very high, it has been estimated that 40 percent of pregnancies are terminated, yet half of these cases are when the women were using contraception.

Contraceptive services pay little attention to unmarried men and women, representing a severe risk to both given the spread of HIV and the high level of unwanted pregnancies and resulting complications. Friendly services for teenage women are a particular need, as they face discrimination in these services. In some cases, FP services might refuse contraceptives to teenage or young unmarried women when they approach, if the health officers there believe sex is only a matter for married women (Binh, VWU).

Abortion

As noted, the rate of abortion is very high, it has been estimated that 40 percent of pregnancies are terminated. In 1999, there were 37.83 reported abortions per 1000 women of reproductive age. However, the number of abortions dropped 40 percent between 1997 and 2001.

However, half of these cases are when the women were using contraception, due to incorrect or inconsistent use, and high rates of 'traditional methods', according to Dr. Ha from the Reproductive health Unit, Hanoi University of Health. In the study of maternal mortality (below), seven of the surveyed 80 deaths were due to unsafe abortion. The causes of death included not receiving essential treatment on time for haemorrhage (at a private clinic), inappropriate professional procedures leading to retained placenta, and infection. Two cases were due to use of "traditional medicine" to abort at home, resulting in death by haemorrhage (MOH, 2002).

Abortion is widely available in Vietnam, even at the commune level, with very little difference in provinces with high minority populations, and there are no laws or popular prejudices preventing it, but these examples reveal continuing problems to poverty and inadequacies of the health system. However, one WHO report (WHO 2003) did suggest that "the H'mong and most CH minorities do not accept abortion or modern contraceptive methods," without giving clear details.

Infant and Child Mortality

Both child and infant mortality have shown an extraordinary decline since 1998, the former from

39% to 23%, the latter from 29% to 18%. However, in both cases, the rate in rural areas is more than double that in urban areas (35/16% and 26/12%).

Regarding region and ethnicity, infant mortality is more than double the national average in the Northern Mountains (40%), though in the CH it is only a little higher (22%). In fact the largely Kinh poor North-Central region has a relatively high rate (30%), indicating one of the problems of seeing poverty as only an ethnic minority issue. With child mortality, the Northern Mountains again show a rate more than double average (51%), but here the CH also has a rather high rate (40%), the second highest rate. The reason for the particularly high rate in the Northern Mountains is unclear, but given the far more remote nature of many parts of this region, compared to the CH, and particularly among the Hmong, geographical access to health centres may be a big factor.

In addition, the education level of the mother is a very clear factor here. Infant mortality is over three times as high among women with no education than average (58%), and child mortality is slightly less than three times as high (66%). These rates drop dramatically among women who have done even some primary school, to about one third higher than average, while among those who have only completed primary school, the rate is about the national average. Completing lower secondary, for some reason, appeared to slightly increase the rate, though this seems difficult to explain, while women completing upper secondary had significantly lower rates than average (so the difference between women who have had no education and those who have completed upper secondary is 4.5-fold in infant mortality). Thus it appears that at least completing primary education has a very dramatic effect on infant and child mortality rates. Part of this is no doubt the greater access to health education with some primary schooling, but to some extent it may correlate with very poor socio-economic situation being responsible for both low primary enrolment and high mortality rates. In particular, it should be noted that Hmong girls in the Northern Mountains have a much lower rate of primary enrolment than any other group in Vietnam.

In all regions, IMR was at least several points higher among boys than girls. In the 1998 VHLSS, it was nationally 8 points higher among boys (40) than girls (32). CMR was also much higher in minority dominated regions (NE - 40, CH - 43, NW - 60). CMR was higher for girls in the RRD and Southeast, and also in NM, but higher for boys elsewhere - in the CH, it was nearly double for boys (56) compared to girls (29) in the 1998 VHLSS (WHO, 2003).

Child Malnutrition

Around two million children under five years of age (30 percent) are underweight according to a 2002 survey (Results of the Child Nutrition Survey among Mothers and Children, 2002), and figures as low as 25 percent have been mooted recently. This represents a significant fall compared to the 36.7 percent in the 1998 VLSS. This would also be consistent with the UNDP's figures of a drop in the rate of undernourished people from some 27 to 18 percent by the end of the 1990s. However, whatever the case may be, two things are clear: the figures remain high, and there are marked differences between regions.

Based on the 1998 figures, the proportion of underweight children ranged from around 30 percent in the RRD and Southeast, to around 40 percent in the Northern Highlands and the two central coastal regions, to a high of 48.9 percent in the Central Highlands (NCSSH, 2001)

Causes of Child Mortality and Malnutrition

Clearly, poverty in general is the cause of both poor nutrition and poor access to health facilities, both of which are overall causes of child mortality and malnutrition. As long as there is poverty, there will be inadequate nutrition among a section of the population, which has to be dealt with at a

higher political-economic level. Nevertheless, these same factors are also the cause of other problems which accentuate child malnutrition and mortality.

One cause of child mortality is disease, and the issue of coverage of the child immunisation program, and other childhood diseases, has been discussed above.

Another cause is a bad start, when children are born underweight, due to lack of adequate nutrition in the mother. The proportion of new born babies weighing less than 2.5 kilograms was very significantly higher in the Central Highlands (16.6%) than anywhere else in the country, where it ranged from 2.7% in the North Central region to 7.3% in the Southeast. However, the proportion weighing over 2.5 kilograms was lowest in the Northern Mountains (42%), much lower than the CH (62%). This is explained by the fact that a massive 53% in the NM “don’t know,” alongside about 20 percent in the CH and the two central coastal regions. Thus the real proportion weighing less than 2.5 kilos is likely to be considerably higher in all four regions, especially the NM. Over 94% of babies in the RRD are over 2.5 kilos. Again these figures closely correlate with educational levels, where babies over 2.5 kilos range from 32% among women with no formal education, doubling to 60 percent among those with some primary, up to 93 percent among those who complete upper secondary education.

Studies have shown a close correlation between the status of new born babies and factors such as the frequency of pregnancy care, work loads during pregnancy and the increase in a mother’s weight during pregnancy (Dinh, Duong, 2004). Thus socio-economic factors not only impact on the nutrition of the child when born, but also on the mother’s behaviour and access to health during pregnancy, which have an extra impact on the strength and health of a new-born child. Regarding the particular study, it revealed that only 60.6 percent of pregnant women in the commune being studied (in Hue) ate more during pregnancy, a somewhat low figure, but 78 percent did light or average work loads, and 43 percent stopped working at least 30 days before delivery. Only two thirds had full weight increase during pregnancy.

As the work-related indicators were better than the eating and weight related ones, it appears in that region there was reasonable understanding of the issues (ie, 83% had the full tetanus toxoid dose), but that malnutrition in the mother due to socio-economic causes was a significant factor. However, ignorance of nutrition issues can still be very significant as the following highlights:

A young pregnant woman from the RRD province of Ninh Binh, living and working in Hanoi, has been eating as minimally as possible throughout her first term of pregnancy. Partly this was to save more money for later when the fetus was bigger. But as workers in Hanoi with family farm in Ninh Binh, a medium province socio-economically, she was not strictly speaking poor. Rather, she expressed the opinion that very little food is needed during the early part of pregnancy, since the fetus is still very small, and it is not good to put on much weight during early pregnancy. This misconception is still widespread in many regions.

The Women’s Union provides extensive advice to pregnant women regarding these and other issues, and conducts door to door work with women known to be pregnant in their neighbourhood. When asked about this, the response was that she is away from her registered neighbourhood in Ninh Binh where she would have been visited. In Hanoi, she is simply a migrant worker, but not an official resident. As such, she falls through the cracks of Vietnam’s extensive networks. This again highlights problems with the residence system.

Maternal Mortality

Officially, maternal mortality fell from 200 to 100 per 100,000 births between 1990 and 2000, but

WHO/UNICEF estimate the actual rate to be about 130. MMR is notoriously difficult to calculate, partly because it is relatively rare, as compared for instance to infant deaths, so very large sample sizes are required, and national estimates in all countries in Asia are well below WHO/UNICEF estimates (WHO, 2001).

Nevertheless, one thing very clear from the data in Vietnam is that the rate is very much higher in mountainous and remote areas and among minorities compared to the lowlands. One recent Health Ministry study (MOH, 2002) of 21 districts in seven provinces (representing the seven ecological regions of Vietnam, 3 districts in each) indicated a MMR of 411 in Cao Bang in the northern mountains, compared to only 45-46 in Ha Tay (Red River Delta) and Binh Duong (Southeast). Provinces in the Mekong, north and south central coasts and even the Central Highlands ranged between 143 and 199 (however, it should be noted that the CH province studied, Dak Lak, is relatively wealthier than chronically poor Gia Lai and Kon Tum).

There are sharp differences between urban and rural MMR's (79 to 145), and lowland to highland MMR's (81 to 269). In particular, maternal death among adolescent women is three times as high in mountainous areas as in lowlands. Overall, 40 percent of all maternal deaths were among women over 40.

'Direct' causes of maternal death accounted for 80 percent of the total, and this included haemorrhage (41%), pre-eclampsia (21.3%), infection (16.4%), abortion (11.5%), and ectopic or uterus rupture, each around 5 percent. Haemorrhage accounted for a higher proportion in the two mountain provinces studied, and in a previous study by Thai Binh medical school it accounted for a higher proportion overall (53%).

Of the one fifth of maternal deaths due to "indirect causes," over 20 percent resulted from obstetric heart disease, while some 37 percent were caused by three major infectious diseases – Hepatitis (10.3%), Pulmonary TB (10.5%) and Malaria (15.8%), stressing the important connection between CDC and MMR.

Of the total, 43.7 percent of these maternal deaths occurred at home, 10 percent in district hospitals, and 30 percent in provincial hospitals. Significantly higher numbers died at home in the CH province of Dak Lak (60%) than in the NM province of Cao Bang (33%) or elsewhere. Thus giving birth at home is clearly a major factor. Dr. Binh from the VWU noted that some minority women in remote areas even give birth in swidden fields, and the death of a mother or child may not even be known by authorities. Around 7.5 percent of deaths occurred on the way to health facilities, mostly due to the late decision to transfer women to higher level facilities.

Regarding the educational levels, women classed as "illiterate" accounted for 30 of the 80 deaths in this survey (37.5%), about two and a half times their percentage of the total population, giving them an MMR of 173; those with primary school education were 36.25 percent of the group, close to their percentage of total population; those with secondary school education made up 20 percent, some four fifths of their proportion of total population; finally, those with a higher than secondary level only accounted for 6 percent of deaths, one quarter of their population share.

The ethnic breakdown of these figures is problematic, because the research gives no figures for the overall population of each group throughout the districts of these seven provinces that were studied. Thus the highest number of deaths were among Kinh women (48.8%), and the report informs us that Kinh were the overwhelming majority of women in all studied sites, but gives no percentage; nevertheless, as Kinh make up 87 percent of the population, we can surmise that the rate among Kinh women is very low. The minorities showing figures were Nung (13.8%), Van Kieu (8.8%), Monong (7.5%) and H'mong (10%). However, there was also no breakdown of the total populations

of these groups in the studied areas, so the percentages are essentially meaningless. Given that the H'mong and Nung each make up just over one percent of Vietnam's population, it is obvious that these percentages are very high; but given that there are more Nung than H'mong in the one NM province studied, the percentage of H'Mong is thus higher. Similarly, the Van Kieu and Monong groups in the CH make up 0.1 percent or less than the total population of the country; thus the MMR among these groups appears from the study quite dramatically higher than the NM minorities. This further underlines the point above regarding the CH figures, because minorities make up a smaller percentage overall in the CH than the NM, thus the somewhat better CH figures do not in any sense indicate a better situation for CH minorities than those of the NM, but quite the opposite.

However, making firm assessments from a total of 80 deaths in 21 districts is very problematic and there appears a need for more research. In fact, the total reported data from the seven provinces as a whole (444 deaths, which the team represents only 55% of the total, thus 796 deaths), shows surprisingly different results in terms of MMR, with the very poor North Central province of Quang Tri, and surprisingly, the Southeast province of Binh Duong, showing higher rates than Cao Bang as a proportion of total population.

Nevertheless, based on the figures in this survey, a comparison with a UNICEF survey in 1990 reveals a significant fall in MMR in all regions except the Northern Mountains, which shows an increase. This clearly indicates the importance of concentrating on this region with its particularly remote geography in many places. However, as noted above, the figures for the Central Highlands would be unrepresentatively small, particularly for minorities there. On the other extreme, as the Red River Delta and the Southeast were represented by semi-rural areas, the likely much lower MMRs of Hanoi, HCMC and other cities are also not recorded.

Major reasons for maternal mortality include (from report)

Antenatal Care

In 2002, mothers received antenatal care for 87 percent of births, including from doctors (46%), trained nurses or midwives (40%), and one percent from a traditional birth attendant. This is a dramatic increase from 71% in 1997, and most of this increase is from doctors (25 to 46%). However, the proportion of women getting antenatal care is higher in urban (96%) than rural (84%) areas.

Such care is highest in the Red River Delta (98%) and Southeast (91%), but also in the poor Kinh North Central region (90%), and slightly lower in the South Central coast and Mekong (around 14-15%). However, in the main minority regions it is much lower, some 77% in the Northern Mountains and 73% in the CH.

While only 52% of women with no education received antenatal care, the rate rises sharply with some primary education (68%) and even more among those completing primary (90%). Among those completing upper secondary, 99.8% receive antenatal care.

Tetanus Toxoid Coverage

The proportions of women receiving tetanus toxoid shots is around 85%, though only 71% receive two doses. The breakdown correlates closely with that for antenatal care – again the NM and CH have around a quarter of mothers with no shots, but also 20 percent in the Mekong. The coverage broken down by educational levels was also virtually identical.

Deliveries in Health Facilities

As seen above, delivery at home rather than a health facility accounted for nearly half the cases of maternal mortality in a MOH survey. Some 79% of births take place in health facilities and 21% at home. This is a steep rise from only 62% in 1997. However, while 98% of births in the RRD, 96% in the Southeast and even 92% in the Mekong take place in health facilities, only around three quarters do in the two central coastal regions, only 63% in the CH, and this drops to a low of 43% in the Northern Mountains.

Only 34% of women with no formal education gave birth in health facilities, and this doubles to 63% among those with some primary and to 78% of those who complete primary, 89% who complete lower secondary and 95% who complete upper secondary.

The very markedly low number in the Northern Mountains in particular correlates closely with the very high level of maternal mortality there, as noted above. Moreover, the very clear correlation with educational levels correlates well with the very low level of primary school attendance among Hmong girls in particular. The particularly remote nature of much of the region is no doubt part of the problem of access to health facilities, as well as the traditionally quite distinct livelihood strategies of the Hmong. The MOH report that showed very high maternal mortality in Cao Bang did not show any marked difference in MMR among the various minorities there or the Kinh. However, the report also did not estimate the number of MMR according to the relative percentages of ethnic groups in the province.

However, the proportion of deliveries in health centres in the CH is still very low, and given the CH have a lower proportion of minorities than the NM, the actual proportion of minority people giving birth at health facilities may be much lower. The figures also indicate that poor Kinh areas in the north and south central coasts, while not as badly off as the minority regions, should also not be ignored in health programs.

According to Ms ... Ha, Head of Reproductive Health at the University of Public Health in Hanoi, the major access issues for women leading to non-use of health facilities for giving birth in minority regions are distance and cost. This is so even if health services are free in minority regions, due to the costs of transport, other costs while at the hospital such as food and accommodating relatives, and opportunity costs due to time off work.

Even in regions where there is a hospital fee, the cost of delivery itself is not so high, quoting 50,000 VND (\$3) at a central level hospital in big cities and 30,000 VND (\$2) at lower levels. However, considering all the other costs (transport, relatives, food, opportunity costs, plus perhaps 1500 VND, or \$1, for a hospital bed), many may still avoid the health facility.

She noted that many minority people also traditionally prefer to deliver at home, and in recognition of this situation, the government now trains birth attendants to go to their homes to assist with birth, with clean delivery kits. Some groups in the CH traditionally give birth in the forest, which among other things also leads to the risk of contracting malaria, a cause of MM. The government tries to be sensitive to their cultures, and thus can only advise them to come to free health facilities. However, the government also provides skilled birth attendants to go to the forest and deliver in their forest huts, and provides clean delivery kits for this purpose. This policy was also noted by Dr. Binh from the VWU. However, Binh noted that in some remote minority areas, women deliver in their swidden fields; it is possible for no-one to know, even if the mother or child die in delivery.

She believes language may sometimes be a problem in certain communities, but the vast majority of minority people speak Vietnamese, and a very large proportion of health workers come from the same minority group as those they are servicing. Government policy is to train health workers from each ethnic group to serve their communities.

Regarding gender sensitivity, she noted that 70-80 percent of all health staff in Vietnam are women, and in particular, very few assistant doctors in the reproductive health field, let alone midwives, are male, so this would not appear to be a problem.

Assistance at Delivery

Around 85 percent of births in Vietnam are performed by a doctor (50%) or a nurse or midwife (35%), up from 77 percent in 1997 (in fact the number performed by a doctor nearly doubled while those performed by nurses and midwives decreased). About 5 percent are performed by a traditional birth attendant, leaving 10 percent without any skilled assistance.

However, the Northern Mountains account for the overwhelming bulk of women not receiving any skilled assistance (ie receiving assistance from friends and relatives), at 37 percent. All other regions had over 90 percent skilled assistance – in fact when traditional birth attendants are included, nearly 95 percent of Central Highland women received skilled assistance, though this region, along with the North Central coast, had the highest percentage of traditional attendants (11%). The problem thus appears overwhelmingly an NM issue, perhaps related to remoteness.

Again, when the mother had no primary education, she was much less likely to receive skilled assistance – only 50 percent received any kind of skilled assistance, which however jumps to 82 percent if the woman has done some primary school (including 11 percent traditional attendants), and then to 95 percent among women who have completed primary. Again these figures correlate with the very low primary school enrolment of H'mong girls in particular.

4. Gender-Based Violence and Trafficking

It is difficult to estimate the number of women and children sold into trafficking, but the NCAW's 2000 report quoted at least 10,000 sold since 1990, and anecdotal evidence suggests the problem remains serious, if not on a huge level. Some 200,000 women are believed to be involved in the sex industry.

The two major trafficking routes through which Vietnamese women and children are taken across borders are from northern Vietnam into China, for marriage or prostitution, and from the Mekong region into Cambodia, for sex work in Cambodia, Thailand or further abroad, or forced labour. These two borders are also central to the sex industry in general, and to the spread of HIV/AIDS. Some southern women are sold abroad to Taiwanese husbands. However, other borders are also important, for example, the main route to Laos is through a border gate in the North Central coast.

The incidence of rape has been rising rapidly, though it is unclear how much of this is an increase in the rate of reportage. In the early 1990s, about 4-500 cases were reported each year, but this increased by 40 percent between 1994 and 1996. Before 1990, child rape cases accounted for 4 to 6 percent of cases, but by 1995 this had risen to 30 percent.

Domestic violence against women “seriously damages women’s physical and mental health, and fear of violence limits women’s ability to access resources for productive and other activities.” It occurs in Vietnam in all regions at all social levels. As of 2000, domestic violence accounted for 16 percent of all court cases, a significant increase. Among types of abuse women have experienced from husbands, 16 percent report having experienced beatings, 18 percent forced sex, and 8 percent prohibition of freedom (NCAW 2000). In 2001, the definition of domestic violence was extended to include restrictions on women’s freedom, and the VWU is spreading this message to women.

Vietnam has ratified all conventions regarding violence against women and the legal system has laws against gender-based violence and against sexual harassment and discrimination against women in the workforce. However, due to strong patriarchal attitudes, especially in many rural areas, which extend to health care workers and police, the cases are rarely brought before the legal system (UN, 2002).

Attitudes remain a problem. A study on the implementation of the Cairo platform in some northern communes found that women were seen as family peace-keepers and were expected to remain silent when a husband lost his temper, and some respondents still believed a wife may be at fault when a husband turned violent as she was 'too talkative'. One small VWU study in 2001 found that only 3.5 percent of the men and 23 percent of the women in the groups considered that beating wives was unacceptable. Only very serious and systematic abuse of women was recognised as "violence." (UN, 2002).

Gender-based violence is strongly correlated to poverty and low educational levels, but also relative degrees of equality within the family, thus, households where husband and wife both earn an income were found to have lower levels of violence (UN, 2002).

According to the NCAW (2000), "little is being done to address the causes or the consequences of domestic violence, either through the health care system, the legal system, local government, the schools, mass organizations or the media. Communities, resident groups, neighbours and relatives intervene when wife abuse becomes dangerous or causes disorder in the resident area. Reconciliation groups, the commune legal committee and the Women's Union may become involved in family conflicts that lead to domestic violence. The goal of their involvement is generally to stop violence and support reconciliation between husband and wife, so that the family may continue to exist as a unit. However, it is rarely treated as a criminal case, and only when the wife presses charges. The legal system treats it as part of divorce proceedings and tends to be more concerned about the integrity of the family."

Dr. Binh from the VWU confirmed that these attitudes remain a serious problem, but that there has been some progress, particularly in terms of interventions. She explained that VWU members are part of mediating teams sent to deal with domestic violence cases, along with others from the Fatherland Front, the police and other bodies. These groups aim to raise awareness of the meaning and the illegality of domestic violence. Community-based programs to "build happy and progressive and equal families," according to Dr. Binh, no longer simply try to get partners back together, as in the past, but analyse the situation in terms of what is in the best interests of the woman. This may include advocating separation or divorce. She claimed that in some cases a woman may want to remain with a violent or abusive husband and the VWU may be the party now recommending divorce based on an assessment of her circumstances.

In recent years, many counselling centres have been established but the demand remains high, and are often poorly qualified to provide appropriate counselling to victims.

A study of attitudes of health workers in CHCs to domestic violence cases (CRFH, 2001) revealed that they usually recommended the battered woman return home. Among the reasons were the view that by not returning the family would be broken and the husband would find another wife, the view that she had nowhere else to go, the lack of skills on the part of the health workers to know how to deal with the situation, the poor facilities in the CHCs to provide shelter, the fear the man would be even more violent if she did not return home and he caught up with her later, and their fear that they would be targeted if they allowed a woman to stay. While in some cases, attitudes remain a problem, as in the first reason, in most of the other cases the local health workers appear to be reacting due to the very real problems of funding, skills, poor conditions and lack of effective

protection. The last reason in particular reveals an essentially hopeless attitude to the idea that the local police could protect either the battered woman or the local health staff, revealing that a serious problem remains regarding attitudes to law enforcement on this issue.

There are also cases where women are beaten and forced into miscarriage. The study showed that health workers often do not check “lower parts” of the body even when they suspect this may have occurred, if the victim does not volunteer the information, which she may not do due to humiliation. When asked why they did not push the issue, they replied either it was a private matter and so the woman should not be pressed if she did not come forward with the information, or that they are so busy with so many clients that they do not have the time to inquire into everything if it appears it may take time for the woman to come out. Again, while the “private matter” argument reveals attitude problems, the aspect of overworked health workers is well-known to anyone living in Vietnam, and reveals the need for more specialised DV services.

‘It takes much time to ask. Furthermore, victims do not answer at once and no-one can wait for them’

a city female health worker

‘We found out immediately when looking at the wound position and wounds in other parts. But the victims only accepted the truth when the police were present. If not, we didn’t force them to answer.’

a rural male health worker

A particularly illogical limitation for women coming forward on DV, according to this report, was that treatment for a normal small accident wound costs 40,000 VND (\$2.50) while treatment for any beating costs 80,000 VND (\$5). It should be first noted that both costs are very high, but clearly this strange structure influences women to explain their wounds as a result of accidents. Victims can be reimbursed, but this requires medical certification and bringing the culprits to court and finding them guilty. I was unable to get information on whether this had changed since this report in 2001.

Health workers made clear they believed they could be of help to DV victims if there was a more coordinated approach from higher levels and the whole society.

‘When there is a certain legal case, the police can’t even protect the victim family from the other side’s revenge much less the doctors. Some time ago, a culprit family came and bargained with a doctor about damage certification. When they were not successful, they threatened this doctor and she had to refuse to be involved in the court proceedings. I heard about that and feel frightened and don’t want to be involved in those things. I only want to practice my technical skills.’

a city male health worker

‘We have so many things to do. No-one talks to us about taking care of these victim women. I think policies and guidance from higher levels are needed for health centres to support or give advice to victim women.’

a city female health worker

The NCAW (2000) asserted there was a pressing need for both preventative strategies including community education campaigns aimed at traditional beliefs on these questions, and work on the consequences, including clearer legal reaction to punish perpetrators and protect victims. While the VWU has reported some progress, it appears much remains ahead on this issue.

5. Ethnic Minority Issues

General Situation of Ethnic Minorities:

(Much of the following, from WHO, 2003, seems to be based on the Living Standards survey of 1998, hence is considerably out of date regarding actual figures for social indicators, most of which will be somewhat lower than today. However, the differences between minorities and Kinh are indicative and largely still pertain)

Ethnic minorities constitute 14 percent of the population yet make up 30 percent of the poor. About 75 percent of ethnic minority people fell under the international poverty line compared to 31 percent of the Kinh majority at that time.

Among ethnic minorities, the Khmer and most of the northern uplands minorities have experienced reasonable growth. However, the Central Highlands minorities and, within the northern mountains, the H'Mong, have been largely left behind in the development process, according to a significant number of studies.

Total literacy among minorities is 73 percent, compared to 93 percent for the Kinh (95% of males and 91% of females). However, enrolment rates have risen for the Hoa (ethnic Chinese), the Tay, Thai, Muong and Nung (all NM groups), while the lowest are for the H'Mong in the NM and the Ba'Na in the CH.

In 1999, net primary enrolment rates were slightly lower for girls than boys across all ethnic groups, but was striking for the H'Mong, with 31.5% for girls against 51.5% for boys. By 2002, according to the new VHLSS, primary enrolment among Hmong boys had risen to about 70 percent, a significant increase, but there had been no change at all in the proportion of enrolled girls (VHLSS 2002). And this is by far the lowest level in the country for both boys and girls – next lowest is among the Ba'na, at overall 57.8%, but there enrolment among girls (60.4%) is higher than for boys (55%), possibly due to the matrilineal traditions in the CH. Even the Dao, generally seen as ethnically close to the H'mong, showed overall rates of over 70 percent, with only a few percentage points difference between boys and girls. This compares to Kinh primary enrolment of 96 percent, where those non-attending are equal numbers of girls and boys.

This situation is even starker with lower secondary education. While Kinh boys and girls both had rates of around 65 percent (back in 1997, significantly higher today), the rates among minorities were some 10-14 percent in the Central Highlands and among the Dao in the NM, 22 percent among the Khmer, and 32-55 percent among most NM minorities. In none of these groups was there a significant difference between the rates of boys and girls. However, the lower secondary rate among the H'mong was overall only 4.5 percent – but with a huge gap between 7.5 percent of boys and only 1.5 percent of girls (UN, 2002).

Of 334 primary schools surveyed in 1998 (VLSS), only 10 provided some courses in an ethnic minority language. The quality of teachers is lower in remote and mountainous areas, and many are not fully trained. This is actually a new problem of the 1990s as teachers were no longer required to go there as in the past. Recent incentives include salary increases – teachers may get up to 1.7 times the normal salary for going to such areas, and up to 3 times the salary levels of health staff of comparable level in such areas.

Child and Maternal Mortality

The report contains old IMR figures (national 36.7, 1999 – today 18), but is useful for the disparities.

At that time, it was 10.5 in HCMC, up to 82.6 in Kon Tum in the CH. IMR for Gia Rai in the CH (69), among the H'mong (56), and all smaller groups combined (59), was much higher than for the Kinh (21). In between, IMR for the Tay, Thai, Muong, Khmer, Hoa, Nung and Dao ranged from 30 (Khmer) to 44 (Dao).

By region, IMR ranged from 23.6 (Southeast) and 26 (RRD), to 58 (NW) and 64 (CH). Other high minority regions like the NE (40) and Mekong (35) were not so different from the north and south central coast (37, 40).

As seen above, MMR is much higher in minority regions, home delivery is overwhelmingly prevalent among minorities (over 80 percent), compared to less than 40 percent among Kinh. Over 40 percent of minority women deliver without skilled assistance.

Many ethnic minorities are not accustomed to deliver in health facilities. In some areas, more than 90 percent delivered unassisted or with family members only, though in most cases the rate was considerably lower than this. Tradition plays a role – among the H'mong, a husband normally assists his wife, and among some CH minorities, women normally go to special huts built for that purpose in the forest. However, limited access to health facilities and low quality service also play a role (according to the WHO team, quoting Poverty Task Force, 2002).

The government tries to be sensitive to their cultures, and thus can only advise them to come to free health facilities, according to Dr. Ha from Hanoi University of Public Health. She explained that access has improved as a result of government policy, as the government and the VWU now train and provides skilled birth attendants to go to assist women who deliver at home, and even to the forest to help women deliver in their forest huts, and provides clean delivery kits for this purpose.

The fertility rate in 1999 ranged from 1.87 (Kinh) and 1.46 (Hoa) to 7 (H'mong), and 5.32 (Gia Rai). For Gia Rai, there was almost no decline since 1989, whereas among the Hmong it declined 24 percent. The decline among Kinh was 48 percent, and among the other northern minorities over 50 percent, even among the Dao, who are closer to the H'mong traditionally than other northern minorities, the decline was 48 percent.

Malaria:

Malaria is mainly prevalent in mountain regions, hence minorities are most at risk. Officially there are still a high number of cases in mountain regions, at 10.9 cases per 1000 in 10 provinces with the highest ethnic minority share of the population (high EM% provinces), compared to 1.2 cases in 10 with lowest ethnic minority share (low EM% provinces) in 2001. However, these were “clinical cases only, not confirmed by laboratory. In the absence of quick diagnostic means, but with safe, cheap and efficient drugs available, it is logical to treat every fever case as a malaria case, in particular in remote areas” (p. 12).

In 2001, laboratory tests confirmed an incidence only 0.9 per 1000 for the country, but this was only 0.1% in the 10 low EM% provinces, compared to 0.7 per thousand in the 10 high EM% provinces. But the figures was a massive but 5 per thousand in the CH, indicating that it is above all a problem for minorities in this region and the rate is thus very low among other high EM% provinces outside of the CH.

However, as noted above, in the CH, severe cases and deaths from malaria occur very often in newly settled population from outside the region. In fact, minorities living in the foothills of the northern and central highlands have a much higher rate of genetic immunity to malaria than either Kinh living in the plains or minorities such as the H'mong living at the mountain tops, and this is consistent with

where malaria transmission generally occurs. Thus outside people from the coastal plains moved to foothills areas are more likely to contract the disease than minorities.

Most northern mountain minorities have their own tradition of sleeping under mosquito nets, so this facilitates the work of the National Malaria Control Program, and net use stands at over 95 percent among most northern minorities, much the same as the national rate.

However, within the north the H'mong have no tradition of sleeping under nets, as they traditionally lived at the top of mountains, beyond the habitat of the *A. minimus* mosquito. But as H'mong communities are resettled lower down, as part of state programs to give them better access to health and education facilities, it exposes them more to malaria.

In many groups in the CH, the introduction of bed nets was difficult. Further, often well-intentioned efforts to encourage minority people to give up 'unhygienic' practices such as keeping livestock underneath their stilt houses have missed the point of these practices, which tended to protect them from mosquitos, which attacked the livestock instead, and left the people, residing higher up, largely alone. This was clearly observed in some parts of the northern mountains by experienced researchers.

In addition, in the CH, many of the poorest minority people no longer live in stilt houses, not due to the previous (largely unsuccessful) attempts at assimilation, but because of the destruction of such a large proportion of forest. The necessary timber for stilt houses does not exist or is inaccessible, so the government provided construction materials, mostly metal, for them to build new houses, but these are on the ground, and thus are more prone to malarial infection than their stilt houses. This was clearly noted by a research team in the region in 1999.

Specifically regarding gender, as noted above, among some CH minorities, women normally go to special huts built for giving birth in the forest, rather than health facilities. This may increase the chances of pregnant women contracting malaria, and this in turn is a cause of maternal or child mortality. The government's initiatives in providing reproductive health care directly to these huts is certainly to be applauded, but may not lessen the malaria risk.

Tuberculosis:

Both the incidence and mortality of TB in low EM% provinces is double that of high EM% provinces. In 2001, the 10 high EM% provinces had an incidence of 30 and a death rate of 0.9 per 100,000, whereas the 10 low EM% provinces had an incidence of 65 and death rate of 2.1 per 100,000. The patterns thus appear the opposite of the malaria patterns.

However, WHO assesses that this most likely "reflects lower access to diagnosis of TB in remote areas, rather than lower prevalence ... Distance, fear of social isolation, indirect costs and poor health services are important causes to delay treatment, in particular for women. In practice, treatment for TB in mountainous and remote regions in Vietnam requires hospitalisation during several weeks or months. Therefore, despite free treatment, total costs are high (eg, opportunity costs)" (p. 13-14).

Leprosy:

In 1983, Vietnam was one of first countries to introduce multi-drug regimens for leprosy. Prevalence dropped from 68.7 per 100,000 in 1983 to 1.9 in 2001. The 15 provinces where it remains slightly more prevalent than average in centre and south include Kon Tum and Gia Lai in the CH, but they are not particularly the most affected. The most affected are Binh Thuan on the south central coast (mostly Kinh) and Tay Ninh in southeast on the Cambodian border (both over 10 per 100,000). Only

38 percent of new cases are female, but the relative female incidence has risen over the last 20 years, suggesting that “cultural factors limit the number of detected women.”

Other CDCs:

In general, acute respiratory infections (ARI) are much more common in the colder climates of the mountains, thus meaning minorities. Pneumonia is thought to be the most important cause of death among children. The plague is still endemic among rodents in the CH, though data about human infection is limited.

Immunisation:

While the 10 low EM% provinces had an EPI coverage of 99.6 percent in 1999, in the 10 high EM% provinces the coverage was 93.4 percent, though this difference has decreased (in 1993, only 68 percent of the latter were covered, compared to 95.5 percent of the former). Now, according to WHO, ethnic minorities in the NM and CH are considered the most enthusiastic participants, and as noted above, no cultural or traditional prejudices against immunisation have been noted. However, distance and in some areas social aversion to CHCs among some minorities remain a problem (according to discussion with Mr. Murakami).

Child malnutrition:

Most provinces in the NM and CH have a high percentage of underweight children, as seen above. From a 2001 survey, total underweight children were 37.7 percent in the 10 highest EM% provinces, and 31.7 percent in the 10 lowest (national average 31.9%). The respective figures for stunting were 44.3 percent and 33.5 percent (national 34.8%), and wasting 10.2 percent and 8.8 percent (national 9%).

Anaemia, mainly due to iron deficiency, is very prevalent in the CH. There has been a huge campaign around Iodine deficiency, reducing the population with low iodine from 84 percent in 1993 to 43.5 percent in 1998. In 2003, UNICEF reports 83 percent of households nationally consuming iodised salt (UNICEF, 2005). The remaining more heavily affected areas are not so much ethnic minority or mountainous areas, but the southeast and the Mekong.

Safe Water

While some 52 percent of the population lacked access to safe water nationally, 87.2% of ethnic minority people did not have access to clean water. UNICEF now gives much higher figures for access to safe water, nationally at 73 percent (93% urban areas, 67% rural areas, UNICEF 2005). This may reflect the particularly energetic campaign in Vietnam. However, the enormous difference between minority regions and average access in the previous study likely remains little changed. Access

Geographical access has greatly improved in the last decade, with big improvements in the road network in most remote regions. However, geographic constraints remain much higher in minority regions than for the general population, and in some areas several hours of walking is still required to reach a health centre. Despite efforts, language and cultural differences still remain issues, especially for smaller groups. While access is free to most minority people, the costs of travel, opportunity costs etc that continue to impact on access for the poor may be much more serious in ethnic minority regions, especially remote ones. A range of mobile health services which go directly to the minority villages and even households, as noted in parts of this report, have made a great impact, and they need to be given support to further expand their activities.

Health staff:

According to WHO (2003), there is limited availability of well-qualified staff who speak the local languages and have knowledge of local customs, and ethnic minority women in particular remain underrepresented among health staff in minority regions. However, according to Dr. Ha, “a large proportion of health staff” in minority regions are from that same minority, though she also underlined the difficulties involved. The exact situation is a little unclear, though it seems clear that in the CH, the proportion of minority staff is much lower than in NM (WHO 2003).

WHO also points out that “in all provinces visited, grants for medical studies are allocated to young ethnic minority people (and /or local Kinh people) on condition that they return after their studies to work in the public health system in their own commune or district. Efforts have been made to appoint staff mastering an ethnic minority language (eg in Cao Bang the majority of the health staff is Tay and the aim is to have at least one Dao or H’mong staff member in the community health centres providing care to Dao or H’mong villages)” (WHO 2003, p. 23).

The problem noted above of the state sometimes not reimbursing CHC’s when it declares waivers of user fees, thus affecting staff wages, supplies and equipment, is acute in minority areas where health care is free. As fees are waived in minority areas, it often means salaries are lower and better qualified staff move elsewhere. The current apparent boosting of CHC funding is thus very important.

Government Policy

Vietnam has long had a strong official policy on ethnic minorities:

- It officially recognised them in constitutions since 1945
- A larger percentage of ethnic minority people are in the National Assembly than their population as a whole (but at lower levels, the involvement of certain ethnic minorities in decision-making process limited)
- The government aims to cut difference between lowlands and highlands via various programs
- Both the Hunger Eradication and Poverty Reduction Program (HEPR, or Program 133) and the Program for Socio-Economic Development in Communes faced with Extreme Difficulties in Mountainous and Remote Areas (Program 135) are heavily focused on ethnic minorities and mountainous regions. “During field visits, newly built district hospitals, community health centres, safe water supply systems and new roads financed under this program have been observed” (WHO 2003, p. 21)
- Government decrees provide exemption from fees, and free health care and treatment at state medical facilities for communities in difficulty, mostly ethnic minorities. Free public health care for all ethnic minorities in the CH and in six NM provinces is stipulated.
- In practice, health care is free for the minorities in the CH, while in the NM, “special health financing strategies currently focus on the poor, in particular those in remote and mountainous areas, rather than on ethnic minority groups (per se). At present such an approach seems justified” (WHO 2003, p. 32)
- The Vietnamese military is also heavily involved in providing health care in remote and mountainous areas, mostly inhabited by minorities

- Compulsory health insurance mainly covers workers in the official sectors, and thus excludes most rural people, especially minorities. However, the government therefore has a system of providing free health insurance cards to the poor and fee waivers. In 2002, the Health Care Fund for the Poor was set up, obliging provinces to allocate at least 70,000 VND per person per year for those targeted as poor.
- Government policy has in the past been largely in the form of slow assimilation, ie aiming at encouraging minorities to adopt to majority Kinh economic and livelihood strategies and cultural norms. This has largely been counterproductive, except among some of the northern minorities traditionally closer to Kinh strategies already. However, in recent years there has been a recognition of the pitfalls of this policy and far more emphasis is now given to the importance of minority cultures when necessary transitions (ie resettlement from very remote areas) take place
- Overall, provinces with a high percentage of ethnic minorities have a significantly greater number of provincial and district hospitals and hospital beds than the national average, and a much higher per capita health budget. However, the number of doctors per capita is slightly less.

Resettlement:

There have been many resettlement schemes of poor Kinh people (and sometimes other minorities) from densely populated areas, mostly in the north, to mountainous areas to relieve population pressure, in the NM but especially in the CH. This has led to increased land pressure, a deterioration of traditional livelihoods and environmental degradation. As noted above, the immigrant populations are often at greater risk of diseases such as malaria.

The other form of resettlement is of ethnic minorities themselves, from higher in the mountains to lower down, where malaria is more prevalent. In addition, as forest land has dwindled with immigration, minorities themselves have less land on which to practice their traditional livelihood patterns, and are thus heavily disadvantaged economically when they attempt to apply traditionally Kinh practices (eg paddy rice farming) on smaller amounts of land, while often being banned from using the remaining forest for traditional livelihood pursuits. This extreme economic disadvantage clearly puts them at greater health risk, especially regarding nutrition. The rise and fall of the world coffee price also had dramatic effects: during the rise from the mid-1990s, many minority people in the CH converted small-holdings to coffee from their traditional mixed strategy, and many others sold land to, or were swindled out of it by, richer Kinh coffee plantation owners. For a time most of these people saw rising incomes, but when the price crashed in 1999-2000, the results were devastating, above all for the poor and minorities, who now lost money but had previously lost land for food security. Thus adult and child malnutrition and child and maternal mortality were obvious results. All these points indicate the need for extreme sensitivity when attempting to apply well-intentioned schemes to remove minority people from extreme isolation or perceived "backward" ways, as many experts from the Kinh majority tend to refer to traditional livelihood patterns.

6. International Conventions on Women's Equality

Cairo International Conference on Population and Development (ICPD)

The International Conference on Population and Development (ICPD), held in Cairo in 1994 underlined the need to reorient population policies by shifting the focus merely from family planning services to a broader agenda including reproductive health and reproductive rights, and to women's empowerment, education and employment which have an important impact on women's negotiating power and hence on women's reproductive health (this and below from CIHP et al, 2002).

In response, Vietnam set up large-scale advocacy programs to introduce these concepts to policy makers and population programmers around the country.

A study of four northern communities in 1999-2001 was conducted to assess the impact of these policies in the context of a number of development projects combining micro-credit with reproductive health education. Among their observations were the following.

Respondents agreed that men and women had become more equal and that women could participate more in activities from which they had previously been excluded, and could participate more in community meetings. However, many (both men and women) expressed the view that women should not become “too equal”. There remained a strong perception of the man’s role as a breadwinner and household head, and woman’s role a housewife and money manager. Man’s work was still considered more important, and because of this, and the fact that women’s work contributed less money to the family economy, men’s health was still appreciated more.

Men believed women were powerful by their role as family money keeper, as they were unable to spend money without their wife’s knowledge, and they believed women were more careful with money than they would be. However, husbands usually had the final say on bigger purchases.

Women were seen as family peace-keepers and were expected to remain silent when a husband lost his temper. Some respondents still believed a wife may be at fault when a husband turned violent as she was ‘too talkative’.

The local Women’s Unions provided micro-credit programs to their members, and women highly appreciated this as because they can thereby access loans at much lower interest rates than elsewhere. The programs also included training programs for women with knowledge in production, cultivation and animal husbandry.

As a result, interviewees reported that women’s position in the family had changed, as their contribution to family economy via these programs gave them a greater voice in family decisions. In addition, being involved in the women’s group meetings gave them a forum to exchange experiences with other women. However, time factors sometimes limited women’s involvement, while certain topics were off limits due to traditional gender norms and women often still endured family strife without complaining.

Women reported that they had become more active in seeking health care for their children and in receiving antenatal examinations. Most couples said they preferred smaller families, but some continued to give birth till they got a boy child, though this was less prevalent than before.

The responsibility for family planning mostly fell on the women, and male contraception was rarely, if ever, used, except as a last resort. Many women discussed health problems with their husbands, but some believed they should not bother their husbands with such ‘trivial’ issues. Issues such as sexually transmitted diseases were generally still seen as too sensitive to be discussed in the family or community.

Health workers had provided women with abundant information related to maternal and child health and family planning, but much of it was a one-way transfer of information, and less time was given to encouraging the women to voice their own concerns, and many were often shy to do so.

However, the overall results of the survey suggested that “empowerment in social and economic spheres does not necessarily translate into empowerment in reproductive health. For example, many women who were socially and economically empowered were still passive in seeking reproductive health services.” This was even the case sometimes among women who seem “quite equal to their

husbands in decision-making about economic and family issues. Even reproductive health programs tend to concentrate on issues like family planning and child health, which are not difficult to talk to husbands about, compared to the still more sensitive issues like male responsibility for contraception, STD's etc. Thus "other types of interventions" are still needed.

On the other hand, "all women who were highly empowered in reproductive health demonstrated at least some level of empowerment in social economic spheres, suggesting that social and economic empowerment may be a necessary but not a sufficient condition for reproductive health empowerment" (CIHP et al, 2002, p. 75, emphasis added).

Beijing International Platform for Action

Twelve critical areas were outlined in the International Platform for Action for women's equality in Beijing in 1995. These covered women and poverty, education, health, violence against women, women and armed conflict, women in the economy, women and decision-making, institutional mechanisms, human rights, the media, the environment and the girl child (Beijing + 5, 2000).

Many aspects of the Beijing platform had already been in various Vietnamese laws, but a raft of new laws followed, as well as amendments to and strengthening of existing laws. In 1997, the government adopted the National Plan of Action in Vietnam by 2000, formulated by the National Committee for the Advancement of Women (NCAW) with contributions from the grass roots level, the VWU etc.

Committees for the Advancement of Women (CAW's) were established in all 61 provinces and in 50 of 53 ministries. All provinces have Provincial Plans of Action (POAs). In the 1997 annual evaluation of the POA, the NCAW claimed its major achievement was that "the first time, the international and domestic direction and strategy about women were disseminated rather widely and started to be understood and implemented by branches, mass organizations and people." The areas which had been most successful in implementing the POA were poverty alleviation, education and training, women's leadership training and access to decision-making structures.

Apart from developing new legislation, the POA sees it necessary to increase women's awareness of current laws to enable them to protect their rights. Objective 5 of the POA states:

5.12 The Ministry of Justice shall, in collaboration with Ministries and branches concerned, provide legal knowledge to all strata and leaders at all levels in order to raise their responsibility for the protection of women's rights.

This is done via the network of Cooperation Councils for Law popularisation and Education established in 1998, and via Vietnam's well-established state structures and mass organizations operating down to the lowest levels.

All twelve areas are relevant to health, for example, under the 'poverty' area, one point was the establishment of the UNFPA's integrated credit and reproductive health fund, by 2000 implemented in 51 communes in 12 provinces, and the extensive literacy and primary education campaigns for women and girls carried out in the 'education' area clearly have an impact on health. However, for the purposes of this report, the main points in the 'health' and 'violence against women' areas will be outlined.

In health, important initiatives included:

- a national campaign for iodised salt distribution, aimed at women in remote and mountainous areas, reducing incidence of goitre by 2 percent per annum

- Decree 37 in 1997 enhancing population and family planning programs
- A three-year reproductive health program (1997-2000) called 'Gender equality and male responsibility in family planning'
- The development by the VWU of a number of social clubs to encourage family planning activities
- A number of studies were undertaken to identify the causes of maternal mortality and high abortion rates and a 'safe motherhood' program was developed from this
- The VWU expanded its program of providing free check-ups and treatment to poor women and children
- The rate of child malnutrition decreased from 45% in 1995 to 33% in 2000
- The occurrence of antenatal check-ups increased 10.3% in 1997 compared to the previous year
- The first national TV series was launched to address AIDS issues
- A strategic plan was developed for the prevention of HIV/AIDS and care for victims for 2000-05, including prevention of mother to child transmission, spreading information to health care workers regarding HIV treatment and management, and a care package and counselling for pregnant women and their children with HIV/AIDS.

Regarding violence against women, important initiatives included:

- An initial study by the VWU and NCAW into domestic violence
- Establishment of a counselling centre for domestic violence in HCMC linked to the '108' hotline for victims of domestic violence
- The production of a video on violence against women, distributed to every province and every CFAW in the country
- The VWU conducted a project entitled 'Combating domestic violence against women in Vietnam', including research on mechanisms to deal with DV, training for police, judiciary and conciliatory committee personnel, and a national awareness campaign
- Directive 766 in 1997 intensifying controls against trafficking of women and children
- A national campaign on information, education and awareness of trafficking in women, with VWU participation, was carried out with support from the International Organisation of Migration (IOM)
- The VWU developed a POA against trafficking in women and rape and sexual harassment of the girl child and adolescents
- In 1997, sentencing for sexual abuse of girls was increased

A second NCAW National Plan was approved in 2002, and partly incorporated into the Comprehensive Poverty Reduction and Growth Strategy (CPRGS) of 2001-5. It included aspects such as organizing training courses for local officers in order to incorporate gender issues effectively in the implementation of the CPRGS, a new Marriage and Family Law in 2000 which stipulates that the names of both husband and wife must be on land-use certificates, increasing the participation of women in "all agencies, sectors and enterprises by 3-5 percent by 2010, and establishing a Learning

Promotion Fund and set targets for women at different levels in training and disciplines. The plan aims to further the goal of providing universal reproductive health care to the whole population, though it is not very specific about how. The CPRGS also aims to reduce women's overburden in domestic work through investing in small-scale technologies to serve family needs in clean water and energy, by greatly expanding the kindergarten and nursery school system, and by "launching campaigns to propagate and educate about family responsibility sharing." All "prototype prejudice against women" is to be removed from textbooks.

UN Millennium Development Goals

The Vietnamese government is actively committed the MDG's, and most are incorporated into its CPRGS. A simple look at the MDG's reveal that Vietnam is far ahead in many respects, but also reveals important areas where progress is not as fast. However, the inequalities revealed in this report, while no different to those of other developing countries, also make clear that even in the relatively successful areas, much still needs to be done among specific sectors of the population.

Regarding the main goals:

- Halve the number of people living in poverty or hunger between 1990 and 2015: Vietnam has reduced poverty from over 70 percent in 1988, to 58 percent in 1993, percent in 1998 and 28 percent in 2002, thus is far ahead of schedule. However, 28 percent poverty remains high, and severe poverty still stands at around 8 percent. One of Vietnam's most serious indicators remains the percentage of underweight children under five - while the rate has also fallen from 53 percent in 1993 to 33 percent by 2000 and perhaps less today, the rate remains very serious, and is much higher in poorer provinces. The percentage of severe underweight children stands at 5.8 percent.
- Achieve universal primary education by 2015: Vietnam has increased the primary education rate from around 88 to 95 percent today, some 92 percent for girls and 98 percent for boys. However, as seen above, the rates are much lower in certain regions, especially for girls
- Reduce child mortality: As seen above, both child and infant mortality have come down very rapidly, to some 23 and 19 per 10,000 respectively, ahead of richer countries in the region, as is the percentage of one year olds immunised against measles (93%). Once again, however, there are very big discrepancies throughout the country.
- Reduce the maternal mortality rate by three quarters between 1990 and 2015: While Vietnam can claim some success in halving MMR from around 200 to 100, the latter figure is disputed and thought to be more like 130. As such, while still significant, this appears one of the slower changing indicators, and is especially high in the NM. By contrast, the proportion of births attended by skilled medical personnel has risen very rapidly and is a high rate compared to the region, but again much lower in the NM
- Halt and begin to reverse the spread of AIDS by 2015: Perhaps the greatest challenge, but it is difficult to predict regarding ten years in the future. At present the problem is clearly growing rapidly rather than halting, even if the rate remains much lower than in Cambodia, Thailand and Burma. Regarding the MDG indicators here, neither the prevalence of HIV among pregnant women 15-24, nor the rate of school attendance by HIV orphans, show any particularly positive signs at this point; the ratio of condom use as a proportion of contraceptive prevalence is only 7 percent (though the contraceptive rate itself is very high), but there has been clear improvement and it is part of national campaigns. In particular, the percentage of married women who understand the causes of HIV and that condoms offer protection is reasonably low (60%), and the proportion of 15-24 year old women with comprehensive knowledge about HIV as low as 25 percent

- Halt and begin to reverse the spread of malaria and other major diseases: As seen above, Vietnam has been particularly successful in the fight against malaria and TB, as well as measles, diphtheria, cholera etc. However, the numbers infected remain serious, and the emerging problems are a number of 'neglected' diseases for which Vietnam has to import expensive medicines, such as Dengue, Encephalitis, Rubella etc.

From this brief summary, the most important areas where progress is somewhat slower are the rate of underweight children, the maternal mortality rate, the percentage of condom use among general contraceptive use, comprehensive knowledge about HIV, and the threat of neglected diseases, as well as some areas where certain minority groups are well behind the rest, as with the percentage of H'mong girls in primary school and of births with a skilled practitioner in the NM

7. Gaps in Government Policy

A number of respondents expressed the view that "most" or "nearly all" government policy was very good in these areas, but that "implementation" is very often a problem which brings results inconsistent with policy intentions. With some important exceptions, this report would tend to back the view that there are a great many very positive policies in the Vietnamese health sector. Moreover, in a great many cases, the problem of "implementation" has a great deal to do with funding levels. Furthermore, the clearest area where few people would see policy as 'good' – the use of user-fees for general health services for most of the population – this also directly relates to funding.

For example, Dr. Ha from Hanoi University of Public Health pointed to the policy of sending doctors to the commune level to boost their numbers till all communes have doctors. However, the problem was that people coming from rural and remote areas often try to stay in the city they studied after graduating. She noted that doctors from cities agreeing to go to remote areas are only offered perhaps "a few dollars extra" in their pay packets. This is vastly less than offered teachers to go to remote areas (who get up to 170% of their normal salary), and this inconsistency has lasted many years and has been widely noted without any apparent change. She said she had no idea why this was so. She explained that the central government declares in policy that x number of CHC's must have x doctors by a certain date. It is then up to the district to decide how to do it, depending on the resources of that district.

There are also often problems getting local rural people in the districts to come to big cities to study medicine, even though the government has preferential policies, especially for ethnic minorities. Even if the government waives all fees for certain groups, people from any poor area have to consider all the other costs of going to live in the city for some years, including accommodation.

Dr. Binh from the VWU listed, apart from "implementation," a number of key gaps in her view.

First was the lack of friendly family planning services for teenage girls, and discrimination against them in existing services. The first is a policy issue, while the second is one of implementation and attitudes among health staff – there is no such discrimination in policy.

Second, Vietnam has good paid maternity leave provisions (4 months on full pay), but as a result some enterprises then don't want to take on women, and there needs to be firmer enforcement of anti-discrimination aspects of the Labor Law regarding this. More importantly, this maternity leave does not apply to the majority of women, who are farmers, or work in the small-scale informal sector, in other words all the poor.

In addition, women, being poorer than men, often still have to work in dangerous and poisonous environments even when pregnant.

Michael Karadjis and Vo Quynh Nga

Appendix

Main Regions of Vietnam

It is important to understand the main ecological regions of the country, as much of this report compares indicators in regions. This is because some regions are clearly poorer and some have a very high proportion of ethnic minority people. They are grouped here according to socio-economic level. It is clear the two poorest regions are those with the highest proportion of minorities.

Low Socio-Economic Level

Northern Mountains (NM) – the poorest region, with the largest proportion of ethnic minorities in the population. Often classed as two regions, the poorer North West (NW) and North East (NE). Vast borderlands with Laos and China.

Central Highlands (CH) – the next poorest region, with the second highest proportion of ethnic minorities. Though the overall GDP has risen, largely due to coffee cultivation, this has tended to accentuate the poverty of the minorities, as the economic gains have been mostly made by the Kinh, including large numbers of immigrants. Thus indicators in the report which sometimes show a better situation for the CH than for the NM must take this into account, as the average includes the larger number of Kinh in this region. Vast borderland with Cambodia.

Medium Socio-Economic Level

North Central coast (NC) – mainly Kinh but with some very small minorities along the mountain range. While in most respects clearly above the NM and CH, the NC has extremely poor soils and bad weather and as a result nutrition levels are often low, even if access to health facilities is quite good. Some parts are particularly poor. All provinces border Laos.

South Central coast, usually just called Central Coast (CC) – likewise mainly Kinh, but with the important Cham minority, the only minority on the coastal plain. In most respects similar to the NC, though without the extreme poor soils. No borderlands.

Mekong Delta (MD) – mainly Kinh but with a very large Khmer minority. Also somewhat in between status, but on certain indicators, the Mekong comes up as very low. Vast borderland with Cambodia which is a very large transit point, greatly affected by cross-border issues of disease, particularly HIV.

High Socio-Economic Level

Red River Delta (RRD) – wealthy agricultural region, and containing Hanoi, Kinh region. Invariably showing the highest or second highest indicators. However, the presence of Hanoi ‘weights’ these indicators, and there remain patches of significant poverty in the RRD, though it is very well-

served. In addition, the far northern strip of coast, north of Hai Phong, is conventionally listed here, and this area borders China, is a major transit point, a key sex work region, and is greatly affected by cross-border issues of disease, particularly HIV.

Southeast (SE) - wealthy agricultural and industrial region, where perhaps half the country's industrial production is concentrated. Includes Ho Chi Minh City (HCMC), mainly Kinh region. Again, presence of HCMC 'weights' the indicators, and there remain patches of poverty here. HCMC itself is currently the leader in the country's growing HIV epidemic, and of the country's sex industry.

Main Minority Groups:

Northern Mountain (NM) minorities - including Thai, Tay, Nung, Muong, Dao. While the NM is overall the poorest region, many of these minorities are actually reasonably well-integrated into mainstream livelihood strategies while preserving much of their traditional culture, and their situation has been improving. While their health, education and poverty indicators are clearly below those of the Kinh, many of the low indicators for the NM are due to the extremely low situation of the H'mong in particular, who are thus worth understanding as a separate case (below). While the Dao are more ethnically related to the H'mong than to most of the other northern minorities, in practice the living standards and the rate of intermarriage with other groups put the Dao closer to the other northern groups than to the H'mong.

H'Mong - also in northern mountains (NM), but with particular problems that stand out from the rest. The H'mong have clearly the lowest social indicators in the country, in particular the number of H'mong girls enrolling in primary school, at 30 percent, stands out. The northern mountains are much more remote than the Central Highlands, and the H'mong live in the most remote parts, traditionally at the tops of mountains, which creates serious issues of access.

Central Highland (CH) minorities, including a number of Austronesian-speaking peoples such as the Gia Rai, and a number of Mon-Khmer groups, such as the Ba'Na. While the CH is not as remote as the NM, the minority groups here have traditionally been far more 'remote' from the Vietnamese mainstream society due to a number of historical, cultural and socio-economic reasons. As a result, while not as severe as the NM in some respects, their social indicators in other respects are considerably worse than those of the NM except for the H'mong.

Khmer - living in the Mekong Delta (MD), while poorer and with lower indicators than the neighbouring Kinh in the Mekong, the Khmer in most respects are very similar to their neighbours in their overall livelihood strategies, based on wet rice cultivation. The position of the Khmer is thus essentially similar to that of the poorer Vietnamese of the Mekong, a region where landlessness has risen more than anywhere else in the country. In general, their position appears to be considerably better than that of the minorities of the NM or CH, though the Mekong gets surprisingly low indicators in some respects, such as literacy rate and malaria transmission. Given the considerable traffic on the Vietnam-Cambodia border, this is an important region for HIV/AIDS transmission, especially considering the far greater spread of HIV in neighbouring Cambodia.

Cham - an Austronesian speaking people living on the south coastal plain, are generally well-integrated into the mainstream, and do not especially stand out in terms of overall social indicators, certainly not like the CH and NM groups, though they are generally considered poor. In general, the south Central Coast is intermediate in terms of human development in Vietnam.

Some small minorities along north central mountain chain, who are very isolated and in some cases their populations are tiny, even close to extinction. The government has done a great deal to help

these people preserve their cultures. They are very poor, but given their small numbers, are not generally considered a large-scale problem in terms of financing human needs. However, it would be unwise to ignore them given their cultural specificity and the fact that any epidemic could have a severe impact on their numbers.

Hoa - ethnic Chinese, mostly urban and with a socio-economic position similar to that of urban Kinh. For the purposes of targeting ethnic minorities as a section of the poor, the Hoa can be omitted.

Provinces with highest concentrations of ethnic minorities:

Cao Bang (95%) NM (NE)
Ha Giang (88%) NM (NW)
Bac Can (87%) NM (NE)
Lai Chau (83%) NM (NW)
Son La (83%) NM (NW)
Lang Son (83%) NM (NE)
Hoa Binh (72%) NM (NW)
Lao Cai (67%), NM (NW)
Kon Tum (53%) CH
Tuyen Quang (52%) NM (NE)
Yen Bai (50%) NM (NW)
Gia Lai (44%) CH

Provinces Classified as Having 'Low Human Development'

Lai Chau (83% EM) NM (NW)
Ha Giang (88% EM) NM (NW)
Kon Tum (53% EM) CH
Gia Lai (44% EM) CH
Son La (83% EM) NM (NW)
Lao Cai (67% EM), NM (NW)
Cao Bang (95% EM) NM (NE)
Bac Can (87% EM) NM (NE)

Mountainous Regions:

All the above provinces with high EM% of population are mountainous, either the NM (NW or NE) or the CH. The NM contains many particularly remote regions.

Border Provinces:

Many NM provinces border either China or Laos, and contain large number of minority people. The CH provinces, with large minority populations, border Cambodia, as do the more western MD provinces, particularly the areas with large Khmer populations. The mainly Kinh NC borders Laos. In addition, the far northern coastal strip, conventionally included as part of the Red River Delta region, borders on China along the coast.

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Local women from Ninh Binh, Hai Duong, Ha Tay

P.S.

* FROM VIETNAM FROM THE LEFT, MONDAY, FEBRUARY 05, 2007, Posted by at 12:04 AM:
<http://mihalisvn.blogspot.com/search?updated-min=2007-01-01T00%3A00%3A00-08%3A00&updated-max=2008-01-01T00%3A00%3A00-08%3A00&max-results=1>

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Footnotes

[1] FAO/UNDP, 2002.

[2] Anh and Hung, 2000, p173-75.

[3] According to Mr. Hitoshi Murakami, EPI officer, WHO, Hanoi, though Vietnam News (28/3/05) claimed that the Hepatitis B vaccine “will be” the 7th to be provided free of charge as of 2005, ‘Hepatitis B vaccine free for infants’.

[4] ‘Hepatitis B vaccine free for infants’, Viet Nam News, 28/3/05.

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[6] ‘TB control faltering due to rise in AIDS, staff shortage’, Viet Nam News, March 19, 2005.

[7] National Committee for the Advancement of Women, 2000, p15.

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[9] ‘Hepatitis B vaccine free for infants’, Viet Nam News, 28/3/05.

[10] Most information below from ‘Rubella epidemic spreads widely in Cu Chi industrial zone’, Lao Dong, 18/3/2005.

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[17] Project provinces are 18 relatively poor provinces targeted by the Population and Family Health Project of the Committee for Population, Family and Children for special attention during the 2002 Demographic and Health Survey.