

Emergency appeal final report

Viet Nam: Hand, foot and mouth disease

Final report

Emergency appeal n° MDRVN010

GLIDE n° EP-2012-000045-VNM

30 April 2013

Period covered by this final report:
3 April 2012 to 31 January 2013.

Appeal target (current): CHF 758,416.

Appeal coverage: To date, the appeal is 82 per cent covered.

[<click to go directly to the final financial report, or view the contact details>](#)

Appeal history:

- This emergency appeal was initially launched on 3 April 2012 for CHF 758,416 to assist 752,255 beneficiaries, including 196,200 direct beneficiaries, for a period of nine months.
- CHF 100,000 was initially allocated from the Disaster Relief Emergency Fund (DREF) to support the initial response of the national society to the emergency.
- Five operation updates were issued on 25 April 2012, 11 May 2012, 23 August 2012, 23 November 2012 and 31 January 2013.



With this final report, the emergency appeal is closed as implementation of all activities has been carried out as planned. To date, this appeal has been 82 per cent covered with contributions totaling CHF 620,283. As there is a remaining balance of CHF 64,233 currently outstanding, IFRC seeks to transfer the funds over the next 30 days to the Viet Nam development operational plan 2013 for health and other needs.

Partners and donors are encouraged to contact the IFRC [Asia-Pacific zone office](#) within the next 30 days for further clarification on this reallocation, if needed.

Summary:

Viet Nam experienced an unprecedented outbreak of hand, foot and mouth disease (HFMD)¹ in 2011, and while appropriate and effective action was taken by VNRC working with the authorities, the country, as a whole, continues to experience a disturbingly high incidence of the disease. As of 15 March 2012, the total number of cases reported by all provinces was higher than the annual caseloads in 2009-2010, as well as 7.5 times higher than the same period in 2011.² There was also concern of a further surge of cases considering the customary April-May and September-October peaks recorded in previous years.

¹ HFMD is a common infectious disease caused by a group of enteroviruses, including Coxsackievirus A16 and Enterovirus 71. While majority of the cases are mild to moderate, the increasing circulation of EV71 has raised concerns as it can cause severe disease and even death in children. Currently, there is no vaccine for prevention nor specific medication for treatment. Children, particularly those under five, have been most commonly affected by HFMD which is characterized by fever, skin eruptions or blisters on hands and feet, and vesicles in the mouth.

² MOH 2012, Report on the HFMD situation nationwide and implemented activities, dated 9 March 2012.

Building on the successful operation in response to the unprecedented HFMD outbreak in 2011, and in response to the request of the People's Committees and the Ministry of Health (MOH) for continued support in addressing the rapidly evolving situation, the Viet Nam Red Cross (VNRC) prepared a nine-month plan of action to carry out intensified HFMD communications at community level with the aim of reducing HFMD illness and deaths.

Through an emergency appeal launched by the International Federation of Red Cross and Red Crescent Society (IFRC) in April 2012, VNRC was able to bring HFMD prevention and control messages to 421 communes of 31 districts in nine provinces. The operation reached 249,463 parents and caregivers of children under five years old, as well as teachers and workers of informal day-care centres (IDC) operating in the communes supported by the appeal. This was achieved through the mobilization of 4,209 trained community volunteers who carried out periodic community awareness campaigns, household and IDC visits, as well as individual and group discussions with parents and caregivers of children under five - including teachers and workers of IDCs – reinforced by the distribution of printed prevention materials. Volunteer efforts were complemented by mass media communications using television, radios and local newspapers.

While all activities in the communities were completed by the end of December 2012, a month-long extension was sought to enable VNRC to carry out end-line surveys and an operational evaluation, as well as a final review meeting, in order to assess the level of achievement and impact of the operation. These also enabled VNRC to capture practices and lessons to further strengthen its capacity of prepare for and respond to health emergencies. The operation has helped to consolidate VNRC's capacity in emergency health response and demonstrated its auxiliary role to the government and health sector in such efforts.

On behalf of VNRC, IFRC would like to thank Canadian Red Cross, Danish Red Cross/Danish government, Directorate General of the European Commission on Humanitarian Aid and Civil Protection (DG ECHO), Hong Kong branch of Red Cross Society of China, Japanese Red Cross Society, Red Cross of Monaco, Singapore Red Cross and Swedish Red Cross for their generous contribution to the appeal.

Lessons learned:

At the end of the operation, a final evaluation was conducted in order to provide VNRC and IFRC with findings, recommendations with the vision to bring forward the identified lesson-learned into future programming. Overall, the evaluation found that the operation was highly relevant to the country's needs, HFMD response priorities, and VNRC's missions. Compared with the 2011 operation, the strategy in 2012 was more effective in that it targeted the population not covered by the MOH. A clear behaviour change communication (BCC) strategy was developed following reviews of the 2011 communication tools and strategy, updated epidemiological pattern, consultations with the IFRC, MOH, WHO, UNICEF, as well as provincial and local leaders. The operation plan was well-designed with an appropriate framework. The project sites were appropriately selected, including the most affected provinces, accounting for about a third of the national caseload. Lessons-learned from previous operation around planning, monitoring, evaluation and reporting as well as scale up project coverage during the peak periods was translated into action. Training for trainers and volunteers was also improved to be more practical. Follow up on behaviour change among target groups was also an emphasis of the operation, in which volunteers were provided with capacity and means to monitor.

However, through carrying out the evaluation, short-comings and factors that hindered the operation were identified and fed into broader learning and future programme improvement. In the implementation, rolling out of communication activities in the community was delayed due to longer time spent on procurement and logistics. Due to the fact that incoming funding happened from April to June, VNRC could only develop detailed action plans by June. To some extent, the strategy that VNRC and IFRC used to divide the operation into two periods, which were matching the time of two spikes of HFMD cases as projected was helpful and allowed the operation to make adjustment when the second peak occurred. However, the operation could have been more effective if the action plan had been determined earlier, allowing more time for actual implementation in the communities.

In summary, through implementation of the HFMD operation, VNRC's system has developed its capacity in public health emergency responses at both the individual and organizational levels. Having a clear communication strategy and carrying out evidence-based interventions – such as implementing baseline and endline knowledge, attitude and practices (KAP) surveys - the experiences gained in the operation has built confidence for VNRC to contribute actively to the development of the national action plan for risk communication for emerging and infectious diseases. The KAP surveys by VNRC were considered as one of the major reference documents for the formulation of the plan. VNRC's role is recognized and articulated in the national plan for giving adequate behaviour change communication to the communities and public in the time of epidemic outbreak.

The situation

As of mid-March 2012, the total number of reported HFMD cases in the country was 15,218, which had surpassed the total annual case loads of 2009-2010 and was 7.5 times higher than the total caseloads in the same period in 2011. Nearly half of the cases concentrated in the southern region of Viet Nam. While the number of cases per week was substantially lower than that during the peak of the 2011 outbreak (an average of 3,000 cases per week), the MOH reports confirmed a slight increase in new cases per week. There was concern of a further surge of cases in the following period because HFMD cases in the country usually peak between April – May and September – October.

Table 1: Comparison of HFMD-related cases of infection and death in January-March 2011 and January-March 2012

	1 January to 31 March 2011	1 January to 31 March 2012
Infection	1,987	15,218
Death	5	11

In 2012, the country continued to experience increased HFMD cases, particularly in September when about 6,000 cases were reported in a week's time. The total number of cases last year was also 35% higher than in 2011, but it was worthwhile to note that the total number of unnecessary deaths among young children was reduced by two-thirds (45 deaths in 2012 against 169 deaths in 2011). The Southern provinces continued to be the area most affected by the outbreak, with the highest HFMD incidence and over 90 percent of all deaths.

During the planning stage, 13 priority provinces were proposed for the operation, as data by the MOH showed that HFMD cases in these provinces accounted for about a third of the national caseload at that time. The cumulative HFMD cases and deaths in the 13 provinces throughout the year are shown in Table 2. In fact, only eight selected provinces of higher priority were started with interventions from the beginning with the ninth province, Ba Ria – Vung Tau, added at a later phase as more funding was secured. These provinces were chosen because of the intensity of the HFMD situation there, in terms of both infections and deaths. As data in table 1 shows, the proportions of both HFMD infections and deaths in these provinces compared to the whole country increased between the periods January – March and April – December 2012, which serve as justification for VNRC interventions there.

Table 2. Cases of HFMD infection and death in the nine project provinces vs. nationwide (2011, before and after intervention in April, 2012)

Name of province	Jan – Dec 2011		Jan – Mar 2012		Apr – Dec 2012	
	cases	deaths	cases	deaths	cases	deaths
A. Central region	17,116	2	3,281	2	14,184	1
Da Nang	827	1	648	1	2,565	0
Quang Ngai	7,149	5	469	0	1,555	0
B. Southern region	70,287	144	10,268	15	17,026	26
Ba Ria – Vung Tau	3,659	6	541	1	6,678	2
Long An	2,973	10	356	0	4,522	3
Soc Trang	3,630	5	252	0	2,292	0
An Giang	2,617	6	610	5	5,014	6
Ben Tre	3,968	3	441	0	5,642	1
Vinh Long	2,464	0	433	1	2,982	1
Dong Thap	6,809	10	1,113	2	7,194	5
C. Total 9 provinces	34,105	46	4,863	10	48,644	18
D. Total 63 provinces	112,370	169	24,716	18	132,938	27
% C/D	30%	27%	20%	56%	37%	67%

Source: Department of Preventive Medicine, MOH, December 2012

Red Cross and Red Crescent action

Achievements against outcomes

Overview

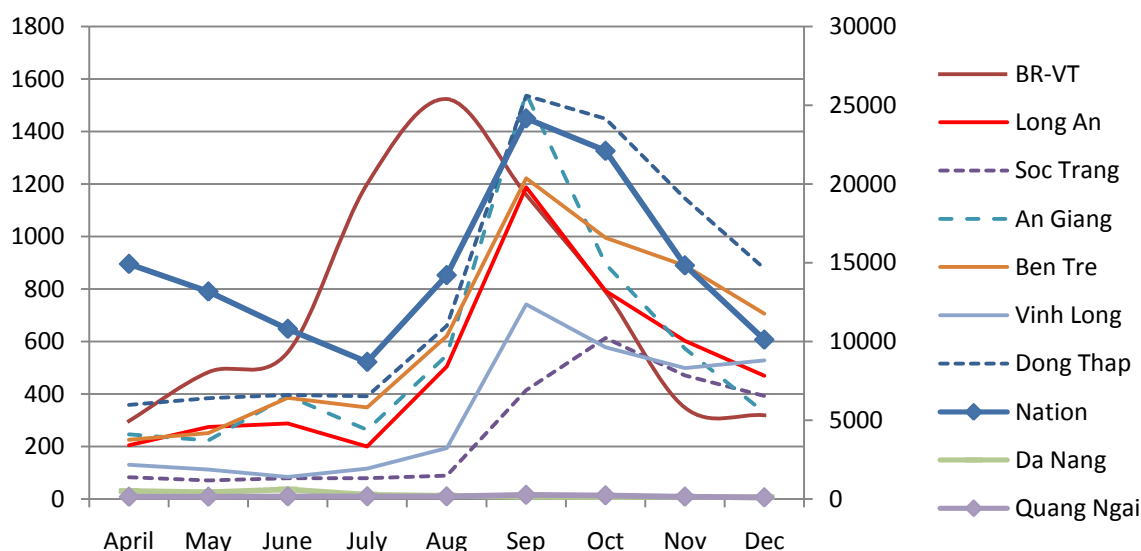
Through ten months of implementing the operation, VNRC has reached to a total of 249,436 direct beneficiaries³ in 421 communes of 31 districts in nine provinces for raising awareness and changing behaviour related to HFMD. The coverage of the operation is slightly differed from the original appeal, which sought to directly benefit 196,200 people in 540 communes of 30 districts in 13 provinces. The adjustment of the action-plan is due to having only 82 per cent of funding covered.

The operation has contributed to reduction of HFMD cases and deaths in the 31 districts in nine intervention provinces. When HFMD communication activities were intensified on the basis of the developed behavior change communication (BCC) strategy, a substantial decrease in the reporting of new infections were noted in districts covered by the operation. From Figure 3 below, it can be inferred that the trends in HFMD infections in the nine project provinces were proportional to that of the entire nation.

³ Total reached beneficiaries include:

- Families with children under five year-old through household visits: 126,270
- Families with children under five year-old through group discussions: 101,210
- Workers in informal day care centres: 2,186
- Children under five year-old in informal day care centres: 15,513
- VNRC staff: 48
- VNRC volunteers: 4,209

Figure 3. HFMD infection in the nine project provinces (left axis) vs. that in the country (right axis) - April-December 2012



Source: GDPM, MOH, December 2012

The operation of VNRC aimed at two main groups: parents and care givers of children under five years (receiving services at household level) and teachers and workers of informal daycare centres. KAP surveys were carried out before and after the operation in order to help VNRC assess the level of knowledge and practices as well as effects of communication efforts. Behaviour change communication activities by VNRC has reached 229,666 comprising 227,480 parents and caregivers of children under five years of age and 2,186 IDC teachers and workers, who were reached through household visits, FGDs and IDC visits. In addition, VNRC also used selected mass communication such as public campaign, local radio and television to further disseminate key messages aiming at families of children under five-years of age and general public in nine provinces. Results of baseline and endline surveys among care-givers at household and informal daycare centres by VNRC also show positive changes related to HFMD among correspondents, particularly knowledge of symptoms and prevention measures. Surveys also found that changes among care-givers in households are more significant to those at informal day-care centres; however, baseline KAP illustrates that knowledge and practices among caregivers of IDC are already better than those at home. This is also supportive by the reality that households are often not reached by mass media and communication efforts prior to VNRC's intervention.

The 2012 HFMD operation has enhanced VNRC's profile in public health and emergency health responses at the national and local levels. In total, VNRC has trained 48 national facilitators in behaviour change communication and HFMD, whom subsequently have trained successfully 4,209 volunteers in the communities. As well as having increased capacity in rapidly rolling out training for epidemic control, VNRC also demonstrated an improvement in community mobilization to respond to HFMD. VNRC has expanded its networks of able health trainers and volunteers who would not only be mobilized for the HFMD operation, but also future emergency health responses. Specifically, VNRC was able to mobilize participation of community members in 421 communes to enhance practices to prevent further HFMD spreading. In addition, the national society also successfully sensitized various mass organizations and local government to partner with them in public campaigns. VNRC has effectively and will continue to engage with the MOH, the National Center for Health Education and Communication (NCHC), WHO, UNICEF, Red Cross Red Crescent Movement partners, as well as local authorities in bringing the lessons learned from the HFMD response into other emergency health and community-based health programmes in the future. Taking lessons-learned from previous operations, VNRC has also improved its capacity in monitoring and evaluation through the implementation of a rapid assessment, the baseline and endline KAP surveys, as well as independent project evaluation.

Emergency health
<p>Goal: Illness and deaths due to hand, foot and mouth disease (HFMD) in 13 priority affected provinces in Viet Nam are reduced in the next nine months.</p>
<p>Outcome: Target groups in 540 communes have improved knowledge and practices that lead to the prevention and control of HFMD</p>
<p>Output 1. At least 196,200 people in 540 communes (30 districts from 13 provinces) have improved knowledge and practices that contribute to HFMD prevention and control</p> <p>Key activities</p> <ol style="list-style-type: none"> 1.1. Update and broadcast key messages via national television channels in six months 1.2. Disseminate television clips to 13 chapters for further broadcasting and dissemination of key messages via provincial radio and newspapers 1.3. Update key messages in existing information, education and communication (IEC) materials in consultation with MOH and WHO 1.4. Print and deliver 700,000 leaflets and 6,000 posters 1.5. Distribute 38,160 bars of soaps for 19,440 informal day-care centres and target beneficiaries at campaigns in the first three months 1.6. Organize 30 public campaigns on HFMD prevention at district level 1.7. Conduct door-to-door visits to 90,000 beneficiary families in three months 1.8. Conduct 16,200 group sensitizations with mothers and members of families with children under five years of age 1.9. Monitor behaviour change among target groups
<p>Output 2. VNRC's capacity to respond to emerging diseases like HFMD is improved.</p> <p>Key activities</p> <ol style="list-style-type: none"> 2.1 Deploy National Disaster Response Team (NDRT) to assist selected provinces with rapid assessment, finalize provincial action plan, and support the KAP survey 2.2 Set up and maintain weekly and monthly reporting for district/provincial and headquarters project team during this nine-month operation 2.3 Participate in relevant coordination meetings on HFMD prevention and emerging diseases at national, provincial and district levels 2.4 Conduct baseline survey 2.5 Organize refresher training and training of trainers (ToT) for 50 provincial instructors on HFMD 2.6 Update/train 5,400 selected commune volunteers on HFMD knowledge, community mobilization and provision of adapted HFMD training, and visibility items. 2.7 Conduct an operations review to capture good practices and lessons learnt to inform VNRC organizational strengthening in emergency health 2.8 Coordinate with MOH and relevant partners to ensure continued alignment of the operation with national efforts as well as to maximize complementary efforts.

Achievements and impacts:

Output 1. At least 196,200 people in 540 communes (30 districts from 13 provinces) have improved knowledge and practices that contribute to HFMD prevention and control.

As mentioned above, VNRC carried out baseline and endline KAP surveys to assess the level of knowledge, attitude and practice among caregivers in IDCs and those at home. The baseline was designed to only survey a small sample size covering eight selected provinces, given the previous baseline KAP survey in 2011 was

supplementary and timing pressure from the start of the operation. The endline survey was carried out in January 2013, after interventions were completed in the 31 communes of nine provinces. It was found out that VNRC's operation has contributed positively to changes in knowledge, attitude and practice among caregivers in IDCs and those at home. Specifically, at project end, 85.6 percent of surveyed respondents could describe correctly what HFMD is while the figure was only 50 percent before the intervention. There has been a positive change before and after the project with hand-washing – one of the key behaviour changes that VNRC wanted to make among target population. Responses by surveyed households and caregivers at IDCs before and after intervention are below:

- **Before cooking:** Households - 81.5 percent (endline), 74.0 percent (baseline); IDCs - 97.5 percent (endline), 91.4 percent (baseline)
- **After defecating:** Households - 89.1 percent (endline), 63.7 percent (baseline); IDCs - 98.8 percent (endline), 94.3 percent (baseline)
- **Before giving food to the child:** Households - 88.1 percent (endline), 76.0 percent (baseline); IDCs - 95.0 percent (endline), 94.3 percent (baseline)
- **After washing or cleaning the child:** Households - 66.1 percent (endline), 52.1 percent (baseline); IDCs - 92.5 percent (endline), 78.6 percent (baseline)

Mass media communication

Awareness raising through mass media included the production and broadcasting of a television clip, radio programmes and publications in local newspapers. Throughout the project, VNRC has maximized the use of communication channels such as printed and internet-based newspapers and radio to disseminate key messages and update the public on the HFMD situation as well as operational progress. The television clip⁴ with key HFMD prevention messages was aired on local television channels from October to December in nine local television channels. Though the broadcasting was delayed due to the longer internal procurement involved in the production of the clip, Red Cross chapters were able to negotiate with local television stations to broadcast it at prime time and free of charge during outbreaks, thus reaching a wider public in target areas. A documentary⁵ was made to highlight project activities by VNRC with financial support from DG ECHO and aired on the national television channel. In the community, VNRC occasionally used local radio and loudspeaker broadcasts, especially during outbreaks, as the means through which the community became aware of the HFMD situation in their district and commune.

Through its own television channel, website and magazine, VNRC also actively disseminated news and articles about HFMD prevention to the 13 priority provinces. Its chapters and branches were active in engaging with local media in disseminating HFMD-related information. Between August and December, each chapter successfully worked with local television and newspapers to publish at least one update through mass media. Over 20 articles on the project were published in various local printed newspapers, in addition to those disseminated through online newspapers, television and radio.

Information, education and communication (IEC) materials

In consultation with the NCHEC, the General Department of Preventive Medicine of the MOH, and the Communicable Diseases Control and Risk Communication unit of WHO in Viet Nam, VNRC had updated key messages in its IEC materials to make them user-friendly, easy to understand and action-oriented. Evaluation results revealed that beneficiaries generally found the messages to be very clear and useful for them in understanding the signs, symptoms, prevention and treatment of the disease. These messages were consistently used in all of VNRC's IEC materials throughout the campaign.

To ensure the key messages reached the target groups, VNRC also utilized colour-printed communication materials, including leaflets, posters and flip charts (see Table 4 below). Calculation of printed IEC materials was based on the actual number of beneficiaries reached in the selected communes and distribution capacity of volunteers. In total, 220,000 leaflets were distributed to participants at mass campaigns, beneficiary families during household visits and FGDs, and IDC workers during visits to IDCs. As the project progressed, the number of leaflets printed was adjusted down according to the actual number of families with children under five and

⁴ http://www.youtube.com/watch?v=pQjNCO_QXos

⁵ http://www.youtube.com/watch?v=CoEfuBf_r-A

IDCs, distribution capacity of volunteers, as well as the materials distributed by the provincial health agencies. 9,200 posters were produced and displayed at appropriate public venues and targeted IDCs. Up to 4,800 flip charts were used by volunteers to facilitate FGDs and/or during household visits.

Posters on HFMD



All of the materials used by VNRC were regarded appropriate and consistent with the information and messages by the MOH, and able to convey clear messages about the disease. The monitoring plan was carried out during the distribution period to make sure materials were given to the targeted beneficiaries. Interviews with beneficiaries also revealed that the communication materials were very easily understood with a lot of useful visuals rather than clustered information. Even for ethnic minorities, many of whom who are illiterate, the materials were still considered understandable and useful to provide them an understanding of HFMD.



A Kotu mother showing the HFMD flyer to her daughter, who was infected with HFMD but was treated in time thanks to the information provided by the Red Cross.

Visits to IDCs with soap distribution

During implementation, VNRC made adjustments to the quantity of soap to be distributed to IDCs and families of children under five in the communes according to the actual target households and IDCs. Distribution of soap was implemented on a monthly basis to the target beneficiaries. By the end of the project, VNRC had distributed 123,364 bars of soap to IDCs and families of children under five years of age who attended group discussions and mass campaigns. Among these, 12,854 bars of soap were distributed to 1,160 IDCs, serving 15,513 children under five and 2,186 caregivers. Another 101,210 bars of soap were distributed to family members attending FGDs, and 9,300 bars were distributed for families of children under five at public campaigns. The distribution of soap served to provide an incentive for families and IDC workers to practice and continue the behavior of hand washing with soap, and

enabled volunteers to observe and give feedback on the practice. One issue that might have undermined the impact of this practice in some areas is the lack of clean water, such as rainwater and river water used by many in the Mekong Delta provinces. VNRC and its partners are addressing this long-term issue of clean water through water and sanitation and other development programmes.

Table 4. IEC materials produced and distributed

IEC materials	Planned	Produced and distributed
Leaflets	700,000	220,000
Poster	6,000 sets	9,200 sets
Flipcharts	4,800 books	4,800 books
Soap	38,160 bars	123,364 bars

Volunteers reached 2,186 caregivers through visits to 1,160 IDCs, including both registered and non-registered (family-based) ones, for behaviour change communication sessions on HFMD prevention. Having resided in their community for a long time and respected by local people, the volunteers were able to identify the very small-scale, family-based daycare centers, and were well-received by these IDCs. The visits were done in an interactive and rather informal manner, allowing volunteers to provide caregivers with in-depth information. The network of volunteers in the project were active in sharing good practices in dealing with HFMD among covered IDCs, as well as providing them with resourceful information about available services. The number of actual target IDCs is much lower than the planned target (6 per cent) due to the lack of precise data on IDCs during the initial assessments. The initial target had to be estimated based on VNRC's HFMD operation in 2011 in urban areas, where the contexts were different from the mostly rural project sites of 2012. The local communities also found the visits of volunteers to IDCs, particularly family-based ones, very effective as these centers have not been reached by mass communication campaigns conducted by local and health authorities and workers. Results from volunteer records showed that about 98 per cent of care givers have acquired good knowledge of HFMD symptoms, infection routes, severe symptoms and hand-washing practice.

Mass campaigns

In coordination with various local agencies and mass organizations, including the district Department of Health Education and Communication, Department of Preventive Medicines, the Women's Union, Department of Education and Department of Culture and Communication, VNRC organized 31 mass campaigns at the district level. Key messages on HFMD prevention were disseminated to 10,345 people (see tables 5 and 6). Participants included beneficiary families, local IDC workers, Red Cross volunteers and staff, and other relevant stakeholders, who received leaflets, posters and soaps at the event. Public officials and local media were also invited to these events, which were well-attended and received a great deal of support from the authorities and health sector. The visibility of Red Cross was highly promoted through the campaigns.

Household visits and FGDs

Through 505,080 household visits and 7,694 FGDs, VNRC's trained volunteers reached a total of 227,480 family members of 126,270 households with children under five years old. While each household were visited four times by the volunteers to follow up on awareness and practices in relation to HFMD, particularly to reinforce the full adoption of key hygiene and sanitation measures, the group discussions allowed households to have more interactive peer discussions and experience-sharing on how to best prevent children from getting HFMD and take care of them once they are suspected to be infected. The evaluation revealed that beneficiaries appreciated the visits by Red Cross volunteers very much as VNRC is the only organization who implemented household visits and group discussions on HFMD prevention in community. One problem with conducting household visits was that every commune was assigned ten volunteers to cover 300 households, regardless of the actual need in each commune. Though volunteers in some districts have displayed flexibility in reallocating volunteers to communes with more households with children aged under five, this issue could be resolved at the management level in future operations.

Through the final evaluation, it was found that the use of mass media complemented by face-to-face household visits were regarded as very effective in delivering knowledge and promoting attitudes and practice to the communities. Households with an infected child that were interviewed during the evaluation indicated that they became aware of HFMD and its extent through mass media, but it was through the information and materials provided by Red Cross volunteers that helped them identify the disease early on and able to provide their child

with timely treatment. According to the endline KAP survey results, 94.8 per cent of household's caregivers and 98.75 per cent of IDC workers regarded the IEC materials as either "useful" or "very useful," especially with 80 per cent of IDC workers considering the IEC materials "very useful."

Table 5. Planned vs. actual coverage of VNRC's 2012 HFMD operation

	Planned	Actual	%
1. Target provinces	13	9	69%
2. Target districts	30	31	103%
3. Target communes	540	421	78 %
4. Target community volunteers	5,400	4,209	80%
5. Target VNRC staff	46	48	104%
6. Mass campaigns	30	31	103%
7. Household visits	360,000	505,080	140%
8. FGDs	16,200	7,694	47%
9. Target IDCs	19,440 ⁶	1,160	6%

Table 6. The number of beneficiaries reached through mass campaigns, FGDs, household visits and IDC visits

	Planned	Actual	%
1. People attending mass campaigns	9,300	10,345	110%
2. People reached through FGDs	66,454	101,210	150%
3. People reached through household visits	90,000	126,270	140%
4. People reached through IDC visits	N/A	2,186	N/A
Total direct beneficiaries	196,200	249,43	127%

⁶ According to the revised workplan, the number of IDCs was reduced from the initially proposed number of 19,440 to 1,034, based on actual need.

Monitoring behaviour change

A set of monitoring tools were developed to help volunteers record the gradual changes in behaviour and practices related to hygiene and sanitation, particularly hand washing. Monitoring results at the end of December showed that among the 126,270 family members whom the volunteers visited at home, about 8.1 per cent still did not practice hand washing correctly, while the number is 1 per cent among IDC workers.

Both the endline KAP survey and evaluation results reveal that there were improvements in awareness and knowledge about HFMD among the target groups. Interviews with and visits to households showed that beneficiaries were very well aware of HFMD, with the majority saying that it's highly possible HFMD would occur to their child, and said they were very afraid. The same goes with caregivers at IDCs, who were also aware of the reporting system once a child was diagnosed with HFMD.

Interviews in districts where the project was implemented in the earlier phase also showed that beneficiaries had sufficient knowledge about HFMD. They were able to tell its signs and symptoms, and ways to prevent transmission, including hand washing at appropriate times, proper covering of food, frequent cleaning of the floor with soap or disinfectants, and separating the sick child from others, among others. With regards to the effectiveness of the project in changing target groups' behaviours, visits to households and IDCs revealed that the majority of beneficiaries improved their behaviours, as seen in their very clean houses, kitchens and availability of soap. Household interviewees said that they cleaned their houses with water, soap or disinfectants at least once a day, and IDCs did so two to three times a day. Before, IDCs only used to wash toys when they looked dirty, but now, they would wash the toys once a week with disinfectants or soap.

In the newly extended districts and communes in the later phase, however, the consensus was that the implementation period was too short (less than two months) for the outcomes to be observable. Even in districts and communes where there was a decrease in the number of cases and deaths throughout the implementation period, it is still a stretch to attribute the decreases to Red Cross action, as it could have been the result of other factors, including the natural progress of the outbreak.

Output 2. VNRC's capacity to respond to emerging diseases like HFMD is improved.

During the operation in 2012, VNRC was able to quickly implement emergency response to address the needs of communities for knowledge and preventive practices to prevent HFMD. Through its large network of volunteers, key messages were delivered to the target audiences via inter-personal communication channel and supported by indirect communication channel. Trained volunteers and staff were able to carry out follow-up and monitoring on progress of behaviour change among target groups. Learning from the previous operation, improvements in recruitment and training of volunteers, monitoring and reporting, VNRC was able to scale up the operation according to the needs. The interventions by VNRC through the operation was perceived positively by local communities and stakeholders as activities were carried out in the time HFMD caseloads were increasing and overstressing response capacity of communities. While the design of the operation was to compliment the national response, VNRC was able to take the lessons learned and results from the operation to contribute to the development of the national plan for communication for emerging and infectious diseases, which was adopted in the beginning of 2013.



A boy from a beneficiary home in Long An province demonstrates hand-washing with soap.

Deployment of the NDRT

VNRC deployed the national disaster response team (NDRT) to eight target provinces in April 2012 to carry out the rapid assessment and baseline KAP survey, and again in January 2013 to carry out the endline KAP survey. Having experiences in previous KAP surveys, the team was able to guide the local teams in survey design, and selection and interviewing of target groups.

Monitoring of activities

Since the start of the operation, VNRC has maintained an active reporting system in which situation and progress are updated monthly by project teams at all levels. In addition, VNRC also put in place a detailed monitoring plan with tools and provided the provincial project teams with skills to report monthly against set indicators and targets. Having situation updates and project progress updates, the project teams were able to collect both quantitative and qualitative data, and track down areas where HFMD cases are on the rise and where VNRC needed to enhance its efforts. Based on this information, VNRC was able to review the situation at the start of September, right before the second peak, and adjusted its action plan to scale up interventions accordingly.

Coordination and collaboration

VNRC has actively participated in coordination mechanism at different levels for the 2012 HFMD outbreak preparedness and response. At the headquarters level, VNRC has actively shared the baseline and endline KAP survey results with the MOH, which were used as one of the main reference documents to develop the national action plan for infectious and emerging diseases. The lessons learned from the nine provinces were actively shared by VNRC at various coordination meetings in order to stress the importance of building capacity and enabling response activities in the community.

At the provincial and district levels, VNRC chapters and branches have worked closely with the Department of Preventive Medicines, Center for Health Education and Communication and other mass organizations in order to carry out awareness raising campaigns as well as interventions at households and IDCs successfully. Coordination efforts resulted in avoidance of duplication in distribution of communication materials and soap among the target groups.

Baseline survey

The baseline survey conducted in April helped provide solid data about the local situation and needs of the community, as well as baseline data to set indicators and targets for the operation and develop the plan of action. In addition, the results from the KAP survey were also useful in redefining key messages and communication activities to reach target groups.

Prior to the deployment of the endline KAP survey in January 2013, with technical help from a national consultant, VNRC has improved the sampling size of the survey in order to increase its representation. The results from both the baseline and endline surveys have helped VNRC assess the effectiveness of interventions as well as areas for improvement in behaviour change communication design. These results have also been shared with all of the relevant stakeholders.

Even though it was qualitative surveys and having some limitations due to relatively small sampling size, the surveys were used by VNRC and various health actors in the country as one of the reference documents for formulation and developing plans for health communication. Besides being used as the reference for the national action plan for communication for infectious and emerging diseases, the surveys were used by various provincial agencies in order to better understand the community's perspectives, their understanding and practices related to HFMD. Thus, the surveys were a good source of reference for better understanding the epidemic and how communication for HFMD prevention at the household level can be best implemented.

Training of trainers

During the nine months of the operation, VNRC trained a total of 48 trainers in the following skills: knowledge of behaviour change and HFMD prevention, and facilitation skills specifically tailored for HFMD operation. Participants were assessed based on the writing-based pre- and post-knowledge test and trial facilitation sessions, which resulted in 39 trainers demonstrating good knowledge and skills on HFMD prevention, and were qualified to provide training to volunteers.

Volunteer training

All of the qualified trainers were then deployed to train 4,209 community volunteers. The post-test results of volunteer training showed that about 90 per cent of volunteers have good knowledge of HFMD and 77 per cent had good knowledge of behaviour change communication (BCC) activities. Such a cascade training model has helped VNRC improve its internal capacity to increase its network on the ground to eventually scale up its interventions. The core trainers from VNRC were able to contribute to sensitization activities of the project in provinces through project meetings and local coordination meetings with other partners such as local and health authorities, and mass organizations and the media, which enabled smooth project implementation.

The trained volunteers were integral to the project implementation. Not only were they able to reach target groups according to the project design and deliver sessions on BCC for HFMD prevention, but they were also very active in community mobilization for mass campaigns and group discussions, which sometimes meant contributing additional time, efforts as well as financial resources. They have taken an active role in enabling targeted households and IDCs in early detection and timely referral of HFMD cases.



A Red Cross volunteer in Da Nang province demonstrates the flip chart and flyer on HFMD.

Final evaluation

At the end of operation, VNRC has conducted a final evaluation. A team of a capable international and two national public health and communication professionals were selected for the final evaluation. The evaluation focused on assessing the appropriateness and relevance, impacts, effectiveness, efficiency and sustainability of the interventions by VNRC. The evaluation was able to bring in findings from the field through interviews and discussion with key informants in six communes of three project provinces as well as interviews with key stakeholders at the national level, such as the MOH (Department of Preventive Medicines and NCHCE), WHO and UNICEF, and partner national societies present in Viet Nam.

Key findings and recommendations of the evaluation were presented and discussed in an internal review meeting in January 2013 among VNRC headquarters, chapters, and the IFRC delegation. The review has enabled VNRC to reflect upon its achievements, lessons learned⁷, as well as discussion on the way forward for VNRC's emergency health responses that takes into account findings and recommendations from the evaluation team. Particularly, issues around standard operating procedures and guidelines for emergency response to infectious and emerging diseases, as well as continued capacity building for VNRC's emergency health will be addressed in VNRC's annual health programme.

Sharing of information with relevant stakeholders

VNRC headquarters and chapters have been present and active at all national and local coordination meetings led by the MOH in HFMD response. Besides providing the KAP surveys to be reference documents for the national action plan for communication for infectious and emerging diseases, VNRC has been active in voicing the needs of communities in health communication efforts in HFMD as well as other emerging diseases. VNRC headquarters also participated in various e-conferences held by the MOH with the provinces to update on the implementation and guide provinces in response activities.

At the provincial level, the chapters have been active in presenting and sharing information at provincial coordination meetings on HFMD. Through these meetings, the chapters were able to update on the status of response by VNRC on the ground as well as contribute to the overall local management of response activities in HFMD.

⁷ Refer to the section on lessons learned on page 2

At project end, stakeholders from the MOH and departments of health, and local communities and authorities were present in the review meeting of VNRC. VNRC was able to sensitize partners on the project achievement as well as facilitate discussion on how response could be more effective in the future.

In the vision of further building capacity for emergency health, VNRC will take the lessons learned from the final evaluation of the operation forward through integrating important activities in its annual health programme. These include completion of planning, monitoring, evaluation and reporting for emergency health, training for facilitators and volunteers in infectious diseases control, contingency planning and developing guidelines for epidemic control. The funding balance from the operation will be used partly to support operational and activity costs. In addition, VNRC will continue to monitor the HFMD situation through its existing collaboration with health agencies at various levels, as well as support chapters in finding alternatives to support trained volunteers to carry out further communication work in the community, if the disease becomes serious. IFRC support structure and expertise from the zone, regional and country offices will work to support VNRC to achieve continuing objectives after the operation ends to ensure the current mechanism of VNRC in epidemic control is functional.

Contact information

For further information specifically related to this operation please contact:

- **Viet Nam Red Cross:** Thai Van Doan, vice president / secretary general;
phone: +84 913 216549; email: doanvanthai62@yahoo.com.vn
- **IFRC country office, Viet Nam:**
 - Michael Annear, head of country office
phone +84 984 605 252; email: michael.annear@ifrc.org
 - Thuan Nguyen, healthcare manager,
phone +84 912 256 224; email: thuan.nguyen@ifrc.org
- **IFRC Southeast Asia regional office, Bangkok:**
 - Anne Leclerc, head of regional office,
phone: +662 661 8201; email: anne.leclerc@ifrc.org
- **IFRC Asia Pacific zone office, Kuala Lumpur:**
 - Al Panico, head of operations
phone: +603 9207 5700, email: al.panico@ifrc.org
 - Andreas Weissenberg, operations coordinator
phone: +6012 230 7895, email: andreas.weissenberg@ifrc.org
 - Jim Catampongan, emergency health coordinator
phone: +603 9207 5779, email: jim.catampongan@ifrc.org
 - Alan Bradbury, head of resource mobilization and PMER
phone: +603 9207 5775, email: alan.bradbury@ifrc.org

Please send all pledges of funding to zonerm.asiapacific@ifrc.org



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1. **Final financial report** [below](#)
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-

How we work

All IFRC assistance seeks to adhere to the [Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations \(NGOs\) in Disaster Relief](#) and the [Humanitarian Charter and Minimum Standards in Disaster Response \(Sphere\)](#) in delivering assistance to the most vulnerable.

The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.



The IFRC's work is guided by [Strategy 2020](#) which puts forward three strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
 2. Enable healthy and safe living.
 3. Promote social inclusion and a culture of non-violence and peace.
-

Disaster Response Financial Report

MDRVN010 - Vietnam - Hand, Foot and Mouth Disease

Timeframe: 02 Apr 12 to 31 Jan 13

Appeal Launch Date: 02 Apr 12

Final Report

Selected Parameters

Reporting Timeframe	2012/3-2013/3
Budget Timeframe	2012/3-2013/1
Programme	MDRVN010
Budget	APPROVED

All figures are in Swiss Francs (CHF)

I. Funding

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
A. Budget		758,416				758,416	
B. Opening Balance		0				0	
Income							
Cash contributions							
<i>China Red Cross, Hong Kong branch</i>		25,296				25,296	
<i>Danish Red Cross</i>		76,667				76,667	
<i>European Commission - DG ECHO</i>		325,185				325,185	
<i>Japanese Red Cross Society</i>		25,000				25,000	
<i>Red Cross of Monaco</i>		6,007				6,007	
<i>Singapore Red Cross Society</i>		50,000				50,000	
<i>Swedish Red Cross</i>		66,543				66,543	
<i>The Canadian Red Cross Society</i>		45,586				45,586	
C1. Cash contributions		620,283				620,283	
C. Total Income = SUM(C1..C4)		620,283				620,283	
D. Total Funding = B + C		620,283				620,283	

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance		0				0	
C. Income		620,283				620,283	
E. Expenditure		-556,051				-556,051	
F. Closing Balance = (B + C + E)		64,233				64,233	

Disaster Response Financial Report**MDRVN010 - Vietnam - Hand, Foot and Mouth Disease**

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Programme	MDRVN010
Budget	APPROVED

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability		
	A					B	A - B	
BUDGET (C)			758,416			758,416		
Relief items, Construction, Supplies								
Water, Sanitation & Hygiene			33,760			33,760	-33,760	
Teaching Materials	63,950		16,686			16,686	47,264	
Other Supplies & Services	14,310						14,310	
Total Relief items, Construction, Sup	78,260		50,446			50,446	27,814	
Logistics, Transport & Storage								
Storage			5			5	-5	
Distribution & Monitoring	41,000						41,000	
Transport & Vehicles Costs			6,667			6,667	-6,667	
Total Logistics, Transport & Storage	41,000		6,672			6,672	34,328	
Personnel								
International Staff	56,000		37,395			37,395	18,605	
National Staff	17,600		17,474			17,474	126	
National Society Staff	214,374		56,274			56,274	158,100	
Volunteers			81,090			81,090	-81,090	
Total Personnel	287,974		192,233			192,233	95,741	
Consultants & Professional Fees								
Consultants	7,000		10,940			10,940	-3,940	
Professional Fees			149			149	-149	
Total Consultants & Professional Fees	7,000		11,089			11,089	-4,089	
Workshops & Training								
Workshops & Training	236,704		155,551			155,551	81,153	
Total Workshops & Training	236,704		155,551			155,551	81,153	
General Expenditure								
Travel			24,181			24,181	-24,181	
Information & Public Relations	43,950		57,321			57,321	-13,371	
Office Costs	4,000		4,142			4,142	-142	
Communications	12,000		4,941			4,941	7,059	
Financial Charges	1,240		5,234			5,234	-3,994	
Other General Expenses			5,751			5,751	-5,751	
Shared Office and Services Costs			3,237			3,237	-3,237	
Total General Expenditure	61,190		104,807			104,807	-43,617	
Indirect Costs								
Programme & Services Support Recover	46,288		33,852			33,852	12,436	
Total Indirect Costs	46,288		33,852			33,852	12,436	
Pledge Specific Costs								
Pledge Reporting Fees			1,400			1,400	-1,400	
Total Pledge Specific Costs			1,400			1,400	-1,400	
TOTAL EXPENDITURE (D)	758,416		556,051			556,051	202,366	
VARIANCE (C - D)			202,366			202,366		

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Programme	MDRVN010
Budget	APPROVED

All figures are in Swiss Francs (CHF)

IV. Breakdown by subsector

Business Line / Sub-sector	Budget	Opening Balance	Income	Funding	Expenditure	Closing Balance	Deferred Income
BL2 - Grow RC/RC services for vulnerable people							
Disaster response	758,416	0	620,283	620,283	556,051	64,233	
Subtotal BL2	758,416	0	620,283	620,283	556,051	64,233	
GRAND TOTAL	758,416	0	620,283	620,283	556,051	64,233	


THE VIET NAM RED CROSS SOCIETY'S EMERGENCY RESPONSE TO THE HAND, FOOT AND MOUTH DISEASE (HFMD) OUTBREAK IN 2012



FINAL EVALUATION REPORT

Ha Noi, February 2013

Independent Evaluation Team
Eva Lam, Nguyen Ly, Nguyen Dinh Cuong

 International Federation
of Red Cross and Red Crescent Societies



ACKNOWLEDGEMENT

The Evaluation Team would like to express our sincere thanks to the International Federation of Red Cross and Red Crescent Societies (IFRC) and Vietnam Red Cross (VNRC) for financial and technical assistance for this evaluation. We gratefully acknowledge the time, valuable inputs, and assistance given by officials, staff and volunteers of VNRC Headquarter as well as RC Chapters and Branches in An Giang, Long An, and Da Nang. It was a great pleasure to meet so many knowledgeable and dedicated colleagues at every operational level. We are indebted to all the respondents from the Ministry of Health (MOH), WHO, UNICEF, and donors of HFMD appeal who generously gave their valuable time and insights to enrich this evaluation.

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Evaluation Team

Eva Lam, Pharm, MPH
Nguyen Ly BA, MPP
Nguyen Dinh Cuong MD, MPH

ACRONYMS

BCC	Behaviour change communication
DM	Disaster Management
DREF	Disaster Relief Emergency Fund
FGD	Focus group discussion
HFMD	Hand, foot and mouth disease
HQ	Headquarters
IDC	Informal daycare center
IEC	Information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
KAP	Knowledge, Attitude and Practice
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCHCE	National Center for Health Communication and Education
PNS	Partner national society
RC	Red Cross
SOP	Standard operating procedure
TOR	Terms of reference
TOT	Training of trainers
UNICEF	United Nations Children's Fund
VNRC	Viet Nam Red Cross
WHO	World Health Organization

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EXECUTIVE SUMMARY

HFMD cases within the first three months of 2012 were 7.5 times higher than same period in 2011 according to the MOH. As of March 9, there were more than 15,000 infections in 61 provinces, including 11 deaths in 8 provinces. The IFRC launched the first HFMD Emergency Appeal to support the emergency response operation implemented by VNRC from April to December 2012. The objective of the operation was to reduce infection, death and spread of HFMD in project provinces via improving knowledge, awareness and practices of the target population to HFMD.

The final evaluation aims to assess the effectiveness and impact of HFMD operation and provide recommendations to improve VNRC emergency health response system in the country. The evaluation team conducted desk review, key informant interviews and focus group discussions with officials/staff, stakeholders, and beneficiaries at different levels in Hanoi and 6 communes in 3 districts of An Giang, Long An, and Da Nang.

Main findings

The operation was highly relevant to the country's needs, HFMD response priorities, and VNRC's missions. Compared with the 2011 operation, the strategy in 2012 was more effective in that it targeted the population inadequately covered by the MOH. A clear BCC strategy was developed following reviews of the 2011 communication tools and strategy, updated epidemiological pattern, consultations with the IFRC, MOH, WHO, UNICEF, as well as provincial and local leaders. The operation plan was well-designed with an appropriate framework. The project sites were appropriately selected, including the most affected provinces, accounting for about a third of the national caseload. However, ethnic, poor and migrant families with children under three, who were considered vulnerable people at risk of HFMD, were not mentioned in strategies. The need-based planning approach was not well implemented due to time and human resource limitations. The same interventions were applied to all communities regardless of differences in population sizes and local characteristics.

The IEC/BCC approaches and messages were culturally relevant to the majority of the target population. Re-design and production of IEC materials were necessary but also time-consuming, contributing to the delay of the operation. Household visits were considered effective in improving the knowledge and practice of parents and children's caregivers. The effectiveness of IDC visits with distribution of soaps varied. Small home-based daycare settings were more likely to benefit from the program than ones with larger scale, since they lacked both the knowledge and infrastructure to prevent HFMD. In reality, many daycare centers selected for intervention were large-scale ones, whose teachers already had sufficient knowledge and practice regarding HFMD prevention. Besides the face-to-face communication, mass media communication through TV and radios were also reported to be effective in raising awareness of the communities about the disease during the outbreak. However, the design and production of such IEC products were also delayed, affecting their effectiveness.

The operation progress was delayed due to procurement procedures, the consultation process with stakeholders, the training of a large number of volunteers, and the design and

production of IEC materials, making the preparation period as long as half of the project duration. As a result, less time was allocated for community interventions.

The appeal received effective technical support from many development and government partners, including IFRC, partner national societies (PNSs), WHO, UNICEF, and MOH. However, the operation faced the challenge of unpredictable fund flows. Planned activities had to be adjusted in accordance with the 82 percent of appeal coverage. In the planning phase, the project took considerable efforts in external and internal coordination. The Emergency Health Coordinator from the IFRC Asia Pacific Zone Office was deployed to Viet Nam to provide technical support in coordinating with key health partners and to prepare the launch of the emergency appeal. At the national level, VNRC's coordination with the health sector and other health partners was effective. But coordination at district and commune levels was not very efficient.

Using a result-based approach, the project established and operated an M&E framework. Baseline and endline KAP surveys were also conducted to measure the results of the project. A systemic reporting framework was developed and maintained. However, the report forms were complicated to the volunteers. The use of a reporting system was likely vague. Supervision of collaborators took place but was still insufficient at the commune level due to the lack of human resources.

As a result of the operation, most people in the community demonstrated their sufficient knowledge about HFMD and practiced preventive measures against the infection. VNRC staff expressed their role of the project in improving their experience and competence. To launch and implement the operation successfully, VNRC Healthcare Department, with effective support from IFRC, has overcome many challenges in funding availability and human resource capacity. Learning by doing, VNRC system has developed its capacity in public health emergency responses at both the individual and organizational levels. Reduction of HFMD cases in selected provinces was implied as an impact of the operation.

Many lessons were learnt from the operation, including: more need-based planning, improvement of coordination at local levels, the need of a contingency plan for health emergencies, better supervision, more responsive operation in a short time period, and more efficient allocation of resources. There are potential considerations in sustaining the results, but also many challenges in fundraising capacity, maintaining communication, and sustaining enabling mechanisms.

Recommendations

For more efficient planning for health emergency response, it is recommended that VNRC establish and maintain a database of local systems, and develops a preparedness plan on health emergencies, which is to be integrated into the existing VNRC DM system. A special mechanism for emergency responses within the VNRC system and an SOP for health emergency response need to be considered. A pre-agreed upon list for a "Hygiene Promotion Kit" is also advised. For faster launch, greater decentralization to VNRC branches is recommended for more timely production and adaptation to local use of IEC materials.

For better BCC performance at community, a more need-based approach should be learnt. In planning, differences in population, socio-economic characteristics, inclusion of the poor, ethnic minorities and migrants should be considered to increase the coverage and

effectiveness of the operation. More supportive supervision to the volunteers is needed. Better coordination with related stakeholders and integration into the current system, especially the health sector at local levels in planning and implementing the operation, are also advisable.

For improving capacity, VNRC first needs to improve the understanding and competence of staff at all levels in responding to epidemic outbreak and health emergencies. The volunteer management system should be enhanced at commune and district levels. Besides, the capacity in procurement and logistics for relief materials in health emergencies is also important.

For improving sustainability, it is recommended that VNRC builds up and maintains a potential network for health emergencies and disease prevention, integrates HFMD prevention and/or hygiene promotion activities into existing health projects with support of PNSs., explores the possibility of provinces with fundraising capacities to continue HFMD prevention and/or hygiene promotion.

1

INTRODUCTION

1.1 BACKGROUND

The HFMD outbreak

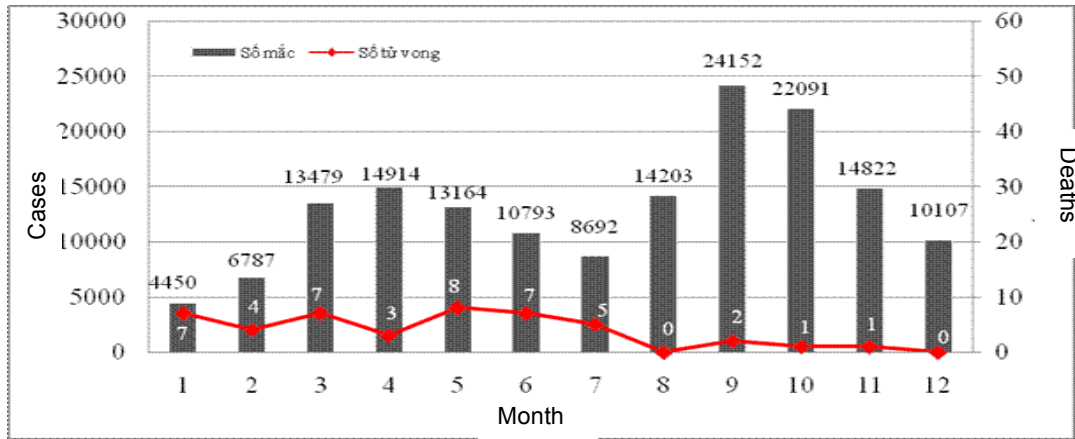
HFMD was first detected in Viet Nam in 2003 with annual caseloads between 10,000 and 15,000. The infectious disease has been included in the national infectious disease surveillance system in Viet Nam since 2008. In 2011, Viet Nam experienced an unprecedented intensity in the disease, with 112,370 infections and 169 deaths. According to the MOH, the reason for the sharp increase in HFMD infection since 2011 was the circulation of a more virulent virus, EV71 subtype, which is responsible for more than half of the cases and causes more deaths than other subtypes. Currently, there is neither a vaccine nor specific treatment for the disease.

In 2011, IFRC had allocated CHF 121,227 from its Disaster Relief Emergency Fund (DREF) to support VNRC in its response to the epidemic. During the five-month operation, VNRC had reached 144,995 beneficiaries through disseminating preventive messages and behavior change communication (BCC) activities. The 2011 operation covered 75 communes in the five most affected provinces of Ho Chi Minh City, Binh Duong, Dong Nai, Quang Ngai and Thanh Hoa. Among these, only Quang Ngai continued to receive intervention in 2012. The operation was considered successful, as the target provinces saw no HFMD-related death during the five months of the operation, and HFMD appeared to have been curbed in these provinces.

New reported cases of HFMD increased sharply in 2012, with over 6,000 reported cases per week in mid September. The number of infections and deaths were 151,100 and 45, respectively.¹ While the number of deaths is less than one-third that of 2011, the number of infections is nearly 35 percent higher. HFMD cases during the year concentrated into two periods: March to May and September to October with two peaks in April and September (see Figure 1). The Southern provinces continued to be the area most affected by the outbreak, with the highest HFMD incidence and over 90 percent of all deaths.

Figure 1. No. of HFMD cases and deaths during 2012

¹General Statistics Office, December 2012



Source: Department of Preventive Medicine, MOH, December 2012

Response strategy and efforts of health sector

The MOH had been actively responding to the HFMD situation in 2012 by calling upon local authorities, health departments in provinces, and mass organizations to strengthen their HFMD prevention efforts. Interventions by the MOH included early detection, containment, treatment and control; monitoring and evaluation of prevention and control efforts, as well as allocation of additional resources for these activities. It also deployed 12 teams to support and supervise HFMD prevention and control activities, and monitor the situation in the 20 target provinces with the most reported cases.

The MOH's BCC strategy was designed to focus on education for prevention for caregivers of children under five years of age, with an emphasis on children under three, at IDCs and households. However, the interventions were mainly implemented in daycare centers and community through campaigns and mass media channels. Direct communication such as household visits were not carried out due to limited resources. Key messages focused on hand washing; safe eating and drinking habits; covering the mouth when coughing and sneezing; separating sick children from others to ensure infection is avoided; and cleaning the floor, surfaces, and play areas as well as children's toys. The MOH also emphasized education for the general public on the symptoms of HFMD, especially severe symptoms that require immediate hospitalization or hospital referral. The Provincial Committees and the MOH have also asked VNRC to extend its support in addressing the current situation by carrying out HFMD communications at community level through its network of branches and trained volunteers.

Viet Nam Red Cross Society

The Viet Nam Red Cross Society (VNRC) is a humanitarian social organization founded on 23 November 1946. Until now, its chapters have been established in almost every commune (more than 99%), many colleges, offices and companies. The Society has a total of 4,553,582 members, 3,943,994 youth and 298,725 Red Cross volunteers participating in the activities of 19,725 branches. For many years, VNRC worked and gained strong capacity and experiences in natural disaster response, including floods and storms. Recently, VNRC has improved its capacity in disease outbreak preparedness and response, including

dengue fever, and avian and pandemic influenza. These new experiences helped VNRC build a network of trained instructors and volunteers, tools, guidelines and IEC materials, and a partnership platform for further scaling up and better response activities to public health threats. Especially, the 2011 response to HFMD outbreak brought about essential understanding and experience in public health emergency response which were also strong bases for the 2012 VNRC response to HFMD.

The International Federation of Red Cross and Red Crescent Societies (IFRC)

The IFRC maintains a country office in Ha Noi, which is part of the IFRC secretariat regional team in Southeast Asia. The IFRC country office is comprised of six programme officers (national and international), five administrative staff and a country representative. It provides support for VNRC in international obligations that are in line with the IFRC Strategy 2020, and the implementation of its strategy. The office also provides technical support for VNRC and coordination of in-country programmes according to the Secretariat's mandate. The country office supports the strategic priorities of VNRC, which were guided by a "development strategy 2010 with vision to 2020" (VNRC 2010). The focus of VNRC plan is to strengthen VNRC's organizational structure and to position itself as the premier humanitarian organization in the country.

At present, nine Red Cross Red Crescent partners are present in Viet Nam to provide programme support to VNRC, covering programs in the areas of disaster response, disaster risk reduction, health, water and sanitation, organizational development, communication, humanitarian diplomacy, as well as program monitoring and evaluation. IFRC has developed a Planning Framework to Support Viet Nam Red Cross Society's which is in line with VNRC Country Plan 2010 – 2015 with vision 2020.

1.2 THE EMERGENCY APPEALS AND OPERATION

Upon the success of the 2011 HFMD operation supported by IFRC DREF, on 3 April 2012, IFRC launched the first HFMD Emergency Appeal to support VNRC response to HFMD outbreak in 2012. The Appeal sought for CHF 758,416 in cash, kind and services to support VNRC to assist 752,255 beneficiaries, including 196,200 direct beneficiaries within nine months, up to the end of December 2012.² CHF 100,000 was initially allocated from DREF on 2 April 2012 to help initiate response by VNRC. The goal, outcome and expected outputs of the operation were identified in the project framework as follows:

- **Goal:** Illness and deaths due to HFMD in 13 priority provinces in Viet Nam are reduced in the next nine months.
- **Outcome:** Target groups in 540 communes have improved knowledge and practices that lead to the prevention and control of HFMD.
- **Output 1.** At least 196,200 people in 540 communes (30 districts from 13 provinces) have improved knowledge and practices that contribute to HFMD prevention and control.

² The appeal was extended for a month to 31 January 2013 to accommodate the endline KAP survey as well as evaluation

- **Output 2.** VNRC's capacity in responding to emerging diseases like HFMD is improved

The original plan was to provide intervention in 540 communes in 30 districts of 13 most affected provinces. However, only eight of the 13 provinces were selected to start up activities due to the slow response and arrival of funds from donors. By September 2012, VNRC and IFRC reviewed HFMD situation and found it to be severe in an additional province, Ba Ria - Vung Tau, while cases in the other four non-intervened provinces did not seem to escalate. The project therefore increased coverage of interventions to a total of nine provinces (eight initial provinces plus Ba Ria – Vung Tau) among thirteen appealed provinces with high HFMD-related cases and death. By the end of the operation, with 82 percent of the appeal covered, or CHF 621,901, VNRC had provided intervention to cover 31 districts of the 9 most affected provinces. .

1.3 EVALUATION: OBJECTIVES, APPROACH, AND METHODS

Objectives

The evaluation of VNRC HFMD response in 2012 aimed to 1) assess the effectiveness and impact of VNRC HFMD operation in target areas, and 2) provide guidance to VNRC in improving its emergency health system and procedure in response to disease outbreaks and other health emergencies in the country, in support of government's response and in coordination with other in-country stakeholders.

Approach and method

The evaluation used the following criteria to evaluate and provide recommendations: relevance and appropriateness, effectiveness, efficiency, impact, and sustainability, which logically linked to the inputs, outputs, outcome, and impact of the project as in the following framework:

Table 1. Framework of the final evaluation

Intervention logic framework			
Inputs/process	Outputs	Outcome	Impact
<ul style="list-style-type: none"> • Threat and need assessment • Operation design and plan • Capacity building • Management and coordination procedure • Outreach and IEC/BCC activities • Fund 	<ul style="list-style-type: none"> • Improved access to outreach IEC activities among target population • Improved capacity of VNRC staff and volunteers in behavior change communication and community involvement 	Improved knowledge and practice in preventing HFMD among target people	Reduced cases of HFMD infection and death
Evaluation framework			
Relevance and appropriate-	Effectiveness		Impact

ness

- | | | |
|---|--|--|
| <ul style="list-style-type: none">• How relevant was the operation to the most vulnerable population at risk of HFMD?• Was the response to the HFMD outbreak in line with the VNRC role and strategy for public health emergencies in the country?• How were targets selected and covered?• How user-friendly and effective were the planning and monitoring tools developed and used by different VNRC levels in the HFMD operational plan of action?• Were guidance and support from VNRC HQ effective for chapters and lower level to implement the operational actions? | <ul style="list-style-type: none">• Has the operation met its stated objectives?• How could the operation improve access to outreach IEC activities among target population?• Did the operation improve the capacity of VNRC staff and volunteers in behavior change communication and community involvement?• How did the VNRC HQ and chapters work with the authorities and other partners in addressing the HFMD situation and in carrying out the operation? (Capacity improvement)• How could the operation improve knowledge and practice in preventing HFMD diseases among target people? | <p>How did the operation contribute to the reduction of HFMD cases and deaths in target communities?</p> |
|---|--|--|

Efficiency

- Was the intervention delivered timely and with quality to the beneficiaries?
- Was training to volunteers sufficient for them to give behavior change interventions to target beneficiaries?
- How efficiently were human and financial resources utilized by VNRC in the operation?
- Were logistics and procurement requirements of the operation respectful to previously-agreed systems and procedures of the IFRC and donors?
- How have the management and technical arrangements across VNRC departments at headquarters and branches been facilitated to meet operational objectives?

Sustainability

- How will capacity improvement continued?
- Is there any financial maintenance and support for future operation?
- Is there any operation mechanism established and maintained?
- What are lessons learnt and good practices for future operation?

Methods of data collection

Desk review of secondary information:

- Secondary written/published materials, including statistics, archived materials
- Review of health data selected from health centers where available
- Communication strategy, HFMD emergency appeal, HFMD operation updates
- Baseline, endline KAP; assessments; presentations/reports from VNRC
- VNRC's strategy 2020.
- National action plan, guidelines on behavior change communication in HFMD
- Previous evaluation reports from VNRC/IFRC and external consultants
- Other information from humanitarian actors in Vietnam

Key informant interviews and/or focus group discussion groups with officials/staff of the following were undertaken:

- VNRC HQ, chapters and branches
- Beneficiaries and partners in target areas
- MOH and local authorities where relevant
- WHO, UNICEF
- PNS
- IFRC
- Donors

Field visits/observations of six communes in three provinces: An Giang, Long An, and Da Nang. In each province, the evaluation team visited and conducted key informant interviews and FGDs with: VNRC chapters and branches (provincial, district and commune levels), the Preventive Medicine Center, the IEC Center, Community Health Center (CHS), beneficiaries, and volunteers.

Limitation

The evaluation was carried out at the national level and in three project provinces (three cities and three districts/towns and communes). Due to the limited resources, qualitative findings from these sites might not be sufficient to represent all intervention sites of the operation. The evaluation team used and analyzed a number of quantitative data from secondary sources such as outbreak data, project reports, baseline and endline KAP survey results, workplans and any other relevant information from the existing system. Therefore, the validity of the findings was also dependent on the quality of these data. To reduce the above-mentioned risks, the evaluation team tried to collect as much information as possible from different reference sources. To validate the findings, the evaluation team worked closely with the project staff and participated in the project's final review workshop to present the initial findings and receive feedback from different stakeholders.

2

FINDINGS AND DISCUSSION

2.1 RELEVANCE AND APPROPRIATENESS

Need identification

VNRC put significant efforts in collaboration with different stakeholders to identify the needs to develop its operational strategies. National outbreak data and findings from recent studies were used as evidence during discussion and planning with partners, particularly WHO and MOH. Building on the strength of VNRC's network, similar to the 2011 cooperation, VNRC's interventions continued to complement government's mass media communication channels by reaching out to the community through interpersonal communications, including household and IDC visits and FGDs. The operation's utilization of mass media and community campaigns also added more value to the national responses. The MOH and People's Committees at different levels appreciated the community-based approach using RC's volunteer network.

To gain a better understanding of the current situation on knowledge, attitude, and practice among population, a KAP survey was designed and conducted at the beginning of the operation. This could be seen as a baseline survey for the intervention to identify needs and suggestions for intervention strategies. A communication strategy (BCC Strategy) for the 2012 VNRC HFMD operation was developed with reviews of 2011 communication tools and strategy, the latest epidemiological pattern, consultations with national and local leaders and education authorities, and preliminary findings of KAP survey on HFMD. Given that the baseline survey was conducted to inform the design of BCC materials and activities, there was an inconsistency between the finding and recommendation in targeting informal day-care centers (IDC). While the findings showed that the knowledge and practice of staff in IDCs were much better than that of household caregivers, the recommendations focused more on the IDCs with distribution of soaps. The validity of the finding might be influenced by its sampling method, which did not really reach out to workers in home-based IDCs as designed.

Design of the operation

The design of the operation appeared to be an appropriate framework to contribute to achieving the expected outputs and outcomes. The log-frame of the project was logically developed with clear identification of objectives and performance indicators with sources of verification. The operation was comprised of two key components: 1) improving knowledge and practice of people and 2) improving VNRC's capacity to respond to disease outbreaks and other public health emergencies. Most informant interviewers agreed that capacity

building would be of a strategic input for successfully performing the operation and sustaining the results. However, capacity development program often requires time and practice for sustaining development changes. Therefore, it was a challenge for VNRC to improve capacity in such a short time with emergent responses at community level.

Targeting

It is relevant that VNRC requested advice and followed the General Department of Preventive Medicine (GDPM), MOH, in changing targets of the intervention from parents and caregivers of children under five to under three years old. Based on the updated epidemiological pattern of the disease, which showed a higher incidence rate in the community instead of schools, the MOH intensified focus in the community including households, community groups, and IDCs in communes. This is considered an appropriate strategy adaptive to change of disease pattern in a timely manner. Due to this change and the time to finalize the key messages in communication, the production of IEC materials, which required revision of key messages, took longer than the expected. This, in conjunction with delay in availability of funding, contributed to delay in the progress.

Coverage

Table 2. Cases of HFMD infection and death in the 13 priority provinces in 2011, 2012 vs. country

Name of province	Jan – Dec 2011		Jan – Dec 2012	
	Cases	Deaths	Cases	Deaths
A. Central region				
Da Nang	827	1	3,213	1
Quang Ngai	7,149	5	2,024	0
B. Southern region				
Ba Ria – Vung Tau	3,659	6	7,219	3
Long An	2,973	10	4,878	3
Can Tho	1,191	1	1,848	2
Soc Trang	3,630	5	2,544	0
An Giang	2,617	6	5,624	11
Ben Tre	3,968	3	6,083	1
Vinh Long	2,464	0	3,415	2
Dong Thap	6,809	10	8,307	7
Kien Giang	2,524	4	2,920	0
Ca Mau	2,337	6	3,674	0
Hau Giang	1,741	6	1,758	0
C. Total 13 provinces	41,898	63	53,507	30
D. Total 63 provinces	112,370	169	157,654	45
% C/D	37%	37%	34%	67%

Source: Department of Preventive Medicine, MOH, December 2012

During the planning stage, 13 priority provinces were proposed for the operation, as data by the MOH showed that HFMD cases in these provinces accounted for about a third of the national caseload at that time. In fact, only eight selected provinces of higher priority were

started with interventions from the beginning with the ninth province, Ba Ria – Vung Tau, added at a later phase as more funding was secured. Based on 82 percent budget appeal coverage as of September and following the second peak in the same month, VNRC, in consultation with IFRC, decided to expand its coverage to 31 districts. Compared to the target, the actual operation covered 82 percent of proposed communes and 66 percent of proposed beneficiaries (see table 3). Total of reached population include family members of children under five year-old, total reached individuals through group discussions, total reached workers in informal daycare centres, and trained RC volunteers and staffs.

Table 3. Planned vs. actual coverage of VNRC’s 2012 HFMD operation

	Planned	Actual	%
1. Target provinces	13	9	69%
2. Target districts	30	31	103%
3. Target communes	540	421	78 %
4. Target community volunteers	5,400	5,400	100%
5. Target workers	46	38	82,6%
6. Target households	196,200	126,270	64 %
7. Group audiences	66,454	101,210	152%
8. Participants of community campaigns	9,300	10,345	111%
9. Target IDCs	19.440	1,034	5%
10. Total reached population	296,840	244,297	82%

Besides prioritization based on the epidemic situation, VNRC also considered the commitment of the local authorities, locally available resources for HFMD, and capacity of local Red Cross branches to ensure the feasibility of the operation. VNRC also considered especially vulnerable groups such as ethnic minorities, extremely poor, and migrant workers during the discussion and selection of the target populations. However, in fact, outreach to such vulnerable groups was not clearly understood and undertaken at the local levels. Though quite visual, the leaflet was not designed in a way clearly reflecting its relevance to ethnic minorities and the illiterate.

It was found that VNRC could develop detailed plans with very limited time, human resource and experience. This also reflected the difficulty in launching a perfect action plan to meet all different needs from communities. In fact, the same quota was allocated for all communes regardless of actual needs related to population size, actual numbers of targeted households and IDCs. Ten volunteers were uniformly selected for each commune, with each volunteer covering 30 households and undertaking 4 visits of each, the numbers of which did not reflect the particular need of individual communes.

According to the new approach, households with under-three-year-old children were selected. As each volunteer was assigned to cover only 30 households, the criteria were established, making disadvantaged households a priority. However, without proper emphasis on

targeting more remote and difficult-to-reach households, and time and skill limitations, volunteers tended to choose households they already knew. In addition, 10 of these 30 households were invited for group sessions, which was not the intention of the organizers – to invite 10 households not targeted during household visits for FGDs. Nevertheless, this overlap was justified as relevant since it could reinforce messages and strengthen awareness and knowledge of caregivers through peer support. However, the criteria for selecting these households for group sessions were again unlikely clear to the volunteers. In fact, some volunteers invited ones who were most likely to be able to participate. This could not guarantee that the most needed households were selected due to their lack of information, mobility, and low education.

IEC/BCC approaches and messages

IEC materials and messages

Re-design of IEC materials was found necessary to be adaptive with updated understanding on epidemiology. To enable VNRC to facilitate the delivery of consistent communication materials complementary to the MOH, coordination meetings on the key messages, communication channels, and use of appropriate IEC materials were organized with the participation of VNRC, IFRC, WHO, UNICEF and the MOH. As a result, a new set of IEC materials including the posters, flipcharts, and leaflets were designed and printed. As mentioned earlier, a considerable amount of time was spent on re-designing the materials, which was considered one of the factors to slow down the operation. This was due to long consultation process followed by translation, adaptation to local context, as well as procurement and printing time. All of the procured IEC materials were distributed, as seen in table 4.



Posters on HFMD

Compared to the materials used in 2011, the newly designed IEC materials, especially the leaflets, were user-friendlier with localized pictures for the target population. All of the materials used by VNRC were regarded appropriate and consistent with the information and messages by the MOH, and able to convey clear messages about the disease.

Table 4. IEC materials produced and distributed

IEC materials	Planned	Produced	Distributed
Leaflets	700,000	220,000	100%
Poster	6,000 sets	9,200 sets	100%
Flipcharts	4.800 books	4,800 books	100%
Lifebuoy soap	38,160 bars	123,364 bars	100%

Communication channels

The operation used a variety of communication channels to reach target groups, including community campaigns, FGDs, household visits and IDC visits, and mass media. Interpersonal communication through household and group sessions served an important role to strengthen understanding, hence improving hygiene practice and enhancing behaviour change. It was learnt that face-to-face communication by the RC volunteers could provide more in-depth information and interactive discussion on the disease and preventive measures. Meanwhile, mass media communication by TV and radios were reported as an effective way to raise public awareness about the diseases and outbreak updates. Follow-up visits were valued as important to monitor knowledge and behavior change of households members. Interviewed beneficiaries indicated that they appreciated the opportunities to talk about the disease with RC volunteers and their neighbors during group sessions.

Thirty one **mass campaigns** were organized at the district level, to which RC staff and volunteers, public officials, IDC workers and teachers, as well as target families were invited. As a result, mass campaigns reached 10,345 people. Interview results showed that these mass campaigns were well-attended by the intended participants, however participation by beneficiary families was not always possible due to the distance from their homes to the district center, where campaigns were organized, and other priorities, among other reasons.

Household visits complemented MOH's HFMD intervention and filled in the gap where the MOH did not have the capacity and resources to. Reaching out to individual households through a dense network of RC volunteers was a key channel to facilitate behavior change among target groups. Beside its strengths being cost-effectiveness and flexibility, household visit requires time and patience, and sometimes additional financial resources for transportation, from the volunteers. In addition, the fact that there was no soap for beneficiaries during household visits also poses a challenge to the volunteers. Household visits are also more difficult to carry out during certain times, particularly harvesting season, when both volunteers and beneficiaries might be busy working in the field. During the implementation, the project reached 126,270 households through 505,080 visits, with an average of 3-4 visits per family per volunteer.

IDC visits with soap distribution were considered less relevant since the teachers/workers already had access to HFMD-related knowledge and prevention methods. Moreover, the evaluation team found that most daycare centers selected for evaluation were not very "informal". They were licensed and had to follow standards required by the education department, including hygiene requirements. This suggests that the project focus more on "informal" home-based settings, which are smaller in scale with 5-7 children, and sometimes not officially registered.

To add more value to household visits, volunteers conducted 4,867 **group sessions** to reach about 100,000 participants. This was regarded as an interactive platform for children caregivers to discuss their concerns, strengthen their knowledge and behavior change. Advantages of this activity were that each session did not require much time but could reach around 10 households. Moreover, participants were more eager to participate as they would receive soaps. Challenges in conducting group sessions included the lack of facilitation skills of volunteers, difficulty in observing and monitoring practice in a short time. The follow-

ing is an outline of the advantages and challenges of different channels as lessons learnt during the operation.

Table 5. Advantages and challenges of the BCC channels and messages used in the operation.

	Advantages	Challenges
1. Channel		
District-level mass campaign	<ul style="list-style-type: none"> • Attract a large number of audience • Able to generate publicity and support from authority • Able to generate participation with soap distribution 	<ul style="list-style-type: none"> • Normally require participation and support of many stakeholders • Not always feasible for target households to attend (distance, timing, etc.)
Mass media (TV and radio)	<ul style="list-style-type: none"> • Effective in raising public awareness about the HFMD outbreak • Complementing face-to-face communication 	<ul style="list-style-type: none"> • Time-consuming in designing messages, causing delay in launching
Group session	<ul style="list-style-type: none"> • More interactive and interesting discussions among participants • Peer learning opportunity • Not requiring long travel to participate 	<ul style="list-style-type: none"> • Require facilitation skills which is still limited among volunteers • Unable to observe and monitor behaviors
Household and IDC visit	<ul style="list-style-type: none"> • Able to reach people at different times and follow up • Able to reach less-motivated and disconnected people • Give opportunity to share in-depth information • Able to observe and monitor behavior change at home 	<ul style="list-style-type: none"> • Time-consuming for volunteers to reach a certain number of beneficiaries
2. Message		
Leaflet	<ul style="list-style-type: none"> • Able to cover information on both HFMD prevention and identification of signs and symptoms • Leaflet can be kept at families for them to read from time to time 	<ul style="list-style-type: none"> • Many scripts require literacy • Easily forgotten due too much information
Flipchart	<ul style="list-style-type: none"> • Visual and user-friendly, even for illiterate people 	<ul style="list-style-type: none"> • Requires facilitation skills by volunteers to explain to beneficiaries
Poster	<ul style="list-style-type: none"> • Visual and easy to understand, with a focus on HFMD prevention 	<ul style="list-style-type: none"> • Not enduring
TV clip	<ul style="list-style-type: none"> • Easily understood and memorized by audience 	<ul style="list-style-type: none"> • Costly • Difficult to reach those who do not have TV or do not watch TV

Due to budget limitation, soaps were distributed at group sessions with limited numbers. Some communes reflected difficulties in selecting which participating households would receive soap during FGDs. According to the volunteers at commune level, poor households might have difficulties in purchasing soaps, and hence were the primary targets for soap distribution by volunteers.

It was reflected that the indirect communication channels, **mass media** in this case, worked well in synergy with interpersonal communication measures. As VNRC had to produce a new video clip based on the new strategy and messages, the broadcast of the clip was delayed until October 2012. Many informants suggested that mass media be launched before or at least at the same time with direct communication in order to complement effectiveness. There were agreements between the chapter authorities and the local TV station, in order to air the clip at hours most appropriate to target children caregivers. The airing frequency much depended on the budget allowed at each chapter during times when there was no outbreak. During an outbreak, the MOH called for free-of-charge broadcast at local media.



2.2 EFFECTIVENESS (OUTCOMES)

The outcomes of the operation were to improve knowledge and practice in preventing HFMD among target people. To contribute to this outcome, there two outputs were planned to be achieved 1) Improved access to outreach IEC activities among target population, and 2) Improved capacity of VNRC staff and volunteers in behavior change communication and community involvement.

Access to outreach IEC activities among target population

The numbers of each IEC activity carried out are detailed in table 6. More than one IEC channel therefore could reach each target individual. Interviews with RC staff, volunteers and communities at the commune level showed that awareness of HFMD would be much enhanced through face-to-face household visits. Practice of hand-washing procedures could also be demonstrated during household visits. The use of mass media complemented by face-to-face household visits were regarded as very effective in delivering knowledge and promoting attitudes and practice to the communities. According to the endline KAP survey results, 94.8 percent of household's caregivers and 98.75 percent of IDC workers regarded the IEC materials as either "useful" or "very useful," especially with 80 percent of IDC workers considering the IEC materials "very useful." Those households whom we interview with a child who had been infected asserted that the information provided by RC volunteers and the IEC materials were very helpful for them to identify the disease early on, in order to provide their child with timely treatment.

As mentioned earlier, the allocation of number of volunteers in each commune was not based on the population size; therefore, the coverage of households varied across communes. One of the local RCs was flexible in tackling the issue wisely by assigning some volunteers in communes with smaller population sizes to carry out activities in neighboring communes with larger population sizes. By this re-allocation of volunteers in different communes of varied population size, the commune with more population could be benefitted with more volunteers instead of 10 volunteers only.

Table 6. The number of mass campaigns, group sessions, household visits, and IDC visits, and populations reached by each

	Workplan	Actual	%
1. Mass campaigns	31	31	100%
<i>People attending mass campaigns</i>	9,300	10,345	110%
2. Group sessions	4,867	4,867	100%
<i>People reached through group sessions</i>	66,454	101,210	150%
3. Household visits	126,300*	126,270	100%
4. IDC visits	1,034**	1,034	100%

(*) According to the revised workplan. It would be only 64% of proposed 196,200 households

(**) According to the revised workplan. The number of IDCs was initially proposed as 19,440.

While most of the general populations in the target provinces were able to access the IEC activities by VNRC, some special groups might have benefited less from the activities. Those special groups of population included the very poor and remote households, ethnic minorities and migrant workers. Due to limited time and lack of transportation support, volunteers might not select households in remote area. These remote households might also be the poorer and more disconnected due to little access to TV and radio. For ethnic minorities, language was not considered a significant barrier as most of them were able to speak Kinh, the official Vietnamese language. However, given the fact that many ethnic minorities were among the poorest and illiterate, their understanding of written forms of IECs might be limited. In one of the districts interviewed, though migrant workers were suspected to be one of the sources of disease, outreach to this group of people was a challenge. This issue requires a more suitable strategy to solve.

With regards to access to mass media information via TV and radio, as already mentioned in the IEC/BCC approach and messages section, these were effective in complementing interpersonal communications by RC volunteers at commune level. TV clippings provided general information and raised awareness about the disease while the radio served to update timely information on the number of cases at district and commune levels. In districts and communes where the radio and loud speakers were widely utilized, people were well aware of the disease situation in their communities. In other places, people were able to receive similar information through word of mouth, which may not be reliable.

Awareness, knowledge, and practice in preventing HFMD among target people

Both the endline KAP survey and evaluation results reveal that there were improvements in awareness and knowledge about HFMD among the target groups. Interviews with and visits to households showed that beneficiaries were very well aware of HFMD, with the majority saying that it's highly possible HFMD would occur to their child, and said they were very afraid. The same goes with caregivers at IDCs, who were also aware of the reporting system once a child was diagnosed with HFMD.



A 6-year-old demonstrates handwashing with soap

Interviews also showed that beneficiaries had sufficient knowledge about HFMD. They were able to tell its signs and symptoms, and ways to prevent transmission, including handwashing at appropriate times, proper covering of food, frequent cleaning of the floor with soap or disinfectants, and separating the sick child from others, among others. With regards to the effectiveness of the project in changing target groups' behaviors, visits to households and IDCs revealed that the majority of the beneficiaries improved their behaviors, as seen in their very clean houses, kitchens and availability of soap. Household interviewees said that they cleaned their houses with water, soap or disinfectants at least once a day, and IDCs did so two to three times a day. Before, IDCs only used to wash toys when they looked dirty, but now, they would wash the toys once a week with disinfectants or soap.

In the newly extended districts and communes in the later phase, however, the consensus was that the implementation period was too short (less than two months) for the outcomes to be observable. Even in districts and communes where there was a decrease in the number of cases and deaths throughout the implementation period, it is still a stretch to attribute the decreases to Red Cross action, as it could have been the result of other factors, including the natural progress of the outbreak.

Capacity building

Capacity building for VNRC, particularly Health Care Department, was aimed as one of the outputs of the operation and considered a long-term and sustainable development. By conducting the various phases of the operation from need identification, training, planning, to implementation and evaluation, VNRC could step by step build up its capacity. The Healthcare Department previously experienced in preparedness through various health projects such as pandemic preparedness, community-based health and first aid (CBHFA), and water and sanitation programs, etc. The 2011 and 2012 HFMD outbreaks contributed to strengthening VNRC's emergency response experience and capacity.

It is clearly seen that individual managerial skills of VNRC staff at the national and provincial levels have improved significantly. Provincial VNRC Chapters were able to exercise flexibility in increasing the number of activities and areas of interventions according to funding inputs and the severity of the outbreak at provincial and district levels. With the addition of new intervention areas, they were also able to adjust the number of household visits and completion time for community volunteers according to the timeframe of the appeal. The capacities of VNRC Chapters/Branches in monitoring and reporting also vary across provinces. Capacity development at the commune level varied and was not clearly observable.

To ensure continuous training, a core team of trainers was established. Most of these trainers were Chapter staff who demonstrated training and facilitation skills. VNRC intended to provide sufficient numbers of trained trainers for each province. However, some provinces could not find competent trainers for their locality and had to borrow trainers from other provinces. From this point, the evaluation team did not clearly see VNRC's efforts in coordinating and using the existing training system of the local health sector.

In addition, capacity building for volunteers was also emphasized throughout the operation, as seen in the 4,209 volunteer trainings organized throughout the implementation period (10 trainings per commune). Table 7 provides details on the numbers of TOT and volunteer trainings.

Table 7. Trainers and volunteers trained during the operation

	Planned	Actual	Percentage
Trainers	46	38	83%
Volunteers	4,210	4,209	100%

The organizational capacity development was also realized in terms of better management structure and mechanism within VNRC. VNRC was able to increase its visibility among local authorities through the operation. If previously VNRC was only known as active in disaster and flood responses, it is now being looked upon as an emerging actor in public health emergencies response. At the district and commune levels, VNRC's visibility in health emergency responses appeared to be more underscored among local authorities and community.

2.3 EFFICIENCY

Efficiency is defined as a measure of how resources/inputs (funds, expertise, time etc.) are converted to results economically. To analyze the efficiency of the operation, the evaluation, therefore, looked at the project's operation inputs, management and coordination, M&E, and budget allocation.

Operation inputs

It is clear that the appeal received sufficient and effective technical support from different partners, such as IFRC, PNS, WHO, UNICEF, and MOH. Moreover, IFRC took important role in helping VNRC in planning, implementing and evaluating the project. Though this indicates good collaboration and coordination, the involvement of IFRC also indicated that VNRC was overly dependent on the support of IFRC in both technique and management. It was reflected that VNRC had learnt experiences from the previous operation and their capacity had improved significantly. This opened the discussion on how to strategically balance support and ownership in the direction to improve the capacity of VNRC.

Table 8. Contributions received by sources (in CHF)

	Sources	Budget
A.	Opening balance	100,000*
B.	Cash contributions	619,886
1	Hong Kong Red Cross (a branch of China Red Cross)	25,296
2	Danish Red Cross	76,667
3	European Commission DG ECHO	324,787
4	Japanese Red Cross	25,000
5	Monaco Red Cross	6,007
6	Singapore Red Cross	50,000
7	Swedish Red Cross	66,543
8	Canadian Red Cross	45,586

*DREF loan, which was reimbursed from the total cash contributions

On the other hand, the operation faced a big challenge in receiving adequate budgets as proposed due to unpredictable fund flows from donors. As a result, the operation lacked pro-activeness due to uncertainty. Although VNRC learnt some lessons from the 2011 operation, it still faced considerable challenges during the planning and implementation phases as follows:

- Public health emergency response was somewhat new to VNRC. It is likely that lessons from the 2011 operation were not enough to push them into developing a preparedness plan. Therefore, it was time-consuming for VNRC to identify priorities and plan the operation.

- In VNRC, there exists SOP for emergency response covering flood and storms. This procedure was, to some extent, useful for the VNRC health team to follow. An appropriate SOP for health emergency response is recommended.
- VNRC has a large network from national to provincial, district, and commune levels. However, most of the staff working in the system are simultaneously responsible for multiple projects and tasks. In the 2012 HFMD operation, VNRC was under shortage of full-time staff, which led to the overload of the project staff.
- Volunteer mobilization was undertaken in consideration of integration with other networks such as the Women Union and the Youth. In fact, some of the volunteers also belonged to other networks, while others had been RC volunteers in other projects. Selection criteria were also another issue. Several volunteers who are students or newly graduates and had never worked in the community expressed a lack of confidence and skills in community work. Besides, volunteers were very enthusiastic but some had to use their own resources for work.

Planning and implementation of the operation

Staff of VNRC's Healthcare Department demonstrated competence in developing a comprehensive and detailed plan of actions (POA), overcoming difficulties and challenges in an emergency response, especially given the unpredictability of funds and lack of human resource to prepare and present the plans to local VNRC.

Unpredictable funding coverage in the early phase of the operation posed a challenge in planning. Especially with lower priority target provinces and districts, no activities could start until funding was secured. After about three months, donors covered 82 percent of the total appealed budget. Planned activities had to be adjusted accordingly. It was not surprising for such an emergency appeal of an outbreak, which did not cause high death toll, to receive funding in a less timely manner than sudden on-set disasters such as floods and storms, which cause immediate destruction to the communities. The relatively slow coming of funding may have impeded early preparation of activities such as volunteers training and materials procurement. The timeline of funding received is outlined in the table below:

Table 9. Funding movement and operational activities of the operation

Timeframe	Incoming funding	Coverage of operation
3-Apr-12	CHF 100,000 as a loan from DREF to start	<ul style="list-style-type: none"> Operation started
Apr-12	28% funding coverage (CHF 213,000)	<ul style="list-style-type: none"> Discussion with VNRC on scope, start-up meeting with target provinces
May-12	32.2% funding coverage (CHF244,303)	<ul style="list-style-type: none"> Detailed budget and work-plan was signed. Started procurement of IEC, and preparation for training.
Jun-12	38.8% (CHF294,303)	<ul style="list-style-type: none"> Training of trainers, volunteers Orientation meeting with implementing chapters BCC campaigns at districts and starting household visits, group discussion Operation started in 292 communes of 20 districts in eight provinces (Long An, An Giang, Ben Tre, Soc Trang, Vinh Long, Dong Thap, Da Nang, Quang Ngai)
Jul-12	82% (CHF619,775)	
Aug-12		
Sep-12		<ul style="list-style-type: none"> Ongoing BCC in existing communes Training of volunteers in extension communes BCC campaigns in extension districts and communes
Oct-12		
Nov-12		<ul style="list-style-type: none"> Ongoing operation in 292 communes in existing 20 districts of eight provinces Extension in 129 communes in 11 districts of five provinces, of which four provinces are existing (Da Nang, Long An, Dong Thap, An Giang) and one is new (Ba Ria - Vung Tau)
Dec-12		
Total	82% (CHF 619,775, compared to the appealed amount of CHF 758,416)	<ul style="list-style-type: none"> 421 communes of 31 districts in nine provinces (Ba Ria - Vung Tau, Long An, Dong Thap, An Giang, Vinh Long, Soc Trang, Ben Tre, Quang Ngai, Da Nang)

Not only the timing of funding confirmation but also the number of donors with interest in supporting an epidemic outbreak was a challenge. Efficiency in securing funding could possibly be improved by strengthening the donor network and communication. Another reason of the delay was the re-designing and printing process of IEC materials. The production work was delayed for a few weeks instead of being done in April as planned. The re-design of the IEC materials was necessary to meet the changed epidemiological patterns and local cultures of different provinces. Procurement and bidding procedures also took considerable time due to the procurement stipulations.

The schedule to implement household/IDC visits and mass campaigns was also delayed from June to August and May to August, respectively. Some communes only started household visits in late September 2012 due to additional funding. It was agreed that significant

time was required in the preparation work and thus the timeframe for community work needed to be shortened to meet the project end time.

Coordination and collaboration

Considerable efforts in external and internal coordination were demonstrated in this HFMD operation. VNRC, with support from IFRC country office, initiated two coordination meetings before launching the emergency appeal, for the purposes of sharing information, planning activities, and mobilizing resources. The Emergency Health Coordinator from the IFRC Asia Pacific Zone Office was deployed to Viet Nam to provide technical support in coordinating with key health partners and preparing the launch of the emergency appeal. Key health partners joining the coordination meeting included WHO, IFRC, VNRC, the National IEC Center as well as the General Directorate for Preventive Medicine of the MOH. A preliminary proposal on the justification of an emergency appeal was conducted with relevant VNRC colleagues and PNS. Information sharing on disease surveillance and situation updates took place consistently among WHO, MOH and VNRC Headquarters. During the epidemic, WHO reported and consolidated disease surveillance information on a weekly basis. WHO also provided technical advices and resources to MOH, and trainings at hospital levels to ensure timely reporting of HFMD cases for surveillance purpose.

With the presence of the IFRC country office, effective and timely coordination was maintained between VNRC and the IFRC Asia Pacific Zone Office, particularly the Health Unit. The deployment of the Emergency Health Coordinator to assist in finalizing the POA after consultation with MOH, WHO, UNICEF and in-country PNS, and the preparation of the IFRC emergency appeal provided significant support to VNRC. Within the Red Cross Red Crescent partners, an internal meeting was conducted to allow relevant VNRC colleagues and PNS to understand the plan and provide opinions from their perspectives in the planning phase. That was a good start to let all relevant parties understand the plan and its impact on the on-going projects of various partners, if any.

At the national level, coordination between VNRC and the health sector and other partners was effective. As a member of the National Steering Committee on Infectious Diseases and Pandemics, VNRC participated in regular coordination meetings led by Ministry of Health to keep a close partnership on management of health emergencies in the country. The close relationship between VNRC and the MOH and other health partners during the preparedness phase could facilitate more efficient coordination work during emergency times. Since all relevant health partners active in the HFDM operation participated in the early planning meeting at the national level, the evaluation team did not identify any misunderstanding of roles and responsibilities at the national level. However, it was found that the good bond between VNRC and other authorities were loosened at lower levels particularly at district and commune levels. Interview results at these levels revealed that coordination at the initial planning phase was satisfactory with clear division of responsibilities among RC volunteers and other authorities at district and commune levels. However, follow-up meetings to update work progress and share difficulties were found to be insufficient to keep their complementary roles in the most effective and efficiency way in some provinces/districts interviewed. Different provinces/districts had different practices in communication with local authorities. Clear instructions to provinces/districts on external communications may be helpful to ensure smooth and consistent external communications at every level.

Coordination between the various VNRC departments, Healthcare Department, and the Disaster Management Department, was well-demonstrated by the efficient mobilization of the NDRT to carry out rapid assessment and baseline KAP survey in the first week after launching the emergency appeal. As mentioned earlier, emergency health operations do not receive the same level of attention by VNRC as emergency operations regarding natural disasters. Without a consensus of putting the operation as priority tasks, some work and procedures might not be processed in a timely manner. Although the outbreak did not cause a high number of deaths compared to other disasters, the HFMD fatality rate was the second highest in the world after China. The death rate had already reached an alarming level. Besides, HFMD and similar health emergencies may lead to catastrophic consequences to families and overwhelm the local health system in Vietnam. The economic impact can also be high compared to other sudden on-set natural disasters. Thus, knowledge and understanding of the impact of such slow on-set and less fatal diseases should be enhanced in VNRC, donors and relevant stakeholders.

VNRC is currently undertaking its SOP on disaster response, which appeared to be effective for coordination. It encompasses specific roles at various levels in the VNRC hierarchy, departments and units and their coordination mechanism during emergency operation. The Healthcare Department is assigned as a supporting party during flood and storm operations to guide healthcare responses, particularly psycho-social support, water and post-disaster sanitation, and disease prevention/health promotion and epidemic control efforts. As VNRC still has to develop SOP for public health emergencies, pre-agreed working procedures and coordination were missing for the HFMD response. Timely support from other concerned departments, particularly on finance and logistics, could have prevented delays in the implementation of the HFMD outbreak response due to such pre-agreement and consensus.

Management and supervision of volunteers

In some communes visited, RC volunteers were mobilized through the existing volunteer network from the health, population, or nutrition programs. Many performed more than one role in the community. From the evaluation team's perspective, the integration with other functions of volunteers could help volunteers better understand and enter their communities to fulfill their tasks. Moreover, overlapping of coverage of households and beneficiaries with other health programs could be minimized or avoided. However, no more than 50 percent of the volunteers were also working for other networks. For single functional volunteers, like several young volunteers in one commune we visited, it was difficult for them to fully realize what the other programs were doing in the communes.

Supervision took place but with insufficient arrangement. This limitation was due to a lack of human resource at commune level. One RC staff at the commune was at the same time a volunteer as well as team leader. From observation of the evaluation team, it was found that such a commune RC staff often lacks the skills in managing and providing supportive supervision beside his/her job as a volunteer.

Monitoring and Evaluation

M&E framework and system were well established to be in line with the result-based management. A baseline survey and a final survey were conducted to monitor and measure the results of the project. A systemic reporting framework was developed and maintained.

Beside the standard reporting required, the use of an M&E system was likely limited, especially at the local levels. Volunteers every day struggled with completion of report for submission to district RC. The district staff would then collect the reports, summarize and send them to higher levels. During interviews, many staff reported that they did not understand the meaning of reports and how to use the data for their work. The report format mainly required quantitative figures, lacking quality assurance tools. The evaluation team shared ideas on this challenge with VNRC since volunteers lacked competence and compliance to standard procedures.

An endline KAP survey using the same questionnaire and methodology was undertaken at the end of the operation. This helped VNRC measure the change as the results of the operation. However, there might have been several issues, which influenced the validity of the studies. First, there were large gaps in the sample sizes of the two surveys: a total of 146 households and 70 IDCs in the baseline survey, versus 810 households and 210I DCs in the endline survey. This difference suggested the p-value be calculated to ensure the validity of the comparison. Second, the data collectors were volunteers who were at the time working for VNRC and knew clearly how the surveys would assess their performance. This likely resulted in bias during data collection.

Costs of operation

The total budget proposed in the appeal was CHF 758,416 and donor response was of CHF 619,775. Total expenditures by both IFRC and VNRC was CHF 555,623 in which the budget transferred to VNRC and nine provinces was CHF 421,402, eq. VND 9,640,845,600. VNRC HQ managed 21 percent and Chapters/Branches received 79 percent. Based on the estimated total of 240,000 population who were directly reached by the operation, the expenditure per a beneficiary is about CHF 2.00. In fact, the outcomes of the operation would not be limited in the direct targets, but more extend population.

The allocation of fund for provinces was made based on the number of communes. Normally, each province received VND 600,000,000 – 900,000,000 (eq. CHF 26,226 – 39,339). An Giang, with the highest number of communes of 63, received the highest proportion of budget (VND 1,129,900,000, eq. CHF 49,388). As mentioned earlier, the operation used commune as the unit for planning, including budget allocation, human resource arrangement, and targeting. In fact, the population sizes of communes are every different, ranging from 5,000 to 20,000. In this case, the project could apply a flexible mechanism of budget allocation for better coverage.

Table 10. Budget allocation and expenditure of the operation 2012 by VNRC (Unit: CHF)

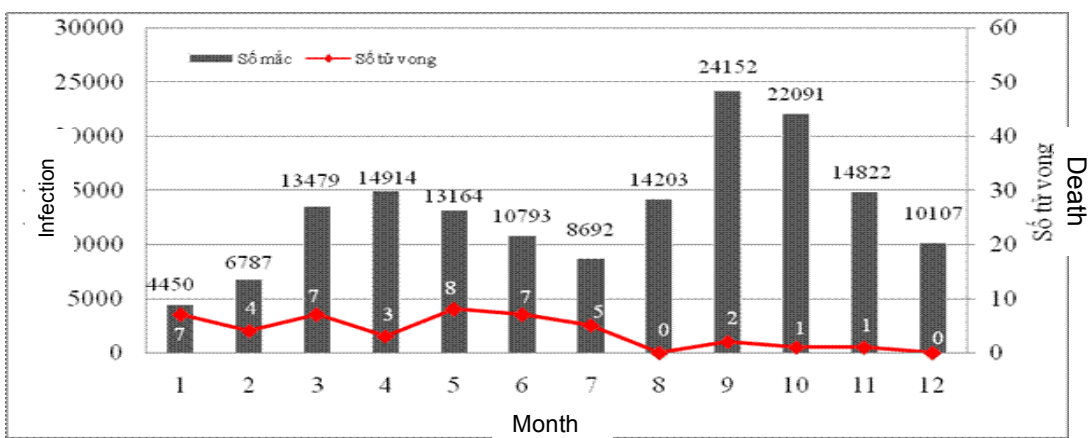
No.	VNRC	No. comm	Budget transferred	%	Budget disbursed 21 Jan 2013	Remaining budget	%
1	VNRC HQ	-	90,958	21	76,807	14,151	16
	Sub-total A	-	90,958	21	76,807	14,151	16
2	An Giang	63	50,950	12	50,062	888	2
3	Long An	52	39,246	9	38,139	1,107	3
4	Dong Thap	45	37,530	9	36,837	693	2
5	Da Nang	51	43,826	10	43,169	657	1
6	QuangNgai	45	39,584	9	39,458	126	0.3
7	SocTrang	32	26,714	6	26,714	-	-
8	Vinh Long	35	29,440	7	29,440	-	-
9	Ba Ria-Vung Tau	43	38,693	9	34,899	3,793	10
10	Ben Tre	55	41,280	9	40,183	1,098	3
	Sub-total B	421	347,262	79	338,901	8,362	2
	Total (A+B)	421	438,220	100	415,708	22,512	5

While budget shortage appeared to be an issue, a portion of the total budget was not disbursed. Among implementers, VNRC HQ and Ba Ria - Vung Tau accounted for the highest proportion of the remaining budget, 16 percent and 10 percent, respectively. It was explained that the remaining budget at VNRC was reserved for the endline KAP, end evaluation, and final review workshop. Other remaining budgets of about VND 183,958,639 (eq. CHF 8,041) from provinces have to be either used for proposed follow-up activities or returned to donors. Although the remaining budget is not very high, the project should consider lessons on how to re-allocate or adjust budget to increase efficiency.

2.4 IMPACTS

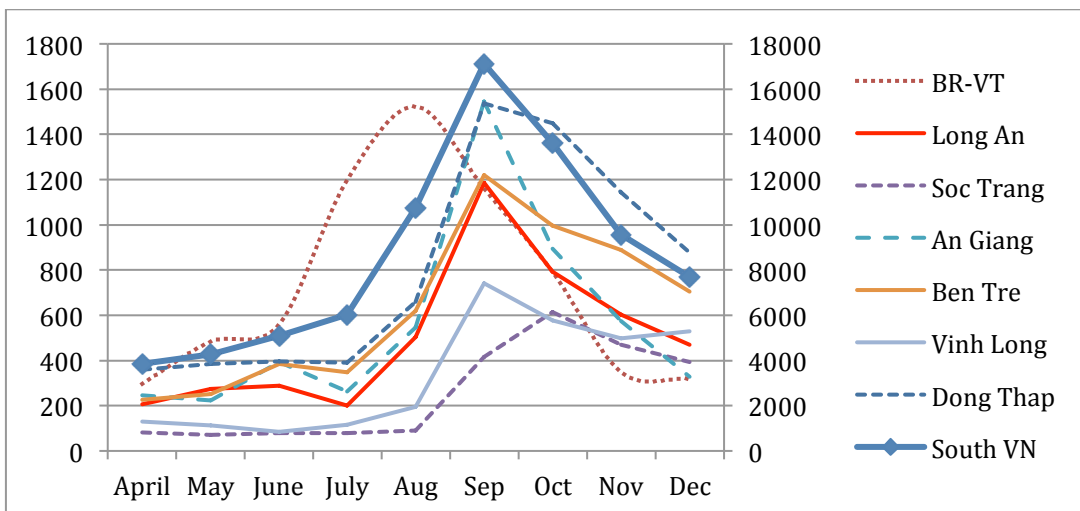
Though the implementation period (September – December) saw a consistent decrease in HFMD infections in project provinces, the number of infections also decreased nation-wide as well as across Southern provinces. From figure 3 below, it can be inferred that the trends in HFMD infections in the seven Southern project provinces were proportional to that of Southern Vietnam overall. One could say that the reductions seen from September on in the project provinces were attributable to RC operation. However, this reduction could be also due to various factors, including the natural progression of an outbreak, effectiveness of MOH’s efforts in controlling HFMD.

Figure 2. No. of cases and deaths of HFMD during 2012



Source: GDPM, MOH, December 2012

Figure 3. HFMD infection in the selected seven Southern provinces (left axis) vs. that in South Viet Nam (right axis) (April-Dec 2012)



Source: GDPM, MOH, December 2012

2.5 SUSTAINABILITY

A key sustainability challenge appears to be related to continuation of hygiene practices of people after the peak of HFMD outbreak is over. The endline KAP results showed that there have been improvements in awareness and knowledge about HFMD among the target groups. Interviews with volunteers and authorities at district and communes levels also showed that beneficiaries were well aware of the risk of the disease and its preventive measures. Yet, it was worried that good hygiene practices will only be seen during HFMD outbreak period. It is possible that people may not practice good hygiene habits after the high peak of the outbreak is over. In fact, HFMD can be reduced by very basic hygiene practices, which are also effective for many communicable diseases. This suggests that the education and communication activities should be continuously carried out in the community.

Interviews with RC chapters and authorities at provincial levels revealed that these basic preventive measures could be integrated in the on-going health and disease prevention projects at provincial, district, or even commune levels. In one of the districts interviewed, a RC ambulance project was implemented and sustained at district level with financial support from the local donors and people. With such locally managed and sustained project, capacity of Chapters and Branches can be enhanced with a sense of ownership as an added value.

Regarding funding sustainability, as already mentioned in the section on *efficiency*, it is generally more challenging to get funding support in HFMD outbreak operations compared to flooding or storm operations as it is not a killer-disease. There was concern about sustainable funding support to manage HFMD in the long run and if the disease become an endemic disease in the country. It should be noted that the main contributors to the HFMD appeal in 2012 were different from those in flood operations in recent years. This reveals the need to increase awareness about public health emergency among donors. Particularly, VNRC needs to strengthen its partnership with different donors in supporting public health emergency in Viet Nam for funding sustainability.

In relation to volunteers' contribution which is a key factor to the success of the operation, it was found that volunteer's passion and good spirits were the main reasons for them to carry the humanitarian assignment given with the limited manpower, timeframe and resources as told by the volunteers. Volunteers' hard work and enthusiasm was highly appreciated by different levels of the RC departments and authorities. Though it is clear that humanitarian commitment was the key requirement to keep volunteers motivated, there is still a need to retain the volunteers and keep their passion in the long run. Interviews at provincial chapters revealed that volunteer retention activities were present in some provinces. Some Chapters realized the importance of volunteer retention program but they did not have the resources for such a program. In one of the Chapters interviewed, a volunteer award program was implemented in the Chapter in cooperation with local authorities.

Undoubtedly, VNRC at all levels have improved their capacity in dealing with health emergencies after the HFMD operation in 2012. In fact, after 2011 operation, VNRC and IFRC sustained the outcome by providing selected provinces in the South with training in planning, evaluation, monitoring and reporting. The nine provinces have benefited from this capacity building and were able to apply in the operation in 2012 operation.

An effective knowledge sharing system is vital to sustainability in terms of project quality, effectiveness and efficiency. After immediate completion of the 2011 HFMD DREF operation, an internal review was conducted by an evaluation team for the purpose of learning and accountability. An internal meeting was held in end of 2011 for the evaluation team to report and discuss findings, lessons learned and recommendations. Provincial chapters, VNRC headquarters, IFRC country staff and relevant authorities attended the internal meetings. Valuable good lessons and recommendations were generated in the meeting and a final report on the internal review was published as a final product. The internal review served as very important reference for the emergency appeal operation in 2012. Key improvements were made such as strengthening of the monitoring and evaluation system in the 2012 operation. Some recommended areas for improvement which require involvement of more working units and organizational capacity building should also be prioritized and carried out accordingly. Evaluation results of the 2012 operation can be incorporated in the on-going improvement plans and timeline.

As the most of the target provinces of the 2012 operation differed from those in 2011, some of them were not fully aware of the internal review results of the 2011 operation though they had a general knowledge about the success of the operation. With a very comprehensive evaluation and learning system already in place, it seemed that the benefits were clearly seen in provinces involved in the operation, but less or even lacking in non-target provinces. Unlike flooding which mainly affects the flood-prone areas and the coastal lines, an outbreak is always unpredictable in terms of locality. Thus, it is worth expanding the knowledge-sharing platform and establishing a systemic learning cycle to emergency health operation for different levels of RC departments.

CONCLUSIONS

3

Generally, the data and observation indicated that the operation has achieved its objectives to improve knowledge and practices among target population and improved capacity of VNRC system in responding to the HFMD outbreak. A reduction of HFMD case in selected provinces indicated an important contribution of the VNRC operation to the national efforts in controlling the outbreak.

The operation was likely high relevant to the country's needs, disease response priorities, and VNRC's missions. It is of an appropriate strategy to target population at risk, which was shifted from under 5-year old children in kindergarten to under 3-year old children staying at home and daycare centers. The operation took efforts to coordinate with MOH and other development partners such as WHO, Unicef in filling in the gaps in current national HFMD responses. To launch and successfully implement the operation, the VNRC Health Department, with effective support from IFRC, has overcome many uncertainties and challenges in fund availability, human resource capacity, and mechanisms for emergency response. The operation involved and received great support from local authorities and mass organizations. Learning by doing, VNRC system has developed its capacity in both individual and system level in public health emergency response.

Many lessons were learnt from the operation, including: more need based planning, more coordination at the local levels, need of contingency plan on health emergencies, better supervision, more responsive operation in short time period, more efficient allocation of resources. There are potential considerations in sustaining the system, but also many challenges such as fundraising capacity, maintaining communication activities, and sustaining local authority's commitment.

4

RECOMMENDATIONS

Valuable lessons were learnt from the 2012 operation, adding to the experience of VNRC in public health emergency response from the 2011 operation. The following recommendations are meant to improve efficiency and effectiveness of future operations.

For more efficient planning for health emergency response

- ❖ Establish and update a database or a mechanism to access such database for the disaster-prone areas of Viet Nam, entailing basic indicators useful for emergency operations such as demographics, health profiles, household geographic distributions, socio-economic profiles, etc. This should be useful for any quick assessment and prioritization in emergency responses.
- ❖ Develop contingency plans for outbreaks/epidemics and other health emergencies which is part and parcel of the overall VNRC DM preparedness and response plan and system. Carry out health emergency preparedness program that builds VNRC capacity to operationalize contingency plan for health emergencies, as well as health components of contingency plans for floods and storms.
- ❖ Establish pre-positioned templates for risk communications and pre-agreed list of materials such as “hygiene promotion kit” which can be reproduced or prepared in a timely manner when need arises.
- ❖ For early preparation of activities and faster funding contribution, it is advisable that VNRC share information on action plans with all stakeholders while enhancing partnership with specific donors who are active in the emergency and humanitarian responses.
- ❖ For a more timely funding contribution in health emergencies, a network of donors with interest in supporting health emergencies could be set up. Communications and promotional work needs to be done before an emergency to build up trust and support from these donors. Operational start-up funds can also be included in health emergencies besides large-scaled emergencies in the current emergency fund release mechanism of VNRC.
- ❖ Establish a special mechanism for emergency situation responses within VNRC system, making procedures more flexible and faster such as procurement, administrative work, and decision and consensus making.
- ❖ Early sharing of updated funding situation and the updated plan of action with the Chapters and Branches, particularly those on the priority list, for more timely planning of implementation

For better BCC performance at community

- ❖ Promote a more need-based approach:
 - Achieve more decentralized decision-making in establishing target numbers based on actual needs such as size of population in communes. Instead of the

uniform allocation of volunteers across communes, the number of volunteers for each commune should be based on the size of the target population.

- Review the balance between more coverage on households versus more in-depth visits during emergency health operations according to the operation timeframe, manpower, and types of epidemics. For example, some epidemics may cause rapid deterioration and high fatality rate. In this case, more coverage may be more effective than in-depth household visits to prevent further spread and increase in cases and fatality.
 - Strengthen communications and coordination among RC branches at commune levels to avoid overlapping of target beneficiaries with the MOH.
 - Develop detailed guidance and instruct volunteers clearly on how to select targets so as to cover the most needy groups and households.
 - Develop a specific plan to outreach especially vulnerable groups, such as the very poor, ethnic minorities, and migrants. Provinces, districts and communities with significant number of migrants, ethnic minorities and very poor or remote households need to adjust communication materials and approaches in order to target these vulnerable groups more effectively.
- ❖ Increase support to volunteers to carry out field activities, in the form of transportation fee, water, food at group sessions or small gifts to kids, etc. General materials for volunteer support and reward could be explored as separate volunteer management projects during non-emergency time for use during emergency operations. It could be one form of disaster preparedness activity.

For improving capacity

- ❖ Improve understanding and competence of staff at all levels in responding to epidemic outbreak and health emergencies (e.g. technical skills, legal framework, coordination skills). Clear roles and responsibilities of staff at all levels before and during the whole emergency health operation cycle should be pre-defined.
- ❖ Improve staff's capacity on procurement and logistics for relief materials in health emergencies.
- ❖ Enhance volunteer management system including volunteer registration, tracking, networking, rewarding, appraisal and retention at HQ levels.
- ❖ Build up skills of staff at district/commune level in motivating and supervising volunteers.
- ❖ As accountability is becoming more important nowadays, the VNRC HQ may take the lead to promote beneficiaries feedback system and build the capacity of chapter levels to implement such system.

For improving monitoring and reporting

- ❖ Enhance the quality of monitoring and reporting contents by including qualitative and open-ended questions to the forms from commune and district levels to higher levels. The current forms for commune and district levels mainly focused on quantitative information and there was no channel for these levels to report challenges and issues in a descriptive way.
- ❖ Enhance quality and efficiency of consolidation of reports at district and provincial levels by improving the skills of staff as well as reviewing the format of reporting forms.

For improving sustainability

- ❖ Continue to improve the understanding of Healthcare Department staff and relevant provincial/district/commune level staff on disaster preparedness.
- ❖ Build up and maintain a potential network for health emergencies and disease prevention projects. Explore the possibility of provinces with funding support to organize volunteer management activities.
- ❖ Integrate HFMD prevention and/or hygiene promotion activities into existing health projects (e.g. CBHFA, Dengue Fever, Water and Sanitation) with support of PNS.
- ❖ Explore the possibility of provinces with fundraising capacities to continue HFMD prevention and/or hygiene promotion.
- ❖ Establish a learning system and cycles with all provinces in the areas of emergency health operations and as part of the disaster management system. Most of the provinces with HFMD interventions in 2012 were different from those in 2011. The disease pattern of epidemics is difficult to predict, unlike some natural disasters related to geographical conditions. To ensure that all provinces can learn from previous operations and adopt lessons learned, knowledge sharing should be extended to all levels. At the national level, a learning platform could be established within VNRC.

APPENDICES

List of people met/interviewed

No.	Name	Position & Affiliation
Viet Nam Red Cross Headquarters		
1.	Dr. Nguyen Huu Hong	Vice President, Viet Nam Red Cross Headquarters
2.	Dao Thi Thanh Tam	Head of Healthcare Department, Viet Nam Red Cross
3.	Pham Thi Quyen	Project Coordinator, Healthcare Department, Viet Nam Red Cross
4.	Vu Huu Tuyen	Project officer, Healthcare Department, Viet Nam Red Cross Headquarters
IFRC		
5.	Nuran Higgins	Acting Head of Delegation, IFRC Viet Nam Delegation
6.	Jim Catampongan,	Emergency Health Coordinator, Asia Pacific
7.	Nguyen Thuan	Health & Care Programme Manager, IFRC Viet Nam
Partner National Societies		
8.	Luigi Viscardi	Country Representative in Viet Nam, Swiss Red Cross
9.	Paul Van Der Laan	Country Representative in Viet Nam, Netherlands Red Cross
10.	PhanThi Minh	Senior Program Officer, American Red Cross
11.	PinoUngaro	Head of Delegation, Italian Red Cross
12.	Thomas Janny	Head of Delegation, French Red Cross
MOH, WHO, UNICEF		
13.	Tran Thanh Duong	Deputy Head of the Department of Preventive Medicine, Ministry of Health
14.	Nguyen Thi Kim Lien	Vice Director, National Center for Health Communication and Education
15.	Nguyen To Tran	Communication for Development Officer, UNICEF Viet Nam
16.	Dr. BabatundeOlowokure	Team Leader, Emerging Disease, Surveillance and Response Team, WHO Viet Nam
17.	Laura Ngo-Fontaine	Risk Communication Officer, WHO Viet Nam
An Giang province		
18.	Huynh Thanh Ngoc	Head of Health Care Department, Provincial Red Cross, An Giang Province
19.	Tran Tan Hanh	Project Officer (Reporting), Health Care Department, Provincial Red Cross, An Giang Province
20.	Nguyen Kinh Luan	Project Accountant, Provincial Red Cross, An Giang Province
21.	Nguyen Van Nep	Chairman, District Red Cross, An Phu District

No.	Name	Position & Affiliation
22.	PhanPhuoc Tan	Vice Chairman, District Red Cross, An Phu District
23.	Tran Thi Cam	Project Officer, District Red Cross, An Phu District
24.	Nguyen Van Nhung	Chairman, Communal Red Cross, Phuoc Hung commune, An Phu district
25.	Tran HuuHanh	Head of Epidemics Control Department, Provincial Center for Preventive Medicine, An Giang Province
26.	Nguyen Ngoc Phuong	Administrative Officer, Communications Department, Provincial Health Bureau, An Giang Province
27.	Nguyen Thanh Tung	District Center for Preventive Medicine, Phuoc Hung Commune, An Phu District
28.	Nguyen Van Set	Commune Health Station, Phuoc Hung Commune, An Phu District
29.	Nguyen Van Minh	Chairman, Commune People's Committee, Phuoc Hung Commune, An Phu District
30.	Nguyen Van Huy	Vice Chairman of Commune PC
31.	8 volunteers	Phuoc Hung Commune, An Phu District
32.	8 volunteers	Long Binh Town, An Phu District
33.	2 informal daycare centers	An Phu Town, An Phu District
34.	2 HHs	Phuoc Hung Commune, An Phu District
35.	2 HHs: Pham ThiTuyen, Tran ThiThuy	Long Binh town, An Phu district
Long An Province		
36.	Tran Thi Phuong Hoang	Project Officer, Provincial Red Cross, Long An province
37.	Huynh Van Khanh	Project Officer, Provincial Red Cross, Long An province
38.	Nguyen Dang San	Chairman, District Red Cross, Can Giuoc District
39.	Nguyen Van Trieu	Vice Chairman, District Red Cross, Can Giuoc District
40.	Le Ngoc Dien	Project Officer, District Red Cross, Can Giuoc District
41.	Doan Tan Luc	Project Officer, District Red Cross, Can Giuoc District
42.	Le Van Bay	Chairman, Town Red Cross, Can Giuoc Town, Can Giuoc District
43.	Huynh Van Thang	Vice Chairman, Commune Red Cross, Truong Binh Commune, Can Giuoc District
44.	Le Thi Kim Oanh	Director, Center for Preventive Medicine, Long An Province
45.	Nguyen Tan Hien	Communications Department, Provincial Health Bureau, Long An Province
46.	Nguyen ThiSanh	Commune Health Station, Truong Binh Commune, Can Giuoc District
47.	Le Nguyen ThanhThuy	Deputy Secretary, Youth Committee, Town People's Committee, Can Giuoc Town, Can Giuoc District

No.	Name	Position & Affiliation
48.	Ho Chi Cuong	Vice-Director, District Center for Preventive Medicine, Can Giuoc town, Can Giuoc district
49.	8 volunteers	Can Giuoc Town, Can Giuoc District
50.	5 volunteers	Truong Binh Commune, Can Giuoc District
51.	2 informal daycare centers	Can Giuoc Town, Can Giuoc District
52.	4 HHs	Can Giuoc Town, Can Giuoc District
Da Nang		
53.	Pham Kinh Dung	Chairman, Provincial Red Cross, Da Nang Province
54.	Dao Truong Tho	Vice Chairman, District Red Cross, HaiChau District
55.	Pham Vu KhanhQuyen	Vice Chairwoman, District Red Cross, Son Tra District
56.	Tran Van Nam	Vice Chairman, District Red Cross, Thanh Khe District
57.	Mr. Quang	Project Accountant, Provincial Red Cross, Da Nang Province
58.	Mr. Tam	Project Officer, Provincial Red Cross, Da Nang Province
59.	Mr. Ba	Vice Chairman, District Red Cross, Ngu Hanh Son District
60.	Vu Thu Tung	Communications Department, Provincial Health Bureau, Da Nang Province
61.	Ms. Mau	Center for Preventive Medicine, Da Nang Province
62.	DinhThi Phuong Thuy	Vice President, District Red Cross, Hoa Vang District
63.	Nguyen Ngoc Tuu	Center for Preventive Medicine, Hoa Vang District
64.	Le Lai	Head of Community Health Center, HoaPhu Commune
65.	Nguyen Van Van	Chairman, Community People's Committee, HoaPhu Commune
66.	Le Van Tho	Chairman, Community Red Cross, HoaPhu Commune
67.	6 volunteers	Hoa Phu Commune, HoaVang District
68.	3 HHs	HoaPhuc Commune, HoaVang District

Documents reviewed

- ❖ VNRC Annual Report 2011
- ❖ VNRC Standard operation protocol (SOP) for disaster response, January 2012
- ❖ Internal review of the VNRC response to the 2011 HFDM outbreak in Vietnam, April 2012
- ❖ Behavior Change Communication Strategy, VNRC Response to the evolving HFMD outbreak, April – December 2012
- ❖ IFRC country plan in Viet Nam 2012-2015: VNRC Strategy 2020 and operational plan 2015, 2011
- ❖ Mid-year report against long-term planning framework, IFRC Viet Nam country office, November 2012
- ❖ DREFs and emergency appeals of VNRC from 2010 to 2012
- ❖ Evaluation of the Mekong floods operation in Viet Nam 2011, IFRC, November 2012
- ❖ Evaluation of VNRC relief response with support from IFRC and PNSs to typhoons Ketsana and Mirinae, 2010
- ❖ VNRC training material on HFMD for community volunteers, 2012
- ❖ Monthly and final reports of the 2012 HFMD operation submitted from the selected provinces to VNRC headquarters
- ❖ Meeting minutes of the MOH, WHO and UNICEF at national level for operation planning, March 2012
- ❖ Towards a safer world report on Asia: Multi-sector pandemic preparedness in the ASEAN region, 2011
- ❖ Review of health data selected from health centers where available
- ❖ Reports of baseline and endline surveys on HFMD, assessment conducted by VNRC, 2011 and 2012

TERMS OF REFERENCE

1. SUMMARY

1.1. Purpose: The International Federation of Red Cross and Red Crescent Societies (IFRC) Delegation in Viet Nam seeks to evaluate the impact and effectiveness of the Viet Nam Red Cross Society response to the hand, foot and mouth disease (HFMD) outbreak in 2012, to identify key lessons and recommendations to improve ongoing and inform future response.

Audience: Viet Nam Red Cross, IFRC, donors, partners

Commissioners: Viet Nam Red Cross, IFRC Delegation in Viet Nam

Reports to: IFRC Head of Delegation, Viet Nam

Duration: 35 days (including 15 days working in Viet Nam).

Timeframe: 11 January to 28 February 2013

Location: Ha Noi, with field work in nine target provinces (Da Nang, Quang Ngai, Ba Ria Vung Tau, Long An, Dong Thap, Soc Trang, Vinh Long, Ben Tre, An Giang)

2. BACKGROUND INFORMATION

While the country has just experienced an unprecedented outbreak of hand, foot and mouth disease (HFMD) which sickened 90,200 and killed 153 children – majority of them was under five year-old in 2011, Viet Nam continued to experience a worrisome high activity of the disease during the first quarter of 2012. By 15 March 2012, the total number of cases reported by all provinces was higher than the annual caseloads in 2009-2011, as well as 7.5 times higher than the same period last year. While southern provinces reported high number of cases and deaths since 2011, the northern and central provinces reported higher number of cases in 2012.

Building on its successful operation in support to national efforts to control the HFMD outbreak in 2011 and in response to the request of the People's Committees and the Ministry of Health for continued support in addressing the evolving situation, the Viet Nam Red Cross Society (VNRC) developed a nine-month plan of action to carry out intensified HFMD communications at community level with the aim of reducing unnecessary HFMD illness and deaths in 13 priority affected provinces. The operation in 2012 has incorporated key lessons learned from the previous response, including improvement in monitoring, guidance supports provided to lower levels and more practical training for volunteers. It sought the support of the International Federation of Red Cross and Red Crescent Societies (IFRC) in the finalisation and implementation of the plan of action, and in the mobilising resources through the launching of an emergency appeal² focusing on behaviour change communication (BCC) in communities, and particularly on achieving the following outcomes:

- At least 196,200 people in 540 communes (30 districts from 13 provinces) have improved knowledge and practices that contribute to HFMD prevention and control
- VNRC's capacity to respond to emerging diseases like HFMD is improved.

To immediately kick-start the operation and anticipating slow response to the appeal, VNRC was provided with a loan of CHF100,000 from the IFRC's disaster relief emergency fund (DREF). By 31 December 2012, the appeal was 82% covered through funds from Canadian Red Cross, Danish Red Cross/Danish government, European Commission Humanitarian Aid and Civil Protection (DG ECHO), Hong Kong branch of Red Cross Society of China, Japanese Red Cross Society, Red Cross of Monaco, Singapore Red Cross and Swedish

Red Cross. The contributions enabled VNRC to carry out all activities outlined in the plan of action, but to slightly revised target population. A month-long no-cost extension was considered to allow VNRC time to meaningfully complete activities, as well as to carry out the end-line survey.

Similar to the 2011 response, this operation was also designed to culminate with an evaluation to capture good practices and lessons which can inform and guide VNRC and IFRC in the further development and institutionalisation of its preparedness and response mechanisms and procedures in the management of disease outbreaks and other health emergencies.

3. PURPOSE AND SCOPE OF EVALUATION

3.1. Purpose

The evaluation the VNRC HFMD response in 2012 will be carried out for the purpose of learning, and accountability to beneficiaries and donors. It will assess the effectiveness and impact of the operation. Findings and recommendations from the evaluation will be used by the health and disaster management departments/units of VNRC and IFRC to inform future emergency health preparedness and response planning, as well as community-based risk reduction programming through behaviour change communication and volunteer mobilisation among others.

3.2. Scope

The evaluation will focus on the achievement of planned outputs and outcomes (results) and the implementation of activities according to the operational plan, within the timeframe from 3 April to 31 December 2012, in 241 selected communes in 31 districts and nine of the provinces, which were severely affected by the HFMD outbreak during the year.

4. OBJECTIVES AND CRITERIA

4.1. Objectives

The evaluation aims at meeting the following objectives:

- Assess the effectiveness and impact of VNRC HFMD operation in target areas
- Provide guidance to VNRC on improving its emergency health system and procedure in response to disease outbreaks and other health emergencies in the country, in support to government's response and in coordination with other in-country stakeholders.

4.2. Criteria

The evaluation will use the following criteria to guide its recommendations:

a. Relevance and appropriateness

- How relevant the operation was to the most vulnerable population at risk of HFMD in Viet Nam?
- Was the intervention delivered timely and with quality to the beneficiaries? How VNRC has ensured beneficiary's feedback in the operation?
- Was the response to the HFMD outbreak in line with the VNRC role and strategy for public health emergencies in the country?

b. Effectiveness

- How effectively has the operation met its stated objectives?
- How effective were the behaviour change communication strategy and activities in contributing to the reduction of HFMD cases and deaths in target communities?
- How user-friendly and effective were the planning and monitoring tools used by different VNRC levels in HFMD operational plan of action?

- Were guidelines, supports from VNRC HQ effective to chapters and lower level to implement the operational actions?
- Was training to volunteers sufficient to give interventions in behaviour change among target beneficiaries?
- Were volunteers' activities in behaviour change communication and distribution of communication materials effective to improve knowledge and practice of target groups in relation to HFMD prevention?
- How have the VNRC HQ and chapters worked with the authorities and other partners in addressing the HFMD situation and in carrying out the operation?

c. Efficiency

- How efficiently were human and financial resources utilized by the VNRC in the operation?
- Were logistics and procurement requirements of the operation respectful to previously-agreed systems and procedures of the IFRC and donors?
- How have the management and technical arrangements across VNRC departments at headquarters and branches been facilitated to meet operational objectives?

d. Impact

- What impact has the operation had on saving lives of young children whom are most vulnerable to HFMD?
- What impact did the operation have on partner organizations, particularly the MoH and regional/local health authorities?
- Was there any unexpected impact?

e. Sustainability

- To what extent has the operation contributed to limiting future HFMD outbreaks in the target areas?
 - Has the operation influenced the way local authorities address issues related to HFMD prevention and control, and how?
 - How will the experience from emergency response to HFMD contribute to VNRC's capacity to address disease outbreak/epidemic control and prevention?
5. METHODOLOGY The evaluation will adhere to established IFRC management policy and standards related to evaluation, and ensuring that processes related to the planning, management and conduct are adhered to including the utilization of evaluation findings and recommendations. The evaluation will be managed by evaluation commissioners – VNRC and IFRC Vietnam office – with advice and guidance from relevant AP zone office units. The evaluation will be carried out by a team (which composition and profile is detailed in Section 8 of the document) which will draw upon the following primary methods:

a. Desk review of secondary information that *will include but is not limited to*:

- Secondary written/published material, including statistics, archived materials
- Review of health data selected from health centres where available
- Communication strategy, HFMD emergency appeal, HFMD operation updates
- Baseline, endline KAP; assessments; presentations/reports from VNRC
- VNRC's strategy 2020
- National action plan, guidelines on behaviour change communication in HFMD
- Previous evaluation reports from VNRC/IFRC and external consultants

- Other information from humanitarian actors in Vietnam
- b. Key informant interviews and/or
- c. Focus discussion groups with officials/staff of the following will be undertaken:
- VNRC HQ, chapters and branches
 - Beneficiaries and partners in target areas
 - MoH and local authorities where relevant
 - WHO, UNICEF
 - PNS
- d. Field visits/observations to selected sites

6. EXPECTED OUTPUTS

The evaluation is expected to deliver the following outputs:

- A presentation on key preliminary findings and recommendations, as part of the final review meeting to highlight practices and lesson learned from the operation and which will be attended by VNRC HQ and relevant chapters, IFRC country office and interested in-country partner NS.
- An evaluation report including executive summary, key conclusions and recommendations. A draft report will be submitted 15 days after the fieldwork in Hanoi, and the final report will be submitted no later than one month after the review (with five days allowed for feedback). VNRC and IFRC intend to produce a case study highlighting the good practices and lessons of the VNRC response to HFMD outbreaks in 2011 and 2012. The evaluation team is requested – when time and capacity allow - to recommend aspects of the operation which are worth featuring, to collect/document statements from beneficiaries, health and local government authorities, and external partners that support the above. VNRC and IFRC Vietnam office have the responsibility to circulate the evaluation report, as well as the dissemination of findings and recommendations. The evaluation team is not authorised to share findings and recommendations without prior consent.

7. TIMEFRAME

The evaluation will be carried out between January and February 2013 to facilitate data collection outlined in the methodology section, as well as the completion of report.

The VNRC and IFRC Vietnam office will jointly provide the evaluation team required logistical and administrative support to ensure that evaluation objectives and activities will be met/carried out according to the above-mentioned schedule.

8. TEAM COMPOSITION AND PROFILE

The evaluation will be carried out by a three-person team consisting of two evaluators from overseas and one evaluator from VNRC; all members are expected to have not been involved in the operation. The evaluation team will work two national staff of the IFRC Vietnam office/in-country PNS as translators.

The team members are expected to have the following skills:

- Demonstrable experience in the conduct of evaluations, preferably evaluations of response to disease outbreaks, health emergencies or disasters
- Technical knowledge and skills in public health, including behavior change communications

- Strong analytical skills and ability to clearly synthesize and present findings, draw practical conclusions and make strategic recommendations
- Excellent English writing and presentation skills, and ability to prepare well-written reports in a timely manner
- Knowledge and experience working with the Red Cross & Red Crescent preferred
- Demonstrated capacity to work both independently and as part of a team
- Experience with travel to remote areas and working/communicating through translation
- Immediately available for the period indicated.

Guides for conducting interviews and FGDs

1. Guide for interviewing donors

Purpose	To understand about the donors' perspectives in funding for HFMD outbreak operation To evaluate capacity of VNRC in building relationship with donors
Interviewee	Donors
Focuses	Key guiding questions
Relevance and efficiency	<ol style="list-style-type: none"> 1. What is your opinion about the VNRC's role in the HFMD outbreak operation in this year? Are you satisfied with the performance of the operation? 2. If yes, what were the best activities that you found? If no, why not? 3. How did you find VNRC's role in public health emergencies in Vietnam? 4. How was the communication among your organization, the VNRC HQ and the IFRC? Is there any way to improve in future? 5. Do you think the operation might have adopted more cost effective alternative strategies or approaches to achieve the same results? 6. Did the information provided by the VNRC HQ and/or the IFRC provide adequate information for you to understand the situation in order to provide the required support you wish? How well was it and how did this affect your organization's decision?
Effectiveness	<ol style="list-style-type: none"> 7. What results did you expected from the VNRC proposal and operation? 8. Do you think that VNRC was able to implement the HFMD operation activities effectively and reached out communities as per their needs and priorities? 9. If yes, what were the best activities that you found? 10. Do you see any change (improved capacity, mechanism...) between this HFMD operation with the previous one in 2011?
Impacts / Coverage	<ol style="list-style-type: none"> 11. Do you see any possible impact from the operation of VNRC? What were expected impact which were not achieved? Why not? 12. Do you think the HFMD operation targeted the worse affected provinces, districts and communes? If not, why?
Sustainability	<ol style="list-style-type: none"> 13. In your opinion, was VRC able to ensure accountability and performance monitoring during the project planning and implementation? 14. If possible, would you or your organization continue to support similar operations in future?

2. Guide for interviewing VNRC

Purpose	To understand about strategies, policy, and operation of VNRC so as to evaluate relevance and effectiveness of the operation
Interviewee	VNRC leader/s, project staff

Focuses	Key guiding questions
Relevance	<ol style="list-style-type: none"> 1. Was the operation in line with the needs of the most vulnerable in relation to the HFMD situation in Vietnam? Do you have any supporting data? 2. How was the operation in line with VNRC's role and strategy for public health in emergencies? 3. How did this fit with efforts by the central and local authorities/other organizations, incl. external donors? 4. How was operation planned? Were the VNRC involved in identifying needs, activities/priorities of the operation? Were the beneficiaries involved in the design of the operation? If yes, how? 5. How were the intervention sites selected? What were criteria? Was there any consideration on socio-economic factors (poverty, ethnic minority, disadvantaged people/areas...)
Efficiency	<ol style="list-style-type: none"> 6. How have management, logistic, financial and technical arrangements across the VNRC been facilitated to meet the operation's objectives? 7. How were the progress and quality of implementation monitored and evaluated? What monitoring tools were used and by whom? 8. How was the management structure for the operation established and executed? 9. How was coordination implemented internally and with external stakeholders? What was successful and what would you change for the future? 10. How well has the VNRC coordinated and worked with the authorities and other partners in addressing the HFMD situation and in carrying out the operation?
Effectiveness	<ol style="list-style-type: none"> 11. Do you see any change (positive and negative consequence) in our organization as a result of the programs? 12. How did the program improve the capacity of your organization?
Impact	<ol style="list-style-type: none"> 13. What impact/s do you see from the operation? 14. Do you have data to prove the impacts?
Sustainability	<ol style="list-style-type: none"> 15. Is there any financial maintenance and support for future HFMD operation? 16. Is there any operation mechanism established and maintained? 17. What are lessons learned from your organization for future operation?

3. Guide for interviewing General Dept. of Prev. Med/MOH/

Purpose	To understand about strategies, policies, and operation of the health sector so as to evaluate relevance and performance of the operation
Interviewee	Director/Vice Director, experts in General Dept. of Prev. Med/MOH
Focuses	Key guiding questions
Relevance	<ol style="list-style-type: none"> 1. Was the operation in line with the needs of the most vulnerable in relation to the HFMD situation in Vietnam? Do you have any supporting data? 2. How did the operation contribute to strategies emergency response by health sector/MOH?

	<p>3. How was operation planned? Did VNRC involve MOH in identifying needs, activities/priorities of the operation? Were the beneficiaries involved in the design of the operation? If yes, how?</p> <p>4. How were the intervention sites selected fit to prioritized areas of the outbreak?</p> <p>5. Do you find any activity of the operation not relevant to the national response framework? What do you suggest for future lessons?</p>
Efficiency	<p>6. Was any coordination mechanism established during the operation? If yes, how did it work?</p> <p>7. Was MOH shared with necessary information about planning, progress and results of the operation? Did your department have any specific activities to support/.supervise the operation?</p>
Effectiveness	<p>8. How did the operation contribute to national/local health capacity in outbreak response?</p> <p>9. How did the operation contribute to improving knowledge and awareness as well as changing behaviors of the people?</p>
Impacts	<p>10. How did the operation contribute to reducing cases and risks at the intervention sites?</p>
Sustainability	<p>11. Do you see any opportunity/challenge for sustaining future HFMD operation</p> <p>18. Is there any financial maintenance and support for future HFMD operation?</p> <p>19. Is there any operation mechanism established and maintained?</p> <p>12. What are the lessons learned from your organization for future operation?</p>

4. Guide for interviewing provincial /district Prev. Med. Center

Purpose	To understand about strategies, policy, and operation of the local health sector so as to evaluate relevance and alignment of the operation
Interviewee	Vice/Director, responsible staff provincial /district Prev. Med. Center
Focuses	Key guiding questions
Relevance	<ol style="list-style-type: none"> 1. Was the operation in line with the needs of the most vulnerable in relation to the HFMD situation in the locality? Do you have any supporting data? 2. How did the operation contribute to strategies emergency response by the local health sector? 3. How was the operation planned? Did VNRC involve the local health sector in identifying needs, activities/priorities of the operation? Were the beneficiaries involved in the design of the operation? If yes, how? 4. How were the intervention sites selected fit to prioritized areas of the outbreak? 5. Do you find any activity of the operation not relevant to the local emergency response framework? What do you suggest for future lessons?
Efficiency	<ol style="list-style-type: none"> 6. Was any coordination mechanism established during the operation? If yes, how did it work? 7. Was you shared with necessary information about planning, progress and results of the operation? Did your department have any specific activities to support/supervise the operation?
Effectiveness	<ol style="list-style-type: none"> 8. How did the operation contribute to developing capacity of the local system in outbreak response? 9. How did the operation contribute to improving knowledge and awareness as well as changing behaviors of the local people?
Impacts	<ol style="list-style-type: none"> 10. How did the operation contribute to reducing cases and risks at the intervention sites?
Sustainability	<ol style="list-style-type: none"> 11. Do you see any opportunity/challenge for sustaining future HFMD operation 12. Is there any financial maintenance and support for future HFMD operation? 13. Is there any operation mechanism established and maintained? 14. What are the lessons learned from your organization for future operation?

5. Guide for interviewing provincial IEC Center

Purpose	To understand about strategies, policy, and operation of the local health education and communication so as to evaluate relevance and alignment of the operation
Interviewee	Leader/s, staff of the IEC center

Focuses	Key guiding questions
Relevance	<ol style="list-style-type: none"> 1. Was the operation in line with the needs of the most vulnerable in relation to the HFMD situation in the locality? 2. How did the operation contribute to strategies emergency response by the local health sector? 3. How were the BCC activities planned? Was the IEC center involved in identifying needs, activities/priorities of the operation? Were the beneficiaries involved in the design of the operation? If yes, how? 4. How were the intervention sites selected fit to prioritized areas of the outbreak? 5. Were BCC activities designed to be appropriate with local context? Local culture?
Efficiency	<ol style="list-style-type: none"> 6. Was any coordination mechanism established during the operation? If yes, how did it work? 7. Was you shared with necessary information about planning, progress and results of the operation? Did your department have any specific activities to support/supervise the operation?
Effectiveness	<ol style="list-style-type: none"> 8. How did the operation contribute to developing capacity of the center in planning and implementing behavior change program? 9. How did the operation contribute to improving knowledge and awareness as well as changing behaviors of the local people? 10. What were the enabling factors and challenges in behavior change among people? 11. Which groups of target audience were most difficult to reach? How did the operation reach these groups? If not, why not?
Impacts	<ol style="list-style-type: none"> 12. How did the operation contribute to reducing cases and risks at the intervention sites?
Sustainability	<ol style="list-style-type: none"> 13. Do you see any opportunity/challenge for sustaining future BCC activities on HFMD prevention and control? 14. Is there any financial maintenance and support for future BCC activities on HFMD prevention and control? 15. Is there any operation mechanism established and maintained? 16. What are the lessons learned from your organization for future operation?

6. Guide for interviewing provincial/district Red Cross

Purpose	To evaluate the coordination across VNRC Departments and other working partners
Interviewee	Provincial / District Red Cross
Focuses	Key guiding questions
Relevance	<ol style="list-style-type: none"> 1. Were the activities of the HFMD outbreak operation in line with the VNRC role and strategy for public health emergencies in Vietnam? 2. Were the operation's activities and priorities complement those of the local authorities and other local health actors? If not, why?

	<p>3. To what extent were the operation and its activities implemented to meet the local needs and priorities of the targeted communities?</p> <p>4. What were needed to enhance the appropriateness of HFMD program of the VNRC in future?</p> <p>5. What criteria did the IFRC/VNRC HQ use to identify priority provinces? How effective do you think?</p> <p>6. Did the HFMD operation target the worse affected provinces, districts and communes? If not, why?</p>
Efficiency	<p>7. Was the monitoring and reporting mechanism across different VNRC levels and working partners user-friendly and effective?</p> <p>8. How was the communications across different VNRC levels in the operation? Is there any way to improve in future?</p> <p>9. Were the logistics and procurement procedures able to meet the needs of this HFMD operation? If not, why?</p> <p>10. Could the operation have adopted more cost effective alternative strategies or approaches to achieve the same results?</p> <p>11. Did the VNRC HQ provide adequate support to carry out the required activities? How useful was it and how did this affect the work?</p> <p>12. To what extent was the VNRC HQ providing sufficient leadership for your decision making?</p> <p>13. Which coordination mechanism was the provincial RC among all partners in the operation? Was the coordination mechanism achieving its purpose?</p>
Effectiveness	<p>14. Did the operation achieve its objectives? what objectives are not achieved? Why not?</p> <p>15. What have been the key issues within your response context?</p> <p>16. How did this HFMD operation compared with the one in 2011? Were the lessons learnt from 2011 useful for the 2012 operations? If yes, what were they?</p>
Impacts	<p>17. Do you see any positive or negative change within your organization and community?</p> <p>18. Do you have any data to show the expected impacts of the operation?</p>
Sustainability	<p>19. Is there any financial maintenance and support for future HFMD operation?</p> <p>20. Is there any operation mechanism established and maintained?</p> <p>21. What are the lessons learned from your Department for future operation?</p>

7. Guide for interviewing Commune People Committee

Purpose	To evaluate the coordination and management between the VNRC Departments and the Commune People Committee
Interviewee	Interview questions for Commune People Committee
Focuses	Key guiding questions
Relevance	<p>1. Were the activities of the HFMD outbreak operation in line with the existing cooperation between VNRC and Commune People Committee in regard to public health emergencies in the commune level?</p> <p>2. To what extent were the operation and its activities implemented to meet the needs and priorities of the targeted communities? Were the</p>

	<p>operation and its activities tailored to the local context? If not, why not?</p> <p>3. What were needed to enhance the appropriateness of HFMD program of the VNRC in future?</p> <p>4. What criteria did the IFRC/VNRC use to identify priority communes? How effective do you think?</p> <p>5. Did the HFMD operation target the worse affected communes? If not, why not?</p>
Efficiency	<p>6. What support the People Committee provided to the operation?</p> <p>7. Did the management and technical support from VNRC Departments provide sufficient support to facilitate the Commune People Committee to meet operational objectives?</p> <p>8. Was there any specific coordination mechanism to be established between different partners and People Committee in responding outbreak?</p> <p>9. Did the information and plans of action provided by the VNRC and other working partners provide a clear and adequate overview of HFMD situation in the affected communities? How useful was it and how did this affect the work?</p>
Effectiveness	<p>10. Did the operation achieve its objectives? what objectives are not achieved? Why not?</p> <p>11. What have been the key issues and achievements within your response context?</p> <p>12. How did this HFMD operation compared with the one in 2011? Were the lessons learnt from 2011 useful for the 2012 operations? If yes, what were they?</p>
Impacts	<p>13. What were the positive and negative consequences and change in the targeted communities as a result of community programs?</p>
Sustainability	<p>14. Is there any financial maintenance and support for future HFMD operation?</p> <p>15. Is there any operation mechanism established and maintained?</p> <p>16. Do you think the volunteers need continuous trainings for future HFMD or other kinds of epidemics operations? If yes, is there any financial support?</p> <p>17. What are the lessons learned from your Department for future operation?</p>

8. Guide for interviewing CHS staff

Purpose	
Interviewee	CHS head and staff
Focuses	Key guiding questions
Relevance	<p>1. Was the operation in line with the needs of the most vulnerable in relation to the HFMD situation in the locality?</p> <p>2. How did the operation contribute to strategies emergency response by the local health sector?</p> <p>3. How were the BCC activities planned? Did CHS center involve in identifying needs, activities/priorities of the operation? Were the beneficiaries involved in the design of the operation? If yes, how?</p> <p>4. How were the intervention selected sites fit to prioritized areas of the</p>

	<p>outbreak?</p> <p>5. Were BCC activities designed to be appropriate with local context? Local culture?</p>
Efficiency	<p>6. Was any coordination mechanism established during the operation? If yes, how did it work?</p> <p>7. Was you shared with necessary information about planning, progress and results of the operation? Did your department have any specific activities to support/supervise the operation?</p>
Effectiveness	<p>8. Did the operation achieve its objectives? which objectives are not achieved? Why not?</p> <p>9. What have been the key issues within your response context?</p> <p>10. How did the operation contribute to developing capacity of the CHS in planning and implementing response operation?</p> <p>11. How did the operation contribute to improving knowledge and awareness as well as changing behaviors of the local people?</p>
Impacts	<p>12. How did the operation contribute to reducing cases and risks at the intervention sites?</p>
Sustainability	<p>13. Do you see any opportunity/challenge for sustaining future activities on HFMD prevention and control?</p> <p>14. Is there any financial maintenance and support for future activities on HFMD prevention and control?</p> <p>15. Is there any operation mechanism established and maintained?</p> <p>16. What are the lessons learned from your organization for future operation?</p>

9. Guide for interviewing commune Red Cross

Purpose	To evaluate the coordination across VNRC Departments and capacity of volunteers in community involvement
Interviewee	Commune Red Cross
Focuses	Key guiding questions
Relevance	<p>1. To what extent were the operation and its activities implemented to meet the needs and priorities of the targeted communities? Were the operation and its activities tailored to the local context? If not, why?</p> <p>2. What were needed to enhance the appropriateness of HFMD program of the VNRC in future?</p> <p>3. What criteria did the IFRC/VNRC use to identity priority provinces? How effective do you think?</p> <p>4. Did the HFMD operation target the worse affected provinces, districts and communes? If not, why?</p>
Efficiency	<p>5. How useful were the IEC/BCC tools user-friendly for training new and old volunteers?</p> <p>6. Was the monitoring and reporting mechanism with higher VNRC level user-friendly and effective? Is there any way to improve in future?</p> <p>7. How was the monitoring and reporting mechanism from commune volunteers to Commune Red Cross? Is there any way to improve in future?</p>

	<p>8. To what extent had the training to volunteers achieved to give interventions to see behavioral change among target communities?</p> <p>9. Were the logistics and procurement procedures able to meet the needs of this HFMD operation? If not, why?</p>
Effectiveness	<p>10. What changes in capacity and competence of old and new volunteers could be seen as results of volunteer trainings?</p> <p>11. Did the operation improve capacity of VNRC staff and volunteers in behavioral change communications?</p> <p>12. To what extent were the trained volunteers able to implement community outreach effectively and reached out to communities per their needs and priorities?</p> <p>13. Did the information provided by higher VNRC levels provide adequate support to carry out the required activities? How useful was it and how did this affect the work?</p> <p>14. Which coordination mechanism was the Commune Red Cross among all partners in the operation? Was the coordination mechanism achieving its purpose?</p> <p>15. How did this HFMD operation compared with the one in 2011? Were the lessons learnt from 2011 useful for the 2012 operations? If yes, what were they?</p>
Impacts	<p>16. What were the positive and negative consequences and change in the targeted communities as a result of community programs?</p> <p>17. Did the management level and technical support from the higher VNRC levels provide sufficient support to facilitate the Commune Red Cross to meet operational objectives?</p>
Sustainability	<p>18. Is there any financial maintenance and support for future HFMD operation?</p> <p>19. Do you think the volunteers need continuous trainings for future HFMD or other kinds of epidemics operations? If yes, is there any financial support?</p> <p>20. What are the lessons learned from your Department for future operation?</p>

10. Guide for FGD with volunteers

Purpose	To explore the perspective and capacity of volunteers in performing the operation
Participant	Volunteers
Focuses	Key guiding questions
Relevance	<p>1. Describe your work as a volunteer:</p> <ul style="list-style-type: none"> • What were your role and responsibilities? • What did you do as a volunteer? • How important was your job? • Who supervised and supported you?
Efficiency	<p>2. What were your most difficulties and challenges during the operation?</p> <ul style="list-style-type: none"> • How did overcome the difficulties? • What are still remaining challenges?

	<ul style="list-style-type: none"> • What do you suggest to improve? <p>3. Did you participate in any training course?</p> <ul style="list-style-type: none"> • What was about? How was it organized? • What did you like from the course? • What did you dislike from the course? • What do you want to learn more? Why? <p>4. How did you work with other people?</p> <ul style="list-style-type: none"> • Understanding clearly about process • Sharing information • Reporting
Effectiveness	<p>5. Overall, do you think that you successfully did your job? How? <i>Probing: Changed behaviors of people, reduced risk...</i> What activities was not very successfully done? Why not?</p> <p>6. Did any specific activity and support to the communities and households make a significant contribution in preventing HFMD outbreaks?</p> <ul style="list-style-type: none"> • What were they and how? • What factors contributed positively to the achievements? • What factors hindered the implementation of the project, and how were they overcome? <p>7. What has you learnt by involving in the operation? Do you feel more confident in working with and educating people and community?</p>
Impacts	<p>8. Were there any positive and/or negative consequences arising from the operation? What are they?</p> <p>9. If VNRC had not carried out the operation, would things be different? How would it be different?</p>
Sustainability	<p>10. How do you think about future operation without any project support?</p>

11. Guide for interviewing Daycare Centre Caregivers

Purpose	<ul style="list-style-type: none"> • To assess the performance of the operation at daycare center • To explore the awareness of private sectors in contributing to public health program
Interviewee	Daycare Centre Caregivers
Focuses	Key guiding questions
Relevance	<p>1. Where and how did you first learn about HFMD – symptoms and ways to prevent the disease?</p> <p>2. Do you think that communication on HFMD prevention and control in your center is necessary? How? If not, why not?</p>
Efficiency	<p>3. Besides the VNRC, was there any other organizations also carrying out HFMD communication activities in your center? If yes, do you think these activities well-coordinated?</p> <p>4. Were you involved in the design of the operation? If yes, how?</p> <p>5. How do you think about the design, approach and activities of the operation? Any irrelevance?</p>

	<p>6. Were the messages in the VNRC leaflets and posters appropriate and easily understood? How could they be improved?</p> <p>7. How did you or your daycare centre use the IEC materials to promote good hygiene practices among the children?</p>
Effectiveness	<p>8. Were the VNRC communication activities useful in helping to prevent or control HFMD in your daycare centre ? How?</p> <p>9. Did you use other means to spread the message to the children and how effective were these?</p> <p>10. Are there other more effective ways that the VNRC could have used to raise the awareness of the children and HHs on HFMD?</p>
Impact	<p>11. Do you see any change (positive and negative consequence) in our center as a impact of the programs?</p> <p>12. How did the program influence the behaviors of children and their families in disease prevention and control?</p>
Sustainability	<p>13. Looking to the future, are you more prepared now to protect the children at your daycare center community from the dangers of HFMD and prevent new outbreaks.</p> <p>14. How will you prepare yourself and your community from another outbreak?</p> <p>15. Do you think children in your center continue their practice on FHMD prevention?</p>

12. Guide for household visit (interview and observation)

Purpose	<ul style="list-style-type: none"> To assess the knowledge, attitude, and practice of people To assess the access to information on HFMD prevention and treatment
Subject	Household member/s
Focuses	Key guiding questions
Knowledge, awareness, and attitude	<p>1. What could be the symptoms of HFMD? Were you aware of these symptoms before?</p> <p>2. What are the signs that the disease is exacerbating? Did you know about these before?</p> <p>3. What are the transmission channels for HFMD? Did you know about these before?</p> <p>4. What do you think about the possibility of HFMD happening to a child in your family or your neighbors'?</p> <p>5. How would you take care of a child with HFMD?</p> <p>6. How do you prevent HFMD from spreading to other children?</p>
Practice	<p>7. How often and when do you wash your child's hands?</p> <p>8. When would you use soap? Why?</p> <p>9. Does your family have a history of HFMD?</p> <p>10. Tell me what happened and how you managed to overcome it?</p>
Access to information	<p>11. How do you about the above information? Did you receive any information or communication materials about HFMD?</p> <p>12. What do you think your role in telling others in the community about</p>

	<p>the information you have learnt on HFMD?</p> <p>13. Did your family receive any support from the Red Cross? If yes, what kinds of support?</p> <p>14. Was the support necessary and delivered timely?</p> <p>15. How did the support help you prevent or respond to the disease?</p> <p>16. How do you assess the contribution of VNRC volunteers in HFMD operation?</p>
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Observation

17. Ask if the family keeps any of the HFMD IEC materials that they can show.
18. Observe the child in the family (if the child is home) and his playing areas. Note any sign of good or insufficient hygienic practices.
19. Ask to observe the kitchen and toilet of the family to see if the family stores and uses soap, and how they store their food.