COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH:

VIET NAM

This project is funded by the European Union

With co-funding support from Sida

CCIHP
CENTER FOR CREATIVE INITIATIVES IN HEALTH AND POPULATION

COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH:

VIET NAM

This project is funded by the European Union

With co-funding support from Sida

1. Introduction

The Socialist Republic of Vietnam is one of Southeast Asia's fastest growing economies. The country is a one-party communist state, and was unified in 1975 after three decades of war[1]. Since then poverty has reduced dramatically. During the period 2010-2013, Vietnam has experienced a significant drop in the poverty rate, shifting from 14.2 % in 2010 to 9.6% in 2012. However, the poverty rate varies across geographic region and among different ethnic minorities. It is noted that ethnic minority households account for 50 % of the total poor households in the country. Urban poverty has also increased alongside internal migration and urbanisation[2].

According to the most recent survey, the population of Viet Nam is more than 90 million people with 49.3% male and 50.7% female (GSO, 2014). The first National strategy on Reproductive Health Care (RHC) for the period 2001-2010, which was approved in 2000, marked the formal recognition of reproductive health (RH) in national policy in addition to the country's primary focus on population and family planning (Phan, 2000). This commitment was affirmed by the approval of the National Strategies on Population and Reproductive Health for 2011-2020 and Vision to 2030 in 2011 (T. D. Nguyen, 2011). In these documents the right to informed choice, gender equity, female empowerment, quality services and counselling that respond to the specific needs of the most socio and economic vulnerable and marginalized groups are identified as important strategies to achieve the national goal on population and reproductive health (MOH, 2011; Phan, 2000).

Box 1: Specific objectives of National Strategies on Reproductive Health Care for the period 2001-2010

- To sustain the fertility reduction trend; to ensure the rights of women and couples to have children and select contraceptive methods of good quality; to reduce unwanted pregnancies and abortion related complications.
- To improve the health status of women and mothers; to obtain a more balanced reduction in maternal mortality and morbidity, perinatal deaths and infant mortality among different regions and target groups, with special attention to disadvantaged areas.
- To provide better RHC to the elderly, particularly to older women; to provide early diagnosis and treatment of breast cancer and other cancers of both male and female reproductive tracts.
- To improve the RH status, including sexual health, of adolescents through education, counselling and provision of RH services suited to different age groups.
- To improve men and women's understanding of healthy sexual relationships and sexuality so they can fully exercise their rights and responsibilities; to promote safe and responsible sexual relationships on the basis of equality and mutual respect to improve RH and quality of life.

(MOH, 2000)

Despite these efforts, in 2013, Viet Nam ranks 121 on the Human Development Index[3]due to its low mean years of schooling and gross national income per capita. Efforts to boost gender equity have brought Vietnam to rank 58 on the Gender Inequality Index[4].

The country is approaching the 'golden population structure' when one person in the dependent age group is supported by two people in the working age group (UNFPA, 2010a). The current dependent rate of Viet Nam is 46% (GSO, 2013a). This is a great opportunity for Vietnam to accelerate economic development. However, the country is also facing emerging challenges. Urbanization increases internal migration, and the government needs to respond with socio, economic, education, and health policies that address the specific needs of this group. After a long history of being hidden and silenced, people in same-sex relationships and transgender people have become more visible. Similar to migrant populations and other marginalized groups, their wide range of unique needs (such as broad-based reproductive health, not just HIV prevention) should be addressed in national programs.

This country profile describes and discusses the status and gaps in sexual and reproductive health in Viet Nam. It will give an overall picture, while specifically mapping the reproductive health status of groups often neglected in health profiles. For example, adolescents and young people, migrant workers, ethnic minority people, people living with disabilities (PWD) and people in same-sex relationship including transgender and transsexual people.

[1] http://hdr.undp.org/en/content/table-1-human-development-index-and-its-components
[4] http://hdr.undp.org/en/content/table-4-gender-inequality-index

2.The status of sexual and reproductive health in Vietnam

2.1. Total fertility rate and imbalanced sex ratio at birth

Viet Nam's population and family planning program has been very successful. The total fertility rate (TFR) reached a replacement level of 2.1 since 2006 and remained at this level until now (GSO, 2014). However, there are big differences in TFR among regions and ethnicities which implies 'the country's birth rate continues to fluctuate unpredictably' commented by the deputy minister of health Dr. Nguyen Viet Tien (VNS, 2014). Eighteen provinces have TFR lower than the replacement level. 27 provinces have TFR higher than the replacement level.

As TFR continues to decline, the younger age group will be relatively smaller than the aging group. This does not favour economic development in Viet Nam. Thus, the population program's slogan has changed from 'Each couple should have one or two children' to 'Each couple should have two children'. In December 2014, the Ministry of Health launched the campaign 'Maintaining a reasonable low birth rate for sustainable development of the country' for national take-action month (Phuong, 2014).

Most people in Viet Nam have adopted the small family model, and an imbalanced sex ratio at birth is an emerging population challenge. In 2009, UNFPA disseminated the first formal report on the issue based on data from the population census. However, the first sign of an increase in the sex ratio at birth had already observed in 2000 (GSO, 2011b). Though the issue is newly developed in Viet Nam, the situation is worrisome because it's intensifying (figure 1).

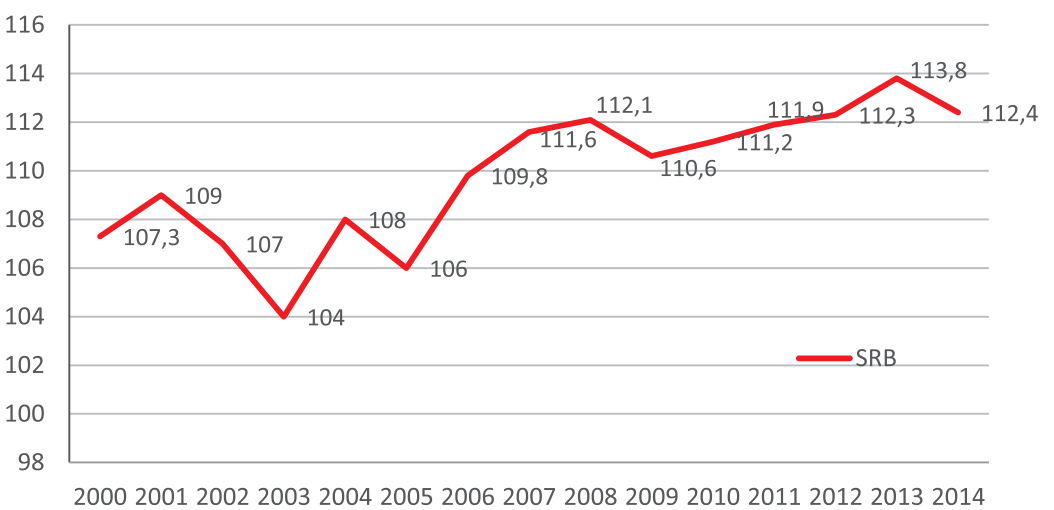
The availability and accessibility of sex diagnosis technology together with the prevailing gender inequity and son preference culture are identified as main causes of the problem. Among them, gender inequity and son preference are the root causes and sex diagnosis technology is supplement (GSO, 2011b, 2012, 2013a; Priya et al., 2012). 57.3% of the women who gave birth two years before the survey do not have preference on the sex of their children. 31.2% want to have a boy and only 11.5% want to have a girl (GSO, 2013a).

The government has tried various policies to improve the situation including media campaigns to raise public awareness on the issue, and banning the use of technology for sex diagnosis during pregnancy (T. D. Nguyen, 2006; Viet Nam National Assembly, 2003).

In 2013, the Ministry of Health proposed 3000 billion Vietnamese dong (about 150 million USD) plan for the period of 2013-2020 to solve the problem. One percent of this budget is to support families who give birth only to girls. 60-70% of the budget is for communication activities to change perception and behaviour, which is *'the main, the most essential, the most important and the most sustainable solution'* for the problem according to Mr. Duong Quoc Trong GOPFP Director (Le, 2013).

The sex ratio at birth in 2014 was 112.4 (112.4 girls per 100 boys) with big differences between urban (110.1) and rural (113.1) areas (Vo, 2014). According to GOPFP, the decrease is due to the implementation of a program to decrease the sex ratio at birth in 40 cities and provinces in the last several years. However, they need time to conclude if this decrease is sustainable (Thuy, 2014). More than 83% of the women know the sex of the foetus before giving birth and this rate keeps increasing overtime despite the legal regulations that prohibit sex diagnosis (GSO, 2013a).

Figure 1: Sex ratio at birth (SRB)



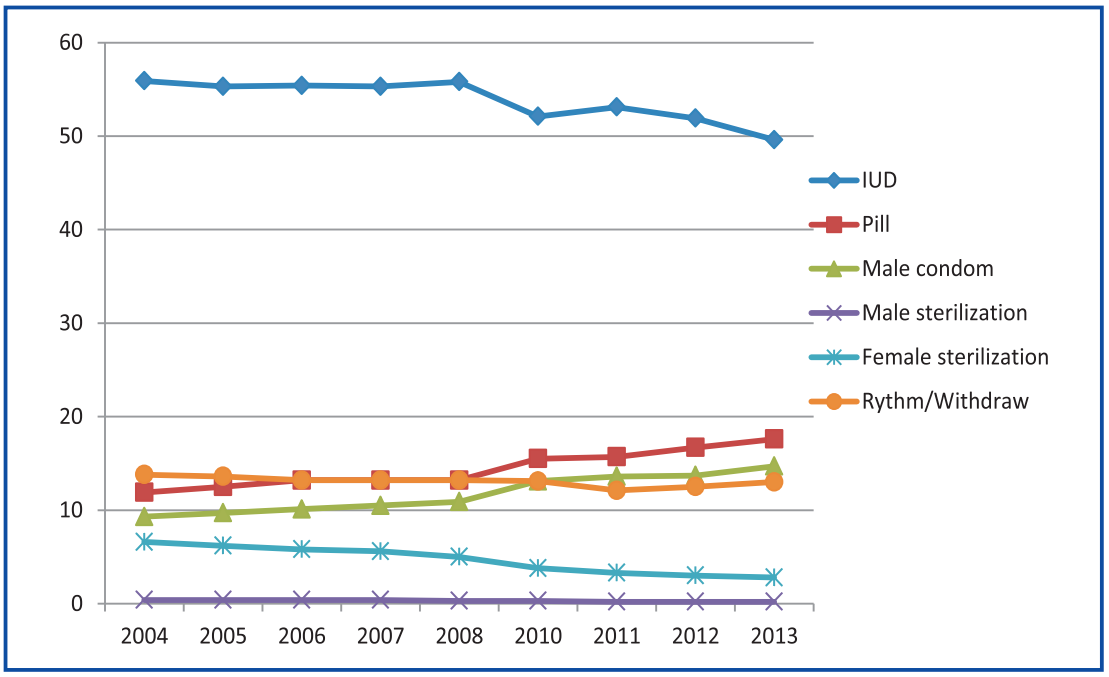
Source: (GSO, 2011b, 2012, 2013a, 2014)

It's important to note that giving birth to a boy is more common among women living in urban areas under better economic conditions and with higher levels of education (GSO, 2011b). Thus, the GOPFP's argument to use economic incentives to lower the sex ratio at birth is not convincing. Education and communication programs to raise public awareness of the consequences of a skewed sex ratio at birth (such as the risk that young men wont find a partner for marriage and the trafficking of women) have not been effective. The short-term pressure for couples to have a boy outweighs the long-term social consequences of an uneven sex ratio. Education and communication programs should focus on traditional beliefs and practices concerning the roles of the son and daughter in the family, not only in term of working labour and economic contribution, but more importantly, on the embedded cultural and family practices in Vietnam. For example, naming the child at birth, praying for the ancestors, financial contributions to family events, recording the family tree, etc. This was done well in the recent exhibition, 'Tradition and Future', launched by the Institute for Social Development Studies (ISDS) in November 2014 (Kim, 2014). In addition, policies and mechanisms should be provided to ensure gender equality in employment, wage and promotion.

2.2. Contraception use

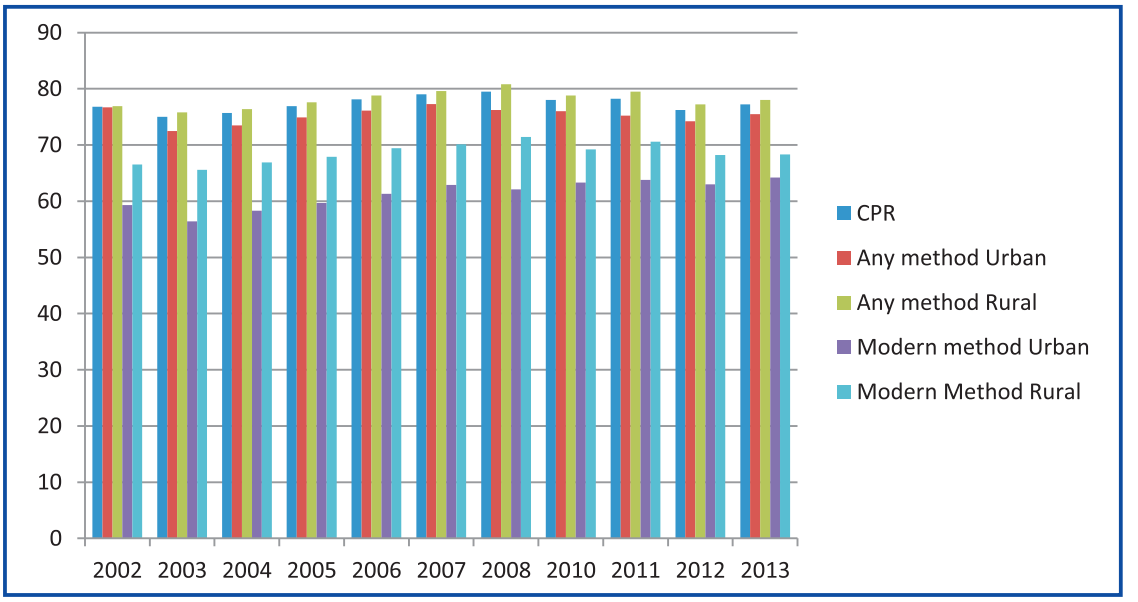
With a long national history or family planning, contraceptive use is high. 77.2% of married women or women with long term partners from the age of 15-49 years old use some forms of contraceptives. Among them, 67.0% use modern methods and almost 10.2% use traditional methods. Among women who do not use any contraceptive method, 60.1% of them are pregnant or want to have children. The Intra-Uterine Device (IUD) is still the most prevalent method, with 49.6% of users. Only 14.7% use the male condom and 17.6% use the pill. The use of the male condom and pill are low, but has increased slowly over time (GSO, 2013a).

Figure 2: Changes in the use of various contraceptive methods in ten recent years



Because the birth rate is often higher in rural than urban areas, the national family planning program has targeted it's efforts here. As a result, the use of contraceptives is higher among rural couples. 78.0% of rural couple use a contraceptive method, whereas 75% of urban couples do. The use of modern methods among these groups is 68.3% and 64.2% respectively. The use of traditional methods is higher among those in living in urban areas (11,3% in urban area versus 9.7% in rural area) (GSO, 2013a). Even in areas with socioeconomic disadvantages, the use of contraceptives is relatively high. More than 70% of women with no or low education use contraceptive method (GSO, 2013a).

Figure 3: Trends on contraceptive prevalence rate



Although contraceptive use is high, unmet need among unmarried women (34.3%) is almost three times higher than among married women (11.2%) (GSO, 2011a). 50.4% of unmarried but sexually active women have unmet needs for modern contraceptive methods. This number is 29.4% for married women (GSO, 2011a). This discrepancy can be attributed to the program's sharp focus on married couples.

Internal migration within Vietnam has increased, with many young women moving to find work in other provinces (UNFPA, 2010b). However, reproductive health services including contraception are often not available and accessible for them. Stigma and discrimination toward this group further prevents them from accessing and using reproductive health services. Gender inequity lowers their capacity to negotiate safer sex (CCIHP, 2012). Their unmet need is higher than other groups (UNFPA, 2011b).

2.3. Maternal care

Maternal mortality ratio (MMR)

The MMR in Viet Nam has decreased by 64% between 1990 and 2013, moving from 140/100,000 live births to 49/100,000 (WHO, UNICEF, UNFPA, World Bank, 2013). The country has been recognized for its progress in achieving MDG5. However, Viet Nam is among 96 countries that do not have complete civil registration. Civil registration is crucial for Viet Nam to have reliable data on its maternal mortality rate.

Infant mortality rate

The infant mortality rate is highly correlated to access to maternal health care and services. As mentioned above, ethnic minority women have less access to reproductive health services, thus their infants are more vulnerable. The infant mortality rate among ethnic minority children is 46/1000, three times higher than the national rate of 16/1000 live births (GSO, 2011a).

Antenatal care

At the national level, there's a high level of antenatal care for pregnant women. Though the number of women getting antenatal care has increased over time, data shows that socio-economic and regional gaps remain (UN Viet Nam, 2011). 96.1% of pregnant women received at least one antenatal check-up during their last pregnancy. 98.6% of urban women got at least one check-up during their last pregnancy in comparison to 95% of rural women. Only 86.7% of pregnant women in the midland and northern mountainous areas got this level of care.

84.5% of pregnant women received at least three antenatal visits during their last pregnancy with 93.5% for urban women and 83.4% for rural women. Only 64.6% of pregnant women in midland and northern mountainous areas received three visits while 94.9% of pregnant women in the South East region got this degree of care (GSO, 2013a).

Only 27.2% of women in the poorest group got four check-up in their last pregnancy, while 88.7% of women in the richest group did (GSO, 2011a). Large disparities are also observed among ethnicities. 67% of Kinh/Hoa women got at least four check-up, while only 21.3% of ethnic minority women got care at this level. 24.9% of ethnic minority women do not get ante-natal care at all. This number is only 1.6% among Kinh/Hoa women. Women with higher education levels get better antenatal care. 87.3% of women with vocational training, college or higher get four antenatal check-up. This number is 5.6% among women without formal education (GSO, 2011a).

In 2011, the UN recommended that Viet Nam adopt four antenatal check-ups as a standard. (UN Viet Nam, 2011). However, the annual population change survey continues to use the three check-up standard (GSO, 2014).

In addition to disparities in access and utilization of antenatal care among regions and groups, the quality of services is also limited. In 2009, the ministry of health issued the National standard guideline for reproductive health care services (MOH, 2009a). However, only 25% of the women were provided with comprehensive antenatal care (UN Viet Nam, 2011). 73.5% of women in the richest group received this package, while only 17.6% of women in the poorest group did. 7% of women with no education got comprehensive services, compared to 67.9% of women with vocational training, college or higher education. Only 33.4% of women in rural areas were provided with antenatal care package, which is half the number of urban women getting the service (64.9%) (GSO, 2011a).

According to the 2009 population census, Viet Nam has more than 6 million people (7.8% of the population) over age five living with disabilities (PWD) (UNFPA, 2011a). Due to stigma and discriminations, people with disabilities (PWD) face difficulty in establishing romantic relationship and getting married (CCIHP, 2011; UNFPA, 2011a). Health providers are not always sensitive and don't have the knowledge and skills necessary to provide appropriate reproductive health services o women with disabilities.

Women with disabilities complain that it is difficult for them to find health facilities that are accessible for people with disabilities in general, and especially hard for women with disabilities (CCIHP, 2011). Though people with disabilities were included as a special target group in the National strategies on population and reproductive health in 2011-2020, the current National standard guidelines on reproductive health care services do not have specific guidelines and standards for the provision of reproductive health services of people with disabilities. Though the population census provides data on living conditions and employment of PWD, it does not give information on birth, contraception and reproductive health care of PWD. There is no data on PWD in the annual population change survey.

Access and use of delivery services

Antenatal care is closely linked to the access and use of delivery services. While 98.3% of Kinh/Hoa pregnant women delivered at a health facility, only 61.7% of ethnic minority women did so (GSO, 2011a). In 2014, 93.8% of births were delivered by skilled birth attendants. This percentage was lowest in the Central Highlands (81.0%) and Northern Midlands and Mountainous area (77.5%). There is a 30% differential between Kinh/Hoa and ethnic minority women in this percentage (GSO & UNICEF, 2015). The proportion of deliveries with skilled birth attendants gradually increased across the MICS survey: from 84% in MICS2 (2000) to 87.7% in MICS 3 (2006) then to 92.9% in MICS 4 (2011) and finally, to 93.8% in MICS 5 (2014) (GSO & UNICEF, 2006, 2015; GSO, 2000, 2011a).

The use of Caesarean-section also raises concern. Almost twice the number of urban women (30.9%) delivered with this method in comparison to rural women (15.5%). Women with higher levels of education used Caesarean (34.5%) more than women with no education (2.8%). This method was used by 35.9% of women in the richest group and by only 6.7% of women in the poorest group. 22.7% of Kinh/Hoa women used Caesarean in comparison to 5.7% of ethnic minority women (GSO, 2011a). While this technique may be overused among those from high socio-economic groups, the low use among disadvantaged groups suggests that these poor, less-educated and ethnic minority women may not be able to access these types of services.

The availability of emergency obstetric care (EMOC) is worrisome. According to Decision 385/2001/QD-BYT, the availability of basic EMOC services at the commune health centre (CHC) level and comprehensive EMOC services at the district level is the main target. The World Health Organisation recommended 6 basic EMOC functions at CHCs for mothers (parenteral antibiotics; parenteral oxytocic; parenteral anticonvulsants; manual removal of the placenta; manual removal of retained products; and assisted vaginal delivery) (WHO, UNFPA, & UNICEF, 2009), but in Vietnam, vaginal assisted delivery is not allowed at CHCs because of a concern for the inability to treat complications in a timely manner (HSPH, 2012). In 2010, only 23.6% of CHCs could perform all basic EMOC functions. The percentage of CHCs performing each EMOC function is presented in table 1.

Table 1: Percentages of CHCs performing basic EMOC services

Percentages of CHCs performing EMOC services	Percentage of CHCs (%)
Normal delivery	83.6
Parenteral anticonvulsants for pre-eclampsia	46.7
Manual removal of placenta	49.5
Removal of retained products	64.7
Parenteral oxytocic drugs	70.4
All basic EMOC services	23.6

Source: Hanoi School of Public Health (2012). Country Report on health system stewardship in Vietnam - HESVIC project (HSPH, 2012)

Comprehensive EMOC including eight functions of EMOC (the six basic functions as in CHCs, plus C-section and blood transfusion) should be available at district and provincial level. The data showed that the coverage of comprehensive EMOC services in district level centers is increasing. Specifically, C-section services availability was 47% in 2007 and is now 59.8% in 2010. Despite the increase, these figures are still low. The main reasons being the shortage of human resources in obstetric health, and lack of operating theatres, blood banks, and other health-related infrastructure (HSPH, 2012). Comprehensive EMOC is available at provincial hospitals due to the availability of resources (HSPH, 2012).

Postnatal care for mother and new-born baby is important because the time after birth is a critical window of opportunity to deliver lifesaving interventions for mother and new-born. Overall, 98.2% of women who gave birth in a health facility stayed 12 hours or more after birth. 88.9% of new-borns received a health check following birth at a facility or at home. This proportion was lowest in the Northern Midlands and Mountainous areas and highest in the South East area. A difference emerged between urban (94.1%) and rural (86.8%) areas, while the figure for Kinh/Hoa (94.3%) was 1.5 times higher than for ethnic minorities (GSO & UNICEF, 2015).

2.4. HIV, AIDS and STIs

The number of newly infected HIV cases has been decreasing annually in Viet Nam as well as the number of HIV/AIDS related deaths. However, the growing number of new cases in remote and mountainous provinces, as well the emerging number of infections in new groups such as the partners of injecting drug users, mean the projected situation of HIV infection and AIDS in Viet Nam is not yet positive. In addition, the slow decrease of high-risk behaviours such as sharing needles and inconsistent condom use with clients and long-term sexual partners among female sex workers, injecting drug users and male sex workers show that the prediction of the epidemic can be complicated and unpredictable (MOH, 2014b). To the end of September 2014, a total of 224,223 HIV infection cases was reported in Viet Nam (MOH, 2014a). From 2007 to present, the mortality rate due to HIV and AIDS has reduced 50-60% annually. Viet Nam still keeps a low prevalence of HIV infection, with 251 per 100,000 people. The Southeast and Northern mountainous regions have the highest prevalence (with a rate of 421/100000 and 361/100000 respectively). In 2013, 26% of injecting drug users still shared needles in the month before the survey. This number was 30% in 2011 and 19.7% in 2012. However, inconsistent use of condom with sex workers has shrunk from 45.7% in 2012 to 29% in 2013. Regular condom use among female sex workers with their male sexual partners reduced from 49.1% in 2011 to 41.1% in 2013 (MOH, 2014b).

While the Vietnam Administration of HIV/AIDS Control (VAAC) report shows that 57% of pregnant mothers receive preventative care for mother to child transmission of HIV (PMTCT), a multi indicator cluster survey (MICS survey) shows that only 36.1% of women from 15-49 years old got HIV tests during their last pregnancy. The percentage of pregnant women living in urban areas that got an HIV test (56.4%) is two times higher than pregnant women living in rural areas (27.7%) (GSO, 2011a).

Men who have sex with men (MSM) are among target groups for the HIV prevention program. However, the current program reaches only 42% of them, mainly male sex workers (MOH, 2014b). In addition to the limitations in capacity of the HIV outreach program, the separation of MSM groups working on HIV and LGBT (lesbian, gay, bisexual and transgender) groups working on LGBT rights due to HIV-related stigma and discrimination makes it harder for HIV prevention programs to reach people who are in same-sex relationship. LGBT groups also blame HIV prevention programs for not being LGBT friendly as they only work with MSM, but not with other groups such as lesbians (Oosterhoft, Hoang, & Quach, 2014).

Evidence-based knowledge of young people on HIV does not yet meet the national goal of 95%. The national survey on young people shows that only 42.5% of young people in the 14-24 age group have sufficient knowledge on HIV (EDUCAIDS, 2011). More than 60% of women ages 15-24 years old know where to get an HIV/AIDS test. However, voluntary testing is still low. 16.2% of women 15-24 years old took an HIV test in the last 12 months but only 7.9% of them got the test result (GSO, 2011a).

On October 25, 2014, the Government of Viet Nam committed to achieving the 90-90-90 targets in 2020. This makes Viet Nam the first country in Asia to adopt these targets (UNAIDS, 2014). This is the country effort to end the HIV epidemic by 2030. At the moment, the ARV program only covers 60% of eligible people. In the context of reduction of funding for HIV and AIDS programs, these 90-90-90 targets in 2020 are real challenges for Viet Nam.

2.5.Reproductive health for Adolescent and young people

In 2013 the adolescent population aged 1019 accounted for 15.6% of the total population with 13,962,000 people (1014 years = 7.6% and 1519 years = 8.0%). Of these, 48.6% are female (GSO, 2013b).

The statistics show that adolescents have a tendency to be sexually active earlier. Specifically, the average age at first sex among sexually active youth is 18.1 in SAVY2, reducing 1.5 years from 19.6 in SAVY1 (MOH, GSO, UNICEF, & WHO, 2010). Though the legal age for marriage in Viet Nam is 18 years old for women and 20 years old for men, data from MICS 2014 shows that there was a high proportion of women who got married before the age of 18 below the legal marriage age (11.2% in MICS 2014 and 12.3% in MICS 2011) (GSO & UNICEF, 2015; GSO, 2011a). Noticeably, nearly 1% of women got married before the age of 15. Young women age 15-19 currently married or in union was 10.3% (GSO & UNICEF, 2015). 7.5% of women 15-19 years old have children. 0.1% of women gave birth before 15 years old. 3% of women between 20-24 years old had children before they were 18 years old. Education and socio-economic condition of the women are closely related to their risk of having children at an early age. For example, 10.1% of women in Tay Nguyen have children before 18 years old. This rate is 10.9% among women 20-24 years old with only a primary school education, while it's 0% among women with at least a vocational or college level schooling. This number is 9.8% among the poorest women and is 0.5% among the richest women (GSO, 2011a).

The age-specific fertility rate (adolescent birth rate) for those aged 1519 was 45 per 1,000 women in 2014. The rate in rural areas (56 births per 1,000 women) is more than double that of urban areas (24 births per 1,000 women). This rate is particularly high in the Northern Midlands and Mountainous area with 107 per 1,000 women. While the adolescent birth rate among Kinh/Hoa people is 30 per 1,000 women, this rate is nearly four times higher than for ethnic minorities (115 per 1,000 women)(GSO & UNICEF, 2015). The percentage of women aged 20-24 years who had at least one live birth before the age of 18 was 4.7% in 2014, and it rose from 3% in 2011 (GSO & UNICEF, 2015; GSO, 2011a).

Only 21% of women ages 15-19 years old who are married or have a long-term sexual partner use a contraceptive method. Young women in rural area get married and have children earlier than young women in urban area. The crude birth rate of rural women ages 20-24 years old is 142 per 1000 people. This is almost double the crude birth rate of young women in urban area (82) (GSO, 2011a).

Box 2: Maternal health of adolescents (GSO & UNICEF, 2015):

According to MICS 2014, there were 124 women under age 20 who had a live birth in the two years preceding the survey. Of these:

- 90.7% received antenatal care from any skilled provider one or more times during the pregnancy (for the 20-34 age group: 96.4% and for 35-49: 95.4%)
- 85.8% delivered in a health facility (for the 20-34 age group: 94.7% and for 35-49: 91.3%)
- 86.9% were assisted by any skilled attendant during delivery (for the 20-34 age group: 94.5% and for 35-49: 93%).
- 77.6% received assistance from a medical doctor during delivery, 9.2% from a nurse/midwife, 1.9% from a traditional birth attendant, 0.7% from a community health worker and 8.9% from a relative/friend (1.6% from other or missing)

[5]90-90-90 targets: by 2020, 90% of people living with HIV will know their HIV status; 90% of people who know their status are on HIV treatment; and 90% of all people on treatment will have undetectable levels of HIV in their body (known as viral suppression).

Though sexuality education has been integrated in school curriculum in Viet Nam since 1997, a recent survey shows that 30% of young people in the 14-24 age group do not have proper knowledge on sexual and reproductive health (MOH, 2009b). The use of contraceptive methods to prevent pregnancy and STIs is low and inconsistent due to lack of information and negotiation skills. Unwanted pregnancy and abortion (including repeated abortion) are common (Pathfinder 2011).

Abortion is legal in Viet Nam. Young people of more than 18 years old can use the service without parental consent. For abortions, routine ID checks are uncommon so if the girl doesn't look too young, she is able to bypass administrative procedure to get the service while legally underage (Pathfinder 2007).

Viet Nam has a master plan for adolescent reproductive health. The Ministry of Health also approved guidelines for youth friendly services. However, very few health facilities can sustain this model after the pilot phase. Lack of resources, low motivation and low service use are main reasons for health managers and service providers to not continue the services (Pathfinder 2009). There is also no official data on health facilities which provide sexual and reproductive health information, counselling and services for adolescents and young people (Klingberg-Allvin, Graner, Phuc, Höjer, & Johansson, 2010).

Contradicting discourses on young people, especially young girls' sexuality, protectionism rather than affirmation of sexual rights, gender blind, reinforcing stereotypes rather than promoting gender and sexual diversities are seen as main causes for the sexual and reproductive health problems of adolescents and young people (CCIHP, 2014b). These issues are more vibrant in the context of contemporary Viet Nam with the widespread use and functioning of social media and similar networking tools, the use of the internet and migration.

2.6. Reproductive health financing

Total health expenditure in Viet Nam has increased from 4.9% of total GDP in 1998 to 6.4% of total GDP in 2008 and 6% in 2013 (Worldbank, 2013). In Viet Nam, health expenditure is considerably higher in many countries in the region. The private expenditure accounts for 60% of the total health expenditure. The state fund, social health insurance and external support make up only 40% of the expenditure for health. Private expenditure includes out-of-pocket household payment (OPP), the contributions of charitable organizations and business and private health insurance. The OPP is always greater than 50% of the total health expenditure. This high level of OPP is problematic as WHO recommends OPP of more than 40% increases the risk of inequity in health. A Healthwatch report in 2011 in Viet Nam showed that the current health financing scheme would bring more benefit for wealthy people (PAHE, 2011). Data shows that the impoverishment impact of health expenditure on poor households in Viet Nam is very high.

In 2014 CCIHP conducted a study with 2000 households in three provinces representing the delta river, the midland and the mountainous areas in the north of Viet Nam. The study aimed to explore spending on reproductive health care (RHC) services and the role of health insurance (HI) in achieving universal access to reproductive health care. The study indicates that less RHC services are covered by HI than other health services. In the study sites, only 1.1% of the out-patient and 11.8% of the in-patient who use RHC services, who are covered by HI. Family planning services are not included in the current HI policy as they belong to the national program. For some other services the co-pay is high. Thus many people, including those from mountainous area, poor and near-poor households will not use RH services though they are insured (CCIHP, 2014a).

The study also shows that ethnic minority women suffer from the risk of impoverishment due to reproductive health care cost 3.08 times higher than Kinh women. This risk with near-poor households is 26.79 times higher than the non-poor households. Health insurance (HI) contributes significantly to reducing this risk. People without HI have almost 4 times higher the of impoverishment due to reproductive health care cost in comparison with people with HI. Despite this benefit, there are fewer poor people using reproductive health care services than paid workers.

Box 3:
"...their [paid workers] access to RHC is actually higher. For example, these people consume 31.3% of the total amount paid by the HI fund pertaining to RHC, including childbirth, in general anything associated with RH, while poor people account for just 11.76%. This means that access to RH services by the poor is at a lower rate than workers with salary. The reason is simple. In urban areas, patients' awareness is higher so they seek medical care for reproductive conditions earlier, while poor people often only seek medical care pertaining to childbirth and often come to clinics when they get sick and not earlier in a preventive way, so the poor's access to health services is often lower" (A social insurance representative in Hoa Binh province).
(CCIHP, 2014a)

While 75% of insured people use their card in intrapartum care, the use of HI card is only 30.3% in the case of reproductive tract infections.

Other insurance non-covered costs such as transportation, administrative procedures and long waiting time are reasons for people not use public reproductive health services that they are entitled to with their HIscheme (CCIHP, 2014a).

2.7. Gender-based violence

National survey shows that 34% of ever-married women suffered from physical or sexual violence by their husband in their life time (GSO, 2010). The survey also indicates that many men and women accept it as a norm. 35.8% of women find that wife beating is acceptable in some situations. This attitude ranges from 48.8% among women in the richest households to 20.1% among women in the poorest households. This attitude is held by 34.3% of Kinh/Hoa women and by 47.2% of ethnic minority women (GSO, 2011a).

The Law on Domestic Violence Prevention and Control was passed in 2006. Necessary attitudes, mechanisms and supporting services to reinforce the law are still not in place in many areas. Sexual violence remains hidden and is almost always unreported due to social taboo and the hesitance and incapability of local authorities to work with the issue (CCIHP 2012).

Vietnam is transitioning into a more modern society. Despite the high level of access to internet and non-criminal legal framework, traditional gender norms and heteronormativity keep stigma and discriminations toward homosexual women, men and transgender people high. People with unconventional gender expressions and same-sex relationship are beaten and threatened by their family members, teachers and friends (ISEE, 2010, 2011, CCIHP, 2012, 2013). There are examples of corrective rape done to lesbians to change homosexuality (CSAGA 2010). Homophobic bullying in school prevails and there is almost no protective mechanism for the victims. Among the bullying victims, 50% said that bullying influenced their study negatively. 34% of them attempted suicide as they could not stand the violence and bullying (CCIHP 2012).

In a study that CCIHP conducted in 2011 with 200 young people with disabilities, 6.25% of them said that they were sexually abused. 50% of them have never told this to anyone (CCIHP 2011).

2.8. Availability of sexual and reproductive health services at different levels of care

Since the introduction of Doi Moi (Reform) in 1986, Vietnam shifted from a centrally-planned economy to a market-oriented economy. This transformation has had a significant impact on the nation's health system with some major reforms including the introduction of user fees for healthcare services (that were previously free) to generate public sector revenue, the legalization of private health services to allow public-private mix, and the commercialization of the pharmaceutical industry (Khe et al., 2002). Currently, Viet Nam's health system consists of a public-private mix (World Health Organization & Ministry of Health Viet Nam, 2012). This section presents the availability of sexual and reproductive health services at different levels of care in public and private sector.

The public health care system in Vietnam is comprised of four different levels. The top is the national level including Ministry of Health and national hospitals. Provincial level (provincial department of health and provincial hospitals) and district level (District health administration, district health centres and district hospitals) are underneath. Commune Health Centres (CHCs) are on the bottom level (Duong, Binns, & Lee, 2004). In addition, each province has a Provincial Centre for Reproductive Health Care - a technical agency to assist in the implementation of reproductive health programmes. SRH services are available at health facilities at all four levels and at the Provincial Centre for Reproductive Health Care (Ngo & Hill, 2011a).

The CHCs are the primary access point for SRH and family planning services. The majority of CHCs (93.4%) have at least one obstetrics/pediatrics assistant doctor or midwife (Vietnam Ministry of Health & Health Partnership Group, 2013). The range of SRH services in CHSs include family planning (FP counselling and distribution), maternal health care (antenatal check-ups, delivery services and postpartum check-ups), gynaecological examinations and treatment, and first trimester abortion (CCIHP, 2014a; Ngo & Hill, 2011b). Service quality at CHCs is normally perceived low with limited staff qualifications, outdated equipment, and limited drugs and supplies so many patients try to seek care at private clinics or bypass their local CHCs and visit higher level hospitals (Ngo & Hill, 2011a; T. T. H. Nguyen, Wilson, & Mcdonald, 2015). Bypassing to higher levels made overcrowding in national and provincial hospitals a serious issue, for example bed occupancy rates at central hospitals were 120% in 2010 (Ministry of Health & Health Partnership Group, 2012). For higher levels of care (i.e, from district level), a referral from CHCs or private clinics is needed with people using health insurance. Contraception, gynaecological services, maternal healthcare, cervical and breast cancer screening, STI/HIV prevention and treatment are available at most of the healthcare facilities from the district to the national level.

The development of the private health sector is strongly promoted by the government to reduce pressures on the public system and it has become an important provider of health care services in Vietnam (Vietnam Ministry of Health & Health Partnership Group, 2013). Private clinics are typically in favour for opening hours, short waiting time, prompt treatment, easy accessibility and respectful attitudes of health providers. Thus, in most cases, private physicians are the first choices for patients (Dao, Waters, & Le, 2008). Private health care services in Viet Nam include private hospitals and private clinics which are normally located in major cities. In rural areas, unlicensed practitioners provide private medical care services and they are not considered part of the formal health system (Ngo & Hill, 2011a). By 2013, the country had over 30 000 private clinics, and more than 150 private hospitals with over 9600 patient beds (accounting for more than 4.8% of patient beds nationally and equivalent to 1.1 beds per 10,000 people) (Vietnam Ministry of Health & Health Partnership Group, 2013). As part of the private sector, private reproductive health services are provided in the reproductive health clinics of specialist obstetricians or gynaecologists or midwives. Many of those health providers work in public hospitals and provide reproductive healthcare services outside their administrative working hours. The reproductive health services at private clinics mostly focus on antenatal care and gynaecological check-ups (Ngo & Hill, 2011b). Furthermore, for mountainous and remote areas where people live far from CHCs and home-delivery culture exists, traditional birth attendants (with or without certificate) who are not part of formal healthcare services often provide home-based delivery services.

There are some reproductive health care services that are provided free at the point of service delivery at the primary healthcare level in Vietnam. Those services include IUD insertion and vasectomy for couples of reproductive age. In many places, contraceptive pills and condoms are distributed free of charge for married couples at CHCs. Moreover, antenatal consultation and check-up and pre-natal tetanus vaccination are also provided free of charge at the primary healthcare level (Ngo & Hill, 2011b).

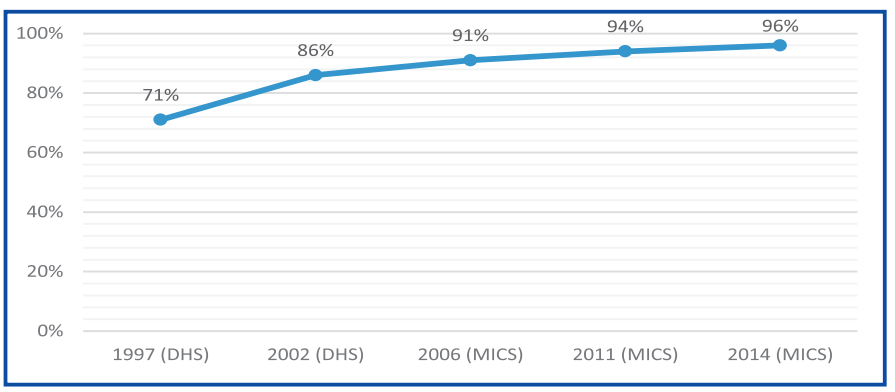
Range of services in the Essential Services Package for Government-sponsored insurance

The law on health insurance 2008 created regulations for a range of services covered by the health insurance fund. Those covered costs include: medical examination and treatment, function rehabilitation, regular pregnancy check-ups and birth delivery; costs of medical examination for screening and early diagnosis of some diseases; and costs of transferal from district hospitals to higher-level hospitals in case of emergency or for inpatients that need technical transferal. Many reproductive health services are not covered by health insurance such as regular reproductive health check-up, prenatal tests and diagnosis for non-treatment purposes, use of obstetric supportive techniques, family planning services or abortion services, except for cases of discontinuation of pregnancy due to fetal or maternal diseases (National Assembly, 2008).

Proportion of women seeking antenatal care from health facilities

Figure 4 indicated that the utilization of antenatal services has increased dramatically during recent years. The proportion of women seeking antenatal care services rose from 71% in 1997 to 86% within 5 years (2002) (NCPFCP, 2003). This percentage was 91% in 2006 and gradually increased through 3 MICS survey to 96% in 2014 (GSO & UNICEF, 2006, 2015; GSO, 2011a). Women in urban areas tend to have a higher proportion of antenatal check-ups than women in rural areas. Moreover, about ¾ of women with a live birth during the last two years received antenatal care at least four times. Women from rural areas, mountain regions, those with lower education, from poorer households and among ethnic minority groups were less likely to receive antenatal care four or more times (GSO & UNICEF, 2015). For types of ANC utilization, while CHCs, private clinics and district hospital are the most common choices of rural women, central or provincial hospitals were most commonly used by the urban women (Tran et al., 2011).

Figure 4: The proportion of women seeking antenatal care services



Proportion of deliveries in public and private health facilities

In the Vietnam Demographic Health Survey 2002, nearly four in five births (79%) were delivered in health facilities, while 21% were delivered at home. This represents a sizeable increase from 62% of births delivered in health facilities in 1997 (NCPFCP, 2003). This proportion dramatically increased to 92.4% in 2011 and 93.6% in 2014. Most institutional deliveries occurred in public sector facilities compared to private sector facilities. For example, the proportion of deliveries in public health facilities was 88.2% and 89.7% in 2011 and 2014, while this percentage was 4.1% and 3.9% respectively in private health facilities (GSO & UNICEF, 2015; GSO, 2011a). The majority of home deliveries occurred in rural areas, in the Northern Midland, Mountainous areas and the Central Highlands, among uneducated women living in households belonging to the poorest quintile and headed by ethnic minorities (GSO, 2011a).

3. Conclusions

There have been improvements in sexual and reproductive health in Vietnam. However, there are gaps between population groups regarding age, marital status, educational level, geography, ethnicity and wealth.

4. Recommendations

For imbalance sex ratio at birth

- Complete the civil registration system to better monitor the trends of sex ratio at birth at different regions and among different demographic groups.
- Promote gender equality in all sectors including education, employment, wage, promotion, etc.
- Raise community awareness on the importance of gender balance for the family and the country's development.
- Develop programs that focus on addressing traditional belief and practice on the roles of sons and daughters in family
- Strengthen the enforcement and implementation of the law that bans learning the sex of the child via ultrasound and sex selective abortion.
- Advocate for commitments and active engagement of authorities at all levels of civil society, and national and international agencies in cooperation and support of activities that control the growth in sex ratio at birth.

For Contraception use

- Promote male involvement and responsibility in contraceptive use through IEC program and contraceptive access improvement.
- Promote the use of modern contraceptive methods instead of traditional methods among different populations and improve access to those modern contraceptive methods
- Family planning programs should pay more attention to adolescents, youth, unmarried and migrant people to address the high unmet need of contraceptive methods among those groups.
- Complete policies, guiding circulars and a feasible financial mechanism to support outreach activities relating to family planning and population provided by outreach workers, commune health stations and district level staff.

For Maternal care

- Develop maternal care programs aiming at women with high risk of adverse pregnancy outcomes such as ethnic minority women, women living with disabilities, and illiterate women
- More efforts and a budget should be in place to equip CHCs with equipment and the skills of basic EMOC. District health facilities should be equipped with infrastructure and taught the skills necessary to provide blood transfusions and give C-section.
- Improve medical education for traditional healthcare providers in remote areas where hospitals or health facilities are inaccessible.
- Ensure the referral system from community to health facilities and between health facilities works by mobilizing the participation and commitment of local authorities and different sectors including health and transportation, especially for mountainous and remote areas.

For HIV, AIDS and STIs

- Revise policy to make sex-disaggregated data available in monitoring and supervision systems. Indicators on intimate partner transmission should also be developed and included in the national indicators for HIV prevention programs.
- Develop education and communication programs on intimate partner transmission to raise awareness of young people, married couples and their families and prevention of intimate partner transmission. The education and communication programs should recognize challenges in prevention of intimate partner transmission by highlighting related gender and sexuality issues.

- Pay more attention to sexuality research on MARPs and their intimate partners such as partners of female sex workers, of mobile/migrant groups (domestic and international) and other sexual minority groups such as transgender, bisexual and lesbian and those research should go beyond behavior to include meaning of sexual relationship, nature of sexual relationship, negotiation power and sexual partners.
- Improve the availability of ARV to meet the need of people living with HIV.
- Increase domestic budget for HIV prevention, care and treatment given the context that international funds are reducing in Vietnam.
- Integrate HIV/AIDS and sexual and reproductive health services to provide comprehensive services for people living with HIV/AIDS.

For Reproductive health for Adolescent and young people

- Develop new approaches to provide reproductive health services to young and unmarried people and migrants and ensure financial resources for these services.
- Provide comprehensive sexuality education with the appropriate content for different ages, for children in and out of schools.
- Encourage the involvement of adolescents and young people in sexual and reproductive health's policy and program planning, implementing and monitoring and give them the opportunity to participate in these processes.
- Promote use of modern contraceptive methods to prevent unwanted pregnancy and abortion through information, education and communication (IEC) programs.
- Expand youth-friendly sexual and reproductive health services across the country, which considers the needs of different groups of young people, especially vulnerable groups.

For Reproductive health financing

- Reform the operational and financial mechanisms in the health sector to reduce out-of-pocket payment and prevent impoverishment impact of health expenditure on poor households.
- Implement a roadmap towards universal health insurance coverage.
- Ensure the state budget for approved health programs.

For Gender-based violence

- Promote gender equality in the community and all sectors and integrate gender equality in school curriculum and other extra-class activities.
- Make essential services for violence survivors available, including emergency shelter, counselling services, healthcare, referral services, and legal support.
- Empower women to address violence in their lives through life skills training, self-help groups, education, job training and legal and financial support.
- There should be more programs that focus on violent male perpetrators, such as education, therapy and support to change their attitudes and behaviors. Men should be involved in programs on gender equality and gender-based violence.
- Improve the health, justice, police and related government sectors and encourage collaboration among them to adequately respond to violence.
- For Availability of sexual and reproductive health services at different levels of care
- Expand towards universal access to sexual and reproductive health services to improve the sexual and reproductive lives of different population.
- Improve quality of sexual and reproductive care at the primary healthcare level (including equipment and human resource quality) to attract more people to come. This will also help prevent overcrowding at higher levels of care.
- Attract healthcare workers to mountainous and rural areas with a package of benefits, incentives and promotion.
- Reinforce public private partnership in the health sector by developing policy and a legislative framework that allows for fair and transparent procurement processes and capacity building.

5. References

CCIHP. (2011). Sexual and Reproductive Rights of People with Disabilities. Ha Noi, Viet Nam.

CCIHP. (2012). Needs assessment of young female migrant workers at industrial zones in Ha Noi. Ha Noi, Viet Nam.

CCIHP. (2014a). Coverage of specific reproductive health services in three northern provinces of Vietnam: scope and variance. Ha Noi, Viet Nam.

CCIHP. (2014b). Policy Brief - Vietnam_Vietnamese.pdf. Ha Noi, Viet Nam: CCIHP.

Dao, H. T., Waters, H., & Le, Q. V. (2008). User fees and health service utilization in Vietnam: how to protect the poor? Public Health, 122, 10681078. http://doi.org/10.1016/j.puhe.2008.01.002

Duong, D. V., Binns, C. W., & Lee, A. H. (2004). Utilization of delivery services at the primary health care level in rural Vietnam. Social Science and Medicine, 59(12), 25852595. http://doi.org/10.1016/j.socscimed.2004.04.007

EDUCAIDS. (2011). Viet Nam: A model of successful UN family collaboration to support a comprehensive education sector response to HIV and AIDS. Ha Noi, Viet Nam: UNESCO and UNAIDS.

GSO. (2000). Analysis of results of the multiple indicator cluster survey 2.

GSO. (2011a). Monitoring the situation of women and children: Multiple Indicator Cluster Survey 2011. Ha Noi, Viet Nam.

GSO. (2011b). Tổng điều tra dân số và nhà ở Việt Nam 2009: Tỷ số giới tính khi sinh ở Việt Nam: các bằng chứng mới về thực trạng, xu hướng và những khác biệt. Ha Noi, Viet Nam.

GSO. (2012). Điều tra biến động dân số và kế hoạch hóa gia đình thời gđiểm 1/4/2012: Các kết quả chủ yếu. Bộ Kế Hoạch đầu Tư.

GSO. (2013a). Điều tra biến động dân số và kế hoạch hóa gia đình thời điểm 1/4/2013: Các kết quả chủ yếu. Ha Noi, Viet Nam.

GSO. (2013b). The April 1, 2013 time-point population change and family planning survey. Report, 354.

GSO. (2014). Điều tra biến động dân số và kế hoạch hóa gia đình thời điểm 1/4/2014: Các kết quả chủ yếu. Ha Noi, Viet Nam.

GSO, & UNICEF. (2006). Viet Nam Multiple Indicator Cluster Survey 2006, Final Report. Retrieved from http://www.childinfo.org/files/MICS3_VietNam_Final Report_2006_Eng_Vi.pdf

GSO, & UNICEF. (2015). Monitoring the Situation of Children and Women: Multiple Indicator Cluster Survey 2014.

GSO, V. N. (2010). National study on Domestic Violence Against Women in Vietnam. Ha Noi, Viet Nam.

HSPH, H. S. of P. H. (2012). Country Report on health system stewardship in Vietnam - HESVIC project, (222970).

Khe, N. D., Toan, N. V, Xuan, L. T. T., Eriksson, B., Höjer, B., & Diwan, V. K. (2002). Primary health concept revisited: where do people seek health care in a rural area of Vietnam? Health Policy (Amsterdam, Netherlands), 61(1), 95109. http://doi.org/10.1016/S0168-8510(01)00198-1

Kim, M. (2014, November). When Viet Nam has only men. Vietnam Net. Ha Noi, Viet Nam.

Klingberg-Allvin, M., Graner, S., Phuc, H. D., Höjer, B., & Johansson, A. (2010). Pregnancies and births among adolescents: a population-based prospective study in rural Vietnam. Sexual & Reproductive Healthcare : Official Journal of the Swedish Association of Midwives, 1(1), 159. http://doi.org/10.1016/j.srhc.2009.09.002

Le, H. N. (2013, March). 3000 billion is not just for supporting family with girls. People Newspaper. Ha Noi, Viet Nam.

Ministry of Health, & Health Partnership Group. (2012). Join Annual Health Review 2012, (December), 1203.

MOH. (2000). National strategy on reproductive health for the 2001-2010 period.

MOH. (2009a). Hướng dẫn chuẩn quốc gia về các dịch vụ chăm sóc sức khỏe sinh sản. Ha Noi, Viet Nam: Ministry of Health Viet Nam.

MOH. (2009b). Survey Assessment of Vietnamese Youth.

MOH. (2011). Main contents of National Strategies on Population and Reproductive Health in Viet Nam for the period 2011-2020. Ha Noi, Viet Nam: Ministry of Health.

MOH. (2014a). Báo cáo công tác phòng, chống HIV/AIDS đến 30/9/2014, 2014, 112.

MOH. (2014b). Tình hình dịch HIV/AIDS. Ha Noi, Viet Nam.

MOH, GSO, UNICEF, & WHO. (2010). Survey Assessment on Vietnanese Youth Round 2 (SAVY 2).

National Assembly. (2008). Law on health insurance.

NCPFCP. (2003). Vietnam Demographic and Health Survey. Report, (September), 1231.

Ngo, A. D., & Hill, P. S. (2011a). Quality of reproductive health services at commune health stations in Viet Nam: Implications for national reproductive health care strategy. Reproductive Health Matters, 19(37), 5261. http://doi.org/10.1016/S0968-8080(11)37555-6

Ngo, A. D., & Hill, P. S. (2011b). The use of reproductive healthcare at commune health stations in a changing health system in Vietnam. BMC Health Services Research, 11(1), 237. http://doi.org/10.1186/1472-6963-11-237

Nguyen, T. D. (2006). Quy định xử phạt vi phạm hành chính về dân số và trẻ em. Ha Noi, Viet Nam: Viet Nam government.

Nguyen, T. D. (2011). Decision 2013QĐ-TTg. Ha Noi, Viet Nam: Prime Minister.

Nguyen, T. T. H., Wilson, A., & Mcdonald, F. (2015). Motivation or demotivation of health workers providing maternal health services in rural areas in Vietnam : findings from a mixed-methods study. Human Resources for Health, 111. http://doi.org/10.1186/s12960-015-0092-5

Oosterhoft, P., Hoang, T., & Quach, T. (2014). Negotiating public and legal spaces: the emergences of an LGBT movement in Vietnam. IDS.

PAHE. (2011). Health equity in Vietnam: A civil soceity perspective. Ha Noi, Viet Nam.

Phan, V. K. (2000). Decision 136/2000/QĐ-TTg. Ha Noi, Viet Nam: Prime Minister.

Phuong, T. (2014, December). Unpredictable of birth rate in Viet Nam. Vnexpress. Ha Noi, Viet Nam.

Priya, N., Abhishek, G., Ravi, V., Khuat, T. H., Mahesh, P., Tran, G. L., … Prabhat, L. (2012). Study on Gender , Masculinity and Son Preference in Nepal and Viet Nam. New Delhi.

Thuy, G. (2014, December). Imbalance sex ratio at birth reduces after many years. Vietnam Plus. Ha Noi, Viet Nam.

Tran, T. K., Nguyen, C. T. K., Nguyen, H. D., Eriksson, B., Bondjers, G., Gottvall, K., … Petzold, M. (2011). Urban - rural disparities in antenatal care utilization: a study of two cohorts of pregnant women in Vietnam. BMC Health Services Research, 11(1), 120. http://doi.org/10.1186/1472-6963-11-120

UN Viet Nam. (2011). Advocacy brief: Antenatal care in Viet Nam. Ha Noi, Viet Nam.

UNAIDS. (2014, October). Viet Nam is the first country in Asia to commit to new HIV treatment targets. UNAIDS. Ha Noi, Viet Nam.

UNFPA. (2010a). Cơ cấu dân số vàng ở Việt Nam: cơ hội, thách thức và các khuyến nghị chính sách. Ha Noi, Viet Nam.

UNFPA. (2010b). Internal migrant and socio-economic development in Vietnam: A call to action. Ha Noi, Viet Nam.

UNFPA. (2011a). PEOPLE WITH DISABILITIES IN VIET NAM Key Findings from the 2009 Viet Nam Population and Housing Census. Ha Noi, Viet Nam.

UNFPA. (2011b). Socio-cultural infl uences on the reproductive health of migrant women. A review of literature in Viet Nam. Ha Noi, Viet Nam: UNFPA.

Viet Nam National Assembly. (2003). Population ordinancce. Ha Noi, Viet Nam: THE STANDING COMMITTEE OF NATIONAL ASSEMBLY.

Vietnam Ministry of Health, & Health Partnership Group. (2013). Vietnam joint annual health review 2013: Towards Universal Health Coverage, (November).

VNS. (2014, December). Ministry of Health launches population action programme. Vietnam News. Ha Noi, Viet Nam.

Vo, T. (2014, December). 7.2 surplus boys among 112.2 boys born. Giadinh.net.vn. Ha Noi, Viet Nam.

WHO, UNFPA, & UNICEF. (2009). Monitoring emergency obstetric care: a handbook. Geneva: WHO, 152(4), 430. http://doi.org/10.3109/01443611003791730

WHO, UNICEF, UNFPA, World Bank, U. N. P. D. (2013). Trends in Maternal Mortality : 1990 to 2013. Geneva, Switzerland.

World Health Organization, & Ministry of Health Viet Nam. (2012). Health Service Delivery Profile Viet Nam.

Worldbank. (2013). Health expenditure, total (% of GDP): Worldbank database. Retrieved from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

About CCIHP

Established in 2008, the Center for Creative Initiatives in Health and Population (CCIHP) has been one of leading NGO in Vietnam in public health. CCIHP's mission to promote equality, diversity and health for all in society is achieved through a multidisciplinary innovative approach of action research, advocacy and intervention. CCIHP actively seek the meaningful involvement and engagement of individuals and communities in its research and innovations. Some examples include Archive of Lesbian, Gay, Bi-sexual and Transgender history, the Health Market photovoice project and exhibition, We saw we say – a project with ethnic minority women. CCIHP is also a pioneer in Vietnam to promote rights, especially sexual and reproductive health and rights of people with disabilities.

Production Team

Authors:
Hoang Tu Anh
Nguyen Thi Vinh

Reviewer:
Sai Jyothirmai Racherla

Template Designer
TM Ali Basir

Photographer
Pham Vu Thien

About the Country Profile

This country profile is developed by the Center for Creative Initiatives in Health and Population as part of the initiative, Strengthening the Networking, Knowledge Management and Advocacy Capacities of an Asia-Pacific Network for SRHR, with the assistance of the European Union. This project is being implemented in <name of country> by <name of partner organisation>, in partnership with the Asian-Pacific Resource and Research Centre for Women (ARROW). Countries covered by the initiative are Bangladesh, Cambodia, China, India, Indonesia, Lao PDR, Maldives, Malaysia, Mongolia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand, and Vietnam. The contents of this publication are the sole responsibility of FRHAM and can in no way be taken to reflect the views of the European Union. Electronic copies are available at frham.org. my, arrow.org.my, and srhrforall.org

Contact us at:
48 Alley 251/08
Nguyen Khang street,
Hanoi, Vietnam
T: +84 4 35770261
E: ccihp@ccihp.org
W: ccihp.org

SRHR for All Campaign
www.srhrforall.org
facebook.com/srhrforall
twitter.com/SRHRforALL

This project is funded by the European Union

With co-funding support from Sida