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## Improving the Quality of Reproductive Health Care Services in Viet Nam

**The role of National Standards and Guidelines for Reproductive Health Care Services**



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## The Role of National Standards and Guidelines for Reproductive Health Care Services

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## ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
CEDAW	Convention on the Elimination of Discrimination against Women
COPE	Client-Oriented Provider-Efficient Services
DOH	Department of Health
HIV	Human Immuno-Deficiency Virus
ICPD	International Conference on Population and Development
MCH-FP	Maternal and Child Health and Family Planning
MDG	Millennium Development Goals
MOU	Memorandum of Understanding
NGO	Non-governmental Organization
NSG	National Standards and Guidelines for Reproductive Health Care Services
RH	Reproductive Health
RHC	Reproductive Health Care
RTI	Reproductive Tract Infections
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WHO	World Health Organization

## PREFACE

In December 2005, the Government of the Socialist Republic of Viet Nam and the United Nations Population Fund (UNFPA) completed the Sixth Country Programme (CP6). To mark the end of 5 years of collaboration (2001-2005), UNFPA undertook a series of studies to draw lessons learned and best practices from the programme's implementation.

This report is prepared by Ms Barbara Bale, a reproductive health expert who has long experience of the health care system of Viet Nam. It documents lessons learned relating to the formulation and implementation of the first National Standards and Guidelines for Reproductive Health Care Services (NSG). It is the outcome of a review of secondary sources of information including reports produced by the Government of Viet Nam, particularly the Ministry of Health, and UNFPA project reports. Other sources of information, much of which is available from web sites in the public health domain, have been referenced in the text or as footnotes.

Since its approval by the Government of Viet Nam in 2002, the NSG has been applied nationally with financial support from the government and donors. The NSG is viewed as a key element in the improved performance of reproductive health providers and raising of the quality of services at all levels. This report therefore identifies valuable lessons for the future application of reproductive health programmes by government, NGOs, United Nations agencies and other concerned stakeholders.

I would like to thank Ms. Barbara Bale for her considerable efforts in completing this report. I would also like to thank Dr. Duong Van Dat of UNFPA Viet Nam for his coordination in preparing and publishing lessons learned and best practices from UNFPA's country programmes. Lastly but most importantly, we would like to acknowledge the reproductive health policy makers and service providers, and their clients who are the essence of the UNFPA assistance programme and for whom this publication is intended to benefit. It is UNFPA's wish that the lessons learned and experiences gained from CP6 will be of use to policy makers, programme managers, health professionals and donors in designing and implementing reproductive health programmes aligned with the Millennium Development Goals (MDG) and the commitments made at the International Conference on Population and Development (ICPD) in Viet Nam.

**Ian Howie**  
Representative  
UNFPA in Vietnam

# BACKGROUND AND CONTEXT

## The International Conference on Population and Development 1994

The International Conference on Population and Development (ICPD) was held in Cairo, Egypt, in September 1994. Delegations from 179 States took part in negotiations to finalise a Programme of Action on population and development for the next 20 years. A new strategy, which emphasised the numerous linkages between population and development, focused on meeting the needs of individual women and men rather than on achieving demographic targets. Central to this new approach is empowering women and providing them with more choices through expanded access to education and health services and promoting skill development and employment. The Programme advocates making family planning universally available by 2015, or sooner, as part of a broadened approach to reproductive health (RH) and rights, and called on Governments to make resources available to achieve this. The Programme of Action recommends a set of important population and development objectives, including both qualitative and quantitative goals that are mutually supportive and are of critical importance to these objectives. Among these objectives and goals are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to RH services, including family planning and sexual health. It places women's rights, empowerment and health at the centre of social and economic advancement.

## UNFPA assistance to Viet Nam

After the ICPD in 1994, UNFPA was designated as the lead United Nations organisation for the follow-up and implementation of the conference's Programme of Action. RH is a key component in UNFPA's governing framework for action and focuses on assisting countries to meet their RH priorities.

UNFPA has been providing assistance to the Government of Viet Nam for 30 years. During this time, the Sixth Country Programme have been completed and the Action Plan for the 7th Country Programme for the period 2006-2010 has begun implementation.

The nature of UNFPA's support to RH service provision has adapted as the health system of Viet Nam has evolved. From responding to the basic material needs (contraceptives, equipment, drugs, etc.) of the country's population programme and contributing to improving national capacity and family planning services as in the 4th Country Programme, UNFPA now focuses on comprehensive RH care service quality improvement and on changing health service users behaviours. One of the early lessons learnt was that a longer commitment is necessary in order to institutionalise changes, ensure sustainability and to consolidate and extend the gains made. Apart from

strengthening access to, and improving the quality of RH services, appropriate attention needs to be given to changing the practices of health providers and the health seeking behaviour of the community.

## What are National Standards and Guidelines for Reproductive Health care services (NSG)?

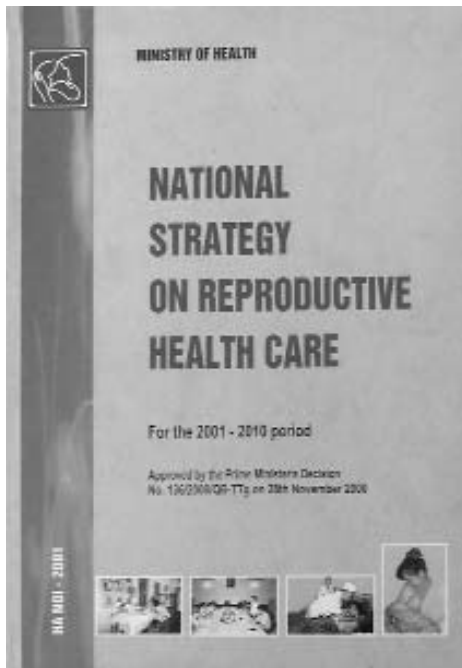
The development and use of NSG are a crucial factor in improving health care services and reducing impediments to quality care. Standards and guidelines are also critical elements in RH education and training, serving as the foundation for curriculum development in both pre-service education and training of practicing professionals.

Standards describe what action should be taken and serve as benchmarks against which to judge performance. Service delivery guidelines provide the detailed, technical information needed to implement national policy. Health care providers use service delivery guidelines in their work as a source of specific, up-to-date information about the health services offered as well as a source of general information to provide quality care.

## What is Quality of Care?

WHO has defined the core elements of quality of care as follows:

- Promotion and protection of health through preventive services (including counselling and education)
- Ensuring accessibility and availability of services
- Ensuring acceptability (including cultural acceptability) of services
- Ensuring standards of practice and technical competence of health care providers
- Ensuring the availability of essential supplies, equipment and medication
- Respectful, non-judgmental client-provider interactions
- Information and counselling for the client and referral when necessary
- Involvement of clients in decision-making
- Comprehensive holistic care integrated into primary health care services
- Continuous monitoring of services
- Ensuring cost-effectiveness and the appropriate use of technology



## The National Strategy on Reproductive Health Care

The Government of Viet Nam developed and approved its first National Strategy on Reproductive Health Care for the 2001-2010 period in 2000 with UNFPA support. A major step towards the implementation of the ICPD Programme of Action, this outlined the goals and objectives for RHC over the next decade, reflecting the situation in the country and acknowledging that reproductive health care activities need a life cycle perspective. The focus is on meeting the reproductive and sexual health needs of individual women, men and couples rather than on demographic targets and takes a comprehensive and integrated RH approach to advance the

objectives of the ICPD to which Viet Nam was a signatory.

The implementation of the National Strategy on Reproductive Health Care<sup>1</sup> for the period of 2001 to 2010 is divided into two phases and a key activity during the first phase (2001-2005) was to:

**“Amend and/or supplement policies and regulation, training materials and documents regulating and guiding the provision of services; execute the strategy for human resource development; strengthen the systems for professional management and monitoring as well as financial and resource management”.**

The development of NSG was viewed as a vital step to operationalise the principles, objectives and actions articulated in the RHC strategy. The NSG would also, according to the RHC strategy,

**“...assist the relevant ministries, committees, governmental and non-governmental organisations and private individuals to improve the quality and sustainability of RHC and to contribute to the successful implementation of the Party's and State's strategy for human development”.**

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<sup>1</sup> National Strategy on Reproductive Health Care, Ministry of Health Ha Noi 2001



# THE NATIONAL STANDARDS AND GUIDELINES FOR REPRODUCTIVE HEALTH CARE SERVICES IN VIET NAM

## The Process

Developing national standards, protocols and guidelines is considered one of the most important factors to improve the quality of RH services. Therefore, under UNFPA's sixth Programme of assistance to Viet Nam for the period 2001-2005, this activity would play an important role in strengthening the technical capacity of the central agencies in delivering RH services and contributing to the achievement of the national RHC strategy.

(NSG) were developed for five main services:

1. Safe motherhood and newborn care
2. Family planning
3. Reproductive tract infections, including sexually transmitted infections and HIV/AIDS
4. Adolescent reproductive health
5. Safe abortion

Counselling would be integrated for each service and the first chapter would cover general guidelines for RH service provision.

The formulation of these national clinical and non-clinical standards for RH services involved six main steps:

1. Formulation of the National Steering Committee, finalisation of topics and working modalities, and recruitment of local and international experts
2. Reviewing existing standards, protocols and guidelines for RH services in Viet Nam and other countries, and developing appropriate national standards, protocols and guidelines for RH services
3. Pre-testing national standards, guidelines and protocols for RH services, and finalising the documents
4. Submission to the Ministry of Health for approval
5. Printing and distribution of the documents nationwide
6. Update and further revision of the established standards/ protocols/ guidelines

Under the leadership of the Department of Maternal and Child Health and Family Planning (now it is called Department of Reproductive Health), the process of developing the NSG in Viet Nam engaged key stakeholders, decision-makers and other leaders to ensure responsiveness to needs and to foster the broad acceptance necessary for implementation by health care providers. UNFPA assisted the Department of

Maternal-Child Health and Family Planning (MCH-FP) to access regional specialists in all areas of reproductive health<sup>2</sup> who worked together with national policy makers and technical institutes to forge a set of standards and guidelines covering a broad range of RH care topics.

Working groups were formed to focus on specific chapters and the National Steering Committee provided guidance on the finalisation of the specific topics within each chapter. After a thorough review of existing documentation, broad based consultations took place with local providers and their clientele and draft chapters were produced. A series of workshops were held to review them, some with the participation of international and national agencies and organisations concerned with reproductive health care provision. Following pre-testing, a long editorial process began, reviewing all the inputs from diverse sources and ensuring each topic and chapter had consistency, congruence and coherence before finalisation and approval in 2002.

## The Contents

The NSG describes which services are offered, who delivers and receives the services, how and where they will be delivered, and what the minimal acceptable level of performance is for each service.

This was the first time that the Ministry of Health had attempted to formalise comprehensively the what, who, where and how of RH care services. The NSG forms an ambitious document of almost 200 pages and each chapter follows a broadly similar format. Each chapter also reflects the consensus reached within the Working Group and during the final review process.

The NSG are divided into six chapters:

### ■ CHAPTER I: GENERAL GUIDELINES

The sub-sections cover the relationship between health care provider and community and between the different levels of the health service; counselling in reproductive health care, outlining general principles as well basic steps and required conditions; blood and fluid transfusion; the use of antibiotics, both prophylaxis and treatment; aseptic principles and hygienic environment of facilities; instruments used in procedures and their sterilisation; essential drugs and criteria for their use at commune level; essential equipment at commune level; RH care facilities at commune level.

### ■ CHAPTER II: SAFE MOTHERHOOD

This is the longest chapter and covers obstetrics, some related gynaecological procedures and care of the newborn. There is information on appropriate counselling topics for each stage of pregnancy, the birth process and postpartum including a large section on breastfeeding. The sub-sections are: antenatal care including management of pregnancy; intrapartum care including the use of the partograph to monitor and manage labour and

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<sup>2</sup> with the exception of safe abortion which was supported by WHO/IPAS

anaesthesia techniques; postpartum care including care of the low birth weight or premature newborns and care of the mother and her baby from immediately after delivery up to 6 weeks postpartum; abnormalities during pregnancy and childbirth including bleeding, uterine rupture, and mal-presentations.

#### ■ CHAPTER III: FAMILY PLANNING

The sub-sections cover counselling, the rights of clients and the instructions for procedures on contraceptive methods, including IUD, condoms, oral contraceptives, injectables (DMPA), emergency contraception, implants, male and female sterilisation and lactational amenorrhoea (LAM).

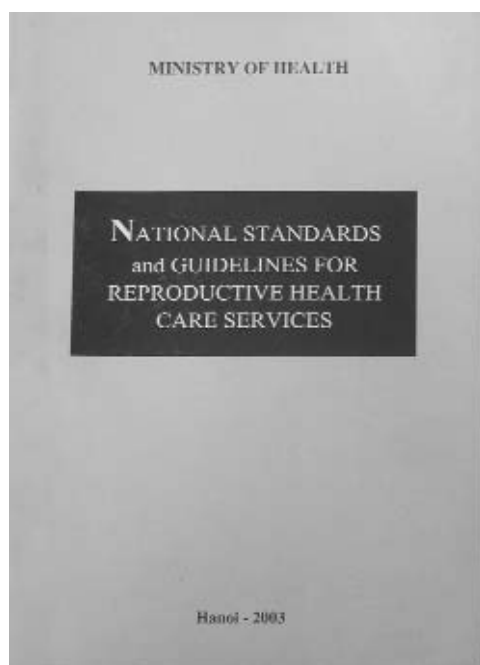
#### ■ CHAPTER IV: REPRODUCTIVE TRACT INFECTIONS AND SEXUALLY TRANSMITTED INFECTIONS

This chapter describes history taking, counselling, diagnosis and testing (including when to suggest HIV testing) and treatment. There is a table for recommended drugs for treating reproductive tract infections (RTIs), including sexually transmitted infections (STIs).

#### ■ CHAPTER V: ADOLESCENT REPRODUCTIVE HEALTH

After some general guidelines this chapter covers counselling including some key issues; the management of RTIs, including STIs in adolescents; examination of male and female adolescents; menstruation, adolescent pregnancy, and contraceptive methods.

#### ■ CHAPTER VI: SAFE ABORTION



The sub-sections of this chapter cover counselling including points for counselling special groups; manual vacuum aspiration (MVA) techniques; medical abortion up to 7 weeks from the last menstrual period (LMP); dilatation and curettage; dilatation and evacuation for 13 to 18 weeks LMP; and the process for preparing MVA instruments.

# CONSTRAINTS AND CHALLENGES IN DEVELOPING THE NSG

Whilst the development of the NSG marked a significant and positive shift in perspective, inevitably there were a number of constraints and challenges in both the format and content.

## Format

Several changes were made in the layout of the NSG to achieve the most user-friendly format. Nonetheless, there are some parts that do not follow a logical sequence. Where possible, this was addressed by cross-referencing, for example, where tetanus vaccination is mentioned in the antenatal examination, the reader is referred to the section on neonatal tetanus prevention.

## Language and terminology

Medical language and its use proved a challenge to the interpretation of clinical procedures and lengthy discussions were needed to reach consensus on defining terminology. For example, clinical terms describing a set of procedures had to be broken down to ensure that there was the same understanding of the component parts. The editing group worked in English and Vietnamese simultaneously to reduce any further confusion due to language and translation.

## Harmonisation and integration

It was recognised that some key midwifery procedures were omitted such as normal delivery and the active management of the third stage of labour. Some technical and procedural aspects of RH care fall under the jurisdiction of the Department of Therapy whose guidelines were not scheduled for review. This was partially resolved by including the existing relevant guidelines of the Department of Therapy in the NSG but there is an obvious mismatch both in content and design.

Many contributors to the development of the NSG believed that at least some aspects of the HIV/AIDS guidelines formulated by the AIDS Division should be integrated. A compromise was achieved by attaching the HIV/AIDS guidelines to the end of the NSG.

Both these issues are in large part due to the vertical organisation of the departments within the Ministry of Health and the tiers of the health system. Each department tends to preserve its autonomy over its designated area, often resulting in coordination difficulties and duplication of effort. The Department of RH is constrained in turn from fully embracing all aspects of a comprehensive approach to RH as certain areas such as HIV are not part of their remit.

## Use of international standards

A prevailing comment received during the final review process was that the NSGs were still too far from international standards in the use of medications of dubious or unstudied efficacy for their stated indication such as

- Use of papaverine to reduce the strength of contractions or for fetal distress
- Application of glutaraldehyde to a normal umbilical stump

Equally, feedback also identified a number of areas where evidence-based practices could have been more fully embraced such as

- Less focus on risk factors during the antenatal period and more on birth preparedness
- Use of revised WHO partograph (excludes the latent phase of labour for easier data management)
- Use of oxytocin as an integral part of the active management of the third stage of labour to prevent haemorrhage by midwives at commune level

The technical experts within the Working Groups were divided on such issues, with the Ministry of Health representatives understandably cautious to adopt unfamiliar practices despite the evidence. In addition, there was concern about allowing mid-level providers to conduct certain procedures as their capacity was considered inadequate. This was seen by others as a missed opportunity to use evidence based procedures and medications, such as the wider use of prophylactic oxytocin as part of the active management of the third stage of labour, which would have had a measurable impact on prevention of postpartum haemorrhage and maternal mortality.

As a result, this first edition fell short of international best practices in some procedures but the process of developing the NSG was also regarded as a capacity building exercise per se, moving the technical advisers and policy makers of the Department of RH and related institutions steadily forward in their knowledge and perceptions. The process of developing the NSGs did not intend to follow a blue print approach but to provide a wider opportunity for change. The structural and legal context of the health system also impinges on the NSGs so change has to be stimulated on a number of fronts, improving the overall enabling environment for service provision.

A review of relevant policies and decrees may be required, including Decree 385, that defines the roles of RH practitioners, to identify possible legal and structural constraints to closing the gap between the NSG and international practice. Determining possible solutions with a broad base of participation and commitment from related government Departments will also ensure better integration of RH procedures.

# THE TRAINING

After the development and approval of the NSG by the Ministry of Health, training manuals and other teaching aid materials were developed and a training programme commenced for in-service providers at province, district and commune levels<sup>3</sup>. Based on the NSG, different training programmes were designed for different target groups of RH care service providers and depending on the target group, training durations ranged from 5-22 working days. The aim was to strengthen the technical capacity of providers at all levels to deliver quality RH services by assisting them to comply with the newly approved NSG.



With UNFPA support, the Ministry of Health established national training teams consisting of specialists in obstetrics, gynaecology and neonatology from central hospitals in Ha Noi, Ho Chi Minh City (HCMC) and Hue. In each UNFPA supported province, a similar team of provincial trainers was established. Designated national trainers were appointed to each province to provide technical support for provincial trainers when conducting refresher training for service providers at the local levels. The provincial obstetric and gynaecological hospital or department was utilised for practical training. Provincial trainers were selected from amongst the best professionals in provincial institutions, and formally appointed by the Department of Health (DOH). The central team worked under the direct coordination of the MCH-FP Department of the Ministry of Health and the national hospitals in Ha Noi, HCMC and Hue.

After a Training of Trainers, which focused on training methodology and theoretical and practical modules, a training programme was conducted at local levels in UNFPA provinces during 2003-2004. RH service providers and managers from provincial to commune levels were trained on the newly approved standards and guidelines using the training package. Four different groups of trainees (managers of RH reproductive health service settings, obstetricians, midwives, and venereologists) received training on all the components of the NSG.

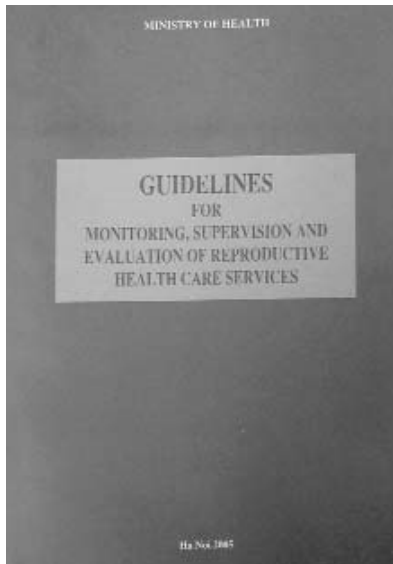
Other provinces, not under UNFPA support, selected components of the NSG and provided training on them for RH service providers using other funding sources such as Government or international agencies. Consequently, not all RH service providers were trained on the NSG and among those trained, not all were trained on all components of the NSG.

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<sup>3</sup> A national training package was jointly developed by IPAS/WHO for abortion component, and UNFPA and Pathfinder for the remaining components i.e. safe motherhood, family planning, adolescent reproductive health, reproductive tract infections, and other related areas.

## THE MONITORING AND SUPERVISION

An appropriate mechanism for the monitoring and evaluation of the training was established within the MCH-FP Department and with the national hospitals in Ha Noi, HCMC and Hue to ensure the quality of the training and to strengthen the training capacity of the central and local levels. This also monitored compliance to standardised practice, together with advocacy activities that encouraged health staff to follow the NSG. As improving the quality of RH services requires skilled health service management as well as technical skills, a training curriculum was developed using a client-oriented approach, with a focus on inter-personal communication skills. Monitoring and evaluation of these activities aimed to help change the behaviour of service providers and managers towards providing better quality RH services through compliance with the NSG.



A monitoring and supervision tool<sup>4</sup> was developed and approved by the Ministry of Health in 2004 to assist supervisors to provide supportive supervision to clinical staff and encourage their compliance with the NSG. This book (known as the 'blue book') provides supervisory staff with specific procedural checklists for use in monitoring visits to health facilities and guidelines on supervision methods. This book also provided managers with guidance on how to monitor progress against standards set in the NSG and encouraged self-assessment of professional practice. According to an assessment of the implementation of the NSG conducted in 2005, 95.8% of the surveyed health facilities had received a copy of the blue book.

UNFPA and other international support was provided to train supervisors in their project sites.

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<sup>4</sup> Guideline for Monitoring, Supervision and Evaluation of Reproductive Health Care Services (2004) Ministry of Health, Viet Nam

# CONSTRAINTS AND CHALLENGES TO IMPLEMENTING THE NSG

An assessment of the implementation of the NSG was conducted in 2005 by the Ministry of Health and the Research Centre for Environment and Health after 2 years of implementation<sup>5</sup>. The overall objective of the assessment was to propose adjustments and modifications to inform a revision of the NSG. Implementation was assessed at four levels of the health system: central, provincial, district and commune. In addition, activities in related departments of the Ministry of Health (such as Finance, Therapy, Science and Training as well as the RH department) and international organisations working in RH (e.g. UNFPA, PATH, IPAS, SC-US, Pathfinder International) were reviewed.

Many of the specific management and technical challenges and constraints in implementing the NSG that are identified in the MOH assessment report are echoed in other recent and relevant documentation such as the Evaluation of the Comprehensive Abortion Care project<sup>6</sup> and the Rapid Maternal and Neonatal Health Care Needs Assessment<sup>7</sup> and are drawn on in the sections below.

## Resistance to change

According to the assessment data, 100% of the surveyed health facilities were implementing the NSG. Most health facilities began their implementation of the NSG in 2002 and 2003 but some districts and communes did not begin implementation until 2004. Resistance to implementing aspects of the NSG was identified in the assessment; often the reasons given for their limited execution were lack of infrastructure, insufficient human resources and the NSG unsuitability for local conditions. Recurring solutions voiced by health staff included the need for consistency and clarity in the NSG and adequate and regular training in new or unfamiliar procedures and practices.

A persistent challenge to changing health practices is the entrenched behaviour of health service providers. Sometimes an ineffective practice needs to be replaced with an evidence based technique; sometimes a harmful practice should be stopped; other simple but effective practices need to be more widely used. For example, routine uterine

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<sup>5</sup> Project Management Board VIE/01/P10, Ministry of Health & the Research Centre for Environment and Health (2005) Assessment report on Implementation of the National Standards and Guidelines for Reproductive Health Care Services, MOH, Ha Noi, Viet Nam

<sup>6</sup> IPAS (2006) Measuring Successes and Challenges: Evaluating Comprehensive Abortion Care in Viet Nam, Ipas, Ha Noi, Viet Nam

<sup>7</sup> UNFPA/PATH (2006) Rapid Maternal and Neonatal Health Care Assessment in UNFPA Supported Provinces of Viet Nam, Ha Noi, Viet Nam



version<sup>8</sup>, a potentially dangerous and unnecessary practice which is not endorsed by the NSG, but still occurs. On the other hand, external bimanual compression<sup>9</sup> is a recognised positive action that can be taken by commune and district level health staff to manage postpartum haemorrhage and is promoted by the NSG (see page 105 English version). Recent research (UNFPA/PATH 2006) demonstrated that few providers (midwives and doctors) could describe the steps of the procedure and none could recall using it.

This is an area worthy of further investigation as social, cultural and economic factors interact to constrain change and obstruct progress. In part, perseverance will pay off over time and changes in attitudes and practices will be seen but with a rapidly transforming socio-economic situation, more attention should be paid to what influences health care service providers acquisition of knowledge, change in practices and professional accountability.

## Misperceptions

An area in the development of the NSG that probably deserved more attention was the need to understand and combat the prevailing perception among health staff that Ministerial-led documentation is primarily a legal requirement, something that must be done to protect the provider and the service from any legal repercussions. While this has some essence of truth, it is a view that is reinforced by the role of professional bodies and the training institutions in Viet Nam who remain weak at promoting professional standards and quality of service as a commendable aim to strive for per se. Thus, the NSG are not regarded by many providers as an instrument to raise the quality of their professional practice but yet another regulation to be followed. The comments below are taken from the NSG implementation assessment and are listed under the advantages of the NSG, emphasising the implicit nature of this understanding.

**"It was legal and approved administrator staff and hospital leaders"**

Staff at large tertiary level hospitals

**"It was much approved by leaders; it was a legal regulation for Ob/Gyn to provide services; it was also the legal documents to reply complaints of the clients"**

Staff at provincial level facilities

**"The NSG was key points, legal documents to protect Ob/Gyn physicians"**

Staff at district level facilities

**"Local governments, organizations and unions approved it very much"**

Staff at commune level facilities

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<sup>8</sup> Inserting hand or instrument to confirm the uterus is empty

<sup>9</sup> A non-invasive measure to reduce postpartum bleeding

## Clients - service demand

In many Southern provinces in particular and increasingly in urban areas all over the country, clients prefer to use private sector services which are often provided by the same staff who offer the service in the state health system. The relationship between the public and private sector will become increasingly complex as clients have both the economic means and social confidence to exert choice. Clients often believe that private services are superior in quality and there is a strongly held assumption that higher fees mean better service. This view leads many clients to seek a higher level of care than their condition requires and in turn, diminishes the case load (and income) of the local health facilities. For instance, two provinces in the South, Tien Giang and Binh Duong, had the lowest proportion of {state} health facilities performing both basic and comprehensive essential obstetric care functions<sup>10</sup>. For local RH service providers, particularly at commune level, there is little opportunity to consolidate their training in the NSG and staff lack confidence in their capacity to provide a quality service as a result.

**"We did not realise that the [poor] quality of the service at the CHS in our commune is the main reason for people not using this service".**

Commune leaders in a district in the South of Viet Nam where  $\frac{3}{4}$  of pregnant women choose to deliver their babies at the district hospital or at a private clinic (UNFPA/PATH 2006)

There remain issues of access to services for a number of special client groups such as those from ethnic minorities and remote or mobile communities. Communication between client and provider is sometimes restricted by language competency or gender. Difficult weather and landscape, lack of transport and insufficient family funds are factors that remain a challenge in improving the quality of RH service delivery to such groups.

## Providers - service supply: some clinical challenges

As the NSG is principally to guide service delivery, the major constraints to implementation lie with clinicians and their managers. Some technical procedures are not adequately described in the NSG or are not based on accepted best practice while others have not been implemented because of a lack of resources.

A recent rapid maternal and neonatal health care needs assessment (UNFPA/PATH, 2006) showed the range of practice around one clinical procedure:

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<sup>10</sup> Baseline survey report on Provision and Utilization of Reproductive Health Care Services in 12 UNFPA supported provinces in Viet Nam. Ha Noi 2003

**"In some Northern provinces injecting oxytocin after the delivery of the baby to prevent haemorrhage is rarely done, whereas in some Southern provinces oxytocin is given routinely in most Commune Health Stations to all women after the delivery of the baby and before the delivery of the placenta to prevent postpartum haemorrhage. In a CHS in the Central Highlands the staff said that the District Health Centre had removed both oxytocin and diazepam from the CHS because there is no doctor so they are not permitted to use these drugs (there is a primary midwife and an assistant doctor with obstetric and paediatric training)".**

(UNFPA/PATH 2006)

The NSG does not describe the actions associated with the use of oxytocin as a means of preventing haemorrhage ('to prevent haemorrhage in the third stage of labour after delivery of the baby' page 73 English version) and do not define what level of provider can use oxytocin as postpartum haemorrhage prophylaxis. As a result, district health staff have defined their own practice and guide their subordinates accordingly:

**"We use oxytocin in this way as this is how the district hospital instructed us"**

Midwife in a Commune Health Station (UNFPA/PATH 2006)

Conversely, the actions needed to manage a case of severe pre-eclampsia or eclampsia are clearly described in the NSG and include the use of magnesium sulphate as an anti-convulsant, a WHO endorsed best practice. The NSG is also specific about what level of provider can take such actions. Nonetheless, most facilities reviewed in this recent assessment were not supplied with the drug, magnesium sulphate, and most health providers could not describe adequately how to manage cases requiring this therapy; therefore, were not able to offer this life saving treatment.

In addition to the inadequate supply of essential drugs to match the requirements of the NSG, other basic provisions such as a clean water source and safe disposal of medical waste are often not in place. There are invariably simple and cheap solutions to improve water, sanitation and safe waste disposal but are not implemented for reasons that are unclear. For example, in several Commune Health Stations in Hoa Binh province, cardboard containers for the safe disposal of sharps, supplied by the Expanded Programme for Immunisation, were cast aside unused, while used needles and syringes were left in an open box.

## Providers - service supply: some management challenges

The interrelationship of health service management with the provision of quality services by clinicians was recognised as central to the improvement of RH care through national standardised practices.

Human resources remain the most significant obstacle to further achievements in the quality of service delivery. The working conditions of RH service providers have a critical influence on their performance. Staff development, recruitment, management (such as deployment, supervision, career plans, incentives) and training opportunities contin-

ue to test health service managers.

Many local health staff voice their desire for more regular and supportive assistance from their supervisors and in turn, senior level staff express their concern at not being able to provide more frequent and useful inputs to the lower levels.

**"District people must help us to improve our knowledge and skills as well as help us with recording and reporting. They should show us what our limitations are so we can learn and avoid the problem next time".**

Commune health staff (UNFPA/PATH 2006)

District level health staff themselves would like to receive more supportive supervision from the provincial level but all levels strive but with limited success to find enough suitably qualified health staff to function in supervisory roles. Unfortunately efforts to strengthen health service management using methodologies such as COPE<sup>11</sup> have not always been regarded as helpful.

**"Even though I have been trained and am now a trainer, I still do not clearly understand so I am not comfortable with monitoring and supervising the implementation of COPE at district hospitals and Commune Health Stations".**

Core COPE trainer from obstetric unit (UNFPA/PATH 2006)

**"It is difficult and useless for us to apply COPE here. We have had to do extra work since implementing the COPE exercises. We have to spend a lot of time to define problems but nothing improves because there is a lack of financial resources. The funding of the Commune Health Station depends on the commune People's Committee [PC], but the PC people do not know what COPE is. Promotional activities for the health service are mainly the work of the mass organisations; those people also know nothing about COPE".**

Head of a Commune Health Station (UNFPA/PATH 2006)

The terms 'monitoring and supervision' are often conflated and the actions taken for both are similar. Supervision frequently lacks a supportive element, regarded more as checking, whereas the central focus of supervision should be the quality of practice offered by the supervisee to clients. The assessment conducted by UNFPA/PATH (2006) in 7 UNFPA supported provinces found *"with the exception of Tien Giang, no supervisors of staff providing maternity and newborn care had any notion of supervision as supportive, a part of improving the quality of performance. Most supervisory activities are concerned with monitoring targets, adjusting records and investigating incidents."*

Monitoring, the regular collection and analysis of information to provide management with early indications of progress and achievement of objectives, remains target oriented. Record keeping is of poor quality, often inaccurate and incomplete. Some provinces have reorganised their district level health management structures and many local health staff feel this has increased their workload in recording and reporting and in some cases, has caused confusion about indicators and reporting lines.

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<sup>11</sup> The goal of COPE (client-oriented provider-efficient services) is to use a process and a set of practical tools to help providers of reproductive health care become more aware of their clients' needs and use available resources more efficiently to improve the quality of services.

## THE CONTRIBUTION OF NSG TO IMPROVING THE QUALITY OF RH SERVICES

The development and approval of the NSG was a major step forward by the Ministry of Health to improve the quality of service provision. In a large, well populated country as diverse as Viet Nam, some constraints to their implementation are to be expected.

Equally, there are some clear and positive changes as a direct result of the NSGs. Previously, guidance and support in all areas of RH care reflected the views and experiences of the health staff in key positions. Often clinical procedures were conducted in accordance with the limited and frequently outdated training received by providers from different sources during their medical and paramedical education.

**"Before the introduction of the Standards and Guidelines, the services in our centre did not follow any models, even the instruments processing was very cursory. With the introduction of the Standards and Guidelines, we partially applied some standards in the provision of services. We received training and supervision and comments [from a project], not only in the process of services but also in the way of thinking and behaviour. I think that it was a turning point in our centre "**

From evaluation of Comprehensive Abortion Care project (Ipas 2005)

Some districts have found a way to provide some support for staff working in remote areas.

**"District staff assign one of their staff to work with us for 1 week every 6 months to strengthen our capacity in maternal child health and family planning".**

Commune Health Station staff in a Northern Mountain province (UNFPA/PATH 2006)

Although difficult to attribute solely to training on the NSG, it is refreshing to hear that a client's abiding memory of her delivery is the attitude of her service provider...

**"The midwife's voice is sweet. When I suffered from labour pains, hearing her voice made me feel calm"**

New mother (UNFPA/PATH 2006)

Potentially life saving treatment is provided at a Commune Health Station.

**A woman in her 3<sup>rd</sup> pregnancy was on the way to the Commune Health Station for delivery but she gave birth at the roadside. The placenta did not deliver and she began to haemorrhage. On arrival at the CHS at she was given 10 IU oxytocin and the placenta was manually removed. Mother and baby are well.**

(UNFPA/PATH 2006)

Communities are becoming better informed. Whilst most deliveries (85%) will be normal and will not require any medical intervention, 'the sun should not set twice on a labouring woman'. A resourceful and confident midwife knows to be prepared and be alert for danger signs but as childbirth is a physiological rather than pathological process, it is likely that all will proceed normally.

**A 37 year old woman, having her first baby, was kept at home for 1 night and 1 day after labour started by her grandmother, a Traditional Birth Attendant. When there was no delivery neighbours and family members called a car to take her to the district hospital. The midwife from the local Commune Health Station arrived with a clean delivery kit and while the woman was being transported by stretcher to the main road, she delivered with the midwife's assistance. The car arrived but as everything was okay, everyone returned home.**

**(UNFPA/PATH 2006)**

The specific requirements of adolescents for RH services were recognised by the Ministry of Health and there is a section in the NSG that covers the particular needs of this group. There are currently 24 million adolescents and youth between 10 and 24 years old in Viet Nam representing a third of the Vietnamese population. Providing RH information and education is important to help young people explore their own attitudes, values and options, as well as to increase their knowledge and understanding of RH issues. Services need to be available and accessible to this group and establishing an enabling policy environment for youth oriented RH information and services at national and local levels to increase utilisation is vital. The NSG acknowledges this and serve to ensure youth needs in RH are addressed.



Photo by Doan Bao Chau

## FUTURE DIRECTION

There are distinct differences between the regions of Viet Nam in RH practices, both in health care seeking behaviour by clients and in the way health staff organise and provide services. Achieving standardised evidence based practice in RH care services therefore needs to be regarded as a long term goal. Bettering the design, content and implementation process of the NSGs will assist in accomplishing this.

### The role of international support

A key factor in the development of the NSG was the involvement of international expertise in providing guidance to the Ministry of Health in best practices. International agencies such as UNFPA and WHO, international NGO such as Pathfinder International, Ipas, PATH and Save the Children and individual experts contributed field based experience from their project sites and provided access to global technical know-how. UNFPA plays a lead role in guiding and coordinating efforts to promote and achieve the ICPD objectives. The negotiation and communication process among the contributors strengthened the relationship between the national health system, particularly with strategic departments at the Ministerial and Provincial levels, and the diverse health and development agencies. As a result, Ministry of Health continued to invite input on the NSG and their implementation from outside sources and the donor projects assisted the implementation of the NSG within their project sites. The advantages of such close collaboration are at least two fold: quality assurance of the content of the NSGs in line with internationally recognised practices and the added value of a broader based dissemination and implementation of the NSG.

In June 2007 under the lead of Ministry of Health, a Memorandum of Understanding (MOU) between UNFPA, WHO, UNICEF, Save the Children-US, Pathfinder International, IPAS and the Ministry of Health was signed. After 5 years of implementation the NSG need to be updated, in part to reflect advances in treatment protocols. All partners have committed to support the Ministry of Health in this process, and the MOU outlines each partner's contribution, both technical and financial, and have agreed to coordinate and collaborate fully. The Ministry of Health is preparing the update during 2007 and is expected to approve a new version of the NSG in early 2008.

The inherent capacity building of national health staff as a consequence of such sustained cooperation with international expertise is evident. Nonetheless, it is a time consuming process and requires patience and commitment from all concerned stakeholders. As the NSG will necessitate regular updating and revision, a crucial aspect of the review and consolidation will be the open exchange between the nominated Ministerial and Provincial level health officials and international colleagues with technical competence and proficiency in RH service delivery. This needs to be systematised with participatory mechanisms in place to encourage dynamic dialogue and the efficient flow of information. With UNFPA in a lead position in line with its mandate,

the relevant UN agencies and international NGOs are well placed to facilitate this iterative process and to provide access to resources to enable evidence based practice to exert its influence on the decision-makers.

International expertise can also help to improve the implementation of the NSG by furthering its support for pre-service training as well as in-service. Fundamental changes at the institutional level in the both the curriculum content and the way it is taught will bring about a positive shift towards better professional standards of practice, supportive supervision and ultimately, improved performance and quality of care.

Assessment of implementation progress would also benefit from international external assistance. It is necessary to have some impartiality when judging performance and to build national capacity in research methodologies that focus less on easily verifiable improvements (infrastructure, equipment, drugs) and more on seeking to tease out the full range of quality of care indicators.

## Evidence based practice

A major aim for the content of the NSG is to bring them closer to international evidence based practices especially in regard to treating pre-eclampsia and eclampsia, preventing postpartum haemorrhage, newborn cord care, contraceptive technologies, the diagnosis and management of sexually transmitted infections and the application of universal precautions. Better integration is needed with the HIV/AIDS guidelines especially around voluntary counselling and testing and the treatment of antenatal women to prevent mother-to-child transmission.

Where the NSG are already in line with best practice but are largely ignored by health providers who continue to be attached to the way they have always worked, innovative behaviour change methods are needed to break the bond. The culture of medical practice itself may also be averse so boundary breaking interdisciplinary collaborations may stimulate change. Physicians remain the most powerful voice in medicine and they are predominantly trained in the use of drugs and surgery to control disease. In addition, pressures on doctors from the pharmaceutical and technology industries to utilise their products are strong.

Training in a public health perspective and exposure to the efficacy of the wide application of proven and effective practices through communities of practice will also encourage a paradigm shift. To increase the likelihood of changing practitioners' habits quality research is essential to demonstrate the pathways between biological, psychological, social, and cultural factors that influence health and how they can form a basis for developing interventions that improve health outcomes.



## Integration

Recurring comments from RH providers focus on the need for the implementation of the NSG to be more user-friendly. Streamlining the monitoring tools and indicators would also alleviate some of the documentation burden that health staff frequently complain of.

**"There is a lot of red tape if Commune Health Station staff need to use diazepam [sedative used in pre-eclampsia]. We have to submit an official letter to the district for permission and request the supply of the drug; after the drug has been used, the empty ampoule has to be returned to the district People's Committee along with certification from the commune People's Committee. Therefore, we do not provide that kind of service because of the administrative procedure"**

Head of a Commune Health Station (UNFPA/PATH 2006)

It is timely to unify the parts of the NSG that fall under the jurisdiction of other Ministry of Health's departments as the NSG are after all, the detailed, technical information needed to implement national policy. Ensuring the policy environment and the Ministerial regulations permit providers to use the relevant and appropriate medications and procedures will ease the confusion often felt by clinicians and provide consistency. Strong leadership and coordination is required from the Ministry of Health to avoid conflicting instructions from different departments which further undermines the confidence of the health provider. Anomalies such as the actual example quoted below, should not be possible.

**" I noticed that on the wall of the Commune Health Station was a paper from the Ministry of Health saying that health staff at commune level are not allowed to use injectable Seduxen (diazepam) or magnesium sulphate (Bo Y te, QD17/2005/QD-BYT, 1 July 2005)"**

Data collector, UNFPA/PATH 2006

Integration of RH services needs to occur at all three levels: at the point of service delivery where RH components are brought together and strong links established with other aspects of health care and related social services to meet people's needs for accessible client-centred comprehensive care; at the health sector level where although the responsibility for policy, programme development, implementation and evaluation may rest with different managers or departments, integration is achieved through effective communication and collaboration; and within national development planning processes where RH policy has synergistic linkages with not only health sector planning but also with other sectors such as education, agriculture, youth, women's affairs, environment and finance<sup>12</sup>.

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<sup>12</sup> For more on integrating sexual and reproductive health care services see <http://www.who.int/reproductive-health/publications/policybrief2.pdf>

## The private health sector

There continues to be a rapid growth of the private health sector in Viet Nam and private practitioners are active in most areas of RH care but especially in abortion provision and the use of technology to assess the progress of pregnancy.

The private sector can fill a gap in the availability and accessibility of public services, often complementing state initiatives and ideally should be integrated with the national health system. Strategies to embrace private providers of reproductive health care services such as disseminating the NSG to private practitioners, improving their knowledge and practices through including them in training, regulation and incentives need to be considered within the context of the NSG.

Strategies to embrace private providers of RH care services such as disseminating the NSG to private practitioners, improving their knowledge and practices through including them in training, regulation and incentives need to be considered within the context of the NSG.

## Training

As standards and guidelines are critical elements in RH education and training, those providing the education, training and supervision of reproductive health service providers require on-going support on competency in and compliance with the NSG. A prerequisite is that educators (and policy makers) are provided with a copy of the NSG and understand what standards and guidelines are and their purpose. Persistent comments documented during the assessment of the NSG implementation refer to their perceived legal role and the erroneous notion that NSG can be adapted according to geographical regions and socio-economic conditions.

**'When composing the NSG on RH care services for a region, it is necessary to consider the its geographical conditions for higher effective {sic}. The NSG should be based on local socio-economical conditions'**

Ministry of Health & the Research Centre for Environment and Health (2005)

The NSG serves as the foundation for curriculum development in both pre-service education and training of practicing professionals. Educational institutions (medical schools, secondary medical schools, departments concerned with providing refresher training) must ensure their staff are competent in their skills and updated with the knowledge base associated with any adjustments and revisions to the NSG. This means improving access to information and strengthening library and online resources. The Ministry of Health has posted the NSG on its web site and further exploration of how information technologies may enhance the dissemination of key knowledge to students, teachers and practitioners is needed.

Teaching methodologies should be participatory and competency based with a humanist perspective to engender an inquiring and caring attitude among students. Exposure to

methodologies such as COPE should continue but greater attention needs to be paid to the enabling environment within which practitioners receiving such training, have to function.

## Presentation

It is important that due attention is paid to the consistency, coherence and comprehension of the detailed content of the NSG. A thorough editing process is essential to smooth out any irregularities in presentation. There are examples that can be reviewed from other countries that illustrate a format that is easy to access and understand.

**'The sets of documents on the NSG had many mistakes, lacked the comprehension.**

**The NSG on RH care services was not detailed at some contents. Personnel structure was overlapped and not specific.**

**The NSG has to be clear, short, exact and necessary for each level.'**

Ministry of Health & the Research Centre for Environment and Health (2005)

## Resources

As in many developing countries, health care providers in Viet Nam dream of a work environment that is new and well equipped. Much is made of the need for well built facilities that are supplied with the latest technology and medicines. Yet quality of care is more about the efficient and effective use of limited resources and increasing access to and the use of RH services.

Ensuring the supply of the RH care essential drugs and equipment on the lists compiled by the Ministry of Health and a welcoming, clean and efficient clinical environment is obviously an important part of the quality of care. Nonetheless, it is the quality of the human resources that is the most important component. Improved working conditions for reproductive health care professionals, including staff training and career development opportunities will enhance the commitment of health care providers to better apply the NSG and in turn, limit unnecessary medication or procedures and increase a respectful attitude towards the client.

## Demand

A key objective of integrated and comprehensive RH care is to ensure that women know their options and exercise them. It goes beyond the clinic and into the wider society, and involves raising the status and educational level of women<sup>13</sup>.

Quality of care is about rights as well as services. When individuals and communities understand their rights, they are more likely to demand appropriate care. This demand can, in turn, influence service providers and health systems by improving their understanding of how to supply better services. Communities can play an important role

<sup>13</sup><http://www.unfpa.org/intercenter/reprints/sexual-2.htm>

in generating demand for appropriate RH services.

In Viet Nam there are an increasing number of mechanisms whereby people can raise RH issues and serve as advocates, collectively exerting pressure for public health service improvements. Feedback from client groups can add a valuable voice to the formulation of NSG. Users can also provide input into monitoring and evaluation efforts to inform the improvement of service delivery.

What clients want when they seek RH care is similar in Viet Nam as in other countries:

- Respect, friendliness and courtesy
- Confidentiality and privacy
- Understanding on the part of providers of each client's situation and needs
- Complete and accurate information, including full disclosure about the side-effects of contraceptives
- Technical competence
- Access and continuity of care and supplies. Access implies that services are reliable, affordable and without barriers
- Fairness. Clients want providers to offer information and services to everyone regardless of age, marital status, sex, sexual orientation, class or ethnicity
- Results. Clients are frustrated when they are told to wait or come back on a different day, or when their complaints are dismissed as unimportant<sup>14</sup>

<sup>14</sup> <http://www.unfpa.org/rh/services.htm>

## CONCLUSION

Both UNFPA and the Government of Viet Nam share a commitment to agreements and conventions such as the 1994 International Conference on Population and Development (ICPD) in Cairo, the Beijing Declaration and Platform for Action, the Convention on the Elimination of Discrimination Against Women (CEDAW), and the achievement of the Millennium Development Goals.

With this shared understanding, UNFPA helps the government to formulate policies and strategies to reduce poverty, support sustainable development and to interpret population trends. As a key part of UNFPA's assistance to Viet Nam, UNFPA continues to provide leadership and support to the Government of Viet Nam to achieve the goals of the National Strategy for Reproductive Health care of which the National Standards and Guidelines for RH Services are a crucial part. After 3 years of implementation, comprehensive application of the NSG is patchy - not all reproductive health service providers have yet been trained on the NSG and among those trained, not all were trained on all components of the NSG. The necessary investment and commitment among managers and decision makers to ensure adequate resources are available for clinicians to provide quality RH services are not always present and the behaviours of providers and clients are not always conducive to the best possible outcomes.

The revision, implementation and monitoring of the NSG requires the Ministry of Health to have strategic and comprehensive plans so that gaps may be addressed in all areas. By standardising the delivery of care, the NSG provides the basis for training materials and tools for monitoring and evaluation of health facilities and the performance of RH service providers. Regular review and a two yearly formal revision are needed as technologies advance and best practices are adjusted. The presence of and adherence to NSG based on international best practices in RH care lead to improved quality of service delivery and ultimately to the reduction of long-term disability and death among the most vulnerable populations.

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