# CONTRACEPTIVE USE PATTERNS IN CENTRAL COAST AREA OF VIETNAM

DOAN DUC LUU



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Thesis

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**CONTRACEPTIVE USE PATTERNS IN CENTRAL COAST AREA OF VIETNAM**

---

Doan Duc Luu
Candidate

---

Kritaya Archavanitkul, Ph.D.
Major Advisor

---

Sairudee Vorakitphokatorn, Ph.D.
Co-advisor

---

Monthree Chulasamaya, M.D., Ph.D.
Dean
Faculty of Graduate Studies

---

Bencha Yoddumnern-Attig, Ph.D.
Chairman
Master of Arts Program
in Population and Family
Planning Research
Institute for Population
and Social Research

Thesis

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on

7 AUGUST, 1995

Doan Duc Luu
Candidate

Kritaya Archavanitkul, Ph.D.
Chairman

Sairudee Vorakitphokatorn, Ph.D.
Member

Pramote Prasartkul, Ph.D.
Member

Monthree Chulasamaya, M.D.,Ph.D.
Dean
Faculty of Graduate Studies

Aphichat Chamratrithirong,Ph.D.
Director
Institute for Population and
Social Research

# BIOGRAPHY

| | |
|---|---|
| **Name** | DOAN DUC LUU |
| **Date of birth** | 28 November, 1957 |
| **Place of birth** | Hanoi, Viet Nam |
| **Institutions attended** | Bachelor of Arts (B.A)<br>Hanoi Foreign Languages<br>Institute, Viet Nam<br>1976-1980<br>Certificate of English<br>University of Canberra<br>Australia<br>Feb - Dec, 1992 |
| **Funding Agency** | AIDAB (Australian International<br>Development Bureau) |
| **Position** | International Relations Officer<br>The National Committee for<br>Population and Family Planning<br>(NCPFP), Hanoi, Viet Nam |

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Name Doan Duc Luu

Degree Master of Arts
(Population and Family Planning Research)

Thesis Supervisory Committee
Kritaya Archavanitkul Ph.D.
Sairudee Vorakitphokatorn Ph.D.

Date of Graduation 7 AUGUST B.E. 2538 (1995)

## ABSTRACT

The aim of this study is to investigate factors affecting family planning behavior among married women of reproductive age in the central coast areas of Vietnam namely Thua Thien Hue, Quang nam-Danang, Phu Yen and Khanh Hoa provinces. Special effort is paid to analyse differences between urban and rural areas relating to contraceptive use patterns. The study uses the secondary data collected by a research unit of the National Committee for Population and Family planning (NCPFP) in 1992. There were all together 3923 respondents in the survey who were married women in the reproductive age 15-49.

The major findings show that there is a positive relationship between contraceptive use and socio-demographic and psychological factors such as age, age at first marriage, number of living children, duration of marriage, and education of both husbands and wives. The data of this survey reconfirms that urban women's knowledge of contraception is higher than that of rural women. Vietnamese women's knowledge of contraception is relatively high although both the average number of living children (2.92) and the average desired number of children (3.15) are still higher than the government target (1-2 children).

The results of the study also reveal that the IUD is still the most popular contraceptive method followed by traditional methods such as rhythm and withdrawal. Other effective methods such as pill, condom, male and female sterilization have a low acceptance rate among users despite the fact that this trend is increasing. Generally, contraceptive use is higher in urban areas than rural one.

With regard to the psychological perspectives, this study finds that son preference is very strong. In addition, the child value in family, especially the strong expectation of residents to live with their sons when they become elderly very high in Vietnam. This performance is much more clear in rural areas than in the urban areas.

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# CHAPTER I

## BACKGROUND INFORMATION

### 1.1 RATIONALE AND JUSTIFICATION

The Socialist Republic of Viet Nam is a tropical country in southeast Asia bordered in the east by the Pacific Ocean, in the north by China and in the west by Laos and Cambodia. with a population 72 million in 1994, Viet Nam is the second most populous country in southeast Asia after Indonesia. With over 900 people per sq. km. of agricultural land, the country is one of the most densely populated countries in the region. Eighty per cent of the population has concentrated in the plains which account for only 30 per cent of the total land area, located between the two fertile deltas of the Red River, in the north, and the Mekong River delta, in the south. The delta areas are separated by almost 900 kilometers of central highlands and narrow coastal plains. About 80 percent of Viet Nam is mountains, high plateaus, and jungles. These areas are of little agricultural productivity. The rice producing deltas provide the bulk of food for the population . Viet Nam is geographically diversified; it includes tropical rain forests, fertile agricultural plains, and forest-clad hills and mountains. The climate is tropical all the year round in the south, and sub-tropical in the north where the winters are cool and dry, and the summers hot and humid.

Viet Nam has an area of about 330,000 square kilometers and is shaped like an extended "S". The middle section of the country is only 60 kilometers wide, the total length of the country is more than 2000 kilometers.

Viet Nam houses about 60 ethnic groups, many of whom live in isolated, difficult to reach mountainous areas. The main ethnic group is the Kinh, who accounts for 87 percent of the population.

Administratively, Viet Nam is divided into 53 provinces. Each province is governed by a People's Committee. The province level units are further divided into approximately 500 districts and these are subdivided into over 8,000 communes, with population groups ranging from 2,000 to 10,000 people. Hanoi, the capital of the country, dominates economic and political life in the north; Ho Chi Minh City, formerly called Saigon, is an important economic pole in the south of Viet Nam.

Viet Nam has a very young population like many other developing countries. The proportion of children under 5 and 15 years of age is 14 % and 39 % of the total population (Central Census Steering Committee, Viet Nam Population Census, 1989). The total fertility rate is 3.8 and the crude birth rate between 31-32 per thousand, giving a population growth rate between 2.2 - 2.4 % per annum. Life expectancy at birth was 67.5 for females and 63 for males. The country is currently classified as among those

having the lowest GNP per capita in the world (estimated at USD 200 per year)(UNDP - 1990).

The government policy to control rapid population growth was first articulated in Viet Nam in the early 1960s. The Government has repeatedly expressed its commitment to reducing the rate of population growth, but has relied on voluntary family planning to attain this objective.

Viet Nam's family planning policy encourages a norm of small families i.e. "each family should have only one or two children, children should be spaced 3-5 years, married women should give birth only at age 22 or later". (Minister's Council Decision, 1988). The long term objective of the population and family planning programme in Viet Nam is : "to achieve a small and healthy family to bring about a happy and prosperous life". (Strategy on population and family planning up to the year 2000), 1993.

Compared with other countries in the region such as Thailand, Indonesia and South Korea, the progress of the family planning programme in Viet Nam has been limited due to the low awareness of contraceptive users, limited availability of contraceptives, and poor service quality. However, socio-psychological factors should be explored to analyze the root of the problem. One major problem concerns the various socio-demographic and cultural factors related to a married couple's decision of

whether or not to adopt birth control. This research looks into the relationship of socio-demographic and cultural factors related to family planning behavior of married women in reproductive age. Of particular interest to this study is the differences of contraceptive use among urban and rural populations. This is a very important aspect for Viet Nam where the population in rural areas accounts for over 80 percent of the total population. This is also the top priority given by the Government of Viet Nam.

## 1.2 OBJECTIVES OF THE STUDY

1. To describe knowledge, attitude and practice of contraceptive use as well as some psychological perspectives relating to desired children of married women in reproductive age in surveyed areas.

2. To examine the relationship between socio-demographic and psychological factors (age, age at marriage, number of living children, education) and contraceptive use, and analyze the difference between urban and rural areas.

# CHAPTER 2

## LITERATURE REVIEW

Fertility is the actual performance of a population in bearing children.This complex phenomenon is determined by a multiple of different factors. Due to its significant role in the process of population growth, social scientists of diversified fields have been investigating these factors. Davis, et al. (1965) first identified what they named intermediate fertility variables, which are the direct fertility determinants. These variables were later quantified by Bongaarts (1982). The complexity of fertility further involved researchers from other fields such as sociology, psychology and anthropology who took particular interests in identifying social, psychological and cultural dimensions related to family planning behaviour.

Fertility rates reflect the sum of births in a population. The occurrence of these events depends on biological, demographic and socio-economic factors, many of which vary between regions and over time. John Bongaarts has identified four primary variables that he named "proximate determinants". These explain most biological differences in fertility levels. The variables are: age at marriage and proportions of women who are married, length of breast-feeding, abortion and contraception. The contribution of

each of these variables to fertility may be observed as a result of their interaction with non-proximate determinants (Population Reference Bureau, 1986).

The proximate determinants of fertility are the biological and behavioral factors through which social, economic and environmental variables affect fertility. The principal characteristic of a proximate determinant is its direct influence on fertility. Some of the conspicuous proximate determinants observed by Bongaarts are : marriage and marital disruption, on set of permanent sterility, postpartum infecundability, natural fecundability, use and effectiveness of contraception, spontaneous intrauterine mortality, induced abortion (Bongaarts and Potter, 1983).

The rapid population growth in Viet Nam is a major obstacle to the socio-economic development and improvement of the living standard of the population. Surveys of many developing countries including Viet Nam revealed that contraceptive use is influenced by a variety of socio-demographic and behavior factors such as age, education, occupation, work status, number of living children, desire for additional children, knowledge of contraceptive methods, exposure to mass media and others (United Nations, 1981; Morris et al, 1981; Kamnuansilpa and Chamratrithirong, 1982; 1985). The Demographic and Health Survey (DHS) 1988 in Viet Nam revealed that there was a significant

difference in the rate of contraceptive prevalence as well as family planning knowledge, attitude and practice (KAP) between areas. It may be due to the difference in socio-economic environments, institutional support for contraception acceptance or the effectiveness of health and family planning workers. The differences in contraceptive prevalence rates between rural-urban areas relate to the population growth rate and to inadequate and ineffective health service delivery efforts and the lack of IEC activities. As long as this situation remains, there will be significant differences in contraceptive practice between rural and urban areas.

This following chapter will look into variables such as rural and urban residence and fertility, age, age at marriage, duration of marriage, number of living children, education, attitudes towards sons and daughters.

## 2.1 SOCIO-DEMOGRAPHIC FACTORS

### 2.1.1 Rural and urban residence and fertility

Numerous studies have been conducted on fertility differentials according to place of residence. It was found that the fertility of those residing in cities was lower than that of rural residents; and these differentials were more or less stable. However, when national birth rates declined these fertility differentials widened in the more pronounced manner among urban upper classes than among others. Rural-urban differences narrowed

down again when birth rates rose after the Second World War. In the United States, the difference between rural and urban fertility was more or less constant between 1920 and 1940. Since 1940, however, this gap between the two narrowed. According to the 1970 census of the United States, the number of children ever born per one thousand ever married women between the ages of 35 and 39 (that is, those who had almost completed their fertility period) was 2,929, 2,990, 3,114, 3,265 and 3,584 in the central cities, urban fringes, other urban areas, rural non-farm areas and rural farm areas respectively. In many European countries, especially in eastern and southern Europe, rural urban fertility differentials continued to manifest themselves even around 1970, although the gap was found to be narrowing. It is expected that in developed countries, these fertility differentials would eventually disappear as the forces of modernization impose increasing homogeneity upon rural and urban areas, and the rural population becomes more urbanized in terms of its attitudes and life style.

Many researchers studied the fertility behaviour of women in metropolitan areas having different residential backgrounds. Implicit in such studies was the expectation that rural migrants to these metropolitan areas would continue to have high fertility values as "a carry over" from rural areas. Such studies have added a new dimension to the study of rural-urban fertility differentials. Many have clearly indicated that, in metropolitan areas, fertility differentials should be studied not only on the

basis of migration status but also on that of the former residence of the migrants. In a Fertility and Family Planning Study conducted in Greater Bombay in 1966, it was found that migrant women with a rural residential background had the highest average number of children ever born (3.42) in comparison with migrant women having urban residential background (2.90) and non-migrant women (3.00). (Principles of Population Studies, A. Bhende and Kanitkar, 1991).

### 2.1.2 Age and duration of marriage

The age at which women marry is an important variable in population growth as marriage often represents the socially sanctioned initiation of sexual activity and childbearing for women. For men, in addition to assuring convenient access to sexual relations, marriage constitutes a commitment to support the children born as a result of sexual activity. Therefore, it is not surprising to find that early marriage is associated with high fertility and late marriage with low fertility. The age at onset of childbearing has a strong impact on fertility rate for a country. Postponement of first birth has already made a large contribution to the overall fertility decline in many parts of the world. A major health and social concern is the high adolescent fertility generally has adverse effects on the health of teen-age mothers and their infants. Furthermore, early motherhood is often related to higher subsequent fertility. Late marriage encourages women to make decisions about childbearing. It is found in many studies that there is a positive relationship between the increase of age and

number of sterilization acceptors (Warsito, 1983. United Nations, 1988).

In Viet Nam, the Marriage and Family Law of 1960 stipulated that the minimum legal age at marriage was 18 for women and 20 for men. Viet Nam's family planning programme in 1982 as in prior years emphasized late marriage, late first birth, and late second birth, known as the " Three Lates ".

Studies investigating the duration of marriage of women (Chang, et,al.1981) realized that the most women who wanted no more children had been married for ten years of marriage and had already the number of children they desired. On the other hand, women with longer duration of marriage duration, generally desired larger families size than those who married for short time. Sun (1978) in a study related to family size in Taiwan during 1961-1976 indicated that marriage duration affects the number of children desired. The results of his survey show different marriage duration for each group of women. For example, the average desired family size of women who had been married for less than five years was 2.6; of women who had five to nine years of marriage 3.1 while for women who had been married for over ten years the desired family size was 3.3. The data indicates that women who had longer marriage duration had larger family than those who had shorter marriage duration.

### 2.1.3 Number of living children

Mitra et al. (Bangladesh Contraceptive Prevalence Survey, 1985) stated that users of modern permanent method formed higher parity groups than women using modern temporary methods. The number of living children determines contraceptive practice. There is a positive relationship between the number of living children and contraceptive prevalence practice. Those who do not want more children are more likely to choose reliable methods (Sumapradja, 1982; Chamratrithirong et al., 1987).

### 2.1.4 Education

Many studies such as in El Salvador, England and the Philippines (Fergusson and McCann, 1976) showed a positive relationship between education and contraceptive prevalence. Educational attainment is a well established indicator of socio-economic status of women (Curtin, 1982) and an important factor affecting decline in fertility (Caldwell, 1982). Studies in several countries (Bhatia, 1979. Curtin, 1982. Sathar, 1988) have also shown that fertility and family planning are influenced by women's education. It is expected that the educated women marry later, show more responsibility for the welfare of their children, discuss problems more freely than uneducated women. The relationship between education and fertility is one of the most clear cut relationships found in fertility studies. The theory of the demographic transition has assigned causal significance to the role of education in the formation of attitudes towards small family

size norms and the practice of contraception (Oni, 1985).

Sadik (1989) observed that in almost every country studied in recent years, educated women have been found to have fewer children. Srinivasan (1978) studied opinions about family size of respondents from India and found that desired family size decreases among husbands who had high school or university education, but remains the same among those with less education.

A positive association between levels of education and contraceptive prevalence has been noted in Thailand and elsewhere (Knodel and Debavalya, 1978). The most educated women might be expected to use the most effective methods, but may be the group most aware of potential side effects of the pill, IUD, and/or injectable (Chamratrithirong, et al.1986).

It is expected that educated women will use contraceptives for a longer period than uneducated wives (Knodel, 1978). Westoff, et al. (1968) studied couples in the United States from 1960-65, they found that the continuation rates of highly educated women were higher than those of less educated women. The opposite results showed in the study on determinants and contraceptive use patterns in Thailand (Leoprapai and Thongthai, 1989). The relation between current contraceptive use and education of women was demonstrated to be curvilinear.

In brief, studies both in Viet Nam as well as abroad have shown that contraceptive use is influenced by many socio-demographic and behavioral factors such as age of women, age of first at marriage, duration of marriage, number of living children, desired number of children, cultural, occupation, and income. The most important factors discussed above include age of respondents, age of marriage, duration of marriage, and education levels.

## 2.2 KNOWLEDGE OF CONTRACEPTIVE METHODS AND USE EFFECTS

Success or failure in family planning is dependent on how much one knows about family planning methods. This means that unless a woman knows about the various methods available in family planning, it is unlikely that she will practice family planning. On the other hand, it cannot be assumed that awareness of family planning will necessarily guarantee that she will accept its use. Knowledge of outlets is correlated with the type of contraceptive use. Women who know about the outlets are less likely to use traditional methods (Pebley and Brackett, 1982); Tsui, 1982, Entwisle et al, 1984.

The Contraceptive Prevalence Survey in the Philippines in 1986 demonstrated that there is still a big gap between the level of family planning knowledge, attitudes (both workers and clients) and level of practice. While the level of awareness became almost universal even as early as 1983, the contraceptive prevalence rate

was only 44 % for the period mid-1986 to mid-1987. Evidence from the contraceptive prevalence survey in Thailand (1979) showed that 97 % of rural women and 98 % of urban women knew at least one contraceptive method. The mean number of known contraceptive method is clearly the pill (International Family planning Perspective, 1980).

The Viet Nam Demographic and Health Survey in 1988 showed that knowledge of at least some methods of contraception is very high among married Vietnamese women in the reproductive age. Almost 94 % of both ever-married and currently married women are aware of at least one modern contraceptive method. Knowledge of IUD is very widespread, followed by abortion, female sterilization, male sterilization and menstrual regulation. Less than half of the women know about the pill or condoms, and a similar number of rhythm and withdrawal. There are, however important differentials. Urban, educated women are more aware of modern methods than rural, illiterate women. There are also important regional differences among women in the south being more aware of the pill, condoms, and female and male sterilization than women in the north. There are also significant differences concerning knowledge of these methods depending upon education level.

The comprehensive knowledge and understanding of what and how different socio-demographic and behavioral factors affect the decision of individuals and couples to accept contraceptive use.

## 2.3 PSYCHOLOGICAL FACTORS

### 2.3.1 Sex preference

Cultural background may influence attitudes towards fertility and acceptability of certain methods of contraception (Reid, 1985). Goode (1963) pointed out that the significance of sons as a variable in determining contraceptive use. In India, Proffecberger, et al. (1968) studied 1395 IUD acceptors in nine New Dehli multiple clinic and found that the preference for sons in Indian culture was an important obstacle to family size limitation. The couples were unwilling to adopt family planning until they had at least two living sons. It was the number of children which had more effect on the desire for additional children and family planning practice rather than the sex of living children. Most Thai couples prefer to have at least one child of each sex. Kamnuansilpa et al. (1982) revealed that contraceptive use was quite high among women with 3 children, even among those whose children were all of the same sex.

Viet Nam is a country that is suffering from centuries of feudal customs and traditional practices that affect family planning behavior. Although the government has adopted appropriate policies such as motivating the masses to practice family planning and decreeing equal status for women, these customs and practices could not be altered overnight. While behavior may be temporarily changed, values, norms and attitudes remain. Thus many Vietnamese still hold onto pro-natalist ideas such as "the elephant has been born to the earth, the earth has to give grass to it". Son

preference still persists, particularly in rural areas with deep-rooted belief such as "one son is worth 10 daughters". Many women who have more than two daughters but no son still want to have a son thereby hampering the goal of population growth reduction.

The VNDHS 1988 indicates that one of the reasons for increased population size is the fertility behavior of the Vietnamese, especially those in rural areas. Couples who live in rural areas always wish to have a large number of children with at least one son. A survey conducted by the Institute of Social Sciences in 1990 noticed that when women in some provinces were asked how many children they wanted. 52 % wanted 3 children with at least one son. A son is very important to the Vietnamese, and some couples continue their fertility until they have a son (Doan Kim Thang, 1985).

Most of the studies showed that contraceptive use is influenced by many socio-demographic and psychological factors. It also confirmed that women's educational attainment is positively related to the use of contraception. Knowledge and attitudes regarding contraception are other factors which have positive effects on the use of contraception.

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3.1 SOURCE OF DATA

This study is based on secondary data received from research conducted in 1992 in the central coast areas of Vietnam including Thua Thien Hue, Quang Nam-Danang, Phu Yen and Khanh Hoa provinces by the research unit of the National Committee for Population and Family planning (NCPFP), (see map on appendix).

The sampling procedure used a multi-stage probability technique. Forty five communes which comprised 4500 households were selected, of which 3888 households had eligible respondents i.e. ever or currently married women in the reproductive age 15-49. There were 3923 respondents.

## 3.2 RESEARCH INSTRUMENT

A standard questionnaire was used for the collection of the data. The questionnaire consisted of three parts, i.e. regional economic, cultural and health conditions, household and individual investigation.

The individual questionnaire was the main survey tool, which included questions about date of birth, marital status, educational level, number of living children, reasons for"son preference", attitudes of respondents' husbands and parents towards having sons, knowledge of common contraceptive methods, and reasons

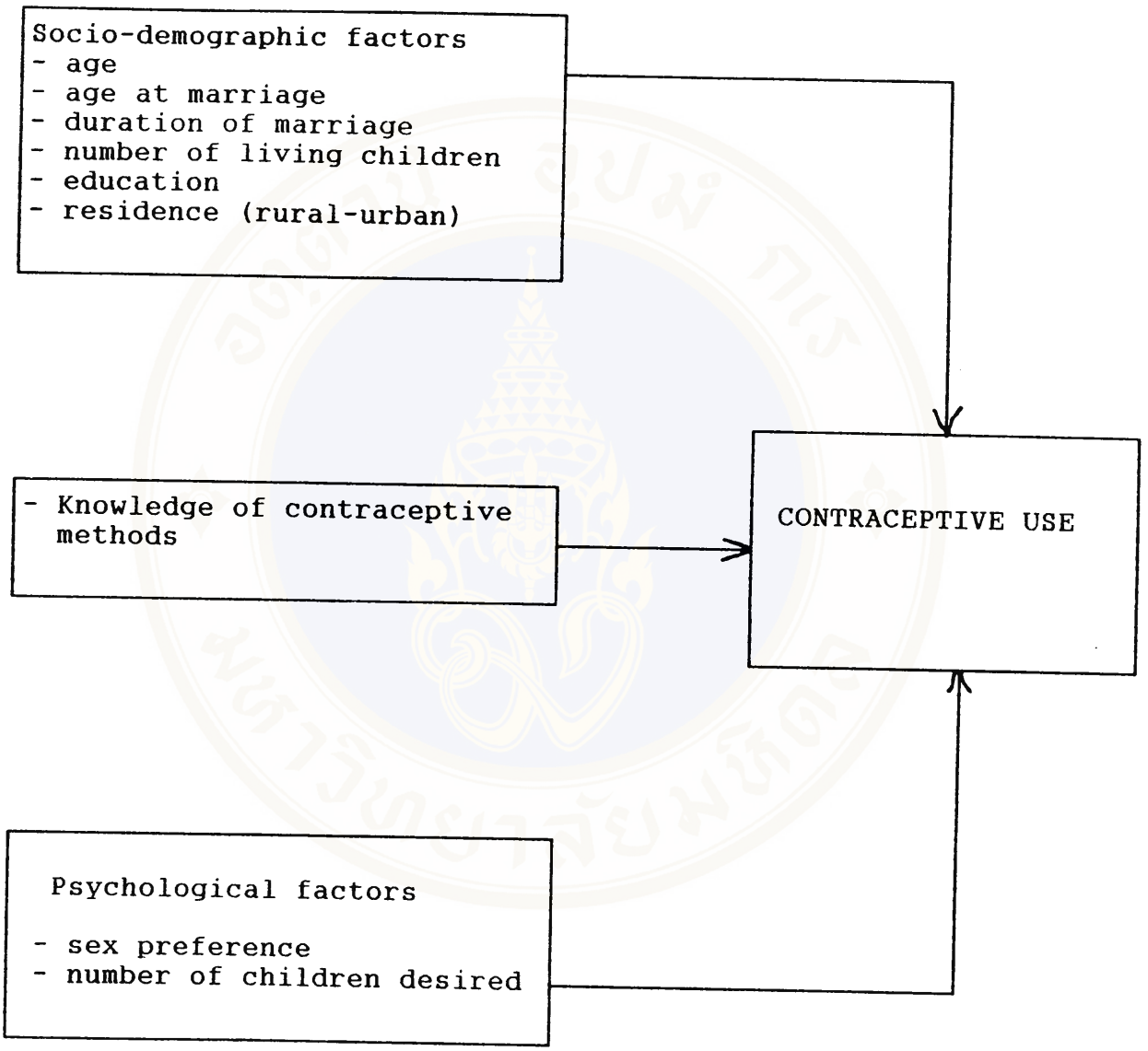
of not using contraceptives. The individual questionnaire was used to collect information on knowledge, attitudes and practice regarding family planning, and data required to understand the relationship between socio-economic and cultural variables and family planning behavior.

### 3.3 PRESENTATION OF CONCEPTUAL FRAMEWORK

There are several factors influencing contraceptive use such as age, education, work status, number of living children, and number of additional children wanted. This study attempts to determine the relationship between selected socio-demographic and psychological factors and contraceptive use, with a particular focus on differences between urban and rural areas.

Independent variables

Dependent variable




All independent and dependent variables will be analyzed according to urban and rural areas. Urban and rural variable is used here as the control variable to compare differences of the contraceptive use pattern between urban and rural areas.

### 3.4 RESEARCH HYPOTHESES

There will be differences between urban and rural areas regarding knowledge, attitude, and practice of contraceptive use.

Socio-demographic factors are related with contraceptive use (both in rural and urban areas).

Knowledge of contraception has a relationship with contraceptive use (both in rural and urban areas).

Psychological factors have influence on contraceptive use.

There will be differences in psychological perspectives between urban and rural areas in relation to contraceptive use.

### 3.5 OPERATIONAL DEFINITION OF TERMS

Socio-demographic and psychological factors are measured in this study by age, duration of marriage, number of living children, education, and sex preference.

**Age** : Age is divided into 7 groups, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49.

**Education** : The level of education is classified into 5

groups, primary, secondary, high school, vocational, University and post university.

**Family planning behavior** : Activities of couples to limit or space births who may be users or non-users of contraceptive methods. Currently using : utilizing a contraceptive method at present. Ever using : used a method before but may be discontinued (drop out) or currently using now. Never using : have never used a method.

**Married women** : currently married women aged 15-49 years, living with spouse.

Psychological factors are the psychological conditions of wife and husband which include total number of children desired, sex preference.

**Urban/ rural population definition:** In the 1989 census, the urban population had been calculated according to the temporary regulation of the Government. Urban areas included quarters inside the city and counties inside the provincial town. District towns to be classified as urban areas should satisfy the following criteria:

A population should be 2,000 persons or more;

persons working in non-agricultural sectors should make up 50% or more of the population.

A district town should be an administrative or industrial center of the district.

### 3.6 DATA ANALYSIS AND MANAGEMENT

The collected data was analyzed by using the SPSS/PC statistical software package. The data has been described by a simple frequency distribution of the sample and analyzed by tests of significance (Chi-square test is used to examine the relationship between variables). Tables were used to summarize, classify and tabulate the findings of the study.

### 3.7 LIMITATION OF STUDY

Because it is based on secondary data, this study is confined within the boundaries of the questionnaire and questions previously asked.

# CHAPTER 4

## RESULTS AND INTERPRETATION

### 4.1 Background Characteristics of the Surveyed women :

#### 4.1.1 Socio-demographic profile.

Table 1: Percentage distribution of ever-married women according to selected characteristics.

| Selected characteristics | Urban (%) | Rural (%) | Total (%) |
|---|---|---|---|
| Age of respondent | | | |
| 15-19 | .9 | 2.1 | 1.8 |
| 20-24 | 10.7 | 14.5 | 13.5 |
| 25-29 | 20.7 | 20.1 | 20.3 |
| 30-34 | 24.1 | 19.6 | 20.8 |
| 35-39 | 16.2 | 21.1 | 19.8 |
| 40-44 | 16.3 | 13.0 | 13.9 |
| 45-49 | 11.1 | 9.4 | 9.9 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1029 | 2894 | 3923 |
| Mean | 33.88 | 32.97 | 33.21 |

Chi-square: 39.19948 DF: 6 Significance: .00000

**Age at first marriage**

| | | | |
|---|---|---|---|
| <19 | 8.9 | 14.6 | 13.1 |
| 19-21 | 36.4 | 44.3 | 42.2 |
| 22-24 | 28.6 | 25.7 | 26.4 |
| 25-29 | 22.2 | 12.8 | 15.3 |
| >=30 | 4.0 | 2.6 | 3.0 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1028 | 2890 | 3918 |
| Mean | 22.47 | 21.39 | 21.67 |

Chi-square: 81.30123 DF: 4 Significance: .00000

**Duration of marriage**

| | | | |
|---|---|---|---|
| <=5 | 28.7 | 28.8 | 28.8 |
| 6-10 | 22.5 | 20.2 | 20.8 |
| 11-15 | 19.4 | 19.8 | 19.7 |
| 16-20 | 12.7 | 14.3 | 13.9 |
| >20 | 16.7 | 16.9 | 16.9 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1027 | 2885 | 3912 |
| Mean | 11.41 | 11.62 | 11.56 |

Chi-square: 3.35913 DF: 4 Significance: .49962

**Number of living children**

| | | | |
|---|---|---|---|
| 0-1 | 27.3 | 26.5 | 26.7 |
| 2 | 26.8 | 20.2 | 21.9 |
| 3 | 17.5 | 17.9 | 17.8 |
| 4 | 12.6 | 15.2 | 14.5 |
| 5 + | 15.7 | 20.2 | 19.1 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1029 | 2894 | 3923 |
| Mean | 2.74 | 2.98 | 2.92 |

Chi-square: 27.00775 DF: 4 Significance: .00002

| Education level | | | |
|---|---|---|---|
| Primary | 3.2 | 10.2 | 8.3 |
| Secondary | 27.4 | 47.9 | 42.5 |
| High school | 31.6 | 28.9 | 29.6 |
| Vocational | 28.4 | 10.0 | 14.8 |
| Uni. & Post | 9.4 | 3.1 | 4.8 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1029 | 2894 | 3923 |

Chi-square: 335.41691 DF: 4 Significance: .00000

| Education of husband | | | |
|---|---|---|---|
| Primary | 1.0 | 2.0 | 1.7 |
| Secondary | 15.3 | 35.1 | 29.9 |
| High school | 27.6 | 36.2 | 33.9 |
| Vocational | 39.1 | 21.9 | 26.4 |
| Uni. and Post. | 17.0 | 4.9 | 8.1 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1003 | 2815 | 3818 |

Chi-square: 335.67906 DF: 4 Significance: .00000

Table 1 shows a general picture of respondents' socio-demographic characteristics. There were 3923 married women in reproductive age of which 26.23 % are urban dwellers and 73.77 % are rural dwellers. The selected background characteristics discussed include age group, age at marriage, number of living children, duration of marriage and level of education achieved for both husbands and wives.

The first part of Table 1 shows the percent distribution of interviewed women by age group. Nearly half of the respondents belong to the age group 25-34 where reproduction mostly occurs. The age group 15-19 is relatively small, reflecting the fact that the proportion of married women among age group 15-19 is very low (only 1,8 %). The mean age of respondents is 34 in urban and 33 in the rural.

Age at marriage is very important as it usually marks the start of reproduction. In this survey, the mean age at marriage is 21.67, similar to the census conducted in 1989. Over half of the interviewed respondents (68.6 %) married at age 19-24. Moreover, we also realized that 13.1 % of respondents married under the age of 19. In rural areas, age at marriage is younger than in urban areas. The data shows that early marriage is still prevalent, especially in rural areas.

When comparing rural and urban areas we learnt that the percentage of married women under 22 was higher in rural areas while more married women married above 22 years of age are in urban areas. Parents in the countryside may want their children to get married early to have more labourers.

Duration of marriage : The majority of women respondents of this survey (28.8 %) were married for less than 6 years. There was no significant difference between the percentage of married women by duration of marriage between rural and urban areas.

Number of living children : 48.6 % of the respondents had less than 3 children, and more than half of the interviewed women 51.4 % aged 15-49 had 3 + children. The women having 4 + children remains high at 33,6 % . When compared with DHS/1988, these percentages were 46.86, 53.14, and 34.56 % respectively. There was no considerable difference between these two surveys, a trend of having many children still dominates. The percentage of women who have 4+ children in rural areas (35.4%) is higher when compared to urban women (28.3%). This suggests that the fertility level in general and in the central part of Vietnam in particular is high. The mean number of living children is 2.92 which indicated that the government's target of each couple having no more than 2 children will be difficult to achieve if the family planning programme is not significantly strengthened, and mainly oriented towards the rural areas.

The level of education of the ever-married women aged 15-49 indicates that the overall literacy rate for Vietnamese women is relatively high. Almost half of respondents (42.5 %) had a secondary school education, only 8.3 % of total respondents had a primary educational level.

When comparing the education level of urban and rural areas, we realized that about 70% of women in urban areas obtained secondary school education or higher while this percentage is 42 % in rural areas. Compared with other developing countries in the

same region, the literacy level of the Vietnamese women is higher which should impact positively on family planning behavior. This may be explained by the fact that Vietnam used to have a socialist system during which the Government paid much attention and subsidized education and health systems.

The education of husbands show that the majority had education levels of secondary school or more. Compare education level of husbands and wives, we see that the husbands' education levels are generally higher than that of their wives. This is also a general trend for the whole country.

### 4.1.2 Knowledge, attitude and practice of family planning.

The knowledge of contraceptive methods among the respondents was assessed by using the interviewed questionnaire which consisted of different types of contraceptive methods. Contraceptive knowledge is defined in the survey as having "heard of" a family planning method.

**Table 2: Percent of ever heard of each contraceptive method by urban and rural areas.**

| Contraceptive methods* | Urban | Rural | Total |
|---|---|---|---|
| 1. IUD | 94.8 | 92.6 | 93.0 |
| 2. Female sterilization | 74.0 | 53.2 | 66.0 |
| 3. Pill | 73.0 | 62.2 | 64.6 |
| 4. Abortion | 70.5 | 57.6 | 60.8 |
| 5. Condom | 76.8 | 53.3 | 59.1 |
| 6. Rhythm | 68.5 | 49.9 | 57.2 |
| 7. Male sterilization | 67.8 | 63.3 | 56.7 |
| 8. Withdrawal | 67.1 | 49.9 | 54.3 |
| 9. Menstrual regulation | 65.2 | 46.4 | 51.2 |

* Multiple responses are allowed.

Table 2 shows that the majority of women respondents had heard of contraceptive methods. This percentage was especially high for the IUD: 93.0% ( rural: 92.6%; urban 94.8%). For some years senior programme officials have considered the IUD to be the main method of contraception. Targets have been set for IUD insertion, and incentives and other bonuses have been applied for both users and providers (Knowledge and attitudes of Grassroots

Family Planning Workers about Contraceptive Methods; Economic and Social Commission for Asia and the Pacific, Bangkok, 1989). The result is that today rural people seem to regard family planning as synonymous with the IUD. In fact, for years a number of medical institutions, especially on district levels had only the IUD available.

Table 2 also shows two tendencies, that knowledge over 60% includes the IUD, pill, Female sterilization and abortion, and that knowledge less than 60% includes the condom, MS, and withdrawal. This difference can be explained by the fact that condoms are not given due consideration by some senior family planning officials because they doubt their effectiveness and consider them a difficult method to popularize in rural areas. (Knowledge and attitudes of Grassroots Family Planning Workers about Contraceptive Methods; Economic and Social Commission for Asia and the Pacific, Bangkok, 1989). Therefore, IEC activities have not concentrated on this method, which has resulted in limited knowledge of these methods.

A comparison between urban and rural areas shows that contraceptive knowledge of urban women is generally higher than rural women. Up to 50% of women in rural areas did not know about condoms and male sterilization, while this applies only 23% and 32% for urban women. The difference may be due to the fact that urban people have higher education level than rural people, so it

is easier for them to get information about contraceptives than rural people. Urban people might have better access to mass media, such as IEC campaigns on population and family planning.

Compared to VN DHS 1988 as well as a 1993 family planning KAP survey, Vietnamese women's knowledge of contraceptive methods is rather high although contraceptive prevalence rate is still low when compared with some regional countries such as Thailand, Indonesia, and South Korea. This is because family planning behaviour depends on many other factors such as availability and accessibility of contraceptives, and service quality. It also takes time before knowledge affects practice.

Whenever a contraceptive use survey is conducted, contraceptive knowledge is investigated to see what is the extent of people's knowledge. It is said that in order to practice ( P ) something, one must get knowledge ( K ) because it is argued that knowledge may lead to a change of attitude ( A ). However, in the family planning behavior, the way from K to A and from A to P is not that simple.

Table 3: Percentage of contraceptive methods used among respondents by rural and urban areas.

| Methods* | Urban | Rural | Total |
|---|---|---|---|
| Percentage of ever used any contraceptive methods. | 77.9 | 63.3 | 67.2 |
| For each method : | | | |
| 1. IUD | 37.1 | 39.2 | 38.4 |
| 2. Pill | 4.5 | 3.0 | 3.3 |
| 3. Condom | 14.4 | 4.3 | 6.8 |
| 4. MS | 0.7 | .0 | 0.4 |
| 5. FS | 5.3 | 3.1 | 3.6 |
| 6. Rhythm | 30.8 | 19.6 | 22.2 |
| 7. Withdrawal | 23.1 | 18.5 | 19.4 |
| 8. Mens-regulation | 1.7 | 0.8 | 1.0 |
| 9. Abortion | 1.8 | 0.6 | 0.9 |

* Multiple responses are allowed.

Table 3 shows the distribution of contraceptive methods used in urban and rural areas. It should be stressed that one of the limitations of this survey was the use of indicator 'ever used any contraceptive method' but did not specify 'currently using'. This indicator was ambiguous in the sense that we did not know that the stated method was the latest one. We only know it was the previous one and a respondent might have used more than one method before. The total percent of all contraceptive methods would be higher than ever used any contraceptive method. This survey allowed respondents to reply more than one contraceptive methods as they ever used. Percentage of ever used any contraceptive methods

was 67.2 % which is rather high when compared with 1988 DHS (62.66%). As we look at each method, we realized that ever used percentage for the IUD was the highest. The family planning programme in Vietnam for many years had to depend on the IUD, and there was a time when people understood that family planning meant percentage of IUD insertion. In the last few years, efforts have been made to promote the "cafeteria approach" but this situation cannot be altered over night.

The percentage of individual using the pill or condom is relatively low. The pill has to be imported, some family planning officials believe that the pill is expensive and therefore not suitable for rural women, who constitute the majority of family planning users in the country. As a result, this increases the use of the IUD.

Other effective contraceptive methods include the tubectomy and vasectomy, female sterilization (3.6%) as compared to male sterilization (0.4 %) which are popular throughout the world, but are not very much in use in Viet Nam. This may explain that Vietnam suffers alot from feudal ideology, or poor knowledge about this method is a cause for a very low percentage of use, some people understood that male sterilization is like 'castration'.

Rhythm and withdrawal are the two traditional contraceptive methods which are considered ineffective methods. However, the percentage of use is still high (in this survey, this percent is 22,2 % and 19,4 % respectively). This is perhaps due to some reasons that either other contraceptive methods are not available, or psychologically, many people who may not like intervening methods.

When comparing ever used contraceptive methods between urban and rural areas, we see that this percentage in urban (77.9%) is higher than in rural areas (63.3%). Except for IUD usage which is higher in rural areas, the use of the remaining contraceptive methods is generally lower in rural areas when compared to urban ones.

**Table 4: Percentage of reasons to use contraceptive methods by urban and rural areas.**

| Reasons* | Urban | Rural | Total |
|---|---|---|---|
| 1. Easy to access | 10.1 | 12.7 | 11.9 |
| 2. Convenient | 52.1 | 53.4 | 53.0 |
| 3. Effective | 29.7 | 24.4 | 26.0 |
| 4. Not harmful to health | 23.0 | 19.6 | 20.6 |
| 5. Not reduction of happiness | 7.8 | 6.9 | 7.2 |
| Cases | 804 | 1860 | 2664 |

* Multiple responses are allowed.

The women practicing contraception have been interviewed about the reasons of choice to use methods. In this survey, the respondents could give multiple answers. Results of the survey show that among 2664 respondents who used any contraceptive methods, 53% of them replied that they chose to use contraceptive methods because of its convenience i.e. the use of such methods does not cause much side effect. 26% said to use them because contraceptive methods are effective, and 20.6% used contraceptives because they are not harmful to their health . More women in urban areas than rural places use contraceptives because of easy access and convenience reasons, while more women in urban than rural areas use contraceptives because they are considered effective, not harmful to their health and do not reduce their happiness.

Table 5: Percentage of reasons for not using contraception by urban and rural areas.

| Reasons* | Urban | Rural | Total |
|---|---|---|---|
| 1. Lack of information | 3.0 | 4.2 | 4.0 |
| 2. Not want to practice FP | 2.5 | 2.1 | 2.2 |
| 3. Disagreement of husband | 4.6 | 10.1 | 9.1 |
| 4. Disagreement of parents | 2.5 | 4.3 | 4.0 |
| 5. Want more children | 10.1 | 9.9 | 10.0 |
| 6. Religious reason | 1.3 | .7 | .8 |
| 7. Harmful to health | 13.9 | 26.5 | 24.3 |
| 8. Reducing of happiness | 5.1 | 5.0 | 5.0 |
| 9. Unavailability | 5.1 | 5.8 | 5.6 |
| 10. Others | 34.6 | 28.1 | 29.3 |
| Cases | 237 | 1109 | 1346 |

* Multiple responses are allowed.

For non-users of contraception, we concluded from the data that "afraid of being harmful to health" is the most common concern of non users (24.3%). The percentage for urban was 13.9 and rural was 26.5. Reasons may include lack of information or biased information about contraceptive methods. This could be overcome by improving IEC activities and providing more methods to users while taking care of side-effects cases which will help reduce rumors relating to this issue.

The next most common reason was that respondents wanted to have more children. The result of this survey also showed that the mean number of children desired is 3.15 which is greater than the government target (1-2 children). Parents, other relatives,

friends and especially husbands' disagreement had an impact on contraceptive use, particularly in rural areas. The data in the above table suggests that if any family planning programmes want to be successful, it must consider men as a specific target group for IEC activities. In Viet Nam, the percentage of Catholic followers was very small, therefore the religious reason only occupies a small percentage. Although other reasons constituted a high percentage, it is difficult to explain what they are. A limitation of this questionnaire includes not listing all reasons, so other reasons might include reasons not mentioned in the list.

In brief, this survey indicates that family planning knowledge of women in Viet Nam rather high. Ever used any contraceptive method in this survey is also higher than in previous surveys. The gap between knowledge and practice is still big, especially in rural areas. The difference between rural and urban areas in terms of knowledge and practice as well as other factors relating to contraceptive use can be explained mainly through the difference in education levels, living conditions and psychological factors. Those who live in rural areas are still affected by traditional factors more than people in urban areas. Therefore, different family planing activities should be targeted for each region.

### 4.1.3 Psychological perspective of respondents

Psychological factors have a great impact on family planning behavior. This survey also looks at psychological aspects relating to family planning behavior such as the number of children desired, with whom they want to live when they are old, and their attitude towards having not a son or daughter.

Table 6: Percent distribution of married women by number of children wanted by urban and rural areas.

| Number of children wanted | Urban | Rural | Total |
|---|---|---|---|
| **Number of children wanted** | | | |
| 0-1 | 1.8 | 1.5 | 1.6 |
| 2 | 53.3 | 31.4 | 37.2 |
| 3 | 13.3 | 20.7 | 18.8 |
| >=4 | 31.6 | 38.1 | 42.5 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1029 | 2894 | 3929 |
| Mean | 2.85 | 3.26 | 3.15 |
| Chi-square : 159.50888 | DF: 3 | Sig: | .00000 |
| **Number of sons wanted** | | | |
| 0 | 1.3 | .8 | .9 |
| 1 | 54.4 | 33.7 | 39.1 |
| 2 | 38.7 | 56.2 | 51.6 |
| >=3 | 5.6 | 9.4 | 8.4 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1029 | 2894 | 3923 |
| Mean | 1.52 | 1.77 | 1.71 |
| Chi-square : 143.20572 | DF: 3 | Sig: | .00000 |
| **Number of daughters wanted** | | | |
| 0 | 3.1 | 2.2 | 2.4 |
| 1 | 65.4 | 52.4 | 55.8 |
| 2 | 28.2 | 41.1 | 37.7 |
| >=3 | 3.3 | 4.4 | 4.1 |
| Total | 100.0 | 100.0 | 100.0 |
| Cases | 1029 | 2894 | 3923 |
| Mean | 1.33 | 1.49 | 1.45 |
| Chi-square : 60.97375 | DF: 3 | Sig: | .00000 |

The result of the study indicated that 38.8 % of respondents wish to have 1-2 children, 18.8 % want to have 3 children, and 42,5 % of respondents want to have over 3 children. This has reflected the fact that the fertility rate is still high in Viet Nam although this trend has been declining in the last decades. This is also a challenging towards the small norm family size from 1 to 2 children encouraged by the government as the wish of the people is still different from the target of the government.

When examining the number of sons wanted, we found that 40,0 % respondents wanted to have 1 son while 51,6 % wanted to have 2 sons. For daughters, this percentage is 55,8 % and 37,7% respectively. In Viet Nam, sex preference is still strong, especially in rural areas, due to the fact that traditionally, women who get married would follow their husbands while men remain with their families, taking care of their parents when they get old.

Over half of the women in urban areas wish to have 1-2 children while only one third of women in rural areas wish this. The percentage of women who wish to have 3+ children is higher in rural areas. 54.4% of urban women wish to have 1 son while 56.2 % of rural women wish to have 2 sons. The mean of number of children wanted is higher in rural areas. As mentioned above, feudal ideology still dominates in rural area. The life of the people in

rural areas is related to land, gardens and family, and they need to have more children, especially sons.

In this survey, a question was put to respondents to investigate the psychology relating to whom they would like to live with when they are elderly.

**Table 7: Percent distribution of a person respondents prefer to live with when old.**

| | Urban | Rural | Total |
|---|---|---|---|
| **Live with whom when old** | | | |
| - First son | 14.7 | 19.8 | 18.5 |
| - Son | 19.6 | 28.5 | 26.2 |
| - Daughter | 5.2 | 2.0 | 2.8 |
| - It depends | 55.1 | 46.4 | 48.6 |
| - Live seperatedly | 5.3 | 3.0 | 3.6 |
| - No answer | .2 | .3 | .3 |
| **Total** | 100.0 | 100.0 | 100.0 |
| **Cases** | 1028 | 2890 | 3918 |
| Chi-square : 83.72959 | DF: 5 | Sig: | .00000 |

The overall results (Table 7) show that up to 44.7% of respondents wanted to live with their sons (this percentage for urban is 34.3 and for rural is 48.3) while this percentage for daughters is only 2.8 % (Urban:5.2 and rural:2.0). The wish to live with sons in rural areas is greater than in urban one as people in the countryside are mainly involved in agriculture, and they would have to depend on their children for work. Aa stable

social security system for the elderly is not developed in Vietnam while in urban areas, however, government employees could enjoy modest pension when retired. This explains why the percentage of 'it depends' is higher in rural areas than urban areas. The preference to live with sons when becoming elderly is very strong in Vietnam, especially in rural areas.

**Table 8: Percentage distribution of reasons for number of children wanted by urban and rural areas.**

| Reasons* | Urban | Rural | Total |
|---|---|---|---|
| **Reason to prefer 1-2 children** | | | |
| 1. Conditions to bring up | 76.4 | 84.0 | 81.3 |
| 2. Not to reduce economy | 49.4 | 39.4 | 43.0 |
| 3. Care for mothers' heath | 32.1 | 37.0 | 35.2 |
| 4. To make the country prosperous | 4.1 | 8.3 | 6.6 |
| 5. Government appeal | 18.0 | 14.6 | 15.9 |
| 6. Others | 1.8 | 1.2 | 1.5 |
| Cases** | 611 | 1048 | 1659 |
| **Reasons to prefer more than 2 children.** | | | |
| 1. In case of a risk | 53.3 | 49.0 | 49.7 |
| 2. More laborers | 9.6 | 15.9 | 14.7 |
| 3. Depend on when old | 49.5 | 61.1 | 59.2 |
| 4. To get more land | .2 | .8 | .7 |
| 5. Others | 13.9 | 10.2 | 10.8 |
| Cases*** | 418 | 1846 | 2264 |

* Multiple responses are allowed.
** Number of respondents who prefer to have 1-2 children.
*** Number of respondents who prefer to have more than 1-2 children.

Table 8 presents the reasons why people prefer a small norm family (1-2 children). The first reason (to have better conditions to take care of their children) accounts for 81.3 %. This indicates that those who accept a small norm family would like to pay more attention to the quality of life of their children, which is in line with the ultimate purpose of the national family planning programme "to have less for better".

A surprising finding is that more rural women prefer to have 1-2 children for the reason 'better conditions to bring up'. This may reflect that parents in rural areas wish to provide better lives in the future for their children, not only consider them as economic units.

The second most common reason is related to the cost of raising a child. It is clear that when a couple pays attention to the value of a child then they take into consideration of the cost of raising a child. This percentage is higher in urban than rural areas because the cost of bringing up children in an urban area is much higher than in rural area. The third most common reason to accept a small norm family relates to protecting a mother's health (35.2 %) which showed that maternal health was given consideration. It was interesting to note that the percentage of respondents who wanted to make the country more prosperous accounts for very little (only 6.6 %), which shows that people only practise family planning

for their personal benefit.

Regarding the reasons why people want to have more than 2 children, Table 8 shows that the first most common reason is "depending on when becoming old"(59.2%). This reflects the fact that a majority of people especially those who live in the countryside have to depend economically on their children when they are elderly. This suggests that if any family planning programme wants to be successful, there should be policies which protect and support the elderly.

The second reason is "to reserve in case of a risk" (49.7%) which indicated that the high infant mortality of the past affects people's decisions today, although scientific and medical achievements nowadays have reduced the infant mortality rate to minimum. If the child survival rates improve then the idea of a small norm family can be more easily accepted.

Other reasons such as "more laborers" and "get more land" account for a higher percentage in rural than urban areas. This can be explained by the fact that rural population who is mainly involved in agriculture, and some contract system policies in agriculture seem to encourage people to have more children so they can have more labourers and land.

In short, in a traditional society like Viet Nam where

the majority of people live in rural areas, feudal ideology has partly affected people behaviour towards having more children. This perspective has affected contraceptive use of couples. The above mentioned reasons indicated that psychological reasons had great effects on the contraceptive use of couples.

## 4.2 The relationship of factors to contraceptive use

### 4.2.1 Relationship of ever used contraception by age of respondents

**Table 9: Percentage of married women who ever used any contraception by age groups and residential areas.**

| Age | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | % | Cases | % | Cases | % | Cases |
| 15-19 | 55.6 | 5 | 32.2 | 18 | 35.3 | 23 |
| 20-24 | 53.2 | 58 | 43.8 | 179 | 45.8 | 237 |
| 25-29 | 71.9 | 151 | 62.5 | 355 | 65.0 | 506 |
| 30-34 | 87.0 | 215 | 73.7 | 412 | 77.8 | 627 |
| 35-39 | 90.8 | 148 | 77.8 | 460 | 80.6 | 608 |
| 40-44 | 86.2 | 144 | 62.4 | 226 | 69.9 | 370 |
| 45-49 | 63.4 | 73 | 49.4 | 134 | 53.5 | 207 |
| Total | 77.9 | 794 | 63.3 | 1784 | 67.2 | 2578 |

Regarding impacts of age upon contraceptive use, it is seen that at younger ages, the ever used percent was low (only 35.3 percent of age group 15-19). It increased with by age of the women with the peak of 77.8 % and 80.6% at the 30-34 and 35-39 age group

respectively and then declined to 53.5 % at the 45-49 age group (Table 9).

Ever used any contraception by age is overall higher in urban than rural areas. The possible reasons for that are mentioned in table 3, including variables such as education level, knowledge, easier access availability of contraception in urban areas than rural areas. Beside government sources of supply, urban people can easily access pills or condoms at the market.

Table 10: Methods ever used by respondents by age groups and residential areas.

| Methods* | Age of respondent | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | |
| **Total** | | | | | | | | |
| 1. IUD | 15.5 | 19.6 | 34.2 | 46.7 | 52.2 | 39.5 | 30.5 | 38.4 |
| 2. Pill | 2.8 | 1.7 | 4.3 | 3.4 | 4.4 | 3.1 | 1.6 | 3.3 |
| 3. Condom | 2.8 | 4.0 | 6.7 | 9.6 | 8.0 | 7.7 | 2.6 | 6.8 |
| 4. MS | .0 | .2 | .0 | .0 | .5 | .4 | 1.8 | .4 |
| 5. FS | .0 | .8 | .9 | 2.3 | 5.4 | 8.1 | 6.5 | 3.6 |
| 6. Rhythm | 15.5 | 18.1 | 22.5 | 27.7 | 24.8 | 20.8 | 13.2 | 22.2 |
| 7. Withdra | 9.9 | 15.1 | 22.0 | 24.8 | 22.5 | 16.9 | 8.0 | 19.4 |
| 8. Men-Reg | 1.4 | .4 | .5 | 1.3 | 1.9 | .9 | .8 | 1.0 |
| 9. Abortio | 1.4 | .0 | .5 | 1.1 | 1.4 | 1.1 | 1.3 | .9 |
| **Cases** | 69 | 515 | 773 | 799 | 762 | 528 | 383 | 3829 |
| **Urban** | | | | | | | | |
| 1. IUD | 22.2 | 18.3 | 32.5 | 44.4 | 50.0 | 38.9 | 27.2 | 37.1 |
| 2. Pill | .0 | 4.7 | 8.0 | 2.4 | 6.1 | 4.8 | .0 | 4.5 |
| 3. Condom | .0 | 14.8 | 12.3 | 18.5 | 17.0 | 16.3 | 3.5 | 14.4 |
| 4. MS | .0 | .0 | .0 | .0 | .6 | 1.2 | 3.5 | .7 |
| 5. FS | .0 | .9 | 1.4 | 3.6 | 7.9 | 12.9 | 6.1 | 5.3 |
| 6. Rhythm | 37.5 | 25.2 | 25.0 | 33.7 | 38.0 | 35.2 | 23.7 | 30.8 |
| 7. Withdra | .0 | 25.0 | 25.4 | 26.7 | 25.9 | 22.4 | 10.8 | 23.4 |
| 8. Men-Reg | .0 | 1.0 | .5 | 2.9 | 3.7 | .6 | .9 | 1.7 |
| 9. Abortio | .0 | .0 | 1.0 | 2.0 | 3.1 | 1.8 | 2.7 | 1.8 |
| **Cases** | 9 | 105 | 205 | 246 | 163 | 163 | 113 | 1004 |
| **Rural** | | | | | | | | |
| 1. IUD | 14.8 | 20.1 | 34.9 | 48.0 | 53.2 | 40.1 | 32.1 | 39.2 |
| 2. Pill | 3.3 | 1.0 | 2.9 | 4.0 | 4.0 | 2.5 | 2.2 | 3.0 |
| 3. Condom | 3.3 | 1.2 | 4.7 | 5.8 | 5.7 | 4.1 | 2.2 | 4.3 |
| 4. MS | .0 | .0 | .0 | .0 | .0 | .3 | .0 | .0 |
| 5. FS | .0 | .7 | .7 | 1.8 | 4.8 | 6.3 | 6.7 | 3.1 |
| 6. Rhythm | 13.1 | 16.7 | 22.0 | 25.6 | 21.7 | 15.3 | 8.9 | 19.6 |
| 7. Withdra | 11.5 | 12.9 | 21.2 | 24.5 | 22.0 | 15.0 | 7.0 | 18.5 |
| 8. Men-Reg | 1.7 | .2 | .5 | .7 | 1.5 | 1.1 | .7 | .8 |
| 9. Abortio | 1.7 | .0 | .4 | .7 | 1.0 | .8 | .7 | .6 |
| Cases | 60 | 410 | 568 | 553 | 599 | 356 | 270 | 2825 |

* Multiple responses are allowed.

If we look at the correlation between age and ever used contraception by each method (table 10), we see that the percentage of these using modern methods such as the IUD, pill, condom is highest at 30-39 age group when compared with other age groups. For both male and female sterilization, percentage of users increased by age. This indicates that at this age group, people have their desired number of children therefore they chose this method (Table 11).

Looking at the contraceptive method mix by age group in urban areas, we see that for modern methods , the highest percentage of IUD, pill and condom usage is 35-39; 25-29 and 30-34 respectively. Meanwhile this highest percentage for rural areas is age groups 35-39; 30-39; and 30-34 respectively, then percentage declined. The use of other modern methods such as MS and FS increased by age group in both urban and rural areas. This rate is the highest at age group 40-44 in urban areas and at age group 45-49 in rural areas. It can be said that urban women completed their family size earlier than rural women.

Except for the IUD, the percentage of methods used such as the pill, condom, withdrawal, and rhythm was higher in urban than in rural areas at all age groups. This can be explained similarly as above under the Table 3.

In general, age is shown to have impact on contraceptive use. At younger ages, the ever used percentage was lower when compared with older groups, but toward the end of reproductive age, this rate gradually decreased. There is the difference between urban and rural areas regarding ever used percentage by age as well as by methods.

### 4.2.2 Relationship of ever used contraception by number of living children

**Table 11: Percentage of ever used contraception by a number of living children and residential areas.**

| No of children | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | % | Cases | % | Cases | % | Cases |
| 0-1 | 59.1 | 165 | 38.9 | 288 | 44.5 | 453 |
| 2 | 86.4 | 236 | 70.8 | 405 | 75.9 | 641 |
| 3 | 88.2 | 157 | 74.1 | 375 | 77.8 | 532 |
| 4 | 85.3 | 110 | 75.3 | 323 | 77.6 | 433 |
| >=5 | 78.5 | 126 | 68.9 | 393 | 71.0 | 519 |
| Total | 77.9 | 794 | 63.3 | 1784 | 67.2 | 2578 |

Number of living children is an important variable affecting the family planning behavior of interviewed women. Table 11 indicates that only 44.5 % of women who had less than 2 children used any contraceptive method while this percentage is very high for women who had 2+ children, who are the main target of family planning campaigns in Viet Nam.

When looking at residence we can see that percentages of married women who ever used any contraceptive method by the number of living children was higher in urban areas than that in rural areas, supported by the fact that women in rural areas tended to have more children than urban women.

Table 12: Methods ever used by respondents by number of living children and residential areas.

| Methods* | No of living children | | | | | Total |
|---|---|---|---|---|---|---|
| | 0-1 | 2 | 3 | 4 | >= 5 | |
| Total | | | | | | |
| 1. IUD | 17.4 | 42.6 | 49.1 | 49.0 | 45.1 | 38.4 |
| 2. Pill | 2.4 | 3.1 | 3.9 | 3.3 | 4.3 | 3.3 |
| 3. Condom | 4.9 | 8.7 | 8.3 | 7.6 | 5.5 | 6.8 |
| 4. MS | .0 | .3 | .1 | .2 | 1.2 | .4 |
| 5. FS | .5 | 2.1 | 2.3 | 6.0 | 9.1 | 3.6 |
| 6. Rhythm | 19.3 | 29.2 | 24.2 | 21.1 | 17.0 | 22.2 |
| 7. Withdrawal | 16.1 | 25.5 | 20.9 | 21.4 | 14.2 | 19.4 |
| 8. Mens-regulatio | .5 | 1.3 | 1.7 | 1.2 | .8 | 1.0 |
| 9. Abortion | .5 | 1.2 | 1.3 | 1.2 | .7 | .9 |
| Cases | 1016 | 839 | 685 | 557 | 732 | 3829 |
| Urban | | | | | | |
| 1. IUD | 19.2 | 43.8 | 42.8 | 47.7 | 41.9 | 37.1 |
| 2. Pill | 5.0 | 4.4 | 5.0 | 3.1 | 4.4 | 4.5 |
| 3. Condom | 13.3 | 15.8 | 17.3 | 14.6 | 10.6 | 14.4 |
| 4. MS | .0 | .7 | .6 | .0 | 2.5 | .7 |
| 5. FS | 1.1 | 1.5 | 4.0 | 13.1 | 14.5 | 5.3 |
| 6. Rhythm | 28.9 | 37.0 | 32.6 | 30.5 | 22.0 | 30.8 |
| 7. Withdrawal | 24.8 | 28.2 | 23.5 | 21.3 | 14.6 | 23.4 |
| 8. Mens-regulatio | .7 | 1.9 | 3.4 | 3.1 | .0 | 1.7 |
| 9. Abortion | .7 | 2.6 | 2.3 | 3.1 | .6 | 1.8 |
| Cases | 274 | 267 | 177 | 128 | 158 | 1004 |
| Rural | | | | | | |
| 1. IUD | 16.8 | 42.2 | 51.6 | 49.8 | 46.3 | 39.2 |
| 2. Pill | 1.5 | 2.6 | 3.6 | 3.5 | 4.3 | 3.0 |
| 3. Condom | 1.9 | 5.5 | 5.3 | 5.6 | 4.2 | 4.3 |
| 4. MS | .0 | .2 | .0 | .2 | .9 | .2 |
| 5. FS | .3 | 2.4 | 1.8 | 4.0 | 7.8 | 3.1 |
| 6. Rhythm | 16.2 | 26.0 | 21.9 | 18.9 | 16.0 | 19.6 |
| 7. Withdrawal | 13.3 | 24.9 | 20.4 | 22.1 | 14.4 | 18.5 |
| 8. Mens-regulatio | .4 | 1.0 | 1.2 | .7 | 1.0 | .8 |
| 9. Abortion | .4 | .5 | 1.0 | .7 | .7 | .6 |
| Cases | 742 | 572 | 508 | 429 | 574 | 2825 |

* Multiple responses are allowed.

Table 12 categorizes the percentage of contraceptive use by methods and number of living children. This percentage increased by number of living children. However, it usually declined when women had 4+ children or reached the age of menopause, only with MS and FS these rates increased by number of children. The family planning programme in Viet Nam should encourage those who have had enough children to use permanent methods.

When comparing urban and rural areas, we discovered that the highest percentage of IUD usage is found among urban women who had 4 children and rural women who had 3 children, then pill and condom for urban women who had 3 children while this rate for rural women who had 3 and 4 children. Women with more children tend to use more permanent methods.

In summary, contraceptive use increases when the number of living children increases. However, it declines among women who have more than 5 children (except regarding permanent methods). This can be explained that majority of women having 5+ children almost reach the end of reproductive age, so that they may not want to use contraception. This tendency in urban and rural areas is similar.

### 4.2.3 Relationship of ever used contraception by level of education.

Table 13: Percentage of married women who ever used any contraception by education and residential areas.

| Level of education | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | % | Cases | % | Cases | % | Cases |
| Primary | 63.6 | 21 | 54.8 | 155 | 55.7 | 176 |
| Secondary | 73.9 | 204 | 60.9 | 823 | 63.1 | 1027 |
| High school | 72.8 | 235 | 63.6 | 518 | 66.2 | 753 |
| Vocational | 83.7 | 241 | 76.6 | 216 | 80.2 | 457 |
| Uni. and Post. | 93.8 | 93 | 83.0 | 72 | 88.6 | 165 |
| Cases | 77.9 | 794 | 63.3 | 1784 | 67.2 | 2578 |

Many surveys have found that the education level of both the husband and wife has strong impact on contraceptive use. This is also shown by the findings of the studies in Viet Nam. Table 13 shows that percentage of contraceptive use increased with each education level, those who had an educational level of primary school was 55.7% and the highest percentage was 88.6% for those who had higher education levels.

The percentage of ever used any contraceptive methods in urban areas is higher than rural ones at all educational levels.

Table 14: Methods ever used by respondents by levels of education and residential areas.

| Methods* | Education of wife | | | | | Total |
|---|---|---|---|---|---|---|
| | Primary | Secondary | High sch. | Vocational | Uni& Post | |
| Total | | | | | | |
| 1. IUD | 33.0 | 39.9 | 37.4 | 38.1 | 41.7 | 38.4 |
| 2. Pill | 1.8 | 3.3 | 2.6 | 5.3 | 4.3 | 3.3 |
| 3. Condom | 3.1 | 5.0 | 6.1 | 12.4 | 17.1 | 6.8 |
| 4. MS | .3 | .6 | .3 | .0 | .0 | .4 |
| 5. FS | 4.6 | 4.0 | 3.3 | 3.1 | 2.1 | 3.6 |
| 6. Rhythm | 11.9 | 15.7 | 21.4 | 37.6 | 54.5 | 22.2 |
| 7. Withdrawal | 16.5 | 15.2 | 19.3 | 26.8 | 39.6 | 19.4 |
| 8. Mens-regulatio | .0 | .7 | .9 | 2.2 | 3.7 | 1.0 |
| 9. Abortion | .3 | .5 | .9 | 1.7 | 2.7 | .9 |
| Cases | 316 | 1636 | 1131 | 564 | 182 | 3829 |
| Urban | | | | | | |
| 1. IUD | 24.2 | 40.4 | 36.9 | 34.5 | 40.2 | 37.1 |
| 2. Pill | 3.0 | 4.3 | 2.8 | 7.3 | 3.1 | 4.5 |
| 3. Condom | 9.1 | 14.0 | 11.1 | 15.6 | 25.0 | 14.4 |
| 4. MS | .0 | 1.4 | .9 | .0 | .0 | .7 |
| 5. FS | 6.1 | 7.3 | 5.6 | 4.2 | 2.1 | 5.3 |
| 6. Rhythm | 21.2 | 21.2 | 23.5 | 39.8 | 58.8 | 30.8 |
| 7. Withdrawal | 21.9 | 13.8 | 21.7 | 29.8 | 38.5 | 23.4 |
| 8. Mens-regulatio | .0 | 1.8 | .9 | 2.1 | 3.2 | 1.7 |
| 9. Abortion | .0 | 1.5 | 1.6 | 1.7 | 4.3 | 1.8 |
| Cases | 33 | 274 | 316 | 287 | 94 | 1004 |
| Rural | | | | | | |
| 1. IUD | 34.6 | 40.0 | 37.7 | 42.5 | 43.8 | 39.2 |
| 2. Pill | 1.8 | 3.2 | 2.5 | 3.5 | 5.7 | 3.0 |
| 3. Condom | 2.5 | 3.2 | 4.2 | 9.6 | 9.1 | 4.3 |
| 4. MS | .4 | .4 | .0 | .0 | .0 | .2 |
| 5. FS | 4.5 | 3.4 | 2.4 | 2.1 | 2.2 | 3.1 |
| 6. Rhythm | 11.3 | 14.9 | 20.9 | 36.9 | 51.7 | 19.6 |
| 7. Withdrawal | 16.7 | 15.8 | 18.8 | 24.7 | 42.5 | 18.5 |
| 8. Mens-regulatio | .0 | .4 | .9 | 2.5 | 4.5 | .8 |
| 9. Abortion | .4 | .4 | .7 | 1.8 | 1.1 | .6 |
| Cases | 283 | 1362 | 815 | 277 | 88 | 2825 |

* Multiple responses are allowed.

When looking at the effect of education on each contraceptive method (Table 14), we realized that with some modern methods such as the IUD, pill and condom and traditional methods as rhythm and withdrawal, shown differences amongst users between lower and higher levels of education. There was no significant difference among different higher levels of education (secondary, high school, vocational and Uni.). For male and female sterilization, this percentage declined as education level increased (4.6 % of respondents with level of primary used female sterilization while only 2.1 % of Uni and post level used this method).

By looking at the percentage of ever users by method and education of wife in urban areas we know that for the IUD and condom use there was a big difference between primary and other higher education levels, but there was no significant difference amongst higher educational levels. For MS and FS, the highest percentage is at secondary level. For traditional methods (withdrawal and rhythm), the percentage increased in parallel to the rise in education level.

In rural areas, it seemed to be no significant difference of ever used of the IUD or pill at different education levels, but the use of remaining contraceptive methods increased by education level.

In brief, we learnt that education level affects the use of contraceptives. However, the difference is not significant amongst from secondary level and higher. Regarding permanent methods, this percentage decreased while education level increased.

The selected variables reflect the actual situation of contraceptive use in surveyed areas. Socio-demographic and psychological factors have affected contraceptive use directly or indirectly. There exists a significant difference in contraceptive use between urban and rural areas due to the different living conditions, education and psychological perspectives.

# CHAPTER V

# CONCLUSIONS AND RECOMMENDATIONS

## 5.1 SUMMARY AND CONCLUSIONS

Rapid population growth is one of the most serious problems in developing countries. Governments of most developing countries have been attempting to reduce the population growth rates by developing family planning programmes. In Viet Nam, population and family planning is an important part of the national development strategy. It is fundamental in raising the quality of life for both the individual family and the entire society.

The aim of this study is to investigate variables affecting contraceptive use among married women of reproductive age in the central coast areas of Viet Nam, and in particular examining the differences between rural and urban areas. The study uses the secondary data collected by a research unit of the National Committee for Population and Family planning (NCPFP) in 1992.

### Major findings of the study

#### Knowledge of contraceptive methods

The findings also reconfirm that Vietnamese women's knowledge of contraceptive methods is very high, and that urban women's knowledge is higher when compared to rural women's

knowledge. There is still a big gap between knowledge and practice regarding contraceptive use. However, the results also find that where the knowledge of contraceptive use is high, it is more likely that people would use more contraceptives.

**Contraceptive use**

The ever used percentage of contraception is relatively high, IUD remains the most used among contraceptive methods. Other effective contraceptive methods such as the pill, condom, and sterilization are rarely used due to their lack of availability. For many years, in many medical institutions, especially at the district level, only the IUD was available. The ever used contraception in urban is higher than in rural areas due to the differences in socio-economic environments, educational level, and psychological perspectives. On the other hand, it has been shown that IEC activities as well as family planning service delivery have not really reached the large rural areas.

**Psychological perspectives**

Regarding the impact of psychological factors, it was found that they had great impacts on contraceptive use, especially in rural areas. The major findings of this study reveal that the desired number of children among respondents (3.15) is still high. This desired number of children is higher in rural areas when compared with urban ones. The percentage of women who wish to have more than 3 children was especially high. This indicates a

challenge for the government who promote the small norm family size of 1 to 2 children. Sex preference is still strong in Viet Nam, and particularly pronounced in rural areas. This shows that feudal ideology is still deeply rooted in the people's mind. The value of children to a family, especially the strong expectation of parents to live with their sons when they become elderly was very high. Results of this study also reveal that there is a difference between the Government's requirements for family planning and the desired number of children of a large number of rural people.

The preference to live with sons when elderly is still strong, and again this applies particularly in rural areas. Children remain a source of security for parents in Viet Nam where a stable social security system has not yet been developed. This suggests that if any family planning programme wants to be successful, it must take into consideration of a comprehensive policy including the policy towards the elderly as a target group.

The findings of this study also indicate that those who accept a small norm family would like to pay more attention to the quality of life of their children. This coincides with the ultimate purpose of the family planning programme i.e. "to have less for better". In a traditional society like Viet Nam where the majority of people live in rural areas, feudal ideology has partly affected people's behaviour towards having more children. This psychology has affected contraceptive use of couples.

In short, the psychological factors explain reasons why people want to use or not use contraception, and why they want to have many children, especially sons.

The relationships of factors and contraceptive use

This study indicates that there was a positive relationship between socio-demographic and psychological factors and contraceptive use, that human fertility cannot be explained by one single factor. It is influenced and determined by many diverse factors. In general, age has strong impact on contraceptive use. At a younger age, ever used percentage was lower as compared to older, but toward the end of reproductive age, this rate gradually decreased. There is the difference between urban and rural areas on ever used percentage by age as well as by methods. Contraceptive use is increased as number of living children increased. However, it declines with women having 5+ children (except permanent methods). This can be explained that the majority of women having 5+ children almost reach the end of their reproductive years so that they may not want to use contraception. This tendency in urban and rural areas is similar.

Education level has affected contraceptive use. Moreover, the difference is not significant from secondary level and higher. For permanent method, this percentage decreased while education level increased. This trend is similar in urban and rural areas.

## 5.2 RECOMMENDATIONS

### 5.2.1 Policy implication

The major findings of this study reveal that there is a positive relationship between family planning behaviour i.e. contraceptive use and socio-demographic and psychological factors such as age, age at first marriage, number of living children, duration of marriage, education of both husbands and wives. A n y family planning programme if wish to be successful must take into account all of these factors. It must study in which ways these factors affect family planning behavior positively or negatively.

The results of this study shows that early marriage affects the fertility patterns of women, especially in rural areas. In order to discourage early marriage, strict legislation and enforcement should be implemented. It is also evident that one of the strategies in dealing with these factors should be the effective implementation of information education and communication (IEC) programme which should be promoted in order to provide people with information on family planning methods and an appropriate and diversified population education programme. These should involve and cover the entire society of the country and specific target groups, especially in rural areas where dominant target groups and young people live, so that they should be able to understand fully the benefits of family planning and accept a small norm family. Consequently, sites of special focus are rural areas particularly regions with high population density and high fertility rates.

Activities should be concentrated in hamlets, sub-hamlets and tribes. Target audiences include couples with two or more children to limit number of families with 3+ children. Target audiences should also include newly married couples to encourage birth delay and spacing. It is not enough to propagandize about family planning. More emphasis should be placed on interpersonal communication channels aimed at motivating eligible couples and educating young generations, making them clearly understand the necessity and benefits of family planning in order to achieve the acceptance of a small family. Family planning clinics must be run in a humane way where clients' free choice of contraceptive methods and high quality of service are ensured. The data of this survey indicated that there was still a son preference existing, especially the strong expectation of residents to live with their children when they get old, this is due to the lack of reliable system to assist them. In order to improve this situation, a stable social security system must be set up for old people.

### Specific policy implications

IEC activities should include educational materials which provide sound information of contraceptive methods as well as avoid misunderstandings. These should be disseminated among households especially in rural areas.

IEC activities should be coordinated with mass media and

mass organizations such as the Women's and Youth Union, Trade Union, Peasants' Association to mobilize people to participate in the family planning programme.

The family planning programme of Viet Nam should further promote more the "cafeteria approach" to satisfy the needs of users so that couples can be free to choose their own methods. The family planning service delivery should be improved to reach people at the grass root level, particularly rural areas where 80 % of population live to ensure convenience and safety for users.

The experiences of the successful family planning programme in Thailand shows that the population problem means much more than family planning and birth control. Family planning should be integrated into development plans, people's every day problems such as clean water, sanitary, health and rural development. These are the immediate concerns of the majority of people, they will eventually understand that fewer children means more prosperity, health and happiness for the family.

### 5.2.2 Suggestions for further studies

There are very few studies about the psychology surrounding family planning behaviour of contraceptive users and non-users. Therefore, the following areas are highly suggested for further studies :

- National and regional representative surveys of socio-psychological factors and their effects on contraceptive use including male participation should be carried out to better understand the situation.

- The current economic situation in Viet Nam is rapidly changing social relations and will undoubtedly have an important impact on population dynamics. Therefore, a comprehensive survey including perception and performance of both contraceptive users and providers is necessary to adjust appropriate family planning policies in the new stage.

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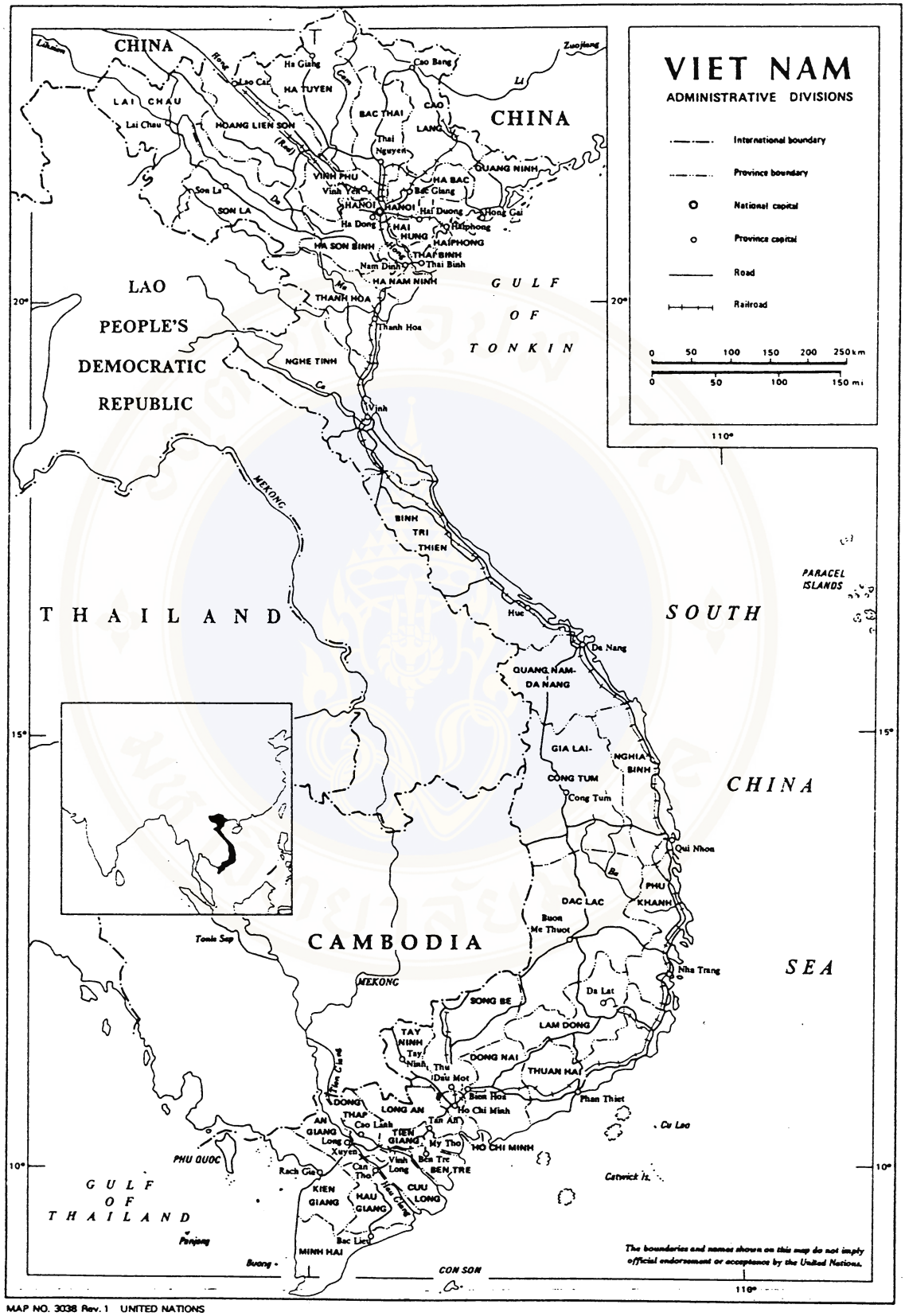
# MAP OF VIET NAM

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