



Child Survival 18 – Vietnam Fourth Annual Report

*Building Partner Capacity for Child Survival
Among Vietnamese Ethnic Populations*

**Dakrong and Huong Hoa Districts
Quang Tri Province, North Central Region, Vietnam**

**Cooperative Agreement No.: HFP-A-00-02-00044-00
1 October 2002 – 30 September 2007**

Prepared and Edited by:

Charlie Kaften, Country Director, SC/Vietnam
Pham Bich Ha, Director for Health, SC/Vietnam
Tran Thi Kiem, Project Manager, SC/Vietnam
David Marsh, Senior Child Survival Advisor, SC/Westport, CT

Save the Children Contact Person:

David Marsh, Senior Child Survival Advisor
54 Wilton Road, Westport, CT 06880
Phone: 203/221-4000
Fax: 203/221-4056

Submitted to USAID/GH/HIDN/NUT/CSHGP
October 31, 2006

TABLE OF CONTENTS

Acronyms	3
A. Main Accomplishments	5
B. Factors Which Have Impeded Progress	10
C. Technical Assistance Required	10
D. Changes from the DIP in Program Planning and Implementation	10
E. Monitoring Plan	11
F. Sustainability	12
G. Specific Information	12
H. Projects in Their First Year	12
I. Project Entering the Final Year	13
J. Family Planning Support	13
K. TB Programs	13
L. Program Management System	13
M. Mission Collaboration	14
N. Timeline of Activities	15
O. Result Highlights	15
P. Does Not Apply	16
Q. Other Relevant Aspects	16
R. Publications/Presentations	16
Annex 1 Project Targets from the DIP and Revision after MTE	17
Annex 2 MTE Amendment Documents	18
Annex 3 Routine Monitoring Data October 2005- July 2006	53
Annex 4 Updated CSHGP Data Form	60

ACRONYMS

ANC	Antenatal Care
BCC	Behavior Change Communication
BEOC	Basic Emergency Obstetric Care
BF	Breastfeeding
CBO	Community Based Organization
CDK	Clean Delivery Kit
CG	Community Guide
CHC	Commune Health Center
CHW	Commune Health Worker
CM	Community Meeting
CS	Child Survival
CSHGP	USAID's Child Survival and Health Grant's Program
DHS	District Health Services
DIP	Detailed Implementation Plan
EBF	Exclusive Breastfeeding
ECCD	Early Childhood Care and Development
ENC	Essential Newborn Care
GMP	Growth Monitoring Promotion
HCMC	Home Care for Mothers and Children
HF	Health Facility
IMCI	Integrated Management of Childhood Illness
INGO	International Nongovernmental Organization
LU	Living University
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information Services
MNC	Maternal Newborn Care
MOH	Ministry of Health
MSG	Men's Support Group
MTE	Mid-Term Evaluation
NERP	Nutrition Education and Rehabilitation Program
NGO	Nongovernmental Organization
OR	Operations Research
PATH	Program for Appropriate Technology in Health
PD	Positive Deviance or Positive Deviant
PDI	Positive Deviance Inquiry
PD-plus	Positive Deviance - plus
PHS	Provincial Health Services
PLA	Participatory Learning Action
PVO	Private Voluntary Organization
PW	Pregnant Women
RTCCD	Research and Training Center for Community Development
SBFG	Supportive Exclusive Breastfeeding Group
SC	Save the Children Federation, Inc.
SNL	Saving Newborn Lives Initiative

SS	Supportive Supervision
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
UN	United Nations
USAID	United States Agency for International Development
VNFO	Vietnam Field Office of Save the Children
WHO	World Health Organization

A. Main Accomplishments

During the past year, significant progress was made toward meeting all of the following objectives in the 34 Project communes of Dakrong and Huong Hoa Districts:

- Increased access to, and use of, maternal, child and newborn health services;
- Improved quality of health services at health facilities and at the household level;
- Increased practice of key household behaviors for maternal, child and newborn health; and
- Contributions to the sustainability of Project activities beyond the initial intervention phase.

The results monitoring tables (See Annex 1) show that several key results have been achieved. The Project has a good Monitoring and Evaluation (M&E) system to collect data and to help Project counterparts to interpret and use data for planning and improving interventions.

The Project Mid-Term Evaluation (MTE) was conducted in October 2005. Based on MTE findings and recommendations, aspects of the Project were revised to ensure the quality and effectiveness of strategies and to help government counterparts plan for Project sustainability and expansion following the close of the Project at the end of 2007 (See Annex 2 for amendment documents).

The following activities contributed to this year's achievements:

1) Improved Maternal Child Health (MCH) services provided by health staff and caring practices for mothers and children at household level

a) Improved commune health center and home-based maternal and essential newborn care services

This year the Project trained 16 additional commune midwives and commune health staff on maternal and essential newborn care. All 78 commune midwives and health staff in the two districts have been trained. These midwives are now equipped to provide proper maternal care for mothers and immediate care for newborns in each hamlet. In addition to providing assistance at birth, trained midwives are able to support Community Guides (CGs) when facilitating Community Meetings (CMs), especially those related to the immediate care of newborns.

b) Strengthened supervision skills of commune and district staff

During the MTE, it was identified that commune midwives lack the necessary skills to provide on-the-job training through the supervision of activities in hamlets and communes. To address this gap, the Project conducted two training courses on Supportive Supervision (SS) for 36 commune midwives. The training also improved midwives' capacity to provide more effective support of Behavior Change Communication (BCC) interventions at community and household levels.

c) Strengthened facilitation skills of Community Guides

One of the weaknesses of the Project, as identified in the MTE, was the passive participation of group members attending community meetings. In response, the Project provided Participatory Learning Action (PLA) training courses for CGs. The PLA tools helped improve the facilitation skills of CGs to make group meetings livelier and more stimulating. This year, 399 CGs were trained on PLA and are now using PLA tools, such as making a map for each hamlet to closely monitor malnutrition and Pregnant Women (PW).

d) Improved nutritional status of children

The issue of deworming children aged from 12 – 24 months is still pending. Although the Project is able to disseminate this message during discussions of deworming at CMs as recommended by WHO, deworming of children aged 12 – 24 months is not allowed because the Ministry of Health's (MOH) deworming guidelines only allow for deworming children age 5 and older who are in school. In order to address this, Save the Children (SC) and WHO organized a workshop in April 2006 with stakeholders from the central level, including the Reproductive Health Department, the National Institute of Nutrition, the Preventive Medicine Department, the Institute of Malaria and Parasitology of Hanoi Medical School, WHO, UNICEF, and leaders from Quang Tri Province, Huong Hoa and Dakrong Districts, to discuss the deworming of children aged 12 to 23 months. At the meeting, CS-18 partners presented data from Project sites about the danger of worms and their impact on child growth and development.

In June 2006, the Project supported district partners to organize a mass deworming of children aged 24 - 56 months. This activity was integrated into a campaign for Vitamin A supplements for children ages 2 - 5 in Dakrong and Huong Hoa. A total of 7,444 children (96% of 2-5 year olds) were dewormed at that time. The results of the deworming were successful, and no children experienced complications. Moreover, given the high coverage achieved, a very positive model was established as local partners and community members were able to see firsthand that there were no side effects or complications. As a follow-up to this activity, Save the Children and WHO need to continue advocating with the MOH to apply the guidelines and implement a deworming strategy as part of Vietnam's nutrition program. The second round of deworming is planned in Quang Tri in December 2006.

e) Initiate Supportive Exclusive Breastfeeding Group (SBFG)

Based on the MTE recommendations, coupled with the persistently low exclusive breastfeeding rates in Vietnam, SC initiated a new approach – the creation of Supportive Exclusive Breastfeeding Groups (SBFGs). The Project supported Community Guides to organize supportive exclusive breastfeeding groups in Huong Hoa District. The initiative was piloted in two hamlets starting in June 2006. The group, comprised of all lactating mothers with children under 12 months old, and pregnant women in their last trimester, met every two weeks. To date, 23 mothers (100% of the eligible women) have joined the two SBFGs. One mother in the group was nominated as a leader to facilitate group discussions, and the commune midwife participated in the group to support the facilitator.

Ways to help mothers continue breastfeeding while working were discussed and practical solutions elaborated. One solution identified was for mothers to express milk and leave it at home for their children when going to work. Mothers discussed and learned from each other how to express their milk and how to keep milk fresh at home. Many barriers were also discussed, such as ants getting into the milk; dogs or cats drinking all milk; and the milk becoming sour. Because all mothers are lactating and know each other, they talked naturally and openly and were able to practice on themselves without feeling shy. The Project provided some bowls and a pan for keeping the expressed milk at home.

The women received valuable information and skills from the SBFG as well. Five pregnant women and one had recently given birth, joined the group and have been exclusively breastfeeding for two months. In order to help mothers provide optimal nutrition for their

children, mothers with children who are 6 months old, were given instructions on safe weaning so that they could keep breastfeeding while introducing complementary feedings. This activity will be assessed and plans for replication will be discussed during a review planned for September.

f) Promote male involvement

In April 2006, a Men's Support Group (MSG) was established in Dakrong and Huong Hoa. The group, comprised of husbands and fathers-in-law in the hamlet, meets every three months to discuss issues of antenatal care (ANC), breastfeeding, family planning, and child nutrition. The main discussion focuses on how to support their wives, daughters, and children so that they receive the optimal care possible. As a result of men's involvement, some families have allowed women to work in the fields close to their houses so the mothers can go home, or family members can bring their babies to the field for breastfeeding in the middle of the work day. Other families have let mothers stay at home for three months to promote exclusive breastfeeding. This is a significant change in the life of women in this minority community.

2) Improved Management Information System (MIS) for the Project

A data collection and analysis system has been established with specific forms and flow of information from the hamlet level upwards. Hamlet health workers make monthly reports and send them to Commune Health Centers (CHC). Commune health staff process this information and send a summary report to the District Health Services (DHS). Staff from the Vietnam Field Office of SC (VNFO) collects the data every month from the DHS and further analyzes it for monitoring purposes (please see Annex 1). We will also seek to integrate this MIS into the health system in a sustainable way.

The Project is in the process of implementing operations research (OR) to assess if the CMs and SBFGs are accepted by women and the community, in order to identify any barriers and enabling factors which impact the success of the groups. The process of collecting, recording and analyzing data from the operations research will also help Project counterparts to improve the efficiency and effectiveness of interventions.

3) Strengthened partnership with, and commitment from Quang Tri Province for program sustainability after Project phase out in 2007

One of the most significant accomplishments of the past year was to strengthen an already close relationship with our District and Provincial partners. We gained support not only from the health sector but also from the leaders of other sectors and departments, including the People's Committee (the local administrative authority), the Education Department, the Women's Union, the Farmer's Association, the Population and Family Planning Network, and the military. Stakeholder support is critical to success in border and mountainous districts with a high proportion of ethnic minorities. The commitment and support from the Quang Tri Provincial Health Service (PHS) is strong. For example, the PHS is planning to provide half of the iron pills and all Clean Delivery Kits (CDK) needed for pregnant women in Dakrong and Huong Hoa Districts next year. This commitment was announced at the sustainability workshop with different Project partners and stakeholders organized in January and March of 2006. The plan to make "model communes" in Dakrong and Huong Hoa, as a practical/real-life training site for other districts in the province, was also shared at the workshop.

4) Implementation of Project activities.

Please refer to Table 1 (below).

Table 1. Year 4 Accomplishments

Project Objective	Key Activities (Project revision after MTE)	Status	Comments
Increased health service accessibility and quality	Train commune midwives on Maternal Newborn Care (MNC), conducted by district trainers (last course for 16 commune midwives)	Completed in April	
	Strengthen referral system: <ul style="list-style-type: none"> - Installed telephone for DHS and CHCs - Ensured staff 24 hrs/day, 7 days/week; mobile support to CHCs for Basic Emergency Obstetric Care (BEOC) and newborn complications Established a referral register for referrals between CHCs and DHS	By July, 2006, 19 telephones were installed in CHCs.	17 CHCs could not have a telephone installed as telephone lines have not reached these communes The district partners committed to contribute some funds to install wireless telephones for these communes through the end of 2007
	Develop and distribute a package of protocols for MNC as an MOH daily guidance for commune health staff	Completed in April	This package, kept at CHCs, is helpful guidance for commune health staff
	Supplying <ul style="list-style-type: none"> - Provide essential equipments for 9 health centers in phase four communes. - Provide iron pills and urine tests CDKs for CHCs as planned 	<ul style="list-style-type: none"> - Done - Done 	Partners committed to contribute : <ul style="list-style-type: none"> - 50% iron pills needed in 2007 and 100% in following years - 100% CDKs needed for 2007 forward
	Deworming for children from 24-59 months old	Completed in June	7,444 children (96%) 24-59 months were dewormed. Another round of deworming in December 06
	Set up outreach ANC at 68 remote hamlets	Completed in Aug.	These activities will be monitored closely in the coming months
Increased practice of key household behaviors on maternal and	Conducted training for CGs on “Interpersonal communication skills”	Continuing in phase four communes	Completed training for phase 3 communes Phase 4 commune will be completed in September

Project Objective	Key Activities (Project revision after MTE)	Status	Comments
child care; Increased use of maternal and child care services	Conducted Training of Trainers (TOT) for 32 district trainers on PLA and roll-out training on PLA for Community Guides by trained district trainers.	Completed at phase 1,2,3 communes.	Continuing training for phase 4 communes
	CGs conduct monthly Growth	On-going	Will be continued by local partners
	Monitoring Promotion (GMP) for children under 2 years old		when project is completed
	Conduct Nutrition Education and Rehabilitation Programs (NERPs) in selected villages (in DaKrong only)	On-going	NERP will be continued in some villages using revised criteria.
	Carry out CMs in 14 Home Care for Mothers and Children (HCMC) topics in all communes	On-going	
	Conduct Men's Support Group meetings (quarterly)	On-going	This new initiative started in April 06
	Pilot BF support groups (in Huong Hoa)	On-going	The groups will be reviewed in Sept 06 before expanding district wide
	Conduct home visits to malnourished children and pregnant women.	On-going	More focus on supporting rehabilitation for malnourished children at home, and refer children to health facility if no improvement in child's nutritional status
Improved sustainability of all activities through partnership strengthening and capacity building	Conduct sustainability workshops with Local Partners at district and province levels.	Two workshops with two districts held in April One workshop with province in March	
	Train commune midwives on MNC, conducted by district trainers (last course for 16 commune midwives)	Meeting every two months Training courses were completed in August	Province planned to have all district staff trained on supportive supervision to build capacity of commune level staff in other districts in the province
	Support and strengthen selected training sites on Behavior Change Communication (BCC) interventions that will serve as models for medical students from other districts and provinces.	Planning and selection process is underway.	Selection criteria will be developed in Sept 06; strengthening and preparation of training sites will follow

5) Additional factors that have contributed to achieving these accomplishments

Local partners are committed to implementing the Project. During the implementation planning process, VNFO staff worked closely with partners and listened carefully to their ideas rather than imposing their own. However, VNFO staff used evidence-based approaches to introduce new concepts or methodologies to win their support during the redesign of the Project, after the MTE.

Positive relationships with the partners and the successful negotiations for redesigning the Project were primarily due to the efforts of the Project Manager, who assumed her new role only 1½ years ago.

B. Factors Which Have Impeded Progress

- The MTE response process delayed implementation. In order to address the recommendations and to respond to USAID's questions and concerns, SC had to spend additional time revising strategies and discussing revisions with partners. This process took approximately three months of the reporting period. However, the resulting revisions to the Project design have improved the quality and effectiveness of the strategies.
- The Project is entering phase 4 communes this year, most of which are very remote and difficult to reach, making it costly and difficult to deliver high quality programming in a timely manner. Because of this, Huong Hoa District and Quang Tri Provincial partners have asked to eliminate the seven least accessible hamlets (of the 80 from the Project design). These seven hamlets are 10-30 kilometers from the commune center, they can only be reached by foot, and there are few families living in them. Partners have committed to serve these seven hamlets after the close of CS-18, once they have gathered experience from the other (moderately inaccessible) phase 4 communes. SC would remain a resource for partners as they attempt to reach these remote communities. The decision to eliminate hamlets remains under review.
- The MOH restructured the health system, dividing district health services into two units (District Health Service and District Hospital). During the division, some of the Project's implementers (e.g., district trainers and supervisors) were shifted under a new management structure and removed from the project. As a result, the partners identified new implementers for whom SC conducted supervision training.

C. Technical Assistance Required

Dr. David Marsh from SC/Westport has provided invaluable support for the Project, including: technical assistance (TA) for overall implementation; an in-depth visit to the Project site; developing the training manuals; conceptualizing and guiding the application of the PD-Plus approach; designing the Operations Research; and developing a monitoring and evaluation plan and tools. His ongoing support is needed to continue meeting the Project objectives.

D. Changes from the Detailed Implementation Plan (DIP) in Program Planning and Implementation

1) Change in the nutrition strategy

As recommended by the MTE, workshops with counterparts in Dakrong and Huong Hoa were organized to thoroughly discuss and revise the nutrition strategy for each district.

NERP sessions are now being implemented in the villages where all three of the following criteria exist:

- The malnutrition rate is higher than 30%;
- The village has at least 6-12 malnourished children in channel B (less than -2SD), C (less than -3SD) and D (less than -4SD); and
- Houses in the village are not too scattered.

According to the revised strategy, NERP sessions will now last for 9 months and will occur 12 days per month. If a child does not show a sign of weight gain while participating in NERP, he/she will be referred to the CHC to check for any physical health problem.

For villages that do not meet these criteria, partners agreed that the intervention would not use the NERP strategy, but rather focus on:

- Regular GMP to help mothers check their children's growth and learn about feeding and caring for them at home;
- Home visits to malnourished children to enhance proper feeding at home; and
- Deworming for all children twice a year, and continued advocacy for deworming under-two year olds.

2) Request for no cost extension for subgrant with Huong Hoa and Dakrong District for two months

As planned in the DIP, a sub-grant agreement with two districts will end in March 2007. However, due to the delays caused by government approval for phase 3 start-up and by the MTE process, a number of activities will still be pending at that time. As a result, the VNCO is requesting a no-cost extension for these sub-grants until May 2007.

E. Monitoring Plan

A data collection and analysis system exists, which involves hamlet health workers submitting monthly reports to Commune Health Centers. Commune health staff process the data and send a summary report to the District level. SC collects the data every month and further analyzes them for monitoring purposes. VNFO staff have developed an Excel data analysis program to automatically calculate key project indicators and their change over time compared against targets. This enables staff to analyze monitoring data in many ways with different variables, with minimal time and effort. One reason that partners did not previously use data for decision making is that the analysis was too cumbersome relative to staff capacity and time. The new data analysis capability will encourage and enable partners to analyze data and use it for decision making on a regular basis. Because this Excel program is easy to use, project partners with limited computer capacity will only have to enter the data and the program will automatically run the analysis, saving time. Project staff use the findings from quarterly data analysis to identify problems and areas which need improvement, give feedback to project partners (through regular Project Steering Committee meetings), and discuss the reasons and solutions. Data were also used for supervision planning.

For instance, through quarterly monitoring data, we found out that the percentage of mothers receiving at least three ANC visits during pregnancy had not yet reached the target of 70% and had not changed much over time. Monitoring data also indicated exactly where the problem occurred. Based on this, Project staff planned and conducted supervision trips to communes with low

coverage of ANC visits, and discussed this with Commune midwives and Project Steering Committee members. As a result we discovered that outreach pregnancy check-ups were not easily accessible due to the location and times held. The possibility of new venues which were closer to isolated hamlets, and combining pregnancy check-ups with community meetings when a lot of mothers were present, were discussed as ways to address this.

Another example of the use of data was in piloting Breastfeeding Support Group activities. Based on data, we found that the status of exclusive breastfeeding in the two pilot hamlets had improved a great deal. This provides strong evidence for the effectiveness of the activity. (Please see Annex 3 for additional information.)

F. Sustainability

The sustainability of key program components, such as the provision of iron tablet, CDKs, and the monthly incentives which CGs receive and are currently provided by SC, faces challenges. SC has been discussing these issues with province and district authorities who have committed to providing long-term support to the program's continuation in these two districts. Quang Tri partners have planned to provide 50% of the iron pills and 100% of CDKs needed in the two districts in 2007. Starting in 2008, the province committed to provide 100% of the iron pills and CDKs for these two districts. However, additional workshops will be organized with Quang Tri partners during the coming year toward the end of the project to emphasize their responsibility for the long-term sustainability of the project in Quang Tri.

An additional strategy that will be utilized to promote sustainability is an adaptation of a modified Living University approach - "model" communes. Such communes are those that are successfully implementing the various components of CS-18. The identification of these locations has already taken place in Dakrong, where provincial staff have begun documenting the successful story of one such commune. Project staff will work with partners to ensure that the models become places for experiential learning, thus fulfilling the basic premise of the Living University. These model communes will extend beyond CS-18. In fact, provincial officials have already committed to this and have agreed to fund travel costs related to supervision and support to ensure that the models are running well. SC will confirm the selection of model communes through both quantitative and qualitative (routine monitoring and operations research data) information sources. CS-18 staff will provide extra support and supervision to the selected model communes to ensure that, in fact, they are optimal sites for experiential learning. To further support the model communes and the learning they can encourage, the project has produced the curriculum, training materials, and skilled training teams. Several potential sites have been identified and requests from potential users have been received.

G. Specific Information

Not Applicable

H. Projects in their First Year

Not Applicable

I. Projects Entering the Final Year

Other than the need for a no-cost extension for partner sub-grants, the Project is on track and expected to end on schedule. Strategies toward sustainability and expansion, as described above, are making good progress and will continue to be implemented to ensure the continuation of activities and results after the project closes.

J. Family Planning Support

Not Applicable

K. TB Programs

Not Applicable

L. Program Management System

1) Financial management system

The sub-grantees' capacity in financial management has been strengthened. SC's finance team conducted an audit in Huong Hoa in order to help them strengthen their financial management system. Despite these efforts, sub-grantees continue to feel the amount of work for monthly financial monitoring is burdensome.

2) Human resources

As the project has expanded into 34 communes, more supervision has been needed to provide support to activities implemented in the hamlets. A full-time Project Assistant was recruited in June 2006 to support monitoring and to assist the Project Manager in managing the project.

A new Director of Health, Pham Bich Ha, was recruited in August 2006 to lead Save the Children's health sector and provide direct support to the Project Manager. The new Director was a Save the Children staff member when the CS-18 project was designed and hence has the institutional memory and experience to help lead this initiative.

3) Communication system and team development

CS-18 Project staff participated in a three-day mini-course on M&E conducted in February 2005 by David Marsh, the Senior Child Survival Advisor from SC/Westport. This training prompted Project staff to focus much-needed attention on developing and operationalizing an information system to track CS-18 progress and provide data to serve as the basis for project decision making. The training also led to stronger support for using routine MOH service statistics and the development of supervisory check-lists, which in turn have informed Quang Tri Province's supervisory system in the health sector.

A one-week communication skills building training workshop was also conducted during the reporting period. This training helped CS-18 staff to improve capacity related to listening skills, negotiation skills, and time management.

4) Local partner relationships (How is the Private Voluntary Organization (PVO) doing as assessed by the local partner?)

SC maintains a very good relationship with local partners. Activities related to safe motherhood, newborn care and child health supported by Save the Children are all highly appreciated by Quang Tri partners. SC has helped Quang Tri partners not only to improve their maternal and child health care program but also to improve their capacity in planning, and M&E. The MOH at the central level also credits SC for effectively supporting the MOH's maternal, child and newborn care program in Vietnam.

5) PVO coordination/collaboration in country

SC collaborates closely with other key partners working to support the Government of Vietnam to improve the health of mothers and children. For instance, SC is part of a safe motherhood and newborn care working group, which is comprised of donors, United Nations (UN) agencies, international nongovernmental organizations (INGOs) and local NGOs. Additionally, Save the Children initiated a safe motherhood network in Quang Tri province. This network is comprised of PHS staff, INGOs and local NGOs working in Quang Tri. A current priority task for this group entails helping Provincial Health Services (PHS) roll-out national standards and guidelines for reproductive health.

6) Other relevant management systems

Not Applicable

7) Organizational capacity assessment

Not Applicable

M. Mission Collaboration

In Vietnam, USAID maintains an "Office" and has not yet upgraded to full Mission status. USAID Vietnam does not have a health program. Nonetheless, Save the Children has maintained close ties with USAID in Hanoi from the outset, including the design and submission of the initial proposal. A letter of strong support was submitted by USAID Vietnam with the proposal submission. Periodic updates are provided to both Daniel Levitt, formerly Health and Humanitarian Program Manager and now HIV Manager, and to Ngo Tien Loi, Development Assistant Specialist. Annual reports are routinely shared with Mr. Levitt and Mr. Loi.

Despite USAID not having a formal health program in Vietnam, both Mr. Levitt and Mr. Loi have been highly supportive of SC's CS-18 Project. In fact, Mr. Loi served as a member of the MTE team and visited the Project site with the MTE team. He also participated in subsequent meetings with partners and staff during which the CSHGP letter responding to the MTE was shared and responses formulated. USAID Vietnam is aware of, and was party to, the decisions made in response to concerns raised by the CSHGP MTE team. SC will continue to keep USAID Vietnam abreast of all key project issues and achievements for the remainder of the project.

N. Timeline of Activities October 1, 2006 - September 30, 2007

Activities	FY2007 (*)			
	Q1 (Oct - Dec)	Q2 (Jan-Mar)	Q3 (Apr-Jun)	Q4 (Jul-Sep)
Health services on maternal and child health care provided at health facility				
1. Install wireless telephone for the 17 remaining commune health centers				
2. Provide monthly maternal and child health care at health facilities and out-reach services at remote hamlets: ANC, delivery, postnatal care for mothers and newborns				
3. Deworming for children aged 24-59 months (**)	Dec,06		Jun 07	
Community based interventions (BCC interventions) on maternal child care in the community				
1. Carry out NERP in 9 hamlets				
2. Implement the BF support groups in selected villages				
3. Food demonstration in the hamlets where they don't conduct NERP				
4. Conduct community meetings, and men support group meetings in all hamlets				
5. Home visits, focusing on malnourished children and pregnant women				
6. Review breastfeeding support group	Oct. 06			
7. Carry out and expand BF support groups in to other hamlets.				
8. Carry out operation research on HCMC				
Project management and sustainability plan				
1. Supportive supervision to activities at hamlet communes.				
2. Monthly Project review meetings at communes				
3. Monthly review meetings of district trainers and supervisors				
4. Quarterly Project review meetings of District Steering Committee				
5. Workshop to discuss plan of action for Project model sustainability and expansion				
6. Conduct final evaluation			June 07	
7. Dissemination workshop for the final evaluation				
8. Project documentation				Sep. 07: Submit final evaluation to HO

O. Result Highlights

Not Applicable (We have provided innovative highlights in the past.)

P. Does not Apply

Not Applicable

Q. Other Relevant Aspects

1) Private donations (Every Mother Every Child) contributed \$ 20,000 to:

- Supply essential medical equipment for MNC activities and iron pills for pregnant women in two district hospitals and 15 commune health centers and polyclinics;
- Support the districts to implement a malaria prevention intervention; and
- Support OR on HCMC.

2) Japanese Social Development Fund is supporting the ECCD project in Dakrong District and contributed \$12,900 to the following activities:

- NERP;
- Training CGs on PLA and Interpersonal Communication Skills;
- Travel costs for district team;
- Iron pills for pregnant women and medicine for deworming; and
- Urine tests kits for pregnant women.

R. Publications/Presentations

Not Applicable

Annex 1

Project Targets from the DIP and Revision after MTE

Objectives & Original Targets	Baseline figure	Target achieved by July 2006	DIP Target revision after MTE
<i>MATERNAL & NEWBORN CARE</i>			
Mothers with TT-2	63.0	91.7	80.0
Communes support emergency referral system (telephone set up)	0	19/19* (100 %)	30%
Mothers whose newborns had clean cord cutting	41.0	96.6	70.0
Mothers received postpartum care	27.0	62.6	50.0
Newborns weighed at delivery.	49.0	83.0	70.0
Decrease by 10% in malnutrition among children 0-24 months	35.4*	33.2	31.8
Infants receiving appropriate complementary feeding	71.0	NA	80%
Mothers receiving iron folate pills during pregnancy	42.0	95.0	70.0
Mothers receiving postnatal Vitamin A	26.0	91.8	50.0
<i>BREASTFEEDING</i>			
Mothers who practice immediate breastfeeding	74.0	NA	80%
Mother who practice exclusively breastfeeding to children for 4 months	32.0	NA	50%
<i>ORGANIZATIONAL DEVELOPMENT</i>			
District and Commune supervisors who use supervision tools.	0		80%
Hamlet & Commune staff who use data for decision-making.	NA	NA	80%
CHC staff and HHWs who use MNC job aids	0	100%	80%
SC Working Papers disseminated:	0	2	Two
<i>SUSTAINABILITY</i>			
CS-18 approaches adopted by communes			
CS-18 approaches adopted by the Quang Tri Provincial MOH			
Two other Organizations in Vietnam adopt CS-18 approaches.			
A number of model communes built up by MOH			

* Baseline figure was 35.4 %, not 39% as incorrectly reported in the DIP (miscalculation); therefore a 10% reduction yields a target of 31.8%.

Annex 2
CS18 Mid-Term Evaluation: Amendment

April 20, 2006

David Marsh, Headquarters CS18 Technical Back-stop and Designer
Tran Thi Kiem, CS18 Project Manager, Vietnam Country Office
Vu Ngoc Khanh, M&E Officer, Vietnam Country Office
Nguyen Minh Phuc, Project Officer, Quang Tri Sub-Office, Vietnam Country Office
Matthew Frey, Director, Vietnam Country Office
Karin Lapping, Acting Technical Director, Vietnam Country Office
Pham Bich Ha, Former Health Advisor & CS18 Designer, Vietnam Country Office
Nguyen Anh Vu, Former CS18 Project Manager, Vietnam Country Office
Mr. Chau Van Hien, Director of District Health Center, Da Krong District
Ms. Pham Thi Nhan, Project Secretary, Da Krong District
Ms. Ho Thi Kim Cuc, Vice-Chair, People's Committee, Da Krong District
Ms. Nguyen Thi Tam, Project Secretary, Huong Hoa District

INTRODUCTION

Save the Children (SC) welcomes the opportunity to respond to the donor's request to clarify issues arising from the recently concluded Mid-Term Evaluation (MTE) Report of the project, *Building Partner Capacity for Child Survival Among Vietnamese Ethnic Minority Populations* (Cooperative Agreement Number HFP-A-00-02-0004400, 1 October 2002-30 September 2007). SC shares the donor's concerns about elements of both the evaluation document itself and the Project.

We, too, were surprised that the evaluation report was neither complete nor fully accurate. But upon reflection there are some likely explanations. The Project is complex (two districts, three sets of government partners, two NGO partners, three ethnic groups, four phases, etc.). In addition, the Project is innovative, testing "the next generation" of the positive deviance (PD) approach: "PD-Plus."

Moreover, the evaluation design faced several constraints. Most of the evaluation team's time was spent in remote corners of the impact area leaving little time to interview individuals in Hanoi who had institutional memory. Much of the time in the field was characterized by hours of hiking through rain, mud, and darkness and double-translation (Pakoh/Van Kieu <-> Vietnamese <-> English) in three unfamiliar cultures. The two SC members on the team were new-comers to the Project, and one had never been to Vietnam. English language skills and accent among Vietnamese key informants occasionally inhibited basic communication, let alone permitted detection of nuance or subtlety. The team interviewed neither the former Project Manager nor the Health Advisor, the two individuals most familiar with the Project. The first author of this paper, having been to Vietnam at least yearly for the past decade, can confidently assert that first impressions only approximate reality.

The foregoing constraints notwithstanding, SC (both headquarters and Vietnam Country Office) and MOH partners agree that the donor is correct to inquire about apparent document and Project short-comings. Indeed, we agree with the donor about some of its concerns.

METHODS

To respond to the donor's 11-point letter of February 1, 2006, we did the following:

- The Current CS18 Project Manager (TTK), M&E Officer (VNK), and Technical Director (now on maternity leave) devoted five days to prepare for the CS18 review.
- The SC headquarters Senior Child Survival Advisor (DM) made an unscheduled 8-day trip to Hanoi to work with the core Project team (TTK, VNK, NMP) and many others to address the donor's and the team's concerns.
- The Project team, the Country Office Director (MF), the Acting Technical Director (KL), and the Advisor (DM) worked for 4 days together and conducted extensive interviews with former Project Manager (NAV) and Technical Director (PBH).
- Provincial and district partners (CVH, PTN, HTKC, NTT) flew to Hanoi for a series of problem-solving meetings.
- The Project Team and Country Office Director flew to the impact area to finalize revised action and sustainability plans.

In total, we estimate that this response required 50 person-days and 7000 USD in travel and in-country expenses from scarce SC private resources.

This response has two parts. Part A consists of a review of Project highlights (pro and con) that the MTE captured and failed to capture. Part B is a point by point response to the donor's 11-point letter.

PART A: FIELD REALITIES VS. MTE REPORT

The MTE Report accurately captured some important aspects of the Project (Table 1). The first column of the table lists the main MTE conclusions that the response team agrees that the document fairly represented. We will not further discuss these unless they relate to one of the donor's 11 points (see Part B).

On the other hand, the MTE report incompletely or inaccurately characterized certain Project phenomena, which the response team wishes to clarify (Table 1, column 2). For example, CS18 stimulated SC's global Project Design, Monitoring and Evaluation (PDME) initiative to develop and present training modules to the whole SC Vietnam Country Office on project design, results monitoring, quality monitoring, activity monitoring, evaluation, and evaluative research during a 3-day workshop in February 2005. These, in turn, led to stronger support for using routine MOH service statistics and the development of supervisory check-lists, which in turn have informed Quang Tri Province's supervisory system in the health sector.

Several Project weaknesses were incompletely characterized in the report. We will address most in Part B, foremost among them, the PD/hearth strategy. Three others deserve mention here, though. The lack of a mid-term survey was a recurrent theme in the MTE report. We opted not to conduct this survey for several reasons. (1) Project operations research in Phase 3 was testing whether Community Guides could monitor behavior with a non-literate form administered during a post-partum household visit; thus, we had some information on household behaviors already. (2) The Project's PDME training (see above) resulted in more systematic use of routine MOH data, which permitted tracking proxies for use of health services and, of course, child weight for age. (3) The baseline survey was, in fact, two large surveys, one for each district, with sufficient power to describe both the Kinh majority and the minority populations in each. This was a huge undertaking for such a remote impact area. (4) Any household survey is costly in time, money, and focus. (5) The donor and the Child Survival Technical Support group seemed to have de-emphasized the need for this in recent years. (6) Finally, the Project is phased, with communes in each phase receiving approximately 12 months of intense activities, so selecting a sampling frame and interpreting findings would have been a challenge. Thus, with proxies for most of the key indicators available, we felt justified in omitting a costly, distracting mid-term survey.

Another weakness deserves brief mention. True, the use of three or more antenatal care (ANC) visits has not improved greatly, but the use of any ANC is extremely high. Moreover, the use of life-saving interventions delivered through or promoted at ANC (clean delivery kit, iron/folate, delivery by skilled attendant, delivery at health facility) is high. In other words, ANC is a delivery for critical interventions. It is not an intervention *per se*.

The final weakness to detail here concerns teaching facilitation skills. True, the Project may have over-reached in attempting to teach so much technical content plus the required community meeting facilitation skills, especially for PD-Plus (see below). On the other hand, the response team feels that Kinh Community Guides may have mastered the skills even if some minority guides have not. The current operations research is testing the feasibility of the approach in Phase 3, so a definitive assessment will be available within a year. Preliminary returns from recent supervisory

visits suggest that many Community Guides are, in fact, demonstrating complex facilitation skills (Tables 3A-B).

The third column in Table 1 lists observations that the MTE overlooked, most notably the 17 strengths in the top cell. We list these strengths in terms of Project-specific strengths, provincial effects, and national effects. First, this innovative Project is developing and testing approaches and tools (“PD-Plus,” behavioral monitoring, training video for facilitation skills) and providing promising graduate students access to its activities. Second, the Project already has achieved scale and/or sustainability within the seven districts in Quang Tri Province. Local television broadcasted Project BCC role-play competitions in Vietnamese and has plans to re-broadcast in minority languages. The Project stimulated a provincial Maternal and Newborn Care Network and informed provincial supervision for the health sector. The provincial MOH has requested a “Living University” site (see below) to aid teaching medical students. With leveraged support from SC’s Saving Newborn Lives Initiative, CS18 translated, adapted, tested, and scaled Essential Newborn Care to Quang Tri Province. With support of WHO, this ENC curriculum is reaching national scale. The Project co-funded a policy-informing anemia prevalence and cause study in the impact area. Other provinces are interested in the CS18 model: Nghe An Province conducted a study tour and video-taped community meetings. Counterpart International requested CS18 materials and manuals for consideration for Quang Binh Province. UNFPA is considering the model for several provinces. SC will use CS18 safe motherhood strategies in Da Nang and Khanh Hoa Provinces. Nationally, the MOH has invited SC to consult to inform Phase II of the national Safe Motherhood and Newborn Program and is considering SC as the managing partner for minorities within the Program. In summary, largely due to CS18, the government of Vietnam regards SC as an, if not the, expert in minority populations.

PART B: RESPONSE TO THE DONOR’S POINTS

Below, we reply point by point to the donor’s queries. We regret any repetition due to the overlapping nature of some of the points.

1. Provide a description that includes an assessment of the main accomplishments and progress made toward achievement of the five program objectives (see page 6 of the DIP).

Our response is two-fold: delivery strategy activities and results monitoring. Since most activities serve more than one result, we present them by intervention group (Table 2). We do, however, report results monitoring by the five project objectives from page 6 of the DIP (Table 4).

In summary, the maternal and newborn care delivery strategies are on track at the facility and community levels (Table 2). Main activities for health workers include adapting Safe Motherhood materials from earlier SC work in Da Krong; developing clinical training manuals, commune health center protocols, and BCC materials; and training 16 trainers who trained 64 health staff who now provide services and support community BCC activities. Activities for Community Guides include developing training manual (for trainers) and handbook (for Community Guides) on 14 maternal and newborn care topics, developing BCC materials, developing training videotape, and training 32 district trainers who trained 900 Community Guides, who now conduct community meetings.

The nutrition delivery strategies are similarly on track. Regarding child nutrition, CS18 has developed a training packet and BCC materials and trained 16 district trainers who train Community Guides, who now conduct 180 hamlet level PD/Hearths. Regarding maternal nutrition, CS18 has

procured iron/folate and supported 46 MOH delivery points, including 26 in remote hamlets. In addition, many community meeting topics and activities directly or indirectly promote child and maternal nutrition.

Quality monitoring for community meetings and hearths (Tables 3A and 3B) shows adequate performance in many areas, especially in conducting the new topic and booster PD inquiries.

Delivery strategies for immediate and exclusive breastfeeding are partially on track, especially through the strategies noted above (clinical training, hearths, and community meetings). Community meetings are a type of breastfeeding support group, although less intense than the La Leche League or other branded approaches. The remainder of the Project aims to strengthen the PD-informed approach to EBF, seeking to identify and learn from examples of the following PD families (husbands who modify requirements for new mothers to resume field work, families who bring infants to working mothers for BF, mothers who return from the field to BF, mothers who express breast milk for others to give while she works, families who arrange for wet-nursing during mother's fieldwork, and possibly others). Indeed, anecdotal reports suggest that women are more commonly returning from fieldwork to breast feed their infants than before the Project. CS18 will experiment with strategies to impart these practices (competition, support group, local advocacy, etc.). Examples of such local solutions (with low cost BCC materials) will inform community meetings and on-the-job training of Commune Health Centre staff, who will promote them among women whom they deliver.

Regarding results monitoring, progress at the goal level (decrease in child malnutrition, measured as weight for age through routine growth monitoring) remains a challenge (Table 4). First, some "good news": the baseline survey value was 39.3%, not 35.4% as noted in the DIP. Regardless, there has been only modest reductions in levels of malnutrition among children less than age two years in Project communes (34 to 27% and 36 to 27% in Da Krong's Phases 1 and 2, respectively and 28 to 24% and 52 to 50% in Huong Ha's Phases 1 and 2, respectively). The most recent data do not include the final results from Phase 2's extended 15-month hearth. Of course, participation in growth monitoring weighing is incomplete, and mothers of malnourished children may be more likely to attend. Responses 4 and 6 (below) shed more light on our community strategies.

On the other hand, the Project is on track to achieve results at the strategic objective ("use") level. Contrary to what is stated in the MTE report, we are able to present indicators for both use of services from routine MOH service statistics AND use of some household behaviors (immediate breastfeeding and a proxy for exclusive breastfeeding among young infants) through our operations research in Phase 3. In summary, use of six of the seven practices that can be tracked have exceeded or nearly met targets: tetanus toxoid vaccine, iron/folate, clean delivery, newborn weighing as a proxy for newborn care, postnatal care, and maternal Vitamin A. Only immediate breastfeeding has declined somewhat although the level is still high. Our proxy for exclusive breastfeeding is admittedly weak (not feeding non-breast milk among mothers visited within 28 days of delivery), but at least the value is high (69%). Levels of appropriate complementary feeding, however, remain unknown. The latter two limitations reflect the fact that the Community Guides only monitor mothers of newborns.

A gap, not noted in the MTE Report, concerns Project monitoring of access and quality results and some of the sustainability results. CS18 has provided all (19/19) communes with telephones where lines exist, but this is only one element of "emergency transport." District training teams regularly use supervision tools, but use among CHC staff is irregular. Regarding job aids, all Community Guides use BCC cards, and all CHCs now have posters explaining the eight steps of essential newborn care and the nine-steps of antenatal care.

Birth registration is now common because of the accompanying social benefits (insurance, free health services) rather than Project activities. Indeed, the Project did not measure it at baseline. Since (1) we have no baseline, (2) CS18 has no related strategies, and (3) the level is influenced by factors larger than the Project, we propose dropping this indicator.

Currently communes use data, but levels of actual planning are unknown.

As noted in Part A, other districts and even other provinces are adopting CS18 approaches and tools, so some sustainability results seem assured already. The Project clearly will not achieve one sustainability result, at least in its present form: the assumption of the Living University by the Research and Training Centre for Community Development (RTCCD). On the other hand, the Project will promote one or more model communes that demonstrate CS18 best practices. The responses to questions 3 (Partners) and 5 (Living University) provide more detail.

Regarding, the “working papers” indicator, the operations research testing the PD-Plus approach will generate one or more such papers. Table 5 shows the results to date from Phase 3. Clearly improvement in use of services (in bold) outpaces improvement in household behaviors, no doubt in part because the community meetings have yet to cover many topics, about which the postpartum visits nonetheless inquire. In addition, CS18 co-funded an anemia study, which has generated a report and which will surely generate a manuscript. Other papers and/or presentations are likely. Indeed, several graduate students have visited the impact area.

In summary, improving nutritional status remains a challenge; behavior change is occurring; and service availability and quality and the enabling environment are improving, and the Project needs more systematic ways to demonstrate these commune-level changes. As an addendum, prompted by this extra-ordinary review, the CS18 team developed protocols to track indicators, categorizing communes by high, middle or low levels of ethnic minorities (Tables 11). Since responding to ethnic minorities’ health challenges is the focus of the Project, we are pleased to observe that these preliminary stratifications suggest progress (often dramatic) in communes with the highest levels of marginalized groups.

2. Describe the progress and status of all proposed strategies and cross-cutting approaches identified for the Nutrition, Breastfeeding and MNC interventions at the health facility and community level as they were described in the DIP. Include information about specific approaches and activities that were proposed including, but not limited to, peer education for youth at Sim Houses, cascading training models and clinical training sequence, SM pilot project experience, IMCI, PDI for maternal rest and nutrition, mother BF support groups, PDI application for better breastfeeding practices, father/grandfather support groups, baby friendly policies, etc.

In summary, CS18 is:

- exceeding expectations (anemia, deworming, malaria),
- completely on track (cascade training sequence, IMCI),
- mostly on track (clinical training sequence),
- somewhat on track and improving (baby friendly policies, PDI for better BF, BF support groups, PDI for maternal rest and nutrition),
- off track but improving (father/grandfather support groups),
- permanently off track (youth peer education at Sim houses) or
- not applicable (SM pilot project experience), according to the item mentioned.

Table 6 details and comments on the status of each.

Here we describe the EBF approach. Improving exclusive breastfeeding is a challenge throughout Viet Nam. The 1997 DHS showed 54% of mothers of infants less than 2 months of age exclusively breastfed, but only 9% of mothers of infants 2-<3.9 months and 1% of infants 4-5.9 months of age did so. Yet some women, even those who return to paddy work shortly after delivery, do successfully overcome the social and cultural barriers to exclusive breast feeding. Using the Positive Deviance approach, CS18 will explore examples of these successful practices, building on previous experience in partnership with the LINKAGES Project in Phu Tho Province and on formative research in Quang Tri Province.

SC will introduce BF support groups in communities in Huong Hoa District where the prevalence of malnutrition exceeds 30% (about 36 hamlets). Female Community Guides will facilitate weekly mother-to-mother breastfeeding support groups, which will be informed and motivated by real-life successful examples from within the women's own village. Guides will encourage attendance of and sharing by PD women (who both work and exclusively breastfeed for four months) and men and/or in-laws (who demonstrate specific positive behaviors that support exclusive breastfeeding) identified through community meetings, BF support groups, or home visits. If hamlets have only male guides, CS18 will provide on-the-job training for female facilitators (preferably PD women).

CS18 can immediately focus on EBF in the remaining communes that meet the criteria. We will adapt the current Community Meeting quality assessment form and apply it to track the mother-to-mother BF support groups, with close attention to attendance, participation, use of the PD approach, etc. Formative research will explore how to monitor change in EBF behavioral determinants. The Acting Technical Director will work with the team to ensure staff understand the concepts and can commence implementation. Additionally, CS18 will benefit from the experience of Kirk Dearden (formerly of the LINKAGES Project), as he will likely become a partner through another funding opportunity later in the summer.

3. Provide an update on the status of key partner agencies involved in program implementation, including MOH, Women's Union, CPFC, RTCCD, Path, Quang Tri SMS and medical schools.

Relations with partners are uniformly good, with one notable exception, as indicated in the MTE Report. Table 7 provides details.

4. Based on our follow-up MTE phone conversation, it is unclear how and when the PD/Hearth phases are being implemented, their progress and how adjustments to the implementation of this activity will occur and in which target area. Provide a clear explanation of the PD/Hearth implementation that includes the current status of each phase in target areas, progress made and remaining activities to be conducted.

The team is not surprised that the donor is not clear about the state of the PD/hearth strategy. It is complicated (Table 8), and incorrectly described in the MTE. Basically there have been four periods of strategy adjustment.

The first adjustment occurred during design and is detailed under point 6 below. In brief, to allow the modified "PD-Plus" approach a chance of success, we by design invited some normal children (and their mothers) to the hearths. In theory, they would provide a "bank" of positive practices

from which to draw. District teams supported including normal (or so-called “Channel A” children) for other reasons as well, i.e., generalized poverty in many hamlets, the need for equity, and perhaps more Project inputs (food and stipends).

The second adjustment came after experience in Phase 1 showed that busy, impoverished, working mothers were reluctant to attend 12-day hearth sessions. Thus the Project gradually decreased the hearth intensity from 12 d/m x 9 m (108 total days over 9 months) to 12 d/m x 3 m + 6 d/m x 3 m + 3 d/m x 9 m (81 total days over 15 m). We thought that the less intense hearth would encourage home practice, which Community Guides could reinforce through home visits. Hearth quality monitoring, commencing in the summer of 2005, showed that participation and community contributions remained low, consistent with food insecurity and extreme poverty in some areas.

The third adjustment came after the MTE, the report of which correctly noted that: (a) much PD expertise resides within the current SC technical team and (b) the CS18 implementation differed from classical PD doctrine. Some of the differences were planned and justified (see #6 below); some arose from credible attempts to respond to field realities (the hearth intensity adjustment), and some were oversights (graduation criteria, deworming). Thus the MTE recommended further adjustments, and the Project agreed to the following at a post-MTE workshop in January 2006: (1) 9 month cycle; (2) only implement in hamlets with 30+% malnutrition and 6+ children; (3) enroll only malnourished children (4) hearth within walking distance; (5) de-worm children <2 and pregnant women; (6) map malnourished children; (7) develop hearth graduation criteria; and (8) discuss nutritional status of children at community meetings.

The fourth adjustment came as we responded to the 11-point letter from the donor. The Da Krong District team, with seven years of experience implementing hearths, is convinced that it is a viable strategy if supervision and community involvement can be strengthened. While they anxiously await the final GMP results that will indicate the effectiveness of the 15-month schedule, they will continue to implement NERP at selected hamlets where malnutrition prevalence is 30% or higher, people live close together and community has strong commitment (as indicated by active commune level associations like Commune Steering Committee and Women’s Union). Dakrong has identified 12 locations that meet these criteria and will thus, implement NERP. In program areas where NERP is not implemented based upon need, CS18 will continue with the other components of the existing program (community meetings on nutrition, deworming for children under five, home visit for counseling families with malnourished children, BCC activities [i.e. role play and complementary food competitions, musical shows], and strengthen national nutrition activities.)

The Huong Hoa District team, on the other hand, has less experience; yet, 15 of the remaining 21 communes in Phases 3 and 4 belong to it. Meanwhile, the Project budgeted 12 months support for each phase, but implementation requires at least 14 months, given local partners’ schedules, orientation, training, etc. However, by reducing the overall number of NERP centers, the NERP cycle will now take 12 months rather than 14, thus, ensuring there is time for the entirety of Phase 4. In areas where malnutrition prevalence $\geq 30\%$, NERP will be replaced by Breast Feeding support groups. In areas with less than 30% malnutrition the program will be the same as that in the areas of Dakrong with low levels of malnutrition.

Additionally, the MOH has identified eight of the 15 remaining communes in Huong Hoa for extra support for nutrition. In these eight communes the national nutrition program which typically consists of GMP and food demonstrations will also provide health examination and food rehabilitation. CS -18 is ensuring more support for activities (i.e., GMP) and complementarity of interventions in these eight communes.

- 5. Please provide a more complete justification and rationale as to why the Living University training model was abandoned. Describe how the issues of capacity building and training which the model spoke to, will now be addressed. Discuss how this decision impacts the scope of work of the project, progress in achieving objectives and indicators and budget implications. We were disappointed to learn that this activity was abandoned since it has been successfully implemented on other CS projects in Egypt and Malawi. Lessons learned about establishing the LU model would be useful to document and share with others.**

Traditional doctrine justifying a Living University to scale up an approach calls for (a) demonstrating the effect of the approach and (b) experience replicating it at least once. These criteria assure that the model is worth scaling up and that programmers have learned both implementation and replication lessons. In CS18's case, we have some evidence that the model works and some experience replicating it Phases 2 and 3. However, there are few Pakoh or Van Kieu populations outside Quang Tri Province, so the generalizability and thus the appeal for this exact model may be limited. The majority of Living University related activities were scheduled for 2006.

Given the above considerations and partner realities, CS18 is proposing to identify and promote "model" communes successfully implementing the various components of CS18 rather than creating a "Living University." The identification of these locations has already taken place in Dakrong where provincial staff has begun documenting the successful story of one such commune. The project staff will work with partners to ensure that the models become places for experiential learning, thus, fulfilling the basic premise of the Living University. These model communes will extend beyond CS18. In fact, provincial officials have already committed to this and have agreed to fund travel costs related to supervision and support to ensure that the models are running well. SC/US will confirm the selection of model communes through both quantitative and qualitative (routine monitoring and operations research data) information sources. CS18 staff will provide extra support and supervision to the selected model communes to ensure that in fact, they are an optimal site for experiential learning. To further support the success of the model communes and the learning s they can encourage, the project has produced the curriculum and training materials, has skilled training teams, has several potential sites and even has requests from potential users (Table 10).

- 6. Provide a discussion with a plan of how the nutrition, MNC and Breastfeeding interventions will benefit from Save the Children's vast institutional experience in these areas during the remaining life of the project and any organizational best practices and lessons learned that will be applied to the project. Given SC's experience with SNL and PD/Hearth there seemed to be a major disconnect and lack of information sharing between the project's approaches and implementation and SC's organizational experiences and successful practices.**

Upon reading the MTE report, the response team expected the donor to question a PD "disconnect." We, too, were surprised at the lack of context for and description of what we are doing (see below). We are puzzled, however, why the donor would suspect a "disconnect" for newborn care. Indeed, CS18 has provided SC an opportunity to apply the state of the art; leverage resources; and conduct district, provincial, and national advocacy on behalf of Vietnam's newborns. There is no "disconnect."

Moreover, we are attempting to advance the state of the art in delivering life-saving newborn (and child) interventions through the PD-Plus experiment. The provenance of this approach involves several steps:

- In the early 1990s, SC's Vietnam Country Office successfully adapted, tested and scaled up a PD-informed approach to reduce childhood malnutrition. Re-evaluation confirmed sustained anthropometric and behavioral effects that were transferred to younger siblings born after the project had ceased. There are many peer-reviewed publications about this.
- In the late 1990s, buoyed by these successes, the SC Office of Health launched a three-year Positive Deviance Initiative to test the effectiveness of the approach on other health outcomes.
- SC's Saving Newborn Lives-1 (2000-2005) supported a successful test of a modified PD/hearth approach for maternal and newborn care in Haripur, Pakistan. We are in the process of writing this up. There are important and interesting methodological issues in transferring from anthropometric (goal level) to behavioral (strategic objective level) outcomes. In other words, the PD/nutrition or "traditional PD" model seeks to identify transferable behaviors that account for successful child growth. But PD for behavioral outcomes must identify transferable behavioral determinants that account for the PD person's positive behavior.
- Meanwhile, SC's Vietnam Country Office successfully pilot-tested the American College of Nurse Midwives' "Home-Based Life Saving Skills" course in two Da Krong communes in 2000-2.
- Thus, the accumulated program learning from PD/nutrition (Vietnam), PD/newborn (Pakistan), and PD/theory (PD Initiative), plus the experience of minority women actively learning through community meetings (Vietnam), led to "PD-Plus." PD-Plus differs from "traditional PD" in important ways (table). In addition to the type of outcome and the focus of the PD inquiry, as stated above, PD-Plus aims to permeate the approach with PD inquiries because *experience has shown that these are so motivating*. Thus, rather than a single labor-intensive baseline PD inquiry, the PD-Plus uses an abbreviated inquiry for every new topic ("new topic PDI") and for reviewing old topics or whenever a new adopter is identified ("booster PDI"). Community implementers aim to capitalize on existing examples and especially new adopters. This, then, is the rationale for the CS18 community meeting strategy.
- The other CS18 community strategy is the PD-informed hearth, for which CS18 still uses a traditional baseline PDI according to VNCO's PD/Hearth manual (and the PVO CORE Group's manual and the BASICS Project's manual). However, we have modified the hearth implementation to include the steps of the "PD-Plus" community meetings, i.e., conducting PD inquiries for each of the 12 hearth topics. The success of this approach requires that positive examples are at hand at least some of the time. Thus, the Project invited, in turn, some normal children (weight for age ≥ -2 Z-scores) to the hearth sessions: 1/3 to the first, 1/3 to the second, 1/3 to the third three-month segment of the 9-month hearth.
- CS18 hosted a graduate student for the summer of 2002 to design an evaluation protocol to test the feasibility, acceptability, and effect of the PD-Plus approach. A refined version of this protocol continues to guide our operations research in Phase 3.

In summary, we believe that the CS18 approaches represent the fruit of a long stream of program learning. There may be a perceived, but not a real, disconnect. Having explained and defended the rationale for what we are doing, we are ready to receive informed criticism.

Table: Traditional PD vs. PD-Plus

Parameter	Traditional PD	PD-Plus
Outcomes	Health status (weight for age)	Behaviors
PD Inquiry Focus	Transferable behaviors that explain uncommonly good health status	Transferable behavioral determinants the explain the uncommonly good behavior
PD Inquiry Timing	Baseline	Whenever new topic introduced (“new topic PDI”) or whenever old topic reviewed or new adopter identified (“booster PDI”)

7. Provide a clear plan describing how the project will engage the USAID Mission on project implementation and progress as well as seeking its input.

In Vietnam, USAID maintains an “Office” and has not yet upgraded to full Mission status. USAID Vietnam does not have a health program. Nonetheless, Save the Children has maintained close ties with USAID in Hanoi since the design and submission stage of this Project. A letter of strong support was submitted by USAID Vietnam with proposal submission. Periodic updates are provided to both Daniel Levitt, formerly Health and Humanitarian Program Manager and now HIV Manager, and to Ngo Tien Loi, Development Assistant Specialist. Annual reports are routinely shared with Mr. Levitt and Mr. Loi.

Despite USAID not having a formal health program in Vietnam, both Mr. Levitt and Mr. Loi have been highly supportive of SC’s CS18 Project. In fact, Mr. Loi served as a member of the MTE and visited the Project site with the MTE team. He also participated in subsequent meetings with partners and staff during which the CSHGP letter was shared and responses formulated. USAID Vietnam is aware of and was party to the decisions made in response to CSHGP MTE concerns.

SC will continue to keep USAID Vietnam abreast of all key project issues and achievements for the remainder of the project.

8. Provide a more complete description of program management, including issues, concerns and solutions (refer to the MTE Guidelines on page 10 – 12). This should include the HQ and field perspective as well as relationships with partners and the community. Based on the MTE follow-up phone conversation, project staff turnover appears to be a key issue and concern, so please include a discussion of the steps being taken to significantly reduce project staff turnover. This section should also describe the lines of communication and type and frequency of technical support provided by HQ to the field, in the past and for the remaining life of the project.

The Project is managed directly by a full time dedicated Project Manager who is a Nurse Midwife with 7 years of public health project management experience. The Project Manager is responsible for coordinating and overseeing all activities of the Project, managing the budget, supervising the field based Project Officer in Quang Tri, coordinating partner relations and completing Project reports and other communication.

Until December 2005, the Project Manager was supported by a full time Hanoi based Project Officer. With the hiring in mid-2005 of the field based Project Officer to better support field

implementation and partner capacity building, this position was converted to part time support to CS18 by a Monitoring and Evaluation Officer. This is a new cross cutting position created by the VNCO to strengthen M&E across all of our health projects and move towards more standardized and upgraded measurement of common program performance indicators.

The Project Manager is supported by other technical and managerial staff as outlined in the Project proposal and DIP.

Over the life of the Project (3.5 years), 2 key staff have left Save the Children: the original Project Manager and the Health Specialist. The original Project Manager resigned in the Spring of 2005. He was replaced by a Project Manager with 5 years of prior public health experience with Save the Children who had been working in the same Project districts on a newborn health project that had been fully integrated with CS18. She brings with her a deep understanding of the project communities, partners and SC systems and has proven over the past year to be a great asset to the Project.

The Health Specialist, who had been part time on CS18, left to pursue an excellent career development opportunity with UNICEF after 8 years of dedicated service to Save the Children. Overall, CS18 has been well managed by competent and committed staff. The turnover experienced has not been unusually high, although it has inevitably caused some transition challenges as organizational history is lost. That said, regular contact has been maintained with both former SC project employees on Project progress and challenges. It is noteworthy that both former employees participated in recently held partner MTE meetings to respond to questions and concerns from CSHGP.

CS18 has been greatly enriched by the intensive technical support and oversight provided by the HQ Senior Child Survival Advisor. This support is provided through bi-annual technical assistance visits of 2-3 week duration, by intensive long distance e-TA on a variety of Project activities. This TA will continue over the remainder of the Project and will be supplemented by periodic conference calls, made more cost effective by the recent availability of web based phone linkages with Vietnam.

The HQ Senior Child Survival Advisor will return to Viet Nam in September, 2006 to provide support to the program and review progress based upon the program designs suggested in this amendment letter.

9. A complete action plan (including a timeline) responding to both the evaluation recommendations and CSHGP concerns. This should include a description and justification of how the project will be streamlined and simplified, if necessary, for the remaining months in the grant period in order to maximize on its achievements and progress. Based on changes to scope and activities, what is the status of the current budget and are there adjustments that need to be made? Clarify and provide a justification for any proposed changes to the budget.

Please see attached timeline and budget. Additionally, the project has been simplified in the following ways:

- Reduced NERPS (total 12 for remainder of Project instead of 80) which reduces amount of training (by total of 233 days) and allows for increased supervision and emphasis on

breastfeeding support groups. Decreasing trainings and NERPS allows for entire Phase 4 to be completed within the LOP.

- Revised expectations for the Living University, substituting "model communes" and related supporting activities (detailed in document earlier)
- Made project more responsive to local needs, i.e., in Huong Hoa more time will be spent on BF than before.
- Aligned with National Nutrition Program to reduce duplication of activities.
- Eliminated two socio-economically well-developed Kinh communes (on the main highway) with low levels of malnutrition, as decided at the MTE review.
- Eliminated Channel "A" well nourished children from participating in any NERP, thus allowing attention and resources to focus on malnourished children
- Built in September review to assess success of Phase 4 implementation (May 2006) and soliciting help from experienced researcher in PD and EBF (Kirk Dearden).

Based on the project revisions the budget has been augmented in the following ways:

Reduced costs through:

- Reduced number of NERPs and associated costs (food etc.)
- Shorter training courses with more focused content
- Building in support from JSDF project for 5 overlapping communes in Da Krong
- Stop sub grant to RTCCD (personnel, admin, overhead)

Savings will be applied to:

- Strengthen activities as detailed in work plan including: refresher training for Community Guides, supervisory visits (commune level budgeted), breastfeeding support groups, deworming children and pregnant women and strengthening home visits
- Recruit one project assistant to help with monitoring and evaluation in field with special emphasis on model communes

10. A plan to address concerns about the sustainability of project approaches during the remaining months of the project, including a plan to assess sustainability during the final evaluation.

In addition to the creation of model communes to foster partner sharing and learning described in question number 5, CS18 has received commitments from government partners to supply iron and clean birth kits after CS18 finishes.

Also, SC/US co-hosted a workshop April 7 with World Health Organization to highlight the need to deworm children 12-23.9 months of age, currently not MOH policy. The workshop included more than 20 participants from WHO, UNICEF, SC/UK, CESVI, MOH, National Institute of Nutrition, Institute of Malariology and Parasitology, and CS18 partners from Quang Tri. Indeed, Mr. Hien, our lead partner from Da Krong, reported findings of small worm prevalence survey among children 12-36 months of age in Da Krong (completed in March 2006). Over half (53%) of children were infected, including 20% with both ascaris and hookworm. Importantly, young infants, 12-24 months of age, had similar infection rates (48% infected overall and 17% with both). After much discussion, the participants concluded: (1) since worm infection is a national public health priority, NIN and Institute of Malariology and Parasitology should consult with MOH to formalize a response; (2) deworming should be done frequently for the whole population and integrated with the hygiene/environment education; (3) deworming drugs are cheap, available and safe for the children from age 12 months up; and (4) many organizations and provinces want a deworming

program but need formal MOH guidance. Quang Tri partners decided to: (a) deworm pregnant women and children 24 -60 months twice yearly and (b) pilot deworming children 12-24 months in hamlets selected for NERPs. The process, albeit a lengthy one, has begun to change national policy based on CS18 experiences, and donors (WHO, UNICEF) have agreed to sustain deworming activities for the duration of CS18 and beyond.

The plan to assess sustainability is presented in the DIP. CS18 partners feel confident that the first three sustainability indicators are relevant and feasible. We suggest eliminating the fourth indicator. The means of verification include quarterly reports from the two districts; and the CS18 Project Manager has an inventory of organizations that have adopted or requested materials or support for learning. Finally, recall the top right cell of Table 1, which demonstrates that sustainability is already in train, irrespective of the indicators that were selected four years ago.

11. Update the partner information on the project data form (at www.childsurvival.com).

Done.

SUMMARY AND CONCLUSIONS

SC thanks the donor for the opportunity to pause again, reflect, re-plan, and set the record straight. Since no donor had ever asked any member of the CS18 MTE Response Team to undertake such an activity, this was a new experience for us. We welcome feedback regarding our feedback on your feedback from the MTE. We are learners.

Here are our main conclusions on the MTE process: it was mixed, specifically:

- The CS18 Team erred by requesting the MTE team leader to emphasize the main Project challenge: the apparent non-effect of our nutrition strategy on childhood malnutrition. This left insufficient time to review other Project strategies and especially strengths, the MTE guidelines notwithstanding.
- Related, the CS18 Team may have erred in selecting the headquarters representative on the MTE Team. Specifically, it substituted an individual more familiar with PD/hearth implementation (the perceived main challenge) instead of the individual who had designed and supported the Project from the outset. This was all the more critical given the overall lack of institutional memory within the MTE team and the persons interviewed.
- The MTE Team leader may have erred in scheduling too much time in the field and too little time in Hanoi to check impressions and to interview knowledgeable informants.

Regarding the Project, the following represent our main conclusions as revealed from the MTE, the donor's 11-point letter, and our response to it.

- The Project is extremely complex, innovative, and generally on track.
- Partner relations are excellent, the "divorce" with RTCCD notwithstanding.
- The Project has national attention and informs maternal and newborn care policy and programming.
- Areas requiring the Project's attention are:
 - PD-informed strategy for EBF
 - SC and partners' use of monitoring data
 - Stratification of monitoring and evaluation data to determine differential effects on Kinh and minority populations (already in progress [Table 11])

- A “living university” equivalent, i.e., a campus demonstrating best practices for trainees and visitors
- The apparent disappointing impact on child nutritional status.

Regarding this last point, the apparent non-effect of the Project on nutritional status, a systematic inquiry would ask the following questions:

- **Did we select the correct interventions?** Clearly, improved complementary feeding and breastfeeding practices rank among the “best buys” in child survival. On the other hand, they are not a complete solution, especially in the presence of food insecurity and childhood illness, over which the Project has minimal influence.
- **Did we select the correct delivery strategies?** The PD/hearth approach is a proven effective strategy, especially in Vietnam. Although the Project modifications have not been previously tested, we doubt that they would alter the effectiveness of the approach in a major way. On the other hand, the strategy is inappropriate for many Project hamlets, specifically those with food insecurity on one hand (as described in the PVO CORE Hearth manual), and those with low levels or numbers of malnourished children and with dispersed populations on the other hand. In the former case, the approach rarely works. In the latter, communities are generally insufficiently motivated to make it work.
- **Did we implement the strategies well?** As is typical, the record is mixed. Hearth quality data show spotty attendance and community contributions. Supervision is not always strong.
- **Are differential effects among sub-populations masked by aggregated data?** Given the stark differences in the composition of the impact area population (ethnic majority vs. minority) and its health profile and customs, one would expect differences, not only in effect, but also in participation and implementation. To date, we have not been able to separate these effects, but it is a priority. Detecting differential effects on age and sex, often among the most important effect modifiers, must await the end-line survey.
- **Are other factors responsible for the lack of effect, especially those beyond the control of the Project?** Food insecurity, for example, has not deteriorated during the Project. If anything, secular trends would be expected to improve the nutritional profile. Vietnam’s child malnutrition level has dropped steadily in the last decade. Furthermore, the improved highway in the impact area will gradually bring economic development. On the other hand, other Project interventions may ironically aggravate the overall childhood nutritional profile. That is, improved maternal and newborn care is likely to permit the safe delivery, survival, and growth of more low birth weight babies, who, on average, will be more likely to remain low weight-for-age throughout childhood. Although credible, the Project cannot verify this phenomenon.
- **Were the evaluation methods (that showed the disappointing impact) sound?** Yes and no. The MTE team worked hard to understand the PD/hearth strategy and interpret its effect. Most of its effort focused on the apparently flawed strategy (which we have explained above) rather than impact. A more complete assessment of impact would have addressed seasonality (especially the hungry season) and an assessment of effect within communes, stratified by ethnicity and/or poverty as a proxy for food security.

In summary, we agree with the MTE team that the PD/hearth strategy needs review. We believe that the interventions are appropriate (but incomplete), the delivery strategies are sound (but can be improved), the quality of implementation is average (but can be improved), there may be interesting and important effects on sub-populations and possibly interaction with other interventions that remain to be examined, and routine GMP service statistics are an incomplete (albeit affordable) way to evaluate impact.

Tables

April 21, 2006

Table 1: CS18 Strengths, Challenges, and Weaknesses vs. MTE Documentation Status

	MTE discussed well	MTE discussed incompletely	MTE did not discuss
CS18 Strength	<ul style="list-style-type: none"> • Severe malnutrition reduced • Use of GMP services improved • Use of immediate breastfeeding improved • Use of facility-based delivery improved • Use of CDK improved • Use of IFA improved • Use of postpartum VAC improved • Family booklet of 14 MNC behaviors designed, distributed, and valued • Saving Newborn Lives resources to equip commune health centers and train MOH staff leveraged • Good baseline studies (3) conducted 	<ul style="list-style-type: none"> • Project Design Monitoring and Evaluation training for Field Office developed and implemented • Routine MOH HIS supported and used • Supervisory check-lists developed and used 	<ul style="list-style-type: none"> • Training video for PD-Plus and facilitation skills developed and used • Behavioral monitoring through non-literate questionnaire tested • PD-Plus and “Booster PDI” tested • 3 student projects supported • Hamlet, commune, and district BCC role-play competition televised on provincial TV (in Vietnamese and planned for re-broadcast in minority languages) • Provincial MOH supervision models informed by CS18 • Provincial MCH Network stimulated by CS18 • Living University to train medical students requested by Province • CS18 materials adapted by JSDF Project • HCMC materials used by Counterpart International • UNFPA considering CS18 model for several provinces • Nghe An Province study tour video-taped community meeting for Finnish project • SC to apply CS18 strategies to Da Nang and Khanh Hoa Provinces with Atlantic Philanthropies support • CS18 & SNL translated, adapted, tested and brought Essential Newborn Care to Province and, with WHO, nationally • MOH requested SC to consult for Phase II of national Safe Motherhood and Newborn program • CS18 co-funded important anemia study to inform national policy • SC regarded as Vietnam’s “minority population expert” • SC under consideration as managing partner for national minority Safe Motherhood

	MTE discussed well	MTE discussed incompletely	MTE did not discuss
CS18 Challenge	<ul style="list-style-type: none"> • Complex project • Two districts; majority vs. minority • Huge training effort • Minority: language, culture, poverty • Isolated communities • EBF constraints • Kinh vs. minority programming (CDK) • Not addressing anemia or FP • Sustainability (salaries, supplies, HEARTH \$) • Volunteers: male > female 	<ul style="list-style-type: none"> • Kinh vs. minority effects 	<ul style="list-style-type: none"> • MOH district partners uneven • USAID unable to meet with Team leader pre- or post-MTE • HEARTH protocol may not fit setting
CS18 Weakness	<ul style="list-style-type: none"> • Levels of overall malnutrition • Lack of increase in exclusive breastfeeding • Hearths too passive • CM topics grouped • RTCCD partnership 	<ul style="list-style-type: none"> • Living University not implemented and how to make it meaningful with only 1 phase left? (Year Three activity) • Not following HEARTH protocol (entry, exit, failure, deworming, home visit) • “Leading expert on PD/Hearth...” (p 32) • Minimal USAID Mission collaboration • Sim houses • Staff turn-over • Minimal hand-over to current PM • PM: “Why project carried out like this”? • Rationale for no mid-term survey • Phased strategy (too short duration) • Teaching facilitation skills • Use of ANC (but ANC content is) • Village PLA and CM sub-optimal • 10 MNC indicators collected; not used 	<ul style="list-style-type: none"> • HQ-PM weak communication for first 6 mos • Supportive supervision weak • BCC materials too costly for national scale • No rigorous monitoring system for some Intermediate Results (newborn registration, emergency transport, use of supervision tools and job aids, communes using data for planning) • Monitoring system does not easily examine effects among minority populations

Table 2: Main Project Elements and Achievements by Intervention Group

Intervention Group	Essential Elements & Approach (from DIP)	Achievements	Comment
MATERNAL and NEWBORN CARE	Antenatal care, birth preparedness, skilled attendance at delivery, home-based care, postpartum care, newborn care, birth registration, emergency obstetric care and referral for neonatal danger signs	<ul style="list-style-type: none"> • Applied SC's model from the Da Krong District Safe Motherhood Networks Project (2000-2) • Developed training manual for district trainers. • Developed protocols for health staff in Commune Health Centers. • Developed BCC materials and handbook for Community Guides (14 topics on Home Care for Mothers and Child). • Developed BCC booklets for families on 14 topics. 	Training Manual and BCC materials development involved SC and partners (PATH, RTCCD). This complex process required several drafts with refinements after each training with finalization in May 2005. BCC pictures and family booklet finalized in September 2005.

Facility Level	<p>SC will work with Hanoi Secondary Medical School (i.e., nursing school) to train Quang Tri provincial trainers in management of pregnancy, normal delivery, postnatal care, newborn care and five basic obstetric emergencies. The provincial trainers will train midwives and health staff in Commune Health Centers.</p>	<ul style="list-style-type: none"> • Ms. Huong (Hanoi SMS) and Dr. Ngoc (Head of Obstetrical Department of Thanh Nhan Hospital, Hanoi) trained 16 provincial and district trainers, in theory and practice, respectively. They trained 4 as trainers and all 16 as supervisors. • Ms. Huong, Dr. Ngoc, Dr. Binh (Hue Medical School), and Dr. Mai (National Obstetrical Hospital) trained all 16 in Essential Newborn Care, a 5-day course integrating CS18 and SC's Saving Newborn Lives Initiative. • The 4 trained SC trainers trained 64 midwives and health staff from all 36 communes in maternal and newborn care (28 days per course, given four times to accommodate all trainees). The 5th and final training will be completed in April 2006. • Quang Tri Province requested SC to conduct the 5-day ENC course for all staff in all 9 districts and communes. SC complied using CS18 trainers and funding from SNL. • Now CHC midwives and health staff conduct: facility-based and outreach ANC, home deliveries when requested; and support to CGs to implement project activities at the village level. • SC equipped all 36 Commune Health Centers with newborn resuscitation equipment, pregnancy check-up packs, normal delivery packs, episiotomy packs and tables for cord care and newborn resuscitation with funding from SNL and SC private funds 	<ul style="list-style-type: none"> • SC was able to leverage Saving Newborn Lives funds to improve Essential Newborn Care capacity in ALL districts throughout the Province.
	<p>SC work with Hue Medical school to provide clinical training for doctors at Huong Hoa District Hospital (CEOC). and Da Krong District Hospital (BEOC).</p>	<ul style="list-style-type: none"> • The team dropped this strategy because: (1) facilities in both district health services cannot provide even BEOC (i.e., no forceps, vacuum aspirator, operation room, blood bank) and (2) capacity of health staff is limited. Hue Medical School agreed to train health staff on CEOC, but the districts did not sponsor their obstetricians because the course was long (3+ months) and facilities unequipped to provide needed support after training. 	

<p>Community Level</p>	<p>Home care for mother and child: CS18 will apply the SM pilot project experiences in Da Krong (i.e., community discussions to identify problems, followed by a series of community meetings employing American College of Nurse-Midwives’ “Home-Based Life Saving Skills” 5-step problem-solving approach to learn better practices). Cascading training model with trained district trainers training Community Guides (CGs) to conduct monthly meetings with women, families and caregivers.</p>	<ul style="list-style-type: none"> • Developed training manual for district trainers on 14 MNC topics and community meeting facilitation skills, illustrating the 5-step approach (modified as “PD-Plus”). • Developed handbook of 14 topics for Community Guides. • Developed 14 sets of pictures (153 total) for the 14 topics for Community Guides to use at community meetings. • Developed a booklet of 14 topics for mothers. • Developed training video illustrating how to conduct a community meeting using 16 facilitation skills. • Trained 32 district trainers who trained 900 Community Guides from 25 communes from Phases 1-3. 	<ul style="list-style-type: none"> • Technical content was complex, requiring 26 days, divided into 5 separate trainings. • Supervision was incomplete because of the intensity of community meetings (230 per month in the 25 communes). • Imparting facilitation skills, especially to minority Community Guides, was challenging due to language barriers. • Kinh majority guides followed 5-step process better than minority guides, who preferred a less structured approach. • Not all topics were relevant to both Kinh and minority populations (but most were) • The video was long (90 minutes) and occasionally boring, but it remains an excellent resource, especially if edited in the future.
	<p>Peer education for Youth at Sim houses: Explore the venue as an entry point for disseminating reproductive health, maternal and newborn care, and nutrition information among teenagers in non-threatening and entertaining ways.</p>	<p>Not done</p>	<p>PATH (partner from 10/02 to 9/05) was responsible for this strategy. In July-Aug 2005, CS18 conducted a small community inquiry among youth and elders and learned that Sim houses have evolved and are no longer as described in the DIP. Indeed, in many hamlets Sim houses no longer exist. The primary challenge for youth is safe sex, which does not match CS18.</p>

NUTRITION - Child	Apply PDI approach. Hearth sessions will be organized by Community Guides who will plan the menus using the PDI information. CS18 will modify the Hearth to include peer educators who are PD caregivers, and who motivate their peers and model good practice.	<ul style="list-style-type: none"> • Developed a training packet (5 manuals, pictures of foods, food squares, posters to develop menus for Hearth), and posters with pictures consisting of 12 messages on malnutrition prevention. • Developed a booklet for mothers consisting of 12 nutrition messages. • Trained 16 district trainers to use training manuals to train Community Guides • Conducted 180 Hearths in hamlets (1-2 hearths/hamlet according to hamlet size). • Hearths ended in the 15 phase 1 & 2 communes. JSDF funding may continue hearths in 4 communes in Da Krong • Phase three communes will start in March 2006. 	Is the PD/Hearth approach appropriate for the project areas? The CORE guideline states it is not recommended if household food insecurity lasts longer than 3 months. Many CS18 households are food insecure 6 -9 months/year (42% of Huong Hoa households = “poor” in 2006). On the other hand, other hamlets fail to reach the magnitude (≥ 6 children) and severity ($\geq 30\%$ prevalence) criteria.
	Growth Monitoring and Promotion	<ul style="list-style-type: none"> • All communes continue to implement GMP and food demonstration days (according to National Program). 	
	Integrated Management of childhood Illnesses (IMCI): Emphasis on better care-seeking behaviors for maternal and newborn care and care-seeking for child illness as well	<ul style="list-style-type: none"> • Developed BCC cards and technical content (two of the 14 topics) for community meetings on danger sign recognition (newborn and child) and care-seeking consistent with national IMCI policy. • Developed BCC cards and technical content (one of the 14 topics) for community meetings on pregnancy-related danger sign recognition, apart from national IMCI policy. 	
NUTRITION - Maternal	Maternal Anemia: ANC nutrition counseling; Women will be encouraged to take Iron/folate antenatal supplement and postnatal Vitamin A within two weeks of delivery.	<ul style="list-style-type: none"> • Distribute iron pills and Vitamin A to women through ANC and at home visits (Community Guides). • Supported 46 points for antenatal check up, including 26 in remote hamlets. • Supplied 100% support for iron/folate for first three years; from 2006 will provide only 50% support (with MOH providing 50%). • Support MOH to provide postpartum Vitamin A . 	

	<ul style="list-style-type: none"> • PDI for maternal rest and nutrition, i.e., seeking “PD husbands”). The project will capitalize on these examples in facilitation of community meetings. 	<ul style="list-style-type: none"> • Happens occasionally, with some documentation in CM reports. 	<ul style="list-style-type: none"> • CGs uncommonly identify and interview PD husband in community meetings because of low male attendance, low participation among those attending, and rare examples of PD behavior among those participating, especially if minority. • CGs challenged to record PDI behaviors (due to low literacy), which delays accurate and timely report submission. • Refresher training (after MTE), will stress quarterly community meetings targeting men.
BREAST-FEEDING Community Level	<ul style="list-style-type: none"> • Mother BF support Groups. • PDI application for better BF practices. • Father/grandparent support groups. 	<ul style="list-style-type: none"> • Promoted EBF, and especially IBF, through community meetings. • Promoted EBF through PD/Hearths. • Not yet rigorously applied PD approach for EBF, apart from the “PD-Plus” community meeting approach. 	<ul style="list-style-type: none"> • As above, refresher training (after MTE) will stress quarterly community meetings targeting men, who are often influence EBF decisions. • Will pilot-test more complete PD approach for EBF through community meetings, with follow-on BF support groups.
Facility Level	<ul style="list-style-type: none"> • Baby friendly hospital: Train CHC staff on counseling new mother about locally discovered strategies to promote BF in face of early postpartum maternal work expectation. • CHC staff be trained on relevant points of the Baby Friendly policy. 	<ul style="list-style-type: none"> • Trained CHC staff on BF best practices through: in-service training; (see MNC component), supervision, and collaboration between midwives and guides for home-based postpartum care. 	<ul style="list-style-type: none"> • Will develop low-cost BCC materials for CHC staff based on local solutions from PD-informed EBF pilot-test.

Table 3A: Quality of Community Meeting (from early experience with supervisory check-lists)

Variable	Q3 2004		Q4 2005	
	#	%	#	%
Attendance rate of target groups > 80%	20	71	16	67
Booster PDI: “Why?” probe	14	56	11	46
Booster PDI: “How?” probe	14	56	17	71
New Topic PDI: “Why?” probe	19	70	8	33
New Topic PDI: “How?” probe	11	41	11	46
Using pictures to share information	5	89	23	96
Demonstrating behavior	15	75	22	92
Use findings from new topic PDI	7	27	5	23
Discuss constraints for adopting new behavior	20	74	16	67
Use role-play and coaching to practice new behavior	18	72	19	79
Use bouncing question	3	12	3	19
Active participation rate > 70%	3	14	2	9

**Table 3B:
Quality of
Hearth
(from early
experience
with
supervisory
check-lists)**

Variable	Q3 2004	
	#	%
Attendance rate	*	*
Contribution rate > 30%	11	37
Meal prepared per menu schedule	23	85
Hygienic food preparation and hand washing practice before feeding children	20	74
Explanation of recipe	24	86
Booster PDI	10	48
Sharing messages	23	77
Active learning	0	0

*Under revision: to be re-categorized and re-calculated.

Table 4: Project Baseline, Target, Revised Target, and Latest Status by Objective (adapted from DIP, p 20)

Objectives	Indicators	Original target	Baseline figure	Revised Target	Latest Level	Source
Improved health status of children Under 5	Decrease of child malnutrition (0-24 months) as measured by < 2 standard deviations below reference median weight-for-age.	30%	39%*	10%	25, 28% 50, 28%	Huong Hoa, Da Krong, Phase 1 Huong Hoa, Da Krong, Phase 2
Increased use of health care services	1. Pregnant women who received two doses of Tetanus Toxoid vaccine	70%	63%	80%	89%	Phase 2 communes, 2005 (MOH)
	2. Mothers who used 100 ANC Iron-folate tablets	50%	42%	70%	66%	Phase 3 communes, 2005 (OR)
	3. Mothers who received postnatal care	50%	27%	50%	60%**	Phase 2 communes, 2005 (MOH)
	4. Newborns weighed within 24 hours of birth	50%	49%	70%	67%	Phase 2 communes, 2005 (MOH)
	5. Mothers who received postpartum Vitamin A supplement	50%	26%	50%	80%	Phase 3 communes, 2005 (OR)
Increased practice of key household health behaviors	1. Deliveries with clean umbilical cord cutting	70%	41%	70%	89%***	Phase 3 communes, 2005 (OR)
	2. Immediate breastfeeding (within 1hr)	30%	74%	80%	66%	Phase 3 communes, 2005 (OR)
	3. Exclusive breastfeeding at < age four months	20%	32%	50%	69%****	Phase 3 communes, 2005 (OR)
	4. Mothers who practice recommended complementary feeding (freq., variety, onset)	80%	71%	40%	unknown	
Increased service accessibility	1. Communes w/emergency transport	30%	0	30%	19/19†	Personal communication with PM
Improved service quality	1. CHC staff using supervision tools	80%	0	80%	Some	Personal communication with PM
	2. CHC staff and HHWs using job aids	80%	0	80%	Yes	Personal communication with PM

Improved Sustainability	3. Newborns registered	70%	?	70%	unknown	
	4. Communes using data for planning	80%	0	80%	Some	Personal communication with PM
	5. PHS adopting Project approaches to other districts (has plan to expand)	Written plan	0	Written plan	Yes	Personal communication with PM
	6. Communes adopting CS18 approaches to other districts	80%	0	80%	Yes	Personal communication with PM
	7. RTCCD taking over LU	80%	0	80%	No	
	8. Two working papers produced	2		2	likely	

*incorrectly stated in the DIP as 35.4%,**postnatal care within 24 hours, ***used clean delivery kit, ****NOT feeding non-breast milk at household visit (sometime within a month of delivery)†The Project has supplied all (19/19) communes on telephone network with a telephone; 17 communes have no access to network.

Table 5: Operations Research Findings – Phase 3

Indicators	Baseline (n= 248)	Quarter 1 (n=117)	Quarter 2 (n=86)
ANC	81	88	97
>= 3 ANC	40	37	29
Iron pill receiving	57	66	95
Iron pill taking for at least 3 months	40	33	66
Delivery at HF's	51	53	41
Delivery by skilled birth attendant	57	60	50
CDK use	11	38	89
Lie with the baby after birth	81	93	93
First bath for baby from 2nd day	69	78	78
Newborn receive other foods than breast milk within 1 month after birth	64	82	66
Postpartum home visit by commune health staffs within 7 days	56	30	31
Mothers took postpartum vitamin A	29	65	80

Table 6: Strategies and Approaches

Strategies and Approaches	Status	Comment
Peer education for youth at Sim houses	Not done	PATH (partner from 10/02 to 9/05) was responsible for this strategy. In July-Aug 2005, CS18 conducted a small community inquiry among youth and elders and learned that Sim houses have evolved and are no longer as described in the DIP. Indeed, in many hamlets Sim houses no longer exist. The primary challenge for youth is safe sex, which does not match CS18.
Cascading training models	<ul style="list-style-type: none"> • Developed training manual for district trainers on 14 MNC topics and community meeting facilitation skills, illustrating the 5-step approach (modified as “PD-Plus”). • Developed handbook of 14 topics for Community Guides. • Developed 14 sets of pictures (153 total) for the 14 topics for Community Guides to use at community meetings. • Developed training video illustrating how to conduct a community meeting using 16 facilitation skills. • Trained 32 district trainers who trained 900 Community Guides from 25 communes from Phases 1-3. • Also: see “Clinical training sequence” below. 	<ul style="list-style-type: none"> • Technical content was complex, requiring 26 days, divided into 5 separate trainings. • Supervision was incomplete because of the intensity of community meetings (230 per month in the 25 communes!). • Imparting facilitation skills, especially to minority Community Guides, was challenging due to language barriers. • Kinh majority guides followed 5-step process better than minority guides, who preferred a less structured approach. • Not all topics were relevant to both Kinh and minority populations (but most were) • The video was long (90 minutes) and occasionally boring, but it remains an excellent resource, especially if edited in the future.
Clinical training sequence	<ul style="list-style-type: none"> • Ms. Huong (Hanoi SMS) and Dr. Ngoc (Head of Obstetrical Department of Thanh Nhan Hospital, Hanoi) trained 16 provincial and district trainers, in theory and practice, respectively. They trained 4 as trainers and all 16 as supervisors. • Ms. Huong, Dr. Ngoc, Dr. Binh (Hue Medical School), and Dr. Mai (National Obstetrical Hospital) trained all 16 in Essential Newborn Care, a 5-day course integrating CS18 and SC’s Saving Newborn Lives Initiative. • The 4 trained SC trainers trained 64 midwives and health staff from all 36 communes in maternal and newborn care (28 days per course, given four times to accommodate all trainees). The 5th and final training will be completed in April 2006. • Quang Tri Province requested SC to conduct the 5-day ENC course for all staff in all 9 districts and communes. SC complied using CS18 trainers and funding from SNL. • Now CHC midwives and health staff conduct: facility-based and outreach ANC, home deliveries when requested; and support to CGs to implement project activities at the village level. 	<ul style="list-style-type: none"> • SC was able to leverage Saving Newborn Lives funds to improve Essential Newborn Care capacity in ALL districts throughout the Province.

	<ul style="list-style-type: none"> • SC equipped all 36 Commune Health Centers with newborn resuscitation equipment, pregnancy check-up packs, normal delivery packs, episiotomy kits and tables for newborn cord care and resuscitation with funding from SNL. • CS18 has not worked with Hue Medical School to provide clinical training for doctors at Huong Hoa District Hospital (CEOC). and Da Krong District Hospital (BEOC). The team dropped this strategy because: (1) facilities in both district health services cannot provide even BEOC (i.e., no forceps, vacuum aspirator, operation room, blood bank) and (2) capacity of health staff is limited. Hue Medical School agreed to train health staff on CEOC, but the districts did not sponsor their obstetricians because the course was long (3+ months) and facilities unequipped to provide needed support after training. 	
SM pilot project experience	This preceded and informed the design of CS18. In 2001-2, SC adapted and tested the American College of Nurse-Midwives' "Home-Based Life Saving Skills" curriculum in 5 Da Krong communes. We expanded the number of topics (from 6 to 14) and modified the active learning approach to test the suitability of the positive deviance approach within community meetings.	
IMCI	Developed BCC cards and technical content (two of the 14 topics) for community meetings on danger sign recognition (newborn and child) and care-seeking consistent with national IMCI policy.	Developed BCC cards and technical content (one of the 14 topics) for community meetings on pregnancy-related danger sign recognition, apart from national IMCI policy.
PDI for maternal rest and nutrition	Happens occasionally, with some documentation in CM reports.	<ul style="list-style-type: none"> • CGs uncommonly identify and interview PD husband in community meetings because of low male attendance, low participation among those attending, and rare examples of PD behavior among those participating, especially if minority. • CGs challenged to record PDI behaviors (due to low literacy), which delays accurate and timely report submission. • Refresher training (after MTE), will stress quarterly community meetings targeting men.
Mother BF support group	Promote EBF, and especially IBF, through community meetings and EBF through PD/Hearths.	<ul style="list-style-type: none"> • The community meeting is a type of BF support group, although much less intense and structured than a LaLeche League model. • As above, refresher training (after MTE), will stress quarterly community meetings targeting men (fathers and grandfathers), who are often influence decisions about duration of EBF.
PDI application for better breastfeeding	Not rigorously applied PD approach for EBF, apart from the "PD-Plus" community meeting approach.	The remainder of the Project aims to strengthen the PD-informed approach to EBF, seeking to identify and learn from examples of the following PD families (husbands who modify requirements for new mothers to resume field work, families who bring infants to working mothers for BF, mothers who return from the field to BF, mothers

		who express breast milk for others to give while she works, families who arrange for wet-nursing during mother's fieldwork, and possibly others). CS18 will experiment with strategies to impart these practices (competition, support group, local advocacy, etc.)
Father/grandfather support group	Happens occasionally, with some documentation in CM reports.	<ul style="list-style-type: none"> • CGs uncommonly identify and interview PD husband in community meetings because of low male attendance, low participation among those attending, and rare examples of PD behavior among those participating, especially if minority. • CGs challenged to record PDI behaviors (due to low literacy), which delays accurate and timely report submission. • Refresher training (after MTE), will stress quarterly community meetings targeting men.
Baby friendly policies	The Baby Friendly Hospital Initiative has lapsed in Vietnam. Nonetheless, the Project has trained CHC staff on BF best practices through: in-service training and supervision. They, in turn, support Community Guides to provide home-based postpartum care, including promoting IBF and EBF. CS18 has not yet, however, incorporated successful local strategies.	(See PDI application for better breastfeeding) Examples of such local solutions (with low cost BCC materials) will inform community meetings and on-the-job training of Commune Health Centre staff, who will promote them among women whom they deliver.
Anemia, deworming, malaria	With private funds, SC worked with Quang Tri Provincial Health Service to develop BCC and training materials on malaria prevention. Under the auspices of CS18, SC co-funded an anemia survey with RTCCD (causes of anemia: worm infestation, diet, hemoglobin, etc.). Through other sources (private and JSDF), SC provided iron/folate to pregnant women and new mothers.	SC continues to support maternal iron/folate supplementation. SC is planning a deworming workshop with WHO to advocate with MOH to allow deworming for children <2. SC will conduct a geohelminth infestation prevalence survey (using JSDF funds) among children <2 to inform this policy, which will allow SC to extend deworming interventions to this vulnerable population, in addition to pregnant women. The combination of the iron and deworming (and malaria) interventions should mitigate anemia in a comprehensive way.

Table 7: Partners

Level	Partner	Role	Status
National	Hanoi Medical College	Project technical resources to develop, adapt and test training manuals (safe motherhood, newborn care, ENC, HCMC), test IEC materials, and conduct TOTs as Master Trainers.	CS18 did not directly partner with Hanoi Medical College, which was a technical adviser in ENC training, with Saving Newborn Lives support.
	Ha Noi Secondary Medical School (nursing)		Trainers trained provincial and district trainers in maternal and newborn care.
	Hue Medical College		SC signed a MOU with the school for technical support for all SC's health projects in the Central Region (including CS18).
Province	Provincial Health Service: Key contact: Dr. Mai Nam; 8-person training/supervising team from Quang Tri Secondary Medical School (nursing), Quang Tri Hospital, and MCH/FP Center		Dr. Mai Nam works closely with SC team in Quang Tri Sub-office and supports district monitoring and planning. The Project advocated for establishing the team, which it now monitors the CHC services.
District	Steering Committee Board, comprised of members of health staff, Peoples' Committee; Women's Union; Farmers' Union, and education sector	Overall management, especially project monitoring and planning	Throughout the life of the project, these Boards have worked closely and effectively with the CS18 team to plan, implement, and monitor project activities as well as to make necessary revisions, such as those based on the MTE findings.
	Directors of District Health Service and Project Secretaries.	Report direct to SC Quang Tri sub-office with: quarterly Progress Report, monthly Action Plan, quarterly Financial Plan, and monthly expenditure and advance records.	In 2004-05, the Director of Da Krong District Health Center spent much time to fulfill his Master's Degree on Parasitology in Hanoi. Now he has finished and has extra time for Project management. The quality of project activities will likely improve even further.
	District training and supervising team: 32 medical doctors and midwives	Train and supervise Community Guides on HCMC, malnutrition prevention, interpersonal communication, etc.; train and supervise CHC staff; provide services; participate in monthly review meeting at communes	CS18 provided a set of planned protocols to support CHC health staff on the job.
Commune (36)	Steering Committee Board comprised of Chairman,	Meets monthly with Community Guiders from villages to review activities and collect reports. CHC staff	Throughout the life of the project, these Boards have worked closely and effectively with the CS18 team to plan, implement,

	Women's Union, CHC staff, and Population and FP motivator.	Board member reports to Project secretaries monthly.	and monitor project activities as well as to make necessary revisions, such as those based on the MTE findings.
Village (220 in the current 25 active communes)	4 Community Guides (for ~900 people)	Implement 1) Community Meeting monthly on HCMC; 2) PD/Hearth @ 12 days per month for 9 months. 3) Home visit for counseling on child nutrition, antenatal care, postpartum care; 4) twice-yearly commune level BCC campaigns; 5) Monthly reporting and review at commune level.	They worked as volunteers with a small stipend (USD 3.50/month) to implement all hamlet-level project activities (requiring 15 days/month). Attrition rate was high in communes of Phase 1 and 2. The guides have limited skills in data, information recording and reporting, which CS18 is strengthening.
PATH	Contract with PATH for the period September 30, 2002 to September 29, 2005	Led the development of BCC strategies and materials and built BCC capacity among Project partners.	SC and PATH collaborated closely and effectively during the contract time.
RTCCD	Sub-grant agreement with RTCCD for the period September 30, 2002 to September 29, 2007	(1) Assume the leading role for Project training for community-based activities (GMP, HEARTH, and BCC), (2) adapt existing SC training manuals for maternal-newborn care and nutrition, and (3) monitor and supervise trainings conducted by master trainers and activities implemented at the commune and hamlet levels.	Because of work not completed on time or with adequate quality, irregular project monitoring schedules, lack of continuity in staffing, irregular supervision within RTCCD, differences in viewpoints about Project requirements and approaches, differing expectations about project performance standards, and changes in the organizational structure and geographic presence of RTCCD with the emergence of ACEP as a largely independent organization, SC and RTCCD agreed to terminate the sub-agreement in May 2005. All required termination procedures were completed by July 2005, including: (1) Agreed termination by April 05 including agreement on final payment; (2) report of audit visit by June 05; (3) final progress report by July 05.

Table 8: PD/Hearth Phases, Plan, Status, Revised Status, and Further Revised Status

Phase	Plan	Status at MTE	Revised Status post MTE (Nov 2005) and MTE Workshop (Jan 2006)	Further Revised Status post MTE Review (Mar 2006)
1	8 communes (5 DK and 3 HH) to serve as training sites for observation and to “transplant” the interventions to others communes	55 hearths were completed through November 2004 when SC support ended; local partners committed to sustain monthly GMP child weighing and twice-yearly food demonstrations.	Community Guides from 15 phase 1 and 2 communes are currently being refreshed after MTE to sustain: monthly community meeting; GMP and food demonstration and hearths	
2	7 communes (3 DK and 4 HH)	65 hearths are running in 57 villages. The Project revised hearth schedule from 9 months per session (12 d/m x 3 m; 6 d/m x 3 m; 3 d/m x 9 m). Phase two hearths will finish in March 2006, and partners will sustain GMP and food demonstrations as above.	Community Guides from 15 phase 1 and 2 communes are currently being refreshed after MTE to sustain: monthly community meeting; GMP and food demonstration and hearths	
3	10 communes (3 DK and 7 HH)	Completed HCMC training for Community Guides who now implement community meetings	55 Hearths (including 10 hearths in 5 Phase 1 Da Krong communes, funded by SC JSDF project) in Phase 3 start April 2006, following revised guidelines: (1) 9 month cycle; (2) only hamlets with 30+% malnutrition and 6+ children; (3) enroll only malnourished children (4) hearth within walking distance; (5) Deworm children <2 and pregnant women; (6) map malnourished children; (7) develop hearth graduation criteria; (8) discuss nutritional status of children at community meetings. Phase 4 Hearths: to be decided	Still under discussion, but may drop Hearths in Huong Hoa and continue as planned in Da Krong, according to district team’s recommendations.
4	11 communes (3 DK and 8 HH): start training in May 2006			

Table 9: PD/Hearth Options

Option	Pro	Con
Drop PD/Hearth in place of GMP, CM, Home Visits for C/D, etc.	<ul style="list-style-type: none"> • Saves \$ • Insufficient time for PD/Hearth (21/36 communes [most difficult] remain) • National plan • Hunger for several months, i.e., PD/Hearth not appropriate 	<ul style="list-style-type: none"> • Less inputs for MOH and people • Knowledge > practice • No CM without HEARTH • National plan as minimal as twice yearly demonstrations
Continue PD/Hearth (A-D children x 9 mos) in hamlets meeting nutritional criteria	<ul style="list-style-type: none"> • Innovative • Practice > knowledge • HEARTH is heart of CM • HEARTH better than nothing 	<ul style="list-style-type: none"> • Mixed success so far. • Attendance in HH low; expects NOT to implement
Continue PD/Hearth (A-D children x 15 mos) in hamlets meeting nutritional criteria	<ul style="list-style-type: none"> • Practice > knowledge • HEARTH is heart of CM • HEARTH better than nothing 	<ul style="list-style-type: none"> • Attendance in HH low • Attendance in HH low; expects NOT to implement
Continue PD/Hearth (B-C children) in hamlets meeting nutritional criteria	<ul style="list-style-type: none"> • MOH expecting this. • Practice > knowledge • HEARTH is heart of CM • HEARTH better than nothing 	<ul style="list-style-type: none"> • Attendance in HH low • Attendance in HH low; expects NOT to implement

Table 10: Living University

Essential Elements & Approach (from DIP)	Achievements	Comment
<ul style="list-style-type: none"> • The Project will establish one LU training site in each of the two districts to enable the rapid expansion of the CS18 approach. • RTCCD, PATH, and SC will conduct training needs assessments and develop training curricula and methods. SC and PATH will provide technical content for training modules, which will be taught jointly by RTCCD and DHS staff. • RTCCD will take over implementation and maintenance of the LU over the course of the Project. RTCCD staff based in Huong Hoa will train in local languages, as needed (i.e., for HHWs). • The expectation is that RTCCD will transfer the LU to the district, which will then continue the LU with relevant trainings. The district MOH staff is responsible for training commune and hamlet staff. 	<ul style="list-style-type: none"> • Project training materials, which included training manual packet, pictures, flipcharts and other supportive materials (doll, placenta, breast model), were developed. • The project has strong district training teams trained in teaching skills, interpersonal communication skills, HCMC, malnutrition prevention, supportive supervision, etc. • District training teams have two years experience in project implementation. • We have a commitment from Mr. Hien (Director of District Health Centre, Da Krong) that with resources from SC's ECD project, he will support hearth and HCMC activities in one or two villages in phase 1 and 2 communes. These should be considered as potential LU sites. • Many (government, NGOs, multilaterals) are interested in the CS18 model; some have visited; other want to visit; Quang Tri Provincial Health Service requests a working site in which to place medical students 	<ul style="list-style-type: none"> • The main implementing partner (RTCCD) is gone, yet the rationale for a working model that can be visited and observed is powerful, not the least of which is that the DIP described it.

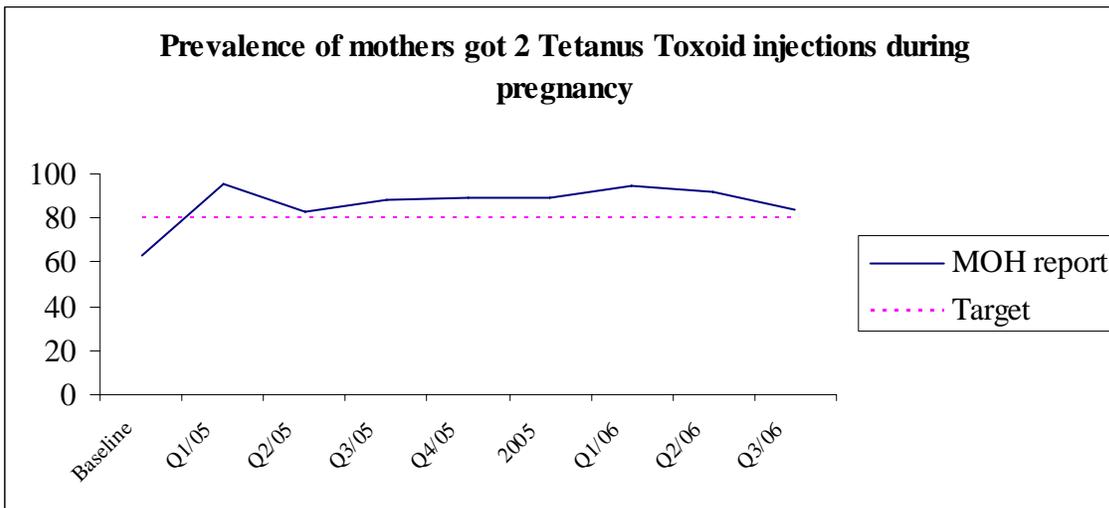
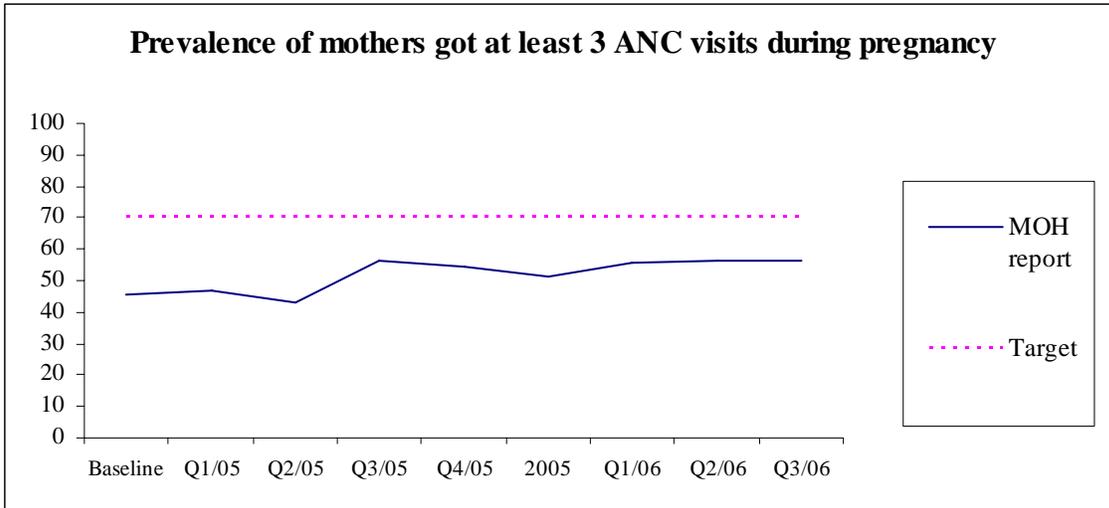
Table 11: Selected Results by Commune Ethnic Composition (preliminary)

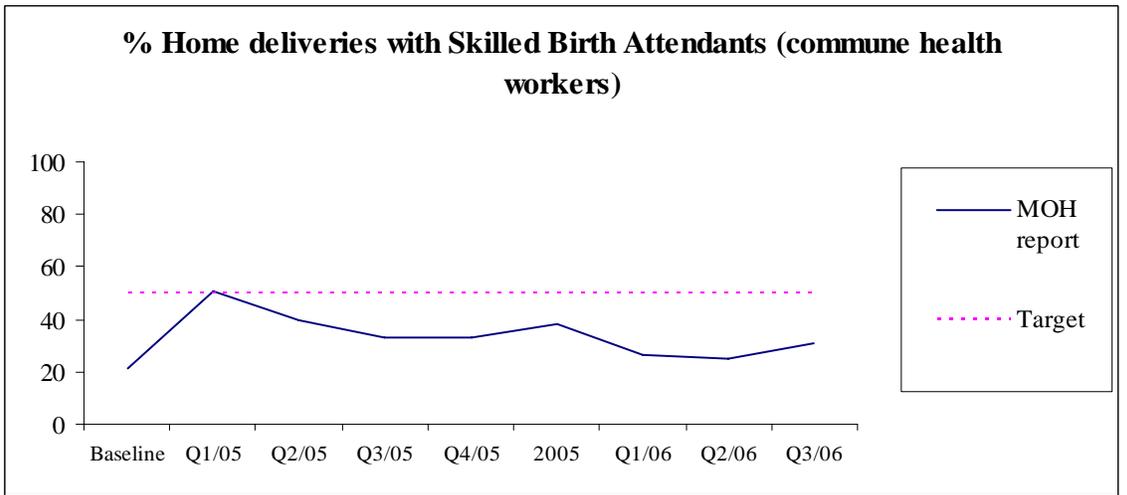
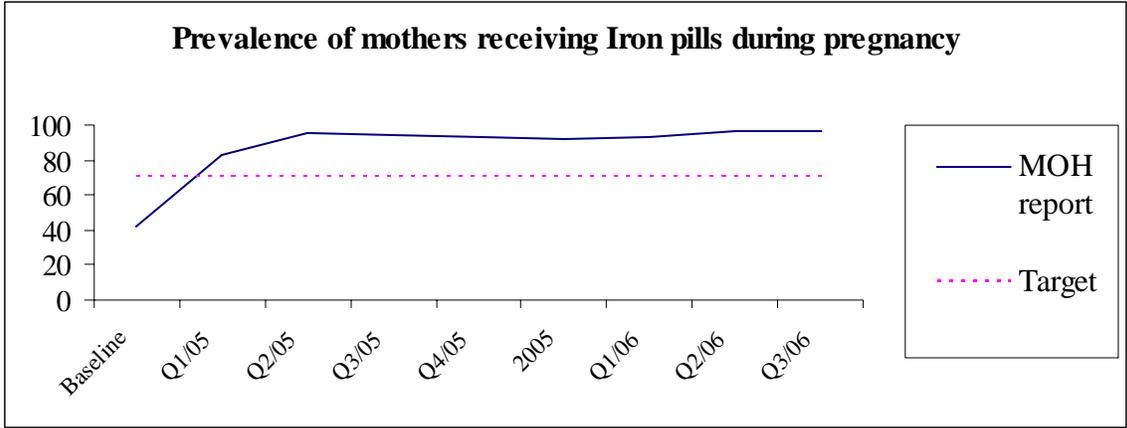
Indicators	Minority communes			Kinh communes			Mixed communes		Target
	Baseline	2004	2005	Baseline	2004	2005	Baseline**	2005	
>= 3 ANC	45	33	44	45	78	70	45	82	70
TT2*	46	87	90	87	97	90	63	80	80
Iron pill*	26	77	92	66	67	90	42	97	70
Deliveries with trained birth attendants*	10	70	72	78	85	88	21	88	50
Clean cord cutting	41	95	91	41	97	97	41	97	70
Postpartum within 7 days*	13	36	55	46	67	69	27	32	50
Postpartum vitamin A	26	61	80	26	92	90	26	97	50
Newborn weighed*	21	65	68	86	86	92	49	97	70
Newborn death		36	22		33	8		-	18

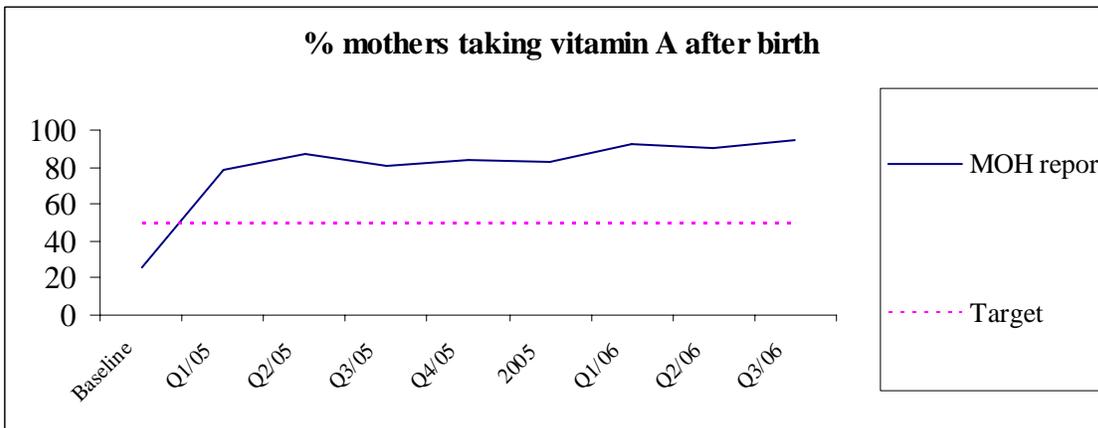
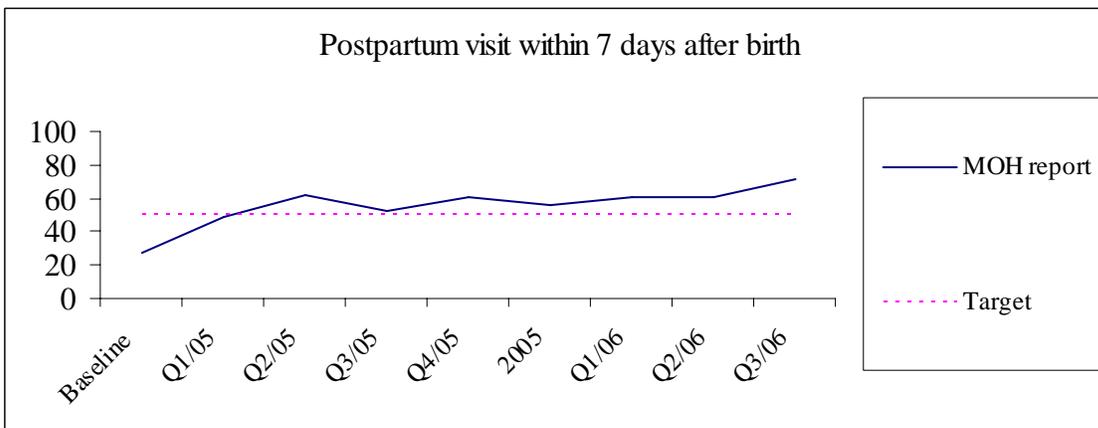
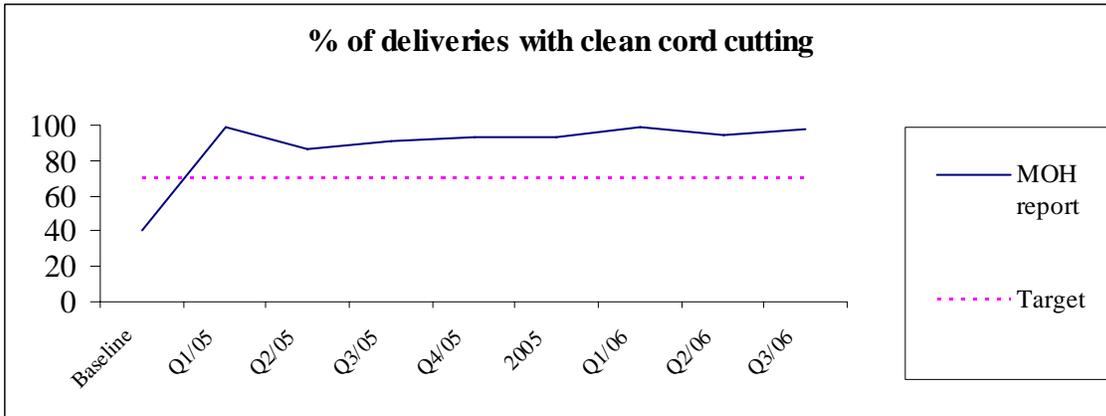
* baseline value is stratified by ethnicity

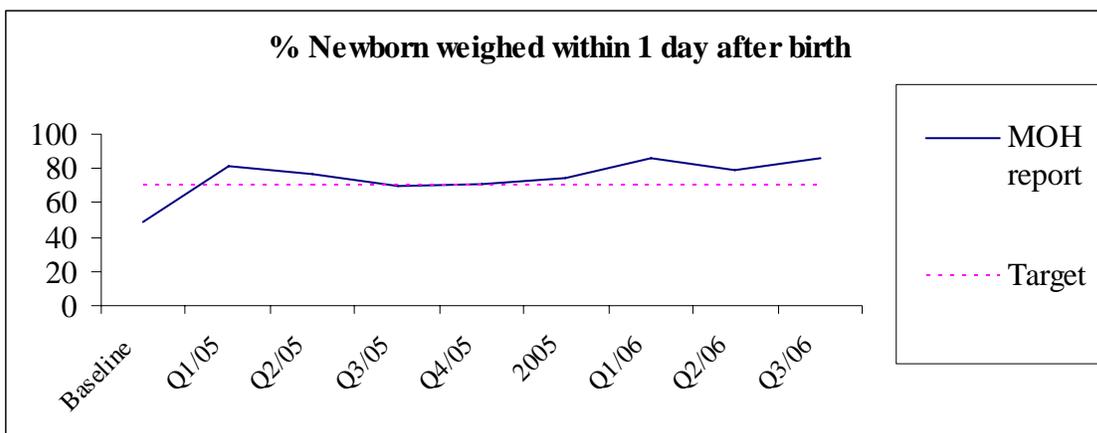
** baseline value for overall

Annex 3
Routine Monitoring Data October 2005 to July 2006:





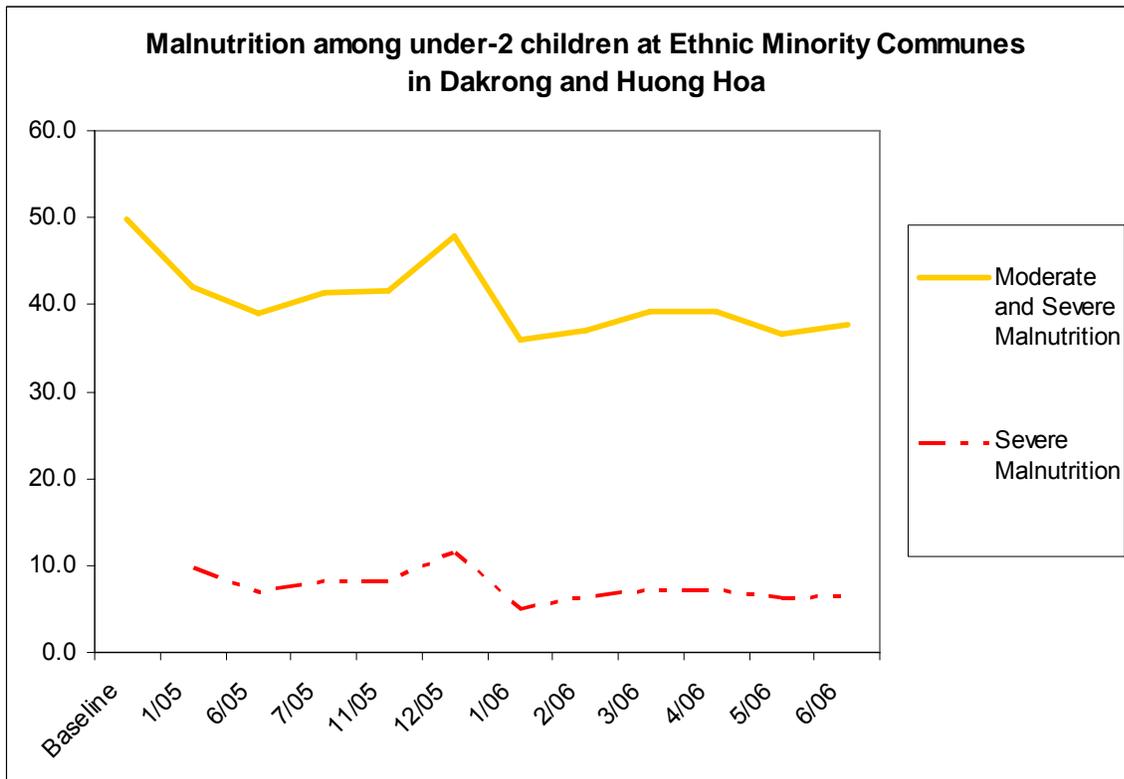
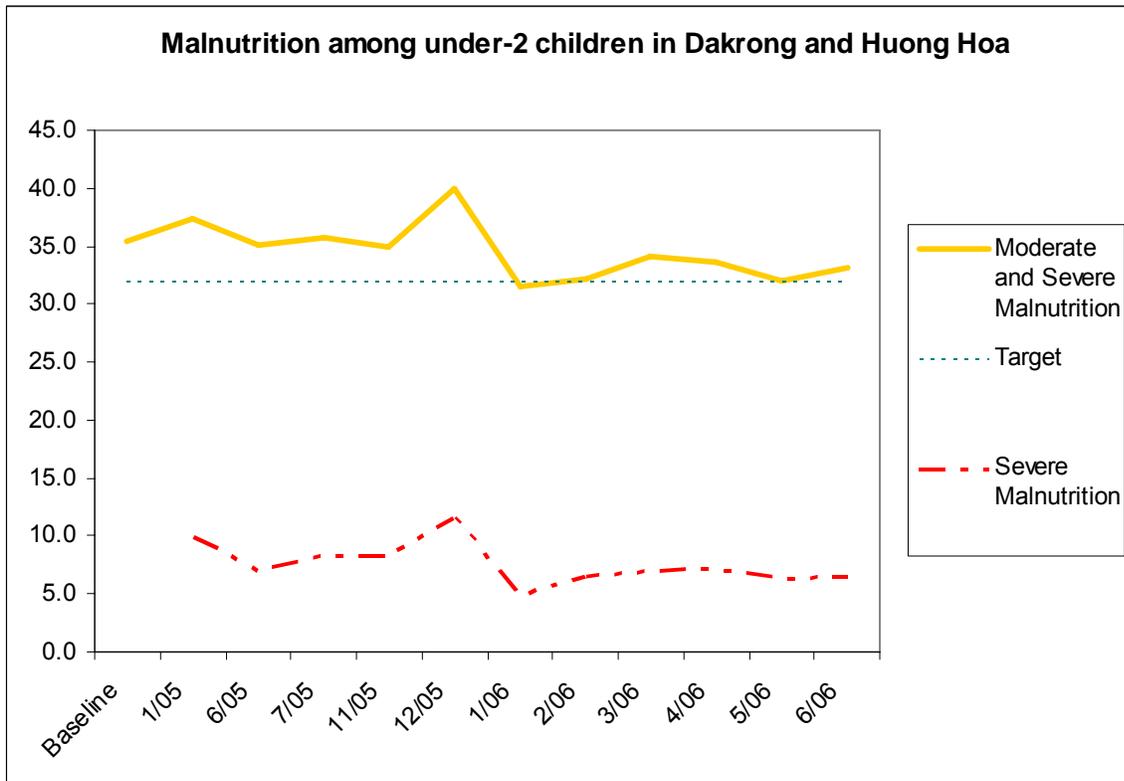




GMP data

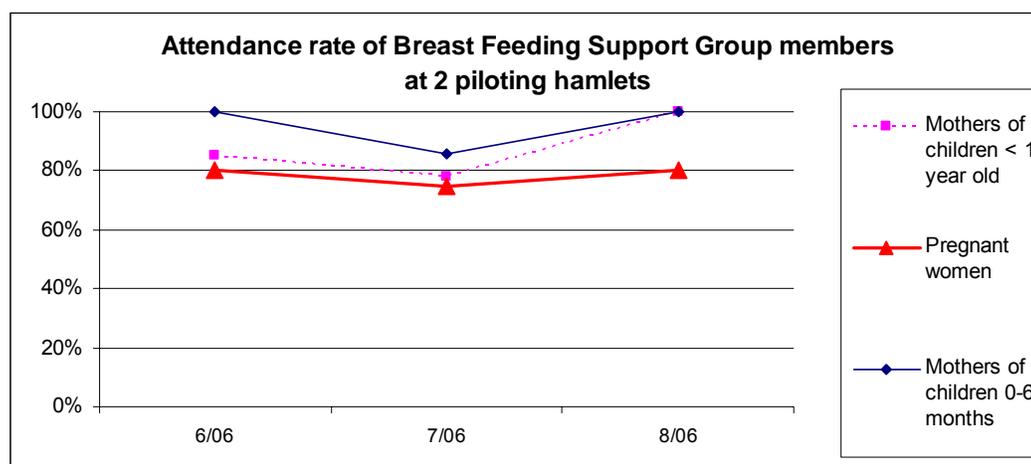
Time	Overall		Ethnic minority communes	
	Moderate and severe malnutrition	Severe malnutrition	Moderate and severe malnutrition	Severe malnutrition
Baseline	35.4		49.8	
Jan 05	37.3	9.9	42.1	11.7
June 05	35.0	7.0	39.0	8.3
June 06	33.2	6.5	37.8	8.2
Target	25.4			

Overall



Monitoring data of Breastfeeding Support Groups in 2 Piloting Hamlets

Target group		May 06	June 06	July 06	August 06
Mother with children less than 1 year	Total number in the hamlet	21	20	18	18
	# attending group meetings	0	17	14	18
Pregnant women at 3rd trimester	Total number in the hamlet	2	5	4	5
	# attending group meetings	0	4	3	4
Mothers with children 0 - 6 months old	Total number in the hamlet	10	7	7	7
	# attending group meetings	0	7	6	7
	# giving EBF	1	3	4	4
	# resume EBF	0	1	1	0
Mothers with children 0 - 3 months old	Total number in the hamlet	4	3	1	3
	# giving EBF	1	2	1	3
Mothers with children 4 - 6 months old	Total number in the hamlet	0	4	6	4
	# giving EBF	0	1	3	1



Annex 4

CSHGP Data Form for CS-18 Vietnam, Second Annual Report

Project Field Contact Information

First Name	Pham Bich
Last Name	Ha
Title	Health and Education Program Director
Address Line 1	[REDACTED]
Address Line 2	[REDACTED]
City	[REDACTED] i
Country	[REDACTED]
Telephone	[REDACTED]
Fax	84-4-943-5697
Email	Hapb@savechildren.org.vn

Project Information

Project Description

Save the Children has been implementing a five-year, two-district Child Survival Project (CS-18), *Building Partner Capacity for Child Survival of Vietnamese Ethnic Minority Population*, in Dakrong and Huong Hoa district, Quang Tri Province. The Project site includes all 36 communes in the two districts, with a total population of 89,000, including 14,000 children under five years old, and 21,000 women of reproductive age.

The goal of CS-18 is to achieve a sustained reduction in maternal and under-five mortality through the following specific objectives: (1) increased service accessibility and availability; (2) improved service quality; (3) increased use of services; (4) increased practice of key behaviors; and (5) sustainability.

Major Project interventions are: maternal and newborn care (45%), nutrition and micro-nutrition (40%), and breastfeeding (15%).

Key strategies include: (1) the positive deviance approach for sustainable community-based rehabilitation and the prevention of malnutrition; (2) positive deviance, pilot-tested for improved newborn care; (3) community meeting approach with application of positive deviance plus method; (4) living university methods for joint health system strengthening and community demand mobilization; and (5) enabling a local NGO, the Regional Training Center for Community Development to take over the Living University (LU) to sustain and scale up successful experience.

Partners

PATH

Dakrong District Health Service

Huong Hoa District Health Service

Project Location DaKrong and Huong Hoa Districts of Quang Tri Province

Target Beneficiaries

<i>Type</i>	<i>Number</i>
Infants (0-11 months)	2,450
12-23 month old children	2,896
24-59 month old children	8,585
0-59 month old children	13,931
Women 15-49	20,897
Estimated number of births	2,768
<i>Urban/Peri-Urban %</i>	<i>Rural %</i>
15.7	84.3

Grant Funding Information

USAID	\$ 1,300,000	PVO Match	\$ 433,342
--------------	--------------	------------------	------------

Date & Project Phase October 31, 2004

<i>General Strategies Planned:</i>			
Microenterprise	No	Social Marketing	No
Private Sector Involvement	No	Advocacy on Health Policy	Yes
Strengthen Decentralized H. System	No	Information System Technologies	No
<i>M& E Assessment Strategies:</i>			
KPC Survey	Yes	Health Facility Assessment	Yes
Organizational Capacity Assessment w/Local Partners	Yes	Org. Capacity Assessment for your own PVO	Yes
Participatory Rapid Appraisal	Yes	Participatory Learning in Action	Yes
Lot Quality Assurance Sampling	No	Appreciative Inquiry-based Strategy	No
Community -Based Monitoring Techniques	Yes	Participatory Evaluation Techniques (for mid term or final evaluations)	Yes

<i>Behavior Change and Communication Strategies</i>			
Social Marketing	No	Mass Media (actually mid-media: loudspeakers, radio-on small scale)	Yes
Interpersonal Communication	Yes	Peer Communication	Yes
Support Groups	Yes		

Capacity Building Targets Planned									
PVO		Non-Gov't Partners		Other Private Sector		Government		Community	
US HQ-Gen	Yes	PVOs	Yes	Pharmacists	No	Nat'l MOH	Yes	Health CBOs	Yes
US HQ-CS	Yes	Local NGO	Yes	Business	No	DHS	Yes	Other CBOs	Yes
FO CS Team	Yes	Networked group	Yes	Traditional Healers	Yes*	----HF Staff	Yes	CHWs	Yes
				Private Providers	No	Other Nat'l Ministry	No		

*Very few TBAs were found, and Project would invite them to LSS trainings.

Key Technical Project Interventions:

Nutrition 40%		IMCI Integer	No	CHW Training	Yes	HF Training	Yes
Min-Pack	No	Gardens	No	Comp. Feeding from 6 months*	Yes	Hearth	Yes
Cont BF to 24 mo	Yes	Growth Monitoring	Yes				

Maternal & Newborn Care 45%		IMCI Integr.	Yes	CHW Training	Yes	HF Training	Yes
EOC	Yes	Neonatal Tetanus	Yes	Recognition of Danger Signs	Yes	Newborn Care	Yes
Postpartum care	Yes	Delay 1st Pregnancy	No	Integrate with Iron and Folate	Yes	Normal Delivery Care	Yes
Birth Plans	Yes	STI Treat't w/ANC	No				

Breastfeeding 15%		IMCI Integr.	No	CHW Training	Yes	HF Training	Yes
EBF 6 months	Yes	LAM	No	Baby Friendly	No		

Rapid CATCH Indicators (based on the data of first 8 Project communes in Dakrong and Huong Hoa districts after 09 months of implementing Project activities)

Indicator	Numerator	Denominator	Percent*
1. Underweight	28	332	8.4%
2. Skilled birth attendant	182	489	37.2%
3. TT-2	437	489	89.4%
4. Delivery had ANC check-up \geq 3 times	205	489	41.9%
5. Home birth with utilization of CDK	220	232	94.8%
6. New mothers who took Vitamin A within two weeks after delivery	281	489	57.5%
7. Postpartum visit within 1 day after delivery	279	489	57%
8. Postpartum visit within 7 days after delivery	165	489	33.7%