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Strengthening Government Health Services on IYCF Counseling in Vietnam

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Presenters

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Nguyen: Good afternoon everyone. Thank you for giving me the opportunity to share some experiences with M&E in Vietnam. So just a little bit about myself. I'm an M&E specialist working for the International Food Policy Research Institute and currently we work on the Alive and Thrive (A&T) project, you can see the logo here. This is a project funded by the Gates Foundation in three countries: Vietnam, Bangladesh, and Ethiopia, with the aim to improve under-nutrition of children and reduce child mortality through improvement of infant and young child feeding practices.

So today I'm going to just focus mainly on Vietnam on strengthening government health services on IYCF counseling. That's a short form of infant and young child feeding practice in counseling in Vietnam through social franchising. So a little bit about the background in Vietnam: in Vietnam infant and young child feeding situation is really sub-optimal. As you can see in the figure although breastfeeding is universal, but exclusive breastfeeding, that means mothers only breast feed without giving water, without giving food early in the first six months only account for 20 percent and early initiation is 60 percent.

In addition pre-lacteal formula feedings. That means feeding of a child too early is really high: 74 percent in children and 34 percent with formula feeding. Dietary diversity and frequency is also sub-optimal. And these are the main contributors for the under-nutrition in Vietnam. It's nearly one out of three children are stunted and one out of

five children are underweight. And one out of five children are underweight. Although we have developed very good in the economy and other things, because you may know that we've just moved from the low income to nearly middle income country.

But still under-nutrition is left behind compared to the other socioeconomic developments. So that's why we focus on improving the infant and young child feeding practice with the aim to improve the under-nutrition. So this figure is a little bit crowded but I just explained the graph reads that – Basically in the literature the social franchising just you know _____ _____ some kind of backing or something. It is basically in business. But in health currently they start to apply for reproductive health, especially reproductive health for women.

And so nutrition is a very new idea and we start to apply it in Vietnam. So like we discussed from yesterday, that we work – the Alive and Thrive project works very closely with the National Institute of Nutrition. That is government, local to work together like franchises. And these works to upgrade infrastructure, branding, publicity building, job aids, and bring the materials. And then at the provincial level, we work with the provincial departments of health and reproductive health centers and they work like sub-franchisors.

And finally the target is we try to build capacity for franchisees. That means the health center at the provincial, district, and community levels. And the service package we provide is counseling services to: pregnant woman, lactating mother, and father and caregiver. So the main idea of that is we work very closely with the government and also the sub-governments at the de-centralized

level - provincial with the hope that when the program ended it can be sustainable because they can absorb it and they can continue the activity.

So today I will focus mainly on the capacity building part. With the training implementation we conducted several trainings. For example first we do the training for the trainers. We call it TOT. There are 29 courses at the central level and the provincial level to train more than 700 trainers. And then from these trainers, they go out to the province or the district level. So they continue to conduct and grow our training with 946 courses.

And they trained more than 3,000 doctors, more than 500 midwives, and more than 15,000 community base workers. So you can see that we did a lot of training. But we are thinking about – So does our training really work? And what is the impact of training? That's why we think very carefully and we design a program and evaluation to assess if the training is really effective or not. And what is the impact of training after that? So we conducted basically in two phases.

The first is we assess the quality of training itself. That one conducted either the class or the training facility. We conduct the desk reviews, the training observation, and the pre- and post- tests to see if the training really is effective as its planned to be. Or are the people – the training of the _____ to the training maker is good enough? And what is the level of impact or improvement and knowledge after the training? And then one year later we conduct another phase we called phase two.

We assess the long-term effect of training on service delivery. That means after the training this

seems good enough. But do they apply their knowledge in their real life? Will they conduct the service delivery? And is that good enough? So we conduct a provider survey, counseling observations to see if they're following the standard of care. Do they have competence and is their performance good enough? And also we conduct a client exit interview to see if the client who comes to the counseling service; how satisfied they are. And are they good with the counseling services?

So basically in the phase one we see that the desk review and training observation, basically trainers are doing a good job as they intended to be. And there's a pre- and post-test. And you can see in the figure if the maximum score of all training is 83 score. So the possible score is the green line. And the after score is the red line. We see a big improvement in most regions north, south, and central. But there's a little bit of variation where someone might do a little bit better than the others.

So if we look at the result we can see that they did a good job. They improved a lot. But still there is some -- because the maximum is 83 and they really didn't get maximum yet. So that means there's some component of training that the trainee may not be able to get it. So we come back to the program and say – And then not only the total score, but each component itself. We come back to the program and say, "Here is something that you did a great job and something you still need to improve."

And then that's what we use for data and add to the course of training and we can improve and make it better. And then for phase two after another year of implementation we conducted a

randomized control trial. We compared between the standard facilities and then the A&T supported facility. The A&T- supported facilities – that means facilities have staff sent to us for training, who come back to work in the facility. And then we see that after a year if the knowledge that they get during the training – if they still remember that, if they still retain the knowledge.

And then you compare between the two. And then we can see that in some places, the standard facilities, even if they don't get our training they're still good because they get the national training. But the other thing, our training – I mean the blue color, the trainees that got our training gets much better knowledge in several knowledge areas related to breastfeeding. And also we noticed, because our practice is counseling, so they need to have good communication still so they can then convey the message, how they interact with the client to convey the message of counseling.

So we also assess if the communication skills are better between A&T facility and standard facility. And you can see that A&T-supported facility staff – they identify problems better. They gave good counseling or relay good information. They know how to use IEC materials better. They give advice better compared to other standard facilities. And finally we also conduct the counseling observation.

We have a checklist to see if they follow the lists of the content, they should during the counseling. And we also see that the – sorry – the A&T supported facilities do much better than the ones that do not. So following that, we can see that after one year they do a good service delivery. That means they bring the knowledge the get from the class, from training. And they do a much

better job in the real-life situations by service delivery.

The takeaway message from here we would like to say is that millions of dollars every year, we use for training, we use for capacity building everywhere. And lots of times we do pre- and post-testing. But later on what happens in the field? Do people getting the knowledge in the class; do they really apply that knowledge? Do they transfer it to make the impact in the field? Are they still doing that? So that's why we try to raise a message that the training programs should have built in assessment plans and that these results must be used to improve training content and plan for refresher training later on.

And we use several techniques like observation. We use intervention sites with matched controls, and various ways of data collection, because training is not just like looking at some direct indicator. But you need to look at several angles around that in order to get the main idea. And just very quickly to show you that another round of our evaluation is another year later. We see that these people, they provide the services. But does the client really use that service and do they change their behavior or not?

So here you can see that in the first six or seven months, it's very challenging to attract clients to go to see this counselor. But then after they do a good job the clients increased sharply in all levels – community, district, and provincial level. So that means that when they do a good job, when they start to create their reputation, the clients start to come to them and the utilization increases.

And finally we were also able to go to the client with household surveys. And then we say - so the counselor who provided you with the counseling service. You go to use it. Do you really change your behavior? And then here you can see that with A&T areas and non-A&T areas, as a baseline it's very similar. But then after the baseline – for example, early initiation, you can see that most of the _____ reduced. But the non-A&T, reduced much more. But why were they reduced? We have a long explanation because in Vietnam the C-section rates increased a lot. And the C-section these people cannot do early initiation, so that's why it was reduced. But in the A&T area it has some _____ that is reduced less than the other one.

And as for exclusive breastfeeding, you will see that it increased in most areas but in the A&T area it increased much more – about ten percent more than the other ones. Pre-lacteal feeding and bottle feeding it also reduced more in the A&T area. So here I just want to emphasize that we had the sequence to see from training in the class to service delivery in the field, and then see if the client uses the service. And then did they change the behavior? So that's all we want to present. Thank you for the chance. [Applause]

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