

## Family planning in Vietnam

A trial of nearly 32,000 quinacrine pellet female sterilisations in Vietnam needs to be seen in the context of a country in transition. Working in Vietnam since 1987 for various United Nations agencies I have witnessed the country's rapid transition from a centrally planned to a market-oriented economy. From being a rice importer, Vietnam has now emerged as a major exporter. After a period of political isolation it is now forming links with the international community. Sadly, the US embargo continues to hinder some investments needed to modernise, and the gross national product is still only around \$200 per head. It is within this context of low budgets and an increasing population of reproductive age, that the country has forged its population and family planning policies. The main objectives are small family size (preferably a two child family), a lower infant mortality rate, from 45 to 25 per 1000, lower child malnutrition rates from 50% to 25%, reduced maternal mortality from 120 to 50/100,000, increase in contraceptive use by 20% from its present rate of 33%, and reduction in fertility rate from 4.0 to below 3 by the end of the century.

There is a strong awareness that, without voluntary but vigorous family planning, the population could double to 170 million within 30 years. The government has trebled its population and family-planning budget, but this still amounts to only 15 US cents a head, while neighbouring countries are said to spend 6–10 times as much. Vietnam may need to spend 60 cents per head to achieve its goals. Even with international donor support Vietnam's budget for population and family planning is tiny.

The search is on to broaden the range of family planning methods currently in use. In 1990 there were reported to be about 1 million abortions, another million insertions of intrauterine devices, around 223,000 pill users, and 23,000 sterilisations. Menstrual regulation is legal and free, and is available in communes where there is a three-year trained health worker. Research is in progress in Ho Chi Minh City on injectable and implanted contraceptives. Acceptance of male sterilisation is said to be increasing. Longer term government policy emphasises increased local production of some contraceptives, including condoms.

The context in which field trials of quinacrine pellet non-surgical female sterilisation have been carried out in Vietnam is multifaceted. In the study by Hieu and co-workers, physicians and midwives trained in IUD insertion were used. Vietnam is currently in the throes of a major overhaul of health manpower and health facilities. It may in future be possible to have one full-time health professional to act as family planning focal point at every commune health station. If quinacrine pellet sterilisation were to be offered on a wide scale, there would, theoretically be no shortage of health staff trainable in such a procedure. However, there are weaknesses in district level health services, including family planning, and problems also in providing health staff with continuing education. Another issue is standard of sterility in the health facilities where this procedure would be done. Further research is also required—for example, on the effects of insertion technique, on the efficacy of quinacrine pellet sterilisation, and on concentration of quinacrine in the uterine cavity in relation to placement and efficacy.

It is thus within a complex web of issues that Vietnam is exploring the use of quinacrine pellet female sterilisation. Financially, this method is attractive. The cost of quinacrine and supplies for two insertions is reported to be less than \$1. The field trial also suggests that around 242 maternal deaths may have been averted during the study. Hieu *et al.* estimate that 1300 clinicians doing 100 or so quinacrine pellet insertions sterilisations a month could meet Vietnam's unmet need for female sterilisation. That could be an important contribution to the country's family planning needs in an era of economic development and modernisation.

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in Namha Province of 0.13% among 18,000 IUD users.

5. There was variation in pregnancy failure rates between studies for those using two insertions, ranging from 0.95 ( $N=105$ ) to 4.54 ( $N=710$ ) per 100 women at 12 months. For all two insertion studies, which were censored to have at least 50 cases at risk at 12 months, the rate was 2.63 ( $N=9461$ ).
6. Further analysis of pregnancy failures by operator experience in two Namha Province studies ( $N=4010$ ) showed that while small experience with quinacrine pellet insertions resulted in higher failure rates, those clinicians who had experience of more than 10 insertions who had failures had mean failure rates that were similar regardless of experience.

This suggested that there was something about their insertion technique or patient selection that contributed to pregnancy failures. We believe two insertion techniques were mainly used. Our recommended procedure was to pass the inserter to the fundus, withdraw it 1/2 cm and then push the inserter plunger. This would deposit all pellets at the fundus. The other technique was the copper T insertion technique which would result in a column of pellets from the fundus extending toward the lower uterine segment. We suspect this difference in insertion technique may account for variation in failure rates among studies.

7. Assistant doctors and the midwife among inserting clinicians had a crude pregnancy failure rate lower

- than that of senior doctors, 3.0 vs. 4.5%, respectively.
8. Among a total of 818 pregnancies in the field trial, 80 were carried to term. One was an anencephalic fetus conceived 2.5 months after insertions of quinacrine. There was one stillbirth conceived 11 months after quinacrine insertions. One baby was delivered proterm and died. The other 77 deliveries resulted in normal infants who remained well.
  9. All insertions in early pregnancy were terminated by menstrual regulation except two; one resulting in an ectopic pregnancy and the other delivery of a normal infant after the study cut-off date.
  10. Side effects as reported in one Namha Province study ( $N = 508$ ) were mild and transient.

Any country or organization is free to add its own value judgements to a risk-benefit standard. They will generally raise the cost and time to complete contraceptive research. The adoption of North criteria for contraceptive research based on risk-benefit analysis of the North is inappropriate for South countries<sup>30</sup>.

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