**MINISTRY OF HEALTH**

# NATIONAL PLAN OF ACTION FOR CHILD SURVIVAL

## 2009 – 2015

**HÀ NỘI, 2009**

# MỤC LỤC

## LIST OF ACRONYMS

| | |
|---|---|
| **ARI** | Acute respiratory infections |
| **CDD** | Control of Diarrhoeal Diseases |
| **CS** | Child survival |
| **EPI** | Expanded Programme on Immunization |
| **IMCI** | Integrated management of childhood illnesses |
| **MGD** | Millennium Development Goal |
| **MOH** | Ministry of Health |
| **NGO** | Non-governmental organization |

**ACTION PLAN FOR CHILD SURVIVAL**
**2009 – 2015**
***(Promulgated in attachment to Decision No… …. by the Ministry of Health)***

## CHAPTER I. OVERVIEW

Since the launch of child survival revolution in early 1980s, the under-5 mortality rate had reduced sharply, globally from 117‰ in 1980 to 93 ‰ in 1990. However, in the later decades, there has been a slowing-down sign of decline. The reduction in the year 2000 did not reach the goal of World Summit for Children. Consequently, the UN member states adopted the Millennium Development Goals, of which the MDG4 is to reduce two-thirds of under-five mortality rate between 1990 and 2015.

Viet Nam has adopted the Millennium Development Goals (MDGs) and shown its strong commitment to reducing child mortality. As a result, impressive achievements have been made. More specifically, under-five mortality rate dropped from 53‰ in 1990 to 26‰ in 2006. In the same period, infant mortality decreased from 44‰ to 16‰. In addition, Viet Nam maintains a high rate of childhood immunization (>95%). Polio has been eradicated in 2000 while maternal and neonatal tetanus has been eliminated in 2005. With these achievements, Viet Nam is likely on track to meet the MDG4 by 2015.

While overall progress on child survival has been impressive, it has not been sufficient to meet MDG4 in all parts of the country. The mortality rate of children in mountainous and rural areas or of poor families is three to four times higher than that of children in lowland areas or of better-off families. Although child mortality has declined in all income groups, the gap between the richest and the poorest family in society is increasing. The access to quality healthcare services is limited in remote and mountainous areas. For instance, in average, the vast majority of women in Viet Nam give birth with skilled assistance (88%), this figure is half of that (44%) in the mountainous areas. While, overall, infant child mortality has declined, progress in newborn survival is far from satisfactory. Limited access and/or low quality of obstetric and newborn care, particularly at remote, minority communities has resulted in the high rates of neonatal mortality which represents about 70 per cent of infant mortality and more than 50 per cent of under-five mortality.

In order to meet the MDG4 in the whole country, further effort is needed to assure universal access to high-impact packages of essential child survival interventions. Every child must be reached by health care services, especially in remote areas. This can be done by strengthening health systems and community partnerships; providing a continuum of care for mothers, newborns and children by

packaging life-saving interventions at every key point of service delivery and in the life cycle; mobilizing sufficient resources to accelerate and sustain progress for child survival; expanding the data, research and evidence base on child survival issues for better programming and interventions; and improving leadership and policies required in taking the lead and own the solutions to the country's child health problems.

Those solutions have been manifested through a National Plan of Action for child survival. This is actually a comprehensive and collective effort made by relevant national stakeholders who come together to identify child health problems, plan for, implement, and evaluate the country's progress for CS. This action plan is not only a joint action as defined but also a guiding documentation on which all child survival organizations and advocates can depend to shape their programs for child survival.

## CHAPTER II. CHILD HEALTH SITUATION AND CHALLENGES

**I.** Child mortality

**1.** Reduction of Child Mortality

Laudable and consistent progress in reducing child mortality has been made in last decades. According the statistics released by MOH, the infant (IMR) and under-five (U5MR) mortality rates reduced from 35‰ and 42‰ in 2001, to 16.0‰ and 26.0‰ in 2006, respectively. To compare with the last decade, the child mortality rate was reduced by half, at the similar level of other countries with the GDP 3 to 4 times higher than Viet Nam. With the constant decline in under-five and infant mortality rates Viet Nam is on track to reach the MDG 4 by 2015.

Challenges**:**

*A large number of Vietnamese children are still dying every year*. **:** given the large population size with a high proportion of people in reproductive age and despite the remarkable reduction in child mortality, the number of dying children remains unacceptably high in Viet Nam. According to UNICEF's State of World's Children 2008[i], the annual number of under-five deaths, in Viet Nam, is 28,000. This translates into about 16,000 newborns dying every year. The number of children under five years old represents about 6.5% of the total population corresponding to an estimate of 6.000.000 children and about 1.200.000- 1.500.000 million infants are born every year. This is a large target group to be looked after.

*Disparity:* the big differences in children's health and nutrition status among different geographical and socio-economic regions pose a great challenge to child healthcare. The mortality rates of children in mountainous and disadvantaged areas or of poor families are three to four times higher than that of children in lowland areas or better-off families[1].

A similar discrepancy is also clearly seen among regions regarding the neonatal mortality. According to a baseline study data on neonatal health care in Quang Ninh[2], there is a nine-fold difference in newborn mortality rate in 2006 between the lowland areas (5‰) and the mountainous ones (45‰).

*Perinatal mortality* (PNMR), which refers to the death of a fetus occurring after 22 weeks of gestation (stillbirths), at the delivery, and early infancy (within seven days after delivery) – an indicator closely associated with mother and neonatal care, shows great disparities among regions across the country. A study conducted in 2001 by the MoH[3] in seven different ecological areas estimated an average perinatal mortality rate of 22,2/1000 live births with big differences among the study areas. The PNMR in Tay

[1] Demographic health Survey 2002
[2] NeoKip Project - Quảng ninh – Baseline data 2006
[3] Trần Thị Trung Chiến – Perinatal mortality survey 2001

Nguyen (the Central Highlands) and the Northern mountainous areas was two times higher than that in the Red River delta and the Southern delta.

*Neonatal mortality accounts for the majority of child morality:* neonatal mortality rate (NMR) is not yet yearly reported in the health statistics. However, according to 2002 Demographic and Health Survey (VDHS) the rate was about 12%o, representing more than half (52%) of all under-five deaths. In addition, some studies conducted in hospitals found the NMR accounting for more than 70% of infant mortality rate.

**2. Causes of child mortality**

According to WHO's analysis, the five leading causes of child mortality in our country are neonatal death, pneumonia, diarrhea, injuries, and measles. Also in line with WHO's assessment, the four main neonatal killers are prematurity, birth asphyxia, severe infections, and congenital malformations. These findings on the main causes of neonatal death is completely consistent with that of several other studies in Viet Nam[4]

The main causes of neonatal mortality including premature, asphyxia, and infections are preventable. Quality improvement in antenatal care, skilled birth assistance, and correct and timely newborn resuscitation are active and effective interventions which can avert many deaths. The experience of other developing countries has also shown that in fact 75% of newborn deaths can be prevented by simple and low-cost interventions (with an estimated additional cost of 1 USD per child). The most important action is to prioritize to deliver the right interventions to those mothers and newborns who need them most.

**II.** Nutritional Status of Children

**1.** ***Nutritional status of children under 5 is on the clear trend of improvement***

Malnutrition is the biggest risk for child mortality. It is estimated by WHO and UNICEF that malnutrition contributes 30% to 50% of child deaths. The areas with high rate of mortality are always accompanying with high prevalence of malnutrition among children. Reduction of child malnutrition in the past decades has importantly contributed to the achievement in reducing child mortality in Viet Nam. So far, the prevalence of malnutrition by age has decreased gradually with an annual reduction rate of 2.6%; from 31.9% in 2001 to 21.2% in 2007. It is important to note that this trend is evident in all areas, even in the Central Highlands where the highest prevalence of malnutrition is found.

[4] Đinh Thị Phương Hòa. Neonatal morbidity and mortality at hospital level and related factors. Medical Study journal. Insert , Vol 35, No2. Special edition for 3rd VN-France Pediatric Sicentific Conference 3, Hà nội 2005; pages 36-40

Vitamin A deficiency control program has covered more than 80% of children aged 6 to 36 months old, thus, contributing to elimination of night blindness and exophthalmia which are clinical manifestations of vitamin A deficiency[5].

With these great achievements, Viet Nam is highly appreciated by the WHO and UNICEF as the only country among the developing ones reaching the targeting point of malnutrition reduction according to the MDG .

**2. Shortcomings**

Although there have been noteworthy improvements in children's nutrition, the malnutrition rate among Vietnamese children is still higher than that of other countries in the region. A point to note is that the number of stunting children decreased remarkably during the 2000 – 2005 period, yet still more than 30% of under-5 children are stunted, making Viet Nam among the 36 countries with 90% of all stunted children worldwide[6]. Stunting during the first 2 years of age has a negative impact on a person's adult height and health in general. Therefore, it is necessary to have a comprehensive long-term intervention strategy act within the window of opportunity from conception until the second birthday to eliminate all forms of malnutrition, including stunting, to improve Vietnamese people's build.

It should be highlighted that disparity among regions is also a shortcoming in children nutrition. Children in the Central Highland (Tay Nguyen) and Northern mountainous areas have the highest weight for age malnutrition rate (respectively, 36% and 32% versus the country average rate of 27%). Especially the stunting malnutrition rate is still very high (over 40%) in some provinces in Tay Nguyen, Quang Ninh, Ha Giang, and Lai Chau provinces while it is only 8.8% in Ho Chi Minh City and 16.8% in Ha Noi.

While the most severe forms of vitamin A deficiencies (VAD) have disappeared, subclinical VAD, however, is still a moderate to severe public health problem. Anaemia is widespread affecting more than one third (30%) of children and pregnant women. This is definitely causing negative impacts on the health of mothers and children.

Another big challenge to the Nutrition Programme is the low rate of exclusive breastfeeding. According to the 2005 annual report of the NIN, only 32% of newborns and 12% of infants between 4 and 6 months old were exclusive breastfed. This situation is due to three main reasons. The first reason is the lack of support from government policy allowing mothers to have more than the current four-month maternity leave, while they need six months for exclusive breastfeeding. The second

[5] Ha Huy Khoi – Progress of Vitamin A deficiency control program in Vietnam, *in* 20 years of prevention and control of micronutrient deficiencies in Vietnam – NIN 2001, Medical Publishing House

[6] The Lancet – Maternal and Child undernutrtion- January, 2008

one is the ineffective implementation of breastfeeding promotion program; namely health care workers lack of knowledge and skills on breastfeeding counseling, not to be strong enough in building as well as strengthening the Baby Friendly Hospitals. In addition, the attractive advertisements and gifts for promotion of milk substitutes from milk product companies have discouraged health care workers and breastfed mothers from promoting and practicing exclusive breast feeding respectively. The third important reason comes from the community itself as people seem to perceive that mothers have insufficient breast milk for 6 month exclusive breastfeeding and that early weaning food will help the baby healthier.

## III. Health Care System

### 1. Health care network

One of the important factors contributing to the success in child heath care in Viet Nam is the existence of a comprehensive health care network and system that covers the entire population. The system has four levels of health care delivery: central, provincial, district, and commune levels.

#### 1.1 Organizational structure

**Central level:** the Ministry of Health is responsible for technical and professional activities in health care including both curative and preventive ones. Most MOH Departments, Administrations have functions and tasks relevant to child health, especially some important ones which can be mentioned as follows. The Maternal and Child Health Department is mainly responsible for child health in the areas of policy development; development and supervision of national standards and guidelines; and collaboration with different Departments, Administrations, Institutes within MoH and relevant institutions in child health activities. The Administration of Medical Services is mainly working in the area of clinical health care and supervising provincial and district hospitals. The General Department of Preventive Medicine and Environment Health is responsible for guiding Preventive Medicine Centers at district level to implement all preventive activities related to child health, especially immunization and injury prevention. The Science and Training Department is in charge of training contents of child health care that are taught in medical universities, colleges and secondary medical schools. The Planning and Financial Department is responsible for overall planning and allocating budgets to all health care programs and activities including those for children.

***Central hospitals and Institutes*:** National Pediatric Hospital and National Obstetrics and Gynecology Hospital, and Children's Hospital No.1 and Tu Du hospital in Ho Chi Minh City are appointed by MOH in giving technical assistance to lower levels, developing and disseminating guidelines, training and following-up all

activities related to child and maternal health care across the country. The National Pediatric Hospital is assigned to be responsible for providing technical assistance to all provinces in the North while Children's Hospital No.1 is assigned to be responsible for all provinces in the South. The institutions responsible for nutrition and preventive programs are National Institute of Nutrition (NIN), National Institute of Hygiene and Epidemiology (NIHE), National Hospital of Tuberculosis and Respiratory Diseases, National Institute of Malariology, Parasitology and Entomology.

***Relevant sectors/branches***: the Department of Child Care in Ministry of Labour, Invalids and Social Affairs (MOLISA) is responsible for issuing legal documents and creating environment and activities that are relevant to comprehensive development of children. It also has a function of collaborating with MOH in the areas of health and nutrition care for children.

**Provincial level**: the Provincial Department of Health is responsible for directing the Provincial Center for Reproductive Health Care, Provincial Center for Preventive Medicine and Provincial General Hospitals in implementing activities relating to child care. These activities include provision of curative and preventive care, training, planning, and monitoring and supervision of child care activities in all districts of the province in order to improve and sustain quality of child health care.

**District level**: the District Preventive Medicine Center (DPMC) consists of specialized units such as reproductive health care, communication, and control of non-communication diseases. It is responsible for child health care activities at district and communal levels. In addition, the district hospital has departments of Obstetrics/Surgery and of Internal Medicince/Paediatrics which are responsible for providing care to children and mothers. The District Preventive Medicine Center and District Health Office are the key bodies that manage all child health care related activities and supervise all Commune Health Centers in conducting all national targeted programs and primary health care activities for children.

**Commune level**: the Commune Health Center (CHC) is responsible for providing primary health care services and implementing child care programs at community level. Each CHC is also in charge of monitoring and supervising the work of village health workers in IEC activities, notification and report of disease outbreaks, home-based child care and monitoring; participation in related health care programs; and management of common child illnesses.

**Shortcomings in the health care network**

The country-wide health care network is the basic foundation for health care activities for the entire population including children. However, the child health care network has been substantially changed by influence of the market-oriented economy and gradual social mobilization of health services. Though, there has not been a comprehensive assessment of organizational structure, human resources, infrastructure, and quality of child health care services, main findings from some studies could be presented as follows:

**Accessibility to health care services**: many women and children in the mountainous and rural areas still have less access to basic health care services such as antenatal care, delivery care, vaccination or quality health consultation and treatment as indicated in the table below.

**Table 1: Coverage of selected Child Survival Interventions (MICS 2006)**

| Intervention | Indicator | Urban | Rural |
|---|---|---|---|
| Tetanus vaccination | Proportion of mothers with a birth in the last 12 months being given neonatal tetanus vaccination | 88% | 78% |
| Skilled birth attendance | Proportion of deliveries attended by skilled birth attendants (doctor or trained nurse and midwife) | 98% | 85% |
| Institution-based delivery | Proportion of births delivered in health facilities | 90% | 56% |
| Care of the newborn | Proportion of infants less than 12 months of age with breastfeeding initiated within one hour after birth | 53.9% | 59% |
| Breastfeeding and complementary feeding | Proportion of infants less than 6 months of age exclusively breastfed | 7.7% | 19% |
| | Proportion of infants 6-9 months of age receiving breast milk and complementary food | 67.9% | 71.2% |
| Micro-nutrient supplementation | Proportion of children 6-59 months of age receiving Vitamin A in the past 6 months | 54.6% | 52.6% |
| | Proportion of women who received one vitamin A capsules within 8 weeks after delivery | 47% | 28% |
| IMCI | Proportion of children 0-59 moths of age who had diarrhoea in the past 2 weeks and were treated with ORS | 100% | 93.9% |
| | Proportion of children 0-59 moths of age | 98.8% | 79.7% |

| | | | |
|---|---|---|---|
| | who had suspected pneumonia in the past two weeks and being treated | | |
| Measles vaccine | Proportion of one year old children immunized against measles | 93% | 85% |

**1.2. Budget for Child Health Care**

The Vietnamese government has promulgated legal documents and allocated funds to meet basic needs in child's health care and protection. Funding for preventive health care and nutrition programmes is almost given from the state budget. For curative activities, in 1991, there was a law granting free health care services for children under six[ii] which was later concretized by the Decree No.95/CP dated August 27, 1994. The Decree states that all children under six are eligible for free examination and treatment at public health care facilities.

However, because of insufficiently secured budget and unclear operational mechanism, the implementation on free health care policy for children under six has remained stagnant. Therefore, in 2005, the Government issued Decree No. 36/2005/ND-CP stipulating in details some articles in the Law on protection, care and education of children, which states in Article 18 that all children under six be provided with free of charge health care check-ups and treatments at public health facilities. the Government also has allocated budget to every health facility for implementation of free of charge policy for children under 6 with the pay-for-service method.

Despite these efforts, funding allocated for health sector is still limited. According to 2001 assessment, the Government spending on health as proportion of total government annual spending was only 6.1% which is among the lowest in the region (Cambodia: 16%; Laos: 8.5%, China: 9.5%)[9]. Therefore, the insufficient spending for child health has been a big obstacle for years without proper solutions to overcome it. As compared to estimate made by WHO and UNICEF, investment in child basic care services needs around 34 USD/child/year, so our country's current level of 7 USD/child/year is too low[10]. Lack of finances due to limited domestic resources has resulted in insufficient provision of necessary services of high quality for children, which is a big hurdle in child healthcare in our country. Another difficulty in investment and expenditure is that the budget is not allocated according to age, thus making it difficult to work out the expenditure to be assigned to child healthcare. The expenditure for preventive activities is a separate category, however, it is divided into two sub-categories of mother-child healthcare – family planning – vaccination, and primary health care and school health; therefore, it is also difficult to calculate the expenditure reserved only for child healthcare.

**1.3. Reporting system**

As regulated, The health information system in general and in child health in particular follows the bottom-up mechanism: the data collected from communes will be reported to CHCs, then to district, provincial and the central level. Every year based on data submitted by all provinces, MOH analyzes and issues the Health Statistic Year Book. There is sufficient data regarding nutrition and immunization in children but other indicators in child health are not available. Some major challenges can be cited as follows:

One major challenge to good public health planning for child health care is the inaccuracy of data. In MOH's Health Statistic Year Book only data regarding IMR is available. Mortality of children from 1-5 years (accounting for more than 1/3 of under 5 mortality) and Neonatal mortality (representing more than 50% of under 5 mortality) are not reported at all in MOH's Health Statistic Year Book.

In other reports on mortality rates, the neonatal mortality, in particular, is often much lower than findings from some studies and the reality. The neonatal mortality in the baseline survey in Quang Ninh province in 2006 was 16.2 ‰, four times higher than that in the reported data of 4.2‰.

The under-reported data is not only concerning on mortality but also in data on the total number and the gender of children born yearly. According to data from the General Statistics Office (GSO) by 2006, only 87.6% of children up to 5 years of age had been registered for birth certificates. Late birth registering, especially of female children, has resulted in imprecise data on newborns as well as lack of statistics of newborn morbidity and mortality. Therefore, newborns' health problems do not receive the due attention and priority, and newborn intervention measures have fallen into ignorance for a long time. Research data in Quang Ninh province shows that every year about 5% of children born without being recorded, 10% of children born at hospitals without gender records.

Also facility-based data on morbidity and case fatality rates in MOH's Health Statistic Year Book is not analyzed according to age so that it is impossible for the MOH to assess the performance of curative care for children. It is high time for the birth-death record and the facility-based health information system to be improved. Such improvements will not only help provide basic information for appropriate intervention but also ensure children's rights in having birth certificates as well as death certificates.

**1.4. Human Resources and Standards of Child Health Care Guidelines**

In general, there are sufficient numbers of health care workers to provide health care for children in Viet Nam at all levels. About 65% of Commune Health Centers (CHC) are staffed with doctors and almost all (93%) have assistant doctors specialized

in paediatrics and obstetrics. The quality of these health care workers, however, might not always be up to the needs. According to the assessment on practice of health staff in newborn care in 7 project provinces by UNFPA, the proportion of health staff practicing enough 7 contents in care of normal newborn after delivery (attaining National Standards) at the provincial and district level were 54% and 37%, respectively.

The *National Standards and Guidelines for Reproductive Health Care Services*, promulgated in 2002, are a legal document defining norms for quality of care and providing guidance for medical staff on their routine work. However, they did not include paediatric care, in general and had only a very small part for newborn care.

*Regarding IMCI implementation*, there are training materials approved by MOH as norms and standards for managing sick and feeding recommendations. These standards of care and guidelines are often updated, though, are not implemented in various health facilities.

The National Hospital of Paediatrics and Children's Hospital No. 1 in Ho Chi Minh City have been making great efforts in updating and developing instructing materials on child healthcare and treatment from the materials by WHO; again, these efforts have only been materialized in pilot projects in several provinces and districts and have not been incorporated into the regular yearly training plan.

**2. Specific Vertical Programs Addressing Child Health Care**

**2.1. Child malnutrition prevention program**

Since the beginning of the 1980s, to date the child malnutrition prevention program has covered all provinces across the country. It is one of programs that have the greatly important impact on CS. Achievements recorded in the child malnutrition prevention program mentioned above have confirmed the success of the malnutrition prevention program. Thus our country has been left out in the list of countries with the high rate of malnutrition rate by weight among other countries. However, as analyzed before, child nutrition area is still facing with many challenges. Therefore, apart from continuing to maintain interventions for improving the nutritional status for mother and child, the malnutrition prevention program should focus on the growth, reduction of child stunting rate, school nutrition, prevention of lack of nutrients, and improve knowledge and practice breast-feeding.

**2.2. Expanded Program on Immunization (EPI)**

Reduction of the preventable diseases by immunization contributed a very important part in decrease child mortality in Viet Nam. After more than 20 years of operation, EPI has made very proud achievements. In 2003 Hepatitis B vaccine was introduced into EPI. In 2005, there were 94% of children under 1 year old received 3

doses of Hepatitis B vaccine in which 62% were given the first dose within 24 hours after delivery. In October 2000, Viet Nam was given the certification for Eradication of polio and elimination of neonatal tetanus in 2005 by WHO. According to MICS survey, in the first year there are 93.7% getting BCG vaccine while 92% get DTP – one dose. 86.5% get repeated shot and 76% get third shot. Similar data is found with anti-polio vaccine shot 1 is 94.2% and the third shot have the lower figures: 73.9%. Anti-measles vaccination in the first year is 82.7%. Generally speaking, the proportion of children who get full vaccination for the most available 6 disease before the first birthday is 61.7%. Apart from that the new vaccines are being studied and implemented in the areas at risks such as vaccines for Cholera, Salmonella. The coverage of the Japanese encephalitis B is also expanding. At the time of the year 2005, there are 308 districts among 51 provinces have vaccinated with encephalitis B for children.

Recorded results show that EPI is the most successful among the vertical programmes related to child health thanks to the political and financial support, from the Government, MOH and leaders at different levels. The high level of awareness and responsiveness of the community on the importance of the immunization in health protection of children are the vital factor for the success of the program. The support from international organizations also played a crucial role. It can say that the support from the international organizations, especially WHO, UNICEF, JICA, GAVI, and the Government of Luxembourg, has made an important contribution to the success of EPI in Viet Nam.

***Challenges*:** Despite this impressive success story with EPI, there are issues related to equity in service delivery that should be taken into account. According to the 2002 Demographic and Heath Survey, the rate of children receiving all the 6 compulsory vaccination in the Northern mountainous area is only half of the rate in the Red River delta area (46% vs. 89%). Given this situation, priority should be made in providing more efforts to those areas with lower immunization coverage, moving towards the target of reaching every child with full immunization.

### 2.3. Acute Respiratory Infections (ARI) Program

Control of Acute Respiratory Infections (ARI) was one of the child health care programs introduced by WHO and UNICEF in Viet Nam, in 1984 and has been implemented since. So far, it has been implemented in over 96% of the country covering 98 % of children under-five. (Report from ARI program – 2003). The programme focused on providing knowledge and skills to mothers to recognize early the signs of disease and bring the child to health facility promptly where it is expected to be managed appropriately. To assure this; the programs also provides training to

health staff on correct diagnosis and treatment of patients and essential drugs for treatment of pneumonia. Since 1999 when MOH adopted IMCI approach for management of child illnesses, the ARI activities were integrated in the IMCI program..

**2.4. Control of** Diarrhoeal Diseases (CDD) program

The Control of Diarrhoeal Diseases (CDD) program started since 1983, in Viet Nam, and up to now this program is implemented routinely in all provinces. The main contents of the program are the promotion of early oral rehydration therapy (ORT) with increased fluids and continued feeding, recommended home fluids and, if necessary, the use of oral rehydration salts solution (ORS) together with good nutrition for children with diarrhoea. This approach has also been included in IMCI, since 1999. The link between safe water supply, sanitation and hygiene practices is well established. In Viet Nam, 89% of the population use improved sources of drinking water, in the North-West and among ethnic minorities however, the proportion is only 73% and 70% respectively. The most visible results of the program are almost no recorded death cases in health facilities due to diarrhoea among children. Dehydration of severe degree had been reduced in health facilities. Also knowledge and practice of mothers in the family and community had been improved obviously. According to MICS3, there were about 95% children with diarrhoea received one or more of recommended home treatment (receive ORS or other fluids).

The priority in the coming years for diarrhoea control are: the use of low osmolarity ORS and zinc supplementation in the management of childhood diarrhoea needs to be implemented nationwide; more behaviour change communication efforts are required to keep up good home management practices for diarrhoea and make up for recent drawbacks as well as key practices directly related to childhood diarrhoea such as the safe disposal of children's faeces and hand washing; and finally to continue efforts to achieving the MDG goals on water and sanitation.

**2.5. Malaria control program**

The program for malaria control, in general, and in children, in particular, has also achieved great successes. Malaria is no longer a great threat to children in Viet Nam. Until the year 2006, there were 1,235 children < 5 years who suffered from malaria and 3 died from this cause, consisting 7% of total deaths by malaria. Globally and regionally, the use of insecticide treated mosquito nets (ITN) and early and appropriate treatment is being used to measure the coverage of malaria control for children. Together with ARI and CDD programmes, the content in Malaria control program was integrated in to IMCI activities.

Maintaining the achievements gained, avoiding the subjectivism of the staff at different levels are the big challenges for the malaria control program at present.

**2.6. Integrated Management of Childhood Illness (IMCI)**

IMCI is the initiative of WHO and UNICEF that aimed to integrate all the different vertical related child health programs such as CDD, ARI, nutrition, EPI, malaria control program, etc. with the objective to improve child health quality of care in the integrated manner for reducing child morbidity and mortality.

IMCI strategy was first introduced in Viet Nam in 1996. After the periods of preparation and piloting, in 1999 MOH adopted the IMCI program. IMCI was considered as an approach for improving quality of child care at the health facilities and communities. Up to now, IMCI has been introduced in 41/64 provinces in the country with more than trained 4,000 health staff and it has been implemented in 7 medical universities and 19 secondary medical schools.

It is difficult to evaluate the effectiveness of IMCI training for health workers, but through the results of medical examination and treatment as well as achievements gained from relevant health programs such as ARI, CDD, EPI and malaria control, it is possible to conclude that  at least, has contributed to these successes. Efforts should be made to strengthen implementation of IMCI in highly NMR prevalent areas (accounting for over 50% of the total child mortality nationwide): namely, Northern Uplands, North Central, Central Coast, Central Highlands; and during the neonatal stage where there is a NMR of over 50% of under 5 child mortality.

*Challenges for IMCI activities*: Although IMCI has been recognized as an action strategy to reduce child morbidity and mortality rates, difficulties are still found in its implementation at all levels. There are several of reasons which can be cited as follows:

At the central level, there have been changes in the personnel of the Steering Committee, which has however not yet been reorganized. No Department of the Ministry of Health is put in charge of managing the activities of IMCI, therefore there has not yet been supervision over the implementation of Directive No. 08/1999 by the Ministry of Health on enhancing the implementation of IMCI in Viet Nam. IMCI office at National Institute of Hygiene and Epidemiology has been facing many difficulties in involving technical staff in its activities. Another obstacle is that there is no yearly regular budget from Ministry of Health for IMCI implementation at provincial level so the operation of IMCI mainly depends on the project and the international organizations. This is reason why IMCI has been implemented for 8 years but the coverage is just only 33% of districts in the whole country, and in each district there are just only some communities put under implementation of IMCI. There has been no effort to target IMCI implementation to those areas where it is needed most and to achieve full coverage there.

At the district and province levels, due to limited resources and not high liability in the implementation, the Steering Committee has irregular activities and the cooperation between the district and province levels is not strong and close. The activities are subject to orientation from the central level and there is no active planning of the activities.

With respect to technical aspects of IMCI implementation, the three components of the strategy have not been implemented comprehensively. Most activities fall under component 1 – Training – and partly component 2 – improving health the system. Component 3 with the important content – improving community and family practices – has been implemented only in five project provinces in the South and piloted in one province in the North. This is a big limitation in IMCI implementation since improving knowledge and practice at community and family plays very important role to reduce remarkably child mortality, especially neonatal mortality that has been evidence in several studies in Nepal, Bangladesh and India.[11,12]

**2.7. Safe environment/injuries and accidents prevention**

Intensified industrialization, a sharp increase of motor vehicles and unsafe environment has increased the rate of accidents and injuries. According to yearly statistics by the Ministry of Health, the mortality rate due to this cause increased significantly from 18.1% in 2001 to 22.3% in 2005, in which many victims were children and the main causes were drowning, traffic accidents and poisoning. In 2003 study on injuries in children less than 20 years old, it was found that out of 2,532 non-fatal injuries in a population, 390 cases (15%) occurred in children under five years old.

**2.8. Prevention of Mother to Child HIV transmission (PMTCT)**

HIV/AIDS has become an epidemic in Viet Nam. In the increasing general trend of HIV infection in the whole population, the rate of HIV infection among women and pregnant women has increased significantly. By the end of 2006, more than 120,000 people have been diagnosed to have HIV/AIDS, of whom 15% were women. According to estimation made for the whole country, the rate of HIV infected among pregnant women is around 0.39%, about 15 – 20 times higher than the rate in the 1990s. Of around 1,500,000 pregnant mothers every year, it is estimated that 6,000 pregnant women have HIV (+). Unless PMTCT intervention is in place, there will be around 2,000 children at risk due to Mother to Child transmission. This puts more burden on child morbidity and mortality.

**2.9. Maternal health care**

The success of the maternal health care interventions plays an important role in improving child health. Such services as ANC, full tetanus immunization, delivery

care and postpartum follow-up have made decisive contribution to healthy newborns and ensuring healthy mothers for child breastfeeding and fostering.

According to Health Statistics Yearbook of MoH, the maternal mortality ratio declined from 200 per 100,000 live births in 1990 to 80 per 100,000 live births in 2005, and the recorded number of deaths caused by obstetric complications dropped nationwide from 140 in 2001 to 93 cases in 2005.

*Challenges*: the Safe Motherhood Programme has given maternal healthcare services to all regions in the country; however, it has not yet provided equal services to all mothers. According to 2002 Demographic and Heath Survey, the proportion of women in Northern mountainous areas receiving obstetric care services is at the lowest in the whole country: 23% did not receive antenatal care services, 27% did not receive tetanus vaccination, 44% gave birth without skilled birth assistance, while 27% of women in Tay Nguyen areas did not receive obstetric care services. Poor quality of maternal care has resulted in direct impacts on newborn's health and survival. Many studies show that pregnant women who received insufficient antenatal care are 2 to 3 times likely to give birth to LBW babies and their babies are likely to have increased risks of having neonatal tetanus, infections, and malformations.

According to the study on maternal mortality in 2002 conducted by MOH, the maternal mortality rate in Cao Bang province was 8 times higher than that in Binh Duong and Ha Tay provinces. The MMR in the rural areas was twice higher than that was in the urban ones, and among minority ethnic groups was 4 times higher than that was in the Kinh group. According to the study on maternal mortality in 2002 conducted by MOH, the maternal mortality rate in Cao Bang province was 8 times higher than that in Binh Duong and Ha Tay provinces. The MMR in the rural areas was twice higher than that was in the urban ones, and among minority ethnic groups was 4 times higher than that was in the Kinh group. It should be noted that main causes of maternal deaths, such as bleeding, infection, eclampsia, and unsafe abortion, can be prevented. Of those unfortunate mothers, 40% die at home, 8% die en route to health facilities. Subsequently, many babies of the pass away mothers died because of complications occurred during mother's pregnancy and at birth, of not having immediate care after birth, and of suffering from malnutrition and/or other diseases as results of not having breast milk and proper feeding.

It is evident that the nutritional status of mothers has an impact on the health and survival of their children. In Viet Nam, the prevalence of anaemia among women is quite high and this is a significant public health concern. A study from NIN in 2006 shows that the prevalence of anaemia among pregnant women was 36.7% with the highest prevalence in Bắc Cạn province (68%), and the lowest in Bắc Ninh province

(16%). It should be noted that even in cities such as Hue and Ha Noi, the prevalence of anaemia among pregnancy is also high at 37-41%. The high prevalence of anaemia is largely due to the infestation with hookworms given that Viet Nam has the highest prevalence of intestinal parasites related diseases in the world. Anaemia in pregnant mother is a risk causing premature/low birth weights and complications at delivery for both mothers and newborns.

Implementation of such interventions for mothers as mentioned above will help improving the health and survival of children. In summary, the prioritized interventions are: (1) improve the nutritional status of women before and during pregnancy; (2) deliver universal coverage of quality antenatal care to mothers in all areas of the country; (3) provide universal coverage of skilled birth attendance and increase proportion of institution-based delivery; and (4) improve the quality of newborn care at health facilities.

**IV. Curative Care for Children**

In curative system, a big problem in child health care is the unsynchronized development of different levels of health services. While certain specialization and technical branches in central and regional hospitals are developed up to international standards, the availability as well as the quality of paediatric health care at district and province level hospitals are gradually decreasing. According to a report by the National Paediatric Hospital (NPH), the current number of hospital beds reserved for children is only 12.5% of the total number of hospital beds comparing to the requirement of 20% to 25% as recommended by the Ministry of Health (MOH). In some Northern provinces, the number of hospital beds for children is even less than 10%. Regarding neonatal health, the situation is even worse. Despite Directive No. 4 by the MOH in 2003 calling for improving neonatal care in public facilities, to date, still 20% of paediatric departments in provincial hospitals do not have neonatal sub-departments or units.

Paediatric emergency care is another week point in the curative system. The National paediatric emergency system does not exist, and newborn resuscitation has not been paid enough attention. Health workers responsible for paediatric emergency care have not been provided with adequate training, especially at district level. Medical equipment for emergency paediatric care is limited. Furthermore, there are no standards and treatment guidelines for emergency paediatric care.

According to a national scale study led by the NPH in 2002, factors that influenced the quality of children's emergency management included late arrival to health facilities, not good prior-care, lack of referral and ambulance care, and unsatisfactory care at referral hospitals. About 42% of patients were hospitalized 3

days after the onset of disease, mainly because family members do not recognize the illness or give their own treatment at home, thus taking the patients to the hospital late. 28% of children with severe illnesses were transferred to higher level hospitals without any prior-treatments, and that of 60% received inappropriate treatments. Besides, unsafe referral transportation is also a factor worsening patients' illnesses and increasing the likelihood of mortality of severely sick children who need referrals. According to the above-mentioned national-study, only 25% of patients are brought to hospitals by ambulance; the majority of patients are carried to hospitals by motorbikes, and especially 10% are brought to hospitals by such simple means of transportation like bicycles, hammock, and stretches, etc. In most referred cases, the patients are not accompanied by medical staff or by those who are incompetent to provide emergency care to patients en route. This leads to the fact that child mortality occurred within 24 hour after hospital admission is very high up to 70-80% in many provincial and district hospitals.

*Challenges in curative care activities*

*Changing child's morbidity pattern: a*s a result of the country's socio-economic and industrial development, the child morbidity pattern has changed clearly as compared with the last decades. According to a national study conducted by the NHP (2000), the vaccine preventable infectious diseases have decreased, and severe malnutrition is almost controlled. In stead, the diseases related to perinatal conditions, congenital malformations, injuries and accidents, cancer and molecule pathology are on the rise remarkably. This is a big challenge in health care services as it requires preparation of human resources, equipment and proper planning for management of the changing morbidity pattern.

Moreover, the outbreaks of epidemics every year always require sufficient provision of human, equipment and medication resources in response to outbreaks of diseases in order to reduce child's mortality and complications.

## V. Impact of strategies, policies on child health care

In general, the system of legal documents relating to child health care (as mentioned in the legal background section), especially to children under five years old demonstrates the concerns of government in terms of political and financial supports. Contents of these documents cover all fields including social, environment, development and professional care relevant to child development and health. The implementation of these documents strategies and policies has gained broad participation of all government branches and mass organizations. Almost all of objectives set forth in such documents are feasible. The necessity and practicability of

these documents serve as a legal framework for the activities aiming at improving child health in Viet Nam.

***Limitations of the existing strategies, policies to the child health care***

*Contents and targets stated in the documents* are rarely based on scientific and practical evidences. The adjustment, amendment and revision of a number of policies are still slow, not catching up with the socio-economic development of the country. It is important to notice that in the efforts to achieve the Millennium Development Goals as committed by the Government, a plan of action addressing the MDG 4 on reduction of children's mortality has not yet been developed.

*Regarding implementation*: there is still a poor collaboration in inter-sectoral activities related to child health care. The lack of detail guidelines makes it difficult for local organizations to implement legal documents. The free of charge policy for children under six is causing overcrowding of patients coming to the big and central hospitals as people want to choose the best hospitals with high quality of care for their children.

*Lack of supervision*: the implementation of several documents has not been regularly supervised leading to ineffective applications in reality. The maintenance of the Baby Friendly Hospital Initiatives, implementation of Decree No.21 regarding Promotion of Nutrition Products for Infants, and Vitamin K1 prophylaxis are a few typical examples to name.

## CONCLUSIONS AND RECOMMENDATIONS FOR PRIORITY INTERVENTIONS FOR CHILD SURVIVAL

Viet Nam has achieved impressive improvements in child health such as remarkable reductions in overall child mortality and malnutrition rates; elimination/eradication of some serious infectious diseases; and continuing improvement in the health status of children as good as the other developed countries in the Region. However, on the way towards the health and survival of Vietnamese children in a world fit for children, Viet Nam still has several main challenges to overcome as follows:

1. There exists a big gap in health care and child health care among different socio-economic and geographical areas. Children in the poor families, in the rural, mountainous and disadvantaged areas still have limited access to quality health and nutrition interventions and health care services, leading to unacceptable high mortality, morbidity, and malnutrition rates. The coverage of essential child survival interventions has not met the demand of children.

2. Although the child mortality has substantially reduced but given the high number of under 5 children in the population structure, Viet Nam is still among the countries that contribute largely to child mortality in the region and the World. The neonatal mortality accounts for a large proportion of IMR (>70%) and U5MR (>50%).
3. The health care system and its quality have not met the demand of care and treatments for children, especially in the fields of emergency, referral care, and newborn care.
4. The monitoring and reporting system for child survival is inadequate including inaccurate vital statistics and substantial shortcomings in management and documentation of maternal and child health information
5. There are two important underlying factors that influence child health and nutrition care:

   a. The budget spending for health care in general in Viet Nam is among the lowest in the region and much lower for children in particular (7 USD/child/year versus the minimum amount of 34 USD/child/year)

   b. Some existing policies and strategies for child health have not yet been put effectively into practice.

In order to address the above mentioned issues, a National Action Plan is needed to create an enabling environment and strengthen activities for child survival in the process of achieving MDG4 – reducing 2/3 of child mortality by 2015 to compare with that in 1990. The priority interventions should focus on increasing the availability of and accessibility to child health care with priorities given to neonatal care, improvements of pediatric network and treatment quality as well as strengthening implementation of strategy, policy for child survival in a most effective manner.

## CHAPTER III. OBJECTIVES

### I. GOAL

To maintain and expand the coverage of essential interventions for child survival in order to decrease disparities, improve child health, and reduce child mortalities in all population groups and regions of Viet Nam, towards the achievement of Millennium Development Goal 4 - :reducing child mortality" by the year 2015.

**Targets** by the year 2015:

1. To reduce the U5MR < 18‰.
2. To reduce the IMR < 15‰.
3. To reduce the NMR < 10‰.

4. To reduce the prevalence of underweight and stunting rates among children under-5 to below 15% and 20% respectively.

**II. Specific objectives**

1. To obtain universal coverage of essential child survival interventions and increase their availability and accessibility particularly in disadvantaged socio-economic, remote and mountainous areas.
2. To improve knowledge and practical skills of health care providers on essential newborn care practices at different levels of the health system in order to reduce neonatal morbidity and mortality rates
3. To consolidate pediatric network through improved infrastructure, enhanced quality of child care and treatment under approach/model of continuum of care from family to community to health facilities.
4. To increase community participation and awareness on child survival and promote best key family practices for child survival and neonatal care at family and community levels.
5. To enhance the effective implementation of policies and guidelines on health care and treatment of children.
6. To improve monitoring and evaluation regarding progress in child survival intervention at national and local levels.

## CHAPTER IV. TARGET GROUPS AND INTERVENTION AREAS

**I. Intervention areas**

Interventions in this National plan of action should cover improvement of service delivery system with a special emphasis on quality, and M&E of intervention on maternal & child health. This is a national-wide action plan for CS. However, as presented in situation analysis, due to the differences between regions/areas and socio-economic conditions, there should prioritized interventions for CS appropriate to each region/area. Criteria for classification of regions/areas may include a number of CS indicators such as mortality, malnutrition, and coverage of CS interventions. Given the availability of reliable data, infant mortality (2006 Health Statistic Year Book) and stunting rates (NIN 2006), among the others, have been used in this action plan to divide 63 provinces/cities into 3 intervention groups (Annex 2) with 33% of provinces having the highest rates of child mortality and malnutrition, 33% of provinces at moderate level, and 33% of provinces at the lowest level. However, this grouping is just relative and for reference purpose since, as shown by the current data, mortality rate and malnutrition rate do not always go together. Moreover, there may also be differences among districts/regions within a province.

- Group 1: to be given first priority for implementation of interventions, including provinces with the following indicators:
  - IMR ≥ 20‰
  - Stunting rate ≥32%
- Group 2: including provinces with:
  - IMR between 14 - 19‰
  - Child stunting rate between 22% - 31%
- Group 3: including provinces with:
  - IMR < 14‰
  - Child stunting rate < 22%

**II. Target groups**

The target group for intervention of this Action Plan consists of all children between 0 – 5 years of age nationwide. However, to have highly effective interventions and synergy effect, child care programmes should be integrated into maternal health care programmes. Therefore, those mothers who are in the period of pregnancy, at delivery and post-delivery are also eligible for intervention target groups in this Action Plan.

**III. Essential CS interventions**

The Regional Child Survival Strategy recommended an Essential package as below:

1. Skilled attendance during pregnancy, intrapartum and postpartum period
2. Care of newborns
3. Breastfeeding and complementary feeding
4. Micro-nutrient supplementation
5. Immunization of children and mothers
6. Integrated Management of Sick Children
7. Use of insecticide-treated bed nets (in malaria prevalent areas)

## CHAPTER V. IMPLEMENTING ORIENTATION FOR CHILD SURVIVAL

1. Enhancing effective implementation of political commitments towards MDG goals by elaborating, amending and developing policies and new documents along with strengthening monitoring and supervision and creating the most favourable conditions (preferential finance, and human resource, etc.) for implementing Action Plan for CS; first and foremost focusing on identified priorities.

2. Mobilizing the participation of all social organizations; promoting intersectoral collaboration in order to concentrate on resolving the priority targets

3. Integrating with relevant strategies, action plans, and programs for maternal and child care. Expanding implementation of IMCI – a strategy known to effectively

reduce child morbidity and mortality; and collaborating maternal and child health activities with other related socio-economic development programs.

4. Mobilizing various resources for child survival including state budget, grant aid, and domestic and foreign assistance; and distributing financial support appropriately according to selected priorities and criteria which are best fit to specific regions and target population.

With reference to these orientations, it is extremely necessary that selected solutions and interventions for child survival have to be adaptive to local epidemiological contexts and situations in various areas in Viet Nam and to be based on scientific evidences and experiences within country and others. The plans need to be highly realistic with detail targets, evaluation indicators and enough resources for completion the objectives.

Inter-sectional supervision and follow up have be implemented following the plan and based on the targets with the directive of local leaders.

## CHAPTER VI. IMPLEMENTING SOLUTIONS

### I. Social mobilization

Social mobilization solution for child survival should be promoted with the new and important perception: it is not only the responsibility of the Government and health care sector but also the participation of the whole society in providing health care services to children. The details are as follows:

1. *Intersectoral collaboration:* implementation of the CS Action Plan should receive the involvement of different ministries and sectors such as health care, finance, planning and investment, culture and information, education and training, labour-invalids-social affairs, etc.

2. *Mobilizing the involvement of social organization and unions:* the Fatherland Front and affinity members play a very important role in promoting and sustaining all child care movements through different kinds of diversified, practical and effective activities. Especially the role of Women's and Youth Unions in delivering BCC activities directly to parents and community people. It is important to get involvement of the Committee for Ethnic Minority Population in scaling up the coverage of priority CS interventions in rural and mountainous areas.

3. Implementation of CS Action Plan should be given support in terms of policy and regulations so that interventions can reach mothers and children across the country. This is an extremely important solution and requires direct organization and direction of the leadership from the Party and the authorities at

different levels. At the same time, there should be involvement of relevant ministries and sectors. Monitoring and evaluation of implementation of promulgated policies and legal documents are also needed.

4. *Heath care sector:* on the one hand should work out a collaborative action plan with relevant organizations and sectors in advance, and on the other hand should consolidate and improve quality of the MCH care delivery network; and diversify both private and public health care services especially those at grassroots level and disadvantaged areas, and for obstetric and paediatric emergency care, counselling, and referrals.
5. *International cooperation*: continue to strengthen and expand international cooperation; recommend stronger collaboration among donors to converge efforts to prioritized areas such as human resource in paediatrics, and provision of equipments for paediatric emergency and newborn care.

**II. Technical solutions**

1. Developing models and applying science and technology appropriate for the local circumstances in order to increase access to essential CS interventions in disadvantaged, mountainous and remote areas. This should be considered the first priority approach in order to reduce the discrepancy in health condition and to create social equality in health care for all mothers and children in different areas. The availability of health care services that provide optimal access and utilization to all mothers and children is the must-be-reached objective.
2. Closely collaborating with other maternal health care programs; developing training materials; providing and strengthening effective use of essential intervention packets for newborn at different levels and conducting training courses to improve knowledge, practical skills for health staff aiming at increasing quality of newborn care and treatment.
3. Developing the detail plans in order to strengthen and ensure the sustainability of paediatric network with the participation of different branches and sectors at different levels: strengthening the organization of paediatric facilities, improving medical equipment, enhancing research, training health staff. Improving quality of care according to the continuum care approach from household to facility including safe referral.
4. Synchronically carrying out IMCI components including care for infants between 0-7 days of age.
5. Developing guidelines and training staff on M&E on contents relating to CS. Integrating basic indicators into annual reports at different levels and MOH's

Statistic Year book. Developing software packages for MCH reporting indicators from district level upwards.

**III. Financial solution**

1. State budget: This is a long-term and stable budget source. Funding for implementation of CS Action Plan should be included in the national targeted programs or ministerial level annual programs. The free health care policy for children under 6 years old has a great supportive impact on the health sector in obtaining a lot of achievements in child health care. In the coming time, it is necessary to concentrate investments prioritized targets and for disadvantaged areas.
2. International aid: even though it is not a long-term and stable source of fund, it has made a very important contribution to practical achievements in intervention activities to improve mother and child health in our country. Mobilizing the international aid still plays a very important role in supporting implementation of activities in CS Action Plan in the coming time.
3. Humanitarian funds: this is a modality that needs to be studied in order to create favourable conditions for in-country and foreign individuals and organizations to donate their contributions. Development of funds is to aim at supporting extremely disadvantaged target group members, unexpected events that are not sufficiently responded to such as disaster and calamities, etc.
4. Community funds: in each community, funds could be established to immediately support the difficult cases that other funds have not yet been able to support. This type of funds is important in the sense that it contributes to increasing the mutual concern and assistance, and raising the sense of responsibility of the public in health care in general and child health care in particular.

**IV. Solutions for capacity-building in management, planning, monitoring, supervision and scientific research**

1. Leadership is of utmost importance in directing implementation of CS Action Plan. Experience gained from past decades is evident for the decisive role of leadership in achieving successes of CS interventions. Such CS interventions should be included in the national socio-economic development agendas.
2. A national steering committee for CS action plan should be established to manage and coordinate planning and implementing efforts for CS. This committee should be participated by programs and departments, Administrations, institutes related to MCH. Leaders of relevant units in the

Steering Committee should be responsible for coordinating activities among programs in order to implement CS activities in the most effective manner.

3. Perfecting the mechanism for management and implementation of action plan. At provincial level, establishment of an executive system vertically down to district level for implementation of the National action plan should be made. Improving capacity in implementation planning and evaluation for staff at different levels.
4. Perfecting the data collection system and reporting. Gradually applying IT in medical record management and monitoring activities conducted in the community
5. Strengthening supervision, supportive activities among different levels of child health care. Developing mechanism for integrated supervision.
6. Conducting programme reviews to track progress, identify problems and solutions, and recommend a way forward.
7. Enhancing scientific research activities, with attention given to intervention models appropriate to different levels, community-based interventional research.

**V. Solutions for Promoting family and community participation for child survival**

1. The family and community play an important role in maternal and child care at household and community levels. They are the first people who recognize child illnesses, provide initial home care practices, and seek for medical assistances. They should be given information on CS so that they are able to actively participate in identification of problems, planning interventions, implementing and conducting M&E in their locality. Enhancement should be made on correct family and community-based care which are appropriate to targeted audience and intervention locations both in terms of the contents and the communication means.
2. It is also the role and responsibility of the family and community to spread out key family practices for CS including hygienic practices, clean water and sanitation, and child injury prevention. Especially in poor and disadvantaged areas where access to health facilities is limited, village health volunteers and/or village health workers should be empowered to deliver selected CS interventions to mothers and children in need. This can be achieved through enforcement of relevant polices on community participation. The defined role of village health workers (VHW) should be consolidated by regulation so that VHWs would be entitled to deliver the relevant maternal and child care practices in practice. In hard-to-reach-areas where access to health facilities is

impossible, VHWs can provided management of child pneumonia or home-based delivery instead of commune health workers. If it is possible, instructions should be given to women staff in IEC for health with certain topics such as nutrition, hygiene, use of ORS for diarrhea children.

## CHAPTER VII. CONTENTS OF WORK PLAN

**Objective 1.** To obtain universal coverage of essential child survival interventions and improve their availability and accessibility for children particularly in disadvantaged socio-economic, remote and mountainous areas

**Targets** by the year 2015:

1. Increase the rate of infants to be given breastfeeding within 1 hour after birth to 90%.
2. Increase the rate of infants less than 6 months of age exclusively breastfed to 50%.
3. Increase the rate of infants between 6-9 moths of age receiving breast milk and reasonable complimentary food to 85%.
4. Increase the rate of children between 6-59 months of age receiving vitamin A in the past 6 months to 90%.
5. Increase the rate of 1 year old children to be fully vaccinated to 90% (mountainous areas: 80%; delta areas: 95%).
6. Increase the rate of 1 year old children to be measles vaccinated to 95% (mountainous areas: 90%; delta areas: 98%).
7. Increase the rate of pregnant mothers to be fully tetanus vaccinated to 95% (mountainous areas: 80%; delta areas: 98%).
8. Increase the rate of facility-based delivery to 95% (mountainous areas: 80%; delta areas: 98%). Ensure the rate of 90% of home-based delivery to be attended by health workers.
9. 80% of infants are given home care visit at least once within the first week after delivery.

**Activities:**

- Maintaining and strengthening essential interventions for CS through national MCH care programs and relevant projects that are currently available.
- Identifying disadvantaged localities for prioritized investments and resources and localities where MMR and NMR are high.

- Enhancing the breastfeeding and reasonable complementary feeding promotion activities through implementation of 2006-2010 National Plan of Action on Child Feeding.
- Improving capacity and strengthening operational activities of the Steering Committee for Child Feeding and Breastfeeding in order to enhance advocacy for resource mobilization in implementing child nutritional activities.
- Reviewing implementation of 2006-2010 National Plan of Action on Child Feeding and developing 2011-2015 work plan.
- Providing training and re-training on breastfeeding to Ob-Ped doctors, midwives, nurses.
- Providing training to VHWs on counseling, advocacy for pregnant women to attend facility-based delivery, and implement essential interventions for CS.
- Providing training to village midwives or VHWs in mountainous and ethnic minority areas to have knowledge on pregnancy management, normal delivery, newborn care.
- Designing appropriate models to deliver services to all mothers and children such as mobile service team for MCH, nutrition, vaccination at village/hamlet, breast-milk support group at the community, etc.

**Objective 2:** To improve knowledge and practical skills of health care workers at different health facility levels and deliver services of essential newborn to community in order to reduce neonatal morbidity and mortality rate

***Targets***: by the year 2015:

1. 95% of health care workers responsible for delivery and newborn care at all public health facility to be trained on essential newborn care, and basic newborn resuscitation in line with NS.
2. 95% of medical universities/colleges and secondary medical schools provide pre-services training on essential newborn care.
3. 50% of provincial hospitals have ward for newborn care with Kangaroo method.

**Activities:**

- Finalizing and promulgating Guidelines on newborn care to be included in the National Standards and Guidelines on Reproductive health care.
- Providing training courses on newborn care in line with the National Standards and Guidelines on Reproductive health covering the whole country, with priority given to the areas with high prevalence of mortality rate.

- Updating the training curriculum on essential newborn care in line with the National Standards and Guidelines on Reproductive health for Medical Universities/colleges and secondary medical schools.
- Establishing training units on newborn care with Kangoroo method and national operational networking.
- Developing models and guidelines for implementing newborn care models in hospitals at different levels. Piloting and scaling up models after approval.
- Providing training courses to health workers at different levels on newborn care (aged between 0 – 7 days) integrated in IMCI protocol.
- Developing and disseminating National manual on home-based essential newborn care to village health workers.
- Running training courses for village health workers on home-based newborn care.

**Objective 3:** To consolidate pediatric network through improved infrastructure, enhanced quality of child care and treatment under approach model of continuum of care from family to community to health facilities.

***Targets*** by the year 2015:

1. 95% of paediatric hospitals have adequate equipment, human resource and infrastructure to provide all specific services on paediatric (including paediatric surgery, and other disciplines such as ENT, ophthalmology, dermatology, etc.) and providing technical assistance to lower levels.
2. 95% of provincial hospitals have pediatric departments/units with proportion of in-patient beds for pediatric is at least 20% including separate pediatric examination section, emergency care room and newborn care unit.
3. 90% of district hospitals have pediatric department including newborn unit; 95 % of health workers in pediatric/interpediatric wards in provincial/district health facilities correctly follow treatment protocols as indicated in the Guidelines for district level; 80% of the staff in the district pediatric examination clinic need to be trained in IMCI.
4. 90% of children are referred from district hospital to higher level hospital by ambulance accompanied with health workers; 80 % of those health workers must be trained on basic paediatric emergency care, including newborn emergency care.
5. 60% of communes have health care workers who are trained on case management of common childhood illnesses.
6. 95% of communes in mountainous areas have village health workers who are trained on case management of common childhood illnesses.

**Activities:**

- Conducting baseline survey on pediatric care network, including organizational structure, human resource, infrastructure and equipment.
- Based on the survey findings, identifying priority areas for consolidation of the national pediatric care network.
- Promulgating guiding documents on organizational structure, human resource, infrastructure and equipment for the national pediatric system.
- Holding workshops to guide the provincial level in implementing the above documents
- Developing the manual for national standards on care of children between 1 month and 5 years of age, including the contents of pediatric emergency care.
- Providing training on National standards on child care after being approved.
- Updating new contents into IMCI protocol: using the new growth chart including the use of zinc and ORS with low endosmosis rate in treatment of diarrhea.
- Expanding implementation of IMCI in all medical universities and secondary medical schools.
- Continuing expansion of IMCI across the country.
- Developing procedures for referral of pediatric patients, including guidelines for care, equipments, essential drugs, escorted health staff, transport means.
- Training to improve knowledge and skills on paediatric emergency care for hospital staff involved in referral and staff in the existing emergency care system.
- Developing materials on home-based and community-based child care as well as implementing home-based maternal and child care.
- Formulating and putting into use the home-based maternal and child health records/profiles with nationwide coverage.

**Objective 4:** To increase community participation and awareness on child survival and best key family practices for child survival and neonatal care at family and community levels

***Targets*** by the year 2015:

1. 80% of communes in rural and mountainous areas have sufficient IEC materials and equipments for activities on maternal and child health care.
2. 80% of mothers and child care givers know key family practices and be able to identify at least 2 danger signs of child illness that need to be brought immediately to health facility.

3. 95% of children between 0-59 months of age who had diarrhoea to be treated with ORT and 80% of them to be treated by zinc.
4. 90% of children between 0-59 months of age who had suspected pneumonia to be taken to health facility for treatment.

**Activities:**

- Organizing workshops to guide provincial level on planning.
- Reviewing, updating and additionally developing IEC materials appropriate to the conditions and culture of each region, especially the ethnic minority areas.
- Developing and distributing IEC materials on home-based MCH care practices focusing on information on care & management of child common diseases, especially diarrhea and acute respiratory infection.
- Integrating IEC contents on MCH care in the currently available communication activities in the community such as "the Safe Community"; "The cultural and healthy village", etc.
- Collaborating with the mass media to launch communication campaigns, discussion fora on MCH, for instance, integrating MCH contents into the on-air program "Health is Gold".
- Collaborating with the child nutritional care programs to implement IEC sessions on breastfeeding and complementary feeding as well as MCH care.
- Expanding component 3 of IMCI Strategy: improving child care practice at the family and the community.

**Objective 5:** To effectively implement policies, guidelines on health care and treatment of children.

***Targets*** by the year 2015:

1. 100% of localities, units implementing the plan to report their review of current documents and propose amendments, adjustments, and targets, objectives, or priorities to be included in the Action Plan for the time to come.
2. 100% of localities completing inclusion of prioritized targets, objectives of Action Plan for Child survival into the Resolution of the People's Council.
3. 100% of relevant sectors, branches taking specific actions/measures to create favourable conditions for the health sector overcoming difficulties, especially in terms of mechanism, funding and human resource for achieving the objectives.
4. 100% of units producing periodical reports every 6 months and every year on the monitoring and evaluation of implementation of promulgated documents.
5. 100% of health facilities providing health care for children under 6 free of charge in line with promulgated policy.

6. 100% of provinces implement Directive No.04/2003/CT-BYT dated 10/10/2003 of the Health Minister on strengthening newborn health care.
7. 100% of provinces have an activity for inspection of the implementing Decree No.21/2006/NĐ-CP dated 27/02/2006 of the Government on trade of child nutritional products.

**Activities:**

- Review and evaluation being conducted by leaders at different levels on implementation of policies, legal documents related to MCH.
- Organizing workshop to guide all DOH, stakeholders related to child health care across the country for planning.
- At provincial level: Setting local prioritized targets of MCH care submitted to and approved by the local People's Council which to be included in the provincial People's Council resolution.
- Review meeting being conducted by each health care facility on implementation of promulgated policies and documents, identifying causes/problems and proposing solutions to the problems.
- Child health care facilities submitting quarterly reports to DOH, Adm.MS, MCH Dept. and HI Dept. on implementation of under 6 child free medical service policy.
- Conducting intersectional monitoring and supervisory visits in collaboration among MOH, MOLISA and MOF.
- Conducting monitoring and supervisory visits mat provincial level every 6 months.
- Providing technical assistance by the leading hospitals in their implementation of Directive No. 04.
- Integrating the implementation of Directive No. 04 into the supervision, monitoring contents and scoring marks for the yearly emulation movement.
- Evaluation of implementation of Directive No. 21 and Revising and amending Decree No. 21 and framework for handling violations.
- Training staff and developing M&E network for implementation of the decree.
- Conducting IEC activities for health workers and the community on implementation of Decree No. 21, on improper advertisement of child feeding products.
- Training of staff specialized in planning at provincial/district levels in implementing CS Action Plan to reach target groups and with high effectiveness.

**Objective 6:** To improve monitoring and evaluation system regarding implementation progress in child survival at national and local levels.

***Target**s by the year 2015*:

1. 100% of provinces sending annual reports regarding indicators on CS essential interventions, maternal and child mortality.
2. 100% of health care workers who are responsible for M&E will be given training in programming and M&E for CS activities.
3. 100% of village health workers will be trained on the contents of monitoring, supervising, and reporting maternal and child mortality cases.

**Activities:**

- Incorporating key indicators on CS into annual statistical report of MOH.
- Conducting survey to assess implementation of CS intervention (every 2 years).
- Strengthening the monitoring, reporting system relating to existing MCH indicators.
- Based on the currently available M&E system, developing the M&E tools for operational activities in the action plan for CS.
- Conducting training on M&E tools at the central and local levels.
- Conduct programme reviews, studies, evaluation of impacts of interventions as well as policies.

## CHAPTER VIII. MANAGEMENT, EXECUTION AND IMPLEMENTATION

Implementation of the Action Plan for Child survival is not only responsibility of the health sector assigned by the Government but also responsibility of the relevant ministries/sectors and organizations, Party's executive committees and authorities at various levels as well as the community as a whole. The health sector should implement professional, technical activities and play its advisory role in giving orientation of activities related to this Action Plan for child survival. Other ministries/sectors, organizations should conduct activities in order to ensure the basic and essential reduction of risks negatively affecting child health and at the same time promoting child health within their function and tasks.

Policy orientations of the Action Plan are to reduce the risk factors, increasing opportunities in accessing services of IEC, medical consultation and treatment, relevant social services, not only for the time being but also for the future. This orientation contains not only technical issues but also participation of ministries/sectors, unions, Party's executive committees at various levels, civil societies, community organizations, families, and specifically and directly – mothers having children covered by the action plan.

### I. Management and execution

#### 1. Establishment of the Steering Committee

1.1. Establishing National Steering Committee for the National Action Plan to be chaired by a MOH leader. Department of Maternal and Child Health plays the standing role. This National Steering Committee consists of relevant Departments, Administrations within MOH. The tasks of the National Steering Committee are to direct, execute and collaborate with units, relevant programs/projects to implement the action plan. Support and guide the provincial level to establish the steering committees, the working groups at different levels to implement the work plan. Direct and solve emerging problems during the course of implementation. Advocate and coordinate supportive resources for activities relating to the Action plan. During the implementation process, the Steering Committee in collaboration with relevant ministries/sectors/branches coordinates inter-sectoral activities in order to achieve the set objectives.

1.2 Establishing a Secretariat to support the Steering Committee to coordinate implementation of the Action Plan.

1.3 Establishing the Steering Committees at local levels for implementation of CS Action Plan under the guidance of the National Steering Committee. DOH leader is the

Chair of the Committee while the committee members are leaders of the relevant stakeholders.

**2. Technical Assistance**

- Establishing a technical assistance group including Institutes and specialized hospitals: The National TB and Respiratory Hospital, NIHE, Institute of Malaria, parasitology and Entomology (NIMPE), NIN, NPH, NOGH.
- Experts who are the group members play the advisory role to the Steering Committee in making technical decisions to action plan implementation activities.

**3. Mechanism for collaborative implementation**

- Closely collaborating with available programs/projects relating to child health care, including the SM program, vertical programs for child health care such as Nutrition, EPI, IMCI, injury prevention, HIV/AIDS prevention, food hygiene and safety, etc.
- Method of collaboration: The Steering Committee provides guidance and coordination of programs/projects to develop annual plans in accordance with the objectives of the National Plan of Action. Integrating activities of the same objective in order to increase the resource and effectiveness of the operational activities. During the implementation process, programs/projects send quarterly/annual reports to the Steering Committee. Documents, guidelines as well as results of conferences/workshops relating to child health care should be shared among the members of the Steering Committee and experts in the technical assistance group.

**4. Responsibilities of the participating units**

- The MCH Department plays its role as a focal point to develop annual plan, monitor and coordinate activities of the Action plan. Organizes meetings of the Steering Committee and send periodical reports to MOH leaders. Reports to the SC and consults it whenever problems emerge during the course of implementation.
- Administration of Medical Services is responsible for technical issues of the activities in the medical service system, collaborating with MCH Dept. in making decisions, guidelines on paediatric care and treatment.
- The General Department of Preventive Medicine and Environmental Health is responsible for technical issues of the activities in the preventive medicine system, collaborating with MCH Dept. in intervention activities on immunization, nutrition, child injury prevention.

- Relevant institutes, Hospitals, and units: Participate in the Steering Committee, collaborating and supporting MCH Dept. to enhance and integrate activities in the area which is under their management into the activities of the Child Survival Action Plan

## II. Organization of implementation

### 1. For the period of 2009-2011

Specific tasks for this period are as follows:

- Perfecting the execution unit: the National Steering Committee, after its establishment, exercises assigned tasks by developing unified objectives, activities for piloting intervention models such as IEC model, MCH care and disease treatment model, intersectoral collaboration model, Ob-Paediatric integration model. Support for provinces in establishment of provincial Steering Committee for directing activities within each province should also be given.
- The national committee should direct the immediate activities such as human resource development, training to be conducted from central level down to local level in order to ensure resources for activities in the phase of nationwide scale-up.
- A mid-term review should be conducted at the end of this period to review the outputs, activities and objectives of the project, drawing experience and lessons learnt or revising necessary contents for further implementation in the next periods.

### 2. For the period of 2012-2015

- Main activities in this period are to scale-up implementation of models nationwide. The central level playing the role of giving technical assistance, monitoring and evaluation of planned activities included in the intersectoral agreed plan.
- Providing more investment to monitoring and supervision. Apart from monitoring provide by the Steering Committee, monitoring to be provided by experts is also important. Periodical report should be made every 6 months on operation conducted by programs, sectors and organizations.
- At the end of this period, there should be an overall review of outcomes and project objectives to draw experience for further implementation in the next period.

**Annex 1. Matrix of detailed activities for Objectives in the Plan of Action**

| Objective | Intervention activities | In coordination with sectors/departments and available programs | Implementation timeframe |
|---|---|---|---|
| **Objective 1**. *To obtain universal coverage of essential child survival interventions and improve their availability and accessibility particularly in disadvantaged socio-economic, remote and mountainous areas* | | | |
| 1. Increase the rate of infants to be given breastfeeding within 1 hour after birth to 90%.<br>2. Increase the rate of infants less than 6 months of age exclusively breastfed to 50%.<br>3.Increase the rate of infants between 6-9 moths of age receiving breast milk and reasonable complimentary food to 85%.<br>• Increase the rate of children between 6-59 months of age receiving vitamin A in the past 6 months to 90%.<br>• Increase the rate of 1 year old | 1. Maintaining and strengthening essential interventions for CS through national MCH care programs and relevant projects that are currently available.<br>2. Identifying disadvantaged localities for prioritized investments and resources and localities where MMR and NMR are high.<br>3. Enhancing the breastfeeding and reasonable complementary feeding promotion activities through implementation of 2006-2010 National Plan of Action on Child Feeding.<br>4. Improving capacity and strengthening operational activities of the Steering Committee for Child Feeding and Breastfeeding in order to enhance advocacy for resource mobilization in implementing child nutritional activities. | - Programs: SM, Malnutrition prevention, EPI, ARI, IMCI, Malaria Control, safe water supply and hygienic environment, injury prevention, PMTCT, Child HIV prevention<br>- MCH Dept.<br>- NIN<br>- Provincial DOH, RHC Center | Yearly from<br>2009-2015 |

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| children to be fully vaccinated to 90% (mountainous areas: 80%; delta areas: 95%).<br>• Increase the rate of 1 year old children to be measles vaccinated to 95% (mountainous areas: 90%; delta areas: 98%).<br>• Increase the rate of pregnant mothers to be fully tetanus vaccinated to 95% (mountainous areas: 80%; delta areas: 98%).<br>8. Increase the rate of facility-based delivery to 95% (mountainous areas: 80%; delta areas: 98%). Ensure the rate of 90% of home-based delivery to be attended by health workers.<br>9. 80% of infants are given home care visit at least once within the first week after delivery | 5. Reviewing implementation of 2006-2010 National Plan of Action on Child Feeding and developing 2011-2015 work plan.<br>6. Providing training and re-training on breastfeeding to Ob-Ped doctors, midwives, nurses.<br>7. Providing training to VHWs on counseling, advocacy for pregnant women to attend facility-based delivery, and implement essential interventions for CS.<br>8. Providing training to village midwives or VHWs in mountainous and ethnic minority areas to have knowledge on pregnancy management, normal delivery, newborn care.<br>9. Designing appropriate models to deliver services to all mothers and children such as mobile service team for MCH, nutrition, vaccination at village/hamlet, breast-milk support group at the community, etc. | | |

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| **Objective 2:** To improve knowledge and practical skills of health care workers at different health facility levels and deliver services of essential newborn to community in order to reduce neonatal morbidity and mortality rate | | | |
| ***Targets***: by the year 2015:<br>1.95% of health care workers responsible for delivery and newborn care at all public health facility to be trained on essential newborn care, and basic newborn resuscitation in line with NS | - Finalizing and promulgating guidelines on newborn care in NS for RHC<br>- Providing training courses on newborn care in line with the National Standards and Guidelines on Reproductive health covering the whole country, with priority given to the areas with high prevalence of mortality rate.<br>- Piloting and scaling-up newborn care models at different levels.<br>- Providing training courses to health workers at different levels on newborn care (aged between 0 – 7 days) integrated in IMCI protocol | - MCH Dept.<br>- MM & NM reduction Program<br>- SM Program<br>- International organizations: UNFPA, WHO, UNICEF, SC | 2009 - 2015<br>- Yearly<br>2009-2010<br>2009-2010 |
| 2. 95% of medical universities/colleges and secondary medical schools provide pre-services training on essential newborn care | - Updating the training curriculum on essential newborn care in line with the National Standards and Guidelines on Reproductive health for Medical Universities/colleges and secondary medical schools. | - DST<br>- MCH Dept.<br>- Medical Uni/College and secondary schools.<br>- DOH and provincial RH Centers<br>- International organizations: UNFPA, | 2009 – 2010 |

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| | | Pathfinder | |
| | - Developing and disseminating National manual on home-based essential newborn care to village health workers.<br>- Running training courses for village health workers on newborn care | - MCH Dept<br>- DST<br>- National Ped hosp, Children Hosp. I<br>- Ob/Gyn Hosp - DOH<br>- provincial RH Centers | 2010<br><br>- Yearly |
| 3. 50% of provincial hospitals have ward for newborn care with Kangaroo method | Establishing training units on newborn care with Kangoroo method and national operational networking | - MCH Dept.<br>- National Ped hosp, Children Hosp. I<br>- Ob/Gyn Hosp., Từ Dũ | 2009-2015 |
| **Objective 3:** To consolidate pediatric network through improved infrastructure, enhanced quality of child care and treatment under approach model of continuum of care from family to community to health facilities | | | |
| ***Targets*** by the year 2015:<br>1. 95% of paediatric hospitals have adequate equipment, human resource and infrastructure to provide all specific services on paediatric (including paediatric surgery, and other disciplines such as ENT, ophthalmology, dermatology, etc.) and providing technical assistance to lower levels | - Conducting baseline survey on paediatric care network, including organizational structure, human resource, infrastructure and equipment.<br>- Based on the survey findings, identifying priority areas for consolidation of the national paediatric care network | MCH Dept.<br>MOH Depts<br>Hospitals | 2009 - 2010 |

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| 2. 95% of provincial hospitals have pediatric departments/units with proportion of in-patient beds for pediatric is at least 20% including separate pediatric examination section, emergency care room and newborn care unit.<br>3. 90% of district hospitals have pediatric department including newborn unit; 95 % of health workers in pediatric/interpediatric wards in provincial/district health facilities correctly follow treatment protocols as indicated in the Guidelines for district level; 80% of the staff in the district pediatric examination clinic need to be trained in IMCI. | - Promulgating guiding documents on organizational structure, human resource, infrastructure and equipment for the national paediatric system<br>- Holding workshops to guide the provincial level in implementing the above documents<br>- Developing the manual for national standards on care of children between 1 month and 5 years of age, including the contents of pediatric emergency care.<br>- Providing training on National standards on child care after being approved.<br>- Updating new contents into IMCI protocol: using the new growth chart including the use of zinc and ORS with low endosmosis rate in treatment of diarrhea<br>- Expanding implementation of IMCI in all medical universities and secondary medical schools.<br>- Continuing expansion of IMCI across the country. | - Personnel Dept, DPF, DEC, MCH Dept., Adm MS, Legislation Dept. - MOH<br>- IMCI program<br>- DOH in provinces | 2010<br>2010-2011<br>2011-2015 |
| 4. 90% of children are referred from district hospital to higher level hospital by ambulance accompanied with health worker; 80 % of those health workers must be trained on | - Developing procedures for referral of pediatric patients, including guidelines for care, equipments, essential drugs, escorted health staff, transport means<br>- Training to improve knowledge and skills on paediatric emergency care for hospital staff involved in | - National PH<br>- Children Hosp. I<br>- MCH Dept, Adm.MS - MOH | 2009<br>2009 - 2010 |

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| basic paediatric emergency care, including newborn emergency care. | referral and staff in the existing emergency care system | | |
| 5. 60% of communes have health care workers who are trained on case management of common childhood illnesses<br>6. 95% of communes in mountainous areas have village health workers who are trained on case management of common childhood illnesses | - Developing materials on home-based and community-based child care as well as implementing home-based maternal and child care.<br>- Formulating and putting into use the home-based maternal and child health records/profiles with nationwide coverage | - MCH Dept.<br>- Child Health care programs<br>- International organizations: WHO, UNICEF, JAICA, Japan Child support Fund | 2009 – 2010 |
| **Objective 4:** To increase community participation and awareness on child survival and best key family practices for child survival and neonatal care at family and community levels | | | |
| ***Targets*** by the year 2015:<br>1. 80% of communes in rural and mountainous areas have sufficient IEC materials and equipments for activities on maternal and child health care.<br><br>2. 80% of mothers and child care givers know key family practices and be able to identify at least 2 danger signs of child illness that need to be | 1. - Organizing workshops to guide provincial level on planning.<br>2. Reviewing, updating and additionally developing IEC materials appropriate to the conditions and culture of each region, especially the ethnic minority areas.<br>3. Developing and distributing IEC materials on home-based MCH care practices focusing on information on care & management of child common diseases, especially diarrhea and acute | - MCH Dept.<br>- Center for IEC in health<br><br>- MCH Dept.<br>- Center for IEC in health<br>- Pop. GD<br>- National PH<br>- IMCI office | 2009-2010<br><br>2010<br><br>2010<br><br>2010<br><br>- Yearly |

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| brought immediately to health facility.<br>3. 95% of children between 0-59 months of age who had diarrhoea to be treated with ORT and 80% of them to be treated by zinc.<br>4. 90% of children between 0-59 months of age who had suspected pneumonia to be taken to health facility for treatment. | respiratory infection.<br>4. - Integrating IEC contents on MCH care in the currently available communication activities in the community such as “the Safe Community”; “The cultural and healthy village”, etc.<br>5. Collaborating with the mass media to launch communication campaigns, discussion fora on MCH, for instance, integrating MCH contents into the on-air program “Health is Gold”.<br>6. Collaborating with the child nutritional care programs to implement IEC sessions on breastfeeding and complementary feeding as well as MCH care.<br>7. Expanding component 3 of IMCI Strategy: improving child care practice at the family and the community | - GDPMEH<br>- Women’s/Youth unions<br>- DOH , Principal RH center | - Yearly |
| **Objective 5:** To effectively implement policies, guidelines on health care and treatment of children | | | |
| ***Targets*** by the year 2015:<br>1. 100% of localities, units implementing the plan to report their review of current documents and propose amendments, adjustments, | - Review and evaluation being conducted by leaders at different levels on implementation of policies, legal documents related to MCH | - MCH Dept.<br>- DOH, RHC CENTER in the province collaborate with related organizations, related civil society. | - Yearly |

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| and targets, objectives, or priorities to be included in the Action Plan for the time to come. | | | |
| 2. 100% of localities completing inclusion of prioritized targets, objectives of Action Plan for Child survival into the Resolution of the People's Council<br>3. 100% of relevant sectors, branches taking specific actions/measures to create favourable conditions for the health sector overcoming difficulties, especially in terms of mechanism, funding and human resource for achieving the objectives. | - Organizing workshop to guide all DOH, stakeholders related to child health care across the country for planning<br>- Setting local prioritized targets of MCH care which to be included in the provincial People's Council resolution.<br>- Training of staff specialized in planning at provincial/district levels in implementing CS Action Plan | - MCH Dept.<br>- IHPS<br>- DOH, RH Center in collaboration with People's Committee and related organizations, related civil society in the province. | - Yearly |
| 4. 100% of units producing periodical reports every 6 months and every year on the monitoring and evaluation of implementation of promulgated documents | - Review meeting being conducted by each health care facility on implementation of promulgated policies and documents, identifying causes/problems and proposing solutions to the problems. | - Health sector.<br>- People's Committee and relevant sectors | - Yearly |
| 5. 100% of health facilities providing | - Child health care facilities submitting quarterly reports | - Adm.MS, MCH Dept. , HI Dept. | - Yearly.<br>- Extraordinary |

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| health care for children under 6 free of charge in line with promulgated policy | to DOH, Adm.MS, MCH Dept. and HI Dept. on implementation of under 6 child free medical service policy.<br>- Conducting intersectional monitoring and supervisory visits in collaboration among MOH, MOLISA and MOF<br>- Conducting monitoring and supervisory visits mat provincial level every 6 months | - DOH collaboration with People's Committee and related organizations, related civil society in the province | upon requests |
| 6.100% of provinces implement Directive No.04/2003/CT-BYT dated 10/10/2003 of the Health Minister on strengthening newborn health care | - Formulating "Guidelines for assessment of facility-based newborn care model at different levels"<br>- Providing technical assistance by the two leading hospitals: The National Paediatric Hospital and Children's hospital No. I in their implementation of Directive No. 04<br>- Integrating the implementation of Directive No. 04 into the supervision, monitoring contents and scoring marks for the yearly emulation movement. | - National Ped hosp<br>- Children Hosp. I<br>- MCH Dept., Adm. MS<br>- DOH, Ped Hosp. Ped wards in Provincial hosp.<br>– Current project with relevant component of MCH care<br>- International organization: WHO, UNICEF, SC/US | 2009 – 2010<br><br>2009 |
| 7. 100% of provinces have an activity for inspection of the implementing Decree No.21/2006/NĐ-CP dated 27/02/2006 of the Government on trade of child nutritional products. | - Evaluation of implementation of Directive<br>- Training staff and developing M&E network for implementation of the decree<br>- Revising and amending Decree No. 21 and framework for handling violations<br>- Conducting IEC activities for health workers and the community on implementation of Decree No. 21, on | - MCH Dept.<br>- IEC Center<br>- Food safety Adm<br>- MOH inspectorate<br>- Women's union<br>- International organization: WHO, UNICEF | 2010<br><br>2009 – 2010<br><br>2009<br>2009 - 2015 |

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| | improper advertisement of child feeding products | | |
| **Objective 6:** To improve monitoring and evaluation system regarding implementation progress in child survival at national and local levels | | | |
| ***Target**s by the year 2015*:<br>1. Annual data and information regarding indicators on CS essential interventions, maternal and child mortality be available at both provincial and national levels | - Incorporating key indicators on CS into annual statistical report of MOH<br>8. Conducting survey to assess implementation of CS intervention (every 2 years).<br>9. Strengthening the monitoring, reporting system relating to existing MCH indicators<br>10. Based on the currently available M&E system, developing the M&E tools for operational activities in the action plan for CS.<br>11. Conducting training on M&E tools at the central and local levels.<br>12. Conduct programme reviews, studies, evaluation of impacts of interventions as well as policies. | - MCH Dept., DPF-MOH<br>- IMCI office, NIHE<br>- DOH, RH centers<br>- International organization: WHO, UNICEF, SC | 2010 |
| 2. 100% of health care workers who are responsible for M&E will be given training in programming and M&E for CS activities | | | 2011 và 2015 |
| 3. 100% of village health workers will be trained on the contents of monitoring, supervising, and reporting maternal and child mortality cases | | | |

**Annex 2. Recommended Priority Areas for CS interventions**

| No. | Group 1 | Group 2 | Group 3 |
|---|---|---|---|
| 1 | Kon Tum | Bắc Giang | Hà Nam |
| 2 | Hà Giang | Hà Tĩnh | Cần Thơ |
| 3 | Cao Bằng | Thái Nguyên | Bình Dương |
| 4 | Điện Biên | Bình Định | Bà Rịa Vũng Tầu |
| 5 | Lai Châu | Bình Phước | Hải Phòng |
| 6 | Quảng Trị | An Giang | Hải Dương |
| 7 | Gia Lai | Trà Vinh | Thành phố Hồ Chí Minh |
| 8 | Yên Bái | Sóc Trăng | Đà Nẵng |
| 9 | Sơn La | Phú Thọ | Hà Nội |
| 10 | Đắc Nông | Quảng Ninh | Thái Bình |
| 11 | Phú Yên | Ninh Thuận | Nam Định |
| 12 | Tuyên Quang | Ninh Bình | Đồng Nai |
| 13 | Hòa Bình | Đồng Tháp | Vĩnh Long |
| 14 | Lào Cai | Vĩnh Phúc | Bạc Liêu |
| 15 | Lạng Sơn | Bình Thuận | Hưng Yên |
| 16 | Thanh Hóa | Hậu Giang | |
| 17 | Nghệ An | Bắc Ninh | |
| 18 | Quảng Bình | Thừa Thiên Huế | |
| 19 | Đắc Lắc | Lâm Đồng | |
| 20 | Bắc Kạn | Long An | |
| 21 | Quảng Nam | Bến Tre | |
| 22 | Quảng Ngãi | Kiên Giang | |
| 23 | | Cà Mau | |
| 24 | | Tây Ninh | |
| 25 | | Tiền Giang | |
| 26 | | Khánh Hòa | |
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**Annex 3. Recommendations on interventions by regions**

| Region | | CS interventions (Priorities are in **bold**) |
|---|---|---|
| **Group 1** | IMR mean ≥ 20<br>Stunting mean: ≥32 | • **Universal coverage of essential CS interventions.**<br>• **Introduction of new and combined vaccine.**<br>• Trained health workers attend delivery and provide essential newborn care |
| **Group 2** | IMR mean: 14-19<br>Stunting mean: 22-31 | • **Universal coverage of essential CS interventions.**<br>• **Introduction of new and combined vaccine.**<br>• **Institutional deliveries with comprehensive newborn care**<br>  • Promotion of hygienic water and sanitation.<br>• Deworming of children 6-59 months and pregnant women. |
| **Group 3** | IMR mean: <14<br>Stunting mean: <22 | • **Universal coverage of essential CS interventions.**<br>• **Introduction of new and combined vaccine.**<br>• **Institutional deliveries with comprehensive newborn care.**<br>• **Promotion of hygienic water and sanitation.**<br>• Deworming of children 6-59 months and pregnant women.<br>• Enhancing child injury/accident prevention. |

**Annex 4. Plan of Action Budget breakdown**

*Total budget* *Unit: USD*

| Activities | Funds/year | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | |
| **Objective 1** | | | | | | | | |
| Maintaining and strengthening essential interventions for CS through national MCH care programs and relevant projects that are currently available. (*) | | | | | | | | |
| Identifying disadvantaged localities for prioritized investments and resources and localities where MMR and NMR are high | 10,000 | | | | | | | |
| Developing, designing appropriate models to deliver services to all mothers and children | 50,000 | 50,000 | 20,000 | 15,000 | 12,000 | 10,000 | | 157,000 |
| Providing training to VHWs on counseling, advocacy for pregnant women to attend facility-based delivery, and implement essential interventions for CS | 630,000 | 630,000 | 630,000 | 630,000 | 630,000 | 630,000 | 630,000 | 4,410,000 |
| Providing training to village midwives or VHWs in mountainous and ethnic minority areas to have knowledge on pregnancy management, normal delivery, newborn care | 320,000 | 300,000 | 300,000 | 300,000 | 300,000 | 300,000 | 300,000 | 2,120,000 |
| Providing training and re-training on breastfeeding to Ob-Ped doctors, midwives, nurses | 90,000 | 120,000 | 90,000 | 80,000 | 80,000 | 800,000 | 800,000 | 2,060,000 |
| Enhancing the breastfeeding and | | | | | | | | |

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| reasonable complementary feeding promotion activities through implementation of 2006-2010 National Plan of Action on Child Feeding(**) | | | | | | | | |
| Improving capacity and strengthening operational activities of the Steering Committee for Child Feeding and Breastfeeding (**) | | | | | | | | |
| Reviewing implementation of 2006-2010 National Plan of Action on Child Feeding and developing 2011-2015 work plan | | 52,000 | | | | | | 52,000 |
| **Objective 2** | | | | | | | | |
| Finalizing and promulgating Guidelines on newborn care to be included in the National Standards and Guidelines on Reproductive health (dissemination workshop, printing) | 45,000 | 50,000 | 45,000 | 800,000 | 800,000 | 800,000 | 800,000 | 3,340,000 |
| Providing training courses on newborn care in line with the National Standards and Guidelines on Reproductive health covering the whole country, with priority given to the areas with high prevalence of mortality rate | | 50,000 | 100,000 | 100,000 | 616,000 | 616,000 | 616,000 | 2,098,000 |
| Piloting and scaling-up newborn care models at different levels | 100,000 | 120,000 | 640,000 | 3,000,000 | 3,000,000 | 3,000,000 | 3,000,000 | 12,860,000 |
| Providing training courses to health workers at different levels on newborn care (aged between 0 – 7 days) integrated in IMCI protocol | 100,000 | 150,000 | 150,000 | 456,000 | 460,000 | 465,000 | 458,000 | 2,239,000 |
| Developing and disseminating National manual on newborn care to village health | 48,000 | 50,000 | 100,000 | 100,000 | 650,000 | 650,000 | 650,000 | 2,248,000 |

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| workers. | | | | | | | | |
| Developing and disseminating National manual on home-based essential newborn care to village health workers. | 640,000 | 630,000 | 630,000 | 630,000 | 630,000 | 630,000 | 630,000 | 4,420,000 |
| Updating the training curriculum on essential newborn care in line with the National Standards and Guidelines on Reproductive health for Medical Universities/colleges and secondary medical schools | 45,000 | | | | | | | 45,000 |
| Establishing training units on newborn care with Kangoroo method and national operational networking | 60,000 | | | | | | | 60,000 |
| **Objective 3** | | | | | | | | |
| Conducting baseline survey on pediatric care network, including organizational structure, human resource, infrastructure and equipment | 55,000 | | | | | | | 55,000 |
| Based on the survey findings, identifying priority areas for consolidation of the national pediatric care network | | 10,000 | | | | | | 10,000 |
| Promulgating guiding documents on organizational structure, human resource, infrastructure and equipment for the national pediatric system | | 30,000 | | | | | | 30,000 |
| Holding workshops to guide the provincial level in implementing the above documents | | 40,000 | | | | | | 40,000 |
| Developing the manual for national | 30,000 | 80,000 | | | | | | 110,000 |

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| standards on care of children between 1 month and 5 years of age | | | | | | | | |
| Providing training on National standards on child care after being approved | | | 50,000 | 100,000 | 100,000 | 900,000 | 900,000 | 2,050,000 |
| Updating new contents into IMCI protocol: using the new growth chart including the use of zinc and ORS with low endosmosis rate in treatment of diarrhea | 20,000 | 50,000 | 50,000 | | | | | 120,000 |
| Expanding implementation of IMCI in all medical universities and secondary medical schools | 25,000 | 50,000 | 30,000 | 30,000 | 30,000 | 30,000 | 30,000 | 225,000 |
| Continuing expansion of IMCI across the country | 650,000 | 650,000 | 650,000 | 650,000 | 650,000 | 650,000 | 650,000 | 4,550,000 |
| Developing procedures for referral of pediatric patients, including guidelines for care, equipments, essential drugs, escorted health staff, transport means | 50,000 | 100,000 | 650,000 | 640,000 | 640,000 | 640,000 | 640,000 | 3,360,000 |
| Training to improve knowledge and skills on paediatric emergency care for hospital staff involved in referral and staff in the existing emergency care system | 50,000 | 50,000 | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 3,300,000 |
| Developing materials on home-based and community-based child care as well as implementing home-based maternal and child care | 50,000 | 150,000 | 645,000 | 645,000 | 645,000 | 645,000 | 645,000 | 3,425,000 |
| Formulating and putting into use the home-based maternal and child health records/profiles | 50,000 | 200,000 | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 3,450,000 |
| | | | | | | | | |
| **Objective 4** | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|
| Organizing workshops to guide provincial level on planning | | 315,000 | 315,000 | 315,000 | | | | 945,000 |
| Reviewing, updating and additionally developing IEC materials appropriate to the conditions and culture of each region, especially the ethnic minority areas | 50,000 | 100,000 | 150,000 | | | | | 300,000 |
| Developing and distributing IEC materials on home-based MCH care practices focusing on information on care & management of child common diseases, especially diarrhea and acute respiratory infection | 50,000 | 150,000 | | | | | | 200,000 |
| Integrating IEC contents on MCH care in the currently available communication activities in the community such as “the Safe Community”; “The cultural and healthy village”, etc | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 1,050,000 |
| Collaborating with the mass media to launch communication campaigns, discussion fora on MCH, for instance, integrating MCH contents into the on-air program “Health is Gold” | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 1,050,000 |
| Collaborating with the child nutritional care programs to implement IEC sessions on breastfeeding and complementary feeding as well as MCH care | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 1,050,000 |
| Expanding component 3 of IMCI Strategy: improving child care practice at the family and the community | 150,000 | 150,000 | 400,000 | 630,000 | 630,000 | 630,000 | 630,000 | 3,220,000 |

| | | | | | | | | |
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| **Objective 5** | | | | | | | | 0 |
| | | | | | | | | 0 |
| Review and evaluation being conducted by leaders at different levels on implementation of policies, legal documents related to MCH | 30,000 | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 3,870,000 |
| Organizing workshop to guide all DOH, stakeholders related to child health care across the country for planning | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 350,000 |
| Setting local prioritized targets of MCH care which to be included in the provincial People's Council resolution | 40,000 | 50,000 | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 3,290,000 |
| Review meeting being conducted by each health care facility on implementation of promulgated policies and documents, identifying causes/problems and proposing solutions to the problems | 650,000 | 650,000 | 650,000 | 650,000 | 650,000 | 650,000 | 650,000 | 4,550,000 |
| Child health care facilities submitting quarterly reports to DOH, Adm.MS, MCH Dept. and HI Dept. on implementation of under 6 child free medical service policy | | | | | | | | 0 |
| Conducting intersectional monitoring and supervisory visits in collaboration among MOH, MOLISA and MOF | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 1,750,000 |
| Conducting monitoring and supervisory visits mat provincial level every 6 months | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 640,000 | 4,480,000 |
| Formulating "Guidelines for assessment of facility-based newborn care model at different levels" | 50,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 950,000 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Providing technical assistance by the two leading hospitals: The National Paediatric Hospital and Children's hospital No. I in their implementation of Directive No. 04 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 350,000 |
| Integrating the implementation of Directive No. 04 into the supervision, monitoring contents and scoring marks for the yearly emulation movement | | | | | | | | |
| Evaluation of implementation of Directive No. 21 | 80,000 | | | 80,000 | | | 80,000 | 240,000 |
| Training staff and developing M&E network for implementation of the decree | 50,000 | 50,000 | 50,000 | 650,000 | 650,000 | 650,000 | 650,000 | 2,750,000 |
| Revising and amending Decree No. 21 and framework for handling violations | 80,000 | 20,000 | | | | | | 100,000 |
| Conducting IEC activities for health workers and the community on implementation of Decree No. 21, on improper advertisement of child feeding products | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 350,000 |
| Training of staff specialized in planning at provincial/district levels in implementing CS Action Plan (736 prov./district staff , 30 persons/course x 25 courses, 3 days/course) | 155,000 | 125,000 | 125,000 | 125,000 | 125,000 | 125,000 | 125,000 | 905,000 |
| | | | | | | | | |
| **Objective 6** | | | | | | | | |
| | | | | | | | | |
| Incorporating key indicators on CS into annual statistical report of MOH | 30,000 | | | | | | | 30,000 |
| Conducting survey to assess | | 80,000 | | 80,000 | | 80,000 | | 240,000 |

| | | | | | | | | |
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| implementation of CS intervention (every two years) | | | | | | | | |
| Strengthening the monitoring, reporting system relating to existing MCH indicators | 60,000 | 60,000 | 60,000 | 60,000 | 60,000 | 60,000 | 60,000 | 420,000 |
| Based on the currently available M&E system, developing the M&E tools for operational activities in the action plan for CS | 20,000 | 20,000 | 20,000 | 20,000 | 20,000 | 20,000 | 20,000 | 140,000 |
| Conducting training on M&E tools at the central and local levels | 60,000 | 60,000 | 300,000 | 300,000 | 300,000 | 300,000 | 300,000 | 1,620,000 |
| Conduct studies, evaluation of impacts of interventions as well as policies | | | 90,000 | | | | 90,000 | 180,000 |
| | | | | | | | | |
| **Total** | **6,163,000** | **7,722,000** | **11,140,000** | **15,286,000** | **15,878,000** | **17,481,000** | **17,554,000** | **91,224,000** |

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**References**

[i] UNICEF's State of World's Children 2008
[ii] Law for Protection, Care and Education of children 1991