PILOT MODEL: 18 MONTH TRAINING of ETHNIC MINORITY MIDWIVES

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PILOT MODEL 18 MONTH TRAINING ETHNIC MINORITY MIDWIVES
(MÔ HÌNH THỬ NGHIỆM CÔ ĐÔ THÔN BÀN 18 THÁNG)

I. EXECUTIVE SUMMARY

While the reproductive health system in Vietnam has experienced positive growth in recent years, areas of the country still experience severe shortages of health workers, particularly mountainous and other remote areas populated by ethnic minorities. In order to lower maternal mortality rates and encourage healthier births, the Ministry of Health (MOH), with support from UNFPA, initiated an 18 month training of Ethnic Minority Midwives.

While training ethnic minority women to be skilled birth attendants is not new, the project has decided to build on the strengths of previous programs and work to eliminate the weaknesses, such as the high drop-out rates of midwives partially due to their exclusion from the health system. The intervention was designed to ensure that, after training, ethnic minority midwives would be able to provide basic maternal and newborn care, as well as first aid for newborns and obstetric complications at the village level. Trainees were chosen from ethnic minority villages so that they spoke the same language, were familiar with local culture, and remained accessible to their patients. The 18 month schedule and materials were created to easily adapt to the local context and prepare trainees to quickly immerse themselves in routine activities after graduation. In addition, at the end of training, participants were able to serve both as a midwife and as a village health worker, which has contributed to addressing the shortage of human resources for health in remote areas.

The program ran at the central, provincial, district and commune level, with trained personnel and management at each stage. Candidates for the program had to be women living in the pilot area who voluntarily agreed to receive the training. They were selected from three groups: women who were not previously trained as a health worker, women currently working as village health workers and individuals who had been trained under a predecessor program for ethnic minority midwives.

As the ethnic minority midwives have only recently begun to practice in their home villages, information about the services they provide is still preliminary. They appear to be filling a distinct local need and have contributed to improving the health of mothers and newborns in their communities. The women will continue to be periodically monitored to ensure that they are following proper protocol.

While the program appears promising, its implementation has faced a number of challenges. Primary issues include interrupted trainings due to difficulties in accessing the remote
mountainous regions, especially during the rainy season, and a greater need for interdepartmental cooperation to oversee the project. The program is currently being reviewed and growth plans will await the results of an end-of-project evaluation to be completed in 2011.

II. BACKGROUND

The reproductive health system in Viet Nam has achieved significant progresses in recent years. Since being introduced in 1991 on the basis of providing quality reproductive health and family planning services, the system has expanded and solidified throughout the country. In 1993, the Department for Maternal and Child Health Care/Family Planning was established within the Ministry of Health (MOH). Presently, the Reproductive Health Care Network in Vietnam is organized into four tiers, identical to the general health system: the central level, the provincial level, the district level and the commune level.

Following the International Conference on Population and Development (ICPD) in 1994 and the Millennium Development Summit in 1999, the Vietnamese government committed to reducing maternal and neonatal mortality through a series of key strategies, policies and related national programs. In 2000, the MOH launched the National Strategy on Reproductive Health Care (NSRH) 2001-2010 as the first action step in reducing the disparities in service provision between regions and target groups. The National Plan of Safe Motherhood 2003-2010 was approved soon after and was to serve as the framework for implementing the NSRH. It aimed to reduce the maternal mortality ratio (MMR) and neonatal mortality by half between 2001 and 2010.

Maternal and infant mortality has generally declined all over the country. According to the MDG report to UN Assembly of Viet Nam in 2010, MMR is 75 for national representation. However, the huge discrepancy remains for this MMR where this indicator is about triple in mountainous regions (108) in comparison to urban and low land areas (36) with confidence intervals of 72-144 and 24-48 respectively. As identified in the 2009 MMR survey report, in general, 28% of maternal death happened at home and approx. 10% on the ways to health facilities. Especially, the mountainous region, maternal deaths that happened at home accounted for 31.3% and 15.6% occurred on the way to health facilities. Among maternal deaths, 65.3% are farmers who are living in rural and mountainous areas. This means that many obstacles remain for women seeking the safe motherhood services that need to be addressed in SM-related programme. According to the 2009 MMR survey, neonatal rate is 7/1,000 live births (interval: 5-9) at the national level; for mountainous, rural and urban areas, the figures are 10, 5 and 4 with intervals of: 8-13; 3-8; 2-7, respectively. Approx. 80% of neonatal death
happened within one week, and 42.8% happened within the first day. Among a total of 341 neonatal deaths identified, 214 occurred in mountainous areas, where their mothers are farmers. About 45% of mothers whose newborns died were not Kinh (the major ethnicity in Vietnam), but other ethnic minorities.

Home deliveries that are unattended by trained health workers is still a common occurrence in mountainous areas, and in some cases account for as much as 58% of all deliveries. Contributing to this figure are the challenges posed by difficult terrain, poverty, cultural barriers, and the lack of qualified health care providers.

Experiences from various programs have shown that in mountainous and other remote areas primarily populated by ethnic minorities, the most effective interventions need to address cultural sensitivity in service delivery. In terms of maternal health, training local ethnic minority women to become village-based birth attendants or ethnic minority midwives is considered to be an effective solution to address cultural barriers. The women understand local customs and speak the local languages, effectively removing the traditional barriers between the service provider and the patient.

Taking this into account, the MOH, with support from UNFPA, initiated the “Pilot Model: 18 month training Ethnic Minority Midwives” in several of the country’s mountainous areas in 2008. The training program is being evaluated in 2011 in order to draw out best practices and lessons learned for potential future scale up, as well as to make policy recommendations for development of this type of service providers.

### III. PROGRAM MODEL

#### a. Context

Internationally, UNFPA has supported Traditional Birth Attendants (TBAs) programs since 1970 in order to improve maternal and child health, founding the Safe Motherhood Initiative in 1987 specifically for this purpose. In the 1990s, UNFPA, jointly with the WHO and UNICEF, issued a statement of support to the global effort aimed at improving reproductive health, specifically targeting TBAs in order to: a) enhance the links between modern health care services and the community; b) increase the number of births attended by trained birth attendants and, c) improve the knowledge, skills, and stature of TBAs (Evaluation findings- Office of Oversight and Evaluation. UNFPA 1996).
In Vietnam, since 1998, Tu Du Hospital in Ho Chi Minh city, with financial support from GlaxoSmithKline, HCM People's Committee, UNFPA and other agencies, began implementing an initiative program, called "500 ethnic minority midwives training program" to train ethnic minority women to become village-based ethnic minority midwives (EMM). This initiative followed a similar model that was proving successful in Nepal. From 1998 to the present, approx. 841 ethnic minority midwives have been trained at the Tu Du Hospital for six to nine months, in which the training covers basic skills in pregnancy-related examination and birth attendance as well as an advanced training course. After training, the EMMs return to work in their villages in the central mountainous areas and highlands (785 persons) and in the Mekong delta in the south (56 persons). Post-training evaluation has shown that the ethnic minority midwives have been able to effectively carry out pregnancy-related consultations, examinations and deliveries, and encourage pregnant women to obtain appropriate immunizations. The EMM have also helped commune health centers in reporting pregnancy management data, including the number of women of a reproductive age and the population of children under the age of 5. The contributions of ethnic minority midwives have also been recognized by the local governments, village patriarchs, local health workers and other members of the community. After working in villages with monitoring and supportive supervision from Tu Dzu hospital for at least 6 to 9 months, many EMM, who have committed to work for their villagers, have been further trained three months for advance obstetric skills. The whole duration of EMM training by Tu Dzu lasts to 15-18 months including basic training and working in villages under supervision of Tu Dzu hospital.

Despite the success of the program, difficulties remain. Because the midwives have not been officially included in the health system, given uniform titles, or paid stable incomes, they were often not appropriately equipped to offer the services they were trained to provide. These inconsistencies have resulted in a dropout rate of about 30%. Of the 554 midwives who continue to work following the training, 422 (76.3%) function as village health workers, 32 (5.7%) as collaborators and 85 (15.3%) as freelance health providers.

Building on the pool of experience provided by Tu Du Hospital model and with the support from UNFPA during 7th Country Programme, as well as technical support from Tu Dzu hospital, the Department for Maternal and Child Health, MOH, has begun to carry out the “Pilot Model 18 month training Ethnic Minority Midwives” since 2008 in order to build on the successes and address some of the challenges of the earlier model.

b. Implementation model

The intervention was designed to ensure that, after training, ethnic minority midwives would be able to provide basic maternal and new-born care, and first aids for new-born and obstetric
complication cases at village level. This is a culture-based approach to increase the accessibility to safe motherhood services in remote and mountainous areas.

Specific objectives of the intervention were identified as follows:

1. Develop and conduct a 18 month training program on midwifery for ethnic minority midwives, building the skills necessary to carry out primary health care, basic maternity services and neonatal care services;
2. Review the effectiveness of the training program;
3. Propose policy recommendations to support and improve the working conditions for ethnic minority midwives and for scaling up.

The intervention model of ethnic minority midwives (EMM) includes three periods:

Phase I. 2008-2010
1. Update training materials for 18 month programme, using the documents of Tu Dzu hospital as basis.
2. Carry out the training programme in Kon Tum, Ha Giang and Ninh Thuan.
3. Develop appropriate policy/regulations for the deployment and retention of the trained midwives in the community after graduation.

Phase II. 2010
1. Carry out the deployment and retention of the trained EMM.
2. Provide trainees with necessary medical instruments and facilitations for working in the community after the graduation.
3. Provide technical backstopping and supervision to their work in the community.

Phase III. 2011
1. Assess the quality of the services provided by the trained EMM in the community.
2. Develop/revise policies/regulations to be more appropriate and advocate for the replication of the intervention model.
3. Develop a plan for replication of the intervention if appropriate.

The intervention was carried out in three of 63 provinces of Vietnam, namely Ha Giang (representative of the northern mountainous areas), Kon Tum (representative of the Central Highlands) and Ninh Thuan (representative of the southern coastal areas). Prioritiy was given to the high and remote mountainous districts in these provinces where women have difficulty in accessing basic safe motherhood services.

Trainees for the programme were chosen among ethnic minority women from ethnic minority villages, so as they can speak the same language, to be familiar with the local culture and more easily reach villagers to provide primary health care and safe motherhood services. They are
trained in 18 months to become “village-based ethnic minority midwives”, with the basic knowledge on obstetric care and primary treatment for obstetrical and neonatal complications.

Trainers of the training program came from both central and provincial level. At central level, they are staff from two central hospitals, Tu Dzu Hospital and National Hospital for Ob./GY. At provincial level, trainers are lecturers at Provincial Medical Secondary Schools, officials from Department of Health (DOH) and staff at the Obstetrics Departments of the Provincial General Hospitals and some selected district hospitals. Trainers also work as supervisors. In addition, Heads of some Commune Health Centers were also trained and worked as supervisors.

The training was developed to ensure that ethnic minority midwives would gain the necessary skills required for a village-based skilled birth attendant, included four separate modules, commonly referred to as “6+3+6+3” formula. Details are as follows:

- **Module I** (first six months) – During the first 6 months, trainees are trained at Provincial Hospital and Medical Secondary School in Ha Giang (for trainees from Ha Giang) and at the Tu Dzu Hospital (for trainees from Ninh Thuan and Kon Tum). The main focuses were basic training on midwifery skills, basic obstetrics/new born care skills, including antenatal care, intra-partum and postnatal care and new born care, health education and family planning advocacy.

- **Module II** (three months) – This module takes place at select Medical Secondary Schools or Training Centers for Human Resources for Health in the three provinces. This module is designed to ensure that trainees receive basic knowledge and skills of a village health worker that allow them to take part in the primary health care programs in their community. After finish this module, the trainees are certificated as “village health workers”.

- **Module III** (six months) – For this module, trainees return and practice in their homelands. During this segment, trainees receive essential medical instruments and drugs for their practice (e.g., Oxytocine, clean delivery kits). They are mainly supervised and supported by supervisors from the District Hospitals and Commune Health Centers where they practice. During this period, provincial and district trainers are also trained by Tu Dzu hospital on monitoring and supportive supervision in order to provide regular visits to locations where trainees are practicing. These supervision trips aim to ensure the trainees gain clinical indicators set for this phase as indicated in the guidelines for implementation of the intervention.
• **Module IV** (last three months) – In the three months prior to graduation, trainees from Ha Giang return to provincial hospital and trainees from Ninh Thuan and Kon Tum come back to Tu Dzu Hospital to receive advanced training on initial management of obstetric and newborn complications.

After graduation, all the trainees were certificated as “Ethnic minority midwives” granting by the Medical Secondary Schools or Training Center for Human resource for health where they were trained.

The training materials used for both the trainers and trainees were developed, tested and revised by the experienced teachers of the Tu Du Hospital during the implementation of the intervention. The materials set includes: (1) Guidelines for implementing the ethnic minority midwives training model (18 months) for provinces; (2) Training materials for four modules for trainers and trainees; (3) Clinical Practice record book: during and after training; and (3) The post-training monitoring and supervision checklists.

On-the-job-training approach with focus on practice at clinical settings under closely supervision and support of experienced clinical midwives is key aspect of this training programme. Moreover, the training program mainly takes place at the province, district and commune level with technical assistance from MOH and Tu Dzu hospital. Therefore, the training program could easily adapt to local context and trainees could quickly get involved in routine activities after graduation. Many international organizations in Viet Nam followed this approach when designing their training project. Comparised with previous training programmes conducted by Tu Dzu Hospital, this training programme is longer because it followed UNFPA/WHO’s recommendation on minimum 18 month should be applied for training on midwifery. As a result, the trainees could practice within two roles in the community, as an ethnic minority midwife and a village health worker. This contributes to solving the problem of the shortage human resources in health care in remote areas.

**IV. HUMAN RESOURCES**

This intervention has been put under the overall management of the central and provincial project management board, and the direct implementation of DOH with technical support from the Maternal and Child Health Department, MOH and Tu Dzu Hospital. The implementation of this intervention has required involvement of policy makers, managers and service providers at all levels from commune to central.
At the central level, the MoH held the highest position within the intervention model and was primarily charged with orientation, the reviewing the rationality in terms of policy, the scientific part and the legality of the model. Within the MOH, the Department for Maternal and Child Health Care and the Project Management Board (PG0010) of the UNFPA supported project coordinate all of the project’s activities. In addition to the Department for Maternal and Child Health Care, the Department for Sciences and Training (MoH), and the Department for Personnel and Organization (MOH), as well as the Tu Du Hospital also took part in the pilot’s implementation.

At the provincial level, under the overall management of the Project Management Board, the Provincial Health Department developed the working plan and budget, and directed the units in the provinces. A collaboration among the Provincial Hospital, Provincial Reproductive Health Center, and the Secondary Medical School/Training Center for Human Resource for Health carried out the training courses, supervision and support at the provincial level. They contributed resources, such as, facilities, trainers and staff to the programme. The Provincial Health Department also formed a Management Committee to manage the ethnic minority midwife training classes. The Committee included individuals such as the Head of the Professional Department (representative for the Department of Health), the leader of the Provincial Reproductive Health Center, and the Head and Chief Nurse of the Obstetrics Department at the Provincial General Hospital.

At the district level, the District Hospital, District Health Center and Reproductive Health Care team were directly responsible for providing practical training, supervision and support for the ethnic minority midwives.

At the commune level, the Commune Health Centre directly managed trainees of the training course.

UNFPA, as the funding agency for this intervention model, has appointed one programme staff to coordinate technical assistance for implementation of the intervention and to provide managerial and technical assistance to provinces. In addition, this person will also facilitate coordination among the provinces, between provinces with MCH departments, MOH project and Tu Dzu Hospital and among departments within MOH. UNFPA staff plays important role in advocating and coordinating the intervention with other UN agencies and development partners who have similar interventions.

V. TARGET POPULATION & OUTREACH
Candidates to receive training under the Ethnic Minority Midwife pilot were selected primarily from the following three groups: (1) women who were not previously trained as a health worker (2) women currently working as village health workers; and (3) individuals trained under the predecessor program run by the Tu Dzu Hospital. Trainee selection criteria mandated that the candidate: (a) be a female living in the pilot area, (b) a woman who voluntarily agrees to participate in the program, (c) and someone who shows commitment to practicing in their home village after completing the training, and (d) the woman must be a respected and trusted member of the community. Due to lower level of education among women in the remote areas, all of trainees have education level below grade 12/12, 95% of them have education less than grade 7/12 and several are only able to read and write Vietnamese. Several meetings were organized at local community level for selecting the candidates based on the above criteria. The villagers –their potential clients in the future – selected them and the women made commitments at the meeting to come back and work for their community after finalization of the course. These written commitments were extremely important with the ethnic minority people, which contributed to the sustainability of the program.

During implementation, DOH organized seminars and other events (some including artistic performances) with patriarchs and other village heads to introduce the ethnic minority midwives to the local populations. Upon returning to their communities, the women themselves undertook promotional activities under the program’s direction. At the provincial and central levels, the project organized workshops, carried out interviews and televised reports, and issued articles to bring attention to the ethnic minority midwife model. Additionally, the model was presented at specialized seminars, workshops, and forums on topics such as population and reproductive health care, nutrition, and HIV/AIDS prevention. A series of advocacy events and a documentary film, Best Practice, have been produced.

VI. PERFORMANCE & MONITORING

Post-pilot evaluation results are not yet available. However, the project has been able to report the following results:

a. Performance

Results of the training activities
Between 2008 and 2009, the Tu Du hospital organized three “Training of trainers” courses for 49 central and provincial trainers, who are lecturers at Provincial Medical Secondary Schools, officials from DOH and staff at the Obstetrics Departments of the Provincial General Hospitals and some selected District Hospitals, and Tu Dzu Hospital. In addition, three training courses for 68 supervisors of provincial, district and commune levels were conducted in three provinces. Assessments made by local leaders in Ha Giang and other provinces revealed that both the trainers and supervisors were very committed, experienced and confident in their work.

Currently, the first batch of training programme has been completed. A total of 65 ethnic minority midwives (EMM) have been trained in 18 months. Among them, 40 EMMs have been trained under the full 18 months. The other 25 EMMs from Ninh Thuan province, who were trained 6 months (Module I) under previous program of Tu Dzu hospital, have received the additional training under Module II, III and IV (during 12 months). All 65 EMM trained in this programme have come back to practice in their home villages. While waiting for the official policies and regulations from the MOH, these women were recruited by the Department of Health to work as village health workers, receiving the monthly allowance appropriate for this position.

As the ethnic minority midwives have only recently begun to practice in their home villages, information about the services they provide and their affect on the community is still preliminary. Initial observations from Joint Government-UN monitoring missions to Ninh Thuan, 2009 and to Ha Giang in 2010 proved that the presence of ethnic minority midwives in mountainous and remote areas fills a distinct local need. Initial evidence also shows that the services provided by these women have contributed to improving the health of mothers and newborns in the communities. Furthermore, as an indirect benefit of the project, women trained to serve as ethnic minority midwives have received not only professional knowledge, but also communication skills and a deeper cultural understanding, knowledge that they will transfer to their communities.

**Results of policy-making activities**

A number of recently approved legal documents have contributed to improve utilization and post training application of EMMs:

- The Joint Circular 147/2007/TTLT-BTC-BYT of the Ministry of Finance and Ministry of Health has authorized the payment of allowances to the trained ethnic minority midwives in the amount of 50,000VND/month (approximately USD $3.00). It could only be considered as incentive for their contribution when taking part to social activity. However, only seven northern mountainous provinces having national target programs
may make this payment. This policy initially applies for EMMs trained by Tu Dzu hospital under the 500 EMM programme as mentioned in the history.

- The National Guidelines on Reproductive Health Care Services, issued by the Ministry of Health in November 2009, have allowed ethnic minority midwives to assist normal home deliveries in cases where the mother does not have enough time to travel to a health setting or insists on delivering at home. More importantly, oxytocine is permitted to be used in all deliveries with assistance from trained birth attendants, including EMM.

- MOH is currently developing related policies and guidelines to legalize new title of “ethnic minority midwife” as an official professional title within of health workforce. The policies will be extremely important because with the polices, all trained and active EMMs by all programmes, such as, Tu Dzu Hospital, UNFPA, Safe Motherhood Initiatives, Pathfinder International will be standardized and they can receive official title and salary.

- Additionally, based on the initiative on EMM, the Draft Strategy on Population and Reproductive Health 2011-2020 has been appraised by the Prime Minister. The Draft hopes to address issues of disparities among regions and among ethnic minority groups, and officially recognize roles of EMM in provision of maternity services in remote and ethnic minority areas.

b. Monitoring and Evaluation

During the project’s pilot period, the trained ethnic minority midwives work in their home villages as village health workers and EMM. An official Practice Handbook is used to record their work and will serve as the primary evidence to evaluate their work results. During the 18 month training program, trainees should obtain all indicators set for clinical practices, including number of pregnancies examined, number of deliveries attended, and the amount of newborn care given. The women are also continuously supervised and recertified monthly by the commune health centre. In addition, the ethnic minority midwives take part in the monthly meeting with the commune health centre that are organized by CHC with participation of all health related staff, to review all health care activities in the commune in the previous month and plan for the next month. The provincial and district supervisors carry out periodic supervision of the services provided by the ethnic minority midwives using protocol designed by the Tu Du hospital.

A review of training program and initial results of service provision is planned in 2011 in order to assess appropriateness and draw good practice. Supervision records, entries in the midwives’ Practice Handbook, and interviews with clients will all be utilized during the review.
VII. CHALLENGES & LESSONS LEARNED

Challenges

- The training package developed by MOH with technical support from Tu Dzu Hospital is used by provincial trainers in three provinces. Because of the societal differences between the pilot regions (e.g., customs related to delivery, facility availability at health stations, etc), provincial trainers needed to revise and adjust their lectures to be suitable to the local context. It is hoped that experiences from the pilot program will help draw out the most suitable lessons from regional experiences in order to standardize the current training materials for use throughout the country.
- As the rainy season made the mountainous terrain extremely difficult to travel, local supervisors were sometimes unable to sufficiently support the ethnic minority midwives.
- Because a number of health stations in mountainous communes do not have the sufficient infrastructure and human resources to attract many patients, many newly-trained midwives found it difficult to work when their clients needed higher-level care.

Lessons Learned

- As the trainers and supervisors at the provincial level are staff from different subordinate agencies of Department of Health, close collaboration among agencies within Department of Health (DOH) with overall management of DOH and between DOH and Project Management Board played a key role in ensuring timely implementation of planned activities. Therefore, the Management Board of the training course included one leader/senior manager of DOH as Co-ordinator is effective working mechanism to collaborate all involved agencies in the training programme and post-training utilization. Beside that, MOH has issued guidelines for implementation of the model, in which roles and collaboration of involved partners at different levels are clearly written.
- The criteria for selection of trainees must be closely complied in order to ensure that their own communities select trainees, have the right educational background to follow contents of the training program. In practice, UNFPA/PMB and DOH in provinces carefully selected trainees based on the actual need of provinces.
- During the period of primarily theoretical training (Modules I and II), trainees should be scheduled to participate in outreach activities, (e.g. hospital’s outreach work in the community) in order to familiarize them with the realities of working in the field.
The supervision and support provided to the trainees during their practice in the community (Module III) and after graduation was an extremely important component to the success of the model. During this phase, trained ethnic minority midwives are put under the direct supervision of supervisors at commune health centre and district health center. Therefore, it is necessary to obtain explicit commitment of support from the commune authorities, commune health centre and district health center, and create a pool of funds for refresher trainings, enhanced supervision, and improved monitoring and evaluation of midwife practices. These activities will be easier to implement and sustain if the EMM became an official professional title in the health care system and supervision and support of their work is delegated to the commune health stations. At the least, trained ethnic minority midwives are temporarily recruited in the health system for working as village health worker and ethnic minority midwives while waiting for further policy/guidelines from MOH.

VIII.  FINANCE

The total original budget for this intervention was USD $289,000. However, the actual expenditure was less than was planned. According to preliminary estimates, the cost of training an ethnic minority midwife in Ha Giang is USD $3,000, including the trainers’ fees. This cost is higher in the Kon Tum and Ninh Thuan provinces due to higher living and transportation costs. However, the actual figures are not yet available.

Currently, as the ethnic minority midwife is not yet an official profession within the health care system, they are working under the title of village health worker. As per the Decree 75 on the allowance for village health worker, they receive 0.5 of the first level of Government salary scale for state civil staff from Government budget and additional 0.3 from UNFPA. By May 2010, first level is equal to 730,000 VND, equiv. to 37 USD.

IX.  GROWTH PLANS

Ha Giang, Ninh Thuan and Kon Tum are mountainous provinces facing significant human resource constraints and having rich cultural heritage from ethnic minority people. Therefore, as assessed by provincial leaders, i.e. Ha Giang province, the intervention model to use trained ethnic minority midwives to provide maternity services for ethnic women at remote villages is culturally acceptable. Currently, two second round training courses are being conducted in Ha
Giang and Ninh Thuan using co-funding mechanism between UNFPA project and by Government contribution. All experiences from the first course, criteria for selection of trainees, materials, facilities and equipments available in the province are applied in the new courses. Trainers in the previous phase also are involved in these courses.

Based on experiences from this pilot program, international organizations, such as, UNICEF and Pathfinder International have begun to support 6 month training courses for ethnic minority midwives in other provinces in the North and Central regions of Vietnam.

Advocacy activities to support the project goals are being carried out on a continuous basis. As an example, ICM and UNFPA used the International Midwife Day, celebrated on May 5, 2010, to promote the following message: “The world needs midwives, now more than ever”. The message was a call to nations to find sustainable solutions to the estimated lack of 350,000 skilled midwives globally.

The Vietnamese Ministry of Health realizes that the health care system is in need of qualified ethnic minority midwives and that the model to train these women needs to be scaled to difficult areas throughout the country. However, it has chosen to wait until the end-of-project review is performed in 2011 before embarking on designing suitable policies to expand the model.
APPENDIX

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List of interviewees:

1. Dr. Le Thi Thanh Huyen – PO, mainly responsible for the program, UNFPA in Hanoi.
2. Dr. Phan Thi Thu Hien – UNFPA in Hanoi
3. Dr. Nguyen Ba Van – Deputy head, PLanning and Profession Division, Ha Giang
   Department of Health.
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