Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARV	Anti Retro-Virals
BCC	Behavior Change Communication
CDC	Centers for Disease Control and Prevention
CHS	Commune Health Station
COC	Continuum of Care
CT	Counseling and testing
DHC	District Health Center
DH	District Hospital
DHD	District Health Department
EM	Ethnic Minority
EPI	Expanded Program of Immunization
FGD	Focus Group Discussion
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HW	Health Worker
HHW	Hamlet Health Worker
HIV	Human Immuno-deficiency Virus
IEC	Information Education Communication
IF	Infant feeding
IYCF	Infant and Young Child Counseling and Feeding
LIFE GAP	Leadership and Investment in Fighting an Epidemic-Global AIDS Program
MCH	Mother and Child Health
NIHE	National Institute of Hygiene and Epidemiology
MOH	Ministry of Health
NPoA	National Plan of Action
OI	Opportunistic Infections
PCR	Polymerase Chain Reaction
PEPFAR	Presidential Emergency Plan For AIDS Relief
PMC	Preventive Medicine Center
PMTCT	Prevention of Mother to Child Transmission of HIV
PMU	Project Management Unit
PLWA	People Living With HIV and AIDS
PW	Pregnant Woman
RF	Replacement feeding
RHC	Reproductive Health Center
RHD	Reproductive Health Department
STI	Sexually Transmitted Infection

UNAIDS	United Nations AIDS Program
UNICEF	United Nations Children's Fund
VAAC	Viet Nam Administration for HIV/AIDS Control
VCT	Voluntary Counseling and Testing
VWU	Viet Nam Women's Union

Notes

(i) In this report "$" refers to US dollars
(ii) In this report "M" refers to 'million'

Contents

Executive summary

Project Description

The Support to Programme Activities for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) in Viet Nam (the Project) was implemented through the Government of Viet Nam (GOV) Ministry of Health (MOH) and Provincial and District Departments of Health (DOH) in five selected pilot districts, and with the support of UNICEF Viet Nam. Planning started in 2001, with implementation of a sub-project Pilot component from June 2004 to December 2007. National level activities are planned to continue through 2010. The total cost of the Pilot was $M1.048.

The overall goal of the Project is to contribute to the reduction of transmission of HIV from mother-to-child in Viet Nam, through a well-functioning PMTCT system, operating according to national standards, and incorporating strong participation from the community. The Project has five main objectives: (i) PMTCT agenda in Viet Nam advocated for, including building national capacity and development of the National Program of Action for PMTCT program; (ii) a model of PMTCT interventions created and tested that can be evaluated and later contribute to nation-wide scale-up activities by the Government of Vietnam; iii. pilot PMTCT project activities functioning in five provinces with high prevalence of HIV. Voluntary counseling and testing (VCT) services at pilot sites established; (iv) best community practices on HIV prevention through behavior change communication (BCC) activities promoted; and (v) best infant feeding practices, in particular, informed decision on feeding by HIV positive mothers promoted.

The Project consists of two components: Component One is implemented at the central level, and supports PMTCT policy, advocacy and monitoring and evaluation, including development of the PMTCT National Plan of Action (NPoA) and related legislation. Component Two is a PMTCT pilot project (the Pilot) implemented at provincial, district, commune and community levels in five Pilot districts (all communes) in one district in each of five high-HIV-prevalence provinces. The current evaluation presented here is an end project assessment of the Pilot component.

The objective of the PMTCT Pilot component is to create and establish a model of PMTCT and voluntary counseling and testing (VCT) interventions operating along the internationally recognized four-pronged approach to PMTCT in five provinces with high HIV prevalence that can be evaluated and contribute to nation-wide scale up of PMTCT activities by the government. The three key result areas of the Pilot are: (i) Women, their partners and adolescents use appropriate information to protect themselves against HIV/AIDS and to prevent transmission of the virus to their children; (ii) pregnant women and their partners and people of reproductive age (in particular adolescents) have access to quality VCT/PMTCT services; and (iii) HIV positive women and their children receive care and support (medical, nutritional and emotional)

Rationale

Prior to 2001, the GOV had focused its HIV/AIDS prevention and control efforts on injecting drug users (IDUs) and sex workers (SW) because reported prevalence in these two groups was high, and appeared low among pregnant women at the time. Nationally, VCT/ PMTCT services were limited and under-funded, and there was no framework in place to guide PMTCT interventions to address increasing rates of mother to child infection and low levels of awareness of PMTCT among the population. In response to this, the GOV set out to develop PMTCT protocols, policies and services, with assistance from UNICEF and other donors including the Centers for Disease Control (CDC-LIFE-GAP) and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), to address the need for PMTCT

services in Viet Nam. The Government's plans are consistent with UNICEF Viet Nam's country strategy and program and are the foundation for this project's goals and design.

Implementation Arrangements

The Project was originally established under the direct management of the RHD as the Executing Agency (EA), and administered through the Provincial Reproductive Health Centers (RHC). Project intervention and support for planning and management was directed primarily to the district level, and administered through the District Health Centers (DHC). In 2005, one year into implementation, the Viet Nam AIDS Administration for HIV/AIDS Control (VAAC) was established, and to avoid implementation of PMTCT in isolation from other national HIV/AIDS prevention and control activities, overall Project coordination and management responsibility reverted to the VAAC. The Project is currently implemented by a central Project Management Board (PMB) established within MOH, and includes the RHD, the VAAC and the Viet Nam Women's Union (VNW). Provincial project management boards were not established within the provincial departments of health in the five targeted provinces.

Initially, Project support for implementation went directly to the DHC. Recent structural changes separated the DHC into three divisions: the district hospital (DH), district preventive medicine center (PMC) and the district health department (DHD). As a result, some Pilot districts implement PMTCT through the district PMC, as stipulated in the NPoA, and in other Pilot districts the focal point for PMTCT is the DH.

Coordination within the new structure is still being worked out within the MOH. Overall guidance is through a project steering committee, chaired by the Minister of Health, with representation from concerned departments of the MOH, including Planning and Finance Department, National Institute of Hygiene and Epidemiology (NIHE), National Obstetric and Gynecology Hospitals, Center for Health Education (CHE) MOH, and Provincial and District People's Committees.

Impact, Outcomes and Sustainability

The end project assessment of the PMTCT Pilot component found initial impact from improving trends in district and individual health center PMTCT data. This is consistent with available GOV data collected at Pilot project sites during the implementation period, and with cross validation from UNICEF project monitoring data. The generally positive impact indicators and outcomes cannot be totally attributed to the UNICEF-supported Project, although key informant interviews in the districts and communes studied referred specifically to the role of the Project for improved processes, outcomes and results. Rather, the Project contributed to overall PMTCT improvements achieved through GOV and international partner activities.

The Project supported the implementation of GOV national programs, and the development of national guidelines and protocols for PMTCT. Continued Project support at the central level aims to strengthen national level policy, advocacy and monitoring and evaluation. Experiences from the Pilot are intended to inform the next steps for taking PMTCT to scale nationwide.

The Project's training capacity building at national, provincial and district levels, and facilitation of PMTCT, VCT, and IEC/ BCC training processes contributed to overall impact. These benefits are continuing, or are planned to continue using GOV funding to expand the Pilot model to new districts in the Pilot provinces. The Pilot training activities were complemented with relevant basic equipment for the district and commune health stations to carry out PMTCT counseling, testing, referrals, and community mobilization and behavior change communication activities.

Coordination of PMTCT activities within the health system was more variable, due to evolving structural changes and ill-defined roles and responsibilities of each division, both at the district level, and between the RHC and the recently established VAAC. Interventions at district and commune levels sought to compliment the existing care and treatment projects implemented by other donors (LIFE-GAP and GFATM) in the Pilot provinces. However, implementation at provincial level was more variable, particularly where provincial level stakeholders were not active in the planning and management process. The newly formed VAAC, and its corresponding Provincial AIDS Centers (PAC) are intended to be the focal points for all HIV/AIDS activities, including PMTCT nationally, and at local levels. Only in HCMC was it evident that this new structure is working, as the HCMC AIDS Committee has long been established, and is strong enough to serve as the entry point for the Pilot project.

The outcomes of Project support to health workers (HW) as well as to hamlet health workers (HHWs), collaborators, and other community volunteers were highly regarded. While skill levels among HWs varied, further refresher training, particularly on counseling skills is needed, and most the volunteer processes rely on GOV funding which has not been consistently provided. Although some Pilot sites operate in remote and mountainous areas with high concentrations of ethnic minorities, Traditional Birth Attendants (TBA) were not mobilized for IEC/ BCC activities, which could be considered during scale-up in selected remote and mountainous areas.

Key informant interviews and group discussions indicated that where local authorities were actively involved, overall results – particularly coordination within and between the health sector and the mass organizations (Women's Union, Youth Union, etc) – tended to be much better. Where the local authorities were not actively engaged, for example, at the provincial levels, the PMTCT systems, support and staff commitment were less evident, particularly after the first year of implementation. Similarly, where the local mass organizations were strongly committed, local health services tended to be more responsive and focused on local communities.

Conclusions and Recommendations

A comprehensive approach to PMTCT requires a program that focuses on all four prongs of the recThe Project successfully developed and tested a model, which can be adapted and replicated by GOV to implement across all four prongs of PMTCT, and under the new NPoA. The Pilot model adapted to the evolving restructuring and decentralization policies, and successfully complimented the other major donor-supported PMTCT activities in project sites. The Pilot demonstrated relevant processes to compliment current GOV health policies and investment.

Impact: The qualitative and available quantitative data show that the Project has had an impact on RH/ MCH indicators, including high rates of HIV-positive women under PMTCT management, (although variable in HCMC, due to lost cases among migrant populations); increasing rates of voluntary testing among pregnant women (currently 62%), and a potentially low rate of sero-conversion (of the 54% tested so far, 100% confirmed negative) among those children exposed to HIV in the Pilot districts. However, the positive outcomes and indicators cannot be attributed exclusively to the Project. The Project's training capacity building at national, provincial and district levels, and local level training processes contributed to overall impact, and are planned to continue using GOV funding for phased scaling up to priority locations nation-wide.

Relevance: The Pilot supported GOV donor priority areas, and was appropriate in its aims and objectives. The design and (evolving) implementation arrangements were highly relevant to the current situation in Viet Nam. CDC, GFATM and other donors are supporting care and treatment components of PMTCT in Viet Nam, with low inputs of technical assistance for capacity-building

resources and delivery capability at the peripheral levels of the health system. UNICEF- supported assistance to this under-funded area will strengthen the outcomes and impacts.

> **Recommendation 1:** *The GOV should plan and carry out a workshop with broad participation from donors, communities, the relevant public and private sectors and other interested parties to disseminate Project findings, discuss lessons learned, solicit feedback and agree on the next steps to take*

Training System Capacity Building: The Project strengthened national policy and planning for PMTCT, and demonstrated training materials and processes to support implementation of the NPoA for PMTCT, which reinforced and established PMTCT in provincial training processes. Capacity building for PMTCT was provided directly to district level DOH, but to a lesser extent at the provincial level for building PMTCT planning and training management systems. With the exception of the long-established HCMC AIDS Committee, which was supported by the Project to plan and administer the piloted PMTCT activities, the new Provincial AIDS Centers (PAC) established in provinces mid-way through the Project did not benefit directly from the Project.

> **Recommendation 2:** *The GOV should prepare a plan to strengthen the PMTCT planning and training management and supervisory capacity at the provincial level for improved training, monitoring and supervision on VCT and IEC/BCC, and with specific implementation strategies for taking successful and sustainable approaches to scale.*

Health Worker Capacity Building: Health staff at all levels, collaborators, members of mass organizations and other community health volunteers highlighted the skills they had gained through the Project, and the practical ways in which the skills were transferred. The communication activities were viewed by many as the most effective component of the project for reaching the target audiences in the community, and the communication skills developed support health staff and communicators across other areas of their health promotion activities as well as for PMTCT. Quality counseling and confidentiality were also viewed as critical factors to promote broader acceptance of VCT, and as a potential means to reduce missing cases.

> **Recommendation 3:** *To ensure quality of services, refresh training and skills practice, particularly on counseling and confidentiality issues, should be provided for appropriate district and commune level health staff. Technical assistance should be mobilized to facilitate the process of strengthening GOV systems to carry out capacity building for PMTCT scale up to other locations and provinces. UNICEF is well positioned to continue central level advocacy and technical support to provincial training management capacity and for refresh training for appropriate health sector and mass organization personnel.*

Equipment and Supplies: Equipment and supplies provided for the Project (IEC materials, audio-visual equipment, computers and clinical supplies) were appropriate, however the Project TVs were under-utilized in some instances, due to overlap with other donor-supported TVs, and also due to limited waiting room space in the health facilities, particularly at commune level. If ANC days are scheduled more frequently, a manageable daily volume of clients would reduce the need for group counseling (and TVs) at CHSs, and allow more time for quality counseling. Stock-outs of rapid test kits were observed in locations where pregnant women were being tested multiple times during their pregnancy, and with no standardized screening for high risk.

> **Recommendation 4:** *Standardized guidelines for supervision and monitoring of PMTCT should be established and training provided to provincial and district level supervisors to support the*

implementation of PMTCT and related protocols and procedures in order to reduce wasteful practices (eg excessive testing) in an environment of limited resources.

Community Mobilization: The Project has made a major contribution toward understanding the key factors for achieving effective outcomes across all four prongs of PMTCT, including increased community mobilization for prevention and care, leading to better maternal and child health outcomes. Project support demonstrated the considerable benefits of strengthening community 'volunteer' health support services at commune and hamlet level to support the current salaried hamlet health workers (HHW) and other national program technical health collaborators (eg family planning, child nutrition). Where local authorities were actively involved, overall results – particularly coordination within and between the health sector and the mass organizations (Women's Union, Youth Union, etc) – tended to be much better, and seem likely to be sustained. Similarly, where the local mass organizations were strongly committed, local health services tended to be more responsive and focused on local communities.

Recommendation 5: *The evaluation recommends full and meaningful participation of end users, beneficiaries – including men, as well as women, PLWA, key GOV personnel, local political leaders and other partners at all levels as a basis for future project design and implementation that support appropriate and sustainable improvements in existing systems and institutions, while reducing dependence on outside assistance, and to mobilize communities – the most available resource – to promote greater self-reliance.*

Coordination: PMTCT services are offered in the five pilot districts as part of routine ANC services in general coordination with provincial HIV/AIDS programs, and include voluntary HIV counseling and testing services, HIV/AIDS information, education and communication activities. Coordination and integration of PMTCT activities across provincial and district health systems was more variable, due to evolving structural changes and ill-defined roles, responsibilities, lines of communication and authority of each division in the DOH, both at the district level – which has had particular implications regarding referral mechanisms, and between the RHC and the recently established PACs at provincial level. Improved integration of PMTCT into general HIV/AIDS prevention and control systems is seen both as a potential means for wider reach to high risk populations, as well as for encouraging greater involvement in HIV prevention activities among adolescents and men, who generally regard PMTCT as exclusively for pregnant women.

Recommendation 6: *Clarification of the roles and responsibilities of DOH departments and divisions involved in PMTCT is urgently required in order to improve coordination. The GOV should consider providing additional supervision and monitoring training for the newly established Provincial AIDS Centers, and make arrangements to continue to expand their monitoring, supervision and technical support to the PMTCT Pilot, to identify problems and make adjustments and recommendations as necessary. More also needs to be done with the private sector for sharing information on PMTCT services, guidelines, protocols, referral, monitoring, and for potential tracking of missing cases.*

Institutional Capacity Development: A measure of preliminary sustainability observed in all districts/ provinces was the existence of the training networks initiated by the Project. The TOT systems, curricula and materials for the PMTCT training programs (VCT, IEC and BCC) were in place, and in some areas (HCMC and Quang Ninh) extended to non-project districts. Existing IEC materials developed by the Project and community-based BCC activities observed in Pilot communities were indicators of sustained outcomes, and support the high priority that should be given to appropriate IEC materials and community awareness activities as PMTCT is scaled up. However, IEC leaflets are in short supply, and refresh training in VCT and IEC/BCC is needed.

Recommendation 7: *Strong central level support and advocacy for training at provincial level should be maintained to ensure broad implementation and continuity of training and other initiatives. UNICEF should consider providing limited implementation support to the GOV as may be needed to ensure that the newly piloted activities maintain momentum and are sustained. Timing is also advantageous as the MOH is currently restructuring, offering flexible entry point for UNICEF to support lasting systemic change.*

Lessons Learned

- The Project successfully developed and tested a model, which can be adapted and replicated by GOV to implement across all four prongs of PMTCT, under the new NPoA.
- Training and capacity building activities and structures can significantly improve skills, knowledge and practice. However, training processes need closely monitored support at implementation and supervisory levels to ensure quality, and at central and senior levels to ensure sustainability
- Capacity building at all levels of the health system - in particular, skills development, adequate supervision support and facilities required for providing quality counseling - can lead to significant health benefits, including increased utilization of services, due to trust and confidence in the health worker skills that have been developed, and quality of services; and improved health outcomes, including better management of HIV-positive pregnant women, husbands/partners, mothers, their children, and other family members.
- Capacity building in the health system and in the community can reduce the perceived need for supplemental financial incentives for health worker and volunteer participation in PMTCT activities and services provision, leading to improved sustainability.
- Support to the decentralized arrangements of the health system require strong planning and management participation at provincial as well as at district levels for enhanced ownership by local health authorities, and to define clear roles and responsibilities.
- Community mobilization strategies that include appropriate and available information, education and communication (IEC) materials, and effective behavior change communication (BCC) activities, if systematically implemented through local structures such as local People's Committees, the Viet Nam Women's Union, Youth Union, Commune Health Station and Hamlet Health Worker networks, can improve health seeking behavior for improved PMTCT outcomes, reduce stigma and discrimination in the community, and can increase early, cost effective voluntary counseling and testing.
- Frequent and careful monitoring of Project implementation is essential to ensure that the newly established PMTCT operational processes and procedures are clearly understood and services carried out correctly and completely by the responsible parties at all levels. On-site monitoring, especially for the newly established PMTCT services, should aim for no less than monthly visits to provide support at district, and selected CHS levels.

I. PROJECT DESCRIPTION

1. *The Support to Programme Activities for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) in Viet Nam* (the Project), which includes PMTCT activities at central level, and in five pilot districts in five provinces in Viet Nam was implemented through the Government of Viet Nam (GOV) Ministry of Health (MOH) and District Departments of Health (DDOH) in the five selected pilot districts, and with support of UNICEF Viet Nam. Planning started in 2001, with implementation from June 2004 through December 2007. The total cost was around $ 1,000,000.

2. The purpose of the Project is to contribute to the reduction of transmission of HIV from mother to child in Viet Nam, through a well-functioning PMTCT system, operating according to national standards, and incorporating strong participation from the community. The Project focus is on building health worker capacity in PMTCT and sexually transmitted infections (STI) prevention and control, and to ensure the availability of necessary equipment and materials for prevention and control activities, as well as adequate counseling and support for HIV-positive mothers and HIV-positive newborns.

3. The Project has two main components: At the central level, UNICEF supports PMTCT policy, advocacy and monitoring and evaluation, including advocacy and technical support for the development of the PMTCT National Plan of Action (NPoA) and related legislation. At the peripheral level, a PMTCT pilot project (the Pilot) at provincial, district, commune and community levels is implemented in five pilot districts - one in each of five high-HIV-prevalence provinces. Following an initial year of needs assessment, project development and counterpart training, including training on Project Management, Voluntary Counseling and Testing (VCT) for PMTCT and Behavior Change Communication (BCC) for PMTCT, actual implementation then ran from June 2005 through December 2007, with UNICEF support to the Pilot is scheduled to phase out by early 2008. Experiences from the Pilot are intended to inform national policy, especially for scale up of PMTCT elsewhere in Viet Nam, with UNICEF Project component support to national level currently planned to continue through December 2010.

4. The Project is designed to compliment activities implementation across all four "prongs" of the internationally recognized four-pronged approach to PMTCT, which includes: (i) primary prevention of HIV/AIDS; (ii) prevention of unwanted pregnancy in HIV-positive women; (iii) prevention of HIV transmission from HIV-positive mothers to children; and (iv) care and support for HIV positive mothers and their children and families. Rather than implementing comprehensive PMTCT, the Project seeks to compliment existing VCT/ PMTCT interventions currently implemented at provincial hospitals in the selected Project sites by providing support for VCT/ PMTCT services and social mobilization at district and community levels. This arrangement has required significant effort to coordinate activities with donors supporting PMTCT at provincial, and in some cases at district level. Recent restructuring within the MOH at district level has presented additional coordination challenges to the Project implementers.

5. The Project objectives are: (i) PMTCT agenda in Viet Nam advocated for, including building national capacity and development of the National Program of Action for PMTCT program; (ii) a model of PMTCT interventions created and tested that can be evaluated and later contribute to nation-wide scale-up activities by the Government of Vietnam; iii. pilot PMTCT project activities functioning in five provinces with high prevalence of HIV. Voluntary counseling and testing (VCT) services at pilot sites established; (iv) best community practices on HIV prevention through behavior change communication (BCC) activities promoted; and (v) best infant feeding practices, in particular, informed decision on feeding by HIV positive mothers promoted.

6. The Project Management Board (PMB) is comprised of the Reproductive Health Department (RHD), the Viet Nam Administration for HIV/AIDS Control (VAAC) and the Viet Nam Women's Union (vWU). The Reproductive Health Department (RHD) is the Executing Agency (EA) for the Project, and responsible for Project planning, organization and implementation, in coordination at all levels within the MOH, with the Viet Nam Women's Union, and with provincial governments. With the establishment of the VAAC in 2005, responsibility for overall coordination of the Project reverted from the RHD to the VAAC, to ensure linkages of PMTCT with other components of the National Strategy on HIV/AIDS prevention and control, as well as with other relevant PMTCT donor support (e.g. CDC/Life-Gap and GFATM). Other Project implementing partners include MOH departments of Planning and Finance, National Institute of Hygiene and Epidemiology (NIHE), National Obstetric and Gynecology Hospitals, Center for Health Education (CHE), Reproductive Health Centers, Provincial AIDS Committees in the five pilot provinces, Provincial and District People's Committees in the project provinces and districts, Mass Organizations and the Secondary Medical Schools in each of the five project provinces. The Project is financed entirely by UNICEF (around $1,000,000, not including management costs). UNICEF also provided Project planning, advisory, on-site training, monitoring and management support. A condensed monitoring and evaluation framework for the PMTCT Pilot is in Annex 1.

7. The Pilot component of the Project aimed to test and establish a model of PMTCT and VCT interventions operating in selected districts with high HIV prevalence that can be evaluated and contribute to nation-wide scale up of PMTCT activities by the GOV. The four-pronged approach is to be implemented at two levels: (i) at health facilities, where VCT will be integrated into ANC and care for women during labor and postnatal care, and ARV prophylaxis provided for HIV-positive women and their infants; and (ii) at the community level and household level, where awareness activities will promote best practices in HIV/AIDS transmission, prevention, and care and support to PLWHA. Comprehensive PMTCT services programming is sought through development of linkages and coordination within and external to the MOH for a continuum of prevention, care, treatment and social support services for HIV positive mothers, children, and family members. These objectives aim to achieve three key project results areas:

i. Women, their partners and adolescents use appropriate information to protect themselves against HIV/AIDS and to prevent transmission of the virus to their children

ii. Pregnant women and their partners and people of reproductive age (in particular adolescents) have access to quality VCT/PMTCT services

iii. HIV positive women and their children receive care and support (medical, nutritional and emotional)

8. Components of the PMTCT Pilot Project are planned for implementation across the four-pronged components of PMTCT. To achieve these goals, the Pilot design included: (i) project orientation activities, (ii) development of training packages, guidelines, and protocols; (iii) TOT for master trainer team at central level, and for provincial/ district trainer teams; (iv) an international study visit to Thailand for senior provincial and district health staff and community leaders to observe well functioning PMTCT programs; (v) training for district and commune health workers (HW) on VCT/ PMTCT, and for district and commune HWs and village health communicators (HC) on IEC/ BCC on PMTCT; (vi) integrate VCT/ PMTCT services into regular ante-natal care (ANC) and post-natal care (PNC) services at provincial and district hospitals and commune health stations (CHS); (vii) produce and distribute IEC/BCC materials for use at all levels, (viii) organize and facilitate community IEC/ BCC activities for PMTCT and community care and support; (ix) project management; and (x) monitoring, on-site training and supervision. The Pilot Evaluation Report documents an external evaluation, which took place as planned at the conclusion of the Project. A summary description of the Pilot project design and implementation processes is in Annex 3

II. EVALUATION METHODOLOGY

A. Objectives of the Evaluation

9. The MOH with the support of UNICEF Viet Nam commissioned an external End Project Assessment of the Pilot component of the Project to (i) identify which parts are working well, or need adjustment, and (ii) to provide information and recommendations to decision-takers on PMTCT activities currently implemented at the Pilot sites, as well as on PMTCT policy for targets/or strategies for the periods 2008-2010 and beyond. The assessment intends to provide a critical understanding of the outcomes, process and impact of the PMTCT Pilot in terms of efficiency, effectiveness, impact, relevance, sustainability and lessons learned following two and a half years implementation in 5 districts. Recommendations are offered about how the strategies, processes and activities could be improved, and about how the work can be monitored and evaluated in the future, including suggestions for scaling up of the activities.

As a participatory process, the end project assessment is intended to help all PMTCT partners to understand the strengths, opportunities and constraints of all aspects of the program, enhancing their collaborative efforts. Partners will be able to assess the implications of findings, which will enable them to implement and follow-up on relevant recommendations. The assessment is also intended to help UNICEF Hanoi to evaluate the impact of its support, and to prioritize areas for further support in the area of PMTCT in the period of 2008-2010 and beyond.

B. Evaluation Approach and Sampling Frame

10. The evaluation approach builds on the existing Pilot monitoring system and process evaluation in all 5 pilot districts, provinces and communes for periodic assessment and analysis.

11. A rapid assessment was carried out using reflexive comparison methods, which rely on the longitudinal study of the treatment group to determine the effects of the program over time. A matched comparison or case control design was not possible as it relies on selecting a comparison or "outside of project" control group to match the treatment group, but the only existing PMTCT-plus services are the UNICEF supported Pilot activities currently under study. A large quantitative baseline survey was conducted prior to commencement of the Project. However, formal comparative analysis of this baseline is beyond the scope of this assessment.

12. Interviews and group discussions were conducted with health managers, supervisors, trainers, obstetricians, pediatricians, midwives, counselors, village health workers, members of mass organizations, and the local political authority at provincial and district levels in each of the five pilot provinces/ districts Group discussions were conducted with pregnant women (PW) attending ANC, and individual in-depth interviews were conducted with HIV-prositive PW or recently delivered mothers using semi-structured question guides. Project partners at central level MOH and at UNICEF in Hanoi were also consulted. Pre and post-test scores provided quantitative data on participant knowledge and understanding of key training content prior to and immediately following Project activities. Logical framework analysis examined selected Project indicators to assess achievement of the stated objectives. Selected PMTCT indicator data from each pilot district was also collected and analyzed for trends over the life of the Pilot.

13. Drawing on the Project monitoring design, introductory meetings and interviews were conducted at the provincial reproductive health centers (RDC) and then at two commune health

stations (CHS) in each of five Project districts, purposefully selected to include "strong" and "weak" CHS in each Pilot district. Findings from these ten CHS were then measured against the baseline data. Client satisfaction surveys were conducted among ANC clients at provincial, district and commune levels. Data collection was carried out as follows:

(i). National level (RHD, VAAC, UNICEF, CDC, GF, Life-Gap)

(ii). One Pilot district to test question guides and observe PMTCT activities

(iii). Five Pilot districts/provinces

(iv). One "weak" or "remote" or not yet very well functioning Pilot CHS

(v). One "strong" or well functioning Pilot CHS

14. Semi-structured question guides for the various target audiences were pre-tested for appropriateness and revised. Data was collected from the provincial and district departments of health, and two selected CHS as follows: group discussions and separate interviews of health workers, village health workers, mass organization members, local authority officials, ANC clients, HIV positive pregnant women or recently delivered mothers, their partners and other family members, and community members attending IEC/ BCC activities on PMCTC. Details of the evaluation team, and an outline of the evaluation design and methodology is in Annex 2.

15. UNICEF provided specialist health sector and evaluation consultants to assist the field work and prepare the project assessment report for the MOH. The evaluation Terms of Reference is in Annex 6. A list of background material and reports are in Annex 7. Fieldwork took place from 27 November to 26 December 2007 in all Pilot districts/ provinces, along with meetings with other stakeholders in Hanoi. Details of the evaluation itinerary and list of provinces, districts and communes visited are in Annex 8.

III. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

16. **Policy Framework:** In key areas, the Project objectives and activities are aligned with Viet Nam's health development targets and priorities, particularly in Reproductive Health (RH) and HIV/ AIDS, the United Nations General Assembly (UNGASS) HIV/AIDS commitments, and Millennium Development Goals (MDGs). The Project complements GOV policies in addressing:

- *The Millennium Development Goals* (MDGs) – reducing maternal mortality and under five child mortality by three quarters (from the 1990 levels)
- *Viet Nam's Socio-economic Development Programme Targets for 2010* - including reducing Under 1 year and Under 5 years mortality; reducing maternal mortality and improving postpartum health
- *Viet Nam's Reproductive Health Goals* – improved reproductive health status by 2010; improved MCH and reproductive health access and service delivery; reduced maternal and child mortality through increased basic health services, education and counseling; and increasing knowledge, education and awareness.
- *Viet Nam's United Nations General Assembly (UNGASS) commitments* – made in June 2001 to "reduce the proportion of infants infected with HIV by 20% by 2005, and by 50% by 2010"

- *Viet Nam's National Strategy on HIV/AIDS Prevention and Control until 2010 with a vision to 2020* – signed into law in 2004, including PMTCT as one of the nine priority areas, and with implementation and scaling up of various activities beginning in 2005
- *Viet Nam Administration for HIV/AIDS Control* – established in 2005, responsible for policy and coordination of all HIV/AIDS activities administered by the MOH at all levels
- *Viet Nam National Plan of Action (NPoA) for Prevention of Mother to Child HIV Transmission (PMCT) 2006-2010 Period* - the NPoA was developed by the RHD with support from UNICEF (component one of the Project), and was approved in 2005
- *Decision No 3653/1999/QD BYT of the Minister of Health of Viet Nam November 15th 1999* - identifies Village Health Worker (VHW) responsibilities to include: (i) health education and communication, including carrying out IEC activities on health promotion, protection and community safety, (ii) community hygiene and health prevention, including community health education on food safety, good nutrition, safe water, parasites control, hygiene latrine, and participation in immunization and epidemic prevention activities; (iii) maternal and child health care, including ANC/PNC promotion and safe delivery options, child health monitoring, and family planning education and provision of contraceptives; (iv) first aid and basic curative care, providing simple care for accidents and injuries, common diseases, and health problems in the community, home care; and (v) carry out activities of public health programs at village level, including vital registrations and epidemics, and manage and properly use medical kit for VHWs.

17. The Project also supports key components of the National Strategy for Reproductive Health Care 2001-2010, which identifies 10 components of reproductive health care in Viet Nam: (i) IEC activities, (ii) safe motherhood, safe newborn and child care, (iii) family planning, (iv) safe abortion, (vi) prevention of reproductive tract infection, including STD/HIV/AIDS, (vii) adolescent reproductive health, (viii) prevention and treatment of infertility, (ix) prevention and early detection of cancer of reproductive tract, and (x) reproductive health for the elderly

18. **Needs:** Research by UNAIDS and UNICEF indicate that globally, in the absence of prevention measures, approximately one third of children with HIV-positive mothers will contract HIV during pregnancy, delivery or through breastfeeding. This risk can be cut in half if women are provided ARV prophylaxis and given safe alternatives to breast feeding. The risk can be reduced by almost three quarters if women receive both ARV prophylaxis, appropriate care at birth, and infant feeding counseling and support. To protect children, measures are needed to prevent HIV infection in parents and HIV transmission to children and HIV-positive parents. The National Strategy for HIV/AIDS control and prevention has identified PMTCT as one of the nine priority areas requiring immediate and sustained intervention. Recent comparative research on PMTCT in Viet Nam as well as pilot project monitoring has also found that PMTCT services are functioning below standard due to numerous challenges both in availability and access to quality PMTCT services. Some of the key constraints that have been identified include; (i) inadequate pre-natal, delivery, and post-partum services; (ii) low knowledge of HIV status among pregnant women; (iii) negative health worker attitudes; general stigma and discrimination; (iv) inadequate access to ARV prophylaxis, treatment and care; (v) inadequate follow-up care for HIV-exposed infants; (vi) inadequate availability and/ or access to infant replacement foods; (vii) lack of maternal knowledge that HIV can be transmitted from mother to child; (viii) lack of/ or inadequate pre- and post test and infant feeding counseling; (ix) referral and other practices that ignore confidentiality; (x) testing kits supply stock-outs, (xi) inadequate and/ or incomplete feedback, data recording and reporting; (xii) physical distance from services, including transportation costs; (xiii) cost for services; (xiv) fragmentation of services.

19. The National Strategy on HIV/AIDS Prevention and Control signed into law in September 2004 mandated the RHD to develop a Nation Plan of Action (NPoA) on PMTCT for the period of 2006-2010. The NPoA target is to contain mother-to-child transmission to below 10% by 2010, and to reach 90% of pregnant women with voluntary counseling and testing (VCT) services and provide prophylaxis to 100% of those testing HIV positive by 2010. Recently established Provincial AIDS Centers (PAC) are to act as the coordinating body for all HIV/AIDS activities, but operate in parallel to the provincial RHC, and their respective roles and responsibility for PMTCT remain unclear. These newly formed PACs are working within constrained budget by running one- or two-day seminars of 80 or more HWs. Information is provided in traditional format, mainly through lectures, some small group work and provision of printed materials on HIV/AIDS prevention, care and treatment under the new national policy. The MOH is well aware that more needs to be done to strengthen the capacity of health workers on VCT, as well as related care and treatment services to develop and support effective PMTCT services. Constraints include insufficient or poor coverage of donor support to GOV budget for training, equipment and supplies, lack of experiential learning opportunities such as study visits to model PMTCT projects, and limited participatory training capacity on PMTCT/ VCT, especially communication and counseling skills, among MOH trainers at provincial and district levels.

20. In the context of Viet Nam's low HIV-prevalence (concentrated epidemic), and low resource settings, the priority challenge for the GOV is to identify confidential, cost-effective ways of identifying the relatively few HIV-positive women early in pregnancy, and to establish efficient referral mechanisms to ensure timely and comprehensive care and treatment. The internationally recognized four-pronged approach to PMTCT offers a comprehensive model to mobilize community resources for IEC and BCC for increased awareness on PMTCT – including support for primary prevention and community mobilization activities to reach pregnant women for more timely access to local ANC and VCT services (prongs one and two) to compliment the existing VCT, care and treatment services (prongs three and four) currently supported by a donors mainly at the provincial levels. Prior to the UNICEF-supported Pilot, little was being done on IEC/ BCC to increase community awareness and mobilization on PMTCT and HIV.

21. To address these issues, the RHD, with the support of UNICEF Viet Nam developed a PMTCT pilot project in which a model was developed and tested for promoting the capacity of District Health Centers (DHC) in five districts with the highest HIV-prevalence in the country. Five districts, including 100% of the communes in each district – a total of 111 communes – were selected for the Pilot project. Participants received training in management of UNICEF supported projects, voluntary counseling and testing, IEC/ BCC training for improved awareness and community mobilization on PMTCT, and a study visit to Thailand to observe well-functioning PMTCT systems.

22. **Priorities:** The Project strongly supports the government's strategy for decentralization of authority to local levels, which also aims to build capacity among provincial health authorities to manage the complex array of programs and services they now oversee – at provincial, district, and village levels. Financial demands are unrelenting and, more often than not, sources of funding are varied, inadequate, and uncertain. Managing these demands requires increasingly sophisticated analytical, planning, and organizational skills. The Project acknowledged the approach of decentralized authority to peripheral levels of the health system, and in particular, the value of mobilizing community organizations and resources for improved PMTCT awareness through the IEC/ BCC activities. However, the Project design supports only to a limited degree at the provincial levels for supervision and monitoring, with the primary intervention for implementation provided directly at the district level. As such, the Project missed an opportunity for strengthening provincial level planning and management capacity for PMTCT. This became more evident during implementation. The Project is also consistent with UNICEF Viet Nam's program principles and strategic direction, which emphasize human rights and evidence-based approaches, gender equity and results based management.

23. The Project further acknowledged the importance of a partnership approach through Project Management Board and technical advisory members made up of representatives within the MOH as well as from the Viet Nam Women's Union. However, no such management board was established at provincial levels. As the sector restructured (approximately midway through the Project), the district health centers (DHC) were divided into three separate entities: DH, PMC and DHD, and with no clear mechanism for coordination of PMTCT (or other health activities in the district. As one PC vice chair put it, "it used to be very easy – I would just meet with the Director of the DHD, but now I must meet with three people." At almost the same time, the VAAC was established within the MOH as a parallel line department along side the RHD, and with no clear lines of authority or communication. Similarly, the PACs have been established in the provinces, and with a few the exception of HCMC where the PAC is long established and strong, have not yet become actively coordinated with the RHC on PMTCT.

24. **Financing:** Government state budget estimates for PMTCT capacity building activities according to the NPoA for 2006-2010 are over USD 30 million, with state budget allocations around USD 6 million and foreign assistance funding requirements are over USD 24 million. In Given limited GOV resources, the inputs for scaling up PMTCT activities need to be tailored to reflect GOV budgets. To this end, the Project design seeks to work within local resource levels, avoiding salary supplements, which virtually all the other large PMTCT projects provide and which run counter to any realistic potential sustainability of the PMTCT models being developed By providing support directly to existing structures, the Project avoids building donor supported PMTCT services which operated in parallel to the MOH system, which were observed in at least one Pilot district. However, with the possible exception of providing transport costs for evaluation study participants invited to the health center for interviews and group discussions, fees paid for project evaluation activities should be stopped, and replaced with more sustainable budget support to provide refreshments, in a similar manner as the VWU provides for meetings.

25. The Project design correctly gave priority to the DHCs and CHCs and to the PHC approaches applied which develop and strengthen the linkages between the health system and the community, particularly the training of VHWs, collaborators and members of mass organizations (Women's Union, Youth Union etc) to carry out PMTCT communication and community mobilization activities. Project stakeholders consistently gave the Project support to the IEC/BCC activities high ratings, and many considered the PMTCT communication activities to be the most important component of the Project. CHS's staffed with 5-6 HWs are typically responsible for areas with populations of 5,000 to 10,000 or more in rural areas, and reportedly up to 22,000 in some Pilot communes in HCMC. As such, the CHS relies heavily on their community health worker networks for community outreach. However, the design lacked sufficient flexibility to respond to the changing situation (para 18) to ensure committed involvement of the provincial health authorities, who were relegated to an ill-defined supervisory role, supplying staff to be trained as trainers, but with no planning or management responsibility. This was also reflected in the financial management arrangements, which by-passed provincial levels, and went directly to the districts. The exception was again HCMC, where the budget was successfully managed and dispersed via the HCMC PAC. The WB, ADB and other donors are funding large PHC loan projects across the country with low inputs of technical assistance to capacity building resources and delivery capability. UNICEF's support along with other donor grant assistance to this under-funded area will strengthen the PMTCT outcomes and impacts.

26. **Scope:** The Project scope was appropriate as it presented a pilot project approach to test a model implemented across all four prongs of the internationally recognized approach to PMTCT, and with a focus on CHS and a selection of high HIV prevalence provinces. The design also draws on traditional strengths of UNICEF, such as maternal and child health, IEC media development and HIV/

AIDS, and with strong participation from the community. However, the large geographical distance separating the three northern project sites from the two southern ones limited project monitoring trips to just quarterly visits and sometimes longer intervals without monitoring support to project sites. Risks also included the division of labor – requiring considerable coordination with other donors working on PMTCT, as well as managing the different levels and divisions within the health system to ensure comprehensive PMTCT services and supplies, including for example, referrals for testing, treatment, follow-up care and social support in the community such as access to infant formula by HIV-positive mothers, who are often poor, and whose husbands may have already died, or for contraceptives, including condoms, which are essential for primary prevention as well as for prevention of pregnancy among HIV-positive women (prongs one and two). The Pilot sites were all high-HIV prevalence areas with considerable donor supported HIV/AIDS prevention and care activities, many of which also supplied condoms. It will be important to examine future strategic options for taking the model to scale, for example, priorities based not only on local and regional HIV prevalence rates, but also on the potential for making linkages with other donor financed PMTCT activities.

27. **Implementation.** The Project supported the RHD, with corresponding units at provincial, district, commune and community levels where village health outreach workers link with the Primary Health Care (PHC) system of the MOH and under the overall coordination of the People's Party at each level. While this provided a strong policy framework and structure for implementation, it was a complex project for several reasons. First, it concerned two sectors – (MOH and Women's Union), multiple levels of services within the MOH system, and coordination among at least three major donors (UNICEF, CDC LIFE-GAP and GFATM). Second, the districts/ provinces lacked experience administering UNICEF-funded projects, which required additional financial management training inputs. Third, the VAAC was formed mid-way through the project, and made responsible for coordination and integration of all HIV/AIDS nationally, as well as at provincial levels via PACs. Whereas PMTCT had originally been under the direct leadership of the RHD, with a strategy for integration into ANC services. This lack of clarity about project objectives and coordination runs through the Project.

28. A fourth implementation challenge was a structural change within the MOH at district level, which split the former Health Center into three separate divisions – DH, PMC and DHD - each with its own director and staff. As stipulated in the NPoA, PMTCT is to be administered through the RHCs. The function in of the new district level structure is still being worked out by the MOH. The RHD has continued to administer the PMTCT Pilot under the MOH, and was well positioned with flexibility and authority to undertake the challenges involved in implementing the Project.

29. A highly competent Project Management Board was set up at central level comprised of the RHD, VAAC and the WU, further reducing risk. However, no such coordinating body was established in the Pilot provinces, and there remains a lack of clarity regarding the roles, responsibility and authorities of each of the project partners, particularly those of the provincial RHC and PAC. A fifth implementation challenge relates to the large distances between pilot project sites – chosen based according to high HIV prevalence rates, but which made it difficult to provide sufficiently close and regular monitoring that is required when introducing any new initiative. Finally, UNICEF's on-going support at the policy level (component one) which provides technical and policy guidance to the Pilot, is at the same time dependent on the policy guidance that should come as a result of the Pilot, all of which are necessary for success of the Project.

30. The Project aimed to develop a model to support effective functioning of PMTCT services under a system of decentralized health administration and management. Under the overall coordination of the Project Executors - RHD, and to a lesser extent, the VAAC, the Pilot implementation was generally

satisfactory. Direct training and experiential learning activities have strengthened the capacity of health workers, volunteers and community members for VCT, IEC and BCC. However, some of the provincial staff interviewed indicated that the process was too 'centrally planned and managed', and less inclusive and supportive of provincial level health managers, supervisors and trainers who, if they had been more involved in the planning and development of training materials and curricula specific to local training and target audience capacities, for example, in areas with large ethnic minority populations, this could have improved their level of enthusiasm, support and supervision of the Pilot project activities.

31. A team of master trainers were trained at central level to plan and facilitate the training activities. VWU and health staff were generally trained separately – and only in some districts were they trained together for communication skills TOT, which has been shown to be useful elsewhere in Viet Nam for partnership building for joint implementation in the future. Participants clearly benefited from the training and monitoring activities, which also provided a suitable framework for PMTCT policy learning at local levels, and for testing and refining capacity building approaches including specific measures aimed at changing prevailing attitudes.

32. **Formulation.** The Pilot generally followed the design that was formulated based on rapid assessment research conducted by the MOH and in consultation with UNICEF Viet Nam.

B. Project Outcomes

33. The evaluation process assessed how and to what extent project inputs benefited and improved (or otherwise) services to beneficiaries. Beneficiaries included pregnant women, their partners, families and community members living in the participating communes. Health workers and health volunteers at commune, district and provincial levels also benefited from project inputs, particularly from training activities, supported with equipment and supplies provision. Impact was assessed using both quantitative and qualitative tools and information. Annex 8 includes the evaluation team itinerary of the facilities, communes and districts visited.

34. **Clinical Data:** PMTCT services in all Pilot sites have been integrated into routine ANC services, and to some extent, are offered in coordination with general provincial HIV/AIDS programming, voluntary HIV counseling and testing services, and HIV/AIDS information, education and communication programs. From June 2005 to September 2007, more than 28,213 PW received counseling, 18,757 PW were tested during pregnancy and 49 PW were prescribed antiretroviral (ARV) prophylaxis in all five Pilot districts. Data showing progress in these key PMTCT performance indicators is summarized in Table 1. The indicators developed by the project are used to assess changes over time. All available clinical data is provided in Annex 12. In most cases there have been positive improvements in these indicators.

Table 1: Selected PMTCT Indicators

Project Indicators	2005 (Jun – Dec)	2006 (Jan – Dec)	2007 (Jan – Sep)	Total
Number of Pregnant Women (PW)	14,771	14,884	9,876	39,531
Number of PW attend ANC regularly (more than twice)	8,270 (56.0%)	12,716 (85.5%)	7,227 (73.2%)	28,213 (71.4%)
Number of PW received pretest counseling	8,270 (100%)	12,716 (100%)	7,227 (100%)	28,213 (100%)
Number of PW got voluntary HIV testing during pregnancy	5,270 (63.7%)	8,110 (63.8%)	5,377 (74.4%)	18,757 (66.5%)
Number of HIV Positive PW received testing during pregnancy	22 (0.42%)	42 (0.52%)	16 (0.3%)	80 (0.43%)
Number of HIV-positive PW received ARV prophylaxis	12 (54.5%)	27 (63.3%)	10 (62.5%)	49 (61.25%)
* Data source from the 5 pilot districts				

35. The overall impact in key PMTCT indicators across all districts/ provinces has been strong with demonstrable improvements in rates of HIV-positive PW under management of the health services (all districts), increasing percentages of PW receiving pre-test counseling (all districts), increasing rates, but to a lesser extent, of PW accepting voluntary testing for HIV; and a potentially low rate of sero-conversion among those infants exposed to HIV - of the 54% tested so far at 18 months, 100% are confirmed negative. Tables 2 and 3 (below) summarize key PMTCT and MCH follow-up care performance indicators at district/ provincial levels:

Table 2: Prevention of Transmission from Mother to Child – By District

Number of HIV positive PW	Cao Loc (5 mothers)	Thuy Nguyen (17 HIV positive mothers)	Uong Bi (14 HIV positive mothers)	Tan Chau (21 HIV positive mothers)	HCMC (41 HIV positive mothers)
Number of PW received ARV prophylaxis	3 (60%) (1 Delivery at home, 5 month pregnancy without treatment	17 (100%)	3 (75%) (1 got the test during labor at Uong Bi hospital there fore the treatmen status is unknown	17 (80.9%) (4 cases lost)	11 (26.8%) (25 cases lost, 1 miscarriage, 1 re-tested with neg. results, 1 delivered on the way, 2 tested at post partum)
Number of newborn received ARV prophylaxis	4 (100%)	17 (100%)	0 (unknown)	19 (86.4%) (1 twin, 1 whose mother tested at delivery,not yet receive ARV	13 (37.1) (2 tested at post-partum)
Number of Infants received Cotrimoxazol	1 (25%)	17 (100%)	3 (75%)		13 (37.1%)
Number of positive women lost track	2 (40%)	1 (5.3%)	KB	4 (19%)	25 (60.9%)

Table 3: Follow-up of Infants Exposed to HIV

Number of children born to HIV positive mothers	Cao Loc (4 children)	Thuy Nguyen (17 Children)	Uong Bi (4 children)	Tan Chau (19 children)	HCM (13 children)
Number of children have HIV negative results after 18 months	1 (25%)	3 (17.6%)	3 (75%)	14 (73.7%)	10 (76.9%)
Number of children not yet reached 18 months	3 (75%) (2 not yet reached 18 months 1 not confirmed)	14 (82.4%)	1 (25%) unknown	5 1 not confirmed 4 not yet reached 18 months	3 (23.1%)
Number of children not breast-fed	3 (73%)	15 (88.2%)	3 (75%)	14 (73.7%)	13 (100%)

36. Improved rates overall were reflected in levels of awareness and understanding on PMTCT and HIV/AIDS among pregnant women surveyed at facility level (Table 4 below). The complete findings from the KAP and Client Satisfaction Survey can be found in Annex 10.

Table 4: Levels of PMTCT Understanding among Pregnant Women

	Cao Loc N=33	Thuy Nguyen N=28	Uong Bi N=32	Tan Chau N=59	HCM N=15
Correct understanding on HIV transmission routes and prevention	63.6%	96.4%	90.6%	66.1%	100%
Insufficient understanding	15.2%	0%	6.3%	8.5%	0%
Incorrect understanding	0%	0%	0%	0%	0%
Don't know	21.2%	3.6%	3.1%	25.4%	0%

37. Positive outcomes and indicators cannot be attributed exclusively to the Project. However key informant interviews in many districts and communes referred specifically to the important and highly effective role of the IEC and BCC activities carried out in the communities, which have been crucial not only for reaching and offering voluntary testing to increasing numbers of the HIV-positive pregnant women, but communication activities have also influenced increasing rates of PW attending ANC services, as well as improved PMTCT awareness among ANC clients in general. The DOHs also reported they intended to continue the Project initiatives after UNICEF support finishes, and in at least one case (Quang Ninh), scaling up of PMTCT to three new districts is already underway, and HCMC has scaled up their PMTCT program to all districts in the city, confirming the ongoing benefits from the project initiatives and outcomes.

38. Taken together, these findings indicate consistent longitudinal improvements in PMTCT services, MCH and health seeking behaviors at commune and district levels, suggesting direct effects of specific interventions (including GOV policies, and of the Project. Existing training structures, community-based communication activities and local leadership involvement are preliminary indicators of sustained outcomes and support high priority that should be given to capacity building for VCT, IEC/BCC and community mobilization as PMTCT is scaled-up.

39 The evaluation of implementation is based on (i) selected indicators set at Project inception, (ii) findings from the Project Monitoring Reports, and (iii) field visits conducted by the evaluation team. The Project outcomes as anticipated at inception were as follows:

i. Knowledge and skills of communities on HIV/AIDS prevention and PMTCT increased

40. Increased knowledge and skills was a major objective of the Pilot and the evaluation indicated evidence of increased awareness on HIV/AIDS prevention in general and PMTCT in particular, as well as reported decreased levels of discrimination of PLWA by the health staff and in the project communities:

> "*There is no longer discrimination to HIV infected women because they are pitiable. In my opinion, they are similar to every other woman, so it is unfair if we keep away from them.' (FGD PW at Thuy Nguyen District)*

> *"Nowadays, through several ways of HIV communication such as video, newspapers, radio, everyone is possible to understand and sympathize with whom infected HIV from their husbands." (FGD communicators at Hop Thanh commune, Cao Loc District)*

41. Some examples include increased participation of VWU and YU in HIV/AIDS and PMTCT communication and community mobilization activities; increased numbers of PW presenting at ANC and accepting VCT; early identification of HIV+ PW due to increased awareness on HIV/AIDS PMTCT in the community, and intervening early to educate mothers on PMTCT and on the need for ANC/ and the benefits of early testing /VCT to know their HIV status, and that ARV treatment is available for free. The resulting increase in service utilization and increased community knowledge has led clients to ask more questions about HIV-related maternal and child health. In addition to helping improve community knowledge about PMTCT and HIV/AIDS, the IEC/BCC activities have improved the relationship between the health service and the community (particularly the VWU) for improved health behaviors and improved community participation in monthly commune meetings on general health information.

42. **IEC Materials:** The RHD, in collaboration with the Center for Health Education (CHE) developed a set of IEC materials for PMTCT, including two versions of leaflets, two posters and a 14 page PMTCT flip chart. The materials are very appropriate, practical and helpful, and all Pilot sites reported a shortage of IEC materials, especially the leaflets, which are popular with PW and reported to provide useful information and provide them with sufficient knowledge to speak with their husband about PMTCT and HIV testing:

> "*I have been provided leaflets introducing about the transfer of HIV from mother to child. They are very helpful as they provide a lot information and taught me how to inform my husband." (FGD PW in Vang Danh, Commune, Uong B District)*

43. Project communication strategies address key PMTCT related issues including: primary prevention of HIV/AIDS for the community; uptake of PMTCT prevention such as VCT, ARVs, infant feeding practice, involvement of men, youth, PLWA and reduce stigma and discrimination for HIV/ AIDS. However, the IEC materials provided are viewed to be only for women attending ANC services, and not necessarily for wider community, particularly men, who typically view PMTCT as something exclusively for women. Other than a clear depiction of couples attending ANC in leaflets and posters, men's involvement in ANC and PMTCT is rarely promoted. There is also a lack of PLWA involvement

in the communication activities, and although communicators have been trained and mobilized from different community groups and organizations (VWU, YU, PCFC, VHW), it is primarily the VWU who are actively conducting PMTCT communication in the communes. The VWU are extremely enthusiastic and active on PMTCT – not only for awareness-raising, but also community mobilization for care and support of PWA in the community, and in collaboration with groups such as the RC, PCFC, and the local authorities. However, the lack of male involvement in community mobilization further promotes the idea that PMTCT is only for women, specifically PW and women of reproductive age.

44. **Training and Supervision** Project training curricula on VCT and BCC were developed at the central level RHD and CHE/MOH, and sent out to the pilot provinces. TOT training on VCT and BCC established core PMTCT trainer teams in each pilot site, including trainers from province and district levels. The pilot project supervision system was set up only at district level, with a limited role for provincial level management support and supervision. Instead, the purpose of the training and supervision intervention was to improve the quality of PMTCT in the district health facilities through a combination of direct training in specific skills and the development of sustainable training and supervision capacity at each pilot site.

45. Twenty-four provincial and district trainers and 1,073 health staff (district and commune) were trained on VCT, 22 provincial and district trainers and 2,921 communicators and health staff were trained on BCC, and 22 provincial and district trainers and 207 health staff were trained on IYCF in the five Pilot sites. The training and supervision intervention of the PMTCT project has been highly successful in terms of training capacity development in each project province, although less successful in terms of building provincial planning and management for PMTCT training, and has been highly valued by trainees and stakeholders interviewed by the evaluation team. However, additional refresh-training and training for replaced and retired trainees is still needed. Health workers interviewed consistently recommended that the PMTCT pilot model supported by UNICEF should be continued in order to assist the MOH, specifically at the provincial level to improve the capacity and function of the decentralized PMTCT training and supervision system. Details on the Project training courses and activities are in Annex 3

46. Project training on IEC and BCC was short in duration (5-7 days), and in some cases, up to 50 people per class were reported by YU participants – due to "training budget constraints" according to the DHD. And despite project criteria provided to identify appropriate people who can work as health communicators (HC), not all of those recruited for the training can actually commit the time to carry out the PMTCT communication activities in the community. It was also suggested that more training time should be spent on practicing skills on using a flipchart, and to have better follow-up after the training course to monitor and support HCs in the community.

> *"The Project aimed to train so many people but they can not function as communicators as they are incapable and they do not want to carry out such task. Therefore, it is necessary to select proper persons to train to carry out the task to save money and time." (FGD with health communicators at Quang Trung Commue, Uong Bi District*
>
> *'After the training course, the trainees should be divided into small groups to monitor and supervise them and give support in timely manner and suggest content to be further trained." (FGD health communicators in the Hop Thanh commue, Cao Loc District)*

47. Almost all of the CHS health staff in project districts received one training course on counseling skills for PMTCT. The training courses were assessed very positively by the trainees, who indicated

many benefits of the training for their day to day counseling work, including good opportunity in the training course for practicing the steps of the counseling process and implementation guidelines according to the MOH counseling protocols. They also benefited with communication skills practice, including skills practice on effective use of a flip chart and leaflets. Health workers trained in VCT reported that the duration of the training was too short, there was insufficient time for practicing skills, and that refresher courses are needed that focus on counseling skills, especially for post-test counseling with a positive result.

> *"Training time for health staff is so limited, a five-day training course including the time for material editing. As a result, the quality of the training course on voluntary test counseling remains low." (FGD supervisors and trainers at Quang Ninh Province)*

> *"We wish to attend more training courses as we only attended one course when participating in this project. We face a lot difficulty in counseling, especially with HIV-infected persons regarding post-test counseling. Hence we need more training courses on this skill." (FGD with health staff at Dong Dang Commue, Cao Loc District)*

48. Health staff benefited from the PMTCT activities in terms of improved management and communication skills, and with opportunities for sharing and learning experiences with the other colleagues. The Project communities have benefited by reducing the numbers of HIV-infected children, improved community knowledge on HIV/ PMTCT, especially among women, and bu initially attracting attention to the importance of male involvement in issues related to HIV/AIDS.

> *"Taking part in such a project, everyone in the commune can gain a lot of benefit for themselves, for example, getting more knowledge, improving skills in communication and so on. In conclusion, it is good for their work as well as helping them educate their children."(FGD communicators at Hop thanh commune, Dong Dang District)*

> *"After the performance of PMTCT project, pre-counseling for PW before HIV testing has been effective in helping them to get more knowledge on HIV. PMTCT not only focuses on PW, but also directs special attention to the husbands." (FGD – communicators at Vang Danh Commune, Uong Bi Dist.)*

ii. Voluntary Counseling and testing (VCT) services available for women and men of reproductive age, particularly adolescents

49. **Availability:** Voluntary Testing and Counseling (VCT) services have been established in all Pilot districts and communes, and 100% of PW go to the ANC for check up, to receive pre-test counseling, and the number of PW who agree to take the blood test for HIV is increasing, although rates of PW accepting HIV testing after receiving pre-test counseling vary, and there is conspicuous a lack of men and adolescent up-take in the VCT and PMTCT activities.

> *"Coming to the ANC for a pregnancy test, I agreed to take blood for HIV test after reasonable counseling from the health staff. Almost all of PW who come to test agree to take blood for HIV test due to helpful and reasonable counseling.' (FGD, PW at Cao Loc Dist, Dong Dang commue)*

50. **Quality of Services:** Concerns were identified by project staff during the monitoring that pertain to the quality of VCT services, including the generally low quality of counseling, both pre-test counseling, which mainly supports knowledge for PW, and post-test counseling, and which, if

carried out by a senior counselor, is done according to standard, but if carried out by other CHS HWs, post-test counseling is particularly weak for both negative and positive results. For example, in Uong Bi, PW were informed of their negative test results without any further information, and when conducting HIV testing early in pregnancy, every PW is advised to be re- tested every 3 months (window period) without any personal risk assessment:

"In case the test shows negative result, health staffs only tell me and advise me for good development of the pregnancy." (FGD PW at Thuy Nguyen Dist, Hoang Dong commune)

"In case the test shows negative result, health staffs also stabilize my mind, and confirm that there is no serious problem. But advise that I should have the second test in the 8th month of pregnancy." (FGD, PW at Vang Danh Commue, Uong Bi District)

51. Health staff at CHS level find counseling for positive results difficult and time consuming, and usually need support from the district, or in some cases, the CSH head can provide quality post-test counseling. In cases where HIV status was known only at the time of delivery, doctors at the hospital have reportedly informed the positive result of the HIV test directly to the relative of the PW while still at the hospital, and the focus has been mainly on the medical interventions:

"I gave birth to my child in Uong Bi hospital and I was tested with HIV. After giving birth, the doctor did not tell me anything, but he informed my mother about my HIV status and then my mother told me." (Interview with positive-PW, Uong Bi District)

"Cases infected with HIV show difficulties in post-test counseling because they want to keep secret their HIV infection. There are cases where we must visit for at least ten times before we were successful" (Interview with health staff in Uong Bi district)

"When we went to the health station antenatal test, health staff gave us lot information about HIV, told us take blood specimen for diseases test including HIV. We just obeyed what the doctor told." (FGD with P W at ANC Thuy Nguyen District

52. All CHS and district staff interviewed expressed strong preference for building CHS capacity for providing counseling services at the commune level, rather than relying on a mobile team of specialized district counselors, and cited a variety of reasons including: CHS better local knowledge and proximity to the population, ANC client convenience, and the limited supervision visits per month that would provide only ' temporary counseling' on their twice monthly visits to the CHS, some of which now offer ANC services every in order to reduce the large caseloads. In the pilot sites, 100% of the CHS staff, and a large number district staff were trained on VCT, many of whom do not provide counseling in their normal daily jobs. Clearly, the cost for training the 10,000 or more existing CHS staff nationwide is prohibitive, and it will be necessary to clearly identify the essential staff who actually do the counseling, and to carefully monitor proposed training lists to ensure that the criteria for selecting the trainees is strictly adhered to. The quality of VCT services offered, particularly at commune level, remains weak for a variety of reasons, including: high HW workload in general, weak counseling skills, insufficient time to provide quality counseling to the large numbers of clients on ANC days; particularly for post-test counseling – which is rarely done for negative results and supervisor assistance is often needed for positive results; limited or no private facility for conducting pre-and post-test counseling, and insufficient facility for using the TV and VDV supplied by the Project for group counseling.

"ANC activities only operate in one day per month therefore the Station is often so crowed. We come

to get antenatal care, prevention injections, and HIV/AIDS, PMTCT counseling from nurses. If anyone wants to have a blood test, her blood was extracted to test. Anyone who has tested once already, it is not necessary to do again… When we received our test result and saw that we were fine, staffs of Station told us to return back home, do not worry and appointed that as soon as delivery, we come to test again to know definitely." (FGD with PW at Vang Danh Commune, Uong Bi District)

"After training on counseling and voluntary HIV testing, we started to counsel about HIV-test for pregnant women who came to take examination at commune health station. At the beginning, there is a lot of difficulties and officials of district hospital come to assist, especially at antenatal care days. Monthly, we have reports based form and sent to the section of PMTCT program management at district hospital" (FGD health staffs, Le Chanh, Tan Chau District, An Giang)

"Taking part of PMTCT program, we have trained on communication, then we came back to commune to implement communicating according to materials which we have been received and guided at training courses. We have a meeting monthly with the head of commune health station to hand in reports based form and discuss on the communicating contents that we had done. If there are any difficulties, the head of commune health station would give assistance. Our direct supervisor is the head of CHS" (FGD communicators, Minh Tan commune, Thuy Nguyen district)

53. Testing: Although the numbers of PW receiving pre-test counseling has increased dramatically, the rate of voluntary HIV testing has not increased to the same extent. Discussions with groups of ANC clients offered some of the possible reasons for this, including: PW change their mind because they have come back the ANC at another day, and there is often only one day per month for HIV testing; they change their mind because they have to discuss with their husbands first; their husband didn't agree because he thinks they do not have risk behavior to get HIV; Some women think that because they already received an HIV test for their first delivery, they do not need another one for the second delivery; some think they don't need the HIV test during their pregnancy because they intend to deliver at the hospital, and the hospital will test them again even though they have already had a HIV test result during their pregnancy.

54. The systems for maintaining test results confidentiality varied across districts. HWs interviewed in Tan Chau explained that their testing procedures do not use a specific code for blood sample testing. Instead, they record the name of the client after obtaining agreement, and transfer the sample to the DH for testing. If they do not accept, they transfer the sample to a VTC center operated by an NGO for testing. Elsewhere, the blood samples are labeled with an encrypted code and in the record books of the health centers (Cao Loc, Thuy Nguyen, Uong Bi). In contrast, HCMC has set up a coding system for all the districts and communes city-wide.

"Blood specimens sent by health centers to Stand-by Health Centre are numbered and labeled; therefore, they will ensure the privacy. As the results are returned to commune, only health staff in charge can know and continue to consult PW positive." (FGD health staffs at Minh Tan Commue, Thuy Nguyen Dist)

'I think that the information about HIV test results of women is kept secret in the medical station. We all visited medical station for antenatal test during pregnant period and we did not hear any information about HIV test result of other women so I believe and think that information is secrete. (FGD PW at Dong Dang commue, Cao Loc dist)

55. In at least one CHS, blood test records and even labeling of blood samples were observed

with names and addresses written directly on the test tubes - as well as a numbered code. One CHS HW explained that this was not a problem because "*there are many names and nobody cares and anyway only the lab techs will see it*." In contrast, a CHS in HCMC was observed using a sophisticated coding system, trained and set up by another donor project, apparently working well, and provides appropriate confidentiality.

56. The financing of rapid test kits when UNICEF support finishes was a concern expressed by DOH officials interviewed. Stock-outs of test kits were reported in some cases, particularly in Uong Bi, where the guidelines for re-testing following the 'window period' provided by the Project are not being followed or are not clearly understood, and in their zeal to cover everyone thoroughly, the CHS counselors did not screen for high risk populations, but rather tested all ANC clients at least twice, and often three times during their pregnancy. While staff turnover has been an issue in Uong Bi and elsewhere, there is a need for closer supervision and monitoring of the VCT services in the CHS. Most of the CHS visited request a second test only for pregnant women assessed as having high risk behaviors). However, CHS visited in Uong Bi generally counseled all of the PW presenting at ANC to have a second or even third test, apparently without any assessment of risk factors – before delivery (about the 8th month of pregnancy)

iii. VCT available for pregnant women and their partners, integrated into ANC services

57. VCT services have been integrated into general ANC services, which also include EPI, nutrition and Family Planning services, usually conducted all on the same ANC days, once or twice per month. Although 100% of the CHS staff in project districts received training on VCT, the number of CHS staff is limited, and the tasks of ANC day are divided among the CHS staff, and only one, usually a midwife, does the counseling – and with rarely sufficient time to do quality counseling on these busy ANC days. Group counseling for PW on the busy ANC days, with individual counseling reserved for HIV-infected PW or individuals with high risk behavior. The volume of couple counseling (husband-wife) is still limited due to the typical ANC priority emphasis on PW. The men that do arrive with their wives usually wait outside, and usually do not participate in the counseling. In HCMC, twice each month on the ANC days, the district MCH/RH team (from district PMC) draw blood and assist group counseling for PW at the CHS. CHS facilities are generally poor, with limited space, and often no private room for counseling. In some CHS, counseling is carried out in the same room designated for the ANC examinations.

> *"When we went to the health station antenatal test, health staff gave us lot information about HIV, told us take blood specimen for diseases test including HIV. We just obeyed what the doctor told." (FGD with P W at ANC Thuy Nguyen District*

58. Some CHSs have arranged for more ANC days per month, or even daily ANC which seems to help reduce the daily case load considerably. Other CHS prefer to schedule all the services as usual, on the same two days per month when the district supervisors from PMC come, particularly in the sentinel surveillance sites, and this also saves the CHS the time and expense of transporting blood samples to the district for analysis.

> *"ANC activities only operate one or two days per month and therefore the Station is often so crowed. We come to get antenatal care, prevention inject, and HIV/AIDS, PMTCT counseling from nurses. Anyone want to have a blood test, her was extract her blood to test. Anyone has tested once already, it is not necessary to do again… When we received our test result and saw that we were fine, staffs of Station told us to come back home, do not worry and appointed that as soon as delivery, we come to test again to know definitely." (FGD with PW at Vang Danh Commue, Uong Bi*

District)

iv. Identified HIV positive women and their newborn receive ARV prophylaxis for PMTCT and care at delivery and post-partum

59. The ARV prophylaxis is available and provided to HIV-positive PW in the pilot districts, but the number of woman receiving prophylaxis is limited due to missing cases after HIV testing, particularly in HCMC, where high risk, mobile populations are difficult to track (give false names, false addresses), and in some remote areas, for example, Cao Loc district, which is 90% ethnic minority, and has some women are delivering at home. Traditional birth attendants (TBA), a locally trusted community resource in remote, ethnic minority (EM) areas, were not involved in the IEC/BCC training, and should be considered for future PMTCT scale-up in the EM areas.

60. One PW interviewed reported that after delivery at the district hospital, health staff there informed her relatives about her HIV infection (Uong Bi), and in another case, DH health staff actually made a phone call to inform the CHS in the woman's hamlet (Tan Chau). In contrast, the standard practice according to CHS staff interviewed in HCMC, the counselor only informs directly to the client infected with HIV, as part of the counseling process (Ho Chi Minh City)

v. Follow-up of HIV positive women carried out by health workers

61. Health staff provide careful follow-up of HIV-positive women, and in close collaboration with their networks of communicators to provide community-based support to HIV-positive women – but to an extent sometimes that strains the balance between adequate follow-up services provision, and the HIV-positive client's need for privacy. Although PW interviewed expressed their appreciation for follow-up support provided by the health staff, there was sometimes a discrepancy between the HW assessments that HIV-positive women tend to be very open about their HIV status, while many of the PW themselves would like to keep their HIV status confidential – and, for example, were not always appreciative of unsolicited house visits.

> *"There is only a case infected with HIV, however, she does not want to disclose to anyone else but a health workers who take her blood for testing. For that reason, our communication team do not come her home for encouragement…..only after a meeting in the health stations of the commune, we were informed of the fact …" (FGD communicators at Hoang Dong commune, Thuy Nguyen District)*

> *"When testing in the commune health center, my HIV positive is kept secret. However, the fact is disclosed as I give birth in the district hospital and I feel very sad and disappointed for the bad rumor from health center of the hamlet."(in – depth interview Mother positive at Le Chanh commue, Tan Chau District)*

62. The degree of misunderstanding between counselor and communicator roles varied across districts, for example, in HCMC, the long-established PAC provides strong administrative and technical guidance for HIV/AIDS and PMTCT, and health staff report closer attention being paid to confidentiality issues. Whereas in other districts, HHWs and VWU communicators were actually informed by the CHS staff which women in the community were HIV-positive. The CHS explanation given was "they need to know which women are infected so that they can provide counseling." It is not easy to keep secret for HIV infected cases because of the necessity in coordination among different organizations, assisting tuition, milk from VWU, and so on.

> *"We were informed by a health staff that a woman in my hamlet is infected with HIV; therefore, we contact her after giving birth to support her mentally, give advice and encourage her." (FGD Health*

communicatos in the Minh Tan commue)

"Women Union of the commune has conducted various activities focusing on HIV infected women such as supporting milk, mental encouragement, persuading them to participate in clubs etc., VWU has organized activities at their home to encourage, take care and give gift to infected cases. Moreover, we also combine with the health station of the commune in these activities." (FGD communicators at Long phu Commue, Tan Chau District)

63. Some creative solutions to the confidentiality issues have been introduced in HCMC. For example, PWA are typically poor, and the WU can raise support in their community to assist. But instead of going directly to the home of the PWA, they give the gift to the CHC staff, who in turn, pass it along to the PWA. In this way, the WU communicators do not need to be given any information (no names or addresses given) that would identify the PWA. Another strategy is to provide follow-up counseling and support by telephone, and it was suggested that if a 24-hour telephone hotline service could be set up, this would provide a very useful, anonymous service. Still, however, the confusion between communicator and counselor roles indicates a need for closer supervision to ensure the guidelines for confidentiality are being followed, and to ensure that the roles and responsibilities of HWs and HCs are clear. HWs are trained to provide the VCT/ counseling, and the HCs are to provide health information. The VWU's strong enthusiasm simply to help may be one reason for over-stepping their HC responsibilities. Perhaps the HCs need clearer job descriptions, as well as explicit instructions to refer difficult cases to the CHS, or to community-based services and clubs for counseling. In response to this, and as a means to also build a stronger relationship between the health sector and the community, one CHS Head felt that health communicators and counselors should be trained together so that they may plan together and assign clearly each one's role and responsibility for PMTCT activities:

'"One of the difficulties I consider to be important for counseling and communication activities is the lack of unity of information on HIV/PMTCT between counselors (CHS) and communicators (HCs). So, sometimes, we have difficulties collaborating. I propose that it is better to have common training courses for both health staff and communicators to unite common skills and activities, rather than the separate training courses [HWs trained separately from HCs]."(IDI Head of CHS at #10 commune, #6 District)

64. Support in terms of budget and local resources depended on involvement of individual PCs and district leadership. Local political and management support for project activities is a crucial factor in sustainability of any development assistance project. In many areas, local PCs were closely involved in community health activities and supported mass organizations and volunteer networks (often through the CPC health sub committee process and raising funds for special assistance projects). In these areas, the results were evident – financial support for CHS, such as the provision of infant formula and transportation costs for HIV-positive women and their children to access treatment at district hospitals. In areas where the political and mass organizations were less committed, for example in city level HCMC, the relations between the health sector and VWU varied, with limited funding, and training opportunities restricted. This suggests that stronger central support and advocacy for training at provincial level is necessary to ensure broader implementation and continuity of training and other project initiatives.

vi. HIV positive women receive support on nutrition

65. Some HIV positive women interviewed reported receiving counseling on replacement feeding, including information about the risk of HIV transmission through breast-feeding, the advantages and disadvantages of infant feeding options, and referral to other organizations for milk

for their children:

> *"After discovering that my HIV test result is positive, doctors instructed me carefully how to bring up and take care of my child. After returning home, doctors from district and commune hospitals visited me and guide me how to take care of my child and advised me not to give suck to him and introduce me to ask for milk."* *(PVS positive mother at Uong Bi District)*

> *"After giving birth, the doctor told me about the risks of HIV infection when feeding child At the same time, he also guided me how to feed the child in the best way. We are in poor condition, so we could not buy milk for our children but only breast feeding for the first 4 months."* *(PVS Positive mother – Uong Bi District)*

66. Other HIV-positive women interviewed expressed concerns about discrimination related to replacement feeding:

> *"Upon acknowledgement of HIV infection and getting protection drug from doctors of the maternity hospital, along with advice not to breast feeding for preventing HIV infection to the child. However, I still keep secret even though there are people who asked me whether I get infection or not. I told them that I was not, and that it was only because I am taking large doses of antibiotic drugs so the child could not suck"* *(In – depth interview – mother positive at Hoang Dong commue, Thuy Nguyen District)*

67. Another HIV-positive woman interviewed said that after delivering at the hospital, she received no counseling on infant feeding, but that the doctors and nurses advised her to use exclusive replacement feeding. Although the PMTCT services provided in the five pilot sites do not provide milk for the children exposed to HIV, each site successfully collaborates with other projects in the area to provide milk for the children for up to 12 months. In another case, the DH approached the district PC to provide replacement foods for one particularly poor mother. Importantly, the vice chairs of the PC in each project district were involved from the start of the Project in PMTCT sensitizing workshops, as well as the international study tour to Thailand.

vii. Appropriate referral to ARV treatment sites (when needed) and to psycho-social support initiatives available for HIV positive women and children

68. HIV-positive women interviewed reported receiving regular monthly growth monitoring of the children, check up on feeding practices, and psycho-social support for themselves and their family members:

> *"After giving birth to may child, I took my child to health station every month to check his weight and have medicine injected. Doctors show their care to me and my child and they often support us with money or milk for my child."* *(HIV positive mother in Minh Tan Commune, Thuy Nguyen Dist)*

> *"After my delivery, a doctor at Hung Vuong hospital gave a seri of addresses where take care and assist HIV-infected patients for me to choose somewhere to check my health situation. Then, I chose An Hoa centre because it is convenient to me. I often come there monthly to receive pills and exam periodic health"* *(HIV-positive mother in #11 commune, #6 District, HCMC).*

> *"After giving birth at Uong Bi hospital, I had been HIV-tested and discovered being HIV-infected. Afterwards, I registered to get health examination to consider I have to get treatment or not but I have not been received any treatment at Uong Bi hospital yet.*

"My homeland is Bac Giang, my parents were so worried that they registed at Bac Giang for me. At the moment, I take pills at Bac Giang and come down there monthly. It is rather hard to travel" (IDI mother positive in Uong Bi district, Quang Ninh).

"After I had given birth yet, the staffs of hospital introduced me a HIV-infected cases room (supported by FHI Project) to take health examination and HIV/AIDS treatment. Now, both of my husband and me are being treated at this room. Monthly, I come there to take pills to drink. Not only pills, I slso received powdered milk for my baby regularly. Generally, it is enough milk to my baby" (IDI mother positive in Long Phu District, Tan Chau, An Giang).

69. **To maintain PMTCT services after UNICEF leaves**, most of the CHS HWs and district health authorities interviewed agreed that the management unit for PMTCT project regulation should be the PMC, as stipulated in the NPoA, and should act within the MOH system to be the unit responsible for management, performance and supervision of all PMTCT activities. One notable exception was Tan Chau DH, which is well supported by an international NGO which provides comprehensive care and treatment services for HIV/AIDS and PMTCT. However, this model of PMTCT managed at the DH is not considered by the evaluation team to be either sustainable or replicable to other districts without considerable, on-going external support. In Thuy Nguyen district, both the DH director and the vice chair of the district PC strongly advise that PMTCT belongs in the PMC existing structure at all levels of the provincial health system. Coordination workshops to clarify the roles and responsibilities of each division in the new district structure are being planned in most districts, with considerable optimism expressed by both the MOH authorities and the local PC representatives that this issue will be worked soon.

70. It was also broadly agreed that the PMTCT program should be conducted in combination with other reproductive health activities, but it is less clear as to how the coordination will work with the new PACs that have recently been set up along side the RHCs in each of the provinces. Refresher training should also be provided each year to improve the quality of pre- and post-test counseling on HIV. Many also expressed their belief that if the counseling quality is strong and professional, there will continue to be increasing rates of PW who are aware of the importance of HIV testing, and with this raised awareness, there will be increased numbers of PW who are willing to pay for the HIV test. The districts also strongly agree on the value and importance of improving HW and HC communication quality in general and in particular for PMTCT community-based communication activities. Plans are being made to organize annual training courses to improve communication knowledge and skills for the communicators in the community and to establish monthly supervisory and monitoring support for the communicators.

"To support and maintain effective performance of PMTCT program, the management unit's regulation agencies should be located in the Preventive Medicine Center because of the fact that this is an action of protection but not of treatment. The Center needs to maintain this activity even if getting a sponsor or not. So, in my opinion, I think that it is not very suitable to conduct the project in hospital and the hospital should only take position as drug supplier (Interview Head of CHS at Minh Tam CHS Thuy Nguyen Dist)

"PMTCT project should also be conducted in combination with the work of reproductive health care. In fact, the reproductive health team often works together with us in various activities and the PMTCT activities are part of the work. Even if it is not supported as a project and we are still able to conduct smoothly." (FGD – Health staff at the Minh Tam commune Thuy Nguyen district)

"After the project is finished, and as the activities are still being made by each person, I think it is

common sense, because the project creates a routine of activities for everyone But the biggest challenge is: whether PW should pay for HIV testing fees because at the moment, they are tested with no testing fees. But I think that if we make counseling better, they'll perceive better about its usefulness and then agree for HIV testing with fee payment .I think we should concentrate on the training, practicing fully for both counselors and communicators for PMTCT, because if it is practiced one time only, they can't complete their work successfully. The practice should be once per year for annual updating of knowledge."(FGD communicators at Quang Trung commune, Uong Bi Dist).

"In order to reach successful and stable result of the project, it is necessary to have support of the supervisor; for example, after training, we learn and practice new communication skills, then we need the help of the supervisor for checking the result, and if it is false, we shall adjust it. Their supervisor's position is the head of commune station, but he has a lot of working, thus, many times we report their result of the practice only." (FGD communicators at Minh Tam commune, Thuy Nguyen District)

C. Project Costs

71. The total cost to facilitate, monitor and evaluate the Project was estimated at $1, 256,124. The actual cost was $1, 047,597, (not including management costs) with a savings of $208,527. UNICEF Viet Nam provided a direct grant to the MOH to cover the entire cost of the Project. The GOV contributed staff time, existing health facilities support and technical inputs. See Annex 4 for summary details on the planned versus actual costs of the Project.

D. Project Schedule

72. The Project was originally scheduled to start in 2001 as part of UNICEF's Country Action Plan (CAP) for 2001-2005, but actual implementation did not start until June 2004. UNICEF support to the Pilot component of the project is planned to phase out early 2008, in order to complete final monitoring phase and final external evaluation. The EA carried out the Project according to schedule, after the initial delays, which is not seen as a major problem. Plans for a workshop to disseminate Pilot component of the Project findings are being discussed.

E. Implementation Arrangements

73. The Project Management Board comprised of the RHD, VAAC and the Viet Nam Women's Union at the national level held regular meetings to ensure interagency coordination. However, coordination and communication between the RHD and PAC at provincial levels and within the newly restructured DOH at sub-provincial levels seems to have been less efficient. Provincial Project Management Boards were not set up to coordinate and administer the day-to-day implementation of the Project. The Project organizational structure is in Annex 5.

74. Some implementation delays, especially during the early years resulted from (i) competing priorities in prevention and control in Viet Nam, and (ii) a lack of staff on the part of UNICEF. Further, the districts originally selected for the Pilot were changed, based on MOH re-assessment of the actual situations, and to more usefully coordinate with other donor-supported project working in those areas. A list of the planned and re-selected districts is in Annex XX. Once these hurdles were overcome however, project implementation and disbursements moved forward efficiently, (any

savings of Project funds through competitive bidding???).

F. Consultant Recruitment

75. Selection engagement of two consultants external to the project (one international and one domestic) consultant was carried out for the external evaluation of the Pilot component of the project. Additional assistance for translation, field data collection and analysis was provided by two staff from a local NGO, and one clerical staff from MOH. No difficulties were encountered and contracts were successfully negotiated individually. The consultants were mobilized within the agreed period and provided services according to a work plan agreed to by both parties.

G. Performance of Consultants

76. The domestic and external consultants' performance was highly satisfactory, assisted by two local NGO staff and one MOH clerical staff for translation assistance, and UNICEF Viet Nam's commitment to Project implementation.

H. Performance of the Executing Agency

77. The Project Executing Agency (EA) met its responsibility in implementing the Project in a timely manner and without reduction of scope. Compliance with Project conditions and agreements was satisfactory. The Project EA made efficient and effective use of the resources. Overall performance of the Project executors was highly satisfactory.

I. Performance of UNICEF Viet Nam

78. UNICEF Viet Nam met its obligations to ensure that the Project activities were carried out as planned. This included extending budgetary support and allocating payments in a timely manner and in accordance to the UNICEF accounting and personnel policies for the Project execution. UNICEF Viet Nam program coordination, administration, finance and field staff also provided on-going advisory, training and translation support to assist facilitation, monitoring and evaluation of Project activities. UNICEF Viet Nam's performance was also highly satisfactory.

IV. EVALUATION OF PERFORMANCE

A. Relevance

79. Both the GOV and UNICEF confirmed that the promotion of PMTCT was a priority for Viet Nam. The Project design was appropriate for the development and testing of a model which aimed to strengthen the capacity of health workers and health volunteers to carry out their roles and responsibilities for PMTCT as stipulated in 2005 NPoA. Although the Pilot was threatened mid-way by major restructuring within of the MOH, with particular implications at provincial and district levels, implementation of the Pilot managed to remain on track and on schedule

80. The Project design reflected a solid understanding of sustainable approaches that support existing systems at a pace that can be reasonably taken over and sustained when UNICEF support finishes. This is in contrast to the other large projects supporting PMTCT in the pilot districts, which pay supplemental salaries to GOV health staff, or fund additional staff at levels beyond GOV budget capacity. Project support at peripheral levels of the health system demonstrated a strong

understanding of capacity constraints and socio-cultural challenges, as well as the cost-effective opportunities through effective mobilization of community resources on PMTCT. The implementation arrangements were generally appropriate, including for example, the choice of pilot districts, all of which have high HIV prevalence. However participatory planning and follow-up a provincial as well as district levels during the course of the Project could have been stronger to ensure adequate ownership on the part of the provincial partners.

81. The Project succeeded in improving access to PMTCT services including for the poor and ethnic minorities, with significant improvement in community awareness on PMTCT and utilization of services. However further improvement is needed in CHS and DOH PMTCT services, in particular pre and especially post-test counseling and confidentiality. Continued donor support for ARV and test kits may be needed to realize the desired impact of these investments. The implementation arrangements were appropriate, and adjusted as per needs of the Project over time, including delegation of authority to the districts/ provinces. The EA and UNICEF were willing to make adjustments to improve Project performance. However, a major issue is low pay of health staff, causing high staff turnover. Changes recommended by the monitoring reviews were generally appropriate and helped make the Project more successful.

B. Effectiveness in Achievement of Purpose

82. The Project succeeded in developing and testing a model for building capacity among health workers, mass organization members and other community health collaborators for community mobilization and communicating on PMTCT for the general population, especially pregnant women, and in care and support for HIV positive women, HIV positive mothers and their children in the community. The training methods and inter-active learning activities were highly appreciated and improved participants' awareness, knowledge and understanding of HIV/AIDS in general, and PMTCT in particular, increasing their confidence and motivation to take on the expanded responsibilities. The Pilot also made significant inputs into demonstrating benefits from and strengthening community volunteer health support services at commune level Appropriate PMTCT IEC materials were developed and distributed to support the BCC training. Throughout the Project, GOV and UNCEF management was pragmatic and focused and donor coordination was managed well considering the complex division of labor among the various partners. The Project has succeeded in developing policies and guidelines for PMTCT monitoring and evaluation, including NPoA , VCT, treatment and care guidelines and protocols. See Annex 1 for details on achievements, based on selected indicators for each Project output.

C. Efficiency of Outputs and Purpose

83. The Project focused on cost-effective interventions. Throughout the Pilot, GOV and UNICEF management was pragmatic and focused. Donor coordination, though not always purposefully promoted, was however sufficient due to the strong presence of active and relevant donors in the Pilot districts to compliment the Pilot interventions. The Project team succeeded in demonstrating important policy changes for implementation across all four prongs of PMTCT.

D. Preliminary Assessment of Sustainability

84. The Project achievements are most likely to be sustainable. However, in order for lasting impact to be realized, appropriate approaches and interventions need to sustained and scaled-up. Assurances of continuation of financing the strengthening and development of PMTCT in some

provinces have demonstrated ownership and commitment through assurances of continuation of financing the strengthening and development of PMTCT implementation and allocations for scaling up to new districts, including expanded capacity building services requiring supplemental budgetary support for training and monitoring and actively seeking local PC and international donor support for supplies such as infant formula and rapid test kits. The scaling-up initiatives should take into account the key factors of participatory planning as well as seeking innovative, sustainable financing arrangements which incorporate local support.

E. Socio-cultural and Other Impacts

85. The Project has made a major contribution toward understanding key factors required for achieving effective PMTCT across all four prongs for increased community mobilization for prevention and care, leading to better maternal and child health outcomes. These include the critical factors of: participation of progressive health sector and community leadership, and partnership building between the health sector and mass organizations (especially the VWU) at district and commune levels. This came about as an unexpected outcome in some districts where the district level TOT on IEC and BCC was conducted jointly for health staff and VWU, and also the PMTCT monthly commune meetings involving VWU and HHWs, both of which have led to greater cross-sector partnership and ownership of PMTCT in the Pilot communes.

86. Most CHS staff and hamlet health workers in the pilot sites were trained separately from the WWU communicators, along the usual vertical organization lines. The prevailing assumption is that health workers and VWU for example, have different education levels and capacities, but in fact, the IEC / BCC curricula is basically the same, and by training these groups together, particularly at the community level can help strengthen the working relationships between health sector and non-health sector personnel, and also provides a stronger operational linkage for the CHS to provide monitoring support to the VWU communicators as well as the HHWs. The Project identified potential forms of support to GOV for improved institutional development, and there is considerable evidence of the generally strong capacity and willingness from the MOH, and from the district and commune PC authorities to continue PMTCT after UNICEF leaves.

V. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

87. The Project is considered highly satisfactory in terms of relevance and implementation, and satisfactory in terms of design, institutional development and sustainability.

88. The Project objectives and scope for the testing of innovative and promising strategies to establish and strengthen PMTCT services in five pilot districts were sound, but more could have been done to develop ownership of the strategies among the appropriate MOH departments.

89. A significant increase in knowledge and understanding of PMTCT was reflected in the interviews, group discussions and from pre-and post-test training scores. Interviews and group discussions revealed consistent improvement in the majority of immediate output and outcome indicators as compared with baseline and subsequent Project monitoring assessments data. There was also considerable difference over time from the on-set of Pilot activities to completion, including improved health worker capacity and skills in VCT and IEC/ BCC, a pattern of more systematic and strict adherence in Project schools to government procedures and guidelines under the new educational

management reform policy.

90. As a model to learn what is needed and how best to provide essential PMTCT services under the new NPoA, the scope was satisfactory. Highlights include the testing of innovative and promising strategies for changing attitudes, improving knowledge, skills and community mobilization for PMTCT; the facilitating of replicable mechanisms for networking between the health system and their communities for greater availability and access to PMTCT by pregnant women – but to a lesser extent men – but suited to local conditions, as well as among groups of provinces and districts for sharing strategies and lessons learned. The Project clearly benefited from considerable financial support from UNICEF. However, implementation was hampered by the restructuring of the MOH at national, provincial and district levels of the health system, which, occurred mid-way through the Project. The result was an increased focus on the details of implementation in the sample of Pilot Project districts in selected localities, with less attention to strengthening the newly structured government system to develop greater cost-effectiveness and sustainable support mechanisms for improved PMTCT management in the long-term.

91. Project implementation was satisfactory. The size of the training workshops was usually appropriate (25-30 per class) but in some cases too large – YU and HHWs interviewed reported 50 participants per training course (Thuy Nguyen), and with little or no opportunity for practicing skills. The Project's (5 to 7- day) training courses were of an appropriate duration for in-service staff and community people. However, refresh training, particularly on communication skills, and for counseling for VCT are needed – and priority for the refresh training should be given to those health staff who provide counseling as part of the normal job. The benefit of additional training was evident among CHS health staff, HHWs and WU communicators observed who had attended one or more training courses from other HIV/AIDS or WU supported projects, in addition to the Project IEC/BCC training, and demonstrated superior communication skills.

92. Specific problems in project implementation included inadequate participatory planning at the provincial level, which could have helped to improve the design, but which has not significantly affected potential for taking the project to scale, and the need for closer, more frequent follow up with project implementers during the monitoring phases of the Project.

B. Lessons Learned

93. The Project successfully developed and tested a model, which can be adapted and replicated by GOV to implement across all four prongs of PMTCT, under the new NPoA.

94. Training and capacity building activities and structures can significantly improve skills, knowledge and practice. However, training processes need support at implementation and supervisory levels to ensure quality, and at central and senior levels to ensure sustainability

95. Capacity building at all levels of the health system - in particular, skills development, adequate supervision support and facilities required for providing quality counseling - can lead to significant health benefits, including increased utilization of services, due to trust and confidence in the health worker skills that have been developed, and quality of services; and improved health outcomes, including better management of HIV-positive pregnant women, husbands/partners, mothers, their children, and other family members.

96. Capacity building in the health system and in the community can reduce the perceived need for supplemental financial incentives for health worker and volunteer participation in PMTCT

activities and services provision, leading to improved sustainability.

97. Support to the decentralized arrangements of the health system require strong planning and management participation at provincial as well as at district levels for enhanced ownership by local health authorities, and to define clear roles and responsibilities.

98. Community mobilization, IEC and BCC, if systematically implemented by way of local structures like People's Committees, the Viet Nam Women' s Union, commune health workers and community health volunteers, can improve health seeking behavior for PMTCT, reduce stigma and discrimination, and increase early, cost effective voluntary counseling and testing.

99. Frequent and careful monitoring of Project implementation is essential to ensure that the newly established PMTCT operational processes and procedures are clearly understood and services carried out correctly and completely by the responsible parties at all levels. On-site monitoring, especially for the newly established PMTCT services, should aim for no less than monthly visits to provide support at district, and selected CHS levels.

C. Conclusions and Recommendations

100. The Project successfully developed and tested a model, which can be adapted and replicated by GOV to implement across all four prongs of PMTCT, and under the new NPoA. The Pilot model adapted to the evolving restructuring and decentralization policies, and successfully complimented the other major donor-supported PMTCT activities in project sites. The Pilot demonstrated relevant processes to compliment current GOV health policies and investment.

101. **Impact:** The qualitative and available quantitative data show that the Project has had an impact on RH/MCH indicators, including high rates of HIV-positive women under PMTCT management, moderate but increasing rates of voluntary testing acceptance among pregnant women during pregnancy (currently 62%), and potentially low rate of sero-conversion (of the 54% tested so far, 100% confirmed negative) among those children exposed to HIV in the Pilot districts. However, the positive outcomes and indicators cannot be attributed exclusively to the Project. The Project's training capacity building at national, provincial and district levels, and local level training processes contributed to overall impact, and are planned to continue using GOV funding for phased scaling up to priority locations nation-wide.

102. **Relevance:** The Pilot supported GOV donor priority areas, and was appropriate in its aims and objectives. The design and (evolving) implementation arrangements were highly relevant to the current situation in Viet Nam. The CDC, GFATM and other donors are supporting care and treatment components of PMTCT in Viet Nam, but with low inputs of technical assistance for capacity-building resources and delivery capability at the peripheral levels of the health system. UNICEF- supported assistance to this under-funded area will strengthen the outcomes and impacts.

> **Recommendation 1:** *The GOV should plan and carry out a workshop with broad participation from donors, communities, the relevant public and private sectors and other interested parties to disseminate Project findings, discuss lessons learned, solicit feedback and agree on the next steps to take*

103. **Training System Capacity Building:** The Project strengthened national policy and planning for PMTCT, and demonstrated training materials and processes to support implementation of the NPoA for PMTCT, which reinforced and established PMTCT in provincial training processes. Capacity

building for PMTCT was provided directly to district level DOH, but to a lesser extent at the provincial level for building PMTCT planning and training management systems. With the exception of the long-established HCMC AIDS Committee, which was supported by the Project to plan and administer the piloted PMTCT activities, the new Provincial AIDS Centers (PAC) established in provinces mid-way through the Project did not benefit directly from the Project.

> **Recommendation 2:** *The GOV should prepare a plan to strengthen the PMTCT planning and training management and supervisory capacity at the provincial level for improved training, monitoring and supervision on VCT and IEC/BCC, and with specific implementation strategies for taking successful and sustainable approaches to scale.*

104. **Health Worker Capacity Building:** Health staff at all levels, collaborators, members of mass organizations and other community health volunteers highlighted the skills they had gained through the Project, and the practical ways in which the skills were transferred. The communication activities were viewed by many as the most effective component of the project for reaching the target audiences in the community, and the communication skills developed support health staff and communicators across other areas of their health promotion activities as well as for PMTCT. Quality counseling and confidentiality were also viewed as critical factors to promote broader acceptance of VCT, and as a potential means to reduce missing cases.

> **Recommendation 3:** *To ensure quality of services, refresh training and skills practice, particularly on counseling and confidentiality issues, should be provided for appropriate district and commune level health staff. Technical assistance should be mobilized to facilitate the process of strengthening GOV systems to carry out capacity building for PMTCT scale up to other locations and provinces. UNICEF is well positioned to continue central level advocacy and technical support to provincial training management capacity and for refresh training for appropriate health sector and mass organization personnel.*

105. **Equipment and Supplies:** Equipment and supplies provided for the Project (IEC materials, audio-visual equipment, computers and clinical supplies) were appropriate, however the Project TVs were under-utilized in some instances, due to overlap with other donor-supported TVs, and also due to limited waiting room space in the health facilities, particularly at commune level. If ANC days are scheduled more frequently, a manageable daily volume of clients would reduce the need for group counseling (and TVs) at CHSs, and allow more time for quality counseling. Stock-outs of rapid test kits were observed in locations where pregnant women were being tested multiple times during their pregnancy, and with no standardized screening for high risk.

> **Recommendation 4:** *Standardized guidelines for supervision and monitoring of PMTCT should be established and training provided to provincial and district level supervisors to support the implementation of PMTCT and related protocols and procedures in order to reduce wasteful practices (eg excessive testing) in an environment of limited resources.*

106. **Community Mobilization:** The Project has made a major contribution toward understanding the key factors for achieving effective outcomes across all four prongs of PMTCT, including increased community mobilization for prevention and care, leading to better maternal and child health outcomes. Project support demonstrated the considerable benefits of strengthening community 'volunteer' health support services at commune and hamlet level to support the current salaried hamlet health workers (HHW) and other national program technical health collaborators (eg family planning, child nutrition). Where local authorities were actively involved, overall results – particularly coordination within and between the health sector and the mass organizations (Women's Union, Youth Union, etc) – tended to be much better, and seem likely to be sustained. Similarly, where the local mass organizations were strongly committed, local health services tended to be more responsive

and focused on local communities.

> **Recommendation 5:** *The evaluation recommends full and meaningful participation of end users, beneficiaries – including men, as well as women, PLWA, key GOV personnel, local political leaders and other partners at all levels as a basis for future project design and implementation that support appropriate and sustainable improvements in existing systems and institutions, while reducing dependence on outside assistance, and to mobilize communities – the most available resource – to promote greater self-reliance.*

107. **Coordination:** PMTCT services are offered in the five pilot districts as part of routine ANC services in general coordination with provincial HIV/AIDS programs, and include voluntary HIV counseling and testing services, HIV/AIDS information, education and communication activities. Coordination and integration of PMTCT activities across provincial and district health systems was more variable, due to evolving structural changes and ill-defined roles, responsibilities, lines of communication and authority of each division in the DOH, both at the district level – which has had particular implications regarding referral mechanisms, and between the RHC and the recently established PACs at provincial level. Improved integration of PMTCT into general HIV/AIDS prevention and control systems is seen both as a potential means for wider reach to high risk populations, as well as for encouraging greater involvement in HIV prevention activities among adolescents and men, who generally regard PMTCT as exclusively for pregnant women.

> **Recommendation 6:** *Clarification of the roles and responsibilities of DOH departments and divisions involved in PMTCT is urgently required in order to improve coordination. The GOV should consider providing additional supervision and monitoring training for the newly established Provincial AIDS Centers, and make arrangements to continue to expand their monitoring, supervision and technical support to the PMTCT Pilot, to identify problems and make adjustments and recommendations as necessary. More also needs to be done with the private sector for sharing information on PMTCT services, guidelines, protocols, referral, monitoring, and for potential tracking of missing cases.*

108. **Institutional Capacity Development:** A measure of preliminary sustainability observed in all districts/ provinces was the existence of the training networks initiated by the Project. The TOT systems, curricula and materials for the PMTCT training programs (VCT, IEC and BCC) were in place, and in some areas (HCMC and Quang Ninh) extended to non-project districts. Existing IEC materials developed by the Project and community-based BCC activities observed in pilot communities were indicators of sustained outcomes, and support the high priority that should be given to appropriate IEC materials and community awareness activities as PMTCT is scaled up. However, IEC leaflets are in short supply, and refresh training in VCT and IEC/BCC is needed.

> **Recommendation 7:** *Strong central level support and advocacy for training at provincial level should be maintained to ensure broad implementation and continuity of training and other initiatives. UNICEF should consider providing limited implementation support to the GOV as may be needed to ensure that the newly piloted activities maintain momentum and are sustained. Timing is also advantageous as the MOH is currently restructuring, offering flexible entry point for UNICEF to support lasting systemic change.*

Annex 1

Pilot project framework

Code	Design Summary	Performance Indicators	Monitoring Mechanisms	Achievements
	Pilot Project Goal A model of PMTCT and VCT interventions created and operating along the internationally recognized four-pronged approach to PMTCT established in five provinces with high HIV prevalence that can be evaluated and later contribute to nation-wide scale up of PMTCT activities by the government.		Short KAP/ client satisfaction survey at selected ANC centers Interviews, FGD with ANC clients, HIV-positive women, health staff, health communicators, People's Committees Observation in DHC, CHS, and in community Annual reports, Project monitoring reports	• **Generally Achieved** A highly appropriate model developed, tested and evaluated in 5 pilot districts with recommendations for improvements needed to ensure quality of services, for sustainability, and for taking the model to scale.
1.	**Result Area One** **Women, their partners and adolescents use appropriate information to protect themselves against HIV/AIDS and to prevent transmission of the virus to their children**	• percent of target population having protective behaviors against HIV infection • percent of target population demand VCT/PMTCT services	• Baseline/ KAP studies • Literature review of existing research	**Not formally Evaluated** Population based survey research was beyond the scope of this evaluation • **Generally Achieved** Moderate increase in target population demand for VCT/ PMTCT
1.1	**Project Outcome** Knowledge and skills of communities on HIV/AIDS prevention and PMTCT increased	• Percent of women in selected locations who can explain key messages on HIV/PMTCT	• Short KAP study at selected ANC centers, behavioral research • Supervision reports	• **Achieve**d General KAP on HIV/AIDS and PMTCT has increased but increases in HIV/ AIDS KAP cannot be totally attributed to the Project
1.1.1	Output Information on HIV, VCT/ PMTCT available and disseminated effectively in the community	• Percent CHS and district health facilities have and use IEC materials on HIV/PMTCT regularly	Short KAP/ client satisfaction survey at selected ANC centers Monthly reports	• **Achieved** Appropriate IEC/ BCC materials developed and distributed, still held by recipients and effectively used in health care settings and community

	Main activities - Provision of IEC materials (including information on available VCT/PMTCT services) - Organizational events on HIV/AIDS and PMTCT - Regular PMTCT sessions by village communicators	• Percent of villages that have at least two PMTCT education sessions / month • Percent of communes organizing regular monthly PMTCT review meetings	Interviews, FGD with women attending ANC Observation in DHC, CHS and in community Project monitoring reports	• **Generally Achieved** 100% at least one PMTCT session per month • **Fully Achieved** 100% of communes hold regular monthly commune PMTCT review meetings
1.1.2	**Output** Increased capacity and competence of village communicators in delivery and management of BCC interventions, with supportive supervision from the district health center and CHS	• Percent of village communicators trained on BCC for HIV and PMTCT • Percent district trainers providing regular supervision to BCC activities	Interviews, FGD with ANC clients, HIV-positive women, health staff, health communicators, People' s Committees	• **Generally Achieved** Appropriate personnel selected to attend BCC training courses; but some class sizes were too large • **Partially Achieved** Regular supervision by the district trainers not always evident, particularly for WU communicators; general supervision and monitoring needs strengthening
1.1.3	**Output** Communities, local authorities and other stakeholders are mobilized and supportive of the HIV/VCT/PMTCT initiatives	• Percent of communes organizing monthly review meetings		• **Fully Achieved** 100% communes organize monthly meetings; local authorities mobilized
2.	**Result Area Two** **Pregnant women and their partners and people of reproductive age (in particular adolescents) have access to quality VCT/PMTCT services**			
2.1	**Project Outcome** VCT services available for women and men of reproductive age, particularly adolescents	• Mother to child HIV transmission rate (target < 10% by 2010) • Percent of pregnant women, their partners and others with access to VCT and PMTCT services in pilot districts (by age, locality, pregnant/pre-pregnant)	Supervisor's reports Referral records VCT National Standards	• **Partially Achieved** Current sero-conversion rate among HIV-exposed pilot district infants = 0%, but only for PW currently under DOH management

				• **Partially Achieved** VCT/ PMTCT service available in all pilot sites, promoted mainly for PW, with low proportion of men and adolescents; quality of services, especially counseling, confidentiality practices are of concern
2.1.1	**Output** VCT provided at all CHS and maternal health care facilities in selected districts **Main activities:** - Health staff trained on VCT - VCT services established - VCT integrated into other activities at the CHS (nutrition day, EPI day, FP day) - VCT integrated into outreach services in remote communes - Post-test counseling organized for all who took the HIV test	• #/% facilities (hospitals, DHC, CHS) in selected localities providing VCT • % health facilities in the selected districts provided VCT for all men, women and adolescents • % communes in the selected districts provided VCT services integrated into other activities such as EPI day, nutrition day		• **Partially Achieved** - Training courses conducted, with improved HW ability and confidence to carry out VCT services, but appropriate personnel not always selected to attend training - VCT integrated into other activities at the CHS, but to a lesser extent into outreach to remote communes, and generally low men and adolescent involvement overall
2.1.2	**Output** HIV quick test, or facilities for blood taking and transfer of sample for HIV test, available at CHS **Main activities:** - Provision of HIV test, other consumables and blood carriers if needed - Mechanisms for blood taking and referral identified - Health workers trained	• % of health staff in the selected districts VCT/ PMTCT • % of health facilities in the selected districts have stock of HIV rapid test, materials for HIV rapid test and IEC materials readily available at health facilities and at WU facilities	Inventory list of equipment supplied to VCT centers Referral protocols/ criteria checklists	- Post-test counseling is generally weak, especially for positive results; often omitted for negative results and confidentiality issues need to be improved - HIV quick test, or facilities for blood taking and transfer of sample for HIV test, available at CHS; IEC materials available at health and WU facilities, but shortage of leaflets

2.2	**Project Outcome** VCT available for pregnant women and their partners, integrated into ANC services	• #/ % of health facilities (hospitals, DHC, CHSs) in selected localities providing VCT/PMTCT integrated into ANC services		• **Partially Achieved** VCT integrated into ANC at the CHS for PW, but to a lesser extent for men and adolescents, as ANC is generally viewed as being for women only
2.2.1	**Output** VCT provided to pregnant women and partners at all CHS and maternal care facilities in selected districts **Main activities:** - Health staff trained on VCT - VCT services established - VCT integrated into other activities at the CHS (ie: nutrition day, EPI day, FP day, etc) - VCT integrated into outreach services in remote communes - Post-test counseling organized for all who took the HIV test	• #/ % of facilities in selected districts providing VCT services integrated into ANC services for pregnant women • % communes in selected districts providing VCT services integrated into other activities such as EPI day, nutrition day, etc • # facilities in selected equipped with HIV test		• **Achieved** 100% of pilot district health and CHS facilities report integrated VCT into ANC for pregnant women • **Generally Achieved** 100% of pilot district health and CHS facilities report Integrated into other activities (EPI, nutrition) However, the heavy case load of clients coming all at once on these combined service days is a burden for HWs, and contributes to lower quality services
2.2.2	**Output** HIV quick test, or facilities for blood taking and transfer of sample for HIV test, available at CHS **Main activities:** - Provision of HIV test, other consumables and blood carriers if needed - Mechanisms for blood taking and referral identified - Health workers trained			• **Generally Achieved** - HIV test kits, other consumables and blood carriers if needed supplied, however stock-outs were reported in some cases - Mechanisms for blood taking and referral identified, however there is an urgent need to address confidentiality issues, related to blood samples – HCMC excepted, effective coding systems to protecti the identity of clients were generally not observed - Health workers have been trained on VCT, but refresh training is needed

2.3	**Project Outcome** Identified HIV positive women and their newborn receive ARV prophylaxis for PMTCT and care at delivery and post-partum	• # and % of HIV (- +) women and their children receiving ARV prophylaxis when needed • % HIV (-+) women receiving IF counseling • % HIV (- +) women supported in their infant feeding choice		• **Generally Achieved** - the majority of mothers and newborns received ARV prophylaxis, however referral problems and lost cases are still an issue
2.3.1	**Output** ARV prophylactic drugs are available without break in stock **Main activities** - Needs assessment/ forecasting on ARV PMTCT drugs regularly performed - Mechanisms for procurement and distribution of ARV clarified - Drugs procured and distributed timely	• % of district hospitals in the selected districts have ARV prophylaxis readily available for HIV infected pregnant women and their babies at birth • % of district hospitals in the selected districts had and used protocols for PMTCT caring for HIV infected pregnant women		• **Generally Achieved** - Some delays in delivery of medical supplies and stocks were reported
2.3.2	**Output** Delivery care and IF counseling are available to all HIV positive women **Main activities** - Provision of relevant IEC materials for counseling - Provision of safe delivery kits ??	• % of HIV infected women received counseling on infant feeding at pre natal and post natal care		• **Generally Achieved** - IF counseling and formula not always sufficient or available – some districts have been successful seeking local sources for formula, with assistance from local PC

2.3.3	**Output** Health staff capable to provide ARV prophylaxis, delivery care and IF counseling **Main activities** - Training, regular up-dating of health staff on PMTCT protocols - Training on delivery care - Training for IF counseling	• % of health staff in the selected districts trained on PMTCT protocols including: ARV prophylaxis, delivery care and post-natal care, and infant feeding counseling		• **Generally Achieved** - Services provided, however quality of IF counseling was variable
3.	**Project Result Three** **HIV positive women and their children receive care and support (medical, nutritional and emotional)**			
3.1 3.1.1	**Project Outcome** Follow-up of HIV positive women carried out by health workers **Output** HIV-positive women and their children receive regular health checks (at health facilities or at home) **Main activities** -Training of health staff on care and counseling for HIV-positive mothers - Organization of follow-up services at CHS level - coordination w/ other community services (i.e. psycho-social	• % HIV+ mother and child receiving follow-up care and support services • % of children born to known HIV+ mothers receive cotrimoxizole prophylaxis • % children born to known HIV+ mothers with confirmatory HIV test at 18 months • % HIV+ mothers and children receiving regular health checks		• **Generally Achieved** - high and increasing rates of PW and children under health care management, with the exception of HCMC, due to persistent lost cases among migrant populations- beginning now to coordinate via PAC across all districts to locate lost cases who have moved to other districts

3.1.2	**Output** Treatment of OI infections provided to HIV-positive mothers and their children **Main activities** - Training of health staff on up-dated protocols on OI treatment for adults and children - Monitoring or universal provision of Cotrimoxizol for all babies born to HIV positive women until confirmation of HIV status	• % of HIV infected mothers and their children in the selected districts received follow-up care by health staff either at heath facility or home • % of health staff in the selected districts trained on follow-up care and support for HIV infected women and their children • % of children born to HIV infected mother received corimoxizole prophylaxis from 6 weeks of age (as per MOH protocol)		• **Generally Achieved** Follow-up care of mothers and children generally provided, except in cases that are lost to follow-up
3.1.3	**Output** HIV test for children born to HIV-positive mothers at 18 months to confirm zero-status **Main activities** - Provision of HIV tests and materials at designated health facilities - support organization of appropriate referral	• % of children born to HIV infected mothers received HIV test to confirm their HIV status at 18 months of age • % confirmed HIV-infected children referred to appropriate heath services for ARV treatment follow-up		• **Achieved** Confirmatory testing carried out at 18 months
3.1.4	**Output** Counseling on infant feeding for HIV infected mother	• % of HIV infected mothers received counseling on infant feeding • % of HIV infected mothers strictly follow the selected choice of infant feeding		• **Generally Achieved** - Counseling on IF not always sufficient
3.2	**Project Outcome** HIV positive women receive support on nutrition			• **Generally Achieved** With support from local resources, eg, local PC

3.2.1	**Output** Health services organized to provide nutritional counseling and follow-up support for HIV positive mothers and children	• % HIV+ women who received counseling and support on nutritional issues		• **Generally Achieved** Variable degrees of nutritional counseling and follow-up provided
3.2.2	**Output** HIV positive women receive support from their family and the community on nutrition	• % of HIV infected mother who received counseling on nutrition for HIV infected mother and children • % of family having HIV infected mothers provided with nutrition support to HIV infected mother • % of HIV infected mothers and their family members counseled on nutrition for HIV infected mother and children		• **Generally Achieved** Family members/ partners interviewed were generally supportive, and local resources were mobilized for IF when needed
3.3	**Project Outcome** Appropriate referral to ARV treatment sites (when needed) and to psycho-social support initiatives available for HIV positive women and children			• **Partially Achieved** - Supplemental referral support was provided by the project in come cases, but specific psyhco-social support initiatives for HIV positive women and children was less evident
3.3.1	**Output** Sites and initiatives in respective localities and mechanisms for referral agreed between different service providers and disseminated to health staff	• % of HIV (-+) women and children having PMTCT services and referred to ARV services/ psycho-social support programs • % of children who were confirmed HIV infected referred to appropriate health care services for ARV treatment and follow-up		• **Partially Achieved** - In some cases, referrals were made to psycho-social support agencies if available in the community however transport costs is an issue for long distances

3.3.2	**Output** Continuous care and support from CHS staff to HIV affected children in their communities **Main activities:** - Training of health staff on follow-up of children under ARV treatment - Regular counseling to parents of HIV-positive children for ARV adherence and control of side affects	• # of referral sites for ARV treatment identified • % of HIV infected mothers and their family members informed about the referral sites • % of HIV infected mothers who received counseling on ARV treatment for both mother and child • % of HIV infected mothers and their children provided with follow-up care on ARV treatment		• **Generally Achieved** - HCMC has a high rate of lost cases, and the PAC is currently working with all districts to identify those who have moved to new areas within the city
	Inputs 1. Management 2. Staff and community members 3. Training 4. Monitoring and Evaluation	• Project Committees • Trainers • Training courses • Study Tour to Thailand • Project monitoring activities in each site – as often as possible • Final evaluation at project end		

Annex 2
Evaluation Design and Methodology

Objectives of the Evaluation

The Ministry of Health and UNICEF Viet Nam commissioned an external evaluation as part of UNICEF's support to the Pilot component of the: Support to Programme Activities for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) in Viet Nam. The assessment is intended to provide a critical understanding of the outcomes, process and impact of the Pilot component of the PMTCT Project that has been implemented since June 2004 in five districts, as well as potential for scaling up. In particular, as the PMTCT package has already been developed by the MOH, the lessons learned and findings will contribute to the National PMTCT scaling up plan of 2008-2010 and provide recommendations for the PMTCT activities currently being implemented at the Pilot sites.

As a participatory process, the end project assessment is intended to help all PMTCT partners to understand the strengths, opportunities and constraints of all aspects of the program, enhancing their collaborative efforts. Partners will be able to assess the implications of findings, which will enable them to implement and follow-up on relevant recommendations. The assessment is also intended to help UNICEF Hanoi to evaluate the impact of its support, and to prioritize areas for further support in the area of PMTCT in the period of 2008-2010 and beyond.

Specifically, the assessment will analyze the outcomes, process, impact and sustainability of the PMTCT pilot project, within the 4 PMTCT prongs of implementation:

- Assess the **efficiency** of the project implementation, including:
  - How efficient was the division of labour of various project partners? What are some of the identified benefits and risks of the project's division of labour?
  - How has the project solicited buy-in, support and response by local authorities? What processes and approaches have been used?
  - To what extent did the project adhere to key principles of human-rights based approach, including gender equity, results based management strategies?
- Assess the **effectiveness** of the PMTCT strategies, processes and activities, and progress made towards achieving the stated objectives; including:
  - How and to what extent has the project improved community mobilization in communicating on PMTCT for the general population, especially pregnant women, and in care and support for HIV positive pregnant women, HIV positive mothers and their children in the community
  - How and to what extent has the project improved rights-based advocacy and institutional learning from project experiences?
  - What, if any, are some of the unintended impact of the project?
  - What are the main challenges and constraints of the project?
- Find out the **impact** so far, on the target audiences and others; including:
  - What is the rate of sero-conversion among infants of HIV positive mother, and how does this relate to the PMTCT ARV prophylaxis regimens used and administered to mother and newborn, and to the infant feeding choice used? How was it supported?
  - Were there changes in knowledge, attitude, behaviour of pregnant women on HIV/AIDS and PMTCT (comparing with base line data)?
- Assess the **relevance** of Project objectives, and whether they are still in keeping with donor, local and national priorities and needs

- Examine the long-term implications: Are the activities sustainable, and what factors will affect **sustainability**, and the implications for scaling up, including;
    - How and to what extent have the project outputs and outcomes been streamlined as part of the local response to Maternal and Child Health and/or HIV/AIDS? In particular, how have project experiences influenced the work of the various stakeholders (VAAC, RHD, National Women Union, District Hospital, Community Health Station), as well as other partners and donors?
    - What is the potential for project activities to continue after its completion?
    - What are the opportunities outside of the project, and within government initiatives, to scale up the project components? What are some of the strategies for UNICEF to engage in these opportunities?
- Record **lessons learned**
- Make **recommendations** about how the strategies, processes and activities could be improved, and about how the work can be **monitored and evaluated** in the future

Evaluation Methods and Process

Participatory techniques and further approaches outlined below will be used for the gathering and analysis of data; participation of all stakeholders including HIV(+) mothers, their family members, especially partner or husband, pregnant women, IEC collaborators and mass organization members will be involved in design of the tools, data collection and dissemination.

The assessment will collect both quantitative and qualitative data through:

- **Stakeholder meetings:** consultations with key partners at the national level regarding overall process of this assessment
- **Review of existing project data and reports:** review project documents, previous assessment report, trip reports, mid term reviews, annual reviews and other documents made available by MOH, VAAC, WU, District and UNICEF staff. For background and reference purposes further information may be gathered, where necessary, from existing government laws and policies, programmes, services and/or projects sponsored by other organizations/ donors.
- **Field visits and observation:** Selected project facilities will be visited to identify clinical and non-clinical areas that need improvement within the process of PMTCT (including observation of counseling sessions, BCC activities, equipment, PMCTC materials, etc.).
- **Qualitative method:** A series of in depth interview and group discussion will be conducted on study subject and relevant people (health workers, community leaders, mass organization, IEC collaborator, Pregnant Women, HIV (+) mother and their family members, especially their husband/partner).
- **Quantitative method:** Collection and summary of quantitative key indicators from sub national level counterparts. A questionnaire on client satisfaction in PMTCT service will be developed and applied for the pregnant women who are selected randomly and had been enrolled in the PMTCT services (at least attending 1 section of PMTCT counseling), without consideration on HIV status.
- **Follow-up to mother-infant pairs enrolled in PMTCT (HIV+ PWs):** All reachable HIV positive mothers who have been enrolled in the PMTCT service in 5 pilot provinces from the start of the project to now will be approached/identified and interviewed. Information obtained will

include: demographics, economical status, knowledge of HIV/AIDS transmission, perceived HIV-related stigma, perceived quality of care received from providers, social support, and the presence of AIDS-related disease at delivery. Additionally, the information on received interventions also will be gathered, such as PMTCT VCT, ARV prophylaxis, infant feeding practice etc. The list of HIV positive mothers who are enrolled in PMTCT service will be identified for tracking. Status of children born to HIV + mothers will be assessed- if HIV test not done yet, the child will be tested for HIV upon mother's consent (HIV antibody test for children more than 18 months and PCR testing for children less than 18 months).

Sampling Frame

- Data collection at national, provincial, district and commune levels
- Data collection in each of the five project districts, two communes per district (4 days in each

Participants

- External consultant, local consultant, and MOH staff (non-Project)
- Interviews and group discussions conducted with relevant health staff (health department managers, physicians, nurses, counselors, trainers, communicators
- Interviews and group discussions with ANC pregnant women, HIV (-) and HIV (+)

Methods

- Observation
- Document review
- Individual interview
- Group discussion
- Pre-and post test data

Data Sources:

PMTCT baseline assessment report, rapid assessment reports, GOV policy documentation, UNICEF project monitoring/ mission reports, training pre- and post-test scores, observation, interviews and group discussions.

Composition of Evaluation Team

Evaluation team members comprised two external evaluation consultants (one international and one national) with technical assistance and logistical support from UNICEF and MOH/ PMU, to coordinate with the project implementers to arrange for meetings, interviews and community group discussions. UNICEF Vietnam office will also provide key document translation and local transportation to study sites.

Evaluation Team Members:

James Cameron Mielke, DrPH
International Consultant/ Team Leader

Do Anh Nguyet, MD
National Consultant

National Research Assistants:

Lang Son
1. Nong Thi Hong
2. Nguyen Thi Lieu
3. Tran Thi Hoa

Quang Ninh
1. Nguyen Thu Ha
2. Nguyen Thanh Huyen
3. Nguyen Lam Giang

Hai Phong
1. Cao Lan Huong
2. Nguyen Thuy Linh
3. Dao Hai Yen

An Giang
1. Dao Thi Yen Phuong
2. Vo Thi Duyen Trang
3. Tran Thi Thanh Thuy

Ho Chi Minh
1. Nguyen Thi Duyen Anh

Key Questions and Indicators

To assess how and to what extent the PMTCT pilot project had made progress towards achieving its objectives, in terms of:

- Achievements
- Constraints/ Action Taken
- Key factors for success or failure
- Sustainability
- Lessons learned
- Recommendations

Data sources:

Project monitoring reports, pre- and post-test scores and other activity completion reports, observation, interviews, group discussion, short survey on KAP/ Client Satisfaction

Suggested Key Questions and Indicators: PMTCT-Plus Pilot Project

How and to what extent are women, their partners and adolescents using appropriate information to protect themselves against HIV/AIDS and to prevent the transmission of the virus to their children.

Indicators:

- Percent of communes conducted BBC activities such as home visit, forum for PW discussion on PMTCT, forum for HIV infected mother meet and discuss.
- Percent of women of reproductive age have basic knowledge on HIV/AIDS and PMTCT

2. How and to what extent are pregnant women and their partners, and people of reproductive health age (in particular adolescents) have access to quality VCT/ PMTCT services.

Indicators:

- Percent of health facilities with a separate room for health education and communication with all necessary materials and equipments to run the health IEC activity.
- Percent of health facilities with one private room for ANC and VCT counseling
- Percent of PW in the district received pre-test counseling on PMTCT
- Percent of PW in the district accepted voluntary HIV test
- Percent of PW who received post-test counseling

3. How and to what extent are HIV positive women and their children receiving care and support (medical, nutritional and emotional)

Indicators:

- Percent of HIV positive mothers who received ARV prophylaxis following MOH protocol
- Percent of HIV positive mothers received STI and OIs treatment when needed
- Percent of infants born to HIV positive mothers received ARV prophylaxis at birth
- Percent of HIV positive mothers practice breast milk replacement
- Percent of HIV positive mother practice exclusive breastfeeding for the first 4 months
- Percent of infants born to HIV positive mother received follow-up testing process at 12 and 18 months

Other indicators not included in the project document, will also be considered for assessment during the evaluation process:

- Percent of babies born to HIV positive mothers received Cotrimoxazole at 4 week age
- Percent of HIV positive mother transferred to ARV treatment services after delivery
- Percent of HIV positive mother dropping out the PMTCT services
- Percent of HIV positive mother feel confident/stigmatized when access the PMTCT services

Evaluation sites will be identified in the 5 pilot districts in consultation with GOV counterparts.

Data collection: Semi-structured individual interviews and FGD using key questions

National Level: Key informant interviews (project managers, core trainers):

- Reproductive Health Department (RHD)/ Ministry of Health
- Life-Gap Program - Viet Nam Administration AIDS Control (VAAC)

- Global Fund - Viet Nam Administration AIDS Control (VAAC)
- UNICEF, Health and Nutrition Unit, PMTCT Program
- CDC

Provincial Level: Group Discussion

- Provincial Reproductive Health Center – Director, Supervisor ,Trainer
- Provincial AIDS Center – Director
- Provincial Hospital - O&G Specialist, Pediatrics Specialist
- CHE - Trainer

District level: Group Discussion: (managers, O&G, supervisors, trainers, counselors

- Health Department - Trainer
- District Hospital – Director, O&G, Pediatrics, Counselor
- District Preventive Medicine Center - Supervisor
- District Women's Union – Head
- Key informant interview with the Vice Chair District People's Committee
- Individual in-depth interviews with 5 HIV (+) pregnant or recently delivered women and at least one family member from any commune invited to the District Center
- Group Discussion: 5-6 ANC pregnant woman randomly invited to district health center
- KAP/ Client Satisfaction Survey at District Center – All ANC pregnant women presenting
- Observation:

  Counseling
  IEC/BCC Activities
  Care and Treatment Services
  Equipment, Supplies
  Referral system
  M & E System

Commune Level: *Interview/ group discussion:*

- CHS Head – one interview
- Midwives/ Counselors – one small group discussion
- Communicators – group discussion with 5-6 communicators from different agencies (Women's Union, Youth Union, etc)

Approximately one hour per group

- Group discussion with ANC pregnant women: 5-6 women randomly invited to CHS
- In-depth interview with 5 HIV (+) women and one family member invited to the CHS
- KAP/ Client Satisfaction Survey: 10 ANC women invited randomly to CHS
- Observation – Counseling at CHS
- Observation – BCC in the community
- KAP/Client Satisfaction Survey: 10 ANC women invited randomly to CHS

Annex 3

PMTCT Pilot Design and Implementation Processes

Support across the four 'prongs' of PMTCT

1. Primary prevention of HIV infection in women

Promote best practices on prevention of HIV transmission:

- Understand the three ways HIV can be transmitted;
- Know and practice ways to protect themselves and their partners from getting HIV infected;
- Know about PMTCT and the importance of getting tested and receiving counseling, and to access care and treatment services when testing positive for HIV.

2. Prevention of unintended pregnancy among HIV-infected women

- Provide information and behavior change communication (BCC) on prevention of unintended pregnancy among HIV-infected women in the community, counseling and health care settings.

3. Interventions to reduce transmission from HIV-infected pregnant and lactating women to their children

- Provide pre-testing counseling for all pregnant women attending antenatal care (ANC) services at commune health stations (CHS) and district hospitals;
- Provide HIV testing for all women who consent to it after pre-testing counseling;
- Provide post-test counseling for all pregnant women, HIV-positive and HIV negative;
- For HIV-positive pregnant women include counseling on: remaining healthy, infant feeding choices, applying ARV prophylaxis for mother and baby.
- Provide appropriate care during labor for HIV-positive pregnant women (minimum invasive intervention during labor, artificial rupture of the membrane; forceps, episiotomies etc)

4. Care and support of women, children, and families infected and affected by HIV/AIDS

- Provide follow-up care, support and referral for HIV-infected women and their children to other related services.

PMTCT Pilot Project Inputs:

Training and Monitoring

To achieve the Pilot Project goals, relevant training materials, guidelines and protocols were developed at central level, appropriate equipment and supplies were provided, and TOT training workshops were conducted to develop a PMTCT training capacity in the pilot provinces. An international study visit to Thailand was conducted to observe successful PMTCT programs. These

processes were followed throughout with on-going monitoring activities. A total of …. participants attended the training workshops, conducted in … batches of …. participants each.

Training Materials, Supplies and Equipment

- Develop textbook on basic information on PMTCT
- Develop training packages on VCT and IF for HIV+ mothers
- Training materials/ supplies procurement
- Development of IEC/BCC materials
- Equipment and supplies procurement

Training and Staff Development

- General Pilot Project Orientation Workshop
- TOT course for central trainers on VCT and HIV and IF
- TOT course for central trainers on IEC/BCC for PMTCT
- DIP workshops with each province/ district in each project province
- Study Visit to observe PMTCT in Thailand for province/ district leaders
- TOT courses for province/ district trainer teams on HIV and IF
- TOT courses for province/ district trainer teams on IEC/ BCC for PMTCT
- TOT courses for province/ district trainer teams on IYCF
- VCT and IF training for province/ district/ commune health staff
- IEC/ BCC intervention training at province, district, commune, and village levels
- IYCF training at province/ district/ commune levels (on-going district/ CHS)
- Pediatric care and treatment training for provincial and district staff (on-going)
- Financial management (HACT) training for province/ district management staff
- DevInfo data management training for central, province and district staff
- Health staff provision of PMTCT services at O&G hospitals and CHS as trained
- Supervision/ on-site training for health staff at province, district, commune levels
- Regular project review meetings at province, district and commune levels
- Advocacy events organized on World AIDS Day, and regularly in the media

Monitoring and Evaluation:

- Ongoing monitoring and on-site advising, during and after training, study tour
- End project evaluation

Training: Voluntary Counseling and Testing (VCT)

Indicator or Activity	2005	2006	2007	Total
# of VCT training				
Cao Loc, Lang Son	7	8		15
Uong Bi, Quang Ninh	4	4		8
Thuy Nguyen, Hai Phong	8	4		12
Tan Chau, An Giang	3	1		4
# 6 HCMC	4			4
Total	26 courses	17 courses		43 courses
Number of health staffs to be trained become trainer				
Cao Loc, Lang Son	3			3
Uong Bi, Quang Ninh	5			5
Thuy Nguyen, Hai Phong	4			4
Tan Chau, An Giang	4			4
# 6 HCMC	5	3		8
Total	21 trainers	3 trainers		24 trainers
Number of health staffs in the districts and communes trained:				
Cao Loc, Lang Son	177	206		383
Uong Bi, Quang Ninh	99	99		198
Thuy Nguyen, Hai Phong	211	105		316
Tan Chau, An Giang	86	30		116
# 6 HCMC	60			60
Total	633 trainees	440 trainees		1073 trainees

Training: Behavior Change Communication

Indicator or Activity	2005	2006	2007	Total
# of BCC training				
Cao Loc, Lang Son		15	7	22
Uong Bi, Quang Ninh	5	5	3	13
Thuy Nguyen, Hai Phong	15		5	20
Tan Chau, An Giang	7		3	10
# 6 HCMC	8			8
Total	35 courses	20 courses	18 courses	73 courses
Number of health staffs to be trained become trainer				
Cao Loc, Lang Son	4			
Uong Bi, Quang Ninh	3			
Thuy Nguyen, Hai Phong	6			
Tan Chau, An Giang	4			
# 6 HCMC	5			
Total	22 trainers			
Number of health staffs in the districts and commues trained:				
Cao Loc, Lang Son		468	211	
Uong Bi, Quang Ninh	208	208		
Thuy Nguyen, Hai Phong	763	183	208	
Tan Chau, An Giang	208	70	154	
# 6 HCMC	240			
Total	1419 trainees	929 trainees	573 trainees	2921 trainiees

Training: Infant and Young Child Counseling for Feeding (IYCF)

Indicator or Activity	2005	2006	2007	Total
Number of IYCF training courses				
Cao Loc, Lang Son			7	7
Uong Bi, Quang Ninh				
Thuy Nguyen, Hai Phong			5	5
Tan Chau, An Giang				
# 6 HCMC				
Total			12 courses	12 courses
Number of health staffs to be trained become trainer				
Cao Loc, Lang Son			6	6
Uong Bi, Quang Ninh				
Thuy Nguyen, Hai Phong			6	6
Tan Chau, An Giang				
# 6 HCMC				
Total			12 trainers	12 trainers
Number of health staffs in the districts and communes trained:				
Cao Loc, Lang Son			97	
Uong Bi, Quang Ninh				
Thuy Nguyen, Hai Phong			110	
Tan Chau, An Giang				
# 6 HCMC				
Total			207 trainees	

Annex 4
Budget for PMTCT Pilot Sub Project

Planned vs Actual

2004		2005		2006		2007		Notes
Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	
300,000	**331,124**	**301,000**	**293,485**	**339,000**	**144,000**	**286,000**	**277,987**	

Notes:

1. Above budget is for PMTCT pilot only (sub project 2) and NOT includes UNICEF & MOH management cost
2. Matching fund from MOH are: human resources, equipment & health facilities

Training Costs Planned vs. Actual

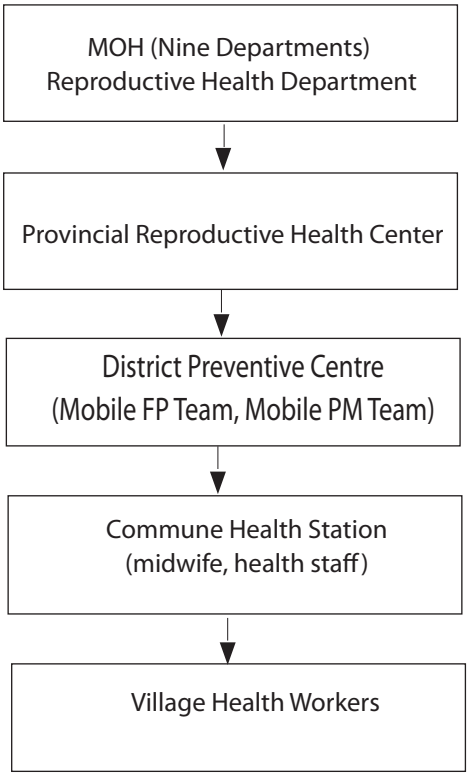
Description	Days	Person (Planned)	Person (Actual)	Cost (Planned)	Cost (Actual)
Training and Staff Development					
Orientation Workshop	1	60	60	$10,000	$10,000
TOT for Master Trainers on VCT and HIV and IF	12	48	45	$30,300	$30,000
TOT for Master Trainers on IEC/ BCC for PMTCT	8	90	90	$22,000	$22,000
DIP Workshops – Districts	2	212	180	$10,400	$8,000
International Study Visit – Thailand	6	18	18	$30,000	$26,600
TOT on VCT and HIV and IYCF	5	59	59	$11,600	$11,600
TOT on IEC/ BCC for PMTCT for Women Union members	8	48	47	$12,100	$11,500
Training on VCT, HIV for Health Workers in 5 districts/ provinces	7	470	470	$55,642	$55,642
Training on IEC/ BCC for communicators	5	1,035	1,035	$55,000	$55,000
Training on IYCF					
Training on Pediatric Care	5	48	48	$9,000	$9,000
Training on Financial Mgt	2	20	15	$3,000	$3,000
Training on DevInfo (2 modules)	6	30	27	$11,500	$11,000
Supervision/ on-site training				$50,000	$50,000

Equipment and Supply PMTCT Pilot Project 2004 - 2007

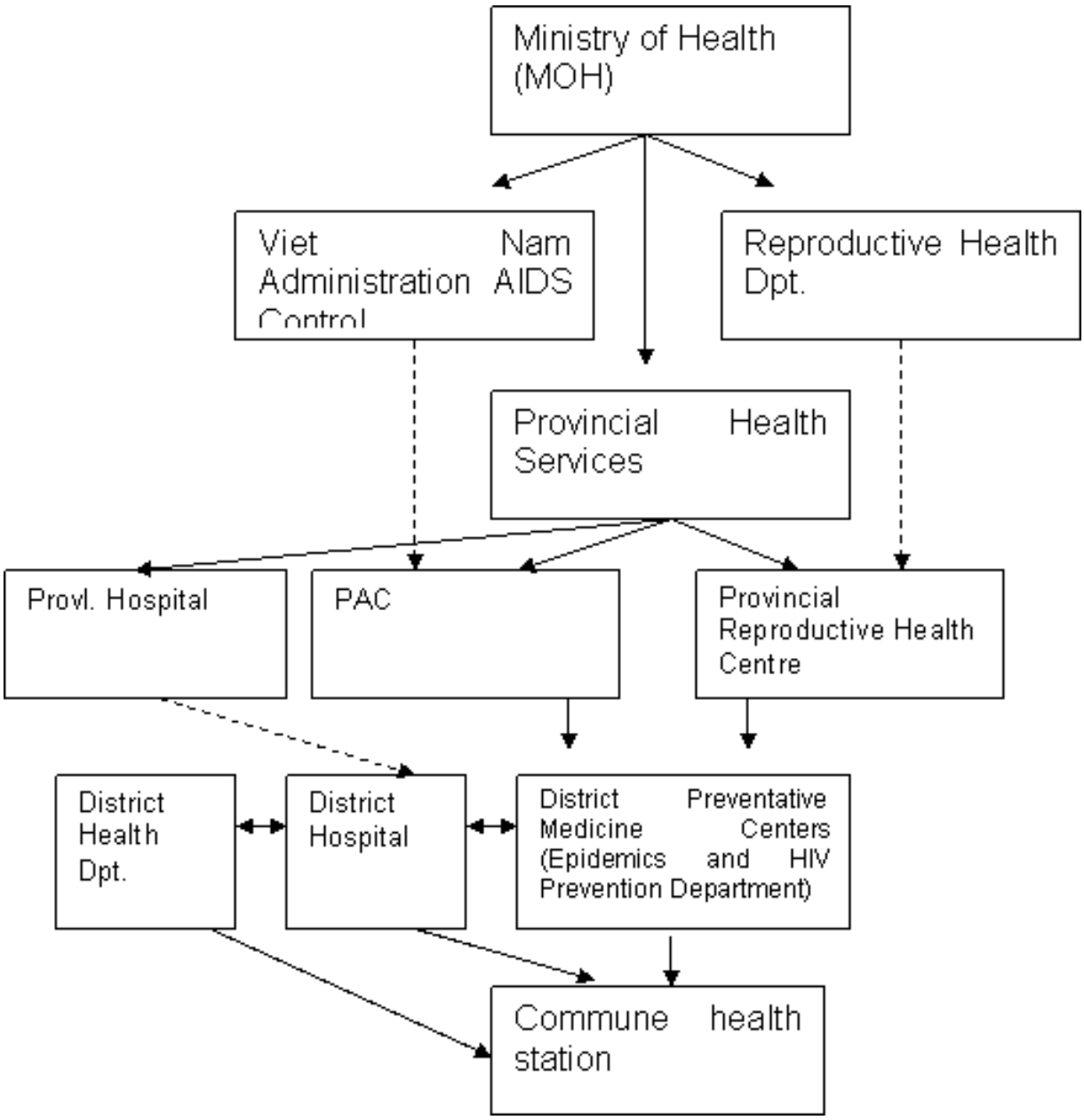
	Item	2004	2005	2006	2007	Notes
	Oven Memert for PMTCT dist	29,290	0	0	0	
	Printing of PMTCT text book	2,962	0	0	0	
	Provision of IEC equipment for pilot dist.	42,879	14,125	11,012	12,128	
	Rapid HIV test kit	32,368		10,326	13,000	
	Overhead projector for training purpose	0	1,305	2,963	0	
	Printing of PMTCT protocol	0	51,419	0	0	
	Disinfection equipment & materials	0	7,155	0	0	
	Test tube, racks for blood sample	0	4,058	0	0	
	Pipet and tips for HIV testing	0	10,440	0	0	
	IEC materials for pilot areas	0	11,161	2,018	2,399	
	Office equipment for project management	0	5,257	3,775	4,497	
	Bookshelves for IEC/BCC materials	0	9,188	0	0	
	Printing of NPoA and PMTCT project document	0	0	1,555	0	
	Computer set for pilot areas	0	0	5,724	19,319	
	IEC bags for collaborators	0	0	6,618	9,528	
	Refrigerator for blood storage	0	0	0	3,120	
	Total	**109,503**	**99,983**	**45,997**	**65,998**	

Annex 5

Structure of the Health System of Vietnam Ministry of Health
Reproductive Health Department



Draft of PMTCT Organization Chart - December 2007



Annex 6

Evaluation Terms of Reference

Title: PMTCT End Project Assessment in Viet Nam

Ref. No.: TA/VN/05/2007

Job Title International & national consultants

Duration: ± 41 days (total 82 days)

Starting Date: 19 November 2007 – 5 January 2008

Location: Ha Noi, Viet Nam

Background

In its initial CPAP 2001-2005, UNICEF planned for a PMTCT pilot project in five districts that would focus on building capacity of health care providers in PMTCT and STI prevention and control to ensure that necessary equipment and materials were available for prevention and control efforts, and provide adequate counseling and support for HIV-positive mothers and HIV-positive newborns. From 2001-2003, although UNICEF had funds for PMTCT activities programmed in its CPC (Country Program of Co-orperation) 2001-2005, there was a period of inactivity due to other competing priorities in HIV/AIDS prevention and control in Viet Nam and a lack of staff on the part of UNICEF. In 2004 UNICEF resolved its staffing issues and started supporting the Reproductive Health Department (RHD) to implement PMTCT activities at both central level and in the five pilot district/provinces. The re-selected district had changed in accordance with MOH's consultation based on real situation at local area of Quang Ninh (Ha long moved to Uong Bi), HCMC (Distric #10 moved to #6) and An Giang (Long Xuyen moved to Tan Chau). The five pilot districts are: Cao Loc/Lang Son, Thuy Nguyen/Hai Phong, Uong Bi/Quang Ninh, Dist. # 6/HCMC, Tan Chau/An Giang.

Due to rapidly increasing rates of HIV among PW and their children, increasing government and international interest in PMTCT, and additional knowledge of the current needs in PMTCT programming in Viet Nam, UNICEF decided to support MOH to implement PMTCT activities at the central level (for the development of the PMTCT NPoA and legislation) and the peripheral level (a PMTCT pilot project at the provincial, district and community level). After a year period of needs assessment, project development and counterpart trainings in different aspects such as project management, VCT for PMTCT and BCC for PMTCT, the pilot project began actual implementation in June 2005 and are being continued into 2007.

Key components of the PMTCT pilot project:

The project planned to implement the four-pronged components of PMTCT globally recommended by UNICEF:

- **Primary prevention of HIV infection in women:**

Promote best practices on prevention of HIV transmission: understand three ways HIV can be transmitted; know and practice ways to protect themselves from getting HIV infected; know about PMTCT and the importance of getting tested and counselled to access services in case HIV (+)

- **Prevention of unintended pregnancy among HIV-infected women**

Provide information on prevention of unintended pregnancy among HIV infected women by communication in the community.

- **Interventions to reduce transmission from HIV-infected pregnant and lactating women to their children:**

- Provide pre-testing counselling for all pregnant women attending antenatal care services at commune health stations and district hospitals;

- Provide HIV testing for all women who consent to it after pre-testing counselling;

- Provide post-test counselling for all PW; for HIV (+) PW, include counselling on: remaining healthy, infant feeding choices, applying ARV prophylaxis for mother and baby.

- Provide appropriate care during labor for HIV positive pregnant women (minimum invasive intervention during labor, artificial rupture of the membrane; forceps, episiotomies etc.)

- **Care and support of women, children, and families infected and affected by HIV/AIDS:**

Provide follow-up care, support and referral for HIV infected women and their children to other related services.

Purpose

The assessment is intended to provide a critical understanding of the outcomes and the process and impact of the PMTCT project as well as possibilities for sustainability and scaling up. In particular, as the PMTCT package has already been developed by the MOH, the lessons learned and findings will contribute to the National PMTCT scaling up plan 2008-2010 as well as reflecting the recommendation for sustaining the PMTCT activities at current project sites.

The assessment is intended to help all PMTCT partners to understand the strengths, opportunities and constraints of all aspects of the programme, enhancing their collaborative efforts. Partners will be able to assess the implications of findings, which will enable them to implement and follow-up on relevant recommendations.

In addition to that, the assessment is also intended to help UNICEF Hanoi to evaluate the impact of its support as well as providing a road map to prioritise areas for further support in the area of PMTCT in the period of 2008-2010 and beyond.

Scope and focus

The assessment will analyze the outcomes, process, impact and sustainability of the PMTCT project:

- Outcomes: achievements and lessons learned along the 4 PMTCT prongs
- Process: efficiency and adherence to standards
- Impact: changes occurred thanks to the project activities
- Sustainability: opportunities and recommendations

Outcomes:

1. To what extent has the project improved community mobilization in communicating on PMTCT for the general population, especially pregnant women and in care and support for HIV positive pregnant women, HIV positive mothers and their children in the community
2. To what extent has the project improved rights-based advocacy and institutional learning from project experiences?
3. What, if any, are some of the unintended impact of the project?
4. What are the main challenges and constraints of the project?

Process:

1. How efficient was the division of labor of various project partners involved in the project? What are some of the identified benefits and risks of the project's division of labor?
2. How has the project solicited buy-in, support and response by local authorities? What processes and approaches have been used?
3. To what extent did the project adhere to the key principles of human-rights based approach, including gender equity, and results based management strategies?

Impact

1. What is the rate of sero conversion among infants of HIV positive mother and how does this relate to the PMTCT ARV prophylaxis regimens used administered to mother and newborn, and to the infant feeding choice used? How was it supported) ?
2. Were there changes in knowledge, attitude, behaviour of pregnant women on HIV/AIDS and PMTCT (comparing with base line data)?

Sustainability:

1. To which extent have the project outputs and outcomes been streamlined as part of the local response to Maternal and Child Health and/or HIV/AIDS? In particular, how has project experiences influenced the work of various stakeholders (VAAC, RHD, National Women Union, District Hospital, Community Health Station), as well as other partners and donors?
2. What is the potential for project activities to continue after its completion?
3. What are the opportunities outside the project, in government initiatives, to scale up the project components? What are some of the strategies for UNICEF to engage in the opportunities?

Geographical locations for the study will be chosen among the 5 pilot provinces.

Indicators for evaluation of the PMTCT project:

Key indicators for PMTCT, in particular impact and outcome indicators, are mentioned in the project document, in the national PMTCT Plan of Action approved by MoH in 2006 as well as in the National HIV M&E framework finalised in 2007.

The following indicators, extracted from the above mentioned documents, might be included to assess the impact of the PMTCT project in the five pilot provinces:

1. % of health facility with a separate room for health education and communication with all necessary materials and equipments to run the health IEC activity.
2. % of health facility had one private room for ANC and VCT counselling
3. % of PW in the district got pre-test counselling on PMTCT
4. % of PW in the district got voluntary HIV test
5. % PW accepted for HIV test upon getting their husband/partner agreement
6. % of PW who received post-test counselling
7. % of HIV positive mother who received ARV prophylaxis following MOH protocol
8. % of HIV positive mother received STI and OIs treatment when needed
9. % of babies born to HIV positive mothers received ARV prophylaxis at birth
10. % of HIV positive mother practice breast milk replacement
11. % of HIV positive mother practice exclusive breastfeeding for the first 4 months
12. % of babies born to HIV positive mother received follow-up testing process at 12 and 18 months
13. % of commune conducted BBC activities such as home visit, forum for PW discussion on PMTCT, forum for HIV infected mother meet and discuss.
14. % of women at reproductive age having basic knowledge on HIV/AIDS and PMTCT

Other interesting indicators, not include in the project document, will be considered to assess during evaluation process:

15. % of babies born to HIV positive mothers received Cotrimoxazole at 4 week age
16. % of HIV positive mother transferred to ARV treatment services after delivery
17. % of HIV positive mother dropping out the PMTCT services
18. % of HIV positive mother feel confident/stigmatised when access the PMTCT services

Evaluation sites will be identified within the 5 pilot districts in consultation with Government counterparts.

Existing information:

The evaluation will draw upon the following existing sources:

- *Baseline Assessment Report – August 2002:* This was conducted during late 2001 in 5 pilot

districts of 5 HIV/AIDS high prevalence: Cao Loc/Lang Son, Ha Long/Quang Ninh (project was moved to Uong Bi since 2004), Thuy Nguyen/Hai Phong, Dist. #10/HCMC (project was moved to Dist. #6 since 2004) and Long Xuyen/An Giang (project was moved to Tan Chau since 2004). The assessment found that the awareness of pregnant women and community on HIV/AIDS and PMTCT were still low and needed improving to reduce the HIV/AIDS transmission.

- *PMTCT Rapid Assessment in Vietnam:* This assessment was joint process between UNICEF and UNAIDS in supporting VAAC to evaluate all existing PMTCT models in Vietnam. The valuable findings (50% HIV positive mother were identified only in labor, not at ANC;, the lack of post test counselling for HIV-negative mothers as a lost opportunity for primary prevention) contributed for development of PMTCT procedure and later Scaling Plan, 2008-2010.
- *Literature:* Project documents (MPO, PPA), project annual reports, trip reports, donor reports, data
- *Policy document/guidelines:* National Strategy on HIV/AIDS ; HIV/AIDS Law ; PMTCT Programme Action; PMTCT Protocol …
- *Key project partners and other PMTCT donors:* they can provide valuable overall picture of the PMTCT project activity.

Evaluation Methods and Process:

The evaluation should use participatory techniques and further approaches outlined below for the gathering and analysis of data; participation of all stakeholders including HIV(+) mothers, their family members, especially partner or husband, PWs, IEC collaborator and mass organization will be promoted in the design of the tools, data collection and dissemination.

The assessment will collect both quantitative and qualitative data through:

- **Stakeholder meetings:** consultations with key partners at the national level regarding overall process of this assessment
- **Review of existing project data and reports:** review project documents, previous assessment report, trip reports, mid term reviews, annual reviews and other documents made available by MOH, VAAC, WU, District and UNICEF staff. For background and reference purposes further information may be gathered, where necessary, from existing government laws and policies, programmes, services and/or projects sponsored by other organizations/donors.
- **Field visits and observation:** Selected project facilities will be visited to identify clinical and non-clinical areas that need improvement within the process of PMTCT (including observation of the counselling sessions, BCC activities, existing equipment, materials on PMTCT, etc.).
- **Qualitative method:** A series of in depth interview and group discussion will be conducted on study subject and relevant people (health workers, community leaders, mass organization, IEC collaborator, PWs, HIV (+) mother and their family members especially their husband/partner).
- **Quantitative method:** Collection and summary of quantitative key indicators from sub national level counterparts. A questionnaire on client satisfaction in PMTCT service will be developed and applied for the pregnant women who are selected randomly and had been enrolled in the PMTCT services (at least attending 1 section of PMTCT counselling), without consideration on HIV status.
- **Follow-up to mother-infant pairs enrolled in PMTCT (HIV+ PWs):** All reachable HIV positive mothers who have been enrolled in the PMTCT service in 5 pilot provinces from the start of the project to now will be approached/identified and interviewed. Information obtained will include: demographics, economical status, knowledge of HIV/AIDS transmission, perceived

HIV-related stigma, perceived quality of care received from providers, social support, and the presence of AIDS-related disease at delivery. Additionally, the information on received interventions also will be gathered, such as PMTCT VCT, ARV prophylaxis, infant feeding practice etc. The list of HIV positive mothers who are enrolled in PMTCT service will be identified for tracking. Status of children born to HIV + mothers will be assessed- if HIV test not done yet, the child will be tested for HIV upon mother's consent (HIV antibody test for children more than 18 months and PCR testing for children less than 18 months).

Accountabilities:

The evaluation will use a participatory process and involve a team composed of independent consultants, project counterparts at central level, sub-national counterparts, community beneficiary, UNICEF and key donor will also provide support.

The following structure is proposed:

- Project counterparts at central level: liaison, coordination of assessment plan, technical advisory. Given the nature of the assessment, and the conflict of interest between assessment team and implementers, the team shouldn't include any implementer i.e. MoH, UNICEF etc.- independent assessment.
- Sub-national counterparts: input to refine evaluation tools, support logistics during data collection process and dissemination (i.e. access records, PW and families to be interviewed)
- PWs, HIV(+) mother and their family members, HWs, community leader, IEC collaborator, Mass organisation provide the input for data collection and dissemination
- UNICEF:
    - Health & Nutrition: Technical assistance throughout the assessment process as well as support to coordination (including necessary logistical support)
    - PSP/M&E Network: Technical assistance in the evaluation design and process, as appropriate

Procedures and Logistics:

Once the consultants are identified, the specific working arrangements and task division will be decided.

Below are the expected tasks and outputs for the consultancy. It is proposed that two qualified consultants are identified, one international and one national consultant, to provide technical leadership and coordination for the assessment process. The international consultant will be the team leader and be accountable to produce the expected outputs of the assessment. UNICEF staff and project team will actively engage in supporting the consultants in the assessment process, and UNICEF's evaluation procedures and guidelines will be strictly followed.

Task	Output	Days
Task 1: Development of assessment design	**Output 1:** Project assessment framework designed	4 days
Task 2: Development of assessment tools and guidelines, with inputs from UNICEF and key counterparts. *This should be done in consultation with national counterparts in terms of selected sites, timing, and accountabilities of key local partners.*	**Output 2:** Assessment tools developed and revised.	3 days

Task 3: Training workshop for assessment team, pre-testing of tools and finalization of tools.	**Output 3:** Assessment team trained and evaluation tools pre-tested and finalized.	3 days
Task 4: Data collection.	**Output 4:** Field work, including group discussions, interviews and observations, conducted and data collected.	15 days
Task 5: Data entry, analysis and draft report.	**Output 5:** Data entered and analysed and draft report produced.	5 days
Tasks 6: Final report writing in both English and Vietnamese, as per UNICEF evaluation report guideline, incorporating feedback from counterparts and UNICEF.	**Output 6:** Final report produced and ready for dissemination.	5 days

Proposed competencies of Consultants:

For International Consultant

- Advanced academic degree in social studies or other relevant field
- Good knowledge and understanding of reproductive health, HIV/AIDS, PMTCT and IEC/BCC at community level
- Good knowledge and experience in undertaking similar type of evaluations, preferably on PMTCT and HIV/AIDS.
- Good knowledge of human rights and child rights and participation.
- Excellent writing skills
- Ability to work with various counterparts, including government, NGOs, and children.
- Working experience and/or knowledge of Viet Nam is an asset.

For National Consultant

- Hold a master degree in Public Health or other health related subject.
- Have at least 5 year experiences in reproductive health, HIV/AIDS.
- Have experiences in evaluating and assessment of project/program.
- Have experiences in doing researches, studies.
- Good English skills.

Time Frame and Work Plan from 19 Nov. 2007 to 05 January 2008

Tasks	Time Allocation	Tentative Dates	Place
Task 1: Development of assessment design	4 days	19-22 Nov	Hanoi
Task 2: Development of assessment tools and guidelines, with inputs from UNICEF and key counterparts	3 days	23-26 Nov	Hanoi
Task 3: Training workshop for assessment team, pre-testing of tools and finalization of tools	3 days	27-29 Nov	Hanoi

Task 4: Data collection HCM: 4 days An Giang: 5 days Quang Ninh: 4 days Hai Phong: 4 days Lang Son: 4 days	21 days (including travel)	30 Nov-24 Dec	An Giang, Ho Chi Minh, Quang Ninh, Hai Phong and Lang Son
Task 5: Data entry, analysis and draft report	5 days	25-29 Dec	Hanoi
Task 6: Final report writing in both English and Vietnamese, as per UNICEF evaluation report guideline, incorporating feedback from counterparts and UNICEF	5 days	31 Dec 07 – 05 Jan. 08	Hanoi
Total: 41 days			

Products:

These products should be made available in English and Vietnamese, in soft and hard copies

- Final assessment report which follows the UNICEF Evaluation Report standards.
- 3-page summary, following UNICEF Evaluation Technical Notes Series no.3 "Writing a good executive summary".
- Standard PowerPoint presentation of key outcomes, lessons learned and recommendations
- A friendly version of the assessment report which will include human interest stories, quotes and recommendations.

It should be noted that ethical considerations will be strictly taken during data collection as well as preparation of evaluation deliverables with regard to informed consent of interviewees, confidentiality and non judgment of their responses.

All completed data sets including filled out questionnaires, records of focused group discussions, in-depth interviews. Reports and reference materials collected during the evaluation should be handed to UNICEF for filing.

Dissemination policy:

As plan the MOH counterparts and UNICEF will jointly organize the National end project review where the results of this assessment will be disseminated. It is also important to ensure that results are fed back to those who contributed to the assessment process as well as to all primary and secondary beneficiaries of the project.

Resource requirements:

- The estimated funds available for this evaluation is US$ xxxx
- Detailed budget will be prepared following agreement of final version of terms of reference and overall evaluation plan with counterparts.

Annex 7

List of Supporting Documents

1. *Baseline Assessment Report – August 2002:* This was conducted during late 2001 in 5 pilot districts of 5 HIV/AIDS high prevalence: Cao Loc/Lang Son, Ha Long/Quang Ninh (project was moved to Uong Bi since 2004), Thuy Nguyen/Hai Phong, Dist. #10/HCMC (project was moved to Dist. #6 since 2004) and Long Xuyen/An Giang (project was moved to Tan Chau since 2004). The assessment found that the awareness of pregnant women and community on HIV/AIDS and PMTCT were still low and needed improving to reduce the HIV/AIDS transmission.
2. *PMTCT Rapid Assessment in Vietnam:* This assessment was joint process between UNICEF and UNAIDS in supporting VAAC to evaluate all existing PMTCT models in Vietnam. The valuable findings (50% HIV positive mother were identified only in labor, not at ANC;, the lack of post test counselling for HIV-negative mothers as a lost opportunity for primary prevention) contributed for development of PMTCT procedure and later Scaling Plan, 2008-2010.
3. *Nation Plan of Action for Prevention of Mother to Child HIV transmission (PMTCT) 2006-2010:* To implement the National Strategy on HIV/AIDS Prevention and Control till 2010 with a vision to 2020 - September 2005: Approved by the Minister of Health on 07 July 2006 under MOH decision No. 20/2006/QD-BYT.
4. *Project documents,* project annual reports, monitoring reports, donor reports, data
5. *National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a vision to 2002;* Decision No. 36/2004/QD-TTg of March 17, 2004
6. *"Strengthening Basic Health Care Network in Disadvantaged Provinces of Viet Nam (Phase 1, 2007-2020)" A country proposal for support to Health System strengthening submitted to Global Alliance for Vaccines and Immunizations. Ministry of Health*
7. *Other policy documents and guidelines;* HIV/AIDS Law ; PMTCT Program Action; PMTCT Protocol , UNGASS commitments

Annex 8
Data Collection Process and Itinerary

Data collection: Semi-structured individual interviews and FGD using key questions

National Level: Key informant interviews (project managers, core trainers):

- Reproductive Health Department (RHD)/ Ministry of Health
- Life-Gap Program - Viet Nam Administration AIDS Control (VAAC)
- Global Fund - Viet Nam Administration AIDS Control (VAAC)
- UNICEF, Health and Nutrition Unit, PMTCT Program
- CDC

Provincial Level

Method: Semi-structured individual interviews and FGD using key questions

Day 1 **Morning:** 09:00 – 10.30 10:30- 11:30	**Provincial level:** 1. Group Discussion: Provincial Reproductive Health Center – Director, Supervisor ,Trainer Provincial AIDS Center – Director Provincial Hospital - O&G Specialist, Pediatrics Specialist CHE - Trainer 2. Orientation training on the KAP questionnaire for Local Research Assistants3. 3. 3. Travel to District
Day 1 **Afternoon:** 13.30 – 15.00 15:00 – 16:30	**District level:** 1. Group Discussion: (managers, O&G, supervisors, trainers, counselors Health Department - Trainer District Hospital – Director, O&G, Pediatrics, Counselor District Preventive Medicine Center - Supervisor District Women's Union - Head 2. Group Discussion: 5-6 ANC pregnant woman randomly invited to district center 3. KAP/Client Satisfaction Survey: All ANC pregnant women presenting
Day 2 **Morning** **Day 2** **Afternoon**	**District Level:** 1. District People's Committee – Vice Chair 2. KAP/client Satisfaction Survey – All ANC pregnant women presenting 3. Observation: Counseling IEC/BCC Activities Care and Treatment Services Equipment, Supplies Referral system M & E System **District Level:** 1. In-depth interviews with 5 HIV (+) pregnant or recently delivered women and at least one family member from any commune invited to the District Center 2. KAP/ Client Satisfaction Survey at District Center – All ANC pregnant women

Commune Level:

Method: Semi-structured individual interviews and FGD using key questions

Day 3 **Morning:** 09.00 – 12.00	**Interview/ group discussion:** 1. CHS Head – one interview 2. Midwives/ Counselors – one small group discussion 3. Communicators – group discussion with 5-6 communicators from different agencies (Women's Union, Youth Union, etc) Approximately one hour per group 4. Observation – Counseling at CHS 5. KAP/Client Satisfaction Survey: 10 ANC women invited randomly to CHS
Afternoon: 13.30 – 16.00	6. Group discussion with any ANC pregnant women: 5-6 women randomly invited to CHS 7. In-depth interview with 5 HIV (+) women and one family member invited to the CHS 8. KAP/ Client Satisfaction Survey: 10 ANC women invited randomly to CHS 9. Observation – BCC in the community
Day 4 **Morning:** 09.00 – 12.00 **Afternoon:** 13.30 – 16.00	**Interview/ group discussion:** 10. CHS Head – one interview 11. Midwives/ Counselors – small group discussion 12. Communicators – group discussion with 5-6 communicators from different agencies (Women's Union, Youth Union, etc) Approximately one hour per group 13. Observation – Counseling at CHS 14. KAP/Client Satisfaction Survey – 10 ANC women invited randomly to CHS 15. Group discussion with any ANC pregnant women: 5-6 women randomly invited to CHS 16. In-depth interview with 5 HIV (+) women and one family member invited to the CHS 17. KAP/ Client Satisfaction Survey: 10 ANC women invited randomly to CHS 18. Observation – BCC in the community

Time Frame and Work Plan from 19 Nov. 2007 to 05 January 2008

Tasks	Time Allocation	Tentative Dates	Place
Task 1: Development of assessment design	4 days	19-22 Nov	Hanoi
Task 2: Development of assessment tools and guidelines, with inputs from UNICEF and key counterparts	3 days	23-26 Nov	Hanoi
Task 3: pre-testing/ finalization of tools	2 days	27-28 Nov	Hai Phong
Task 4: Data collection HCM: 5 days An Giang: 5 days Quang Ninh: 4 days Hai Phong: 4 days Lang Son: 4 days	22 days (including travel)	29 Nov-24 Dec	An Giang, Ho Chi Minh, Quang Ninh, Hai Phong and Lang Son
Task 5: Data entry, analysis and draft report	5 days	26-30 Dec	Hanoi
Task 6: Final report writing in both English and Vietnamese, as per UNICEF evaluation report guideline, incorporating feedback from counterparts and UNICEF	5 days	31 Dec 07 – 05 Jan. 08	Hanoi
	Total: **41 days**		

Data Collection Sites

Lang Son province: Cao Loc district

1. Lang Son Reproductive Health Center
2. District Hospital
3. Dong Dang Commune (Strong)
4. Hop Thanh Commune (Weak)

Quang Ninh Province: Uong Bi District

1. Quang Ninh Reproductive Health Center
2. Uong Bi Preventive Medicine
3. Vang Danh Commune (S)
4. Quang Trung Commune (W)

Hai Phong Province: Thuy Nguyen District

1. Hai Phong Reproductive Health Center
2. District Hospital
3. Minh Tam Commune (S)
4. Hoang Dong Commune (W)

An Giang Province: Tan Chau District

1. Health Department Service
2. District Hospital

3. Long Phu Commune (S)
4. Le Chanh (W)

Ho Chi Minh City

1. Ho Chi Minh AIDS Committee
2. # 6 Preventive Medicine Center
3. # 11 Commune
4. # 10 Commune

Data Collection Itinerary

Date	District	Interviews and Discussions	Province
Tuesday 27 Nov	Thuy Nguyen	Pre-test/ finalize tools	Hai Phong
Wed 28 Nov		Finalize Tools; travel to Lang Son	Hanoi
Thursday 29 Nov	Cao Loc	Province/ District Health Center	Lang son
Friday 30 Nov		District Health Center	Lang son
Saturday 1 Dec		Commune Health Station	**Lang son**
Sunday 2 Dec	Hotel/Rest	Data analysis and rest	**Lang son**
Monday 3 Dec		Commune Health Station	**Lang son**
Tuesday 4 Dec	LL/ Hanoi	Lang Son- Hanoi in morning Meeting in afternoon – UNICEF	Ha noi
Wednesday 5 Dec	Uong Bi	Travel to QN in morning Working in afternoon – Province	**Quang Ninh**
Thursday 6 Dec		District Health Center	**Quang Ninh**
Friday 7 Dec		Commune Health Station	Quang Ninh
Saturday 8 Dec		Commune Health Station	**Quang Ninh**
Sunday 9 Dec	Hotel/Rest	Data analysis and rest	
Monday 10 Dec		Working in morning – DHC Travel to HP in the afternoon	**Quang Ninh**
Tuesday 11 Dec	Thuy Nguyen	Province/ District Health Center	Hai Phong
Wed 12 Dec		District Health Center	Hai Phong
Thu. 13 Dec		Commune Health Station	**Hai Phong**
Friday 14 Dec		Commune Health Station	**Hai Phong**
Saturday 15 Dec		Travel to HN- HCM in morning Travel to HCMC- AG in afternoon	**An Giang**
Sunday 16 Dec	Hotel/ rest	Data Analysis/ Rest	An Giang
Monday 17 Dec	Tan Chau	Province/ District Health Center	An Giang
Tuesday 18 Dec		District Health Center	An Giang
Wed 19 Dec		Commune Health Station	An Giang
Thursday 20 Dec		Commune Health Station	An Giang
Friday 21 Dec	District #6	Travel AG to HCM – Province PM	HCM
Saturday 22 Dec		District Health Center	HCMC
Sunday 23 Dec	Hotel/ rest	Data Analysis/ Rest	HCMC
Monday 24 Dec		Commune Health Station	HCM
Tuesday 25 Dec		Commune Health Station	HCMC
Wed 26 Dec		DHC in AM; Travel HCM-HN PM	Hanoi

Annex 9
List of Persons Consulted

Lang Son Province

Reproductive Health Center

1. Dr. Quang	Vice Director of Reproductive Health Center
2. Dr. Nong	Pediatric Department of Provincial Hospital
3. Dr. Huyen	O&G Department of the Provincial Hospital
4. Dr Lan	O&G Department of the Provincial Hospital
5. Dr Thuan	Trainer Province level

Cao Loc District Hospital

6. Dr But	Director of Cao Loc District Hospital
7. Dr Trinh	AIDS Program Officer
8. Dr Yen	Pediatric Department
9. Dr Dzung	O&G Department
10. Dr Hung	Surgeon Department
11. Dr Giang	Family Planning Team
12. Dr Mai	Family Planning Team
13. Ms Nu	Counselor

Hop Thanh Commune Health Station

14. Ly Thi Xuan	Head of CHS
15. Hoang Thi Luc	Health staff
16. Lam Thi Dao	Health staff
17. Hoang Thi Dai	Health staff
18. Truong Thi Bich Nguyet	YU - communicator
19. Nguyen Thi Kim	Health communicator
20. Pham Thi Minh	Health communicator
21. Nguyen Thi Binh	Health communicator
22. Nguyen Thi Thanh	WU - communicator
23. Truong Van Ngo	V. Director of commune committee

Dong Dang Commune Health Station

24. Nguyen Thi Tuyet	Head of CHS
25. Luu Thi Tinh	Nurse - Counselor
26. Nguyen Thi Van Anh	Nurse – Counselor

Cao Loc People's Committee

27. Nguyen Quoc Hung	Vice Chair, District People's Committee

Quang Ninh Province

Reproductive Health Center

28. Phung Thi Kim Dzung	Director of the Center
29. Bui Thi Luyen	O&G provincial Hospital
30. Nguyen Thanh Huyen	MD at the RH center – PMTCT Trainer
31. Nguyen Lam Giang	MD at the RH center – PMTCT Trainer

Uong Bi Preventive Medicine

32. Nguyen Van Thuy	Director of Uong Bi Preventive Medicine
33. Nguyen Trung Hoan	Head of planning Department
34. Nguyen Thi Nhung	WU representative
35. Doan Thi Kim Dzung	PMTCT program officer

District People's Committee

35. Le Văn Son	Vice Chair, District People's Committee

Vang Danh CHS

36. Tran Trung Diep	Head - Vang Danh CHS
37. Pham Thi Nguyen	Nurse
38. Mai Thi Viet Hong	Nurse
39. Trinh Bich Hong	Midwife
40. Nguyen Thi Yen	Technician
41. Communicators	YU Representatives
42. Communicators	WU Representatives

Quang Trung CHS

43. Nguyen Thi Chung	Communicator
44. Nguyen Thi Tinh	Communicator

Hai Phong City

Provincial Reproductive Health Center

39. Vu Van Cong	Director of AIDS Center
40. Doan Thi Thanh Huong	Director of RH Center
41. Nguyen Mai Anh	MD at O&G hospital
42. Nguyen Van Chinh	MD at Health Communication Center
43. Nguyen Ba Hoe	Vice Director of RH Center
44. Cao Lan Huong	MD at RH Center, PMTCT trainer
45. Doan Thi Hai Yen	MD at RH Center, PMTCT trainer

Thuy Nguyet District

District People's Committee

46. Tran Lanh	Vice Chair, District People's Committee

Thuy NguyenDistrct Hospital

48. Bui Xuan Huong	Director of Hospital
49. Dao Thi Chung	Vice director of Preventive Med Center
50. Dinh Thi Yen	Head of Pediatric Department
51. Pham Thi Thuy	Vice head of O&G Department
52. Nguyen Thi Hop	RH team – PMTCT Supervisor
53. Nguyen Thi Hien	RH team – PMTCT Supervisor
54. Le Thi Thuy	Preventive Med Center – PMTCT supervisor
55. Nguyen Thi Hanh	Preventive Med center – PMTCT supervisor
56. Nguyen Van Lap	Preventive Med center – PMTCT supervisor

Minh Tan Commune

57. Do Dang Khiem	Head of CHS
58. Vu Thi Xuan	Midwife – communicator
59. Le Thi Tuyet	Midwife – Communicator

Hoang Dong Commune

60. Nguyen Dinh Bang	Head of CHS
61. Nguyen Thi Thanh	Nurse
62. Vu Thi Nguyet	Nurse
63. Nguyen thi Phan	Communicator
64. Bui Thi Lien	Communicator

65. Tran thi Phu	Communicator
66. Nguyen Thi Ha	Communicator

An Giang Province

An Giang Health Service

67. Pham Thi Son	An Giang Health Service
68. Ha Thi Nga	RH Center
69. Pham Mi Lien Huong	RH Center
70. Lam Thi Thu	RH Center
71. Tran Thi Hoai Xuan	RH Center
72. Tran Van Sang	RH Center
73. Nguyen Thanh Thuy	O&G Department

Tan Chau District

District People's Committee

74. Mr. Chau Dung	Vice Chair, District People's Committee

Tan Chau District Hospital

75. Nguyen Van Ty	Vice Director of District Hospital
76. Nguyen Ngoc Hanh	Vice Director Prev Medicine Center
77. Pham Thi Ai Khanh	Vice head of O&G department
78. Le Thi Phuong	PMTCT Trainer
79. Ngo Kim Thanh	PMTCT supervisor
80. Le Tran Minh Chau	PMTCT officer
81. Nguyen Phuoc Hai	Head of District Health Derpartment

Long Phu Commune

82. Pham Thi Nhu	Head of Commune Health Station
83. Nguyen Ba Dai	Health Staff
84. Nguyen Thi Tham	Health staff
85. Nguyen Thi Kim Phuong	Health Staff
86. Nai thi Triet	Health Staff
87. Phan Thi Phuong	Health Staff
88. Luong Thuy Nghia	
89. Communicators	YU representatives
90. Communicators	WU representatives

Le Chanh Commune

91. Huynh Ngoc Phung	Commune Health Station
92. Huynh Thi Le Hang	Commune Health Station
93. Nguyen Van Tan	Commune Health Station
94. Nguyen Van Ba	Commune Health Station

Ho Chi Minh City

95. Lê Thuý Lan Thảo	Vice Chairman of AIDS Committee
96. Nguyễn Quốc Chinh	Vice Director of RH Center
97. Nguyễn Thị Hoàng Lan	Preventive Medicine
98. Trần Thị Thuỳ	Pediatrict No 2 Hospital
99. Võ Thị Ngọc Sương	Tu Du Hospital
100. Nguyễn Kim Ngân	Hung Vuong Hosptal
101. Phạm Thị Hải Ly	PMTCT Prog Officer AIDS Committee

Hospital District 6

102. Nguyen Thi Hang	O&G Department
103. Do Thu Hong	RH department Preventive medicine
104. Cao Nga Hong Le	RH department Preventive medicine
105. Nguyen Thi Ngoc Thu	Preventive medicine

11 Commune Health Station

106. Le Thi Bich Thuy	Head of CHS
107. Pham Thi Thanh Hoa	Communicator

10 Commune Health Station

108. Tran Thi Ngoc Nhung	Head of CHS
109. Ha Thanh Hoang	Midwife
110. Nguyen Thi Thu Hien	
111. Bui Thi Lien Huong	

District People's Committee

107. Le Thi Vuon	Vice Chair, District People's Committee

Ministry of Health – Hanoi (Project Management Unit)

108. Dinh Thi Phuong Hoa	Vice Director, Dept of Reproductive Health, MOH
109. Nguyen Van Kinh	Vice Director General of the VAAC, Director of Global Fund / HIV/AIDS in Vietnam

International Partners

110. Luisa Brumana	HIV/AIDS Specialist, UNICEF, Hanoi
111. Nguyen Ngoc Trieu	Programme Assistant, UNICEF
112. Mai Thu Hien	Project Officer, PMTCT, UNICEF
113. Le Thai Binh	Section Chief – PMTCT, CDC

Pregnant Women and Positive Mothers Interviewed

Location	Number of PW at ANC (client survey	Number of PW FGD, individual interview	Number of Positive mother	Number of Relative member
Lang Son (Dong Dang)	33	21	0	0
Quang Ninh (Uong Bi)	32	16	13	2
Hai Phong (Thuy Nguyen)	28	11	2	0
An Giang (Tan Chau)	59	17	7	2
Ho Chi Minh (District 6)	15	3	8	5
Total	**167**	**68**	**31**	**8**

Annex 10
Client Satisfaction Survey at ANC

This is my: □ First visit □ Second or more than one visit

Today I saw: □ A counselor □ A doctor □ Lab staff

A staff member greeted me within 15 minutes of my arrival at the center

□ Agree □ Disagree

There was a place for me to sit while I was waiting

□ Agree □ Disagree

The service was free of charge

□ Agree □ Disagree

Please state what you had to pay for:_____

The service is very careful to respect my privacy and keep my information confidential

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree*

Overall, the sevices I received were good and I am happy with the service

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree*.

Why:_____
_____

How can the service be improved? Specific recommendation?
_____
_____
_____

Counseling

I was given clear and useful information about how to protect myself and others from HIV and STI

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree*

Are you confident to protect yourself after reveiving the counselling at ANC?

- □ *Yes*
- □ *No*

Why:_____
_____

I felt comfortable asking the counselor questions

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree.*

Why:_____
_____

The counselor appeared comfortable talking to me about sensitive issues such as sex

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree*

The couselor asked me about different risk and when exactly these risk had occurred.

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree*

The counselor explained the window period for HIV in a way I could understand.

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree*

Are you confident to negociate with your husband/partner about safe sex

- □ *Yes*
- □ *No*

Why:_____
_____

The counselor clearly explained the meaning of my test results.

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree.*

I was provided with some results strategies and offered assistance related to how to tell my partner about my HIV test, or my STI

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree.*

Blood Tests

The time it takes for my test result to come back to me is too long

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree.*

The person who took my blood was carefull and respectful.

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree.*

Providers PMTCT services

I felt comfortabl asking the question

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree.*

The Provider wore gloves when conducting body exam

- □ *Agree*
- □ *No phisical exam by provider*
- □ *Disagree*

The provider clearly explained the health problem

- □ *Very much agree*
- □ *Agree*
- □ *Don't know*
- □ *Disagree*
- □ *Very much disagree*

Do you have any suggestions for how w can improve PMTCT services

KAP about HIV/AIDS

1. Have you ever received about HIV/AIDS transmistion from mother to child. *(Tick v in one of 2 boxes)* ?

□ Yes □
□ No □ -----> Do not ask the following questions

2. Where do you receive information of HIV/AIDS transmistion from mother to child? What is the main information source? What is the most favourable source? *(Fill in the table as instructed)*:

Sources	**Sources that have distributed the information** *(Tick v)*	**Main sources** *(Tick v)*	**Most favourable** *(Tick v)*
Radio			
TV			
Newspaper			
Village radio			
Commune health workers			
Village Women Union			
Relatives			
Neighbours			
Other (write in the blank rows)			

3. How does the mother transmit HIV / AIDS to her baby *(Tick v in the suitable boxes)* ?

□ Don't know □

□ During pregnancy □

□ During delivery □

□ Through breastfeeding □

□ Touching the baby such as kissing, bathing the baby...□

□ Other: □, *(specify)*: .....

4. How do you prevent mother to child transmission of HIV *(Tick v in the suitable boxes)*?

□ Don't know □

□ Pregnant women have to prevent themselves from infection □

□ (safe sex, no drug injections, not sharing the same syringe..)

□ HIV/AIDS women should not become pregnant □

□ HIV / AIDS pregnant women should have check-up and preventive remedy□

□ HIV / AIDS pregnant women should not breastfeed □

□ Wash the newborn baby right after birth □

□ Personal belongings should be separated □

□ Other □ *(specify):* .....

5. If 100 women who have HIV- infected gave birth to 100 infants, How many of the infants would typically become infected:

□

□ eeding_____

6. Name two maternal factors that may increase the risk of HIV transmission during pregnancy

_____

7. Name two factors that may increase the risk of HIV transmission during breasfeeding

_____

Understanding of pregnant mothers on PMTCT in five districts

	Cao Loc (lang Son) N = 33		Thuy Nguyen-Hai Phong N = 28		Uong Bi -Quang Ninh N= 32		Tan Chau -An giang N= 59		# 6 HCMC N = 15	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Correct and sufficient	21	63.6 %	27	96.4%	29	90.6 %	39	66.1 %	15	100%
In sufficient	5	15.2 %			2	6.3 %	5	8.5 %		
In correct	0	0								
Don't know	7	21.2 %	1	3.6%	1	3.1%	15	25.4 %		
Total	**33**	**100%**	**28**	**100 %**	**32**	**100 %**	**59**	**100%**	**15**	**100%**

Satisfaction clients at ANC

	Cao Loc (lang Son) N = 33		Thuy Nguyen-Hai Phong N = 28		Uong Bi -Quang Ninh N= 32		Tan Chau -An giang N= 59		# 6 HCMC N = 15	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Confideniality										
- Agree	29	87.9 %	28	100%	27	84.4%	49	83.1%	15	100%
- Don't know	4	12.1%			5	15.6 %	10	16.9%		
Satisfaction on HIV counseling services										
- very safisfaction	33	100%	28	100%	32	100%	59	100%	15	100%
- Don't know										
HIV testing										
- Times for HIV test is too long	2	6.1%			5	15.6%	2	3.4%		
- Times for HIV test is enough time	31	93.9%	28	100%	27	84.4 %	57	96.6%	15	100%
Satisfaction client about PMTCT provider										
- very safisfaction	33	100%	28	100%	30	93.7 %	57	96.6%	15	100%
- Don't know					2	6.3%	2	3.4%		

Annex 11

Proposed steps for project expansion

1. The Pilot has demonstrated some important and innovative approaches and techniques for strengthening PMTCT services for improved RH/ MCH outcomes in five districts/ provinces with HIV prevalence. Interviews and group discussions brought forth ideas and recommendations on how best to carry forward the Project benefits and lessons learned for broader and sustained coverage. The following are some of the suggestions and points raised:

i. Partnership Building: Establish and strengthen partnerships among the key players in PMTCT. This process can begin at a workshop to disseminate Pilot project experiences and lessons learned. Key representatives at all levels, from the community to national level, should be encouraged to participate. Findings from related research may also be presented here.

ii. National PMTCT/ HIV/AIDS Planning: National HIV/AIDS and PMTCT planning under the direction of the VAAC will map priority sites for scaling up the Pilot model nation-wide.

iii. Donor Coordination: Donor coordination meeting planned under the direction of the VAAC to bring together all the key players in PMTCT, in order to divide up the needed inputs.

iv. Strategic/ Action planning: Arrange for joint planning and proposal development of sustainable approaches to support PMTCT capacity building on a broader scale. One approach could be to move from models that provide subsidized support directly to health facilities and community-levels to one that more broadly supports the existing decentralized system of health services to provide efficient, effective and on-going capacity building, monitoring and evaluation of PMTCT. One issue that has been raised consistently is to ensure local level participation and relevance in whatever approach is taken. Some possible components to this approach include:

- **Orientation/Sensitizing Workshop:** Establish clarity of purpose among key leaders
- **Training needs assessment:** Identify essential training needs in provinces/ region, and test the existing training materials for appropriateness and modify according to local contexts and capacities.
- **TOT Courses:** TOT courses should provide participants with comprehensive orientation and sensitization components as well as practice of participatory teaching and learning techniques. Under the direction of the central HIV/AIDS technical working group, develop the TOT courses, and provide training and technical support. Province-wide or multi-province TOT could be coordinated for broader coverage. Then each team of core HIV/AIDS/ PMTCT trainers develops their provincial plan for PMTCT TOT courses, and service provider training in their districts and communes.
- **Training of Trainers (TOT):** Identify and provide training to a core group of PMTCT trainers from PAC, RHC, O & G and pediatric hospitals, and secondary medical schools in each province – identified based on specific and strictly adhered to criteria according to their actual job responsibilities, and their strong enthusiasm and commitment to PMTCT strengthening, and with sufficient time to realistically and effectively carry out regular training of PMTCT supervisors and service providers.

v. Training Courses on VCT and IEC/ BCC: The teams of provincial and district trainers include PAC and RHC trainers and mobile team members, O&G/ pediatric clinical trainers, and provincial secondary medical schools who together plan and deliver training courses on (i) HIV voluntary Counseling and Testing (VCT), (ii) community-based health promotion skills and behavior change communication (BCC) for PMTCT, and (iii) monitoring and supervision. Training takes the form of training workshops,

local study visits to well-functioning PMCTC models in Viet Nam, and field practice. Total participants in each course is 25-30 persons

- **Local Study Visits and Feedback Workshops:** District and commune level health staff, hamlet health workers, members of mass organizations, local authority and other community members can visit nearby districts and provinces to observe PMTCT models, and then present lessons learned in local feed-back workshops,
- **District IEC/ BCC Training Structure:** Provincial and District trainers who complete relevant TOT courses coordinate and conduct health promotion courses as a team in their Districts and Communes. One District trainer in each province is also a member of the PAC, linking the PMTCT training activities with overall HIV/AIDS training resources and support. Participatory, action oriented methods include brainstorming, drama, case study, small group discussion, role play and group exercise.
- **IEC/ BCC Courses for Health Communicators;** Courses are conducted in the selected districts, and include participants from District and Commune levels, and who are trained together, including health staff, mass organizations, population collaborators, peoples committees, and general community members as follows:
- **Each District:**
    - District Preventive Medicine Center (mobile team/ counselors)
    - District Women's Union members
- **Each Commune:**
    - Commune Health Staff (responsible for counseling at the CHS)
    - Hamlet Health Workers (health communicators)
    - Volunteer Communicators: (Women Union, Youth Union, Farmer Association Child Protection/ Care Committee, Population/ Family Planning Collaborator)

vi. Financing: UNICEF Viet Nam is well positioned to advocate for sustainable models for PMTCT, which clearly builds upon the pilot project experiences. Donor funding should however, coordinate with appropriate counterpart funding and staff time commitments to enhance institutionalization for sustained SBM support.

vii. Counterpart Funding: Suggestions include: DOH facility-based approaches which draw on local DOH training budgets, local community fund-raising through PC and mass organizations, and area-based approaches for pooling resources regionally.

viii. Timing: The timing is favorable for supporting institutional strengthening as the health system is currently undergoing restructuring, particularly for HIV/AIDS coordination under the newly established VAAC and PACs, and at the district level DOH, which recently divided into the three divisions: DH, PMC, and DHC. The new regulations are established under the National Strategy and National Plan of Action.

2. Low Prevalence Districts

Situation

- Most clients are HIV – Negative
- VCT is less emotionally burdensome for both clients and providers

- Have resources to provide individualized follow- up support.
- HIV/AIDS is not priority
- Knowledge of PMTCT is within the community is lower and fewer health worker are able to carry out PMTCT.

Activities for PMTCT

1. Capacity building for the staffs on PMTCT:

- Establish the core trainer team (provincial and district trainers) to provide training for selected CHS health staff on PMTCT (VCT and BCC), identified based on clear criteria:
  - Only individuals who will actually conduct VCT and BCC in their normal work
  - Health staff, communicators who have skills in counseling and communication
  - IEC/ BCC training for health staff, HHWs, WU/ YU - training courses conducted together to build strong cross-sector working relationship, and supported by CHS
  - Refresh training every year – for those actually doing VCT/ BCC (eg, counselors)
  - Local Study Visits/ Feedback: learn and share experience with other provinces

2. Communication activities

- Integrate PMTCT communication activities with other primary health care (PHC) mother/child health (MCH) and reproductive health (RH) and HIV/AIDS programs
- Target groups: involve men as well as PW and women of reproductive age
- IEC materials provided to all target groups in the community, not only for PW

3. Focal point for the PMTCT program: (low prevalence areas)

- Preventive Medicine Center (PMC) manages and supervises all PMTCT activities in CHS, with technical assistance from District Hospital (DH) O&G Department

4. Care support and referral system:

- District PMC supports and supervises CHS for follow-up and support for HIV-positive PW and positive mothers in the community.
- CHS, PMC and DH O&G department develop/ agree clear procedure for referrals of HIV-positive PW to delivery, for infant feeding counseling, and follow-up.
- List of places which provide services for PLWHA including ARV treatment produced and made available to PWs and positive mothers at ANC centers

3. High Prevalence Districts

Situation.

- High numbers of HIV-positive PW, mothers, and their partners
- Potential for counselors burnout - focus on improving quality of counseling
- Staff shortages and high client demand for curative services

- HIV/AIDS a priority health issue - many other donor-supported HIV/AIDS projects
- High awareness/ knowledge on PMTCT and HIV in the community, with available information on HIV/AIDS, PMTCT from other projects working in the area
- There is a need to strengthen collaboration among the various projects.

Activities for PMTCT

1. Establish Project Management Board for PMTCT/ HIV/AIDS – District Level

Management Board Chair: Vice Chairman of District People's Committee

Coordination	Technical Assistance
Provincial AIDS Center	Provincial Hospital
Preventive Medicine center District Hospital	District Hospital - O& G department - Pediatric department District Preventive medicine - FP/supervision team
Chairman of Commune people Committee Head of WU	Head of CHS

- Focal Point is the District Preventive Medicine Center - can advocate for the PMTCT program, mobilize resources, coordinate partners and provide ongoing support
- Develop a coordinating mechanism for relevant policy, technical and service delivery to implement common policies, guidelines, and to share information and resources

2. Capacity building for health staff, communicators, managers and coordinators

- Counseling skills
- Communication skills
- Management skills
- Develop a cost-effective and efficient blood sample coding system, with supporting computer software to manage data related to PLWA in the province and districts

3. Communication activities

- Integrate PMTCT communication activities with other primary health care (PHC) mother/child health (MCH) and reproductive health (RH) and HIV/AIDS programs
- Target groups: involve men as well as PW and women of reproductive age
- IEC materials provided to all target groups in the community, not only for PW

4. Set up care and support referral systems

- Coordinate between District preventive medicine and District hospital to support care and treatment for PW positive and m

Annex 12

Clinical Performance Indicators in Five Pilot Districts

Indicator	2005 (Jun – Dec)	2006 (Jan – Dec)	2007 (Jan – Sept)	Total
Number of PW	14,771	14,884	9,876	39.531
Thuy Nguyen- Hai Phong	3,800 (25.6%)	4,059 (27.3%)		7.859 (19.9%)
Uong Bi – Quang Ninh	1,534 (13.4%)	1602 (10.8%)	1676 (16.9%)	4812 (12.1%)
Cao Loc- Lang Son	1,387 (9.4%)	1382 (9.3%)	1062 (10.7%)	3831 (9.7%)
Tan Chau – An Giang	4471 (30.3)	4501 (30.2%)	4086 (41.4%)	13058 (33%)
#6 Dist – Ho Chi Minh	3579 (24.2%)	3340 (22.4)	3052 (30.9%)	9971 (25.2%)
Number of PW go to ANC/ PW	8,270 (56.0%)	12,716 (85.5%)	7,227 (73.2%)	28,213 (71.4%)
Thuy Nguyen- Hai Phong	2867 (34.7%)	4059 (31.9%)		6926 (24.5%)
Uong Bi – Quang Ninh	1096 (13.2%)	1046 (8.2%)	1612 (22.3%)	3754 (13.3%)
Cao Loc- Lang Son	829 (10%)	905 (7.1%)	784 (10.8%)	2518 (8.9%)
Tan Chau – An Giang	2250 (27.2%)	4192 (32.9%)	2494 (35.5%)	8936 (31.7%)
#6 Dist – Ho Chi Minh	1228 (14.8%)	2514 (19.7%)	2337 (32.3%)	6079 (21.5%)
Number of PW got pre-test counseling	8,270 (100%)	12,716 (100%)	7,227 (100%)	28,213 (100%)
Thuy Nguyen- Hai Phong	2867 (34.7%)	4059 (31.9%)		6926 (24.5%)
Uong Bi – Quang Ninh	1096 (13.2%)	1046 (8.2%)	1612 (22.3%)	3754 (13.3%)
Cao Loc- Lang Son	829 (10%)	905 (7.1%)	784 (10.8%)	2518 (8.9%)
Tan Chau – An Giang	2250 (27.2%)	4192 (32.9%)	2494 (35.5%)	8936 (31.7%)
#6 Dist – Ho Chi Minh	1228 (14.8%)	2514 (19.7%)	2337 (32.3%)	6079 (21.5%)
Number of PW got voluntary HIV test in during pregnancy/ nmber of PW got Pretest counseling	5270 (63.7%)	8110 (63.8%)	5,377 (74.4%)	18757 (66.5%)
Thuy Nguyen- Hai Phong	1251 (13.8%)	2683 (33.1%)		3934 (20.9%)
Uong Bi – Quang Ninh	612 (11.6%)	1046 (13%)	1074 (20%)	2732 (14.6%)
Cao Loc- Lang Son	543 (10.3%)	905 (11.2%)	614 (11.5%)	2062 (11%)
Tan Chau – An Giang	1636 (31%)	2058 (25.4%)	1908 (35.4%)	5602 (29.8%)
#6 Dist – Ho Chi Minh	1228 (23.3%)	1418 (17.5%)	1781 (33.1%)	4427 (23.6%)

Indicator	2005 (Jun – Dec)	2006 (Jan – Dec)	2007 (Jan – Sept)	Total
Number of PW positive after testing in during pregnancy/PW got voluntery HIV test during pregnancy	22 (0.42%)	42 (0.52%)	16 (0.3%)	80 (0.43)
Thuy Nguyen- Hai Phong	5 (22.7%)	12 (28.6%)		17 (21.25%)
Uong Bi – Quang Ninh		2 (4.8%)		2 (2.5%)
Cao Loc- Lang Son		1 (2.4%)	3 (18.75%)	4 (5.0%)
Tan Chau – An Giang	6 (27.3%)	10 (23.8%)	2 (12.5%)	18 (22.5%)
#6 Dist – Ho Chi Minh	11 (50%)	17 (40.4%)	11 (68.75%)	39 (48.75%)
Number of PW positive after testing during the delivery/Total of PW Positive	1 (4.3%)	3 (6.7%)	4 (20%)	8 (9.1%)
Thuy Nguyen- Hai Phong				
Uong Bi – Quang Ninh		2 (66.7%)		2 (25%)
Cao Loc- Lang Son			1 (25%)	1 (12.5%)
Tan Chau – An Giang	1 (100%)		2 (50%)	3 (37.5%)
#6 Dist – Ho Chi Minh		1 (33.3%)	1 (15%)	2 (25%)
Number of PW positive received ARV prophylaxis/PW positive during precgnancy	12/22 (54.5%)	27/42 (64.3%)	10/16 (62.5%)	51/80 (63.75%)
Thuy Nguyen- Hai Phong/PW positive in Thuy Nguyen	5/5 (100%)	12/12 (100%)		17/17 (100%)
Uong Bi – Quang Ninh/PW positive in Uong Bi		3/4 (75%)		3/4(75%)
Cao Loc- Lang Son/PW positive in Cao Loc		1/1 (100%)	2/4 (50%)	3/5 (60%)
Tan Chau – An Giang/PW positve in Tan Chau	6/7 (85%)	9/10 (90%)	2/4 (50%)	17/21 (80.9%)
#6 Dist – Ho Chi Minh/PW positive in #6 dist	1 /11 (9.1%)	4/18 (22.2%)	6/12 (50%)	11/41 (26.8%)
Number of newborn from PW + have PMTCT prevention/total of newborn from positive mother	12/12 (100%)	29/32 (90.6%)	11/13 (84.6%)	52 (91.2%)
Thuy Nguyen- Hai Phong	5 (41.6%)	12 (41.4%)		17
Uong Bi – Quang Ninh		3 (10.3%)		3
Cao Loc- Lang Son		1 (3.4%)	2 (18.2%)	3
Tan Chau – An Giang	6 (50%)	9 (31%)	3 (27.3%) (1 twin)	18
#6 Dist – Ho Chi Minh	1 (8.3%)	4 (13.8%)	6 (54.5%)	11

Indicator	2005 (Jun – Dec)	2006 (Jan – Dec)	2007 (Jan – Sept)	Total
Number of newborn from PW + without PMTCT prevention/total of newborn from Positive mother	0	3/32 (9.4%)	2/13 (15.4%)	5/57 (8.8%)
Thuy Nguyen- Hai Phong				0
Uong Bi – Quang Ninh		1		1
Cao Loc- Lang Son		1		1
Tan Chau – An Giang		1		1
#6 Dist – Ho Chi Minh			2	2
# of HIV positive mother who use breast milk replacement/total of newborn from positive mother	10/12 (83.3%)	25/32 (78.1%)	13/13 (100%)	48/57 (84.2%)
Thuy Nguyen- Hai Phong/ total of newborn from positive mother in Thuy nguyen	5 /5 100	10/12 (83.3%)		15/17 (88.2%)
Uong Bi – Quang Ninh/ total of newborn from positive mother in Uong Bi		3/4(75%)		3/4(75%)
Cao Loc- Lang Son total of newborn from positive mother in Cao loc		1/2 (50%)	2/2 (100%)	3/4 75%)
Tan Chau – An Giang total of newborn from positive mother in Tan Chau	4/6 (66.7%)	7/10 (70%)	3/3 (100%)	14/19 (73.7%)
#6 Dist – Ho Chi Minh total of newborn from positive mother in #6 district	1/1 (100%)	4/4 (100%)	8/8 (100%)	13/13 (100%)
Number of newbor received ARV prophylaxis at birth	13	29	11	53
Thuy Nguyen- Hai Phong/ total of newborn from positive mother in Thuy nguyen	5/5 (100%)	12 /12 (100%)		17/17(100%)
Uong Bi – Quang Ninh/ total of newborn from positive mother in Uong Bi	0	0	0	0
Cao Loc- Lang Son total of newborn from positive mother in Cao loc		2/2(100%)	2/2(100%)	4/4 (100%)
Tan Chau – An Giang total of newborn from positive mother in Tan Chau	7/7 (100%)	10/10 (100%)	2/4 (50%)	19/21 (90.5%)
#6 Dist – Ho Chi Minh total of newborn from positive mother in #6 district	1/1 (100%)	4/4 (100%)	8/8 (100%)	13/13 (100%)
Number of babies born to HIV positive mother received cotrimoxazol	6	20	8	34
Thuy Nguyen- Hai Phong	5/5 (100%)	12/12 (100%)		17/17 (100%)
Uong Bi – Quang Ninh		3/4 (75%)		3/4(75%)
Cao Loc- Lang Son		1/4 25%)		1/4(25%)
Tan Chau – An Giang				
#6 Dist – Ho Chi Minh	1/1 (100%)	4/4 (100%)	8/8 (100%)	13/13 (100%)

Referrals

Indicators	2005	2006	2007	Total
Number HIV positive mother transferred to ARV treatment services after delivery	8/23 (34.8%)	13/45 (28.9%)	9/20 (45%)	30/88 (35.2%)
Thuy Nguyen- Hai Phong				
Uong Bi – Quang Ninh				
Cao Loc- Lang Son				
Tan Chau – An Giang	7/7(100%)	8/10	2/4 (50%)	17/21 (80.9%)
#6 Dist – Ho Chi Minh	1/1(100%)	5/18	7/12	13/41 (31.7%)
Number of HIV positive mothers drop out of PMTCT	9/23 (39%)	13/45 (28.9%)	10/20 (50%)	31/88 (35.2%)
Thuy Nguyen- Hai Phong	1/5	0/12		1/17 (5.9%)
Uong Bi – Quang Ninh				No data
Cao Loc- Lang Son		0/1	2/4 (50%)	2/5 (20%)
Tan Chau – An Giang	0/7	2/10 (15.4%)	2/4 (20%)	4/21 (19%)
#6 Dist – Ho Chi Minh	8/11 (72.7%)	11/18 (61.1%)	6/12 (50%	25/41 (61%)

Data Collection Form From Reporting in the Community

Clinical data

		2005					2006					2007					Total	
No	**Indicator**	**Thuy nguyen**	**Uong bi**	**Cao Loc**	**Tan chau**	**#6 dist.**	**Thuy Nguyen**	**Uong bi**	**Cao loc**	**Tan chau**	**#6 dist.**	**Thuy nguyen**	**Uong bi**	**Cao Loc**	**Tan chau**	**#6 dist.**	**NO**	**%**
	# PW	3800	1534	1387	4471	3579	4059	1602	1382	4501	3340		1676	1062	4086	3052	39531	
	# PW go to ANC	2867	1096	829	2250	1228	4059	1046	905	4192	2514		1612	784	2494	2337	28213	
	# PW got pre- test counselling on PMTCT	2867	1096	829	2250	1228	4059	1046	905	4192	2514		1274	784	2494	2337	28213	
	# PW got voluntary HIV test - in pracgnancy	1251	612	543	1636	1228	2683	1046	905	2058	1418		1047	614	1908	1781	18757	
	One time				1632		2681			2045					1899			
	Two times				4		2			13					9		28	
	Three times																	
	- During the delivery			70	8			2	96	39	1		0	112	26	1	357	

	# PW positive after testing	5	0	0	7	11	12	4	1	10	18		0	4	4	12	88	
	- in pracgnancy	5			6	11	12	2	1	10	17			3	2	11	80	
	- during the delivery				1			2			1			1	2	1	8	
	# PW who received post – test	1249	612	505	976	1228	2683	1134	840	1658	2418		1074	579	1579	1781	18316	
	- PW Negative	1244	612	505	969	1217	2671	1130	839	1648	2400		1074	575	1575	1769	18228	
	- PW Posistive	5			7	11	12	4	1	10	18			4	4	12	88	
		2005					**2006**					**2007**						
No	**Indicator**	**Thuy nguyen**	**Uong bi**	**Cao Loc**	**Tan chau**	**#6 dist.**	**Thuy Nguyen**	**Uong bi**	**Cao loc**	**Tan chau**	**#6 dist.**	**Thuy nguyen**	**Uong bi**	**Cao Loc**	**Tan chau**	**#6 dist.**	**NO**	**%**
	# HIV positive mother who received ARV prophylaxis	5	0	0	6	1	12	3	1	9	4			2	2	6	51	
	# HIV posistive mother who received STI and Ois treatment	0	0	0	6	1	0		0	8	4			0	2	6	27	
	# newborn from PW+ have PMTCT prevention	5	0	0	6	1	12	3	1	9	4			2	3	6	52	
	# newborn from PW+ don't have PMTCT prevention	0	0					1	1	1						2	5	
	# of HIV positive mother practice breast milk replacement	5	0	0	4	1	10	3	1	7	4			2	3	8	48	

	# Babies born to HIV positive mothers received Cotrimoxazol at 4 week age	5	0			1	12	3	1		4					8	34	
	# HIV positive mother transferred to ARV treatment services after delivery	0	0	1	7	1	0	0	0	8	5			0	2	7	31	
	# HIV positive mother dropping out the PMTC services	1	0	0	0	8	0	0	0	2	11			2	2	6	32	