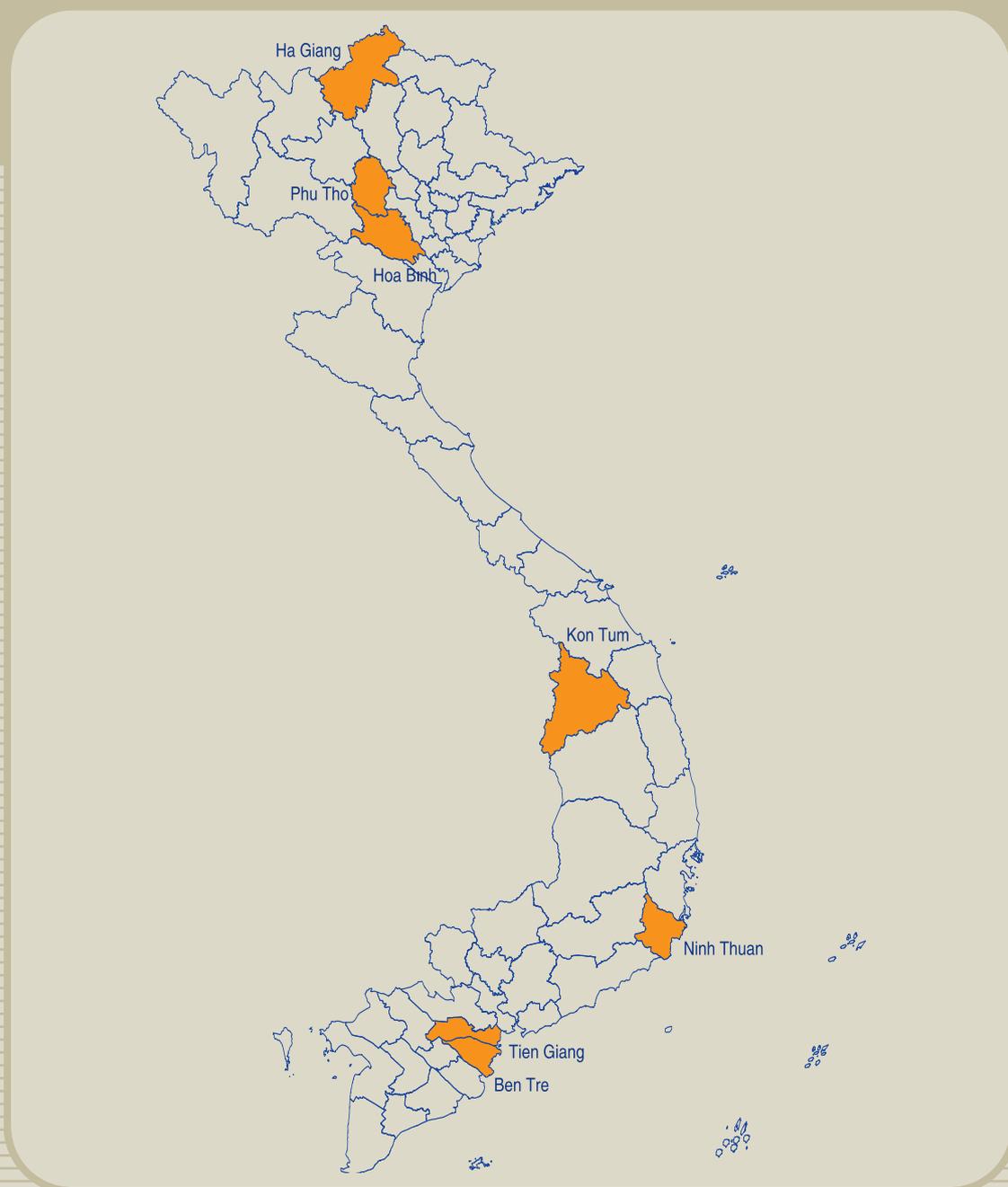


# BASELINE SURVEY REPORT

## PROVISION AND UTILISATION OF REPRODUCTIVE HEALTH CARE SERVICES IN SEVEN UNFPA-SUPPORTED PROVINCES IN THE 7<sup>TH</sup> COUNTRY PROGRAMME



**B A S E L I N E   S U R V E Y   R E P O R T**

**PROVISION AND UTILISATION OF  
REPRODUCTIVE HEALTH CARE SERVICES  
IN SEVEN UNFPA-SUPPORTED PROVINCES  
IN THE 7<sup>TH</sup> COUNTRY PROGRAMME**

**HA NOI - 2006**

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## PREFACE

**T**he 7<sup>th</sup> Country Programme of cooperation between the Government of Viet Nam and the United Nations Population Fund (UNFPA) was approved for the period 2006-2010. Since implementation in June 2006, the goal of the programme has been to contribute to improving the quality of life of the Vietnamese people through (i) improved quality of and access to reproductive health services and (ii) improved implementation of policies and programmes related to population and gender mainstreaming.

The programme provides support to seven provinces: Ha Giang, Phu Tho, Hoa Binh, Kon Tum, Ninh Thuan, Tien Giang and Ben Tre. To ensure the programme's support is most beneficial to and effective for recipient provinces, a baseline survey on the provision and utilisation of reproductive health services was undertaken by the Ministry of Health and UNFPA prior to the actual start, from the end of 2005 to the beginning of 2006, through a sub-contract with the Research Centre for Rural Population and Health of the Thai Binh Medical College. Targeting the audience at provincial, district and communal levels, the survey covered 252 health facilities, 2,583 reproductive health care and population staff, 1,456 married women aged 15-49 with children under 24 months of age, 1,456 men with wives aged 15-49 having children under 24 months and 1,464 unmarried adolescent women aged 15-19 in surveyed provinces.

This survey report provides valuable information on the provision and quality of reproductive health services in light of the National Standards and Guidelines for Reproductive Health Care Services. It also gives readers insight into the level of community knowledge and practice in reproductive health services. In addition, the report describes the planning, monitoring and evaluation process undertaken by UNFPA and concerned organisations for the Country Programme. It will serve as a solid reference at the end of the programme in 2010 when an end-line survey will be initiated to measure the impact.

I would like to thank the research team of the Research Centre for Rural Population and Health of the Thai Binh Medical College, the Ministry of Health and the seven provinces for making this valuable report a reality. I would also like to thank all the women and men and all the health and population staff who actively participated in and contributed to this survey.

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*The survey on “Provision and Utilisation of RH Care Services in Seven UNFPA-supported Provinces in the 7<sup>th</sup> Country Programme” was completed successfully and on schedule. First of all, we would like to express our sincere thanks to the United Nations Population Fund (UNFPA) and the Project VIE/01/P10 for their highly effective technical and financial support in this survey.*

*We would also like to thank MOH for their monitoring, supervision and support throughout the survey. We are grateful to several local organisations in Phu Tho, Ha Giang, Hoa Binh, Ninh Thuan, Kon Tum, Ben Tre and Tien Giang for their strong support and cooperation with the investigators during data collection at the field sites.*

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ASSOC. PROF. DR. **Trinh Huu Vach**  
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RURAL POPULATION AND HEALTH

## ABBREVIATIONS

CHC	Commune/Precinct Health Centre
DHC	District Health Centre
EOC	Essential Obstetric Care
Exam.	Examination
FP	Family Planning
Gyn.	Gynaecology
HF	Health Facility
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
IEC	Information – Education – Communication
MCH	Maternal and Child Health
MOH	Ministry of Health
MR	Menstrual Regulation
MVA	Manual Vacuum Aspirato
NS	National Standards
PGH	Provincial General Hospital
CPFC	Committee for Population, Family and Children
SP	Service providers
SU	Service user
OB	Obstetric
Ped.	Paediatric
Prov.	Province
RCRPH	Research Centre for Rural Population and Health
RH	Reproductive Health
RTIs	Reproductive Tract Infections
STDs	Sexually Transmitted Disease
UNFPA	United Nations Population Fund
WHO	World Health Organisation

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# SUMMARY

The cross-sectional survey, “Provision and Utilisation of RH Care Services in Seven UNFPA-supported Provinces in the 7<sup>th</sup> Country Programme”, was conducted from November 2005 to February 2006. Among the seven surveyed provinces, four were selected from the 6<sup>th</sup> country programme (Ha Giang, Phu Tho, Hoa Binh, and Tien Giang) and three were newly selected for the 7<sup>th</sup> country programme (Ninh Thuan, Kon Tum, and Ben Tre). The survey mainly aimed to assess the current status of the provision and utilisation of reproductive health (RH) care services in seven provinces and identify indicators to support monitoring and supervision of the project implementation in the 7<sup>th</sup> country programme, which can serve as a basis for the project impact evaluation to be conducted at the end.

The survey assessed health facilities, service providers (SPs), RH programme staff and population programme staff and educators at all three levels and within three community target groups (women, men and adolescents). A total of 252 health facilities at the three levels were selected for assessment, including 14 provincial health facilities (Provincial General Hospital and the Maternal and Child Health/Family Planning Centre), 28 district health facilities (Ob/Gyn department at district hospital and the MCH/FP brigade), and 210 CHCs. Notably, health facilities at the district and communal levels were randomly selected from a list of the existing health facilities at all levels. From these health facilities, 665 SPs were randomly selected. As many as 2,583 RH programme staff, population programme staff and population/FP educators at the three levels were also selected. There were 1,470 women aged 15-49 having children under 24 months, 1,470 men with wives aged 15-49 rearing children under 24 months, and 1,470 unmarried adolescents aged 15-19 selected. Random sampling method was applied in this survey.

Both interview and observation methods were used with eight different sets of questionnaires for data collection. The observations were taken at all the selected health facilities while interviews were performed with all the survey target group members (both sides: service provision and community). Notably, the availability and quality of RH care services were assessed according to the National Standards (NS) on RH care services promulgated by the Ministry of Health (MOH) in Decision No. 3367/QD-BYT dated September 12, 2002 and some technical and professional regulations in RH care services for health facilities stipulated in Decision No. 385/2001/QD-BYT dated February 13, 2001.

## **Analysis of the collected data shows that:**

Infrastructure, equipment and essential drugs for RH in surveyed health facilities, especially at the communal level, was still limited and much lower than the standard level required in the NS.

Professional knowledge of SPs was rather good but not comprehensive. Knowledge of SPs in the provinces involved in the 6<sup>th</sup> country programme (Ha Giang, Phu Tho, Hoa Binh, and Tien Giang) was considerably better than that of SPs in the new provinces in the 7<sup>th</sup> country programme (Ninh Thuan, Kon Tum, and Ben Tre).

Practices of SPs were fairly good and considerably better in provinces involved in the 6<sup>th</sup> country programme than in the new provinces in the 7<sup>th</sup> country programme.

Awareness, attitudes and behaviour of RH programme staff, population programme staff and population/FP educators at the three levels (provincial, district and communal) were not sufficient for management.

Knowledge, attitudes, and behaviour about RH care of women aged 15-49 having children under 24 months of age, men with wives aged 15-49 having children under 24 months of age, and unmarried adolescents aged 15-19 were still inadequate. However, such aspects in provinces involved in the 6<sup>th</sup> country programme were slightly better than those of the new provinces in the 7<sup>th</sup> country programme.

The relationship between the service provision side and the service utilisation side was rather good. This relationship in provinces involved in the 6<sup>th</sup> country programme was more improved than that of the new provinces in the 7<sup>th</sup> country programme

**Based on the assessment results, some recommendations were made as follows:**

Strengthening status of physical infrastructure, equipment, and essential drugs for health facilities at all levels, especially at the communal level; improving professional knowledge and skills for programme staff and educators working the field of RH and population/FP; conducting IEC activities for the community on RH issues.

In short, the current status of RH care services at all three levels of the seven provinces should be improved to meet the requirements of the NS. For more details, please refer to the full report and the annex.

## INTRODUCTION

### Background

In order to evaluate impact and implementation of the 7<sup>th</sup> country programme (2000-2010) supported by UNFPA, this baseline survey on “Provision and Utilisation of RH Care Services in the 7 UNFPA-supported Provinces” was conducted from November 2005 to January 2006 in the seven UNFPA-supported provinces. They included three Northern provinces (Ha Giang, Phu Tho, Hoa Binh), two Central and Highland provinces (Ninh Thuan, Kon Tum) and two Southern provinces (Tien Giang, Ben Tre). Among the seven surveyed provinces, four were involved in the 6<sup>th</sup> country programme (Ha Giang, Phu Tho, Hoa Binh, and Tien Giang) and three were new provinces in the 7<sup>th</sup> country programme (Ninh Thuan, Kon Tum, and Ben Tre).

As an independent research agency, the Research Centre for Rural Population and Health (RCRPH) at Thai Binh Medical College was selected to conduct this baseline survey to identify problems and provide unbiased recommendations as well as standard samples for the implementation of the programme.

### Survey objectives

In the framework of the 7<sup>th</sup> country programme supported by UNFPA in Vietnam, the survey sought to:

1. Assess the actual situation of the provision and utilisation of RH care services in the seven UNFPA-supported provinces in terms of physical infrastructure, equipment, human resources and quality of RH care services at the provincial, district and communal levels according to the NS on RH care services (promulgated on September 12, 2002), the technical regulations in RH care services and some specific standards set up within this survey.\*
2. Evaluate knowledge, attitudes and the practices of RH SPs at the provincial, district and communal levels in the seven provinces according to the NS on RH care services.
3. Evaluate knowledge, attitudes and practices of RH programme staff, population programme staff and population/FP educators at the provincial, district and communal levels in the seven provinces.
4. Evaluate knowledge, attitudes and practices regarding RH care services of the target groups in the community in surveyed provinces.

### Outline of the report

The report has five chapters:

- Chapter 1 presents the study method, including the survey design, survey scope, sample size, sampling, data collection, organisation and implementation.
- Chapter 2 presents the situation of provision of RH care services at all levels of the seven provinces.

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\* To evaluate some specific contents for RH care, the UNFPA Oversight and Evaluation Group set up specific evaluation standards combined with the National Standards on RH care services to use in the survey. Details are presented further in the report.

- Chapter 3 presents the KAP of the RH programme staff, population programme staff and population/FP educators at the three levels of the seven provinces.
- Chapter 4 presents the KAP of women aged 15-49 having children under 24 months, men with wives aged 15-49 rearing children under 24 months and unmarried adolescents aged 15-19.
- Chapter 5 presents the perceptions of SPs and service users regarding the quality of RH care services. Finally, Chapter 6 presents conclusions and recommendations.

## CHAPTER 1 METHODOLOGY

### 1.1. STUDY DESIGN AND DATA COLLECTION TOOLS

This is a cross-sectional survey with the proposal designed from the end of 2001 to 2002 and supplemented in 2005. Eight sets of questionnaires for interview and observation, coded Q1M, Q2M, Q3M, Q4M, Q5M, Q6M, Q7M and Q8M, were developed, pre-tested and completed according to the NS, in addition to technical procedures, specific evaluation indicators set up from intervention and constructive comments from experts. Questionnaire 1 (Q1M) evaluated the physical infrastructure, equipment and instruments at all three levels. Questionnaire 2 (Q2M) evaluated the knowledge, attitudes and practices of SPs at all three levels. Questionnaires 3, 4 and 5 (Q3M, Q4M and Q5M) evaluated the knowledge, attitudes and behaviours of the women, men and adolescents, respectively. Questionnaires 6, 7 and 8 (Q6M, Q7M, Q8M) evaluated knowledge, attitudes and behaviours of the RH programme staff, population programme staff and population/FP educators. Additionally, checklists for observations were used together with Q1M and Q2M.

### 1.2. SAMPLE SIZE AND SAMPLING

Both service provision and utilisation were evaluated in this survey. A total of 252 health facilities at the three levels were selected for assessment. Fourteen provincial health facilities were chosen. In each province, two health facilities were selected for evaluation, including the provincial general hospital and the MCH/FP centre. At the district level of each province, four health facilities (district hospital Ob/Gyn department) were randomly selected from a list of all existing district health facilities; a total of 28 district health facilities were selected in seven provinces. At the communal level of each province, 30 CHCs were randomly chosen from the list of all existing CHCs. It is worth note that during the sampling process, in order to ensure the progress of the survey, the communes that required more than six hours of travel time to reach their district health centres by common means of transportation were not included in the sampling list (for instance, those in Ha Giang, Kon Tum, and Ninh Thuan).

In addition, 665 SPs at the three levels including 105 SPs at provincial and district levels were randomly selected. However, SPs at the communal level were intentionally selected (by the CHC head and a health staff in charge of RH care services). In summary, for each province, 15 SPs at the provincial level (10 from the provincial general hospital and five from the MCH/FP centre), 20 SPs at district level and 60 SPs at the communal level were selected. SPs at provincial and communal levels were those from the same health facilities chosen previously while SPs at the district level were from both health facilities selected in advance, namely the Ob/Gyn department of the district hospital and the district MCH/FP team that were not chosen for audit.

As many as 2,583 RH programme staff, population programme staff and population/FP educators at the three levels were also selected. Regarding RH programme staff, each province had nine staff working at the provincial level (three from the Provincial Health Department, three from the Provincial MCH/FP

## BASELINE SURVEY REPORT - 7<sup>TH</sup> COUNTRY PROGRAMME

centre, and three from the provincial hospital Ob/Gyn department), and 24 staff from four districts (six from each district: two leaders of the District Health Centre, two from the district hospital Ob/Gyn department, and two from the district MCH/FP team). Regarding population programme staff, each province had nine staff working at the provincial level (three from the provincial Committee for Population, Family and Children - CPFC - and three from the provincial Women's Union, as well as three from the provincial Farmers' Union), 24 staff from four districts (six from each district: two from the District CPFC, two from the District Women's Union, and two from the Farmers' Union), and 120 staff from 30 communes (four from each commune: two population collaborators, one communal Women's Union staff, and one communal Farmers' Union staff).

Three community groups were selected to participate in the survey. There were 1,470 women aged 15-49 having children under 24 months, 1,470 men with wives aged 15-49 rearing children under 24 months and 1,470 unmarried adolescents aged 15-19. The calculation of the sample size of the community group is presented in Annex 1. The minimum sample size was based on the programme targets, baseline survey objectives, sampling strategies, budget allocation, time limitation and requirements to ensure the accuracy of the survey results. To meet these requirements the sample size was calculated with a 95% level of accuracy and an absolute deviation of 10%, all of which were based on the (random) cluster sampling method. The sample size for each community group, as calculated, was 192. It was then rounded to 210 to have 30 survey clusters at the communal level. As many as seven interviewees from each community group were selected from each commune using the "door to door" strategy. In order to supervise and evaluate the programme, this sample size will be utilised in the end-line survey for a rational comparison between findings before and after intervention when the budget is able to support such an endeavour.

### 1.3. DATA COLLECTION

Data collection from the provinces was prepared by investigators from Thai Binh Medical College and the UNFPA office before the commencement of data collection in the field. Investigators collaborated closely with local agencies to recruit and train interviewers and to formalise suitable plans for data collection.

In each province, the data collection was conducted by all three groups of investigators and supervisors who were well trained in advance. The interviews with RH programme staff, population programme staff, population/FP educators and SPs, and the audit of infrastructure, equipment and essential drugs at provincial and district levels were conducted by three doctors from Thai Binh Medical College. Additionally, six Ob/Gyn doctors from the Secondary Medical School of each province conducted surveys at the communal level. The three community groups were interviewed by investigators from the provincial statistical office or district statistical office. Notably, in the interviews with community groups, male investigators interviewed male interviewees, female investigators interviewed female interviewees and younger investigators interviewed unmarried adolescents.

The quality of data collection process was ensured by the thorough and systematic supervision of the independent supervisors from MOH, National Committee for Population, Family and Children (NCPFC) and UNFPA. The entire procedure of training for investigators, selection of district/communes and selection of the first household in a village was supervised closely. At least 5% of questionnaires were randomly selected to be double-checked in the field. Supervisors, team leaders and investigators cooperated closely with each other to enhance the quality of the survey.

### 1.4. DATA PROCESSING, ANALYSIS AND REPORT WRITING

Collected data was carefully checked before being processed and analysed. All the questionnaires sent from the field were manually checked one by one before being entered into the computers. Double entry of the data using EPI-INFO Version 6.04 was then performed by two independent persons to reduce data entry errors.

The collected data were analysed by researchers at RCRPH and UNFPA with Visual FOX PRO Version 7.0. Microsoft Excel and SAS Version 8.2 following dummy tables set up in advance and unified by UNFPA Hanoi and the report-writing group. Discussions between investigators and UNFPA experts were regularly conducted to arrive at optimal data presentation in the report, and at the same time to ensure the accuracy of the procedure.

The report was written by a group of experts from Thai Binh Medical College who had rich experience in the field of population. However, to ensure the quality of the report, two special procedures were applied. Summary of the baseline survey data and draft reports were presented across the seven provinces for comments to revise afterwards. The seven reports were then used as data resources to write the final report representing all provinces incorporating key findings and recommendations from the separate report of each province.

### **1.5. LIMITATIONS**

The biggest limitation of the report was lack of certain documents, except for the survey reports of the 6<sup>th</sup> country programme, used as reference when conducting the survey. Two reasons were: all of the contents on RH care services in this survey were evaluated according to the NS recently promulgated and not applied in previous studies; and the community groups were selected by specific groups (including women aged 15-49, men with wives aged 15-49 having children under 24 months of age, and unmarried adolescents aged 15-19). These target groups had never been assessed in any previous studies. Therefore, it was impossible to make comparisons between findings in this survey and those in others.

In addition, adolescents selected in this survey were kept to ages 15-19, not the 10-19 recommended by World Health Organisation standards, so findings are limited to the higher age bracket.

That there were no qualitative studies is also a limitation of the survey. The collected data is therefore descriptive only, and without in-depth analysis of the actual situations. This also limited the picture of information on all aspects of the interventions.

## CHAPTER 2 STATUS OF RH CARE SERVICE PROVISION

### 2.1. INFRASTRUCTURE, EQUIPMENT AND ESSENTIAL DRUGS FOR RH CARE SERVICES

#### 2.1.1. RH care infrastructure at the commune level

##### *Service rooms at CHCs*

Service rooms at CHCs were assessed as defined in the NS. According to the NS, each CHC should have six separate rooms or at the least four rooms for RH care (gynaecological, FP, delivery and patient room). However, the inventory showed that out of 210 CHCs of the seven provinces, the number attaining NS was still low.

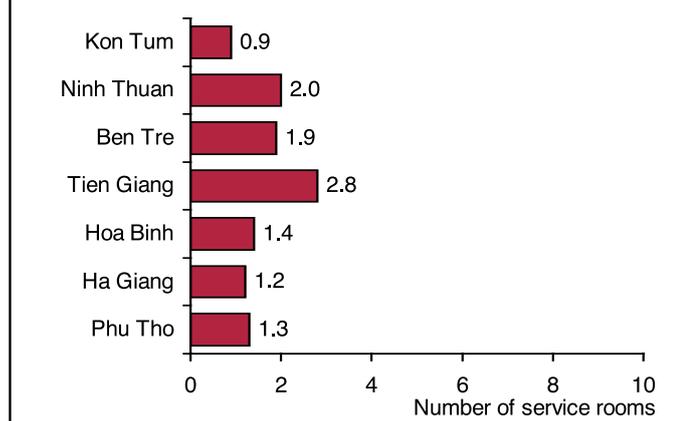
**Table 1. Number of service rooms available at the CHCs**

Rooms	CHCs having separate rooms	% CHCs having separate rooms
1. Pregnancy examination room	32	15.2
2. Gyn examination room	67	31.9
3. FP room	19	9.0
4. Delivery Room	65	31.0
5. Patient room.	107	51.0
6. IEC, counselling room	56	26.7
<i>Number of rooms available at CHCs</i>		
1. Having 6 rooms	3	1.4
2. Having at least 4 rooms	3	1.4

The shortage of service rooms at CHCs was common in the provinces. Almost none had the required six separate rooms or at least four rooms for RH care as defined in the NS. Among six types of rooms, the “patient room”, was found with the highest proportion, yet accounting for only 51%. Most CHCs did not have an “FP room” (available at only 9% of CHCs of the seven provinces). This lack of service rooms led to room sharing at CHCs, which does not ensure the requirements of hygiene and infection prevention and might increase risks of cross-infection to the clients.

Among the seven surveyed provinces, only 3.3% of CHCs in Tien Giang and 6.7% of CHCs in Ninh Thuan had at least four service rooms as defined in the NS. In the other five provinces, none of the surveyed CHCs had at least four service rooms. On average, the number of existing service rooms at CHCs was found the highest in Tien Giang (2.8 rooms), followed by Ninh Thuan (two rooms), Ben Tre (1.9 rooms), and Kon Tum (0.9 rooms).

**Figure 1. Average number of service rooms at CHCs by province**



**CHCs attaining NS in service rooms**

As evaluated according to the NS, the quality of service rooms at CHCs was still low.

**Table 2. Service rooms at CHCs against NS**

Rooms	CHCs having separate rooms	% CHCs having separate rooms	The NS attaining level (%CHCs)			
			≤ 50%	51-75%	76-99%	100%
1. Pregnancy examination room	32	15.2	9.4	25.0	65.6	0.0
2. Gyn examination room	67	31.9	22.4	44.8	25.4	7.5
3. FP room	19	9.0	15.8	31.6	47.4	5.3
4. Delivery Room	65	31.0	26.2	20.0	50.8	3.1
5. Patient room.	107	51.0	24.3	36.4	36.4	2.8
6. IEC, counselling room	56	26.7	10.7	19.6	55.4	14.3

Among existing separate rooms at CHCs, the proportion of those attaining NS was still low. No Gyn examination rooms attained NS and only 14.3% attained NS, for communication room. The quality of service rooms attaining d" 50% NS was mostly found for the delivery room (26.2% of the existing delivery rooms at surveyed CHCs) and patient room (24.3%).

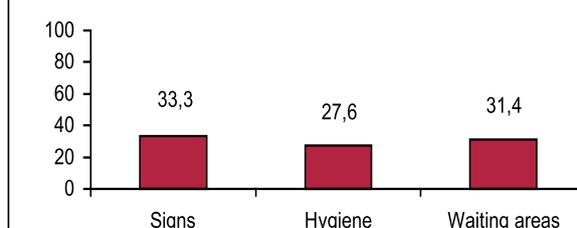
Quality of service rooms measured against the NS was varied among the seven surveyed provinces. Tien Giang province had 16.7% of sites with gyn. examination rooms and 11.1% of FP rooms attaining 100% NS; 20% of delivery rooms in Phu Tho attained NS. For patient rooms, 5.3% of CHCs in Phu Tho, 8.3% in Ha Giang and 5.9% in Ninh Thuan attained NS. For communication rooms, 28.6% of CHCs in Ha Giang, 27.3% in Hoa Binh, 20% in Tien Giang and 9.1% in Ninh Thuan attained NS (See Table 46 in Annex).

**2.1.2. Status of signs, hygiene and waiting areas at CHCs**

CHCs at selected localities were observed to assess the status of their signage, hygiene and waiting areas according to the NS. The surveyed results showed that the proportion of CHCs attaining NS on signs, hygiene and waiting areas reached < 30%.

Mean scores (on the 100-points scale) on the surveyed contents are presented in the table below:

The mean score on hygiene (70.6) was a little higher than that of signs (62.3) and waiting areas (60.5). Tien Giang province attained the highest score on their signs, hygiene and waiting areas (95.8, 93 and 88.3 respectively). Provinces with CHCs having the lowest mean scores on signs were Kon Tum (30.8) followed by Ben Tre and Ninh Thuan (37.5). The lowest mean scores for hygiene and waiting area were found in Ha Giang (53.3 and 20.8, respectively).

**Figure 2. Percentage of CHCs attaining NS on signs, hygiene and waiting areas****Table 3. Mean scores on the status of signs, hygiene and waiting area at CHCs**

Province	Signs	Hygiene	Waiting area
Phu Tho	87.5	73.3	58.3
Ha Giang	66.7	53.3	20.8
Hoa Binh	80.0	61.9	52.5
Tien Giang	95.8	93.0	88.3
Ben Tre	37.5	71.5	76.7
Ninh Thuan	37.5	80.4	76.7
Kon Tum	30.8	61.1	50.0
<b>Mean</b>	<b>62.3</b>	<b>70.6</b>	<b>60.5</b>

### 2.1.3. Essential instruments and equipment for RH care at CHCs

#### Availability of instruments and equipment

Seven sets of instruments for RH care at CHCs were inventoried and assessed in terms of complete or incomplete sets. The average number of complete or incomplete sets was then counted for each CHC.

**Table 4. Availability of instruments/equipment at the CHCs**

Sets of instruments	Complete sets			Incomplete sets		
	% CHCs having	Total of sets	Average number of sets/CHC	% CHCs having	Total of sets	Average number of sets/CHC
1. Set for delivery	64.3	187	0.9	46.7	130	0.6
2. Set for cutting and suturing the perineum	33.8	80	0.4	61.0	137	0.7
3. Set for checking of the cervix	17.1	44	0.2	53.8	120	0.6
4. Set for neonatal resuscitation	33.8	79	0.4	38.1	83	0.4
5. Set for insertion and removal of IUDs	52.4	138	0.7	56.7	163	0.8
6. Set for Gyn. examination	46.2	147	0.7	62.4	235	1.1
7. Single valve Karman MVA	22.9	49	0.2	48.1	134	0.6

The sets of instruments were most commonly found to be incomplete in each CHC were those for delivery (64.3% of CHCs), followed by the set for insertion and removal of IUDs (52.4%), Gyn. examination (46.2%) and for checking of the cervix (17.1%). On average, each CHC only had 0.9 complete sets for delivery, and 0.7 complete sets for insertion and removal of IUDs and Gyn. examination. The set for checking of the cervix and single valve Karman MVA were found at the lowest numbers, an average of 0.2 complete sets for each CHC.

According to the NS on RH care services, each CHC should have three sets for delivery, one set for cutting and suturing the perineum, one set for checking the cervix, one set for neonatal resuscitation, one set for insertion and removal of IUDs, three sets for Gyn. examination and one single valve Karman MVA. The inventory results showed that only 3.3% of CHCs had three complete sets for delivery, 7.1% had three complete sets for Gyn. examination, 33.8% had at least one complete set for cutting and suturing the perineum, 17.2% had at least one complete set for checking of the cervix, 33.9% had at least one complete set for neonatal resuscitation, 52.4% had at least one complete set for insertion and removal of IUDs and 22.9% had at least one single valve Karman MVA.

The numbers of complete sets of instruments at CHCs were classified into four levels: no complete sets, one

**Table 5. Percentages for complete sets of instruments**

Sets of instruments	Complete sets			
	0	1	2	>=3
1. Set for delivery	35.7	43.8	17.1	3.3
2. Set for cutting and suturing the perineum	66.2	30.0	3.3	0.5
3. Set for checking cervix	82.9	16.2	0.5	0.5
4. Set for neonatal resuscitation	66.2	32.4	0.5	1.0
5. Set for insertion and removal of IUDs	47.6	44.3	5.2	2.9
6. Set for Gyn. Examination	53.8	33.3	5.7	7.1
7. Single valve Karman MVA	77.1	22.4	0.5	0.0

**Table 6. Percentage of CHCs having complete sets of instruments**

Province	Having No complete sets	Having 1-3 complete sets	Having 4-6 complete sets	Having 7 complete sets
Phu Tho	6.7	40.0	50.0	3.3
Ha Giang	10.0	30.0	50.0	10.0
Hoa Binh	6.7	73.3	20.0	0.0
Tien Giang	16.7	10.0	40.0	33.3
Ben Tre	53.3	43.3	3.3	0.0
Ninh Thuan	0.0	80.0	20.0	0.0
Kon Tum	36.7	56.7	6.7	0.0

to three complete sets, four to six complete sets and seven complete sets (at least one complete set for each type). The results are presented in the table below:

According to this classification, 33.3% of CHCs in Tien Giang, 10% of CHCs in Ha Giang and 3.3% of CHCs in Phu Tho had seven complete sets (at least one complete set for each type). Provinces with the highest proportion of CHCs having no complete sets were Ben Tre (53.3%) and Kon Tum (36.7%).

#### *Other instruments/equipment*

According to the NS, each CHC should have 13 other types of equipment for RH care services. The observations and inventories applied two standards, the number of CHCs having equipment and the number of usable instruments. The average number of usable instruments at each CHC is presented in Table 47 in the annex. The proportion of CHCs having all 13 types of other equipment for RH care services accounted for 2.9%. The mean score (on the 100-point scale) for the seven provinces on this issue was only 59.5.

Least available at CHCs were the dry heat steriliser (available at only 27.1% of sites), procedure table (32.9%), boiler (electric) and plastic container with cover for cold sterilisation (38.6%). The lack of such equipment has a negative effect on prevention and control of infection.

#### **2.1.4. Equipment for infection control at health facilities**

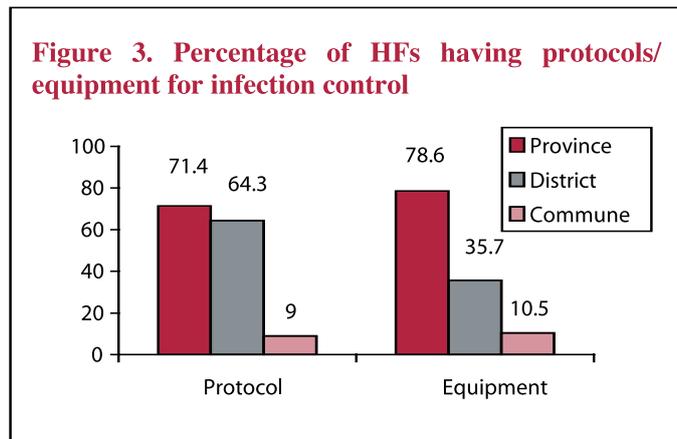
In general, five types of protocol and six types of equipment/instruments are stipulated in infection control. All surveyed health facilities were inventoried to evaluate the availability of these documents and equipment. The results are presented in Table 48 in the annex. The protocols and equipment for infection control varied among the three levels and were fewest at the communal level. Most of the health facilities at the three levels had at least five out of six types of equipment for infection control. Although most of the health facilities at the provincial level had goggles for SPs at risk of exposure to blood and body fluids (78.6%), they were found to be in serious shortage at most health facilities at the district level (35.7%) and CHCs (13.3%).

It was not difficult to supply protocols to health facilities. However, they were only available at most of the provincial and district levels, leaving the CHCs with the most shortages. The most available document, the protocol for instruction of infection prevention, was found at only 59.5% of CHCs, followed by the protocol for processing used metal equipment (47.1%). The other protocols were available at less than 30% of CHCs.

Figure 3 shows that 71.4% of health facilities at the provincial level and 64.3% at the district level had sufficient types protocols for infection control as defined in the NS, while health facilities at the communal level scored 9%. Health facilities attaining 100% NS on equipment/instruments for infection control at the provincial level (78.6%) was much higher than that at the district level (35.7%) and the communal level (10.5%).

Generally, health facilities at all three levels had an

**Figure 3. Percentage of HFs having protocols/equipment for infection control**



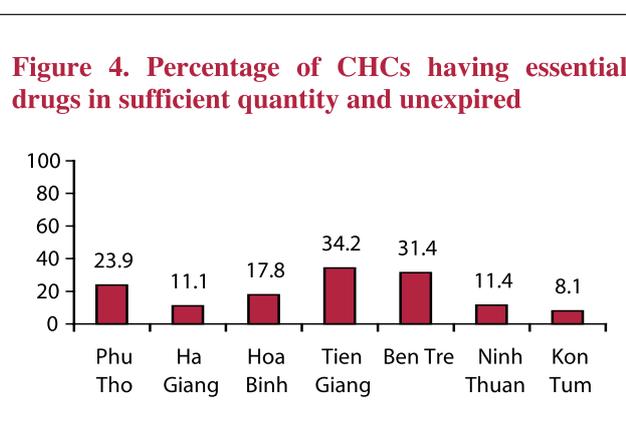
**Table 7. Average number of protocols/equipment for infection control at HFs**

Province	Mean	
	Protocol	Equipment
Phu Tho	2.0	4.7
Ha Giang	2.2	2.7
Hoa Binh	2.9	3.9
Tien Giang	3.5	5.5
Ben Tre	2.2	4.1
Ninh Thuan	2.2	3.9
Kon Tum	0.6	1.7
Mean	2.2	3.8

average of 2.2 out of 5 types of protocol for infection control as defined in the NS. The highest number available was found in Tien Giang province (3.5 types) and the lowest in Kon Tum province (0.6 types). Regarding equipment for infection control, health facilities had an average of 3.8 out of 6 types of equipment as defined in the NS. The highest scores for available equipment were found in Tien Giang province (5.5 types) and the lowest in the Kon Tum province (1.7 types) (See Table 49 in the annex). The average numbers for protocols/equipment for infection control at health facilities of provinces involved in the 6<sup>th</sup> country programme were 2.7 and 4.2 respectively, higher than that of the new provinces in the v country programme (1.6 types of protocols and 3.3 types of equipment).

**2.1.5. Essential drugs for RH care at CHCs**

Ten groups of essential drugs for RH care services at CHCs were inventoried according to the NS. Availability of these medicines was assessed against three criteria: 1) Sufficient quantity and unexpired 2) Available but not sufficient quality and 3) Unavailable (see Table 50 in the annex). Essential drugs for RH were in serious shortage at CHCs. There were no groups of drugs found to be sufficient and unexpired at any CHCs. Intravenous transfusion fluids (59.5% of CHCs), contraceptives (33.8%) and sedatives (33.3%) were found most sufficient and still viable (unexpired) drugs available. Least available were analgesics/anaesthetics with Opi (1.4% of CHCs), followed by septics and antiseptics (1.9%) and antibiotics (2.4%). Notably, most of CHCs lacked analgesics/anaesthetics with Opi and sedatives (65.7% and 59%, respectively) and antihypertensives were not available at 30.5% of CHCs.



CHCs with sufficient and unexpired groups of drugs were highest in Tien Giang province (34.2%) and lowest in Kon Tum province (8.1%).

Most CHCs had three types of contraceptives, including condoms (86.2% of sites), oral pills (82.4%) and IUDs (79%). The proportion of CHCs having emergency oral contraceptives was only 18.6% while injectable contraceptives were available at 46.2% of all surveyed CHCs.

**Table 8. Availability of contraceptives at CHCs**

Contraceptive methods	CHCs having contraceptive		Average number
	n	%	
Condoms	181	86.2	484.1
IUDs	166	79.0	12.2
Emergency oral contraceptives	39	18.6	8.0
Oral contraceptive pills	173	82.4	145.5
Injectables	97	46.2	13.1

**2.1.6. Essential obstetric care at all levels**

Essential obstetric care was assessed against two criteria: basic and comprehensive standards. According to the WHO, the basic essential obstetric care consists of six types of service (see Table 9) and is applied at all three levels. Similarly, the comprehensive essential obstetric care consists of eight types of service and is applied at the provincial and district levels only.

In this survey, the National Standards on essential obstetric care were applied rather than WHO standards. Therefore, the classification of the basic and comprehensive essential obstetric care may be different from the previous. According to the National Standards, the basic obstetric care, as mentioned above, consists of six types of service applied for the provincial and district levels. But only five types of service were

applied at the communal level (no uterine curettage for retained placenta). The comprehensive standard, not applied for the communal level, consists of eight types of service for the provincial and district hospitals and seven types of service for the provincial MCH/FP centre (excluding Caesarean section). Findings on essential obstetric care are presented in the table below:

**Table 9. Status on essential obstetric care**

Contents	Level		
	Province n=14	District n=28	Commune n=210
<i>Types of essential obstetric services</i>			
1. Injection/transfusion of antibiotics	71.4	100.0	78.1
2. Injection/transfusion of oxytocics	78.6	92.9	73.3
3. Injection/transfusion of sedatives for convulsion prevention in pre-eclampsia and eclampsia	57.1	82.1	21.4
4. Placenta removal and uterine checking	50.0	100.0	44.8
5. Uterine curettage for retained placenta	78.6	96.4	
6. Normal delivery assistance	50.0	100.0	81.9
***Attaining the basic standard of essential obstetric care	50.0	78.6	16.7
<i>Comprehensive obstetric service</i>			
7. Caesarean section	100.0	46.4	
8. Blood transfusion	50.0	39.3	
***Attaining the basic standard of comprehensive obstetric care (at provincial and district levels)	50.0	39.3	

In general, essential obstetric care services were not provided widely at health facilities at the provincial and district levels. The proportion of health facilities attaining the basic essential obstetric care standard was only 78.6% at the district level, 50% at the provincial and 16.7% at the commune level. Notably, the injection/transfusion of sedatives for convulsion prevention in pre-eclampsia and eclampsia was provided in the fewest number of CHCs (only in 21.4% of CHCs). Similarly, the proportion of health facilities providing comprehensive essential obstetric care services was only 50% at the provincial level and 39.3% at the district level.

The proportion of CHCs attaining basic essential obstetrical care standards (five services) was highest in Tien Giang province (50%), followed by Phu Tho (43.3%), and lowest in Kon Tum (0%) and Hoa Binh, Ben Tre, Ninh Thuan (all 3%). This proportion in the provinces involved in the 6<sup>th</sup> country programme (27.5%) was considerably higher than that in the new provinces in the 7<sup>th</sup> country programme (2.2%) (See 52 in the annex).

## 2.2. INFORMATION ON RH CARE SPs

### 2.2.1. Qualifications of the SPs

SPs were interviewed from the selected provincial and district RH care facilities as well as two health staff from each of 30 CHCs (the head of the CHC and person in charge of RH care services). Table 10 below shows a general view of the qualifications of interviewed SPs (in percent). However, it was not a comprehensive figure for all RH SPs in seven provinces.

**Table 10. Qualifications of interviewed SPs**

Qualification	Level			Mean (n=655)
	Pro. (n=105)	Dist. (n=136)	Comm. (n=414)	
1. MD specialised in obstetrics and gynaecology	27.6	9.6	1.0	7.0
2. General doctor and in other specialisations	9.5	6.6	14.3	11.9
3. Ob/Paediatric assistant doctor	13.3	32.4	19.6	21.2
4. Asst. doctor with other specialisations	2.9	6.6	34.5	23.7
5. Midwife (university, college or secondary levels)	42.9	39.0	16.9	25.6
6. Primary midwife or nurse	1.9	5.1	10.6	8.1
7. Nurse (university, college or secondary levels)	1.9	0.7	3.1	2.4

The qualifications of the selected SPs varied among different levels and within each level. The proportions of interviewees qualified in obstetrics (MDs specialised in obstetrics and gynaecology, midwives and Ob/Paediatric assistant doctors) at the provincial level (83.8%) and at the district level (81%) were higher than those at the communal level (37.5%). Most MDs specialising in obstetrics were at the provincial level (27.6%) and district level (9.6%). At the communal level, assistant doctors with other specialisations accounted for the highest proportion (34.5%) followed by Ob/Paediatric assistant doctors (19.6%), college or secondary midwives (16.9%), general doctors and doctors in other specialties (14.3%) and primary midwives or nurses (10.6%).

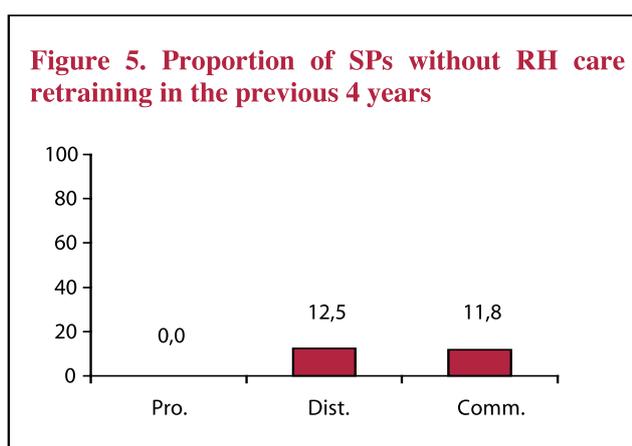
### 2.2.2. RH care training and retraining for SPs

The proportion of SPs that did not receive retraining during the previous four years was low and found only at the district level (12.5%) and communal level (11.8%).

In general, most of the interviewed SPs had received training in school and refresher training on common services such as pregnancy examination, delivery attendance, neonatal care, postnatal care and FP services (excluding injectable contraceptives, Norplant and sterilisation).

In comparison, among seven provinces, the proportion of SPs without retraining on any RH care service in the previous four years was significantly different. The proportion of SPs who had not been retrained on any RH care service in the previous four years in provinces involved in the 6<sup>th</sup> country programme (4.2%) was lower than that in the new provinces in the 7<sup>th</sup> country programme (23.9%). This proportion was found highest in Kon Tum (75%), followed by

**Figure 5. Proportion of SPs without RH care retraining in the previous 4 years**



Ben Tre (10%). Other provinces had no staff who had received retraining. At the communal level, SPs who had not received retraining were highest in Kon Tum (37.9%), followed by Ha Giang (18.3%), Ben Tre (13.6%), Ninh Thuan (10.3%), Phu Tho, and Hoa Binh (1.7%), while in Tien Giang, no SPs had ever received retraining.

### 2.2.3. Responses to selected statements on RH

SPs at the three levels were asked their opinions on eight statements on RH care. Findings are presented in Table 11.

**Table 11. Percentage of SPs agreed with proposed statements on RH care**

Statements	Pro.	Dist.	Com.	Mean
1. Counselling is a must for the health provider to provide to any client	97.1	100.0	97.1	97.7
2. HIV test is a must when infection is suspected	92.4	97.1	89.6	91.6
3. Health providers are reluctant to provide information/counselling on sexuality to clients	3.8	2.2	15.9	11.1
4. Medical equipment in this facility have been effectively used to serve the clients	84.8	77.2	80.2	80.3
5. There are not enough health education materials to distribute to clients	75.2	83.1	72.2	75.0
6. Professional skills of providers in this facility meet people's needs for examination and treatment	58.1	30.1	56.0	51.0
7. Clients have the right to discuss with health workers about treatment method	87.6	96.3	89.4	90.5
8. Health workers are SPs and service users are clients	97.1	97.8	98.8	98.3

Most SPs at all levels agreed with the affirmative statements, “Counselling is a must for the health provider to provide to any client”, “Clients have the right to discuss with health workers about treatment method” and “Health workers are SPs and service users are clients”.

But few interviewed thought that “Health providers are reluctant to provide information/counselling on sexuality to clients” (11.1%), with the highest percentage found at the communal level (15.9%). Notably, just over half of interviewed SPs agreed with the statement “Professional skills of providers in this facility meet people's needs for examination and treatment”, with the lowest percentage at the district level (30.1%).

### 2.2.4. SPs' knowledge on RH care

SPs' knowledge on RH was assessed in four main fields: 1) Safe motherhood 2) Family planning and abortion 3) Adolescent RH and 4) RTIs/STDs. Findings and comments are displayed in each separate field:

#### Safe motherhood

##### *Knowledge among SPs on pregnancy check-ups in the last trimester*

The questions about general examination, obstetric check-up and discussion were used to assess knowledge of SPs on safe motherhood. The mean score of each section was calculated according to the National standard and presented by level. (See Table 55 in the annex).

**Table 12. Percentages for SPs attaining 100% NS for knowledge on final trimester antenatal care**

Knowledge	Pro.	District	Com.	Total
1. General examination	21.9	18.4	21.7	21.1
2. Obstetric check-up	74.3	82.4	71.5	74.2
3. Discussion	31.4	27.9	34.5	32.7

Knowledge among SPs regarding obstetric check-ups was rather good (74.2% attaining 100% NS) and much higher than that of the general examination (21.1% attaining 100% NS) and discussion (32.7% attaining 100% NS). There was no significant difference between levels. In the section regarding general examination, “breast examination” received responses from the fewest SPs. Similarly, in the discussion section, the aspect concerning estimated delivery date received the fewest responses.

The scores of all three aspects of the obstetric examination section in each province are presented in Table 56 in the annex. The table below presents the mean scores for all seven provinces.

In general, the score on the general examination section was 71.5. The highest score was found in Tien Giang province (95.1) and the lowest were in Ben Tre, Ninh Thuan and Kon Tum (ranging from 59 to 60 points). The mean score of the general examination section in provinces involved in the 6<sup>th</sup> country programme (80.3) was much higher than that in the new provinces in the

7<sup>th</sup> country programme (59.5). For the obstetric examination section, Tien Giang also had the highest mean score (99.7), while the lowest was in Kon Tum (79.6). The mean score of the obstetric examination section in provinces involved in the 6<sup>th</sup> country programme (93.1) was much higher than that in the new provinces in the 7<sup>th</sup> country programme (83.5). The province having the highest score in the discussion section was still Tien Giang (93.4), and the lowest were in Ben Tre, Ninh Thuan and Kon Tum (about 63 points). The mean score of the discussion section in provinces involved in the 6<sup>th</sup> country programme (79.0) was also much higher than that in the new provinces in the 7<sup>th</sup> country programme (63.4).

**SPs’ knowledge on steps in pregnancy check-ups**

SPs responses to questions on identifying steps in pregnancy check-ups are presented in Table 57 in the annex. The proportion of SPs at all levels who could correctly and completely name all nine steps of a pregnancy check-up was not high (42%) and there was no significant difference among the three levels.

The mean score on sections concerning pregnancy check-ups achieved by SPs at the district and communal levels (76.2 and 75 respectively) was higher than that at

the provincial level (67.3). Tien Giang and Phu Tho were the highest (95.6 and 93), and the lowest was Kon Tum (38.5). The mean score for provinces in the 6<sup>th</sup> country programme (85.6) was much higher than that of the new provinces in the 7<sup>th</sup> country programme (58.1).

**Knowledge among SPs on abnormal signs during delivery**

SPs’ knowledge on safe motherhood was also assessed through recognising abnormal signs during delivery (tested with eight correct signs and five incorrect signs). Interviewers did not read out these signs when interviewing.

**Table 13. Scores (100-point scale) of SPs’ knowledge on pregnancy check-up, by level**

Attaining NS	Prov	Dist.	Com.	Mean
1. General examination	68.4	71.2	72.4	71.5
2. Obstetric examination	89.5	93.1	87.6	89.1
3. Discussion	69.8	73.4	72.8	72.4

**Table 14. Mean score (100-point scale) of SPs on steps in pregnancy check-up, by province**

Province	Province	District	Com.	Mean
Phu Tho	94.1	96.7	91.5	93.0
Ha Giang	92.6	89.5	64.4	74.2
Hoa Binh	77.0	79.5	80.7	79.9
Tien Giang	100.0	95.0	94.7	95.6
Ben Tre	43.7	58.9	71.4	64.3
Ninh Thuan	43.7	77.8	78.0	72.2
Kon Tum	20.0	36.7	43.9	38.5
<b>Mean</b>	<b>67.3</b>	<b>76.2</b>	<b>75.0</b>	<b>74.1</b>

The proportion of SPs with knowledge attaining 100% NS on abnormal signs during delivery was the highest at the district level (52.9%), followed by the provincial level (41%) and the communal level (37.4%).

In general, at all three levels, more than two-thirds of SPs could identify all eight abnormal signs. The sign of “diastolic BP 100 mm Hg” was known by most SPs (95%), and “woman’s pulse 95 beats/minute” was known the least (69.3%) (See Table 59 in the annex).

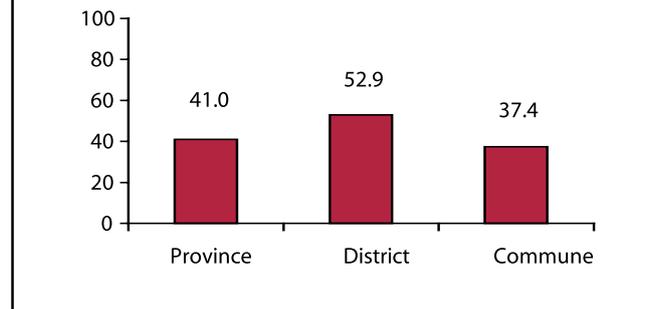
To make a comparison among seven provinces, the mean scores of SPs on identifying abnormal signs during delivery were calculated for all levels such that each correct choice would gain one point and each wrong choice would lose one point. To gain the maximum score, an SP had to know all eight correct choices and have none incorrect. The total scores were then calculated on the 100-point scale. Using that approach, Phu Tho had the highest mean score (80), while the lowest mean score was found in Ninh Thuan and Kon Tum (ranging from 60 to 61 points). Mean scores for SPs’ knowledge on abnormal signs during delivery in provinces involved in the 6<sup>th</sup> country programme (77.1) was much higher than that in the new provinces in the 7<sup>th</sup> country programme (63.5). The general mean score was highest at the district level (82.5) and lowest at the communal level (66.6) (See Table 60 in the Annex).

### *SPs’ knowledge on internal examination when delivery starts*

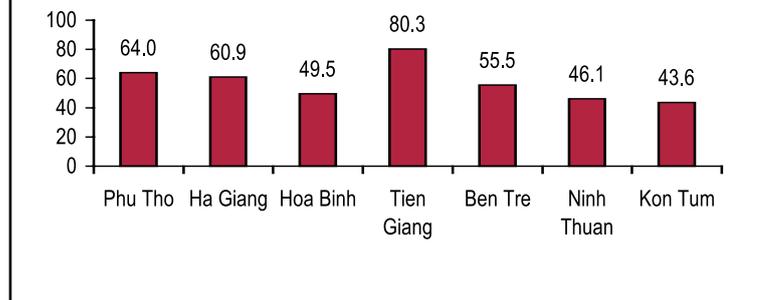
There are six aspects to be assessed when conducting an internal examination for a woman in labour, checking the cervix effacement and dilatation, checking the status of amniotic fluid, membrane rupture elapsed time, checking the descent of the foetus’ head in the pelvic area, checking the pelvis, checking infection of amniotic fluid, estimating delivery time, and delivery prognosis (see Table 61 in the annex). The proportion of SPs who identified these six aspects was very low. Only 10.5% at the provincial level, 5.1% at the district level and 4.3% at the communal level had responses attaining 100% NS. The aspect of “Check the cervix effacement and dilatation” was mentioned the most (93%) and the content of “Check infection of amniotic fluid” was mentioned the least (17.3%).

Among the seven provinces, the SPs in Tien Giang had the best knowledge about internal examinations (80.3 points), and those in Kon Tum had the poorest knowledge on this issue (43.6 points). The mean score for SPs’ knowledge on internal examination of provinces involved in the 6<sup>th</sup> country programme (63.6 points) was remarkably higher than that in the new provinces in the 7<sup>th</sup> country programme (48.4 points).

**Figure 6. SPs with knowledge attaining 100% NS on 8 danger signs during delivery**



**Figure 7. Mean scores for SPs’ knowledge on internal examination for women in labour**



**Knowledge on care of the mother and newborn after delivery**

SPs were asked about their knowledge regarding care of the mother and newborn after delivery, including three major aspects. They were normal neonatal care right after delivery, care of mother within 24 hours after delivery and care of newborn within 24 hours after delivery.

The interview results are presented in Table 64 in the annex. The proportion of SPs with knowledge regarding care of the mother within 24 hours after delivery attaining NS was high (73.7% for all three levels) and much higher than their understanding concerning care of the newborn within 24 hours after delivery (22%) and normal neonatal care right after delivery (17.1%). The sections regarding normal neonatal care right after delivery which received responses from the lowest proportion of SPs were “Inject vitamin K1. 1mg unique dose” (37.1%) and “Clean eyes with sterile water or saline and put Argyrols drops (silver nitrate) in eyes to prevent infection due to gonococcus” (32.2%).

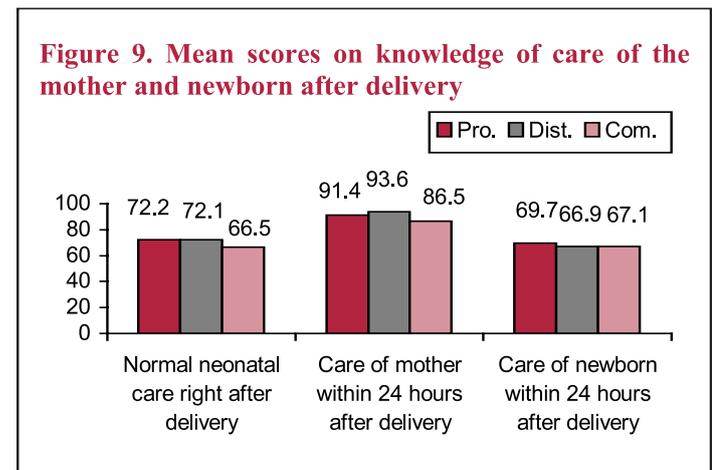
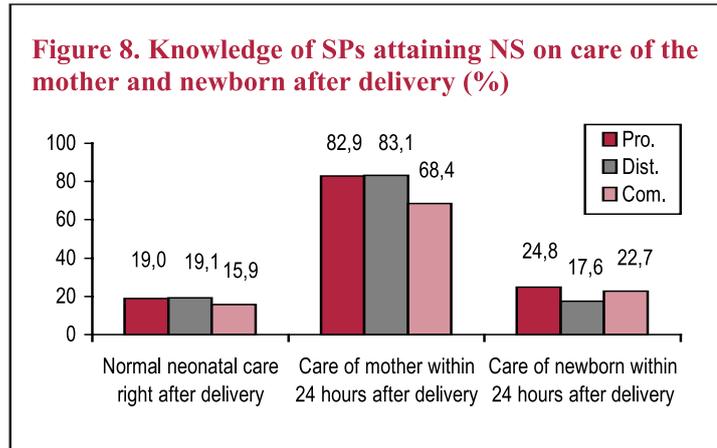
The mean scores of each section by level are presented in Table 65 in the annex.

Mean scores for “Care of the mother within 24 hours after delivery” were higher than those for other areas, but in all three sections the difference among the levels was not clear.

Tien Giang province had the highest mean scores on Normal neonatal care right after delivery (95.4 points), care of mother within 24 hours after delivery (98.9 points) and care of newborn within 24 hours after delivery (92.3 points). Kon Tum province had the lowest mean scores on these three sections (57.1 points, 79.3 points and 50.3 points, respectively). Mean scores on all three sections in the mother and newborn care in the 6<sup>th</sup> country programme (73.5 points, 92.6 points and 77.0 points respectively) were also significantly higher than those of the new provinces in the 7<sup>th</sup> country programme (61.9 points, 83.5 points and 54.4 points respectively).

**Knowledge on common risks to preterm newborns**

Knowledge of SPs regarding common risks impacting preterm newborns was assessed through open-ended questions. This method was used in order to assess knowledge of SPs without prompting.

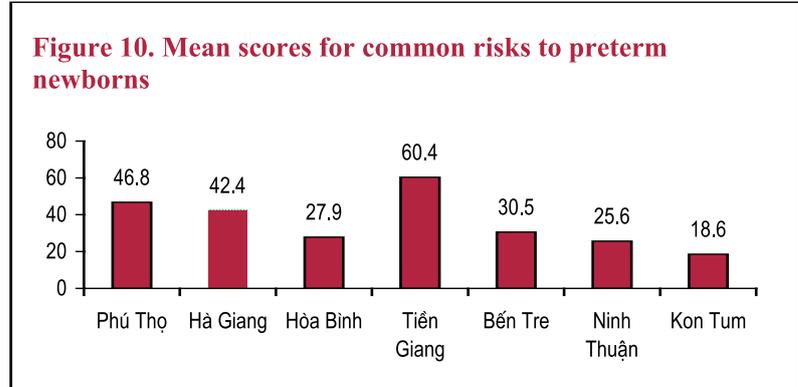


**Table 15. Percentage of SPs knowing the common risks to preterm newborns**

Information	For three levels
1. Birth asphyxia	51.0
2. Hypothermia	56.0
3. Decreased blood glucose	20.6
4. Respiratory distress	57.9
5. Infection	47.9
6. Hemorrhage	16.5
7. Prolonged jaundice	28.6
8. Disturbances of digestive tract	10.5
Don't know	3.7
Attaining 100% NS	1.5

Knowledge among SPs concerning common risks to preterm newborns at these levels was very limited. The proportion of with knowledge attaining NS was very low (1.5%) and there was not much different among the three levels. Only three out of eight risks were identified by 50-60% of SPs, namely birth asphyxia (51%), hypothermia (56%) and respiratory distress (57.9%). Less than 21% of SPs at all levels identified decreased blood glucose, haemorrhage and disturbances of the digestive tract (See Table 66 in the annex).

Mean scores for SPs' knowledge on common risks to preterm newborns at all levels were found to be highest in Tien Giang (60.4 points) and lowest in Kon Tum (18.6 points). The mean scores on common risks to preterm newborns for provinces involved in the 6<sup>th</sup> country programme (44.3 points) were higher than those of the new provinces in the 7<sup>th</sup> country programme (24.9 points).



#### Knowledge on post-partum warning signs and management

Knowledge among SPs on post-partum warning signs was also assessed by open-ended question. Responses were deemed sufficient when SPs could adequately identify five warning signs without suggestion, detailed in Table 16.

**Table 16. Percentage of SPs who could name post-partum warning signs**

Signs	Pro.	Dist.	Com.	Mean
1. Prolonged and increased bleeding	95.2	95.6	94.0	94.5
2. Smelly vaginal discharge	22.9	25.7	45.7	37.9
3. Prolonged fever	24.8	25.7	63.3	49.3
4. Prolonged and increased abdomen pain	33.3	39.0	41.5	39.7
5. Convulsion	28.6	29.4	24.2	26.0
Attaining 100% NS	2.9	7.4	7.2	6.6

The above table shows that the proportion of SPs knowledgeable about post-partum warning signs was still low, except for “Prolonged and increased bleeding” (94.5% of interviewed SPs at all levels); the other four warning signs received responses from under 50% of SPs. “Convulsion”, although easily recognised, received responses from only 26% of SPs. Notably, the proportion of SPs at the provincial level that were knowledgeable on this issue was lower than that at the two lower levels. More than 7% of SPs at the district and communal levels attained NS, and this proportion at the provincial level was only 2.9%.

Mean scores on post-partum warning signs were found to be highest in Tien Giang (68.7 points) and Phu Tho (60.2 points); and lowest in Kon Tum, Ninh Thuan and Ben Tre (34.6 points, 40.2 points and 41.3 points, respectively) (See Table 68 in the annex). The mean scores regarding SPs knowledge about post-partum warning signs in provinces involved in the 6<sup>th</sup> country programme (57.4 points) were higher than those in the new provinces in the 7<sup>th</sup> country programme (38.7 points).

The SPs' knowledge concerning the correct responses to abnormal signs in the mother and newborn after delivery was also assessed based on a list of necessary responses (See Table 69 in the annex).

Generally, most SPs at the provincial and district levels were knowledgeable about the correct responses to the warning signs from the mother. The proportion of SPs attaining 100% NS on reactions to the warning signs to the mother at the provincial level (66.7%) was higher than that of those SPs at the district

(62.5%) and communal (30.2%) levels. The proportion of SPs at the communal level with correct response to “haematoma”, citing that “it is necessary to transfer to higher level health facilities” was the lowest (57.5%).

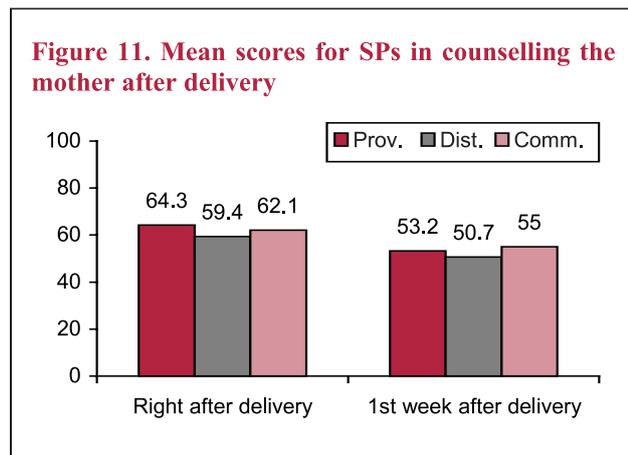
Regarding the knowledge on the correct responses to abnormal signs from the newborn, most SPs at all three levels knew the correct response to the warning signs. The proportion of SPs with correct knowledge attaining 100% NS on this aspect was 61.9% at the provincial level, 48.5% at the district level and 33.8% at the communal level.

Mean scores of all three levels regarding their responses to warning signs in the mother and newborn after delivery were the same (about 79 points). Tien Giang province had the highest mean score on responses to warning signs from the mother (98 points) and newborn (93.9 points), and that of Kon Tum province was the lowest (59.4 and 62.2. respectively) (See Table 70 in the annex). The mean score on responses to warning signs from the mother and newborn in provinces involved in the 6<sup>th</sup> country programme (85.7 and 84) was considerably higher than that of the new provinces in the 7<sup>th</sup> country programme (69.9 and 72.9, respectively).

**Counselling the mother after delivery**

SPs were interviewed on their knowledge concerning counselling for the mother after delivery at two points, right after delivery and within the first week after delivery. The mean scores on the 100-points scale were calculated by each period of time and are presented in the figure below.

In general, knowledge among SPs concerning counselling of the mother right after delivery was better than in the first week after delivery (61.9 points and 53.9 points for all three levels). More than 80% of SPs at all three levels mentioned two points. These were “self monitoring of bleeding and uterine shrinkage” and “breastfeeding 30 minutes after delivery, breastfeeding the baby exclusively”. But two other elements, namely “monitoring and care of newborn” and “counselling family members to monitor and care for mother and newborn” were mentioned by only about 40% of SPs. The elements least mentioned were “FP/contraceptive method counselling” (30.2%), “vaccination” (33.7%) and “cord care” (37.4%) (See Table 71 in the annex).



Comparison among the seven provinces shows that Tien Giang had the highest score on counselling the mother right after delivery and within the first week after delivery (91.5 and 81.9, respectively); and Kon Tum had the lowest score (44.6 and 40) (See Table 72 in the annex). The mean score for SPs on counselling the mother right after delivery and within the first week after delivery for provinces in the 6<sup>th</sup> country programme (70.7 and 59.8) was remarkably higher than that of the new provinces in the 7<sup>th</sup> country programme (49.8 and 45.7).

The actual level of SPs’ knowledge on counselling the mother after delivery at three levels was well below the NS and retraining in this issue should be strengthened in the future.

**Family planning and abortion**

**Knowledge of SPs on counselling clients coming for IUDs insertion or abortion**

Knowledge among SPs on family planning and abortion was assessed for clients coming for IUD insertions and abortions. Investigators posed open-ended questions (See Table 73 in the annex). The table

below shows mean scores for counselling of clients coming for IUDs or abortions.

No SPs at any level could identify the five appropriate aspects of counselling on IUD insertion as defined. Fewer than 45% were able to properly identify three out of the five aspects. Notably, “Inform client that IUD can be removed if she wants to” was mentioned by only 16.3% of SPs. The mean score on knowledge of counselling to clients coming for IUD insertion was 51.3 and there was no significant difference among the three levels.

**Table 17. Mean score of SPs on counseling in IUD insertion and abortion**

Contents	Prov.	Dist.	Comm.	Mean
IUD insertion	50.9	51.5	51.4	51.3
Abortion	53.3	50.3	48.7	49.8

For counselling on abortion, most SPs could name only two out of the five aspects. The other three aspects were mentioned much less, especially “return for examination in case of smelly leucorrhoea” (30.8%). The mean score on counselling for abortion was low (49.8 points) and lowest at the communal level (48.7).

Among provinces, Tien Giang had the highest mean score on counselling clients coming for IUD insertion or abortion (70.9 and 76.4 respectively), and Kon Tum had the lowest score on this issue (29.7 and 24.5, respectively) (see Table 74 in the annex). The mean scores on counselling for IUD insertion or abortion in provinces involved in the 6<sup>th</sup> country programme (58.8 and 56.7) were considerably higher than that of those SPs in the new provinces in the 7<sup>th</sup> country programme (41 and 40.2).

### **Reasons for using contraceptive methods**

SPs were asked to explain why IUDs are the most commonly used contraceptive method in the community while condoms and oral pills are used much less. Findings (see Table 75 in the annex) showed that more than two-thirds responded with “efficiency”, “convenience”, “durability” and “safety” (67%, 73.6% and 53.1% respectively).

According to SPs, clients’ main reason against condom was “reduced sensation” (66.1%), followed by “dislike” (47.9%), “afraid of side effects” (33.1%), and “uncomfortable feeling to ask for condoms” (22.7%).

The two most commonly cited reasons for less preference of oral pills were “afraid of side effects” (64%) and “easy to forget” (38.9%). Other reasons mentioned were “dislike” (19.4%), “method failure” (18%), and “uncomfortable feeling to ask for oral pills” (12.4%).

**Table 18. Knowledge among SPs on common issues regarding adolescent RH**

Issues	Total
1. Early sex debut	30.1
2. No condom use when having sex	42.4
3. Unwanted pregnancy	20.6
4. RTIs	17.9
5. STDs	13.9
6. Early child bearing	22.7
7. Lack of knowledge on puberty and pregnancy signals	39.1
8. Menstrual disorder	23.1
9. Sexual abuse/rape	6.0
10. HIV infection due to lack of knowledge	13.1

### **Knowledge of SPs on adolescent RH**

SPs were asked their opinions on issues regarding adolescent RH. Table 18 incorporates responses on 10 issues that need to be addressed, relating to adolescent RH. .

The three negative statements regarding adolescents’ health most often mentioned by SPs were “no condom use when having sex” (42.4%), “lack of knowledge on puberty and pregnancy signals” (39.1%) and “early sex debut” (30.1%).

**Table 19. Recommendations of SPs on contraceptive methods for adolescents**

	Mean
1. Combined oral contraceptives	
2. Condom	64.1
3. IUD	98.8
4. Injectable	2.1
5. Norplant	7.8
6. Emergency contraceptive pills	4.9
7. Sterilization	80.9
8. Calendar/rhythm method	0.5

Although problems that negatively affect adolescents’ health are becoming increasingly common, knowledge among SPs on adolescent RH counselling was relatively low (only 0.9% attaining 100% NS on all nine issues needed for counselling adolescents). The mean score was only 28.9 and there was no significant difference among the three levels. The counselling issues mentioned by the fewest SPs were discharge syndrome (vaginal or urethra), violence among adolescents (both 6.3%), and emission/masturbation (7.3%) (See Table 76 in the annex).

In regards to recommendations by SPs for meeting adolescent RH care needs, findings showed that

most SPs at all three levels proposed the solution of “regular counselling” (63.4%), followed by “private and confidential counselling” (53%), and “collaboration with schools and unions” (more than 42.4%). Yet as many as 5.8% of interviewed SPs had no recommendations on this issue (See Table 77 in the annex).

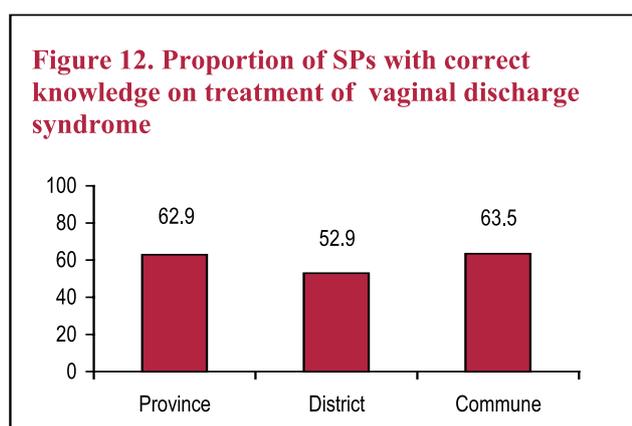
As “early sex debut” becomes more common among adolescents, this survey focused on their use of contraceptive methods. SPs were asked about their recommendations for contraceptive methods for adolescents, and findings are as follows.

At each level and at all three levels, most SPs recommended that adolescents should use condoms (98.8%) and emergency contraceptive pills (80.9%), followed by combined oral contraceptives” (64.1%). However, the proportion of SPs that mentioned the calendar/rhythm method was rather high (38.6%). Sterilisation, Norplant, injectables and IUDs were considered unsuitable for adolescents; a very low proportion of SPs showed agreement on their usage (0.5%, 4.9%, 7.8%, and 2.1% respectively).

**RTIs and STDs**

Knowledge among SPs on RTIs/STDs was assessed through questions about the treatment of vaginal discharge syndrome, counselling on gonorrhoea and treatment of STDs.

Although vaginal discharge is a common clinical syndrome, only 61.2% of SPs gave the correct treatment, which was “Combination of concurrent treatment of STI due to Tricomonas, Bacteria and Candida”. Surprisingly, SPs’ knowledge at the district level seemed poorer than that at the provincial and communal levels.



The proportion of SPs (at all three levels) who gave the correct treatment of vaginal discharge syndrome was the highest in Hoa Binh province (74.7%) and the lowest was in Ben Tre province (42.6%) (See Table 80 in the annex). The proportion of SPs with the correct treatment of vaginal discharge syndrome in provinces involved in the 6<sup>th</sup> country programme (68.1%) was much higher than those in the new provinces in the 7<sup>th</sup> country programme (51.8%).

Gonorrhoea is a dangerous STD and counselling patients may improve the effectiveness of their treatment as well as prevent transmissions. However, knowledge of SPs in regards to this issue was still poor. While most SPs paid attention to “early treatment and adherence to the treatment plan” (66.1%), “transmission

to sex partners” (64.9%) and “correct and regular condom use” (58.9%), only a few SPs mentioned “vulnerability of acquiring HIV” (11%) and “consequences of gonorrhoea” (28.9%). The mean score on counselling patients with gonorrhoea was only 44.6 points, which was higher at the communal level (48) than at the provincial and district levels (38.4 and 39.1) (See Table 79 in the annex).

### Knowledge on infection control

In regards to infection control in RH care services, the most important aspect is hand washing and times of hand washing. However, at all three levels, the proportion of SPs that had a sufficient understanding of the eight determined points of time in order to control infection was very low. The proportion of SPs with knowledge attaining 100% NS on all eight points of time for hand washing was only 8.7% (14.3% at the provincial level, 5.9% at the district level and 8.2% at the communal level). The point mentioned least by SPs were “before going home” (26.7%), “after taking off gloves” (30.7%), “early in the working day” (31%) and “before removal of sterilised instruments for storage” (35.1%) (See Table 81 in the annex).

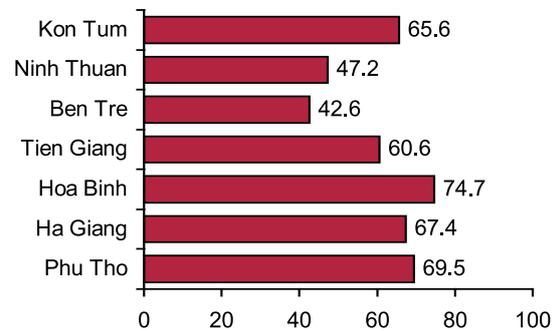
In regards to infection control, SPs should be knowledgeable about the steps of hand washing at the very least. However, findings from interviews showed that such understanding was not as high as expected. The proportion of SPs that gave complete responses regarding the seven steps of hand washing was only 50% at the provincial and district levels and 41.1% at the communal level. The proportion of SPs who gave sufficient answers on hand

washing steps in the correct order was low (22.9% at all three levels). The 5th step, “use fingertips of one hand to scrub the palm of the other, 10 times” was mentioned the least by SPs (60.2%) (See Table 82 in the annex).

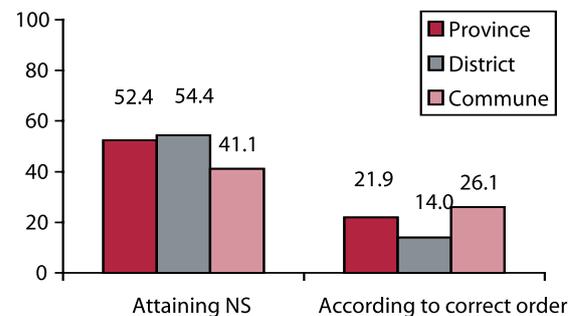
Investigators also gave 11 types of RH services and asked SPs to choose the services in which the use of sterilised gloves is required. This was done in order to assess SPs’ knowledge of infection control. As defined in the NS, there are 4 out of 11 types of service in which the use of sterilised gloves is required. Table 20 shows the proportion of SPs with the correct choices.

The proportions of SPs with correct and complete choices attaining 100% NS on all four types of service

**Figure 13. The proportion of SPs with the correct knowledge on treatment of vaginal discharge syndrome**



**Figure 14. Knowledge among SPs on hand washing for infection control**

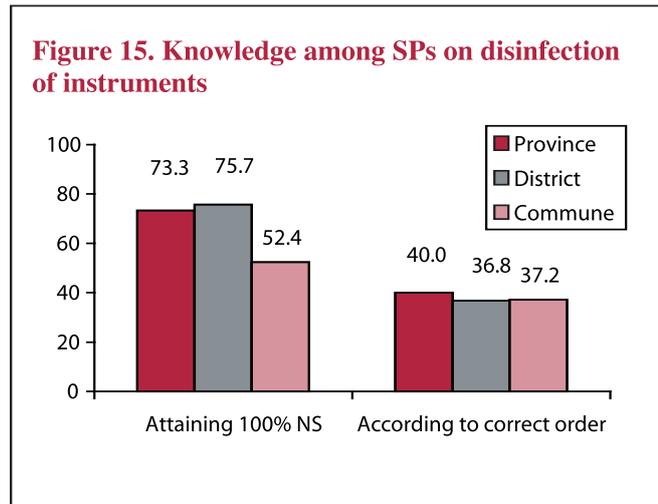


**Table 20. Services in which the sterilised gloves are required.**

Information	Levels			
	Pro. n=105	Dist. n=136	Com. n=414	Mean n=655
Abortion	94.3	94.1	88.4	90.5
Norplant implant/removal	69.5	85.3	65.7	70.4
Placenta removal and uterine checking	100.0	100.0	96.9	98.0
Newborn emergency aid	75.2	80.9	78.5	78.5
Attaining 100% NS	62.9	76.5	55.3	60.9

was the highest at the district level (76.5%) and the lowest at the communal level (55.3%). All four types of service that require sterilised gloves were correctly chosen by more than 70% of SPs.

Knowledge of SPs on infection control was assessed through their knowledge of the main steps in the disinfection of instruments. Most SPs at the provincial and district levels gave complete answers on four main steps in the disinfection of instruments, but this proportion at the communal level was only slightly more than 50%. The proportion of SPs who gave adequate answers on the four steps in the correct order was low and there little difference among all three levels.



Thus, knowledge among SPs on infection control at all three levels, especially the communal level, was not sufficient and they should be regularly supervised in the future.

**2.2.5. SPs’ practice of reproductive health care**

*Interpretation of sample partographs*

A sample partograph in which a labouring woman was in the “alert” status was used to evaluate SPs’ ability in reading results. Table 21 shows an urgent need in the improvement of the SPs’ ability in reading partograph.

**Table 21. Percentage of SPs who could interpret the mother’s status in the partograph**

Option of status	Pro. (n=105)	Dist. (n=236)	Com. (n=414)	Mean (n=655)
1. Normal	12.4	14.0	10.1	11.3
2. Alarm	60.0	66.2	42.5	50.2
3. Need action	11.4	13.2	16.7	15.1
4. Don’t know	16.2	6.6	29.7	22.7

Only about half of SPs knew that the partograph was at the “alert” level (correct selection), with the lowest proportion at the communal level (42.5%). As many as 22.7% of SPs could not interpret the partograph. Of

these numbers, most of them were at the communal level (29.7% vs. 16.2% at the provincial level and 6.6% at the district levels).

The proportion of SPs who could interpret the partograph correctly was the highest in Tien Giang (90.4%) and lowest in Kon Tum (9.7%) (See Table 85 in the annex). The proportion of SPs who could interpret the partograph correctly in provinces involved in the 6<sup>th</sup> country programme (60.4%) was significantly higher than that in the new provinces in the 7<sup>th</sup> country programme (36.2%).

**Pregnancy check-ups**

Pregnancy check-up skills were assessed using the nine steps as defined in the NS. The mean scores (on the 100-point scale) on each step and by each level are presented in the table below.

SPs at all three levels seemed to pay more attention to the “Ob examination” (a mean score of 85.6) while they paid less attention to the “asking” step (Step 1). The lowest score belonged to the step of “urine test”, especially at CHCs (23.3 points compared to 43.2 points at the district level and 40.9 points at the provincial level). Lack of equipment and instruments may have been the cause of these problems at CHCs.

Apart from the “testing” step, which SPs at the communal level performed less than that at the district and provincial levels, the other steps were conducted with the same or slightly higher proportion of SPs.

Among seven provinces, the results were highest in Tien Giang, with the nine steps having higher scores than those in other provinces. Kon Tum and Ben Tre had the lowest scores in many steps (See Table

86 in the annex). The mean scores of SPs on practicing the nine steps of pregnancy check-ups in provinces involved in the 6<sup>th</sup> country programme were higher than those in the new provinces in the 7<sup>th</sup> country programme.

### *Recording in normal delivery records*

The recording ability of SPs in normal delivery records was checked to assess the manner of recording signs/symptoms occurring among pregnant women. Based on the regulations by the NS, seven signs/symptoms were proposed to be monitored (See Table 87 in the annex). In general, the majority of the records at all three levels were able to identify and track the seven signs/symptoms. SPs at the provincial level had the best recording practices; with 5/7 signs/symptoms recorded in 100% of the selected delivery records. The corresponding proportion at the district and communal levels was slightly lower but still high. At all three levels, the parameters of “amniotic fluid” and “foetus-position development” were recorded the least (89.1% and 91.7%). The mean scores of SPs on recording in normal delivery record were 97.3 points at the provincial and district levels and 94.9 points at the communal level.

### *Recording in partograph*

Obstetrical records were also checked to evaluate SPs’ skills in recording through partographs. Five of the technical topics are summarised in Table 23.

The practice of recording through partographs was not complete at all three levels. While a relatively high proportion of SPs cited “start noting when the labour really starts” (up to 89.3% attaining NS), and “recording the progress of labour” (79.4% attaining NS), the

proportion of those attaining NS on recording the “mother status” was only 21.9%. SPs’ weakest area in recording through partographs was found in recording the “mother status” and “reaction upon results presented on partograph”. Recording of partographs among delivery records was completed most adequately at the provincial level and the least at the district level (see Table 88 in the annex).

Among seven provinces, the proportion of SPs that began recording the partograph when labour started was the highest in Kon Tum (100%) and the lowest in Phu Tho (71.1%). The proportion of those who recorded the progress of labour and the foetal status attaining NS was also highest in Kon Tum (100%) and lowest in Ben Tre (53.8% and 26.9% respectively). The proportion of those who recorded the mother’s status to NS levels was found to be the highest in Hoa Binh (32.2%) and lowest in Kon Tum (0%). The

**Table 22. SP pregnancy check-ups by percentage**

Steps	Pro. (n=71)	Dist. (n=88)	Com. (n=307)	Mean (n=466)
1. Ask	26.8	20.5	42.2	35.7
2. General examination	69.6	66.6	69.3	68.8
3. Ob examination	93.7	91.2	82.1	85.6
4. Urine test	40.9	43.2	23.3	29.7
5. Tetanus vaccination	67.6	59.1	70.0	67.6
6. Medicine prescription	53.5	63.6	65.8	63.5
7. Counselling, health education	57.3	62.9	70.6	67.1
8. Recording in logbook	42.6	40.1	57.7	52.0
9. Informing the result, make appointment, instruction	57.3	53.8	49.9	51.8

**Table 23. SPs scores for recording on partographs, by percent**

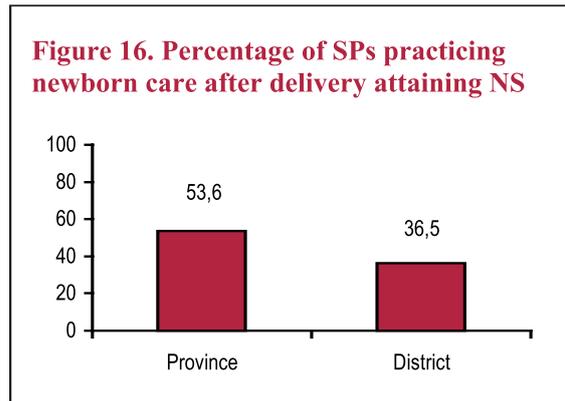
Information	Attaining NS
Start noting	89.3
The progress of labour	79.4
Foetal status	55.5
Mother status	21.9
React upon result presented on partograph	29.2

proportion of those reacting upon results presented on the partograph attaining NS was highest in Ninh Thuan (63.6%) and lowest in Kon Tum (0%) (See Table 89 in the annex).

**Normal newborn care after delivery practice**

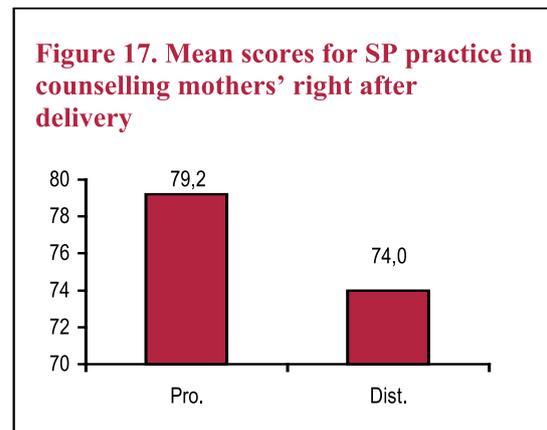
The SPs’ skills regarding normal newborn care after delivery were also assessed according to the NS. Seven aspects were observed to evaluate practice on this issue.

The proportion of SPs practicing all seven aspects in normal newborn care after delivery (attaining NS) at the provincial level (53.6%) was higher than that at the district level (36.5%). Five out of seven aspects were practiced by over 90% of SPs. Two aspects practiced by the fewest number of SPs were “injecting vitamin K1. 1mg unique dose” (59.7%) and “clean eyes with sterile water or saline and put Argyrols drops (silver nitrate) in eyes to prevent infection due to gonococcus “(47.9%) (See Table 90 in the annex).



**Counselling the mother immediately after delivery**

Four topics for counselling the mother following delivery was placed on the checklist to evaluate SPs skills in this respect (see Table 91 in the annex). Two aspects discussed by the fewest number of SPs at the provincial and district levels were the counselling of family members on monitoring and care of the mother and the newborn (47.8%), and counselling the mother on monitoring and care of the newborn (61.6%). The mean score of SPs on counselling the mother after delivery at the provincial level (79.2 points) was a little higher than that at the district level (74 points). The mean score for both levels was the highest in Tien Giang and Hoa Binh (95.7 and 88.6 points respectively), and the lowest in Phu Tho and Kon Tum (63.2 and 67.5 points) (See Table 92 in the annex). The mean score of SPs on the practice of counselling the mother after delivery in provinces involved in the 6<sup>th</sup> country programme (84.5 points) was higher than that in the new provinces in the 7<sup>th</sup> country programme (65.3 points).



**IUD insertion**

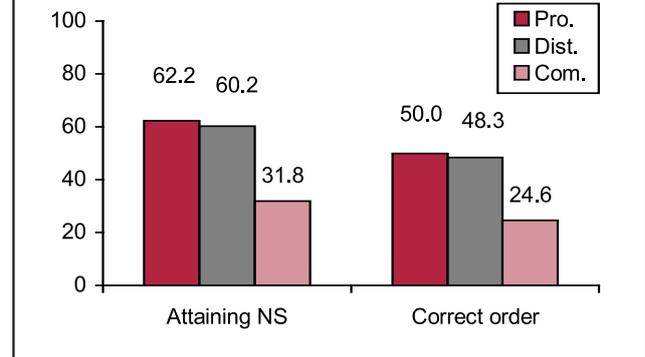
As many as 28 specific steps were observed when SPs practiced inserting the IUD. The findings from the observations of 110 SPs at the provincial and district levels are presented in Table 93 in the annex. The proportion of SPs at the provincial and district levels attaining NS was low (22.2% at the provincial level, 13.8% at the district level). The steps completed by the smallest proportion of SPs were “ask the clients to urinate” (35.6% at the provincial level and 38.5% at the district level) and “explain the steps of the procedure” (48.9% at the provincial level, 32.3% at the district level). The other contents were practiced by most SPs.

The mean scores of SPs on IUD insertion were generally equal between the provincial level (96.7 points) and the district level (82.3 points). Provinces having the highest mean scores on this issue were Tien Giang (97.5 points) and Hoa Binh (93.6 points), and Phu Tho (50 points) and Kon Tum (68.3 points) had the lowest scores (See Table 94 in the annex). The mean score for SPs in IUD insertion in the 6<sup>th</sup> country programme (90.8 points) was significantly higher than that in the new provinces in the 7<sup>th</sup> country programme (77.5 points).

*Hand washing practices*

Over 60% of SPs at the provincial and district levels and 31.8% at the communal level adequately practiced the seven steps of hand washing. The proportion of those practicing the sufficient number of steps and in the correct order was lower (34% for three levels). The steps practiced by the lowest proportion of SPs (about 60%) were Step 4 (use the fingers of one hand to scrub the surface of each finger of the other hand 10 times) and Step 5 (use fingertips of one hand to scrub the palm of the other 10 times) (see Table 95 in the annex).

**Figure 18. Handwashing steps against NS, by percent**



## CHAPTER 3

# KNOWLEDGE, ATTITUDE AND BEHAVIOUR OF RH/POPULATION PROGRAMME STAFF AND EDUCATORS

### 3.1. RH PROGRAMME STAFF

#### 3.1.1. General information on surveyed target groups

Of the 635 RH programme staff that participated in the survey, 9.4% were at the provincial level, 25.7% at the district level and 64.9% were at the communal level.

All RH programme staff at all three levels (provincial, district and communal levels) received formal technical training at the elementary level or over. Additionally, 91.4% were trained in the medical profession. The staff who were assigned to manage/monitor RH programmes had studied at the university and college levels and were found with the highest proportions at the provincial level (88.3%), followed by the district level (52.1%) and communal level (17.5%).

Up to 62.4% of RH programme staff at all three levels were women and 72.4% were Kinh ethnicity (See Table 96 in the annex).

**Table 24. Training/retraining of respondents on operational issues**

Training items	Training		
	Untrained	Previous 1-3 years	More than 3 years ago
Contents of National Strategy for Population in Vietnam, 2001-2010 period	59.7	34.0	6.3
Contents of National Strategy for Reproductive Health Care, 2001-2010 period	47.2	45.7	7.1
Gender and gender equity in Reproductive Health Care	58.3	38.6	3.2
Violence and violence prevention for women	55.3	41.4	3.3
Management of quality in Reproductive Health Care	45.2	49.4	5.4
Behavioural Change in provision of RH services	38.6	57.0	4.4

A notable point in the training and retraining of RH programme staff at all three levels was the proportion that had not been trained/retrained on the issues related to population strategy and the RH care strategy. Generally, the proportion of RH programme staff that had not been retrained on any of the six contents was 27.1%. Inversely, 26.3% of RH programme staff at all three levels had been retrained on all six issues. The majority of staff had been trained/retrained on these issues in the previous three years.

### 3.1.2. RH programme staff knowledge on RH management

The National Strategy on Reproductive Health for 2001-2010 was issued in accordance with Decree No. 136/2000/QĐ-TTg, dated November 28, 2000. When asked about the main objectives of the Strategy, many RH programme staff could give satisfactory responses. The proportion of those who were not able to identify any contents was 33.9%, mainly at the communal level (35%) and district level (41.7%). The proportion of those who were able to name the two objectives, “improving the present RH status” and “reducing the situation of imbalance among regions and areas” was only 14.3%, and mainly at the provincial level (40%). The proportion of those at all three levels that were knowledgeable about these two objectives was the highest in Phu Tho (33.7%), and lowest in Ninh Thuan and Hoa Binh (2.4% and 4.3%, respectively) (See Table 98 and Table 99 in the annex). The proportion of the staff that was knowledgeable about the two objectives of the National Strategy for Reproductive Health for 2001-2010 in provinces involved in the 6<sup>th</sup> country programme (19.7%) was considerably higher than that in the new provinces in the 7<sup>th</sup> country programme (6.8%).

**Table 25. Understanding of the main solutions in the National Strategy on Reproductive Health**

Solutions	%
Knowing 1 solution	25.4
Knowing 2 solutions	20.0
Knowing 3 solutions	11.8
Knowing 4 solutions	5.4
Knowing 5 solutions	2.5
Knowing 6 solutions	2.2
Knowing 7 solutions	1.1
Don't know	31.7

Knowledge among RH programme staff at all levels on the key solutions of the National strategy on RH in the 2001-2010 period was very limited. As many as 31.7% of respondents (32% at the communal level and 39.9% at the district level) could not identify any solutions; very few knew about all three solutions. The most mentioned solution of the Strategy, “strengthening IEC activities”, accounted for only 59.1%. The others were mentioned by under 30% of RH programme staff.

The mean score of RH programme staff regarding their knowledge about the main solutions of the National Strategy on RH care was low (22.3), highest in Ha Giang and Phu Tho (38.4 and 33.9), and lowest in Ninh Thuan and Kon Tum (14) (see Table 100 and Table 101 in the annex). The mean score on this issue in provinces involved in the 6<sup>th</sup> country programme (27.7) was remarkably higher than that in the new provinces in the 7<sup>th</sup> country programme (14.7).

#### *About the annual plans*

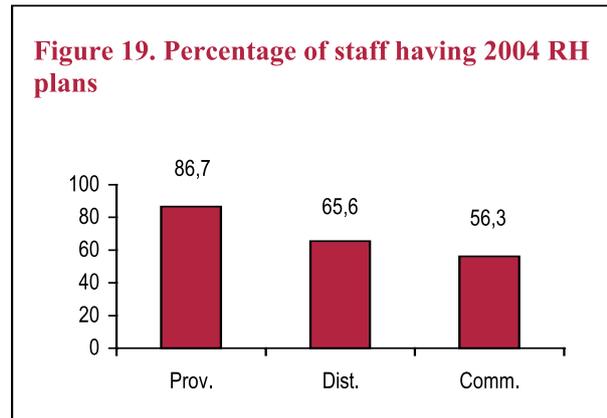
Findings from the answers to the question “What are the primary contents of a good annual plan?” show that all the given contents were mentioned by more than 40% of respondents. About 18.6% of them could identify the five main contents of a good annual plan, but 12.3% could not identify any of these contents. Ben Tre province had the highest mean score (79.6), while the lowest mean score was found in Kon Tum (30.9) (See Table 102 and Table 103 in the annex). The mean score on this issue in provinces involved in the 6<sup>th</sup> country programme (54) was not much higher than that in the new provinces in the 7<sup>th</sup> country programme (50).

Among 635 interviewees, 61.6% had RH/FP plans for 2004 to show the investigators at the time of the survey (86.7% at the provincial level, 65.6% at the district level and 56.3% at the communal level). As many as 11.3% of the respondents reported that their health facilities did not have RH/FP plans for 2004.

**Table 26. Understanding about items needed for BCC in RH/FP annual plans**

Contents	% (n=635)
Knowing 1 content	16.2
Knowing 2 contents	18.6
Knowing 3 contents	22.2
Knowing 4 contents	12.1
Knowing 5 contents	18.6
Don't know all 5 contents	12.3

According to interviewers, among the 391 RH/FP plans for 2004 observed, 41.9% contained the five main contents. The proportion of provinces with plans containing the five contents was the highest in Ben Tre (66.7%) and Tien Giang (64.8%), and the lowest in Kon Tum (7.1%), Hoa Binh (9.3%) and Ninh Thuan (11.3%) (See Table 105 and 106 in the annex). The proportion of plans containing the five contents in provinces involved in the 6<sup>th</sup> country programme (48.5%) was higher than that in the new provinces in the 7<sup>th</sup> country programme (38.3%).



Additionally, from the assessment of the interviewers, 39.9% of the observed plans did not clearly differentiate the varied budgetary sources in their itemised budget breakdown and 58.3% did not express any priorities (See Table 107 and Table 108 in the annex).

**Table 27. Main contents in annual plans for 2004**

Contents	% (n=391)
Knowing 1 content	6.9
Knowing 2 contents	12.0
Knowing 3 contents	13.6
Knowing 4 contents	24.3
Knowing 5 contents	41.9
Don't have all 5 contents	1.3

According to the interviewees, upon completion, copies of those plans were disseminated. The majority of the plans were sent to the higher level for reporting purposes (93.9%), others to their unit for notification and implementation (85.9%), and the fewest in number to the lower level for implementation (78.3%) (See Table 109 in the annex).

**Supervision**

Supervision is a task of the utmost importance because it ensures successful implementation. About 95% of interviewees said that their facilities conducted supervisory activities in the implementation of the RH/FP plans.

Overall, at all three levels, the most common form of supervision that the interviewees applied to their RH/FP plans was on the basis of “on-site evaluation, direct observation” (88.6%), followed by “checking records, log books, and reports” (70.5%), and “integrating supervision into other programmes” (54.2%). The least applicable was “inviting independent agencies or supervision teams” (11.3%) (See Table 110 in the annex).

All supervisory visits should be accompanied by suitable supervision tools, but more than half of interviewees reported not having such tools, especially those at the communal level (65.6%, including interviewees who said that they used their personal books), followed by the provincial level (16.7%) and district level (14.9%). The most widely used supervision tools were forms/checklists (36%) and questionnaires (33.7%) (See Table 111 in the annex).

Activities that should be done after each supervision session include writing reports, reporting to leaders, giving feedback to health facilities and sharing supervision results with stakeholders. Findings showed that 54.1% of respondents wrote reports, 72.4% reported to leaders, 74.1% gave feedback to health facilities and 40.6% shared supervision results with stakeholders. It is critical to give feedback to the supervised health facilities to help them draw experience as well as to adjust/revise their work plan (See Table 112 in the annex).

During the last three years, only about half of interviewees reported that the staff in their health facility had received training regarding supervision of their RH/FP programme, with the lowest proportion at the

communal level (43%) and the highest at the provincial level (73.3%) and district level (55.2%) (See Table 113 in the annex).

### *Attitude toward selected statements related to RH*

Four positive statements that received agreement from 80% of the respondents, including “It is obligatory for health workers to conduct counselling with every client” (97.8%), “Medical equipment in this facility has been effectively used to serve the clients” (81.3%), “Clients have the right to discuss with health workers on treatment approaches” (89.3%), and “Health workers are health care SPs and patients are users” (99.4%). The other positive statement, “The professional qualification of health workers at this facility is sufficient to respond to people’s needs for health care”, received agreement from only 54.2% of respondents with the smallest number at the provincial level (31.9%). The negative statement, “Health education materials are not enough to distribute to clients” still received agreement from 72.9% of SPs, with the biggest number at the provincial level (80.4%). The false statement that “health workers take necessary precaution measures of HIV only when they contact clients who are suspected of HIV/AIDS” was still agreed by 39.5% of respondents, most at the communal level (52.4%) (See Table 114 in the annex).

### *The need to prioritise training*

Priorities in training for CHC heads and midwives were investigated through respondents’ subjective opinions (See Table 115 in the annex). According to the RH programme staff at the provincial and district levels, the item that should be prioritised in training CHC heads was “planning skills” (68.3% at the provincial level and 53.4% at the district level). RH programme staff at the communal level and the CHC heads themselves said that “RH technical skills” should be prioritised (46.1%).

When asked about topics to be prioritised in retraining midwives, RH programme staff at all three levels unanimously recommended that it be “counselling skills” (32.1% of all respondents, 40% at the provincial level, 44% at the district level and 26% at the communal level), followed by “normal delivery assistance” (17%). However, other important issues relating to the child survival - “newborn care” and “postpartum care” - were suggested to be prioritised in training by only a few staff (7.1% and 1.6% respectively) (See Table 116 in the annex).

### *RH programme management*

Interviewees were asked “What are the primary management issues for RH/FP programme management?” to assess their knowledge on RH/FP programme management. The results (see Table 117 in the annex) showed that knowledge among RH/FP programme staff regarding management at the three levels was still limited and insufficient; 12.6% of them did not know what issues were related to management, especially those staff at the communal (16.5%) and district levels (7.4%). The two aspects of time and information were mentioned by very few staff (11.7% and 11.5%). Most RH programme staff at all three levels could name one to four issues and very few were able to adequately mention five to six management issues

There should be six aspects for behaviour change communication (BCC) in a good RH/FP plan. But very few RH programme staff could name all six aspects (1.1%). Up to 17.5% of them did not know any of these points, most at the communal (22.6%) and district level (11%). The proportion of RH programme staff who mentioned the BCC in RH/FP was no more than 40% (see Table 118 in the annex).

It is clearly stated in the National Strategy on Reproductive Health for 2001-2010 that “the IEC and advocacy activities should be accessible to all target groups, including public-elected representatives, scientists, political and religious leaders, social workers, members of women’s union and youth league, school pupils’ parents, community prestigious people, with a special focus on men’s responsibility and undertaking on RH and sexual health”. The responses to the request “Please name the prioritised target groups according to the BCC in RH/FP” showed that women within reproductive age were considered to be the target group of BCC in RH/FP by most respondents (87.7%), followed by adolescents and youth (79.2%). The target groups that received the fewest responses were couples (59.1%), men (46.1%), leaders

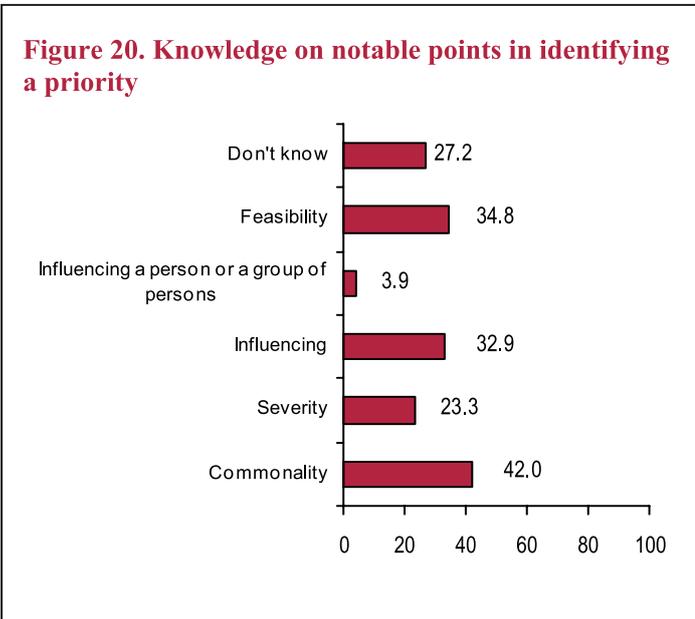
and prestigious members of the community (27.6%), SPs (16.1%) and unmarried people (12%) (See Table 119 in the annex).

The proportion of interviewees who were knowledgeable about the notable points in identifying RH issues to be prioritised was still low. These notable points, including commonality, severity, impact on the community and feasibility, were mentioned by a low proportion of respondents, specifically, 27.2% of respondents (34.7% at the communal level, 15.3% at the district level and 8.3% at the provincial level) could not identify these points as priorities in RH.

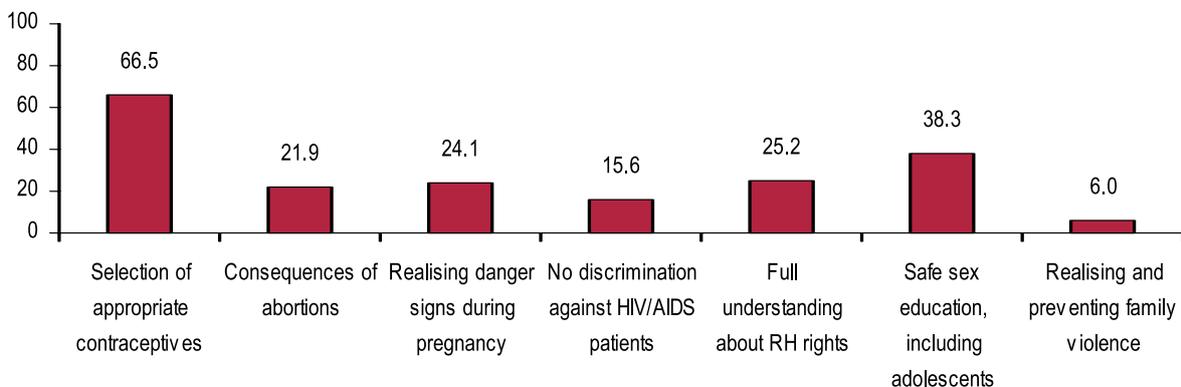
Among the 635 interviewees, the proportion of those at provincial levels who were able to identify the three issues of priority was the highest (81.7%), followed by those in the district level (72.4%), and the communal level (36.4%). Inversely, 14.1% of respondents at the communal level and 2.5% at the district level still did not know what these three issues of priority were.

The issues that were mentioned the most were "training the counselling skills for health care providers" (50.7%), followed by "increasing the proportion on the mother and newborn examinations/care after delivery" (33.5%) and "increasing the proportion on using available health services in their health facilities" (27.1%) (See Table 121 in the annex).

According to RH programme staff, the issues of priority in BCC were the selection of contraceptives (66.5%), followed by safe sex education, including adolescents (38.3%). Others, such as the consequences of abortion, recognition of danger signs during pregnancy, no stigma and discrimination towards people living with HIV/AIDS, full knowledge on clients' rights, and realising family violence and violence prevention received responses from under 30% of respondents (See Table 122 in the annex).



**Figure 21. Elements for focus in undertaking BCC for the public**



The understanding of programme staff at all three levels about the important aspects for RH supervision at the grassroots level was low and insufficient; especially at the communal level (24.3% of respondents could not know any contents). The proportion of RH programme staff who sufficiently knew the seven aspects of supervision was very low (1% at the communal level, 7.4% at the district level and 10% at the provincial level). Almost all aspects were identified by less than 55% of respondents (See Table 123 in the annex).

## 3.2. POPULATION/FAMILY PLANNING PROGRAMME STAFF

### 3.2.1. Background information on the survey target groups

Of the population/family planning programme staff who participated in the survey, 7.1% were at the provincial level, 19.5% at the district level and 73.5% at the communal level. All the population/family planning programme staff at the provincial level had received training from the primary level and upward, of which 2.5% held college degrees from a medical university and 14.9% held college degrees from a non-medical university. Additionally, 64.8% of the population/family planning programme staff at the communal level had not completed any technical school from primary level upward. The proportion of female staff accounted for 57%, which was higher than the proportion of male staff (43%). As many as 36.4% of the interviewed population programme/family planning staff were not Kinh ethnicity (see Table 124 in the annex).

Among the population/family planning programme staff at all three levels, 60-70% had received training or retraining on technical/operational issues, mostly in the previous three years. Overall, the proportion of population/family planning programme staff at all three levels that had been retrained on the six issues was 44.6% and the proportion of those who had not received any training/retraining on the issues related to the National Population Strategy and National RH Strategy was 19.5%.

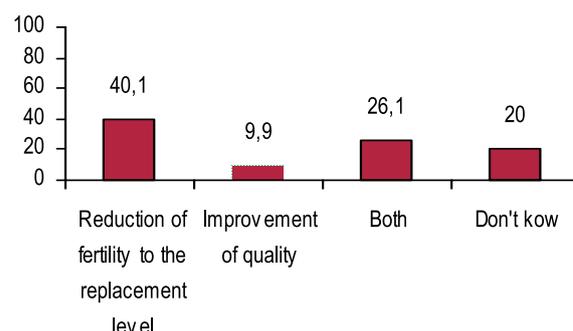
### 3.2.2. Knowledge among population/family planning programme staff on population and FP management

**Table 28. Training/retraining of respondents on technical/operational issues**

Contents	Training/Retraining (%)		
	None	1-3 years ago	Over 3 years ago
Contents of National Strategy for Population in Vietnam for 2001-2010 period	35.1	54.1	10.7
Contents of National Strategy for RH Care, 2001-2010 period	33.1	58.7	8.1
Gender and gender equity in RH care	32.0	60.1	7.9
Violence and prevention of violence to women	39.0	53.4	7.5
Behaviour Change Communication in provision of RH services	31.6	60.1	8.1
Management of quality of RH care	37.6	53.3	9.1

When asked about the contents of the National Population Strategy for the 2001-2010 period, the proportion of respondents who were able to give satisfactory responses was still not high. The proportion of those who were unable to identify any objectives was 20%, of which 23.4% were at the communal level, 12.7% at the district level and 5% at the provincial level. The proportion of those who were able to identify two objectives including “reduction of fertility to the replacement level” and “improvement of quality” was 26.1%; this proportion at the provincial (58.3%) was higher than that at the district level (48.5%) and at the communal level (17%). The proportion of the staff at all three levels that were able to identify these two objectives was the highest in Tien Giang (47.9%) and Ben Tre (43.4%), and the lowest in Ninh Thuan (9.9%) and Hoa Binh (12.3%) (See Table 127 in the annex). The proportion of staff able to identify two objectives of “National strategy on Population for 2001-2010 period” in provinces involved in the 6<sup>th</sup> country programme (28.5%) was not much higher than that in the new provinces in the 7<sup>th</sup> country programme (22.8%).

**Figure 22. Knowledge on content of the National Strategy on Population for 2001-2010 period**



**Table 29. Knowledge on the main solutions of the National Strategy for Population**

Solution	% (n=848)
Knowing 1 solution	26.4
Knowing 2 solutions	22.8
Knowing 3 solutions	13.4
Knowing 4 solutions	8.4
Knowing 5 solutions	1.3
Knowing 6 solutions	1.5
Don't know	26.2

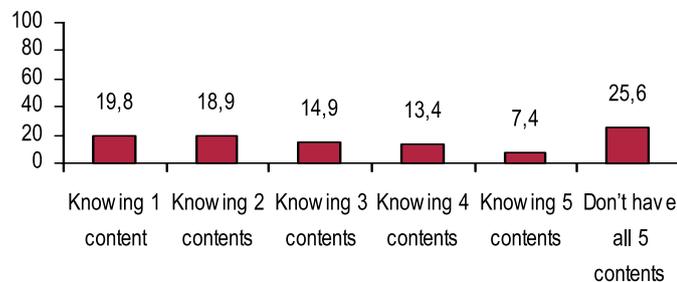
The knowledge of population/family planning programme staff at all levels on key solutions of the National strategy on population in the 2001-2010 period was very limited, especially at the communal level. Up to 26.2% of respondents (31.3% at the communal level, 13.3% at the district level and 8.3% at the provincial level) did not know of any solutions. Very few people knew five to six solutions. The solution most often mentioned from the National Strategy on Population at all three levels was “Strengthening BCC in provision of RH services” (51.3%). The least mentioned was “Heightening the quality of RH care services” (12.7%) (See Table 128 in the annex).

**Knowledge on the annual plan**

Interviewees were asked about the main contents of a suitable annual plan; findings are presented in the nearby figure. A suitable plan has five main contents but only 7.4% of population/family planning programme staff could name all five. Up to 25.6% of interviewees (33.7% at the communal level, 3.6% at the district level and 1.7% at the provincial level) were unable to identify the main contents of a suitable plan.

Apart from the content “Specific objectives”, which received responses from 57.9% of interviewees, most contents received responses from less than 40% of interviewees at all levels (See Table 129 in the annex). The population/family planning programme staff could not construct a suitable annual plan because their knowledge of the main contents needed was still very limited and it is necessary to hold a training course on planning for the population/family planning programme staff at all levels.

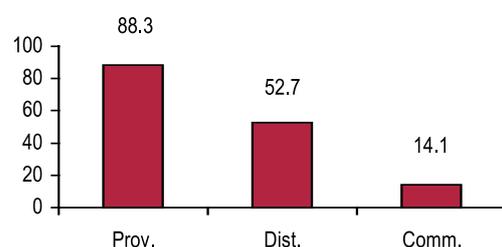
**Figure 23. Percentage of RH staff with knowledge on key contents of a good plan**



Among the 848 interviewees, only 26.9% had population/FP plans for 2004 to show the investigators at the time of the survey, of which the proportion of those at the provincial level (88.3%) was higher than at the district level (52.7%) and at the communal level (14.1%). About 36.1% of respondents at the communal level, 12.7% at the district level and 1.7% at the provincial level reported that their health facilities did not have the population/FP plans for 2004.

As assessed by the interviewers, the proportion of population/FP plans for 2004 having all five contents as required was 44.3%, of which the proportion of those at the district level (57.5%) was higher than that at the provincial level (39.6%) and at the communal level (34.1%). The content of “time allocation”, the least mentioned, also accounted for 72.8% (See Table 131 in the annex). The proportions of provinces with population/FP plan for 2004 having all five contents were Tien Giang (69.4%), Ben Tre (68.1%), Ha Giang

**Figure 24. Percentage of staff having a 2004 Population plan to show**



**Table 30. Main contents in annual plans for 2004**

Contents	% (n=228)
Knowing 1 content	3.1
Knowing 2 contents	8.3
Knowing 3 contents	17.1
Knowing 4 contents	24.6
Knowing 5 contents	44.3
Don't have all 5 contents	2.6

(71.4%), Phu Tho (15.4%), Hoa Binh (12%), Ninh Thuan (9.1%) and the lowest was Kon Tum (0%) (See Table 132 in the annex). The proportion of population/FP plans for 2004 having the complete five contents in provinces involved in the 6<sup>th</sup> country programme (48.5%) was considerably higher than that in the new provinces in the 7<sup>th</sup> country programme (38.3%).

According to the interviewees, 30.7% of the observed plans did not clearly express the varied budgetary sources (56.8% at the communal level, 23% at the district level) while 50.9% of them had shown local budgetary allocation; 25.4% of

them showed central allocation of budget and 31.1% showed separate budgetary allocation from supportive projects (See Table 133 in the annex).

It was also revealed that among the observed plans, priorities were not shown in 6.9% of the plans at the district level. Up to 60.1% of those plans (86.8% at the provincial level, 73.6% at the district level and 30.7% at the communal level) had shown that the priority was given to disadvantaged areas while 41.7% of those plans at three levels had shown that the priority was given to areas inhabited by ethnic minorities/underprivileged people. Notably, only 32% (45.3% at the provincial level, 43.7% at the district level and 12.5% at the communal level) had shown priority to facilities providing health care and FP services to clients (See Table 134 in the annex).

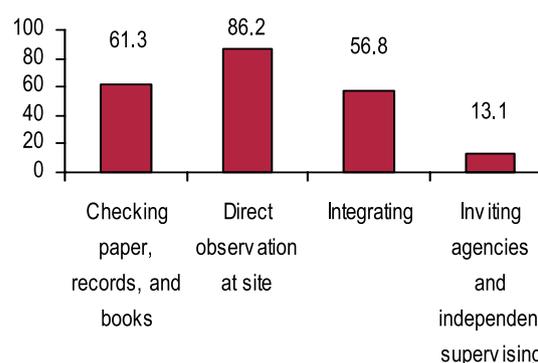
According to interviewees, their plans were sent to different destinations upon completion. They were sent to the higher level for reporting purposes (97.4%), followed by the lower levels for implementation (93.9%) and kept internally for information sharing and implementation purposes (87.7%) (See Table 135 in the annex).

### *About supervision*

Supervision is a very important activity, as it ensures the successful implementation of plans. Up to 92.6% of interviewees said that their organisations had supervision on implementation of activities in population and FP plans. The most common form of supervision applied to population and FP programme implementation was “On-site evaluation and direct observation” (86.2%), followed by “Checking paper, records, logbooks” (61.3%), and “Integrating supervision into other programmes” (56.8%). The least common form was “Inviting independent supervising agencies/teams” (13.1%).

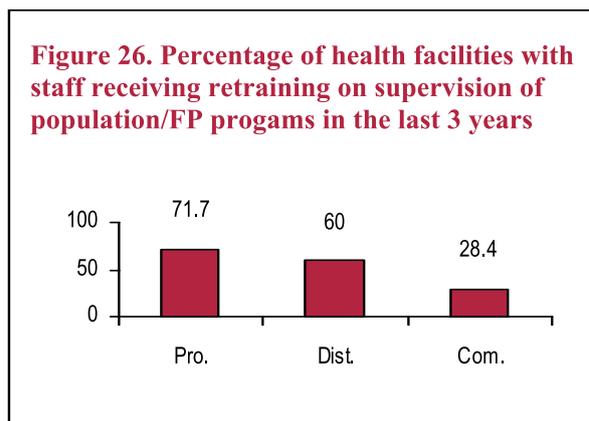
All supervision sessions must have the appropriate tools. However, up to 62.8% of the interviewees admitted that they did not have any tools for supervision (personal notebooks were not considered supervision tools). Respondents who reported that they had no supervision tools were found in the highest numbers at the communal level (75.3%), followed by the district level (34%), and the provincial level, the lowest at 15.5%. The supervision tools used by interviewees were forms/checklists (20%) and questionnaires (27.1%) (See Table 138 in the annex).

Activities that should be completed after each supervision session include writing reports,

**Figure 25. Supervision of implementation in population/FP plans**

reporting to leaders, giving feedback to the health facilities and sharing supervision results with stakeholders. Findings showed that 60% of respondents wrote reports, 72.7% reported to leaders, 60.8% gave feedback to health facilities and 35% shared supervision results with stakeholders. It is critical to give feedback to the supervised health facilities to help them draw experiences as well as adjust their work plans accordingly (See Table 139 in the annex).

Over the last three years, only 37.6% of respondents reported that the staff in their health facility had received training on supervision of population/FP activities. The lowest numbers were found at the communal level (28.4%) and the most at the provincial level (71.7%).



**Attitude towards selected statements related to RH**

**Table 31. Percentage of respondents agreeing with statements related to RH/population**

Information	Pro. n=60	Dist. n=165	Com. n=623	Mean n=848
1. Counselling is a must for population staff to provide to any client	100.0	97.0	95.2	95.9
2. Health education materials on population/FP in this locality have been effectively used to serve the clients	88.3	87.3	91.0	90.1
3. Insufficient health education materials on population/FP to distribute to clients	48.3	53.3	70.1	65.3
4. Professional skills of population staff in this locality meet people’s needs for examination and treatment	65.0	46.1	44.1	46.0
5. Clients have the right to discuss with health workers about treatment method	93.3	93.9	93.4	93.5
6. Health workers are SPs and service users are clients	100.0	97.0	99.4	98.9

Among six statements, four positive statements that received agreement from more than 90% of respondents were “It is an obligatory job for population staff to conduct counselling with every client”, “IEC materials of population/FP are used effectively in the service of patients”, “Clients have the right to discuss treatment methods with health workers”, and “Health workers are SPs and service users are clients”. The statement “Professional skills of providers in this facility meet people’s needs for examination and treatment” was agreed by only 46% of interviewees with the lowest proportion found at the communal level (44.1%). The negative statement, “Health education materials are not enough (sufficient quantity) to distribute to clients” was agreed by 65.3% of interviewees with the highest proportion found at the communal level (70.1%) (See Table 141 in the annex).

**Priority to be given to the training**

According to the population/family planning programme staff at the provincial and district levels, first priority should be given to the training of communal population collaborators in “counselling skills” (30% at the provincial level, 33.9% at the district level). Communal population/family planning programme staff or other staff agreed that “population/FP technical skills” should be the first priority (39.2%). For all three levels, the three issues which should be prioritised for population/family planning programme staff were “ population/FP technical skills” (33.5%), “counselling skills” (24.6%), and “communication skills” (21.3%) (See Table 142 in the annex).

**Issues of management in Population/FP programmes**

There are six aspects of management in population/FP programmes, but population/FP programme staff

knowledge of managerial aspects at all levels was still insufficient. As many as 21.5% of interviewees did not know what the managerial aspects were with the highest proportion at the communal level (26.5%). Very few were able to identify all six aspects and only 2.5% were able to identify five aspects. The two least mentioned aspects were time management (9%) and information management (12.1%) (See Table 143 in the annex).

A suitable plan for Population/FP programme BCC activities should contain six aspects, but only 0.4% of interviewed population/FP programme staff were able to identify all six aspects while very few listed four to five aspects (6.4%). Notably, 32.8% of respondents could not identify any aspects that should be included in their plan, particularly at the communal level (40.9%).

The aspect, “Identify priority problems to be resolved”, had the highest proportion of identification by interviewees at 30.9% while “Compose key messages to be used”, received the lowest proportion, at 16.6% (See Table 144 in the annex).

Regarding the request “Please name the prioritised target groups on BCC in Population/FP”, a high proportion of respondents (78.9%) cited the target group women of reproductive age. Adolescents/young people were also mentioned by a high proportion of respondents (68.3%). Other priority target groups for BCC on Population/FP were couples (52.7%), men (48.1%), leaders and prestigious members of the community (23.6%), unmarried people (8.8%) and SPs (7.3%) (See Table 145 in the annex).

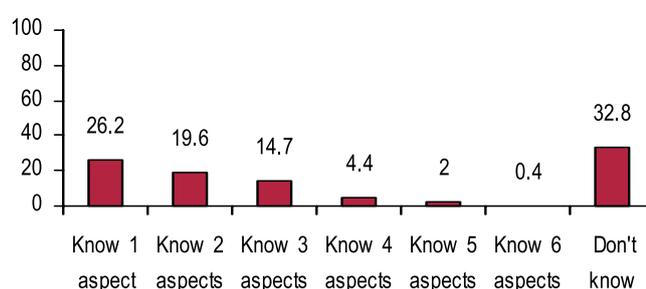
The proportion of interviewees with knowledge of considerations that should be taken in identifying population/FP issues to be prioritised was found to be low. Those considerations, such as commonality, severity, influence on the community and feasibility, were mentioned by a low proportion of respondents. Notably, 43% of respondents were not able to identify any of the considerations while the highest proportion was found at the communal level (54.4%).

The proportions of Population/FP staff that were able to point out three RH/FP issues of priority at the provincial and district levels (75% and 76.4%) were much higher than at the communal level (19.3%). The specific issues that were mentioned by the majority of Population/FP staff were “Train SPs on counselling skills” (28.9%), “Increase the proportion of the mother and newborn care after delivery” (27.4%) and “Increase the use of condoms,

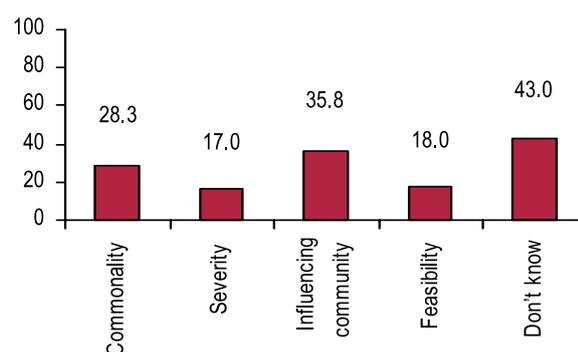
**Table 32. Percentages for knowledge on management issues in population/FP programmes**

Information	% (n=848)
Know 1 aspect	28.3
Know 2 aspects	23.0
Know 3 aspects	14.6
Know 4 aspects	8.8
Know 5 aspects	2.5
Know 6 aspects	1.3
Don't know	21.5

**Figure 27. Percentages for knowledge on BCC in population/FP activities**



**Figure 28. Percentages for knowledge on the identification of priority issues in population/FP**



contraceptives, and decrease the use of IUDs” (27%). However, 25.8% of Population/FP staff at the communal level and 3.6% at the district level were unable to identify any of the three priority issues (see Table 147 in the annex).

According to interviewed Population/FP staff, the issue, “Selection of contraceptives”, was mentioned by most interviewees (58.4%) as a focus for BCC activities. The other contents, such as “Consequences of abortions”, “Realising danger signs during pregnancy”, “No stigma and discrimination against HIV/AIDS-infected people”, “Full understanding about RH rights”, “Safe sex education, including adolescents” and “Realising and preventing domestic violence” were mentioned by 9.9% of interviewees. And 13.4% of them (16.5% at the communal level, 6.1% at the district level and 1.7% at the provincial level) did not mention any of the issues for BCC (See Table 148 in the annex).

The understanding of Population/FP programme staff at all three levels about the important points for Population/FP supervision at the grass-roots level was still low and insufficient. Up to 31.3% of them were unable to identify any points while the highest proportions were found at the communal level (39.8%). Yet only 1.1% of them knew all seven points. The important points, such as “Forms/checklists as tools for supervision”, “Skills of supervision”, “Assisting lower levels during supervision” and “Feedback to the supervised facilities” were mentioned by less than 25% of interviewees (for all three levels) (see Table 149 in the annex).

### 3.3. POPULATION/FP PROGRAMME COMMUNICATION STAFF

#### 3.3.1. Background information on survey target groups

The majority of staff directly involved in the communication activities in Population/FP programmes had completed technical school from elementary level upward. Of that group, 72.6% possessed university and college degrees. However, 91.6% of Population/FP communication staff at the communal level had not completed any technical school from elementary level upward, and many of them were found to be at a secondary school level of education (52.1%). Among interviewed communication staff, the number of women was proportionally higher (67%) than males, while 37.2% ethnicity other than Kinh. The chief functions of provincial and district Population/FP communication staff were evenly distributed into three groups (population officers, Women’s Union staff and Farmers’ Association staff). At the communal level, those who were involved in Population/FP communication were population collaborators (40.8%), Women’s Union staff (27.1%) and Farmers’ Association staff (24.3%) (See Table 150 in the annex).

The proportion of Population/FP communication staff trained or retrained on issues directly related to population/FP activities was low; 35% to 51% had not been trained on technical issues. In general, 24.6% of staff had not been trained on any of the above six aspects. Otherwise, 31.2% of the staff had been retrained on all six aspects and most of them were trained in the previous three years.

#### 3.3.2. Knowledge on Population/FP communication and counselling

**Table 33. Training/retraining of population staff on technical issues**

Contents	Training/retraining		
	None	1-3 yrs. ago	more 1-3 yrs. ago
1. National Strategy on Population in Vietnam for 2001-2010 period	51.2	43.6	4.7
2. National Strategy on Reproductive Health Care, 2001-2010 period	44.5	52.2	2.8
3. Gender and gender equity in reproductive health care	44.7	51.4	3.7
4. Violence and prevention of violence to women	49.4	47.0	3.4
5. Quality of reproductive health care	48.7	47.4	3.8
6. Population communication and reproductive health care	34.8	57.8	6.5

When asked about the main contents of the National Strategy for Population during the 2001-2010 period, the proportion of educators who could identify two key objectives was low, especially among those at the district and communal levels (see Table 152 in the annex). None of the contents could be mentioned by 34.1% of respondents at the communal level, 24.1% at the district level and 11.3% at the provincial level. The proportion of staff that could identify two key objectives, namely “reducing fertility to the replacement level” and “improvement of population quality”, was higher at the provincial level (67.7%) than at the district (44.6%) and communal level (27.3%).

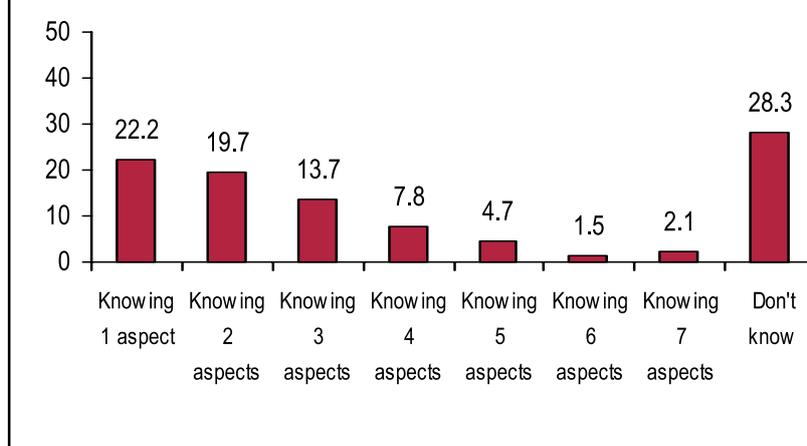
Knowledge among educators on behaviour change communication was not adequate. The proportion of those able to suggest six to seven RH aspects needed for community BCC was low (3.6%) while 28.3% of the communication staff (30.2% at the communal level, 26.5% at the district level and 8.1% at the provincial level) were not able to name any aspects. The aspect, “selection of appropriate contraceptives” (considered by most respondents as a focus of RH BCC) accounted for only 53.5%. The other six aspects were mentioned by less than 32% of respondents (See Table 153 in the annex).

Communication is the means of sharing and exchanging information from a giver to a receiver so as to achieve a level of understanding, awareness and a change in behaviour and attitudes. Findings from interviews showed that more than 70% of respondents were able to correctly describe the concept of communication. However, 13.5% of those at the communal level did not know the concept of communication.

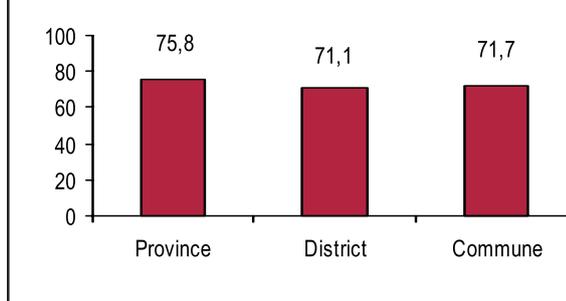
Different forms of Population/FP communication can be applied to certain target groups, but the proportion of staff at all levels who could name the forms of communication were not high and remained insufficient. The various forms of communication mentioned by the interviewees in ranking order were “direct talks” (76.8%), “home visits” (53.8%), “distributing IEC materials” (29.8%), “counselling” (28%), and “self-taught” (9.7%). The other two forms, “making phone calls” and “personal letters”, were mentioned by very few staff (3.7% and 1.5% respectively) (See Table 155 in the annex).

The forms of group meeting/discussion mentioned by the most respondents (74.9%), and much higher in comparison with others, were “presentation” (33.8%), and communication campaign and utilisation of visual aids (films, slide projection, models and pictures) (20%). The other forms mentioned by a few respondents included study visits for experience exchange, role-plays, demonstration and dramas. Notably, 14.9% of respondents at the communal level were unable to identify any forms of communication to apply to the target group (See Table 156 in the annex).

**Figure 29. RH issues for Behavior Change Communication**



**Figure 30. Proportion of staff with correct knowledge on the concept of communication**

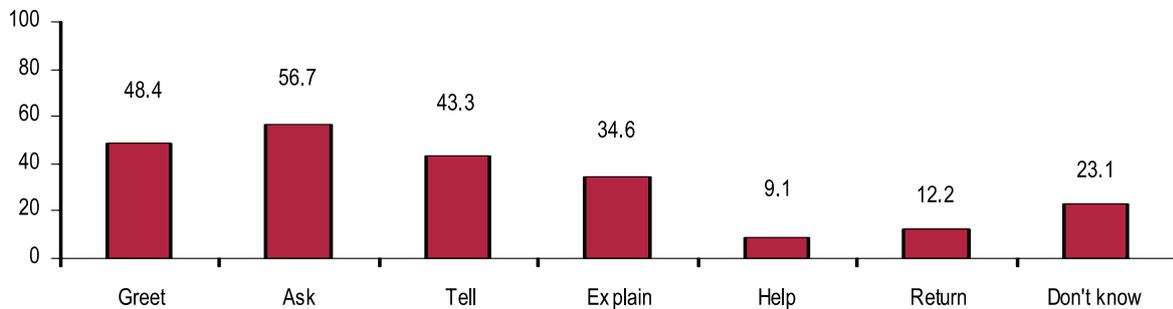


In order for counselling to be effective, it is necessary to know and understand some key points. The most important point is to identify the stage in which the behaviour change process is occurring. This point was mentioned by only 35.8% of respondents, most of whom were at the provincial level (64.5%), followed by the district level (45.8%), and the fewest at the communal level (31.7%). The second important point that the attitudes of the counsellors reflect “sympathy and sincerity” and they “express respect to the clients by attentively listening and looking in the eye”. These received 42.9% and 25.6% responses respectively. The third important point concerning the expression of respect to clients, refraining from making decisions on their behalf through “avoiding speaking loudly, making judgment and showing personal opinions” and “clients are to make decision” received responses from 15.6% and 12.9% of respondents respectively. Up to 34.1% of respondents (38.2% at the communal level, 22.3% at the district level and 11.3% at the provincial level) did not know these points of importance in regards to counselling.

It’s a matter of course for Population/RH counselling staff to know and understand the aims of the work. However, the interview results showed that apart from the aim of providing clients with information mentioned by most respondents (66%), other aims were mentioned by no more than 30% (See Table 158 in the annex). Up to 23.3% of respondents at the communal level failed to address the aims of Population/RH counselling activities.

There are six basic steps in the counselling process that counsellors have to comply with. The proportion of respondents that knew all six steps was low, especially at the communal level (See Table 159 in the annex). Generally, 23.1% of respondents (24.2% at the communal level, 20.5% at the district level and 14.5% at the provincial level) did not know the steps of counselling. The step that received the most responses was “asking about the clients’ situation”, which accounted for 56.7%, and the step that received the least responses was “reducing clients’ nervousness” (9.1%).

**Figure 31. Staff knowledge on the basic steps of the counselling process**



The five basic skills a counselling worker must have are asking, listening, observing, explaining, and encouraging. The proportion of interviewed communication staff that were able to identify all five skills was low. At total 22.4% of respondents (23.9% at the communal level, 20.5% at the district level and 8.1% at the provincial level) were unable to identify any skills no one skill was ever mentioned by more than half of respondents. (See Table 160 in the annex)

A well-designed message should satisfy eight requirements: clarity, specificity, easily understood; precision; applicability; relevance to target group’s needs; appropriate to the target groups; appropriate to local culture; appropriate to the National Strategy for RH/FP; and concise. The proportion of respondents who were able to identify all eight requirements of a good message was very low. Other than the requirements, “clarity, specificity, easily understood”, mentioned by 60.6% of respondents, the majority of requirements were mentioned by less than 35% of respondents while 24.1% of those at the communal level and 9% at the district level could not identify any of the requirements of a well-designed message (see Table 161 in the annex).

Many different types of cultural and art/dramatic form can be integrated into communications to convey Population/FP messages to the community. The proportion of respondents able to propose various forms

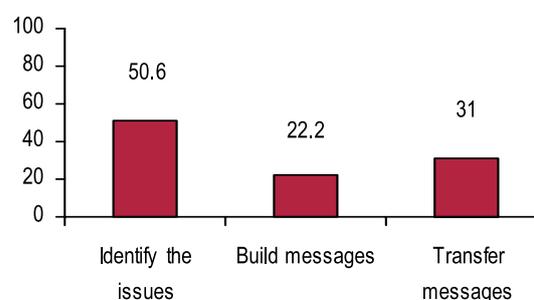
of cultural and art/dramatic activities to convey Population/FP messages were: dramas (55.1%), poems (34.9%), and storytelling (32.5%), commentaries on pictures and feature films (25%) and quizzes (12.1%). The knowledge of the staff at the provincial and district levels was better than that at the communal level (See Table 162 in the annex). There were still 20.2% of respondents at the communal level who did not know of any uses for other forms of cultural and art/dramatic activities to convey RH/FP messages.

The three steps in an information and advocacy are identifying the issues for advocacy, developing messages, and conveying messages to the target groups. The proportion of respondents who could name these steps was low. Notably, 37.8% of respondents (41.8% at the communal level, 29.5% at the district level and 6.5% at the province level) were not familiar with the number of steps nor did they know the specific steps that should be covered in the advocacy process.

Up to 98.4% of interviewees at the provincial level, 85.5% at the district level and 62.8% at the communal level had heard about BCC through group discussions (See Table 164 in the annex).

Of those interviewees who had heard of small group discussions (generally 68.4% for all three levels), the proportions of respondents who could explain the advantages of small group discussion were: “group discussion could help everyone have an opportunity to share skills and mutual assistance” (56.5%); “encouraging people to take part in the group activities” (47.5%); and “creation of effective learning environment” (46.9%). There was no significant difference between the three levels (See Table 165 in the annex)

**Figure 32. Staff knowledge on the basic steps of advocacy, in percent**



## CHAPTER 4

# KNOWLEDGE, ATTITUDE AND BEHAVIOURS OF THE COMMUNITY ON RH CARE

### 4.1. DEMOGRAPHIC CHARACTERISTICS OF TARGET GROUPS

The total number of respondents that participated in the survey was 4,379, including 1,459 women 15-49 years of age and rearing children under 24 months of age (hereinafter referred to as women), 1,456 men with wives 15-49 rearing children under 24 months of age (referred to as men), and 1,464 unmarried adolescents (referred to as adolescents). Details of demographic characteristics of the target groups are presented in Table 166 in the annex).

Out of the interviewed women and men, over 90% were in the 20-39 group. As for adolescents, females accounted for a higher percentage (56.5%) than males (43.5%). In the selected sample, 58.7% of subjects were Kinh ethnicity, the rest being ethnic minorities. However, in a number of provinces, such as Hoa Binh, most respondents were ethnic minorities.

The education level was fairly equal between men and women. Nearly half of the interviewed men and women received education at the basic secondary level. A smaller proportion received education at the primary level and high school (40% for both groups). In addition, there were a proportion of men and women who had never gone to school (10.1% and 6.9% respectively). The proportion of university/college graduates in the study sample was low.

Up to 79% of the interviewed women in this study had had one to two pregnancies and the remainder had had at least three pregnancies. In a similar trend, 87.7% of the interviewed women had one to two children while the rest had at least three children. Out of the interviewed women, the proportions having had at least three pregnancies were found to be the highest in Kon Tum and Ninh Thuan provinces (28.7% and 28.1% respectively), and the proportions of those women having three or more children were also the highest in Kon Tum and Ninh Thuan (25.4% and 21.4%) (See Table 167 in the annex). The proportions of women having had at least three pregnancies and having three or more children were lower in the 6<sup>th</sup> country programme (18.8% and 8.7% respectively) than those in the new provinces in the 7<sup>th</sup> country programme (24.1% and 17%).

### 4.2. ACCESS TO INFORMATION

Access to information of the interviewees was assessed by checking whether they had heard about six topics of reproductive health, and through what sources of information. The quality of information was also assessed by checking the attitudes towards a number of statements about reproductive health. The

results showed that out of the eight topics, four topics were known to over two-thirds of the interviewees (see Table 168 in the annex). The three topics that were mentioned by the least proportions of interviewees were psycho-physiology of puberty (57.9%), domestic violence and prevention (57.7%), and gender and gender equity in reproductive health (53.2%).

The knowledge about reproductive health varied between adults and adolescents while the proportions of women and men interviewees having heard about RH care during pregnancy, delivery, and the post-delivery period were found to be higher in comparison with that of the adolescents. The proportion of adolescents having heard about puberty psycho-physiology was found to be higher.

Women and men interviewees had heard about 5.2 out of 8 RH topics while adolescents had heard about 3.9 topics on average. The average number of RH topics known to interviewees was highest in Phu Tho (6.2 topics) and the lowest in Ha Giang and Kon Tum (3.4 topics) (See Table 169 in the annex). The number of RH topics known in provinces involved in the 6<sup>th</sup> country programme (5.2 topics) was higher than that in the new provinces in the 7<sup>th</sup> country programme (4.2 topics).

In terms of information sources, mass media (TV/radio, books and newspapers), health workers, mass organisation/union members and population collaborators/village health workers were chief for all three target groups. Apart from TV and radio, which were the main sources of RH information for all three groups, the interviewed women and men also received considerable RH information from population collaborators, health workers and mass organisation/union members. As for adolescents, the information came from their schoolteachers, books and newspapers (see Table 170 in the annex).

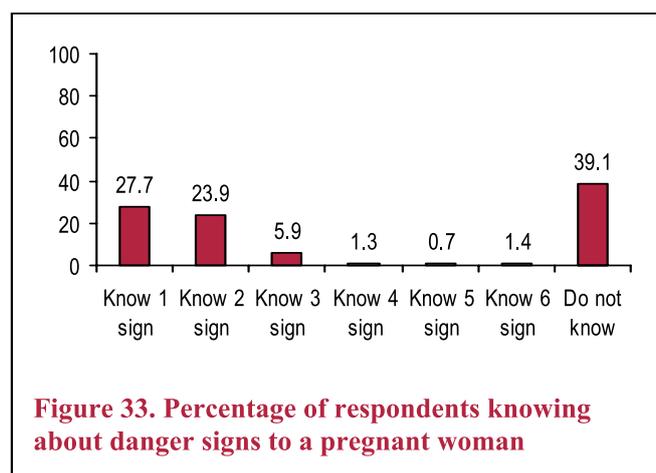
In terms of information quality, the majority agreed with the statement that: “One can be pregnant if having sex without condoms” (79.4%), and “One should not get married before 19 years of age” (71.9%). However, around one-third to half of the interviewees agreed with the following negative statements: “Unmarried persons should not know about RH issues” (29.1%), “The right of making decisions in the family belongs to the husband” (31.8%), “There is a reluctance to ask for or buy condoms” (43.7%), and “Contraceptive methods are for married people only” (51.3%).

This, misconceptions toward RH issues will be a big obstacle in RH care services. According to interviewees, women and children being beaten is rather common (20.6% interviewees acknowledged this). And the concept of premarital has initiated many contrasting ideas. In this study, up to 34% of respondents said “premarital sex is acceptable if the two people really love each other”. While it is hard to conclude whether this idea is right or wrong, in addition to a proportion (10.4%) reporting that abortions are quite common in their areas, there is a need for further improvement in the encouragement of contraceptive use, especially condom use among adolescents (see Table 171 in the annex).

### 4.3. SAFE MOTHERHOOD

#### 4.3.1. Realisation and management of abnormal signs in pregnancy

Six major abnormal signs that may endanger pregnant women were given in the questionnaire to assess both interviewed women and men in this matter. Both women and men should know these signs so that such issues can be addressed in a timely manner. The survey results are shown in Table 172 in the annex. The figure below illustrates the percentages of men and women who know of the danger signs during pregnancy.



Interviewees' knowledge about danger signs was still limited; 39.1% were unable to mention any of the six common danger signs during pregnancy, and within that group the proportion of men (44.7%) was higher than that of women (33.4%). Very few interviewees were able to identify more than three signs (3.4%). Of the six signs, "vaginal bleeding" and "abdominal pains" were mentioned by the highest proportions. However, these proportions (30.8% and 33.4% respectively) were far less than 50%. In addition, the two signs of "oedema" and "convulsion", although easily recognisable, received responses from low proportions (9.6% and 6.4% respectively).

The average number of signs related to pregnancy mentioned by men and women was 1.1. The number was highest in Phu Tho (2.1 signs) and lowest in Ha Giang (0.6 signs) (See Table 173 in the annex). The number of danger signs during pregnancy mentioned by men and women in provinces involved in the 6<sup>th</sup> country programme (1.2 signs) was not much higher than that in the new provinces of the 7<sup>th</sup> country programme (1 sign). It is obvious that this figure is drastically low, considering the number of signs that should be identified. For that reason, education of women within the reproductive age on danger signs during pregnancy should be further emphasised and pressed, to be a focus of an intervention programme.

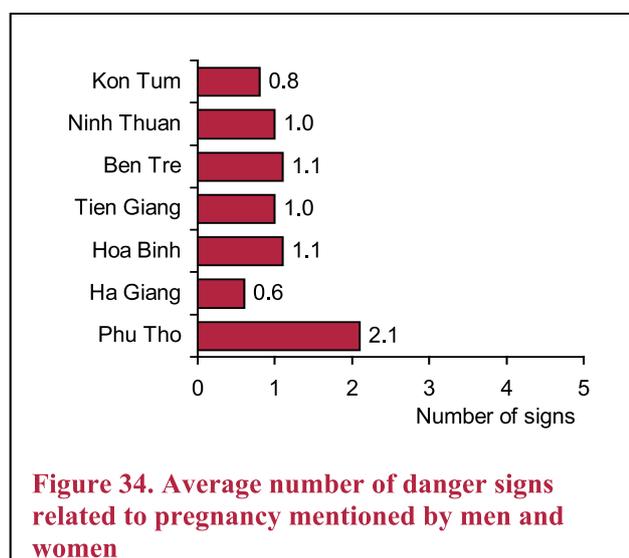


Figure 34. Average number of danger signs related to pregnancy mentioned by men and women

Public health facilities play an important role in the management of danger signs during pregnancy. When asked to read and select the choices, most interviewees (96.7%) able to mention at least one danger sign said that they would come to public health facilities whenever they observed danger signs during pregnancy. Some said that they would invite physicians to their home for treatment or seek help in private clinics. Very few interviewees selected "leave it as it is", "self-treatment", or "traditional god praying".

Table 34. Knowledge on management of obstetric emergencies, by percent

Actions	Mean (n=1,856)
Do nothing	0.6
Self-treatment	1.2
Invite health workers	10.1
Visit public health facility	96.7
Visit private health facility	8.0
Visit traditional doctors	0.1
Traditional worship	0.1

### 4.3.2. Pregnancy check-ups

#### Knowledge and practice for pregnancy check-ups

When asked about the number of check-ups during their last pregnancy, 84.4% of the women knew that they should have at least three check-ups, but a percentage of 6.0% said that they didn't need any pregnancy check-ups.

Table 35. Knowledge and practice on pregnancy check-ups in the last pregnancy (%)

Number of pregnancy checkup	Knowledge (n=1,459)	Practice (n=1,459)
Once	1.4	4.2
Twice	7.5	11.4
Three or more	84.4	77.2
Don't know/no check-up	6.0	5.7
Had check-up but did not remember	-	1.4

The knowledge and practice on pregnancy check-ups was relatively similar. In practice, 77.2% of the interviewed women said that they had had three or more pregnancy check-ups during their last pregnancy, but a proportion of 5.7% did not go for pregnancy check-ups in their latest pregnancy.

There was a large difference between the highest proportion of full check-ups and the lowest proportion in the provinces: Tien Giang had the highest percentage of women having had three or more full pregnancy check-ups (99%), and Kon Tum and Ha Giang had the lowest proportions (41.4 and 51.4% respectively) (see Table 177 in the annex). This could be due to the fact that Ha Giang and Kon Tum have difficult geographic conditions (mountainous provinces), which have an adverse affect on the ability of women to go for check-ups at health facilities when needed. In addition, it may be due to the low understanding of people in those provinces, thus leading to the low proportions of women going for pregnancy check-ups. For that reason, the programme should find supportive measures to improve the quality of pregnancy care for these provinces. In reality, the proportions of women having had three or more full pregnancy check-ups in provinces in the 6<sup>th</sup> country programme (82.9%) was considerably higher than the new provinces in the 7<sup>th</sup> country programme (69.7%).

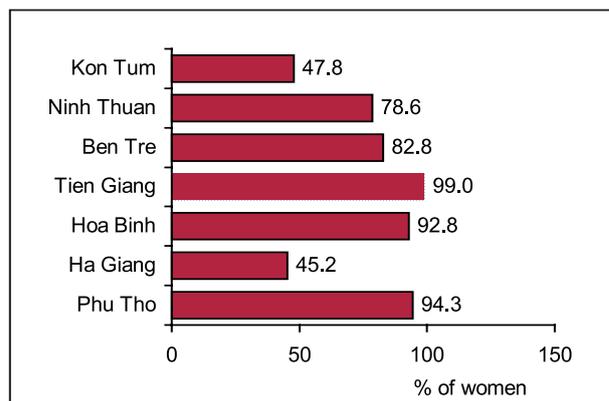
### *Places for pregnancy check-ups*

Most women interviewees went to public health facilities for pregnancy check-ups (or CHCs, or at higher-level health facilities). About 17.3% of interviewed women visited private health facilities. Thus, public health facilities were the reliable places for pregnancy check-ups but private health facilities also had a part.

### *Vaccination against Tetanus*

According to MOH standards, pregnant women are to receive compulsory vaccinations and the reality shows that there are many other aspects to take into account in regard to this issue. When asked about the number of injections for vaccination against tetanus in the first pregnancy, 69.9% of women agreed that it was two additional injections. Others disagreed, of whom 5.5% said they should have one more injection and 24.6% said that they should have three or more additional injections (See Table 179 in the annex).

As presented in the table above, only 71.8% of interviewed women had had full vaccination against tetanus in their previous pregnancies while 17.1% of them did not have full vaccination. In particular, 7.4% did not have any injections and in general women's tetanus vaccination records did not correspond to their knowledge.



**Figure 35. Percentages for women having at least three pregnancy check-ups in the last pregnancy**

**Table 36. Percentages for knowledge on places for antenatal check-ups during the last pregnancy**

Places of antenatal care	Women (n=1,376)
1. CHCs	78.0
2. Higher level health facilities	34.9
3. Commune/village/hamlet health workers' home	1.9
4. Private clinics	17.3
5. Traditional doctors	0.1

**Table 37. Tetanus vaccinations at last pregnancy**

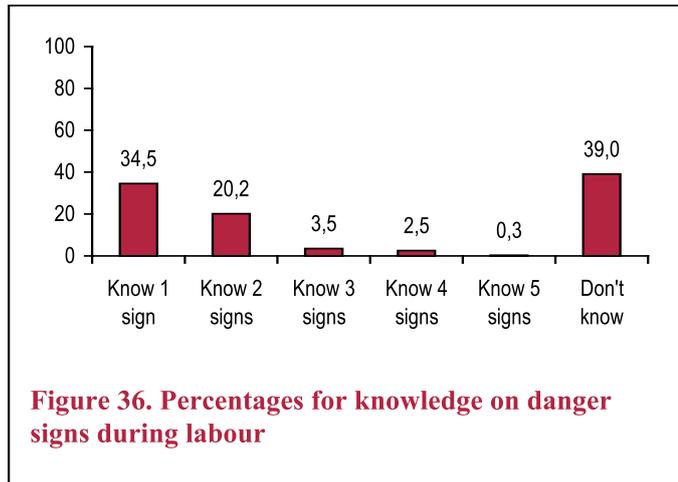
Number of vaccinations	Women (n=1459)
Not fully vaccinated	17.1
Fully vaccinated	71.8
Can't remember number	0.8
No vaccination	7.4
Do not remember	2.8

On average, the proportion of women with full vaccinations in their most recent pregnancies was highest in Phu Tho (83.7%) and the lowest in Ha Giang (60.6%) (See Table 181 in the annex). The proportion of women with full vaccinations in their most recent pregnancies in provinces involved in the 6<sup>th</sup> country programme (73%) was only slightly higher than that in the new provinces in the 7<sup>th</sup> country programme (70.3%).

**4.3.3. Delivery**

**Knowledge on danger signs for women during labour**

The understanding of interviewed women and men about danger signs during labour was assessed against five signs. Knowledge was poor. As many as 39% of interviewees (33.7% of women, 44.3% of men) were unable to identify any danger signs to women during delivery. Only a very small proportion was able to identify three signs (6.3%). The sign mentioned by most of the interviewees was sharp abdominal pain and massive bleeding, and did not exceed 33%. The sign mentioned by the least number of interviewees was convulsion (7.4%), although these signs are easy to recognise (see Table 182 in the annex).



**Figure 36. Percentages for knowledge on danger signs during labour**

The average number of danger signs known by women was 1 and those known by men was 0.9, of which the highest number was found in Phu Tho (1.7 signs) and the lowest was found in Ha Giang and Kon Tum (0.5 and 0.7 signs respectively) (see Table 183 in the annex). The number of danger signs known by women and men interviewees in provinces involved in the 6<sup>th</sup> country programme (1.0 sign) was slightly higher than that in the new provinces in the 7<sup>th</sup> country programme (0.9 signs).

**Place of delivery and delivery assistants**

Table 38 points out that the majority of interviewed women and men (78.6%) reported that they went to public health facilities for delivery during their most recent pregnancy. However, a considerable proportion of them also had home deliveries (18.9% of women and 19.8% of wives) (See Table 184 in the annex).

**Table 38. Percentages for last delivery and birth attendants**

Information	Mean (n=2,915)
<i>Places for delivery</i>	
Public health facilities	78.6
Private health facilities	2.0
At home	19.3
<i>Delivery assistances</i>	
Health staff	83.1
Traditional birth attendant	5.0
Husband/family member/other	11.7
None	0.3

In terms of delivery assistants, the majority of women and wives that were interviewed reported that they had received delivery assistance from health workers. However, a small proportion received assistance from non-technical people like husbands or family members. Notably, 0.3% of the interviewed women and men cited 'self-assistance' in delivery.

As shown in Table 185 in the annex, the proportion of women having home deliveries was the highest in Kon Tum and Ha Giang (64.1% and 46.9% respectively). On the contrary, in Tien Giang, there were no

home deliveries. Similarly, the deliveries without assistance from health workers were found to be the highest in Kon Tum and Ha Giang (56.5% and 41.9%), and lowest in Tien Giang (0.5%).

Although the general picture regarding delivery place and assistance illustrates that a larger proportion of deliveries were at public health facilities and assisted by health workers, there were still a considerable proportion of deliveries without assistance by health workers. For this reason, education and awareness regarding the need for deliveries to be assisted by health workers must be improved.

### *The role of families during deliveries*

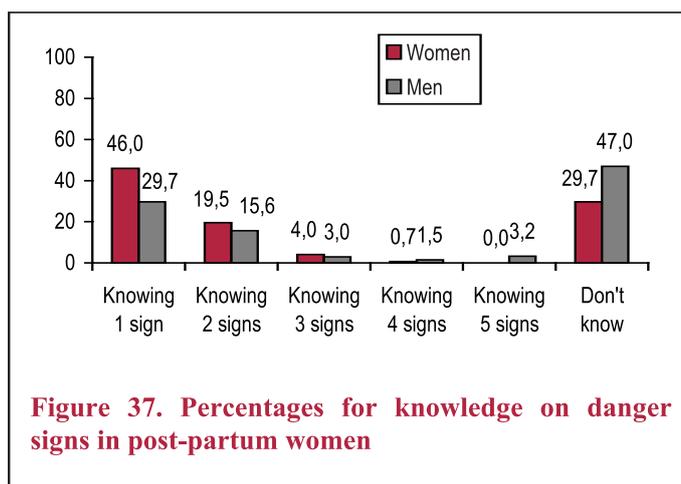
As presented in Table 186 in the annex, different types of people assisted women at delivery. However, of these types, husbands accounted for the largest proportion. For example, nearly 80% of interviewed women said that they were taken by their husbands to delivery places (excluding home deliveries). Similarly, most of the interviewed women reported that their husbands helped them in their preparations for delivery. In addition, mothers, mothers-in-law and other family members also played an important role, though to a lesser extent.

### 4.3.4. Post-delivery care

#### *Knowledge about danger signs for post delivery women*

The question, “What signs show that the labouring woman is facing danger?” accompanied with five signs were used to assess knowledge of post delivery issues.

As presented in Table 187 in the annex, the knowledge of both women and men about danger signs in the post-delivery period for women was limited; 29.7% of women and 47% of men interviewees failed to mention any danger signs. The majority of women and men were able to identify only one or two signs. Out of the five signs, the sign mentioned by the majority of the interviewees was “prolonged and increased bleeding”, but could only account for 45%. Of the other four danger signs, none received responses from 25% of the interviewees. The lowest was “smelly vaginal discharge” (3.9%) and “convulsion” (6.1%).



**Figure 37. Percentages for knowledge on danger signs in post-partum women**

On average, women and men were able to mention 1 danger sign post-delivery women (See Table 188 in the annex). The highest number of danger signs mentioned by interviewed women and men was in Phu Tho (1.9 signs) and the lowest were in Ha Giang and Kon Tum (0.5 ñ 0.6 signs). The number of signs known by women and men in provinces involved in the 6<sup>th</sup> country programme (1.1 signs) was slightly higher than that in the new provinces in the 7<sup>th</sup> country programme (0.8 signs).

#### *Knowledge about responses to post-delivery danger signs*

A question was posed to find out about the responses of interviewed women and men in the case that a woman exhibits post-delivery danger signs. The interview results showed that out of those able to identify the post-delivery danger signs, the majority responded that they would go to public health facilities (93.1%) or invite health workers to their home for treatment (11.8%). The other approaches were mentioned by very low proportions (See Table 189 in the annex).

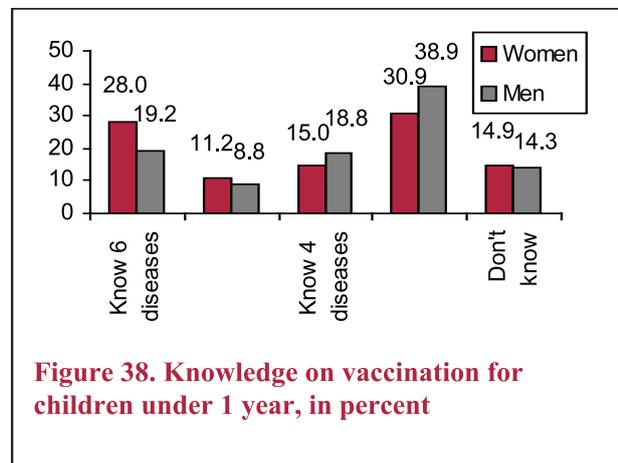
In short, men’s and women’s knowledge about danger signs during pregnancy, labour, and post-delivery

was low. One positive point was that both target groups selected public health facilities for treatment in the case of any above-mentioned danger signs during pregnancy.

**4.3.5. Knowledge and behaviours during breastfeeding**

The results of interviews regarding the knowledge and practice of initial breastfeeding showed that 71% of interviewees knew the right time to start breastfeeding, as recommended by MOH, as soon as possible within 30 minutes after delivery. In reality, only 61.9% started breastfeeding within 30 minutes after their most recent delivery, which was lower in comparison to their knowledge about it (See Table 190 in the annex).

Exclusive breastfeeding means feeding the child with breast milk without supplementary food or drink. According to recommendations by MOH, exclusive breastfeeding should continue until the child is four to six months old. But survey results showed that only 58.3% of women and 43.8% of men knew that exclusive breastfeeding should continue through that period. The proportion of those practising exclusive breastfeeding during the correct time period was nearly similar to that of the proportion having the right knowledge; 41.6% of women interviewees had practiced exclusive breastfeeding for four to six months, and 12.5% had a child less than six months who they were currently exclusively breastfeeding (see Table 191 in the annex).



**Figure 38. Knowledge on vaccination for children under 1 year, in percent**

**4.3.6. Knowledge on vaccination for children**

Women and men’s knowledge about the diseases that need vaccination for children less than one year of age was poor. Tetanus was mentioned by the majority of interviewees, but did not exceed 71% of men and women. While 14.6% of women and men were unable to identify the six diseases that need vaccination for children less than one year of age, only 28% of women and 19.2% of men were able to identify all six diseases.

**4.4. FAMILY PLANNING**

Knowledge among interviewed women and men about contraceptives was assessed with various questions. First, they were asked if they knew about contraceptives as well as the availability of condoms and oral contraceptive pills. They were then asked about which form of contraceptive they were currently using. Last, they were asked for their thoughts about why condoms and oral pills were not widely used. Additionally, their knowledge of the appropriate time to use contraceptives after birth was assessed.

**Knowledge about contraceptives**

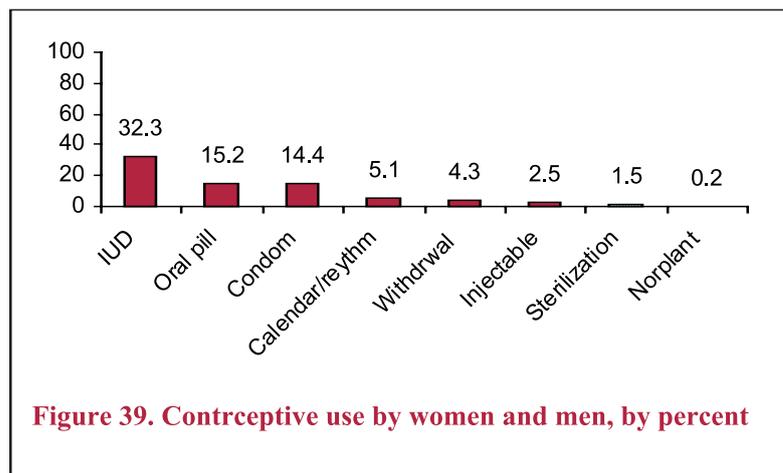
Knowledge among interviewed women and men about contraceptives was unevenly distributed. The three modern contraceptives known to most interviewees were condoms (85.3%), oral contraceptive pills (81%), and IUDs (64.5%). The other contraceptives were known by a smaller proportion (under 30%), and were much lower, such as emergency oral pills (4.3%). Only 18.8% of the interviewees were able to mention traditional methods such as “calculation of menstruation cycles/rhythm method”. In general, adults who were knowledgeable about contraceptives accounted for a larger proportion in comparison with adolescents; 16.3% of adolescents were unable to identify any of the nine contraceptives (See Table 193 in the annex).

There was a considerable difference among groups of interviewees and provinces. The average number of contraceptives (out of the nine methods) that was mentioned by women was 3.6 methods and 3.4 among men. The smallest number was found among adolescents (2.4 methods). The highest number of contraceptives mentioned by all three groups of women, men and adolescents was found in Phu Tho (4.1 methods) and the lowest was in Ha Giang (2.5 methods) (See Table 194 in the Annex). The number of contraceptives mentioned by the interviewees in provinces involved in the 6<sup>th</sup> country programme (3.3 methods) was slightly higher in comparison with the new provinces in the 7<sup>th</sup> country programme (2.9 methods).

### *The use of contraceptives*

Over three quarters of the interviewed women and men used contraceptives during the period of the survey (75.7%). The rest did not (24.3%).

Of the nine contraceptives in existence, IUDs were used by the majority of interviewees (32.3%), followed by oral contraceptive pills (15.2%), and condoms (14.4%). Other forms of contraceptives were used by very low proportions, and notably, emergency oral pills were not yet used by any of the respondents (See Table 196 in the annex).



**Figure 39. Contraceptive use by women and men, by percent**

Users referred to the convenience and effectiveness of contraceptives and the counselling of population collaborators/village health workers when selecting suitable contraceptives (58.3%, 41% and 26.6% respectively) (See Table 197 in the annex). Although these factors are important, it is also necessary to offer counselling on the usefulness as well as the possible unwanted side effects of contraceptives, so that they can make the suitable contraceptive choice for themselves.

Of the reasons for not using contraceptives, 42% of men and women mentioned “breastfeeding”. However, it should be noted that it is only during the first six months of exclusive breastfeeding and before menstruation resumes that this temporary contraceptive method can be applied. Up to 16.7% of interviewees were not using contraceptives because they wanted to have a child. Additionally, the fear of an adverse impact on health as a result of contraceptive use was mentioned by 8.5% of interviewees (see Table 198 in the annex).

### *Reasons for the less prevalent use of condoms and contraceptives*

Two multiple-choice questions were given to find out why condoms and oral contraceptive pills were not in wide use. The obtained results are presented in Table 199 in the annex. The reasons cited by most interviewees for the less prevalent use of condoms and oral pills were fragmented. Most said that “people don’t like to use condoms” (26.3%), followed by “fear of side effects” (13.2%). As for oral contraceptive pills, “fear of side effects” and “easy to forget” were the leading reasons (46.4% and 39.8% respectively). Thus, a large number of people do not have an accurate understanding about condoms and oral pills, leading to their lesser use. For that reason, communication activities on the usefulness of these two contraceptives should be targeted at adolescents.

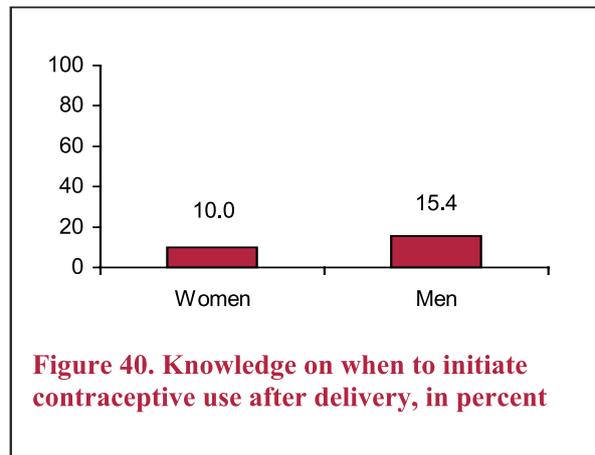
There were differences in the reasons for the less prevalent use of condoms and oral pills among provinces (See Table 200 in the annex). As for condoms, the reason that “people don’t like to use condoms”, was

mentioned by very few respondents in Ben Tre (3.9%), but by many in Hoa Binh (40.1%), Phu Tho and Ninh Thuan (34.3%). Similarly, the reason, "fear of side effects", was mentioned by a smaller proportion of respondents in Ben Tre (6.3%), but by a larger proportion in Hoa Binh (22.4%). As for oral pills, Ninh Thuan and Kon Tum cited "fear of side effects" (29.7% and 17.3% respectively) and "easy to forget" (28.9% and 22.5%), with those proportions lower than percentages in Phu Tho (71.1% and 62%). It is notable that in Ben Tre, communication efforts played an important role in the messages about condoms and oral pills. Almost none of the interviewees in Ben Tre cited poor advocacy and communication as the reason for the low use of condoms and oral pills. For all provinces, the distribution and prices of these two contraceptives were not obstacles to their use.

There was a difference among provinces with regard to the perceptions about the use of condoms and oral contraceptive pills. While only 2.6% of interviewees in Ha Giang said that condoms were in wide use, the corresponding proportion was 48.9% in Ben Tre. Similarly, only 5.5% of interviewees in Ha Giang said that oral contraceptive pills were in wide use, while the percentage was up to 64.3% in Ninh Thuan.

**Knowledge about when to use contraceptives after delivery**

Although it is critical to correctly understand the appropriate time for contraceptive use after delivery when resuming sex and the survey results are worth special attention. When asked about when one should use contraceptives after delivery, only 12.7% (10% of women, 15.4% of men) answered correctly "immediately when resuming sexual activity" while 10.8% did not know. It was also evident that a large number of interviewees (34.6%) did not understand by their responses, "after six months' time, regardless of breastfeeding", or "until menstruation returns" (See Table 201 in the annex).



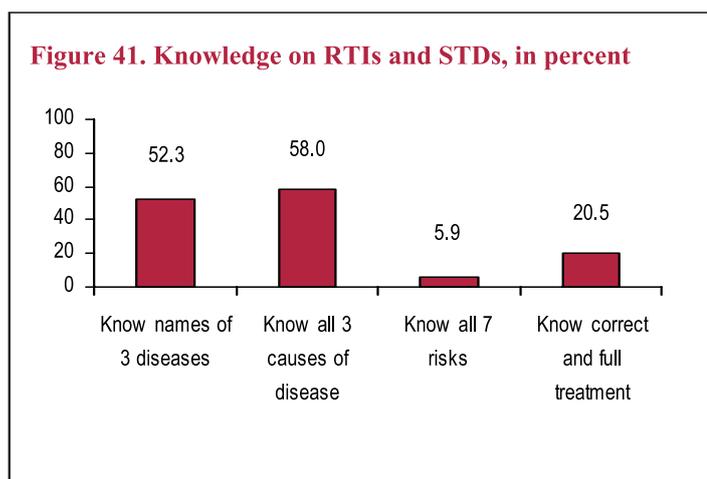
**Figure 40. Knowledge on when to initiate contraceptive use after delivery, in percent**

The comparison made among provinces showed that the proportion of interviewees who correctly understood that contraceptives should be used right away when sexual activity resumes was the highest in Phu Tho (21.1%) and lowest in Ben Tre (1.2%). Details are presented in Table 202. The fact that a large proportion of the interviewees lacked a complete understanding about when to use contraceptives after delivery is an issue of attention for the programme in the future. In practice, the percentage of the interviewees with the right understanding about when to use contraceptives in provinces involved in the 6<sup>th</sup> country programme (16.3%) was considerably higher than that in the new provinces in the 7<sup>th</sup> country programme (7.9%).

**4.5. RTIS, STDS, AND HIV/AIDS**

**4.5.1. Knowledge about RTIs and STDs**

Questions were posed to women, men, and adolescent interviewees to assess their knowledge about the names, causes, and risks of infection along with their understanding of the treatment of RTIs and STDs. The interview results showed that the knowledge of women, men, and adolescents about RTIs and STDs was inadequate, especially in regards to the



**Figure 41. Knowledge on RTIs and STDs, in percent**

consequences of those diseases to women and the issues of treatment given to a patient when it is detected.

The three most common RTIs, gonorrhoea and syphilis, were suggested to assess the level of understanding of the interviewees about RTIs/STDs. The interview results show that 52.3% of respondents were able to mention the names of these three diseases, of which significant women and men who could identify all three (59.6% and 57.5%). Adolescents reached 39.9%. The rest of the interviewees (23.4%) had never heard about these diseases, and there was not much difference among the three groups. Those proportions fluctuated between 63 and 68 % (See Table 203 in the annex).

The average number of RTIs/STDs identified by interviewees in the seven provinces was two and there was not much difference between the three groups of interviewees. The interviewees in Phu Tho were able to mention the most diseases (2.7 out of 3) and the least were in Ha Giang (1.1) (See Table 204 in the annex). The average number of diseases mentioned by the interviewees in provinces involved in the 6<sup>th</sup> country programme was 2.2, which was higher in comparison with the new provinces in the 7<sup>th</sup> country programme (1.7 diseases).

Of the interviewees who were able to identify at least one out of the three above mentioned RTIs/STDs, most knew the three causes. The proportions of women and men who were knowledgeable on all three causes (62.4% and 62.4%) were found to be higher than adolescents (49.1%). The causes, “sex with many partners without condoms”, and “sex with an infected person without condoms”, and “unsanitary genital organs” were mentioned by 76-80% of interviewees (see Table 205 in the annex).

The average number of causes of RTIs and STDs mentioned by women, men, and adolescents were rather even (1.8%, 1.9%, and 1.7 reasons). Phu Tho accounted for the largest proportion of interviewee groups able to identify the average number (2.6 reasons), while the lowest was in Ha Giang (1.0 cause) (see Table 206 in the annex). The average number of causes of RTIs and STDs, in provinces involved in the 6<sup>th</sup> country programme (2.1 causes) was higher than those in the new provinces in the country programme (1.5 causes).

There are seven effects to women infected with RTIs and STDs. The knowledge among women and adolescents about these effects was limited; 21.1% of interviewees were unable to identify any of the effects to women infected with RTIs and STDs, of which interviewed women accounted for the highest percentage (31.5%), followed by men (21.5%) and adolescents (10.0%). Very few people were able to mention three or more effects. The effects mentioned by the highest proportion were infertility (45.5%), of which adolescents (66.9%) scored higher than men (43.3%) and women (26.7%). The effect mentioned the least was ectopic pregnancy (15.3%), of which adolescents accounted for 37.5%, also higher than that of men (6.1%) and women (2.7%). In general, the knowledge of adolescents about the effects of RTIs and STDs was better than that of married men and women (See Table 207 in the annex).

The proportion of interviewees that had an accurate and complete understanding of the proper treatment of RTIs and STDs was very low (see Table 208 in the annex). Only one-fifth of interviewees knew that “treatment should be given to the infected person and all the people having sexual activities with him/her”. The proportion of adolescents who understood the proper treatment (38.5%) was higher than that of women and men (11.2 and 12.3% respectively). By contrast, the majority of the interviewees did not understand that “it is necessary to treat only the patient” and “it is necessary to treat both the husband and the wife”. A small proportion of respondents still did not know whom to treat for STD infections (4.9%).

The proportion of interviewees who had a correct and complete understanding of the proper treatment of RTI and STD infections was highest in Ben Tre (30.4%) and lowest in Ninh Thuan (11.7%) (See Table 209 in the Annex). The proportion of interviewees with a correct and complete understanding of the proper treatment of RTIs and STDs in provinces of the 6<sup>th</sup> country programme was 20.3%, similar to that in the new provinces in the 7<sup>th</sup> country programme (20.8%).

#### 4.5.2. Knowledge about HIV/AIDS

Interviewees' knowledge about HIV/AIDS was assessed for three aspects: 1) HIV transmission routes 2) prevention measures and 3) recognition of an HIV infected person. The interviewees were also asked "In your opinion, if a health worker performs an HIV blood test for a person without his/her consent, is it wrong or right?"

In general, the knowledge of HIV transmission routes was fairly good. Over 91% of interviewees had heard about HIV/AIDS. The majority of interviewees (between 71 and 84%) were able to identify five transmission routes, such as "unsafe blood transfusion, having sexual intercourse without using condoms, sharing syringes and needles, transmission from mother to child, and contact with blood and body fluids of HIV infected". Those who were able to identify all five transmission routes accounted for 54.4%. However, 26.6% were incorrect in their thinking that "mosquito and insect bites" can transmit HIV/AIDS, while 5.3% said that "normal contact" could transmit HIV (See Table 211 in the annex).

On average, adolescents could identify four out of five HIV transmission routes. This rate is slightly higher than that of women and men (3.6 and 3.5 routes). The average number of HIV transmission routes identified by interviewees by province is presented in Table 212 in the annex. The highest number was found in Tien Giang (4.7 routes) and lowest in Kon Tum and Ha Giang (2.5 and 2.7 routes). The number of HIV transmission routes identified by interviewees in provinces of the 6<sup>th</sup> country programme was four routes, which was higher than that in the new provinces in the 7<sup>th</sup> country programme (3.2 routes).

Although the proportion of interviewees knowing the forms of HIV transmission was rather high, the proportion of those that knew the preventive measures was not. The percentage of interviewees that could name the seven preventive measures was very low (2.4%) and the proportion that could name five or more preventive measures accounted for only 11.5% of interviewees that had heard about HIV/AIDS. "Avoiding sexual intercourse with many partners" and "using condoms in sexual intercourse" were mentioned by 50% of the interviewees as the most important HIV preventive measure. Measures least mentioned were "only use sterilised medical instruments" and "avoiding contact directly with blood and vaginal fluids of HIV infected persons" (See Table 213 in the annex).

On average, adolescents knew 2.6 out of 7 HIV prevention measures, which was slightly higher than that of men (2.3) and women (1.9). In Phu Tho, the number was 3.7 while it was only between 1.5 and 1.7 in Kon Tum, Ha Giang and Ninh Thuan (See Table 214 in the annex). The number of HIV preventive measures mentioned by the interviewees in provinces involved in the 6<sup>th</sup> country programme was 2.6, which was higher than that in the new provinces in the 7<sup>th</sup> country programme (1.9).

Apart from the high proportion of interviewees who knew that blood testing is the correct way to identify an HIV infected person (91.5%), 20% still believed that it is possible to identify an HIV-infected person through their appearance and lifestyle. Notably, the proportion of adolescents with that misperception (35.5%) was higher than that of women and men (10.5% and 13.7%) (See Table 215 in the annex). Hoa Binh had the highest proportion of interviewees with that misperception (25.2%), while it was found to be the lowest in Kon Tum (7.5%) (See Table 216 in the annex).

There were interesting discoveries regarding the perceptions of interviewees on the regulations on HIV blood tests. In accordance with professional management of HIV/AIDS infection, those who were suspected of contracting HIV/AIDS should be given pre-test and post-test counselling. Thus, it is not proper for health workers to conduct a blood test on a HIV suspected person without first acquiring his/her consent. However, for those individuals who are in high-risk behaviour groups (such as commercial sex workers, injecting drug users, STD patients) and attending rehabilitation courses at a centres for detoxification, and if counselling proves to be ineffective, then the health workers have the right to ask for mandatory testing as stipulated in HIV/AIDS prevention legal documents. In the interview, 66.8% of the interviewees had a correct understanding about this regulation, and this proportion in adolescent interviewees (77.7%) was higher than that of women (68.1%) and men (54.6%). Phu Tho and Hoa Binh had the highest proportions of understanding about the regulation (76.2%), and the lowest were in Ha

Giang and Kon Tum (32.8 and 46.5% respectively) (See Table 218 in the annex). The proportion of the interviewees with correct understanding about this regulation on HIV blood testing in provinces involved in the 6<sup>th</sup> country programme was 62.5%, which was slightly higher than that in the new provinces in the 7<sup>th</sup> country programme (58.8%).

#### 4.6. ABORTIONS

##### *Knowledge about places that perform abortions and abortion consequences*

Interviewees' knowledge about places for abortion and its consequences was assessed against Vietnam's legal documents on abortion. Vietnam law allows any woman to have a safe abortion at health facilities with adequate conditions and license to perform health care.

The results of interviews conducted with women and men (See Table 219 in the annex) showed that the percentage of women and men reporting that public health facilities were the proper places for safe abortions was the highest (72.8%), while 12.5% mentioned private health facilities. Those results correspond to current practice where abortions are mainly performed by public health facilities and a small number are conducted by private health facilities. However, 25.7% of interviewees (21.2% women and 30.2% men) did not know where to find places for safe abortions.

Interviewees' knowledge about the effects of abortion was low (See Table 220 in the annex). Up to 38.1% of interviewed women and men did not know of any effects of abortion. The proportion that knew of the effects did not exceed 35%. The mental effects (mental disturbances) were mentioned by a very small number (6.1%). Only 0.1% of women and 2.9% of men were able to mention all four effects of abortions. The rate of those who knew three effects was also very low (2.6%).

##### *Facts on abortion*

One of the significant findings was that the proportion of abortions was very low in this survey. According to the demographic health survey (DHS) in 2002, during the five year period (1997-2002), the total rate of abortion among women 15-49 was 61.7%. But in this survey, the abortion rate was 9.2%, obtained through interviews conducted with women. Of those who had abortions, the majority had only one; only 10.4% had two and 1.5% had three. The highest proportion of women having had abortions was in Tien Giang (17.1%) and Phu Tho (13.4%), and the lowest was in Kon Tum (1.4%). The percentages of women having abortions in Ha Giang, Hoa Binh, Ben Tre and Ninh Thuan fluctuated between 6.7% and 9% (See Table 222 in the annex).

It is difficult to identify the causes of such a low rate. It may be that the women in this survey were younger (72.3% were under 30) than those interviewed in the 2002 DHS survey (31.3% were under 30 and were married). For this reason they are less susceptible to the risk of abortion. Additionally, the fact that women should only have one or two children (of whom one was under 24 months of age) was a condition in this survey, which made them less susceptible to the risks of abortion with unplanned pregnancy.

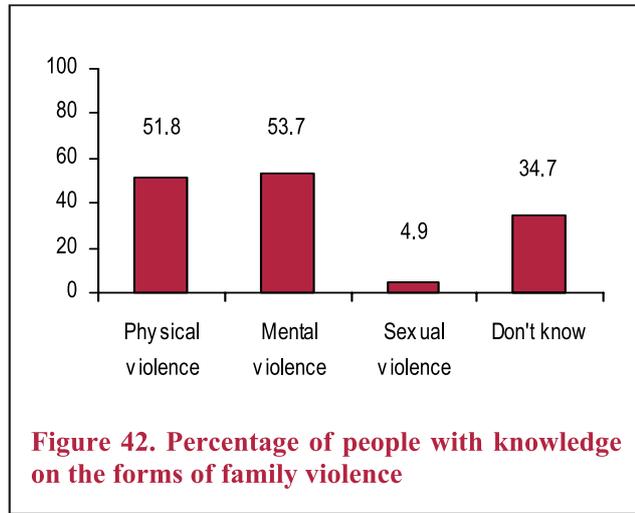
Locations for abortion and the effects were significant topics in this survey. As many as 78.4% of the interviewed women had had abortions at public health facilities, while 20.9% of the women had their abortions at private health facilities.

Of the women having abortions, 91.8% had no complications during and after. Among the rest, 3% had prolonged bleeding, 1.5% had smelly leucorrhagia, 0.7% had retained placenta and 2.2% had other abnormal signs.

**4.7. FAMILY VIOLENCE AND PREVENTION**

The responses to the question “What are the forms of family violence?” are summarised in the following figure:

The proportion of interviewees able to identify the forms of family violence was found to be low; 34.7% could not identify any forms of family violence and there was not much difference among the study groups. A proportion of 51.8% of interviewees knew forms of family violence, such as physical violence (slapping, pulling ears, striking on the head, striking on the thighs, shaking, pushing down, blows, etc.), and 53.7% knew about mental violence (scolding, insulting, driving away, threatening to abandon, etc.). Only 4.9% of the interviewees knew that sexual violence (rape, sexual abuse, adolescent sexual abuse, incest, sex trading, etc.) was also a form of family violence. There was no significant difference in the knowledge about the forms of family violence among target groups.



**Figure 42. Percentage of people with knowledge on the forms of family violence**

“Substance abuse” was mentioned the most, (40.9%), followed by “troubles in family conditions” (33.4%), “changes in personal temperament and behaviour” (10.1%), “influence by violent films or photos”, and “a reaction to the family and society” (5%). A small proportion of interviewees said that one of the causes was “for pocket money” (3%) and “for being accepted into gangs” (0.6%). Up to 37.1% of interviewees could not identify any causes of family violence.

**Table 39. Percentage of people with knowledge on causes of family violence**

Causes of violence	Mean (n=4,379)
Don't know	37.1
Influence by violent films, pictures	5.1
Changes in temperament and behaviour	10.1
Difficult family conditions	33.4
Substance abuse	40.9
Reaction to family and society	5.0
To be admitted to gangs	0.6
For pocket money	3.0

The consequence of health damage was mentioned most by the interviewees (41.2%) as a result, followed by mental injury (34.7%). The other consequences received responses from less than 12% of the interviewees. The proportion of the interviewees who did not know any of the consequences (35.5%) was in correlation to the proportion of interviewees who knew none of the forms of family violence (34.7%).

**Table 40. Percentage of people with knowledge on the consequences of family violence**

Consequences of violence	Mean (n=4,379)
Don't know	35.5
1. Psychological injury	34.7
2. Unwanted pregnancy	2.3
3. STDs, HIV/AIDS infection	3.2
4. Sexual disorder	0.8
5. Worry, loss of sleep, appetite, addictive use, nightmare, suicide	11.4
6. School drop-out	9.0
7. Health damage	41.2

In the previous three years, 7.7% of interviewees (13.6% of adolescents, and 6.4% women) had suffered from physical violence (slapping, pulling ears, striking on the head, striking on the thighs, shaking,

pushing, etc.) and 15.1% had suffered from mental violence (scolding, insulting, driving away, threatening to abandon, etc.), mainly adolescents (26.8%). A small number of women and adolescents had suffered rape, forced sex or sexual abuse.

Thus, interviewees' knowledge about family violence and its forms was rather low, mainly in

regards to physical and mental violence. The proportion of interviewees knowledgeable about the causes of family violence was also low. In the previous three years, 7.7% of interviewees had suffered from physical violence and 15.1% had suffered from mental violence, mainly adolescents.

**Table 41. Incidences of family violence in the previous three years**

Forms	Women (n=1,459)	Men (n=1,456)	Ado. (n=1,464)
Slapping, ear boxing, striking on the head, pinching, pushing to fall, detaining, blows, starvation	6.4	3.0	13.6
Scolding, insulting, driving away, abandoning, neglecting	12.8	5.6	26.8
Rape, forced sex	0.5	0.0	0.2
Sexual abuse	0.3	0.3	0.3
Incest	0.1	0.0	0.1

## CHAPTER 5

# THE RELATIONSHIP BETWEEN PROVISION AND UTILISATION OF REPRODUCTIVE HEALTH CARE SERVICES

### 5.1. AVAILABILITY OF RH CARE SERVICES

#### *Frequency of RH service provision*

SPs at all three levels were asked about the frequency of the five types of RH services they provided. They were safe motherhood (pregnancy check-ups, delivery assistance, newborn care and care of post-delivery mothers), family planning services at all three levels, (permitted by Decision No. 385/QD/2001-BYT on provision and guidance on use of oral contraceptive pills, condoms, insertion of IUDs, injectables, counselling on contraceptives, and provision of RH services to adolescents), family planning services which were not allowed to be provided at the communal level (according to Decision No. 385/QD/2001-BYT (Norplant, vasectomy, and sterilization), abortion services (menstruation regulation with single valve Karman, abortion with 2 valve Karman, D&C, and medical abortion) and RTI/STD examination, treatment, and counselling.

The interviewer read the types of RH services one by one, and the SP interviewees gave responses to the four choices: (a) number of clients for daily service provision (b) weekly basis (c) monthly basis, and (d) quarterly basis. The following table points out the proportions of SPs confirming that they provided such services to clients on a daily basis.

*Regarding safe motherhood services:* Generally, with all four kinds of safe motherhood services, all three levels performed services for clients on a daily basis and accounted for the highest percentage, in which provincial level SPs had a higher proportion of clients available to perform daily safe motherhood (88.6%) in comparison with that at the district level (83.8%) and the communal level (54.6%).

*Regarding FP services allowed at all three levels in compliance with Decision No. 385/QD/2001-BYT:* Generally, all six elements of FP services were performed by most of the SPs. Similar to services of safe motherhood, the proportions of service providers at the provincial and district levels having more clients to whom to provide daily services were higher

**Table 42. Percentage of SPs providing daily RH services**

Service type	Prov. (n=105)	District (n=136)	Comm. (n=414)
Safe motherhood	88.6	83.8	54.6
FP (allowed to perform at all three levels)	71.4	77.2	57.0
FP (allowed to perform at provincial and district levels only)	10.5	2.2	
Abortions	50.5	61.8	13.0
RTIs and STDs	68.6	62.5	49.5

(71.4 and 77.2% respectively) in comparison with that at the communal level (57%).

*Regarding services that not allowed at the communal level in compliance with Decision No. 385/QĐ/2001-BYT:* In general, all three types of services were performed by 30.5% of SP at the provincial level and 15.5% at the district level. The proportion of SPs at the provincial level having clients to whom to provide daily and quarterly services was higher than that on a weekly and monthly basis. At the district level, the proportion of SPs having clients to perform this type of service for on a quarterly basis was the highest.

*Regarding abortion service:* Generally, with all four elements of abortion service, 71.4% of SPs at the provincial level, 83.1% at the district level and 33.7% at the communal level had performed this service. Of those SPs having performed the service, over a half at the provincial and district levels had clients to whom to provide daily service. The proportion of SPs at the communal level performing “menstruation regulation with single valve Karman” on a daily basis was slightly higher than the weekly, monthly and quarterly basis.

*Regarding examination, treatment and counselling for RTIs/STDs patients:* The majority of SPs at all three levels had performed these services. SPs at all three levels said that clients seeking daily services accounted for the highest proportion, with the number of clients seeking services performed at the provincial level occurring more frequently than those at the district and communal levels.

#### *Status of clients' visits to health facilities*

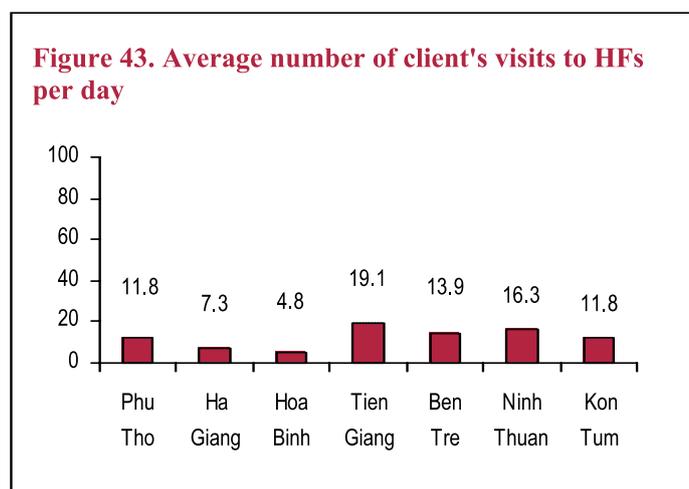
All surveyed health facilities had their retrospective data (kept in record books) reviewed in terms of clients' visits to facilities for services (excluding number of children and women seeking immunisation) within a year (from 1/1/2004 to 31/12/2004). The retrospective data is summarised in the table below.

**Table 43. Average number of client visits to CHCs in 2004**

Information gained from interviews	CHCs (n=206)	
	1 year	1 day
Average number of client's visits to HF	4440.4 ± 3677.0	12.2 ± 10.1
Average number of clients/one health worker	1107.3 ± 919.8	3.0 ± 2.5

According to data at CHCs, in 2004 there were 763 to 8,117 visits made by types of clients (2.1 to 22.3 visits to CHC for services). The average number of client per health worker per day was from 0.5 to 5.5. The retrospective results show a large difference in numbers of clients visiting CHCs. Some CHCs had very few clients, while others had rather high numbers of clients. The reason for some CHCs having few clients can be explained by the fact that they were near certain district or provincial hospitals, or that they had not been able to win the confidence of clients. Therefore, the number of client visits to the higher level was greater than that to the communal level.

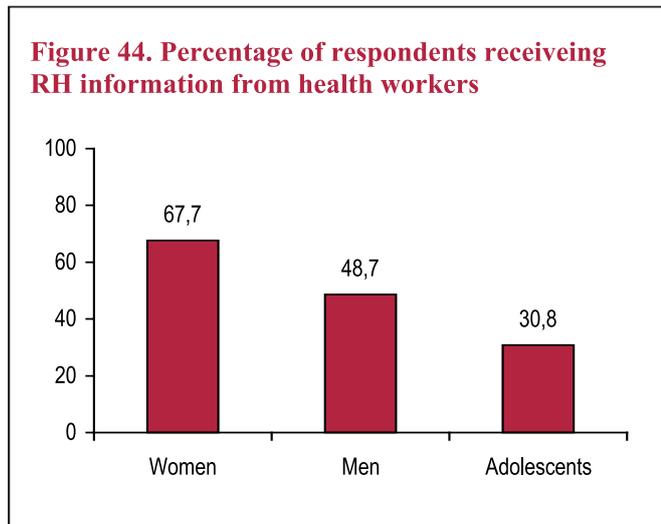
The average number of clients/day at CHCs was the highest in Tien Giang and Ninh Thuan (19.1 and 16.3 clients/day) and the lowest were in Hoa Binh and Ha Giang (4.8 and 7.3 clients/day).



5.2. COMMUNITY OPINIONS ON SERVICE PROVISION

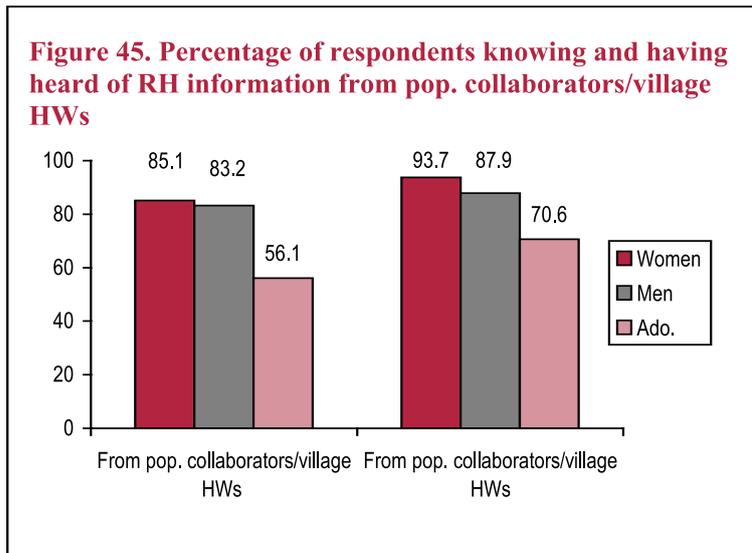
On resources for RH information, health workers were mentioned with the proportions presented in the figure below:

One of the duties of health workers is to supply information on health, health care and disease prevention in general and reproductive health in particular. In reality, 67.7% of women confirmed that they had been informed about RH care topics by health workers, which is a much higher proportion than that in the adolescent group (30.8%). Thus, unmarried adolescents in the 15-19 age group are in great need of RH information, but received very little from health workers.



In answering the question “Do you know who the population collaborator or village health worker in your area is?” 74.8% of interviewees said that they did. The proportion of adolescents who knew the population collaborator/village health workers in their areas (56.1%) was much lower than the proportion of women (85.1%) and men (83.2%).

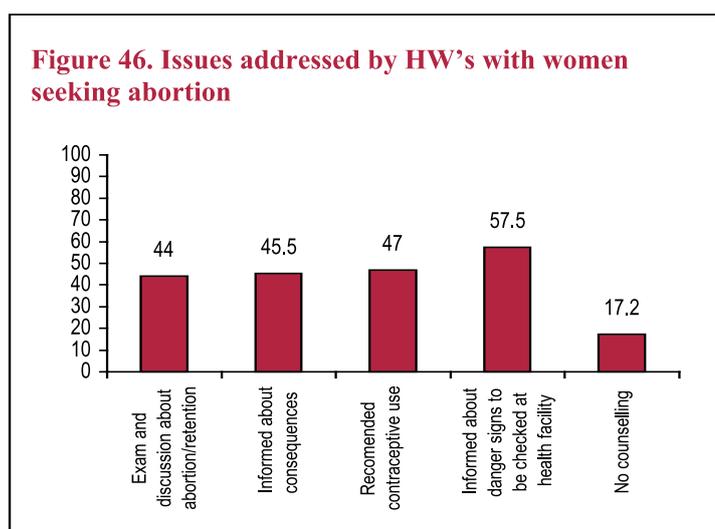
Of the interviewees who knew their population collaborators/village health workers, 85.8% confirmed that they had heard about RH/FP topics. The percentage of adolescents that confirmed the knowledge of RH/FP topics (70.6%) was also much lower in comparison with women and men (93.7 and 87.9% respectively).



The results of interviews with women, men and adolescents about places selling/providing condoms and oral contraceptive pills are presented in Table 230 in the annex. The proportion of interviewees reported that places for condoms and oral pills were CHCs (73%) and population collaborators/village health workers (42%) was the highest, and higher than the proportion referring to drug stores (39%). The corresponding proportion of adolescents was much lower than the proportion of adults, but the percentage knowing that drug stores were another location to acquire condoms and oral pills was higher than that of adults. This once again shows that health workers and population collaborators had not considered adolescents as important targets for communication and advocacy, and likewise, adolescents were reluctant to contact health communicators and educators.

According to law, there are a number of issues that birth assistants must discuss with the mother and relatives post-delivery. However, this study proves that this is not always done in practice. The issues mentioned by women and men were vaccination for the child (76.1%), breastfeeding (75.9%), monitoring the health conditions of the mother and child (65.6%) and use of contraceptives when resuming sex (47.2%). The proportion of women responding to these four issues was higher than that of men, perhaps because they were the direct targets of health workers. Yet 3.7% of women and 10.8% men confirmed that they had not been counselled by health workers after delivery or after their wives’ deliveries (See Table 231 in the annex).

The women who had had abortions were asked whether they had been counselled by health workers in different ways. Figure 46 shows that the proportion of women confirming that they had been counselled by health workers when they came for abortions was still low; 17.2% of women who had abortions reported that they had not been counselled by SPs. The SPs' most frequent counselling topic was "to come back for re-examination when noticing abnormal signs", which was confirmed by many women and did not exceed 57.5%. The other three topics were also addressed by SPs, as confirmed by 44-47% of women who had sought abortions. This issue should be taken into consideration, as clients might change their decision if they were counselled completely and comprehensively.



Women, men and adolescent interviewees were asked to read the statements on health facilities available in their areas one by one. Each statement was accompanied by four choices: true, not always true, false, and don't know. All statements were worded so as to be affirmative. Table 44 summarises the response "true" for each statement.

**Table 44. Percentage of respondents agreeing on the statements about HFs**

Statements	CHCs (n=4,292)	District hospital (n=1,692)
1. Health workers are always available at CHCs	87.5	96.9
2. Health workers are always helpful and open	79.0	76.2
3. Clients don't need to wait long	64.3	58.7
4. The facility is clean and comfortable	81.5	87.8
5. There is a separate area for unmarried persons	14.4	23.2
6. Health workers are highly qualified	61.3	73.4
7. Health workers take time to talk with clients about their health	53.7	56.5
8. Client information is kept confidential	61.4	68.1
9. Equipment is sufficient and clean	61.8	76.1
10. Communication materials are available on contraceptives (pictures and pamphlets)	85.6	90.1
11. Informative materials are available to distribute for visiting people and clients	49.7	48.4
12. Essential drugs are available at CHCs	85.4	92.4
13. Satisfaction with service quality	75.3	76.8

The four out of the 13 statements on CHCs and district hospitals that received agreement from over 80% of the interviewees in all three groups were 1) Health workers are always available at the HFs 2) HF is clean and tidy 3) There are pictures/motivational images about contraceptives at HFs and 4) There are common drugs available at HFs. All the other positive statements received agreement from slightly over half of the interviewees. Yet the statement that "there is an exclusive area for unmarried persons" was agreed by very few interviewees. In general, the statements on availability ("Health workers are always available at the HFs"), hygiene ("HF is clean and tidy"), health workers' qualification ("Health workers are technically qualified") and infrastructure ("medical equipment/instruments are sufficient and clean", "There are pictures/motivational images about contraceptives at HFs", "There are common drugs available at HFs") concerning district health hospitals were agreed by higher proportions of interviewees in comparison with that at communal health facilities. By contrast, regarding statements on attitudes, CHCs had a higher proportion of interviewees' in agreement than district hospitals. However, 75.3% of the interviewees felt satisfied with service quality at local CHCs, which was not much lower than district hospitals (76.8%).

Thus, CHCs and district hospitals received positive feedback from the community. The proportions of interviewees agreeing with the positive statements about the technical and infrastructure issues at the district hospitals were higher than those about the CHCs. In contrast, regarding statements on attitudes, CHCs had a higher proportion of interviewees' agreement than district hospitals.

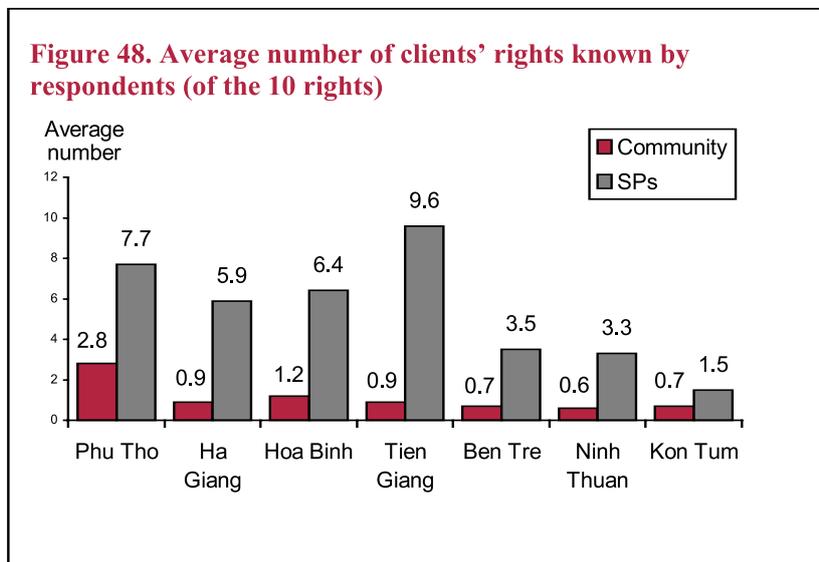
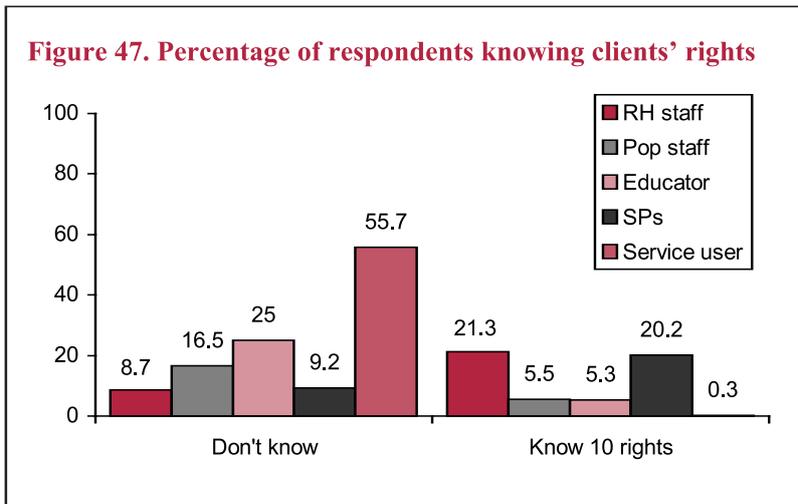
On average, out of the 13 statements, 9.3 statements on CHCs and 9.2 statements about district hospitals were agreed by the interviewees as "true", as presented in Table 235 and Table 236 in the annex. The highest proportion was in Phu Tho and Tien Giang, and the lowest was in Kon Tum. The average numbers of statements agreed by the interviewees in provinces in the 6<sup>th</sup> country programme were 9.5 and 10.1, higher than those in the new provinces in the 7<sup>th</sup> country programme (7.4 and 8.2 statements).

**5.3. BOTH SIDES' VIEWS ON ISSUES RELATED TO REPRODUCTIVE HEALTH**

There are 10 client's rights regulated by the IPPF. These rights were publicised by IPPF through the VINAFPA and have been officially regarded as the clients' rights to reproductive health. The interview results show that the RH programme staff and SPs' knowledge about clients' rights was much better than that of Population/FP programme staff, educators and target groups in the community. The proportion of people knowing about all 10 clients' rights was highest in the groups of RH programme staff (21.3%) and RH SPs (20.2%), and was lowest among the target groups in the community (0.3%). On the contrary, the proportion of people that failed to mention any clients' rights was highest among the target groups in the community (55.7%), and was the lowest among the RH programme staff (8.7%) and RH SPs (9.2%).

RH programme staff and RH SPs named seven out of 10 rights. Half of the members of group of communicators and target groups in the community could mention none of these rights (see Table 237 in the annex).

On average, SPs in the seven provinces knew 5.4 clients' rights, and the community groups only knew 1.1 rights (See Table 238 in the annex). The highest number of clients' rights known by most SPs was found in Tien Giang (9.6) and Phu Tho (7.7 rights), and the least was in Kon Tum (1.5 rights). The highest number of clients' rights known by most community members was found in Phu Tho (2.8 rights), and the least was in Ninh Thuan (0.6 rights), Ben Tre and Kon Tum (0.7 rights). The number of clients' rights known to the interviewees in the community and SPs in provinces involved in the 6<sup>th</sup> country programme was 1.4 and 7.4 respectively, which was higher compared with provinces in the 7<sup>th</sup> country programme (0.6 and 2.7 ).



Regarding reasons for the less prevalent use of condoms and oral pills (indicators were read by the community interviewees, not the SPs), the results showed that both SPs and the community groups agreed with the two reasons for the less prevalent use of condoms, namely “clients/people do not like condoms” and “fear of side effects”, apart from the reason of “condoms reduce satisfaction” which was mentioned by most SPs (the community groups were not given this indicator). The reasons for the less prevalent use of oral contraceptive pills mentioned by most of SPs and community groups were “fear of side effects” and “easy to forget” (see Table 239 in the annex).

## CHAPTER 6

# MAIN FINDINGS AND RECOMMENDATIONS

### 6.1. MAIN FINDINGS

❖ **Infrastructure, equipment, essential drugs for RH at the surveyed health facilities, especially at the communal level, are still limited and much lower than the standard level required in the NS**

- Among the seven surveyed provinces, only 3.3% of CHCs in Tien Giang and 6.7% of CHCs in Ninh Thuan had at least four service rooms as defined in the NS. Among existing separate rooms at CHCs, the proportion of those attaining NS was still very low. No Gyn. examination rooms attained NS and the highest proportion of those attaining 100% NS, found for communication/counselling room was only 14.3%.
- The status of signs, hygiene and waiting areas at health facilities at all three levels was much improved yet the proportion of CHCs attaining NS on signs, hygiene and waiting areas only accounted for about 30%.
- Only 3.3% CHCs had three complete sets for delivery, 7.1% had three complete sets for Gyn. examination, 33.8% had at least one complete set for cutting and suturing the perineum, 17.2% had at least one complete set for the checking of the cervix, 33.9% had at least one complete set for neonatal resuscitation, 52.4% had at least one complete set for insertion and removal of IUDs and 22.9% had at least one single valve Karman MVA.
- The proportion of CHCs having the sufficient number (13 types) of equipment for RH care services accounted for 2.9%. The most insufficient types of equipment at CHCs were the dry heat steriliser (available in 27.1% of CHCs), procedure table (32.9%), boiler (electric) and plastic container with cover for cold decontamination (38.6%).
- 71.4% of health facilities at the provincial level and 64.3% at the district level had suitable types of protocol for infection control as defined in the NS while that proportion at the communal levels was 9%. The proportion of health facilities attaining 100% NS on equipment/instruments for infection control at the provincial level (78.6%) was much higher than that at the district level (35.7%) and communal level (10.5%).

- The essential drugs for RH care services at CHCs were still in serious shortage. No groups of drugs that are sufficient and unexpired were found at any CHCs. The sufficient and unexpired drugs were found most commonly for intravenous fluids (available in 59.5% of CHCs), contraceptives (33.8%) and sedatives (33.3%); least were analgesics/anaesthetics with Opi (1.4% of CHCs), followed by septs and antiseptics (1.9%) and antibiotics (2.4%).
- Most CHCs had three types of contraceptives, including condoms (available in 86.2% of CHCs), oral pills (82.4%) and IUDs (79%). The proportion of CHCs having emergency oral contraceptives was only 18.6%; the proportion for injectable contraceptive was 46.2%.
- 50% of health facilities at the provincial level and 39.3% at the district level attained the comprehensive essential obstetrical care; 16.7% of CHCs attained the basic essential obstetrical care. The proportion of CHCs attaining basic essential obstetrical care (which includes five services) was the highest in Tien Giang province (50%), followed by Phu Tho (43.3%) and the lowest in Kon Tum (0%) and Hoa Binh, Ben Tre, Ninh Thuan (the same 3%). The injection/transfusion of sedatives for convulsion prevention in pre-eclampsia and eclampsia was provided the least at CHCs (available in only 21.4% of CHCs).

❖ **Most SPs at all levels were retrained on RH care services within the previous four years**

Only 12.5% SPs at the district level and 11.8% at the communal level did not receive retraining. The proportion of those who had not been retrained in the previous four years was found highest in Kon Tum (75%), followed by Ben Tre (10%). At the communal level, the proportion of SPs who never received retraining was highest in Kon Tum (37.9%), followed by Ha Giang (18.3%), Ben Tre (13.6%), Ninh Thuan (10.3%), Phu Tho and Hoa Binh (the same 1.7%) while in Tien Giang, there were no SPs who had not received retraining.

❖ **Professional knowledge of SPs was rather good but not comprehensive. Knowledge of those in provinces involved in the 6<sup>th</sup> country programme (Ha Giang, Phu Tho, Hoa Binh and Tien Giang) was remarkably better than knowledge of those in the new provinces in the 7<sup>th</sup> country programme (Ninh Thuan, Kon Tum and Ben Tre)**

- Knowledge of SPs on obstetric check-ups was rather good (74.2% attaining 100% NS) and much better than that on general examination section (21.1% attaining 100% NS) and discussion (32.7% attaining 100% NS). Knowledge on this issue had not much difference among levels. In the section on general examination, the practice of breast examination received responses from the fewest SPs. Similarly, in the discussion section, the content of estimated delivery date received responses from the fewest SPs.
- The proportion of SPs at all levels that could correctly and completely name the nine steps of pregnancy check-ups was not high (only 42%) and not much difference was found among the three levels. The mean scores of SPs on sections of pregnancy check-up in provinces involved in the 6<sup>th</sup> country programme (85.6) were remarkably higher than that of the new provinces in the 7<sup>th</sup> country programme (58.1).
- The proportion of SPs with knowledge attaining 100% NS on abnormal signs during delivery was the highest at the district level (52.9%), followed by the provincial level (41%) and the communal level, which was the lowest, (37.4%). The mean score of SPs on knowledge on the abnormal signs during delivery in provinces involved in the 6<sup>th</sup> country programme (77.1) was remarkably higher than that of the new provinces in the 7<sup>th</sup> country programme (63.5).
- The proportion of SPs who identified the six contents was very low; only 10.5% of SPs at the provincial level, 5.1% at the district level and 4.3% at the communal level had answers attaining 100% NS. The content of “Check the cervix effacement and dilatation” was mentioned the most (93%), while the content of “Check infection of amniotic fluid” was mentioned the least (17.3%). SPs in Tien Giang province had the best knowledge on the internal examination (80.3 points), and

those in Kon Tum had the poorest knowledge on this issue (43.6 mean points).

- The proportion of SPs with knowledge on care of mother within 24 hours after delivery attaining NS was high (73.7% for all three levels) and much higher than that on care of the newborn within 24 hours after delivery (22%) and normal neonatal care right after delivery (17.1%). The contents on normal neonatal care right after delivery receiving responses from the lowest proportion of SPs were “Inject vitamin K1. 1mg unique dose” (37.1%) and “Clean eyes with sterile water or saline and put Argyrol drops (silver nitrate) in eyes to prevent infection due to gonococcus” (32.2%). SPs in Tien Giang province had the highest mean scores while those in Kon Tum had the lowest score on three aspects of care of the mother and newborn.
- Knowledge of SPs on common risks to preterm newborns at the three levels was very limited. The proportion of SPs with knowledge attaining NS was very low (1.5%) and there was no significant difference among the three levels. Three risks that received responses from under 21% of SPs at all levels were “decreased blood glucose”, “haemorrhage and disturbances of digestive tract”. The mean scores of SPs’ knowledge on common risks to preterm newborns in provinces involved in the 6<sup>th</sup> country programme (44.3 points) were higher than those in the new provinces in the 7<sup>th</sup> country programme (24.9 points).
- The proportion of SPs knowing post-partum warning signs was still low. Only slightly more than 7% of SPs at the district and communal levels attained NS, and this proportion at the provincial level was only 2.9%. The mean scores on knowledge about the post-partum warning signs of SPs in provinces involved in the 6<sup>th</sup> country programme (57.4 points) were higher than those in the new provinces in the 7<sup>th</sup> country programme (38.7 points).
- The proportion of SPs attaining 100% NS on responses to the warning signs to the mother at the provincial level (66.7%) was higher than that of those at the district (62.5%) and communal (30.2%) levels. The proportion of SPs with correct knowledge attaining 100% NS on the right reactions to abnormal signs to the newborn was 61.9% at the provincial level, 48.5% at the district level and 33.8% at the communal level. SPs in Tien Giang province had the best knowledge on responses to the warning signs to the mother and newborn, while the knowledge of those in Kon Tum province was the poorest. The mean scores on reactions to warning signs to the mother and newborn in provinces involved in the 6<sup>th</sup> country programme (85.7 and 84 respectively) was remarkably higher than that of the new provinces in the 7<sup>th</sup> country programme (69.9 and 72.9).
- Knowledge of SPs on counselling the mother after delivery and within the 1st week after delivery was still limited. The mean scores on counselling were 61.9 points and 53.8 points for all three levels. The mean scores recorded by SPs on counselling the mother right after delivery and within the first week after delivery in provinces involved in the 6<sup>th</sup> country programme (70.7 and 59.8) were remarkably higher than those in the new provinces in the 7<sup>th</sup> country programme (49.8 and 45.7 respectively).
- Knowledge of SPs on counselling the clients coming for IUD insertion or abortion was still limited. The mean score for knowledge on counselling clients coming for IUDs insertion was 51.3 and there was no significant difference among the three levels. The aspect of “Inform client that IUD can be removed if she wants to” was mentioned by only 16.3% of SPs. The mean score on knowledge about counselling on abortion was low (49.8 points) with the lowest found at the communal level (48.7). The mean scores of SPs with knowledge on counselling clients coming for IUD insertion or abortion in provinces involved in the 6<sup>th</sup> country programme (58.8 and 56.7) were remarkably higher than that of those in the new provinces in the 7<sup>th</sup> country programme (41 and 40.2).
- More than two-thirds of SPs reported that IUDs were the most commonly used form of contraceptive because of their high efficiency/convenience, long durability and safety (67%, 73.6% and 53.1% respectively). The reasons most commonly cited for the less prevalent use of condoms were “sensation reduced” (66.1%), followed by “dislike” (47.9%), “afraid of side effects” (33.1%),

and “uncomfortable feeling to ask for condoms” (22.7%). The two primary reasons for the less prevalent use of oral pills were “afraid of side effects” (64%) and “easy to forget” (38.9%).

- In regards to the negative statements associated with adolescent’s health, SPs mostly mentioned three statements, which were “no condom use when having sex” (42.4%), “lack of knowledge on puberty and pregnancy signals” (39.1%) and “early sex debut” (30.1%). Most SPs at all three levels proposed the solution of “regular counselling” (63.4%). However, knowledge of SPs on counselling on RH care for adolescents was still very low (0.9% attaining the NS). Most SPs felt that adolescents should use three contraceptives: condoms (98.8%), emergency contraceptive pills (80.9%), and combined oral contraceptives” (64.1%).
- Although vaginal discharge is a common clinical syndrome, only 61.2% of SPs responded with the correct treatment protocol of “Combined treatment of STI due to Tricomonas, Bacteria and Candida”. The proportion of SPs at all three levels that knew the correct treatment of the vaginal discharge syndrome was the highest in Hoa Binh province (74.7%) and the lowest in Ben Tre province (42.6%). The proportion of SPs that knew the correct treatment of vaginal discharge syndrome in provinces involved in the 6<sup>th</sup> country programme (68.1%) was remarkably higher than that of those in the new provinces in the 7<sup>th</sup> country programme (51.8%).
- Knowledge of SPs on counselling for gonorrhoea was still weak. The mean score on counselling of gonorrhoea was only 44.6 points, which was higher at the communal level (48) than at the provincial and district levels (38.4 and 39.1, respectively).
- The proportion of SPs that sufficiently knew about the points of time when hand washing is needed in infection control was very low. The proportion of SPs with knowledge attaining 100% NS on all eight points of time needed to wash the hands was only 8.7% (14.3% at the provincial level, 5.9% at the district level and 8.2% at the communal level).
- The proportion of SPs with full answers on all seven steps of hand washing was only 50% at the provincial and district levels. The proportion of SPs who answered enough steps in the correct order was low (22.9% at all three levels).
- The proportion of SPs with correct and full choices attaining 100% NS on all four types of service was the highest at the district level (76.5%) and the lowest at the communal level (55.3%).
- Most SPs at the provincial and district levels completely identified the four main steps for disinfection of instruments but the proportion of SPs who completely identified the four steps in the correct order was low (37-40%) and there was no significant difference among all three levels.

❖ **Practice of SPs was rather good. The practice of SPs in provinces involved in the 6<sup>th</sup> country programme (Ha Giang, Phu Tho, Hoa Binh and Tien Giang) was remarkably better than that of the new provinces in the 7<sup>th</sup> country programme (Ninh Thuan, Kon Tum and Ben Tre)**

- SPs at all three levels seemed to pay more attention to the “Ob examination” step (a mean score of 85.6) while they paid less attention to the technical steps. The lowest score belonged to the “urine test”, especially at the CHCs (23.3 points compared to 43.2 points at the district level and 40.9 points at the provincial level). SPs in Tien Giang practiced the steps better, with 9 steps having higher scores than those in other provinces, while Kon Tum and Ben Tre had the lowest scores in many steps
- The ability of SPs in interpreting the partograph was still weak. Only slightly more than 60% of SPs at provincial and district level could interpret the partograph correctly (in the alert status); the communal level had the lowest proportion (42.5%). The proportion of SPs who could interpret the partograph correctly was the highest in Tien Giang (90.4%) and lowest in Kon Tum (9.7%). The proportion of SPs who could interpret the partograph correctly in provinces involved in the 6<sup>th</sup> country programme (60.4%) was significantly higher than that in the new provinces in the 7<sup>th</sup>

country programme (36.2%).

- Most of the normal delivery records at the three levels had the entries of seven signs/symptoms to be followed up. But the partograph was not used adequately at all three levels. While the proportion of SPs who responded with “start noting when the labour really starts” and “recording the progress of labour” accounted for 89.3% and 79.4% attaining NS respectively, the proportions of those attaining NS on “recording the mother’s status” and “management based on recorded partograph” were only 21.9% and 29.2%, respectively.
- The proportion of SPs completely practicing the seven aspects in normal newborn care after delivery (attaining NS) at the provincial level (53.6%) was higher than that at the district level (36.5%). Two aspects practiced by the fewest SPs were “injecting vitamin K1. 1mg unique dose” (59.7%) and “clean eyes with sterile water or saline and put Argyrol drops (silver nitrate) in eyes to prevent infection due to gonococcus “(47.9%).
- The mean score of SPs on counselling the mother after delivery at the provincial level (79.2 points) was a little higher than that at the district level (74 points). The mean score of SPs on the practice of counselling the mother after delivery in provinces involved in the 6<sup>th</sup> country programme (84.5 points) was higher than that in the new provinces in the 7<sup>th</sup> country programme (65.3 points).
- The proportion of SPs at the provincial and district levels attaining NS was low (22.2% at the provincial level, 13.8% at the district level). The aspects completed by the lowest proportion of SPs were the “ask the clients to urinate” (35.6% at the provincial level and 38.5% at the district level) and “explain the steps of the procedure” (48.9% at the provincial level, 32.3% at the district level). The mean score of SPs on IUDs insertion practice in provinces involved in the 6<sup>th</sup> country programme (90.8 points) was significantly higher than that in the new provinces in the 7<sup>th</sup> country programme (77.5 points).
- Over 60% of SPs at the provincial and district levels and 31.8% at the communal level completely practiced the seven steps of hand washing. The proportion of those practicing the sufficient number of steps and in the correct order was lower (34% for all three levels).

❖ **Awareness, attitudes and behaviour of RH programme staff, population/FP programme staff and population/RH educators at the three levels (provincial, district and communal) was not up to management standards**

- There was a remarkable proportion of the programme staff and educators who had not been trained/retrained on professional issues. The proportion of RH programme staff who had not been retrained on any of the six professional aspects was 27.1%; that of population/FP programme staff was 19.5% and that of the educators was 24.6%.
- The knowledge of the three groups of programme staff and educators on the basic contents of the National Strategy on RH for the 2001-2010 period and the National Strategy on Population for the 2001-2010 was still limited. Approximately 30% of the programme staff and educators could not name any basic contents of the above two strategies.
- Knowledge of RH programme staff and population/FP programme staff on aspects that should be included in their work plan was still not sufficient. Yet of the surveyed institutions, the contents needed to present in an annual plan for RH or population/FP activities in 2004 were remarkably better than their level of knowledge about it. Many of the observed plans did not clearly differentiate financial sources in the section on budget allocation.
- Almost all interviewees reported that their facilities supervised the implementation of the RH/FP plans and the most common form of supervision that the interviewees applied to RH/FP plans was on the basis of “on the spot evaluation, direct observations” However, most RH programme staff and population/FP programme staff reported that they did not have supervision tools; the proportion

of those who did the work of following up each supervision session, especially the feedback to the supervised health facilities, was still not high. The proportion of RH programme staff and population/FP programme staff who were trained on supervision tasks in the last three years was still low.

- According to RH programme staff and population/FP programme staff at provincial and district levels, the topics which needed to be prioritised when training CHC heads and population officers in their localities were “planning skills” and “counselling skills”. Those at the communal level themselves considered that “RH and population/FP technical skills” should be prioritised.
- Knowledge on managerial contents of RH programme staff and population/FP programme staff at all three levels was still limited and inadequate, especially at the communal level.
- Knowledge on key contents of a BCC plan on RH/population/FP of the RH programme staff and population/FP programme staff at all three levels is still limited, especially at the communal level.
- The proportion of respondents that knew the notable points in identifying a RH issue to be prioritised was still low. The selection of a suitable contraceptive was most frequently mentioned by respondents including programme staff and educators as the most prioritised RH topic in BCC activities conducted in the community at present time.
- Most educators gave the correct answers regarding aspects of communication. The forms of communication mentioned by most respondents were direct talks and home visits; the most suitable form of communication for a group of people mentioned by most of respondents is the meeting/group discussion.
- The proportion of educators that had a correct and complete understanding of the steps of counselling, the basic skills of a counsellor, and requirements for creating a good message as well as the basic steps of an advocacy plan was still low and the lowest numbers were found at the communal level.

❖ **Knowledge, attitudes, behaviour on RH care of women aged 15-49 having children under 24 months of age, men with wives aged 15-49 having children under 24 months of age and unmarried adolescents aged 15-19 were still inadequate. However, knowledge in the provinces involved in the 6<sup>th</sup> country programme (Ha Giang, Phu Tho, Hoa Binh and Tien Giang) was slightly better than that of the new provinces in the 7<sup>th</sup> country programme (Ninh Thuan, Kon Tum and Ben Tre).**

- Out of the eight topics, four were recognised by over two-thirds of the interviewees. The three topics that were mentioned by the smallest proportions of interviewees were psycho-physiology of puberty (57.9%), family violence and prevention (57.7%), and gender and gender equality in reproductive health (53.2%). Women and men interviewees had heard about 5.2 out of 8 RH topics, while adolescents had heard about 3.9 topics on average. The average number of RH topics recognised by the interviewees was the highest in Phu Tho (6.2 topics) and the lowest in Ha Giang and Kon Tum (3.4 topics). The number of RH topics recognised in provinces involved in the 6<sup>th</sup> country programme (5.2 topics) was higher than that in the new provinces in the 7<sup>th</sup> country programme (4.2 topics).
- In terms of information sources, besides the mass media (TV/radio, books and newspapers) which was the most important source of information for all three target groups, population collaborators/village health workers, health workers, and union staff were also important information sources for women and men. For adolescents, the information came from their school teachers, books and newspapers.
- Most people agreed with the statements, “One can be pregnant if having sex without condoms” (79.4%), and “One should not get married before 19 years of age” (71.9%). Around one-third to half

of the interviewees agreed with the negative statements, “Unmarried persons should not know about RH issues” (29.1%), “The right of making decisions in the family belongs to the husband” (31.8%), “There is a reluctance in asking to buy condoms” (43.7%), and “Contraceptive methods are for married people only” (51.3%).

- Knowledge of men and women about danger signs to women during pregnancy, during delivery and after delivery was still limited. However, most men and women said that they would seek public health facilities whenever they faced obstetric danger signs. The number of danger signs (before, during and after delivery) identified by men and women in provinces involved in the 6<sup>th</sup> country programme was not much higher than that in the new provinces of the 7<sup>th</sup> country programme.
- Only 77.2% of the women interviewees said that they had had three or more pregnancy check-ups. Tien Giang had the highest percentage of women having three or more complete pregnancy check-ups (99%), and Kon Tum and Ha Giang had the lowest proportions (41.4 and 51.4%). The proportions of women having three or more complete pregnancy check-ups in provinces in the 6<sup>th</sup> country programme (82.9%) was considerably higher than the new provinces in the 7<sup>th</sup> country programme (69.7%).
- Only 71.8% of the women interviewees had had full vaccinations. The proportion of women with full vaccinations in their most recent pregnancies was the highest in Phu Tho (83.6%), and the lowest was found in Ha Giang (60.6%). The proportion of women with full vaccinations in their most recent pregnancies in provinces involved in the 6<sup>th</sup> country programme (73%) was only slightly higher than that in the new provinces in the 7<sup>th</sup> country programme (70.3%).
- Of the 18.9% of women who still gave birth at home, the highest proportion was found in Kon Tum and Ha Giang (64.1% and 46.9%). Similarly, more than 10% of the deliveries were done without assistance from health workers, mostly in Kon Tum and Ha Giang (56.5% and 41.9%),
- Only 61.9% of women began breastfeeding within the first 30 minutes after delivery in their most recent delivery, which was much lower than the proportion that was knowledgeable about the practice (71%). Up to 41.6% of women interviewees had practiced exclusive breastfeeding for four to six months, and 12.5% of them were currently practicing exclusive breastfeeding with their children under six months, which corresponds with their knowledge (58.3%).
- Women and men’s knowledge regarding diseases that require vaccination for children under one year of age was poor. Only 28% of women and 19.2% of men were able to identify all six diseases needing immunisation for children under one year of age.
- Three modern contraceptives that were known to most of the interviewees were condoms (85.3%), oral contraceptive pills (81%), and IUDs (64.5%). The other contraceptives were known by smaller proportions (under 30%), were much lower, such as emergency oral pills (4.3%). Up to 16.3% of adolescents were unable to identify any of the nine forms of contraceptives. The number of contraceptives that were mentioned by the interviewees in provinces involved in the 6<sup>th</sup> country programme (3.3 methods) was slightly higher in comparison with the new provinces in the 7<sup>th</sup> country programme (2.9 methods).
- Over three-quarters of the women and men interviewees used contraceptives during the period of the survey. The IUD was used by most of the interviewees (32.3%), followed by oral contraceptive pills (15.2%), and condoms (14.4%). The others were used by very low proportions, and notably, emergency oral pills were not used at all.
- Contraceptive users referred to the convenience and effectiveness of contraceptives as well as the counselling of population collaborators/ village health workers when selecting suitable contraceptives (58.3%, 41% and 26.6% respectively).
- According to respondents, the two leading reason for the less prevalent use of condoms were that

“people don’t like to use condoms” (26.3%) and “fear of side effects” (13.2%). As for the oral contraceptive pills, “fear of side effects” and “easy to forget” were the leading reasons (46.4% and 39.8% respectively).

- The understanding of women and men regarding when to use contraceptives after delivery was still rather low. Only 12.7% (10% of women, 15.4% of men) of the opinions were correct in noting that contraceptives should be used “right away when resuming sexual activities”, but 10.8% did not know this. The percentage of interviewees with the correct understanding about when to use contraceptives after delivery in provinces involved in the 6<sup>th</sup> country programme (16.3%) was considerably higher than that in the new provinces in the 7<sup>th</sup> country programme (7.9%).
- The knowledge of women, men and adolescents about RTIs and STDs was not sufficient, especially in regards to the consequences to women, as well as the treatment given to target groups when a patient is detected. Only 52.3% of respondents were able to identify three diseases (RTIs, gonorrhoea and syphilis). Among those who could identify the diseases, about 60% could also explain the three causes of disease. Up to 21.1% of the interviewees were unable to identify the effects of the diseases. Only one-fifth of the interviewees knew that “treatment should be given to the infected person and all the people having sexual activities with him/her”. The average number of diseases and their causes mentioned by respondents in provinces of the 6<sup>th</sup> country programme was higher than that in the new provinces in the 7<sup>th</sup> country programme.
- The knowledge about HIV transmission routes of the three target community groups was fairly good. More than 91% of them had heard about HIV/AIDS. The majority of the interviewees (71-84%) were able to mention the five transmission routes. The number of HIV transmission routes mentioned by the interviewees in provinces of the 6<sup>th</sup> country programme was four routes, which was higher than in the new provinces in the 7<sup>th</sup> country programme (3.2 routes). Although the proportion of the interviewees knowing the forms of HIV transmission was rather high, the proportion of those who knew the preventive measures was not high. The percentage of interviewees who knew all seven preventive measures was very low (2.4%).
- Most of the respondents knew that public health facilities were the places for safe abortions. However, up to 25.7% of the interviewees (21.2% were women, and 30.2% were men) did not know where to find places for safe abortions. Knowledge of women and men about the effects of abortions was low. A percentage of 38.1% of women and men interviewees did not know any of the effects of abortions.
- The abortion rate in this survey was very low (9.2% of interviewed women). Respondents’ knowledge regarding the places and effects of abortion indicates a positive outlook. Up to 78.4% of interviewed women had their abortions at public health facilities and 20.9% had abortions at private health facilities. Of the women having abortions, 91.8% had no complications.
- Knowledge of respondents about family violence was insufficient and inadequate. More than one-third of the interviewees could not identify any forms and consequences of family violence. The proportion of respondents who could identify the forms of family violence was rather high, and mostly cited physical and mental violence. Yet the proportion of respondents that could explain the consequences and causes of violence was still low. In the last three years, 7.7% of the interviewees suffered from physical violence while 15.1% suffered from mental violence, mainly adolescents.

❖ **The relationship between service provision and service utilisation was rather good. This relation in provinces involved in the 6<sup>th</sup> country programme (Ha Giang, Phu Tho, Hoa Binh and Tien Giang) was more improved than that in the new provinces in the 7<sup>th</sup> country programme (Ninh Thuan, Kon Tum and Ben Tre)**

- According to SPs, other than the abortion service that is permitted to be conducted at the provincial and district level only, the other four types of services include safe motherhood, FP (allowed to be

conducted at all three levels), abortion; and RTI/STD examination, treatment and counselling. These four were conducted by all levels on a daily basis more than others (weekly, monthly and quarterly). SPs at the provincial level had more clients than those at the other levels.

- According to the inventory data at CHCs in 2004, there was an average of 2.1-22.3 visits to CHC for services everyday (this includes all types of services and not only for RH care services). The average number of clients/day to CHC was the highest in Tien Giang and Ninh Thuan (19.1 and 16.3 clients/day/CHC), and the lowest was in HÚa Bính and Ha Giang (4.8 and 7.3 clients/day/CHC).
- Only 67.7% of women, 48.7% of men and 30.8% of adolescents confirmed that they had been informed by health workers about RH care topics.
- 74.8% of respondents (85.1% of women, 83.2% of men and 56.1% of adolescents) knew the population collaborators/village health workers in their locality. Among them, 85.8% confirmed that they had heard about RH/FP topics. When asked about places to acquire condoms and oral pills, the responses of CHCs (73%) and population collaborators/village health workers (42%) were the highest, followed by the proportion of those who referred to drug stores (40%).
- According to community opinion, the quality of services at CHCs and district hospitals was rather good. The proportion of respondents who agreed with the positive statements in terms of technical issues, equipment and essential drugs of district hospitals was higher than that of CHCs. Inversely, the proportion of respondents who agreed with the positive statements on the attitudes of SPs at CHCs was higher than that of district hospitals. On average, out of the 13 statements given, 9.3 statements on CHCs and 9.2 statements about district hospitals were agreed by the interviewees as “true”. The average number of statements on CHCs and district hospitals agreed by the interviewees in provinces involved in the 6<sup>th</sup> country programme was 9.5 and 10.1, which was higher than that in the new provinces in the 7<sup>th</sup> country programme (7.4 and 8.2 statements).
- RH programme staff and SPs’ knowledge about clients’ rights was much better than that of population/FP programme staff, educators and target groups in the community. The proportion of people who could identify all 10 clients’ rights was highest in the groups of RH programme staff (21.3%) and RH SPs (20.2%), and the lowest was among the target groups in the community (0.3%). The number of clients’ rights known to the community interviewees and SPs in provinces involved in the 6<sup>th</sup> country programme was 1.4 and 7.4 rights, which were higher in comparison to the provinces in the 7<sup>th</sup> country programme (0.6 and 2.7 rights).
- Regarding the reasons for the less prevalent use of condoms and oral pills, both the SPs and the community groups agreed that the two most common reasons were “clients/people do not like condoms” and “fear of side effects”. Additionally, the “condoms reduce satisfaction” was mentioned by most SPs. According to most SPs and community groups, the reason for the less prevalent use of oral contraceptive pills was “fear of side effects” and “easy to forget”.

## 6.2. RECOMMENDATIONS

### ❖ For infrastructure, equipment and essential drugs for RH care services

- It should be ensured that each CHC has at least four technical rooms for RH care services as defined in the NS. The delivery room should not be shared with the Gyn room or FP room. Supportive policies need to be given to CHCs for their earlier attainment of the NS. When considering support given to infrastructure, equipment and essential drugs, priorities should be applied according to regional/geographical factors and the quantity of service users to avoid waste.
- CHCs should have seven complete sets of instruments for RH care services as defined in the NS. Instruments have to be arranged in sets and sterilised to be ready for provision of services to

clients/patients. Other equipment such as procedure tables, electric boilers, and driers should also be supplied. Any incomplete sets should be supplemented in order to be complete sets for provision of services.

- All 10 groups of essential drugs should be supplied for RH care services provided at CHCs. However, they should be updated and labelled with the name of the group of drugs, not the brand name. There should also be more frequent checks of drug cabinets at CHCs to manage and supplement them as well as to keep track of expiration dates.
- Regular monitoring and supervision should be conducted on the implementation of regulations on signs, hygiene, and waiting areas in health facilities, especially at CHCs.
- All six types of protocols and equipment for infection control should be provided and used at all health facilities, especially at the communal level. There also needs to be more provision of goggles for SPs who undergo risks of being exposed to blood and body fluids.
- All the essential obstetrical care services as defined in the NS should be conducted at all three levels. Particularly, CHCs have to be able to provide five types of essential obstetrical care service according to the NS and the Ob/Gyn departments of the district and provincial hospitals have to be able to provide eight types of essential obstetrical care service while the MCH/FP centre should have the ability to provide seven types of essential obstetrical care service (except Caesarean section).

#### ❖ For service providers

Findings on knowledge and skills of SPs in this survey should be used as the basis for designing and developing training materials. The focus should be on strengthening the ability of SPs in counselling (to mothers after delivery and within the 1st week after delivery, clients for IUD insertion and abortion and adolescents and clients having RTIs/STDs); interpreting partograph; infection prevention; basic essential obstetrical care; pregnancy check-up; delivery assistance; care after delivery; recognizing danger signs to the mother before, during and after delivery and detection/management of abnormal signs in the mother and newborn. All SPs should have full knowledge on clients' rights when providing services.

#### ❖ For the programme staff and educators working in the field of RH and population/FP

- Training should be organised for all staff assigned to the task of supervision and monitoring RH and population/FP programmes and educators of the population/FP programme. The training should focus on technical issues and the basic contents of the National Strategy on RH for the 2001-2010 period and the National Strategy on RH and Population for the 2001-2010 period.
- Training should be organised for staff assigned to the task of supervision and monitoring RH and FP programmes at all level, especially at the communal level. The training should cover planning, contents and forms of supervision, and technical issues related to management. Additionally, it should also provide and guide the participants in the use of supervision tools.
- Training should be organised for educators of the population/FP programme to help them grasp different forms of communication and the basic aspects of messaging and advocacy.

#### ❖ For the community side

- Communicate the danger signs to women during pregnancy, during delivery, and after delivery for women and men so that responses can be made in a timely manner.
- Communication and education should be carried out in the community so that women and men know that exclusive breastfeeding during the first six months and the absence of menstruation

before it resumes is only a temporary contraceptive method; it is necessary to use contraceptives when resuming sexual activities after delivery to avoid unwanted pregnancy.

- Communication and education should be carried out in the community so that women, men and adolescents correctly and completely understand the necessary treatment of RTIs and STDs upon infection and that it is necessary to treat the infected person and all the partners he or she has had sex with.
- Communication and education should be carried out so that women, men and adolescents can correctly and completely understand the ways to prevent HIV transmission.
- Communication and education should be conducted so that women, men and adolescents are knowledgeable about the immediate and long term consequences of abortions so that active and initiative use of contraceptives can be applied to avoid unwanted pregnancy.
- IEC activities should be carried out on clients' rights to the community so that they can supervise health staff when receiving RH care services.

## REFERENCES

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4. MOH. *National Standards and Guidelines on RH care services*. Ha Noi, 2002.
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## ANNEX 1 DET AILED METHODOLOGY

### *Sample size for the assessment of the community side :*

Formula for sample size calculation:

$$n = z^2_{1-\alpha/2} pq/d^2$$

Where:

- n: minimum sample size using random sampling
- Z<sub>1-α/2</sub>: confidence level index, with confidence level of 95%
- P: proportion of population with characteristics under research (research property)
- Q = 1-P: proportion of population without research property
- d: Expected deviation decided by researchers

The survey applied the two-step random cluster sampling as follows:

**Step 1:** Randomly select 30 communes from the list of all the communes in the province. The 30 communes chosen for assessment of the service provision side were also the ones chosen for assessment of service utilisation side. All of the groups of interviewees were selected in step 2.

**Step 2:** In each of the selected communes, randomly select three hamlets/villages. After a hamlet/village was selected, from its centre, randomly select the first household to find interviewees (using the series number of a paper currency). The first household might or might not have the interviewee. The next was the household closest to the previous (“door to door” strategy).

### *Sample size and sampling for each province:*

	RH SP	Community	
Provincial level	Randomly select RH SPs 10 staffs x 01 prov. hospital = 10 staff 01 audit x 01 prov. hospital = 01 audit ----- 05 staff x 01 MCH centre = 05 staff 01 audit x 01 MCH centre = 01 audit		
District level	Randomly select 4 DHCs 05 staff x 4 DHCs = 20 staff 01 audit x 4 DHCs = 4 audits		
Communal level	Randomly select 30 CHCs 02 staff x 30 CHCs = 60 staff 01 audit x 30 CHCs = 30 audits	7 women x 30 comm. = 210 7 men x 30 comm. = 210 7 adolescents x 30 comm. = 210	
	Province	District	Commune
SDPs	02	04	30
SPs	15	20	60
Facility audit	02	04	30
Target groups (*)			630
			Total
			36
			95
			36
			630

Abbreviation: Staff: health staff; Audit: audit of health facilities; CHC: communal health centre  
Note: (\*) target groups: women, men and adolescents



ANNEX 2  
TABLES

Table 45. Number of service rooms available at CHCs

Rooms	CHCs having separate rooms	% of CHCs having separate rooms	Level of attaining NS (% of CHCs)			
			? 50%	51-75%	76-99%	100%
1. Pregnancy examination room	32	15.2	9.4	25.0	65.6	0.0
2. Gyn examination room	67	31.9	22.4	44.8	25.4	7.5
3. FP room	19	9.0	15.8	31.6	47.4	5.3
4. Delivery Room	65	31.0	26.2	20.0	50.8	3.1
5. Patient room	107	51.0	24.3	36.4	36.4	2.8
6. IEC counselling room	56	26.7	10.7	19.6	55.4	14.3

Table 46. Proportion of service rooms attaining 100% NS in each province

Province	Pregnancy examination room	Gyn examination room	FP room	Delivery Room	Patient room	IEC. counselling room
Phu Tho	0.0	0.0	0.0	20.0	5.3	0.0
Ha Giang	0.0	0.0	0.0	0.0	8.3	28.6
Hoa Binh	0.0	0.0	0.0	0.0	0.0	27.3
Tien Giang	0.0	16.7	11.1	0.0	0.0	20.0
Four provinces	0.0	10.6	8.3	6.1	3.3	22.6
Ben Tre	0.0	0.0	0.0	0.0	0.0	0.0
Ninh Thuan	0.0	0.0	0.0	0.0	5.9	9.1
Kon Tum	0.0	0.0	0.0	0.0	0.0	0.0
Three provinces	0.0	0.0	0.0	0.0	2.1	4.0

Table 47. Other equipment and instruments at the CHCs

List	Number of CHCs having equipment	% of CHCs having equipment	Number of useable sets of instruments	Number of useable sets of instruments / TYT
Drug cabinet	169	80.5	308	1.5
Delivery table	177	84.3	201	1.0
Procedure table	69	32.9	93	0.4
Gynaecological examination table	129	61.4	145	0.7
Instrument table	141	67.1	177	0.8
Clean bed (with net hanger) and mosquito net	173	82.4	594	2.8
Boiler (electric)	81	38.6	96	0.5
Dry heat steriliser	57	27.1	65	0.3
Autoclave	125	59.5	135	0.6
Plastic container with cover (for cold sterilisation)	81	38.6	132	0.6
Nylon cloth or sheet	148	70.5	391	1.9
Container of gauze and cotton	175	83.3	272	1.3
Container of sheets and drapes	99	47.1	119	0.6
Attaining 100% NS	2.9			
Attaining 76-99% NS	26.7			
Attaining 51-75% NS	44.3			
Attaining ≤ 50% NS	26.2			
Average	59.5			

**Table 48. Availability of protocols and equipment for infection prevention at health facilities**

Items	Prov.	Dist.	Com.
<i>Protocols</i>			
Protocol for infection prevention	100.0	92.9	59.5
Protocol for processing used metal equipment	100.0	78.6	47.1
Protocol for processing used clothes/drapes	92.9	82.1	27.1
Protocol for processing used MVA instruments	92.9	85.7	28.1
Protocol for processing medical wastes	85.7	67.9	19.0
Attaining 100% NS	71.4	64.3	9.0
Attaining 76-99% NS	28.6	17.9	10.5
Attaining 51-75% NS	0.0	0.0	12.9
Attaining ≤ 50% NS	0.0	17.9	67.6
<i>Equipments</i>			
Operation area has running tap, sterilised waters	100.0	89.3	63.8
Soap available for SPs to wash hands	100.0	89.3	68.6
Dry clean towel for SPs	100.0	92.9	53.3
Having enough sterilised gloves for each client and each operation	92.9	96.4	78.6
Having enough goggles for SPs who have risk of being exposed to splash of blood and body fluids	78.6	35.7	13.3
Having enough decontamination solution	100.0	92.9	73.3
Attaining 100% NS	78.6	35.7	10.5
Attaining 76-99% NS	14.3	42.9	31.0
Attaining 51-75% NS	7.1	10.7	17.6
Attaining ≤ 50% NS	0.0	10.7	41.0

**Table 49. Mean number of protocols and equipment for infection prevention at the health facilities**

Province	Province		District		Commune		Total	
	Protocol	Equipment	Protocol	Equipment	Protocol	Equipment	Protocol	Equipment
Phu Tho	5.0	5.0	4.5	5.0	1.4	4.6	2.0	4.7
Ha Giang	4.5	6.0	4.0	5.3	1.8	2.1	2.2	2.7
Hoa Binh	4.5	6.0	5.0	5.3	2.6	3.6	2.9	3.9
Tien Giang	5.0	6.0	5.0	5.8	3.2	5.4	3.5	5.5
Four provinces	4.8	5.8	4.6	5.3	2.3	3.9	2.7	4.2
Ben Tre	5.0	5.0	5.0	5.3	1.6	3.9	2.2	4.1
Ninh Thuan	4.5	6.0	3.3	4.5	1.9	3.7	2.2	3.9
Kon Tum	4.5	6.0	1.8	3.8	0.1	1.2	0.6	1.7
Three provinces	4.7	5.7	3.3	4.5	1.2	2.9	1.6	3.3
Total	4.7	5.7	4.1	5.0	1.8	3.5	2.2	3.8

**Table 50. Essential drugs available at the CHCs**

Items	Sufficient		Available		Unavailable	
	n	%	n	%	n	%
1. Analgesics, anaesthetics						
- Without Opi	22	10.5	179	85.2	9	4.3
- With Opi	3	1.4	69	32.9	138	65.7
2. Antibiotics	5	2.4	203	96.7	2	1.0
3. Antihypertensives	49	23.3	97	46.2	64	30.5
4. Septics and antiseptics	4	1.9	201	95.7	5	2.4
5. Antispasmodics	49	23.3	141	67.1	20	9.5
6. Oxytocics	41	19.5	143	68.1	26	12.4
7. Sedatives	70	33.3	16	7.6	124	59.0
8. Vitamins and minerals	19	9.0	185	88.1	6	2.9
9. Contraceptives	71	33.8	119	56.7	20	9.5
10. Others						
- Intravenous fluids	125	59.5	51	24.3	34	16.2
- Antimalaria (in affected areas)	38	18.1	144	68.6	28	13.3
Attaining 100% NS	0.0					
Attaining 76-99% NS	0.0					
Attaining 51-75% NS	1.0					
Attaining ≤ 50% NS	99.0					
Average	19.7					

Table 51. Mean number of essential drugs available at the CHCs

Items	Phu Tho	Ha Giang	Hoa Binh	Tien Giang	Four provinces	Ben Tre	Ninh Thuan	Kon Tum	Three provinces	Total
1. Analgesics. anaesthetics										
- Without Opi	3.3	6.7	0.0	36.7	11.7	23.3	3.3	0.0	8.9	10.5
- With Opi	0.0	3.3	3.3	3.3	2.5	0.0	0.0	0.0	0.0	1.4
2. Antibiotics	6.7	3.3	0.0	3.3	3.3	3.3	0.0	0.0	1.1	2.4
3. Antihypertensives	10.0	0.0	13.3	70.0	23.3	43.3	20.0	6.7	23.3	23.3
4. Septics and antiseptics	6.7	3.3	0.0	3.3	3.3	0.0	0.0	0.0	0.0	1.9
5. Antispasmodics	63.3	0.0	50.0	23.3	34.2	0.0	16.7	10.0	8.9	23.3
6. Oxytocics	43.3	10.0	6.7	50.0	27.5	23.3	3.3	0.0	8.9	19.5
7. Sedatives	63.3	0.0	23.3	70.0	39.2	70.0	6.7	0.0	25.6	33.3
8. Vitamin and minerals	10.0	3.3	0.0	33.3	11.7	6.7	3.3	6.7	5.6	9.0
9. Contraceptives	20.0	26.7	46.7	20.0	28.3	93.3	26.7	3.3	41.1	33.8
10. Others										
-Intravenous fluids	40.0	53.3	60.0	96.7	62.5	100.0	26.7	40.0	55.6	59.5
-Antimalaria (in affected areas)	20.0	23.3	10.0	0.0	13.3	13.3	30.0	30.0	24.4	18.1
% of drugs sufficient and unexpired	23.9	11.1	17.8	34.2	21.8	31.4	11.4	8.1	16.9	19.7

Table 52. The types of essential RH care services at CHCs

Province	Injection/transfusion of antibiotics	Injection/transfusion of oxytocics	Injection/transfusion of sedatives for convulsion prevention	Placenta removal and uterine checking	Normal delivery assistance	Attaining the basic National Standard (5 aspects)
Phu Tho	90.0	90.0	56.7	83.3	93.3	43.3
Ha Giang	90.0	76.7	16.7	50.0	93.3	13.3
Hoa Binh	96.7	70.0	3.3	53.3	80.0	3.3
Tien Giang	80.0	80.0	60.0	66.7	63.3	50.0
Four provinces	89.2	79.2	34.2	63.3	82.5	27.5
Ben Tre	60.0	90.0	3.3	20.0	86.7	3.3
Ninh Thuan	93.3	66.7	3.3	36.7	73.3	3.3
Kon Tum	36.7	40.0	6.7	3.3	83.3	0.0
Three provinces	63.3	65.6	4.4	20.0	81.1	2.2
Total	78.1	73.3	21.4	44.8	81.9	16.7

Table 53. Proportion of SPs not retrained on RH care in the previous 4 years

Province	Level			Total
	Province	District	Commune	
Phu Tho	0.0	0.0	1.7	1.1
Ha Giang	0.0	0.0	18.3	11.6
Hoa Binh	0.0	0.0	1.7	1.1
Tien Giang	0.0	0.0	0.0	0.0
Four provinces	5.0	0.0	5.4	4.2
Ben Tre	0.0	10.0	13.6	10.6
Ninh Thuan	0.0	0.0	10.3	6.7
Kon Tum	0.0	75.0	37.9	39.8
Three provinces	28.9	30.4	20.6	23.9
Total	0.0	12.5	11.8	10.1

Table 54. Percentage of SPs in agreement with proposed statements on RH care

Statements	Prov.	District	Comm.	Total
Counselling is a must for the health provider to provide to any client	97.1	100.0	97.1	97.7
HIV test is a must when infection is suspected	92.4	97.1	89.6	91.6
Health providers are reluctant to provide information/counselling on sexuality to clients	3.8	2.2	15.9	11.1
Medical equipment in this facility has been effectively used to serve the clients	84.8	77.2	80.2	80.3
Health education materials to distribute to clients is not sufficient	75.2	83.1	72.2	75.0
Professional skills of providers in this facility meet people's needs for examination and treatment	58.1	30.1	56.0	51.0
Clients have the right to discuss treatment methods with health workers	87.6	96.3	89.4	90.5
Health workers are SPs and service users are clients	97.1	97.8	98.8	98.3

**Table 55. Percentage of SPs who could identify the aspects of antenatal check-up in the last trimester**

Knowledge	Levels			Total (n=655)
	Prov. (n=105)	District (n=136)	Comm. (n=414)	
<b>General examination</b>				
1. Height measuring	53.3	69.1	76.1	71.0
2. Weight measuring	71.4	77.2	86.7	82.3
3. Pulse	89.5	77.9	81.6	82.1
4. Blood pressure	98.1	96.3	94.0	95.1
5. Skin. membranes. edema examination	74.3	74.3	72.5	73.1
6. Breast examination	38.1	33.8	37.9	37.1
7. Chest examination	54.3	69.9	57.7	59.7
8. Others	11.4	6.6	9.7	9.3
<i>Attaining 100% NS</i>	21.9	18.4	21.7	21.1
<i>Attaining 76-99% NS</i>	12.4	23.5	19.6	19.2
<i>Attaining 51-75% NS</i>	41.9	36.8	44.2	42.3
<i>Attaining ≤ 50% NS</i>	23.8	21.3	14.5	17.4
<i>Average according to the National Standard</i>	68.4	71.2	72.4	71.5
<b>Obstetric examination</b>				
1. Uterine, abdomen measuring	93.3	95.6	95.7	95.3
2. Fetal presentation	83.8	89.0	80.7	82.9
3. Fetal heartbeat	91.4	94.9	86.5	89.0
4. Others	16.2	7.4	8.9	9.8
<i>Attaining 100% NS</i>	74.3	82.4	71.5	74.2
<i>Attaining 76-99% NS</i>	0.0	0.0	0.0	0.0
<i>Attaining 51-75% NS</i>	20.0	14.7	21.3	19.7
<i>Attaining ≤ 50% NS</i>	5.7	2.9	7.2	6.1
<i>Average according to the National Standard</i>	89.5	93.1	87.6	89.1
<b>Consultation</b>				
1. Normal or abnormal pregnancy	74.3	75.0	72.0	73.0
2. Estimated delivery date	59.0	65.4	67.9	66.0
3. Estimated place of delivery	68.6	77.2	71.7	72.4
4. Counselling on nutrition. labour. hygiene and rest	77.1	75.7	79.7	78.5
5. Others	11.4	9.6	15.5	13.6
<i>Attaining 100% NS</i>	31.4	27.9	34.5	32.7
<i>Attaining 76-99% NS</i>	0.0	0.0	0.0	0.0
<i>Attaining 51-75% NS</i>	31.4	41.9	34.3	35.4
<i>Attaining ≤ 50% NS</i>	37.1	30.1	31.2	31.9
<i>Average according to the National Standard</i>	69.8	73.4	72.8	72.4

Table 56. Score per 100 on knowledge of pregnancy check-ups by level

Province	Province	District	Commune	Total
<b>General examination</b>				
Phu Tho	67.6	70.7	78.3	75.0
Ha Giang	75.2	77.1	70.0	72.3
Hoa Binh	68.6	80.7	80.5	78.7
Tien Giang	99.1	97.9	93.2	95.1
Four provinces	77.6	81.6	80.5	80.3
Ben Tre	55.2	43.6	65.1	59.0
Ninh Thuan	55.2	59.8	61.1	59.9
Kon Tum	58.1	66.4	57.6	59.6
Three provinces	56.2	56.4	61.3	59.5
Total	68.4	71.2	72.4	71.5
<b>Obstetric examination</b>				
Phu Tho	97.8	96.7	90.0	92.6
Ha Giang	95.6	100.0	86.1	90.5
Hoa Binh	88.9	91.7	89.5	89.8
Tien Giang	100.0	100.0	99.4	99.7
Four provinces	95.6	97.1	91.2	93.1
Ben Tre	91.1	90.0	85.9	87.6
Ninh Thuan	75.6	79.2	86.2	83.2
Kon Tum	77.8	91.7	75.9	79.6
Three provinces	81.5	87.5	82.7	83.5
Total	89.5	93.1	87.6	89.1
<b>Consultant</b>				
Phu Tho	66.7	62.5	75.0	71.1
Ha Giang	78.3	85.0	70.4	74.7
Hoa Binh	81.7	81.3	74.6	77.1
Tien Giang	100.0	97.5	90.3	93.4
Four provinces	81.7	81.6	77.5	79.0
Ben Tre	48.3	61.3	69.1	64.1
Ninh Thuan	56.7	59.4	65.1	62.6
Kon Tum	56.7	63.8	65.1	63.4
Three provinces	53.9	61.6	66.4	63.4
Total	69.8	73.4	72.8	72.4

**Table 57. Percentage of SPs who could identify the steps of pregnancy a check-up**

Steps	Levels			Total (n=655)
	Pro. (n=105)	Dist. (n=136)	Com. (n=414)	
Ask	72.4	91.9	84.1	83.8
General examination	87.6	91.2	92.8	91.6
Ob examination	88.6	94.1	89.9	90.5
Urine test	71.4	72.1	64.3	67.0
Tetanus vaccination	52.4	68.4	70.8	67.3
Medicine prescription	53.3	61.8	65.5	62.7
Counselling, health education	62.9	71.3	66.7	67.0
Recording in logbook	56.2	70.6	72.5	69.5
Informing the result, make appointment. instruction	61.0	64.7	69.1	66.9
Don't know	8.6	2.2	5.8	5.5
<i>Attaining 100% NS</i>	41.0	42.6	42.0	42.0
<i>Attaining 76-99% NS</i>	16.2	22.1	22.9	21.7
<i>Attaining 51-75% NS</i>	8.6	14.7	13.8	13.1
<i>Attaining ≤ 50% NS</i>	34.3	20.6	21.3	23.2
<i>Average according to the National Standard</i>	67.3	76.2	75.0	74.1

**Table 58. Mean score per 100 -points on the steps of pregnancy check-up, by province**

Provinces	Province	District	Commune	Total
Phu Tho	94.1	96.7	91.5	93.0
Ha Giang	92.6	89.5	64.4	74.2
Hoa Binh	77.0	79.5	80.7	79.9
Tien Giang	100.0	95.0	94.7	95.6
Four provinces	90.9	90.1	82.8	85.6
Ben Tre	43.7	58.9	71.4	64.3
Ninh Thuan	43.7	77.8	78.0	72.2
Kon Tum	20.0	36.7	43.9	38.5
Three provinces	38.8	56.4	64.5	58.1
Total	67.3	76.2	75.0	74.1

Table 59. Percentage of SPs who could identify abnormal signs during a normal delivery

Knowledge	Levels			
	Province	Dist.	Com.	Total
<i>Correct signs</i>				
1. Woman's pulse 95 beats/minute	55.2	64.0	74.6	69.3
2. Systolic BP 145 mmHg	91.4	96.3	86.7	89.5
3. Diastolic BP 100 mmHg	97.1	97.1	93.7	95.0
4. Amniotic fluid with meconium	99.0	98.5	89.1	92.7
5. Fetal heart 110 beats/minute	81.0	92.6	74.9	79.5
6. Uterine contraction lasts 60 seconds in latent phase	87.6	96.3	66.2	75.9
7. Six uterine contractions in ten minutes	88.6	96.3	74.9	81.5
8. Active phase: cervix dilates less than 1cm in an hour	82.9	91.9	78.7	82.1
Attaining 100% NS	41.0	52.9	37.4	41.2
Attaining 76-99% NS	23.8	33.1	21.7	24.4
Attaining 51-75% NS	29.5	12.5	25.6	23.5
Attaining ≤ 50% NS	5.7	1.5	15.2	10.8

Table 60. Score per 100-points on knowledge of abnormal signs to the mother during a normal delivery (gain 1 point for each correct answer, lose 1 point for each wrong answer)

Province	Province	District	Commune	Total
Phu Tho	84.2	88.1	76.3	80.0
Ha Giang	85.0	88.1	61.3	70.7
Hoa Binh	79.2	80.6	78.1	78.8
Tien Giang	88.3	90.6	72.5	78.9
Four provinces	84.2	86.9	72.0	77.1
Ben Tre	70.8	79.4	65.3	69.2
Ninh Thuan	57.5	68.8	58.6	60.3
Kon Tum	64.2	79.4	53.9	61.0
Three provinces	64.2	76.3	59.3	63.5
Total	75.6	82.5	66.6	71.4

**Table 61. Percentage of SPs who could identify the contents of internal examination of women in labour**

Information	Levels			Total (n=655)
	Pro. (n=105)	District (n=136)	Com. (n=414)	
Check the cervix effacement and dilatation	96.2	97.8	90.6	93.0
Check the status of amniotic fluid, how long the membrane ruptured	81.9	89.7	76.3	80.0
Check descent of the foetus' head in the pelvic area	92.4	91.2	81.2	85.0
Check the pelvis	51.4	39.0	41.3	42.4
Check infection of amniotic fluid	26.7	14.7	15.7	17.3
Estimate the delivery time and anticipation.	29.5	34.6	21.7	25.6
Other	3.8	5.1	9.7	7.8
Don't know	1.0	0.0	3.9	2.6
<i>Attaining 100% NS</i>	10.5	5.1	4.3	5.5
<i>Attaining 76-99% NS</i>	19.0	21.3	15.9	17.6
<i>Attaining 51-75% NS</i>	26.7	21.3	24.4	24.1
<i>Attaining ≤ 50% NS</i>	43.8	52.2	55.3	52.8
<i>Average according to the NS</i>	63.0	61.2	54.5	57.2

**Table 62. Mean score for knowledge on Ob. examination**

Provinces	Province	District	Commune	Total
Phu Tho	63.3	70.8	61.9	64.0
Ha Giang	75.6	69.2	54.4	60.9
Hoa Binh	63.3	52.5	45.0	49.5
Tien Giang	88.9	83.3	77.1	80.3
Four provinces	72.8	69.0	59.6	63.6
Ben Tre	48.9	47.5	59.9	55.5
Ninh Thuan	48.9	52.1	43.7	46.1
Kon Tum	52.2	50.8	38.8	43.6
Three provinces	50.0	50.0	47.5	48.4
Total	63.0	61.2	54.5	57.2

Table 63. Percentage of SPs who could identify aspects of newborn care right after delivery

Knowledge	Province	District	Commune	Total
<i>The normal newborn care right after delivery</i>				
Clear the baby's airway	92.4	97.1	83.8	87.9
Dry the baby's body and keep him/her warm	93.3	97.1	89.4	91.6
Umbilical Cord care	96.2	98.5	95.9	96.5
Assess the baby's condition. sex; check for any deformity; weigh and measure the baby's length	61.9	72.8	64.5	65.8
Clean eyes with sterile water or saline and put Argyrol drops (silver nitrate) in eyes to prevent infection due to gonococcus	34.3	27.9	33.1	32.2
Inject vitamin K1. 1mg unique dose	46.7	41.2	33.3	37.1
Return baby to mother within 30 minutes for initiation of breast-feeding	81.0	69.9	65.7	69.0
<i>Attaining 100% NS</i>	19.0	19.1	15.9	17.1
<i>Attaining 76-99% NS</i>	18.1	11.0	11.4	12.4
<i>Attaining 51-75% NS</i>	50.5	60.3	51.4	53.1
<i>Attaining ≤ 50% NS</i>	12.4	9.6	21.3	17.4
<i>Average attaining the NS</i>	72.2	72.1	66.5	68.6

**Table 64. Percentage of SPs who could identify the aspects of mother and newborn care within 24 hours after delivery**

<b>Knowledge</b>	<b>Province</b>	<b>District</b>	<b>Commune</b>	<b>Total</b>
<i>Care of mother within 24 hours after delivery</i>				
1. Pulse	87.6	89.7	84.3	86.0
2. BP	88.6	91.2	87.4	88.4
3. Uterine involution	94.3	97.1	81.2	86.6
4. Vaginal bleeding	95.2	96.3	93.2	94.2
<i>Attaining 100% NS</i>	82.9	83.1	68.4	73.7
<i>Attaining 76-99% NS</i>	0.0	0.0	0.0	0.0
<i>Attaining 51-75% NS</i>	5.7	10.3	16.2	13.3
<i>Attaining ≤ 50% NS</i>	11.4	6.6	15.5	13.0
<i>Average attaining the NS</i>	91.4	93.6	86.5	88.8
<i>Care of newborn within 24 hours after delivery</i>				
1. Respiration	55.2	66.2	69.6	66.6
2. Skin colour	69.5	61.0	55.8	59.1
3. Breastfeeding	90.5	88.2	86.7	87.6
4. Umbilical bleeding	62.9	54.4	65.0	62.4
5. Excretion	70.5	64.7	58.5	61.7
<i>Attaining 100% NS</i>	24.8	17.6	22.7	22.0
<i>Attaining 76-99% NS</i>	26.7	28.7	25.6	26.4
<i>Attaining 51-75% NS</i>	25.7	29.4	26.8	27.2
<i>Attaining ≤ 50% NS</i>	22.9	24.3	24.9	24.4
<i>Average attaining the NS</i>	69.7	66.9	67.1	67.5

**Table 65. Score per 100-points for knowledge on mother and newborn care within 24 hours after delivery**

Knowledge	Province	District	Commune	Total
<i>Care of normal newborn right after delivery</i>				
Phu Tho	68.6	67.9	63.1	65.0
Ha Giang	71.4	66.4	62.6	64.8
Hoa Binh	81.9	70.7	65.2	69.0
Tien Giang	99.1	99.3	93.2	95.4
Four provinces	80.2	76.1	71.0	73.5
Ben Tre	70.5	61.4	69.0	67.6
Ninh Thuan	59.1	67.0	59.4	60.7
Kon Tum	55.2	70.7	53.0	57.1
Three provinces	61.6	66.3	60.5	61.9
Total	72.2	72.1	66.5	68.6
<i>Care of mother within 24 hours after delivery</i>				
Phu Tho	96.7	95.0	93.3	94.2
Ha Giang	100.0	96.3	86.3	90.5
Hoa Binh	93.3	87.5	85.0	86.8
Tien Giang	100.0	100.0	98.3	98.9
Four provinces	97.5	94.7	90.7	92.6
Ben Tre	78.3	91.3	86.0	85.9
Ninh Thuan	83.3	96.9	82.8	85.4
Kon Tum	88.3	88.8	73.7	79.3
Three provinces	83.3	92.0	80.9	83.5
Total	91.4	93.6	86.5	88.8
<i>Care of newborn within 24 hours after delivery</i>				
Phu Tho	77.3	66.0	80.3	76.8
Ha Giang	85.3	77.0	66.7	71.8
Hoa Binh	72.0	63.0	67.7	67.4
Tien Giang	100.0	95.0	89.5	92.3
Four provinces	83.7	75.3	76.0	77.0
Ben Tre	49.3	51.0	61.7	57.5
Ninh Thuan	48.0	57.5	56.6	55.3
Kon Tum	56.0	57.0	46.6	50.3
Three provinces	51.1	55.0	55.0	54.4
Total	69.7	66.9	67.1	67.5

**Table 66. Percentage of SPs who could identify the most common risks to preterm newborns**

Information	Pro.	Dist.	Com.	Total
1. Birth asphyxia	41.0	49.3	54.1	51.0
2. Hypothermia	63.8	62.5	51.9	56.0
3. Decreased blood glucose	35.2	20.6	16.9	20.6
4. Respiratory distress	67.6	69.1	51.7	57.9
5. Infection	43.8	34.6	53.4	47.9
6. Haemorrhage	13.3	11.0	19.1	16.5
7. Prolonged jaundice	33.3	23.5	29.0	28.6
8. Disturbances of digestive tract	11.4	8.1	11.1	10.5
9. Other	7.6	5.1	21.3	15.7
10. Don't know	1.0	2.2	4.8	3.7
<i>Attaining 100% NS</i>	1.9	0.7	1.7	1.5
<i>Attaining 76-99% NS</i>	2.9	3.7	3.1	3.2
<i>Attaining 51-75% NS</i>	9.5	7.4	13.0	11.3
<i>Attaining ≤ 50% NS</i>	85.7	88.2	82.1	84.0
<i>Average attaining the NS</i>	38.7	34.8	35.9	36.1

**Table 67. Knowledge on common risks to preterm newborns**

Provinces	Province	District	Commune	Total
Phu Tho	39.2	55.6	45.8	46.8
Ha Giang	43.3	45.6	41.0	42.4
Hoa Binh	43.3	23.8	25.4	27.9
Tien Giang	61.7	45.6	65.0	60.4
Four provinces	46.9	42.7	44.3	44.3
Ben Tre	22.5	22.5	35.2	30.5
Ninh Thuan	37.5	23.4	23.1	25.6
Kon Tum	23.3	25.0	15.1	18.6
Three provinces	27.8	23.7	24.5	24.9
Total	38.7	34.8	35.9	36.1

Table 68. Score per 100-points on warning signs in the mother after delivery

Provinces	Province	District	Commune	Total
Phu Tho	32.0	69.0	64.3	60.2
Ha Giang	46.7	55.0	54.0	53.1
Hoa Binh	49.3	41.0	49.3	47.6
Tien Giang	62.7	53.0	75.6	68.7
Four provinces	47.7	54.5	60.8	57.4
Ben Tre	22.7	20.0	53.2	41.3
Ninh Thuan	38.7	38.8	41.0	40.2
Kon Tum	34.7	24.0	38.3	34.6
Three provinces	32.0	26.8	44.2	38.7
Total	41.0	43.1	53.8	49.5

Table 69. Percentage of SPs who could identify the correct responses to abnormal signs in the mother and newborn after delivery

Correct knowledge	Province	District	Comm.	Total
<i>Mother</i>				
Pulse 95 beats/minute	74.3	79.4	62.6	67.9
BP 90/60 mmHg	100.0	100.0	100.0	100.0
Soft uterus, and the fundus is equal to or higher than the umbilical level	92.4	94.9	75.4	82.1
Uterine closes while vagina keeps bleeding	92.4	96.3	74.2	81.7
Bleeding amount over 250ml and still continues	84.8	75.7	69.8	73.4
Haematoma			57.5	57.5
Perineum torn level 3.4			73.2	73.2
Attaining 100% NS	66.7	62.5	30.2	42.7
Attaining 76-99% NS	18.1	23.5	14.7	17.1
Attaining 51-75% NS	10.5	11.8	37.0	27.5
Attaining ≤ 50% NS	4.8	2.2	18.1	12.7
Average attaining the NS	88.8	89.3	73.2	79.0
<i>Newborn</i>				
1. Cyanosis, howling	91.4	90.4	75.4	81.1
2. Avoidance of breastfeeding	65.7	69.1	46.4	54.2
3. Continued avoidance of breastfeeding		67.6	79.7	76.7
4. Umbilical bleeding	93.3	95.6	87.2	89.9
5. Hypothermia	93.3	96.3	92.3	93.3
Attaining 100% NS	61.9	48.5	33.8	41.4
Attaining 76-99% NS	0.0	29.4	34.3	27.8
Attaining 51-75% NS	23.8	17.6	17.2	18.3
Attaining ≤ 50% NS	14.3	4.4	14.7	12.5
Average attaining the NS	86.0	83.8	76.2	79.3

**Table 70. Mean score per 100-points on the correct responses to abnormal signs in the mother and newborn after delivery**

<b>Provinces</b>	<b>Province</b>	<b>District</b>	<b>Commune</b>	<b>Total</b>
<i>Mother</i>				
Phu Tho	100.0	92.0	80.0	85.7
Ha Giang	98.7	100.0	64.1	77.1
Hoa Binh	84.0	80.0	82.4	82.1
Tien Giang	100.0	100.0	96.9	98.0
Four provinces	95.7	93.0	80.8	85.7
Ben Tre	96.0	99.0	68.8	79.5
Ninh Thuan	74.7	75.0	68.5	70.7
Kon Tum	68.0	76.0	51.5	59.4
Three provinces	79.6	83.9	62.9	69.9
Total	88.8	89.3	73.2	79.0
<i>Newborn</i>				
Phu Tho	83.3	95.0	84.0	86.2
Ha Giang	100.0	77.0	68.7	75.4
Hoa Binh	85.0	76.0	81.0	80.6
Tien Giang	96.7	95.0	92.9	93.9
Four provinces	91.3	85.8	81.6	84.0
Ben Tre	96.7	95.0	76.6	83.7
Ninh Thuan	71.7	81.3	70.7	72.8
Kon Tum	68.3	67.0	59.0	62.2
Three provinces	78.9	81.1	68.8	72.9
Total	86.0	83.8	76.2	79.3

**Table 71. Percentage of SPs who could identify the issues for counselling the mother after delivery**

<b>Knowledge</b>	<b>Prov.</b>	<b>District</b>	<b>Comm.</b>	<b>Total</b>
<i>Right after delivery</i>				
Self monitoring of bleeding and uterine shrinkage	92.4	94.9	81.4	86.0
Monitoring and care of newborn	28.6	32.4	43.7	38.9
Breastfeeding 30 minutes after delivery, breastfeed the baby exclusively	91.4	82.4	77.3	80.6
Counselling family members to monitor and care of mother and newborn	44.8	27.9	46.1	42.1
<i>Attaining 100% NS</i>	19.0	17.6	19.8	19.2
<i>Attaining 76-99% NS</i>	0.0	0.0	0.0	0.0
<i>Attaining 51-75% NS</i>	27.6	20.6	30.4	27.9
<i>Attaining ≤ 50% NS</i>	53.3	61.8	49.8	52.8
<i>Average attaining the NS</i>	64.3	59.4	62.1	61.9
<b>In the first week after delivery</b>				
Hygiene (e.g. bathing, no steeping, washing breasts, change napkins, no douche, no intercourse in the first 6 weeks...)	81.9	87.5	84.1	84.4
Nutrition (e.g. having enough nutrients, drinking a lot of water)	86.7	91.2	84.3	86.1
Gentle work/movement	30.5	43.4	55.1	48.7
Following up of abnormal signs in the first days (bleeding increases, increase of abdominal pain, fever, dizziness, headache)	78.1	66.2	50.5	58.2
Breast feeding, exclusive breast-feeding for the first 4 to 6 months	64.8	51.5	66.2	62.9
FP/contraceptive method counselling	26.7	19.9	34.5	30.2
Monitoring the baby (dangerous signs: not sucking, not breathing, cyanosis)	50.5	35.3	43.5	42.9
Cord care (bleeding, wet, smelt)	35.2	36.8	38.2	37.4
Vaccination	24.8	25.0	38.9	33.7
<i>Attaining 100% NS</i>	6.7	1.5	6.5	5.5
<i>Attaining 76-99% NS</i>	11.4	13.2	15.7	14.5
<i>Attaining 51-75% NS</i>	37.1	30.1	33.3	33.3
<i>Attaining ≤ 50% NS</i>	44.8	55.1	44.4	46.7
<i>Average attaining the NS</i>	53.2	50.7	55.0	53.8

**Table 72. Score per 100 points on knowledge for counselling the mother after delivery**

	Province	District	Commune	Total
<i>Right after delivery</i>				
Phu Tho	60.0	56.3	70.0	65.5
Ha Giang	71.7	68.8	62.1	65.0
Hoa Binh	71.7	57.5	59.6	61.1
Tien Giang	100.0	100.0	86.4	91.5
Four provinces	75.8	70.6	69.5	70.7
Ben Tre	53.3	35.0	60.6	54.0
Ninh Thuan	43.3	51.6	52.6	50.8
Kon Tum	50.0	45.0	43.1	44.6
Three provinces	48.9	43.3	52.1	49.8
Total	64.3	59.4	62.1	61.9
<i>Within the first week after delivery</i>				
Phu Tho	39.3	48.3	59.3	53.8
Ha Giang	51.1	53.9	55.2	54.3
Hoa Binh	58.5	43.9	48.7	49.2
Tien Giang	86.7	82.2	80.6	81.9
Four provinces	58.9	57.1	60.9	59.8
Ben Tre	53.3	40.6	53.3	50.6
Ninh Thuan	40.7	45.1	48.5	46.6
Kon Tum	43.0	40.0	39.3	40.0
Three provinces	45.7	41.7	47.1	45.7
Total	53.2	50.7	55.0	53.8

**Table 73. Percentage of SPs who could identify issues for counselling clients for IUDs and abortion**

Contents	Province	District	Comm.	Total
<b>For IUD insertion</b>				
1. Information on IUD (effect, side effect, complication)	80.0	79.4	79.0	79.2
2. Guide for client monitoring IUD	32.4	33.8	46.1	41.4
3. Remind client to return for examination	87.6	87.5	70.3	76.6
4. Guide to use drug after IUD insertion	41.0	48.5	41.8	43.1
5. Inform client that IUD can be removed if she wants to	13.3	8.1	19.8	16.3
<i>Attaining 100% NS</i>	3.8	3.7	7.2	6.0
<i>Attaining 76-99% NS</i>	17.1	15.4	17.9	17.3
<i>Attaining 51-75% NS</i>	24.8	27.9	25.8	26.1
<i>Attaining ≤ 50% NS</i>	54.3	52.9	49.0	50.7
<i>Average attaining the NS</i>	50.9	51.5	51.4	51.3
<b>For abortion</b>				
1. Consequences of abortion	21.9	36.0	43.0	38.2
2. How to avoid unwanted pregnancy	54.3	46.3	49.3	49.5
3. Return for examination in case of bleeding	83.8	79.4	64.7	70.8
4. Return for examination in case of increased abdomen pain	74.3	63.2	54.6	59.5
5. Return for examination in case of smelt leucorrhoea	32.4	26.5	31.9	30.8
<i>Attaining 100% NS</i>	4.8	5.1	6.5	6.0
<i>Attaining 76-99% NS</i>	21.0	11.0	18.4	17.3
<i>Attaining 51-75% NS</i>	29.5	37.5	23.9	27.6
<i>Attaining ≤ 50% NS</i>	44.8	46.3	51.2	49.2
<i>Average attaining the NS</i>	53.3	50.3	48.7	49.8

**Table 74. Mean score per 100 points for SPs on issues to address when counselling clients coming for IUD insertion and abortion**

<b>Provinces</b>	<b>Province</b>	<b>District</b>	<b>Commune</b>	<b>Total</b>
<i>After IUD insertion</i>				
Phu Tho	56.0	56.0	54.3	55.0
Ha Giang	49.3	49.0	56.3	53.7
Hoa Binh	62.7	55.0	54.7	56.0
Tien Giang	77.3	79.0	66.4	70.9
Four provinces	61.3	59.8	57.9	58.8
Ben Tre	40.0	39.0	56.6	50.2
Ninh Thuan	37.3	46.3	43.8	43.2
Kon Tum	33.3	35.0	26.9	29.7
Three provinces	36.9	39.6	42.5	41.0
Total	50.9	51.5	51.4	51.3
<i>After abortion</i>				
Phu Tho	44.0	54.0	50.0	49.9
Ha Giang	56.0	52.0	48.3	50.3
Hoa Binh	54.7	46.0	51.0	50.5
Tien Giang	82.7	83.0	72.5	76.4
Four provinces	59.3	58.8	55.4	56.7
Ben Tre	52.0	48.0	50.2	50.0
Ninh Thuan	50.7	46.3	45.2	46.3
Kon Tum	33.3	22.0	23.1	24.5
Three provinces	45.3	38.2	39.5	40.2
Total	53.3	50.3	48.7	49.8

Table 75. Reasons for IUD, condom and oral pill use in the community

Contents	Prov.	District	Comm.	Total
<b>IUD (reason for wide use)</b>				
1. IUDs are available	7.6	9.6	23.2	17.9
2. Quota assigned	0.0	5.9	12.6	9.2
3. Health staff are familiar with IUD, seen as good and appropriate	3.8	4.4	16.9	12.2
4. Clients prefer as IUD is free	37.1	36.8	36.0	36.3
5. Clients prefer because of IUD efficiency	69.5	69.1	65.7	67.0
6. Client prefer as it is safe	72.4	59.6	46.1	53.1
7. Client prefer as it is comfortable, IUD lasts for a long time	85.7	86.0	66.4	73.6
Other (inconvenient)	11.4	5.9	11.1	10.1
Don't know/Don't answer	0.0	0.0	0.5	0.3
<b>Condom (reasons for its less prevalent use)</b>				
1. Not available, hard to buy	1.9	1.5	7.0	5.0
2. Cannot afford	1.9	2.2	7.5	5.5
3. Condom quality is not good	16.2	8.8	8.0	9.5
4. Afraid of side effects	43.8	54.4	23.4	33.1
5. Customers don't like condoms	62.9	63.2	39.1	47.9
6. People feel uncomfortable buying condoms	23.8	22.1	22.7	22.7
7. Sensation reduced	78.1	75.0	60.1	66.1
8. Lack of contraceptive experience	23.8	11.0	16.4	16.5
9. Ineffective communication and education	6.7	12.5	6.5	7.8
10. People don't know about condoms	0.0	0.7	2.7	1.8
Other (inconvenient)	7.6	5.9	15.5	12.2
Don't know/Don't answer	1.0	0.0	1.0	0.8
<b>Oral pills (reasons for its less prevalent use)</b>				
1. Not available, hard to buy	6.7	0.0	8.0	6.1
2. Cannot afford	9.5	2.9	7.0	6.6
3. Quality of pills are not good	1.9	3.7	1.7	2.1
4. Afraid of side effects	93.3	91.9	47.3	64.0
5. Customers don't like	21.0	19.1	19.1	19.4
6. People feel uncomfortable buying	14.3	9.6	12.8	12.4
7. Lack of contraceptive experience	14.3	21.3	17.9	18.0
8. Ineffective communication and education	9.5	14.7	4.1	7.2
9. People don't know about pills	0.0	0.0	3.4	2.1
Other (easy to forget)	49.5	56.6	30.4	38.9
Don't know/Don't answer	0.0	0.0	1.7	1.1

**Table 76. Knowledge of SPs on RH issues needed to counsel adolescents**

Issues	Province	District	Commune	Total
Body developing characteristics, puberty psychology	38.1	41.2	35.0	36.8
Normal and abnormal menstruation	44.8	47.1	30.4	36.2
Pregnancy and delivery	22.9	33.8	31.6	30.7
Contraceptives	47.6	37.5	57.5	51.8
Vaginal and urethra discharge	5.7	6.6	6.3	6.3
Having nocturnal emissions, self-abuse	7.6	5.9	7.7	7.3
Safe sexual intercourse	60.0	48.5	57.7	56.2
Violence	4.8	0.0	8.7	6.3
RTIs/STDs	23.8	16.9	33.3	28.4
Others	1.9	2.9	7.0	5.3
Don't know	11.4	1.5	9.7	8.2
Attaining 100% NS	0.0	0.0	1.4	0.9
Attaining 76-99% NS	2.9	0.0	3.9	2.9
Attaining 51-75% NS	6.7	4.4	10.9	8.9
Attaining ≤ 50% NS	90.5	95.6	83.8	87.3
<i>Average attaining the NS</i>	28.4	26.4	29.8	28.9

**Table 77. Recommendations of SPs on satisfying adolescents' needs in RH care**

Recommendations	Province	District	Com.	Total
1. Quick	11.4	16.9	34.5	27.2
2. Private and confidential	54.3	52.9	52.7	53.0
3. Unprejudiced and sympathetic	29.5	26.5	19.6	22.6
4. Convenient time and place	16.2	16.2	23.7	20.9
5. Free or reduced fee	13.3	15.4	22.5	19.5
6. Connected to school, unions	43.8	57.4	37.2	42.4
7. With regular counselling	62.9	77.9	58.7	63.4
8. Other	14.3	8.1	5.3	7.3
Don't know	6.7	1.5	7.0	5.8

Table 78. Recommendations of SPs on suitable contraceptives for adolescents

Contraceptives	Province	District	Comm.	Total
1. Combined oral contraceptives	74.3	73.5	58.5	64.1
2. Condoms	98.1	100.0	98.6	98.8
3. IUD	2.9	0.7	2.4	2.1
4. Injectable	1.0	3.7	10.9	7.8
5. Norplant	1.9	2.2	6.5	4.9
6. Emergency contraceptive pills	78.1	84.6	80.4	80.9
7. Sterilisation	0.0	0.0	0.7	0.5
8. Calendar/rhythm method	52.4	55.9	29.5	38.6

Table 79. Knowledge of SPs on RTIs/STDs

Information	Province	District	Comm.	Total
<b>Methods of treatment for vaginal discharge syndrome</b>				
Etiological treatment with personal diagnostic experience	29.5	43.4	27.3	31.0
Combined treatment of STI due to Tricomonas, Bacteria and Candidas	62.9	52.9	63.5	61.2
Don't know	7.6	3.7	9.2	7.8
<b>Counselling on gonorrhoea treatment</b>				
Consequences of	21.9	22.8	32.6	28.9
Early treatment and observation of treatment plan	56.2	60.3	70.5	66.1
Transmission to sex partners.	48.6	59.6	70.8	64.9
Identify and provide treatment for partners, even when there is no symptom	44.8	31.6	37.9	37.7
Correct and regular condom use	47.6	57.4	62.3	58.9
Possibility of acquiring HIV	11.4	2.9	13.5	11.0
<i>Attaining 100% NS</i>	2.9	0.0	4.8	3.5
<i>Attaining 76-99% NS</i>	6.7	1.5	11.6	8.7
<i>Attaining 51-75% NS</i>	6.7	12.5	15.2	13.3
<i>Attaining ≤ 50% NS</i>	83.8	86.0	68.4	74.5
<i>Average attaining the NS</i>	38.4	39.1	48.0	44.6

**Table 80. Percentages for SPs with correct responses to vaginal discharge syndrome, by province**

Provinces	Province	District	Commune	Total
Phu Tho	60.0	35.0	83.3	69.5
Ha Giang	100.0	70.0	58.3	67.4
Hoa Binh	53.3	50.0	88.3	74.7
Tien Giang	86.7	30.0	64.4	60.6
Four provinces	75.0	46.3	73.6	68.1
Ben Tre	40.0	80.0	30.5	42.6
Ninh Thuan	46.7	37.5	50.0	47.2
Kon Tum	53.3	65.0	69.0	65.6
Three provinces	46.7	62.5	49.7	51.8
Total	62.9	52.9	63.5	61.2

**Table 81. Percentage of SPs knowledgeable of the times for hand washing in infection control**

Time	Levels			
	Pro.	Dist.	Comm.	Total
	n=105	n=136	n=414	n=655
At the start of a working day	36.2	27.9	30.7	31.0
Before examination, injection, blood transfusion	69.5	69.9	75.6	73.4
Before removal of sterilised instruments for storing	34.3	43.4	32.6	35.1
Before wearing sterilised gloves, doing procedure/operation	68.6	65.4	63.8	64.9
After contact with patients	69.5	68.4	71.3	70.4
After contact with blood or body fluids of the patient	47.6	58.8	47.6	49.9
After taking off gloves	32.4	27.2	31.4	30.7
Before going home	30.5	24.3	26.6	26.7
Don't know/no answer	0.0	0.0	1.4	0.9
<b>Attaining 100% NS</b>	14.3	5.9	8.2	8.7
<b>Attaining 76-99% NS</b>	1.9	4.4	4.1	3.8
<b>Attaining 51-75% NS</b>	13.3	19.1	20.3	18.9
<b>Attaining ≤ 50% NS</b>	70.5	70.6	67.4	68.6
Average	48.6	48.2	47.4	47.8

Table 82. Percentages for SPs knowledge of the steps in hand washing for infection control

Steps	Levels			
	Pro.	Dist.	Comm.	Total
	n=105	n=136	n=414	n=655
Remove watch, jewellery from hands; wet hands with soap solution	81.9	90.4	83.1	84.4
Scrub the palms of each hand against each other, 10 times	82.9	88.2	74.2	78.5
Use one palm to scrub the back of the other hand, 10 times	81.9	80.1	63.0	69.6
Use the fingers of one hand to scrub the entire surface of each finger of the other hand, 10 times	72.4	75.0	59.9	65.0
Use fingertips of one hand to scrub the palm of the other hand, 10 times	67.6	70.6	54.8	60.2
Rinse all parts of the hands under the water	89.5	91.2	81.6	84.9
Use a dry and clean towel to dry hands	85.7	87.5	69.1	75.6
<i>Name in correct order</i>	21.9	14.0	26.1	22.9
<i>Don't know/don't answer</i>	6.7	2.9	8.7	7.2
<b>Attaining 100% NS</b>	52.4	54.4	41.1	45.6
<b>Attaining 76-99% NS</b>	16.2	13.2	11.6	12.7
<b>Attaining 51-75% NS</b>	16.2	22.8	17.9	18.6
<b>Attaining ≤ 50% NS</b>	15.2	9.6	29.5	23.1

Table 83. Percentages for SPs knowledge on the steps for disinfection of instruments

Steps	Levels			
	Province	Dist.	Comm.	Total
	n=105	n=136	n=414	n=655
1. Primary decontamination	95.2	97.8	79.0	85.5
2. Cleaning	95.2	94.9	86.5	89.6
3. Hi-level decontamination	80.0	82.4	70.5	74.5
4. Sterilization	91.4	89.0	76.1	81.2
<i>Name in the correct order</i>	40.0	36.8	37.2	37.6
<i>Don't know</i>	2.9	1.5	7.2	5.3
<b>Attaining 100% NS</b>	73.3	75.7	52.4	60.6
<b>Attaining 76-99% NS</b>	0.0	0.0	0.0	0.0
<b>Attaining 51-75% NS</b>	21.0	17.6	24.2	22.3
<b>Attaining ≤ 50% NS</b>	5.7	6.6	23.4	17.1

**Table 84. Ability of SPs on reporting the partographs**

Choice	Province (n=105)	District (n=236)	Com. (n=414)	Total (n=655)
Normal	12.4	14.0	10.1	11.3
Alert	60.0	66.2	42.5	50.2
Need the action	11.4	13.2	16.7	15.1
Don't know	16.2	6.6	29.7	22.7

**Table 85. The proportion of SPs correctly reporting the partograph**

Provinces	Province	District	Commune	Total
Phu Tho	53.3	55.0	41.7	46.3
Ha Giang	86.7	80.0	36.7	53.7
Hoa Binh	86.7	70.0	36.7	51.6
Tien Giang	100.0	100.0	84.7	90.4
Four provinces	81.7	76.3	49.8	60.4
Ben Tre	66.7	85.0	49.2	59.6
Ninh Thuan	26.7	56.3	37.9	39.3
Kon Tum	0.0	15.0	10.3	9.7
Three provinces	31.1	51.8	32.6	36.2

**Table 86. Mean score of SPs on practicing the steps of pregnancy check-ups at the provincial level**

Provinces	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
Phu Tho	35.9	76.8	92.7	41.8	88.2	84.7	82.8	62.4	57.3
Ha Giang	9.5	67.4	92.9	45.2	71.4	85.7	73.0	39.3	48.8
Hoa Binh	54.9	83.1	93.0	31.7	66.2	71.8	85.5	56.7	58.7
Tien Giang	63.5	91.5	97.0	56.1	89.2	91.9	87.4	73.7	68.6
Four provinces	47.2	82.1	94.0	43.4	80.9	83.3	84.1	62.2	60.3
Ben Tre	16.5	43.5	69.4	20.6	42.4	29.4	29.0	34.1	39.9
Ninh Thuan	13.6	57.1	82.2	12.7	69.5	67.8	65.0	69.1	46.3
Kon Tum	36.6	61.8	77.8	6.3	49.3	31.0	54.5	23.6	40.4
Three provinces	22.3	53.3	75.7	13.7	52.1	40.5	47.3	40.2	41.8
Total	35.7	68.8	85.6	29.7	67.6	63.5	67.1	52	51.8

**Table 87. Proportion of normal delivery records recorded with signs/symptoms as required**

Signs/symptom	Province n=7	District n=28	Comm. n=97	Total n=132
1. Pulse	95.2	100.0	99.0	99.0
2. Blood pressure	100.0	100.0	99.0	99.2
3. Uterine contractions	100.0	96.4	90.4	92.2
4. Fetal heart	100.0	98.8	99.0	99.0
5. Amniotic fluid	100.0	95.2	86.6	89.1
6. Cervix dilatation and effacement	100.0	100.0	97.6	98.2
7. Fetus-position development	85.7	90.5	92.4	91.7
<i>Average attaining the NS</i>	97.3	97.3	94.9	95.5

**Table 88. Percentage of partographs recorded with signs/symptoms as required**

Contents	Pro. n=6	Dist. n=25	Com. n=97	Total
<b>Start noting when the labour really starts</b>	77.8	81.3	92.1	89.3
Attaining 100% NS	77.8	81.3	92.1	89.3
<b>The progress of labour</b>				
1. Cervical dilatation	100.0	92.0	95.2	94.8
2. Move to the alert area when the cervix dilates more than 3cm	100.0	85.3	88.0	88.0
3. Descent of the presenting part	100.0	89.3	91.1	91.1
4. Uterine contractions	100.0	92.0	88.7	89.8
Attaining 100% NS	100.0	74.7	79.4	79.4
<b>Foetal status</b>				
1. Foetal heart rate (counted for 1 minute)	100.0	92.0	92.1	92.4
2. Amniotic fluid: colour, amount	77.8	76.0	78.7	78.1
3. The moulding of the foetal head	66.7	53.3	68.7	65.6
Attaining 100% NS	61.1	46.7	57.4	55.5
<b>Mother status</b>				
1. Pulse, blood pressure	100.0	97.3	96.9	97.1
2. Temperature	88.9	80.0	93.5	90.6
3. Urine tests: protein, amount in ml	61.1	45.3	53.3	52.1
4. Any drugs used	38.9	36.0	52.6	48.7
5. The amount of any intravenous fluid supplied	38.9	18.7	25.8	25.0
Attaining 100% NS	38.9	17.3	22.0	21.9
<b>React upon result presented on partograph</b>	55.6	16.0	30.9	29.2
Attaining 100% NS	55.6	16.0	30.9	29.2

**Table 89. Partograph use in obstetric recording attaining 100% NS by province**

Provinces	Begin recording in the partograph	Process of labour	Status of pregnancy	Status of mother	React upon result presented on partograph
Phu Tho	71.1	77.8	58.9	24.4	12.2
Ha Giang	75.0	87.5	41.7	25.0	37.5
Hoa Binh	100.0	100.0	69.0	32.2	57.5
Tien Giang	95.2	85.7	69.8	23.8	28.6
Four provinces	86.7	87.9	63.3	26.9	33.3
Ben Tre	93.6	53.8	26.9	11.5	3.8
Ninh Thuan	97.0	66.7	48.5	12.1	63.6
Kon Tum	95.0	60.8	38.3	10.8	20.0
Three provinces	100.0	100.0	100.0	0.0	0.0

**Table 90. Percentage of SPs practicing steps of newborn care after delivery**

Contents	Pro. (n=56)	Dist. (n=63)	Total (n=119)
Clear the baby's airway.	100.0	100.0	100.0
Dry the baby's body and keep warm	94.6	98.4	96.6
Cord care	100.0	98.4	99.2
Assess the baby's condition, sex; check for any deformity; weigh and measure the baby's length.	87.5	93.7	90.8
Clean eyes with sterile water or saline and put Argylrol drops (silver nitrate) in eyes	57.1	39.7	47.9
Inject vitamin K1. 1mg unique dose	75.0	46.0	59.7
Return baby to mother within 30 minutes for initiation of breast-feeding.	92.9	88.9	90.8
<i>Attaining 100% NS</i>	53.6	36.5	44.5
<i>Attaining 76-99% NS</i>	16.1	11.1	13.4
<i>Attaining 51-75% NS</i>	25.0	49.2	37.8
<i>Attaining ≤ 50% NS</i>	5.4	3.2	4.2
<i>Average</i>	86.7	80.7	83.6

**Table 91. Percentage of SPs practicing proper steps for counselling mothers right after delivery**

Contents	Pro. (n=60)	Dist. (n=78)	Total (n=138)
1. Self monitoring of bleeding and uterine shrinkage	98.3	98.7	98.6
2. Monitoring and care of newborn	68.3	56.4	61.6
3. Breastfeeding 30 minutes after delivery, breastfeed the baby exclusively	100.0	94.9	97.1
4. Inform family members on the monitoring and care of mother and newborn	50.0	46.2	47.8
<i>Attaining 100% NS</i>	48.3	37.2	42.0
<i>Attaining 76-99% NS</i>	0.0	0.0	0.0
<i>Attaining 51-75% NS</i>	21.7	26.9	24.6
<i>Attaining ≤ 50% NS</i>	30.0	35.9	33.3
<i>Average</i>	79.2	74.0	76.3

**Table 92. Mean score per 100 points on counselling the mother after delivery**

Provinces	Province	District	Total
Phu Tho	64.3	62.5	63.2
Ha Giang	100.0	67.5	79.7
Hoa Binh	87.5	89.3	88.6
Tien Giang	100.0	92.5	95.7
Four provinces	90.6	80.3	84.5
Ben Tre	70.0	52.9	60.9
Ninh Thuan	62.5	80.6	72.1
Kon Tum	60.0	75.0	67.5
Three provinces	66.1	64.5	65.3
Total	79.2	74.0	76.3

**Table 93. Observed result on SPs' practice at the provincial and district levels for IUD insertion**

Contents	Pro. (n=45)	Dist. (n=65)	Total (n=110)
Provide counselling on IUD's effects, side effects, monitoring signs, etc.	82.2	84.6	83.6
Ask client to empty her bladder	35.6	38.5	37.3
Cover the table with a clean sheet	75.6	55.4	63.6
Check instruments and IUD packet	62.2	53.8	57.3
Explain the steps of insertion for client	48.9	32.3	39.1
Wash hands	97.8	96.9	97.3
Wear clean gloves	97.8	95.4	96.4
Perform a bimanual exam to determine position, uterine volume, and appendage	93.3	86.2	89.1
Sterilise genitals	100.0	100.0	100.0
Cover the table with sterile sheet	77.8	70.8	73.6
Load the IUD into insertion tube	100.0	100.0	100.0
Wear sterile gloves	88.9	75.4	80.9
Open the vagina with a valve	100.0	98.5	99.1
Swab the vagina. Cervix	100.0	98.5	99.1
Grasp the cervix	100.0	100.0	100.0
Sounding the uterus	100.0	100.0	100.0
Estimate the uterine height	95.6	84.6	89.1
Insert the IUD into the uterus	100.0	100.0	100.0
Use "no touch" technique	82.2	70.8	75.5
Cut the string for about 2-3 cm, fold the end into a opistho-fornix (backed pouch)	100.0	96.9	98.2
Discharge the cervix	100.0	98.5	99.1
Re-swab	100.0	96.9	98.2
Unleash the valve	100.0	98.5	99.1
Tell client that procedure has ended	62.2	60.0	60.9
Wash hands	64.4	58.5	60.9
Have client rest for at least 30 minutes	75.6	70.8	72.7
Provide drugs with usage instructions	93.3	95.4	94.5
Make appointment for follow-up visit	95.6	87.7	90.9
<b>Attaining 100% NS</b>	22.2	13.8	17.3
<b>Attaining 76-99% NS</b>	55.6	52.3	53.6
<b>Attaining 51-75% NS</b>	22.2	32.3	28.2
<b>Attaining ≤ 50% NS</b>	0.0	1.5	0.9
<b>Mean score</b>	86.7	82.3	84.1

**Table 94. Mean score on observing SPs' practices in IUD insertion at the provincial and district levels**

Provinces	Province	District	Total
Phu Tho	-	50.0	50.0
Ha Giang	87.1	69.8	76.0
Hoa Binh	94.7	92.9	93.6
Tien Giang	98.3	96.8	97.5
Four provinces	95.5	87.7	90.8
Ben Tre	81.9	78.4	80.0
Ninh Thuan	85.7	85.1	85.2
Kon Tum	69.9	67.0	68.3
Three provinces	78.4	76.8	77.5
Total	86.7	82.3	84.1

**Table 95. Percentage of SPs practicing steps of hand washing in infection control**

Steps	Pro. (n=98)	Dist. (n=118)	Com. (n=346)	Total (n=562)
Remove watch, jewellery from the hands; wet the hands with soap solution	100.0	99.2	92.5	95.2
Scrub the palms of each hand with each other, 10 times	90.8	97.5	80.9	86.1
Use the palm of one hand to scrub the back of the other hand, 10 times	85.7	91.5	65.0	74.2
Use the fingers of one hand to scrub the entire surface of each finger of the other hand, 10 times	71.4	79.7	51.2	60.7
Use finger tips of one hand to scrub the palm of the other hand, 10 times	81.6	70.3	50.0	59.8
Clean all parts of the hands under the water	100.0	100.0	96.5	97.9
Use a dry and clean towel to dry the hands	96.9	94.9	75.4	83.3
Name in correct order	50.0	48.3	24.6	34.0
<i>Attaining 100% NS</i>	62.2	60.2	31.8	43.1
<i>Attaining 76-99% NS</i>	18.4	20.3	15.3	16.9
<i>Attaining 51-75% NS</i>	14.3	17.8	31.2	25.4
<i>Attaining ≤ 50% NS</i>	5.1	1.7	21.4	14.4
<i>Average</i>	89.5	90.4	73.3	79.7

**Table 96. General information on RH programme staff**

Information	Province	District	Commune	Total
	n=60	n=163	n=412	n=635
<i>Managers</i>	9.4	25.7	64.9	100.0
<i>Technical qualification</i>				
Medical university, college	88.3	52.1	17.5	33.1
Medical primary, secondary school	10.0	42.9	71.4	58.3
Other university, college	1.7	0.6	0.5	0.6
Other primary, secondary school	0.0	4.3	10.7	8.0
<i>Gender</i>				
Male	55.0	39.9	34.2	37.6
Female	45.0	60.1	65.8	62.4
<i>Ethnic</i>				
Kinh	91.7	76.7	68.0	72.4
Others	8.3	23.3	32.0	27.6

**Table 97. Training and retraining of RH programme staff on professional issues**

Contents	L1	L2	L3
The 2001–2010 strategy of population	59.7	34.0	6.3
The 2001–2010 strategy of RH	47.2	45.7	7.1
Gender and gender equity	58.3	38.6	3.2
Violence and violence prevention against women	55.3	41.4	3.3
RH care services management	45.2	49.4	5.4
Behaviour change communication in RH care services	38.6	57.0	4.4
Without any training	27.1		
Trained on all 6 contents	26.3		

Note: L1: without training; L2: trained 1-3 years ago; L3: trained more 3 years ago

**Table 98. Percentage of RH programme staff with knowledge on key contents of the 2001-2010 RH National Strategy**

Contents	Province	Dist.	Comm.	Total
	n=60	n=163	n=412	n=635
1.Improve the current RH care services quality	45.0	39.3	44.7	43.3
2.Reduce the difference between regions	3.3	9.2	3.4	4.9
Both above	40.0	8.0	13.1	14.3
Other	6.7	2.5	5.6	4.9
Don't know	5.0	41.7	35.0	33.9

**Table 99. Correct knowledge on 2 objectives in main aspects of National Strategy on RH. 2001-2010 period**

Provinces	Province	District	Commune	Total
Phu Tho	77.8	26.1	30.0	33.7
Ha Giang	33.3	12.5	22.0	20.7
Hoa Binh	22.2	4.2	1.7	4.3
Tien Giang	44.4	4.2	23.3	20.4
Four provinces	44.4	11.6	19.2	19.7
Ben Tre	44.4	8.3	0.0	6.5
Ninh Thuan	0.0	0.0	3.5	2.4
Kon Tum	44.4	0.0	10.5	11.1
Three provinces	33.3	2.9	4.6	6.8
Total	40.0	8.0	13.1	14.3
Don't know	0.0	0.0	21.7	14.0

**Table 100. Percentage of RH programme staff with knowledge on key solutions of the RH National Strategy**

Contents	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Strengthen IEC activities	70.0	52.1	60.2	59.1
2. Complete and develop personnel system	55.0	25.8	22.8	26.6
3. Complete policies and legal documents supporting the strategy	18.3	9.8	10.7	11.2
4. Socialise the cooperation with organisations in and outside of Vietnam	30.0	9.2	8.5	10.7
5. Train and do scientific studies	38.3	13.5	8.5	12.6
6. Support budget for RH care services	41.7	19.6	17.2	20.2
7. Strengthen management of RH care services	38.3	11.0	13.8	15.4
Other	1.7	2.5	5.1	4.1
Don't know 7 solutions	6.7	39.9	32.0	31.7
Know 1 solution	15.0	17.2	30.1	25.4
Know 2 solutions	25.0	21.5	18.7	20.0
Know 3 solutions	21.7	14.1	9.5	11.8
Know 4 solutions	13.3	3.1	5.1	5.4
Know 5 solutions	6.7	1.2	2.4	2.5
Know 6 solutions	6.7	1.2	1.9	2.2
Know 7 solutions	5.0	1.8	0.2	1.1

**Table 101. Mean score on knowledge on key solutions of RH National Strategy. by province**

Provinces	Province	District	Commune	Total
Phu Tho	57.1	24.8	33.8	33.9
Ha Giang	46.0	41.7	35.8	38.4
Hoa Binh	27.0	16.1	6.2	10.8
Tien Giang	46.0	28.0	25.0	27.8
Four provinces	44.1	27.7	25.2	27.7
Ben Tre	30.2	7.7	16.5	15.5
Ninh Thuan	23.8	15.0	13.3	14.5
Kon Tum	55.6	7.1	10.5	14.1
Three provinces	38.1	9.7	13.5	14.7
Total	41.7	20.2	20.3	22.3

**Table 102. Percentage of RH programme staff with knowledge on key contents of a good plan**

Contents	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Specific objectives	83.3	66.3	69.7	70.1
2. Indicators for evaluation	76.7	60.7	51.7	56.4
3. Personnel distribution	61.7	48.5	34.5	40.6
4. Time distribution	45.0	42.3	48.8	46.8
5. Persons responsible	66.7	47.9	44.7	47.6
Other	11.7	4.9	9.0	8.2
No 5 contents	5.0	8.6	14.8	12.3
Know 1 content	3.3	18.4	17.2	16.2
Know 2 contents	16.7	20.9	18.0	18.6
Know 3 contents	31.7	21.5	21.1	22.2
Know 4 contents	15.0	12.3	11.7	12.1
Know 5 contents	28.3	18.4	17.2	18.6

Table 103. Mean score on contents of a good annual plan

Provinces	Province	District	Commune	Total
Phu Tho	84.4	51.3	46.3	51.3
Ha Giang	68.9	55.8	60.7	60.2
Hoa Binh	44.4	25.0	40.0	36.6
Tien Giang	71.1	89.2	58.7	67.7
Four provinces	67.2	55.4	51.4	54.0
Ben Tre	84.4	70.8	82.4	79.6
Ninh Thuan	30.0	40.0	37.9	37.8
Kon Tum	71.1	37.5	21.8	30.9
Three provinces	65.8	50.0	47.8	50.0
Total	66.7	53.1	49.9	52.3

Table 104. Percentage of organisations having the 2004 annual plan on RH/FP

Contents	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
Available and observed at the time of survey	86.7	65.6	56.3	61.6
Available but not observed at the time of survey	11.7	26.4	29.6	27.1
None	1.7	8.0	14.1	11.3

Table 105. Key contents in the 2004 RH plan

Contents	Prov.	District	Comm.	Total
	n=52	n=107	n=232	n=391
1. Specific objectives	82.7	77.6	89.2	85.2
2. Indicators for evaluation	88.5	87.9	75.0	80.3
3. Personnel distribution	73.1	72.0	64.2	67.5
4. Time distribution	71.2	59.8	78.9	72.6
5. Persons responsible	67.3	67.3	76.7	72.9
No 5 contents	0.0	3.7	0.4	1.3
Know 1 content	5.8	7.5	6.9	6.9
Know 2 contents	19.2	10.3	11.2	12.0
Know 3 contents	15.4	16.8	11.6	13.6
Know 4 contents	5.8	22.4	29.3	24.3
Know 5 contents	53.8	39.3	40.5	41.9

**Table 106. The proportion of 2004 RH/FP annual plans having 5 contents**

Provinces	Province	District	Commune	Total
Phu Tho	66.7	50.0	25.0	42.9
Ha Giang	50.0	0.0	73.9	43.8
Hoa Binh	0.0	0.0	14.8	9.3
Tien Giang	100.0	100.0	44.8	64.8
Four provinces	33.3	65.4	41.3	48.5
Ben Tre	77.8	54.2	70.6	66.7
Ninh Thuan	0.0	0.0	16.7	11.3
Kon Tum	33.3	0.0	0.0	7.1
Three provinces	52.9	45.7	26.2	38.3
Total	53.8	39.3	40.5	41.9

**Table 107. Comments on budget allocation in the 2004 RH plans**

Contents	Prov.	District	Comm.	Total
	n=52	n=107	n=232	n=391
1. With allocation of local budget	61.5	60.7	40.9	49.1
2. With allocation of central budget	38.5	16.8	9.1	15.1
3. With allocation of budget of project, others	57.7	32.7	5.2	19.7
No clear budget allocation	15.4	23.4	53.0	39.9

**Table 108. Prioritisation in the RH plans**

Contents	Prov.	District	Comm.	Total
	n=52	n=107	n=232	n=391
Priority to areas of difficulties	63.5	69.2	15.9	36.8
Priority to areas with ethnic minority/unprivileged people	34.6	13.1	7.8	12.8
Priority to areas without supporting projects	30.8	19.6	3.4	11.5
Priority to HFs with FP client availability	32.7	9.3	4.3	9.5
No clear priorities	28.8	27.1	79.3	58.3

**Table 109. Itineraries of the RH plans**

Contents	Prov.	District	Comm.	Total
	n=52	n=107	n=232	n=391
1.Higher level (to report)	100.0	100.0	89.7	93.9
2.Lower level (to implement)	86.5	86.0	72.8	78.3
3.Within units	82.7	80.4	89.2	85.9
Not delivered	0.0	0.0	0.4	0.3

Table 110. Supervision of the implementation of RH/FP plans

Contents	Prov.	District	Comm.	Total
	n=60	n=154	n=389	n=603
1. Checking paper, records, books	78.3	70.1	69.4	70.5
2. Direct observations at site	91.7	91.6	86.9	88.6
3. Inviting agencies, independent supervising agencies	16.7	4.5	13.1	11.3
4. Integrating	56.7	55.2	53.5	54.2
Others	6.7	1.9	4.9	4.3
Don't remember/Don't know	0.0	0.6	1.5	1.2

Table 111. Supervision tools

Contents	Prov.	District	Comm.	Total
	n=60	n=154	n=389	n=603
1. Form/ checklist	75.0	69.5	16.7	36.0
2. Questionnaire	60.0	56.5	20.6	33.7
Other (personal books)	10.0	5.2	30.1	21.7
None	6.7	9.7	35.5	26.0
Don't know/remember	0.0	1.3	2.1	1.7

Table 112. Work following supervision by RH staff

Contents	Prov.	District	Comm.	Total
	n=60	n=154	n=389	n=603
1. Writing reports	75.0	39.6	56.6	54.1
2. Reporting to leaders	76.7	69.5	73.0	72.5
3. Feedbacks to supervised facilities	85.0	79.9	70.2	74.1
4. Sharing supervision results with stakeholders	43.3	27.9	45.2	40.6
Others	0.0	7.1	5.9	5.6
None	0.0	0.0	0.8	0.5
Don't remember	0.0	0.6	1.8	1.3

Table 113. Percentage of RH programme staff with training on supervision of RH and population in the previous 3 years

Information	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
Yes	73.3	55.2	43.0	49.0
No	26.7	42.9	52.4	47.6
Don't remember	0.0	1.8	4.6	3.5

**Table 114. Percentage of RH programme staff in agreement of the proposed statements on RH care**

<b>Information</b>	<b>Prov. n=60</b>	<b>District n=163</b>	<b>Comm. n=412</b>	<b>Total n=635</b>
Counselling is a must for health provider to provide to any client	100.0	99.4	96.8	97.8
Medical equipment in this facility has been effectively used to serve the clients	76.7	85.3	80.3	81.3
Health education materials are not enough to distribute to clients	78.3	80.4	69.2	72.9
Professional skills of providers in this facility meet people's needs for examination and treatment	68.3	31.9	60.9	54.2
Clients have the right to discuss with health workers about treatment method	91.7	90.8	88.4	89.3
Health workers are SPs and service users are clients	100.0	100.0	99.0	99.4
HIV test is a must when infection is suspected	15.0	16.0	52.4	39.5

**Table 115. Percentage of RH programme staff with knowledge on items of priorities for retraining for CHC heads**

<b>Items</b>	<b>Prov.</b>	<b>District</b>	<b>Comm.</b>	<b>Total</b>
	<b>n=60</b>	<b>n=163</b>	<b>n=412</b>	<b>n=635</b>
1. Counselling skills	3.3	9.8	13.1	11.3
2. Planning skills	68.3	53.4	19.7	32.9
3. Communication skills	8.3	4.9	6.8	6.5
4. Supervision skills	11.7	8.0	10.0	9.6
5. RH technical skills	8.3	23.9	46.1	36.9
Others	0.0	0.0	2.2	1.4
Don't know	0.0	0.0	2.2	1.4

**Table 116. Percentage of RH programme staff with knowledge on key topics in training for midwives**

Information	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Counselling skills	40.0	44.8	26.0	32.1
2. IUD insertion skills	1.7	2.5	9.2	6.8
3. Communication skills	6.7	7.4	13.8	11.5
4. Infection prevention	10.0	12.9	11.2	11.5
5. Safe abortion	1.7	1.2	9.7	6.8
6. Pregnancy examination	1.7	3.1	3.9	3.5
7. Normal delivery assistance	28.3	14.7	16.3	17.0
8. Newborn care	5.0	11.7	5.6	7.1
9. Postpartum care	5.0	1.2	1.2	1.6
Others	0.0	0.6	1.7	1.3
Don't know	0.0	0.0	1.5	0.9

**Table 117. Percentage of RH programme staff with knowledge on management issues in RH/FP programmes**

Contents	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Personnel	86.7	64.4	60.4	63.9
2. Infrastructure equipment	76.7	61.4	56.6	59.7
3. Budget	63.3	53.4	23.8	35.1
4. Types of services and medical programmes	66.7	57.1	42.0	48.2
5. Time	15.0	9.2	12.1	11.7
6. Information	18.3	9.2	11.4	11.5
Don't know 6 aspects	0.0	7.4	16.5	12.6
Know 1 aspect	10.0	17.8	24.3	21.3
Know 2 aspects	21.7	24.5	23.5	23.6
Know 3 aspects	16.7	25.2	17.5	19.4
Know 4 aspects	40.0	17.8	10.9	15.4
Know 5 aspects	6.7	3.1	4.9	4.6
Know 6 aspects	5.0	4.3	2.4	3.2

**Table 118. Percentage of RH programme staff with knowledge on BCC in RH/FP points needed for a good plan**

Contents	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Identify actual status	53.3	46.6	23.1	32.0
2. Identify priority problems to be resolved	55.0	32.5	36.7	37.3
3. Identify target indicators	45.0	41.7	34.0	37.0
4. Compose key messages to be used	33.3	9.8	21.4	19.5
5. Set up out put indicators	46.7	19.0	26.5	26.5
6. Chose suitable communication channels	31.7	16.6	17.0	18.3
Other	3.3	1.8	6.1	4.7
Don't know 6 contents	0.0	11.0	22.6	17.5
Know 1 content	20.0	41.7	29.9	32.0
Know 2 contents	35.0	25.8	25.0	26.1
Know 3 contents	23.3	15.3	14.1	15.3
Know 4 contents	10.0	4.3	6.6	6.3
Know 5 contents	5.0	1.2	1.5	1.7
Know 6 contents	6.7	0.6	0.5	1.1

**Table 119. Percentage of RH programme staff with knowledge on target groups for BCC in population and FP**

Information	Prov. n=60	District n=163	Comm. n=412	Total n=635
1. Couples	68.3	59.5	57.5	59.1
2. Men	41.7	38.0	50.0	46.1
3. Women f reproductive age	75.0	84.0	91.0	87.7
4. Unmarried people	10.0	9.8	13.1	12.0
5. Adolescents and youth	70.0	76.1	81.8	79.2
6. SPs	31.7	22.1	11.4	16.1
7. Community leaders	56.7	31.3	21.8	27.6
Other	6.7	3.7	8.7	7.2
Don't know 7 contents	0.0	0.0	1.2	0.8
Know 1 content	5.0	5.5	8.7	7.6
Know 2 contents	20.0	23.3	19.7	20.6
Know 3 contents	35.0	35.0	31.3	32.6
Know 4 contents	13.3	23.9	19.2	19.8
Know 5 contents	15.0	7.4	12.4	11.3
Know 6 contents	6.7	3.1	6.6	5.7
Know 7 contents	5.0	1.8	1.0	1.6

**Table 120. Percentage of RH programme staff with knowledge on the identification of priority issues in RH**

Information	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Commonality	60.0	49.1	36.7	42.0
2. Severity	40.0	20.2	22.1	23.3
3. Influencing community	51.7	25.2	33.3	32.9
4. Influencing small groups of individuals	8.3	1.8	4.1	3.9
5. Feasibility	66.7	53.4	22.8	34.8
Other	1.7	0.6	3.2	2.4
Don't know	8.3	15.3	34.7	27.2

**Table 121. Percentage of RH programme staff with knowledge of 3 issues of priority**

Issues	Prov. n=60	Distr. n=163	Comm. n=412	Total n=635
Promote clients' rights in the community and among SPs	18.3	20.2	16.7	17.8
Train SPs on counselling skills	70.0	78.5	36.9	50.7
Increase the use of condoms and contraceptives; decrease use of IUDs	10.0	11.7	35.0	26.6
Increase use of available health services at the grassroots level	48.3	32.5	21.8	27.1
Increase the proportion of the mother and newborn care after delivery	43.3	42.9	28.4	33.5
Decrease abortion and increase safe abortion	16.7	12.3	8.7	10.4
Increase examination and treatment of RTIs/STDs and for HIV/AIDS	36.7	41.1	16.7	24.9
Increase adolescent RH services	35.0	19.6	18.2	20.2
Counsel and respond to cases of violence at the health facilities	1.7	1.8	1.5	1.6
Know 1 issue	1.7	6.7	24.3	17.6
Know 2 issues	16.7	18.4	25.2	22.7
Know 3 issues	81.7	72.4	36.4	49.9
Don't know	0.0	2.5	14.1	9.8

**Table 122. Percentages for RH programme staff addressing issues of priority in BCC activities**

Issues	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Selection of contraceptives	78.3	70.6	63.1	66.5
2. Consequences of abortions	35.0	19.0	21.1	21.9
3. Recognising danger signs during pregnancy	48.3	31.3	17.7	24.1
4. No discrimination against HIV/AIDS patients	36.7	19.6	10.9	15.6
5. Full understanding about RH rights	36.7	24.5	23.8	25.2
6. Safe sex education. including adolescents	63.3	37.4	35.0	38.3
7. Realising and preventing family violence	15.0	3.1	5.8	6.0
Other	8.3	5.5	15.8	12.4
Don't know	0.0	1.2	9.5	6.5

**Table 123. Percentage of RH programme staff with knowledge on important elements in supervising communal level RH activities**

Information	Prov.	District	Comm.	Total
	n=60	n=163	n=412	n=635
1. Specific aims	66.7	37.4	46.6	46.1
2. Tools for supervision	78.3	63.8	27.2	41.4
3. Skills of supervision	63.3	52.1	24.0	35.0
4. Plans for supervision	75.0	58.3	47.8	53.1
5. Assisting lower levels	45.0	39.9	21.4	28.3
6. Feedback to the supervised	30.0	14.1	22.3	20.9
7. Budget responding	41.7	46.0	18.4	27.7
Others	0.0	0.6	3.2	2.2
Don't know 7 aspects	1.7	2.5	24.3	16.5
Knowing 1 aspects	10.0	14.7	20.1	17.8
Knowing 2 aspects	15.0	22.7	19.2	19.7
Knowing 3 aspects	11.7	27.6	13.1	16.7
Knowing 4 aspects	21.7	12.3	11.7	12.8
Knowing 5 aspects	11.7	9.2	7.5	8.3
Knowing 6 aspects	18.3	3.7	3.2	4.7
Knowing 7 aspects	10.0	7.4	1.0	3.5

**Table 124. Background information on population/population programme staff**

Information	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
<i>Manager</i>	7.1	19.5	73.5	100.0
<i>Technical qualification</i>				
Medical university, college	10.0	7.3	0.5	2.5
Medical primary, secondary school	5.0	9.7	5.0	5.9
Other sectoral university, college	73.3	44.2	1.4	14.9
Other sectoral primary secondary schools	11.7	35.2	28.3	28.4
Other	0.0	3.6	64.8	48.3
<i>Gender</i>				
Male	50.0	46.7	41.4	43.0
Female	50.0	53.3	58.6	57.0
<i>Ethnic</i>				
Kinh	78.3	73.9	59.4	63.6
Others	21.7	26.1	40.6	36.4

**Table 125. Training/retraining of population staff on technical issues**

Contents	L1	L2	L3
1. National Strategy for Population in Vietnam for 2001-2010 period	35.1	54.1	10.7
2. Strategy for Reproductive Health Care 2001-2010 period	33.1	58.7	8.1
3. Gender and gender equality in reproductive health care	32.0	60.1	7.9
4. Violence and prevention of violence against women	39.0	53.4	7.5
5. Behaviour Change Communication in provision of RH services	31.6	60.1	8.1
6. Management of quality of reproductive health care	37.6	53.3	9.1
Not retrained		19.5	
Trained 6 contents		44.6	

Note: L1 is no training; L2 is trained 1-3 years ago; L3 is trained >3 years ago

**Table 126. Knowledge among population staff about aspects of the National Strategy on Population for the 2001-2010 period**

Aspects	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
Reduction of birth to replacement level	16.7	24.2	46.5	40.1
Improvement of equality	18.3	9.1	9.3	9.9
Both above	58.3	48.5	17.0	26.1
Other	8.3	7.9	6.4	6.8
Don't know	5.0	12.7	23.4	20.0

**Table 127. Knowledge of population staff about two aspects of the National Strategy on Population for the 2001-2010 period, by province**

Provinces	Province	District	Commune	Total
Phu Tho	55.6	58.3	18.9	29.3
Ha Giang	66.7	37.5	16.9	24.6
Hoa Binh	33.3	29.2	5.6	12.3
Tien Giang	100.0	100.0	28.4	47.9
Four provinces	63.9	56.3	17.4	28.5
Ben Tre	100.0	95.8	23.6	43.4
Ninh Thuan	11.1	13.0	9.0	9.9
Kon Tum	33.3	0.0	16.9	14.5
Three provinces	50.0	37.7	16.5	22.8
Total	58.3	48.5	17.0	26.1

**Table 128. Knowledge among population programme staff about key solutions in the National Strategy on Population for the 2001-2010 period**

Solutions	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
1.Strengthen programme management	43.3	42.4	9.8	18.5
2.Strengthen BCC activities	60.0	57.6	48.8	51.3
3 Improve the quality of health care	66.7	43.0	26.5	32.5
4.Improve the quality of health information system	20.0	18.8	10.4	12.7
5. Improve people’s education, strengthen role of family and gender equality	38.3	37.0	12.5	19.1
6. Strengthen socialization of population activities	25.0	23.6	15.9	18.0
All 6 contents	6.7	4.8	0.2	1.5
Others	13.3	3.0	7.5	7.1
Don’t know 6 solutions	8.3	13.3	31.3	26.2
Know 1 solution	8.3	10.3	32.4	26.4
Know 2 solutions	20.0	27.3	21.8	22.8
Know 3 solutions	26.7	22.4	9.8	13.4
Know 4 solutions	25.0	18.8	4.0	8.4
Know 5 solutions	5.0	3.0	0.5	1.3
Know 6 solutions	6.7	4.8	0.2	1.5

Table 129. Knowledge among population programme staff about key contents of a good plan

Contents	Prov.	District	Comm.	Total
1. Specific objectives	73.3	84.8	49.3	57.9
2. Indicators for evaluation	70.0	55.2	30.5	38.1
3. Personnel distribution	63.3	53.3	19.7	29.4
4. Time distribution	50.0	40.6	27.6	31.7
5. Persons responsible	61.7	53.3	28.9	36.0
Other	15.0	6.1	12.7	11.6
Don't know 5 contents	1.7	3.6	33.7	25.6
Know 1 content	15.0	9.1	23.1	19.8
Know 2 contents	16.7	27.9	16.7	18.9
Know 3 contents	16.7	24.8	12.0	14.9
Know 4 contents	30.0	24.8	8.8	13.4
Know 5 contents	20.0	9.7	5.6	7.4

Table 130. Percentage of organisations having the 2004 annual plan on Pop/FP

Plan	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
Available and observed at the survey time	88.3	52.7	14.1	26.9
Available but not observed at the survey time	10.0	34.5	49.8	44.0
None	1.7	12.7	36.1	29.1

Table 131. Main contents included in the 2004 annual plan on Pop/FP

Contents	Prov.	District	Comm.	Total
	n=53	n=87	n=88	n=228
1. Specific objectives	75.5	90.8	94.3	88.6
2. Indicators for evaluation	90.6	87.4	69.3	81.1
3. Personnel distribution	88.7	73.6	51.1	68.4
4. Time distribution	60.4	79.3	73.9	72.8
5. Persons responsible	79.2	81.6	78.4	79.8
No contents	1.9	4.6	1.1	2.6
Know 1 content	1.9	1.1	5.7	3.1
Know 2 contents	3.8	3.4	15.9	8.3
Know 3 contents	24.5	16.1	13.6	17.1
Know 4 contents	28.3	17.2	29.5	24.6
Know 5 contents	39.6	57.5	34.1	44.3

**Table 132. The proportion of 2004 annual plans on Pop/FP that include the 5 contents, by province**

Provinces	Province	District	Commune	Total
Phu Tho	0.0	23.1	25.0	15.4
Ha Giang	66.7	71.4	80.0	71.4
Hoa Binh	0.0	25.0	12.5	12.0
Tien Giang	66.7	100.0	44.8	69.4
Four provinces	33.3	65.4	41.3	48.5
Ben Tre	100.0	80.0	38.9	68.1
Ninh Thuan	0.0	0.0	16.7	9.1
Kon Tum	0.0	0.0	0.0	0.0
Three provinces	52.9	45.7	26.2	38.3
Total	39.6	57.5	34.1	44.3

**Table 133. Comments on budget allocation in the 2004 population plans**

Contents	Prov.	District	Comm.	Total
	n=53	n=87	n=88	N=228
1. With allocation of local budget	56.6	59.8	38.6	50.9
2. With allocation of central budget	45.3	28.7	10.2	25.4
3. With allocation of budget of project. others	60.4	37.9	6.8	31.1
With no clear budget allocation	0.0	23.0	56.8	30.7

**Table 134. Prioritization in the population plans**

Contents	Prov.	District	Comm.	Total
	n=53	n=87	n=88	N=228
Priority to areas of difficulties	86.8	73.6	30.7	60.1
Priority to areas of ethnic minority/unprivileged people	49.1	66.7	12.5	41.7
Priority to areas without supporting projects	45.3	52.9	8.0	33.8
Priority to HFs with FP client availability	45.3	43.7	12.5	32.0
No clear priorities	0.0	6.9	0.0	2.6

**Table 135. Itineraries of the population plans**

Contents	Prov.	District	Comm.	Total
	n=53	n=87	n=88	n=228
1.Higher level (to report)	98.1	98.9	95.5	97.4
2.Lower level (to implement)	100.0	96.6	87.5	93.9
3.Within units (to know and implement)	84.9	86.2	90.9	87.7

**Table 136. Supervision of the implementation of population plans**

Contents	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
Yes	96.7	92.7	92.1	92.6
No	3.3	7.3	7.9	7.4

**Table 137. Supervision of the implementation of population plans****Table 138. Supervision tools****Table 139. Following up on supervision**

**Table 140. Training on supervision of RH/FP supervision in the previous 3 years**

Contents	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
Yes	71.7	60.0	28.4	37.6
No	26.7	38.8	63.7	56.3
Don't remember	1.7	1.2	7.9	6.1

**Table 141. Percentage of population programme staff that agrees about proposed statements on RH care**

Statements	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
Counselling is a must for health provider to provide to any client	100.0	97.0	95.2	95.9
Medical equipment in this facility has been effectively used to serve the clients	88.3	87.3	91.0	90.1
Health education materials are not enough to distribute to clients	48.3	53.3	70.1	65.3
Professional skills of providers in this facility meet people's needs for examination and treatment	65.0	46.1	44.1	46.0
Clients have the right to discuss with health workers about treatment method	93.3	93.9	93.4	93.5
Health workers are SPs and service users are clients	100.0	97.0	99.4	98.9

**Table 142. Items of priority for retraining of population staff**

Information	Prov.	Dist.	Comm.	Total
	n=60	n=165	n=623	n=848
1. Counselling skills	30.0	33.9	21.7	24.6
2. Planning skills	26.7	18.2	7.2	10.7
3. Communication skills	16.7	25.5	20.7	21.3
4. Supervision skills	3.3	2.4	4.3	3.9
5. RH technical skills	20.0	17.0	39.2	33.5
Others	3.3	0.0	3.4	2.7
Don't know	0.0	3.0	3.5	3.2

Table 143. Knowledge on management issues in Pop/FP programmes

Contents	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
1. Personnel	76.7	68.5	56.0	59.9
2. Infrastructure. equipment	55.0	46.7	31.9	36.4
3. Budget	75.0	60.0	15.4	28.3
4. Types of services and medical programmes	40.0	33.9	25.2	27.9
5. Time	18.3	13.3	6.9	9.0
6. Information	20.0	20.6	9.1	12.1
Don't know 6 aspects	1.7	9.7	26.5	21.5
Know 1 aspect	10.0	11.5	34.5	28.3
Know 2 aspects	30.0	34.5	19.3	23.0
Know 3 aspects	25.0	21.2	11.9	14.6
Know 4 aspects	26.7	18.2	4.7	8.8
Know 5 aspects	6.7	3.0	1.9	2.5
Know 6 aspects	0.0	1.8	1.3	1.3

Table 144. Knowledge of population programme staff about BCC in Pop/FP activities needed for a good plan

Contents	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
1. Identify actual status of BCC activities	61.7	54.5	16.1	26.8
2. Identify priority problems to be resolved	56.7	43.6	25.0	30.9
3. Identify target indicators	41.7	45.5	19.6	26.2
4. Compose key messages to be used	20.0	22.4	14.8	16.6
5. Set up output indicators	48.3	26.7	17.3	21.3
6. Chose suitable communication channels	36.7	35.2	10.8	17.3
Other	6.7	4.2	9.3	8.1
Don't know 6 contents	6.7	11.5	40.9	32.8
Know 1 content	13.3	14.5	30.5	26.2
Know 2 contents	20.0	32.7	16.1	19.6
Know 3 contents	38.3	25.5	9.6	14.7
Know 4 contents	11.7	9.1	2.4	4.4
Know 5 contents	10.0	4.8	0.5	2.0
Know 6 contents	0.0	1.8	0.0	0.4

**Table 145. Knowledge of population programme staff about target groups for BCC in population activities**

Information	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
1. Couples	86.7	66.1	45.9	52.7
2. Men	66.7	57.0	44.0	48.1
3. Women of reproductive age	78.3	75.8	79.8	78.9
4. Unmarried people	6.7	10.3	8.7	8.8
5. Adolescents and youth	70.0	72.7	66.9	68.3
6. SPs	20.0	7.9	5.9	7.3
7. Community leaders	31.7	37.0	19.3	23.6
Others	13.3	6.1	10.8	10.0
Don't know all 7 aspects	0.0	1.8	3.9	3.2
Knowing 1 aspect	5.0	6.7	13.6	11.7
Knowing 2 aspects	16.7	16.4	28.4	25.2
Knowing 3 aspects	20.0	32.7	29.1	29.1
Knowing 4 aspects	31.7	27.3	16.2	19.5
Knowing 5 aspects	25.0	12.1	5.9	8.5
Knowing 6 aspects	1.7	1.8	1.9	1.9
Knowing 7 aspects	0.0	1.2	1.0	0.9

**Table 146. Knowledge on the identification of priority issues in RH/FP**

Information	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
1. Commonality	51.7	44.8	21.7	28.3
2. Severity	43.3	38.8	8.7	17.0
3. Influencing community	70.0	59.4	26.3	35.8
4. Influencing small groups of individuals	23.3	17.6	3.1	7.3
5. Feasibility	51.7	39.4	9.1	18.0
Other	3.3	0.6	3.5	2.9
Don't know	8.3	12.7	54.4	43.0

Table 147. Percentage of knowledge on 3 issues of priority in RH/FP

Information	Province n=60	District n=165	Commune n=623	Total n=848
Promote clients' rights in the community and among SPs	33.3	35.8	15.9	21.0
Train SPs on counselling skills	58.3	44.2	22.0	28.9
Increase the use of condoms, contraceptives; and decrease to use IUD	13.3	20.0	30.2	27.0
Increase the use of available health services at the grassroots health level	35.0	26.7	13.0	17.2
Increase the proportion of the mother and newborn care after delivery	43.3	51.5	19.4	27.4
Decrease abortion and increase safe abortion	18.3	22.4	9.1	12.4
Increase the quality of examination and treatment of RTIs/STDs and HIV/AIDS	25.0	29.1	11.9	16.2
Increase adolescent RH services	35.0	32.7	15.6	20.3
Counsel and respond to cases of violence at the health facilities	3.3	2.4	1.1	1.5
Know 1 issue	10.0	4.2	29.4	23.1
Know 2 issues	15.0	15.8	25.5	22.9
Know 3 issues	75.0	76.4	19.3	34.3
Don't know	0.0	3.6	25.8	19.7

Table 148. Percentage of population programme staff able to identify issues of priority in BCC

Contents	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
1. Selection of contraceptives	68.3	71.5	53.9	58.4
2. Consequences of abortions	36.7	37.6	17.8	23.0
3. Realizing danger signs during pregnancy	21.7	41.2	9.6	16.6
4. No discrimination against HIV/AIDS patients	28.3	23.0	8.2	12.5
5. Full understanding about RH rights	41.7	29.1	23.6	25.9
6. Safe sex education, including adolescents	51.7	56.4	19.6	29.0
7. Realizing and preventing family violence	23.3	17.6	6.6	9.9
Other	16.7	6.1	15.4	13.7
Don't know	1.7	6.1	16.5	13.4

**Table 149. Percentage of population programme staff with knowledge on important elements in supervising population activities in communes**

Information	Prov.	District	Comm.	Total
	n=60	n=165	n=623	n=848
1. Specific aims	71.7	57.6	29.9	38.2
2. Tools for supervision	78.3	52.1	10.1	23.1
3. Skills of supervision	35.0	37.6	13.8	19.9
4. Plans for supervision	76.7	61.2	33.2	41.7
5. Assisting lower levels	25.0	27.3	14.1	17.5
6. Feedbacks to the supervised	20.0	20.6	13.0	15.0
7. Budget responding	58.3	47.9	13.0	23.0
Other	5.0	1.2	4.7	4.0
Don't know all 7 contents	3.3	9.1	39.8	31.3
Knowing 1 content	6.7	10.3	27.0	22.3
Knowing 2 contents	13.3	12.7	15.1	14.5
Knowing 3 contents	26.7	30.3	7.9	13.6
Knowing 4 contents	13.3	19.4	5.9	9.1
Knowing 5 contents	26.7	12.1	3.5	6.8
Knowing 6 contents	5.0	3.0	0.6	1.4
Knowing 7 contents	5.0	3.0	0.2	1.1

Table 150. Background information on educators

Information	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
<i>Education</i>				
Primary	0.0	0.6	17.8	14.1
Secondary	1.6	3.0	52.1	41.6
Higher school	3.2	6.6	21.7	18.3
Primary, secondary technical school	21.0	56.0	7.0	15.5
College, University	72.6	31.9	1.1	10.0
Others	1.6	1.8	0.2	0.6
<i>Gender</i>				
Male	32.3	33.7	32.9	33.0
Female	67.7	66.3	67.1	67.0
<i>Ethnic</i>				
Kinh	93.5	72.3	58.6	62.8
Others	6.5	27.7	41.4	37.2
<i>Work position</i>				
Population officer	33.9	31.9	2.6	9.0
Women's union staff	32.3	32.5	27.1	28.2
Farmers' union staff	33.9	34.3	24.3	26.5
Population collaborator	0.0	1.2	40.8	32.3
Village health worker	0.0	0.0	2.9	2.3
Others	0.0	0.0	2.3	1.8

Table 151. Training/retraining of population programme staff on technical issues

Contents	L1	L2	L3
1. National Strategy for Population in Vietnam for 2001-2010 period	51.2	43.6	4.7
2. Strategy for Reproductive Health Care, 2001-2010 period	44.5	52.2	2.8
3. Gender and gender equality in reproductive health care	44.7	51.4	3.7
4. Violence and prevention of violence to women	49.4	47.0	3.4
5. Quality of RH care services	48.7	47.4	3.8
6. Population and RH care communication	34.8	57.8	6.5
Not retrained	24.6		
Trained 6 contents	31.2		

Note: L1 is no training; L2 is trained 1-3 years ago; L3 is trained >3 years ago

**Table 152. Knowledge of population programme staff about content of the National Strategy on Population for 2001-2010**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
Reduction of birth to replacement level	4.8	19.3	25.5	23.4
Improvement equality	14.5	8.4	12.4	11.9
Both above	67.7	44.6	27.3	32.4
Other	3.2	3.6	2.1	2.4
Don't know	11.3	24.1	34.1	31.2

**Table 153. Percentage of educators that can identify priorities in BCC**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Selection of contraceptives	69.4	57.8	51.4	53.5
2. Consequences of abortions	53.2	31.9	29.5	31.2
3. Realizing danger signs during pregnancy	32.3	31.9	16.3	19.7
4. No discrimination against HIV/AIDS patients	35.5	20.5	13.6	15.9
5. Full understanding about RH rights	35.5	24.7	25.7	26.1
6. Safe sex education. including adolescents	61.3	39.2	17.5	23.5
7. Realizing and preventing family violence	22.6	8.4	10.5	10.9
Other	8.1	4.2	4.5	4.7
Don't know all 7 aspects	8.1	26.5	30.2	28.3
Knowing 1 aspect	9.7	10.2	25.5	22.2
Knowing 2 aspects	21.0	13.9	20.8	19.7
Knowing 3 aspects	12.9	29.5	10.6	13.7
Knowing 4 aspects	29.0	12.7	5.3	7.8
Knowing 5 aspects	14.5	6.6	3.6	4.7
Knowing 6 aspects	3.2	0.0	1.7	1.5
Knowing 7 aspects	1.6	0.6	2.4	2.1

**Table 154. Percentage of educators with knowledge on definition of communication**

Answers	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
Correct	75.8	71.1	71.7	71.9
Incorrect	24.2	24.1	14.8	16.8
Don't know/don't answer	0.0	4.8	13.5	11.4

**Table 155. Percentage of educators knowledgeable on the forms of communication**

Ways	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Direct talk	88.7	86.7	74.0	76.8
2. Home visit	43.5	66.3	52.0	53.8
3. Phone call	14.5	11.4	1.3	3.7
4. Letter writing	0.0	2.4	1.4	1.5
5. Self study	27.4	18.7	6.6	9.7
6. Counselling	56.5	44.0	22.7	28.0
7. IEC materials (leaflet, booklet, etc.)	56.5	42.8	25.3	29.8
Don't know	12.9	0.6	4.5	4.4
Don't know 7 forms	3.2	1.2	15.5	12.6
Knowing 1 form	4.8	12.7	23.9	21.0
Knowing 2 forms	30.6	27.1	34.4	33.0
Knowing 3 forms	32.3	36.7	17.1	21.0
Knowing 4 forms	22.6	16.9	6.3	8.9
Knowing 5 forms	4.8	4.8	2.9	3.3
Knowing 6 forms	1.6	0.6	0.0	0.2
Knowing 7 forms	0.0	0.0	0.0	0.0

**Table 156. Percentage of educators with knowledge on the forms of communication for a group of people**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Lecturing	59.7	51.2	28.4	33.8
2. Group discussion	80.6	80.7	73.3	74.9
3. Study visit	19.4	17.5	13.8	14.7
4. Role play	12.9	13.9	2.1	4.6
5. IEC campaign	24.2	29.5	18.6	20.6
6. Sample making	9.7	10.2	4.5	5.7
7. Play on the stage	12.9	7.2	6.3	6.8
8. Models to observe: projector, pictures	48.4	44.0	13.1	20.0
Other	19.4	7.8	3.5	5.1
Don't know	3.2	1.2	14.9	12.1

**Table 157. Percentage of educators with knowledge on key aspects of counselling about Pop/RH**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
Identify the stages of behaviour change country programme of the client	64.5	45.8	31.7	35.8
Show sympathy, be friendly	69.4	51.2	39.3	42.9
Show respect to the client: listen, look in the eye	29.0	27.1	25.1	25.6
No loud speaking or giving out private ideas	21.0	20.5	14.2	15.6
Clients are decision makers	45.2	25.9	7.9	12.9
Don't know	11.3	22.3	38.2	34.1

**Table 158. Percentage of educators with knowledge on the aims of counselling**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Provide information to clients	82.3	82.5	61.6	66.0
2. Help clients	24.2	25.3	16.0	17.9
3. Resolve confusing problems for clients	40.3	22.3	14.1	16.9
4. Explain to clients	43.5	51.2	24.2	29.6
5. Help clients to choose method	29.0	19.3	11.9	14.1
6. Take part in changing their behaviour	58.1	26.5	19.5	22.8
Don't know	3.2	3.6	23.3	19.0

**Table 159. Percentage of educators with knowledge on the steps of counselling**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Greet warmly	69.4	69.3	42.7	48.4
2. Ask about the reasons	75.8	64.5	53.7	56.7
3. Tell the multiple selection of methods	45.2	40.4	43.8	43.3
4. Help to choice	56.5	39.8	32.0	34.6
5. Explain how to apply chosen method	29.0	18.1	5.8	9.1
6. Return if needed	43.5	22.9	7.8	12.2
Don't know	14.5	20.5	24.2	23.1

Table 160. Percentage of educators with knowledge on basic skills when counselling

Contents	Prov. n=62	District n=166	Comm. n=838	Total n=1066
1. Asking skills	67.7	53.0	46.5	48.8
2. Listening skills	58.1	51.2	37.1	40.5
3. Observation skills	41.9	30.1	24.9	26.7
4. Explanation skills	71.0	50.6	43.9	46.5
5. Encouraging skills	53.2	44.0	33.1	35.9
6. Other	3.2	0.6	5.3	4.4
Don't know	8.1	20.5	23.9	22.4

Table 161. Percentage of educators with knowledge on how to write a good message

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Clear, easy to understand	87.1	69.3	56.9	60.6
2. Correct	58.1	42.2	30.8	34.1
3. Easy to apply	32.3	39.2	26.0	28.4
4. Related to respondents	32.3	20.5	10.6	13.4
5. Suitable with each target group	51.6	36.7	17.2	22.2
6. Suitable with local custom	48.4	39.8	20.4	25.0
7. In the framework of the National Strategy on population	8.1	8.4	9.7	9.4
8. Easy to remember	54.8	54.2	21.8	28.8
Don't know	0.0	9.0	24.1	20.4

Table 162. Percentage of educators with knowledge on integrating ways to transfer messages

Content	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Play	74.2	78.3	49.0	55.1
2. Poem	51.6	47.0	31.3	34.9
3. Quiz	19.4	16.3	10.7	12.1
4. Story telling	33.9	33.1	32.2	32.5
5. Show pictures, movies	43.5	30.1	22.6	25.0
Other	17.7	25.3	11.9	14.4
Don't know	3.2	1.2	20.2	16.2

**Table 163. Percentage of educators with knowledge of the basic steps of an advocacy**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
1. Identify the aims	82.3	59.0	46.5	50.6
2. Design messages	54.8	24.7	19.3	22.2
3. Transfer messages to target groups	41.9	35.5	29.2	31.0
Don't know	6.5	29.5	41.8	37.8

**Table 164. Percentage of educators having ever heard about BCC via group discussion**

Contents	Prov.	District	Comm.	Total
	n=62	n=166	n=838	n=1066
Yes	98.4	85.5	62.8	68.4
No	1.6	14.5	37.2	31.6

**Table 165. Knowledge of strong points of communication via small group discussion**

Contents	Province	District	Commune	Total
	n=61	n=142	n=526	n=729
Share skills and assist one another	65.6	59.9	54.6	56.5
Create a proactive and effective environment	54.1	46.5	46.2	46.9
Encourage people to take part in the group's activities	59.0	61.3	42.4	47.5
Others	1.6	1.4	4.8	3.8
Don't know	3.3	0.7	7.4	5.8

Table 166. Demographic characteristics of target groups (community side)

Information	Women	Men	Adolescents	Total
	n=1459	n=1456	n=1464	n= 4379
<i>Age</i>				
15-19	6.8	1.0	100.0	36.0
20-24	33.9	17.7		17.2
25-29	31.6	34.9		22.1
30-34	16.7	27.1		14.6
35-39	9.0	13.0		7.3
40-44	1.7	4.7		2.1
45-49	0.3	1.2		0.5
> 50	0.0	0.3		0.1
<i>Gender</i>				
Male	0.0	100.0	43.5	47.8
Female	100.0	0.0	56.5	52.2
<i>Ethnic</i>				
Kinh	61.9	57.5	56.6	58.7
Other	38.1	42.5	43.4	41.3
<i>Religion</i>				
Buddhism	4.6	2.7	1.4	2.9
Catholicism	8.8	8.7	7.4	8.3
Protestantism	0.1	0.1	0.5	0.2
Other	2.6	1.9	3.1	2.5
Non-religion	84.0	86.3	87.6	86.0
<i>Education</i>				
No schooling	10.1	6.9	1.2	6.1
Primary	27.5	25.3	9.2	20.7
Secondary	43.9	47.0	37.4	42.7
High school	15.1	18.1	51.5	28.3
College, university	3.4	2.6	0.7	2.2
<i>Times of pregnancy</i>				
1-2	79.0			
3 and more	21.0			
<i>Number of children</i>				
1-2	87.7			
3 and more	12.3			

*Interviewing the target groups*

**Table 167. The proportion of women having had at least 3 pregnancies and 3 children**

Provinces	Women having had at least of 3 pregnancies	Women having had at least of 3 children
Phu Tho	19.1	7.2
Ha Giang	20.2	12.0
Hoa Binh	13.9	6.7
Tien Giang	21.9	9.0
Four provinces	18.8	8.7
Ben Tre	15.2	3.9
Ninh Thuan	28.1	21.4
Kon Tum	28.7	25.4
Three provinces	24.1	17.0
Total	21.0	12.3

**Table 168. Percentage of people who have heard of RH issues**

RH issues	Women n=1459	Men n=1456	Adolescents			Total n=4379
			Men n=637	Women n=827	Total n=1464	
1. Psycho-physiological matters of puberty	52.1	51.3	66.7	72.9	70.2	57.9
2. Contraceptive methods	91.8	94.9	75.2	81.3	78.6	88.4
3. Care of pregnant women	84.2	80.7	30.1	50.5	41.7	68.8
4. Delivery and postpartum care	82.2	77.2	25.0	43.2	35.2	64.8
5. Effects of abortion	73.8	76.8	59.8	69.5	65.3	72.0
6. Sexually transmitted diseases (gonorrhoea, syphilis)	68.4	75.1	71.1	71.5	71.3	71.6
7. Violence and violence prevention in family	60.1	63.7	50.4	48.2	49.2	57.7
8. Gender and gender equality in RH	55.1	55.2	47.6	50.5	49.2	53.2

*Interviewing the target groups. Investigators read the issues in turn*

Table 169. Mean number of RH issues

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	6.6	6.5	5.1	5.6	5.4	6.2
Ha Giang	3.6	4.2	2.3	2.7	2.5	3.4
Hoa Binh	5.9	5.9	4.4	5.2	4.9	5.6
Tien Giang	6.2	6.2	4.2	4.7	4.4	5.6
Four provinces	5.5	5.7	4.0	4.6	4.3	5.2
Ben Tre	5.3	5.5	3.6	3.7	3.6	4.8
Ninh Thuan	4.9	5.0	3.1	3.5	3.3	4.4
Kon Tum	3.7	3.4	2.5	3.7	3.1	3.4
Three provinces	4.7	4.6	3.0	3.6	3.4	4.2
Total	5.2	5.2	3.6	4.2	3.9	4.8

Table 170. Percentage of people with knowledge on sources of information on RH issues received

Sources of information	Women	Men	Adolescents			Total n=4073
			Male n=541	Female n=736	Total n=1277	
Wife/Husband, Father/Mother	27.1	34.9	39.7	52.7	47.2	36.1
Other family members	26.5	29.8	29.2	34.9	32.5	29.5
Friends/neighbours	39.4	49.2	50.6	52.4	51.7	46.7
Union staff	62.1	42.0	36.6	42.0	39.7	48.0
Health workers	67.7	48.7	28.5	32.5	30.8	49.5
Population collaborators/ village health workers	72.6	71.4	33.3	37.5	35.7	60.6
Teachers	18.2	7.7	78.7	78.1	78.4	33.4
TV/radio	63.4	72.3	80.6	77.6	78.9	71.3
Commune loud-speaker system	33.4	40.5	32.3	32.1	32.2	35.5
Books, newspapers	39.9	49.4	73.9	77.9	76.2	54.6
Movies, photos, plays	29.4	30.8	53.4	51.2	52.2	37.0

**Table 171. Percentage of people agreeing with proposed statements on RH issues**

Opinions	Women n=1459	Men n=1456	Adolescents			Total n=4073
			Men n=637	Women n=827	Total n=1464	
Premarital sex is acceptable if the two persons really love each other	31.3	43.3	33.8	23.9	28.2	34.3
One should not get married before 19 years of age.	68.3	74.9	73.6	71.9	72.7	71.9
It's uncomfortable to buy or ask for a condom	42.1	45.9	46.3	40.6	43.1	43.7
One can become pregnant if having sex without any contraceptive	78.2	88.7	71.3	71.2	71.2	79.4
Contraceptive methods are for married people only	60.0	53.6	35.0	44.4	40.3	51.3
Unmarried persons should not know about RH issues	30.0	36.3	21.5	20.8	21.1	29.1
Abortion is common in this precinct	15.4	7.0	8.6	9.1	8.9	10.4
Decision maker in the family is the husband	29.1	29.7	35.6	37.4	36.6	31.8
Still experiencing violence against women and children in this locality	17.6	14.6	29.8	29.1	29.4	20.6

*Interviewing the target groups. Investigators read the issues in turn*

**Table 172. Percentage of people with knowledge on danger signs during pregnancy**

Danger signs	Women (n=1459)	Men (n=1456)	Total (n=2915)
Prolonged fever	19.5	19.5	19.5
Headache	8.3	12.5	10.4
Oedema	8.0	11.3	9.6
Bleeding from vagina	36.2	25.5	30.8
Convulsion	3.4	9.4	6.4
Abdomen pain	37.2	29.7	33.4
Others	5.8	4.2	5.0
Don't know	31.5	41.1	36.3
Don't know all 6 above signs	33.4	44.7	39.1
Knowing 1 sign	30.8	24.7	27.7
Knowing 2 signs	27.7	20.2	23.9
Knowing 3 signs	6.2	5.5	5.9
Knowing 4 signs	1.4	1.2	1.3
Knowing 5 signs	0.3	1.0	0.7
Knowing 6 signs	0.1	2.7	1.4

*Interviewing women and men. Investigators don't read the choices*

**Table 173. Mean number of knowledge on danger signs to the pregnancy women (among 6 signs)**

Provinces	Women	Men	Total
Phu Tho	1.9	2.4	2.1
Ha Giang	0.6	0.5	0.6
Hoa Binh	1.3	1.0	1.1
Tien Giang	1.3	0.6	1.0
Four provinces	1.3	1.1	1.2
Ben Tre	1.2	1.0	1.1
Ninh Thuan	0.9	1.2	1.0
Kon Tum	0.8	0.8	0.8
Three provinces	1.0	1.0	1.0
Total	1.1	1.1	1.1

**Table 174. Percentage of people with knowledge on management of obstetric emergencies**

Actions	Women (n=999)	Men (n=857)	Total (n=1856)
No treatment	1.0	0.1	0.6
Self-treatment	1.4	1.1	1.2
Invite health workers	9.9	10.4	10.1
Visit to public health facility	95.7	97.9	96.7
Visit private health facility	8.6	7.4	8.0
Invite traditional health workers	0.1	0.1	0.1
Worshipping	0.1	0.0	0.1

*Interviewing women and men. Investigators read the choices in turn*

**Table 175. Percentage of people with knowledge of the number of antenatal visits needed during pregnancy**

Number of antenatal visits	Women (n=1459)	Men (n=1456)	Total (n=2915)
1. Once	1.4	1.4	1.4
2. Twice	7.5	10.0	8.7
3. Three or more	84.4	80.6	82.5
Don't need	0.8	0.6	0.7
Don't remember	6.0	7.4	6.7

**Table 176. Percentage of people reporting on antenatal visits during their most recent pregnancy**

Number of antenatal visits	Women (n=1459)	Men (n=1456)	Total (n=2915)
Once	4.2	3.4	3.8
Twice	11.4	13.3	12.4
Three or more	77.2	76.0	76.6
None	5.7	2.3	4.0
Don't remember	1.4	3.8	2.6
Don't know	0.0	1.2	0.6

*Interviewing women and men. Investigators read the choices in turn*

**Table 177. The proportion of women with sufficient number of pregnancy check-ups**

Provinces	Women	Men	Total
Phu Tho	94.3	89.0	91.6
Ha Giang	45.2	57.6	51.4
Hoa Binh	92.8	93.2	93.0
Tien Giang	99.0	96.1	97.6
Four provinces	82.9	83.9	83.4
Ben Tre	82.8	89.9	86.4
Ninh Thuan	78.6	71.5	75.1
Kon Tum	47.8	34.9	41.4
Threere provinces	69.7	65.3	67.5
Total	77.2	76.0	76.6

**Table 178. Percentage of people with knowledge on place of antenatal check-ups during their most recent pregnancy**

Place of antenatal care	Women (n=1376)	Men (n=1421)	Total (n=2797)
CHCs	78.0	80.9	79.5
Health facilities at higher levels (district, provincial, central)	34.9	39.3	37.1
Commune/Village/hamlet health workers' home	1.9	0.8	1.4
Private clinics	17.3	14.6	15.9
Traditional herbalists/birth attendants	0.1	0.1	0.1

*Interviewing women and men. investigators read the choices in turn*

**Table 179. Percentage of people with knowledge on the number of tetanus vaccinations in their first pregnancy**

Number of tetanus vaccinations	Women (n=1459)	Men (n=1456)	Total (n=2915)
One shots	5.5	14.5	10.0
Two shots	69.9	61.0	65.5
Other (>3 shots or don't know)	24.6	24.5	24.6

**Table 180. Percentage of people reporting on the status of tetanus vaccinations during their most recent pregnancy**

Status of tetanus vaccinations	Women (n=1459)	Men (n=1456)	Total (n=2915)
Have vaccination	89.8	85.4	87.6
Not fully vaccinated	17.1	14.4	15.8
Fully vaccinated	71.8	50.9	61.4
Cannot remember the number of tetanus vaccinations	0.8	20.1	10.4
No vaccination	7.4	3.3	5.4
Don't remember	2.8	11.3	7.1

**Table 181. The proportion of women having full vaccinations**

Provinces	Women	Men	Total
Phu Tho	83.7	66.5	75.1
Ha Giang	60.6	51.9	56.2
Hoa Binh	73.7	52.7	63.2
Tien Giang	73.8	36.7	55.4
Four provinces	73.0	52.0	62.5
Ben Tre	68.1	63.3	65.7
Ninh Thuan	74.3	55.1	64.7
Kon Tum	68.4	30.1	49.3
Three provinces	70.3	49.4	59.9
Total	71.8	50.9	61.4

**Table 182. Percentage of people with knowledge on warning signs for women during labour**

Warning signs	Women (n=1459)	Men (n=1456)	Total (n=2915)
Abdominal pain	31.4	34.0	32.7
Bleeding from vagina	36.7	27.3	32.0
Fever	6.4	15.4	10.9
Convulsion	5.0	9.8	7.4
Early breaking of the amnion before delivery	19.5	8.0	13.8
Others	3.4	1.8	2.6
Don't know	32.5	43.0	37.7
Do not know the signs above	33.7	44.3	39.0
Knowing 1 sign	39.3	29.7	34.5
Knowing 2 signs	22.3	18.1	20.2
Knowing 3 signs	3.6	3.4	3.5
Knowing 4 signs	1.0	4.0	2.5
Knowing 5 signs	0.1	0.5	0.3

*Interviewing women and men. Investigators don't read the choices in turn*

**Table 183. Mean number of warning signs to women during labour (among 5 signs)**

Provinces	Women	Men	Total
Phu Tho	1.4	2.0	1.7
Ha Giang	0.6	0.4	0.5
Hoa Binh	1.2	0.7	1.0
Tien Giang	1.3	0.7	1.0
Four provinces	1.1	1.0	1.0
Ben Tre	1.1	1.1	1.1
Ninh Thuan	0.9	0.9	0.9
Kon Tum	0.6	0.7	0.7
Three provinces	0.8	0.9	0.9
Total	1.0	0.9	1.0

**Table 184. Percentage of people reporting on place of most recent delivery and birth attendants**

Information	Women (n=1459)	Men (n=1456)	Total (n=2915)
<i>Place for delivery</i>			
Public health facilities	79.5	77.8	78.6
Private health facilities	1.7	2.3	2.0
Semi-public health facilities	0.0	0.2	0.1
At home	18.9	19.8	19.3
<i>Delivery assistance</i>			
Health staff	83.5	82.7	83.1
Traditional birth attendant	4.9	5.0	5.0
Husband	2.8	3.0	2.9
Member of family	7.7	8.5	8.1
Others	0.8	0.6	0.7
None	0.3	0.3	0.3

*Interviewing women and men. Investigators read the choices in turn*

**Table 185. Places for most recent delivery and birth attendants**

Provinces	Place of delivery		Birth attendants	
	At home	At health facilities	Health staff	Others
Phu Tho	4.1	95.9	98.8	1.2
Ha Giang	46.9	53.1	58.1	41.9
Hoa Binh	3.1	96.9	97.4	2.6
Tien Giang	0.0	100.0	99.5	0.5
Four provinces	13.5	86.5	88.4	11.6
Ben Tre	0.7	99.3	98.8	1.2
Ninh Thuan	15.8	84.2	85.9	14.1
Kon Tum	64.1	35.9	43.5	56.5
Three provinces	27.0	73.0	75.9	24.1
Total	19.3	80.7	83.1	16.9

**Table 186. Percentage of interviewees reporting on assistance during their most recent delivery**

Answer	Women (n=1459)	Men (n=1456)	Total (n=2915)
<i>Women accompanied by their husband</i>			
Yes	77.9	74.4	76.1
No	5.9	6.6	6.2
Don't remember	0.1	0.1	0.1
Not accompanied by their husband because of delivery at home	16.2	18.9	17.5
<i>The people who help women to prepare for delivery</i>			
Husband	83.1	80.0	81.6
Mother in law	42.7	49.2	45.9
Own mother	37.3	36.7	37.0
Others	16.7	15.0	15.8
None	1.2	0.5	0.9

**Table 187. Percentage of people with knowledge of warning signs of post-partum women**

Signs	Women (n=1459)	Men (n=1456)	Total (n=2915)
Prolonged and increased bleeding	53.9	36.1	45.0
Smelly vaginal discharge	1.2	6.7	3.9
Prolonged & high fever	16.4	16.6	16.5
Prolonged and increased abdomen pain	24.2	24.7	24.4
Convulsion	4.2	8.0	6.1
Don't know	3.6	2.4	3.0
Don't know all 5 signs	29.7	47.0	38.4
Knowing 1 sign	46.0	29.7	37.8
Knowing 2 signs	19.5	15.6	17.6
Knowing 3 signs	4.0	3.0	3.5
Knowing 4 signs	0.7	1.5	1.1
Knowing 5 signs	0.0	3.2	1.6

*Interviewing women and men. Investigators don't read the choices in turn*

**Table 188. Mean number of knowledge of warning signs to post-delivery women (among 5 signs)**

Provinces	Women	Men	Total
Phu Tho	1.6	2.2	1.9
Ha Giang	0.7	0.4	0.5
Hoa Binh	1.1	0.8	1.0
Tien Giang	1.2	0.5	0.9
Four provinces	1.2	1.0	1.1
Ben Tre	1.1	0.9	1.0
Ninh Thuan	0.8	0.9	0.8
Kon Tum	0.5	0.7	0.6
Three provinces	0.8	0.8	0.8
Total	1.0	0.9	1.0

**Table 189. Management of warning signs for post-partum mothers**

Management	Women (n=1061)	Men (n=806)	Total (n=1867)
No treatment	1.2	0.0	0.7
Self treatment	1.3	0.6	1.0
Invite health worker	13.1	10.2	11.8
Visit public health facility	91.0	96.0	93.1
Visit private health facility	4.6	7.8	6.0
Visit traditional health workers	0.7	0.1	0.4
Worshipping	0.3	0.2	0.3
Others	1.3	0.0	0.7
Don't know	1.1	1.2	1.2

**Table 190. Percentage of people with knowledge and practise of initial breastfeeding**

Contents	Women (n=1459)	Men (n=1456)	Total (n=2915)
<i>Know about when to start breastfeeding</i>			
As soon as possible (within 30')	75.7	66.3	71.0
From 30' to 1h	13.0	19.6	16.3
Other	4.9	6.4	5.6
Don't know	6.4	7.8	7.1
<i>Practise of breast feeding for the first time</i>			
Within 30'	65.1	58.7	61.9
From 30' to 1h	16.2	19.8	18.0
Other	15.0	9.5	12.3
Don't remember/ Don't know	3.6	12.0	7.8

**Table 191. Percentage of people with knowledge and practise of exclusive breastfeeding**

Contents	Women (n=1459)	Men (n=1456)	Total (n=2915)
<i>Know about exclusive breastfeeding (full breastfeeding)</i>			
1-2 months	1.9	1.4	1.6
3-4 months	24.5	19.2	21.8
5-6 months	58.3	43.8	51.0
6 months and more	9.5	19.2	14.4
Don't know/don't remember	5.9	16.4	11.1
<i>Practise exclusive breastfeeding</i>			
1-2 months	6.0	3.0	4.5
3-4 months	33.4	25.5	29.5
4-6 months	41.6	35.0	38.3
6 months and more	5.6	11.1	8.4
Don't know/don't remember	0.8	11.0	5.9
Their children are exclusively breastfed	12.5	14.4	13.5

**Table 192. Percentage of people with knowledge on vaccination against diseases in children**

Diseases	Women (n=1459)	Men (n=1456)	Total (n=2915)
Tuberculosis	48.9	49.0	48.9
Diphtheria	48.0	33.7	40.8
Whooping cough	56.9	52.0	54.4
Tetanus	68.9	71.2	70.1
Poliomyelitis	54.2	53.4	53.8
Measles	64.1	58.7	61.4
Other	25.6	25.8	25.7
Don't know 6 diseases above	14.9	14.3	14.6
Knowing 1 disease	4.0	10.0	7.0
Knowing 2 diseases	10.4	13.0	11.7
Knowing 3 diseases	16.5	15.9	16.2
Knowing 4 diseases	15.0	18.8	16.9
Knowing 5 diseases	11.2	8.8	10.0
Knowing 6 diseases	28.0	19.2	23.6

Table 193. Percentage of people who could identify contraceptive methods

Contraceptives	Women n=1459	Men n=1456	Adolescents			Total n=4379
			Men n=637	Women n=827	Total n=1464	
Condom	84.0	92.2	79.9	79.7	79.8	85.3
Oral pill	86.2	85.0	67.7	75.2	71.9	81.0
Emergency oral pills	4.0	4.4	4.2	4.7	4.5	4.3
IUD	84.0	73.3	30.1	40.9	36.2	64.5
Sterilization	35.9	29.3	22.6	19.0	20.6	28.6
Injectables	15.0	16.3	5.3	3.6	4.4	11.9
Norplant	25.6	11.5	8.2	10.8	9.6	15.6
Withdrawal	5.0	1.4	3.3	2.4	2.8	3.1
Calendar/Rhythm	24.1	22.6	8.2	10.9	9.7	18.8
Other	0.2	0.3	1.9	0.8	1.3	0.6
Don't know all 9 methods	4.5	2.0	18.7	14.4	16.3	7.6
Knowing 1 method	3.3	3.3	8.5	8.3	8.4	5.0
Knowing 2 methods	10.0	19.1	33.8	31.2	32.3	20.5
Knowing 3 methods	28.0	36.7	19.2	23.7	21.7	28.8
Knowing 4 methods	28.5	21.4	11.6	12.3	12.0	20.6
Knowing 5 methods	16.2	9.7	3.3	6.2	4.9	10.3
Knowing 6 methods	6.2	5.4	3.0	2.5	2.7	4.7
Knowing 7 methods	2.5	1.8	1.1	0.8	1.0	1.8
Knowing 8 methods	0.5	0.5	0.8	0.2	0.5	0.5
Knowing 9 methods	0.3	0.2	0.2	0.2	0.2	0.3

*Interviewing the target groups. investigators don't read any choices*

Table 194. Mean number of contraceptives known by interviewees

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	4.4	4.2	3.8	3.6	3.6	4.1
Ha Giang	2.8	2.8	1.7	1.9	1.8	2.5
Hoa Binh	4.1	3.4	2.3	2.8	2.6	3.4
Tien Giang	4.0	3.4	2.3	2.6	2.5	3.3
Four provinces	3.8	3.5	2.5	2.7	2.6	3.3
Ben Tre	3.3	2.9	2.0	2.2	2.1	2.8
Ninh Thuan	3.9	3.4	1.4	1.6	1.5	2.9
Kon Tum	2.9	3.4	2.4	2.8	2.6	3.0
Three provinces	3.4	3.2	2.0	2.2	2.1	2.9
Total	3.6	3.4	2.3	2.5	2.4	3.1

**Table 195. Use of contraceptives**

Using contraceptives	Women (n=1459)	Men (n=1456)	Total (n=2915)
Use	72.5	79.0	75.7
Don't use	27.5	21.0	24.3

**Table 196. Rate of contraceptive use, percent**

Contraceptives	Women	Men	Total
1. Sterilization	1.5	1.5	1.5
2. IUD	33.5	31.1	32.3
3. Injectables	2.3	2.7	2.5
4. Norplant	0.1	0.3	0.2
5. Oral Pills	13.2	17.3	15.2
6. Emergency Oral Pills	0.0	0.1	0.0
7. Condoms	10.5	18.3	14.4
8. Withdrawal	4.9	3.8	4.3
9. Calendar/Rhythm	6.4	3.7	5.1
Other	0.1	0.2	0.2
No use of any	27.5	21.0	24.3

*Women and men, investigators did not read choices.*

**Table 197. Percentage of people and their reasons for using contraceptive methods**

Reasons	Women (n=1058)	Men (n=1149)	Total (n=2207)
It is available	14.2	12.4	13.3
Reasonable price	4.3	8.7	6.6
It is convenient	58.1	58.4	58.3
Recommended by health worker/pop. collaborator	19.5	33.2	26.6
Only know of this method	1.2	4.7	3.0
High effectiveness	40.5	41.4	41.0

Table 198. Reasons for not using contraceptive methods

Reasons	Women (n=400)	Men (n=307)	Total (n=707)
1. Tried but not suitable	4.3	0.7	2.7
2. Plan to have another baby	13.0	21.5	16.7
3. Might affect health	6.8	10.7	8.5
4. Breastfeeding	44.3	39.1	42.0
5. Husband does not allow/don't like	4.5	7.8	5.9
6. Too expensive to buy	0.5	0.0	0.3
Don't have the wanted methods	0.3	0.0	0.1

*Interviewing women and men. Investigators read choices in turn, Table 155. Reasons for the less prevalent use of condoms and oral pills in community*

Table 199. Reasons for the less prevalent use of condoms and oral pills

Reasons	Women	Men	Total
<i>Condom</i>	n=1459	n=1456	n=2915
1. Condom is not available for sale	3.0	2.7	2.8
2. Cannot afford to buy	2.1	0.9	1.5
3. Not good quality	6.9	8.7	7.8
4. Afraid of side effects	15.4	11.0	13.2
5. People don't like to use	24.6	28.1	26.3
6. People don't know about condoms	3.8	3.2	3.5
7. Afraid to be seen as sexually promiscuous	6.6	5.6	6.1
8. Poor education and communication	1.3	4.4	2.8
9. Method failure	8.0	5.1	6.6
10. Condom is commonly used	18.8	21.2	20.0
<i>Oral pills</i>	n=1459	n=1455	n=2914
1. Pills are not available for sale	2.6	5.2	3.9
2. Cannot afford	1.3	1.6	1.5
3. Afraid of side effects	40.1	52.8	46.4
4. Easy to forget	47.2	32.4	39.8
5. People don't know about pills	6.3	6.4	6.3
6. Afraid to be seen as sexually promiscuous	4.5	1.4	2.9
7. Poor education and communication	1.9	4.5	3.2
8. Method failure	9.0	11.5	10.3
9. Pills are commonly used	28.4	23.7	26.1

**Table 200. Reasons for the less prevalent use of condoms and oral pills in community reported by people**

Provinces	Phu Tho	Ha Giang	Hoa Binh	Tien Giang	4 prov.	Ben Tre	Ninh Thuan	Kon Tum	3 prov.	Total
<i>Condoms</i>										
Condom is not available for sale	1.2	6.2	2.6	1.2	2.8	0.0	1.4	7.2	2.9	2.8
Cannot afford to buy	1.7	0.7	2.2	0.5	1.3	0.0	0.2	5.0	1.8	1.5
Not good quality	13.9	2.9	6.0	7.9	7.7	17.0	1.4	5.7	8.0	7.8
Afraid of side effects	21.1	8.6	22.4	11.8	15.9	6.3	10.8	11.2	9.5	13.2
People don't like to use	34.2	32.3	40.1	13.7	30.1	3.9	34.3	25.6	21.3	26.3
People don't know about condoms	2.6	9.8	4.8	3.6	5.2	0.7	0.7	1.9	1.1	3.5
Afraid to be seen as sexually promiscuous	7.7	15.8	3.8	5.0	8.1	7.5	0.7	2.2	3.5	6.1
Poor education and communication	3.8	2.9	8.2	0.7	3.9	0.0	2.6	1.7	1.4	2.8
Method failure	9.1	8.1	4.1	13.2	8.6	1.0	7.4	2.9	3.8	6.6
Condom is commonly used	7.7	2.6	14.4	12.5	9.3	48.9	32.6	21.8	34.4	20.0
<i>Oral pills</i>										
Pills are not available for sale	1.0	7.7	2.2	0.7	2.9	0.0	1.0	14.8	5.3	3.9
Cannot afford	1.9	1.0	2.9	0.5	1.6	0.5	0.0	3.6	1.4	1.5
Afraid of side effects	71.1	33.3	42.3	72.6	54.8	47.2	29.7	28.9	35.2	46.4
Easy to forget	62.0	47.1	56.5	49.5	53.8	23.8	17.3	22.5	21.2	39.8
People don't know about pills	2.6	22.0	8.4	2.9	9.0	0.7	1.9	5.7	2.8	6.3
Afraid to be seen as sexually promiscuous	2.6	11.7	2.9	0.5	4.4	1.0	0.0	1.7	0.9	2.9
Poor education and communication	3.3	6.2	7.9	1.2	4.7	0.5	1.9	1.2	1.2	3.2
Method failure	20.3	26.1	0.7	7.0	13.5	0.7	14.4	2.6	5.9	10.3
Pills are commonly used	7.9	5.5	13.7	7.5	8.6	39.4	64.3	44.5	49.4	26.1

**Table 201. Percentage of people giving opinions on when to initiate of contraceptive methods after delivery**

Time	Women (n=1459)	Men (n=1456)	Total (n=2915)
After 6 months whether breast feeding or not	32.8	36.5	34.6
When resuming sexual activity	10.0	15.4	12.7
After 6 months if exclusive breast feeding and there is enough breast milk	2.2	2.7	2.4
As soon as menstruation resumes	16.7	11.9	14.3
Other	30.0	20.3	25.1
Don't know	8.4	13.2	10.8

*Interviewing women and men. Investigators read choices in turn*

**Table 202. Percentage of people giving correct opinions on when to initiate contraceptive methods after delivery**

Provinces	Women	Men	Total
Phu Tho	19.1	23.0	21.1
Ha Giang	15.4	16.7	16.0
Hoa Binh	17.7	23.7	20.7
Tien Giang	10.5	4.3	7.4
Four provinces	15.7	16.9	16.3
Ben Tre	0.5	1.9	1.2
Ninh Thuan	1.9	4.8	3.4
Kon Tum	4.8	33.0	18.9
Three provinces	2.4	13.3	7.9
Total	10.0	15.4	12.7

**Table 203. Percentage of people with knowledge on RTIs and STDs. by target groups**

Diseases	Women n=1459	Men n=1456	Adolescents			Total n=4379
			Men n=637	Women n=827	Total n=1464	
1. Gynaecological problems	73.7	64.8	39.9	57.1	49.6	62.7
2. Gonorrhoea	65.5	73.0	69.2	64.6	66.6	68.4
3. Syphilis	63.5	69.2	65.3	65.1	65.2	66.0
Never heard of any	22.8	22.7	26.7	23.1	24.7	23.4
Knowing 1 disease	11.3	5.2	6.6	11.2	9.2	8.6
Knowing 2 diseases	6.4	14.6	22.3	21.5	26.2	15.7
Knowing 3 diseases	59.6	57.6	34.4	41.1	39.9	52.3

**Table 204. Mean number of knowledge on RTIs/STDs (among 3 diseases)**

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	2.9	2.8	2.6	2.6	2.6	2.7
Ha Giang	1.1	1.3	0.8	1.1	1.0	1.1
Hoa Binh	2.3	2.4	2.1	2.5	2.3	2.4
Tien Giang	2.5	2.6	2.3	2.4	2.4	2.5
Four provinces	2.2	2.3	1.9	2.2	2.1	2.2
Ben Tre	2.2	2.5	1.7	1.7	1.7	2.1
Ninh Thuan	1.9	2.0	1.3	1.5	1.4	1.8
Kon Tum	1.4	1.0	1.4	1.3	1.3	1.2
Three provinces	1.8	1.8	1.5	1.5	1.5	1.7
Total	2.0	2.1	1.7	1.9	1.8	2.0

**Table 205. The proportion of people who know the causes of RTIs/STDs**

Reasons	Women n=1127	Men n=1126	Adolescents			Total n=3356
			Men n=467	Women n=636	Total n=1103	
Unsanitary genitals	83.5	78.6	56.7	73.0	66.1	76.1
Having sexual intercourse with many partners without condoms	76.8	85.7	75.2	74.5	74.8	79.1
Having sexual intercourse with infected persons without condoms	73.9	82.1	86.1	80.2	82.7	79.6
Don't know any causes	6.0	2.6	4.3	4.2	4.3	4.3
Knowing 1 cause	16.4	11.0	17.3	16.8	17.0	14.8
Knowing 2 causes	15.4	24.1	34.5	25.9	29.6	22.9
Knowing 3 causes	62.4	62.4	43.9	53.0	49.1	58.0

**Table 206. Mean number of knowledge on causes of RTIs/STDs (among 3 causes)**

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	2.6	2.7	2.3	2.5	2.4	2.6
Ha Giang	1.0	1.0	0.8	1.1	0.9	1.0
Hoa Binh	2.3	2.5	1.7	2.1	1.9	2.3
Tien Giang	2.6	2.2	2.3	2.5	2.4	2.4
Four provinces	2.1	2.1	1.8	2.1	1.9	2.1
Ben Tre	1.7	1.9	1.4	1.5	1.5	1.7
Ninh Thuan	1.3	1.9	1.4	1.4	1.4	1.5
Kon Tum	1.2	1.1	1.2	1.3	1.3	1.2
Three provinces	1.4	1.6	1.3	1.4	1.4	1.5
Total	1.8	1.9	1.6	1.8	1.7	1.8

**Table 207. Percentage of people with knowledge of the effects of RTIs and STDs on women. 2005 survey**

Effects	Women n=1127	Men n=1126	Adolescents			Total n=3356
			Men n=465	Women n=636	Total n=1103	
Prolonged infection	35.7	40.2	52.7	57.1	55.2	43.6
Ectopic pregnancy	2.7	6.1	34.7	39.6	37.5	15.3
Infertility	26.7	43.3	66.2	67.5	66.9	45.5
Miscarriage, preterm/ underweight newborn	10.4	21.9	43.9	49.2	47.0	26.3
Transmission to newborn	9.9	13.9	47.8	49.4	48.7	24.0
High risk of HIV infection	8.2	12.5	63.2	56.3	59.2	26.4
High risk of uterine cancer	7.3	19.4	31.5	34.0	32.9	19.8
Other	16.0	6.5	3.9	5.3	4.7	9.1
Don't know all 7 effects	31.5	21.5	9.9	10.1	10.0	21.1
Knowing 1 effect	43.0	32.9	14.1	15.1	14.7	30.3
Knowing 2 effects	19.9	32.8	14.1	12.7	13.3	22.1
Knowing 3 effects	4.6	6.0	13.3	13.5	13.4	8.0
Knowing 4 effects	0.8	1.7	16.3	13.4	14.6	5.6
Knowing 5 effects	0.1	0.7	12.2	9.1	10.4	3.7
Knowing 6 effects	0.1	0.4	9.4	9.9	9.7	3.3
Knowing 7 effects	0.0	4.1	10.7	16.2	13.9	5.9

**Table 208. Percentage of people with knowledge on proper treatment when a person has RTIs and STDs**

Treatment strategy	Women n=1127	Men n=1126	Adolescents			Total n=3354
			Men n=465	Women n=636	Total n=1101	
The infected person only	40.8	33.5	38.3	35.8	36.9	37.1
Both wife and husband	43.7	52.7	13.1	17.1	15.4	37.4
Infected person and all who had sex with him/her	11.2	12.3	39.4	37.9	38.5	20.5
Other	0.0	0.0	0.2	0.3	0.3	0.1
Don't know	4.3	1.5	9.0	8.8	8.9	4.9

**Table 209. The proportion of people with correct knowledge on proper treatment when a person has RTIs and STDs**

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	15.1	1.0	40.4	32.1	36.0	17.3
Ha Giang	14.6	18.1	40.5	40.0	40.2	23.6
Hoa Binh	15.4	7.7	49.3	51.2	50.5	25.2
Tien Giang	11.6	13.0	23.7	30.4	27.0	17.1
Four provinces	14.1	8.8	37.0	39.2	38.3	20.3
Ben Tre	7.0	22.8	67.7	67.8	67.7	30.4
Ninh Thuan	5.2	21.5	4.9	9.9	8.3	11.7
Kon Tum	8.9	4.6	42.2	29.3	35.3	17.8
Three provinces	6.8	17.9	42.9	35.9	38.7	20.8
Total	11.2	12.3	39.2	37.9	38.4	20.5

**Table 210. The proportion of interviewees who have heard about HIV/AIDS**

Information	Women n=1459	Men n=1456	Adolescents			Total n=4379
			Men n=637	Women n=827	Total n=1464	
Heard about	86.5	93.8	93.1	93.6	93.4	91.2
Have not heard about	13.5	6.3	6.9	6.4	6.6	8.8

**Table 211. Percentage of people with knowledge on HIV/AIDS transmission routes**

Transmission routes	Women n=1262	Men n=1365	Adolescents			Total n=3994
			Men n=593	Women n=774	Total n=1367	
Normal contact	5.7	5.1	5.1	5.3	5.2	5.3
Mother to child	84.7	81.8	86.3	85.8	86.0	84.2
Have sex without condom	83.7	77.0	85.5	82.7	83.9	81.5
Mosquitoes/insect bite	31.9	19.4	28.3	29.3	28.9	26.6
Direct contact with blood, fluid of the infected	75.4	57.2	78.4	82.2	80.5	71.0
Needle sharing	83.0	78.4	91.2	91.5	91.4	84.3
Unsafe blood transfusion	83.2	75.3	82.3	81.3	81.7	80.0
Don't know	2.5	4.6	2.9	1.8	2.3	3.1
Knowing 1 routes	4.8	5.9	2.2	2.2	2.2	4.3
Knowing 2 routes	7.5	11.9	3.9	4.7	4.3	7.9
Knowing 3 routes	10.5	14.3	10.6	12.7	11.8	12.2
Knowing 4 routes	14.7	19.4	20.2	19.5	19.8	18.1
Knowing 5 routes	60.0	43.9	60.2	59.2	59.6	54.4

*Interviewing the target groups. investigators read the choices in turn*

Table 212. Mean number of correct knowledge on HIV transmission routes (among 5 routes)

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	4.5	4.3	4.6	4.7	4.6	4.5
Ha Giang	2.3	2.5	3.2	3.2	3.2	2.7
Hoa Binh	4.2	4.2	3.9	3.9	3.9	4.1
Tien Giang	4.7	4.6	4.6	4.8	4.7	4.7
Four provinces	3.9	3.9	4.1	4.1	4.1	4.0
Ben Tre	3.0	3.1	4.4	4.6	4.5	3.5
Ninh Thuan	3.6	3.6	4.0	3.6	3.7	3.6
Kon Tum	2.5	2.0	2.8	3.1	3.0	2.5
Three provinces	3.0	2.9	3.7	3.8	3.7	3.2
Total	3.6	3.5	4.0	4.0	4.0	3.7

Table 213. Percentage of people with knowledge on HIV/AIDS prevention

Preventive Measures	Women n=1262	Men n=1365	Adolescents			Total n=3994
			Men n=593	Women n=774	Total n=1367	
Avoid sharing syringe or use sterile syringe only	45.5	32.5	46.7	53.0	50.3	42.7
No drug injection	34.9	51.4	54.3	50.4	52.1	46.4
Use condom when having sex	51.5	50.0	54.3	45.6	49.4	50.3
No sex with multiple partners	51.8	66.6	55.6	56.7	56.3	58.4
Use only screened blood for transfusion	23.1	17.9	35.1	37.0	36.1	25.8
Use sterile medical equipment only	6.2	11.3	14.0	16.1	15.2	11.0
Avoid direct contact with blood, semen, and vaginal discharge of HIV infected persons	9.9	11.1	25.0	22.5	23.6	15.0
Others	3.7	1.8	3.5	4.9	4.3	3.3
Don't know	9.0	6.5	10.5	10.6	10.5	8.7
Knowing 1 method	22.7	21.8	11.3	13.0	12.3	18.8
Knowing 2 methods	29.9	31.4	24.6	25.1	24.9	28.7
Knowing 3 methods	22.4	20.2	23.9	22.5	23.1	21.9
Knowing 4 methods	9.7	10.9	10.8	10.1	10.4	10.4
Knowing 5 methods	3.8	4.0	8.1	8.0	8.0	5.3
Knowing 6 methods	1.4	4.2	6.6	4.8	5.6	3.8
Knowing 7 methods	1.0	0.9	4.2	5.9	5.2	2.4

**Table 214. Mean number of knowledge on HIV prevention (among 7 methods)**

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	3.2	3.7	4.4	4.0	4.1	3.7
Ha Giang	1.5	1.4	2.2	1.9	2.0	1.6
Hoa Binh	2.2	2.6	2.2	2.5	2.4	2.4
Tien Giang	2.5	2.5	2.6	2.4	2.5	2.5
Four provinces	2.4	2.6	2.8	2.7	2.8	2.6
Ben Tre	1.7	2.2	3.5	3.7	3.6	2.5
Ninh Thuan	1.3	2.2	1.5	1.8	1.7	1.7
Kon Tum	1.1	1.2	1.9	2.2	2.1	1.5
Three provinces	1.4	1.9	2.4	2.6	2.5	1.9
Total	1.9	2.3	2.7	2.6	2.6	2.3

*Interviewing the target groups. Investigators don't read any choices*

**Table 215. The proportion of interviewees who believed they could accurately identify an HIV/AIDS infected person**

Ways	Women n=1262	Men n=1365	Adolescents			Total n=3994
			Men n=593	Women n=774	Total n=1367	
By their appearance	3.4	4.5	10.6	9.3	9.9	6.0
By their appearance and lifestyle	7.1	9.2	27.3	24.3	25.6	14.1
Blood test	92.9	88.2	92.4	94.6	93.6	91.5
Don't know	5.9	11.4	3.9	3.7	3.8	7.1

*Interviewing the target groups. Investigators read the choices in turn*

**Table 216. Proportion of interviewees who believed they could accurately identify an HIV infected person by appearance and lifestyle, in percent**

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	6.2	5.3	29.8	28.3	29.0	13.4
Ha Giang	17.5	8.2	38.0	30.0	34.0	19.2
Hoa Binh	8.8	29.9	36.4	35.6	35.9	25.2
Tien Giang	2.4	8.7	39.5	37.6	38.6	16.7
Four provinces	7.7	13.0	35.9	33.1	34.4	18.5
Ben Tre	5.1	10.1	21.6	29.5	26.2	14.0
Ninh Thuan	13.4	16.9	45.3	28.9	34.4	21.6
Kon Tum	10.6	1.9	12.2	8.2	10.0	7.5
Three provinces	9.5	10.1	24.8	23.3	23.9	14.7
Total	8.5	11.8	31.5	28.7	29.9	17.0

**Table 217. Attitudes towards health workers performing HIV testing without clients' consent, percent**

Attitude	Women n=1262	Men n=1365	Adolescents			Total n=3994
			Men n=593	Women n=774	Total n=1367	
Wrong	24.6	31.1	15.2	12.0	13.4	23.0
Right	68.1	54.6	76.1	78.9	77.7	66.8
Don't know	7.3	14.4	8.8	9.0	8.9	10.3

**Table 218. Proportion of respondents who thought that health workers performing HIV testing without clients' consent is wrong**

Provinces	Women	Men	Adolescents			Total
			Men	Women	Total	
Phu Tho	79.4	66.5	84.2	81.4	82.7	76.2
Ha Giang	12.5	42.4	48.6	38.1	43.3	32.8
Hoa Binh	73.2	69.6	79.2	89.5	85.7	76.2
Tien Giang	63.8	61.8	65.1	72.3	68.6	64.8
Four provinces	57.3	60.0	68.1	71.7	70.0	62.5
Ben Tre	80.4	44.4	90.9	92.6	91.9	72.3
Ninh Thuan	55.2	50.2	69.1	66.7	67.5	57.6
Kon Tum	47.8	23.4	64.2	71.3	68.1	46.5
Three provinces	61.0	39.3	74.9	76.5	75.9	58.8
Total	58.9	51.2	70.8	73.9	72.5	60.9

**Table 219. Awareness of locations for abortion services**

Locations for abortion services	Women (n=1459)	Men (n=1456)	Total (n=2915)
Public health facility	77.2	68.3	72.8
Private health facility	11.7	13.3	12.5
Traditional health workers	0.1	0.1	0.1
Others	0.3	0.0	0.1
Don't know	21.2	30.2	25.7

**Table 220. Respondents' awareness of the consequences of abortion, in percent**

Consequences	Women (n=1459)	Men (n=1456)	Total (n=2915)
Suffer from serious mental issues	4.7	7.4	6.1
Easy to be infected with RTIs/STDs	28.2	26.5	27.3
Childless	29.6	38.6	34.1
Possibility of death	19.4	25.1	22.3
No problems	1.1	1.2	1.1
Others (health effects)	22.9	11.2	17.0
Don't know all 4 consequences	38.4	37.8	38.1
Knowing 1 consequence	42.8	36.4	39.6
Knowing 2 consequences	17.5	19.1	18.3
Knowing 3 consequences	1.3	3.8	2.6
Knowing 4 consequences	0.1	2.9	1.5

Table 221. The proportions of people who have experienced abortion and number of abortions (men noting for wives)

Information	Women (n=1459)	Men (n=1456)	Total (n=2915)
Had experienced abortion	9.2	3.7	6.4
Once	87.3	77.8	84.6
Twice	10.4	20.4	13.3
3 times	1.5	0.0	1.1
More than 3 times	0.0	1.9	0.5
Never	88.6	94.2	91.4
Don't know/don't remember	2.3	2.1	2.2

*Interviewing women and men*

**Table 222. Abortion by province, in percent**

Provinces	Women	Men	Total
Phu Tho	13.4	9.1	11.2
Ha Giang	6.7	6.2	6.5
Hoa Binh	7.7	1.9	4.8
Tien Giang	17.1	3.9	10.6
Four provinces	11.2	5.3	8.3
Ben Tre	8.8	1.4	5.1
Ninh Thuan	9.0	3.4	6.2
Kon Tum	1.4	0.0	0.7
Three provinces	6.4	1.6	4.0
Total	9.2	3.7	6.4

Table 223. Place of abortion (men noting for their wives)

Places	Women (n=134)	Men (n=54)	Total (n=188)
Public health facilities	78.4	85.2	80.3
Private health facilities	20.9	14.8	19.1
Semi-public health faculties	0.7	0.0	0.5

Table 224. Complications during abortion (men noting for their wives)

Complications	Women (n=134)	Men (n=54)	Total (n=188)
Haemorrhage/prolonged bleeding	3.0	3.7	3.2
Retained placenta	0.7	0.0	0.5
Complication treated at hospital	0.0	0.0	0.0
Smelly vaginal discharge	1.5	0.0	1.1
Don't remember	1.5	1.9	1.6
Other	2.2	5.6	3.2
Don't know	0.7	0.0	0.5
No complications	91.8	88.9	91.0

Table 225. Percentage of SPs who had clients for RH care services

Services	Province (n=105)				District (n=136)				Commune (n=414)			
	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)
Safe motherhood	88.6	2.9	1.9	4.8	83.8	9.6	0.7	2.2	54.6	19.3	12.8	6.0
Family Planning (allowed to practise at all three levels)	71.4	6.7	9.5	8.6	77.2	15.4	2.9	1.5	57.0	19.1	18.4	4.8
Family Planning (allowed to practise at only the provincial and district levels)	10.5	2.9	7.6	9.5	2.2	1.5	2.2	9.6	0.7	0.2	0.2	1.0
Abortion	50.5	7.6	3.8	9.5	61.8	18.4	2.9	0.0	13.0	7.7	7.2	5.8
RTIs/STDs	68.6	12.4	6.7	5.7	62.5	21.3	8.8	5.1	49.5	16.7	21.0	8.9

Note: (a): number of people practise services daily; (b) weekly; (c) quarterly

**Table 226. Opinions of SPs on status of clients coming to health facilities from 1/1/2004 to 31/12/2004, according to levels**

Information	Province (n=105)	District (n=136)	Commune (n=414)
Many	28.6	21.4	12.4
Average	35.7	60.7	66.2
Few	35.7	17.9	21.4

**Table 227. Number of clients visiting CHCs from 1/1/2004 to 31/12/2004**

Information	Commune (n=206)	
	One year	One day
Average number of patients coming to health facilities	4440.4 ± 3677.0	12.2 ± 10.1
Average number of patients/health staff	1107.3 ± 919.8	3.0 ± 2.5

**Table 228. Proportion of respondents knowing population collaborators or village health workers**

Knowledge	Women n=1459	Men n=1456	Adolescents			Total n=4379
			Men n=637	Women n=827	Total n=1464	
Yes	85.1	83.2	53.7	58.0	56.1	74.8
No	14.9	16.8	46.3	42.0	43.9	25.2

**Table 229. Proportion of respondents who had received RH information from population collaborators or village health workers**

Information	Women n=1244	Men n=1211	Adolescents			Total n=3278
			Men n=342	Women n=481	Total n=823	
Yes	93.7	87.9	62.9	76.1	70.6	85.8
No	6.3	12.1	37.1	23.9	29.4	14.2

**Table 230. The proportion of respondents who knew of places that sold and provided condoms and oral contraceptive pills**

Places	Women n=1459	Men n=1456	Adolescents			Total n=4379
			Men n=637	Women n=827	Total n=1464	
<i>Condoms</i>						
CHCs	70.9	84.3	61.4	63.6	62.6	72.6
Population collaborators/village health staff	48.9	51.9	24.2	25.5	24.9	41.9
Pharmacies	37.6	37.1	45.5	43.9	44.6	39.8
Private health facilities	1.7	0.6	2.0	4.0	3.1	1.8
Friends	0.0	0.1	0.0	0.2	0.1	0.1
Others	0.9	0.3	3.1	3.3	3.2	1.5
Don't know	14.2	4.7	25.6	27.1	26.4	15.1
<i>Oral pills</i>						
CHCs	73.7	82.9	59.3	66.1	63.2	73.3
Population collaborators/village health staff	51.4	49.2	23.9	26.5	25.3	42.0
Pharmacies	37.8	35.6	43.5	45.3	44.5	39.3
Private health facilities	2.0	0.6	2.4	5.1	3.9	2.2
Friends	0.0	0.1	0.2	0.0	0.1	0.1
Others	0.9	0.2	2.8	3.7	3.3	1.5
Don't know	9.2	5.8	27.9	22.0	24.6	13.2

**Table 231. The proportion of respondents reporting on midwives' counselling at last delivery (two target groups)**

Contents	Women (n=1291)	Men (n=1277)	Total (n=2568)
Following up the mother and child's health	65.2	65.9	65.6
Breastfeeding	84.6	67.2	75.9
Vaccination	83.8	68.3	76.1
Using contraceptives when resuming sexual intercourse	50.4	44.0	47.2
Counselled but did not remember	4.8	10.2	7.5
Others	1.1	0.6	0.9
Did not receive counsel	3.7	10.8	7.2

**Table 232. Issues discussed with clients for abortion**

Contents	n = 134	%
Pregnancy check-up and discussion on keeping or aborting	59	44.0
Consequences of abortion	61	45.5
Advice on using contraceptives	63	47.0
Return if needed	77	57.5
Others	5	3.7
Did not inform	23	17.2

**Table 233. Opinions of community on the quality of RH care services at CHCs**

Opinions	The proportion of respondents agreed with the statements (%)			
	Women n=1439	Men n=1436	Adolescents n=1417	Total n=4292
Health workers are always available at CHCs	91.6	88.2	82.6	87.5
Health workers are always helpful and open	89.2	78.3	69.4	79.0
Clients don't wait long	73.7	69.6	49.3	64.3
The CHC is clean and comfortable	88.1	84.1	72.3	81.5
There is a separate area for unmarried persons	12.7	15.7	14.7	14.4
Health workers are highly qualified	66.7	63.4	53.6	61.3
Health workers spend time to talk with clients about their health	63.4	53.1	44.6	53.7
Client information is kept confidential	65.2	67.0	51.9	61.4
Equipment is sufficient and clean	63.0	66.5	55.9	61.8
Communication materials are available on contraceptives (pictures and pamphlets are available)	89.2	89.1	78.5	85.6
Informative materials are available to distribute to visiting people and clients	57.7	47.7	43.8	49.7
Essential drugs are available at CHCs	86.5	84.5	85.0	85.4
Satisfaction with service quality	82.3	78.3	65.3	75.3

Table 234. Agreement with selected statements on CHCs (among 13 statements), percent

Provinces	Women	Men	Adolescents	Total
Phu Tho	11.1	10.0	10.9	10.6
Ha Giang	6.7	8.0	7.6	7.4
Hoa Binh	10.0	10.5	8.4	9.6
Tien Giang	11.4	10.7	9.1	10.4
Four provinces	9.8	9.8	9.0	9.5
Ben Tre	10.0	10.0	5.9	8.6
Ninh Thuan	8.7	8.0	5.2	7.3
Kon Tum	7.3	4.9	6.8	6.3
Three provinces	8.6	7.6	6.0	7.4
Total	9.3	8.8	7.7	8.6

Table 235. Opinions of the community on the quality of RH care services at district hospitals

Opinions	The proportion of respondents agreed with the statements (%)			
	Women n=579	Men n=677	Adolescent n=436	Total n=1692
Health workers are always available at health facilities	97.4	96.5	96.8	96.9
Health workers are always helpful and open	86.2	72.8	68.3	76.2
Clients don't wait long	63.9	64.8	42.2	58.7
The facility is clean and comfortable	88.9	89.4	83.9	87.8
There is a separate area for unmarried persons	15.0	34.0	17.4	23.2
Health workers are highly qualified	75.0	70.5	75.9	73.4
Health workers spend time to talk with clients about their health	57.0	58.8	52.3	56.5
Client information is kept confidential	67.9	73.1	60.6	68.1
Equipment is sufficient and clean	75.1	76.5	76.8	76.1
Communication materials are available on contraceptives (pictures and pamphlets are available)	88.8	91.3	90.1	90.1
Informative materials are available to distribute to visiting people and clients	50.1	45.3	50.9	48.4
Essential drugs are available at health facilities	95.7	87.9	95.2	92.4
Satisfaction with service quality	80.8	73.0	77.5	76.8

**Table 236. The proportion of opinions agreed about the statements given out on the district health facilities (among 13 statements)**

Provinces	Women	Men	Adolescents	Total
Phu Tho	10.2	10.0	10.8	10.3
Ha Giang	9.2	10.3	9.3	9.4
Hoa Binh	10.5	9.9	6.5	9.3
Tien Giang	10.6	11.1	10.1	10.6
Four provinces	10.3	10.4	9.6	10.1
Ben Tre	9.5	11.6	7.6	10.0
Ninh Thuan	7.8	9.7	8.2	8.5
Kon Tum	7.5	5.2	7.9	6.5
Three provinces	8.4	8.3	7.8	8.2
Total	9.4	9.3	8.9	9.2

**Table 237. Knowledge of respondents on clients' right on RH care**

Information	RH staff	Pop./FP staff	Educators	SPs	Service users
	n=635	n=848	n=1066	n=655	n=4379
Be provided with information	71.7	52.8	48.9	71.8	24.4
Have access to RH services and Information	57.5	38.6	32.7	55.4	17.0
Free to select, refuse or stop using contraceptives	77.6	58.0	45.1	71.6	12.9
Receive safe services	49.3	30.8	27.4	50.5	9.5
Information kept confidential	60.5	37.7	32.4	61.4	11.1
Have privacy	44.4	26.2	22.6	39.5	2.9
Be comfortable when receiving health services	56.2	30.7	30.2	39.5	6.4
Be respected	37.2	19.3	17.8	52.4	9.6
Can receive the services as wanted	46.1	24.2	22.7	40.3	5.4
Can express opinions about quality of services	62.4	40.6	28.8	59.5	10.9
Don't know 10 rights	8.7	16.5	25.0	9.2	55.7
Knowing 1 right	4.7	10.6	10.9	4.4	14.2
Knowing 2 rights	9.0	17.8	13.6	11.6	13.8
Knowing 3 rights	11.3	10.8	14.2	8.5	7.5
Knowing 4 rights	8.2	9.0	9.1	7.9	3.9
Knowing 5 rights	6.5	9.8	8.1	9.3	2.2
Knowing 6 rights	6.3	8.3	5.6	9.2	1.4
Knowing 7 rights	9.0	5.9	4.0	8.2	0.6
Knowing 8 rights	8.2	4.0	2.9	6.9	0.2
Knowing 9 rights	6.9	1.9	1.5	4.6	0.2
Knowing 10 rights	21.3	5.5	5.3	20.2	0.3

Table 238. Average number of clients' rights (among the 10 rights) mentioned by respondents

Provinces	Community				SPs
	Women	Men	Adolescents	Total	
Phu Tho	2.7	2.9	2.8	2.8	7.7
Ha Giang	1.0	1.0	0.7	0.9	5.9
Hoa Binh	1.0	1.1	1.5	1.2	6.4
Tien Giang	1.1	0.5	1.0	0.9	9.6
Four provinces	1.5	1.4	1.5	1.4	7.4
Ben Tre	1.4	0.0	0.7	0.7	3.5
Ninh Thuan	0.2	0.9	0.6	0.6	3.3
Kon Tum	0.3	0.4	1.3	0.7	1.5
Three provinces	0.6	0.4	0.9	0.6	2.7
Total	1.1	1.0	1.2	1.1	5.4

Table 239. Percentages of reasons for the less prevalent use of condoms and oral pills in community

Reasons	Community	SPs
<i>Condoms</i>		
Condom is not available for sale	2.8	5.0
Cannot afford to buy	1.5	5.5
Not good quality	7.8	9.5
Afraid of side effects	13.2	33.1
People don't like	26.3	47.9
Uncomfortable when buying or asking for condoms	6.1	22.7
Sensation reduced	-	66.1
Failed method	6.6	16.5
Poor education and communication	2.8	7.8
People don't know about condom use	3.5	1.8
Other (inconvenient)	-	12.2
<i>Don't know/Don't answer</i>	-	0.8
<i>Oral pills</i>		
Pills are not available for sale	3.9	6.1
Cannot afford to buy	1.5	6.6
Not good quality	-	2.1
Afraid of side effects	46.4	64.0
People don't like oral pills	-	19.4
Uncomfortable when buying or asking for pills	2.9	12.4
Failed method	10.3	18.0
Poor education and communication	3.2	7.2
People don't know about pills	6.3	2.1
Other (easy to forget)	39.8	38.9
<i>Don't know/Don't answer</i>	-	1.1