One such area is health care. Before the beginning of *doi moi* in 1986, Vietnam had an impressive health care infrastructure which provided extensive coverage through a relatively dense network of central, provincial and district hospitals as well as commune health care centres. Even well into the early 1990s, Vietnam had 170 commune health centres per million which compared favourably coverage elsewhere in Asia.[29] Through the late 1980s and early 1990s, however, Vietnam's health care system has encountered growing difficulties. Because the fiscal austerity imposed by *doi moi* meant that the government was no longer able to support these centres and the attenuating public health programmes.

With virtually no resources coming from the now defunct commune cooperatives, local health provision has suffered dramatically. The use of contraceptives among lesser-educated women has dropped, resulting in birth rates that are significantly higher by international standards. Approximately 40% of all children remain malnourished; predictably, malnutrition is significantly higher in rural areas than in urban centres. Some 65% of the sick now opt for 'self-treatment', which includes obtaining and using medication without consulting and guidance from a trained doctor. As expected, this phenomenon is especially acute among the poorest of the poor; around 70% of the poorest quintile choose self-medication as compared to 55% among the wealthiest. In the context of the crisis, where all government ministries have been required to reduce discretionary spending by 40%, the situation is likely to worsen.

The growing gap in Vietnam's health care system highlights a potential role that Canada might play in helping Vietnam confront the effects of the crisis. Rather than focusing its efforts on poverty alleviation, Canadian policy in Vietnam should broaden its focus so that over the medium- to long-term it can help to prevent 'poverty exacerbation'.

Human Security and Insecurity: Subjective Views

As with both the Philippine and Malaysian cases, the implications of the crisis have gone beyond the realm of income/poverty and government spending. Because some 80% of the population lives in rural areas and is relatively isolated from mass media, the impact of the regional crisis is virtually unknown to many in the country. Combined with government controls on the dissemination of information, many Vietnamese people have very little conception of how the crisis could diminish their own expectations and livelihoods over the next few years. In order to gauge this, one must draw on examples of individual or group behaviour that reflects (either implicitly or explicitly) some assessment of the future.

Borrowing behaviour is one such indicator. Arguably, decisions to borrow are based on some expectation as to whether or not the future will continue to deliver sufficient prosperity to allow the borrower to pay back the loan. Normally, it is difficult to gain access to reliable information in the banking sector. However, the Vietnam-Canada Rural Finance Project, a relatively new micro-credit lending scheme established by Développment international

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UNDP in addressing important social sector priorities, in particular poverty alleviation. This is something of a unique problem encountered by aid agencies operating in countries where the state has a strong role. Because the Vietnamese government requires foreign agencies to direct their efforts through the state apparatus, there is very little room for donor agencies to redirect their efforts towards the local level and engage directly with non-state actors to confront various human security challenges.

[29] China, for example, has only 63 health centres per million while Indonesia has 32 and Thailand has 141.