Council wrote the reports and submitted the report draft by the end of July 2002. Based on JICA's comments on the first draft, the Council's revised and final report is being submitted by September 2003.

1.4 Limitations of the Study

Because not all study sites were selected in this mid-term assessment, the results may not be a completely accurate representation of provincial accounts, but the four study sites are a fairly balanced sampling of Nghe An districts, according to the characteristics listed above. What is a balanced account is that the selected CHCs all represent 25% of the total number of CHCs within each district.

There was also a limitation on the number of people interviewed, due to limited time of the research team. With the exception of the DHC, each research team was only able to spend a half-day at each selected health facility, so they interviewed only about two RH clients (ANC and FP) clients on. Though this average of daily interviews is less than in the 2001 Baseline Survey, it is only slightly less. In 2001, each survey team had full day visits of selected facilities, but only was able to meet about three RH clients a day.

It is also important to note that because of Nghe An MCH/FP Centers regulation that abortion, including MR services, are only provided at the district health facilities (DHC), there are no abortion clients at CHCs. Therefore, the information gathered on this type of client is scarce.

Chapter 2
Description of the study sample

2.1. Characteristics and Statistics of the Surveyed Health Facilities and Clients

A total of 28 health facilities in four districts of Nghe An were surveyed in this mid-term assessment, in other words four district health centers (14%) and 24 commune health centers (86%).

At survey time, 8 health facilities had no clients; the rest had 52 clients receiving RH services (ANC, FP and abortion). The research team found that on average, about 2 ANC/FP/abortion clients visit a health facility per half-working day. According to health providers, the clients usually come to the facility according to the schedule fixed for certain services as assigned by facility managers (for antenatal check or FP), or on a day when the district FP team comes to provide FP or vaccination services to the community. During harvest time, clients often come to the health facility early in the morning or late in the afternoon (before or after working hours in the field).

The two survey groups split up and conducted 52 observations of service provision , provider-client interactions and general observations of clients receiving three types of RH services: antenatal check-ups, FP and abortion. The majority of the observations were for service provision: ANC accounted for 65 percent (34 cases), FP for 19 percent (10 cases) and abortions for 15 percent (8 cases).

Clients at visited facilities were asked to participate in an interview . There were 43 clients interviewed, of whom three-fourths (77 %) were ANC clients and nearly one-fourth (23 %) were FP clients.

Out of 10 FP clients interviewed, only one intended to be injected with a contraceptive and the rest received IUDs. Also among these 10 clients, seven were new clients and the other three were there to get their IUDs replaced. Only six of them have an IUD inserted and the other four did not get the service due to an existing infection, a poor quality IUD (copper wire was rusty), because they were pregnant or because they were asked to return after the next menstrual period for a proper insertion.

Out of 34 ANC clients, 13 (38 %) were in their first pregnancy; 19 (59 % were in their second and just only two (6 %) were in their third. The average age of women surveyed in this study at their first pregnancy is 25.6 years.

During the time when the research team worked at these selected facilities, eight abortion clients visited the three DHCs (except the Tan Ky DHC). Of these abortion clients, the team observed four abortion clients. Three of these clients however, returned to their home without having the service, because they could not afford the service fees, and one client was asked to come back in the afternoon when the team had moved to another

study site. Research ethics prevented the research team from interviewing abortion clients after procedures.

2.2. Demographic and Socio-economic Characteristics of Clients

Age, sex, marital status and parity: All clients for all services interviewed are females. Almost are 20-29 years old, nearly one-fourth is 30-39, and a small percentage (2 percent) of clients is 40 and over. Most clients are married. About 33 percent have no children, 60 percent have one or two children, and 7 percent have 3 or more children.

Ethnicity, education and occupation: Around 93 percent of clients are the Kinh majority and 95 percent are non-religious. In terms of education, 19 percent have attained primary education, 28 percent have attained lower secondary education and 44 percent have attained upper secondary education. Sixty-five percent are farmers and 23 percent are government employees. Clients working in other sectors make up a small percentage (under 10 percent).

There was no difference in demographic and socio-economic status of surveyed clients between the two project areas, i.e. JICA Phase I (Dien Chau and Nghia Dan districts) and JICA Phase II (Anh Son and Tan Ky districts)

2.3. Demographic and Socio-economic Characteristics of Health Providers

Professional level: A total of 32 health providers were interviewed in this assessment, of these 65 percent are midwives, 31 percent are obstetric-pediatric assistant-doctors, and three percent are medical doctors of other specialties. These statistics are similar to the results of the 2001 baseline survey. In this mid-term assessment, midwives and obstetric-pediatric assistant-doctors are the major health providers included in the sample study on RH service provision at the district and commune public sector health facilities of Nghe An province.

Age, sex, marital status and number of living children: All health providers are married women (100 %). More than half (53 percent) are in the range of 30-39 years old, one-third are 40. Four-fifths (81 percent) have had one or two children, one-sixth (16 percent) have 3 or more children. Only 3 percent have no children yet.

Ethnicity and religion: The majority of health providers are non-religious. Most of them (88 percent) are of the Kinh majority. Providers of other ethnic groups are few (12 percent).

2.4 Demographic Characteristics of Local Officers Involved in FGDs and IDIs.

A total of 134 persons were involved in 17 FGDs and 23 IDIs at the district and commune level. Of these, 88 percent are female. The average age is 43 years, and 96 percent are married. District officers involved in FGDs include health officers (deputy directors of DHCs, the head of the Obstetrics Department of DHC), women's union

officers (chairperson and vice-chairperson) and heads of local population committees. Commune officers interviewed include commune chairmen, population officers, women's union officers, and heads of CHCs. Officers involved in IDIs are village population collaborators/motivators. Many of them are also women officers or health workers. Commune officers are farmers or pensioners. Population motivators or women's union officers work part-time. The average working years of a district officer are 23, and of a commune officer are 9.

Chapter 3
Results of Assessment

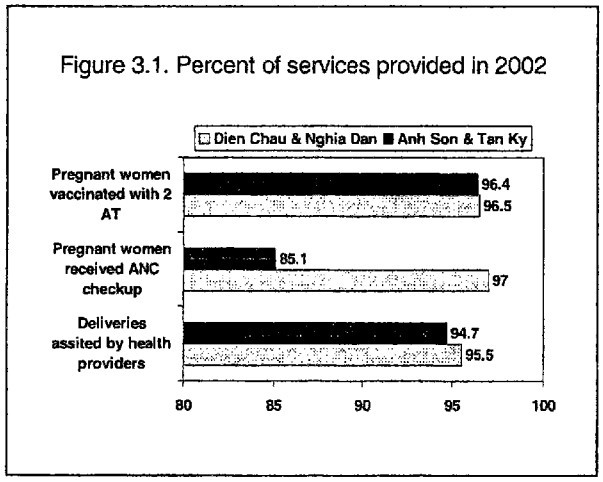
The objective of the Nghe An JICA Project is to improve women's RH by providing essential equipment for RH activities at the district and commune health facilities, providing refresher training to improve providers' competence, especially midwives', distributing IEC materials to women's unions and promoting collaboration among organizations involved in RH activities.

Results of the assessment are presented in terms of *effectiveness, efficiency and relevance* of the program towards the improvement of RH activities in Nghe An.

The report will highlight the assessment on the quality of reproductive health services for women, especially at the grassroots level. Has the quality been improved? The quality of RH services was reflected in the package approach including the readiness of health facilities in providing RH services to women, in having essential equipment that the facility requires, the technical competence of health providers the availability of IEC materials and contraceptive methods and supply, and supervision. The quality of RH services was assessed through the quality of services given to clients including health providers' attitude in providing service, especially the interpersonal communication between provider and client, counseling, technical competence and mechanism for continuity of service use and clients' satisfaction. Quality of RH services can also be reflected through the effective collaboration between different relevant organizations in the promotion of community health at the grassroots level, JICA's role in providing medical equipment, training of health staff, providing health education and IEC materials and the effective work of the Project Steering Committees (PSC) and especially the presence of long-term Japanese health consultants at project sites.

3.1 Quality of women's RH care

The attention towards quality of maternal and RH care is partly evident through investments to ensure the readiness of health facilities to provide services. Important upporting components mentioned include the infrastructure of facilities, provider's technical competence, the availability of IEC materials and activities, logistics, recording system and regular monitoring and supervision of the facility activities by a higher level.



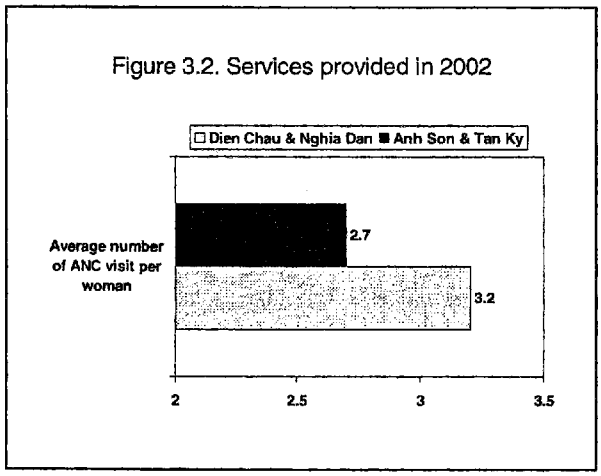
3.1.1 Readiness to provide women's RH care: Package Approach

a. RH services provided to local clients

The 2001 Baseline Survey shows that all RH services are available at almost all health facilities in Nghe An province, according to assigned functions and tasks of each level of health care. Therefore, this mid-term assessment (MTA) doesn't include in-depth examinations into all kinds of RH services actually provided by the various facilities, but it investigates the availability of essential laboratory tests at these facilities. The results show that early pregnancy tests, routine blood tests, routine urine test and wet mounts are available at four DHCs ; gram stains of microbes is available at 3 out of 4 DHCs. While all visited CHCs can provide early pregnancy tests, 8.3% routine blood tests and 54% routine urine tests.

b. Selected indicators on women's RH care

In this survey, several key indicators on maternal healthcare are measured; these are the percent of pregnant women whose delivery is attended by trained health providers, the average number of pregnancy check-ups per pregnant woman and the percent of pregnant women who received two shots of tetanus toxoid. Calculations of these indicators is based on 2002 statistics of surveyed CHCs; thus the validity of data greatly depends on the quality of each facility's recording.



For all four districts, about 92 percent of pregnant women received ANC and 95 percent of pregnant women's deliveries were attended by health care providers. Each pregnant woman had an average of three pregnancy check-ups during their pregnancy. Ninety-seven percent of pregnant women received tetanus vaccinations and 96 percent of delivering women used home-based maternal record. The percentages in Dien Chau and Nghia Dan facilities are higher than those in Anh Son and Tan Ky facilities. For example, 97 percent and 85 percent of pregnant woman in Dien Chau and Nghia Dan had pregnancy check-ups. Similarly, 98 percent and 93 percent of women who delivered used home-based maternal records. Each pregnant woman had an average of 3.2 and 2.7 pregnancy check-ups respectively. These percentages are higher than those of the baseline survey (see figure 3.1 and 3.2).

c. Infrastructure, facilities and equipment

Road accessibility: Almost all health facilities in Nghe An are easily accessible by different types of roads. Sixty percent of the facilities are accessible to higher levels by asphalt roads, 21 percent by dirt roads and very few by paved or tarred roads, or by rivers.

Convenient transport promotes clients' use of facilities and is important for both client and provider in the case of emergencies.

Working toilets: Working toilets are a major convenience for clients and provide them with a private space for urine collection for a lab test or performing personal hygiene before a gynecological exam. At the research team's visit, all CHCs had bathrooms, wells and toilets within the CHC area because of the support from the Japanese ODA project. In addition, each CHC has another toilet, which was built under the national health program run by the Ministry of Health (MOH) with the World Bank's loan. Thus, most facilities have one or two working toilets. In some facilities, one toilet is for providers and another for clients. In some facilities, only one toilet is used and the other is used for another purpose such as facility storage. This was noted as an unreasonable overlap of resources during FGDs with providers.

> *"Each CHC has a hygiene complex including a bathroom a well and a toilet with support from the Japanese ODA project. The national health project supported by the World Bank also provides these facilities, so now each CHC has two bathrooms, two wells and two toilets. All 21 communes in our district are in the same situation. We asked to use money for other purposes but it has not been approved. That's why there is such duplication."* (Male, aged 60, medical doctor, T.K district)

> *"There is a World Bank-funded 5-room health facility with a toilet and bathroom in Dien Chau and Japanese ODA also has a small project to build a bathroom, well and toilet which cost 12 million VND. So, in each commune, there are two similar facilities, one from the Japanese ODA and another from the World Bank. That's an overlap. It's better if part of the money were used for other purposes."*(Male, aged 55, obstetrician, D.C district)

Observation by the survey teams shows that 61 percent of health facilities have working toilets and of these, 39 percent are locked. The percentages of use in Dien Chau and Nghia Dan are higher than in Anh Son and Tan Ky. Almost all (89%) of functioning toilets are clean.

In some CHCs where these supporting facilities are working, some even is locked. Providers explained that they had to lock these toilets to keep them clean, and when clients needed them, they would open them.

Toilets are locked due to a number of reasons. Some facilities have no water, particularly during the dry season, since some wells in Anh Son are dry and that means that health providers have to go to other places to get water that is not enough for working toilets. Because of this, some facilities use traditional two-compartment latrines, which need no water. It is also that quality of these toilets is low. Even in some facilities of Anh Son and Tan Ky, there exist problems such as the wells are too deep and weak pumping machines do not work, water pipes are broken and there is no pump or non-working

pump, and water containers leak. A CHC provider complained once about irresponsibility of the bidding company in building the facility.

> *"Workers said that next month they would return to install a 1.2-million VND pumping machine, but they quit and never come back. Another problem is that drainage pipes of the toilet are too small, so it is usually obstructed."* (Female, aged 35, assistant doctor, CHC)

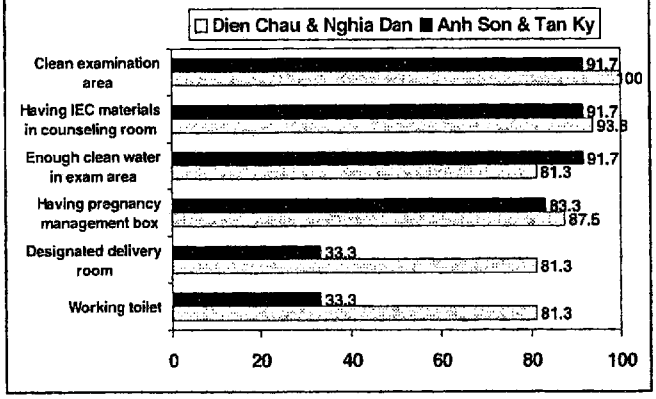
Another problem for maintaining toilets running properly is ensuring their proper usage. Some toilets are only used for several months, then break down due to misuse, especially due to clients.

Telephones and electricity: Only 35 percent of the surveyed facilities have access to telephone services. These percentages are 56 percent in Dien Chau and Nghia Dan and only 8 percent in Anh Son and Tan Ky. The availability of a telephone is considered an element of readiness to provide services, since it is essential in facilitating professional communication among various levels of the health system. Eighty two percent of health facilities have regular access to the national electricity network. The percentages in Dien Chau and Nghia Dan are higher than those in Anh Son and Tan Ky (94% as compared to 67%). Regular availability of electricity is a great advantage in professional practice in assisting delivery, managing emergency conditions or using electrical equipment sterilizers.

Separate examination room: Once health facilities have separate examination rooms, good hygiene conditions and shorter waiting times are assured. Most surveyed facilities have been newly built over the last 2-3 years under the national health program. However, service rooms are very small with an area of nearly 10m2. With such a small space, there is different equipment including delivery table, gynecological exam table, cabinet, rolling instrument table that one may think is a showroom rather than a service room.

In most of the surveyed health facilities, there's just one room for all three services including pregnancy check-ups, FP and gynecological examinations. Two-thirds of the facilities have a separate delivery room. These percentages in Dien Chau and Nghia Dan (81%) are higher than those in Anh Son and Tan Ky (33%) (Figure 3.3). Nearly one-third of the facilities have separate pregnancy check-up rooms and about one-sixth have separate FP rooms, and only 7 percent

Figure 3.3. Percent of facilities with infrastructure status (n=28)



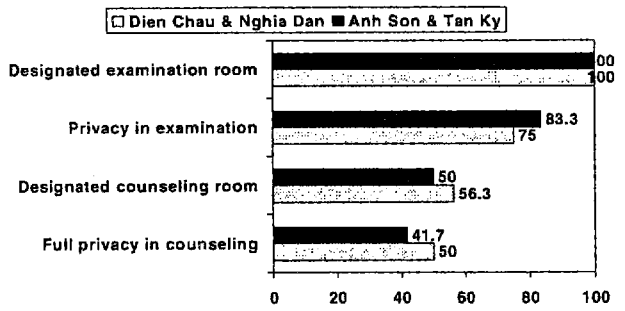
have rooms for FP services. Except for delivery rooms, the percentage of facilities with separate service rooms in this survey is lower than that of the 2001 baseline survey.

Almost all (86 percent) of the CHCs have *tickle-file boxes* for pregnancy management. These figures are 88 percent in Dien Chau and Nghia Dan and 83 percent in Anh Son and Tan Ky.

Cleanliness, adequate light: Most (96 percent) of health facilities have a clean examination room, 93 percent have adequate light in their examination room, 86 percent have clean water in the room, and 96 percent have a recovery room, of which 96 percent were judged to be clean. These figures of health facilities in Dien Chau and Nghia Dan are higher than those in Anh Son and Tan Ky (Figure 3.3). These rates also are higher as compared to the Baseline Survey 2001.

Privacy: It is necessary to ensure privacy for clients during counseling and medical examination. This allows confidential discussion of private and sensitive topics between clients and providers. In this mid-term assessment, 100 percent of health facilities have a designated room for examination and 54 percent have a designated room for counseling. The mid-term situation is better than that of the 2001 Baseline Survey.

Figure 3.4. Percent of health facilities ensuring privacy in service provision (n=28)



Recently, the Ministry of Health (MOH) has put counseling as an RH/FP task, which contributes and promotes counseling activities at all health facilities. The quality of counseling as well as environmental factors ensures that successful counseling is still an issue for discussion. The percentage of examination rooms with privacy is 79 percent, while only 46 percent have designated rooms for counseling. In fact, physical space at CHC is very limited. It may not be realistic to have a separate room for counseling. It is more important that health providers appreciate counseling and provide counseling frequently to their clients. The situation is still better as compared to the baseline survey (31%). Most counseling rooms have enough IEC materials and a bookcase given by JICA's project. Most health facilities in Dien Chau and Nghia Dan have more experience in ensuring proper infrastructure for counseling since the baseline survey, with 56 percent of the facilities having designated rooms for counseling and 50 percent ensuring privacy. Meanwhile, 50 percent of health facilities in Anh Son and Tan Ky districts have designated rooms for counseling and only 42 percent ensure privacy (Figure 3.4).

Delivery room: JICA 's support has brought about a great change in equipping delivery rooms. The situation has much been improved compared to the 2001 baseline survey. In most of the surveyed health facilities, standard criteria for a delivery room have been ensured. Delivery rooms are well-ventilated and clean with floors paved with glazed bricks and a cement ceiling. The proper equipment of a delivery room include a working ceiling lamp, gynecological examination lamp and available lantern to use when the electrical current is out, a container of already boiled water with a wooden handle, a cabinet for equipment, essential drugs for delivery, a kit for neonatal resuscitation, clean and sterile cloths for covering instruments, boiled soap in a closed box and used water drained into a closed tank outside the labor room. The percentages of health facilities with standard delivery rooms in Dien Chau and Nghia Dan are higher than those in Anh Son and Tan Ky. The fact that delivery rooms have been so well-equipped testifies to JICA 's commitment of ensuring a clean delivery to protect the health of mothers and their babies in Nghe An, insomuch as can be gathered from Phase I of health facilities maintenance.

Table 3.1: Delivery room status, by type of facility and by project areas

	Health Facilities at Dien Chau and Nghia Dan districts	Health Facilities at Anh Son and Tan Ky districts	All facilities of 4 districts
Delivery room			
Well – ventilated	100.0	100.0	100.0
Possibility for dirt to enter	25.0	16.7	21.4
Window with a screen or a curtain	100.0	83.3	92.9
Working ceiling lamp	93.8	83.3	89.3
Working gynecological exam lamp	81.3	58.3	71.4
Equipped with lamp or lantern to use during blackout	68.8	83.3	75.0
Equipped with a container of boiled water	100.0	100.0	100.0
Equipped with a container of boiled water with a wooden handle longer than 20cm	56.3	66.7	60.7
Clean floor	100.0	100.0	100.0
Equipped with a cabinet for equipment	100.0	100.0	100.0
Equipped with oxytocin or ergometrin	100.0	100.0	100.0
Equipped with a kit for neonatal resuscitation (catheter with 4-5 mm in diameter 20 ml bulb syringe for suctioning infants, sterile compresses, two resuscitating balloons)	87.5	83.3	85.7
Resuscitation box is stored in a separate sterile tray	75.0	25.0	53.6
Clean, sterile cloths available for covering instruments	87.5	83.3	85.7
Boiled soap is prepared in a closed box	100.0	91.7	96.4
Used water is drained into a closed tank outside the labor room	81.3	83.3	82.1

Facilities and equipment: Equipment is an essential support for health providers to deliver the full and necessary range of quality reproductive health services. Usually, equipment is distributed according to assigned tasks and functions of a given category of facility. Thus, assessment of the equipment of surveyed health facilities is an important component in this survey.

In health facilities of Nghe An, beside equipment provided by MOH and JICA, other equipment has been provided by the German GTZ project and UNICEF. Almost of medical equipment at grass-root level are provided by JICA. IDIs and FGDs show that local officersappreciate JICA's support in upgrading the infrastructure of health facilities through providing equipment for maternal and RH activities at the district and commune level.

> *"We see that the JICA project provides equipment for all 32 CHCs. As far as I know, infrastructure of all 32 CHC have been upgraded and provided with equipment. In the past, there was no delivery table but now we've got a good one. The infrastructure has become good enough that women don't have to travel the long distance from commune to district for their health service anymore."* (Female, aged 48, women's union staff, N.D district)

JICA-funded equipment greatly helps professional work, improves the quality of examination and treatment and provides other services to the people as well.

> *"Before 2002, there were difficulties in equipment and infrastructure. Many CHCs had neither delivery tables nor instruments for gynecological examinations. Some CHC used patient beds instead of delivery tables. With JICA support, RH/FP work has been much improved. For example, steam sterilizers greatly help CHCs in sterilizing cotton and compresses. Infection control is the most important thing to ensure. JICA has provided us with standard instruments, supporting facilities and their upgrade. It is extremely beneficial to the community."* (Female, aged 35, obstetrician, T.K district)

Along with equipment, improved technical competence of providers has helped to ensure good MCH/FP services and make clients feel comfortable to receive services:

> *"In the last few years, pregnant women who came here for delivery were often anxious about CHC's instruments. Now it is different, since all instruments are sterilized. If the CHC has to buy instruments by itself, it would take much time and may be very complicated. The JICA project has helped the CHC very much. Pregnant women now feel at ease to come here for the delivery of their child."* (Female, aged 49, P/FP collaborator)

In this assessment, facility inventory doesn't explore each equipment item as in the baseline survey 2001, since JICA has a standard list of essential equipment provided to health facilities at each level. In terms of equipment, this survey refers to the review of

equipment, which is either not used, inappropriate, or of low status by the time of the survey.

In this assessment, research teams paid attention to some types of equipment, which didn't work at the time of survey or were not appropriate to a given health facility but they didn't try to identify the specific sources of equipment supply. Most of the medical equipment seen at surveyed health facilities were in good condition and were functioning but there were few of them either with a poor status at the time of survey or not being appropriate at commune level. The survey team has observed that 23 of the studied health facilities (82%) have at least one instrument in poor status and 22 (79%) have at least one instrument not in use due to lack of demand or duplication of material.

District level: Except for the Anh Son DHC, the other three DHCs report that some of their instruments are of poor status. For example, the colposcope easily gets covered in a fungus, the hand-washing machine doesn't always work, the air-conditioner is broken, the meter device on the oxygen- maker doesn't work, the Doppler (fetal heart rate detector) device doesn't work since its probe is broken and the incubator for newborns doesn't work either, delivery kits get easily stained, the manual-operated aspirator cannot work due to its loss of negative pressure and medical instruments for major operations also become rusty.

Facilities managers find it difficult to manage equipment due to insufficient funding for regular maintenance and repairing. Providers reported that there was no clear regulation on maintaining and upgrading equipment, determining who was responsible and where the money exists for that. There were already problems with the colposcope when technicians were trained one year after the instrument had been provided. Health providers wish to have training on how to utilize and maintain medical instruments properly so they can prolong their duration.

Commune level: The research team found evidence of some broken instruments, including: manual-operated aspirator that doesn't work due to a loss of negative pressure since its rubber tube has deteriorated, a fuel-operated steam sterilizer that is broken due to a broken valve. Scissors and Pozzi forceps have become rusty, in addition to regular stethoscopes, sphygo-manometer, a kit for neonatal resuscitation, gynecological exam kits, electrical scale, incubator for newborn and steam sterilizers were all found to be broken. In some CHCs of Anh Son and Tan Ky districts, gynecological examination lamps, even newly received ones do not work. Health providers also mentioned the poor status of equipment, which was confirmed in FGD:

> *"Some equipment is of low quality and quickly breaks. For example, nasal aspirators made in China don't work after being used for only a short period. Electric steam sterilizers also made in China don't work since their boiling system was broken and needed repairing....* (Male, aged 39, assistant doctor, CHC)

Also at the CHCs, some instruments are not appropriate for use with local conditions. For example, in most of the CHCs in Tan Ky and Anh Son districts, electronic steam sterilizers are not in use because of insufficient power and electric fees that are more expensive than the facility could afford. Although electronic steam sterilizers can be used on fire, CHCs do not use. Instead, providers had to use a small boiling device, because it is convenient and not costly. Thus, sterilization of some instruments such as cotton, sponges, and compresses by using steam sterilizers was not possible.

In addition some facilities were found to have much equipment like gynecological exam tables (3-4), provided by the MOH and JICA. Since the room was small though, extra tables had to be moved out. Some facilities had extra rusty-proof-patient beds. Others were provided with rolling equipment trays, but they were not in use. Some facilities had such technical equipment (provided by GTZ) that they did not know how to use them. Several facilities have had Karman syringes provided by IPAS, but did not use them because CHCs are not allowed to perform abortions.

> *"Since we have JICA support, we are in surplus of some medical equipment, so we lend some of this equipment to the DHC. The DHC has borrowed from the CHC two rolling equipment trays and aspirators for menstrual regulation (MR), because the CHC is not allowed to perform abortions."* (Female, aged 55, assistant doctor, CHC)

Providers also mentioned about issues at DHC where types of equipment provided by the project are fewer than those in the CHC, while demand is higher at the DHC.

Having acknowledged a weakness in providing medical equipment to health facilities during Phase I, during Phase II of the project, JICA made efforts to have an appropriate correction to ensure that all medical equipment given to health facilities could be effectively used. In addition, in FGDs and IDIs researchers found that health facilities have been so dependent to the donor in equipment maintenance and repair. To make full use of medical equipment given to health facilities, the Project Steering Committee, and especially the project recipient should discuss with donors in providing essential medical equipment which is appropriate to the facility's function and tasks and staff's competence. There is also a need for a plan and related budget for equipment maintenance, repair or replacement in time.

d. Human readiness

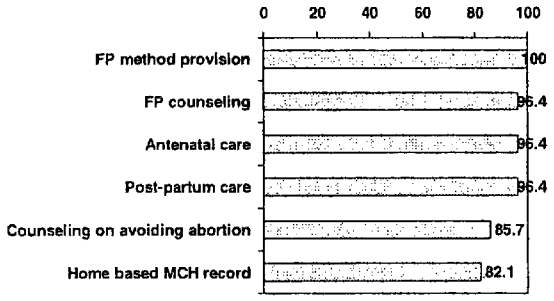
Technical competence and experience of providers. Among 32 providers interviewed, most (66%) were midwives, then assistant-physicians in Obstetrics & Pediatrics (31%). The majority of them are experienced. The mean number of years working in the facility where they were interviewed is 12 and in the health sector is 13. They have an average training duration of 26 months in RH issues. These health providers received refresher training on RH issues in which the last training was given 15 months ago. At each visited CHC, there were 4-6 providers on average.

Staff members were asked if they directly provided RH services. Similar to the baseline survey results, nearly 100 percent of them were actively involved in the delivery of services including family planning, antenatal and postpartum care, gynecological examination and treatment, RTI/STD diagnosis, treatment and counseling, and counseling for abortion reduction. The percentages of service providers in Dien Chau and Nghia Dan are slightly higher as compared to Anh Son and Tan Ky districts.

Basic training: Basic training is important groundwork that helps providers understand essential skills necessary to provide services. Like results from the baseline survey, staff at district and commune levels in Nghe An have received basic training in most major reproductive health issues, including family planning, antenatal care, postpartum care, management of obstetrical complications, gynecological examination/treatment, RTI/STDs diagnosis, treatment and counseling, childcare, and HIV/AIDS counseling.

Refresher training: Refresher training is a very important intervention to improve and update providers' knowledge and improve their competence to ensure good quality services. In this assessment, health staff were asked about the basic and refresher training they had had in the last three years, including training from JICA 's project, government's health projects and other donors. Most of interviewed health staff had refresher training with more than 94 percent of DHC and CHC providers in Dien Chau and Nghia Dan. This percentage in Tan Ky and Anh Son is 79 percent. Compared to the baseline survey (67%), the percentage of providers who have followed refresher training has increased significantly, which shows a great attention to improve technical competence of providers in Nghe An. At the time of assessment, some facilities reported that their staff was attending an upgrading training course (BA. in medicine or other kind of training).

Figure 3.5. Percent of providers receiving refresher training on selected topics (n=32)

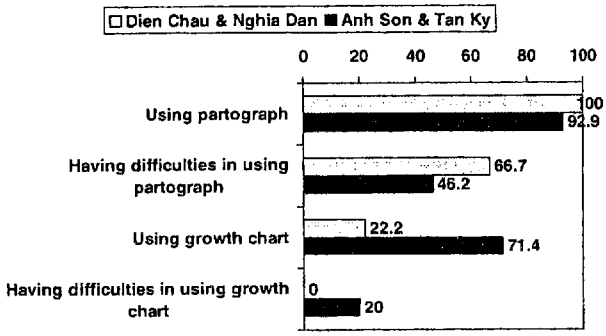


The topics that have been covered in refresher training are (in descending order) family planning services, RTI/STD counseling, management of obstetrical complications (100 percent), family planning counseling, antenatal care and postpartum care, gynecological exam and treatment, RTI/STD diagnosis and treatment and abortion reduction counseling (86%) (Figure 3.5).

In recent years, health providers have paid more attention to counseling. The percentage of providers in Dien Chau and Nghia Dan DHC receiving counseling in FP, abortion, and HIV/AIDS is higher than that in Anh Son and Tan Ky.

Most providers received training in skills to perform an ANC exam and management of labor. This percentage is much higher than that from the Baseline Survey, particularly since 100 percent of providers know how to apply the skills such as prenatal risk screening, use of partograph to manage labor, performing an intravenous infusion, internal and external bimanual compress of the uterus in case of hemorrhage, suturing (repairing), a perineal cut in episiotomy, speculum and bimanual examination.

Figure 3.6. Percent of providers using partograph and child growth chart (n=32)



A partograph helps providers monitor and timely identify risks during labor for timely management or referral. In the past, most health staff, especially those working at CHCs, rarely used the partograph The use of partograph in management of delivery is an important issue in JICA 's training curriculum. In this assessment, we found that the majority of interviewed providers reported having used partographs to manage labor and among them 40% could use it properly and easily (Figure 3.6)

Interviews of DHC providers show that they understood the importance of utilization of a partograph, but they did not fully see its practical usefulness. They also talked about the inconvenience of using it. Usually, at CHCs a midwife assists in the delivery without assistance from any other health staff because she may be the only staff available in CHCs at that time. It is not feasible for a midwife to manage both the delivery (with sterile gloves on) and fill in the partograph (with a ball-point or a pen) at the same time. So they can only fill-out the partograph after the delivery has been completed (Figure 3.6).

With regards to child growth chart, 44 percent of interviewed providers reported having used it and 20 percent of providers in Tan Ky and Anh Son reported difficulty in using it.

FGDs and IDIs also reveal that the JICA project has made great contributions in providing training to improve providers' technical competence, especially midwives. They know how to use all the equipment properly and effectively in their professional practice.

> *"Since we get JICA support, RH/FP program has many advantages. Just in Tan Ky, 21 midwives from 21 CHC received a refresher training. They are very pleased because they can perform an IUD insertion."* (Female, aged 45, Obstetrician, T.K district)
> *"Owing to the JICA project, the technical competence of providers has much improved compared to previous years when the project was not yet implemented.*

We cooperate with other organizations in the district and improve people's knowledge and understanding. Pregnant women as well as women of reproductive ages also get an understanding of RH." (Female, aged 47, medical doctor, N.D. district)

Providers interviewed highly appreciated JICA's training curriculum and method:

"It's a good thing that JICA combines both training and practice. We are provided with steam sterilizers and we receive training on how to use them. It's important that we can apply knowledge from the training. A number of graduated midwives don't even have all the proper knowledge, but after training, they can properly manage." (Male, aged 30, obstetrician, A.S. district)

Once grassroots level providers' technical competence is improved, clients will trust them and be assured to go to the facility for service. This helps reduce client/patient pressure at DHCs:

"Recently JICA had a one-month refresher training for midwives. They had good knowledge from the training. In general, at this DHC there are few IUD insertions and some antenatal check-ups referred from CHCs. These are women with edema or a proteinuria. At DHCs, there are more abortion clients while gynecological examinations, IUD insertions and contraceptives are available at CHCs. We also supervise RH campaigns. It's not the same as previous years when we ourselves did everything. Now we only help when CHC providers are unable to do so. So it's better." (Female, aged 33, obstetric-pediatric assistant, A.S district)

The JICA training curriculum has put more emphasis on training for the commune level. The numbers of district providers who have been trained were not many and most of them received training through monitoring and supervision. Although the project planned to encourage health providers to train their colleagues after they themselves have were trained, so that relevant DHC staff may have enough technical skills to conduct supervision of lower level. However, some DHCs could not do this because trained staff may afterward move to another place or there is a turnover in staff within health facilities, some district providers find it difficult to monitor and supervise:

"District providers should be trained when they come to do supervision in commune. The DHC nominated only one provider to attend the training, but she's in another training, so now at this facility there is no trainee from the JICA training. Others could not go, as they do not know about it. That's why I have to do the supervision myself." (Female, aged 45, obstetrician, T.K district)

"There is no refresher training for DHC midwives. JICA only provides each CHC one staff member (usually one midwife) to attend the course. DHC staff has to do supervision after training. There is a supervision trip each month to know how well midwives do and what the changes are in the CHC. At the end of last year,

we also requested the project to have another refresher training because of staff change (for example, some providers, after training, moved to other communes)" (Female, Obstetrician N. D district)

Project Steering Committee members, especially Vietnamese, should keep in mind a turnover rate of staff during the planning of refresher training of health providers at different levels, so that a replacement can be made in time. When introducing a new technology such as the application of partographs for every delivery, supervision should be conducted frequently in order to ensure that health providers comply with the proper method.

e. IEC materials and activities

IEC topics and distribution: In this assessment, the identification of available IEC materials was realized through direct observation when the survey team visited the health facility. Information on all kinds of RH topics has been made available to some extent among the IEC materials. Most health facilities (90 percent) have IEC materials on various topics relating to FP, antenatal care, breast-feeding and child care. These percentages are higher compared to the 2001 Baseline Survey. In general, these percentages in Dien Chau and Nghia Dan are higher than those in Anh Son and Tan Ky, except FP, childcare and prevention of RTI/STD. At the time of the survey, Maggies aprons are available at only 8 percent of health facilities in Anh Son and Tan Ky.

Main sources of IEC materials in Nghe An are from the MOH (100 percent), the national/provincial Committee for population, family and children (CPFC) (79%) and JICA (61%). Although IEC materials are available at most health facilities, only 32 percent of facilities report having sufficient quantities to distribute to clients, 42 percent have IEC materials but not enough to give to clients and the rest (21%) have no IEC materials at all. Facilities in Dien Chau and Nghia Dan have more IEC materials than those in Anh Son and Tan Ky districts (Table 3.2).

However, through FGD and IDI, we found that JICA has provided many IEC materials through the Women's Union. Most villages have a JICA bookcase with around 43 book titles relating to ANC, adolescent sexual health, FP and other family planning topics that are accessible to clients for their reading.

Table 3.2: Percent distribution of facilities having enough IEC materials to distribute to clients, by project area

Having IEC materials to give to clients	Health Facilities at Dien Chau and Nghia Dan districts	Health Facilities at Anh Son and Tan Ky districts	All facilities of 4 districts
Yes, enough to give to clients	25.0	41.7	32.1
Yes, not enough to give to clients	43.8	50.0	46.4
Not at all	31.3	8.3	21.4
Total	100.0	100.0	100.0
(n)	16	12	28

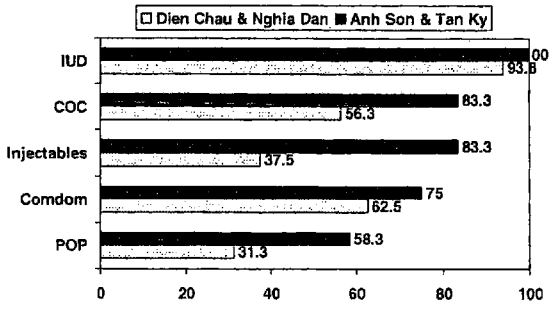
Facility inventory

f. Supplies and logistics

The availability of clean delivery kits and ferrous tablets: The availability of disposable delivery kits at facilities is considered necessary. The PCPFC project has provided disposable sterile delivery kits to health facilities, especially to those CHCs in remote and mountainous areas. In its training curriculum to Women's Union members, JICA provided training on how to use clean delivery kits, but did not provide the kits. The survey results show that 7 percent of facilities have clean delivery kits with an average of 10 kits per facility and 39 percent have ferrous tablets for anemic pregnant women with an average of 30 bottles/flippers.

Availability of supplies/contraceptives: The availability of supplies/ contraceptives contributes to increase client's choice. The government is responsible for the provision of contraceptives through the public health facilities and CCPFC network. Usually, contraceptives are available at all levels of public health facilities. But non-clinical contraceptives such as oral pills and condoms are also provided through the channel of CCPFC. At the grassroots level, P/FP collaborators provide condoms and oral pills directly to users.

Figure 3.7. Percent of health facilities providing various contraceptive methods (n=28)

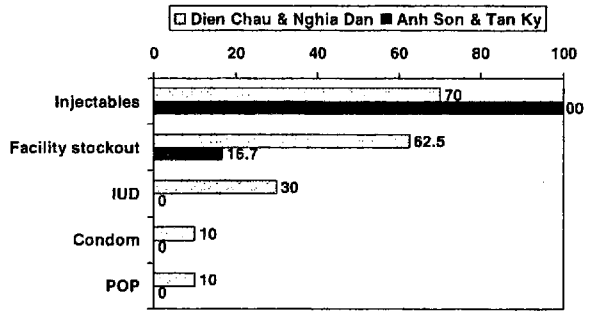


Survey results show that IUDs are available at 96 percent of health facilities; combined oral pills and condoms at 68 percent of facilities. However, injectable contraceptives are available at only 57 percent of facilities, and progestin-only-pills (POP) at 43 percent. Due to strong cooperation between population and health sectors, condoms and pills are available at two-thirds of health facilities for distribution to clients. The percentages of facilities with contraceptive

availability at Anh Son and Tan Ky are higher than those in Dien Chau and Nghia Dan (Figure 3.7).

Shortage of contraceptive methods: Because of a shortage of contraceptive methods, clients are not satisfied and may discontinue contraceptive use. The shortage of FP methods at health facilities is reflected in this survey. Forty-three percent of facilities reported having a shortage of at least one method within the last 6 months. Injectable contraceptives are the most frequent method not available at 75 percent of the facilities. The percentages of facilities in Dien Chau and Nghia Dan that are in shortage of FP methods are higher than in Anh Son and Tan Ky (Figure 3.8). Especially, IDIs and FGDs showed that due to a shortage of methods, clients had to shift to other methods, which were mostly combined oral pills.

Figure 3.8. Percent of contraceptive stockouts during last 6 months (n=28)



Also from IDIs and FGDs, the survey team gathered that not only were injectable not available, but also the supply of other methods was delayed and not timely in some facilities:

> *"Pills and condoms are not available for several months. So I tell clients to buy them at the CHC 's pharmacy or in t the market."* (Female, aged 50, P/FP collaborator, D.C district)

In order to ensure that contraceptives are not in a shortage, a buffer stock for each contraceptive method should be made, especially for a new method like injectable whose supply has not been well provisioned.

g. Record keeping, reporting and supervision

In this assessment, reviewing of register books on MCH/FP aims to assess providers' capacity in record keeping and reporting. A total of 13 types of register books were reviewed. Almost all facilities (over 90 percent) have client register books, which cover ANC, referral, deliveries, home-based maternal records, counseling, and IUD insertion. More than 80 percent have client register books on the use of condoms, pills and injectables. The record- keeping is well implemented. Record- keeping in facilities of Nghia Dan and Dien Chau is better than that in Anh Son and Tan Ky.

Although CHCs submit their quarterly and yearly reports to DHCs using a unique form assigned by the provincial health office, most facilities do not keep a copy of these reports. Therefore, being requested to provide health service statistics, providers had to search through register books, and sometimes statistics are not consistent.

Supervision: Almost all facilities reported receiving supervisory visits during the last six months. The mean number of supervisory visits per facility during this period is 3.6 in the last six months. The mean number of supervisory visits at Dien Chau and Nghia Dan facilities (4.2) is higher than Anh Son and Ky Son facilities (2.8). The purpose of the supervision reported by nearly all facilities is to check register books (96%), examine the delivery of RH services (79%), and provide comments and suggestions for improving quality of services (61%). Forty-two percent of the facilities report that the purpose of supervision is to identify problems. About 14 percent report that it is to encourage the staff and to reward those facilities that perform well.

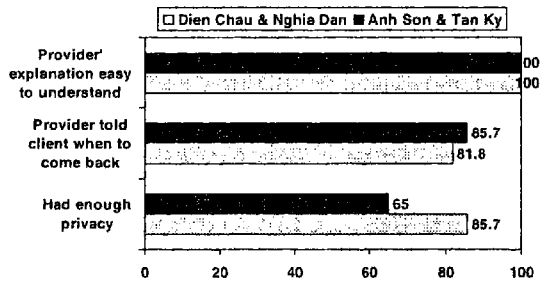
3.1.2. Quality of RH/FP service provision – strengths and weaknesses

a. Provider-client relationship

The provider-client relationship has a substantial impact on clients' satisfaction with services they receive. When the provider-client relationship is good, clients will be more self-reliant and ready to tell providers their problems. Interviews of clients presented the same results of the 2001 Baseline Survey - that the provider-client relationship is good at all surveyed facilities. Forty-four percent of 43 clients surveyed wanted to ask questions during the service interaction. They felt comfortable telling their problems to providers. Providers listened and answered their questions, and service providers spent sufficient time with them. Eighty-four percent of clients said providers issued appointments for a follow-up visit.

For clients receiving examinations and procedures, health providers gave explanations to four-fifths of clients before performing a procedure. The result is similar to the 2001 Baseline Survey. In general, providers explained results after, rather than giving information before an examination. Most clients (98 percent) reported that health providers explained their results, and that providers' explanations were easy to understand. Seventy-six percent of clients felt that there was sufficient privacy and respect during a medical examination or procedure. Figure 3.9 presents indicators on provider-client relationship.

Figure 3.9. Inter-personal relation (n=43)



b. Choice of family planning methods

The quality of services provided to clients seeking FP methods includes the element of informed choice of a contraceptive method, which is most appropriate for an individual client. Information and advice on various FP methods given to the clients during

counseling sessions are very important. The provider's behaviors or biases for or against specific FP methods may have impacts on the client's acceptance of the method.

One of the key factors for determining the quality of FP services is that the client has the opportunity to state her preferred method and whether that method is appropriate or not to her health or social circumstances. The provider will explain and give her other FP options to help her make a final decision. Out of 10 FP clients observed across all facilities, 8 voluntarily told the providers of their preferred IUD. Thus, for these clients, providers only introduced IUD during counseling. Just 3 clients were told about other methods available at the facilities such as injectable contraceptives and condoms. Mentioning only a few methods also limits clients' ability to make a choice.

Interviews of providers show a tendency in providing FP options for clients. Thirty-eight percent of interviewed providers reported having provided contraceptive methods to unmarried women; methods recommended are condoms, pills, and IUDs. More than 90 percent of providers believed that STD clients should use a specific contraceptive method, especially condoms. For some specific contraceptive methods, providers require the spouse's agreement. Sixty-nine percent said they asked for the spouse's consent when they provided sterilization. One-third required the spouse's agreement for injectable contraceptives and condoms. Less attention was paid to other methods; only 22 percent of providers required the spouse's consent for abortion.

Table 3.3. Percent of health providers who request spouse's agreement before providing a contraceptive method, by project area

	Health Facilities at Dien Chau and Nghia Dan districts	Health Facilities at Anh Son and Tan Ky districts	All facilities of 4 districts
Combined Oral Pill (COP)	11.1	14.3	12.5
IUD	27.8	14.3	21.9
Injectable	33.3	35.7	34.4
Condom	44.4	35.7	40.6
Sterilization	61.1	78.6	68.8
Emergency contraception	5.6	0.0	3.1
Abortion	27.8	14.3	21.9
(n)	18	14	32

Health provider interviews

c. Information exchange

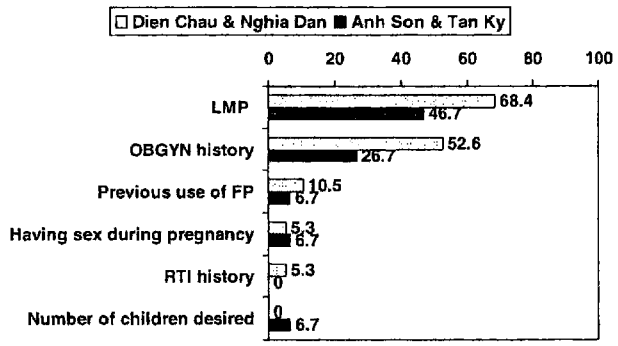
The information flow from clients to health providers is important since it gives providers basic information about clients, such as demographic characteristics, pregnancy and medical history, their desire for children, the use of family planning methods and history sexual behavior. This information helps health providers to select reproductive health services appropriate to clients' needs. During service interactions, health providers can

give clients information relevant to the purpose of their visit, provide necessary guidance and correct misconceptions about services.

Information exchange with ANC clients

An observation of 34 ANC clients reveals that provider-client information exchange is weak in Nghe An. Only 59 percent of providers asked clients' last date of menstruation47 percent asked about previous pregnancy check-ups, and 41 percent asked about gynecological exam history. Other issues were not mentioned including FP (previous use of family planning methods was asked by only 9 percent of providers), RTI/STD history (only 2.9%) and the number of desired children (only 2.9%). Figure 3.10 presents some selected indicators on information exchange between health providers and clients.

Figure 3.10. Percent of ANC clients who discussed various issues during visit (n=34)



Comparing information exchange between facilities of two district groups, the percentage of providers at Dien Chau's and Nghia Dan's facilities who discussed issues with clients is higher than at Anh Son and Tan Ky's facilities, for example, medical history (53 % vs. 27 %), number of living children (47 % vs. 7 %), age of the youngest child (32 % vs. 12 %), last date of menses (68 % vs. 47 %), vaccination against tetanus (53 % vs. 40%), and previous pregnancy check-ups (58 % vs. 33 %). However, providers of Anh Son and Tan Ky's facilities exchanged more information than those of Dien Chau and Nghia Dan's facilities such as medical history menstruation (47 % vs. 21%), and expected date of delivery (47 % vs. 16 %).

Counseling is still relatively weak in all surveyed facilities, communes and districts. Seventy-nine percent of ANC observations show that health providers informed clients about nutrition during pregnancy, maternal and fetal risks and made appointments for check-ups. Fifty-nine percent gave counseling on care during pregnancy (nutrition, appropriate rest and work schedules). More than half (53%) recommended clients come to the facility in the event of warning signs. Over 40 percent explained about effects of ferrous tablets, personal hygiene and home-based maternal record for the next visit. Few providers discussed caution when using medicine (12%), postpartum FP practice (12%) and sexual activity during pregnancy (10%). Thus, providers missed opportunities to exchange important information with ANC clients about preferred places for child delivery, maintenance of good sexual health and cautions to apply when using medicines and practicing postpartum FP.

When discussing with clients about possible abnormal symptoms which may arise during pregnancy, the most-discussed sign was abdominal pain (50%). About 41 percent mentioned swollen feet and face, headaches and exhaustion. Other signs mentioned, though mentioned less include fever, exhaustion, absence of fetal movement and heavy vaginal bleeding.

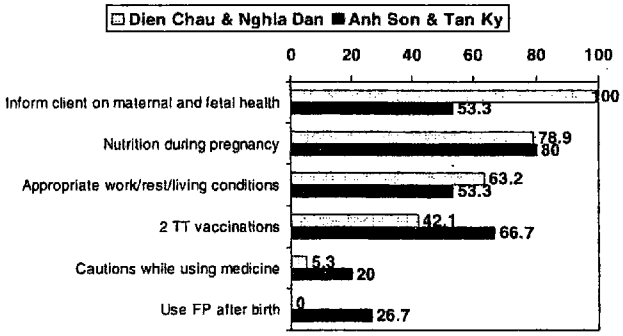
Table 3.4: Percent of ANC clients who had discussions with their providers and received counseling on warning signs of potential pregnancy complications

	Health Facilities at Dien Chau and Nghia Dan districts	Health Facilities at Anh Son and Tan Ky districts	All facilities of 4 districts
Discussed warning signs of pregnancy complications			
Abdominal pain	57.9	40.0	50.0
Vaginal bleeding	31.6	40.0	35.3
Fever	5.3	0.0	2.9
Exhaustion and heavy breathing	5.3	26.7	14.7
Swollen feet and face	31.6	53.3	41.2
Headaches	36.8	46.7	41.2
No feeling of fetal movement	31.6	26.7	29.4
(n)	19	15	34

ANC observation

Lack of providers also has an impact on counseling. During an observation of a district facility over one morning, there was only one provider who provided examinations, treatment and recording to over 10 clients receiving various services (gynecological exam, ANC, FP etc.). Therefore, indeed they did not have enough time to provide counseling to clients.

Figure 3.11. Percent of ANC clients who discussed and received counseling on the warning sign/symptoms (n=34)



Providers in Anh Son and Tan Ky provided more counseling than in Dien Chau and Nghia Dan. Issues discussed were many: warning signs (80 % vs. 32 %), effect of ferrous tablets (80 % vs. 32 %), personal hygiene (53 % vs. 42 %), ANC visits (67 % vs. 26 %), two shots of tetanus vaccination (67 % vs. 42%), and postpartum FP practices (27% vs. 0 %). The only issues discussed more by providers in Dien Chau and Nghia Dan than in Anh Son and Tan Ky were appropriate work schedule (63 % vs. 53 %), preparation for birth (42 % vs. 33 %) and information on maternal and fetal health (100 % vs. 53 %) (Figure 3.11).

Information exchange with FP clients

Because only 10 FP clients were observed, these observations are not representative. However, the observations do reveal poor FP counseling. Good counseling is a very important factor in providing FP services. Counseling helps clients choose an appropriate FP method and gain a better understanding of the selected method. But in these surveyed facilities, providers introduced only one or two methods when presenting contraceptive methods, which depended on whether the referred methods were available at the facility or not.

Few clients received comprehensive counseling on a specific method of family planning. Information exchanged includes last date of menses, previous contraceptive method and menstrual cycle. In-depth information such as instructions for use, effects and contradictions, management of side effects, switching to another method, and prevention of STI are not mentioned. During information exchange, providers used IEC materials such as leaflets, and method samples to just four clients.

Information exchange and counseling before and after abortion

There were eight abortion clients at district facilities. Observations show that during provider-abortion client interactions, providers discussed about client's age, Ob-Gyn history, abortion history, number of living children, menstruation and last date of menstruation, and previous use of FP practices. This helps providers have more information to provide adequate counseling, appropriate procedures and management to clients to avoid unwanted pregnancy and subsequent abortion complications.

Counseling aimed to help reduce abortion is also mentioned in IDI and FGD. Abortions are performed at DHCs with favorable professional conditions and facilities. The majority of providers were trained in counseling, so the counseling was regularly carried out:

> *"We provide counseling before and after abortion. We do that in most abortion cases. In general, there are few staff s, so during recovery time we tell clients if they still have vaginal bleeding, they should come here again, and how to use FP methods. In fact, there are many abortions in this facility: 118 abortions and 89 MR in the first quarter of this year."* (Female, aged 45, obstetrician, T.K District)

> *"Generally, we try hard to reduce abortions. First, the Obstetric Department has a room for counseling after abortion. Here we provide FP counseling to abortion clients. Secondly, postpartum women also receive counseling on FP methods. The high abortion rate in Nghia Dan is partly due to women from neighboring districts who come here to seek abortions."* (Female, aged 47, medical doctor, N.D district)

Because CHCs in Nghe An province are not allowed to perform abortions, a number of health providers and population and family planning (P/FP) collaborators do not know

the situation of abortion in their commune. Some providers say they are aware of the situation, since women seeking abortions must get a referral letter from the CHC. Most of the abortion cases are due to contraceptive failure. CHC providers know about the number of abortions in their commune through a regular monthly meeting held at the DHC with CHCs midwives. According to a report from the Tan Ky DHC's manager, at each monthly meeting the DHC will deliver a list of abortion clients from each commune within the district to midwives for post-abortion counseling.

P/FP collaborators reported they also included abortion counseling in IEC activities for pregnant women or FP users. In the IEC materials, they explained the consequences of abortion towards women's health and recommended appropriate and safe contraceptive methods that would prevent having to make that choice.

> *"We encourage our clients that have contraceptive failure to come to the DHC for an exam and have a safe abortion. Then we advise clients to use some contraceptive methods to protect themselves, if not their health will be affected as well as their family economy."* (Female, aged 49, commune Women's Union staff, N.D district)

> *"We also tell clients that repeated abortions will affect their uterus and health, and there may also be a possibility of uterine rupture. Usually after counseling they are willing to use safer reproductive health methods. Good hygiene practices can also prevent infection."* (Male, aged 33, commune P/FP collaborator, T.K district)

Although counseling on abortion was available, most population/family planning collaborators did not receive training on this issue; they just gave counseling based on their own understanding of abortion issues and through reading relevant materials. Therefore, many collaborators asked for more training and knowledge of counseling so that they can better counsel women.

d. Technical competence of health providers

Technical competence of providers is an important element of quality of care. It has a significant impact on clients' confidence in services, and clients readily commented on it. Technical competence mainly refers to the clinical techniques of health providers, ensuring correct clinical procedures such as the asepsis protocol in performing a pelvic examination. Technical competence also encompasses counseling skills, service provision skills, management of side effects or any other problems that may arise. Providers with technical competence will gain clients' confidence and ensure provision of high-qualified services. In this study, technical competence of providers is assessed through observations of ANC, FP and abortion service provision.

Technical competence of antenatal care service provision

Of a total of 43 clients who were observed, seven received their first antenatal care (ANC). The mean duration of gestation was 17 weeks. The mean duration of gestation at the first antenatal visit in this assessment is lower than in the 2001 baseline survey (17 vs. 29 weeks). Early pregnancy check-ups help women receive counseling on nutrition, hygiene, appropriate working regimens, and warning signs of abnormalities/complications during pregnancy.

Very few clients (seven cases) had a first antenatal visit where analysis of ANC procedures was not representative. The majority of clients got blood pressure and pulse rate measured, however, basic procedures necessary for ANC such as physical examination, client's height measurements, blood pressure and pulse rate measurements, assessment of anemia and edema were not regularly carried out (these might be done at previous visits).

Twenty-seven percent of ANC clients got tests for uterine analysis. The percentages of clients in Dien Chau and Nghia Dan who received blood tests and ultrasound scans are 5 percent and 37 percent.

Eighty-eight percent of ANC clients used home-based maternal records.

Technical competence of FP service provision

With regards to IUD, there is more besides counseling technical competence of providers that is important. Screening examinations of contradictions are vital. Improper IUD insertions may cause infections or enhance an existing infection, IUD expulsion or displacement. Observations of six IUD clients show that most providers complied with IUD insertion procedures. However, sterilization was not ensured in some facilities where both sterilized and non-sterilized instruments were stored together.

Technical competence of abortion service provision

In general, MR/abortion procedures were technically well performed at surveyed health facilities. However, the provision of abortion services should be reconsidered to ensure client's convenience and safety. For example, if an abortion client needs to purchase pain-killers or other medicines to be used in the procedure, she should be informed well in advance so that she can prepare money and doesn't miss the procedure only because she has no money at the time of the scheduled procedure.

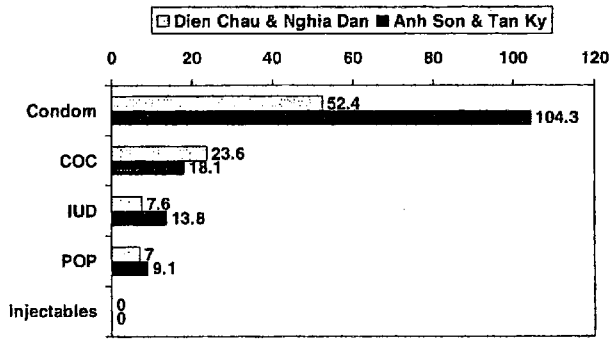
Counseling after abortion: Providers pay more attention to the importance of taking preventive antibiotics, warning signs after abortion and management of abortion consequences. Discussions and counseling on possible FP methods are necessary to help clients avoid unwanted pregnancy after abortion, thus reducing repeated abortions and improving women's health. Two out of four clients were given counseling and FP services after abortion. They were also were reminded to come back for a follow-up visit.

e. Mechanisms to encourage continuity of services

Another element of quality of care is ensuring that clients continue to use services. There should be a good monitoring mechanism to help clients manage side effects during pregnancy and post-abortion and to remind clients to come back for follow-up visits and to provide other reproductive health services according to clients' needs. In addition, in order to successfully encourage clients to continue using a service, it must be convenient and easy to access.

The availability of certain contraceptive methods at health facilities will ensure a continuity of service provision to meet clients' needs. On average, each facility has 20 cycles of combined oral pills, eight cycles of progestin-only –pills (POP) and 10 IUDs. Except for four facilities having about 200 – 600 condoms, each facility has 75 condoms on average. Figure 3.12 presents the average number of FP commodities available at health facility by two district groups.

Figure 3.12. Average number of FP methods available (n=28)



Beside health facilities, P/FP collaborators also provide pills and condoms. IDIs of collaborators reveal that the provision of these contraceptives is very flexible. P/FP collaborators can come to client's house to distribute condoms, or clients can inform collaborator of his/her need, so that each month clients will receive condoms from the collaborator. Usually, a pill client will receive one cycle per month; condom client will get 10 condoms per month, some get more and some get less. Most P/FP collaborators reported they had a sufficient quantity of condoms and pills to give to users.

> *"Each client gets about 7-10 condoms per month. Some clients ask for less or more condoms. If any client doesn't use them, I'll come to his/her home to ask why."* (Female, aged 34, commune P/FP collaborator, T.K district)

> *"Generally in recent years, condom supply and provision are good. Each month a client usually receives 10 condoms."* (Female, aged 53, commune P/FP collaborator, A.S district)

Many facilities in all four districts were not continuously supplied with injectable contraceptives, so when clients needed to take the next injection, the method was not available. In this case, clients had to switch to other methods:

> *"Last year injectables were not sufficient so the provision was not good. Because of the unavailability of the method, clients may have no confidence in provider's*

technical competence." (Female, aged 45, medical doctor, D.C district)
"There are some issues in providing injectables because it depends on technical competence. Due to delayed supply, some women can't get the method when they need the second shot." (Female, aged 44, commune P/FP collaborator, N.D district)

"Injectables are not sufficient, which lead to out-of-date shots. Although it is not yet common, it's better to have regular and sufficient supply." (Female, commune Women's Union staff, T.K district)

Thus it can be said that contraceptive methods are widely provided in all surveyed sites. However, at some facilities, the supply and distribution are not regularly and timely. Some facilities in Tan Ky and Anh Son discussed common side effects of injectables (amenorrhea and prolonged bleeding period) that contributed to a high discontinuation rate. According to the 2002 reports of DHCs, discontinuation rates are 23 percent in Tan Ky, 33 percent in Nghia Dan, 41 percent in Anh Son and 69 percent in Dien Chau. About three-fourths of clients receiving RH services were recommended to come back for follow-up visit.

f. Acceptability, accessibility, and appropriateness of services

Acceptability, accessibility, and appropriateness of health services were assessed by interviewing clients and observing them during the process of provider-client interactions for FP, ANC, and RTI/STD services. In order to evaluate the accessibility of services, clients were asked about their travel time to the facility, access to IEC materials, and use of other services. Clients were also asked to evaluate their access to information on correct use of drugs, reasons for choosing the facility, frequency of and satisfaction with visits.

The overall average travel time to a facility reported by clients was 20 minutes. To travel to the facility, 44 percent of clients used a bicycle, 16 percent used a motorbike, and 32 percent walked.

Client's consent towards services reflects quality of services judging by their views. Client's assessment depends much on what clients understand by the idea of quality of service that they need to obtain.

Assessment results show that 91 percent of clients reported they received all services and information, 95 percent were satisfied with services provided. Among clients coming to health facilities for RH services, 30 percent were given medicine or prescription, and most reported they knew how to use the medicine.

Although various IEC materials were available, there was not enough quantity to distribute to clients. So, only three clients received IEC materials to read at the facility or bring home.

The availability of alternative health facilities for client's choice: nearly two-thirds of clients said they knew other facilities (in addition to where they were surveyed) near their house. Some 50 percent knew other hospitals and CHCs. Only 15% of them mentioned provincial health facilities and another 11% private health facilities. Thus, clients selected these facilities because of good services (58 %) and convenience (35 %).

3. 2 Cooperation among Organizations in RH/FP Work

3.2.1 Cooperation among Programs, Donors and Roles of JICA's RH Program in Improving Quality of Maternal and RH Services

Over the last years, the RH program in Nghe An has received great support from the government and other international organizations such as JICA, the World Bank (WB), UNICEF, Marie Stopes International (MSI/UK), GTZ (Germany), Spain and other agencies. However, only JICA aims at comprehensively supporting the women's RH program, which is implemented in all health facilities and communes of the province. Other programs focus on some specific issues at a specific number of districts or communes. Among surveyed districts, Tan Ky is a district with the support from several donors such as JICA, Marie Stopes International, GTZ and Spain.

From IDIs and FGDs, it was noted that basically supports from different agencies to the RH program don't overlap, except some instruments such as a delivery table, gynecological exam table and a steam sterilizer. In general, all health facilities try to make full use of all supports to improve the quality of the RH services.

> *"There's no overlap in these supported projects. WB mainly focuses on upgrading facilities and providing medicines. GTZ provides support upon our requests, which are not the same as WB support. JICA provides support different from GTZ support."* (Male, aged 55, medical doctor, D. C district)

> *"JICA provides strict management of abortion, while GTZ puts its emphasis on FP. Each project has its own purposes. Thus, these are both of great help. We get more from these additional training courses."* (Female, aged 33, assistant-Doctor in Obstetrics, A.S district

> *"Besides the JICA project, we've got an RH project from Spain. I have just received training on health and nutrition."* (Female, aged 41, commune women's union staff)

IDIs and FGDs of district and commune providers show a high appreciation of JICA's contribution. According to interviewed health providers, the project has brought great changes in women's RH care in Nghe An. These are not only support for infrastructure, equipment, facilities, improvement of provider's technical competence, but also essential changes in working ways and styles to improve client-oriented quality of service and raise people's awareness, particularly women during their reproductive ages.

Community health promotion is an important element of the RH project supported by JICA. The project has especially focused on women at the commune level and make efforts to improve women's RH. In addition to support of health facilities, community staff and women also benefited from the JICA project through training courses for women's union staff, P/FP collaborators, and distribution of IEC materials on women's health care, which were appropriate to people's understanding. These materials have improved technical competence of women's union staff and P/FP collaborators, who are also women's union staff and raised people's awareness as well, especially women.

> *"JICA 's brochures, posters, and other materials are distributed to almost every women's union staff. It's very convenient. I think it's a good thing that we are provided with information. We don't have to inform and communicate to women, they can see IEC materials and read all information they want to know. That's the best of all."* (Female, aged 48, district women's union staff, N.D district)

> *"JICA provides a total of 299 book-cases to the village level in Nghe An. It's very convenient for women including those of reproductive ages. Each out of 299 bookcases has 9 copies and each copy consists of 27 books on RH care from puberty to menopause. It's a useful source of information for women to access RH issues."* (Female, commune P/FP collaborator, A.S district)

> *"We receive many IEC materials from CHC. For example, I got 45 materials of 7-8 kinds. I distributed them according to users' ages. For example, I give materials on menopause to women above 49 years, and materials on puberty to adolescents."* (Female, aged 50, commune P/FP collaborator, D.C district)

P/FP collaborators are very impressed by JICA 's attractive and lively ways of training. They said the training materials are well compiled, understandable and there are illustrations appropriate to users in rural areas:

> *"JICA 's materials are lively and easy to remember. Women find it easy to remember short comics, poems, and songs on breastfeeding and antenatal care... I can remember them for long time."* (Female, commune P/FP collaborator, women's union staff, A.S district)

> *"In general, JICA 's training materials are well-prepared with detailed instructions and illustrations, so that women can thoroughly understand. After training they can apply new knowledge into practice."* (Female, aged 42, commune Women's Union staff, D.C district)

With support from JICA and other program, RH/FP program has achieved a comprehensive improvement. Women's knowledge on healthcare has clearly improved through communication, training, and collaborator's counseling. Villages are provided with a bookcase for women to read and obtain information on diseases. This improvement in knowledge can change women's behavior in seeking health care services

from CHC. Now they themselves can come to the facility for general healthcare, ANC check-up and delivery.

> *"In the past, few pregnant women had antenatal check-ups. Since the t JICA project, more pregnant women go to health facility for ANC. Women in the past often gave births at home. Now women are aware of the importance of having ANC and food intake during pregnancy."* (Female, aged 52, T.K district Women's Union staff)

> *"It's difficult to implement projects in areas where local people are catholic because they consider that God doesn't allow it. Since the Women's Union launched their campaign on 'happy family', which means fewer children so they can be raised better, women understand. The Women's Union collaborates with other organizations to integrate JICA 's RH program into their work. Women have been using contraceptive methods such as pills and condoms. Several persons have been sterilized, and that's a good thing. In addition, priests also give support. The Women's Union and CCPFC have conducted a motivation of women in accepting FP methods."* (Female, aged 42, head of commune Women's Union, D.C district)

> *"It is because there was no such a program, or when the program first started, it was very difficult to ask women to go to health facilities for antenatal check-ups as they were very reluctant. They still did not have a good feeling about that. Now it's totally different. Women both can have examinations and receive necessary medicine. This is a great success. We are much indebted to JICA 's project. The number of women with gynecological diseases are reducing."* (Female, aged 47, N.D district Women's Union staff)

JICA has paid much attention to women's health and instructions for the nutrition regimen for pregnant women, children and weaning. Due to reasonable nutrition regimen during pregnancy, the infant malnutrition rate has considerably declined

Another advantage of the project is having JICA' s long-term consultants who work very closely with their Vietnamese partners from provincial to commune level. This has brought about a mutual learning and experience sharing. It has been a few years since the implementation of the project, and health providers, women's union staff, P/FP collaborators and other trainees have gotten much knowledge from Japanese experts, such as hard working spirit and effective working method.

> *"JICA experts work a hard 8 hours per day. In the past, if there was a meeting scheduled at 7 am, it would be held at 8.30 or even later. With JICA project, this habit has totally changed."* (Female, aged 52, T.K district Women's Union staff)

> *"Through the project activities, we learn a lot from JICA 's working spirit, job responsibility and compassion for patients. JICA provides us with equipment, knowledge, working capacity and style of an industrial and developed society. In*

IEC activities, they give us detailed and precise instructions as stated in leaflets." (Female, aged 48, district Women's Union staff, A.S district)

"The JICA project provides instructions on childcare, including different kinds of food and how to prepare good food, and pregnant women's rights. This is necessary knowledge for women. CHC has made obvious improvements in its human resources both from the head to the staff. When receiving services, clients are warmly welcomed and given detailed instructions by the staff." (Female, aged 48, commune P/FP collaborator, D.C. district)

3.2.2 Cooperation among Organizations in RH Activity

Like elsewhere in Viet Nam, the RH program in Nghe An province has been implemented with the collaboration of various local organizations and sectors at the provincial/ district/commune level. These are members of Vietnam's political and social organizations: People' Committee, Women's Union, Committee for Population, Family and Children, health sector and other relevant organizations such as the Farmer's Union and Youth Union. Among these organizations, the cooperation in RH activities between Women's Union, Committee for Population, Family and Children and the health sector was very close and effective. The Women's Union carries out communication and advocacy to raise its members' awareness and knowledge about RH/FP. CPFC staff at district and commune levels provided counseling services and some contraceptives. Health professionals provide maternal and RH services and clinical contraceptive methods

In order to implement the RH Project in Nghe An, a project management structure had been developed at all level of project implementation, from province to commune. At each level, there is a project steering committee (PSC) , which includes representatives of the local administrative authority, the health sector, Population Committee and Women's Union. Usually, these Project Steering Committee members are also heads of the above-mentioned organizations. That is why there was an advantage in such collaboration in implementing the project.

It is said that the cooperation in the RH/FP among population, health sectors and Women's Union as well as other local organizations is an advantage and rather effective. This close cooperation is clearly shown in meetings of the population committee with the participation of other organizations, in communication campaigns, services provision and integration of these activities into each organization's activities.
These meetings often include discussions reviewing current implementation of population/RH activities, operation of coming activities and the cooperation of organizations in these activities. The participation of different organizations, especially that of the local authority, health office and women's union in these meetings has contributed to the efficiency of the RH work in general and the MCH/FP in particular.

"Such good cooperation is due to the monthly meeting with heads of the population board, CHCs, Women's Union and other P/FP collaborators. This is a large commune but the population/RH activities are well-implemented." (Female, aged 50, commune Women's Union Staff, A.S district)

"I see that there is regular cooperation between DHCs and CHCs. Some CHCs invite DHC health workers to provide periodical health exams to women on the occasion of Women's Day (March 8) or Viet Nam Women's Union Day (October 20). If available, women can be given medicine and they are very pleased. At each of JICA 's training course, prominent members of the Women's Union are invited to attend so as to communicate to community people." (Female, aged 55, D.C district Women's Union staff)

"Such cooperation between the population and health sector is good. Campaigns and other activities are well integrated to find solutions for any emerging problem. For instance, when condoms become out of stock the district population commission is contacted for a timely supply." (Female, aged 47, medical doctor, N.D district)

"There is a close cooperation among population, health sectors and women's union for RH care in remote areas. Health providers are responsible for technical competence. We launch campaigns in all 21 communes. The cooperation is good." (Male, aged 60, medical doctor, T.K district)

The CPFC has a network of P/FP collaborators who have been working hard in all villages for many years. These are persons who may have some position in the local authority or mass organizations such as Women's Union, Youth Union or as village health workers. Besides monitoring local P/FP statistics, these collaborators are also involved in IEC activities, encourage people to use contraceptive methods, provide pills and condoms and conduct communication on ANC and child nutrition. JICA training provides them with more knowledge on communication skills:

"Such good cooperation is due to the monthly meeting with heads of the population board, CHCs, Women's Union and other P/FP collaborators. This is a large commune but the population/RH activities are well-implemented." (Female, aged 50, commune Women's Union Staff, A.S district)

In the population/family planning program of Viet Nam in general and of Nghe An in particular, two systems of service provision exist: the population system provides condoms and pills, while the health system provides clinical methods such as IUDs, injectables, sterilization and MR/abortion. Generally, with such assignment, issues have arisen between the two systems when their duties overlap, such as when health providers have to make a request of pills and condoms from the population system. This dependency sometimes leads to a situation in which health facilities do not have the supplies that clients need when they visit these facilities. However, in many IDIs and FGDs at surveyed facilities, interviewed health providers confirmed that this problem is

relatively small since P/FP collaborators provide health providers with an adequate amount of pills and condoms.

> *"In our village, we have no problems distributing pills and condoms. At the CHC, cooperation in providing injectables and IUD is good."* (Female, aged 55, nurse *cum* commune P/FP collaborator, D.C district)

> *"I think that this assignment is reasonable. The CHC provides good clinical services. We, as grass-roots counselors, can only provide condoms and pills."* (Female, aged 43, CCPFC staff, N.D district)

Campaigns at communes clearly reveal such cooperation. Provision of RH/FP services or IEC activities on RH and immunization are carried out through these campaigns. In preparation for these campaigns, population workers and women's union staffs are often accountable for communication and advocacy, while health providers are responsible for technical issues.

> *"IEC activities have been carried out at each grass-roots level in close collaboration with the population committee. For example, we invite health providers from the DHC to make presentations on Maternal and RH in our seminars. In that way, local women can be provided with more knowledge."* (Female, aged 52, Head of T.K district Women's Union)

> *"In FP practice and RH care, Women's Union plays an advisory role and cooperates with other organizations. Each year, we conduct IEC activities and promote women to accept contraceptive methods. In this work, health providers both ensure technical demands and carry out IEC work. We can do certain IEC activities, but we still have to invite health providers to do some more detailed things."* (Female, D.C district Women's Union staff)

At commune level, one of the advantages in cooperation is that one staff may take up various responsibilities. For example, a CCPFC staff or P/FP collaborator can be at the same time on staff with the Women's Union.

> *"In terms of profession, population and women's union staffs have a good cooperation. Population committee staff often agree with us that it is an advantage that the population committee staff is also head of the Women's Union"* (Female, aged 48, head of district Women's Union, N.D district)

> *"We have a good cooperation in different activities such as motivating women to have ANC visit or accept an IUD insertion and with the supply of contraceptive devices. The cooperation between the population sector and the women's union is effective. The local authority also pays much concern. For example, the commune chairman is head of the population committee (CCPFC), which is an advantage."* (Female, aged 53, CCPFC staff, A.S district)

Party leaders and the local authority also give support on the population work and integrate it into their regular work. At the commune level, P/FP collaborators reaffirm a good cooperation among the three partners. The authority also makes favorable conditions for an active participation.

> *"In our commune, the local authority and organizations pay much attention to our work. In a recent meeting, the authority assigned local organization/ sector with duties on population issues. Therefore, all organizations/ sectors have to be involved."* (Female, aged 46, commune P/FP collaborator, D.C district)

> *"Commune leaders pay special attention to every party's and government's policy and closely cooperate with CHC and women's union to operate the work. Things will be better when the local authority plays a major role. There must be multi-sector cooperation in population work."* (Female, aged 49, CCPFC staff, N.D district)

In line with comments on the necessity for a close cooperation among organizations, some people surveyed have spoken of certain disadvantages in cooperation such as complicated procedures and inconveniences for clients. For example, after P/FP collaborators motivate clients to accept family planning practices, sometime these clients are not welcomed at health facilities. In the case of sterilization, each client has to take a lot of procedures:

> *"It sometimes happens that when a woman accepts IUD insertion, she goes to the health facility, but finds no provider. Now three women accept FP methods, but they can't get the methods because providers are away for training. It's also difficult."* (Female, aged 44, CCPFC staff, N.D district)

> *"It's very complicated. Some persons want sterilization and they have to go even 5 times to try to get sterilized, but they still do not get the method, because they have to bring with them several documents and go to the district population committee (DCPFC) for necessary procedures."* (Female, aged 47, medical doctor, D.C district)

3.2.3 Difficulties of grassroots P/FP collaborators

Large area, difficult travel, people's low awareness

In IDIs and FGDs, P/FP collaborators mentioned about their difficulties due to the large areas under their responsibility, the difficulty of travel and people's low awareness, especially in the mountainous communes of Tan Ky and Anh Son districts.

> *"It's a fact that the commune is too far from the district center. It stretches more than 7 km with 3 bridges, and the villages are separated by a river so the travel between them is difficult. In the rainy season, it takes two or three trips traveling*

by boat to reach the commune center." (Female, aged 45, commune Women's Union staff, A.S district)

"Generally, the area is large and people's lives are e difficult. It's most difficult when we do communication through broadcasting, as the fields are large and people often move. Radio communication sometimes doesn't reach people." (Male, aged 33, commune P/FP collaborator, T.K district)

In a village, there are only 45 households living in an area of 4 square kilometers. That's very difficult for a P/FP collaborator when her job is the same as her colleague on plain land. She said, *"I am poor. I have no motorbike and travel is not easy. There are three hills between houses."* (Female, aged 47, commune P/FP collaborator, A.S district)

Moreover, because of people's low awareness, particularly people living in remote and mountainous areas. People have poor knowledge on benefits of the RH/FP program towards themselves and their families.

"My village is large with many persons, of whom many are Catholic and the traveling is difficult. You know that here Catholic people have low education and limited awareness and knowledge." (Female, aged 41, commune P/FP collaborator, T.K district)

"It's difficult that ethnic and Catholic women have low education, which limits their understanding. There are many difficulties in ANC and delivery." (Female, aged 53, CCPFC staff, A.S district)

The view "respect men, despise women" places boys in the position of continuing the family nameor labor force are still strong not only among old persons, but also young persons and women. Influenced by patriarchy or pressured by her husband's family, many women still get pregnant, hoping to have a son. It's difficult for collaborators when they conduct their IEC activity."

"It's not easy to encourage husbands to practice contraception. For example, when I talk with them, they mention t having sons and daughters. Many couples have only daughters and in this situation their husbands do not allow their wives to practice FP. When we encourage these women to practice FP, we also have to talk with heads of their family clan, their mothers and fathers of both sides, and their husbands. We keep on motivating these women to use contraceptive methods and take care of their family health." (Female, aged 45, commune Women's Union staff, A.S district)

"The most difficulty is when we talk to women who have only sons or only daughters. However, we still have to talk with them. They are influenced by their families and husbands. Many of women understand, but some insist on having another birth." (Female, aged 33, commune P/FP collaborator, D.C district)

Another obstacle is regional condition that sometimes strongly affects people's preference for many children and sex of a child. It's difficult for farmers but more difficult for coastal fishermen:

> *"As we live in coastal areas, if we only have daughters, we have no son to continue our traditional fishing work. Now if someone has 3 or 4 daughters, of course she will give birth to a son to continue the family lineage. For people here, having no son is totally impossible."* (Female, aged 52, commune P/FP collaborator, D.C district)

Lack of men's active participation: Contraceptives for men are few, and since they are not aware of their roles in FP, their participation is little.

> *"It's also difficult when there are few contraceptive methods for men, only male sterilization (vasectomy) and condoms. Many do not accept sterilization because of the fear that it can lead to some health and mental disorders. So it's not easy to encourage them to use FP methods. Several years ago, some men accepted sterilization, but since then there is none. Together with female methods, we motivate men to use condoms. Sterilization is not easy to promote."* (Male, aged 47, commune P/FP collaborator, T.K district)

> *"Rural people say using condoms is not convenient. They sometime forget, condoms break or they use them incorrectly, many people want to use IUD, with which they don't have to worry about negligence. That's why condom use is so minimal."* (Female, aged 50, commune P/FP collaborator, D.C district)

Providers' difficulties: Among interviewed P/FP collaborators, many were not given training and skills, so there are some limitations in counseling and communicating. On the other hand, changes in organizational mechanisms also affect collaborators' activities. Some collaborators, after receiving training, take other tasks or do not take up the work due to the desire to finish their four-year terms in each Congress of the Women's Union. New collaborators who haven't got training are embarrassed about operation and management.

> *"Beside their tasks as village Women's Union staffs, some women work as P/FP collaborators for a few years. They can't work on a regular basis because their term is limited. Thus, the task is always new and difficult."* (Head of CHC, D.C district)

Limited funding: Low allowance is mentioned by most P/FP collaborators. A collaborator's responsibility includes supervising population change, keeping book registers and recording and conducting IEC activity. The job is time-consuming and they have to work hard. The monthly allowance of about VND 20,000-25,000 is very low. Therefore, the majority of collaborators said they took this job as a volunteer and work with more pleasure than they would in a paid job:

"Of course, there are many difficulties. With VND 20,000 allowance each month, I often attended meetings and performed IEC activities. Sometimes I had to travel 5-6 times to meet and talk with people. The allowance is very low, but collaborators are enthusiastic, as they are also members of women's association and the task is similar." (Female, aged 39, commune P/FP collaborator, A.S district)

"Sometimes I think of my work as fun. As I am no longer young now, I must be a good collaborator to promote young persons. An allowance of VND 25,000 is too low, but I still fulfill the task. I want more training provided to women involved in campaigns." (Female, aged 51, commune P/FP collaborator, N.D district)

Some women do not think of the allowance as salary or subsidies, but just a "community gift". *"Actually it's not an incentive, but a small gift for collaborators."* (Female, CCPFC staff, N.D district)

3.3. Recommendations of Local Officers to Improve RH/FP Work

a. Continuation of further training of local officers

In FGDs and IDIs, officers interviewed said that district and commune health providers should be given more training to improve their technical competence as well as to know how to use equipment to make full use of government's and donor's support. At the same time, training courses are also opportunities for new substitutes to work better.

"At present grass-roots workers' knowledge is too low to use equipment provided. They don't know how to use some equipment. They only receive several months worth of training on delivery and the use of partograph. Now they need to be both given training and practice in even the smallest thing such as use f specific equipment. I suppose all providers should be given training, with a priority to midwives, so that they can have better access and provide supervision of local activities." (Female, aged 54, DCPFC staff of T.K district)

Others believed that along with strengthening training to improve grass-roots provider's technical competence, local authorities need to do the best to have enough numbers of medical doctors working at the commune level to meet people's demands in treatment of diseases.

"In order to ensure community health care, we suggest expanding project support for the training of medical doctors at CHCs. At present, the technical competence of health providers is still low and cannot meet people's health care needs." (Female, aged 54, head of CHC, T.K district)

It's a similar situation with the population sector. Many collaborators haven't got refresher training. (For example, Tan Ky district's quota for staff training is only 50

collaborators while there are 300 collaborators in total.) Due to low levels of knowledge and poor counseling skills of collaborators, they need to have more basic training:

> *"We have some shortcomings. Because of low levels of education, we need more training to have a better knowledge in order to do better IEC work."* (Female, aged 29, commune P/FP collaborator, A.S district)

> *"With regards to counseling, we want the project to provide more IEC materials and training courses to improve women's knowledge and better communication work."* (Female, aged 43, commune P/FP collaborator, N.D district)

Because of different education levels, commune staff suggest that the training time should be appropriate to staff's various education levels. For example, with the same training content, staff working in plain land may need one-day training while their counterparts in mountainous and remote areas may need two-day training.

b. Providing more equipment to grass-roots health facilities

Although JICA provides commune facilities with basic equipment, in some places with difficult conditions, interviewed health providers propose that either JICA or the health sector should provide some additional equipment to CHC. There is still a lack of basic equipment:

> *"In general, we make good use of equipment provided by JICA. Many forceps of all kinds are now of no use. If possible, the project can provide us some more equipment as our commune is still poor and can't afford to buy it. Gynecological exam kits are too few, lamps do not work and there are no Oto-Rhino-Laryngology (ORL) kits. We want more equipment."* (Female, head of CHC, N.D district)

> *"In health care, the most things we lack include disinfectants, gloves, disinfecting solutions, cotton and sponges... Gloves that are repeatedly sterilized are not good."* (Female, medical doctor, N.D district)

c. Promoting IEC/advocacy on RH/FP among different target audiences

According to suggestions from FGDs and IDIs, JICA program as well as population committees of different levels should strengthen postpartum counseling to improve knowledge in RH in close relation with FP. This should be considered a measure to protect maternal and child health.

> *"Promoting postpartum counseling may contribute in the reduction of unwanted pregnancy. It's common that because of low awareness on postpartum contraception, many women get pregnant soon after delivery then they have to*

seek abortion. They don't know when to use FP methods and which methods should be used." (Male, aged 30, medical doctor, A.S District)

Through interviews, many interviewees recommended that because of P/FP collaborators' limited knowledge and skills, provincial/district experts and full-time health staff should come to communes to provide new and useful information to local staff. More people will be eager to participate.

> *"Psychologically, women want higher-level health providers to attend and give a talk in meetings because of limited knowledge of grass-roots staff. They want the involvement of higher-level staff so that they can have more information and more trust."* (Female, aged 33, commune P/FP collaborator, N.D district)

> *"It's a fact that Catholic women do not an appropriate FP practice. You should perform IEC activities in a community. It will not be effective if only P/FP collaborators do that."* (Female, aged 53, commune Women's Union staff, A.S district)

At the same time, men's participation in FP should be promoted. Respondents reported that the FP movement would be more effective when men participate in it. Organizations with men's participation should be active in promoting and educating men to share with women in FP and contraceptive use.

> *"We want peasant's union and local authorities to also conduct training for men, so they can have their part in FP. There should be policy for men to share responsibility with women to reduce women's burden in contraception."* (Female, aged 55, commune P/FP collaborator, D.C district)

d. Diversified types of IEC materials will produce different information channels to rapidly and widely reach more people

Regarding IEC materials, many persons were told there should be more brochures, and leaflets to distribute to people who may have the demand. These materials should be clearly presented and understandable for different users:

> *"There should be more leaflets appropriate to rural women, persons with high and low, and no education level. Materials should be short and easy to read."* (Female, aged 48, A.S district Women's Union staff)

> *"In each training, there should be leaflets to distribute to women. At present, there are not enough quantity of leaflets for the large number of women who want to have them. There are no leaflets for community persons. I suggest to have more leaflets to be given to members of our Union (Women's Union)."* (Female, aged 48, head of commune Women's Union, D.C district)

Together with printed materials, local people want other types of IEC materials such as videos, which they reported that they are more attractive and are accessible to more people.