

**NATIONAL STRATEGY  
ON REPRODUCTIVE HEALTH CARE  
FOR THE 2001-2010 PERIOD**

**RATIONALE FOR STRATEGY FORMULATION**

The Communist Party and State of Vietnam always attaches great importance to policies and strategies for human development and, in particular, in respect of women's and children's rights.

The Constitution of Vietnam declares that men and women enjoy equal rights in all aspects and states: *'The State, society, families and individuals have the responsibility to provide health care and protection to mothers and children; and to carry out the population and family planning (PFP) programme'*. In 1960, the National Assembly adopted the Law on Marriage and Family based on four principles, namely, freedom of marriage, monogamy, gender equality and protection of women's and children's rights, and in 1989, adopted the Law on Protection of People's Health which stated: *"All people can freely select and use contraceptive methods; all acts of obstruction or compulsion in the implementation of family planning shall be prohibited; women have the right to have abortion(s) if desired, to receive gynaecological examination and treatment and health check-ups during pregnancy and medical services when giving birth at health facilities etc."*

Such high-level political commitments facilitated the attainment of major achievements in the provision of health care to the people in general and to women and children in particular.

However, many problems remain with the health status of women, children and adolescents. The main reason is that, due to socio-economic difficulties during the 1990s, Vietnam could only focus on resolving some urgent problems related to mother and child health (MCH) and certain aspects of reproductive health care (RHC), and could not cover all aspects of RHC. Also, there have been shortcomings in respect of perception, services, policy mechanisms, and financing, related to RHC provision.

On entering the new century, Vietnam needs a reproductive health (RH) strategy to provide health care to the people, particularly to women, mothers and children, in a broader sense and with a more comprehensive approach, as expounded in the programme of actions of the 1994 Cairo International Conference on Population and Development (ICPD) which Vietnam has committed to carry out.

The Cairo Conference unanimously held “*that Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Implicit in this last condition are the rights of men and women to be informed on and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, and the right of access to appropriate health care services that will able women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant*”<sup>1</sup>.

The National Strategy on Reproductive Health Care for 2001-2010 is outlined and promulgated to elaborate the contents of the Resolution of the 4<sup>th</sup> Party Central Committee Meeting (VII legislature) on urgent problems in the provision of people’s health care and protection, the Resolution of the 4<sup>th</sup> Party Central Committee Meeting (VII Legislature) on population and family planning policy, as well as the strategic orientations on People’s Health Care and Protection and Vietnam’s Population Strategy in the 2001-2010 period.

This strategy reflects the official, principles, objectives and actions to be taken in RH and RHC in Vietnam for the next decade and assists the relevant ministries, committees, governmental and non-governmental organizations and private individuals in conducting activities, dictated by their functions, to improve the quality and sustainability of RHC and to contribute to the successful implementation of the Party’s and State’s strategy for human development.

## **PART ONE**

### **THE STATUS OF REPRODUCTIVE HEALTH (RH) AND REPRODUCTIVE HEALTH CARE (RHC)**

#### **I. Fundamental achievements**

Despite the absence of exceptional economic growth, Vietnam has attained remarkable achievements in the field of health and RH. Strong support induced by policy and people’s broad access to primary health care services made important contributions to such achievements.

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<sup>1</sup> WHO definition of Reproductive Health: "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed on and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will able women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant"

Over the past years, the Government's growing investments in health protection and PFP facilitated the reinforcement and development of a nation-wide network of health and family planning services at the community level. Preventive and curative services for mothers and children, pre-natal, safe delivery and post-natal care, FP services etc., provided by both the public and private sectors, have expanded with improving quality. Thanks to this, the following encouraging results in RH have been obtained:

- A comparison between 1989 and 1999 figures show that the average number of children born to a woman of reproductive age has been reduced from 3.8 to 2.3 and the natural growth rate has been on the downturn, from 2.21% to 1.43% (1).
- From 1990 to 1999, the maternal mortality ratio was reduced from 200/100,000 live births to 100/100,000 live births and number of obstetric complications decreased by 52% (2).
- Infant mortality rate has been reduced from 45,1‰ in 1994 (3) to 36,7‰ in 1999 (1).
- Mortality rate of children under five has been reduced from 55‰ in the 1982-1986 period to 37.7‰ in the 1992-1996 period (4) and the malnutrition rate among children under five has been reduced from 44,9% in 1994 (5) to 36,7% in 1999<sup>2</sup> (6).
- Contraceptive prevalence rate increased from 53.7% in 1988 to 75.3% in 1997 (7) and the percentage of delivery assisted by health professionals was up from 55% during the 1990-1994 period to 71% in the 1995-1997 period (8).

These achievements have been possible thanks to a judicious policy and concrete guidance from the Party and government authorities at all levels, the efforts made by the entire network of health and PFP services, the active participation of all sectors, mass organisations, people's response, and the valuable and effective financial and technical assistance and expertise from different countries, international organisations and NGOs.

## **II. Outstanding problems**

1. Despite a reduced birth rate, the quality of FP remains low. This is demonstrated by a fairly high failure rate of contraceptive methods amongst certain groups. The national average number of children born to each woman of reproductive age is 2.3 but in the mid-land, mountainous, and coastal areas, Central Vietnam, and the Central Highlands, this figure remains well over 3 or 4 per woman.
2. Vietnam's population is increasing by one million each year. It is therefore, estimated that by the year 2020, Vietnam's population may reach approximately 100 million including 22 million adolescents aged between 10 and 19. People of this age group constitute both the country's main human resource in the near future and also a high-risk group in respect of RH. However, little has been done for adolescent reproductive

health care (ARH).

3. There have been many shortcomings in the provision of care to pregnant women and mothers. The percentage of pregnant women receiving pre-natal care and deliveries assisted by health professionals remains low. Post-natal care, counselling on breast-feeding, and infant care still fall short of expectations. The cause of this situation has been the poor performance of the network of mother and child health services, particularly in disadvantaged areas. This also explains why maternal mortality due to obstetric complications and peri-natal mortality remain high in these areas.
4. The high prevalence of RTIs and STDs, and the fast growing incidence of HIV infection, particularly among young people under 25, is giving rise to public concern. Also, information, education, and communication (IEC) activities on the provision of preventive and curative services have not been widely promoted to involve all establishments inside and outside the health sector, both State-run and private.
5. Despite the high infertility rate among couples of reproductive age, preventive and curative measures for this problem, particularly the application of advanced technologies, remain very limited.
6. Cancer ranks second among the causes of women's death after infectious and parasitic diseases. Most prevalent are breast and cervical cancers. Cancer prevalence is higher in the countryside than in urban areas.
7. The reproductive health of the elderly is also posing many problems to be resolved within the framework of RHC activities in the years to come.

### **III. Challenges**

1. The inadequate awareness about the elements and significance of RH and the lack of understanding about RH protective measures, socio-cultural behaviours associated with lifestyle, and care-seeking behaviour, particularly in areas inhabited by ethnic groups or remote areas of low socio-economic development, all combine to create outstanding RH problems as stated earlier.

Although attention has been given by the Party, administration and mass organisations at all levels to people's health care and MCH/FP, there has not been proper guidance provided due to the lack of knowledge and information on RH and sexual health.

IEC and counselling on RH still faces many constraints with regard to form and message contents, the identification of key cadres and IEC skills, the production of IEC materials, and finance etc.

2. There remain many shortcomings and constraints regarding the existing network of

MCH/FP services which has been in operation for many years. There is a serious shortage of health professionals, particularly midwives, who cannot meet the current need and whose low general knowledge and skills have not been periodically updated. The operation of a RHC service supervision network is ineffective and there is little opportunity for improving the situation. All this make the MCH/FP services less attractive to the users. The situation is exacerbated in remote and mountainous areas and causes health indicators to vary notably between urban and rural areas and between regions.

3. Attention has been paid to budget allocations in this field but it has not met people's growing needs whilst mobilisation of community participation remains difficult in poverty-stricken areas.
4. Constraints regarding the guidance and management of RHC include failure to define the needs of certain aspects of care, particularly RHC in a broad sense; failure to upgrade and/or supplement regulations on task division, technical quality etc. to make them complete and suitable to new perceptions; ineffective and inadequate operation of the health management information system; and the monitoring network for RHC service delivery. Most of the members of the network, providing guidance and management of RHC activities at all levels, are men.
5. The roles in RH of ministries, committees, mass organisations, government and non-government organisations and private individuals, have not been analysed to identify their participation and/or a co-ordination mechanisms in order to create an aggregate strength for RHC activities.

## **PART TWO**

### **PRINCIPLES AND OBJECTIVES**

#### **I. Principles**

1. Investment in RH and in health as a whole is also an investment for development.
2. Equality must be ensured so that all people have access to reproductive health and family planning information and services which are of good quality and suited to the economic conditions of Vietnamese society. Particular attention should be paid to disadvantaged groups, the poor, those who rendered meritorious services to the country, inhabitants of mountainous, remote and environmentally-sensitive areas.
3. To ensure gender equality and promote the women's role in decision-making on RH-related issues, as well as the men's role and responsibility in FP and RH.

4. To be active and to take the initiative in all preventive aspects of RH and RHC
5. To combine modern medicine with traditional medicine in RHC.
6. RHC is the concern of all society and the responsibility of every individual, family, community, the Party and government authorities at all levels, as well as of all sectors, mass organisations and social and occupational institutions.

## II. Goal and objectives

### Goal

*To achieve by the year 2010 a marked improvement in the RH status and narrow the gap between the regions and target groups by better meeting the changing reproductive health needs over the life cycle, and to do so in ways that are sensitive to the diversity of circumstances of local communities, with particular attention to disadvantaged areas and target-groups.*

#### Targets

<i>Total Fertility Rate:</i>	2.0
<i>Maternal Mortality Ratio:</i>	70/100,000
<i>Infant Mortality Rate:</i>	25‰
<i>Peri-natal mortality rate:</i>	18‰
<i>Low Birth Weight (below 2500 gram):</i>	6%
<i>Malnutrition rate among children under five years:</i>	20%

### Objectives

#### Objective 1

*To create a remarkable change in perception, as well as support and commitment, to the attainment of the objectives and elements of RHC among people of all strata, first of all among senior officials at all levels.*

#### Targets:

<i>Percentage of RHC service delivery points giving RH counselling:</i>	90%
<i>Percentage of RHC service users receiving RH counselling:</i>	90%
<i>Percentage of adolescents and adults having basic RH knowledge:</i>	60%
<i>Percentage of Party and Government officials having RH understanding:</i>	90%

#### Objective 2

*To sustain the fertility reduction trend; to ensure the rights of women and couples to have children and select contraceptive methods of good quality; to reduce unwanted pregnancies and abortion related complications.*

Targets:

Percentage of couples using any contraceptive method:	78%
Percentage of couples using modern contraceptive methods:	70%
The rate of abortion per 100 live births:	25%
Percentage of abortion acceptors who receive counseling on the harmful effects of abortion and methods of pregnancy prevention:	90%

### Objective 3:

*To improve the health status of women and mothers; to obtain a more even reduction in maternal mortality and morbidity, peri-natal deaths and infant mortality between different regions and target-groups, with special attention to disadvantaged areas and to beneficiaries of government policies.*

Targets:

<i>Percentage of pregnant women receiving pre-natal care:</i>	90%
<i>Percentage of pregnant women receiving 3 pre-natal check-ups:</i>	60%
<i>Percentage of mothers receiving at least 1 post-natal check-up:</i>	60%
<i>Percentage of deliveries assisted by trained health workers:</i>	97%
<i>Percentage of deliveries at health facilities:</i>	80%
<i>Reduced rate of obstetric complications over total deliveries by:</i>	50%

### Objective 4 :

*Effective prevention to reduce incidences, and proper treatment of RTIs and STDs, including HIV and infertility related problems.*

Targets:

<i>Reduction of RTI incidence by:</i>	50%
<i>Reduction of STD incidence by:</i>	30%

### Objective 5

*To provide better RHC to the elderly, particularly to older women; provide early diagnosis*

*and treatment of breast cancer and other cancers of both male and female reproductive tracts.*

Targets:

*Percentage of health facilities providing early diagnosis of breast and cervical cancer: 50%*

### Objective 6

*To improve the RH status, including sexual health, of adolescents through education, counselling and provision of RHC services suited to different age groups.*

Targets:

*Percentage of RHC service delivery points giving RH information, education and counselling to adolescents: 80%*

*Percentage of adolescents receiving RH information, education or counselling and having an understanding about RH and sexual health: 70%*

### Objective 7

*To improve the knowledge men and women about sexual relations and sexuality to fully exercise their rights and responsibilities towards fertility; to promote safe and responsible sexual relations on the basis of equality and mutual respect to improve RH and the quality of life.*

Target:

*The percentage of men and women receiving information, education and counselling about sexual relations and sexuality : 70%*

## **PART THREE**

### **SOLUTIONS**

#### **I. Information, Education, Communication, and Advocacy**

1. Information about RH policies and education in various forms, suitable for different target-groups, should be disseminated. The aim is to improve the level of understanding and encourage the voluntary participation of families, couples and individuals and involve others to join in meeting the RH objectives.
2. To make use of a range of diverse communication channels: person-to-person; through the national communication network; the general school curriculum; different

forms of folk arts and culture; seminars involving community leaders

3. IEC and advocacy should be made available to all target groups, from elected deputies at all levels, scientists, religious and political leaders to social activists, women and youth groups, pupil-parent associations, and public figures, focusing particularly on what men should do to fulfil their responsibility towards reproductive and sexual health.
4. To train IEC specialists, State and private RHC service providers, on necessary knowledge and skills for advocacy and counselling activities, and know-how to best apply the results of RH research to provide adequate information to the target-groups.
5. To promote and improve the quality of IEC contents as follows:
  - Awareness raising to the effect that FP is first of all for the benefit of oneself and one's family, to encourage couples neither to start a baby too early nor too late, to have adequate spacing between births, and to prevent unwanted pregnancy and abortion. Priority in awareness-raising is given to men, couples under 30 with two children, and people living in remote areas.
  - Promote healthy pregnancy, including hygiene; prevention of RTIs and STDs; and the need to have least three pre-natal checks; counselling in proper breastfeeding, post-abortion counselling; prevention and treatment of infertility.
  - IEC and counseling about sexual development and sexuality for adolescents to help them understand about healthy sexuality, to have easy and convenient access to good quality RHC/FP services for prevention of unwanted pregnancy, unsafe abortion and STDs. Particular attention in this respect should be paid to adolescent groups living in the countryside, remote areas and from poor families, with a low level of education. The content of sex and sexuality education should be included into the school curriculum.
  - IEC on RH of the elderly and explanation about the psycho-physiological changes particularly in menopausal women; about cancers, with promotion of prevention and treatment methods to give people the necessary understanding in this respect.

## **II. Organisation of RHC service delivery network**

1. RHC services available at all levels of the health care delivery network include 7 elements as follows:
  - 1.1 *Family Planning*: to diversify contraceptive methods by providing, on a broad scale, new contraceptive methods, supplying sufficient condoms and other devices, and to combine it with the prevention of STDs, including HIV/AIDS.

- 1.2 *Ensure the provision of pre-natal, safe delivery and post-natal care, infant and child care.* Pre-natal care services should be promoted to reduce the rate of women receiving no pre-natal check-up and increase the rate of expectant mothers who receive 3 proper pre-natal check-ups. Increase the percentage of deliveries assisted by trained health workers, provide more facilities, equipment and qualified health personnel for obstetric and surgical obstetric wards of district hospitals, particularly districts in the highland, remote areas and offshore islands. This will enable these district hospitals to provide essential obstetric care and deal with obstetric emergencies to reduce maternal mortality. Post-natal care is intended to help mothers take good care of their health, prevent complications and/or diseases after childbirth and to provide counselling on infant care, breast-feeding and family planning. Mothers should be helped to make judicious decisions about the timing of their next pregnancy. Post-natal care provided should be recorded and summarised for subsequent evaluation.
- 1.3 *Safe abortion, effective management of post-abortion complications and provision of post-abortion care.* Qualified health personnel, medical equipment and other supplies for safe abortion, effective treatment of post-abortion complications, and delivery of post-abortion care and counselling, should be made available.
- 1.4 *Prevention and treatment of RTIs, STDs, HIV/AIDS.* All health facilities and certain FP services with adequate facilities and qualified personnel should be given equipment and other supplies for diagnosis and treatment of common RTIs and STDs. In remote areas where transport is difficult, mobile teams should be organised for diagnosis and treatment of such diseases and should implement the preferential policy for diagnosis and treatment, such as fee exemption or reduction for poor or needy families, in areas with high incidence of such diseases.
- 1.5 *Early detection and treatment of reproductive tract cancers.* Examinations should be organised for as many people as practicable, for early detection of cancer, particularly among women, by applying simple testing or techniques. Examinations for cancer detection should be done every 6 months or once a year. There must be tools for taking specimens and laboratory tests, with attention paid to women aged 45 and over. RHC services for the elderly, and diagnosis, treatment, and care of cancer patients in hospital, must be well provided for within hospitals, in accordance with their assigned functions.
- 1.6 *Prevention and treatment of infertility.* Early detection and treatment of infertility-related diseases by strengthening and improving the quality of infertility diagnosis and treatment technology at all levels, alongside

the promulgation of legal document(s) on donation and receipt of oocytes, sperm and other issues concerning artificial fertilization.

- 1.7 *Adolescent RH.* Counselling points and/or centres, where adolescent RHC services are also provided, should be organised in a way that psychologically suits adolescents. Such centres should be reliable providers of counselling and technical assistance to adolescents. Services shall include the supply of suitable contraceptive methods, such as condoms for prevention of STDs, safe abortions, and treatment of RTIs etc. Where conditions permit, a gynaecological ward for young female patients should be set up. Activities for adolescent RH and against social evils should be combined, paying special attention to groups of adolescents living in the countryside, remote areas and children from poor families with a low level of education.
2. The above-mentioned RHC elements shall not be put into effect separately by health or family planning services delivery points according to their assigned functions. The 7 RH elements shall be accomplished by all levels of health care service provision according to their stipulated technical functions. However, it shall be carried out mainly through the primary health care network and with direct support from family, village, commune and corresponding levels, maternity houses, inter-commune polyclinics and district hospitals, with community participation and close co-ordination with different sectors, mass organisations, Vietnamese and foreign NGOs, and private health services. It must be integrated with other national programmes, such as Population and Family Planning, Child Care and Protection, Nutrition, HIV/AIDS etc.
  3. Further studies should be conducted on new forms of RH and adolescent health counselling and services, which have not been available before.
  4. Efforts should be made to provide village health workers for all villages throughout Vietnam, particularly in remote areas, and to provide RHC training and practice to these village health workers. Every commune health station should have midwife, and by the year 2010 all such midwives must be graduates of secondary medical schools. All obstetric wards at district hospitals should have obstetrician(s), paediatrician(s) and secondary/bachelor midwives. Provincial and central hospitals, whilst fulfilling the task of applying RHC advanced technology, should gradually plan to have medical doctors specialised in such areas as child gynaecology, adolescent gynaecology and andrology etc.
  5. As well as strengthening the organisation of the RHC network, there will be provision of (refresher) training to its personnel and supply of equipment to ensure the quality of techniques in RH diagnosis, prevention, emergency services, treatment, and also communication equipment, transport of patients in emergency, IEC

materials etc., all according to the list stipulated for each level of treatment, but first of all for essential obstetric care and obstetric emergencies at the district level.

6. To ensure priority in budget allocation and regular and sufficient supply of good quality pharmaceuticals, according to a standard drug list, for prevention and treatment of RH-related conditions and diseases for the RHC service delivery network at the community and district levels, areas with difficulties, particularly areas with high rates of maternal mortality, peri-natal mortality and child mortality, such as the Central Highlands, mountainous areas, central coastal areas etc., and to apply fee exemption or reduction for the poor and those who rendered meritorious services to the country, members of ethnic groups etc.
7. To train, support, and monitor private providers in delivery of RHC services to ensure the adequate quality of such services.

### **III. Policies in support of the National RHC Strategy**

Policies which should be promulgated to support the national RHC Strategy include:

1. Policies which encourage the acceptance of and practice for small- sized families, promote gender equality and equal treatment to children of both sexes..
2. Policies that encourage the application of modern contraceptive methods and promote a wide range of contraceptive methods to raise the efficiency of FP. Such policies should include increased budget allocations to advocacy and social marketing in combination with the exemption and reduction of fees for service and methods, and rewards to individuals and units delivering quality services.
3. Policies which help achieve the objective of equality and narrow the gap in RH and Reproductive Health Care provision between the urban and rural areas, between regions and target-groups. They shall be designed to attract government employees to work at the community level and in areas with difficulties. Such policies may be in the form of material incentives or support (e.g. higher allowance, priority for in-country and/or overseas training etc.). Later, policies requiring new graduates from colleges to provide obligatory service in mountainous areas shall be considered for adoption.
4. Policies in support of beneficiaries under other government policies, such as people living in areas with many difficulties. Such policies may take the form of full or partial exemption of RHC /FP service charges etc.
5. Policies encouraging government employees to further study to improve their

professional performance may take many forms, such as skills competition where rewards, material or non-material, are given.

6. Regulatory documents on all technical and managerial aspects of RHC activities, such as safe motherhood, ARH, (e.g. regulations on supply, logistics, contraceptive projections, policies on human resource development, research, IEC on RH etc.)

#### **IV. Socialisation, inter-sector and international co-operation**

1. All communities should be mobilised to carry out RHC activities by integrating such activities in the action plan/programme of sectors, mass organisations and localities. Appropriate elements of RHC should be incorporated into the rules of the hamlet, village or ward etc. to ensure compliance by every family. Activities should generate community participation in RH in the form of IEC campaigns and National Weeks on RH/ FP.
2. Efforts should be made to further raise the efficiency of co-operation between ministries, committees and mass organisations etc. in RH activities, based on the study of the role and possible impact created by these organisations on RH. The aim is to expressly define their participating roles and mechanisms for such co-operation. These efforts should actively involve the private health network, national NGOs in RHC and provide legal and technical support as well as RHC training to these organisations.
3. Bilateral and multi-lateral co-operation with different countries, and international organisations and NGOs in RH should be expanded and improved in term of effectiveness.
4. Periodical exchanges of information, experiences, and co-ordination of actions between parties involved in RH activities should be organised.

#### **V. Training and Research**

##### 5.1. Training and Retraining

- a. RHC training programmes and teaching materials at medical schools should be revised and updated with new knowledge or provided with the parts which are missing or not available according to the technical responsibilities assigned to different levels of the RHC services. There should be plans for retraining the existing staff of the health service network as well as of other sectors, committees, mass organisations etc. to assist people to be well informed of up-to-date knowledge and skills, particularly new elements of RHC, such as prevention and treatment of STDs, counselling and care after abortion, emergency contraception, adolescent RH and sexual health, counseling and IEC on gender and men's role in reproductive

and sexual health. Attention should be paid to practical training and development of communication and counselling skills. Regular supervision of the use of knowledge, skills and training materials in routine work should be carried out to evaluate the utilization of training and to help health workers further develop their capacity.

- b. Retired health workers and members of the armed forces in remote areas should be retrained and better utilised to provide sufficient staff for an effective RHC service network at all levels, particularly at the village and community levels.
- c. The Ministry of Health and other ministries, sectors, committees, and mass organisations should consider developing a (refresher) training programme for non-medical cadres (such as workers of culture and information services, media workers, teachers, mass motivators, police, border guards etc.) who have good general knowledge and communication skills to enable them to be teachers or facilitators of RH, sexual and sexuality education.

#### 5.2. Research and application of scientific and technological advances

- a. Given the concept that biological, social and environmental factors always exert a complex and aggregate impact on human health, research on health in general and on gender, sexuality and reproductive health in particular, should always be set in the context of the conditions and circumstances of the environment, family and society. Inter-disciplinary research, therefore, must emphasise thorough methodology which, in turn, will attract co-operation from international organisations and NGOs.
- b. The orientation for RH research in the coming decade will focus on three aspects: bio-medical research, sociological research and research into policy and mechanisms relating to RH and RHC services.
  - Regarding bio-medical aspects of RH, it is necessary to further study subjects which have seldom been dealt with, or not at all, such as infertility, breast-feeding, diseases of the reproductive system, and in particular, cancer of the reproductive organs, sexual health and behaviour, RH of adolescents, male reproductive health and men's knowledge, attitude and practices relating to their RH etc.
  - Research into genetic issues, effects which lead to sequelae, such as congenital deformities, mental retardation etc. caused by Agent Orange and/or other toxins. Applied research on gene screening.
  - Research in traditional medicine, to promote and modernise traditional methods for prevention and treatment of RH problems and FP applicable to RH, such as methods and formulas for contraception, abortion, increasing physical fitness during pregnancy and after delivery, enriching breast milk, treatment of post-partum haemorrhage, and prolapse of the uterus etc.

- Sociological research shall cover epidemiological research on RH, such as maternal and child morbidity and mortality, peri-natal mortality, complications, side effects of contraceptive methods, epidemiology of RTIs and STDs etc.
  - Research into sociological aspects of RH, such as identification of the unmet needs for contraception, high-risk sexual behaviour, testing of the results of interventions for maternal health at the community level. Further research should be carried out amongst individuals and families, on gender relations between men and women, men's role and responsibilities in RH, adolescents' attitude and behaviour in respect of RH, adolescents' lifestyle and 'social evils', RH aspects relating to development
  - Research into policy and mechanisms to increase and improve the quality of RH activities, particularly the mechanism for co-ordination and integration of RH-related activities between ministries, sectors, and mass organisations
- c. The quality and output of research should be improved, the results of research should be regularly disseminated and utilized. Comparison of notes among researchers and between researchers and policy-makers should be encouraged and promoted.
- d. More input must be given to activities for scientific information, including supply of printed and other materials, to provide researchers with easy access to sources of materials, both national and international.

## **VI. Financing and Logistics**

1. Budget for the implementation of the RHC strategy in the next decade shall come from the State budget, health insurance, hospital and service fees, funds from bilateral and multilateral co-operation, NGOs and community contributions, in which government input is the main source, and will be allocated as a budget line at all levels of the health care network. The total budget for RHC shall steadily increase but the State budget component may be reduced relatively when other funding sources increase.
2. All resources for RHC services including FP clinical services shall be managed in a way that accords with the average need of between 6,000 to 8,000VND per person per year. All concerned organisations, including ministries, sectors, governmental and non-governmental organisations, international organisations and private organisations, are encouraged to co-ordinate activities for proper and effective use of resources so that RHC activities are properly carried out. The RHC budget, including the budget for FP/MCH and the extended elements of RHC, shall be increased annually by between 500 to 600VND per person per year corresponding to the country's economic and population growth rates, thus meeting the growing demands for

more yet better activities to meet the objectives of the strategy.

3. Priority in the use of funds from all sources for RHC services must be given to areas with difficulties, and beneficiaries of government policies; the poor with the coefficient ranges from 1,5 to 2 who receive little RH care from governmental health institutions. The financial management system should be well organised and supervision and monitoring improved to ensure transparency and to assist in measurement of increased use of RHC services among the target-groups.
4. It is necessary to calculate the cost for a RHC service package (consisting of 7 elements) at each level of health care delivery in order to plan and make available such services, to use the local budget rationally and effectively and, depending on local financial needs and capacity, either supplement or reduce the components of such a package.
5. For the growing expansion of reproductive health care activities, where condition permits, effective strategies for cost-recovery including social marketing, cost-sharing and community-based services, should be promoted.

## **VII. Leadership and Management**

1. *Leadership of the Party and administration at all levels* constitutes the decisive factor for the RHC Programme to be implemented effectively, thus making a real contribution to the socio-economic development of the country. The Party, committees and administrations at all levels, should issue instructions, resolutions and include reproductive health care activities into their plan for the socio-economic development of the locality. RHC activities should be regularly monitored and implementation of the same evaluated.

2. *Management of the Reproductive Health Care Programme.*

A Steering Committee for Reproductive Health Care shall be set up at every administrative level, from the central to the lower levels. The Central Steering Committee, which is the highest level administration, shall be responsible for putting forward, as well as amending and/or supplementing, the national RHC policy and strategy.

The local steering committees shall be responsible for guiding and supervising the implementation of the national RHC strategy in the localities and proposing to the central steering committee amendments and/or supplements, if any, to the national strategy.

The Ministry of Health is the executive agency responsible for bringing together departments, committees, mass organisations, governmental and non-governmental

organisations for reproductive health care planning, for providing guidance, reviews, evaluation, and reports on the implementation of the strategy.

3. Strengthening the management and co-ordination of reproductive health care activities
  - 3.1 The MOH's role as State manager of reproductive health care activities should be strengthened and the number of women holding key positions in the management and operation system of reproductive health care activities at all levels, should be increased. A mechanism for the co-ordination of guidance, operations, and implementation of reproductive health care activities should be established.
  - 3.2 The need for all aspects of reproductive health care should be identified to lay the groundwork for planning the implementation in various phases.
  - 3.3 Regulatory documents dealing with professional and technical aspects, organization, management, as well as other aspects relating to RHC activities, should be promulgated. A system for monitoring the implementation of these regulatory documents should be set up to improve the quality of services and to prevent and rectify shortcomings in a timely manner.
  - 3.4 A plan should be drawn up to foster a contingent of key managers in RH, who will be provided with regular refresher training to improve their management capacity for planning, guidance, inspection, monitoring and evaluation.
  - 3.5 Efforts should be made to complete and uniformly apply the Health Management Information System (HMIS) over the whole country, to establish a system of RH indicators, including provision of services and quality of services at all levels of health care delivery. Indicators of the efficiency and impact of reproductive health care should be closely monitored. The network for collection of information and statistics should be well organised to fully reflect the reproductive health care activities of all key players, including governmental and non-governmental organisations as well as collective and private individuals. The mechanism established should promote the exchange and sharing of information among parties, including international organisations and the private health system, on issues relating to RH.

#### **PART FOUR**

#### **ORGANISATION FOR IMPLEMENTATION**

1. The Ministry of Health shall be responsible for co-ordinating, with concerned agencies, to develop the implementation plan for the national programme of reproductive health care and for submitting it to the Government for

approval, and for co-ordinating and supervising the implementation of such a programme.

2. Ministries, ministerial agencies, mass and social organisations which carry out RH-related activities shall have the following responsibilities:

2.1 The National Committee for Population and Family Planning (NCPFP) shall be responsible for defining and reporting to the Ministry of Health on the long-term and annual objectives and targets on population development and family planning.

The NCPFP shall co-ordinate with ministries, ministerial agencies, government agencies, mass and social organisations in promoting IEC for FP and RH; shall provide training to senior officials and officials involved in population and family planning on the management of the Population and Family Planning Programme and the integration of RHC contents into this programme. The NCPFP shall organise data collection, and its processing, storage and dissemination, and meet the requirements for the management, co-ordination and execution of population, family planning and RHC activities.

2.2 The Ministry of Planning and Investment (MPI) shall be responsible for co-ordinating with the Ministry of Health in elaborating, consolidating and balancing the long-term and annual plans on health and RHC and submitting such plans to the Government for approval.

2.3 The Ministry of Finance shall be responsible for joining with MOH and MPI in elaborating and submitting to the Government the financial plan to ensure the execution of RHC activities; joining with MOH in considering a budget line for RHC activities to be added to the existing budgetary lists of the MOH at all levels and in identifying the mechanism for allocation, use and monitoring of funds to be used for RHC activities to attain the set objectives.

2.4 The Ministry of Education and Training shall be responsible for outlining and guiding the implementation of the programme on gender, reproductive and sexual health education for students of general schools, colleges, universities, secondary vocational schools and other forms of education. The Ministry shall co-ordinate with the MOH in planning to provide teachers with more knowledge and skills for teaching and imparting the contents of sexual development, sexuality and RH. The Ministry shall participate in IEC activities relating to RHC for pupils and students

2.5 The Ministry of Culture and Information shall be responsible for planning and guiding the execution of diverse forms of IEC for RHC and protection in the mass media. The Ministry shall also be responsible for the training of

personnel, supply of RH-related IEC materials for ministerial agencies assigned to execute these tasks.

2.6 The General Statistics Office (GSO) shall be responsible for co-ordinating with the MOH in collecting, processing and providing timely, accurate data and information about RH, as well as relevant data on socio-economics and the execution of RHC activities.

2.7 Mass and social organisations shall be responsible for co-ordinating with the MOH and the NCPFP in developing IEC materials suitable for the specific target group(s) of each organisation; setting up and training a network of motivators who will play a key role in IEC activities, involving their members in RHC activities. Mass and social organisations shall also guide the integration of appropriate RHC activities into the action plans and programmes of their organisations, organise clubs and/or centres where information and counselling on RH and sexual health, suitable to the characteristics of their members, are available. These clubs and/or centres can provide simple RHC services which do not require complicated techniques (e.g. distribution of and counselling on condom use) in accordance with guidance from health institutions. These organisations shall also take part in community-based social marketing and supply of contraceptive methods, such as the oral contraceptive pill, condoms etc, as well as in inspection and monitoring of RHC services in the communities, regularly sending their comments to the MOH.

3. The plan for implementation of the RHC strategy is divided into two phases:

*Phase I (2001-2005).*

- Maintain IEC and advocacy activities and the provision of existing services, establishing and maintaining a favourable environment for RHC activities.
- Amend and/or supplement policies and regulation, training materials and documents regulating and guiding the provision of services; execute the strategy for human resource development; strengthen the systems for professional management and monitoring as well as financial and resource management.
- Gradually incorporate some new RH elements to the current reproductive health service package.
- Build a mechanism for co-ordination among partners in carrying out RHC activities at all levels.
- Build an information system based on gender and RH indicators which have been selected for monitoring and evaluation

- Select field studies on some priority RHC subjects, build successful models for nation-wide replication.
- Increase activities to meet the needs of adolescent RHC and mobilise men's participation in RH.
- Promote the supply of information and services to the remote areas and areas inhabited by ethnic groups.

*Phase 2 (2006-2010). During this period, efforts shall be made to:*

- carry on activities which were started in phase 1
- focus on identifying impact indicators in a more comprehensive manner alongside monitoring indicators to meet the requirements for higher quality of care.
- promote the provision of sufficient RHC services in a broad sense at all levels.
- institutionalize the planning, inspection and evaluation of the managers on the basis of effective use of more reliable data.
- carry on training activities, research, inspection, evaluation and quality IEC activities to constantly upgrade providers' knowledge and skills.

Throughout the process of implementing the strategy, it is important to focus on capacity building along with most effective resource investment to ensure the sustainability of the National Reproductive Health Care Programme.

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