



HÖGSKOLAN
DALARNA

EXAMENSARBETE

Delivery care in Quang Ninh province, Northern Vietnam.

*- resources and access to safe
care.*

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Abstract

Every mother and child has the right to survive childbirth which requires skilled birth attendants together with referral and available emergency obstetric care (EmOC). The objective of the study was to describe delivery care routines at different levels in the health care system in Quang Ninh province, Northern Vietnam. The design was cross sectional using a structured questionnaire. Two districts in Quang Ninh province with 40 Community Health Centres (CHC), three district hospitals and one region hospital was included in the study, in total 138 (CHC n=105 and hospitals n=33) health care providers participated. In our study 20% (CHC) of the health care providers assisting deliveries at CHC were midwives and health care provider's in our study further report to have assisted at less than 10 deliveries/year (81% of respondents at CHC). Findings show that the health care provider's routines and care for women during labour and delivery vary and that there is a need for re-training and that women in labour should be cared for by health care providers with adequate training like midwifery. In our study CHC had poor resources to provide basic or comprehensive EmOC. Our findings indicate that there is a need for re-training in delivery care among health care providers and since the number of deliveries at CHC is few they should be handled by someone who is a skilled birth attendant. Our findings also show a variation in care routines during labour and delivery among health care providers at CHC and hospital levels and this also show the need for re-training and support from proper authorities in order to improve maternal and newborn health.

Key words: Delivery care – Health care providers – CHC and hospital – Vietnam.

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Introduction

Every mother and newborn child has the right to survive pregnancy and childbirth and it is the responsibility of families, communities and local and national governments to prevent their deaths (1). Even though most of maternal deaths are avoidable, 1500 women die each day from pregnancy or childbirth related complications. Most maternal deaths (99%) occur in the low-income countries (2). These deaths are mostly consequences of poor health and nutritional status of the mother together with inadequate care before, during and after delivery. A consequence of high maternal mortality is high neonatal mortality and poor child survival (3). Neonatal mortality in the world is estimated to about 4 million per year and is due to causes like preterm, pneumonia/sepsis, asphyxia, congenital, tetanus, diarrhoea and other (4). The requirements for improvements in newborn health are essential care during pregnancy, assistance during childbirth and the immediate postpartum period from someone with midwifery skills and ability to provide critical interventions for the newborn during the first days of life. Skilled attendants are crucial at every delivery and referral and available emergency obstetric care in case of emergency for mothers and newborns is essential (3).

The International Confederation of Midwives (ICM) has a definition of midwives “A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery” (5). WHO defines a skilled birth attendant as “an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (6). In the world 34% of deliveries occur with no skilled attendant present, in the high-income countries skilled attendants assist in more than 99% compared to 62% in the developing world (7). In some countries the percentage of deliveries by skilled birth attendants is high but the maternal and newborn morbidity and mortality remain high and therefore the quality of care needs to be reviewed (3). Skilled care at birth can make a difference between life and death, since skilled practitioners can with their knowledge and skills use adequate techniques as the partograph which shows the progress of the labour and maternal and foetal condition. The partograph is a tool used to assess the progress of labour and identify when interventions are

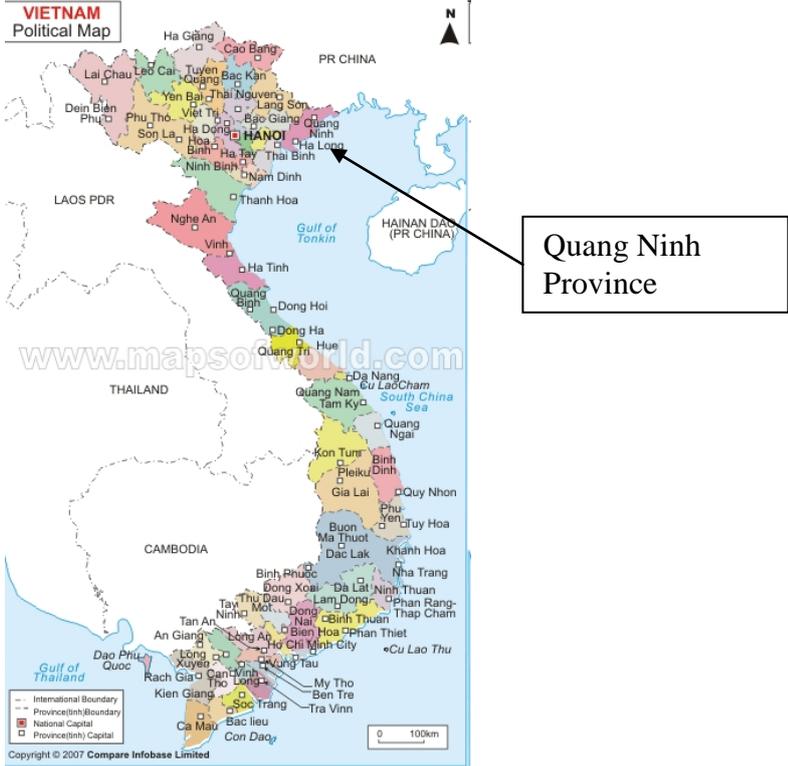
necessary (8). Aseptic technique, drugs like oxytocin which reduces the risk of bleeding effectively if it is given right after birth and drugs used to lower the risk of eclampsia (convulsions) is also of importance (2). Skilled attendants care for women during pregnancy, childbirth and the postpartum period and they support the women in different ways. The care includes counselling, support, managing complications and can take place in health facilities or in family homes. The skilled attendants need equipment, supplies and medicines in order to provide this care. The effect of skilled care at birth can be seen through history and evidence from many countries in the world but it takes long- term investments that sustains. In the world today the numbers of skilled attendants are insufficient and new resources must focus on recruiting, training and retaining health workers with midwifery skills. In order to achieve this, incentives such as satisfactory pay scales, improved status and respect within the health system and career advancement opportunities is required (9). The obstacles that prevent women from receiving care that they need before, during and after childbirth are many. Poor quality reproductive health care, the lack of access to health facilities due to no transport or not be able to afford to pay transport costs or health services fees. Women's low status in society and cultural beliefs can also undermine women's access to adequate health care (2). If women had affordable and good- quality obstetric care 24 hours every day almost every of these cases could be saved. Delay often contributes to maternal deaths, delay in seeking care, in reaching appropriate care and in receiving care at the health facility (10). There are many aspects of delivery care that need to be considered. Economy (money to pay for transport and care) is one factor that is important when discussion on delivery care. Another is the cultural and social contexts such as decision-making in relation to health care seeking during pregnancy and delivery (at home, commune health centre and hospital). Family members and the pregnant women's perception of the quality of care delivered at public and private facilities is another important aspect (11). To reduce maternal mortality two vital components are skilled care for every pregnant woman by a health professional with midwifery skills during pregnancy and childbirth and emergency obstetric care (EmOC), to ensure access in time for women that have complications. EmOC are divided in basic and comprehensive functions and it is recommended that there should be minimum four facilities that offer basic EmOC for every 500,000 people and one facility with comprehensive EmOC (10).

The Vietnamese context

Vietnam is a country in the Western Pacific region and has a population of about 86,206,000 (2006) people (12), 27percent live in urban areas (2006) and 14 percent of the population are

ethnic minorities (13). Vietnam is divided into 63 provinces and each province has several districts and the districts are divided in communes. This division also represents the division of the health system since each district has a district hospital (DH) and each commune has at least one community health centre (CHC). At the provincial level there is always a provincial hospital (PH) and sometimes a regional hospital.

Figure 1. Map of Vietnam and Vietnams provinces.



Source: <http://www.mapsofworld.com/vietnam/maps/vietnam-political-map.jpg>

The health of the Vietnamese people have been improved substantially in recent years but still there are growing health inequalities among different groups and geographical areas. Poverty and ethnicity effect maternal and child mortality and infant mortality are almost eight times higher in some remote areas than in urban areas (14). Vietnam has worked with improving reproductive health care and services since the International Conference on Population and Development in Cairo 1994 in order to meet the people’s needs and reduce maternal mortality rate and infant morality rate (15). The total fertility rate (per woman) was 2.2 (2006) and birth attended by skilled health personnel was 88 percent (2006), 82 percent in rural areas and 99 percent in urban areas (2002) (16). Births attended by professional assistance were supervised by a doctor 50% (2002) and had increased from 27 percent (1997) while supervision by a

nurse or midwife had declined from 50 percent (1997) to 35 percent (2002) (17). Of all the births 10 percent are performed with caesarean section (2002) (16). About 79 percent (2002) of the deliveries was in health facilities while 21 percent of deliveries were at home (17). Vietnam had a maternal mortality rate of 150/100000 women (2005) (18). Vietnam has experienced a decrease of under – five mortality (probability of dying (per 1000) under age five years) and infant mortality (probability of a child born in a specific year or period dying before reaching the age of one) the last decade but figures for neonatal deaths have been stable, the neonatal mortality rate (per 1000 live births) is 12 (2004) both sexes (19). This reflects better living conditions among the general population but indicate weaknesses within delivery care in Vietnam (20). The ministry of Health in Hanoi published in 2003 the National Standard and Guidelines for Reproductive Health Care Services, a document developed based on scientific evidence (15). The guidelines aim is to be applied to all public and private health facilities as a legal foundation, manual for health workers and as a base for education for health workers (15).

To improve the health of newborns it is vital to ensure high quality of care during pregnancy and delivery. Delivery care should include skilled attendants at birth, clean delivery, and ability to recognize danger signs occurring during delivery and take necessary actions, keeping the newborn warm and dry and promote early initiating of breastfeeding (21). However, little research has been done to describe the quality of care focusing on the care routines taking place within the different levels of delivery care in Vietnam and the work environment of health care providers within the delivery care.

Objectives

The main objective of the study is to describe delivery care routines at different levels primary and secondary level in the health care system in Vietnam. The studies specific objective is to describe health care provider's delivery care routines and care of women giving birth in community health centres and hospitals in the Quang Ninh Province, Northern Vietnam.

Table 1. Information about the study's setting.

Variable	Dong Trieu district	Yen Hung district	Uong Bi
Population	156700	138 181	109004
Number of hospitals			
District hospital	2*	1*	0
Regional hospital	0	0	1*
Number of CHC	21(20*)	19*	-
Number of deliveries/ year hospital			
District hospital			
Regional hospital	265 (2006), 214 (2006)	1273 (2008)	1435 (2008)
Number of deliveries/year CHC	0-58 (2005)	0-82 (2005)	-

* included in the study

Sample and subjects

The subjects are health care providers that care for women during labour and delivery and work in the chosen setting in either Community Health centres (CHC), districts hospitals or the region hospital in Uong Bi. Forty CHC (21 in Dong Trieu and 19 in Yen Hung) and 3 district hospital (2 in Dong Trieu and 1 in Yen Hung) and 1 region hospital (in Uong Bi) were included in the study. Inclusion criteria were health care providers that care for women during labour and delivery and work at CHC, district hospital or region hospital in the chosen setting. Exclusion criteria were health care providers that were not present when the research assistants came to the health facilities and presented the study and distributed the questionnaire. Total number respondents were 138 health care providers. From the 40 CHCs that was included in the study only one CHC did not have possibility to participate due to being occupied by their work. From the region hospital in Uong Bi only midwives were asked to participate. There are total 30 midwives working at the obstetric and gynaecological departments, a couple was on maternity leave and 20 midwives participated in the study. In all the CHC and district hospitals all health care providers that cared for women during delivery were asked to participate.

Instrument

The questionnaire for health care providers (see appendix III for English and IV for Vietnamese) was developed by the research team and reflect the ministry of Health National standards and guidelines for reproductive health care services from 2003 (15) and UNFPA checklist for planners of emergency obstetric care (10).

Questionnaire

Below are the definitions of the activities measured in the questionnaire.

Progress of labour (described as part of prognostic factors of an abnormal labour)

- uterine contractions
- cervical effacement and dilation
- foetal descent (15).

Monitoring during labour (15) see table 1.

Table 2. Monitoring during labour (15).

Factor	Latent phase	Active phase
Pulse	1 hourly	1 hourly
Blood pressure	1 hourly	1 hourly
Temperature	4 hourly	
Foetal heart	Every 30 minutes	Every 15 minutes
Uterine contractions	1 hourly	Every 30 minutes
Amniotic fluid	4 hourly	2-4 hourly
Foetal descent	1 hourly	Every 30 minutes
Moulding of the foetal head		2- 4 hourly
Cervical dilation	4 hourly	2-4 hourly

Average foetal heart beat is from 120-160 bpm, over 160 or below 120 refers to foetal distress.

Latent phase of labour starts when cervix is fully effaced and dilated up to 3 cm and active phase of labour when cervix is open 3-10 cm.

The colour of amniotic fluid is normally transparent or opalescent (15).

Apgar score includes breathing, heart beat, skin colour, muscle tonus and irritability is observed at 1 minute after birth and 5 after birth (23).

Normal bleeding during childbirth is 500ml (24)

Basic EMOC functions are intra venous (iv) /intra muscular (im) antibiotics, iv/im oxytocin, iv/im anticonvulsants, manual removal of placenta, assisted vaginal delivery and removal of retained products. And the comprehensive EmOC includes all the basic functions and caesarean section and blood transfusion (10).

The questionnaire was translated from English to Vietnamese by one of the supervisors and then checked by the other supervisor and one of the research assistants. The questionnaire distributed to health care providers contains 77 questions in total and contains both closed and open-ended questions. The questions entail professional background and information about the workplace, clinical delivery practise and care for normal labour and childbirth and ability to provide emergency obstetric care. The questionnaire was pilot tested by 2 persons, one midwife and one nurse (not included in the data material) and minor revision was made concerning phrasing. After the first day of data collection some additional phrasing changes were made but since the content of the questions was the same the data from the first day is included in the data material.

Data collection

The data was collected by two research assistant's one was a nurse and the other one an assistant doctor and they went to the CHC and the hospitals. The research assistants were trained by the researcher and one of the supervisors before starting the data collection. The researcher and one of the supervisors accompanied the research assistant on some occasions. The research assistant first gave a short oral introduction to the project and gave examples of some questions in every of the three sections in the questionnaire and about informed consent. The health care providers were also informed through a letter of information about the project (see appendix I English, appendix II Vietnamese) and if they gave their consent they answered the questionnaire. The data collector was present during the time the respondents filled in the questionnaire and could answer questions from the respondents about the questions. The research assistants asked health care providers who handled women during labour and childbirth to answer the questionnaire.

Data analyses

The data from the questionnaires was entered in Microsoft Office Excel 2003 by the researcher. The data from the closed questions was analysed by calculating proportions in the two different study groups, one group consisting of health care providers working at CHC (n =105) and one group consisting of health care providers working in hospitals (n=33).The data from the open questions in the questionnaire was translated by one research assistant and entered by the researcher. The findings from the open questions describe different information about care and routines during labour and delivery and were answered by the health care

providers from a few words until a couple of sentences. Some of the findings are highlighted with quotes from the open-ended questions.

Ethical considerations

Ethical approval for the study has been obtained from the Ethical research committee at Högskolan Dalarna, Sweden and health leaders in different levels in Quang Ninh province, Vietnam. All subjects have been informed verbally and in writing (see appendix I English, appendix II Vietnamese) about the project and that their participation is voluntary and can be withdrawn at any time during the project. The subjects are anonymous and cannot be identified through the data.

Findings

Description of the two study groups is presented under three headings, *Care and practise during labour* and *Delivery care and practise after delivery* and *Emergency obstetric care*. Below is information of the respondent's professional background (Table 3).

Table 3. Background information of respondents.

Variable	Commune Health Centre (CHC) (n= 105)	Hospitals (n= 33)
Professional background		
Midwife	22	28
Doctor	16	5
Nurse	27	0
Other*	40	0
Years of basic training		
<u>Midwife</u>		
<1 year	4	
2-3 years	17	21
>4 years	1	6
<u>Doctor</u>		
3 -4 years	8	1
> 6 years	7	3
<u>Nurse</u>		
2-3 years	25	
<u>Other*</u>		
2-3 years	34	
4 years	3	
Retraining in the last 5 years		
Yes	57	16
No	45	17
Number of deliveries the last year		
0-10	86	8
11-50	12	4
51-200	1	5
201-500	0	3
501-1000	0	6

*Other professions in table 2 represents general assistant doctors, assistant nurse, assistant dentist, traditional assistant doctors, and person that worked with rehabilitation and acupuncture, and some did not specify their profession.

Not all respondents answered all the questions which are the reason for loss of number of respondents in the table.

There were a total of 138 health care providers that participated in the study by answering the questionnaire. The basic training of the health care providers varied for all different professions and the length of work experience ranged from 1-34 years for CHC and 8months-32 years among hospital staffs. Among all the participants half (52 %) had received some re-training in the last five years. Among these most (80 %) had re-training that concerned reproductive health care. Almost all (99%) in this group answered that they thought the level of re-training was adequate. The proportion of health care providers with re-training at CHC was 54 percent and the corresponding figure in the hospital group was 48 percent. The health care provider answers to the question to how many deliveries they assisted/ performed during the last year varied. Most of the providers at CHC (81%) reported that they had assisted/performed less than at 10 deliveries in the last year. Within the group from CHC nurses had assisted in the care of women during delivery in 0-20 cases in the last year, midwives 0- 27 cases and doctors (including assistant doctors) 0- 56 cases.

Care and practise during delivery

Factors to follow labours progress was described by the respondents. One third (26%) of the health care providers from CHC and the hospitals (27%) could identify all three factors (foetal decent, cervix effacement and dilation and uterus contraction) that reflect the progress of labour. Half of the respondents from CHC (55%) and from the hospitals (69%) could describe the correct cervix status during latent stage of labour and 87% (CHC) and 93% (hospitals) cervix status during active stage of labour. Vaginal examination was described to be performed every two- four hours among 49% (CHC) and 57% (hospitals) and 33% (CHC) and 27% (hospitals) did vaginal examinations every hour. 74% of the health care providers at CHC examined the uterine contractions every 30- 60 minutes and 81% of health care providers at the hospitals did the same.

Foetal status

The foetus status was described by respondents to be checked by heart rate and by colour of amniotic fluid which was described by respondents in open-ended questions. The foetus heart

beat was examined with foetal stethoscope by 92 percent at CHC and corresponding figure at hospital was 21 percent. Almost 40 percent of the hospital group answered that they used doptone while 30 percent answered that they used both foetal stethoscope and doptone. More than half 60 percent (CHC) and 63 percent (hospitals) of the respondents examined foetal heart beat every 15-30 minutes. Distress from the foetus was defined as heart beat under 120 beats per minute (bpm) or over 160 bpm by 29 percent of health care providers at CHC compared to 60 percent of health care providers at hospital of the remaining providers in both groups. In the open- ended questions some respondents described other signs of foetus distress, such as abnormal amount of amniotic fluid, weak or not being able to hear the heart rate, infrequent heart beats or general description that heart beat is fast or slow. The colour of normal amniotic fluid was described by 96% of the respondents in both groups.

Monitoring during labour

Respondents also described other examinations of the pregnant woman in labour like measuring blood pressure, pulse, weight, temperature and taking urine sample in open- ended questions. A majority (81%) of the respondents at CHC had access to partograph chart in their workplace compared to all (100%) in the hospital group. Almost all, 80% (CHC) and 93% (hospitals) that had access to the partograph also used the partograph chart to monitor the woman during labour. Cervix dilation, descent of presenting part, uterine contractions, foetal heart rate, colour of amniotic fluid, pulse, blood pressure, temperature of mother were factors recorded on the partograph chart. Most respondents recorded on the partograph chart during labour 73% (CHC) and 93% (hospitals) some answered that they filled in the chart both during labour and after delivery (7% CHC and 6% hospitals) 6% of respondents working at CHC reported that they only filled it in after delivery. Below are respondent's answers to open-ended question concerning counselling during labour and delivery and they describe different examinations and information given to the woman concerning her coming labour and delivery.

“examine the cervix effacement and dilation, follow up the uterus contractions, blood pressure, baby heart rate” (Midwife at CHC).

“ask about the history of first delivery, examine the woman pulse, temperature and blood pressure, check the cervix dilation” (Assistant doctor at CHC).

Information and instructions during labour and delivery

Information and instructions were one category that emerged from the analyses of the open-ended questions and included information about the woman's conditions and information about delivery at CHC or choice to deliver at hospital. Information and instructions described concerned normal labour and delivery, information about possible complications and the importance to inform the health care providers if there is any risk signs. That it is important to coordinate with the health care provider through out the labour and delivery and follow the instructions of the health care provider. How the woman can be as comfortable as possible during labour and how breathing technique can be helpful during labour and when it is time to push. The women should not start to push too early but follow the instructions of the health care provider. Health care providers also gave women information that pain in delivery is normal and that the woman should try to stand the pain. Information and instructions to the women about nutrition, hygiene and physical activity during labour was given by the health care providers. Information about care of mother during labour and care for mother and baby after delivery and information about breastfeeding was also given to the women.

“pregnant prepare that there will be pain, advise about nutrition during labour, should have their family there, choice to deliver in CHC or hospital” (Midwife at CHC).

“advise woman not to be worried, eat food with good nutrients, believe in midwives and doctors, keep calm in waiting for delivery, all health workers will do as well as possible to follow up and help her to deliver” (Doctor at hospital).

“breathe in deeply and effectively, relax follow the fit position, eat food to support nutrition, trust doctor, tell midwife if you have any trouble” (Midwife at hospital).

“advise woman about nutrition and hygiene before delivery, advise woman how to follow up the uterus contract. When delivering, tell woman how to push right and how to lay in bed to delivery” (Midwife at hospital).

“inform about the conditions of women in labour, instruct about nutrition, hygiene and urinate, instruct how to breathe and how to lie on bed in delivery room and how to push” (Midwife at hospital).

Birth positions

Of the respondents 50% (CHC) and 39% (hospitals) advised the woman to lie on her back during delivery. 42% (CHC) and 36% (hospitals) advised about a semi- sitting position for the woman during delivery, a few respondents at the hospital recommended other positions like lying on the side or standing up.

Care routines during labour and delivery

Almost half (46%) of the health care providers working at CHC and more than half (63%) working at hospitals always emptied the woman's urine bladder with a catheter before childbirth. Episiotomy was performed on every primipara by 41% of the respondents working at CHC compared to 36% working at hospital. Other reasons for episiotomy given by 37% (CHC) and 42% (hospitals) included when the perineum widen bad, if the perineum is thick, to fasten the delivery, easier for baby to come out to protect the baby's head or prevent any damage to baby, big baby, pre-term foetus, if there is a risk for rupture and when the rupture can be complex.

Health care providers described, in answers to the open- ended questions, pain during labour and delivery and the method for pain- relief described was breathing in deeply and frequent. Most health care provider at CHC (81%) only had breathing and relaxation to provide women with and the corresponding figure for hospital health care providers was 60%. Together with the breathing method massage to the lower back was recommended by additional 4% (CHC) and 18% (hospitals) and other method like drug injection, acupuncture was only mentioned by a few health care providers. The answers from the open- ended questions revealed that another breathing technique was advised when it came time to push and the women were told not to shout in order to avoid losing energy but to try and relax and keep strong between the uterus contractions.

Support during labour and delivery

One category from the analyses to the open- ended questions was the woman's belief in herself. The support from the health care provider to the woman focused on mental support including empowering and encourage that the woman should belief in herself and not to worry about the labour but to keep good spirit. The woman should trust herself, her spirit,

keep calm and be secure in her own capacity. The woman should be informed in order to be prepared for pain and the labour work. The woman should think about a good thing and trust in this delivery, that labour will be good and mother and baby are healthy. In the open-ended questions the health care providers described that the family should be present for the woman and make the woman feel secure during labour. Of the respondents 73% at CHC and 87% at hospitals did not let the woman's relative stay in the delivery room during delivery and the most common reason were that the delivery room is sterile. Other reasons mentioned were that it will affect the woman negatively, undermine her ability to concentrate and families present would affect the work of the health care provider. A small share of the health care staff at CHC (20%) and the hospital staff (6%) did encourage family to be present as that would make the woman feel calm and secure, she would be supplied with food and drinks.

Trust and confidence in the health care provider was the other category in analyses that emerged from the open-ended questions and focused on ensuring the woman to trust and believe in the health care providers. The woman should feel secure with the care and follow the instruction from the health care provider. The health care providers should make eye contact, encourage, empower and praise the woman and take an interest in the woman in order to make a good and close contact. The woman should be advised to be calm and relaxed and given adequate care and information about labour and delivery. The health care providers will do their best to help the woman in delivery and the woman should be comfortable and trust that she and her baby will be safe.

Care and practise after delivery

Care routines after delivery

Oxytocin was described to be used by some before delivery when labour is prolonged or the progress is slow, with ordination of a doctor, but by most health care providers it was describe to be used after delivery. Most answered that they administered oxytocin right after the baby had come out but some administered the drug after the placenta had been delivered or for managing bleeding after delivery. Of the respondents 26% (CHC) and 36% (hospital) administered 5 units of oxytocin were as 48% (CHC) and 36% (hospital) administered 10 units of oxytocin. Of the respondents 84% (CHC) and 96% (hospital) assessed the baby after delivery using Apgar score. Of the health care providers working at CHC 24% could account for all five Apgar assessment factors and 2% answered right on the correct times to assess

them compared to 93% at hospital who knew the five assessment factors and 0% who knew the two times. The majority of the respondents (88% at CHC and 87% at hospital) waited for placenta to be delivered spontaneously and all of them answered that they examined the placenta after it had been delivered. Of the respondents 93% of both groups said that they did a manual inspection of the uterine cavity of all women after placenta had been delivered. Most respondents 54% (CHC) and 72% (hospital) answered that the maximum amount a woman is allowed to bleed during normal delivery is 300ml. According to 47% of health care providers working at CHC and 60% working at hospital the mother and newborn was discharged 12-24 hours after delivery but some mother and their newborns stayed 2-3 days after delivery before discharge according to 37% at CHC and 33% at hospital.

Monitoring after delivery

In the analyses of the open-ended questions concerning counselling after delivery many health care providers give information and advice concerning care and monitoring of the woman after delivery. The woman should follow up bleeding and fluids and she was advised that usage of less than 4 bandages/day was normal but if it is more the woman should inform the health care provider. The woman should massage the bottom of uterus for the first hours after delivery and follow up the uterine contractions and be informed that pain is because of the contractions and that it helps to reduce bleeding. She should clean and care for the breasts. After delivery the woman should be informed how to follow up the suturing of rupture. The woman should get instruction about practising to urinate early after delivery.

The woman should inform the health care provider if she feels her condition is abnormal in some way and the health care providers should explain and instruct the woman of problems that may occur after delivery. The health care provider checks the woman's blood pressure, pulse, temperature, respiratory rate. The woman should be given adequate information in order to care for herself and her baby.

Care of newborn

In the open-ended questions advice like that the baby should lie in a room without wind and how to keep the baby warm were given to the women. Some of the respondents in the study gave advice concerning vaccination for the baby and the importance to follow the vaccination schedule. Hygiene for the baby was another category and entailed advice about how to keep the baby clean, how to give the baby a bath and care of the umbilical cord with changing of bandage that covers the umbilical cord. Some health care providers described in their answers

to the open- ended questions about facilitating the contact between the mother and newborn by advising about letting the baby lie beside the mother in order to help create the connection between them. A majority (86%) of respondents at CHC and (96%) of respondents at hospitals promoted skin to skin contact between mother and newborn in order to keep the baby warm and to increase emotion between mother and baby and to stimulate breastfeeding. Skin to skin contact was also described by a few health care providers to stimulate respiration and heart beat of baby.

Most advise concerning the care of the newborn in the answers to the open- ended questions was about breastfeeding. Breastfeeding should start as soon as possible and be given for 20 minutes to 1 hour and the mother should continue to breastfeed completely for 4-6 months. Instruction how to give the breast milk for the baby in the right way and that the breast should be cleaned before giving breast milk, massage of the breast was another advise. Advise how to follow up the coming of breast milk, not to limit the times of feedings but to give the baby breast milk whenever he/she needs. Inform and explain about the usefulness of breast milk to the mother.

Emergency obstetric care

Mapping of the different health care facilities ability to provide EmOC and comprehensive EmOC is described below (Table 4).

Table 4. Access to basic EmOC and comprehensive EmOC

Question	CHC n=105	Hospitals n=33
Access to iv/im antibiotics		
Yes	62 (59%)	32 (96%)
No	39 (37%)	1 (3%)
Access to iv/im oxytocin		
Yes	103 (98%)	33 (100%)
No	1 (<1%)	0
Access to iv/im anticonvulsants		
Yes	60 (57%)	30 (90%)
No	32 (30%)	2 (6%)
Possible to perform manual removal of placenta		
Yes	54 (51%)	33 (100%)
No	46 (43%)	0
Possible to perform manual removal of retained products		
Yes	82 (78%)	32 (96%)
No	16 (15%)	1 (3%)
Assisted vaginal delivery with vacuum extraction		
Yes	9 (8%)	28 (84%)
No	90 (85%)	5 (15%)
Assisted vaginal delivery with forceps		
Yes	1 (<1%)	12 (36%)
No	101 (96%)	21 (63%)
Possible to perform Emergency caesarean section		
Yes	1 (<1%)	30 (90%)
No	100 (95%)	3 (9%)
Possible to give blood transfusion		
Yes	2 (1%)	29 (87%)
No	100 (95%)	3 (9%)
Access to neonatal resuscitation equipment		
Yes	56 (53%)	33 (100%)
No	42 (40%)	0
Perform skilled neonatal resuscitation		
Yes	66 (62%)	31 (93%)
No	30 (28%)	0
Referral of patient to higher level by the health facility		
Yes	32 (30%)	33 (100%)
No	70 (66%)	0

Not all respondents answered all the questions which are the reason for loss of number of respondents in the table.

Health care providers working at hospital can provide women with both basic and comprehensive EmOC and provide the newborn with skilled neonatal resuscitation (93%) if needed and they can also provide referral including transportation to the patient when needed. The health care providers working at CHC can not provide women with basic EmOC since they cannot perform assisted vaginal delivery and some don't have im/iv essential drugs as anticonvulsants and antibiotics. About half of the respondents at CHC (53%) described that

the CHC had neonatal resuscitation equipment while 40% answered they did not have the equipment. 62 percent of the health care providers at CHC answered that they could perform skilled neonatal resuscitation. More than half (66%) of the CHC respondents described that their health facility could not provide for help in referral of patients to a higher level.

Discussion

The main objective of the study was to describe delivery care routines at different levels in the health care system in Vietnam. The specific objective was to describe health care provider's delivery care routines and care of women giving birth in community health centres and hospitals in the Quang Ninh Province, Northern Vietnam.

To our knowledge this is the first cross sectional study to describe delivery care routines and practice at different levels in the health care system in Northern Vietnam. The fact that only 20 percent (CHC) as showed in our study of the health care providers assisting deliveries at CHC are midwives is an important finding and might have implications for the quality of care women receive during delivery in the rural area of Vietnam.

An international study that assessed maternal and neonatal health services in 49 developing countries across the world show that women living in rural areas do have many disadvantages concerning maternal health care compared to urban women. The services were rated on a scale by several experts in each country. Rural women had less access to 24- hour district hospital (57.7% rural areas, 81.3% urban areas), delivery care by trained professional attendant (43.9% rural areas, 75.5 urban areas), treatment for postpartum haemorrhage (34.8 % rural areas, 68.6% urban areas) and management of obstructed labour (33.% rural areas, 69.0% urban areas) (25).

Earlier studies from Vietnam indicate that 72 percent of deliveries at primary care settings were attended by trained health care providers but this proportion was lower (60%) in coastal and highland areas. It is however unsure what professional background these health care providers have and if they are specifically trained to assist a delivery. The government has since then implemented several interventions to improve access and quality of maternity services at CHCs. These interventions included upgrading public health facilities, procurement of medical equipment and training of health care providers (26). It seems that these interventions have not reached all facilities within the health care system in Northern Vietnam. Our study does not provide population based information regarding the health care providers that assist women at delivery in rural Vietnam. However, it indicates that health care providers at community health care level do not always have appropriate professional background to assure a safe delivery.

The fact that health care provider's in our study further report to have assisted at less than 10 deliveries/year (81% of respondents at CHC) is another aspect to consider when improving

the health care services in order to prevent morbidity and mortality among the newborns. A certain number of deliveries/year is important for a health care provider to keep the clinical competence. A review article points out that several countries from similar setting lack human resources, especially skilled birth attendants to assure safe delivery for all women (27). Coverage of educated and trained health care providers with skills to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period is important in order to reduce maternal and neonatal mortality (28). The fact that not all of the respondents in our study are midwives and/or skilled birth attendants may reflect on the low proportions to some of our questions concerning labour and delivery care. Our study shows that the health care provider's ability to follow the progress of labour was not optimal. Only one third (26%) of the health care providers from CHC could identify all three factors (foetal descent, cervix effacement and dilation and uterus contraction) that reflect the progress of labour. The corresponding figure for the hospital group was similar (27%). Correct description of cervix status during active stage of labour was reported by most of the respondents with little difference between groups. In our study the health care providers described variation in routines such as emptying the woman's urine bladder with a catheter before delivery, performing episiotomy, administering different doses of oxytocin after delivery, knowledge concerning of Apgar score and what it entails although almost all health care provider described that they used Apgar in assessment of the newborn. Signs of foetal distress in form of heartbeat under 120 bpm or over 160 bpm were only described by 29 percent of health care providers at CHC. These findings show that the health care provider's routines and care for women during labour and delivery vary and that there is a need for re-training and that women in labour should be cared for by health care providers with adequate training like midwifery. A study that included 49 countries showed that re- training within five years had inter medium ratings, training for new medical staff had low ratings, nurses and midwives were more likely to receive re- training than doctors (25). Weakness within delivery care as reported from a review article are scarcity of trained staff, poor quality of care, delayed use of services and affordability barriers (28). A study from Vietnam about client-perceived quality showed that the clients appreciated the communication skills and conduct of the health care providers at primary health care but perceived their competence to be low (29). This is in accordance with our findings indicating that health care providers at CHC have lower clinical competence but do safeguard women's ability to deliver by empower and encourage her during the process of labour. The health care providers describe their counselling to women during and after delivery to be coherent with the standard guidelines. Breastfeeding was

further mentioned and promoted by most health care providers as a topic in counselling after delivery. Another positive finding from our study was the high proportion of health care providers that reported to use the partograph chart when monitoring the labour (80% CHC and 93% hospital) and that most health care providers promoted skin – to skin contact between mother and newborn after delivery. .

The finding in our study is worrisome, that the poor resources at CHC limit health care provider's ability to provide both basic and comprehensive EmOC. About half of health care providers at CHC described that they could perform skilled neonatal resuscitation and that they had the equipment for that. Most CHC could not provide patients with referral to higher health facility it was up to the patients to provide for it themselves such as transportation. The hospitals according to the respondents could provide both basic and comprehensive EmOC to women and they also had transportation to provide patients with in need of referral.

Earlier studies, with focus to strengthen the emergency obstetric care in Vietnam, conclude that hospitals in particular can improve their capacity to treat life- threatening conditions whereas upgrading CHC would be a greater task since they are many more. Improving the management of life- threatening conditions in hospitals will have limited effect in areas where clinic and home delivery cater for most deliveries (30). Another study assessed needs in emergency obstetric services using the UN indicators of basic and comprehensive EmOC in three countries and Vietnam was one of the countries. Five facilities in two provinces was surveyed in Vietnam and the results showed that the recommended number of facilities with comprehensive EmOC was fulfilled but there was a shortage of facilities providing basic EmOC. The lack of facilities providing basic EmOC was explained by many factors but the main one was health care planners focus on prioritizing hospital clinics before CHC. Even if the criteria of the UN indicators are met concerning EmOC accessibility, quality and utilization the maternal and neonatal mortality may still remain high (31). The reasons are often related to delay in receiving adequate health care as shown in a descriptive study from Thailand (10, 31). In our study more than half (66%) of respondents working at CHC answered that their facility could not provide referral with transportation to patients. A review article points out that weak referral links, poor communication and transport, long distances and care with low quality limits access of care to those who may need it most are other obstacles to receive health care (28). Our respondent's ability to perform skilled neonatal resuscitation and their access to equipment for neonatal resuscitation at their workplace was poor at CHC. Our findings indicate that the respondents at hospitals both had equipment for

neonatal resuscitation and answered that they had ability to perform skilled resuscitation. However, among respondents at CHC 53 percent answered that their facility had neonatal resuscitation equipment while 62 percent answered they had ability to perform skilled neonatal resuscitation. It is recommended internationally that neonatal resuscitation should be integrated as a component in EmOC assessments (27).

Methodology consideration

Cross sectional design was chosen since the objective of the study was to describe delivery care routines at different levels in the health care system in Vietnam. The study's objective was to describe health care provider's delivery care routines and care of women giving birth in community health centres and hospitals in the Quang Ninh Province, Northern Vietnam. Our study includes health care providers from three district and one regional hospital and 40 CHCs. The sample size was determined by the number of health care providers that were present and able to participate at the health facility when the data collectors came to collect data. All CHCs but one in the two districts was represented by at least one health care provider (usually 2-4/ CHC). The health care providers both at CHC and hospitals that worked and was not occupied with patients when the data collectors came participated in the study.

A questionnaire was chosen as an instrument for the study since the objective was to describe delivery care routines at different levels in the health care system in Vietnam. One weakness is that the instrument was developed by the research group and had not been previously tested and our study can therefore be seen as a pilot- study. The content of the questionnaire is however based on national and international documents regarding practice within delivery care. The questionnaire need minor revision before it can be used in further research.

Translation of the questionnaire has been made by members of the research group and has been double checked. The health care providers were all asked to participate through a letter of information about the study and the researcher. The data collection took place at the respondent's workplaces and a research assistant came and introduced the study and questionnaire to all CHC and hospitals during a time period of 2 weeks. The respondents were informed orally and in writing about the study and then they filled in the questionnaire if they gave their consent to participate. The research assistant was present during the time the respondents filled in the questionnaire and could answer any questions. The questionnaire was answered anonymous and provided the respondents the possibility to answer freely and

openly. The closed-ended questions can limit the health care provider in their answers. There were some open-ended questions in the study but the respondents had limited space and therefore it was hard for them to answer in detail. The analyses of the open-questions were content analysis even though the material was limited. The researcher wanted to illustrate the health care providers own descriptions of their care and routines concerning labour and delivery. The material from the closed questions was analysed and presented by proportions shown in percent to show the difference between the two groups (CHC and hospital).

Conclusions and clinical implications

The study provides information regarding factors that have implications for the health care provider's ability to perform in accordance with the National Standard Guideline for Vietnam. Our study has a small sample size but give an insight in the delivery care in Quang Ninh province Northern Vietnam and more research is needed in this area in order to improve maternal and newborn health. Our findings indicate that there is a need for re-training in delivery care among health care providers and since the number of deliveries at CHC is few they should be handled by someone who is skilled birth attendant. Our findings also show a variation in care routines during labour and delivery among health care providers at CHC and hospital levels and this also show the need for re-training and support from proper authorities in order to improve maternal and newborn health. This study hopes to be of value concerning the clinical work of the health care providers in Quang Ninh province, Vietnam. Further research more in depth and larger scale about the quality of delivery care (including care routines and procedures) together with description of the health care system and the health educational system in Vietnam is needed to understand the resources and abilities of the health care providers care of women during labour and delivery in Quang Ninh province.

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Appendix

Appendix I. Informed consent for health care providers.

This is a consent letter to invite health care providers and midwifery students to participate in the study of delivery care in Quang Ninh province, Vietnam.

Dear friends,

We would like to send this official letter of informed consent of **the study of delivery care in Quang Ninh province, Vietnam** to the leaders and health care providers in Vietnam- Sweden Uong Bi hospital, Dong Trieu District General Hospital, Health Centre in Mao Khe, Dong Trieu District Health Bureau, Yen Hung District Hospital, Yen Hung District Health Bureau, all the Community Health Centres (CHC) in Dong Trieu and Yen Hung, this letter is also sent to midwifery students in their last year in nursing school in Quang Ninh.

The main aim of the study is to describe delivery care routines at different levels in the health care system in Vietnam. The studies objectives are to describe health care providers and midwifery student's delivery care routines and care of women giving birth in community health centres and hospitals in the Quang Ninh Province, Northern Vietnam. This study is important because it hopes to contribute to the health of women during delivery and the health of the newborns in the Quang Ninh Province, Northern Vietnam.

To implement this study we will use a questionnaire of *routine delivery care in health facilities in Quang Ninh province, Vietnam* we will invite health care providers in these health facilities and midwifery students at the end of their education to answer this questionnaire. This information letter will be distributed to all health care providers working with deliveries in 4 hospitals and 40 CHC in the Quang Ninh province and midwifery students close to graduation from Quang Ninh nursing school. If you give your consent to participate please fill in the questionnaire. Your participation in this study is completely voluntary and you can withdraw your participation at any time during the study.

The study is reviewed concerning research ethics by the Ethical research committee at Högskolan Dalarna, Sweden and health leaders in different levels in Quang Ninh province, Vietnam. The questionnaires content will be handled by the Swedish midwifery student and the data will be analysed statistically and descriptive. The information from the questionnaire will be treated in a way that protects the confidentiality and anonymity of the respondents. The result will be used for research and training according to regulation.

The study's result will be presented in a degree project for the student's midwifery degree. If you wish to take part of the study's result please contact the midwifery student, contact information below. We will also inform about the results in order to contribute for maternal and newborn health in Quang Ninh.

Thank you very much for your attention and involvement in this study.

Further information are given by the study's responsible below,

081017 Falun

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Appendix II. Informed consent letter to health care providers, Vietnamese.

Thư thông báo mời cán bộ Y tế và sinh viên Nữ hộ sinh tham gia Nghiên cứu Chăm sóc Phụ nữ khi sinh ở tỉnh Quảng Ninh, Việt Nam

Thưa anh/chị,

Chúng tôi xin gửi thư thông báo mời cán bộ Y tế và sinh viên Nữ hộ sinh tham gia **Nghiên cứu thường qui chăm sóc phụ nữ khi sinh ở tỉnh Quảng Ninh, Việt Nam** tới các cán bộ lãnh đạo, cán bộ y tế đang công tác tại Bệnh viện Việt Nam Thụy Điển Uông Bí, Bệnh viện Đa khoa huyện Đông Triều, Trung tâm Y tế Than khu vực Mạo Khê, Phòng Y tế huyện Đông Triều, Bệnh viện Đa khoa huyện Yên Hưng, Phòng Y tế huyện Yên Hưng và các Trạm Y tế trên địa bàn huyện Đông Triều và Yên Hưng; và các sinh viên nữ hộ sinh năm cuối của trường Cao đẳng Y tế Quảng Ninh.

Mục tiêu chính của nghiên cứu là mô tả các thường qui chăm sóc phụ nữ khi sinh ở các cơ sở y tế, bao gồm các trạm y tế và bệnh viện trên địa bàn tỉnh Quảng Ninh. Vì vậy chúng tôi mong muốn các cán bộ Y tế và các sinh viên nữ hộ sinh năm cuối trao đổi kinh nghiệm thực tế của mình để góp phần nâng cao Sức khỏe Bà mẹ và Trẻ Sơ sinh cũng như đóng góp cho chương trình đào tạo nữ hộ sinh Việt Nam và Thụy Điển.

Để triển khai nghiên cứu, chúng tôi sử dụng bộ câu hỏi *Tìm hiểu thường qui chăm sóc phụ nữ khi sinh tại các cơ sở y tế trong tỉnh Quảng Ninh* và trân trọng kính mời các cán bộ y tế và các sinh viên Nữ hộ sinh đang làm công tác chăm sóc phụ nữ khi sinh tại các cơ sở y tế được chọn tham gia nghiên cứu nói trên trả lời bộ câu hỏi này.

Thư thông báo mời tham gia nghiên cứu này sẽ được gửi tới các cán bộ y tế đang tham gia chăm sóc phụ nữ khi sinh tại 40 Trạm Y tế, 4 bệnh viện và các sinh viên Nữ hộ sinh năm cuối của Trường Cao đẳng Y tế tỉnh Quảng Ninh. Các anh/chị có thể khẳng định sự đồng ý tham gia nghiên cứu tự nguyện của mình bằng cách trả lời tất cả các câu hỏi trong bộ câu hỏi nghiên cứu này. Tuy nhiên, các anh/chị cũng có quyền rút lui không tham gia nghiên cứu ở bất cứ thời điểm nào mà anh chị không muốn.

Nghiên cứu này đã được duyệt thông qua của Hội đồng Y đức trong Nghiên cứu của Trường Dalarna, Thụy Điển và được sự đồng ý của các cấp lãnh đạo Y tế tỉnh Quảng Ninh, Việt Nam. Một sinh viên Nữ hộ sinh Thụy Điển sẽ phụ trách chính phần phân tích tổng hợp kết quả nghiên cứu và đảm bảo các thông tin luôn được thực hiện theo đúng các nguyên tắc dành cho nghiên cứu khoa học và đào tạo cán bộ.

Kết quả nghiên cứu sẽ được trình bày trong báo cáo kết quả học tập của sinh viên nữ hộ sinh. Nếu các anh/chị muốn biết kết quả nghiên cứu, đề nghị liên hệ với các cán bộ theo địa chỉ phía dưới.

Xin trân trọng cảm ơn anh/chị đã quan tâm và tham gia nghiên cứu này.

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Appendix III. Questionnaire for health care providers.

Questionnaire

Number

In order to increase our knowledge about delivery care in Vietnam we have designed this questionnaire as part of the co-operation between Uong Bi General Hospital, Vietnam and Högskolan Dalarna, Sweden.

Please read each question and tick in the boxes that you think is correct (there can be several that are right to one question) and please write yourself in the empty boxes.

Section 1 Your professional background and workplace.	
1.1 What is your profession?	1. Doctor <input type="checkbox"/> 2. Midwife <input type="checkbox"/> 3. Nurse <input type="checkbox"/> 4. Other.....(<input type="checkbox"/>)
1.2 How many years basic training do you have?	Number of years.....
1.3 When did you graduate?	
1.4 Where do you work?	1. Community health centre <input type="checkbox"/> 2. District hospital <input type="checkbox"/> 3. Provincial hospital <input type="checkbox"/> 4. Other.....(<input type="checkbox"/>)
1.5 How many years work experience do you have?	CHC.....years District hospitalyears Provincial hospitalyears
1.6 Have you had any re-training the last 5 years?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
1.7 If yes at question 1.6, what was the content of the re-training?	
1.8 Do you think the level of re-training is adequate?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
1.9 Does your workplace have a delivery room?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
1.10 How many women can deliver at the same time in the delivery room?	Number of.....
1.11 During the last year how many deliveries have you assist/performed?	Number of.....
Section 2 Clinical delivery practise and care for normal labour and delivery.	
2.1 Describe the counselling you give women during labour and delivery.	
2.2 Write the correct gestational week after preterm, term, post mature.	Preterm..... Term..... Post mature
2.3 Which factors reflect progress of labour?	1. Foetal decent <input type="checkbox"/> 2. Mothers age <input type="checkbox"/> 3. Cervix effacement and dilation <input type="checkbox"/> 4. Uterine contractions <input type="checkbox"/> 5. Mothers attitude <input type="checkbox"/>
2.4 Do you have access to partograph charts in your	1. Yes <input type="checkbox"/>

workplace?	2. No ()	
2.5 Do you monitor the process of labour using partograph chart?	1. Yes () 2. No ()	
2.6 If yes to question 2.5 When do you fill out the partograph	1. During labour () 2. After delivery () 3. Other.....()	
2.7 What do you record on the partograph (please tick what information you register on the partograph)	1. Cervix dilation () 2. The descent of presenting part () 3. Uterine contractions () 4. Foetal heart rate () 5. Colour of amniotic fluid () 6. Amount of amniotic fluid () 7. Mothers pulse () 8. Mothers blood pressure () 9. Mothers temperature () used () 10. Drugs 11. Other ().....	
2.8 Describe cervix status during latent phase of labour.	1. Cervix not effaced () 2. Cervix is effaced and dilated < 3 cm () 3. Cervix is effaced and dilated > 3 cm ()	
2.9 Describe cervix status during active phase of labour.	1. Cervix dilated 1-3 cm () 2. Cervix dilated 3-10 cm ()	
2.10 How often do you do vaginal exams?	1. Every hour () 2. Every two-four hours () 3. Other.....()	
2.11 What is normal cervical dilatation in active phase cm/h?	1. 0,5 cm/h () 2. 1 cm/h () 3. 1,5 cm/h () 4. 2 cm/h ()	
2.12 Please write how many uterine contractions are normal/ 10 minutes in active labour?	1. 1 contraction/ 10 min () 2. 2-4 contractions/10 min () 3. More then 5 contractions/10 min()	
2.13 How often do you examine uterine contractions?	1. Every 30-60 minutes () 2. Every 1 ½ hours () 3. Every 2 hours ()	
2.14 Please write normal foetal heart beat (beats/minute)		
2.15 Please write signs of foetal distress?		
2.16 How do you exam foetal heart beats?	1. Foetal Stethoscope () 2. Cardiotocography () 3. Doptone ()	
2.17 How often do you exam foetal heart beat?	1. Every 5 minutes () 2. Every 15-30 minutes () 3. Every 30-60 minutes ()	
2.18 What is acceptable blood pressure during labour?		
2.19 What colour is normal amniotic fluid?	1. Transparent () 2. Green () 3. Brown ()	
2.20 Can you perform amniotomy if needed?	1. Yes () 2. No ()	
2.21 What effect can amniotomy have?	1. Augmentation of labour () 2. Induce labour () 3. Prolonging labour ()	

2.22 What type of pain relief do you provide women with during labour and delivery?	1. Breathing and relaxation () Acupuncture () 3. Oxygen () 4. Pain relief injection () 5. Epidural anaesthesia () 6. Other.....()	2.
2.23 What position during delivery do you advise the women to use?	1. Lying on her back () 2. Semi- sitting position () 3. Lying on the side () 4. Standing up () 5. Other ()	
2.24 Do you let the mothers relative stay in the delivery room and why?	1. Yes () 2. No ()	Why
2.25 Do you empty the woman's urine bladder with a catheter before childbirth?	1. Seldom () 2. Sometimes () 3. Always ()	
2.26 Do you perform episiotomy?	1. On every women () 2. On every primipara () 3. Other.....() Why....	
2.27 Do you protect the perineum during delivery?	1. Yes () 2. No ()	
2.28 Please select the correct actions to perform with a healthy newborn after deliver and then put them in the order you perform them.	Dry the baby () Suction of the airway () Initiate breastfeeding () Skin to skin contact () Weigh the newborn () Clean eyes with saline () Assess status of newborn () Cut and clean the cord () Cover the cord stump ()	
2.29 Do you assess the status of the baby using Apgar score?	1. Yes () 2. No ()	() If no move to 2.32
2.30 What is included in Apgar score?	1. Birth weight () 2. Height () 3. Heart rate () 4. Breathing () 5. Temperature of the newborn () 6. Skin colour () 7. Muscle activity/ tonus () 8. Irritability ()	
2.31 At what times should Apgar score be observed?	1. Right after birth () 2. 1 minute () 3. 3 minutes () 4. 5 minutes () 5. 7 minutes () 6. 10 minutes () 7. 15 minutes () 8. Others.....()	
2.32 Do you promote skin- to- skin contact between the mother	1. Yes ()	

and newborn and why?	2. No ()	Why....
2.33 For how long should the healthy newborn lay skin- to – skin?	1. 5 minutes () 2. 10-20 minutes () 3. 30- 60 minutes () 4. 1-2 hours () 5. > 2 hours () 6. Other ()	
2.34 What is the definition of low birth weight for newborn children?	1. Weight is less then 3000grams () 2. Weight is less then 2500grams () 3. Weight is less then 2000 grams () 4. Weight is less then 1500 grams () 5. Weight is less then 1000 grams ()	
2.35 Do you administer oxytocin?	1. Yes () 2. No ()	
2.36 When do you administer oxytocin?		
2.37 What dose of oxytocin do you administer?	1. 1 unit () 2. 5 units () 3. 10 units () 4. 15 units ()	
2.38 Do you wait for spontaneous placenta delivery?	1. Yes () 2. No ()	
2.39 If yes to question 2.38 how many minutes can you wait before taking action?	1. About 5 minutes () 2. About 15 minutes () 3. About 30 minutes ()	
2.40 What kind of actions do you perform if placenta has not delivered spontaneously?	1. Empty urine bladder () 2. Administrate more oxytocin () 3. Manual removal of the placenta ()	
2.41 Do you examine the placenta and membranes after it has been delivered?	1. Yes () 2. No ()	
2.42 If yes to question 2.41 what do you examine?		
2.43 Do you perform manual inspection of the uterine cavity on all women after delivery of placenta?	1. Yes () 2. No ()	
2.44 Can you explain the degrees of ruptures?		
2.45 Which degrees of ruptures does the midwife suture?		
2.46 Do you administer pain relief before suturing?	1. Yes () 2. No ()	
2.47 What kind of pain relief do you use before suturing?	1. Local anaesthesia () 2. Pain relief injection () 3. Oxygen () 4. Other..... ()	
2.48 What amount of bleeding is allowed during normal childbirth?	1. Up to 300ml () 2. Up to 500ml () 3. Up to 1000ml ()	
2.49 Describe the counselling you give mothers after delivery.		
2.50 What time are healthy mothers and newborns discharged?	1. Before 6 hours 2. 6-12 hours after delivery () 3. 12-24 hours after delivery () 4. 2-3 days after delivery () 5. Other.....()	

2.51 Do you have the national standard guideline concerning delivery care in your workplace?	1. Yes () 2. No ()
2.52 What part of the guideline is most useful for your work?	
Section 3. Access to Emergency Obstetric Care	
3.1 Please write most common obstetric complications you handle in your work.	
3.2 Are iv/im antibiotics available where you work?	1. Yes () 2. No ()
3.3 Is iv/im oxytocin available where you work?	1. Yes () 2. No ()
3.4 Are iv/im anticonvulsants available where you work?	1. Yes () 2. No ()
3.5 Can manual removal of placenta be performed where you work?	1. Yes () 2. No ()
3.6 Can removal of retained products be performed where you work?	1. Yes () 2. No ()
3.7 Can assisted vaginal delivery with vacuum extraction be performed where you work?	1. Yes () 2. No ()
3.8 Can assisted vaginal delivery with forceps be performed where you work?	1. Yes () 2. No ()
3.9 Can emergency caesarean section be performed where you work?	1. Yes () 2. No ()
3.10 Can blood transfusion be performed where you work?	1. Yes () 2. No ()
3.11 Does your work place have neonatal resuscitation equipment?	1. Yes () 2. No ()
3.12 Can you perform skilled neonatal resuscitation?	1. Yes () 2. No ()
3.13 Can patients be referred to a higher level if needed?	1. Yes () 2. No ()
3.14 If yes to question 3.13 in what kind of transportation does the women mostly use?	1. On bicycle 2. On motorbike 3. Local bus 4. Taxi 5. By ambulance from the hospital 6. Other.....

Thank you for your participation!

Appendix IV. Questionnaire for health care providers, Vietnamese.

Bộ câu hỏi tìm hiểu Thường qui chăm sóc phụ nữ khi sinh tại tỉnh Quảng Ninh, 2008			
	Trân trọng kính mời anh/chị tham gia trả lời bộ câu hỏi này để chia sẻ kiến thức và kinh nghiệm của anh/chị trong hoạt động Chăm sóc phụ nữ khi sinh cho chương trình hợp tác đào tạo cán bộ Nữ hộ sinh của Bệnh viện Việt Nam Thụy Điển Uông Bí và Trường Đại học Dalarna, Thụy Điển.		
	<i>Đề nghị anh/chị đọc kỹ từng câu hỏi và chọn lựa trả lời theo suy nghĩ của mình.</i>		
Phần 1: Thông tin chung			
1,1	Anh/chị làm nghề gì?	ÿ 1. Bác sĩ	
		ÿ 2. Nữ hộ sinh	
		ÿ 3. Điều dưỡng	
		ÿ 4. Khác: @	
1,2	Thời gian đào tạo cơ bản bao nhiêu năm?	Số năm:	
1,3	Anh/chị tốt nghiệp năm nào?		
1,4	Anh/chị hiện đang làm việc tại cơ sở y tế nào?	ÿ 1. Trạm Y tế	
		ÿ 2. Bệnh viện huyện	
		ÿ 3. BV. VNTĐ UB	
		ÿ 4. Khác: @	
1,5	Anh/chị đã có bao nhiêu năm làm việc tại:	ÿ 1. Trạm Y tế
		ÿ 2. Bệnh viện huyện
		ÿ 3. BV. VNTĐ UB
1,6	Anh/chị có được đào tạo lại lần nào trong thời gian 5 năm trở lại đây?	ÿ 1. Có	
		ÿ 2. Không	Chuyển 1.9
1,7	Nếu có, anh/chị cho biết các nội dung mình đã được đào tạo lại là gì?		
1,8	Anh/chị thấy nội dung và thời gian anh/chị được đào tạo lại như thế có phù hợp không?	ÿ 1. Có	
		ÿ 2. Không	
1,9	Cơ sở y tế của anh chị có phòng đẻ không?	ÿ 1. Có	
		ÿ 2. Không	

1,10	Phòng đẻ đó có thể chăm sóc tối đa bao nhiêu ca đẻ trong cùng một thời gian?	Số ca:.....
1,11	Anh/chị đã trực tiếp đỡ đẻ/hỗ trợ bao nhiêu cuộc đẻ trong năm qua?	Số ca:.....
Phần 2: Thông tin về thường qui chăm sóc phụ nữ khi đẻ thường		
2,1	Anh/chị hãy mô tả những tư vấn của anh/chị thường làm cho sản phụ trong thời gian chuyển dạ.	
2,2	Anh/chị hãy điền tuổi thai theo tuần cho các trường hợp sinh non, sinh đủ tháng và sinh già tháng ở bên.	ý 1. Sinh non ý 2. Sinh đủ tháng ý 3. Sinh già tháng
2,3	Theo anh/chị các yếu tố ảnh hưởng đến tiến triển cuộc chuyển dạ là các yếu tố nào?	ý 1. Độ lọt của ngôi thai ý 2. Tuổi sản phụ ý 3. Độ xóa, mở cổ tử cung ý 4. Cơ co tử cung ý 5. Thái độ của sản phụ
2,4	Cơ sở y tế của anh/chị có bảng biểu đồ chuyển dạ không?	ý 1. Có ý 2. Không
2,5	Anh/chị có sử dụng biểu đồ chuyển dạ không?	ý 1. Có ý 2. Không Chuyển sang 2.8
2,6	Nếu có, anh/chị ghi các thông tin vào đó khi nào?	ý 1. Trong thời gian chuyển dạ ý 2. Sau khi đẻ ý 3. Khác.....
2,7	Anh/chị thường ghi các thông tin gì trong biểu đồ chuyển dạ ? (đề nghị đánh dấu vào cáo chọn lựa của anh/chị).	ý 1. Độ mở cổ tử cung ý 2. Độ lọt của thai ý 3. Tần số cơn co ý 4. Nhịp tim thai ý 5. Màu sắc nước ối ý 6. Số lượng nước ối ý 7. Mạch ý 8. Huyết áp

		ý 9. Nhiệt độ ý 10. Các thuốc đã sử dụng ý 11. Khác:
2,8	Anh/chị hãy mô tả tình trạng cổ tử cung trong giai đoạn chuyển dạ tiềm tàng	ý 1. Cổ tử cung chưa xóa ý 2. CTC đã xóa và mở < 3 cm ý 3. CTC đã xóa và mở > 3 cm
2,9	Anh/chị hãy mô tả tình trạng cổ tử cung trong giai đoạn chuyển dạ tích cực	ý 1. Cổ tử cung đã mở 1 - 3 cm ý 2. CTC đã mở 3 - 10 cm
2,10	Anh/chị thường khám âm đạo bao nhiêu lần một lần?	ý 1. 1 giờ 1 lần ý 2. 2 - 4 giờ 1 lần ý 3. Khác:
2,11	Anh/chị cho biết độ mở cổ tử cung bình thường trong giai đoạn chuyển dạ tích cực là bao nhiêu cm/giờ?	ý 1. 0.5 cm/giờ ý 2. 1 cm/giờ ý 3. 1.5 cm/giờ ý 4. 2 cm/giờ
2,12	Anh/chị cho biết tần số cơn co tử cung bình thường trong giai đoạn chuyển dạ tích cực là bao nhiêu cơn co trong 10 phút?	ý 1. 1 cơn co/10 phút ý 2. 2 - 4 cơn co/10 phút ý 3. > 5 cơn co/10 phút
2,13	Anh/chị thường đo cơn co tử cung bao nhiêu lần một lần?	ý 1. 30 - 60 phút 1 lần ý 2. 1 giờ rưỡi 1 lần ý 3. 2 giờ 1 lần
2,14	Anh/chị cho biết tần số tim thai bình thường là bao nhiêu lần trong 1 phút?/1 phút
2,15	Anh/chị cho biết dấu hiệu của suy thai?	
2,16	Anh/chị sử dụng dụng cụ gì để nghe tim thai?	ý 1. Ống nghe tim thai ý 2. Máy theo dõi tim thai ý 3. Máy doppler
2,17	Bao nhiêu lâu anh/chị kiểm tra nhịp tim thai một lần?	ý 1. 5 phút một lần ý 2. 15 - 30 phút một lần ý 3. 30 - 60 phút một lần
2,18	Anh/chị cho biết giới hạn tối đa huyết áp sản phụ có thể chấp nhận trong giai đoạn chuyển dạ là bao nhiêu?	
2,19	Anh/chị cho biết màu sắc nước ối bình thường là như thế nào?	ý 1. Trong

		Cho trẻ nằm tiếp xúc da-kê-da với mẹ ()
		Cân cho trẻ ()
		Lau sạch mắt bằng nước muối ()
		Đánh giá tình trạng trẻ ()
		Cắt rốn và sát trùng rốn ()
		Băng kín rốn ()
2,29	Anh/chị có dùng bảng Apgar để đánh giá tình trạng ngay của trẻ sơ sinh ngay sau đẻ không?	ÿ 1. Có
		ÿ 2. Không Chuyển 2.32
2,30	Anh/chị cho biết bảng Apgar bao gồm các chỉ số gì?	ÿ 1. Cân nặng
		ÿ 2. Chiều dài
		ÿ 3. Nhịp tim
		ÿ 4. Nhịp thở
		ÿ 5. Nhiệt độ
		ÿ 6. Màu sắc da
		ÿ 7. Trương lực cơ
		ÿ 8. Phản xạ
2,31	Anh/chị thường đánh giá điểm Apgar vào thời điểm nào sau đẻ?	ÿ 1. Ngay sau đẻ
		ÿ 2. 1 phút
		ÿ 3. 3 phút
		ÿ 4. 5 phút
		ÿ 5. 7 phút
		ÿ 6. 10 phút
		ÿ 7. 15 phút
		ÿ 8. Khác
2,32	Anh/chị có hướng dẫn người mẹ thực hiện tiếp xúc da-kê-da giữa mẹ và con sau đẻ không? Tại sao?	ÿ 1. Có
		ÿ 2. Không
		Tại sao?
2,33	Theo anh/chị thời gian trẻ tiếp xúc da-kê-da với mẹ bao nhiêu phút/giờ trong ngày thì tốt nhất?	ÿ 1. 5 phút
		ÿ 2. 10 - 30 phút
		ÿ 3. 30 - 60 phút
		ÿ 4. 1 - 2 giờ
		ÿ 5. > 2 giờ
		ÿ 6. Khác

2,34	Anh/chị cho biết định nghĩa trẻ đẻ nhẹ cân là trẻ có cân nặng khi đẻ như thế nào?	ÿ 1. Cân nặng khi sinh < 3000 g	
		ÿ 2. Cân nặng khi sinh < 2500 g	
		ÿ 3. Cân nặng khi sinh < 2000 g	
		ÿ 4. Cân nặng khi sinh < 1500 g	
		ÿ 5. Cân nặng khi sinh < 1000 g	
2,35	Anh/chị có sử dụng oxytocin cho cuộc đẻ không?	ÿ 1. Có	
		ÿ 2. Không	
2,36	Anh/chị sử dụng oxytocin cho sản phụ vào thời điểm nào của cuộc đẻ?		
2,37	Anh/chị cho biết liều lượng oxytocin thường dùng cho sản phụ là bao nhiêu?	ÿ 1. 1 đơn vị	
		ÿ 2. 5 đơn vị	
		ÿ 3. 10 đơn vị	
		ÿ 4. 15 đơn vị	
2,38	Anh/chị có chờ rồi đỡ cho rau ra tự nhiên không?	ÿ 1. Có	
		ÿ 2. Không	
2,39	Anh/chị có thể chờ tối đa bao nhiêu phút trước khi anh/chị cần can thiệp nếu rau không ra?	ÿ 1. Khoảng 5 phút	
		ÿ 2. Khoảng 15 phút	
		ÿ 3. Khoảng 30 phút	
2,40	Anh/chị sẽ làm gì nếu rau thai không ra tự nhiên?	ÿ 1. Thông đái cho sản phụ	
		ÿ 2. Cho thêm oxytocin	
		ÿ 3. Lấy rau bằng tay	
2,41	Anh/chị có kiểm tra rau thai không?	ÿ 1. Có	
		ÿ 2. Không	
2,42	Anh/chị kiểm tra những điểm gì của rau thai?		
2,43	Nếu anh/chị thấy sót rau, anh/chị có thể tiến hành kiểm soát tử cung bằng tay không?	ÿ 1. Có	
		ÿ 2. Không	
2,44	Anh/chị hãy phân loại độ rách của tầng sinh môn		
2,45	Tầng sinh môn bị rách ở độ nào thì người nữ hộ sinh được phép khâu?		
2,46	Anh/chị có giảm đau cho người mẹ trước khi khâu tầng sinh môn	ÿ 1. Có	

	không?	ÿ 2. Không	Chuyến 2.48
2,47	Anh/chị thường sử dụng phương pháp giảm đau nào trước khi khâu tầng sinh môn cho người mẹ?	ÿ 1. Gây tê tại chỗ	
		ÿ 2. Tiêm thuốc giảm đau	
		ÿ 3. Thở ô xy	
		ÿ 4. Khác	
2,48	Số lượng máu chảy tối đa cho phép của một cuộc đẻ thường là bao nhiêu?	ÿ 1. 300 ml	
		ÿ 2. 500 ml	
		ÿ 3. 1000 ml	
2,49	Anh/chị hãy mô tả những tư vấn mà anh/chị thường làm cho người mẹ sau đẻ		
2,50	Thời gian nằm viện (tại cơ sở y tế của anh/chị) cho người mẹ đẻ thường và con sinh khỏe mạnh là bao nhiêu lâu (giờ/ngày)?	ÿ 1. Dưới 6 giờ	
		ÿ 2. 6 - 12 giờ	
		ÿ 3. 12 - 24 giờ	
		ÿ 4. 2 - 3 ngày	
		ÿ 5. Khác	
2,51	Cơ sở Y tế của anh/chị có quyền "Hướng dẫn chuẩn Quốc gia về Chăm sóc sức khỏe sinh sản" của Bộ Y tế năm 2003 không?	ÿ 1. Có	
		ÿ 2. Không	Chuyến 2.53
2,52	Anh/chị thấy phần nào trong cuốn tài liệu đó bổ ích nhất đối với anh/chị?		
Phần 3: Thông tin về thường qui chăm sóc cuộc đẻ có biến chứng			
3,1	Anh/chị hãy cho biết các biến chứng sản khoa mà anh/chị thường gặp?		
3,2	Cơ sở Y tế của anh/chị có thuốc kháng sinh để tiêm bắp hoặc tiêm TM cho sản phụ không?	ÿ 1. Có	
		ÿ 2. Không	
3,3	Cơ sở y tế của anh/chị có thuốc oxytocin để tiêm bắp hoặc tiêm TM cho sản phụ không?	ÿ 1. Có	
		ÿ 2. Không	
3,4	Cơ sở Y tế của anh/chị có thuốc chống co giật dùng đường tiêm	ÿ 1. Có	

	bắp hoặc tiêm TM không?	ỹ 2. Không
3,5	Cơ sở Y tế của anh/chị có thể thực hiện được thủ thuật bóc rau nhân tạo không?	ỹ 1. Có
		ỹ 2. Không
3,6	Cơ sở Y tế của anh/chị có thể thực hiện được thủ thuật kiểm soát buồng tử cung để lấy rau sót không?	ỹ 1. Có
		ỹ 2. Không
3,7	Cơ sở Y tế của anh/chị có thể sử dụng máy giác hút khi có chỉ định cho cuộc đẻ không?	ỹ 1. Có
		ỹ 2. Không
3,8	Cơ sở Y tế của anh/chị có thể thực hiện thủ thuật Forcep khi có chỉ định không?	ỹ 1. Có
		ỹ 2. Không
3,9	Cơ sở Y tế của anh/chị có thể thực hiện mổ đẻ không?	ỹ 1. Có
		ỹ 2. Không
3,10	Cơ sở y tế của anh/chị có khả năng truyền máu khi có chỉ định không?	ỹ 1. Có
		ỹ 2. Không
3,11	Cơ sở y tế của anh/chị có dụng cụ hồi sức cấp cứu cho trẻ sơ sinh không?	ỹ 1. Có
		ỹ 2. Không
3,12	Anh/chị có thể cấp cứu hồi sức sơ sinh thành thạo không?	ỹ 1. Có
		ỹ 2. Không
3,13	Cơ sở của anh/chị có điều kiện (phương tiện) để chuyển bệnh nhân lên tuyến trên khi cần thiết không?	ỹ 1. Có
		ỹ 2. Không
3,14	Nếu bệnh nhân phải chuyển, bệnh nhân thường được chuyển đi bằng phương tiện gì?	ỹ 1. Xe đạp
		ỹ 2. Xe máy
		ỹ 3. Xe ô tô buýt
		ỹ 4. Xe taxi
		ỹ 5. Xe ô tô cấp cứu của BV
		ỹ 6. Khác
Xin trân trọng cảm ơn anh/chị đã tham gia nghiên cứu!		