

Joint appraisal report

Country	Viet Nam
Reporting period	January to December 2014
cMYP period	Ends in December 2015 (new c-MYP development in progress)
Fiscal period	January to December
Graduation date	January 2015

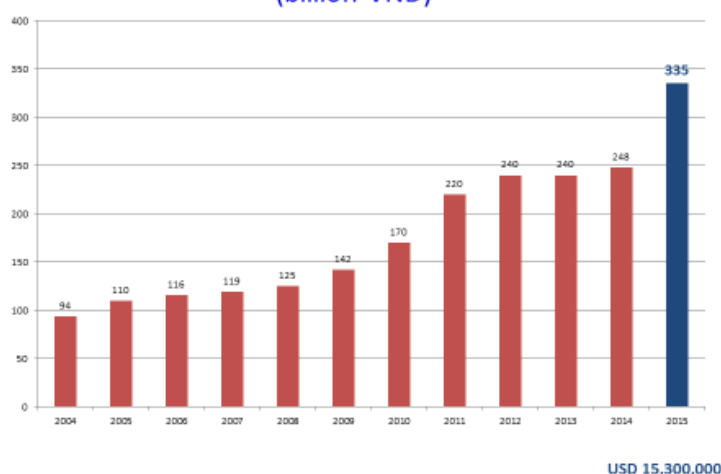
1. EXECUTIVE SUMMARY

1.1. Gavi grant portfolio overview

The relationship between Viet Nam and Gavi can be described in three phases starting way back in year 2002 with introduction of Hepatitis B vaccine and injection safety. Five years later in year 2007, Vietnam became the first Gavi eligible country to take support for Measles second dose introduction and newly launched Health System Strengthening window. Hepatitis B vaccine was transitioned to Pentavalent vaccine in year 2010, and then Vietnam became the first and only Gavi recipient country supported through the Health system funding platform. In recent years Gavi and its partners worked closely with the country for its response to Pentavalent vaccine suspension in 2013 as well as a large campaign with MR vaccine covering close to 20 million children aged 1-14.

Viet Nam's economic growth has been robust leading to its crossing Gavi's eligibility threshold. This impacted the country's ability to introduce more of new vaccines as the reliance on domestic financing is not fully assured. EPI budgets have largely remained stable as illustrated by the following graph:

Total financing from Government for EPI
(billion VND)



USD 15,300,000

However, recent discussions have escalated to the Ministries of Finance and Planning & Investment seeking more funding for EPI to facilitate introduction of new vaccines. The program has been promised an increase of its budget by at least 10% each year. It should be noted that the country is convinced on the need for new vaccines, such as PCV, HPV and Rotavirus vaccine. However, it is constrained by its limitations to secure the required domestic finances, noting that the new vaccines are far costlier than the traditional EPI vaccines. A further consideration for prioritizing the new vaccines include country's vision to manufacture all vaccines in the country. For example, it already produces JE vaccine and Rotavirus vaccine

though neither of them is prequalified by WHO for procurement by UNICEF. Further, health system upgrading and delivery costs associated with new vaccine introduction are significant.

The HSS support in Viet Nam was designed to concentrate the resources in ten selected provinces, identified using the criteria for choosing the ones with lower coverage than other provinces. With an overall national focus on building HR capacities, resources have been preferentially dedicated on competency based training of grassroots commune and village health workers. Conduct of regular and frequent outreach services in ten provinces has been a strategy to achieve higher performance and coverage. As Vietnam has now passed Gavi's eligibility threshold and given the implementation status of the current HSS grant, it will not be eligible to apply for another HSS grant.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- Vietnam completed a large campaign with MR vaccine covering 20 million children between 1 and 14 years age. This was in response to disease outbreaks every 3-4 years in the country. 98.2% coverage was achieved with the campaign. The country is already using routine MSD in its EPI and will transition to MR vaccine. An additional advantage of the MR campaign is building public confidence in the vaccination program which suffered in past due to AEFI deaths and vaccine suspension.
- The strength of the EPI program was demonstrated in restoration of Vietnam's vaccination coverage to 95%. In the previous year, the coverage with DTP3 had dropped to 59% only due to vaccine suspension for 5 months. The Government is empowered with more technical information and has introduced several protocols for an immunization sessions to mitigate occurrence of AEFIs. This has helped in restoring public confidence. This will certainly reduce the probability of a strong decision like vaccine suspension in future.
- The Government commitment to EPI program is high. This is substantiated by the fact that the program will receive at least 10% increase funding each year. In addition the Government is actively considering introduction of other new vaccines into the program.
- The National vaccine store can be considered as a model facility following sound inventory management practices. Good vaccine management practices widely observed in EPI review.
- The National regulatory Authority received the WHO certification.
- Health System Program is delivering the outputs as planned. The programmatic progress and financial reporting are timely and satisfactory

Challenges

- Vietnam did address the issues around AEFIs and vaccine confidence quite well. However, there is continuing lack of full trust in the Government programs. Recently concluded coverage survey highlighted vaccine hesitancy as an important reason for reluctance in acceptance of vaccination program.
- Vietnam is a high coverage country. Yet there are several ethnic minorities and mountainous areas in Northern part which lack good access to the services. The ten provinces supported by the HSS program are doing fine. The lessons from these provinces, mainly focusing on outreach services, need documentation and scaling up.

<ul style="list-style-type: none"> • The Provinces take primary responsibility for delivery of public health services. Their funding for the health sector varies a lot with some provinces not allocating any funding for delivery of EPI services. Similarly, funding by the National Government is under stress with an expected increase in its co-financing as a graduating country. • There is good triangulation of coverage data in Vietnam with frequently conducted MICS and coverage surveys. However, there is presence of a large private sector in large cities of Vietnam which does not report the performance to the EPI. • EPI review highlighted low coverage of HepB birth dose and DTP booster at two years of age. Different schedules for MR and MMR are followed in public services and the private sector. • It is unclear how the HSS grant will transition out. Vietnam cannot apply for Gavi support for HSS again. There are specific concerns about sustainability of HSS supported activities. • Vietnam visualizes itself as a vaccine exporting country in future especially after its NRA has been certified by WHO. However, the manufacturers have issues which need to be addressed, for example, local production of OPV and Rotavirus vaccines is suspended at the moment. • IPV introduction will be postponed by a quarter due to global shortages. There are further concerns at approval of fewer doses by Gavi than requested due to 25% difference between the country's birth cohort with the one used by Gavi; and, absence of open vial policy that would lead to much higher vaccine wastage.
<p>Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)</p>
<ul style="list-style-type: none"> • MOH should evaluate existing HSS grant, including an endline survey to complement the baseline survey, and gather lessons learnt that could be applied nationally for ensuring sustainability of efforts. • Define strategy for low access communes/districts/provinces and estimate costs for service delivery for these areas, in coordination with the NEPI. • Analyse and plan for cold chain capacity needs, including replacement of aging equipment/infrastructure and expansion ensuing from planned new vaccine introductions. This should make use of the upcoming EVM assessment findings and be integrated into the improvement plan within the larger EPI review suggestions.

1.3. Requests to Gavi's High Level Review Panel

<p>Grant Renewals</p> <p>New and underused vaccine support</p> <ul style="list-style-type: none"> • <i>Renewal of Pentavalent vaccine in the existing presentation</i> <p>Health systems strengthening support</p> <ul style="list-style-type: none"> • The program has been fully approved by the HLRP. The panel should note that the last tranche has not been disbursed due to large balance of funds. As on end June 2015, the grant had a balance of more than \$9 million in the bank. The mission was further informed that the HSS project is expected to achieve its objectives by mid-2016 and that there will still be unspent funds of more than \$4 million. The project implemented its activities 6 months later than planned timeline. The savings were made from sources such as wage, operational cost and actual expenditures being lower than planned. Extensive discussions were held
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during the JA mission on utilization of the resources keeping in view the long term benefits to the EPI program with continued focus on coverage and equity.

1.4. Brief description of joint appraisal process

Vietnam scheduled a national EPI Review in end June/early July. This became the right opportunity to align the joint appraisal to make use of most recent situational analysis. The EPI review was integrated with a coverage evaluation survey with division of the country into eight survey units.

The appraisal mission started from last two days of the EPI review when the findings from the field review teams were compiled and presented. The following period of the mission consisted of appraisal dedicated discussions, focusing on annual progress for the year 2014 and recommendations for next year 2016.

The composition of the appraisal team also consisted of some participants from the EPI review – besides in-country participants, UNICEF colleague from EAPRO participated for major part of the JA. WHO WPRO deputed technical officers from EPI and HSS for parts of the appraisal. The initial discussions also included the EPI Coordinator from WHO (WPRO). Gavi secretariat participated with two members including the Senior Country Manager. In addition, the JA opportunity was utilized to present and discuss the Grant Performance Monitoring Framework which is expected to be instituted from 2016 replacing one time submission of annual progress report. The respective responsible officer from Gavi secretariat took this responsibility besides her actively participating in all elements of the appraisal.

EPI and HSS support windows are implemented separately in Vietnam with oversight by different coordination committees. The debrief by the JA team included members of the both ICC and HSCC. Therefore, the JA process was fully aligned with in-country oversight mechanisms.

No field visits were made as the EPI review was fully informed of the field situation. National Vaccine Store was physically visited to look at the inventory and vaccine/supply stocks especially the Pentavalent and MR vaccines. The stock management at the national store is satisfactory, in fact a model system. The emphasis is on better management rather than physical handling of the vaccines – for example, all locally sourced vaccines are directly shipped to the Regional/Provincial stores; the emphasis is on minimizing the hold-up time at National store. The mission was informed that there is no separate national store for dry supplies like the injection supplies.

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

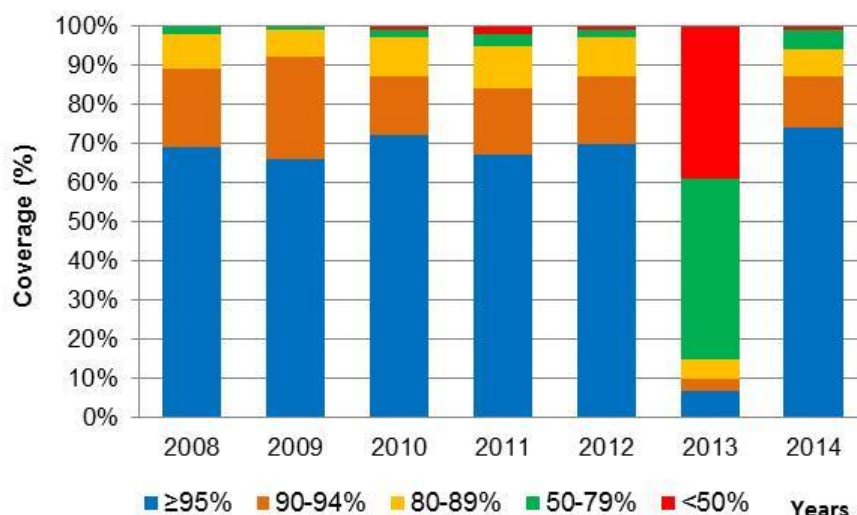
Viet Nam has well-functioning Immunization programme in place for decades, with overall high vaccination coverage achieved and dramatic reduction of vaccine preventable diseases. The strong immunization system serves as a solid foundation for implementing all the planned activities supported through Gavi support since 2002. In the past over a decade, the country has demonstrated its high commitment and great ability to making good progress with the investments from Gavi.

The national authority for vaccines (NRA) is now functional as recognized by WHO and this allows domestic vaccine producers to apply for WHO prequalification of their vaccines. This has further enhanced country's interest in new vaccine introductions for the ones which could be manufactured nationally.

The programme has been facing a few critical challenges. Measles outbreaks occurring every 3 or 4 years, though overall in a decreasing trend over time, has revealed that gaps are still existing in achieving universally high coverage among hard-to-reach population groups, such as certain ethnic minority groups in the rural setting and emerging & increasing migrants in the urban setting. The latest 2014 MICS (full report not yet published) shows a significant difference between DPT1 (96.3) and DPT3 (88.6). Coverage disparity is persistent and prevalent amongst the poor and ethnic minorities as only 72.2% of the poorest and 69.4% non-Kinh children comparing with 83.2% of the richest and 84.6% of Kinh children were fully immunized respectively.

Following the reports of suspected AEFI cases associated with DTP-HepB-Hib vaccine in late 2013, there was extensive media reporting. Though independent investigation concluded there was no concern on quality of the vaccine yet declining confidence on safety of the vaccine and even on overall vaccination emerged; and consequently the coverage for the first and third doses of DTP-HepB-Hib dropped to 83% and 59% in 2013. The MOH and NEPI have been making tremendous efforts to restore the public's trust on the programme and coverage recovered as over 95% in 2014. Yet some concerns on AEFI still remain, not only among the public but also among some vaccination providers; resulting in hesitancy to provide hepatitis B birth dose, frequency of outreach services and guidance on multiple injections at a same visit.

Viet Nam DTP3 coverage by district



In response to the above challenges, the MOH and NEPI have developed action plans while are facing resource constraints to fully implement those plans particularly at subnational levels.

In spite of the continued concern with the AEFIs, it should be noted that restoration of high coverage in 2014 is an acknowledgement of strong community demand for the vaccination. It can be concluded that the Government is much better informed and will find it much harder to call for a strong decision like vaccine suspension in future.

The recent EPI review has witnessed that the overall investment on EPI is considered insufficient by all levels (national, provincial, district and commune levels). There are various problems to secure sufficient funding for operation of immunization programme. The currently available resources meet about 60% of the needs nationwide. Further there are emerging needs for financing of new vaccines and expansion of cold chain storage capacity (including replacing aging cold chain equipment). National investment remains as a major source for immunization programme nationwide. There are variable funding allocations from local governments, such as increased resources (e.g. Ha Noi), limited funding allocation though good economic growth (e.g. Ho Chi Minh) and no investment (e.g. Binh Phuoc and Quang Binh).

Though the country is keen to protect its children from more vaccine preventable diseases through introducing more new vaccines, financial resources are a critical constraint. Further the country is now a Gavi graduating country so financial sustainability of the programme gained high attention. The discussions are going on regarding feasible strategy and timeframes for new vaccine introduction in both short and long terms.

Simultaneous to Gavi graduation, external development assistance to Vietnam is declining rapidly. The number of national healthcare projects are being reduced, however, EPI would remain as one and receive an annual increase of 10% budget for immunization. Further the projected positive trend in economic growth, decentralization of budget with public health sector functions devolved to the sub-national levels and growth of the private sector in large cities will be a potential opportunity to influence and leverage funding for immunization. All external development partners have been reducing their commitments to the country as the country is moving into a fast growing low-middle income category.

2015 is an important year for the immunization programme in the country, with EPI review completed, EVMA scheduled in August 2015 and development of cMYP planned in August-September 2015. The Government is likely to take strategic decisions on introduction of new vaccines.

Currently MOH of Viet Nam is developing the next 5 years health action plan 2016-2020, of which primary healthcare system strengthening and universal healthcare coverage are key priorities, amongst the others. This offers an opportunity for further integration of and creating new mechanisms for financing immunization services, for instance, through healthcare insurance. JA mission was informed that Planning for 2016-20 is the theme for this year's Joint Annual Health Review (JAHR) in October 2015.

The current Gavi-supported HSS grant is focusing on 10 provinces, and managed by a separate Project Management Unit. The HSS grants have been largely investing on primary health care training (including MNCH and EPI), with a priority given to Village Health Workers from ethnic minorities. There is a component of supporting outreach services in hard-to-reach areas, benefiting about 10% of the villages in the 10 project provinces.

While the HSS has contributed to improving local capacity of healthcare staff at grassroots level, it seems challenging to measure its contribution to strengthening the healthcare system in general and immunization system in particular. The HSS's support for implementation of outreach immunization sessions has contributed to increasing local coverage.

Organization of outreach immunization spots follow MoH protocols regarding planning, monitoring and evaluation, specifically as follows:

- Development of professional criteria (in accordance with MoH regulations): in each commune, from 1 to 5 outreach spots are supported (actually more than 70% of communes have 1 or 2 outreach spots); difficult, mountainous, islands communes are supported; villages facing difficult travelling to CHCs; villages often isolated in rainy seasons.

- Provincial Department of Health reviews list of existing outreach spots, select spots to be supported by the project basing on set criteria and endorse the spots to be supported.

- The project supports costs for travelling, drinking water, purchasing of soap, plastic chairs for outreach spot.

- Implementation: monthly, CHCs lists targeted groups to be immunized at CHCs and outreach spots; makes immunization plan (including: task assignment for CHWs and VHWs, mobilization of participation from mass organizations, vaccines estimation, vehicles, records, tools, anti-sock and emergency boxes), sends notice of immunization to targeted groups, informs time and place of immunization.

- Immunization procedures strictly follow MoH protocols and in accordance with MoH regulations (cross checking targeted groups, records, immunization books; doses; consultancy-counselling-vaccination-post-vaccination monitoring-notice of next immunization...). Immunized children are counselled and reminded of the next immunization. HWs makes post-immunization reviews. In case any children who misses immunization or whose immunization is delayed, she/he will be immunized in the next immunization session or HWs will call his/her mother to take him/her to the outreach spots. Almost all children are immunized monthly excepting in some extremely difficult communes, children are immunized following the period of 8-9 months/year.

- After immunization session at the outreach spot, CHCs manage list of targeted groups. For delayed or missed immunization cases, plan is made for immunization in the next session. CHCs review vaccines, medical supplies and destructing vaccines as regulated. In monthly meeting with VHWs, CHCs inform VHWs of the above mentioned groups. As a result, all targeted groups are managed (except for migrant children, children of parents move to work in a far away places...)

- District HWs are assigned to oversight and technically support CHCs on immunization days as well as responsible for data collection... In regular monitoring and evaluation visits by district level, provincial level requests to review and report on implementation of outreach immunization spots in the supervised CHCs.

- Outreach immunization spots are managed as regulated by MoH and in accordance with the project management mechanism.

- HSS PMU requests project provinces report the implementation and management of outreach spots twice a year (bi-annual, annual).

- However, this activity has just covered 15% of villages/10 project provinces. The project offers support to more villages, but localities hesitate to expand.

As regards the sustainability, HSS will develop strategies to ensure sustainability and scaling up of its HSS activities in the extension period if approved.

- During implementation of project activities, PMU and provinces have focused on discussions, sharing experiences and lessons learned on the maintenance of project sustainability upon its ending.
- In meetings, workshops at all levels, leaders of provincial health sector highly appraise HSS model for its contribution to solutions to prioritized health issues systematically (capacity building, supply of essential medical equipment, increasing immunization coverage, management capacity building)
- Measure of HSS contributions to grassroots health sector is manifested in many levels: activity indicators are great contributions. Measure of awareness quality requires studies, evaluations for references and demonstrations.

Two coordination bodies are involved to oversee the implementation of Gavi grants in the country, namely ICC focusing on immunization programme and HSCC focusing on the HSS grants. There is little coordination between the National EPI and Gavi HSS PMU due to structural organization, also attributable to changes in Gavi policies on HSS support during past decade. However, the HSS provided the following statement to underscore the collaboration:

- In project design, HSS PMU consulted NEPI regarding needs, priorities and interventions of the project.
- HSSCC - Chair is the Vice Minister in charge of preventive health (management of General Department of Preventive Health, NIHE) and requests HSS PMU prioritize the project investment in grassroots health and immunization in HSSCC meetings. Director of NIHE is a member of HSSCC who oversees, supports project activities and endorses project plans and reports. In 2015, to consolidate HSSCC under steering of the Chair of HSSCC, Director of General Department of Preventive Health becomes a member (Decision No. 1538/ Q Đ-BYT dated 23 April 2015).
- Training programs and curriculum regarding capacity building for HWs on EPI (ToT courses and training courses on EPI in practice) are designed by NEPI. NEPI gives technical support and monitors training courses conducted in provinces. Knowledge, skills of HWs are standardized and meet MoH requirements on criteria for HWs involving in supply of immunization services (having EPI certificate) contributing to improve immunization quality and increase coverage as commune level can provide more services.
- HSS PMU has closely coordinated with NEPI in development of list of cold chain equipment to be supplied. List of beneficiary CHCs, DHWs are shared with NEPI to avoid overlap.
- During project implementation, HSS PMU participated in ICC meetings and vice versa.
- However, due to the project document was approved with fixed activities, adjustments are hardly made. In the extension period, HSS PMU will more closely working with NEPI to address needs and priorities appropriately.

In conclusion, given the size of the country and the challenges, the MOH and NEPI are keen that Gavi continues to support the Viet Nam's immunization programme during and after the graduation phase, particularly in addressing a few important needs like equity, restoring public's trust, covering funding gaps for expanding cold chain storage capacity/replacing aging cold chain equipment in order to sustain the gains made in the past over a decade with all the investments from the Gavi.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

Considering introduction of new/underutilized vaccines and implementation of supplementary immunization activities starting from 2002 Gavi supported the following activities in the Socialist Republic of Viet Nam:

- roll out of birth dose of HepB mono vaccine (2002-2007);
- introduction of second dose of Measles vaccine for six-year old children (2007-2011);
- introduction of Hib containing Pentavalent vaccine (DTP-HepB-Hib [2010-2015]);
- implementation of Rubella catch up campaign for 9-month – 14-year old males and females prior to introduction of MR vaccine (2014-2015);
- introduction of one dose of Inactivated Polio Vaccine (2016 onwards).

Vaccination coverage objectives indicated in the 2014 Annual Progress Report (95-96%) are basically in line with the adopted regional targets. According to the administrative coverage information reported in the 2014 UNICEF-WHO joint reporting form (JRF) the National Extended Programme of Immunization (NEPI) is overall on track in terms of reaching and sustaining coverage targets. However, for HepB birth dose coverage rate is historically low ranging between 50% and 70%. Due to increased numbers of AEFIs administration of Hib-containing pentavalent vaccine was suspended by the MoH in 2013 from May to September. This resulted in 59.36% coverage for Penta3 in 2013. However, in 2014 Penta3 coverage was restored to high level (95%). No vaccine stock-outs reported/registered in 2014. In 2014 the country was expected to procure 908,900 doses of Pentavalent vaccine as a co-financing responsibility. However, due to higher price of the vaccine the Government could secure, the EPI was able to procure only 760,000 doses in 2014. The rest 148,900 doses are planned to be procured in 2015.

Overall wastage rates reported in 2014 (APR-2014) are in line with the planned targets. However, with regards to IPV situation is expected to be different. Although recently WHO has published revised Multi-Dose Vial Policy the national immunization policy of Viet Nam still does not apply it in practice. Thus, the estimated wastage rate for IPV in 10 dose vial presentation in Viet Nam will be around 35%, according to the NEPI, however, if revised MDVP is applied then recommended wastage rate for 10-dose vial should be not greater than 20%.

Implementation of Measles/Rubella Supplementary Immunization Activities was planned for 2013-2014. However due to late registration of the vaccine in the country (May 2014) actual implementation of the campaign started on 15th September 2014. In application submitted to GAVI the target population for the campaign was 9 months through 14 year old children. However, actual target population was from 1 to 14 year old children. The country changed target population because according to the manufacturer of the MR vaccine registered in the country it is recommended for children starting from 12 months of age.

On conclusion of the campaign, 20,095,947 children were covered in comparison to the planned number of 22,925,499. The approximation of of 3 million can be ignored since according to administrative data SIA coverage reached 98%, which was confirmed by the

post-campaign survey (97%). Average wastage rate is reported around 20% which is lower than planned (25%).

In Viet Nam, both males and females have equal rights for health care, education and other basic rights. However, despite the country achieved and sustains high coverage with routine vaccines there are some issues that need to be properly addressed. Thus, from equity perspective according to the findings of the recently conducted EPI review (2015) coverage gaps exist among some population groups, e.g. living in remote mountain areas, some ethnic minority groups, and migrants. Another issue relates to vaccination of children in private sector in two largest cities and provision of non-EPI vaccines in public sector facilities. According to estimation of the national authorities (NEPI) the share of the private sector in vaccinating children may constitute up to 15%. These challenges affect data quality. One of the problems with data quality is accuracy of denominator/target population. The NEPI acknowledges that due to migration, presence of hard-to-reach communities the denominator might not be accurate and reflect the exact target population. Another problem is the number of children vaccinated in the private sector. The private health care institutions providing vaccination currently do not report to the NEPI. Primary health care workers in some cities and areas try to monitor the children vaccinated in the private institutions, however, this approach is not universal and in the current circumstances it is not possible to precisely estimate the share of private market in vaccinating children in Viet Nam.

In 2015 Viet Nam is planning to introduce with GAVI support one dose of IPV vaccine in routine immunization schedule. This introduction is a part of global polio eradication initiative, therefore, its importance and proper implementation cannot be overestimated. Initially the country was planning to introduce the vaccine in October 2015, however due to global limited supply of IPV vaccine Viet Nam will not be able to introduce the vaccine earlier than January 2016. According to the country's application the target population for 2015 and 2016 was indicated as 457,915 and 1,850,260 children under 1 year of age respectively. According to GAVI's decision letter approved numbers are much lower, e.g. 326,500 and 1,242,900 for 2015 and 2016 respectively. Even considering the latest reported number of surviving infants (JRF 2014) which is 1,737,471 for 2015, the approved target population for 2016 means that almost half a million children simply will not be able to receive IPV vaccine and get protection against poliovirus type 2. This situation needs to be resolved by GPEI and Gavi.

Yet another key milestone is WHO certification of Vietnam's National regulatory Authority. This opens up the possibility of vaccine introduction/support by nationally produced quality assured vaccine products. This factors in significantly in country's consideration for introduction of new vaccines into its EPI program.

3.1.2. NVS renewal request / Future plans and priorities

Pentavalent vaccine has been restored back reaching high coverage in 2014. There was pressure on vaccine stocks in the first quarter of 2015 since many children who missed the vaccine in 2013 came back to receive delayed vaccination. This was coupled with the fact that some stocks of the vaccine received prior to its suspension got expired. Pentavalent vaccine will continue to receive Gavi support, however, the country co-financing will ramp up by 20% each year. In last quarter of 2015, Vietnam will procure its co-financed part of the vaccine, including the short number last year for which it is considered as a default country at present.

Considering underestimated target population number approved for IPV support in 2016 it is crucial to adjust this number in order to make sure that the country receives required number of doses to cover actual target population. The situation with IPV vaccine in Viet Nam is further complicated by the limited supply of IPV vaccine and delayed introduction – May 2016 instead of planned October 2015. Introduction of IPV vaccine is an important part of global polio eradication plan. If the vaccine is not introduced before April 2016 (when global switch

from tOPV to bOPV is scheduled to happen) then of the entire birth cohort will not be protected against type 2 poliovirus till the time IPV is actually introduced. During the discussions, it was informed that Vietnam should reach out to Gavi after IPV introduction if and when they expect utilization of IPV stocks within following three months' period.

Viet Nam is a graduating country meaning that the country is not eligible to apply for GAVI support after 2015. However, it still has an opportunity to apply for new vaccines by September 2015 deadline. The country is considering introduction of rotavirus, pneumococcal, Japanese encephalitis and human papillomavirus vaccines. However, final decision is not made. In addition current cMYP ends in 2015 therefore in order to be able to apply for new vaccine support the country needs to develop new cMYP. The NEPI requested technical support in developing new cMYP, particularly in costing the financial part of the plan.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

Vietnam continues to report satisfactorily on completion of activities pursued in the 10 provinces supported through HSS. Higher than 90% of planned activities for 2014 were conducted, with only the supply of essential equipment to district health centres, commune health centres and village health workers reported below 90% completion (80% complete). By April 2015, all courses planned till end 2014 were completed. The delays for this specific activity are explained in detail in the APR, noting legal process changes and the need to ensure a thorough review of equipment needs as key factors in the delay. The HSS project management unit (PMU) are confident that all procurement planned under the HSS grant will be completed by November 2015 and supplied to beneficiary facilities and health workers.

For most of the other activities not 100% completed in 2014, the remaining activities have already been completed in 2015 (e.g. remaining training courses).

Considering that the vast majority of indicators included in the HSS M&E framework pertain to activity or process level indicators, Vietnam has complimented this monitoring with focused evaluations of different HSS support activities. For example, the "Evaluation of outreach immunisation sessions in some project communes funded by Gavi" assessed that commune health workers have good knowledge and skills in immunisation (percentage of health workers who knew about correct immunisation schedules, dosage, injection routes and sites ranged from 70-90%).

In 2014, HSS funds supported 2,256 outreach immunisation spots, benefiting about 10% of villages within the selected 10 provinces receiving HSS support. Around 274,843 children were immunised through these outreach spots and 64,408 women were vaccinated against Tetanus. These outreach spots also provided integrated delivery of other health interventions, such as the provision of Vitamin A. The majority of beneficiaries of the outreach activities are ethnic children and women.

All evaluations and HSS progress reports are shared with the HSCC and they request feedback from each province to ensure that the recommendations from each of these focused evaluations are considered and appropriately taken forward for 2015 and 2016 HSS activities.

As highlighted above, considering Vietnam's upcoming graduation from Gavi, it is vital that Vietnam conducts the endline survey and overall evaluation of their HSS support, to gather lessons learned and establish plans for sustainability of the activities supported by HSS. Lessons learnt will be shared with stakeholders at central and local levels. Documentation of project materials will be focally carried out. HSS model is disseminated, encouraged to be scaled up. In 2014 review workshop, the project director held a special discussion on

maintenance of HSS model and sustainability of the project after it ends, especially plan for regular investment sources to achieve targets on capacity building, immunization coverage, maintenance of supplied equipment, integration of cost of laboratory services into general cost of district level and health insurance package. This evaluation should also shed more light on some of the results of the project overall. For example, not just confirming the numbers of village health workers trained, but also looking at the numbers of these health workers who returned to their villages and how long they subsequently worked there. Vietnam must also evaluate how to transfer the current financing model for HSS activities from Gavi HSS funding to the government, otherwise there is a real risk of termination of current HSS activities post-graduation. It is recommended that the HSS PMU use the evaluation to seek recommendations on how to maximise sustainability of HSS activities such as training, ensuring the maintenance of equipment purchased and how to continue outreach activities. HSS PMU will propose funding sources for specific activities for sustainability, in the meantime, shares HSS model with other projects for application and scale up. Support from local authorities are focused and mobilised by provincial health departments.

Despite good implementation rates in terms of activity completion in 2014, with \$8.47 million remaining to be spent for HSS implementation before the end of 2015, there are questions about whether Vietnam may need more time to fully utilise HSS funds. The last tranche of \$4,247,712 was disbursed in 2014. The final tranche of \$3,562,452 remains to be disbursed by Gavi. Low utilisation of funds (40%) persisted in 2014 (although a marked improvement on the 16% cash utilisation rate reported in the 2013 APR). Although the HSS PMU is confident that the remaining \$5.1 million to be spent on procurement in 2015 will be spent in time, there remain questions about their ability to spend the remaining \$3.35 million for activities such as training and outreach by end 2015. The PMU stated that 6-9 month training courses for VHWs which were opened in 2014 will be complete in 2015 and budget for these courses will be disbursed in 2015. The budget will be used for training activities, support outreach immunization spots, JAHR, supervision and monitoring in 10 project provinces, which makes up 3 million US dollars. Remaining budget for procurement will be disbursed in 2015 as well. Thus, disbursement of remaining \$3.35 million by the end of 2015 is feasible. The 2014 APR states several activities will be carried forward to 2016, including provision of additional training courses, continued support to 2,320 outreach spots, support for the JAHR 2016, M&E visits at various levels, and additional studies and research.

During the JA, the HSS PMU requested an extension of the HSS grant to 2017 in order to spend the final tranche (yet to be disbursed by Gavi). It clarified that all grant objectives of the grant will be achieved by mid-2016 therefore these funds would be spent to largely maintain / extend current activities. HSS PMU was strongly encouraged to develop a proposal for this final tranche of funds in collaboration with NEPI and partners as opposed to viewing it as a simple extension. Concerns were raised about the sustainability of current activities and continued value / need of these in comparison to other potential investments. Several activities recommended as part of the recent EPI review, such as costing analyses, were highlighted as key needs that could be supported by HSS funds, particularly in view of HSS underspend to date. The PMU stated that it would closely work with NEPI to identify prioritized activities in the extension period. Actual implementation of the project activities in the past years has shown that project activities and objectives crucially meet practical needs of the provinces (more training courses for VHWs and EPI training for HWs to increase capacity of grassroots HWs). Costing analysis will be a prioritized activity.

Vietnam appears to have relatively robust immunisation data systems in place. The latest independent survey conducted (MICS5, 2014) recorded DTP3 coverage as 88.6%; MCV1 at 86.2% and fully immunised child as 75.6%. WUENIC, country administrative reported data and official estimate all report consistently the same coverage estimates for several years. Despite no evident discrepancies, NEPI did identify data quality as an area that could be

further improved. Viet Nam does not currently have a data quality improvement plan in place nor conducts independent data quality assessments. However, supervisory visits do assess data quality and seek to establish timeliness, accuracy and completeness of reporting. NEPI highlighted timely data as a particular area for future attention and the recent EPI review recommends the need to standardise birth registration systems and strengthen existing systems to enable health workers to trace children.

3.2.2. Strategic focus of HSS grant

As described in the original proposal, the overall objective of this HSS support is to strengthen the health care system, with a focus on grassroots level in 10 provinces to contribute to sustained and increased high coverage of quality basic health services, particularly EPI and MCH outcomes. The HSS PMU classified project activities under three main themes:

- 1) Development of human resources for health in challenging provinces;
- 2) Strengthening service delivery capacity to provide good basic health care services; and
- 3) Strengthening management capacity in response to the needs for health sector reform and development.

These three themes appear to continue to be of relevance in Vietnam, and several aspects, such as the ongoing need to provide management and immunisation in practice in training, were specifically highlighted in the recent EPI review as areas for ongoing need / attention. Priorities will be given to EPI training, outreach immunization spots, integration of supervision on immunization – utilization of equipment – post training, development of AHR, HMIS. HSS will coordinate with NEPI to prioritize immunization model in difficult areas, activities contributing nationwide immunization system (policy, IEC for immunization).

The selection of Gavi HSS impact and output indicators are also strategically aligned with Vietnam's selected essential health indicators, notably percentage of children under one year of age fully immunised, percentage of villages with a village health worker, percentage of community health centres meeting national health benchmarks and child and maternal mortality. These indicators are included in the 5-year health sector plan (2011-2015), included in the Joint Annual Health Reviews and Viet Nam's HMIS.

As noted above, there are questions pending about whether the final tranche of Gavi HSS grant could be further aligned with current needs and priorities, for example, through incorporating and supporting some of the EPI review recommendations, working closely with NEPI.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

The program has been fully approved. However, the last tranche of \$3.56 million is yet to be disbursed to the country, driven by slower than planned utilization of the funds. At the time appraisal, it was reported that the project had a balance of over \$9.4 million in end June 2015. During the JA mission, extensive discussions were held with both PMU and members of HSCC on the options which could consolidate EPI infrastructure in the future. The project estimates an unutilized balance of \$4.2 million towards end of the originally planned duration of the program. It was recommended that the HSS and EPI must work together on how to utilize the remaining HSS funds with an objective of long-term utilization and sustainability. As a graduating country with high coverage, Vietnam will not have another HSS grant from Gavi.

3.3. Graduation plan implementation (*if relevant*)

Vietnam became a graduating country since January 2015. It has expressed an interest to apply for selected new vaccines by September 2015. It is recommended that a graduation assessment for Vietnam should be carried out after review of Vietnam's planned application for new vaccines in November 2015.

3.4. Financial management of all cash grants

It is important to note that a cash programme audit is to be conducted on behalf of Gavi by Price Waterhouse Cooper (PWC) in Q3 2015 (September-October). This audit will conduct a thorough review of Gavi's investments, particularly HSS, and MR campaign operational costs.

HSS funds continue to be managed by the HSS PMU and the 10 provinces receiving support. Annual workplans are developed and approved with associated financial plans and budget. These are submitted to the Minister of Health for approval. Based on the approved plans by the MoH, Provincial Peoples' Committees endorse the implementation and financial plans for their own provinces. The approved provincial plans are the core documents for Provincial Finance Departments to manage and follow-up the use of funds at provincial level. All 10 provinces prepare quarterly financial reports on the project funding sources and utilisation of funds. These are shared with the PMU and reported to HSCC, MoH and Gavi. All Gavi HSS transactions are uniquely coded, reported at activity level and retained for external audit purposes and accounting control.

For the reporting period of 01 January to 31 December 2014, the GAVI- Health Systems Strengthening (HSS) fund reported a balance of 8,340,255 USD to be carried over into 2015. The majority of the HSS fund was utilized for the implementation of Objective 1 (Support Human Resource Development for Health, 61.73%), Objective 3 (Strengthening of Management Capacity for Health Sector Reform, 15.42%), and Objective 2 (Supply of Essential Equipment, 13.91%).

During the JA mission, the PMU also reported on HSS expenditures from 01 January to 30 April 2015. When combined with the income from the third tranche payment in late 2014, the remaining balance for the HSS grant as of 30 April 2015 is 11,480,410 USD. The PMU outlined the projected disbursements in the last 6 months of 2015 to be approximately 8,473,880 USD, of which 5,121,299 USD (60.44%) will be utilized on procurement of essential equipment that were delayed in 2014.

It is worth noting that these Health Systems Strengthening activities remain fully funded by Gavi HSS funds, but unlike vaccine procurement, the government has yet to take financial co-ownership of these activities. It is essential for the sustainability of the EPI programme, as well as the wider delivery of health services in Vietnam, to sustain these activities beyond the expiration of Gavi support in 2016.

The country is due to share its report on the use of ISS funds in 2014 (remaining balance as end of 2013 was \$150,373. Gavi is expected to receive the 2014 financial statements showing 2014 opening balance, expenditure and closing balances. Similarly, Vietnam is requested to submit an audit report for 2014.

Vietnam has submitted audited financial statements for the period of 2013 up until fiscal year end 31 December 2014 for the Measles-Rubella campaign. The auditors reported that, "*in our*

opinion, the Financial Statements give a true and fair view, in all material respects, of the financial position of the project.” The cash programme audit will have to review remaining cash expenditures in 2015 and how much exactly of these funds remain unspent. During the JA mission, NEPI estimated there is around \$4 million left unspent between the vaccine introduction grant and operational costs received for the MR campaign. NEPI provided the financial statements and reports on cash utilization and proposal for use of the remaining funds. The plans to utilize the remaining funds on EPI activities mainly focused on a limited MR campaign for two additional years’ cohorts (children aged 15 and 16 years) and child bearing age group women since it is left with large stocks of the vaccine also.

Total expenditure for the immunization programme is approximately 62.8 million USD in 2014, a significant increase from 23.2 million USD in 2013. This increase is mainly attributed to a significant increase in SIAs (campaign) costs from the nationwide Measles Rubella campaign. Government expenditure on immunization programme has also increased from 12.8 million USD in 2013, to 15.4 million USD in 2014, representing a 20.4% increase; however government funding only represented 24% of the total financing in 2014, due to the significant funding from Gavi for the MR campaign, making Gavi the major source of financing for the EPI program (75%). As a proportion of the total General Government Expenditure on Health, the government expenditure on immunization programme has increased from 0.30% in 2013 to approximately 0.36%* in 2014 (*GGHE as reported in 2013).

Government expenditures primarily covered for Traditional vaccines (32.49%), other recurrent costs (19.24%), and new and underused vaccines (18.70%). The profile of the government expenditures has remained similar to that of 2013, where the above three expenditure categories remain the major expenditures on immunization from government funding. Despite the overall increase in government funding as aforementioned, it is surprising to observe an absolute decrease on financing for new and underused vaccines (-14.02%) and other recurrent costs (-18.70%), whilst a significant increase for traditional vaccine (+24.14%), coldchain equipment (+500%) and campaign costs (+2142%) was observed. The introduction of the MR campaign is likely to have changed the priorities on immunization expenditures in 2014.

Vaccine costs (for both traditional and new vaccines), from all sources, are approximately 18.4 million USD, representing 29.30% of total expenditures in 2014; this has increased in absolute terms, but decreased in proportionate terms from 70.17% in 2013. This significant decrease can be again attributed to the significant campaign costs in 2014. Other than activities implemented by UNICEF, WHO, GAVI is the only external donor towards vaccine costs in Vietnam, 2014.

It is worth noting the vaccine schedule for Vietnam will include the introduction of IPV in 2015, and this is likely to increase vaccine costs for Vietnam. However, IPV costs will be covered entirely by Gavi/GPEI. Vietnam has consistently increased its effort in taking financial ownership of their immunization program over the past years, but still remains heavily reliant on Gavi for new and underused vaccines financing. In consideration of the relatively short time before Vietnam must become financially fully self-sustainable, any interest in the expansion of its vaccine portfolio to include new vaccines must be considered very carefully. Vietnam may no longer apply or renew for HSS support, and the country should prioritize in meeting the fiscal needs of its existing programme costs, such as sustaining its HSS activities, as well as fully financing its routine vaccine portfolio to its entirety by 2017.

Recommended Actions	Responsibility (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
Conduct the EVM assessment, develop and cost the Improvement plan including cold chain expansion	Government, <u>UNICEF</u> , WHO	October 2015	Already covered in business plan
Develop a new c-MYP and application for Gavi support should the Government decide so	Government, <u>WHO</u> , UNICEF	September 2015	Already covered in business plan
MR campaign – provide final reports, fund utilization report and plan for utilization of unutilized vaccine stocks/funds	Government	August 2015	None
Introduction of IPV in routine EPI and switching from tOPV to bOPV.	Government, <u>WHO</u> , <u>UNICEF</u>	May 2016	Indicated in TA
Conduct an evaluation of HSS grant with endline survey, including lessons learnt for sustainability and scale up of the activities	<u>HSS PMU</u>	June 2016	Funded through the HSS grant
Develop a plan for full utilization of HSS grant beyond June 2016 in close consultation and endorsement by the EPI program	<u>HSS PMU</u>	December 2015	None
Communications: implement the national communication plans for EPI focusing on demand generation and vaccine hesitancy	Government, <u>UNICEF</u>	Long term activity – strategy and plan in place by December 2015	UNICEF TA
Introduce policy/regulation for reporting of vaccination in private health care facilities	<u>Government</u> , WHO, UNICEF	June 2016	None

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

The following areas will be the focus of NEPI in Viet Nam in 2016 and beyond:

- 1). To achieve high and equitable vaccination coverage, as a foundation to achieve and sustain the gains made in eradication/elimination (polio, MNTE, measles, rubella,) and control of other VPDs (e.g. Hepatitis B).
- 2). To improve performance of VPD surveillance, with a priority given to AFP and measles/rubella surveillance. Developing and implementing a VPD surveillance improvement plan following an in-depth surveillance review has been recommended during the recent EPI review.
- 3). To prepare for introduction of new vaccines including financing, cold chain system expansion, communications, training, etc.
- 4). To continue increasing the public's confidence on the immunization programme.

The WHO and UNICEF will work together to assist the MOH/NEPI in developing the new cMYP as well as implementing the annual EPI workplan to address the priorities highlighted above, with the following focuses from each organization:

WHO

In line with the GIVS and GVAP, WHO has been supporting NEPI/MoH;

1. Strengthen routine immunization activity, especially in the hard-to-reach population. "30 years of vaccination in Vietnam: Impact and cost-effectiveness of the national expanded program on immunization" was published in Vaccine for better advocacy. (ref. Vaccine 33S (2015) pp A233-A239)
2. Strengthen VPDs' surveillance including case-based national surveillance for AFP and Fever & Rash, and sentinel surveillance for Japanese encephalitis, congenital rubella syndrome (CRS), rota virus diarrhea, invasive bacterial meningitis and typhoid fever. This includes the support to NIHE in Hanoi and Pasteur Inst in HCMC as the accredited national laboratory under WHO/WPRO laboratory network.
3. Support NEPI for outbreak investigation and immunization response for measles (large outbreak in 2010, 2013-14) and polio (VDPV type2 outbreak in 2012), including measles SIA in 2010, Polio SIA in 2012 and MR-SIA in 2014-15. Measles, MR and polio SIA has been closely monitored by WHO and UNICEF joint team.
4. Support MoH to make National Regulatory Authority (NRA) for vaccine functional. The technical support has continued for last 14 years since 2001. The formal NRA assessment was conducted on 13-17 April 2015 by WHO international assessment team. NRA was certified as functional now by WHO from June 2015. The next evaluation will be in next two years. The vaccine pre-qualification process can be started.
5. Support NEPI to conduct EPI review with WHO/UNICEF/PATH international team in June 2015. 8 provinces were selected. 30 cluster survey covered a sample size of 14,400 samples to assess coverage, including that for DPT4/MCV2, TT for PAB and MR-SIA. Facility based survey was conducted at provincial PMC, two district PMCs and four commune HCs in each of 8 provinces.

In the WHO biennium 2014-15, WHO supported NEPI, total amount more than 1,2 million USD for above activities. The main achievements were included in the following reports;

1. Report of national verification committee (NVC) for measles elimination
2. Report of national certification committee (NCC) for polio eradication
3. NEPI's national surveillance report; AFP, measles/rubella, and sentinel surveillance report of JE, rota, bacterial meningitis and CRS
4. Laboratory performance report from NIHE and PI on polio, measles/rubella, JE, rota and bacterial meningitis
5. Accreditation report for WHO lab-network on polio, measles/rubella and JE
6. HepB BD impact of AEFI in Vietnam in 2013 on chronic HepB infection, Congenital rubella syndrome (CRS) in 2011-2012, - CRS epidemic after rubella epidemic in 2010-2011 (ref, Vaccine 33 (2015) pp3673-3677)
7. Report of MR-SIA (not yet available)
8. NRA formal assessment report
9. EPI review report will be drafted in August 2015

UNICEF:

UNICEF has been playing an important role in supporting for improving equitable access to immunizations, raising public awareness and building up trust on immunization, communication capacity building, timely planning and procurement of vaccines and devices, facilitating registration of new vaccines financed by Gavi, and co-chairing the ICC.

In the reporting period, UNICEF provided support to the following areas:

1. In response to a request from NEPI, UNICEF assisted NEPI in developing a national Plan to Strengthen Immunization Services in Hard-to-reach Areas in Viet Nam; and also in simplifying national guidelines to adapt Reaching Every Community Strategy (REC).
2. With UNICEF's support, MOH and national EPI developed and endorsed a National Communication Plan for Immunization, 2014-2016.
3. UNICEF supported development of a Media Toolkit and training senior officials from MOH, EPI and all provinces, as an effort in enhancing the national capacity in planning for, responding to AEFIs, and engaging with mass and social media to maintain trust and confidence on immunization.
4. For MR SIA and MR introduction, communication strategies and communication package (e.g. video clips, leaflets and posters) were developed, piloted and used in the national wide MR campaign. In addition, effort was made to timely plan, procure and distribute MR vaccines and devices.
5. In area of supply chain system, UNICEF has contracted a global expert to lead EVMA in Viet Nam and assisted in developing EVM Improvement Plan in 2015; and also procured 1775 Fridge Tags to assist NEPI in establishing continuously temperature monitoring systems.
6. For IPV introduction, UNICEF assisted NEPI in developing the application proposals, registering vaccine and arranging IPV supply.

In addition, UNICEF will be providing technical assistance in Q4 2015 in development of a training package, operational guideline, and the IPV Switch Plan for introduction of IPV.

4.2 Future needs

WHO

In line with the priorities highlighted in the Section 4.1, WHO likes to propose the following technical assistance sharing with UNICEF the key elements in its country support program for Immunization in 2016 - 2017, with associated funding needs to ensure the planned activities to be well implemented:

1. To secure essential human resources allocated in WHO Vietnam to provide senior technical assistance to NEPI/MoH to implement above various critical EPI activities.

Funding need for HR; 250,000 USD per year for P5 Medical officer post.

Background; At present the EPI activity in WHO CO is supported only by one Medical Officer EPI, In addition one short term professional (STP) and one short term consultant (STC) are assigned temporarily now with the following responsibilities: STP assists on VPD surveillance including new vaccines. STC assists NRA on six functions in four institutes.

It is critical to continue and have support from Gavi for WHO the position of Medical Officer EPI as at the present others donors could not find the sources of support for this position for the last 3 years and it was supported by Gavi funds. It is especially important when taking into account the plan of MoH to introduce New vaccines during 2016-2020 and address the issues of growing vaccine hesitancy, needs to strengthen AEFI surveillance, growing vaccine hesitancy requiring provision of regular technical assistance from WHO on day to day basis. In addition WHO Medical office will continue to address the multiple responsibilities including major outbreak of vaccine preventable diseases investigation, and outbreak immunization response, requiring the coordination with WHO on all levels as Regional office and WHO HQ and partners, and also to address the needs of WHO technical support in multi year planning, advocacy to the partners including high level policy making for introduction of new vaccines, Immunization system strengthening and development and updating of National EPI multi year plans in context of evolving program needs. At the present the fund for P5 post is essential, but unstable and needed to be secured.

2. To accelerate and to improve the VPDs' surveillance is essential activities of EPI. VPD surveillance such rota, JE and Hib and Pneumococcus bacterial meningitis help MoH of the evidence based introduction of new vaccines with the financial sustainability assessment of government.

Funding need: 150,000 USD per year

Background; WHO CO support NEPI of the most of case-based and sentinel surveillance. In order to secure the present surveillance system and to expand the provincial sites for population based data, the stable fund is needed.

3. To support NEPI to monitor the increasing population in the large cities becomes important issue to sustain the quality of routine immunization in Vietnam.

Funding need; 100,000 USD per year

Background; The new innovative intervention is explored to monitor the population who access immunization both EPI and non-EPI vaccine. This would require the new funding to support NEPI.

4. To secure the safety, quality and efficacy of domestic and non-domestic vaccine, the functional NRA is essential for MoH Vietnam.

Funding need; 100,000 USD per year

Background; WHO CO's assistance to maintain and sustain NRA quality is critically important. Re-assessment is planned in next 2 years. The vaccine pre-qualification application can be started now, but need the funding support as well.

UNICEF:

Based on the analysis emphasized in the earlier sessions of the JA and the recommendations from the 2015 EPI Review, UNICEF will focus its support in the next few years in three areas as follows:

1. Improving immunization equity,
2. Enhancing immunization supply chain systems,
3. Restoring the public' confidence on immunization programme.

UNICEF likes to propose the following technical assistance as the key elements in its Country Programme for Immunization in 2016 and 2017 with associated funding needs to ensure the planned activities to be well implemented:

1. To secure the essential human resources, to be built on the existing HR structure/staffing, to implement the activities and achieve the expected outcomes highlighted below.

Indicative budget: 120,000/year (covering 60% of the salary costs of one existing MCH specialist and 40% of the salary costs of one existing C4D specialist)

Modality: national staff

Justification: Currently there is one MCH specialist (national staff) available to support EPI in UNICEF Viet Nam and this takes 60% of his key assignments. In addition, there is one C4D specialist, who work under the coordination of the MCH specialist, providing support to MOH and EPI to assist in implementing the national communication plan; and this work takes up 40% of this staff's key assignments. Given there is no EPI post in UNICEF Viet Nam, the GAVI funding will be crucial to secure such capacity within UNICEF Viet Nam to support MOH and NEPI.

2. To accelerate the implementation of the national Plan to Strengthen Immunization Services in Hard-to-Reach Areas.

Indicative budget: 100,000/year

Activities: workshops/trainings, supportive supervision, and monitoring and assessment, and refining the plan or strategy through external consultants when needed.

Deliverables: EPI officials in 91 districts with low coverage as identified in the national plan have improved knowledge and skill; micro plans will be developed, updated and implemented by > 90% commune HCs by end 2017.

Justification: analysis reveals that HR capacity gap is one of bottlenecks contributing to low coverage in hard-to-reach areas, thus capacity building is essential to empower the responsible staff at district and commune levels to properly develop and apply micro-plans, monitor progress and timely take correct actions.

3. To assist NEPI in developing a national cold chain replenishment plan; and timely implement a new EVM Improvement Plan and regularly monitor progress.

Indicative budget: 80,000/year

Activities: develop and regularly update national cold chain inventory, trainings, regular supervision, and external consultants when needed.

Deliverables: cold chain replenishment Plan in place; tasks/activities timely implemented against the timelines defined in the new EVM IP.

Justification: a cold chain replenishment plan is essentially needed for preparation of new vaccine introduction in next 5-10 years. There are capacity gaps at subnational levels to understand new/updated standards/systems (e.g. consciously temperature monitoring systems, new SOPs).

4. To assist in implementing of the national EPI communication action plan; and monitor and assess the progress against the subnational action plans. .

Indicative budget: 100,000/year

Activities: advocacy workshops, trainings, supervision, evaluate progress and lessons learned, documentation

Deliverables: by end of 2016, senior officials from social and mass media organizations, sectoral unions, political and social organizations have improved understanding of the benefit of immunization and introduction of new vaccines through at least 03 national and regional social seminars and workshops.

Justification: building trust on immunization remains a priority in MOH and NEPI, while there are gaps in awareness from influential figures; also gaps exist in HRs (including capacity) and budget at subnational levels to implement the core activities defined in the national communication plan.

In summary: UNICEF TA focuses on increasing coverage in hard to reach areas, enhancing supply chain systems, and building up and restoring trust on immunization through assistance in implementing of the national plans in those three areas. Funding needs include 120,000\$ for HRs and 280,000\$ for activities annually.

1. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:

In Vietnam, the NVS and HSS support window have different oversight mechanisms. As the two bodies endorsed the respective APRs in preceding three months, Government Managers were requested to invite the members of two bodies to the respective debriefs. The process consisted of the JA team presenting the observations from the review and discussion on the recommendations moving forward. Issues of importance raised by the team included a request for HSS support extension, end of support evaluation, implementation of selected recommendations from the recently concluded EPI review and mechanisms to establish/consolidate information sharing between the Gavi HSS and EPI program.

A debrief meeting with key ICC members was organized separately.

Issues raised during debrief of joint appraisal findings to national coordination mechanism:

- 1) Extension of the HSS support (no cost) – The general agreement was that instead of continuing the current activities as before, the HSS program should jointly work with the EPI to determine the needs in either ten focus provinces or more widely, and take up activities/procurement according to the long term program needs.
- 2) As a graduating country with well performing EPI, there is no possibility of a new HSS support for Vietnam in future. The project has been recommended to conduct a comprehensive review of the program to determine lessons relating to utilization of trained workers, impact and sustainability. A costing study examining the unit cost of delivery to achieve a fully immunized child should be conducted to understand costs in a typical province as well those provinces with hard to reach areas and ethnic minorities.
- 3) It is likely Viet Nam would apply for Gavi support for JE and Rotavirus vaccines, taking into view the most recent WHO certification of the NRA. This means that the country could use the nationally manufactured vaccine products. Before initiating the application process, the Government will send a letter to Gavi asking several questions for clarifications in advance. The questions relate use of nationally produced products, funding levels in case of local procurement and timelines for introduction.
- 4) The ICC emphasised the great work done by EPI in 2014, particularly with the MR campaign and highlighted the busy future period for the team with the cMYP needing to be developed, finalisation of EPI review, the upcoming EVM assessment, work to prepare any final vaccine applications to Gavi as well as the request for EPI to take on responsibility / oversight of vaccinations provided through the private sector.
- 5) Both ICC and HSCC voiced their support for an earlier JA mission next year (perhaps in April or May) in order to better align with their planning cycle. This timing would work well with data availability and reporting.

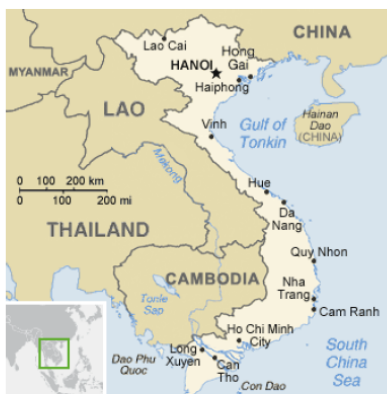
Any additional comments from

- Ministry of Health: HSS will take actions to follow up recommendations stated in the joint appraisal and proposes that GAVI makes final tranche to HSS as grant commitment.
- Partners:
- Gavi Senior Country Manager:

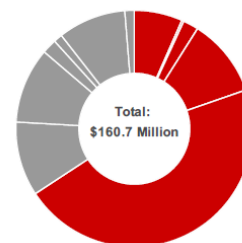
Annex A. Key data

Vietnam

Total population (2015)	93,386,630
Birth cohort (2015)	1,388,460
Surviving Infants (surviving to 1 year per year, 2015)	1,370,017
Infant mortality rate (deaths < 1 year per 1000 births, 2013)	19/1000
Child mortality rate (deaths < 5 years per 1000 births, 2013)	24/1000
World Bank Index, IDA (2012)	3.78
Gross Nation Income (per capita US\$, 2013)	1,740
Co-financing status (2015)	Intermediate
No. of districts/territories (2013)	698



Non-vaccine support: 34% (\$54,982,911)
 Vaccine support: 66% (\$105,675,341)



Data refers to disbursed values, date as per above chart

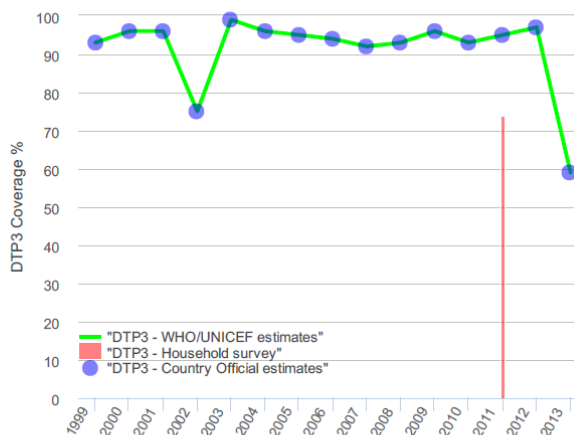
Gavi support for Vietnam

Type of support	Approvals 2001-2020 (US\$) (31 Mar 2015)	Commitments 2001-2020 (US\$) (31 Mar 2015)	Disbursements 2000-2015 (US\$) (31 Mar 2015)	% Disbursed (31 Mar 2015)	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Health system strengthening (HSS 1)	\$16,285,000	\$16,285,000	\$16,285,000	100%																
Health system strengthening (HSS 2)	\$24,400,000	\$24,400,000	\$16,589,836	68%																
HepB mono (NVS)	\$10,602,218	\$10,602,218	\$10,602,218	100%																
Immunisation services support (ISS)	\$1,930,500	\$1,930,500	\$1,930,500	100%																
Injection safety support (INS)	\$3,226,000	\$3,226,000	\$3,226,000	100%																
IPV (NVS)	\$1,823,000	\$3,036,000	\$450,470	25%																
Measles (NVS)	\$3,373,500	\$3,373,500	\$3,373,500	100%																
Measles-Rubella (NVS)	\$17,190,711	\$17,190,711	\$17,190,711	100%																
MR - Operational costs (OPC)	\$14,901,575	\$14,901,575	\$14,901,575	100%																
Penta (NVS)	\$75,516,858	\$75,516,858	\$74,058,443	98%																
Vaccine Introduction Grant (VIG)	\$3,161,000	\$3,161,000	\$2,050,000	65%																
Total	\$172,410,362	\$173,623,362	\$160,658,253																	

Red line on table indicates duration of support based on commitments.
 Commitments: Multi-year programme budgets endorsed in principle by the Gavi Board. These become financial commitments upon approval each year for the following calendar year.
 Approvals: Total Approved for funding

Vietnam DTP3 / immunisation coverage

DTP3 - WHO/UNICEF estimates (2013)	N/A
Grade of confidence	N/A
DTP3 - Official country estimates (2013)	59%
M:F sex ratio at birth (2015)	1.09
Household survey: DTP3 coverage for male (2011)	72.50%
Household survey: DTP3 coverage for female (2011)	76.20%
Household survey: Last DTP3 survey (2011)	74%
% districts achieving > 80% DTP3 coverage (2013)	14%
% districts achieving < 50% DTP3 coverage (2013)	39%
MCV WHO/UNICEF estimates (2013)	98%
Polio WHO/UNICEF estimates (2013)	93%



Number	Achievements as per JRF		Targets (preferred presentation)							
	2014		2015		2016		2017		2018	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation
Total births	1,716,869	1,750,358	1,737,471	1,737,471		1,758,321		1,844,251		1,866,382
Total infants' deaths	0	0	0	0		0		0		0
Total surviving infants	1716869	1,750,358	1,737,471	1,737,471		1,758,321		1,844,251		1,866,382
Total pregnant women	1,716,869	1,751,223	1,737,471	1,737,471		1,758,321		1,844,251		1,866,382
Number of infants vaccinated (to be vaccinated) with BCG	1,631,025	1,682,062	1,650,597	1,650,597		1,670,405		1,752,039		1,773,063
BCG coverage[1]	95 %	96 %	95 %	95 %	0 %	95 %	0 %	95 %	0 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,648,194	1,671,897	1,667,972	1,667,972		1,670,405		1,752,039		1,773,063
OPV3 coverage[2]	96 %	96 %	96 %	96 %	0 %	95 %	0 %	95 %	0 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1[3]	16,310,260	1,669,008	16,505,970	16,505,970		1,670,405		1,752,039		1,773,063
Number of infants vaccinated (to be vaccinated) with DTP3[3][4]	1,614,715	1,666,674	1,634,091	1,634,091		1,670,405		1,752,039		1,773,063
DTP3 coverage[2]	94 %	95 %	94 %	94 %	0 %	95 %	0 %	95 %	0 %	95 %
Wastage[5] rate in base-year and planned	0	5	0	0		5		5		5
Wastage[5] factor in base-year	1.00	1.05	1.00	1.00	1.00	1.05	1.00	1.05	1.00	1.05
Number of infants vaccinated (to	1,631,026	1,669,008	1,650,597	1,650,597		1,670,405		1,752,039		1,773,063

be vaccinated) with 1st dose of DTP-HepB-Hib										
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	1,631,026	1,666,674	1,634,091	1,634,091		1,670,405		1,752,039		1,773,063
DTP-HepB-Hib coverage[2]	95 %	95 %	94 %	94 %	0 %	95 %	0 %	95 %	0 %	95 %
Wastage[5] rate in base-year and planned	5	5	5	5		5		5		5
Wastage[5] factor in base-year	1.05	1.05	1.05	1.05	1	1.05	1	1.05	1	1.05
Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,648,194	1,705,204	1,667,972	1,667,972		1,670,405		1,752,039		1,773,063
Measles coverage[2]	96 %	97 %	96 %	96 %	0 %	95 %	0 %	95 %	0 %	95 %
Pregnant women vaccinated with TT+	1,545,182	1,589,745	1,563,729	1,563,729		1,582,489		1,659,826		1,679,744
TT+ coverage[7]	90 %	91 %	90 %	90 %	0 %	90 %	0 %	90 %	0 %	90 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0		0		0		0
Vit A supplement to infants after 6 months	4,843,830	5,629,850	4,843,830	4,843,830	N/A	4,500,000	N/A	4,500,000	N/A	4,500,000
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %

Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Country to report on utilization of cash funds for MR campaign in next year's report	Fully complied – financial statement provided
Conduct cash program audit	Rescheduled to September 2015 by Gavi secretariat
Conduct graduation assessment	Planned towards end of 2015 or early 2016

Annex C. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

In consultation with WHO and UNICEF, the country planned to conduct a national review of the EPI program. This became the right opportunity for the joint appraisal considering availability of most recent situational analysis. The EPI review was integrated with a coverage evaluation survey with division of the country into eight survey units.

The appraisal started from last two days of the EPI review when the findings from the field review teams were compiled and discussed. The following days consisted of appraisal related discussions, focusing mostly on annual progress for the year 2014 and recommendations for next year 2016.

The composition of the appraisal team also took advantage of participants from the EPI review – besides in-country participants, UNICEF colleague from EAPRO participated for major part of the JA. WHO WPRO deputed technical officers from EPI and HSS respectively for the appraisal. The initial discussions also included the EPI Coordinator from WHO (WPRO). Gavi secretariat participated with two staff members including the Senior Country Manager. The JA opportunity was also utilized to present and discuss the Grant Performance Monitoring Framework which is expected to be instituted from next year replacing one time submission of annual progress report. The respective officer from Gavi secretariat took this responsibility besides participating in all elements of the appraisal.

EPI and HSS support windows are implemented separately in Vietnam with oversight by the respective coordination committees. The debrief by the JA team included several members of the two committees fully aligning with the outcomes and recommendations. The PMU for HSS provided significant comments when the JA draft was shared with the Government officials. These comments have been incorporated in this report.

No field visits were made as the EPI review informed of the field situation. National Vaccine Store was physically visited to look at the inventory and vaccine/supply stocks especially the Pentavalent and MR vaccines. The stock management at the national store is satisfactory, in fact a model system. The emphasis is on better management rather than physical handling of the vaccines – all locally sourced vaccines are directly shipped to the Regional/Provincial stores; the emphasis is on minimizing the hold-up time at National store and absence of a national store for dry supplies like the injection supplies.

Annex D. HSS grant overview

General information on the HSS grant							
1.1 HSS grant approval date		Sept 2011					
1.2 Date of reprogramming approved by IRC, if any		N/A					
1.3 Total grant amount (US\$)		USD 24,400,000					
1.4 Grant duration		4 years					
1.5 Implementation year		May 2012 – 2015					
(US\$ in million)	2009	2010	2011	2012	2013	2014	2015
1.6 Grant approved as per Decision Letter				3.69	12.90	4.25	3.56
1.7 Disbursement of tranches							Pending
1.8 Annual expenditure				0.08	2.57	5.60	-
1.9 Delays in implementation (yes/no), with reasons		Yes; Supply of essential medical equipment (activity 5) reported slower progression towards the 2014 target. Under the new bidding law (Bidding Law No. 43/2013/QH 2013), the procurement of equipment, including cold chain, are delayed and will be disbursed between Q2-Q4 in 2015 instead.					
1.10 Previous HSS grants (duration and amount approved)		USD 16,285,000 (2007 – 2010; HSS1)					
<p>1.11 List HSS grant objectives</p> <p>Objective 1: Support Human Resources Development for Health</p> <p>Act 1. Provide 6-9 month training courses for VHWs- Organize 24 training courses for 912 VHWs</p> <p>Act 3. Training courses on EPI in Practice for CHWs- Organize 40 training courses for 1600 CHWs</p> <p>Act 4. Training courses on MCH for CHWs- Organize 40 training courses for 1600 CHWs</p> <p>Objective 2: To strengthen management capacity to deliver basic health services through ensuring adequate supply of essential equipment for health facilities</p> <p>Act 5. Supply of essential equipment to DHCs, CHCs and VHWs- Provide essential equipment to 30 DHCs, 500 CHCs. Provide 10,000 VHW kits</p> <p>Act 6. Support outreach immunization spots in mountainous communes- Support 2230 outreach immunization spots</p> <p>Objective 3: To strengthen capacity in response to the needs for health sector reform and development in the new situation</p> <p>Act 7. Training courses on health planning and M&E for provincial and district health managers- Organize 15 training courses for 600 health managers</p> <p>Act 8. Support for Joint Annual Health Review (JAHR)- Support the development of JAHR 2014</p>							

Act 9. Support for M&E and supervisory visits- Promote M&E visits of central level, provincial level and district level

Act 10. Support for initiatives and policies to strengthen the basic health network- Support departments,

institutes, research agencies and provinces to conduct research, policy researches and innovations to strengthen grassroots health care system

Act 11. International workshop, training, study tours 01 trip organized to support staff of line ministries, sectors to attend international conferences, workshops and short-term study visits overseas- 01 trip organized to support staff of line ministries, sectors to attend international conferences, workshops and

short-term study visits overseas

Act 12. Local training/ workshops - Support annual project workshops in the central and provincial levels.

Project Management

Office equipment and supplies- Office equipment and furniture purchased

Running cost- Telephone, photocopy, stationery

Salary for project staff- Salary for 9 PMU full-time staffs paid on monthly basis

Allowance for PMU- Allowances for 5 PMU members paid on monthly basis

Annual Financial Audit- An independent auditing company recruited

International and national consultant - Hire consultants to support the implementation of the project (M&E, training, procurement of equipment etc...)

1.12 Amount and scope of reprogramming (if relevant)

No reprogramming of HSS grant proposed.

Annex E. Best practices (OPTIONAL)

The vaccine stock management at national level is a good example for other similar countries. The focus is on managing the stocks at different levels, fully utilizing the Regional and Provincial stores. This reduces the pressure on National store on holding the vaccine stocks. In fact, nationally produced vaccines are directly shipped to the Regional/Provincial stores by the manufacturers.

Annex F. Provisional recommendations from EPI review (2015)

SUMMARY RECOMMENDATION AND STRATEGIES FOR NEXT CMYP

1. Immunisation Policy

- One system for EPI/Non EPI
- Immunisation Policy for regulation of immunisation service quality and immunisation schedule

2. Immunisation Services Equity

- Outreach/Mobile strategy for high risk populations
- Communication strategies using VHW networks
- Development of urban EPI strategy

3. Information & Planning Systems

- System to assist health workers to track mobile and migrant populations(rural and urban)
- Improved and standardised coverage monitoring and planning at CHC and district levels

4. Infrastructure / Cold Chain planning

- Cold chain replenishment plan (including replacement) and Vaccine Management Improvement Plan/linked to cMYP.

5. Human Resources Development for EPI

- Maintain middle level management and immunisation in practice training to account for turn over of staff

6. Immunisation Financing

- Regulation to reduce disparities between provinces for financing of operational costs
- Vaccine financing

7. Immunization safety/AEFI

- Maintain existing initiatives in injection safety/AEFI response
- Consider development/revision of national waste management policy/strategy