Why Is Oral Contraceptive Use in Vietnam So Low?

By John Knodel, Phan Thuc Anh, Truong Viet Dung and Dao Xuan Vinh

An examination of reasons why oral contraceptives represent less than 5% of modern method use in Vietnam, based on structured discussions with program implementers and on interviews with women who are actual or potential pill users, indicates that promotion of the pill has been minimal and that demand is low. Many program implementers perceive the IUD to be a better method under most circumstances, and they lack accurate knowledge about the pill. For example, a large proportion believe that it is necessary for pill users to skip one or two cycles every year to restore their hormonal balance. In addition, most do not believe that rural women can remember to take the pill daily. In contrast, most current or former pill users report that they have not had serious difficulty in remembering to take the pill on a daily basis. The inadequate knowledge and negative attitudes toward the pill among program implementers can be traced to the structure of the family planning program and to the assumptions underlying population policy in Vietnam.

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Since the early 1960s, Vietnam (first the North and then, after reunification, all of the country) has had both a family planning program and a policy encouraging lower fertility. While the initial aims of promoting family planning were to improve the welfare and labor-force productivity of women—seen at the time as especially important given the drain on the male labor force produced by the war—the goal of lowering fertility (and thus the growth rate) became explicit by the early 1970s.

Population issues have been given increasing political attention by the government ever since, as was signaled by a series of government decisions and decrees issued to promote family planning and other population-related activities throughout the country. Most recently, the Communist Party Central Committee passed a resolution on population and family planning in January 1993, and in June 1993 Vietnam's prime minister approved a "Population and Family Planning Strategy to the Year 2000."[1]

Even though the Vietnamese government has given population matters a great deal of attention during the last few decades, the national family planning program has been limited in scope, largely synonymous with the provision of IUDs. (Although menstrual regulation and abortion have also been provided to a significant extent,* they are not considered to be family planning methods within the program.[2]) According to the nationally representative 1988 Vietnam Demographic and Health Survey, 33% of currently married women aged 15–49 used the IUD—88% of all users of modern methods.[3] In contrast, fewer than 1% of women were using oral contraceptives.

The situation has apparently changed little since then. Two surveys undertaken in 1993 revealed continued low use of the pill and dominance of the IUD: According to both the 1993 Demographic and Family Planning Survey and the 1993 KAP/IEC survey, which was conducted in mid-1993 in seven provinces, pill use had risen to only 2% among married women of reproductive age. Moreover, pill use represented only 4–5% of all modern method use, while the IUD represented 78–83% of modern method use in the two surveys.†

This situation contrasts sharply with those of other countries in the region that have similar (or higher) overall prevalence rates. For example, according to Demographic and Health Surveys undertaken in the late 1980s in Indonesia and Thailand, users of oral contraceptives constituted 34% and 28% of all users, respectively.[4]

In recognition that providing a wider selection of methods to potential users is likely to increase contraceptive prevalence, Vietnam's Council of Ministers adopted in 1988 an official policy of promoting the ready availability of a broad range of methods through the government family planning program.[5] The June 1989 Health Law passed by the National Assembly strongly stressed that individuals have the right to use the method of their choice;[6] this aspect of the policy was reconfirmed in a 1993 resolution of the Communist Party Central Committee and repeated in a strategy plan approved by the Prime Minister.[7] The United Nations Population Fund (UNFPA) has recently provided substantial quantities of oral contraceptives to be distributed through the government health system.‡

Given the new emphasis in the family planning policy on expanding the method mix, this article examines why rates of oral contraceptive use in Vietnam are so low and how barriers to use might be overcome. We focus both on program implementers and on actual and potential users

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*For example, government data released in 1991 indicated that more than one million menstrual regulations and induced abortions were carried out in 1990. (See: J. Allman et al., "Contraceptive Requirements and Logistics Management Needs in Viet Nam," draft report prepared for the United Nations Population Fund, Aug. 1993.)

†Figures for the 1993 Demographic and Family Planning Survey (carried out nationally by the General Statistical Office) are calculated from data provided in V. Nhan, 1994 (see reference 1); figures for the KAP/IEC survey (conducted jointly by the General Statistical Office and the Institute of Sociology) are based on original tabulations from the raw data.

‡The total supply of pills in the country obviously sets a ceiling on the possible prevalence. According to the UNFPA plan, the number of pill cycles supplied to the government would be sufficient for an overall prevalence of 2.8% among married women of reproductive age. To this must be added the supply available from the private sector, which is unknown. However, the 1993 KAP/IEC indicates that approximately one-third of pill users get their supply from private-sector outlets. If this is roughly representative of the country as a whole and does not include a large proportion of illegally obtained government pills, the pill supply in Vietnam in 1993 could have permitted only about a 4% prevalence rate. Despite this low supply, our results indicate little evidence that shortages are felt at supply points.

of oral contraceptives in an exploratory study that is not meant to be statistically representative of the country or of the groups interviewed. Nevertheless, the data provide considerable information gathered in a systematic manner on a wide range of issues related to current levels of pill use.

In Vietnam, contraceptive services are provided free through the Ministry of Health, where responsibility is assigned to the Department of Maternal and Child Health and Family Planning (MCH/FP). This is the primary source of contraceptives in the country, although they are also available from the private sector, especially through pharmacies and some nongovernmental organizations. The government program, however, is multisectoral and involves a range of ministries and mass organizations (government-sponsored organizations intended to mobilize support and act at the grass-roots level) whose role is to educate, promote and encourage family planning use.

The National Committee for Population and Family Planning, a ministerial-level body established in 1984, is charged with formulating population policy and managing implementation among the various ministries, agencies, levels of government and mass organizations. It has established a functioning network of committees at the provincial level and is in the process of establishing them at the district and commune level. The national committee includes members from eight ministries and four mass organizations.[8]

Study Design

The study that we report on here was carried out by the Centre for Human Resources for Health in Hanoi. In the main data collection, which took place from June 1993 through August 1993, information was gathered from Ministry of Health personnel involved in the family planning program at all levels: provincial health bureau staff, including those in charge of the MCH/FP unit; district health center staff, including those involved in mobile teams; intercommune polyclinic staff; commune health station staff; and hamlet primary nurses. A few of these persons were in largely managerial positions, especially those at the provincial level; others provided services directly to the users. In many cases, managerial and service provision responsibilities overlapped.

Outside the health system, information was collected from members of the various Provincial Committees for Population and Family Planning (PCPFPs) and, at the commune level, from representatives of the People's Committee and the Woman's Union, since all of these organizations are charged with promoting family planning use. For convenience, we refer collectively to all of these as program implementers; we also refer to the subset of program implementers who are within the health system as health workers.

Three data collection approaches were employed to gather data suitable for both quantitative and qualitative analysis:

- Structured discussions with program implementers (usually in groups of two or three) were based on prepared discussion guidelines, with mostly open-ended questions. The questions were tailored to the particular level of implementer, although a number of questions were common for all or at least several different levels.
- Two short closed-ended questionnaires were administered to program implementers at the conclusion of the structured discussions. One addressed the possible causes of low levels of pill use and was answered orally by the implementers as a group, with only the group's collective opinion recorded. The second dealt with knowledge and attitudes about the pill and was completed individually by each respondent who was present for the discussion.
- In addition, interviews using typical survey-style questionnaires were conducted with four purposively targeted groups of women who were actual or potential users of the pill: current pill users, former pill users, never-users of the pill who were using another method, and women who had never used the pill and were not using any other method. Depending on the purpose of analysis, these four samples were combined in various ways.

Fieldwork was conducted in 12 provinces divided equally among northern, central and southern Vietnam.* In half of the provinces (two in each region), data were collected only from program implementers at the provincial and district level; no data were collected from provider groups at the intercommune or commune level or from individual women. In the other six provinces (two in each region), data were collected from the full array of program implementers and women.

In each province, two districts were visited—24 districts altogether. In the six provinces where data were gathered below the district level, one commune per district and (where they existed) one intercommune polyclinic or MCH/FP center was visited. In each commune, interviews were conducted with the health station staff, up to two hamlet nurses (if there were any), one representative of the Women's Union, and the chairman of the People's Committee.

In total, 106 discussions were held with program implementers, either singly or in small groups. In addition to answers provided to the mostly open-ended questions posed in these discussions, these yielded 106 closed-ended questionnaires on the group's opinions of the perceived causes of low pill use and 212 individually answered closed-ended questionnaires on knowledge and attitudes regarding the pill.

Convenience samples of current pill users, former pill users, current users of other methods and nonusers were inter-

Table 1. Mean scores given to reasons for low pill use and percentage distribution, by importance of reason, Program Implementers' Survey, Vietnam, 1993 (N=106)

Reason	Mean score	Importance of reason				
		Very important	Somewhat important	Minor reason	Not a reason	Total
Lack of desire to use pill	1.85	26	40	28	7	100
Inconvenient to use pill	1.63	20	38	28	14	100
Lack of information, education and communications material	1.62	23	36	23	19	100
Insufficient efforts to promote the pill by:						
Commune health workers	1.60	15	46	23	16	100
National program officers	1.57	19	42	15	24	100
Provincial health workers	1.47	13	44	19	24	100
District health workers	1.42	13	40	24	24	100
Lack of incentive payments to health workers for providing pill	1.08	9	28	26	38	100
Lack of awareness of pills among women needing contraception	0.90	10	20	21	50	100
Poor knowledge of pill among commune health workers	0.82	5	23	23	50	100
Difficult access for users	0.72	2	23	21	55	100
Poor knowledge of pill among district health workers	0.65	4	16	22	58	100
Inadequate supply	0.36	2	10	9	78	100

*The study provinces were selected partly on a purposive basis and partly on a convenience basis, to permit interprovincial travel within the time constraints of the field work. Within each province, districts were preselected by systematic random sampling. Selection of communes was made at the time of visits to the districts, largely on a convenience basis.

viewed in both the provincial capitals and the selected communes of the six provinces where the full array of data was collected. In each of the 12 communes and in each of the six provincial towns, attempts were made to find five women in each of the four target groups. Overall, 363 women were interviewed, divided about evenly among the four categories. Approximately one-third of these women were from an urban setting (the provincial capital), and the remainder were from rural communes.

In addition to the data collected as part of the fieldwork, we also draw on information from the seven-province KAP/IEC Survey conducted in 1993. We made particular use of questions related to pill use that had been added to the questionnaire at our request and were asked of approximately 175 women who had ever used the pill. These data have the advantage of being based on large probability samples in the provinces covered.

Implementers' Views

Perceived Reasons for Low Pill Use

At the conclusion of each of the 106 discussions with program implementers, the interviewers read out a list of factors that could potentially account for low levels of pill use in their area. The participants were asked to judge each factor as very important, somewhat important, a minor reason, or not a reason for low pill use. When more than one participant took part in the discussion, their collective judgment was sought. To calculate the order of importance of these factors, we assigned a score of 3 to factors rated "very important," 2 to those judged "somewhat important," 1 to factors thought to be a "minor reason" and 0 to those thought "not a reason."

Table 1 shows the mean scores for each factor, and lists the factors in their judged order of importance. According to the scoring system, program implementers believed that low demand—expressed as a "lack of desire to use the pill" among potential users—was the most important reason for low levels of pill use (a mean score of 1.85). The belief that the pill is inconvenient for women to use emerged as second in importance in implementers' thinking (a mean of 1.63), followed by a lack of information, education and communications materials and by the perception that program implementers at each level of the system (national through commune) had made little effort to promote the pill. All of the above factors were rated as either very important or somewhat important in more than half of the discussions. Other factors were seen as being distinctly lower in importance, having been rated in the majority of discussions as only a minor reason or none at all.

Table 2. Percentage distribution of groups of program implementers, by answers to questions concerning appropriateness of oral contraceptive use, and number of groups, by answer, according to type of group

Type of group	Total	Is the pill appropriate for rural women?			Can rural women remember to take the pill daily?			Is the IUD almost always better than the pill?		
		Yes	No	Other	Yes	No	Other	Yes	No	Other
% distribution	**100.0**	**47.2**	**42.5**	**10.3**	**29.2**	**63.2**	**7.5**	**60.4**	**28.3**	**11.3**
All groups	**106**	**50**	**45**	**11**	**31**	**67**	**8**	**64**	**30**	**12**
Provincial health worker	12	5	4	3	2	9	1	10	2	0
PCPFP member	12	5	5	2	1	11	0	5	5	2
District health worker	24	10	9	5	1	19	4	18	4	2
Polyclinic personnel	9	4	5	0	5	4	0	6	3	0
Commune health worker	11	6	5	0	3	6	2	6	3	2
Hamlet nurse	14	5	9	0	4	10	0	10	4	0
Women's Union rep.	12	8	4	0	9	2	1	5	4	3
Commune People's Committee chair	12	7	4	1	6	6	0	4	5	3

Note: The numbers shown represent the number of discussions in each category of program implementer in which the collective judgment of those present was as indicated. The percentage distributions in the first row are based on all 106 discussions.

The ranking of supply problems as the least important factor accords with reports in the discussions that the vast majority of officially designated supply and distribution points at the provincial, district, intercommune and commune levels had pills in stock. Also, very few respondents said that they had had any problem during the last two years in getting their supply on time. Moreover, while a number of discussions indicated that health workers had more pill cycles in stock than they needed, only personnel at one intercommune polyclinic and one commune health station indicated that their stock was too low. This supply situation appears to have improved over that reported in the 1990 Vietnam Survey of Accessibility of Contraceptives,[9] although precise comparisons cannot be made, given the very different sampling procedures and ways in which results were reported.

Attitudes Toward the Pill

While the program implementers are undoubtedly correct in thinking that the demand for oral contraceptives is minimal at present, this view may condition providers' own attitudes towards promoting or recommending the pill. When program implementers were asked directly if oral contraceptives were an appropriate method for rural women (who constitute approximately four-fifths of all Vietnamese women), fewer than half (47%) of discussions concluded that they were (see Table 2). Among program implementers, only a majority of Women's Union representatives and, to a lesser extent, Commune People's Committee representatives expressed a favorable view.

Program implementers often mentioned that rural peasant women could not remember to take the pill daily. Table 2 shows that in fewer than one-third (29%) of discussions did participants conclude that rural women were capable of taking the pill every day. This view was very common in discussions at almost every level; Women's Union representatives were the only groups in which the majority concluded otherwise. This exception is perhaps significant, however, given that these Women's Union representatives are rural women themselves.

The bias toward the IUD was also clearly revealed in discussions with program implementers. When asked how the pill compared with the IUD, participants in a substantial majority of discussions (60%) indicated that they thought the IUD was almost always better than the pill. Again, this view was prevalent across all groups.

Another indication of program implementers' negative view of the pill comes from the individual questionnaires they completed, which asked a number of questions about their pill-related attitudes and knowledge. The majority (53%) of the more than 200 program implementers agreed with the statement that for most women the pill is inconvenient to take (not shown). This is not surprising, given that the pill's inconvenience was one of the factors rated as most important in the low prevalence of pill use. This view was particularly common among PCPFP members, with 73% agreeing that the pill is inconvenient. In contrast, only 26% of individuals outside the health system (such as Women's Union representatives and People's Committee representatives) agreed with this statement.

Table 3. Percentage of program implementers disagreeing with incorrect statements about oral contraceptives, by implementer group

Statement	All	Prov. health worker	PCPFP member	District health worker	Intercommune & commune health worker	Commune nonhealth worker
It is very difficult to get pregnant after stopping pill use	82	91	54	90	77	61
Most pill users have bad side effects that last for a year or longer	71	89	54	76	64	45
A woman missing one pill runs a high risk of pregnancy	45	32	54	50	51	42
It is good for pill users to stop use for one or two cycles every year	34	25	36	32	39	48

Note: The data in this table are based on 212 respondents. The base numbers on which the percentages are calculated include those who indicated that they did not know about the issue being asked.

Knowledge About Oral Contraceptives

Questionnaire responses concerning pill-related knowledge were also quite revealing. Virtually all program implementers were aware that the pill can be a very effective method, with 99% agreeing that, "if taken as instructed, the pill is very effective in preventing pregnancy." Moreover, a very large majority (91%) agreed that "if taken as instructed, the pill is at least as effective as the IUD." Program implementers also mostly believed that the pill is safe, as reflected by the fact that 91% disagreed with the statement that "the pill is quite dangerous for women's health."

On other items, however, correct knowledge was less apparent. Table 3 shows that while a large majority of health workers responded correctly about the effect of the pill on a woman's ability to become pregnant after stopping use, this proportion was far lower among PCPFP members and commune nonhealth workers (such as Women's Union and People's Committee representatives). Among these two groups, only 54% and 61%, respectively, disagreed with the statement that "it is often very difficult for women who take the pill to get pregnant once they stop using the pill." In addition, although the rate of correct responses (77%) was higher among intercommune and commune health workers than among the nonhealth workers, it was substantially below that among health workers at the higher levels of the health system (90–91%).

Likewise, even though the majority of program implementers disagreed with the statement that "most women who use the pill typically have unpleasant side effects that last for a year or longer," nonhealth workers fared far worse on this item than did health workers; among the latter, intercommune and commune health workers fared worse than health workers at higher levels. Fewer than half (45%) of commune nonhealth workers and only slightly more than half (54%) of PCPFP members disagreed with the statement. At the intercommune and commune level, fewer than two-thirds (61%) of health workers gave the right answer; in contrast, the rate of correct responses was much higher among those at the provincial and district levels.

Program implementers did far worse in correctly assessing the danger of missing a single pill: Fewer than half (45%) of our overall sample knew that there is little additional risk of pregnancy after a single missed pill, despite substantial scientific evidence to this effect.[10] Moreover, this misunderstanding was common among all categories of program implementers. Such overestimation of the danger of pregnancy from a missed pill, coupled with the belief that rural women are unable to remember to take the pill daily, is likely to discourage the promotion of oral contraceptives by program implementers.

The most common misunderstanding that we identified concerned the belief that women need to stop taking the pill for 1–2 cycles every year, apparently to periodically restore their hormone levels. Only one-third (34%) of program implementers correctly disagreed with the statement "it is good for pill users to stop use for one or two cycles every year." Moreover, in no program implementer category did a majority disagree.

Although we are uncertain about the origin of this misconception, it probably derives from views common during the early days of pill use, when little was known about the hormonal effects of long-term use and when doses were high. The relative isolation of the Vietnamese medical profession from much of the rest of the world during the last two decades is probably responsible for the persistence of this out-of-date view. If the advice is followed, it makes pill use considerably less convenient for the user and increases the risk of pregnancy, as it encourages the use of less-effective methods during the interim period between stopping and resuming use. In any event, this view has permeated information, education and communications material, and thus is certain to be perpetuated if not corrected.

Several information leaflets that the research team collected in the course of the fieldwork also said that the pill should not be used by women over age 35. The internationally recommended contraindication with respect to older age is restricted only to women who habitually smoke. This distinction is quite relevant in Vietnam, since the vast majority of Vietnamese women presumably do not smoke.

Women's Perspectives

Knowledge and Attitudes

The questions about knowledge and attitudes regarding oral contraceptives asked of Vietnamese women were the same as those administered to the program implementers. Only women who indicated they had heard of oral contraceptives were asked these questions. Most women (79%) who had never used the pill had heard of the method. Table 4 summarizes the results for several questions, cross-tabulated according to the women's experience with

Table 4. Percentage of women agreeing or disagreeing with selected statements about oral contraceptives, by pill-use experience, Women's Survey, Vietnam, 1993

Statement	Current user (N=85)	Former user (N=91)	Never user* (N=148)
Agree that pill is very effective at preventing pregnancy if taken as instructed	98	82	59
Agree that, if taken as instructed, pill is at least as effective as IUD	86	76	52
Disagree that pill is quite dangerous for women's health	82	64	40
Disagree that it is often very difficult for former pill users to become pregnant	52	54	34
Disagree that most pill users typically have unpleasant side effects lasting for one year or longer	74	59	21
Disagree that if user forgets to take pill for one day, she has good chance of becoming pregnant	58	34	16
Disagree that it is good for women to stop using pill for 1–2 cycles every year	47	36	19

*Results exclude 39 women who never heard of the pill. *Note:* The base numbers on which the percentages are calculated include those who indicated they did not know about the issue being asked.

Table 5. Among women who ever used the pill, percentage who experienced various side effects

Side effect	All (N=176)	Current users (N=85)	Former users (N=91)
Feeling hot	33	32	35
Headache	26	22	30
Menstrual pain	20	16	23
Weight gain	19	25	14
Nausea	15	13	16
Other	22	22	22
None	26	28	24

pill use. (Women who had never used the pill were pooled, regardless of whether they were using some other method).

Experience using the pill is strongly associated with having correct knowledge about it. For almost every item shown, current users were most likely to have correct knowledge, and for all items, never-users were the least likely. In addition, the percentage of former users who knew about an item typically was much closer to that of current users than of never-users. Indeed, in some cases never-users' level of correct knowledge about oral contraceptives was extremely low. Only with respect to the basic issue of the pill's effectiveness did more than half of never-users familiar with the pill exhibit correct knowledge (59% agreeing that the pill is effective in general and 52% that the pill is as effective as the IUD).

Even among women who were current or former pill users, correct knowledge was quite low on some issues. Only slightly more than one-half (52% and 54%, respectively) correctly disagreed that pill use impedes a woman's ability to become pregnant after she stops using it, and fewer than one-half (47% and 36%, respectively) correctly disagreed with the idea that it is good to stop taking the pill for one or two months per year.

To determine women's attitudes toward the pill, respondents were asked if they agreed that "the pill is inconvenient to take for most women" (not shown). Only a small minority of current users (15%) and a higher proportion of former users (33%) agreed that the pill is inconvenient. In fact, the large majority of current users (80%) and more that one-half of former users (57%) explicitly disagreed that the pill is inconvenient. Results were similar for rural and urban women. Overall, women with experience in using oral contraceptives were far more sanguine about the convenience of the method than were most program implementers.

On the other hand, women who never used the pill (but had heard of it) were not particularly positive about it. More of such women indicated that the pill is inconvenient (42%) than did women with prior experience with the pill; only 32% of never-users explicitly disagreed that pills are inconvenient, and more than one-fourth (26%) said they did not know. It seems likely that program implementers' opinions could have considerable influence over whether such women would select the pill as their family planning method.

Remembering to Take the Pill Daily

Evidence both from ever-users in our own survey and from current pill users who participated in the seven-province 1993 KAP/IEC Survey provided some insight into the issue of whether Vietnamese women (particularly rural women) can remember to take the pill daily. In our interviews with both current and former pill users, fewer than one in five ever-users (19%) believed it is difficult to remember to take the pill every day. Moreover, there was virtually no difference between urban and rural women in this respect (20% vs. 19%). Former users were slightly more likely to say so than were current users (21% vs. 18%).

In both surveys, current pill users were asked whether they had forgotten to take any pills in either of the last two months. When we combined information for the two samples (the numbers in each survey being quite small), we found that among 168 current users for whom such information was available, the large majority (82%) said they had not forgotten any pills during the last two months (88% of urban women and 80% of rural women). Most women who forgot occasionally to take a pill did so only once or twice; only 7% said they had forgotten three or more pills over the two preceding months, with no urban-rural difference.

These findings contradict the opinions of program implementers that rural Vietnamese women cannot remember to take the pill. They are also quite consistent with research findings from Thailand showing that 76% of all users (77% of rural women and 70% of urban women) had taken all of their pills during the previous month.[11]

Importance of Side Effects

Table 5 summarizes current and former pill users' experience with side effects. Only about one in four women who ever used the pill (26%) said they had not experienced any side effects after starting the method. The most commonly reported side effect was "feeling hot" (reported by 33%). As far as we are aware, this side effect has not been noted elsewhere,* perhaps because it is not routinely included among the possible response categories. Most other side effects reported are fairly common complaints elsewhere as well, and with the exception of weight gains, all were reported more frequently by former users than by current users.

Table 6. Percentage of pill users who experienced a side effect, by duration of most persistent side effect

Duration	All (N=123)	Current users (N=57)	Former users (N=66)
1 month	26	32	21
2–3 months	22	26	18
≥4 months	10	12	8
Until now/ until quit pill	39	25	52
Other	3	5	2
Total	100	100	100

Table 6 shows data on the duration of the most persistent side effect experienced by each woman. Although side effects were commonly reported, in many cases they did not last more than a few months. Assessing the average duration of side effects is complicated by the fact that current users were still experiencing some side effects and that many former users had been experiencing them when they terminated pill use. Nevertheless, among current users, quite a large proportion of respondents (58%) reported that the side effect of longest duration went away within the first few months of use.

Table 7 (page 16) reports the reasons women who had ever stopped using the pill gave for terminating pill use. These results include the reasons for termination among current users who resumed use, as well as among former users who did not resume use. Among the latter, side effects were clearly the most frequently cited reason for stopping use. Only relatively small proportions of former users cited a difficulty in remembering to take the pill daily or the method's inconvenience as reasons for quitting.

Among current users who terminated and then resumed pill use, the most common reason for termination was the residual "other" category, rather than those that

*The response fits in well with the "hot-cold" concepts of medicines and foods, which are quite pervasive in popular thinking in the region. (See: K. Streatfield and J. Ross, "Cultural Models and Health," paper presented at the Workshop on New Approaches to Anthropological Demography, International Union for the Scientific Study of Population, Barcelona, Nov. 10–13, 1993; L. Manderson, "Hot-Cold Food and Medical Theories: Overview and Introduction," *Social Science and Medicine*, **25:**329–330, 1987; and E. Anderson, Jr., "Why is Humoral Medicine So Popular?" *Social Science and Medicine*, **25:**331–337, 1987.)

Table 7. Percentage of ever-users of the pill, by reasons for stopping use, according to whether they resumed use

Reason	All	Resumed	
	(N=108)	No (N=83)	Yes (N=25)
Side effects	50	57	28
Resupply problem	1	1	0
Wanted to become pregnant	11	12	8
Difficult to remember to take pill daily	12	11	16
Inconvenient	7	8	4
Other	31	22	60

Note: Because respondents were permitted to state multiple reasons, percentages add to more than 100%.

we had anticipated when constructing the questionnaire. Upon checking the comments written by interviewers, we found that in many cases a health worker had advised the woman to stop using the pill periodically—again, a reflection of the misunderstanding among many health workers about this issue.

Women using methods other than the pill were asked if they were planning to switch methods and to what method they expected to change. Women not using any contraceptive method were asked if they planned to use a method and what method that would be. In both instances, those who did not say that they would use the pill were asked why not.

As indicated in Table 8, fear of side effects (including fear of health risks) dominated as the most common reason for not selecting the pill among both groups. Substantial proportions also mentioned being afraid that they would forget to take the pill daily, and some referred to the inconvenience of taking the pill. Undoubtedly, these fears of forgetting are genuine, and for some women may be well-founded. However, in response to a question about their reason for choosing the pill, 53% of ever-users mentioned that they chose the pill because it was convenient.

Discussion

The results of our 1993 study of why pill use is low in Vietnam clearly show two problems: little promotion by providers and a low level of demand from potential users. These are, of course, linked. Family planning acceptors are often influenced by the advice of health workers: If they are not advised to choose the pill, or not even informed about the pill, then it is unlikely that they will request the method. Sixty percent of current or former users of the pill surveyed said they had been advised by a health worker to use the pill, and 80% of those who received this advice said it strongly influenced them. Interestingly, pill users were more likely to have been advised by health workers than were IUD users, probably an indication that health workers have a particular influence on the acceptance of unfamiliar methods.

To understand the results of our study more fully, we must consider the nature of the former and current population program and policy. In particular, the past emphasis on the IUD, the implementation and structure of the program, and the underlying assumptions of the population policy all contribute to the current situation.

Past Emphasis on IUD

Undoubtedly the most important reason for low current levels of pill use, and the reason that affects most other factors, is the fact that the pill was only recently introduced into Vietnam's program in a meaningful way. The singular emphasis on the IUD in the past has led to a strong bias toward this method among program implementers, as well as a lack of comprehensive, accurate and up-to-date knowledge about other methods, including the pill. There are reasons for the heavy emphasis on the IUD, not least of them the relative costs of the two methods in a country where oral contraceptives are not locally produced.

One consequence of the past emphasis on the IUD is that most health workers have received training focused primarily on this method. Almost all health workers at the provincial, district and commune levels (except for hamlet nurses) reported that they had received some training in family planning, and many had had training on IUD insertion; none, however, reported receiving training focused primarily on oral contraceptives, and most said that in their broader training, the pill received either no or very superficial treatment.

Current Program Structure

In addition to the lack of training in the provision of oral contraceptives, important aspects of the current population policy and the structure of the family planning program militate against pill promotion. Despite the newly declared policy to diversify the contraceptive mix by promoting free and informed choice from among a broad range of safe and effective methods, the actual thrust of the policy and program appears to be disproportionately concentrated on sterilization. The most obvious example of this is the current central government policy to give incentive payments to acceptors of sterilization (both male and female) and to their motivators (i.e., whoever is responsible for their decision to be sterilized). All health workers that we interviewed reported this policy to us.

Moreover, in a number of places where the research team visited, local incentives had been added to those prescribed by the central government. In some cases, local jurisdictions also offered nonmonetary incentives to IUD acceptors (such as a certain amount of free rice or release from communal service obligations), although this practice is now apparently far less common than in the past.

In none of the visited sites were incentives provided for pill acceptors. The message conveyed by such policies is that sterilization and the IUD are a higher priority than the pill. Although a number of program implementers we interviewed expressed dislike for the incentive system, the message that high priority was to be given to sterilization was unlikely to be missed. Some explicitly suggested that incentives need to be offered for the pill if its use is to increase.

In discussions with health workers at levels below the province, a number mentioned that supervisors at the next higher level seemed most interested in numbers of sterilization and IUD acceptors, and that failure to reach satisfactory numbers for these methods brought pressure from their superiors. In contrast, superiors showed little interest in the numbers of acceptors of other methods, including the pill. Such a situation undoubtedly reflects current policy as it is actually implemented. Again, this does little to stimulate program implementers to promote oral contraceptives.

Underlying Policy Assumptions

Vietnam's current population and family planning policy is based on the underlying assumption that in the absence of constant promotion and monitoring of their

Table 8. Percentage of women using a method other than the pill and of those using no method, by reasons for not selecting the pill

Reason	Using other method (N=29)	Using no method (N=51)
Never heard of pill	3	16
Unavailable	0	4
No one recommended it	24	12
Fears side effects	52	45
Fears forgetting to take it	31	27
Not convenient	7	8
Other	17	14

Note: Because respondents were permitted to state multiple reasons, percentages add to more than 100%.

behavior, much of the public does not desire small families or want to use contraceptives. Indeed, discussions with program implementers revealed a lack of confidence in the inherent will of many couples, especially those in rural areas, to have few children: A number mentioned that the prevalence of desires for many children, particularly sons, to help in farming and other economic activities posed serious problems for successfully implementing the family planning program.

Thus, People's Committees and mass organizations (such as the Women's Union) are charged with ensuring local couples' compliance with respect to reproductive behavior. Incentives for keeping families small are mixed with disincentives for exceeding the recommended number of births. On the assumption that most Vietnamese couples will tend to have larger families than government policy deems appropriate, many of those charged with implementing the program prefer methods that pose minimal compliance problems once they are accepted. Such attitudes reinforce preferences for the IUD, for which the risk of noncompliance after insertion is low, and dampen enthusiasm for the pill, for which the possibility of noncompliance is far greater. Of course, compliance is even less of a problem with sterilization, a point that is likely to have influenced the emerging emphasis on sterilization at the national policy level.

The belief that preferences for small families and substantial demand for contraception are lacking is contradicted by survey data collected in recent years. Although couples in the past have averaged large numbers of births, surveys indicate that recently married couples—i.e., those whose preferences will most influence fertility in the future—express quite low family-size desires. For example, according to the 1988 Demographic and Health Survey, women married for less than five years preferred 2.6 children overall, and comparable rural women preferred 2.7. In the 1993 KAP/IEC survey, recently married men and women said they preferred only 2.2 children, on average.[12] Although couples may deliberately understate their true preferences when confronted by some official-looking interviewer, these survey results suggest that family-size preferences are not as high as is typically assumed by population policymakers and by many program implementers who participated in our study.

In our discussions with rural women, we were impressed with what appeared to be genuine expressions of preferences for small families among younger women, who explained these preferences in terms of the economic (rather than political) necessity to limit their number of children. Quite possibly, Vietnam's rapidly changing socioeconomic circumstances are altering fertility desires and thus rendering the assumptions of policymakers and family planning providers out of date. The example of very substantial fertility decline in nearby Thailand, where quite similar attitudes were expressed and a wide range of contraceptives were available but where little official pressure was exerted on couples, may be quite instructive in this respect.[13]

Conclusions

The foregoing analysis of the factors underlying low levels of pill use in Vietnam clearly point to the need for a national training program specifically focusing on oral contraceptives—one to be undertaken at all administrative levels, from the province to the commune, both for health system workers responsible for providing contraceptives and for nonhealth personnel responsible for motivating acceptance and monitoring use of family planning. In addition, there is a clear need to develop and distribute appropriate standardized information, education and communications material for both program implementers and potential users. In addition to redressing the apparent deficiency in knowledge about the pill and about how to promote its use, a training program and information materials will heighten awareness among providers and motivators in charge of implementing the national family planning policy.

Policymakers in charge of the family planning program would also do well to examine the impact of the current incentives scheme, especially the incentives for sterilization. If, as one might suspect, incentives distort the free and informed choice of contraceptive methods and thus inhibit the promotion of methods whose selection is not similarly rewarded, a reassessment of that policy would be in order.

Because of a lack of promotion of pill use, as well as the low level of demand, there does not at present appear to be a supply problem with respect to the pill. However, if promotion and demand improve, a number of aspects of the supply and distribution system may impede an increase in pill use. For example, pill resupply for both users and providers at the lower levels usually occurs on a monthly basis. The large majority of pill users interviewed in our study reported receiving only one cycle at a time. In several of the more remote districts and communes, the lack of adequate transportation and the difficult roads might create problems for a method such as the pill, which requires constant resupply.

The distribution system is characterized by other cumbersome procedures as well. In general, physical exams are mandatory for women who wish to obtain the pill from a government outlet. Thus, an initial prescription usually requires the presence of a medical doctor. In addition, some providers require that users return their used pill packet in order to receive a new one. (The used packets are apparently needed by the provider to prove that the previous supply has been distributed and not misappropriated. They also serve as a way to monitor user compliance.) Such procedures and regulations could become more problematic if demand and use become significant, and thus merit reconsideration if potential supply and distribution problems are to be avoided or alleviated.

Even without a change in the level and nature of pill promotion, demand for the pill (as well as for other alternatives to the IUD) will likely rise as a result of inevitable increases in couples' familiarity with contraception, through the limited official promotional efforts, occasional mass media reports and word-of-mouth. It is noteworthy that 86% of currently married women of reproductive age reported in the 1993 KAP/IEC survey that they had heard of the pill, compared with only 47% in the 1988 Demographic and Health Survey.[14] Nevertheless, the increase in use (as well as the quality of use) is likely to be modest without active intervention by providers. Experience elsewhere suggests that with proper provision and information, education and communications, the pill could become an acceptable and popular method in Vietnam also.

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14. Special tabulations of raw data from the 1993 KAP/IEC survey, 1993; and NCPFP, 1990, op. cit. (see reference 3).

Resumen

Al examinar las razones por las cuales el uso de anticonceptivos orales es inferior al 5% del uso de métodos modernos en Vietnam, en base a discusiones formales con las personas encargadas de ejecutar el programa y mediante entrevistas realizadas a mujeres que utilizan o son usuarias potenciales de la píldora, se ha constatado que la promoción de la píldora es mínima y que la demanda es baja. Muchas de las personas encargadas del programa consideran que el DIU es un mejor método en la mayoría de las circunstancias, y no conocen adecuadamente el método de la píldora. Por ejemplo, una gran proporción cree que es necesario que las usuarias de la píldora dejen de tomarla por uno o dos ciclos cada año, para recuperar el equilibrio hormonal. Además, la mayoría no cree que las mujeres de las zonas rurales puedan recordarse de tomar una píldora diariamente. En contraste, la mayoría de las usuarias actuales o ex-usuarias de la píldora indican que nunca tuvieron dificultades serias en recordarse de tomar sus dosis todos los días. La falta de conocimiento adecuado y la actitud negativa hacia la píldora que tienen las personas encargadas de los programas pueden atribuirse a la organización del programa de planificación familiar y a las suposiciones en que se basan la política demográfica de Vietnam.

Résumé

L'examen des raisons pour lesquelles les contraceptifs oraux représentent moins de 5% de la pratique contraceptive moderne au Viêt Nam, sur la base de discussions structurées avec les responsables de la mise en œuvre des programmes et d'entrevues avec les femmes qui utilisent ou qui pourraient utiliser la pilule, révèle une promotion minimale et une faible demande de la méthode. De nombreux responsables des programmes voient dans le stérilet une méthode généralement mieux adaptée et sont mal informés au sujet de la pilule. Beaucoup croient, par exemple, que la prise de la pilule doit être interrompue pendant un ou deux cycles par an pour permettre le rétablissement de l'équilibre hormonal de la femme. Ils estiment de plus, pour la plupart, que les femmes des milieux ruraux oublieraient probablement de prendre chaque jour leur pilule. Par contre, la plupart des utilisatrices actuelles ou passées ont déclaré n'avoir pas éprouvé de difficulté majeure à ce niveau. L'information inadéquate et les attitudes négatives des responsables de la mise en œuvre des programmes vis-à-vis de la pilule trouvent leur origine dans la structure du programme de planification familiale et dans les présomptions fondamentales de la politique démographique du Viêt Nam.