

*Committee for Ethnic Minorities*  
*UNICEF*

# *Reaching out for Change*

*Hanoi, 2003*

*A qualitative assessment of government healthcare and education policies affecting the women and children of ethnic minorities*

*Carried out in five provinces:  
Lai Chau, Ha Giang, Kon Tum, Nghe An, and Soc Trang*

## ***Acknowledgement***

The Department of Policies on Ethnic Minorities, of the Committee of Ethnic Minorities wishes to thank the United Nations Children's Fund (UNICEF) for positive assistance provided for the research and evaluation of education and health policies for ethnic minority children and women in especially difficult communes in mountain and remote areas.

Our thanks also goes to the research team for having finalised the report on the assessment evaluation. The report is very useful, having provided information and analysed the implementation of education and health policies in difficult areas under Programme 135 from the viewpoint of researchers. It has helped the Committee of Ethnic Minorities revise and recommend new policies and make them more practical and effective for ethnic minorities, especially children and women. The Committee of Ethnic Minorities hopes to enjoy continued cooperation with UNICEF to advance the well-being of all ethnic minority children and women in Viet Nam.

The Department of policies on Ethnic Minorities,  
Committee of Ethnic Minorities

## ***Foreword***

Most research puts ethnic minorities, particularly children and women, among the country's most disadvantaged groups – many live in remote and difficult-to-reach areas and have been left behind by the country's rapid socio-economic development. It is therefore both welcome and reassuring that the Government of Vietnam has placed the health and education of ethnic minorities at the fore of the socio-economic development agenda

Vietnam's ratification of key international treaties such as The Convention on the Rights of the Child (CRC) and the Convention Against all Forms of Discrimination Against Women (CEDAW) provide an important legal and ethical framework for the promotion of human rights, particularly those of children and women – indigenous children are explicitly recognised as rights-holders by the CRC. UNICEF-assisted programmes are working to promote greater awareness of these rights, in part by employing a bottom-up approach to policy assessment that actively solicits the views of children and women as primary rights-holders.

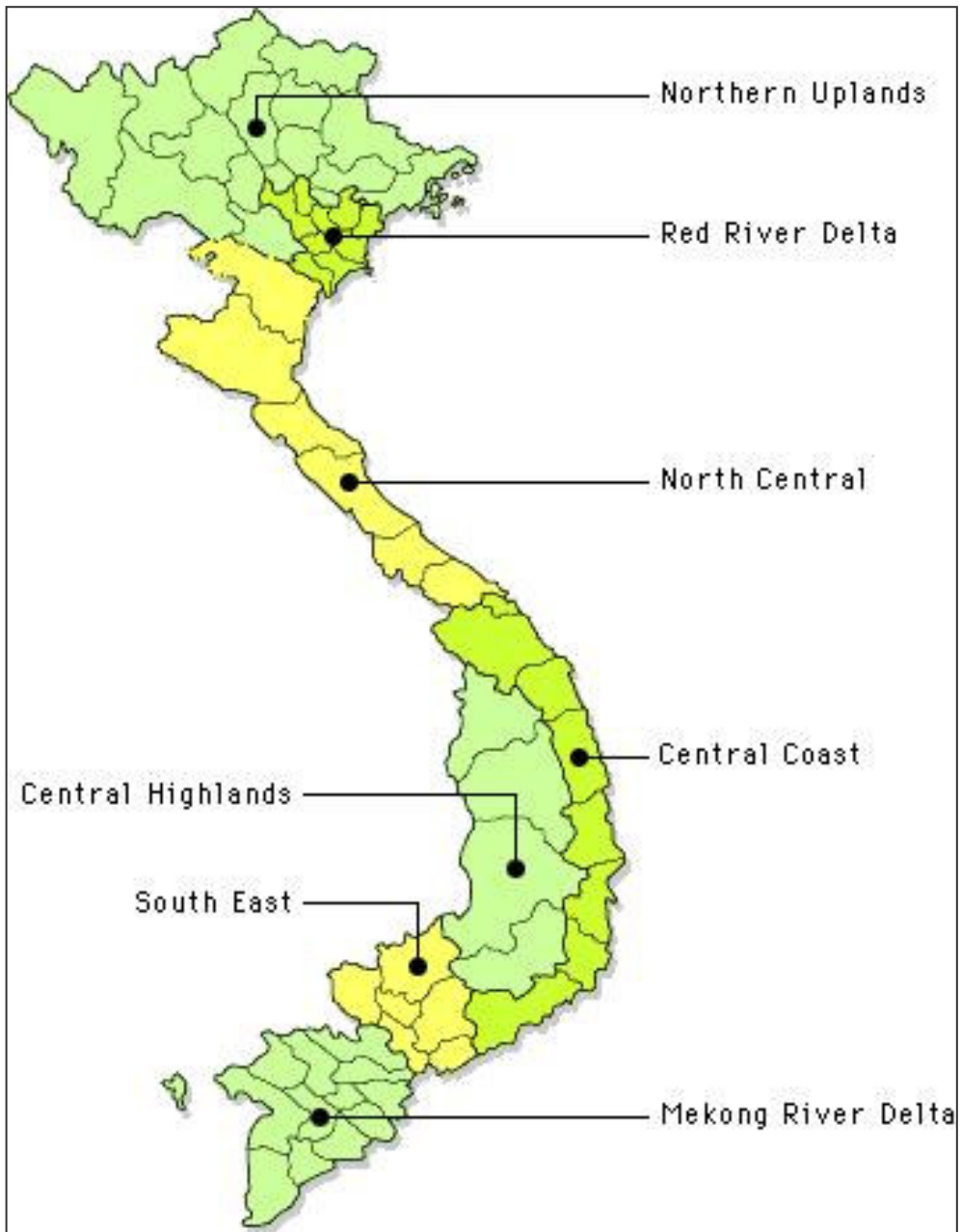
Following this approach, this study highlights several Government policies that uphold the basic rights of ethnic minority children to health and education. Education policies reviewed include tuition fee exemptions, the provision of notebooks and textbooks, secondary boarding schools, admission to higher education, and teacher salaries and rotation schemes. Health policies examined include the subsidised delivery of medicines and iodised salt and the provision of free healthcare services.

Specifically, the assessment looks at factors affecting the implementation of health and education policies under Programme 135, policies that protect the rights of ethnic minority children and women, especially those living in remote and difficult-to-reach areas. It highlights areas in which rights are being successfully upheld, and those where they have been neglected and deprived.

UNICEF Viet Nam has been pleased to work with the Committee on Ethnic Minorities and the Department of Ethnic Minority Policy to conduct this study. Findings reflect emerging areas that demand priority support from duty bearers to uphold the essential rights of ethnic minorities and other marginalised population groups. We believe this study can serve as both a catalyst and reference for the development of comprehensive policies and programmes that reinforce successes, reduce disparities and empower communities.

Anthony Bloomberg  
Representative

*Map of Vietnam*



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## Executive summary

This report looks at government health and education policies in [especially difficult and remote ethnic minority areas] under Programme 135<sup>1</sup> through the eyes of ethnic minority women and children [a group marginalised not only by geography but also by social status, gender and age]. It was produced to provide human insight into current policies and suggest appropriate changes to the way they are carried out.

The objectives of the report are to:

- Study existing, and implement new government healthcare and education policies to help ethnic minority women and children in difficult-to-reach areas;
- Recommend policy changes based on study findings;
- Build capacity of Committee of Ethnic Minorities officials at the province and State level by introducing new methods of data collection and analysis and providing enhanced policy assessment skills.

The study found the education system in these areas to be chronically understaffed and underfunded. Some new schools had been built under Programme 135, though most existing schools were temporary bamboo structures. Ramshackle classrooms, textbook shortages, crowded residences, and a lack of clean water and electricity were commonplace.

The study team also discovered specific problems related to individual minority groups. Large numbers of Khmer children, for example, dropped out or took extended time off school to participate in customary rituals and temple retreats. Moreover, many teachers did not speak the local dialect of their areas and had problems communicating with students. Gender disparities remain highly marked [girls were given far fewer opportunities to learn than boys as continued schooling was seen as an obstacle to marriage].

Teachers often lost interest their work, and many said existing salaries and bonuses were not enough to make living and teaching in mountain areas a secure and satisfying job. A high percentage were unqualified by Ministry of Education and Training Standards and did not attend regular training courses.

Few ethnic minority students graduated from high school, and of those that did, most did not go on to higher education. Priority admission to universities

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<sup>1</sup> The collective title of the government's socio-economic development policies for disadvantaged communes in remote and mountain areas.

and colleges is being granted to ethnic minority students under Programme 135, but the scheme was found to be insufficiently promoted, and most high-school graduates simply joined the regular workforce.

Health problems were similar to those in education, centring on inadequate facilities and staff shortages. Private clinics and pharmacies were operating in remote districts, but the quality of private facilities and care was found to be much lower than in the delta regions. Programmes to promote family planning and pregnancy check-ups were catching on in urban areas but failing to reach residents in remote villages; most ethnic-minority mothers still give birth at home as is their custom.

More promisingly, however, the study found women and children in most remote villages were receiving regular vaccinations, and subsidisation schemes for both medicines and iodised salt were in place (though there were some questions about the way medicines were delivered and the quality of iodised salt). Moreover, hamlet health workers □ trained volunteers sent to remote villages to offer health advice and deliver medicines □ were having a strong positive effect

But ignorance of available treatment and long-held cultural beliefs meant most ethnic minority women and children still relied heavily on self-treatment such as traditional medicine and customary worship practices. Even in the case of a serious illness, many said they would not go to the health centre for treatment.

To address these issues, this report not only recommends measures to attract teachers and health workers to ethnic minority areas but also identifies important social and cultural barriers that need to be addressed, particularly with the help of well-educated teachers and officials from ethnic minority groups themselves. Lastly, it is acknowledged many policies studied herein are still in their infancy and will take several years to show clear results.

## **Preface**

### **Background**

Since the establishment of the Socialist Republic of Vietnam and particularly during the *doi moi* (State reform) process initiated in 1986, the government has taken great interest in the socio-economic development in ethnic minority areas. Economic development has been encouraged through direct investment, land-use policies and poverty reduction strategies. Social policies such as fixed settlement, education and healthcare delivery have been given priority attention, while the cultural and spiritual practices of ethnic minority groups have been respected. All of these policies have been designed to give preferential treatment to ethnic minorities living in remote and disadvantaged areas.

To determine the effectiveness of such policies, it is necessary to look closely at those they are intended to benefit. Past research has focussed on ethnic minorities as a whole and there is little information on the specific impact of health and education policies on women and children. More work and careful field analyses are needed to fill the information gap.

### **Objectives**

- Study existing, and implement new government healthcare and education policies to help ethnic minority women and children in difficult-to-reach areas;
- Recommend policy changes based on study findings;
- Build capacity of Committee of Ethnic Minorities officials at the province and State level by introducing new methods of data collection and analysis and providing enhanced policy assessment skills.

### **Methodology**

#### Participatory method

Data for this report have been collected through observations, group discussions, and both in-depth and informal interviews. Reports and analysis provided by provinces, districts, communes, individual schools and healthcare centres have been used as a source of background information.

## Sampling

The study was carried out in 10 districts of five provinces: Lai Chau, Ha Giang, Nghe An, Kon Tum, and Soc Trang. An attempt was made to select two districts in each province facing notably different economic and social problems. In each district, two communes were selected for analysis.

All the districts selected had high percentages of ethnic minority residents and were located in highly disadvantaged parts of the country. Infrastructure in these districts was very limited □ often there was no post office, main market, or access to the national power grid. Transport in most communes was limited to one unpaved road.

Characteristics of five provinces					
	Lai Chau	Ha Giang	Nghe An	Kon Tum	Soc Trang
Location	- North West Vietnam	- North East Vietnam	- Southern North East Vietnam	- Central Highlands	- Mekong River Delta region
Land area	16919.2 km <sup>2</sup>	7 884.4 km <sup>2</sup>	16 487.3 km <sup>2</sup>	9 614.5 km <sup>2</sup>	3223.3 km <sup>2</sup>
2001 population	616,300	625,700	2,913,800	330,700	1,213,400
Ethnic Groups	46 groups including: -Thai: 35.1% -H'Mong: 29.0% -Dao: 6.7% -Kho Mu: 2.5% -Ha Nhi: 2.4%	40 groups including: -H'Mong: 30.5% -Tay: 25.4% -Dao: 15.4% -Nung: 9.9% -Giay: 2.2%	38 groups including: -Thai: 9.4% -Kho Mu: 0.9% -H'mong: 0.9%	35 groups including: -Xo Dang: 25.1% -Ba Na: 12.0% -Gie Trieng: 8.1% -Gia Rai: 5.1%	26 groups including: -Kho Me: 28.9%
Administrative units	12 districts: -2 major towns -10 rural districts -156 communes, precincts and rural towns	10 districts: -1 major town -9 rural districts -191 communes, precincts and rural towns	19 districts: -1 city -1 major town -17 rural districts -466 communes, precincts and rural towns	8 districts: -1 major town -7 rural districts -82 communes, precincts and rural towns	8 districts: -1 major town -7 rural districts -102 communes, precincts and rural towns

Selected study areas		
Province	District	Commune
Lai Chau	1. Tuan Giao 2. Dien Bien Dong	1. Toa Tinh 2. Na Son
Ha Giang	3. Quan Ba 4. Dong Van	3. Ta Van 4. Sinh Lung
Nghe An	5. Ky Son 6. Tuong Duong	5. Huoi Tu 6. Luu Kien
Kon Tum	7. Dak To 8. Kon Plong	7. Tu Mo Rong 8. Po E
Soc Trang	9. My Xuyen 10. My Tu	9. Tai Van 10. Phu Tan

There were five focus group discussions organised in each province, with each group consisting of six to eight persons. The focus group discussions were made up of province and district-level officials, teachers and local residents. In addition, fifty in-depth interviews were carried out in each province. Interviewees included education and healthcare officials, teachers, students and local residents. Central-level officials responsible for policy formulation and monitoring were consulted in the drafting of this report.

### **Research team**

The team was led by Dr. Nguyen Ngoc Thanh of the Institute of Ethnology and included Dr. Tran Van Ha and Committee of Ethnic Minorities (CEM) officers Dinh Phuong Thao, Luong Thu Chau, Vo Van Bay and Tran Chi Mai. UNICEF representative Nguyen Thi Van Anh contributed to the overall study design and took part in several interviews. Additionally, Dr. Tran Binh, Tran Hong Hanh and Nguyen Thi Thanh Binh helped out with interviews in Lai Chau, Ha Giang and Nghe An.

A draft report was presented at a December 12 workshop in Hanoi, which was later revised for submission to CEM and UNICEF based on feedback from the central government and other concerned agencies.

### **Programme 135**

Programme 135 is the collective title of the government's socio-economic development policies for disadvantaged communes in remote and mountain areas. The goal of the Programme is to increase living standards in these areas by bringing development in line with other parts of the country. Zone III is the programme's term for the country's most disadvantaged and remote areas and encompasses 2,325 communes nation-wide, including the 10 studied in this report. The majority of people living in Zone III are members of ethnic minority groups.

The main Programme 135 policies for communes are:

**Land policies:** The government is allocating agricultural and forested land to ethnic minority groups as part of long-term, fundamental poverty reduction and equitable development measures in rural and mountain areas.

Policies for investment and credit: To support poor families, the state is encouraging rural households to group together to increase production, secure loans and use credit more effectively. Priority loans are being granted to infrastructure development projects, small-scale irrigation works, rural road building, electricity supply, new schools and health stations, and clean-water supply systems.

**Human resources development policies:** The government is providing funds to train commune officials in modern education methods and provide students in disadvantaged areas with textbooks, notebooks and school fee exemptions. Informal education for out-of-school children and illiterate adults is also being organised, along with vocational training courses.

**Health policies:** Programmes to prevent malaria and goitre are being implemented alongside regular vaccination and healthcare programmes for children and women. Residents of extremely difficult communes are being provided with free healthcare at district and commune health centres.

**Transport subsidies:** Subsidies to ease the flow of goods into ethnic minority areas have been in place since 1996 and will be continue to be applied. The State provides per-tonnage transport subsidies for goods essential to farm production in remote communities.

### **Policy implementation procedures**

Policy dissemination follows a top-down approach. State policies are discussed by provincial people's councils and passed on to provincial people's committees based on people's council resolutions. They are then handed to provincial departments and district people's committees for further discussion. After details are finalised, policies are given to communes to be practically implemented. The process is inefficient and fraught with delays □ it

is not uncommon for approved policies to take three to five months to reach communes.

Compounding the problem, there is a lack of coordination between administrative levels. The health budget, for example, is transferred to the provinces very late in the year. Medicines ordered during the last half of the year under Programme 135 are not delivered until the first quarter of the next year. During the average four-month delay, many drugs simply lie in storage. In another example, the team discovered officials from the Department of Ethnic Minority Affairs in Soc Trang □ the body assigned to supervise the implementation of Programme 135 policies □ were unaware of important transport subsidies for disadvantaged areas.

Communes have not taken an active role in policy formulation, mainly due to a shortage of educated officials. This has created problems for local residents. When policies are formulated, those affected are not consulted and results are not monitored at a local level (most projects are monitored by district-level or higher officials). When solicited, local input is often ignored, though a local authority signs a hand-over protocol when work is finished.

At one village studied, local leaders had recently held a meeting to determine the location for a new school. The majority of villagers suggested the school be constructed inside the village to make it convenient for children to attend. In the end it was built over 2km away along national road. Though developers saved on the cost of transporting construction materials, children must now walk 4km to and from school every day. Mobilising local residents to work on Programme 135 projects has also been problematic □ many projects are carried out during the height of the farming season when residents are busy in the fields, and some project contractors have delayed payment.

## **Education policies**

Education is the basis of any economic and social development and has been made a top priority by the Government of Vietnam. Yet the education system in ethnic minority areas is lagging far behind the rest of the country.

### **Education system overview**

The education system in the study area was comprised of four levels: kindergarten, primary, secondary and high school. In each province studied, there were boarding schools at both the provincial and district level. In all provinces with the exception of Soc Trang, there were resident-supported boarding schools at the commune level.

Many primary and secondary classes in the study area were found to be multigrade with two or three levels combined in same class (multigrade classes are not always necessary and depend on student numbers). Yet despite the increased student numbers, many parents said they supported the system because it meant children did not have to leave home to study in far-away towns. Primary schools in many communes were also offering grades six, seven and eight to prevent older students from travelling to secondary schools in other areas (primary school traditionally ends at grade five).

### **Educational facilities and physical conditions**

Many new schools had been constructed under Programme 135, but there remained a chronic shortage of classroom space. Most students surveyed said their classrooms had only a few tables and chairs □ some were forced to sit seven to a table. Classroom facilities were generally inadequate and of poor quality. Kindergartens were usually temporary structures or private residences and the vast majority of village schools were simple bamboo structures. In many cases the lack of classrooms meant students had to attend school in shifts. At the Tai Van 1 primary school in Soc Trang, for example, there were as many as three shifts per day, cutting average learning time by over an hour per day.

Along with crowded classrooms, the study found a lack of dormitory space at boarding schools. In one instance, over 170 Hmong students were denied lodging and had to spend the year in temporary bamboo structures built by their parents. At another school, there were no dormitory rooms for visiting students and they were charged VND30,000 per month to rent rooms from nearby residents. What students were afforded dormitory accommodation often had to put up with cramped conditions □ in one 12sqm room at the

Thuong Duong district boarding school, 24 students were made to eat, sleep and do homework in their beds.

Teacher accommodation was found to be Spartan. Single teachers at the Thuong Duong boarding school were provided with 3sqm of personal living space in a room shared by two to three others. Married couples were allotted 6-9sqm private rooms. Only a few long-time teachers were given land on which to build homes, plant crops, and raise animals (an extra source of income).

Utilities were often substandard and most schools did not have regular access to electricity. At one primary school, generators supplied power from six to nine in evening, after which teachers used oil lamps to prepare classes. In more remote areas, there was no indoor plumbing and all bathing and washing was done in streams.

## Teachers

Teacher-student ratio in study districts			
District	Teachers	Students	Average class size
Ha Giang			
1. Dong Van	620	10706	17
2. Quang Ba	620	9506	15
Lai Chau			
3. Tuan Giao	65	1245	19
4. Dien Bien Dong	574	9698	17
Nghe An			
5. Ky Son	894	15854	17
6. Tuong Duong	1208	19170	15
Kon Tum			
7. Dac To	603	14460	24
8. Kon Plong	389	8198	21
Soc Trang			
9. My Tu	1560	42154	27
10. My Xuyen	1495	41380	27

Source: Vietnam General Statistics Office 2002 figures

Teachers at district boarding schools all held university or college degrees, but most primary school teachers were unqualified by Ministry of Education standards (grade 12 plus two years of additional training). In some remote areas, the level of

Examples of teacher qualifications  
*Toa Tinh primary school (Tuan Giao, Lai Chau):*

- Number of teachers: 26 teachers
- Of those unqualified: 18 teachers

*Tai Van Secondary School (My*

unqualified teachers reached 50 per cent.<sup>2</sup> Lai Chau and Nghe An were found to have the least-qualified teachers, some with only five years of primary education and three years of additional training. Many provinces were also facing serious teacher shortages, especially at upper levels. Soc Trang officials said the province needed close to 2000 additional teachers while one-third of those currently working were unqualified.

### **Training courses**

There were short- and long-term training courses available for teachers as well as continuing education programmes in most areas. Annual training courses  some organised through universities  were held in district and provincial centres, but many of the least qualified teachers did not attend.

Reasons for unqualified teachers not attending training courses:

- Teacher's level of education was not sufficient to attend the course;
- Teacher was advanced in years and unwilling to adopt new teaching methods;
- School did not reimburse travel expenses, making it financially difficult for teacher to attend far-away workshops and training sessions.

Language barriers also presented a problem at some schools. Kinh teachers who could not speak the language of their area had difficulty communicating with students. In all five provinces surveyed, only Khmer teachers in Soc Trang met the minimum language requirements set out by the Ministry of Education and Training. Some officials proposed training more teachers of ethnic minority descent who could then conduct classes in their own language, but the small number of ethnic minority students moving on to higher education meant recruiting qualified candidates was difficult.

*"Ethnic minority teachers are trained in many different ways; however they do not have solid fundamental knowledge. If we want ethnic minority teachers we should invest more in boarding schools to provide them with fundamental knowledge at an earlier age."*

- Official of the Office for Education and Training of Tuong Duong district, Nghe An.

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<sup>2</sup> Vuong Xuan Tinh, Bui The Cuong. Healthcare and Education Needs of the Mekong River Delta's Ethnic Minorities, Asian Development Bank, Hanoi, 2000

## Teacher resources

Teachers from every school studied said they had too few teaching aids (pictures, maps, diagrams) and most relied on simple □chalk and talk□ methods. Some used makeshift teaching aids and purchased additional manuals with their own funds. In a typical example, the Ta Van school in Ha Giang was provided with one set of reference manuals that teachers were asked to borrow in turn, meaning some were forced to prepare classes with no resources at all.

## Dropouts and absences

Enrolment statistics were collected at the beginning of the year and did not take into account the many students that dropped out at the end of the second semester to assist their parents with farming duties. Annual dropout rates for ethnic minority children were found to be much higher than the national average, and the rate of school-aged children attending classes was less than 50 per cent in some communes. At Ma Che village in Sinh Lung commune, 34 out of 53 school-aged children were attending classes at the beginning of the year, but only 25 by the middle of the first term.

*“Students here that have graduated from primary school have huge gaps in their general knowledge. They do not understand even, odd and decimal numbers, and cannot follow upper-level programmes. Teachers complain, but I don’t know what do to. Students end up feeling discouraged and ashamed and drop out.”*

- Member of Management Board of Tai Van primary school, My Xuyen, Soc Trang

Many parents said they did not understand the advantage of keeping their children in school and pulled them out to help with farming duties or housework. Children in the study area dropped out for these and other reasons:

- Child was taken out of school by parents to help with domestic duties
- Nomadic nature of child’s family made it difficult to attend regular classes
- Child had sibling(s) already at school (parents of large families

Ratio of boys to girls <i>Huoi Tu primary and secondary school, Ky son, Nghe An, 2001-2002</i>		
Grade	Boys	Girls
One	68	30
Two	63	24
Three	60	30
Four	68	38
Five	58	25
Six	116	26
Seven	85	16
Eight	68	7

believe sending only one or two children to school is sufficient)

- Child felt embarrassed when he was forced to compete academically with much younger children (children from ethnic minorities start school comparatively late and often learn alongside Kinh students)
- Child did not have enough warm clothes to wear in winter
- Child was forced to cross a large body of water on the way to and from school, and his or her family could not afford boat fares
- Child became seriously ill and took a long time to recover
- Child was teased and ridiculed for cultural practices (Khmer children are required by Buddhist law to shave their heads in March and August, a custom for which they are often teased at school)
- Child found the low morale of his or her teacher not helpful in encouraging them to go to school

The official dropout rate for girls in the study area was nearly twice that for boys as most parents said they saw continued schooling as an obstacle to marriage (girls were typically married at age 16). It is also fairly commonplace in many ethnic minority cultures for boys to be granted more privileges than girls as they are responsible for the care of their parents later in life.

Researchers learned Khmer boys at the age of 13 were required to spend from three months to three years away on temple retreats. When the boys left home, Khmer girls often dropped out of school to take their place in the fields.

In addition to the high dropout rate, prolonged absences were found to be a problem. For most students from ethnic minority groups, boys and girls alike, time was taken off school for traditional festivals, celebrations and customary rituals.

### **Women and education**

Most women over 30 had only completed grade three; by and large, they were unable to assert themselves in business and were underrepresented in government agencies. The majority of women over 40 were illiterate, with the exception of chairwomen of commune women's unions who had all completed grades three to seven.

Students from Po E commune (Kon Plong district, Kon Tum province) took time off school for the following reasons:

- Buffalo killing festival  
7-10 days
- Community rituals and prayers  
2 days
- Farming work  
7 days

Literacy campaigns had been organised in many areas. However the lack of newspapers, magazines and other reading materials provided little chance to practise reading and writing skills. Furthermore, women said they were not encouraged to attend community reading classes as duties at home claimed most of their attention. Survey figures showed men in these areas were much more literate than women □ early marriage constantly drew women away from educational opportunities and towards the home where there was little access to outside sources of information.

*“Khmer men are provided with more opportunities to learn. They are sent to temples to improve their knowledge. Khmer women are not. Many Khmer women work in the fields and do domestic chores leaving little time for education.”*

- Female interviewee, 40, Soc Trang Women’s Union

### **Exemption and reduction of tuition fees**

Students in Zone III are legally exempt from paying school fees as part of Programme 135. All the students interviewed said they had not been asked to pay regular tuition fees; however their families had to make small contributions to school upgrades and pay annual fees not covered under Programme 135. If these fees were not paid, students could be held back from higher grades.

*“Our school collects money from students every year. The family of one boy in our school could not afford these fees. Teachers reminded him time and time again of this obligation. In the end the shame forced him to drop out.”*

- Member of Women Union, Huoi Tu, Ky Son, Nghe An province

<b>Additional fees</b>			
Tuong Duong Primary and Secondary School, Ky son, Nghe An		Na Son Secondary School, Dien Bien Dong, Lai Chau	
School construction	VND 35,000-45,000	School construction	VND 10,000
Class fund	VND 5,000-	Reward fund	VND 3,000
Transcripts	20,000 VND	Electricity	30,000
	2,000-27,000	Wooden bed	VND 3,000

Additionally, many parents sold farm produce to put their children through school. But because of the calendar difference between the school year and the farming season, fees were often paid after the fact.

*“I remember the days when school was cheap but we could not go because of the war. Now when we can go, everything costs money, including*

*examinations. I don't understand why everything should cost so much money. Most of the people here are poor and can't afford to send their children to school."*

- Female interviewee, 40, Resident, Luu Kien, Thuong Dong, Nghe An

## **Provision of notebooks and textbooks**

### **Notebooks**

Some notebooks were supplied free-of-charge to students in Zone III, although the number and quality varied from province to province. Kon Tum, for example, provided 96-page notebooks as opposed to the 48-page notebooks provided by the other four provinces. Notebooks were allocated based on student registers and students had to sign to verify receipt. Grades one and two students said they received enough notebooks, but students from grades three upwards said they often ran out and had to purchase more.

The study also found official notebook distribution figures were not always accurate. The Nghe An Department of Education and Training said each student from grades one to five received 10 to 12 notebooks per year, but some reported receiving only five or six. In each case, students said the allotted 10 to 12 notebooks would have met their needs. When asked about the discrepancy, officials from the department quoted high shipping costs, and one official claimed teachers were holding back notebooks to use as prizes for outstanding students.

### **Textbooks**

Students throughout the study area used old and out-of-date textbooks, often sharing a single copy between groups of two or more. When no textbooks were available, lessons were written on the board for students to copy down. At many schools, newer textbooks had been supplied though Programme 135, though in small numbers.

*"The Ministry of Education and Training in Nghe An has not kept its commitment to schools. In remote districts, only 30 per cent of textbooks required are supplied and the humid weather means these textbooks are easily damaged. Also, programmes change so frequently that all the textbooks we have are out of date."*

- Male Interviewee, 54, Nghe An Department of Education and Training

Textbooks for grades seven upwards were in very short supply, particularly foreign language textbooks. In some cases, there were only enough

Vietnamese language textbooks for one-third of students and textbooks written in minority languages such as Khmer were uncommon. Teachers in one commune said they had only enough math and Vietnamese textbooks to distribute to all students; for all other subjects, students were given copies to share.

Many schools had borrowing schemes whereby students could take textbooks home to study; the better their academic record, the more books they could take home. In some instances, children were asked to pay a deposit for each book borrowed and if a child then lost his or her textbook, the money was retained by the school. At some district boarding schools, children were asked to purchase their textbooks outright.

### **Ethnic Boarding schools**

There were two types of boarding schools in the study area: district boarding schools and resident-supported commune boarding schools. District boarding schools housed students in dormitory residences and generally limited classes to the secondary level while resident-supported commune boarding schools housed students in the community and offered grades four and five in addition to secondary-level classes. Both schools housed from 150 to 400 students on average.

Poor students at boarding schools in minority areas did not pay tuition fees and received a monthly scholarship of VND140,000. Though the scholarship was meant to cover all expenses, schools sometimes charged additional fees that could not be met. At the Ky Son boarding school, students were charged VND17,000 per year for health insurance and security fees, and were asked to work once a week or face a penalty of VND1000 to 2000. Fees were even higher at the Tuong Duong Boarding School.

Source: Teacher interview, Tuong Duong boarding school, Ky son, Nghe An

### **District ethnic boarding schools**

Student's contribution at the Tuong Duong boarding school	
Items	Fees
School construction	50,000
Drinking water	19,000
Social insurance	16,000
Parent's association fee	20,000
Youth Union membership fee	12,000
	20,000
Public welfare labour <sup>3</sup>	10,000
School construction labour	40,000
Dormitory construction for	

Selection boards made up of representatives from district education bureaux, Fatherland fronts, Ho Chi Minh youth unions, women's unions and local

<sup>3</sup> understood as a small payment for government provided labour

farmers' associations controlled admission to boarding schools. Applicants had to be from poor ethnic minority families living in especially difficult areas.

The Ky Son ethnic boarding school in Nghe An gave priority to students who met the following criteria:

- Living in a remote area
- Outstanding academic record
- Poor
- From Kho Mu and Hmong ethnic background

Some provinces put limits on the number of children per family attending district schools. In Lai Chau and Ha Giang for example, each family was entitled to enrol only one child.

District boarding schools gave students necessities such as clothes, blankets, sleeping mats and mosquito nets, and some also provided paying jobs. At the Dong Van district boarding school, boys were paid VND10,000 per day to guard the school premises during the *Tet* holiday. The school also provided an allowance of 10,000 per student per month (in cash or rice equivalent) during the summer break. However many students complained there were not being given proper meals. At the Ky Son boarding school, students were given rice cakes in the morning, and rice with fish or meat for lunch and dinner. Some complained the meals were not filling enough. At the Thuong Duong boarding school, students also had VND15,000 deducted from their annual meal scholarships for other fees, leaving only enough for meagre lunches and dinners. As a result some began skipping breakfast making it difficult to concentrate during morning classes.

Long commutes were also a problem. Because of the lack of dormitory space, many students travelled long distances to and from school each day, waking up before 5am each morning and travelling home through the jungle at night with a torch. Students who rented houses far away from school were often distracted from their studies by local youths who introduced them to various unhealthy practices. Visits home were also infrequent. Students at the Tuong Duong boarding school said they saw their families no more than three times a year, depending on financial circumstances and road conditions.

### **Resident-supported communal boarding schools**

Resident-supported communal boarding schools were studied in Lai Chau, Ha Giang, Nghe An and Kon Tum Provinces. In practice, they operated in a very similar manner to district boarding schools, the main difference being children returned home on the weekends and all meals were supplied or paid for by

parents. Resident support manifested itself in a number of ways and varied from district to district. Residents in some areas provided houses and classrooms for students, and in others they contributed between 25 and 30 kg of maize to each school per year. At the Sinh Lung primary school in Dong Van, students were supported with small allowances to purchase food between harvests.

As in district schools, children were provided with pots and pans, sleeping mats and wooden beds; however unlike in district schools, these necessities were provided by the community. In some cases, cooks were arranged to prepare meals, though in others, students were provided with cooking utensils and asked to prepare meals for themselves. Some said the time it took to prepare meals detracted from their studies. Occasionally, the number of students also exceeded available lodging. At two schools in Kon Tum province, the lack of space forced students to sleep and eat in their classrooms. As in most remote areas, bathrooms were dirty and there was a lack of private space.

### **Selected admission policies to universities, colleges, and technical schools**

Priority admission to universities, colleges and technical training schools was being granted to students in disadvantaged areas under Programme 135 policies. A number of places were set aside each year by The Ministry of Education and Training to be distributed to districts and communes in Zone III. Provincial selection committees were appointed each year, with members drawn from provincial people's committees, women's unions and government ministries. As part of their mandate, these committees appointed members to district recruitment committees.

To qualify for priority admission, each candidate in the study area had to be a resident of his or her province for at least three years, live in an "underprivileged" area and have completed grade 12. Places were awarded based on availability and the quality of student applications.

In 2001, the number of students granted a place under Programme 135 was less than the number of places allocated in all provinces studied with the exception of Nghe An; only a small percentage of students from ethnic minority groups completed grade 12 and were eligible to apply. In addition, many students graduated from township schools not recognised by the programme. In Nghe An, where the number of students sent to university actually exceeded the number of places by 12, it was alleged that many did not satisfy the admission qualifications. One official said children of officials no longer living in remote areas had been questionably selected.

*“There were some false statements made on CVs. Also, according to a Council of Nationalities report, many Kinh students declared themselves members of ethnic groups.”*

- Official, 60, Committee for Ethnic Minorities.

A lack of information about the selection process also hampered applications; many students did not understand their entitlements under current policies. District recruitment committees, which did not include anyone from boarding school management or technical and vocational training schools, were not always actively supportive. Most ethnic minority students entered the workforce directly after finishing grade 12.

Several places allocated to communes in remote areas, particularly difficult areas in Zone III, went unfilled as there were not enough qualified students to claim them. One official proposed handing out the unfilled places to qualified applicants in other communes; however some residents expressed fears this would lead to students taking unfair advantage of ambiguities. Several district education officials said the push to select students from remote areas was unjustified, pointing out that students from district schools always scored higher on exams than those from remote areas.

*“It would call for a re-evaluation if we disqualified a student from a district town who achieved a high mark and selected a student from a remote village who achieved a very low one. We would rather have the most capable student coming back [from university] to teach at our school.”*

- Male teacher, 47, Tuong Duong boarding school, Nghe An

The push to send students from disadvantaged areas to higher education through the use of selection quotas meant those who entered university were not as well prepared as students from more affluent areas. A number dropped out or were forced to repeat courses. Some officials recommended ethnic minority students not be allowed study □important subjects□ like medicine and pharmacy and should be trained instead to teach at kindergartens and primary schools. They said poor performance at university was limiting ethnic minority teachers□ capacity when they returned to their home communes to teach.

Moreover, ethnic minority students who performed well at university often found work in more □favourable□ parts of the country after graduation and chose not to return to their home communes. The chance of finding gainful employment in disadvantaged areas is rare and the attraction of the city is strong. University diplomas and transcripts were also given directly to students, leaving authorities with no power to insist they take up work in

specific areas. Furthermore, many graduated with skills they felt they could not make use of in underdeveloped parts of the country.

*“The selection policies are very good for developing human resources but we need to develop a plan to place students in good jobs after they graduate.”*

- Male CEM officer, 60, in Nghe An

In addition to promoting higher education, officials said they planned to open teachers' colleges in remote areas to train cadres and school administrators. The schools would also offer short-term training courses for standout students from ethnic minority groups.

### **Teacher salaries**

All teachers interviewed said they received their salaries and allowances regularly and on time (teachers at remote schools are entitled to special allowances worth 70 per cent of their pay). But teachers said their present salaries did not meet essential needs, often quoting the high cost of travel – poor transportation infrastructure meant one journey home could cost three months wages. Some teachers also taught two shifts per day leaving no time to make any additional income, and young teachers were unable to save money to send home to their families.

*“I have enough money for meals, but if I want to buy some good blankets I have to ask for help from my family.”*

-Female, teacher, 27, in Na Son commune, Dien Bien Dong District, Lai Chau province.

Teachers at district boarding schools received higher salaries than those at resident-supported communal boarding schools, and this was officially justified by the fact that they took care of children during the day and night. Teachers transferred from district boarding schools to district training and education bureaux were only entitled to receive a basic salary, a practice many disagreed with.

The government has been trying to entice teachers to work in mountain regions by offering a series of specific policies and bonuses. According to a recent decision (Decision 164, 1999), male teachers with five years' experience and female teachers with four years' experience are entitled to an extra month's salary and allowances each year (male teachers with 10 years experience and female teachers with eight were entitled to two months extra). Teachers said they were also given money to purchase warm clothes.

But most teachers working in mountain areas said the bonuses were not enough to cover high living costs. At one school in Quan Ba, teachers called for an additional VND100,000 per year to purchase warm blankets. Some teachers working in townships said the practice of limiting bonuses to remote and mountain areas was unfair. Teachers working at the Tuong Duong boarding school □ who had seen their allowances reduced from 70 to 40 per cent of their salaries □ felt the cost-of-living in townships warranted similar allowances.

### **Rotation scheme**

Teachers who had been working in mountain areas for a set minimum duration (five years for men, four years for women) were legally entitled to be transferred to schools in lowland areas, but it was found the system was rarely adhered to. The research team discovered many eligible teachers had lodged numerous transfer requests to no avail. One 40-year-old man who had been teaching in a mountain school for 19 years and a 54-year-old man who had been teaching for 30 years said they were still waiting to be transferred to schools near their lowland homes, after having lodged several requests.

Government officials said the reason for the failure of the rotation system was an oversupply of teachers in lowland and delta areas. In addition, teachers from mountain areas were described as less qualified than their lowland counterparts and unlikely to be accepted at lowland schools. Most officials agreed the problem was affecting the morale of teachers and the quality of instruction, and needed to be addressed quickly. Some teachers suggested developing new system based on forced rotation.

*“For every teacher that is rotated from a mountain school to a lowland school, one teacher from a lowland school should be sent to mountain school. After two years, they could be allowed to move back. That would at least give me the chance to see my family in Anh Son.”*

- Female teacher, 27, Ky Son boarding school, Nghe An

Others suggested making it more attractive for teachers to remain in mountain areas.

*“If people receive special enough treatment here, they can marry and settle down with peace of mind. Part of that treatment would mean increased salaries and allowances as well as land to build houses. At present, even teachers from ethnic minority groups do not want to work in the mountains.”*

- Male official, 56, Nghe An Department of Education and Training

## Health policies

### Health system overview

Healthcare policies across the country are administered at the provincial, district and commune level. Provinces take responsibility for the overall administration of State policies and operate provincial hospitals, districts manage health centres and polyclinics, and communes operate local health centres and oversee the network of hamlet health workers.

The Committee for Population and Family Planning, and the Committee for the Care and Protection of Children have merged to form the National Committee for Population, Family and Children (CPFC). There were horizontal CPFC branches in each province studied, but the implementation of policies was uneven as most branches were newly created.

In recent years, there has been a remarkable improvement in the standard of healthcare services offered to disadvantaged areas. Along with expanded public facilities, private clinics and pharmacies have emerged. Before private healthcare, hospital treatment and the distribution of medicines was the sole responsibility of the State, but growing number of private pharmacies and clinics has resulted in a significant diversification of services (though healthcare as a whole remains under the control of the State).

However the quality of services offered by private clinics was found to be

<b>Private healthcare facilities in My Tu district</b>	
District population	201061
After-work clinics	21
Pharmacies	21
Private dentists	11
Traditional medicine clinics	7

substandard in many areas. Most were run by retired doctors or recent medical-school graduates who were unable to find work in city hospitals, and understaffing was chronic. Technology was of such a low standard that all laboratory and x-ray work was out-sourced to district health centres and provincial hospitals. Some private clinics were also being run by public health workers in their spare time as a source of extra income.

Health regulations state that anyone looking to open a private clinic or pharmacy must have a professional degree from a recognised medical institutions or traditional medicine centre and must pass a short-term training course provided by the district or province. But the team found many private clinics and pharmacies, including those specialising in traditional medicine, were operating without commercial registration. In several districts, the actual number of private pharmacies and clinics far exceeded the reported number.

In addition to private pharmacies, the team observed medically untrained individuals taking medicines by motorbike to remote communes where they were sold at mountain markets (medicines were also peddled to river communities by boat). The quality of medicines and the advice provided by these sellers was found to be poor and many drugs were expired or of questionable quality.

### Health care workers

The drive to provide disadvantaged provinces with quality public healthcare services in recent years was evident in the number of qualified public health workers in the study area. Most doctors, assistant doctors, pharmacists and nurses had trained professionally at medical universities and colleges and received proper qualifications.

But despite the increased quality of caregivers, there were chronic staff shortages in many commune health centres. In a typical example, just two of the ten commune health centres surveyed in Soc Trang were

District	Residents per doctor
Ha Giang	
1. Quang Ba	2367
2. Dong Van	3913
Lai Chau	
3. Tuan Giao	4809
4. Dien Bien Dong	5066
Nghe An	
5. Ky Son	5915
6. Tuong Duong	5045
Kon Tum	
7. Dac To	5871
8. Kon Plong	5452
Soc Trang	
9. My Tu	201061
10. My Xuyen	191610

Source: Vietnam, General Statistics Office figures, 2002

adequately staffed □ the remaining eight were in urgent need of doctors, assistant doctors, paediatricians and obstetricians. Commune health centres were often forced to rely on the services of assistant doctors and nurses, many asked to perform well beyond their training. As in the education sector, difficult living conditions and low salaries were blamed for the shortfall.

*“Some health workers have poor consultation skills and are only capable of treating moderately harmful diseases.”*

- Male health worker, 40, Kon Plong District Health Centre, Kon Tum

### Hamlet health workers

Hamlet health workers are trained volunteers sent to remote villages to provide basic medical services and healthcare information. Often, they instruct residents on mosquito net use, drinking water purification and good nutrition.

Workers in the study area were given from one to six months training at district health centres and provided with a monthly stipend of VND40,000 to VND80,000.

Many hamlet health workers reported travelling long distances, sometimes through bad weather, to deliver goods and advice to remote villages. Such dedication earned them great respect in ethnic minority communities, many of which developed close personal relationships with their "volunteer visitors". Most hamlet health workers were themselves from local ethnic groups, embodying a common tradition of helping out in times of trouble.

Along with information, hamlet health workers were provided with a medical kit containing syringes, scissors, a thermometer, stethoscope, bandages and a variety of medicines to distribute free-of-charge. But many reported not having enough medicines to meet demand, a problem some addressed by dividing single doses between patients. Government health officials interviewed said hamlet health workers' basic training was not sufficient to be providing this sort of service.

*"Unfortunately, hamlet health workers do not know about some medicines and are not well qualified."*

- Male official, 42, Tuong Duong District People's Committee, Nghe An

The requirements for becoming a hamlet health worker were not consistent from province to province. In Kon Tum, Nghe An, Soc Trang and Lai Chau applicants had to be "trustworthy" and have a grade three education, while in Ha Giang, they simply had to be able to read and write and willing to volunteer for training. There were no gender requirements and men were more often selected than women. However despite low levels of training, hamlet health workers were the only link between the State-run health system and those living in remote enclaves and villages, and a vital source of supplies and information.

## **Children and health**

### **Subsidised immunisation policy**

The government has made women and children's health a top priority, with a special emphasis on immunisations. Almost all children in the study area had received regular immunisations, and knowledge of the importance of vaccinations was widespread. However some interviewees said the immunisation process needed to be made easier; parents from To Mo Rong commune had to walk with their children for a full day to the commune health centre to be immunised, and sometimes the shortage of vaccine meant they

were turned back and forced to return at a later date. There were other instances when the number of children immunised was low because vaccinations coincided with the harvest when families were busy in the fields.

*“This year I brought my child to the health centre three times, and each time I had to return because they had no vaccine.”*

- Female interviewee, 32, Long Leng Hamlet, Tu Mo Rong, Dak To, Kon Tum

## **Malnutrition and disease**

Programmes to fight malnutrition in young children were in place in all communes studied and appeared to be well-promoted. In a typical group discussion involving six women from Phu Tan commune, three said they were aware of malnutrition programmes in their area, and the three others (each with children under five) said they attended nutritional training courses every two months. The content of the training courses was reported to be well presented and easy to understand, and the biggest complaint was the cost of a balanced diet.

Pneumonia was reported to be the most serious disease affecting the health of children in the study area, followed in order by diarrhoea, bronchitis and cholera (in some communes there were also isolated incidences of dengue fever). Different diseases affected children in different provinces, with the weather and access to clean water key environmental factors. Not surprisingly, disease and malnutrition were much more prevalent in remote communes than in urban areas. As with most health issues, mothers in more remote villages had less access to nutritional information than those in towns and cities, and rarely took their children for health check-ups.

## **Women and health**

### **Pregnancy**

A recent campaign has been underway to strengthen women's healthcare in ethnic minority areas by promoting pregnancy check-ups and routine health examinations. The campaign has centred on improving communication and breaking down unhealthy habits. Yet many women in disadvantaged areas remain unaware of the importance of their own health and the number who go for pregnancy check-ups and routine examinations is low.

*“Very few women come for pregnancy check-ups and gynaecological examinations because they are shy. This means the number of women who acquire gynaecological diseases is high. Also they are usually worried more about working for their families than about their own health.”*

- Male health worker, 47, My Tu, Soc Trang

Reasons for women not going for pregnancy check-ups:

- Unaware of the need for a check-up (not told of the importance of UV2 vaccination, etc.)
- Faced personal inhibitions over check-up procedure
- No female health worker to perform procedure
- Unable to afford transport to commune or district health centre (or transportation not available)
- Husband would not agree to the procedure
- Husband would insist on accompanying wife during procedure causing embarrassment (reported by Hmong women)

Most women who did visit their commune health centre during pregnancy came only for one examination close to delivery, not the two or three previous visits recommended by doctors.

It was uncommon for some ethnic minority women to deliver their children at commune health stations – only when there was a problem with delivery or in the case of an illegitimate child were they likely to give birth away from home. In many cases cultural practices associated with individual ethnic beliefs favoured home-births.

*“In our commune, pregnant women do not go to the health centre to deliver their children. The majority of people here are Hre, and their custom is to deliver in a seated position with the help of the family. If they go to the health centre, they are forced to lie down, something that is not their custom.”*

- Male health worker, 31, Po E commune, Kon Plong district, Kon Tum

In the weeks following delivery, women interviewed did not take adequate time to rest and recover – most went straight back to work at home or in the fields. The high birth rate among ethnic minorities meant delivery was seen as a common occurrence that did not merit extended time off work.

<b>Ha Giang Women's Health Statistics</b>	
Women receiving check-ups	5862
Diagnosed with gynaecological diseases	87,0%
Of those, fungal infections	20,7%
Bacterial infections	79,3%
2001 Report of Committee for	

Women's health issues in the study area were not limited to pregnancy and included a high incidence of gynaecological diseases at all times of the year. Women of ethnic minorities worked long hours in water contaminated with harmful bacteria, and there was little fresh water for cleaning - most bathing and washing was done in contaminated lakes and rivers. Everywhere, there was a lack of personal hygiene.

### **Family planning**

Family planning was still an alien concept in remote areas - though it appeared to be catching on in some urban and lowland areas - and related programmes were faced with many obstacles. Customs forbidding the use of contraceptives were prevalent in many ethnic groups.

Men were much less likely to use contraceptives than women. Contraceptive use appeared to be catching on with women in some areas and many husbands were unwilling to abide their wives using contraceptives such as IUDs, saying they did not want them putting "strange things" inside their bodies.

Some incidences of contraceptive failure due to improper use were discovered. Meetings and counselling sessions arranged through commune women's unions to educate residents on the proper use of contraceptives appeared to be having a positive effect - a large number of women said they attended or would be interested in attending such meetings - yet serious cases of contraception misuse leading to abortion or internal damage were observed. The problem seemed to particularly affect Hmong women and highlighted the urgent need for new and expanded interventions.

### **Limited approach to health system**

Unless they were faced with serious illness, most people questioned said they would not go for treatment at health centres. The idea of brining a healthy family member all the way to a health centre for a check-up or was seen as difficult and absurd. "If there is nothing wrong, then why go to the health centre?" was the opinion of most residents. For women in particular, serious health complications were usually diagnosed too late to be effectively treated.

Self-treatment was by far the preferred form of treatment. Prayers and offerings to gods and spirits were carried out by traditional healers, but the lack of scientific knowledge meant these practices were not accompanied by modern forms of treatment. Offering communal prayers and religious sacrifices was particularly common in the case of a seriously ill child - often a much more trusted means of treatment than going to the health centre.

Most officials agreed enhanced awareness and communication were needed to break through these cultural barriers. Some counselling programmes were available at women's unions but were unpractical for many rural residents who were unable to travel long distances to attend. In all areas, media access in the form of television, newspapers and magazines was very limited.

### **Subsidisation policy for medicines**

A vital component of the government's health strategy in disadvantaged areas is the medicine-subsidisation policy. Under the programme, some essential medicines are delivered free of charge while others fall under a subsidised set-pricing system. In addition to over the counter drugs, the programme provides health centres with vaccines, contraceptives (given to women at no cost) and antibiotics. Strict accounting regulations are in place to make sure all funds provided by the programme are properly used.

In each commune studied, officials were asked to compile a list of "underprivileged" households entitled to receive subsidised medicines and treatment. Those on the list were given certification papers that they could then use to prove their eligibility at health centres. The registration system drew many complaints. Some poor families said they had been left off the list entirely and, to prove their eligibility, had to obtain a hand-written letter of verification stamped by a commune people's committee official. Moreover, because certification did not expire, newly-rich households were still taking advantage of subsidised treatment policies long after they were needed, while households that had fallen into poverty after lists were compiled could not get the required documents for subsidised treatment. From these observations, it was evident a more timely review process was needed.

The ordering process for subsidised medicines was not very efficient and fraught with delays. Under the process, communes sent a list of required medicines to the director of the district health centre for approval. These submissions were referred to as "plans of action". Medicines were then ordered from private or public pharmacies subsidised by the State to provide drugs at discount rates.

The team found an average four-month delay from the time the medicines were ordered to the time they were delivered to commune health centres. During this delay, many drugs simply lay in storage and some passed their expiry dates. Figures from the Soc Trang Health Department showed the province had VND 739,000,000 (US\$48,000) worth of Programme 135 medicines in storage in 2002. When shipments finally arrived, they often included expired drugs.

Hamlet health workers made special medicine deliveries to remote areas □ arranged in advance so residents could make sure they were at home □ and in some cases distribution of subsidised medicines was arranged by commune women's unions.

One of the misconceptions encountered by the team was that drugs were □free for the taking□. In fact high population densities meant subsidised medicines were spread thinly across communes and shortages were common. The head of one commune health centre said the lack of subsidised medicines meant eligible residents could only receive VND 10,000 worth of free drugs each year. If residents exceeded the limit, they were asked to pay regular prices for additional drugs.

### **Subsidisation policy for iodised salt**

Subsidised iodised salt was made available to disadvantaged communes in the study area as part of the National Iodine Deficiency Control Programme. The Programme is directed at women and children in remote areas: the group determined most at risk of developing iodine deficiencies.

The delivery of iodised salt to communes was generally arranged through contracts with private delivery companies. Many of these contracts were organised by provincial ethnicity committees with links to private delivery companies. The government subsidised the cost of transportation to the centre of commune clusters.

The process of supplying the iodised salt to residents was similar to that used for medicines: each commune made a list of □underprivileged□ families and passed that information on to district and provincial health authorities. In some areas, hamlet health workers supplied the salt to remote villages, and in others, villagers were asked to collect their allotment from commune health centres. Commune shops were also subsidised to provide low-cost salt to residents. The policy has a positive effect □ most residents questioned said they used iodised salt in their daily meals and health officials said the incidence of goitre had dropped off sharply (the average family interviewed went through about 5kgs of iodised salt per year).

There were, however, some questions raised over the quality of iodised salt supplied by private companies. Provincial health officials in Nghe An said salt samples taken from trucks and production facilities of one company were found to have only 80 per cent of the required iodine content. Most salt was delivered directly to communes and did not go through any quality checks, as communes did not have the financial or technical means to perform tests.

## **Delivery of free healthcare services**

The study confirmed those entitled to free healthcare under Programme 135 were not being charged medical fees at commune and district health centres (including out-patients) and the services of hamlet health workers were provided at no cost to remote residents. Additionally, some visits to traditional medicine centres were being covered by the state. Many residents said they preferred going to district health centres over commune health centres as the quality of treatment was better.

There were isolated cases of ethnic minority patients claiming undue favouritism. Some said they witnessed certain patients receiving special treatment at commune health centres because they were on good personal terms with staff members. Special treatment was said to include priority medical examinations and free supplies. This made some people reluctant to go to health centres, and instead they purchased medicines from mountain markets.

## **General awareness**

Along with a shortage of health workers, equipment and facilities, ignorance of government programmes was a major obstacle to policy implementation. When questioned, many residents said they had no idea they were the targeted beneficiaries of government programmes and simply took advantage of what services were available. Most were surprised to hear they were entitled to free medicines and treatment under Programme 135.

*“On previous trips to the commune health station, we had no idea about Programme 135 and where we could ask for drugs provided under the programme.”*

- Male interviewee, 40, Thai, Luu Kien commune, Tuong Duong, Nghe An

*“If the health worker says drugs are free, we take them, if we have to pay, we pay.”*

- Female interviewee, 49, Resident, PoE commune, Kon Plong, Kon Tum

## Recommendations

In light of study findings, this report recommends a number of general changes to health and education policies under Programme 135. It is acknowledged many current problems are the result of a simple shortage of funds; however it is important to identify weak spots that can be addressed with future funding.

### *Education recommendations*

To continue improving education, it is necessary to invest in better facilities, particularly in remote villages where existing bamboo structures are not strong enough to withstand the weather and make learning very difficult. All new schools should be built to reflect the higher standards set by Programme 135. Hygiene should also be made a priority to prevent the spread of disease, and healthy living habits should be promoted from a younger age.

Stipends provided to boarding students should be increased to cover the cost of three nutritious meals per day and more should be done to provide upper-level students with sufficient notebooks and textbooks.

Communication programmes to convince parents to keep their children in school should be initiated, and programmes that promote higher education should be upgraded. New ways should be found to select students for higher education, and the right to a good education at any level should be promoted, regardless of age, gender or ethnicity.

Teachers in remote areas should have their salaries re-evaluated in light of the high cost of living, and a workable rotation scheme should be implemented giving teachers a chance to improve their skills in lowland areas. Private housing for teachers should be provided with better access to water and electricity. Enough teaching manuals should be provided so there are copies for each teacher, and more teaching aids should be supplied. The government should also make an effort to ensure experienced teachers are employed as managers of provincial departments of education, as they are aware of teachers' specific needs and the situation on the ground.

### *Healthcare recommendations*

Health facilities should be upgraded across the board and more attention paid to services at the hamlet level. Budget distribution at all levels needs to be better coordinated to prevent long delays in medicine distribution, and there

should be increased communication between related government sectors to make the process of supplying healthcare services more efficient.

Reproductive healthcare and family planning programmes should be expanded and made accessible to those in remote areas. Vaccination programmes for children should be timed so as not to coordinate with the harvest and large stores of vaccine should be kept on hand to prevent mothers from being turned away from health centres and asked to return with their children at a later date. Target specific programmes should be implemented to overcome unhealthy practices and customary habits, and there needs to be more healthcare information provided to members of ethnic minorities in their own language.

Salaries for health workers in remote areas should be increased to make working in disadvantaged areas more attractive, and hamlet health workers should be given more training and larger stipends as they are the only connection between the healthcare system and villagers in remote areas. Lastly, there needs to be more coordination between provinces to ensure training standards are equal across provinces and the quality of healthcare does not vary with location.

## **Appendix**

### **Appendix 1.1: Healthcare questionnaire for individual interviews**

#### **Infrastructure**

- Is there a health centre in your village? If not, how far is it from your village to commune health centre? If the commune health centre is a long way away, how does that impact the care of your health?
- Could you describe facilities available and the general condition of your commune health centre?
- How would you recommend the health centre improve its facilities?

#### **Healthcare Needs**

- Do you feel the health centre in your commune meets the needs of yourself and other villagers? If no, what needs are not being met?
- Do health workers visit residents in your village monthly?
- Are there any permanent health workers in your village? If so, what are would you say their duties are?

#### **Health services**

- Are there any private pharmacies in your village? If so what medicines are available to be purchased? What medicines do you buy?
- Are you provided with medicines free-of-charge at your health centre?

#### **Treatment locations**

- Are there any diseases that your children suffer from on a regular basis? If yes, please name them.
- Where do you take your children to be treated? Why?
- Which diseases would you have treated at your commune health centre?
- Which diseases would you have treated at district or provincial health centres?
- Which diseases would you have treated by traditional healers or private healthcare workers?
- What diseases would you self-treat, and how?

#### **Healthcare programmes**

- What healthcare programmes are implemented in your villages? Who benefits from these programmes?

- Since these programmes have been implemented, has the health situation improved in your area?
- Are child or children vaccinated? If so, what diseases are they vaccinated against and at what age did they receive them?
- How are vaccinations organised? Are they administered in commune or village health centres? Are there any difficulties receiving vaccinations at health centres?
- Did you have to pay for the vaccination(s)? If so, how much were you charged?
- Are you aware of any healthcare programmes for women? If so, what are they? What benefits would you say they bring?
- What would you say needs to be done to improve the health of women?
- What kinds of diseases do women in your village often suffer from?
- Does the health of women suffer during any particular time of year? If so, could you speculate as to why?
- Are you provided with iodised salt free-of-charge? If not, how much does it cost to purchase in your area?

## **Appendix 1.2: Healthcare questionnaire for group interviews.**

### **Local residents' understanding of government and internationally-funded healthcare programmes**

- What healthcare programmes are available in your area? How do you benefit from these programmes?
- What do you know about the implementation of Programme 135 health policies in your commune?
- Which programme 135 health policies are implemented in your area? How do you think they affect development?
- What would you say are the concrete results of Programme 135 health policies in your area?
- What childcare programmes exist in your area?
- Do you see any problems in the way childcare programmes are implemented? If so, how could these problems be overcome?
- Do you feel you adhere to any customs that affect your views on child healthcare?
- How would you rate the quality of the public health service (including cost of medicines, skill of health workers, condition of facilities and availability of health insurance.)?
- Has your family had any difficulty accessing public health services?

### **Health workers**

- Are you happy with your current salary? If not, why?
- Would you say the medicines available in your health centre meet the needs of local people? If not, What additional medicines does your centre require?
- Do you think current healthcare policies including treatment, methods and the provision of drugs are suitable for ethnic minorities areas? If not, why?

### **Commune leaders**

- What role do local leaders take in the implementation of health care policies?
- How do you feel these policies could be improved upon?
- Do you think policies governing hamlet healthcare workers are suitable?

**District and provincial officials**

- Are the current healthcare policies as implemented suitable to local conditions? If not, what more needs to be done?
- How would you rate the impact government healthcare programme in your area?
- What kind of co-operation occurs between healthcare agencies and other government and international bodies in your area? How do you manage the situation?

What difficulties have you encountered regarding the implementation of healthcare policies?

## **Appendix 1.3: Questionnaire for in-depth interviews on education programmes and related issues**

### **Parents and teachers**

- Please tell us about education in your area. Does the physical condition of schools meet the needs of students?
- What do you know about education policies and programmes for ethnic minorities?
- Do health policies for schoolchildren meet with local needs? If not, what more needs to be done?
- Does your family have pay for schooling? If so, how much and what form does the payment take?

### **Teacher salaries**

- What is your fixed term salary? Along with government allowances, how much do you receive in total per year?
- When do you usually receive your salary? Is it often delayed?
- When was the last time your salary was increased? When is your present salary valid until?
- What other income sources do you rely on besides your salary and government allowances?
- How much does the income you receive from teaching make up of your entire income?
- Are you satisfied with your salary and allowances? If not, why not?
- What would you say is lacking in terms of the governments salary and allowance policy? How should it be changed?

### **Tuition fee reduction policies**

- Do you pay your child or children's tuition? If so, for what grades? How much do you pay per month?
- Do you have to contribute any other funds to your child or children's school? If so, how much and what for?
- Are you aware of government policies on the reduction of tuition fee for certain areas? If so, do these policies make a difference in terms of sending your child or children to school?

### **Textbook policies**

- Apart from tuition exemption polices, what else in your opinion should the government be doing to make education more accessible?

- Are your children provided with textbooks free-of-charge? Are they able to borrow textbooks? If so, for what grades?
- For what subjects are your children able to borrow textbooks? Are they new or old? What is their general condition? How long are they lent the books for? If the books are lost or damaged, are there any penalties?
- If there are not enough textbooks provided, do you buy textbooks for your children? Do your children have to borrow from other classmates?
- If you have had to buy textbooks for the year 2002-2002, what textbooks have you bought and for what grades? How much did you spend?
- How would you rate the supplied textbooks in terms of your child's learning?
- Do you have any children attending boarding schools, college or universities? If so, which educational institution they attend?
- Where they given any incentives to study? If so, what were they?
- Are you aware of the selected admission policy?
- Are your children eligible for selected admission?
- Do you think the selected admission policy is transparent? If not, what can be done to make the policy more transparent?
- How would you rate the impact of the policy in terms of its effect on ethnic minorities in your locality?

### **Questionnaire for student interviewees**

1. Did you have to pay tuition fees or contribute financially in any other way to your school during the academic year of 2001-2002? If you were late paying tuition fees, what reason did you give?
- 2 .How many textbooks were you provided with? Were they given to you or are you borrowing them? Did you have to buy any?
3. Do you feel you were provided with enough textbooks?
4. Are there any classmates of yours who do not have enough textbooks? What can be done about the situation?
5. Do you attend a boarding school? If so, how were you granted a place?
6. What kind of financial and material benefits do you receive from your school (Allowances, clothes, notebooks, textbooks etc)?

## **Appendix 1.4: Questionnaire for group discussion on education issues**

### **Teachers**

- Do you feel current salaries and government allowances for teachers in Zone III provide with an adequate standard of life? If not, please elaborate.
- What measures should be taken attract more teachers to schools in Zone III?
- Are policies to subsidise student tuition fees in Zone III enough to bring about increased enrolment and a better quality of education? If not, please elaborate.

### **Parents**

- Have tuition fee exemption policies affected your decision to send your child or children to school?
- Do you think that the policies that give preferential treatment to certain children in your area are fair? Why or why not?

### **Local Officials**

- How would you describe the role of local officials in the implementation of education policies?
- Can you see a connection between education and socio-economic development in your area?

### **District and provincial officials**

- Do you feel current education policies are suitable to local conditions? If not, what more should be done?
- Has the implementation of education policies in your area produced concrete results?
- Is there any coordination between different agencies/institutions to implement education policies? What form does that coordination take?
- Are you facing any difficulties when it comes to the implementation of education policies? If yes, please supply examples.

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