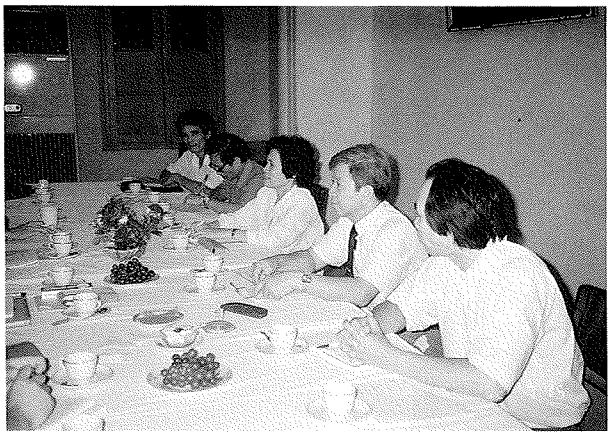
Report on the Basic Survey of Population and Development in Southeast Asian Countries
——Viet Nam——

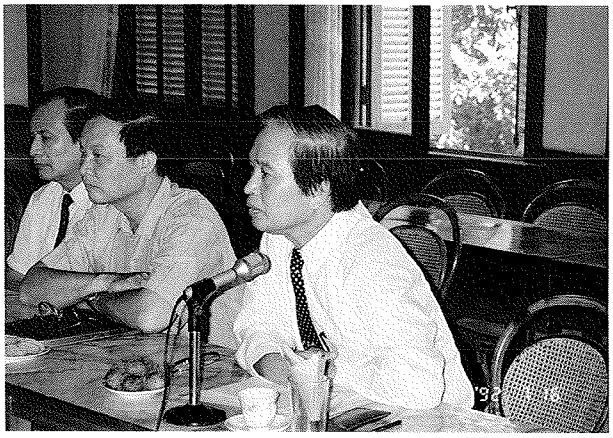
MARCH 1993

The Asian Population and Development Association

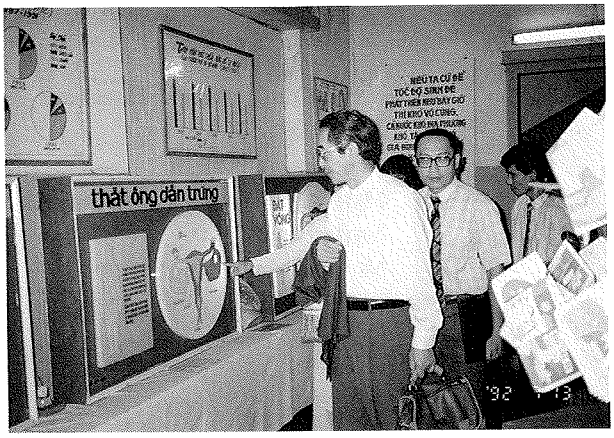


◀ At the Commission for Health and Social Affairs
Center:
Ms. Nguyen Thi Than, Chairwoman
Second from right:
Mr. Tran Minh Viet, Advisor

At the Ministry of Health ▶
Prof. Dr. Pham Song, Minister

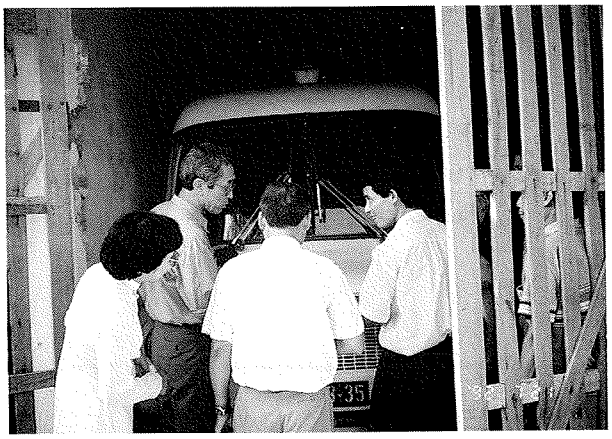


◀ At the Embassy of Japan
From the left:
Ambassador Hiroyuki Yushita
Mr. Minoru Kiryu, team leader



◀ At the Ho Chi Minh City Population and Family Planning Committee

Ho Chi Minh City ▶



◀ An old ambulance at Ha Nam hospital

Foreword

This report presents the findings of a basic survey of population and development in Vietnam. In 1992, the Asian Population and Development Association (APDA) was entrusted with the survey project, "Basic Survey of Population and Development in Southeast Asian Countries" by the Ministry of Health and Welfare and Japan International Corporation of Welfare Services. APDA selected Vietnam as the country in which its field survey would be conducted. The actual survey and analysis of the resultant findings were conducted by APDA's survey committee (Chairperson, Dr. Toshio Kuroda, Director Emeritus, Nihon University, Population Research Institute).

For effective application of population policies in the Southeast Asia and other countries, population dynamics as population growth, diseases, mortality, reproduction, population distribution and internal migration, as well as static data of the population including family structure and population structure by age must be closely defined. In addition, effects of these factors on living and welfare standards, and medical care must be reviewed.

The objective of this survey was to contribute to resolving the problems related to population and development in Asian nations, by conducting a detailed survey of population dynamics, living and welfare standards and health and medical care and other aspects in the Southeast Asian countries.

The field survey was conducted with the guidance and cooperation of Ambassador Hiroyuki Yushita and Kouji Okudaira Second Secretary of the Embassy of Japan in Vietnam, and Ms. Nguen Thi Than, Chairwoman of Commission for Health and Social Affairs, the National Assembly. In Japan, members of Policy Planning & Evaluation Division, Minister's Secretariat, Ministry of Health and Welfare and Department of Policies, Economic Cooperation Bureau, Ministry of Foreign Affairs, cooperated in the planning and arrangements of the field survey. I would like to express my heart-felt gratitude to all of them.

In conclusion, I sincerely hope that this report would contribute to the further advancement of the population and development program in Vietnam as well as the Japanese Government's effective cooperation with Vietnam.

Furthermore, I would like to add that this report is the responsibility of APDA and does not necessarily reflect the views nor policies of the Ministry of Health and Welfare or the Japanese Government.

March, 1993
Fukusaburo Maeda
Chairman
The Asian Population and
Development Association

Contents

Chapter One

OUTLINE: A DRAGON RISING UNDER DOI MOI - VIETNAM'S PERSPECTIVES FOR THE FUTURE -

In 1929 at the outburst of the Great Depression, the American W.S. Thompson (1887 - 1973) cited the Indochinese peninsula as one of the world's danger spots in his work "Danger Spots of World Population". He stated that the "demographic pressure" generated by the imbalance between the high population growth rate and resources threatened peace.

The population growth rate of the three nations in the Indochinese peninsula is still high today - 2.9% in Laos, 2.5% in Cambodia and 2.1% in Vietnam, far above the average annual rate of 1.9% for Southeast Asia as a whole (1992 ESCAP, Population Data Sheet). However, the size of populations of the three nations of Indochina is extremely disparate. Vietnam's population of approximately 70 million accounts for 84% of the total population of the three nations together (approximately 83 million). Thus, changes in the population of the Indochinese peninsula are determined by changes in the population of Vietnam.

The annual population growth rate of Vietnam was an extremely high 3 to 4% over the two decades from the latter half of the 1950s through the first half of the 1970s. The abrupt decrease of the growth rate in the last half of the 1970s is an important basic indicator for anticipating the future of Vietnam's population.

There are several important points which should be kept in mind when considering the

outlook for the future of Vietnam.

First, that Vietnam faced extreme difficulties during the time of global peace following World War II. Vietnam was occupied by the Japanese army during World War II and fought a war for its independence over the decade following the World War II until 1954. Ten years later, in 1964, it fought the Vietnam War, an extremely harsh war which lasted until 1975. In the three decades following World War II, Vietnam only saw ten years of peace.

While many ASEAN nations were experiencing rapid economic growth and demographic transition, the fact that the Vietnamese population of 70 million has suffered the agonies of these wars is an important element which should not be overlooked when considering Vietnam's future. We can expect much from the enthusiastic attitude of the Vietnamese people with respect to economic growth and demographic transition, which have been delayed due to unavoidable circumstances, as well as from their strong desire to catch up to the level of development of Vietnam's neighbors.

When we look at Vietnam's troubled history, it is interesting to see that there are a number of similarities with the history of China. Over the ten-year period from 1966 to 1976, China experienced the "Cultural Revolution", often cited as a factor which severely hindered China's modernization. Though it cannot be compared to China's Cultural Revolution, the Vietnam War took place over approximately the same period, from 1964 to 1975. Despite their different characters, these events greatly retarded the development of the two countries.

Another point is the major restructuring of socialist economy in the two countries. After the Cultural Revolution, China adopted a new economic policy which surprised the world. This policy called for a major shift from collective farming to production by contract and a free market. Vietnam, on the other hand, strengthened its Soviet-style economic system after the Vietnam War and thus saw no new developments in its economy. It was only in December of 1986, some ten years behind China, that Vietnam launched its new economic policy in what is called a "historical shift". This new policy marks a change to individual responsibility, a market economy, and the recognition of private enterprise.

When considering Vietnam's future perspectives, one point of particular importance is the possibility for progress in demographic transition in the country, where the population growth rate is still high. First, to look some statistical facts, the crude birth rate has recently dropped below 30 per thousand. However, the total fertility rate (TRF) is still a high 3.9 per thousand. On the other hand, the infant mortality rate (IMR) is under 40 (38 per 1000 births), lower than the Philippines' figure of 41 per thousand. In addition, if we calculate the demographic transition index which indicates how much the total fertility rate and average life expectancy have decreased and been prolonged, it is a low 0.63 (according to Kuroda's calculations*), the same as the Philippines which has the lowest demographic transition index in Southeast Asia. However, it is natural to consider that Vietnam's actions with respect to

population policies are far behind those of other Southeast Asian countries.

Nevertheless, if we consider the factors behind demographic transition in Vietnam and in particular the drop of the birth rate, we can easily foresee that the process of demographic transition will proceed at a speed by no means slower in Vietnam than in other Asian countries where it is rapid.

The first factor for this is the marked change in the general people's understanding of family planning. According to the "1988 Demographic Health Survey", 39% of married women (ages 15 to 44) were using birth control. Also, with regard to the number of children desired, in 1988 the percentage of people who said they would like to have 4 children and more ranged from as high as 74% in some regions to a minimum of 55%. In 1991, however, the majority of the people said they wanted 2 or 3 children (JOICFP, interim evaluation, oral information given by Mrs.Sumie Ishii).

The second factor is the high literacy rate (93% for men of 10 and over, 84% for women). The third is the fact that in 1988 - 1989 women account for 46.9% of the labor force population, higher than the figure for Thailand (45.1%). Finally, Doi Moi, which is based on the new economic policy, will no doubt play an effective role in promoting the idea of family planning. With the strengthening of the government's policies and the cooperation of such international organizations as the U.N., we can expect the fertility transition in Vietnam to be achieved even quicker than foreseen.

In addition, Vietnam will be able to effectively apply the lessons learned from the various experiences of demographic transition in neighboring Southeast Asian and East Asian countries to its own demographic transition, and the active cooperation of these countries will no doubt contribute to accelerating demographic and industrial transition in Vietnam.

* Based on Kuroda's paper prepared for Nihon University International Symposium on Economic and Social Development in East Asia: Policies, Management and Population, January 26-29, 1993, Tokyo.
Demographic transition index for Vietnam is calculated by using the formula shown in Table 1 of the paper.

Chapter Two

POPULATION IN VIETNAM

1 Population Size and Age Composition

The main characteristics of the population in Vietnam is its large size, a high population growth rate, and the effects of the Vietnam War. Table 1 shows the population indices for Vietnam and neighboring countries. As can be seen on this table, the population of Vietnam is 64 million (1988), and the population growth rate is 2.4%. Thus, aside from Indonesia, Vietnam has the largest population among the countries shown here, and the highest level of population growth. This high population growth rate indicates that Vietnam's population has a youthful age composition and vitality. One example is the percentage of the young population. In Vietnam, the young population (0 to 14 years of age) accounts for 40.0% of the total population, the highest among these countries. The Vietnam War has left deep traces in the countries age composition. Figure 1 shows the population pyramid for Vietnam. As can be seen, the population in the 40 to 55 year age bracket has been heavily reduced by the effects of the war.

However, the advantage of the population's vitality can also be seen as a disadvantage. For example, because of the high population growth rate, Vietnam's population density (1987) has already reached 191 persons per square kilometer, the highest among the countries shown

on the table. If this population density continues to grow, demographic pressure will also naturally grow, leading to a deterioration of the living environment and other problems. In addition, the high dependent population index is also a major problem. A nation's population can be divided into three groups by age: the young population (0 to 14), the population of productive age (15 to 64), and the aged population (65 and over). The young and aged population form the dependent population which is supported by the population of productive age. The dependent population index (= (young population + aged population) ÷ population of productive age) indicates the number of dependent persons which 100 persons of productive age must support. In Vietnam where the young population is high, the burden of the dependent population on the population of productive age is of course higher than in other countries. This population situation presents serious problems for Vietnam now, and will continue to do so in the future.

2 Population Growth and Population Issues

Let us look at the problems caused by this population growth, taking the medical administration as an example. Table 2 shows the major medical indices for Vietnam. As can be seen from the table, the number of physicians per 1000 persons increased slowly but steadily from 1.8 in 1976 to 3.6 in 1990. The number of hospital beds has been declining slightly since 1987, but grew steadily from 165,000 in 1976 to 224,000 in 1987. This shows that Vietnam's government is actively promoting its medical administration policies. It should be noted that from 1976 to 1988, the number of beds per 1000 persons hovered around the 35 bed mark and has not notably increased. To put it tersely, the efforts of the government are not taking the form of physical improvements to the medical situation.

The major reason for this is that the efforts of the government are offset by the population growth. Curbing the population growth rate is of major significance for promoting the medical administration. Thus, an abrupt rise in the population has major socioeconomic and political effects.

What will be the trend in Vietnam's population in the future? How does Vietnam's government expect its population to grow in the future? Table 3 shows the results of a population estimate conducted by the General Statistical Office. We can see that the population, which was at a level of 64 million persons in the 1990-94 period, is expected to rise to 88 million (low level estimate), 90 million (intermediate level estimate), or 93 million (high level estimate) in the 2010-14 period. Whichever figure is correct, the fact remains that population will grow rapidly in the future. This growth will be a major obstacle to promoting the government's medical administration policies and will also create serious problems in other fields.

3 Trends in Population Dynamics

Changes in population are brought about by such factors of population dynamics as births and deaths (the natural growth rate which is the difference between these) and by migration. In general, however, since international migration of population has so little effect on the total population as to be negligible, the main factors in changes to a country's population are births and deaths. So how have the birth and death rates in Vietnam been changing? Unfortunately, as is often the case with developing countries, there is no sufficiently established system for vital statistics in Vietnam, and in reality estimates based on sample surveys and hospital statistics are being used for such calculations. In fact, various different figures are available for some population indices. As will be discussed in subsequent chapters (for example in the report on the survey in Vietnam and in the proposals for strategies), the establishment and expansion of a vital statistics system is a major strategy issue for promoting population policies in Vietnam.

To avoid this problem, in this chapter we will use the vital statistics estimates prepared by the United Nations, which we can assume are relatively reliable. The birth and death rates for Vietnam and neighboring countries shown in Table 4 have been prepared using the United Nations' estimates. We can see from the table that the birth rate in Vietnam in the 1950-55 period was lower than in neighboring countries. After this, however, Vietnam's birth rate decreased slower than in neighboring countries, so in the 1985-90 period it was highest among these countries. Mortality, on the other hand, decreased much faster in Vietnam than in the other countries, and whereas Vietnam had the highest mortality in the 1950-55 period, in the 1985-90 period it had the lowest. We can see this as the reason that Vietnam's natural growth rate has increased so abruptly.

4 Demographic Transition in Vietnam

These trends in population dynamics can be explained with the theory of demographic transition. The theory of demographic transition is a hypothesis which systematically explains the demographic tendencies in a certain country and the trends in the birth and death rates which indicate these tendencies in relation to the stage of socioeconomic development. Here we will outline this theory (refer to Figure 2). As socioeconomic development proceeds, high birth and death rates tend towards low birth and death rates. This is called demographic transi-

tion, and this process can be divided into four stages. In the first stage, both the birth and death rates are high (low development stage). In the second stage, there is an abrupt drop of the death rate while the birth rate remains stagnant (rising slightly at first, then dropping slightly) (beginning development stage). In the third stage, the birth rate drops following the death rate (progressive development stage). Finally, the low birth and low death rates of the fourth stage are reached (high development stage). Here, the natural growth rate which is the difference between the birth and death rates is first low (first stage), then increases to high (second stage), next decreases from this high level (third stage), and finally becomes low (fourth stage).

Though we do not have sufficient data on Vietnam's vital statistics, judging overall from the various data available we can believe that the population dynamics in Vietnam are currently going through the process described in the theory of demographic transition. Also, to judge from Figure 3, we can say that Vietnam's population dynamics are now likely in the second stage of transition.

However, a point that deserves special attention concerning demographic transition in Vietnam is that the causes bringing about demographic transition are thought to be different. In the above example of the theory of demographic transition, demographic transition progressed naturally as socioeconomic development proceeded. This is endogenous demographic transition. So what are the factors in the changes in the population dynamics of Vietnam? Because of various restrictions, one being the lack of data, we cannot easily reach a conclusion to this question. It will be necessary to actively promote research on this in the future. Still, it is not difficult to imagine that the delay in the drop of the birth rate was largely influenced by the Vietnam War. Also, we must look at the facts that the birth rate dropped suddenly despite the influence of the Vietnam War, the ensuing economic troubles, and the economic blockade, and in particular that today mortality is low, despite the severe shortages of capital and equipment caused by the poor economy and the economic blockade. The major causes for this can be thought to be the great efforts the government is putting into health and medical services for the people, and the efforts and competence of the personnel supporting health and medical services in Vietnam (for details on this matter, refer to the report on the survey in Vietnam). Considering this, we can say that Vietnam's demographic transition is due to exogenous factors such as government policy.

The rapid decline of the death rate and the sluggish drop of the birth rate naturally result in a high natural growth rate. As can be seen from Table 4, the natural growth rate was 2.2% in the 1985-90 period, and will drop to approximately 1.8% in the 2000-05 period and reach 1.2% in the 2020-25 period. As already stated, population growth gives rise to various problems and can seriously affect a government's economic development plans. Thus, in order to curb the population, the Vietnamese government is aggressively promoting family planning programs. Vietnam's family planning programs are characterized by the fact that they stress maternal

health and IEC (Information, Education and Communication) activities. Thus, this can be seen as an attempt to, in the field of maternal health, reduce the infant mortality rate through such means as vaccinations and increase the rate of children who survive to adulthood in order to create the environment for a transition from many to few births per woman, and in the field of IEC activities, to increase the awareness of couples about family planning and motivate them so that the family planning programs progress smoothly. However, the lack of capital and equipment already mentioned is a serious obstacle here as well (refer to the report on the survey in Vietnam).

5 Domestic Population Migration

As is the case in China, free migration is not currently permitted in Vietnam. Under the government's population policy, migration from one place to another is only possible with official authorization. The purposes of the government's population redistribution plans are:

(1) To reduce the demographic pressure in the Red River delta.
(2) To curb the population growth rate in cities and towns, and in particular in large cities.
(3) To redistribute the population of provinces and districts, and to consolidate villages and commune.
(4) To use population redistribution policies for national defense and security purposes.

The population migration shown in Figures 4 and 5 was conducted under these policies. Here we should note that:

(1) Migration to large cities and industrial zones accounts for a large share of domestic population migration.
(2) Migration from former North Vietnam to former South Vietnam accounts for a large share of domestic population migration.

The first point requires little explanation. Less obvious is the second point, whose major cause can be found in purpose (4) above, national defense and security. After Vietnam's unification, the government actively promoted migration of former North Vietnamese citizens to former South Vietnam for political reasons.

The domestic population migration has had major socioeconomic influences, among others on the medical treatment system. For example, in Song Be Province which was visited in our survey, population influx has increased greatly, and as a result there appears to be a growing antipathy towards population influx, partly due to outbreaks of malaria. In our survey we also obtained information that illegal migration is increasing in recent years, but because it is illegal it is difficult to learn its extent.

6 Conclusion

We have now discussed Vietnam's population situation. We can see the severe population problems Vietnam is facing. This is the reason the government of Vietnam is actively promoting maternal health, IEC activities and family planning programs in an attempt to curb the population. However, as discussed in the report on our survey in Vietnam, the country has excellent human resources, so we can say that once economic activities get on track it is quite possible that the situation will take a turn for the better.

Table 1 Population Indices for Vietnam and Neighboring Countries

Country	Population (in millions)			Population growth rate (%)	Share of young population (%)	Population density (per km^2)	Dependent population index
	1988	2000	2025	1980-88	1988	1987	(%) 1988
Vietnam	64	83	117	2.4	40.0	191	79.5
Indonesia	175	213	282	2.1	37.3	89	69.7
Thailand	54	64	83	1.9	34.2	104	62.9
Myanmar	40	50	69	2.1	37.9	58	72.4

Source: Prepared from "*Population Trends (Collection of Population Statistics, 1989)*" and *World Development Report 1990.*

Table 2 Major Medical Indices

Year	No. of physicians (in 1000s)	No. of physicians per 1000 persons	No. of beds (in 1000s)	No. of beds per 1000 persons
1976	9.1	1.8	165.4	33.6
1977	9.1	1.8	178.7	35.4
1978	12.2	2.7	192.4	37.4
1979	12.3	2.3	193.7	36.9
1980	12.9	2.4	198.8	37.0
1981	13.8	2.5	194.7	35.4
1982	15.0	2.7	197.4	35.1
1983	16.1	2.8	200.7	35.0
1984	17.4	2.9	201.0	35.3
1985	19.1	3.2	210.6	35.2
1986	19.0	3.2	214.1	35.0
1987	20.9	3.4	223.6	35.8
1988	21.3	3.3	223.0	35.0
1989	22.3	3.5	217.6	33.6
1990	23.3	3.6	205.1	32.3

Source: Vietnam Government.

Table 3 Future Population Estimates

(Unit: 1000s of persons)

Type of estimate	Periods				
	1989–94	1995–99	2000–04	2005–09	2010–14
Low level	64,412	71,707	78,224	83,240	88,053
Intermediate level	64,412	71,946	78,986	85,042	90,601
High level	64,412	72,200	79,184	86,964	93,430

Source: Detailed Analysis of Sample Results.

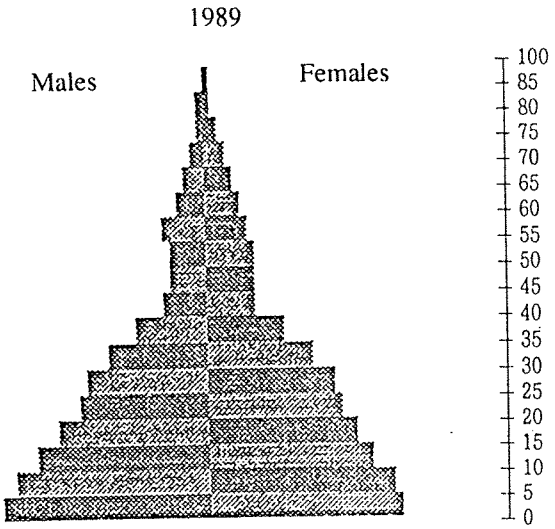
Table 4 Trends in Vital Statistics for Vietnam and Neighboring Countries 1955 - 2025

(Units: %)

	Country	1950~55	1985~90	2000~05	2020~25
Crude birth rate	Vietnam	41.8	31.9	24.2	17.5
	Indonesia	43.0	27.4	19.9	15.6
	Thailand	46.6	22.3	18.6	14.1
	Myanmar	42.2	30.6	25.1	17.3
Crude death rate	Vietnam	28.5	9.5	6.4	5.7
	Indonesia	26.1	11.2	8.5	8.1
	Thailand	19.2	7.0	6.3	7.4
	Myanmar	23.7	9.7	7.1	6.3
Natural growth rate	Vietnam	13.3	22.4	17.8	11.8
	Indonesia	16.9	16.2	11.4	7.5
	Thailand	27.4	15.3	12.3	7.0
	Myanmar	18.5	20.9	18.0	11.0

Source: Prepared from "*Population Trends (Collection of Population Statistics, 1989)*"

Figure 1 Vietnam's Population Pyramid



Source: Detailed Analysis of Sample Results.

Figure 2 Demographic Transition Process (Model Case)

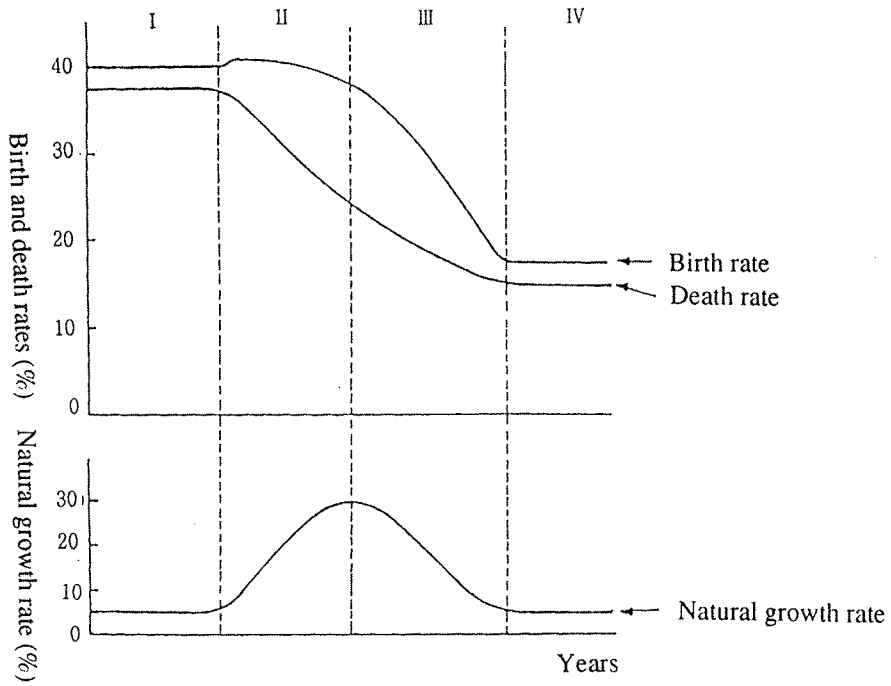
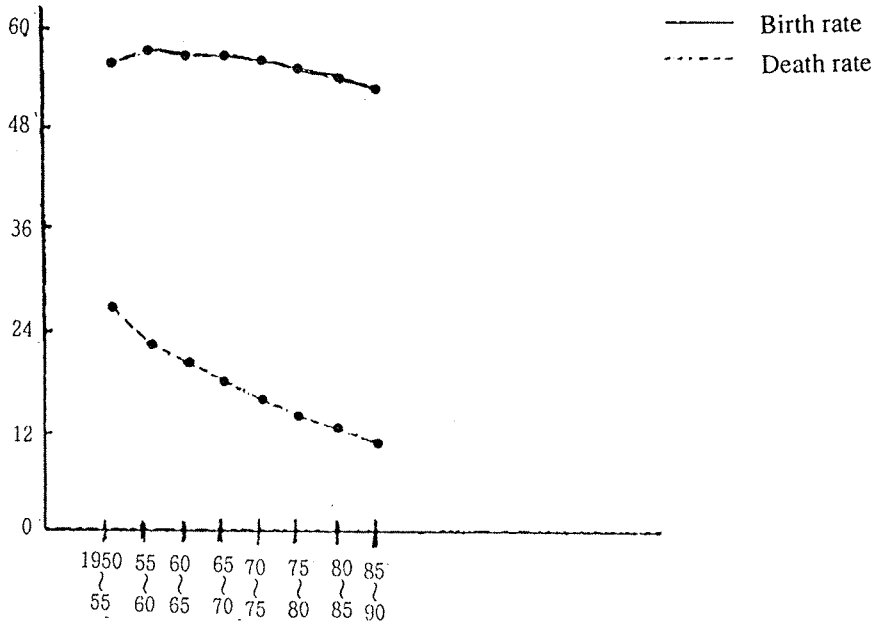
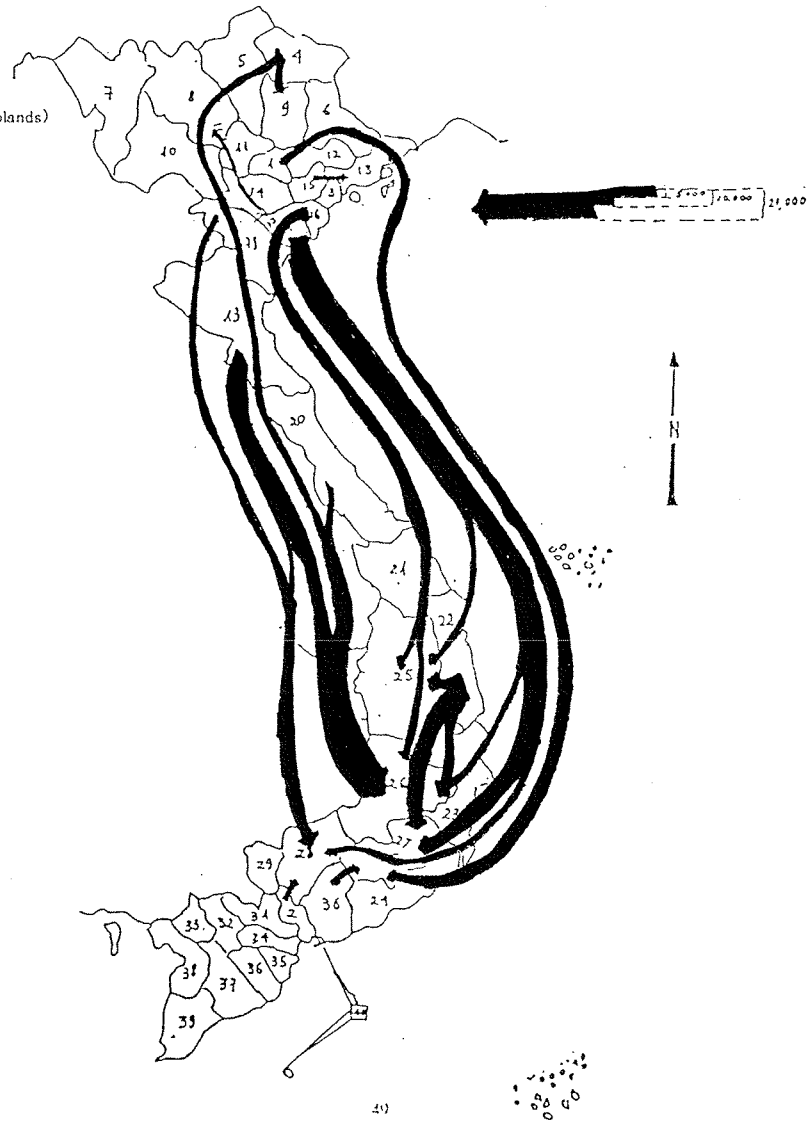


Figure 3 Demographic Transition in Vietnam



Source: World Population Prospects

Figure 4 Population Migration to Economic Zones, 1984 - 1989



Miền núi Trung du Bắcbó (Northern Uplands)
4. Cao Bằng
5. Hà Tuyên
6. Lang Son
7. Lai Châu
8. Hoáng Liên Son
9. Bắc Thái
10. Son La
11. Vinh Phú
12. Hà Bắc
13. Quảng Ninh

Bóng sông Hồng (Red River Delta)
1. Thủ bó Hà Nói
3. Thành phó Hải Phóng
14. Hà Son Bình
15. Hải Hưng
16. Thái Bình
17. Hà Nam Ninh

Bắc Trung bó (North Central)
18. Thanh Hóa
19. Nghệ Tinh
20. Bình Tri Thiên

Duyên hải Miền tung (Central Coast)
21. Quảng Nam-Bè Nàng
22. Nghà Bình
23. Phú Khánh
24. Thuận Hải

Tay Nguyên (Central Highlands)
25. Gia Lai-Kong Tum
26. Bắc Lắc
27. Lâm Bóng

Bóng Nam bó (Southeast)
2. Thành phó Hó Chí Minh
28. Sông Bé
29. Tây Ninh
30. Bóng Nai
40. Vúng Tàu-Côn Bảo

Bóngng bằng sóng Ciulong (Mekong River Delta)
31. Long An
32. Bóng Thấp
33. An Giang
34. Thên Giang
35. Bến Tre
36. Cúu Long
37. Hàu Giang
38. Kiên Giang
39. Minh Hải

Source: Detailed Analysis of Sample Results.

Figure 5 Inter-provincial Migration, 1984 - 1989

Miền núi Trung du Bắcbộ (Northern Uplands)
4. Cao Bằng
5. Hà Tuyên
6. Lang Son
7. Lai Châu
8. Hoàng Liên Son
9. Bắc Thái
10. Son La
11. Vinh Phú
12. Hà Bắc
13. Quảng Ninh

Bồng sống Hồng-(Red River Delta)
1. Thủ bộ Hà Nội
3. Thành phố Hải Phòng
14. Hà Son Bình
15. Hải Hưng
16. Thái Bình
17. Hà Nam Ninh

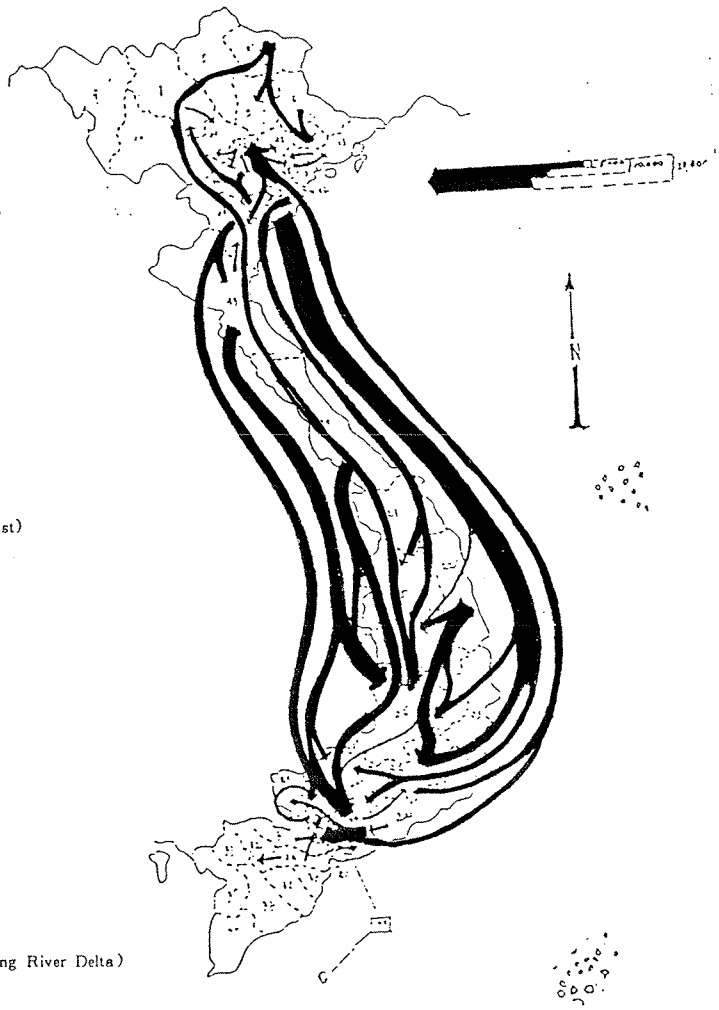
Bắc Trung bộ (North Central)
18. Thanh Hóa
19. Nghệ Tĩnh
20. Bình Trị Thiên

Duyên hải Miền tung (Central Coast)
21. Quảng Nam-Bẹ Nẵng
22. Nghà Bình
23. Phú Khánh
24. Thuận Hải

Tay Nguyên (Central Highlands)
25. Gia Lai-Kong Tum
26. Bắc Lắc
27. Lâm Bồng

Bồng Nam bộ (Southeast)
2. Thành phố Hồ Chí Minh
28. Sông Bé
29. Tây Ninh
30. Bồng Nai
40. Vủng Tàu-Côn Bảo

Bồngng bằng sống Ciulong (Mekong River Delta)
31. Long An
32. Bồng Tháp
33. An Giang
34. Thên Giang
35. Bến Tre
36. Cửu Long
37. Hậu Giang
38. Kiền Giang
39. Minh Hải



Source: Detailed Analysis of Sample Results.

Chapter Three

OUTLINE OF HEALTH AND MEDICAL SERVICES

1 Health and Medical Services Situation

1) Nutrition and calories

The economic situation in the past was quite poor. However, with the move to a market economy, we can now expect the nation's living conditions to improve. The malnutrition which is the fourth leading cause of death proved the poor economic situation in the past. In 1989, a survey on nutrition was conducted for 7,100 children, and the overall malnutrition rate was 44.62%. By region, this rate was highest in rural areas (78.6%), followed by mountainous areas (14.2%) and urban areas (7.2%) (see Table 1).

Low nutrition is seen even in pregnant women, most of whom are not able to increase their weight by 12kg during their pregnancy. As a result, the percentage of underweight (2500g or less) newborns of pregnant women suffering from malnutrition is high, particularly in the northern central coast (23.3%), followed by the Tay Nguyen highland (13.9%), the northern high & midland (12.2%), and the Red River delta (9.9%). In this way, there are differences from region to region.

On the other hand, the average caloric intake per meal in Vietnam is 1,928 kcal. If we look at the percentage of the three major elements of nutrition, protein accounts for 12.3% (15.5%), fat 8.4% (25.3%) and carbohydrates 70.3% (59.2%) (figures in parentheses are values for Japan). Thus the percentage of carbohydrates is high.

2) Environmental hygiene

(1) Environmental pollution

The main cause of pollution in urban areas is industrialization. Industrial wastes and smoke is polluting the air, water and soil. Pollution measurements indicate values of 30 to 300 times the tolerance standards. The major cause of pollution in rural areas is insecticides, and 9.5% of farmers complain of chronic toxic symptoms. There is also the worry about the long-lasting effects on health caused by the 57kg of dioxins used during the American war. As for pollution of foods, 40.5% of the samples tested did not meet safety standards.

(2) Extent of water supply and sewer systems

37.8% of the nation has safe water supplies, while 45.5% uses proper latrines, but there are major differences between regions (see Table 2).

3) Vaccination coverage

In 1970, the percentage of children under the age of 1 vaccinated with six types of vaccines (BCG, polio, measles, diphtheria, pertussis and tetanus) reached 80% (see Table 3). In addition, pregnant women are actively vaccinated against tetanus.

4) Malaria prevention measures

There are one million cases of malaria annually, so the government gives blood tests and distributes antimalarials. For the malaria figures in 1990, slide tests were given on 2,116,777 blood samples, 6.44% were positive, there were 1,056,479 cases of malaria, 11,613 cases of malignant malaria, 3,340 malaria deaths, and antimalarials were distributed to 2,484,614 people.

5) Measures against goiter

Goiter is a major cause of lowered intellectual capacities, but can be prevented with doses of iodine. In Vietnam, goiter is common in mountainous regions, but there is a wide disparity between regions, running from 27.7% to 66.4%. The goiter morbidity rate is low in the Red River delta and the Mekong River delta.

2 Health and Medical Institutions

1) Health manpower

The total number of health personnel (including state, cooperative and private staff) is 239,500. The number of medical doctors is 26,954, or 4.07 per 10,000 inhabitants (see Table 4). When compared to Japan's rate of 34.0 per 10,000 inhabitants, we can see that there is a need to train more medical doctors.

2) Number of students

There are 13,000 students at four faculties of medicine, one faculty of pharmacy , and one faculty of medicine and pharmacy. There are also 49 secondary schools of medicine and one secondary school of pharmacy, with an enrollment of between 15,000 and 30,000 students.

3) Number of hospitals and patient beds

Table 5 shows the number of different types of hospitals and patient beds. Sanatoriums and leprosy asylums are still important centers for treating chronic diseases. One characteristic of the health system in Vietnam is the existence of health stations with patient beds throughout the country.

4) Medical treatment situation

From the aspect of ensuring medical treatment, since 1986 the problems of insufficient budgets, lowered hospital quality and aging of health equipment are progressing. Table 6 shows six indicators, all of which are declining, resulting in a drop in quality of health care. The percentage of the national budget allotted to health care has only increased 0.69% from 1986 (3.31% or 3.99 billion VN$) to 1990 (4% or 367.72 billion VN$). On the other hand, Vietnam receives US$ 25 million annual in international aid, from UNICEF, WHO and other organizations.

To improve the situation, there are plans to increase the budget, and on the medical front to form networks, make improvements and establish laws on hospital fees, hospital services, the emergency system, the nursing system, rehabilitation, and so on.

3 Mortality and Morbidity

1) Ten leading causes of mortality

According to the statistics of the Vietnamese Ministry of Health, 60% of the ten leading causes are infectious diseases (see Table 7), though concrete figures are not indicated. Also, the high incidence of intracranial trauma, the 10th leading cause of mortality, is a phenomenon peculiar to Vietnam.

2) Disease structure

The situation of disease in Vietnam is characterized by the fact that malaria, hemorrhagic fever, and acute respiratory infections are diseases which display high morbidity and mortality rates, trachoma, diarrhea and rhinopharyngitis a high morbidity rate, and rabies a high mortality rate. Cholera and recurrent fever, both epidemic diseases, are also present. Here we are considering infectious diseases and other factors which affect health, so we will examine such factors in order as follows.

(1) Parasites and infectious diseases

Table 8 shows the morbidity and mortality (and their rates) for 1990. Some contagious diseases peculiar to tropical areas are also present.

(2) Venereal diseases

As Vietnam moves to a socialist market economy, the number of tourists is increasing, and with this venereal diseases are also on the rise (see Table 9). As for AIDS, in November, 1991, the serum of 75,744 persons in high risk groups was inspected. 30 were found to be HIV positive, of which 29 were foreigners. Some measures to prevent AIDS which are currently being taken are education, epidemiological surveys, the reduction of habitual drug users and prostitutes, prevention of infection through blood, prevention from transplacental infection, and the formation of networks of testing facilities.

(3) Non-infectious diseases

As measures to prevent infectious diseases advance, the number of non infectious diseases eventually increases. According to hospital records for 1990, the number of cases of the diseases shown on the table are increasing (see Table 10).

(4) Maternal mortality

Malnutrition is the fourth leading cause of mortality in Vietnam, and affects not only children but adults as well. In particular, malnutrition among pregnant women is closely linked to the birth of underweight infants and pregnancy complications. Table 11 shows maternal mortality by age group, Table 12 complications related to pregnancy from 1986 through 1990. The situation is improving gradually, but improvements are needed in such things as the number of pregnancies, the interval between pregnancies, prevention of infection, deliveries in proper institutions with doctors present, transfusion systems, etc.

(5) Occupational diseases

As of June, 1986, 4,898 cases of occupational diseases had been reported. Of these, the most numerous were silicosis with 4,392 cases (89.7%), followed by occupational deafness with 458 cases (9.3%) and lead intoxication with 36 cases (0.37%). Silicosis occurred most commonly in coal mine workers (33.7%) followed by metallurgy workers (30.6%) and transport workers (9.7%).

(6) Transport accidents

According to a hospital survey, in 1988 there were 23,728 cases of transport accidents, with 5128 hospitalizations and 179 deaths.

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Strategy for health for all by the year 2000 and strategic health plan for the period 1990-1995 in Vietnam. Socialist Republic of Vietnam, Ministry of Health, Hanoi, 1992.

Table 1 Malnutrition in children under 5, (1989)

	Total		Urban		Rural		Mountainous	
	No.	%	No.	%	No.	%	No.	%
Normal	3,932	55	287	55	2,915	53	730	61
Malnutrition I	2,088	29	138	26	1,642	30	308	26
II	909	13	65	13	716	13	128	11
III	171	2	26	5	131	2	14	1

Table 2 Proper use of latrines and safe water in 1990

Regions	Proper use of latrines (%)	Supply of safe water (%)
Northern high and midland	46.40	38.60
Red river delta	51.20	33.50
Northern central coast	55.40	67.80
Southern central coast	42.70	31.10
Tay Nguyen highland	30.90	17.70
Eastern part of South Vietnam	50.60	28.50
Mekong river delta	28.00	25.40
National average	45.47	37.80

Table 3 Annual trends in vaccination coverage (%)

Type of vaccination	1986	1987	1988	1989	1990
TB	54.5	84.7	75.0	93.6	89.9
Polio	44.7	50.6	70.0	87.9	86.7
Measles	38.8	41.5	66.0	88.7	86.6
Diphtheria, pertussis and tetanus	42.6	50.6	70.0	87.9	86.7
Vaccination coverage against tetanus in pregnant women Vaccinated women/pregnancies			1	18	21.9

Table 4 Health manpower

Medical doctors	26,954人	(4.07 per 10,000 persons)	
Assistant physicians	46,961人(	〃	7.09人)
Registered midwives (middle level)	5,065人		
Registered midwives (initial level)	8,296人(	〃	2.02人)
University graduate pharmacists	5,752人		

Table 5 Hospitals and patient beds

Type	Institutions	Patient beds
Research institutes with patient beds	8	1,750
General/specialized hospitals	774	110,849
Intercommunal polyclinics	871	8,030
Midwives	64	1,081
State health stations	1,692	13,186
Community health stations	9,024	62,060
Leprosy asylums	20	3,547
Sanatoriums	112	9,198

Table 6 Curative care indicators (per 1000 population)

Indicators	1986	1987	1988	1989	1990
Number of consultations	130,480	129,718	114,999	77,293	66,904
Number of in-patient admissions	6,431	6,510	6,270	5,107	4,515
Number of hospital day/persons	52,616	53,444	49,281	37,581	34,307
Average duration for the treatment of 1 in-patient day/person	8.1	8.2	7.8	7.4	7.3
Average number of day beds occupied per month (day/bed/month)	29	28.5	26.5	22.9	20.8
Average number of consultations per person per year	2.31	2.07	1.8	1.2	1.0

Table 7 Ten leading causes of mortality

1. Malaria	6. Lung tuberculosis
2. Meningo-cerebral hemorrhage	7. Acute bronchitis
3. Perinatal diseases	8. Meningitis
4. Malnutrition	9. Hypertension
5. Pneumonia	10. Intracranial trauma

Table 8 Morbidity and mortality of infectious diseases (1990)

Disease	Morbidity	Morbidity rate (per 10,000)	Mortality	Mortality rate (per 10,000)
1. Malaria	1,060,000	256.44	3,340	0.81
2. Respiratory infections	120,497	29.15	1,368	0.33
3. Tuberculosis	23,752	5.74	613	0.15
4. Tetanus	864	0.21	222	0.054
5. Diarrhea	75,887	18.36	215	0.05
6. Hemorrhagic fever	30,580	7.40	200	0.05
7. Other infections	24,645	5.95	96	0.023
8. Parasitic diseases	84,934	20.55	74	0.018
9. JEB	1,141	0.276	70	0.017
10. Viral hepatitis	5,184	1.254	57	0.014
11. Rabies	10,903	2.64	48	0.012
12. Diphtheria	837	0.09	46	0.011
13. Measles	4,052	0.98	24	0.006
14. Cholera	629	0.15	14	0.003
15. Whooping cough	2,147	0.52	13	0.003
16. PAA	268	0.065	12	0.003
17. Trachoma	99,639	24.11	0	0.00
18. Rhinopharyngitis	48,563	11.75	6	–
19. Recurrent fever	7	0.019	0	0.00
20. Plague	27	0.007	2	–

Table 9 Yearly trends in AIDS and other venereal diseases

	1986	1987	1988	1989	1990
Syphilis	10,800	11,400	7,900	7,800	8,800
Gonorrhea	8,100	9,600	7,900	7,300	152,000
HIV +				67	49
AIDS					1
Other venereal diseases	12,600	13,600	13,100	13,300	332,300

Table 10 Morbidity and mortality of non-infectious diseases (1990)

Disease group	Morbidity		Mortality	
	No.	%	No.	%
Cardiovascular	67,104	16.23	2,293	0.55
Cancers	21,537	5.21	390	0.09
Mental diseases	14,489	3.51	18	
Arthritis	8,091	19.57	4	
Gastro-intestinal	173,743	42.27	895	0.22
Goiter	7,330	17.73	1	

Table 11 Maternal mortality by age group

Mothers' age	Maternal mortality (%)
< 18 years old	7.2
18 ~ 24	6.5
25 ~ 29	7.7
30 ~ 34	11.8
35 ~ 39	25.0
> 40	55.9

Table 12 Yearly trends in complications related to pregnancy and mortality

Complication	1986	1987	1988	1989	1990
Uterine rupture					
Deaths/cases	32/196	45/323	20/175	28/156	14/213
Mortality (%)	(16.3)	(13.9)	(11.4)	(18.0)	(6.6)
Eclampsia					
Deaths/cases	34/1,061	46/1,442	15/1,184	24/1,042	32/1,448
Mortality (%)	(3.2)	(3.2)	(1.3)	(2.4)	(2.2)
Uterine hemorrhage					
Deaths/cases	55/4,776	113/5,784	53/5,119	35/4,455	54/7,180
Mortality (%)	(1.2)	(2.0)	(1.0)	(0.8)	(0.8)
Post-partum infections					
Deaths/cases	43/1,553	55/2,931	37/1,951	27/1,918	21/3,321
Mortality (%)	(2.8)	(1.9)	(1.9)	(1.4)	(0.6)
Abortion	41,823	60,310	66,243	65,920	59,924

Chapter Four

REPORT ON FIELD SURVEY

Introduction

This survey was conducted in Vietnam from July 12 through July 25. The survey schedule was prepared primarily by the Commission for Health and Social Affairs (CHSA) of the National Assembly of Vietnam. Four locations were visited: Hanoi City, Ho Chi Minh City, Song Be province and Nam Ha province. In keeping with the objectives of the survey, the institutions visited were primarily those involved in health and medical activities, including hospitals and institutions in the population and family planning organizations.

In addition, in relation to economic development, we also had the chance to visit factories and other sites of economic activity.

Below is a description of the institutions visited in Vietnam and the data collected on population and family planning.

1 Institutions Visited

(1) Health Department of Ho Chi Minh City

Ho Chi Minh City is located in southern Vietnam. As of 1991, it had a population of 4.2 million on an area of 42,000 ㎢, with 3 million inhabitants concentrated in the 2,000 ㎢ metropolitan area.

The following is a description of the population and health situation according to materials obtained at the Health Department.

The population growth rate of Ho Chi Minh City is a high 2.6% (in 1991). This is due to the birth rate of 21.4‰, the death rate of 5.2‰, the natural increase rate of 1.6% and the social increase rate of 1%. The social increase is due primarily to people from northern and central Vietnam seeking employment around Ho Chi Minh City.

30% of the population of Ho Chi Minh City is in the 0 to 14 age, 65% in the 15 to 64 age, and 5% of the population is 65 and older. Of the population in the 15 to 64 age, 55% is economical active population, having employment of some type. By gender, 48% of the population is male, 52% female.

The maternal mortality rate is 4 per 10,000 live birth, and the infant mortality rate is 25‰ to 35‰.

The percentage of birth weight 2,500g or less is 9.5%, and this figure has been decreasing in the past few years.

The average life expectancy in Ho Chi Minh City is 64 years for males, 68 years for females.

In 1991, 56% of births took place in hospitals, 30% in maternity clinics, 13% in clinics and 1% at home.

86.52% of infants aged one year and under are vaccinated.

For methods of contraception, use of IUDs accounts for 23% of the total, condoms 15%, oral pill 4.6%, sterilization 1.7%, and the rhythm method and induced abortion together 55.7%. The City's policy is to increase the rate of use of IUDs, condoms and oral pill, and decrease the rate of induced abortion. Contraceptive services are offered to citizens free of charge.

For the supply of water in Ho Chi Minh City, 660,000 ㎥ of water is supplied per day to the 4.2 million inhabitants. In addition, there are 2,000 shallow wells with the cooperation of UNICEF in nearby agricultural villages. The water from these shallow wells is for washing only, and must be boiled before used for drinking. Still, these shallow wells are a valuable source of water for agricultural villages.

Ho Chi Minh City produces 1.2 million cubic meters of waste water per day, most of which is drained directly to rivers with no treatment whatsoever. In the same way, the city produces 1400 tons of garbage per day, and only a small portion of it is used as fertilizer.

As for international cooperation on population, health and medicine in Ho Chi Minh City, the World Health Organization (WHO) and other U.N. organizations provide cooperation in various fields. UNICEF conducts the shallow well project for rural villages mentioned above and a nutrition improvement project. The United Nations Population Fund (UNFPA) operates family planning projects, in particular distributing IUDs and other contraceptives, provides public information materials on population and family planning, and offers population education for mothers in the region.

Finally, the population goals of Ho Chi Minh City is introduced. The targets of population of Vietnam established by the government are formulated by Population and Family Planning Committee of Ho Chi Minh City establishing population goals for the regional level. The population increase rate in Ho Chi Minh City for 1991 was 2.6%. The goal for 1995 is to reach a population growth rate of 1.5%, excluding the social increase rate. The target natural growth rate is 2.0%, the target death rate 0.5% in 1995.

(2) Pediatric Hospital No. 1 - Ho Chi Minh City

Pediatric Hospital No. 1, located in Ho Chi Minh City, is associated with related hospitals in southern Vietnam, and also acts as a medical training hospital. It provides medical care for infants and children from ages 0 to 15, for 16 provinces in southern Vietnam.

Pediatric Hospital No. 1 was established in 1954. The number of beds at the hospital rose from 270 in 1956 to 650 in 1981. Its medical activities include treatment and rehabilitation, prevention, research and training.

Hospital expenses have been US$330 per year per bed since 1988. Of this, US$250 is covered by the government, US$80 by the patient.

As of April, 1992, the staff of the hospital consisted of 108 physicians, 5 pharmacists, 3 dentists 150 nurses with one-year training, 201 nurses with 3-year training, 153 administrative personnel, and 119 others, for a total of 739. Of these, 4% of the total of the staff of the hospital have received training abroad, mainly in the U.S., France, England, and the former Soviet Union.

Pediatric Hospital No. 1 has instituted a program called "Application of In-hospital Primary Health Care (PHC)". This program consists of the following:

(1) Priority policies: The establishment of five training centers for diarrhea, acute respiratory illness (ARI), nutrition, dengue fever, and malaria.

(2) The use of appropriate technologies.
(3) In-hospital hygiene education.
(4) Research rooted in the region.
(5) "Technological transfer" on priority epidemics
(6) Assistance to low level regions.

The hospital's treatment activities are divided into four sectors: the outpatient sector, the inpatient sector, the rehabilitation sector and the nutrition sector.

First, the outpatient sector includes a 15-bed emergency unit, and in addition to general pediatrics, a diarrhea department, an ophthalmology department, a dermatology department, a pediatric surgery department, consultations on orthopedics, a dentistry sector, a pediatric surgery room, a laboratory and a pharmaceutical room.

The inpatient sector includes a 60-bed general pediatrics ward, a 45-bed infectious disease ward, a 65-bed DHF, a 75-bed GI ward, a 75-bed pulmonary disease ward, a 60-bed cardiology ward, a 50-bed renal disease ward, 20 beds for neonatals, 20 beds for traditional medicine, a 30-bed ENT, a 130-bed surgery ward, and 20 beds for burn patients.

The rehabilitation sector conducts rehabilitation for 1500 cases yearly.

The nutrition sector has been involved in research in the following fields since 1981:

(1) Acute infantile enteritis
(2) Dengue fever
(3) Purulent [suppurative] pericardial inflammation
(4) Rheumatic fever and rheumatoid cardiopathy
(5) G6PD deficiency
(6) Infantile accidents
(7) Thoracic surgery
(8) ARI
(9) Chronic diarrhea
(10) Primary Health Care (PHC)

Concerning emergency treatment at Pediatric Hospital No. 1, 10% of hospitalized patients are admitted under emergency circumstances, and there are 3,800 emergency admissions annually. By disease, the five major causes of emergency admission are 1031 cases of dengue fever, 312 cases of acute respiratory disease, 209 cases of diarrhea, 177 cases of convulsion due to high fever, and 124 cases of acute infantile enteritis. The major diseases by cause of death are 83 cases of acute respiratory disease, 52 cases of encephalitis, 35 cases of dengue fever, 26 cases of diarrhea and 21 cases of acute infantile enteritis.

Pediatric Hospital No. 1 conducts training for general pediatrics upon invitation for medical students, nursing students and midwives from medical schools. It also trains physicians, assistant physicians, and nurses of southern Vietnam.

There are five major training organizations for pediatrics, for acute infantile respiratory diseases, diarrhea, dengue fever, improvement of nutrition and emergency treatment.

Training in basic pediatrics is offered to physicians, assistant physicians, nurses, midwives and regional PHC workers.

In addition, Pediatric Hospital No. 1 is also actively involved in activities for improving nutrition and social welfare.

Finally, the director of the hospital states the following concerning management of the hospital:

First, sick neonatals die on the way to the hospital. The neonatal death rate in such cases is as high as 50%. Ambulances are needed urgently in order to solve this problem. Next, there are only three old incubators for premature infants. New incubators are also urgently needed.

(3) Tu Du Hospital

Tu Du Hospital is where Vietnamese twins Viet and Duc, the separated Siamese twins well-known in Japan, are hospitalized.

Tu Du Hospital was established in 1937 by a donation from Germany. After this, wards were added through donations from France, U.S., Japan and southern Vietnam.

Tu Du Hospital specializes in gynecology, neonatal and pediatric care. It has 750 beds and 1,200 to 1,500 outpatients per day. It has four departments, a gynecology department, a neonatal department, a family planning department and a disabled child department.

The staff consists of a total of 929 persons, of which 819 are women. There are 132 physicians, more than half of whom are young, so retraining is conducted once a week for the young physicians. There are a total of 368 nurses and midwives, and 20 pharmacists.

One of the problems the hospital is currently facing is a lack of medicines. This is a serious problem faced by other medical institutions in Vietnam as well, and one which requires urgent solutions.

Tu Du Hospital has stronger relations with Japan than other hospitals, and has received assistance from the Japanese Red Cross and other Japanese medical institutions. The hospital is hoping for more cooperation on a private basis.

(4) Song Be Provincial Health Department and Population and Family Planning Committee

Song Be Province is located 40km north of Ho Chi Minh City, and is a province with a

high immigration of population from other provinces. The total provincial population as of 1992 is 1,062,314, of which 442,483 or 41% are in the 0 to 14 age. 10% of the population is made up of Khmer, Tay and other minorities.

Song Be Province covers an area of 9,859.3 km2, and its main industry is agriculture. The main agricultural products are rice, cashew nuts and rubber, and timber is also produced. The average per capita income is a low US$150 to US$180.

The population density in the province is disparate. In Thuan Au, Thu Dau and Mot Town, the population density is 1,400/km2, whereas in Phuoc Long, Bu Dang it is an extremely low 50/km2. In addition, there is much immigration to Song Be Province from northern and central Vietnam, and the social increase is high.

Concerning the health and medical situation in Song Be Province, there is a high number of cases of malaria, dengue fever, and infant diseases due to the effects of chemicals used during the Vietnam War. For malaria, a national project is aiming at the extermination of mosquitoes. Family planning and maternal and child health measures include a program for improving the health level of children and the distribution of contraceptives for promoting family planning.

Finally, to look at health and medical figures from 1989 to 1991, in 1989 25,240 infants received BCG vaccinations, and this number rose to 31,312 in 1990. In 1989 there were 14,733 cases of malaria with 151 deaths, and in 1991 there were 30,356 cases malaria with 191 deaths. The person responsible for provincial health considers that the reasons for these increases in 1991 were the large migration of population from other regions, the decrease in medical treatment standards, and the lack of medicines.

To look at contraception in family planning programs, the use of IUDs increased slightly from 14,244 cases in 1990 to 15,180 cases in 1991. Over the same period, the use of oral pill multiplied by 4.5 times from 2,478 to 11,121 cases, and the use of condoms also increased greatly from 5,122 cases to 15,912 cases. Sterilization also increased from 330 cases to 832 cases.

(5) Polyclinic Hospital of Song Be Province

The Polyclinic Hospital of Song Be Province was established in 1898 by a French medical doctor, named Chaput. The hospital consists of three sectors: a pediatrics department, an outpatient and professional technique department, and a surgery and functional examination.

The number of beds is as follows:

100 beds in the internal medicine department, 50 beds in the surgery department, 50

beds in the gynecology and obstetrics department, 50 beds in the pediatrics department, 30 beds in the neonatal department, 25 in the emergency and intensive care unit department, 40 beds in tranmatology department, 25 beds in the tuberculosis department, 20 beds in the psychiatry department, and 10 beds in the stamatology and ORL department.

The number of medical personals is as follows:

78 physicians, 6 obstetricians, 4 pediatricians, 13 surgeons, 19 internists, 7 dentists, 8 pharmacists, 2 radiologists, and 96 nurses.

The medical situation at the hospital is introduced.

The number of births at the hospital in 1991 was 1,835, of which 929 were male, 906 female. The total number of deaths was 449, of which 103 were over 50 years of age, 49 were neonatals within 7 days, 53 neonatals within 28 days, 98 nurslings within 1 year, 118 infants and child from age 1 to 4, and 28 others.

The number of in-hospital deaths due to infectious diseases was 145.

The number of low birthweight infants under 2,500g was 287, 15.6% of the total of 1,835 births.

To look at the hospital's facilities, water is supplied from a well in the hospital, and the sewage situation is poor. For electricity the hospital uses both public electricity and an in-hospital generator.

(6) Song Be Provincial Vocational Training Center

There are 23,000 unemployed in Song Be Province. Because of this, the provincial government has established an vocational training center for the technical training of the unemployed and the young, and is thus promoting the development of human resources. Areas of training include first sewing techniques for women, carpentry training for men, including minors, and training of repair techniques for cars and motorcycles.

In 1991, 500 trainees graduated from the center, of which approximately 60% found employment. The center is aiming at graduating 1000 trainees in 1992.

(7) Ministry of Health

Health policies and projects are introduced focusing mainly on Strategy for Health for all by the year 2000 and Strategic Health Plan for the period 1990-1995 in Vietnam, prepared by Ministry of Health.

This strategy is in line with WHO policy on the promotion of health for all by the year 2000.

Vietnam's health strategy stresses the following points:

1. Early prevention, taking measures to prevent the entrance or the occurance of diseases, rather than to interrupt transmission.
2. Comprehensive health care, covering health promotion, disease prevention, curative care and rehabilitation for various target groups, from the feotus and the elderly.
3. Full community participation, to allow health care "by the people, with resources from the people, for the benefit of the people".
4. Planned health sector economics, mobilizing four sources of health care financing (the government, the community, foreign aid, and health service revenue), with resource allocation based on rational criteria related to population size weighted for certain social characteristics.
5. Reorganization of health services, improving their quality and their accessibility by health care distribution based, not on administrative borders, but on the distribution of user populations, with special consideration for their geographical, cultural and social characteristics.
6. Association of eastern with western medicine, to allow the synthesis of traditional medicine and modern medicine, with leading centers of high technology orientated towards basic needs.
7. Promotion of medical ethics, combining morality, technology, and regulations with four quality of care.
8. Intersectral collaboration in health, involving political authorities, communities and social organizations in a joint effort aimed at reaching high health standards relative to the level of socio-economic development.
9. Legislation and socialization of public health actions.

The strategie health plan for the period 1990 - 1995, as well as the strategy for HFA 2000 in Vietnam, was developed on

- the situational analysis of socio-economic developments affecting the health status.
- the identification of health problems and priorities.
- the review of resources.
- the making of national health policies.
- the development of health programs.

Disease patterns in Vietnam are introduced. According to the results of the 1989 national census, the population of Vietnam has exceeded 64 million. The population under the age of 1 is 1.9 million, the population in the 1 to 4 age is 7.1 million, the population in the 5 to 9 age is 8.6 million, the population in the 10 to 14 age is 7.5 million, and the population in the 15 to 49 age is 30.6 million, of which 16 million are females at fertile age. The population in the 50 and over age is 8.5 million. The population has increased by 12 million as compared to

the national census of 1979.

The literacy rate for those aged 13 and under is 88%. The agricultural population is 32 million, 73% of the total population. (Source: The General Statistical Office, Vietnam, 1991.)

According to a rural survey in 1989, the monthly income per farmer households is 37,500 don (11,000 don = US$ 1 as of July, 1992), and expenditures are 34,400 don.

Vietnam is a developing country and the annual per capita income is under US$ 200. The health budget accounts for less than 4% of the GNP, and health expenditures per capita in 1990 were only US$ 0.5.

There are two types of disease patterns in Vietnam, the pattern of developing countries with malnutrition and infectious diseases and the pattern of industrialized countries with cancers and cardiovascular diseases.

According to health statistics from 1986 to 1990 (source: Ministry of Health, 1991), highest mobidity was from the following diseases:

1. Malaria
2. Trachoma and sequelae
3. Diarrhea
4. Acute bronchitis
5. Acute rhinopharyngitis
6. Tooth-ache and gingivitis
7. Pregnancy, delivery and post-partum complications
8. Hemorrhagic fever
9. Eye inflammations
10. Hemorrhage during pregnancy and delivery

and the leading causes of mortarity were from:

1. Malaria 2. Meningo-cerebral hemorrhage 3. Perinatal diseases 4. Malnuturition 5. Pneumonia 6. Lung tuberculosis 7. Acute bronchitis 8. Meningitis 9. Hypertension 10. Intracranial traum There is some interaction between a high population growth rate, low income and the disease pattern of developing countries.

It is known that ill health and poverty are part of the same vicious circle. The health sector in Vietnam has some favourable preconditions for health and health service development.

1. A wide networks of more than 9,000 commune health stations for primary health care (PHC).
2. A structured system of curative care from central, provincial to district level with more than 700 general and specialized hospitals and more than 1,000 polyclinic.
3. A large and experienced health staff with more than 200,000 members.
4. The commitment of the government and local authorities for the implementation of de-

fined health policies.

5. The international support by means of technical and financial assistance.

Fourth, economic reforms and health promoting in Vietnam is introduced.

Economic reforms has both negative as well as positive effects on health and health services.

A positive effect is that health services have become more active than before the economic reforms were introduced.

A negative effect is that it has become more difficult for people of the poorer classes to receive health services. This is why the Vietnam government established in 1990 its health strategy for the 1991-1995 period based on the strategy "Health for all by the year 2000".

Because Vietnam has introduced market mechanisms under socialism, it has become increasingly difficult for the poorer classes to receive health services, due in part to the rise in the price of medicines. Because of this, it is necessary to equalize the opportunities of the wealthy and poorer classes to receive health services. At the same time, an issue of major importance is to increase health and medical care budgets.

Finally, family planning and maternal and child health situation are introduced. Vietnam's health strategy for 1990-1995 calls for the family planning and maternal and child health program to be one of the top priority programs.

The Vietnamese government is implementing family planning and maternal and child health programs in the following 17 areas:

1. Supply of contraceptives essential drugs
2. Delivery of maternal and child health care and family planning services
3. Promotion of clinical research study
4. Training programs for health care workers in the maternal and child health care and family planning
5. Assistance for the management of condom factories
6. Integrated projects for environmental sanitation, parasite control, maternal and child health care and family planning for family health
7. Survey and research programs on human reproduction
8. Vaccination programs for the six major child diseases, including polio eradication and umbilical tetanus elimination
9. Improved quality of health care in relationship to pregnancy and nursing mothers
10. Control diarrhea diseases
11. Control acute respiratory infections
12. Control goiter and cretinism in children
13. School health
14. Control infant rheumatism

15. Control vitamin A deficit and blindness in children
16. Control maternal anemia
17. Rehabilitation for disabled children

In addition to the 17 programs above, secondary programs include the strengthening of the health care network and the promotion of primary health care.

The rate of use of contraceptives in Vietnam was 38% in 1988. The total fertility rate was 5.5 in 1975, but decreased to 3.8 in 1989. The infant mortality rate in 1989 had dropped to 46‰. This figure is lowest among developing countries with a per capita income of US$ 300 or less. In other words, these accomplishments were made possible because of Vietnam's high literacy rate.

(8) National Committee for Population and Family Planning

In 1963, a Department of Population and Family Planning was established within the Ministry of Health. Later, as the Vietnamese government came to stress the importance of population issues, the National Committee for Population and Family Planning (NCPFP) was established as an independent institution.

The first chairman of the NCPFP was Vietnam's deputy prime minister. Currently the prime minister acts as chairman. The NCPFP is related to the Ministry of Finances, the Ministry of Labor, the Ministry of Health, the General Statistical Office, youth organizations, agricultural organizations, women's organizations, and labor committees, all of which cooperate on the NCPFP's activities.

The main duties of the NCPFP are the acceptance of foreign assistance in the population and family planning area and the distribution of funds domestically.

The largest source of assistance from abroad is the United Nations Population Fund (UNFPA), which has provided a total of US$ 54 million from 1978 to 1991, and is expected to provide US$ 25 million from 1992 to 1996. Of the NCPFP's total budget, 62% is used for purchasing contraceptives for family planning projects.

Information, education and communication (IEC) is important for implementing population and family planning programs, but the NCPFP's budget goes mostly to purchasing contraceptives, so its IEC activities are insufficient.

NCPFP plans for the future call for introducing movale vehicles to provide population education using videos and distributing contraceptives, and for stressing the importance of population and family planning at the local level.

The NCPFP distributes contraceptives free of charge. Users of IUDs, which account for 60% of contraceptives used, are given IUDs free of charge and also receive 10 to 15kg of

unhulled rice as an incentive. However, the NCPFP is considering charging for the oral pill and for condoms due to the financial burden of free distribution.

(9) Hanoi

The health care situation and environment of the city of Hanoi are introduced.

As of 1989, Hanoi, the capital of Vietnam, had a population of 3,056,549 and an average annual growth rate of 2.3%. As for the population composition, 33.4% of the population is in the 1 to 14 age, 61.6% in the 15 to 64 age, and 5% in the 65 and over age. In 1991 there were 44,852 births, 22,866 males and 21,986 females. Of the population in the 15 to 64 age, 360,983 or 17.2% of the total are females of fertile age.

The total area of the city of Hanoi is 213,000 ha. The old city district has an area of 48,000 ha or one fifth of the total area, and a population of 1.09 million or one third of the total population.

The Hanoi water system has a capacity for supplying 320,000㎥ of water per day. This system has been installed with the cooperation of the French government dating from 1985. It is managed by the Hanoi Water Supply Company which was established in 1980. Prices are divided into four categories: citizen, government, commerce and foreigners. Prices are highest for foreigners. On the average, water prices are five times higher in 1992 as compared to 1983. The rise in prices is due to cuts of governmental subsidies and the introduction of the market mechanism.

The city of Hanoi is promoting a "two-child policy". The population and family planning situation in Hanoi are observed.

When a government encourages smaller families, this is accepted by urbanites, but is not easily accepted by suburbanites. Some reasons are that housing in the urban area is more cramped, urbanites have a higher level of education and more knowledge about family planning, and suburbanites follow old traditions which hold that it is better to have more children. The city of Hanoi has therefore set priorities for promoting smaller families. First, that improved living standards lead to fewer children. Second, decreasing the number of births by improving maternal and child care standards. And decreasing the number of births by strengthening the health network.

Finally, the city of Hanoi is strongly requesting Japanese cooperation for promoting its population and family planning programs, specifically for broad-ranged population education focusing mainly on young adults.

(10) Nam Ha Province

Nam Ha Province is located 100km southeast of Hanoi. As of January, 1992, its population was 2,505,883 in an area of 2,500km². Its main industry is agriculture.

As for the population composition, there are 1,222,618 males and 1,283,265 females, 48.78% and 50.22% respectively. By age, 36.63% of the population is in the 0 to 14 age, 56.43% in the 15 to 64 age, and 6.94% in the 65 and over age. The number of women of fertile age is 614,948, of which 410,984 are married. The average family consists of 3.6 members.

By area of residence, the rural population is overwhelming high at 92.42% of the total population, with the urban population only 7.58%.

Administratively, the province is divided into one city, Nam Dinh (capital of the province), 11 districts and 339 communes. Geographically it is divided into mountainous areas, the Red River delta, and a 72km-long coastline.

By industry, agriculture accounts for 80%, consisting mainly of the production of rice but also of sericulture. Shrimp is produced along the coast. There is also a textiles industry.

On the average, rice is produced in two crops per year, though this differs from area to area. The annual harvest is of 6 tons in unhulled rice.

The average per capita income in Nam Ha Province is US$ 200, though in some rural areas it is less than US$ 45.

To look at the health and medical care in Nam Ha Province, there are two general hospitals, one provincial hospital, and health services are offered through local health bureaus.

The main diseases are infectious diseases, and individual prevention and treatment services are offered locally for malaria, maternal and child health, tuberculosis, mental diseases, leprosy, trachoma, etc.

Finally, the province's family planning program is introduced. Nam Ha Province is promoting informational and educational activities on family planning, medical services related to family planning, and free distribution of contraceptives like other provinces. These activities, however, are not having the desired effects, due to insufficient knowledge of family planning and the fact that 20% of the population is Christian.

2 Health Care, Population and Family Planning Issues in Vietnam

As stated above, during our survey in Vietnam we visited many institutions, focusing on the fields of health care, population and family planning. Now we will describe the knowledge gained from this survey and discuss problems which need to be overcome in the future.

(1) Gap between north and south

When considering the situation in Vietnam, it is important to keep in mind the country's history. Today's Vietnam, that is the Socialist Republic of Vietnam, was born when former North Vietnam and South Vietnam were unified in 1976. Former North Vietnam (hereafter referred to as northern Vietnam or the northern region of Vietnam) followed a socialist economy, whereas former South Vietnam (hereafter referred to as southern Vietnam or the southern region of Vietnam) was a member of the capitalist world. This historical fact has subtle but major effects on the daily lives of the Vietnamese people and their economic activities. For example, though we have no statistical data to back this up, the standard of living is higher in southern Vietnam than in northern Vietnam, as can be seen by the better state of the infrastructure, the homes, and the people's clothing.

It is clear that rectifying this gap between north and south is a major issue which the government must deal with in the future. The government, which is enthusiastically supporting economy development, is promoting the introduction of the market economy. However, as can be seen by the country's historical background, the people in the southern region are very familiar with the market economy, but the people in the northern region are not at all accustomed to the market economy. Because of this, it is likely that quite some time will be necessary to rectify the gap between north and south. This gap can be seen in various areas, and deserves careful consideration when proposing and implementing developmental programs in the fields of health, medical care and population.

(2) Establishment and expansion of a vital statistics system

Like other developing countries, the Socialist Republic of Vietnam has no established system of vital statistics. Because of this, data obtained from sample surveys or statistics collected by major hospitals are used for calculating various vital indices. This method is sufficient for learning the basic trends in such things as the birth rate, death rate, infant mortality rate and causes of death, but cannot be used to learn details. For example, there is more than one figure for the population growth rate. Establishing a vital statistics system requires large sums of money and many personnel, so it cannot be done immediately, but detailed data will become increasingly important for implementing more precise policies in the fields of health, medical care and population. It would seem necessary to begin training personnel and conducting case studies now.

(3) Health and medical care

The quality, quantity and methods used by health and medical care workers (physicians, nurses, midwives, medical technicians, etc.) seemed to be quite reasonable for a developing nation. Medical workers with the proper education and qualifications were present even in the most local medical institutions. When we were visiting a pediatrics hospital, the nurses always closed the door of the neonatal room from the inside to keep out bacteria when visitors came. We saw many similar examples at other medical institutions. This shows that nurses, midwives and medical technicians are well trained.

The most serious problems are with medical equipment, materials and medicines. During our stay in Vietnam we visited many health and medical institutions, from the central level to the local level, and most were suffering from insufficient equipment. Concretely, there were hospitals in which broken equipment could not be fixed, hospitals which forced to stall expansion, and hospitals in which only two of four surgery rooms were operating due to lack of facilities and equipment. In particular, a problem common to most hospitals was the decisive lack of medicine. This is demonstrated by the fact that Vietnamese hospitals do not have the smell of disinfectants characteristic of hospitals in other countries. These problems have an economic cause -- financial difficulties. However, these are problems which affect the health of the nation, so they should be resolved quickly.

There is an important matter which should be considered when working at solving these problems. That is, the gap between north and south can also be seen in the problem of deficiencies. For example, in the southern region of Vietnam, the situation of medical facilities and medicines differs according to the hospital manager's abilities to collect funds. When the manager is able to obtain assistance from non-governmental organizations (NGOs), the situation of medical facilities and medicines is relatively good. When this is not the case, however, the situation is extremely poor. In the northern region, on the other hand, medical equipment and medicines are lacking equally in all hospitals, with no individual hospitals having better conditions. If this point is not kept in mind, medical care policies will be less effective.

Despite these circumstances, health institutions enjoy a high degree of trust among citizens. This seems to be due mainly to the strong will of medical workers and their upkeep and management abilities. For example, old surgery facilities and equipment, 35-year old ambulances, X-ray devices which in Japan are out-of-date, old tonometers and other instruments which are almost antiques are repaired and still used today. Still, there are limits to relying on the personal and organizational capabilities of medical workers. The situation of medical and health care in Vietnam is now reaching these limits. The Vietnamese government needs to take urgent measures.

(4) Establishment and expansion of the emergency medical care system

One problem facing the medical and health care system is the establishment and expansion of an emergency medical care system. The death rate for emergency patients on their way to hospitals is extremely high, and some medical facilities are working to reduce this rate. On the other hand, a relatively large number of regions have no emergency medical care systems. The main problems in establishing and expanding such systems involve the lack of equipment, such as ambulances, the means of communications, and so on.

However, there are many problems even in the systems which do exist. According to our observations, such systems seem to consist of hospitals with emergency treatment sectors and ambulances sending their ambulances upon request from citizens. This seems extremely ineffective, what with problems in means of communication, management and upkeep of equipment, and finding emergency personnel. Vietnam should strive to centralize its emergency medical care system as is the case in Japan and many other foreign countries. In order to discover what type of emergency medical care system is best fit for Vietnam, it would seem necessary to review current systems and study the emergency medical care systems of foreign countries.

(5) Family planning and maternal health care

Vietnam, faced with the problem of population growth, is actively promoting family planning programs. These programs stress maternal health care and IEC (information, education and communication) and are designed in an extremely rational fashion. This is because as long as the infant mortality rate is high, there is little interest in family planning (this is confirmed by the infant survival hypothesis), and even if the infant mortality rate decreases, family planning will not spread unless people are motivated through education and information. Simply distributing contraceptive appliances and medicines does not improve the results of family planning. It is no exaggeration to say that the results of family planning programs depend on maternal health care and IEC supporting the programs from the side.

Concerning maternal health care, Vietnam is making persistent efforts and improving infant health, as can be seen by the high vaccination rates discussed in the previous section. IEC activities are also aggressive. For example, there are many travelling dissemination teams which motivate people from the grass roots level.

However, we cannot say that there are no problems at all. According to information obtained at the central level, the major means of family planning is the use of IUDs, condoms

and the pill (see the previous section for more details), which would appear to be spreading relatively steadily. However, information obtained in our observations of medical institutions at the most local levels indicate that many artificial terminations of pregnancy are performed at medical institutions. It is well known that artificial termination of pregnancy severely harms women's health. It will be important in the future to try to keep the number of artificial terminations of pregnancy as low as possible and to further spread healthy methods of family planning. In addition, IEC activities are faced with the problem of insufficient equipment, as already mentioned. Projectors and other such devices are necessary for promoting IEC activities, but these are lacking. This is another issue to be dealt with in the future.

Finally, it also seems necessary to keep in mind the gap between north and south when promoting family planning. IUDs are the preferred method in Vietnam's northern region, where as the pill seems preferred in the southern region. Considering such preferences and differences in awareness can have an effect when promoting IEC activities at the grass roots level.

(6) Public health (drinking water and sewage)

The supply of clean drinking water is extremely important for maintaining the health of the nation. In Vietnam, drinking water is supplied through water services, small water supply systems and wells. Roughly speaking, large urban areas use the water from water services, medium and small provincial cities use the water from small water supply systems, and rural areas use well water. Small water supply systems risk becoming sources of water system-related infectious diseases if they are not properly maintained, and well water (especially from shallow wells) must be boiled before used as drinking water. In addition, sewage is often drained directly in rivers, so there are many problems from the viewpoint of environmental preservation. There is much room for improvement in these areas as well.

In this area, another matter of interest is the management of waterworks in urban areas. Vietnam is currently introducing market principles and is promoting the privatization of state enterprises. As a result, in Hanoi the management of the water supply system has been privatized and its managers have adopted a policy stressing profit. However, water supply systems are public utilities and in many ways are not suited for privatization. In the current market economy it is becoming increasingly important to establish a balance between the private and public sectors, in a so-called mixed economy organization. We cannot deny the fact that in excessively promoting the introduction of market principles, Vietnam is attempting to establish a market economy which is overly textbookish.

(7) Conclusion

We have now pointed out various issues facing the medical and health care systems, family planning and maternal health in Vietnam. To sum up the situation in a few words, Vietnam is compensating for its lack of funds and equipment through its proficient personnel. In this sense, the educational institutions which put forth this capable personnel is the source of energy supporting Vietnam today. With this abundance of human resources, we can assume that if only Vietnam had funds and equipment, the activities of its medical institutions could develop relatively smoothly.

However, Vietnam is actively promoting economic development and reforming its systems and it is true that this is causing some confusion. For example, as already stated, the excess zeal in introducing market principles has led to the privatization and pursuit of profits even for water supply systems, which are public utilities, and this is obviously going too far. Still, this confusion can surely be overcome through a process of trial and error. In one sense it demonstrates the country's desire for reforms and should be looked on favorably.

In addition, as already stated several times, the gap between the northern and southern regions of Vietnam is an important issue to be overcome. The government will surely ask that this gap, which is due to historical reasons, be carefully considered when managing policies and systems at the national level. For example, there are differences in expectations for foreign assistance between medical institutions in the north and south. Whereas southern Vietnam has expectations for assistance from non-governmental organizations (NGOs), northern Vietnam has expectations for official development assistance. A substantial amount of time will be required to overcome this problem.

Chapter Five

SURVEY MEMBERS AND ITINERARY

Japanese Committee

Toshio Kuroda	Director Emeritus, Nihon University Population Research Institute
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Cooperators (Survey in Vietnam : July 12 - July 25, 1992)

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Nguyen Thi Hoai Thu	Vice Chairwoman, CHSA
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Tram Thang Huy	Pharmacist, MIHCFPC, HCMC
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Pediatric Hospital No. 1

Nguyen Thi Ngoc Anh	Director

Tu Du Hospital

Nguyen Thi Ngoc Phuong	Director
Ta Thi Chung	Vice-Director
Tran Huu Lap	Vice-Director
Nguyen Thi Man	Vice-Director

Song Be Province

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Nguyen Zuoc Thai	Vice-Chairman, P.C.
Vo Ky	Vice-Chairman, People's Council (P.C.l.)
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Dang Khoi	Chairman of People's Committee of Nam Ha
Vu Tinh	Vice-Chairman of People's Council of Nam Ha
Nguyen Huu Duong	Secretary of People's Council of Nam Ha
Phan Van Bay	Director of Health Service of Nam Ha
Pham Guang Tou	Chairman, People's Council of Kim Bang District
Pham Quoc Hung	Secretary of Party, Xuan Thu District (XTD)
Vu Xuan Tinh	Chairman of People's Committee, Xuan Thuy District

Survey Itinerary

(July 12 - July 25, 1992)

Date	Activities
July 12 (Sun.)	• Departure from Narita, stopover in Hong Kong. • Arrival in Ho Chi Minh City. • Courtesy call on Ms. Nguyen Thi Hoai Thu, Vice Chairwoman, Commission for Health and Social Affairs (CHSA).
July 13 (Mon.)	• Visit to Ho Chi Minh City Health Service. Briefing on the Ho Chi Minh City population, family planning and health situation from Dr. Duong Quang Trung, Director of Health Service. • Visit to Ho Chi Minh City Committee for Population and Family Planning. Observe of the committee's facilities. • Visit to Pediatric Hospital No. 1. Briefing on the hospital's medical activities from Dr. Nguyen Thi Ngoc Anh, Director. • Visit to Tu Du Hospital. Briefing on the hospital's medical activities from Dr. Nguyen Thi Ngoc Phuong, Director.
July 14 (Tues.)	• (Move from Ho Chi Minh City to Song Be Province) • Visit to Song Be Province Health Service Dept. Briefing on population, family planning and health situation from Dr. Vu Ganh, Director. • Visit to Song Be Province Population and Family Planning Committee. Briefing on family planning and maternal and child health in Song Be Province from Dr. Vu Thi Kim Tinh, Permanent Deputy President. • Visit to Song Be General Hospital. Briefing on the hospital's medical activities from Dr. Pham Ngoc Thai, Director. • Visit to the Song Be Provincial Labour Training Center. Observe woodworking and sewing operations of the Center.
July 15 (Wed.)	• (Move from Song Be to Hanoi) • Courtesy call on Ms. Nguyen Thi Than, Chairwoman of CHSA, the National Assembly. Briefing on population and development in Vietnam from Mr. Tran Minh Viet, Adviser and Director of Dept. for Standing Committee.

Date	Activities
July 16 (Thurs.)	• Pay homage to President Ho Chi Minh. • Visit to Ministry of Health. Briefing on health and medical care in Vietnam from Prof. Dr. Pham Song, Minister. • Visit to National Committee for Population and Family Planning (NCPFP). Briefing on international cooperation for population and family planning in Vietnam from Prof. Mai Ky, Minister.
July 17 (Fri.)	• Visit to Center for the International Cooperation and Support of Scientific Progress for Population and Family Planning of the State Institute of Sciences. Briefing on the center's population and cooperation activities from Dr. Eng Nguyen Ngoc Quan, President. • Visit to Olof Palme Pediatrics Hospital. Observe the hospital's facilities.
July 18 (Sat.)	• Visit to General Statistics Office. Briefing on population and health statisctics in Vietnam from Dr. Nguyen Viet Cuong, Director. • Visit to the Institute for Protection of Mothers and Newborns. Briefing on the institute's activities from Dr. Nguyen Kim Ton.
July 19 (Sun.)	• Free.
July 20 (Mon.)	• Visit to Hanoi Health Department. Briefing on health and medical services in Hanoi city from Dr. Bui Thi Hiep, Deputy Director, Hanoi Health Service. • Visit to Hanoi Urban Project Department. Briefing on Hanoi's water systems from Mr. Nguyen Dinh Nhiem, Director of the Hanoi Water Supply Company. • Courtesy call on Prof. Dr. Tran Thi Tam Dan, Vice-Chairwoman of Hanoi City and Chairwoman of Population and Family Planning. • Visit to People's Committee of Hanoi City. Briefing on Hanoi's population and medical activities from Prof. Dr. Tran Thi Tam Dan.
July 21 (Tues.)	• (Move from Hanoi to Nam Ha Province) • Visit to Kim Bang District Office. Briefing on the district from Mr. Pham Quang Ton, Chairman of the People's Council. • Visit to Ha Nam Hospital. Observe the hospital's facilities.

Date	Activities
July 22 (Wed.)	• Visit to Xuan Thuy District. Observe the district's fisheries and cocooneries. • Visit to Nam Ha Population and Family Planning Center. Observe the center's facilities.
July 23 (Thurs.)	• (Move Nam Ha Province to Hanoi) • Visit to Japanese Embassy. Courtesy call on and report of survey findings to Ambassador Hiroyuki Yushita.
July 24 (Fri.)	• Report of survey findings to Ms. Nguyen Thi Than, Chairwoman of the CHSA, the National Assembly. • Arrangement of collected of materials.
July 25 (Sat.)	• Departure from Hanoi, stopover in Hong Kong. • Arrival in Narita.

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General View of Vietnam

Provinces

1. Ha Noi
2. T.P. Ho Chi Minh
3. Hai Phong
4. Cao Bang
5. Ha Tuyen
6. Lang Son
7. Lai Chau
8. Hoang Lien Son
9. Bac Thai
10. Son la
11. Vinh Phu
12. Ha Bac
13. Quang Ninh
14. Ha Son Binh
15. Hai Hung
16. Thai Binh
17. Ha Nam Ninh
18. Thanh Hoa
19. Nghe Tinh
20. Quang Binh
21. Quang Tri
22. Thua Thien-Hue
23. Quang Nam-Da Nang
24. Quang Ngai
25. Binh Dinh
26. Phu Yen
27. Khanh Hoa
28. Thuan Hai
29. Gia Lai-Kon Tum
30. Dac Lac
31. Lam Dong
32. Song be
33. Tay Ninh
34. Dong Nai
35. Long An
36. Dong Thap
37. An Giang
38. Tien Giang
39. Ben Tre
40. Cuu Long
41. Hau Giang
42. Kien Giang
43. Minh Hai
44. Vung Tau-Con Dao