PHASE 2 PROJECT TEAM MEMBERS AND RESEARCH TOPICS

North America based advisors
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Vietnam based advisors (****** denotes **co-principal investigators/**topic team supervisors for **Phase 2**)
**Dang Nguyen Anh, Ph.D. *Sociology*. Associate Professor and Vice-President, Vietnam Academy of Social Sciences (VASS) and Director, Institute of Sociology (IOS) Ha Noi
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**Nguyen Huu Minh, Ph.D. *Sociology.* Professor, Director, Institute for Family and Gender Studies (IFGS), VASS, Ha Noi
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Le Minh Giang, M.D., Ph.D. *Medical Anthropology.* Lecturer, Department of Epidemiology, Hanoi Medical University (HMU), Ha Noi

Team members and advisors to work on topics for comparative analysis
1. Dang Nguyen Anh, Nguyen Duc Vinh (Ph.D. *Demography*, IOS), Nghiem Thi Thuy (M.A. *Sociology*, IOS) Advisor: Anil Deolalikar
2. Nguyen Huu Minh, Tran Quy Long (M.A. *Sociology*, IFGS), Tran Thi Hong (Ph.D. *Sociology,* IFGS) . Advisor: Anil Deolalikar
3. Le Thanh Sang and Nguyen Thi Nhung (M.A. *Culturology*, SISS). Advisor: Hy Van Luong
4. Vu Manh Loi and Dao Thi Khanh Hoa (M.A. *Sociology*. MOH). Advisor: Judith Tanur.

Starting from November 2015, the teams will work on the next set of topics or will look more in-depth at the topics that they have been analyzing. Example of the types of questions that will be explored are listed below.

1. Dang Nguyen Anh, Nguyen Duc Vinh and Nghiem Thi Thuy: **More in-depth analysis of Health Insurance Coverage and Utilization and how it is working in the 12 surveyed communes.**
   - What does the data (qualitative and quantitative) tell us about how HI is functioning on the ground in our 12 communes? What works? What doesn't? What are problems/ barriers to utilization and are they different between R1 and R2 or between treated and untreated communes? Are there differences in how well it functions by commune, province, socio-economic group or gender?
   - How can the HI scheme and utilization can be improved based on what the data is telling you about what is going on and why? What factors seem to depress usage (for example, stigma, poor service, "weak" medicine, etc.) and how can they be overcome?
   - What are we learning about the changing role of the CHC due to HI rules and regulations? The CHC used to serve everyone during its official hours. Does it only serve HI patients now during official hours? If true, what are implications of that?

2. <u>Nguyen Minh, Tran Quy Long and Tran Thi Hong</u>: **More in-depth analysis and broader examination of the issues related to Safe Motherhood and infant care behavior and/or knowledge in relationship to AP and AP inspired interventions.**
   - Do the CHCs that have one or both of the **Safe Motherhood and Sisterhood services** interventions show evidence of decreased home birth delivery, increased ante natal checkups and/or decreased the number of low birth weight babies? Comparison would be between R1 and R2 and between treated and untreated communes. The team can emphasize the situation for the disadvantaged by comparing R1 and R2 with attention to the disadvantaged (using low income or low education as proxies) and look at change in knowledge and behavior.
   - The team could also look at knowledge and how reproductive health knowledge has changed between R1 and R2.

3. <u>Le Thanh Sang and Nguyen Thi Nhung</u>: **CHC Assessment and Models: Build an assessment tool for the CHCs based on assessment of each of the 12 CHCs**.
   - What can we say about a "model" CHC – or several model depending on the external environment? Looking at the best CHCs (My An, Ninh Tho and Tan Thai): Why are they good? What makes them work? How have the interventions helped?
   - Compare experiments with privatization models. Look at the way each is working and discuss pros and cons of each. Is there a best model for privatization? If yes, what can we learn from it that could be scaled up.
   - The Role of Leadership. Draw out leadership as an element that is important for success.
   - The three worst CHCs are all remote. What does remote mean? Are any working at all well? If so, why? What are their shared characteristics that make them worst cases? What are their circumstances/contexts? What can we learn from examining the "failed" cases?

4. <u>Vu Manh Loi</u>: **Utilization of CHCs among the disadvantaged**
   - How well are the disadvantaged of various kinds being served by the system? Those with mental and physical disabilities, (Can we identify them?), ethnic minorities, the poor. How well are the needs of the elderly being met? In the HH Survey, there are questions about how likely they are to use CHC, their satisfaction, how they use HI.
   - Once we look at how well each of these categories is being served, the second question could be, what are the characteristics of the CHCs in which they are best served and most satisfied? Here the inquiry is whether any of the AP interventions are relevant to how well these groups are being served and if so how and with what effect if any?

5. <u>Dao Thi Khanh Hoa</u>**: Analysis of each intervention**-- **assess each AP intervention across communes where it is found.** How is the intervention itself functioning? Does it work well? How effective is it? What are the fade and duration effects? Under what conditions does an intervention work better? This analysis will mostly use the qualitative date, especially the case studies but perhaps also the in-depth interviews and facilities surveys. The original case study (2011) of Son Lam and Ninh Tho is a model for this. That case study takes each intervention present in one of the communes and asks how it is functioning.   AP Interventions include:
   - Infrastructure and basic equipment (All Provinces)
   - Family Medicine Doctor (KH Only)
   - MSI and Save the Children (All Provinces but not all CHCs)
   - Laboratory Equipment (KH only)
   - Health Management Information System (TN only)
   - Private Pharmacy Referrals (TN and VL)