

HEALTHCARE AND FOOD SECURITY: CASE STUDY IN TWO ETHNIC GROUPS IN KY SON DISTRICT, NGHE AN PROVINCE, VIETNAM

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1. Back Ground

Health and food security are organically related. Food security and community health are assessed through two main indicators - poverty and malnutrition. On our planet, at least 12 million people die of hunger every year, two thirds of them are children. Up to 44% of the world's population is absolutely poor who are living in South Asian countries (National Politics Publishing House, 2003, pp. 95). While the mortality rate of children under five in rich countries is under 1% and the malnutrition rate of children under five is 5%, these figures in poor countries are around 50% (Ministry of Planning and Investment, 2006, pp. 20-25).

Poverty, morbidity, and lack of knowledge on healthcare have directly affected the quality of life. Vietnam remains one of the poorest and least developed countries in the world. In 2006, the poverty rate of households in the country was 17% and about 22% of children under five are malnourished. Up to 34% of children under five suffer iron deficiency. In poor and disadvantaged regions, this rate is up to 70% (National Nutrition Institute, 2005). Since embarking on *Doi moi* (Renovation policy) in 1986, Vietnam's economy enjoyed the highest growth rate in Asia, second only to China. At the 10th National Congress of the

Communist Party of Vietnam, the objective was set to remove Vietnam out of the list of poor countries by 2010, and become an industrialized country by 2020. Alongside with national economic development, healthcare for the people has constantly improved. Improving people's health is not only the task of the health sector but of all sectors in society.

This survey discusses the relationship between health care and food security of the Thai in Pha Danh Commune and the Khmu in Ta Ca Commune (Ky Son District, Nghe An Province, Vietnam). During the survey, comparisons are made with the Thai in Natoum Village, Muong Kham District, and the Khmu in Din Dam Village, Nong Hed District, Xiang Khouang Province - the two survey sites in Laos under this project. The objectives of this survey are to: a) have an overview on healthcare in the survey sites; b) identify factors affecting healthcare of ethnic minority groups in survey sites; c) study how healthcare affects food security and coping measures against food shortages of household families; and d) compare the findings from the survey sites in Vietnam and the two survey sites in Laos. Based on the findings, this report makes some recommendations to improve community health in survey sites, thus contributing to ensuring food security.

The following research methods have been applied in the survey:

- Inter-disciplinary method: Combining with the survey conducted by agro-forestry and economic ethnologists through discussions and information exchanges.

- In-depth interview: In-depth interviews are conducted with village and commune health providers, villagers, particularly household families suffering illnesses.

- Focus group discussion: In each survey site, focus group discussions are held - groups of village officials, women, men and mixed group.

- Participatory observation: During field visits, observations are made on the state of health of villagers, sanitary conditions and health services etc.

- Comparative method: Comparison made between two survey sites in each country and between survey sites of the two countries.

2. Overview on Literature

According to WHO/UNICEF, the cause of infant mortality is mainly due to diseases which can be prevented and treated such as diarrhea, pneumonia and food deficiency. Malnutrition is related to about 50% of all deaths of children worldwide. Global statistics show that malnutrition is a factor in 61% of all incidents of child mortality from diarrhea, 57% of all incidents of child mortality from malaria, 52% of all incidents of child mortality from pneumonia and 45% of all incidents of child mortality

from measles. About 20% of the population in East Asia and the Pacific has no access to clean water for drinking; about one billion people live in unsanitary conditions. Such factors are related to 90% of deaths due to diarrhea. Countries which have low population rate accessing clean water sources and sanitation are countries that have highest infant mortality rate under five. Large disparities remain between regions and poor urban and rural areas (WHO/UNICEF, 2006, pp. 5-9).

Vietnam is a developing country, but has a system of healthcare equal to countries with higher incomes. In Vietnam, the malnutrition rate of children under five - an important indicator relating to poverty and hunger - has reduced remarkably, from 50% in 1990 to 22% in 2006. The mortality rate of children under one year old has dropped from 46% in 1990 to 18% in 2005, equal to the rate in countries having income per capita two or three times higher than Vietnam. The poverty rate of households reduces from 58.1% in 1993 to 17% in 2006, or more than 30 million Vietnamese people have escaped poverty. However, over 90% of poor households are living in rural areas, concentrating mainly in the Northwest, Northeast, North central region and the Central Highlands. At present 65% of ethnic minorities remain poor (Ministry of Planning and Investment, 2006, pp. 20-25). According to the 2004 Household Living Standard Survey, 7.32% of the population in poor group received medical treatment over the last 12 months, while the figure in the

rich group is only 6.57% (UNDP, General Statistics Office, 2006).

Vietnam has officially implemented the National Target Program on Hunger Eradication and Poverty Reduction since 1998 (Decision No. 135/1998/QĐ-TTg dated 31/7/1998). This is one of the poverty reduction efforts made by Vietnam in order to achieve the Millennium Development Goals and its own national goals. The Vietnamese Government has launched a program to provide free health checks up and treatment to the poor (Decision No. 139/2002/QĐ-TTg dated 15/10/2002). Government programs have made a great contribution to poverty reduction, improving the quality of life and reduction of health cost burden to most of the poor, most of whom are ethnic minorities living in remote areas in the country.

3. Main Findings

3.1. State of Health in Two Survey Sites

3.1.1. Situation of Healthcare

Health status is an important factor of human capital that affects food security. Through the survey, it is noted that indicators relating to health of the two ethnic groups are distinctively different. While only 2.9% Thai households have members suffering from respiratory infections and malaria, the figure of the Khmu is 12.7%. Thai women see no sign of pale complexion and anemia during pregnancy while 22% of pregnant Khmu women suffer anemia. Only 2.9% of Thai children are stunted while the figure in Khmu children is 19%. As the chart below demonstrates, incidents of various indicators of poor health vary between the two ethnic groups (Table 1).

Table 1: Situation of morbidity in two survey sites

Indicators	Thai (%)	Khmu (%)
Household members, particularly children often suffer from respiratory infections and malaria	2.9	12.7
Asthma, mental disorder and rheumatism (according to respondents)	17.65	15.9
Stunted children	2.9	19.0
Household women members (particularly during pregnancy) see sign of pale complexion	0.0	22.0
Poor health unable to do hard work (according to respondents)	2.9	22.0

Source: Household survey, 2007.

According to the results of the household survey, up to 14 households (14.3%), including 5 average, 6 poor and 3 hungry households often contract chronic diseases, congenital defects and other diseases. Meanwhile, for well-off households, their members do not contract these diseases as often.

In normal practice, the proportion of morbidity in high-income group is lower than in low-income group because well-off families can afford foods rich in nutrition and vitamins, leading to better health outcomes. This has been proven through the data of the 1998 household living standard survey. Those in the group of lowest average spending per capita are more likely to suffer from diseases (42.9%) than those in the highest spending group (39.3%). 34.8% of males in the rich group suffer from diseases and illnesses while this figure in the poor group is 41.1%. The morbidity rate in rural areas is 42.4%, higher than that in urban areas which is 38.7% (General Statistics Office, 1999). Reasons for high morbidity rate in rural areas include low living standards, hard manual work and low educational level.

In-depth interviews show that in any household having sick members, its income is seriously affected. In Pieng Pho Village,

most of poor households have sick members and have to spend much money on medical treatment. Moreover, the state of health is both the cause and outcome of food shortages. Through Table 1, it is noted that in general, the health of Pieng Pho villagers is much better than that of Binh Son 1 villagers. Observations and interviews in Binh Son 1 Village show that women here often suffer from head-ache, vertigo - a sign of anemia and nutrition deficiency.

3.1.2. Diseases and Illnesses

According the a report on commune health statistics in 2006, there are differences in the types of diseases often seen in the two survey communes. In Ta Ca Commune, people mostly contract influenza: 6.2% (compared to the number of checks up) while in Pha Danh Commune, people mostly contract acute respiratory infections: 6.0%, and other diseases such as bronchical infections: 3.4%, diarrhea: 2,5% and pneumonia: 2.0%. During in-depth interviews and focus group discussions in the two survey sites, it is noted that people in Binh Son 1 Village (of Khmu ethnic group) have living conditions, food, housing and health conditions much lower than those of the Thai (in Pieng Pho Village).

Table 2: Statistics of health checks up and treatment and some common diseases in two communes in 2006

No.	Some information	Pha Danh		Ta Ca	
		Quantity	%	Quantity	%
A	General activities				
1	Total population	2,735	-	4,120	-
2	Total number of health checks up	1,809	100.0	1,190	100.0
	- Percent of health checks up compared to total population	-	66.1	-	28.9

3	Total gynecological checks up	299	16.5	431	36.2
	- Total number of gynecological treatment	167	9.2	326	27.4
	- Percent of gynecological treatment compared to total number of gynecological checks up	-	55.9	-	75.6
4	Total number of in-patients	19	1.1	12	1.0
	- Total number of out-patients	1,256	69.4	145	12.2
B	<i>Some common diseases</i>				
1	Influenza	13	0.7	74	6.2
2	Acute respiratory infections	109	6.0	12	1.0
3	Pneumonia	37	2.0	18	1.5
4	Bronchial infections	61	3.4	15	1.3
5	Diarrhea	45	2.5	12	1.0

Note: Percent compared to total number of checks up.

Source: 2006 report of the commune health station.

3.1.3. Health Services and Privileged Policies

3.1.3.1. Modern Medicine and Government Health Policy

In Vietnam, the commune health station in the two survey sites has been established in 1970s. However, its operation has really been effective since 1990s. In Laos, as commune does not exist, there is no commune health station, only village health facilities. The functions and tasks of village health facilities in Laos are limited in terms of professional skills and availability of medicines and medical equipment. Village health providers in Laos have only been provided with some common drugs, and many of them neither know how to carry out immunizations or obstetric services. Some providers only received one-week training. In case of illness, patients have to travel to the district or Vietnam (if their location is close to the Lao-Vietnam border) for medical treatment.

Healthcare for the people has much improved since the launch of the Program on

free health checks up and treatment for the poor (Program 139) in 2002. In particular, children under six years old receive health checks up and medical treatment free of charge nationwide. However, in the two survey sites in Ky Son District, Nghe An Province, due to cumbersome administrative procedures and the loss of legal papers, more than 20% of the local population do not receive medical insurance cards for free checks up and treatment. Moreover, people often receive such cards very late, sometimes not until the third or fourth quarter of the year, thus its validity in terms of time is very short. In Laos, there is no program on free health checks up and medical treatment for poor patients and children under six years old. In cases of very poor households who are certified by the community and the head of the village they are given free checks up and treatment. In Din Dam Village, people suffering from common diseases coming to Vietnamese health facilities in the border area (2 km from the village) to get free medicines and treatment.

Table 3: Use of health services by households of different economic conditions

Health facilities where treatment is provided	Households' economic state				Total
	Well-off	Average	Poor	Food-poor	
Village health providers	3	7	17	9	36
	75.0%	17.5%	41.5%	69.2%	36.7%
Commune health station	1	19	16	3	39
	25.0%	47.5%	39.0%	23.1%	39.8%
District, provincial, central hospitals	0	7	3	1	11
	0.0%	17.5%	7.3%	7.7%	11.2%
Private drugstores	0	2	1	0	3
	0.0%	5.0%	2.4%	0.0%	3.1%
Local practitioners	0	2	2	0	4
	0.0%	5.0%	4.9%	0.0%	4.1%
Ceremonial offerings for disease treatment	0	1	0	0	1
	0.0%	2.5%	0.0%	0.0%	1.0%
Self-treatment	0	2	1	0	3
	0.0%	5.0%	2.4%	0.0%	3.1%
Without treatment	0	0	1	0	1
	0.0%	0.0%	2.4%	0.0%	1.0%
Total	4	40	41	13	98

Source: Household survey, 2007.

Data of the Household Living Standard Survey 2004 show that up to 17.1% of poor households receive medical treatment from the commune health station, while the figure in the rich group is only 3.6%. Only 3.3% of poor households go to private health facilities for treatment, while the rate in the rich household group is double (7.1%). In this survey, it is noted that most of the people select village health facilities (36.7%) and commune health stations (39.8%) for checks ups and treatment, particularly people in the well-off group. The figures are

corresponding to the high income households in the survey sites who do not contract serious diseases. About 11.2% of households having sick members go to district hospitals and upper levels for medical treatment. Most of them are average, poor or hungry households. One household still maintains the custom of ceremonial offerings to treat diseases and one household has no medical treatment when a member falls ill. As reported by the community, the Khmu in Binh Son 1 Village is still much affected by the custom of

treatment of diseases through ceremonial offerings. One of the reasons for this is that relatives lend pigs and chickens to the family with sick members to make ceremonial offerings and only when their family members are sick, the borrowers have to return them to the lenders to make ceremonial offerings. That is why many poor households can still afford to organize ceremonial offerings for treating diseases.

3.1.3.2. Roles of Traditional Medicine

The use of medicinal herbs for treatment has long existed in the Thai and the

Khmu and has been handed down from one generation to another. However, the treatment using medicinal herbs by the Khmu in Binh Son 1 Village is more limited than that of the Thai in Pieng Pho Village. Only one or two persons in the village know how to treat diseases with medicinal herbs, but cannot treat many types of diseases and very few villagers ask them for help. Meanwhile in Pieng Pho Village, there are 7 practitioners using herbal medicines who can treat many types of diseases. Conversely, the Khmu are less interested in utilizing traditional medicine.

Box 1: *Mr. Lo Van Thuan, 41 (Pieng Pho Village, Pha Danh Commune) has stomach ache and duodenum for 10 years now. He has to sell four cows for VND 12 million. The provincial hospital fees cost him VND 9 million for three times. In the last 5 years, he has spent nearly VND 40 million on medical treatment but he has not yet fully recovered. Although he has medical insurance, the hospital does not have all types of medicines he needs so he has to buy them from outside.*

The practice of traditional medicine in the two survey sites is highly community based and for mutual help. When someone is ill, the family goes to see the traditional medical practitioner to ask for medicinal herbs free of charge. After recovery, they bring some wine, rice and a chicken to thank the practitioner. In some cases, when going to ask for herbal remedies, they already bring such things to the practitioner and after recovery, they again bring some more to thank the practitioner. In the two survey sites in Laos, the practice of traditional medicine is much more limited than that in the two survey sites in Vietnam.

Although the role of traditional medicine is undeniable, modern medicine (as practiced in health stations) and traditional

medicine have not yet been combined. Practitioners of traditional medicine have handed down the traditional medical practice from one generation to another without any control from the health sector. At commune health station, there are no traditional medicine practitioners and no plans for the development of traditional medicine in the commune, although the Ministry of Health has recommended that 20% of patients should be provided with traditional medicines at the commune level.

3.1.4. Spending on Healthcare

Decision 139 of the Government on free health checks up and medical treatment for the poor has had a great impact on the state of health of the people. However, although medicines are given free of charge,

a person is only entitled to receive free medicines worth no more than 15,000 VND/month and 70,000 VND/year at the commune level. For serious patients and those who suffer chronic diseases, their family still has to spend a lot of money on their treatment.

Box 1 shows that for a well-off household family, if a member is ill, particularly the head of the household, the family faces a great risk. In addition to having to sell property for medical treatment, the household has to cover expenses for other family members who accompany to serve the sick in hospital. As a

consequence, the household loses some labour at the same time, thus it earns no income or its income reduces much. Illness greatly affects household economy and food security, and may negatively impact on the well being and economic security of relatively affluent families.

Table 4 shows that although the disparity in spending on healthcare between the poorest (4.31%) and the richest family (5.77%) is not big in terms of absolute figures, this disparity is remarkable. Each poor household only spends VND 298,800 on healthcare a year, while the figure of the richest household is VND 1,614,100, four or five times more than poor household.

Table 4: Individual spending on healthcare in 2002

	% of specialized checks up and treatments	VND 1,000/year						% of household expenditure
		Treatment	Drugs	Medical equipment	Contribution	Insurance	Total	
Poorest	46.3	151.6	137.1	3.3	2.4	4.5	298.8	4.31
Near poorest	48.4	254.4	187.1	5.5	2.3	7.4	456.7	5.02
Middle	48.8	365.9	213.0	6.2	2.0	10.9	598.1	5.28
Near richest	52.6	553.9	262.9	8.6	1.9	16.8	844.0	5.78
Richest	56.3	1110.4	449.8	21.4	1.4	31.1	1614.1	5.77
Whole country	50.6	520.6	260.6	9.6	2.0	15.1	807.9	5.29

Note: Individual health spending calculated in some patients who have health checks up and medical treatment or buy drugs.

Source: Estimations using data from Vietnam National Health Survey 2002 and Household Living Standard Survey 2002 (Vietnam Development Report, 2004, pp. 67).

Table 5 below shows household spending on food and foodstuff which is up to 65.8% of the total household expenditure. Except spending on children's education of 10.6%, spending on other things such as clothing, shoes and sandals is 5.7%, health 4.8%, and house repair 2.7%. There is almost no spending on

entertainment. Comparing the two ethnic groups, there are distinct differences. More than 50% of the expenditure of the Khmu is for the purchase of food while this figure of the Thai is 34.4%. Spending on children's education by the Thai is 4.7 times higher and on healthcare 4 times higher than the Khmu.

Table 5: Average monthly household expenditure in two survey sites (%)

Spending Items	Thai	Khmu	General
Rice	34.4	50.8	43.1
Foods	24.9	20.8	22.7
Children's education	18.3	3.9	10.6
Festivals, funerals, weddings	5.3	3.4	4.3
Drugs, hospital fees	8.0	2.0	4.8
Clothing, shoes, sandals	5.9	5.6	5.7
Production tools, appliances	1.3	1.0	1.1
Tax and fees	1.6	1.9	1.8
Oil, electricity, fire-woods	0.1	1.9	1.1
Housing construction, repair	0.2	5.0	2.7
Gasoline	0.0	0.1	0.1
Telephone	0.0	3.6	1.9

Source: Household survey, 2007.

According to WHO, Vietnam's budget allocated for healthcare is 7 USD/person/year, only higher than Laos and Cambodia in Southeast Asia (5 USD), and much lower than other regional countries (WHO, 2005). According to the Household Living Standard Survey 2004 (UNDP, General Statistics Office, 2006) in Vietnam,

the average spending on healthcare is VND 359,690/person/month. The figure for the rich group is VND 715,220, 4 times more than the poor group (VND 160,420). Spending on medical treatment and healthcare is VND 25,300, in which the poor group VND 11,040, only one fifth of the rich group (VND 51,080) (see Table 6).

Table 6: Average monthly spending per household member by 5 income groups

Unit: VND 1,000

Spending items	General	5 income groups				
		Group 1	Group 2	Group 3	Group 4	Group 5
Whole country	359.69	160.42	225.99	293.84	403.92	715.22
<i>Spending on food, drink and smoking</i>	<i>192.47</i>	<i>106.62</i>	<i>138.16</i>	<i>169.18</i>	<i>213.19</i>	<i>335.61</i>
Food	45.66	43.18	45.79	46.40	46.24	46.72
Foodstuff	98.73	47.60	68.57	87.50	113.12	177.11
Fuel	9.97	7.14	7.79	8.68	10.84	15.41
Eating and drinking outside family	27.57	4.17	9.87	17.99	31.60	74.32
Drinking and smoking	10.54	4.53	6.14	8.62	11.39	22.06
<i>Non-food and non-smoking Spending</i>	<i>167.22</i>	<i>53.80</i>	<i>87.84</i>	<i>124.66</i>	<i>190.73</i>	<i>379.61</i>
Clothing, hats, shoes and sandals	16.39	8.25	11.42	14.15	18.51	29.64
Housing, water, electricity, sanitation	14.87	4.13	6.63	9.95	15.51	38.18
Household appliances, equipment	32.68	10.68	17.65	25.69	38.30	71.17
Medicines, healthcare	25.30	11.04	16.33	20.19	27.93	51.08
Transport and postal services	38.80	7.72	14.94	26.92	46.82	97.74
Education	22.75	8.13	13.80	17.91	27.47	46.52
Culture, sports, entertainment	4.52	0.21	0.53	1.21	3.43	17.25
Others	11.91	3.63	6.52	8.63	12.77	28.03

Source: Household Living Standard Survey, 2004.

3.2. Factors Affecting Healthcare and Causes of Morbidity

3.2.1. Poverty and Nutrition

The Food and Agriculture Organization (FAO) has provided the following general standard formula in terms of kilogram calories: in cold weather region, on average a person must intake 3,000 Kcalo/day; and in hot weather region, on an

average a person must intake 2,500 Kcalo/day. But in developing countries, the average intake per person is less than 2,000 Kcalo/day, not enough energy for working.

In Vietnam, due to great disparities in the living conditions between urban and rural areas, particularly remote areas, the rate of malnourished women and children is very high. According to a survey report of the Institute of Nutrition, about 20% of rural

households intake less than 2,000 Kcalo/day (National Nutrition Institute, 2005).

Comparing the nutrition of the two ethnic groups, distinct differences are noted. The Thai always have three meals a day, even during pre-harvest period. Poor households try all means to maintain three meals a day. In a meal, besides rice (sticky or plain rice), there are always other food such as meat, fish, bean curd, eggs and green vegetables, thus providing four kinds of nourishment - protein, fat, starch and vitamins. Surrounding each house is an organic vegetable garden providing different types of seasonal vegetables to the household. It is organic because they neither use chemicals nor fresh manures to grow vegetables. The Khmu does not often have enough nutrition in their meals. Very few households can ensure three meals a day, particularly during

pre-harvest period, and poor households suffering from food shortages. Very few households have a vegetable garden around their house. When facing food shortages, they do not try to find replacement foods, but mostly work as hired labourers to earn money to buy rice and even wait for government's support. While the Thai can do weaving, handicrafts, make fish nets and go fishing the Khmu know very little about these activities.

Table 7 shows the differences between the two ethnic groups of Thai and Khmu. While in the Thai village, 67.7% households are well-off and average, 26.5% households are poor and only 5.9% households suffering food shortages, in the Khmu village, only 31.8% households are well-off and average, up to 50.8% households are poor and 17.5% households suffer food shortages.

Table 7: Wealth ranking by household groups and by ethnic groups

Ethnic group	By household groups				Total
	Well-off	Average	Poor	Food-poor	
Thai	2	21	9	2	34
	5.9%	61.8%	26.5%	5.9%	100.0%
Khmu	2	18	32	11	63
	3.2%	28.6%	50.8%	17.5%	100.0%
Kinh	0	1	0	0	1
	0.0%	100.0%	0.0%	0.0%	100.0%
General	4	40	41	13	98
	4.1%	40.8%	41.8%	13.3%	100.0%

Source: Household survey, 2007.

The two ethnic groups of Thai and Khmu in the two survey sites in Laos share many similarities with the two ethnic groups in the two survey sites in Vietnam. However, the Khmu in Din Dam Village, due to being located near a highway and close to the Lao-Vietnamese border and having more exchanges with outsiders, have better living standards than the Khmu in Binh Son 1 Village in Vietnam.

3.2.2. Environmental Sanitation and Access to Clean Water

Between the two survey sites of the Thai and the Khmu in both Vietnam and Laos, there are some distinct differences. On environmental sanitation, the Thai village is much cleaner than that of the Khmu. Both villages have a separate area to keep buffaloes and cows. But the Khmu let their pigs run freely, their children do not have enough warm clothes, some of them even do not put on trousers or shirts and their bodies, and as a consequence their legs and hands become very dirty. This is the cause of zotic related diseases such as parasitic, digestive,

diarrhea and some serious diseases such as hepatitis and encephalitis etc. The environmental sanitation in the two survey villages in Laos is much better than that in Vietnam. In Natoum village (of the Thai) in Laos, buffaloes and cows are kept separately. If any household lets its cattle enter the village the household would be seriously punished.

In all the four survey sites in Vietnam and Laos there is a clean water source taken from the mountain through pipeline to the village or from drilled wells. However, according to reports from the local authorities, the water source in Pieng Pho Village is not sanitary because the upstream is close to the fields where fertilizer and pesticides are used. In the two survey sites in Laos, water supply is more limited than that in the two survey sites in Vietnam, particularly in dry season. The custom of drinking un-boiled water in the two survey sites in Laos is more popular than in the two survey sites in Vietnam. This greatly affects healthcare, especially digestive-related and parasitic diseases.

Table 8: Indicators of clean water and environmental sanitation, comparison between two countries

Indicators	Vietnam		Laos	
	Pieng Pho Village	Binh Son 1 Village	Natoum Village	Din Dam Village
Latrines	100%	0%	100%	100%
Sanitary latrines	6.9%	-	72.6%	100%
Use of safe water	100%	100%	100%	100%

Source: Household survey and fieldwork, 2007 and 2008.

Concerning latrines in the two survey sites in Laos, they are much better than in the two survey sites in Vietnam. In Pieng Pho Village, 100% households have latrines, but only one household (of the commune's chairman) has a septic tank and the rest dug latrines. Meanwhile 100% households in Binh Son 1 (of the Khmu) do not have latrines, even dug latrines. The unavailability of latrines coupled with the custom of relieving oneself randomly in forests, fields, rivers and streams have greatly affected environmental sanitation, water sources and community healthcare. Yet, according to reports from the commune health station, the morbidity rate in the village is very low. Data from in-depth interviews and focus group discussions show that common diseases related to unsanitary environment include diarrhea, parasitic worms and digestive diseases. In both survey sites in Laos, 100% households have latrines. While only 72.6% households in Natoum Village have septic tanks, the figure in Din Dam Village is 100%. While households in Din Dam Village received assistance from a project to build their septic tanks, households in Natoum Village spent their own money on the construction of their semi-septic tanks. This helps reduce remarkably diseases related to environmental sanitation such as parasitic worms and diarrhea.

3.2.3. Customs and Habits Affecting Human Health

In the past, when falling ill, people treated their illnesses with traditional medicine, using herbs collected from forests, made ceremonial offerings, saw fortune tellers to tell their diseases etc. They had no access to modern medicine.

Today, although the custom of treatment of diseases by ceremonial offerings and shaman has reduced much, it somehow still remains, particularly among the Khmu community. This change started since the establishment of the commune health station which provides access to modern healthcare services and communication and information delivered to the local people on treatment of diseases with modern medicine. In addition, the Government has adopted policies toward ethnic minorities, and remote and disadvantaged areas such as free health insurance to the poor and people living in most disadvantaged communes supported by Program 135. As a result of these programs, people here do not have to spend money on treatment of common diseases.

Up to now, the Khmu is still largely affected by the custom of disease treatment by ceremonial offerings more than the Thai. Through the survey, it is noted that this way of disease treatment remains popular in Binh Son 1 Village while it is almost no existent in Pieng Pho Village. This is similar in the two survey sites of the Thai and the Khmu in Laos. However, the Thai and the Khmu in Laos practice ceremonial offerings for treatment of diseases more than those in Vietnam.

3.2.4. Social Behaviors and Lifestyle Affecting Health

The two villages of the Thai in Laos and in Vietnam have no drug users or those related to drugs, prostitution and HIV/AIDS. However, in the two Khmu villages in Laos and Vietnam, due to being located along the drugs trafficking route, people are more or less related to drugs. According to

incomplete statistics, there are drugs-related persons in these two villages. This greatly affects the lives of the villagers in general and their health in particular. This is because drug trafficking will very easily lead to drug use, prostitution and HIV infection.

The habit of drinking wine during festivals and New Year days remains in the survey villages. Quarrelling and fighting are often caused by people who get drunk. Such a drinking habit has made many people drunk and dependent on wine, leading to liver weakness, cirrhosis and death. In Binh Son 1, villagers drink much and together with limited nutrition, their health is not good. During our field work in Binh Son 1 Village, we observed dozens of wine jars in the house of the head of the village (about several hundred liters) in preparation for the wedding of his son.

The habit of smoking cigarettes and pipe tobacco is also popular in the two survey sites, particularly in the Khmu village. Asked about the harmful effect of

cigarettes and pipe tobacco, many respondents did not know and considered smoking normal because they have used to it for a long time now.

According to reports from the World Health Organization (WHO), Vietnam is rated as one of the countries having highest smoking rate worldwide - 56.1% males and 1.8% females (WHO, 2005) smoke. It is reported by the Ministry of Health that every year 30,000 - 40,000 persons in Vietnam died of smoking-related diseases. The World Health Organization has warned that if it is not prevented in time, about 10% of Vietnamese population will die of smoking related illnesses at young age (WHO/UNICEF, 2006, pp. 5-9).

3.3. Impact of Health on Food Security and Coping Measures to Food Shortages

This section focuses discussion on the impacts of health on food security through five capital sources: natural, human, social, financial and material.

Box 2: Mrs. Lu Thi Mau, of the Kho-mu (in Binh Son 1), 27, cannot speak the national language. She has two daughters, the eldest is five years old and the youngest is four month old. She had an infant died right after being born (her second birth). She herself has been ill for five years now. She suffers from fatigue, head ache and vertigo and cannot eat. She had medical treatment but not free of charge because she has lost her medical insurance card. Her family stays in a temporary, shabby house. The family suffers food shortages for 7 - 9 months a year. Her husband has to work for the Thai or the Hmong to earn money to feed his wife and children.

Household families with members suffering from chronic and serious diseases often fall into extremely difficult situation. Sudden changes in health often reduce sources of labour and cost much money for medical treatment and other related spending. They are mentioned as one of the causes to family poverty. Reduction of direct and indirect

spending on medical treatment for poor households can create an important security net, in particular for those households whose members are seriously ill and are referred to district or higher level hospitals for the commune health station fails to treat them. The cost for medical treatment, although it is free, remains high an unaffordable by most of

the household families, particularly those ethnic minorities supported by Government Program 135.

Mrs. Mau's family is a typical example. Her whole family lives in a temporary hut. There is no property worth more than VND 100,000 in her house. The family has only a small pig which was sold for VND 100,000 to cover her hospital fee. She could not borrow money from other villagers as they are not much richer than her. Moreover, even if they have money, they do not dare to lend her fearing that she is certainly unable to repay. During her period of medical treatment, she could only borrow VND 350,000. So, analyzing the five sources of capital, her family is poor in all five sources: natural - not enough land to till; human - one person works to feed four family members; social - not enough allowance because the whole community is poor; financial and material - nothing. All of these deficiencies become a vicious circle which she cannot escape from. In terms of her health, she does not suffer any serious disease mainly asthenia caused by factors analyzed earlier, driving herself and her family into an extremely difficult situation. This is a typical example on the inter-relation between health and food security. The coping measure to food shortages applied by Mrs. Mau's family is to work for other people to earn money to buy food. Because just having enough money to buy food, her family cannot improve the meals for its members. In other words, the meals do not provide enough nutrition and thus cannot ensure good health for family members. This is another vicious circle.

Conclusion

- Healthcare for people has been attached great importance to by the Vietnamese Communist Party and Government since regaining independence and has developed remarkably since the implementation of the *Doi moi* (Renovation) Policy, particularly since the policy of exempting and reducing of medical treatment fees for poor people and children under six years old.

- In the survey sites in both Vietnam and Laos, the Thai ethnic group has better outcomes in education. They are better able to look after their own health, and keep their living environment clean, than the Khmu. However, in terms of latrines, the two survey sites in Laos are better than those in Vietnam.

- Factors affecting community health in the two survey sites, particularly in the village of the Khmu, are clean water and sanitation. Knowledge of hygiene and health care, sufficiently nutritious diets, and a prudent approach to alcohol consumption, help contribute to enhancing community health.

- The use of medicinal herbs for treatment of diseases in the two survey sites is spontaneous and has not yet been encouraged by the local authorities and health facilities. Compared to the two survey sites in Laos, people in the two survey sites in Vietnam use more herbal medicines for treatment of diseases.

- Although customs and habits affecting community healthcare have been limited much, they still exist in the two survey sites, particularly in the village of the Khmu. The custom of making

ceremonial offerings for treatment of diseases in the two survey sites in Vietnam has reduced much than the past, but remains quite popular in Laos.

- The relationship between food security and healthcare has expressed clearly in these two survey sites, particularly in the village of the Khmu. It is related to and directly affects the five sources of capital: natural, human, social, financial and material. If a household family has members suffering illnesses, its five sources of capital will be affected. This is similar in the village of the Khmu in Laos.

Recommendations

- The effectiveness of policies toward ethnic minority groups, particularly privilege policies on people's health should be maintained and developed. This is a precious experience in the fight against poverty in general and healthcare for ethnic minorities in particular.

- Communication and education should be provided so that people learn how to protect and care for their health. Target groups should be informed about the use and preservation of clean water, environmental sanitation, nutrition, and protection and care for mother's health.

- Domestic water sources should be maintained and improved for the people. Effective measures should be taken to protect and use clean water.

- The efficiency of cattle rearing in concentrated and protected areas should be developed. The community should be mobilized to build and use sanitary latrines such as septic tanks and semi-septic tanks.

The experience from Lao villages can be applied. Wastes should be collected and treated, especially cattle and poultry dung on village roads.

- The effectiveness and quality of local health services should be maintained and developed by providing training and re-training to health staff including village health providers to update knowledge and professional skills.

- The use of alcohol among the people should be minimized. Regulation on penalties should be in place against those who are drunk and disorder public.

- Local authorities and health sector should encourage people to maintain and develop the use of locally available herbal medicines and remedies to treat diseases, including common and serious diseases.

- Gradually eliminate old customs that affect community healthcare such as ceremonial offerings for disease treatment, and restraints from foods and taboo during pregnancy and childbirth.

- The two tasks of ensuring food security and healthcare should be fulfilled at the same time and measures taken to ensure household food security. This is one of the requirements demanding uniform coordination between different sectors such as health and agro-forestry and guidance from local authorities.

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