



**Child Survival 18 – Vietnam**  
**First Annual Report**

***Building Partner Capacity for  
Child Survival of Vietnamese Ethnic Populations***  
**Quang Tri Province, North Central Region, Vietnam**

**Cooperative Agreement No.: HFP-A-00-02-00044-00**

**1 October 2002 – 30 September 2007**

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Submitted to USAID/GH/HIDN/NUT/CSHGP  
October 31, 2003

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### Annexes

Annex A. Responses to Recommendations Made in the DIP Review

## Acronyms

ACNM	American College of Nurse-Midwives
ANC	Antenatal Care
BCC	Behavior Change Communication
BDS	Behavioral Determinants Study
BEOC	Basic Emergency Obstetric Care
BPP	Birth Preparedness (Package)
CDK	Clean Delivery Kit
CG	Community Guide
CHC	Commune Health Center
CM	Community Meeting
CS	Child-survival
CSTS	Child Survival Technical Support
DHS	District Health Services
DIP	Detailed Implementation Plan
ENC	Essential Newborn Care
EOP	End of Project
FP	Family Planning
HBLSS	Home-Based Life-Saving Skills
HCMC	Home Care for Mothers and Children
HCMI	Home Care for Mothers and Infants
HCMN	Home Care for Mothers and Newborns
HFA	Health Facilities Assessment
HH	Household
HMIS	Health Management Information Services
HO	Home Office (of Save the Children, located in Westport, CT)
HW	Health Worker
KPC	Knowledge, Practice, and Coverage
LU	Living University
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCNC	Maternal/Child and Newborn Care
MCNH	Maternal/Child and Newborn Health
MN	Maternal and Newborn
MNC	Maternal Newborn Care
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTE	Mid-Term Evaluation
NERP	Nutrition Education and Rehabilitation Program
OCAT	Organizational Capacity Assessment
OR	Operations Research
PD	Positive Deviance or Positive Deviant
PDI	Positive Deviance Inquiry
PHS	Provincial Health Services
PVO	Private Voluntary Organization

RTCCD	Research and Training Center for Community Development
SC	Save the Children Federation, Inc.
SNL	Saving Newborn Lives Initiative
TA	Technical Assistance
TOT	Training of Trainers
USAID	United States Agency for International Development
VNFO	Vietnam Field Office of Save the Children

## **A. Program Progress**

### **Main Accomplishments:**

#### **1. Established a good partnership with Dakrong and Huong Hoa Districts, and Quang Tri Province**

The greatest accomplishment we achieved was to build a strong relationship with our district and provincial partners. We have gained political support not only from the health sector but also from all of the leaders of various sectors/departments including the Education Department, the Women's Union, the Farmer's Association, the Military, and the Population and Family Planning Network. The commitment and support from the district leaders are a prerequisite for the success of the project especially for these two districts, as they border Laos and more than 50% of their population comes from minority groups. The commitment and great support from Quang Tri Province Health Service and MCH/FP Department provides additional technical and management resources to the project, and helps to ensure greater ownership and sustainability of the CS-18 program.

#### **2. Organized DIP workshops and prepared DIP**

Save the Children, in cooperation with RTCCD and PATH, successfully organized and facilitated two DIP workshops in April 2003; one with representatives from five communes in Dakrong District and another one with representatives from three communes in Huong Hoa District. The DIP workshops stimulated partners' interest, responsibility and commitment for the project. It also encouraged serious discussion about specific project interventions and realities for each commune.

#### **3. Implemented project activities as planned**

Even though SC staff encountered many challenges during the first year of the project, which is often the most challenging stage for any project, we still managed to keep all activities going as planned (see Table 1). It was especially important that we met our goals as timely implementation built trust and confidence with our Dakrong and Huong Hoa partners.

#### **4. Collected baseline data to inform project interventions**

With very helpful TA from SC headquarters, we conducted three baseline studies: (a) Household Survey, (b) Health Facility Assessment, and (c) Behavioral Determinants Study. The results of these studies informed preparation of the DIP, and particularly helped us to develop Behavior Change Communications (BCC) interventions for activities at the household level.

### **Factors that have contributed to achieving these accomplishments:**

1. SC has been working on a child nutrition project in four communes in Dakrong District since 1999. Our successful working relationships within the district and the province helped to ensure that we would have a strong base for CS-18.
2. As a result of our participatory approach with district and provincial partners, all of our activities are discussed and planned with partners. We respect partners, listen to their ideas, and never impose outsider's ideas on them. Rather, we use evidence-based approaches to introduce new concepts or methodologies and win support for these ideas and methodologies.

3. As mentioned above, the policy makers in Dakrong and Huong Hoa are very sensitive with strict regulations from administrative and foreign affair authorities. These guidelines require SC to follow certain regulations related to access and presence of foreigners in the area. We followed these regulations carefully and respected the established rules. We also respected the culture of the Pako and Vankieu minority groups, including appreciating their good practices and encouraging them to participate, to be creative, and to feel more accountable for their actions.

4. One important factor that facilitated our success was the tremendous amount of detailed preparation we performed for each activity. From the project orientation workshop with the province, to orientation of district partners, baseline studies, DIP workshops and activities at the hamlet and commune levels, our advanced preparation helped us to be successful in implementing project activities.

5. Supportive and very helpful TA from home office was an important factor that helped our team to achieve our objectives. We received helpful TA for our baseline studies, for planning the evaluation of the PDI approach for the behavior change interventions, and for producing training manuals for child nutrition activities and home care for mothers and children.

6. The establishment and staffing of a regional office in Quang Tri was important in enhancing local partner coordination and providing more effective logistical and technical support for project activities.

### **Achievements from October 2002 to September 2003**

Specific objectives of the project:

- Increased use of maternal, newborn and child care services.
- Increased practice of key household behaviors on maternal and child care.
- Increased service accessibility.
- Improved service quality.
- Improved sustainability of project activities after the project is phased out.

**Table 1. Accomplishments During Year One**

#	Activity	Target achieved		Comment
		Planned	Achieved	
<b>Start-up Activities</b>				
1	Sign MOU between SC and provincial partners	Oct 02	Yes	
2	Conduct Orientation Workshops for province and district partners	Nov 02	Yes	
3	Set up Quang Tri office	Nov 02- Feb 03	Yes	
4	Recruit staff	Nov 02- Feb 03	Yes	
5	Conduct baseline assessment: <ul style="list-style-type: none"> <li>- Design Household (HH) Survey, Health Facility Assessment (HFA) and Behavioral Determinants Study (BDS).</li> <li>- Conduct HH survey and HFA</li> <li>- Conduct BDS</li> </ul>	Oct-Nov 02  Dec 02- Jan-Mar 03	Yes  Yes Yes	
6	Complete three baseline assessment reports	Mar 03	Yes	
7	Conduct DIP workshops at Dakrong and Huong Hoa districts and complete the DIP report	Apr 03	Yes	
8	Sign MOU between SC and District People's Committee	Jun – Jul 03	Yes	Based on this MOU, SC could sign Sub-agreements with District health service
9	Sign Sub-grant agreements with RTCCD	Jul 03	Yes	
10	Sign Sub-grant agreements with PATH	Jul 03	Sep. 03	
11	Sign Sub-grant agreements with local partners (Dakrong and Huong Hoa District Health Services)	Jul-Aug 03	Mostly completed	The sub-grant agreement form developed by USAID is very complicated for local partners who can not read and understand English. Therefore, SC conducted a Sub-grant workshop to introduce these documents and explain some specific issues to our partners. The Sub-grant agreements are now

				ready to be signed in early October 2003.
<b>Health Services/District Level</b>				
1	Provide essential equipment and supplies for MNC and EmOC at both District Health Services	May 03	Not completed	Due to delay in signing Sub-grant with district health services
2	Revise Maternal and Newborn Care manuals based on existing Safe Motherhood Manuals and new National Standards on Reproductive Health Care	May-Jun 03	Yes	
3	Conduct TOT for DHS trainers in Maternal and Newborn Care	Jul-Sep 03	Jul-Aug 03	Obstetricians from the Province Hospital, the Medical Secondary School and the MCH/FP Center assisted with this training
4	Reintroduce the MOH standard protocols in MNC for district trainers	Jun-Dec 03	Jul-Aug 03	Completed during TOT for DHS trainers in Maternal and Newborn Care
5	Train DHS trainers and supervisor in monitoring MNC with supervision checklists	Jun-Dec 03	Jul-Aug 03	Completed during TOT for DHS trainers in Maternal and Newborn Care
6	Train DHS staff in HMIS (develop and train district trainers and supervisors in data collection forms)	Jun-Dec 03	Jul-Aug 03	Completed during TOT for DHS trainers in Maternal and Newborn Care
7	Establish and strengthen referral activities: <ul style="list-style-type: none"> <li>- Install telephone for Ob/Gyn Dept. in DHS</li> <li>- Ensure staff 24hrs/7 days; mobile support to CHCs for BEOC and Newborn complications</li> <li>- Establish a referral register to keep records (cases from CHCs)</li> </ul>	Jun-Dec 03	Not completed  On going	Due to delay in signing Sub-grant agreement with district health services.
<b>Health Services/Commune Level</b>				
1	Provide essential equipment and supplies for MNC and EmOC Commune Health Centers	May 03	Not completed	Due to delay in signing Sub-grant agreements with district health services
2	Training for CHC staff on MNC, including protocols	Oct-Dec 03	Nov 03	
3	Training for CHC staff in HMIS (data	Jun-Dec	Nov 03	In-service training for

	collection forms)	03		CHC staff on MNC will be conducted in November 03
4	<p>Establish and strengthen referral activities:</p> <ul style="list-style-type: none"> <li>- Install telephone for Ob/Gyn. Dept. in CHC</li> <li>- Ensure staff 24hrs/day, 7 days/week; mobile support to CHCs for BEOC and newborn complications</li> <li>- Establish a referral register to keep records (cases from CHCs)</li> <li>- Establish outreach (ANC, Birth assist; postpartum MN care)</li> </ul>	After signing sub-grant agreement	Not completed	<p>Due to Sub-grant Due to delay in signing Sub-grant agreements with district health services</p> <p>After training for CHC staff on MNC</p> <p>After training for CHC staff on MNC</p> <p>After training for CHC staff on MNC</p>
<b>Community Activities/District, Commune and Household Levels</b>				
1	Transfer the nutrition and HBLSS models to RTCCD and PATH	June 03	Jun 03	
2	Community Mobilization in MNC; HBLSS – HCMI for Van Kieu minorities: Revise HBLSS manuals and train for district trainers	Jul-Dec 03	December 03 to March 04	We develop home care for mothers and children (HCMC) which is modified from HBLSS manual for BCC activities at hamlet level.
3	Community Mobilization in MNC; Birth Preparedness Package for Kinh majority	Jul-Dec 03	December 03 forward regularly	
4	<ul style="list-style-type: none"> <li>➤ Revise Nutrition curriculum, including pictures, posters (separate modules for Kinh/Van Kieu)</li> <li>➤ Conduct TOT on Nutrition session for DHS and RTCCD staff</li> <li>➤ Initiate commune level implementation of PDI (TA initial supervision, on-going supervision)</li> </ul>	<p>Jun-Jul 04</p> <p>Jun-Jul 04</p> <p>Jul-Aug 04</p>	<p>Jun-Sep 03</p> <p>Sep 03</p> <p>Nov 03</p>	This activity was planned to do in June 04 after we do HCMC but we change to do nutrition first, so we started to do it in June 03, and HCMC later.

## **B. Factors Which Have Impeded Progress**

The sub-grant agreement is a very complicated document for staff to understand. SC staff attended two workshops, one international and one local, in order to understand these documents. It is even more complicated for our local partners, who cannot read English, to understand and sign the sub-grant agreement. It has taken a great deal of staff time and effort to effectively translate necessary parts of the agreement, to explain the agreement to the partners, and to ensure understanding and cooperation.

## **C. Technical Support Needed**

We received very helpful support from Dr. David Marsh, Mr. Eric Swedberg and other child survival experts in SC headquarters as well as from USAID Child Survival Technical Support group (CSTS). David Marsh supported us in developing the baseline assessment studies, applying PD-plus in BCC interventions, developing monitoring and evaluation plan and tools for program interventions. Mr. Eric Swedberg gave us prompt responses to our queries on program guidelines, instructions and updates on CS issues. We also got helpful comments and suggestions from CSTS for the DIP report.

## **D. Changes in Program Implementation/Planning from the DIP**

The Vietnam Field Office recently received additional funding from the Saving Newborn Lives Initiative to carry out more in-depth maternal and newborn care components of the child survival project. These funds will help the CS project to have a comprehensive model for saving mothers and newborns at both the health facility and household levels. This additional funding will support the following activities: 1) Training for commune and district staff on essential newborn care (ENC); 2) Training for community guides to facilitate community meetings on caring for newborns at home; and 3) Advocacy activities for newborns at the national level (e.g. dissemination workshop for a report on the “State of the World’s Newborns: Vietnam”). We believe that the joint funding from USAID and SNL will add value to the project and will help SC in Vietnam to create a comprehensive model for child survival programming that will be instrumental as a model for national level planning, program design and advocacy.

There are no changes for the nutrition interventions and home care for mothers and children, except that we have changed the order in which these interventions will take place (i.e., nutrition first). Home care for mothers and children will start in March of 2004. The reasons for the shift is that we need less time to revise training manuals for nutrition and more time for developing a new training manual for home care of mothers and children. In this new manual, we will introduce the “PD-Plus Approach” for behavior change at the household level.

## **E. Responses to Recommendations Made in the DIP Review**

We appreciate comments that we received from the DIP reviewers, which have helped us to clarify project implementation and interventions. Please see Annex A for responses to these questions.

## **F. Program Management System**

- Financial Management System: We completed and signed sub-grant agreements with RTCCD and PATH. However, we were not able to sign the sub-grant agreement with Dakrong and Huong Hoa Districts until October 1, 2003 due to the complications related to language differences and comprehension of the sub-grant agreement document as previously mentioned. A strong financial management system has been designed put in place. It requires the SC Program Officer to check all advances made to sub-grantees to ensure that the money is spent on planned activities. Expense claims are then reviewed by the SC Program Officer and Accountant and are approved by the Deputy Director quarterly. This management system exerts careful control, however, our partners have to spend a lot of time preparing advances every month.
- Human Resources: SC created a strong project team for CS-18. We have a Senior Technical Specialist who is responsible for technical issues related to CS-18. One full-time Program Officer is designated to manage the implementation of project activities. One Program Officer based in Quang Tri, helps two districts to implement the activities at the commune and hamlet levels. The Vietnam team receives effective technical backstopping from HO.
- Local Partner Relationships: Save the Children has a good reputation and is well respected by Quang Tri partners. Monthly project review meetings are organized at the commune level. At the district level, quarterly project review meetings are organized with the People's Committee, the Health Department, the Women's Union, and the Population and Family Planning Network to review project activities implemented during the previous quarter. PATH, RTCCD and SC staff attend the quarterly meetings to help the district team address challenges that arise when implementing project activities.
- PVO Coordination/Collaboration In-Country: Every month, Program Officers and representatives of PATH, RTCCD and Save the Children meet to review activities implemented during the month. They also identify problems raised during project implementation, propose solutions, and make plans for upcoming activities. Meeting minutes are kept.

**G. Detailed Workplan for 1<sup>st</sup> October 03 – 30<sup>th</sup> September 04**

**Table 2. Detailed Workplan for 1<sup>st</sup> October 2003 – 30<sup>th</sup> September 2004  
Dakrong and Huong Hoa District, Quang Tri Province**

#	Activity	2003			2004									
		10	11	12	1	2	3	4	5	6	7	8	9	
	<b>Health Service</b>													
	Provide essential equipment for MNC and EmOC for DHSs and CHCs													
	Training on MNC for commune midwives, conducted by district trainers (first 14 communes of two districts)													
	Training on MNC for commune health staff, conducted by district trainers (first 14 communes of two districts)													
	Strengthen referral system: - Install telephone for DHS and CHCs - Ensure staff 24hrs/day, 7 days/week; mobile support to CHCs for BEOC and newborn complications - Establish a referral register to keep records (cases from CHCs)													
	Implement health services on MNC at DHS and 14 CHCs													
	Implement outreach services by commune midwife (ANC, birth assistance; postpartum MN care; home visit) at 14 communes													
	Conduct supervision (using supervision checklists)													
	Train district and province trainers and supervisors in supportive supervision													
	<b>Community Activities</b>													
	Training on nutrition for community guides of first eight communes, conducted by district trainers													
	Implement nutrition activities at first eight communes of two districts													
	Develop: - Facilitation skills for community guides - Home-based Care for Maternal and Child (HCMC) manuals and materials (the first topics) based on existing HBLSS manual - M&E tools for Community meetings													

Revise Birth Preparedness Package (BPP) for Kinh people													
Test HCMC and BPP manuals and materials in the field													
Conduct the first TOT on HCMC and BPP for district trainers													
Training for community guides on HCMC (the first topics) and BPP													
Develop the HCMC manual and materials with new topics													
Conduct the 2 <sup>nd</sup> TOT on new HCMC topics for district trainers													
Training for community guides of first eight communes on new HCMC topics													
Implement community meetings at hamlet level in first eight communes													
Training on nutrition for community guides of expanded six communes, conducted by district trainers													
Implement nutrition activities at expanded six communes of two districts													
Conduct supervision (using supervision checklists)													

## H. Program Highlights (Optional)

As VNFO is in the first year of the program implementation, we do not have any program highlights this year.

### Program Challenges

The project serves two mountainous districts with minority populations that have poor living conditions and poor infrastructure. These present big challenges for improving the health status of women and children without providing physical support from the project. Therefore, we need to find the way to mobilize and use resources available from the community.

The project requires strong and intensive supervision support from district and province staff after trainings, especially for BCC interventions at the hamlet level. However, project implementation is based on staff from the two districts, who are already working with government health and development programs. We are trying to find a way to coordinate supervision activities among district staff, province staff, RTCCD, PATH and SC staff, in order to ensure project quality and optimize the use of key personnel.

Partnership with PATH and RTCCD is also a challenge for program implementation as RTCCD and PATH have somewhat limited capacities for the activities they are responsible for. It is

important to remember that PD-Plus is a new approach for them, and developing training manuals for district trainers to use to conduct trainings for Community Guides who are illiterate, is an enormous challenge. SC needs to assist by developing these training manuals, which was originally assigned to RTCCD. SC will help RTCCD by conducting TOT on HCMC for district and province trainers, and supervising activities at the hamlet level.

## **Annex A. Responses to Recommendations Made in the DIP Review**

Q: The baseline KPC sampling was done with separate samples for each of two districts. However, given the differences between the minority and majority populations, and that different intervention strategies will be used to reach them, baseline and subsequent data collection could be more meaningful if aggregated based on people group rather than district.

A: That is good question, however we have to do separate samples for each district because each one needs data for the district itself, which helps district to track program progress for each district. There are also some differences in geographical and economical situations between the two districts, so we conducted the HH surveys separately for each district. The findings show some differences between the minority and majority populations in both districts, thus the strategies for interventions will be different for the minority and the majority populations in each district. For example, to improve health services, more outreach service will be established for the minority than the majority population. In order to improve household key practices, community meetings (modified from HBLSS by ACNM manual) are more appropriate for minority populations, but home visits may be more appropriate for majority population. In general, we have some key intervention strategies for each population, but we will apply various, appropriate intervention strategies for each population to reach the goals of the project.

Q: Why is the Program Manager based in Hanoi? Will this person be able to adequately build capacity in the team and partners from afar?

A: The Program Manager is based in Hanoi, but at least 50% of his time will be in the field with the field-base team. Additionally, the Quang Tri team travels to Hanoi at least once a month for monthly all staff meetings and program team meetings. We have sufficient opportunities to meet, review and support each other. The Program Manager's presence in Hanoi also supports the extensive networking that we are doing to link our work in Quang Tri with the national technical working groups, the MOH planning processes and donor advocacy.

Q: p. 18: The number of iron tablets is not stated. Are you interested in mechanism for dispensing tablets (tablets received by mothers) or in actual quantity consumed during pregnancy?

A: We are interested more in the actual quantity of iron tablets consumed during pregnancy than the number dispensed, but it is not realistic for us to track that. Therefore, we have to monitor the iron tablets dispensed instead of the number of iron tablets consumed during pregnancy. It would be great if USAID could share experiences from other countries that worked as we are exploring ways to try to monitor the actual number of iron tablets consumed in some communes.

Q: It is not entirely clear in the Executive Summary (p. 6) what the rationale is for the different approaches to the two main groups, minority and Kinh majority. The approach described for the Kinh is better developed conceptually, even though the project professes a greater emphasis on the minorities.

A: The rationale for different approaches for the Kinh and minority populations.

	<b>Rationale for Intervention Approaches</b>	<b>Intervention Approaches</b>
<b>Minority</b>	<ul style="list-style-type: none"> <li>▪ Far away from health facility, main road.</li> <li>▪ Lack access to health services and to CDK and micronutrient supplements.</li> <li>▪ Low use of health service.</li> <li>▪ Lack of access to information on maternal child and newborn care (MCNC), maternal and newborn complication.</li> <li>▪ Poor knowledge of caring for mother, newborn around delivery, obstetric complication and newborn complications.</li> <li>▪ Strong beliefs and social norms resulting in some negative practices in caring for mothers and children at home.</li> </ul>	<ul style="list-style-type: none"> <li>▪ More outreach service to hamlet, households (ANC, CDK, birth attendants, Vitamin A, iron tablets etc.).</li> <li>▪ Train commune health staff on caring for mothers and newborns to improve health staff's confidence and competency, which will increase community's trust and utilization of health services in the commune.</li> <li>▪ Use various approaches for BCC while applying the key home care for mother and infant (HCMI) approach, the modification from HBLSS by ACNM, to achieve the key home care practices for mothers and infant at home. PD-plus, which is modified from PDI for nutrition intervention, will be applied in the HCMI.</li> </ul>
<b>Kinh</b>	<ul style="list-style-type: none"> <li>▪ Closer to health facilities, main road.</li> <li>▪ Have more access to health services and to CDK and micronutrient supplements (CHC, pharmacy, money).</li> <li>▪ More use of health services.</li> <li>▪ Have more access to information (health staff, radio, TV, newspaper, high school) on maternal child and newborn care (MCNC), maternal and newborn complication.</li> <li>▪ Poor knowledge of MCNH care, obstetric and newborn complications.</li> <li>▪ Fewer beliefs and social norms resulting in some negative practices in MCNH care.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Train commune health staff on caring for mothers and newborns to improve health staff's confidence and competency, which will increase community's trust and utilization of health services in the commune.</li> <li>▪ Use various approaches for BCC while applying the key home visit approach and using leaflets and posters to disseminate info on MCNC. PD-plus, which is modified from PDI for nutrition intervention, will be applied in the HCMI.</li> </ul>

Q: The Executive Summary (p. 7) gives the impression that SAVE is providing technical assistance to PATH on developing BCC materials and implementation of BCC activities. Later, PATH's central BCC role is clarified.

A: As SC has experience in PDI in HCMN, SC will provide technical support to RTCCD and PATH. During the project implementation, SC, RTCCD and PATH will work together to help local partners implement the project. PATH's role will be more in development of materials for the BCC interventions.

Q: The text generally assumes that the reader is familiar with SAVE approaches and tools, such as Positive Deviance and the Living University (which I am). For readers unfamiliar with these tools, it would be useful to provide a bit more exposition about them. My personal feeling is that the DIP "overuses" some of these terms, when more generally known terms such as information gathering or baseline investigation or formative research would give just as clear or clearer description of the activity. For example, on p. 42, the section PDI Application for Better Breastfeeding Practices is not REALLY about a PDI application in the sense PDI is usually used by SAVE.

A: It is true that it will be difficult for readers who are unfamiliar with the terms PD and LU. David Marsh, provided TA in Vietnam to the Vietnam team and described the PD-Plus concept. This concept is used as a main approach for program interventions: "PD-Plus" aims to capitalize on SC's extensive experience using the Positive Deviance (PD) approach for social and behavior change by applying it to new outcomes while modifying it for use throughout the intervention rather than just formative research. In addition, SC will stress behavioral, rather than health status, outcomes, and will identify the determinants of these behaviors among the PD individuals and explore ways to transfer them to non-doers in two settings, community meetings and NERPs (Nutrition Education and Rehabilitation Programs). Specifically, SC will test whether semi-literate Community Guides can apply PD to: (1) identify new adopters of target behaviors promoted at earlier events, (2) conduct "booster PD inquiries" (PDI) among these new adopters, (3) identify current doers of the target behavior introduced at the present session, (4) conduct "mini-PDIs" among these doers, and (5) use the information from these booster and mini-PDIs to encourage further adoption of among non-doers.

Q: I was especially interested in reading about the Behavioral Determinants Study, p. 26, but found the discussion somewhat disappointing. While it is an interesting description of behavioral and cultural findings, I was expecting somehow a more conclusive report about how the internal and external factors listed as potential determinants either did or did not prove important. In the same vein, I personally would like more information on what SAVE means in references to PD-plus with a greater emphasis on behavioral determinants.

A: It is true that we did not include how to use the internal and external enabling factors to motivate behavior changes in the community. It is explicitly described in the PD- Plus concept and in the Home Care for Mother and Infant (HCMC) manual that we are working on. (We will document and keep them as annexes for the final report of CS-18). The training manual will be used by district and province trainers to train community guides (CG) who are village worker at the hamlet level. They will discuss all of the enabling factors to facilitate the community meeting

(CM) for behavior changes. At the CM, where groups of pregnant women, new mothers, grandmothers, or fathers gather to share and learn about caring for mothers and children at home, CG will conduct “Mini PDI” (upon introducing a new behavior) and “Booster-PDI” (upon identifying a new doer or a recently introduced behavior) and use the enabling factors gained from the queries to facilitate an active discussion and negotiation for a behavior change among participants.

Q: How will CHC midwife and health staff be motivated/supported to provide outreach services to minority areas?

A: In the rural areas of Vietnam, especially in a minority community, people who work at a government office or in a government system (village health workers) are considered to have a higher level of education than villagers, and villagers tend to follow their advice. All health staff want to have good knowledge, be professionally competent and have good working conditions at their job. The reality is that they rarely receive refresher training, they lack knowledge and skills, and they are not confident about giving advice or managing cases at commune health centers or in homes. When commune health staff have an opportunity to receive refresher training, they gain knowledge and skills. Their motivation increases when they are able to provide services or save the lives of mothers and children in their community. They then gain respect from the community and they are motivated to continue to do a good job. We do not pay them a salary, but they see the benefit of having the community’s trust and respect. We also work with the district health service to identify ways to more effectively organize their work and to strengthen the links between the province, district, commune and village.

Q: Are the Father/Grandparent Support Groups described on p. 42 REALLY support groups, or are they just a few meetings?

A: The ideal is to have father/grandparent support groups that actually help them to better understand the needs of women and actively support their wives/daughters-in-law at home. We had some positive experiences in Ha Tinh province with a breastfeeding program. In this project, we used the regular meetings of the Farmer Association, a predominantly male organization with strong membership and participation at a grassroots level. Through this community network we will gradually introduce topics related to maternal/child and newborn care. This idea was discussed with all Dakrong and Huong Hoa participants at the DIP workshop in April 2003. We will explore this approach to see how it works and then will document it.

Q: There are MANY community interventions to be conducted by CGs and commune health staff. For example, at the top of p. 44, the DIP says: “After training, CGs 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.” These sounds like an overwhelming program. Is it overly ambitious? Sustainable?

A: It is true that Community Guides (CG) will implement all these activities with support from commune health staff (CHS). Actually, the main activities being implemented by the community guides in every hamlet include:

1) Organizing and facilitating Nutrition Education Rehabilitation Programs (NERP) sessions that help rehabilitate malnourished children and prevent malnutrition among children under two years old in the community. NERP sessions will be organized for two consecutive weeks each month, and will last for nine months in each hamlet. NERPs are a series of ten meetings attended by pregnant women and mothers with malnourished children where trained Community Guides facilitate active learning of evidence-based model practices, many of which were discovered through the PDI. NERPs typically involve: (a) all mothers contributing PD foods daily; (b) teams of two mothers cooking a nutritious meal; (c) mothers practicing good hygiene and active child feeding; (d) Guides facilitating interactive learning of additional good household practices; and (e) CGs monitoring the process (attendance, contributions, etc.) and outcomes (child weights, graduation, etc.). Step Four (interactive learning of household practices) will include “mini-PDIs” and “booster PDIs,” which will more actively engage participants than the previous lecture format.

2) Organizing a series of community meetings to talk about caring for mothers and children at home with one specific topic for each meeting. For some topics, which need to cover many behaviors such as breastfeeding (sucking difficulties, problems with mothers’ breasts etc.), we may need more than one community meeting to cover all of the messages for the topic. The community meeting will take place once a month and will be carried out through the end of the project. For some communes where all of the topics on maternal and child care are covered, we may develop IMCI messages for the community meeting. At the community meetings attended by 5-15 women of reproductive age, trained Community Guides will introduce a new topic with one or more “emphasis behaviors” for the women to consider adopting. Meetings typically involve: (a) review of recent topics and behaviors from prior meetings; (b) “booster PDIs” when appropriate; (c) discussions of current practices (including a “mini-PDI”) related to the topic of the day; (d) presentations of ideal practices for the day’s topic through the use of carefully prepared, field-tested materials; (e) discussions around the feasibility of attendees adopting the emphasis behaviors or suitable compromises; (f) active role-playing to practice the new behaviors, where appropriate; and (g) monitoring, which includes household visits postpartum.

3) Home visits to pregnant women and new mothers. This activity focuses on tracking pregnant women at home through the postpartum period. CM and home visit activities support each other for promoting optimal practices in caring for mothers and children at home.

4) Organizing a campaign or drama contest for information about caring for mothers and children among community members. These activities will be designed as social events that involve all community members and will include messages about caring for mothers and children.

Q: Again a question on the CGs: it is not clear whether this cadre is already in place or needs to be introduced. p. 45 (under Project Management Plan) states that the participation of CGs will “depend on their individual interest and commitment.” This makes it sound like CGs are unpaid volunteers, but I haven’t yet seen anything explicit in the DIP about this point.

A: Community Guide (CG) is the term we use to indicate a group of village people who actively participate in health and social or community development activities in the village or commune. In this project, the CG are made up of people from the three key groups of village health workers, family planning motivators, and women's union members and all are supported by the village leader. These people belong to the existing health and administrative system of the government. Village health workers and village leaders are paid by the government, while village women's union members are not paid but are elected by the village. They have some level of education and are respected by people in the village and the commune. CGs are in place and committed to the health activities in the hamlet. We are helping them to do a better job. Other members of large organizations such as the Red Cross and the Farmer's Association, can also coordinate activities with the CG depending on their level of interest and commitment. The CS-18 project encourages and welcomes the participation of all members of organizations in hamlet activities.

Q: Workplan Table 5 raises a question under Activity 5 about an activity for which sufficient funding is not available. Is this a question about the HMIS? The structure of this table is a little confusing. It appears this table is replaced by the more comprehensive Table 7 Workplan?

A: Sorry for confusing you. Please ignore this reference as it was our editing mistake.

Q: I feel like a broken clock, since I had a similar point to make in my review of SC Guinea's DIP. But the project data sheet makes clear from the start that the baseline KPC survey only included the indicators that are of direct relevance to the project's objectives, and basically did not measure any other Rapid CATCH indicators. There is little point for me to present again here the interest of collecting this information, but let me try again:

- Since this project fits within the Child Survival and Health-Grants Program (as opposed to the MNC, and Nutrition, and Micro-nutrients, and Breastfeeding-Grants Program), it might be of use to collect a small set of indicators (developed by the CORE M&E WG) which presents an overall picture of Child Survival and Health in all areas of intervention. (Actually, all it would require is the collection of just 6 more indicators; I believe the marginal cost of including 6 more questions to the KPC would have been very limited.) Although I find this reason for collecting the CATCH indicators sufficient in itself, I agree that it does not weigh a lot on the project itself, unlike the next one:
- Given resource constraints, I would be surprised if the local MOH partners (DHS and PHS) had many opportunities to conduct population based health surveys. Given that SC is coming as a partner, a capacity building partner, to work with the MOH, why not take advantage of a KPC survey to include a few questions that might not be direct targets of the project, but would certainly be of great value to the MOH (for example full immunization? -- or are there population based coverage surveys conducted with other partners?) In terms of capacity building, it seems that fitting the project's efforts within the MOH mission (no doubt including more than the project interventions) has more benefits over the long term. And this means helping the MOH keep the 'big picture' of its mission, even if the project targets more specifically certain interventions where DHS and PHS can benefit from the partnership.<sup>1</sup>

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<sup>1</sup> My sentiment on this is reinforced by the later comment that "the MOH has a culture of target-driven performance, not service quality." (page 17) If that is the case, the MOH might be "hijacked" to set its eyes on the project's targets and forget about the broader population health needs it is supposed to serve.

This point comes back in Section E1, given the close collaboration of SC and MOH partners on progress monitoring.

A: That is great idea but given the reality of minority group in the sample (it took almost two hours for them to answer the questionnaire), we believe that it is too much for them as they have difficulty with recall. If we ask them additional questions, it may affect the quality of their responses. After testing the field procedure and the questionnaire, we had to omit some questions to make it feasible for the respondents to answer. We agree that it is a great idea and if it were currently possible, it would be of great benefit for the PHS and DHS in Quang Tri.

Q: In section E1 -- "monitoring and feedback system" -- the DIP appropriately identifies "good communication and trust between different levels of health services" as something important. Along with accountability and mutual respect (Organizational Change, page 17), I would see this as one of the 'soft issues' that will make a difference in the long run. Can SC think of any way to make this importance more explicit, even in its evaluation plan? This could be something to think of by the MTE. In terms of the Organizational Capacity part of this and tracking change, I would encourage SC to combine self-assessment with some externally verifiable measures if possible; if self-assessments (OCAT) are going to be repeated, this could actually be a good OR topic, to develop better understanding of institutional capacity building processes AND their measure.

A: Thank you for the encouragement and suggestion to consider this. We are actively reviewing this.

Q: Reading page 17 and then Table 1 (page 18) I wasn't clear whether a new KPC was planned for the MTE or simply at the EOP. A mid-term KPC is not an absolute necessity but I think it might be a worthy expense, for example to monitor the speed of progress in a project designed with natural phases (e.g. the expansion of the LUs). Also to compare the evolution of the gap between KPC indicators in Da Krong and Huong Hoa. [If this is the case, please also refer back to my 'broken clock' comment above.]

A: We did not budget for a KPC at the midterm evaluation, but we will track project progress by collecting data monthly from health facility system records, maternal cards, household monitoring forms and community guide books. This information will track the progress of the project. Another KPC will be conducted at the end of the project and the findings will be compared with the findings from the baseline KPC.

Q: The section on HW performance seemed to focus a lot on monitoring performance. I imagine this is because it was in the M&E section. Hopefully SC will advance supportive approaches to supervision.

A: Yes, we provide supervision tools and methods of supportive supervision to province and district trainers, which will help them to conduct supportive supervision to activities being implemented in the hamlets. The supervision tools will be developed, tested and then used by trained district and province trainers.

Q: In the technical section, because HCMN will be promoted through "a participatory community-based approach", I imagine changes in communities will be key to the success or failure of the sustainability plan. Is there any thought to bring appropriate capacity assessment tools at the community level? Is it thought outside of the scope of the project, or simply not feasible?

A: The capacity assessment will be accomplished by checking: monthly commune project review meeting minutes; monthly plans by communes and districts; district management board quarterly project review meeting notes; and supervision tools used for activities at the hamlet and commune levels. At the commune and hamlet levels, we will use the monitoring tools that track community meetings and NERP activities. We will also use the pictorial household monitoring tool to track women from pregnancy through the postpartum period, and their newborns.