NATIONAL STRATEGY

ON REPRODUCTIVE HEALTHCARE

FOR THE 2001-2010 PERIOD

RATIONALE FOR STRATEGY FORMULATION

The Communist Party and State of Vietnam always attaches great importance to the policy and strategy for human resource development and in particular to the respect of women's and children's rights.

The Constitution of Vietnam declares that men and women enjoy equal rights in all aspects and states: "The State, society, family and citizen have the responsibility to provide health care and protection to mothers and children; and carry out the population and family planning (PFP) programme. In 1960, the National Assembly adopted the Law on Marriage and Family based on four principles, namely freedom of marriage, monogamy, gender equality and protection of women's and children's rights, and in 1989, adopted the Law on Protection of People's Health which stated: "All people can freely select and use contraceptive methods, all acts of obstruction or compulsion in the implementation of family planning shall be prohibited; women have the right to have abortion(s) if desirable, to receive gynecological diagnosis and treatment and health check-up during pregnancy and medical service when giving birth at health facilities etc. " Thus high-level political commitments facilitated the attainments of major achievements in the provision of healthcare to the people in general and to women and children in particular.

However, there remain many problems with the health status of women, children and adolescents. The reason is that, due to socio-economic difficulties during the 90s, Vietnam could only focus on resolving some urgent problems related to mother and child health (MCH) and certain aspects of reproductive healthcare (RHC), and could not cover all RHC aspects. Also, there have been shortcomings in respect of perception, services, budget and policy mechanism and financing relating to RHC.

Entering the new century, Vietnam needs an RHC strategy to provide healthcare to the people, particularly to women, mothers and children, in a broader sense and with a more comprehensive approach as expounded in the programme of actions of the 1994 Cairo International Conference on Population and Development (ICPD) to which Vietnam has committed to carry out.

The Cairo Conference unanimously held "that Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will able women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".

The National Strategy on Reproductive Health for 2001-2010 is mapped out and promulgated to elaborate the contents of Resolution of the 4 th Party Central Committee Meeting (VII legislature) on urgent problems in the provision of the people's healthcare and protection, Resolution of the 4 th Party Central Committee Meeting (VII Legislature) on population and family planning policy as well as the strategic orientations on People's Healthcare and Protection and Vietnam's Population Strategy in the 2001-2010 period. This strategy reflects the official views, objectives and things to be done in RHC in Vietnam for the next decade and assists the relevant ministries, sectors, governmental and non-governmental organizations and private individuals in conducting activities dictated by their functions to improve the quality and sustainability of RHC and contributing to a successful implementation of the Party's and State's strategy for human development.

PART ONE

THE STATUS OF REPRODUCTIVE HEALTH (RH) AND REPRODUCTIVE HEALTHCARE (RHC)

I. Fundamental achievements

Despite the absence of a special economic growth, Vietnam has recorded remarkable achievements in the field of health and RH. Strong support induced by policy and people's broad access to primary healthcare services made an important contribution to such achievements. Over the past years, the growing Government's investments in health protection and PFP facilitated the establishment and reinforcement of a nation-wide network of health and family planning services at the communities. Preventive and curative services for mothers and children, pre-natal, safe delivery and post-natal care, FP services etc. provided by both the State and private sectors have been expanded with improving quality. Thanks to this, the following encouraging results in RH have been obtained:

• A comparison between 1989 and 1999 figures shows that the average number of children born to a women of reproductive age has been reduced from 3.8 to 2.3 and the natural growth rate has been on the downgrade, from 2.21 % to 1.43% (1).
• From 1990 to 1999, maternal mortality rate was reduced from 200/100,000 live births to 100/100,000 live births and obstetrical incidence decreased by 52% (2).
• Infant mortality rate has been reduced from 45.1% in 1994 (3) to 36.7% in 1999 (1).
• Mortality rate of children under five has been reduced from 55% in the 1982-1986 period to 37.7% in the 1992-1996 period (4) and the malnutrition rate among under five children has been reduced from 44.9% in 1994 (5) to 36.7% in 1999 (6).
• Contraceptive prevalence rate increased from 53.7% in 1988 to 75.3% in 1997 (7) and the percentage of delivery assisted by health professionals was up from 55% during the 1990-1994 period to 71% in the 1995-1997 period (8).

These achievements have been possible thanks to a judicious policy and concrete guidance from the Party and government authorities at all levels, the efforts made by the entire network of health and PFP services, the active participation of all sectors, mass organizations, people and the valuable and effective financial and technical assistance and expertise from different countries, international organizations and NGOs.
II. Outstanding problems

Despite a reduced birthrate, the quality of FP remains low. This is demonstrated by a fairly high failure rate of contraceptive use. The average number of children born to a reproductive age women is 2.3 but in the mid-land, mountainous, coastal areas, central Vietnam and the Central Highlands, this figure remains well over 3 or 4.

Vietnam's population grows by one million each year. It is therefore, estimated that by the year 2020, Vietnam's population may reach approximately 100 million including 22 million adolescents aged between 10 and 19. People of this age group constitute both the country's main human resource in the near future and also the high-risk group in respect of RH. However, not much has been done for adolescent reproductive healthcare (ARH).

There have been many shortcomings in the provision of care to pregnant women and mothers. The percentage of pregnant women receiving pre-natal care and deliveries assisted by health professionals remain low. Post-natal care, counseling on breast-feeding and child nursing still fall short of expectations. The cause of this situation has been the poor performance of the network of mother and child health services particularly in areas where the going is rough. That also explains why obstetric complications and peri-natal mortality rate remain high in these areas.

The high prevalence of RTI and STD, the fast growing of HIV/AIDS, particularly among young people under 25 are giving rise to public concern. Also, IEC activities and provision of preventive and curative services have not been widely promoted to involve all facilities inside and outside the health service, both State-run and private.

Despite the high infertility rate among couples of reproductive age, preventive and curative measures for this problem, particularly the application of high technologies remain very limited.

Cancer ranks second among the causes of women's death after infectious and parasitic diseases. Most prevalent are breast and cervical cancer. Cancer prevalence is higher in the countryside than in urban areas.

RH of the elderly is also posing many problems to be resolved within the framework of RHC activities in the years to come.

III. Challenges

1. The inadequate awareness about the elements and significance of RH and the lack of understanding about RH preventive measures, the backward customs in one's way of life and care-seeking behavior particularly in areas inhabited by ethnic groups or remote and of low socio-economic development all combine to create outstanding RH problems as stated earlier.

Although attention has been given by the Party, administration and mass organizations at all levels to people's healthcare and MCH/FP, there have not been proper guidance provided due to the lack of knowledge and information on RH and sexual health.

IEC and counseling on RH still face many constraints with regard to types and message contents, the identification of players and IEC skills, the production of IEC materials and budget etc.

There remain many shortcomings and constraints regarding the existing network of MCH/FP services which have been in operations for many years. There is a serious shortage of health professionals, particularly, birth attendants who cannot meet the current needs and whose low general knowledge and skills have not been periodically upgraded. The operation of RH service quality control network is ineffective and leaves little chance for improving the situation. All of these make the MCH/FP services less attractive to the users. Things are even more serious in remote and mountainous areas and make health indicators notably vary between urban and rural areas and between regions.

Attention has been paid to budget allocations to this field but it has not met people's growing needs whilst mobilization of community participation remains difficult in poverty-stricken areas.

Constraints regarding the guidance and management of RH include failure to define the needs of certain aspects of care, particularly RHC in a broad sense and to upgrade and/or supplement regulations on task division, technical quality etc to make them complete and suitable to new perceptions; ineffective and inadequate operations of the health information management system and the monitoring network for RH service delivery. Most of the members of the network for guidance and management of RHC activities at all levels are men.

The roles of ministries, sectors, mass organizations, government and non-government organizations and private individuals in RH have not been analysed for identifying their participation and/or coordination mechanism in order to create an aggregate strength for RHC activities.

PART TWO

VIEWS AND OBJECTIVES

I. Views

1. Investment in RH and in health as a whole is also investment for development.

Equality must be ensured so that all people have access to RH/FP information and services which are of good quality and suitable to the economic conditions of Vietnamese society. Particular attention should be paid to disadvantaged groups, the poor, those who rendered meritorious services to the country, inhabitants in mountainous, remote and environmentally-sensitive areas.

To ensure gender equality in RH and promote women's role in decision-making on RH-related issues as well as men's role and responsibilities in FP and RHC.

To be active and take the initiative in all preventive aspects of RHC

To combine modern medicine with traditional medicine in RHC.

RHC is the common cause of the society and the responsibility of every individual, family, community, Party and government authorities at all levels as well as of all sectors, mass organizations and social and occupational institutions.
II. Objectives

Common objectives

• achieve by the year 2010 a marked improvement in the RH status and narrow the gap between the regions and target groups by better meeting the diversified reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities, and pay particular attention to areas and target-groups having difficulties.

Targets

<table>
<thead>
<tr>
<th>Total Fertility Rate: 2 children</th>
<th>Maternal Mortality Rate: 70/100,000</th>
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<tbody>
<tr>
<td>Infant Mortality Rate: 25%</td>
<td>Perinatal mortality rate: 18%</td>
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<tr>
<td>Low Birth Weight (below 2500 gram): 6%</td>
<td>Malnutrition rate among infants under five: 25%</td>
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Specific Objectives

Objective 1

• create a recognized change in perception as well as support and commitment to the attainment of the objectives and content of RH among people of all strata, first of all among senior officials at all levels.

Targets:

- Percentage of RH delivery points giving RH counseling: 90%
- Percentage of RH service users receiving RH counseling: 90%
- Percentage of adolescents and older people having basic RH knowledge: 60%
- Percentage of Party and Government officials having good RH understanding: 90%

Objective 2

• sustain fertility reduction trend; to ensure women and couples of their right to have children and select contraceptive methods of good quality; to reduce unwanted pregnancies and abortion related complications.

Targets:

- Percentage of couples using contraceptive methods: 78%
- Percentage of couples using modern contraceptive methods: 70%
- The rate of abortion on 100 live births: 25%
- Percentage of abortion acceptors who are informed about the harmful effects of abortion and methods of prevention: 90%

Objective 3:

To improve the health status of mothers and other women; obtain a more balanced reductions in maternal mortality and morbidity, perinatal deaths and infant mortality between different regions and target-groups, with special attention to areas with difficulties and to beneficiaries of government policies.

 Targets:

- Percentage of pregnant women receiving prenatal care: 90%
- Percentage of pregnant women receiving 3 prenatal check-ups: 60%
- Percentage of mothers receiving at least 1 postnatal check-up: 60%
- Percentage of deliveries assisted by health professionals: 97%
- Percentage of deliveries at health centers: 80%
- Reduced rate of obstetric complications over total deliveries: 50%

Objective 4

Effective prevention to reduce incidences of RTI and STD including HIV/AIDS and infertility.

Targets:

- Reduction of RTI incidence by: 50%
- Reduction of STD incidence by: 30%

Objective 5

Provide better RHC to the elderly, particularly to old women; provide early diagnosis and treatment of breast cancer and other cancer of both male and female reproductive tracts.

Targets:

- Percentage of health facilities providing early diagnosis of breast and cervical cancer: 50%

Objective 6

• improve the status of RH, sexual health of adolescents through education and counseling and provision of RH services suitable to different age groups.

Targets:

- Percentage of RH service delivery points giving RH information, education and counseling to adolescents: 80%
- Percentage of adolescents receiving RH information, education or counseling and having an understanding about RH and sexual health: 70%

Objective 7

• raise the level of understanding of men and women about sex and sexuality for fully exercising the rights and responsibility towards fertility, promote safe and responsible sexual relations on the basis of equality and mutual respect to improve RH and the quality of life.

Target:

The percentage of men and women receiving information, education and counseling about sex and sexuality: 70%

PART THREE

SOLUTIONS

I. IEC and mobilization

- Information about RH policies and education in diversified form suitable to different target-groups should be disseminated. The aim is to improve the level of understanding and encourage voluntary participation from families, couples and individuals and mobilize others to join in meeting the RH objectives.

To make a diversified use of communication channels, ranging from person-to-person, via the national communication network, to general school curriculum, different form of folk arts and culture, seminars involving community leaders

IEC and mobilization should be made available to all target groups, from elected deputies at all levels, scientists, religious and political leaders to social activists, women’s and youth’s groups, associations of pupils’ parents and public figures, focussing particularly on what should men do to fulfill their responsibility towards reproductive and sexual health.
To train IEC specialists, State and private RH service providers who have the necessary knowledge and skills for motivation and/or counseling, who know how best to apply the results of RH research to provide adequate information to the target-groups.

To promote and improve the quality of IEC contents as follow:
- Awareness raising to the effect that FP is first of all for the benefit of oneself and one's family, to persuade couples neither to start a baby too early or too late, to have good spacing between births and to prevent unwanted pregnancy and/or abortion. Priority in awareness-raising is given to couples under 30 with two children and couples living in remote areas.
- IEC work concerning pregnancy hygiene including prevention of RTI and STD, the need to have least three pre-natal checks before childbirth, breast feeding counseling, post-abortion counseling and prevention and treatment of infertility. IEC, e.g., a) best times for the procedure, b) motivation to the procedure, c) counseling to the procedure, etc. should be organized in a way that psychologically suits the adolescents. Such centers should be reliable providers of counseling and technical assistance to the adolescents. Services shall include the supply suitable contraceptive methods, such as condoms for prevention of RTI, abortions and treatment of RTI etc. Where conditions permit, a gynecological ward for young female patients should be set up. Activities for adolescent RH and against social evils should be combined, paying special attention to groups of adolescents living in the countryside, remote areas and children from poor families with low level of education.

II. Organization of RH service delivery network

1. RH services available at all levels of the healthcare delivery network shall carry out 7 tasks as follow:
   1.1 Family Planning: to diversify contraceptive methods by providing on a broad scale new contraceptive methods, sufficiently supplying condoms and other devices to combine it with the prevention of STD including HIV/AIDS.
   1.2 Ensure the provision of pre-natal, safe delivery and post-natal care, infant and child care. Pre-natal care services should be promoted to reduce the rate of mothers without receiving pre-natal check-up before childbirth and increase the rate of expectant mothers who receive 3 proper pre-natal checks-up. Efforts should be made to increase the percentage of deliveries assisted by health professionals, provide more facilities and qualified health personnel for obstetric and surgical obstetric wards of district hospitals, particularly districts in the highland, remote areas and offshore islands. This enables these district hospitals to provide essential obstetric care and deal with obstetric emergencies to reduce maternal mortality. Post-natal care should be intended to help mothers take good care of their health, prevent complications and/or diseases after childbirth and receive counseling and care, breast-feeding and family planning. Mothers should be helped to make judicious decision on the next birth. Post-natal care should be recorded and summed up for subsequent evaluation.
   1.3 Safe abortion, effective treatment of post-abortion complications and provision of post-abortion care. Qualified health personnel, medical equipment and other supply for safe abortion, effective treatment of post-abortion complications and delivery of post-abortion care and counseling should be made available.
   1.4 Prevention and treatment of RTI, STD, HIV/AIDS. All health facilities and certain FP services with good facilities and qualified personnel should be given equipment and other supply for diagnosis and treatment of common RTI and STD. In remote areas where transport is difficult, mobile teams should be organized for diagnosis and treatment of the same infections and implement preferential policy on diagnosis and treatment such as fee exemption or reduction for the poor or needy families in areas with high incidence of such diseases.
   1.5 Early detection and treatment of reproductive track cancers. Examinations should be organized for as many people as practicable, for early detection of cancer particularly among women by applying simple testing or techniques. Examinations for cancer detection should be given every 6 months or once a year. There must be tools for taking specimen and laboratory tests, with attention paid to women aged 45 upwards. RH services for the elderly and diagnosis, treatment and care of cancer patients at hospitals must be well provided at hospitals in accordance with their assigned functions.
   1.6 Prevention and treatment of infertility. Early detection and treatment of infertility-related diseases by strengthening all levels of health care and improving the quality of infertility diagnosis and treatment technology along with the promotion of regulatory document(s) on donation and receipt of oocyte, sperm and other issues concerning artificial insemination.
   1.7 Adolescent RH. Counseling points and/or centers where adolescent RH services are also given should be organized in a way that psychologically suits the adolescents. Such centers should be reliable providers of counseling and technical assistance to the adolescents. Services shall include the supply suitable contraceptive methods, such as condoms for prevention of RTI, abortions and treatment of RTI etc. Where conditions permit, a gynecological ward for young female patients should be set up. Activities for adolescent RH and against social evils should be combined, paying special attention to groups of adolescents living in the countryside, remote areas and children from poor families with low level of education.

The above-mentioned RH contents shall not be put into effects separately by health or family planning services according to their assigned functions. All the 7 contents shall be accomplished by services at all levels of healthcare at the stipulated technical level. However, it shall be done mainly through the primary healthcare network and direct support from family, hamlet, commune and corresponding levels, maternity house, inter-communal polyclinic and district hospital with community participation and close co-ordination with different sectors, mass organizations, Vietnamese and foreign NGOs, private health services and must be integrated to other programmes such as Population and Family Planning, Childcare and protection, malnutrition, HIV/AIDS programmes etc.

Further study should be conducted on new form of adolescent RH counseling and services, which had not been available before.

Efforts should be made to make community health workers available to all hamlets throughout Vietnam particularly in remote areas and provide RH training and practice to community health workers. Communal health stations should have enough birth attendants and by the year 2010 all such birth attendants must be qualified nurses from secondary medical schools. All obstetric wards at district hospitals should have obstetrician(s), pediatrician(s) and nurses who got either intermediate or tertiary training. Provincial and central hospitals, whilst fulfilling the task of applying RH high-tech, should gradually plan to have medical doctors specialized in such specialty as child gynecology, adolescent gynecology and andrology etc.

As well as strengthening of the organization of the RH network and provision of (refresher) training to its personnel and supply of equipment to ensure good quality of techniques in RH diagnosis, prevention, emergency services, treatment, communication equipment, transport of patients in emergency, IEC materials etc. according to the list stipulated for each level of treatment, first of all for essential obstetric care and obstetric emergency at the district level.

To ensure priority in budget allocation and regular and sufficient supply of good quality pharmaceuticals according to a standard drug list for prevention and treatment of RH-related symptoms and diseases for RH service delivery network at the community and district levels, areas with difficulties particularly areas with high rates of maternal mortality, pen-natal mortality and child mortality such as the Central Highlands, mountainous areas, central coastal areas etc., to apply fee exemption or reduction to the poor and those who rendered meritorious services to the country, members of ethnic groups etc.

To train, assist and monitor private providers in delivery of RH services to ensure the good quality of such services.

III. Policies in support of National RH Strategy
Policies which should be promulgated to support the national RH Strategy include:

1. Policies which encourage the acceptance of and practice for small- size family, and which set great store by gender and give equal treatment to children
Policies encouraging the application of modern contraceptive methods and dissemination of a wide range of contraceptive methods to raise the efficiency of FP. The content of such policies include increased budget allocations to IEC, social marketing in combination with the exemption and reduction of service fee and devices, rewards to individuals and units delivering good services.

Policies which help achieve the objective of equality and narrow the gap in RH and Reproductive Healthcare between the urban and rural areas, between regions and target-groups. They shall be designed to attract government employees to work at the community and in areas with difficulties. Such policies may be in the form of material incentives or support (e.g. higher allowance, priority in in-country and/or overseas training etc.). Later, policies requiring new graduates from colleges to provide obligatory service in mountainous areas shall be considered to be adopted.

Policies in support of beneficiaries under government policy and people living in areas with many difficulties. Such policies may take the form of full or partial exemption and reduction of RH /FP service charge etc.

Policies encouraging government employees to further study to improve their profession in many form such as participation in skills competition where rewards material or non-material are given.

Regulatory documents on all technical and managerial aspects of RHC activities such as safe motherhood, ARH (e.g. regulations on supply, logistics, contraceptive projections, policies on human resource development research and development, IEC on RH etc.)

IV. Socialization, inter-sectoral and international cooperation

1. All communities should be mobilized in carrying out RHC activities by integrating such activities in the action plan/programme of sectors, mass organizations and localities. Appropriate elements of RH should be incorporated into the rules of the hamlet, village or ward etc to as to be complied with by every family. Movements should be conducted for community participation in RHC in the form of IEC campaigns and National Weeks on RH/FP.

Efforts should be made to further raise the efficiency of cooperation between ministries, sectors and mass organizations etc in RH activities on the basis of study on the role and possible impact created by these organization on RH. The aim is to expressly define their participating roles and mechanism for such cooperation. We should vigorously involve the private health network, national NGOs in RHC and provide legal and technical support as well as RHC training to these organizations.

The effectiveness of bilateral, multi-lateral cooperation with different countries and international organizations and NGOs in RH should be promoted.

Periodical exchanges of information, experiences and co-ordinate actions between organizations involved in RH activities should be organized.

V. Research and Study

5.1. Training and Retraining

a. RH training programmes and teaching materials at medical schools should be revised and updated with new knowledge or parts which were missing or not available. This work should take into consideration the technical tasks assigned to different levels of RH services. There should be plans for retraining of the existing staff of the health service network as well as the sectors, mass organizations etc to keep these people well informed of updated knowledge and skills particularly new elements of RH such as prevention and treatment of RTI, STD, counseling and care after abortion and/or emergency contraception, adolescent RH and sexual health. Attention should be paid to practice training and development of communication and counseling skills. We should regularly supervise the use of knowledge, skills and training materials in routine work to evaluate the result of training and help the health workers further develop their capacity.

b. Retired health workers, members of the armed forces in remote areas should be retrained and better used to have sufficient staff for an effective RH service network at all levels particularly at the village and/or community levels.

c. The Ministry of Health, sectors and mass organizations should consider developing a (refresher) training programme for non-medical cadres (such as workers of culture and information services, media workers, teachers, mass motivators, police, border guards etc.) who have good general knowledge and communication skills to make them teachers or facilitators on RH, sex and sexuality.

5.2. Research and application of scientific and technological advances

a. Given the concept that biological, social and environmental factors always exert a complex and aggregate impact on human health, research on health in general and on gender, sexuality and reproductive health in particular are always put in the conditions and/or circumstances of natural environment, family and society. Inter-discipline research, therefore, must be highlighted in methodology and must attract cooperation from international organizations and NGOs as well.

b. The orientation for RH research in the coming decade shall focus on three aspects: bio-medicinal research, sociological research and research into policy and mechanism relating to RH and RH services.

Regarding bio-medicinal aspect of RH, it is necessary to further study subjects which have only been seldom or not at all dealt with such as infertility, breast-feeding, diseases of the reproductive system particularly cancer of the reproductive organs, sexual health and behavior, RH in adolescents and men and knowledge, attitude and practice relating to their RH etc.

Research into genetic issues, effects which lead to sequela and/or inborn deformities, mental retardation etc. caused by Agent Orange and/or other toxins. Applied research on gene screening. Research on inheritance, promotion and modernization of traditional methods for prevention and treatment, FP applicable to RH such as methods and recipe for contraception, abortion, increasing physical fitness during pregnancy and after delivery, enriching mother milk, treatment of metrorrhagia and prolapse of uterus etc. Sociological research shall cover epidemiological research on RH such as maternal and child morbidity and mortality, perinatal mortality, accidents, side effects of contraceptive methods, epidemiology of RTI and STD etc.

Research into sociological aspects of RH such as identification of the unmet needs for contraception, high-risk sexual behavior, testing of the results of interventions for maternal health at the community level. Further research should be conducted on individual, family, the humane, equitable and responsible relations between men and women, men's role in and responsibility towards RH, adolescents' attitude and behaviour in respect of RH, adolescents' way of life and social evils, RH aspects relating to development.

Research into policy and mechanism to step up and improve the quality of RH activities, particularly the mechanism for co-ordination and/or integration of RH-related activities between ministries, sectors and mass organizations.

c. The quality and output of research should be improved, the results of research should be regularly announced and applied. Comparison of notes among researchers and between researchers and policy-makers should be encouraged and promoted.

d. More inputs must be given to activities for scientific information including supply of printed matters and other materials to provide researchers with easy access to sources of materials, national and international.

VI. Financing and Logistics

1. Budget for implementation of RH strategy in the next decade shall come from the State budget, health insurance, hospital and service fees, funds from bilateral and multilateral cooperation, NGOs and community contributions in which government input is the main source and entered as a budget line at all levels of the healthcare network. The total budget for RH shall be constantly growing but State budget component may be relatively reduced when other funding sources increase.

All resources for RH services including FP clinical services shall be managed in a way that accords with the average need of between 6,000 to 8,000VND per
inhabitant per year. All concerned organizations including ministries, sectors, governmental and non-governmental organizations, international organizations and private organizations are encouraged to co-ordinate activities for rational and effective use of resources so that RH activities are properly carried out. RH budget including budget for FP/MCH and the extended parts of RH shall be increased annually by between 500 to 600VND per inhabitant per year corresponding to the country's economic and population growth rates, thus meeting the growing demands for more yet better activities to meet the objectives of the strategy.

Priority in the use of funds from all sources for RH services must be given to areas with difficulties, beneficiaries of government policy; and the poor whose poverty coefficient ranges from 1.5 to 2 and who have little capital shall be entitled to RH services provided by State. The financial management system should be well organized and supervision and monitoring improved to ensure transparency and help measure the increased use of RH services among the target-groups.

It is necessary to calculate the cost for a RH service package (consisting of all the 7 contents) at each level of healthcare delivery to plan and make available such services, use the local budget rationally and effectively and depending on local financial needs and capacity, either supplement or reduce the components of such package.

For a growing expansion of reproductive healthcare activities, where appropriate, effective strategies for cost-recovery including social marketing, cost-sharing and community-based services should be promoted.

VII. Leadership and Management

1. Leadership of the Party and administration at all levels constitutes the decisive factor for the RH Programme to be effectively implemented, thus making an real contribution to the socio-economic development of the country. The Party committees and administrations at all levels should issue instructions, resolutions and include reproductive healthcare activities into the plan for socio-economic development of the locality. RH activities should be regularly monitored and implementation of the same evaluated.


The Steering Committee for Reproductive Healthcare shall be set up at every administrative level, from the central to the community level. The Central Steering Committee, which is the highest-level administration, shall be responsible for putting forward as well as amending and/or supplementing the national RH policy and strategy.

The local steering committees shall be responsible for steering and supervising the implementation of the national RH strategy in the localities and proposing to the central steering committee amendments and/or supplements, if any, to the national strategy.

The Ministry of Health is the executive agency and responsible for joining departments, sectors, mass organizations, governmental and non-governmental organizations in reproductive healthcare planning, providing guidance, reviews, evaluation and making reports on the results of implementation of the strategy.

3. Strengthening management and co-ordination of reproductive healthcare activities

3.1 The MoH role as State manager in reproductive healthcare activities should be strengthened and the number of women holding key positions in the management and operation system of reproductive healthcare activities at all levels increased. A mechanism for co-ordination in guiding, operating and carrying out reproductive healthcare activities should be established.

3.2 The needs for all aspects of reproductive healthcare should be defined to lay the groundwork for planning the implementation in various phases.

3.3 Regulatory documents dealing with professional and technical aspects, management as well as other aspects relating to RH activities should be promulgated. The system for monitoring the implementation of these regulatory documents should be set up to improve the quality of services and timely prevent and rectify shortcomings.

3.4 Plan should be mapped out to foster a contingent of key managers in RH, regularly provide refresher training to improve their management capacity for planning, guidance, inspection, monitoring and evaluation.

3.5 Efforts should be made to complete and uniformly apply the Health Management Information System (HM IS) in the whole country, establish a system of RH indicators, provision of services and quality of services at all levels of health care delivery. The indicators about the efficiency and impact of reproductive healthcare should be closely monitored. The network for collection of information and statistics should be well organized to fully reflect the reproductive healthcare activities of all eligible players including governmental and non-governmental organizations as well as the collective and private individuals. The mechanism should be established to promote the exchange and sharing of information among the parties including international organizations and private health systems on issues relating to RH.

PART FOUR

ORGANIZATION FOR IMPLEMENTATION

1. The Ministry of Health shall be responsible for co-ordinating with concerned agencies mapping out the plan for implementation of the national programme on reproductive healthcare and submit it to be approved the Government and for co-ordinating and supervising the implementation of such programme.

Ministries, ministerial agencies, mass and social organizations which carry out RH-related activities shall have the following responsibilities:

The National Committee on Population and Family Planning (NCPF) shall be responsible for defining and reporting to the Ministry of Health, the long-term and annual objectives and targets on population growth and family planning, NCPF shall co-ordinate with ministries, ministerial agencies, government agencies, mass and social organizations in popularizing IEC on FP and RH; providing training to senior officials and officials involved in population and family planning on management of Population and Family Planning programme and integration of RH contents in this programme. NCPF shall organize data collection, processing, storage and dissemination, meet the requirements for management, co-ordination and execution of population and family planning and RH activities.

2.2 The Ministry of Planning and Investment (MPI) shall be responsible for co-ordinating with the Ministry of Health in elaborating, consolidating and balancing the long-term and annual plans on health and RHC and submitting such plans to the Government for approval.

2.3 The Ministry of Finance shall be responsible for joining the MoH and MPI in elaborating and submitting to the Government the financial plan to ensure the execution of RHC activities; joining the MoH in considering a budget line for RHC activities to be added to the existing budgetary lists of the MoH and all levels and in identifying the mechanism for allocation, use and monitoring of funds use for RHC activities to obtain the set objectives.

2.4 The Ministry of Education and Training shall be responsible for mapping out and guiding the implementation of the programme on gender, reproductive and sexual health education for pupils of general schools, colleges, universities, secondary vocational schools and other form of education. The Ministry shall co-ordinate with the MoH in planning to provide teachers with more knowledge and skills for teaching and imparting the contents of sex, sexuality and RH. The Ministry shall participate in IEC activities relating to RHC for pupils and students.

2.5 The Ministry of Culture and Information shall be responsible for planning and guiding the execution of IEC in diversified form on the mass media for RHC and protection. The Ministry shall also be responsible for training of personnel, supply of RH-related IEC materials and means for ministerial agencies assigned to execute these tasks.

2.6 The General Statistics Office (GSO) shall be responsible for co-ordinating with the MoH in collecting, processing and timely providing accurate data/information about RH as well as relevant socio-economic fields and the execution of RHC activities.

2.7 Mass and social organizations shall be responsible for co-ordinating with the MoH and the NCPF in compiling IEC materials suitable to the
specific target group(s) of each organization; setting up and training a network of motivators who play a key role in IEC activities and involving members of relevant organizations in RHC activities. Mass and social organizations shall also guide the integration of appropriate RHC activities in plan/programme of actions of their organizations, organize clubs and/or centers where information and counseling on RH, sexual health suitable to the characteristics of their members, are available. These clubs and/or centers can provide simple RH services which do not require complicated techniques (e.g. distribution on and counseling on condom use) in accordance with guidance from health institutions. These organizations shall also take part in community-based social marketing and supply of contraceptive methods such as the pills and condoms etc as well as in inspection and monitoring of RH services in the communities and regularly send their comments to the MoH.

The plan for implementation of the RHC strategy is divided into two phases:

**Phase 1 (2001-2005). During this period efforts shall be made to:**
- maintain IEC activities and the provision of existing services, establishing and keeping a favorable environment for RHC activities.
- amend and/or supplement policies, administrative system, training materials and documents regulating and guiding the provision of services, execute the strategy for man power development, strengthen the systems for professional management and monitoring as well as financial and resource management.
- gradually incorporate some new RH components to the current health service package.
- build a mechanism for co-ordination among partners in carrying out RHC activities at all levels.
- build an information system based on gender and RH indicators which have been selected for monitoring and evaluation
- select field studies on some priority RH subjects, build successful models for nation-wide replication.
- step up activities to meet the needs of adolescent RHC and mobilize men's participation in RH.
- promote the supply of information and services to the remote areas and areas inhabited by ethnic groups.

**Phase 2 (2006-2010). During this period, efforts shall be made to:**
- focus on identifying impact indicators in a more comprehensive manner alongside monitoring indicators to meet the requirements for higher quality of care.
- promote the provision of sufficient RH services in a broad sense at all levels.
- institute managers' planning, monitoring and evaluation on the basis of effective use of more reliable data.
- carry on training activities, research, inspection , evaluation and good quality IEC to constantly upgrade caders' knowledge and skills.

Throughout the process of implementing the strategy, it's important to focus on capacity building whilst defining the orientation for how best to invest resources to ensure sustainability of the National RHC Programme.

### RH AND RHC INDICATORS TO BE ACHIEVED BY END OF 2010

<table>
<thead>
<tr>
<th>Indicators</th>
<th>1999 figure</th>
<th>2010 targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. ON REPRODUCTIVE HEALTH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Total fertility rate-TFR (average number of children/one woman of reproductive age)</td>
<td>2.3</td>
<td>2.0</td>
</tr>
<tr>
<td>2. Maternal mortality rate MMR- maternal deaths/100,000 live births</td>
<td>100</td>
<td>70</td>
</tr>
<tr>
<td>3. Infant mortality rate-IMR- death rate of children under one year of age (960)</td>
<td>36.7</td>
<td>25</td>
</tr>
<tr>
<td>4. Low birthweight rate-LBWR- rate of new-born weighing less than 2500g</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>5. Malnutrition rate among the under five</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Peri-natal mortality rate -PMR (960)</td>
<td>34%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>18</td>
</tr>
</tbody>
</table>

| **B. PROVISION OF SERVICES** | | |
| 1. Percentage of RH services providing information, education and counseling on RH | - | 75% |
| 2. Percentage of RH services providing information, education and counseling on RH to adolescents | - | 75% |
| 3. Percentage of service users receiving information and counseling on RH and contraceptive methods | - | 75% |
| 4. Percentage of reproductive age population being aware of abortion risks and preventive measures. | - | 75% |
| 5. Reduction in abortions compared with the year 2000 | - | 50% |
| 6. Percentage of expectant mothers receiving pre-natal care | 71%(97) | 75% |
| 7. Percentage of expectant mothers receiving at least 2/3 good quality pre-natal checks-up | 41%(97) | 60% |
| 8. Minimum number of post-natal checks for one mother | 1 | 2 |
| 9. Percentage of deliveries assisted by health professionals | 77%(97) | 97% |
| 10. Percentage of RH services which run out of drugs and whose essential equipment are not timely supplemented | - | <10% |

**Annex 1a**

The targets on reproductive health and reproductive health care to be achieved in the year 2005 and 2010
A. In terms of reproductive health
1. Total Fertility Rate (average number of children/1 woman at reproductive age)
   - Objective 2005: 2.3
   - Objective 2010: 2.1
   - Achieved: 3.9

2. Percentage of couples using contraceptive methods (%)
   - 2005: 75.3
   - 2010: 78.0
   - Achieved: 76.0

3. Percentage of couples using modern contraceptive methods
   - 2005: 58.8
   - 2010: 60.0
   - Achieved: 70.0

4. Maternal mortality rate/100,000 live births
   - 2005: 38.7%
   - 2010: 28.0%
   - Achieved: 20.0%

5. Infant mortality rate (%)
   - 2005: 5.2
   - 2010: 20.0
   - Achieved: 18.0

6. Low birth weight (below 2500 gr)
   - 2005: 8%
   - 2010: 7%
   - Achieved: 7%

7. Malnutrition rate among infants under five
   - 2005: 36.7%
   - 2010: 28%
   - Achieved: 20%

8. Perinatal mortality rate (%)
   - 2005: 2.2
   - 2010: 2.0
   - Achieved: 2.5%

9. Obstetric complication-related mortality
   - 2005: 3.2%
   - 2010: 2.8%
   - Achieved: 2.5%

10. Rate of abortion/100 live births
    - 2005: 51.9%
    - 2010: 35%
    - Achieved: 25%

B. In terms of RH service delivery
1. Percentage of RH service delivery points giving information, education and counseling about RH
   - 2005: 30%
   - 2010: 50%
   - Achieved: 75%

2. Percentage of RH service delivery points giving information, education and counseling to adolescents
   - 2005: 30%
   - 2010: 50%
   - Achieved: 75%

3. Percentage of RH service users receiving information, counseling about RH and contraceptive methods
   - 2005: 30%
   - 2010: 50%
   - Achieved: 75%

4. Percentage of abortion acceptors who are informed about the harmful effects of abortion and methods of prevention
   - 2005: 30%
   - 2010: 50%
   - Achieved: 75%

5. Reduction of abortion incidence in comparison to the year 2000
   - 2005: 50%

6. Percentage of pregnant women receiving pre-natal care
   - 2005: 71%
   - 2010: 80%
   - Achieved: 90%

7. Percentage of pregnant women receiving 3 good quality pre-natal check-ups
   - 2005: 41%
   - 2010: 55%
   - Achieved: 60%

8. Percentage of mothers receiving pre-natal care provided to mothers
   - 2005: 1
   - 2010: 1.5
   - Achieved: 2

9. Percentage of deliveries assisted by health professionals
   - 2005: 77%
   - 2010: 85%
   - Achieved: 97%

10. Percentage of mothers who deliver at health facilities
    - 2005: 62%
    - 2010: 70%
    - Achieved: 80%

11. Percentage of RH service delivery points running out of essential drugs and equipment without timely back-up
    - 2005: 30%
    - 2010: 20%
    - Achieved: <10%

Annex 1b
Indicators for monitoring and evaluation

INDICATORS OF RH SERVICE DELIVERY

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Source</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recording system is available to monitor the RH service delivery. Know how to analyze it for planning, monitoring, reviewing and evaluation purposes</td>
<td>Book keeping, statistics, data recording</td>
<td>All levels</td>
</tr>
<tr>
<td>2. Percentage of couples who have access to RH services</td>
<td>Statistics, data recording books</td>
<td>All levels</td>
</tr>
<tr>
<td>3. Percentage of couples using contraceptive methods</td>
<td>HMIS instruments</td>
<td>All levels</td>
</tr>
<tr>
<td>4. Percentage of pregnant women receiving at least 1 pre-natal care</td>
<td>HMIS instruments</td>
<td>All levels</td>
</tr>
<tr>
<td>5. Percentage of deliveries assisted by health professionals</td>
<td>HMIS instruments</td>
<td>All levels</td>
</tr>
<tr>
<td>6. Percentage of mothers receiving post-natal check-up</td>
<td>HMIS instruments</td>
<td>All levels</td>
</tr>
<tr>
<td>7. Percentage of babies receiving infant care</td>
<td>HMIS instruments</td>
<td>All levels</td>
</tr>
<tr>
<td>8. Number of health facilities providing IEC</td>
<td>Provincial and National annual final report</td>
<td>Provincial and Central levels</td>
</tr>
<tr>
<td>9. Number of high risk pregnant women and STI cases which were managed and referred</td>
<td>HMIS instruments</td>
<td>District level</td>
</tr>
<tr>
<td>10. Number of pregnant women with anemia using iron tablets</td>
<td>Survey</td>
<td>All levels</td>
</tr>
<tr>
<td>11. Percentage of pregnant women receiving TT vaccination with at least 2 boost</td>
<td>Survey</td>
<td>All levels</td>
</tr>
<tr>
<td>12. Providing essential child and infant care</td>
<td>District, Province, National Final annual report</td>
<td>Implementing areas</td>
</tr>
<tr>
<td>13. Percentage of couples shifting from using periodic contraceptive methods to permanent ones</td>
<td>HMIS/statistics data recording books</td>
<td>Central, Provincial levels</td>
</tr>
<tr>
<td>14. Percentage of couples who get married, or start a baby too early</td>
<td>Statistic data recording books</td>
<td>District, Provincial, Central levels</td>
</tr>
<tr>
<td>15. Percentage of abortion-related births</td>
<td>HMIS</td>
<td>All levels</td>
</tr>
<tr>
<td>16. Percentage of abortion-related complications</td>
<td>HMIS</td>
<td>All levels</td>
</tr>
<tr>
<td>17. Percentage of pregnant women receiving 3 prenatal check-up</td>
<td>Statistic data recording books</td>
<td>All levels</td>
</tr>
<tr>
<td>18. Rate of obstetric complications</td>
<td>Statistic data recording books</td>
<td>All levels</td>
</tr>
<tr>
<td>19. Regularly providing training to improve knowledge and skills of RH care providers</td>
<td>Raports/statistics</td>
<td>District, Provincial, Central levels</td>
</tr>
<tr>
<td>20. Percentage of health care facilities regularly receiving sufficient drugs, instruments and equipment</td>
<td>Raports/statistics</td>
<td>District, Provincial, Central levels</td>
</tr>
<tr>
<td>21. Percentage of clients satisfied with RH services</td>
<td>In-depth survey</td>
<td>Households/community</td>
</tr>
</tbody>
</table>
II. INDICATORS OF QUALITY OF RHC SERVICES

<table>
<thead>
<tr>
<th>IMPACT INDICATORS</th>
<th>Periodical survey</th>
<th>District, Province, Central levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Fertility Rate (TFR) and specific TFR</td>
<td>Periodical survey</td>
<td>District, Province, Central levels</td>
</tr>
<tr>
<td>2. Maternal Mortality Rate</td>
<td>Delivery registration</td>
<td>District, Province, Central levels</td>
</tr>
<tr>
<td>3. Neonatal Mortality Rate</td>
<td>Delivery registration</td>
<td>District, Province, Central levels</td>
</tr>
<tr>
<td>4. Low Birth Weight Rate (below 2,500 gr)</td>
<td>Statistics recorded at health facility</td>
<td>District, Province, Central levels</td>
</tr>
<tr>
<td>5. Malnutrition rate among children under five</td>
<td>Statistics recorded at health facility</td>
<td>District, Province, Central levels</td>
</tr>
</tbody>
</table>

Reproductive Health Care Service Package available at levels

<table>
<thead>
<tr>
<th>RHC package at levels</th>
<th>Family planning</th>
<th>Safe Motherhood- Neonatal care</th>
<th>Safe Abortion-Management of complications</th>
<th>Prevention and treatment of RTI and STD</th>
<th>Prevention and treatment of infertility</th>
<th>RHC for aged women, reproductive tract cancers</th>
<th>Adolescent Reproductive health</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Hospitals</td>
<td>Counseling, condom/pills</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
</tr>
<tr>
<td>Commune Health Station</td>
<td>Counseling, condom/pills</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
</tr>
<tr>
<td>Community Village</td>
<td>Counseling, condom/pills</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
<td>Contraceptive pills distribution and condom distribution</td>
</tr>
<tr>
<td>Households</td>
<td>IEC Center Referring</td>
<td>IEC Center Referring</td>
<td>IEC Center Referring</td>
<td>IEC Center Referring</td>
<td>IEC Center Referring</td>
<td>IEC Center Referring</td>
<td>IEC Center Referring</td>
</tr>
</tbody>
</table>

Annex Il

Annex IIIa

Detailed descriptions of the RHC services required at levels

1. Households

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Specific requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY PLANNING</td>
<td>Know the needs in FP</td>
</tr>
<tr>
<td>SAFETY MOTHERHOOD AND NEWBORN CARE</td>
<td>1. Know how to access to contraceptive methods providers</td>
</tr>
<tr>
<td></td>
<td>1. Identify pregnant women and recognize abnormal or dangerous signs.</td>
</tr>
<tr>
<td></td>
<td>2. Know how to care the baby under the professional guidances and instructions.</td>
</tr>
<tr>
<td>SAFE ABORTION AND MANAGEMENT OF ABORTION-RELATED COMPLICATIONS</td>
<td>1. Recognize the signs/symptoms of abortion-related complications.</td>
</tr>
<tr>
<td>PREVENTION-TREATMENT RTI-STD- HIV/AIDS-INFERTILITY- RH</td>
<td>2. Know how to access to the health facilities for care and treatment</td>
</tr>
<tr>
<td>ADOLESCENT</td>
<td>1. Recognize the symptoms of RTI and STD and where can access to the facilities for treatment</td>
</tr>
<tr>
<td></td>
<td>2. Able to be aware of possible causes and methods</td>
</tr>
</tbody>
</table>
for prevention including condom use.

3. Communication and Education within family:
   a. Exchange ideas between parents and children
   b. Advise not to get married early
   c. Ensure the nutritious meals for adolescents, especially for girls
   d. Encourage to join school for study, particularly for girls.

RHC FOR AGED WOMEN,
REPRODUCTIVE TRACT CANCERS

1. Pay attention to the aged members in family, especially old aged women
2. Be aware of how to recognize or detect oneself the simple signs of breast cancer and other reproductive tract cancers.

Annex III.b
II. Community-Village Health Care Workers Same as for households level, plus:

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Specific requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY PLANNING</td>
<td>IEC and counseling about sex and sexuality for both men and women including adolescents;</td>
</tr>
<tr>
<td></td>
<td>Mobilize to have early marriage and baby;</td>
</tr>
<tr>
<td></td>
<td>Supply contraceptives through community-based network such as VHWs, TBAs, motivators,</td>
</tr>
<tr>
<td></td>
<td>teachers, WU members, NGOs, etc.;</td>
</tr>
<tr>
<td></td>
<td>Social marketing for condom and pills distribution from sources available at community;</td>
</tr>
<tr>
<td></td>
<td>Counsel and refer for other contraceptive methods;</td>
</tr>
<tr>
<td></td>
<td>IEC about Lactation Amenorrhea Method (LAM).</td>
</tr>
<tr>
<td>SAFE MOTHERHOOD AND</td>
<td>Counsel/Educate on breast feeding, nutrition, FP, restoration and exercise, etc;</td>
</tr>
<tr>
<td>NEWBORN CARE</td>
<td>Recognize the high risk signs</td>
</tr>
<tr>
<td></td>
<td>Recognize and refer the high risk pregnancies, early recognition of complications;</td>
</tr>
<tr>
<td></td>
<td>Recognize the serious signs such as membrane rupture more than 12 hours, prolapse of</td>
</tr>
<tr>
<td></td>
<td>the cord, hemorrhage, etc;</td>
</tr>
<tr>
<td></td>
<td>Perform deliveries with clean delivery kit assisted by midwife or TBA.</td>
</tr>
<tr>
<td></td>
<td>Early recognition of complications during labour for referring to the nearest upper</td>
</tr>
<tr>
<td></td>
<td>level;</td>
</tr>
<tr>
<td></td>
<td>Arrange and organize transport for referring;</td>
</tr>
<tr>
<td></td>
<td>Newborn resuscitation (home delivery);</td>
</tr>
<tr>
<td></td>
<td>Thermal control by immediate warming and breast feeding;</td>
</tr>
<tr>
<td></td>
<td>Promote and provide instruction on breast feeding;</td>
</tr>
<tr>
<td>SAFE ABORTION AND</td>
<td>Counsel on FP and prevention of unwanted pregnancy;</td>
</tr>
<tr>
<td>MANAGEMENT OF ABORTION-</td>
<td>supply pills and condoms;</td>
</tr>
<tr>
<td>RELATED COMPLICATIONS</td>
<td>Refer timely to the relevant health facility;</td>
</tr>
<tr>
<td></td>
<td>Recognition of miscarriage and its complications;</td>
</tr>
<tr>
<td>PREVENTION-TREATMENT RTI-</td>
<td>Education/Counseling about sex and sexuality;</td>
</tr>
<tr>
<td>STD-HIV/AIDS-INFERTILITY</td>
<td>Promote and distribute condoms;</td>
</tr>
<tr>
<td></td>
<td>Education on prevention of infertility;</td>
</tr>
<tr>
<td>RHC FOR AGED WOMEN,</td>
<td>Visit and take care of aged people at home;</td>
</tr>
<tr>
<td>REPRODUCTIVE TRACT</td>
<td>Detect and provide instruction on how to check oneself for early symptoms of breast</td>
</tr>
<tr>
<td></td>
<td>cancer and other RTCs.</td>
</tr>
<tr>
<td>RHC ADOLESCENT</td>
<td>Provide information about sex and sexuality;</td>
</tr>
<tr>
<td></td>
<td>Instruction and explanation about FP methods, available contraceptive methods, the</td>
</tr>
<tr>
<td></td>
<td>danger and harm of being pregnant and having baby early.</td>
</tr>
</tbody>
</table>

Annex III.c
3. Commune Health Station
Same activities undertaken at lower levels, plus:

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Specific requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY PLANNING</td>
<td>Supervise and monitor the activities taken place at community, village levels;</td>
</tr>
<tr>
<td></td>
<td>Indicate and supply contraceptive pills, condoms, IUD;</td>
</tr>
<tr>
<td></td>
<td>Follow-up those who use contraceptive methods;</td>
</tr>
<tr>
<td></td>
<td>Counsel and refer the sterilization cases as needed;</td>
</tr>
<tr>
<td></td>
<td>Counsel/manager the cases with side effects, changing method as indicated;</td>
</tr>
<tr>
<td></td>
<td>Supply more options of contraceptive methods to be selected;</td>
</tr>
<tr>
<td></td>
<td>IEC about LAM</td>
</tr>
<tr>
<td>SAFE MOTHERHOOD AND</td>
<td>Perform prenatal checks (3 times), examining breast tumors;</td>
</tr>
<tr>
<td>NEWBORN CARE</td>
<td>Recognize the high risk factors and complications of pregnancies such as membrane</td>
</tr>
<tr>
<td></td>
<td>rupture more than 6 hours, prolapse of the cord, hemorrhage, pre-eclampsia, severe</td>
</tr>
<tr>
<td></td>
<td>anemia, heart diseases, diabetes, etc.;</td>
</tr>
<tr>
<td></td>
<td>TT Immunization, malaria treatment for pregnant women;</td>
</tr>
<tr>
<td></td>
<td>Perform normal delivery; supervising, assisting home delivery;</td>
</tr>
<tr>
<td></td>
<td>Early recognition of labour complications such as obstructive hemorrhage, evacuating</td>
</tr>
<tr>
<td></td>
<td>uterus with retained remnants of placenta as needed and referring to upper level;</td>
</tr>
<tr>
<td></td>
<td>Umbilical care (cut and tie cord), eye drops, resuscitating for newborn with asphyxia,</td>
</tr>
<tr>
<td></td>
<td>malformation, sickness and referring;</td>
</tr>
<tr>
<td></td>
<td>Breast feeding after birth, immunization as schedule;</td>
</tr>
<tr>
<td></td>
<td>Growth monitoring chart, encourage breast feeding.</td>
</tr>
</tbody>
</table>
SAFE ABORTION AND
MANAGEMENT OF ABORTION-
RELATED COMPLICATIONS

PREVENTION-TREATMENT RTI-
STD-HIV/AIDS-INFERTILITY

1. Check the diagnosis of miscarriage done by lower level.

2. Treat shock and resuscitate, and refer patients in good conditions.

3. Symptomatic examination and treatment of RT common diseases;

4. Refer the difficult cases for diagnosis (pelvic pain, abnormal vaginal discharge, urethral discharge, genatal ulceration including at scrotum, etc.)

5. Promote and distribute condoms.

6. Educate about prevention of RTI and infertility

RELATED COMPLICATIONS

1. Systolic examination and treatment of RT common diseases;

2. Refer the difficult cases for diagnosis (pelvic pain, abnormal vaginal discharge, urethral discharge, genatal ulceration including at scrotum, etc.)

PREVENTION-TREATMENT RTI-
STD-HIV/AIDS-INFERTILITY

1. Symptomatic examination and treatment of RT common diseases;

2. Refer the difficult cases for diagnosis (pelvic pain, abnormal vaginal discharge, urethral discharge, genatal ulceration including at scrotum, etc.)

3. Promote and distribute condoms.

4. Educate about prevention of RTI and infertility

PREVENTION-TREATMENT RTI-
STD-HIV/AIDS-INFERTILITY

1. Symptomatic examination and treatment of RT common diseases;

2. Refer the difficult cases for diagnosis (pelvic pain, abnormal vaginal discharge, urethral discharge, genatal ulceration including at scrotum, etc.)

3. Promote and distribute condoms.

4. Educate about prevention of RTI and infertility

RHC FOR AGED WOMEN

1. Examine to detect breast cancer and other RTCs and refer.

REPRODUCTIVE TRACT CANCERS (RTC)

1. Supply easily contraceptive pills and condoms;

2. Ensure to provide adolescent all adequate prenatal, natal, postnatal care by changing the current MCH/FP services to be more appropriate to adolescents’ psychology and conditions.

3. Educate about family life at clinics and schools

RHC FOR AGED WOMEN

1. Examine to detect breast cancer and other RTCs and refer.

REPRODUCTIVE TRACT CANCERS (RTC)

1. Supply easily contraceptive pills and condoms;

2. Ensure to provide adolescent all adequate prenatal, natal, postnatal care by changing the current MCH/FP services to be more appropriate to adolescents’ psychology and conditions.

3. Educate about family life at clinics and schools

Annex III.d
4. Maternity, Polyclinic

Same activities undertaken at lower levels, plus:

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Specific requirements</th>
</tr>
</thead>
</table>
| FAMILY PLANNING | 1. Supply the contraceptives  
2. Insert and remove IUD  
3. Conduct menstrual regulation  
4. Manage complications  
5. Post abortion care, educate on space pregnancy to prevent unwanted pregnancy |
| SAFE MOTHERHOOD AND NEWBORN CARE | 1. Conduct prenatal care, identify high risk pregnant women to refer, such as vesico-vaginal fistula, pre-eclampsia, malpresentation, previa placenta, uterus pre-rupture and rupture, early rupture of membrane, 5 Pirth, pregnant women with medical conditions such as heart, liver, kidney disorders, hypertension, severe anemia, malnutrition, cephalo-pelvic disproportion, difficult obstetric history, previous cesarian section  
2. Use oxytocin, ergometrine after abortion, after placenta delivery for treatment of hemorrhage  
3. Evacuate uterus to manage postpartum hemorhage (remove retained bits of placenta), consult the upper level if beyond capacity  
4. Primary emergency care of obstetric accidents and refer |
| SAFE ABORTION AND MANAGEMENT OF ABORTION-RELATED COMPLICATIONS | 1. Treat threatened abortion  
2. Initially treat with antibiotics and oxytocin  
3. Evacuate uterus after incomplete abortion within 1 week  
4. Refer the incomplete abortion after 1 week  
5. Use mild analgesics for pain relief |
2. Manage the STD by basing on the clinical symptoms if diagnosis equipment is not complete, under the instruction of upper level  
3. IEC for prevention and promoting the condom use |
| RHC FOR AGED WOMEN | 1. Examine to detect breast cancer and other RTCs and refer. |
| REPRODUCTIVE TRACT CANCERS (RTC) | 1. Improve the current MCH/FP services to adapt with adolescent psychology and conditions under the form of polyclinic where counseling and provision of FP/HIV/Infertility services can be available  
Supply easily contraceptive pills and condoms. |
| RHC FOR AGED WOMEN | 1. Examine to detect breast cancer and other RTCs and refer. |
| REPRODUCTIVE TRACT CANCERS (RTC) | 1. Improve the current MCH/FP services to adapt with adolescent psychology and conditions under the form of polyclinic where counseling and provision of FP/HIV/Infertility services can be available  
Supply easily contraceptive pills and condoms. |
| RHC FOR AGED WOMEN | 1. Examine to detect breast cancer and other RTCs and refer. |
| REPRODUCTIVE TRACT CANCERS (RTC) | 1. Improve the current MCH/FP services to adapt with adolescent psychology and conditions under the form of polyclinic where counseling and provision of FP/HIV/Infertility services can be available  
Supply easily contraceptive pills and condoms. |
| RHC FOR AGED WOMEN | 1. Examine to detect breast cancer and other RTCs and refer. |
| REPRODUCTIVE TRACT CANCERS (RTC) | 1. Improve the current MCH/FP services to adapt with adolescent psychology and conditions under the form of polyclinic where counseling and provision of FP/HIV/Infertility services can be available  
Supply easily contraceptive pills and condoms. |
<p>| RHC FOR AGED WOMEN | 1. Examine to detect breast cancer and other RTCs and refer. |</p>
<table>
<thead>
<tr>
<th>Type of service</th>
<th>Specific requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FAMILY PLANNING</strong></td>
<td>1. Perform the long-term effect FP methods 2. Manage the side effects 3. Sterilization, all types.</td>
</tr>
<tr>
<td><strong>SAFE MOTHERHOOD AND NEWBORN CARE</strong></td>
<td>1. Manage the high risk pregnancies. 2. Perform difficult deliveries, malpresentations 3. Manage pre-eclampsia, eclampsia, treat shock, infections, pregnant women with anemia, heart disease, hypertension 4. Able to perform forceps and vacuum extractor. 5. Perform first cesarian section 6. Remove ovarian cysts in combination with or without sterilization 7. Perform subtotal hysterectomy due to uterus atonia or postpartum hemorrhage 8. Care special low birth weight and pre-mature baby (more than 1.800 gram) 9. Feed babies more than 2000 gr</td>
</tr>
<tr>
<td><strong>SAFE ABORTION AND MANAGEMENT OF ABORTION-RELATED COMPLICATIONS</strong></td>
<td>1. Perform abortion curettage for pregnancies under 3 months 2. Manage and treat complications of abortion 3. Local anesthesia, general anesthesia 4. Diagnose and refer serious complications such as septicemia, peritonitis, renal failure, etc.</td>
</tr>
<tr>
<td><strong>PREVENTION-TREATMENT OF RTI-STD-HIV/AIDS-INFERTILITY</strong></td>
<td>1. Diagnose (clinical and laboratory) and treat RTIs and STDs 2. Diagnose and treat infertility and refer as needed 3. IEC about prevention and promote using condoms</td>
</tr>
<tr>
<td><strong>RHC FOR AGED WOMEN, REPRODUCTIVE TRACT CANCERS (RTC)</strong></td>
<td>1. Examine to detect breast cancer and other RTCs and refer.</td>
</tr>
<tr>
<td><strong>RE ADOLESCENT</strong></td>
<td>1. Improve the current MCH/FP services to adapt with adolescent psychology and conditions under the form of polyclinic where counseling and provision of FP/HIV/infertility services can be available 2. Supply easily contraceptive pills and condoms. 3. Ensure to provide adolescent all adequate prenatal, natal, postnatal care under the guidance of MoH; Educate about family life at clinics and schools</td>
</tr>
</tbody>
</table>

Annex III.F.6. Provincial hospital

Same activities undertaken at lower levels, plus:

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Specific requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FAMILY PLANNING</strong></td>
<td>1. Remove IUD by abdominal endoscopy 2. Perform sterilization after delivery</td>
</tr>
<tr>
<td><strong>SAFE MOTHERHOOD AND NEWBORN CARE</strong></td>
<td>1. Internal manipulation of fetus presentation 2. Active management of labour and delivery (monitoring delivery) 3. Difficult delivery with breech presentation 4. Second or third cesarian section 5. Total or Sub-total hysterectomy 6. Operating extra uterine pregnancy associated with no shock 7. Uterine fixation operation 8. Repair complicated tears (laceration to the sphincter of anus) 9. Care of special premature newborn, less than 1,800 gram</td>
</tr>
<tr>
<td><strong>SAFE ABORTION AND MANAGEMENT OF ABORTION-RELATED COMPLICATIONS</strong></td>
<td>1. Abortion curettage (pregnant more than 3 months). 2. Curettage for retained products of conception after miscarriage, endometrial biopsy 3. Repair (suture) uterine perforation caused by curettage 4. Diagnosis and management of serious complications such as septicemia, peritonitis, renal failure, etc.</td>
</tr>
</tbody>
</table>
PREVENTION-TREATMENT
RTI-STD-HIV/AIDS-
INFERTILITY
1. Laboratory investigation such as microbiology, serology, cytology for diagnosis of STDs.
2. Treat difficult cases of RTI and STDs
3. Diagnosis and treatment of barren infertility.

RH FOR AGED WOMEN,
REPRODUCTIVE TRACT CANCERS (RTC)
1. Cytological biopsy and cytological diagnosis for cancer and suspected cancer cases.
2. Examine, early detect and treat breast cancers, cervical cancers at early stage.
3. Total or sub-total hysterectomy for treatment of uterine myofibroma, choriocarcinoma or corpus uterine cancers.
4. Cervix conization, prostatectomy.

RH ADOLESCENT
1. Provide counseling and specialized reproductive health care to adolescent.

Annex IV
Estimated budget for Reproductive Health Care during the period 2001-2010

<table>
<thead>
<tr>
<th>Activities</th>
<th>2001-2005</th>
<th>2006-2010</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A FAMILY PLANNING</td>
<td>29  561  530</td>
<td>41  689  730</td>
<td>70  1190 1260</td>
</tr>
<tr>
<td>B CHILD HEALTH</td>
<td>34  647  681</td>
<td>46  1007 1053</td>
<td>80  1854 1734</td>
</tr>
<tr>
<td>C SAFE MOTHERHOOD</td>
<td>5  175  180</td>
<td>10  259 261</td>
<td>10  431 441</td>
</tr>
<tr>
<td>D REPRODUCTIVE TRACT DISEASES</td>
<td>2.5  117.5 120</td>
<td>2.5  167.5 170</td>
<td>5  285 290</td>
</tr>
<tr>
<td>E ADOLESCENT HEALTH</td>
<td>1  59  60</td>
<td>1  84 85</td>
<td>2  143 145</td>
</tr>
<tr>
<td>F RH FOR AGED PEOPLE</td>
<td>1  10  11</td>
<td>2  20 22</td>
<td>3  32 35</td>
</tr>
<tr>
<td>G UPGRADING EQUIPMENT AND FACILITIES</td>
<td>0  60  60</td>
<td>0  60 60</td>
<td>0  120 120</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72.5</strong> 1618.5 1691</td>
<td><strong>96.5</strong> 2347.5 2444</td>
<td><strong>169</strong> 3966 4135</td>
</tr>
</tbody>
</table>

Estimation: 4135 billion VND including
Central level: 169 billion VND
Community level: 3966 billion VND

Annex V
Organization structure of steering committee at central and community levels
1. CENTRAL STEERING COMMITTEE

Responsibilities:
The Central Steering Committee which is the highest-level administration, shall be responsible for putting forward as well as amending or supplementing the National Policy and Strategy on Reproductive Health Care

Members
The Minister of Health shall be the Chairman of the Central Steering Committee, the members include representatives from Ministries, Agencies, Committees, Mass Organizations at central level and one representative from NGOs which is involved in Reproductive Health.

2. PROVINCIAL STEERING COMMITTEE

Responsibilities:
The Provincial Steering Committees shall be responsible for steering and supervising the implementation of the national RH strategy in its own province, and proposing to the Central Steering Committee amendments and/or supplements, if any, to the national strategy

Members
The Vice Chairman of the Provincial People's Committee shall be the Chairman of the Provincial Steering Committee, The Director of Provincial Health Service shall be the Executive Vice Chairman and members include some leading persons who are nominated by provincial departments, sectors.

3. DISTRICT STEERING COMMITTEE

Responsibilities:
The District Steering Committees shall be responsible for steering and supervising the implementation of the national RH strategy in its own district, and proposing to the Provincial and Central Steering Committees amendments and/or supplements, if any, to the national strategy

Members
The Vice Chairman of the District People's Committee shall be the Chairman of the District Steering Committee, The Director of District Health Center shall be the Executive Vice Chairman and members include some leading persons who are nominated by district departments, sectors.