STUDY ON THE QUALITY OF FAMILY PLANNING SERVICES IN VIET NAM

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CONTENTS

List of Figures

List of Tables

List of Boxes

Annexes

ACKNOWLEDGEMENTS

Although Viet Nam has made considerable improvements in its family planning service delivery system, there are persistent concerns about the quality of family planning services as well as Viet Nam's contraceptive discontinuation and failure rates.

To meet the high demand for reliable evidence on the quality of family planning services, the Ministry of Health and United Nations Population Fund (UNFPA) Viet Nam commissioned the Human Development Research Centre (HDRC) in partnership with the Research and Training Centre for Community Development (RTCCD) to conduct the "Study on the Quality of Family Planning Services in Viet Nam".

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It is our hope that this report is useful for policymakers, program managers, health professionals, researchers and donors in designing and implementing policies and programs which effectively respond to the modern contraceptive needs of Vietnamese people, toward achieving the ultimate objectives of the International Conference on Population and Development and the Sustainable Development Goals in Viet Nam.

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EXECUTIVE SUMMARY

Over the past four decades, Viet Nam has made considerable improvements in its family planning (FP) service delivery system. However, there are persistent concerns about the quality of family planning services as well as Viet Nam's contraceptive discontinuation and failure rates.

The objective of this study was to conduct empirical research on the quality of family planning services, contraceptive discontinuation and failure rates in Viet Nam using a mixed-methodology. The specific sub-objectives were: (1) to assess the quality of family planning services provided at public and private health facilities across the country; (2) to assess client perception of the family planning service quality and the level of client satisfaction with the family planning services rendered; (3) to explore contributing factors to the quality of family planning services and client satisfaction from both user and provider perspectives; (4) to estimate the overall and method-related discontinuation rate and failure rate and associated determinants and risk factors; and (5) to assess the relationships between service quality and the rates of contraceptive use discontinuation and failure.

Methodology

The study adopted both probabilistic and purposive sampling approaches. A probabilistic sampling method was used to ensure the survey was nationally representative at household and facility levels. Quantitative data was collected through facility surveys and household surveys. The facility survey included five aspects: a checklist of available services and relevant capacity related information (i.e., facility survey), client exit survey, facility manager interview, service provider interview and service delivery observation. The household survey broadly covered 5,998 women (15–49 years of age) across 6 regions, 20 districts, 120 communes/precincts and 240 villages/wards of Viet Nam. The facility survey was conducted within the household survey area. In this study, the quantitative data analysis techniques included uni-variate analysis, bi-variate analysis and more generally, multivariate analysis. The quantitative data were analyzed using Cox regression, odds ratios (Cochran's and Mantel-Haenszel statistics), analysis of variance, linear regression, bivariate and multivariate logistic regression (Hosmer-Lemeshow goodness of fit) and Z-statistic.

Key Findings

Status and quality of FP services: The overall quality of service score (index) for CHCs was 0.88 (out of 1.0), suggesting that most CHCs have the necessary infrastructure, equipment and providers to offer FP services. Nevertheless, only 9.7 percent of CHCs satisfied all 25 facility preparedness indicators. Facility preparedness quality varied by place of residence (urban and rural) and by region. In the North and South Central Coast and Central Highlands, no CHCs satisfied all 25 indicators, but 31.3 percent of CHCs in the southeastern region satisfied all 25 indicators. In terms of provider quality assessment indicators, 27.2 percent of CHCs satisfied all 12 indicators. In the southeastern region, 62.5 percent of CHCs satisfied all 12 indicators, but only 6.7 percent did in the Central Highlands. In contrast, a very high proportion of CHCs satisfied all three of the indicators, reflecting strong management and supervision by relevant authorities. Indicators related to management and supervision also varied by residence (urban-rural) and region. All CHCs in the North and South Central Coast met all three indicators, but only 60 percent did in the Central Highlands. Notably, a proportion of CHCs did not satisfy indicators related to adequate method supply (pill, condom and intrauterine device), about 30 percent of CHCs reported a labor shortage for providing family planning services and only 51.5 percent of providers at CHCs encouraged clients to return for follow-up visits.

The score for district and above-level facilities was 0.75, while the overall quality of service score for non-government (private and NGO) facilities was 0.58.

CHCs are the most popular facilities for family planning services among women using modern contraceptive methods (55.1 percent); 90 percent of women have sought care at CHCs. Comparatively, 15.5 percent have gone to district and above-level facilities and 8.7 percent to private/NGO facilities.

A client spends an average of 11.9 minutes reaching the facility and 10.8 minutes waiting (22.7 minutes total) before meeting a family planning (FP) service provider.

Client satisfaction: 93 percent of clients were satisfied with the services they received, yet only 40 percent would recommend their facility to neighbors and relatives. The most important factors in referring a facility to others were a client's place of residence ($p=0.004$), years of education ($p=0.080$), time it took to reach the facility ($p=0.081$), display of IEC materials ($p=0.065$), providers asking client screening questions ($p=0.068$) and providers suggesting follow-up visits ($p=0.011$).

Contraceptive prevalenrate rate (CPR): The study estimates that 80.5 percent of currently married women aged 15–49 are using any contraceptive method, and 64.4 percent are using modern contraceptive methods. The intrauterine device (IUD) was the most preferred method (25.2 percent), followed by the oral pill (19.3 percent) and condoms (13.3 percent).

The CPR is higher in urban areas than rural. The overall CPR is significantly higher ($p=0.022$) among the Kinh ethnic majority, due to their significantly ($p<0.001$) higher rate of traditional contraceptive use compared to ethnic minorities. The highest CPR, found in the Southeastern Region, was associated with the highest use of traditional methods (27.2 percent). At the same time, the lowest CPR, in the Red River Delta, was associated with the lowest use of traditional methods (10.5 percent). These data suggest reliance on traditional methods and limited modern method use, and indicate a need to consider means of transforming traditional method users into informed users of modern methods. Global evidence reveals transitioning to modern methods reduces the incidence of contraceptive discontinuation, method failure and abortion, and allows modern contraceptive method users to have more control over their fertility and family planning.

Effectiveness was not the only factor that motivated clients to adopt modern FP methods. This study identified a number of diverse influencing factors, such as place of residence, ethnicity, past experience with unplanned pregnancy, number of live births and age at first pregnancy.

FP method discontinuation: The 12-month discontinuation rate is generally high for resupply methods: highest for injectables (58.5 percent) followed by condoms (42.5 percent). IUDs have a much lower discontinuation rate (21 percent). Intention to have children (44.6 percent) was the most frequent reason for discontinuation. About 32.2 percent stopped using their method due to health concerns and 17.7 percent discontinued out of fear of side effects. This suggests inadequate service quality – if users are made aware of the official and verified health impacts and minor side effects, such discontinuation is uncommon. Additionally, 9.8 percent of respondents discontinued due to method failure (2.3 percentage points higher than 2002 estimates), another major concern of service quality.

Method failure: The overall method failure rate was 7.4 percent (i.e., 7.4 percent of FP method use ends in unplanned pregnancy without considering a time boundary). The failure rates were higher for traditional methods ($p<0.001$) than modern methods. On average, 1 in every 6 uses of traditional methods ends in unplanned pregnancy, lowering to 1 in every 20 uses of modern methods. More so, 9.1 percent (i.e., 1 in every 11 women of reproductive age) of women ever experienced unplanned pregnancy. Among them, 24.4 percent experienced unplanned pregnancy more than once.

Pregnancy termination: The total abortion rate (TAR) in Viet Nam is 0.42, in other words, 2 in 5 women experience at least one abortion in their reproductive life. About 17.4 percent of women had experienced both induced and spontaneous termination of pregnancy, 19.6 percent in urban areas and 16.5 percent in rural areas. Across the regions, it varied between as low as 7.7 percent in the North and South Central Coast and as high as 33.5 percent in the Red River Delta.

There was a strong correlation between the age at first marriage, age at first pregnancy and age at first pregnancy termination.

Status of service provider: According to the survey, 37.8 percent of the modern contraceptive method users (irrespective of marital status) did not receive any counseling from FP service providers before adopting contraceptive methods, a concerning sign of inadequate screening.

Though there was moderate awareness of the advantages and benefits of modern contraceptives, there was minimal awareness of possible side effects. This suggests FP service providers need to provide more comprehensive and thorough information, ensuring the basic reproductive right of clients to make informed choices. Only 56.6 percent of modern method users could recall the instructions for the proper use of their current modern contraceptive method, though it is unclear if that is the result of incomplete counseling or a simple lack of recollection on the part of the client. A mechanism to broadcast information about correct FP method use would likely lower the rate of contraceptive discontinuation and incidence of unplanned pregnancy.

Although providers did not ask screening questions in more than one-fourth of instances (26.7 percent), most clients were still satisfied with the services they received. Given the individual nature of choosing contraceptives that suit each person's lifestyle and preferences, screening questions are an integral part of ensuring the feasibility of contraceptive use. Client satisfaction in spite of this absence could indicate: (i) the client was unaware of the importance of screening questions, and/or (ii) the providers relied on the client's choice rather than screening for the appropriate method. Both are vulnerabilities in current family planning services. Though most providers have received training in relevant FP service provision fields, their service delivery is in need of considerable improvement.

Recommendations

Based on the key findings presented above, the following recommendations for policymakers would make substantial strides towards enhancing the quality of FP services as well as client satisfaction in Viet Nam. Moreover, they will help clients be adequately informed and make better choices in the context of access to family planning as part of a human rights-based approach, ultimately reducing contraceptive discontinuation, method failure and abortion rates and promoting reproductive health well-being.

Recommendations for FP laws, policies and programs:

A1: Given the high FP service coverage in the country, the national FP strategy should devote more attention to the quality of sexual and reproductive health and family planning in line with the Programme of Action (POA) of the International Conference on Population Development (ICPD) and Sustainable Development Goals (SDGs).

A2: The Ministry of Health (MOH) should formulate pertinent policies enshrining quality FP services as a right of all eligible citizens.

A3: Given the rapid growth of private and NGO sector engagement in FP service and commodity provision, and service quality concerns in these settings, the government should establish and effectively implement a national mechanism for monitoring and assuring the quality of FP

commodity and service provision at all steps of the product cycles. A specific guideline to facilitate district monitoring teams to supervise FP service quality is needed.

A4: The government should develop national standards and guidelines on quality FP services and commodities in line with World Health Organization (WHO) guidelines.

A5: The General Office of Population and Family Planning (GOPFP) should consider introducing participatory quality FP service delivery audits across facilities, as implemented by representatives from local People's Committees, population and family planning offices, service providers, civil society organizations and relevant research communities.

A6: An appropriate toolkit should be designed for participatory FP service quality audits, using a reproductive health rights-approach in line with the ICPD, national standards and socio-cultural context of Viet Nam.

A7: The quality audit toolkit should be adapted to various regions, residential contexts, types of facilities and quality differentials by facility.

A8: The government should introduce multi-dimensional quality FP services in the quality monitoring and supervision framework at all levels.

A9: Given the significant role of population collaborators in providing non-clinical methods with very high discontinuation rates, the GOPFP should develop national guidelines on monitoring the performance of population collaborators.

A10: As the contraceptive mix is skewed toward intrauterine devices (IUDs), the MOH should strive to balance the contraceptive mix and give clients more choices.

Recommendations for FP service delivery organizations:

B1: The quality of family planning services is a multi-dimensional variable. Therefore, while facility preparedness, provider quality and the status of management and supervision are important, quality improvement programs should consider measuring failure rates and perceived quality of care among clients. Information on client satisfaction collected at exit interviews is not a good indicator for measuring the quality of FP services.

B2: Given the high rate of natural contraceptive users and its high failure rate, the GOPFP should design a strong communication strategy to minimize the use of natural methods and increase the rate of modern contraceptive use, particularly in Southeastern Region.

B3: The study found a number of facilities still have relatively low overall quality of service scores, and particularly low scores in one or more specific components. Interventions should focus on enhancing service quality at these facilities, especially facility preparedness and skilled human resources.

B4: To ensure clients have the information they need to make informed choices, counseling should provide more details on various aspects of family planning services (advantages and disadvantages, side effects, instruction on proper use of methods, etc.) as well as addressing the needs of new clients and clients intending to switch methods. In addition, counseling must include proper screening of new clients as well as before they start using a new method. It should also cover pre- and post-abortion counseling, which, in turn, will help prevent repeat instances of unplanned pregnancy and its inherent unmet need for contraception.

B5: The GOPFP should develop culturally sensitive FP services that provide more FP options for ethnic minority women, promoting their ability to make informed choices and reducing the contraceptive discontinuation rate among these vulnerable groups.

B6: The GOPFP, along with relevant bodies, should undertake measures to ensure a consistent supply of all types of contraceptives are distributed to respective facilities in compliance with MOH regulations.

B7: The MOH and GOPFP should ensure all facilities have an adequate number of trained staff to provide quality family planning services.

B8: Foundational trainings on FP services as well as periodic basic refresher trainings are needed for all staff involved in providing FP services.

B9: The Department of Health (DOH) and Department of Population and Family Planning (DPFP) should consider establishing independent or inter-district teams to conduct monitoring and supportive supervision along with providing hands-on training where necessary.

B10: The client charter of rights should be widely disseminated across the country, involving all relevant stakeholders and using all possible channels (including mass and virtual media).

B11: Arrangements should be made to display culturally appropriate and adequate information, education and communication (IEC) FP service-related materials in all relevant facilities.

B12: Vigorous behavior change communication (BCC) activities should be geared toward male participation in family planning to increase the use of male condoms and vasectomies and balance the currently skewed contraceptive mix.

Recommendations for the FP research agenda:

C1: Conduct the national FP service survey every five years to track the status of reproductive health, including FP services, with a special emphasis on the quality of FP services, contraceptive discontinuation, method failure, abortion and unmet contraceptive need.

C2: Based on secondary analysis of the survey data, the following thematic research monographs can be developed: (i) FP services: Quality and client satisfaction in Viet Nam; (ii) Client needs and client satisfaction in rights-based family planning services: A Viet Nam case study; (iii) Contraceptive discontinuation, switchover and method failure abortion in Viet Nam; and (iv) International Conference on Population Development, Sustainable Development Goals and FP services in Viet Nam.

Key Results

Indicator	Estimate (%)
Contraceptive prevalence rate (married women aged between 15 and 49 years)	80.5
Modern method use rate	64.4
Percentage of current modern FP method users who adopted a method without counseling from an FP service provider	37.8
Percentage of current modern FP method users who do not have adequate knowledge about correct contraceptive method use	43.7
Percentage of CHCs in highest quality group	46.6
Percentage of CHCs in lowest quality group	6.8
Percentage of clients who would refer their facility to others	40.2
Overall FP method discontinuation rate	32.3
Percentage of discontinuation due to method failure	9.8
Overall method failure rate	7.4
Percentage of women aged between 15 and 49 who have ever experienced unplanned pregnancy	9.1
Total abortion rate	0.42
Percentage of women aged between 15 and 49 who have ever experienced induced or spontaneous pregnancy termination	17.4


HIV/AIDS

CHAPTER 1: INTRODUCTION

1.1 Background

1.1.1 History of FP Service Delivery in Viet Nam

Family planning (FP) is one of the most cost-effective public health interventions for reducing maternal mortality and morbidity and helping improve women's equity, equality and empowerment. FP saves lives by preventing unplanned pregnancies. It also minimizes the need for abortions and lowers the risk of mortality due to factors related to pregnancy and childbirth.

Globally, despite extensive efforts and investments to reduce maternal mortality, the rate remains alarmingly high in many developing countries. Approximately 38 percent of pregnancies in Asia are unplanned and 21 percent of all pregnancies end in induced abortion, indicating a high unmet need for contraception. Meeting the unmet need for contraception can prevent as much as 70 percent of unplanned pregnancies and lower maternal and newborn mortality rates alongside it. Fully meeting the need for modern contraception would result in an overall reduction of total unintended pregnancies by 74 percent, from 32.2 million to 8.5 million [2]. To transform this into a commendable success, both married and unmarried individuals urgently require improved and unfaltering access to FP services. This also includes making adequate information and regular counseling support accessible.

Viet Nam has made significant achievements in FP programs in recent decades. The population growth rate reduced from 3.8 percent in 1960 to 2.4 percent in 1975 [3], then further to 1.07 percent in 2016 [4]. The total fertility rate (TFR) reduced from 6.3 births per woman in 1960 to 2.09 in 2014 [5].

The FP program in Viet Nam began as an unofficial program in 1963, officially instituted through the Council of Ministers Decree No 162-HDBT/1988 and further reinforced by Resolution 4/1993. The emphasis was rooted in a two-child per couple policy, with 3-5 years between each child [6] and the target population in the 1980s consisted entirely of married women. Since its inception, the FP program in Viet Nam has relied heavily on intrauterine devices (IUDs). Strong campaigns were launched in the 1980s promoting exclusive IUD use, followed by emphatic promotion of female (tubal) sterilization in the mid-1990s. Consequently, for decades, the IUD dominated Viet Nam's contraceptive method mix. Other modern methods, such as pills, injectables and condoms, received little attention [7].

After the Doi Moi (Reform) era, the state was required to supply free birth control devices (such as IUDs, condoms and birth control pills) to health facilities for individual couples of reproductive age. Partly attributed to the emergence of the private sector, other contraceptive methods such as pills and condoms began gaining traction.

However, a recent study demonstrated that not all condoms available in the open market comply with the WHO/UNFPA 2010 Specification requirements for male latex condoms [8]. Other research revealed that 78 percent of married women between the ages of 15 and 49 were using some form of contraception: 67 percent were using a modern method while 11 percent were still using a traditional method [9]. Population collaborators (PC) provide pills and condoms to users in their community for free or with subsidized costs. On the other hand, various FP services are provided at all health facilities, ranging from hospitals to community health clinics, for free, partly subsidized or at full cost.

1.1.2 Current FP Service Delivery System Structure

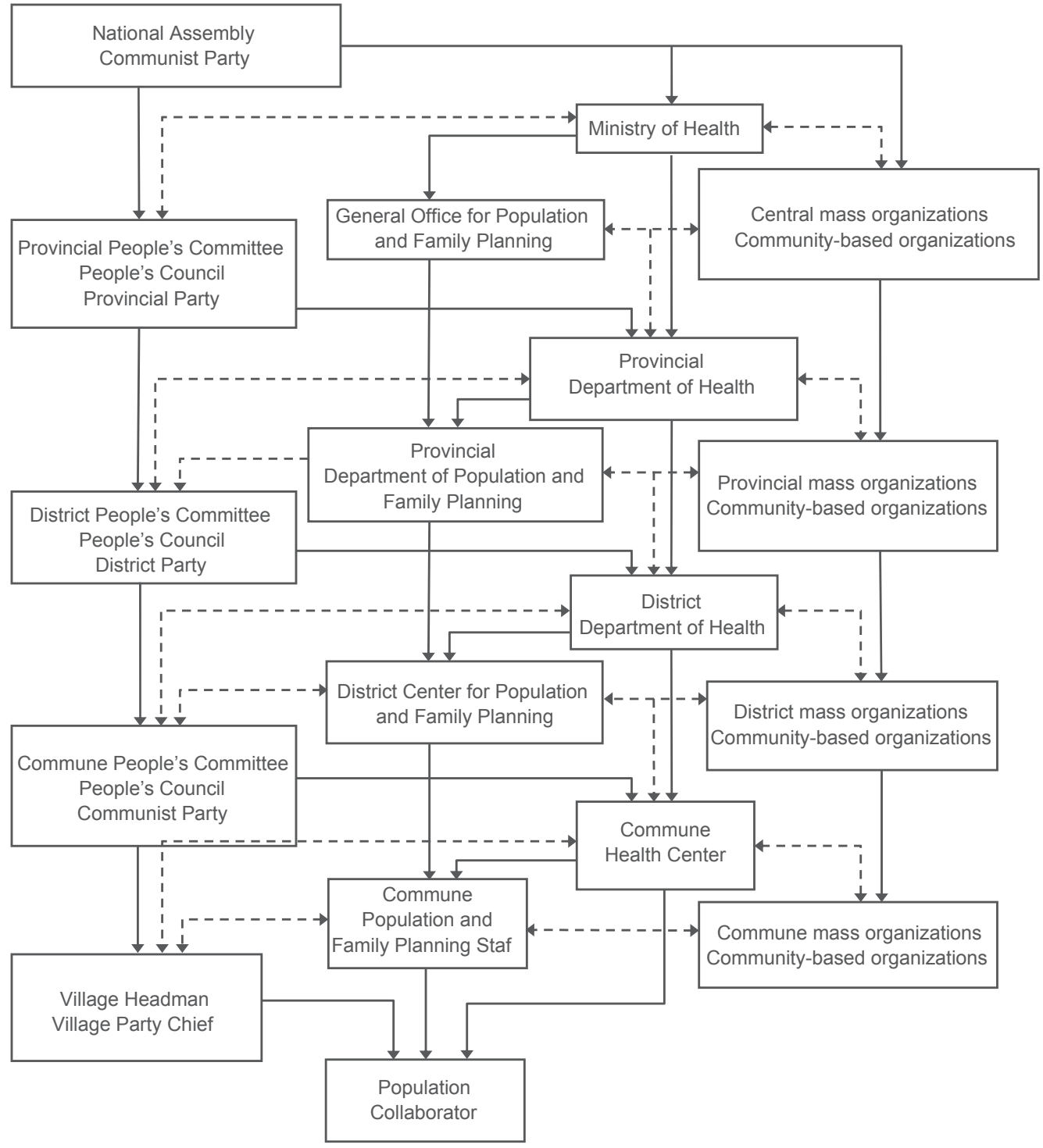
The FP service delivery system underwent structural transformations in the last two decades. In 1992, the Viet Nam Commission for Population and Family Planning was established to coordinate FP service delivery. The commission was then renamed the Viet Nam Commission for Population, Family and Children (VCPFC) in 2001. In July 2007, the National Assembly dissolved the VCPFC and divided its functions into three ministries (the Ministry of Health; Ministry of Labor, Invalids and Social Affairs; and Ministry of Tourism and Culture), and the Ministry of Health (MOH) was tasked with FP services. The General Office of Population and Family Planning (GOPFP) was established under the MOH to manage population and FP related issues shortly after the dissolution of the VCPFC [3]. Figure 1.1. depicts the structure of the population and FP sector in Viet Nam, comprising public and private sectors providing clinical and non-clinical services.

The public FP facilities extend from provincial hospitals to commune health centers (CHC). While the GOPFP assumed overall responsibilities for population and FP related issues, FP services are provided under the Maternal and Child Health (MCH) network at all levels. Each province has a network providing FP services for well-defined target groups. The Provincial Center for Reproductive Health (PCRH), (in Vietnamese Trung tam Cham soc Suc khoe Sinh san tinh), the District Unit for Family Planning and Nutrition (in Vietnamese Doi KHHGD va Dinh duong) and the CHC (in Vietnamese Tram Y te xa) are the main providers of FP services. These services include distributing condoms and contraceptive pills as well as administering IUDs and contraceptive injections. All health facilities – public, private, provincial or commune level – provide counseling services. The private FP sector, including private clinics and NGOs-owned clinics, also provides services like condoms, pills, IUDs and contraceptive injections.

The common feature between the public and private health sectors is that the majority of the health workers have dual responsibilities. For example, they might provide both FP and obstetrics or newborn care services. The major FP workforce is general practitioners or midwives at CHCs and province and district hospitals who were trained on FP techniques.

In addition to public and private sector facilities, FP service delivery system includes voluntary population collaborators (PCs) who provide information on FP and non-clinical contraceptives (pills and condoms) at the household level.

Figure 1.1: Structure of FP service delivery system and its relationship with other organizations



Source: Developed by HDRC study team based on relevant official documents and discussion with leaders and experts of GOPFP.

1.2 Rationale for the Study

Viet Nam's contraceptive prevalence rate (CPR) has seen a substantial increase since the founding of the VCPFC. In 1997, the CPR was as high as 75 percent [10], a 22 percentage point increase from the earlier decade [7]; CPR further increased to 76.5 percent [11] in 2002 and has remained consistently high since.

Yet challenges persist, demanding policymakers, researchers and other relevant FP service stakeholders find pragmatic solutions to issues like quality of services, client satisfaction, FP method discontinuation and method failure.

Before this study, there was little information available about (i) the quality of family planning services, (ii) client perception of service quality, (iii) contraceptive discontinuation and (iv) method failure. This study sought to explore these dimensions of family planning services utilizing empirical evidence drawn from a nationally representative survey. Toward this end, this study utilized both supply - and demand-side perspectives of existing FP service quality.

The study findings can be used to design evidence-based advocacy policies and programs that develop and reinforce human rights-based family planning services that meet national quality standards (Box 1.1 and 1.2).

Box 1.1: Definition of reproductive health from ICPD 1994 [1]

"Reproductive health…. implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right [sic] of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law……..."

ICPD 1994, Programme of Action, paragraph 7.2. page 45

Box 1.2: "ICPD AND HUMAN RIGHTS:
20 years of advancing reproductive rights through UN treaties"

The ICPD Programme of Action recognizes that "reproductive rights… rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so." To implement this, states agreed that individuals must have access to a variety of safe, quality, effective, affordable, convenient and acceptable methods of family planning.

Programme of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5-13, 1994, para. 7.3 & Principle 8, U.N. Doc. A/ CONF.171/13/Rev.1 (1995) [ICPD Programme of Action, paras. 7.2, 7.5(a), 7.12 & 7.14(c)].

States also committed to ensuring that family planning programs abide by human rights norms and ethical and professional standards. To this end, the provision of contraceptive services must: be free from coercion and discrimination, ensure informed decision-making, respect privacy and confidentiality and respect the dignity of all persons. States should use all available means to ensure that voluntariness is at the foundation of all family planning programs. The ICPD Programme of Action recognizes that government schemes designed as either incentives or disincentives to individuals and families about whether to have children have been ineffective and counterproductive and that demographic goals, such as targets or quotas, should not be imposed on family planning providers. Furthermore, states agreed to "identify and remove all the major remaining barriers to the utilization of family-planning services" including "unnecessary legal, medical, clinical and regulatory barriers."

[ICPD Programme of Action, para. 7.17]

ICPD AND HUMAN RIGHTS: 20 years of advancing reproductive rights through UN treaty bodies and legal reform, Center for Reproductive Rights, UNFPA, available at:

http://www.unfpa.org/sites/default/files/pub-pdf/icpd_and_human_rights_20_years.pdf

1.3 Objectives of the Study

The overall objective of this study was to conduct mixed-method research on the quality of family planning services, contraceptive discontinuation and failure rates in Viet Nam. The specific objectives were as follows:

1. Assess the quality of family planning services provided at public and private health facilities across the country.

2. Assess client perception of family planning service quality and the level of client satisfaction with rendered services.

3. Explore the factors that contribute to the quality of family planning services and client satisfaction from both user and provider perspectives.

4. Estimate the overall and method-related discontinuation rate, failure rate, associated determinants and risk factors.

5. Assess the relationships between service quality and the rates of contraceptive use discontinuation and failure.

1.4 Organization of the Report

This report is composed of eleven chapters. Chapter 1 presents the history of family planning (FP) service delivery in Viet Nam, current structure of FP service delivery, rationale and objectives of the study. Chapter 2 delineates study methodology, including conceptual frameworks, study design, sample size and design, study protocol data collection instruments, study implementation and data analysis methods. Chapter 3 details the demographic characteristics of the respondents of the women survey, facility survey and PC survey. Chapter 4 broadly explains pertinent and current contraceptive prevalence rate issues and its concomitant factors, including client knowledge about modern FP methods. Chapter 5 maps out the quality of FP services at different facility levels in public and private/NGO sectors. The chapter also analyzes the factors influencing FP services. Chapter 6 examines client satisfaction with FP services and associated factors. It also narrates the determinants of client satisfaction on FP services. Chapter 7 describes the role of PCs, followed by their service quality and client satisfaction. Chapter 8 delves into FP method discontinuation by user and incidence of method failure. Furthermore, it explores factors affecting discontinuation and FP method failure as well as explains the extent of association between discontinuation and method failure. Chapter 9 outlines the findings related to abortion and presents relevant estimates. It also explores the relationship between abortion, discontinuation and method failure, and other relevant indicators while identifying factors affecting abortion. Chapter 10 evaluates the relationship between service quality and its relevant outcomes like modern method use, method discontinuation, method failure and abortion. The chapter also examines the link between specific indicators and service quality. Chapter 11 distills the key messages of the report along with corresponding references and recommendations.

CHAPTER 2: METHODOLOGY AND IMPLEMENTATION

This chapter maps the survey methodology, including a conceptual framework, survey design and sampling strategy. In addition to a detailed summary of data collection instruments, the chapter also presents an implementation plan, data analysis method and study limitations.

2.1 Conceptual Framework

2.1.1 Quality of Family Planning: A Conceptual Framework[1]

According to the World Health Organization (WHO), quality of care means a process of making strategic choices in health systems. The specific approach of the WHO Sexual and Reproductive Health Services Framework highlights the importance of high-quality care policies and strong political support. The framework is divided into three parts, program effort – including the policy and political environment that defines what services are provided, financial and human resources allocated to service provision, and program management and structure (WHO, 2011).

Discussions on the quality of family planning services is not a new subject within the health care literature base. It came to the forefront and ignited both forceful and favorable arguments with the launch of a seminal framework developed by Judith Bruce in 1990[2]. Since then, health care specialists have widened the scope of quality of care and suggested new areas to develop.

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1 *Definitions of key variables are available in Annex A.*

2 *Bruce, J., Fundamental elements of the quality of care: a simple framework. Stud Fam Plann, 1990. 21(2): p. 61-91.*

The International Planned Parenthood Federation (IPPF) Quality of Care Framework identifies seven key elements pertaining to the provision of quality services: (1) a safe and confidential environment; (2) comprehensive integrated services; (3) well-managed services; (4) highly skilled and respectful personnel; (5) secured supply chain management system; (6) adequate financial resources; and (7) effective communication and feedback systems. The key elements are designed to ensure client rights and provider needs. The guiding principles and values incorporate IPPF's Quality of Care Charter on "Rights of the Client, Needs of Service Providers". Client rights include accurate and up-to-date information; easy access to services; choice of services and methods; privacy, safety, comfort and dignity when receiving services; confidentiality; continuity of services; and right of opinion. Service provider needs include: continuous learning and training, accurate and up-to-date information, proper infrastructure to provide high-quality services, guidance and backup from managers and supervisors and respect and encouragement.

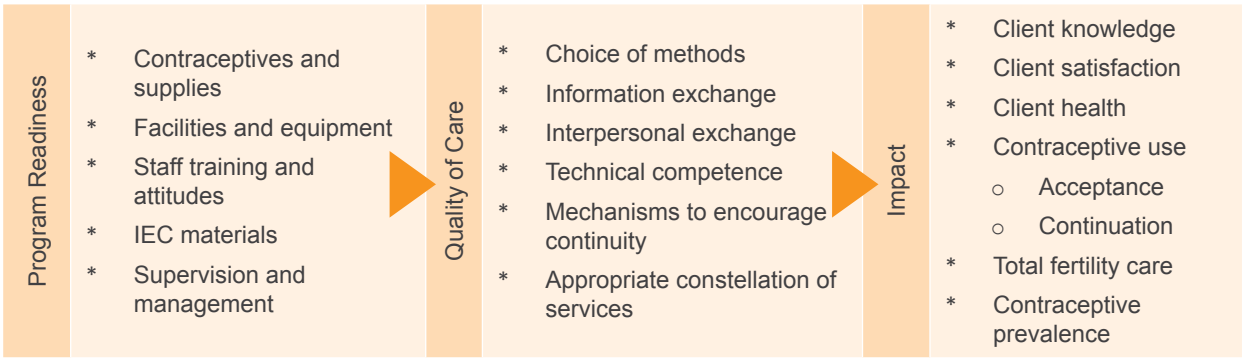
Beyond any reasonable doubt, clients are at the center of quality of care. Clients have the right to receive the highest quality of services – spanning from the way clients are looked at the time of receiving services to the readiness of the facility to offer high-quality services. Clients should feel capable of making informed choices, be satisfied with the services they receive and be able to reach their sexual and reproductive health goals. This necessitates that providers follow protocols and guidelines, positively interact with clients and provide them with accurate information. Clients should be empowered to make decisions about services offered, treatments received and the perceived functionality of the health system.

IPPF defined Quality of Care according to the needs of the providers as well as the rights of the clients, as shown in Box 2.1 and Figure 2.1 [13]:

Box 2.1: Components of client rights and provider needs

Client Rights	Provider Needs
Information	Training
Access	Infrastructure
Choice	Guidance
Safety	Respect
Privacy	Feedback
Confidentiality	Information
Dignity	Supplies
Comfort	Back-up
Continuity	Encouragement
Opinion	Self-expression

Figure 2.1: Conceptual framework of quality of care (by IPPF)



The new UNFPA Global Strategy for Family Planning (Choices not Chance) also strives to emphasize quality of care as a vital issue and included improving quality of care as one of its outputs. The framework of Improving Quality of Care in FP is based on improving technical capacity, adherence to standards and guidelines, availability of a wide range of choices (method mix), strengthening interpersonal communication skills and improving service delivery.

According to the Bruce-Jain framework, family planning service quality consists of six fundamental elements or dimensions: choice of methods, technical competence, information given to clients, interpersonal relationships, mechanisms to ensure follow-up and continuity and an appropriate constellation of services [14].

2.2 Study Design

This study followed both a probabilistic and purposive sampling approach. A judicious application of probabilistic-sampling approach ensured national representativeness of the survey at the household and facility level. On the other hand, the qualitative survey deliberately used purposive sampling, and as expected, provided additional information explaining and validating the survey findings to ensure representativeness.

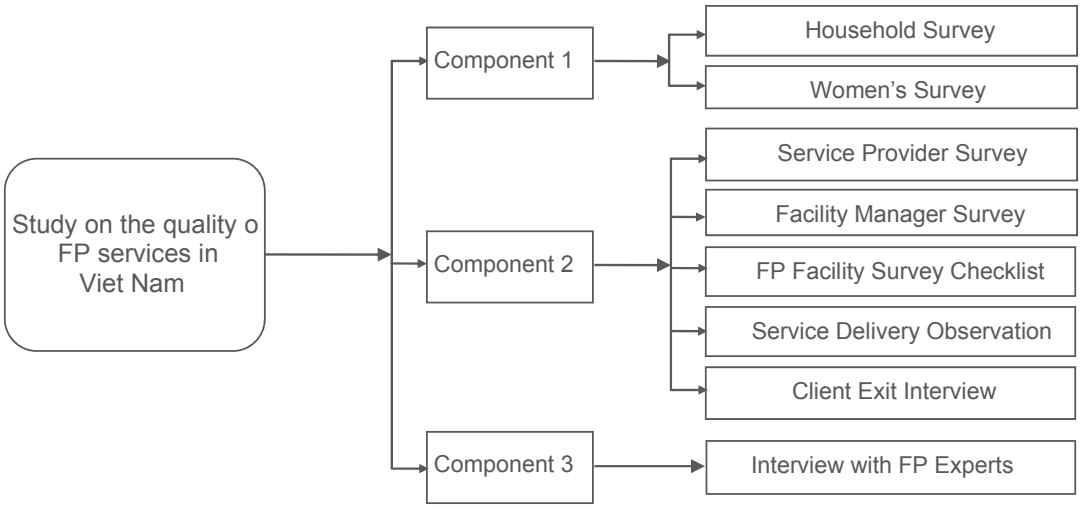
While collecting empirical evidence on the quality of FP services, the study included three vital components as follows (Figure 2.2):

Component 1: Surveys of households and women

Component 2: Facility survey/service provider survey (in relation to FP services)

Component 3: Qualitative research with FP experts

Figure 2.2: Study components



Quantitative data collection had two components: a facility survey and a household survey. The facility survey consisted of five aspects: a checklist of available services and relevant capacity-related information (i.e. facility survey), client exit survey, facility manager interview, service provider interview and service delivery observation. The household survey includes household listing and interviewing women aged 15–49 years. Eligible women in a selected household willing to participate in the survey were interviewed. Due to limitations in the sampling process, the findings from the client exit survey and service provider interviews cannot be generalized at the national level.

2.3 Sample Size and Sample Design

2.3.1 Women of Reproductive Age (15–49 years)

Sample Size of Women of Reproductive Age

The primary respondents in this survey were women aged 15–49. They were interviewed through a household survey. According to the Multiple Indicator Cluster Survey (MICS) 2014, the contraceptive prevalence rate (CPR) in Viet Nam was 76.7 percent. Using this statistic figure (p=0.77), the study calculated the necessary sample size using the following formula:

$$n = \frac{Z^2PQ}{e^2} \text{ X deff}$$

Where,

n = Estimated sample size
P = CPR in Viet Nam
Q = 1- P
Z = Standard normal variate value at 95% confidence level
e = Precision level
deff = Design effect

The estimated sample size for each ecological region with design effect 3.0 is 860. The design effect was set at 3.0, considering that the selection strategy followed a multi-stage (three stages) sampling method. Importantly, due to the unavailability of credible information on design effects used in similar surveys in Viet Nam, such design effect was used to minimize estimation variance. For a better field administration, the sample size was adjusted and rounded up to 1,000 for each ecological region, yielding a total sample size of 6,000 women (age 15–49) to be interviewed in this survey.

Sample Design for the Women's Survey

The sample was stratified and selected in three stages. Where appropriate, a province was randomly selected from each ecological region, which was then stratified into urban and rural areas. From this, 12 sampling strata were created. Implicit stratification and proportional allocation was made at each of the lower administrative levels by sorting the sampling frame within each sampling stratum before sample selection, according to administrative units at different levels, and by using a Probability Proportional to Size (PPS) sampling method during the first stage.

Districts were selected from each stratum during the first stage[3]. The number of district(s) selected from each stratum was determined according to the population and household distribution, using the most recent census data. Selections were independent across stages. District(s) within each stratum were selected using PPS sampling. During the second stage, five communes/precincts

3 *The detailed geographical coverage of the survey is available in Annex D.*

were selected from each district using PPS. From there, two villages/wards were randomly selected from each commune/precinct, yielding a total of 240 selected villages/wards. Finally, households were carefully selected from each village/area to interview women aged 15–49.

Twenty-five eligible women (aged 15-49) were interviewed from each selected village/area. Households were selected by going door-to-door with specified predetermined equal intervals. In total, 5,998 women actually participated in the women actually survey.

Table 2.1: Selected province from each ecological region

Ecological Regions	Province
Red River Delta	Hanoi
Northern Mountains	Yen Bai
North and South Central Coast	Phu Yen
Central Highlands	Dak Lak
Southeastern Region	Dong Nai
Mekong Delta	An Giang

Map of Vietnam (surveyed provinces in blue color)

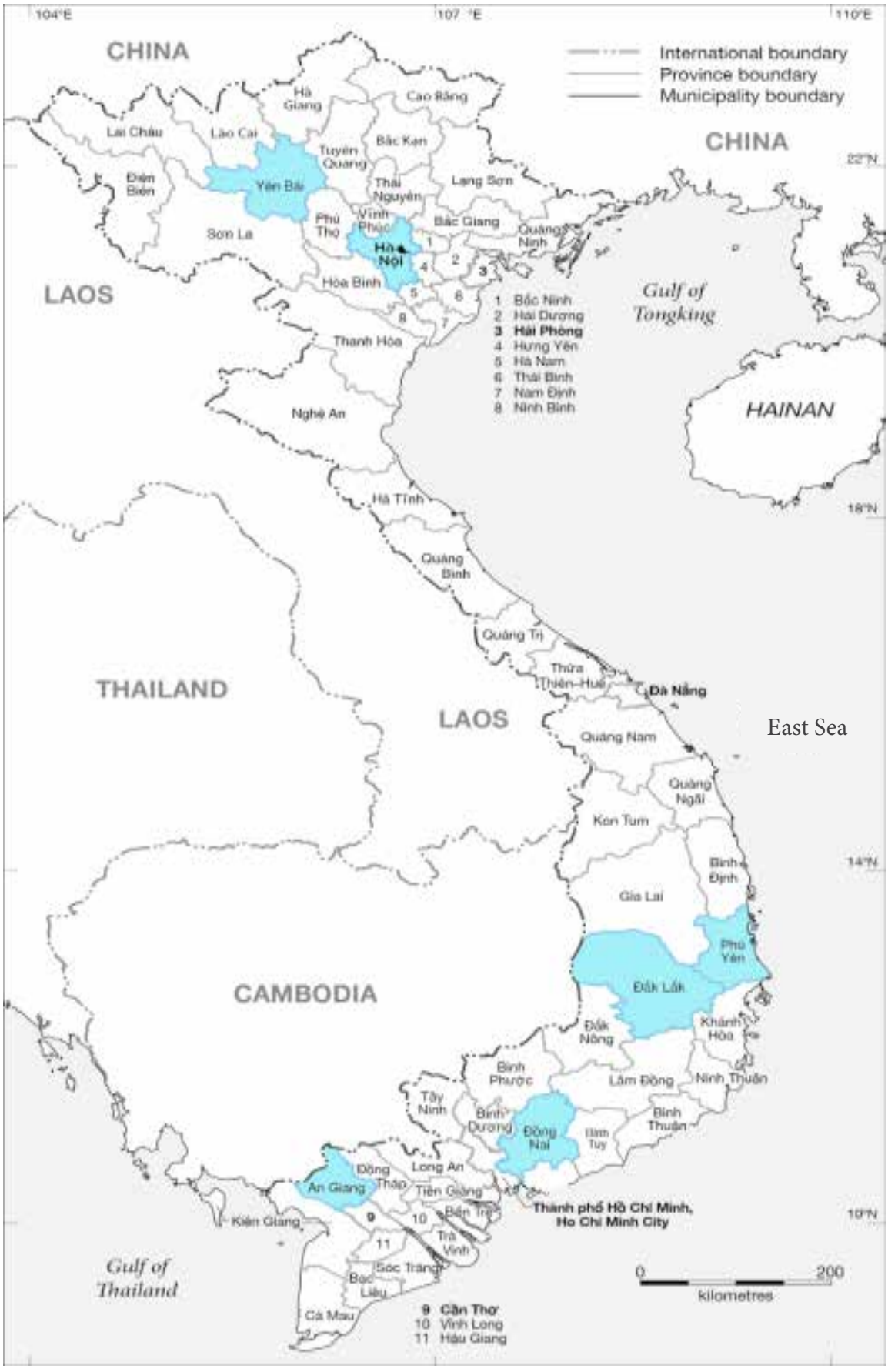
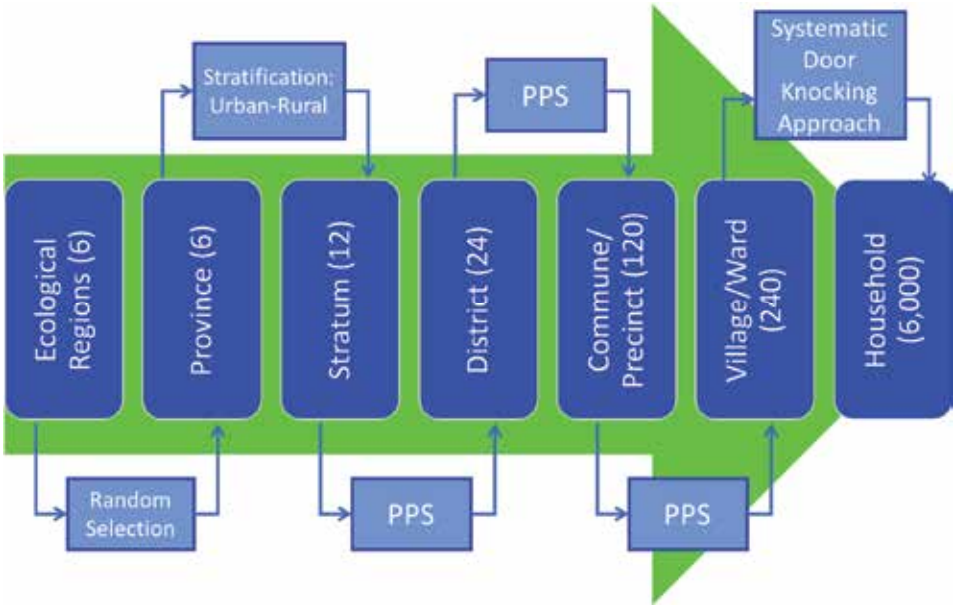


Figure 2.3: Stages of sample selection



2.3.2 Facility Survey

The facility survey was undertaken to assess health facilities at the provincial, district and communal level. The facility survey included facility observation, client exit interviews, a service provider survey, a facility manager survey and service delivery observation. Facilities were selected within the selected geographical areas of the household survey. Table 2.2 illustrates the sample distribution for the facility survey.

Facility Observation

This survey was expected to cover a total of 120 facilities, including 20 district-level facilities and 10 province-level facilities (to reflect the commune/precinct sample size: 6 provinces × 4 districts × 5 communes/precincts). Moreover, attempts were made to conduct facility observation in 20 purposively selected private/NGO-led FP service delivery facilities using a structured checklist.

Client Exit Survey

Client exit surveys took place at provincial-level facilities (reproductive health centers and provincial hospitals), district-level facilities (district health centers, district hospitals and preventive health centers), and facilities in major urban areas (non-governmental FP service delivery facilities). A total of 720 clients participated in exit interviews using a separate close-ended questionnaire regarding their satisfaction level while receiving family planning services.

Service Provider Survey

One service provider was interviewed from each selected health facility, resulting in a total 147 provider interviews. This survey was also conducted using close-ended structured questionnaires.

Facility Manager Survey

Facility managers were interviewed at provincial-level facilities (reproductive health centers and provincial hospitals), district-level facilities (district health centers, district hospitals and preventive health centers) and commune-level facilities (commune health centers). A total of 147 facility managers were interviewed using a close-ended structured questionnaire.

Service Delivery Observation

Service delivery observations were made at provincial and district hospitals and obstetric specialists observed 35 FP service delivery facilities. Observations focused on providing all types of FP services (including inserting IUDs, general FP examinations, FP client screening and counseling).

Population Collaborator

Community PCs were also interviewed using a structured questionnaire, randomly selected from each community included in the survey. A total of 110 collaborators were interviewed during the survey.

Table 2.2: Distribution of facility survey

Administrative Unit	Facility Type	Facility Observation	Service Provider Interview	Facility Manager Interview	Service Delivery Observation	Client Exit Interview	PC interview
Province (public)	RH Center/ Provincial Hospital	8	7	8	16	604	0
District (public)	District Health Center/ District Hospital/ Preventive Health Center	18	18	21	12	20	0
Commune (public)	Commune Health Center	113	112	103	0	24	110
Private	Private/NGO-led Facility	9	10	9	7	72	0
Total		148	147	141	35	720	110

2.4 Data Collection Instruments[4]

The ***women's survey*** (key respondents: women aged 15–49) was designed to determine the knowledge, attitudes and practices related to the use of FP methods; method specific discontinuation rate; and contraceptive failure among women of reproductive age. In addition, it was instrumental in assessing the quality of received family planning services. During the survey, two types of close-ended questionnaires were used to interview eligible women: a household questionnaire and a women's questionnaire. The main purpose of the household questionnaire was to identify eligible women. As such, only one household questionnaire was completed per household. Within each household, a questionnaire was administered to any eligible woman available and willing to participate[5] in the survey.

The ***health facility survey*** provided data on the readiness of each facility to serve clients. Information was collected about the types of services provided, the types and quantity of supplies in-stock, the condition of the facility, the types of records kept, etc. The service provider interview and facility manager interview assessed their technical knowledge of FP and identified any gaps in service provision. The client exit interview collected information about the client's experience at a given health facility.

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4 *Survey questionnaires are available in Annex C. In addition, contents (indicator list) of each survey questionnaire are available in Annex B.*

5 *This strategy minimized respondent selection bias (to avoid selecting only the eldest or youngest member of a household) for the survey.*

Data collection instruments were prepared to collect data and information in line with the objectives of the study. Table 2.3 describes which data collection instrument were prepared and used for which specific objective of the study.

Table 2.3: Study objectives and related questionnaire focus[6]

Specific objectives of the study		Research tools
Objective 1	Assess the quality of FP services provided at public and private health facilities across the country	Service facility observation Service provider survey Service manager survey Population collaborators
Objective 2	Assess client perception and appraisal of the FP service quality, and the level of client satisfaction with the services rendered	Women's survey questionnaire Client exit survey
Objective 3	Explore factors that contribute to the quality of FP services and client satisfaction from both user and provider perspectives	Women's survey questionnaire Household survey questionnaire Client exit survey Service provider survey
Objective 4	Estimate the overall and method-related discontinuation rate, failure rate and associated determinants and risk factors	Women's survey questionnaire
Objective 5	Assess the relationships between service quality and the rates of contraceptive discontinuation and failure	Women's questionnaire Client exit survey Service facility observation Service provider survey Service manager survey

2.5 Survey Implementation

2.5.1 Protocol Finalization

The standard protocol for data collection along with the questionnaires, observation formats and checklists were developed in consultation with obstetrics and gynecology experts from the National Hospital of Maternal and Child Care. Survey preparatory efforts were initiated as soon as the proposal was accepted (September 25, 2015). The draft protocol was prepared and presented in an open discussion meeting on October 29, 2015 and then to a technical committee on November 2, 2015. After incorporating comments and suggestions from the participants and experts, the protocol was approved on November 15, 2015. Using the draft questionnaires, two pretests were conducted: one on November 15 in Hanoi and one on November 27 in Ha Nam. Experts reviewed and revised the draft questionnaires, after which they were finalized on November 29, 2015.

2.5.2 Training and Data Collection

A qualified data collection team was recruited and trained. A team of medical graduates was recruited to carry out the health facility survey, including interviewing health facility managers, service providers and PCs, as well as observing the FP services provided at facilities. A team of public health graduates conducted the client exit survey in clinical settings, including provincial centers for RH care, provincial hospitals, district FP units, district hospitals and selected CHCs. A team was formed for interviewing woman in the household, consisting of members from the Women's Union and Youth Union, public health students and social workers. Most of the team members were females. All members of the survey teams were trained through classroom and practice sessions. A team of skilled supervisors was also trained to supervise and monitor the

6 *Indicator list by specific objective and source of information is available in Annex B.*

survey implementation and ensure high-quality data collection.

A national survey manager coordinated the overall survey activities conducted by the field survey teams. In addition, a group of supervisors visited each commune to provide supportive supervision to local data collectors. UNFPA provided one supervisor to accompany the team in five of the provinces (with the exception of Yen Bai). The UNFPA supervisor observed the data collection at both health facilities and the household level and provided feedback directly to field manager and national survey manager, enabling timely correction and adjustments to the survey implementation. The data collection process took place from mid-November to the end of December 2015.

2.5.3 *Preliminary Findings Preparation*

Data was cleaned by the end of March 2016. Using these data, preliminary findings were prepared and submitted by the end of May 2016 and presented to the GOPFP on June 15, 2016. Preliminary findings were presented to technical experts at UNFPA Viet Nam the next day (June 16, 2016). This final report was prepared taking comments received from GOPFP, UNFPA and other national experts into account.

2.6 Data Analysis

The primary unit of analysis in the study was women aged 15–49, with results summarized by ecological regions, urban-rural strata and relevant selected demographic characteristics (i.e., ethnicity, understanding of the Vietnamese language, etc). Data were analysed using SPSS. The level to which quantitative data was analyzed by type of data/information collection instrument is shown in Table 2.4.

Table 2.4: Quantitative data analysis

Survey type		Commune	District	Region	Residence		All
					Rural	Urban	
Household survey		√	√	√	√	√	√
Client exit survey				√	√	√	√
Facility survey	Public				√	√	√
	Private						√
	NGO						√
Facility manager interview					√	√	√
Service provider interview					√	√	√
Population collaborator interview					√		√
Service delivery observation							√

Note: Tick mark (√) indicates the analysis unit level by type of data collection instrument

In this study, quantitative data analysis techniques included univariate analysis, bivariate analysis and multivariate analysis. Cox regression was applied during analysis of the method of discontinuation. For this purpose, incidence of death was replaced by incidence of discontinuation (within 12 months). For the rest of the data, odds ratios were estimated to understand the effect of two categorical variables (quantitative variables were organized into categorical variables). Cochran's and Mantel-Haenszel statistics were applied during estimations of odds ratios to assess whether the common odds ratio was 1. Binary logistic regression was used to identify

factors affecting discontinuation and method failure. Hosmer-Lemeshow goodness of fit test was conducted for logistic regression. Analysis of variance was applied to determine the difference in means among regions for provider quality score and facility preparedness score. Linear regression and binary logistic regression were used to assess the relationship among service quality, provider quality, facility preparedness, satisfaction and discontinuation, among other relevant variables.

Z-statistics were used to assess the difference between proportions and means of two independent variables when appropriate and included the p-values in writing. The measurement levels of the variables were taken into account while analyzing the data, and the following statistical techniques were used for each level:

For nominal and ordinal variables: frequency distributions, graphical representations, cross tabulations and computation of new variables using existing ones.

For continuous variables: statistic, means, computation of nominal and ordinal variables (if necessary), graphical representations and confidence intervals (as necessary).


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CHAPTER 3: RESPONDENT DEMOGRAPHIC, SOCIO-ECONOMIC AND REPRODUCTIVE HEALTH CHARACTERISTICS

This chapter presents the background characteristics of the respondents of the women's survey, facility survey, service provider survey, facility manager survey and population collaborator survey. The background characteristics of women's survey respondents include selective information on demographic characteristics (age, ethnicity, level of Vietnamese language comprehension, education, occupation, marital status and age at first marriage) and reproductive history. The characteristics of facility survey respondents spanned age, sex and position (designation). PC survey characteristics encompassed age, sex, duration of service, status of training received and duration of work in a month.

3.1 Characteristics of Studied Women

3.1.1 Age

The survey covered all six regions of Viet Nam and collected data from 5,998 women of reproductive age (15–49 years). Of the survey population, the proportion of respondents from urban areas was 27.9 percent (Table 3.1). The average age of women in household survey was 33.8 years (median 33.0 years) with a substantial proportion of respondents concentrated between 25 and 34 years (40.4 percent). On average, the age of urban respondents was slightly higher than that of rural respondents (34.8 years and 33.5 years, respectively). Average ages of respondents varied slightly by region. About 13.5 percent of women were below 25 years and 46.0 percent were 35 years and above.

Table 3.1: Distribution of women by their current age (in completed years, percent)

Age	Region						Residence		Total
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	Southeastern Region	Mekong Delta	Urban	Rural	
15-19	1.1	4.3	4.5	3.3	0.3	2.3	3.0	2.5	2.6
20-24	9.4	13.5	13.8	11.9	8.5	8.5	7.7	12.2	10.9
25-29	19.6	17.1	22.5	17.1	17.0	16.7	15.5	19.4	18.3
30-34	26.3	19.9	19.5	22.1	23.4	21.3	22.5	22.0	22.1
35-39	22.5	16.8	17.0	18.5	18.1	19.3	20.7	17.9	18.7
40-44	13.4	16.4	13.7	15.6	18.6	19.3	17.1	15.8	16.2
45-49	7.8	12.0	9.0	11.3	14.1	12.4	13.5	10.2	11.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	1,002	1,000	993	998	1,006	999	1,677	4,321	5,998
Aver-age	33.6	33.5	32.4	33.7	35.2	34.7	34.8	33.5	33.8
Medi-an	33.0	33.0	32.0	33.0	35.0	35.0	35.0	33.0	33.0

3.1.2 Marital Status

On average, 95.0 percent of respondents were currently married and 98.3 percent had ever been married (including 3.3 percent were not currently married, but had been married before). Of all the interviewed women, only 1.6 percent had never been married (Table 3.2). The proportion of currently married women was higher in rural areas than urban. However, the proportion of women currently not married but previously married as well as the proportion of never married women was higher in urban areas than rural (Table 3.2). Among the regions, the Red River Delta had the highest proportion of currently married women (97.6 percent), while the North and South Central Coast had the lowest (91.4 percent).

Table 3.2: Distribution of women by their current marital status (percent)

Current marital status	Region						Residence		Total
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	Southeastern Region	Mekong Delta	Urban	Rural	
Never married	0.1	2.8	4.3	1.0	0.8	0.8	3.6	0.9	1.6
Currently married	97.6	94.2	91.4	94.8	96.8	95.4	92.0	96.2	95.0
Ever-married but currently not	2.3	3.0	4.2	4.2	2.4	3.8	4.4	2.9	3.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	1,002	1,000	993	998	1,006	999	1,677	4,321	5,998

3.1.3 Education

Respondents attended an average of 8.6 years of schooling and a median of 9.0 years (Table 3.3). Compared to rural women (7.91 years), the mean years of schooling is higher in urban areas (10.2 years). On average, women from the Red River Delta region spent over 11 years in school, higher than other regions. Women in the Mekong Delta, on average, had 6.4 years of schooling.

Overall, 30.4 percent of women had completed higher secondary school or above and 37.4 percent had incomplete lower secondary. In the Red River Delta region, 53.8 percent of women had completed higher secondary school or above. This region had the highest proportion of women who had completed higher secondary school or above. In terms of women having completed higher secondary school and above, all other regions were far behind the Red River Delta. Compared to their rural counterparts, the education levels of urban women were higher. In the North and South Central Coast, 10.8 percent of women had not received any education. In the Northern Mountains and Mekong Delta, 8.8 percent and 7.9 percent of woman had not received any education, respectively. On average, 5.6 percent of respondents, reportedly, had not received any education (2.4 percent in urban areas and 6.9 percent in rural areas).

Table 3.3: Distribution of women by their level of schooling (percent)

Level of schooling (years)	Region						Residence		Total
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	South-eastern Region	Mekong Delta	Urban	Rural	
None	0.1	8.8	10.8	3.8	2.4	7.9	2.4	6.9	5.6
Primary incomplete (1 – 4)	2.3	13.8	6.9	9.2	10.1	27.1	8.3	12.6	11.4
Primary complete (5)	3.0	9.9	11.3	8.2	11.3	13.8	6.2	10.8	9.5
Lower secondary incomplete (6-8)	36.1	34.9	37.3	43.7	40.4	32.3	30.9	40.0	37.4
Lower secondary complete (9)	3.3	3.4	3.6	5.9	4.0	2.7	3.6	3.9	3.8
Higher secondary incomplete (10-11)	1.4	1.6	2.3	2.3	2.2	1.6	2.0	1.8	1.9
Higher secondary complete and above (12 and above)	53.8	27.6	27.8	27.0	29.5	14.4	46.6	23.9	30.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	1,002	966	967	923	918	910	1,620	4,066	5,686
Mean (year)	11.21	7.93	8.22	8.68	8.74	6.40	10.21	7.91	8.56
Median (year)	12.00	9.00	9.00	9.00	9.00	6.00	10.0	8.0	9.0

3.1.4 Occupation

About 80.3 percent of woman were employed (including 0.6 percent classifying themselves as students); the rest (19.7 percent) were unemployed/housewife (Table 3.4). Among the respondents, 79.7 percent were income earners. Specifically, 36.4 percent women were working in agriculture, followed by 22.5 percent in the service/trading sector and 12.0 percent as office employees, intellectuals or clerks. The proportion differed by place of residence and by region.

Table 3.4: Distribution of women by occupation (percent)

Occupation	Region						Residence		Total
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	South-eastern Region	Me-kong Delta	Urban	Rural	
Agriculture	16.3	74.1	43.3	64.3	8.2	14.0	13.1	45.7	36.6
Manufacturing/ construction	6.2	1.7	2.1	1.0	27.3	3.8	7.7	6.8	7.0
Service/trading	42.0	9.7	16.9	14.6	26.1	26.7	31.4	19.3	22.7
Office/intellec-tual clerk	18.8	9.2	12.2	11.8	13.4	6.9	21.4	8.5	12.1
Student	0.4	0.4	1.5	0.4	0.2	0.6	1.1	0.4	0.6
Unemployed / Housewife	14.6	4.6	23.6	7.8	24.7	42.9	23.6	18.2	19.7
Other	1.8	0.3	0.3	0.1	0.1	5.0	1.7	1.1	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	1,001	991	988	988	994	993	1,660	4,295	5,955

3.1.5 Ethnicity, Comprehension of Vietnamese Language and Migration Status

By ethnicity, 77.7 percent women interviewed belong to the Kinh ethnic majority (Table 3.5). Data indicates a high concentration of ethnic minority populations in the Northern Mountains (60.6 percent) and moderate concentration in the Central Highlands (35.0 percent), North and South Central Coast (21.5 percent) and Mekong Delta (10.0 percent).

Most of the women understood the Vietnamese language very well (92.6 percent) and only 1.4 percent reported that they did not understand it at all.

As to the migration status of the respondents, over nine-tenths of the women were residents of the survey areas and 8.2 percent had migrated there. The Central Highlands and Southeastern Region had a relatively high concentration of migrants (15.5 percent and 13.2 percent respectively).

Table 3.5: Distribution of women by ethnicity, migration status and understanding of the Vietnamese language (percent)

Region	Ethnicity		Migration Status			Understanding of the Vietnamese language			n
	Kinh	Ethnic	Resident	Long term	Short term	Very well	A little	Not at all	
Red River Delta	98.9	1.1	91.3	8.4	0.2	100.0	0.0	0.0	1,002
Northern Mountains	39.4	60.6	95.5	4.5	0.0	86.2	12.3	1.5	1,000
North and South Central Coast	78.5	21.5	96.0	3.3	0.5	93.4	5.8	0.8	993
Central Highlands	65.0	35.0	84.5	15.4	0.1	84.0	14.3	1.4	998
Southeastern Region	93.9	6.1	86.8	12.6	0.6	99.8	0.2	0.0	1,006
Mekong Delta	90.0	10.0	96.9	3.1	0.0	92.0	3.5	4.5	999
Total	77.7	22.3	91.9	7.9	0.2	92.6	6.0	1.4	5,998

3.1.6 Household Size

The average household size of respondents was 4.3 members. For 61.6 percent of respondents, their household size was between 3 and 4 members, and 29.1 percent had between 5 and 6 members (Table 3.6). Overall, the urban and rural households did not vary by size. The average size of households did vary slightly by region, however. Southeastern Region households, on average, had 4.5 members; the North and South Central Coast had 4.1 members. The highest proportion of households across the regions had between 3 and 4 persons, followed by households with 5-6 members.

Table 3.6: Distribution of surveyed households by size (percent)

Household size	Region						Residence		Total
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	South-eastern Region	Mekong Delta	Urban	Rural	
1-2	1.6	2.6	5.4	4.2	2.8	5.2	4.0	3.5	3.6
3-4	61.0	65.7	64.9	64.2	58.4	55.9	63.2	61.0	61.6
5-6	31.9	26.1	25.7	26.8	32.1	31.6	26.2	30.2	29.1
7-8	4.7	4.7	3.5	4.0	5.1	5.6	4.9	4.5	4.6
9+	0.8	1.0	0.5	0.8	1.6	1.8	1.7	0.9	1.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	981	921	922	922	956	950	1,552	4,100	5,652
Average HH size	4.4	4.3	4.1	4.2	4.5	4.4	4.3	4.3	4.3

3.1.7 Age at First Marriage

The overall median and mean age of surveyed women at their first marriage was 22 years (Table 3.7). The median age was a little higher in urban (23 years) areas than in the rural areas (21 years). The median age at first marriage was the highest in the Southeastern Region (23 years) and lowest in the Northern Mountains (20 years). The most common age of women at first marriage was between 20 and 24 years, followed by between 15 and 19 years.

Table 3.7: Distribution of women by age at first marriage (percent)

Background characteristics	Age at first marriage (in completed years)										n
	<15	15-19	20-24	25-29	30-34	35-39	40+	Don't know	Mean (year)	Median (year)	
Residence											
Urban	0.0	17.9	49	27.1	4.0	1.1	0.2	0.7	23.1	23.0	1,603
Rural	0.4	30.5	50.3	15.7	2.4	0.7	0.0	0.0	21.6	21.0	4,272
Region											
Red River Delta	0.0	17.9	53.1	25.2	3.0	0.8	0.0	0.0	22.8	22.9	1,001
Northern Mountains	0.2	38.9	45.5	11.8	1.9	0.4	0.0	1.3	20.9	21.0	958
North and South Central Coast	0.2	28.3	52.7	16.6	2.0	0.2	0.0	0.0	21.5	21.6	948
Central Highlands	1.0	33.5	46.9	15.8	2.1	0.6	0.1	0.0	21.4	21.5	984
Southeastern Region	0.1	18.6	51.0	25.5	3.4	1.4	0.0	0.0	22.8	22.8	996
Mekong Delta	0.0	25.8	50.4	17.8	4.4	1.2	0.3	0.1	22.3	22.4	988
Total	0.3	27.1	49.9	18.8	2.8	0.8	0.1	0.2	22.0	22.0	5,875

3.1.8 Age at First Pregnancy

The overall median age of women at first pregnancy was 22 years, the same as the median age at first marriage (Table 3.8). However, compared to average age of women at first marriage (22 years), their average age at first pregnancy was 22.8 years (Table 3.8). By place of residence, the median age at first pregnancy was higher among urban women (24 years) than rural women (22 years). Across the regions, the median age at first pregnancy was a little higher (23 years) in the Red River Delta, Southeastern Region and Mekong Delta, and lower (21 years) in the Northern Mountains. The most common age at first pregnancy was between 20 and 24 years (52.2 percent). Nonetheless, a notable 18.2 percent of women became pregnant during their teenage years - between 15 and 19 years old.

Table 3.8: Distribution of women by age at first pregnancy (percent)

Background characteristics	Age at first pregnancy (in completed years)							n (applicable)
	15-19	20-24	25-29	30-34	35+	Mean	Median	
Residence								
Urban	10.6	47.7	33.1	5.8	1.4	23.9	24.0	1,606
Rural	21.0	54.0	19.6	3.6	0.8	22.4	22.0	4,230
Region								
Red River Delta	11.0	53.8	30.1	4.3	0.8	23.5	23.0	998
Northern Mountains	25.9	55.1	15.1	2.1	0.3	21.7	21.0	972
North and South Central Coast	20.4	53.7	21.3	2.7	0.6	22.4	22.0	947
Central Highlands	25.1	49.0	20.2	2.7	0.7	22.1	22.0	969
Southeastern Region	12.3	48.9	30.4	5.9	1.4	23.7	23.0	975
Mekong Delta	14.6	52.8	22.8	7.4	1.7	23.5	23.0	975
Total	18.2	52.2	23.4	31.3	0.9	22.8	22.0	5,836

3.1.9 Number of Pregnancies

On average, Vietnamese women had 2.3 pregnancies in their lifetimes. The mean number of lifetime pregnancies varied slightly by place of residence and by region.

Table 3.9: Distribution of women by the number of pregnancies
(all pregnancies including current pregnancy, percent)

Background characteristics	Number of pregnancies						n (applicable)
	1	2	3	4	5+	Average	
Residence							
Urban	24.2	46.5	18.7	6.8	3.8	2.2	1606
Rural	20.0	43.9	22.0	9.7	4.4	2.4	4230
Region							
Red River Delta	14.2	45.2	23.4	11.3	5.8	2.5	998
Northern Mountains	19.5	42.7	23.8	10.7	3.3	2.4	972
North and South Central Coast	26.3	46.1	20.2	5.0	2.4	2.1	947
Central Highlands	21.9	42.7	22.8	7.9	4.6	2.3	969
Southeastern Region	20.3	45.5	18.5	10.3	5.4	2.4	975
Mekong Delta	24.9	45.2	17.9	8.2	3.7	2.2	975
Total	21.1	44.6	21.1	8.9	4.2	2.3	5836

3.2 Provider Characteristics

Almost all the service providers were female (Table 3.10). Since this survey focused more on the lowest tier of family planning service delivery, many of the interviewed service providers were from CHCs (76.3 percent) and the majority were midwives (72.1 percent) (Table 3.11). Most of the interviewed facility managers were also from CHCs (76.2 percent).

Table 3.10: Distribution of service providers in facilities and managers by region, residence and sex (percent)

Type	Region						Residence		Sex		n
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	South-eastern Region	Mekong Delta	Urban	Rural	Male	Female	
Service providers in facilities	12.2	17.0	17.7	17.7	18.4	17.0	35.4	64.6	1.4	98.6	147
Managers	12.9	17.1	18.6	15.0	18.6	17.9	30.7	69.3	-	-	140

Table 3.11: Distribution of service providers in facilities by facility type (percent)

Position of provider	Type of facility providing family planning services							Total	Percent
	Provincial hospital	Provincial RH center	District hospital /Health center (Obs. dept)	District RH/ FP nutrition unit	Commune health center	Private/ NGO-led facility	Others		
Obs./Gyn. Doctor	2	2	2	0	1	4	1	12	8.2
Assistant Doctor in Obs. and Pediatrics	0	0	2	3	15	0	1	21	14.3
Midwife	0	2	0	8	93	2	1	106	72.1
General practitioners trained in FP counseling	0	1	2	1	2	0	1	7	4.8
FP and population communal officer	0	0	0	0	1	0	0	1	0.7
Total	2	5	6	12	112	6	4	147	100.0
Percent	1.4	3.4	4.1	8.2	76.2	4.1	2.7	100.0	

The average age of PCs interviewed was 45 years (only 10 percent were less than 30 years old) (Table 3.12). Their average years of experience were 9.5 years. One-third (32.7 percent) of the PCs had five years of experience or fewer, while 37.3 percent had over 10 years of experience (Table 3.13).

Table 3.12: Distribution of PCs interviewed by age, region and place of residence (percent)

Age (in completed years)	Region						Residence		Total
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	Southeast-ern Region	Mekong Delta	Urban	Rural	
<30	0.0	5.0	16.7	15.8	10.5	11.1	8.3	10.8	10.3
30-39	30.8	55.0	27.8	21.1	10.5	11.1	16.7	28.9	26.2
40-49	30.8	15.0	38.9	47.4	5.3	27.8	37.5	24.1	27.1
50-59	30.8	0.0	11.1	15.8	57.9	38.9	16.7	27.7	25.2
60+	7.7	25.0	5.6	0.0	15.8	11.1	20.8	8.4	11.2
n	13	20	18	19	19	18	24	83	107
Average (year)	46.2	42.4	42.2	41.3	50.8	47.9	46.9	44.5	45.0
Median (year)	49.0	37.0	42.5	42.0	54.0	50.5	45.5	46.0	46.0

Table 3.13: Distribution of PCs interviewed by years of experience, region and place of residence (percent)

Years of experience (in completed years)	Region						Residence		Total
	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	South-eastern Region	Me-kong Delta	Urban	Rural	
1-5	7.7	40.0	11.1	45.0	26.3	55.0	30.8	33.3	32.7
6-10	53.8	20.0	50.0	35.0	26.3	5.0	42.3	26.2	30.0
11-15	15.4	10.0	27.8	15.0	15.8	25.0	7.7	21.4	18.2
16-20	23.1	30.0	5.6	5.0	15.8	5.0	15.4	13.1	13.6
20+	0.0	0.0	5.6	0.0	15.8	10.0	3.8	6.0	5.5
n	13	20	18	20	19	20	26	84	110
Mean (year)	11.4	9.8	9.6	7.9	10.2	8.8	9.0	9.6	9.5
Median (year)	10.0	7.0	9.0	8.0	9.5	4.5	7.0	9.5	8.0

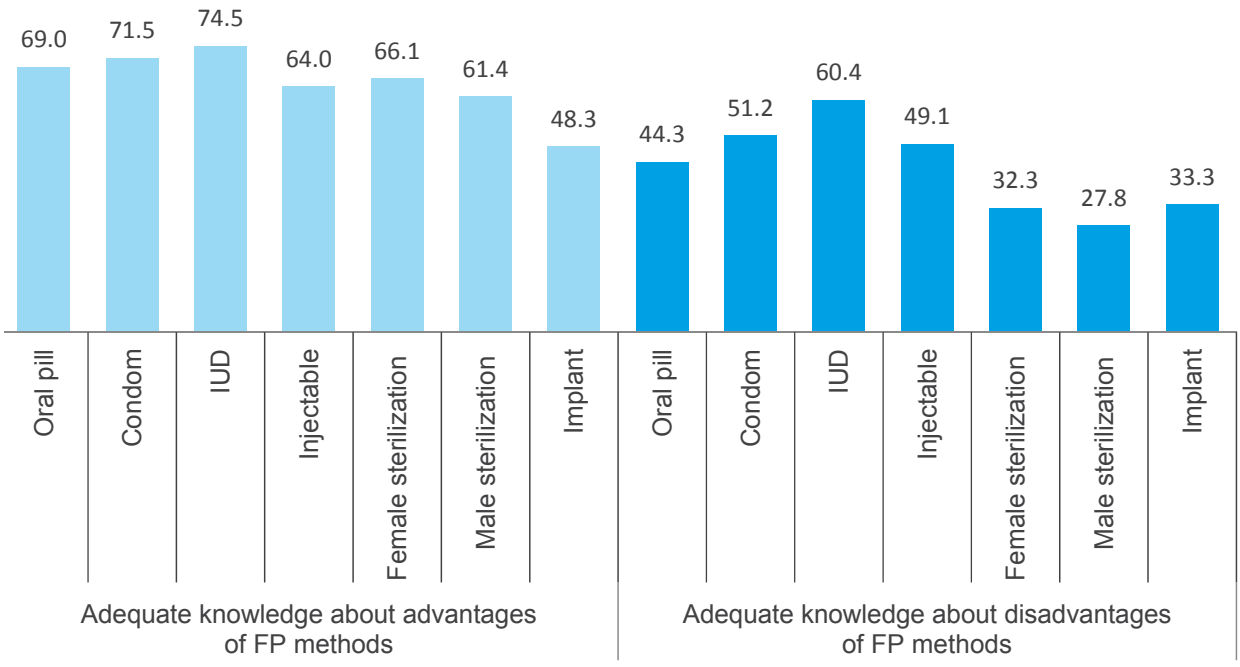
CHAPTER 4: CONTRACEPTIVE KNOWLEDGE AND UTILIZATION

This chapter analyzes the contraceptive knowledge and utilization of surveyed women. It also explores the inextricable link between modern Contraceptive use and a number of demographic variables.

4.1 Client Knowledge of FP Methods

In Viet Nam, there are a variety of distinct issues related to FP. The majority of respondents had heard about modern FP methods. As observed, the proportion of women equipped with knowledge of family planning methods was higher for oral pills, condoms and IUDs, compared to other FP methods (Figure 4.1). There was a minor difference between urban (95.4 percent) and rural (97.0 percent) knowledge. Knowledge increased correspondingly with years of schooling (Annex Table 4.1). When asked about their knowledge of the comparative advantages and disadvantages of FP methods, women were consistently more knowledgeable about the advantages of modern FP methods than the disadvantages (Figure 4.1). There was a difference between urban and rural women in terms of knowledge of the disadvantages of the modern FP methods that they had heard of – urban women were consistently more aware of disadvantages than rural women. Such a difference was also visible between Kinh and ethnic minority women, though ethnic minority women were largely aware of FP methods (Annex Tables 4.2 and 4.3).

Figure 4.1: Distribution of women by adequate knowledge about the advantages and disadvantages of FP methods by types (percent)



There was also a lack of adequate knowledge that appropriate use of any modern contraceptive method carries risk of complications, side effects, discontinuation and method failure. The study enquired whether current users of modern FP methods knew how to correctly use the FP method they were currently using. According to their responses, 37.8 percent of the modern method users (irrespective of marital status) did not receive any counseling from FP service providers before adopting the method (Table 4.1), increasing the likelihood of misuse and user error. This scenario (with condoms as an exception) demonstrates a lack of proper screening before adopting FP methods. Among users of modern methods who have sought advice from providers, only 56.3 percent had adequate knowledge about how to correctly use their respective FP method.

Table 4.1: Distribution of respondents with adequate knowledge on using modern contraceptive methods (percent)

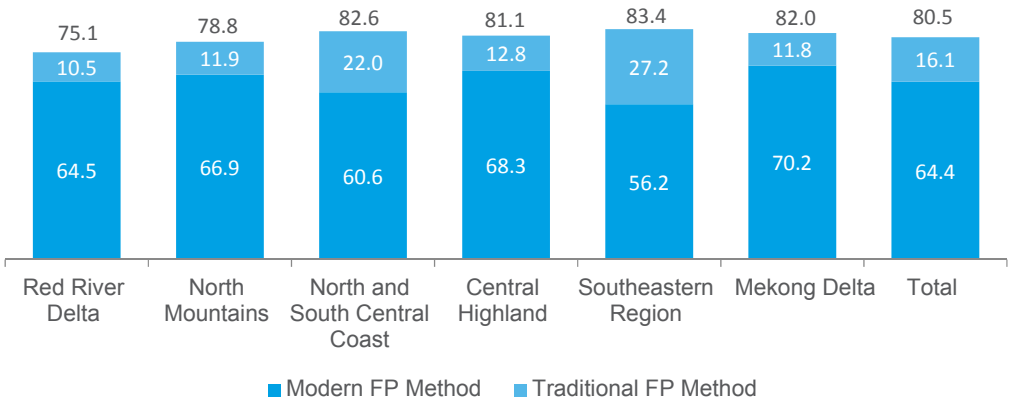
FP method	Current FP users who adopted a method without counseling from FP service provider		Current FP method users who have adequate knowledge	
	Percentage	n (applicable)	Percentage	n (applicable)
Pills	48.7	1,130	64.3	580
Condoms	52.5	787	53.7	374
IUDs	26.8	1,453	49.8	1,063
Injectables	19.8	131	61.9	105
Female sterilization	18.3	213	69.0	174
Implants	5.1	39	70.3	37
All	37.8	3,753	56.3	2,333

4.2 Current Use of FP Method

This section examines the current use of FP methods. Current use of FP methods, otherwise known as the CPR, is the proportion of currently married women who reported that they or their partners were using an FP method at the time of the survey. The survey found that 80.5 percent of currently married women aged 15–49 were using any contraceptive method at the time of the survey (Table 4.2). About two-thirds (64.4 percent) of all married women were using a modern method and one-fifth (16.1 percent) were using a traditional method. IUDs were the most preferred method (25.2 percent), followed by oral pills (19.3 percent) and condoms (13.3 percent).

The CPR and the use of modern methods was slightly higher in urban areas than rural areas, but not statistically significant (p>0.1). There were some variations in CPR across regions. The overall CPR was highest in the Southeastern Region (83.4 percent) and lowest in the Red River Delta (75.1 percent). However, the highest CPR in the Southeastern Region was associated with the highest use rate of traditional methods (27.2 percent), while the lowest CPR in the Red River Delta corresponded to the lowest use rate of traditional methods (10.5 percent) (Figure 4.2).

Figure 4.2: Composition of contraceptive prevalence rate by region



Compared to modern methods, traditional contraceptive methods have a higher risk of method failure. As such, the assumption is that if traditional method users become aware of the high effectiveness of modern methods, then some of the traditional method users would be likely to switch to a modern method. In terms of overall CPR, the Central Highlands was fourth (81.1 percent) among the six regions, but represented the highest use rate of modern methods (68.3 percent).

The overall CPR was significantly higher (p=0.022) among the Kinh population than ethnic minorities, which is due to their significantly (p<0.0001) higher rate of traditional contraceptive use. There is a significantly (p=0.00108) higher rate of modern contraceptive method use among ethnic minority populations. With the exception of condoms and implants, the proportion of ethnic minority populations using modern contraceptive methods is higher compared to Kinh populations.

CPR also varied by age. Among young women, the use of any method increases with age; CPR was lowest (49.6 percent) among currently married young women (15-19). Women aged 35-39 had the highest CPR (88.3 percent), though it did then decline to 85.3 percent at age 40-44 and further to 76.7 percent at age 45-49.

The study observed a similar trend in the use of modern contraceptive methods. Oral pills were the most popular method among married women aged 30 and below, with IUDs becoming the most popular method thereafter. IUD use showed a steady increase from the youngest age group

(15-19 years) to the 35-39 age group, followed by a decline (Table 4.2).

CPR appeared to rise with increases in the number of living children. The CPR among women with no children was only 20.3 percent, and it was primarily comprised of traditional methods (11.5 percent). There was a significant difference ($p<0.001$) in the CPR between women with two or more children and women with less than two children. CPR among women with one or no living children was 70.4 percent (with 48.9 percent using a modern method), rising to 87 percent (with 63.2 percent using a modern method) among women with two or more children. CPR followed a skewed normal distribution across years of marriage; only 65.7 percent within first 5 years of marriage, then increasing up to 88.3 percent at 10-14 years of marriage, then declining beyond 15 years of marriage.

Table 4.2: Distribution of currently married women of reproductive age (15–49) by current use of FP methods (percent)

Background characteristics	Total use of any FP methods	Modern FP method							Traditional FP Method			n (applicable)
		Total modern FP methods	Oral pills	Condoms	IUDs	Injectables	Female sterilization	Implants	Total traditional FP methods	Periodic abstinence	Withdrawal	
Residence												
Urban	81.5	66.1	18.3	18.9	23.5	1.0	3.3	1.2	15.4	4.3	11.1	1,543
Rural	80.1	63.8	19.7	11.2	25.8	2.7	3.8	0.5	16.3	4.7	11.6	4,156
Region												
Red River Delta	75.1	64.5	11.2	23.0	28.1	0.3	1.5	0.3	10.5	3.6	7.0	978
Northern Mountains	78.8	66.9	18.2	11.8	27.4	1.6	7.3	0.6	11.9	3.4	8.5	942
North and South Central Coast	82.6	60.6	18.5	11.2	25.4	2.4	2.1	0.9	22.0	4.3	17.7	908
Central Highlands	81.1	68.3	13.0	9.4	34.5	5.7	4.7	1.0	12.8	1.3	11.5	944
Southeastern Region	83.4	56.2	19.4	15.1	18.0	1.2	2.0	0.5	27.2	12.3	14.9	974
Mekong Delta	82.0	70.2	35.7	8.8	17.9	2.4	4.5	0.8	11.8	2.3	9.4	953
Ethnicity												
Kinh	81.1	63.3	18.2	14.9	25.1	1.4	3.1	0.7	17.8	5.5	12.2	4,444
Ethnic	78.2	68.3	23.4	7.7	25.7	5.2	5.7	0.6	9.9	1.1	8.8	1,255
Understanding of the Vietnamese language												
Very well	80.6	64.0	18.5	14.1	25.4	1.8	3.5	0.7	16.6	4.9	11.7	5,287
A little	78.9	70.3	30.0	3.0	23.1	8.9	4.2	1.2	8.6	0.3	8.3	337
Not at all	77.8	68.1	30.6	0.0	20.8	8.3	8.3	0.0	9.7	1.4	8.3	72
Current age												
15-19	49.6	43.8	22.3	12.4	7.4	0.8	0.0	0.8	5.8	0.8	5.0	121
20-24	68.0	53.8	19.8	14.2	17.2	2.0	0.0	0.7	14.2	2.5	11.8	612
25-29	76.3	60.1	21.5	15.4	19.6	2.6	0.5	0.6	16.2	3.2	13.0	1,067

Background characteristics	Total use of any FP methods	Modern FP method							Traditional FP Method			n (applicable)
		Total modern FP methods	Oral pills	Condoms	IUDs	Injectables	Female sterilization	Implants	Total traditional FP methods	Periodic abstinence	Withdrawal	
30-34	84.5	69.7	22.0	15.2	27.5	2.2	1.8	1.0	14.8	4.0	10.8	1,282
35-39	88.3	72.9	22.1	13.3	30.1	2.7	3.8	0.9	15.4	5.0	10.4	1,083
40-44	85.3	67.0	16.7	10.9	29.2	2.3	7.4	0.4	18.4	6.8	11.5	920
45-49	76.7	57.2	8.0	8.6	27.0	1.6	11.7	0.2	19.5	6.8	12.7	614
Number of living children												
None	20.3	8.8	2.7	5.5	0.5	0.0	0.0	0.0	11.5	3.3	8.2	182
1	68.8	54.1	18.9	16.1	16.9	1.4	0.0	0.6	14.7	2.7	12.0	1,394
2	87.2	70.6	20.8	13.9	29.2	2.3	3.5	0.8	16.6	5.1	11.5	2,976
3	87.6	71.5	18.9	10.5	31.7	2.9	7.3	0.2	16.1	4.8	11.3	832
4+	83.8	65.1	17.5	6.7	20.6	5.1	14.3	1.0	18.7	7.9	10.8	315
Years of marriage												
0-4	65.7	51.9	17.1	17.0	14.9	1.5	0.7	0.6	13.7	2.9	10.8	1,246
5-9	82.2	65.8	20.7	17.1	23.4	2.6	1.2	0.9	16.4	4.3	12.1	1,317
10-14	88.3	72.6	25.8	11.0	30.2	2.4	2.5	0.8	15.7	4.7	11.0	1,019
15-19	87.3	70.8	20.8	11.1	31.5	2.8	3.8	0.8	16.4	5.4	11.0	943
20-24	85.8	66.2	15.3	8.3	31.4	2.4	8.4	0.4	19.6	6.3	13.3	751
25-29	77.2	61.1	10.1	9.8	25.5	1.6	14.1	0.0	16.0	5.7	10.3	368
30+	57.5	47.5	10.0	5.0	10.0	5.0	17.5	0.0	10.0	0.0	10.0	40
Total	80.5	64.4	19.3	13.3	25.2	2.3	3.7	0.7	16.1	4.6	11.5	5,699

4.3 Reasons for Not Using FP Methods

Service providers, managers and clients were asked why different FP methods weren't accepted. The most frequently mentioned reason was the misconception that taking pills invariably causes infertility. Often, the reasons for not using condoms included lack of cooperation from male partner, lack of sexual pleasure and feeling shy in acquiring condoms. Among long-acting methods, IUDs were common and there were few mentioned reasons for not using it. The study observed that IUD use increases with age. The availability of IUDs and the awareness campaign around it made IUDs the leading FP method in Viet Nam.

Implants are not readily available and fewer people were aware of it, and injectables were even less popular. Reasons given for the low acceptance of injectables were amenorrhea, the possibility of weight gain and spotting between menstrual periods. There was also a low acceptance rate of permanent methods (i.e. sterilization), even among people with two or more children, aged 40 and above, mainly attributed to the lack of protection against sexually transmitted diseases (STDs) and the minor operation required (Annex Tables 4.5 to 4.12).

4.4 Factors Influencing the Use of Modern FP Methods

Effectiveness was not the only consideration when choosing a modern FP method. Using binary logistic regression with users of modern contraceptives as the dependent variable, a number of

factors were found to influence the choice of modern FP methods. Eighteen independent variables were investigated and factor identification followed an iteration process until a minimum number of variables were identified.

The results revealed that ethnic minority women were significantly more likely (93 percent) ($p<0.01$) to use modern contraceptive methods than Kinh women, though the differences in long-acting method use were not statistically significant (see Tables 4.3 and 4.4). Experience with unlanned pregnancy and age at first pregnancy were the most common influencing factors for the use of both modern and long-acting contraceptive methods. Women who had never experienced unplanned pregnancy were 46 percent more likely to use modern contraceptive methods (odds ratio[7]: 1.46; $p<0.05$) and 56 percent more likely to use long-acting contraceptive methods (odds ratio: 1.56; $p<0.05$) when compared to those who had ever experienced unplanned pregnancy (. Women who experienced their first pregnancy before 26 were 25 percent more likely (odds ratio: 1.25; $p<0.05$) to have adopted a modern contraceptive method. Among others, having two or more living children was significantly associated with using modern contraceptive methods.

Table 4.3: Factors associated with modern contraceptive method use

Variable	Outcome	Use of modern methods		Odds ratio[7] (95% CI)	Risk ratio[8]: Traditional method
		Yes	No		
Residence	Rural	2,686	683	1	0.915(0.802, 1.044)
	Urban	1,067	243	1.117 (0.949, 1.314)	1
Ethnicity	Kinh	2,871	799	1	0.578 (0.486, 0.688)
	Ethnic	882	127	1.933 (1.579, 2.365)*	1
Experience of unplanned pregnancy	Yes	314	108	1	0.746 (0.627, 0.888)
	No	3,386	799	1.458 (1.156, 1.838)*	1
Age at first pregnancy	26+ years	722	210	1	0.836 (0.729, 0.985)
	<26 years	2,965	688	1.253 (1.053, 1.493)*	1
Number of living children	<2	823	234	1	0.863 (0.757, 0.984)
	2+	2,930	692	1.204 (1.019, 1.423)*	1
Age of respondent	26+ years	3,219	798	1	0.973 (0.826, 1.151)
	<26 years	534	128	1.034 (0.840, 1.273)	1
Years of marriage	16+	1,284	339	1	0.919 (0.815, 1.036)
	<16	2,408	572	1.111 (0.956, 1.292)	1
**Significant at 5% level of significance*					

Women who had never experienced unplanned pregnancy were 56 percent more likely to use long-acting methods compared to those ever experienced unplanned pregnancy (odds ratio: 1.56; $p<0.05$). In addition, women who had never terminated a pregnancy were 35 percent more likely to use long-acting methods (odds ratio: 1.35; $p<0.05$). Similarly, women who married after 26 years of age and were not housewives were 25 percent (odds ratio: 1.25; $p<0.05$) and 23 percent (odds ratio: 1.23; $p<0.05$) more likely to use long-acting methods, respectively.

7 *An odds ratio is a relative measure of effect, which allows the comparison of the target group of a study relative to a reference group. The odds of occurring an event A to group P compared to group Q is 1.5 means that the odds of happening the event A to group P is 1.5 times higher (50% greater possibility) compared to group Q.*

8 *Risk ratio is the comparative probability of happening an event compared to a specific group compared to a reference group. The risk of not using long-acting method is (1/0.972)=1.13 times higher among Ethnics compared to Kinhs.*

Table 4.4: Factors associated with long-acting contraceptive method use

Variable	Outcome	Use of long-acting methods		Odds ratio (95% CI)	Risk ratio: Other method
		Yes	No		
Ethnicity	Kinh	1,155	2,515	1	0.972 (0.925, 1.021)
	Ethnic	337	672	1.092 (0.942, 1.266)	1
Experience with unplanned pregnancy	Yes	101	321	1	0. 882 (0.833, 0.934)
	No	1,377	2,808	1.559 (1.235, 1.967)*	1
Occupation	Housewife	260	654	1	0.938 (0.985, 0.982)
	Other	1,209	2,464	1.234 (1.052, 1.447)*	1
Age at first pregnancy	26+ years	264	668	1	0.932 (0.89, 0.976)
	<26 years	1,213	2,440	1.258 (1.074, 1.474)*	1
Age at marriage	26+ years	194	479	1	0.946 (0.897, 0.997)
	<26 years	1,292	2,661	1.199 (1.002, 1.435)	1
History of pregnancy termination	Yes	222	601	1	0.913 (0.871, 0.957)
	No	1,269	2,541	1.352 (1.143, 1.599)*	1

**Significant at 5% level of significance*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CHAPTER 5: QUALITY OF FAMILY PLANNING SERVICES PROVIDED AT PUBLIC AND PRIVATE HEALTH FACILITIES

The distinct and diverse issues surrounding the quality of FP services provided at public and private health facilities in Viet Nam all demand adequate attention.

This chapter evaluates the quality of FP services at different facility levels. Service quality is examined separately for public facilities at different levels: (a) CHCs (grassroots level) and (b) district-level and above facilities[9]. Non-governmental facilities (including both private and NGO-led facilities) were also assessed separately. Differentiating these groups was essential, given the various types of services provided at the different levels (Decree 43/2013, MOH[10]). This chapter contains an analysis disaggregated for national and regional levels along with urban and rural differentials where applicable.

FP service delivery in Viet Nam also includes front line PCs at the village level going door-to-door, but the purview of this chapter is limited to quality of services at the facility level.

9 *District reproductive health and nutrition unit, district reproductive health center, district hospital, provincial reproductive health center and provincial hospital.*

10 *Web page of THONG TIN BENH VIEN [HOSPITAL INFORMATION]. Available at http://thongtinbenhvien.com/danh-sach-benh-vien [Accessed 15 July 2016].*

5.1 Assessment Methods for Quality of Services

Three of the broader considered components for assessing the quality of FP services were: (i) facility preparedness; (ii) provider quality; and (iii) management and supervision. For assessing the state of quality of services, a list of pertinent indicators was prepared in compliance with a rights-based approach, public health concern, compliance with National Standards and in line with the Bruce Quality of Care Framework [14]. All relevant indicators are shown in Box 5.1.

Box 5.1: Indicators used to assess family planning service quality

Basic Physical Amenities: a) functional electricity, b) waiting room, c) functional toilet and d) counseling room (Source: Form F)

Equipment, Instruments: a) instrument trolley; b) examination lights; c) post-operative care room; d) pain relief, anesthesia drugs, lidocaine and shock management kits; e) necessary sterilized equipment; f) functional sterilizer in clinic; g) functional operation theater; h) operating table; i) lights for placental inspection; and j) sufficient number of beds for post-operative care (Source: Form F)

Logistics: a) adequate supply of oral pills, b) adequate supply of condoms, c) adequate supply of IUDs, d) adequate supply of implants and e) adequate supply of medical and surgical requisites for long-acting and permanent methods (Source: Form F)

IEC materials, Job Aids and Registers/record: a) IEC materials in-clinic, b) job aids on advantages and disadvantages, c) job aids to check eligibility, d) contraceptive supply records in facility, e) records of staff instruction on check-ups and f) monthly report submitted on time (Source: Form F)

Adequacy of Manpower Services: No manpower shortages for family planning services (Source: Form F)

Available Services: a) provision of condoms, b) provision of IUDs, c) provision of pills, d) provision of injectables, e) provision of implants, f) provision of female sterilization (tubectomy), g) quantity of FP service integrated campaigns organized last year and h) services for managing complications among family planning clients (Source: Form M)

Provider Trainings: a) received training on providing IUDs, b) received training on providing injectables, c) received training on providing implants, d) received training on providing tubectomies, e) received training on providing vasectomies and f) received training on providing National Standard Guideline for Reproductive Health Care Services (Source: Form P)

Provider Skills: a) insert IUDs, b) provide injectables, c) place implants, d) perform tubectomies, e) perform vasectomies, f) counsel using the GATHER approach (Greets client, Asks client about themselves, Tells client about choices, Helps clients make informed choices, Explains fully how to use the chosen method, and Suggests/welcomes return visits) and g) receive updated information on family planning methods (Source: Form P)

System Management Components: a) receive supplies from higher authorities, b) receive adequate support from higher authorities when requested and c) technical supervisory visit from a higher authority in the last three months (Source: Form P)

The type of services that each specific facility should provide in compliance with MOH directives was accounted for while determining that particular facility's quality of services' score. A sub-list of indicators applicable for each specific facility type was prepared to this end. A facility preparedness score (FPS), provider quality score (PQS), management supervision score (MSS) and quality of service score (QSS) were estimated for each of the study facilities.

Facility survey data were collected by administering three separate forms: (i) Form M, (ii) Form F and (iii) Form P (see Box 5.1), generating three sub-sets which were then cross-matched, manager, facility and provider. If the value of some of the indicators was missing for a few facilities during the cross-matching estimation process[11], such facilities were excluded.

11 *For ensuring consistency, any record (data in any of the manager, facility or provider survey formats) that contained missing value(s) against one or more indicators was not considered for assessment.*

Service quality was assessed separately for (i) CHCs, (ii) family planning service-providing facilities at the district-level and above and (iii) non-governmental facilities (private/NGO-led facilities combined).

Equal weights were assigned to all indicators. Each of the indicators provided a categorical answer (yes or no). If the answer to an indicator was 'yes' for a health facility, then the assigned score was a 1, else the score was deemed 0. Then the scores of all the applicable indicators for each of the facilities were aggregated to generate a single value. The quality of services score (as well as FPS, PQS and MSS) for each of the facilities was adjusted for 1 (maximum possible score is 1, i.e., individual scores of all the indicators under consideration were 1 in a facility).

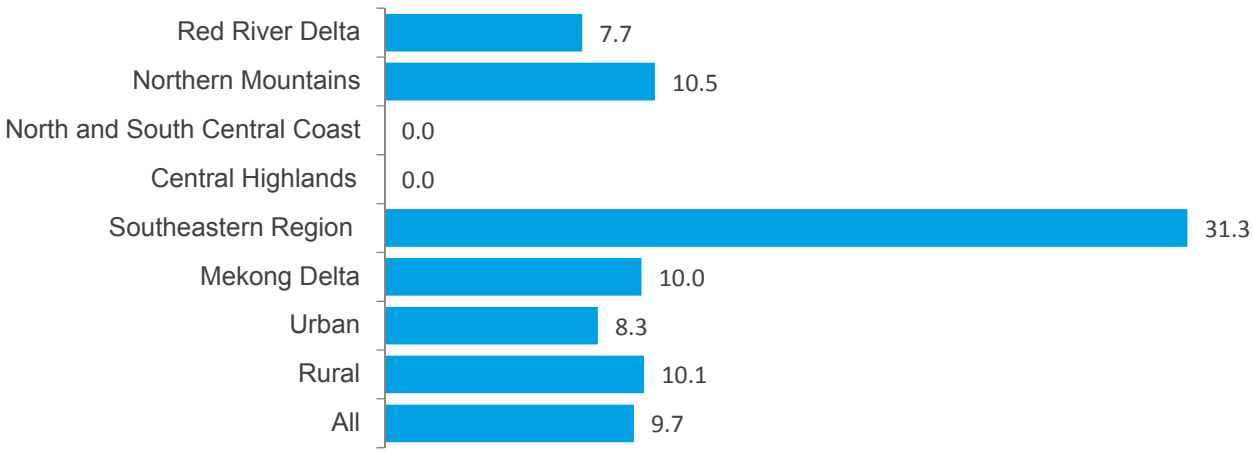
5.1.1 Quality of Family Planning Services at CHCs

The status of indicators used to assess facility preparedness for providing quality services at the commune level was investigated while analyzing survey data (Annex Table 5.1), using twenty-five selected indicators relevant for CHCs.

Data shows that 9.7 percent of CHCs satisfied all 25 facility preparedness indicators (Figure 5.1). Though 85.0 percent of CHCs met at least 20 out of 25 indicators, the proportion of CHCs that satisfied the indicators related to adequate method supply (pill, condom and IUD) was low. Notably, about 30 percent of centers were experiencing a manpower shortage for providing FP services.

Facility preparedness varied by place of residence (urban and rural) and by region. In the North and South Central Coast and Central Highlands, no CHCs satisfied all 25 indicators, but 31.3 percent of CHCs in the Southeastern Region satisfied all 25 indicators.

Figure 5.1: Distribution of CHCs satisfying all 25 facility preparedness assessment indicators by place of residence and region (percent)



In terms of provider quality assessment indicators, 27.2 percent of CHCs satisfied all 12 indicators (Figure 5.2), but the majority of CHCs (85.0 percent) satisfied at least 5 out of the 12 (Annex Table 5.2). Providers discussed return visits with clients in 51.5 percent of centers. Similar to indicators of facility preparedness, provider quality also varied by place of residence (urban and rural) as well as by region. In the Southeastern Region, 62.5 percent of CHCs satisfied all 12 indicators, but only 6.7 percent did in the Central Highlands.

A very high proportion of CHCs satisfied all three of the indicators, indicating successful management and supervision by relevant authorities (Annex Table 5.3). Indicators related to management and supervision also varied by residence (urban-rural) and region. All CHCs in the North and South Central Coast met all three indicators (Figure 5.3), but only 60 percent did in the Central Highlands.

Figure 5.2: Distribution of CHCs satisfying all 12 provider quality assessment indicators by place of residence and region (percent)

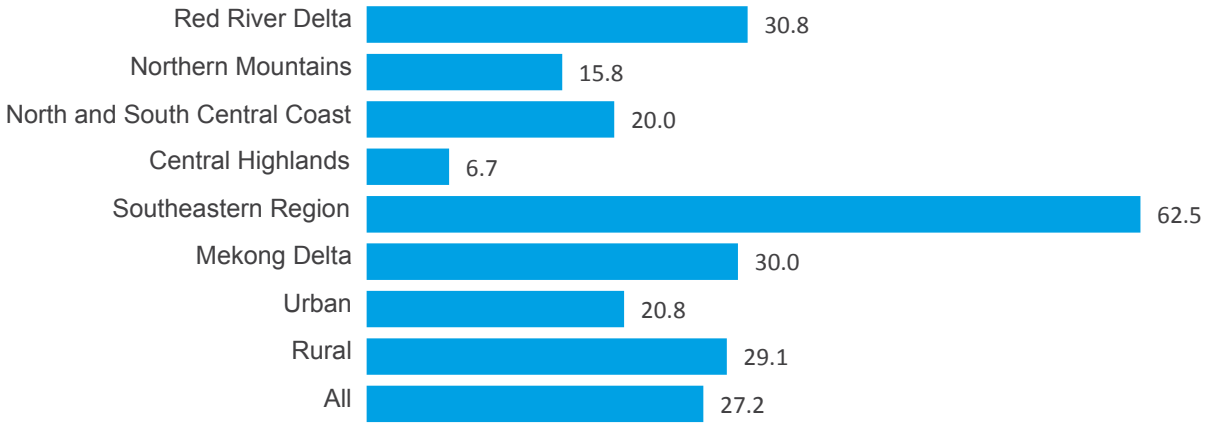
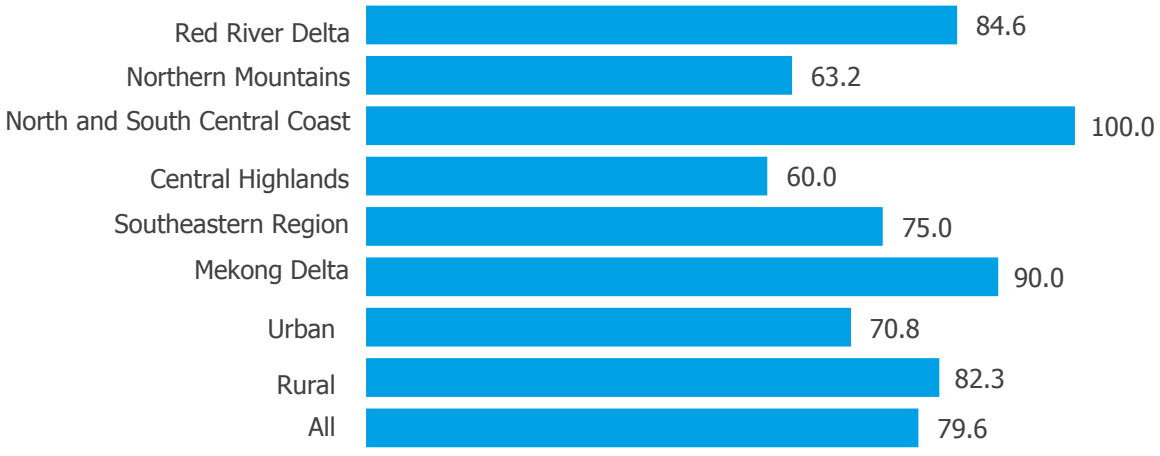


Figure 5.3: Distribution of CHCs satisfying all three management and supervision assessment indicators by place of residence and region (percent)



The state of indicator compliance is presented in Table 5.4. Common underperforming indicators included: (i) providers did not suggest or welcome return visits in 48.5 percent of CHCs, (ii), job-aids were not available to evaluate individual eligibility for specific methods in 31.1 percent of CHCs, (iii) 30.1 percent of CHCs were experiencing a shortage of trained FP manpower, (iv) providers did not fully explain how to use the chosen method in 26.2 percent of CHCs and (v) providers had not received training on the National Standard Guideline for Reproductive Health Care Services (NGFRHCS) in 23.3 percent of CHCs.

5.1.2 Composite Quality of Service Score for CHCs

The composite quality of service score was estimated for each CHC. All scores were classified into three groups based on the maximum and minimum values.

Facility Preparedness: The average CHC facility preparedness score was 0.90 (ranging from 0.72 to 1.00). More than half (56.3 percent) of the centers fell in the highest range (0.91 – 1.00) with another fifth (28.2 percent) ranging from 0.82 to 0.90 (Table 5.1). Most of the CHCs in the Southeastern Region (87.5 percent) scored in the highest group. In the North and South Central Coast and Red River Delta regions, the corresponding proportions were 55.0 percent and 53.8 percent, respectively. About a quarter of CHCs in the Northern Mountains (26.3 percent) and Central Highlands (26.7 percent) fell in the lowest section from 0.72 to 0.81.

Facility preparedness scores varied by place of residence and region. There were significant differences between average facility preparedness scores across the distinct regions (p=0.001).

Table 5.1: Distribution of facility preparedness score by place of residence and region (percent)

Score	Residence		Region						Total
	Urban	Rural	Red River Delta	Northern Mountains	North South Central Coast	Central Highlands	South-eastern Region	Mekong Delta	
0.72 - 0.81	20.8	13.9	7.7	26.3	25.0	26.7	0.0	5.0	15.5
0.82 - 0.90	37.5	25.3	38.5	31.6	20.0	46.7	12.5	25.0	28.2
0.91 - 1.00	41.7	60.8	53.8	42.1	55.0	26.7	87.5	70.0	56.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	24	79	13	19	20	15	16	20	103
Mean	0.878	0.904	0.905	0.876	0.874	0.867	0.950	0.920	0.898
Median	0.880	0.920	0.920	0.880	0.920	0.880	0.960	0.920	0.920
Minimum	0.720	0.760	0.760	0.760	0.720	0.800	0.880	0.800	0.720
Maximum	1.000	1.000	1.000	1.000	0.960	0.960	1.000	1.000	1.000
p-value	0.114		0.001						

Provider Quality: The average CHC provider quality score was 0.82 (ranging from 0.25 to 1.0). About 64.1 percent of centers were in the highest scoring group, between 0.76 and 1.0. The Southeastern Region and Mekong Delta had the highest proportion of CHCs in the top scoring group with 87.5 percent and 75.0 percent, respectively (Table 5.2). In the Northern Mountains and Central Highlands, more than one-fifth of centers had the lowest scores (ranging from 0.25 to 0.5). Average provider quality scores varied significantly by region (p=0.001).

Table 5.2: Distribution of provider quality score by place of residence and region (percent)

Score	Residence		Region						Total
	Urban	Rural	Red River Delta	Northern Mountains	North South Central Coast	Central Highlands	South-eastern Region	Mekong Delta	
0.25 - 0.50	8.3	6.3	0.0	21.1	0.0	13.3	6.3	0.0	6.8
0.51 - 0.75	25.0	30.4	38.5	31.6	35.0	40.0	6.3	25.0	29.1
0.76 - 1.00	66.7	63.3	61.5	47.4	65.0	46.7	87.5	75.0	64.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	24	79	13	19	20	15	16	20	103
Mean	0.816	0.824	0.846	0.732	0.833	0.728	0.927	0.867	0.822
Median	0.833	0.833	0.833	0.667	0.833	0.750	1.000	0.833	0.833
Minimum	0.500	0.250	0.583	0.500	0.583	0.250	0.500	0.583	0.250
Maximum	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
p- value	0.839		0.001						

Management and Supervision: On average, the management-supervision component of quality CHC services scored 0.91 (ranging from 0.33 to 1.0) (Table 5.3), indicating a nearly ideal level of management and supervision within CHCs. Of all CHCs, 79.6 percent of the facilities scored in the highest group - between 0.78 and 1.0. Only six of the 103 participating centers fell in the lowest group (0.33 - 0.55). Average management-supervision score varied significantly by region (p=0.030).

Table 5.3: Distribution of management supervision score by place of residence and region (percent)

Score	Residence		Region						Total
	Urban	Rural	Red River Delta	Northern Mountains	North South Central Coast	Central Highlands	Southeast-ern Region	Mekong Delta	
0.33-0.55	12.5	3.8	0.0	15.8	0.0	6.7	6.3	5.0	5.8
0.56-0.77	16.7	13.9	15.4	21.1	0.0	33.3	18.8	5.0	14.6
0.78- 1.0	70.8	82.3	84.6	63.2	100.0	60.0	75.0	90.0	79.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	24	79	13	19	20	15	16	20	103
Mean	0.861	0.928	0.949	0.825	1.000	0.844	0.896	0.950	0.913
Median	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Minimum	0.333	0.333	0.667	0.333	1.000	0.333	0.333	0.333	0.333
Maxi-mum	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
p-value	0.123		0.030						

Quality of Family Planning Services: The average CHC quality of service score was 0.88 (ranging from 0.65 to 1.00) (Table 5.4). Nearly half of CHCs (46.6 percent) scored between 0.78 and 0.89, and another 46.6 percent of centers were in the highest scoring range between 0.90 and 1.00. Scores did not vary by place of residence or region.

Nearly all of the CHCs in the Southeastern Region (93.8 percent) belonged to the high scoring category (0.90 – 1.00) with the remaining 6.3 percent falling in the middle category (0.78 – 0.89). In the Mekong Delta and Red River Delta, 65.0 percent and 46.2 percent of CHCs scored in the highest group, respectively. None of the CHCs in the Mekong Delta, Red River Delta or Southeastern Region were in the lowest scoring category (0.65 – 0.77). The proportion of CHCs in the high scoring category were much lower in the Northern Mountains and Central Highlands (21.1 percent and 6.7 percent, respectively). The proportion of CHCs in the middle scoring category (0.78 – 0.89) in these regions was 57.9 percent and 80.0 percent, respectively.

Table 5.4: Distribution of CHC quality of service score by place of residence and region (percent)

Score	Residence		Region						Total
	Urban	Rural	Red River Delta	Northern Mountains	North South Central Coast	Central Highlands	Southeastern Region	Mekong Delta	
0.65 - 0.77	16.7	3.8	0.0	21.1	5.0	13.3	0.0	0.0	6.8
0.78- 0.89	41.7	48.1	53.8	57.9	50.0	80.0	6.3	35.0	46.6
0.90 - 1.00	41.7	48.1	46.2	21.1	45.0	6.7	93.8	65.0	46.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	24	79	13	19	20	15	16	20	103
Mean	0.858	0.882	0.890	0.829	0.871	0.823	0.939	0.906	0.876
Median	0.863	0.875	0.875	0.825	0.875	0.825	0.950	0.913	0.875
Minimum	0.700	0.650	0.800	0.700	0.725	0.650	0.800	0.800	0.650
Maximum	1.000	1.000	0.975	0.950	0.950	0.975	1.000	1.000	1.000
p-value	0.162		0.000						

Analysis of CHC quality of service scores revealed that there was a significant difference between average scores in different regions (p=0.000).

Altogether, 48 out of the 103 CHCs fell into the highest quality group (QSS between 0.91 and 1.0) with 6 in Red River Delta, 4 in the Northern Mountains, 9 in the North and South Central Coast, 15 in the Southeastern Region and 13 in the Mekong Delta. Another 48 CHCs fell in the middle group (QSS between 0.78 and 0.89) with 7 in the Red River Delta, 11 in the Northern Mountains, 10 in the North and South Central Coast, 12 in the Central Highlands, 1 in the Southeastern Region and 7 in the Mekong Delta. Ultimately, 7 CHCs were in the lowest quality group (QSS between 0.65 and 0.77) with 4 in the Northern Mountains, 2 in the Central Highlands and 1 in the North and South Central Coast. It is worth noting that 45 CHCs had facility preparedness scores (FPSs) below 0.9, another 23 had provider quality scores below 0.75, and 21 had management supervision scores below 0.8. Five CHCs did not have high-quality scores in any of the three categories (i.e., FPS below 0.9, PQS below 0.75 and MSS below 0.8). Annex Table 5.13 has details about Quality of Service Scores (QSSs) by components and by CHCs.

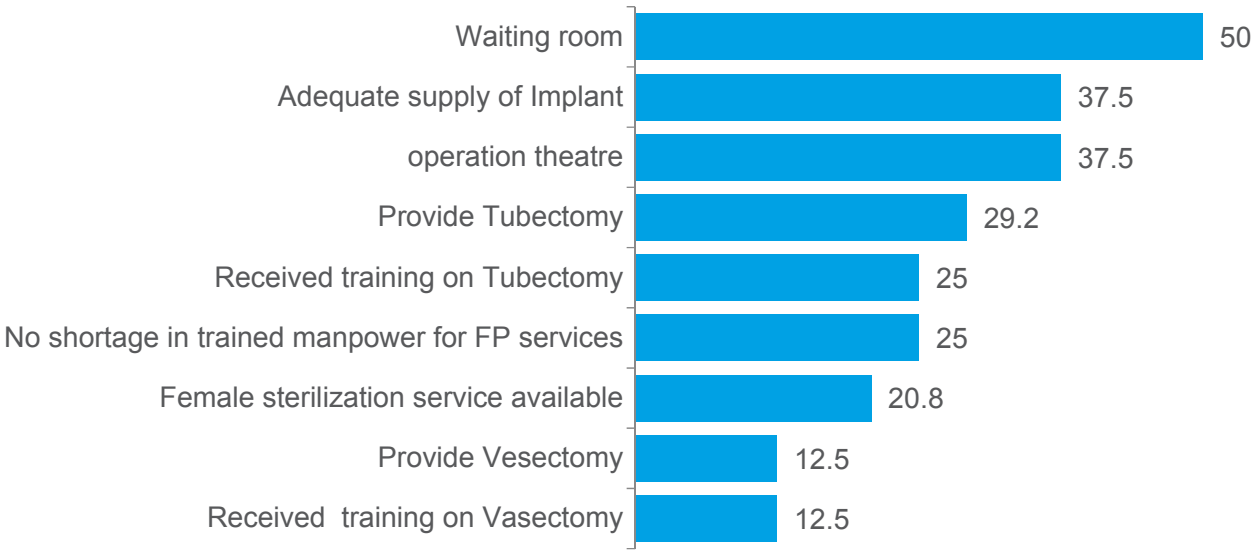
5.2 Quality of Family Planning Services at District-Level Facilities and Above

Facility Preparedness: Thirty indicators were used to assess facility preparedness for providing applicable family planning services in district-level facilities and above. Annex Table 5.4 presents the level of compliance of the indicators. For 16 of the 30 indicators, the facilities were either nearly or fully prepared to provide quality services (compliance between 80 and 100 percent). Some of the other 14 indicators do not need focus or targeted improvement, such as some facilities not needing to have separate operation theaters or post-operative rooms because they

have a district hospital or district reproductive health center within close proximity. However, other indicators were concerning, such as 75 percent of district-level facilities and above reporting a shortage of trained personnel to provide the full range of family planning services.

Provider Quality: Eighteen relevant indicators were selected to assess the state of provider quality in district-level facilities and above. For half of the 18 indicators, between 83.3 and 100.0 percent of facilities had either ideal or close-to-ideal provider quality (Annex Table 5.5). About 75 percent of facilities had personnel trained on contraceptive injectables and the NGFRHCS, and 62.5 percent had staff trained on implants. The proportion of facilities offering tubectomies and vasectomies (and had the trained manpower to do so) was low. The demand for permanent methods in Viet Nam is currently low, as confirmed by the GOFPP during the review of this study's preliminary findings. However, having trained personnel for those who do seek permanent methods is a part of providing a full range of family planning services at district-level facilities and above (MOH decree 43, 2013[12]).

Figure: 5.4: Poor compliance quality assessment indicators at district-level facilities and above (percent)



Management and Supervision: The overall state of management and supervision related to family planning services for district-level facilities and above is satisfactory (Annex Table 5.6). Whether or not a technical supervisor visits facilities is a meaningful indicator for enhancing quality of services, but only 58.3 percent of district-level facilities and above reported that their technical supervisors visited their facilities within last three months preceding the survey.

Given this context, the study explored contributing factors for non-compliance with quality indicators at district-level facilities and above. Nine of the 51 total indicators had poor compliance (Annex Tables 5.4-5.6); the lowest 6 indicators of which were related to sterilization and availability of trained manpower for FP services (compliance ranging between 12.5 percent and 29.2 percent) (Figure 5.4).

Score of Quality of Family Planning Services: The study estimated the quality of family planning service score using the three dimensions of quality (facility preparedness, provider quality and management-supervision). Section 5.2 outlines the methodology for this estimation. The average quality of service score for district-level facilities and above was 0.75 (ranging from 0.51 to 0.94) (Table 5.5). This quality of service score (0.75) was calculated by aggregating the three separate

12 *Web page of THONG TIN BENH VIEN [HOSPITAL INFORMATION]. op. cit.*

scores: average facility preparedness score of 0.75 (range: 0.43 – 0.97), provider quality score of 0.69 (range: 0.39 – 1.0) and management-supervision score of 0.81 (range: 0.33 -1.00).

About 58.3 percent of district-level facilities and above had scores between 0.71 and 0.90, and 16.7 percent of facilities fell into the bracket ranging between 0.61 and 0.70.

Table 5.5: Distribution of facility preparedness, provider quality, management supervision and quality of services scores of district-level facilities and above (percent)

Scores	Facility preparedness	Provider quality	Management and supervision	Quality score
Up to 0.5	4.2	16.7	12.5	0.0
0.51 - 0.60	20.8	4.2	0.0	16.7
0.61 - 0.70	4.2	29.2	33.3	16.7
0.71 - 0.80	29.2	33.3	0.0	37.5
0.81 - 0.90	37.5	4.2	0.0	20.8
0.91 - 1.00	4.2	12.5	54.2	8.3
Total	100.0	100.0	100.0	100.0
n	24	24	24	24
Mean	0.75	0.69	0.81	0. 75
Median	0.77	0.69	1.00	0.82
Minimum	0.43	0.39	0.33	0.38
Maximum	0.97	1.00	1.00	0.99

5.3 Quality of Family Planning Services at Non-Governmental Facilities

Though this study attempted to include non-governmental facilities (combining private and NGO-led facilities), only nine out of the 20 originally sampled facilities could be surveyed. Such a small sample size limits the ability to produce concrete or representative findings. As such, the information presented in this section should be taken at face value and with reservations. The non-governmental facilities surveyed were similar to district-level facilities, and as such, the indicators used to assess service quality were similar to that of district facilities.

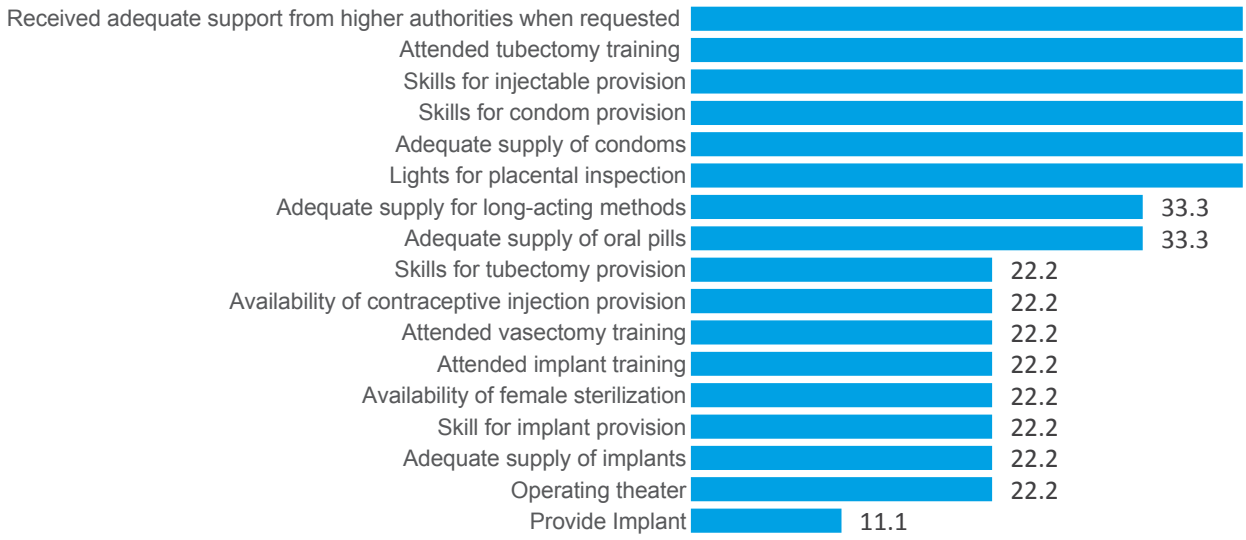
Facility Preparedness: Only 11 out of 32 indicators in non-governmental facilities were at a nearly ideal level of preparedness (the proportion of facilities complying with these indicators was above 80.0 percent) (Annex Table 5.9), though between 66.6 percent and 77.8 percent of facilities complied with another seven indicators. Nearly all facilities had the necessary equipment, and two-thirds had sufficient trained manpower for providing family planning services. Only 22.2 percent of facilities had an adequate supply of implants, and 55.6 percent had an adequate supply of medical and surgical requisites for long-acting and permanent method procedures.

Provider Quality: Six out of 17 provider quality indicators had strong compliance (Annex Table 5.10), ranging between 88.9 percent and 100.0 percent, and medium compliance with another four provider quality indicators, ranging from between 66.6 percent and 77.8 percent.

The state of authority **management and supervision** was lagging behind the state of facility preparedness and provider quality (Annex Table 5.11) and needs improvement.

Compliance was less than 50 percent for 17 of the 52 total indicators (Annex Table 5.12). Availability of implant services was the lowest reported indicator, with only one out of nine facilities surveyed providing the service (Figure 5.5).

Figure 5.5: Poor compliance quality assessment indicators at non-governmental facilities (percent)



The **quality of service score** was estimated using a methodology similar to that for district-level facilities and above. The average quality of service score for non-governmental facilities was 0.58 (ranging from 0.31 to 0.90) (Table 5.6) with an average facility preparedness score of 0.65 (range: 0.19 – 0.97), provider quality score of 0.59 (range: 0.28 – 0.78) and management-supervision score of 0.52 (range: 0.0 – 1.0).

Table 5.6: Distribution of facility preparedness, provider quality management and supervising and overall quality of service scores of non-governmental (private/NGO-led) facilities (percent)

Scores	Facility service	Provider quality	Management and Supervision	Quality score
Up to 0.5	11.1	22.2	44.4	25.9
0.51 - 0.60	33.3	22.2	0.0	18.5
0.61 - 0.70	22.2	33.3	11.1	22.2
0.71 - 0.80	0.0	22.2	0.0	7.4
0.81 - 0.90	11.1	0.0	0.0	3.7
0.91 - 1.00	22.2	0.0	44.4	22.2
Total	100.0	100.0	100.0	100.0
n	9	9	9	9
Mean	0.65	0.59	0.52	0.58
Median	0.61	0.61	0.67	0.63
Minimum	0.19	0.28	0.00	0.15
Maximum	0.97	0.78	1.00	0.91

The study collected information on service quality through observation techniques. Due to time and resource constraints, data was only collected from the district-level and above, as well as from non-governmental facilities. Moreover, the indicators used for such data collection differed from those used in other types of survey techniques in the study. Thus, the observation data has not been included in estimating the quality of service scores by type of facilities for maintaining compatibility.

To better understand the quality of service at the district-level and above as well as at non-governmental facilities, the observation data is presented below (Table 5.7), however, the number of observations carried out at each type of facility was not sufficient to derive any statistically significant conclusions.

Table 5.7: Distribution of health facility by type and indicator compliance status (percent)

Indicators	District- and above-level facilities	n	Private/ Non-government facilities	n
Clinic signboard visible	89.3	28	85.7	7
List of services displayed outside	53.6	28	71.4	7
Service charge list	60.7	28	57.1	7
Adequate sitting arrangements	68.0	25	85.7	7
Framed posters on FP services	56.0	25	28.6	7
Clean outpatient department	81.5	27	85.7	7
Clean procedure room	92.6	27	71.4	7
Dry sterilizer	82.6	23	40.0	5
Autoclave	78.3	23	80.0	5
Scrubbing place is adjacent to OT Room	89.3	28	83.3	6
Has basin with an elbow tap and running water	46.4	28	33.3	6
Windows are closed	82.1	28	71.4	7
Slippers exclusively for procedure room	59.3	27	28.6	7
Single (large) spot light available in the procedure room	78.6	28	71.4	7
Procedure table with plastic cover or sheet	67.9	28	71.4	7
Procedure table with small step available	89.3	28	85.7	7
Cupboard is used for equipment	89.3	28	71.4	7
Instrument trolley for essential instruments, drapes, etc.	75.0	28	57.1	7
Sterilized kits for procedures are available	92.9	28	71.4	7
An additional tray to keep all emergency medicine	78.6	28	57.1	7
Ambubag, oxygen cylinder and suction machine available	50.0	28	42.9	7
Waste disposal basket with lining or proper lid	92.9	28	85.7	7
Chlorine solution bucket & clean detergent water bucket	92.9	28	85.7	7
Counselor trained on counseling	96.4	28	100.0	7
Staff trained on infection prevention	64.3	28	42.9	7
Providers trained on IUD procedure	100.0	28	85.7	7
Providers trained on implant procedure	75.0	28	42.9	7
Providers trained on tubectomy procedure	39.3	28	42.9	7
Providers trained on vasectomy procedure	32.1	28	28.6	7
Auditory privacy during counseling	57.1	28	33.3	6
Visual privacy during counseling	53.6	28	33.3	6
Provider responds to client's questions	96.3	27	83.3	6
Listening to client's concerns	96.3	27	80.0	5
Having a flip chart for counseling	71.4	28	16.7	6

Indicators	District- and above-level facilities	n	Private/ Non-government facilities	n
Method-specific checklist/job-aid available	60.7	28	16.7	6
Having pelvic & penile model available for counseling	39.3	28	28.6	7
Client feedback confirms what provider communicated	57.7	26	28.6	7
Provider assists client in giving consent for procedure	88.5	26	85.7	7
Client informed of procedure's benefits	84.6	26	85.7	7
Client informed of procedure's related risks/ complications	73.1	26	85.7	7
Client informed of alternatives	80.8	26	85.7	7
Chloramine 0.5% solution is available	96.0	25	85.7	7
Submerging instruments under the surface of the solution	100.0	25	85.7	7
Drawing chlorine solution into syringe and tube then rinse	88.0	25	85.7	7
Disassemble all parts of the instruments	92.0	25	85.7	7
Soaked in the decontamination solution for 10 minutes	100.0	25	85.7	7

Summary on Quality of FP Services in Studied Health Facilities

The quality of FP services depends on 3 components: (i) facility preparedness, (ii) provider quality (technical skill) and (iii) management and supervision. To assess the service quality of a facility, the study estimated a facility preparedness score (FPS), provider quality score (PQS) and management supervision score (MSS) separately. The quality of service score (QSS) for each of the surveyed facilities was then estimated by averaging these 3 scores. Estimates show that the average quality score for CHCs is high (quality score: 0.88 out of 1.0) and 46.6 percent of CHCs fell into the highest quality score group category (range: 0.90 - 1.00); only 6.8 percent were in the lowest category (range: 0.65 – 0.77), meaning 59.2 percent of CHCs are above average. Among the district-level facilities and above, 45.8 percent were above the median quality score (0.75). Similarly, 44.4 percent of private/NGO-led facilities scored above the median level (0.60). Primary quality barriers were shortages of trained staff for providing FP services and inadequate supply of contraceptives year-round, irrespective of facility type.

However, only 9.7 percent of CHCs satisfied all 25 facility preparedness indicators. Facility preparedness's quality varied by place of residence (urban and rural) and by region. In the North and South Central Coast and Central Highlands, no CHCs satisfied all 25 indicators, but 31.3 percent of CHCs in the Southeastern Region satisfied all 25 indicators. In terms of provider quality assessment indicators, 27.2 percent of CHCs satisfied all 12 indicators. In the Southeastern Region, 62.5 percent of CHCs satisfied all 12 indicators, but only 6.7 percent did in the Central Highlands. In contrast, a very high proportion of CHCs satisfied all three of the indicators reflecting the status of management and supervision by relevant authorities. Indicators related to management and supervision also varied by residence (urban-rural) and region. All CHCs in the North and South Central Coast met all three indicators, but only 60 percent did in the Central Highlands.

CHAPTER 6: FAMILY PLANNINNG-SEEKING BEHAVIORS AND CLIENT SATISFACTION

Client satisfaction is a desired health care outcome directly related to the utilization of health services. It reflects the gap between expectations and experience from the client's point of view. Put it in another way, client satisfaction is an indirect measure of client perceptions on reproductive health service quality including FP. It is closely associated with client interactions with the physical amenities of the facility and the provider. Presumably, if someone is satisfied with the service quality of a particular facility, she/he is likely to refer it to others. Thus, client satisfaction as well as client intention to refer a facility to others are two proxy indicators of client perception on service quality.

This chapter assesses FP-seeking behaviors, client satisfaction with FP services and associated factors. Section 6.1 presents the level of client satisfaction and intention to refer neighbors and friends to the facility. The corresponding section also examines factors that contribute to client intention to refer. Section 6.3 investigates the relationship between client satisfaction and the quality of FP services. Section 6.4 analyzes the determinants of client satisfaction on family planning services.

6.1 Family Planning Service-Seeking Behavior and Client Experience Visiting Facilities

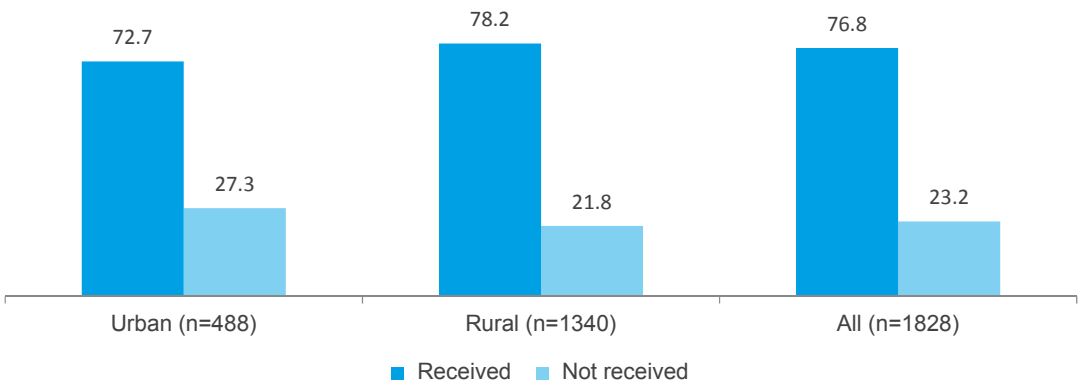
Type of Facility Visited for FP Method: A substantial proportion of women currently using modern contraceptive methods went to CHCs (55.1 percent) for various FP services including counseling; 15.5 percent went to district-level facilities and above and 8.7 percent sought services from private/NGO-led facilities (Table 6.1). PCs provided services to 20.7 percent of FP clients. Though PCs do not provide any direct clinical FP services, they do provide counseling and/or referrals. CHCs do not offer sterilizations or implant insertion, so those who visited CHCs for these services (28 out of 1,315 people) most likely went for counseling or for other services (including follow-up, treatment of side effects or mobile camps conducted by district FP and nutrition units).

Table 6.1: Distribution of respondents by use of current method and facility type (percent)

Type of facility	Pills	Condoms	IUDs	Injectables	Female sterilization	Implants	All
Provincial hospital	1.5	1.8	3.7		24.7	3.6	4.0
Provincial RH center	1.3	2.6	4.0	2.5	4.7	32.1	3.3
District hospital (obstetrics)	1.7	1.1	7.2	3.7	50.7	7.1	7.5
District FP and nutrition teams			0.7		4.7	7.1	0.7
Commune health centers	46.1	48.0	67.2	74.1	12.0	35.7	55.1
Population collaborator	47.6	43.2	2.4	6.2	2.0		20.7
Private/NGO-led clinic	1.8	3.3	14.8	13.6	1.3	14.3	8.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n (applicable)	716	271	1143	81	150	28	2389

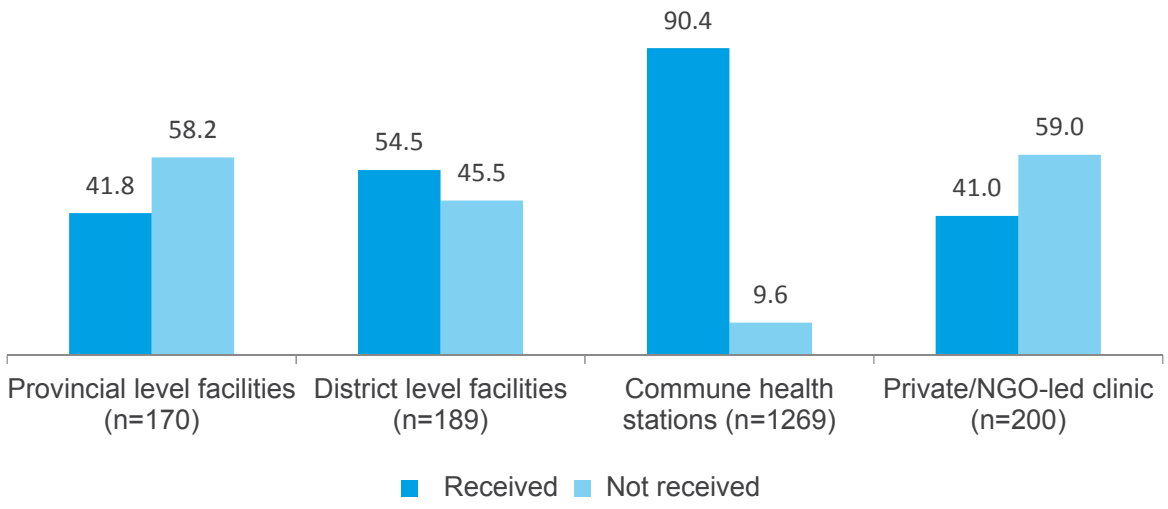
Receiving Required Service: About 76.8 percent of clients received the services they sought in the facility they visited. The proportion was higher (p=0.0139) in rural areas compared to urban areas (Figure 6.1). There was also a significant (p<0.05) difference between ethnic minorities (86.2 percent) and Kinh populations (74.3 percent) in terms of receiving their required services.

Figure 6.1: Distribution of respondents by whether they received the required services (percent)



Notably, 90.4 percent of respondents who visited CHCs received the services they needed (Figure 6.2). Reportedly, 41.8 percent of those who visited provincial-level facilities received the services they sought, as did 54.5 percent of those who visited district-level facilities. About 41.0 percent respondents who visited private/NGO-led facilities received their desired services.

Figure 6.2: Distribution of respondents who received required services by type of facilities (percent)



Distance: The average time it took to reach FP service facilities was about 12 minutes (Table 6.3) with 70.3 percent of respondents living 11 minutes away. A small percentage of respondents (3.6 percent) needed more than 30 minutes to travel, and 12.9 percent of respondents needed between 16 minutes and 30 minutes to reach their FP service facility (Table 6.2).

Table 6.2: Distribution of respondents by distance between home and facility (percent)

Distance (in minutes)	Provincial hospital	Provincial RH center	District hospital (obstetrics)	District family planning and nutrition unit	Commune health centers	Private/ NGO-led clinic	Total
Up to 5	27.7	15.6	33.3	17.6	40.3	30.8	36.7
6-10	33.0	46.8	24.7	41.2	35.9	21.9	33.6
11-15	11.7	5.2	14.4	11.8	13.8	11.9	13.2
16-30	20.2	20.8	18.4	29.4	8.4	28.4	12.9
More than 30	7.4	11.7	9.2	0.0	1.6	7.0	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n (applicable)	94	77	174	17	1258	201	1821
Mean (minute)	15.14	17.86	15.29	13.47	10.09	16.11	11.87

The distance between a client's home and facility varied depending on the region (p = 0.000). In the Mekong Delta, the average travel time was 15.6 minutes (Table 6.3), with 5.6 percent of clients traveling more than 30 minutes.

Table 6.3: Distribution of respondents by distance between home and facility by region (percent)

Distance (in minutes)	Residence		Region						All
	Urban	Rural	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	South-eastern Region	Mekong Delta	
Up to 5	35.0	37.3	66.8	34.5	39.7	32.9	29.2	18.6	36.7
6-10	43.1	30.1	20.1	35.0	31.5	37.5	41.3	35.6	33.6
11-15	10.2	14.3	9.7	15.0	13.3	15.9	9.6	15.8	13.2
16-30	9.8	14.0	2.7	12.7	12.4	11.0	13.4	24.5	12.9
More than 30	1.8	4.3	0.7	2.7	3.0	2.7	6.5	5.6	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n (app)	489	1332	298	220	330	328	322	323	1821
Mean (minute)	10.57	12.35	7.80	11.21	10.90	11.74	13.50	15.57	11.87
p-value	0.002				0.000				
Maximum	120	120	120	60	45	90	120	90	120

Waiting Time: The average client wait time was 10.8 minutes to meet their health care provider (Table 6.3). Within CHCs specifically, their average wait time was 9.5 minutes. About 82.1 percent of clients had to wait 15 minutes (85.3 percent of CHC clients, specifically).

Table 6.4: Distribution of respondents by wait time (percent)

Waiting time (in minutes)	Provincial hospital	Provincial RH center	District hospital (obstetrics)	District family planning and nutrition unit	Commune health centers	Private/ NGO-led clinic	Total
Up to 15	75.0	54.9	80.5	81.8	85.3	72.7	82.1
16-30	20.5	25.5	16.1	9.1	12.9	26.0	15.3
31-45	2.3	5.9	1.1	9.1	0.4	0.6	0.8
More than 45	2.3	13.7	2.3	0.0	1.4	0.6	1.8
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n (applicable)	44	51	87	11	1007	154	1354
Mean (minute)	13.32	27.82	11.74	14.55	9.48	12.28	10.80

Client wait time varied depending on region ($p = 0.017$). Clients in the Northern Mountains needed to wait about 13.1 minutes, on average, while clients in the Red River Delta waited 8.6 minutes. About 4.2 percent of clients in the Southeastern Region and 1.6 percent of clients in the Red River Delta waited more than 30 minutes.

Table 6.5: Distribution of respondents by wait time and region (percent)

Waiting time (in minutes)	Residence		Region						All
	Urban	Rural	Red River Delta	Northern Mountains	North and South Central Coast	Central Highlands	Southeastern Region	Mekong Delta	
Up to 15	85.2	81.0	84.9	82.1	73.3	85.0	84.4	81.4	82.1
16-30	12.2	16.3	13.5	15.4	24.4	12.6	11.4	15.7	15.3
31-45	0.9	0.8		1.2	0.5	0.8	1.5	1.0	0.8
More than 45	1.7	1.9	1.6	1.2	1.8	1.6	2.7	1.9	1.8
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n (applicable)	344	1010	252	162	221	246	263	210	1354
Mean (minute)	11.75	10.47	8.58	9.94	11.76	10.72	12.32	11.30	10.80
p-value	0.110		0.017						
Maximum	180	180	60	75	60	100	180	60	180

The study also highlighted client experiences during their facility visit. Most of the clients (76.1 percent) mentioned that the facility had IEC materials on display. Promisingly, 85.8 percent of clients found their provider empathetic and 83.3 percent felt their provider listened to them. A substantial proportion of women (77.3 percent) mentioned their provider told them about follow-up visits. However, only 67.2 percent of women who went to the facility to start using a new method reported that the provider asked screening questions.

Table 6.6: Distribution of client experiences during facility visits (percent)

Indicators	Yes	No	Don't remember	n
Displaying IEC materials	76.1	23.9	0.0	1,726
Provider was empathetic	85.8	6.6	7.6	1,735
Provider listened to client	83.3	7.8	8.9	1,735
Provider asked supplementary questions	55.7	31.2	13.1	1,735
Provider gave choices	68.2	20.6	11.2	1,735
Provider explained positive and negative aspects	73.4	16.5	10.1	1,735
Provider asked screening questions	67.2	32.8	0.0	703
Provider discussed follow-up visits	77.3	22.7	0.0	1,571

6.2 Status of Client Satisfaction

Client satisfaction questions were posed to respondents who currently use any modern methods and received services (counseling and/or the full range of FP services) from any facility (CHC, district family planning and nutrition unit, district reproductive health center, district hospital, provincial reproductive health center, provincial hospital or private/NGO-led clinic).

The respondents were asked to rate their level of satisfaction. Five possible options[13] were presented for each respondent to express their level of satisfaction.

A majority 93.0 percent of clients were either satisfied (71.1 percent) or very satisfied (21.9 percent) with the service(s) offered by the particular facility. The proportion of satisfied clients varied significantly (p=0.001) by residence (urban: 89.6 percent and rural: 94.4 percent). The proportion of clients who were satisfied (satisfied and very satisfied aggregated together) varied by type of facility: 93.5 percent of clients were satisfied with CHCs, 90.9 percent with district-level facilities and above and 93.8 percent with private/NGO-led facilities.

Table 6.7: Distribution of respondents by level of satisfaction, residence and facility type (percent)

Level of satisfaction	Residence		District and above facilities	Commune health center	Private/NGO-led facilities	All
	Urban	Rural				
Very satisfied	16.6	24.0	19.3	24.0	11.6	21.9
Satisfied	73.0	70.4	71.6	69.5	82.2	71.1
Somewhat	9.2	4.1	7.1	5.2	4.8	5.5
Quality improvement needed	0.2	0.2	0.3	0.2	0.0	0.2
Not satisfied	0.9	1.4	1.7	1.2	1.4	1.3
All	100.0	100.0	100.0	100.0	100.0	100.0
n (applicable)	433	1,131	296	1,122	146	1,564

Box 6.1: Percentage distribution of satisfied clients by quality type of CHCs

Quality level	Satisfied clients (%)
Low (quality score: 0.65-0.77)	83.1
Medium (quality score: 0.0.78-0.89)	93.8
High (quality score: 0.90-1.00)	94.1
p-value	0.002

The study examined the relationship between the quality of services provided by CHCs and client satisfaction. Ultimately, 94.1 percent of clients who received services from high-quality CHCs (with a quality of services score ranging between 0.90 and 1.00) were satisfied (Box 6.1). The proportions of satisfied clients who received services from medium- (quality score: 0.78-0.89) and low-quality (quality score: 0.65-0.77) centers were 93.8 percent and 83.1 percent, respectively. There was a significant difference among the stated proportions of satisfied clients (p=0.002), indicating that an increase in quality of services may lead to an increase in client satisfaction.

The study also disclosed client intentions to refer others to the particular facility they visited, assuming that satisfied clients would be likely to refer the facility to others. Eligible respondents were asked if they would refer their facility, a) yes, b) maybe or (c) no. About 77.4 percent of clients would recommend the facility to others (meaning they answered either “yes” or “maybe”). Though the majority of clients were satisfied with services, only about 40.2 percent of clients (who said ‘yes’) had a clear intention to refer, and 37.2 percent of those who said “maybe” were undecided whether to refer the facility or not. The difference between the proportion of “yes” and “maybe” answers was not significant (p=0.089).

13 *(a) Very satisfied, (b) satisfied, (c) somewhat satisfied, (d) quality improvement needed and (e) not satisfied.*

A significantly higher proportion of respondents from rural areas (44.2 percent) had clear intentions to refer others (p=0.000) compared to urban respondents (29.4 percent). A significant proportion (p=0.000) of urban respondents (53.8 percent) were undecided about referring the facility, in comparison with rural respondents (31.0 percent).

Table 6.8 Distribution of respondents by intention to refer, residence and facility (percent)

Intention type	Residence		District and above facilities	Commune health centers	Private/NGO-led facilities	All
	Urban	Rural				
Yes	29.4	44.2	38.0	41.5	34.7	40.2
Maybe	53.8	31.0	41.1	34.6	49.3	37.2
No	16.7	24.8	20.9	24.0	16.0	22.6
All	100.0	100.0	100.0	100.0	100.0	100.0
n (applicable)	418	1,120	292	1,102	144	1,538

In identifying factors associated with client satisfaction, the study highlighted that levels of client satisfaction were mostly concentrated (93.0 percent) in two of the five levels – highly satisfied (21.9 percent) and satisfied (71.1 percent) – with the remaining three levels constituting only 7.0 percent of responses, combined. There was a more even distribution regarding client intentions to refer: 40.2 percent intended to refer, 37.2 percent were confused, and 22.6 percent did not intend to refer. As such, client intention to refer others was used as a superior proxy of client satisfaction.

The study attempted to explore the factors that influenced a client's intention to refer their facility to others. Broad variable categories like demographics (place of residence, ethnicity, understanding of the Vietnamese language, age and years of schooling), family planning service-seeking behaviors (contraceptive use status and seeking services to treat side effects) and client experience (satisfaction with amenities and interactions with providers) were used primarily to identify influencing factors. Client intention to refer the facility by response categories – yes (convinced to refer), maybe (confused) and no (not convinced) – was examined against indicators related to each broad variable category.

There was no significant difference in the proportion of respondents who intended, did not intend or were confused when analyzed by place of residence, ethnicity, language, age, education or type of contraceptive used (Table 6.7).

Table 6.9: Distribution of respondents by their intention to refer and selected demographic variables (percent)

Indicators	Intention to refer					
	Did not intend		Intended		Confused	
	%	n (applicable)	%	n (applicable)	%	n (applicable)
Residence						
Urban	20.0	348	20.0	618	39.0	572
Rural	80.0		80.0		61.0	
Ethnicity						
Kinh	75.0	348	77.0	618	82.0	572
Ethnic minority	25.0		23.0		18.0	

Indicators	Intention to refer					
	Did not intend		Intended		Confused	
	%	n (applicable)	%	n (applicable)	%	n (applicable)
Understanding of the Vietnamese language						
Very well	95.0	348	93.0	618	93.0	572
A little	4.0		6.0		5.0	
Not at all	1.0		0.0		2.0	
Respondent's years of schooling						
0	9.0	335	3.8	601	4.9	532
1-5	22.7		20.3		19.5	
6-10	45.4		42.8		47.0	
11 and above	23.0		33.1		28.6	
Age						
Less than 25	10.0	348	9.0	618	8.0	572
25-35	42.0		44.0		44.0	
More than 35	48.0		47.0		48.0	

Client intention to refer did not vary substantially by wait time. About 76.0 percent of clients who intended to refer their facility reported a wait time of less than 10 minutes. The proportion was the same among those who did not intend to refer, and 69.0 percent of clients who were confused/not sure about referring waited less than 10 minutes. A negligible proportion of respondents reported that the waiting area was comfortable.

A significant 82.0 percent of eligible respondents who intend to refer reported seeing IEC materials in the waiting area, as did 70.0 percent of those who did not intend to refer.

Table 6.10: Distribution of respondents by intention to refer and selected variables related to client visit experience (percent)

Client satisfaction related to facility amenities		Intention to refer type					
		Did not intend		Intended		Confused	
		%	n (applicable)	%	n (applicable)	%	n (applicable)
Waiting time	Less than 10 min	76.0	246	76.0	478	69.0	398
	10 min and above	24.0		24.0		31.0	
Waiting area comfortable		5.0	314	2.0	581	3.0	513
IEC materials		70.0	315	82.0	579	83.0	512

Among those who intended to refer, a higher proportion of respondents mentioned positive client-provider interactions compared to those who were confused or did not intend to refer (Table 6.5). These findings indicate that clients take provider attitudes/behaviors into consideration when deciding to refer a facility or not. Positive interaction components included empathetic attitudes, listening to the client, asking supplementary questions, offering choices, explaining both advantages and disadvantages of specific methods, asking screening questions and discussing follow-up visits.

Table 6.11: Distribution of respondents by intention to refer and selected client-provider interaction variables

Indicators	Intention to refer type					
	Not intend		Intend		Confused	
	%	n (applicable)	%	n (applicable)	%	n (applicable)
Provider was empathetic	85.0	320	91.0	583	85.0	513
Provider listened to client	85.0		90.0		84.0	
Provider asked supplementary questions	55.0		67.0		56.0	
Provider gave choices	68.0		79.0		71.0	
Provider discussed positive and negative aspects of specific methods	71.0		84.0		78.0	
Provider asked screening questions	45.0	121	77.0	270	75.0	212
Provider discussed follow up visits	65.0	340	84.0	615	78.0	569

6.3 Determinants of Client Satisfaction with FP Services

A list of indicators likely to influence client satisfaction was used to determine any associations using a statistical tool (Chi-square). Indicators with significant associations with an intention to refer were regressed using both unadjusted and adjusted binary logistic regression analysis tools.

Unadjusted logistic regression analysis (where a positive intention to refer was a dependent variable) revealed that all selected indicators associated with a positive intention to refer health facilities to their relatives or friends (Table 6.10). The considered indicators were: place of residence (p=0.004), years of education (p=0.080), short time to reach the facility (p=0.081), display of IEC materials (p=0.065), provider asking screening questions to determine appropriate methods (p=0.068) and provider discussing follow-up visits (p=0.011).

Adjusted odds ratio unveiled the following:

- Rural clients are 2.1 times more likely to intend to refer than urban clients.
- Clients with more than 10 years of schooling are 43 percent more likely to intend to refer compared to those with fewer years of schooling.
- Clients who live in relatively close proximity to CHCs (<=15 minutes) are 1.6 times more likely to intend to refer than those living more than 15 minutes away.
- Clients who noticed IEC materials displayed in their CHC were 1.7 times more likely to intend to refer than those who did not.
- Clients who considered their provider empathetic were 1.8 times more likely to intend to refer compared with those who did not.
- Clients who were asked screening questions were 1.5 times more likely to intend to refer.
- Clients informed of follow-up visits were 1.9 times more likely to intend to refer than those who were not.

Table 6.12: Factors associated with client intention to refer

Independent variables	Reference category	Unadjusted odds ratio	95% CI of unadjusted odds ratio		Adjusted odds ratio	p-value
			Lower	Upper		
Residence	Urban	0.526***	0.414	0.670	0.480***	0.004
	Rural	1				
Ethnicity	Ethnic	1.461***	1.247	1.713	1.385**	0.045
	Kinh	1				
Years of education	10 years and below	0.699***	0.561	0.871	0.703*	0.080
	Above 10 years	1				
Distance from the clinic	15 minutes and less	1.829***	1.338	2.501	1.583*	0.081
	Above 15 min	1				
Display of IEC materials	Yes	1.256*	0.960	1.642	1.658*	0.065
	No	1				
Provider was empathetic	Yes	1.647***	1.175	2.309	1.783	0.146
	No	1				
Provider listened to client	Yes	1.641***	1.185	2.273	0.850	0.679
	No	1				
Provider asked supplementary questions	Yes	1.582***	1.270	1.971	1.321	0.236
	No	1				
Provider gave choices	Yes	1.630***	1.271	2.089	0.850	0.619
	No	1				
Provider discussed positive and negative aspects of specific methods	Yes	1.721***	1.314	2.254	1.160	0.642
	No	1				
Provider asked screening questions	Yes	1.930***	1.343	2.774	1.522*	0.068
	No	1				
Provider discussed follow-up visits	No	0.511***	0.394	0.663	0.520***	0.011
	Yes	1				
Constant					0.259	0.014

****Significant at 1% level of significance;*
***Significant at 5% level of significance;*
**Significant at 10% level of significance*

Dependent variable: Client's intention to refer others to facility

Client ethnicity, having an empathetic provider, a provider who listened to the client, a provider who asked supplementary questions, a provider who gave choices and a provider who explained both the positive and negative aspects of specific methods were all important aspects related to client satisfaction (Table 6.11). Using variables like place of residence, ethnicity, years of education, distance to the clinic and display of IEC materials in the clinic, another model was made (model 1), in which all variables included in the logistic regression model (except displaying IEC materials) were significantly associated with a positive intention to refer (an indicator of client satisfaction). Model 2 was then constructed by including "provider was empathetic" as a variable. Logistic regression analysis showed that all variables (except display of IEC materials) taken together in model 2 were significant in informing client satisfaction. This combination of variables was common in models 3–8.

IEC material display became a significant factor in model 7 and model 8. The rest of the variables related to client-provider interactions were included in models 3–6 interchangeably and found to be significant factors in combination with common variables. If variables like "provider asked screening questions" and/or "provider discussed follow-up visits" were added in model 3–6, several variables (included in each of the models) became insignificant. As such, model 8 was constructed by adding variable "provider discussed follow-up visits" with variables used in model

7. The logistic regression analysis of model 8 showed that all eight variables contained in the model were significantly associated with client satisfaction. Further inclusion of variables (with those of model 8) yielded results where a number of variables became insignificant which had earlier been significant factors of client satisfaction.

In model 8, the odds ratio upheld the following:

- Rural client intention to refer was 2 times higher than urban clients.
- Ethnic minorities were 1.7 times more likely to refer compared to Kinhs.
- An additional year of schooling increases client intention to refer by 6 percent.
- Clients living within 15 minutes of CHCs were 1.6 times more likely to intend to refer, compared with those living further away.
- Clients who saw IEC materials displayed in CHCs were 1.7 times more likely to intend to refer.
- Clients who found their provider to be empathetic were 1.8 times more likely to intend to refer.
- Clients who were asked screening questions were 1.6 times more likely to intend to refer.
- Clients who were told about follow-up visits were 1.9 times more likely to intend to refer.

Table 6.13: Factors associated with client intention to refer (adjusted odds ratio)

Dependent variable: Client's intention to refer others to their facility									
Indicators	Refer-ence	Model-1	Model-2	Model-3	Model-4	Model-5	Model-6	Model-7	Model-8
Residence	Rural	0.444*** (0.000)	0.450*** (0.000)	0.455*** (0.000)	0.462*** (0.000)	0.460*** (0.000)	0.451*** (0.000)	0.483*** (0.003)	0.496*** (0.005)
Ethnicity	Ethnic	0.751* (0.051)	0.733** (0.036)	0.728** (0.033)	0.702** (0.018)	0.719** (0.026)	0.742** (0.045)	0.576** (0.021)	0.597** (0.032)
Education	Years of school-ing	1.065 (.000)	1.065 (.000)	1.064 (.000)	1.060 (.000)	1.062 (.000)	1.063 (.000)	1.062 (.010)	1.061 (.012)
Distance	Above 15 min	1.557** (.011)	1.551** (.012)	1.558** (.011)	1.565** (.011)	1.577** (.010)	1.575** (.010)	1.562* (.091)	1.593* (.080)
IEC materials	No	1.256 (0.119)	1.216 (0.188)	1.213 (0.194)	1.181 (0.267)	1.164 (0.313)	1.139 (0.389)	1.908** (0.017)	1.732** (0.045)
Provider was empathetic	No		1.778*** (0.002)	1.602** (0.039)	1.517** (0.032)	1.512** (0.042)	1.473* (0.053)	1.960** (0.049)	1.826* (0.081)
Provider listened to client	No			1.190 (0.429)					
Provider asked sup-plementary questions	No				1.489*** (0.002)				
Provider gave choices	No					1.374** (0.034)			
Provider discussed positive and negative aspects of methods	No						1.547*** (0.006)		
Provid-er asked screening questions	No							1.948*** (0.002)	1.639** (0.030)
Provider discussed follow up visits	Yes								0.522** (0.011)
Constant		0.574 (0.006)	0.231 (0.000)	0.220 (0.000)	0.227 (0.000)	0.223 (0.000)	0.203 (0.000)	0.120 (0.000)	0.171 (0.000)
Hosmer-Lemeshow test[14] (p-value)		0.645	0.868	0.725	0.777	0.724	0.641	0.157	0.426

*** *Significant at 1% level of significance;*
** *Significant at 5% level of significance;*
* *Significant at 10% level of significance*

14 *The Hosmer-Lemeshow (HL) test is used to determine the goodness of fit of logistic regression model.*

CHAPTER 7 POPULATION COLLABORATORS: FRONTLINE SERVICE PROVIDERS

Viet Nam's FP service delivery mechanism also includes frontline service providers, population collaborators (PCs), at the village level. Besides public and private sector facilities delivering FP services at different levels, the FP service delivery system includes commune population workers at the commune level and voluntary PCs who provide information on FP and non-clinical contraceptives at the household level. This chapter reviews the role of PCs in service delivery, service quality and client satisfaction.

7.1 PC Preparedness for Quality Service Delivery and Workload

The study found that 96.4 percent had received at least some kind of FP training (Table 7.1), especially on FP methods and counseling skills. However, 21.7 percent of PCs had not been trained on socially marketing contraceptives, despite their critical role in motivating people to use FP methods.

About 94 percent of PCs asked about their clients' health history while providing FP services. Almost all PCs (98 percent) instructed their clients on how to take oral contraceptive pills, and 84.4 percent explained the correct technique for using condoms.

On average, a PC is responsible for 172 couples. Reportedly, a PC tends to visit about 19 couples and spend about 4.87 days providing FP services each month, and receives VND 238,459 (approximately USD 10.74) per month for the service.

Table 7.1: PCs in the FP service delivery system: training, working pattern and workload

Indicator	Value	n
Preparedness (percent)		
Received any training related to FP services	96.4	110
Received any training on monitoring couples and reporting FP usage	92.5	106
Received any training on FP methods	98.1	106
Received any training on counseling skills	94.3	106
Received any training on FP community mobilization	95.3	106
Received any training on socially marketing contraceptives	78.3	106
Engaged in motivating people to use FP	95.5	110
Coverage and workload		
Average number of couples in the area	172	110
Average number of days spend by PC on FP in a month	4.87	106
Average number of home visits made in last 30 days	18.75	110
Purpose of home visit (percent)		
Providing services related to condoms	60.9	110
Providing services related to daily oral pills	72.7	110
Providing services related to promoting IUDs	44.5	110
Providing information, education and counseling on FP	82.7	110
Involvement in FP product supply (percent)		
Involved in supplying FP methods	93.6	110
Involved in supplying pills	97.1	110
Involved in supplying condoms	87.4	110
Asked about client health condition	93.9	110
Gave instructions on taking daily oral pills	98.0	110
Reported that some daily oral pill clients asked for alternative methods	67.3	110
Reported ability to help daily oral pill clients choose an alternative FP method	100.0	110
Explained the correct technique for using condoms	84.4	110
Reported ability to show pictorial manual to clients	78.9	110
Average amount of monthly financial support received by PCs (VND)	238,459	110

Notes: n is the number of studied PCs

7.2 Client Satisfaction with Service Quality

An impressive 61.8 percent of clients received required services from PCs. More than 9 out of 10 clients found PCs to be empathetic and 88.2 percent felt listened to. However, PCs did not offer choices to 41 percent of clients. Around 30 percent of clients were not informed about both the positive and negative aspects of methods, and PCs did not ask 78.8 percent of clients screening questions.

Nevertheless, most clients (93.8 percent) were satisfied with the quality of services they received from PCs; 44.2 percent intended to refer their PC and 27.5 percent were not sure.

Table 7.2: Client satisfaction with PC services

Indicators		%	n (applicable)
Sought health services for complications/side effects		14.3	475
Received required services		61.8	466
PCs were empathetic		90.2	460
PCs listened to client		88.5	461
PCs asked supplementary questions		59.0	461
PCs gave choices /options		68.3	461
PCs discussed both positive and negative aspects		70.3	461
PCs asked screening questions		21.2	471
Clients were satisfied with the quality of services		93.8	401
Would refer PCs	No	28.3	389
	Yes	44.2	
	Maybe	27.5	

As evidenced above, PCs are an integral part of the FP service delivery system in Viet Nam. As such, the overall quality of FP services largely depends on the PC service quality. The quality of FP services is instrumental in reducing discontinuation and method failure which will be discussed in the following chapter.


HALATAMOL 250 MG

CHAPTER 8: METHOD DISCONTINUATION AND METHOD FAILURE

This chapter investigates FP method discontinuation and failure, as well as explores the factors affecting discontinuation and failure. It ultimately attempts to determine the extent of associations between discontinuation and method failure.

8.1 Discontinuation of Contraceptive Methods

8.1.1 Discontinuation Rate of Contraceptive Methods

Contraceptive discontinuation as the result of psycho-social-cultural factors is an important public health concern. It contributes to unplanned pregnancy, which in turn, can lead to increases in maternal, neonatal and infant morbidity or mortality. As a consequence, discontinuation rates can be treated as a measure of family planning service quality, with high rates of discontinuation interpreted as a sign of missed opportunities to promote and sustain contraceptive use [15].

In fact, discontinuation of family planning method in this survey is defined as failure to use a contraceptive continuously within the last 6-12 months [16].

$$\text{Contraceptive discontinuation rate within 6-12 months} = \frac{\text{Number of contraceptive '}m_i\text{' using episodes ended within 6-12 months}}{\text{Total number of episodes when women (or partner) used contraceptive method '}m_i\text{'}} \times 100$$

The survey data was collected from women who had ever used more than one FP method and used it continuously. Contraceptive discontinuation rate in this study was estimated depending on the duration (in months) of an episode of FP method use. In this situation, in the absence of a consistently used FP method, there is a greater chance of pregnancy.

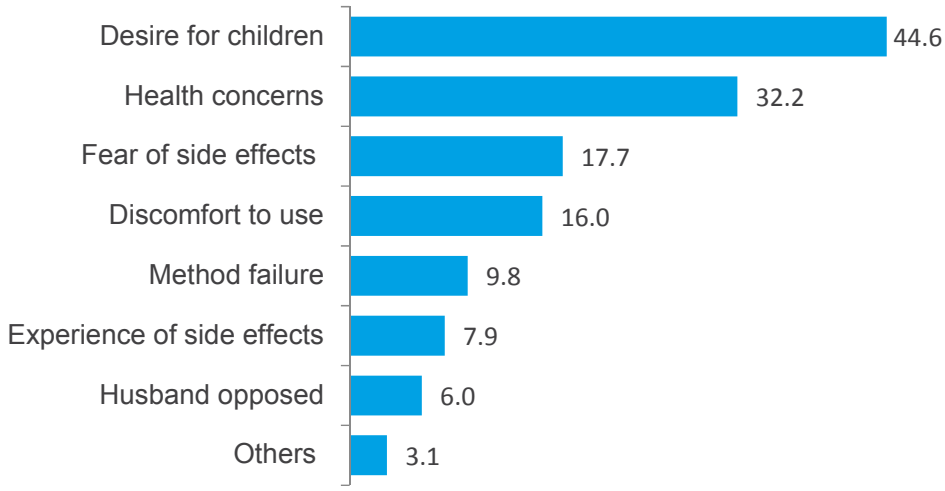
The 12-month discontinuation rate was high for resupply methods (Table 8.1). Injectables had a discontinuation rate of 58.5 percent within 12 months of use – the highest rate – followed by condoms (42.5 percent) and pills (38.9 percent). IUDs had a much lower discontinuation rate (21 percent). These rates, however, differ depending on the definition of discontinuation. FP method discontinuation differed significantly (p=0.02) between urban and rural residents. Understanding of the Vietnamese language was a significant predictor (p=0.02034) of method discontinuation. Among regions, the discontinuation rate in the Red River Delta was significantly higher (p=0.00038) than the national average; the discontinuation rate among the remaining regions fell between 27.4 percent and 33.5 percent.

Table 8.1: Contraceptive method discontinuation rates

Inspection category			6-month discontinuation rate		12-month discontinuation rate		Episodes (n)
Method specific							
Pills			30.7		38.9		537
Condoms			33.2		42.5		325
IUDs			15.4		21.0		804
Injectables			36.6		58.5		82
Periodic abstinence			18.3		27.5		109
Withdrawal			22.9		35.8		179
Any method			23.9		32.3		2,036
Any modern method			24.3		32.2		1,760
Residence							
Any method	Urban		20.0	p=0.0203	28.1	p=0.0226	496
	Rural		25.1		33.6		1,540
Any modern method	Urban		19.0	p=0.0042	26.3	p=0.0035	411
	Rural		25.9		34.0		1,349
Region							
Any method	Red River Delta		33.1		41.4		411
	Northern Mountains		20.5		28.2		440
	North and South Central Coast		21.1		30.8		237
	Central Highlands		18.4		27.4		321
	Southeastern Region		26.1		33.5		284
	Mekong Delta		22.5		31.3		355
Any modern method	Red River Delta		34.1		42.0		352
	Northern Mountains		18.8		24.3		378
	North and South Central Coast		24.0		33.3		204
	Central Highlands		17.2		26.5		291
	Southeastern Region		27.1		34.2		225
	Mekong Delta		24.8		33.9		310
Ethnicity							
Any method	Kinh		24.6	p=0.1936	33.0	p=0.2187	1,568
	Ethnic		21.7		30.0		480
Any modern method	Kinh		25.4	p=0.0615	33.4	p=0.0672	1,318
	Ethnic		21.0		28.7		442
Understanding of the Vietnamese Language							
Any method		Very well	24.6	p=0.0065	33.0	p=0.0203	1,883
		Not very well	15.2		24.2		165
Any modern method		Very well	24.2	p=0.6892	31.8	p=0.1615	1,636
		Not very well	25.8		37.9		124

8.1.2 Reasons for Contraceptive Method Discontinuation

Figure 8.1: Reasons for contraceptive method discontinuation
(applicable cases, multiple responses)



Unsurprisingly, a desire for children was the most frequently reported reason for FP method discontinuation (44.6 percent). However, 32.2 percent and 17.7 percent of discontinued episodes were due to health concerns and fear of side effects, respectively, both of which are reflections of service quality. If FP method users are aware of the true health impacts and their associated side effects, they rarely discontinue on such grounds. Another concerning 9.8 percent of episodes discontinued due to method failure (2.3 percentage points higher than the 2002 rate [11], a key service quality concern). However, these reported reasons include any type of method (including traditional methods), and many modern FP method users (38 percent) do not consult with FP service providers prior to using their method[15]. As such, the study analyzed the three most commonly reported FP methods separately[16]: pills, condoms and IUDs.

Desire for children continued to be the dominant reason for method discontinuation. However, there were significantly greater health concerns among condom ($p<0.0001$) and pill ($p=0.0232$) users. Condom users were less concerned with health or side effects, rather, the key reason for discontinuation was discomfort (34.5 percent), which categorically raises a fundamental question about male participation in FP. This is further evidenced by the fact that 18.2 percent of husbands opposed the use of condoms as an FP method, which is significantly higher ($p<0.0001$) than the overall discontinuation figure taking all methods into account.

8.1.3 Factors Associated with Contraceptive Method Discontinuation

Factors influencing method discontinuation were determined using Cox regression. Incidence of discontinuation replaced incidence of death and the duration of method (discontinuation within 12 months) use was adopted accordingly. Inspection variables were the covariates. Numerical inspection variables were recorded as categorical variables for the purpose of analysis. All variables were inspected for an association with discontinuation by applying a Chi-square test prior to Cox regression.

15 *See, details in chapter 4.*

16 *See, details in chapter 4.*

Analyses were only done for modern FP methods. A sub-set of original data was used for explaining the applicable discontinuation cases (i.e., cases with all necessary data). The analysis covered discontinuation of any modern method. In this regard, a separate explanation was put forward for three of the frequently used modern FP methods: pills, condoms and IUDs.

Place of residence (p=0.005), ethnicity (p=0.009), language (p=0.011), respondent years of schooling (p=0.002), being a housewife (p=0.002), respondent age less than 30 years (p=0.000), having fewer than 2 living children (p=0.000), using traditional methods (p=0.000) and follow up visits (p=0.003) were all significant at a 5 percent level of significance (Table 8.2). Using a traditional FP method increased the likelihood of discontinuation by more than 2.5 times compared with modern methods. Having less than 2 living children was the second-most influential factor; the probability of discontinuation increased by 88 percent. The likelihood of discontinuation was higher in rural areas, among Kinh populations and among those with a strong understanding of the Vietnamese language.

Table 8.2: Hazard ratio obtained through Cox regression

Variable	Reference category	Any modern method			Pills			Condoms			IUDs		
		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio	
		p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value
Residence	Urban	0.003	1	0.005	.007	1	0.012	0.121	1	0.101	0.088	1	0.053
	Rural		1.438 (1.119,1.849)			1.476 (1.090,1.999)			1.333 (0.945,1.880)			1.439 (0.990,2.080)	
Ethnicity	Ethnic	0.01	1	0.009	0.026	1	0.030	0.134	1	0.126	0.260	1	0.198
	Kinh		1.389 (1.086,1.777)			0.702 (0.51,0.966)			1.358 (0.918,2.028)			0.822 (0.610,1.108)	
Understanding of Vietnamese	Very well	0.029	1	0.011	0.130	1	0.032	0.107	1	0.143	0.107	1	0.111
	Not very well		1.587 (1.11,2.27)			1.650 (1.044,2.608)			2.099 (0.778,5.663)			1.603 (0.897,2.886)	
Respondent's years of schooling	More than 5 years	0.004	1	0.005	0.068	1	0.118	1.000	1	0.823	0.049	1	.071
	Not more than 5 years		1.388 (1.105,1.743)			1.261 (0.943,1.687)			1.049 (0.689,1.597)			1.296 (0.978,1.718)	
	More than 9 years	0.002	1	0.002	0.019	1	0.023	0.822	1	0.865	0.023	1	0.05
	Not more than 9 years		1.374 (1.12,1.685)			1.359 (1.043,1.769)			0.974 (0.714,1.327)			1.324 (0.998,1.757)	
Respondent occupation	Not housewife	0.002	1	0.002	0.006	1	0.021	0.621	1	0.488	0.177	1	0.251
	Housewife		0.684 (0.537,0.871)			0.705 (0.523,0.949)			0.856 (0.550,1.330)			0.816 (0.576,1.153)	

Variable	Reference category	Any modern method			Pills			Condoms			IUDs		
		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio	
		p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value
Respondent's age	≥26 years	0.000	1	0.000	0.001	1	0.002	0.057	1	0.084	0.003	1	0.001
	<26 years		0.515 (0.394,0.672)			0.564 (0.394,0.808)			0.687 (0.448,1.052)			0.534 (0.366,0.78)	
	≥30 years	0.000	1	0.000	0.000	1	0.000	0.000	1	0.000	0.000	1	0.000
	<30 years		0.495 (0.402,0.608)			0.543 (0.414,0.712)			0.451 (0.33,0.617)			0.548 (0.411,0.732)	
Total number of live births	1 or no children	0.000	1	0.000	0.000	1	0.002	0.000	1	0.000	0.068	1	0.05
	<2 children		1.881 (1.495,2.366)			1.619 (1.196,2.193)			1.826 (1.313,2.541)			1.428 (0.997,2.046)	
	2 or less children	0.205	1	0.223	0.482	1	0.39	0.326	1	0.227	0.35	1	0.382
	<3 children		1.154 (0.916,1.454)			1.14 (0.845,1.539)			1.285 (0.855,1.931)			0.884 (0.671,1.165)	
Previous history of method failure	No	0.431	1	0.398	0.024	1	0.05	0.175	1	0.11	0.101	1	0.149
	Yes		0.896 (0.694,1.157)			0.736 (0.353,1.011)			0.747 (0.522,1.008)			0.794 (0.58,1.086)	
Ever terminated pregnancy	No	0.896	1	0.891	0.501	1	0.50	0.006	1	0.008	0.443	1	0.588
	Yes		1.015 (0.891,1.265)			0.94 (0.689,1.201)			0.651 (0.475,0.894)			0.926 (0.702,1.222)	
Experience with side effects	No	0.937	1	0.81	0.735	1	0.661	0.57	1	0.539	0.514	1	0.414
	Yes		1.033 (0.791,1.351)			0.927 (0.662,1.299)			0.881 (0.588,1.320)			0.854 (0.585,1.247)	
Knowledge on appropriate use of method	No	0.162	1	0.159	0.88	1	0.623	0.366	1	0.264	0.592	1	0.469
	Yes		1.227 (0.923,1.631)			1.131 (0.692,1.85)			1.396 (0.778,2.506)			1.187 (0.746,2.506)	
Provider explained positive and negative aspects	No	0.13	1	0.113	0.531	1	0.397	1.000	1	0.922	1.000	1	0.908
	Yes		0.757 (0.536,1.068)			0.827 (0.533,1.283)			0.972 (0.548,1.723)			0.971 (0.588,1.604)	

Variable	Reference category	Any modern method			Pills			Condoms			IUDs		
		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio		Chi-square	Hazard Ratio	
		p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value	p-value	Estimate (95% CI)	p-value
Provider discussed follow up visits	Yes	0.003	1	0.003	0.309	1	0.269	0.790	1	0.923	0.033	1	0.022
	No		1.439 (1.129,1.834)			1.203 (0.867,1.670)			0.982 (0.677,1.424)			1.467 (1.057,2.035)	
Using any traditional methods before discontinuation	Yes	0.000	1	0.000									
	No		2.519 (1.911,3.322)										
Home visit by PC in last 6 months	No	1.000	1	0.937	0.257	1	0.282	0.409	1	0.48	0.366	1	0.256
	Yes		1.01 (0.783,1.304)			0.83 (0.59,1.166)			0.87 (0.591,1.280)			1.214 (0.889,1.696)	
Satisfaction with quality of FP service	No	0.213	1	0.153	0.824	1	0.594	0.426	1	0.32	0.115	1	0.165
	Yes		1.2 (0.934,1.542)			1.094 (0.707,1.519)			1.209 (0.831,1.758)			1.271 (0.906,1.782)	
Informed choices	No	1.000	1	0.989									
	Yes		0.998 (0.701, 1.42)										
Time to reach FP service facility	More than 11 minutes	0.126	1	0.108	0.036	1	0.05	0.13	1	0.237	0.519	1	0.377
	<11 minutes		0.791 (0.595,1.053)			0.699 (0.483,1.011)			0.732 (0.437,1.228)			0.845 (0.581,1.228)	

The probability of discontinuation increased by 39.0 percent if the respondent had less than six years of schooling. This probability, however, decreased by only 37.0 percent if the respondent had less than 10 years of schooling. Respondent's current age also predicted a similar scenario. The possibility of discontinuation decreased by 48.5 percent if the age of the respondent was less than 26, and it increased by 50.5 percent for respondents aged less than 30 years.

The distance to FP facilities (10 minutes or less) was not statistically significant when examining against all modern methods (p=0.108), but was significant (p=0.05) for those using the daily oral pill. Previous history of method failure generated similar outcomes. The influencing variables for pills were similar to those of any modern method.

Most demographic variables were found to be insignificant against condoms, with the exception of respondent's current age and having less than 2 living children – the only two variables found to be significant among all four inspection categories[17]. The possibility of discontinuation decreased by 26.4 percent with previous history of condom method failure. Place of residence, ethnicity and understanding of the Vietnamese language were not significant factors influencing IUD use (i.e., the use of IUDs was uniform across geographical coverage). The possibility of IUD discontinuation increased by 46.7 percent when providers did not recommend follow-up visits.

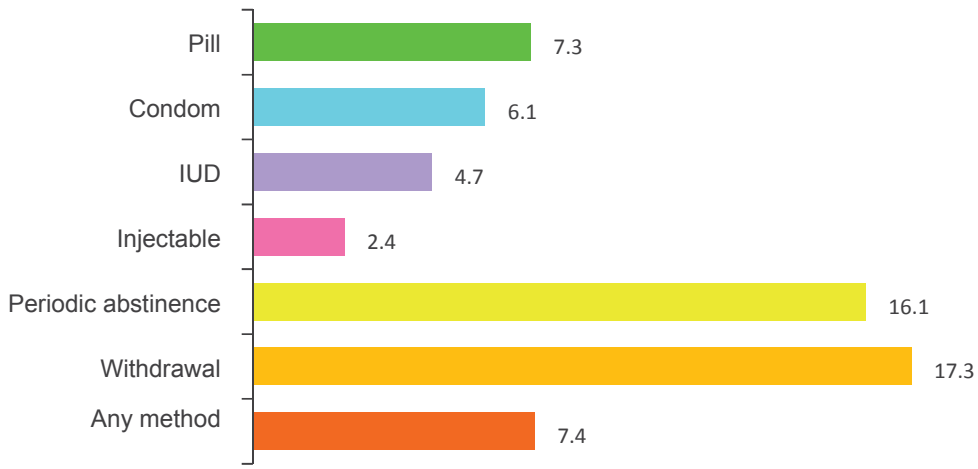
8.2 Method Failure

8.2.1 Method Failure Rate

As noted earlier, method failure is one of the reasons for method discontinuation. Contraceptive method failure is defined as conception occurring in an act of intercourse when a contraceptive method is in use [17].

$$\text{Contraceptive method failure rate} = \frac{\text{Number of contraceptive '}m_i\text{' users who became pregnant during using '}m_i\text{' method}}{\text{Total number of episodes when women (or their partners) were using contraceptive method '}m_i\text{'}} \times 100$$

Figure 8.2: FP method failure rate



17 *Any modern method, Pill, Condom, and IUD. See Table 7.2 for details.*

As shown in Figure 8.2, the estimated overall method failure rate was 7.4 percent, meaning 7.4 percent of FP method use episode ends in unplanned pregnancy without considering any time bound. Data revealed that failure rates were higher for traditional methods ($p<0.001$) than modern methods. On average, one in every six episodes of traditional method use ended in unplanned pregnancies, compared to 1 in 20 episodes for modern methods.

Further analysis took experience with unplanned pregnancy into account. Data (found in Annex Table 8.1) revealed that 9.1 percent, or one in every eleven women of reproductive age, had ever experienced unplanned pregnancy. Among them, 24.4 percent experienced unplanned pregnancy more than once, suggesting this could be related to the quality of FP services.

The lifetime method failure rate was highest in the Northern Mountains (13.3 percent), followed by the Red River Delta (12.9 percent) and the Southeastern region (8.9 percent). No significant difference was found between ethnicities, place of residence or language comprehension.

Traditional contraceptive methods, though they have a greater risk of method failure (as compared to modern methods), constitute a relatively high proportion of the CPR (16.1 percent). Traditional methods have a greater risk of method failure, resulting in unplanned pregnancies and potentially leading to abortion. If traditional contraceptive method users were to switch to modern contraceptive methods, the incidence of method failure and abortion would likely reduce, and it would give the method user more control over his/her family planning approach.

8.2.2 Factors Influencing Method Failure

A long list of variables was associated with method failure. At first, all variables were examined for one-to-one (bi-variate) association using Chi-square test. Then binary logistic regression was conducted with the variables that were significantly associated. While conducting binary logistic regression, an iteration process was applied to identify the variables significantly associated with ever experiencing unplanned pregnancy.

This binary logistic regression, however, is associated with partial and semi-partial correlation. Hence, a separate odds ratio analysis was conducted to determine the association of each variable with the dependent variable of ever experiencing unplanned pregnancy.

In achieving significant Hosmer and Lemeshow goodness of fit, we received the following independent variables after a repeated iteration process:

- Incidence of method discontinuation
- History of pregnancy termination
- Number of living children
- Years of education
- Understanding of the Vietnamese language

The above exercise carefully included a number of other variables correlated with pregnancy termination, but were found to be insignificant in the above equation. Considering the fact that those variables may also be found significant under a different set of analysis for the same purpose, odds ratios of such variables were computed for the incidence of unplanned pregnancy. Such an analysis exposed that risk of unplanned pregnancy increased by 46 percent (odds ratio: 1.46; $p<0.05$) for women aged 26 and more. In addition, respondents who had been married for more than 16 years had a 29 percent higher possibility of experiencing an unplanned pregnancy (Table 8.3).

Table 8.3: Odds ratio for selected variables related to unplanned pregnancy (lifetime)

Variable	Outcome	Unplanned pregnancy in lifetime		Odds ratio (95% CI)
		Yes	No	
Ethnicity	Kinh	369	3,787	1
	Ethnic	112	1,002	1.147 (0.918, 1.433)
Occupation	Unemployed/housewife	111	1,050	1
	Income generating	365	3,705	1.073 (0.858, 1.341)
Satisfied with services	Yes	185	1,956	1
	No	105	1,104	0.994 (0.774, 1.278)
Age of respondent	<26 years	51	708	1
	26+ years	430	4,081	1.463 (1.082, 1.977)*
Years of marriage	<16	278	3,066	1
	16+	192	1,645	1.287 (1.061, 1.562)*
**Significant at 5% level of significance*				

CHAPTER 9: ABORTION

This chapter outlines the findings related to abortion. At the outset, total abortion rate (TAR) was calculated, and the relationship between abortion, discontinuation, method failure and other relevant indicators are explored to identify factors affecting abortion.

The study also collected information on the total number of live births and total number of abortion incidences for respondents in their lifetime. Moreover, the total number of reproductive years (respondent current age–15) already lived by the respondents was drawn from the survey.

9.1 Total Abortion Rate

Broadly defined, the TAR is the total number of abortions a woman is likely to have in her lifetime if current levels persist. This lifetime risk is a cohort measure and can be calculated with period measures (age-specific abortion rates) or approximated by multiplying the abortion rate by the length of the reproductive period (30-35 years) (Bertrand and Tsui, 1995). The estimated TAR in Viet Nam is 0.42 (i.e., 42 in 100 women experience at least one abortion in their reproductive lifetime).

Estimation Method: Total Abortion Rate

The analysis included ever-married women, since none of the respondents reported seeking an abortion before marriage. Survey data provided the number of ever-married women included in the survey and the total number of abortions they reported. In addition, the average age of ever-married women was estimated using cleaned survey data. The average lifetime of reproductive years spent by eligible (ever-married) women was obtained by subtracting 15 from their average age. Then the total reproductive years already lived was determined by multiplying the average lifetime of reproductive years with number of ever married women. Meanwhile, the average number of pregnancy terminations per year was computed by dividing the total number of pregnancies by the average lifetime of reproductive years. The total abortion rate (TAR) was obtained by first dividing the average number of pregnancy terminations per year with the number of ever married women included in the survey, then multiplying the result by 35.

Table 9.1: Estimation of total abortion rate

Estimation	Value	Estimation method
Number of ever-married women included in the survey	5,898	Frequency analysis from survey data
Average age of ever-married women included in the survey	33.96 years	$\frac{\sum \text{current age of everfrom survey da in the survey}}{\text{Number of ever everfrom survey dataysurvey}}$
Minimum reproductive age	15 years	Definition
Average lifetime reproductive years at the time of the survey	18.96 years	Average age of everveyrried women – Minimum reproductive age
Total reproductive years of surveyed women 15-49	111,826	Average lifetime reproductive years by the time of the survey × Number of ever married women included in the survey
Total termination of pregnancies	1,352	Frequency analysis from survey data
Pregnancies terminated per year	71.31	$\frac{\text{Total termination of pregnancies}}{\text{Average lifetime reproductive years by the time of the survey}}$
Abortion cases per year/total applicable population	0.0121	$\frac{\text{Total termination of pregnancies}}{\text{Average lifetime reproductive years by the time of the survey}}$
TAR	0.42	(Abortion cases per year/total applicable population) ×35

9.2 Termination of Pregnancy

In total, 17.4 percent of women experienced pregnancy termination in their lifetime; 19.6 percent of women in urban areas and 16.5 percent in rural areas (p=0.0058). Across the regions, it varied between 7.7 percent in the North and South Central Coast and 33.5 percent in the Red River Delta (Annex Table 9.1).

The average number of pregnancy terminations (induced abortion) was 1.3 per woman (who had ever experienced pregnancy termination), or 1.5 among urban and 1.3 among rural women. Of these women, 73.1 percent terminated a pregnancy once, 21.8 percent twice and 5.1 percent three or more times during their lifetime (Annex Table 9.2). The median age of women at first termination was 26 years, which was slightly higher (27 years) in urban areas. Most women terminated their first pregnancy between 25-29 years (33.8 percent), followed by 20-24 years (26.6 percent). Compared to Kinh populations (31.4 percent), terminating a pregnancy before age 25 was more common among ethnic minority populations (41.2 percent) (p=0.00652) (Table 9.2). Among those who had terminated a pregnancy, the majority (83.9 percent) reported that their most recent termination was carried out within the first 12 weeks of pregnancy (Annex Table 9.3).

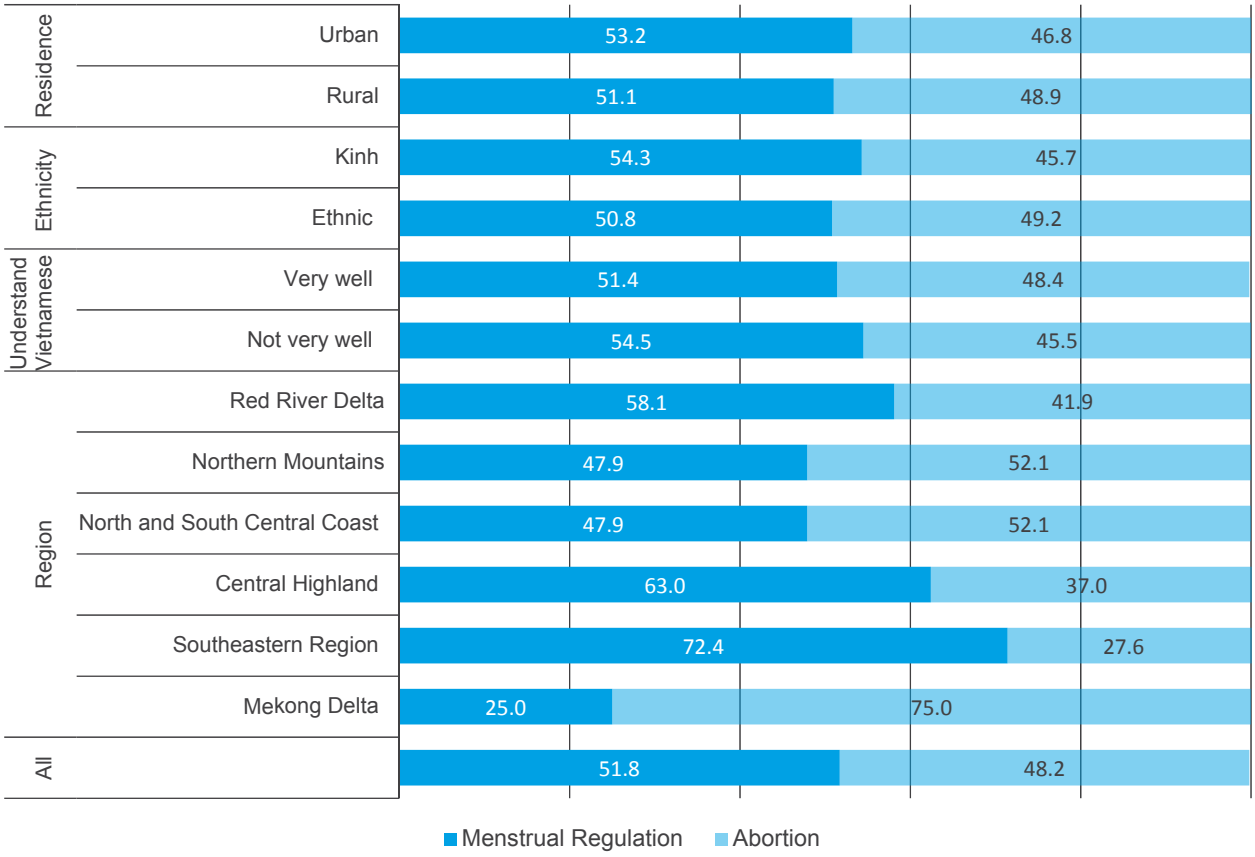
Table 9.2: Distribution of women by age at first pregnancy termination among those who had terminated a pregnancy (percent)

Residence, ethnicity, language proficiency and region	Age at termination of first pregnancy (in completed years)							n (applicable)
	15-19	20-24	25-29	30-34	35-39	40+	Mean	
Residence								
Urban	3.2	27.6	40.1	21.9	6.5	0.7	27.0	279
Rural	3.9	31.4	37.6	16.0	8.0	3.1	26.0	614
Ethnicity								
Ethnic	6.0	35.2	36.5	12.0	7.3	3.0	26.3	233
Kinh	2.9	28.5	39.1	19.8	7.6	2.1	27.3	660
Understanding of the Vietnamese Language								
Very well	3.3	30.3	38.9	18.2	7.2	2.2	27.1	823
Not very well	8.6	30.0	32.9	12.9	11.4	4.3	26.6	70
Region								
Red River Delta	1.6	28.9	39.9	20.5	6.8	2.3	27.3	308
Northern Mountains	3.3	30.7	43.1	15.7	5.5	1.8	26.7	274
North and South Central Coast	11.9	33.9	20.3	20.3	11.9	1.7	26.7	59
Central Highlands	8.5	25.6	39.0	15.9	9.8	1.2	27.0	82
Southeastern Region	3.1	26.2	33.8	16.9	12.3	7.7	24.8	65
Mekong Delta	2.9	37.1	34.3	16.2	7.6	1.9	26.7	105
All	3.7	30.2	38.4	17.8	7.5	2.4	27.0	893

Terminations were done using menstrual regulation (MR) in more than half (51.8 percent) of cases; the other 48.2 percent were abortions induced by other means (Figure 9.1). There was no significant difference between urban and rural residents (p=0.51) or ethnicities (p=0.27), but variations across regions were sizable, with the highest MR rate in the Southeastern Region (72.4 percent), followed by the Central Highlands (63 percent). Induced abortions were highest in the Mekong Delta (75.0 percent), followed by 52.1 percent both in the Northern Mountains and the North and South Central Coast (Annex Table 9.4). Private/NGO-led clinics and government-owned district hospitals (obstetrics) were the two most preferred places for pregnancy termination (24.7 percent and 23.9 percent), followed by CHCs (20.8 percent) and provincial hospitals (12.6 percent). Government-owned district hospitals were more utilized by rural women, while urban women tended to utilize private clinics. (Annex Table 9.5).

Regardless of place of residence and region, most of the pregnancy terminations were conducted by doctors specializing in obstetrics (60.0 percent), followed by midwives (14.4 percent). Pregnancy terminations were more commonly done by doctors in urban areas (p<0.0001) (Annex Table 9.6).

Figure 9.1: Distribution of women across area of residence, ethnicity, language proficiency and region by method of termination of last pregnancy (percent)



9.3 Abortion and its Associated Factors

Early pregnancy, which usually depends on age at first marriage, poses a particular threat to the physical and psychological well-being of adolescents who are yet to reach full maturity, increasing the risks during pregnancy – including preterm birth, stillbirth, low birth-weight, infection, hemorrhage, anemia and mortality as well as contributing to higher fertility [18].

Evidence found that age at first marriage, age at first pregnancy and age at first pregnancy termination are significantly correlated (Table 9.3). Pearson correlation coefficient revealed that age at pregnancy and age at marriage were not very strongly associated (Pearson correlation coefficient was around 0.5) but such associations were still statistically significant. The correlation between age at first marriage and age at first pregnancy was strong and significant.

Table 9.3: Correlations between age at first marriage, age at first pregnancy and age at first pregnancy termination

Variables under inspection		Pearson correlation co-efficient	p-value	n
Variable 1	Variable 2			
Age at first pregnancy termination	Age at first pregnancy	0.519	0.000	891
Age at first pregnancy termination	Age at first marriage	0.489	0.000	878
Age at first marriage	Age at first pregnancy	0.932	0.000	5,727

There is also significant linear relationship with age at first termination, age at first pregnancy and age at first marriage.

Age at first termination	=	12.550 (p=0.000)	+	0.656 (p=0.000)	×	Age at first marriage (Adjusted R^2=0.268)
Age at first termination	=	10.778 (p=0.000)	+	0.715 (p=0.000)	×	Age at first pregnancy (Adjusted R^2=0.238)

There is only 0.8-year gap (significant, p<0.001) between the average age at first marriage and the average age at first pregnancy; 85.5 percent of married women became pregnant within the first two years of marriage. Among all married respondents, only 55 (only 1 percent) reported becoming pregnant before marriage, and 35 refused to report their age at first termination. Nearly one-fifth of women (18.2 percent) experienced pregnancy before age 20 (27.3 percent were married before 20), but only 3.7 percent reported terminating their first pregnancy before age 20.

Ever experiencing abortion was the dependent variable when exploring relevant factors. A long list of variables was inspected to determine associations. All variables were first inspected for one-to-one (bi-variate) association using a Chi-square test, then binary logistic regression was conducted among significantly associated variables with multiple iterations. This binary logistic regression was associated with partial and semi-partial correlation, hence, a separate odds ratio analysis was carried out to understand the association of each variable with the dependent variable of ever-experiencing abortion. In achieving significant Hosmer and Lemeshow goodness-of-fit, we received the following variables after a repeated iteration process:

- Place of residence
- Ethnicity
- Total number of pregnancies
- Experience with unplanned pregnancy
- Years of education
- Age at marriage
- Number of living children

Table 9.4: Factors influencing abortion (binary logistic regression)

Variables	Coefficient	Odds Ratio	95% CI for Odds Ratio		p-value
			Lower	Upper	
Residence	-0.507	0.602	0.489	0.742	0.000
Ethnicity	-0.524	0.592	0.473	0.741	0.000
Total number of pregnancies	1.598	4.942	4.386	5.570	0.000
Experience with unplanned pregnancy	1.771	5.876	4.583	7.532	0.000
Years of education (less than 5 years)	0.789	2.201	1.775	2.729	0.000
Age at marriage (less than 25 years)	-0.278	0.758	0.607	0.945	0.014
Number of living children (less than 2)	1.581	4.860	3.630	6.505	0.000
Constant	-5.482	0.004			0.000

The above exercise included a number of other variables correlated with abortion but determined to be insignificant for the above equation. As they would likely be significant in a different analysis set, their odds ratios were computed for the incidence of abortion. Incidence of discontinuation

increased the possibility of unplanned pregnancy (not statistically significant, p>0.05), and the possibility of unplanned pregnancy incidence was higher (not statistically significant, p>0.05) among women who did not understand the Vietnamese language well.

9.4 Live Births

The average total number of live births (over a lifetime) was 1.99 per woman (Table 9.5). The total number of live births was the highest in the Southeastern Region and Central Highlands (2.15 and 2.09). The same was relatively lower in the Northern Mountains, Mekong Delta and Red River Delta with 1.88, 1.92 and 1.94, respectively.

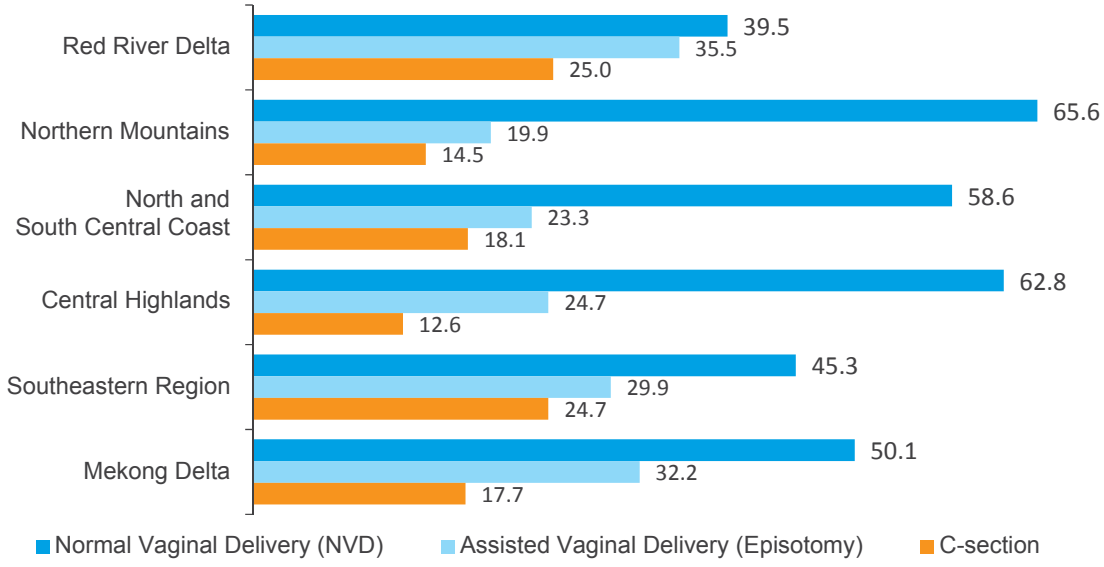
Table 9.5: Distribution of women by number of live births (over a lifetime) (percent)

Background characteristics	Total number of live births				n (applicable)
	Total number of normal vaginal deliveries	Total number of assisted vaginal deliveries (Episiotomy)	Total number of C-sections	Total	
Residence					
Urban	0.91	0.58	0.38	1.83	1,606
Rural	1.29	0.56	0.22	2.05	4,230
Region					
Red River Delta	0.84	0.75	0.39	1.94	998
Northern Mountains	1.31	0.39	0.20	1.88	972
North and South Central Coast	1.32	0.45	0.25	1.96	947
Central Highlands	1.47	0.49	0.17	2.09	969
Southeastern Region	1.13	0.67	0.35	2.15	975
Mekong Delta	1.07	0.63	0.24	1.92	975
Total	1.19	0.57	0.27	1.99	5,836

On average, of the total 1.99 live births, 1.19 were normal vaginal deliveries, 0.57 were assisted vaginal deliveries and 0.27 were caesarean sections (C-sections). Normal vaginal delivery was more common in rural areas, whereas assisted vaginal delivery and C-section delivery was relatively higher in urban areas.

By regions, the total number of live births was the highest in the Southeastern Region (2.15) and Central Highlands (2.09), as compared to the Red River Delta (1.94) and Mekong Delta (1.92). In terms of the most recent delivery, 81.2 percent of live births were delivered vaginally, including 53.5 percent normal vaginal deliveries and 27.7 percent assisted. The rate of normal vaginal delivery was higher in rural areas than urban areas (57.5 percent in rural areas and 43.0 percent in urban, p<0.0001). In contrast, C-section delivery was 11.1 percentage points higher (p<0.0001) in urban areas than rural areas (26.9 percent in urban and 15.8 percent in rural). Across the regions, normal vaginal delivery was more prevalent in the Northern Mountains and Central Highlands (65.6 percent and 62.8 percent) compared to other surveyed regions, which ranged between 39.5 and 58.6 percent. On the other hand, C-sections were more prevalent in the Red River Delta and Southeastern Region (25.0 percent and 24.7 percent) compared with the other four regions ranging between 12.6 and 17.7 percent (Annex Tables 9.9 and 9.10).

Figure 9.2: Distribution of women across regions by type of most recent delivery (percent)



CHAPTER 10: RELATIONSHIP BETWEEN SERVICE QUALITY AND ASSOCIATED OUTCOMES

This chapter explores the dyadic relationship between quality of services and its relevant outcomes: modern contraceptive method use, method discontinuation, method failure and abortion. Client perception and quality score were used to assess service quality. This chapter also examines the inseparable link between specific indicators and service quality.

10.1 Assessing Service Quality

Service quality was assessed through client perception and CHC quality score. CHC quality score was prepared using 40 variables (divided into three categories: (i) facility preparedness, (ii) provider quality and (iii) management and supervision) identified by the facility and provider survey[18]. The clients (women aged 15-49) expressed their perceptions through two distinct questions. Firstly, clients were asked to rate their satisfaction regarding the quality of FP services on a five-point scale, and second, they were asked if they planned to refer their facility to their neighbors and relatives.

Prior to examining the relationships between service quality and the specific study variables (modern contraceptive method use, method discontinuation, method failure and abortion), the relationships between quality score and client perceptions were critically examined through binary logistic regression.

18 *Detailed methodology is described in chapter five*

The unadjusted estimates did not reveal any significant association regarding client perceptions and intention to refer neighbors or relatives for any sub-category of quality score (Table 10.1). The total score (p=0.0894) was also not significantly associated. However, the adjusted estimates (Table 9.1) suggest that facility preparedness (p=0.087) is associated at a 10 percent level of significance, and management and supervision is associated (p=0.000) at a 1 percent level of significance with intention to refer neighbors and relatives. On the contrary, perception of satisfaction was significantly associated with provider quality as well as management and supervision for both adjusted and unadjusted estimates. These findings suggest that client perceptions are a possible proxy for service quality.

Table 10.1: Association between quality scores and client perception

Category of quality score	Unadjusted estimates					Adjusted estimates				
	Co- efficient	Odds	95% CI for Odds		p-value	Co- efficient	Odds	95% CI for Odds		p-value
			Lower	Upper				Lower	Upper	
Perception on referring facility to neighbors and relatives										
Facility preparedness	1.003	2.726	0.389	19.093	0.313	1.723	5.600	0.778	40.296	0.087
Provider quality	-0.937	0.392	0.14	1.098	0.392	-0.419	0.658	0.228	1.899	0.439
Management and supervision	-0.817	0.442	0.311	0.628	0.442	-0.830	0.436	0.302	0.629	0.000
Constant						-0.433	0.648			0.329
Perception on satisfaction										
Facility preparedness	0.092	1.096	0.05	2.825	0.953	-0.764	0.466	0.020	10.843	0.634
Provider quality	3.049	21.096	4.754	93.617	0.000	2.581	13.211	2.864	60.949	0.001
Management and supervision	0.834	2.303	1.370	3.873	0.002	0.637	1.890	1.087	3.286	0.024
Constant						1.112	3.041			0.107

10.2 Quality of Service Scores and Associated Outcomes

Modern contraceptive method use is significantly associated with client perception of satisfaction. Analysis suggests that satisfied clients are 2.4 times (p=0.000) more likely to use modern methods. Discriminant analysis, however, indicates that there are no significant differences among average quality scores for facility preparedness (p=0.889), provider quality (p=0.197) or management and supervision (p=0.767) for modern method users and non-users, and only 71 percent of predictions would be correct using these variables. Results of binary logistic regression (Table 102) support the findings from the discriminant analysis. Facility preparedness (p=0.696), provider quality (p=0.259) and management and supervision (p=0.689) are not significantly associated with the use of modern contraceptive methods, and the total score is not significantly (p=0.498) associated.

Method discontinuation echoed the results from modern method use. Among those who have discontinued a method for any reason other than a desire for more children are 33 percent (p=0.244) more likely to be dissatisfied. Again, there were no significant differences between average quality scores for facility preparedness (p=0.716), provider quality (p=0.854) or management and supervision (p=0.417). Moreover, only 65 percent of predictions would be correct using these variables. The results of binary logistic regression (Table 9.2) found that facility preparedness (p=0.637), provider quality (p=0.869) and management and supervision (p=0.39) were not significantly associated with the use of modern contraceptive methods.

Table 10.2: Association between modern contraceptive method use and discontinuation with quality scores (binary logistic regression)

Dependent variable	Category of quality score	Unadjusted estimates					Adjusted estimates				
		Co-efficient	Odds	95% CI for Odds		p-value	Co-efficient	Odds	95% CI for Odds		p-value
				Lower	Upper				Lower	Upper	
Use of modern contraceptive method	Facility preparedness	0.262	1.299	0.233	7.236	0.765	0.343	1.410	0.252	7.903	0.696
	Provider quality	-0.582	0.559	0.209	1.496	0.247	-0.571	0.565	0.209	1.524	0.259
	Management and supervision	-0.079	0.924	0.676	1.264	0.622	-0.065	0.938	0.684	1.286	0.689
	Constant						1.036	2.819			0.011
Discontinuation of modern method	Facility preparedness	-0.539	0.583	0.032	10.619	0.716	-0.704	0.495	0.027	9.171	0.637
	Provider quality	0.159	1.172	0.216	6.36	0.854	0.142	1.153	0.213	6.245	0.869
	Management and supervision	0.222	1.249	0.73	2.136	0.417	0.237	1.268	0.738	2.178	0.390
	Constant						0.634	1.885			0.363

Incidences of method failure were found to be associated with quality scores, as were incidences of pregnancy termination, though neither were found to be significantly associated with client satisfaction. About 17 percent (p=0.392) of respondents who experienced method failure were less likely to be satisfied with their services. Either way, considerable variations were found in the average quality scores for management and supervision (p=0.004) and provider's quality (p=0.067) at a 7 percent level of significance, though it was not significant for facility preparedness (p=0.595) or the total quality score (p=0.586). Notably, 92 percent of incidences of method failure could be correctly predicted using these sets of variables. Facility preparedness (p=0.521) was not significant, but provider quality (p=0.035) and management and supervision (p=0.002) were significantly associated with incidence of method failure (Table 10.3).

Inspecting the history of pregnancy termination, average quality scores for management and supervision (p=0.000) and facility preparedness (p=0.069) had large differences at a 7 percent level of significance (Table 10.3). Though the difference was not significant for provider quality (p=0.268), these sets of indicators could correctly predict 84 percent of the pregnancy termination cases. The total score (p=0.019) also exposed a significant difference.

Table 10.3: Association between method failure and pregnancy termination with quality scores (binary logistic regression)

Dependent variable	Category of quality score	Unadjusted estimates					Adjusted estimates				
		Co-efficient	Odds	95% CI for Odds		p-value	Co-efficient	Odds	95% CI for Odds		p-value
				Lower	Upper				Lower	Upper	
Incidence of method failure	Facility preparedness	0.6	1.823	0.113	29.5	0.673	0.905	2.472	0.156	39.169	0.521
	Provider quality	1.545	4.689	0.896	24.553	0.067	1.756	5.790	1.133	29.583	0.035
	Management and supervision	-0.655	0.519	0.331	0.814	0.004	-0.722	0.486	0.310	0.761	0.002
	Constant						-2.752	0.064			0.000

Dependent variable	Category of quality score	Unadjusted estimates					Adjusted estimates				
		Co-efficient	Odds	95% CI for Odds		p-value	Co-efficient	Odds	95% CI for Odds		p-value
				Lower	Upper				Lower	Upper	
History of pregnancy termination	Facility preparedness	0.267	1.305	0.428	3.985	0.64	-1.434	0.238	0.035	1.644	0.146
	Provider quality	-1.802	0.165	0.024	1.149	0.069	0.626	1.871	0.618	5.665	0.268
	Management and supervision	-0.774	0.461	0.333	00639	0.000	-0.777	0.460	0.331	0.640	0.000
	Constant						-0.580	0.560			0.198

Quality scores did not provide conclusive results for associated outcomes. This indicates that service quality as a uniform unit may not a significant factor. Rather, further inspection to explore the association between specific quality components and outcome indicators is highly recommended.

10.3 Observations on Quality Aspects

Over 90 percent of respondents (women aged 15–49) reported that they were satisfied with their FP services. Only 69.2 percent, however, were able to recall that the daily oral pill was an FP method, unprompted. The recall rates for IUDs and condoms were 65.9 percent and 58.5 percent, respectively. Given that almost 95 percent of respondents had ever used an FP method, the recall rate should have been higher. These recall rates could indicate a low level of informed choice. About 38 percent of FP method users (irrespective of whether their method was modern or traditional) reported that they did not consult with an FP service provider prior to use, which increases the likelihood that they are not aware of how to use the method appropriately and are therefore vulnerable to side effects and method failure.

There is also a potential bias clouding method choice and use. As demonstrated, users of modern method[19] were more aware of the positive effects than the negative effects of various methods[20]. Having an incomplete understanding of the method suggests a lack of comprehensive counseling on the part of FP service providers. In addition, only 56.6 percent of modern method users could recall how to use their current method properly. Though it is quite possible they received instructions but simply were not able to recall them, leading to incorrect use of family planning methods, and consequently can cause method failure.

Many of the respondents were dissatisfied because they did not receive their desired method. Though a client may use whatever method they desire, the provider still must conduct a screening process to suggest the best method. Though many clients visited FP service providers to initiate a new method use or to switch to another method, providers did not ask screening questions in more than one-fourth (26.7 percent) of the visits. Despite this, most of the clients were satisfied, indicating two possible things: (i) clients were not aware of what comprehensive family planning services should include, and (ii) providers mostly relied on client preferences rather than screening for the most appropriate method. Both are vulnerabilities of good quality FP services. Most providers were trained in FP service provision, but their client service delivery still requires improvement.

19 *See, details in chapter 4.*

CHAPTER 11: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

The report has been prepared based on the rights-based approach adopted by the International Conference on Population and Development (ICPD) 1994 in Cairo. The definition of reproductive health was also echoed in the United Nations Fourth World Conference on Women (Beijing Declaration of 1995) [19]. Accordingly, as an indispensable part of human rights, every couple has the right to avail essential quality FP services. It is the obligation of the state to fulfill the inevitable need for FP services. In Viet Nam, the Government has organized a well-connected FP service delivery system, involving public and private sector institutions at the national, provincial, district, commune and village level. The study explored the quality of FP services and its particular dimensions in line with the defined objectives. This chapter is devoted to summarizing the main findings of the study along with the corresponding references. It also presents key conclusions and provides recommendations for further improvement in the quality and utilization of FP services in Viet Nam.

11.1 State of Contraceptive Use

In Viet Nam, the proportions of currently married women of reproductive age (15–49 years) who can recall that the daily oral pill, condoms and IUDs are family planning methods are 69.2 percent, 58.5 percent and 65.9 percent, respectively. To compare, in Indonesia, the proportion of currently

married women (15–49 years) with knowledge on modern methods is remarkably high (pills, 97.3 percent; IUDs, 82.3 percent; injectables, 98.0 percent; implants, 89.0 percent; and condoms, 84.4 percent) [20]. Almost all currently married women (15–49 years) in Egypt know about the pill, IUDs and injectables, and 90.0 percent know about the implant [21].

The CPR among currently married women (15–49 years) in Viet Nam is 80.5 percent. Over the years, Viet Nam has been considered one of the countries with the highest contraceptive use rate [22]. Viet Nam's CPR is slightly lower than that of Eastern Asia (82.0 percent), but higher than northern Europe (77.0 percent) and North America (75.0 percent) (27). Among Southeast Asian countries, the proportion of modern method use in Thailand is much higher (76.5 percent), though the CPR in Thailand is slightly lower than Viet Nam's (78.5 percent) [23]. In Indonesia, the CPR was 61.9 percent in 2012, while the proportion of traditional method users was only 4.0 percent (in Viet Nam the same was 16.1 percent). Historically, IUDs have dominated the method mix in Viet Nam, but their share is beginning to decrease. This study found that the proportion has declined to 25.2 percent from 37.7 percent in 2002 [11]. About 30.1 percent of women in Egypt use IUDs, the leading FP method, and only 2.0 percent use traditional methods [21].

The study refutes the assumption that ethnic minority women were less likely to have access to modern family planning methods than Kinh women. A higher proportion of ethnic minority women are currently using modern contraceptive methods (68.3 percent) than Kinh women (63.3 percent). However, the total CPR was higher among Kinh women (81.1 percent compared to 78.2 percent). It implies that the Kinh women are more vulnerable to method failure and unplanned pregnancy than ethnic minority women, given traditional method use is higher among Kinh women. The high CPR and strong knowledge of FP methods among ethnic minority women are the result of the national FP program's efforts to support ethnic minorities since 2010 [24, 25].

The national budget only covers 15 percent of FP needs in the country, and mainly for ethnic minorities [26]. The majority of FP commodities (85 percent) are provided by the it development sector [27], requiring the government to it development, particularly in terms of FP service and commodity quality control. These efforts would help reduce gaps between population groups.

Given that the highest CPR – found in the Southeastern Region – was associated with the highest use rate of traditional methods (27.2 percent) while the lowest CPR – found in the Red River Delta – was correlated with the lowest use rate of traditional methods (10.5 percent), it is necessary to think about ways of transforming traditional method users into modern method users.

A considerable proportion of modern contraceptive method users (37.8 percent) did not receive counseling from FP service providers before adopting the method, suggesting gaps in knowledge of how to correctly use the method. However, among modern contraceptive method users who sought advice from providers, only 56.3 percent had adequate knowledge about how to properly use their respective FP method. That does not necessarily indicate they were not counseled, as it is likely most of them simply forgot their instructions. An appropriate solution in this instance would be a mechanism to remind FP method users about how to appropriately use FP methods. Such a mechanism is likely to lower the rate of discontinuation and incidence of unplanned pregnancy, and is an integral part of basic reproductive health rights and facilitating informed client choice.

Over 90 percent of respondents (women aged 15–49) reported that they were satisfied with their FP services, but only 69.2 percent were able to recall the daily oral pill as a family planning method (unprompted), 65.9 percent remembered IUDs and 58.5 percent remembered condoms. These rates are low, considering that almost 95 percent of these respondents had ever used an FP method. Such a recall rate for FP method could indicate a low level of informed choice. A sizeable portion of FP method users (irrespective of whether they used modern or traditional methods) mentioned that they did not consult with an FP service provider (37.8 percent) prior to

use, which increases the likelihood they are not aware of the method's appropriate use and are vulnerable to side effects and method failure.

There is also a potential bias clouding method choice and use. As demonstrated, users of modern method were more aware of the positive effects than the negative effects of various methods[21]. Having an incomplete understanding of the method suggests a lack of comprehensive counseling on the part of FP service providers. In addition, only 56.6 percent of modern method users could recall how to use their current method properly. Though it is quite possible they received instructions and simply were not able to recall them, incorrect use of family planning methods can cause method failure.

Many of the respondents were dissatisfied because they did not receive their desired method. Though a client may use whatever method they desire, the provider still must conduct a screening process to suggest the best method. Though many clients visited FP service providers to initiate a new method use or to switch to another method, providers did not ask screening questions in more than one-fourth (26.7 percent) of the visits. Despite this, most of the clients were satisfied, indicating two possible things: (i) clients were not aware of what comprehensive family planning services should include, and (ii) providers mostly relied on client preferences rather than screening for the most appropriate method. Both are vulnerabilities of good quality FP services. Most providers were trained in FP service provision, but their client service delivery still requires improvement.

11.2 Service Quality

Though there are debates among researchers on how to develop a comprehensive methodology for measuring the quality of health services [28-30], in general and FP services [31] in particular, this study measured the quality of FP services in various facilities from the view of professionals. Specifically, assessments were made based on professionally defined standards, prepared in compliance with rights-based approaches, public health concerns and the National Standards of Viet Nam, as well as in line with the Bruce's Quality of Care Framework.

This study used 40 indicators (25 for measuring the technical preparedness of a given facility, 12 for assessing provider quality and 3 for assessing management and supervision of the service delivery system) to estimate the quality of FP services. The results indicated that the average CHC quality is high (quality score: 0.88 out of 1.0): 46.6 percent of CHCs fell in the highest category quality score group (range: 0.90 – 1.00) and only 6.8 percent were in the lowest category (range: 0.65 – 0.77). Nevertheless, only 9.7 percent of CHCs satisfied all 25 facility preparedness indicators. Facility preparedness's quality varied by place of residence (urban and rural) and by region. In the North and South Central Coast and Central Highlands, no CHCs satisfied all 25 indicators, but 31.3 percent of CHCs in the Southeastern Region satisfied all 25 indicators. In terms of provider quality assessment indicators, 27.2 percent of CHCs satisfied all 12 indicators. In the Southeastern Region, 62.5 percent of CHCs satisfied all 12 indicators, but only 6.7 percent did in the Central Highlands. In contrast, a very high proportion of CHCs satisfied all three of the indicators, reflecting strong management and supervision by relevant authorities. Indicators related to management and supervision also varied by residence (urban-rural) and region. All CHCs in the North and South Central Coast met all three indicators, but only 60 percent did in the Central Highlands.

The study used a similar methodology to assess the FP service quality of district-level facilities and above. Nearly half of the facilities (45.8 percent) came in above the median quality score despite a relatively small number of samples. Notably, the proportion of providers trained on injectables, implants, tubal ligations and vasectomies (female and male sterilizations, respectively) in such facilities was lower than expected (75.0 percent, 54.0 percent, 25.0 percent and 12.5 percent,

21 *See, details in chapter 4.*

respectively). Another concerning indicator was 41.7 percent of district-level facilities and above did not receive a visit from their technical supervisor(s) in the three months preceding the survey.

Though this study also attempted to measure the quality of FP services in private and NGO-led facilities, the data collection team was not able to access most of these facilities. A number of the facilities covered did not provide a full range of family planning services. Ultimately, the small sample size did not lend itself to any statistically valid conclusions on the quality of private and NGO-led services. Generally, the quality of services score in non-governmental facilities was low compared public facilities.

Irrespective of facility type, a shortage of contraceptive supplies, a shortage of trained manpower for FP services and a lack of regular supervisory visits were all fundamental factors hindering the quality of facility preparedness. All relevant stakeholders, including policymakers and program managers, should take necessary action in this regard. It is imperative that the universal, rights-based approach to FP formulated by the ICPD (within culturally acceptable norms and the legal framework of Viet Nam) be considered during the development and implementation of initiatives to this end.

11.3 Client Satisfaction

In Viet Nam, 93.0 percent of respondents were satisfied, including 21.9 percent very satisfied and 71.1 percent satisfied. Only 7.0 percent of respondents reported not being satisfied. Comparatively, a study conducted in Thailand found that 23.3 percent of patients were highly satisfied, 61.4 percent were medium satisfied and 15.3 percent had low satisfaction [32]. Another recent study conducted in Ethiopia found that 75.3 percent of clients had a high level of satisfaction [33]. However, about 40.2 percent of clients expressed their clear intention to refer in Viet Nam, while 37.2 percent faltered about whether to refer or not and 22.6 percent clearly mentioned that they had no intention to refer.

The study did not delve further into the discord between the high levels of client satisfaction and low intention to refer. The reasoned argument regarding this discordance is likely to be their low awareness of a client's charter of rights as well as the rights enshrined in the ICPD Programme of Action.

In exploring probable factors that influence client satisfaction (intention to refer), different models were tested using logistic regression. The model contained the following eight predictors: (i) place of residence (urban-rural), (ii) ethnicity, (iii) education, (iv) distance, (v) display of IEC materials in waiting area, (vi) providers' empathetic attitude, (vii) provider asking screening questions and (viii) provider discussing follow-up visits. These predictors were considered the most appropriate for explaining factors associated with client satisfaction and were all significantly associated with a client's intention to refer.

11.4 Discontinuation, Method Failure and Abortion

High discontinuation rates are often an indication of low-quality FP services. A high rate of discontinuation can be a sign of missed opportunities to promote and sustain contraceptive use. Discontinuation rate for any method was 32.3 percent within 12 months of use. Discontinuation rates within 12 months of method use were much higher for temporary methods like the daily oral pill (38.9 percent), condoms (42.5 percent) and injectables (58.5 percent) than long-acting methods like the IUD (21.0 percent). Discontinuation of periodic abstinence and withdrawal were 27.5 percent and 35.8 percent, respectively.

The discontinuation rates in Indonesia and Egypt highlight a comparative picture. In Indonesia, the discontinuation rate for any method within 12 months was 27.1 percent. The method specific discontinuation rates within 12 months of method use for modern contraceptive methods were 40.7 percent for pills, 31.2 percent for condoms, 24.7 percent for injectables and 5.7 percent for IUDs [20]. Periodic abstinence (rhythm) had a 22.8 percent discontinuation rate; withdrawal's was 19.9 percent. The percentage of discontinuation due to method failure was 6.8 percent.

Around 3 in 10 FP users (30.1 percent) in Egypt discontinued within 12 months of initiation [21]. IUDs had the lowest discontinuation rate (14.3 percent) and pills had the highest (41.5 percent) followed by injectables (37.9 percent). Overall, 11.0 percent of discontinuations were due to method failure; i.e., the woman became pregnant while using a method.

In Viet Nam, the overall method failure rate (FP method use episode ends in unplanned pregnancy without considering any time bound) was 7.4 percent. Analysis revealed that, on average, 9.1 percent of women in Viet Nam had ever experienced unplanned pregnancy. Among them, 24.4 percent experienced unplanned pregnancy more than once. Such estimates indicate that method failure and subsequent unplanned pregnancy is an issue regarding the quality of FP services.

11.5 Study Limitations

The study had certain limitations. First, the sample size of private and NGO facilities was small. The study team was only able to access nine facilities (five private and four NGO) due largely to a lack of response from the facilities. Second, the best possible survey design was a two-stage sampling strategy where it was possible to select communes at the first stage across Viet Nam. Third, because of resource constraints, service delivery observations were not possible beyond the district level. Fourth, also due to limited resources, the study team could not adopt the reproductive calendar method used by MEASURE Evaluation to assess information regarding FP method switchover. Within the framework of the main findings of the report, it was not possible to conduct mathematical modeling to estimate key outcome variables, including discontinuation rate and method failure rate. The proposed thematic monographs will enable in-depth analysis on these topics.

11.6 Key Conclusions

Knowledge of FP methods: The survey identified a discord between a woman's education level and her knowledge of family planning methods. Though they may have known the methods, they could not recall them spontaneously.

Contraceptive use: the overall contraceptive use rate is high very. However, traditional method remains relatively high among contraceptive users.

Quality of FP services: A substantial proportion of CHCs (46.6 percent) complied with 36 out of the 40 QSS indicators. However, only 2.9 percent of CHCs complied with all 40 indicators, while 9.7 percent conformed to 39 indicators, and 21.4 percent with 38 indicators. A majority of CHCs (53.4 percent) still need improvement to offer a close-to-ideal service quality.

Most of the providers were trained in FP service provision, but still required service delivery improvement.

Client satisfaction with FP services: Though 93.0 percent of clients were satisfied and 40.2 percent expressed a clear intention to refer, 22.6 percent did not intend to refer. Another 37.2 percent wavered in their decision about whether to refer or not, indicating that client perception about the quality and state of services provided in CHCs are incongruous.

Factors that contribute to FP service quality and client satisfaction: Shortages of contraceptive supply and trained manpower for FP services coupled with a lack of supervisory visits on a regular basis are fundamentally hindering the quality of facility preparedness. The following eight factors associated with client satisfaction were significant predictors of client intention to refer: (i) place of residence (urban-rural), (ii) ethnicity, (iii) years of education, (iv) proximity to facility, (v) display of IEC materials in waiting area, (vi) providers' empathetic attitude, (vii) provider asking screening questions and (viii) provider discussing follow-up visits.

FP method discontinuation and failure rates: The 12-month discontinuation rate for any contraceptive method was 32.3 percent. Discontinuation rates within 12 months of method use were much higher for temporary methods (pills, 38.9 percent; condoms, 42.5 percent; injectables, 58.5 percent; periodic abstinence, 27.5 percent; and withdrawal, 35.8 percent) than long-acting methods (IUDs, 21.0 percent).

The overall method failure rate was 7.4 percent, 9.1 percent of women had ever experienced unplanned pregnancy and 24.4 percent of them had experienced unplanned pregnancy more than once.

Relationships between service quality and FP method discontinuation and failure rates: Unplanned pregnancy coupled with a higher discontinuation rate indicates that issues related to FP service quality should be a focal area for policymakers and national-level program managers.

11.7 Recommendations

In light of the findings of this report, policymakers should consider the following recommendations instrumental in enhancing the quality of FP services as well as client satisfaction in Viet Nam. They will also help clients make informed choices, contributing to a human rights-based approach, and may lead to a reduction in the discontinuation of contraceptive methods, and therefore a reduction in the incidences of method failure and abortion. Together, these will ultimately accelerate the process of attaining reproductive health well-being.

FP law, policy and program recommendations

Recommendation 1: Given the existing high coverage of FP services in the country, the national FP strategy moving forward should dedicate more attention to the quality of sexual and reproductive health and FP in line with the Programme of Action from the ICPD and SDGs.

Recommendation 2: The MOH should propagate pertinent policy(ies) enshrining high-quality FP services as a right of all eligible citizens.

Recommendation 3: Given the rapid growth of the private and NGO sector in FP service and commodity provision, and service quality concerns at these settings, the government should establish and effectively implement a national mechanism for assuring the quality of FP commodities and services at all steps of the product cycles. A specific guideline to facilitate district FP teams to monitor and supervise FP service quality at these facilities is needed.

Recommendation 4: The government should develop national standards and guidelines on FP service quality and commodities following WHO guidelines.

Recommendation 5: The GOPFP should consider introducing participatory quality auditing of FP service delivery in all facilities involving representatives from People's Committees, population and family planning offices, service providers, civil society organizations and relevant research communities.

Recommendation 6: An appropriate quality audit toolkit should be devised to facilitate the participatory audits of FP service quality, based on the reproductive health rights-based approach enshrined in the ICPD, national standards and the socio-cultural context of Viet Nam.

Recommendation 7: A quality audit toolkit should consider differences in regions, place of residences, types of facilities and quality differentials by facility.

Recommendation 8: The government should introduce multi-dimensional quality FP services in the quality monitoring and supervision framework at all levels.

Recommendation 9: Given the significant role of PCs in providing non-clinical methods (with a very high discontinuation rate), the GOPFP should develop national guidelines on monitoring the performance of PCs.

Recommendation 10: The contraceptive mix is skewed to IUDs and other female methods, and as such, the MOH should strive to balance the contraceptive mix to give clients more choices.

Recommendations on FP service delivery organization

Recommendation 11: The quality of FP services is a multi-dimensional variable. While facility preparedness, provider quality and the status of management and supervision are important, quality improvement programs should also consider measuring failure rates and client-perceived quality of care. Information on client satisfaction collected during exit interviews is unlikely to be a good indicator for measuring the quality of FP services.

Recommendation 12: Given the high rate of traditional contraceptive use and its high failure rate, the GOPFP should develop a good communication strategy to minimize the use of traditional methods and increase the rate of modern contraceptive use, particularly in the Southeastern region.

Recommendation 13: The study found that a number of facilities still have relatively low overall quality of services scores, and consistently low scores in one or more components. Interventions should strive to enhance the quality of services score of these facilities, and particularly facility preparedness and skilled human resources for FP services.

Recommendation 14: To further widen the scope of informed client choice, counseling should provide more information on various aspects of family planning services (advantages and disadvantages, side effects, instruction on proper use of methods, etc.) as well as address the needs of new clients and those intending to switch methods. In addition, counseling should be linked to proper screening of new clients before they start using a method. It should also cover pre- and post-abortion counseling to reduce stigma and repeat instances of unplanned pregnancy.

Recommendation 15: The GOPFP should develop culturally sensitive FP services that provide more FP options for ethnic minority women to improve their access to informed choice and reduce the discontinuation rate among these vulnerable groups.

Recommendation 16: The GOPFP, along with other relevant bodies, should undertake measures to ensure a year-round supply of all type of contraceptives to facilities in compliance with MOH regulations.

Recommendation 17: The MOH/GOPFP should ensure that all facilities have adequate numbers of trained staff to provide quality FP services.

Recommendation 18: Training mechanisms should be strengthened in terms of providing

foundational FP service training as well as periodic refresher trainings to all staff involved in providing FP services.

Recommendation 19: The Department of Health and the Department of Population and Family Planning may consider independent or inter-district teams for providing monitoring and supportive supervision along with the provision of hands-on training where and when applicable.

Recommendation 20: The client charter of rights should be widely disseminated across the country involving all relevant stakeholders and using all possible channels (including mass and virtual media).

Recommendation 21: Arrangements should be made to display culturally appropriate and informative FP service-related IEC materials in all relevant facilities.

Recommendation 22: As the contraceptive mix is still skewed toward female methods, vigorous behavior change communication activities should be arranged to encourage male participation in family planning, increasing the use rate of male condoms and vasectomies.

Recommendations on the FP research agenda

Recommendation 23: Conduct a national survey on FP services every five years to track the status of reproductive health, including family planning services with special emphasis on the quality of FP services, discontinuation, method failure, abortion and meeting unmet need.

Recommendation 24: Based on secondary analysis of the survey data, the following thematic research monographs can be developed: (i) FP services: Quality and client satisfaction in Viet Nam; (ii) Client needs and client satisfaction in rights-based family planning services: A Viet Nam case study; (iii) Contraceptive discontinuation, switchover and method failure abortion in Viet Nam; and (iv) International Conference on Population Development, Sustainable Development Goals and FP services in Viet Nam.

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ANNEX A:

DEFINITION OF KEY VARIABLES

Abortion[1] is defined as pregnancy termination prior to 20 weeks' gestation or a fetus born weighing less than 500g. However, for this survey, pregnancy termination prior to 20 weeks' gestation has been considered an abortion. The word abortion is often used to mean only ***induced abortions***. An abortion which occurs spontaneously is also known as a ***miscarriage***.

Abortion rate represents the number of induced abortions occurring in a specified reference period (e.g., one year) per 1,000 women of reproductive age (15-44 or 15-49)[2].

Abortion ratio is the number of abortions per 1,000 live births.

The ***total abortion rate*** is the total number of abortions a woman will have in her lifetime if current level persists. This can be approximated by multiplying the abortion rate by the length of the reproductive period (30-35 years).

Client, for this study, is defined as a married woman aged 15-49 who has used family planning methods.

Contraceptive acceptance rate is the percent of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time, almost always reported for married women or those in a sexual union (Measure Evaluation, USA)[3].

Contraceptive discontinuation[4]***,*** according to the US National Health Survey of Family Growth**,** is failure to use a contraceptive continuously within the past 6 months or 12 months.

Contraceptive failure is defined as a conception occurring in an act of intercourse when a contraceptive method is in use.

Contraceptive prevalence rate is the percentage of women who are using, or whose sexual partners are using, any form of **contraception**. It is usually measured among married women aged 15-49 only.

An ***FP service provider*** is the person counseling, distributing and/or inserting a family planning method for clients.

Health facility is the place where health services, including family planning services, are provided by FP service providers to clients.

Exit client is the person/individual who is leaving health facility after receiving any family planning services.

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1 *The National Center for Health Statistics, the Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO)*

2 *Source: Measure Evaluation Website. Weblink: http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/pac/abortions-per-1-000-live-births accessed on 01 July 2012*

3 *Measure DHS, ICF International, Calverton, Maryland, USA*

4 *Trussell J, Vaughan B (1999). Contraceptive Failure, Method - Related Discontinuation and Resumption of Use: Results from the 1995 National Survey of Family Growth*

ANNEX B:

INDICATOR LIST BY SPECIFIC OBJECTIVES AND SOURCE OF INFORMATION

Objective	Indicator	Questionnaire
Objective 1: Assess the quality of FP services provided at public, private and NGO sectors health facilities across the country	Provider demonstrates good counseling skills	P, M
	Provider assures client of confidentiality	P, M
	Provider asks client about reproductive intentions	P, M
	Provider discusses which method the client would prefer	P, M
	Provider mentions STIs and HIV/AIDS (initiates or responds)	P, M
	Provider discusses / promotes dual method use – when and if needed	P, M
	Provider treats client with respect/courtesy	P, M
	Provider tailors key information to the particular needs of the specific client	P, M
	Provider gives accurate information on the chosen method (how to use, possible side effects, complications, etc)	P, M
	Provider gives instructions on when to return and the reason for follow-up	P, M
	Provider follows infection control procedures outlined in guidelines	P, M
	Provider recognizes/identifies contraindications consistent with guidelines and explains the reasons to the client	P, M
	Provider performs clinical procedures according to guidelines	P, M
	Facility has all approved methods available; no stock-outs	F
	Facility has all basic items needed for the delivery of methods available through service delivery point (SDP) (e.g., sterilizing equipment, gloves, blood pressure cuff, specula, adequate light, and water)	F
	Facility offers privacy for pelvic exam/IUD insertion and removal	F
	Facility has family planning targets for health facilities / health care providers at different levels	F
	Facility has mechanisms to make programmatic changes based on client feedback	F
	Facility has received a supervisory visit in the last 3 months (depending on the level of care)	F
	Facility has adequate and proper storage of contraceptives and medicines (away from water, heat, direct sunlight; not expired) on the premises	F
	Facility has method for forecasting utilization	F
	Has pre-service and in-service training of health professionals in family planning	F
	Facility has trained health professionals with counseling skills	F
	Facility has advocacy materials	F
	Facility has national guidelines, protocols and / or job aids	F
	Facility has service providers trained to maintain user confidentiality	F
	Facility has a system to maintain adequate auditory and visual privacy of clients	F
	Facility receives a supervisory visit at least once every 3 months	F
	Facility send regular consumption data to higher levels quarterly	F

Objective	Indicator	Questionnaire
Objective 2: Assess client perception of FP service quality and the level of client satisfaction with rendered services	Cause of discontinuation	W
	Contraceptive failure history	W, H
	Satisfaction with counseling	W
	Instruction on using FP methods	W
	Knowledge on advantages of FP methods	W, H
	Knowledge on disadvantages of FP methods	W, H
	Instruction on using FP methods	W, H
	Knowledge on advantages of FP methods	W, H
	Knowledge on disadvantages of FP methods	W, H
	Staff treats client with dignity and respect	E
	Client actively participates in discussing and selecting their method (feels “empowered and involved” in decision-making)	E
	Client receives her / his method of choice	E
	Client believes the provider will keep her / his information confidential	E
	Waiting time is acceptable	E
	Provider was empathetic	E
Objective 3: Explore the factors that contribute to the quality of FP services and client satisfaction from both user and provider perspectives	Including distance from home and traveling time	W
	Any possible cause of contraceptive failure	W
	Any counseling before collection/insertion of contraceptives	W
	Satisfaction with counseling	W
	Waiting time	W
	Counseling and management	W
	Client satisfaction with FP services	W
	Provider treats client with respect/courtesy	P, M
	Provider tailors key information to the particular needs of the specific client	P, M
	Provider gives accurate information on the chosen method (how to use, possible side effects, complications, etc)	P, M
	Provider gives instructions on when to return and the reason for follow-up	P, M
	Provider follows infection control procedures outlined in guidelines	P, M
	Facility has all basic items needed for the delivery of methods available through service delivery point (SDP) (e.g., sterilizing equipment, gloves, blood pressure cuff, specula, adequate light, and water)	F
	Facility offers privacy for pelvic exam/IUD insertion and removal	F
	Facility has mechanisms to make programmatic changes based on client feedback	F
	Facility has adequate and proper storage of contraceptives and medicines (away from water, heat, direct sunlight; not expired) on the premises	F
	Facility has service providers trained to maintain confidentiality of the users	F
	Facility has system to maintain adequate auditory and visual privacy of clients	F
	Facility has trained health professionals with counseling skills	F
	Facility has advocacy materials	F
	Facility has national guidelines, protocols and / or job aids	F

Objective	Indicator	Questionnaire
Objective 4: Estimate the overall and method-related discontinuation rate and failure rate and associated determinants and risk factors	Age at first marriage	W
	Age at first FP method used	W
	No. of living children	W
	History of contraceptive use	W, H
	History of changing contraceptives	W
	Cause of method change	W, H
	History of contraceptive discontinuation	W
	Cause of discontinuation	W, H
	History of contraceptive failure	W
	Contraceptive used during failure	W, H
	Use of emergency contraceptives	W, H
	Where contraceptive was collected/inserted during failure	W
	Including distance from home and traveling time	W
	Any possible cause of contraceptive failure	W
	Any counseling before collection/insertion of contraceptives	W
	Satisfaction with counseling	W
	Waiting time	W
	Insertion of IUD	W, H
	Supply of contraceptives	W
	Counseling and management	W
	Client satisfaction with FP services	W
Objective 5: Assess the relationships between service quality and the rates of contraceptive use discontinuation and failure	Instruction on using FP methods	W
	Knowledge on advantages of FP methods	W
	Knowledge on disadvantages of FP methods	W
	Provider demonstrates good counseling skills	W
	Provider assures client of confidentiality	P, M
	Provider asks client about reproductive intentions	P, M
	Provider mentions STIs and HIV/AIDS (initiates or responds)	P, M
	Provider treats client with respect and courteously	P, M
	Provider gives accurate information on the method accepted (how to use, possible side effects, complications)	P, M
	Provider follows infection control procedures outlined in guidelines	P, M
	Provider performs clinical procedures according to guidelines	P, M
	Facility has all approved methods available; no stock-outs	P, M
	Facility has all basic items needed for the delivery of methods available through service delivery point (SDP) (e.g., sterilizing equipment, gloves, blood pressure cuff, specula, adequate light, and water)	P, M
	Facility has adequate and proper storage of contraceptives and medicines (away from water, heat, direct sunlight; not expired) on the premises	P, M
	Has pre-service and in-service training of health professionals in Family Planning	P, M
	Staff treats client with dignity and respect	E
	Client actively participates in discussing and selecting their method (feels “empowered and involved” in decision-making)	E
	Client receives her / his method of choice	E
	Client believes the provider will keep her / his information confidential	E
	Waiting time is acceptable	E
	Provider was empathetic	E

Objective	Indicator	Questionnaire
Note: *Exit Client Survey Questionnaire (E)* *Health Facility Observation Questionnaire (F)* *Household Questionnaire (H)* *Health Manager Survey Questionnaire (M)* *Service Observation Questionnaire (O)* *Service Provider Survey Questionnaire (P)* *Women Questionnaire (W)*		

ANNEX C:

DATA COLLECTION INSTRUMENTS

Study on the quality of family planning services in Viet Nam

Form C: Questionnaire for Family Planning Collaborator and Village Health Worker

'Hello. My name is …….We are conducting this survey on family planning services in Vietnam for the Ministry of Health.

We would highly appreciate your participation in this survey. I would like to ask you some questions about the family planning services you have provided to the villagers. The survey is expected to take 5 to 10 minutes. Your identity and whatever information you provide will be kept strictly confidential and will not be used for any purpose other than this research.

Participation in this survey is voluntary and you can choose not to answer any personal question or any of the questions at all. However, we hope that you will participate in this survey since your views are important.

At this time, please feel free to ask me anything about the survey.
May I start the interview now?

PART 1: IDENTIFICATION

a1	Data collector ID ___ ___ intid Team leader ID ___ ___ teamid Data Enter ID ___ ___ dataname	Date __ __/ 12 / 2015 Date __ __/ 12 / 2015 Date __ __/ 12 / 2015	dateint dateteam datenter
a2	Province: …….. Code	__ __	proid
a3	District: …….. Code	__ __	distid
a4	Location Urban Rural	[ ] 1 [ ] 2	area
a5	Commune …….. Code	__ __	comid
a6	Village name: …….		hw
a7	Name of the respondent: ……..		
a8	Age	__ __	
a9	Gender: Male [ ] 1 Female [ ] 2		
a10	Phone: …….		
a11	Contact Address: …….		

PART 2: EXPERIENCE

1	How many years have you been working on this position (round to the nearest year)?	__ __ years	c1
2	Have you ever been trained on FP? *Yes* *No*	 [ ] 1 [ ] 0 *Skip to 6*	c2
3	If yes, what were you trained on?	**Yes** **No**	c3
	monitoring couples and reporting on FP usage	[ ]1 [ ]0	
	FP methods	[ ]1 [ ]0	
	Counselling skills	[ ]1 [ ]0	
	Community mobilization for FP	[ ]1 [ ]0	
	Social marketing of contraceptive devices	[ ]1 [ ]0	
	Other health issues……	[ ]1 [ ]0	

4	How long was the first course (round to the nearest number of days)? (Fill 99 if interviewee doesn't remember.)	__ __ __ days	c4
5	Who was the training agency?		c5
	General Office of Population and FP	[ ] 1	
	Reproductive health center	[ ] 2	
	Department of population	[ ] 3	
6	Do you participate in any annual training/retraining courses on FP?		c6
	Yes	[ ] 1 *If Yes* __ __ *days*	
	No	[ ] 0	
7	Are you motivating people to use family planning methods?		c7
	Yes	[ ] 1	
	No	[ ] 0	
8	Do you also have other roles in the community?		c8
	Village Health Worker	( ) 1	
	Women's Union	( ) 2	
	Youth Union	( ) 3	
	Father Frontier	( ) 4	
	Farmer's Union	( ) 5	
	Others (specify) ……..…..	( ) 6	
	Do nothing	( ) 7	
9	How many days per month do you work on FP efforts?	__ __ days	c9
10	Do you know the number of couples in your area?	__ __ couples *"99" if don't know*	c10
11	How many couples are using FP right now that you know of?	__ __ couples	c11
12	In the last 30 days, how many couples did you visit at their HOME?	__ __ couples	c12
	In which, did you: Provide condoms	__ __ *couples*	
	Provide contraceptive pills	__ __ *couples*	
	Encourage them to go for IUD insertion	__ __ *couples*	
	Educational promotion about family planning	__ __ *couples*	
13	Are you distributing family planning methods?		c13
	Yes	[ ] 1	
	No	[ ] 0	
14	Which method(s) are you distributing?		c14
	Pills	( ) *Ask from 15-22*	
	Condoms	( ) *Ask from 23-26*	
	Others (specify) ……..…..	( ) *Skip to 27*	
15	If yes to the pill, how many cycles of pills have you distributed during the last month?	__ __ __ tablets	c15
16	If yes to condoms, how many condoms have you distributed during the last month?	__ __ __ box	c16
		Yes **No**	
17	Before distributing pills, have you asked the clients any questions regarding their current health condition?	[ ]1 [ ]0	c17

18	Have you told them about the side effects of the pill?	[ ]1 [ ]0	c18
19	Have you told them about how to take the pill correctly?	[ ]1 [ ]0	c19
20	Have you told them what to do in case they miss a pill?	[ ]1 [ ]0	c20
21	Is there anyone coming for alternatives due to side effects?	[ ]1 [ ](*If "0" skip to 23*	c21
22	If yes, were you able to help them find alternatives?	[ ]1 [ ]0	c22
23	How many condoms have been distributed during the last month?	__ __ _ boxes	c23
24	For those you provide condoms to for the first time, do you tell them how to use them correctly?	[ ]1 [ ](*If "0" skip to 27*	c24
25	If yes, do you have any pictorial manuals to show them how to use them correctly?	[ ]1 [ ](*If "0" skip to 27*	c25
26	If yes, are you able to show that pictorial manual to the couples regarding the use of condoms?	[ ]1 [ ]0	c26
27	Have you been trained about the indications to use long-term and permanent family planning methods?	[ ]1 [ ]0	c27
28	If yes, do you refer the couples to appropriate facilities nearby for long-term and permanent methods?	[ ]1 [ ]0	c28
29	Do you face any difficulties in executing this role?		c29
	Reaching a certain number of new couples for FP use	( ) 1	
	Lack of training	( ) 2	
	Low incentives	( ) 3	
	People do not welcome the free methods	( ) 4	
	People don't want to share their FP issues with me	( ) 5	
	Others (specify) ……..…..	( ) 6	
	Difficulty in traveling/lack of money/ shortage of supplies	( ) 7	
	No difficulties	( ) 8	
30	What monthly financial support do you receive for being a Population/FP collaborator?	__ __, __ __ __, __ __ __ dong	c30

31	Does anyone supervise your performance?	**Weekly**	**monthly**	**Quarterly**	**Biannually**	**Annually**	**More than a year**	c31
	Communal Healthcare Center	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5	( ) 6	
	Commual Population Officer	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5	( ) 6	
	District FP facilities	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5	( ) 6	
	FP facilities from provincial levels & higher	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5	( ) 6	

NOTE: ……

Study on the quality of family planning services in Viet Nam

FORM E- EXIT CLIENT QUESTIONNAIRE

Interview exit client who use:	FP services	Abortion
	FP Counseling services	Gyn check up

Hello. My name is …….We are conducting a survey on family planning service use in Vietnam for the Ministry of Health.

We would very much appreciate your participation in this survey. I would like to ask you some questions about the family planning services you just received from the service provider. Your information will help the government understand the current quality of family planning services and take necessary steps towards its improvement. The survey is expected to take 5 to 10 minutes. Your identity and whatever information you provide will be kept strictly confidential and will not be used for any purpose other than this research study.

Participation in this survey is voluntary and you can choose not to answer any individual question or any of the questions at all. However, we hope that you will participate in this survey since your views are important.

At this time, please feel free to ask me anything about the survey.
May I begin the interview now?

[ ] **ONE** ANSWER ACCEPTED ( ) **MULTIPLE** ANSWERS ACCEPTED

PART 1: IDENTIFICATION

a1	Data collector ID ___ ___	intid	Date	__ __/__ __/ 2015	dateint
	Team leader ID ___ ___	teamid	Date	__ __/__ __/ 2015	dateteam
	Data Enter ID ___ ___	dataname	Date	__ __/__ __/ 2015	datenter
a2	Province:……	*Code*	__ __		proid
a3	District: ……	*Code*	__ __		distid
a4	Location	Urban	[ ] 1		area
		Rural	[ ] 2		
a5	Commune: ……	*Code*	__ __		comid
a6	Type of facility providing family planning services				facility
		Provincial hospital	[ ] 1		
		Provincial RH center	[ ] 2		
		District hospital / health center (Obstetric dept.)	[ ] 3		
		District RH/FP nutrition unit	[ ] 4		
		Commune health station	[ ] 5		
		Village FP collaborator	[ ] 6		
		Private clinic/ NGO-led clinic / Private hospital	[ ] 7		
		Pharmacy	[ ] 8		
		Other: _____	[ ] 9		

PART 2: FAMILY PLANNING SERVICE USE EXPERIENCE

1	Did you receive any family planning-related services today?		e1
	Yes	[ ] 1	
	No	[ ] 0	
2	What was the purpose of THIS visit?		e2
	Receive information on suitable FP methods	( ) 1	
	Counseling on method selection	( ) 2	
	Screening for a eligible methods / Selection of methods	( ) 3	
	Receiving methods (or supplies)	( ) 4	
	Visit related to side effects	( ) 5	

	Visit related to complications	( ) 6		
	Visit related to resupplying	( ) 7		
	Visit related to method removal	( ) 8		
	Gyn check up	( ) 9		
	Abortion	( ) 10		
	Others(specify):……..	( ) 11		
3	Please share with us which of the following family planning methods you use?			e3
	Pills	( ) 1		
	IUD	( ) 2		
	Injectable	( ) 3		
	Male sterilization	( ) 4		
	Female sterilization	( ) 5		
	Implant	( ) 6		
	Periodic abstinence	( ) 7		
	Withdrawal	( ) 8		
	None	[ ] 9		
	Others (specify):……..	( ) 10		
4	How long was your traveling time to this facility? (in minutes)	__ __ __	munites	e4
		Yes	No	
5	Were the facility's working hours suitable for you?	[ ] 1	[ ] 0	e5
6	Did you see the provider you wanted to meet?	[ ] 1	[ ] 0	e6
7	Who did you visit?			e7
	Doctor	[ ] 1		
	Doctor's assistant	[ ] 2		
	Midwife	[ ] 3		
	Nurse	[ ] 4		
	Family planning counselor	[ ] 5		
	Village FP collaborator	[ ] 6		
	Communal FP specialized staff/officer	[ ] 7		
	Other (specify)……..	[ ] 8		
8	How long did you have to wait before you saw the provider during your last vist? (in minutes)	__ __ __		e8
	If question 3 = 7, 8, 9, Ask Question 9 If question 3 = 1 - 6, Skip to Part 3			
9	Did the provider give you more information about FP?			e9
	Yes	[ ] 1		
	No	[ ] 0	*Skip to Part 3*	
10	If yes, what FP method provider gave you information?			e10
	Pills	( ) 1		
	Condom	( ) 2		
	IUD	( ) 3		
	Injectable	( ) 4		
	Implant	( ) 5		
	Female sterilization	( ) 6		
	Male sterilization	( ) 7		
	Periodic abstinence	( ) 8		
	Others……..	( ) 9		
	What information did the FP method provider give you?	Yes	No	e11
	Advantages	[ ] 1	[ ] 0	
11	*Disadvantages*	[ ] 1	[ ] 0	

	Service provision location	[ ] 1			[ ] 0	
	Eligible screening criteria	[ ] 1			[ ] 0	
	PART 3: PERCEPTIONS OF QUALITY OF CARE					
	Now I would like to ask your opinion about the quality of care provided by this health facility					
	Health examination and care	**3**	**2**	**1**	**0**	e12
12,1	In your opinion, is the health worker in this health facility capable of providing examinations and identifying health problems for clients?	Very capable	Somewhat capable	Hardly or not at all capable	No response or do not know	
12,2	In your opinion, was the medicine that the health staff in this health facility prescribed:	The drug needed	Generally the drugs that are needed	Not all the drugs are needed	No response or do not know	
12,3	In your opinion, can clients receive medicine in this health facility?	Very conveniently	With relative convenience	With difficulty	No response or do not know	
12,4	Clients cared for in this health facility will likely face:	No complications at all	Almost no complications	Some complications	No response or do not know	
	Health Personnel	**3**	**2**	**1**	**0**	
12,5	In your opinion, the health staff in this health facility examines their clients:	Well	Relatively well	Not well	No response or do not know	
12,6	In your opinion, the counseling provided by health staff is:	Fully adequate	Somewhat	Not at all	No response or do not know	
12,7	In your opinion, did the health staff listen to you when you explained your visit and your needs?	Fully listened	Somewhat	Not at all	No response or do not know	
12,8	In your opinion, were health staff compassionate?	Very much	Somewhat	Not at all	No response or do not know	
12,9	In your opinion, the health staff were:	Respectful	Somewhat	Not at all	No response or do not know	
12,10	In your opinion, the time that the health staff took to explain your health was:	Adequate	Less adequate	Inadequate	No response or do not know	
12,11	In your opinion, the staff in this facility explained the advantages/disadvangates and side effects of FP methods:	Very specifically	Somewhat specifically	Almost no information	No response or do not know	
12,12	In your opinion, staff in this facility adequately discussed follow-up visits	In verbal and written form	In verbal form	Not at all	No response or do not know	
12,13	How was the attitude of the health workers?	Nice and gentle	Somewhat gentle	Shouting at clients	No response or do not know	
	Facilities, Service Accessibility and Fee	**3**	**2**	**1**	**0**	
12,14	In your opinion, how was the service fee?	Reasonable	Somewhat resonable	Not reasonable	No response or do not know	
12,15	How far is the distance from your place to this center?	Near	Rather far	Very far	No response or do not know	
12,16	In your opinion, is the number of health workers here:	Adequate	Somewhat adequate	Inadequate	No response or do not know	
12,17	In your opinion, the screening equipment in this health facility is:	Well suited	Somewhat suited	Not well suited	No response or do not know	
12,18	In your opinion, how were the waiting room, checkup room, conseling room and procedure room?	Clean	Somewhat clean	Not clean	No response or do not know	

12,19	In your opinion, did the waiting room, checkup room, conselling room and procedure room meet your privacy criteria?	Yes	Partly	No	No response or do not know	
12,20	In your opinion, how were the leaflets and brochures left for clients to read in the waiting room?	Adequate	Somewhat adequate	No leaflets/ brochures	No response or do not know	

13	Considering all costs (direct, travel time, wage/earning loss) how do you rank this facility?		e13
	Very expensive	[ ]1	
	Expensive	[ ]2	
	Acceptable	[ ]3	
	Cheap	[ ]4	
	Very cheap	[ ]5	
14	Will you suggest this facility to your friends/ neighbors?		e14
	Maybe	[ ] 1	
	Yes	[ ] 2	
	No	[ ] 0	
PART 3: DEMOGRAPHIC INFORMATION			
15	Name of the respondent: ……..		resp
16	Age (in completed years)	___	age
17	Family's phone: ……..		tel
18	What is your ethnic group?		e30
	Kinh	[ ] 1	
	Others	[ ] 2	
19	What is your religion?		
	No religion, just pray for ancestors	[ ]1	
	Christian	[ ]2	
	Buddism	[ ]3	
	Other (specific)…….	[ ]5	e31
20	How many years did you go to school?	…….years	e32
21	What is your job at present?		
	Agriculture	[ ]1	
	Industry/Construction	[ ]2	
	Service/Trade/Business	[ ]3	
	Officer	[ ]4	
	Student/Pupil	[ ]5	
	Unemployed/Housewife	[ ]6	e33
22	What is your marital status?		e34
	Unmarried, have boyfriend (not living together)	[ ] 1	
	Unmarried, have boyfriend (living together - defacto)	[ ] 2	
	Married, living together	[ ] 3	
	Married, not living together	[ ] 4	
	Seperated	[ ] 5	
	Divorced	[ ] 6	
	Widow/widower	[ ] 7	
23	How many children do you have?	…… Children	e35

***** CHECK THE QUESTIONNAIRE & THANK THE RESPONDENT**

NOTE:……

Consideration about additional questions: Did he/she contribute suggestions for the service provider?

Study on Quality Assurance of Family Planning Services in Vietnam

FORM F_FAMILY PLANNING FACILITY SURVEY CHECKLIST

Hello. My name is …….We are conducting the survey on family planing service use in Vietnam for the Ministry of Health.
We would highly appreciate your participation in this survey. I would like to ask you some questions about the family planning services that your facility provides. This research has received technical and ethical approval by the Ministry of Health and the University of Public Health and has been approved for implementation in the province by the Department of Health.
May I start the interview now?

[ ] ONE answer accepted **( ) MULTIPLE** answers accepted

PART 1: SCREENING QUESTION, INTERVIEWEE AND INTERVIEWER DETAILS

a1	Data interviewer ID ___ ___	intid	Date __ __/__ __/ 2015	dateint
	Team leader ID ___ ___	teamid	Date __ __/__ __/ 2015	dateteam
	Data Enter ID ___ ___	dataname	Date __ __/__ __/ 2015	datenter
a2	Province: ……..	Code __ __		proid
a3	District : ……	Code __ __		distid
a4	Commune: ……	Code __ __		comid
a5	Location	Urban	[ ] 1	area
		Rural	[ ] 2	
a6	Type of health facility:	Provincial hospital	[ ] 1	facility
		Provincial RH center	[ ] 2	
		District hospital / health center (Obs dept)	[ ] 3	
		District RH/FP nutrition unit	[ ] 4	
		Commune health station	[ ] 5	
		FP collaborator	[ ] 6	
		Private clinic/NGO clinic	[ ] 7	
		Pharmacy	[ ] 8	
		Other: _____	[ ] 9	
Key contact person of the health/FP center				
a7	Name of the respondent ……			informant
a8	Sex:		Male [ ] 1 Female [ ] 2	infsex
a9	Age:		__ __	age
a10	Position			infopost
		Obs/Gyn Doctor	[ ]1	
		Assistant Doctor in Obs and Pediatrics	[ ]2	
		Midwife	[ ]3	
		General practitioners trained in FP, MVA and counseling	[ ]4	
		Technician	[ ]5	
		Family planning/population communual officer	[ ]6	
		Other (specify:……	[ ]7	
a11	Tel. no		……	infotel

PART 2: BASIC INFORMATION ABOUT THE HEALTH/FP CENTER

	Question	Yes	No		
1	Does the facility have functional electricity connection?	[ ]1	[ ] 0	*Skip 3*	f1
2	Is the electricity functioning (at the moment)? this interview)?	[ ]1	[ ] 0		f2
3	Does the facility have a waiting room for FP clients?	[ ]1	[ ] 0		f3
4	Does the facility have a functioning toilet for patients/FP clients?	[ ]1	[ ] 0	*Skip 6*	f4
5	Is there running water in the toilet?	[ ]1	[ ] 0		f5
6	Does the facility have a room for family planning counseling?	[ ]1	[ ] 0	*Skip 8*	f6

7	Is proper privacy for clients maintained in counseling room?	[ ]1 [ ] 0	f7
8	Does the facility have an operating theater for clinical FP services?	[ ]1 [ ] 0	f8
9	Does the facility have a room beside operating theater for client post-operative care?	[ ]1 [ ] 0	f9
10	How many beds are there for client post-operative care? *NA*	__ __ beds [ ] 0	f10
11	**Equipment and Instruments**	**Yes** **No**	f11
a	Operating table: clean, stainless steel	[ ] 1 [ ] 0	f11xa
b	Instrument trolley: stainless steel, mobile	[ ] 1 [ ] 0	f11xb
c	Lights for examination	[ ] 1 [ ] 0	f11xc
d	Two chairs	[ ] 1 [ ] 0	f11xd
e	Light for placental inspection	[ ] 1 [ ] 0	f11xe
f	Pain relief, anesthesia drugs, lidocain, shock management kits	[ ] 1 [ ] 0	f11xf
g	Other necessary sterilized equipment for FP procedure	[ ] 1 [ ] 0	f11xg

PART 3: SUPPLY OF FAMILY PLANNING METHODS AND MSR FOR LAPM

		Yes	**No**	
12	Are there any current shortages of oral pills?	[ ] 1	[ ] 0	f12
13	Are there any current shortages of condoms?	[ ] 1	[ ] 0	f13
14	Are there any current shortages of IUDs?	[ ] 1	[ ] 0	f14
15	Are there any current shortages of implants?	[ ] 1	[ ] 0	f15
16	Is there adequate supply of long acting methods? as per demand on regular basis?	[ ] 1	[ ] 0	f16
17	Are there any current shortages of MSR for LAPM right now?	[ ] 1	[ ] 0	f17
18	Which MSR for LAPM have current shortages? *(If any, please encircle the number)*			f18
	Not provide the service fill 9 **1. MSR for IUD:**	**Yes**	**No**	f18.1
	IUD Table	[ ] 1	[ ] 0	f181x1
	Spot light/ Touch light	[ ] 1	[ ] 0	f181x2
	Sponge holding forceps	[ ] 1	[ ] 0	f181x3
	Small, middle & big size bi-vulve, Cuscose speculum	[ ] 1	[ ] 0	f181x4
	Tenaculam/ Volselum	[ ] 1	[ ] 0	f181x5
	Uterine sound	[ ] 1	[ ] 0	f181x6
	Scissors	[ ] 1	[ ] 0	f181x7
	Straight artery forceps	[ ] 1	[ ] 0	f181x8
	Sterile Gloves	[ ] 1	[ ] 0	f181x9
	Surgical trey with cover to preserve equipment	[ ] 1	[ ] 0	f181x10
	Gully pot to preserve cotton ball	[ ] 1	[ ] 0	f181x11
	Cotton ball	[ ] 1	[ ] 0	f181x12
	Providine iodine	[ ] 1	[ ] 0	f181x13
	IUD sterilizer (with 3 rack)	[ ] 1	[ ] 0	f181x14
	Stove/ Heater	[ ] 1	[ ] 0	f181x15
	If the facility does not provide the service, fill 9 **2. MSR for Implant:**	Yes	No	f18.2
	O.T. Table	[ ] 1	[ ] 0	f182x1
	Armrest or extra table	[ ] 1	[ ] 0	f182x2
	Norplant capsule	[ ] 1	[ ] 0	f182x3
	Germ-free tray, Surgical draw sheet, Gully pot	[ ] 1	[ ] 0	f182x4
	Germ-free Gloves	[ ] 1	[ ] 0	f182x5
	Soap	[ ] 1	[ ] 0	f182x6
	Antiseptic Solution (Providine iodine, Chlorohexidine)	[ ] 1	[ ] 0	f182x7
	1% Lidocaine without Adrenaline	[ ] 1	[ ] 0	f182x8
	2 cc Disposable syringe	[ ] 1	[ ] 0	f182x9
	Pre-loaded Implant applicator	[ ] 1	[ ] 0	f182x10

Elastomeric dressing matrix or Band -aid or Germ-free gauze with surgical tape	[ ] 1	[ ] 0	f182x11
Medicine for managing emergency situations (Anaphylactic shock)			
Injection Promethazine hydrochloride (25 mg- 2 ampule)	[ ] 1	[ ] 0	f182x13
Injection Hydrocortisone (100 mg)- 2 Vial/ ampule	[ ] 1	[ ] 0	f182x14
Injection Adrenaline (1: 1000)- 2 Vial/ ampule	[ ] 1	[ ] 0	f182x15
If the facility does not provide the service, fill 9 **3. MSR for Tubectomy:**	Yes	No	f18.3
a. Medicine Injection Atropine Sulfate (0.6 mg/ ml)	[ ] 1	[ ] 0	f183xa1
Injection Promethazine (12.5 mg/ ml)	[ ] 1	[ ] 0	f183xa2
(a) Injection Pathedine (25 mg/ ml) or (b) Injection Pentazocine (30 mg/ ml)	[ ] 1	[ ] 0	f183xa3
Injection Xylocaine (1%, 50 ml)	[ ] 1	[ ] 0	f183xa4
Capsule Amoxicillin or any other Broad-spectrum antibiotic	[ ] 1	[ ] 0	f183xa5
Tablet Diazepam (5 mg/ tablet)	[ ] 1	[ ] 0	f183xa6
Tablet Paracetamol (500 mg/ tablet)	[ ] 1	[ ] 0	f183xa7
Tablet Iron + Folic acid	[ ] 1	[ ] 0	f183xa8
b. Surgical Equipment Cotton (100 gm)	[ ] 1	[ ] 0	f183xb1
Surgical bandage (20 yards/ edge)	[ ] 1	[ ] 0	f183xb2
Chromic catgut (sterile, 1-0, 152 cm)	[ ] 1	[ ] 0	f183xb3
Providine iodine solution (100 ml)	[ ] 1	[ ] 0	f183xb4
Surgical gloves (size 6.5)	[ ] 1	[ ] 0	f183xb5
Surgical gloves (size 7)	[ ] 1	[ ] 0	f183xb6
Disposable sterile syringe (10 CC)	[ ] 1	[ ] 0	f183xb7
Disposable sterile syringe (5 CC)	[ ] 1	[ ] 0	f183xb8
Surgical blade (sterile, size-10)	[ ] 1	[ ] 0	f183xb9
Uristick GP-2 (for glucose & albumin test)	[ ] 1	[ ] 0	f183xb10
Sterile disposable lancet	[ ] 1	[ ] 0	f183xb11
Elastomeric dressing matrix (duo-durm, Size 10 cm × 10 cm)	[ ] 1	[ ] 0	f183xb12
Cutting curved needle	[ ] 1	[ ] 0	f183xb13
Cutting straight needle	[ ] 1	[ ] 0	f183xb14
Curved round body needle	[ ] 1	[ ] 0	f183xb15
Silk thread (1-0)	[ ] 1	[ ] 0	f183xb16
If the facility does not provide the service, fill 9 **4. MSR for Vasectomy:**	Yes	No	f18.4
a. Medicine Injection Xylocaine (1%, 50 ml)	[ ] 1	[ ] 0	f184xa1
Capsule Amoxicillin or any other Broad-spectrum (for 7 days)	[ ] 1	[ ] 0	f184xa2
Tablet Paracetamol (500 mg/ tablet)	[ ] 1	[ ] 0	f184xa3
Tablet Vitamin B-complex	[ ] 1	[ ] 0	f184xa4
b. Surgical Equipment Cotton (100 gm)	[ ] 1	[ ] 0	f184xb1
Surgical bandage (20 yards/ edge)	[ ] 1	[ ] 0	f184xb2
Providine iodine solution (100 ml)	[ ] 1	[ ] 0	f184xb3
Surgical gloves (size 6.5)	[ ] 1	[ ] 0	f184xb4
Surgical gloves (size 7)	[ ] 1	[ ] 0	f184xb5
Disposable sterile syringe (5 CC)	[ ] 1	[ ] 0	f184xb6
Uristic GP-2 (for glucose & albumin test)	[ ] 1	[ ] 0	f184xb7
Elastomeric dressing matrix (duo-durm, size 10 cm × 05 cm)	[ ] 1	[ ] 0	f184xb8
Sterile disposable lancet	[ ] 1	[ ] 0	f184xb9

	Condom	[ ] 1	[ ] 0	f184xb10
	Silk thread (1/20)	[ ] 1	[ ] 0	f184xb11
If the facility does not provide the service, fill 9 **5. MSR for Managing Emergency Situation:**		Yes	No	f18.5
a. Emergency Equipment				
Oxygen therapy unit	Filled up Oxygen cylinder	[ ] 1	[ ] 0	f185xa1
	Cylinder stand or trolley	[ ] 1	[ ] 0	f185xa2
b. Therapy set :	Pressure meter	[ ] 1	[ ] 0	f185xb1
	Flow meter and control bulb	[ ] 1	[ ] 0	f185xb2
	Cylinder key (it may be attached to cylinder)	[ ] 1	[ ] 0	f185xb3
	Face mask with tube	[ ] 1	[ ] 0	f185xb4
	Water bottle with ring	[ ] 1	[ ] 0	f185xb5
	Airway tube	[ ] 1	[ ] 0	f185xb6
	Suction machine (electric/ manual) (If suction machine is not available then one MR syringe and catheter is necessary)	[ ] 1	[ ] 0	f185xb7
	Manual resuscitator or Ambubag	[ ] 1	[ ] 0	f185xb8
	Emergency light (3 battery touch lighter or rechargeable electric touch lighter)	[ ] 1	[ ] 0	f185xb9
	Metallic catheter (for women)	[ ] 1	[ ] 0	f185xb10
	Laperatomy set (with venesection kit for vein flow)	[ ] 1	[ ] 0	f185xb11
c. Emergency MSR which should be replaced after use				
	Atromatic catgut ('0')	[ ] 1	[ ] 0	f185xc1
	Ryle's tube	[ ] 1	[ ] 0	f185xc2
	Folley's catheter	[ ] 1	[ ] 0	f185xc3
	Elastic catheter	[ ] 1	[ ] 0	f185xc4
d. List of emergency medicine		[ ] 1	[ ] 0	
	Naloxone injection (0.4 Mg/ ml)	[ ] 1	[ ] 0	f185xd1
	Epinephrine (Adrenaline 1:1000) 1 mg/ ml injection	[ ] 1	[ ] 0	f185xd2
	Hydrocortisone injection (100 mg)	[ ] 1	[ ] 0	f185xd3
	Promethazine injection (25 mg/ml)	[ ] 1	[ ] 0	f185xd4
	5% Dextrose in normal saline (500 ml bag)	[ ] 1	[ ] 0	f185xd5
	Normal saline (500 ml bag)	[ ] 1	[ ] 0	f185xd6
	Diazepam injection (10 mg/ml)	[ ] 1	[ ] 0	f185xd7
	10% Calcium Gloconate injection (10 ml/ ampule)	[ ] 1	[ ] 0	f185xd8
	7.5% Sodium-bicarbonate injection (25 ml/ ampule)	[ ] 1	[ ] 0	f185xd9
	Aminophyline injection (250 mg/10 ml)	[ ] 1	[ ] 0	f185xd10
	Atropine injection (0.6 mg/ ml)	[ ] 1	[ ] 0	f185xd11
	Physostigmine injection (1 mg/ml)	[ ] 1	[ ] 0	f185xd12
	Butterfly infusion Set	[ ] 1	[ ] 0	f185xd13
	Sterile disposable syringe, 2/5/10/50 ml size	[ ] 1	[ ] 0	f185xd14
		Yes	No	
19	Is the clinic sterilizer working properly?	[ ] 1	[ ] 0	f19
PART 4: AVAILABILITY OF METHOD-SPECIFIC JOB AIDS				
		Yes	**No**	
20	Are there IEC materials in your clinic to provide information on family planning services to clients?	[ ] 1	[ ] 0 Skip to Part 5	f20
21	If yes, what types of IEC materials are used in your clinic to provide information on family planning services?			
	Leaflets	[ ] 1	[ ] 0	f21x1

	Flip chart	[ ] 1	[ ] 0	f21x2
	Wall chart	[ ] 1	[ ] 0	f21x3
	Model	[ ] 1	[ ] 0	f21x4
	Video	[ ] 1	[ ] 0	f21x5
22	Are there method-specific job-aids on advantages and disadvantages of contraceptives on the table / hanging on the wall of the provider room at the health/FP facility?	[ ] 1	[ ] 0	f22
23	Are there method-specific job-aids to check medical eligibility criterion for starting contraceptives on the table/hanging on the wall of the provider room at the health/FP facility?	[ ] 1	[ ] 0	f23

PART 5: RECORD-KEEPING AND REPORTING

		Yes	**No**	
24	Does the facility have: A client follow-up book	[ ] 1	[ ] 0	f24x1
	Contraceptive supply records	[ ] 1	[ ] 0	f24x2
	Client contraception records	[ ] 1	[ ] 0	f24x3
25	Do clinic staff call and note client feedback after providing services?	[ ] 1	[ ] 0	f25
26	Do clinic staff note client feedback about service improvements?	[ ] 1	[ ] 0	f26
27	Do clinic staff instruct clients to come back for a follow-up visit?	[ ] 1	[ ] 0	f27
28	Was a hard copy of the last monthly report submitted at right time? [Verify the form for submission day of last month's report]	[ ] 1	[ ] 0	f28
29	Was the monthly FP-MIS report uploaded at the right time last month? [Verify the date of submission from FP-MIS dataset in last month]	[ ] 1	[ ] 0	f29
		[ ] 99	Not applicable	

PART 6: HUMAN RESOURCES

Type of human resources in family planning facility		**Posts**		
		Currently posted	**Sanctioned Post**	
30	Total staff in the facility			**f30**
31	Total doctors in the facility			f31
32	Total number of Obs/Gyn doctors			f32
		(I f32=0, skip to 34)		
33	Number of Obs/Gyn doctors trained in:			f33
	Provision of short-term FP methods			
	Provision of LAPMs			
	Management of FP method complications			
34	a. Total assisstant doctors in obstetrics and pediatrics			f34x1
		(If f34=0, skip to 35)		
	b. Number of assistant doctors in obstetrics and pediatrics trained in:			f34x2
	FP service counseling			
	Assisting doctors in providing and managing LAPM complications			
	Maintaining and sterilizing operation theatre instruments & MSR			

35	a. Total general practitioners who are trained and certified in providing FP methods, manual vaccumm aspiration and counseling			f35x1
		(If f35=0, skip to 36)		
	b. Number of general practitioners trained in:			
	FP service counseling			f35x2
	Assisting doctors in providing and managing the complications of LAPMs			f35x3
	Maintaining and sterilizing operation theatre instruments & MSR			f35x4
36	Total number of midwifes and assistant doctors			f36
37	Total number of pharmacists			f37
38	Total number of medical technologists and laboratory technicians			f38
39	Total number of clinic aids and cleaners			f39
40	Total number of guards			f40

Human resourses

41	Do you have any manpower shortages in your clinic for providing family planning services?		f41
	Yes	[ ] 1	
	No	[ ] 0 *Skip to 43*	
42	What kind of manpower shortages are there?		f42
	Trained traveling doctor	( ) 1	
	Trained traveling counselor	( ) 2	
	Trained doctor for providing IUDs, implants, tubectomies and vasectomies	( ) 3	
	Trained nurse for OT assistance	( ) 4	
	Trained manpower for handling sterilizer	( ) 5	
	Aya/Sweeper	( ) 6	

Family Planning Activities of Clinic

43	Number of FP clients that received counseling services in last 3 months? (7-8-9/2015)	__ __ __ clients	f43

44	Name of FP services	Type of FP services provided in the last 3 months (Yes=1; No=0)	Number of clients who received FP services in the last 3 months from this facility	Number of FP clients treated for complications in the last 3 months by specific FP services	f44
a	Condom	[ ]1 [ ]0	__ __ __ clients	__ __ __ clients	
b	IUD	[ ]1 [ ]0	__ __ __ clients	__ __ __ clients	
c	Oral pill	[ ]1 [ ]0	__ __ __ clients	__ __ __ clients	
d	Injectables	[ ]1 [ ]0	__ __ __ clients	__ __ __ clients	
e	Implant	[ ]1 [ ]0	__ __ __ clients	__ __ __ clients	
f	Tubectomy	[ ]1 [ ]0	__ __ __ clients	__ __ __ clients	
g	Vasectomy	[ ]1 [ ]0	__ __ __ clients	__ __ __ clients	

45	How many IUD recipients came for removals as a result of complications or discomfort in the last 3 months? (7-8-9/2015)	__ __ __ clients	f45
46	Does your clinic provide services for managing FP complications?		f46
	Yes	[ ] 1	
	No	[ ] 0 *Skip to Part 7*	
		Yes **No**	

a	Does your clinic provide supplies to FP clients for managing complications?	[ ] 1 [ ] 0	f46a
b	Does your clinic provide follow-ups for FP clients for managing complications?	[ ] 1 [ ] 0	f46b
c	Does your clinic have a referral arrangement with higher-level facilities for managing family planning complications, as needed?	[ ] 1 [ ] 0	f46c

IF YOU ARE FROM A PROVINCIAL/DISTRICT FACILITY, THE QUESTIONNAIRE IS FINISHED. THANK YOU FOR YOUR TIME.

PART 7: CHS (Only for commune health station service providers)

47	What is the population size of your catchment area?	__ __ __ __ __ people	f47
	In which: Male	_____	
	Female	_____	
	Don't know	[ ] 99	
48	How many eligible couples are there in your working area?	_____	f48
	Don't know	[ ] 99	
49	How many eligible couples are currently using any modern FP method in your area? *(Collect information from monthly MIS report)*	Quantity	f49
	Condoms	__ __ __	
	IUD	__ __ __	
	Oral pills	__ __ __	
	Injections	__ __ __	
	Implant	__ __ __	
	Vasectomy	__ __ __	
	Tubectomy	__ __ __	
	Periodic abstinence	__ __ __	
	Others: ……	__ __ __	
	Don't know	[ ] 999	
50	In 2014, how many camps were organized in your commune to provide FP services?	__ __ *If 0 skip to 52*	f50
51	If yes, how many camps were organized during the last year (2014) for each of the FP approaches below? Provider: doctor=1; doctor assistant=2; Midwife=3; other=4	Number of camps (2014) / Provider (Code)	f51
	Condoms	__ / __	
	IUD	__ / __	
	Oral pills	__ / __	
	Injections	__ / __	
	Implant	__ / __	
	Tubectomy	__ / __	
	Vasectomy	__ / __	
	Periodic abstinence	__ / __	
	Others:……	__ / __	
52	What was the reason for not arranging FP service provision camps?		f52
	Shortage of trained manpower	( ) 1	

	Shortage of vehicle	( ) 2	
	Shortage of MSR	( ) 3	
	Shortage of short-acting method	( ) 4	
	Shortage of long-acting method	( ) 5	
	Lack of initiative from FP manager/field force	( ) 6	
	Low/ no incentive for these type of efforts	( ) 7	
	People in this area are very conservative	( ) 8	
	Others (specify)……	( ) 9	

***** CHECK THE QUESTIONNAIRE & THANK THE RESPONDENT***

Notes: ……

Study on the quality of family planning services in Viet Nam

HOUSEHOLD QUESTIONNAIRE

[ ] ONE ANSWER ACCEPTED ( ) MULTIPLE ANSWER ACCEPTED

PART 1: IDENTIFICATION

a1	Enumerator ID ___ ___	intid	Date	__ __/12/15	dateint
	Team leader ID ___ ___	teamid	Date	__ __12/15	dateteam
	Data Enter ID ___ ___	dataname	Date	__ __/12/15	datenter
a2	Province		Province code	___	proid
a3	District		District code	___	distid
a4	Commune		Commune code	___ ___	comid
a5	Name of area/village		Household code	___ ___	hhid
a6	Name of household head:				tel
a7	Urban or rural? *Urban*		[ ] 1		are
	Rural		[ ] 2		

PART 2: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Household members: List all household members ___ ___ **person**

List all household members, with the primary survey respondent listed first. The remaining members should be listed from oldest to youngest

No.	Name	B.Sex *1=Male* *2=Female*	Year of birth	Married *1 = Yes* *0 = No*	Employed *1 = Yes* *0 = No*
01		___	_____	___	___
02		___	_____	___	___
03		___	_____	___	___
04		___	_____	___	___
05		___	_____	___	___
06		___	_____	___	___
07		___	_____	___	___
08		___	_____	___	___
09		___	_____	___	___
10		___	_____	___	___

PART 3: HOUSEHOLD CHARACTERISTICS

1	What is your main source of water?		h1
	Piped in to residence/plot	[ ] 1	
	Piped to public tap	[ ] 2	
	Public well	[ ] 3	
	River/stream/spring/pond/lake	[ ] 4	
	Rainwater	[ ] 5	
	Bottled water	[ ] 6	
	Others: ……..	[ ] 7	
2	Does your household have electricity?		h2
	Yes	[ ] 1	
	No	[ ] 0	
3	What kind of toilet does your household have?		h3
	Private flush toilet	[ ] 1	
	Shared flush toilet	[ ] 2	
	Traditional pit	[ ] 3	
	Ventilated improved pit toilet	[ ] 4	
	No facility/bush/field	[ ] 5	
4	What kind of fuel is used for cooking?		h4
	Gas / electricity / gas & Electricity	[ ] 1	
	Diesel	[ ] 2	
	Firewood, coal, straw/grass	[ ] 3	
5	Does the household have:	*Yes* *No*	h5
	Jeep/Car/SUV	[ ] 1 [ ] 0	
	Power tiller	[ ] 1 [ ] 0	
	Harvester	[ ] 1 [ ] 0	
	Thresher	[ ] 1 [ ] 0	
	Rice plantation machine	[ ] 1 [ ] 0	
	Motor vehicle/ Boat	[ ] 1 [ ] 0	
	Scooter/motorbike	[ ] 1 [ ] 0	
	Washing machine	[ ] 1 [ ] 0	
	Refrigerator	[ ] 1 [ ] 0	

	Geyser/water heating system	[ ] 1 [ ] 0	
	Air conditioner (gas-based cooling)	[ ] 1 [ ] 0	
	Computer	[ ] 1 [ ] 0	
	Television	[ ] 1 [ ] 0	
	Electric Fan	[ ] 1 [ ] 0	
	Cell phone	[ ] 1 [ ] 0	
	Bicycle	[ ] 1 [ ] 0	
	Watch clock	[ ] 1 [ ] 0	
	Chair/tables	[ ] 1 [ ] 0	
	Access to internet	[ ] 1 [ ] 0	
6	Number of bedrooms used:	__ __ room	h6
7	Total floor space of bedrooms (in sq m):	__ __ __ __ m2	h7
8	Dwelling ownership		h8
	Private house (individual)	[ ] 1	
	Private house (shared with other families)	[ ] 2	
	Rented house (individual)	[ ] 3	
	Rented house (shared)	[ ] 4	
	Own flat (individual)	[ ] 5	
	Own flat (shared)	[ ] 6	
	Rented flat (shared/individual)	[ ] 7	
	Hostel	[ ] 8	
	House on stilts	☐	
9	Main wall material		h9
	Natural walls	[ ] 1	
	Rudimentary walls	[ ] 2	
	Finished walls	[ ] 3	
10	Main roofing material		h10
	Natural roofing	[ ] 1	
	Rudimentary roofing	[ ] 2	
	Finished roofing	[ ] 3	
11	Main floor material		h11
	Natural floor	[ ] 1	
	Rudimentary floor	[ ] 2	
	Finished floor	[ ] 3	
12	Travel time from the household to the nearest commune health center (in minutes by usual means of commuting)	__ __ __ __ minutes	h12
13	Travel time from the household to the nearest district hospital (in minutes by usual means of commuting)	__ __ __ __ minutes	h13

***** CHECK THE QUESTIONNAIRE & THANK THE RESPONDENT***

NOTE:

Study on Quality Assurance of Family Planning Services in Vietnam

Form M- Questionnaire for Health Facility Manager Interview

	[ ] **ONE** answer accepted ( ) **MULTIPLE** answers accepted			
PART 1: IDENTIFICATION				
a1	Data collector ID ___ ___	intid	Date __ __/__ __/ 2015	enum
	Team leader ID ___ ___	teamid	Date __ __/__ __/ 2015	superv
	Data Enter ID ___ ___	dataname	Date __ __/__ __/ 2015	entry
a2	Province: ……..	Code	__ __	Provid
a3	District : ……	Code	__ __	Distid
a4	Location	Urban	[ ] 1	area
		Rural	[ ] 2	
a5	Commune……	Code	__ __	comid
a6	Type of health facility:	Provincial hospital	[ ] 1	facility
		Provincial RH center	[ ] 2	
		District hospital / health center (Obs dept)	[ ] 3	
		District's RH/FP nutrition unit	[ ] 4	
		Commune health station	[ ] 5	
		Population/FP collaborator	[ ] 6	
		Private clinic/NGO clinic	[ ] 7	
		Pharmacy	[ ] 8	
		Other: _____	[ ] 9	
a7	Respondent ……			informant
a8	Phone: ……			add
PART 2: SUPPLY OF FAMILY PLANNING METHODS				
1	Which FP methods do you currently provide to clients?		**Yes** **No**	m1
		Condom	[ ] 1 [ ] 0	
		IUD	[ ] 1 [ ] 0	
		Pill	[ ] 1 [ ] 0	
		Injectable	[ ] 1 [ ] 0	
		Implant	[ ] 1 [ ] 0	
		Female sterilization	[ ] 1 [ ] 0	
		Male sterilization	[ ] 1 [ ] 0	
		Periodic abstinence	[ ] 1 [ ] 0	
		Others (specify)……..	[ ] 1 [ ] 0	
2	Do you have any current MSR shortages of tubectomy, vasectomy, IUD or implant right now?			m2
		Yes	[ ] 1	
		No	[ ] 0	
PART 3: BCC/ COUNSELING AND OTHER ISSUES				

3	Are there any initiatives or BCC activities in your health facility to make clients aware of family planning methods?			m3
	Yes	[ ] 1		
	No	[ ] 0	Skip to 10	
4	Are there IEC materials in your health facility to provide information, educate and communicate about family planning services?			m4
	Yes	[ ] 1		
	No	[ ] 0	Skip to 10	
5	If yes, what types of IEC materials are used in your health facility to provide information on family planning methods? Frequency: 1=daily; 2=weekly; 3=monthly; 4=quarterly; 5=biannually ; 6=annually			m51
			Frequency	m52
	Leaflets	( ) 1	__	
	Flip chart	( ) 2	__	
	Wall chart	( ) 3	__	
	Model	( ) 4	__	
	Poster	( ) 5	__	
	Video	( ) 6	__	
6	How does your facility communicate and consult with clients about family planning methods?			m6
	Discussion/Counseling in-person	( ) 1		
	Group meeting	( ) 2		
	Radio	( ) 3		
	TV	( ) 4		
	Posters	( ) 5		
	Others (specify)……	( ) 6		
7	Which is the most effective method to disseminate FP methods, in your opinion?			m7
	Direct communication with clients	[ ] 1		
	Group meeting	[ ] 2		
	Radio	[ ] 3		
	TV	[ ] 4		
	Poster	[ ] 5		
	Others (specify)……	[ ] 6		
8	Does the health worker in your facility provide information on the following FP methods?			m8
	Periodic abstinence method	( ) 1		
	Withdrawal method	( ) 2		
	Lactational ammenorroea	( ) 3		
9	Does your service providers use materials/visual aids to inform clients of the effectiveness and side effects of the contraceptives?			m9
	Yes	[ ] 1		
	No	[ ] 0		
	Don't know	[ ] 99		

10	Does your health facility use the contraceptive job aid (with indications and contraindications) to screen clients before administering contraceptives?			m10
	Yes	[ ] 1		
	No	[ ] 0		
	Don't know	[ ] 99		
11	Do you have any mechanisms to collect client feedback? Frequency: 1=daily; 2=weekly; 3=monthly; 4=quarterly; 5=biannually ; 6=annually		Frequency	m11
	Comment box	( ) 1	__	
	Client satisfaction rating system	( ) 2	__	
	Client exit survey	( ) 3	__	
	Email survey	( ) 4	__	
	Others (Specific)……	( ) 5	__	
PART 4: REASONS FOR NOT ACCEPTING/DISCONTINUING FP METHODS				
12	In your opinion, what are the main reasons clients don't accept/discontinue taking oral pills? *(Note: DO NOT SPEAK OUT)*			m13
	Not aware of the method	( ) 1		
	Not always available in FP clinics/pharmacies	( ) 2		
	Expensive	( ) 3		
	May decrease breast milk	( ) 4		
	May increase weight	( ) 5		
	Drop hemorrhage between two menstrual periods	( ) 6		
	Risk of becoming permanently infertile	( ) 7		
	Does not prevent STD/HIV/AIDS	( ) 8		
	Need to take daily	( ) 9		
	Use other contraceptive methods	( ) 10		
	Want to have more children	( ) 11		
	Others (specify)……..	( ) 12		
13	What are the possible reasons clients don't accept / discontinue using condoms?			m14
	Not aware of the method	( ) 1		
	Not always available in FP clinics/pharmacies/ shops	( ) 2		
	Expensive	( ) 3		
	Do not know how to use condoms	( ) 4		
	Allergic to condoms	( ) 5		
	Need to use during every sexual intercourse	( ) 6		
	Buying condoms is shameful	( ) 7		
	Decreased sensation during sex	( ) 8		
	Interruption of sexual activities	( ) 9		
	Male partner is not cooperative	( ) 10		

	Need to be ready even if not having sex	( ) 11	
	Use other contraceptive methods	( ) 12	
	Want to have more children	( ) 13	
	Others (specify) ……	( ) 14	
14	What are the possible reasons clients don't accept / discontinue injectables?		m15
	Not aware of injectables	( ) 1	
	Not always available in FP clinics	( ) 2	
	Expensive	( ) 3	
	Drop hemorrhage between two menstrual periods	( ) 4	
	May increase weight	( ) 5	
	Need to visit FP worker for injections	( ) 6	
	May decrease sexual desire	( ) 7	
	Does not prevent against STD/HIV/AIDS	( ) 8	
	Use other contraceptive methods	( ) 9	
	Want to have more children	( ) 10	
	Others (specify) ……	( ) 11	
15	What are the possible reasons clients don't accept / discontinue IUD?		m16
	Pain in lower abdomen	( ) 1	
	Increased bleeding during menstruation	( ) 2	
	Sometimes IUD comes outside of vagina	( ) 3	
	Become pregnant before insertion	( ) 4	
	Vaginal damage	( ) 5	
	Need experienced worker to insert and remove IUD	( ) 6	
	Need to examine the string after each menstruation	( ) 7	
	Does not prevent STD/HIV/AIDS	( ) 8	
	Increase risk of diseases transmission through reproductive organs	( ) 9	
	Use other contraceptive methods	( ) 10	
	Want to have more children	( ) 11	
	Others (specify)……..	( ) 12	
16	What are the possible reasons clients don't accept / discontinue implants?		m17
	Drop hemorrhage between two menstrual periods	( ) 1	
	Long periods of light bleeding	( ) 2	
	Expensive	( ) 3	
	Stopped menstruation	( ) 4	
	Headache, vomiting tendency and weight gain	( ) 5	
	Feeling of tiredness	( ) 6	
	Weight/pain in breast	( ) 7	
	Hazards of opening and using by oneself	( ) 8	
	Need small operation to insert and remove	( ) 9	

	Bleeding problems	( ) 10	
	Does not prevent STD/HIV/AIDS	( ) 11	
	Use other contraceptive methods	( ) 12	
	Want to have more children	( ) 13	
	Others (specify) ……	( ) 14	
17	What are the reasons clients do not accept tubectomy?		m18
	It's permanent	( ) 1	
	Has risks, as an operation	( ) 2	
	Expensive	( ) 3	
	Pain during recovery	( ) 4	
	Possibility of ectopic pregnancy	( ) 5	
	Need to come to health facility for operation	( ) 6	
	Need trained doctors and assistants	( ) 7	
	Does not prevent STD/HIV/AIDS	( ) 8	
	Use other contraceptive methods	( ) 9	
	Want to have more children	( ) 10	
	Others (specify)……	( ) 11	
18	What are the reasons clients do not accept vasectomy?		m19
	It's permanent	( ) 1	
	Has risks, as an operation	( ) 2	
	Expensive	( ) 3	
	It does not work immediately	( ) 4	
	Have to wait for 3 months to be effective	( ) 5	
	Need to use condom for intercourse before it becomes effective	( ) 6	
	Need to come to health facilities for operation	( ) 7	
	Need trained doctors and assistants	( ) 8	
	Does not prevent STD/HIV/AIDS	( ) 9	
	Use other contraceptive methods	( ) 10	
	Want to have more children	( ) 11	
	Others (specify)……	( ) 12	

***** CHECK THE QUESTIONNAIRE & THANK THE RESPONDENT***

NOTE: ……

FORM 0- FP SERVICE DELIVERY OBSERVATION CHECKLIST

	[ ] ONE ANSWER ACCEPTED ( ) MULTIPLE ANSWERS ACCEPTED			
PART 1: FAMILY PLANNING FACILITY LOCATION AND LEVEL				
a1	Data collector ID ___ ___	intid	Date __ __/12/ 2015	enum
	Team leader ID ___ ___	teamid	Date __ __/12/ 2015	superv
	Data Enter ID ___ ___	dataname	Date __ __/12/ 2015	entry
a2	Province: ……..		Code	Provid
a3	District : ……		Code	Distid
a4	Type of health facility:	Provincial hospital	[ ] 1	facility
		Provincial RH center	[ ] 2	
		District hospital / health center	[ ] 3	
		District RH/FP nutrition unit	[ ] 4	
		Commune health station	[ ] 5	
		Population/FP collabrator	[ ] 6	
		Private hospital/private clinic/NGO clinic	[ ] 7	
		Pharmacy	[ ] 8	
		Other: _____	[ ] 9	
a5	Owner's Name ……..			resp
a6	Telephone: ……..			add
PART 2: GENERAL OBSERVATION CHECKLIST				
I.	**PHYSICAL FACILITIES**			
1	Signage	**Yes**	**No**	csvc1
	Clinic signboard visible	[ ] 1	[ ] 0	a
	List of services displayed outside	[ ] 1	[ ] 0	b
	Service charge list	[ ] 1	[ ] 0	c
	List/name of service providers (doctors)	[ ] 1	[ ] 0	d
	Room no. with name plate	[ ] 1	[ ] 0	e
	Advertisement/display boards in the catchment area	[ ] 1	[ ] 0	f
	Location finders (arrows/signs)	[ ] 1	[ ] 0	g
	Signage processes service provider	[ ] 1	[ ] 0	h
2	Client waiting rooms	**Yes**	**No**	csvc2
	Adequate sitting arrangements	[ ] 1	[ ] 0	a
	Adequate light	[ ] 1	[ ] 0	b
	Adequate no. of running fans	[ ] 1	[ ] 0	c
	Facilities for safe drinking water	[ ] 1	[ ] 0	d
	Functioning audio-visual equipment	[ ] 1	[ ] 0	e
	Framed posters on FP services	[ ] 1	[ ] 0	f
3	Cleanliness	**Yes**	**No**	csvc3
	OPD	[ ] 1	[ ] 0	a
	Procedure room	[ ] 1	[ ] 0	b
4	Equipment			csvc4
	Dry sterilizer	[ ] 1	[ ] 0	a
	Autoclave	[ ] 1	[ ] 0	b
	Electric boiler	[ ] 1	[ ] 0	c
	Plastic box with special covering lids for high-level disinfection and chemical sterilization	[ ] 1	[ ] 0	d
5	Scrubbing	**Yes**	**No**	csvc5
	Hand washing sink			
	Is adjacent to OT room	[ ] 1	[ ] 0	a
	Has basin with an elbow tap and running water	[ ] 1	[ ] 0	b
	Procedure Room			
	Clean	[ ] 1	[ ] 0	a
	Glass windows, shutter for dust proofing, net to prevent insects	[ ] 1	[ ] 0	b
	Windows are closed	[ ] 1	[ ] 0	c
	Walls covered with tiles at least 1.6 m high (tiles/mosaic or enamel painted)	[ ] 1	[ ] 0	d
	Slippers exclusively for procedure rooms	[ ] 1	[ ] 0	e
	Single (large) spotlight	[ ] 1	[ ] 0	f
	Procedure table with plastic cover or sheet	[ ] 1	[ ] 0	g
	Procedure table with small step available	[ ] 1	[ ] 0	h
	Cupboard with equipment	[ ] 1	[ ] 0	i
	Trolley is as small as possible	[ ] 1	[ ] 0	j
	Three-battery torch light or generator	[ ] 1	[ ] 0	k

	Instrument trolley for the essential instruments, drapes, timer, etc.	[ ] 1	[ ] 0	l
	Sterilized kits for procedure are available	[ ] 1	[ ] 0	m
	An additional tray to keep all emergency medicine with multiple chambers, BP instruments, stethoscope, etc.	[ ] 1	[ ] 0	n
	Ambubag, oxygen cylinder and suction machine available, well-maintained and out-of-sight when not in use, but identified easily (by logo)	[ ] 1	[ ] 0	p
	Emergency resuscitation procedure flow chart displayed in the OT for easy reference	[ ] 1	[ ] 0	q
	Waste disposal basket with lining or proper lid	[ ] 1	[ ] 0	r
	Bucket with chlorine solution for decontamination and bucket with clean detergent water	[ ] 1	[ ] 0	s
	Emergency protocol/flow chart displayed	[ ] 1	[ ] 0	t
6	Emergency Drugs	**Yes**	**No**	csvc6
	Following Emergency drugs should be present in a tray:			
	Injection Atropine Sulphate 0.6 mg (2 ampoules)	[ ] 1	[ ] 0	a
	Injection Promethazine HCL 25 mg (2 ampoules)	[ ] 1	[ ] 0	b
	Injection Adrenaline (1: 1000) (2 ampoules)	[ ] 1	[ ] 0	c
	Injection Hydrocortisone 100mg (with distilled water)- 2 vials	[ ] 1	[ ] 0	d
	Injection Naloxone 0.4 mg (five ampoules)	[ ] 1	[ ] 0	e
	IV fluid 5% DNS & 5% DA (500 cc) 2 bags or bottle with IV set (2 sets)	[ ] 1	[ ] 0	f
	Inj. Pathedine	[ ] 1	[ ] 0	g
	Inj. Aminophylline	[ ] 1	[ ] 0	h
	Inj. 25 % Glucose	[ ] 1	[ ] 0	i
II.	**MANPOWER**			
1	At the moment of observation:	**Yes**	**No**	nl1
	Manpower available according to approved organogram			
	Trained counselor	[ ] 1	[ ] 0	a
	Infection prevention (doctor, health care staff,...)	[ ] 1	[ ] 0	b
	Family planning	[ ] 1	[ ] 0	c
	Providers trained on IUD placement	[ ] 1	[ ] 0	d
	Providers trained on implant placement	[ ] 1	[ ] 0	e
	Providers trained on tubectomy	[ ] 1	[ ] 0	f
	Providers trained on vasectomy	[ ] 1	[ ] 0	g
	Providers trained on MR	[ ] 1	[ ] 0	h
	Doctors trained in adult resuscitation (CPR) (doctor, paramedics)	[ ] 1	[ ] 0	i
III.	**COUNSELING AND PROCEDURAL I FORMATION/INFORMED CONSENT AND SCREENING**			
1	Total privacy maintained during counseling:	**Yes**	**No**	sl1
	Auditory privacy	[ ] 1	[ ] 0	a
	Visual privacy	[ ] 1	[ ] 0	b
2	Provider addresses customer needs during counseling by:			sl2
	Responding to questions	[ ] 1	[ ] 0	a
	Listening to customer concerns	[ ] 1	[ ] 0	b
3	Have a flip chart for counseling	[ ] 1	[ ] 0	sl3
4	Have method-specific checklist/job aid on the table/ up on the wall to inform clients of the advantages and disadvantages of the various family planning mehods	[ ] 1	[ ] 0	sl4
5	Provider uses service /method-specific job aids to inform client of the advantages and disadvantages of the various family planning methods during counseling	[ ] 1	[ ] 0	sl5
6	Have a contraceptive display board for counseling	[ ] 1	[ ] 0	sl6
7	Provider assesses if customer has any other service needs (assesses missed opportunities)	[ ] 1	[ ] 0	sl7
8	Have pelvic & penile model for counseling	[ ] 1	[ ] 0	sl8
9	Provider confirms that customer understands what was communicated during counseling by taking feedback	[ ] 1	[ ] 0	sl9

10	Provider discusses other methods/services available in addition to customer's desired method/service	[ ] 1	[ ] 0	sl10
11	Provider assists client in deciding whether or not to have a procedure	[ ] 1	[ ] 0	sl11
12	Client is informed of the following prior to giving consent and before undergoing the procedure:	[ ] 1	[ ] 0	sl12
	Benefits of the procedure	[ ] 1	[ ] 0	a
	Any risks or possible complications	[ ] 1	[ ] 0	b
	Any alternatives	[ ] 1	[ ] 0	c
13	Havie method-specific checklist/job aid on the table/ up on the wall to check medical eligibility for starting new contraceptive methods	[ ] 1	[ ] 0	sl13
14	Provider uses method-specific checklist/job aid to check medical eligibility for starting new contraceptive methods	[ ] 1	[ ] 0	sl14
IV.	**INFECTION PREVENTION**			
	Instrument sterilization process			
1	**Decontamination**	**Yes**	**No**	cnk1
	Chloramine 0.5% solution is available	[ ] 1	[ ] 0	a
	Submerge instruments under the surface of the solution	[ ] 1	[ ] 0	b
	Draw chlorine solution into the syringe and tube then rinse	[ ] 1	[ ] 0	c
	Disassemble all parts of the instruments	[ ] 1	[ ] 0	d
	Soak in the decontamination solution for 10 minutes	[ ] 1	[ ] 0	e
2	**Cleaning**	**Yes**	**No**	cnk2
	Clean the instruments with soap and water	[ ] 1	[ ] 0	a
	Clean dirty areas carefully, such as the teeth and apex of the instruments	[ ] 1	[ ] 0	b
	Use a brush to clean the instruments	[ ] 1	[ ] 0	c
	Rinse the syringe and tube	[ ] 1	[ ] 0	d
	Wash the intrusments with clean water again	[ ] 1	[ ] 0	e
3	**High-level disinfection (HLD): Boiling**	**Yes**	**No**	cnk3
	Submerge instruments under the surface of the water	[ ] 1	[ ] 0	a
	Start the timer when the water starts boiling	[ ] 1	[ ] 0	b
	Boil the instruments for 20 minutes	[ ] 1	[ ] 0	c
	Remove with sterile forceps and put in a sterile box	[ ] 1	[ ] 0	d
	Dry under ambient conditions	[ ] 1	[ ] 0	e
	Put in a sterile box with stickers clearly indicating the expiration date	[ ] 1	[ ] 0	f
4	**High-level disinfection: Soaking in chemicals**	**Yes**	**No**	cnk4
	Submerge instruments under the surface of the water	[ ] 1	[ ] 0	a
	Soak in chemicals used for high-level disinfection for 20 minutes.	[ ] 1	[ ] 0	b
	Soaked instruments are then washed in sterile water	[ ] 1	[ ] 0	c
	Put in a sterile metallic box with stickers clearly indicating the date and name of the conductor	[ ] 1	[ ] 0	d
5	**Steam sterilization**	**Yes**	**No**	cnk5
	Wrap the instruments with a sterile cloth	[ ] 1	[ ] 0	a
	Process the instruments seperately in the autoclave	[ ] 1	[ ] 0	b
	The wrapped instruments must be locked and the windows open when processing	[ ] 1	[ ] 0	c
	Under the instructions of the manufacturer	[ ] 1	[ ] 0	d
	Maintain the temperature of 121oC for 30 minutes for wrapped instruments, and 20 minutes for unwrapped instruments	[ ] 1	[ ] 0	e
	Put in a sterile box with stickers clearly indicating the expiration date	[ ] 1	[ ] 0	f

6	**Dry heat sterilization**	**Yes**	**No**	cnk6
	After cleaning, the instruments are dried and put in seperate boxes with cover	[ ] 1	[ ] 0	a
	Start timing when the temperature reaches a specific point	[ ] 1	[ ] 0	b
	Maintain the temperature pf 170oC for 1 hour or 160^{o}C for 2 hours	[ ] 1	[ ] 0	c
	Put in a sterile box with stickers clearly indicating the expiration date	[ ] 1	[ ] 0	d
7	**The duration of use**	**Yes**	**No**	cnk7
	Highly disinfected instruments should be used within 3 days	[ ] 1	[ ] 0	a
	Boiled instruments should only be used within 24 hours	[ ] 1	[ ] 0	b
	Sterilized instruments can be stored up to 1 week	[ ] 1	[ ] 0	c
8	Demonstrates compliance with waste disposal standards: (Encircle 'yes' if all 4 indicators comply)	**Yes**	**No**	cnk8
	Sharp objects are disposed of in a non-penetrable container			
	Utility gloves are used during handling contaminated waste			
	Liquid waste (0.5% Chlorine solution) is poured down a utility drain or non-septic toilet	[ ] 1	[ ] 0	
	Contaminated waste is burned daily in the incinerator / burned and buried in pit if incinerator is not available			
9	**Hand washing - Wearing gloves for operation**	**Yes**	**No**	cnk9
	Soaps, aseptic brushes and aseptic cloth are available	[ ] 1	[ ] 0	a
	Have boiled water with taps; open or close taps without using hands	[ ] 1	[ ] 0	b
	Hands do not wear jewelry and nails are cut	[ ] 1	[ ] 0	c
	Moisten arms and hands; slope hands and wrists to let water flow down	[ ] 1	[ ] 0	d
	Use brushes, soaps to clean hands, fingertips, interstitial nails, arms and elbows carefully	[ ] 1	[ ] 0	e
	Wash hands 3 times per day, each time from 3 to 5 minutes	[ ] 1	[ ] 0	f
	Do not let hands touch anything	[ ] 1	[ ] 0	g
	Rinse hands and arms in clean water and reverse fingers	[ ] 1	[ ] 0	h
	Put hands above arms	[ ] 1	[ ] 0	i
	Dry hands with aseptic cloth then soak hands in antiseptic solution	[ ] 1	[ ] 0	j
	Do not to let fingers contact the outside of the gloves. When wearing gloves, only hold the gloves' neck	[ ] 1	[ ] 0	k
10	Wear gloves at proper times (Encircle 'yes' if all 4 indicators comply)	**Yes**	**No**	cnk10
	Gloves worn for client care involving blood or body fluids			
	Gloves worn whenever handling bloody items, including instruments or sheets			
	Gloves changed between client contacts	[ ] 1	[ ] 0	
	Clean, heavy duty gloves used when cleaning instruments, equipment, tables and rooms or when handling or disposing of any clinical waste			
V. RATIONAL DRUG USE (RDU)		**Yes**	**No**	sdt1
1	Prescription writing is appropriate and clear including the following: (Note: Encircle 'Yes' if all 10 are 'yes')			
	Date			
	Name of client	[ ] 1	[ ] 0	

	Age of client			
	Diagnosis / provisional diagnosis of the disease			
	Correct dosages of prescribed drugs			
	Duration of prescribed drugs			
	Necessary instructions are written clearly			
2	Antibiotics are prescribed only for clinically diagnosed diseases that require antibiotics according to guidelines and standards	[ ] 1	[ ] 0	sdt2
3	Dispenses drugs with a label that includes instructions for use according to the prescription	[ ] 1	[ ] 0	sdt3
4	Dispenser takes feedback from customer	[ ] 1	[ ] 0	sdt4
5	Drug store complies with the standards as following: (Note: Encircle 'Yes' if all 6 are 'yes')	**Yes**	**No**	sdt5
	Dry	[ ] 1	[ ] 0	
	Have adequate no. of fans			
	Adequate distance from wall maintained for keeping the shelves			
	Have ventilation fans			
	Use bin card			
	First expiry first out (FEFO) followed			

PART 3: SPECIFIC FAMILY PLANNING SERVICES DELIVERY OBSERVATION CHECKLIST

For Part 3, only observe health staff as they perform services with clients or models/impersonators
DO NOT INTERVIEW

I.	**DOES THE HEALTH FACILITY PROVIDE CONDOM SERVICE?**	**Yes [ ] 1 No [ ]0**	***If = 0 => skip to Part II***	
1	When observed, who received the service?			bcs1
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
2	Provider demonstrates correct condom use using penile model and relevant job aids (emphasizing on the following) (Note: Encircle 'Yes' if all 4 are 'yes')	**Yes**	**No**	bcs2
	How to put condom on an erect penis	[ ] 1	[ ] 0	
	How to avoid air entering at the tip of the condom			
	How to remove the condom after intercourse			
	How to dispose of a used condom			
3	Provider explains benefits of condoms for pregnancy avoidance, prevention of sexually transmitted diseases	[ ] 1	[ ] 0	bcs3

II	**DOES THE HEALTH FACILITY PROVIDE FAMILY PLANNING COUNSELING?**	**Yes [ ] 1 No [ ]0**	***If= 0 Skip to part III***	
1	**Greeting (communicating)**	**Yes**	**No**	tvbcs1
	Greets the client warmly, is friendly and builds trust	[ ] 1	[ ] 0	a
	Asks him/her and his/ her partner to sit down	[ ] 1	[ ] 0	b
	Introduces themselves: name, job position and responsibility	[ ] 1	[ ] 0	c
2	**Asking**	**Yes**	**No**	tvbcs2
	Asks for information about the client's health and contraceptive needs	[ ] 1	[ ] 0	a
	If client's issue involves special consideration of confidientiality, ask client whether it is OK for client's companion to be present for the counseling. Respect client's decision	[ ] 1	[ ] 0	b
	Asks about client's living condition, medical history and gynecological diseases	[ ] 1	[ ] 0	c
	Asks about marital status and pregnancy history	[ ] 1	[ ] 0	d
	Asks about sexual activities	[ ] 1	[ ] 0	e
	Asks about contraceptive methods client has already used	[ ] 1	[ ] 0	f
	Uses almost all open-ended questions	[ ] 1	[ ] 0	g

	Listens carefully, is patient and avoids speaking too much	[ ] 1	[ ] 0	h
3	**Telling**	**Yes**	**No**	tvbcs3
	Introduces and displays the appropriate contraceptive methods suitable to the client's needs and behaviours	[ ] 1	[ ] 0	a
	Provides proper information, including both advantages and disadvantages, possible side effects and complications of specific methods	[ ] 1	[ ] 0	b
	Focuses on the client's interests and explain when the client does not understand	[ ] 1	[ ] 0	c
4	**Helping**	**Yes**	**No**	tvbcs4
	Helps the client select the most appropriate method	[ ] 1	[ ] 0	a
	Does not influence the client's choice	[ ] 1	[ ] 0	b
	If the client selects a method that could be inappropriate or contra-indicated, the counselor gently advises him/her on alternatives	[ ] 1	[ ] 0	c
5	**Explaining**	**Yes**	**No**	tvbcs5
	When the client selects a method, explains how to properly use it	[ ] 1	[ ] 0	a
	Explains the procedure (especially with clinical methods such as IUDs and sterilization)	[ ] 1	[ ] 0	b
	Explains the reasons for method failure and how to prevent it	[ ] 1	[ ] 0	c
	Talks to the client about symptoms and side effects, and how to deal with them at home	[ ] 1	[ ] 0	d
	Explains the warning signs and how to deal with them	[ ] 1	[ ] 0	e
	Clearly explains the degree of reversibility of the contraceptive method	[ ] 1	[ ] 0	f
	Explains why regular examination is needed and encourages the client to follow this advice	[ ] 1	[ ] 0	g
	Adequately explains any misunderstandings that the client may have	[ ] 1	[ ] 0	h
	Asks the client to list out important points and gives feedback	[ ] 1	[ ] 0	i
6	**Make an appointment for the next visit**			tvbcs6
	Before saying goodbye, tells the client that he/she can make regular visits as scheduled;	[ ] 1	[ ] 0	a
	Tell client that if abnormal signs appear, he/she may come back at any time	[ ] 1	[ ] 0	b
	Encourages clients to come back whenever they need to discuss their own reproductive healthcare or their family's	[ ] 1	[ ] 0	c
	Welcomes and pleases clients about counseling and health care services	[ ] 1	[ ] 0	d
	Says goodbye	[ ] 1	[ ] 0	e
III.	**DOES THE HEALTH FACILITY PROVIDE PILLS?** **Yes [ ] 1 No [ ]0**		***If = 0àPart IV***	
1	When observed, who received the service?			vutt1
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		

2	Provider explains what to do in case of missed pill (Note: Encircle 'Yes' if all 4 are 'yes')	**Yes**	**No**	vutt2
	Explain about when and how to use oral pill *Provides counseling on oral pill* *Explains when and how to use ECP* *Date of follow-up visit*	[ ] 1	[ ] 0	
3	Provider discusses the following: (Note: Encircle 'Yes' if both 2 are 'yes')	**Yes**	**No**	vutt3
	Warning signs	[ ] 1	[ ] 0	a
	Side effects	[ ] 1	[ ] 0	b
4	**Issues Discussed**	**Yes**	**No**	vutt4
	Known or suspected pregnancy	[ ] 1	[ ] 0	a
	Bulging blood vessels	[ ] 1	[ ] 0	b
	Cardiovascular disease	[ ] 1	[ ] 0	c
	Over 35 years of age and smoking (15 or more cigarettes/day)	[ ] 1	[ ] 0	d
	Frequent severe headache along with blurred vision	[ ] 1	[ ] 0	e
	Presence of breast cancer	[ ] 1	[ ] 0	f
	Hypertension	[ ] 1	[ ] 0	g
	Diabetes	[ ] 1	[ ] 0	h
	Liver disease	[ ] 1	[ ] 0	i
	Bleeding between periods	[ ] 1	[ ] 0	j
	Are you taking medication to treat tuberculosis, fungal diseases, sedatives and anticonvulsants?	[ ] 1	[ ] 0	k
	Breastfeeding a child under 6 months old	[ ] 1	[ ] 0	l
IV.	**DOES THE HEALTH FACILITY PROVIDE INJECTABLES?** **Yes[ ] 1 No [ ]0** ***If = 0àPart V***			
1	When observed, who received the service?			tttt1
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
2	Provider follows the correct steps in providing injectables as per guidelines: (Note: Encircle 'Yes' if all 5 are 'yes')	**Yes**	**No**	tttt2
	Counsels properly *Counsels on the folllow-up injection* *Does not waste medicine by trying to remove air bubble from syringe (ensure dose 1cc)* *Does not massage the injection site and tells customer not to massage or rub the site* *Disposes of the disposable syringe as per guidelines*	[ ] 1	[ ] 0	
3	Provider discusses the following: (Note: Encircle 'Yes' if both 2 are 'yes')			tttt3
	Warning signs *Side effects*	[ ] 1	[ ] 0	
	Injectable counseling			
		Yes	**No**	
4	**Greeting (communicating)**			tttt4
	Greets the client warmly, is friendly and builds trust	[ ] 1	[ ] 0	a
	Introduces themselves: name, job position and responsibility	[ ] 1	[ ] 0	b
5	**Asking**			tttt5

	Asks for information about the client's health and contraceptive needs	[ ] 1	[ ] 0	a
	Asks what the client knew about injectable contraceptives. Identifies the client's misperceptions and explains the correct way	[ ] 1	[ ] 0	b
6	**Telling**			tttt6
	Tells client about the advantages and disadvantages of injectable contraceptives	[ ] 1	[ ] 0	a
	Focuses on the problems the client is interested in	[ ] 1	[ ] 0	b
	If client has misperceptions about injectable contraceptives, explains the correct way without criticizing	[ ] 1	[ ] 0	c
7	**Helping**			tttt7
	Helps client comprehend and make decisions about chosing injectable contraceptives	[ ] 1	[ ] 0	
8	**Explaining**			tttt8
	Explains the timing of injections, which depend on the client's current physical condition	[ ] 1	[ ] 0	a
	Explains the risk of pregnancy after missing an injection	[ ] 1	[ ] 0	b
	Specifies side effects and treatment	[ ] 1	[ ] 0	c
	Explains what is normal and what is not around the injection spot. Observes whether this spot has any infections or abscesses	[ ] 1	[ ] 0	d
	Responds satisfactorily all client questions	[ ] 1	[ ] 0	e
	Administers the first injection if client's physical condition is appropriate	[ ] 1	[ ] 0	f
9	**Make an appointment for a follow-up visit**			tttt9
	Before saying goodbye, explains that the client can return for an examination or follow-up at any time	[ ] 1	[ ] 0	a
	next injection will be done	[ ] 1	[ ] 0	b
	Provide contraceptive implant flyer, if available	[ ] 1	[ ] 0	c
V	**DOES THE HEALTH FACILITY PROVIDE IUDs?** **Yes [ ] 1 No [ ]0**			***If = 0 => Part VI***
1	When observed, who received the service?			dvtt1
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
2	Pre-IUD counseling	**Yes**	**No**	dvtt2
	Provider demonstrates IUD on model pelvis for the client	[ ] 1	[ ] 0	
	Provider obtains informed consent (both in writing and orally) from IUD customer before procedure	[ ] 1	[ ] 0	
	Pre-IUD Clinical Assessment			
3	When observed, who received the service?			dvtt3
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
4	**Eligible Screening**	**Yes**	**No**	dvtt4
	Are you looking forward to having your first child?	[ ] 1	[ ] 0	a
	Do you think you are pregnant?	[ ] 1	[ ] 0	b
	Have you ever had abnormal vaginal discharge or felt itching and pain in your genital area?	[ ] 1	[ ] 0	c
	Have you received treatment at any gynecologic facility ?	[ ] 1	[ ] 0	d
	Do you often have menorrhagia, prolonged bleeding or dysmenorrhea ?	[ ] 1	[ ] 0	e
	Have you ever suffered from an ectopic pregnancy?	[ ] 1	[ ] 0	f
	Have you ever been diagnoised with cardiovascular disease?	[ ] 1	[ ] 0	g
	Have you or your husband ever suspected having an STD?	[ ] 1	[ ] 0	h
	Form 40a: IUD insertion procedure (TCu-380A)			
5	When observed, who received the service?			dvtt5

	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
6	**A - Preparation**	**Yes**	**No**	dvtt6
	Checks the instruments and IUD packet (expiratory date and if intact)	[ ] 1	[ ] 0	a
	Explains the on-going procedure to the client and asks them to empty their bladder	[ ] 1	[ ] 0	b
	Asks the client to lie on the examining table in the gynecological position, then performs a bimanual exam to identify the position of the uterus, its volume and check the ovaries	[ ] 1	[ ] 0	c
	Swabs the perineum with an aseptic solution (using the first forceps). Covers with the sterile drape	[ ] 1	[ ] 0	d
	Provider's position: wearing sterile gloves, sitting on a chair between the client's thighs. If there is an assistant, the assistant sits or stands on the left of the provider (wearing sterile gloves on hands that hold the valve or other instruments)	[ ] 1	[ ] 0	e
	B - Procedure of IUD insertion (TCu-380A type)			
7	***B1 - Revealing the cervix***	**Yes**	**No**	dvtt7
	Open the vagina with a valve	[ ] 1	[ ] 0	a
	Swab the cervix and the fornices with betadine (using the 2nd forceps)	[ ] 1	[ ] 0	b
	Grasp the cervix with a Pozzi tenaculum (12 hour or 10 and 2 hour).	[ ] 1	[ ] 0	c
8	***B2 - Sounding the uterus***			dvtt8
	Insert the uterine sound in the correct direction without touching the vaginal wall	[ ] 1	[ ] 0	a
	Determine the depth of uterus.	[ ] 1	[ ] 1	b
9	***B3 - Load the IUD into the insertion tube inside package***			dvtt9
	Check the package and the expiration date	[ ] 1	[ ] 0	a
	Tear the package in proper position and peel only one third of the package	[ ] 1	[ ] 0	b
	Load the rod into the insertion tube (tube's head touches IUD's bottom)	[ ] 1	[ ] 0	c
	Load the IUD into the head of insertion tube (not to exceed one minute)	[ ] 1	[ ] 0	d
	Set the green depth-gauge of the insertion tube in the correct direction, corresponding to the uterine depth	[ ] 1	[ ] 0	e
10	***B4 - Inserting the IUD into the uterus***			dvtt10
	From initiating IUD insertion up to this point is under 5 minutes	[ ] 1	[ ] 0	a
	Hold the tenaculum and pull the cervix up	[ ] 1	[ ] 0	b
	Hold the tube in the correct position and direction, gently pushing through the cervical os until the tube touches the fundus	[ ] 1	[ ] 0	c
	Hold the rod to withdraw the insertion tube and release the arms	[ ] 1	[ ] 0	d
	Push the insertion tube slightly until the IUD touches the fundus	[ ] 1	[ ] 0	e
	Hold the insertion tube to withdraw the rod	[ ] 1	[ ] 0	f
	Withdraw the rod	[ ] 1	[ ] 0	g
	Cut the string at 3 cm from the cervical os, fold the end into the posterior fornix	[ ] 1	[ ] 0	h
11	***B5 - Removal of the instruments***			dvtt11

	Remove the tenaculum	[ ] 1	[ ] 0	a
	Disinfect the cervix and vagina with betadine, stop bleeding (if any)	[ ] 1	[ ] 0	b
	Remove the vaginal retractor or speculum	[ ] 1	[ ] 0	c
	Tell the client that the procedure is finished	[ ] 1	[ ] 0	d
	Form 40b: Insertion of IUD (Multiload type)			
12	When observed, who received the service?			dvtt12
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
	Subjects	**Yes**	**No**	
13	**A - Preparation:**			dvtt13
	Check the instruments and IUD packet (expiratory date and if intact)	[ ] 1	[ ] 0	a
	Explain the on-going procedure to the client and ask them to empty their bladder	[ ] 1	[ ] 0	b
	Ask the client to lie on the examining table in the gynecological position, then perform a bimanual exam to identify the position of the uterus, its volume and check the ovaries	[ ] 1	[ ] 0	c
	Swab the perineum with an aseptic solution (using the first forceps). Cover with a sterile drape	[ ] 1	[ ] 0	d
	Provider's position: sitting on a chair, between the client's thighs. If there is an assistant, the assistant sits or stands on the left of the provider (wearing sterile gloves on the hand that holds the valve or other instruments)	[ ] 1	[ ] 0	e
	B - Procedure of IUD insertion			
13	***B1 - Revealing the cervix***			dvtt13
	Open the vagina with a valve	[ ] 1	[ ] 0	f
	Swab the cervix and the fornices with betadine (using the 2nd forceps)	[ ] 1	[ ] 0	g
	Grasp the cervix with a Pozzi tenaculum (12 hour or 10 and 2 hour)	[ ] 1	[ ] 0	h
14	***B2 - Sounding the uterus***			dvtt14
	Insert the uterine sound in the correct direction without touching the vaginal wall	[ ] 1	[ ] 0	a
	Determine the depth of the uterus	[ ] 1	[ ] 0	b
15	***B3 - Insert the IUD***			dvtt15
	Check the package and the expiration date	[ ] 1	[ ] 0	a
	Tear off the packet; set the depth-gauge of the insertion tube to the correct direction and corresponding uterine depth	[ ] 1	[ ] 0	b
	Hold the tenaculum in one hand and pull the cervix up	[ ] 1	[ ] 0	c
	Hold the insertion tube in the other hand (with IUD inside), push the IUD gently through the cervical os, following the uterine direction until it touches the fundus	[ ] 1	[ ] 0	d
	Withdraw the insertion tube	[ ] 1	[ ] 0	e
	Cut the string at 3cm from the cervical os, fold the end into the posterior fornix	[ ] 1	[ ] 0	f
16	***B4 - Remove the instruments***			dvtt16
	Remove the tenaculum	[ ] 1	[ ] 0	a
	Disinfect the cervix and vagina with betadine, stop bleeding (if any)	[ ] 1	[ ] 0	b
	Remove the vaginal retractor or speculum	[ ] 1	[ ] 0	c
	Tell the client that the procedure is finished	[ ] 1	[ ] 0	d
VI.	**DOES THE HEALH FACILITY PROVIDE IMPLANTS?** **Yes [ ] 1 No [ ]0**	***If= 0à part VII***		qctt
1	When observed, who received the service?			qctt1
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		

2	Provider explains implant using flip chart	[ ] 1	[ ] 0	qctt2
3	Provider obtains informed consent (both in writing and orally) from the client before the procedure	[ ] 1	[ ] 0	qctt3
4	Provider demonstrates the correct procedure for inserting the implant according to guidelines, with special emphasis on the following: (Note: Encircle 'Yes' if all 4 are 'yes')	**Yes**	**No**	qctt5
	Correct administration of local anesthesia (1% Lidocaine)	[ ] 1	[ ] 0	
	Insert the trocar (with a capsule loaded) through the incision			
	Load each capsule one by one			
	Stop bleeding (if any)			
5	Provider ensures privacy during the procedure	[ ] 1	[ ] 0	b
6	Provides post-procedure counseling as per standards	[ ] 1	[ ] 0	c
VII.	**DOES THE HEALTH FACILITY PROVIDE TUBECTOMY?** **Yes [ ] 1 No [ ]0** ***If = 0à part VIII***			**todtr**
1	When observed, who received the service?			todtr1
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
2	**FEMALE STERILIZATION BY TUBAL LIGATION & TUBECTOMY**			
	Performance	**Yes**	**No**	todtr2
	Perform a general clinical examination, counsel, explain in-detail and get written informed consent	[ ] 1	[ ] 0	a
	Catheterize the bladder or ensure client has passed urine before the operation	[ ] 1	[ ] 0	b
	Conduct baseline laboratory investigations: bleeding time and coagulation time	[ ] 1	[ ] 0	c
	Surgeon and assistant: wash hands, wear gown and gloves and strictly follow aseptic requirements	[ ] 1	[ ] 0	d
	Gynecological examination: identify position and ulterus's volume and mobility	[ ] 1	[ ] 0	e
	Change aseptic gloves. Apply antiseptic solution on incision, vulva and vagina. Use the fundal elevator (as needed)	[ ] 1	[ ] 0	f
	Apply local anaesthesia or other methods	[ ] 1	[ ] 0	g
3	**Small incision (minilap):**			todtr3
	Small incision (minilap): vertical or horizontal, Length of the incision is less than 5cm	[ ] 1	[ ] 0	a
	Incision is located vertically on the fundus downward	[ ] 1	[ ] 0	b
	Pass through layer by layer and open the peritoneum	[ ] 1	[ ] 0	c
4	**Seek and define the tube starting from the uterus**			todtr4
	Adjust the fundal elevator (if it's available) in order that the fundus downward closes to the abdominal wall	[ ] 1	[ ] 0	a
	Use finger or forcep to seek the tube in the uterine horn	[ ] 1	[ ] 0	b
	Trace the pavilion of the fallopian tube to confirm	[ ] 1	[ ] 0	c
5	**Tubal ligation & Tubectomy**			todtr5
	Using Allis forceps, clamp the pavilion of the fallopian tube close to the uterine horn without blood vessels to raise waist out	[ ] 1	[ ] 0	a

	Sew up through the pavilion of the fallopian tube using suture. Clamp one side of the tube and tight over the other side	[ ] 1	[ ] 0	b
	Cut above the clamped point of the fallopian tube	[ ] 1	[ ] 0	c
	Check bleeding, stop bleeding carefully (if any)	[ ] 1	[ ] 0	d
	Disinfect the cut/wound with betadine, remove sutures	[ ] 1	[ ] 0	e
	Apply similar tubal ligation and tubectomy technique on the opposite fallopian tube	[ ] 1	[ ] 0	f
	Close the abdomen in layers	[ ] 1	[ ] 0	g
	Disinfect the abdominal wall and apply a bandage	[ ] 1	[ ] 0	h
	Counsel post surgeon	[ ] 1	[ ] 0	i
VIII.	**DOES THE HEALTH FACILITY PROVIDE VASECTOMY?** **Yes [ ] 1 No [ ]0** ***If= 0à Part 3***			**todt**
1	When observed, who received the service?			todt1
	Real clients	[ ] 1		
	Model/impersonator	[ ] 2		
2	**MALE STERILIZATION WITH VASECTOMY**			**todt2**
	Subjects	**Yes**	**No**	
	Perform a general surgical examination, counsel, explain in-detail and apply voluntarily with guarantee letter	[ ] 1	[ ] 0	a
	Catheterize the bladder or ensure client has passed urine before the operation	[ ] 1	[ ] 0	b
	Conduct baseline laboratory investigations: bleeding time and coagulation time	[ ] 1	[ ] 0	c
	Cover the client with a sterile drape; expose the scrotum through the drape's window.	[ ] 1	[ ] 0	d
	Surgeon and assistant: wash hands, wear gown and gloves and strictly follow aseptic requirements	[ ] 1	[ ] 0	e
	Local anesthesia is used: lidocaine 1% (without adrenalin).	[ ] 1	[ ] 0	f
	Subjects	**Yes**	**No**	
	Apply the three-finger technique to locate the vas	[ ] 1	[ ] 0	g
	Grasp the vas with forceps through the scrotal skin	[ ] 1	[ ] 0	h
	Puncture the scrotal skin with dissecting forceps	[ ] 1	[ ] 0	i
	Disclose and elevate the right vas	[ ] 1	[ ] 0	j
	Grasp the vas with the ringed clamp	[ ] 1	[ ] 0	k
	Strip the sheath	[ ] 1	[ ] 0	l
	Occlude and cut the vas	[ ] 1	[ ] 0	m
	Place a piece of sheath to separate the two cut ends of the vas	[ ] 1	[ ] 0	n
	Occlude and cut the left vas	[ ] 1	[ ] 0	o
	It is not necessary to suture the scrotal skin. Just apply a bandage over the puncture site	[ ] 1	[ ] 0	p
	Counseling after the surgery	[ ] 1	[ ] 0	q
PART 4. SATISFACTION ISSUES OF CLIENTS AND PROVIDERS				
I.	**Client satisfaction issues**	**Yes**	**No**	hl
	Running TV with videos on FP services in waiting rooms	[ ] 1	[ ] 0	a
	Drinking water access for clients	[ ] 1	[ ] 0	b
	Clean toilet facilities for clients	[ ] 1	[ ] 0	c
	List of service charges displayed in waiting spaces	[ ] 1	[ ] 0	d
	Clients are called on a first-come, first-serve basis (other than emergencies)	[ ] 1	[ ] 0	e
	Waiting time is less than 30 minutes	[ ] 1	[ ] 0	f
	Complaint book present and clients are informed of it	[ ] 1	[ ] 0	g
II.	**Provider satisfaction issues**	**Yes**	**No**	hl2
	Comfortable working place	[ ] 1	[ ] 0	a
	Equipped according to standards	[ ] 1	[ ] 0	b
	Imparted with relevant trainings	[ ] 1	[ ] 0	c
	Provided with clean aprons and other materials to maintain a hygienic and safe environment	[ ] 1	[ ] 0	d

FORM 0- FP SERVICE DELIVERY OBSERVATION CHECKLIST

	[ ] ONE ANSWER ACCEPTED ( ) MULTIPLE ANSWERS ACCEPTED				
PART 1: FAMILY PLANNING FACILITY LOCATION AND LEVEL					
a1	Data collector ID ___ ___	intid	Date __ __/12/ 2015		enum
	Team leader ID ___ ___	teamid	Date __ __/12/ 2015		superv
	Data Enter ID ___ ___	dataname	Date __ __/12/ 2015		entry
a2	Province: ……..		Code		Provid
a3	District : ……		Code		Distid
a4	Type of health facility: Provincial hospital		[ ] 1		facility
	Provincial RH center		[ ] 2		
	District hospital / health center		[ ] 3		
	District RH/FP nutrition unit		[ ] 4		
	Commune health station		[ ] 5		
	Population/FP collabrator		[ ] 6		
	Private hospital/private clinic/NGO clinic		[ ] 7		
	Pharmacy		[ ] 8		
	Other: _____		[ ] 9		
a5	Owner's Name ……				resp
a6	Telephone: ……				add
PART 2: GENERAL OBSERVATION CHECKLIST					
I.	**PHYSICAL FACILITIES**				
1	Signage		**Yes**	**No**	csvc1
	Clinic signboard visible		[ ] 1	[ ] 0	a
	List of services displayed outside		[ ] 1	[ ] 0	b
	Service charge list		[ ] 1	[ ] 0	c
	List/name of service providers (doctors)		[ ] 1	[ ] 0	d
	Room no. with name plate		[ ] 1	[ ] 0	e
	Advertisement/display boards in the catchment area		[ ] 1	[ ] 0	f
	Location finders (arrows/signs)		[ ] 1	[ ] 0	g
	Signage processes service provider		[ ] 1	[ ] 0	h
2	Client waiting rooms		**Yes**	**No**	csvc2
	Adequate sitting arrangements		[ ] 1	[ ] 0	a
	Adequate light		[ ] 1	[ ] 0	b
	Adequate no. of running fans		[ ] 1	[ ] 0	c
	Facilities for safe drinking water		[ ] 1	[ ] 0	d
	Functioning audio-visual equipment		[ ] 1	[ ] 0	e
	Framed posters on FP services		[ ] 1	[ ] 0	f
3	Cleanliness		**Yes**	**No**	csvc3
	OPD		[ ] 1	[ ] 0	a
	Procedure room		[ ] 1	[ ] 0	b
4	Equipment				csvc4
	Dry sterilizer		[ ] 1	[ ] 0	a
	Autoclave		[ ] 1	[ ] 0	b
	Electric boiler		[ ] 1	[ ] 0	c
	Plastic box with special covering lids for high-level disinfection and chemical sterilization		[ ] 1	[ ] 0	d
5	Scrubbing		**Yes**	**No**	csvc5
	Hand washing sink				
	Is adjacent to OT room		[ ] 1	[ ] 0	a
	Has basin with an elbow tap and running water		[ ] 1	[ ] 0	b
	Procedure Room				
	Clean		[ ] 1	[ ] 0	a
	Glass windows, shutter for dust proofing, net to prevent insects		[ ] 1	[ ] 0	b
	Windows are closed		[ ] 1	[ ] 0	c
	Walls covered with tiles at least 1.6 m high (tiles/mosaic or enamel painted)		[ ] 1	[ ] 0	d
	Slippers exclusively for procedure rooms		[ ] 1	[ ] 0	e
	Single (large) spotlight		[ ] 1	[ ] 0	f
	Procedure table with plastic cover or sheet		[ ] 1	[ ] 0	g
	Procedure table with small step available		[ ] 1	[ ] 0	h
	Cupboard with equipment		[ ] 1	[ ] 0	i
	Trolley is as small as possible		[ ] 1	[ ] 0	j
	Three-battery torch light or generator		[ ] 1	[ ] 0	k

FORM 0- FP SERVICE DELIVERY OBSERVATION CHECKLIST

	[ ] ONE ANSWER ACCEPTED ( ) MULTIPLE ANSWERS ACCEPTED				
PART 1: FAMILY PLANNING FACILITY LOCATION AND LEVEL					
a1	Data collector ID ___ ___	intid	Date __ __/12/ 2015		enum
	Team leader ID ___ ___	teamid	Date __ __/12/ 2015		superv
	Data Enter ID ___ ___	dataname	Date __ __/12/ 2015		entry
a2	Province: ……..		Code		Provid
a3	District : ……		Code		Distid
a4	Type of health facility: Provincial hospital		[ ] 1		facility
	Provincial RH center		[ ] 2		
	District hospital / health center		[ ] 3		
	District RH/FP nutrition unit		[ ] 4		
	Commune health station		[ ] 5		
	Population/FP collabrator		[ ] 6		
	Private hospital/private clinic/NGO clinic		[ ] 7		
	Pharmacy		[ ] 8		
	Other: _____		[ ] 9		
a5	Owner's Name ……				resp
a6	Telephone: ……				add
PART 2: GENERAL OBSERVATION CHECKLIST					
I.	**PHYSICAL FACILITIES**				
1	Signage		**Yes**	**No**	csvc1
	Clinic signboard visible		[ ] 1	[ ] 0	a
	List of services displayed outside		[ ] 1	[ ] 0	b
	Service charge list		[ ] 1	[ ] 0	c
	List/name of service providers (doctors)		[ ] 1	[ ] 0	d
	Room no. with name plate		[ ] 1	[ ] 0	e
	Advertisement/display boards in the catchment area		[ ] 1	[ ] 0	f
	Location finders (arrows/signs)		[ ] 1	[ ] 0	g
	Signage processes service provider		[ ] 1	[ ] 0	h
2	Client waiting rooms		**Yes**	**No**	csvc2
	Adequate sitting arrangements		[ ] 1	[ ] 0	a
	Adequate light		[ ] 1	[ ] 0	b
	Adequate no. of running fans		[ ] 1	[ ] 0	c
	Facilities for safe drinking water		[ ] 1	[ ] 0	d
	Functioning audio-visual equipment		[ ] 1	[ ] 0	e
	Framed posters on FP services		[ ] 1	[ ] 0	f
3	Cleanliness		**Yes**	**No**	csvc3
	OPD		[ ] 1	[ ] 0	a
	Procedure room		[ ] 1	[ ] 0	b
4	Equipment				csvc4
	Dry sterilizer		[ ] 1	[ ] 0	a
	Autoclave		[ ] 1	[ ] 0	b
	Electric boiler		[ ] 1	[ ] 0	c
	Plastic box with special covering lids for high-level disinfection and chemical sterilization		[ ] 1	[ ] 0	d
5	Scrubbing		**Yes**	**No**	csvc5
	Hand washing sink				
	Is adjacent to OT room		[ ] 1	[ ] 0	a
	Has basin with an elbow tap and running water		[ ] 1	[ ] 0	b
	Procedure Room				
	Clean		[ ] 1	[ ] 0	a
	Glass windows, shutter for dust proofing, net to prevent insects		[ ] 1	[ ] 0	b
	Windows are closed		[ ] 1	[ ] 0	c
	Walls covered with tiles at least 1.6 m high (tiles/mosaic or enamel painted)		[ ] 1	[ ] 0	d
	Slippers exclusively for procedure rooms		[ ] 1	[ ] 0	e
	Single (large) spotlight		[ ] 1	[ ] 0	f
	Procedure table with plastic cover or sheet		[ ] 1	[ ] 0	g
	Procedure table with small step available		[ ] 1	[ ] 0	h
	Cupboard with equipment		[ ] 1	[ ] 0	i
	Trolley is as small as possible		[ ] 1	[ ] 0	j
	Three-battery torch light or generator		[ ] 1	[ ] 0	k

FORM 0- FP SERVICE DELIVERY OBSERVATION CHECKLIST

	[ ] ONE ANSWER ACCEPTED ( ) MULTIPLE ANSWERS ACCEPTED			
PART 1: FAMILY PLANNING FACILITY LOCATION AND LEVEL				
a1	Data collector ID ___ ___	intid	Date __ __/12/ 2015	enum
	Team leader ID ___ ___	teamid	Date __ __/12/ 2015	superv
	Data Enter ID ___ ___	dataname	Date __ __/12/ 2015	entry
a2	Province: ……..		Code	Provid
a3	District : ……		Code	Distid
a4	Type of health facility:	Provincial hospital	[ ] 1	facility
		Provincial RH center	[ ] 2	
		District hospital / health center	[ ] 3	
		District RH/FP nutrition unit	[ ] 4	
		Commune health station	[ ] 5	
		Population/FP collabrator	[ ] 6	
		Private hospital/private clinic/NGO clinic	[ ] 7	
		Pharmacy	[ ] 8	
		Other: _____	[ ] 9	
a5	Owner's Name ……			resp
a6	Telephone: ……			add
PART 2: GENERAL OBSERVATION CHECKLIST				
I.	**PHYSICAL FACILITIES**			
1	Signage	**Yes**	**No**	csvc1
	Clinic signboard visible	[ ] 1	[ ] 0	a
	List of services displayed outside	[ ] 1	[ ] 0	b
	Service charge list	[ ] 1	[ ] 0	c
	List/name of service providers (doctors)	[ ] 1	[ ] 0	d
	Room no. with name plate	[ ] 1	[ ] 0	e
	Advertisement/display boards in the catchment area	[ ] 1	[ ] 0	f
	Location finders (arrows/signs)	[ ] 1	[ ] 0	g
	Signage processes service provider	[ ] 1	[ ] 0	h
2	Client waiting rooms	**Yes**	**No**	csvc2
	Adequate sitting arrangements	[ ] 1	[ ] 0	a
	Adequate light	[ ] 1	[ ] 0	b
	Adequate no. of running fans	[ ] 1	[ ] 0	c
	Facilities for safe drinking water	[ ] 1	[ ] 0	d
	Functioning audio-visual equipment	[ ] 1	[ ] 0	e
	Framed posters on FP services	[ ] 1	[ ] 0	f
3	Cleanliness	**Yes**	**No**	csvc3
	OPD	[ ] 1	[ ] 0	a
	Procedure room	[ ] 1	[ ] 0	b
4	Equipment			csvc4
	Dry sterilizer	[ ] 1	[ ] 0	a
	Autoclave	[ ] 1	[ ] 0	b
	Electric boiler	[ ] 1	[ ] 0	c
	Plastic box with special covering lids for high-level disinfection and chemical sterilization	[ ] 1	[ ] 0	d
5	Scrubbing	**Yes**	**No**	csvc5
	Hand washing sink			
	Is adjacent to OT room	[ ] 1	[ ] 0	a
	Has basin with an elbow tap and running water	[ ] 1	[ ] 0	b
	Procedure Room			
	Clean	[ ] 1	[ ] 0	a
	Glass windows, shutter for dust proofing, net to prevent insects	[ ] 1	[ ] 0	b
	Windows are closed	[ ] 1	[ ] 0	c
	Walls covered with tiles at least 1.6 m high (tiles/mosaic or enamel painted)	[ ] 1	[ ] 0	d
	Slippers exclusively for procedure rooms	[ ] 1	[ ] 0	e
	Single (large) spotlight	[ ] 1	[ ] 0	f
	Procedure table with plastic cover or sheet	[ ] 1	[ ] 0	g
	Procedure table with small step available	[ ] 1	[ ] 0	h
	Cupboard with equipment	[ ] 1	[ ] 0	i
	Trolley is as small as possible	[ ] 1	[ ] 0	j
	Three-battery torch light or generator	[ ] 1	[ ] 0	k

Study on Quality Assurance of Family Planning Services in Vietnam

Form P_QUESTIONARE FOR INTERVIEW OF SERVICE PROVIDER

Hello. My name is …….We are conducting a study on family planning use in Vietnam for the Ministry of Health
We would very much appreciate your participation in this survey. I would like to ask you some questions about the family planning methods you provide clients. The survey is expected to take 30 to 45 minutes. Your identity and whatever information you provide will be kept strictly confidential and will not be used for any purpose other than this research.
Participation in this survey is voluntary and you can choose not to answer any individual question or any of the questions. However, we hope that you will participate in this survey since your views are important.
At this time, please feel free to ask me anything about the survey.
May I begin the interview now?

[ ] **ONE** answer accepted ( ) **MULTIPLE** answers accepted

PART 1: SCREENING QUESTIONS, INTERVIEWEE AND INTERVIEWER DETAILS

a1	Data collector ID ___ ___	intid	Date __ __/__ __/ 2015	dateint
	Team leader ID ___ ___	teamid	Date __ __/__ __/ 2015	dateteam
	Data Enter ID ___ ___	dataname	Date __ __/__ __/ 2015	datenter
a2	Province: ……..	Code	__ __	proid
a3	District: ……..	Code	__ __	distid
a4	Commune ……..	Code	__ __	comid
a5	Location	Urban	[ ] 1	area
		Rural	[ ] 2	
a6	Type of facility providing FP services			facility
		Provincial hospital	[ ] 1	
		Provincial RH center	[ ] 2	
		District hospital / health center (Obs dept)	[ ] 3	
		District RH/FP nutrition unit	[ ] 4	
		Commune health station	[ ] 5	
		FP collaborator	[ ] 6	
		Private clinic/NGO clinic	[ ] 7	
		Pharmacy	[ ] 8	
		Others: _____	[ ] 9	
a7	Health Worker name: ……..			hw
a8	Sex:		Male [ ] 1 Female [ ] 2	sex
a9	Your position::	Obs/Gyn Doctor	[ ] 1	infopost
		Assistant Doctor in Obs and Pediatrics	[ ] 2	
		Midwife	[ ] 3	
		General practitioners trained in FP, MVA and counseling	[ ] 4	
		Technician	[ ] 5	
		FP and population communal officer	[ ] 6	
		Other (specify)……	[ ] 7	
a10	Your telephone number:……			tel

PART 2: HEALTH WORKER CAPACITY

1	Do you personally provide the following contraceptive methods?	**Yes**	**No**	p1
	IUD insertion	[ ]1	[ ]0	
	Contraceptive injections	[ ]1	[ ]0	
	Implant insertion	[ ]1	[ ]0	
	Tubectomy	[ ]1	[ ]0	
	Vasectomy	[ ]1	[ ]0	

2	Have you ever been trained on providing the following contraceptive methods?	**Yes**	**No**	p2
	IUDs	[ ]1	[ ]0	
	Contraceptive injections	[ ]1	[ ]0	
	Implants	[ ]1	[ ]0	
	Tubectomy	[ ]1	[ ]0	
	Vasectomy	[ ]1	[ ]0	
3	Have you heard of the National Guidelines for RH care service (updated version in 2009)	**Yes**	**No**	p3
		[ ]1	[ ]0 *Skip to 7*	
4	Have you been trained or guided of these NGFRHCS?	**Yes**	**No**	p4
		[ ]1	[ ]0	
5	Do you have a copy of the NGFRHCS on hand?	**Yes**	**No**	p5
		[ ]1	[ ]0 *Skip to 7*	
6	Can you show me the NGFRHCS?	**Yes**	**No**	p6
		[ ]1	[ ]0	
7	Tell me steps of counseling a NEW CLIENT who needs FP service?			p7
	Greeting	( ) 1		
	Ask clients about themselves	( ) 2		
	Tell clients about their choices	( ) 3		
	Help clients make an informed choice	( ) 4		
	Explain fully how to use the chosen method	( ) 5		
	Return visits should be welcomed	( ) 6		
8	Do you use a method-specific job-aid to inform clients of the advantages and disadvantages of contraceptives?	Yes [ ] 1	No [ ] 0	p8
9	Do your clients ask you to clarify the family planning method they want?	[ ] 1	[ ] 0	p9
10	Is consent received from clients after giving information and before providing any methods?	[ ] 1	[ ] 0	p10
11	Do you maintain confidentiality of information after providing FP services?	[ ] 1	[ ] 0	p11
12	Do you get updated information on FP methods from your higher authority?	[ ] 1	[ ] 0	p12
13	Do you get supplies from your higher authority?	[ ] 1	[ ] 0	p13
14	Do you get adequate support from your higher authority when you ask for it?	[ ] 1	[ ] 0	p14
15	Did you receive a visit from a technical supervisor in the last 3 months?	[ ] 1	[ ] 0	p15
16	Do you know of any HIV screening services in your area?			p16
	Don't know	[ ] 2		
	Yes	[ ] 1		
	No	[ ] 0		
17	Does your health facility have posters, leaflets or phamplets about HIV visible to clients during FP counseling?	Yes [ ] 1	No [ ] 0	p17
18	Have you ever refered any clients to an HIV screening service?	Yes [ ] 1	No [ ] 0	p18

PART 3: DISADVANTAGES, MISUNDERSTANDINGS AND REASONS FOR NOT ACCEPTING FAMILY PLANNING				
19	Now, I'm going to ask you about the possible reasons behind low acceptance of contraceptive methods IN COUPLES IN GENERAL in your clinic			p19
a1	Is the use of pill in your clinic low, medium or high?			
	High	[ ] 1	*Skip to b1*	p19a1
	Medium	[ ] 2	*Skip to b1*	
	Low	[ ] 3		
a2	If LOW, what are the reasons behind low acceptance of pills?			
	Low awareness	( ) 1		p19a2
	Not always available in FP clinic	( ) 2		
	Need to take daily	( ) 3		
	To avoid post-pill amenorrhea	( ) 4		
	May decrease breast milk	( ) 5		
	May increase weight	( ) 6		
	Drop hemorrhage between two menstrual periods	( ) 7		
	Does not protect against STD/HIV/AIDS	( ) 8		
	Risk of becoming permanently infertile	( ) 9		
	Use other contraception	( ) 10		
	Does not remember	( ) 11		
	Want to have more children	( ) 12		
	Others (specify)……	( ) 13		
b1	Is the use of condom in your clinic low, medium or high?			p19b1
	High	[ ] 1	*Skip to c1*	
	Medium	[ ] 2	*Skip to c1*	
	Low	[ ] 3		
b2	If LOW, what are the reasons behind low acceptance of condoms?			p19b2
	Low awareness	( ) 1		
	Not always available in FP clinic	( ) 2		
	Do not know how to use condoms	( ) 3		
	Allergics to condom	( ) 4		
	Need to use during every sexual intercourse	( ) 5		
	Buying condoms is shameful	( ) 6		
	Decreased sensation during sex	( ) 7		
	Interruption during sexual activities	( ) 8		
	Men are not cooperative	( ) 9		
	Need to be ready even when not having sex	( ) 10		
	Use other contraception	( ) 11		
	Want to have more children	( ) 12		
	Other (specify)……	( ) 13		
c1	Is the use of injectables in your clinic low, medium or high?			p19c1
	High	[ ] 1	*Skip to 20*	
	Medium	[ ] 2	*Skip to 20*	
	Low	[ ] 3		
c2	If LOW, what are the reasons behind low acceptance of injectables?			p19c2
	Low awareness	( ) 1		
	Not always available in FP clinic	( ) 2		
	Drop hemorrhage between two menstrual periods	( ) 3		
	May increase weight	( ) 4		
	Need to visit medical staff for injections	( ) 5		
	May decrease desire for sex	( ) 6		
	Does not protect against STD/HIV/AIDS	( ) 7		

	Amenorrhea	( ) 8	
	Currently use other contraceptive methods	( ) 9	
	Want to have more children	( ) 10	
	Others (specify) ……	( ) 11	
20	Now, I'm going to ask you about the possible reasons behind low acceptance of contraceptive methods in couples who already have one child in your clinic		p20
a1	Is the use of IUDs among couples who already have one child in your area low, medium or high?		p20a1
	High	[ ] 1 *Skip to b1*	
	Medium	[ ] 2 *Skip to b1*	
	Low	[ ] 3	
a2	If LOW, what are the easons behind low acceptance of IUDs?		p20a2
	Low awareness	( ) 1	
	Not always available in FP clinic	( ) 2	
	Pain in lower abdomen	( ) 3	
	Increased bleeding during menstruation	( ) 4	
	Sometimes IUD comes out of the vagina	( ) 5	
	Became pregnant	( ) 6	
	Damage to the vagina	( ) 7	
	Needs experienced worker to insert and remove IUD	( ) 8	
	Need to examine the string after each menstruation	( ) 9	
	It does not protect against STD/HIV/AIDS	( ) 10	
	Reproductive organ transition risks increase	( ) 11	
	Pain during sex	( ) 12	
	Use other contraception	( ) 13	
	Want to have more children	( ) 14	
	Others(specify)……..	( ) 15	
b1	Is the use of implants among couples who already have one child in your clinic low, medium or high?		p20b1
	High	[ ] 1 *Skip to 21*	
	Medium	[ ] 2 *Skip to 21*	
	Low	[ ] 3	
b2	If LOW, what are the reasons behind low acceptance of implants?		p20b2
	Low awareness	( ) 1	
	Drop hemorrhage between two menstrual periods	( ) 2	
	Prolonged light bleeding	( ) 3	
	Stopped menstruation	( ) 4	
	Headache, vomiting tendency and weight gain	( ) 5	
	Fatigue	( ) 6	
	Weight/pain in breast	( ) 7	
	Hazard to open and use by one's self	( ) 8	
	Need small operation to insert and open	( ) 9	
	Transition, bleeding problems	( ) 10	
	Does not protect against STD/HIV/AIDS	( ) 11	
	Implant shortages	( ) 12	
	Use other contraception	( ) 13	
	Want to have more children	( ) 14	
	Others (specify) ……	( ) 15	
21	Now, I'm going to ask you about the possible reasons behind low acceptance of contraceptive methods in couples who already have two children in your clinic		p21
a1	Is the use of tubectomy among couples who already have two children in your clinic low, medium or high?		p21a1

	High	[ ] 1	*Skip to b1*	
	Medium	[ ] 2	*Skip to b1*	
	Low	[ ] 3		
a2	If LOW, what are the reasons behind low acceptance of tubectomy?			p21a2
	It's a permanent method (want to have more children)	( ) 1		
	Risks of a small operation	( ) 2		
	Pain for a few days after operation	( ) 3		
	Possibilities of ectopic pregnancy	( ) 4		
	Need to come to service center for operation	( ) 5		
	Need trained doctor and assistant	( ) 6		
	Does not protect against STD/HIV/AIDS	( ) 7		
	Use other contraception	( ) 8		
	Pain while performing	( ) 9		
	Others (specify)……	( ) 10		
b1	Is the use of vasectomy among couples who already have two children in your clinic low, medium or high?			p21b1
	High	[ ] 1	*End*	
	Medium	[ ] 2	*End*	
	Low	[ ] 3		
b2	If LOW, what are the reasons behind low acceptance of vasectomy?			p21b2
	It is a permanent method (Want to have more children)	( ) 1		
	Risks of a small operation	( ) 2		
	It does not work immediately after operation	( ) 3		

STUDY ON THE QUAILITY OF FAMILY PLANNING SERVICES IN VIET NAM

FORM W- WOMEN QUESTIONNAIRE

Household code ____. ____. ____ ____. ____ ____ **Member code** __ __

Villiage District Commune Household

Investigator greet the respondent and introduce the survey according to the guidlines

AGREE TO BE INTERVIEWED [ ] 1 REFUSED [ ] 2 --> stop

Just interview women 15-49 [ ] Married and using an FP method

[ ] Single and have had sexual intercouse

[ ] ONE ANSWER ACCEPTED **( ) MULTIPLE ANSWERS ACCEPTED**

PART 2: WOMEN'S BACKGROUND INFORMATION

1	Full name: ……..		Tel: ……	w1
2	Status of household membership	*Member*	[ ] 1	w2
		Non-member/Visitor	[ ] 2	
3	Are you resident or migrant?			w3
		Resident of this province	[ ] 1	
		Long-term migrant	[ ] 2	
		Short-term migrant	[ ] 3	
4	What is your religion ?			w4
		No religion	[ ] 1	
		Buddhist	[ ] 2	
		Catholic	[ ] 3	
		Protestant	[ ] 4	
		Cao Dai	[ ] 5	
		Hoa Hao	[ ] 6	
		Islamic	[ ] 7	
		*Other (specify)*_____	[ ] 8	
5	Which ethnicity are you?	*Kinh*	[ ] 1	w5
		Ethnic	[ ] 2	
6	How well do you understand the Vietnamese language?	*Very well*	[ ] 1	w6
		A little	[ ] 2	
		Not at all	[ ] 3	
7	What is the highest class/grade/ level passed/school completed in years?		__ __ years	w7
8	What is your current occupation?	*Agriculture*	[ ] 1	w8
		Manufacturing / construction	[ ] 2	
		Service / trading	[ ] 3	
		Office clerk	[ ] 4	
		Student	[ ] 5	
		Unemployed / Housewife	[ ] 6	
		Other (specify): ……	[ ] 7	
9	Current marital status			w9
		Unmarried, have a boyfriend but not living together	[ ] 1 *Skip to 11*	
		Unmarried, have boyfriend and living together (De-facto)	[ ] 2 *Skip to 11*	
		Married and living together	[ ] 3	
		Married but not living together	[ ] 4	
		Separated	[ ] 5	
		Divorced	[ ] 6	
		Widow	[ ] 7	
10	How old were you when you were first married (in completed years)?		__ __ years	w10
11	How old were you when you first became sexually active?		__ __ years	w11

	(Don't answer/ Don't remember=99)		
12	Husband/partner's current age (in completed years)? *(Don't answer/ Don't remember=99)*	__ __ tι Tuổi	w12
13	Husband/partner's years of schooling (highest class/grade/level passed/completed in years) *(Don't know/ Don't answer = 99)*	__ __ năm	w13
PART 3: REPRODUCTIVE HISTORY			
14	Have you ever been pregnant? *Yes* *No*	[ ] 1 [ ] 0 *Skip to Part 4*	w14
15	Are you currently pregnant? *Yes* *No*	[ ] 1 [ ] 0	w15
16	Age at first pregnancy (in completed years)	__ __ years	w16
17	How many times you were pregnant (total number of pregnancies including latest/current pregnancy)?	__ __ times	w17
18	Have you ever a terminated pregnancy? *Yes* *No*	[ ] 1 [ ] 0 *Skip to 27*	w18
19	How many times you have terminated a pregnancy (total number of induced terminations)?	__ __ times	w19
20	Age at first pregnancy termination (in completed years) *(Don't answer= 99)*	__ __ age	w20
21	Duration of last pregnancy when terminated?	__ __ weeks	w21
22	How did you terminate your last pregnancy? *Manuatrial Regulation* *Abortion*	[ ] 1 [ ] 2	w22
23	Where did you terminate your last pregnancy?		w24
	Provincial hospital	[ ] 1	
	Provincial RH center	[ ] 2	
	District hospital (obstetrics)	[ ] 3	
	District's family planning and nutrition unit	[ ] 4	
	Commune health stations	[ ] 5	
	Population/FP collaborator	[ ] 6	
	Private/ NGO-led clinic	[ ] 7	
	Pharmacy Stores	[ ] 8	
	Others (specify)_____	[ ] 9	
24	Who conducted the termination last time?		w24
	Obs doctor	[ ] 1	
	Doctor's assistant	[ ] 2	
	Midwife	[ ] 3	
	Nurse	[ ] 4	
	Family planning counselor	[ ] 5	
	Population-family planning specialized staffs/officers	[ ] 6	
	Village Population-family planning collaborator	[ ] 7	
	Others (specify)_____	[ ] 8	
	Don't know	[ ] 99	
25	What was your most prominent feeling after you had your last pregnancy termination?		w25
	Happy	( ) 1	
	Feel nothing, relieved	( ) 2	
	Sad	( ) 3	
	Guilty	( ) 4	
	Angry	( ) 5	

	Shameful	( ) 6		
	Regret	( ) 7		
	*Others (specify)*_____	( ) 8		
26	What was your husband's most predominant feeling after your last pregnancy termination?			w26
	Don't know	[ ] 99		
	Happy	( ) 1		
	Feel nothing, relieved	( ) 2		
	Sad	( ) 3		
	Guilty	( ) 4		
	Angry	( ) 5		
	Shameful	( ) 6		
	Regret	( ) 7		
	*Others (specify)*_____	( ) 8		
27	Total number of live births (in lifetime)	__ __		w27
	In which *Total number of normal vaginal deliveries (NVD)*	__ __	*If all = 0, skip to Part 4*	
	Total number of assisted vaginal deliveries (Episiotomy)	__ __		
	Total number of C-sections	__ __		
28	What type of delivery did you have last time?			
	Normal vaginal delivery (NVD)	[ ] 1		w28
	Assisted vaginal delivery (Episiotomy)	[ ] 2		
	C-section	[ ] 3		
PART 4: FAMILY PLANNING SERVICE USE				
29	Have you heard about family planning? *Yes*	[ ] 1		w29
	No	[ ] 0	**KẾT THÚC**	
30	What methods have you heard of?			w30
	Pill (daily pill)	( ) 1	*Ask question 31-33*	
	Condom	( ) 2	*Ask question 34-36*	
	IUD	( ) 3	*Ask question 37-39*	
	Injectable	( ) 4	*Ask question 40-42*	
	Male sterilization	( ) 5	*Ask question 43-45*	
	Female sterilization	( ) 6	*Ask question 46-48*	
	Implant	( ) 7	*Ask question 49-51*	
	Periodic abstinence	( ) 8	*If 30=8, 9, 10 Skip to Part 5*	
	Withdrawal	( ) 9		
	*Others (specify)*_____	( ) 10		
	PILL			
31	**Advantages of the pill**			w31
	Very effective when used correctly	( ) 1		
	No need to do anything at time of sexual intercourse	( ) 2		
	No need to worry about pregnancy	( ) 3		
	Monthly periods are regular	( ) 4		
	Lighter monthly bleeding	( ) 5		
	Fewer days of bleeding	( ) 6		
	Milder and fewer menstrual cramps	( ) 7		
	Can be used as long as a woman wants to prevent pregnancy	( ) 8		
	Can be used at any age	( ) 9		
	Can be used by women who have children and by women who do not	( ) 10		
	User can stop taking pills at any time	( ) 11		
	Fertility returns soon after stopping/ No rest period needed	( ) 12		
	Can be used as an emergency contraceptive after unprotected sex	( ) 13		
	Can prevent or decrease iron deficiency (anemia)	( ) 14		

	Inexpensive	( ) 15		
	Others (specify) ……..	( ) 16		
	Do not know	( ) 99		
32	**Common side effects**			w32
	No counseling on side effects	( ) 1		
	Nausea (most common in first 3 months)	( ) 2		
	Spotting or bleeding between menstrual periods, especially if a woman forgets to take her pills or takes them late (most common in first 3 months)	( ) 3		
	Mild headaches	( ) 4		
	Breast tenderness	( ) 5		
	Slight weight gain	( ) 6		
	Amenorrhea	( ) 7		
	Not highly effective unless taken every day	( ) 8		
	Difficult for some women to remember every day	( ) 9		
	New packet of pills must be on hand every 28 days	( ) 10		
	May cause mood changes including depression, decreased interest in sex	( ) 11		
	Very rarely can cause a stroke, blood clots in the deep veins of the legs, or a heart attack	( ) 12		
	Not suitable for women with high blood pressure and women who are age 35 or older and smoke 15 or more cigarettes per day	( ) 13		
	Do not protect against STDs/HIV/AIDS	( ) 14		
	Other (specify)……..	( ) 15		
	Do not know	( ) 99		
33	**Source of pill**			w33
	Provincial hospital	( ) 1	*Review questions 31 to know the next question*	
	Provincial RH center	( ) 2		
	District hospital (obstetrics)	( ) 3		
	District's family planning and nutrition unit	( ) 4		
	Commune health stations	( ) 5		
	Family planning collaborator	( ) 6		
	Private/ NGO-led clinic	( ) 7		
	Pharmacies	( ) 8		
	Others (specify)_____	( ) 9		
	CONDOM			
34	**Advantages of condoms**			w34
	Prevents pregnancy when used correctly	( ) 1		
	Prevents STDs and increased risks caused by STDs, including HIV/AIDS	( ) 2		
	Can be used soon after childbirth	( ) 3		
	Safe, no hormonal side effects	( ) 4		
	Help prevent ectopic pregnancies	( ) 5		
	Can be stopped at any time	( ) 6		
	Easy to keep on-hand for unplanned sexual intercourse	( ) 7		
	Can be used by men of any age	( ) 8		
	Can be used without seeing a health care provider first	( ) 9		
	Usually easy to obtain and sold in many places	( ) 10		
	Enable a man to take responsibility for preventing pregnancy and disease	( ) 11		
	Increased sexual enjoyment without needing to worry about pregnancy or STDs	( ) 12		
	Other (specify)……..	( ) 13		
	Do not know	( ) 14		

35	**Disadvantages of condoms**			w35
	Reduced sexual enjoyment	( ) 1		
	Some people may be allergic to the lubricant on some brands of condoms	( ) 2		
	Takes time to put the condom on the erect penis before intercourse	( ) 3		
	Supply must be ready even if the woman or man is not expecting to have sex	( ) 4		
	Small possibility that condom will slip off or break during sex	( ) 5		
	Condoms can weaken if stored too long or in too much heat, sunlight, or humidity, or if used with oil-based lubricants	( ) 6		
	A man's cooperation is needed for a woman to protect herself from pregnancy and disease	( ) 7		
	Fear of being stigmatized when receiving or buying condoms	( ) 8		
	Other (specify)……..	( ) 9		
	Do not know	( ) 10		
36	**Sources of condoms**			
	Provincial hospital	( ) 1		w36
	Provincial RH center	( ) 2		
	District hospital (obstetrics)	( ) 3		
	District's family planning and nutrition unit	( ) 4	*Review questions 30 to know the next question*	
	Commune health stations	( ) 5		
	Family planning collaborator	( ) 6		
	Private/ NGO-led clinic	( ) 7		
	Pharmacies	( ) 8		
	Others (specify)_____	( ) 9		
	IUD			
37	**Advantages of IUD**			w37
	Effective long-term pregnancy prevention	( ) 1		
	Little to remember	( ) 2		
	No interference in sex	( ) 3		
	Increased sexual enjoyment without needing to worry about pregnancy	( ) 4		
	No hormonal side effects with copper-bearing IUD	( ) 5		
	Copper-bearing and inert IUDs have no effect on amount or quality of breast milk	( ) 6		
	Can be inserted immediately after childbirth (except hormone releasing IUDs)	( ) 7		
	Can be inserted immediately after induced abortion (if no evidence of infection)	( ) 8		
	Can be used through menopause (one year or so after last menstrual period)	( ) 9		
	No interactions with any medicines	( ) 10		
	Helps prevent ectopic pregnancies (Less risk of ectopic pregnancy than in women not using any family planning methods)	( ) 11		
	Other (specify)……	( ) 12		
	Do not know	( ) 99		
38	**Diadvantages of IUD**			w38

	May cause pain and lumbar region fatigue after insertion	( ) 1		
	There may be vaginal discharge and smell	( ) 2		
	More prone to infections	( ) 3		
	Longer and heavier menstrual periods	( ) 4		
	Bleeding or spotting between periods	( ) 5		
	More cramps or pain during periods	( ) 6		
	Severe cramps and pain for first 3 to 5 days after insertion	( ) 7		
	Not suitable for women who have STDs	( ) 8		
	Perforation (piercing) of the wall of the uterus (very rare if inserted properly)	( ) 9		
	Does not protect against sexually transmitted diseases (STDs) including HIV/AIDS	( ) 10		
	Not suitable for women who suffer from pelvic inflammatory disease (PID)	( ) 11		
	Medical insertion procedure is complex and requires pelvic exam	( ) 12		
	Occasionally a few women faint during the insertion procedure	( ) 13		
	Some pain and bleeding or spotting may occur immediately after IUD insertion	( ) 14		
	Client cannot stop IUD use on her own	( ) 15		
	A trained health care provider must remove the IUD	( ) 16		
	May come out of the uterus, possibly without the woman's knowing (more common when IUD is inserted soon after childbirth)	( ) 17		
	Does not protect against ectopic pregnancy	( ) 18		
	Some women may not want to put her fingers into her vagina	( ) 19		
	Other (specify)……..	( ) 20		
	Do not know	( ) 99		
39	**Sources of IUD**			w39
	Provincial hospital	( ) 1	*Review questions 30 to know the next question*	
	Provincial RH center	( ) 2		
	District hospital (obstetrics)	( ) 3		
	District's family planning and nutrition unit	( ) 4		
	Commune health stations	( ) 5		
	Family planning collaborator	( ) 6		
	Private/ NGO-led clinic	( ) 7		
	Pharmacies	( ) 8		
	Others (specify)_____	( ) 9		
	Injection			
40	**Advantages of injectables**			w40
	Very effective	( ) 1		
	Private, no one else can tell that a woman is using it	( ) 2		
	Long-term reversible pregnancy prevention	( ) 3		
	One injection prevents pregnancy for at least 3 months	( ) 4		
	Does not interfere with sex	( ) 5		
	Increased sexual enjoyment without needing to worry about pregnancy	( ) 6		
	No daily pill-taking	( ) 7		
	Allows some flexibility in return visits, client can return as much as 2 weeks early or 2 weeks late for next injection	( ) 8		
	Can be used at any age	( ) 9		
	Quantity and quality of breast milk are not impacted	( ) 10		
	Can be used by nursing mothers as soon as 6 weeks after childbirth	( ) 11		

	No estrogen side effects	( ) 12	
	Does not increase the risk of estrogen-related complications such as heart attacks	( ) 13	
	Helps prevent ectopic pregnancies	( ) 14	
	Helps prevent uterine fibroids	( ) 15	
	May help prevent iron-deficiency anemia	( ) 16	
	May make seizures/convulsions less frequent in women with epilepsy	( ) 17	
	Others (specify)……	( ) 18	
	Do not know	( ) 99	
41	**Disadvantages of injectables**		w41
	Light spotting or bleeding. Most common at-first	( ) 1	
	Heavy bleeding. Can occur at-first for very few women	( ) 2	
	Arnenorrhea. Normal, especially after first year of use	( ) 3	
	May cause weight gain	( ) 4	
	Delayed return of fertility when stopped using. About 4 months longer wait before pregnancy compared to women who had been using combined oral contraceptive	( ) 5	
	Requires another injection every 3 months	( ) 6	
	May cause headaches	( ) 7	
	May cause breast tenderness	( ) 8	
	May cause moodiness	( ) 9	
	May cause nausea	( ) 10	
	May cause hair loss	( ) 11	
	May cause reduced sex drive	( ) 12	
	May cause acne in some women	( ) 13	
	Does not protect against sexually transmitted diseases including HIV/AIDS	( ) 14	
	Others (specify)……	( ) 15	
	Do not know	( ) 99	
42	**Sources of Injectable**		w42
	Provincial hospital	( ) 1	*Review questions 30 to know the next question*
	Provincial RH center	( ) 2	
	District hospital (obstetrics)	( ) 3	
	District's family planning and nutrition unit	( ) 4	
	Commune health stations	( ) 5	
	Family planning collaborator	( ) 6	
	Private/ NGO-led clinic	( ) 7	
	Pharmacies	( ) 8	
	Others (specify)_____	( ) 9	
	What do you know about male sterilization?		
43	**Advantages of male sterilization**		w43
	A single, quick procedure that leads to life-long, safe and very effective family planning	( ) 1	
	Nothing to remember except to use condoms or another effective method for at least the first 20 ejaculations or the first 3 months, whichever comes first	( ) 2	
	No interference with sex	( ) 3	
	Increased sexual enjoyment without worrying about pregnancy	( ) 4	
	No supplies to acquire and no repeat clinic visits needed	( ) 5	
	No apparent long-term health risks	( ) 6	
	Slightly more effective than female sterilization	( ) 7	
	Slightly safer	( ) 8	
	Easier to perform than female sterilization	( ) 9	
	Cheaper than female sterilization	( ) 10	

	Other (specify)……	( ) 11		
	Do not know	( ) 99		
44	**Disadvantages of Male sterilization**			w44
	Usually uncomfortable for 2 or 3 days	( ) 1		
	Pain in the scrotum, swelling and bruising (short-term)	( ) 2		
	Brief feeling of faintness after the procedure	( ) 3		
	Bleeding or infection may occur at the incision site or inside the incision	( ) 4		
	Blood clots may happen in the scrotum	( ) 5		
	Requires minor surgery by a specially trained provider	( ) 6		
	Not immediately effective	( ) 7		
	Reversal surgery is not available	( ) 8		
	No protection against sexually transmitted diseases (STDs), including HIV/AIDS	( ) 9		
	Unable to have more children	( ) 10		
	Other (specify)……	( ) 11		
	Do not know	( ) 99		
45	**Sources of Male Sterilization**			w51
	Provincial hospital	( ) 1	*Review Question 30 to know the next question*	
	Provincial RH center	( ) 2		
	District hospital (obstetrics)	( ) 3		
	District's family planning and nutrition unit	( ) 4		
	Commune health stations	( ) 5		
	Family planning collaborator	( ) 6		
	Private/ NGO-led clinic	( ) 7		
	Pharmacies	( ) 8		
	Others (specify)_____	( ) 9		
	Do not know	[ ] 99		
	What do you know about female sterilization?			
46	**Advantages of female sterilization**			w46
	A single procedure leads to life-long, safe, and very effective family planning	( ) 1		
	Nothing to remember	( ) 2		
	No supplies needed	( ) 3		
	No repeat clinic visits required	( ) 4		
	No interference with sex	( ) 5		
	Does not affect a woman's ability to have sex	( ) 6		
	Increased sexual enjoyment without worrying about pregnancy	( ) 7		
	No effect on breast milk	( ) 8		
	No known long-term side effects or health risks	( ) 9		
	Others	( ) 10		
	Do not know	( ) 99		
47	**Disadvantages of female sterilization**			
	Painful few days after the procedure	( ) 1		w47
	Infection or bleeding at the incision may occur	( ) 2		
	Internal infection or bleeding may occur	( ) 3		
	Internal organs may be injured	( ) 4		

	With local anesthesia alone or with sedation, rare risks of allergic reaction or overdose	( ) 5		
	With general anesthesia, occasional delayed recovery and side effects	( ) 6		
	Risk of overdose	( ) 8		
	Death due to anesthesia overdose or other complication may occur in very rare instances	( ) 9		
	Requires minor surgery by a specially trained provider	( ) 11		
	Slightly more risky than vasectomy	( ) 12		
	Often more expensive than vasectomy	( ) 13		
	Reversal surgery is not available	( ) 14		
	No protection against sexually transmitted diseases (STDs) including HIV/AIDS	( ) 15		
	Unable to have more children	( ) 16		
	Others	( ) 17		
	Do not know	( ) 99		
48	**Sources of female sterilization?**			w48
	Provincial hospital	( ) 1	*Review questions 30 to know the next question*	
	Provincial RH center	( ) 2		
	District hospital (obstetrics)	( ) 3		
	District's family planning and nutrition unit	( ) 4		
	Commune health stations	( ) 5		
	Family planning collaborator	( ) 6		
	Private/ NGO-led clinic	( ) 7		
	Pharmacies	( ) 8		
	Others (specify)_____	( ) 9		
	Do not know	[ ] 99		
	What do you know about implants?			
49	**Advantages of implants**			w49
	Very effective, even in heavier women	( ) 1		
	A single decision can lead to very effective contraception for up to 5 years, and is reversible	( ) 2		
	No need to do anything at time of sexual intercourse	( ) 3		
	Increased sexual enjoyment without worrying about pregnancy	( ) 4		
	Requires no daily pill, repeat injections or repeated clinic visits	( ) 5		
	Effective within 24 hours after insertion	( ) 6		
	Fertility returns almost immediately after capsules are removed	( ) 7		
	Quantity and quality of breast milk do not seem to be impacted	( ) 8		
	Can be used by nursing mothers starting 6 weeks after childbirth	( ) 9		
	No estrogen side effects	( ) 10		
	Helps prevent iron deficiency anemia	( ) 11		
	Helps prevent ectopic pregnancies	( ) 14		
	Insertion involves only minor pain of anesthesia needle	( ) 15		
	Not painful if anesthetic is given properly	( ) 16		
	Others	( ) 17		
	Do not know	( ) 99		
50	**Disadvantages of Implant**			w50
	Changes in menstrual bleeding are normal	*( ) 1*		
	Light spotting or bleeding between monthly periods (common)	*( ) 2*		
	Prolonged bleeding (uncommon, and often decreases after first few months)	*( ) 3*		
	Amenorrhea	*( ) 4*		
	Headache, dizziness and nausea	( ) 5		

	Enlargement of ovaries or enlargement of ovarian cysts	( ) 6		
	Breast tenderness and/or discharge	( ) 7		
	Acne or skin rash	( ) 8		
	Change in appetite	( ) 9		
	Weight gain	( ) 10		
	Hair loss or more hair growth on the face	( ) 11		
	Capsules must be inserted and removed by a specially trained health care provider	( ) 12		
	Some women may not want anything inserted in their arms	( ) 13		
	Some women may be bothered that implants may be seen or felt under the skin	( ) 14		
	Discomfort for several hours to 1 day after insertion for some	( ) 15		
	Others	( ) 16		
	Do not know	( ) 99		
51	**Sources of Male Sterilization?**			w51
	Provincial hospital	( ) 1	*Review questions 30 to know the next question*	
	Provincial RH center	( ) 2		
	District hospital (obstetrics)	( ) 3		
	District's family planning and nutrition unit	( ) 4		
	Commune health stations	( ) 5		
	Family planning collaborator	( ) 6		
	Private/ NGO-led clinic	( ) 7		
	Pharmacies	( ) 8		
	*Others (specify)*_____	( ) 9		
	Do not know	[ ] 99		
PART 5: FAMILY PLANNING PRACTICES **Now I would like to ask about all methods you have ever used.**				
52	Have you ever used any family planning methods?			w52
	Yes	[ ] 1	*Skip to 54*	
	No	[ ] 0		
53	Why have you never used a family planning method?			w53
	Don't know	( ) 1		
	Not interested	( ) 2		
	Religious reasons	( ) 3		
	Husband objects	( ) 4		
	Health reason	( ) 5		
	Not having sex	( ) 6	*Skip to Part 9*	
	Trying to have children	( ) 7		
	Facility is too far away	( ) 8		
	Inadequate information	( ) 9		
	Too expensive	( ) 9		
	Others (specify) ……..	( ) 10		
54	If yes, how old were you when you first used a family planning method ? (Don't remember = 99)		__ __ years	w54
56	Please tell me all the FP you have used in order		Code	w56
	a	First FP method	__ __	
	b	Second FP method	__ __	
	c	Current FP method	__ __	
	d	Immediate past FP method	__ __	

Code			
1	*Pill*	*6*	*Male sterilization*
2	*Condom*	*7*	*Female sterilization*
3	*IUD*	*8*	*Periodic abstinence*

	4 Injectable *5 Implant*	*9 Withdrawal* *10 None* *99 Not applicable*		
57	Where did you receive counseling and service provision for the first FP method?		*Review Question 56* *If only one method used, skip to Question 58.* *If 2 methods used, skip to 59.* *If 3 methods used, skip to 60.* *If method used>=4, skip to 61*	w57
	Provincial hospital	[ ] 1		
	Provincial RH center	[ ] 2		
	District hospital (obstetrics)	[ ] 3		
	District family planning and nutrition teams	[ ] 4		
	Commune health stations	[ ] 5		
	Family planning collaborator	[ ] 6		
	Private/ NGO-led clinic	[ ] 7		
	Pharmacies	[ ] 8		
	Others (specify)_____	[ ] 9		
58	***If you use only one FP method:***	**Yes**	**No**	w58
a	Before using that method, did you see a health worker or FP collaborator for counseling?	[ ]1	[ ]0 *If 0 --> 58c*	
b	Did the provider inform you of the possible side effects of the methods?	[ ]1	[ ]0	
c	Did you have enough information to make your decision?	[ ]1	[ ]0 *Finish 58d skip to Part 6*	
d	Were you able to get the method that you wanted?	[ ]1	[ ]0	
59	***If you used 2 FP methods:***	**Có**	**Không**	w59
a	Before using the first method, did you see a health worker or FP collaborator for counseling?	[ ]1	[ ]0 *Nếu 0 --> 59c*	
b	Did the provider inform you of the possible side effects of the methods?	[ ]1	[ ]0	
c	Did you have enough information to make your decision?	[ ]1	[ ]0	
d	Were you able to get the method that you wanted?	[ ]1	[ ]0	
e	How long did you use the first method (in completed months) [review Question 56a]?	__ __ months or __ __ years		
	(Don't remember,= 99)			
f	Why did you stop using that method (in Q. 56a)			
	Fertility-related reasons			
	Not having sex	( ) 1		
	Infrequent sex	( ) 2		
	Menopausal/hysterectomy	( ) 3		
	Sub-fecund/Infecund	( ) 4		
	Became pregnant (method failure)	( ) 5		
	Want (more) children	( ) 6		
	Opposition to use			
	Respondent (self) opposed	( ) 7		
	Husband opposed	( ) 8		
	Others opposed	( ) 9		
	Religious prohibition	( ) 10		
	Method-relative reasons			
	Lack of supply	( ) 11		
	Lack of side-effect management	( ) 12		
	Lack of complication management	( ) 13		
	Working hours of resupply facility are not suitable	( ) 14		
	FP service provider was not empathetic	( ) 15		

	FP service provider/facility did not maintain the confidentiality/privacy of clients	( ) 16		
	FP service provider did not inform me of the possible side effects /complications	( ) 17		
	Heath concerns	( ) 18		
	Fear of side effects	( ) 19		
	Lack of access/too far	( ) 20	*Finish, skip to Part 6*	
	Costs too much	( ) 21		
	Inconvenient to use	( ) 22		
	Interferes with body's natural processes	( ) 23		
	Others (specify) ……..	( ) 24		
60	***If you used 3 FP methods:***	**Yes**	**No**	w60
a	Before using the first method, did you see a health worker or FP collaborator for counseling?	[ ]1	[ ]0 *If 0 --> 60c*	
b	Did the provider inform you of the possible side effects of the methods?	[ ]1	[ ]0	
c	Did you have enough information to make your decision?	[ ]1	[ ]0	
d	Were you able to get the method that you wanted?	[ ]1	[ ]0	
e	How long did you use the first method (in completed months) [review Question 56a]? (Don't remember,= 9)	__ __ months or __ __ years		
f	Why did you stop the first method			
	Fertility-related reasons			
	Not having sex	( ) 1		
	Infrequent sex	( ) 2		
	Menopausal/hysterectomy	( ) 3		
	Sub-fecund/Infecund	( ) 4		
	Became pregnant (method failure)	( ) 5		
	Want (more) children	( ) 6		
	Opposition to use			
	Respondent (self) opposed	( ) 7		
	Husband opposed	( ) 8		
	Others opposed	( ) 9		
	Religious prohibition	( ) 10		
	Method-relative reasons			
	Lack of supply	( ) 11		
	Lack of side-effect management	( ) 12		
	Lack of complication management	( ) 13		
	Working hours of resupply facility are not suitable	( ) 14		
	FP service provider was not empathetic	( ) 15		
	FP service provider/facility did not maintain the confidentiality/privacy of clients	( ) 16		
	FP service provider did not inform me of possible side effects /complications	( ) 17		
	Heath concerns	( ) 18		
	Fear of side effects	( ) 19		
	Lack of access/too far	( ) 20		
	Costs too much	( ) 21		
	Inconvenient to use	( ) 22		
	Interferes with body's natural processes	( ) 23		
g	How long did you use the SECOND method (56b) [review Question 56b]?	__ __ months or __ __ years		
h	Please share your reason(s) for switching from the second method to your current method (56c)			

	Respondent opposed	( ) 1	
	Husband opposed	( ) 2	
	Others opposed	( ) 3	
	Religious prohibition	( ) 4	
	Lack of supply	( ) 5	
	Heath concerns	( ) 6	
	Fear of side effects	( ) 7	
	Lack of access/too far	( ) 8	
	Costs too much	( ) 9	
	Inconvenient to use	( ) 10	
	Interferes with body's natural processes	( ) 11	
	Unexpected pregnancy	( ) 12	
	Others: ……..…	( ) 99	
i	How many weeks between the two methods did you not use any other modern FP method?	__ __ Weeks *Skip to Part 6*	
61	***If you used 4 or more FP methods:***	**Yes** **No**	w61
a	Before using the first method, did you see a health worker or FP collaborator for counseling?	[ ]1 [ ]0 *If 0 => 61c*	
b	Did the provider inform you of the possible side effects of the methods?	[ ]1 [ ]0	
c	Did you have enough information to make your decision?	[ ]1 [ ]0	
d	Were you able to get the method that you wanted?	[ ]1 [ ]0	
e	How long did you use the first method (in completed months) [review Question 56a]? *Don't remember = 99*	__ __ months or __ __ years	
f	Why did you stop using the fist method? [56a]		
	Fertility related reasons		
	Not having sex	( ) 1	
	Infrequent sex	( ) 2	
	Menopausal/hysterectomy	( ) 3	
	Sub-fecund/Infecund	( ) 4	
	Became pregnant (method failure)	( ) 5	
	Want (more) children	( ) 6	
	Opposition to use		
	Respondent (self) opposed	( ) 7	
	Husband opposed	( ) 8	
	Others opposed	( ) 9	
	Religious prohibition	( ) 10	
	Method-relative reasons		
	Lack of supply	( ) 11	
	Lack of side-effect management	( ) 12	
	Lack of complication management	( ) 13	
	Working hours of resupply facility are not suitable	( ) 14	
	FP service provider was not empathetic	( ) 15	
	FP service provider/facility did not maintain the confidentiality/privacy of clients	( ) 16	
	FP service provider did not inform me of possible side effects /complications	( ) 17	
	Heath concerns	( ) 18	
	Fear of side effects	( ) 19	

	Lack of access/too far	( ) 20	
	Costs too much	( ) 21	
	Inconvenient to use	( ) 22	
	Interferes with body's natural processes	( ) 23	
	Others: ……	( ) 24	
g	How long did you use the second method (in completed months) [review Question 56b]? *Don't remember = 99*	__ __ __ months	
h	How long did you use your most recent previous FP method (in completed months) [review Question 56b]? *Don't remember = 99*	__ __ __ months	
i	Please share your reason(s) for switching over from your most recent previous method (56d) to current method (56c)?		
	Respondent opposed	( ) 1	
	Husband opposed	( ) 2	
	Others opposed	( ) 3	
	Religious prohibition	( ) 4	
	Lack of supply	( ) 5	
	Heath concerns	( ) 6	
	Fear of side effects	( ) 7	
	Lack of access/too far	( ) 8	
	Costs too much	( ) 9	
	Inconvenient to use	( ) 10	
	Interferes with body's natural processes	( ) 11	
	Unexpected pregnancy	( ) 12	
	Others: ……	( ) 99	
k	How many weeks between the two methods [56d] and [56c] did you not use any other modern FP methods?	__ __ Weeks	

PART 6: RECALL OF THE CURRENT / NEAREST FP SERVICE EXPERIENCES

62a	What method you are currently using?			w62a
	Cross check with Q56c	*Pill*	[ ] 1	
		Condom	[ ] 2	
		IUD	[ ] 3	
		Injectable	[ ] 4	
		Male sterilization	[ ] 5	
		Female sterilization	[ ] 6	
		Implant	[ ] 7	
		Periodic abstinence	[ ] 8	
		Withdrawal	[ ] 9	*If 62a=8, 9, 10, 11 Skip to Part 7*
		None	[ ] 10	
		Others	[ ] 11	
62b	Where did you receive consulting and FP services?			w62b
		Provincial hospital	[ ] 1	
		Provincial RH center	[ ] 2	
		District hospital (obstetrics)	[ ] 3	
		District's family planning and nutrition unit	[ ] 4	
		Commune health stations	[ ] 5	
		Family planning collaborator	[ ] 6	

	Private/ NGO-led clinic	[ ] 7		
	Pharmacies	[ ] 8		
	*Social network, friends, others*_____	[ ] 9		
63	Did you seek counseling from a health worker before using [the curent method]?			w63
	yes	[ ] 1		
	No	[ ] 0	*Skip to 71*	
	If 63=1, Finish Q 63, Crosscheck Question 62a.	*If 62a=1, skip to Q 64*		
If	*- If 62a =2, skip to 65*	*- If 62a =5, skip to 68*		
	- If 62a =3, skip to 66	*- If 62a =6,skip to 69*		
	- If 62a =4, Skip to 67	*- If 62a =7, skip to 70*		
64	Did the health service provider inform you of the following things about the pill?	**Yes**	**No**	w64
a	You can start taking 'active' pills any day. However, take the first 'active' pill (from a new packet) on the first day of next menstrual period	[ ]1	[ ]0	
b	To take one pill each day	[ ]1	[ ]0	
c	Continue taking pills for 21 consecutive days	[ ]1	[ ]0	
d	Wait 7 days before starting to take pills again	[ ]1	[ ]0	*Skip to 71*
e	If forgotten, take pill as soon as remembered	[ ]1	[ ]0	
f	It is best to take the pills at the same time each day	[ ]1	[ ]0	
g	If side effects/complications arise visit nearest facility/provider immediately	[ ]1	[ ]0	
65	Did the health service provider inform you of the following things about condoms?	Yes	No	w65
a	How to correctly put on condoms	[ ]1	[ ]0	
b	Condom should be taken off without spilling semen	[ ]1	[ ]0	
c	Dispose the condom in a pit latrine, burn, or bury	[ ]1	[ ]0	
d	Not to use a condom more than once	[ ]1	[ ]0	*Skip to 71*
e	If a condom breaks, use emergency contraceptive pill	[ ]1	[ ]0	
f	Instructed on taking emergency contraceptive pills	[ ]1	[ ]0	
66	Did the health service provider inform you of the following things about IUDs?	**Yes**	**No**	w66
a	Instructed return visit after next menstrual period or in 3 to 6 weeks	[ ]1	[ ]0	
b	Perform check up, pelvic examination, and make sure IUD is in place	[ ]1	[ ]0	
c	Instructed you on how to check IUD	[ ]1	[ ]0	
d	Suggested checking to make sure the IUD is in place after menstrual period	[ ]1	[ ]0	
e	Suggested checking that IUD is in place after noticing any possible symptoms of serious problems	[ ]1	[ ]0	*Skip to 71*
g	Informed of any possible symptoms of serious problems while using an IUD	[ ]1	[ ]0	
h	Inform you of the kind of IUD you have	[ ]1	[ ]0	
i	When to remove or replace your IUD	[ ]1	[ ]0	
k	If side effects/complications arise visit nearest facility/provider immediately	[ ]1	[ ]0	
67	Did the health service provider inform you of the following things about injectables?	**Yes**	**No**	w67

a	To come back on time (determine next date) for next injection if possible	[ ]1	[ ]0		
b	If not exactly on date, a day within two weeks early or later is acceptable	[ ]1	[ ]0	*Skip to 71*	
c	After two weeks of determined date you should use condom or avoid having sex until next injection	[ ]1	[ ]0		
e	If side effects/complications arise visit nearest facility/provider at earliest	[ ]1	[ ]0		
68	Did the health service provider inform you of the following things about male sterilization?	**Yes**	**No**		w68
a	To use condoms or another effective family planning method for at least the next 20 ejaculations or 3 months after the procedure—whichever comes first	[ ]1	[ ]0		
b	To rest for 2 days	[ ]1	[ ]0		
c	To keep the incision clean for 2 days	[ ]1	[ ]0	*Skip to 71*	
d	Return for follow up within 7 days to remove stitches	[ ]1	[ ]0		
e	A health worker should examine the incision site	[ ]1	[ ]0		
g	If side effects/complications arise visit nearest facility/provider immediately	[ ]1	[ ]0		
69	Did the health service provider inform you of the following things about female sterilization?	**Yes**	**No**		w69
a	To rest for 2-3 days	[ ]1	[ ]0		
b	To keep incision clean and dry for 2-3 days	[ ]1	[ ]0		
c	To be careful not to rub or irritate the incision for a week	[ ]1	[ ]0		
d	To not have sex within 1 week of procedure	[ ]1	[ ]0		
e	Return for follow up within 7 days to remove stitches	[ ]1	[ ]0	*Skip to 71*	
g	Informed about ectopic pregnancy risk	[ ]1	[ ]0		
h	If side effects/complications arise visit nearest facility/provider immediately	[ ]1	[ ]0		
70	Did the health service provider inform you of the following things about implants?	**Yes**	**No**		w70
a	Keep the incision area dry for 4 days	[ ]1	[ ]0		
b	Can take off gauze after 2 days and adhesive bandage after 5 days	[ ]1	[ ]0		
c	Informed of probable swelling and bruising for first few days	[ ]1	[ ]0		
d	Told you to see a nurse or doctor if capsules come out	[ ]1	[ ]0	*Skip to 71*	
e	Instructed you to come back for a follow up visit	[ ]1	[ ]0		
f	Visit health facility to discontinue implant use	[ ]1	[ ]0		
g	If side effects/complications arise, visit nearest facility immediately	[ ]1	[ ]0		
71	How long have you been using your CURRENT method (56c)?	__ __ months		or __ __ years	w71
72	Did you seek any health care for complications/side effects?				w72
	Yes	[ ] 1	*Skip to 76*		
	No	[ ] 0			
	No side effects	[ ] 99	*Skip to 78*		
73	Why did you not seek care?				w73
	The complications/side effects were minor; the provider was properly notified about complications/side effects			( ) 1	
	The complications resolved on their own; but the provider was not properly notified			( ) 2	
	Too far away			( ) 3	
	Service too expensive			( ) 4	

	Working hours (schedule) of facility are not suitable	( ) 5		
	Husband opposed	( ) 6		
	Did not understand what to do	( ) 7		
	Work load (working women)	( ) 8		
	Have slight infections but felt it was unnecessary to go for a check	( ) 9		
	Other (specify)……..	( ) 10		
74	If the symptom has not improved, have you visited any FP facilities to getting relief from side effect/complication?			w74
	Yes	[ ] 1	*Skip to 76*	
	No	[ ] 0		
75	Why not?			w75
	Working hours (schedule) of resupply facility are not suitable	( ) 1		
	FP service provider is not empathetic	( ) 2		
	FP service provider/facility do not maintain the confidentiality/ privacy of clients	( ) 3		
	FP service provider does not inform me of the possible side effects /complications	( ) 4	*Skip to 81*	
	Too far	( ) 5		
	Too expensive	( ) 6		
	Privacy reasons	( ) 7		
	Others (specify) ……..	( ) 8		
76	Where did you go?			w76
	Provincial hospital	[ ] 1		
	Provincial RH center	[ ] 2		
	District hospital (obstetrics)	[ ] 3		
	District family planning and nutrition unit	[ ] 4		
	Commune health stations	[ ] 5		
	Family planning collaborator	[ ] 6		
	Private/ NGO-led clinic	[ ] 7		
	Pharmacies	[ ] 8		
	Others_____	[ ] 9		
77	Who did you visit?			w77
	Doctor	[ ] 1		
	Doctor's assistant	[ ] 2		
	Midwife	[ ] 3		
	Nurse	[ ] 4		
	Family planning counselor	[ ] 5		
	Family planning collaborator	[ ] 6		
	Population-family planning specialized staff/officers	[ ] 6		
	Others: _____	[ ] 7		
	Don't know	[ ] 99		
78	How long does it take to reach the nearest family planning service facility provider using your usual mode of travel?	__ __ __ minutes		w78
79	Did you receive the services you sought last time you visited an FP service facility provider?			w79
	Yes	[ ] 1	*Skip to 81*	
	No	[ ] 0		
80	If no, why?			w80
	Working hours (schedule) of resupply facility are not suitable	( ) 1	*Finis 80, Check 62b*	
	FP service provider was not empathetic	( ) 2		

	FP service provider/facility does not maintain the confidentiality/privacy of clients	( ) 3	*If 62b=1-5 & 7, skip to 81*	
	FP service provider did not inform me of possible side effects /complications	( ) 4	*If 62b= 6 skip to 88*	
	Too far	( ) 5	*If 62b=8, 9 skip to 93*	
	Too expensive	( ) 6		
	Privacy reasons	( ) 7		
	Others: ……	( ) 8		
81	How long did you have to wait before you saw the provider during your last visit?	__ __ __ minutes *Don't remember = 99*		w81
82	Was the waiting area comfortable?	**Yes** [ ]1	**No** [ ]0	w82
83	Did you see any FP-related informational material there?	[ ]1	[ ]0 *If 0, Skip to 88*	w83
84	What type of FP-related informational material did you see there?			w84
	Leaflet	( ) 1		
	Flip chart	( ) 2		
	Wall chart	( ) 3		
	Model	( ) 4		
	Poster	( ) 5		
	Audio visual/Video	( ) 6		
	Others (specify) ……..	( ) 7		
		Yes	**No** **Don't remember**	w85
85	Was there any educational material on HIV/AIDS/STIs?	[ ]1	[ ]0 [ ] 9	
86	Do you consider the FP materials to be sufficiently informative?	[ ]1	[ ]0 [ ] 9	w86
87	Do you consider those materials to be easily understandable?	[ ]1	[ ]0 [ ] 9	w87
87,5	Did you find the provider to be empathetic?	[ ]1	[ ]0 [ ] 9	w88
89	Did the provider listen to you when you discussed the purpose of your visit?	[ ]1	[ ]0 [ ] 9	w89
90	Did the provider ask you any supplementary questions?	[ ]1	[ ]0 [ ] 9	w90
91	Did the provider give you choices /options that serve your purpose?	[ ]1	[ ]0 [ ] 9	w91
92	Did the provider explain the positive and negative aspects of the options?	[ ]1	[ ]0 [ ] 9	w92
93	If your last visit (within the past 6 months) was related to selecting a new FP method (first/ switching over to another), did the provider ask you any screening questions?			
	Yes	[ ] 1		w93
	No	[ ] 0		
	Not applicable	**[ ] 99**	*Skip to 96*	
94	What did the provider ask you and/or inspect for before suggesting or providing any family planning method?	**Yes**	**No** **Don't remember**	w94
	Age	[ ]1	[ ]0 [ ]9	
	Height-weight measurement/overweight /obesity	[ ]1	[ ]0 [ ]9	
	Pregnancy history and family history	[ ]1	[ ]0 [ ]9	
	Menstruation status	[ ]1	[ ]0 [ ]9	
	Pregnancy status	[ ]1	[ ]0 [ ]9	
	Pregnancy outcome	[ ]1	[ ]0 [ ]9	
	Post-pregnancy status (postpartum/post abortion etc.)	[ ]1	[ ]0 [ ]9	
	Postpartum status	[ ]1	[ ]0 [ ]9	
	Health and medication status	[ ]1	[ ]0 [ ]9	
	Smoking status	[ ]1	[ ]0 [ ]9	
	Blood pressure check	[ ]1	[ ]0 [ ]9	
	History of high blood pressure	[ ]1	[ ]0 [ ]9	

	Drug interaction	[ ]1	[ ]0	[ ]9	
	Diabetes	[ ]1	[ ]0	[ ]9	
	Cardiovascular disease	[ ]1	[ ]0	[ ]9	
	Surgical history	[ ]1	[ ]0	[ ]9	
	Thromboembolic disorder	[ ]1	[ ]0	[ ]9	
	History of stroke	[ ]1	[ ]0	[ ]9	
	24. Gallbladder problems	[ ]1	[ ]0	[ ]9	
	25. Hepatic Virus	[ ]1	[ ]0	[ ]9	
	26. Cirrhosis	[ ]1	[ ]0	[ ]9	
	27.Cholestasis (jaundice)	[ ]1	[ ]0	[ ]9	
	28. Hepatic cancer	[ ]1	[ ]0	[ ]9	
	Anemia	[ ]1	[ ]0	[ ]9	
	Sickle cell disease	[ ]1	[ ]0	[ ]9	
	31. Schistosomiasis	[ ]1	[ ]0	[ ]9	
	Migrane history	[ ]1	[ ]0	[ ]9	
	Status/Medical history of the genitals and contraceptives usage	[ ]1	[ ]0	[ ]9	
	Vaginal bleeding patterns	[ ]1	[ ]0	[ ]9	
	History/status of breast cancer	[ ]1	[ ]0	[ ]9	
	History/status of cervical cancer	[ ]1	[ ]0	[ ]9	
	History/status of ovarian cancer	[ ]1	[ ]0	[ ]9	
	Pelvic inflammatory disease	[ ]1	[ ]0	[ ]9	
	Sexually transmitted diseases	[ ]1	[ ]0	[ ]9	
	HIV infection/AIDS	[ ]1	[ ]0	[ ]9	
	Others	[ ]1	[ ]0	[ ]9	
95	Did the servce provider counsel you on HIV/AIDS/STIs?	[ ]1	[ ]0	[ ]9	w95
96	In last 6 months, did an FP/ population collabrator visit you at home?				w96
	Yes	[ ] 1			
	No	[ ] 0	*Skip to 98*		
	Don't know	[ ] 99	*Skip to 98*		
97	If yes, what did they discuss with you? *Birth interval*	( ) 1			w97
	Benefits of birth control	( ) 2			
	FP methods	( ) 3			
	Breastfeeding	( ) 4			
	Introduction to each method	( ) 5			
	Source of FP provision	( ) 6			
	Promote IUD use, advise visiting a facility for FP checkups	( ) 7			
	Remind about follow-up visit schedule	( ) 8			
	Others	( ) 9			
PART 7: SATISFACTION					
98	Are you satisfied / did you feel that you received the best family planning method suitable for you?				w120
	Yes	[ ] 1	*SEE INSTRUCTIONS BELOW FOR THE NEXT QUESTION*		
	No	[ ] 0			
	Don't know	[ ] 99			
	If *- 62a=8, 9, 10 & 98=1 --> Skip to Part 8*	*- 62a=1 to 7 & 63=1 & 98=1, skip to 100*			
	- 62a=8,9,10 & 98=0/99,ask Q 99 & skip to P 8	*- 62a=1 to 7 & 63=0 & 98=1 Skip to Part 8*			
99	Why are you not satisfied?				w121

	I was interested in a different method	( ) 1	
	The provider did not explain the options to me properly	( ) 2	
	I did not understand the provider's explanations properly	( ) 3	
	The provider did not spend enough time with me	( ) 4	
	The provider did not listen to my history properly	( ) 5	
	The suggested method is too expensive for me	( ) 6	
	The provider did not convince me that the method I asked for is not suitable for me	( ) 7	
	The provider did not convince me that the method s/he suggested asked is suitable for me	( ) 8	
	Other (specify) ……..	( ) 9	
100	Did the provider talk to you about a follow-up visit?		w122
	Yes	[ ] 1	
	No	[ ] 0	
101	Did you pay for the service? *Yes*	[ ] 1	w101
	No	[ ] 0 *Skip to 104*	
102	If yes, how would you rate the payment for services? *(don't remember= 99)*	__. __ __ __.__ __ __VND	w102
103	Considering all costs (direct, travel time, wage/earning loss) how do you rank it?		w103
	Very expensive	[ ] 1	
	Expensive	[ ] 2	
	Acceptable	[ ] 3	
	Cheap	[ ] 4	
	Cost almost nothing	[ ] 5	
104	Considering the commute time, waiting time, time spent with facility/provider, how long did you have to spend during your LAST VISIT for receiving family planning services?	__ __ __ minutes *Don't remember [ ] 99*	w104
105	Have you ever encountered a male family planning service provider?		w105
	Yes	[ ] 1	
	No	[ ] 0 *Skip to 107*	
106	Were you comfortable discussing family planning methods/problems with the male service provider?		w106
	Yes	[ ] 1	
	No	[ ] 0	
107	Are you satisfied with the quality of service?		w107
	Very satisfied	[ ] 1	
	Satisfied	[ ] 2	
	Somehow	[ ] 3	
	Needs to improve the quality	[ ] 4	
	Not satisfied	[ ] 5	
108	Will you suggest the facility where you went last time to your friends/ neighbors?		w108
	Maybe	[ ] 2	
	Certainly, Yes	[ ] 1	
	No	[ ] 0	
PART 8: METHOD FAILURE			
109	Have you ever experienced unplanned pregnancy while you were using an FP method?		w109
	Yes	[ ] 1	
	No	[ ] 0 *Skip to Part 9*	
110	How many times (in your lifetime) have you experienced unplanned pregnancy?		w110
	One	[ ] 1	
	Twice	[ ] 2	

	More than twice	[ ] 3	
111	What method you were using when you last experienced an unplanned pregnancy?		w111
	Pill	[ ] 1	
	Condom	[ ] 2	
	IUD	[ ] 3	
	Injectable	[ ] 4	
	Male sterilization	[ ] 5	
	Female sterilization	[ ] 6	
	Implant	[ ] 7	
	Periodic abstinence	[ ] 8	
	Withdrawal	[ ] 9	
112	Did you continue to use that method afterwards?		w112
	Yes	[ ] 1	
	No	[ ] 0	

PART 9: FAMILY PLANNING SERVICES AND MEDIA

Have you ever heard of FP methods through the communications channels below?	Noticed any planning related information (ever)	When was the last time you noticed such information (Code)	Were those materials sufficiently informative?	Were the materials easily understandable?
	Yes=1; No=0		***Yes=1; No=0***	***Yes=1; No=0***
Paper-based newspaper / magazine/journal	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
Internet / social network	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
Loudspeaker / poster / leaflet	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
Radio	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
Television	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
FP collaborator / VHW	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
Private + NGO clinic's HWs	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
Public facility's health worker	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0
Interpersonal	[ ]1 [ ]0	____	[ ]1 [ ]0	[ ]1 [ ]0

***1** = 2 weeks;* ***2** = 3-4 weeks ;* ***3** = 1-3 months ;* ***4** = 3-6 months ;*
***5** = 7-12 months ;* ***6** = more than 1 year;* ***7** = don't remember*

***** CHECK THE QUESTIONNAIRE & THANK THE RESPONDENT* Note**

ANNEX D:

LIST OF SURVEYED SITES AND CODING

Province	District	Commune / Precinct
1. HÀ NỘI	1. Quận Hai Bà Trưng	1. Phường Phạm Đình Hổ
		2. Phường Đồng Nhân
		3. Phường Thanh Nhàn
		4. Phường Vĩnh Tuy
		5. Phường Minh Khai
	2. Huyện Phúc Thọ	6. Xã Sen Chiểu
		7. Xã Long Xuyên
		8. Xã Thanh Đa
		9. Xã Phụng Thượng
		10. Xã Liên Hiệp
	3. Huyện Đan Phượng	11. Xã Thọ An
		12. Xã Liên Hồng
		13. Xã Liên Trung
		14. Xã Tân Hội
		15. Xã Đông Tháp
	4. Huyện Thanh Trì	16. Thị trấn Văn Điển
		17. Xã Tả Thanh Oai
		18. Xã Tứ Hiệp
		19. Xã Ngũ Hiệp
		20. Xã Vạn Phúc
2. YÊN BÁI	1. Thành phố Yên Bái	1. Phường Yên Ninh
		2. Phường Đồng Tâm
		3. Phường Hợp Minh
		4. Xã Minh Bảo
		5. Xã Tân Thịnh.
	2. Thị xã Nghĩa Lộ	6. Phường Trung Tâm
		7. Phường Tân An
		8. Phường Cầu Thìa
		9. Xã Nghĩa Lợi
		10. Xã Nghĩa Phúc
	3. Huyện Văn Chấn	11. Xã Tú Lệ
		12. xã Nậm Lành
		13. xã Nghĩa Sơn
		14. xã Thạch Lương
		15. xã Bình Thuận
	4. Huyện Văn Yên	16. Xã Châu Quế Thượng
		17. Xã Đông Cuông
		18. Xã Tân Hợp
		19. Xã Đại Sơn
		20. Xã Hoàng Thắng

Province	District	Commune / Precinct
3. PHÚ YÊN	1. Thành phố Tuy Hòa	1. Phường 8
		2. Phường 3
		3. Phường 7
		4. Phường Phú Đông
		5. Xã Bình Kiến
	2. Thị xã Sông Cầu	6. Phường Xuân Phú
		7. Phường Xuân Thành
		8. Xã Xuân Lộc
		9. Xã Xuân Hòa
		10. Xã Xuân Thịnh
	3. Huyện Sông Hinh	11. Xã Ea Lâm
		12. Xã Ea Bá
		13. Xã Đức Bình Đông
		14. Xã Ea Bia
		15. Xã Sông Hinh
	4. Huyện Sơn Hòa	16. Xã Sơn Định
		17. Xã Cà Lúi
		18. Xã Sơn Xuân
		19. Xã Echa Rang
		20. Xã Suối Bạc
4.DAK LAK	1. Thành phố Buôn Ma Thuột	1. Phường Thống Nhất
		2. Phường Thành Công
		3. Phường Ea tam
		4. Phường Ea tu
		5. Xã Hòa Khánh
	2. Huyện Ea súp	6. Xã Ia lốp
		7. Xã Ea Rok
		8. Xã Ia rve
		9. Xã Cư Kbang
		10. Xã Cư Mlan
	3. Huyện Krông Buk	11. Xã Cư Né
		12. xã Chư Kbo
		13. xã Cư Pơng
		14. xã Ea sin
		15. xã Pơng Drang
	4. Huyện M drắk	16. Xã Ea Pil
		17. Xã Ea H'Mlay
		18. Xã Ea m'doal
		19. Xã Cư m'ta
		20. Xã Krông Á

Province	District	Commune / Precinct
5. ĐỒNG NAI	1. Thành phố Biên Hòa	1. Phường Tân Hòa
		2. Phường Quang Vinh
		3. Phường Quyết Thắng
		4. Phường Tân Vạn
		5. Xã Phước Tân
	2. Huyện Tân Phú	6. Xã Phú Lâm
		7. Xã Tà Lài
		8. Xã Phú Thịnh
		9. Xã Phú Xuân
		10. Xã Phú Bình
	3. Huyện Vĩnh Cửu	11. Xã Trị An
		12. Xã Vĩnh Tân
		13. Xã Thanh Phú
		14. Xã Tân Bình
		15. Xã Mã Đà
	4. Huyện Trảng Bom	16. Xã Thanh Bình
		17. Xã Sông Thao
		18. Xã Bắc Sơn
		19. Xã Bình Minh
		20. Xã Hưng Thịnh
6. AN GIANG	1. Thành phố Long Xuyên	1. Phường Đồng Xuyên
		2. Phường Bình Đức
		3. Phường Mỹ Phước
		4. Phường Mỹ Thới
		5. Phường Mỹ Hà
	2. Huyện Tri Tôn	6. Xã Lạc Quới
		7. Xã Vĩnh Phước
		8. Xã Lương An Trà
		9. Xã An Tức
		10. Xã Ô Lâm
	3. Huyện Châu Phú	11. Xã Khánh Hòa
		12. xã Mỹ Phú
		13. xã Vĩnh Thạnh Trung
		14. xã Bình Long
		15. xã Bình Thủy
	4. Thị xã Tân Châu	16. Phường Long Châu
		17. Xã Vĩnh Xương
		18. Xã Tân Thạnh
		19. Xã Long An
		20. Xã Châu Phong

ANNEX E:

DATA TABLES

Tables of Contents

Annex Tables: Chapter 4

Table 4.1: Percentage distribution of the women by knowledge of family planning method

Background characteristics	Ever heard of FP	Oral pill	Condom	IUD	Injectables	Male sterilization	Female sterilization	Implant	Periodic abstinence	Withdrawal	Others	NR	N
Residence													
Urban	95.4	66.0	64.3	64.5	15.9	7.3	11.8	11.7	17.5	22.4	0.8	0.4	1677
Rural	97.0	70.5	56.2	66.4	21.1	3.3	10.2	8.0	12.2	18.1	0.1	0.0	4321
Region													
Red River Delta	99.4	73.5	73.6	74.6	14.7	3.5	5.2	12.5	12.5	15.4	0.9	0.1	1002
North Mountains	97.8	72.4	67.0	80.2	16.6	5.0	17.9	9.3	16.6	18.9	0.1	0.0	1000
North and South Central Coast	94.9	53.8	49.8	55.1	17.5	3.0	5.8	7.4	7.8	17.1	0.0	0.1	993
Central Highland	96.2	69.7	61.2	71.2	32.1	9.5	18.0	11.8	15.9	26.3	0.4	0.0	998
Southeastern Region	97.7	69.1	58.3	58.4	18.3	5.0	9.0	9.1	21.7	25.0	0.1	0.2	1006
Mekong Delta	93.2	76.9	40.8	56.0	18.6	0.6	7.8	3.7	7.6	13.5	0.2	0.2	999
Ethnicity													
Kinh	96.8	69.4	60.6	66.1	17.6	4.7	9.7	9.8	14.9	20.0	0.3	0.1	4658
Ethnic	95.7	68.7	51.2	65.1	26.6	3.4	14.0	6.3	9.6	16.9	0.2	0.0	1340
Understanding Vietnamese language													
Very well	96.6	68.8	59.7	66.2	18.1	4.4	10.1	9.2	14.5	20.1	0.3	0.1	5552
A little	97.5	75.3	48.5	64.8	39.6	3.9	18.3	6.1	4.7	11.9	0.0	0.0	361
Not at all	90.2	65.9	19.5	50.0	36.6	2.4	13.4	3.7	0.0	2.4	1.2	0.0	82
Years of schooling													
0	93.4	63.6	29.8	57.1	24.8	0.9	14.4	3.4	3.8	11.3	0.3	0.0	319
1-5	95.8	64.0	45.4	64.2	17.9	1.4	8.4	3.5	9.3	15.9	0.1	0.1	1189
6-10	96.5	68.1	56.8	67.6	18.2	3.2	9.2	7.0	13.0	18.6	0.2	0.0	2345
11 and above	97.8	74.5	75.5	66.8	21.1	7.8	12.1	16.0	19.6	24.3	0.6	0.2	1833
All	96.5	69.2	58.5	65.9	19.6	4.4	10.6	9.0	13.7	19.4	0.3	0.1	5998

Table 4.2: Percentage distribution of the women by knowledge of 5 important advantages of modern family planning methods they heard of

Background characteristics	Oral pill		Condom		IUD		Injectables		Male sterilization		Female sterilization		Implant	
	Percentage	n (applicable)	Percentage	n (applicable)	Percentage	n (applicable)	Percentage	n (applicable)	Percentage	n (applicable)	Percentage	n (applicable)	Percentage	n (applicable)
Residence														
Urban	71.6	1106	76.2	1078	77.2	1082	65.7	266	65.0	123	67.7	198	56.1	197
Rural	68.0	3046	69.4	2430	73.5	2870	63.5	913	58.3	142	65.5	440	43.9	344
Region														
Red River Delta	53.7	736	67.6	737	68.3	747	52.0	147	42.9	35	67.3	52	35.2	125
North Mountains	74.0	724	73.6	670	81.4	802	46.4	166	52.0	50	57.2	179	43.0	93
North and South Central Coast	79.6	534	78.4	495	73.9	547	64.9	174	73.3	30	74.1	58	43.8	73
Central Highland	76.7	696	81.5	611	79.9	711	80.7	320	81.1	95	82.2	180	75.8	118
Southeastern Region	67.5	695	69.0	587	76.4	588	61.6	184	42.0	50	53.3	91	40.2	92
Mekong Delta	65.8	768	55.1	408	64.8	559	61.8	186	42.9	6	58.2	78	45.9	37
Ethnicity														
Kinh	67.6	3232	70.9	2822	73.1	3079	62.6	820	58.2	221	66.9	451	46.8	455
Ethnic	73.6	920	73.9	686	79.5	873	67.0	356	76.6	46	64.4	187	56.5	85
Understanding Vietnamese														
Very well	68.1	3822	71.1	3313	73.8	3678	62.1	1003	59.7	247	67.9	558	46.9	509
A little	78.3	272	76.6	175	84.6	234	69.2	143	80.0	14	51.5	66	73.9	22
Not at all	81.5	54	87.5	16	80.5	41	96.7	30	100.0	2	54.5	11	66.7	3
Years of schooling														
0	68.0	203	70.5	95	75.8	182	73.4	79	50.0	4	60.9	46	63.6	11
1-5	67.8	761	63.9	540	75.2	763	62.1	213	47.1	17	60.8	100	42.9	42
6-10	66.6	1596	67.2	1331	72.5	1585	59.4	426	54.7	75	63.9	215	43.6	163
11 and above	71.0	1366	78.2	1384	76.0	1225	64.6	387	62.9	143	68.6	222	49.3	294
All	69.0	4151	71.5	3509	74.5	3955	64.0	1175	61.4	266	66.1	637	48.3	538

Table 4.3: Percentage distribution of the women by knowledge of 5 important disadvantages of modern family planning methods they heard of

Background characteristics	Oral pill	N	Condom	N	IUD	N	Injectables	N	Male sterilization	N	Female sterilization	N	Implant	N
Residence														
Urban	50.2	1106	57.2	1078	62.7	1082	54.1	266	36.6	123	36.4	198	41.4	197
Rural	42.1	3046	48.5	2430	59.6	2870	47.7	913	20.3	142	30.5	440	28.7	344
Region														
Red River Delta	33.7	736	45.6	737	57.7	747	27.3	147		35	3.8	52	21.6	125
North Mountains	56.6	724	61.0	670	78.1	802	32.9	166	22.0	50	31.8	179	32.3	93
North and South Central Coast	47.7	534	52.5	495	58.9	547	46.6	174	16.7	30	22.4	58	30.1	73
Central Highland	58.9	696	68.1	611	69.6	711	69.9	320	56.8	95	60.0	180	56.7	118
Southeastern Region	37.1	695	43.1	587	49.7	588	41.6	184	8.0	50	7.7	91	27.2	92
Mekong Delta	33.6	768	29.9	408	39.9	559	55.1	186		6	24.4	78	21.6	37
Ethnicity														
Kinh	39.8	3232	49.1	2822	57.2	3079	46.3	820	21.8	221	29.0	451	31.4	455
Ethnic	59.8	920	59.6	686	71.8	873	55.7	356	56.5	46	40.1	187	43.5	85
Understanding Vietnamese														
Very well	42.1	3822	50.5	3313	59.5	3678	46.8	1003	24.2	247	30.6	558	31.4	509
A little	67.3	272	62.3	175	74.4	234	59.4	143	71.4	14	37.9	66	69.6	22
Not at all	75.9	54	75.0	16	63.4	41	73.3	30	100.0	2	63.6	11	33.3	3
Years of schooling														
0	50.7	203	47.4	95	65.4	182	55.7	79	33.3	4	39.1	46	45.5	11
1-5	42.6	761	43.3	540	58.6	763	50.2	213	35.3	17	33.0	100	31.0	42
6-10	41.7	1596	45.8	1331	59.0	1585	46.7	426	28.0	75	27.0	215	30.1	163
11 and above	47.3	1366	59.5	1384	64.1	1225	45.2	387	20.3	143	30.9	222	33.3	294
Total	44.3	4151	51.2	3509	60.4	3955	49.1	1175	27.8	266	32.3	637	33.3	538

Table 4.4: Percentage distribution of married women by ever use of family planning methods

Background characteristics	Any method		Modern methods								Traditional methods			
	Any FP method	N	Any modern FP method	Oral pill	Condom	IUD	Injectables	Feale sterilization	Male sterilization	Implant	Any Traditional method	Periodic abstinence	Withdrawal	N
Residence														
Urban	94.8	1572	89.1	36.2	33.5	41.3	2.1	1.3		3.5	24.0	8.3	16.9	1490
Rural	94.7	4073	88.6	37.6	22.0	50.9	6.3	1.0	0.1	4.1	26.0	8.2	18.9	3857
Region														
Red River Delta	94.4	967	93.0	29.6	44.8	52.7	0.7	0.4		1.6	21.8	9.2	14.5	912
North Mountains	89.2	1006	93.6	38.0	22.1	61.5	3.6	1.2	0.2	7.7	22.4	7.4	16.1	897
North and South Central Coast	96.3	890	83.2	29.9	20.1	45.6	5.7	1.5		2.2	29.2	7.2	23.2	857
Central Highland	97.1	888	93.3	31.1	23.0	56.8	11.7	1.2		5.1	18.7	2.4	16.6	862
Southeastern Region	95.7	976	75.9	33.5	24.4	33.2	2.8	0.7		2.1	38.8	17.5	23.7	934
Mekong Delta	95.9	923	93.8	61.0	16.0	40.2	6.8	1.4		4.7	21.1	5.0	16.2	885
Ethnicity														
Kinh	95.1	4417	87.3	35.0	27.5	46.8	3.7	1.1	0.0	3.3	27.9	9.8	19.5	4200
Ethnic	93.3	1230	93.9	45.3	16.7	53.6	10.5	.9	0.1	6.1	16.4	2.6	14.4	1147
Understanding Vietnamese														
Very well	94.7	5244	88.2	35.5	26.3	48.3	4.2	1.1	0.0	3.8	26.6	8.8	19.0	4966
A little	94.9	331	96.5	59.6	12.1	51.0	16.6	1.3		4.5	10.5	.3	10.2	314
Not at all	96.9	67	93.8	56.3	1.6	32.8	20.3			9.4	10.9	1.6	9.4	64
Years of schooling														
0	95.7	289	93.8	50.4	8.7	57.6	14.1	1.4		10.1	17.0	1.4	15.6	276
1-5	96.1	1139	88.8	42.2	15.1	53.6	8.3	.6		5.7	27.0	8.1	19.4	1094
6-10	94.5	2236	88.5	36.0	21.3	53.0	3.9	1.0	0.1	3.2	25.3	7.7	18.7	2113
11 and above	94.1	1700	87.6	32.2	41.3	37.7	2.6	1.4		2.1	27.0	10.7	18.3	1599
All	94.7	5647	88.7	37.2	25.2	48.2	5.1	1.1	0.0	4.0	25.4	8.2	18.4	5347

Table 4.5: Percentage distribution of the women by causes of non-use of family planning method

Background characteristics	Don't know	Not interested	Religious reasons	Husband objects	Health reason	Not having sex	Interested in children	Facility far away	In-adequate information	Others	No response	N
Residence												
Urban	7.6	25.2	7.6	4.2	11.8	9.2	48.7		.8	9.2	4.2	119
Rural	6.1	10.3	.6	1.2	12.2	7.6	47.1	.3	.6	20.4	4.6	329
Region												
Red River Delta	3.7	17.1			7.3	3.7	54.9		1.2	26.8	2.4	82
North Mountains	6.3	8.8	1.3	1.3	13.8	11.3	45.0		1.3	18.8	7.5	80
North and South Central Coast	5.9	8.2			15.3	10.6	51.8			7.1	2.4	85
Central Highland	8.2	23.7	1.0	5.2	11.3	7.2	45.4			21.6		97
Southeastern Region	2.2	11.1	20.0	2.2	15.6	2.2	53.3			8.9	4.4	45
Mekong Delta	11.9	13.6		3.4	10.2	11.9	33.9	1.7	1.7	16.9	13.6	59
Ethnicity												
Kinh	5.1	15.0	3.5	1.3	12.7	5.1	49.7	.3	.6	19.1	3.5	314
Ethnic	9.7	12.7		3.7	10.4	14.9	42.5		.7	13.4	6.7	134
Understanding Vietnamese												
Very well	5.0	14.0	2.8	1.0	12.3	6.8	50.6	.3	.8	17.5	3.8	399
A little	17.9	17.9		12.8	12.8	17.9	25.6			15.4	5.1	39
Not at all	20.0	10.0				20.0	10.0			20.0	30.0	10
Years of schooling												
0	9.1	18.2		4.5	22.7	22.7	27.3			13.6	4.5	22
1-5	8.3	8.3	2.1	4.2	16.7	14.6	39.6			16.7	4.2	48
6-10	7.7	19.4	1.9	2.6	12.3	7.7	41.3		1.3	19.4	5.2	155
11 and above	3.6	11.3	3.6	1.0	10.3	4.1	60.8		.5	15.5	3.1	194
All	6.5	14.3	2.5	2.0	12.1	8.0	47.5	.2	.7	17.4	4.5	448

Table 4.6: Percentage distribution of service providers interviewed by possible reasons behind low acceptance of pill

Background characteristics	Not always available in FP clinic	Need to take daily	To avoid post pill amenor-rhea	May decrease breast milk	May increase weight	Drop hemorrhage between two menstrual period	Risk of becoming infertile for whole life	Use other contraception	N
Residence									
Urban	8.3	8.3	16.7		20.8	12.5	29.2	16.7	24
Rural		8.0	4.0	2.0	10.0	8.0	14.0	18.0	50
Region									
Red River Delta		8.3	16.7	8.3	16.7	8.3	8.3	25.0	12
North Mountains	6.3						6.3	25.0	16
North and South Central Coast		20.0	20.0		40.0	20.0		40.0	5
Central Highland	9.1	9.1	9.1		18.2	9.1	18.2	9.1	11
Southeastern Region		15.8	10.5		15.8	10.5	21.1	10.5	19
Mekong Delta					9.1	18.2	54.5	9.1	11
Position of FP Service providers									
Obs./Gyn. doctor		16.7	33.3		33.3	33.3	50.0		6
Assistant Doctor in Obs. and Pediatrics			11.1				22.2	22.2	9
Midwife	1.8	7.1	3.6	1.8	12.5	7.1	16.1	17.9	56
General practitioner been trained in FP, MVA, coun-seling	33.3	33.3	33.3		33.3	33.3		33.3	3
All	2.7	8.1	8.1	1.4	13.5	9.5	18.9	17.6	74

Table 4.7: Percentage distribution of service providers interviewed by possible reasons behind low acceptance of condom

Background characteristics	Not always available in FP clinic	Do not know how to use condom	Allergy to condom	Need to use during every sex	To collect or buy condom is shameful	Decrease feeling during sex	Interruption during sexual activities	Male are not that much cooperative	Need to be ready to hand in-spite of not having sex	N
Residence										
Urban	21.1		10.5		5.3	36.8		36.8		19
Rural		2.1	8.5	2.1	12.8	27.7	6.4	36.2	6.4	47
Region										
Red River Delta			14.3			14.3		14.3		7
North Mountains				5.9	5.9	17.6		29.4	11.8	17
North and South Central Coast		14.3	14.3		14.3	57.1	14.3	28.6	14.3	7
Central Highland	18.2		9.1		9.1	27.3		45.5		11
Southeastern Region	22.2		22.2		11.1	33.3		55.6		9
Mekong Delta			6.7		20.0	40.0	13.3	40.0		15
Position of FP Service providers										
Obs./Gyn. doctor	33.3		33.3			33.3		66.7	16.7	6
Assistant Doctor in Obs. and Pediatrics			11.1	11.1		33.3	22.2	22.2	11.1	9
Midwife	2.1	2.1	4.3		14.9	27.7	2.1	31.9	2.1	47
General practitioner been trained in FP, MVA, counseling	25.0		25.0			50.0		75.0		4
All	6.1	1.5	9.1	1.5	10.6	30.3	4.5	36.4	4.5	66

Table 4.8: Percentage distribution of service providers interviewed by possible reasons behind low acceptance of injectables contraceptives

Residence, Region, and Position of service providers	Not aware of Injectables	Not always available in FP clinic	Drop hemorrhage between two menstrual period	May increase weight	Need to come to medical staff for taking injection	May decrease desire for sex	Amenorrhea	N
Residence								
Urban	6.1	33.3	24.2	27.3	6.1	3.0	54.5	33
Rural	3.1	6.3	17.2	20.3	3.1	1.6	32.8	64
Region								
Red River Delta		6.3	12.5	18.8	6.3		37.5	16
North Mountains	9.1	36.4	9.1	4.5	4.5			22
North and South Central Coast	10.0		40.0	60.0			60.0	10
Central Highland		23.1	30.8	23.1	7.7	7.7	46.2	13
Southeastern Region	6.3	12.5	31.3	43.8	6.3	6.3	68.8	16
Mekong Delta		5.0	10.0	10.0			50.0	20
Position of FP Service providers								
Obs./Gyn. doctor		25.0	75.0	62.5	12.5	12.5	75.0	8
Assistant Doctor in Obs. and Pediatrics		7.7	15.4	15.4	7.7		30.8	13
Midwife	5.6	15.3	15.3	19.4	2.8	1.4	37.5	72
General practitioner been trained in FP, MVA, counseling		25.0		25.0			50.0	4
All	4.1	15.5	19.6	22.7	4.1	2.1	40.2	97

Table 4.9: Percentage distribution of service providers interviewed by possible reasons behind low acceptance of IUD by couple having one child

Background characteristics	Feeling of pain in lower abdomen	Increased bleeding during menstruation	Sometimes IUD comes outside of vagina	Sometimes vagina becomes damaged	Needs experienced worker to take and remove of IUD	Need to examine the string after each menstruation	It does not protect STD/HIV/AIDS	Reproductive organs transition increase	Pain while performing	N
Residence										
Urban	12.5							12.5	12.5	8
Rural	33.3	16.7	16.7	16.7	8.3	8.3	8.3	8.3	8.3	12
Region										
Red River Delta	100.0							100.0	100.0	1
North Mountains										2
North and South Central Coast	50.0	25.0	25.0	25.0	25.0		25.0			4
Central Highland	25.0		25.0							4
Southeastern Region	16.7					16.7		16.7		6
Mekong Delta		33.3		33.3					33.3	3
Position of FP Service providers										
Obs./Gyn. doctor	33.3							33.3		3
Assistant Doctor in Obs. and Pediatrics						100.0				1
Midwife	26.7	13.3	13.3	13.3	6.7		6.7	6.7	13.3	15
General practitioner been trained in FP, MVA, counseling										1
All	25.0	10.0	10.0	10.0	5.0	5.0	5.0	10.0	10.0	20

Table 4.10: Percentage distribution of service providers interviewed by possible reasons behind low acceptance of implants by couple having one child

Background characteristics	Not aware of Implants	Drop hemorrhage between two menstrual period	Little bleeding for a long time	Stopped menstruation	Headache, vomiting tendency and weight gain	Feeling of tiredness	Weighty /Pain in breast	Hazard to open and use self	Need small operation to take and open	Transition, bleeding problem	It does not protect STD/HIV/AIDS	The shortage of source of provision	N
Residence													
Urban	5.9	5.9	8.8	14.7	2.9				2.9		2.9	64.7	34
Rural	9.8	14.1	8.7	9.8	6.5	3.3	2.2	7.6	12.0	2.2	4.3	63.0	92
Region													
Red River Delta	6.7	20.0	6.7	20.0	13.3	13.3	6.7	13.3	40.0	6.7		46.7	15
North Mountains	5.3	5.3	10.5	10.5	10.5		5.3				5.3	89.5	19
North and South Central Coast	12.5	8.3	8.3			4.2		8.3		4.2	8.3	66.7	24
Central Highland	4.5		4.5					9.1			4.5	72.7	22
Southeastern Region	4.2	25.0	12.5	25.0	12.5				12.5		4.2	66.7	24
Mekong Delta	18.2	13.6	9.1	13.6				4.5	13.6			36.4	22
Position of FP Service providers													
Obs./Gyn. doctor	14.3	28.6	14.3	42.9	28.6				14.3			71.4	7
Assistant Doctor in Obs. and Pediatrics	5.3	15.8	5.3	21.1	10.5	5.3	5.3	10.5	10.5			57.9	19
Midwife	9.6	9.6	8.5	7.4	3.2	2.1	1.1	5.3	9.6	2.1	5.3	63.8	94
General practitioner been trained in FP, MVA, counseling		20.0	20.0									60.0	5
FP and population communal officer													1
All	8.7	11.9	8.7	11.1	5.6	2.4	1.6	5.6	9.5	1.6	4.0	63.5	

Table 4.11: Percentage distribution of service providers interviewed by possible reasons behind low acceptance of tubectomy by couple having two children

Background characteristics	Need to think before taking decision as it's a permanent method (Want to have more children)	Have risk in spite of being a small operation	Pain remains for a few days after operation	Possibilities of Ectopic pregnancy	Need to come to service center for operation	Need trained doctor and assistant	It does not protect STD/ HIV/ AIDS	Use other contraception	Pain while performing	Others	N
Residence											
Urban	37.5	10.0	2.5		12.5	5.0	2.5	45.0	2.5	17.5	40
Rural	53.5	10.5	1.2		8.1	2.3	1.2	36.0	4.7	5.8	86
Region											
Red River Delta	27.8	5.6			11.1			44.4		11.1	18
North Mountains	50.0	22.7			9.1		4.5	63.6	9.1	9.1	22
North and South Central Coast	28.6		4.8		14.3	4.8	4.8	33.3	4.8	28.6	21
Central Highland	68.4	15.8			10.5	5.3		31.6	5.3		19
Southeastern Region	57.7		3.8		11.5	7.7		34.6	3.8	7.7	26
Mekong Delta	55.0	20.0						25.0			20
Position of FP Service providers											
Obs./Gyn. doctor	30.0	10.0						60.0	10.0	20.0	10
Assistant Doctor in Obs. and Pediatrics	41.2	11.8			11.8			41.2		5.9	17
Midwife	53.3	9.8	2.2		8.7	4.3	1.1	35.9	4.3	7.6	92
General practitioner been trained in FP, MVA, counseling	33.3	16.7			33.3		16.7	50.0		33.3	6
FP and population communal officer											1
All	48.4	10.3	1.6		9.5	3.2	1.6	38.9	4.0	9.5	126

Table 4.12: Percentage distribution of service providers interviewed by possible reasons behind low acceptance of vasectomy by couple having two children

Background characteristics	It is not possible to take child again as it is a permanent method (Want to have more children)	There have some risk in spite of being a small operation	It does not work immediately after operation	Need to come to service center for operation	Need trained doctor and assistant	Does not protect STD/HIV/AIDS	Because the women is already using a permanent contraceptive method so their partner do not need to use it	Others	N
Residence									
Urban	8.5	8.5	2.1	6.4	2.1	4.3	17.0	17.0	47
Rural	29.5	7.4		7.4	2.1	2.1	24.2	4.2	95
Region									
Red River Delta	22.2	5.6		16.7			38.9	5.6	18
North Mountains	4.0	4.0				4.0	8.0	4.0	25
North and South Central Coast	26.1			13.0	4.3	4.3	13.0	17.4	23
Central Highland	28.0	12.0		4.0			8.0	12.0	25
Southeastern Region	33.3	3.7	3.7	11.1	7.4	7.4	44.4	7.4	27
Mekong Delta	20.8	20.8					20.8	4.2	24
Position of FP Service providers									
Obs./Gyn. doctor	10.0			10.0			50.0	20.0	10
Assistant Doctor in Obs. and Pediatrics	25.0	15.0		5.0			25.0	5.0	20
Midwife	25.0	7.7	1.0	7.7	2.9	2.9	20.2	7.7	104
General practitioner been trained in FP, MVA, counseling						14.3		14.3	7
FP and population communal officer									1
All	22.5	7.7	.7	7.0	2.1	2.8	21.8	8.5	142

Annex Tables: Chapter 5

Table 5.1: Distribution of facility preparedness assessment indicators applicable for commune health center (CHC) by place of residence and by region (%)

Indicators	Residence		Region						All
	Urban	Rural	Red River Delta	North Mountains	North South Central Coast	Central High Land	South Eastern Region	Mekong Delta	
Basic Physical Amenities									
Functional electricity	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
Waiting room	79.2	81.0	76.9	47.4	90.0	86.7	87.5	95.0	80.6
Functioning toilet	95.8	97.5	100.0	94.7	100.0	93.3	100.0	95.0	97.1
Counseling room	87.5	91.1	100.0	73.7	90.0	80.0	100.0	100.0	90.3
Equipment and Instruments									
Equipment and instruments: instrument trolley	95.8	91.1	100.0	73.7	95.0	100.0	100.0	90.0	92.2
Equipment and instruments: lights for examination	95.8	89.9	92.3	94.7	95.0	86.7	87.5	90.0	91.3
Equipment and instruments: pain relief, anesthesia drugs, lidocain, shock management kits	91.7	87.3	61.5	78.9	90.0	100.0	93.8	100.0	88.3
Equipment and instruments: necessary sterilized equipments	100.0	98.7	100.0	100.0	95.0	100.0	100.0	100.0	99
Logistics									
Adequate supply of oral pill	75.0	91.1	84.6	100.0	60.0	93.3	100.0	90.0	87.4
Adequate supply of condom	66.7	81.0	76.9	89.5	55.0	60.0	100.0	85.0	77.7
Adequate supply of IUD	95.8	98.7	100.0	100.0	100.0	86.7	100.0	100.0	98.1
Functioning sterilizer in clinic	91.7	92.4	92.3	94.7	95.0	86.7	87.5	95.0	92.2
IEC materials, Job Aids and Registers/record									
IEC material in clinic	100.0	97.5	100.0	94.7	95.0	100.0	100.0	100.0	98.1
Job-aids on advantage and disadvantages	91.7	79.7	100.0	84.2	75.0	53.3	93.8	90.0	82.5
Job-aids to check eligibility	75.0	67.1	92.3	73.7	85.0	13.3	81.3	65.0	68.9
Contraceptive supply records in facility	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
Staff instruct on recheck-up	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
Monthly report submitted	100.0	96.2	100.0	100.0	90.0	100.0	93.8	100.0	97.1
Manpower and Services									
No shortage in manpower for FP services	83.3	65.8	61.5	68.4	55.0	80.0	62.5	90.0	69.9
Services for management complications to FP clients	66.7	87.3	61.5	73.7	85.0	100.0	100.0	75.0	82.5
Camp organized last year	66.7	92.4	100.0	100.0	100.0	60.0	87.5	70.0	86.4
Condom service available	79.2	87.3	84.6	94.7	65.0	93.3	100.0	80.0	85.4
IUD service available	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
Pill service available	87.5	92.4	84.6	100.0	75.0	100.0	100.0	90.0	91.3
Injectables service available	70.8	93.7	92.3	52.6	95.0	93.3	100.0	100.0	88.3
N	24	79	13	19	20	15	16	20	103

Table 5.2: Distribution of provider quality assessment indicators applicable for commune health center (CHC) by place of residence and by region (%)

Indicators	Residence		Region						All
	Urban	Rural	Red River Delta	North Mountains	North South Central Coast	Central High Land	South Eastern Region	Mekong Delta	
Providers' Training									
Received training on providing IUD	91.7	96.2	100.0	100.0	95.0	73.3	100.0	100.0	95.1
Received training on contraceptive injection	62.5	87.3	84.6	52.6	90.0	73.3	93.8	95.0	81.6
Received training on NGFRHCS	79.2	75.9	100.0	78.9	60.0	46.7	81.3	95.0	76.7
Providers' Skills									
Provide IUD in clinic	100.0	97.5	100.0	100.0	95.0	93.3	100.0	100.0	98.1
Provide contraceptive injection	75.0	92.4	92.3	47.4	100.0	93.3	100.0	100.0	88.3
Provider Use GATHER Approach for Counseling									
Greets client	95.8	84.8	84.6	89.5	95.0	80.0	87.5	85.0	87.4
Ask client about themselves	87.5	75.9	76.9	63.2	90.0	66.7	93.8	80.0	78.6
Tells clients bout choices	83.3	79.7	84.6	73.7	80.0	73.3	87.5	85.0	80.6
Help clients to make informed choice	87.5	78.5	69.2	68.4	95.0	73.3	93.8	80.0	80.6
Explain fully hoe to use the chosen method	83.3	70.9	69.2	68.4	65.0	73.3	93.8	75.0	73.8
Suggests/Welcomes return visits	45.8	53.2	53.8	47.4	40.0	46.7	81.3	45.0	51.5
Use updated information on FP method	87.5	96.2	100.0	89.5	95.0	80.0	100.0	100.0	94.2
N	24	79	13	19	20	15	16	20	103

Table 5.3: Distribution of management and supervision assessment indicators applicable for commune health center (CHC) by place of residence and by region (%)

Indicators	Residence		Region						All
	Urban	Rural	Red River Delta	North Mountains	North South Central Coast	Central High Land	South East-ern Region	Mekong Delta	
Management and Supervision Status									
Receive supply from higher authority	83.3	96.2	100.0	84.2	100.0	86.7	100.0	90.0	93.2
Receive adequate support from higher authority when requested	83.3	89.9	84.6	78.9	100.0	80.0	87.5	95.0	88.3
Technical supervisor from higher authority paid visit in last 3 months	91.7	92.4	100.0	84.2	100.0	86.7	81.3	100.0	92.2
N	24	79	13	19	20	15	16	20	103

Table 5.4: Percentage distribution of compliance of indicators used for assessment of quality of services in CHC (%)

Indicators	Percentage
A. Facility Preparedness	
Basic Physical Amenities	
Functional electricity	100.0
Waiting room	80.6
Functioning toilet	97.1
Counseling room	90.3
Equipment and Instruments	
Equipment and instruments: instrument trolley	92.2
Equipment and instruments: lights for examination	91.3
Equipment and instruments: pain relief, anesthesia drugs, lidocain, shock management kits	88.3
Equipment and instruments: necessary sterilized equipments	99.0
Logistics	
Adequate supply of oral pill	87.4
Adequate supply of condom	77.7
Adequate supply of IUD	98.1
Functioning sterilizer in clinic	92.2
IEC Materials, Job Aids and Registers/records	
IEC material in clinic	98.1
Job-aids on advantage and disadvantages	82.5
Job-aids to check eligibility	68.9
Contraceptive supply records in facility	100.0
Staff instruct on recheck-up	100.0
Monthly report submitted	97.1
Manpower and Services	
Shortage in manpower for family planning services	30.1
Services for management complications to family planning clients	82.5
Camp organized last year	86.4
Condom service available	85.4
IUD service available	100.0
Pill service available	91.3
Injectable service available	88.3
B. Provider Quality	
Providers' Training	
Received training on IUD	95.1
Received training on contraceptive injection	81.6
Received training on NGFRHCS	76.7
Provide IUD in clinic	98.1
Provide contraceptive injection	88.3
Provider Use GATHER Approach for Counseling	
Greets clients	87.4
Asks clients about themselves	78.6
Tells clients about choices	80.6
Helps clients to make informed choice	80.6
Explains fully how to use the chosen method	73.8
Suggests/Welcomes return visits	51.5
Uses updated information on family planning method	94.2
C. Management and Supervision	
Receive supply from higher authority	93.2
Receive adequate support from higher authority when requested	88.3
Technical supervisor from higher authority paid visit in last 3 months	92.2
N	103

Table 5.5: Distribution of facility preparedness assessment indicators applicable for district and above level facilities by place of residence and by region (%)

Indicators	Residence		Region						All
	Urban	Rural	Red River Delta	North Mountains	North South Central Coast	Central High Land	South Eastern Region	Mekong Delta	
Basic Physical Amenities									
Functional electricity	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Waiting room	46.7	55.6	100.0	33.3	25.0	25.0	50.0	75.0	50.0
Functioning toilet	80.0	100.0	100.0	100.0	100.0	50.0	100.0	75.0	87.5
Counseling room	66.7	44.4	66.7	66.7	25.0	25.0	66.7	100.0	58.3
operation theatre	40.0	33.3	66.7	33.3	0.0	50.0	66.7	0.0	37.5
post-operative care room	66.7	88.9	100.0	33.3	75.0	75.0	100.0	50.0	75.0
Equipment and Instruments									
Equipment and instruments: operating table	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Equipment and instruments: instrument trolley	86.7	100.0	100.0	66.7	100.0	75.0	100.0	100.0	91.7
Equipment and instruments: lights for examination	93.3	100.0	100.0	100.0	100.0	75.0	100.0	100.0	95.8
Equipment and instruments: lights for placental inspection	53.3	77.8	66.7	33.3	75.0	25.0	100.0	50.0	62.5
Equipment and instruments: pain relief, anesthesia drugs, lidocain, shock management kits	86.7	88.9	100.0	100.0	100.0	50.0	83.3	100.0	87.5
Equipment and instruments: necessary sterilized equipments	93.3	100.0	100.0	100.0	100.0	75.0	100.0	100.0	95.8
Logistics									
Adequate supply of oral pill	60	88.9	100	33.3	100	0	83.3	100	70.8
Adequate supply of condom	53.3	66.7	100	33.3	100	25	50	50	58.3
Adequate supply of IUD	86.7	100	100	66.7	100	75	100	100	91.7
Adequate supply of Implant	33.3	44.4	66.7	33.3	50	25	16.7	50	37.5
Adequate supply of MSR for LAPM	60.0	66.7	66.7	100.0	50.0	50.0	66.7	50.0	62.5
Functioning sterilizer	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
IEC materials, Job Aids and Registers/ record									
IEC material	80.0	88.9	100.0	100.0	100.0	50.0	83.3	75.0	83.3
Contraceptive supply records in facility	86.7	77.8	100.0	33.3	75.0	100.0	83.3	100.0	83.3
Staff instruct on recheck-up	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Monthly report submitted	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Manpower and Services									
No shortage in manpower for FP services	33.3	11.1	33.3	0.0	50.0	50.0	0.0	25.0	25.0
Services for management complications to FP clients	86.7	100.0	100.0	100.0	100.0	75.0	100.0	75.0	91.7
Condom service available	66.7	66.7	100.0	33.3	100.0	50.0	50.0	75.0	66.7
IUD service available	93.3	100.0	100.0	66.7	100.0	100.0	100.0	100.0	95.8
Pill service available	73.3	100.0	100.0	33.3	100.0	50.0	100.0	100.0	83.3
Injectables service available	66.7	77.8	100.0	0.0	100.0	50.0	66.7	100.0	70.8
Implant service available	80.0	33.3	100.0	66.7	25.0	100.0	33.3	75.0	62.5
Female sterilization service available	20.0	22.2	33.3	0.0	0.0	50.0	33.3	0.0	20.8
N	15	9	3	3	4	4	6	4	24

Table 5.6: Distribution of provider quality assessment indicators applicable for district and above level facilities by place of residence and by region (%)

Indicators	Residence		Region						All
	Urban	Rural	Red River Delta	North Mountains	North South Central Coast	Central High Land	South Eastern Region	Mekong Delta	
Providers' Training									
Received training on IUD	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Received training on contraceptive injection	80.0	66.7	100.0	33.3	75.0	75.0	66.7	100.0	75.0
Received training on Implant	60.0	44.4	66.7	33.3	25.0	75.0	66.7	50.0	54.2
Received on Tubectomy	20.0	33.3	33.3	0.0	0.0	25.0	66.7	0.0	25.0
Received training on Vasectomy	6.7	22.2	33.3	0.0	0.0	0.0	33.3	0.0	12.5
Received training on NGFRHCS	66.7	88.9	66.7	100.0	100.0	25.0	83.3	75.0	75.0
Providers' Skills									
Provide IUD	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Provide contraceptive injection	73.3	66.7	100.0	0.0	100.0	75.0	50.0	100.0	70.8
Provide Implant	73.3	44.4	66.7	66.7	75.0	75.0	33.3	75.0	62.5
Provide Tubectomy	26.7	33.3	33.3	0.0	0.0	50.0	66.7	0.0	29.2
Provide Vesectomy	6.7	22.2	0.0	0.0	0.0	25.0	33.3	0.0	12.5
Use updated information on FP method	80.0	88.9	100.0	100.0	100.0	50.0	83.3	75.0	83.3
Provider Use GATHER Approach for Counseling									
Greets client	86.7	100.0	100.0	100.0	100.0	75.0	100.0	75.0	91.7
Ask client about themselves	86.7	88.9	100.0	100.0	75.0	100.0	66.7	100.0	87.5
Tells clients bout choices	93.3	100.0	100.0	100.0	100.0	75.0	100.0	100.0	95.8
Help clients to make informed choice	80.0	88.9	100.0	100.0	75.0	50.0	83.3	100.0	83.3
Explain fully hoe to use the chosen method	86.7	100.0	100.0	100.0	100.0	100.0	83.3	75.0	91.7
Suggests/Welcomes return visits	86.7	77.8	100.0	100.0	100.0	50.0	66.7	100.0	83.3
N	15	9	3	3	4	4	6	4	24

Table 5.7: Distribution of management and supervision assessment indicators applicable for district and above level facilities by place of residence and by region (%)

Indicators	Residence		Region						All
	Urban	Rural	Red River Delta	North Mountains	North South Central Coast	Central High Land	South Eastern Region	Mekong Delta	
Receive supply from higher authority	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Receive adequate support from higher authority when requested	80.0	88.9	100.0	33.3	100.0	100.0	83.3	75.0	83.3
Technical supervisor from higher authority paid visit in last 3 months	53.3	66.7	33.3	33.3	100.0	75.0	50.0	50.0	58.3
N	15	9	3	3	4	4	6	4	24

Table 5.8: Percentage distribution of compliance of indicators used for assessment of quality of services in district and above level facilities (%)

Indicators	Percentage
Basic Physical Amenities	
Functional electricity	100.0
Waiting room	50.0
Functioning toilet	87.5
Counseling room	58.3
operation theatre	37.5
post-operative care room	75.0
Equipment and Instruments	
Equipment and instruments: operating table	100.0
Equipment and instruments: instrument trolley	91.7
Equipment and instruments: lights for examination	95.8
Equipment and instruments: lights for placental inspection	62.5
Equipment and instruments: pain relief, anesthesia drugs, lidocain, shock management kits	87.5
Equipment and instruments: necessary sterilized equipments	95.8
Logistics	
Adequate supply of oral pill	70.8
Adequate supply of condom	58.3
Adequate supply of IUD	91.7
Adequate supply of Implant	37.5
Adequate supply of MSR for LAPM	62.5
Functioning sterilizer	100
IEC materials, Job Aids and Registers/record	
IEC material	83.3
Contraceptive supply records in facility	83.3
Staff instruct on recheck-up	100.0
Monthly report submitted	100.0

Manpower and Services	
No shortage in manpower for FP services	25.0
Services for management complications to FP clients	91.7
Condom service available	66.7
IUD service available	95.8
Pill service available	83.3
Injectables service available	70.8
Implant service available	62.5
Female sterilization service available	20.8
Received training on IUD	100.0
Received training on contraceptive injection	75.0
Received training on Implant	54.2
Received training on Tubectomy	25.0
Received training on Vasectomy	12.5
Received training on NGFRHCS	75.0
Providers' Skills	
Provide IUD	100.0
Provide contraceptive injection	70.8
Provide Implant	62.5
Provide Tubectomy	29.2
Provide Vesectomy	12.5
Use updated information on FP method	83.3
Greets client	91.7
Ask client about themselves	87.5
Tells clients about choices	95.8
Help clients to make informed choice	83.3
Explain fully hoe to use the chosen method	91.7
Suggests/Welcomes return visits	83.3
Receive supply from higher authority	100.0
Receive adequate support from higher authority when requested	83.3
Technical supervisor from higher authority paid visit in last 3 months	58.3
N	24

Table 5.9: Distribution of facility preparedness assessment indicators applicable for non-government (private and NGO) facilities (%)

Indicators	Percentage
Basic Physical Amenities	
Functional electricity	100.0
Waiting room	66.7
Functioning toilet	100.0
Counseling room	55.6
operation theatre	22.2
post-operative care room	55.6
Post operative bed	66.7
Equipment and Instruments	
Equipment and instruments: operating table	88.9
Equipment and instruments: instrument trolley	88.9
Equipment and instruments: lights for examination	88.9
Equipment and instruments: lights for placental inspection	44.4
Equipment and instruments: pain relief, anesthesia drugs, lidocain, shock management kits	88.9
Equipment and instruments: necessary sterilized equipments	88.9
Functioning sterilizer	100
Logistics	
Adequate supply of oral pill	33.3
Adequate supply of condom	44.4
Adequate supply of IUD	77.8
Adequate supply of Implant	22.2
Adequate supply of long acting method	33.3
Adequate supply of MSR for LAPM	55.6
IEC materials and Registers/record	
IEC material	66.7
Contraceptive supply records in facility	55.6
Staff instruct on recheck-up	88.9
Monthly report submitted	66.7
Manpower and Services	
No shortage in manpower for FP services	66.7
Services for management complications to FP clients	88.9
Condom service available	44.4
IUD service available	88.9
Pill service available	66.7
Injectables service available	44.4
Implant service available	22.2
Female sterilization service available	22.2
N	9

Table 5.10: Distribution of provider quality assessment indicators applicable for non-government facilities (%)

Indicators	Percentage
Providers' Training	
Received training on IUD	88.9
Received training on Implant	22.2
Received training on contraceptive injection	77.8
Have training on providing Tubectomy	44.4
Have training on Vesectomy	22.2
Received training on NGFRHCS	66.7
Providers' Skills	
Provide IUD	88.9
Provide contraceptive injection	22.2
Provide Implant	11.1
Provide Tubectomy	22.2
Use updated information on FP method	55.6
Provider Use GATHER Approach for Counseling	
Greets client	88.9
Ask client about themselves	77.8
Tells clients about choices	100
Help clients to make informed choice	100
Explain fully hoe to use the chosen method	88.9
Suggests/Welcomes return visits	77.8
N	9

Table 5.11: Distribution of management and supervision assessment indicators applicable for non-government (private and NGO) facilities (%)

Indicators	Percentage
Receive supply from higher authority	55.6
Receive adequate support from higher authority when requested	44.4
Technical supervisor from higher authority paid visit in last 3 months	55.6
N	9

Table 5.12: Percentage distribution of compliance of indicators used for assessment of quality of services in non-government (private and NGO) facilities (%)

Indicators	Percentage
Basic Physical Amenities	
Functional electricity	100.0
Waiting room	66.7
Functioning toilet	100.0
Counseling room	55.6
operation theatre	22.2
post-operative care room	55.6
Post operative bed	66.7
Equipment and Instruments	
Equipment and instruments: operating table	88.9
Equipment and instruments: instrument trolley	88.9
Equipment and instruments: lights for examination	88.9
Equipment and instruments: lights for placental inspection	44.4

Equipment and instruments: pain relief, anesthesia drugs, lidocain, shock management kits	88.9
Equipment and instruments: necessary sterilized equipments	88.9
Functioning sterilizer	100
Logistics	
Adequate supply of oral pill	33.3
Adequate supply of condom	44.4
Adequate supply of IUD	77.8
Adequate supply of Implant	22.2
Adequate supply of long acting method	33.3
Adequate supply of MSR for LAPM	55.6
IEC materials and Registers/record	
IEC material	66.7
Contraceptive supply records in facility	55.6
Staff instruct on recheck-up	88.9
Monthly report submitted	66.7
Manpower and Services	
No shortage in manpower for FP services	66.7
Services for management complications to FP clients	88.9
Condom service available	44.4
IUD service available	88.9
Pill service available	66.7
Injectables service available	44.4
Implant service available	22.2
Female sterilization service available	22.2
Providers' Training	
Received training on IUD	88.9
Received training on Implant	22.2
Received training on contraceptive injection	77.8
Have training on providing Tubectomy	44.4
Have training on Vesectomy	22.2
Received training on NGFRHCS	66.7
Providers' Skills	
Provide IUD	88.9
Provide contraceptive injection	22.2
Provide Implant	11.1
Provide Tubectomy	22.2
Use updated information on FP method	55.6
Provider Use GATHER Approach for Counseling	
Greets client	88.9
Ask client about themselves	77.8
Tells clients about choices	100
Help clients to make informed choice	100
Explain fully how to use the chosen method	88.9
Suggests/Welcomes return visits	77.8
Receive supply from higher authority	55.6
Receive adequate support from higher authority when requested	44.4
Technical supervisor from higher authority paid visit in last 3 months	55.6
N	9

Table 5.13: Overall quality of services score by components and CHC

Region	District	Commune	Facility pre-paredness score	Provider quality score	Man-age-ment and super-vision score	Quality of Services score	State of quality category
Rerd River Delta	Huyện Phúc Thọ	Xã Sen Chiểu	0.88	0.83	1.00	0.88	Middle
		Xã Long Xuyên	1.00	0.58	0.67	0.85	Middle
		Xã Thanh Đa	0.96	0.83	1.00	0.93	Highest
		Xã Phụng Thượng	0.88	0.75	1.00	0.85	Middle
	Huyện Đan Phượng	Xã Thọ An	0.88	1.00	1.00	0.93	Highest
		Xã Liên Hồng	0.96	0.75	1.00	0.9	Highest
		Xã Liên Trung	0.92	0.75	1.00	0.88	Middle
		Xã Đông Tháp	0.96	1.00	1.00	0.98	Highest
	Huyện Thanh Trì	Thị trấn Văn Điển	0.92	0.75	1.00	0.88	Middle
		Xã Tả Thanh Oai	0.92	1.00	1.00	0.95	Highest
		Xã Tứ Hiệp	0.76	0.92	0.67	0.8	Middle
		Xã Ngũ Hiệp	0.88	0.83	1.00	0.88	Middle
		Xã Vạn Phúc	0.84	1.00	1.00	0.9	Highest
North Moun-tains	Thành phố Yên Bái	Phường Yên Ninh	0.80	0.50	0.67	0.7	Lowest
		Phường Đồng Tâm	0.92	0.83	1.00	0.9	Highest
		Phường Hợp Minh	0.88	0.58	1.00	0.8	Middle
		Xã Minh Bảo	1.00	0.50	1.00	0.85	Middle
		Xã Tân Thịnh.	0.88	0.83	1.00	0.88	Middle
	Thị xã Nghĩa Lộ	Phường Trung Tâm	0.84	0.58	0.33	0.73	Lowest
		Phường Tân An	0.96	0.50	1.00	0.83	Middle
		Phường Cầu Thìa	0.76	0.67	0.33	0.7	Lowest
		Xã Nghĩa Phúc	0.84	0.67	1.00	0.8	Middle
	Huyện Văn Chấn	Xã Tú Lệ	0.92	0.67	0.67	0.83	Middle
		xã Nậm Lành	0.80	0.83	0.33	0.78	Middle
		xã Nghĩa Sơn	0.84	0.92	1.00	0.88	Middle
		xã Thạch Lương	0.96	1.00	0.67	0.95	Highest
		xã Bình Thuận	0.92	1.00	1.00	0.95	Highest
	Huyện Văn Yên	Xã Châu Quế Thượng	0.76	1.00	1.00	0.85	Middle
		Xã Đông Cuông	0.80	0.92	0.67	0.83	Middle
		Xã Tân Hợp	1.00	0.58	1.00	0.88	Middle
		Xã Đại Sơn	0.84	0.50	1.00	0.75	Lowest
		Xã Hoàng Thắng	0.92	0.83	1.00	0.9	Highest

Region	District	Commune	Facility pre-paredness score	Provider quality score	Man-age-ment and super-vision score	Quality of Services score	State of quality category
North and South Central Coast	Thành phố Tuy Hòa	Phường 8	0.72	0.67	1.00	0.73	Lowest
		Phường 3	0.92	0.92	1.00	0.93	Highest
		Phường 7	0.84	0.83	1.00	0.85	Middle
		Phường Phú Đông	0.80	0.83	1.00	0.83	Middle
		Xã Bình Kiến	0.84	0.75	1.00	0.83	Middle
	Thị xã Sông Cầu	Phường Xuân Phú	0.84	1.00	1.00	0.9	Highest
		Phường Xuân Thành	0.76	0.92	1.00	0.83	Middle
		Xã Xuân Lộc	0.92	0.83	1.00	0.9	Highest
		Xã Xuân Hòa	0.92	0.75	1.00	0.88	Middle
		Xã Xuân Thịnh	0.88	0.67	1.00	0.83	Middle
	Huyện Sông Hinh	Xã Ea Lâm	0.76	1.00	1.00	0.85	Middle
		Xã Ea Bá	0.92	0.83	1.00	0.9	Highest
		Xã Đức Bình Đông	0.96	0.83	1.00	0.93	Highest
		Xã Ea Bia	0.96	0.75	1.00	0.9	Highest
		Xã Sông Hinh	0.92	0.92	1.00	0.93	Highest
	Huyện Sơn Hòa	Xã Sơn Định	0.96	0.92	1.00	0.95	Highest
		Xã Cà Lúi	0.96	0.67	1.00	0.88	Middle
		Xã Sơn Xuân	0.92	0.58	1.00	0.83	Middle
		Xã Echa Rang	0.92	1.00	1.00	0.95	Highest
		Xã Suối Bạc	0.76	1.00	1.00	0.85	Middle
Central High-land	Thành phố Buôn Ma Thuột	Phường Thống Nhất	0.84	0.83	0.67	0.83	Middle
		Phường Thành Công	0.88	0.92	0.67	0.88	Middle
		Xã Hòa Khánh	0.84	0.83	1.00	0.85	Middle
	Huyện Ea súp	Xã Ia lốp	0.88	0.25	0.33	0.65	Lowest
		Xã Ea Rok	0.80	0.83	0.67	0.8	Middle
		Xã Ia rve	0.84	0.92	1.00	0.88	Middle
		Xã Cư Mlan	0.80	0.92	1.00	0.85	Middle
	Huyện Krông Buk	xã Chư Kbo	0.92	0.58	1.00	0.83	Middle
		xã Cư Pơng	0.88	0.75	1.00	0.85	Middle
		xã Ea sin	0.96	0.42	0.67	0.78	Middle
		xã Pơng Drang	0.92	0.67	1.00	0.85	Middle
	Huyện M drắk	Xã Ea Pil	0.80	0.75	1.00	0.8	Middle
		Xã Ea H'Mlay	0.96	1.00	1.00	0.98	Highest
		Xã Ea m'doal	0.80	0.58	0.67	0.73	Lowest

Region	District	Commune	Facility pre-paredness score	Provider quality score	Man-age-ment and super-vision score	Quality of Services score	State of quality category
Southeastern Region	Thành phố Biên Hòa	Phường Tân Hòa	1.00	1.00	1.00	1	Highest
		Phường Quang Vinh	0.96	1.00	1.00	0.98	Highest
		Phường Quyết Thắng	1.00	0.75	1.00	0.93	Highest
		Xã Phước Tân	0.92	0.92	0.67	0.9	Highest
	Huyện Tân Phú	Xã Phú Lâm	0.88	1.00	1.00	0.93	Highest
		Xã Tà Lài	0.92	1.00	1.00	0.95	Highest
		Xã Phú Xuân	0.92	0.92	1.00	0.93	Highest
		Xã Phú Bình	0.92	1.00	1.00	0.95	Highest
	Huyện Vĩnh Cửu	Xã Trị An	1.00	0.83	1.00	0.95	Highest
		Xã Vĩnh Tân	1.00	1.00	0.67	0.98	Highest
		Xã Thanh Phú	0.88	0.92	1.00	0.9	Highest
		Xã Tân Bình	0.96	1.00	0.33	0.93	Highest
	Huyện Trảng Bom	Xã Thanh Bình	0.92	0.50	1.00	0.8	Middle
		Xã Bắc Sơn	0.96	1.00	0.67	0.95	Highest
		Xã Bình Minh	0.96	1.00	1.00	0.98	Highest
		Xã Hưng Thịnh	1.00	1.00	1.00	1	Highest
Mekong Delta	Thành phố Long Xuyên	Phường Đồng Xuyên	0.92	1.00	1.00	0.95	Highest
		Phường Bình Đức	0.88	0.92	1.00	0.9	Highest
		Phường Mỹ Phước	0.92	0.92	0.67	0.9	Highest
		Phường Mỹ Thới	0.96	1.00	1.00	0.98	Highest
		Phường Mỹ Hà	0.96	0.83	0.33	0.88	Middle
	Huyện Tri Tôn	Xã Lạc Quới	0.92	0.75	1.00	0.88	Middle
		Xã Vĩnh Phước	0.96	0.83	1.00	0.93	Highest
		Xã Lương An Trà	0.88	0.75	1.00	0.85	Middle
		Xã An Tức	0.96	0.83	1.00	0.93	Highest
		Xã Ô Lâm	1.00	0.75	1.00	0.93	Highest
	Huyện Châu Phú	Xã Khánh Hòa	0.84	0.83	1.00	0.85	Middle
		xã Mỹ Phú	0.96	1.00	1.00	0.98	Highest
		xã Vĩnh Thạnh Trung	1.00	1.00	1.00	1	Highest
		xã Bình Long	0.80	0.75	1.00	0.8	Middle
		xã Bình Thủy	0.96	0.83	1.00	0.93	Highest
	Thị xã Tân Châu	Phường Long Châu	0.96	0.92	1.00	0.95	Highest
		Xã Vĩnh Xương	0.84	1.00	1.00	0.9	Highest
		Xã Tân Thạnh	0.84	0.83	1.00	0.85	Middle
		Xã Long An	0.92	1.00	1.00	0.95	Highest
		Xã Châu Phong	0.92	0.58	1.00	0.83	Middle

Annex Tables: Chapter 8

Table 8.1: Percentage distribution of respondents by experience of unwanted pregnancy in life time

Characteristics	Method failure (ever)	n (applicable)
Residence		
Urban	8.0	1470
Rural	9.6	3800
Ethnicity		
Kinh	8.9	4789
Ethnic	10.1	481
Understanding of Vietnamese language		
Very well	9.3	4896
Not very well	7.2	374
Region		
Red River Delta	12.9	905
North Mountains	13.3	856
North and South Central Coast	3.8	846
Central Highland	7.6	860
Southeastern Region	8.9	923
Mekong Delta	8.1	880
All	9.1	5270

Table 8.2: Factors influencing method failure

Variable	Coefficient	Odds ratio	95% CI for Odds ratio		p-value
			Lower	Upper	
Incidence of method discontinuation	0.903	2.468	1.999	3.047	0.000
History of pregnancy termination	2.264	9.623	7.780	11.902	0.000
Number of living children	0.327	1.386	1.231	1.561	0.000
Years of education	-0.225	0.799	0.627	1.017	0.069
Understanding of Vietnamese language	0.603	1.828	1.158	2.886	0.010
Residence	0.191	1.211	0.944	1.552	0.132
Constant	-4.980	0.007			0.000

Annex Tables: Chapter 9

Table 9.1: Percentage distribution of women by ever termination of pregnancy

Background characteristics	Ever termination of pregnancy		n (applicable)
	Yes	No	
Residence			
Urban	19.6	80.4	1606
Rural	16.5	83.5	4230
Ethnicity			
Ethnic	79.6	20.4	1299
Kinh	83.5	16.5	4537
Understanding of Vietnamese			
Very well	82.6	17.4	5399
Not very well	82.4	17.6	437
Region			
Red River Delta	33.5	66.5	998
North Mountains	31.4	68.6	972
North and South Central Coast	7.7	92.3	947
Central Highland	10.4	89.6	969
Southeastern Region	7.9	92.1	975
Mekong Delta	12.7	87.3	975
All	17.4	82.6	5836

Table 9.2: Percentage distribution of women by number of termination of pregnancy (All number of induced terminations)

Background characteristics	Number of termination of pregnancy				n (applicable)
	1	2	3+	Average	
Residence					
Urban	65.0	26.1	8.9	1.5	314
Rural	76.7	19.9	3.4	1.3	700
Ethnicity					
Ethnic	78.1	16.6	5.3	1.3	265
Kinh	71.3	23.7	5.1	1.3	748
Understanding of Vietnamese					
Very well	72.9	22.0	5.1	1.3	936
Not very well	75.3	19.5	5.2	1.3	77
Region					
Red River Delta	68.6	23.4	8.1	1.4	334
North Mountains	71.5	23.6	4.9	1.4	305
North and South Central Coast	80.8	19.2	--	1.2	73
Central Highland	78.2	15.8	5.9	1.3	101
Southeastern Region	83.1	14.3	2.6	1.2	77
Mekong Delta	74.2	24.2	1.6	1.3	124
All	73.1	21.8	5.1	1.3	1014

Table 9.3: Percentage distribution of women by time of last termination of pregnancy

Background characteristics	Time of last termination of pregnancy (week)				n (applicable)		
	Up to first 12 weeks	13-28 weeks	29-40 weeks	Don't answer/ Don't remember/Don't known	Average		
Residence							
Urban	81.5	6.4	0.3	11.8	6.3	313	
Rural	85.0	3.9	1.0	10.1	6.1	700	
Region							
Red River Delta	90.4	4.2		5.4	5.9	334	
North Mountains	88.2	3.9	0.7	7.2	5.8	305	
North and South Central Coast	67.1	4.1		28.8	5.9	73	
Central Highland	75.2	5.9	1.0	17.8	6.5	101	
Southeastern Region	77.9	5.2	1.3	15.6	7.0	77	
Mekong Delta	76.4	6.5	3.3	13.8	7.2	123	
All	83.9	4.6	0.8	10.7	6.2	1013	

Table 9.4: Percentage distribution of women by method of termination of last pregnancy

Background characteristics	Method of termination of last pregnancy		n (applicable)
	Menstrual Regulation	Abortion	
Residence			
Urban	53.2	46.8	314
Rural	51.1	48.9	698
Ethnicity			
Kinh	50.8	49.2	748
Ethnic	54.5	45.5	264
Understanding of Vietnamese			
Very well	51.6	48.4	935
Not very well	54.5	45.5	77
Region			
Red River Delta	58.1	41.9	334
North Mountains	47.9	52.1	305
North and South Central Coast	47.9	52.1	73
Central Highland	63.0	37.0	100
Southeastern Region	72.4	27.6	76
Mekong Delta	25.0	75.0	124
All	51.8	48.2	1012

Table 9.5: Percentage distribution of women by place of termination of last pregnancy

Background characteristics	Place of termination of last pregnancy							n (applicable)
	Provincial hospital	Provincial RH center	District hospital (obstetrics)	District's Family planning nutrition Unit	Commune health stations	Private/NGO-led clinic	Others	
Residence								
Urban	19.6	9.9	17.6	1.0	10.3	28.2	13.5	312
Rural	9.5	5.9	26.7	2.2	25.6	23.1	7.0	696
Ethnicity								
Ethnic	15.6	8.9	23.5	.3	17.5	24.2	10.1	744
Kinh	4.2	2.3	25.0	6.1	30.3	26.1	6.1	264
Understanding of Vietnamese								
Very well	13.5	7.7	24.8	1.8	19.0	24.2	8.9	932
Not very well	1.3		13.2	1.3	43.4	30.3	10.5	76
Region								
Red River Delta	18.4	1.2	24.4	.3	22.0	16.6	17.2	332
North Mountains	7.2	15.1	23.4	5.6	29.6	15.8	3.3	304
North and South Central Coast	11.3	2.8	19.7	--	4.2	52.1	9.9	71
Central Highland	11.9	2.0	37.6	--	15.8	26.7	5.9	101
Southeastern Region	17.1	11.8	14.5	--	10.5	39.5	6.6	76
Mekong Delta	8.9	7.3	21.0	--	16.1	41.9	4.8	124
All	12.6	7.1	23.9	1.8	20.8	24.7	9.0	1008

Table 9.6: Percentage distribution of women by person who terminated the last pregnancy

Background characteristics	Person who terminated the last pregnancy									n (applicable)
	Obs Doctor	Doctor's assistant	Midwife	Nurse	Family Planning Counselor	Population-Family planning specialized staffs/ officers	Village Population-Family planning collaborator	Others	Don't know	
Residence										
Urban	71.2	3.5	8.0	0.6	--	--	--	1.3	15.4	312
Rural	55.0	11.2	17.2	0.6	--	--	0.1	1.3	14.5	696
Region										
Red River Delta	75.3	6.3	4.2	0.6	--	--	0.3	0.9	12.3	332
North Mountains	48.0	13.8	23.7	1.0	--	--	--	--	13.5	304
North and South Central Coast	62.0	1.4	5.6	1.4	--	--	--	1.4	28.2	71
Central Highland	65.3	12.9	2.0	--	--	--	--	5.0	14.9	101
Southeastern Region	69.7	2.6	22.4	--	--	--	--	--	5.3	76
Mekong Delta	37.1	8.1	29.0	--	--	--	--	3.2	22.6	124
All	60.0	8.8	14.4	0.6	--	--	0.1	1.3	14.8	1008

Table 9.7: Percentage distribution of women by sense of feeling after they had their last termination of pregnancy

Background characteristics	Sense of feeling after their last termination of pregnancy								n (applicable)
	Happy	Feel nothing, relieved	Sad	Guilty	Angry	Shameful	Regret	Others	
Residence									
Urban	0.6	30.8	61.7	8.8	1.3	3.9	6.8	4.9	309
Rural	1.6	38.4	53.0	8.5	0.6	1.3	6.1	3.5	693
Region									
Red River Delta	--	48.2	43.3	5.2	0.6	--	4.5	7.0	330
North Mountains	3.0	39.0	53.3	5.3	--	1.0	3.3	2.7	301
North and South Central Coast	--	9.7	84.7	18.1	4.2	16.7	19.4	--	72
Central Highland	1.0	17.0	70.0	28.0	--	4.0	14.0	2.0	101
Southeastern Region	--	18.7	73.3	6.7	--	--	8.0	2.7	75
Mekong Delta	2.5	37.7	54.9	5.7	2.5	1.6	3.3	3.3	123
All	1.3	36.0	55.7	8.6	0.8	2.1	6.3	3.9	1002

Table 9.8: Percentage distribution of women by sense of feeling of their husband after they had their last termination of pregnancy

Background characteristics	Sense of feeling of their husband									n (applicable)
	Don't know	Happy	Feel nothing, relieved	Sad	Guilty	Angry	Shameful	Regret	Others	
Residence										
Urban	12.0	--	36.6	49.5	2.9	0.6	--	3.6	1.9	309
Rural	14.6	1.7	37.2	45.3	3.8	0.3	0.1	4.6	1.3	693
Region										
Red River Delta	5.8	--	53.3	36.7	2.4	0.3	--	3.9	1.8	330
North Mountains	21.9	3.7	35.5	42.2	2.0	--	--	1.7	1.7	301
North and South Central Coast	20.8	--	16.7	65.3	8.3	--	--	13.9	--	72
Central Highland	17.8	--	12.9	64.4	12.9	1.0	--	7.9	--	101
Southeastern Region	8.0	--	20.0	69.3	1.3	1.3	--	6.7	--	75
Mekong Delta	11.4	0.8	39.0	44.7	0.8	0.8	0.8	1.6	3.3	123
All	13.8	1.2	37.0	46.6	3.5	0.4	0.1	4.3	1.5	1002

Table 9.9: Percentage distribution of women by all number of live births (in lifetime)

Background characteristics	All number of live births				n (applicable)
	All number of normal Vaginal delivery (NVD)	All number of Assisted Vaginal delivery (Episiotomy)	All number of C-section	All deliveries	
Residence					
Urban	0.91	0.58	0.38	1.83	1606
Rural	1.29	0.56	0.22	2.05	4230
Region					
Red River Delta	0.84	0.75	0.39	1.94	998
North Mountains	1.31	0.39	0.20	1.88	972
North and South Central Coast	1.32	0.45	0.25	1.96	947
Central Highland	1.47	0.49	0.17	2.09	969
Southeastern Region	1.13	0.67	0.35	2.15	975
Mekong Delta	1.07	0.63	0.24	1.92	975
All	1.19	0.57	0.27	1.99	5836

Table 9.10: Percentage distribution of women by type of last delivery

Background characteristics	All number of live births			n (applicable)
	Normal Vaginal Delivery (NVD)	Assisted Vaginal Delivery (Episiotomy)	C-section	
Residence				
Urban	43.0	30.1	26.9	1563
Rural	57.5	26.8	15.8	4153
Region				
Red River Delta	39.5	35.5	25.0	983
North Mountains	65.6	19.9	14.5	954
North and South Central Coast	58.6	23.3	18.1	908
Central Highland	62.8	24.7	12.6	945
Southeastern Region	45.3	29.9	24.7	966
Mekong Delta	50.1	32.2	17.7	960
All	53.5	27.7	18.8	5716

ANNEX F:

MEMBERS OF THE STUDY TEAM

MEMBERS OF THE STUDY TEAM

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