

*“ Between morality and reality ”*

**Midwives and doctors views on  
adolescent abortion and contraceptive counselling  
in Vietnam**

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## **Abstract**

**Background:** Vietnam has one of the highest abortion rates in the world and adolescent abortions are thought to constitute at least one third of all cases. Lack of balanced reproductive health information and services to adolescents and negative social attitudes to adolescent sexuality are contributing factors to the high abortion rates. Health providers are important in guiding and counselling adolescents on how to protect their reproductive health, but there is a lack of studies on the health providers' own views on their work in adolescent reproductive health care.

**Aim:** The aim of the study was to explore values and attitudes of doctors and midwives to adolescent sexuality and abortion, their views on abortion and contraceptive counselling for adolescents and their own training needs in this regard.

**Methods:** In a qualitative research approach, non-participatory observations of care in abortion clinics and focus group discussions (FGD) were used to collect data. Doctors and midwives from three health care facilities in Quang Ninh province in Northern Vietnam participated in a total of eight FGDs. Data were analysed using qualitative content analysis.

**Findings:** Two major themes emerged, reflecting the contradictions between the cultural norms and values condemning pre-marital sexual relations and the reality of the health care providers working with adolescents in abortion services. On the one hand the participants had strongly negative attitudes to adolescent sexuality and abortion, considering these dangerous for health and future happiness. On the other hand they expressed a pragmatic and caring attitude towards the young girls and couples coming for abortion. The moral dilemma of health providers in relation to adolescents in reproductive health services should be considered in their training programmes.

**Keywords:** adolescent sexuality, adolescents abortion, Vietnam, focus group discussion, nursing-midwifery education, counselling.

## **Introduction**

Unprotected sex leading to unintended pregnancy, abortion and an increasing numbers of sexual transmitted infections, including HIV, among adolescents are major public health problems globally. It has been estimated that around 2-4.4 million abortions occur among adolescent women in low income countries each year, most of which are unsafe abortions (1,2). Young people's sexual behaviour reflects a changing society but health care services have been slow to develop realistic and relevant service for youth (3). Societal norms condemning pre-marital sex often set barriers to rational decision-making and resource allocation and in many countries health services for adolescents are still grossly inadequate and often not youth-friendly (4). The World Health Organisation (WHO) has identified the special problems of adolescents in contraception and abortion services and emphasised the importance of high quality provider-client interaction in order to gain their confidence and assist them to protect their sexual and reproductive health (5).

Midwives are a core group of professionals that meet the special needs of adolescents within reproductive health services. WHO, the International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO), define the midwife's professional responsibilities to encompass sexual and reproductive health care in a life perspective (6). WHO's technical and policy guidelines, made to assure safe abortion globally, has recognised the need to involve midwives and other midlevel providers, to increase access to and improve the quality of abortion services for women worldwide. This was also highlighted at an international conference held in South Africa in 2001, aiming to promote the role of midlevel providers within abortion care. It was recommended that in situations where abortion is legal, safe abortion care and counselling should be integrated into basic education and in-service training of midlevel providers working in reproductive health (7).

In Vietnam abortion is legalized since many years and abortion rates are among the highest worldwide among countries with official abortion registration. Adolescent abortion is said to increase and constitute about one third of all abortions. The aim of this study was to explore values and attitudes of midwives and doctors' in relation to adolescent sexuality, abortion and contraceptive needs in Vietnam, as well as their own training needs. By deepening the understanding of midwives' views on

adolescent reproductive health issues we hope to contribute to the development of relevant training curricula for this professional group.

## **Background**

The population of Vietnam is estimated to be 80 million, and young people 15 to 24 years constitute about 20 percent (8). After long periods of war and international isolation, Vietnam is experiencing rapid economic growth and socio- demographic change. Youth values and life styles are also changing and pre-marital sex is becoming more common. This is an extremely sensitive issue in Vietnam, where Confucian morals strongly condemn premarital sexual relations (9) and the typical response of the older generation is prohibition and silence. Policy makers and health managers in Vietnam are now addressing the responsibility of the health sector to protect adolescents' reproductive health (10,11).

### **Abortion care in Vietnam**

Abortion has been legal in Vietnam since 1945 but became widely used in the 1980s in connection with the strictly implemented policies to limit births to two children per family (12). Currently within the public sector there are 78-83 abortions per 1000 women in reproductive age (13). All Vietnamese women have the right to abortion on demand and in principle they are assured confidential treatment. Unmarried women asking for abortion will usually present themselves as married and it is therefore difficult to know their share of all abortions.

The most commonly used method in Vietnam for termination of pregnancy from 2-12 gestational weeks is the manual vacuum aspiration (MVA), known as the menstrual regulation (MR) method if performed up to six weeks of gestation. Dilatation and curettage (D&C) is still used in facilities lacking MVA, which is the preferred method. Medical abortion method, using mifepristone and misoprostole, was introduced in 2002 and may be used up to 7 weeks (49 days) of pregnancy. Between 12-18 weeks of gestation dilation and evacuation (D&E) is used to terminate a pregnancy (10). According to the recent Vietnamese National Standards and Guidelines for Reproductive Health Care Services, women seeking abortion should be informed about abortion procedures, complications, risks and available contraceptive methods before and in connection with the abortion. A counsellor in abortion care

should have specific training in and knowledge about abortion care and methods including contraceptive counselling (14). However, studies in Vietnam have shown that counselling time in abortion service is usually very short, even non-existent (10, 16, 17).

## **The study**

### **Study setting**

The study was conducted during March and April 2002 in Quang Ninh province in The North East of Vietnam. Quang Ninh, with a population of about one million, is a mixed rural – industrial province with an important coal mining industry and a growing tourist industry in Ha Long Bay. The province has among the highest abortion and HIV rates in the country (18).

The study subjects were selected from three health facilities in Quang Ninh Province, two general hospitals and one Mother and Child Health clinic (MCH). The clinic was chosen as it differed from the two other sites by participating in a project for the upgrading of abortion services, including the training of the staff in abortion care and contraceptive counselling.

### **Sample and methods**

In order to get a general picture of the abortion services and the context, informal observations were made by the first author (MK) at each setting included in the study. Eleven abortion clients were followed from admission to discharge, which usually took around two hours per client. The findings were used in developing the thematic guide for the focus group discussions (FGD), a qualitative method often used when sensitive topics are being explored, rather than individual interviews where the person may feel constrained to give her or his personal views (19). The major topics included in the guidelines were values and attitudes of the participants to adolescent sexuality and abortion; what they considered to be barriers to providing high quality counselling and care for this group of clients, and their own responsibilities and training needs in the area of adolescent reproductive health. All staff at the clinics were informed about the aim and method of the study and were invited to participate in the discussions. A total number of 40 midwives (all women) and 28 doctors (including 2 men) volunteered to take part, which represented the large majority of

all staff working at the abortion clinics. They were divided by profession into eight groups with 6-10 participants in each. FGD participants' ages ranged from 25-50 years of age with a mean age of 38 years. Almost all the participants were married and many had teenage children. The FGDs were held in a conference room at each facility, lead by a Vietnamese moderator experienced in the conduct of FGDs. On an average, discussion lasted one and a half hour. The first author (MK) participated as an observer in all eight sessions together with a translator. Field notes were taken during discussions, noting the interaction of the participants and the general atmosphere in the groups. All FGDs were tape-recorded. After each group discussion the research team met to discuss any unclear points and raised issues of special interest, which were then fed into the next FGD (20).

### **Data analysis**

Qualitative content analysis was used to analyse data. The tape-recorded FGDs were transcribed in Vietnamese and translated into English by a professional translator. As the language structure of Vietnamese and English are very different, word-by-word translation is impossible and it may be difficult even for an experienced translator to capture the full meaning of the original text. To compensate for this, the research group spent considerable time comparing the translated transcripts with the original text and discussing its meaning. Reading and re-reading the text, open codes were applied by two of the researchers independently and similar codes were grouped into sub-categories. These were then compared between the researchers, modified and expanded during analysis (21). Two main categories were defined: (a) barriers to providing quality abortion counselling and care for adolescents, and (b) values and attitudes toward adolescent sexuality and abortion. In the analysis we have attempted to highlight diversity within and between the groups and to identify emerging themes and underlying meanings in their socio-cultural context (22).

### **Ethical consideration**

Participation was voluntary and participants were informed that all data would be analysed and presented group wise to avoid individuals being recognised. Research permission was granted from the Ministry of Health in Hanoi, the Quang Ninh health

authority, the Uong Bi General Hospital (UBGH) directorate and from the research ethics committee at Karolinska Institute, Stockholm, Sweden.

## **Findings**

We first present findings from the non-participatory observations conducted at the abortion clinics, followed by findings from FGDs. On the topic of barriers to quality abortion care, we present participants' views on general qualities and characteristics of abortion services and contraceptive methods, and what they consider particularly important, appropriate or inappropriate for adolescents.

### **Observations on abortion services**

Women arrived early in the morning to the abortion clinics for registration and examination. If there was no contra-indication for an abortion, the procedure was performed within one hour. The abortion, which usually took around 15 minutes, was performed using MVA as the main method at all three study sites apart from one clinic, which lacked sufficient equipment and had to resort to using D&C for the last clients. Pain relief was given in different forms. The most commonly used analgesic was Paracetamol in tablet form given prior to the abortion procedure and a Para-cervical block (PCB) with local anaesthetics. An injection of morphine was given to women who were the last to have an abortion procedure, to substitute for local anaesthetics, which were often finished at the end of the day.

Observations at the clinic indicate that the women/clients were treated respectfully but there was a lack of both privacy and time. At the two hospital clinics interaction between health care provider and client was minimal and dominated by one-way communication with the women answering questions. The women were not encouraged to be active in discussions and few of them asked questions. All women stayed at the clinic for post abortion care (PAC) for about half an hour, but in reality few of them were examined. All women were provided with a prescription of antibiotics before being discharged after the abortion but few of them seemed to get any information about contraception. The MCH clinic differed from the hospital clinics in that they provided individual counselling in privacy to all women before abortion.

## **Barriers to the provision of good quality abortion care and counselling**

### *Technical skills and equipment*

The major components mentioned for the provision of high quality abortion care were in order of importance; (a) technically skilled providers who could conduct safe abortion procedures, (b) availability of standard equipment to perform a safe abortion, and (c) adequate provision of pain relief.

Some of the participants stated that they often had to use old equipment and technique, such as curettage, which they felt were more painful for the women than MVA. Several of them stressed the fact that the poor access to new equipment was a barrier to assure safe abortions. Participants also raised the need for new methods of pain relief in abortion services.

### *Convenient abortion services e*

Other than technical deficiencies, some of the initial barriers identified by participants in providing good quality abortion care were the long waiting times due to a very detailed medical record taking, and the lack of privacy. These were considered general problems, but acted as disincentives particularly for adolescent clients, as they were concerned about the need to remain anonymous and get the procedure over with as quickly as possible. It was suggested that in order to attract more adolescent clients from the private clinics, waiting time at the public clinics should be reduced and the administrative procedures simplified. Separate rooms for the unmarried were other suggestions for how to make them choose public rather than private clinics which, according to several of the FGD participants, provided less safe services.

### *Creating confidence*

According to many participants the most important thing in counselling adolescents in connection with abortion was to listen to women with respect and empathy. The group of midwives from the MCH clinic in particular stressed the importance of providing a friendly initial reception and sufficient time to make the women feel confident. This was thought to be essential especially when meeting adolescents the first time, as stated by one group of midwives:

*The young people who come to us are normally shy, we need to respect their feelings and gradually find out reasons for the pregnancy. We can then discuss and advice*



*them about contraception. But their secret should be kept safe.... We need time when we counsel our clients because we have to talk to them individually. For a Vietnamese it is very difficult to confide in a person you don't know well, especially when it comes to such personal matters. Therefore, time is an important factor.*

Several barriers to providing good counselling were brought up in a group of doctors from hospital setting:

*In fact, doctors and midwives are busy with professional tasks, which give us little time to give detailed counselling. We do not have a separate room for counselling and therefore it has to be integrated in examination and abortion procedures. The problem is not only the lack of time. We do not know how to give effective counselling.*

Discussing how counselling should ideally be provided, most participants wanted it to take place in a separate room with one client at a time. Someone suggested that group counselling, gathering several clients with similar problems, could be an alternative way if there was a shortage of time for individual counselling. Clients with similar problems, especially adolescent girls or couples, could then share experiences and support each other. Counselling with the client's partner present was thought to be the best counselling situation.

### **Attitudes towards adolescent sexuality and abortion**

A strongly negative attitude towards pre-marital sexual relations was near unanimous in all groups. 'Healthy life styles' was an expression often heard in the groups and a vital component of this was seen as sexual abstinence before marriage, while its opposite, 'unhealthy life styles', was closely related with pre-marital sexual relations. One group of hospital midwives was particularly condemning and suggested that the best thing would be to forbid premarital sex altogether. The only slightly diverging views came from a group of doctors who said that as sexuality is 'a normal part of development', open communication about it would be beneficial. But even for those, the moral stance was clearly that it is preferable to avoid sexual relations before marriage.

*Warning of the dangers*

A major concern among participants was the perception of both premarital sexual activity and abortion as ‘dangerous’ and, consequently, that counselling should focus on warning young people of the danger and bad consequences of engaging in sexual relations before marriage. Especially midwives from the two general hospitals stressed this aspect:

*I think that first we should inform our clients about the risks of having premarital sex, then about abortion and its bad effects on their health and later fertility. Premarital sex also affects their studies. Adolescents should have a clear and healthy love, meaning to avoid premarital sex if they are not ready to marry.*

Despite these generally negative attitudes towards the behaviour of their young clients, there was a pragmatic approach among most doctors and midwives alike, saying that as one cannot forbid or prevent adolescent from engaging in sex, they need to be given support and information to avoid the ‘negative consequences of sex’. What exactly the information should be about was a point of contention in many discussions. Some maintained teaching ‘good morals’ first, stressing the value of chastity before marriage to ensure a happy married life. Others were more inclined to advocate that adolescents should be taught what contraceptives are suitable for them and where to access them.

However, it was clear among the participants that they did not consider this to be their responsibility as members of health staff at an abortion clinic. Education and information to adolescents should be done by ‘society’, i.e. youth unions, schools, parents etc. As health workers at abortion clinics, the participants felt that their main responsibility was to warn the young women, and preferably the couples, of the dangers of abortion as a way to make them avoid an unwanted pregnancy in the future. One group of midwives explained how this was done:

*We often make use of their boy friends’ presence to show how hurt their girlfriends are after abortion and explain to them about complications and risks of abortion in order to threaten them.*

The danger and possible complications of abortion that the health workers wanted to instil in their young clients were primarily the risk of becoming infertile, and of

‘getting hurt’. Whether this meant only the physical pain during and directly after the procedure, or also a more lasting ‘pain’ was not probed in our discussions.

#### *Opinions on contraceptive methods for adolescents*

Discussing suitable contraceptives for adolescents, opinions varied. ‘No sex is the best contraception’ was a logical point of view of those with the most negative attitudes towards pre-marital sex. The IUD was considered to be a good contraceptive method as such, but only for married women as the unmarried were thought to ‘have more sex’ if they had an IUD inserted. Some considered the contraceptive pills to be unsuitable for adolescent girls, partly because of their perceived negative effect on their future fertility and health (it was thought by some to cause cancer), partly because of inciting them to ‘have more sex’. Others thought the pill might be a good alternative for adolescents, but they were aware that the unmarried girls felt the pill to be inconvenient, as they needed to remember to take it every day and that it was difficult to hide from inquisitive parents.

Many considered the condom as the most suitable contraceptive for adolescents as it prevents not only unplanned pregnancies but also HIV and STD. But participants were aware that the use of condom was problematic. Several of them had met with young women coming for abortion, who had explained that they themselves wanted to use condoms but their boy friend did not approve.

Emergency Contraceptive Pill (ECP) is fairly new in Vietnam but was mentioned by some as a suitable method for adolescents, who have an irregular sex life. There was a general feeling among the participants that most providers, including themselves, lack knowledge of modern contraceptive methods. For example, opinions about ECP were divided; some thought it was not good for regular usage while others thought it could be taken up to four times a month or more. One group of midwives complained:

*How can we advise our clients when we don't have sufficient knowledge of modern contraceptive methods ourselves*

## **Discussion**

The barriers identified by FGD participants for the provision of attractive and high quality abortion care for adolescents at their own facilities, were basically technical and managerial (better equipment, shorter waiting time, less complicated procedures, separate rooms and more time for counselling). Participants expressed a need for more training in counselling skills and knowledge of adolescent reproductive health and contraceptive needs. With regard to content of counselling, the major theme emerging from the FGDs was that of the risk and danger associated with pre-marital relations and abortion. This was evident both in the way they discussed contraceptives suitable for adolescents and the alleged negative consequences of abortion. The 'danger' of pre-marital sex was expressed in the general idioms of the dominant moral climate of contemporary Vietnam, i.e. as 'unhealthy', 'bad for studies', with negative repercussions for future happiness in marriage, etc. Other research from Vietnam confirms that despite its apparent prevalence, premarital sex is still strongly condemned and considered as a degradation of Vietnamese culture. "The purity of youth is often seen as a symbol of the purity of the country, the culture and young women in particular are considered as guardians of 'traditional' moral values" (9). Thus, the negative attitudes among the FGD participants towards adolescent sexuality can be seen not only as a worry about individual behaviour and 'risk taking' but also about the dangers of disintegration of 'traditional' moral values and cultural identity (23).

Labelling adolescent sexuality as 'risk taking behaviour' is the most common perspective in societies where 'traditional' values and moral strictures against premarital sex prevail. As in our study, 'risk and danger' and condemning attitudes are the dominant messages reaching adolescents in many countries when their sexuality is at stake, whether in the family, at school or in their contacts with the health services (24). For example, one study from Ghana revealed how providers restricted the access of unmarried young people to reproductive health care, arguing that this was done in order to protect their culture and preserve traditional values (23). The consequences of the negative attitudes of the health providers' may expose adolescents to serious health hazards. It is well known that adolescents are more prone than married women to delay abortion seeking, to go to unskilled providers and/or to use dangerous methods of abortion, exposing them to higher risks of abortion related mortality and morbidity (1). Also in Vietnam second trimester abortions are thought to be more common in the young age groups (10). We have only anecdotic

information on the abortion care seeking of Vietnamese adolescents, but it is suspected that private clinics may in fact cater for most adolescent abortion clients. Participants from our study suggested that private clinics are preferred by adolescents due to the simpler administrative procedures and greater degree of professional secrecy. We suggest that the private clinics may also be preferred due to less judgemental attitudes from the providers.

This study has amply demonstrated the dilemma of health care providers in their meetings with the young unmarried women and couples coming to abortion clinics. Living in a culture which strongly emphasises the value of especially female virginity before marriage, the participants could but express their disapproval of pre-marital sexual relations. But they also demonstrated a pragmatic and human approach to their young clients. Many of them were parents of adolescents and might be struggling with contradictory norms and values in their own families. Preliminary results from a study among midwifery students in Vietnam (25) reveal that most of the students, whose mean age was just over 20, also had strongly negative attitudes towards premarital sex. This indicates that the contradictions between cultural values and social practice remain strong among the younger generation of future health care providers in Vietnam.

The Vietnamese National Standards and Guidelines for Reproductive Health Care Services underline the importance of providing adolescents with supportive and non-judgemental counselling (14) For this to come true there is a need not only to incorporate technical aspects of contraception and abortion into training programmes at all levels, which is the current emphasis, but also to make students and health care providers aware of the influence of their own attitudes and values. The basic training curricula for medical and midwifery students in Vietnam is almost entirely focussed on medical and technical aspects, while there is little attention to the moral, social and gender aspects of adolescent sexuality and reproductive health. Several international studies have shown that training health care providers in communication skills, including value clarification on adolescent sexuality and gender, remarkably improve the quality of care and counselling given to adolescents clients (26, 27, 28, 29).

In conclusion, it is evident that the counselling task of health providers in adolescent reproductive health services in Vietnam is a highly delicate and complicated one, which needs recognition. The contradiction between cultural norms and actual practice is rarely more acute than when the young generation challenges

the most intimate and cherished cultural value - the virginity of its youth, especially of its young women. Acknowledgement of the cultural and societal context of the health care providers and students is basic for understanding their attitudes and behaviour in adolescent counselling and care. We suggest that value clarification in education and in-service training programmes would help students and providers reflect on their own attitudes and moral values in relation to adolescent sexuality and its consequences. This would give them a better platform as professionals to face the challenges of adolescent reproductive health and rights in the rapidly changing socio-cultural environment of Vietnam today.

### **Limitations of the study**

Focus group discussions are considered the method of choice for exploring people's opinions, views and attitudes about a certain topic in an interactive setting, which capture how views are constructed and expressed (30). On the whole our focus group discussions were very lively and carried out in a friendly atmosphere. We had deliberately composed the groups to avoid hierarchical relations (doctors and midwives separately) and interaction seemed easy. However, as is common in the Vietnamese culture, the older participants tended to take the lead in the discussions, possibly bending these towards more 'traditional' views. Only two male participants were included in the FGD, both young and not very talkative. Thus, our findings represent mainly female perspectives. Research on male attitudes and among younger health providers would complement the findings of this study.

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