



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

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

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

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Prepared and Edited by:

Matthew Frey, Field Office Director, SC/Vietnam
Bruce Rasmussen, Deputy Director for Health and Education, SC/Vietnam
Nguyen Anh Vu, Project Manager, SC/Vietnam
Ngo Van Toan, Maternal and Child Health Specialist, SC/Vietnam
David Marsh, Senior Child Survival Advisor, SC/Westport, CT

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Acronyms

ANC	Antenatal Care
BCC	Behavior Change Communication
BEOC	Basic Emergency Obstetric Care
BPP	Birth Preparedness Package
CDK	Clean Delivery Kit
CG	Community Guide
CHC	Commune Health Center
CS	Child Survival
DHS	District Health Services
DIP	Detailed Implementation Plan
EmOC	Emergency Obstetric Care
ENC	Essential Newborn Care
GMP	Growth Monitoring Promotion
HBLSS	Home-Based Life-Saving Skills
HCMC	Home Care for Mothers and Children
LU	Living University
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information Services
MNC	Maternal Newborn Care
NERP	Nutrition Education and Rehabilitation Program
NGO	Nongovernmental Organization
PATH	Program for Appropriate Technology in Health
PD	Positive Deviance or Positive Deviant
PDI	Positive Deviance Inquiry
PD-plus	Positive Deviance - plus
PHS	Provincial Health Services
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
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VNFO	Vietnam Field Office of Save the Children

I. Progress of the Program

Main Accomplishments:

During the past year, the following objectives were met in the initial 15 project communes in Dakrong and Huong Hoa Districts:

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

The illustrative results monitoring tables (Annex 1) show that several results appear to have been achieved, at least according to routine administrative records. The Project is just now commencing to facilitate routine data collection, analysis, interpretation, and response. Indeed, these graphs include the initial plots of all data collected to date. We are in the process of collecting routine service data that pre-date implementation of relevant activities (i.e., as a “baseline”). We have just started to use the household postpartum pictorial questionnaire, which will enable the monitoring of reported household behavior as well.

The following factors and activities contributed to these achievements.

1) Integration of Essential Newborn Care (ENC) interventions supported by SC’s Saving Newborn Lives (SNL) Initiative.

In 2003 the Vietnam Field Office received additional funding from the SNL Initiative to implement more in-depth maternal and newborn care components integrated into the CS-18 Project through March 2005. The objectives of the SNL Initiative complement CS-18 objectives, creating synergies and adding value, specifically to:

- Improve household practices for a wider/deeper range of behaviors.
- Improve access to quality essential newborn care services.
- Conduct local and national advocacy, including support for developing a National Newborn Health Action Plan.

With SNL support, a more comprehensive set of activities is being implemented to save the lives and improve the health of mothers and newborns. These activities include: 1) Training for commune and district health staff on essential newborn care (ENC), along with the provision of life-saving equipment such as Ambu bags for newborn resuscitation; and 2) Training for community guides to facilitate community meetings on caring for newborns at home.

2) Strengthened capacity of Research and Training Center for Community Development (RTCCD), the local NGO that is a sub-grantee for CS-18.

RTCCD staff have been integrally involved in developing the specific behavior change communication (BCC) strategies and materials for the project, including Nutrition Education and Rehabilitation Program (NERP), PD-Plus and Home Care for Mothers and Children (HCMC) community meetings. They have also conducted training of trainers (TOT) training courses with direct supports from SC staff. This “on-the-job” capacity building has been supplemented by regular

coaching and support to understand and practice the project’s BCC and training approaches. Post-training follow-up of health staff and Community Guides (CGs) is also being done by RTCCD.

The concept of a “Living University” (LU) has been introduced to RTCCD and will be monitored as the project progresses. Through the LU strategy, RTCCD can become a continuing resource to promote replication of successful learning methodologies developed and tested by CS-18.

3) Improved management information system (MIS) for the project.

A data collection and analysis system has been set up with specific forms and flow of information from the hamlet level upwards. Hamlet health workers make monthly reports and send them to Commune Health Centers (CHC). Commune health staff process this information and send a summary report to the District Health Services (DHS). SC collects the data every month from the DHS and further analyzes it for monitoring purposes (please see Annex 1). In the coming period, the project will improve the regular presentation and feedback of data so that health staff and managers at each level can benefit and improve their work. We will also seek to integrate this MIS into the health system in a sustainable way.

4) Strengthened partnership with Dakrong and Huong Hoa Districts.

One of the most significant accomplishments of the past year was to strengthen an already close relationship with our District and Provincial partners. We gained political support not only from the health sector but also from the leaders of other sectors and departments, including the People’s Committee (the local administrative authority), Education Department, Women’s Union, Farmer’s Association, Population and Family Planning Network and the military. All of these are critical to success in border and mountainous districts with a high proportion of ethnic minorities.

The commitment and support from the Quang Tri Provincial Health Service (PHS), especially Dr. Tran Van Thanh, PHS Director, provided additional technical and managerial resources to the project and helped to ensure greater ownership and sustainability of the project. The Provincial Hospital supported maternal and newborn care training for district and commune midwives in the project area. Provincial trainers regularly accompanied district trainers and project staff to conduct the trainings and supportive supervisions in health facilities and at community level.

5) Implementation of project activities in keeping with the project DIP, with some activities added under the SNL Initiative.

Table 1. Year 2 Accomplishments

Activity	Timeframe		Note
	Planned	Achieved	
Health Services			
Provide essential equipment for Maternal and Newborn Care (MNC) and Emergency Obstetric Care (EmOC) to DHSs and CHCs	Oct-Dec 2003	Feb 2004	
Train commune midwives on MNC, conducted by district trainers (first 14 communes of two districts)	Oct-Nov 2003	Yes	

Activity	Timeframe		Note
	Planned	Achieved	
Train district trainers on updated Essential Newborn Care (ENC)		Apr-May 2004	SNL component
Train commune midwives on updated ENC, conducted by district trainers (first 14 communes of two districts)		Jul 2004	SNL component
Train commune health staff on MNC, conducted by district trainers (first 15 communes of two districts-one additional commune was established from a few existing communes)	Mar-Apr 2004	Aug-Sept 2004	Integrated with SNL's ENC training.
Strengthen referral system: <ul style="list-style-type: none"> - Installed telephone for DHS and CHCs - Ensured staff 24 hrs/day, 7 days/week; mobile support to CHCs for Basic Emergency Obstetric Care (BEOC) and newborn complications - Established a referral register for referrals between CHCs and DHS 	Oct 03 - Sep 04	Yes	
Implement health services on MNC at DHS and 14 CHCs (included Antenatal Care (ANC) check up; Tetanus Toxoid (TT) vaccination; distribution of iron pills, Clean Delivery Kit (CDK) and vitamin A)	Nov 03 - Sep 04	Yes	
Implement outreach services by commune midwives (ANC, birth assistance; postpartum MNC; home visits) in 14 communes	Nov 03 - Sep 04	Yes	
Conduct supervision using checklists	Nov 03 - Sep 04	Yes	
Train district and province trainers and supervisors in supportive supervision	Jun 04	Apr-May 04	Integrated with SNL ENC training
Community Activities			
Train community guides on nutrition in the first 8 communes, conducted by district trainers	Nov-Jan 04	Yes	
Implemented nutrition activities in the first 8 communes (GMP; NERP)	Nov-Sep 04	Yes	
Develop: <ul style="list-style-type: none"> - Facilitation skills for community guides - Home Care for Mothers and Children (HCMC) training manuals based on existing HBLSS topics and some new topics (e.g., Maternal Anatomy and Antenatal Care) - HCMC training tools (the first 6 topics) - Monitoring & Evaluation tools for Community Meetings - Revised Birth Preparedness Package (BPP) for Kinh people 	Dec-Feb 04	Jan-May 04, except the BPP material	We have a change on the utilization of BPP.

Activity	Timeframe		Note
	Planned	Achieved	
Test HCMC materials in the field	Mar 04	Jun 04	
Conduct the first TOT on the first 6 topics of HCMC for district trainers	Mar 04	Jul 04	Local partners not available earlier.
Train community guides on HCMC on the 15 first communes (the first 6 topics)	Mar-Jun 04 (first 8 communes)	Aug-Oct 04 (first 15 communes)	CGs need to learn facilitation skills in HCMC training before nutr. training
Develop the HCMC manual and materials with new topics	Mar-Apr 04	Aug 04	
Conduct the second TOT on the 8 new HCMC topics for district trainers	May 04	Not yet	Local partners not available earlier.
Train community guides in the first 8 communes on new HCMC topics	Jun-Aug 04	Not yet	Local partners not available earlier.
Implement community meetings at hamlet level in the first 8 communes	Mar-Sep 04	Aug-Sep 04 in 15 communes	
Train on nutrition for community guides of the 6 expanded communes, conducted by district trainers	Jun-Aug 04	Not yet	District trainers not available earlier. The 7 expanded communes need HCMC training before nutrition training.
Conducted supervision using supervision checklists	Dec-Sep 04	Yes	
Conducted BCC campaigns at hamlet and commune levels		Mar 04	Conducted in the first 8 communes focusing on nutrition messages.
Capacity building for local partners			
Conducted study tour for local partners (provincial and commune levels) to a well-established SC Safe Motherhood project site in Quang Tri Province. Also conducted an Internal Review Workshop for reviewing implementation lessons learned to date		May 04	Supported management capacity building.

6) Additional factors which have contributed to achieving these accomplishments:

- Local partners have shown great commitment to implementing the project. We carefully planned and worked with them during the implementation process. We respected our partners, listened to their ideas, and did not impose our ideas. Rather, we used evidence-based approaches to introduce new concepts or methodologies to win their support.
- The project design and action plan are sound. Preparation for project implementation was done carefully before carrying out any project activity.
- We applied appropriate approaches for BCC such as Positive Deviance Inquiry (PDI), PD-Plus and HCMC Community Meetings. This helped us to mobilize local people to participate in project activities.
- Some local partners have very limited capacity. Therefore, in order to build capacity for them, we designed more training materials such as a video (produced in May 2004) and a counseling manual (will be developed in the second quarter of FY 2005) to serve as training materials for Community Guides.
- The core project staff from SC, PATH and RTCCD made great efforts to work together as a coordinated and integrated team. Team members supported each other on both technical and managerial matters.
- Supportive and helpful TA from SC's Home Office was an important factor in helping our team to achieve project objectives. This included extensive help with formulating the HCMC training manual and planning the evaluation of the PD-plus approach for the behavior change interventions (prepared as an Operations Research protocol).

II. Factors Which Have Impeded Progress

- CS-18 is working in a mountainous area with minority groups. The local people have limited education and knowledge, and they can not understand and communicate well in the Kinh language. This is the main barrier for implementing the BCC interventions.
- Although the project design is strong, the pace for implementation is too fast for local partners who have been suffering from work overload.
- We faced a constraint while monitoring project activities in the field due to the scattered population in this remote area.
- There was a difficulty in developing the BCC training manual, which needs to be suitable for the local people. It is an enormous challenge to develop a meaningful training manual with the scope and depth of technical content we want, along with the specialized approaches of PD, PD-Plus, NERP and HCMC. It has taken considerably more time and effort on this than originally envisioned.
- Some trained local staff moved or changed jobs. This created difficulties in the implementation of project activities for district and commune teams.

III. Technical Support Needed

Dr. David Marsh from SC Headquarters has provided invaluable support for overall review of project implementation on the ground (including an in-depth visit to the project site); developing the training manuals; conceptualizing and guiding the application of the PD-Plus approach; designing

the Operations Research; and developing a monitoring and evaluation plan and tools. His ongoing support is needed to continue following through with all aspects of the project.

IV. Changes from the DIP in Program Planning and Implementation

1) According to the DIP, the HCMC manual and materials will be developed for minority groups while the BPP and interpersonal communication training will be developed for the Kinh majority group. In August 2004, during development of the HCMC manual and materials, the project team decided on the following:

- The contents of the BPP must be integrated into the HCMC manual and materials. The HCMC activities apply for both Kinh and minority groups.
- The BPP card will be replaced by the home visit book of HCMC.
- The monitoring and assessment card of mother and newborn care from the second week to the sixth week of the BPP will be replaced by the monitoring health book of the HCMC.
- Additional training on counseling and communication skills will be conducted for Kinh CGs and perhaps also for minorities.
- The project brochure will replace the general information leaflet of the BPP.

The above changes were due to the following reasons:

- Most information, messages, and practices of the BPP are available in the HCMC manual and materials, but updated information and techniques on immediate care of newborns at birth were not enough.
- The contents of the HCMC manual emphasized community meeting facilitation skills, but the BPP does not. The BPP includes the interpersonal communication training.
- During the training, supervision, and monitoring trips, project staff found that interpersonal communication and counseling capacity of local counterparts were very limited.
- If we apply the BPP for the local partners, it will be too much training for them. Moreover, the project has many planned training courses that will cause training overload for the local staffs and ultimately delay project activity implementation.

2) We plan to reduce the scope of peer education of adolescents through *Sim House* because this involves new target groups, new messages and new strategies that will result in work overload for local trainers and CGs. A modified approach to reaching adolescents will be piloted in a few hamlets, probably with PATH taking the leading role for this component.

3) We plan to delay Phase III-Program Expansion for six months because our training partners at the district level are not able to keep up with a faster pace, and also our partners at the community and household levels cannot work any faster.

V. Program Management System

Observation	Assessment	Response
VNFO is using standard protocols for reporting and controlling expenses.	The standard financial report forms are too complicated for local sub-grantees.	SC's finance team conducted training on compliance of financial regulation for local sub-grantees in March 2004 in order to reinforce what was learned after sub-grant management training last August.
The amount of work for sub-grantees for monthly financial monitoring is burdensome.	<p>The sub-grantees' capacity in financial management should be strengthened.</p> <p>SC's finance team needs to be more involved in ongoing financial monitoring.</p>	<p>SC's finance team conducted an audit of RTCCD in Dakrong in May 2004 (Huong Hoa is planned for October 2004) in order to help them strengthen their financial management system.</p> <p>SC staffs in the Quang Tri sub-office, including the Admin/Finance Officer, are taking a more active role in monitoring and in coordinating with the Hanoi finance team.</p>
SC's Program Manager, Dr. Vu, will spend 25% of his time studying for an MPH at HSPH starting in Oct 04, and will last for 2 years. This will ultimately create a strong CS-18 project team.	There is a potential gap in overall project management.	A full-time Program Assistant was recruited in August 2004 to support monitoring and to assist the Project Manager in managing the project. In addition, SC has a new national Senior MCH Advisor who will also support CS-18 implementation.
Monthly review meetings with the core implementing partners (SC, PATH and RTCCD) over the past year have been very useful for communication, coordination and planning.	Many planning and implementing details have been managed through this activity.	Continue the monthly review meetings.
Project staff have regularly participated in quarterly review meetings conducted by the District Steering Committees and monthly review meeting conducted by the Commune Steering Committees.	This has helped to maintain a very good relationship with local partners. We have also helped address challenges in project implementation and have given in-depth feedback on their progress reporting.	Actively continue this practice.

VI. Detailed Workplan for October 1, 2004-September 30, 2005 [the Shading: planned time of implementation]

No	Activities	2004			2005									
		10	11	12	1	2	3	4	5	6	7	8	9	
I.	Capacity building for the provincial and district staffs and trainers													
1	Continued TOT on Home Care for Mothers and Children (HCMC): topic 7 – 14		9 days											
2	TOT on counseling for district trainers							5 days						
3	Training on supportive supervision for district trainers					3 days								
4	Training on project management leaders of districts													
II.	Community activities (in the 15 currently implemented communes)													
1	Conduct training in HCMC for community guides in the 15 communes													
	Topic 3 - 6: (4 topics x 1.5 days x 2 rounds)		12 days											
	Topic 7 - 14: (8 topics x 1.5 days x 2 rounds)				24 days									
2	Conduct training in nutrition for community guides in the 7 communes (8 communes were trained): 28 days			28 days										
3	Training on counseling for community guides													
4	Implement community activities: nutrition activities (GMP, NERP), community meeting on HCMC, home visit													
5	Other BCC activities: BCC campaigns; mass media; mobile communication													
III.	Improve health services (in the 21 other communes - not yet implemented)													
1	Conduct training in MNC for commune health staffs of the 21 communes													
	Training for midwives in 11 communes (Dakrong: 6 communes, Huong Hoa: 5 communes)					28 days								
	Training for midwives in the 10 other communes in Huong Hoa							28 days						

VII. Program Highlights (Optional): “Facilitation Skills Training Package with Video”

“PD-Plus” aims to amplify and strengthen the traditional PD approach, which has generally worked well to rehabilitate malnourished children. In contrast to the traditional approach, the PD-Plus approach in the Community Meeting format: (1) primarily targets behaviors (e.g., clean cord care, etc.), not health status (e.g., weight-for-age); (2) implements a PDI for each new monthly topic, not just at Project baseline; (3) requires identifying behavioral determinants (i.e., the “why?” and the “how?” questions) rather than just the behaviors that lead to an improved health status; (4) requires local Community Guides to conduct these PDIs rather than more skilled district trainers or expatriate advisors; and (5) requires these Guides to have facilitation skills to ensure lively adult learning at the Community Meetings, and especially to identify transferable behavioral determinants among current users of new behaviors and recent adopters of previously introduced behaviors.

SC was hard-pressed to identify existing training materials to promote these 14 facilitation skills (calling on the quiet one, bouncing, asking the open-ended “why?” question, teaming with a co-facilitator, etc.). Thus, we drafted our own curriculum, greatly supplemented by a low-cost, video-taped simulated Community Meeting, written by the team, and acted out by district trainers and village women.

“Take One” of the Community Meeting is a 90-minute realistic enactment of each step of the process and each facilitation skill. The video is an excellent resource to orient potential users to this innovative and ambitious intervention. Currently we use it to train implementers in both the steps of the Community Meeting and in the critical facilitation skills that make it happen.

Not surprisingly, the first use of the first version of the video is imperfect: it is too long. In response, we plan to make two, 30-40 minute shorter versions, one to introduce the steps and sub-steps of the Community Meeting, and the other to demonstrate several examples of each of the 14 facilitation skills. We may, cost permitting, augment the existing footage by sandwiching each teaching segment between a slide that introduces the content and a slide that summarizes the key points just observed. The current English and Vietnamese transcripts that accompany the video will quickly permit identifying the desired segments for each short version.

We believe that the next version of the training materials, especially the chapter and short video devoted to Facilitation Skills, will interest development partners beyond CS-18. Indeed, the facilitation skills are generic and could be applied usefully to many community mobilization efforts in Vietnam. Indeed, there may also be a regional interest in these materials.

VIII. Other Relevant Aspects

SC is contributing SNL and private donation funds as SC's match in CS-18 (total \$208,099 of SNL and \$27,419 in FY2004):

1) SNL funds were used to:

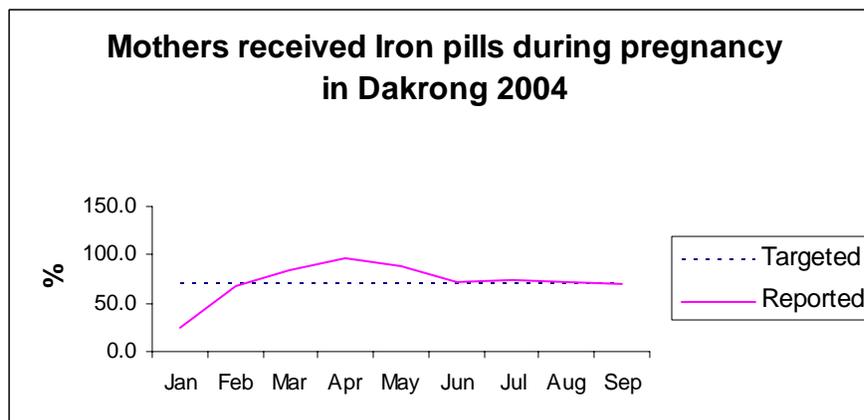
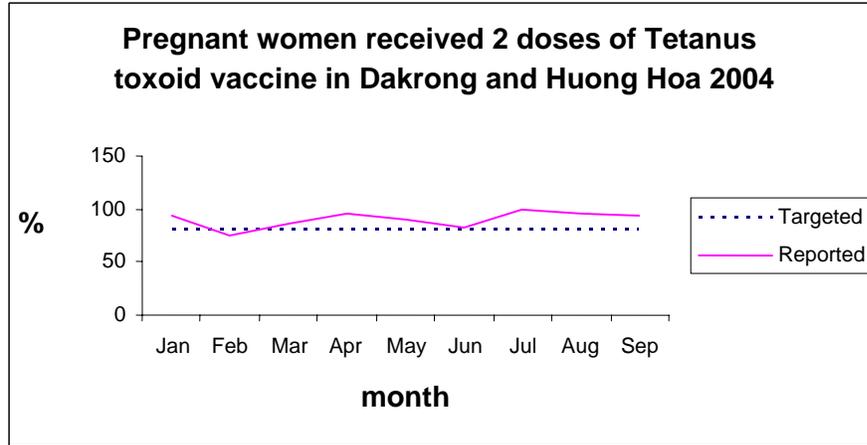
- Conduct training sessions for health staff on ENC.
- Print HCMC pictures and produce HCMC materials (videotape, models for conducting community meeting).
- Conduct BCC campaigns at the community level.
- Conduct advocacy on newborn health at national level.

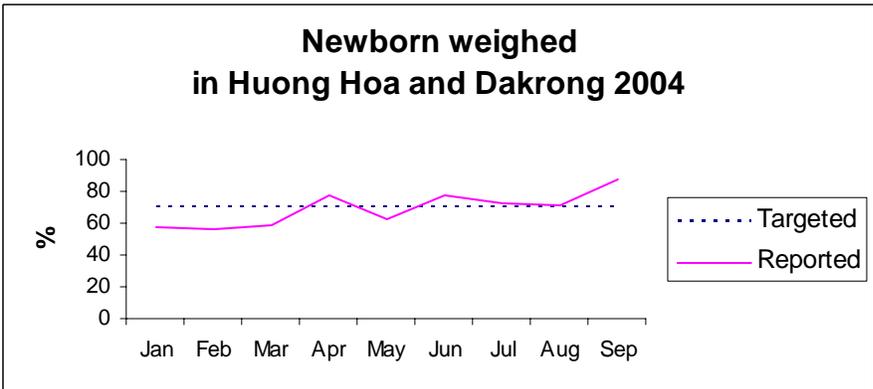
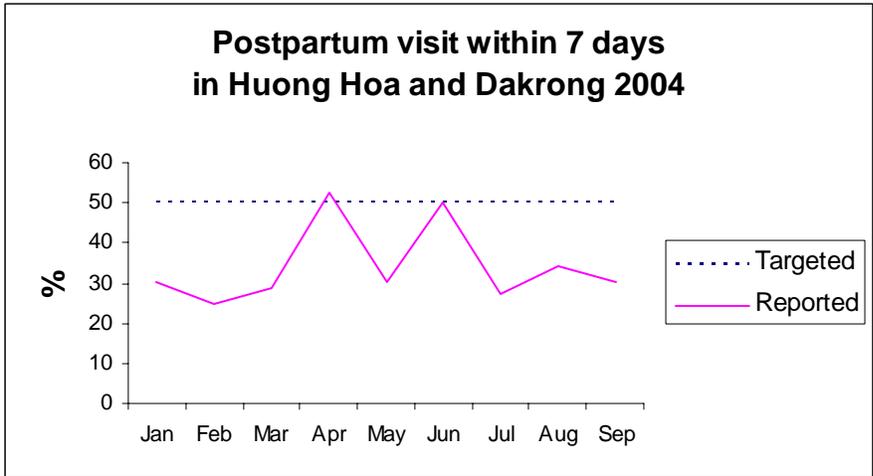
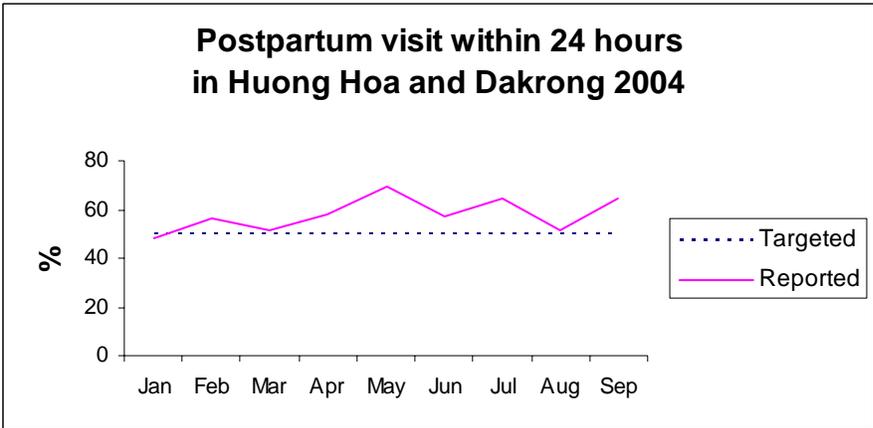
2) Private donation (Every Mother Every Child) funds were used to:

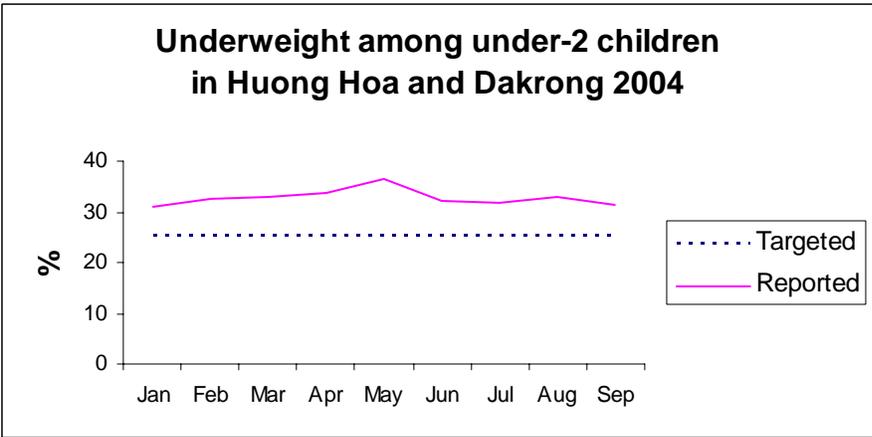
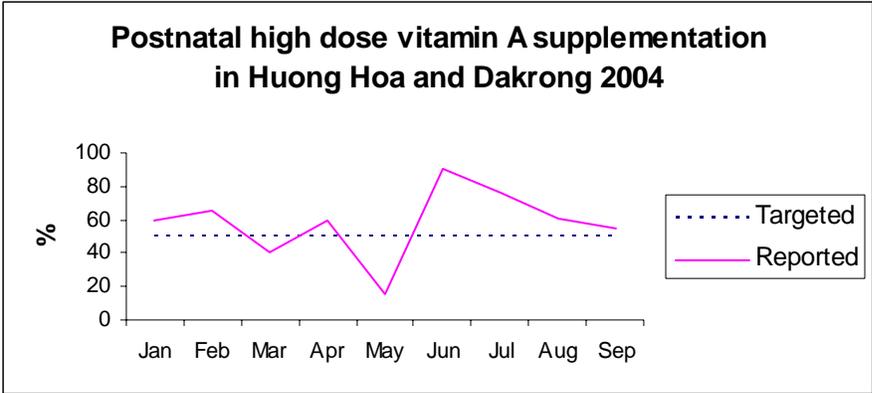
- Contribute to a research project on anemia in Dakrong and Huong Hoa District. The research objective was to assess the anemia situation in pregnant women and children under five in 34 communes. Analysis is still in progress.
- Supply essential medical equipment for MNC activities in 2 district hospitals and 18 commune health centers and polyclinics.
- Support the Dakrong DHS to implement a malaria prevention intervention.
- Conduct advocacy at the central level by conducting a National Workshop on Safe Motherhood.
- Contribute to developing nutrition training manuals.

Annex 1

Routine Monitoring Data 2004







Annex 2

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

Project Field Contact Information

First Name	Ngo Van
Last Name	Toan
Title	Health Program Specialist
Address Line 1	141 Le Duan Street
Address Line 2	Hai Ba Trung District
City	Hanoi
Country	Vietnam
Telephone	84-4-943-5696
Fax	84-4-943-5697
Email	ToanNV@savechildren.org.vn

Project Information

Project Description

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

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

Major project interventions are: maternal and newborn care (45%); nutrition and micronutrition (40%), and breastfeeding (15%).

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

Partners

RTCCD

PATH

Dakrong District Health Service

Huong Hoa District Health Service

Project Location Da Krong and Huong Hoa Districts 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 October 31, 2004

General Strategies Planned:			
Microenterprise	No	Social Marketing	No
Private Sector Involvement	No	Advocacy on Health Policy	Yes
Strengthen Decentralized H. System	No	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	No	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: loudspeakers, radio-on small scale)	Yes
Interpersonal Communication	Yes	Peer Communication	Yes
Support Groups	Yes		

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

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

Key Technical Project Interventions:

Nutrition 40%		IMCI 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.	Yes	CHW Training	Yes	HF Training	Yes
EOC	Yes	Neonatal Tetanus	Yes	Recognition of Danger Signs	Yes	Newborn Care	Yes
Postpartum care	Yes	Delay 1st Pregnancy	No	Integrate with Iron and Folate	Yes	Normal Delivery Care	Yes
Birth Plans	Yes	STI Treat't w/ANC	No				

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

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

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