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Health Staff's Experiences with Training and Implementation of Early
Essential Newborn Care in Two Provinces in Vietnam



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Abstract

Background: Infant- and neonatal mortality are decreasing in a slower pace than under-five mortality. Early essential newborn care are guidelines describing how childbirth and newborn care should be performed to prevent morbidity and mortality. The thesis will describe the Department of Health supported training and implementation of early essential newborn care, conducted in collaboration with Alive & Thrive. The main objective is to gain insight into health staff's attitudes and experiences about challenges and benefits regarding training and implementation.

Methods: In-depth interviews based on a semi-structured interview guide were conducted with health staff working in Alive & Thrive supported hospitals in Quang Nam and Da Nang in Vietnam. Health staff (n=21) were recruited from eight health facilities by convenience sampling. Descriptive data were reported to Alive & Thrive by hospitals receiving their support, covering the period from January 2015 to December 2017. Data on percentages of newborns receiving immediate skin-to-skin contact and early initiation of breastfeeding were analyzed.

Results: Health staff's experiences about training and implementation of early essential newborn care and increased execution rates, indicate that training is necessary. Health staff experience several benefits from implementing the practice. Challenges, such as staff shortage and barriers when applying the practice were identified. For successful implementation, a working environment facilitating early essential newborn care, health staff adapting the practice as a routine, and increased knowledge among mothers were perceived essential.

Conclusion: To address health staff behaviors related to birth attendance, capacity building is necessary. Despite challenges, training of health staff increases the percentage of newborns receiving early essential newborn care, and implementation brings positive impact on health staff, mothers, and newborns. The demand to receive early essential newborn care is increasing, and implementation is a lifesaving opportunity.

Key words: Vietnam, early essential newborn care, early initiation of breastfeeding, health staff

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List of Abbreviations

A&T	Alive & Thrive
BMS Code	International Code of Marketing of Breastmilk Substitutes
EENC	Early Essential Newborn Care
EIBF	Early Initiation of Breastfeeding
DOH	Department of Health
MDG	Millennium Development Goal
MOH	Ministry of Health
SDG	Sustainable Development Goal
U5MR	Under- Five Mortality
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

1.0 Introduction

Child mortality [U5MR], referring to the number of deaths per 1000 live births before the age of five, is an indicator that is useful to describe the health- and nutrition status of a country or parts of the world (You, Hug, Ejdemyr, & Beise, 2015). In 1990 the global U5MR was accounted to more than 12 million children, and through enormous efforts done by governments internationally, mainly by trying to reach the Millennium Development Goals (MDGs), U5MR was halved by the year 2015. Nevertheless, this means that in the year of 2015 almost 6 million children died before the age of five. This equals approximately 16 000 lives every day. The MDG target to reduce U5MR by two-thirds was not reached. Therefore, the work is still ongoing and further targeted in the Sustainable Development Goals [SDG's] which are to be reached by 2030 (Hug, Sharrow, & You, 2017).

The global U5MR are decreasing, but infant- and neonatal mortality rates, referring to the number of deaths per 1000 live births before one year and 28 days, are still high. Reduction in these rates are happening in a much slower pace than the reduction in U5MR, as complications due to birth practice and premature newborns has proved to be more difficult to prevent than mortality caused by infectious diseases. Today, infant- and neonatal mortality rates therefore accounts for a higher percentage of U5MR than before (United Nations Children's Fund [UNICEF], 2015). In 2016, neonatal mortality accounted for 46 % of all under-five deaths globally. This period, the 28 first days of life, is considered the most vulnerable time for child survival, where most deaths happens during the first week of life. Between 2017 and 2030, about 30 million newborns would die if the current trends on neonatal mortality continue, and the burden is unevenly spread across regions (Hug, Sharrow, & You, 2017).

About eighty percent of the estimated 30 million deaths would happen in southern Asia and sub-Saharan countries. Southern Asia is one of the areas where the neonatal mortality rate is still high and accounted for approximately 39 % of all newborn deaths in 2016 (Hug, Sharrow, & You, 2017). In the western pacific region, statistics show that every second minute, a newborn die. This accounts for about 230 000 newborn deaths every year. 50 000 of these children could have been saved through simple, preventive measures related to birth practice in health facilities (World Health Organization [WHO], 2014a).

Vietnam is one of the countries in Asia that nearly managed to reach the MDG target on reduced infant mortality (Socialist Republic of Vietnam, 2015). Still, 12,4 per 1000 children die within 28 days after birth. Most of these deaths happens during the first three days of life, commonly

due to birth practice that is not beneficial to the newborn and that could have been prevented through simple measures (Save the Children, 2014). Examples of such practices might be when the umbilical cord is cut too soon, when the newborn is not dried properly or when the first breastfeed is delayed due to lower priority against supplementation of vitamin K and other routine check-ups right after birth. Such birth practices might increase the stress of the newborn, interfere with their ability to adapt, and increase the risk of hypothermia, infections, breathing problems and death (WHO, 2014b).

To eliminate harmful and outdated birth practices like those mentioned, the WHO developed specific guidelines describing how child birth, and newborn care should be completed during and right after birth to prevent morbidity and mortality among newborns and ensure quality of care in the first 24 hours after birth. The steps included in the guidelines are referred to as Early Essential Newborn Care [EENC] (WHO, 2014b), and consists of the following:

- Immediate and thorough drying of the baby
- Immediate skin-to-skin contact
- Not to cut the umbilical cord before pulsations stops, apart from critical situations – the cord shall be cut with sterile equipment and should not be covered
- Encourage early initiation of breastfeeding [EIBF] when feeding cues occur (biting, seeking for the breast, drooling etc.) (WHO, 2014a).

According to the WHO (2014a), this birth practice routine should be implemented through services already existing in health facilities.

1.1 Collaboration with Alive & Thrive

The thesis is written in collaboration with Alive & Thrive [A&T], which is an initiative managed by FHI 360 and funded by the Bill & Melinda Gates foundation and the governments of Canada and Ireland. Their aim is to save lives by preventing illness and ensure healthy growth and development through healthy breastfeeding and complementary feeding practices (A&T, not dated a).

To provide health staff in hospitals for women and children with a method that ensures every newborn will receive the best care possible during and after birth, the Ministry of Health [MOH] in Vietnam approved a technical guideline on essential maternal and newborn care in November 2014 (Socialist Republic of Vietnam, 2014), and a guideline on C-section delivery in November 2016 (Socialist Republic of Vietnam, 2016). The WHO, UNICEF and A&T supported the MOH training and supportive supervision for rolling out these policies. Based on these guidelines,

A&T collaborated with Departments of Health [DOH] in seven different provinces across Vietnam to support the implementation of EENC in health facilities. In total, A&T supported training of 779 health staff in 104 hospitals from December 2014 to March 2015 (A&T, not dated b). After three years of implementation, there have been no study to describe the implementation of EENC in Vietnam. To fill the gaps, this study was conducted to describe the A&T supported training and implementation of EENC by gaining deeper insight to health staffs' personal attitudes and experiences about benefits and challenges regarding the training and further implementation.

2.0 Study objectives

The aim of the study is to describe the Department of Health supported training and implementation of EENC in two provinces in Vietnam, conducted in collaboration with A&T. The thesis will describe health staffs' attitudes and experiences about the training and implementation of EENC. More specifically, the learning objectives of the study are the following:

1. Describe the percentage of infants who receive immediate skin-to-skin contact and early initiation of breastfeeding in two different provinces that have received A&T supported training
2. Describe the health staffs' personal experiences about the training and implementation of EENC in their workplaces
 - 2.1 What are the health staffs' attitudes and experiences about the training and implementation of EENC in their workplaces?
 - 2.2 What benefits and challenges does health staff experience when implementing EENC?
 - 2.3 What does the health staff experience as necessary for successful implementation of EENC?
 - 2.4 What are the health staffs' experiences about exclusive breastfeeding and breastfeeding practices in their workplaces?

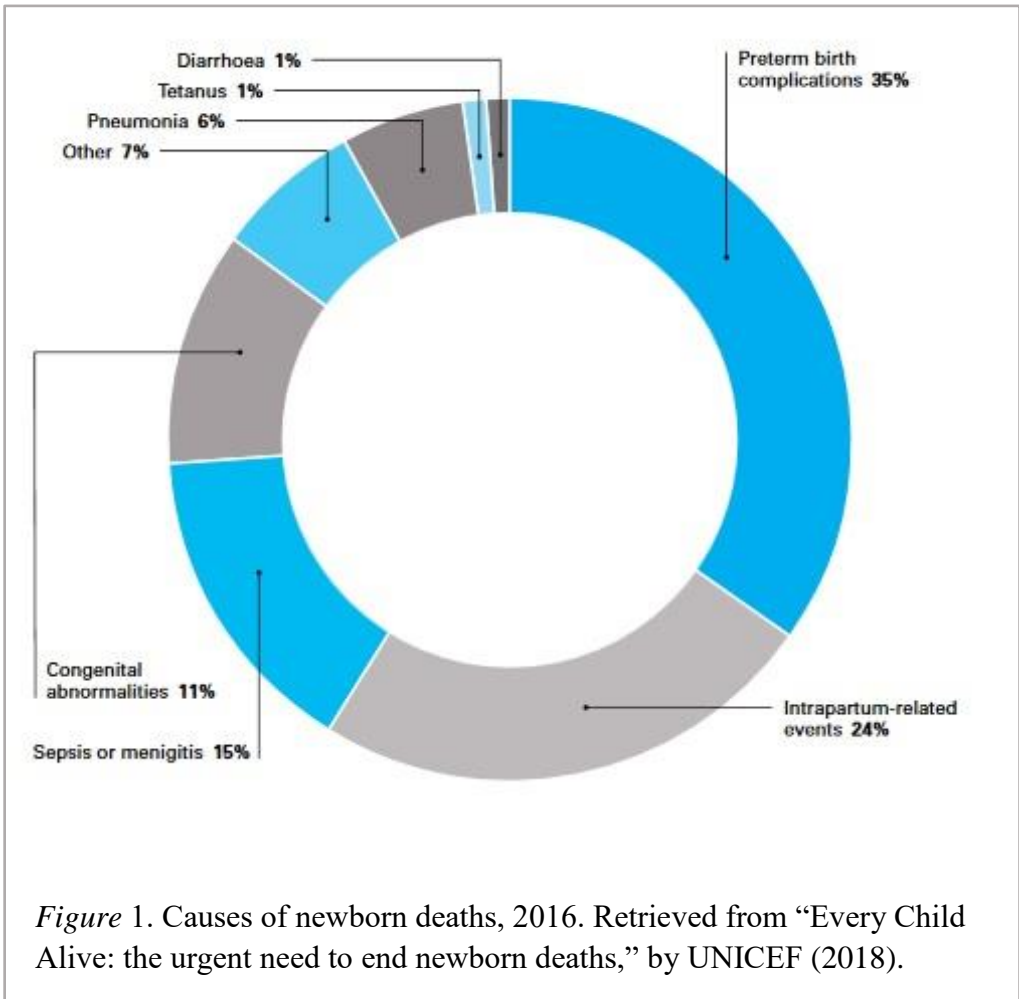
2.1 Structure of the thesis

This thesis is written in two separate parts. In the first part, theoretical background, elaborations on methods, descriptive results on implementation of EENC in Da Nang and Quang Nam, discussion of descriptive results, methodological discussion and suggestions to further research are presented. The second part of the thesis is a draft for an article formatted according to the requirements of Public Health Nutrition. Since the numbers of words for the article were limited, it was decided that the article should only include qualitative findings covering learning objective 2.

3.0 Theoretical background

3.1 Main causes of newborn deaths

Newborn deaths are reduced in a much slower pace than U5MR, mainly due to causes that can be easily prevented, such as inappropriate hospital practices related to birth methods that is not beneficial to neither the newborn nor the mother. The main causes of newborn deaths, as shown in figure 1 (UNICEF, 2018), are related to complications due to premature deliveries, neonatal infectious diseases and deaths related to complications during delivery. Complications during delivery are often referred to as *intrapartum related deaths* (Save the Children, 2014), and will be the expression used when further talking about such complications in this thesis.



3.1.1 Premature deliveries

According to Save the Children (2014), preterm deliveries accounts for about one third of all newborn deaths. This is defined by the WHO as “babies born alive before 37 weeks of pregnancy are completed”. Further, preterm birth can be placed into three different categories: 1. extremely preterm, defined as less than 28 weeks, 2. very preterm, where the baby is born between week 28 and week 32, and 3. moderate or late preterm, which refers to newborns born in the between 32 and 37 weeks (WHO, 2017a). In year 2015, complications due to premature birth accounted for 1 million deaths, where 75 % of these could have been prevented by ensuring essential care for the newborn during and after birth. (WHO, 2017a) Examples of essential care for preterm newborns are heart rate and distress monitoring of the newborn during delivery and immediate skin-to-skin contact and EIBF (Save the Children, 2014).

3.1.2 Infections

Of the three causes mentioned, neonatal infections are the third most common (Vergnano et al., 2016), and accounts for about 36 % of all newborn deaths (WHO, 2017b). The risk of the newborn acquiring an infection during birth can be reduced by ensuring clean surroundings and equipment, breastfeeding of the newborn as well as given hygienic care of the umbilical cord. Further, the risk can be reduced by screening, immunization of the mother and other preventive measures (Save the Children, 2014).

3.1.3 Intrapartum-related deaths

Complications during child delivery results in about 814,000 neonatal deaths each year, almost a quarter of all newborn deaths. Most of these in low and middle-income countries due to the lack of access to quality care (Wall et al., 2010). Skilled birth attendance where the health staff is prepared and able to react immediately in case of critical situations, such as the baby having breathing problems after birth or need for caesarean section, is the most crucial measure to prevent newborn death caused by birth complications (Save the Children, 2014).

Together, the three causes mentioned accounts for about 80 % of all newborn deaths. The causes and conditions are all preventable and possible to treat with easy and effective evidence-based interventions (WHO & UNICEF, 2014). In 2012 2,9 million newborns died globally from preventable causes within 28 days after birth. By ending preventable mortality, 2 million of these newborns can be saved every year. Further, statistics show that 43 % of all newborn deaths can be prevented by care from skilled birth attendant during delivery (Save the Children, 2014)- A skilled birth attendant is defined by the WHO as

An accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (WHO, 2004, p. 1).

3.2 The World Health Organization: “Early Essential Newborn Care”

In the West Pacific Region, a newborn dies every second minute, and newborn deaths accounts for 54 % of U5MR. Most of these deaths is a result of the causes mentioned in the previous chapter and is concentrated mainly in the first 24 hours of life. Every year 231 000 newborn die in the West Pacific Region, and estimates show that 50 000 of these babies can be saved by implementing simple and effective measures in hospitals and health facilities (WHO, 2014a). As most of the causes of newborn deaths are preventable, the WHO have developed specific guidelines, referred to as *Early Essential Newborn Care* [EENC], with the aim of ensuring quality of care during and in the first 24 hours after birth by preventing harmful and outdated birth practices (WHO, 2014b).

“Early Essential Newborn Care: A Clinical Practice Pocket Guide,” describing the practical implementation of EENC, was published in 2014. The guide includes the most updated information on how to perform EENC and is targeting all health staff attending deliveries (i.e. midwives and doctors) and other health staff that are taking care of newborns. The purpose of the pocket guide is to serve as a guiding tool to ensure all deliveries are conducted with practice that does not harm the health of either the mother or the baby – both prenatal and postnatal, and to create a supportive working environment for full implementation (WHO, 2014b).

3.2.1 Harmful birth practices

Harmful birth practices can be defined as practices that interferes with the baby’s ability to adapt and feed well, and might be caused by lack of knowledge, traditional customs, or beliefs. According to the WHO (2014a), examples of such practices might be when the baby is not dried immediately after birth, when the umbilical cord is cut before pulsation stops, when suctioning of the baby’s nose and mouth is conducted even though the baby has no trouble breathing, or when breastfeeding is delayed because other routine check-ups are prioritized. Such as immunization, weighing and other examinations of the baby. This should not be done before the first breastfeed is completed (World Health Organization Western Pacific Region [WHO

WPRO], 2014). Birth practices like these are harmful to the newborn as it increases the risk of anemia, breathing problems etc. Further, separation from the mother too early after birth can lead to distress, hypothermia, and infections because of being exposed to bacteria's, which again will increase the risk of death (WHO, 2014a).

3.2.2 “The First Embrace”

The first embrace refers to the first 90 minutes after delivery and is considered the core in the concept of EENC. “The first embrace” consists of four steps that should happen within these 90 minutes, as these are the most crucial ones for newborn survival. The four steps that should be implemented are the following:

- Immediate and thorough drying of the baby
- Immediate skin-to-skin contact
- Not to cut the umbilical cord before pulsations stops, apart from critical situations – the cord shall be cut with sterile equipment and should not be covered
- Encourage EIBF when feeding cues occur (biting, seeking for the breast, drooling etc.) (WHO, 2014a).

3.2.2.1 Skin-to-skin contact

Skin-to-skin contact refers to the practice where the newborn is dried immediately after birth and put directly onto the mothers' chest. This has been proved to be beneficial to both the mother and the newborn because it helps both feel calm, helps the baby's regulation on breathing, heart rate and body temperature, and keeps the baby away from dangerous bacteria that might lead to infections. Further, it is shown that skin-to-skin contact stimulates breastfeeding and release of the hormone oxytocin, known as the “love hormone,” in the mother, while at the same time stimulating digestion and feeding cues with the baby (UNICEF, not dated). In addition, several studies show that immediate skin-to-skin contact between the mother and the baby is associated with EIBF (Lau et al., 2018), and improved breastfeeding rates (Moore, Bergman, Anderson & Medley, 2016). To achieve the positive effects mentioned, the newborn should be allowed to stay on the mother's chest for at least an hour without interruptions (UNICEF, not dated), until the first breastfeed is finished (Moore et al., 2016). The practice is beneficial to all newborns, including newborns born with C-section, and newborns born prematurely (WHO WPRO, 2014). For premature and low birthweight newborns continuous and prolonged skin-to-skin contact is recommended, as it has proved to be effective on both the prevalence of breastfeeding and thermal control. The method is often

referred to as *kangaroo mother care*, where the newborn is placed in a kangaroo position on the mothers' chest (WHO, 2003).

3.2.2.2 Early initiation of breastfeeding

EIBF refers to breastfeeding within an hour after birth and is strongly depending on skin-to-skin contact not being interrupted. Evidence indicates that mothers and newborns following the recommendation on skin-to-skin contact are more likely to breastfeed within an hour after birth, as well as the duration of overall breastfeeding. By initiating breastfeeding within the first hour of birth, the baby will receive colostrum, also known as the “first milk” (WHO, 2017b). Colostrum is rich in nutrients, and contains different components boosting the immune system of the newborn and helps protect against disease and infection (Uruakpa, Ismond & Akobundu, 2002). As mentioned earlier, infectious diseases accounts for about 1/3 of all newborn deaths. Therefore, receiving colostrum can help prevent neonatal mortality. Further, a recent systematic review and meta-analysis on timing of breastfeeding show that delayed initiation, meaning later than an hour after birth, doubles the risk of neonatal mortality (Khan, Vesel, Bahl & Martines, 2015).

4.0 Methods

This chapter describes what research methods have been used for collecting, analyzing, and reporting of both descriptive data and in-depth qualitative data collected to answer the thesis.

The purpose of the study is to describe the training and implementation of EENC in two A&T supported provinces in Vietnam. Qualitative research method was employed to achieve better understanding of the health staffs' personal attitudes experiences about training and implementation of EENC. In addition, descriptive data that ensures an overview of the percentages of newborns who have received immediate skin-to-skin contact and EIBF in the two provinces included in the study were analyzed to supply the qualitative data.

4.1 Descriptive data

4.1.1 Data collection

A&T monitors the implementation of EENC in the provinces they have supported by collecting data on two core indicators in EENC. One indicator is newborns reported to receive skin-to-skin contact. The second indicator is measured by newborns receiving EIBF. The descriptive data included in this specific study consists of the same indicators, for both vaginal and C-section deliveries. Descriptive data were included from the two provinces Quang Nam and Da Nang in central Vietnam and describes the implementation of EENC in all A&T supported hospitals in these two provinces. The hospitals supported by A&T with training and implementation of EENC are reporting the numbers themselves in a log book after every birth. Every monthly quarter these numbers are further reported to A&T, who develops trend analyzes to monitor the implementation. Because the descriptive data needed are collected continuously by the hospitals, there were no need to gather additional descriptive data in purpose of this specific study. The descriptive data included was shared in an English format via email by A&T in February 2018, containing data from the beginning of the implementation in January 2015 to December 2017. For organizing and analyzing the data reported, the software program Microsoft Excel was employed.

4.2 Qualitative research approach

The purpose of the study is to describe the training and implementation of EENC in two A&T supported provinces in Vietnam, by gaining a better understanding of the participants attitudes and experiences with the A&T supported training and implementation. To answer the thesis, a qualitative approach was chosen. Qualitative studies are often defined as studies where the researcher seeks to gain insight in individuals personal feelings, experiences, and opinions

about a certain phenomenon by gathering in-depth data (Lapan, Quartaroli, & Riemer, 2011). In-depth data can be collected through face-to-face interviews by talking directly to the participants in a natural setting where the phenomenon under study is being experienced (Creswell, 2013). Interviews are among of the most common methods to gather data where the aim of the research is to gain a better understanding of how participants experience a certain phenomenon. This research method is often categorized into three different forms; unstructured, semi-structured and structured interviews (DiCicco-Bloom & Crabtree, 2006). For this specific study, individual semi-structured interviews were considered the most suitable method and can be described as “a conversation in which you know what you want to find out about” (Miles & Gilbert, 2005). This interview technique adds structure to the conversation as it is based on questions developed beforehand, as well as it allows the interviewer to talk freely and ask questions related to the dialogue (DiCicco-Bloom & Crabtree, 2006). When being able to change and add questions during the interview, it is possible to ask questions and talk about experiences that might be important to individual participants of the study and further gain deeper insight in different aspects of the research question (Miles & Gilbert, 2005). According to Creswell (2013) the final report when doing qualitative research should include “the voices of the participants, the reflexivity of the researcher, a complex description and interpretation of the problem, and its contribution to the literature or a call for change” (Creswell, 2013).

4.3 Qualitative data

4.3.1 Interview guide

Prior to the study, an interview guide was developed in collaboration with counsellors at Oslo Metropolitan University and A&T staff (appendix 1). The interview guide contained relevant questions placed into different categories and served as an aid to ensure that all necessary topics were highlighted during the interviews. Using an interview guide it was possible to carry out controlled, but flexible conversations as described by Brinkmann and Kvale (2009), but more structured than an informal conversation. One of the main advantages with the interview guide was that the participants were asked questions about the same topics, which makes it easier to compare the different answers when analyzing the final dataset (McNamara, 2009).

4.3.2 Data collection

The interviews were conducted in the two provinces Da Nang and Quang Nam in Vietnam in September and October 2017, by the student herself. A&T decided which provinces to include in the study. The two provinces included are located next to each other and were chosen because of the time available for conducting field visit and their different rates in EENC indicators after

implementation. The interviews were conducted with both health managers, midwives, and doctors who attend in vaginal and C-section deliveries from eight different hospitals and reproductive health centers. The participants in the study had received A&T supported training in EENC and are working with birth attendance in A&T supported hospitals. There were completed 21 interviews in total, where 19 of the interviews were recorded on tape, with approval from the interviewees. The last two cases did not agree to be recorded, therefore data from these two interviews are based on hand written notes only. All interviews were done at the interviewees workplace, mainly because the interviews were done during their worktime, but also because surroundings that are safe and comfortable to the interviewee might feel more supportive and be less distracting (McNamara, 2009). The interviews were done individually to help the participants feel comfortable answering the questions asked. The interviews lasted between 20 minutes and 1,5 hours, with most interviews lasting about 30 minutes.

Because the researcher could not speak the native language of the informants, and most of the participants were not sufficiently familiar with English to feel comfortable in an interview situation and understand and answer the questions properly, it was necessary with assistance from an interpreter. The interpreter was arranged by A&T, who also helped with the recruitment of the participants for the study, based on which hospitals they support with the implementation of EENC.

To participate in the study, the interviewee had to have experience with attending deliveries from before EENC was implemented in their workplace and be working with EENC and birth attendance. Apart from that, it was not considered necessary with other specific inclusion or exclusion criteria for participation. The sampling was convenient, meaning that the study population was nonrandom and easy accessible at the time of the research project (Etikan, Musa & Alkassim, 2016).

4.3.3 Transcription

As mentioned earlier, most interviews were recorded on tape. By making use of a recorder, it was possible to focus more on the interviewees' body language, eye contact, whether the interviewee seemed comfortable talking about the subject etc., which are non-verbal expressions that might be important to the analyzation of the statements (Bailey, 2008). This was important in this case, because the interviews were conducted with assistance from an interpreter, and it was difficult to interpret the cadence when not speaking the language. The two interviews that were not recorded, was transcribed based on hand written notes from the interview only.

To make sure every discovery from the interview setting was rendered as correctly as possible, the interviews were transcribed in Microsoft Word shortly after the interviews were conducted. The transcriptions were done verbatim, as they were written word-by-word exactly what was being said in the recording (Poland, 1995).

4.3.4 Thematic analysis

For analyzing and interpretation of the data it was chosen to conduct a thematic analysis. This method of analyzing data, is described by Braun and Clarke (2006) as “a method for identifying, analyzing, and reporting patterns within data”. Relevant patterns of meaning were identified by repeated reading of the transcriptions. Further, different parts from the interviews were organized into different “codes,” which is defined by Braun and Clarke (2006) as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon.” After coding the data, all relevant statements were placed into broader themes to achieve an overview of the statements. The themes identified were mainly based on questions from the interview guide, as these were perceived the most relevant ones in relation to the aim of the study (Braun & Clarke, 2006). Further, some additional themes were identified during the process of coding the data. The themes identified are the following:

1. Personal opinions about the training
2. Reasons for EENC to be implemented in hospitals
3. How to increase the learning outcome from the training
4. Changes in practice after implementation of EENC
5. Challenges with the implementation of EENC
6. The importance of a supportive working for implementation to succeed
7. Breastfeeding in the hospital and after discharge from the hospital

Last, the different statements were compared to identify similarities and disagreements between the participants, and to identify statements relevant to answer the thesis. This analyzing method helped get an overview of the data by placing every statement of relevance into categories (Thagaard, 2009).

4.4 Observations

Although observation was not one of the main methods for collecting data in this study, as there were no official observation forms employed, the research team performed some key observations on the implementation of EENC and breastfeeding environment during the field

visits. The observations are presented in Table 2 and are included to describe the overall situation in the hospitals and reproductive health centers included in the study.

4.5 Ethical considerations

The study does not contain sensitive information that can link the interviewees to the study and because the study was considered service related, it was not necessary to apply for ethical approval. The participants were informed in advance about their right not to answer certain questions and that they will stay anonymous throughout the whole process of this research, as well as their right not to be recorded on tape. Verbal and written consent was given. A draft of the consent letter was developed in English (appendix 2) and further translated to Vietnamese (appendix 3) with help from the interpreter who assisted the interviews. The Norwegian Centre for Research Data assessed and registered the study (appendix 4).

5.0 Results

In this chapter, data that was not added to the article are presented. These include descriptive data on the percentages of newborns who received skin-to-skin contact and EIBF between January 2015 and December 2017 and key observations performed during the field visit.

5.1 Descriptive data

In the following section, descriptive data on newborns receiving skin-to-skin contact and percentages of newborns receiving EIBF will be presented for the provinces of Da Nang and Quang Nam. In addition, an overall description of hospitals supported by A&T in the two provinces is provided.

5.1.1 Description of Alive & Thrive supported training and implementation

Table 1: Number of hospitals and health staff supported by A&T by province

	Alive & Thrive Supported Training		Timeline (2015)
	No. of Hospital Supported	No. of Health Staff Trained	Implementation Started
Da Nang	13	185	April
Quang Nam	23	92	April

Table 1 shows an overview of the number of hospitals A&T supported hospitals and health staff that has received A&T supported training in Danang and Quang Nam. As for December 2017, 100 % of the supported hospitals sent monthly reports with the purpose of monitoring the implementation.

5.1.2 EENC in Da Nang

Figure 2: percentage of newborns who received skin-to-skin immediately after birth, in A&T supported hospitals in Da Nang from January 2015 and December 2017

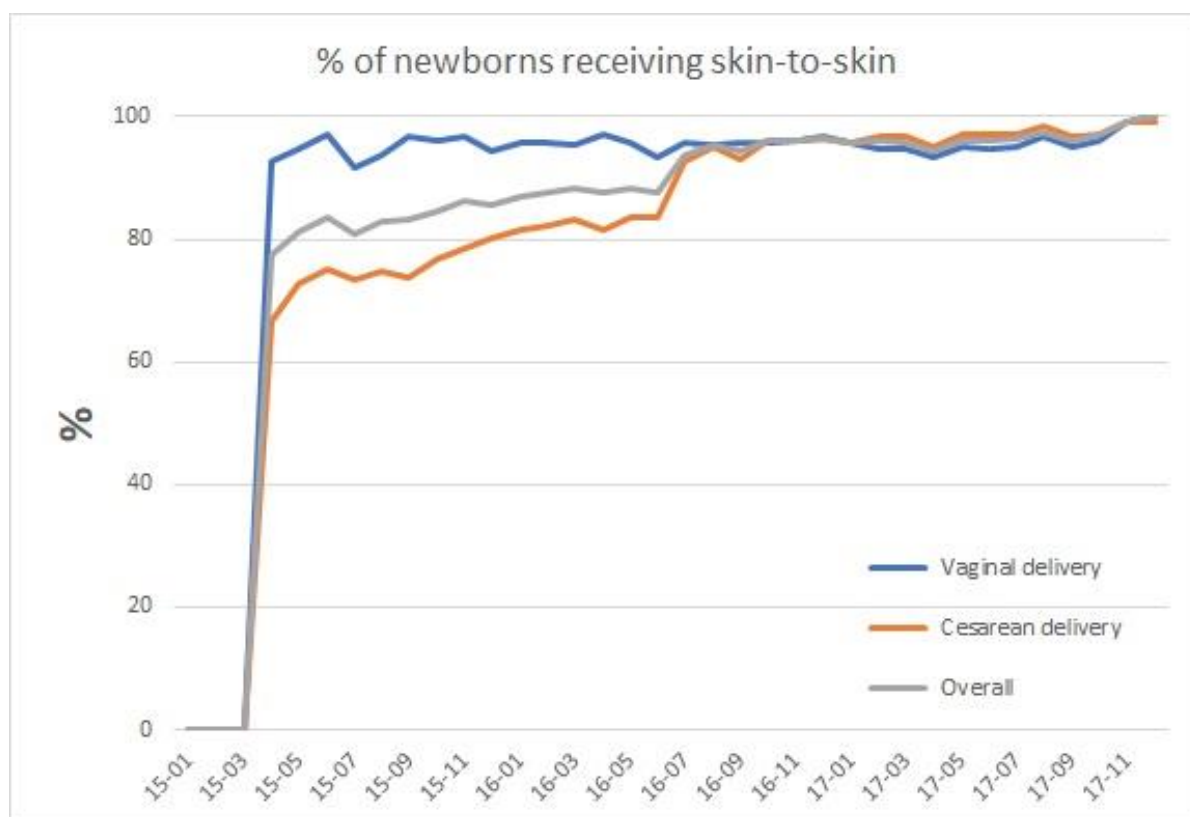


Figure 2 shows the percentages on how many newborns who received skin-to-skin contact following the EENC guidelines between January 2015 and December 2017. The overall percentage increased from none reported cases in January 2015 to 77 % reported cases after EENC was implemented. After a year, in April 2016, the rate had further increased with 11 %. In December 2017, the overall percentage of newborns receiving skin-to-skin was reported 100 %. For vaginal deliveries, the data show that the registered percentage of newborns who received skin-to-skin went from none reported cases during the first quarter of 2015, increasing to 93 % after EENC was implemented. After a year the rate had increased with 5 % more, reaching 97 %. As for December 2017, 100 % of the newborns born vaginally in A&T supported hospitals in Da Nang received skin-to-skin contact immediately after delivery. For C-section deliveries, the registered percentage of newborns who received skin-to-skin contact went from none reported cases, to 67 % in April 2015. After approximately one year, 82 % of the children born with C-section received skin-to-skin immediately after birth. As for December 2017, 99 % of newborns born to C-section received skin-to-skin in Da Nang province.

Figure 3: percentage of newborns breastfed within one hour after birth in A&T supported hospitals in Da Nang between January 2015 and December 2017.

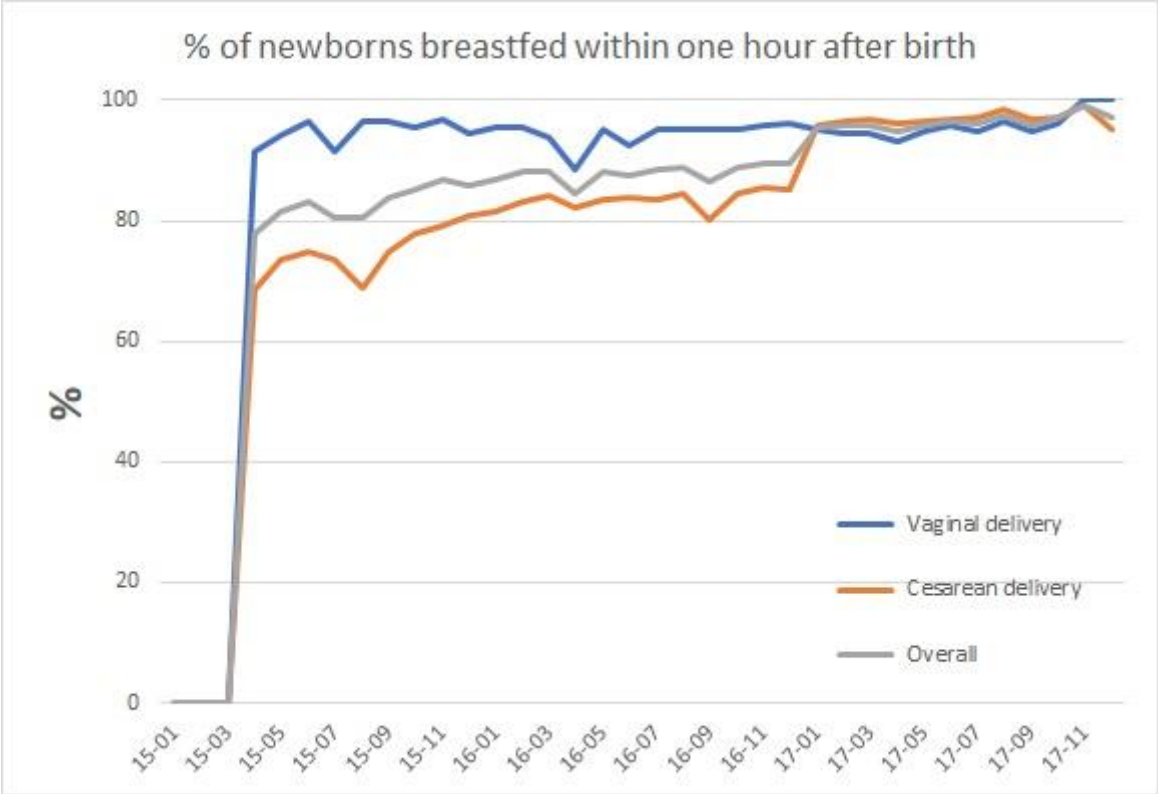


Figure 3 shows that the overall reported percentage of newborns breastfed within one hour after birth have increased from none reported cases in the first quarter of 2015, to 97 % in December 2017. In December 2017, 100 % of newborns born vaginally received EIBF compared to 95 % of the newborns born to C-section.

5.1.3 EENC in Quang Nam

Figure 4: percentage of newborns who received skin-to-skin immediately after birth in A&T supported hospitals in Quang Nam between January 2015 and December 2017.

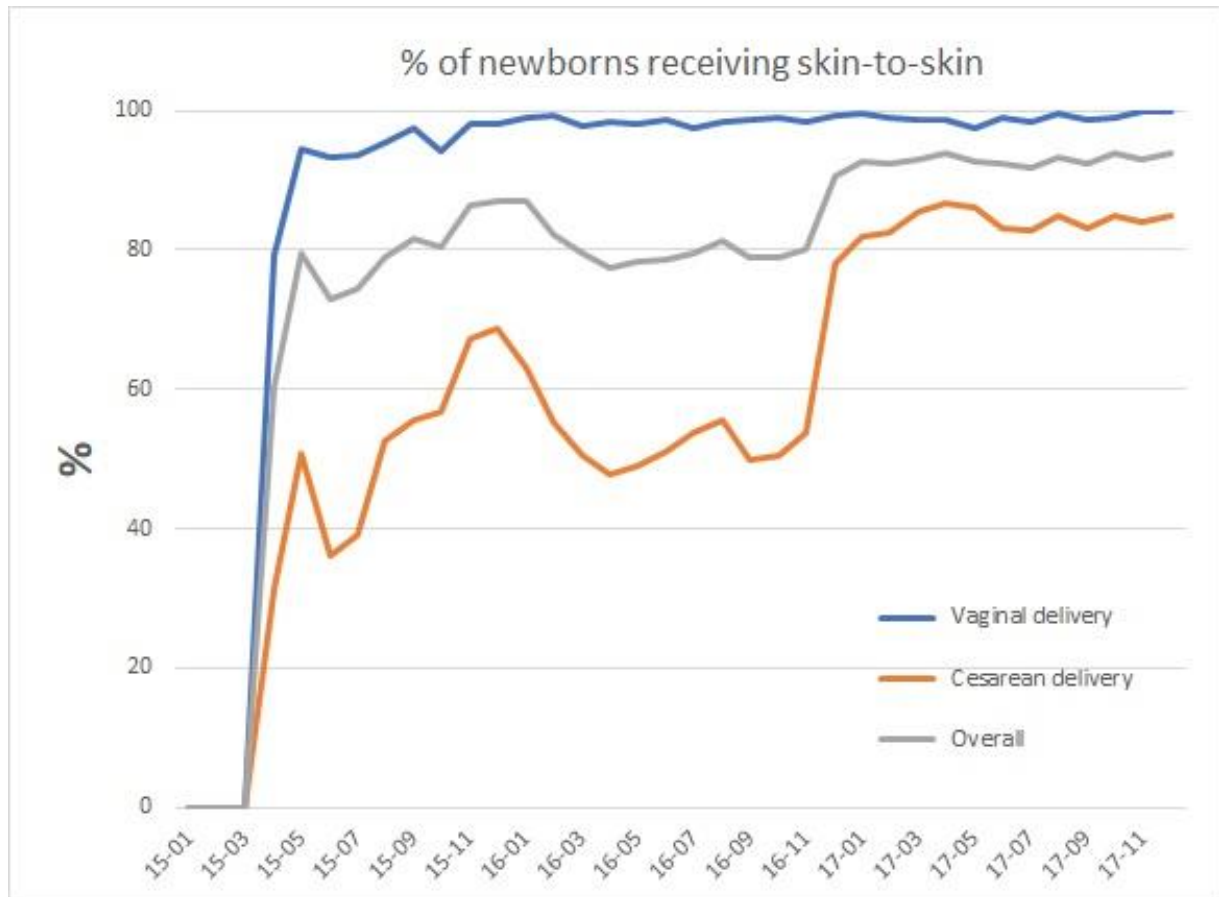


Figure 4 shows that the percentage of newborns receiving skin-to-skin contact after birth in Quang Nam have been somewhat unstable compared to the percentage of newborns receiving skin-to-skin in Da Nang province. This is especially palpable for C-section deliveries. In December 2017, 85 % of the newborns born to C-section received skin-to-skin contact, compared to 100 % of newborns born vaginally. In total, 94 % of newborns born in Quang Nam received skin-to-skin contact immediately after birth in December 2017.

Figure 5: percentage of newborns who were breastfed within one hour after birth in A&T supported hospitals in Quang Nam between January 2015 and December 2017.

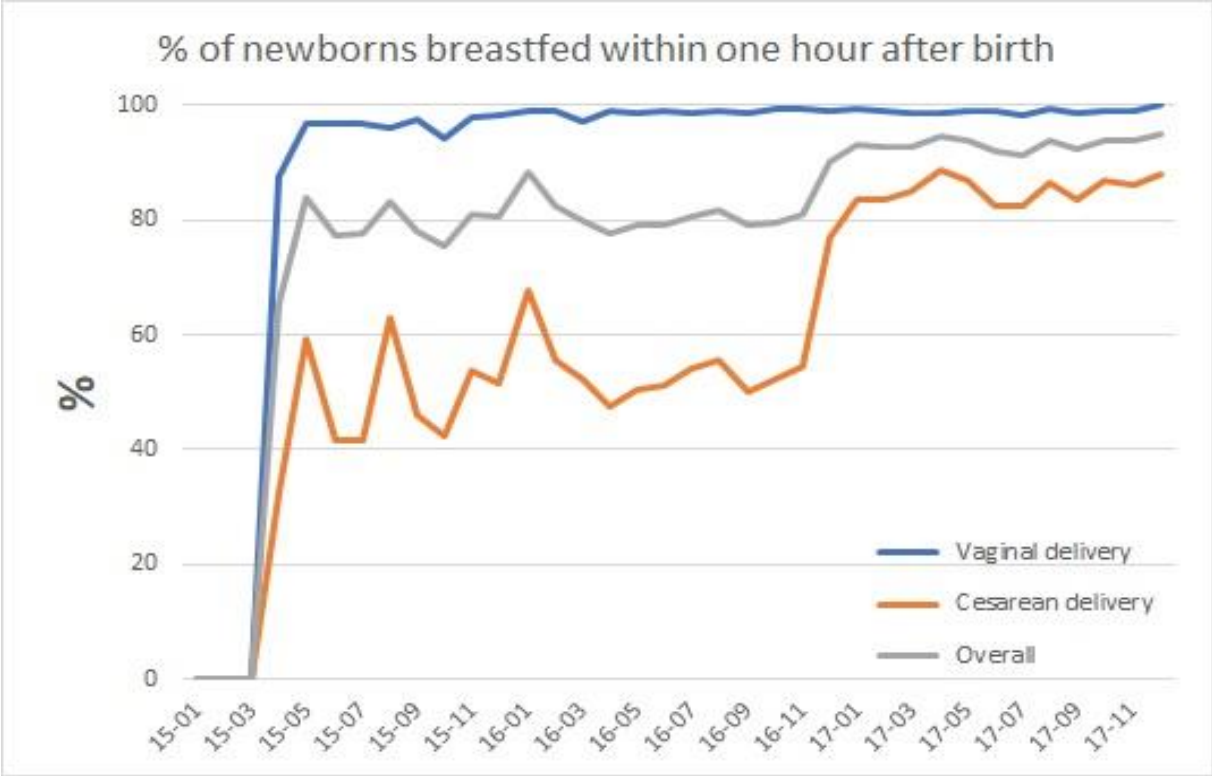


Figure 5 shows that the percentage of newborns who received breastfeeding within an hour after birth have been unstable after the implementation of EENC, mainly for C-section deliveries, with percentages following the same pattern as Figure 4. Further, the Figure shows that the percentage evened out from January 2017, and that the rate has been stable since then. In December 2017 88 % of all newborns born to C-section received breastfeeding within an hour after birth, compared to 33 % in April 2015. For C-section deliveries, numbers reported in December 2017 shows a 3 % gap between newborns receiving skin-to-skin contact (Figure 4) and newborns breastfed one hour after birth. For vaginal deliveries, 100 % of all newborns received breastfeeding within an hour after birth in December 2017. Overall, 95 % of newborns born in Quang Nam in December 2017 received breastfeeding within one hour after birth, compared to 66 % in April 2015.

5.2 Observations

Table 2: Observations from field visits

	Da Nang				Quang Nam			
	Reproductive health center	Provincial hospital	District hospital	Private hospital	Reproductive health center	Provincial hospital	District hospital	Private hospital
Mother with baby after vaginal delivery	NA	Yes	Yes	Yes	NA	Yes	Yes	Yes
Mother with baby after cesarean delivery	NA	Yes	Yes	Yes	NA	Yes	Yes	Yes
Mother rooming in with baby in postnatal ward	NA	Yes	Yes	Yes	NA	Yes	Yes	Yes
Kangaroo care by mothers	NA	Yes	Yes	Yes	NA	Yes	Yes	Yes
Kangaroo care by fathers, grandmothers, or others	NA	Yes	-	-	NA	Yes	Yes	-
Violation of the BMS Code (infant formula ads or materials; selling infant formula at health facilities; infant formula by the client's bed).	No	No	No	No	No	No	No	No
Breastfeeding posters displayed	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Breastfeeding counseling room available	Yes	Yes	Yes	Yes	Yes	Yes	-	-
Nutritional counseling session observed	Yes	-	-	-	-	-	-	-
Human Milk Bank visited	NA	Yes	Yes	NA	NA	NA	NA	NA

NA = not applicable, Yes = service delivered, No = not observed, - = no data

Table 2 shows that in health facilities delivering birth attendance, mothers and newborns were together in the postnatal ward after delivery, both for C-section and vaginal deliveries. Further all health facilities delivering birth attendance delivered kangaroo mother care for sick and premature newborns. No violation of the international code of marketing breastmilk substitutes [BMS Code] was observed, specifically there were no observations of advertisements violating the BMS Code, sales of breastmilk substitutes were not observed, and there was not observed any breastmilk substitutes by the clients' beds in postnatal care. In addition, posters promoting breastfeeding was observed in all health facilities visited except one, and breastfeeding counselling rooms were observed in six out of eight health facilities visited.

6.0 Discussion of descriptive results

This chapter reflects upon the descriptive data on percentages of newborns receiving EENC, measured by skin-to-skin contact and EIBF, in Da Nang and Quang Nam province.

For Da Nang province, monitoring reports from A&T supported health facilities show an increase from none reported cases in January 2015 to a 100 % of newborns receiving skin-to-skin contact in December 2017. In Quang Nam province, the implementation has shown to be more challenging, and the percentage of newborns receiving both skin-to-skin contact and EIBF have been somewhat unstable compared to the percentages reported in Da Nang province. A trend especially palpable for newborns born to C-section. In December 2017, 85 % of the newborns born using this birth method received skin-to-skin contact, compared to 100 % of newborns born vaginally. This means that in total, 94 % of newborns born in Quang Nam province in December 2017 received skin-to-skin contact immediately after birth. Data collected in this study cannot explain why there is a difference between the two provinces, as this was not the aim of this study. Nevertheless, strong internal forces within Da Nang province, promoting the implementation of EENC, might be a reason explaining why the implementation ran smoother in this province compared to Quang Nam. In addition, other studies have identified staff shortage and shortage in equipment as factors affecting the performance of neonatal care (Tosif et al., 2018) which might be a contributing factor. Further, descriptive data analyzed show similar trends in EIBF as skin-to-skin in Quang Nam, where the percentage of newborns receiving EIBF is lower for the group born to C-section compared to the group born vaginally. Even though C-section deliveries in some cases may be lifesaving to both the mother and the newborn (Ghahiri & Khosravi, 2015), studies show that this birth method is associated with higher risks of complications, especially respiratory complications after birth (Tita et al., 2009). In cases where the newborn needs to be taken away from the mother right after birth due to such complications EIBF might be interrupted, which also may be the reason C-section delivery is associated with lower percentages of newborns receiving EIBF in Quang Nam province. Nevertheless, key observations performed during the field visits in September and October 2017, showed supportive breastfeeding environments in hospitals visited in both provinces, as there were posters promoting breastfeeding displayed in most hospitals, and there were no sales of breastmilk substitutes.

Overall the A&T supported training and implementation have led to an overwhelming increase in the percentage of newborns who receive EENC for both vaginal and C-section deliveries. Observations and reports from A&T supported health facilities indicate that newborns receiving

EENC are calmer, cry less, have a pink, healthy color to their skin and breastfeed more easily. In addition, the mothers are reported to be healthier and need less support from health staff after delivery (A&T, not dated b).

6.1 Suggestions to further research

Qualitative findings presented in the second part of this theses indicates that C-section deliveries were perceived a challenge when performing EENC. Mainly due to high C-section rates and staff shortage. As it was perceived that there is a need to reduce C-section rates in Vietnam to increase health among mothers and newborns and to reduce workload of health staff, future research should investigate why some women in Vietnam still chose to have C-sectional deliveries despite increased knowledge in newborn care, and how to eliminate these barriers.

7 Discussion of methodology

This chapter reflects upon challenges related to the completion of the study. Strengths and limitations of methodological approach, data collection, sources of bias and generalization are presented and discussed, as these might affect the overall quality of the study.

7.2 Data collection

Individual in-depth interviews were considered the most suitable method to collect data on health staffs' personal experiences, thoughts, and opinions about different aspects of the implementation of EENC in their workplaces. Individual in-depth interviews provide a "deeper" and more detailed information that might be hard to highlight using other data collection techniques (Boyce & Neale, 2006), which was the main reason this was considered the most suitable data collection method for this study. By conducting in-depth interviews based on a semi-structured interview guide the questioning was broad and open-ended, which turned out to have multiple advantages. Firstly, semi-structured interviews made it possible to gain deeper insight into themes and issues considered important to the interviewee, that was not mentioned in the interview guide. This way, important issues and reflections that was not thought of while developing the interview guide was highlighted. Secondly, the fact that it was possible to dive deeper into the themes and issues that mattered the most to the interviewees made the interview situation more natural and relaxed. On the other hand, this method gives a lot of power to the interviewees, as they have more control during the conversation and this way, also more control over the data collected (Choy, 2014). For instance, the health staff interviewed in this study might have wanted to "prove" that they were satisfied with the A&T supported training, and that there was no need for improvements in either training or support with the following implementation. Therefore, it needs to be taken into consideration that relevant themes and subjects that was not covered by the interview guide might have missed out, and that some of the responses during the interviews could be biased (Choy, 2014; Boyce & Neale, 2006).

Furthermore, A&T, who helped organize the interviews is the same organization that conducted the training. It needs to be taken into consideration that this might, and probably did, affect the participants and their answers during the interviews. Especially when asked about questions covering their satisfaction and learning outcome from the training and what could have been done differently to improve the learning outcome.

In addition, a large number of interviews were conducted in a relatively short period of time. All 21 interviews were finished in just one week. This was an intense experience as there were a lot of new impressions to digest when visiting different health facilities. The fact that the qualitative data collection was this time-intensive, can be considered a limitation of the study as it might have influenced the overall quality in some of the interviews. Still, when being aware of the risk of decreasing the quality from the beginning of the data collection, it hopefully has not affected the results.

Further, most interviews needed to be done in collaboration with an interpreter as the researcher did not speak the native language of the participants. This was challenging as it took a lot of energy to follow the interpretations during the interviews. In addition, the interpreter is employed in the A&T office, which might have influenced the participants' answers as the study was conducted to describe the A&T supported training. It is also important to note that, even though there are no reason to assume that the answers disseminated by the interpreter were not correct or inconclusive, the formulation of both the questions asked and the answers might have been changed or reworded during the interviews. Overall, collaboration with an interpreter during this study was experienced to be somewhat challenging. Firstly, it was experienced hard to gain direct and optimal contact with the participants, as one would like to have during in-depth interviews. Secondly, some sentences seemed to be cut short when the interpreter could not find the correct English word for what the participant communicated in Vietnamese. Lastly, in some occasions it appeared as if what was being interpreted was more like a "summary" rather than a direct interpretation, though it is hard to tell when not speaking the native language. This, of course, might have led to important information being missed out. If it was possible to conduct the interviews in English directly with the participants, the results probably would have been more correct. The difficulty with the language barrier continued when transcribing the interviews, as it was sometimes hard to understand what the interpreter communicated with the Vietnamese accent. Nevertheless, this was not a huge problem other than being time consuming, as hand written notes from the interviews helped to catch up when it was hard to understand what was being said. In relation to this challenge, it was an advantage that the interpreter was working in the A&T office. This made it possible to double check when there were any doubts about what was being said.

7.2.1 Generalization of the findings

Another weakness when choosing a qualitative approach using individual in-depth interviews, is that it is not possible to generalize the findings of this specific study to all health staff working with EENC. As described by Payne and Williams (2005), generalization can be described as drawing general conclusions, claiming that what is true for the study sample at one point of time will also be true elsewhere. Even though this study provides important and detailed information about the participants included, it is not possible to claim that their experiences and attitudes can be generalized to other health staff working with EENC in other hospitals. Often, qualitative studies are not generalizable because the study sample often is too small, and the sample is not chosen randomly (Boyce & Neale, 2006). This is also true for this specific study, as the sampling was convenient where participants were recruited due to their experience with implementing and working with EENC, and because they were easy accessible at the time when the interviews were conducted (Etikan, Musa & Alkassim, 2016). Nevertheless, the aim of this study was not to generalize the findings, but to provide in-depth and detailed information about health staffs' experiences and attitudes when implementing a new birth method in their workplaces, as this information might be useful in the future.

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Health staffs' Experiences with Early Essential Newborn Care in Two Provinces in Vietnam

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Background: Early essential newborn care refers to guidelines describing how childbirth and newborn care should be conducted to prevent morbidity and mortality among newborns. The main objective is to describe the Department of Health supported training and implementation of early essential newborn care, conducted in collaboration with Alive & Thrive, by gaining insight to health staff's attitudes and experiences about challenges and benefits regarding training and implementation of the guidelines.

Methods: In-depth interviews based on a semi-structured interview guide were conducted. Health staff were recruited from eight health facilities by convenience sampling.

Setting: Quang Nam and Da Nang in Vietnam in September and October 2017.

Subjects: Health staff (n=21) working in Alive & Thrive supported hospitals in Vietnam.

Results: Health staffs' attitudes and experiences indicate training was necessary to eliminate harmful birth practices. After implementation, health staff experience that mothers and newborns are healthier, and that conducting vaginal deliveries is more effective. A working environment facilitating early essential newborn care and increasing demands from mothers is necessary for implementation to succeed. Challenges, like staff shortage and skepticism to the new practice were identified.

Conclusion: Although there are challenges, training and capacity building is necessary to address health staffs' behaviors related to birth attendance. Correct practice brings positive impacts to the health staff attending birth, mothers, and newborns. The demand to receive this specific birth practice is increasing, and skills, knowledge, and correct implementation is a lifesaving opportunity.

Key words: Vietnam, early essential newborn care, early initiation of breastfeeding, health staff

Background

Under-five mortality [U5MR], referring to number of deaths per 1000 live births before the age of five, is a useful indicator to describe health among children⁽¹⁾. In 1990 global U5MR was accounted to 12,7 million children. To address this concern, U5MR was targeted in the United Nations Millennium Declaration [MDG's]⁽²⁾. Through enormous efforts internationally, U5MR was halved by 2015⁽³⁾. Despite this progress, 5,6 million children died in 2016, mainly from preventable causes, and the goal to reduce U5MR by two-thirds was not reached. Therefore, the work to reduce child mortality is still ongoing and further targeted in the Sustainable Development Goals [SDG's], a framework following up on the MDG's to be reached by 2030⁽⁴⁾.

Even though global U5MR has decreased since targeting the concern, infant- and neonatal mortality rates, referring to the number of deaths per 1000 live births before one year and 28 days after birth, are still high⁽¹⁾. Reduction in these rates are happening in a slower pace than the reduction in U5MR, as complications related to birth practice and premature children has proved to be difficult to prevent⁽³⁾. The neonatal period is considered the most vulnerable time for child survival, and in 2016, neonatal mortality accounted for 46 % of all deaths among children under five years⁽⁴⁾. Therefore, more effective, and affordable interventions on newborn care is required⁽⁵⁾.

In South-East Asia, neonatal mortality is still high. Statistics for the region show that 230 000 newborns die every year. Through simple, preventive measures, 50 000 of these lives could be saved⁽⁶⁾. In Vietnam, indicators measuring U5MR show that the progress have been somewhat slow, but close to achievement⁽⁷⁾. Still, 12,4 per 1000 newborn die during the neonatal period. Most of these deaths happen within the first three days, commonly due to birth practices that could have been prevented by skilled birth attendance⁽⁸⁾. To eliminate harmful birth practices, the World Health Organization [WHO] developed specific guidelines describing how deliveries and newborn care should be performed. The guidelines are a set of steps, referred to as *Early Essential Newborn Care* [EENC]⁽⁹⁾, consisting of immediate and thorough drying of the newborn, immediate skin-to-skin contact, not to cut the umbilical cord before pulsations stops, and early initiation of breastfeeding [EIBF]⁽⁶⁾.

The Ministry of Health [MOH] in Vietnam approved a technical guideline on essential maternal and newborn care in November 2014⁽¹⁰⁾, followed by a guideline on C-section deliveries in November 2016⁽¹¹⁾. To implement these policies, the WHO, United Nations Children's Fund

[UNICEF] and Alive & Thrive [A&T], which is an initiative that aims to prevent illness and ensure healthy growth and development of children⁽¹²⁾, supported the MOH training of EENC and supportive supervision. A&T collaborated with Departments of Health in seven provinces across Vietnam. The support can be described as “capacity building”⁽¹³⁾ where increased knowledge, skills, and further monitoring to support and empower health facilities is central. In total, A&T supported training of 779 health staff in 104 hospitals from December 2014 to March 2015⁽¹⁴⁾. After three years, there have been no study to review the implementation of EENC in Vietnam. To fill the gaps, this study was conducted to describe the A&T supported training in EENC by gaining deeper insight to health staffs’ personal attitudes and experiences about benefits and challenges regarding the training and implementation.

Methods

Data Collection

Study Sample

Qualitative data were collected from eight health facilities in two A&T supported provinces; Da Nang and Quang Nam in Vietnam. The data collection was conducted in September and October 2017. In Da Nang, some hospitals had already initiated procedures of EENC before the A&T supported implementation, hence to strong motivating forces. Nevertheless, 13 health facilities and 185 health staff were provided with training. In Quang Nam, 92 health staff from 23 health facilities received training. Health staff recruited to participate in this study consisted of 21 midwives, doctors and health managers working in health facilities that had received A&T support in training and implementation of EENC. Participants were recruited by convenience sampling, meaning the study sample were not chosen randomly and were easy accessible at the time of the study⁽¹⁵⁾. An overview of the study sample is presented in Table 1. To be included in the study, the participants had to work with birth attendance and newborn care and have experience with birth attendance from before EENC was implemented in their workplace. Apart from this, no other inclusion or exclusion criteria was used.

Interview guide

Prior to the study, a semi-structured interview guide was developed to add more structure to the conversations. The interview guide included questions divided into relevant topics, including questions about 1) expectations to learning outcome from the training, 2) opinions about what could have been done differently to increase the learning outcome, 3) challenges regarding the implementation, 4) whether health staff experience any changes in working environment, 5)

experiences about EIBF and exclusive breastfeeding in their communities, and 6) what the health staff experience as necessary for implementation to succeed. The interview guide was written in English and further interpreted to Vietnamese during the interviews with assistance from an interpreter arranged by A&T. To ensure a safe and familiar environment⁽¹⁶⁾, and to fit the interviewees time schedule, interviews were conducted at the interviewees workplace. To document the interviews, 19 out of 21 interviews were recorded while two interviews were documented by handwritten notes only.

Transcription and analysis

Transcriptions of recordings and handwritten notes were conducted in Microsoft Word shortly after the data collection. The transcriptions only include words spoken, meaning that pauses, laughter, and other types of body language were excluded⁽¹⁷⁾.

Interviews were analyzed using a thematic approach with the purpose of identifying relevant patterns within the data set⁽¹⁸⁾. Relevant segments from each interview was identified and coded. The codes were further aggregated under themes⁽¹⁹⁾. The themes were mainly based on questions in the interview guide, consisting of 1) personal opinions about the training, 2) reasons for EENC to be implemented in hospitals, 3) how to increase the learning outcome from the training, 4) changes in practice after implementation, 5) challenges with the implementation, 6) the importance of a supportive environment for successful implementation, and 7) breastfeeding in the hospital and after discharge. Statements from each theme were compared to examine whether there were any similarities or disagreements, and to identify statements relevant to the purpose of the study.

Results

Health staffs' attitudes and experiences about implementing EENC

When asked about personal opinions about the training in EENC, most health staff expressed they were satisfied and experience their work is more effective today than before EENC was implemented. Typically, it was stated they learned a lot from the training and they see the benefits this practice has for the mother and the newborn.

"(...) it is a simple practice, but it's good for the mother and the baby."

(Doctor1)

Some explained that at the hospital they thought their previous birth practice was satisfying, but after training in EENC they realized it was not. Further, some explained how newborn care was practiced in their workplace in the past:

“... Previously, when a baby was born, it was not put in skin-to-skin contact with the mother. And not breastfed early. The baby might lay next to the mother, but not with the mother”

(Midwife 3)

“So, previously I think that EENC is only related to the obstetric, OB/GYN department, it’s only applied for the vaginal deliveries. But then I attended the training, I know that it also applies for C-sections. (...)”

(Doctor 4)

When asked about experiences about performing EENC, one of the interviewees explained how the birth practice brings positive experiences to the workday:

“It brings happiness into my work (...) we see the benefits of EENC and we see the actions of the baby. Like seeking for the breast, and everything is very natural and very happy to see that.”

(Midwife 2)

Benefits of implementing EENC

Benefits for the mother and the newborn

All interviewees reported that implementing EENC has been successful, and they experience several benefits from implementing the practice. One interviewee shared experiences on how EENC helps mothers recover faster from C-section deliveries than before, where mothers often suffered from side effects due to medications:

(...) Before we applied EENC in the hospital there was quite a lot of side effects that the mother faced after the C-sections. The mother was very tired, or the body was shaking or things like that. But when applying EENC, the mother focus on taking care of the baby. And they feel more excitement and feel better after C-section.

(Midwife 8)

Another interviewee explained how mothers are touched when the baby is put directly to their chest:

“(...) they cry – but this is happy tears. Because some, they have already delivered, but their other babies they did not receive EENC, but when they receive EENC for this baby they are really happy.”

(Health manager 1)

Positive effects on breastfeeding

Some interviewees also talked about how implementation of skin-to-skin contact has helped reduce usage of breastmilk substitutes in the hospital, because the baby's suckling helps the milk production and the mothers can see themselves that the milk production is good:

“(...) We see that the mothers are very happy although they are tired after the delivery, but when they are with the baby they forget all the tiredness and they see that the milk production is better. They see the benefits of breastmilk. (...)”

(Midwife 2)

Although the breastfeeding rates are observed to increase, it was stated some mothers may choose to give breastmilk substitutes despite health staff advising against it. Misconceptions about the baby's needs, and strongminded grandparents were perceived to be important reasons to this challenge:

“(...) For example, some women, they get the skin-to-skin contact and they get the EIBF, but when their babies cry they are still thinking that they don't have enough milk. So, some of them give artificial milk to their babies, because their baby cry.”

(Health manager 2)

“(...) There are some cases when the barriers from the grandparents - when they say that the mothers' milk is not nutritious. That it will make the baby thin. Then they will feed with formula.”

(Midwife 3)

One interviewee talked about cases where the mothers' milk has not come yet, and the grandparents asks for the baby to be fed with breastmilk substitutes. To avoid such cases, empowerment among mothers were observed to be important:

“(...) My observation is that these days younger mothers are more...have more power to persuade the grandparents to follow them (...)”

(Health manager 1)

When asked about whether there are any differences in the attitude towards breastfeeding between younger and older mothers, the same interviewee explained how younger mothers often have easy access to knowledge. Knowledge was thought to be an important factor to whether the mother is likely to breastfeed.

(...) There are differences between the younger and the more older mothers. When the younger mothers, they have access to knowledge, so they are more likely to breastfeed exclusively. And for experienced people – because they already raised some children, and they see that their children still grow and are healthy and intelligent (...)

(Health manager 1)

Another interviewee experienced that older generations are supportive of breastfeeding, and that younger mothers with limited knowledge might think formula is easier:

“(...) They think that using formula is easier. Or expressing the milk and feeding the baby with a bottle is easier for them. And the baby will not stick to the mother all the time (...)”

(Midwife 3)

The same interviewee explained that most of the time, when the mothers have knowledge, they will practice.

Mothers' demanding EENC

When talking about the mothers' reacting positively to EENC, several participants explained how they observe mothers' today have more knowledge about EENC due to increased information from different channels. It was repeated by several participants that mothers today

ask to receive EENC, which is an important reason for the hospitals to implement the practice and perform the steps correctly.

“Since we implemented the EENC we see that it attracts more clients to come to the hospital, because the people now, they have got a lot of information from the mass media channels (...)”

(Health manager 3)

(...) I think for the common woman, most of them know about the skin-to-skin contact-method. So now, when they come to the hospital, the women even know that they have the right to have the skin-to-skin contact-service, so now the women themselves can request in the hospital. I heard stories that when women come to the hospital, they ask “do you provide skin-to-skin contact?” I think it is good to educate women well, so that they know their right (...)

(Health manager 2)

Practical benefits for the health staff

In addition to being beneficial to mothers and newborns, the interviewees explained how they experience practical benefits from implementing EENC. Typically, it was stated that vaginal deliveries are easier and more effective because less staff is needed, and newborns are observed to be healthier:

“Yes, the job is easier. Because previously we would need a person to take care of the baby. Now we do not need that person anymore. With just one person we can be around in case of emergency (...)”

(Midwife 2)

“For the hospital, we do the skin-to-skin. This can be implemented widely in the operating room and delivery room. And at the neonatal unit, we get benefits from that because there are less sick babies (...)”

(Doctor 5)

Challenges when implementing EENC

C-section deliveries

Although health staff do not experience any specific challenges conducting vaginal deliveries, some challenges were identified when talking about C-sections. It became clear that conducting C-sections was experienced as challenging by many participants. Also, even though participants observe the knowledge of EENC have increased among mothers, it was perceived problematic that some women schedules for C-section delivery:

“...That is everywhere in Vietnam. Some families chose the date, the hour of birth.”

(Health manager 2)

“(...) A problem in our country the C-section rate now is very high, and we need urgent solutions (...) we need to – one is educating the women about the benefits of vaginal delivery, and the disadvantages of C-section. (...)”

(Doctor 5)

Apart from the overall challenge that many women request for a C-section delivery, the fact that this birth method acquire more staff was repeatedly stated as challenging.

“(...) When the mother is transferred to the intensive care room after the operation, they do not have enough staff to take care of the mother and the baby and keep the baby with the mother”

(Health manager 1)

“(...) one midwife will be in the C-section room to support the EENC skin-to-skin. But then, if there are more patients here – it’s a delivery – they will need to go back and support with the delivery, so the skin-to-skin will be interrupted.”

(Midwife 1)

C-section during night shift vs. day shift

Additionally, conducting C-sections during night shifts was highlighted as challenging by some. Also, this due to heavy workloads:

“(…) If we have many cases of C-section at the same time, or during the night shift – it’s less staff to do that. So, we cannot do skin-to-skin contact as expected. (…)”

(Doctor 3)

It was explained that usually there are less supervision during the night. This was stated as a challenge when first implementing, as no one would correct the staff if the steps were not performed correctly. Further, it was explained how the health staff now have adapted EENC as a routine, and this is observed to be working well:

There were differences when they first implemented this. During the dayshift, with the supportive supervision from the head midwife and the head of the department, they do it very completely. But then, during the night shift, due to the workloads, and more patients – without the supportive supervision and the on-site support from the head midwife and the head of the department, normally the midwife would shorten the duration on EENC – skin-to-skin (…). But now everything has become a routine activity, and they do it very well.

(Midwife 6)

Health staff barriers

In addition to heavy workloads, barriers with staff when first implementing was pointed out by several participants when asked about challenges. The barriers mentioned were mainly related to skepticism of applying and adapting to new routines.

“One of the challenges with the staff is about the delayed cord clamping, and the requirement not to cover the baby’s umbilical cord. Because some health staff they are a little bit in doubt about this step (…)”

(Health manager 1)

(...) For example, first they do the cleaning with the liquid in the baby's mouth and the nose – they need to take it out. And if they apply EENC they would not do that. And if they would not do that were afraid that the baby would choke – that it would create a problem for the baby. And the second thing is about the delayed cord clamping. Previously they would cut the cord, and they would apply some kind of alcohol onto the cord – to prevent infections. But now, with delayed cord clamping and EENC they will not apply any alcohol. So, they were afraid of infection. So that's a thing they hesitated to do (...)

(Midwife 5)

“(...) the nurses and the midwives will do the deliveries, so they were afraid that the baby would fall when they put the baby on the mother's chest (...)”

(Doctor 1)

The same interviewee then explained that after EENC was applied, they realized that what they had practiced before was not correct and suggested increased supportive supervision could be a solution to avoid and to prevent issues like faulty practice and skepticism to new procedures.

Learning outcome from the A&T supported training

Theoretical vs. practical training

When asked about the learning outcome from A&T supported training, most participants expressed the training was effective because implementation have been successful. Nevertheless, some had suggestions to what could have been done differently to increase the learning outcome. One suggestion was to include more practical training, because most of what they learned was theory.

“(...) They did not have much practice during the course.”

(Doctor 1)

More staff attending the training

Also, it was stated that only a few staff got the chance to participate in training, which might cause difficulties and disagreements when implementing new routines;

“Only a few staff were sent to attend the training, not all (...) I would like for all the staff to attend to get the same information.”

(Midwife 4)

“(...) more staff to attend the training. Some of them attended the training, and they came back and re-trained others. But this is not as good as if all the staff attended the training from the provincial trainers”

(Midwife 7)

More in-depth knowledge

Further, it was suggested that the training could be more detailed. One interviewee asked for more information about long-term benefits to be included:

“We would like to have more in-depth knowledge on the benefits of skin-to-skin for the baby – for long terms. Especially for the pre-term and low birth weight babies – because there are some infections that happens later (...)”

(Health manager 1)

How to successfully implement EENC in health facilities

Adapt EENC as the new “routine”

The importance of adapting EENC as the new routine for implementation to succeed was stated by many and were considered key to make sure every newborn receives the best care possible.

“I think that EENC is very necessary for both the mother and the baby. So, the doctors and the midwives here are very supportive to this. We try our best to do that as a routine, so that no cases will be missed out.”

(Doctor 2)

Supportive environment at the workplace

When discussing the working environment in the hospitals, it was expressed that support from the leader board is important to make implementation of EENC effective. One interviewee explained how the environment in the hospital changed after it was requested to implement EENC, and how close collaboration with other departments and support from the hospital director made implementation easier:

(...) With the environment there's a lot of change (...) Previously they had only 32 midwives, but now there are 48 midwives. And they also received collaboration from relevant departments, including the infection control department and the anesthesia department, so that helped their work more smoothly. Also, close collaboration with other departments and support from the director of the hospital (...) Before that, they didn't have the cap to cover the head of the baby, they didn't have the clothes to cover the baby. But then they were provided, when they requested to do EENC (...)

(Midwife 6)

It was expressed by several of the participants the importance of a supportive leader board for implementation to succeed.

Discussion

The Importance of Skilled Birth Attendance

Findings show that health staff interviewed were satisfied with the training, agreeing training and implementation of EENC were necessary to eliminate birth practices they now perceive harmful to newborns. Changing routines itself was by some experienced as a barrier to implement EENC and that it was especially hard to convince birth attendants who had not attended the original training to change their practice. For instance, it was explained how health staff were sceptic of placing newborns on the mothers' chest right after birth because of fear of the newborn falling. According to Save the Children⁽⁸⁾, assistance from a skilled birth attendant during delivery can prevent about 43 % of all newborn deaths. Nevertheless, *quality of care* is equally important as access to health services. This is illustrated by the fact that in some countries rates in EIBF are higher for deliveries where a skilled birth attendant is not present compared to deliveries attended by health staff. There are several reasons that might explain this. For instance, health staff may perform practices not supportive of skin-to-skin contact and

EIBF, like separating newborns from mothers immediately after birth due to routine check-ups. Or they may lack time, skills, and knowledge to support mothers in EIBF. To overcome this challenge and being able to deliver quality care to every newborn, proper training of health staff attending deliveries and those caring for newborns right after birth is needed ⁽²⁰⁾. Health staff participating in this study observed the barriers they faced when implementing EENC was erased when they observed the actual benefits from performing the practice correctly. It became clear the participants experience the training have provided them with proper knowledge and skills to help both mothers and newborns stay healthy during and after delivery. Apart from being beneficial to mothers and newborns health staff experience practical benefits from implementing EENC as birth attendance is more effective today than before. Especially vaginal deliveries, which was perceived as another important reason to implement EENC.

Personal Motivation

In this study, scientific evidence indicating EENC is favorable to mothers and newborns, health staff observing actual benefits, and mothers requesting and expecting to receive EENC were expressed as motivating factors for health staff to implement the practice. Health staff having an inner motivating force, believing every life should be saved, is an important aspect of *quality* in health care. According to UNCIEF⁽²⁰⁾, this often depends on the mothers and families expecting the health staff will do everything in their power to help mothers and newborns stay healthy, as this study also indicates.

A&T Supported Training vs. “re-training”

Some participants in this study expressed it as negative that not all health staff were offered to attend the A&T supported training, but instead attended a “re-training.” It was argued that it might be harder to convince health staff to follow guidelines and implement new routines if they had not received the original information. This might be an issue in cases where information shared in the original training are left out during “re-training.” This study did not collect data on differences in knowledge and skills between health staff attending original training vs “re-training,” and cannot make assumptions to whether there is any actual difference between the two groups. Nevertheless, a study conducted by Woods and Theron⁽²¹⁾, investigating improved cognitive knowledge in midwives based on a Perinatal Education Programme, found solid improvement in knowledge in midwives who attended a self-directed course. Further, a study comparing self-directed training and training with instructors, found no differences between the two training strategies for improved essential newborn care⁽²²⁾. In cases where a lot of staff needs training this should be taken into consideration, as self-directed

training might empower health staff to influence the hospital leaderboard in a greater extent⁽²¹⁾. In this study, a supportive leaderboard and a supportive working environment facilitating EENC was repeatedly stated as one of the reasons that implementation has been successful. In their study conducted in 1995 Woods and Theron found that health staff trained in their own workplace were able to influence management protocols in cases of conflict with the hospital authorities, and state that personal involvement is an important motivating force for training and implementation to succeed⁽²¹⁾.

Theoretical vs. Practical Training

Some participants argued there was not much practice during the training, and that this should be included increasing the learning outcome. It is individual how people learn best, and that they learn what is being perceived as relevant to their own lives. Learning experiences seems to be more lasting when participants is motivated to learn⁽²³⁾. In this study, participants expressed they were eager to learn about EENC because they want to perform a birth practice beneficial to mothers and newborns. This personal motivation may have had positive effect on their learning outcome from the training. Additionally, some health staff who received training had many years of experience working with birth attendance. Adult learners are often more critical than traditional-age students as they are more experienced and value their life experiences highly. Further, they are often more interested in practical learning than theory and wants to learn exactly what is relevant to their work⁽²³⁾, as mentioned by participants in this study. On the other hand, adult learners are often highly motivated – with motivation being one of the important factors influencing learning outcome⁽²³⁾. This study does not investigate the actual improvement in knowledge level and skills among health staff. Still, monthly monitoring reports from A&T supported hospitals indicates implementing EENC have had a positive impact. Newborns are observed to be calmer, cry less, have a pink, healthy color to their skin and breastfeed more easily than before. Further, mothers are reported to be healthier and need less support from health staff after delivery⁽¹⁴⁾. Even though this specific study cannot make any assumptions to whether there has been a significant improvement in knowledge after the training, other studies that investigated this in the past found significant improvements in both knowledge and skills among health staff, and significant improvement in practice of essential newborn care after completed training⁽²⁴⁻²⁵⁾.

Challenges with the Implementation

Even though more newborns receive EENC after conducted training, some challenges, mainly related to C-section deliveries were identified. Mainly, the participants talked about staff

shortage compared to workload being the primary challenge. It was argued that for vaginal deliveries, EENC is easy to perform even with only one birth attendant present. This, because right after the delivery the mother is usually able to hold the newborn herself. The birth attendant is then free to give essential care to the mother. For C-section deliveries, more staff is needed to care for mothers and newborns. This is particularly an issue when there are more C-sections happening simultaneously. Therefore, even though knowledge, skills and personal motivation among health staff may have improved after training, other challenges, like heavy workloads and staff shortage, may reduce the performance and quality of care⁽²⁶⁾. According to a study conducted by Prata et al.⁽²⁷⁾, health facilities of many developing countries are not able to handle the amount of annual deliveries and argue that the actual capacity of health facilities should be acknowledged by strategies targeting the limitations.

Limitations of the study

Individual in-depth interviews made it possible to gain deeper and more detailed insight into the experiences and attitudes of the study sample, which might have been hard to highlight using other data collection techniques. Nevertheless, this data collection technique comes with limitations. First, it is not possible to generalize the findings from this study to other health staff working with EENC, as the sampling was convenient and too small to generalize⁽²⁸⁾.

In addition, the interviews were conducted in a relatively short period of time, which might have influenced the quality of some interviews. The researcher did not speak the native language of the participants, and most participants were not sufficiently familiar with English for this to be used as primary language during interviews. Therefore the use of an interpreter was required. This may have limited the contact between the researcher and the interviewee, which is an important aspect of qualitative research method⁽²⁹⁾. Further, the interpreter is employed in the A&T offices, which might have affected the participants during the interviews.

Conclusion

This study indicates that although there are challenges, capacity building in EENC is necessary to address health staffs' behaviors related to birth attendance. Further, mothers giving birth today often have easy access to knowledge and health staff participating in this study experience that mothers are empowered to request what is best for their newborn. Therefore, the demand for EENC to be performed and practiced correctly is increased. Nevertheless, even though knowledge, skills and personal motivation among health staff may have improved after training, lack of staff available for birth attendance may in some cases limit the performance. Last, health staff ask for more practical training and in-depth knowledge that can be related to exactly what

is relevant to their work. Overall, this study indicates that practice of EENC brings positive impacts to both health staff, mothers, and newborns. Skilled birth attendance and correct implementation of EENC is a lifesaving opportunity that should not be missed.

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Ethics: Verbal and written consent were given. The purpose of the interview was explained to the participants prior to the interview, as well as their right not to answer certain questions and that they will stay anonymous throughout the analyzation process, development of this article and after completed research. The Norwegian Centre for Research Data assessed and registered the study.

Conflict of interest: None.

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Tables

Table 1: Participants recruited for the study (n=21)

Table 1: Participants recruited for the study (n=21)

Study Sample		
Midwife	Doctor	Health Manager
11	7	3

Appendix 1: Interview guide

Introduction for Interviews in Hospitals in Da Nang and Quang Nam:

Thank you for taking the time to talk to me today. Before we start I wanted to give you a brief introduction to why I am here. I am a Masters' student in Public Health Nutrition, from Oslo University College in Norway. For my Masters' Thesis, I am doing an assessment of the implementation of Early Essential Newborn Care, with main focus on breastfeeding. I will use the information I get from our talk today, to answer some of the questions in my master's thesis. This will be anonymous, which means that I will not mention your name in my assignment or what hospital you work in. If it is ok with you the interview will be recorded, so that it is easier for me to transcribe it later and get the information correct. These recordings will be deleted as soon as I hand in my assignment in May 2018.

Also, I want to let you know that if there are any questions you do not wish to answer because of personal reasons etc., please let me know, and we will skip those questions.

Does this sound ok?

Background:

1. How long have the interviewee been in his/her profession?
2. Can you tell me how a "normal day" at work is like?

The training in EENC:

1. What expectations did you have to what you were going to learn during the training?
2. Which of the topics that were reviewed during the training were especially relevant to you and the hospital you work in?
3. Do you feel that you have learned what you expected to learn from the training?
4. In your opinion, what could have been done differently to increase the learning outcome from the training?

The time after completed training:

1. In what way has the training influenced your practice of your profession?
2. Do you feel that it is challenging to perform what you learned during the training in practice?
 - a. What is more challenging/why is this challenging?
 - b. Are these challenges something you discuss with your colleagues?
3. Do you observe that there has been a change in practice/routines in your Unit/Hospital?
4. In what way does your workplace facilitate for full implementation of EENC?
 - a. In what areas do you think that the facilitation can be improved?

EENC and breastfeeding:

1. First, I would like you to describe what happens when a child is born when it comes to Early Initiation of Breastfeeding – please, tell me something about your experience
2. Is this something new, after you attended the training?
 - a. If so, what happened before?
3. What is your experiences with the mothers' reactions to Early Initiation of Breastfeeding?

4. In your opinion, does the mothers' have sufficient knowledge about exclusive breastfeeding and the benefits of this?
5. What measures are taken if the mother/child is unable to breastfeed?
6. What would you say is the general attitude towards exclusive breastfeeding in your community?
7. What do you think could improve exclusive breastfeeding among mothers in your community?
8. At this regard, did the EENC-training provide you with new knowledge that you can use to improve exclusive breastfeeding?

Benchmarks of EENC

1. Can you explain how the policy from the Ministry of Health was disseminated?
2. At this point, how is the EENC program financially supported?
 - a. Do you get sufficient funding?
3. What is your experience related to how the key stakeholders react to the policy? Do they think that the policy is good/bad?

Health Facility EENC Standards

1. Can you please elaborate on how the training in EENC has influenced the policies and environment in your hospital?
 - a. In your opinion, has the implementation of EENC been successful so far?
 - b. Based on your own experiences, what can be done to make the implementation even more successful?
 - c. Can you tell me something about the challenges you have experienced related to the implementation of EENC?
2. How are the strengths and areas of improvement addressed by the EENC hospital team in your hospital? Can you give me some examples? (How do they gather the data, what are the criteria's?)
3. What measures are being done to make sure that your hospital works to improve and sustain quality of care in the future?
4. Can you explain what is done if inappropriate clinical practices are identified?
 - a. Do you experience that there are any differences in practice of EENC between the day shift and the night shift?
5. Is there a policy against promotion of baby food/ infant supplies in your hospital?
 - a. How do you prevent that health staff does not promote this to the mother or other family members of the newborn?

Questions on Coverage Indicators for EENC

1. What challenges do you experience related to vaginal deliveries?
 - a. In your opinion, what might be the solution to these challenges?
2. What challenges do you experience related to C-sectional deliveries?
 - a. In your opinion, what might be the solution to these challenges?

Questions on Impact Indicators for Newborn Health

1. Can you explain how the data about EENC is collected?
 - a. Do you experience that it is challenging to collect these data?
 - b. Based on your personal experience with collection of data, do you have any suggestions to how these challenges could be solved?

2. Can you explain how the data you collect on EENC implementation is used to improve the program?
 - a. Can you describe what measures is done if negative trends are identified?
3. In what ways do you feel that the reporting is helping your work?
4. At this point, are you collecting data on whether the mother is breastfeeding by discharge or not?
 - a. Do you have a way of registering whether the baby has received any supplements apart from breastmilk before discharge?

Closing:

Is there anything you would like to add?

Appendix 2: Consent letter, English draft

FHI 360

Written Informed Consent for In-Depth Interview

Name of Study: An assessment of the Implementation of Early Essential Newborn Care in Hospitals in Vietnam – Master’s Thesis

Sponsor by Gates Foundation through Alive & Thrive
Principal investigator Nguyen My Ha, 7th floor, 18 Ly Thuong Kiet, Hanoi, Vietnam. Tel:
(844) 3 9348560.

Reason for the Study

I am a master’s student in Public Health Nutrition at Oslo University College in Norway. For my Master’s Thesis, I am doing an assessment of the implementation of Early Essential Newborn Care, with main focus on breastfeeding. The information and results from our talk will help me answer some of the questions in my Thesis.

Your Part in the Study

Your participation is anonymous, which means that your name or what hospital you work in will not be mentioned in the assignment, and that the results cannot be traced back to you.

How You Were Identified

I am asking you to participate because you received the Alive & Thrive supported training in Early Essential Newborn Care.

Possible Risks and Benefits

There is no risk for you to be identified after taking part in the study.

Confidentiality

No one except the Masters’ Student and translator from Alive & Thrive will know that you took part in the study. If you agree, the interview will be recorded. This will make it easier for to transcribe it and get the information correct. These recordings will be deleted as soon as the assignment is handed in in May 2018. If you do not want the interview to be recorded, please let me know before we start the interview and we will not do the recordings.

If the results of the study are published, your name will not be shown.

Consent Form to Be Signed by Participants

The participants review the written informed consent for Interview and state that the following:

I have reviewed the written informed consent for In-Depth Interview and I agreed to be in this focus group study.

Please print clearly:

(Participants' Name)

(Signature of Participant)

Date

Appendix 3: Consent letter, Vietnamese final version

FHI 360

Mẫu chấp thuận tham gia Phỏng vấn sâu

Tên đề tài: Đánh giá thực trạng triển khai hoạt động Chăm sóc sơ sinh thiết yếu sớm tại các Bệnh viện ở Việt Nam

Dự án Alive & Thrive

Điều tra viên chính: Malene Skui, Chuyên ngành Dinh Dưỡng cộng đồng, Đại học Oslo, Na Uy.

Mục đích của khảo sát

Chúng tôi mời Anh/Chị tham gia cung cấp thông tin cho cuộc khảo sát của dự án Alive & Thrive (tổ chức FHI 360) để tìm hiểu thực hành Chăm sóc sơ sinh thiết yếu sớm (EENC) hiện tại nhằm cung cấp thông tin cho công tác xây dựng hoạt động của dự án trong thời gian tới; đồng thời, hỗ trợ trả lời các câu hỏi trong Luận văn thạc sĩ của điều tra viên chính.

Sự tham gia của Anh/Chị

Có khoảng 20 cán bộ y tế và quản lý cơ sở y tế sẽ tham gia khảo sát, mỗi cuộc phỏng vấn sâu kéo dài khoảng 30-45 phút.

Tên tuổi và đơn vị công tác của Anh/Chị sẽ không được đề cập trong báo cáo phân tích.

Tại sao Anh/Chị được mời tham gia

Anh/Chị được mời tham gia khảo sát vì Anh/Chị đã tham gia khóa tập huấn EENC cho trẻ thường do dự án A&T hỗ trợ và/hoặc trực tiếp làm công tác EENC tại đơn vị.

Các nguy cơ và lợi ích

Không có nguy cơ nào đối với Anh/Chị khi tham gia khảo sát.

Tính bảo mật

Chỉ có điều tra viên chính và cán bộ dự án A&T làm phiên dịch viên biết nội dung cuộc phỏng vấn của Anh/Chị. Nếu Anh/Chị đồng ý, cuộc phỏng vấn mới được ghi âm. Việc ghi âm chỉ nhằm mục đích đảm bảo nội dung trả lời được ghi lại một cách đầy đủ nhất. Bản ghi âm các cuộc phỏng vấn sẽ được xóa bỏ sau khi phân tích dữ liệu và hoàn tất luận văn thạc sĩ của điều tra viên chính vào tháng 5/2018. Đánh dấu vào 1 trong 2 ô dưới đây:

Đồng ý ghi âm

Không đồng ý ghi âm

Nếu kết quả khảo sát được công bố, tên tuổi của Anh/Chị vẫn được giữ bí mật.

CHẤP THUẬN CỦA NGƯỜI CUNG CẤP THÔNG TIN

Người tham gia xem xét kỹ nội dung Mẫu chấp thuận và cam kết như sau:

Sau khi xem xét kỹ Mẫu chấp thuận tham gia thảo luận nhóm, tôi đồng ý tham gia khảo sát và giữ kín tất cả các thông tin được trao đổi.

(Tên người tham gia)

(Chữ ký người tham gia)

Ngày

Appendix 4: Assessment by the Norwegian Centre for Research Data



Sigrun Henjum
Postboks 4 St. Olavs plass
0130 OSLO

Vår dato: 23.04.2018

Vår ref: 60329 /3 /HJP

Deres dato:

Deres ref:

Vurdering fra NSD Personvernombudet for forskning § 31

Personvernombudet for forskning viser til meldeskjema mottatt 13.04.2018 for prosjektet:

60329	<i>En vurdering av implementeringen av «Early Essential Newborn Care» på sykehus i syv provinser i Vietnam</i>
<i>Behandlingsansvarlig</i>	<i>Høgskolen i Oslo og Akershus, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Sigrun Henjum</i>
<i>Student</i>	<i>Malene Skui</i>

Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet og øvrig dokumentasjon finner vi at prosjektet er meldepliktig og at personopplysningene som blir samlet inn i dette prosjektet er regulert av personopplysningsloven § 31. På den neste siden er vår vurdering av prosjektopplegget slik det er meldt til oss. Du kan nå gå i gang med å behandle personopplysninger.

Vilkår for vår anbefaling

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

- opplysningene gitt i meldeskjemaet og øvrig dokumentasjon
- vår prosjektvurdering, se side 2
- eventuell korrespondanse med oss

Vi forutsetter at du ikke innhenter sensitive personopplysninger.

Meld fra hvis du gjør vesentlige endringer i prosjektet

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke [endringer](#) du må melde, samt endringsskjema.

Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i [Meldingsarkivet](#).

Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Ved prosjektslutt 30.06.2018 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

Se våre nettsider eller ta kontakt dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Marianne Høgetveit Myhren

Hanne Johansen-Pekovic

Kontaktperson: Hanne Johansen-Pekovic tlf: 55 58 31 18 / hanne.johansen-pekovic@nsd.no

Vedlegg: Prosjektvurdering

Kopi: Malene Skui, ma_sku@hotmail.com



TILBAKEMELDING PÅ BEHANDLING AV PERSONOPPLYSNINGER PROSJEKT

Personvernombudet registrerer at datainnsamlingen allerede er gjennomført. Prosjekter som omfattes av meldeplikten skal meldes senest 30 dager før oppstart. En viktig del av ombudets rolle er å veilede i prosessen med informasjon og samtykke. Førstegangskontakt med utvalget bør derfor vente til personvernombudets vurdering foreligger. Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger omfattes av meldeplikten iht. personopplysningsloven forskrifter § 31.

Det er oppgitt i meldeskjema at studenten ikke meldte prosjektet i forkant av datainnsamlingen høsten 2017 da hun og veileder trodde at det ikke ville bli samlet inn personidentifiserende informasjon i prosjektet. Prosjektet er likevel vurdert som meldepliktig da det er anvendt lydopptak, og det er samlet inn bakgrunnsvariabler, samt at intervjuguiden åpner opp for at de registrerte gjengir egne erfaringer/spesifikke hendelser.

Personvernombudets anser likevel personvernulempen for de registrerte som lav da omfanget av identifiserende informasjon er lite, og det ikke samles inn sensitive personopplysninger. Videre anser vi det som positivt at studenten har tatt kontakt for å avklare hvorvidt prosjektet er meldepliktig.

PROSJEKTVURDERING

Formålet med prosjektet er å vurdere implementeringen av «Early Essential Newborn Care» på sykehus i syv provinser i Vietnam. Utvalget består av 21 ansatte ved 8 sykehus i Vietnam. Datamaterialet har blitt samlet inn ved personlige intervjuer. Utvalget ble gitt skriftlig og muntlig informasjon om prosjektet, og samtykket skriftlig til å delta. Vår vurdering er at informasjonsskrivet til utvalget var godt utformet og tilfredsstillende kravet om et informert samtykke etter loven.

Personvernombudet forutsetter at du behandler alle data i tråd med Høgskolen i Oslo og Akershus sine retningslinjer for datahåndtering og informasjonssikkerhet. Vi legger til grunn at bruk av privat pc er i samsvar med institusjonens retningslinjer.

PROSJEKTSLUTT OG ANONYMISERING

Prosjektslutt er oppgitt til 30.06.2018. Det fremgår av meldeskjema at du vil anonymisere datamaterialet ved prosjektslutt.

Anonymisering innebærer vanligvis å:

- slette direkte identifiserbare opplysninger som navn, fødselsnummer, koblingsnøkkel
- slette eller omskrive/gruppere indirekte identifiserbare opplysninger som bosted/arbeidssted, alder, kjønn
- slette lydopptak

For en utdypende beskrivelse av anonymisering av personopplysninger, se Datatilsynets veileder:

<https://www.datatilsynet.no/globalassets/global/regelverk-skjema/veiledere/anonymisering-veileder-041115.pdf>