MATERNITY CARE IN VIETNAM

CURRENT SITUATION AND VISION TOWARDS 2030

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Objectives

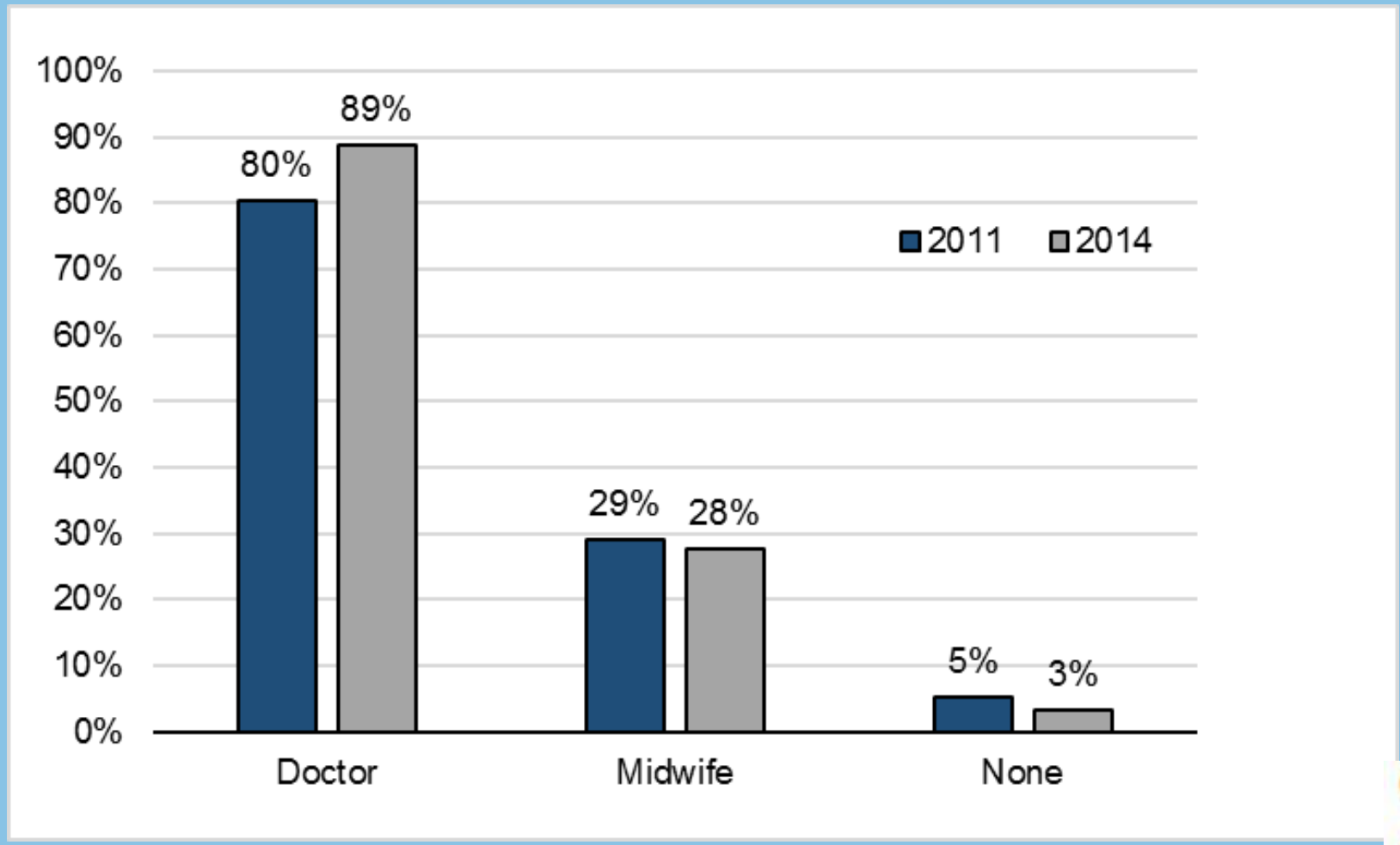
To discuss on maternity care in Vietnam with vision towards 2030

Methods

Secondary data analysis from national studies:

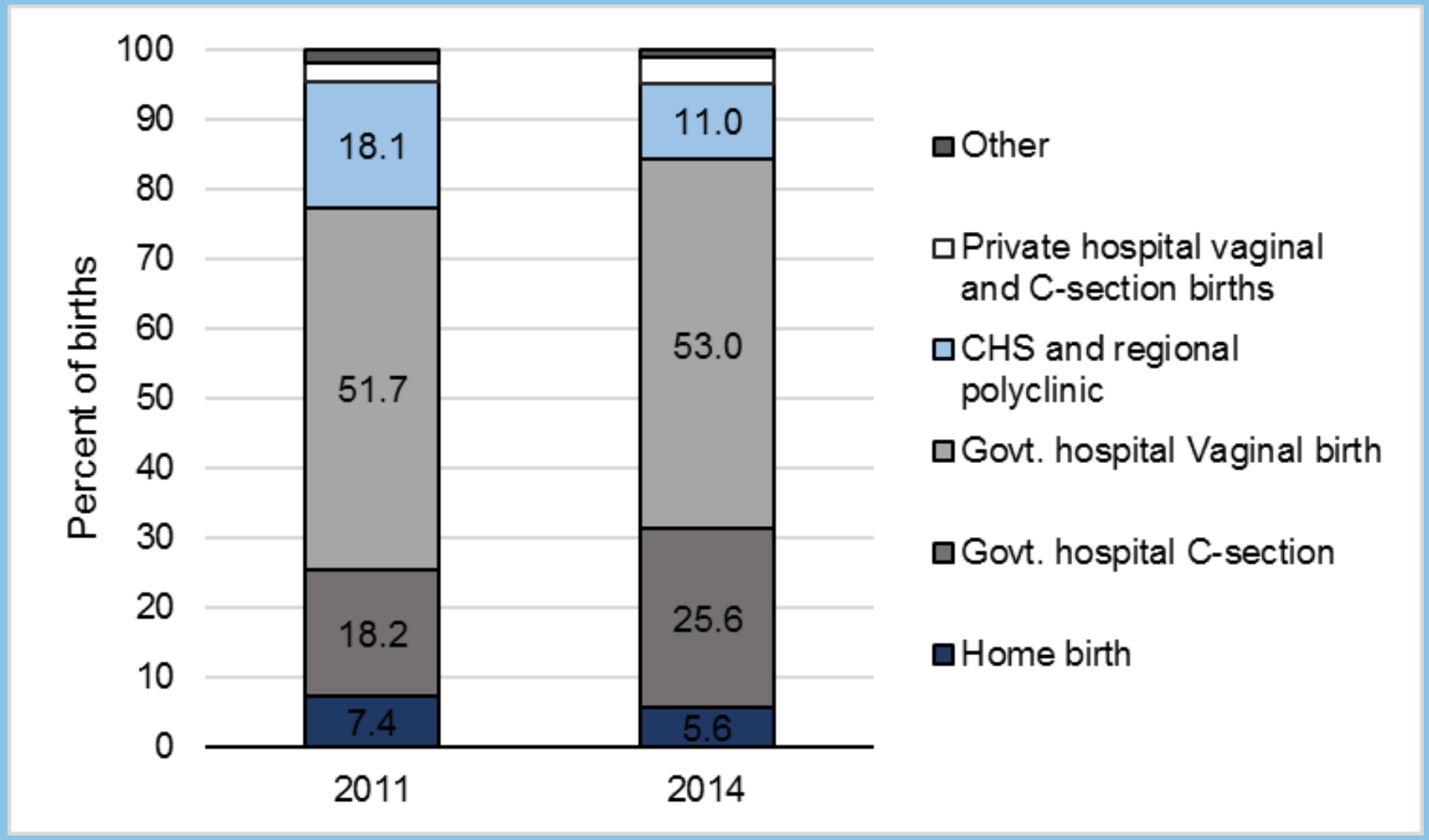
- 2016 National Midwifery Report (2017)
- National Study on Quality of Family Planning Services (2017)
- National Survey on Sexual and Reproductive Health among Vietnamese Adolescents and Young Adults aged 10-24 (2017)
- Exploring barriers to accessing maternal health and family planning services in ethnic minority communities in Viet Nam (2017)
- MISCs 2011 and 2014
- MCH reports 2010 and 2013
- National Population Change Surveys (2010-2017)
- State of World Midwifery Report (2014)

Who is providing antenatal care?



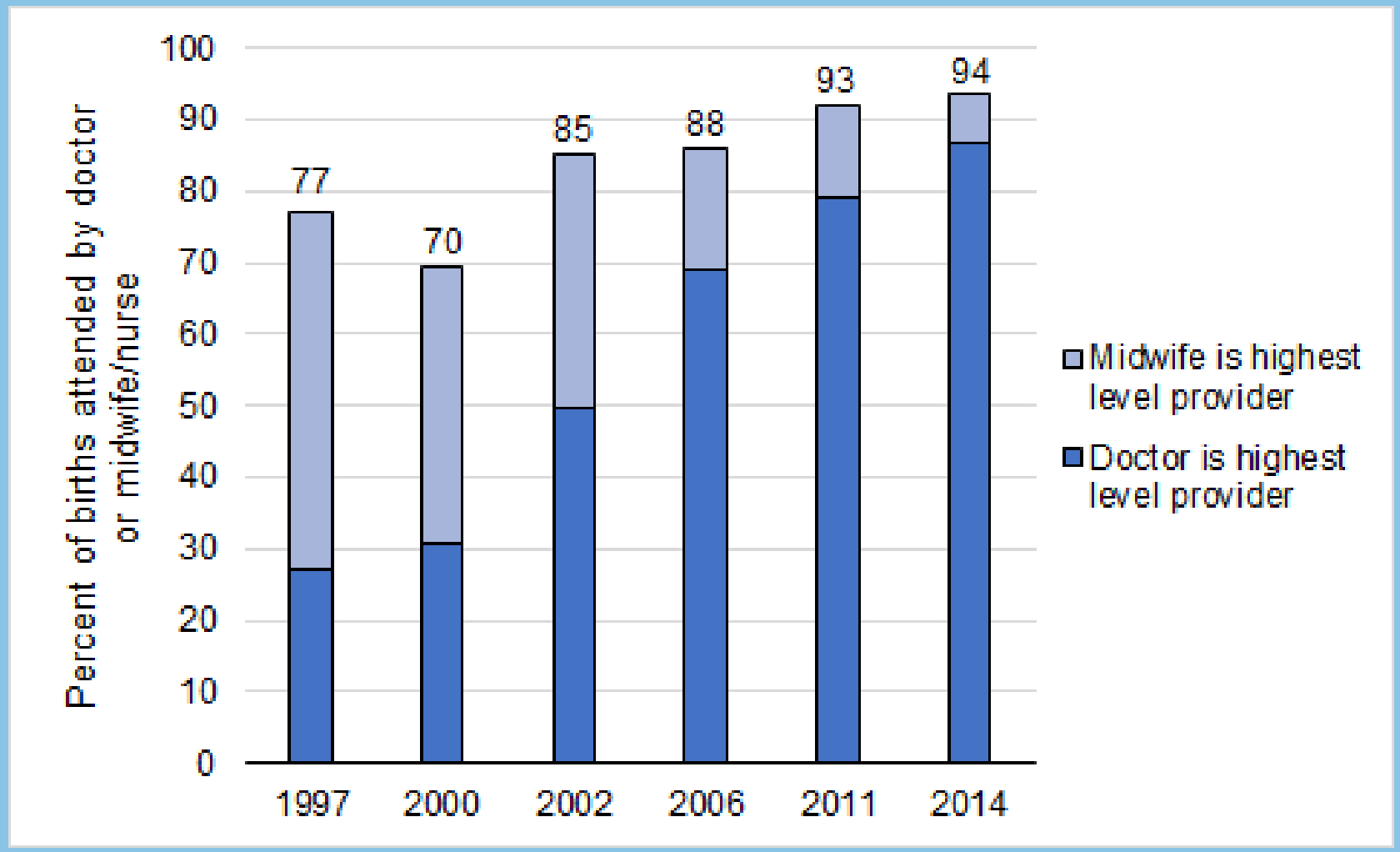
Source: MICS 2011, MICS 2014

Where do women give birth?

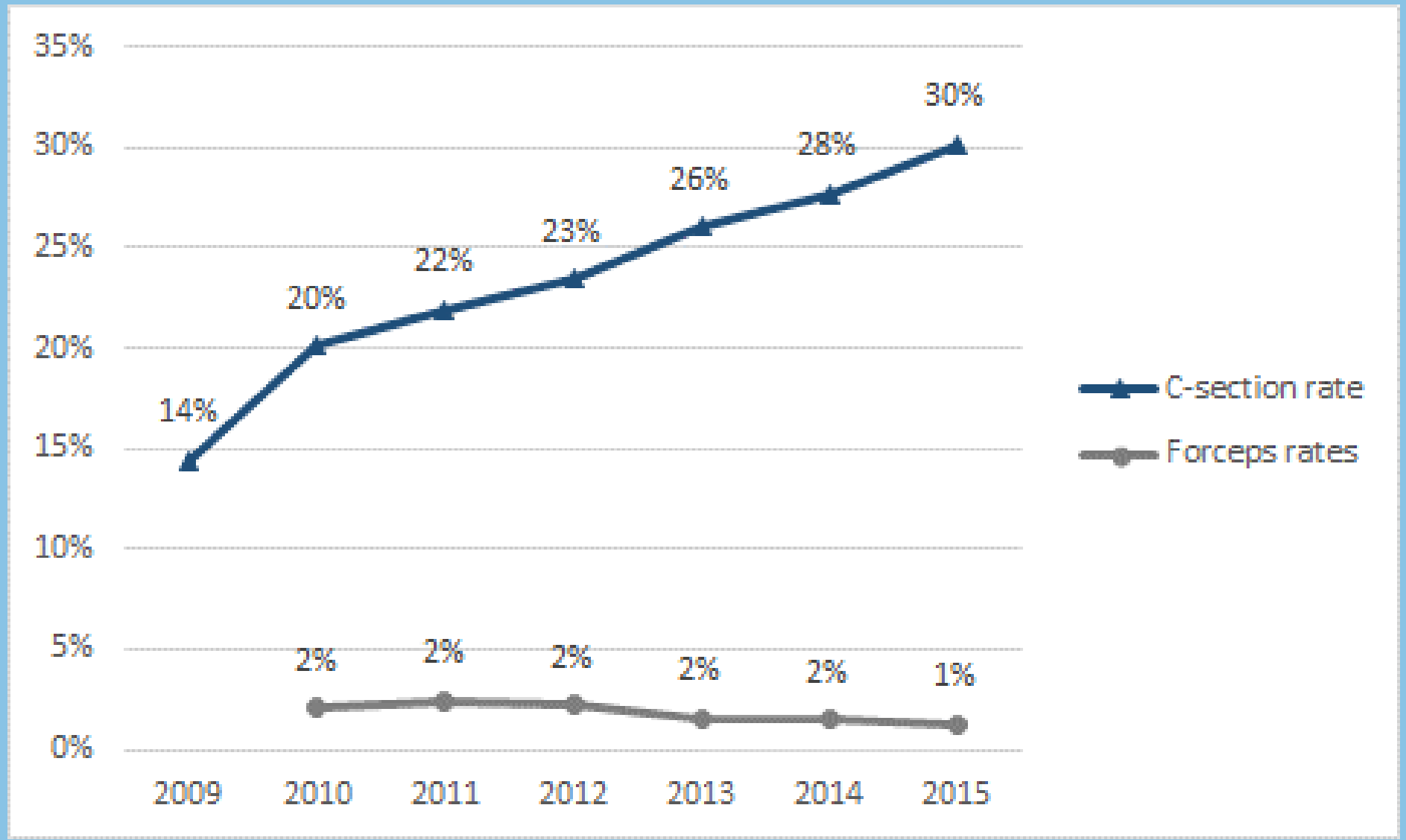


Source: MICS 2011, MICS 2014

Upward trends in trained provider providing assistance at birth, but evidence of medicalization

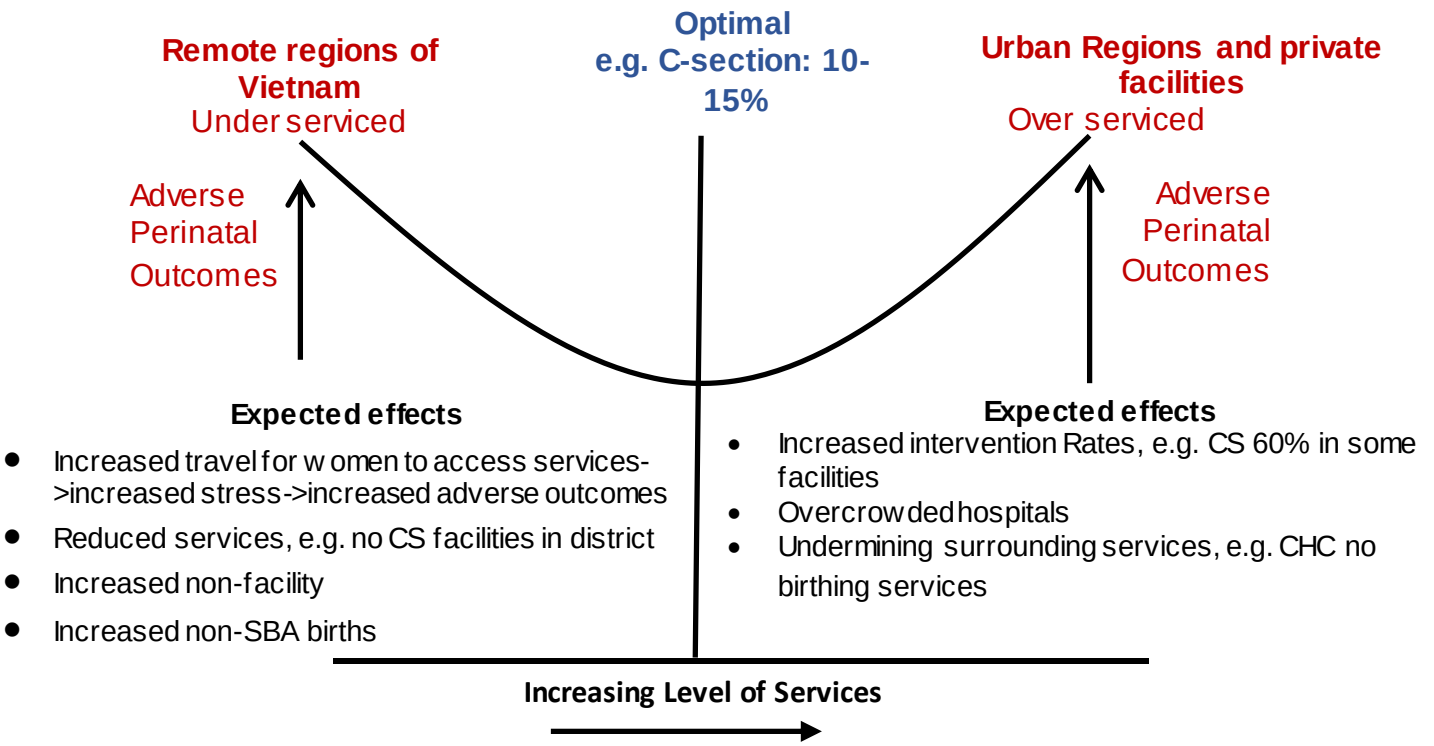


Alarming trends in C-section r



Too little care VS. too much intervention

Level of maternity services and population need



Adapted with permission from: Grzybowski, S. et al. Planning the optimal level of local maternity service for small rural communities: A systems study in British Columbia. Health Policy. 2009 92(2):p. 149-157

Barriers to compliance with technical guidelines

- Maternal mortality audits reveal non-compliance with guidelines.
- Dissemination, update training and compliance are incomplete.
- Continuing Medical Education credits required to maintain professional registration, but no statistics to know if policy is enforced.
- Anecdotal evidence from the field that not all guidelines are known or followed, even in provincial hospitals.
- Overcrowding, lack of continuity of care and record keeping, and other organizational issues may also contribute to this.

Medical Model VS. Midwife Model of Care

The Medical Model of Care	The Midwife Model of Care
Definition of Birth	
• Childbirth is a potentially pathological process. • Birth is the work of doctors, nurses, midwives and other experts. • The woman is a patient.	• Birth is a social event, a normal part of a woman's life. • Birth is the work of the woman and her family. • The woman is a person experiencing a life-transforming event.
Birthing Environment	
• Hospital, unfamiliar territory to the woman. • Bureaucratic, hierarchical system of care.	• Home or other familiar surroundings. • Informal system of care.
Philosophy and Practice	
• Trained to focus on the medical aspects of birth. • "Professional" care that is authoritarian. • Often a class distinction between obstetrician and patients. • Dominant-subordinate relationship. • Information about health, disease and degree of risk not shared with the patient adequately. • Brief, depersonalized care. • Little emotional support. • Use of medical language. • Spiritual aspects of birth are ignored or treated as embarrassing. • Values technology, often without proof that it improves birth outcome.	• See birth as a holistic process. • Shared decision-making between caregivers and birthing woman. • No class distinction between birthing women and caregivers. • Equal relationship. • Information shared with an attitude of personal caring. • Longer, more in-depth prenatal visits. • Often strong emotional support. • Familiar language and imagery used. • Awareness of spiritual significance of birth. • Believes in integrity of birth, uses technology if appropriate and proven.

Midwife–led care

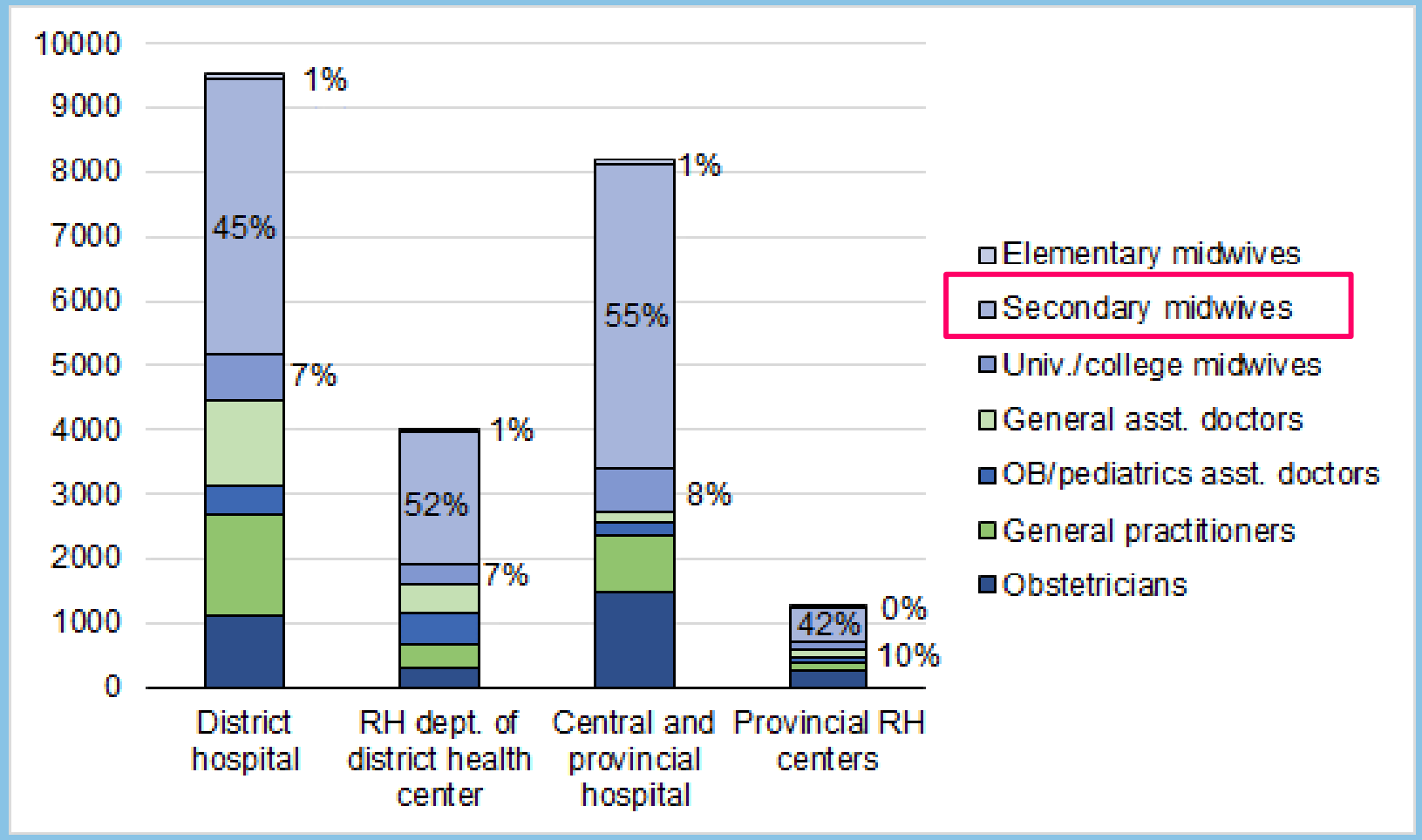
- In midwife-led care, the emphasis is on ***normality, continuity of care and being cared for by a known, trusted midwife during labour.***
- Midwife-led continuity of care is delivered in a multi-disciplinary network of consultation and referral with other care providers.
- ***This contrasts with*** medical-led models of care, where an obstetrician or family physician is primarily responsible for care, and with shared-care, where responsibility is shared between different healthcare professionals.

Two big questions?

1. Why are not midwives the leading providers for normal delivery in hospital settings?

2. Why don't women give birth in the CHS?

Availability of midwives in hospitals



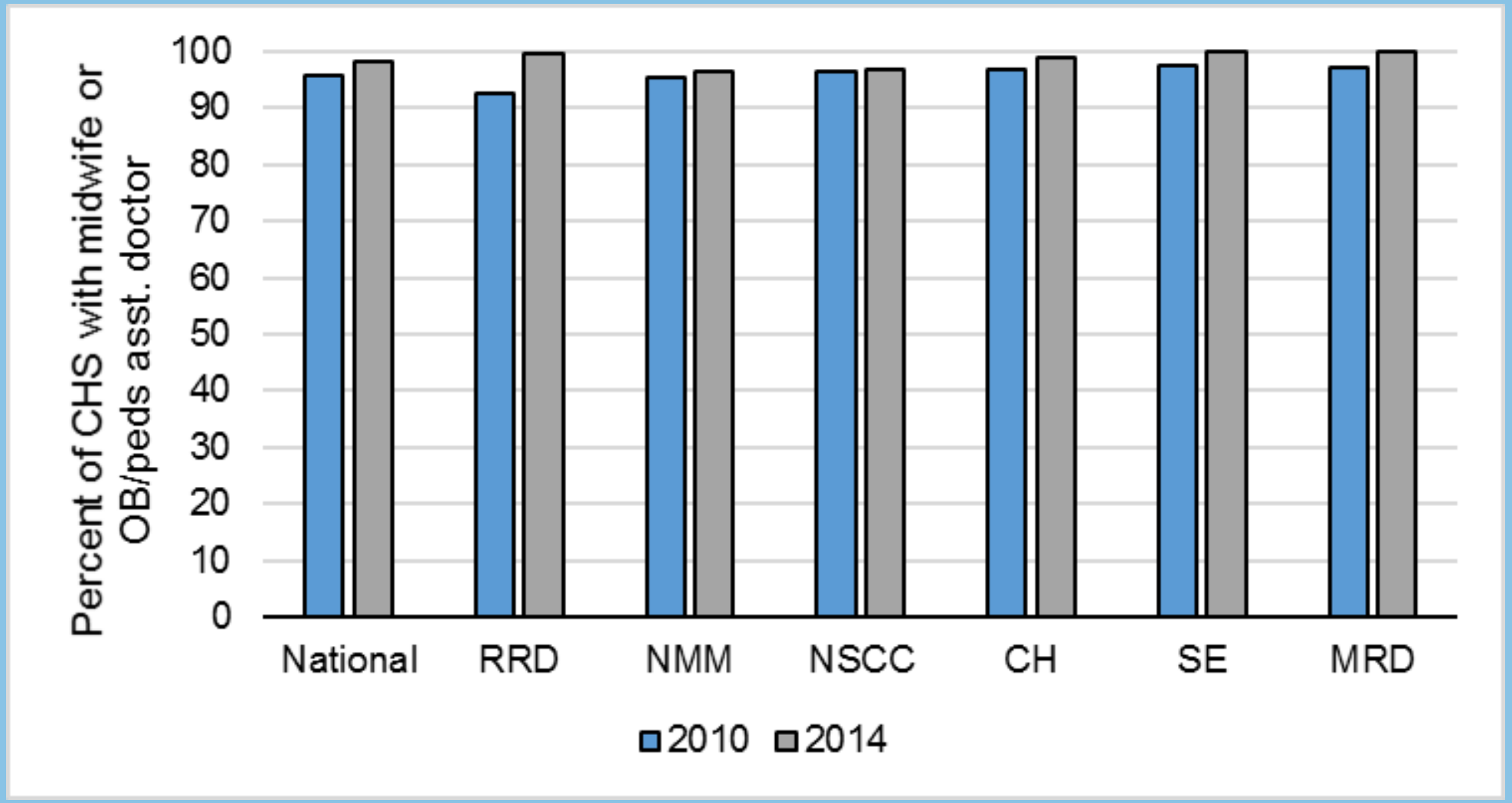
Misperceptions among women and families

- "The perception is that in order to get the highest quality of care, they [women] must be cared for by a senior clinician and that is simply not the case. Midwives provide a sense of normality and by having a midwife they know during pregnancy it allows the mother to feel comfortable and at ease during labour which in turn is much better for the baby." (Cochrane study)

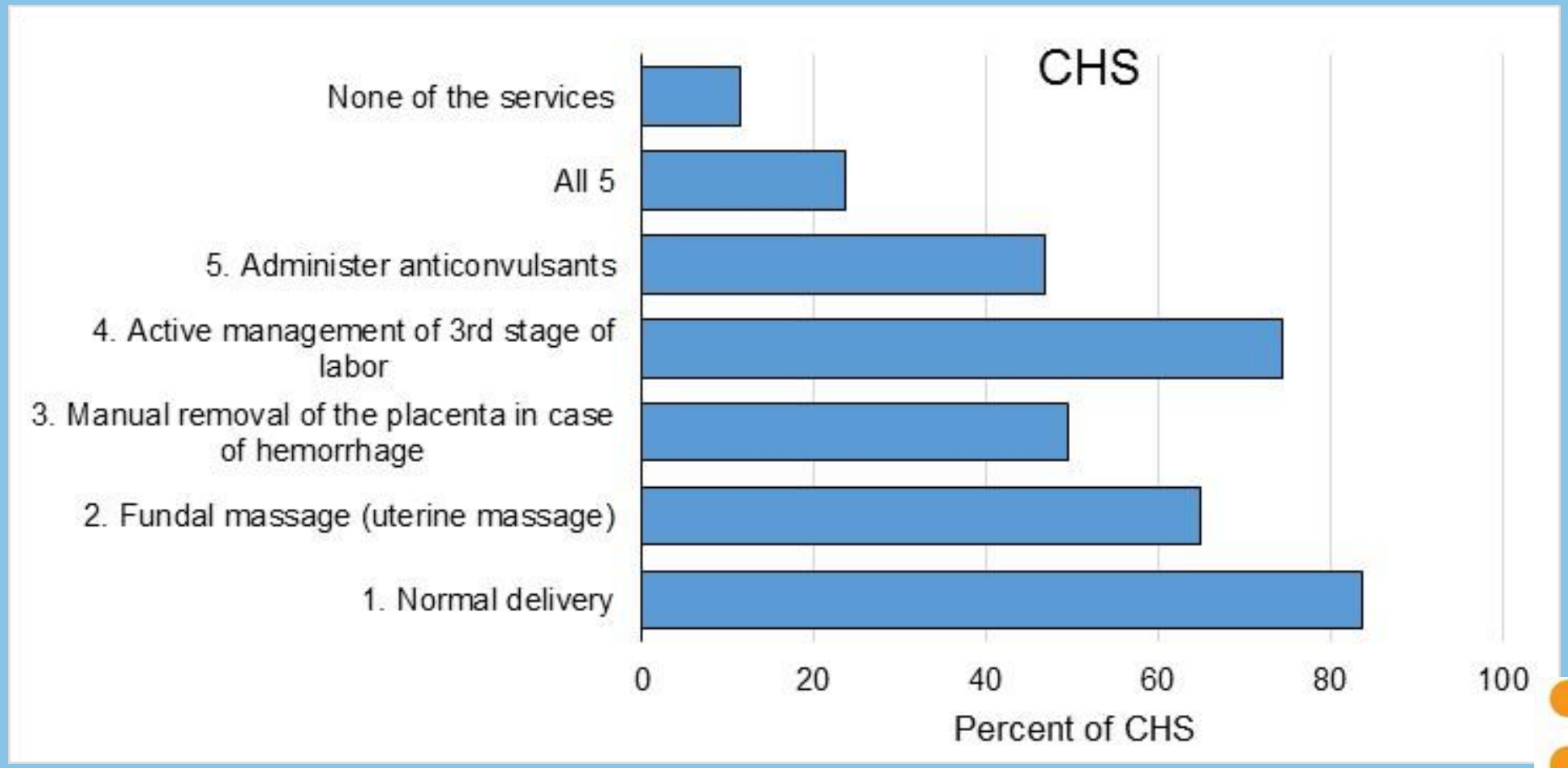
Misperception among obstetricians

- Women can't handle the pain of normal delivery –> So how can they tolerate the pain after C-section, when recovery takes far longer and pain may persist as a result of adhesions.
- Vietnamese women are too sedentary, their perineum is too small, they need episiotomy or C-section to help the birth along? Yet Vietnamese-born women in Australia have much lower episiotomy rates than in Vietnam.

Availability of midwives at CHS



Need to strengthen universal availability of Emergency Obstetric Services at CHS (2010)



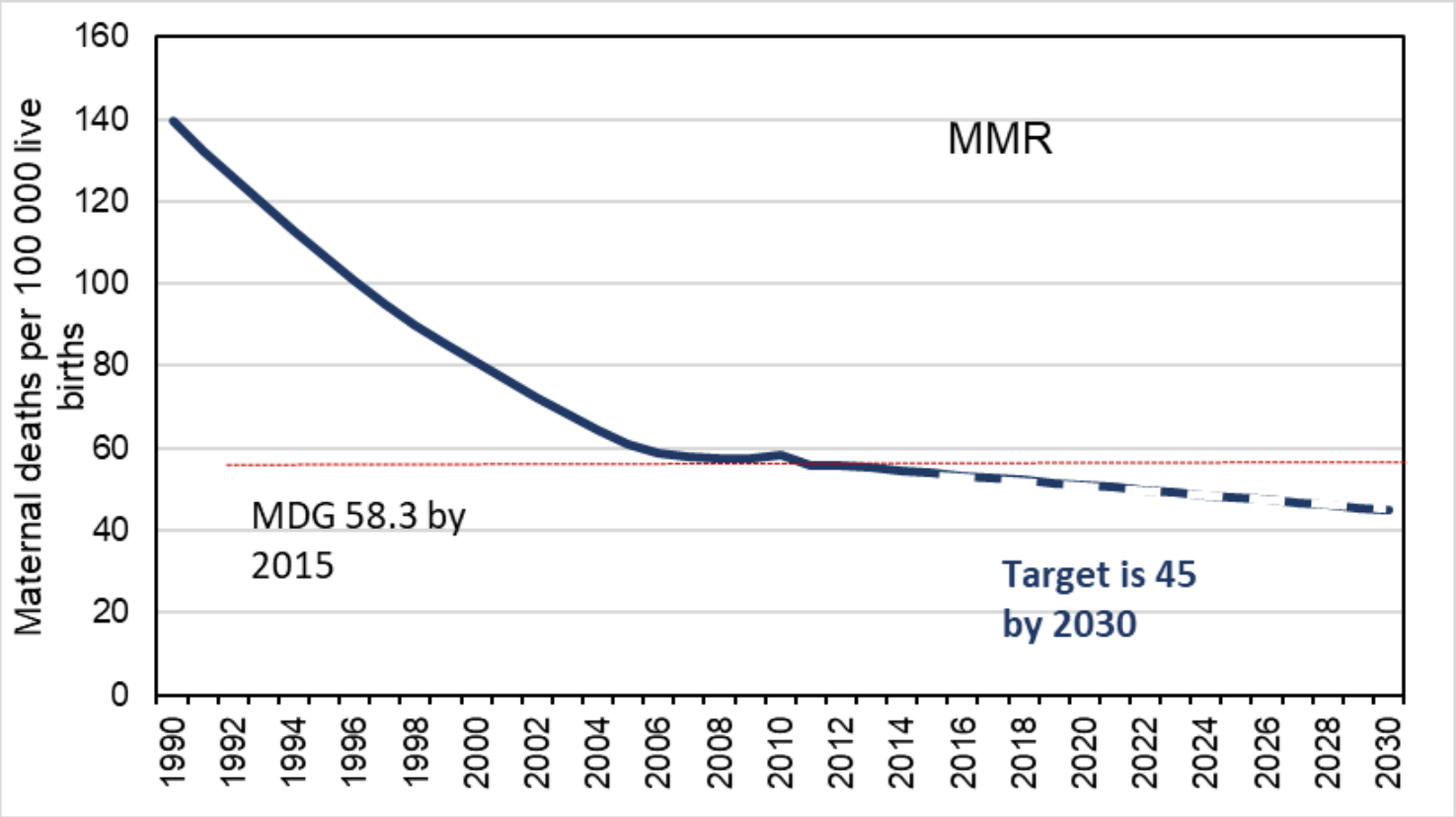
Source: MCH Survey 2010

Financial incentives?

- Health insurance and user fee payment for C-section is substantially higher than normal delivery (2,223,000 VND versus 675,000 VND).
- Health insurance does not reimburse normal delivery at the commune health station (unclear which regulation, but confirmed in several searches of FAQs of VSS).
- Obstetricians get paid a surgical salary supplement for C-section, but not for normal delivery.

2030 VISION ON MATERNITY CARE

Ambitious goal on maternal mortality reduction by 2030



QUALITY OF MATERNAL HEALTH SERVICES

- Women centered services (privacy, respectful, satisfaction, socio-cultural determinants, etc)
- Delivery is memorable experience, not traumatic event
- Options on delivery positions and pain relief medicines
- Husband/relative's companion during delivery
- Minimal unnecessary C-sections and episiotomy

Recommendations

Governance

- Develop code of conduct to make explicit what respectful care is;
- Coordinate upgrade training of midwives;
- Enforce compliance with reproductive health guidelines
- To ensure “not too little and not too much care”;
- Enforce competency and CME requirements for professional registration.
- Establish and function midwifery council for accreditation and licensing

Maternity care delivery

- Well-trained VBAs in networked system in remote areas with strengthened emergency transport
- Midwifery-led care in hospitals
- CHS strengthened to serve as primary birthing location for uncomplicated pregnancy, transfer for obstetric emergency and follow-up postpartum and neonatal care
- Private birthing facilities encouraged to serve as alternative to CHS for primary birthing location for uncomplicated pregnancy

Recommendations

Financing

- Ensure that health insurance covers CHS's antenatal care, normal deliveries and emergency obstetric care packages

Human resources

- Prioritize upgrade training of midwives to ensure they have all essential competencies for providing comprehensive midwife care; Urgently review and revise Circular 26
- Upgrade training of midwives to university level to serve as instructors in midwife training establishments;
- Ensure appropriate continuing medical education to deepen and broaden competencies of OB-GYNs and midwives.

Information systems

- Vital information to understand reproductive health needs and unmet need of unmarried individuals; maternal and neonatal mortality audits; workforce and training statistics

Pharmaceuticals and Equipment

- Ensure availability of essential obstetric drugs and birthing instruments in CHS
- Ensure adequate simulation equipment for training establishments.

THANK A LOT

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