Improving Abortion Care in Thanh Hoa Province, Viet Nam

A Project Review

October 2004

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Contents

Acknowledgements vi

Executive summary vii

Overview 1
- Public health context 1
  - International and Vietnamese policies on reproductive health 1
  - Maternal mortality, abortion, and contraception in Viet Nam 2
  - PATH in Viet Nam 3
  - The Abortion Care Project 3
  - Goals 3
  - Activities 3
  - Location 4

Methodology 6
- Review goals 6
- Data collection 6
- Analysis 7

Review findings 8
- Progress on improving facilities and services 8
  - Providers found equipment useful 11
  - MVA most common abortion technique 10
  - Level of competence among providers high, with minor omissions 11
  - Further improvements in infection prevention needed 11
  - STI knowledge high among providers, low among clients 12
  - Knowledge of complications high, but information not shared 12
  - Improvement in counseling needed 12
  - Contraception provision low 13
  - Follow-up appointments high, but clients may not return 13
  - Complications difficult to assess 13
  - Providers unaware of Ministry of Health's standards and guidelines 14
- Progress on sustaining change in health-seeking behavior 14
  - Few clients return for follow-up 16
  - Health education materials valued 16
  - Project timeline too short for successful media campaigns 16
  - Room for improvement in counseling 16
  - Rate of repeat abortions 17
- Progress on establishing linkages and referral systems 17
  - Linkages between health service levels and facilities 17
  - Referral systems .....
- Other review findings 18
  - Training found useful for improving practices 18
  - Some difficulties with training identified 19
  - Supervision workshops useful, but supervision requires more time 19
  - Difficulty in achieving objectives in short time frame 20
  - Client-oriented services not a familiar concept 20

Limitions of data collection 20
Concern over availability of postabortion contraception 20
Results of workshop on review findings 21

Recommendations and conclusions 22
Specific recommendations 22
Project design 22
Training 22
Supervision 23
Coordination 23
Equipment 24
Health education 24
Data collection 24

Annexes 25
Annex 1. Review team and list of key informants 25
Annex 2. Review tools 26
Annex 3. Minutes of review findings dissemination workshop 466
Annex 4. Maps 48

Tables

Table 1. Activities carried out under the Abortion Care Project 5

Table 2. Type and number of interviews and subjects covered 7

Table 3. Summary of progress on improving the quality of facilities and community-based abortion services 9

Table 4. Total number of complications 13

Table 5. Complications by type 14

Table 6. Summary of progress on sustaining change in health-seeking behaviors 15

Table 7. Summary of progress on establishing linkages and referrals between district and provincial institutions and other community health facilities 18

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Executive summary

This report documents a review of the Abortion Care Project, administered by PATH under a grant from the William and Flora Hewlett Foundation.

The project goals were to:

- Reduce abortion-related infection and complications by improving the quality of health care facilities and community-based abortion services.
- Sustain behavior change among community members in seeking treatment of postabortion complications and preventing sexually transmitted infections (STIs), including HIV and AIDS.
- Establish linkages and referrals on abortion related complications, STIs, and HIV between district health services and provincial institutions and other community health facilities.

Project activities included supplying equipment, training health personnel on abortion technique and counseling, and raising awareness within the community. PATH, Thanh Hoa Provincial Health Services and Thanh Hoa Maternal Child Health Family Planning Center implemented the project in Thanh Hoa Province and Cam Thuy District, Viet Nam, from June 2002 through June 2003.

The review consisted of a desk review of relevant documents, clinical and facility observations, plus several types of interviews: in-depth interviews with abortion-service providers and clients and focus group discussions with various stakeholder groups.

The review documented several positive results. First, the review validated the replacement of dilation and curettage (D&C) by manual vacuum aspiration (MVA) for early first-trimester abortion and confirmed the capacity of health staff at the commune level, such as midwives and assistant doctors, to provide abortion services for women with a pregnancy gestation up to six weeks. Second, infection prevention and control improved, although sustaining the gains and making further progress may prove difficult. Third, the project began to establish linkages between different provincial institutions involved in providing abortion services and in strengthening the existing referral system. The project also created a useful foundation for addressing the unmet needs of abortion clients and in identifying the gaps in current services.

Unfortunately, deficiencies in the overall provision of abortion services—notably the inadequate counseling and supply of postabortion contraception—still exist. Likewise, there is no evidence of any sustainable change in health-seeking behavior for treatment of abortion complications or prevention of sexually transmitted infections, including HIV. The lack of detectable changes in these areas may be at least partially due to the project's short timeframe.

In line with the international Millennium Development Goals, which acknowledge the importance of reproductive health status as a social development indicator, the Vietnamese Government is committed to improving the quality of reproductive heath care services. The review team concluded that PATH's Abortion Care Project contributed to this effort.

Overview

This report documents a review of the Abortion Care Project, administered by PATH under a grant from the William and Flora Hewlett Foundation. The purpose of the project was to improve abortion care, counseling, and management of abortion complications. Project activities included supplying equipment, training health personnel on abortion techniques and counseling, and raising awareness within the community. PATH, Thanh Hoa Provincial Health Services and Thanh Hoa Maternal Child Health Family Planning Center implemented the project in Thanh Hoa city and Cam Thuy District of Thanh Hoa Province, Viet Nam, from June 2002 through June 2003. The review, led by an external consultant, consisted of a desk review of project documentation, clinical observation, and various types of interviews—including in-depth interviews with key informants and focus group discussions with various types of health care providers and other stakeholders. The review took place from April to June 2003.

Public health context

Amidst international efforts to improve the reproductive health of women, Viet Nam has set its own goals and has recently approved a set of standards and guidelines for reproductive health.

International and Vietnamese policies on reproductive health

The International Conference on Population and Development, held in Cairo in 1994, created momentum for improving reproductive health status. A number of subsequent global and regional conferences sustained that momentum, with participating United Nations (UN) agencies, governments, and nongovernmental organizations pledging to continue to address reproductive health needs.

More recently, the UN Millennium Summit in 2000 yielded the Millennium Declaration, an articulation of commitments made by UN member states in conferences throughout the 1990s, and the Millennium Development Goals—a framework for measuring progress in eliminating poverty. Several goals acknowledge the importance of improving women's health and status. For example, Millennium Development Goal 5 is to improve maternal health—specifically to reduce the maternal mortality ratio between 1990 and 2015 by three-quarters.

The government of Viet Nam participated in and signed the Millennium Declaration and adapted the Millennium Development Goals to its own national reality by setting targets and indicators under the Comprehensive Poverty Reduction and Growth Strategy.[1] The health objectives under this strategy are incorporated in the Ministry of Health's National Strategy on Reproductive Health Care for 2001–2010 (RHC strategy)[2] and the Population Strategy[3] for the same period.

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[1] Vietnam Development Information Centre. *The Comprehensive Poverty Reduction and Growth Strategy (CPRGS) – Vietnam.* Ha Noi; May 2002.
[2] Viet Nam Ministry of Health. *National Strategy on Reproductive Healthcare for the 2001–2010 Period*. Ha Noi: MOH.

The RHC strategy very much reflects a policy shift from reducing the birth rate through a strong emphasis on contraception[4] to a more integrated and comprehensive reproductive health care and rights approach.[5] The goal of the RHC strategy is to achieve a marked improvement in reproductive health, particularly among disadvantaged areas and specific groups such as youth (one-quarter of the population).

Maternal mortality, abortion, and contraception in Viet Nam

Reducing maternal mortality is one important objective of the RHC strategy. As in many developing countries, maternal mortality data in Viet Nam are unreliable, but a recent study[6] indicates that the national maternal mortality ratio (MMR) is around 165 per 100,000 live births. In disadvantaged, remote areas, the ratio is more than 400 per 100,000 live births. The RHC strategy sets a goal to reduce the maternal mortality ratio to 80 per 100,000 live births by 2005 and to 70 per 100,000 live births by 2010.

In setting this goal, the Government of Viet Nam recognizes the need to reduce abortion-related complications. Unsafe abortion accounts for about 11.5 percent of maternal deaths in Viet Nam,[7] where abortion is both legal and widely available. Viet Nam has the highest abortion rate (83.3 abortions per 1000 women aged 15 to 44 years)[8] in the region—among the highest in the world—and a high repeat abortion rate. Many abortions occur less than six weeks from the last menstrual period (LMP).

The government also recognizes the need to increase the availability and use of contraception. The high levels of induced abortion reflect an unmet need for effective contraception, and the many repeat abortions experienced by Vietnamese women are, in part, due to the weakness of family planning counseling and services in the context of abortion.[9] While the contraceptive prevalence rate has been increasing, there are still significant differences among provinces. In richer provinces, nearly 70 percent of married women aged 15 to 49 years use modern contraceptive methods, compared to only 51 percent in the 12 less well-off provinces.[10]

In September 2002, under the framework of the RHC strategy, the Ministry of Health approved a set of standards and guidelines for reproductive health care. The section on safe abortion defines which health workers are permitted to perform abortions, specifies the abortion technique to be used according to pregnancy gestation, and outlines the steps to be taken by providers offering quality abortion services, including provision of postabortion care and counseling on methods of pregnancy prevention. These standards and guidelines proved vital in endorsing the technical components of the Abortion Care Project.

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[3] Vietnam Commission for Population, Family and Children (VCPFC). *Vietnam Population Strategy 2001–2010*. Hanoi: VCPFC; 2004.
[4] The two-child policy has been rescinded in a recent Population Ordinance, May 2003.
[5] The Maternal-Child Health and Family Planning Department of the Ministry of Health has just announced that it will now be known as the Department of Reproductive Health.
[6] Viet Nam Ministry of Health, MCH-FP department. Maternal mortality study in 7 regions of Viet Nam (draft). MOH; 2003.
[7] Ibid.
[8] www.ipas.org/english/where_ipas_works/ asia/vietnam/index.pdf
[9] World Health Organization (WHO). *Abortion in Viet Nam: An Assessment of Policy, Programme and Research Issues.* WHO/RHR/HRP/ITT/.99.2. Geneva: WHO; 1999.
[10] United Nations (UN). *Millenium Development Goals: Bringing the MDGs Closer to the People*. The UN in Viet Nam; November 2002.

PATH in Viet Nam

Improving women's health has been a priority of PATH's for more than two decades, and PATH began working in Viet Nam in the early 1980s. PATH assisted the Institute for the Protection of Mother and Newborn in Ha Noi in conducting and evaluating a training course on a new intrauterine contraceptive device. More recently, PATH jointly managed a safe motherhood project as a partner of NGO Networks for Health.[11] Currently, PATH provides technical assistance on behavior change communication to an ongoing child survival project administered by Save the Children US.[12]

The Abortion Care Project

The overall objective of the project was to improve maternal health in Viet Nam by improving abortion care. The initial focus of the project was on postabortion care. However, based on needs expressed by Vietnamese collaborators and the overlaps amongst providers of abortion and postabortion care, the project also addressed expanding the range and quality of abortion services to include safer procedures for early abortion, better counseling before and after abortion, and improved management of complications, which would help to decrease abortion related morbidity and mortality.

Goals

The project goals were as follows:

1. To reduce abortion-related infection and complications by improving the quality of health care facilities and community-based abortion services.

2. To sustain behavior change among community members in seeking treatment of postabortion complications and preventing sexually transmitted infections, including HIV and AIDS.

3. To establish linkages and referrals on abortion-related complications, sexually transmitted infections (STIs), and HIV between district health services and provincial institutions and other community health facilities.

Activities

After discussion with the Thanh Hoa Provincial Health Services, PATH and Thanh Hoa Provincial Health Services' partners selected project partners and established a project management board, which consisted of the vice-director of Thanh Hoa Provincial Health Services, the head of the Health Professional Unit of Thanh Hoa Provincial Health Services, and the director of the Maternal and Child Health–Family Planning (MCH-FP) Center. They were in charge of oversight of project implementation. A participatory planning process was followed to develop the work plan, based on the findings of the needs assessment done in June 2002, and the project partners agreed upon a scope of work. The project staff provided supervision and technical support to all activities and assisted the project management board with management and logistical arrangements. Overall the Provincial Health Services

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[11] Quang Xuong Safe Motherhood Best Practices project document; 1999.
[12] Save the Children. *Child Survival – 18 Vietnam, First Annual Report*. Save the Children Vietnam; October 2003.

provided coordination and support, and a project secretary was nominated from the staff of the MCH-FP Center.

Table 1 provides a brief summary of the activities that PATH and partners implemented under the Abortion Care Project. The project focused principally on training providers in improved abortion technique, counseling, and postabortion care—including management of complications. The project also supplied equipment necessary for conducting manual vacuum aspiration and inspection of tissue and conducted campaigns promoting postabortion care and family planning.

Location

Province-level activities were concentrated in the MCH-FP Center and the Provincial Obstetric and Gynecological Hospital, located in Thanh Hoa city. District-level activities were implemented in Cam Thuy District Health Center and ten communes within Cam Thuy District, including two polyclinics (see Annex 4). The project also provided abortion service equipment to Quang Xuong District, and staff from the district were invited to join trainings. (PATH and partners had recently implemented a safe motherhood project in Quang Xuong District. The project did not include abortion care due to donor restrictions.)

Table 1. Activities carried out under the Abortion Care Project

Activity	Scope	Date
Planning and preparation		
Needs assessment	Conducted in Thanh Hoa province.	June 2002
Stakeholder workshop	Reviewed assessment findings and developed plan of action with partners.	July 2002
Equipment supply	Distributed basic instruments, including MVA double-valve syringes.	Aug 2002–Jan 2003
Training		
Training for provincial trainers	Covered six topics of comprehensive abortion care, including MVA technique.	Aug–Sep 2002
Training for private providers	Covered comprehensive abortion care, including MVA technique.	Oct 2002–Jan 2003 (2 courses)
Training for district staff	Covered comprehensive abortion care, including MVA technique.	November 2002
Training for provincial and district health staff	Covered postabortion counseling.	December 2002
Training for commune midwives and assistant doctors	Covered comprehensive abortion care, including MVA technique.	Dec 2002–Jan 2003
Workshop for provincial- and district-level supervisors	Covered supervision for quality of care.	March 2003
Training for private pharmacists	Covered postabortion counseling.	April 2003
Health promotion		
Development and distribution of client information	Developed and distributed leaflets for clients on postabortion care, contraception, and STIs.	Nov 2002–March 03
Media campaign	Media campaigns on radio and television on abortion care and complications.	Dec 2002–Jun 2003

Abbreviations: MVA—manual vacuum aspiration; STIs—sexually transmitted infections

Methodology

The project's short implementation period made it impractical to evaluate the project based on specific indicators. One year is too short a time in which to implement activities and demonstrate results. It is necessary, however, to gain some sense of progress and to document successes to date. PATH commissioned a local international consultant to conduct the project review. The consultant and PATH established a review team, composed of partners and stakeholders in the project (see Annex 1). The team collected and analyzed data from April 29 to June 2, 2003.

Review goals

The review goals determined by the review team were as follows:

1. Assess progress toward objectives—including training, supervision, and changes in practice—and make recommendations for future abortion care programs.

2. Identify the challenges and lessons learned from implementing the project.

3. Identify areas of "best practices" which could be suitable for scaling up and documenting.

4. Review the referral system in operation at commune, district, and province levels as well as in the private health sector.

5. Review use and maintenance of new equipment supplied by the project.

6. Review the clinical data collected at commune, district, and province levels.

7. Document current investments of resources into improving abortion services, and make recommendations for future investments

Data collection

Data collection consisted of a desk review and various types of interviews. The desk review included consideration of:

- Relevant documents, including a needs assessment conducted by PATH in June 2002[13]
- Health service statistics
- Training and supervision reports
- Health education materials developed during the project

Table 2 describes the types of interviews the review team conducted. All respondents received a small monetary stipend for participating.

[13] Abortion Care Project - Needs Assessment Report, internal document. PATH, 2002.

Table 2. Type and number of interviews and subjects covered

Type of Interview and Number Conducted	Summary of Subjects Covered in Interview
In-depth with abortion service providers (12)	Information about provider and facility; knowledge and skills of provider; project inputs such as equipment, trainings, and health-promotion material.
In-depth with clients, mostly immediately after procedure (9)	General information, including medical history, accessibility of facility, and perception of service provision.
Facility observations (15)	Availability and type of instruments, medicines, and IEC materials in the procedure room; availability of counseling room and IEC materials; infection prevention and instrument processing.
Procedure observations (10)	Reception, pregnancy confirmation, and gestation determination; pre-procedure counseling; procedure; post-procedure follow-up and counseling; case and record management; impressions of observer.
Focus group discussion with PMB (1)	Progress toward objectives, constraints of implementation, suggestions.
Focus group discussion with district leaders (1)	Progress toward objectives, constraints of implementation, suggestions.
Focus group discussion with heads of CHCs (1)	Progress toward objectives, constraints of implementation, suggestions.
Focus group discussion with private pharmacists (1)	Role in counseling, project inputs.
Focused group interview with abortion care trainers and supervisors	Progress toward objectives, constraints of implementation, suggestions.

Abbreviations: CHC—commune health center; IEC—information, education, and communication; PMB—Project Management Board

The review team designed data collection tools (Annex 2) to mirror the needs assessment tools when possible (thus saving time in translation and making comparisons easier) and to match the Ministry of Health's reproductive health care standards and guidelines. Tools included a structured instrument for the in-depth interviews, guidelines for the focus group discussions, and checklists for facility and procedure observations. The field data collection included facility observation and procedure observation, which was carried out during a six-day trip to the project sites in Thanh Hoa, including two days in Cam Thuy District.

Analysis

To develop a matrix for identifying best practices and making comparisons with the needs assessment and supervision reports, reviewers grouped the review goals with corresponding project goals and quality indicators. To identify trends, the reviewers sorted interview responses and observations under the groupings of *goals* and *indicators*. In most cases, cross-analyzing the different sources of data provided validation of the findings and endorsed the more subjective information. The data collected was very rich, and the results reported in the next section attempt to encapsulate and summarize the range of practices and views of respondents. The review team considered this encapsulation particularly important when respondents described constraints, suggestions for improvement, or ideas about future activities.

Review findings

This section describes overall progress on the project goals:

- Improve the quality of health care facilities and services and of community-based abortion services.
- Sustain change in health-seeking behavior among community members.
- Establish linkages and referral systems among health care providers.

The review team used the Ministry of Health standards and guidelines and WHO's *Managing Complications in Pregnancy and Childbirth* manual to compare the needs assessment findings with best practices in abortion care. This is discussed where relevant, as other findings are not directly linked to the project goals.

Progress on improving facilities and services

Table 3 provides a summary of the review findings regarding quality of health care facilities and services and of community-based abortion services.

Providers found equipment useful

The project supplied some basic equipment to all facilities receiving support: double-valve syringes, cannulae, a lamp box for tissue inspection, instruments for examination, containers for processing instruments, and some health-education materials for the counseling room. All providers interviewed reported finding this equipment useful, and it clearly has had a positive impact on the use of MVA and procedures such as examining the products of conception.

At government health facilities, the leaders of the nurses, midwives, or assistant doctors are responsible for the maintenance and renewal of the equipment. At private facilities, the providers themselves maintain equipment. The syringe in one private facility reviewed looked rather worn and was two years old. The project management board thought the supply and use of a box with a light bulb inside for the examination of the products of conception was a very good initiative. The communes, polyclinics, and the district health center at Cam Thuy all complained of insufficient decontamination chemicals, such as chlorine and Cidex disinfectant.

Table 3. Summary of progress on improving the quality of facilities and community-based abortion services

Measure	Review Findings	Means of Measurement
Number of supervised abortion procedures using properly sterile equipment and supplies and proper hygiene (hand washing, gloves, etc.).	All used properly sterilized equipment and supplies, but 4/10 observed (all province-level) did not wash hands properly. Private facilities used electric oven for sterilization process.	Observations and FGD
Number of abortions using (1) MVA procedure only, (2) D&C, (3) both D&C and MVA.	MCH-FP Center, DHC Cam Thuy, CHSs only conduct MVA. Case loads range from 2 to 200 per month. Ob/Gyn hospital conducts 10–15 D&C per month.[14] No data available on those providing both MVA and D&C.	Observations
Number of providers—including private providers—demonstrating competency in MVA, including pain management.	All providers observed demonstrated technical competence in MVA procedure. All administered oral analgesia and paracervical block.	Observations
Number of providers examining products of conception.	All providers did check correctly.	Observations
Number of providers monitoring vital signs 30 minutes after procedure.	4/10 observed did not do either or both pulse and blood pressure check after procedure.	Observations
Number of abortion clients receiving HCG test and physical examination prior to abortion.	6/10 observed clients received HCG tests, of which 2 tested at home. If client has already had a test outside the facility or has had ultrasound, HCG is not repeated; half of observed providers did not do physical exam.	Observations
Number of trained providers, including private health workers, demonstrating knowledge of signs and symptoms of abortion complications and STIs, including HIV.	All demonstrated knowledge of STIs and abortion complications. Half screened for STIs, but none discussed STIs with client. Most (7/9) clients did not know any signs of STIs. No provider explained possible long-term effects of abortion, and 3/10 did not explain about abortion complications. Most clients (8/9) knew at least two signs of complications.	Observations FGD IDI
Number of abortion clients receiving counseling before, during, and after abortion.	Amount of detail insufficient. Counseling often done while doing something else. Most (7/10) did not provide counseling before or during procedure about the abortion method used. Postabortion contraceptive counseling was weak: all did not mention at least five contraceptive options. Many (6/9) clients could name three methods. Observers rated 5/10	Observations FGD IDI

[14] Review also found the ob/gyn hospital performed 10–30 Kovacs procedures (a method used to terminate pregnancy in the second trimester) per month.

Measure	Review Findings	Means of Measurement
	providers as “no” for counseling skills. Most (10/12) providers recognize the need for quality family planning counseling and contraceptive provision.	
Number of facilities ensuring privacy for counseling.	The two private clinics visited were not able to ensure adequate privacy.	Observations
Number of providers fully informing client before asking client to sign consent.	3/10 providers asked the client to sign consent before client was fully informed.	Observations
Number (%) of women who leave health facility after abortion with specific contraceptive method.	Health system data: 16 clients out of 1893 left with IUD, 85% left with condoms, 14% with OC. Out of 1613 clients: 33% left with condoms, 66% with OC, 1% sterilization (both provincial facilities). Supervision checklist overall figures: condom 24%, OC 26%, IUD 2.3%, 40% unclear. Few (2/10) providers observed gave condoms; remainder gave nothing. Many (6/9) clients interviewed received no contraception; four had wanted an IUD.	Desk review Observation
Number of women who leave health facility after abortion with follow-up appointment for physical check-up two weeks after procedure.	All providers scheduled a follow-up appointment two weeks after procedure—except MCH, who made it seven days after procedure.	Observation
Number of providers correctly recording data on abortion complications and STIs, including HIV.	Most private facilities have no case records—only a general book. They tend not to record time and method of abortion or contraceptive method chosen by client. Review tool not sensitive enough.	Observation
Number of providers correctly following training protocol and guidelines for treatment.	Many (7/12) have treatment and procedure protocols; less than half (5/12) have not heard of the MOH standards and guidelines.	Observation
Number (%) of project commune midwives who demonstrate competency in MVA and postabortion counseling	All CHS staff trained (12 commune midwives) deemed competent in MVA procedure.	Desk review Observations

Abbreviations:

CHS	Commune Health Station	HCG	human chorionic gonadotropin	MOH	Ministry of Health
D&C	dilation and curettage	IDI	in-depth interview	MVA	manual vacuum aspiration
DHC	District Health Center	IUD	intrauterine device	OC	oral contraceptive
FGD	focus group discussion	MCH-FP	Maternal and Child Health and Family Planning	STIs	sexually transmitted infections

MVA most common abortion technique

By far the most common technique for first-trimester abortion was manual vacuum aspiration (focus group discussions, in-depth interviews, procedure observations). This is a dramatic increase since the needs assessment was conducted. It should also be noted that the use of double-valve syringes for MVA has almost replaced the use of single-valve syringes. Only

one provider (in the private sector) used sharp curettage after MVA with a single-valve syringe for pregnancies between six and eight weeks gestation. For pregnancies of nine- to twelve-week gestation, two providers (one at province level and one at district level) stated that they do MVA followed by sharp curettage. The continued use of the Kovacs method[15] for second-trimester abortions at the Provincial Ob/Gyn Hospital highlights the gap in available alternatives, such as dilatation and evacuation for second-trimester abortions. Most providers were aware of medical abortion, and some knew of at least one of the drugs used (misoprostol), but none has received any training in this abortion technique.

Level of competence among providers high, with minor omissions

Based on procedure observations, it was found that the technical competence of MVA providers at all levels was excellent. Pain management has improved; so all clients now receive both oral analgesics and a paracervical block, apart from those clients with a contraindication for oral analgesics. The timing of administration of the oral analgesia was not always appropriate to ensure the maximum benefit to the client. However, all providers now examine the products of conception. Training emphasizes that this step can substantiate an intrauterine pregnancy. There were, however, some small but important omissions in the proficiency of the overall procedure. For example, providers did not always confirm pregnancy by a human chorionic gonadotropin (HCG) test—especially when the client said she had done one at home already—or when ultrasound was used. According to the Ministry of Health's standards and guidelines, an HCG urine test should always be done before a termination of pregnancy under 12 weeks. The client sometimes has to buy a test at a nearby pharmacy and take it to the provider, but the cost is small (around VND3,000[16]). The Provincial Ob/Gyn Hospital requires every woman to have an ultrasound check for pregnancy. Ultrasound costs the client more than an HCG test. Moreover, the hospital has only one ultrasound machine, and clients often waited for a long time. In addition, it is not common practice to ask the client about signs and symptoms of pregnancy, such as breast tenderness, nausea, and vomiting. Half of the providers observed at all facilities did not perform a general physical examination of the client prior to abortion, and none of them asked about drug allergies or sensitivities. Providers still do not consistently monitor a client's vital signs 30 minutes after an abortion procedure.

Further improvements in infection prevention needed

From the observations of clinical practice, the facility checklist, and the regular supervision reports, it was apparent that efforts have been made to improve infection prevention and control measures. Nonetheless, universal precautions were not yet reliable across the different levels of the health system. Under observation, all providers at all levels used sterile equipment and supplies. However, the steps for decontamination and high-level disinfection or sterilization were not always followed correctly. Both private facilities used a conventional electric oven for sterilization, placing the instruments inside for 20 to 30 minutes at a temperature of 100-300ºC. This methodology is not a satisfactory way of sterilizing metal instruments. Some commune health stations and polyclinics lacked sufficient disinfectants, such as Cidex, and several did not have a clean water source. At provincial facilities, some providers still did not always wash their hands with soap and clean water at crucial points in

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[15] Placing extra-amnion of a saline-filled bag or condom inside cervix to induce labor.
[16] Equivalent to about US $ 0.19.

the procedure. The safe disposal of medical waste and sharps, such as disposable needles, was also inconsistent at all observed facilities.

STI knowledge high among providers, low among clients

Typically, providers' knowledge of sexually transmitted infections, including HIV, was observed to be high, through in-depth interviews and supervision checklists, but few discussed with their clients how they might protect themselves or recognize an infection. In contrast, most clients could not describe any signs or symptoms of an STI. Only half of the providers observed screened for a reproductive tract infection (RTI)—including sexually transmitted infections—prior to abortion, yet an acute RTI is the sole contraindication for MVA abortion up to 12 weeks gestation, according to the Ministry of Health's standards and guidelines.

Knowledge of complications high, but information not shared

Similarly, through the in-depth interviews, it was observed that the knowledge level of providers about the signs and symptoms of abortion complications was thorough, but providers did not consistently share this information with their clients. No provider under observation discussed any possible long-term health sequelae of abortion, especially repeated abortion. Although the risk of infertility or ectopic pregnancy is low according to the World Health Organization,[17] the prompt recognition of a complication and provision of the correct treatment is important in risk management. Most clients knew at least two signs or symptoms of a complication.

Improvement in counseling needed

There was an increased awareness (there was almost none at the time of baseline assessment) among reproductive health service providers of the importance of the counseling process, which is described in the Ministry of Health's standards and guidelines. Nevertheless, the findings by the review team on counseling, based on observations, indicated that, at best, providers viewed counseling as giving advice or providing information. There was little supportive discussion about options, such as whether to continue with the pregnancy, what contraceptive methods to use, or when to resume sexual activity. Often, providers gave information while filling in the medical notes. Although client satisfaction was high, with most clients appreciating the polite and friendly staff and their technical competence, both providers and reproductive health care service leaders recognize the need to improve the quality of postabortion counseling, particularly the contraceptive component. The difference between the perception of the supervisors and the observations of the reviewers is worth noting. According to supervision reports, almost all providers have counseled their clients adequately before, during, and after the abortion procedure. As noted above, this was not what was found during this review. A notable exception was around the topic of counseling. In their reports, supervisors indicated clear and impressive progress in counseling skills and content. The review findings, however, did not suggest improvement. This contradiction may highlight differences in conceptual understanding and expectations of counseling and its benefits.

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[17] World Health Organization (WHO). *Safe Abortion: Technical and Policy Guidance for Health Systems.* ISBN 92 4 159034 3. Geneva: WHO; 2003.

Contraception provision low

During observation, almost all postabortion clients left the facility without any form of contraception. Although data from facilities shows a high number of contraceptive devices distributed after abortion, in reality, many women who have had a first-trimester abortion—even at a provincial health facility, where they are approved and trained to insert IUDs—still leave without a method of contraception. Providers and facility managers often said in their interviews that procuring methods of contraception other than IUDs was problematic because population issues, including the free or subsidized supplies of nonclinical contraceptives, fall under the network of the National Committee for Population and Family Care (the Population Committee). However, during review, the two abortion providers (both at a commune health station) who ensured that their clients did not leave without contraception were not permitted to insert IUDs, but found a way to work with their colleagues from the Population Committee. They procured condoms for their clients, and one of them also arranged an appointment for her client to return for IUD insertion by the district mobile team (an outreach group). Four of the six clients interviewed who did not receive any contraceptive method wanted an IUD.

Follow-up appointments high, but clients may not return

Based on the desk data reviews and observations, all abortion providers gave their clients a follow-up appointment for two weeks after the procedure, except the MCH-FP Center, where appointments were made for seven days afterwards. In the in-depth interviews and focus group discussions, some providers expressed their concerns that most clients do not return for their follow-up physical examination.

Complications difficult to assess

The clinical data (Tables 4 and 5) are suggestive of an overall reduction of the complication rate, with Cam Thuy District reporting no complications since the implementation of project activities.

There are a number of reasons, however, why the data are equivocal. It appears that the clinical data available were collected and presented by supervisors to the project at arbitrary times. Sometimes statistics for one month were provided, other times aggregate data for a number of months was provided. Tracking trends over time and attempting to link any changes to training inputs is therefore difficult. As the project implemented activities for only a year, perhaps the important figures are those collected during the needs assessment and those collected during this review. Another difficulty in the level of usefulness of the clinical data is how complications are defined. Sometimes, they are presumed to be complications per se; other times they are the number of immediate, postprocedure complications. Signs and symptoms of infection related to the procedure would rarely be expected to be evident while the client is still in the facility recovering. There is also the temptation to show small numbers as a percentage, which may be misleading. For example, out of a total of 17 abortions performed in one month in Cam Thuy District Health Center, there was one complication, which is depicted as a 5.88 percent complication rate. In addition, the nature of the complication is not stated. Providers interviewed believe that the most common complication is incomplete abortion followed by infection.

Table 4. Total number of complications

Facility	Needs Assessment Data (January–May 2002)	Review Data (June 2002–April 2003)
MCH-FP Center	No number, but 3.82%	40 out of 1893 cases (2.11%)
Ob/Gyn Hospital	34 out of 868 cases (3.9%)	27 out of 1613 cases (1.67%)
Cam Thuy DHC	22 out of 387 cases (5.7%)	0 out of 397 cases (0%)
Polyclinics (2)	0 out of 59 cases (0%)	No data (included in DHC)
CHSs (10)	22 out of 264 cases (8.3%)	No reported cases
Private facilities	No data	8 out of 654 cases (1.22%)

Abbreviations:
CHS Commune Health Station
DHC District Health Center
MCH-FP Maternal and Child Health and Family Planning

Table 5. Complications by type

Facility	Needs Assessment Data (January–May 2002)	Review Data (June 2002–April 2003)
MCH-FP Center (% of complications)	Infection: 19.9% Endometritis: 18.3% Incomplete abortion: 61.8%	Infection: 3/40 complications Hemorrhage: 2/40 Incomplete abortion: 35/40
Ob/Gyn Hospital	Endometritis: 15/34 Hemorrhage: 19/34	Infection: 10/27 Hemorrhage: 3/27 Perforated uterus: 2/27 Incomplete abortion: 12/27
Polyclinics (2)	No data available	Data included in DHC
CHSs (10)	Infection: 13/22 Endometritis: 1/22 Hemorrhage: 4/22 Incomplete abortion: 4/22	No reported cases
Private facilities	No data	No data

Abbreviations:
CHS Commune Health Station
DHC District Health Center
MCH-FP Maternal and Child Health and Family Planning

Providers unaware of Ministry of Health's standards and guidelines

Although more than half of the interviewed health care providers had procedure and treatment protocols for safe abortion, neither the private providers nor those at the commune level had heard of the Ministry of Health's standards and guidelines. During the review process, the project gave providers a copy for their own reference.

Progress on sustaining change in health-seeking behavior

Table 6 provides a summary of the review findings regarding sustaining change in the health-seeking behaviors of community members. PATH sought to encourage women to seek treatment for abortion complications and to take steps to prevent STIs, including HIV. Efforts

toward behavior change included providing tools and advice to health care providers and promoting health in the community through media.

Table 6. Summary of progress on sustaining change in health-seeking behaviors

Indicator	Review Findings	Means of Measurement
Number (%) of women who attend follow-up appointment.	Provincial or private facilities: 1–2%. District level facilities: 7%. From the health system data: MCH, 20% clients returned Ob/Gyn Hospital, 3.7% clients returned DHC, 17% clients returned Private facilities, 24% clients returned CHSs, 60% clients returned.	Desk review
Number (%) of women who are referred by another facility, including private sector, for reproductive health services.	85% at Ob/Gyn Hospital (a tertiary-level facility). Some difficulties with data for other facilities, but number is small.	Desk review
Number of different types of IEC documents produced, number of campaigns, and number of people reached.	IEC documents: 20,000 leaflets on signs and symptoms of abortion complications produced and distributed, 60 posters on client rights, 110 posters on postabortion care. Campaigns: 8 television and 8 radio spots on province and district stations on Population Day, loudspeaker broadcasts in 10 project communes.	Desk review
Number (%) of women who receive IEC materials during postabortion counseling.	8/9 clients received abortion-care leaflets at the time of leaving health facility.	Observations IDI
Number of facilities, including private sector, with private area for counseling services.	All government project site facilities have private area. Private facilities do not.	Observations
Number of private pharmacists trained.	21/445 Thanh Hoa city private pharmacists trained on counseling for family planning and abortion complications.	Desk review
Number (%) of clients who received counseling on complications and FP methods.	4/9 clients received counseling on complications, 7/9 on contraception. According to supervision checklists 92–100% of clients at health facilities received counseling.	Observations Desk review IDI
Number (%) of postabortion clients who can accurately name 4 signs of abortion complications, 3 signs of STIs, and 2 methods to prevent HIV/STI infection.	8/9 could name 2–4 signs of complications. 7/9 did not know any signs of STIs; 6/9 knew two correct ways to prevent STI infection.	IDI
Number of clients (%) who have had previous abortion, including how many abortions	2nd abortion range 2.88–8.3% of total abortions. 3rd abortion range 0.9–2.3% of total abortions. Higher figures at Ob/Gyn Hospital, DHC, and private facilities.	Desk review
Number (%) of women who return for reproductive health services.	8/9 had used before for range of reproductive health services; 9/9 would return for abortion service.	IDI

Abbreviations:
CHS Commune Health Station IEC information, education, communication DHC District Health Center
MCH-FP: Maternal and Child Health and Family Planning STIs sexually transmitted infections

Few clients return for follow-up

A vast improvement in the provision of follow-up appointments is evident. It is unclear why the staff of the MCH-FP Center chose to make appointments for one week after the procedure rather than two weeks afterward, as recommended by WHO. Very few clients return for their follow-up examination; however, the proximity of the facility to the client's home (and therefore, convenience) may play some part. Not surprisingly, many of the abortion clients at the Provincial Ob/Gyn Hospital come by referral from other facilities, as the hospital is the tertiary level institution serving a province population of 3.5 million.

Health education materials valued

Clients and providers alike viewed very favorably the health-education materials on safe abortion, including postabortion care leaflet, poster, and abortion training curriculum developed as part of the project. Most clients had received the leaflet on postabortion care, and private pharmacists found it very useful for both themselves and their customers. The pharmacists used it as a basis for counseling their postabortion customers. Clients generally were very satisfied with the amount of information they received from providers, whereas eight out of the twelve providers interviewed would like to have health-education materials specifically addressing repeat abortion.

Most of the providers did not use any health-education materials, including contraceptive devices, for counseling on contraception, but all facilities had posters displayed and most had models. The MCH-FP Center had a video and showed clips on infection prevention, abortion procedures, and family planning.

Project timeline too short for successful media campaigns

The project supported the development and broadcast of several abortion-care messages on province television and district and commune radio on a monthly basis (contents of these messages are in Annex 4). These television and radio networks cover all communes in Thanh Hoa province. However, it is hard to measure how successfully these messages reach people in the community. Also, to be effective, a media campaign needs to be sustained over a longer period of time.

Room for improvement in counseling

All government facilities have a private area for counseling. The private facilities, however, are overall in much poorer condition, and neither facility reviewed had a private area for counseling. Counseling was observed to be an area in need of improvement, yet information from supervision reports shows that most providers believe they counsel 100 percent of their clients on contraception and abortion complications. During the review, it was clear that counseling was inadequate on normal recovery, recognizing complications, and postabortion contraceptive options.

Abortion clients also know little about the signs and symptoms of STIs, but could describe at least two ways to prevent them. Clients' knowledge about other reproductive health issues was gained from health workers or the media.

The project supported the training of private pharmacists on the danger signs of abortion-related complications and counseling skills. Pharmacists play an important role as informal advisers on unplanned pregnancy, particularly for women aged 20 to 24 years. Pharmacies

situated near colleges had the most business associated with abortion, with students asking for advice, as they are reluctant to go to a doctor. The students tend to be in later pregnancy and want an introduction to a discreet provider (suggesting that many are unmarried women). The pharmacists usually advise them to go to the MCH-FP Center or the Provincial Ob/Gyn Hospital, but most would prefer to go to a private provider.

Rate of repeat abortions

The rate of repeat abortion is very high in Viet Nam, and Thanh Hoa is no exception. Nationally, it is estimated that there are two abortions for every live birth. According to facility-based data collected from June 2002 to April 2003, second abortions were 8 percent of total abortions and third abortions were nearly 2.3% in some facilities in Thanh Hoa. However, this is a marked improvement on the data from the needs assessment, where it was estimated that the second abortion rate was 20 to 35 percent and the third abortion rate 10 to 25 percent of the total abortions. Three clients interviewed had just had their second abortion. The number of referrals to the Provincial Ob/Gyn Hospital may account for the high rate of repeat abortions in this facility. Possible reasons for the large numbers of repeat abortions at the district level are less clear. Nonetheless, a substantial element leading to repeat abortions must be associated with inadequate contraceptive counseling and provision at the time of abortion.

Progress on establishing linkages and referral systems

Table 7 provides a summary of the review findings regarding establishing linkages and referral systems.

Linkages between health service levels and facilities

Professional linkages between different departments and different facilities are difficult to establish if they are not part of the hierarchical reporting and supervision duties as defined by the management system of the health service. There are different management lines for technical and administrative areas. Both the MCH-FP Center and the Provincial Ob/Gyn Hospital are accountable overall to the Provincial Health Services but do not convene naturally over technical issues. According to the project management board, the technical collaboration of the MCH-FP Center and the Provincial Ob/Gyn Hospital needs official endorsement. However, the director of the MCH-FP Center expressed interest in further professional liaison between his Center and the Provincial Ob/Gyn Hospital.

Referral systems

Tracking referral patterns using the national health management information system (HMIS) seems to be problematic. In part the problems relate to the intrinsic complexity of the system and its limitations. However, for abortion complications, providers are clear when and where to refer their clients. For other reproductive health problems, clients would be referred to another department or to the next level of facility. The review process was unable to yield much concrete information about such cross-referrals.

Table 7. Summary of progress on establishing linkages and referrals between district and provincial institutions and other community health facilities

Indicator	Review Findings
Number of quarterly meetings of project management board.	Met twice; minutes available. Interest in further professional exchange between MCH-FP Center and Ob/Gyn Hospital.
Number of referrals of abortion complications, STIs, HIV cases from other facilities (CHS to DHC, DHC to province level).	Scant data. Pharmacists and private facilities referred most. Referral form as such does not exist. District-based outreach team for reproductive health services ("mobile team") a catalyst for close cooperation between CHS, Women's Union, and Population Committee collaborators. Scant data. 10/12 providers give case record and an introduction letter; also staff member accompanies client. 2/12 send the client with no information. DHC reported giving no referrals during project period. MCH-FP Center sent one postabortion case to Ob/Gyn hospital due to hemorrhage. Private facilities referred three postabortion cases; place and reason not known. Pharmacists sent six postabortion cases to MCH-FP for fever, prolonged bleeding, and vaginal discharge.
Number of project CHSs providing emergency postabortion services.	All project sites able to provide emergency postabortion service.
Number (%) of women who are referred by another facility, including private sector, for reproductive health services.	85% at Ob/Gyn hospital (tertiary-level facility). Some difficulties with data for other facilities, but number is small.

Abbreviations:

CHS Commune Health Station
DHC District Health Center
MCH-FP Maternal and Child Health and Family Planning
MVA manual vacuum aspiration
STI sexually transmitted infection

Other review findings

Training found useful for improving practices

In all, a total of 80 abortion service providers were trained on MVA technique, infection prevention, and abortion counseling. Some providers at province and district levels were already familiar with MVA, with some using single-valve syringes for the procedure. Postabortion counseling was an integrated component of the training for providers in both public and private sectors; however, it was a stand-alone training for private pharmacists and provincial and district abortion providers.

On the basis of focus group discussions and in-depth interviews, all trainees considered the training content to be appropriate and useful for their practice. They particularly appreciated the information on pain control, postabortion counseling, infection prevention, MVA technique, and tissue inspection. Most of them reported having no difficulties incorporating what they learned into their practice. Trainers thought the most useful topics were how to use the double-valve syringes for MVA, infection prevention, counseling, tissue inspection, and supervision.

Some difficulties with training identified

Gaining enough practice during training was sometimes a problem for some trainees because of the small number of clients. Abortion is usually a walk-in service, so numbers tend to be unpredictable. This would need to be taken into consideration for future MVA trainings. Although both trainers and trainees enjoyed the more participatory teaching techniques the trainers used, participatory teaching still presents some challenges for the trainers. Feedback from trainees indicates that trainers are often rather didactic, sometimes speak too fast, raise vague questions, and give complicated explanations. Further training for trainers in the use of participatory methods would be helpful.

Trainers in focus group discussions felt that sometimes the logistical arrangements for training were not adequate, citing transportation, accommodations, and level of per diem as examples. The project management board endorsed the trainers' views and also cited a need for more training equipment, such as a projector.

Supervision workshops useful, but supervision requires more time

For health care providers in supervisory roles, there were two workshops on supervision for quality of care. These workshops covered clients' rights, supervision skills, and supervision tools, including checklists, self-assessment, and constructive feedback. Those who attended learned how to make a supervision plan, give feedback, decide priorities, and observe procedures and facilities. The supervisors thought the checklists were clear and appropriate. During the review, most of the abortion providers interviewed stated that they received weekly visits or spot checks by their board of directors or the planning department. The Provincial Health Services do a supervisory visit to private practices every three months. However, not all supervisors were able to attend the supervision workshops, and those who did not attend reported difficulties in undertaking their supervisory responsibilities. The overall timeframe and schedule for individual visits was also not considered adequate.

Difficulty in achieving objectives in short time frame

Although PATH paid close attention to the project implementation and progress, and partners knew that the project would last only one year and would have modest resources, the project objectives were very ambitious.

Sustained behavior change inevitably requires a longer period of time and should not be sacrificed for quick results. Perhaps the project could be seen as a first phase and that should be reflected in the design. In developing indicators of progress toward achieving the project objectives, smaller and more specific objectives might have served the project better. Specific indicators that collectively are attributable to an overall indicator may have ensured a better fit with the objectives and may have been easier for the supervisors to handle.

Client-oriented services not a familiar concept

A rights approach to reproductive health care is not a familiar concept in Viet Nam, and in busy provincial facilities, it is not easy to give the kind of client-oriented service that the project promoted. The accountability of staff at lower level facilities tends to be linked in part to the fact that they belong to the same small community that they serve. Interestingly, most of the customers of the private pharmacists were friends, relatives, or neighbors, and the pharmacists felt it was vital to be trusted and respected, recognizing the connection between a quality service and a successful business.

Limitions of data collection

The quality of clinical data and the lack of uniformity in its collection hindered the project in tracking achievements, such as the reduction in complications and repeat abortion. In the provincial health facilities, according to the Project Management Board, abortion care providers did not give complete information to health recorders. This statement implies that it is not the provider who enters information about their cases into the facility data bank. There are other examples that indicate that sometimes the data source drawn on by the recorder was not accurate. Also the books of abortion cases kept by health facilities differ from one another. Some have a column for the date of abortion, while others do not. The order of columns is also different. Certainly data collection and documentation is a major challenge for the health system in Viet Nam, and inputs on documentation in general and on recording accurate information, including how and why, in particular may need to be greater.

Concern over availability of postabortion contraception

The lack of provision of contraceptives for postabortion clients is a key concern. According to the Project Management Board, most health facilities do not have contraceptives (condoms, contraceptive pills, etc.) that they can provide for postabortion clients. Although state health facilities usually have IUDs, the commune health stations supported during this project are not permitted to insert IUDs. There is no reason under the Ministry of Health's standards and guidelines why staff of the commune health station who have been trained in IUD insertion cannot undertake this procedure.[18] The head of the Cam Thuy District Health Center, who is responsible for the staff at the commune health station in his district, seemed willing to consider addressing this omission.

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[18] The only time staff at the commune health station are not permitted to insert an IUD is postpartum, when the uterus is soft and there is an increased danger of perforation.

Results of workshop on review findings

A workshop was held by PATH and Thanh Hoa Provincial Health Services in Thanh Hoa on 8 August 2003 to share the review results formally with all partners (Annex 5 contains the minutes of this meeting). At the time of the workshop, the Provincial Health Services committed to:

- Following up the supervision of trained providers.
- Certifying trained midwives at the commune health stations, thus enabling them to continue to provide abortion service at the commune level.
- Supporting supervision, equipment supply, recording, infection control, and complication follow-up for the private sector.

In addition, participants acknowledged that the project had helped to strengthen the links between the private and public sectors for abortion services.

Recommendations and conclusions

This section documents the recommendations and conclusions of the review team.

The abortion care project that PATH implemented in Thanh Hoa province from June 2002 to June 2003 has demonstrated some noteworthy accomplishments. Although the review team cannot assert that the project's ambitious objectives were achieved, progress has certainly been made. For example, the review validated an impressive result in the replacement of D&C by MVA for early first-trimester abortion and confirmed the capacity of health staff at the commune level, such as midwives and assistant doctors, to provide an abortion service for women with a pregnancy gestation of between six and twelve weeks. In addition, infection prevention and control improved, although sustaining the gains and making further progress may prove difficult. Deficiencies in the overall provision of abortion services—notably inadequate counseling and supply of postabortion contraception—still exist. The project began to establish linkages between different provincial institutions involved in providing abortion services and in strengthening the existing referral system. The project also created a useful foundation for addressing the unmet needs of abortion clients and in identifying the gaps in current services.

Specific recommendations

The review team made a number of recommendations for project scale-up or future efforts toward safe abortion in Viet Nam. These recommendations cover the following topics: project design, training, supervision, coordination, equipment, health education, and data collection.

Project design

- A thorough design phase, using comprehensive baseline data, is necessary.
- Special attention should be given to the selection of partners and implementation sites.
- Project design should blend the overall public health context with the local situation but remain flexible as activities unfold, allowing for any adjustment in light of increased understanding of needs and capacities.
- If the timeframe is short, the concept of phasing should be introduced to uphold the quality of implementation.

Training

- At a meeting of Thanh Hoa provincial leaders about the Ministry of Health's reproductive health care standards and guidelines, which were approved by the government in September 2002, the Project Management Board expressed concern over how Thanh Hoa could find the resources to upgrade health staff and conform to the new directive. The training required would be considerable, as Thanh Hoa is a large province with 27 districts and 631 communes.
- Continued efforts are required to advance the competence of abortion care providers in the following areas: (1) infection control, including basic hygiene, instrument

processing, and medical waste disposal; (2) compulsory HCG urine testing for all first-trimester abortions and reduction in the use of ultrasound; (3) screening for reproductive tract infections before abortion by MVA; (4) counseling—both content and technique—with particular attention to postabortion contraception, prevention of reproductive tract infections, including sexually transmitted infections, and recognition of postabortion complications.

- Trainers need more input on participatory teaching methods and adult learning, the use of training materials, and planning training schedules.
- Supply of training equipment that encourages active learning, coupled with guidance on how to maximize its use, may empower the trainers.
- Stronger links with the secondary medical school should be made to influence pedagogical methods with a view to supporting sustainable provincial training cadres.
- As pointed out by Ipas,[19] timing is crucial: Don't move on to train districts and communes too soon, as a sustainable level of best practice must be reached before trainers are able to train others.
- An increased number of private-sector participants should be included in relevant training courses.
- Training in clinical contraceptive provision for commune-level providers should go hand in hand with training in early abortion.
- Some training on abortion services for the heads of commune health stations would help them to support their staff.
- More attention should be paid to reaching agreement on the logistical and financial arrangements with project partners.

Supervision

- The use of the checklist as a supervisory and self-monitoring tool requires further intensive support.
- Greater time allocation for supervisory visits, both in frequency and length, is needed.
- Innovative inputs that may increase the frequency and usefulness of constructive supervision and supervisors' accountability should be considered. One suggestion is to strengthen the supervisory role of the district-based mobile teams.

Coordination

- Technical links between the Provincial Ob/Gyn Hospital and the MCH-FP Center should be developed further.
- Ways of addressing the lack of collaboration with the National Committee for Population-Family-Children, particularly over nonclinical contraceptive provision, should be explored.

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[19] Information gathered from a discussion with Ipas training services advisor in June 2003.

- The commune health stations would benefit from a means of communication with the District Health Center.
- The project's efforts to draw in the private sector around safe abortion should continue.

Equipment

- The inadequate supplies of disinfectants in the commune health stations should be investigated to determine whether it is a problem of distribution or funds.
- The sustainable supply of double-valve MVA kits needs further discussion with the Provincial Health Services.

Health education

- Broader reproductive health information for the community disseminated through the mass organizations, such as the Women's Union and the Youth Union, and developed in partnership with the local cultural centers, would integrate clinical provision with community-based demand.
- Some of the health education materials, such as tapes and video produced for broadcast could not be used in the district and communes because they lack audio-visual equipment. Materials developed targeting clients waiting for services in such facilities should not rely on sophisticated equipment or electricity

Data collection

- To help monitor and evaluate progress, a format for collection of clinical data should be agreed upon before the needs assessment and used consistently and regularly throughout the project.
- Project clinical indicators should concur with the existing health information system.
- The person designated as responsible for supplying statistical data to the project should be drawn from the appropriate department within the provincial health system and, if necessary, should receive training.

Annexes

Annex 1. Review team and list of key informants

Review team

From Ha Noi:

- Barbara Bale, consultant
- Dr Ho Sy Hung, Institute for the Protection of Mothers and Newborns (IPMN)
- Bui To Van, PATH
- Luu Thanh Huong, PATH

From Thanh Hoa:

- Dr. Tran Thi Hoan, MCH-FP Center
- Dr. Hoang Thi Thanh, Head of Health Professional Department of Provincial Health Services
- Dr. Tran Thi Hanh, MCH-FP Center
- Dr. Le The Truong, Provincial Women's Hospital
- Dr. Du Quang Lieu, Cam Thuy District Health Center

Key informants

- Staff and clients of the Provincial Women's Hospital, Thanh Hoa
- Staff and clients of the MCH-FP Center in Thanh Hoa
- Staff and clients of the District Health Center, Cam Thuy, Thanh Hoa
- Staff and clients of Cam Phu, Cam Binh, and Cam Tan commune health stations
- Heads of 10 commune health stations and 2 polyclinics in Cam Thuy
- Private providers in Thanh Hoa City and Bim Son District
- Private pharmacists in Thanh Hoa City and suburbs
- Dr. Phan BichThuy, Ipas, Ha Noi

Annex 2. Review tools

Appended here are the interview tools, guidelines for group interviews/focus group discussions (FGD), and checklists, including:

1. Interview Tool for Abortion Clients
2. Interview Tool for Abortion Care Providers
3. Guidelines for Focus Group Discussion/Group Interview With Project Management Board/Facility Leaders (including heads of commune health stations)
4. Guidelines for Focus Group Discussion With Trainers and Supervisors
5. Guidelines for Focus Group Discussion With Private Pharmacists
6. Checklist for Observation of Abortion Service Facility
7. Infection Prevention Checklist
8. Abortion Procedure Checklist

1. INTERVIEW TOOL FOR ABORTION CLIENTS

Name of interviewer:________________________

Venue:

- Ÿ Provincial obstetrics & gynecology hospital
- Ÿ Provincial MCH-FP Center
- Ÿ District health center
- Ÿ Polyclinic
- Ÿ Commune Health Station
- Ÿ Private health service

I. General information

1. Age:
2. Ethnicity:
3. Marital status:
4. Address:
5. Education:
6. Profession:
7. Number of pregnancies:
8. Number of children born alive:
9. Number of abortions:
10. Did you have any complications after your previous abortions? If so, what were the complications? Where did you go for treatment of the complications? Fill in table below.

Number of abortion	Date	Which facility (Location)	Complications (Yes or no)	Facility where complications were treated (Location)
1st				
2nd				
3rd				
4th				
5th				

II. Accessibility to the health facility

11. What is the distance from your home to this abortion facility?
12. How long does it take you to travel this distance – how many minutes and by which means of transportation?
13. Are the working hours of the abortion facility convenient for you? If not, why not?
14. How many times have you used the abortion service here?
15. What other reproductive health services do you use at this facility? Where do you go for other reproductive health services?
    (Specify: e.g. contraception, delivery, gynecological problems)
16. How did you know that this facility offers an abortion service?
    (Specify: e.g. doctor's referral, pharmacist's referral, poster, radio, newspaper, friends, relatives etc.)
17. Why have you chosen this facility for your abortion?
    (Specify: e.g. the technical ability of the health staff, convenient and close to home, the price, other facilities are not as good...)

III. Client perceptions of abortion service provision

18. How long did you wait from the time of arrival at the facility until you had your abortion procedure? Was this length of time acceptable or unacceptable to you?
19. Did any of the administrative procedures make you feel uncomfortable or cause you any inconvenience? If so, what?
20. How much was the total cost of the examination and procedure? How much was your laboratory test?
21. Do you think the total cost of this abortion is: too expensive (cannot afford), moderate cost (can afford), inexpensive (can easily afford)

22. When you arrived at the facility, were you given instructions on how to use the service here? *(Prompt: Were the instructions clear? Did you face any difficulties in understanding what to do or where to go next?)*
23. Were you satisfied with the cleanliness of the procedure room? If not, what aspect was not satisfactory?
24. Were you satisfied with the level of privacy in the procedure and counseling rooms? If not, explain about the lack of privacy.
25. Are the attitudes of the health workers polite and friendly and did they make you feel comfortable and respected?
26. Did you ask the health staff about any concerns? If not, why not?
27. Did the health staff listen to you and answer your concerns?
28. Did the health staff explain to you before, during, and after the procedure?
29. Did you sign the informed consent form before the procedure?
30. Do you think the health staff explained everything clearly to you?
31. Did the health staff use health education materials for counseling? If so, what types did they use? *(Specify: e.g. leaflet, flip chart, poster, models, etc.)*
32. Were you given any health education materials to take home? If so, what? *(Specify: e.g. project leaflet, other leaflet, etc.)*
33. What counseling information did you receive? *(Specify: recognising complications and what to do, contraceptive methods, how to take any medicine given, how to take care of yourself, including the use of traditional medicine, follow-up visit appointment, etc.)*
34. Was there anything else you would have liked to know about?
35. Do you think the health staff allowed enough time for counseling?
36. Were you given a follow-up appointment after the abortion procedure?
37. Please name 4 signs of abortion complications.
38. Did you feel confident in professional level of the health staff?
39. Where will you go if abortion complications occur? *(Specify: commune health station, district health center, polyclinic, provincial health facilities, central health facilities, private health facility)* Why?
40. If you have another abortion in the future, will you return to this facility or go to another? Why?
41. If the commune health station is able to provide abortion services and to treat abortion related complications would you use the service at the commune level? Why?
42. Do you know about family planning methods? If so, how did you learn about them?
43. Were you given any contraceptive after the abortion procedure? If so, what?
44. What family planning method do you intend to use?
45. Did the health staff give you written information on where you can obtain this method?
46. Have you received any other information about reproductive health such as STIs, HIV/AIDS? Where did you hear about it? Do you think that this information is necessary?
47. Please name 3 signs of a STI.
48. Please name 2 methods to prevent STI/HIV infection.
49. Are you satisfied with the service today? Why or why not?
50. What things did you like about this health facility?
51. What things did you not like about this health facility?
52. In your opinion, how could the services in this facility be improved?

2. INTERVIEW TOOL FOR ABORTION CARE PROVIDERS

Name of interviewer:___________________________
Venue:

- Ÿ Provincial obstetrics & gynecology hospital
- Ÿ Provincial MCH-FP Center
- Ÿ District health center
- Ÿ Polyclinic
- Ÿ Commune Health Station
- Ÿ Private health facility

I. Information on health care provider

1. Age:
2. Title:
3. Gender:
4. Ethnicity:
5. Training:

II. Information on health facility

6. Do you think that the number and professional level of staff is appropriate for the range of services provided and the number of clients?
7. What tests are done for the client before she has the abortion procedure? How long do they take and where are they done?

Type of test	Time to perform test and receive results (minutes)	Where is test performed?	
		On site	Off site
HCG urine pregnancy test			
HCG blood pregnancy test			
Ultrasound			
Other			

8. Do you think that the instruments, essential medicines and facilities are adequate for a quality abortion service? If not, why not?

III. Information on knowledge and skills of abortion care providers

9. Have you been trained to provide abortion service? When was your last training? What topics did it cover?
10. Please explain to me the signs and symptoms of an abortion complication. *Ask for at least 4 signs/symptoms.* Please explain to me 3 signs of an STI and 2 methods to prevent STI/HIV. Do you screen for RTI before abortion procedure?
11. What methods are used for abortion at 6-8 weeks gestation in your facility? Why does your facility use these methods?
12. What methods are used for abortion at 9-12 weeks gestation in your facility? Why does your facility use these methods?
13. How often is each procedure/treatment used in the facility to manage abortion cases and/or abortion-related complications? *(Read out a-e and ask the respondent to estimate on average how many cases are treated with each procedure/treatment per month)*

    a. Dilatation and evacuation (D&E) ________ cases per month.
    b. Dilation and curettage (D&C) ________ cases per month.
    c. Vacuum aspiration (MVA & EVA) ________ cases per month.
    d. Medical abortion ________ cases per month.
    e. Other (specify) ____________

14. On what cases do you use a single-valve syringe for MVA?
15. Do you know about double-valve syringes? If so, what cases can you use a double-valve syringe for MVA?
16. Do you know about medical abortion? Have you received any training on medical abortion? Can you tell me what medicines and their dosages are needed to carry out a medical abortion?

17. Do you use pain medicine before and during the abortion procedure? If so, what methods and medicine did you use? If not, why not?
18. Have you ever had to deal with any abortion-related complications? If so, what type of complications? What is the most common? How did you treat the complications? (*Relate treatment with complication; see table below.*) Which cases did you refer to a higher level?

Type of complication	Rank most to least common (1-7)	Treatment protocol for complication	Referrals to what type/level of facility
Intra-abdominal injury			
Hemorrhage			
Infection/sepsis			
Incomplete abortion			
Cervical perforation			
Shock			
Air embolism			
Other			

19. Do you have standards, guidelines, and protocols for abortion methods and treatment of complications? Are they useful? May we see them? *If seen, mark against points below. What is/are the content/s of the protocol/s? (tick [√] for all that apply)*
    - On how to use MVA instruments
    - On how to perform E&C procedure/treatment
    - On how to perform D&C procedure/treatment
    - On how to assess client's status
    - On how to establish rapport with client
    - On how to assess the uterus
    - On how to observe universal precautions (infection prevention)
    - On how instruments should be sterilized
    - On how to provide postabortion family service and counseling
    - On how to manage pain control
    - On how to treat complications
20. Have you heard about the new reproductive health care standards & guidelines approved by the MOH last September? GIVE COPY AT END OF INTERVIEW
21. What aspect of the abortion procedure do you think you could do better? What aspect would you like to receive more training on? Prompt to be specific; see below.
    - Assessment of pregnancy gestation
    - MVA technique
    - Pain management
    - Tissue inspection
    - Infection control/prevention
    - Prevention and treatment of abortion related complications
    - Postabortion counseling
    - Aftercare instructions
    - Family planning counseling
    - STI/HIV screening
    - Integrating other RH issues into counseling and referrals for abortion clients
    - Other skills or knowledge training that you need to improve the quality of abortion care
22. When a client seeks your help for abortion or treatment of an abortion related complication that you are not able to treat, which facility do you refer her to?
23. If a client has other reproductive health problems (i.e., not related to abortion) which facility do you refer her to? *(Specify which facility for what type of RH problem.)*
24. Do you receive regular technical and management supervision? Who is your supervisor? How often do they visit you at your facility? How often do you meet your supervisor to discuss work?
25. Do you participate in training and supervising others? Describe your activities in training and supervision. *(Specify what level, frequency, type, etc.)*

IV. Information on project inputs

26. Were you trained in abortion procedure and care by the PATH project? If so, what did you find the most useful for you?
27. Were the training topics appropriate for your practice? What difficulties do you face in implementing the knowledge and skills you have gained from the training?
28. Have you had any other in-service training on abortion care besides the PATH project? If so, please give details (e.g., who provided the training, on what, for how long, when?).
29. What suggestions do you have to improve abortion procedures for the client and for the provider? What do you think is needed to increase the quality of the abortion service and to reduce repeat abortions?
30. Can you describe what information you provide to another facility when you refer a client? May we have a copy of the form/ letter of introduction that you use?
31. Did your facility receive any new equipment under the project? If so, what? Was this useful for your practice? If so, why?
32. Who maintains the equipment and orders a replacement if it is broken?

3. GUIDELINES FOR FOCUS GROUP DISCUSSION/GROUP INTERVIEW WITH PROJECT MANAGEMENT BOARD/FACILITY LEADERS

Group: heads of CHS/PMB/other abortion facility leaders (specify)
How many in group:
Location:
Facilitators:
Was the discussion taped?

1. What project activities were you responsible for implementing during this project?

2. What aspect of this project has been the most interesting for you professionally? Have you learnt anything new through the project implementation? *E.g., technical, way of working (process), training style, etc. – probe.*

3. How do you feel about the objectives of the project? *May need to refresh:*

   To reduce abortion-related infection and complications by improving the quality of facilities and community-based postabortion services

   To sustain behavior change towards seeking treatment of postabortion complications and STIs and HIV/AIDS prevention among community

   Establish linkages and referrals on abortion-related complications, STIs, and HIV between district health services and provincial institutions and other community health facilities

4. What do you think have been the benefits to communities of this project? What contributions are you making to achieve and sustain these benefits? Please explain and give examples.

5. How close is the project to achieving its objectives? What else does it need to do to achieve these objectives?

6. What part of the implementation process has been the most difficult? Explain why. *Could be management, financial, timeframe, technical – explore.* What were the problems/ constraints you encountered? Were you able to solve them? How?

7. Do the policies of this facility/health service restrict the provision of abortion and postabortion services in any way? (age, marital status, finance, etc). How has this affected the usefulness of the project activities?

8. How have the national RH care standards and guidelines been disseminated in the facilities under the project? How will they be implemented? Do you see any difficulties with implementing the national RH care guidelines?

9. Do you think the professional level of health workers in reproductive health meets demands (GOV standards and clients)? Role of CHW midwives to district mobile team?

10. What aspect of RH care provision do you think requires more training inputs? *Probe as follows:*
    - Abortion care (comprehensive)
    - Abortion procedure (technical/clinical)
    - Pregnancy management/antenatal care
    - Family planning
    - Abortion complication treatment
    - Communication skills
    - Pregnancy options counseling skills
    - Making referrals for other reproductive health services
    - Community outreach skills
    - Other (specify)

11. What other abortion care inputs (GOV & other) are there planned or currently being implemented in your facility/department?

12. What have you learned from your experience in project implementation that would be helpful for improving the implementation of the same types of activities in other new areas of the country and for scaling up the program?

13. Is there anything that you would like to do differently in the future under the project? *Explore: focus, process, management structure, supervision, etc.*

More specifically for heads of CHS:

1. What abortion methods for the first trimester are available in your facility? Mark all that apply.

1. Evacuation and Curettage (E&C)
2. Dilation and Curettage (D&C)
3. Manual Vacuum Aspiration (MVA)
4. Electrical Vacuum Aspiration (EVA)
5. Medical abortion

2. Which staff member carries out the abortions in your facility (e.g., midwife, assistant doctor)?

3. Which staff member is consulted for abortion complications? Are you able to provide emergency postabortion services? - Referral

4. How many of your staff are competent in MVA?

5. How many abortions do you do in one month? E.g., how many did your facility do in April 2003?

6. Do you think the equipment and drugs in your facility are adequate for abortion services? If not, what is insufficient and why?

7. What contraceptive methods are available in your facility?

8. Do you have a private area for counseling services?

4. GUIDELINES FOR FOCUS GROUP DISCUSSION WITH TRAINERS AND SUPERVISORS

How many in group:
Location:
Facilitators:
Was the discussion taped?

1. What activities were you responsible for during this project?
   Ask trainers.
   Ask supervisors.

2. Tell me about your experiences in training:
   - i) Were the topics useful for the trainees? Was the training time long enough? Were the training curricula and materials adequate? Was the methodology appropriate? Was the venue comfortable? Was the per diem adequate? Did you have enough support from project staff?
   - ii) What was the most popular (most fun, enjoyable, useful) part of the training? What difficulties did you experience as a trainer doing this work? Did you learn anything new while doing this training?

3. Tell me about your experiences in supervision:
   - i) Did you learn anything new during the supervision workshop? Like what? How much of your total work time do you usually spend on supervising others? Was the frequency of supervision required by the project too often or not enough? Did you find the checklist useful? If there were not enough clients, did you ask the practitioners to arrange their workload to fit with your supervision schedule? Was the per diem adequate? Did you have enough support from project staff?
   - ii) What difficulties did you experience in supervising the project-related activities? How would you improve the checklist so that it will be used every time a practitioner is supervised? What do you think about different kinds of supervision that support/help the practitioner to provide a quality service (coaching, mentoring, etc.)?

4. Tell me more about how the project has helped/improved abortion care services. *Prompt on best practices or areas for scaling up*. What ideas do you have to make the training and supervision of practice more successful/useful? Do you think your own experience of being supervised could be improved? In what way?

5. Were there any difficulties in reporting to the project staff the outcome of the supervision visits? Was it too much work? Was the report format easy to use? How could it be improved so that reporting is more accurate?

5. GUIDELINES FOR FOCUS GROUP DISCUSSION WITH PRIVATE PHARMACISTS

How many in group:
Location:
Facilitators:
Was the discussion taped?

1. Where is your pharmacy (location)?

2. What is your position at the pharmacy? (Mark all that apply)
   - Owner
   - Pharmacist
   - Pharmacist with pharmacy certificate
   - Shopkeeper

3. According to your experience, do the local people come to pharmacies for treatment when they are sick? Do you think they come to the pharmacist first before going to the doctor? If so, why?

4. According to your experience, do women with an unplanned or unwanted pregnancy seek treatment at your pharmacy? Why don't they go to the health facility?

5. What kind of services do they request? (Mark all that apply)
   - Pregnancy test
   - Abortifacients
   - Prenatal vitamins
   - Referral for abortion
   - Referral for prenatal care
   - Others (specify)

6. What age group(s) most frequently seeks your assistance regarding unplanned pregnancy?

   Below 20 years ☐

   20 to 24 years ☐

   25 to 30 years ☐

   Above 30 years ☐

Why do you think more women aged ___ come to the pharmacy?

7. Do you provide the same service for women of all ages?

8. What services do you provide at your pharmacy? (Mark all that apply)
   - Pregnancy test
   - Abortifacients *(Ask about misoprostol and mifepristone.)*
   - Prenatal vitamins
   - Referral for abortion *(Ask: How does the referral arrangement work?)*
   - Referrals for prenatal care (*Ask: How does the referral arrangement work?)*
   - Other (specify)

9. Is your pharmacy linked to any state health facility in any way?

10. Do customers ask about how to treat abnormal symptoms after their abortion? If so, what abnormal symptoms do they usually ask about? Is it the woman herself who asks?

11. Do you provide women with medication to treat their abnormal symptoms or do you routinely refer them back to the clinic where they received their abortion? If *yes*, where did you refer to?

12. Do customers buy medicine for treatment of RTIs at your pharmacy? Who usually buys, men or women? Do you explain how to use the treatment to them? Do you instruct them to go to the health facility? If so, which one (level)?
13. Do you think it is the role of the pharmacist to provide instructions, advice, counseling for customers? Do you enjoy this role? Why?
14. Do you have pamphlets and/or leaflets on reproductive health that you can give to your customers? If *yes*, what kinds? *(See the example.)*
15. Do you receive any health education materials produced by the PATH project?
16. Do you use these materials while you provide instruction, advice, and counseling for the customer? If not, why?
17. Were you trained by the project on the signs and symptoms of abortion complications and RTIs as well as how/when to instruct your customers to use the health services if necessary?
18. Has the training been helpful? In what way?
19. What reproductive health topics have you advised your customers on in the last month? About how many customers have you advised on abortion-related matters in the last month?

6. CHECKLIST FOR OBSERVATION OF ABORTION SERVICE FACILITY

	I. Procedure Room	Adequate	Inadequate	Comments
1.	Dimensions (15m^2)			
2.	Light, e.g., swivel-head lamp			
3.	Waiting area			
4.	Recovery rooms			
5.	Privacy of the procedure room			
6.	Examination/procedure table with stirrups			
7.	Clean water source			
8.	Plastic bucket with decontamination solution, sterilisation or HLD agent (for instruments)			
II. Instruments and Medicines (availability)				
9.	Pregnancy tests			
10.	Abortion instruments: vaginal speculum, tenaculum, sponge forceps, vacuum syringes, flexible cannulae of different sizes, dilators, 10-ml syringe & 22-gauge spinal needle, strainer for tissue inspection, receptacles & basins, gauze/swabs *CHECK CANNULAE & SYRINGES FOR SATISFACTORY MAINTENANCE*			
11.	Gloves: new or HLD for examination; new or disinfected for utility			
12.	Antiseptic solution, analgesics (e.g., ibuprofen, pethidine), sedatives (e.g., diazepam), local anaesthetic (e.g., lidocaine), broad-spectrum antibiotics, oxytocin			
13.	Contraceptive methods: condoms, IUD, OC pill			
III. IEC Materials (availability & type)				
14.	IEC materials on: abortion, abortion complications, family planning and HIV/AIDS displayed in service area (specify)			
15.	Video, audiocassettes, posters, leaflets, handbooks/manuals, models, others (specify)			
IV. Counseling Room & IEC (availability)				
16.	Counseling room or area that is quiet and private			
17.	IEC materials on abortion, abortion complications, family planning and HIV/AIDS available in the counseling room. Specify type (e.g., video, audiocassette, posters, etc.).			
18.	Clients provided with IEC materials to take home			

7. INFECTION PREVENTION CHECKLIST

I. Facilities and Procedure			Adequate	Inadequate	Comments
1.	Availability of 0.5% chlorine solution				
2.	Proper mixture of chlorine solution				
3.	Changes sheet for each client				
4.	Wears mask and cap				
5.	Washes hands with soap and clean water before gloves & after procedure				
6.	Changes gloves for each client				
7.	Cleans examination table with chlorine solution after each procedure				
8.	Provides clean sanitary towel				
9.	Observes sterile conditions during procedure (swab, no touch technique)				
10.	Safe disposal of sharp instruments				
11.	Safe medical waste disposal				
II. Instrument Processing					
12.	**Decontamination steps**				
a.	Soaks all instruments in 0.5% chlorine solution				
b.	Draws the solution through the cannula into the syringe				
c.	Allows instruments to soak for at least 10 minutes				
d.	Uses gloves to remove forceps.				
13.	**Cleaning steps**				
a.	Disassembles the syringes				
b.	Washes the instruments in clean water with detergent				
c.	Scrubs with soft brush				
d.	Rinses with clean water				
14.	**Sterilization or high-level disinfection steps**				
a.	Boiling Cannula only	Decontaminates & cleans as above			
		Boils fully immersed for 20 minutes			
b.	Cidex Syringe & cannula	Soaks in Cidex solution (2%) for 10 hours (cannula) Soaks in Cidex solution (2%) or 0.5% chloramines for 20 minutes			
		Rinses with sterile or boiled water & dries with sterile cloth			
15.	**Storage**				
a.	Stores in dry, sterile, covered container				
b.	Uses within the day				

8. ABORTION PROCEDURE CHECKLIST

I. Introduction

1.	**Name of abortion service facility**	___________________________
	The abortion care provider is from: Provincial Ob/Gyn hospital Provincial MCH/FP Center Cam Thuy District Health Center Polyclinic (name) Commune health station (name)	œ œ œ œ œ
2.	**The abortion care provider is a:** Obstetrician Assistant doctor with Ob/Pediatrics training Midwife Other	œ œ œ œ
	Observer _________________________________	Date____________

Instructions for observer: *Ask the permission of the client and the health care providers before the observation. Be careful not to interfere with the procedure and communication between the client and providers. Ensure that your presence does not lead to assessing and consulting. Find an appropriate position near the client but opposite to the provider. Choose answers that are the most appropriate from your observation of the entire procedure.*

To the health care provider: *Hello, I'm a representative of PATH. We are conducting a review of the Abortion Care Project. May I observe your procedure to know more about abortion service provision? The information is strictly anonymous and will only be used to improve project design and the quality of abortion services. It will not interfere with your practice. After you have finished, may my colleague or I talk with you about your work? You can ask me to stop observing at any time.*

To the client: *Hello, I'm a representative of PATH. We are conducting a review of the Abortion Care Project. May I observe your procedure to know more about abortion service provision? The information is strictly anonymous and will only be used to improve project design and the quality of abortion services. After the procedure, may my colleague or I talk with you about your visit today? You can ask me to stop observing at any time.*

II. Reception

Question No.	Observation Did the provider	Yes	No	Remarks
3.	Confirm that the client wanted an abortion			
4.	Take a full medical history of the client			
a)	Age			
b)	Marital status			
c)	Medical history (heart, kidney, lung diseases)			
d)	Reproductive history: no. of pregnancies, live births/children, methods of delivery, including if caesarean section, ectopic pregnancy, gynecological surgery			
e)	Date & method of any previous abortion			
f)	Menstrual cycle			

g)	The first day of last menstrual period			
h)	Current contraceptive method used			
i)	Asked reasons for unwanted pregnancy (no use of contraceptive methods or failed, other)			
j)	History/symptoms/signs of RTIs/STIs			
k)	Other (specify)			

III. Pregnancy Confirmation and Gestation

Question No.	**Observation** **Did the provider . . . . . .**	**Yes**	**No**	**Remarks**
5.	Take the following actions to confirm pregnancy and assess gestation			
a)	Signs			
-	Number of days since the first day of the client's last period			
-	Signs of pregnancy (breast tenderness, nausea/vomiting)			
b)	Physical examination			
-	Washed hands with clean water and soap before vaginal examination			
-	Used sterile gloves during vaginal exam			
-	Used a sterile condom for vaginal exam instead of gloves			
-	Prepared instruments before examination			
-	Used sterile instruments during the examination			
-	Asked the client to breathe deeply to relax her muscles			
-	Did a bi-manual exam			
-	Screened for RTI			
-	Dropped all the soiled instruments directly into a chlorine solution immediately after use			
-	Explained each step of the examination before it happened to the client			
c)	Laboratory tests			
-	Urine test for pregnancy (HCG)			
-	Ultrasound scan			
-	Other laboratory tests (specify)			
d)	General physical exam (pulse, blood pressure, lungs, heart, abdomen…)			
e)	Ask about any drug sensitivity/allergy			

IV. Pre-Procedure Counseling

Question No.	Observation **Did the provider . . . . . .**	Yes	No	Remarks
6.	Ask the client about her reasons for abortion			
7.	Counsel the client about her choices (abortion or continue her pregnancy)			
8.	If the client chose abortion, did the provider explain the abortion methods available to the client?			
9.	If so, what abortion methods were mentioned?			
a)	Manual vacuum aspiration			
b)	Electric vacuum aspiration			
c)	Dilatation and curettage			
d)	Other methods (specify)			
10.	Explain the advantages of each abortion method			
11.	Explain the disadvantages of each abortion method			
12.	Explain the selected abortion procedure to the client			
13. a)	Explain methods of pain management to the client			
b)	If so, which methods were mentioned?			
-	Paracervical block			
-	Oral analgesics			
-	Atropine injection			
-	Other (specify)			
c)	Ensure the client took the oral analgesics 30 minutes before the procedure			
14. a)	Explain the signs and symptoms of possible complications of the procedure			
b)	If so, which complications were discussed?			
-	Shock			
-	Hemorrhage			
-	Uterine perforation			
-	Infection			
-	Other (specify)			
15. a)	Explain about the possible long-term effects of abortion			
b)	If so, which?			
-	Infertility			
-	Ectopic pregnancy			
-	Other (specify)			
16. a)	Provide counseling on contraceptive methods			
b)	If so, which methods? (IUD, oral contraceptives, DMPA, condoms)			
17.	Ask about any drug sensitivity/allergy			
18.	Ask the client or the representatives of the client (if the client is under 18) to sign the informed consent form before the abortion procedure			
19.	Show empathy to the client			

V. Procedure

Question No.	Observation **Did the provider . . . . . .**	Yes	No	Remarks
20.	Use clean gowns, aprons, masks, and goggles during the procedure			
21.	Wash his/her hands with clean water and soap			
22.	Use sterile gloves			
23.	Explain each step of the procedure to reassure the client			
24.	Do a vaginal exam to assess the size and position of the uterus			
25.	Sterilize/clean the procedure areas			
a)	Drape the procedure areas with sterile cloths			
b)	Swab with antiseptic the vulval & perineal area			
26.	Place speculum, expose cervix, clean cervix and vagina with antiseptic			
27.	Insert the speculum gently			
28.	Place the tenaculum in the right place			
29.	Administer a paracervical block			
30.	Measure uterine depth by cannula			
31.	Dilate cervix further if necessary			
32.	What abortion method was used?			
a)	MVA ♥ go to question 34			
b)	D&C ♥ go to question 37			
c)	Other (specify)			
33.	How did the provider use the cannula?			
a)	Chose the cannula size that fits the client's uterus size			
b)	Used sterile cannula			
c)	Used no-touch technique to handle the cannula during the entire procedure			
34.	How did the provider use the syringes?			
a)	Used disinfected syringes			
b)	Inspected the syringes for vacuum before using			
35.	Inspect the tissue/products of conception			
36.	Use sterile D&C instruments (dilators, curette, forceps)			
37.	Measure the size and position of the uterus			
38.	Dilate the cervix			
39.	Use no-touch technique to handle the D&C instruments during the entire procedure			
40.	Swab the cervical and vaginal areas after the procedure			

VI. Post-Procedure Follow-Up and Counseling

Question No.	Observation Did the provider	Yes	No	Remarks
41.	Check pulse and blood pressure after the procedure			
42.	Check and follow-up bleeding after the procedure			
43.	Ask the client to rest at least 30 minutes after abortion procedure			
44. a)	Prescribe antibiotics			
b)	Prescribe other medicine			
45.	Advise about the signs of a normal recovery from abortion procedure			
46.	Counsel on postabortion care			
a)	Instruct on routine personal hygiene and nutrition post abortion			
b)	Tell the client about resumption of sexual activity			
47.	Explain the danger signs requiring a return to facility			
48.	Inform the client when she could become pregnant again			
49.	Counsel the client about family planning/contraception			
50.	If so, what methods were mentioned?			
a)	Oral contraceptive pills			
b)	IUD			
c)	Condom			
d)	Injectables (DMPA)			
e)	Implants			
f)	Female sterilization			
g)	Male sterilization			
h)	Natural Family Planning			
i)	Other			
51.	Use health education materials during family planning counseling process			
52. a)	Provide a contraceptive method or give a prescription/referral immediately			
b)	If so, which method?			
-	Oral contraceptives			
-	IUD			
-	Condoms			
-	Injectables (DMPA)			
-	Male sterilization			
-	Female sterilization			
-	Other			
53. a)	Schedule a follow-up visit			
b)	If so, when? (how many days after procedure)			
54.	Process instruments, including checking for damage			
55.	Dispose of medical waste safely			

VIII. Case and Record Management

Question No.	Observation **Review records for . . . . . .**	Yes	No	Remarks
56.	Availability of items in the general book:			
a)	Age			
b)	The first day of last menstrual period			
c)	Reproductive history including information on any previous abortion			
d)	Abortion method			
e)	Time of abortion procedure			
f)	Complications			
g)	Reasons for referral and the client's condition if the client is referred from another facility			
h)	Code of the client			
57.	Availability of items in the case record:			
a)	Age			
b)	The first day of last menstrual period			
c)	Reproductive history including information on any previous abortion			
d)	Relevant medical history			
e)	Size of uterus			
f)	Gestation			
g)	Abortion method			
h)	Time of abortion procedure			
i)	Complications			
j)	Reasons for referral and the client's clinical condition if the client is referred from another facility			
k)	Code of the client			
58.	Correlation of the general book and case record			

VIII. Impressions of Observer

Question No.	Observation What did you think about	Yes	No	Remarks
59.	The client			
a)	Able to ask provider about her worries, concerns, need for information			
b)	Willing to provide related information			
c)	Showed fear and anxiety			
d)	Clear and open communication			
60.	The provider			
a)	Expressed respect and rapport			
b)	Listening skills			
c)	Encouraged client to ask			
d)	Explained and helped the client in decision-making			
e)	Reassuring			
f)	Provided accurate information			
g)	Counseling skills			

Any further comments or observations . . . .

Annex 3. Minutes of review findings dissemination workshop

Date: August 8, 2003

Venue: Thanh Hoa Hotel

Attending: 60
Thanh Hoa provincial MCH/FP Center
Thanh Hoa provincial health service
Thanh Hoa provincial women's hospital
Thanh Hoa provincial People's Committee, Department of Foreign Relations
Thanh Hoa provincial Committee for Population, Family, and Children
Institute for the Protection of Mothers and Newborns (IPMN)
Hong Duc College
Center for Community Research Development (local nongovernmental organization)
Cam Thuy district health center
Cam Thanh polyclinic
Cam Tan polyclinic
Bim Son private clinic
Cam Thanh commune health station
Cam Phu commune health station
Cam Thach commune health station
Cam Ngoc commune health station
Cam Tan commune health station
Cam Chau commune health station
Cam Binh commune health station
Phuc Do health station
PATH staff

Content

- Welcome by Dr. Tran Thi Hanh, Thanh Hoa Provincial MCH/FP Center, and Trinh Thu Huong, PATH

- Introduction of participants by Dr. Le Dang Vien – Director, Thanh Hoa Provincial MCH/FP Center

- Opening by:
  Dr. Nguyen Ngoc Thanh – Deputy Director, Thanh Hoa Provincial Health Service
  Nguyen Hoang Yen – Senior Project Officer, PATH
  Kim Ngoc Hiep – Thanh Hoa Provincial People's Committee

- Process of making work plan and indicators – Dr. Tran Thi Hanh, Thanh Hoa Provincial MCH/FP Center

- Implementation process or structure for implementing – Dr. Tran Thi Hanh, Thanh Hoa Provincial MCH/FP Center

- Indicator comparison – Nguyen Hoang Yen, Senior Project Officer, PATH

- Presentation of review findings against objectives:
  Progress against project objectives – Bui To Van, Project Officer, PATH
  Including experience of Dr. Vu Ngoc Luu, Head of Cam Binh CHC
  Including experience of private health worker, Dr. Le Thi Thiem, Bim Son private clinic

- Best Practices – Dr. Ho Sy Hung, Ob/Gyn faculty, Ha Noi Medical School

- Referral system
  Dr. Bui Thi Thuy – Cam Thuy DHC
  Dr. Nguyen Ba Hoach – Thanh Hoa Provincial Health Service
  Dr. Nguyen Thi Hang – Thanh Hoa Provincial MCH/FP Center

- Clinical data – Dr. Luu Thi Thanh Huong, Junior Project Officer, PATH

- Lessons learnt and challenges – Dr. Le Dang Vien, Director, Thanh Hoa Provincial MCH/FP Center

- Investment for improving abortion services and recommendation for future investment –Nguyen Hoang Yen, Senior Project Officer, PATH

Questions & Answers on Review Findings

Q: Why did the results of supervision and results of review contradict each other? (Dr. Truong – Thanh Hoa Provincial MCH/FP Center)

A: Because the perception of the supervisors and the observations of the reviewers was different.

Group Discussion: (3 groups) – facilitated by Dr. Vien and Ms. Yen

After hearing the project review findings and lessons learned, what are your ideas to improve the project—e.g., design, structure, mechanism, supervision, etc.?

- Project design: Should be a long-term project and include training for head of CHSs.
- Should increase the time of clinical practice for training courses and practice norms.
- Instruments and facilities: Should supply instruments before launching the project and support telephone installation.
- Project management: Need more commitment from district and commune level; should supply record forms under MOH regulations.
- Project supervision: Should increase the time for supervision.

Suggestions and recommendations for sustaining project

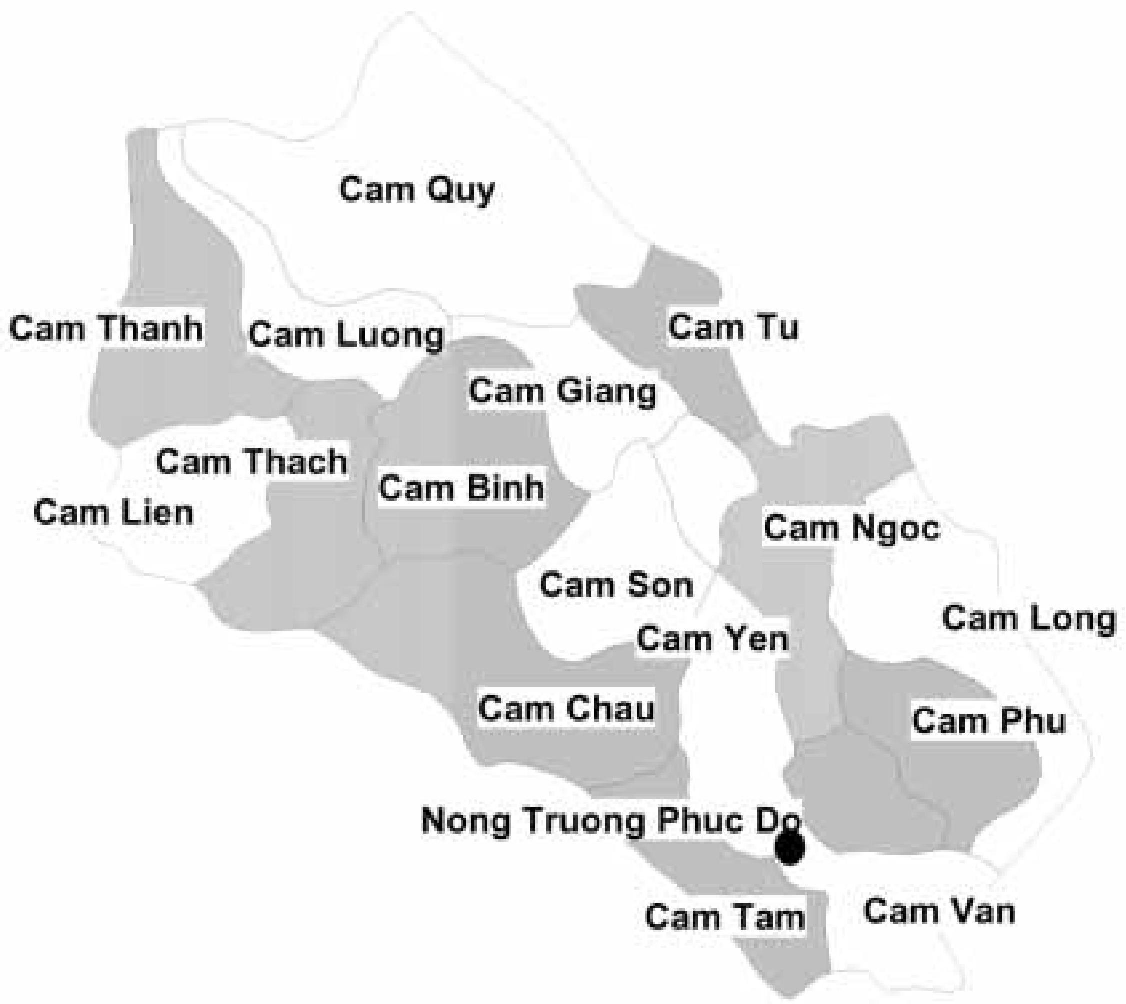
- Invest in instruments and materials for decontamination step.
- Provide updates and refresher training.
- Increase supervision and self-supervision.
- Promote public communications.
- Cooperate with mass organizations.
- Allow private health sector to buy instruments.

Suggestions and recommendations for future project

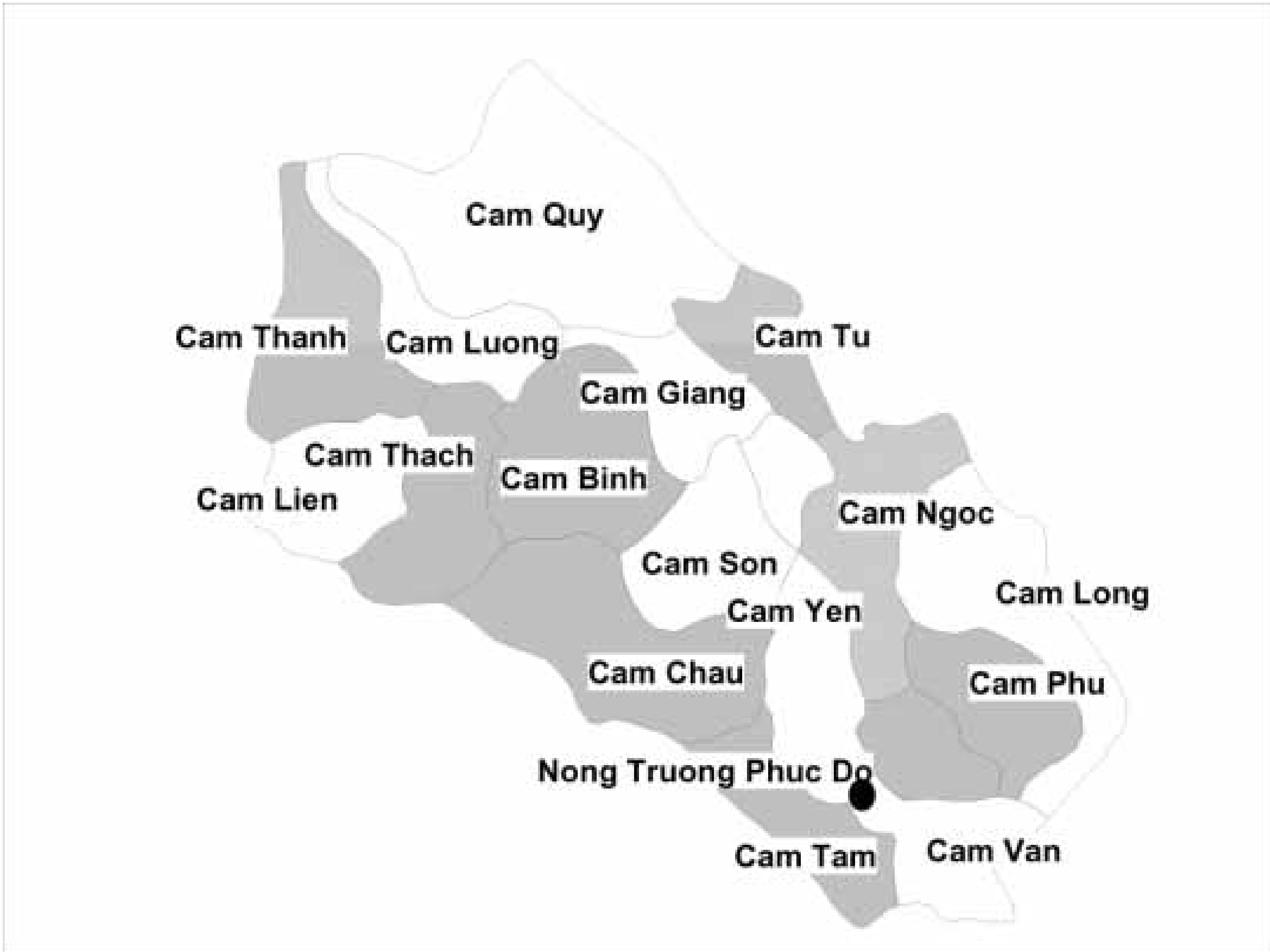
- Extend the project duration and extend to other CHSs.
- Equip telephone line for commune level.
- More involvement of private health sector in the project activities.
- Provide training for heads of CHSs and increase the time for midwives training.
- Coordinate budget from other related projects and inter-sectors.
- Develop behaviour change communication materials that are appropriate for the local context.
- Develop training materials in line with the national standards and guidelines.
- Develop indicators and supervision tool.

Wrap up by Nguyen Hoang Yen, Senior Project Officer, PATH

Annex 4. Maps



CAM THUY DISTRICT MAP


Cam Quy
Cam Thanh
Cam Luong
Cam Tu
Cam Giang
Cam Thach
Cam Binh
Cam Lien
Cam Ngoc
Cam Son
Cam Long
Cam Yen
Cam Chau
Cam Phu
Nong Truong Phuc Do
Cam Tam
Cam Van