



Child Survival 18 – Vietnam
Cooperative Agreement No.: HFP-A-00-02-00044-00

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

Quang Tri Province, North Central Region, Vietnam
1 October 2002 – 30 September 2007

Detailed Implementation Plan (DIP)

Submitted by:

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Acronyms and Terms

ACNM	American College of Nurse-Midwives
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BCG	Tuberculosis Vaccine
BEOC	Basic Emergency Obstetric Care
BF	Breastfeeding
BPP	Birth Preparedness (Package)
CDQ	Community Defined Quality
CDK	Clean Delivery Kit
CENP	Community Empowerment and Nutrition Program
CEOC	Comprehensive Emergency Obstetric Care
CHG	Community Guide
CHC	Commune Health Center
CPFC	Committee for Population, Family and Children
CS	Child-survival
CSC	Commune Steering Committee
CSTS	Child Survival Technical Support
DHS	District Health Services
DIP	Detailed Implementation Plan
DOH	District Health Office
DS	Danger Signs
DSC	District Steering Committees
EBF	Exclusive Breastfeeding
EmOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
FO	Field Office
FP	Family Planning
GMP	Growth Monitoring and Promotion
GOV	Government of Vietnam
HBLSS	Home-Based Life-Saving Skills
HCMN	Home Care for Mothers and Newborns
HFA	Health Facilities Assessment
HH	Household
HHW	Hamlet Health Worker
HIS	Health Information System
HIV/AIDS	Human Immune-deficiency Syndrome/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information Services
HO	Home Office (of Save the Children, located in Westport, CT)
HQ	Headquarters (of Save the Children)
IEC	Information, Education and Communications
IFA	Iron Folic Acid
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IU	International Unit
KPC	Knowledge, Practice, and Coverage
LBW	Low Birth Weight

LOE	Level of Effort
LU	Living University
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
MNC	Maternal Newborn Care
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MWG	Minority Working Group
MSG	Mono-Sodium Glucomate
NERP	Nutrition Education and Rehabilitation Program
NGO	Nongovernmental Organization
OR	Operations Research
ORT	Oral Rehydration Therapy
PC	People's Committee
PD	Positive Deviance or Positive Deviant
PDI	Positive Deviance Inquiry
PHS	Provincial Health Services
PLG	Program Learning Group
PO	Project Officer
PVO	Private Voluntary Organization
RH	Reproductive Health
RTCCD	Research and Training Center for Community Development
SC	Save the Children Federation, Inc.
SC/VNFO	Save the Children/Vietnam Field Office
SM	Safe Motherhood
SMS	Secondary Medical School
SNL	Saving Newborn Lives Initiative
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
U5MR	Under Five Mortality Rate
UNICEF	United Nations Children's Fund
VAC	Vitamin A Capsule
VHW	Village Health Worker
WU	Women's Union

Vietnamese Terms

<i>Thay mo/thay thuoc</i>	Traditional/indigenous healers
<i>Gia lang</i>	Hamlet elder

Section A: Executive Summary

This Detailed Implementation Plan (DIP) further elaborates Save the Children's (SC) child survival Project, "Building Partner Capacity for Child Survival of Vietnamese Ethnic Minority Populations." The Project will target ethnic minority people in the North Central Region of Vietnam, specifically in two districts (Da Krong and Huong Hoa) of Quang Tri Province. While targeting the disadvantaged minorities, the Project will, in fact, cover the whole population of the two districts. Responding to communities' expressed needs, Ministry of Health priorities, and SC national and global strategy, the Project seeks a sustainable reduction in infant, under 5, and maternal mortality in these ethnic minority districts through strengthening the quality and accessibility of existing health services and through improved and sustained household level practices. The health profile of these districts accurately represents the situation in most of Vietnam's highlands, with minority populations marginalized from the mainstream Vietnamese population. As such, SC proposes to develop successful community-based models and pilot-test innovative approaches, which will be promoted for similar highland communities in other areas of the country through partners and collaborating organizations, thus promoting further replication and achieving scale.

Although Vietnam's (total population 77.6 million) overall national health statistics (maternal mortality ratio [MMR] and under five mortality rate [U5MR], 170/100,000 live births and 44/1000 births, respectively) are not particularly alarming, they unfortunately mask important regional and ethnic differences and do not clearly demonstrate the gravity of the health status of the traditionally underserved minority people. Indeed, Quang Tri Provincial MOH estimates for MMR, IMR, and U5MR in the impact districts are high (339, 73, and 156, respectively). One third (31% in Huong Hoa) to one half (48% in Da Krong) of the children are underweight.¹ Districts compared to 33% nationally. The high mortality and morbidity result from non-practice of key household behaviors (e.g., exclusive breastfeeding, appropriate complementary feeding, newborn care); low use of key services, especially among the ethnic minorities (e.g., 26% use of antenatal care, 82% unattended home delivery, 13% use of postnatal care²); and inaccessible, low quality services (e.g., emergency obstetric care).

Strategies: The Government of Vietnam (GOV) has invested heavily in public health for ten years, and national statistics confirm progress, but mountainous, minority, remote areas have seen little improvement. Commune and district health centers are poorly equipped and under-utilized, and health workers are poorly trained. Remote hamlets have limited access to Commune Health Centers (CHCs), and illness is generally treated at home. Pregnant women deliver at home, and nutrition and breastfeeding practices remain poor. CS-18 will work to reduce this gap through strengthening the health services offered in the District Health Service (DHS) and CHCs and their outreach activities and through community mobilization for adoption of better household practices and care seeking behaviors. The Project will train a Hamlet Health Worker [HHW] network and support other community volunteers to bring health services and behavior change interventions directly to the households (aiming to reduce unhealthy practices related to pregnancy, labor and delivery, newborn care, child nutrition, and breastfeeding). Concurrently, the Project will enhance the capacity of health

¹ Baseline KPC Survey, SCUS/Vietnam 2003

² Ibid

workers, facilitate supervision, and strengthen and support both the outreach services and the referral system for the emergency care.

There are a few modest changes from the initial proposal (clinical training in emergency obstetric care for physicians and midwives and HCMN [Home Care for Mothers and Newborns], training for HHWs), but no changes in the choice of interventions and the approximate level of effort on each, including: maternal and newborn care (45%), nutrition and micronutrients (40%) and breastfeeding (15%). The Project relies on existing health personnel, structures, relationships, priorities and plans and follows the MOH policies. Similarly, there was no change in Project site; it includes all 34 communes in the two rural mountainous districts, with a current total population of 87,070 including 13,931 children under age five years and 20,897 women of reproductive age. During the first two years, the Project will concentrate on implementing activities under maternal and newborn care interventions, in alignment with the stated GOV priorities.

The goal of the program is to achieve sustained reductions in maternal and under-five mortality, through the following program objectives: (1) increased use of maternal, newborn and child care services, (2) increased practice of key household behaviors, (3) increased service accessibility, (4) improved service quality, and (5) improved sustainability of all activities through development and further strengthening of the key Project partners.

The Project will employ the following major strategies to achieve these objectives: (1) community mobilization for better maternal and newborn care through a two-pronged approach tailored to the two main groups: minority and Kinh majority. For the minority group, HHWs will conduct regular community meetings with pregnant women, new mothers and family members to introduce HCMN messages through role-play and negotiation building on current practices, based on SC's recent experience using ACNM's Home-Based Life-Saving Skills (HBLSS) for Safe Motherhood in Da Krong. For the Kinh group HHWs will conduct home visits with MNC messages from the Birth Preparedness Package (BPP) developed by Program for Appropriate Technology (PATH) and SC informed by SC's Safe Motherhood experience in Quang Xuong and Da Krong; (2) the Positive Deviance (PD) approach for sustainable community-based rehabilitation and prevention of malnutrition building on SC's eight years of experience with Hearth/PD in Vietnam low-land populations; (3) the PD approach pilot-tested for improved newborn care building on early SC experience in Pakistan; (4) breastfeeding support groups which incorporate PD and other active learning methods building on past experience with the LINKAGES Project; (5) the Living University (LU) method for health system strengthening and community demand mobilization building on SC's nation-wide experience in Vietnam; (6) additional innovative behavior change approaches for ethnic populations with profound cultural and linguistic barriers in partnership with PATH; and (7) strengthening a local NGO, the Regional Training Center for Community Development (RTCCD) to enable decentralized and transfer of training responsibilities under the LU model to sustain and scale up successful experience.

The CS-18 Project reflects SC experience and expertise with the community-level implementation of all three interventions, and builds on current innovative SC work with breastfeeding and maternal nutrition and its recent experience in Safe Motherhood in Quang Xuong and Da Krong Districts, working with both ethnic Vietnamese majority people as well as the ethnic highland minority groups. The additional innovative BCC approaches to be introduced with PATH will include peer education for teenagers in reproductive health,

maternal and newborn care, and child nutrition at traditional *Sim Houses* among the minority Van Kieu group.

Key partner agencies involved in program implementation include the MOH, the Women's Union, and the Committee for Population, Family and Children (CPFC) at the province level in Dong Ha (provincial capital) and at district level in Da Krong and Huong Hoa Districts, and at the commune level. For improvements in health services, the main clinical training activities will be implemented through Quang Tri Secondary Medical School (SMS) trainers, province health trainers and district health trainers, who will in turn train CHC midwives in maternal and newborn care, following the MOH guidelines for each service level. In addition, SC will collaborate with two medical training institutions to strengthen Quang Tri organizations: Hue Medical School and Hanoi Secondary Medical School to provide clinical training for doctors on basic and comprehensive emergency obstetric care.

For improvement of household practices, the key partners involved in implementing the BCC activities at the village level are community guides who are HHWs, staff from the Women's Union, and CPFC. District and province Women's Union, CPFC and district health staff together will provide training and supervision for community meetings at each village. Based on SC's experience on HCMN, PD inquiries, and Hearth activities for child nutrition, SC will provide technical assistance to RTCCD, a local NGO, and to PATH, a US-based NGO, on developing BCC materials and implementation of BCC activities. During the Project implementation, PATH will creatively develop new strategies for BCC for these two districts. It is envisioned that as a result of the concerted effort to strengthen RTCCD, they will eventually assume the responsibility for most of the training and supervision within the Project by applying the Living University concept. Furthermore, the Project design reflects extensive discussion with other health districts, the MOH, and the National Institute of Nutrition in Hanoi. The Project will benefit from and inform the global agendas of SC's Saving Newborn Lives Initiative and Positive Deviance Initiative.

The original CSHGP application was in the New Grant category covering a five-year period, starting October 1, 2002, ending September 30, 2007. To fund this program SC has been granted \$1,300,000 of USAID funding, with a 25% match from SC or \$433,342 for an annual cost per beneficiary in Year Five of \$ 9.06.

Mr. Mark Rasmuson was the initial USAID Mission representative, with whom SC has been in close contact in the process of development of this Project proposal. Following his departure from Hanoi, SC is in contact with Mr. Daniel Levitt.

Principal authors of this DIP are Ms. Inga Oleksy, Delhi-based consultant, and Dr. David Marsh, SC Senior CS Advisor based in Westport, CT. Dr. Pham Bich Ha and Dr. Nguyen Anh Vu, both based in SC/VNFO, made important contributions to the report as well as other health staff of the VNFO.

Dr. David Marsh continues to be the contact person for the DIP at SC/HQ.

Section B: CSHGP Data Form (on-line submission attempted without success)

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Project Information

Project Description Save the Children's (SC) child survival Project, "Building Partner Capacity for Child Survival of Vietnamese Ethnic Minority Populations" will target ethnic minority people in the North Central Region of Vietnam, specifically in two districts (Da Krong and Huong Hoa) of Quang Tri Province. While targeting the disadvantaged minorities, the Project will, in fact, cover the whole population of the two districts. Responding to communities' expressed needs, Ministry of Health priorities, and SC national and global strategy, the Project seeks a sustainable reduction in infant, under 5, and maternal mortality in these ethnic minority districts through strengthening the quality and accessibility of existing health services and through improved and sustained household level practices. As the health profile of these districts represents very much the situation in most of Vietnam's highlands, with minority populations marginalized from the mainstream Vietnamese population, SC proposes to develop successful community-based models and pilot-test innovative approaches, which will be promoted for similar highland communities in other areas of the country through partners and collaboration organizations, thus promoting further replication and achieving scale.

The interventions and the approximate level of effort on each are: maternal and newborn care (45%), nutrition and micronutrients (40%) and breastfeeding (15%). The Project relies on existing health personnel, structures, relationships, priorities and plans and follows the MOH policies. Similarly, there was no change in Project site; it includes all 34 communes in the two rural mountainous districts, with a current total population of 87,070 including 13, 931 children under age five years and 20, 897 women of reproductive age. Reflecting the stated GOV priorities, during the first two years, the Project will concentrate on implementing activities under maternal and newborn care intervention.

The goal of the program is to achieve sustained reductions in maternal and under-five mortality, through the following program objectives: (1) increased use of maternal, newborn and child care services, (2) increased practice of key household behaviors, (3) increased service accessibility, (4) improved service quality, and (5) improved sustainability of all activities through development and further strengthening of the key Project partners.

The Project will employ the following major strategies to achieve these objectives: (1) community mobilization for better maternal and newborn care through a two-pronged approach tailored to the two main groups: minority and Kinh majority. For the minority

group, HHWs will conduct regular community meetings with pregnant women, new mothers and family members to introduce HCMN messages through role-play and negotiation building on current practices, based on SC's recent experience using ACNM's Home-Based Life-Saving Skills (HBLSS) for Safe Motherhood in Da Krong. For Kinh group HHWs will conduct home visits with MNC messages from the Birth Preparedness Package (BPP) developed by Program for Appropriate Technology (PATH) and SC informed by SC's Safe Motherhood experience in Quang Xuong and Da Krong; (2) the positive deviance (PD) approach for sustainable community-based rehabilitation and prevention of malnutrition building on SC's eight years of experience with hearth/PD in Vietnam low-land populations; (3) the PD approach pilot-tested for improved newborn care building on early SC experience in Pakistan; (4) breast-feeding support groups which incorporate PD and other active learning methods building on past experience with the LINKAGES Project; (5) the Living University (LU) method for health system strengthening and community demand mobilization building on SC's nation-wide experience in Vietnam; (6) additional innovative behavior change approaches for ethnic populations with profound cultural and linguistic barriers in partnership with PATH; and (7) strengthening a local NGO, the Regional Training Center for Community Development (RTCCD) to enable decentralized and transfer of training responsibilities under the LU model to sustain and scale up successful experience.

Partners Key partner agencies involved in program implementation include MOH, Women's Union, and Committee for Population, Family and Children (CPFC) at the province level in Dong Ha (provincial capital) and at district level in Da Krong and Huong Hoa Districts, and at the commune level. For improvement of health services, the main clinical training activities will be implemented through Quang Tri Secondary Medical School (SMS) trainers, province health trainers and district health trainers, who will in turn train CHC midwives in maternal and newborn care, following the MOH guidelines for each service level. In addition, SC will collaborate with two medical training institutions to strengthen Quang Tri organizations: Hue Medical School and Hanoi Secondary Medical School to provide a clinical training for doctors on basic and comprehensive emergency obstetric care.

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Project Location North Central Region of Vietnam, specifically in two districts (Da Krong and Huong Hoa) of Quang Tri Province

Target Beneficiaries

Type	Number
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
Urban/Peri-Urban %	Rural %
15.7	84.3

Grant Funding Information

USAID	\$ 1,300,000	PVO Match	\$ 433, 342
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Date & Project Phase April 28, 2003; DIP

General Strategies Planned:			
Microenterprise	No	Social Marketing	No
Private Sector Involvement	No	Advocacy on Health Policy	Yes
Strengthen Decentralized H. System	Yes	Information System Technologies	No
M& E Assessment Strategies:			
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	Yes	Appreciative Inquiry-based Strategy	No
Community -Based Monitoring Techniques	Yes	Participatory Evaluation Techniques (for mid term or final evaluations)	Yes

Behavior Change and Communication Strategies			
Social Marketing	No	Mass Media (actually mid-media: Loud speakers, 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 Integr	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.	No	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	?				

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

Rapid CATCH Indicators

Indicator	Numerator	Denominator	Percent*
1. Underweight	142	400	35.4%
2. Birth interval < 24 mos	**	**	**
3. Skilled birth attendant	203	400	55.5%
4. TT-2	250	400	63.0%
5. EBF (< 6mos)	39	122	31.8%
6. CF & BF	55	55	100%
7. Full vaccination	***	***	***
8. Measles vaccination	***	***	***
9. Bednet	216	400	60.3%
10. Child danger signs	240	400	60.0%
11. Illness diet	**	**	**
12. HIV risk reduction	**	**	**
13. Handwashing	**	**	**

*Indicators are weighted by cluster and district, so calculated values may differ somewhat from quotient from dividing the numerator by the denominator.

**Not asked.

***Not asked correctly (i.e., “ever had any immunization?”).

Section C: DIP Preparation Process

Preparation of this DIP followed a bottom-up program planning approach, involving all key Project partners and stakeholders in the conceptualization process in three major steps: (1) consensus building in two, two-day DIP workshops in the districts, during which the participants received information about the upcoming CS Project, developed a common

vision of the Project and elaborated preliminary workplans; (2) processing of the two workshops' outcomes by the facilitators, consolidation and refinement of the broad plans, and agreement on partners' roles and responsibilities; and (3) drafting of the DIP document by the consultant, with detailed feedback from SC.

DIP Workshop The first step involved broad consensus building through two, two-day district-based participatory workshops involving stakeholders, implementing partner agencies and the external consultant.

1. The agenda of the workshops was prepared by the SC staff and refined by the workshop facilitators over a period of two days in Dong Ha, Quang Tri province at SC's new office.
2. The facilitators consisted of key partner agency staff (PATH and RTCCD assigned to the Project), the district staff, and an external consultant.
3. The participants included representatives of the provincial level Health Authorities, Secondary Medical School (i.e., one that trains nurse-midwives), District and Commune Health representatives as well as commune level key implementing actors including representatives of various mass organizations (Women's Union, People's Committee, Farmers Union, etc. [complete list included below]).
4. Workshop objectives, materials (both presentations and handouts, as well as group discussion guidelines and topics) were jointly elaborated in group work by the facilitators.
5. Workshop presentations on CS Project Overview, Baseline Research Findings and best practices were elaborated by SC staff (and consultant) and reviewed by all facilitators in the preparation process (over a two-day period in Dong Ha).

Workshop Objectives:

1. Clarify and confirm participants' expectations of the Project.
2. Present best practices in maternal, newborn and child care.
3. Review the approved CS-18 proposal, with its key goals and objectives.
4. Share baseline information from the district with the stakeholders.
5. Identify key activities to address specific local health problems (preliminary workplan).
6. Engage all participants in the process and encourage their contributions.
7. Obtain and generate enough information to write the DIP (not yet met, unrealistic).
8. Discuss roles and responsibilities of implementing partners (met partially, MOH partners).
9. Create a shared vision among all program partners and strengthen program relationships.
10. Obtain participants' commitments for implementation

DIP Workshop Participants: **Province:** People's Committee (PC), Province Health Service, MCH/FP, Preventive Medicine Center, Quang Tri Secondary Medical School, Women's Union (WU). **District:** People's Committee (PC), District Health Service (DHS), WU, Border Security Military, CPFC, Farmers' Association, Red Cross Association. **Commune:** PC, Head of CHC and commune midwife, WU, CPFC From each represented commune (five for each commune).

DIP Workshop Facilitators/Organizers: **SC/Hanoi:** Dr. Ha (Health Program Specialist), Dr. Vu (CS Project Manager), Dr. Bui Thi Tu Quyen, intern (student form Hanoi SPH); SC/Dong Ha: Mr. Nam (CS Project Coordinator); Ms. Inga Oleksy, Consultant for DIP preparation and writing. **PATH/Hanoi:** Ms. Nguyen Hoang Yen, Senior Project Officer (BCC specialist). **RTCCD:** (local community development and training NGO based in

Hanoi and Huong Hoa, Quang Tri): Ms. Tran Thi Huong (Support Staff), Ms. Truong Thi Xuan (Project Officer), Ms. Nguyen Thi Huong, (Project Officer).

Processing Workshop Outputs The second step in the DIP preparation consisted of processing the outcomes of the workshops (broadly designed plans) by the key implementing agencies in an interactive process led by the consultant in Dong Ha and Hanoi (about 1.5 days). The broad plans derived at the workshops were reviewed by the facilitators in two groups. They were then consolidated and transcribed into specific strategies and activities designed to reach the program objectives and organized into a two-year workplan. Specific responsibilities were assigned to each implementing partner agency, according to their identified strength and expertise. This interactive process led by the consultant took one day. Further prioritization and refinement by SC and PATH continued in Hanoi (in recognition of partners' capabilities and the field's absorptive capacity). Ongoing discussions about the clarification of each partner's role in the Project resulted in draft role descriptions. The third draft of a workplan was produced in two sections: services strengthening and community-based BCC activities.

Workshop Process and Impressions The objectives of the workshops were met, and both the facilitation and the participation were extraordinary. Workshops utilized participatory adult learning techniques, including multi-media presentations, facilitated group discussions (in different group configurations to maximize information sharing among the participants), and several plenary question/answer sessions. To maintain the high energy, a very dynamic interactive facilitation process, with many experienced facilitators (SC, RTCCD, PATH, DOH), was applied and included creative warm-up activities. Participants and facilitators (from the implementing partners) ate lunch together to further promote interaction and exchange between them. Participants from all levels actively discussed the maternal and child care problems in their districts and communes as well as Project strategies, activities and intervention approaches to improve service delivery and quality at health facilities and BCC strategies for improving key household behaviors.

The first workshop was held in Da Krong Province (April 3-4), where SC had prior programmatic health and BCC experience. On April 5 the facilitators' team processed the lessons learned from the first workshop and revised and refined them for the second workshop in Huong Hoa, a new district. Relatively small adjustments were made as follows: agenda was revised to allow more time for group discussions and presentations, presentations were shortened and consolidated, group discussion topics were further refined, and all materials and handouts were simplified.

Drafting the DIP The third step involved the actual writing of the DIP, which was done by an external consultant, (based in Delhi), in close communication (active feedback and clarification process) between the consultant based in India, the SC Sr. Child Survival Advisor based in SC/HQ in Westport, CT, and the SC field staff based in Hanoi.

The first two steps took place in Vietnam over the period of 14 days, starting and ending in Hanoi, with nine days spent in the Quang Tri province, for a total of 12 consultant days in Vietnam. The actual DIP document was drafted over the period of 10 days in April.

Project Start-up Activities

The following Project start-up activities have been accomplished since the award and the official beginning of the Project:

1. SC held a meeting with the Province People's Committee and Province Health Service to formally notify them of the Project's approval and to sign a Partnership Agreement with Quang Tri Province Health Services on the implementation of the CS-18 Project in Da Krong and Huong Hoa Districts (October 2, 2002).
2. SC organized an orientation workshop in November 2002 with local partners from both districts to: (a) officially inform them of the Project award, and (b) to discuss follow-up activities to complete the DIP process, specifically regarding baseline studies.
3. SC established a regional office in Dong Ha town (capital city of Quang Tri Province) and launched it on January 2, 2003. Mr. Nam, a PHS staff member, was seconded as a CS-18 Project Coordinator, based at the new SC office for the five-year CS Project implementation period.
4. In collaboration with the Hanoi School of Public Health, SC conducted two studies to obtain baseline information for the Project (December 2002 - January 2003):
 - a. Standard CS Household Survey with selected CATCH indicators to assess the beneficiaries' knowledge, attitudes and practices regarding the maternal, newborn and child care issues. Drafting of the report has begun.
 - b. Health Facility Survey (developed specific checklists as study instruments) to assess the current level of equipment and functioning of the existing health services at both district and commune levels. Drafting of the report has begun.
5. In collaboration with RTCCD, SC conducted a Behavioral Determinant Study to identify normative maternal, newborn, and child care practices and their enabling factors/barriers among target beneficiaries (minority women).
6. SC led DIP preparation/orientation two-day workshops in both Da Krong and Huong Hoa Districts in Quang Tri province (as discussed above).

Follow-up for DIP Preparation Process

1. Finalize the Minutes for the both DIP workshops in Vietnamese and English. Keep a copy of each on file.
2. Using Minutes, draft a brief report from each workshop (in Vietnamese and English) and send Vietnamese versions to both districts and SC/Dong Ha office.
3. Finalize the baseline study reports, have them translated into Vietnamese and disseminated among the Project partners.
4. Develop and sign sub grant agreements, including SOW, Project description, workplan, and budget, with PATH, RTCCD, and Huong Hoa, Da Krong Districts.
5. Have the SOW for partner agencies (PATH and RTCCD) developed, approved and signed.
6. Begin the revisions of the existing HCMN and child nutrition materials and other activities in work-plan.

Section D: Changes from Original Proposal

There are some changes from the original proposal:

1. Project Interventions Approach:

Health Services:

- The content of the training courses for commune and district midwives will include a package for maternal and newborn care including Basic Emergency Obstetric Care (BEOC), which was not included in the original proposal.
- We also plan to add clinical training for obstetricians at Huong Hoa Hospital on Comprehensive Emergency Obstetric Care (CEOOC) as improved competence of district obstetricians in Huong Hoa Hospital is one of the objectives for Huong Hoa District proposed by both the Huong Hoa District and by province health service.

BCC at the Household Level:

- We added training for community guides on HCMN (a modification of HBLSS), which was not proposed in the original proposal because at the time of proposal development we did not know the usefulness and appropriateness of this approach for the minority community in Da Krong and Huong Hoa Districts.
- More topics on reproductive health and MNC for adolescent girls and boys as recommended from the behavioral determinant study will be included in the intervention.

The changes for both the health services and the BCC interventions will require changes in Project's budget.

2. Partnership:

SC plans to sign a sub-grant agreement not only with PATH and RTCCD, but also with Huong Hoa and Da Krong Districts.

Section E: Detailed Implementation Plan

E1. Program Monitoring and Evaluation Plans

The Project management team, PHS, and DHS in each district will jointly monitor progress towards objectives using carefully selected indicators (Tables 2 and 3), through combined critical review of HIS data and other information through interactive meetings.

Current Data Collection Systems The existing MOH data collection system is designed to track vital statistics, use of services, and health activities. This includes monthly hamlet and commune data for use of antenatal services, micronutrient distribution, and the nutritional status of children and mothers. The MOH acknowledges significant underreporting of vital events. CS-18 will stress counting and reporting newborn births, deaths, and maternal deaths.

SC's 2001 HIS study revealed that the complexity of existing forms is a major barrier to accurate reporting at the hamlet and commune levels.¹ The study also found that the current HIS system requires health workers to fill out several record-books that do not allow for rapid assessment. Basic district-level data were not readily available for 2002, further confirming that data collection and its application are a major weakness that the Project must address. CS-18 will strive to overcome the existing data collection problems and strengthen the new process using HIS information as a powerful tool for tracking activities, creative problem-solving, short- and long-term planning, and measuring progress towards objectives. It is expected that local staff will eventually be able to identify local trends (applying available catchment population information), and extract lessons learned.

Monitoring Methods Health Facility level (DHS/CHC): To simplify existing data collection at the health service (HS) level and align it better with the CS-18 monitoring needs, the Project will discuss how the existing data collection forms can be used better in order to provide the necessary information to track CS-18 indicators at the province and district levels. Currently, for example, no information is collected about postnatal and newborn care. If deemed necessary, the Project will assist in developing complementary forms, for example revising a form for postnatal and newborn care, currently piloted in four Safe Motherhood Project communes in Da Krong District. These forms could be used alongside the existing HIS, as required by the MOH to serve all stakeholders' information needs. The Project will be able to more fully and accurately collect maternal and newborn care data from the village, commune and district levels.

Community Level: To capture information about community-based services, basic hamlet-level data will be collected by Community Guides (CHGs) for health activities at the household level and by commune health staff for health service at CHC and outreach services, including vital events (births, deaths), use of key services (e.g., clean delivery, postpartum care and Vitamin A capsule [VAC], birth weighing, birth registration, growth monitoring and promotion [GMP]), and child nutritional status. This information is reported monthly to the CHC, which aggregates them and submits a report to the district. In addition, CHCs, will complete MOH forms that include some indicators of interest to the Project (e.g., facility births, antenatal care and iron/folate (IFA), TT-2, postpartum VAC).

Monitoring and Feedback System: During the monthly meetings of the DHS and the CHCs, information will not only be reviewed and verified, but will also be critically analyzed (in a constructive manner) to identify problems, plan, and coordinate feedback to communes and hamlets. CS-18 will train DHS and CHC staff in HMIS data collection, analysis and application. The Project will emphasize the importance of good communication and trust between different levels of health services. A similar process will be followed in the monthly meetings of the CHC staff with CHGs, with more attention given to coaching CHGs in their reporting duties (completing forms, collecting data and simple analysis) and analyzing collected information (in-depth on a quarterly basis), and reviewing feedback from the DHS from the previous cycle. CS-18 will strengthen the communication, motivation, and analytical skills of the CHC staff who facilitate these meetings. The Project will sequence training for HIS priorities (first data completeness, then validity, interpretation, and response).

SC/Hanoi technical staff will review HIS data, ensure their appropriate quarterly reporting and use for drafting Annual Project reports, study protocols and documentation, and facilitate the midterm and final evaluations. SC/HO will provide regular feedback and coaching on all

HMIS activities, as necessary. SC/HO, in conjunction with SC/Vietnam will be responsible for submission of the DIP, second and fourth year annual reports, and the midterm and final evaluation reports.

Baseline, Midterm and Endline Studies To inform Project design and refine targets, CS-18 conducted three baseline studies: standard household population-based survey (KPC), health facility assessment, and a qualitative study on behavioral determinants among minorities. In Year Three, the Project will conduct an internal midterm evaluation to review the process of the Project implementation in the 14 communes, including monthly data collection, appropriateness of intervention approach; tools for Project monitoring/supervision and lessons learned. The same quantitative studies, using an identical methodology will be repeated in Year Five to provide endline data that will be compared with the baseline to document Project impact.

SC will collaborate with the DHS, RTCCD and PATH for qualitative studies, including Positive Deviance inquiries (PDIs), for each intervention. These studies will assess community health beliefs, vocabulary, and care-seeking behaviors to guide the development of BCC messages and approaches for target populations. The commune survey (conducted during CHC monthly meetings at baseline, mid-term, and endline) will assess the presence and function of emergency transport systems and use of data for decision-making. A related, abbreviated CHC survey will assess MNC equipment, essential supplies (VAC, TT, etc.), and supervision methods and tools.

Measuring and Documenting Organizational Change All capacity building for SC and the local partners will serve Project objectives and be designed to build mutual respect and accountability. SC has experience with developing implementation agreements with district and local partners. Formal evaluations of the local partners' capacity and developing capacity building plans with them will be new to SC/VNFO. As this is likely to be sensitive for the DHS, SC must create a safe, open, trusting environment. Weak pre-service training or poor technical support and supervision would result in unmotivated staff. The MOH has a culture of target-driven performance, not service quality. CS-18 training and support will aim to change the status quo. Specific indicators have been identified for that purpose and further confirmed in the DIP development process. The Project will also assess organizational development using PACT's Organizational Capacity Assessment Tool, "OCAT to assess partner capacity during the baseline, midterm, and final evaluations. Annual, mid-term, and final CS-18 Project Reports will document organizational change.

Indicators Table 1 demonstrates how Project progress and impact under specific interventions will be measured with the CSHG indicators, frequency of their measurement and data source. Table 2 reports on the revised Project targets (based on the baseline assessments) and links specific indicators to the Project objectives. In order to measure the incremental progress towards achieving final program targets, CS-18 will identify additional interim and process indicators that will be collected at the CHC and hamlet levels. These indicators (and interim targets) will be identified through a participatory process through meetings with the local implementing agencies. Furthermore, opportunities for making some of these indicators (and targets) commune-specific to better reflect minority versus Kinh majority health situations, will be explored. Examples of such additional indicators may include: number of home deliveries assisted by skilled attendants, mothers' knowledge of maternal/newborn danger signs, number of lactating mothers participating in the Mothers' BF support groups, and mothers' knowledge of recommended BF behaviors, etc.

TABLE 1: PROJECT INTERVENTIONS, TARGETS, INDICATORS, AND METHODS

Objectives & Original Targets	Indicator	Indicator Source	Data Source	Frequency
MATERNAL & NEWBORN CARE				
70% of mothers with TT-2	% Mothers who received two or more TT doses during or before last pregnancy.	SNL	<ul style="list-style-type: none"> • HH survey • HIS: MOH TT-2 vaccinations given as proxy 	<ul style="list-style-type: none"> • Survey: Baseline (B), mid-term (M), end-line (E) • HIS: quarterly
30% of communes with emergency transport system.	% Communes with functioning emergency transport system.	SC	<ul style="list-style-type: none"> • Commune survey 	<ul style="list-style-type: none"> • Survey: B, M, E
70% of mothers whose newborns had clean cord cutting	% Mothers whose newborn's cord was cut with a clean/new instrument or a clean birth kit was used.	SNL	<ul style="list-style-type: none"> • HH survey • HIS: HHW records and MOH distribution records 	<ul style="list-style-type: none"> • Survey: B, M, E • HIS: quarterly
50% of mothers received postpartum care	% Mothers who received postpartum care within 3 days of delivery.	SNL	<ul style="list-style-type: none"> • HH survey • HIS: HHW or Birth Attendant records 	<ul style="list-style-type: none"> • Survey: B, M, E • HIS: quarterly
50% of newborns weighed at delivery.	% Newborns weighed within 1 or 3 days of delivery.	SC	<ul style="list-style-type: none"> • HH survey • HIS: HHW or Birth Attendant records 	<ul style="list-style-type: none"> • Survey: B, M, E • HIS: quarterly
70% of newborns registered at birth.	% Newborns registered by age 28 days.	SC	<ul style="list-style-type: none"> • HH survey • HIS: HHW or Birth Attendant records 	<ul style="list-style-type: none"> • Survey B, M, E • HIS: quarterly
NUTRITION				
Decrease by 30% in malnutrition among children 0-24 months	% Children 0-24 months < 2 standard deviations below reference median weight-for-age.	KPC2000+	<ul style="list-style-type: none"> • HH survey • HIS: MOH GMP 	<ul style="list-style-type: none"> • Survey B, M, E • HIS: quarterly
80% of infants receive appropriate complementary feeding	% Infants aged 6-9 months who received breast milk and solid foods in last 24 hours.	KPC2000+	<ul style="list-style-type: none"> • HH survey 	<ul style="list-style-type: none"> • Survey: B, M, E
50% of mothers receive antenatal iron	% Mothers who received/ bought iron supps. while pregnant.	KPC2000+	<ul style="list-style-type: none"> • HH survey (review of Maternal Health Card) • HIS: MOH IFA distribution 	<ul style="list-style-type: none"> • Survey: B, M, E • HIS: quarterly
50% of mothers receive postnatal Vitamin A	% Mothers who received Vit. A dose during first 2 months after delivery.	KPC 2000+	<ul style="list-style-type: none"> • HH Survey (review of Maternal Health Card) • HIS: HHW records and MOH 	<ul style="list-style-type: none"> • Survey B, M, E • HIS: quarterly
BREASTFEEDING				
30% of mothers practice immediate breastfeeding	% Mothers who breastfed their infant within 1 hour of birth.	SNL	<ul style="list-style-type: none"> • HH survey 	<ul style="list-style-type: none"> • Survey: B, M, E
20% of young infants exclusively breastfed	% Infants aged 0-5 (<1, 0-3, 0-5) months who were fed breast milk only in the past 24 hours.	SNL & KPC2000+	<ul style="list-style-type: none"> • HH survey 	<ul style="list-style-type: none"> • Survey: B, M, E

ORGANIZATIONAL DEVELOPMENT				
80% of District and Commune supervisors use supervision tools.	% District and Commune supervisors using supervision tools.	SC	<ul style="list-style-type: none"> HIS: MOH supervision records 	<ul style="list-style-type: none"> HIS: quarterly
80% of Hamlet & Commune staff use data for decision-making.	% Hamlet & Commune staff collect and use data for decision-making.	SC	<ul style="list-style-type: none"> Commune Survey HIS: Monthly Commune Meeting reports 	<ul style="list-style-type: none"> Survey: B, M, E HIS: quarterly
80% CHC staff and HHWs use MNC job aids	% CHC staff and HHWs using MNC job aids and other CS-18 BCC materials.	SC	<ul style="list-style-type: none"> HIS: Monitoring and Supervision records 	<ul style="list-style-type: none"> HIS: quarterly
Two SC Working Papers disseminated	# SC Working Papers on SC & CSTS web site.	SC	<ul style="list-style-type: none"> Web-site survey 	<ul style="list-style-type: none"> Survey: on-going
SUSTAINABILITY				
CS-18 approaches adopted by communes	District & commune work plans for the post Project period include CS-18 approaches/activities.	SC	<ul style="list-style-type: none"> District and commune work plans. SC Project staff field supervision reports 	<ul style="list-style-type: none"> E
CS-18 approaches adopted by the Quang Tri Provincial MOH	PHS has a plan to expand CS-18 approaches to other districts.	SC	<ul style="list-style-type: none"> Province Health Service work plans. SC Project staff field supervision reports. 	<ul style="list-style-type: none"> E
Two other Organizations in Vietnam adopt CS-18 approaches.	# Organizations in Vietnam adopting CS-18 approaches.	SC	<ul style="list-style-type: none"> LU records and follow-up of LU graduates. 	<ul style="list-style-type: none"> On-going
RTCCD adopts the LU method.	The LU method is adopted by RTCCD.	SC	<ul style="list-style-type: none"> SC Project staff observations RTCCD reports 	<ul style="list-style-type: none"> On-going

Methods for Monitoring Health Workers Performance Supervision. Since the on-site supervision of HHWs does not currently take place routinely within the Health Services structure, CS-18 will work with MOH partners to establish and maintain new supervision norms, such as: (1) bi-monthly supervisory visit to the districts and communes by provincial MCH/FP staff; (2) monthly DHS visits to each CHC; and (3) monthly support visits to each hamlet by CHC staff, periodically accompanied by district staff. Supervision includes observing activities (including Hearths, breastfeeding support groups, home visits, and other BCC activities) and service for quality and comprehensiveness (through the use of checklists and client exit interviews), review of health records, feedback, technical support, personal affirmation, and planning.

Revised Project Targets Table 2 below presents revised Project targets against core objectives selected in the Project proposal. We have concerns about some baseline indicator values, especially those pertaining to breastfeeding. The quantitative indicators for immediate and exclusive breastfeeding certainly overestimate the current situation and they are inconsistent with both qualitative information in the Behavioral Determinants Study and with a second quantitative indicator from the Household Survey. Regarding immediate breastfeeding, we argue in the Behavioral Determinants Study that current birthing practices precluded home-delivering mothers from initiating breastfeeding sooner than two hours after delivery. Perhaps the KPC indicator was misinterpreted due to language difficulties or due to the commonly observed challenge in determining precise times of events, especially among

non-literate rural informants. Regarding exclusive breastfeeding, at least in Huong Hoa District, approximately 44% of mothers of infants less than four months old report exclusive breastfeeding, but 71.4% of them have already introduced complementary feeding. We realize that the indicators measure different phenomena (and both can be true and need not total 100%), but we are puzzled that the same indicators almost total 100% (102% to be exact, i.e., 83.8% and 18.2%, respectively) in Da Krong. We are in the process of reviewing the exclusive breastfeeding (EBF) question sequence and linguistic implications from the Household Survey now. Further BF assessments will have to be made during Year One of the Project to obtain a better understanding of the situation.

TABLE 2: REVISED PROJECT TARGETS ACCORDING TO OBJECTIVES

Objectives	Indicators	Original target	Baseline figure	Revised Target
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%	35.4%	10%
Increased use of health care services	1. Pregnant women who received two doses of Tetanus Toxoid vaccine	70%	63%	80%
	2. Mothers who used 100 ANC Iron-folate tablets	50%	42%	70%
	3. Mothers who received postnatal care	50%	27%	50%
	4. Newborns weighed within 24 hours of birth	50%	49%	70%
	5. Mothers who received postpartum Vitamin A supplement	50%	26%	50%
Increased practice of key household health behaviors	1. Deliveries with clean umbilical cord cutting	70%	41%	70%
	2. Immediate breastfeeding (within 1hr)	30%	74%	80%
	3. Exclusive breastfeeding at < age four months	20%	32%	50%
	4. Mothers who practice recommended complementary feeding (freq., variety, onset)	80%	71%	40%
Increased service accessibility	1. Communes w/emergency transport	30%	0	30%
Improved service quality	1. CHC staff using supervision tools	80%	0	80%
	2. CHC staff and HHWs using job aids	80%	0	80%
Improved Sustainability	1. Newborns registered	70%	?	70%
	2. Communes using data for planning	80%	0	80%
	3. PHS adopting Project approaches to other districts (has plan to expand)	Written plan	0	Written plan
	4. Communes adopting CS-18 approaches to other districts	80%	0	80%
	5. RTCCD taking over LU	80%	0	80%
	6. Two working papers produced	2		2

Supervision Logistics CHC staff currently access remote communes via motorcycles and/or bicycles for supervisory visits. CS-18 district staff also have access to a vehicle, motorcycle or transportation for hire. RTCCD, SC, and PATH staff will regularly take part in supervisory visits to provide on-the-job supervisory training to district and provincial counterparts. These efforts will concentrate on district staff as the key Project Managers, but will also include the Dong Ha based CS-18 Program Coordinator, CHC staff, and Community Health Guides (CHGs). The Hanoi-based Health Program Manager will spend at least one week every other month in Quang Tri Province to participate in monthly meetings, training activities, and supervisory visits, to assure proper documentation and experience transfer and to monitor progress towards Project objectives.

Tools to Promote Quality of Services CS-18 will enhance quality through competency-based training (and revision of existing training curricula and manuals), provision of basic equipment, and COPE method, possibly augmented by SC's Community-Defined Quality (CDQ)ⁱⁱ model of provider-client dialogue. Follow-on technical support and supervision will be scheduled on a regular basis. The District Health Trainers will conduct supervisory visits at the CHCs, and CS-18 will provide basic equipment for conducting delivery and newborn resuscitation. Furthermore, in conjunction with the training activities, the Project will facilitate the development and provision of service protocols, following the national standard guidelines for RH by MOH (including: ANC, normal delivery, five obstetric complications, newborn status assessment and newborn resuscitation, and infection control), and defining performance standards and supervision checklists. CS-18 will also assist in facilitating the outreach for MNC services from CHCs.

The competency of health workers at all levels and of the volunteers will be measured during training (participation in problem-analysis and planning and post-tests) and in the field (monitoring tools and supervisory checklists). SC participation and observation of Steering Committee meetings at the district and commune levels will allow for the assessment of competency. Provincial-level meetings will offer a forum not only for Project support but also for promoting partner ownership of these new activities and their replication to new districts. Competency of technical staff, supervisors, and service-providers will be improved through systematic feedback during monitoring and supervision visits, mini-workshops at monthly meetings, and regularly scheduled on-site technical support visits. Refresher training will be scheduled when necessary.

Sharing Lessons Learned The Project will document experience and share with other SC programs at the provincial and national levels in Vietnam through the National Ethnic Minority Working Group, the national Safe Motherhood Working Group. It will share globally through SC's annual Program Learning Group (PLG) and the Columbia University EmOC/Gates Foundation Annual program meetings (assured through 2003). The *Positive Deviance Initiative*ⁱⁱⁱ will support development and dissemination of PD Working Papers and perhaps peer-reviewed publications, through current partnerships at HO with Emory, Yale, and Tufts University. The *Saving Newborn Lives Initiative* will similarly disseminate relevant experience through publications and international forums.

Operations Research CS-18 affords a rich Operations Research (OR) context. Potential OR partners include: the LINKAGES Project, the *Saving Newborn Lives Initiative*, the *Positive Deviance Initiative*, and several universities, among others. Potential questions are: (1) Does the PD approach improve newborn care, breastfeeding, and/or child nutrition in Quang Tri? (2) Which BCC approaches are most effective in improving behavior among minorities? (3) How can the LU maintain program quality during replication in Years Three and Four? (4) How well will COPE or SC's Community Defined Quality (CDQ) approach bridge the provider-client gap? How effective is the Home-Based Life Saving Skills (HBLSS) approach in improving both care seeking and household behaviors among minority populations? What practical solutions (compromise between the workload and infant care) can be identified to facilitate recommended BF behaviors among minority women? Developing these and other questions awaits Project funding and input from additional stakeholders.

E2. Summary of Baseline and Other Assessments

- 1. Facility Survey**
- 2. Household Survey**
- 3. Behavioral Determinants Study Survey**
- 4. Additional Country and Local Context Information**

For the purpose of better informing the foundation of the CS-18 Project and to enable systematic tracking of changes in key indicators (to document the Project impact), SC conducted three baseline assessments: (1) A Health Facility Survey to assess the current capacity of the existing health system to provide maternal, newborn and child care services, (2) A Household Survey to assess the mothers' knowledge and behaviors relating to maternal, newborn and child health care seeking behavior and beliefs, and (3) A Behavioral Determinants Study to explore the factors and beliefs that influence and shape the current behaviors among the highland minority populations in Project area.

In addition, the evaluation of SC's Safe Motherhood Project in Da Krong District was completed in April 2003. Preliminary positive results provided valuable information for the CS-18 Project, especially related to working with minority populations in maternal and newborn care. We had intended to include a summary of these findings in this section, but as of this writing, the report is not yet available. We will be able to discuss it during the DIP debriefing, however. For each of the three baseline studies, we will also include additional comments added by stakeholders during the DIP workshops.

1. Health Facility Assessment (HFA)

Introduction Save the Children/US launched a five-year child survival Project, *Building Partner Capacity for Child Survival of Vietnamese Ethnic Minority Populations*, in two districts of Quang Tri Province in Vietnam's North Central Region in October 2002. As part of a baseline assessment, we conducted an abbreviated Health Facility Survey, along with a Population-based Household Survey and Behavioural Determinants Study.

Methods In December 2002, we surveyed 10 facilities, five each in Da Krong and Huong Hoa Districts. We surveyed three Commune Health Centers (CHCs), one polyclinic, and the one District Health Service (DHS) in each district. We surveyed one central and two remote CHCs in each district, along with their Village Health Workers (VHWs). We visited each facility for one day, using inventory checklists and interview guides to assess maternal, newborn, and child health service availability and quality. Specifically we measured: availability, training, and supervision of personnel; service availability, schedule, and quality; availability of drugs, equipment, health education material, and supplies; health information system; and facility infrastructure. We intended to use observation checklists to assess antenatal and delivery care, but we substituted structured interviews since no relevant services occurred on the survey days.

Results Health staff at all levels demonstrated courtesy, interest, and cooperation. Health personnel: Several VHWs were untrained while those who were trained had never received refresher training. CHCs were fully staffed. Most had primary level midwives (18 months of training). Some CHC nurses or physician assistants had received additional training and were upgraded to physicians. On the other hand, the DHSs were understaffed, which limited commune outreach. Little upgrading occurred. Supervision: Most DHS supervision of CHC

staff occurred through vertical programs (i.e., malaria prevention) or through monthly meetings of CHC heads with DHS. Similarly CHC staff rarely supervised VHWs except in campaigns (i.e., immunization, antenatal care [ANC], Vitamin A). VHWs did receive support in data management during periodic reviews at their CHCs.

Service availability: Few facilities offered the required 0730-1700 and 24-hour emergency services and utilization was low. Few CHCs provided regular ANC outreach. Instead CHCs either coordinated with the DHS to conduct pregnancy examination campaigns every other month, or DHS teams provided monthly CHC-based ANC. Some CHC midwives conducted occasional home deliveries. CHC staff and VHWs provided Vitamin A capsules to children and postpartum women at the hamlet or household level every six months. Iron distribution strategies varied between pregnancy campaigns and CHC-based ANC clinics where staff sold or gave out monthly supplies, usually without counseling. Immunization outreach worked well, but growth monitoring was not regular in all communes. Successful outreach relied on VHWs mobilizing community participation.

Service Quality: Patient counseling was poor, and home-based maternal cards were not usually distributed. CHC staff did not know the indications for oxytocin, with some misusing it at delivery. CHC staff omitted key ANC components, such as weighing, chest auscultation, vaccination, and counseling. Midwives are not able to provide first aid in the management of five obstetric complications and newborn resuscitation. Drugs: Most CHCs had a number of essential drugs (except for contraceptives, anti-hypertensives, major analgesics, and intravenous anticonvulsants), but a full range was not consistently available (especially iron pills, clean delivery kits (CDKs), egotamine, salbutamol, and Vitamin A). Equipment and supplies: Delivery, but not newborn resuscitation, equipment was available. Facilities at all levels generally lacked means to warm newborns. Facilities had health education posters, but lacked printed material for distribution. Health information: Information flowed from VHWs to CHCs to the DHS. Copies did not remain at lower levels, nor did CHC teams use the data. CHC ANC and delivery logs were incomplete, and referral logs were rare. Infrastructure: Some CHCs had telephones, but none had an ambulance. Facilities were often small and dilapidated and lacked safe solid waste disposal.

Emergency Obstetric Care - District Health Services: The District Hospital is not capable of providing Comprehensive Emergency Obstetric Care (CEOC) for obstetric complications. Even Basic Emergency Obstetric Care skills are not present at the DHS, let alone at the CHCs. There are no protocols for management of obstetric complications, newborn health status assessment, or management of newborn resuscitation in case of birth asphyxia. There are no maternal cards or partograph sheets available at the CHC and district hospitals. There are no records kept about maternal and newborn complications. Records on maternal and newborn deaths and health status are still inaccurate and underestimate the actual numbers.

Discussion The basics of a system are in place. Villages and CHCs have personnel, facilities, and services which are loosely linked through communications, periodic meetings, and some outreach activities with VHWs playing a critical mobilizing role. The links between CHC and DHS seem weaker. Vertical programs (Vitamin A, immunizations) seem to work better than routine services. Indeed, maternal and newborn care is poor at all levels. Antenatal care, when available, is heavily clinical with inadequate emphasis on iron/folate and counseling, especially for danger signs and birth preparedness. Delivery care, which is greatly underused, lacks oxytocin protocols, referral channels, and utilization review.

Postnatal care, which is also underused, is hindered by low levels of contraceptives. Newborn care lacks resuscitation equipment, including warming methods.

DIP Workshop Participants' Comments Consistent with the above HFA study findings were some additional comments shared by the DIP workshop participants, who observed that management-wise, the services are not systematically organized, resulting in a great deal of wasted effort. The referral system is poorly organized, with no reliable transfer of information between health service levels and there are no phones and no reliable transportation. VHWs are idle, there is no patient follow-up, women do not receive ANC, and health staff are not as active as they could be in advertising and offering these services to women. Generally they have poor communication skills and negative attitudes toward clients. The training and skills of the existing commune health staff are limited. Records are not kept properly for various reasons (mainly poor education and staff do not understand them properly), and midwives are not conscientious workers or have low skills and poor attitudes towards women.

2. KPC Household Survey - Summary

Introduction SC has launched a five-year child survival Project in two minority districts in Quang Tri Province. The Project aims to improve the use of maternal, newborn, and child health behaviors and health services. To that end we conducted a baseline household survey in December, 2003.

Methods We conducted two identical, simultaneous household surveys, one each in Da Krong and Huong Hoa Districts. We interviewed 200 women with children less than age 24 months in each district (total sample = 400). We selected 25 hamlets (probability proportional to their population size), and we identified eight eligible households per hamlet, along a randomly selected ray from the hamlet leader's house. Teams of two interviewers and one supervisor gathered data on reported practices and use of services for the current living youngest child and weighed that child using local growth monitoring scales. We analyzed the data in CSAMPLE to account for differing cluster and district sizes, and we used EPINUT to calculate weight-for-age. We calculated indicators by district and ethnic group and stratified by distance to facility and maternal parity, age, education, and type of employment.

Results General: Ethnic minorities accounted for 58.5% (44.7% Van Kieu and 13.8% Pakoh mothers) of the total population with important differences between districts (86.4% vs. 48.2% minorities in Da Krong and Huong Hoa, respectively). The 400 children were well distributed by age and sex (48.5% female). Illiteracy was high especially among women, (46.8% vs. 16.8% among mothers and husbands, respectively). Most worked in agriculture (79.9% vs. 74.0% mothers and husbands, respectively). About a third of all households owned a radio (32.5%) or television (33.1%) with large differences in the latter by district (39.5% vs. 15.5% in Huong Hoa and Da Krong, respectively). Almost three quarters (72.1%) of all families lived within one hour of a health facility. About half (55.7%) had latrines.

Maternal Care: Most mothers (79.6% overall) in both districts reported having at least one antenatal care check-up during their previous pregnancy; most of these (75.7%) claimed at least two visits. Reported antenatal iron use was low, especially in Da Krong (42.4% overall; 23.0% vs. 49.5% in Da Krong and Huong Hoa, respectively, for taking any antenatal iron). Nearly two thirds of mothers (63.0%) in both districts reported at least two tetanus vaccinations. Slightly more than half (56.2%) delivered at home, of which 42.5% received a Clean Delivery Kit (50.0% vs. 24.6% in Huong Hoa vs. Da Krong, respectively), most of

whom (92%) used it. Few (20.9% overall; 8.5% vs. 26.4%, respectively in Da Krong and Huong Hoa, respectively) used a skilled birth attendant.

Just over half the mothers in both districts (53.1%) delivered **alone and unattended**. Cord care among those who delivered at home was unclean (40.6% cut the cord with a bamboo splinter; 45.5% tied it with jute). Few received postnatal care or postnatal Vitamin A supplementation (26.9% and 25.6%, respectively). More than half (60.3%) of the mothers reported using an insecticide-treated bednet. In general, minority status, distance from health service greater than one hour, maternal illiteracy, and maternal agricultural work all resulted in less optimal reported practices. Mothers' knowledge of pregnancy-related danger signs (DS) was low (41.5-46.8% knew no DS and 12.2-21.7% knew at least two DS for pregnancy, labor, or delivery).

Newborn Care: Few mothers (6.6%) reported giving prelacteal feedings, and most (74.2%) reported initiating breastfeeding in the first hour, but some (11.5% overall; 18.2% vs. 9.1% in Da Krong and Huong Hoa, respectively), delayed until the second day. Nearly half (48.7%) reported that the infant was weighed on the first day. Minority or illiterate mothers were more likely to forego immediate breastfeeding or delay initiation until after the first day. Mothers' knowledge was low for immediate newborn DS (52.2% knew no DS and 22.3% knew at least two DS) and later newborn DS (35.0% knew no DS and 28.8% knew at least two DS).

Child Nutritional Status and Care: A third (35.4%) of the children were malnourished (47.5% vs. 31.0% < -2 weight-for-age Z-score in Da Krong vs. Huong Hoa, respectively). Again, minority status, greater distance from the health facility, illiteracy, and agricultural work – but not child sex – were associated with higher levels of malnutrition. Mothers in both districts reported high use of childhood Vitamin A supplements and vaccinations (79.9% and 86.5% of children ever received any). As expected, mothers' reported exclusive breastfeeding declined with infant age (45.3%, 37.7%, and 31.8% for infants less than age two, four, and six months, respectively.) Mothers were more likely to report exclusive breastfeeding for girls than for boys up to age four months (50.0% vs. 25.5%) and six months (42.1% vs. 22.2%). Minority or illiterate mothers, and especially mothers who lived more than one hour from the nearest health facility, were far less likely to exclusively breastfeed. Mothers reported continued breastfeeding (81.2%), especially if they were minorities (92.0% vs. 65.1% for minority vs. Kinh, respectively). Mothers' reported complementary feeding frequencies were high in both districts (91.3% \geq 2 meals/day for 6-8 months olds; 71.9% \geq 3 meals/day for 9-11 months olds; and 80.3% \geq 3 meals/day for 12-23 months olds).

Discussion The health of mothers and children, especially newborns, in these two districts could be greatly improved by better household practices (including essential newborn care) and better use of selected health services (especially clean delivery, preferably by a skilled provider, and postpartum care). Reported breastfeeding and complementary feeding practices are somewhat better than expected; however, the rate of childhood malnutrition is high. These maternal and child health indicators are strongly associated with district, ethnicity, and other indicators of poverty, such as literacy, work, and distance from a health facility. These variables are likely related to each other, and multivariable analysis is needed to assess the risk associated with each. Nonetheless, district-level interventions, in partnership with Ministry of Health, that target minority communities, should efficiently improve indicators. We suspect that this survey over estimates the level of the health indicators because the sample for each cluster commenced at the hamlet leader's house, which was probably centrally located. Key findings are presented in the Table 3 below.

DIP Workshop Participants' Comments Participants' feedback was consistent with study findings. Many expressed concern about the gravity of some indicators. They recognized that the low use of ANC and postnatal care services is a problem and that the majority of women deliver at home by themselves and that newborns do not receive good care. Consequently, many women do not practice the “three cleans” during delivery (blade, surface, hands). Also newborn mortality is underreported, so the extent of the problem is not known. Most babies are not exclusively breastfed for the first four months due to social norms. Malnutrition rates among children under two years old is high. Poor hygiene practices are rampant; caretakers do not wash their hands at critical times and children are given unboiled water to drink.

TABLE 3: KEY INDICATORS

Indicator	Da Krong District (%)	Huong Hoa District (%)
Maternal Care		
Mothers who had 3 ANC visits	36	48
Mothers who received 2 TT shots	62	64
Mothers who used ANC Iron Folate	23	49
Mothers who delivered at home	65	53
Mothers who delivered at home ALONE	54	53
Mothers who received CDK	25	50
Mothers who used CDK at home delivery	20	47
Mothers who practiced “clean floor” at home delivery	14	28
Mothers who received postnatal care	17	31
Mothers who received postnatal Vitamin A supplements	21	27
Newborn care		
Weighed on 1 day	35	53
Breastfeeding initiated in first hour	65	78
Mothers gave prelacteal feeding	6	6
Child feeding and nutrition		
Mothers exclusively breastfed <4 months	18	44
Mothers exclusively breastfed <6 months	16	37
Complementary feeds introduced 1-3 months	84	71
Complementary feeds introduced 4+ months	11	16
Feeding frequency as recommended	80-91	80-91
Complementary feeds with starchy foods	97	99
Complement. feeds with Vitamin-rich foods	37	42
Complement. feeds with protein-rich foods	46	51
Complement. feeds with fat-rich foods	13	15
Children 0-23 months who were underweight	35	31

3. Behavioral Determinants Study – Summary

Introduction Behavior change is central to public health interventions. As SC launches a five-year child survival Project in two minority districts in Quang Tri Province, we wanted to complement baseline household and health facility surveys with a behavioral determinants study to identify the prevailing maternal, newborn, and child health practices and to describe the reasons for these behaviors in order to inform our behavior change interventions. This study represents a unique contribution to better understanding the traditional beliefs of the minority populations in North Central Vietnam.

Methods In March 2003, we visited three communes in Da Krong and Huong Hoa Districts. We conducted 26 in-depth interviews (17 in Huong Hoa) and four group discussions (two in Huong Hoa) of women with children less than five months old, as well as one review of a recent newborn death. Initially we planned to use the in-depth interviews to characterize community norms and the group discussions to test eight “elicitation questions,” which had been shown earlier in Quang Tri to efficiently demonstrate behavioral determinants. Based on field realities, we modified the protocol, asking the elicitation questions at the end of 16 in-depth interviews and using the group discussions to further describe community norms. Two teams of two researchers each (facilitator and note-taker) conducted all studies. We computerized all of the notes in Vietnamese and organized them according to care for pregnancy, delivery, postnatal period, immediate newborn period, immediate breastfeeding, exclusive breastfeeding, and children less than 24 months old. We identified beneficial and harmful practices for each topic and characterized the determinants of harmful practices as internal (knowledge, beliefs, confidence, etc.) or external (norms, time, service availability and quality, etc.).

Results The ethnic balance of interviewees (19 Pakoh and 47 Van Kieu) mirrored their representative populations in the two districts. A “good woman” obeys her husband, performing household chores and fieldwork from dawn to dusk. Her diet is monotonous, whether pregnant or not and includes rice, cassava with a few vegetables or fruits, and MSG. There are no pregnancy-related taboos or “eating down.” She obtains an antenatal care (ANC) check-up if available, especially for reassurance that a difficult delivery is not anticipated. If she receives tetanus vaccinations or iron, she does not know why.

Birth planning consists of her gathering roots for a postpartum tea, identifying a local woman to assist with some birth tasks, gathering extra wood, and preparing old clothes for the newborn. She has an incomplete understanding of danger signs (aside from breech and prolonged labor), since she believes that the birth process is a normal event. She works until labor commences. Delivery is traditionally believed to be highly unclean (especially the blood and other bodily fluids associated with birth), so she delivers away from the main living area to prevent others from falling ill, performing key tasks herself (receiving the baby, handling the baby and cutting the cord). If there is an attendant, her role is limited; she helps set up the delivery area and boils water for tea or bathing. The mother delivers in a squatting position.

The mother ignores the newborn until her placenta is expelled, believing that an undelivered placenta, especially if separated from the baby, will withdraw up to her heart and kill her. Thus, she and all attendants vigorously massage her abdominal to force it out. She then ties the cord once, usually with hemp, cuts it either with a razor blade or bamboo stick, and then sometimes applies charcoal or other powder to the stump. She then wipes and wraps the newborn, sets the baby aside, and buries the placenta. Then she bathes the baby, wraps him/her in different clothes, sets the baby aside again, and bathes herself. Since the newborn is not a full family member until a ceremony after cord separation, any illness or death is attributed to fate. Reported newborn danger signs include not breathing or moving after birth and, for older newborns, cessation of sucking, warm to touch, persistent crying, coughing, and diarrhea.

The mother spends one to two weeks postpartum resting by a continuous fire, warming herself to dry the blood, consuming copious amounts of herbal tea, and bathing herself and her newborn daily. The family only seeks postnatal care for difficulties, such as fever,

excessive bleeding, or extreme fatigue. Initiation of breastfeeding occurs no sooner than two hours postpartum and requires an active, crying infant. She neither offers prelacteal feedings, nor attempts to breastfeed a quiet baby. She expresses and discards her initial colostrum because it is believed to be old and spoiled or contaminated with vegetables (from her diet), which are unfit for a newborn. Nearly every mother gives complementary feeding in the first two months because of crying, hunger, watery breastmilk, or her poor diet (unlike Kinh mothers), and especially because she returns to field work about two weeks postpartum. She leaves the infant in the care of his/her siblings or grandmother.

The mother prepares the day's food each morning, storing it in small baskets, one for each family member. Adults drink boiled tea while children drink untreated stream water. By the time an infant is eight months old, they eat the family menu, avoiding some diarrhea-causing vegetables. While fruits and vegetables are abundant in these hamlets, most are not consumed for lack of time, taste, or expectation of benefit. Many families raise livestock for sale, but not for family consumption except for special events. Van Kieu hamlets have *sim* houses, which provide evening and overnight separate accommodations for adolescent girls and boys (keeping them separated) – a unique “cultural institution” allowing for the teenagers to socialize and interact relatively free of adult control.

Discussion Overall, there were no differences regarding care and its determinants for mothers, newborns, and children in these two ethnic groups (apart from the *sim* houses). We found examples of beneficial and harmful practices for each although, in most cases, the benefits were incomplete. We characterized determinants of harmful practices as internal or external because programmers can address the former at the individual beneficiary level while the latter require either group change or environmental change (Table 3). The elicitation questions in their current form were not as useful as expected, probably because these non-literate, agricultural, isolated women could not easily understand abstract or hypothetical questions. The Pakoh and Van Kieu people valued new or “modern” information, and we are optimistic that these communities can learn better behaviors quickly, especially if they are given opportunities to practice them.

DIP Workshop Participants' Comments Once again additional input further confirmed the findings. Women do not seek health care services because they are shy and follow prevalent social norms. Women do not prepare for delivery, because giving birth is considered a normal event and because it is believed that if they do, they will be “asking for complications.” They are fatalistic in their belief system. Similarly, if a newborn baby dies, it is beyond anyone's control. Many mothers deliver alone, due to the belief that anyone who comes in contact with delivery-related fluids will fall ill as a result (except the mother). Most babies are not exclusively breastfed for the first four months of life due to the social norm that mothers must work away from home soon after delivery. They believe that colostrum is sour and therefore discarded. Husbands do not generally take care of their wives and children. Women continue to work hard throughout pregnancy without any allowances for additional rest or food. Workshop participants did confirm the cultural importance of lying next to the fire after delivery, frequent bathing, and herbal tea for postpartum recovery. Children do not receive nutritious foods, partly because of the belief that vegetables will make them sick and therefore they mainly exist on starch (rice) and salt.

4. Additional Country and Local Context Information

Current Country Context and Constraints The most recent census (1998) found the total population of Vietnam to be 77.6 million people, most of whom are concentrated in the fertile

lowland areas. Almost 80% of the country's terrain consists of mountains, high plateaus, and jungles and is not very good for farming. These areas are sparsely populated by one or more of 54 minority groups. The economic reform process, *Doi Moi*, launched by the Vietnamese government in 1986 has increased the Gross Domestic Product and reduced poverty. However, the shift from a centrally planned to a market economy reduced budgets for social services which further marginalized women, children, the disabled, and minority groups. Vietnam ranks 108 on the Human Development Index.^{iv}

Disease Surveillance Data for Program Area Specific disease surveillance information for program area is not available, thus the Project uses national and regional data. Maternal and child mortality rates are highest in the highland areas which best represent the Project target area. MMR for the northern mountainous and Central Highlands is almost ten-fold that of the Red River Delta (411 vs. 46 deaths/100,000 live births) MOH - 2002. Likewise, the Central Highland under-five mortality rate (U5MR) is two and a half times as high as the Red River Delta (108 vs. 44).^v However, since regional figures include populations from fertile coastal lowlands and midlands, as well as from the less hospitable highlands, they, too, underestimate the situation in highland Da Krong and Huong Hoa Districts. Reliable mortality data for these districts are not available due to incomplete vital registration.^{vi} Estimates by the DHS suggest very high levels for infant mortality (IMR) (73/1,000) and U5MR (156/1,000).^{vii} The Quang Tri Provincial U5MR (51), is certainly unrepresentative of the two Project districts since the province includes large swaths of relatively wealthy lowland communities. MMR in Quang Tri is 163 /100,00 live births (MOH 2002).

Child Malnutrition: As confirmed by our baseline household survey, nearly half of children under five years old are underweight in Da Krong (48%) and nearly a third (31%) in Huong Hoa Districts, as compared with 35% province-wide and 33% nationally.^{viii} Iodine deficiency disorders are common, with 25% of school-aged children being iodine deficient and 12.4% with palpable goiters in 1999 (compared with a national rate of 10.1%). In addition, nationally 60% of children under age two are iron-deficient.^{ix} The 1997 Vietnam Demographic and Health Survey indicates that about half (53.5%) of mothers of infants less than two months old exclusively breastfeed, but only 8.6% of infants age 2-3.9 months and 1.3% of infants 4-5.9 months old are exclusively breastfed.^x LINKAGES research indicates that pre-lacteal feeding is almost universal in Northern Vietnam,^{xi} but it was rare (6%) in our survey.

Maternal and Newborn Health: In addition to MMR (discussed above), other national indicators include maternal malnutrition (32% with a Body Mass Index <18.5), low birth weight (18.5%), IMR (36.7), and stillbirths (7%).^{xii} SC's *State of the World's Newborns*^{xiii} adds the additional relevant national indicators for antenatal care (71%, 1995-99), TT-2 (85%, 1997-99), delivery by skilled attendant (77%, 1995-00), and neonatal mortality (18/1000 live births, 1995-00). In addition, nearly 6% of pregnant women suffer night blindness nationally, while 50% of lactating mothers exhibit pre-clinical stages of Vitamin A deficiency.^{xiv} Iron deficiency anemia affects 44% of all pregnant women nationally,^{xv} and anemia in the CS-18 Project site is reported by Provincial Health Service (PHS) officials to be nearly universal. Pakoh women often have six or seven pregnancies with intervals of approximately 1.6 years.^{xvi} In Quang Tri, the 97 reported cases of obstetric complications in 2000, while admittedly incomplete, included infection (52%), hemorrhage (33%), eclampsia (3%), uterine rupture (2%) and tetanus (1%). The reported HIV infection rate for the province is 43.4/100,000 inhabitants.^{xvii}

MOH System – Opportunities and Constraints Vietnam’s public health service system has extensive rural coverage, but as discussed above in the Health Facility Assessment Study results, it suffers from inadequate staff training and low utilization, especially among minorities who must overcome language, culture, distance, and financial barriers due to increasing service fees at all health centers. The rural health infrastructure depends on links between Provincial, District, and Commune People’s Committees, which oversee implementing public health Projects. There is very little outreach done and CHCs rarely go to the villages. CHC staff mainly provide services at the CHC, except for some assistance to district teams in vertical health campaigns (such as carrying out EPI activities) at the village level. CHC staff rely on Hamlet Health Workers (HHW) who interact directly with communities. It is unusual for minorities to staff health service facilities, exacerbating the minorities’ sense of isolation.

The Quang Tri Province MCH/FP Department manages and supervises public health services throughout the province, where the Province Hospital with Pediatric and Obstetric departments provide Comprehensive Emergency Obstetric Care (CEOC). Quang Tri Province plans to dedicate resources to strengthening health and social services, including facility improvement, community education and outreach. Plans include construction of permanent health centers in communes throughout the province by 2005 with at least seven doctors per 10,000 people. Health priorities are: clean water, nutrition, and environmental protection. The province will work closely with NGOs to ensure that development plans coincide with the existing priorities.

The Da Krong District Health Service includes a staff of 11 doctors (one obstetrician), ten midwives, six nurses, six secondary nurses, 33 primary nurses, and 41 assistant doctors. There is one vehicle for district-wide health programming, supervision and monitoring. All 13 communes in Da Krong have CHCs, two inter-communal polyclinics serving three to four communes each, and one district hospital. Three to five health staff with backgrounds in medicine or nursing staff each CHC. Two mobile teams (six staff designated for FP and maternal health and ten for disease prevention), located at the DHS, conduct outreach focusing on periodic FP, monthly EPI, and response to outbreaks of disease such as malaria and diarrhea. The distance from the most remote hamlets to the CHC is from several hours to two days’ walk, with the District Hospital more than 80 km away.

The Huong Hoa District Health Service, established in 1989, is newer and better staffed (18 doctors (two obstetricians), 38 assistant doctors, 36 nurses, and nine midwives). Like Da Krong, the DHS has two mobile outreach teams, consisting of six staff for FP and maternal health and 13 for disease prevention. The one DHS ambulance for all health services is not always functional. The district has one polyclinic, staffed by a doctor, two assistant doctors, a pharmacist, and a midwife. There are CHCs in 17 of 21 communes. A team of four (assistant doctor, midwife, and two nurses) typically staff CHCs in Huong Hoa. Hamlets average 8 kms (roughly a three-hour walk) from the CHC with some requiring a two days’ walk. Overall quality of existing services is poor, as discussed above and in the Health Facility Assessment.

Community-based Health Services Providers The **Women’s Union** is an established mass organization with a network from the central to the hamlet levels. At the commune level, the head of the WU and two vice chairs support the WU at the hamlet. WU hamlet members are resources for health and development. They mostly are farmers, volunteering in health education, disease prevention activities, and support for the MOH’s outreach. The WU is always the key partner for behavior change intervention in health and in other development

programs. Each hamlet has one Hamlet Health Worker (HHW) who resides in each hamlet and receives a stipend from the MOH. HHWs are trained by the district health trainers in topics such as malaria control, EPI, and environmental sanitation. District teams and CHC staff support and supervise HHWs. Their job responsibilities include health talks and home visits in support of national MOH programs for ARI, EPI, FP, and ANC. Most communities have **birth attendants**, who are women living in the community with some experience with delivery, but no formal training. **Traditional healers** exist in all communities and as discussed below, are consulted for the treatment of specific illnesses.

E3. Program Description by Objective, Intervention, and Activities

I. Program Overview

Program Goal and Objectives The goal of CS-18 is to achieve sustained reductions in maternal and under-five mortality, through the following program objectives: (1) Increased use of maternal, newborn and child care services, (2) Increased practice of key household behaviors, (3) Increased service accessibility, (4) Improved service quality, and (5) Improved sustainability of all activities through development and further strengthening of the key Project partners.

Technical Interventions The following three technical interventions have been selected based on documented need and GOV priorities: Maternal and Newborn Care (45% LOE), Nutrition and Micronutrients (40% LOE), and Breastfeeding (15% LOE). The Project relies on existing health personnel, structures, relationships, priorities and plans and follows the MOH policies. Since all of the interventions are closely related, the selected strategies and activities are mutually reinforcing. The Project will use the following strategies to achieve Project objectives:

- 1. Maternal and Newborn Care (45% LOE):** The Project will seek to improve key household behaviors, promote the use of ANC, increase the number of deliveries attended by a skilled attendant where feasible, enhance postnatal maternal and newborn care, and improve access to emergency care in the event of complications. CHGs will be trained in organizing community meetings with pregnant women, new mothers and family members to discuss, negotiate and apply the best practices of care for mothers and newborns at home, timely referral in case of complications, and door-to-door counseling. They will be supported by CHC-based health staff whose skills will also be upgraded to provide maternal and newborn care service through outreach services and at CHCs. Although pregnant women and new mothers will remain the primary targets for these interventions, major community mobilization activities will be initiated to sensitize husbands, in-laws, community leaders, and hamlet elders about the subject. In addition, ACNM-developed home-based pictorial Life Saving Skills modules, BPP, and peer counseling through the *Sim Houses* will be utilized to disseminate related messages and information. All of these approaches will build on the two-year experience gained from a Safe Motherhood Project in Quang Xuong District, Thanh Hoa Province, and experience in a similar Project in Da Krong District.
- 2. Nutrition and Micronutrients (40% LOE):** The Project will strive to reduce malnutrition among children under age five through: (1) the Positive Deviance (PD)

Approach for sustainable community-based rehabilitation and prevention of malnutrition – building on SC’s eight years of experience with Hearth/PD in Vietnamese lowland populations. The Project will also promote better nutrition among pregnant women. In addition, recognizing that many school-aged children are the primary caretakers for babies/their younger siblings while parents are working in the fields, CS-18 will promote innovative approaches which include inviting kindergarten and primary teachers to participate in nutrition and hygiene education, and pilot the child-to-child learning approach for primary and kindergarten levels.

3. **Breastfeeding (BF)** (15% LOE): The Project will aim to improve BF practices in the target area through: (1) support groups for lactating mothers and (2) EBF promotion at the hamlet level including EBF PD mothers who can share their experiences in achieving EBF in the face of fieldwork to other women in the hamlet. This intervention will be closely linked with the PDI approach and education about the introduction of appropriate complementary feeding. An aggressive community mobilization approach will be utilized to ensure that fathers, grandparents, and hamlet elders are also targeted, recognizing their cultural role as the decision makers at household level. CS-18 will also encourage Baby Friendly Policies for those women who have facility-based deliveries at CHC, DHS, and PHS.

These three technical interventions will be implemented on two key levels: (1) health services strengthening to improve the quality, availability and accessibility of health care services and (2) community level behavior change communication strategies to improve the utilization of appropriate household behaviors and promote beneficial care seeking behaviors.

Health Services Strengthening At the health services level, the Project will work towards improving the quality, availability and accessibility of care. The Project will improve service quality by both upgrading the MNC clinical skills of key DHS and CHC staff through competency-based training, supervision, and support, according to MOH guidelines, and helping to secure necessary equipment and supplies. CS-18 will also strengthen the facility-based information and referral systems, and the overall efficiency of the service delivery mechanisms (via COPE and CDQ methodology). The Project will improve service availability through strengthening the outreach activities, ensuring that midwives from the CHC go regularly to the communities and deliver basic ANC, delivery, newborn, and postnatal care, and provide support and supervision to health education and BCC activities conducted by CHGs. Additionally, efforts will be made in the selection of CHGs to include minority women, in order to facilitate their access to minority target groups. Finally, the Project will increase demand for services through PD-informed mobilization and community-provider dialogue around community-perceived service quality (i.e., CDQ).

Behavior Change Communication strategies and materials will reflect the local health knowledge and beliefs, using data from qualitative studies (including PD inquiries), population-based surveys, and SC’s extensive experience with similar programs in Vietnam. In all cases, BCC methods will involve interactive adult “active learning techniques.” Community members will learn in familiar settings, such as in their homes or hamlet groups, where new norms can be established, new skills tried, new knowledge gained, new self-efficacy (the belief that one can successfully perform the practice) assured, and new beliefs adopted based on observed success. Recognizing that about half of minority women and one-third of men are illiterate, BCC materials will be primarily pictorial (non-literate). Some BCC materials will also use local minority languages recently transcribed into Vietnamese as

appropriate, (until recently, these languages were unwritten). Together with RTCCD and PATH, SC will make a special effort to develop and impart clear, consistent, locally relevant messages. Local health workers, peer educators, and WU staff will use these materials to disseminate messages at families' homes and in the hamlets.

BCC strategies will be influenced by an improved "Positive Deviance-plus" (PD-plus) approach informed by SC's recent PD experience described in a December 2002 supplement in the Food and Nutrition Bulletin. The PD-plus will have greater emphasis on behavioral determinants, monitoring quality of implementation, use of "booster PDIs" to learn from new adopters, use of PD for advocacy in the community and perhaps through mass media, and use of "PD-lite," i.e., stripped down PDIs to stimulate discussion and motivate dialogue around behavior change.

Phased in Implementation With three closely linked technical interventions to introduce during the period of five years, CS-18 will gradually phase in the interventions, following a natural life cycle approach, starting with maternal and newborn care (MNC), then adding breastfeeding (BF) and eventually infant and young child nutrition.

II. Detailed Activities by Intervention

Intervention 1: Maternal and Newborn Care (45% of effort)

Problem Birthing practices among the Kinh majority differ greatly from the ethnic minorities chiefly targeted by CS-18. Most women deliver at home without skilled attendants present, practice unclean delivery, and do not know how to address maternal and newborn complications. There is no special attention given to pregnancy; women do not universally receive antenatal care, and rarely receive postnatal care. Many minority women have five to seven children over their lifetime.

Target Group The Project will target all pregnant women, new mothers, newborns, and their caregivers and families to improve maternal and newborn care in target areas through an integrated approach to maternal and newborn care. Promotion of key household behaviors will be the centerpiece of this intervention, consistent with the conceptual framework proposed by SC's Saving Newborn Lives Initiative³. Concurrently, the Project also will target CHC and DHS health staff to improve MNC health services at health facilities and at outreach services.

Two-prong Approach for Two Sub-groups There are two different sub-groups within the CS-18 Project area (the majority Kinh and the minority Pakoh and Van Kieu), for whom SC will introduce two different approaches. The Kinh majority tend to be literate, but impoverished, and under-utilize existing health services. The aim for this group is to further educate them about the services and to encourage them to use them more. The minority groups have low literacy levels, tend to live in more geographically remote settings, and are socio-economically more disadvantaged. They also have profound cultural beliefs and traditions that provide a basis for their custom to give birth alone, and overall to not utilize existing health services. Although ultimately the efforts will be made to integrate minorities into the mainstream Vietnamese society, the Project will rely on interim strategies.

³ Save the Children and Women & Children First, (2001) *State of the World's Newborns – A Report from Saving Newborns' Lives*: Washington, DC: Save the Children, pull-out table.

Essential Elements of MNC include: Antenatal Care (ANC); Birth Preparedness (BP); Skilled Delivery Care; Postpartum Care; Newborn Care and Emergency Obstetric/Neonatal Care and are further discussed below:

- a. Antenatal Care** The antenatal care component will promote the importance of a healthy pregnancy and of obtaining full ANC. The CHC midwife conducts monthly ANC sessions at the CHCs, mainly accessed by Kinh majority women. In order to reach the minority women the CHC midwife and health staff will provide outreach ANC services at hamlets with support from CHGs, who will inform and motivate pregnant women to access them. Women will be encouraged to have their first ANC exam during the first trimester and to seek at least three ANC check-ups during each pregnancy. A maternity care card will be completed for each pregnant woman to track changes in health status, including weight gain. CS-18 will work to increase care-seeking for complete ANC through community mobilization activities. CHGs, with support from the commune midwife and health staff, will increase the number of organized BCC activities and home visits with women, men as the heads of households and decision-makers, and the extended family. Village leaders' support and engagement will be sought, and CHGs will play a key role in this education, counseling, and mobilization effort.

Complete ANC services include: three prenatal examinations and pregnancy counseling; two Tetanus Toxoid (TT) injections; iron folate supplementation and counseling; presumptive antihelminthic treatment; symptomatic anti-malarial treatment; blood pressure measurements; weight gain monitoring; interactive nutrition education through food preparation demonstrations; hygiene education; BF promotion; and birth preparedness.

- b. Birth Preparedness** CS-18 will encourage and assist women to plan for a clean delivery with CDK. Other key elements of BP include: selection of a skilled birth attendant (with some life-saving or at least "time-buying" skills training), knowledge of maternal and newborn danger signs, routine newborn care (clean cord care, immediate warming, drying), planning for immediate and exclusive BF, making arrangements for child care and household chores, and planning for accessing emergency care.

Families will be counseled to set aside funds for potential emergency transportation. CS-18 will support hamlet leaders in the development of a community fund for emergency transportation, if feasible, in addition to ensuring that suitable transportation is available. The CHGs will play key roles in training for, and supporting, changes in birth practices and in health seeking behaviors. The experience from SC's current safe motherhood (SM) activities will provide valuable insights into appropriate interventions in these areas, including community transport and funding schemes.

- c. Skilled Attendance at Delivery** CS-18 will encourage women to deliver with the assistance of a skilled attendant and to insist on a clean delivery. As the most effective way to ensure delivery at a health facility, the Project will continue to encourage institutional delivery at CHCs, where the majority of the Kinh women already deliver. The Project will strengthen the quality of care offered by the CHCs and ensure that referral linkages are made to access Emergency Obstetric Care at the district or province level as needed. CHC midwives will receive training in order to provide basic EOC in addition to normal delivery services. This will include: (1) administration of oxytocin for

postpartum hemorrhage; (2) administration of antibiotics for presumed infection; (3) administration of anticonvulsions for eclampsia; and (4) manual removal of placenta and retained products. The MOH's new standard RH guidelines do not allow for the performance of assisted vaginal delivery (the remaining function of international BEOC definition) at Commune Health Centers. At Huong Hoa District Hospital, doctors and midwives will be trained to provide CEOC including the six BEOC functions as well as blood transfusions and cesarean sections with anesthesia.

Home-Based Care Since most deliveries (81%) among targeted minority groups take place at home, with about 62% without anyone else present, CS-18 will explore options for home-based care. CS-18 will strongly encourage women and their families to make plans in advance to have a skilled attendant at delivery, or at least an attendant (family member, friend) who is trained in life-saving, time-buying skills (see below). The Project will also work to improve the conditions under which women deliver, particularly discouraging the practice of laboring and delivering alone. The Project will train pregnant women and their families in HCMN (Home Care for Mother and Newborn), including the use of CDK, building on the experience of the SM Project in Da Krong. These kits include a razor, plastic sheet, bar of soap, strong tie, and three pieces of gauze. Quang Tri Province MCH/FP will continue to make and provide the kits for all 34 communes in the two districts. CS-18 will strive to ensure that women plan for a clean delivery, understand the "three cleans" (surface, hands and clean cord), obtain a CDK, and practice the "three cleans" at birth. These messages and skills will be shared through group-based adult interactive learning sessions using adaptations of ACNM's Home-Based Life Saving Skills modules, recently piloted in Da Krong.

- d. Postpartum Care** CS-18 will promote postpartum care within 24 hours (preferably within six hours) of delivery by skilled CHC staff, or CHGs. This visit will include checking the mother for danger signs (particularly bleeding), providing uterine massage to decrease postpartum hemorrhage if necessary, and advising the mother of essential newborn care. The postpartum visit will also include counseling women about reducing their workload for longer than the customary two weeks, advice about BF and how to address potential difficulties, and nutrition counseling (eating an extra meal daily, eating foods rich in energy, protein, and vitamins, and giving the new mother a 200,000 IU capsule of Vitamin A). Women will also be advised about the hamlet-based BF support groups, family planning, and other related health activities in their commune. Since Postnatal Care in Vietnam is a new intervention, SC will document this experience carefully and ensure that "lessons learned" are shared and fed back into the program implementation.

Mothers will be encouraged to get a six-week postpartum check up at the CHC or to obtain one at home from a CHC midwife. At that visit, the mother will also obtain contraceptive information and services, as well as counseling about health benefits of spacing births for by three or more years. As the MOH has an existing FP program, an outreach postnatal contact will be an opportunity to encourage women to seek those services soon after childbirth.

- e. Newborn Care and Birth Registration** The Project will promote newborn care, including baby weighing and registration, preferably by a CHC health worker (trained in essential newborn care, newborn resuscitation, first aid, identification and referral for premature and low birth weight babies [LBW]). CS-18 will focus on a follow up visit by

CHGs, who are trained in the recognition of danger signs for mothers and newborns, within the first three days following delivery. Thus, the Project will train women, their families, and community members to use CDKs, provide clean care for the umbilical cord, warm and dry the newborn immediately, provide immediate, exclusive BF, and recognize and respond to newborn danger signs. During the follow up visit, the CHC staff will also provide individual health education, schedule newborn immunizations for BCG, OPV and Hepatitis B, and promote registration and weighing of the newborn baby. If not done yet, the CHGs will visit the new mother and weigh the baby using the scale used for GMP in the hamlet (each HHW has one scale used for the GMP program in the hamlet). Alternatively, the Project will test the use of a 5-kg portable scale which will be provided for newborn weighing only, easily available in Vietnam, but not yet tested in a field situation.

Birth registration is important, not only to gauge the magnitude of neonatal death, but also to plan service provision and to register the child for primary school. At present, birth registration only happens if the birth occurs at a health facility. SC will advocate increasing access to birth registration through CHC protocols and at postnatal visits by commune health staff and CHGs.

- f. Emergency Obstetric and Neonatal Care** Since maternal complications can be sudden and unpredictable, and since about 15% of all pregnant women will develop one, it is crucial to have quality EOC services available. According to the MOH model, CEOC is available at the Provincial and District Obstetric Hospital, while BEOC is available at the Commune Health Centers. However, as demonstrated by the HFA and confirmed by DIP workshop participants, emergency obstetric care is not optimal. C-18 will strengthen BEOC at CHC, through refresher training of the CHC staff, including nurses, midwives, and assistant doctors to ensure that they are competent to attend normal deliveries, can provide first aid and referral for obstetric complications, and newborn resuscitation. CS-18 will also provide training in CEOC and newborn care, including routine and special care, for doctors in Huong Hoa hospitals.

Referral The Project will install a telephone at the DHSs' Ob/Gyn Departments, which will have round-the-clock operating capacity seven days a week (a point repeatedly brought up by the DIP workshop participants) to provide mobile support for commune staff. The Project will assist DHS in setting up a referral book at the Ob/Gyn Departments to record all cases of obstetric complications received from communes. Due to the geographic distances between the commune and DHS, DHS mobile teams can provide advice by telephone and take ambulances to the CHC if referral is indicated and if the ambulance is available. If not, the DHS staff must ask the CHC staff and family to find local transportation for the woman or newborn. The Project will also install a telephone at each CHC to enable them to call DHS for help.

Facility Level Approach

Clinical Training Sequencing SC will work with Hanoi Secondary Medical School in providing a clinical training for Quang Tri Secondary Medical School, province health trainers, and district health trainers on management of pregnancy, normal delivery, postnatal care, newborn care, and management of five basic emergency obstetric care functions (excluding assisted vaginal delivery) following the new standard guidelines for RH issued by the MOH. These well-trained instructors will train all commune and district midwives on the

above topics for maternal and newborn care and provide follow-up supervision of midwives at Commune Health Centers and at out-reach activity. SC will work with the Hue Medical School to provide clinical training for doctors in CEOC at Huong Hoa District Hospital. There are two district hospitals, Da Krong and the Huong Hoa Hospitals, but only Huong Hoa Hospital has enough doctors, midwives and the necessary infrastructure to provide CEOC. On the other hand, Da Krong Hospital is close to the province hospital (30 minutes by car). However, it has shortages of doctors and midwives and the operating theater is under construction and is not yet well equipped. Therefore, Da Krong District Hospital staff will be trained only in BEOC, not CEOC.

Community Level Approach

Home Care for Mothers and Newborns (HCMN) Qualitative research into birthing practices in Da Krong identified the need to develop a participatory community-based approach to promote and improve safe birthing practices and referral to emergency obstetric care. Consequently, in addition to strengthening the CHC-based and outreach services, the Project is adapting and field testing the ACNM Home-based Life-Saving Skills approach, calling it Home Care for Mothers and Newborns (HCMN).

What is HCMN? HCMN is a family focused, community level intervention developed to bridge the gap between the unpredictable life-threatening complication that occurs at home, and the professional emergency care that is available only at the referral facility. The goals of HCMN include enabling mothers and family members to recognize the unpredictable complications for mother and newborn; having basic knowledge and skills to respond to these complications to buy time; and deciding to seek health care at health facility and going to the health facility fast. This approach should reduce maternal and neonatal mortality/morbidity by increasing access to basic life-saving measures within the home and community and by decreasing delays in reaching referral sites where life-threatening problems can be managed.

Community-Based Process: Initial Community Meetings The HCMN builds in existing community knowledge and behaviors through the community meeting process. The goal is to develop a consensus on a set of practices through negotiation. Since the practices are safe, culturally acceptable, feasible, and accessible to anyone at home, they are likely to be used when needed. This approach to behavior change is consistent with community-level problem solving and competency-based training. The CHGs will follow five key steps at each community meeting which include: (1) introducing the day's topic; (2) discussing current practices in the community regarding the topic; (3) introducing best practices for the topic learned from health staff; (4) negotiating for adopting the best practice; and (5) role-playing the new practice. During discussion of step two, the CHG will encourage participants to share their experience and possibly identify PD individuals who are "doers" among a mass of "non-doer" counterparts. Experience has shown that facilitated discussion between "non-doers" and "doers" is lively, enlightening, and leads to options for behavior change for the group. It respects and incorporates local values and safe practices and ensures community ownership of the initiative and consequent acceptance of the newly introduced health practices. (Certainly many local groups will not have a "doer" in their midst for key behaviors. It remains to be seen how acceptable and effective a PD "case" imported from a nearby hamlet will be in stimulating discussion). In these community meetings, participants are recognized as equal contributors. The meetings are built on the principles of adult learning, and use role-plays to master specific time-buying skills, such as external uterine compression for

postpartum hemorrhage. The process is dynamic and the outcomes are specific to the needs identified by the community.

SM Pilot Project Experience In Da Krong the community identified specific problems in maternal care, and SC developed specific training modules that included corresponding pictures. Seven modules already developed and implemented in three minority communes were well received; two more are under development. They included: (1) Maternal and Newborn Problems, (2) Bleeding During Pregnancy, (3) Prevention of Excessive Bleeding After Delivery, (4) Infection Prevention Through Use of CDK, (5) Birth Delay or Prolonged Labor; (6) Too Small Baby, and (7) How to Feed a Small Baby.

CS-18 proposes to apply the lessons learned from the SM Project in Da Krong and documented by the recent evaluation to further revise and enhance the produced materials (one reoccurring comment was that the pictorial materials, currently only in black-and-white, would be more attractive and effective if they were in color). Furthermore, with the success of the pilot, the community group discussions have already identified seven additional topics for HCMN modules: Referral to the Health Facility, Resuscitation for the Newborn, Birth Preparedness, Too Many Children or Birth Spacing and Family Planning, How to Feed Children Under Two Years Old, Exclusive Breastfeeding, and Hygiene. The Project will develop the additional materials as needed and pilot test them in the communities using the PD methods as applicable.

Cascading Training Model The HCMN model of cascade training uses a system of CHGs who are HHW, WU and CPFC staff, who have been trained by district trainers in conducting participatory community meetings. CHGs are selected from one of the mass organizations represented at the commune level (population motivators, women's union members, etc.), according to their level of motivation, engagement and acceptance by the community or from community members in each hamlet. The CHGs, in turn, conduct meetings with women, families and caregivers using pictures to convey messages and take action cards to remind people of the problems and immediate actions at home. In turn, the community members are encouraged to share these messages among their family members and neighbors. The district trainer and commune health staff provide supervision and support to the CHGs.

Peer Education for Youth at *Sim Houses* The Viet Kieu people have a tradition of *Sim Houses*, group houses where teenage girls gather and sleep (away from their family). CS-18 will explore this venue as an entry point for disseminating RH, MNC and nutrition information among teenagers in non-threatening and entertaining ways. RTCCD and PATH will develop community-based training modules in conjunction with local CHGs, teenagers, and Youth Union members. Through this forum the Project will initiate discussions on prevalent community values and beliefs, and their effects on women's and children's status, thereby initiating a process of critical questioning and creative problem-solving, creating attitudes more open to adopting recommended household behaviors. The Project will explore drama, role-plays, songs, competitions, health fairs and other creative approaches.

Intervention 2: Nutrition and Micronutrients (40%)

Target Groups Key suboptimal nutrition behaviors in the Project area relate to the observation that families tend not to pay attention to young children's food intake and diet. The child eats what is available to the rest of the family. Diet for the family is limited and

rarely includes eggs, peanuts, or fish although these can be found locally. Children under one year of age are not generally given vegetables, duck meat, or fish. Children typically stay at home without adult supervision, since adults work in the fields.

The nutrition and micronutrient component will focus on children under two years old and their caregivers, with particular attention to those under one year old and women ages 15-49 years old, aiming to: (1) rehabilitate malnourished children, (2) promote optimal child nutrition in health and sickness; and (3) promote optimal maternal nutrition for both the mother and fetus. Key strategies for this intervention include: (1) Positive Deviance/Hearth in conjunction with (2) GMP sessions and interactive (3) school-based Nutrition Education sessions, building on ten years of successful experience in Vietnam, and recently also among the minority groups in Da Krong.

While concentrating on community-based approaches, CS-18 will also strengthen the nutrition components at the CHC and DHS levels, ensuring that health providers are competent in the management and rehabilitation of severely malnourished children and in nutrition counseling for mothers, and that appropriate referral protocols are developed and followed. Specifically, CS-18 will promote EBF for the first four months of a child's life, complementary feeding with a range of nutritious foods from about four to 24 months, BF for 24 months, adequate nutritional care of sick and malnourished children, and adequate intake of Vitamin A, iron, and iodine. The GOV has recently amended its policy for EBF from "for four months" to "from four to six months." Given the near universal early introduction of complementary feeding in these districts, CS-18 will aim for four months of EBF during this Project.

A. Child Nutrition

PDI Experience in Da Krong District SC and the Da Krong District have successfully implemented Hearths in four communes since 2001, and CS-18 will build upon this experience. Families believe that rice is adequate for children so they do not often provide vegetables, shrimp, crabs, or other local foods to the child. Identified PD foods were fish, shrimp, and greens, which are promoted for the diet of young children. Key sub-optimal nutrition behaviors in the Project area relate to the observation that families tend not to pay attention to young children's food intake and diet. The child eats what is available to the rest of the family.

Positive Deviance Inquiry PD approach is based on the observation that most communities include impoverished families with well-nourished children, who are living proof that it is possible for poor families to have well-nourished children *today*, before major economic improvements take place. It demonstrates that appropriate feeding behaviors (types of foods and frequency) are more important to children's nutritional status than relative wealth and food security. Although some families experience food insecurity during part of a year, most malnutrition results from poor feeding practices and non-consumption of nutritious foods. Traditionally, few fruits and vegetables (natural sources of vitamins and micronutrients) are consumed despite their wide availability; for example, ripe papaya (rich in Vitamin A) or dark leafy vegetables (rich in iron and magnesium) are simply not considered desirable. Through the PD method, CS-18 will identify these families, describe the unique behaviors that have enabled them to raise healthy children, explore the underlying enabling factors that encouraged the unusual behaviors, and disseminate this information among their less successful neighbors through the Hearth sessions and other channels. CHGs will facilitate the

behavior change based on PD food and PD caring practices from PDI results. The Hearth approach provides an additional opportunity to include peer educators and CHGs in the behavior change process.

Hearth (or Nutrition Education and Rehabilitation Program [NERP]) The actual Hearth sessions will be organized by HHWs, who will plan the menus using the PDI information. CHGs will refer the mothers of malnourished children (initially <-3 Z weight-for-age, then perhaps <-2.5 or <-2 , according to the local levels of malnutrition) to the two-week, six mornings per week, Hearth sessions. Under the guidance of CHGs, mothers will contribute food, prepare meals, practice hygiene and active feeding as they give their children local, affordable foods using menus “discovered” through PDIs.

As a new Hearth modification, peer educators (local PD caregivers or mothers of children who graduated from Hearth) will motivate their peers and model good practice. These facilitated groups learn active feeding strategies (and other key behaviors, such as food preparation, food handling, hygiene, etc.) from the CHG, the peer educator, and especially from each other. They establish new norms, boost each other’s confidence through directly observing improved child well-being and growth, and gain new skills and knowledge. SC’s experience is that the majority of the children recover after 2-3 cycles of Hearth and that behavior change among the caregivers is sustained beyond Hearth. Those children who do not recover after two cycles of Hearth are referred to health facility for additional assessment and care. Hearths will initially focus on rehabilitating malnourished children since the Project expects to confront a serious malnutrition problem in many communes. With experience and success, the Project will modify the Hearth format and entry/exit criteria, perhaps merging them with BF support groups.

Growth Monitoring and Promotion CS-18, will regularly weigh all children under two years old through ongoing MOH hamlet GMP sessions, in order to track the progress of all children, including those in the Hearth sessions. In addition to active learning, HHWs will lead daily discussions on relevant “Emphasis Behaviors,” such as use of oral re-hydration therapy (ORT) for diarrhea, immunizations, recognition of and care-seeking for child danger signs, and use of twice yearly Vitamin A capsule for children 6-36 months of age, per MOH policy. In addition, CHGs and peer educators will conduct household visits to follow-up on children between Hearth sessions. CHGs facilitating Hearths, GMP sessions, and other community BCC activities will stress adequate nutritional intake through consumption of a varied and consistent diet, nutritional management of children during illness, optimal BF (described below), use of Vitamin A supplements (MOH policy) obtained at home visits, community meetings, or health facility.

Integrated Management of Childhood Illnesses (IMCI) In Vietnam, IMCI is being piloted by UNICEF in four provinces since 2000 with TOTs for provincial and district health staff and workshops to train nurses and midwives. Although Quang Tri Province is not a part of this pilot activity, all CS-18 approaches are totally consistent with the emerging doctrine of Household and Community IMCI.^{xviii} This means that behavior change, community services, and community-facility links are central strategies. Although the Project does not include childhood illness interventions, it is anticipated that community mobilization and behavior change activities (with emphasis on better care-seeking behaviors for maternal and newborn care) will likely improve care-seeking for child illness as well. Hearths will stress this and the importance of continued feeding during illness and increased (catch-up) feeding after illness.

Micronutrients Further activities for the CS-18 micronutrient strategy will be elaborated in the course of the life of the Project. For example, SC is currently reviewing a protocol from RTCCD proposed for the CS-18 impact area, “An assessment of the current status and causes of anaemia in pregnant women and children three years old in malarious endemic area of Vietnam.”

B. Maternal Nutrition

Maternal Anemia In conjunction with ANC nutritional counseling, HHWs and WU staff will encourage pregnant women to consume a diet rich in micronutrients to benefit their own health as well as that of their unborn baby. An initial concern about “eating down” (whereby pregnant women decrease their nutritional intake for fear of difficult delivery with a large baby), which is a contributing factor to low birth weight (LBW) and maternal complications in some settings, was not observed here. Minority women have poor diets in pregnancy, because they have poor diets in general. They often do not have a sufficient caloric intake for lack of food (lack of rice), and poor eating habits (no Vitamin A- or iron-rich fruits and vegetables). Women will be especially encouraged to take consistent iron/folate antenatal supplements and postnatal Vitamin A supplements within two weeks of delivery per MOH guidelines. The danger of severe anemia and heavy bleeding during delivery and postpartum period will be communicated. Presumptive treatment for hookworm, endemic to Vietnam (observed in both Da Krong and Huong Hoa Districts), and symptomatic treatment for malaria, will also be encouraged, per MOH policy.

PDI for Maternal Rest and Nutrition A heavy workload is a fundamental factor in compromising both women’s health and newborn care among target populations (especially minorities, but also among the Kinh majority). Workload management during and after pregnancy will be covered during birth preparedness sessions, at community meetings, and through home visits by commune health staff and CHGs. Workload management and maternal diet will be specifically discussed at a community meeting with husbands and in-laws, or through other channels such as farmer association meetings, drama, and health contests. Formative research has identified a few “PD husbands” who either personally assumed their wives’ fieldwork for a full two months postpartum or severely lowered work expectations. The Project will capitalize on these examples and facilitate negotiation to change some families’ behaviors and perhaps norms at the community meeting. Whether such entrenched behavior is amenable to change through PD advocacy remains to be seen.

Intervention 3: Breastfeeding (15%)

Problem LINKAGES research in Vietnam found that nearly all mothers practice breastfeeding, but very few (less than 2%) practice exclusive breastfeeding (EBF) for the internationally recommended six months. A key obstacle to the adoption of EBF by mothers in rural Vietnam was the social norm that mothers returned to heavy work in the fields shortly after delivery (about two weeks in target areas). Only a crying baby is put to breast and very few are exclusively BF, with most receiving complementary foods (mainly rice) within a couple of weeks of birth. Interestingly enough, HH survey observed exclusive BF to be twice as prevalent for female babies than male babies who are four months old. CS-18 will further investigate the underlying factors for this.

Target Group The primary targets of the BF intervention will be mothers of children under 24 (and especially under four) months and pregnant women, but the Project will also target fathers, grandparents, and other influential decision makers in the community, recognizing the importance of their support for lactating mothers at the household level.

Essential Elements CS-18 will promote immediate (within one hour of birth) BF, exclusive BF for the first four months, and continued BF for 24 months in conjunction with the introduction of appropriate complementary feeding practices between the ages of four to nine months. The Project will also discourage any prelacteal feedings and educate women about the health benefits of immediate BF for both baby and for maternal postpartum recovery. Information about these best practices will also be disseminated under the other two technical interventions (MNC and Nutrition), both at the community and facility levels through mutually reinforcing messages and activities. The Project will use home visits by CHG, WU members, peer educators, and support groups to achieve this. CS-18 will also promote BF through ANC, postnatal care, newborn care, GMP, Hearth sessions, and household visits to follow up on Hearth graduates.

Community Level Approach

Mothers BF Support Groups As the main vehicle for the community-level BF promotion, HHWs will organize informal mothers' support groups in their hamlets. Groups will meet monthly following the La Leche League Model^{xx} for community-based, mother-to-mother BF support groups. Small groups of BF mothers and pregnant women (four to eight total) will convene with a facilitator for about one hour at a participant's home or a local gathering place. Initially, facilitators will be the CHGs, but later, this function will be assumed by successful lactating mothers who will be coached as peer educators. The groups will allow mothers to share experiences, challenges, and solutions from their own neighborhood.

DHS staff from Ha Tinh Province where SC pilot-tested this approach reported that mothers were highly enthusiastic about attending such support groups. Furthermore, formative research in Da Krong identified a few PD women who, in fact, succeeded in EBF for four to six months *even though they returned to fieldwork two weeks post-delivery*. We believe that their strategies and examples (coupled with healthier babies) will motivate their neighbors to replicate these positive behaviors. Promoters will urge women with BF difficulties to seek care from CHGs or CHC staff. The Project will assure quality of this intervention through competency-based training and monitoring the use of non-literate job aids for such topics as preparing for BF, initiating BF, BF while working, BF and birth-spacing, dealing with common BF problems, introducing complementary solid foods, etc.

PDI Application for Better Breastfeeding Practices The Project will use information collected from PDIs and other baseline studies to explore with villagers the feasibility of several strategies, including bringing infants to the paddy, wet-nursing, expressing breast milk, delaying returning to full-time fieldwork, returning from fieldwork to breastfeed, and arranging fieldwork close enough to home to promote BF. All strategies require and seek involvement of other family members (especially fathers) and reviewing gender roles and work responsibilities and their implications for the health status of mothers and babies.

Father/Grandparent Support Groups In addition to mothers' support groups, CS-18 will encourage community leaders and volunteers to initiate meetings for fathers and/or grandparents as well, recognizing their influential roles in the household. SC experience in

Ha Tinh Province identified a mother who reported that “it is important for fathers and grandparents to receive the same breastfeeding education because otherwise, we will go home and the they will not believe us.”

Facility Level Approach

Baby Friendly Policy At the facility level (both at DHS and CHC), Baby Friendly Policies will be introduced to ensure that women who have facility-based deliveries receive appropriate support to initiate BF immediately and counseling about best practices in BF. CHC staff will be trained in promotion and support of BF and in the management of common BF problems, such as engorgement, blocked duct(s), cracked and/or sore nipples, and insufficient milk supply. The Project will also train CHC staff to counsel new mothers about locally discovered strategies to promote EBF in the face of early postpartum maternal work expectations. CHC staff will also be trained on relevant points of the Baby Friendly policy and will assist in their implementation at the CHC level. The Baby Friendly classification ensures that the following are in place:

1. The baby is put to mother’s breast soon after delivery (ideally within one hour).
2. Staff are trained in the promotion of BF and the dangers of breast milk substitutes.
3. Newborn babies are kept in the same room as the mother.
4. No breastmilk substitutes are advertised in the facility.
5. “No bottles” signs are posted in the facility.

Training Approaches for All Interventions

CS-18 will deploy two types of training:

Clinical Training Training for commune and district health staff on maternal and newborn care, management of complications, and counseling requires two steps. Hanoi Secondary Medical School will conduct a TOT for a training team consisting of doctors and midwives from DHS, province hospital, and Quang Tri Secondary Medical School. Topics will include maternal and newborn care and complication management and active participatory training methods, including facilitating, coaching, and mentoring skills. Trained trainers then conduct training for commune and district midwives on maternal and newborn care, complication management and health counseling. Specific topics are: ANC, normal delivery with routine active management of third stage of labor, newborn care, postnatal care, first aid for EOC and infection control. Trained trainers will later provide supportive supervision at CHCs and outreach services. All training uses a competency–based approach with models in the class and clinical training at the hospital. Students must perform certain skills before pronounced “competent” during the practical training. Training in year one begins with the TOT, followed by the training of staff and HHWs in eight initial Project communes (five in Da Krong and three in Huong Hoa).

Community-Based Training Training for community members for best practices in maternal and newborn care also uses a two-stage approach. RTCCD and SC will conduct a TOT for candidates from district and province WUs, CPFCs, and district FP teams. HCMN and BPP topics include: caring for mother before, during and after delivery; caring for newborns; using CDK; recognition and response to mother and newborn complications and timely referral, breastfeeding, and child nutrition.

The training team will train CHGs and commune health staff on these topics. After training, CHGs will conduct community meetings, mother-to-mother support groups, father/in-law support group, home visits, NERPs, and groups with single girls and boys at *Sim Houses*. District training teams, and commune health staff will provide supportive supervision for these activities at hamlets and help CHGs master their training skills.

Both TOT and training for CHGs will be conducted using adult learning techniques including active participation, role-plays, using pictorial training materials and locally-made teaching aids such as dolls with detachable placentas, uteri, and breasts. All participants will have the chance to discuss and practice using visual aids at the training course.

Phased in Implementation/Training The Project will start with five communes in Da Krong and three communes in Huong Hoa and then expand to eight more communes in Year Two. The first eight communes will serve as training sites for subsequent communes to observe and “transplant” the interventions to their communes. Thus, implementation in 26 communes overall will be informed by the actual experience from the first and/or second phase intervention at the commune level through the LU replication mechanism.

All members of the training cascade (including the district trainers, CHC staff and CHGs) will receive relevant quality-based training, including: competency-based training with criteria for acceptability; training in the use of job aids (non-literate, as appropriate); training in the use of supervisory checklists; training in how to benefit from participating in supervision either as a supervisee or supervisor; and training in facilitating and benefiting from community-provider dialogue around perceived quality issues. CS-18 will monitor the quality of training as well as implementation of interventions through the use of selected process indicators.

Living University Training Model

The **Living University** (LU), a recognized SC strategy for replication,^{xx} was developed by SC in Vietnam as a demonstrably successful mechanism for program expansion and replication. In Vietnam, the LU enabled the SC nutrition program, which began in 1990 to expand and be replicated by 15 national and international partners to reach 440 communes with a total population of 2,200,000. SC developed a total of three LU training centers (i.e., administrative and technical centers) in Thanh Hoa, Thai Binh and Quang Ngai Provinces.

A new LU will support both health systems strengthening and community behavior change in Quang Tri. The initial “campus” will be a sub-district comprised of the District Health Center and several CHCs. The “students” will include district, commune, and hamlet health workers, and beneficiaries. The “courses” are the multi-level learning opportunities for providers and beneficiaries covering various aspects of the interventions. The “faculty” are provincial and district MOH Master Trainers whose skills SC has developed through RTCCD trainers. **The LU approach** commences in Year Three with the addition of 13 more communes (five in Da Krong and eight in Huong Hoa), continuing in Year Four with the remaining 13 communes of Da Krong and Huong Hoa, and participants invited from outside of the Project districts and province.

The actual course of implementation will be refined as the Project activities progress to maintain its bottom up foundation. Built on the principle of “learning by doing,” the

approach fosters local capacity to implement and sustain development Projects. After a successful model is demonstrated in several pilot communes, future implementers from other communes or districts visit the site. They not only learn the Project’s conceptual framework, but also take part in practical, structured tours to observe all relevant activities. After experiencing the Project firsthand, participants discuss, question, evaluate, and challenge what they observed, and plan replication in their own area. They then return to begin their own pilot, with TA from SC staff. These new districts then become small LUs to replicate the program locally.

The Project will establish one LU training site in each of the two districts to enable the rapid expansion of the CS-18 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 are responsible for training commune and hamlet staff. Their continued endorsement of Project objectives, knowledge of the technical content, and the need for on-going training, will facilitate sustainability.

III. PROJECT MANAGEMENT PLAN

Community Health Guides CHGs are the key cadre deployed for implementing CS-18 BCC activities at the village level. These individuals will be selected from mass organizations active in their communes, primarily staff from Women’s Unions and CPFC. Other staff such as those from the Farmers’ Association or the Red Cross will be invited to participate in the program implementation, but their participation will depend on their individual interest and commitment at each commune. District and province Women’s Union, CPFC and district health staff together will provide training and follow-up supervision to the community meeting at each village.

Expanding on SC’s experiences in HCMN, PDI and NERP for child nutrition, the Project (SC specifically) will provide TA for RTCCD, a local NGO, and PATH, a US-based NGO, on developing BCC materials and implementation of BCC activities. During the Project implementation, PATH will creatively develop new strategies for BCC for these two districts. It is expected that as a result of a concerted effort to strengthen RTCCD, it will be able to assume the responsibility for most of the training and supervision within the Project through the Living University.

TABLE 4: CS-18 PROPOSED HUMAN RESOURCE SYSTEM

Cadre	Responsibilities	Supervised by:	Identified from:
DHS trainer team	1.Oversee CHC – based health services 2.Oversee/monitor outreach from CHCs 3.Oversee referral system for MNC and follow-up referrals from CHC 4. Have TOT skills and train CHC staff in COPE, MNC, ... 5.Provide support to CHC, CHG team in outreach activities 6.Check and provide feedback to monthly report to CHC	PHS; MCH/FP	DHS MCH Staff

CHC midwife	<ol style="list-style-type: none"> 1. Clinical care at CHC 2. Outreach services 3. Communicate with DHS mobile team for referrals 4. Coach CHGs in community-based BCC activities 5. Coach CHGs in interpersonal counseling skills 6. Support and supervise CHGs in carrying out BCC activities in MNC, CN at hamlets. 7. Make monthly service reports to DHS 	DHS	Assigned
Community Health Guides (CHGs)	<ol style="list-style-type: none"> 1. Support midwife in outreach services 2. Make census of the catchment area: pregnant women and new mothers (babies <1yr) 3. Conduct home visits to new mothers w/postpartum care and counseling / health education 4. Conduct Health Education mtgs 5. Facilitate initial BCC activities (HCMN, NERPs, Mothers' BF support groups) at hamlet 6. Coach women from the groups to become peer educators 7. Make monthly report on BCC activities 8. Facilitate referral process from household to CHC (transport, funds, link w/Health Services); 9. Organize initial community orientation meetings (this meeting is done by PC chairman of the commune) 10. Facilitate initial Peer Education at Sim Houses 11. Facilitate Child-to-child activities 	CHC staff (midwife), District trainers	Selected in hamlet from one of active mass orgs. – hamlet specific (WU, FU, YU)
Peer Educators (Graduated PD mothers and teenagers) with CHGs,	<ol style="list-style-type: none"> 1. Facilitate and lead subsequent Mothers' BF Support Groups 2. Facilitate and lead subsequent NERP cycles 3. Facilitate and lead subsequent Sim Peer Ed sessions 	CHGs, CHC staff	Graduated PD members of BCC groups

Management Structure The Project will be managed to ensure high quality results while preparing local partners to develop their own capacity to administer and give technical oversight to CS activities. SC/Hanoi will provide overall management of the Project, including receiving and dispersing funds and documentation support for the design and implementation of CS-18 M&E activities. The SC Vietnam FO Director will have overall country management responsibility for the Project, assisted by the Hanoi-based Health Program Specialist, Dr. Pham Bich Ha. The CS Project Manager, also based in Hanoi, will have general oversight of the CS-18 team and will supervise the full-time Project Officer (PO) in Quang Tri Province. The Quang Tri PO will manage field-based activities and coordination between local partners at the provincial and district level.

CS Project Steering Committees Following the enthusiastic recommendations from the DIP workshops, CS-18 will facilitate the creation of **District Steering Committees** consisting of DHS staff, WU, and Peoples' Committee members in both Da Krong and Huong Hoa in June 2003 to kick-off the Project implementation. Provincial Project staff will participate in these meetings as required. **Commune Steering Committees (CSC)** with the same core compositions will also be created in each commune. The management team and Steering Committees will each meet monthly during the first year of the Project and probably quarterly in subsequent years. Project Officers, technical staff, and relevant partners will participate in all DSC meetings and some CSC meetings as part of routine supervision and support. These meetings will also serve as forums for capacity building mini-workshops on themes such as M&E, technical updates on CS interventions, and sustainability strategies. Province meetings between Project stakeholders will take place on an as needed basis to address problems and opportunities as they arise.

CS-18 Implementing Partners As the implementing partner, the **Provincial and District Health Services** will dedicate their existing staff to CS-18. Technical staff from both levels will assure the systems and service-delivery strengthening elements of the Project, including the initiation of new approaches for outreach and BCC. DHS staff will have the responsibility for training CHC staff, community health workers, volunteers, and peer educators. They will also support, supervise, and monitor community-based activities, assisted by RTCCD and SC as appropriate. CS-18 management and reporting structure will be consistent with existing practice within the health services. Service statistics and reporting of Project indicators will move on a monthly basis from commune to district to province. SC will support the PHS analysis and utilization of Project data for Project management and promote application of learning between districts within and beyond Project sites.

RTCCD will be responsible for managing the Project's training component from Year Three of Project implementation. RTCCD will also assign two Training Officers based in its Huong Hoa office at 100% effort level (Years One through Three), one for each district who will report directly to the Training Coordinator in Hanoi. SC will closely support the transfer of the LU training methods during Project Years One and Two, but its role will diminish as local partners gain skills to manage training activities. RTCCD will work with SC to promote the Project as an LU site for other interested public and private organizations in Vietnam.

PATH will ensure that all BCC activities and material development serving the Project objectives are implemented appropriately and on time. PATH will assist to design baseline studies, which will inform BCC. PATH will be responsible for developing appropriate messages and communications based on determined social norms, beliefs, knowledge, and behavior. Coordinating closely with RTCCD and SC through a team-based approach, PATH will also be responsible for developing BCC training modules or curricula for district and commune MOH staff, HHWs, peer educators and WU staff.

CS-18 will cultivate **lines of communication** and strong institutional and individual relationships in a variety of ways. A CS-18 **Management Team** will consist of the Health Program Specialist, the CS Project Manager, the Program Officers, and senior representatives from PATH and RTCCD (with relevant Directors joining as needed). The team will hold meetings in Hanoi and monitor progress towards objectives, making key Project management decisions, and sharing relevant information.

Work Plans SC will use work plans (as in Tables 5-7) for program implementation, monitoring, and follow-up during the Management Team meetings in Hanoi, and in the Steering Committee meetings in the field. As each team reviews activities against those programmed, staff will analyze problems and make adjustments for the next quarter.

<p>FACILITY LEVEL (Commune Health Center):</p> <ol style="list-style-type: none"> 1. Provision of essential equipment & supplies for MNC at all CHCs (and for BEOC). 2. Training for CHC staff on MNC care (protocols). 3. Train CHC staff in HMIS (develop revised data collection forms – train staff in their use) 4. Establish and strengthen referral activities (telephone, staff, register) <ol style="list-style-type: none"> a. Install telephone for each CHC b. Ensure staff 24 hrs/ 7 days; on call for home visits: BEOC & newborn complications c. Establish a referral register (record diagnosis, First Aid, referral, follow-up) 5. Establish outreach (ANC, Birth Assist., Postnatal MN care; support BCC activities, HBLSS) <p>-----</p> <ol style="list-style-type: none"> 6. This is a topic of HBLSS training 7. Support and supervise to BCC activities done by CHGs (esp. HBLSS training) 	<p>May 03 Oct-Dec 2003 June – Dec03 June – Dec03 (we will do this step by step following the 5 years plan for gradual phase-in,</p>	<p>Trained trainers from DHS, province MCH/FP Dept., 2ry Med. School in Quang Tri; SC/US</p> <p>CHC midwife & HHW, CHG, Midwives and commune health staff, CHC midwife, HHW, CHG Midwife, HHW, CHG</p>	<p>Equip/supplies-CHC CHC Staff trained Staff skilled in HMIS</p> <p>Referral Outreach established</p>
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<p>COMMUNITY LEVEL: BCC activities in MNC</p> <ol style="list-style-type: none"> 1. Community Mobilization in MNC; HBLSS for Van Kieu minorities <ol style="list-style-type: none"> a. Revise existing 7 modules; (w/birth preparedness topics and minority focus) b. 1st TOT on HBLSS for DHS staff c. Training for CHC/village staff; Launch commune level implementation of HBLSS d. TA in initial supervision of HBLSS activities e. Develop additional HBLSS modules as identified through community activities f. 2nd TOT on HBLSS with newly developed modules g. Commune level implementation of HBLSS (group education sessions); h. On-going supervision of commune HBLSS activities (TA in initial supervision) 2. Community Mobilization in MNC; Birth Preparedness Package for Kinh majority <ol style="list-style-type: none"> a. Revise the existing BPP package b. TOT for province/DHS and RTCCD staff c. Training for CHC/Village staff d. Supervise commune activities, including <u>household level</u> e. Organize MNC/BPP Drama competitions (based on SM project experiences) 3. Peer Education for Van Kieu minority youth in RH&MNC) via Sim houses developed 4. TOT for hamlet-based peer-educators and RTCCD staff 5. Conduct Operation Research on selected topics (HBLSS, PDI for Newborn Care, etc.) <p>-----</p> <p>BCC ACTIVITIES IN NUTRITION (POSITIVE DEVIANCE INQUIRY AND HEARTH MODEL)</p> <ol style="list-style-type: none"> 1. Revise Nutrition curriculum, including pictures, posters (separate modules for Kinh/Van Kieu) 2. Conduct TOT on Nutrition session for DHS and RTCCD staff 3. Initiate commune level implementation of PDI (TA initial supervision, on-going supervision) <p>Kindergarten and elem. School teachers invited to participate in NERP centers</p>	<p>Apr-June 2003 July-Sep 2003 July-Sep 2003 July-Sep 2003</p> <p>Oct-Dec 2003 Oct-Dec 2003 Oct-Dec 2003 Oct-Dec 2003</p> <p>Apr-June 2003 June-Aug 2003 July 2003-cont. Sep/Oct 2003</p> <p>Dec03-May 2004</p> <p>April-June 2004 April-June 2004</p> <p>Oct-Dec 2003</p> <p>June-July 2004 June-July 2004 July-Aug 2004</p>	<p>RTCCD, PATH, SC CHC midwife, RTCCD PATH, RTCCD, SC, dist. trainers PATH, RTCCD, SC</p> <p>PATH, RTCCD, SC RTCCD, DHS, PATH PATH, RTCCD RTCCD, DHS (SC)</p> <p>PATH, RTCCD PATH, RTCCD DHS, PHS, RTCCD, PATH,RTCCD</p> <p>DHS, PATH</p> <p>PATH, RTCCD PATH, RTCCD</p> <p>SC, HSPH (interns), RTCCD, and PATH</p> <p>RTCCD, PATH, SC RTCCD , SC, SC, RTCCD (RTCCD)</p> <p>PATH, RTCCD PATH, RTCCD</p>	<p>7 modules revised Staff skilled –HBLSS HBLSS-1 launched HBLSS-1 supervised</p> <p>New modules ready Staff skilled-HBLSS HBLSS-2 launched HBLSS-2 supervised BPP package revised Staff skilled – BPP BPP launched BPP supervised Drama competition</p> <p>Program developed Staff skilled-Peer Ed OR conducted Nutrition materials revised PDI implementation</p>
<p>HOUSEHOLD LEVEL:</p> <ol style="list-style-type: none"> 1. Home visits to all pregnant and postpartum women by CHGs for MNC counseling launched. 	<p>Oct 2003-onwards</p>	<p>Midwife, HHWs, CHGs</p>	<p>Home visits operational</p>

TABLE 6. WORKPLAN TABLE (SHOWING SELECTED DIP GUIDELINE REQUESTED INFORMATION IE. RESULTS, INDICATORS, MEASUREMENT, METHODS, BASELINE VALUES, AND END OF PROGRAM TARGETS)

Result/Intermediate Result	#	Indicator and Source (see footnote)	Method	Baseline Value	EOP Target	Int'n.
Goal: Improved health status of women & children < age 5 years	1	% 0-23 month olds < -2 Z-scores weight-for-age	KPC Survey			
SO-1: Improved use of key MCH services, in Da Krong and Huong Hoa districts.	2	% of mothers who report having made 3+ ANC visits to a health facility while pregnant with last child. ^{1,(3)}	KPC Survey	45%	70%	MNC
	3	% of 0-23 month olds whose birth was attended by skilled health personnel. ^{1,3}	KPC Survey	21%	50%	MNC
	4	% of mothers who received 2 doses of Tetanus Toxoid vaccine	KPC Survey	70%	80%	MNC
	5	% of mothers who received 100 ANC Iron/Folate tablets	KPC Survey	42%	80%	MNC
	6	% of mothers who received postnatal care	KPC Survey	27%	60%	MNC
	7	% of mothers who received postpartum Vitamin A supplement	KPC Survey	26%	60%	MNC
	8	% of newborns weighed within 24 hrs of birth	KPC Survey	49%	80%	MNC
SO-2: Increased Practice of Key household Behaviors	9	% of mothers who deliver at home and practice clean cord cutting (CDK use)	CS-18 Records	39%	70% **	MNC
	10	% mothers who started to breastfeed immediately (within 1 hr of birth)	KPC survey	74%	85%	All
	11	% of 0-4 month olds exclusively breastfed during the last 24 hours. ³	KPC Survey	32%	60%	All.
	12	% of mothers practicing appropriate complementary feeding	KPC Survey	80%	90%	All
IR-1: Increased household level knowledge of selected MCH issues.	13	% of mothers who know 2+ pregnancy danger signs	KPC Survey	22%	60%	MNC
	14	% of mothers who know 2+ delivery danger signs	KPC Survey	15%	40%	MNC
	15	% of mothers who know 2+ postpartum danger signs. ³	KPC Survey	12%	40%	MNC
	16	% of mothers who know 2+ newborn danger signs. ³	KPC Survey	22%	50%	MNC
	17	% of mothers who have birth plan including transport and funds	CS-18 Records	?	50%	MNC
IR-3: Improved service quality and accessibility	18	% of communes with functioning emergency transport	CS-18 Records	0%	30%	MNC
	19	% of CHC staff using supervision tools	CS-18 Records	0%	30%	All
	20	% of CHC staff and HHWs using job aids	CS-18 Records	0%	80%	All
	21	% of hamlets with hamlet-based birth attendant trained in LSS	CS-18 Records	0%	80%	MNC

	22	% of LSS-trained DHS midwives who correctly manage normal pregnancies, deliveries, & obstetric complications	ACNM LSS Forms	?	80%	MNC
	23	% of LSS-trained CHC midwives who correctly manage normal pregnancies, deliveries, & obstetric complications.	ACNM LSS Forms	?	80%	MNC
IR-4: Improved sustainability.	24	% of newborns registered within 1 day of birth..	Final Eval.	40%	70%	MNC
	25	% of CHCs using data for planning	Final Eval.	None	50	All
	26	Number of CS-18 strategies successfully scaled up by DHS beyond CS-18 area	CS-18 Records	None	3	All

* **Indicator source:** 1: CS-14; 2: BASICS HFA; 3: KPC 2000 / 2000+ / CATCH; () = indicator revised

TABLE7: WORKPLAN TABLE (SHOWING REMAINING DIP GUIDELINE REQUESTED INFORMATION, I.E. MAJOR ACTIVITIES, TIME-FRAME, RESPONSIBLE PERSONNEL AND BENCHMARKS)

Goal: Improved health status of women and children < age of 5 years. SO 1: Improved use of MNC health services. SO-2: Increased practice of key household behaviors.																												
Indicator 1. % of 0-23 month olds <-2 Z-scores weight-for-age Indicator 2. % of mothers who report to have made 3+ ANC visits while pregnant Indicator 3. % 0-23 month olds whose birth was attended by skilled health personnel (home delivery) Indicator 4. % of mothers who received 2 doses of Tetanus Toxoid vaccine Indicator 5. % of mothers who received 100 ANC Iron-Folate tablets Indicator 6. % of mothers who received postnatal care Indicator 7. % of mothers who received postpartum Vitamin A supplementation Indicator 8. % of newborns weighed within 24 hours of birth Indicator 9. % of mothers who practiced clean cord cutting during their home delivery (CDK use) Indicator 10. % of mothers who started to breastfeed within 1 hour of delivery Indicator 11. % of 0–4 month olds exclusively breastfed during the last 24 hours Indicator 12. % of mothers who practice appropriate (per guidelines) complementary feeding (onset, frequency, variety, continued BF)																			KPC survey									
Major Activities	2002			2003									2004									Personnel	Benchmarks					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Jul	Aug	Sep	Year 1	Year 2	
HOUSEHOLD LEVEL																												
Pregnant women make birth plans involving other family members.																X	X	X	X	X	X	X	X	X	X	HHW, CHG, SC, RTCCD	TBD	TBD
Mothers who have had 3+ ANC visits at facility or home (outreach)																X	X	X	X	X	X	X	X	X	X	CHC, CHG	TBD	TBD
Postpartum mothers receive checkups by CHC staff during home visits																X	X	X	X	X	X	X	X	X	X	CHC	TBD	TBD
Mothers receive TT vaccine either at CHC or home (outreach)																X	X	X	X	X	X	X	X	X	X	CHC	TBD	TBD
Mothers receive 100 ANC Iron-Folate tablets																X	X	X	X	X	X	X	X	X	X	CHC	TBD	TBD

HEALTH FACILITY- Commune Health Centers																															
Full range of ANC care is offered, both at facility and through outreach																		X	X	X	X	X	X	X	X	X	X	X	CHC, HHW	TBD	TBD
All Pregnant women counseled on birth planning																		X	X	X	X	X	X	X	X	X	X	CHC staff, HHWs	TBD	TBD	
All new mothers counseled about BF, and on nutrition																		X	X	X	X	X	X	X	X	X	CHC staff, HHWs	TBD	TBD		
CHC staff are skilled in normal delivery and MNC																		X	X	X	X	X	X	X	X	X	CHC staff, HHWs	TBD	TBD		
CHCs have MNC protocols and CHC staff are trained in their use																		X	X	X	X	X	X	X	X	X	CHC staff, HHWs	TBD	TBD		

IR-1: Increased household level knowledge of selected MCH issues.																												
Indicator 13. % of mothers who know 2+ danger signs in pregnancy																								KPC survey				
Indicator 14. %of mothers who know 2+ danger signs in delivery																								KPC survey				
Indicator 15. % of mothers who know 2+ postpartum danger signs.																								KPC survey				
Indicator 16. % of mothers who know 2+ newborn danger signs.																								KPC survey				
Indicator 17. % of mothers who have a birth plan including transport and funds																								CS-18 records				
Major Activities	2002			2003									2004									Personnel	Benchmarks					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Jul	Aug	Sep	Year 1	Year 2	
Household																												
Pregnant women and mothers attend LSS sessions and learn about maternal danger signs (pregnancy, delivery and postpartum)														X	X	X	X	X	X	X	X	X	X	X	X	CHG	Phase 1 Comms.	Phase 2 Comms.
Community / Health Facility																												
BCC activities conducted with pregnant women and mothers about maternal danger signs (pregnant, delivery, postpartum)														X	X			X	X			X	X			SC, CHG, RTCCD, PATH	Phase 1 Comms.	Phase 2 Comms.
BCC activities conducted with pregnant women to improve knowledge, care, & care seeking for newborns														X	X			X	X			X	X			SC, CHG, RTCCD, PATH	Phase 1 Comms.	Phase 2 Comms.
Pregnant women, husbands & family members participate in LSS sessions on birth planning																X	X	X		X	X	X		X	X	CHGs, RTCCD	Phase 1 Comms.	Phase 2 Comms.
Hamlet-based health committees have regular CS-18 meetings																										CHGs, RTCCD	Phase 1 Comms.	Phase 2 Comms.

IR-3: Improved service quality and accessibility																														
Indicator 18. % of communes with functioning emergency transport Indicator 19. % of CHC staff using supervision tools Indicator 20. % of CHC staff and HHWs. Using job aids. Indicator 21. % of hamlet with hamlet-based birth attendant trained in LSS. Indicator 22. % of LSS-trained DHS midwives who correctly manage normal pregnancies, deliveries and obstetric complications.. Indicator 23. % of LSS-trained CHC midwives who correctly manage normal pregnancies, deliveries, & obstetric complications																								CS-18 records CS-18 records CS-18 records ACNM LSS forms ACNM LSS forms ACNM LSS forms						
Major Activities	2002			2003												2004									Personnel	Benchmarks				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 1	Year 2			
Health Facility- Commune Health Centers																														
CHCs provided needed equipment, supplies and drugs for MNC												X	X	X													DHS, SC	Equip in place	Equip in place	
CHCs have MNC treatment protocols and staff are trained in their use														X	X	X	X	X	X	X	X	X	X	X	X	X	DHS, SC	Protocols	Protocols	
CHC staff trained in counseling techniques														X	X	X	X										DHS, SC	Counsel. Training	Counsel. Training	
CHC staff trained in routine MNC and BEOC, First Aid, LSS														X	X	X	X										DHS,SC	Regular Supervis.	Regular Supervis.	
CHC staff supervised monthly by DHS staff														X	X	X	X										DHS, SC, RTCCD	Regular Supervis.	Regular Supervis.	
CHC staff conduct outreach MNC activities monthly to catchment hamlets																	X	X	X	X	X	X	X	X	X		CHC, RTCCD	Outreach	Outreach	
CHC staff provide support and supervision to LSS, and other BCC activities conducted by CHG																	X	X	X	X	X	X	X	X	X		CHC, CHG	BCC by CHGs	BCC by CHGs	
Data collection forms developed and provided to all CHCs															X	X	X	X	X	X	X	X	X	X	X	X		CHC, SC	Forms in place	Forms in place
Referral system to DHS is established, including 3 elements (telephone, staff on-call, register)																			X	X	X	X	X	X	X		DHC, CHC, SC	Referral System	Referral System	
Basic service data routinely collected by CHC staff														X	X	X	X	X	X	X	X	X	X	X	X		CHC, GHC	Data collected	Data collected	

Supervision plans developed for HHWs and CHGs and supervision conducted regularly by CHC staff																				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	CHC, GHC, SC RTCCD	Supervis. plans	Supervis. plans		
CHCs provided with IEC materials																						X	X												PATH, SC RTCCD	IEC materials	IEC materials		
District																																							
DHSs provided needed equipment, supplies and drugs for MNC to CHCs																						X	X												DHS, CHC, SC	Equip. in place	Equip. in place		
DHSs have MNC treatment protocols and staff are trained in their use																								X	X	X										DHS, CHC, SC	Protocols	Protocols	
DHS staff trained in counseling techniques																								X	X	X										DHS, CHC, SC	Counsel Training	Counsel Training	
DHS staff trained in routine MNC and BEOC, First Aid, LSS and CEOC																							X	X	X											SC, DHS	DHS Clinical Training	DHS Clinical Training	
DHS staff supervises CHC staff monthly, according to a supervision plan																										X	X	X	X	X	X	X	X	X	X	X	SC, DHS, RTCCD	Supervis.	Supervis.
TOTs on MNC for trainers from DHS, province MCH/FP, OB/Gyn ,Quang Tri 2ry Med School including routine MNC and EOC																							X	X												SC, DHS,	TOT	TOT	
Training in MNC for CHC staff conducted																									X	X	X	X	X	X	X	X	X	X	X	X	DHS, CHC, SC	CHC staff trained	CHC staff trained
Protocols for MNC developed and staff trained in those																											X	X	X	X	X	X	X	X	X	X	DHS, CHC, SC	Protocols in place	Protocols in place
Referral system from CHC is supported and established to Provincial level																											X	X	X	X	X	X	X	X	X	X	DHS, CHC, SC	System in place	System in place
TOTs on supportive supervision and staff monitoring																																			X		SC staff	TOT	TOT
Supervision plans developed and supervision taking place (regular and spot) following checklists																								X	X	X	X	X	X	X	X	X	X	X	X	SC staff	TBD	TBD	
Monthly reports submitted by CHCs consolidated																							X	X	X	X	X	X	X	X	X	X	X	X	X	CHC, DHS, SC	TBD	TBD	

IR-4: Improved sustainability.																													
Indicator 24. % of newborns registered within 1 day of birth.																										Final Evaluation			
Indicator 25. Number of CHCs using data for planning.																										Final Evaluation			
Indicator 26. Number of CS-18 strategies successfully scaled up by HCS beyond CS-18 areas..																										PLG Report			
Major Activities	2002			2003												2004									Personnel	Benchmarks			
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 1	Year 2		
District																													
SC establishes an office in Dong Ha, Quang Tri province				X																							SC-HO	office	Office
Quang Tri Program Officer hired					X																						SC-HO	PO	PO
CS-18 staff supervise baseline surveys in Da Krong and Huong Hoa districts			X	X																							SC-HO	Surveys done	Studies done
CS-18 Program Manager participates in annual meetings of SC's OH Program Learning Group								X												X							SC-HO	Meeting Attended	Meeting Attended
CS-18 midterm assessment studies																								X			All partners	Study	Study
Provision of technical materials for baseline assessments	<																										SC		
Joint drafting of Detailed Implementation Plan, & annual reports					X	X						X													X		All partners	DIP, AR	DIP, AR
Technical backstopping through e-mail correspondence	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		SC	TA	TA
Program Manager participates in SC regional PD/H training, trains other staff in PD/H	<																										SC	Training Attended	Training Attended
TA visit from ACNM to follow-up community based training in LSS		X								X																	SC	TA	TA

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- ⁱⁱⁱ Report of a Planning Meeting, *Towards New Applications of the "Positive Deviance" Approach in Save the Children's Programs*, August 3, 2000, Westport (CT): Save the Children.
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- ^v UNICEF Vietnam, (2000) Children and Women, A Situation Analysis 2000, Hanoi: UNICEF.
- ^{vi} SC's recent study (Bramley, Samantha, (2001) Maternal Mortality Reporting in Vietnam – Looking Behind the Statistics, Hanoi: SC/US) of recording maternal deaths in Vietnam suggests that official maternal death statistics are quite incomplete.
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