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Final Project Evaluation

SAFE MOTHERHOOD INITIATIVE

PROJECT VIE/03/P21 (2003-2005)

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ABBREVIATIONS

CHC	Commune Health Centre
MCH	Maternal and Child Health
MCH/FP	Centre for Maternal and Child Healthcare and Family Planning
MOH	Ministry of Health Vietnam
NTBG	National Technical Backstopping Group
RNE	Royal Netherlands Embassy
RH	Reproductive Health
RTCCD	Research and Training Center for Community Development
SMI	Safe Motherhood Initiative
SM/NBC	Safe Motherhood and New Born Care
SMNP	National Plan on Safe Motherhood
PMB	Project Management Board

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I. PROJECT DESCRIPTION

a. Under the support of the Royal Netherlands Embassy (RNE), the Ministry of Health Vietnam (MOH) developed the National Plan on Safe Motherhood that was approved by the Minister of Health on November 5, 2003. The National Plan on Safe Motherhood (SMNP) consists of two phases of implementation. *Phase I* of the National Plan (2003-2005) aims to build management capacity to MOH at different levels in safe motherhood programs, to advocate for further investment in safe motherhood, and test alternative intervention approaches that will be the foundation for broader implementation in Phase II. *Phase II* of the National Plan (2006-2010) will be expanded nation-wide in order to contribute to the implementation of the National Strategy for Reproductive Health Care. *Safe Motherhood Initiative (SMI) project* VIE/03/P21– a part of the phase I of the SMNP has been implemented by the MOH Vietnam during the period 2003-2005 with financial support from Netherlands Embassy.

b. The project goals were to improve the quality of obstetric care, strengthen SM and NBC related activities in order to reduce maternal and neonatal mortality in Vietnam. The project objectives aims to (1) strengthen capacity of central, regional and provincial levels to effectively manage SM/NBC activities; (2) implement prioritized and comprehensive SM/NBC interventions in three provinces and draw lessons learned for the future national application; (3) implement advocacy and information, education and communication/behaviour change communication (IEC/BCC) related activities in order to increase the awareness and support of decision makers and the community to desired objectives of SMNP; and (4) to prepare for the second phase of SMNP.

c. The project to pilot provinces (sub-project) had four components: (i) increase of availability and accessibility to SM/NBC services; (ii) improve quality of SM/NBC services; (iii) increase of community awareness on and acceptability of SM/NBC services; and (iv) enable supporting environment on SM/NBC.

Increase of availability and accessibility of SM/NBC service: focused on upgrading labor room, ANC examination room at Commune Health Centres (CHCs), providing essential equipments serving SM/NBC services, responding to and managing obstetric and peadiatric emergencies, performing postpartum visits, providing outreach services at communes/villages.

Improve quality of SM/NBC services at provincial/district/commune levels: sought to train core provincial trainers, to train staff at provincial/district/commune/village levels on SM/NBC contents provide SM services in–line with national standards, conduct COPE exercises, and conduct supportive supervision.

Increase of community awareness on and acceptability of SM/NBC services: prioritized to conduct community meetings, distribute IEC/BCC materials (Poster, leaflet, cassette tapes, CD), conduct IEC contests, conduct radio/TV broadcasting and communication through newspapers.

Enable supporting environment on SM/NBC: concentrated on organizing advocacy workshops, seeking supportive commitment from local authorities and mobilizing referral fund from communities.

d. The full intervention activities as mentioned in point c above were implemented in six districts of three provinces Ha Tay, Quang Tri and Kien Giang (2 districts per province and all communes in the selected districts). The pilot implementation at 6

districts aims to draw good intervention models, best practices and lessons learned for the SMNP phase II. In addition, 22 other provinces involved in the project for TOT training activity only (training the provincial core trainers), aiming to prepare an enormous technical core trainer group for phase two. The provincial hospitals (PHs) and department of health (DOH) of such 22 provinces were expected to utilize the technical core trainer groups (trained by the national trainers) for providing further trainings on national standards and guidelines on SM/NBC and related areas to health service providers in their provinces. These trainings maybe integrated with other RH projects currently implemented in the local settings.

e. The MOH and UNFPA jointly executed the project. UNFPA directly received fund from RNE and transfer fund to four partners (three provinces and MOH) and two sub-contractees (PATH and SC/US). The MOH coordinated and implemented project activities. To support provincial authorities to implement the project at three pilot provinces, PATH US provided technical supports to Kien Giang and Ha Tay while SC/US technically assisted Quang Tri.

II. EVALUATION OF SMI PROJECT VIE/03/P21

2.1. Evaluation objectives

The evaluation of the Safe Motherhood Initiative Project VIE/03/P21 aims to:

1. Identify the achievements and constraints of the project design, implementation and coordination process at all levels.
2. Provide recommendations for implementation of the Phase II of the National Plan on Safe Motherhood at the central and local levels.

2.2. Evaluation methods

Qualitative method, secondary data analysis and workshop/meetings were applied for data collection.

Qualitative method: In Hanoi, team leader conducted 12 interviews with key stakeholders from RNE, RH dept of MOH, UNFPA, WHO, PATH US and SC/US. Question guideline was emailed to the project director and project manager at MOH and answers were emailed back to the team. In the field, the evaluation team conducted 27 interviews with informants at province/district/commune levels. Those informants came from MCH/FP Centre Department of Health and Women's Union at all levels. Informal chats were carried out with four midwives. Most of interviews were recorded, in parallel with handwriting.

Secondary data analysis: focused on reviewing project documents, plan, reports, papers, presentations, and notes of previous meetings during the project implementation. In addition, literature reviews of SM models applying in other developing countries were undertaken to assess the current SMI model applied in phase I.

Workshop/meetings: after the completion of data collection from Hanoi and the field, a debriefing of the evaluation findings was presented at a workshop March 29 for plenary discussion and contribution of further information for the evaluation. Comments from this workshop were used to enable the research team to present the formal evaluation results at the SMI workshop (March 31).

2.3. Evaluation sites

Data collection was undertaken at three pilot provinces. Three districts were selected they were Hoai Duc (HaTay), Vinh Linh (QuangTri) and Phu Quoc (KienGiang) and in each district the team visited two communes.

2.4. Evaluation schedule

This assignment was undertaken in an impressive short duration.

17 March 2006	Contract signed with the evaluation team
20-28 March	Data collection in Hanoi
22-28 March	Data collection in HaTay, QuangTri and KienGiang
29 March	Presentation of evaluation findings – plenary discussion
31 March	Overall project meeting – official presentation of findings
1 – 19 April	Report writing and additional data collection in Hanoi
20-27 April	Final report

To overcome time limitation, the evaluation team divided into three groups. Two groups collected data in Quang Tri and Kien Giang and one group visited HaTay and conducted interviews with key stakeholders in Hanoi.

2.5. Evaluation team

The evaluation was undertaken by a team from the Research and Training Center for Community Development (RTCCD) Vietnam.

The team consisted of five health professionals, led by Dr. Tran Tuan who was a senior epidemiologist. Dr. Tran Tuan was Takemi Research Fellow at the Harvard School of Public Health in 1994-1995, and was awarded doctoral degree in epidemiology and population health at the University of Newcastle in 2004. Dr. Tran Tuan had ten years of experience in working as a lecturer of community health at the Hanoi Medical School. Currently he was invited to be senior advisor for bilateral programs on health service system between Vietnam and international countries.

The remaining four members of the team had backgrounds in public health and epidemiology, of which three had Master degree and one currently was PhD candidate at London South Bank University.

2.6. Evaluation context

The evaluation was undergone in a very special context. First, there were many different expectations of the evaluation findings. Some expected that the evaluation pointed out changes in community, quantitative changes in behaviours and knowledge of local people and health service providers, difference in maternal/neonatal mortality rate and impacts at all level. However, these expectations were somewhat beyond the scope of the evaluation assignment that targeted the achievements/constraints of project design, implementation and coordination, and lessons learned for phase II.

Second, time stress was a limitation of the evaluation. The evaluation team highly appreciated the collaborative and constructive attitudes of key stakeholders and stakeholders at province/district/commune levels who agreed to frankly share information with us in a very short notice of the evaluation schedule Finally, the evaluation team were informed that all project partners were very much expected to read lessons learned for phase II, this would be the focus of the assignment, however it should be delivered in a way that everyone would be pleased. It was challenging for the team, however, it was true that criticism would block one's minds and awake their defend. Therefore, the team agreed to bring about suggestions and lessons learnt which bear the systematic features and for the system changed positively in phase II rather than to raise comments on or lessons learnt for individuals.

III. EVALUATION FINDINGS

3.1. Evaluation of Design and Implementation

3.1.1. Relevance of design and formulation

The project responded to the Vietnam Development Goals number 4 "Reduce child mortality, child malnutrition and reduce the birth rate" and Goal 5 "Improve maternal health", aiming to contribute for the achievement of Millennium Development Goals.

The project fitted into the National Strategies for Reproductive Health (RH). Within this strategy, the Government committed significant efforts to improve the service delivery network for RH including maternal and child health (MCH). The first National Plan on Safe Motherhood was approved in 2002, providing strategic direction for Safe Motherhood and Newborn Care activities during 2003-2010. This national plan addresses four targets among the six national targets: reduction of maternal mortality, infant mortality, prenatal mortality and low birth weight. In addition, the Government approved the first 'National Standards and Guidelines for RH care services' in 2002 in which protocols for maternal health and NBC are significant component.

The project met the theme that was strongly supported by governmental bodies. The Communist Party and State of Vietnam always attaches great importance to policies and strategies for human development and, in particular, in respect of women's and children's rights, including the right to a standard of living adequate for the health and well-being, to a special care and assistance for motherhood and childhood.

The project appropriately targeted key problems in maternal and child health in Vietnam. The average national maternal mortality ratio in Vietnam was at 165/100 000 (ranged from 124 to 916/100 000), which is higher than that in other neighbour countries.

Perinatal mortality stood highly at 22.3/1000 live births (ranged from 17 to 37/1000)[1]. It has been identified that critical weaknesses in human resources, infrastructure and equipment for SM/NBC, limited community awareness and participation have resulted in poor quality service provision and low utilization rate.

The project appropriately addressed key issues in improving provision of SM/NBC services. It focused on all levels of referral linkages within the health systems, strengthening of MCH worker competence and emphasized IEC/BCC and advocacy. Advocacy focused on increasing awareness of community health workers, pregnant mothers and their families on the need for safe motherhood and newborn care services and on motivating women and newborns to use them. It contributed to improving the quality of the health facilities, thus making them more acceptable to women and newborns.

The project design is relevant by focusing on the main outputs that contributed to the foundation establishment for the second phase. At the central level, first, the project established and trained a huge number of technical core trainers in 25 provinces – who would be key human resource of the phase II - that were expected to provide further trainings on SM/NBC and related areas to health service providers in the provincial settings. Second, the project established National Technical Backstopping group who was expected to provide technical consultations to MOH in SMNP implementation. Third, the project developed an enormous number of training and IEC/BCC materials on SM/NBC and related areas that can be used for the second phase. Fourth, the project developed the strategic framework and detailed implementation plan for the second phase as well as mobilized fund for implementing this plan. Fifth, the capacity of PMB was challenged in practice and somewhat improved to prepare for phase II implementation.

At the provincial level, the comprehensive interventions on SM/NBC were designed and piloted base on three-delay conceptual framework “delay in seeking care, delay in reaching a treatment facility and delay in receiving adequate treatment at the facility”. The design accurately reflected the strategy to reduce the maternal and neonatal mortality and morbidity rate by promoting (i) an awareness of women in reproductive age and pregnant women about birth preparedness and danger signs of obstetric and neonatal emergency, and (ii) a system of timely transport (community-based referral) to health facilities (III) improvement of quality of SM/NBC services at health facilities, especially quality of obstetric and neonatal emergency care.

However, the design of the project has some limitations. First, the project formulation could have been improved in terms of duration and time allocation to activities. Two years for such four objectives, including preparation of materials and human resources for SMNP phase II is short, which requires at least three years. It seemed that the project lacked a very important component – preparation stage: There was no place in the Time Table for Activities (in Project Document) where items of the establishment of PMB, Steering Committee, provincial management committee or consultant recruitment, etc and other preparation activities were found. Details will be described in section 3.1.4.

[1] Estimates of the population-based study on RH conducted in 21 districts of seven provinces by UNFPA in 2001.

Second, site selection was considered as a limitation of this project, as none of the selected communes was mountainous with high proportion of ethnic minority whose culture and beliefs are significantly different from the majority Vietnamese Kinh people. The access to and quality of SM/NBC services is also in great disparity compared with those in lowland districts. In phase II, the SMNP needs to depart from the starting point - pilot a model - in mountainous unless lessons and experiences from organizations who have been working in such areas are well reviewed and analysed by RH department.

Third, another room for the project design improvement is enhancing the integration mechanism in 22 provinces, which received training component only. So far, to what extent the core technical trainer group in 22 provinces was used that was not fully aware of by the two co-ordination agencies MOH and UNFPA. It would be a big waste if an enormous number of staff were trained but not or little been used. Fourth, better use of the NTBG is a issue which needs to address in phase II.

3.1.2. Relevance of project activities and outputs

On theory, proposed project activities appeared to support the achievement of outputs. However to achieve objective 1 that emphazises on strengthening capacity all levels to effectively manage SM and NBC related activities and focus to output 4, 6 and 10, the training program on project management including planning, monitoring and reporting and evaluating program and coordination skills should have been designed and provided to program managers at all levels. This training program also aims at improving the capacity of the program mangers in identifying the gaps in SM/NBC for the whole country and in designing appropriate interventions addressing these gaps as well as capacity in fund mobilization for the NPSM.

3.1.3. Project costs

The project cost estimated at project document was $US1,733,025 equivalent including the contributions from Vietnam side, of which $US14,254 for national training package development, $US604,125 was for training at all levels, $US101,439 for essential drugs and equipment, $US60,630 for infrastructure upgrading, $US40,880 for national package and prototyped IEC/BCC material production, US$81,619 for IEC/BCC activity implemented from central to commune levels. It can be said that around 40% of the expenditures was for training and materials production – preparation for SMNP phase II. Total actual project expenditure amounted to $US 1,707,359 accounting for 98.5% of the planned budget. As this is the phase I of the SMNP, most of the expenditure were planed for activities at central and provincial levels. In phase II, more cost should be allocated to communities for essential and drug equipment supplies, infrastructure upgrading and IEC/BCC activities.

3.1.4. Project schedules

Royal Netherlands Embassy approved the project in Dec 2003. Until April 2004, the National Professional Program personnel for UNFPA and supportive staff for PMB were recruited, spending four months which cost normally one or two months in other projects. The project encountered considerable delays in the procurement of medical equipment, supplies and infrastructure upgrading in comparison to established plan (Appendix 4). As a result, training was forced to be in hurry. The RNE approved the UNFPA request to extend the project closing date by a total three months (31/12/2005 to 31/3/2006) to complete planned activities.

Frankly, MOH and UNFPA intensively did many of activities for staring the project. The first six months of the project was preparation period, which should have been considered in the project design. The selection of the pilot district, baseline assessment were discussed and conducted in January and February. The project management board at MOH and three provinces were established during February. In March, MOH and UNFPA co-recruited local and international staff for the project. Four launching workshops were organized in three provinces and at central level in March. In April the MOH and UNFPA agreed on roles of international organizations involved in the program. During April, four sites opened bank accounts. The first workplan from MOH arrived UNFPA at the end of March 2004. The fund transferred from RNE to UNFPA was available in June 2004. During that time, accountants of all sites were trained on new financial management system of UNFPA.

It can be said the lack of time allocation to preparation period and to training material revision and development activity in the project timeframe did affect to the whole project implementation process.

3.1.5. Project coordination

UNFPA and RH department of MOH jointly co-executed the project. WHO was involved to support in training manual development. SCUS and PATH US involved in supporting provincial teams to plan, monitor and implement project activities. From *emic* views (personnel in the project), the coordination from province to commune was fine. However, having two agencies co-executing the project at central level led to complications in operation and difficulty in agreement seeking. Although the mechanism of coordination and role of each agency were clear, different viewpoints and expectations (perception about role of NTBG, mission done by international experts for developing strategic framework for implementing phase II, assessment of work done by INGOS...) during project implementation led to misunderstanding between to co-executive agencies. It was highlighted that the way setting up the project coordination did not support the objective 1 'strengthening MOH capacity'. Although the project had two managerial units, project partners commented that they were not fully understood of the structure of the SMI PMB 'never understood who is MOH'. A change in SMNP coordination mechanism was strongly supported by all project stakeholders.

3.1.6. Consultant recruitment, procedure and performance

The project recruited one long-term international consultant, two short-term international consultants and a national consultant team during the project implementation.

UNFPA was mainly in charge of recruiting international consultants. The long-term international consultant – working as a SM specialist on a full-time basis at the PMB office to increase the professionalism of the project office and foster project work - was interviewed via tele conference and selected with the agreement of RH dept It took two months for recruiting this consultant seemed that the two co-executive agencies fairly satisfied with the long-term consultant performance. However, she contributed to the project implementation less than expected due to poor health status. She had spent only 6 months for working with project during 11 months of staying in Vietnam.

The short-term international consultancy team was directly selected by UNFPA to address seven objectives, mainly focusing on review of SMI P21 implementation, identify

& prioritise the SMNP phase II, give comments on the SMNP, formulate strategic framework and give recommendations for phase II. It appeared clearly that there were opposite comments about performance of the consultancy team. Similarly, with the short-term national consultancy team to assess the overall implementation of SM/NBC projects/programs in Vietnam and to develop a complete detailed action plan for phase II, different viewpoints on the consultancy team performance were posed to the evaluation team.

3.1.7. Performance of MOH and UNFPA

Overall comments: both agencies have tried their best to complete the project activities despites variety of difficulties incurred.

UNFPA were applauded for their useful assistance to RH dept in training manuals and IEC/BCC material development, backstopping RH dept in training and monitoring, instructions to provinces and advocacy event organization. Although knowing that it was financial regulation of UNFPA, most of project partners at province, district and commune levels complained that the financial report system applied in the project was too complicated which took much of time to prepare.

The MOH, represented by the RH dept, was appreciated for their coordination in training manual and IEC/BCC material development, establishment of NTBG and inter-sectoral management committee, instructions to provinces in SMI implementation and national workshop organization. The most comments on their shortcomings were not actively taking leading role in project management, using junior supportive staff in the project office, not properly use of NTBG and consultants, and being unrealised potential capacity of technical supports.

3.1.8. Performance of PATH and SC/US

To provincial teams, PATH US and SC/US performed their responsibilities well although different approach caused some difficulties at the start. Provincial and district staff confirmed that they did not complete the proposed activities without supports from PATH and SCUS staff. Applying competency-based training and on-the-job training approaches, PATH and SC/US team instructed provincial/district teams how to make plan, implement and monitor a project in steps and assisted to organize community events for SM/NBC activities.

At central level, appreciation from most project partners was given to the contributions of PATH and SCUS in assisting provinces to complete project activities in short duration. They performed satisfactorily and were able to complete their assignments. However, there was a minor comment about the little background of PATH staff in SM/NBC.

3.2. Evaluation of Performance

To evaluate the success of a Safe Motherhood project/program, changes in maternal and neonatal mortality must be documented and then convincingly attributed to the program. Both steps present technical challenges. No single study can adequately assess progress with respect to maternal & neonatal mortality, and a number of techniques should be evaluated, each for the light it sheds on the complete picture. For technical reasons, maternal and neonatal mortality measures are inconvenient ways to quantify program success over the short term. In addition, the project duration of two years is too short and interventions to communes were implemented for 13 months,

including training component. It was very difficult to see any changes in maternal and neonatal mortality and if any, it is impossible to conclude such progress to be the project achievement. Therefore, the evaluation of achievement of project long-term objective is not suitable in this evaluation study. Instead, the team focused on the achievement of short-term objectives and outputs.

3.2.1. Achievement of four short-term objectives

Overall, all four short-term objectives were achieved. The question is to what extent the project objectives were achieved.

Objective 1: to strengthen capacity of the central, regional and provincial levels to effectively manage the SM/NBC activities.

This objective is partly achieved. At the central level, the evidence that national coordination and capacity of RH dept has been strengthened was unclear. First, there has been no document referencing the situation of RH dept capacity prior to project implementation. Second, the overlap in coordination and decision-making role, and different viewpoints of two co-executive agencies proved that things have not been improved much. Third, opinions of various stakeholders were clearly different on this issue.

At provincial level, evidence of capacity strengthened at 22 training-involved provinces was not documented in any form. Although there was a comment that these 22 provinces received the TOT training only thus they should not be assessed under the scope of this evaluation. However, from our viewpoint, once the core trainer group of 22 provinces was trained using the project budget, their capacity and performance should be reviewed and assessed. In terms of capacity of relevant staff at three pilot provinces HaTay, QuangTri and KienGiang, all project staff confirmed and reports documented that they learnt how to manage a project since involving in P21. To HaTay and KienGiang things appeared to be true as none of health facilities this two province have ever been granted any international project. For QuangTri, it might be difficult to say whether there was any capacity change as the Provincial Health Department has been experiencing with various health-related projects and in particular child survival project (similar to SM/NBC) implemented by SCUS in the province. From our observations, UNFPA, PATH and SC have done quite a lot of tasks *for* provincial team in terms of planning and reporting to meet the deadline, which should not have been gone in this way.

Objective 2: to implement prioritised and comprehensive SM/NBC interventions in selected localities and draw lessons learned for phase II.

This objective is fully achieved. All project stakeholders agreed that training, infrastructure upgrading and medical equipment provision were implemented well despites of time stress.

Objective 3: implement advocacy and IEC/BCC activities in order to increase the awareness and support of decision makers and the community to desired objectives of the SMNP

This objective is fully achieved. IEC/BCC activities at community level were very well organized. The next step for phase II is how to transform commitments and verbal supports of the decision makers and local authorities into actions and to sustain such actions.

Objective 4: to prepare for the phase II of SMNP

This objective is partly achieved. The preparation of detailed workplan for phase II is almost obtained with dissemination workshops organized. The design for phase II implementation was near to finalization. However, capacity of the project office and linkages within MOH's departments (Therapy, Preventive, Planning, Science & Research) for SM/NBC coordination and integration are still suggested for further improvement.

3.2.2. Achievement of outputs

The project had ten outputs. In this section, all outputs are reviewed to answer four main questions: (i) are all the outputs and activities of the project being implemented, (ii) are all the materials and components of the project of good quality, (iii) is the project reaching its target group and (iv) do the project participants satisfy with the activities?

Output 1. A national training package on SM/NBC updated, approved and implemented by the MOH.

A set of 7 training manuals was revised to comply with the National Standard and Guidelines for SM/NBC.

1. Newborn care (3 volumes): a reading text book and handbook for health providers and a training manual for trainers. This component aimed to complement the existing gaps in the national standards and guidelines on newborn care.
2. Changing Behaviour and Practice (3 volumes): a handbook for Manager, for service provider and training manual for trainers.
3. Information, Education, Communication/Behaviour Change Communication Skills (2 volumes): training manual for trainers and a handbook for trainees.
4. Training manuals for SM/NBC for village health workers (2 volumes): manual for trainers and a handbook for trainees.
5. Training manuals on supportive supervision for SM/NBC activities (2 volumes): manual for activity supervision and manual for training supervision.
6. Emergency Obstetric Care (3 volumes): training manual for trainers, handbook for service providers, and reference book for service providers.
7. Quality Management and Client-Oriented, Provider-Efficient Service (5 volumes): training manual for trainers, handbook for service providers, handbook for managers, COPE implementation guideline, COPE tools for service providers at provincial/district level, COPE tools for service providers at commune level.

Two training manuals below, which were developed by UNICEF (8) and the project VIE/01/P10 (9) were also revised intensively by the project to make the national training package completed.

8. Verbal Autopsy of Maternal Death (3 volumes): a protocol, a fieldwork manual and questionnaire.
9. Training manuals on national guidelines and standards for reproductive health services: SM/NBC, family planning, safe abortion, RTIs including STI/HIV/AIDS, integrated counselling.

In addition, a set of IEC documents were designed and developed, including a leaflet, six posters, one pamphlet and a CD.

The project has produced an impressive amount of skill-based training manuals, creating a qualified national training package on SM/NBC available for phase II and for organizations working in SM/NBC. This output is fully achieved.

Output 2: A technical core group for SM/NBC established in all 25 provinces
This activity is the preparation phase for the implementation of the national SM/NBC program nation-wide. The MOH and UNFPA developed TOR for the core groups that defined criteria for selection and memberships. Beneficiaries mainly came from health facilities plus representatives from Women's Union, Farmer Union, Youth Union, IEC centre and Radio station (for IEC activities). In each province, the Department of Health required districts to select potential staff who met the established criteria and sent those to the TOT training courses on SM/NBC and related areas. According to assessments of local staff in three pilot provinces, the project selected the right persons for training courses.

In total, technical core group for SM/NBC were established in 25 provinces and 428 person was trained on different topics. For three project provinces 124 provincial staff were trained on National Standards and Guidelines on SM/NBC, 45 on Emergency Obstetric Care, 85 on Behaviour Change on SM/NBC, 83 on IEC/BCC for SM/NBC, 80 on Quality Management/COPE, 47 on Supportive Supervision and 102 on Maternal Mortality Audit (Appendix 1).

What did provincial trainers think of courses attended?

> *This is the first time we attended project-related training courses, which were delivered in a systematic way. Although there were many courses provided, each course was organized in a serious manner* (a member of provincial PMB in HaTay).
>
> *I am very interested with Quality Management & COPE course. It is new and very useful to our daily practice. Now we develop COPE exercise for each situation to improve health workers' practice and train health workers in districts and communes* (A doctor in Kien Giang).

Were there any difficulties during the TOT training implementation?
Due to time needed for implementing project activities at central level including training of national trainers, developing training materials, the first TOT was not conducted until Oct-Nov 2004, 11 months after UNFPA signing contract with RNE and 9 months after the project launch workshop. The course supportive supervision was conducted in Oct 2005, three months before the project due if the 3-month extension was not counted.

The last course on Emergency Obstetric Care was carried out during the extension. The short duration of the project stressed the its implementation.

Although all courses have been delivered as plan in terms of number, too many training courses in a short time of 3-4 months is a barrier to the training quality and a pressure on provincial trainers who in turn would trained district and commune health workers. Follow-up instructions, supervision or couching provincial trainers at 22 provinces from Hanoi-based agencies and supports from DOH is needed to ensure effectiveness of the project training activity. In other words, there should have frequent opportunities for provincial trainers at 22 provinces to practice so that they are skilful enough to be technical core trainer group in phase II.

Output 3: National Co-ordination of SM/NBC activities improved.
For the project management, at ministry level, the Inter-sectoral Steering Committee was set up which was headed by the Minister of Health and operated with participants from Ministry of Planning and Investment, Ministry of Foreign Affairs, National Committee for Population Family and Children and Women' Union. The Project Management Unit (PMB) at RH department was established which was headed by the RH department director with a total of 13 members. It has been commented by most of project stakeholders that these two managerial units were not productive and responsibilities fell into shoulders of full-time staff.

Although the coordination mechanism has been established, a smooth coordination between UNFPA and PMB was not achieved. Pressure of time and different perspectives were considered as rooted causes. In addition, a lack of working principles on co-execution in day-to-day work including decision making principles, conflict-based solving approach and involvement of top leaders from RH dept. and UNFPA in conflict arrangement, caused a continuance of misunderstanding and difficulty in agreement seeking.

Output 4: Capacity of the MOH in monitoring, supervision and evaluation, and technical backstopping SM/NBC strengthened.

All activities of this output were implemented as plan. The National Technical Backstopping Group was set up with 18 members coming from leading national-level hospitals and institutes. In the first phase, the Terms of Reference for this group had been well developed. Under which this group was expected to provide technical consultations to the Ministry of Health in implementation of the SMNP 2003-2010 and all projects related to SM/NBC by providing ideas for development of coordinating mechanism of project's activities as well as mother and newborn care activities nationwide and studying, revising intervention patterns on safe motherhood and newborn care to develop prioritized and comprehensive interventions. However, more than half of them were at management leading positions and they involved in the project on voluntary basis, thus it was very difficult for them to leave the institute work and be gather for the project assignments. In addition, materials were not circulated to them for reading before technical meeting, leading to less effective and time-consuming meetings. It was assessed by many agencies involving in this project that the NTBG was not effectively used and it was a waste to use such leading experts in monitoring trips to provinces. There were two questions raised: what is the main role of NTBG – provide strategic comments to MOH for SM/NBC or assist to revise manual? For the

latter role, is it necessary and cost-effective to use the leading experts who were at management position?

Strengths of this project were to complete the updated monitoring and evaluation tools for SM/NBC and sustain a frequent monitoring system to the project sites conducted by province and district trainer group and members of PMB, UNFPA, NTBG and even RNE. In comparison to other projects coordinated by MOH, this project got more supports from international organizations during implementation. Aside from UNFPA and WHO's supports, HaTay and KienGiang teams got direct assistance from PATH US and QuangTri team was closely supported by SCUS in project planning, training, activity implementation, monitoring and reporting.

The project also followed standards to implement baseline survey and end-project evaluation, integrating with phase II development. The evaluation team suggested that findings of the baseline survey would be more useful for the assessment of SMNP performance rather than for the project P21 performance.

Output 5: Lessons and experiences in area of SM/NBC collected and reviewed for application in the selected project sites.

This output was achieved.

A baseline assessment and review of current safe motherhood interventions in Vietnam was conducted by the School of Public Health to provide guidance for planning intervention activities in the three provinces during April and June 2004. The final draft of these studies is available. A workshop was held in August to disseminate the results of these studies.

The results from the baseline assessment showed that there are deficiencies in the capacity of the health system in the six selected districts in the provision of SM/NBC services, such as inadequate staff skills, poor infrastructure, and lack of some essential equipment. In addition, awareness of pregnant women and their family members on danger signs occurring during pregnancy, delivery, and post-delivery is limited. These factors were taken into account when developing a work plan for the provinces. This survey would provide baseline level of knowledge, attitudes of pregnant women before intervention that can be compared to the results after intervention when the SMNP ends.

The study reviewing SM/NBC interventions in Vietnam from 1994 to 2004 showed that the common framework for these interventions is the "three delays" model. Some lessons learned and best practices from different projects were shared in the workshop among different involved agencies.

Output 6: Prioritised and comprehensive activities on SM/NBC implemented in six districts
It was very impressive that all proposed activities were conducted even though time was stress.

Under the project, six district health centers (DCH) and all 104 communes in 6 districts were equipped with essential medical equipments (appendix 2). 24 Commune Health Centers (CHC) were upgraded with new delivery room. Six motobikes were granted to six districts' mobile teams for outreach service provision and supervision. Referral fund

were established in all communes with initial amount of 2 millions VND supported by the project and double of such amount mobilized from community contributions.

In terms of infrastructure and equipment upgrading, the principle of decentralization was applied quite well in this project. The provincial team were given full responsibility and power to manage this component: purchasing medical equipment, developing, analysing, bidding and selecting contractors for CHC upgrading. However, there are three issues for improvement in phase II. First, due to lack of experience in construction procedure, bidding was ignored or financial liquidation did not meet national criteria or process delayed in some communes. In phase II, clear instructions of infrastructure upgrading procedure ought to be developed and closely monitor to be provided during implementation. Second, communes should be given the right to select essential medical equipment to be purchased to void being granted unnecessary items (e.g. too many patient beds while in-patients were very rare at CHC– 7 beds in a 15-meter room of which 2 were equipped by the project). Third, infrastructure upgrading and medical equipment provision should be provided at early start of the project to create environment for health workers to practice and make the service available to villagers.

In terms of training, the project trained an enormous number of district/ commune health providers (1311 person-courses) and village health workers (1406 person-courses) (see appendix 1). COPE exercises were widely introduced to DHCs and CHCs, working out solutions for patient care. Overall, commune health providers and members of communal Women's Union commented that they were satisfied with the training "have never been trained in a systematic way and thorough as in this project". The only suggested changes in phase II from commune people were to make the interval between two courses longer and to increase more WU management members in the training courses.

With regards to IEC/BCC, the existing materials for use in community mobilization activities for SM/NBC were adapted and produced for the project use. In addition, 969 health workers, WU members, family population collaborators and representatives of other community-based organizations were trained on behaviour change on SM/NBC. This group then worked as community educators to convey the project messages to every villager. At provincial level, 56 articles were published and workshops were organized to call for supportive actions from local authorities. Provincial health leaders issued one regulation on applying SM/NBC national standards in the health services at three levels. People Committee issued decision on funding for continuous improvement of two DHCs and CHCs. The HaTay Provincial Health Department is planning a study tour for other district health facilities to visit the comprehensive model on SM/NBC. At district and commune level, there were more than 4000 times that SM/NBC messages were broadcasted on local radio and loudspeakers. Small group communication sessions in villages were established and routinely in operation. According to health providers in communes, an increase of health provider capacity via training, health facility upgrading and IEC/BCC activities together contributed to increase concerns of community people to safe motherhood, use of health facilities and build their trusts on CHCs capacity.

Output 7: Awareness and support of the community and decision makers to desired objectives of the SM/NBC.

USD40,880 was spent on IEC/BCC products revision, design, printing including posters, pamphlets, leaflets and cassette tapes to distribute to project sites. Twelve articles on SM/NBC were published on the national newspaper 'Health and Life' (*Suc khoe va Doi song*). SM/NBC-related shows were on VTV1 in 2004-2005 of session 'Health Safety' (*Suc khoe An toan*). The project P21 was the biggest project on SM/NBC and it has filled the gap of IEC/BCC on SM/NBC by producing good and consistent materials for advocacy.

Output 8: Capacity of the MOH to implement IEC/BCC activities for communities on SM/NBC strengthened.

This output is fully achieved. Core technical trainer group from 25 provinces were trained in 10 days about IEC/BCC with five representatives from each province. At central level, a set of IEC/BCC materials was developed by prototying the existing IEC/BCC materials from diffrent organizations. This set was sent to provinces for printing and distributing to health promoters, and health providers within provinces. The MOH had coordinated to process of material adaptation/design and printing well. Qualified IEC/BCC materials (adequate and easy-to-understand messages, colourful images, good paper quality and different design and format) were printed and distributed to health providers, community educators and end-users timely.

Output 9: Detailed workplan for the second phase of the implementation of SMNP developed and disseminated to appropriate stakeholders.

To assist MOH in developing the detailed implementation workplan for the phase II of SMNP, a consultancy work has been assigned to a team of five national specialists. The assignment is near to finalization.

Output 10: Strengthened capacity of MOH in project management and implementation

In this project, PMB office has coordinated all activities as plan with managerial supports from MPI and UNFPA. Four workshops were implemented. PMB conducted regular and ad hoc monitoring trips to local sites. Auditing and annual review meeting were timely implemented. The question is that would RH dept be able to manage the SMNP effectively in a professional manner.

According to opinions of project stakeholders, SMI is a big project and RH dept has tried their bests to complete many project activities under pressure of time and in a complication of partnerships. At least they have learned management lessons from the project context. However, there were still rooms for improvement and only if the following points were considered and addressed, phase II would be implemented professionally by RH department. First, there should have more linkages between departments within MOH, rather than making it to be a stand-alone project or program, to foster the integration mechanism for SMNP. Second, more experienced personnel are required at supportive positions for the RH department director and vice director. Third, RH dept must play an active leading role in SMNP management, identify their needs and require supports from relevant agencies. Four, there should have an independent mechanism for performance audit or quality assurance to assess the program performance and management of RH dept in SMNP implementation.

In summary, all of the expected outputs of the project were achieved, albeit late in implementation for some activities. The project has applied innovative ideas which created unique features for SMI Vietnam and to increased quality of activities: competency-based training approach, COPE approach, supportive supervision, use of traditional folk songs & music in IEC/BCC and community-based referral fund. The project P21 has completed enormous steps of preparation for the SMNP phase II.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

4.1. Overall assessment

This is the biggest project on SM/NBC implemented in Vietnam. The project's overall assessment (focusing on short-term objectives and outputs) is successful. This is despite a very slow and difficult start of the project. All project partners have tried their bests to complete their assignments. On the whole, the project was implemented fairly well at province, district and commune levels. The project has done quite a good job to prepare for the SMNP phase II: producing a complete national training package on SM/NBC, monitoring and evaluation tools, IEC/BCC materials and detailed implementation workplan for phase II and training a huge number of technical core trainer group.

4.2. Lessons learned

The following key lessons were learned from the internal project context:

1. Need a preparatory stage for setting up management and financial project system; shorten the process of project preparation: personnel recruitment, planning, approval and budget transfer
2. Top management support is critical to implementation. Senior program staff is very much needed for a big project management, in particular the SMNP.
3. Financial report should be in simple and unified format for all levels.
4. Better use of other members in PMB, Inter-sectoral Steering Committee and NTBG.
5. Clear responsibility and decision-making role and principles of co-execution should be identified to void overlap in operation, conflicts in decision making and delays. The mechanism of solving conflicts should be set up.
6. Clear mechanism for use of trained technical core trainer group in 22 provinces after Training of Trainers. Integration mechanism is strongly needed to provide them opportunities of practice.
7. The report forms should be developed before project implementation. Trainings on recoding and reporting project achievements should be provided to mangers before implementing activities
8. Duplication in training should be avoided in the context of province that have received many health-related projects.

9. Training on project management, monitoring, reporting and supportive supervision should be introduced to managerial staff at the start to ensure proper management performance.

10. Closer supervision during training, infrastructure upgrading implementation. Local supervisors are suggested to use.

11. Monthly salary for project personnel who are still at governmental position is required unless it is the national program.

4.3. Recommendations

Vietnam is under rapidly changing in terms of contextual variables, not all lessons from phase one – success and failures, strengths and weakness – might be applied to phase II. In overall, the relationships between the health care providers and users would become clearer in the coming years under some new policies which aim to protect the users rather than to protect the (public) providers as observed in the past. The role of private health care providers and non-profit health care organization would be considered more adequately in any new health policy released. The Public Administration Reform (PAR) would be accelerated to assure the government system management is healthy. It is also expected that quality assurance system for the health sector in general and for he reproductive health (including safe mother hood and newborn care) will be established with the involvement of the civil society organization. Supports from the international side would be integrated more into the government management system when the concept of "sector wide approach" to be introduced. In addition, the rapid development of digital life and technology is making daily change in the health care system, for both users and providers.

The detailed implementation plan for SMNP phase II has been drafted with identifications of priorities, strategies, approach and budget requirements. The following recommendations are made under the above vision of contextual changes as well as in consideration to the outlines of the drafted implementation workplan:

AT CENTRAL LEVEL

Recommendation 1: RH department should take the leading role in coordination for nation wide SMNP (budget management, planning, advocacy, communication, calling for technical supports and fund mobilization). It is strongly suggested that senior program staff must be recruited.

Recommendation 2: Coordination within MOH is required. There should have interactions among Therapy, Preventive, Planning, Science and Research Departments for SMNP, under leadership of inter-sectoral steering Committee.

Recommendation 3: SMNP should be integrated with other health programs to maximize the use of other programs' resources for SMNP.

Recommendation 4: The preparatory stage of the program should be designed before the actual program implementation. This stage should be implemented extensively including personnel recruitment, setting up project management structure and

coordination mechanism, baseline assessment, revision of all training materials and carefully planning.

Recommendation 5: The program should be delivered to province quick. Time allocated to personnel recruitment, plan approval and other procedure must be minimum spent.

Recommendation 6: There should have independent agencies (i.e., outside of the government system) to conduct performance audit to RH department to ensure transparency, activity and quality monitoring and problem identification and recommendations.

Recommendation 7: An information monitoring system should be set up early to be able to evaluate the achievement of SMNP goal. A consideration of using data from various large-scale surveys should be thought of, however, survey validity is a concern, making sure that figures are reliable and methods are appropriate.

Recommendation 8: Enhancing more the involvement of Local NGOs in SMNP. Some LNGOs could take the similar role that INGO did in the phase one, especially for the implementation of the project in the disadvantaged areas. Some could work as an independent monitor for project implementation

AT PROVINCE – DISTRICT - COMMUNE LEVELS

Recommendation 9: Planning should be implemented at province or even district and commune levels and Provincial Department of Health should be active in integrating SMNP with other project/program in the local setting.

Recommendation 10: The use of technical assistance agencies should be continued for regions where there has no previous experience of implementing a project/program or capacity of local staff is weak.

Recommendation 11: Training TBAs and equip CHCs and DHCs in remote communes/districts with adequate resources (providing new or replacing out-of-order equipment to meet the MOH's medical equipment standards) to ensure that mother and children who cannot travel to district and province health facilities are able to access to qualified safe motherhood and newborn care services at CHC and basic SM/NBC at home during delivery.

APPENDIX 1: TRAINING COURSES CONDUCTED BY P21

Order	Title of training	Title of trainees trained	Number of trainees	Who were Trainers	Duration of courses (# of days)	The main topics of training	Time of conducting training courses (months/year)
A	**Training on national standers and guidelines SM/NBC**						
1	TOT for national trainers on Teaching skills	National trainers	16	International Specialist. Dr. Behire	03 days	Interactive training skills, presentation, Demo, coaching skills	Sep – 04
2	Training of Provincial Trainers on National Standards and Guidelines on SM/NBC	Provincial Core trainers on SM/NBC	124	National trainers	11 days	Training skills in normal care and care of complicated access during pregnancy, childbirth and postpartum	Oct 04 – Jun 05
3	Training to service providers on National Standards and Guidelines on SM/NBC	Midwives, doctors, nurses from CHCs, DHs and PHs	561	Provincial trainers	15 days	Normal care and care of complicated access during pregnancy childbirth and postpartum	Nov 04 – May 05
4	Training to village health workers on National Standards and Guidelines on SM/NBC	Village health workers	437	Provincial trainers	5 days	Normal care and care of complicated access during pregnancy and postpartum	Nov 04 – May 05
B	**Training on Emergency Obstetric care**						
5	TOT to national trainers on Competency-based Teaching skills in	National trainers	15	International consultant, Dr. Rajat	5 days	Competency – Based training skills in EmOC	Nov – Dec 05

	EmOC						
6	Training to service providers on EmOC	Provincial trainers	45	National trainers	25 days (10 days in class, 15 days for practice in hospital)	Management of obstetric complication, UN process Indicators	Dec 05 – Mar 06
C	**Training on Behaviour Change**						
7	TOT to provincial managers on Behavior change on SM/NBC	Provincial trainers	85	National trainers	10 days	Methodology for group work on identifying problems and solutions to these problems addressing compliance with national standards and guidelines	Feb – Aug 05
8	Training to provincial/ district managers and service providers on Behavior change on SM/NBC	Midwives, doctors, nurses from CHCs, DHs and PHs	498	Provincial trainers	5 days	Methodology for group work on identifying problems and solutions to these problems addressing compliance with national standards and guidelines	Mar – May 05
D	**Training on IEC/BCC**						
9	TOT to provincial service providers on Behavior change on SM/NBC	Provincial trainers	83	National trainers	10 days	IEC/BCC skills and the key messages on SM/NBC	Feb - Aug 05
10	Training to	HWs, WU	969	Provincial	3 days	IEC/BCC skills and	Mar – May 05

	promoters on Behavior change on SM/NBC	members, population collaborators		trainers		the key messages on SM/NBC	
E	**Training on Quality Management/Cope**						
11	TOT to provincial service providers on Quality Management/Cope	Provincial trainers	80	National trainers	10 days	Management, planning, and quality improvement using COPE approach	Jan – Aug 05
12	TOT to provincial/ district service providers on Quality Management/Cope	Leaders of CHCs	252	Provincial trainers	5 days	Management, planning, and quality improvement using COPE approach	Feb – Apr 05
F	**Training on Supportive Supervision**						
13	Training on Supportive Supervision on SM/NBC to provincial/district health workers	Provincial/district HWs	47	National trainers (Dr.Nhuan, Ms.Yen, Dr,Bang)	4 days	Tools, steps and skills needed for supportive supervision	Oct – 2005
G	**Training on Maternal Mortality Audit**						
14	Training on Maternal Mortality Audit to provincial/district health workers	Provincial/district HWs	102	National trainers	10 days	Definition of maternal death, guideline on how to conduct MMA and provincial plan on MMA	Aug – Sept 05
Total number of trainees			**3314**				

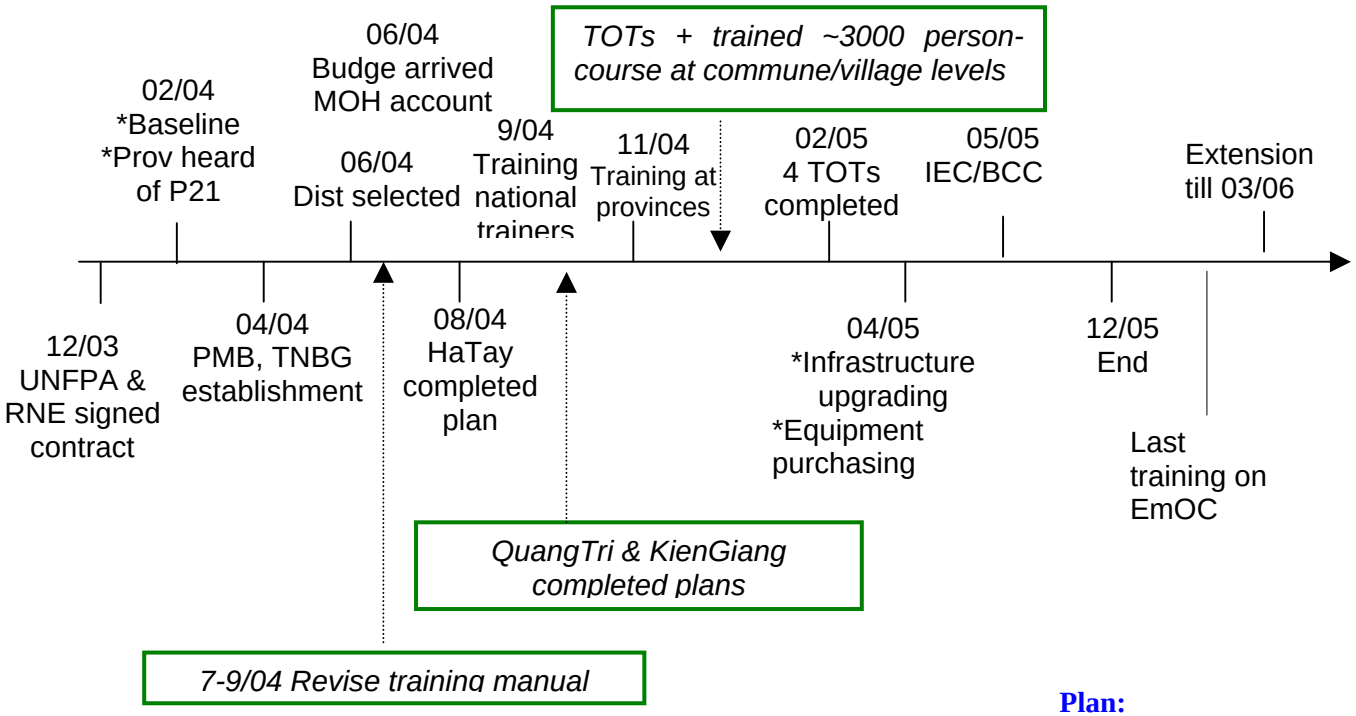
APPENDIX 2: SUMMARY OF HEALTH FACILITIES CONSTRUCTED/RENOVATED.

Province	Number of Health Facilities Constructed/Renovated		
	Provincial hospital	District hospital	Commune Health Centre
Ha Tay	0	0	8
Kien Giang	0	0	13
Quang Tri	0	0	3
Other 22 provinces	0	0	0
Total	**0**	**0**	**24**

APPENDIX 3: LIST OF MAJOR TECHNICAL OUTPUTS

1. Training manual on Newborn care
2. Training manual on Changing Behaviour and Practice
3. Training manual on Information, Education, Communication/Behaviour Change Communication Skills
4. Training manuals for SM/NBC for village health workers
5. Training manuals on supportive supervision
6. Comprehensive Emergency Obstetric Care Manual
7. Training manual on Quality Management and Client-Oriented, Provider-Efficient Service
8. 01 leaflet on SM/NBC
9. 06 posters
10. 01 pamphlet
11. 01 CD on SM/NBC
12. 01 cassette tape on IEC/BCC for SM/NBC

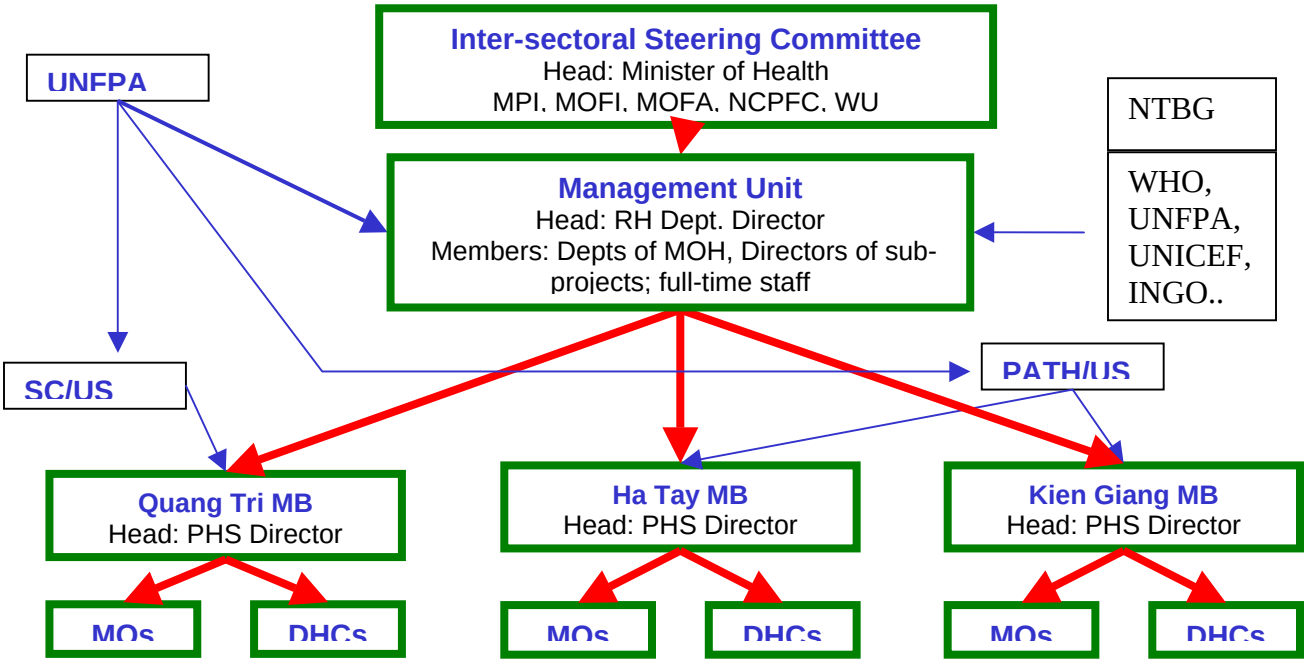
APPENDIX 4: IMPLEMENTATION SCHEDULE



Plan:

Mar 04-Mar 05: training at central, provinces & communes.
Mar-Oct 04: infrastructure & equipment upgrading
Jan-Mar 04: establishment of PMB, NTBG

APPENDIX 5: PROJECT COORDINATION MECHANISM



APPENDIX 6: LIST OF THE EVALUATION TEAM

Team leader

Tran Tuan	MD, PhD

Team member:

Tran Thu Ha	MPH (Women's Health), PhD candidate
Tran Thu Huong	MPH (Women's Health)
Tran Dinh Dung	MSc.
Nguyen Thu Trang	BPH