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THE USE OF MEDICAL ABORTION IN VIETNAM: FACILITATORS, BARRIERS, AND CONTEXTS

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ABSTRACT

Background

The medical abortion (MA) (mifepristone/misoprostol) was legally available in 2002 as a birth control method in Vietnam, following several in-country clinical trials. Although empirical evidence indicated the safety, efficacy and acceptability of MA for early pregnancy termination, this method of induced abortion remains under-utilized. Little is known about contextual factors (e.g., social, cultural, political and economic) that contribute to the limited use of MA in Vietnam. To address this shortcoming, this study aims toassess the current structural and administrative regulations and policies applied to MA in the health system in Vietnam, and to explore social, political, economic, and cultural influences that affect women's decision to seek MA versus surgical abortion and providers' selection of this abortion method.

Methods

Multiple qualitative research methods were applied, including: in-depth interviews of clients and service providers, key informant interviews of relevant stakeholders, and policy documentary analyses. Thematic analyses were undertaken on textual data while content analyses were performed on policy documents.

Findings

There is clear evolvement in structure regulations over the past 10 years towards universal application of MA in the state healthcare system of Vietnam. The increased numbers of MA users are marked, reflecting the positive responses of the health system, health providers, and abortion seekers to this policy change. MA appears to have been well-accepted by both providers and users as an alternative method given a range of possible health complications, physical and psychological consequences, and spiritual or moral concerns associated with the traditional surgical abortion (SA) method. In addition, legal and societal approves of

induced abortion could largely serve as an important catalyst for the move towards wider use of MA services in Vietnam.

Structural impediments to universal provision of MA, however, still exist, at least at sub-national levels, indicating the gap between policy change and implementation practice. The Vietnamese Ministry of Health remains cautious, restricting secondary midwives, who are allowed to perform SA, from providing MA. Hesitance in licensing MA of provincial level health authorities and reluctance of district-level health managers in adopting the MA method have made the provision of MA services impossible in some provincial and district-level health facilities. Additionally, lower financial incentives for providers could be an issue, weakening doctors' interests in the use of MA, though the total costs of both abortion methods paid by clients are similar.

Conclusions

There is a marked progress towards wider use of MA in Vietnam, though the coverage of this service has not been to its full potential within the well-established health system. Availability of both abortion methods can help expand women's ability to choose the method that most suits their medical and psychological reproductive health needs. Along with expanding the supply of MA service, efforts should be made to remove structural barriers to universal use of this abortion method in Vietnam.

I. Introduction

Vietnam is among the countries with the highest abortion rates in the world (Maria F. Gallo et al. 2006, May). Medical abortion (MA) (mifepristone/misoprostol) was first introduced in Vietnam in 1993 and legally adopted for use on a wider scale in the National Standards and Guidelines on Safe Abortion in 2002 following several in-country clinical trials. Although empirical evidence documented the safety, efficacy and acceptability of MA for early pregnancy termination (Nguyen 1999; Elul, Hajri et al. 2001), this method of induced abortion remains under-utilized in Vietnam. Moreover, there are substantial regional differentials in the use of MA between the North, Center, and South of Vietnam (CAC Project 2007).

Assessments conducted in hospitals following clinical trials reported that women who experienced MA felt that MA is a more natural abortion method, not involving any surgical instruments, less risky for future fertility, and less likely to interrupt their daily lives (Ganatra, Bygdeman et al. 2004). However, clients also complained about high costs, long follow up that involves multiple visits, and few experienced drugs' side effects (e.g., nausea, diarrhea, fatigue, prolonged bleeding) associated with MA. On the providers' account, doctors with prior experience in performing MA generally commented that MA was easier for women, less risky and would save hospital expenditure on surgical equipment and operating theatre costs. At the same time, higher failure rates, clients' poor compliance, and insufficient financial incentives contributed to providers' hesitance to use this abortion method. From operational perspectives, high price and unsteady supplies of mifepristone/misoprostol, restricted application of MA to central and provincial level hospitals, and restricted provision of service to clients within 30 minute travel to the health facility were documented as major structural barriers to the widespread use of MA in Vietnam (Bygdeman 2003; Galo 2008).

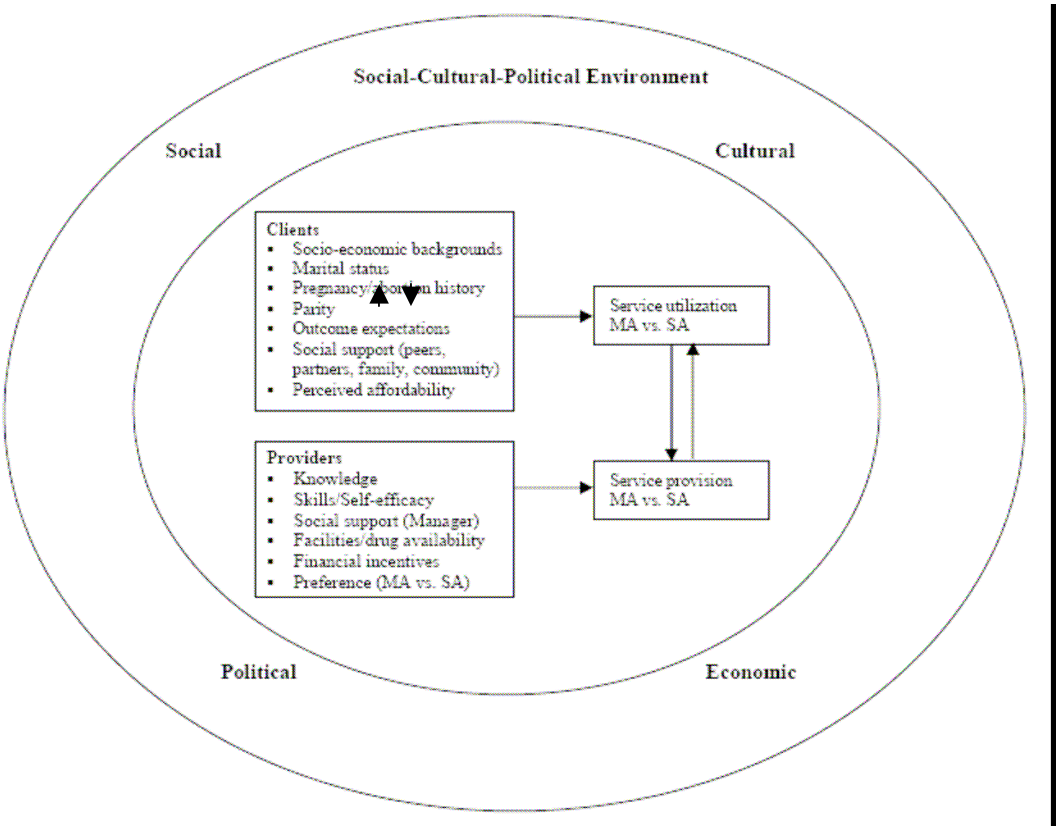
Previous assessments, however, conducted in the experimental condition and primarily focused on individual factors that affect the provision and utilization of MA service. Therefore, little is known about contextual factors (e.g., social, cultural, political and economic) that contribute to the use of MA in Vietnam. This shortcoming might have rendered efforts to seek appropriate strategies to promote the use of MA in the country ineffective. The aims of the present study are to: 1) explore social, political, economic and cultural influences that affect women's decision to seek MA versus surgical abortion and providers' selection of this abortion method; 2) to assess the current structural and administrative regulations and policies applied to MA in the health system in Vietnam. These specific aims are to be answered by 3 research questions: (i) What are users' and providers' perspectives on MA? (ii)What are key barriers and facilitators related to MA and how these influence women's choice and providers' selection of MA versus surgical abortion? and (iii) How the current structural and administrative regulations and policies affect the application of MA in Vietnam?

II. Methods

2.1. Analytical framework

Our study will develop and test a conceptual model that considers the complex social, political and cultural contexts relevant to the study population (**Figure 1**). On the clients' account, studies in Vietnam and elsewhere on reproductive health service utilization and abortion service in particular have reached a consensus that the decision to use a service as responses to the typical knowledge, attitude, and behavior measures is situated within the interplay of: (1) political: awareness of political, legal, and structural regulations applied to the service; (2) economic: family/ household composition; education; income;

Figure 1. Conceptual model of the study



perceived social class; (3) social: neighborhood characteristics; social support from peers, bosses, officials, partners, and families; and (4) cultural: gender roles; subjective norms, issues of stigma and confidentiality.

From providers' perspectives, available studies found that frequency and quality service delivered by health service providers is affected by their professional knowledge and expertise (e.g., medical knowledge, knowledge about their clients), attitudes towards service provision, outcome expectations, and self-efficacy or skills. In addition, whether or not the service providers get support or encouragement from their colleagues, their manager, community, or local government can increase or decrease the likelihood of high quality service delivery. Also, the frequency of quality service delivery depends to some degree on

whether the providers have favorable working environments (e.g., working facilities and infrastructure, equipment and supply, financial incentives), and on whether the government policy (e.g., budget allocation, financial incentives) encourages them to perform their job.

2.2 Study sites

This study were conducted in three sites, representing 3 regions in Vietnam where MAs are performed, including: Center for Reproductive Health Care in Ho Chi Minh city (Southern representative); Provincial Reproductive Health Center and General Hospital in Khanh Hoa province (Central representative); and Hanoi Gyn/Obs Hospital (Northern representative).

2.3. Data collection methods

This study applied qualitative research method, using in-depth interviews with clients and providers. In addition, stakeholder and documentary analyses were performed to gather information policies and structural barriers or facilitators related to abortion and to MA in particular. Based on findings from literature review, the research team had deliberated together to develop data collection tools, including: guidelines for interviews of key stakeholders, doctors, midwives, and users of SA and MA. The tools were then pilot tested in each study province before to be used for interviews. The data collection methods are described below.

In-depth interview. In-depth interviews were semi-structured, based on data collection guidelines developed by the research team. Interviews gathered information clustering around each of four domains listed in the conceptual model. For example, interview of clients collected client demographic information, pregnancy and abortion history, social economic status and their experience of having abortion including the process of making a decision on type of abortion, perception of counseling quality, abortion procedure performance, financial expenditure, and socio-cultural aspects that might affect their decision to select MA.

Interview of providers gathered their knowledge of MA, self-efficacy to perform services and their personal preference of abortion methods. The interview also sought to elicit providers' perception of women's compliance with the procedure, their views on financial incentives and training they received, and their perceptions of administrative or policy regulations applied to MA.

Stakeholder and documentary analyses

The purpose of stakeholder and documentary analyses was to assess the priorities, appropriateness, and relevance of the current related policy/regulations applied to MA in the Vietnamese health system. Documents that were collated for analyses, including: National Strategy (2000-2010) for Reproductive Health Care, National Guidelines on Reproductive Health and Family Planning Services, National Technical Guidelines on MA.

Stakeholder analyses involved a series of key informant interviews with representative from Ministry of Health: Department of Maternal and Child Health, Department of Therapy, Gynecology and Obstetrics Association, and national experts from the Central Gynecology/Obstetrics Hospital. These informants were identified to have directly involved in the development of national guidelines and instruction manuals for administering MA in Vietnam including those who have been serving as national trainers on MA method. Interview of key stakeholders focused on exploring their views on the utilization of MA, legal or structural barriers to wider use and their position in support of the wider use of MA in Vietnam.

2.4. Sampling, participant recruitment, and interview procedure

The study used purposive and quota sampling. In each selected health facility, we interviewed 4 doctors, 4 midwives who were providing MA services, and 12 clients aged 18-30 (married and unmarried) who used MA or SA service. Clients were recruited with assistance of the midwife in the health facility where women attended the service. Written

consent and appointment for an interview were obtained. Women were interviewed at their home or in a convenient location by a female interviewer 2 weeks after they underwent an abortion.

In addition, 5 interviews with key stakeholders were complete, including: Head of the Department of Maternal and Child Health, Representative of the Therapy Department – Ministry of Health, Head of the Vietnam Gynecology/Obstetrics Association, 2 MA training experts who participated in developing guidelines for MA from Hanoi Gynecology/Obstetrics Hospital and Central Gynecology/Obstetrics Hospital. Data collection was completed in 3 month from November-2010 to January – 2011. All interviews were digitally recorded and transcribed verbatim for analyses. The list of study respondents was presented in table 1.

2.5. Data analyses

Thematic analyses were undertaken on in-depth interview data. The analyses process began with coding of textual data. The codes were then clustered for common

Table 1. Study participants

Informants	Hanoi	Khanh Hoa	HCMC
Doctor	4	4	4
Midwife	4	4	4
Unmarried SA users	3	3	3
Married SA users	3	3	3
Unmarried MA users	3	3	3
Married MA users	3	3	3
Stakeholders	5	-	
Total	**25**	**20**	**20**

themes or issues. Common themes were drawn in two ways. First, once coded, all text segments responding to each code and sub-code were pulled and reviewed for thematic commonalities or clusters of commonalities. Second, thematic commonalities were analyzed with specific reference to the appropriate research question. We used provider data to triangulate client views on the use of MA services.

To facilitate the analysis of existing policies/regulations on abortion,the health policy triangle framework (Walt, Shiffman et al. 2008) were used. This framework focuses on content, context, process, and actors of a health policy. Specifically, content analyses were performed on collated policy documents with reference to specific contexts when the policy/regulation was promulgated and implemented. Comparative analyses of stakeholders' interviews focused on similarities and differences in their expressed views on the application of MA in the health system in Vietnam. The analyses also explored interactions among different stakeholders surrounding abortion policies/regulations. Data from interviews of service providers and clients were considered to explore their perspectives in response to the current policies/regulations on MA.

III. Findings

1. Medical abortion in Vietnam in contexts

Vietnam ranks among the countries with the highest abortion rates in the world [1]. National demographic surveys indicate one-fourth of births are unplanned, with 22% of pregnancies from 1999-2002 ending in abortion. The Vietnam's Ministry of Health (MOH) reported 518,745 abortions in 2006, at a rate of 33.4 abortions per 100 live births (Ministry of Health 2007). While women may delay until the second trimester to seek abortion due to late detection or hesitance in decision making, most research suggests a majority of women seek abortion in the earlier stage and about two thirds of abortions were carried out during the first 6 weeks of pregnancy (Ministry of Health 2007).

MA was first introduced in Vietnam in 1993 – 1999 through several clinical trials conducted by Population Council and Ministry of Health in several hospitals in Ho Chi Minh City and Hanoi. These trials found that MA was safe, effective, and feasible and could be an alternative to surgical abortion (Nguyen 1999; WHO 1999; Ngoc, Nhan et al. 2004).

In attempts to provide more evidence of the efficacy and acceptability of this method at different levels of the Vietnam health care system, in 2001, Population Council also supported MOH to conduct a trial on a home-based administration of misoprostol in eight health facilities in North, Central, and South Vietnam. This study involved 1601 women seeking abortion service (Ngoc, Nhan et al. 2004). This multi-site study indicated a high degree of client satisfaction with MA experience, and home – based MA was safe and feasible for introduction on a wide scale to the healthcare system of Vietnam.

Subsequently, in 2002, MA was legally approved and officially introduced in the National Standards and Guidelines on Safe Abortion by Ministry of Health (MOH) (Ministry of Health 2002). However, it was introduced with the precaution: no home-based administered MA was recommended. The procedure involves a regimen of a combination of 200 mg of mifepristone followed by 400 mcg of oral misoprostol 48 hours later for gestations up to 49 days. A four-hour observation period was requested after the misoprostol administration, followed by a third visit 2 weeks later to check completeness of the procedure. According to the guideline, only obstetrics/gynecology specialists at the central or provincial level hospitals or reproductive health centers were allowed to perform MA. Mid-level providers (e.g., mid-wife) who were permitted to perform surgical abortion were not authorized to provide this abortion service. Also, clients must be within 30-minute access to the hospital.

Despite the positive findings from clinical trials and the need for this abortion service available nationwide (Nguyen 1999; Bygdeman 2003), the rate of using this method was still low and limited within 30 over the total of 63 cities and provinces in the country. Data from the comprehensive abortion care project (CAC) (IPAS International) that covered 7 health facilities (2 central and 5 provincial health facilities) revealed that MA accounted for only 5.4% of all abortions during the period of 2001 – 2005 (CAC Project 2007).

Regional differential use of MA was also noted. MA has been increased more rapidly in the South compared to the North. For example, while in Tu Du central Gyn/Obs hospital in the South, the number of MA acceptors almost equaled the number of manual vacuum abortion (MVA) or electrical vacuum abortion (EVA) users in the first six months of 2006 (MVA: 2,634; EVA: 2539 and MA: 2,464), the corresponding number was as low as one sixth of MVA users in the National Gyn/Obs Hospital in the North (MVA: 1,213; MA: 202). Data from some other provincial level hospitals during the same period also indicated a low and differential use of MA (e.g., Khanh Hoa in the center): MVA: 776 cases; MA: 90 cases; Hai Phong (in the north): MVA: 2,638 cases; EVA: 43 cases, MA: 119 cases; Dong Nai (in the south: MVA: 1,809 cases; MA: 344 cases) (CAC Project 2007). Some authors assumed that regional difference in culture and social economic status of women might have influenced women's decision to choose MA vs. surgical abortion (Ganatra, Bygdeman et al. 2004). However, no evidence exists to support this assumption.

Assessments on the application of MA in Vietnam and elsewhere indicated that women chose MA because they considered this method to be safe, more natural, not involving surgical instruments, and inducing less pain (Ganatra, Bygdeman et al. 2004; Berer 2005; PATH and Ministry of Health 2006; Gallo and Nghia 2007). Clients were generally satisfied with the MA service. However, women also complained about amount of time needed and number of visits required for completion of an abortion (at least 2 visits: one for using medication, one for re-examination), and experience of drugs' side effects (e.g., nausea, diarrhea, fatigue and prolonged bleeding) (Tamang 2005; PATH and Ministry of Health 2006). The cost of MA was almost double the cost of (PATH and Ministry of Health 2006) due to the high price of drugs (mifepristone/misoprostol) involved, and costs associated with time and travel for revisits. For example, the cost for MA procedure (user fee) at central hospitals such as Tu Du or National Gyn/Obs Hospital is US$23.7; at the provincial level is

US$20.4, while the cost of MVA is US$ 8.5 and US$ 6.92, respectively. Besides, the waiting time at the health facility after taking medication (15' for the first time, and 3-4 hours for the second time) was stressful for women, especially in a hospital with a high volume of clients.

On the providers' account, previous studies suggested some factors that might hinder the provision of MA in Vietnam. These include a high failure rate that resulted in subsequent vacuum aspiration, clients' poor compliance with the medication regimen, and loss to follow up, and low financial incentives for providers (Ganatra, Bygdeman et al. 2004). In addition, studies in other developing countries indicate that providers' professional motivation and preference to use MA affect women's decision to choose abortion service. For example if doctors were keen to gain surgical skills and experience, they would advise women to have a surgical abortion. On the other hand, if abortion was a matter of giving out information, dispensing pills and monitoring progress, giving support, providers would advise women to have a MA (Henshaw, Naji et al. 1993; Berer 2005; Tamang 2005).

Several policies and structural barriers to the widespread use of MA in the health system in Vietnam have been documented. For example, the supplies of drugs are unsteady. This is because Mifepristone was not registered in Vietnam and thus not available over-the -counter (Bygdeman 2003). In addition, only central and provincial levels hospitals were allowed to provide MA services. At the same time, clients living further than 30 minute travel (by any means) to a health facility were not allowed to use MA.

After 10 years since the MA was first introduced, MOH had amended the national guideline in 2009 that lifts restrictions on the provision of MA. Key stakeholders involved in the development of this guideline included Department of Maternal and Child Health, Department of Treatment Medicine – MOH, and national experts from tertiary Gyn/Ob hospitals. Compared to the first national guideline developed in 2002, the amended guideline expanded the application of MA to a wider range of clients and health facilities. MA now can

be administered to the gestations up to 12 weeks instead of 7 weeks in the former guideline; restricted travel time to the health facility increased from 30 minutes to 1 hour. Private clinics and district hospitals that were previously not allowed to provide MA could be licensed to perform this service when meeting eligible criteria.

2. Facilitators for the wider use of MA in Vietnam

As reported by most provider respondents (i.e., doctors and midwives), MA have been increasingly used in Vietnam over the past 5 years. MA was considered as a supplementary method to provide a wider choice for women who seek pregnancy termination. MOH's support for the widespread use of this abortion method, the growing number of providers, increased awareness of the MA service among women, and availability of domestic drugs were major facilitators for the wider use of MA in Vietnam.

Towards a wider provision of MA services, MOH had lifted restrictions on provision of MA services in the amended guideline as noted earlier. The training of trainers program for provincial level providers commissioned by MOH had been underway. Provincial trainers then train district providers in their respective provinces. Training materials were developed by leading experts in major tertiary Gynecology/Obstetrics hospitals and were standardized for consistent use nationwide. In 2010, training of trainers was complete in 41 out of 63 provinces and cities in the country.

From a technical point of view, the amended guideline incorporated lessons learned and experience distilled from past 10 years, and involved expertise from leading national gynecology and obstetrics experts. All of these would contribute to safer delivery of the MA service. Service providers commented that the amended guideline were more comprehensive and included clearer instructions on indications, anti-indications, eligible criteria for providers and clients, and detailing technical guidance on standard procedures and management of complications that may occur in association with MA administration. The

eligible criteria applied to service providers, for example, restricted to specialist gynecologists or obstetricians who must be skilled in SA and must attend training on MA can ensure that complications or failure of MA can be effectively managed by the same provider and health facility. Furthermore, MOH instructions on eligible criteria of providers, clear indications and anti-indications could prevent overuse or misuse of MA by unqualified health staff or facilities (e.g., pharmacy), minimizing undesirable effects. For example, one national gynecologist expert commented:

> The MOH guideline requires that MA service providers must be specialist gynecologists or obstetricians who are skilled in SA and are trained on MA. These strict criteria together with the technical guideline developed by national experts could help ensure the safe delivery of MA services and avoid over-use of this method by unqualified providers including pharmacies.

Compared to 5 years ago, one significant barrier to the widespread use of MA caused by high price and unsteady or inadequate supplies of drugs had been removed. Drugs are now produced domestically, providing women with easy access at a cheaper price. The costs of MA service previously much higher than SA had reduced significantly to meet the costs of SA service. The locally produced drugs also ensured the timely and adequate supply as well as a wider distribution to all parts of the country. In addition, imported drugs available in the market had diversified the range of drug supply and offered women with a wider choice of drugs when using MA services:

> Drugs for MA are produced domestically, which are much cheaper than foreign-made drugs. In addition, several foreign companies also provide drugs, increasing the range of drug supplies. (National training expert 1) (2)

From client perspectives, awareness of MA had been increasing along the growing number of providers and users. Women could access information on MA from multiple channels. First, the increasing number of MA providers and standardization of the MA procedure (e.g., counseling, medication, and follow up), particularly in hospitals, had increased awareness of MA services among abortion service seekers, which then spreads out among the women community through word-of-month communication. Client interviews indicate that peer experience and recommendations had been a major source of information for those who seek abortion services. The growing number of MA users also meant that more women were able to learn about MA services from their peers. Second, the increasing use of the Internet, particularly among young women, facilitated the rapid spread of information on the MA method. For example one unmarried MA user revealed: "Information on MA can be easily found by web browsers as many teens share their MA knowledge and experience on the online forum" (22 years old MA user-Hanoi). Third, the wide dissemination of information on complications associated with SA had lead many women who want to terminate their pregnancy to turn to MA service.

From a societal and cultural perspective, the legalization of abortion in Vietnam had eased the difficulties in communicating abortion services among women and between them and their partner. To a similar extent, the approval of premarital sex, at least among young people, and increased premarital sexual activity could have facilitated the spread of information about pregnancy and abortion, including MA service. In some religious groups (e.g., Catholic), SA was considered as a social taboo and was forbidden as this involves surgical instruments and physician interference on the fetus. Under these circumstances, women who want to obtain an abortion too often turn to MA if this service is locally

available. MA was considered by women as more natural and free from being accused of breaching moral standards attached with their religious affiliation.

3. Barriers to the wider use of MA in Vietnam

Despite growing use, provision of MA services remained concentrated in tertiary hospitals and provincial-level health facilities in major cities and towns. In addition, a substantial regional variation in the use of MA services still exists. MA was used more widely in the Center and the South. For example, as providers we interviewed estimated, MAs only accounted for 15-20% of the total abortions in Hanoi Gynecology/Obstetrics hospital, compared to 50% in Khanh Hoa provincial general hospital, and 40% in Ho Chi Minh Center for Reproductive Health Care.

The reasons for limited use of MA, at least in the north, were many. At the national level, little attention had been given to comprehensive and intensive measures to promote the wider use of MA throughout the country. Beyond the training activities, MOH had yet promulgated decrees, instructions, or guidelines on how to expand the provision of MA service to all levels health facilities in all parts of the country. Service providers and experts respondents criticized that MOH had not been proactive in promoting the widespread use of MA. This criticism was also reflected in interviews of MOH representatives who indicate while the MOH supports the use of MA as a measure to offer women a wider choice of abortion services, no more efforts should be made to promote the use of this abortion method. Also, the MOH does not encourage provision of MA in remote areas where access to specialist obstetricians or gynecologists or emergency care is difficult.

At the provincial level, provincial health authorities in many provinces had been reluctant to provide license for physicians who want to provide MA services. Similarly, the head of the district-level health facilities and providers were unwilling to apply this new method because it requires a higher level of staff expertise and more stringent control of the

medication procedure while they remained uncertain about its clinical outcomes and effectiveness as compared to the traditional abortion methods. Also, according to the MOH guideline, the health facility must provide SA if MA was unsuccessful without charging additional service fees.

While the training program had been standardized and training for provincial trainers had implemented for several years, there was no post-training monitoring and supervision to follow up the provision of MA services at the sub-national levels (i.e., provincial and district). The limited training budget at the provincial level had resulted in inadequate coverage of training for district-level health facilities and staff, and subsequently leading to the lack of qualified physicians and low availability of MA services:

> Though training on MA were conducted in many provinces, there have been no post-training monitoring and supervision, so effectiveness of training and how they (trainees) implement MA in their health facilities are largely unknown. (National training expert_1) (4)

At the grassroots level, there had been no communication activities for the wider use of MA based in the community. Retrospectively, information on MA services had been primarily provided in the form of the pre-abortion counseling offered at health facilities. Women were unable to access information on MA services from their community with many only being informed about this service not until they come to the clinic. Commune reproductive health workers were not trained on MA and there were no requirements or incentives for them to disseminate MA services in their community.

> ...One shortcoming in disseminating MA is the lack of training for family planning promoters or reproductive health service workers at the commune level on advantages and disadvantages of this abortion method. (Gyn/Obs Association). (5)

At the health facility levels, hospitals seemed to be cautious in expanding provision of MA services. For example, doctors in 3 health facilities under the study reported that they only provided MA services to pregnancies up to 7 weeks gestation though the MOH had allowed MA to be offered to pregnancies up to 9 weeks gestation. In addition, women in Hanoi Gyn/Ob hospital abortion clinic that had the lowest percentage of MA users reported that midwives at the counseling room tended to advise clients to use SA. While this comment could be right or wrong given a number of anti –indications applied to MA, the following quote from a SA client illustrates this point:

> ...The counselor did not mention about the other abortion method (MA) until I asked for. Responding to my queries, she only talked about discomforts after taking drugs such as pain or cramps, nausea, headache before the fetus can be expelled. She also emphasized the risk of failure or incomplete abortion, and the need for coming back for SA if that is to be happened. I felt that she wanted me to use SA rather than MA. (HN_M_SA_1) (6)

The higher requirements on levels of staff expertise could also limit the widespread use of MA. While assistant nurses or midwives were permitted to perform SA, only specialist gynecologists or obstetricians could be licensed to provide MA service. The provision of MA services by private providers remained unknown. This deficiency coupled with easy access to

drugs from a pharmacy pauses a great challenge in ensuring the safe delivery of MA services by the private sector.

> The role of private sector is very important as a significant proportion of clients, especially young women or adolescents seek abortions from private clinics for the concerns over their privacy and confidentiality. In addition, with flexible opening hours, private clinics can provide more convenient access to services. (Gyns/Obs Association) (7)

4. Provider perspectives on MA

Both doctors and midwives we interviewed showed a neutral position when judging advantages and disadvantages of MA and SA in terms of medication procedure, price, and clinical effectiveness. They all believed that no method among these two were neither optimal nor superior to the other. Instead, these services were complementary to each other and thus should be simultaneously provided. They also supported the wider use of MA as a means to offer wider choices for women who want a pregnancy termination.

All doctors and midwives considered MA to be safe, light, and inducing less pain. Some doctors preferred MA for their spiritual or moral beliefs: "For superstitious/spiritual reasons, some doctors do not want to perform SA as this is considered as the act of killing a human being" (Doctor 1(Minh)– Hanoi). In addition, doctors believed that the use of MA can save hospital expenditure due to costs associated with surgical equipment and theatre operation. However, similar to findings from previous experimental studies noted earlier, doctors often associated its disadvantages with complicated and time-consuming medical procedure, higher failure rates (8% vs. 2%), longer follow up period, prolonged bleeding, and frequent experience of drug side effects (dizziness, nausea, headache, diarrhea). Particularly,

failure or incomplete abortion, and sometime severe symptoms of drug side effects had forced doctors to perform SA to help women terminate their pregnancy:

> Some doctors do not prefer MA for at least 2 reasons. First, the successful rate is lower than SA. Second, bleeding is heavier and goes on longer time (up to 2-4 weeks), even after the fetus has been aborted. In addition, many women do not like MA as they have to see the fetus expelled from their body, which does not happen with SA. (National training expert_1)

> After taking drugs, many clients came back to the hospital requiring immediate SA when experiencing intolerable symptoms of drug side effects. (Doctor_1_Minh _HN) (8)

In addition, MA requires more proper clinical screening and more thorough counseling to guide women on the medication schedule, follow up visits, discomforts caused by drug size effects, and possibility of failure. Doctors had to spend more time (at least 2 weeks) on follow up of clinical outcomes which largely depends on women's compliance with the medication regimen and procedure, their return for follow up examinations, and women's ability to timely inform doctors about complications if these occur. All of these could be a great challenge for the doctor and women, particularly those with a low level of education and thus less sensitive to information given during the counseling session or those living far from the health facility. In all 3 health facilities under the study, doctors reported a low proportion of women returning the clinic for a follow up examination. Whether or not clients comply with the medication regimen was beyond the doctor's control.

The MA procedure including the time for taking drugs is mostly implemented by patients with minimal physician's control. The physician only serves as the counselor to offer consultation. With SA, the doctor plays a key role and is able to control the entire surgical procedure. (Doctor – Hanoi) (9)

It is very difficult to monitor patient compliance with the MA medication procedure. Many patients seem to listen attentively when attending the counseling session. But after taking drugs they think that is all,... finished, ..they do not follow doctor's instruction anymore, especially young women. (MA doctor – Khanh Hoa) (10)

5. Client perspectives

5.1. Reasons for using and not using MA

Reasons for many women opting for MA included less pain, being free from the risk of uterine sepsis and long-life sequelea (e.g., infertility, uterine rupture), and less concerned about privacy and confidentiality issues. Particularly, concerns about the risk of infertility lead many young and unmarried women resorted to MA to terminate their pregnancy, though they were advised that the failure rate of MA is higher. For a similar reason, married women who want to delay having a child also preferred MA. A few other women turned to MA after experiencing intolerable pain or complications associated with SA (e.g., bleeding), or incomplete abortion. Some womendecided to use MA after seeing SA users struggling with the pain when they attended the abortion clinic. On the other hand, women who had a successful MA tended to request this service independent of their age or marital status. These women also said that they would recommend other to use MA rather than SA services.

MA using drugs is an easy method to obtain an abortion. It is more confidential than SA. I can stay at home and take drugs on my own. Going to the clinic, I feel very

embarrassing when meeting many people. With these advantages, I think MA is acceptable. (HCMC_S_MA_2)

On the other hand, married and older women who were less concerned with the confidentiality issues and reproductive functions preferred SA. They related SA with the quick procedure, being free from drug side effects, and lower failure rates. Discomforts caused by pain and bleeding associated with SA last for a much shorter period of time. Women, therefore, was more certain about the clinical outcomes and effectiveness after leaving the health facility. In addition, women with small children and those who live far away from a health facility felt difficult to comply with MA procedures and thus often choosing SA. Some women also related their preference to SA with that they do not have to see the fetus being expelled from the body. The peer experience with MA failure or drug side effects also affected women's decision denying MA service: "...My neighbor said she got fatigue for a week after taking drugs. She also got severe pain that was heavier than menstrual cramps even when the fetus was expelled." (HCMC_M_SA_1) (12).

There appear to be marked regional differences. Women in Khanh Hoa and Ho Chi Minh seemed to be more favored of MA as compared to their counterparts in Hanoi. MA was the first choice of many women when they first learned about this service during the counseling session, unless application of MA was impossible (e.g., pregnancy of more than 7 weeks gestation).There was also a marked difference in the decision making process among women in the three health facilities under the study. Most MA user respondents in Hanoi and HCMC had made decision before visiting the health facility, while those in Khanh Hoa mostly decided to use MA after attending the pre-abortion counseling session. These were because MA clients in Hanoi and HCMC often knew about MA before going to the health facility while women in Khanh Hoa, a more rural province, were not aware of this abortion

method until after they attended the counseling session. Therefore, counseling offered at the abortion clinic in Hanoi and HCMC appeared to have a little impact on women's decision on whether to use MA or SA, while women in Khanh Hoa tended to rely on information given by health staff to make their own decision.

> I was unaware of MA before going to the clinic. As my understanding, SA was the only measure to terminate pregnancy. At the clinic, I was counseled on MA that was said straightforward, confidential, and safe so I decided to use this method. (KH_S_MA_2_22) (13)

5.2. MA acceptability

The majority of MA users who successful obtained an abortion were satisfied with clinical outcomes, effectiveness, and the price they paid. They also commented that discomforts caused by pain, bleeding, and drug side effects were tolerable and acceptable, which could offset severe pains or risks of infections and infertility that otherwise SA may have. Particularly, most women who experienced both MA and SA preferred MA for reasons listed earlier. These women also said that they would recommend others who want a pregnancy termination to use MA. This was contrast with the view of few women who experienced MA failure or severe complications (e.g., excessive pain and bleeding), thus denying use of this service although they initially preferred MA:

> I feel I have made a wrong decision when choosing MA service. I has been suffering from prolonged bleeding that makes me feel weak and tired. If I have another unplanned pregnancy, I will ask for SA, not daring to use or recommend other to use this method any more. (KH_M_MA_2_38)

It appears that women's acceptance of MA also depends on their individual pain tolerance or threshold. While most women who successfully underwent a MA reported light pain (as menstrual cramps) and little bleeding (as the menstrual period), many other experienced intolerable pain (e.g., as delivery) and prolonged or excessive bleeding, incurring multiple visits to the health facility. Under these circumstances, these women were turning to SA service.

> Patients who have a low pain threshold or tolerance often reported severe pain when using MA even after taking pain relief drugs. Moreover, the pain which lasts for a longer period of time, coupled with symptoms of drug side effects such as nausea, diarrhea, make patient turning to SA for a quick procedure and outcome. (MA doctor–Khanh Hoa)

In addition to client perceptions of clinical effectiveness, quality of counseling was found to affect client acceptance of MA services. Insufficient counseling for the patients on the possible drug side effects and possibility of failure had produced dissatisfaction as reported by many MA clients, weakening their confidence in the safety and effectiveness of the MA service. Poor counseling that gave insufficient information on possible health consequences of MA as criticized by many women in Hanoi had resulted in a situation in which women could not distinguish normal and abnormal symptoms after taking drugs (e.g., pain, bleeding), leading to either over-expectation of MA clinical outcomes or over-concern when experiencing discomforts due to drug size effects or bleeding: "Doctors counseled on bleeding and abdominal pain as light as that in the menstruation period, so I do not expect much bleeding and pain like this. I have felt very nervous." (HN_M_MA_1) (16)

In general, MA was more widely accepted by women clients as compared to SA. Intolerable pain was listed as a major reason for women to deny SA services. Almost all women who successfully obtained a MA we interviewed said that they would recommend other to use MA service for pregnancy termination. In contrast, those who also experienced a SA said that their advice to other women is to try to avoid SA by preventing unplanned pregnancy or detecting pregnancy early when MA can be administered: " If someone wants to abort, it is better to do early so that MA can be administered. Using drugs is less traumatic, while SA is very painful". (KH_S_SA_1_20) (17)

5.3. Perceptions of service quality and provider responsiveness

There were large differences in women's perceptions of service quality and responsiveness across study health facilities. In Hanoi, almost all women clients attributed abortion services to long waiting time, unfriendly reception and uncaring staff, poor clinic facilities and environment, lack of privacy and confidentiality. In addition, none of MA clients in Hanoi reported being able to contact the clinic staff on the given telephone number for consultation after leaving the hospital during the 2 week follow up; instead they had to go to the hospital every time they need a consultation. Staff were described unresponsive to clients queries or concerns. In Khanh Hoa and HCMC, in contrast, clients were all pleased with staff attitudes, clinic physical environment and facilities, and the way health staff communicate with patients. Women were also able to contact health staff after taking drugs from their home by phone, even after working hours on the physician's mobile phone number.

With regards to pre-abortion counseling, most women in Hanoi felt bad about the counseling session. They criticized that counseling was not thorough, providing little information about advantages or disadvantages of MA for women to make informed decision themselves. The counseling room was often crowded, where women felt that their privacy and confidentiality were not well protected. Women had no time to ask questions or

expressed their concerns with health staff. MA clients in Hanoi seemed to be uncertain about abnormal symptoms after taking drugs (e.g., unable to distinguish normal and excessive bleeding or pain) to inform the doctor for a clinical examination.

> I think the counseling was too structured, following a pre-designated procedure disregarding client level of education or responses. All information given was about what would happen after taking drugs: pain, bleeding, health consequences,..." (HN_M_SA_1). (18)

In Khanh Hoa and HCMC, on the other hand, most women were pleased with the counseling session. They praised information given, which enabled them to make their own judgments of MA clinical outcomes and recognize abnormal symptoms for timely clinic visits. Particularly, in HCMC, a board listed advantages and disadvantages of the 2 abortion methods was displayed at the clinic reception to assist women in deciding an abortion method. The different in quality of counseling was also evident in that none women in Khanh Hoa and HCMC who underwent SA felt that doctor tend to direct them to SA while several women in Hanoi reported that feeling.

IV. Discussion

As far as we are aware, this is the first qualitative study that examines the evolvement in the use of medical abortion in Vietnam since it was first introduced. It provides richer understanding of contextual, social, and political factors underlying women and providers decision with regards to the use of MA services. There is clear evolvement in structure regulations over the past 10 years towards universal application of MA in the state healthcare system of the country. The increased numbers of MA users are marked, reflecting the positive

responses of the health system, health providers, and abortion seekers to this policy change. MA appears to have been well-accepted by both providers and users as an alternative method given a range of possible health complications, physical and psychological consequences, and spiritual or moral concerns associated with the traditional SA method. In addition, legal and societal approves of induced abortion could largely serve as an important catalyst for the move towards wider use of MA services in Vietnam.

Responses of the health system, at least at the central level, were evident in that many structural barriers that have impeded the provision of MA services (Ganatra et al., 2004) were removed. This significant progresswas a result of a policy change process, involving multiple players within the health system. MOH has been proactive in supporting the wider use of MA services, expanding the number of health facilities authorized to provide services, increasing numbers of service providers, and obtaining a wider range of drug supply while reducing the price. National guidelines on MA has been modified and standardized for consistent use on a national scale, providing health facilities with detailed operational and technical instructions for provision of MA services. In addition, significant reduction in the costs of MA as a result of locally produced drugs, making the costs of both methods similar, has lifted economic concerns for clients when choosing MA service for their pregnancy termination.

Impediments to universal provision of MA, however, still exist, at least at sub-national levels, indicating the gap between policy change and implementation practice. MOH remains cautious, restricting secondary midwives, who are allowed to perform SA, from providing MA. Hesitance in licensing of provincial level health authorities and reluctance of district-level health managers in adopting the MA method have made the provision of MA services impossible in some provincial and district-level health facilities. Additionally, though not mentioned by provider respondents, financial incentives could be an issue, weakening

doctors' interests in MA as reported in earlier studies (Ganatra et al., 2004). While total costs of both methods paid by clients are similar, doctors receive a lower payment from providing MA service as a larger part of user fees is to cover drug costs. In addition, as any other surgical treatments, patients often voluntarily make under table payment to the doctor with the hope for more proper surgery and better care. Most SA clients we interviewed reported that they often pay 200,000 VND ($US 9) as a gift for the doctor.

At the client level, our study confirms previous findings in Vietnam and elsewhere that MA is considered as more natural, less pervasive, and more private, inducing less pain and trauma (Nguyen et al., 1999; Ganatra et al., 2004; Henshaw et al., 1993). Our findings also indicate that women's decision on whether to use MA or SA was dependent on the complex interaction between their personal background (age, marital status, number of living children), their knowledge of MA services and service availability, outcome expectations associated with each abortion method, and social support from their peers, partners, or service providers. For example, young and unmarried women were more likely to opt for MA for their concerns over privacy and possible long-term sequelea that SA may cause on their reproductive function. In addition, peers' experience or recommendations, providers' advice or consultation all play an important role in directing women to MA service, particularly among new abortion seekers.

In line with earlier studies (CAC Project, 2007; Ganatra et al., 2004), regional differences in the level of use of MA services are clear. Providers in HCMC and Khanh Hoa seemed to be more concerned with superstitious and moral issues, and thus more likely to select MA to keep them away from ambivalence about doing abortions. In addition, higher level of use of MA in the South could be in part explained by higher quality of counseling session, more caring and responsive staff at the clinic, and more accessible staff during the follow up period . There might have been other factors that can explain this difference, but

these would have been difficult to discern in the present study given a small sample of health facilities and participants.

Our findings highlight that quality of services, particularly of the counseling session at the abortion clinic, is crucial in helping women to make informed decision, choosing an appropriate abortion method. This also influences client compliance with the MA medication regimen, their likeliness to return for follow up visits, and level of satisfaction with services rendered and treatment outcomes. Poor counseling might lead to a situation in which women are ignorant about physical discomforts associated with MA, triggering anxiety and emotional and psychological distress when experiencing symptoms of drug size effects even when abortion is successful.

Limitations of the study should be noted. A small sample of health facilities in three provinces means that findings should be interpreted with caution when being generalized throughout Vietnam. The study did not include informal and private providers, and thus unable to explore the extent to which women can access MA services from these providers. Given that self-medication using drugs purchased from a pharmacy is a common practice in Vietnam, whether or not women use over-the-counter MA drugs remains unknown.

In conclusion, our study shows a marked progress towards wider use of MA in Vietnam, though the coverage of this service has not been to its full potential within the well-established health system. Availability of both abortion methods can help expand women's ability to choose the method that most suits their medical and psychological reproductive health needs. Along with expanding the supply of MA service, efforts should be made to ensure the safe delivery and improve service quality that respects client choice and is responsive to their needs and expectations.

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