CHAPTER I

INTRODUCTION

1. Background

By allowing women the freedom to control the number and spacing of their births, family planning not only helps women preserve their health and fertility but also contributes to improving the overall quality of their lives. Family planning also contributes to improve children's health and ensuring that they have access to adequate food, clothing, housing, and educational opportunities (WHO, 2000).

In Vietnam, recognizing, the importance of the population issue in the process of socio-economic development, the government has paid attention to family planning services. Thanks to that, significant achievements in health and reproductive health have been made:

(1) Life expectancy has risen from 63.0 in 1980 to 69.0 in 1999 due to improved nutrition, reduced infant mortality rate and reduced mortality from infectious diseases such as malaria, and measles.

(2) The infant mortality rate has continuously reduced from 83/1,000 in 1979 down to 45/1,000 in 1989. At present, the infant mortality rate has been estimated as 37/1,000.

(3) The population growth rate reduced from 2.40 % in 1985 to 1.75 % in 1998

(4) The maternal mortality rate reduced from 2.00% in 1985 to 1.37 % live birth in 2001

(5) The total fertility rate reduced from 3.80 in 1989 to 3.50 in 2000 (MOH, 2001).

Family planning in Vietnam

With most of its growing population under age 30, family planning and reproductive health services are a national priority. In 2000, Government has promulgated Decision No 147/ QD-TTg on ratifying the Vietnam population strategy for the period 2001-2010 in order to raise the quality of life of each person, family, and society.

In order to achieve these strategic objectives, many solutions are given. Among them, reproductive health care and family planning emphasize on:

(1) Improving the quality of reproductive health care and family planning services, within the framework of primary health care.

(2) Satisfying the needs of the population in terms of reproductive health care and family planning.

(3) Limiting unwanted pregnancies

(4) Reducing the abortion rate.

Since the 1980s, Vietnam's population policy has encouraged a maximum of two children per family. The family planning program is targeted at married women and their husband.

Vietnam has a policy to encourage using contraception. Some modern methods such as IUD, condom, and oral pills are provided free of charge. In addition, nationally, new acceptors of sterilization are given bonuses and incentives, as are new acceptors of the IUD in some provinces according to local initiatives.

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Public sector:

The Ministry of Health is responsible for contraceptive services delivery through its extensive network of health facilities at communal, inter-communal, district and provincial levels. The Commune health Center is responsible for the distribution of pills and condoms, and since 1993, for intra-uterine devices (IUD) insertion and menstrual regulation where physical infrastructure and staff training permit. IUD insertions are also provided by mobile teams organized by the district health office, who travel to Commune Health Centers. The community-based program consists of the family planning staff and part-time motivators, many of whom are recruited from organizations such as the Vietnam Women's Union and from retired health staff. Part-time motivators receive brief family planning training. They conduct regular visits to provide health education and family planning motivation to households.

Private sectors:

Contraceptives, including injectables, oral pills, and condoms are increasingly available through private pharmacies. Private practitioners play an important role in expanding contraceptives and services delivery.

2. Rationale of the study

In Vietnam, although widely offered contraception, the abortion rate is still high. The use of abortion in the country has increased greatly in the past decade. According to official statistics, the national incidence of abortion was 70,281 in 1976; 811,176 in 1987, 1.37 million in 1993 and 1.5 million in 1996 (Henshaw, Singh, Haas, 1999a; MOH, 1997). The

abortion rate (abortions per 1,000 women aged 15-49) was about 27 in 1988, which increased sharply to 83 in 1996.

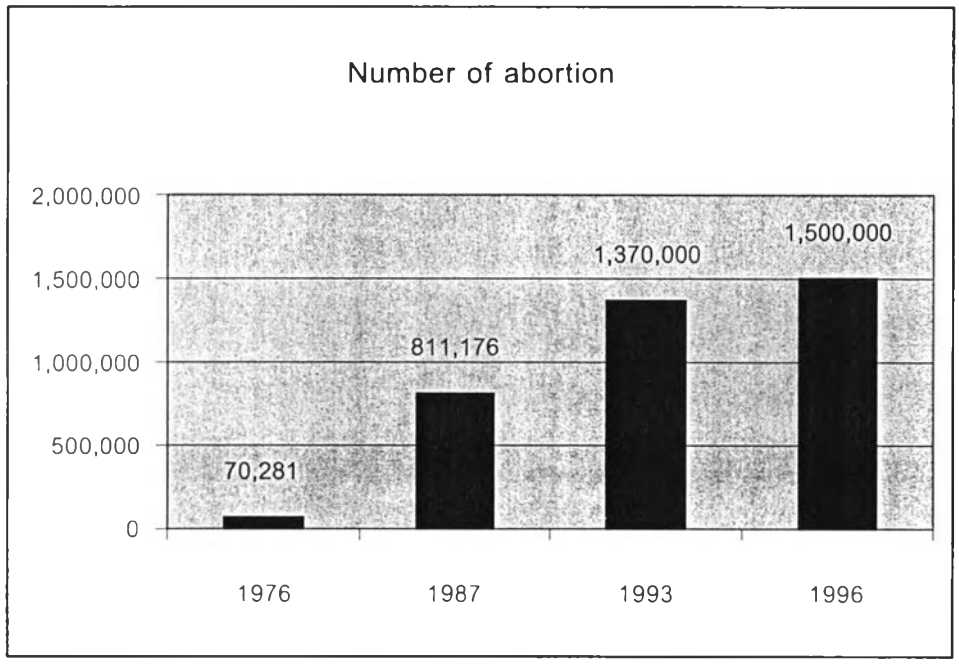

Figure 1: Number of abortion in 1976, 1987, 1993, and 1996

The true abortion rate in Vietnam maybe one-third higher than the reported rate because the large expansion in the provision of abortions in the private sector cannot be taken into account. As such Vietnam's rate of abortion stands as one of the highest in the world (Henshaw, Singh, & Haas 1999b).

A high abortion rate may reflect a shortcoming in the family planning program and a low rate of contraception in some areas in the country.

In Vietnam, there is little information regarding the prevalence of using family planning services, and abortion among married women of childbearing age in rural areas, especially

in remote areas. Sondong district is a remote area of Bacgiang province, Vietnam. Tuandao commune is located in the mountain areas of Sondong district with a population mainly are farmers doing forestry and agriculture. Therefore, my study focused on identifying the prevalence of using contraceptives including abortion rates and related factors that affect the using family planning services among married women of childbearing age in remote areas like Tuandao commune, Sondong district, Bacgiang province, Vietnam. This study may assist the authorities to develop appropriate family planning programs for remote areas.

3. Research questions

(1) What is the prevalence of using contraceptives among married women of childbearing age in Tuandao commune, Sondong district, Bacgiang province, Vietnam?

(2) What are the related factors that affect the utilization contraception in Tuandao commune, Sondong district, Bacgiang province, Vietnam?

4. Research objectives

4.1. General objective:

To assess the utilization of contraceptives including abortion among married women of childbearing age in Tuandao commune, Sondong district, Bacgiang province, Vietnam in 2004.

4.2. Specific objectives:

(1) To determine the prevalence of using contraceptives and abortion rates among married women of childbearing age in Tuandao commune, Sondong district, Bacgiang province, Vietnam.

(2) To describe the socio-demographic characteristic of married women of childbearing age

(3) To describe respondents' attitudes towards the contraceptives in Tuandao commune health center.

(4) To describe the variety contraceptive methods used among married women of childbearing age

(5) To determine the factors that related to utilization of contraceptives among married women of childbearing age.

5. Study conceptual framework

Based on the revised model of health service utilization of Andersen (1995), the conceptual framework of health-seeking behavior developed by Kroeger (1983), and the concept of WHO on accessing to maternal health services (1998), the conceptual framework for this study was:

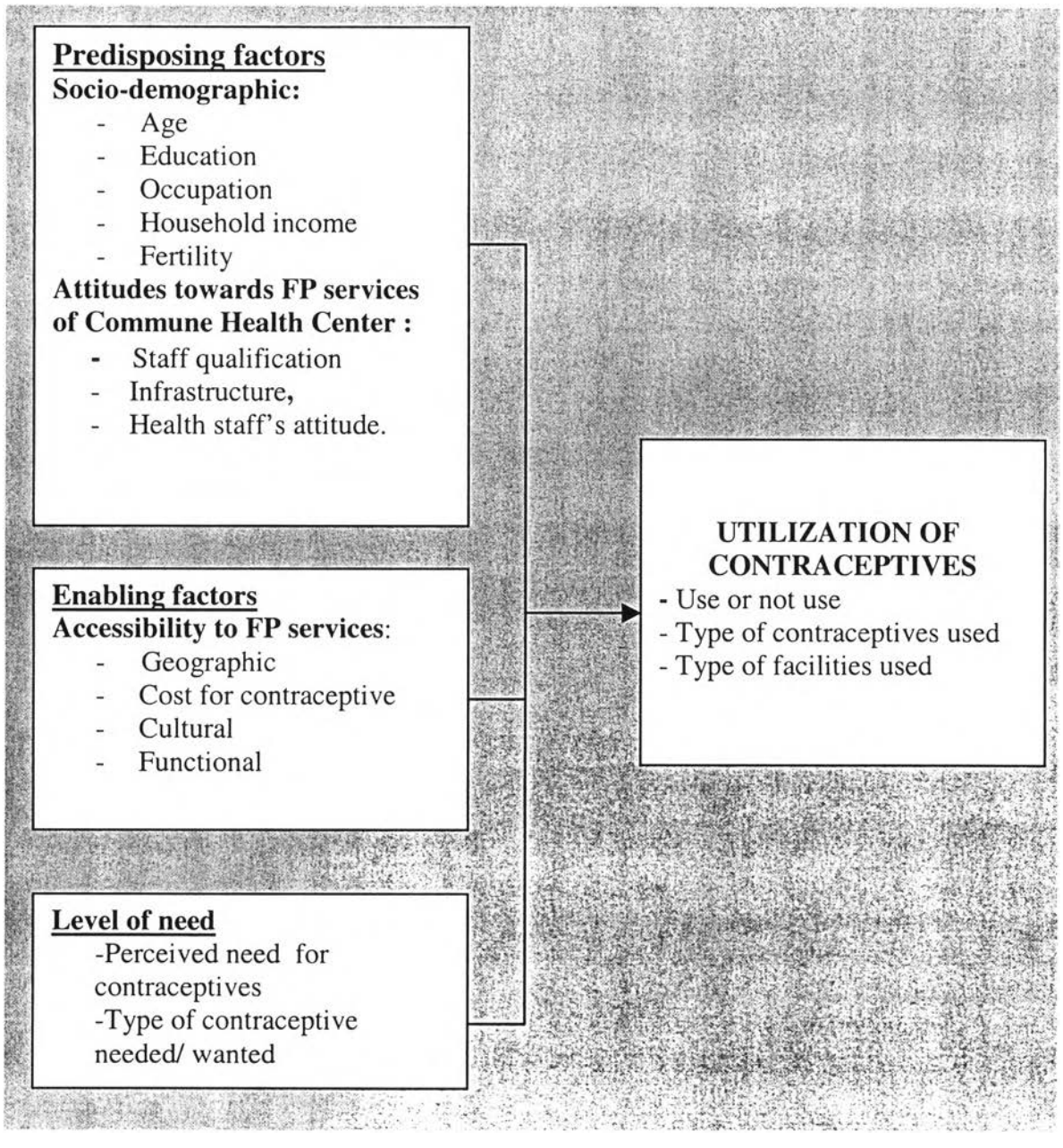

Figure 3: Study conceptual framework (Based on Andersen revised model (1995), Kroeger (1983), and WHO (1998).

6. Operational definitions of terms

Variables were measured by frequencies and proportions among respondents.

6.1. Contraception:

In this study, contraception refers to methods to prevent or terminate pregnancy. Contraceptive methods are divided into modern methods and traditional methods.

(1) Modern methods include Intra-Uterine Devices (IUD), condom, female sterilization, emergency pills, oral pills, and injection

(2) Traditional methods group includes withdrawal, and periodic abstinence.

(3) Emergency method: medical assisted abortion.

6.2. Accessibility

WHO defines accessibility is a continuous supply of care that is geographically, financially, culturally and functionally within the easy reach of whole community.

(1) Geographical accessibility means the distance, travel time, and means of transportation are acceptable to people.

(2) Financial accessibility means whatever the methods of payment used, the services are affordable for the community and the country

(3) Cultural accessibility means technical and managerial method used are in line with the cultural patterns of the community

(4) Functional accessibility: the right kind of care is available on continuous basic to those who need it whenever they need it and it is provided by health team required for its proper delivery (WHO, 1978).

In this study, the following variables are considered:

(1) Geographical variables: distance

(2) Financial variables: Free of charge contraceptives, services cost, and out of pocket payment

(3) Cultural variable: prefer to have many children

(4) Functional variables: available contraceptives, and information provided.

6.3. The utilization of family planning services

According WHO, the utilization was defined as the combination of access and personal health behaviors.(Report of the Technical consultation on effective coverage in health systems. WHO/EIP/OSD/ 10.01).

In this study, the utilization of contraceptives refers to the relationship between predisposing factors, enabling factors, and level for contraceptives.

(1) *In the predisposing factors*, there are three categories: demographic, social, and belief. Demographic variables include age, and fertility. The social variables include education, occupation, and household income. Belief variable refers to attitude towards available contraceptives at the commune health center.

(2) *Enabling factors* include access to contraceptives (Geographic, cost, cultural, and functional factors)

(*3) Illness level* is referred to perceived need for contraceptives.

6.4. Education level

Subjects are classified in five categories according to the education program that they had gone through. Illiterate are individuals who could not read and write. Primary school level refers to individuals who have less than 6 years of school education. Secondary school level refers to individuals who had 6 to 9 years of school education. High school level refers to people who had 10 to 12 years of school education. Graduate refers to the individuals who graduated from university or a professional school.

6.5. Household income

Household income refers to the total of income, which all family members earn per month in Vietnam dong (VND). It is classified into three categories using the classification of Ministry of Labors:

(1*) Level 1*: the average income per individuals in the family per month is less than 100,000 VND (for instant, if the family size is 4, so household income per month less than 400,000 VND).

(2) *Level 2*: the average income per individuals in the family per month from 100,000 to 200,000 VND (for instant, if the family size is 4, so household income per month from 400,000 to 800,000 VND).

(3) *Level 3*: the income per individuals in the family per month more than 200,000 VND (for instant, if the family size is 4, so household income per month more than 800,000 VND).

6.6. Occupation

Occupation refers to the current job or work of subjects to earn a living. It includes the following four categories: farmer, employee, business, and others. Farmer is the people who mainly do farming. Those are governmental staff and paid- employment counted as employee. Business is the people doing trade. Others include housewives, handicraft-makers and jobless.