Improved Quality of Reproductive Health Care in Viet Nam
An Overview of the Reproductive Health Projects
International Partners

Pathfinder International is dedicated to improving the lives of women and families throughout the developing world by supporting high-quality family planning and Reproductive Health services. With its partners, Pathfinder prevents and treats HIV/AIDS, provides care to women suffering from complications of unsafe abortion, reaches adolescents with services tailored to their needs, and advocates for sound reproductive health policies in the U.S. and abroad. Pathfinder is the managing partner of the Reproductive Health Projects (RHPs).

EngenderHealth has worked for 60 years to make RH services safe, available, and sustainable for women and men worldwide. It works around the globe in partnership with governments and non-governmental organizations (NGOs) to help health care workers, administrators, physicians, hospital staff, and counselors deliver high-quality health care services.

Ipas is an international NGO that has worked for three decades to reduce abortion-related deaths and injuries; increase women’s ability to exercise their sexual and reproductive rights; and improve access to RH services, including safe abortion care.
INTRODUCTION

In 1994, the Maternal Child Health/Family Planning Department of the Viet Nam Ministry of Health (MOH) entered into an unprecedented partnership with three international NGOs seeking to improve the quality and range of public sector Reproductive Health (RH) services. Funded by a private donor, the Reproductive Health Projects (RHPs) was launched at a time when 89 percent of all contraceptive method clients were served by public provincial Maternal and Child Health/Family Planning (MCH/FP) facilities. These provincial facilities provided services and supported district and commune-level facilities, but though coverage was extensive, there were strong concerns about service quality. No national clinical standards or training materials existed, providers offered little or no client counseling, infection prevention was a concern, and facilities were often degraded and not client-friendly. While aggregate health indicators were improving, barriers to improved RH included an extremely limited contraceptive method mix, a large unmet need for family planning (FP), and heavy reliance on abortion for fertility regulation (see Box 1 below).

Pathfinder International has served as the managing partner of the RHPs, joined by Engenderhealth and Ipas. The RHPs began an ambitious training program with MCH/FP facilities in four provinces. Provincial trainers were trained with newly-developed TOT materials, and competency-based clinical training was offered to providers from provincial clinics. These providers were responsible not only for direct provision of services, but also for training and supervising others at the district and commune levels. The project upgraded MCH/FP centers – later called RH Care Centers, providing necessary equipment and supplies so that trained providers could practice at the level they were trained. In addition, the project conducted rigorous on-site training follow-up, monitoring, and supervision.
The program’s second phase, beginning in 1998, expanded on this comprehensive approach. With additional support from a second donor, the Royal Netherlands Embassy, the program further improved service delivery and strengthened training and management capacity by:

- Replicating Phase I activities in four additional provinces;
- Adding training and support in new RH content areas, including Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs);
- Diffusing clinical training, monitoring, supervision, and quality improvements to district-level health centers and commune-level health stations in all eight provinces;
- Reinforcing clinical training through systematic training follow-up and monitoring;
- Training additional trainers and enhancing training-of-trainers (TOT);
- Training staff from all provincial centers in record-keeping, management/supervision, financial accountability, and other management topics.

By the end of Phase II, essential infrastructure, capacity, and systems were promoting quality services from provincial to district and commune levels. An independent assessment team conducted a Strategic Appraisal (SA) to review progress and constraints in the program. They concluded in 2000 that the RHPs had “achieved remarkable success in providing comprehensive RH training to medical staff and made significant contributions to

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**SUMMARY OF PROGRAM PHASES**

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| Phase I | 1994-98 | Improve the quality of care and range of services through clinical training and facility upgrades. Build training capacity. | • MOH  
• Maternal Child Health and Family Planning Centers of 4 provinces: Ha Noi, Ho Chi Minh City, Thua Thien-Hue and Soc Trang  
• Ha Noi Ob/Gyn Hospital  
• Private US donor | • Training developed and approved:  
- Family planning  
- Safe abortion  
- Infection prevention  
- Counseling  
- Quality of care  
- RTIs/STIs  
• Trained trainers  
• Improved quality of care at provincial centers  
• Renovated/equipped facilities |
| Phase II | 1998-2002/03 | Expand program to four additional provinces. Expand training to district and commune levels in all provinces | • MOH  
• Maternal Child Health and Family Planning Centers of original 4 provinces and 4 new provinces: Quang Ninh, Vinh Phuc, An Giang and Can Tho  
• Ha Noi Ob/Gyn Hospital  
• Private US donor & Royal Netherlands Embassy | • Established training teams in 8 provinces  
• Trained 2,300 providers in comprehensive RH  
• Introduced integrated supervision systems in 8 provinces  
• Additional facility upgrades (including IEC materials and MVA equipment) in 8 provinces |
| Phase III | 2002-08 | Promote sustainability through improved management and planning, training systems, and policies, through dissemination and diffusion of program approaches. Use established model to address emerging RH priorities. | • MOH  
• National Ob/Gyn Hospital & Tu Du Hospital  
• Provincial Health Services and Reproductive Health Centers of 8 continuing provinces  
• Ha Noi Ob/Gyn Hospital  
• Provincial Health Services and Reproductive Health Centers of 3 new provinces: Hau Giang, Quang Binh and Thai Nguyen  
• Private US donor (through 2007) and Royal Netherlands Embassy | • Enhanced training capacity of provincial training teams  
• Training teams conducting comprehensive RH training, IS/RHC training and other training  
• Trained 240 supervisors in IS/RHC  
• Piloted in-service training network, social marketing, YFS and maternal health initiative  
• Built strategic planning and advocacy skills  
• 2 strategic plans approved by Provincial People’s Committees  
• 8 RHPs provinces have advocacy plans  
• Disseminated record-keeping system  
• National RH Guidelines, National RH curriculum, and IS/RHC curriculum approved and disseminated |
| Phase IV | 2008-10 | Institutionalize national in-service training network. Promote replication of new service delivery approaches. | • MOH  
• Provincial Health Services and Reproductive Health Centers of 8 long-term provinces  
• Ha Noi Ob/Gyn Hospital  
• Provincial Health Services and Reproductive Health Centers of 3 initial provinces: Hau Giang, Quang Binh and Thai Nguyen  
• Provincial Health Services and Reproductive Health Centers of 5 new provinces (to be determined)  
• Royal Netherlands Embassy | N/A |
improving the quality of RH health care...“ Based on this, the partners of the project began to consider how to sustain interventions.

The RHPs’ two donors then offered the program a unique opportunity: a program phase specifically dedicated to consolidating, replicating, and phasing over achievements. Phase III focused on institutionalizing key achievements and helping the MOH scale up high-impact program components at the national level. During Phase III, the RHPs worked with the MOH to facilitate approval of program approaches and training curricula, and to develop and disseminate relevant policies, guidelines, and protocols. At the provincial level, it has focused on consolidating and diffusing management and service delivery approaches, strengthening training capacity even further, and building commitment of policymakers to sustain program activities.

In 2006, the successes achieved in eight provinces expanded to three additional provinces. Service interventions were also expanded to include emerging priorities, such as training and support for RH services for youth, and maternal health in underserved areas.

In the pages that follow, we present the story of this evolving program, specifically its efforts to improve service quality in sustainable and scalable ways. We look at the strategies the RHPs employed and its achievements, and briefly, at plans for the future.

**In the years before the RHPs**, Viet Nam had seen great strides in its health indicators. Total fertility declined from 5.1 in 1979 (WHO 1995) to 3.1 in 1993 (VNICDS 1995), and by 1994, 44 percent of married women aged 15-49 were using a modern contraceptive method (VNICDS 1995). Infant mortality had declined between 1984 and 1994 by 20 percent, and child mortality had declined by an even greater proportion (VNICDS 1995). Public sector FP and MCH services were widely available, thanks to an extensive network of clinics and strong national policies, and a new policy supported a broader contraceptive mix. Other indicators, however, suggested strong need for improvement:

**Unmet FP need and abortion**: Total unmet need (for any method or for an effective method) was estimated to be 32 percent in 1994 (VNICDS 1995). One indicator of unmet FP need is use of abortion. A 1994 study of service statistics estimated that a Vietnamese woman had an average of 2.5 abortions during her lifetime (Goodkind 1994), and more than 1.4 million abortions and menstrual regulation procedures were performed in 1993 (WHO 1995). The postabortion contraceptive acceptance rate, meanwhile, was estimated by the MOH to be less than 10 percent.

**Method mix**: Intrauterine devices (IUDs) accounted for nearly three-quarters of modern contraceptive use in 1994 (VNICDS 1995), suggesting a very limited method mix. Despite what WHO termed “strong policy commitment to broadening method choice,” policies continued to stress long-acting methods, and the government still offered FP motivators and providers “credit” only for new users of the IUD and sterilization. New acceptors of sterilization also received incentives, as did new IUD users in some provinces (WHO 1995).

**STIs**: The National Institute of Venerology and Dermatology estimated that 20 to 40 percent of the rural population currently had a reproductive tract infection (cited by WHO 1995).

**Maternal health care**: Basic maternal care did not reach half the population: in 1994, 43 percent of women received no antenatal care from a trained provider, and 44 percent delivered their children at home (VNICDS 1995). Fewer than one-third were immunized against tetanus, and while at least 60 percent were estimated to be anemic, iron pills were not typically provided (cited by WHO 1995).
From the beginning, RHPs partners understood that to improve service quality, they had to address multiple aspects of service delivery. Most critically, they needed to improve provider counseling and clinical skills and upgrade clinics, so providers could use their new skills unhampered by insufficient supplies, inadequate equipment, or degraded facilities. Supervisors and managers needed better preparation to monitor provider and facility performance. Strategies used to effect these improvements are discussed below.

**STRATEGY 1: Establish a decentralized training program.**
A comprehensive RH training course, approved by the MOH for widespread use by provincial training teams, includes fifteen modules covering supervision, FP, counseling, infection prevention (IP), RTIs, maternal care, safe abortion, postabortion FP, and youth-friendly services (YFS). Training was designed for a variety of staff, including physicians, physician assistants, and midwives.

A set of TOT modules was developed to build the capacity of a core group of trainers. Training teams were established in each of the eight provinces to ensure local sustainability of training interventions. More than one hundred fifty provincial trainers received basic TOT courses, 37 received intermediate-level TOT, and 33 received advanced TOT. Training facilities in the 8 MCH/FP centers were upgraded with anatomical models and other training equipment and supplies. Program staff and consultants rigorously monitored training, providing coaching and feedback based on standardized tools.

**STRATEGY 2: Provide comprehensive RH training.**
The RHPs approach to training is systematic and comprehensive, informed by Adult Learning Theory. Combining rigorous, evidence-based content with facilitative competency-based methodologies, trainings are approached from a realistic assessment of what providers already know and need to know to provide high-quality RH services. Training combines didactic methods with hands-on practice, both with models and with clients, so trainees can try out new skills under the supervision of a trainer before returning to their workplace. Trainings are conducted at provincial RH centers rather than larger hospital facilities, to keep them relevant to the facilities where trainees work. All trainings are:

- Consistent with national policies, guidelines, and protocols, and with international standards;
- Designed based on the findings of a needs assessment;
- Comprehensive in their attention to the range of RH/FP skills needed;
- Offered by rigorously trained and supervised training teams;
- Designed to reliably transfer competencies to adult learners. They include
  - Specific, measurable objectives;
  - Participatory training techniques, such as case studies, role plays, and discussion;
  - Simulation skills practice;
  - Clinical practicums and on-site observation;
  - Knowledge, attitudes, and skills checklists;
  - Exercises for the development of action plans;
- Evaluated transparently and objectively;
- Supported by rigorous training follow-up that includes on-the-job coaching and feedback, conducted by trainers and RHPs staff;
- Supported by facility upgrades, facility-level advocacy, and improved systems.

“[This training has been extraordinary. I have been able to learn many new skills in the areas of pregnancy examination, normal delivery, and neonatal care (as per the National Standard Guidelines) and also apply them in my daily clinical practice. At the training I realized how outdated my skills were and how important it is to be aware of the latest techniques to deliver quality care to clients.”

– Trainee, Safe Motherhood and Newborn Care Training Course.
Training is evolving. Training curricula are continually being improved and updated. The program recently developed and piloted a new holistic (“integrated”) counseling module, based on broad issues of gender and sexuality in the context of FP use, pregnancy and abortion, and STI/HIV risk assessment. Adapted from EngenderHealth’s Comprehensive Counseling module, the new curriculum was approved by MOH in 2007. Trainers in all eight provinces trained in the use of this module have now trained province- and district-level providers. The RHPs has also recently developed training for provincial teams in Adolescent RH, adapted primarily from Pathfinder’s Reproductive Health Services for Adolescents Module. Training in medical abortion is provided by Ipas, using training materials developed for the Viet Nam context. The program regularly conducts RH updates on topics of interest, such as cervical cancer or contraception for adolescents and perimenopausal women.

STRATEGY 3: Provide continuing technical support to training graduates.

Training is not an end in itself. To become comfortable using new skills, and to solve problems arising in the workplace, trainees need ongoing support. The RHPs’ comprehensive approach offers this, first through rigorous follow-up training, then through structured monitoring and supervision.

Training follow-up. Trainers visit their students shortly after training to observe use of new skills. They offer coaching and guidance, ensure compliance with new practices, and help solve emerging problems. During these visits, trainers coach providers and gather information for later use in discussions with provinces, to define ways to better institutionalize the practices.

Integrated supervision for quality of care. In Viet Nam, higher-level health institutions supervise lower-level facilities, but supervision has not generally focused on technical quality. Supervisors receive little guidance about how to conduct a supervision visit. In the absence of protocols or standardized definitions of quality, they often focus on targets and administrative issues. Too often assessments become punitive, which does little to promote quality or provider morale. An independent 2002 assessment found that supervisors often had insufficient clinical knowledge in the areas they were meant to supervise, and visits were usually limited to one day, half of which could be consumed by greetings and introductions. Because there was no follow-up, a problem might not be solved even after dozens of visits.

The RHPs piloted a new supervision approach in provincial RH centers and selected district sites, called Integrated Supervision for RH Care (IS/RHC). This approach:

- Considers not just individual performance, but factors at all levels that influence quality (eg., facilities, equipment, supplies, training, and organization of services);
- Defines quality from both the clinical and client’s perspectives;
- Involves systematic review of service delivery, service statistics, and client exit interviews;
- Engages staff at all levels - from cleaners to managers - in problem identification and action;
- Relies on supportive coaching and modeling by supervisors;
- Encourages follow-up on issues raised during earlier supervision visits.

During two-day visits each quarter, supervisors and staff use tools such as facility review, observation of clinical and counseling services using standardized checklists, service statistics, exit interviews, and self-assessment. Staff then develop an action plan, which they implement between supervisory visits. Implemented effectively, IS/RHC fosters self-learning, individual responsibility, teamwork, a commitment to quality, and sustained service improvement. IS/RHC is now operational in more than 40 facilities in eight provinces, and

“Last year I attended a two-week training course in comprehensive reproductive healthcare with Mrs. Ngoc. Earlier this year I went to a one-week advanced training course on the same subject. A few days after the course finished, Mrs. Ngoc came to our place to check if we could apply the new skills to our job. Whenever we had any trouble she would help us immediately.”

– Provider, Long My district, Hau Giang province.
will be expanded to new provinces shortly. The program has continued to improve the system and staff’s ability to use it. Because of the central role data plays in IS/RHC, the program conducted workshops on the effective use of data for decision-making for provincial health managers and staff.

**STRATEGY 4: Improve service infrastructure.**

To be effective, providers require basic infrastructure, in addition to training, follow-up, and effective supervision. Running water, functioning equipment, IP supplies, and informational materials for their clients are essential. Key infrastructure and service improvements included:

- **Client-education materials.** The program developed and made available a range of informational materials, including flipcharts and cue cards about contraceptive methods; posters, client brochures, and booklets; and a video on counseling.

- **Facility upgrades:** Facility improvements provide a broader range of RH services. Renovations and improved layouts provide for reception, counseling, sterilization areas, clinical procedures and recovery rooms, and a sufficient supply of high-quality RH equipment. New equipment and supplies include sterilizing chemicals and autoclaves, instruments, essential drugs, voluntary surgical contraception (VSC) kits, minilab kits, manual vacuum aspiration (MVA) equipment, and improved lighting. A 2002 IS/RHC assessment determined that facility improvements effectively motivated staff, making them more responsible and accountable to the institution.

- **Client-based record-keeping system.** The An Giang RH center, with RHPs assistance, created a record-keeping system that, for the first time, allowed providers to retrieve clients’ medical records. Now, medical histories are available for review and updates at RH centers in all project provinces. The system is being piloted now at the district level, and the MOH has recommended the system for replication in other provinces.

**STRATEGY 5: Make services more accessible to underserved groups.**

Services can be improved if made more appropriate or accessible to those who need, but often cannot access them. Once sites had achieved a baseline of quality in facilities, RH skills, and supervision, they could expand and modify services to underserved groups. For example, the program trained providers and upgraded facilities in eight remote and disadvantaged districts of three provinces, to improve maternal care where maternal health indicators were unfavorable.

Recognizing changes in social norms, in 2004, the RHPs undertook groundbreaking work to pilot a potentially replicable model for Youth Friendly Services (YFS). Pilot facilities included provincial RH centers, a municipal Ob/Gyn hospital, a district health center and a commune health station. Pathfinder’s Reproductive Health Services for Adolescents training module was adapted to meet MOH standards and guidelines; (elements of these training materials have since been incorporated into the MOH’s National RH Training Curriculum). Using these materials, the program trained trainers, who subsequently trained relevant providers working at the province level. Training was followed with site visits to ensure application of skills. Sites each established a “Green Question Service” (GQS) especially for young people, providing a wide range of counseling and RH services, delivered with increased sensitivity to privacy and to adolescent health needs. Government partners used their own funds to renovate facilities to include youth-only waiting areas, counseling rooms, and sometimes examination rooms. An expanded range of youth-focused educational materials were placed in waiting areas and counseling rooms. Services were promoted to young people through youth centers, bookstores, pharmacies, the media, and school-based peer educators.
QUALITY RESULTS

The skills of RHPs’ trained trainers have been recognized by the MOH and in independent assessments. Quarterly monitoring visits and service statistics confirm the high quality of RH services at RHPs-supported sites, particularly at the provincial level. Quality results from a Strategic Appraisal and other assessments are discussed below.

RESULT 1: Provinces are capable of training physicians, midwives and physician assistants at the province, district, and commune level.
The Strategic Appraisal noted centers had a “genuine commitment to providing high-quality RH training.” Specific training-capacity results included:

- A decentralized training program. The training program was successfully decentralized to eight provinces;
- A high-quality RH curriculum. The RH curriculum successfully used both for training and to standardize clinical practice;
- Training and training-management capacity in place and functioning. The RHPs successfully built capacity for systematic planning and training management, developing second, and sometimes third generation local trainers. Now, as a result of program TOTs and other support, more than 220 trainers have gained the skills to plan and conduct training needs assessments, develop training exercises, plan training programs, and evaluate training. They are conducting training courses for provincial, district-, and commune-level service providers, including comprehensive clinical RH for new staff, training on National RH Standards and Guidelines, and RH technology updates. The more advanced trainers conduct TOT courses as well.

RESULT 2: Over 2600 providers have improved clinical skills.
The clinical training program has reached more than 2600 doctors, midwives and physicians assistants from 11 provinces (8 initial partners and three new provinces joining the program in 2006) with the comprehensive RH training curriculum. According to the SA, provider technical skills have been judged to be “very good” and training participants expressed a high level of satisfaction with the training generally and particular appreciation for the how relevant the training content was to their day to day work.

RESULT 3: Providers and facilities have adopted a new client orientation.
When the program began, MOH FP services served national demographic objectives, with relatively little emphasis put on the needs of clients. Informed choice was limited by poor counseling, inaccurate client information, and limited choice of methods. As a result of the program:

- Providers are counseling clients. Providers counsel clients with an awareness and appreciation of the benefits of counseling, referring to a client’s history and using the new record-keeping system approved for replication. Women can now obtain accurate information on available contraceptive methods through counseling, IEC materials, videos, and from providers during examinations and procedures.
- Considering the client’s perspective is now standard operating procedure. The program requires staff to regularly assess client satisfaction and consider the client’s perspective when proposing service improvements.

RESULT 4: Clients have access to a broader range of services and contraceptives.
A diverse range of family planning methods and services are now readily available in all sites. Clients are almost equally likely to leave the RH Care Centers with a condom, pills or an IUD. Use of Depo Provera has increased steadily in recent years, while sterilization and vasectomy are increasingly uncommon. Implanon has recently been introduced in some sites, according

"It is the first time I could talk like this. I didn’t think that this information would be provided here. I just thought that I came here for a clinical procedure like other hospitals. Even in a private health clinic, they won’t provide counseling like this."
- Abortion client, age 20, Ha Noi.
to MOH guidelines. In addition to family planning and abortion care, clients receive gynae care, ante-natal care, STI diagnosis and treatment, and a range of other services.

In addition, a significant achievement of the project has been to increase rates of postabortion contraceptive use. Today, the majority of abortion clients leave RHPs-supported RH Care Centers with a method of contraception.

RESULT 5: Centers meet international standards for key services.
A number of services offered at RHPs-partner sites meet international standards for quality. Infection Prevention (IP) procedures are strictly followed and are generally better than those at other RH sites. IP instruments are usually adequate to client load, as are equipment and supplies for all steps of decontamination, cleaning, and sterilizing or high-level disinfecting. Evaluators observed hand-washing between clients 96 percent of the time, and noted that sterile towels were always available and used, and universal precautions were followed in all MVA and IUD procedures.

Similarly, abortion procedures are of high quality. A 1997 MOH assessment noted the over-use of dilation and curette (D&C) to terminate pregnancies between six and 12 weeks. As a result of the program's training, facility upgrade, supervision, and advocacy work:

- **Safe abortion services have been updated.** D&C has been virtually eliminated at the provincial and district levels, where it had previously been common. It is replaced with MVA, and more recently with medical abortion (MA) as well. The latter is now available at the national referral hospital and in 22 provinces, including eight RHPs-supported provinces. The number of women choosing MA is increasing steadily.

- **Abortion services are of good quality.** MVA procedures are available at almost all sites, with excellent provider technical and interpersonal skills around procedures, and adherence to IP. MVA is well explained to clients, who are counseled to alleviate anxiety during procedures. Complication rates are low and postabortion complications rare.

- **Women increasingly choose contraceptive methods postabortion.** Between 1999 and 2007, postabortion contraceptive acceptance increased greatly at RHPs sites, from 48 percent to 82 percent, as indicated below. Postabortion contraception use has undoubtedly contributed to a substantial decline in abortion use in RHPs-supported provincial centers. In 1999 abortions represented 13.1% of all services provided, while in 2007 abortions represented only 8.9% of services.

RESULT 6: Clients are highly satisfied with services.
Work to make services more responsive to clients has paid off. Quarterly monitoring visits conducted by RHPs staff and provincial supervisors confirm high rates of client satisfaction. In addition:

- The vast majority of clients interviewed for the 2000 SA were fully satisfied with the quality of services they received. Providers were commended for their warmth, friendliness, and respectfulness, “which clients regard highly and speak of as a reason they come for care.”

- Satisfaction among women attending 5 clinics piloting a social marketing initiative in 2004-06 ranged from 87 percent to 100 percent, with most sites scoring over 90 percent.

- Satisfaction among youth attending six new YFS ranged between 89 percent and 100 percent.

- In 2006, client satisfaction at all participating sites was rated 4.6 out of 5.0.

RESULT 7: Client use of RH services increased.
Client visits at the eight provincial RH centers increased from 115,000 in 1999 to a projected 172,000 visits in 2007, an increase of 50 percent.
RESULT 8: Monitoring and supervision have improved.
According to the SA, managers monitor sites well, and supervision improved after the introduction of standardized checklists and the new emphasis on supportive supervision. Most importantly, a culture of mentoring and problem solving developed in the Centers. In addition, supervisors’ confidence improved as a result of the comprehensive RH training they received through the program.

Several years later, with IS/RHC operational in eight provincial RH centers and a total of 32 districts within these provinces, improvements are being sustained. An assessment of the IS/RHC pilot in 2001 found that the approach was highly positive and engendered a sense of “mutual understanding, a respectful working environment and teamwork between employers and employees.” Interviewees reported that the working atmosphere had changed, resulting in supervisees feeling more empowered and enjoying increased sense of ownership. In addition, once recommendations are implemented, the site staff reported feeling more invested in and responsible for the services and facilities.

In addition to increased client satisfaction (discussed above), RHPs program staff note the following changes when monitoring implementation of the new system:

- **Supervision practices.** Supervisors more consistently provide clinical coaching and feedback, analyze information related to quality of care, foster an environment conducive to high-quality services, and use objective criteria for evaluating performance;
- **Organization of services.** Facilities have taken action to improve services, such as creating counseling rooms for privacy, improving waiting areas, making client-education materials more available, and improving client flow to decrease waiting time;
- **Facility management.** Data collection has improved and is more consistently used to identify problems; managers involve staff in identifying problems and solutions and encourage dialogue between staff and the management board; staff better understand client rights and consider client perspectives, and are more open to and appreciative of supervision.

RESULT 9: Previously underserved groups are now being reached.
Three provinces have developed a replicable model for providing YFS within existing public health facilities. An evaluation of this pilot found, “great improvement in the environment for the provision of YFS at the pilot GQS units when compared with the baseline study.” They found that virtually all of the 236 clients interviewed were satisfied with provider attitudes and services provided. Eighty-five percent said that providers were friendly, and 88 percent said they were sympathetic, nonjudgmental, and tactful. They also reported feeling comfortable in the rooms dedicated for youth use. Observations of service provision confirmed that youth counseling was of good quality. The number of young people obtaining services at the pilot Ho Chi Minh City, An Giang, and Ha Noi facilities increased by 29 percent, 32 percent, and 21 percent, respectively. The evaluation concluded that the model’s success was due in part to strong support (and financial contributions) from local authorities, as well as to the strong foundation of service quality already existing at participating sites.

Based on the success of this pilot, the model is being replicated in an additional five RHPs provinces, and in additional sites within the three pilot provinces, for a total of 19 sites. Early experience from the pilot contributed to the government’s formulation of a national strategy on adolescent health and national guidelines for provision of YFS.

“Earlier, before refresher clinical training and integrated supervision, adoption of postabortion family planning was around 45 percent [in our center]. Today, with the new counseling skills and approach, 85 percent of abortion clients leave the center with a family planning method. It took a lot of close supervision and nurturing of counseling skills to achieve this level, as well as changing staff attitudes toward clients. [...] The number of abortions has gone down from 600 per month to 600 per quarter due to counseling and increased use of family planning.”

– Staff member, Quang Ninh RH Care Center.
Too often, positive change is not sustained after donor funding comes to an end. Models are introduced; staff, management, and clients experience their value; but then partners lack the capacity, resources, and political support needed to sustain results. To avoid such an outcome, the RHPs collaborated with the MOH and provincial partners to implement an entire program phase dedicated to sustainability—improving the MOH’s ability to manage and scale-up RHPs interventions; institutionalizing in-service training and improved supervision; attracting clients; and helping provincial health departments and RH Care Centers advocate for their needs with local governments.

**STRATEGY 1: Build national and provincial policymaker support for sustaining and replicating interventions.**

RHPs advocacy is key to program success, at both national and provincial levels. The program advocated for government funding contributions and for adoption and replication of specific quality practices, policies, training materials, and tools.

**The MOH.** The RHPs works with the MOH at the national level to enhance program sustainability and facilitate replication of its approaches. The RHPs was involved in the 2002 developing and updating the 2008 versions of National Standards and Guidelines. The program and partners also contributed technical assistance and financial resources to the development of the 2005 national RH curriculum, including guidance for the use of paracervical block for abortion procedures, cost-effective disinfection solutions, and more comprehensive counseling.

**Provincial Health Services.** Funding and some policy decisions in Viet Nam’s decentralized system are made at the provincial level. The RHPs involved the Provincial Health Services (the health planning/management and policy arm of provincial government) in designing sustainability interventions and approaches, orienting officials to program achievements, and discussing what was required of both partners to sustain and scale them
Provinces contributed funding as a condition of involvement. At first, specific items were contributed (e.g., MVA equipment, and training). Later, five provinces developed better strategic planning and advocacy skills, and, developed strategic plans which specifically built in resource needs based on lessons learned and achievements from the RHPs. Two of these plans were approved in 2007 and the remaining two are under review by Provincial People’s Committees.

**STRATEGY 2: Help the MOH and provinces institutionalize and scale up key systems. IS/RHC.** In the early years of the project, the RHPs trained key provincial staff in IS/RHC, training, feedback and coaching techniques, etc. In 2000, the SA found that the RHPs had “significantly” increased the capacity of provincial staff to manage and supervise staff at the district and commune level. By 2004, IS/RHC had been successfully introduced in eight provincial RH centers and three to four pilot districts in each of these eight provinces.

To institutionalize and further disseminate this system, the program:

- Secured MOH approval of the curriculum as a nationally recognized approach to supervision and disseminated it to 64 provinces.
- Trained 11 national-level trainers to provide IS/RHC training to provinces not supported by the RHPs.
- Trained 48 provincial trainers to conduct IS/RHC training in their provinces and in neighboring provinces through the training network.
- Held orientation workshops for managers and providers at the province and district level.
- Adapted IS/RHC tools to reflect quality standards for safe motherhood and YFS services.
- Assisted provincial RH centers to advocate for funding for IS/RHC training and follow-up.

After 2006, provincial health authorities took steps to scale up IS/RHC in their provinces. Five provinces extended training and undertook IS/RHC implementation in additional districts of the province with local budgets. Two Provincial Health Services issued policy decisions to make IS/RHC the official approach to supervision of RH care in the province. One province also offered training in IS/RHC to other sub-sectors of the health system, using RHPs trainers.

**In-service training.** Viet Nam now has high-quality training curricula, refurbished training facilities, and a pool of highly skilled trainers, but there is no system to ensure ongoing in-service training. National training institutes, such as the National Obstetrics and Gynecology Hospital in Ha Noi and the Tu Du hospital in Ho Chi Minh City, are overburdened: they do not have sufficient facilities or enough qualified trainers to train staff from 64 provinces, nor do their current resources allow them to readily conduct training needs assessments, provide training follow-up, or supervise improved practices. Forthcoming legislation will likely require health worker licensing and re-licensing, which will create yet more demand for training. Provinces cannot always pick up the slack: some RH centers have outstanding training expertise, but there is no mechanism to allow neighboring provinces to take advantage of this resource.

The program is building support for and piloting a national in-service training network that can link RHPs training successes to a recognized, established structure within the MOH. The network, now being piloted, consists of institutions at three levels, each with its own roles and responsibilities:

- **MOH:** The MOH guides, monitors, promotes, and provides policy and other support;
- **Two leading hospitals** (the National Obstetrics and Gynecology Hospital in Ha Noi and Tu Du hospital in Ho Chi Minh City): These institutes offer technical support and supervision to provincial training facilities, and provide training certificates;
Provincial RH care centers: RH care centers conduct RH training for provincial, district, and commune-level health workers. During the pilot phase, with RHPs support, three RH care centers are providing this training, each for one neighboring province. Trainers can provide training in 21 RH content areas, using a wide range of curricula, all tested in Vietnam. Because training occurs in a neighboring province (rather than, for example, at the national level), it is less expensive, and trainees are able to practice with patients who are similar in terms of both culture and health issues to those they will later serve.

The provincial training network offers training to neighboring provinces at a cost approximately 1/3 that of the cost of training when conducted directly by the RHPs office. To date, more than 300 providers have been trained through the network.

While supporting the pilot network, the RHPs is helping the MOH devise a regulatory framework for delivery of in-service training. This includes elaboration of a mechanism to recognize qualified trainers; and human resource management; and accreditation of training sites. It is also strengthening the TOT, training-management, and supervision capacity of the national training institutes. At the national policy level, the RHPs is also supporting the development of a legal framework for continuing medical education, which is expected to be codified in a new law in 2009.

Quality standards. A MOH-led working group, with support from the RHPs, developed quality standards. Network trainers must participate in a certification course designed and conducted by the Ha Noi University Training Department, which is responsible for certifying training skills, while network hospitals certify clinical skills. To date, 48 trainers have received both certifications. The network has also defined technical requirements for training centers, covering space, equipment, and norms for client interaction. Finally, the network has defined pedagogical standards for training, which include use of participatory methods and follow-up, and an appropriate balance of skills-based and didactic sessions.

STRATEGY 3: Work with provinces to improve use of advocacy and strategic planning.
While developing annual plans and 5-year strategies, RH care centers can guide government priorities and resource allocation to ensure sustained use of RHPs interventions. To do this, however, they needed stronger advocacy and strategic planning skills.

Strategic planning. Planning in Vietnam is often done simply by adjusting plans from the year before. The RHPs invited both RH care center managers and Provincial Health Services staff from five provinces without five-year plans to take a more strategic approach. It assisted provinces first to conduct needs assessments, gather evidence, and conduct planning meetings with stakeholders. Then it conducted a workshop for Provincial Health Services staff from five provinces, and followed this up with similar workshops for individual provinces. It helped provinces review data-collection processes at field sites, conducted workshops to help analyze those data, and helped provinces develop provincial five-year plans on RH care. RHPs staff also provided technical assistance to ensure that plans were in line with the national strategy, addressed emerging RH needs, contributed to sustainability, and were linked with advocacy efforts. Provincial partners consulted provincial authorities at all stages of the planning process, gathering strong support for their plans. Importantly, in several partner provinces, a number of key RHPs achievements have now been incorporated into provincial 5-year plans and budgets.

Advocacy. If program interventions and approaches are to be sustained and, in some cases, diffused to the district and commune level, RH care center leadership (usually medical personnel) must be prepared to advocate with government officials. An independent assessment in 2003 found that while RH care center leadership received strong political
support from local government, managers’ insufficient planning, budgeting, and proposal-writing skills would be a barrier to sustainability. To improve advocacy, the RHPs:

- **Trained staff in advocacy.** The program held trainings for 40 leaders of both RH centers and Provincial Health Services on strategic planning, proposal writing, and advocacy. Trainees learned that health authorities want more data analysis in proposals, better budget justifications, targets related to provincial strategies, citation of relevant regulations, and better presentations. Trainees learned how to partner with the media—cultivating contacts, managing press conferences, and packaging messages. And they learned to identify issues that required advocacy and develop advocacy plans.

- **Supported the Centers to prepare and implement advocacy plans.** Advocacy plans outline issues, objectives, target primary and secondary audiences, advocacy messages (backed by data), specific activities, resources needed, responsible persons, and timelines. In Viet Nam, the highest authority targeted by advocacy is usually involved in the advocacy process from the initial stages. This allows all involved to come to early agreement or work out differences before the specific advocacy objectives are made public. For their first advocacy effort, most RH center managers supported sustaining IS/RHC. For example, in one province, the manager asked the Provincial Health Service to request all districts to include IS/RHC in their district plans and another province advocated to make IS/RHC routine practice at all RH sites in a city.

**STRATEGY 4: Help provinces market services to clients.**

Improved service quality in Viet Nam has not always led to increased use of services. To create additional demand, the RHPs implemented a pilot social-marketing initiative. Social marketing is well accepted in Viet Nam; it has been used to encourage purchase of condoms and oral rehydration solutions, but the RHPs pilot effort was the first time it has been used to attract clients to RH facilities. Based on findings from interviews with 3,500 youth and married women of reproductive age, the program introduced social marketing principles and activities to 11 RH facilities in five provinces in 2004-2006. To learn as much as possible, the service promoted (and therefore the target group) and the type of facility involved were varied.

Using study results, individual clinics prepared social marketing plans to promote services using print materials, radio and television spots, community talks, and a youth web page. An evaluation of the pilot looked at target group awareness of services and promotional materials, as well as increases in client volume, client satisfaction, and the proportion of new clients who attributed their attendance to social-marketing efforts. During the pilot period, attendance by married women at participating sites increased between 13 percent and more than 100 percent depending on the particular site, with between 47 percent and 83 percent of new clients attributable to the social marketing activities. Youth use of YFS increased by a similar margin (though the baseline at the site where attendance doubled was very small), with an even larger proportion of new clients reporting that they had been attracted to services by social-marketing activities or materials. Use by these groups has continued to increase beyond the pilot phase, prompting the RHPs to continue and expand social marketing of the new Youth Friendly Services sites in 2008.

To aid replication, the RHPs in collaboration with the MOH held a dissemination workshop, after which the five pilot provinces held their own provincial workshops. A national dissemination workshop was then held by the MOH at its national RH meeting in January 2007.

“Social marketing is essential. It not only helps the health facility increase its client volume, but spreads information on reproductive health care services and facilities to the community. We think that social marketing is our task, and we need to mobilize resources for this work.”

– Dr. Nguyen Tien Thang, Director of Vinh Phuc RH Care Center.
The program’s mix of advocacy, capacity-building, systems-development, and other interventions has greatly increased local ability to sustain RHPs’ quality improvements.

RESULT 1: The MOH is taking key steps to sustain program approaches, and make them available nationally.

As a result of RHPs advocacy and technical inputs, the MOH has:
- Developed a national RH training curriculum, using the RHPs’ comprehensive curriculum as an official reference document;
- Approved IS/RHC training materials for national dissemination, supported by a national dissemination workshop for all 64 provinces. They also joined the RHPs in training 11 national-level IS/RHC trainers, who will serve as a national training team for replicating IS/RHC nationwide as well as participating in IS/RHC experience-sharing workshops;
- Conducted routine monitoring and participated in regular IS/RHC monitoring trips to RHPs sites to ensure that provision of RH services is consistent with national standards and guidelines.
- Approved national RH standards and guidelines in 2002 and is now updating them, with RHPs technical and financial support;
- Approved medical abortion (2002);
- Approved national YFS guidelines;
- Disseminated RHPs Social Marketing experience to 64 provinces;
- Disseminated YFS and Social Marketing to MOH institutions and a wide range of RH stakeholders in Viet Nam;
- Developed criteria for standardization and certification of in-service training in RH;
- Launched the Pilot RH In-Service Training network;
- Elaborated a plan for approving a client-oriented record keeping system developed in An Giang with support from the RHPs;
- Agreed to approve and disseminate the RHPs basic and advanced TOT curricula.
RESULT 2: Key systems for insuring quality are being sustained, institutionalized, and replicated.
The MOH and provincial stakeholders are demonstrating commitment to sustaining two key systems for improving and assuring quality: in-service training and IS/RHC.

In-service training. Since the founding of the pilot in-service RH training network, RH care centers have trained more than 300 health workers in neighboring provinces, while continuing to train staff in their own province. An assessment of the pilot by the Health Strategy and Policy Institute (an affiliate of the MOH) concluded that the in-service RH training network is both useful and feasible. Stakeholders were found to consider network training to be of high quality and concluded that the network's decentralized approach of providing training at provincial RH care centers for neighboring provinces was appropriate. The biggest potential barrier was lack of government funds for training, but it is envisioned that the government and donors will dedicate funds in future, including when medical licensing and re-licensing become mandatory. In the meantime, network leaders hope they can attract requests from Provincial Health Services, NGOs, and donors to provide training in additional provinces. An evaluation scheduled for 2008 will look at how the network should function in the future. If findings are positive, the MOH has expressed interest in scaling up the network in support of its national target program, which envisions large scale training activities from 2008. RHPs-supported centers in five additional provinces — in Ha Noi, Ho Chi Minh City, Soc Trang, An Giang, and Quang Ninh — have indicated that they are ready and willing to join as training facilities.

IS/RHC. Some 240 provincial- and district-level supervisors in program provinces have been trained in IS/RHC, and the MOH has officially approved and disseminated the IS/RHC curriculum. The system has been introduced to non-pilot districts using local funds. The approach has been institutionalized in five provinces and successfully integrated into routine monitoring, thanks to province-led advocacy for resources and supportive policies. IS/RHC has been adapted and will be applied in 2008 to YFS in 7 provinces and 8 Safe Motherhood districts in 3 provinces. Several international organizations working in Viet Nam have further adopted the IS/RHC in their provincial programs.

RESULT 3: Provinces are taking increasing responsibility for sustaining program interventions.
Today the Provincial Health Services enjoy improved linkages with RHPs. With greater awareness of achievements and contributions, they now support using provincial funds to diffuse these advances to the district and commune level. This new partnership has also facilitated important policy and regulatory support. For example:

- Provincial partners contribute 19 percent to 65 percent of project budgets from local funds. The RHPs has phased out facility renovation and no longer provides equipment and supplies; provinces have taken on all of these expenditures. All provinces have likewise conducted RH and IS/RHC training using local funds;
- Five provinces have developed and submitted five-year plans for RH with priorities aligned with sustaining achievements in in-service training, IS/RHC, YFS, facility renovation, and postabortion contraceptive use. Provinces have advocated to gain support for these plans, and two have been approved to date — an important achievement, as these plans will guide RH activities for years to come;
- Facility staff are advocating with higher-level authorities for increased resources and improved policies. Several provinces have issued regulations and other policy guidance related to sustaining and expanding IS/RHC, MVA instrument procurement, high-quality clinical practices (e.g., paracervical block), and other quality of care-related improvements.

“...the course in Vinh Phuc is very useful and the trainers delivered very interesting lectures. They even brought models for our practice in class. We were also able to practice on patients. Only by this way can we remember the skills and apply them when we go back home. For district level staff like us, we have never been given courses of such quality.”

– Maternity ward provider, Pho Yen General Hospital, Thai Nguyen province.
CONCLUSIONS

The RHPs has accomplished significant results over its life. With a total investment averaging less than 2 million dollars per year, the program made a concerted effort to build and sustain quality improvements through capacity building and by promoting partnership and ownership and of project achievements.

The program established a culture of quality.
The quality-improvement approach taken by the RHPs is not just rigorous training, but it is distinguished because actions taken by the program bridge training and service delivery. International experience confirms that improved provider competence does not always lead to improved provider performance. Providers need adequate facilities and equipment, supportive supervision, and something more intangible: they need to know quality is important — important to supervisors, clients, and peers. Concern for quality must be in the air, it must be the common reference point around which all activities revolve. The RHPs set the tone early in the project by conducting workshops on quality of care, and developing quality-of-care indicators with which to monitor quality improvements. Staff conducted quarterly medical monitoring visits using quality-of-care checklists that reviewed counseling, IP, clinical procedures, and other areas. Furthermore, they engaged in constant dialogue with managers, providers, and clients about quality. They grew a new client orientation, reorganizing and expanding services to be more responsive to client needs, and ensuring that clients, with full information, made decisions about their own RH care. Through such efforts, a culture of quality was established. Newly trained providers not only counseled clients, but, according to the SA, truly understood why counseling was important. And IP achievements were not only impressive, but were a source of pride to providers working in RHPs-supported clinics.

Visionary donor support allowed partners to institutionalize quality improvements.
Program donors took an unusually long-term view, allowing the RHPs to evolve, responding to opportunities and needs as they arose. Because of this flexibility and vision, the RHPs was able to thoughtfully build partnerships, models, skills, values, and the commitment needed to make a difference. Innovations were not just introduced, they were valued by clients, service providers, managers, and policymakers, who then were willing to advocate for, and dedicate resources to, sustaining, expanding, and replicating them. The result will be a long-lasting and potentially far-reaching difference in the way RH services are delivered in Viet Nam.

Working in partnership facilitated ownership and sustainability.
The long duration of the RHPs has allowed for a considerable depth of engagement. Vietnamese partners report feeling both appreciative of and challenged by the rigorous, regular monitoring employed by the project. In particular the longer duration has allowed trust and appreciation to develop on both sides, which makes the technical assistance more effective and leads to greater quality improvements. As a partner put it: “Other donor projects just wait for reports from us, but are not active in the field. Their projects are small in size and short in terms of project duration, while the RHPs with Pathfinder International is deeper and broader.”

Regular discussions with all partners encourage collaboration mechanisms, promoting joint planning, joint evaluation, and joint celebration of success.
WHAT'S NEXT

Phase IV, which will extend to 2010, is designed to support the further institutionalization and consolidation of a national in-service RH clinical-training network. On the one hand, policy development will continue with the goal of approving standards of high quality RH training. On the other, the training network will extend high quality RH training, particularly in more remote and economically disadvantaged provinces through additional provincial training facilities. The network will be promoted and enhanced with the goal of being fully independent by the project’s expected close in 2010. More than 600 additional providers are expected to benefit from high quality clinical training provided through the network.

REFERENCES


Kane, Thomas T. et al. 2007, Strategic Appraisal of the Reproductive Health Program of Viet Nam.


The Reproductive Health Projects 2002, IS/RHC Assessment, Pathfinder International Viet Nam, Ha Noi.

