3

UNFPA

Knowledge and Behaviour of Ethnic Minorities on Reproductive Health

Knowledge and Behaviour of Ethnic Minorities on Reproductive Health

HA NOI 2007

Table of contents

List of Tables

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-retroviral drugs
BCC	Behaviour Change and Communication
CHC	Commune Health Center
CP6	Country Programme Six
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IUD	Intra-uterine device
MOH	Ministry of Health
NGO	Non-Governmental Organization
Pop/RH	Population/Reproductive Health
PC	Population Collaborator(s)
RH	Reproductive Health
SP	Service provider
TBA	Traditional Birth Attendant
WHO	World Health Organization
VHW	Village Health Worker(s)

Preface

In December 2005, the Government of the Socialist Republic of Viet Nam and the United Nations Population Fund (UNFPA) completed the Sixth Country Programme (CP6). To mark the end of 5 years of collaboration (2001-2005), UNFPA undertook a series of studies to draw lessons learned and best practices from the programme's implementation.

This research report is prepared by a social anthropologist, Dr. Graham Fordham. The report documents changing patterns of reproductive health knowledge and behaviour of the ethnic minority community in mountainous provinces. It is the outcome of a short qualitative research project conducted in Ha Noi, and Ha Giang provinces of North Viet Nam between late October 2006 and early January 2007.

Critically, the report based on qualitative research, aims to move on from existing descriptive quantitative data by providing, within the limits of the research parameters, analyses that are as detailed as possible. Key issues discussed in the report include family planning, safe motherhood, HIV/AIDS, gender rights and equality, domestic violence, and the conduct of media in BCC activities. The report contains valuable lessons for future application of reproductive health programmes by government, NGOs, United Nations agencies and other concerned stakeholders.

I would like to thank Dr. Fordham for his considerable efforts in completing this report. I would like to thank Dr. Duong Van Dat of UNFPA Viet Nam for his coordination in preparing and publishing lessons learned and best practices from UNFPA's country programmes. It is UNFPA's wish that the lessons learned and experiences gained from CP6 will be of use to policy makers, programme managers, health professionals and donors in designing and implementing reproductive health programmes aligned with the Millennium Development Goals (MDG) and the commitments made at the International Conference on Population and Development (ICPD) in Viet Nam.

Ian Howie
Representative
UNFPA Viet Nam

Executive summary

Overview

This report discusses lessons learned and best practice from the implementation of UNFPA's Sixth Country Programme (2001-2005). It is the outcome of a short qualitative research project conducted between late October 2006 and early January 2007 in Hanoi and in the Hoa Binh and Ha Giang provinces of North Viet Nam. Data from this project, coupled with data contained in existing UNFPA/MOH programme reports and evaluations plus data from broad range of scholarly publications, have been used to make an analysis of the conduct and outcomes of CP6 and to identify lessons learned and best practices.

It is emphasized that as a great deal of evaluation work has already been conducted in relation to the Sixth Country Programme, this report has specifically aimed not to replicate these works, but to cover areas that have not yet been addressed or have been addressed only superficially. Critically, it aims to move on from existing descriptive quantitative data by providing, within the limits of the research parameters, analyses that are as detailed as possible and that have real practical application in the implementation of Seventh Country Programme and other future programmes at both the national and provincial level.

Family Planning

- All clients (men, women and adolescents) generally demonstrated increased knowledge of contraceptive methods during the CP6 project period. However, significant provincial discrepancies exist, with clients in mountainous and remote provinces demonstrating much lower levels of knowledge than in less remote provinces, and women and girls a better knowledge of contraceptive methods than men or adolescent boys
- Understandings about how clients pursue their reproductive goals would be enhanced if the appropriate data to enable the plotting of clients' "career paths" of contraception is collected
- Unplanned pregnancy amongst teenaged girls should not be viewed as being due solely to a lack of knowledge about contraceptives. Often the root cause is lack of knowledge and experience with relationships. Although they know about contraception, young lovers allow a pregnancy to occur as they expect their relationship will lead to marriage, however, their relationship unexpectedly terminates
- It is suggested that future BCC programming directed to youth should focus not solely on contraception, but that they should also address relationship issues. Such programming should draw on life skills materials which have been disseminated by WHO. These have been widely used in the Southeast Asia region and could be easily adapted to suit the local context

- FP activities amongst ethnic minority groups will only achieve optimum effectiveness if they address cultural barriers such as preference for large families and dislike of condoms due to beliefs about masculinity

Safe Motherhood

- Safe motherhood programmes conducted among the majority Kinh population, show a substantial increase in the proportion of women having three or more pregnancy checkups and giving birth in public health facilities. However, the benefits of these programmes do not extend to members of ethnic minority groups. As a result, in some ethnic minority areas, fully equipped RH facilities are under-utilised and trained providers, under-employed
- When Hmong or other minorities refuse to take advantage of prenatal care or to utilize public delivery facilities, it is emphasized that this is not due to a commonly believed reluctance to allow intervention by males, or to any form of blanket rejection of the RH facilities. Rather it relates to a combination of complex rituals surrounding births that are more easily performed at home, in concert with practical issues such as a reluctance to travel long distance during the last stage of pregnancy
- In order to remove barriers and extend prenatal care to Hmong women or other minorities, and in order to facilitate an accommodation between the safe delivery births offered at CHCs and the barriers that are currently preventing these taking place, in addition to talking with women, efforts should be directed to dialogue with ethnic minority leaders, elders and villagers in general

HIV/AIDS

- Over the period of CP6 levels of knowledge about HIV/AIDS in respect to HIV transmission routes, prevention strategies, and issues of recognition of persons infected with HIV have increased. However, despite this, most persons, health providers and clients alike, do not really view HIV/AIDS has having much relevance to their own life - instead it is viewed as a disease of others - mainly drug addicts and prostitutes
- In respect to the design and conduct of future HIV control BCC activities, research is needed so that we can understand to what extent people believe HIV/AIDS to be a qualitatively different from the STIs with which they are already familiar

Rights, Gender Equality and Domestic Violence

- Issues of rights and gender equality are understood in the narrowest sense, and as a result outcomes have been restricted to a narrow sphere. Efforts should be made during training to broaden understanding of these issues
- BCC campaigns against domestic violence have been minimally effective with almost half of VHWs/Pop workers not viewing this as a priority issue. Improved understanding of domestic violence and related issues should be emphasized in future BCC counseling and training activities

- To the extent that CHC service providers address domestic violence their role is restricted to giving medical aid and counseling - reactive rather than proactive. It is suggested that they be encouraged to adopt a more proactive approach
- It is suggested that alcohol plays a role in the instigation of domestic violence and that research will be needed to understand how this issue can be best addressed

Media for the Conduct of BCC Activities

- More minority language audio BCC materials need to be produced to supplement face-to-face activities, and efforts must be directed towards ensuing that the equipment to play media is provided alongside the media
- Electromechanical technologies such as the cassette tapes, currently used for BCC activities, are outdated. New solid-state technologies would benefit communities in remote and mountainous provinces. A pilot study in the use of these technologies is recommended
- The technological organization of Viet Nam's television broadcasting system offers "narrow casting" to address tightly defined target groups. The use of this facility should be investigated further particularly for conducting small scale testing of various BCC messages aimed at specific minority groups

Brief description of UNFPA's Sixth Country Programme

In collaboration with the Vietnamese Government, UNFPA developed the Sixth Country Programme (CP6) of assistance to Viet Nam for the period 2001 - 2005, to assist in implementing the new National Population Strategy for 2001 - 2010 and the first ever National Strategy for Reproductive Health Care for 2001 - 1010. The programme builds on the experiences and lessons learned through previous programmes and responds to the country's population dynamics and reproductive health needs. It aims to contribute to the attainment of a higher quality of life for the Vietnamese people through improved reproductive health, a harmonious balance between population dynamics and sustainable socio-economic development, and the achievement of equal opportunities in social development. CP6 focused on building national capacity for improving reproductive health care and creating a favorable policy environment for implementation of population and reproductive health activities. Like Fifth Country Programme, by contrast with earlier programmes, CP6 moved the focus on population activities from fertility reduction to quality of life and reproductive health.

The programme consisted of two sub-programmes namely, Reproductive Health (RH) and Population and Development Strategies. Advocacy and Information-Education-Communication (IEC) were integrated into the two sub-programmes as crosscutting issues.

The budget for CP6 was USD27 million, of which USD20 million came from the UNFPA regular fund, and USD7 million from other sources[1]. The Government of Viet Nam committed VND120 billion (both in cash and in kind), equivalent to some USD8 million, and took responsibility for executing about 75% of the country programme budget. UNFPA executed about 25% of the budget focusing on technical and management backstopping to the programme implementation.

[1] It notes that the actual expenditure of CP6 during 2001-2005 was USD30,392,508 of which USD20,508,267 from the regular fund and USD9,884,241 from the mobilized fund.

Introduction

The Research Project

This report is based on a small qualitative research project that was conducted by UNFPA in late 2006, in the Hoa Binh and Ha Giang provinces of North Viet Nam. The research took a qualitative perspective in order to transcend the highly descriptive nature of the existing quantitative data reporting on UNFPA's Sixth Country Programme, and in order to investigate issues that are not amenable to quantitative analysis. It aimed at gaining a more detailed understanding of how the health care reforms implemented under CP6 impacted on both health care providers and on their clients, and at ascertaining how future reforms might be carried out yet more effectively.

It is important to note that qualitative research is fundamentally different to quantitative research. Quantitative research focuses on an extensive sample of data and primarily derives meaning from an analysis of statistical relationships. By contrast with quantitative research, qualitative research focuses deeply on issues of meaning - cosmology, the logic of cultural practice, and ideology, and has a deep concern with issues of reflexivity - but only a limited concern with statistical relationships. Importantly, by contrast with quantitative research, qualitative research works intensively on relatively small numbers of people in one or more communities, and due to its deep level of analysis and the nature of the issues it addresses, its outcomes are considered to be relevant to the broader population.

Importantly, when the results of qualitative research are presented it is normal to present some of the cultural data to illustrate the conclusions drawn from the analysis of that data. It does this because it is concerned to fully inform the reader about the social situation it examines and because it aims to draw attention to the complexity of meaning and social action. Thus it is a useful way of understanding the response to programming, and "bridging the gap" between programming aims and the community response.

Through a fine-grained examination of the baseline and endline survey reports, as well as a broad corpus of other relevant documents pertaining to CP6 (see below, and also bibliography), in concert with small qualitative research projects conducted in Hoa Binh and Ha Giang provinces, the research focused on a selection, or "raft", of the many RH issues addressed under CP6. From this examination the research aimed to draw out lessons learned and to make recommendations for best practice under CP7 and subsequent RH programmes.

It should be noted that the research project and this report in regard to lessons learned/best practice outcomes of CP6, have focused primarily on areas which to date have not been well covered in evaluations of CP6. The many areas of CP6 RH care reform in which existing research and evaluations have already identified lessons learned issues are only addressed in this report if the report is able to add a substantial contribution to that which is known already.

Research Methodology

Literature Review

The first part of the research consisted of an extensive literature review of all literature relevant to CP6. This included the Sixth Country Programme document, the Sixth Country Programme Baseline Survey Report, and the Sixth Country Programme Endline Survey Report[2]. Literature surveyed also included the endline survey reports for the two provinces selected for field research as well as endline survey reports for several other provinces, the survey forms used for data collection during these surveys, and reports on training activities carried out under CP6[3]. Other literature reviewed included reports produced by PATH and Pathfinder, and a wide selection of scholarly literature dealing with reproductive health and HIV/AIDS in Viet Nam.

Drawing on the consultant's special expertise as a social anthropologist a wide range of anthropological literature dealing with relevant reproductive health issues, issues concerning social and institutional change, and cultural issues related to specific RH concerns relevant to Viet Nam's many minority groups was also consulted[4]. Discussions about the implementation of CP6 were also held with senior officials from the Ministry of Health and the Viet Nam Commission for Population, Family and Children. Senior staff from two NGOs (PATH and Pathfinder International) were also interviewed, as were the senior staff and researchers at the Thai Binh Medical College Research Centre for Rural Population and Health who were responsible for conducting baseline and endline surveys for CP6.

Field Research

The research component of the project involved paying field visits of three days each to Hoa Binh and Ha Giang provinces, and in each province two communes and their respective health centers were visited. In Hoa Binh, Lien Son commune in the Luong Son district, and Phu Minh commune in the Ky Son district were visited, and in the Xin Man district of Ha Giang province, visits were made to Na Tri and Pa Vay Su Communes. In each province the communes visited were chosen as one was considered relatively successful and one less successful Lien Son and Na Tri being considered the more successful communes. As ethnic minority group issues are currently of particular concern for UNFPA, as much less is known about the nature of these problems, and as the results of CP6 suggested that there are some problems specific to ethnic minority groups that are

---

[2] UNFPA. United Nations Population Fund Sixth Programme of Assistance to the Socialist Republic of Viet Nam. UNFPA. Hanoi. nd. UNFPA, Baseline Survey Report: Provision and Utilization of Reproductive Health Care Services in 12 UNFPA-supported Provinces. UNFPA. Hanoi. 2003; Endline Survey Report; UNFPA. Endline Survey Report: Provision and Utilization of Reproductive Health Services in 11 UNFPA-supported Provinces in the 6th Country Program. Hanoi. 2006; UNFPA, Final Report: The Sixth Country Programme of Cooperation Between Viet Nam and the United Nations Population Fund (2001 - 2005). Hanoi. 2006.

[3] UNFPA. End-Line Survey Report: Actual Situation of the Provision and Utilization of Reproductive Health Care Services in Hoa Binh Province. UNFPA: Hanoi; UNFPA. 2006. End-Line Survey Report: Actual Situation of the Provision and Utilization of Reproductive Health Care Services in Ha Giang Province. UNFPA. Hanoi. 2006; UNFPA and National Economics University Population Centre. Key Findings and Recommendations (monitoring of Training Activities in 11 UNFPA-supported Provinces, CP6, 2004). UNFPA and National Economics University Population Centre. Hanoi. 2004.

[4] Note: Only that anthropological literature directly relevant to the analysis made in this report is cited here.

not yet adequately addressed, a special focus was directed to these groups was made during the research period.

The teams conducted interviews and focused discussions with a large number of people (both RH providers and their villager clients). In respect to the people met during the research, the teams interviewed health service managers and providers at all levels from that of the province to the district, commune and village level, and they also conducted interviews with trainers and with population and mass organization collaborators (Women's Union, Youth Union). Importantly, as well as conducting interviews and focused discussions with health care providers, the researchers spent time interviewing and talking with village volunteers and a small selection of village families (who were contacted with the assistance of the village volunteers). In Hoa Binh province families were interviewed in their own house. However, due to time constraints and the fact that villages were located some distance from the Commune Health Center, in Ha Giang province the families traveled to meet the researchers at the Commune Health Center.

The research was conducted by Dr. Graham Fordham, working via local translators (Dr. Pham Thuy Minh and Dr. Nguyen Xuan Hong) from the UNFPA office, in Hanoi. Interviews were conducted in Vietnamese and translated into English. Due to lack of Vietnamese language fluency among the Hmong in Pa Vay Su commune in Ha Giang, interviews were conducted in the Hmong language with assistance from a local person fluent in both Hmong and Vietnamese, and then translated into English. Dr. Fordham took full research notes in a combination of shorthand and English, and the translators recorded important Vietnamese language and cultural concepts.

Research Findings

This section of the report discusses research findings in respect to lessons learned/best practice on the basis of the experience of CP6 in regard to several broad areas, each of which addresses several specific issues. The areas addressed include: family planning, safe motherhood, HIV/AIDS, media for the conduct of BCC, and issues concerning rights, gender equality and domestic violence.

Family Planning

Family planning must be considered one of the successes of CP6. As the Table 1 demonstrates, the contraceptive user rate increased over the project period from a user rate of 77.9% to a to a current user rate of 80.6% at the time of the 2005 endline survey. Additionally, as Table 2 indicates clients (men, women and adolescents) generally demonstrated an increase in knowledge about contraceptive methods during the project period. Thus of nine possible contraceptive methods, the average number given by all respondents was 3.4 in the baseline survey and 3.6 in the endline survey. However, as Table 1 shows, there are large differences between some provinces, with respondents in remote and mountainous provinces having a much lower level of contraceptive knowledge than those in less remote areas. Overall adults had a superior knowledge of contraceptives than either male or female adolescents. And, similarly, both women and girls had a better knowledge of contraceptive methods than did men or adolescent boys. This suggests a greater concern with the consequences of unwanted pregnancy on the part of women and adolescent girls. Importantly, it also suggests the need for further work in regard to gender equity issues in regard to shared responsibility for contraception.

Client Rights/Counseling Issues in Relation to Contraception

Discussions with service providers and clients showed that, in general, contraceptive counseling achieved good results. Women are being offered a range of contraceptive choices and the opportunity to change their form of contraception. As one CHC provider noted:

> "Clients now feel very happy and are quite surprised. Previously when they would ask for a contraceptive method I would select the one I thought most appropriate. Now I tell them about three or four types of contraceptive methods and the details about these, and the client selects the one they find most appropriate".

Table 1: Percentage of people currently using contraceptives (%)

Using contraceptives	Women		Men		Mean	
	2003 n=2,310	2005 n=2,305	2003 n=2,305	2005 n=2,303	2003 n=4,615	2005 n=4,608
Use	73.0	77.4	82.7	83.8	77.9	80.6
No use	27.0	22.6	17.3	16.2	22.1	19.4

Source: End-Line Survey Report: Provision and Utilization of Reproductive Health Care Services in 11 UNFPA-Supported Provinces in the 6th Country Programme. UNFPA 2006. p. 94.

Table 2: Average number of contraceptives known by interviewees

Province	Women		Men		Adolescents						Mean	
					Male		Female		Mean			
	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005
Thai Binh	4.6	5.3	4.8	5.5	2.8	2.9	2.9	2.8	2.9	2.8	4.1	4.6
Phu Tho	3.6	4.4	3.7	4.2	2.6	3.8	2.7	3.5	2.7	3.6	3.3	4.1
Quang Nam	4.8	4.5	3.6	4.5	2.3	3	2.6	3.2	2.5	3.1	3.6	4.0
Da Nang	5.8	5	4.2	3.9	2.6	2.4	2.8	2.9	2.7	2.7	4.2	3.9
Binh Duong	4.8	4.4	3.6	4.2	2.3	2.1	2.7	2.5	2.6	2.3	3.7	3.6
Yen Bai	4.6	5	3	3.4	2.1	1.8	2.2	1.9	2.2	1.9	3.3	3.4
Hoa Binh	4	4.1	4	3.4	2.2	2.3	2.5	2.8	2.4	2.6	3.5	3.4
Khanh Hoa	3.4	3.9	4.1	4	2.1	1.9	2.4	2.5	2.2	2.3	3.2	3.4
Tien Giang	3.8	4	3.4	3.4	2.2	2.3	2.5	2.6	2.4	2.5	3.2	3.3
Binh Phuoc	3.6	3.6	3.1	3.6	1.8	1.5	2.3	1.8	2.1	1.7	2.9	3.0
Ha Giang	2.5	2.8	2.8	2.8	1.1	1.7	1.3	1.9	1.3	1.8	2.2	2.5
Mean	4.1	4.3	3.7	3.9	2.2	2.4	2.5	2.6	2.4	2.5	3.4	3.6

Source: End-Line Survey Report: Provision and Utilization of Reproductive Health Care Services in 11 UNFPA-Supported Provinces in the 6th Country Programme. UNFPA 2006. p. 93.

All women with whom the issue was discussed said that they appreciated these new practices very much. Family planning provider also pointed out that, by comparison with the past, that the success of FP BCC campaigns have meant that a high percentage of women are already aware of a range of contraceptive choices and that they now often come to the CHC and ask for a particular type of contraceptive. In some cases their knowledge is quite detailed. One Hoa Binh CHC provider interviewed by the research team pointed out that women requesting IUDs already knew which type they wanted as they knew which type caused discomfort or other problems, and which type was most likely to be successful. Interviews confirmed endline survey findings that convenience and effectiveness are the primary factors people consider with choosing a form of contraception.

Importantly, comments by a commune provider from Ha Giang suggest that women's increased knowledge about contraception and RH activities in general is not solely due to successful BCC campaigns, but also a result of the "multiplier effect" promoted through

good counseling. Thus, in response to a question about the time taken to conduct a successful counseling session, the commune provider pointed out that:

> "Yes, it takes more time when you counsel them, but then they will tell others and this will save time later".

Clients can receive counseling at the CHC or, as one Hoa Binh VHW explained, in their own home. She gave the example of a young newly married women visiting her at the CHC to seek contraceptive advice, and said that she later visited the woman at her husband's parental home for the purpose of providing private counseling for the husband and wife together.

Contraception and involved factors

In some cases an important part of counseling provided for clients consists of convincing a husband of his need to accept the responsibility for contraception and use condoms, if his wife cannot tolerate forms of contraception such as oral pills or IUDs. However, one village health worker pointed out a problem here that some men are unwilling to accept this responsibility, as they do not like condoms. Discomfort and lack of sensation were mentioned as a major reason for male dislike of condoms. Population workers pointed out that:

> "Men mostly understand about the advantages of using condoms for family planning and for STDs and AIDS. But they also say that it is not convenient so they do not use them".

Thus, it is likely that in some cases couples who are listed using as condoms for family planning purposes, are in fact not engaging in consistent condom use due to this fact. It is also noted that this dislike of condoms is an issue that will need to be addressed in BCC programming on HIV/AIDS.

However, it is likely that in addition to admitted dislike and consequent non-use or inconsistent use of condoms for contraception, for some couples the use of condoms (and other contraceptive methods such as oral pills - which may be "forgotten") for family planning may be a mechanism through which they maintain an appearance of conformity to programmes aimed at fertility control while, at the same time, allowing for ongoing covert attempts to produce sons. Recent research by Belanger points out that although people sometimes refer to themselves as being "old fashioned" or "backward" in their desires for a son, and despite their awareness of the financial costs of having large families, there are persisting social pressures on both men and women to produce sons[5]. In respect to her research in Ha Tay province, Belanger points out that[6]:

---

[5] D. Belanger. 2006. "Indispensable Sons: Negotiating Reproductive Desires in Rural Viet Nam," Gender, Place and Culture. Vol. 13/3. pp. 251 - 265.

[6] D. Belanger. 2006. "Indispensable Sons: Negotiating Reproductive Desires in Rural Viet Nam," Gender, Place and Culture. Vol. 13/3. p. 262.

"All women aged 40 years and under who exceed the two child limit claimed a contraceptive failure to justify their subsequent pregnancy(ies) and birth(s)…. Such justification is considered acceptable and normal"

Belanger also suggests that in the case of IUDs, family planning workers are able to check the veracity of women's claims regarding contraceptive failure, and cites instances of women being fined or scolded for removing their IUDs. However, in the case of condoms (or oral pills) where contraceptive failure can be blamed on breakage or forgetfulness, FP workers do not have grounds for suggesting women deliberately court pregnancy. Importantly in regard to the success of FP programmes, she points out that[7]:

"Fertility change does not necessarily mean a change in values and can even result in attempts to maintain values"

This issue is important for FP staff at the CHC level. If providers are aware that clients who are desperate for sons may deliberately engineer contraceptive failure in order to escape the censure of RH providers and friends alike, they could improve this situation by providing appropriate counseling. Critically, the style of counseling called for in this instance is not about contraception, but about social structure, social change and the new gender values of the modern world.

Two areas were identified as facing significant barriers to effective FP programming activities. The first is contraception amongst adolescents, in respect to addressing issues such as early sexual activity and the prevention of unwanted pregnancy, as well as the control of STIs and HIV. Providers at the CHC in Na Tri commune, Ha Giang (where the population is 90% Tay) identified a specific RH problem amongst adolescents. This is the issue of young people who fall in love, and who commence sexual activities, sometimes with the consent of their parents, but whose relationship breaks up unexpectedly leaving the female partner pregnant and seeking an abortion, sometimes at an extremely late stage.

Importantly, it is stressed that this issue is not solely a minority group issue. There is other much recent qualitative work from (North) Viet Nam dealing with sexual risk taking and unplanned pregnancy among Vietnamese youth, which also suggests that much of the demand for abortion amongst unmarried young people is often not the result of lack of knowledge about contraception at the time of early sexual experience. Rather, it is the result of relationships of love and companionship (and sometimes movie fueled notions

[7] D. Belanger. 2006. "Indispensable Sons: Negotiating Reproductive Desires in Rural Vietnam," Gender, Place and Culture. Vol. 13/3. p. 260.

Photo by Doan Bao Chau

of romantic love) that view failure to use contraception as a stamp of authenticity on a relationship that instead of leading to marriage as anticipated, are unexpectedly terminated, leaving the female partner with few options but to seek an abortion[8]. Poor communication about sexual issues on the part of boyfriends and girlfriends, and a lingering belief that contraception is for married couples are also identified as contributing to unexpected and unwanted pregnancies amongst young women[9].

All persons interviewed suggested that although sexuality and Reproductive Health issues are now incorporated in the school curriculum, the manner in which they are addressed is theoretical and relatively in effective. This suggests that RH communicators and volunteers at the CHC facilities, have a vital role to play in communicating RH knowledge to adolescent groups. As noted in the report on lessons learned from the health sector, the key to raising awareness of contraception and related issues depends on effective BCC campaigns and better provider "group work" skills that address issues such as adolescent shyness and lack of confidence. The content of materials must reinforce knowledge about contraception, safe sex practices and the, issue of relationships. It would be useful if the implementation of activities referred to life skills materials that have been broadly utilized in the Southeast region and thus there is much material that might be easily adapted to the local context[10].

A second important barrier to effective FP programming concerns the low implementation rate of FP activities among minority groups. As the data in Table 2 above demonstrates, provinces such as Ha Giang are largely populated by minority groups with comparatively less knowledge about contraceptives than people in Kinh dominated provinces. However, failure to use contraceptives by members of some minority groups may not be due solely

---

[8] T. Gammeltoft. 2002. "Seeking Trust and Transcendence: Sexual Risk-Taking Among Vietnamese Youth," Social Science and Medicine. Vol. 55. pp. 483 - 496.

[9] D. Belanger. et al. 1999. "Single Women's Experiences of Sexual Relationships and Abortion in Hanoi, Vietnam," Reproductive Health Matters. Vol. 7/14. pp. 71 - 82.

[10] World Health Organization. 1994. The Development and Dissemination of Life Skills Education: An Overview. Geneva: WHO.

to language and cultural barriers. Interviews with Hmong villagers suggested that even with contraceptive knowledge there was evidence of cultural preference for large families. To date, this issue has not been optimally addressed in BCC campaigns. Although villagers are well aware of the cost of raising children in the modern world including education needs and other economic considerations, cultural (or lifestyle factors) still push them towards a preference for large families. For example three male Hmong village volunteers from the Pa Vay Su commune of Ha Giang pointed out that in the past Hmong wanted large families to defend their land from incursion, however that these days this was unnecessary.

Importantly, interviews revealed Hmong preference for IUDs is based on the belief that if men use contraception, particularly sterilization (but likely also condoms) this will weaken and render them unfit for the heavy work of the fields. Similar beliefs are sometimes found in other cultures, where masculinity equates with free flowing semen and a consequent loss of humoral balance and ill-health if the flow is impeded. If not correctly addressed, such beliefs pose a significant barrier to the successful implementation of FP and HIV prevention programmes. Implementation of effective FP programmes amongst Hmong and other minority groups, or special target groups amongst the Kinh majority population, should be built on an understanding of the respective cultural values.

Summary

- All clients (men, women and adolescents) generally demonstrated an increase in knowledge about contraceptive methods during the project period. However, there are significant differences between provinces, with clients in mountainous and remote provinces having much lower levels of knowledge than those in less remote provinces, and women and girls have a better knowledge of contraceptive methods than did men or adolescent boys
- Good counseling has a "multiplier effect" in the community as clients share new knowledge with others
- In the case of teenage pregnancy, it is often the case that it is not so much that lack of knowledge about contraceptives that is at issue, but lack of knowledge and experience with relationships. Young lovers allow a pregnancy to occur as they expect their relationship will lead to marriage but then their relationship unexpectedly terminates leaving the female partner with an unwanted pregnancy
- BCC activities with youth need to work not just on knowledge about contraception but also on relationships
- Optimum effectiveness of FP programmes amongst ethnic minorities will only be achieved if these correctly address the real cultural barriers

Safe Motherhood

The Sixth Country Programme devoted significant resources to the provision of delivery rooms and equipment, and on the training of staff as well as on BCC activities in the community to ensue that a higher percentage of women would utilize public health facilities for pregnancy check-ups and for delivery. Overall these programmes were effective. As Tables 3 and 4 show, between the baseline survey of 2003 and the endline survey of 2006, the proportion of women having three or more pregnancy checkups increasing from 81.5% to 87/1%. Also, over the same period the proportion of women giving birth in public health facilities increased from 85.1% to 91.7% (Table 4).

Table 3: Percentage of women having three and more antenatal care visits

Province	Women		Men		Mean	
	2003	2005	2003	2005	2003	2005
Tien Giang	88.1	99.0	83.3	96.1	85.7	97.6
Da Nang	85.7	93.3	82.9	94.3	84.3	93.8
Hoa Binh	85.2	92.8	74.8	93.2	80.0	93.0
Phu Tho	87.1	94.3	72.9	89.0	80.0	91.6
Thai Binh	95.7	97.1	85.7	83.8	90.7	90.5
Binh Duong	90.5	95.7	88.0	83.3	89.2	89.5
Khanh Hoa	82.9	90.5	74.8	84.8	78.8	87.6
Quang Nam	89.0	91.9	68.8	73.3	78.9	82.6
Yen Bai	84.8	89.5	71.9	67.1	78.3	78.3
Binh Phuoc	71.0	67.9	62.9	77.7	66.9	72.9
Ha Giang	36.2	45.2	38.8	57.6	37.5	51.4
Total	81.5	87.1	73.1	81.8	77.3	84.4

Source: End-Line Survey Report: Provision and Utilization of Reproductive Health Care Services in 11 UNFPA-Supported Provinces in the 6th Country Programme. UNFPA 2006. p. 89.

Table 4: Percentage of people telling about the places for last delivery and birth attendants (%)

Provinces	Places for delivery				Birth attendants			
	At home		At health facilities		Health workers		Others	
	2003	2005	2003	2005	2003	2005	2003	2005
Phu Tho	11.0	4.1	89.0	95.9	91.7	98.8	8.3	1.2
Ha Giang	68.0	46.9	32.0	53.1	42.5	58.1	57.5	41.9
Quang Nam	8.9	6.7	91.1	93.3	92.8	95.2	7.2	4.8
Binh Phuoc	18.1	12.1	81.9	87.9	85.0	91.4	15.0	8.6
Yen Bai	22.6	12.4	77.4	87.6	89.8	92.4	10.2	7.6
Binh Duong	0.7	0.2	99.3	99.8	98.1	98.3	1.9	1.7
Hoa Binh	14.3	3.1	85.7	96.9	93.1	97.4	6.9	2.6
Thai Binh	0.0	0.0	100.0	100.0	100.0	100.0	0.0	0.0
Tien Giang	1.0	0.0	99.0	100.0	99.3	99.5	0.7	0.5
Da Nang	2.1	1.2	97.9	98.8	98.1	99.5	1.9	0.5
Khanh Hoa	16.9	4.3	83.1	95.7	85.5	96.7	14.5	3.3
Mean	14.9	8.3	85.1	91.7	88.7	93.4	11.3	6.6

Source: End-Line Survey Report: Provision and Utilization of Reproductive Health Care Services in 11 UNFPA-Supported Provinces in the 6th Country Programme. UNFPA 2006. p.91.

However, although these outcomes over the eleven provinces are highly encouraging, in provinces with high levels of ethnic minority groups the results were quite low, with only a minority of women having pregnancy check-ups, and relatively few women utilizing birth facilities, instead preferring deliveries at home. Thus, in Ha Giang province, for instance the percentage of women having at least three pregnancy check-ups increased

from 36.2% to 45.2% over the course of the project, and the percentage of women delivering at health facilities increased from 32% to 53.1%. The Hmong in particular seem to be extremely reluctant to utilize public health facilities for delivery.

When the research team visited in Pa Vay Su commune in Ha Giang (which is approximately 97% Hmong), they found out that over the past year 100% of deliveries had been undertaken at home with the assistance of women's husbands, some of which had been attended by village health workers (the majority of whom were male). By contrast, in Na Chi commune where about 90% of the population is Tay, 52 births were carried out at the CHC and only 6 were undertaken at home.

The research addressed the problem of safe motherhood, and particularly the issue of safe motherhood programmes amongst ethnic minority groups. Safe motherhood has broad application across all ethnic minority groups, and if the issue can be successfully addressed here amongst groups such as the Hmong, then the model can be translated and used amongst other ethnic minorities.

The problem of Ethnic Minority Groups and Low Usage of Public Birth Facilities

Various explanations have been proposed regarding why, Hmong in particular, do not want to utilize public health facilities either for health check-ups or for delivery. Most have gender- or culture-based explanations. Thus some claim that Hmong will not allow another person, especially a man in the house at the time of the birth. Others have suggested that given the location of Hmong villages in relation to CHCs the distances are too great to travel for pregnant women. However, as an anthropologist, the consultant was not particularly satisfied with either explanation. The idea that others are not allowed in the house at the time of birth, or they are not allowed to view women's genitals seemed more an "off-the-cuff" rationalization rather than a real substantive reason. And what constitutes a "long distance" to travel to a health center is itself a cultural construction - and one that needs to be viewed in the context of the distances that women normally travel during their activities in their village and fields.

Indeed a recent work by the UNFPA/PATH cites a volunteer health worker who suggests that there are good reasons to be suspicious about simple generalizations about this issue. For example it cites a CHC provider from Nan Ma commune (Xin Man district of Ha Giang) as saying "Hmong women are shy and will not allow themselves to be examined and even husbands are not allowed to touch," but it also cites a Hmong woman as saying "The reason women don't come to the CHC has nothing to do with shyness[11]."

Birth

As noted above, in Pa Vay Su commune of Ha Giang, over the past year 100% of deliveries have been at home, although some home births have involved. The common explanations

[11] UNFPA/PATH. 2006. Rapid Maternal and Neonatal Health Care Needs Assessment in UNFPA Supported Provinces of Viet Nam (DRAFT). UNFPA: Hanoi.

for Hmong low rates of pre-natal examination and reluctance to utilize CHC birth facilities, those noted above, were not consistent with the research findings. Thus, it was found that Hmong women were willing to visit the health center for the fitting of an IUD by a male assistant doctor, and it was also found that some of the deliveries at home had been assisted by male village health workers (this commune has no midwife) and they advised that women were not shy about having unrelated men assist in their birth.

In-depth interviews were conducted with health volunteers and with village men and women in order to ascertain and understand some of the cultural practices surrounding the birth process amongst the Hmong. They revealed that Hmong women normally give birth in their own homes assisted by their husband. He gives them a traditional herbal drink prior to the delivery in order to ease the delivery and, following the delivery, another herbal drink assists in shrinking the uterus and in the prevention of excessive bleeding. Following the birth the husband also massages his wife's stomach in order to help the expulsion of the placenta. Then, for three days following the delivery the woman stays on the ground near a fire. After that when there is no more mess due to blood she moves to the bed. Like many cultural groups Hmong believe that the birth process involves the mother losing significant amounts of heat[12]. Thus the fire is not just to keep warm from the cold weather, it is also considered important to replace lost "heat" and, according to Hmong belief, it also helps shrink the uterus following delivery. Also, although the question was not addressed during the interviews, as alcohol is believed to be heating, Hmong women normally drink strong alcoholic drinks in the period following birth as this too is seen as restoring heat lost during the birth process.

It is suggested that the practices in respect to birth amongst the Hmong are issues that should be addressed in during CP7 programme activity in order to increase the percentage of Hmong women having at least three pregnancy check-ups, and to increase the percentage of Hmong women giving birth at a health care facility. Failure to use birth facilities or to utilize the services of volunteers is the result of traditional practices that might be changed using appropriate village levels consultations in concert with a BCC campaign. Critically, as a recent report by UNFPA/PATH points out, when the issue is being addressed through community consultations, these should focus not solely on women and their husbands, but should also incorporate on village leaders and elders[13]:

> "Given that men and older family members often make the decisions within the family, it is particularly important that educational activities target these groups".

[12] C. Fishman et al. 1988. "Warm Bodies, Cool Milk: Conflicts in Post Partum Food Choice for Indochinese Women in California," Social Science and Medicine. Vol. 26/11. pp. 1125 - 1132

[13] UNFPA/PATH. 2006. Rapid Maternal and Neonatal Health Care Needs Assessment in UNFPA Supported Provinces of Viet Nam (DRAFT). UNFPA: Hanoi. p.89.

Possibly the best way to begin would be to develop a pilot study among a Hmong group in one commune in Ha Giang, and following success to then extend this to other districts. In the case of women who elect to carry out delivery at a public health facility, it might be appropriate to incorporate their husband in the delivery routine at public health facilities, massaging their wife's stomach and so on - an appropriate modification of the normal cultural practice - in order that they retain some of their traditional role in the delivery process. Also, following the birth, it might also be possible to give the placenta to the husband so that he can take it back to the family house and carry out necessary traditional rituals. When this issue was raised during informants with villagers they indicated that this might well be possible, but that it was an issue that needed further discussion.

Critically, in respect to how the barriers to an increased level of safe motherhood amongst ethnic minorities might be removed, it must be remembered that cultural practices belong in a network or cluster, and that they do no exist in isolation. If these issues are addressed effectively, and a higher percentage of ethnic minority women begin to get pre-natal care and safe delivery (in their homes with assistance of trained health workers or in public health facilities) then, due to the increased level of contact with these women, there will be an increased opportunity to carry out important educational activities in regard to issues such as tetanus vaccination and regarding recognition of post-partum danger signs.

Summary

- The fact that in some ethnic minority areas RH facilities are almost unused and trained providers are under-employed is an extraordinary waste of resources.
- When cultural factors are drawn on to explain the actions of particular ethnic minority groups we need to be sure we fully understand the situation and that we do not attempt to explain complex situations through reducing them to simple mono-causal factors
- Low rates of ethnic minorities taking advantage of prenatal care and making use of public delivery facilities are not due to a reluctance to allowing intervention by males or to any form of blanket rejection of the RH facilities
- Many ethnic minorities do not utilize delivery facilities due to a combination of complex rituals surrounding births that are more easily performed at home, in concert with practical issues such as a reluctance to travel long distance during the last stage of pregnancy
- Efforts should be directed to dialogue with ethnic minority leaders, elders and villagers in general, in order to facilitate an accommodation between the safe delivery births offered at CHCs and the barriers that are currently preventing these taking place

HIV/AIDS

Over the course of the project people's knowledge about HIV increased considerably, in respect to knowledge about HIV transmission routes, prevention strategies, and the impossibility of recognizing persons infected with HIV. As Table 5 (below) demonstrates there is now an extremely high level of recognition of the disease over the entire population, and the level of recognition has increased during the course of the project.

Table 5: Percentage of people having heard of HIV/AIDS (%)

Answer	Women		Men		Adolescents						Mean	
					Male		Female		Mean			
	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005
n	2,310	2,305	2,305	2,303	998	997	1,306	1,310	2,304	2,307	6,919	6,915
Yes	94.4	95.0	97.2	97.8	95.9	96.3	96.3	97.3	96.1	96.9	95.9	96.6
No	5.6	5.0	2.8	2.2	4.1	3.7	3.7	2.7	3.9	3.1	4.1	3.4

Source: End-Line Survey Report: Provision and Utilization of Reproductive Health Care Services in 11 UNFPA-Supported Provinces in the 6th Country Programme. UNFPA 2006. p. 984.

Table 6: Average number of right HIV/AIDS transmission routes known by interviewees (among 5 right transmission routes)

Provinces	Women		Men		Adolescents						Mean	
					Male		Female		Mean			
	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005
Binh Duong	4.6	4.7	4.6	4.9	4.7	4.6	4.8	4.6	4.8	4.6	4.7	4.7
Tien Giang	4.7	4.7	4.7	4.6	4.5	4.6	4.5	4.8	4.5	4.7	4.6	4.7
Quang Nam	4.6	4.6	4.0	4.6	4.4	4.6	4.7	4.7	4.6	4.7	4.4	4.6
Phu Tho	4.4	4.5	4.7	4.3	4.4	4.6	4.5	4.6	4.4	4.6	4.5	4.5
Yen Bai	4.5	4.4	4.6	4.3	4.7	4.6	4.9	4.7	4.8	4.7	4.6	4.5
Thai Binh	5.0	4.7	4.4	4.4	4.9	4.6	4.9	4.5	4.9	4.6	4.8	4.5
Da Nang	4.9	4.7	4.7	3.5	4.9	4.8	5.0	4.8	4.9	4.8	4.9	4.4
Khanh Hoa	3.9	4.2	4.0	4.7	4.5	4	4.4	4.6	4.5	4.4	4.1	4.4
Hoa Binh	4.3	4.2	4.5	4.2	4.8	3.9	4.7	3.9	4.7	3.9	4.5	4.1
Binh Phuoc	4.1	3.4	4.3	4	4.3	4.4	4.4	4.5	4.4	4.5	4.3	4.0
Ha Giang	2.4	2.3	3.3	2.5	2.8	3.2	3.0	3.2	2.9	3.2	2.9	2.7
Mean	4.3	4.2	4.4	4.2	4.4	4.4	4.5	4.5	4.5	4.4	4.4	4.3

Source: End-Line Survey Report: Provision and Utilization of Reproductive Health Care Services in 11 UNFPA-Supported Provinces in the 6th Country Programme. UNFPA 2006. p. 99.

However, it is suggested that in order to remove a potential future barrier to successful BCC activities on HIV/AIDS, it would be useful to investigate how villagers conceive HIV as a disease that is (or, most likely, is not) believed to be qualitatively different from other STIs and RTIs with which they may be familiar. The experience elsewhere with HIV is that during the early period of the epidemic, such as Viet Nam is now experiencing, that populations typically understand HIV as yet another form of STI and as such fail to appreciate the extent to which it differs from these[14]. If this is the case here, this "old" understanding constitutes a significant barrier to effective BCC activities on HIV/AIDS.

[14] G. Fordham. 2004. A New Look at Thai AIDS: Perspectives From the Margin. Berghahn: Oxford and New York.

In respect to knowledge about HIV transmission routes, as Table 6 (below) demonstrates, with the exception of Ha Giang, there is generally a high level of knowledge in this area. In Ha Giang responses to both the baseline and endline surveys indicate that people in this province have only a limited knowledge of HIV transmission routes, with respondents able to provide only 2.7 out of a possible 5 transmission routes. However, by contrast with a generally good knowledge of HIV transmission routes, knowledge of HIV prevention methods is much lower in all provinces with, out of seven possible prevention methods, the highest number of ways of prevention being found in Thai Binh (3.5 - 4.3 ways) and the lowest number being found in Ha Giang (1.2 - 1.6 ways).

The most common way of avoiding HIV was given as avoiding sex with multiple partners (70.1%), with a much lower percentage of respondents giving the avoiding of sharing needles (57.1%) and no drug injection (57.9%). The use of a condom when having sex was mentioned as a means of avoiding contracting HIV by 53.7% of respondents.

When interviewed RH health care providers claimed that villagers in their commune now know about HIV, but that their knowledge was not really "good". Importantly, they emphasized that in most cases knowledge about HIV and about the real risk that HIV represents are highly abstract issues, as HIV is very new and as the threat of HIV seems very remote from most people's lives. As one CHC provider put it:

> "There is a very low level of knowledge about how dangerous AIDS is and the people do not know enough about ways to protect themselves from infection, and that this is because AIDS is a new disease"

Perhaps the real limit to knowledge about HIV/AIDS of both villagers (and RH care providers) is their failure to appreciate just how much of a potential risk HIV poses in their district. The researchers heard both RH care providers and villagers comment that:

> "There's no AIDS here", or "there's no risk here men just sleep with their wives", "people here know about condoms for protection", "there is no injecting drug use here" or "there is no problem here as we know who all the injecting drug users are".

In one case when the question of sexually transmitted HIV was raised, a CHC provider (Hoa Binh province) noted, "there is no problem here as there are no prostitutes in the commune".

Another important aspect of HIV/AIDS knowledge that improved somewhat during the course of the project was that by comparison with the baseline survey, by 2005 a lower percentage of persons (19.9% down from 27.4%) believe that that they can identify people who are living with HIV/AIDS by appearance or lifestyle. However, that a significant minority of respondents still believe that they can identify people infected with AIDS in this manner is a significant barrier to HIV/AIDS safety and should be addressed.

The scholarly literature on Viet Nam's HIV/AIDS epidemic suggests that factors such as easy cross-border mobility and intra-provincial transport, a large number of migrant workers and a sex industry where drug use is combined with the sale of commercial sex means that the current "window" stage of Viet Nam's AIDS epidemic will likely not continue indefinitely. Unfortunately these factors suggest that there is great potential for the transformation of the epidemic to spread from high-risk populations such as injecting drug users and prostitutes to the general population[15]. The AIDS literature from Thailand and elsewhere also suggests that it is highly likely that this progression will take place, the question being not if, but rather when, the transition comes about. Thus, it is suggested that both villagers and RH providers need a higher level of awareness of the potential risk that HIV presents in their communities, and so that they do not view HIV as being solely a threat to drug addicts and prostitutes.

Summary

- Villagers and RH providers alike need a higher level of knowledge about the very real risk of HIV/AIDS
- We need to know exactly how people understand HIV/AIDS as a qualitatively different disease from RTIs and STIs
- Yet more work is needed to correct the misunderstanding that you can tell may have HIV/AIDS by lifestyle or appearance
- More BCC work is needed to make all people appreciate the fact that HIV/AIDS is not just a disease of drug users and prostitutes, that it concerns everybody

Rights, Gender Equality and Domestic Violence

Issues of client rights, gender equality and preliminary attempts to address domestic violence formed part of BCC training of health staff and members of collaborating organizations. Notably, these activities received were much less emphasized than contraception and safe motherhood. A 2004 report by the UNFPA/National Economics University Population Center notes that, subsequent to training, the most common communication topics addressed by providers were contraceptive methods (60%) and safe motherhood (50%), while gender equality and domestic violence prevention were only 30% and 10% respectively. Worryingly, the report notes that although domestic violence was observed in all provinces and although over one third of service providers had dealt with clients who had suffered domestic violence, almost half (43%) of VHWs/pop workers did not view domestic violence prevention as their task[16].

---

[15] Trung Nam Tran, Detels, R., and Hoang Phuong Lan. 2006. "Condom Use and its Correlates Among Female Sex Workers in Hanoi, Vietnam," Aids and Behaviour. Vol. 10/2. pp. 159 - 167; Trung Nam Tran et al. 2005. "Drug Use Among Female Sex Workers in Hanoi, Vietnam," Addiction. Vol. 100. pp. 619 - 625; Khuat Thu Hong. 2003. Adolescent Reproductive Health in Vietnam: Status, Policies, Programs, and Issues. Policy Project: Hanoi.

[16] UNFPA and National Economics University Population Centre. 2004. Key Findings and Recommendations: Monitoring of Training Activities in 11 UNFPA-Supported Provinces, CP6, 2004. Hanoi: NEUPC. p. 30

In addition to the limited focus on these areas factors such as the newness of these concepts for both providers and for the general population, the difficulties VHWs/Pop workers found with the implementation of effective BCC campaigns, and also due to the limited time for the intervention, outcomes in this area were not very particularly high. In respect to client rights issues, for example, there have been some successes, however, these have been fairly narrowly defined. As indicated above a focus on reproductive rights have given women the possibility of choice of contraceptive methods and the right to change method if they wish. Similarly posters listing client rights have been put on display in most CHCs, yet always in the Vietnamese language even in provinces where a high percentage of clients are ethnic minorities with a low level of literacy in Vietnamese. So they are inaccessible to a large percentage of their target audience.

In respect to gender equality, the field research addressed these issues during interviews with both providers and villagers, and found that BCC campaigns had produced some real changes in the gender equality area. However, here again the results were in a fairly narrow area. Thus, in the RH area men in all districts have been counseled regarding the need to share the responsibility for contraception. Also, in Phu Minh commune of Hoa Binh coordinators and volunteers pointed out that amongst the Muong ethnic minority group campaigns for gender equality had had some impact as, contrary to practice in the past, men and women now ate together and women are now accepted as having an equal right (alongside their husband) to greet guests to their house. It is suggested that the main barrier to more effective BCC work in these areas in that the issues are understood in only the most narrow sense and, as a result, more effective outcomes will not be gained until workers at all levels have a broader understanding.

However, in regard to domestic violence the research suggests that campaigns against domestic violence have not progressed particularly far beyond some consciousness raising and giving a name to a behaviour that is all too common[17]. Interviews at commune level in Hoa Binh suggested that women suffering from domestic violence sometimes visit the CHC for medical care. However, the sense of the researcher was that VHWs/pop collaborators saw their role in relation to domestic violence as being "reactive" and ameliorative, offering medical care and counseling the female party.

Evidence suggests that direct intervention in situations of domestic violence is not common and referral to police or other local authorities occurs only in the most extreme ongoing cases. Discussions with providers suggested that domestic violence counseling is limited to encouraging victims to adjust to the situation by avoiding violent contexts rather than reinforcing their right to live without fear or violence.

---

[17] J. Bourk-Martignoni. nd. Violence Against Women in Vietnam: Report Prepared for the Committee on the Elimination of Discrimination Against Women. OMCT: Geneva; H. Rydstrom. 2003. "Encountering 'Hot' Anger: Domestic Violence in Contemporary Vietnam. Violence Against Women. Vol. 9/6.pp. 676 - 697; Le Thi. 2006. Single Women in Vietnam. Hanoi: The Gioi Publishers.

Overall, in all these three areas, perhaps the best assessment of the situation is made in a recent Viet Nam Commission for Population, Family and Children project report which notes regarding the results of programmes in the RHC/FP areas, that[18]:

> "The awareness, attitudes and behaviors related to RHC/FP and gender equality are still limited, especially among male group [sic] and in remote, isolated and ethnic minorities areas where people's knowledge is low and backward customs and practices persist".

There is substantial work that is required to be undertaken in all these areas. It is suggested that, as pointed out in the reports on lessons learned from training interventions in the health sector, in respect to barriers to the successful conduct of BCC activities, the focus of training in these areas should ensue not just knowledge of facts but on understanding, and that BCC activities should emphasize not solely the need for client rights and gender equality, and for a reduction in domestic violence, but that more focus be given to discussing practical mechanisms by which these goals might be achieved.

In relation to the specific area of domestic violence there is almost always a relationship between alcohol consumption and domestic violence[19]. Several UNFPA reports dealing with CP6 issues have made brief mention of high levels of alcohol consumption amongst various social groups, particularly amongst some ethnic minorities. However, there is very little substantive data in this area. It is suggested that future work on gender-based violence will require the conduct of high quality quantitative and qualitative research in order to understand more about drinking patterns, about how alcohol consumption related to the totality of cultures, and about how patterns of drinking are currently being transformed by the many economic and social changes currently being experienced in Viet Nam. It is only through understanding the situation clearly that BCC campaigns can be directed to this issue as one of the most important root causes of gender-based violence.

Summary

- Issues of rights and gender equality are understood in the narrowest senses and as a result outcomes have been restricted to a narrow sphere. Efforts should be made during training to broaden understanding of these issues
- BCC campaigns against domestic violence have been only minimally effective and almost half VHWs/Pop workers do not view addressing this issue as an important part of their role. This fact must be redressed through continued training
- To the extent that service providers address with domestic violence their role is restricted to giving medical aid and counseling - reactive rather than proactive. It is suggested that they should be encouraged to adopt a more proactive approach

---

[18] Vietnam Commission for Population, Family and Children. 2006. Final Project Report VIE/01/P12. VCPFC: Hanoi.

[19] G. Fordham. 2005. "Wise" Before Their Time: Young People, Gender-Based Violence and Pornography in Kandal Stung District. Phnom Penh: World Vision Cambodia.

- It is suggested that alcohol plays a role in the instigation of domestic violence and that research will be needed to understand how this issue can be best addressed

Media for the Conduct of BCC Activities

As many UNFPA and other reports have already pointed out, Viet Nam's many ethnic minorities and their general low level of literacy both in their own language and in Vietnamese raises a major problem for the development of suitable IEC/BCC materials. Importantly, although much BCC work in Viet Nam has often relied on "single channel" media for these activities, mass media, print materials, face-to-face and so on. However, best practice in this area utilizes (mutually reinforcing) multiple channels for interventions, for example, a combination of face-to-face and flip charts in concert with electronic media to achieve much higher outcomes than single channel interventions[20].

Steps toward addressing the lack of IEC materials for Viet Nam's ethnic minority groups include the development of some IEC materials using the ethnic minority language, as well as posters and other pamphlets where the portraits are of the relevant ethnic minority group. In some districts (such as Xin Man district) where there is a low level of television ownership and where access to electricity is limited, and where a high percentage of the population are not fluent in Vietnamese, BCC presentations in the local language have made on weekly market days and cassette tape BCC materials recorded in the local language have been supplied to Commune Health Centers. However, there are often equipment barriers to these activities as, in the Pa Vay Su commune, for example, where the research found that the BCC tapes with which the CHC had been supplied were not able to be used as the cassette tape recorders to play them had not yet been procured.

Village BCC Activities

The proposal to produce audio IEC/BCC media in local languages for extension of RH services to ethnic minority groups is commendable. However, two points regarding the use of current technology should be considered. First, cassette tapes and cassette players now fall into the category of outdated technology and cassette players, dependent on battery power, often become unusable due to the short life of batteries and lack of regular supplies. Second, both the cassettes and players are relatively fragile and typically break down, in remote and mountainous areas when exposed to intense exposure to dust and moisture.

The use of small solid-state devices such as MP3 players for transmission of IEC/BCC messages to remote ethnic minority groups should be investigated. If played through miniature amplifiers these devices produce adequate volume to address groups. The MP3 player also has practical advantages. It is relatively cheap to purchase, has very low power

[20] G. Laverack et al. 2003. "Transforming Information, Education and Communication in Vietnam," Health Education. Vol. 103/6. pp. 366.

Photo by Doan Bao Chau

requirements and greater input/output capacity than cassette tapes. Further, the MP3 is lightweight, easily transportable, and is not susceptible to climate variations. These factors would benefit communities in remote and mountainous districts where RH communicators and volunteers must walk considerable distances to visit client groups. The message content can be updated more easily and efficiently than cassette tapes. A trial of these devices should be implemented in a remote region such as Ha Giang, and assessed for ease of use, general effectiveness and ability to withstand climate conditions.

BCC and Utilization of the Electronic Media

Communicators and village volunteers pointed out that during CP6 electronic media applied in conjunction with the print media for dissemination of Pop/RH information, made their job easier. Interviewees reported greater awareness of key RH issues that has made it easier for them to engage in discussion at public venues[21]. In remote areas such as Ha Giang where access to television is limited either through poverty or lack of electricity, market days provided an opportunity for the dissemination of RH messages using pre-recorded tapes or videocassettes.

While conducting field research in Hoa Binh province the research team was fortunate in that the Hoa Binh provincial programme office had invited the manager of the provincial television station, to participate in a meeting between the

[21] Ministry of Health. 2006.Project Progress Report 2005 and End-Project Report of VIE/01/P10 2002 - 2005. Ministry of Health: Hanoi.

researchers and provincial level administrators. As a result of this initial meeting the researcher organized a subsequent meeting at the provincial television station to pursue areas of interest. At this meeting the research team were told about the effect of Viet Nam's many mountainous provinces on television broadcasting. Due to the mountainous topography of many provinces the television broadcast network must use many repeaters in order to ensure coverage, each repeater covering only a narrow geographical "footprint". This is a different situation to many other countries where the topography is flatter, and where as a result the transmission of television signals from each transmission tower covers a relatively wide footprint.

The situation for television broadcasting in Viet Nam, is the one that lends itself to "narrow casting", a process that involves directing selected media messages to specific segments of the public defined by values, preferences, or demographic or other attributes (such as ethnic group membership). Audience segmentation allows campaigns to both avoid the presentation of inappropriate message content, and to avoid the exclusion of specific important target groups[22]. It is a context that might well be used by UNFPA, the Ministry of Health and other collaborating agencies to both carry out and to improve Pop/RH BCC activities. The situation is ideal, given the particular situation of Viet Nam with many ethnic groups with distinct cultures, which likely require a combination of generic and specifically tailored messages. Narrow casting allows not only the tailoring of messages to ethnic minorities living in specific districts. More importantly, as it is possible to transmit, for example, a BCC message only to one relatively tightly defined district it also provides an ideal opportunity for the conduct of fine-grained research, regarding the BCC messages that are most effective with particular ethnic groups.

Such narrow casting would also lend itself to local regional minority groups being involved in the production of BCC materials, about HIV/AIDS, for example, directed to their own communities. To some extent this is being done already with Hmong language programmes being produced for Hmong communities. However, this context is one that has much more potential than is currently being utilized - both in terms an extension of BCC media to focus on other ethnic groups, and in terms of the research possibilities it offers.

Production of BCC Materials for Electronic Media

An important issue in regard to the production of BCC materials for the use amongst ethnic minorities in remote areas is the cost of production. Discussions with RH communicators and volunteers yielded the suggestion that real "on the ground" issues might be addressed very effectively by using lightly edited video taped "real life" training sessions. In remote provinces such as Ha Giang, for example, recordings might be made of volunteers having discussions with small groups of village women in their own languages, and then these might later be used as a resource for the initiation of similar discussions in other communes/villages.

---

[22] G. Laverack et al. 2003. "Transforming Information, Education and Communication in Vietnam," Health Education. Vol. 103/6. pp. 364.

Summary

- More minority language audio BCC materials need to be produced - and efforts must be directed towards ensuing that the equipment to play media is provided alongside the media
- By now electromechanical technologies such as cassette tapes for BCC activities are an outdated and high maintenance/short life technology by comparison with new solid-state technologies that offer many advantages in remote and mountainous provinces. A pilot study of the use of these technologies is recommended
- The technological organization of Viet Nam's television broadcasting system offers the ability to do "narrow casting" to address tightly defined target groups. The use of this facility should be investigated with a view to narrow casting so specific minority ethnic groups. Importantly this facility offers the ability to research and do small scale testing of various BCC messages

Conclusion

This report on the client side lessons learned of CP6 has been based on qualitative research designed to compliment and extend existing quantitative research and reporting through the addition of socio-cultural data to allow a more detailed and more comprehensive analysis of programme results. The report confirms the measurable impact of achievements during CP6, particularly the quality of RH care provided in Viet Nam. Through identification of some barriers to programme effectiveness among ethnic minority communities the report has been able to suggest programme activities that could achieve higher level of outputs.

In conclusion, UNFPA's Country Programmes have moved the focus on population activities in Viet Nam from fertility reduction to quality of life and reproductive health. As this focus gains strength and issues such as adolescent reproductive health, gender equality, client rights and domestic violence attain a greater prominence in programme activities, the data necessary for analyzing and transforming social processes will increasing be beyond the scope of that which can be provided by quantitative research alone. It is hoped that this report will serve as a demonstration of how qualitative research might be integrated with quantitative research in all areas of programme work in order to provide a higher level of understanding about how programme activities might be implemented with a yet higher degree of success.

Bibliography

Belanger. D. 2006. "Indispensable Sons: Negotiating Reproductive Desires in Rural Vietnam," Gender, Place and Culture. Vol. 13/3. pp. 251 - 265.

Belanger, D. and Khuat Thu Hong. 1999. "Single Women's Experiences of Sexual Relationships and Abortion in Hanoi, Vietnam," Reproductive Health Matters. Vol. 7/14. pp. 71 - 82

UNFPA/PATH. 2006. Rapid Maternal and Neonatal Health Care Needs Assessment in UNFPA Supported Provinces of Viet Nam (DRAFT). UNFPA: Hanoi

Bourk-Martignoni, J. nd. Violence Against Women in Vietnam: Report Prepared for the Committee on the Elimination of Discrimination Against Women. OMCT: Geneva

Fishman, C., Evans, R. and Jenks, E. 1988. "Warm Bodies, Cool Milk: Conflicts in Post Partum Food Choice for Indochinese Women in California," Social Science and Medicine. Vol. 26/11. pp. 1125 - 1132.

Fordham. G. 2004. A New Look at Thai AIDS: Perspectives From the Margin. Berghahn: Oxford and New York

Fordham, G. 2005. "Wise" Before Their Time: Young People, Gender-Based Violence and Pornography in Kandal Stung District. Phnom Penh: World Vision Cambodia.

Gammeltoft, T. 2002. "Seeking Trust and Transcendence: Sexual Risk-Taking Among Vietnamese Youth," Social Science and Medicine. Vol. 55. pp. 483 - 496

Gladwell, M. 2000. The Tipping Point: How Little Things Can Make a Big Difference. London: Abacus.

Ibrahim, J.E. 2001. Phenomenon of Quality and Health-Care: Snowball or an Avalanche?". Journal of Quality in Clinical Practice. Vol. 21. pp. 40-42.

Kane, T.T., Middleton, J. and Shapiro, K. 2000. Strategic Appraisal of the Reproductive Health Programme of Vietnam. Hanoi: Pathfinder International.

Laverack, G. and Dao Huy Dap. 2003. "Transforming Information, Education and Communication in Vietnam," Health Education. Vo. 103/6. pp. 363 - 369.

Le Thi. 2006. Single Women in Vietnam. Hanoi: The Gioi Publishers.

Pranee Liamputtong. 1999. "Infant Feeding Practices: The Case of Hmong Women in Australia," Health

Care for Women International. Vol. 23, pp. 33 - 48.

Pranee Liamputtong. 2002. "Infant Weaning Practices Among Hmong Women in Melbourne," Australian Journal of Primary Health - Interchange. Vol. 5/2, pp. 27 - 37.

Rosenthal.R. 1986. "Media Violence, Antisocial Behaviour, and the Social Consequences of Small Effects," Journal of Social Issues. Vol. 42/3.pp. 141 - 154.

Rydstrom, H. 2003. "Encountering 'Hot' Anger: Domestic Violence in Contemporary Vietnam. Violence Against Women. Vol. 9/6.pp. 676 - 697.

UNFPA. nd. United Nations Population Fund Sixth Programme of Assistance to the Socialist Republic of Viet Nam. UNFPA: Hanoi.

UNFPA. 2003. Baseline Survey Report: Provision and Utilization of Reproductive Health Scare Services in 12 UNFPA-Supported Provinces Viet Nam. UNFPA: Hanoi.

UNFPA. 2006. End-Line Survey Report: Actual Situation of the Provision and Utilization of Reproductive Health Care Services in Ha Giang Province. UNFPA: Hanoi.

UNFPA.2006. End-Line Survey Report: Actual Situation of the Provision and Utilization of Reproductive Health Care Services in Hoa Binh Province. UNFPA: Hanoi.

UNFPA. 2006. End-Line Survey Report: Provision and Utilization of Reproductive Health Care Services in 11 UNFPA-Supported Provinces in the 6th Country Programme. UNFPA: Hanoi.

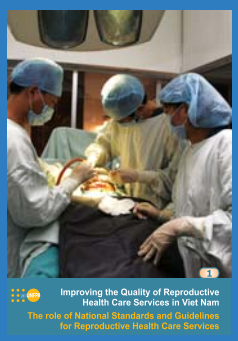
UNFPA. 2006. Final Report: The Sixth Country Programme of Cooperation Viet Nam and the United Nations Population Fund (2001 - 2005). UNFPA: Hanoi.

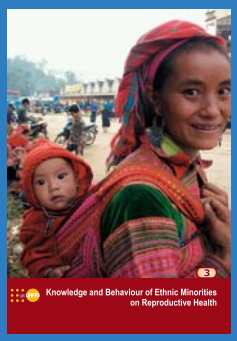
UNFPA and National Economics University Population Center. 2004 Key Findings and Recommendations (monitoring of Training Activities in 11 UNFPA-Supported Provinces, CP6, 2004). Hanoi: 2004.

Vietnam Commission for Population, Family and Children. 2006. Final Project Report VIE/01/P12. VCPFC: Hanoi.

World Health Organization. 1994. The Development and Dissemination of Life Skills Education: An Overview. Geneva: WHO.

IN 2007 UNFPA PUBLICATIONS ON BEST PRACTICES AND LESSONS LEARNED INCLUDE THE FOLLOWING REPORTS





UNFPA

1st Floor, UN Apartment Building
2E Van Phuc Compound
Ba Dinh District, Ha Noi, Viet Nam
Tel: +84 4 823 6632
Fax: +84 4 823 2822
Website: http://vietnam.unfpa.org
Email: unfpa-fo@unfpa.org.vn