



**ASEAN Inter-Parliamentary Assembly (AIPA)
Seminar on
“Accelerating the Achievement of MDG-5 through the Role of Women
Parliamentarians”**

Phnom Penh, Cambodia, 9 -12 March 2011

**MDG-5: Improve Maternal Health
Report represented by Vietnam delegation**

Major achievements:

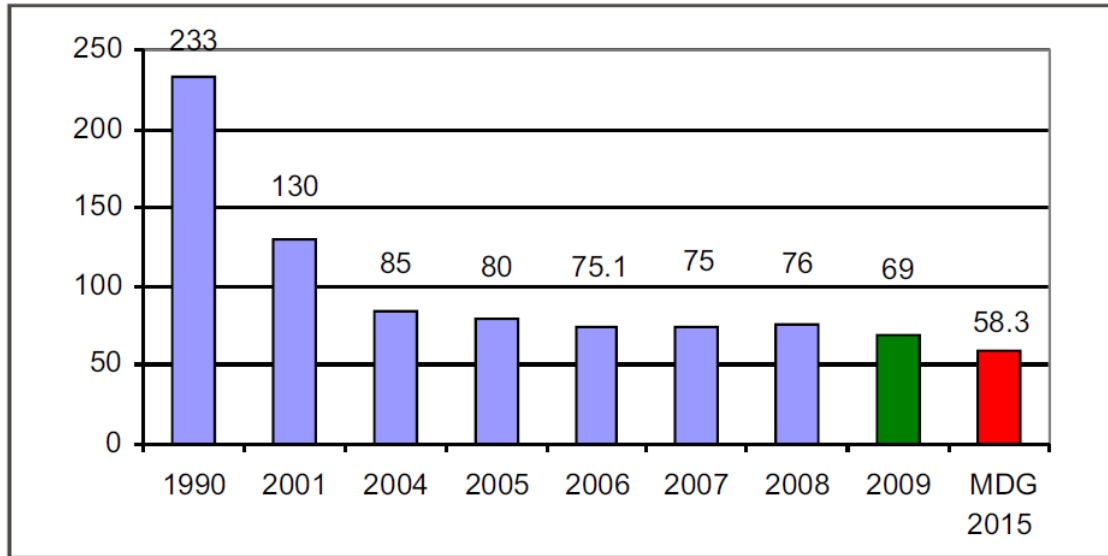
- Maternal mortality has decreased by approximately two thirds in Viet Nam, from 233/100,000 live births in 1990 to 69/100,000 live births in 2009, and is expected to decrease to 68/100,000 live births in 2010.
- Viet Nam also witnessed progress in mothers' healthcare. Facilities, hospitals, clinics and training of medical staff have been gradually improved to provide accessible reproductive healthcare services to every mother.

I. Achievements

1. Maternal mortality

Maternal mortality decreased from 233/100,000 live births in 1990 to 80/100,000 live births in 2005 and 69/100,000 live births in 2009, and is expected to reduce to 68/100,000 live births by 2010 (Chart 1). However, throughout the 2006-2009 period, the maternal mortality rate remained unchanged. Thus in order to accomplish this goal, as well as the goal of reducing maternal mortality to 58.3/100,000 live births by 2015, Viet Nam needs to put even more effort into implementing its policies and programmes.

Chart 1: Maternal mortality
(Unit: maternal deaths per 100,000 live births)



(Source: Ministry of Health)

2. Prenatal check-ups and births attended by trained health workers

Women's reproductive health has improved as the number of pregnant women receiving more than three prenatal check-ups has increased over recent years. The national average reached 86.4 percent in 2008 and was even higher in some region, such as the Red River Delta (98.5 percent), the South Central Coast (94.5 percent) and the Southeast (94.5 percent) (Table 1). This reflected improvements in the quality of prenatal care in recent years. It was also an important factor contributing to safer deliveries, as well as the reduction of obstetrical complications, maternal mortality and neonatal deaths.

Table 1: Pregnant women receiving more than 3 prenatal checks
Unit: Percent

	2005	2006	2007	2008
NATIONWIDE	84.30	86.51	86.20	86.40
Red River Delta	97.28	98.48	99.00	98.50
Northeast	80.64	78.80	85.10	83.70
Northwest	70.42	62.85	68.40	68.00
North Central Coast	92.41	94.06	90.60	92.30
South Central Coast	92.90	92.12	93.30	94.50
Central Highlands	70.70	72.04	69.70	69.50
Southeast	84.52	90.95	91.10	94.50
Mekong River Delta	85.56	86.80	90.90	90.30

(Source: Ministry of Health)

The high and sustained number of women receiving more than 3 prenatal check-ups during pregnancy and having births attended by trained health workers is one of the main reasons for the reduction of maternal mortality. The national average was 95 percent, of which two regions, the Red River Delta and the Mekong River Delta, had 100 percent (Table 2).

Table 2: Births attended by trained health workers

Unit: Percent

	2005	2006	2007	2008
NATIONWIDE	92.71	94.30	94.8	94.8
Red River Delta	99.92	100	100	100
Northeast	88.95	91.40	91.6	92.1
Northwest	63.20	87.20	79.7	79.2
North Central Coast	90.97	97.40	98.2	98.6
South Central Coast	96.00	96.9	98	97.9
Central Highlands	85.25	86.8	91.3	91.6
Southeast	99.14	99.2	99.4	99.4
Mekong River Delta	97.97	99.8	99.9	100

(Source: Ministry of Health)

3. Pregnant women receiving two doses of tetanus vaccination

Nationwide, almost 95 percent of pregnant women receive two doses of tetanus vaccination. Recently, this figure has increased in the Central Highlands (to almost 93 percent) and decreased in the Northwest (to as low as 80 percent).

Table 3: Pregnant women receiving two doses of tetanus vaccination

Unit: percent

	2005	2006	2007	2008
NATIONWIDE	92.71	94.6	94.0	94.5
Red River Delta	99.92	99.8	99.6	99.8
Northeast	88.95	91.7	91.5	93.5
Northwest	63.20	87.2	85.1	79.6
North Central Coast	90.97	98.4	98.0	97.7
South Central Coast	96.00	98.4	98.2	98.5
Central Highlands	85.25	88.5	86.8	92.8
Southeast	99.14	96.3	97.0	97.0
Mekong River Delta	97.97	96.3	96.2	97.0

(Source: Ministry of Health)

4. Women aged 15-49 using contraceptive methods

Contraceptive use among women aged 15 to 49 increased from 73.9 percent in 2001 to nearly 80 percent in 2008. In particular, women aged 30-44 had a comparatively high average of contraceptive use of 87 percent (Table 4). Among new contraceptive users, condoms were the most popular method, followed by birth control pills and intrauterine devices IUDs. The rate remains quite constant across various provinces. Only certain provinces had contraceptive usage rates considerably lower than the national average, such as Dien Bien (70.8 percent) and Kon Tum (68.1 percent).

Table 4: Contraceptive use among women aged 15 to 49
(Unit: percent)

	2001	2002	2003	2004	2005	2006	2007	2008
NATIONWIDE	73.9	76.9	75.3	75.7	76.9	78.0	79.0	79.5
15-19	21.0	22.5	23.2	21.0	23.4	25.8	28.2	29.4
20-24	51.0	53.8	51.1	49.0	51.1	54.8	55.4	55.0
25-29	72.2	73.9	71.3	71.1	72.4	73.9	73.4	72.7
30-34	82.0	83.9	82.1	82.6	83.5	84.3	84.4	84.3
35-39	86.4	88.7	86.3	87.3	88.3	89.1	89.6	89.8
40-44	83.6	86.5	84.1	86.9	88.0	88.4	89.4	89.9
45-49	63.5	68.9	70.7	69.2	70.9	71.2	75.2	77.8

(Source: Ministry of Health)

The percentage of couples adopting contraceptive methods has increased over time, to 78 percent in 2007. The use of modern contraceptive methods (IUDs, sterilization, birth control pills and condoms) constituted a large proportion, approximately 86 percent of the total number of contraceptive users.

These achievements are in large part due to the expansion of the reproductive healthcare service network from central to provincial level. There are reproductive healthcare centres in every province, and most district healthcare centres include facilities for reproductive healthcare.

At local level, 98.6 percent of communes have healthcare centres; 55.5 percent of communes gained national standards for healthcare service; 65.9 percent of communes have doctors; 93

percent of communes have midwives and obstetric physicians and paediatrists; 84.4 percent of hamlets and small villages have active healthcare workers; and 100 percent of hamlets and residential blocks have voluntary consultants on family planning.

Nationwide, 12 hospitals specialize in Ob-Gyn and 12 others specialize in paediatrics. Adding to these are tens of thousands of private healthcare facilities, including two Ob-Gyn hospitals. Social organizations and a network of community providers also offer a range of services to meet public need.

Most midwives, paediatric physicians and healthcare workers are trained and have basic and nationally standardized skills in reproductive healthcare and family planning; collaborators on

family planning also receive training which provides them with knowledge and skills to provide counseling and non-clinical contraceptive methods to members of the community.

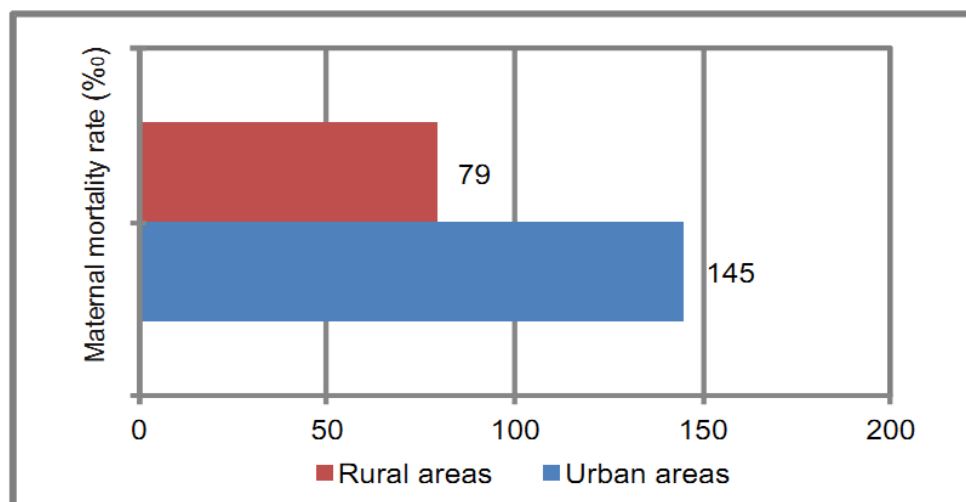
II. Difficulties and challenges in maternal health

The rate of pregnant women receiving at least 3 prenatal check-ups differed significantly between regions. While the Northwest and Central Highlands only achieved a rate of 70 percent, regions with more favourable conditions such as the Red River Delta and the Mekong River Delta achieved approximately 95 percent. This is partly due to differences in prenatal care practices and partly due to difficulties in accessing maternal healthcare services in disadvantaged areas. Disparities also exist in the rate of births attended by trained health workers. While the rate was less than 80 percent in the Northwest it was over 90 percent in all other regions.

An emerging issue related to maternal health in general and reproductive health in particular is the recent alarming rise in abortions among teenagers. Viet Nam has a high abortion rate, with 20 percent of these being teenagers, not even accounting for abortions at private clinics which are outside of our control and thus cannot be estimated. The Survey Assessment of Vietnamese Youth 2 (SAVY2) in 2010 showed that approximately 7.5 percent of teenagers had premarital sex and lacked knowledge about sex, leading to high rates of abortion.

Maternal mortality varies considerably between urban and rural areas (Chart 2). Major causes are haemorrhages, infection, eclampsia, and unsafe abortions, which are all preventable. Raising mothers' awareness of the importance of self-care and self-protection could prevent such causes.

Chart 2: Maternal mortality disparity between urban and rural areas



(Source: UNICEF (2008), based on the VHLSS from the General Statistics Office)

Geographical factors, the educational level of mothers and traditional practices in mountainous, remote and disadvantaged rural areas constitute major obstacles to the reduction of maternal mortality. In addition, the ability to access reproductive healthcare services may also be a cause affecting differences in the maternal mortality rate.

The reproductive healthcare service network, though strengthened, remains inefficient in remote and mountainous areas. Many reproductive healthcare centres at provincial level have gone into decline. As for reproductive healthcare at the district level, the infrastructure is not yet fully in place. In addition to unfavourable working conditions, at all levels insufficient numbers of medical staff are available. As for the staff structure, the ratio of university educated staff to primary and intermediate level staff remains low.

III. Maternal health interventions, national assembly roles and national strategies

1. Maternal health interventions

The following interventions have been shown to improve maternal and neonatal health and should be considered in Vietnam's effort to strengthen maternal and neonatal health policies and programs.

- Increase access to reproductive health, sexual health, and family planning services, especially in rural areas. Due to the lack of access to care in rural areas, maternal death rates are higher in rural areas than in urban areas. In addition, many men and women in rural and urban areas lack access to information and services related to HIV/AIDS and other STIs.
- Strengthen reproductive health and family planning policies and improve planning and resource allocation. Many countries have strong maternal health policies, but implementation of the policies may be inadequate. Often, available resources are insufficient or are used inefficiently. In some cases, advocacy can strengthen policies and increase the amount of resources devoted to reproductive health and family planning. In other cases, operational policy barriers – barriers to implementation and full financing of reproductive health and family planning policies – must be removed.
- Increase access to and education about family planning. Another feature that relates closely to preventing maternal mortality is the provision of family planning. Family planning helps women prevent unintended pregnancies and space the births of their children. It thus reduces their exposure to risks of pregnancy, abortion, and childbirth. Reliable provision of a range of contraceptive methods can help prevent maternal deaths associated with unwanted pregnancies.
- Increase access to high quality antenatal care. High quality antenatal care includes screening and treatment for STIs, anemia, and detection and treatment of hypertension. Women should be given information about appropriate diet and other healthy practices and about where to seek care for pregnancy complications. The World Health Organization's recommended package of antenatal services can be conducted in four antenatal visits throughout the pregnancy.
- Increase access to skilled delivery care. Delivery is a critical time in which decisions about unexpected, serious complications must be made. Skilled attendants – health professionals such as doctors or midwives – can recognize these complications, and either treat them or refer women to health centres or hospitals immediately if more advanced care is needed. Women in rural areas live far distances from quality obstetric care, so improvements depend greatly on early recognition of complications, better provisions for emergency treatment, and improved logistics for rapid movement of complicated cases to

district hospitals. Increased medical coverage of deliveries, through additional skilled staff and service points, are basic requirements for improving delivery care. Reliable supply lines and staff retraining programs are also critical.

- Provide prompt postpartum care, counselling, and access to family planning. It is important to detect and immediately manage problems that may occur after delivery, such as hemorrhage, which is responsible for about 25 percent of maternal deaths worldwide. Postpartum care and counselling will help ensure the proper care and health of the newborn. Counselling should include information on breastfeeding, immunization, and family planning.
- Improve postabortion care. About 13 percent of maternal deaths worldwide are due to unsafe abortion. Women who have complications resulting from abortion need access to prompt and high quality treatment for infection, hemorrhage, and injuries to the cervix and uterus.
- Strengthen health promotion activities. Mass media should be used to educate the public about pregnancy and delivery, and community-level organizations should assist this through systematic programs. An important step for health promotion, in order to prevent negative maternal health outcomes, is to have the Ministry of Health supply adequate educational materials regarding safe practices.

2. National Strategies

In Vietnam, many existing national strategies and policies directly and indirectly impact MDG-5 outcomes. Numerous government programs and plans broadly address different components of these multi-faceted issues:

- Five-Year Socio-Economic Development Plan 2006-2010: The plan details increased investment in primary healthcare, with an explicit focus on education in reproductive health, nutrition, traffic safety, and tobacco control. Objectives include improving the “material and spiritual life” of women and raising their quality of education and job training in ways that ensure “rational human resource structures.” The plan also outlines support for residents of socio-economically-challenged communities and communities in mountainous, island, and border regions.
- National Strategy for Reproductive Health Care 2001-2010: Key objectives include improving the nation’s overall reproductive health status and narrowing the disparities between different regions and target groups. The strategy outlines seven objectives, including improving the health status of women and mothers and reducing maternal mortality and morbidity, prenatal deaths, and infant mortality with “specific attention to disadvantaged areas and to beneficiaries of government policies.”
- National Plan on Safe Motherhood 2003-2010: Key elements of this plan include increasing delivery of new tools and equipment at the provincial and district levels and the expansion training for doctors and nurses in essential newborn care.
- National Action Plan for Child Survival: Implemented by Save the Children in partnership with the Ministry of Health and other partners, this plan aims to reduce newborn deaths by introducing a newborn care intervention package and updating national guidelines and standards.
- Strategy for Protection and Care of the People’s Health 2001 - 2010: Specific objectives include reducing maternal and under-one-year mortality and reducing malnutrition among

newborns. Implemented solutions aim to improve quality and access of reproductive care services and prioritize investment in maternal and child health services.

- National Nutrition Strategy 2001-2010: Specific objectives of this strategy include promoting exclusive breastfeeding practices, reducing malnutrition rates for women and children, and increasing women's nutritional health literacy.

3. National Assembly roles

Parliaments have a crucial role to play on MDG-5 issues within the broader context of the health sector and the overall national development agenda. IPU have identified five core actions that parliamentarians can take in positioning, promoting and protecting the health of women:

- Representing the voice of women
- Advocating for MDG-5, nationally and internationally
- Legislating to ensure universal access to essential care
- Budgeting for maternal health
- Holding the government to account for implementing policies

In 2002, the Government of Vietnam established the Health Care Fund for the Poor. This fund provides free health care to almost 15 million people who are poor or members of ethnic minorities – close to 20% of the total population. This initiative has dramatically increased access to health care among these traditionally underserved population groups.

In 2004, the Law on Child Protection, Care and Education was enacted by the National Assembly. The National Health Insurance Law was passed in 2008 and came into effect in July 2009. Parliamentarians played a critical role in the development of both of these laws. They used their representative function by organizing visits to their constituencies, ensuring that constituents' concerns were reflected in the drafting process. National Assembly also convened consultations and hearings with experts from around the country and conveyed their perspectives on drafts of the law to the drafting committee. Recommendations to the drafting committee were often reflected in subsequent drafts of the law.

National Assembly also played a key part in mobilizing additional resources for health recently. It helped to secure an increase from 8% to 10% in the health sector's share of the total government budget. The increase is aimed at improving health outcomes and modernizing the health system. Parliamentarians contributed by consulting their constituencies and through their in-depth knowledge of the health sector's needs and priorities, gained through expert hearings and interactions with the Ministry of Health.

Vietnam's parliament is very active in monitoring the implementation of the Law on Child Protection, Care and Education, and the National Health Insurance Law. Parliamentarians organize meetings at the central level with Ministry of Health, Ministry of Education and other relevant ministries. They also make field trips and organize meetings with provincial and district leaders as well as members of local communities. The monitoring missions' findings and recommendations are documented and reported to the health ministry, which has an obligation to tell parliament how the recommendations will be addressed. Monitoring efforts lead to better implementation of the laws. Between 2007 and 2009, the proportion of the population covered by social health insurance increased from 49% to 55%. Further monitoring of the health insurance law is needed to ensure that coverage continues to increase and that benefits are delivered effectively.