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Achieving the Millennium Development Goals

UNFPA's responses to the needs of Safe Motherhood and Newborn Care in Viet Nam

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HA NOI 2007

"No nation can be developed when women are denied the right to health, and no nation can progress when large numbers of women die while giving life".

Thoraya Obaid, Executive Director of UNFPA, during her keynote address to the 60th World Health Assembly, Geneva, 15th May 2007

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Abbreviations

CEDAW	Convention on the Elimination of Discrimination Against Women
CPAP	Country Programme Action Plan
CPRGS	Comprehensive Poverty Reduction and Growth Strategy
CP6	Sixth Joint Programme of Cooperation (2001-2005)
CP7	Seventh Joint Programme of Cooperation (2006-2010)
ESCAP	UN Economic and Social Commission for Asia and the Pacific
GDP	Gross Domestic Product
GSO	General Statistics Office
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IDTs	International Development Targets
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOFA	Ministry of Foreign Affairs
MOH	Ministry of Health
MPI	Ministry of Planning and Investment
NSGs	National Standards and Guidelines for Reproductive Health Care Services
NGO	Non-Governmental Organisation
PATH	Programme for Appropriate Technology in Health
PCPFCs	Provincial Committees for Population, Family and Children
RHC	Reproductive Health Care
SMI	Safe Motherhood Initiative
TT	Tetanus toxoid
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNIFEM	United Nations Development Fund for Women
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteers
VCPFC	Viet Nam Committee for Population, Family and Children
WHO	World Health Organisation
WTO	World Trade Organisation

Preface

In December 2005, the Government of the Socialist Republic of Viet Nam and the United Nations Population Fund (UNFPA) completed the Sixth Joint Programme of Cooperation (CP6). To mark the end of 5 years of collaboration (2001-2005), UNFPA undertook a series of studies to draw lessons learned and best practices from the programme's implementation.

This report is prepared by Ms Barbara Bale, a reproductive health expert and specialist in maternal and newborn health, who has long experience of the health care system of Viet Nam. It documents the progress made in improving the health of women and their babies and UNFPA's role in the successes to date. It also points towards the direction needed to achieve the Millennium Development Goals (MDGs) that directly and indirectly impact on maternal and child health. This report is the outcome of a review of secondary sources of information including reports produced by the Government of Viet Nam, particularly the Ministry of Health, and UNFPA project reports. Other sources of information, much of which is available from web sites in the public domain, have been referenced in the text or as footnotes.

The Millennium Development Goals form a blueprint agreed to by all countries and the world's leading development institutions at the Millennium Summit in 2000 to make unprecedented efforts to meet the needs of the world's poorest by 2015. This document identifies valuable lessons for the planning and application of future maternal and newborn health programmes by government, NGOs, United Nations agencies and other concerned stakeholders to ensure the achievement of the MDGs in Viet Nam.

I would like to thank Ms Barbara Bale for her considerable efforts in completing this report. I would also like to thank Dr Duong Van Dat of UNFPA Viet Nam for his coordination in preparing and publishing lessons learned and best practices from UNFPA's country programmes. Lastly but most importantly, we would like to acknowledge the reproductive health policy makers and service providers, and their clients who are the essence of the UNFPA assistance programme and for whom this publication is intended to benefit. It is UNFPA's wish that the lessons learned and experiences gained from CP6 will be of use to policy makers, programme managers, health professionals and donors in designing and implementing reproductive health programmes aligned with the Millennium Development Goals (MDG) and the commitments made at the International Conference on Population and Development (ICPD) in Viet Nam.

Ian Howie
Representative
UNFPA in Viet Nam

Background and context

What are the Millennium Development Goals?

The original International Development Targets (IDTs) were derived from agreements and resolutions of the world conferences organised by the United Nations in the 1990s. At the UN Millennium Summit in September 2000, heads of State and representatives of Governments from some 189 countries adopted the Millennium Declaration committing their nations to a new global partnership to reduce extreme poverty by 2015. A set of targets with corresponding indicators were agreed upon and are known as the Millennium Development Goals (MDGs).

Millennium Development Goals

Goal 1	Eradicate extreme hunger and poverty
Goal 2	Achieve universal primary education
Goal 3	Promote gender equality and empower women
Goal 4	Reduce child mortality
Goal 5	Improve maternal health
Goal 6	Combat HIV/AIDS, malaria and other diseases
Goal 7	Ensure environmental sustainability
Goal 8	Develop a global partnership for development

The eight MDGs are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions, while promoting gender equality, education, and environmental sustainability. The MDGs are an agreed blueprint that guides development priorities for governments, donors and practitioner agencies worldwide.

The first seven goals are mutually reinforcing and are directed at reducing poverty in all its forms. The last goal - global partnership for development - is about the means to achieve the first seven. Goals 4 and 5 are specifically concerned with improving the health of women and children. There was no target or indicator set at the Millennium Summit for universal access to reproductive health.

Safe motherhood and newborn care

Safe Motherhood

In 1987 the World Bank, in collaboration with the World Health Organisation (WHO) and the United Nations Population Fund (UNFPA), sponsored a conference on safe motherhood in Nairobi, Kenya to help raise global awareness about the impact of maternal mortality and morbidity. The conference launched the Safe Motherhood Initiative (SMI), which issued an international call to action to reduce maternal mortality and morbidity by one half by the year 2000.

Safe motherhood covers a broad range of direct and indirect efforts to reduce deaths and disabilities resulting from pregnancy and childbirth. Direct efforts include those to ensure that every woman has access to a full range of quality, affordable sexual and reproductive health services. This incorporates recognising the risks encountered during pregnancy, rapid referrals when necessary, professional care of women in childbirth and treatment of obstetric emergencies. Indirect efforts include delaying the age of marriage and first pregnancy and limiting the number of pregnancies. The health and care of the newborn was considered implicit in safe motherhood activities.

The strategies to make motherhood safer and to improve newborn survival include the following:

Maternal Care

- Providing family planning services
- Providing post abortion care
- Promoting antenatal and postnatal care
- Ensuring skilled assistance during childbirth
- Improving essential obstetric care
- Addressing the reproductive health needs of adolescents

Newborn Care

- Cleanliness (clean delivery including clean cord care)
- Thermal protection
- Initiation of breathing (resuscitation if necessary)
- Early and exclusive breast feeding
- Eye care
- Immunisation
- Management of newborn illness
- Care of the pre-term and/or low birth weight baby

What about sexual and reproductive health?

Sexual and reproductive health may be summarised as follows:

- All individuals make informed choices about sexuality and reproduction, for a safe and satisfying sexual life, free of violence and coercion
- Women proceed safely through pregnancy and childbirth
- Couples have the best chance of having a healthy infant
- Women avoid unwanted pregnancy and the consequences of unsafe abortion
- Access to prevention, treatment and care for sexually transmitted infections including HIV

Safe motherhood is an integral part of **sexual and reproductive health** and is a large component of reproductive health care service delivery. **Newborn health** is not usually included in the definition of sexual and reproductive health but the linkages between maternal and newborn health care are vital for the wellbeing of both mother and baby. The integration of maternal and newborn care is also necessary for programming as the mother and baby invariably share the same health care provider.

Reproductive health, including sexual health, is sometimes known as the missing MDG[1], and was finally endorsed as a new target - universal access to reproductive health by 2015 - in October 2006 under Millennium Development Goal 5: to improve maternal health. A brief summary follows of key activities that led to the explicit placing of reproductive health within the MDG framework, acknowledging its importance to socio-economic development. This shift was reflected in turn among the policy makers within the Government of Viet Nam.

The 5th Asian and Pacific Population Conference 2002

The UN Economic and Social Commission for Asia and the Pacific (ESCAP) and UNFPA organised the Fifth Asian and Pacific Population Conference in Bangkok. In preparation for the ten year anniversary of the International Conference on Population and Development (ICPD), the conference brought together 23 countries in the Asia Pacific region, including representation from Viet Nam, to review progress on the implementation of the ICPD Programme of Action in the region, examine obstacles, and adopt a plan for action to ensure further progress.

The Millennium Project 2002 - 2006

The Millennium Project was commissioned by the United Nations Secretary General in 2002 to develop a concrete action plan for the world to achieve the Millennium Development Goals and to reverse the poverty, hunger and disease affecting billions of people. The independent advisory body presented its final recommendations in January 2005 and the thematic task force reviewing the child health and maternal health Millennium Development Goals (4 and 5) recommended that faster progress should be made among the poor and other marginalised groups and the target of 'universal access to reproductive health services' be included.

The World Summit 2005

The World Summit held in New York City in September 2005 was convened five years after the Millennium Summit to assess progress towards attaining the MDGs and to reiterate the *'strong and unambiguous commitment by all governments, in donor and developing nations alike, to achieve the Millennium Development Goals by 2015'*[2]. Article 57 (g) on universal access to reproductive health services was included under MDG 5, finally acknowledging the interplay reproductive health has in achieving other MDGs and its importance in reducing poverty.

Viet Nam Development Goals and Targets

As part of the follow up to the Millennium Declaration and as requested by the General Assembly, UN Country Teams generated progress reports in programme countries.

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[1] Horton R. 'Reviving reproductive health' Lancet November 4, 2006 Vol 368:1549

[2] United Nations Department of Public Information (2005) World Summit Fact Sheet

In 2001, this represented for Viet Nam a first stocktaking, monitoring, and analysis of the International Development Targets and Millennium Development Goals which was internationally comparable. This was followed by a consultative process among representatives of government, bilateral, multilateral and non-governmental organisations which included an in-depth exercise of "localising the MDGs for the Viet Nam context". The resulting documentation fed into the Government of Viet Nam's preparation of the Comprehensive Poverty Reduction and Growth Strategy (CPRGS) and, focusing on themes taking Government strategies as a starting point, explored the links with the MDGs. This thematic focus allowed the inclusion of key development issues in Viet Nam which would not automatically be covered by the MDGs and to establish indicators which are relevant for Viet Nam's strategic objectives.

"The Millennium Development Goals (MDGs) have a lot in common with Viet Nam's own development targets, therefore, the commitment to the MDGs is of great significance for the country. Since the President made a commitment to the international community on implementing the MDGs in 2000, the Prime Minister has instructed the Ministry of Planning and Investment (MPI) to integrate the realisation of those goals with the country's socio-economic targets. The MPI-designed comprehensive poverty reduction and hunger elimination strategy (CPRGS) was approved by the Prime Minister as early as in 2001. Under the CPRGS, Viet Nam nationalised the MDGs to make them adaptable to the country's actual situation. These goals were integrated into the country's socio-economic development programme. For that reason, Viet Nam was able to mobilise more resources for the realisation of the MDGs".

Source: Ministry of Foreign Affair of Viet Nam (http://www.mofa.gov.vn/en/)

In May 2002 the Government of Viet Nam published the Comprehensive Poverty Reduction and Growth Strategy which reflected their commitment to achieving the international targets. This helped to align Viet Nam's planning cycle with the MDGs but also recognised Viet Nam's considerable achievements in recent years; for example, poverty had already been halved between 1990 and 2000.

"This document specifies objectives, tasks, mechanism, policies and general solutions of the 10-year strategy for socio-economic development for the 2001-2010 period, the 5-year socio-economic development plan for the 2001-2005 period and the other sector and field strategies. The Comprehensive Poverty Reduction and Growth Strategy (CPRGS) also reflect the millennium development objectives of the United Nations that Viet Nam has committed to implement".

Source: Government of Viet Nam (2002) Introduction to the Comprehensive Poverty Reduction and Growth Strategy

Although the formulation and the approval of the CPRGS was a major step forward in integrating the MDGs into Viet Nam's social and economic development policies and raised the quality dimension, in the final targets and indicators, neonatal health and reproductive health were not included.

GOAL 4: REDUCE CHILD MORTALITY	GOAL 5: IMPROVE MATERNAL HEALTH
Target ■ Reduce the infant mortality rate to 30 per 1000 live births by 2005 and 25 by 2010 and at a more rapid rate in disadvantaged regions. ■ Reduce the under-5 mortality rate to 36 per 1000 live births by 2005 and 32 by 2010. ■ Reduce under-5 malnutrition to 25% by 2005 and 20% by 2010.	**Target** ■ Reduce the maternal mortality ratio to 80 per 100,000 live births by 2005 and 70 by 2010 with particular attention to disadvantaged areas. Source: Government of Viet Nam (2002) the Comprehensive Poverty Reduction and Growth Strategy

Concurrently, the government of Viet Nam developed and approved its first National Reproductive Health Care (RHC) Strategy in 2001 with UNFPA support. This outlined the goals and objectives for reproductive health care over the next decade in line with the ICPD Programme of Action.

The UN Country Team continued to support the Government of Viet Nam to monitor progress towards the MDGs and to encourage further integration of socio-economic policies. In 2005 the government prepared a national MDG Report for presentation at the Millennium Summit Plus Five that provided details of the country's achievements since 2000 and outlined the remaining challenges for the next decade. The list of achievements documented is impressive with the most recent household survey data indicating that the poverty rate in 2004 was less than half that recorded in 1993. However, the report also makes clear that Viet Nam still faced important development challenges despite rapid economic growth sustained over two decades. Viet Nam remains a poor country and income disparities are widening among geographic areas and ethnic groups. Access to and the quality of health care varies significantly from place to place and among income groups, with an increasing private expenditure burden for health care presenting a particular challenge. The spread of HIV/AIDS remains a real threat to continued development progress.

In November 2005 the UN Country Team produced a publication[3] as a contribution to the planning efforts of the government as it prepared the 2006-2010 Socio-Economic Development Plan. The aim of the paper was to consider national objectives from the perspective of the MDGs, and to suggest concrete indicators of social progress relevant to both the MDGs and Viet Nam's specific socio-economic conditions to help policymakers fully integrate the MDGs into Viet Nam's own national planning mechanisms.

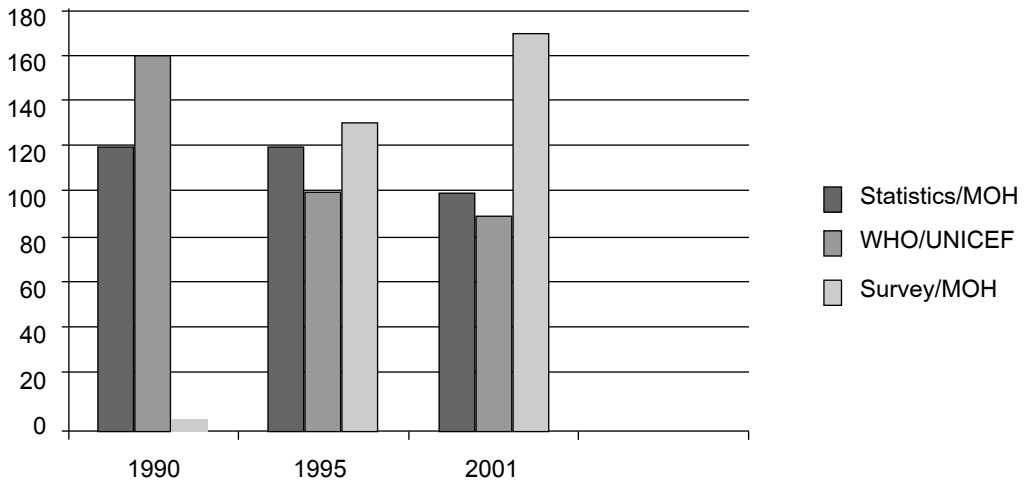
It presented a number of concrete suggestions informed by the reports and analyses produced by the Millennium Project and these included highlighting the lack of neonatal data and the importance of sexual and reproductive health and the mainstreaming of gender. Viet Nam was identified as a potential 'MDG fast track' country that has the capacity to absorb additional overseas development assistance.

[3] United Nations Country Team Viet Nam (2005) MDGs and Viet Nam's Socio-Economic Development Plan 2006-2010, Ha Noi, Viet Nam

Maternal and newborn health in Viet Nam

The achievements in addressing maternal and child mortality over the last two decades have been remarkable with both mortality and morbidity showing a steady decline. In 2003 a Ministry of Health survey[4] on maternal mortality for the year 2001 defined a ratio of 45 per 100,000 live births in Binh Duong province (close to Ho Chi Minh City), compared with 162 in Quang Tri (Central) and 411 in Cao Bang (Northern Mountains), with a national figure of 165 per 100,000 live births. Leading causes of maternal mortality are haemorrhage, obstructed labour and infection. However, routine official data shows that the national maternal mortality ratio has already fallen below 100 per 100,000 deaths yet there is adequate evidence that maternal deaths are both under reported and misreported[5]. There is little accurate information or data on maternal morbidity such as obstetric fistula in Viet Nam. However, for every woman who dies, some twenty others face serious or long-lasting consequences[6].

Maternal mortality ratio for Viet Nam



Although noteworthy improvements in maternal health have been accomplished, maternal deaths are still all too frequent, particularly in the regions of the Central Highlands and the Northern Mountains. Maternal mortality is the vital indicator with the greatest disparity between developed and developing countries with the highest maternal and neonatal death rates occurring among poor populations and Viet Nam is no exception.

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4 Ministry of Health (2003) Maternal Mortality Study. Ha Noi, Viet Nam

5 See for example, Bramley S. (2001) Maternal Mortality Reporting in Viet Nam: Looking Behind the Statistics. Save the Children (US). Ha Noi, Viet Nam

6 http://www.unfpa.org/mothers/morbidity.htm

Figures for neonatal mortality are especially difficult to collect but a study conducted in 2001 gave a national estimate of perinatal mortality[7] of 22.2 per 1000 live births. Data from the study also suggested that mountainous areas, including the Central Highlands have the highest rates. UNICEF provides an infant mortality rate for the year 2005 of 16 per 1000, almost all occurring under 1 month of age. Major causes of neonatal mortality are low birth weight (including prematurity) and asphyxia, all of which are also strong predictors of morbidity and long term adverse outcomes.

Although infant and under-five mortality is decreasing, and Viet Nam has eliminated maternal and neonatal tetanus as a public health problem[8], neonatal deaths account for the largest proportion of child deaths. Again, under reporting hinders constructive planning to address the issues. Mortality during the neonatal period is considered a strong indicator of both maternal and newborn health.

UNFPA assistance to Viet Nam

The United Nations Population Fund (UNFPA) is directed in its work by several international agreements, in particular the 1994 International Conference on Population and Development (ICPD) in Cairo. UNFPA's work is also guided by the Beijing Declaration and Platform for Action, the Convention on the Elimination of Discrimination Against Women (CEDAW), and it contributes to the achievement of the MDGs. UNFPA firmly believes poverty cannot be eradicated without achieving the ICPD goals and that reproductive rights are central to women's empowerment and gender equality and equity. Commitment to these goals is shared by the Government of Viet Nam, which has endorsed these agreements and conventions. With this shared understanding, UNFPA helps the Government to formulate and implement policies and strategies to reduce poverty and support sustainable development. The Fund also assists the Government to collect and analyse population data that helps in understanding population trends and contributes a population and reproductive health perspective to the UN Country Team.

The first three country programmes, from 1978 to 1991, focused mainly on essential family planning and maternal and child health commodities and services. The fourth country programme, from 1992 to 1996, continued the activities of the previous programmes, but the content was modified in line with the outcomes of the ICPD. Strategies for population and development were revised from being target orientated to needs driven and instead of focusing mainly on maternal-child health and family planning, the scope became a more holistic reproductive health approach.

The fifth UNFPA-supported country programme 1997-2000, was formulated in line with the objectives of the 1993 National Population Strategy up to the year 2000. As a result

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[7] perinatal mortality = death of a fetus of more than 22 weeks gestation and babies up to the seventh day of life. The study is cited in Safe Motherhood Project document VIE/03/P21 (2003-2005). Ministry of Health, October 2003.

[8] International Midwifery (2006) 'Viet Nam eliminates maternal and neonatal tetanus'

of the fifth country programme, the management and planning capacity of the Ministry of Health, the Viet Nam Commission for Population, Family, and Children, and other partner agencies was strengthened. The programme also contributed to an increase in the country's contraceptive prevalence rate and a decrease in the total fertility rate. Measurable improvements in the delivery of reproductive health services took place in the eight provinces in which the UNFPA programme was concentrated.

UNFPA Viet Nam recently concluded its sixth country programme for 2001-2005. The programme assisted the Government in implementing the new National Population Strategy for 2001-2010 and the first ever National Strategy for Reproductive Health Care for 2001-2010. In addition, National Standards and Guidelines for Reproductive Health Care Services were developed and approved by the Ministry of Health in 2002. The seventh country programme for 2006-2010 has commenced and will build on the success and lessons learned in the sixth country programme.

As a member of the United Nations Country Team, UNFPA contributed to the strategic planning process for achieving the Viet Nam Development Goals and continues to assist the government to monitor progress towards achieving the MDGs. The work of UNFPA in the fields of reproductive health and rights, women's empowerment and population issues is essential to the achievement of all of the MDGs and directly contributes to MDG 1 (reducing poverty), MDG 3 (gender equality), MDG 4 (child health), MDG 5 (maternal health), and MDG 6 (combating HIV/AIDS and other diseases).

Viet Nam's achievements in safe motherhood and newborn care

1. National Reproductive Health Care Strategy 2001

A major step towards the implementation of the ICPD Programme of Action was the approval by the Government of Viet Nam of the first National Reproductive Health Care Strategy in 2001, providing strategic direction for reproductive health services, including safe motherhood and newborn care activities for the period 2001-2010. Of the six national targets, four are specifically related to maternal-child health: the reduction of maternal mortality, infant mortality, perinatal mortality, and low birth weight.

2. National Standards and Guidelines for Reproductive Health Care Services 2002

With further support from UNFPA, the Ministry of Health developed National Standards and Guidelines to operationalise the principles, objectives and actions articulated in the strategy of which activities and benchmarks for maternal health and newborn care are a significant component. Implementation of the Reproductive Health Care Strategy and monitoring of performance against the standards are contributing to a steady improvement in the quality of maternal and newborn health care and other reproductive health care services nation-wide. In 2005 an assessment of the implementation of the National Standards and Guidelines[9] showed that despite persistent shortcomings in human resources, supervisory practices and training, providers were beginning to organise and deliver services in a more systematic manner. In turn, clients were noticing an improvement in the quality of care and this was reflected in an increased case load at facilities.

A unified Health Management Information System (HMIS) was adopted in 2002. Simple forms, with a networked computer database at the district and provincial levels, are gradually replacing the numerous reporting forms of vertical programmes. A monitoring and supervision tool[10] was developed in 2004 by the Ministry of Health to assist supervisors to provide supportive supervision to clinical staff and encourage their compliance with the National Standards and Guidelines on Reproductive Health Care Services.

3. National Safe Motherhood Master Plan 2003-2010

Safe motherhood programmes were launched by the Ministry of Health in 1995 but were mostly small scale interventions in a few provinces. In 2003 the Ministry of Health

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[9] Ministry of Health & the Research Centre for Environment and Health (2005) Assessment report on Implementation of the National Standards and Guidelines for Reproductive Health Care Services. Ha Noi, Viet Nam

[10] Ministry of Health (2004) Guideline: Monitoring, Supervising and Evaluating Reproductive Health Service. Ha Noi, Viet Nam

developed a National Safe Motherhood Master Plan for 2003-2010 to address the continuing high rates of maternal and neonatal mortality as identified in the maternal mortality survey. This was an important step in the implementation of the Reproductive Health Care Strategy. A safe motherhood needs assessment was conducted in 2003 to inform the plan.

The content of the Master Plan includes identifying targets and priority ranking at the national and regional levels; setting priority targets at the national and regional levels; and a guide to budget estimation and implementation. Key strategies were identified: increase availability and accessibility to essential obstetric and neonatal care; improve the quality of obstetric and neonatal care; strengthen management and human resources; and improve conditions related to maternal-child health such as HIV/AIDS prevention. The plan also emphasised the need to address accessibility to and availability of services in mountainous and remote areas predominantly inhabited by minority groups.

The targets of the Safe Motherhood Plan to be reached by 2010 (compared with a base-line in 2000) are:

- Reduce maternal mortality ratio by 50%

- Reduce perinatal mortality rate by 20%

- Reduce low birth weight by 25%

Phase I of the Safe Motherhood Master Plan (2003-2005)

Phase I of the Safe Motherhood Master Plan aimed to build implementation capacity, advocate for further investment in safe motherhood, and test alternative intervention approaches that would be the foundation for broader implementation in Phase II.

The Safe Motherhood Initiative of Viet Nam, funded by the Government of the Netherlands, is a collaborative effort between the Ministry of Health, UNFPA, and other UN agencies and non-governmental organisations active in safe motherhood. It contributed to the achievements of Phase I of the Master Plan by implementing prioritised and comprehensive interventions in three provinces (Ha Tay, Quang Tri and Kien Giang) and by preparing the Ministry of Health for Phase II through capacity building and advocacy.

Phase II of Safe Motherhood Master Plan (2006-2010)

In Phase II of the National Plan (2006-2010) the aim is to expand safe motherhood activities nationwide, with each province designing a separate plan based on the local context. It is estimated that at least 70% of provinces, cities and towns in Viet Nam need to implement safe motherhood activities as defined in the national plan in order to attain the objectives.

4. Active management of the third stage of labour 2007

Active management of the third stage of labour consists of three integrated principles: giving oxytocin immediately after the delivery of the baby, delivering the cord by controlled cord traction and massaging the uterus. It is the WHO recommended practice

for the prevention of postpartum haemorrhage, the main cause of maternal mortality in Viet Nam. In 2004, PATH and the Ministry of Health collaborated on a study in six districts of Thanh Hoa province to evaluate the use of active management of the third stage of labour in commune health centres and district hospitals. The advocacy effort to Ministry of Health on WHO recommended practice by UNFPA and NGOs such as PATH, Save the Children USA, Pathfinder International and Volunteer Service Abroad resulted in an official guideline of the Ministry of Health issued in May 2007 recommending the use of active management of the third stage of labour nationwide.

5. Elimination of maternal and neonatal tetanus 2006

Maternal and neonatal tetanus is preventable through hygienic birth practices and immunisation of women of childbearing age with the tetanus toxoid (TT) vaccine. In the 1980s some 20,000 Vietnamese babies died annually of tetanus before the age of one month. Immunising pregnant women confers protection to their newborns and also protects them against maternal tetanus. Clean delivery practices have contributed to reducing the infection of unprotected newborns. In February 2006 the Ministry of Health, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) announced that maternal and neonatal tetanus have been eliminated in Viet Nam.

Progress towards millennium development goals 4 and 5

In August 2005, the Government of Viet Nam reported on its progress in achieving the MDGs. Summarised below are the achievements for goals 4 and 5:

GOAL 4: REDUCE CHILD MORTALITY	GOAL 5: IMPROVE MATERNAL HEALTH
■ Reduction in the under-5 mortality rate, from 58 per 1000 live births in 1990 to 31.5 in 2004 (Source: World Bank, UNICEF and GSO 2004). ■ Under-1 year mortality rate has declined, from 44.4Ê in 1990 to 21Ê in 2003 and to an estimated 18Ê in 2004 (***Source:*** World Bank, UNICEF and GSO 2004).	■ Reduction in maternal mortality ratio from 120/100,000 live births in 1990 to 85/100,000 in 2004 ■ The average number of antenatal checks increased from 1.9 in 1999 to 2.5 in 2003 ■ The percentage of pregnant women receiving tetanus vaccination increased from 85.4% in 1999 to 91% in 2003 ■ More than 90% of pregnant women and deliveries are now cared for by skilled health workers. The percentage for the urban areas and the deltas is more than 98%.

Although the results for goals 4 and 5 are impressive, the Government recognises that disaggregation of the data shows a wide disparity between regions. Significant differences are seen when data from the Northern and Central Highlands are compared with that from urban and delta areas. This in part reflects the difficulty of accessibility to basic health care services because of topography but also these areas are largely populated by some of the 53 ethnic minority groups in Viet Nam who are further marginalised by cultural practices and poverty.

Mortality estimates based on information from routine reporting from all levels of the health system consistently show better results than detailed surveys. According to the government's MDG progress report which uses figures from the General Statistical Office (GSO), Viet Nam will achieve the MDG of reducing the child mortality rate by two thirds before 2015. As the official national maternal mortality ratio was 85 per 100,000 in 2004 Viet Nam declares with confidence that it will achieve the MDG of reducing the MMR by three quarters (from the 1990 level) to 62 per 100,000 by 2015.

The evidence continues to show that there is a high level of under and misreporting of both maternal and newborn deaths and failure to disaggregate data conceals the growing disparities. At the commune level in particular the validity of data is low. A recent study concluded that registrars of deaths identified the inadequate functioning of administrative structures with respect to supervision, training and collaboration between systems as a reason for the low quality of death data in the routine system[11]. Improved quality of data is vital to ensure interventions are planned, designed and implemented that address the needs of local populations and truly achieve the MDGs.

[11] Tran Quang Huy (2007) Mortality in Rural Viet Nam: Validity of Routine Reporting and Experiences from a Surveillance System PhD thesis Karolinska University

Lessons learnt over the last 5 years

Along with a phenomenal pace of economic growth, Viet Nam has managed to reduce its poverty rate by more than half from 58 per cent in 1990 to 19.5 per cent in 2004 and has demonstrated a steady decline in overall maternal and infant deaths.

The design of the Sixth Country Programme (CP6) helped to ensure smooth implementation of a wide range of activities across diverse geographical areas and demonstrated the importance of successful national execution in promoting local initiatives, enhancing ownership of the programme, and strengthening the implementation capacity of the Government.

Nonetheless there are some key lessons to be learnt from the implementation of reproductive health activities over the last 5 years that need to be built upon if Viet Nam is to reach the Millennium Development Goals and its localised Viet Nam Development Targets in maternal and newborn health by 2015. Review and evaluation of UNFPA supported activities and further appraisal such as the rapid assessment of maternal and neonatal health care needs conducted in 2006 in UNFPA supported provinces[12] helped to identify issues that affect client utilisation of the health services and the quality of service provision.

Policy areas

Alignment of CP6 with the government's development strategies, particularly the Reproductive Health Care Strategy and the Population Strategy, and the greater integration in the design of behavioural change communication activities proved a strong and positive influence on the efficiency and effectiveness of implementation.

The Ministry of Health[13] has identified the following challenges in implementing the MDGs for maternal and child health:

- The government budget for the health sector is still limited and policies on salaries, hospital fees and health insurance are inadequate
- The Safe Motherhood services in some areas are of poor quality; means supplying these services are insufficient or not of the appropriate technical standard; and some health care workers have insufficient training or motivation
- There are differences in resource allocation between rich and poor regions. As a result the child mortality rates in remote and mountainous areas remain too high
- There is an imbalance within the health sector, between the specialised branch and grassroots health care centres; between preventative health and curative care; between traditional and modern medicine, and between training and the utilisation of human resources

[12] UNFPA/PATH (2006) Rapid Maternal and Neonatal Health Care Needs Assessment in UNFPA supported provinces of Viet Nam. Ha Noi, Viet Nam

[13] Socialist Republic of Viet Nam August (2005) Viet Nam Achieving the Millennium Development Goals. Ha Noi, Viet Nam

Data

The UN Country Team identified an urgent need to improve data collection, distribution and analysis in Viet Nam. Information is still lacking on a wide range of basic development indicators and questions remain about data quality, gaps in data, and a lack of dis-aggregation, making it difficult to track progress by gender, age, and ethnicity. Almost all nationally available data comes from government sources. However, there are significant differences in data from different government sources, particularly when comparing routine reporting data from administrative systems with survey data.

Geographical focus

The geographic scope of CP6 proved too extensive to allow effective implementation of all proposed reproductive health activities, particularly those in remote and mountainous areas. Ha Giang, a rural province in the Northern Mountains with a high minority population, consistently and significantly fell shorter than the other 11 UNFPA supported provinces on all indicators.

Transportation and communication are the two main issues for remote localities: for the clients; the service providers; and for the implementation, monitoring and supervision of activities by UNFPA staff and partners. Provision of obstetric and neonatal first aid and a well-coordinated referral system are vital in saving lives among isolated rural communities. As a rule, the further away the referral facility, the earlier intervention is needed.

Participation and ethnicity

Under CP6 the decentralisation of project management enabled partners to increase their effectiveness in implementing activities but the involvement of local partners in designing project activities was limited. In general, ethnic minorities especially have not shared in the many benefits of the past decade's socio-economic developments partially as a result of existing social and cultural divisions. Not all communities are able to access basic health services, and this is particularly the case for ethnic minority people living in remote mountainous areas.

The needs assessment (UNFPA/PATH 2006) found that although the local leaders (People's Committee, Women's Union, Youth Union and village heads) have an overall sense of responsibility for their communities, most knew very little about maternal and child health apart from family planning and immunisation and were keen to do more to help improve the health of women and children in their communes.

Services

According to the needs assessment by UNFPA/PATH, many district hospitals in disadvantaged areas cannot provide comprehensive obstetric care, and few maternal-child health and family planning centres can manage abortion complications. Low quality of care discourages utilisation of services. In addition, there are great regional differences in service provision and utilisation. Often practices are not evidence based and the knowledge, skills and attitudes among service providers of maternal and newborn care remain weak. Apart from strengthening access to, and improving the quality of, reproductive

health services, appropriate attention needs to be given to changing the practices of health providers.

One of the key challenges for UNFPA is to ensure that the National Population and Reproductive Health Care Strategies are properly implemented at the local levels. Some participating agencies, organisations and provinces still lack capacity in management and need more technical assistance to achieve the depth and quality in monitoring activities in maternal and newborn health care provision.

Below are some examples of remaining technical challenges in provision of maternal and newborn care services:

- Little or no supportive supervision to lower levels; conflation of supervision and monitoring with a focus on targets and investigation
- Incomplete implementation of technical best practices as described in the National Standards and Guidelines such as the provision and use of magnesium sulphate for treatment of severe pre-eclampsia and eclampsia
- Erroneous recording and reporting, including the use of the partograph to monitor and manage labour
- Lack of newborn care knowledge and skills among paediatricians and others providing newborn care
- Poor application of universal precautions for infection prevention and control
- Midwifery training environments lack congruity with Safe Motherhood and Baby Friendly Initiatives

Clients

It is clear that a better informed community will access services more frequently and in a timelier manner. Behavioural change and communication activities have helped to increase the reproductive health seeking behaviour of communities and individuals. There remains a gap in understanding among service providers and policy makers that quality of care is a major influence on utilisation of services even in remote areas and among specific groups such as ethnic minorities and young people.

The rapid maternal and neonatal health care needs assessment in UNFPA supported provinces, concluded that in Ha Giang (Northern Mountains) and Kon Tum (Central Highlands) hardly anyone uses the Commune Health Station and women only use the district level services if things go wrong. This is partly because of a belief that having a baby is a normal process and women and their families feel no need to deliver anywhere but home. But it is also because many communities do not see any advantage to delivering at a health facility, with women preferring the comfort and support of family and traditional birth attendants.

Clients and their families need simple, clear and unbiased information about pregnancy, childbirth and childcare. More women are being seen by doctors and fewer by nurses and midwives as the desire to have often needless procedures such as an ultrasound scan during pregnancy increases. There is social, cultural and medical pressure to have unnecessary procedures while in turn, simple measures such as immediate and exclusive breastfeeding and treatment of intestinal parasites during pregnancy are not promoted actively enough.

Focus for achieving the MDGs over the next 5 years

Key best practices in safe motherhood and newborn care

A scheduled revision of the National Standards and Guidelines for Reproductive Health Care Services will base changes in safe motherhood and newborn care practices. This needs to bring them closer to international evidence based practices especially in regard to:

- Treating pre-eclampsia and eclampsia
- Micronutrient supplements and deworming for antenatal women
- Preventing postpartum haemorrhage
- Immediate care of the newborn, including cord care and breast feeding
- Postnatal care including vitamin A
- Contraceptive technologies
- Diagnosis and management of sexually transmitted infections
- Post abortion care
- Application of universal precautions for infection prevention and control
- Voluntary counselling and testing for HIV and the treatment of positive antenatal women to prevent mother-to-child transmission

Contrary to the government's suggested measure to improve child health, that is *'persuade more mothers to give birth at health care centres'*[14] , the priority should be on skilled attendance at delivery (whether at home or at a facility) with a strengthened referral system to a centre which can provide comprehensive essential obstetric care, including care of a sick newborn.

Focus on poor, marginalised populations

The reduced number of provinces under CP7 will help to centre activities where the need is greatest. Advocacy is required to encourage government and other safe motherhood and newborn care activities to address the geographical and ethnicity dimensions to ensure more equitable life chances. Activities should be tailored to local communities and their context as well as meeting the needs of the central and provincial levels of Government.

Social disparities and inequality among regions, genders and ethnic groups are on the rise and the cost of health care is now a major cause of households falling back into poverty. It is estimated that the poverty rate for ethnic minorities in 2002 was 69.3 per cent, compared to 23.11 per cent for the majority Kinh ethnic group[15].

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[14] Socialist Republic of Viet Nam (2005) Viet Nam Achieving the Millennium Development Goals pp38

[15] Data from GSO website (www.gso.gov.vn)

Improve data quality

The United Nations agencies in Viet Nam have urged the government, donor organisations, research institutions and others to pay greater attention to the quality of data, improve coordination of data collection efforts, and ensure the collection and dis-aggregation of data by age, gender and ethnic group to provide a stronger basis for more targeted and effective policies.

Most health centres do not record causes of neonatal mortality and more than half of those who die before one month of age are unregistered and their deaths go unrecorded. Many are registered late, with over 30 percent of registrations taking place after the child has reached six months of age[16]. Neonatal mortality should be tracked as a national indicator.

Training

The midwife remains the key provider of care for both mothers and newborns and attention must be given to the clinical learning environments in which they acquire their knowledge and skills. A more flexible course structure that fosters student centred learning with mentoring and appraisal systems, that includes problem solving skill development and community based supervised practice would endow students with a more humanist perspective. Further efforts to heighten the professional status of the midwife are needed.

Under CP6, a series of textbooks and manuals for the reproductive health clinical competency-based training curriculum for midwives at secondary medical schools, were almost completed. Training courses for trainers in all secondary medical schools in using this client oriented methodology were conducted.

In CP7, interventions to improve maternal and neonatal health focus on improving the provision of emergency obstetric and newborn care (which includes referral) by assuring a skilled attendant at delivery. A group of British experts are assisting the Ministry of Health and the educational institutions to implement the midwifery training program at secondary medical schools. This effort to improve pre-service training will provide skilled birth attendants for the years to come.

In tandem, Sydney University (Australia) is providing technical assistance to the Ministry of Health and medical education institutions on enhancing the in-service training for providers (obstetricians and neonatologists) on knowledge and skills to respond to obstetric and new born emergencies in UNFPA supported provinces. A system of medical teaching of which the key elements are that it is Structured, Clinical, Objective, Referenced, Problem-based, Integrated and Organised, known as SCORPIO, will provide national and provincial core trainers with competency-based teaching methods based on small group, multi-disciplinary skills training that is participant or student centred. It is expected that this training will be rolled out nationwide and will ensure that treatment of complications at the referral facility is improved.

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[16] Data from UNICEF reports

Behavioural changes

Community mobilisation to raise public awareness on maternal and neonatal issues and the establishment and operation of community-based referral systems for the treatment of complications will also be a priority for CP7.

A better understanding of the nature of change and how change can be encouraged and facilitated in both individuals and communities is needed. In mountainous areas such as Ha Giang and Kon Tum, almost all women deliver at home partly because they consider, correctly, that birth is a normal process. The population as a whole needs to be aware of danger signs and to plan for a journey to a health facility if necessary. Dynamic approaches in communication are required to reach those with limited or no literacy, those living in isolated areas and mobile populations to provide them with basic but vital information.

Behavioural change is also needed among the communities of practice who provide maternal and newborn care services such as community based birth attendants, midwives, and doctors in both the public and private sectors. Continued close collaboration with mass organisations such as the Viet Nam Committee for Population, Family and Children (VCPFC), the Women's Union and the Youth Union remain vital to behavioural change and communication activities. Local leaders are a useful interface between the needs and demands of their communities and the supply of services provided by health staff, supporting clients' rights and promoting quality of care.

UNFPA's continued support

A high priority of the Seventh Country Programme Action Plan (CPAP) for the period 2006-2010 of cooperation between Viet Nam and UNFPA is to continue to work in partnership to support the national efforts to implement the National Safe Motherhood Plan. As described, support will be provided to pre-service and in-service training schools to enhance the quality of graduating midwives and doctors.

Activities at the local level will focus on eight provinces: Binh Dinh, Ha Giang, Phu Tho, Hoa Binh, Tien Giang, Ninh Thuan, Kon Tum and Ben Tre. Greater emphasis will be placed on assistance and interventions that are specific for each province's needs, allowing for more concentrated support to remote and mountainous areas with poor and marginalised populations. For example, based on each province's situation, CP7 will provide support to a number of districts in difficult rural areas to improve and strengthen the quality of emergency obstetric and neonatal care services. In addition, piloting of outreach approaches, community-based blood banks, emergency referral systems, and training of ethnic minority women as providers of basic emergency obstetric care will contribute to finding ways to reach the poorest and most disadvantaged groups.

Sample of detailed activities in UNFPA supported provinces

Training

- **Refresher training for health managers** on service quality management, logistics management, supportive supervision, monitoring and evaluation. Provincial trainers

will provide training for the health staff of all levels and guidance for other participating partners on reproductive health care.

- **Refresher training on National Standards and Guidelines for Reproductive Health Services**. The national training programme on reproductive health care of the Ministry of Health will be used to train service providers at all levels.
- **Pre-service training programme for secondary midwives** at provincial Secondary Medical School. This 2-year training course for students will include teaching theory, practice and assessing of student's ability. The support will include monitoring, supportive supervision and evaluation for implementing this new programme.
- **18-month training programme for "ethnic minority midwives":** this training programme is designed for ethnic minority women who reside in mountainous and remote regions and have low educational level. During 18 month training, they will learn how to manage maternal deliveries including some parts of complication management. Ethnic women are selected by local authorities according to practical criteria. Local authorities shall undertake to use those trainees in the local health care system after their satisfactory completion of the training course.
- **Priority districts:** training will be given to district and commune health staff on safe motherhood, family planning, reproductive tract infections, and adolescent reproductive health.
- **Specialised training in obstetrics and** for general practitioners at the provincial and district levels working in the field of reproductive health care.
- **Training on utilisation of medical equipment** for service providers at district and provincial level.

Equipment

- **Training equipment.** The obstetric ward of the provincial hospital and the Centre for Reproductive Health will conduct the training activities for service providers and managers at all levels. Training equipment, including pre-clinical training models for these two agencies will be provided.
- **Reproductive health equipment and essential drugs** in compliance with the National Standards and Guidelines for Reproductive Health Care will be provided based on needs
- **Means of transport.** One motorbike per selected district for the reproductive health team for supervision purposes will be provided.

Management

- **Monitoring, supervision and technical assistance to lower levels** by provincial level and in priority districts in the implementation of the National Standards and Guidelines on Reproductive Health Care
- **Enhancement of the capacity** of the province in management and implementation of programme activities.
- **The effective operation of the Project Management Office:** in recruiting personnel;

in the supervision, evaluation, and coordination activities of executing and technical assistance agencies.

- **Supply** of office equipment, means of transport for such activities

Basic and comprehensive emergency obstetric and neonatal care

- Provision of emergency care for obstetric and neonatal clients at provincial hospitals and in selected districts and communes. This support includes training, equipment and drug supply and transportation

Outreach services and referral system/ Community based activities

- District reproductive health mobile teams to provide **routine outreach** reproductive health care services at commune level, including antenatal care, counselling on birth preparedness, the need for emergency transport plans, knowledge of danger signs and actions to be taken, newborn care as well as routine family planning services. Priority will be given to ethnic minority and remote communes.
- The **development of a community-based referral system** for safe motherhood in some selected communes in selected districts.
- The Provincial Women's Union will implement **a community-based referral model** for timely transport of women with complications to health facilities in some communes in selected districts.
- The piloting of a **model of maternal and neonatal care conducted by ethnic minority midwives in remote areas.** The focus will be on antenatal care, clean delivery, emergency management and stabilisation of obstetric complications, care of the newborn.
- **Behaviour change communication and advocacy activities**
- **Training of trainers in behavioural change communication and advocacy skills** related to sexual and reproductive health for staff of PCPFC, Department of Health Department of Culture and Information, local media and mass organisations.
- **Training for communicators** at province, district, commune and village levels. Assessment will be used for adjusting the content and training programme to suit local culture and tradition
- **Adjust and produce community communication materials** on maternal and neonatal health
- **Community-based reproductive health behavioural change communication activities** organised at the commune and village levels in selected districts with active participation of the community, especially village heads and minority men and women groups. Topics will cover safe motherhood such as emergency obstetric and neonatal care, prevention of sexually transmitted infections including HIV/AIDS, reproductive rights and gender.
- Provincial television and radio stations to **produce and broadcast programmes on maternal/ neonatal health**, some in local minority languages.
- **Advocacy activities** targeting local leaders, religious leaders, community gatekeepers, and other influential groups on sexual and reproductive health issues.

Conclusion

Viet Nam has made great progress in economic and social development, but widening disparities in social wellbeing are emerging. In this phase of Viet Nam's development - recent accession to WTO, human development progress, ever-increasing GDP and a goal to reach middle income status by 2010 - ensuring this progress is as inclusive as possible is vital if Viet Nam is going to reach the MDGs in every province, district and commune[17].

The Government of Viet Nam strongly reconfirms its determination to continue its implementation of the Millennium Declaration and realise the Millennium Development Goals by 2015. International support will continue to be needed as further gains towards achieving the MDGs are challenged by the isolation of some segments of the population to information and knowledge necessary for them to improve their lifestyles. In addition, the apparent progress reflected in improvements in a number of quantitative national MDG indicators of which maternal and neonatal health are examples, masks some significant shortcomings in underlying quality. This issue of quality will need to be redressed to achieve the MDGs in full[18].

In August 2007, the Government of Viet Nam and the United Nations in Viet Nam signed the 'One Plan', a common action plan until 2010 and part of the 'One UN Initiative'. The One Plan brings together in one coherent programming framework the programmes of 6 UN entities - UNICEF, UNDP, UNFPA, UNAIDS, UNIFEM and UNV. It combines and synthesises the work of UN agencies to better support Viet Nam in achieving its goals as expressed in the Millennium Declaration, the Millennium Development Goals and Viet Nam's Socio-Economic Development Plan.

The UN has identified in the One Plan five outcomes that reflect the country's development challenges and the comparative advantage of the six UN agencies participating in the One Plan:

1. Equitable and inclusive social and economic policies, plans and laws
2. Universally available, high-quality social and protection services
3. Environmental protection and the rational use of natural resources
4. Accountable, transparent and participatory governance
5. Reduced vulnerability to natural disasters

The United Nations Population Fund (UNFPA) was designated the lead United Nations organisation for the follow-up and implementation of the International Conference on

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17 'Growth with Equality' Viet Nam Economic Times interview with UN Resident Coordinator, John Hendra, UNDP Viet Nam, 9th April 2007

18 United Nations Country Team Viet Nam (2002) Bringing the MDGs Closer to the People. Ha Noi, Viet Nam

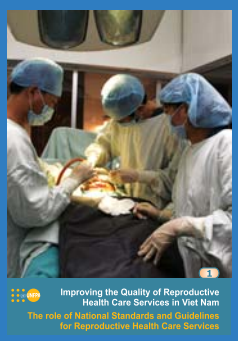
Population and Development (ICPD) Programme of Action in 1994. Its mission is to assist countries in achieving the goals laid out in the Programme of Action, providing financial and technical assistance on reproductive health and population programmes, *'to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect'*[19].

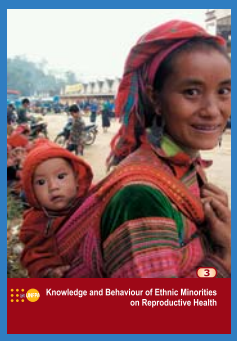
Reaching the goals of the Programme of Action is also essential for achieving the Millennium Development Goals and fulfilling Viet Nam's Socio-Economic Development Plan. UNFPA brings its special expertise and leadership in reproductive health and rights, women's empowerment and population issues to the collaborative effort of meeting these goals. As part of the 'One UN', UNFPA is central to this endeavour and its particular support directly contributes to MDG 1 (reducing poverty), MDG 3 (gender equality), MDG 4 (child health), MDG 5 (maternal health), and MDG 6 (combating HIV/AIDS and other diseases). By maximising the contributions of the participating UN agencies and strengthening the United Nations as a competent and effective partner of the Vietnamese Government, the 'One UN' will continue to support the country's development process for the interests of the Vietnamese people, thereby building a prosperous, equitable and democratic Viet Nam[20].

[19] Part of UNFPA's mission statement. See http://www.unfpa.org/about/mission.htm

[20] See http://unvietnam.wordpress.com/ for further information on the One UN Initiative in Viet Nam

IN 2007 UNFPA PUBLICATIONS ON BEST PRACTICES AND LESSONS LEARNED INCLUDE THE FOLLOWING REPORTS





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