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UNFPA

Childbirth in Ethnic Minority Communities

A Qualitative Study in Binh Dinh Province

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Table of contents

Lits of Tables

Trang

List of Abbreviations

BCC	Behaviour Change Communication
DOH	Department of Health
ICPD	International Conference on Population and Development
IEC	Information-Education-Communication
IUD	Intra-Uterine Device
MDG	Millennium Development Goals
MOH	Ministry of Health
NZAID	New Zealand's International Aid & Development Agency
PCPFC	Provincial Committee for Population, Family and Children
RH	Reproductive Health
STDs	Sexually Transmitted Diseases
SWOT	Strength, Weakness, Opportunity, Threat
UNFPA	United Nations Population Fund

Preface

The United Nations Population Fund (UNFPA), in collaboration with the Binh Dinh People's Committee, is in the final implementation stage of a US$3 million project on maternal and child health scheduled for completion at the end of 2008. The project is funded by the New Zealand International Aid and Development Agency (NZAID).

In 2005, the mid-term review concluded that, while the project had made positive progress in delivering quality reproductive health services to the urban and lowland populations of Binh Dinh province, this was less evident among the more vulnerable ethnic minority people living in mountainous and remote areas, and among migrants and youth.

In response to this situation, a qualitative research study was undertaken in September, 2007, led by Mr. La Manh Cuong, lecturer from the Hanoi School of Public Health, to determine the current situation and to make recommendations for improvements. The study included a short field visit to 3 of the project communes of the H're, Bana and Cham minority groups in An Lao, Vinh Thanh and Van Canh districts, respectively.

Particularly, the research team focused on identifying the strengths, weaknesses, threats and opportunities inherent in the existing reproductive health service and delivery network available to ethnic minority people living in these geographically challenging areas. This report examines the results of the research study, raises discussion on culture and traditions that prevent optimum access to the health network and finally and makes recommendations on how RH service delivery might be improved.

I would like to thank Mr. La Manh Cuong for completing the study. I would also like to thank Dr. Duong Van Dat and Dr. Nguyen Tien Dung of UNFPA Viet Nam for providing coordination and technical support for the study. Special thanks to Mr John Egan of NZAID for his constructive and valuable comments.

On behalf of UNFPA, I uphold the view that the findings in this report will be particularly useful to policy makers, programme managers, health professionals and donors in designing and implementing more appropriate reproductive health programmes for ethnic minority people, in alignment with the Millennium Development Goals and commitments of the International Conference on Population and Development.

Ian Howie
Representative
UNFPA in Viet Nam

Executive summary

This report documents and analyzes the results of a small, qualitative study of RH health delivery and services provided to ethnic minority people living in three communes located in mountainous and remote districts of Binh Dinh province, Vietnam.

The study included data collection in An Lao, Vinh Thanh and Van Canh districts between 27-29 November, 2007. Primary data was collected during in-depth interviews, focus group discussions and from non-participatory observations. Working sessions were recorded and videotaped, then transcribed and analysed in accordance with each study objective. Secondary data was resourced from the project base line survey, mid-term review study, relevant project documents and sub-contract reports.

Objectives, discussion, analyses and recommendations of the research study can be found in the main content of this report. Some key findings and recommendations can be summarised as follows:

- Many commune clinics in the three districts covered by this study which were provided with equipment and facilities for clinical deliveries have few or no clients. The skills and knowledge of health workers, therefore, eroded.
- Understanding of the birth giving practices and customs of the ethnic minority, for example, the uncomfortable feeling of exposing private parts to health workers, the fear of having perineum cut after delivery, the use of fire, worship and herbal medicines, mid-wife support, and specific birth delivery positions, remains poor among health workers. The study found two thirds of the health workers in three communes had never witnessed any home-based delivery.
- The existing reproductive health services are not relavant to the local customs and practices. Of the three communes visited, only Vinh Kim can accommodate in-patients while the other two are unable to offer client beds either before or after delivery.
- Availability of trained health workers is limited, with health workers responsible for other programmes at the same time (tuberculosis, malaria, child immunisation, and reproductive health) which affects their capacity to provide reproductive health services.
- Preference of fast track to district-level clinics for delivery is common among ethnic minorities, particularly in Vinh Thanh district.
- Monitoring of project activities at the local level remains limited and infrequent because, among others, district-level health workers are insufficient, transportation difficult, and coordination between the health centers and family planning teams inadequate. Monitoring of community behaviour change communication (BCC) activities is difficult as it usually takes place at night.

Background Information

Brief description of the maternal and child health project in Binh Dinh Province

The project entitled "Improving the quality and utilisation of maternal and child health services in Binh Dinh Province" (VIE/03/P20) was designed and developed by UNFPA in partnership with central ministries and implemented by provincial authorities with financial, support from NZAID. The project was initiated during the UNFPA Sixth Programme (2001-2005) and is scheduled for completion at the end of 2008 in compliance with the mandate of the Seventh Country Programme (2006-2010)

The project aims to improve the quality of life for women, adolescents and children in specific districts of Binh Dinh province, home to 30,578 ethnic minority people of which the Bana, Cham and H're comprise 2%.

The project objectives are:

1. To strengthen the capacity of the DOH in providing quality maternal and child health services.
2. To strengthen the capacity of the DOH, PCPFC and involved organisations in providing education, access to RH information and specific services for adolescents and young people.
3. To increase the support of leaders at all levels for, and the participation of the community in implementing maternal and child health activities by improving advocacy and BCC capacity of staff in the Department of Health (DOH), Provincial Committee for Population, Family and Children (PCPFC), mass organisations, and mass media.
4. To strengthen the capacity and skills of the MOH and involved organisations in supervision, monitoring and evaluation; and provision of technical backstopping for maternal and child health related activities.

The project, initially scheduled from February 2004 to December 2007 was extended to December 2008. The UNFPA and the People's Committee of Binh Dinh Province are the co-executing agencies. NZAID provided USD 2,993,760 to fund the project.

Rationale

Recent studies in Vietnam indicated that reproductive health status of ethnic minorities is poorer than the national average. According to WHO, infant mortality rate (IMR) in Western North was 58.3‰ and Central Coast 40.6‰ compared to the national level 36.7‰ (WHO, 2003). Data from 2007 population change survey indicated that total fertility rate (TFR) for Central Highland region where a big proportion of ethnic minority groups reside, is 2.77 compared to the national average of 2.07 (GSO, 2008).

The research team holds the view that there are several factors behind the persistence of poor health conditions, particularly reproductive health, for ethnic minority people. They have less access to good quality health services compared to the majority population; they live in more challenging geographical conditions (mostly in mountainous and remote areas); they speak different languages; their religious practices and traditional customs are poorly understood by the mainstream population; and their infrastructure and facilities, including transport, electricity and water supply, are inadequate.

In response to these poor conditions the Government of Vietnam introduced the National Strategy on Reproductive Health 2001-2010, aiming "to achieve by the year 2010 a marked improvement in the reproductive health status and narrow the gap between the regions and target groups, by better meeting the changing reproductive health needs over the life cycle, and to do so in ways that are sensitive to the diverse circumstances of local communities, with particular attention to disadvantaged areas and target-groups."

More specifically, the Strategy anticipates improvement in several reproductive health indicators by 2010. These include: adoption of modern contraceptives, 70%; infant mortality rate, 70/100,000; decrease in abortion rate, 50%; decrease in infant low birth weight rate, 6%; decrease in number of malnourished children under aged 5 years, 20%.

During the past three decades, UNFPA has established its reputation in Viet Nam as a leading organization in the area of population and reproductive health/family planning. The current UNFPA Country Programme 7 (2006-2010) continues to focus on disadvantaged communities by improving reproductive health facilities and services, and addressing key RH issues in BCC and training activities for the general public and policy-makers.

The is no doubt that the health conditions of women and children in the mountainous and remote regions are relatively poor compared to other more accessible parts of Binh Dinh province. This is evidenced in the baseline survey conducted by the United Nations in 2007, The survey also found that in the mountainous areas, only 40% of pregnant women received three or more ante-natal checkups; and only 10% of deliveries were assisted by trained health workers (whereas the provincial average rates are 78% and 50% respectively).

In Binh Dinh province, the ethnic Bana account for 55.9% of the ethnic minority population, the H'rê, 26.6% and the Cham 16.6%. The project emphasises improvement in the capacity and quality of health care networks and expansion of maternal and child health services and delivery in 22 specifically identified communes in An Lao, Van Canh, Vinh Thanh, Hoai An and Tay Son districts.

The mid-term review reported encouraging improvements in quality of health services for women, children and adolescents and in delivery capacity of community and health care networks at all level (UNFPA, 2005). However, the review also found the project had been less successful in meeting the challenges of delivering reproductive health information and services to the ethnic H're, Bana and Cham people. Indeed, periodical monitoring visits to the districts of An Lao, Vinh Thanh and Van Can reported that, despite input of information, equipment and training, clinics located in remote areas continue to operate in difficult and compromised conditions, providing assistance to very few birth deliveries and, in some cases, none at all.

This situation raises the following questions:

1. Why is such a small proportion of ethnic minority people using the clinic services, despite project investment in infrastructure, medical equipment and human resources training?
2. What are the technical barriers to service delivery?
3. How do traditional customs and practices influence access to reproductive health information and services provided by clinics?
4. What should be done on the supply side to respond to the specific needs of ethnic minority people?

Research Methodology

The research study was implemented in Binh Dinh province with field visits conducted in September 2007, focussing on ethnic minority women in the reproductive age group 15-45, residing in An Dung commune of An Lao district (ethnic H're), Vinh Kim commune of Vinh Thanh district (ethnic Bana) and Canh Hiep commune of Van Canh district (ethnic Cham).

In response to the findings of the mid-term review, the study outlined three objectives:

1. To analyse the mode of delivery of health services for ethnic minority in Binh Dinh province (based on the SWOT model).
2. To examine the influence of local beliefs and cultural customs on health behaviour and practices of the ethnic minorities regarding utilization of RH services; and
3. To make recommendations on how to improve provision of RH care services and IEC/BCC activities for ethnic minority people in the remote and mountainous areas of Binh Dinh province.

Informants included:

At the district level

* Director of the District Health Centre
* Director of the District Bureau of Health
* Family planning officers
* Committee for Population, Family and Children (CPFC) officers

At the commune level

* Director of the Commune Health Centre
* Mid-wives
* Commune population officers

At village level

* Hamlet health workers
* Village leaders
* Healers
* Couples, including women who had given birth at home or at the clinic.

The study combined qualitative methods with ethnographic observation.

Secondary data was resourced from the project base line survey, mid-term review study, project documents and regular project reports. Additional reference material was found in other UNFPA publications and relevant studies.

Field work: Individual and group interviews and non-participatory observations were conducted during the field visit to three mountainous districts of Binh Dinh province. Informants were

purposively recruited. Interviews were based on semi-structured questionnaires to identify: Strengths, Weaknesses, Opportunities and Challenges in the delivery of reproductive health services (SWOT Analysis). These results provided the basis for recommendations. Ethnological observation and audio-visual technology enhanced the research team's understanding on how cultural factors can influence the level of service use.

Interviews were recorded digitally, and then transcribed in conjunction with fieldwork notes. Grounded theory was also applied to analyze information. Findings were categorised to comply with research questions and objectives. Excel (Microsoft word) was used to consolidate data.

In the course of completing this study, particularly the field work, the research team was faced with two constraining factors. First, the language barrier whereby only very few ethnic minority people (mainly ethnic Cham) understood or were able to respond to the interview questions in the Kinh dialect (the main language of Vietnamese). A local health worker helped with translation. However, correct understanding of questions and responses depended on the the skills of the interpreter and, in some cases, this may have impacted on the reliability of information. The second constraint involved the time factor. Geographical conditions, poor roads, faulty telephone lines and lack of mobile phone services all conspired to slow down travel and communication, particularly in accessing the most remote communes of the three districts.

However, despite the geographical and time constraints, the research team felt confident of achieving credible results that would enable substantive analysis and recommendations.

Research Findings

Delivery of reproductive health services to ethnic minorities in the three upland districts of Binh Dinh province

An Lao

An Lao is an upland district of Binh Dinh, covering an area of approximately 70,000 hectares, mainly agrarian and forestry land. Of the population of approximately 26,000 people/6,000 households, ethnic minorities account for 40%, mainly ethnic H're, Bana and Cham. The district consists of nine communes and one town.

The nine communes all have clinics of which six are equipped to provide reproductive health services. The remaining three, An Toan, An Nghia and An Vinh are not in this position.

Of the six communes with adequate health service facilities, An Hoa and An Tam are home to Kinh people while the remainders are home to ethnic minority people. RH services at the commune level include provision of gynaecological examination, contraceptive methods (Intra-uterine device (IUD) insertion, injecting and oral contraceptives, condoms) and birth delivery.

Contraceptive use by men (condoms) remains very limited whereas injecting and oral contraceptives, IUD and female sterilization are widely used among women.

Gynaecological examination and treatment services are confined to infectious diseases caused by poor hygiene. No reports are available on STD detection and treatment.

> *Gynaecological diseases here are not as complicated as in the city, mainly infection caused by poor hygienic conditions. We have not detected any STD yet.*
>
> (A family planning team member)

Safe motherhood service delivery in the six communes, include ante-natal care, regular ante-natal checkup, and vaccination against tetanus for mothers. In the remaining three communes, the family planning team conducts regular ante-natal checkups and vaccination against tetanus for pregnant women.

The record shows that, of the six clinics provided with facilities, equipment and personnel for birth attendance and deliverery, only An Hoa received clients while the remaining five commune clinics had none.

> *Clinical delivery is conducted only in An Hoa commune whose population is Kinh. It is well equipped and staffed.*
>
> (A family planning team member)

Vinh Thanh

Vinh Thanh district comprises nine communes and one hamlet, including two newly-divided communes (i.e. Vinh Tap and Vinh Thanh townlet), where health facilities and infrastructure are under construction. Reproductive health services are available in seven communes, including ante-natal care and counselling, gynaecological examination, oral and other contraceptives.

However, significantly few clinical deliveries take place in any of the seven communes. An in-depth interview between the research team and Bureau of Health officials revealed that in the two of the most remote communes, inhabited by ethnic Bana, the option of home birth delivery prevails. Clients in the remaining five communes most often travel to the the district health centre for delivery, bypassing the services of the commune clinics.

Although ante-natal checkup and gynaecological examination are available at the Vinh Kim commune clinic, there are very few deliveries. This is evidenced by the fact that, of the 14 deliveries in the first six months of 2007, seven took place at home (50%), five at the commune clinic, and two at the district health centre.

Table 1: Ante-natal Check-up in Vinh Kim Commune

No	Activity	Description	In 2006	First half of 2007
1	Antenatal care	Number of women receive antenatal checkups	34	14
		Average number of antenatal checkups	03	03
		Number of women get vaccinated against tetanus	34	14
2	Delivery	Number of deliveries in health setting	17	07
		Number of deliveries assisted by health workers	17	07
		Total deliveries	34	14
3	Postnatal care	Number of women receive at least one postnatal care	10	04

As can be seen from the table, 50% of deliveries were conducted at the clinics in 2006 and in the first half of 2007, with less than 30% of women seeking post-natal care.

The commune clinic worked with the family planning team to provide 70 women with gynaecological examination, of which 65 receive treatment, reflecting the high prevalence of gynaecological diseases.

Table 2: Percentage of people using contraceptives in Vinh Kim Commune in 2006 and 2007

No	Activity	In 2006	In first half of 2007
1	IUD	32	36
2	Injections	62	44
3	Oral contraceptives	86	104
4	Condoms	53	05
5	Sterilization	0	0
Total of couples adopting modern contraceptives		**233**	**189**

Van Canh District

Van Canh is an upland district in the south of Binh Dinh province, 40 kilometers from Quy Nhon City. Its terrain is characterized by hills, mountains and forest. The district comprises seven communes, namely, Canh Vinh, Canh Hien, Canh Hiep, Canh Thuan, Canh Hoa, Canh Lien and one townlet. Van Canh district has a population of 24,500 people, mainly ethnic Kinh, Cham and Bana, of which 6,504 are women aged between 15 and 49 years.

With project support, health centres have been built in the seven communes, and health workers have completed short training courses, ranging from three to nine months.

Despite the provision of services and equipment in the 7 seven commune clinics, including condoms, injecting and oral contraceptives, IUD insertion, and ante-natal checkups, most clinical deliveries continue to be conducted in the communes of Canh Hien and Canh Vinh where the majority population is ethnic Kinh. Of the five remaining communes, only one reported a clinical delivery with clients preferring to fast track to higher level clinics (mainly to townlet centre) with home-based delivery prevailing in the remaining four communes.

An officer of Van Canh Bureau of Health, a former leader of the family planning team, confirmed that home-based delivery is high in the ethnic Cham community, accounting for 100% in Canh Lien, 50% in Canh Hiep, and 40% in Canh Hoa. These births are often assisted by a traditional healer. He attributes the low rate of clinic-based delivery to lack of client trust in both services and health workers. Further, the fact that there is no accommodation in the clinics either before or after delivery, is a further inconvenience.

Table 3: Record of clinical deliveries at the commune health centres in Van Canh district in the first half of 2007

Commune	Total deliveries	Prenatal checkup 3 or more times	Delivery at the public clinic	Delivery at the private clinic	Home-based delivery	Delivery without health workers
Canh Vinh	68	68	58	10	0	0
Canh Hien	14	14	12	2	0	0
Canh Hiep	18	12	10	0	8	8
Canh Thuan	21	19	7	0	14	14
Canh Hoa	27	24	10	0	17	17
Canh Lien	19	0	0	0	19	19
Townlet	36	30	33	0	3	2
Total	**203**	**167**	**130**	**12**	**61**	**60**

Source: Van Canh Heath Statistical Report, first and second quarters of 2007

Canh Thuan, Canh Hoa and Canh Lien communes report a high rate of home birth deliveries. The study team visited Canh Hiep, ranking fourth in terms of non-clinic delivery. Of the total 1884 residents, ethnic Cham make up 1,476; Kinh 386; and others 22. There are 943 women aged between 15 and 49. The 2007 third quarter report of the Canh Hiep commune health centre showed that:

Total deliveries	:	29
Number of women having 3 or more ante-natal checkups	:	16 (55%)
Home-based deliveries without health worker's assistance	:	17 (60%)
Number of women having 2 or more post-natal checkups	:	19 (66%)

As verified in the third quarter report, a high rate of home-based deliveries occurs without the assistance of trained health workers (60%) while ante-natal and post-natal care remain at the median level.

The report also confirmed that 285 couples (80%) use contraception for which females take major responsibility (91%) while only 9% of males apply condoms (16 men) or request sterilization (7 men).

The following is the summary of reproductive health services in the three upland communes of Binh Dinh, based on SWOT analysis:

Strengths

(1) The project offered health workers in mountainous districts a chance to be trained and re-trained. Their management capacity is improved as a result of capacity-building courses.

(2) The availability and accessibility of RH services at commune level was enhanced, involving family planning team, obstetrical ward at the health centre, building public trust into the system.

> *The capacity building and provision of medical equipment and facilities result in public trust and better image of commune clinics, which attracts more clients.*
>
> (A district health manager)

(3) The utilization of some RH services increased as the result of IEC promotion. While there used to be a clear gap between ethnic minorities and Kinh; IEC has brought them closer together, removing barriers to health information, and the result is an increasing the number of clinical deliveries in the ethnic minority area.

> *I was told that clinical delivery is better for health so I decide to give birth to the second child at the clinic.*
>
> (A H're woman, aged 20, An Dung commune)

Weaknesses

(1) Skills and knowledge of birth attendants were 'eroded' due to the limited use of services. Two-thirds of commune health clinics have not conducted any deliveries so far.

> *Our trained birth attendants do not have a chance to practice as there is no clinical delivery, for example in the townlet clinic and in Vinh Thuan, so their skills are eroded.*
>
> (A district health manager)

On the other hand, clients are concerned that the lack of personnel may have negative impacts on the quality of service at the clinic.

The clinic now has only one birth attendant who lacks experience and fails to ensure quality, so I do not dare to have clinical delivery.

(A Bana woman, An Dung commune)

(2) Equipment is at risk of being ruined because of (i) few clients, (ii) low-quality or broken parts, (iii) no adequately trained technicians due to high staff turnover.

Equipment is not put into full use, or even not utilised at all. It is reported technical staff in charge of the equipment have been assigned to other jobs or undertake training.

(A district health manager)

(3) The design and model of RH care facilities are outdated, failing to meet the needs of the clients (Current demands and standard require the facility consist of four or five rooms).

We expect the clinic to offer beds and carers for the mother and the child.

(A H're woman, An Dung commune)

(4) As health workers in charge have to work on different programmes, they have insufficient time and resources to dedicate to RH work. Health workers in Van Canh and Vinh Thanh communes lack cultural sensitivity and knowledge of delivery practices of the ethnic Cham and Bana people.

(5) Investment in equipment for delivery services in the commune health clinics near district health centres (particularly Vinh Thanh) is wasteful and ineffective as clients choose to give birth at the district level.

(6) Communication activities conducted in the communes have not resulted in behaviour change as expected.

Opportunities

(1) Information delivery on RH resulting from IEC promotion programs helps strengthen trust among ethnic people and encourages them to seek RH services.

As commune health workers advised me to take ante-natal care, I visited Ms. Ngut (a health worker), a health worker, twice at the clinic for that purpose. I will go to the district hospital for ultrasound test in June.

(A H're woman, aged 24, An Dung commune)

(2) Health facilities have seen an increasing number of clients, despite the trend to fast track to district level, thereby reducing deliveries at home.

The commune clinic does not offer full service, and its equipment is not good. My house is quite near the district hospital. It takes just 20 minutes, so clinical delivery over there is more convenient.

(A H're man, aged 28, An Dung commune)

The provincial people's committee and donors are willing to continue improving health services in ethnic minority areas of the province.

Threats

(1) RH staff turnover has adverse impact on RH services, especially clinic-based delivery, but also undermines gaining the trust of ethnic people.

> *"When I gave birth to this child, Ms. Ngut [a health worker], the commune health worker, was attending a training course. As the head of the clinic was the only birth attendant (as that's a man), I was too embarassed, and decided to give birth at home".*
>
> (A H're woman, aged 19, An Dung commune)

(2) Territory partition threatens the access and support from health workers.

> *Canh Lien commune is isolated, and it takes half a day to travel from one village to another. Let's imagine how a woman can have clinical delivery when she is going into labour. You know, it takes us a day to walk from the commune center to the district.*
>
> (A district health worker)

(3) Lack of understanding and integration of cultural and delivery practices into existing services may continue to restrict client access to clinic-based delivery.

> *Our tradition of home delivery dates back long before the government was formed. Ethnic minorities like us have no difficulty in birth-giving. Only ethnic Kinh people living in modern society face that kind of difficulty. Ethnic minority women just take herbal medicines during home delivery which are as good as taking pills, and have their parents to provide care.*
>
> (A H're patriarch, An Dung commune)

> *Home delivery "position" is better, making the baby stronger. It is difficult to breathe with clinical delivery position. We would go to the clinic for delivery if it was the same as at home with the use of fire.*
>
> (A H'rê woman, aged 25, An Dung commune)

Village health workers do not function properly, especially those in Vinh Kim and Vinh Thanh communes where health workers are men, unsuitable for encouraging women to seek RH services due to gender sensitivity.

(4) The quality of the equipment provided is poor. Field visits found that some of the fetal dopplers were no longer functioning; and obstetrical monitoring machines were broken. In mountainous clinics, many drying machines were under-utilised because of few or no client, or broken due to wrong use.

> *As an officer in charge of monitoring equipment in those clinics, I found that many were made in China with very poor quality, for example, fetal dopplers and gyneacological monitoring machines which were nearly broken. The under-utilised drying machine now looks rusty and unhygienic.*
>
> (A project officer)

Barriers to accessing reproductive health services

Home deliveries have been the normal practice for a very long time in the ethnic H're, Bana and Cham communities of Binh Dinh province, usually supported by a mid-wife or mother-in-law/mother. Women adhere to the belief that they should wear skirts stretching from their hips to ankles to prevent the newborn from falling and their private parts from exposure.

H're and Bana women choose to give birth in a corner of the room, while Cham women give birth in the supine position either inside or outside the house. In addition, making a fire also plays an important role based on the assumption that the newborn leaving from the warmth of the womb will be extremely vulnerable to the cooler termperature. (Currently, the practice of lighting fire is not applied at the local clinic).

Worship is important, often led by a local sorcerer, before and after delivery. The use of herbal medicines is also popular, particularly in the H're culture.

> *Women need to take herbal medicine to take clotted blood out of them after delivery. They need to have fire to keep the child warm and boil the herbal roots.*
>
> (A H're woman, An Dung commune)

Illustration of the H're delivery position in Binh Dinh

It is clear that the birth delivery position of the H're (picture above) differs from the clinical position (picture below). All H're and Bana women interviewed during the research study, agreed that the traditional delivery position is more convenient and comfortable compared to the supine position most commonly used in clinics, that involves lying on a bed with stirrups to hold the mother's legs.

Geographical borders restrict access to services. As the only available means of transport, it takes at least four hours to walk from several of the villages to the commune health centre. This is particularly the case in the mountainous and remote districts where access to health services, particularly clinical delivery, is more restrictive compared with significantly higher utilization of services in lowland areas.

Infrastructure of the commune clinic cannot accommodate women either before or after delivery. District health officers suggest that a standard reproductive health facility should have at least five rooms/beds to accommodate in-patients. In fact, the research team found that most clinics in the three upland districts did not meet this standard, with the exception of the An Hoa clinic in An Lao district.

The tendency of health workers to hold several positions limits the allocation of their time and resources, and detracts from the quality of RH services. Besides reproductive health, a commune health worker may also be responsible for district nutrition, tuberculosis (TB) and vaccination. It is often the case that clients have to wait until a health worker finishes his/her work on TB or vaccination before obtaining reproductive health services.

> *Although a health worker takes charge of reproductive health, he or she is also assigned to do two or three other jobs. They have to do other jobs in response to client demands, despite their fixed RH sessions on Monday, Wednesday and Friday on the timetable.*
>
> (A district health officer)

The high incidence of poverty impacts directly on the level and use of health services. The ethnic people in all three communes in this study exist under extremely difficult circumstances. Despite the fact that pregnant women are targeted by a national programme which provides user fee exemption, this does not include transport, accommodation and meals for those people accompanying them to the clinic. This financial imposition prevents people in remote areas from accessing services, reinforcing the emphasis on home deliveries. Some local women report that district health officers sometimes ask them to pay for napkins and milk for the infant – these payments are not required after giving birth at home.

> *It is not enough to call for clinical delivery because people often cannot afford to cover the costs for those who take the woman to the clinic. Parents cook and relatives prepare herbal medicines during home delivery, which is more convenient.*
>
> (A H'rê patriarch, An Dung commune)

A commune health worker commented:

> *What motivates people here go to the hospital is they are able to get medicine free-of-charge. They will not revisit if they are asked to pay. It is the same situation with delivery. In fact finding money to feed the baby is already difficult, so there is no way for them to pay for delivery services. They say because they are so poor that they rely on government subsidy; this means that asking them for payment is not acceptable.*
>
> (A commune health worker)

Lack of appropriate training, skills and experience is a common trait among commune health workers who are ethnic minority. A health official in An Lao district commented that, despite their training, commune health workers have few opportunities to practice their skills and gain experience in clinic-based delivery. There is also the question of the relevancy of the training content offered to ethnic minority staff returning to work in the mountainous areas. The director of An Lao District Health Centre states:

> *While the training schedule and content are good for some, the ability of H're health workers to absorb information, remains poor. An ethnic minority health worker from a mountainous region may not acquire much knowledge, reflected in the way they tend to remain quiet during the training and are reluctant to ask questions. Trainers do not understand what their needs really are.*
>
> (Director of a District Health Center)

It is difficult to monitor the performance of commune health workers on a regular basis, due to the insufficient number of qualified staff at both district and commune levels. For example:

1. An Lao's four-member family planning team is kept very busy with their daily work at the centre. Yet, the team is also responsible for reproductive health care in the three communes where the RH care services have not been implemented.
2. Collaboration between the Bureau of Health and the District Health Centre isweak particularly in monitoring reproductive health services at the commune level, thus limiting opportunities for intergrated collaboration and information sharing.
3. IEC activities are relatively ineffective and difficult to monitor as they were mainly conducted at night in residential areas difficult to access

IEC activities play an important role in changing community attitudes toward reproductive health thereby increasing utilization of services. Small group communication in An Vinh and Vinh Thanh communes has potential not only to deliver ante-natal care and contraceptive information but also to encourage attendance by men, fathers and patriarchs viewed by the community as the 'gate keepers' in promoting reproductive health services. A change in attitude could lead to an increased number of women opting for clinic-based delivery. However, to be successful, small group communication also needs to provide trainers with strong BCC skills.

> *When asked why they do not give birth at the clinic or have ante-natal checkup, the husband responds that he does not understand the benefits and therefore does not take his wife to the clinic. As the wife depends on her husband's decision, the accuracy of information given to the husband is extremely vital.*
>
> (A family planning team member)

Direct referral to the district level is common practice. There are several reasons why clients choose to fast track to district health centres for delivery services, especially in Vinh Thanh. First, clients feel put more trust in health workers at the district level than at the commune level. Second, district health centres can provide adequate accommodation, including a post-delivery room, where women can enjoy some peace. Third, cultural exchange between Kinh people (mainly living in the central areas) and other ethnic minorities (mainly Bana) has highlighted the benefits of clinical rather than home deliveries among some ethnic groups.

This raises the question of the effectiveness of investment in developing the services of the five clinics located outside the district centre. The Bureau of Health director views this investment as a waste of resources because, without clients, equipment becomes redundant and the skills and knowledge of health workers, eroded.

> *It is a waste of money to invest in equipment for the five communes located near the centre. As long as the services remain under utilized, the knowledge and skills of mid-wives will be further eroded and equipment ruined.*
>
> (a District Health Manager).

On the other hand, the district family planning team responsible for delivering mobile services to those communes without clinics desperately needs this equipment. Yet, when the District commune director was asked why under utilised equipment provided by the project to the

five clinics could not distributed to the family planning team, he responded that the equipment should be kept for emergency cases. This put this point of view despite the fact that the clinics concerned are not providing any birth delivery services.

Relocation of clinics - in the two communes, Vinh Thanh and Vinh Kim, the health centres were relocated to make room for a hydro-power plant. This has interfered with clinic efficiency and operation is yet to be resolved, thus affecting service quality.

Poor performance of the village health workers is compounded by weak coordination at the commune and village levels particularly in Vinh Thanh and An Lao districts. Commune health workers avoid providing local clinic services, either by referring women to the district clinic for delivery, or assisting in home-based delivery.

Gender sensitivity - For of the six health workers in Vinh Kim are men. Although elected to their positions, trained village health workers are unable to apply their skills to home-based deliveries, due to gender sensitivity. Pregnant women feel embarrassed in the presence of a stranger, particularly a man, during delivery, and this discourages ethnic Bana from seeking assistance from male health workers. They are also very hesitant to expose their private parts, a requirement for gynaecological examination at the clinic infront of males who are not their husbands.

> *I am too embarrassed to go to the clinic for delivery, because I have to take off.*
>
> A Bana woman, aged 21, Vinh Thanh

> *Women feel very shy to have a gynaecological examination. They might immediately cover up or leave the examination room, if someone happens to come in.*
>
> (A commune midwife)

Several Bana women expressed fear of perineum cutting, relatively common in clinic deliveries. They heard negative reports from women who had experienced this practice.

> *Women feel too scared to have delivery at the clinic, especially giving birth to the first child, for fear of perineum cutting.*
>
> (A commune midwife)

Interviews with health workers at Vinh Thanh revealed a lack of cultural sensitivity towards the preference of ethnic minority women for home-based deliveries. The majority of Vinh Thanh district health workers and commune midwives are ethnic Kinh. Most have never observed or assisted a home-based delivery nor are they able to communicate with clients in the local ethnic minority dialect. The study found their understanding of local birth sub-cultures very poor. On the other hand, the district health workers tend to blame the limited use of local services by ethnic minority women on their low community educational levels and general lack of awareness.

Recommendations to improve delivery of reproductive health services and IEC activities for ethnic minorities in Binh Dinh province

At the commune level

1. Respect the differences in birth giving practices and customs by acknowledging the needs of ethnic minority women and allowing religious practice before delivery; preferred birth delivery positions (i.e. accommodate traditional birth positions) when requested.

2. Reorganize the clinic to allow adequate space to conduct reproductive health services including rooms for clients stay after delivery.

3. Respect the client, by conducting gynaecological examination, IUD insertion and antenatal checkup in a private and friendly setting.

4. Provide appropriate assistance for home-based delivery including provision of clean delivery package.

5. Target men, patriarchs and community leaders in promoting IEC on RH issues. This can be achieved by carrying out IEC activities in crowded places where men like to gather such as markets and schools.

6. Place priority on meeting training specific needs of ethnic health workers to build their skills for serving their communities in the long term. At present, the mid-wives in Vinh Kim, Vinh Thanh and Canh Hiep come from low lying parts of the province and lack incentive to work consistently or for extended periods in mountainous and remote areas. This results in an on-going shortage and turnover of trained staff.

7. Recruit female health workers at the hamlet level. Training should be coordinated by health workers at the district and commune levels with the purpose of strengthening and improving local capacity to assist with both home birth deliveries and referrals to the commune health centre.

At the district level

8. Strengthen coordination among the health centres, hospitals and family planning teams by conducting capacity building activities for commune level through training and re-training courses, regular updating of knowledge, and raising awareness of cultural sensitivities.

9. Review the equipment provided by the project, and re-distribute to those in need, e.g. to family planning teams.

10. Increase monitoring communication activities at the community by strengthening the collaboration between the health centres and Bureau of Health.

At the provincial level

11. Re-training of ethnic minority health workers at the commune and village levels:
    - Revise training curriculum to become more user-friendly for ethnic minority people.
    - Strengthen health staff capacity and skills in conducting ante-natal examination, gynaecological examination, IUD insertion, and RH delivery services to ethnic minority clients at the health centre/district hospitals. This will not only enhance knowledge, skills and confidence of commune health workers, but also facilitate communication between service providers and clients.
    - Provide health workers and healers in remote areas with clean/sterile delivery packages to assist with home-based birth delivery in those households located far from the nearest clinic.
12. Strengthen coordination between the District Health Centre and Department of Health in delivering services and re-training health workers at village and commune levels.
13. Mobilize fund for upgrading of RH services, including pre- and post-delivery client accommodation, in selected commune health centres to encourage local demand.
14. Guide health workers towards a more integrated cultural approach in providing reproductive health services more compatible to ethnic minority needs; this will require health workers to undergo specific training.

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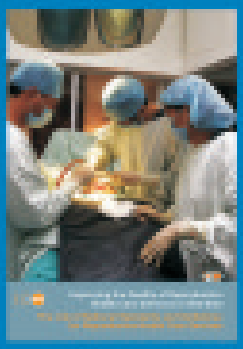



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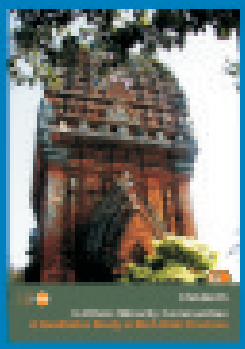
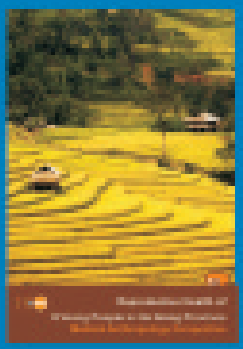

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