Experiences in expanding national reproductive health programmes
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Cover: With her husband standing by, a pregnant migrant worker from a rural area in China undergoes a physical examination in a hospital in Beijing.

Photo Credit: AFP
CONTENTS

Introduction ............................................. 2
Cambodia: Success story in reducing maternal mortality ....... 3
China: Comprehensive approach in improving reproductive health .... 7
Malaysia: Advancing confidential enquiry into maternal deaths ....... 10
Vanuatu: A multidisciplinary approach for improving reproductive health ...... 13
Viet Nam: The models of preventing unsafe abortion and continuum of care .... 16
INTRODUCTION

Countries and areas of the WHO Western Pacific Region have made significant efforts to improve access to reproductive health in the last few decades. During the consultative meeting for the finalization of the *Regional Framework for Reproductive Health in the Western Pacific*, participants from the ministries of health requested that the document be accompanied by accounts of experiences in expanding and strengthening national reproductive health programmes from selected countries. This suggestion was followed up and five countries, Cambodia, China, Malaysia, Vanuatu and Viet Nam, submitted their contributions.

Every country has a unique approach in expanding and strengthening reproductive health programme according to its situation and needs. The sharing of country experiences would, therefore, provide an opportunity for countries to learn from each other. *Experiences in expanding national reproductive health programmes* aims to facilitate such process, as well as demonstrate examples on how to implement integrated reproductive health services as elaborated in the *Regional Framework for Reproductive Health in the Western Pacific*.

Contributions on experiences in expanding reproductive health programmes from the five countries are greatly appreciated. It is hoped that this publication would be useful for decision makers and programme managers for reproductive health in their efforts to achieve universal access to reproductive health. It is also hoped that more countries would document and share their experiences in expanding and strengthening national reproductive health programmes.
Maternal mortality ratio (MMR) in Cambodia, with an estimated population of 14.3 million in 2011, was estimated to be over 600 deaths per 100,000 live births in the 1990s. The rate remained stagnant at around 450 per 100,000 live births between 2000 and 2005 and, between 2005 and 2010, it declined significantly to 206 per 100,000 live births with a range of 124 to 288 per 100,000 live births (Figure 1).

The following key factors led to the dramatic success.

**A strong political commitment for national development**

The regime in power during 1975–1979 left the country in ruins, with only 45 skilled professionals surviving. Following the regime’s departure, emergency relief and gradual national reconstruction began in the 1980s. In the 1990s, the Government gained its strength and international recognition, especially after an election in 1993. Since 1997, Cambodia has improved its stability, peace and social order, permitting intensified national development.
The Rectangular Strategy Phase II of the Royal Government of Cambodia highlighted four key objectives:

1. Strengthening peace, stability and social order;
2. Ensuring the achievement of a sustainable high rate of economic growth;
3. Ensuring the reduction of poverty rate of more than 1% per annum and the improvement in key social indicators, especially education, health and gender equity; and
4. Ensuring the extent of effectiveness, quality and reliable public services.

Despite the global economic crisis, Cambodia has seen an average annual economic growth of 7% per annum since 1993, with a gradual reduction in families living in absolute poverty. The average household possessions too have risen dramatically. More than half of the families now own a TV, cell phones and motorbikes, as illustrated in Figure 2, thus enabling them to receive health messages and connect with the health system more easily. In addition, the Government has invested in infrastructure building and ensuring the effectiveness, quality and reliability of public services, including roads, bridges and health facilities such as health posts, health centres, subnational and national referral hospitals.

**Figure 2. Household possessions in Cambodia, 2000–2005**


### Health sector actions: strengthening health systems based on primary health care

The Health Strategic Plan 2008–2015 focuses on four health priority programmes, including reproductive, maternal, newborn and child health to improve major health indicators. The annual operational plan and the three-year rolling plan aim to:

(i) improve reproductive, maternal, newborn and child health;
(ii) contribute to reduction of maternal, newborn and child morbidity and mortality, and
(iii) achieve the Millennium Development Goals (MDG) by 2015. A series of systematic interventions have steadily improved the access to skilled birth attendance and reproductive, maternal and newborn health care in the last 10 years.
More midwives, earlier with a one-year and now with a three-year training background, are being produced and sent to remote areas. Focused training, coaching, mentoring, training follow-up and supportive supervision to health centres’ midwives are conducted to ensure quality of care. These steps are often implemented in collaboration with partner organizations. For several years now all health centres have been providing emergency services for 24 hours a day. In addition, construction of maternity waiting homes and extended delivery rooms at health centres has made these services more accessible. The Royal Government of Cambodia also provides various incentives to birth attendants for safe delivery at public health facilities. They include, among others, a bonus between US$ 10.00 and 15.00 for every live birth, financial mechanism for fee exemption, free of charge delivery for the poor, expansion of health equity fund, government-subsidized scheme, community-based health insurance and voucher scheme.

**Achievement**

The systematic and stepwise work in a committed political environment and a favourable national development context has resulted in a dramatic increase in the utilization of maternal and newborn health services in public facilities, as reflected in Table 1.

Antenatal care (ANC) coverage, skilled attendance at birth, access to and utilization of Caesarean section, HIV-testing and services for the prevention of mother-to-child transmission of HIV, and child immunization coverage have increased steadily. Figure 3 illustrates the steadily increasing availability of skilled care at birth. Besides increase in coverage, quality of care has also been improved. Thus, correct use of partograph, active management of third stage of labour and evidence-based use of magnesium sulfate for managing pre-eclampsia/eclampsia, are all increasing, besides availability of medicines, supplies and equipment.

<table>
<thead>
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<th>Key indicators</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
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<tbody>
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<td>Number of midwives (in public sector only)</td>
<td>3028</td>
<td>3027</td>
<td>3678</td>
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<tr>
<td>% of antenatal care (ANC 2)</td>
<td>22</td>
<td>33</td>
<td>73</td>
</tr>
<tr>
<td>% of delivery by Caesarian section</td>
<td>1.1</td>
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<td>% of HIV+ pregnant women received ART (public sector only)</td>
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<tr>
<td>% of postnatal consultation (PNC 2)</td>
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<td>32</td>
<td>70</td>
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<tr>
<td>Total fertility rate (average number of children per woman)</td>
<td>4</td>
<td>3.4</td>
<td>3</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (%)</td>
<td>19</td>
<td>27</td>
<td>35</td>
</tr>
</tbody>
</table>

Experiences in expanding national reproductive health programmes

Figure 3. Coverage of facility births and skilled birth attendance (SBA) in public facilities, 200-2013


Summary of health sector interventions

The key interventions introduced by the Ministry of Health to accelerate progress in the areas of maternal, newborn and child health are the following:

1. Placement of midwives to health centres where there was none, through increasing production, recruitment and deployment of midwives.

2. Improved continuum of care for women and newborns, through increasing antenatal care, delivery by skilled birth attendants at health facilities, improving provision of health information, counseling and birth spacing services, increasing voluntary confidential counseling and testing of HIV during pregnancy and childbirth.

3. Increased access to safe delivery at health facilities, by
   - establishing/strengthening referral system, including referral from communities to health facilities;
   - continuing to build maternity waiting home or extended delivery room at health centres and referral hospitals in rural areas;
   - continuing to provide government incentives for safe delivery at public health facilities;
   - increasing coverage of emergency obstetric and neonatal care and 24-hour services; and
   - strengthening financial mechanism for fee exemption/free services for the poor, expansion of health equity fund, government- subsidized scheme, community-based health insurance/voucher scheme.

4. Improved quality of health care services, through building capacity and skills of health staffs, including provision of better quality medical supplies, drugs and equipment.

There were contributions from all health development partners to sustain development in health sectors, including United Nations agencies, donor community, nongovernmental organizations and private sector, individuals, communities, Red Cross volunteers, parliamentarians and senators.
Experiences in expanding national reproductive health programmes

Comprehensive approach in improving reproductive health

CHINA

China is the most populous developing country in the world. The vast territory of 9.6 million square kilometres—7% of the world’s total—was inhabited by 1.35 billion people in 2011, which is approximately 20% of the world’s total. The Government promotes coordinated development between population, economy, society, environment and resources. At the same time, it has improved people’s living standards by ensuring them better living and working conditions. China currently features the second fastest-growing human development index in the world.

Over the past 30 years, China has made remarkable progress in the areas of population and development. Between 1990 and 2010, life expectancy in China rose from 69 to 73. During the same period, maternal mortality ratio declined from 94.7 to 37 per 100 000 live births (see Figure 4) and total fertility rate went down from 5.8 (1970) to 1.6 children per woman.

Figure 4. Maternal mortality ratio (per 100 000 live births), 1990-2010, by urban-rural setting

Source: Ministry of Health, China, 2011.
For improving the health of the population, especially in areas of reproductive health, the Government has implemented the following approaches:

1. **Continuous improvement of laws, policies and regulations, especially on reproductive health.**
   The Government has developed a comprehensive policy and legal framework, including the following laws on (i) maternal and infant health care; (ii) protection of women’s rights and interests; and (iii) population and family planning. In 2009, the guideline on furthering reform of the medical service system was promulgated to ensure that a basic health care system be established by 2020 which will cover maternal health and other components of reproductive health services for both urban and rural residents. The Government allocated US$ 3 billion in 2009 for supporting development of grass-root health infrastructures. In 2011, the per capita subsidy standard was raised from 15 to 25 Yuan (approximately US$ 3.5) for basic public health services.

2. **Establishment and improvement of a nationwide service network that covers maternal and infant health care, family planning and other components of reproductive health services in both rural and urban areas.**
   These measures have been established at the county, township and village levels, where basic family planning services are provided free of charge and hospital delivery services are subsidized. These are considered the most effective measures to reduce maternal mortality ratio. For each woman getting hospitalized delivery in a rural area, the average subsidy is 500 Yuan, while some areas such as Beijing, Inner Mongolia, Shanghai and Shanxi increased the subsidy to 600–800 Yuan. In Shanxi, Ningxia and Tibet provinces, delivery is free at all health facilities—in townships as well as at the county level. In Tibet and Yunnan provinces, extra subsidy is provided to the person who accompanies the mother. With these effective interventions in place, the contraceptive prevalence rate was 84.6% among married couples and hospital delivery rate was 94.5% in 2009 and 98.1% in 2011. The number of counties where the hospitalized delivery rate was below 80% dropped to 109 in 2011 from 334 in 2008.
3 Provision of equitable public health and reproductive health services to migrants.

The total number of migrants in the country reached 211 million in 2009, and it is expected that an additional 300 million people will be migrating from rural to urban areas in the future. The Government has ensured that these migrants have equitable access to basic health care, including reproductive health services. With such approach, the gaps in major health indicators between urban and rural areas, and among regions, have decreased further. The reduction in MMR and the infant mortality rate, from 2009 to 2011, is higher in rural areas than in urban areas. In the western region – which is less developed – it is higher than the middle and eastern provinces. In 2008, MMR in rural areas was 1.24 times the urban rate, which was later reduced to 1.05 times in 2011.

4 A comprehensive approach to addressing population issues.

Investment in a holistic human development has been one of the priorities. The Government is committed to stabilizing the low fertility rate and promoting coordinated and sustainable development of population, economy, society, resources and the environment, including responding to the global climate change.
Maternal mortality ratio (MMR) in Malaysia has been steadily decreasing, from around 500 per 100,000 live births in the 1950s to 28.1 in 2000 (Figure 6). In the 1970s it was 150 per 100,000 live births. To reduce it further, the Ministry of Health initiated the confidential enquiry into maternal deaths method (CEMD), a new system, to investigate maternal deaths. It was neither confidential nor comprehensive, and the system, adapted from a similar system used in England and Wales, was continually improved. To implement CEMD, a national committee responsible for reviewing maternal deaths was established.

The essential feature of CEMD in reviewing maternal deaths is independent, multidisciplinary, non-punitive and anonymous. The principal aim is to identify remediable factors in the management of cases as well as the constraints that contribute to deaths. Maternal deaths are investigated through the road-to-death approach using a standard format. The integrated approach allows all personnel in various disciplines involved in the care of the women to justify their management. The remediable actions are taken at operational levels when the shortfalls are identified. At the national level, the enquiry enables formulation of policies and recommendations to prevent similar deaths in the future and further strengthen specific areas of maternal health.

The process of investigating maternal death

Coordinators are appointed in the hospital and at the community level to identify maternal deaths, which are reported within 48 hours to the national secretariat of the CEMD, based at the Division of Family Health Development in the Ministry of Health. A notification format with the essential data of the deceased is also sent to the national secretariat. A code number is assigned to every maternal death reported. Maternal deaths are investigated and reviewed at individual hospital where the death occurred, as well as at district and state levels before submitting reports to the national level.
The CEMD Committee consists of multidisciplinary members who meet regularly to audit all maternal deaths systematically and identifies the causes and associated factors which led to death. These meetings are unbiased, non-judgmental and conducted in a confidential manner. All identifying information of the deceased, health facility and health personnel involved are erased. Confidentiality is maintained to ensure that the findings are for the purposes of improvement of practice and not for punitive actions. The members will present their reviews and reports, as well as comments and recommendations. After discussion, the cause of death is confirmed, classified and an international classification of diseases (ICD) code number is assigned to each case. The committee identifies remediable clinical, non-clinical and patient factors from each case. The data are entered using relevant software programme and analysed for the CEMD reports which are published at regular intervals.

### The benefits

The essence of establishing an enquiry system is to improve maternal and newborn health through improving obstetric service delivery. The benefits of implementing CEMD include the following:

1. The findings are used to justify the need for increasing budget allocation and health personnel in the obstetric discipline. Recommendations from the enquiries are incorporated into strategies and programmes suitable for different population groups and included in the national plan of action to reduce maternal mortality.

2. Data collection has vastly improved and, due to the anonymous nature of the enquiry, more accurate data on maternal mortality are made available to the CEMD than to the vital registration system. Data from both systems are matched to look for discrepancies, and harmonized so the maternal mortality ratio reported by CEMD and Department of Statistics are now comparable.

3. The interventions from the CEMD focus on management of obstetric emergencies that bring additional funding for training of health care providers in this area. Training manuals, protocols and guidelines were developed to improve knowledge, skills and competencies of health care providers. The availability of essential medicines for obstetric emergencies such as magnesium sulphate for managing hypertensive disorders in pregnancy is improved. Also, community health nurses have been trained to set intravenous infusions for pregnant women.

At primary care level, alternative birthing centres (ABC) were built to facilitate deliveries by health personnel for women with no identified risk, as well as for those who stay in the remote areas. Urban ABCs were established to decongest the high-risk labour wards in some major hospitals.

At hospital level, high dependency wards were set up with specialists to decrease patient load in the intensive care unit. The obstetric ‘red alert’ system was used for communication to facilitate fast, efficient and coordinated team management of selected obstetric emergencies. The importance of multidisciplinary care for pregnant women was necessary as mortality from existing medical conditions was increasing. Combined clinics by the obstetrician and physician was re-emphasised in hospitals with specialists. In addition, pre-pregnancy care was introduced in hospitals and health clinics to counsel high-risk patients, especially those with medical conditions. Family planning for high-risk women was also introduced through the Quality Assurance Programme.

The way forward

Some factors limiting the implementation of CEMD system include shortage of trained staff to conduct the investigation. Frequent turnover of health personnel can lead to incomplete and inconsistent reporting of cases which can result in lack of timeliness in completing the report. Dedicated committees on maternal deaths need to be established at all levels, especially at the national level, and meet regularly to review all maternal deaths and ensure timely printing of relevant reports.

The CEMD is a systematic review of all maternal deaths and can be used as an important monitoring tool in the reduction of maternal mortality. The principle of confidentiality should be maintained throughout the enquiry to investigate all deaths without fear or prejudice. This confidential enquiry system can produce timely and accurate maternal mortality data. The lessons learned from this process are utilized for adapting safer clinical practice and overcoming other local barriers to ensure that similar deaths can be prevented in the future. With good implementation of CEMD, the quality of obstetric care in health facilities could be improved to make pregnancy safer.
The Republic of Vanuatu is an archipelago of about 80 islands spreading over 900 km in the South Pacific Ocean, to the east of Australia and west of Fiji. About 25% of its population of approximately 240 000 live in urban areas. The gross national income per capita is US$ 4310, while the total expenditure for health in 2009 was 4% of the gross domestic product or US$ 175 per capita.

The Health Sector Strategy 2010–2016 highlights Vanuatu Government’s commitment to revitalisation of primary health care, with an “all-of-health” approach to strengthen access to services and improve health equity. While the overall health goal is to improve the health of all people living in Vanuatu, the reduction of maternal and infant morbidity and mortality rates remain national priorities.

The reproductive profile of the country (Table 2) shows that while the Millennium Development Goals (MDGs) 2015 countdown is just around the corner, Vanuatu is off-track for achieving its MDG 5 targets, especially in the reproductive health indicators related to fertility. Contraceptive prevalence rate is fairly low at 38%. There is a high rate of unmet needs for family planning, while adolescent fertility remains relatively high.

The Ministry of Health recognizes that to achieve the desired outcomes, a comprehensive programme must address both clinical and public health aspects of reproductive health along the continuum of care of maternal, newborn and child health in an integrated fashion, within the resources available. In addition, the delivery of services must aim to strengthen mechanisms for achieving improved access to the essential services for all, especially in rural areas and outer islands.
Interdisciplinary partnership and collaboration for better results

Within an under-resourced health system, the Ministry of Health recognizes the value of interdisciplinary partnership and collaboration among clinicians, public health officials and other stakeholders to achieve synergy among different programme components. Addressing reproductive health from both clinical and public health perspectives is, therefore, a logical way to strengthen health systems issues, particularly service delivery, supplies and commodities, human resources, health information and improved management and coordination. The approach also gives room to exercise the integration of important cross-cutting issues, such as rights-based approach, gender issues, health inequity and social determinants of health to reinforce collective impact on reproductive health.

Based on these considerations, a maternal, newborn and child health committee was established in March 2011 to support the vision of an integrated reproductive health approach through partnership and collaboration across related disciplines. The purpose of the Maternal, Neonatal and Child Health (MNCH) Committee is to provide a regular forum for discussing health of mothers, newborns and children, including other reproductive health issues. Such a mechanism helps to facilitate progress in the achievement of MDGs 4, 5 and 6 targets. The ultimate aim of the committee is to strengthen services to improve quality of life and health outcomes in Vanuatu.

Membership. The MNCH Committee engages the participation of core members and co-opted members. The core members, by virtue of their professional roles and responsibilities in MNCH, are required to participate in all scheduled committee meetings. The co-opted members are invited to participate in selected meetings where the agenda includes a specific area that relates to their area of expertise. The Secretary, in consultation with the Chair, extends invitations to co-opted members. Core members include relevant staff members of the main referral hospital, e.g. from maternity unit, antenatal clinic, family planning and paediatric unit; officials from reproductive health programme and representatives of the United Nations Children’s Fund (UNICEF) and the World Health Organization (WHO). Co-opted members may include staff from the pharmacy unit, sexually transmitted infections/HIV programme, child health, nutrition, nursing school and other related programmes.

<table>
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<tr>
<th>Indicators</th>
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<tbody>
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<td>Population</td>
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<td>Population growth rate</td>
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<td>2009 population census</td>
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<tr>
<td>Total fertility rate (average number of children per woman)</td>
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<td>2009 population census</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>86 per 100,000 live births</td>
<td>MOH report, 2010</td>
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<td>Birth by skilled birth attendants</td>
<td>74%</td>
<td>Multi-indicator survey, 2007</td>
</tr>
<tr>
<td>Antenatal coverage</td>
<td>78%</td>
<td>Multi-indicator survey, 2007</td>
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<tr>
<td>Contraceptive prevalence rate</td>
<td>38%</td>
<td>Multi-indicator survey, 2007</td>
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<td>Adolescent fertility rate, 15–19 years</td>
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<td>2009 population census</td>
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<tr>
<td>Unmet need for family planning</td>
<td>30%</td>
<td>Cost-benefit analysis of unmet need for family planning, 2012</td>
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</table>

*Source: Ministry of Health, Vanuatu*
Functions

The main functions of the MNCH Committee are the following.

1. To collectively discuss interventions to improve maternal, neonatal and child health at all levels of health services delivery, taking into account both technical and health systems issues.

2. To develop, implement and review standard guidelines and protocols for common life-threatening MNCH conditions.

3. To advise on appropriate staff development, training and capacity-building to improve MNCH delivery; staff performance and accountability for improved results; staff distribution; and candidate selection for participation in sponsored trainings and meetings held locally and abroad.

4. To conduct regular maternal and perinatal death reviews and other similar monitoring activities to track the achievement of MDGs 4 and 5 targets.

5. To review, on an ongoing basis, the implementation of the national Reproductive Health Strategy to ensure that all elements are addressed and that progress is made.

6. To advise the Ministry of Health executive committee on technical matters related to MNCH, to inform them of progress in health service delivery, and to seek its support where relevant.

The MNCH Committee operation in improving reproductive health service delivery

The MNCH Committee meets on the first Wednesday of every month at the Vila Central Hospital Library. The Committee has a designated chairperson, a deputy chairperson and a secretary who serve for at least six months. New office bearers are selected by the Committee and current bearers are eligible for re-selection based on mutual agreement. The decisions made at the meetings are recorded, including actions to be followed up by assigned members within a timeframe.

The Chair or the Deputy Chair moderates the meetings and facilitates the discussions based on a prepared agenda, and ensures that agenda items are discussed and decisions reached by majority rule. The meetings aim to be completed within one and a half hours. The Secretary prepares the meeting agenda in consultation with the Chair, sends out meeting notices and reminds members — five days ahead (by email) and one day ahead (by mobile text message) — of each scheduled meeting.

The Secretary prepares the minutes and distributes them to all members within a week following each meeting. The minutes record the decisions made at the meetings and actions to be taken, which may be assigned to specific members or groups based on their positions and responsibilities. Assigned members provide updates on progress of actions taken via email before the next meeting date. This helps to facilitate efficient follow up of actions and reduces time spent on “matters arising from last meeting”.

The MNCH Committee is still in the early phase of operations. There is acknowledgement that the Committee is technically well-grounded due to a strong mix of technical members who are well-positioned to address reproductive health in an inclusive and holistic approach, taking into consideration different aspects of clinical, public health and management areas of programme delivery. Since its establishment, the Committee has reviewed the status of MDGs 4 and 5 in Vanuatu; developed various MNCH management guidelines and protocols and established maternal and perinatal review meetings.
Viet Nam has made substantial progress toward increasing coverage of family planning and maternal and newborn health services over the past decades. By implementing the National Strategy on Population and Reproductive Health 2001–2010, Viet Nam has gained many important achievements on population and reproductive health, including family planning and maternal and newborn health. The contraceptive prevalence rate has increased from 68% in 1996 to 80% in 2010, while modern method use has increased from 53% to 68% with the intrauterine contraceptive device (IUD) as the dominant method. Maternal mortality ratio was estimated at 59 per 100 000 live births in 2010, while neonatal mortality rate was 12 per 1000 live births and coverage of skilled care at birth was 84%.

Women-centred comprehensive abortion care

Viet Nam is one of the countries with highest abortion rates in the world. About 500 000 abortion cases were reported from the public sector in 2006, and at least the same number of cases utilised services in private health sector. In 2001, there were 45.1 abortions per 100 live births, with an estimated 20–30% of cases involving young and unmarried women. In spite of liberal laws and the availability of abortion services at public and private sectors, unsafe abortions contributed to about 11.5% of maternal deaths in 2002. To address this issue and advance women’s reproductive rights, the Ministry of Health has expanded family planning services to prevent unwanted pregnancy, as well as to promote a women-centred comprehensive abortion care approach in collaboration with Ipas.

The women-centred comprehensive abortion care (CAC) provides abortion service that takes into account the various factors that influence a woman’s individual health needs, her personal circumstances and ability to access the service. It provides safe, high-quality, affordable and acceptable service to women that is decentralized to the local level possible. The service aims to understand each woman’s social circumstances and individual needs and tailor her care accordingly. It also aims to reduce the number of unplanned pregnancies and abortions, identifies and serves women with other sexual or reproductive health needs and ensures affordability and sustainability.
The major interventions of CAC initiative include the following:

1. Introduction of strengthened service delivery aspects by developing standardized protocols of service delivery; training of service providers in the use of manual vacuum aspiration (MVA), medical abortion, dilatation and evacuation, counseling, infection prevention, pain control, post-abortion contraception, record-keeping and attention to confidentiality and privacy, meeting the needs of clients and making services more woman-centred.

2. Setting up a supervisory team at each site following development of the performance-improvement approach.

3. Training of a master team in woman-centred care and training-of-trainer skills. Trainers made subsequent monitoring visits to augment initial training.

The significant improvements made so far have been on information and counseling, client-provider interaction and technical competence in safe techniques. All women at district and commune levels were provided abortion services using MVA method. It was reported that there were fewer cases of repeat abortion and that contraceptive prevalence rate has increased. Despite the good progress, further improvement is still needed, such as encouraging utilization of services at district- and commune-level facilities. Other service improvements include addressing provider reluctance to change established practices, eliminating shortages of essential equipment (MVA aspirator and cannulae) at primary care level, use of post-abortion contraceptives, provision of adequate information and counseling and improving availability of communication materials.

Continuum of care from household to hospital for maternal and newborn health

The Ministry of Health of Viet Nam also promotes continuum of care for maternal and newborn health from household to hospital in improving quality of care. In collaboration with United Nations agencies and development partners, including Save the Children, the following approaches have been carried out.

1. Increasing access to and availability of information and key services. This has been provided by bringing care closer to the community, systematically link each level of care and promote timely and appropriate care-seeking, while ensuring the continuum of care. Essential and comprehensive maternal and newborn health services are established in all health facilities, especially at commune health centres and district hospitals. As a result, there has been a reduction in the number of obstetric complications and sick newborns transferred to the higher level health facilities. Emergency referral funds were also set up to support the safe transfer of mothers and newborns to health facilities.

2. Increasing quality of essential and emergency maternal and newborn health care at all levels. This is carried out by strengthening the health system, including introducing competency-based training techniques and development of training manuals, improving supervisory practices, and establishing an ongoing quality improvement system. The clinical training includes improving skills on active management of the third stage of labour, use of partograph, management of postpartum hemorrhage, essential newborn care and newborn resuscitation.

3. Enhancing community understanding of healthy practices and acceptance and generating interest in utilising health services. Improved awareness and acceptance of health messages by mothers, husbands, and family members on maternal and newborn care practices are ensured through a variety of community-based activities. These include training village health workers and members of the Women’s Union to promote better care-seeking practices and meet the needs of minority populations. These activities have resulted in an increased rate of delivery at commune health centres, particularly in remote, mountainous areas and among minority communities.
Strengthening management and delivery of maternal and newborn health services, while building an enabling social and policy environment through close collaboration with key stakeholders. Supportive supervision and tools for improving quality of care have been institutionalized. These ongoing activities will also be used as a catalyst to leverage additional government funds as well as funds from other donors to sustain and scale up interventions province-wide. The best practices and effective interventions of the project were put in the national guidelines and training manuals as well as the national action plan for child survival for country-wide use.

Moreover, the Ministry of Health in collaboration with WHO and other United Nations agencies is currently in the process of improving information and accountability for women’s and children’s health. A roadmap for this purpose has been developed with participation of development partners and nongovernmental organizations. This is a global initiative following the launch of the *Global Strategy for Women’s and Children’s Health* in 2010 by the United Nations Secretary General.