ADVOCACY BRIEF

ANTENATAL CARE IN VIET NAM

PURPOSE

The purpose of this advocacy brief is to raise public awareness and political commitment of stakeholders to improve maternal health in Viet Nam, contributing to the Government's efforts to enhance universal access to sexual reproductive health (SRH) and speed up progress towards achieving the targets of International Conference on Population and Development (ICPD) and the Millennium Development Goals, with an emphasis on MDG 5.

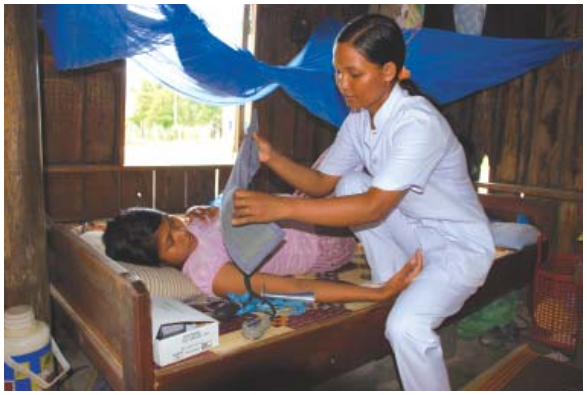
KEY MESSAGES:

- The national coverage of antenatal care (ANC) for pregnant women in Viet Nam has been steadily increasing. However, disparities in coverage persist between regions and groups.
- There is a need to develop and implement appropriate policies to reduce disparities in access to and quality of ANC in remote and disadvantaged areas;
- There is a need to improve the quality of ANC, especially in the Northern Midlands and Mountains and Central Highlands, targeting rural women, ethnic minority women, poor women, and women with lower education;
- There is a need to improve the health information system, including adoption of the 4 ANC visits indicator for international comparison, and to improve health financing and management structures.

INTRODUCTION

1. Significant disparities in access to antenatal care among different regions and groups

Coverage of antenatal care (ANC), a Millennium Development Goal (MDG) indicator, in Viet Nam, shows that approximately 93% of women received at least one ANC check-up during their last pregnancy [1, 2]. While this is a promising outcome, the World Health Organization (WHO) recommends four ANC visits during pregnancy to ensure all benefits are available to women and their unborn babies[3]. In Viet Nam about 79% of pregnant women received at least three ANC check-ups during the three trimesters[2] and only 59.6%, four ANC visits [1].



Regional disparities occur in the proportion of women receiving ANC. In the Red River Delta and Southeast regions 99% of women received ANC services, compared with 82.8% living in the Northern Midlands and Mountains regions [1]. The highest proportion of women receiving ANC three or more times during pregnancy was also found in the Red River Delta and Southeast regions, while the lowest levels were observed in the Northern Midlands and Mountains, and in the Central Highlands [1]. Chart 1 illustrates regional disparities in ANC access.

ANC utilization in Viet Nam is characterized by significant demographic and socio-economic disparities. In rural areas, there is a direct link between ethnic minority women, with low levels of education and income and their access to ANC. One in every four ethnic minority women has not received any ANC. Just half of the rural women observed had received at least four ANC checkups during their last pregnancy [1]. One-fifth

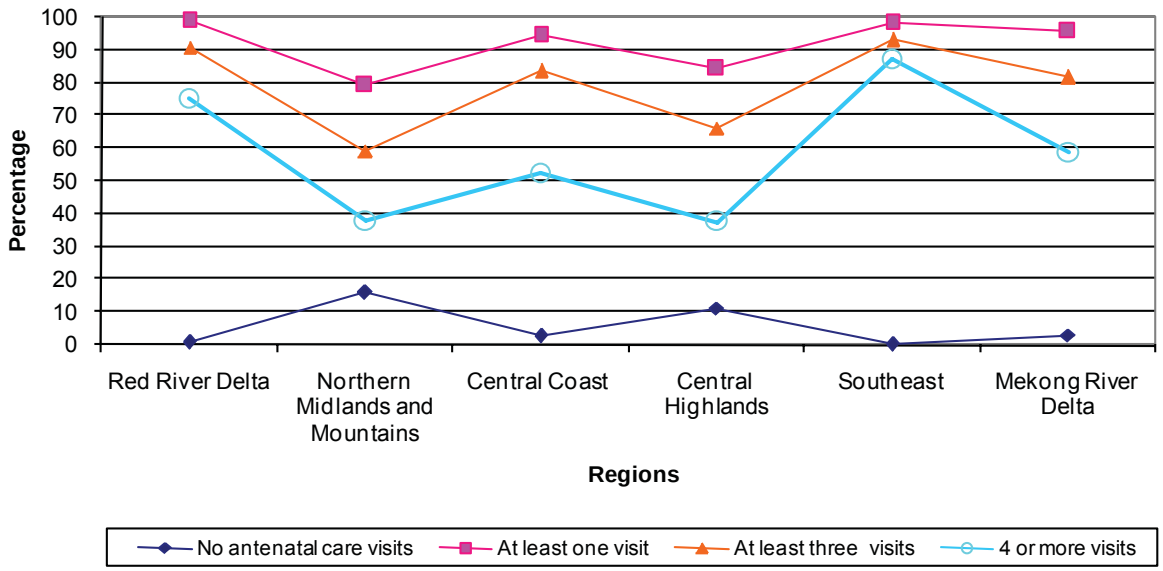


Chart 1: ANC by region (source: GSO, 2010)

of women living in the poorest households had not received any ANC, a rate that is substantially higher than for women in the middle income or richest households (less than one per cent). More than half of out-of-school women had not received any ANC, compared with less than six per cent of women with primary education or above [1].

2.Limited quality of antenatal care

The majority of women had not received the full package of standard ANC, as instructed by the Ministry of Health and stipulated in the National Guidelines for Reproductive Health Care Services in 2009 [4-6]. More than half of pregnant women had not undergone a blood test; between 20% and 35% of women had not undergone a urine test, blood pressure examination and/or full tetanus immunization. Only one in every four observed women had received comprehensive ANC [6].

Although no official data exists on the coverage of micro-nutrient supplementation for pregnant women, some studies indicate that iron-folic acid is unavailable to pregnant women in many areas. Such absence of coverage contributes towards the relatively high prevalence of anemia in the population, affecting about one-third of pregnant women [8]. Moreover, because iodized salt is no longer a subsidized commodity, Viet Nam has recently seen an increase in the percentage of pregnant women with iodine deficiency [9, 10].

ISSUES

1. Adverse effects on women's health

Levels of access to and utilization of ANC contribute to disparities identified among women giving birth under the care of trained health providers. In some ethnic minority regions, over 90% of deliveries occur at home of which 80% are not supported by a trained health provider [4]. Research indicates that limited access to ANC services is associated with pre-term labor, low birth weight and perinatal death [3, 18]. A study in the US reveals that peri-natal mortality is three times higher among women who did not received ANC and gave birth without a trained professional health provider in attendance, than for other women [19].

2. Factors that may contribute to unequal access to ANC and limited quality of care

Lack of demand and inaccessibility

Women do not have adequate knowledge about pregnancy, nutrition and health care [12-14]. A study among Vietnamese women shows that: 35.7% of women did not consider ANC necessary; 29.5% did not understand their need for ANC and; 17.6% felt too embarrassed to use these services [14].

Poverty, remote distances from health facilities and lack of transportation, clearly inhibit or prevent women from accessing ANC. Due to limited financial resources, many pregnant

women are unable to pay for ANC services [6, 10]. In addition, ethnic minority women often experience communication difficulties and lack understanding of the purpose of counseling services and health education on ANC [12].

Lack of facilities and equipment

Facilities and equipment for ANC are significantly limited at the grassroots level. Few commune health centres (CHCs) have adequate equipment to meet the 9 standards of ANC [12, 15]. For example, 97.9% of CHCs are unable to provide the full package of equipment for pregnancy examinations [11].

Inadequate quantity and limited competence of health workforce

There is a shortage of competent health care providers and the existing health professionals exhibit gaps in their knowledge and skills relating to safe motherhood and ANC. According to the Ministry of Health, many health providers are not recipients of post-graduate refresher training; in 20% of CHCs, staff members had received no training in safe motherhood during the past three years [11].

Gaps in the implementation of ANC policies and quality assurance

The Ministry of Health has developed and issued a number of regulations and guidelines in support of ANC. However, implementation of these policies is challenging due to a number of barriers such as inadequate resources, insufficient

quality of training, low capacity of health providers, and limited oversight and enforcement [12]. In addition, training in monitoring and supervision of private health sector staff is limited, thus also affecting the quality of ANC service delivery [12].

Gaps in the health information system

In the health information system, the MOH has not yet updated the ANC coverage indicator as recommended internationally, to stipulate at least four ANC visits instead of three as part of the routine monitoring system. Indicators for measuring the quality of ANC continue to be inadequate in the health information and reporting system. WHO-recommended indicators, such as the percentage of women with a birth plan at the 37th week of pregnancy, and the level of satisfaction with ANC services, [3] are not yet available.

CALL FOR ACTION

The Ministry of Health can coordinate with line ministries and provinces to:

1. Increase the demand for ANC and reduce inequality in services

- Develop and implement policies to support maternal health providers, especially skilled birth attendants and village midwives of ethnic minority origin, to ensure adequate and competent human resources for ANC in remote and mountainous areas.
- Develop relevant, cost-effective demonstration models, to improve access to ANC for pregnant women in the most disadvantaged areas.
- Strengthen the communication program to increase demand for ANC among pregnant women, with special focus on community-based activities that reach disadvantaged groups such as the ethnic minorities.

2. Improve the quality of antenatal care

- Strengthen human resources for maternal health care, both in coverage and competence, by training health providers in competency-based approach to safe motherhood, ANC and counseling, in compliance with the national strategy for reproductive health.

- Integrate concepts of gender and ethnic sensitivity, and sexual and reproductive health rights into training courses for health workers, to alter perceptions and raise awareness in providing services to women, especially vulnerable women.
- Provide nutritional education, and iron and folic acid supplements, in the intervention packages for pre-pregnant and pregnant women.

3. Enhance the management of ANC, improve the health information system and mobilize financial support

- Strengthen monitoring quality of ANC services, especially in remote and mountainous areas, and apply supportive supervisory techniques for service delivery and in-service training, to improve the service quality.
- Strengthen the health information and reporting system, ensuring it is regularly updated and includes adoption of the 4 ANC visits indicator and relevant data from the private sector.
- Implement social and operational research, to redress limitations in the quality of health care and to improve understanding of the cultural, social, economic and structural barriers preventing women from utilizing ANC services.

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UNFPA Viet Nam

Tenancy A1, Golden Westlake Executive Residences, 151 Thuy Khue Street, Tay Ho District, Ha Noi

Tel: +84 - 4 - 3.823.6632 | Fax: +84 - 4 - 3.823.2822 | Email: unfpa-fo@unfpa.org.vn | Web: http://vietnam.unfpa.org