TaLkingPoiNts

More to Demand: Abortion in Vietnam

by Do Thi Hong Nga

Vietnam has perhaps the most liberal policy on abortion in Southeast Asia.

Abortion on demand has been legal in the country since the 1960s as the government considers abortion as primarily an issue of social justice. But the national landscape of reproductive health and reproductive rights is not entirely rosy. Having one of the highest rates of abortion in the region is not exactly a good sign. Instead, this reflects a lacuna that indicates the need for further government intervention in public health in the advancement of women's empowerment and gender equality.

Promising Progressive Policies

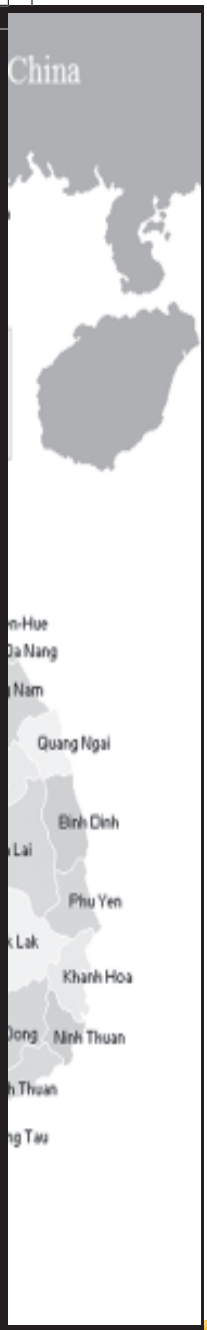
The Constitution of Vietnam declares that men and women enjoy equal rights in all aspects and circumstances such as reproductive health: "The State, society, family and citizen have the responsibility to provide health care and protection to mother and children; and carry out the population and family planning program."

Back in 1960, the Vietnamese National Assembly adopted the Law on Marriage and Family which is based on four principles, namely: freedom of marriage; monogamy; gender equality; and protection of women's and children's rights. By 1989, the Law on Protection of People's Health was approved, affirming the people's right to choose contraceptive methods. Further, it states that: "Women have the rights to have abortion; to receive gynecological diagnosis and treatment, and health check-up during pregnancy; and medical service when giving birth at health facilities."

These actions generated strong support from the international community, including the United Nations Population Fund and non-government organisations (NGOs). In the 1980s, the government encouraged small-sized families, ideally with two children, spaced three to five years. By 1997, Vietnam had a 75 million population with an annual growth rate of 2.2 percent. Total fertility rate (TFR) has been declining since the 1980s. In 1987, TFR stood at four children but from 1989 to 1993, the rate was pegged at 3.3 per cent. This even lowered for the period of 1992 to 1996 with 2.7 children. At present, the TFR is estimated at 2.2 children.

According to the 2006 Health Statistical Yearbook, the Vietnamese population reached 84 million with the growth rate of 1.26 per cent. The contraceptive prevalence rate (CPR) is at 67 per cent and incidents of abortion number more than 500,000.

The Ministry of Health (MOH) and the National Committee for Population (NCPFP) are at the helm of the national family planning programme. Family



In 2006, Vietnam's population stood at 84 million. Its total fertility rate has been 2.2 children in the last few years but incidents of abortion number more than 500,000.

Photo by Andre Lettau, from Wikimedia Commons

planning services and abortions are provided through the MOH network of clinical sites which include: central and provincial hospitals, provincial family planning centres, district hospitals and health centres, intercommunal polyclinics, and commune health centres.

The NCPFP's family planning field workers at the commune level are responsible for information, education, commununication (IEC) activities, and the distribution of oral contraceptives and condoms. They are supported by volunteer workers, typically members of commune level mass organisations, including the Vietnam Women Union.

A physician, assistant physician or trained midwife with MOH approval can legally perform abortions. As defined by the current National Abortion Standards and Guidelines (NASGs), abortion services are provided at three administrative levels of the health system: (1) abortion from six to 18 weeks from the last menstrual period (LMP) is available at central and provincial hospitals; (2) abortion from six to 12 weeks of LMP is also available at district health stations; and (3) communal health clinics may only offer abortion to women who are not more than six weeks pregnant.

Private clinics in certain provinces are also allowed to perform abortion on six-week pregnant women. Abortion up to 22 weeks is only permissible in cases of abnormal fetus; when pregnancy is a result of rape; or when there is a risk to the mother's life. Women who do not have any of these circumstances are usually advised by doctors to bring their pregnancy to term, with the options of staying in places arranged by hospitals and putting up their children for adoption.

Fees for abortion services vary according to the administrative level of health clinics and to the economic status of provinces. In general, the fees for abortion range from VND 40,000 (US$ 4) for first trimester abortion to VND 1,500,000 (US$100) for the second trimester abortion. In poor, rural and mountainous areas, abortion services are free of charge. Failed family planning subscribers may also avail of abortion services free of charge.

Telling Success

Although the government has poured resources, especially in the 80s and 90s, into family planning, challenges still remain in making contraceptives more accessible. To begin with, the target population of the family planning programmes has always been married couples in reproductive age only. Unmarried women in reproductive ages, who are often more vulnerable, have no access to subsidised programmmes and products. Various contraceptives are neither widely available nor distributed to people who need them most. Counseling on the use of contraception is also not a priority among family planning workers.

Although abortion policies and family planning programmes are anchored on the goal of empowering women, much remains to be done in order to make men realise their stake in the process. In most cases, men are the decision makers on which type of contraceptive solution couples would tap, even as this creates greater implications on women's bodies and health than on men's. This may lead to unwanted sex or unsafe sex, that the prospect of abortion becomes unsurprising.

There are a myriad of reasons—clinical, economic and social—which force women to choose abortion. Some of

Illustration by Jim Marpa

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these include failure in their use of contraceptives, the lack of capacity to support another mouth in the family, and the unmarried status of the mother complicated by the probable non-acceptance by society of her offspring.

Women view the experience of abortion with considerable worry and fear. For them, abortion must be avoided as much as possible. It is not a substitute for the use of contraception. Yet many women who use traditional contraceptive methods such as periodic abstinence and withdrawal, consider abortion as a back up. They think that traditional and natural family planning pose less risks to their health and ability to work than the use of modern contraceptive methods, such as intra-uterine devices or oral contraceptives.

In Vietnam, manual vacuum aspiration (MVA) is usually applied for six to 12 week gestation, while dilation and cutterage (D&C) and Kovacs are common procedures for second trimester abortion.

In 1995, cases of abortion peaked to 1.3 million. This was reduced in 2003 with 504,377 abortions or 38.7 abortions for every 100 live births.

The prevalence of abortion also speaks of the gaps in providing ancillary services. It reflects the inadequate awareness on reproductive health, including proper knowledge on the use contraceptives among the population. In a research study conducted by Ipas in 2006, a farmer with four children, shared: "I thought I wouldn't have my period anymore. I didn't feel anything abnormal. In my previous pregnancies, I felt like eating this or that. This time I was working hard in the fields so I didn't have an examination until my pregnancy was big [14 weeks]."

Another farmer with two children, also narrated: "I used both the calendar method and condoms. I didn't use condoms everyday. Condoms are distributed free of charge, but no one gave me instructions. The distributor in my village is 70 years old. She didn't tell me anything. My husband had to ask someone how to use them. I couldn't ask, I was so shy."

In 1987, the World Health Organisation (WHO) conducted the "Strategic Assessment on Abortion in Vietnam" together with the MOH and NCPFP. Its findings affirmed a telling observation: abortion services are often isolated from other family planning services.

The study noted, for instance, the lack of counseling which would have informed women and couples on family planning beyond the traditional contraceptive methods and would have helped women who were to undergo abortion. No attention was paid for post-abortion care, including post-abortion contraception. There was very poor infection prevention practice. No provision for pain control was made.

The situation even worsened with the economic crisis of the 1980s, causing severe shortage of resources. The

quality of health services had become weaker particularly at the periphery. In response to this, the government implemented a number of changes in its health policies in 1989, including the introduction of user fees, legalisation of private practice, and sales of medicines on the open market.

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Ipas

Ipas is a global organisation focusing on reproductive health and rights, aiming to reduce maternal deaths from unsafe abortion. With offices in 20 countries particularly in Africa and Latin America and the Carribean, Ipas performs advocacy, training, research, and direct support services, among many others.

Ipas has been promoting a woman-centered comprehensive abortion care approach that takes into account the various factors that influence a woman's individual health needs—both physical and mental—as well as her personal circumstances and her ability to access services.

For more information, visit the Ipas website:http://www.ipas.org

Confronting the Challenges of Comprehensive Abortion Care

In response to the recommendations of the WHO assessment as well as the National Reproductive Health Strategy 2001-2010, Ipas, together with the MOH and other government and civil society stakeholders initiated a five-year project dubbed "Comprehensive Women-Centered High-Quality Abortion Care (CAC) Model in the Reproductive Health System of Vietnam" in 2001.

The CAC model aims to empower women in deciding for the best pregnancy options by enabling them to learn more about these options in a sensitive and comfortable manner. The model also focuses on follow-up care such as contraceptive counseling and method provision; investigating the violence incidents a patient may have undergone such as rape; referrals for reproductive tract infections and other reproductive health care; infection prevention techniques; and post-abortion counseling, among many others.

The implementation of the project in various hospitals and centres around the country, including those on the level of communes, necessitated "train the trainors" trainings for service providers; development of information education campaign materials; improvement of infrastructure and services especially counseling; provision for medicines, among others.

Safer abortion techniques such as (MVA), dilation and evacuation (D&E) were introduced in the hope of replacing traditional but risky methods such as D&C and Kovacs. CAC also developed a suite of comprehensive abortion

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services such as counseling, infection prevention practices, post-abortion care, and post-abortion contraception provision.

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Interviews with physicians, midwives, and patients revealed the success of this women-centered care approach. For example, most women who had undergone abortion reported that providers demonstrated concern on their health and gave them the opportunity to ask questions. Ninety-six per cent of women reported being counseled on different contraceptive methods, while 60 per cent of the patients in the provinces availed of post-abortion contraceptives and 90 per cent of the patients in the communes received this service.

As one service provider said, "In the past, we provided counseling, but it was insufficient. With the Project, we provide more comprehensive counseling. Before, we often introduced one contraceptive method to the clients, only mentioned the good points and ignored the disadvantages of the method. In the past we worked as a machine."

CAC was also linked to another initiative of Ipas, the Smart Women Club, which provides spaces for women who had abortions to discuss their experiences and provide emotional support with each other.

During the CAC implementation at different administrative levels, the project leaders and implementors worked to remove barriers for women who would like to access to safe abortion services. They no longer had to show identification cards nor seek the approval of their husbands. Aside from training hospital staff on the methods, reproductive rights, including the right to safe abortion services, were emphasised.

Along with the improvement of the quality of abortion services, the National Abortion Standards and Guidelines (NASG) was also developed with technical assistance from WHO and Ipas. The national CAC training materials, curriculum, IEC materials were also developed and are now being used widely by the MOH. The CAC model is currently being expanded to many other provinces by the MOH. Advocacy workshops on safe abortion service were also organised jointly by the government's Social Affairs Committee of the National Assembly and Ipas for parliamentarians, representatives of People's Councils from the provinces.

Next Steps

An evaluation of the project found that there is still resistance in reorganising work flows in hospitals and clinics, and in considering modern contraceptive methods.

For example, the role of mid-level providers is underestimated, perceived differently in the Northern and Southern parts of the country. Although competent and capable of providing quality abortion services, mid-level providers are not allowed to perform abortion in public hospitals because premium is placed on doctors. They are limited to counseling on medical abortion.

Vietnam has set two clear goals: (1) to reduce the recourse to abortion; and (2) to strengthen quality of abortion services.

With the rapid growth of big cities and towns, private service providers have eased the workload of the public health system. But the situation is different in the provinces. In provinces where the private sector is prohibited from providing abortions, services are done covertly and therefore, are far more difficult to regulate.

Health managers for safe abortion, are also limited by financial resources. There is a very small budget, around US$20,000 in 2007 allocated for purchasing instruments and the re-tooling of service providers, especially on the most up-to-date abortion techniques.

The government, MOH and the Women's Union, have raised concerns on decreasing the level of unwanted pregnancies and utilisation of abortion as well as enhancing the safety and quality of care in abortion services provided by the public sector. Still, not much effort has been made to improve the quality of abortion care in the private sector. In this light, Vietnam has set two clear goals: (1) to reduce the recourse to abortion; and (2) to strengthen quality of abortion services.

Implementing the changes recommended by the CAC project will, indeed, present significant challenges to the government and the NGOs and international organisations working in Vietnam to improve the quality of family planning and reproductive health services, including abortion. But the expected gains in improving the reproductive health of Vietnamese women make it worth the effort. ■

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