

## Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analyzed, and explained where relevant.

<b>Country</b>	Socialist Republic of Viet Nam (Vietnam)
<b>Reporting period</b>	2015
<b>Fiscal period</b>	January to December
<b>If the country reporting period deviates from the fiscal period, please provide a short explanation</b>	Not applicable
<b>Comprehensive Multi Year Plan (cMYP) duration</b>	2016 to 2020
<b>National Health Strategic Plan (NHSP) duration</b>	2016 to 2020 (Five year Health Plan)

### 1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – Pentavalent vaccine	Extension	2017		As per vaccine request	
NVS – JE campaign	To be noted	2017		Already approved	
HSS – E.g. Core tranche	No-cost extension	2017		Already fully disbursed	

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	Cold Chain equipment Platform	2016	2017
	Japanese encephalitis vaccine	2015 (IRC approved)	2017

\*Not applicable for countries in final year of Gavi support

### 2. COUNTRY CONTEXT (maximum 1 page)



*This section does not need to be completed for joint appraisal update in interim years*

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

After 2017, Vietnam will graduate from the group of countries receiving IDA loans, external assistance in the form of grants will be gradually cut with a shift towards concessionary loans or foreign commercial loans for health sector projects. In addition, the state budget deficit remains high in a context of rapidly rising public debt will affect the ability to increase investments in the state health sector including support for immunization.

MOH has approved and disseminated the national strategic plan for people's healthcare, protection and promotion in the period 2016-2020 with estimated budget. The plan sets one immunization indicator of achieving more than 90% of children under fully immunized every year and action of improving accessibility to new generations of vaccines and protecting people against vaccine preventable diseases, ensuring sufficient supply of vaccines, and promoting the research and production of vaccines. The total estimated budget is 742,320 billion VND, equivalent to 8.4% of the total state budget

expenditure if expenditure from Government bond is included. The plan has not yet clearly indicated the budget being allocated for immunization in the next five years, however, EPI would remain as a priority preventive healthcare programme. Since 2010, the national immunization program has seen an average annual increase of about 15 percent. The increased resources, however, have been mostly used to meet the vaccine (pentavalent) co-financing requirement, and there is evidence of insufficient financing to fully cover the operational costs.

Decentralization is also accelerating with half of general expenditures and three-quarters of capital expenditures executed. There exists considerable variation across different provinces on the amount of resources they allocate to the immunization program. Currently, the provincial level EPI programs generally rely on the National EPI for most of their funding. It is evident that provinces would not be able to increase fiscal space at local levels to close the funding gaps for healthcare. This is potential for national EPI to advocate and mobilize local budget for immunization.

In 2015, national EPI completed the national EPI review, Effective vaccine management assessment (EVMA) followed with development of an improvement plan and the cMYP. These key documents have enabled EPI to be able to advocate and mobilize for further funding support from MOH and Govt. for immunization, for example the proposal of having Govt. budget to co-financing 50% of the total budget for procurement of cold chain equipment through the recent established CCE by GAVI and partners.

The Gavi-supported HSS grant has been largely investing on primary health care training (including MNCH and EPI), focusing on improving the performance of commune and village health workers at primarily healthcare level. In addition, there is a component of supporting outreach services in hard-to-reach areas, focusing on increasing the immunization coverage to close the inequity gaps at sub-national level. With the strategic direction of the healthcare sector towards primary healthcare system strengthening with increasing Govt' investment in the next 5 years, the results, lessons learnt and good practices of the Gavi HSS would be used to advocate for replication and scaling up in the coming primary healthcare system strengthening agenda and programmes of MOH.

### 3. GRANT PERFORMANCE AND CHALLENGES *(maximum 3-4 pages)*



*Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5*

#### 3.1. New and underused vaccine (NVS) support

##### 3.1.1. Grant performance, lessons and challenges

*[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]*

Vaccination coverage reported in the 2015 Joint Reporting Form (JRF) surpassed the regional immunization targets, reaching 97% for the third dose of DTP-HepB-Hib vaccine (Penta3) and Polio (OPV3) and 97% for the first dose of measles containing vaccine (MCV1). This suggests the National Expanded Programme of Immunization (NEPI) is back on track in terms of reaching and sustaining high vaccination coverage after a decline in 2013 due to issues reported in the 2015 JA, mainly the vaccine suspension following AEFI related deaths.

Improvement is also seen in reducing inequity in immunization. In 2015, the JRF reports that only 8% of the 707 districts reached <90% Penta3 coverage compared to 12% of districts in 2014 and 2012.

In 2015, thirty-five (35) districts reported a DTP drop-out rate greater than 10%, an improvement compared to 54 districts in 2014, 49 in 2012 and 81 in 2011.

Furthermore, significant improvement is noted for the birth-dose of Hepatitis B vaccine. The country reports 70% coverage in 2015 as compared to 55% in 2014 and 56% in 2013. With exception of 2012, hepatitis B birth-dose has been below 60%.

As in 2014, no vaccine stock-outs were reported/registered in 2015, a noticeable improvement as compared to previous years in which vaccine stock-outs also affected the district level.

In 2015, the country received 5,718,700 doses Pentavalent vaccine, out of the 5,540,200 doses as from Gavi's decision letter. In addition, the country received in the same year 178,500 doses that correspond to 2014 batch of shipments.

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

- roll out of birth dose of HepB monovalent vaccine (2002-2007);
- introduction of second dose of Measles vaccine (2007-2011);
- introduction of Hib containing Pentavalent vaccine (DTP-HepB-Hib [2010-2015]);
- implementation of Measles-Rubella catch up campaign for 9-month – 14-year old age group followed by introduction of MR vaccine in routine EPI (2014-2015);

Moving forward, Gavi support will be utilized for introduction of one dose of Inactivated Polio Vaccine (2017/18) and an age-wide campaign with Japanese encephalitis vaccine.

Viet Nam is a transitioning country meaning that the country is not eligible for new GAVI support since 2016. As a last opportunity, it did apply for funding for expansion of Japanese encephalitis vaccination in Viet Nam in September 2015 which has been accepted by Gavi. A decision letter from Gavi is expected in coming weeks.

The country is actively considering introduction of rotavirus vaccine using the domestic product and government financing in 2018. There is no active consideration for Pneumococcal and Human papillomavirus vaccines mainly due to limitations of government financing and non-availability of external funding. As of now, no decisions have been made on when to introduce these vaccines. An important consideration will be to use vaccines manufactured in the country when possible.

From September 2014 to May 2015, Viet Nam conducted a wide age range measles-rubella campaign targeting children 1 through 14 years of age. In all 19,735,753 children were vaccinated, 98% of the estimated target.

As part of global polio eradication initiative Viet Nam was planning to introduce with GAVI support one dose of IPV vaccine in routine immunization schedule by the end of 2015. However, due to limited global supply of IPV introduction of the vaccine is postponed till the 4th quarter of 2017 (according to the latest available information from UNICEF). In the application submitted to the GAVI the country indicated 1,850,260 children under 1 year of age as target population for 2016. However, according to the GAVI's decision letter, approved number was 1,242,900. Even considering the latest reported number of surviving infants 1,730,532 (projection for 2016 in JRF 2015), the approved target population for 2016 is almost half a million less. If not revised this will leave almost one third of the birth cohort unprotected against polio type 2. This situation needs to be resolved by GPEI and Gavi.

### 3.1.2. NVS future plans and priorities

*[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]*

There is a need in continued support for bacterial meningitis (Hib, pneumococcus, and N. meningitides) surveillance in 3 sentinel hospitals to determine burden and monitor trends. Such support would enable future knowledge for evidence based decision process to consider the impact of currently used new vaccines in routine immunization schedule and those which might be in future perspective considered for the introduction. It should include:

- Continued support for rotavirus surveillance in 2 sentinel hospitals
- Technical support for JE surveillance by stepwise expansion of surveillance sites
- Support for new/underused vaccine evaluation and research projects: e.g., project to evaluate and measure burden of IB-VPD surveillance, proposed project to develop sentinel surveillance for intussusception, possible cost-effectiveness study for JE vaccination

Underestimated number of target population approved for IPV support in 2016 should be adjusted to make sure that the country receives required number of doses to cover actual target population. The situation with IPV introduction in Viet Nam is further complicated by the limited global supply of the vaccine and delayed introduction – 4th quarter of 2017 instead of initially planned October 2015. Introduction of IPV vaccine is an important part of global polio eradication plan because after the switch from tOPV to bOPV, which is happening in April-June 2016, IPV is the only mean of protection of the population against type 2 poliovirus. For Viet Nam current situation means that almost one and a half birth cohort will not be protected against type 2 poliovirus until the IPV vaccine is introduced in the 4th quarter of 2017. As part of mitigating activities WHO recommends to the countries with delayed introduction of IPV, including Viet Nam, catch-up vaccination of those who were eligible for one dose of IPV after the switch. Therefore, it is critical to adjust the quantity of IPV vaccine for 2016-2017 to make sure that eligible children are protected against type 2 poliovirus.

### 3.2. Health systems strengthening (HSS) support

#### 3.2.1. Strategic focus of HSS grant

*[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunization, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]*

As described in the original proposal, the overall objective of this HSS support is to strengthen the health care system, especially at basic level (district, commune/wards, village / hamlets) to contribute to sustained and increased high coverage of quality basic health services, especially EPI and maternal and child health outcomes in difficult areas.

The HSS PMU classified project activities under three main themes:

1. Support human resource development for basic level health in challenging provinces; Provide training courses for village health workers (6-9 months) to meet certification criteria of the MoH. Training courses on EPI for district hospital staff (EPI management and HepB birth dose), training courses for EPI in practice for CHWs and for MCH for CHW.
2. Strengthening service delivery capacity to provide good basic health care services through ensuring adequate supply of essential equipment for health facilities; Supply of essential equipment to DHC, CHC and VHWs and support outreach immunization spots in mountainous hard to reach communities.
3. Strengthening management capacity in response to the needs for health sector reform and development in the new situation; Training course on health planning and M&E for provincial and district health managers; Support for Joint Annual Health Review; Support for M&E and supervisory visits (bi-annual visits); support for researches, initiatives and policies development to strengthen the basic health networks, workshops, trainings and study tours

These three areas continue to be of relevance in Vietnam, and several aspects, such as the ongoing need to provide training and capacity building for immunization and management, were specifically highlighted in the EPI review (2014) as areas for ongoing need / attention. During the field visits of the Joint Appraisal (May 2016) attention was brought to favorable impression of the program and the improvements in quality of the immunization sessions in particular.

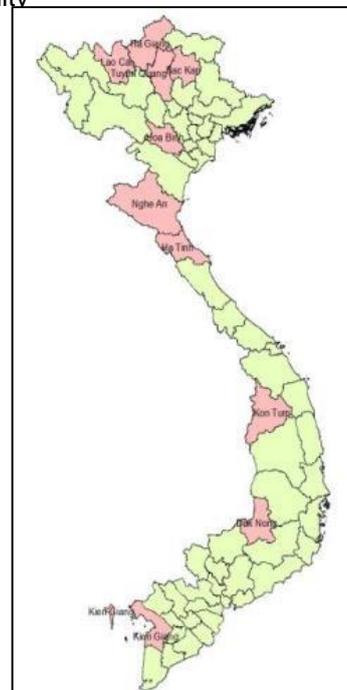
Ten provinces that were selected for prioritization for the HSS grant investments were selected based on criteria of poverty and low performance on immunization indicators (Ha Giang, Bac Kan, Tuyen Quang, Lao Cai, Hoa Binh, Nghe An, Ha Tinh, Kon Tum, Dac Nong, Kien Giang). The total population in these provinces is 10.65 million across 113 districts. The programme covers 19805 villages in 1893 communes, out of which 748 communes are categorized by the Government as difficult communes (hard to reach, large ethnic minority population). Majority of health workers at village/community level are female health workers (70.1%) and many belong to ethnic minority (56.3%).

Apart from building capacity for health workers through training, provision of essential equipment is one of the pre-conditions for the quality and effective health service delivery. The HSS grant supported essential equipment for 30 district health centers commune health centers, and provide VHWs tool bags for in project provinces. The health facilities with direct involvement in immunization and maternal health care activities in remote and outlying areas in the 10 project provinces (prioritized districts based on hardship and newly established districts/communes). The grant has a clear focus on equity and hard to reach communities.

Sustainability of the grant activities/ outcomes was discussed during the Joint Appraisal; the trainings have allowed for certification of VHWs, and ensured that 98% of villages covered have a VHW. Consumables of medical kits provided are expected to be replenished by the local health authorities once utilized. There is work ongoing to advocate with provincial health authorities to mobilise resources for additional budget for additional monthly immunization outreach spots for hard to reach communities (\$12 per monthly session for transport and water, buying plastic chair or tables equipped in the some outreach spots, in addition to already funded HR, consumables).

This is to mobilize additional resources beyond what is provided from the central level for HR, consumables etc. It was discussed to leverage the end of grant evaluation to look at providing evidence of the positive results of investing in additional outreach to help advocate with the provincial health authorities. 2017 will be the last year with Gavi HSS support and it will be important to look at how some of the training activities will be maintained / fully taken over by the provinces.

The selection of Gavi HSS impact and output indicators were aligned with Vietnam's selected essential health indicators, notably percentage of children under one year of age fully immunized, 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 Viet Nam's HMIS and General Statistics Office (GSO), and reported in the Joint Reporting Form (JRF). There is a new national health plan (2016-2020) with the same priorities as the HSS grant. The grant performance framework is being updated with targets for 2017 according to the no cost extension.



### 3.2.2. Grant performance and challenges

*[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]*

#### **Implementation arrangement**

The grant is managed by a Programme Management Unit, with MoH staff, situated in Hanoi. The activities are implemented through the provincial health department and in turn the lower levels (district health centers, district hospitals, commune health centers and village health workers). The PMU is working closely with NEPI/NIHE- MOH, MCH- MOH, Planning and finance, Manpower and Organization department in MoH in designing of the project. The PMU has a coordinating function and it is staffed with three accountants and MoH chief accountant (part time) to follow the financial management of the grant. Financial management and procurements are following the MoH requirement and regulations. The NEPI-NIHE and MCH departments are involved in the technical aspects (training materials, training of trainers) the M&E and supportive supervision in the provinces toward

immunization and MCH activities and health staff capacity building at local level. At central level other stakeholders are involved in program oversight through HSCC.

In term of supportive supervision: NEPI and MCH has been provided supportive supervision activities during local training courses conducted and after local training activities to be sure the change of knowledge, skills and work efficiency of HWs at grass roots levels. Besides these activities, the NEPI and MCH regularly provided M& E activities for provinces in whole country (the national vertical programs of MOH).

At provincial and district levels: the local supportive supervision activities have provided by 6 months or quarterly for EPI and MCH by the project. Provincial health department, Provincial preventive medicine centers, P MCH, provided regularly M&E as their local vertical programs.

### **Implementation status**

In 2015 activities and trainings were conducted as planned, and most activities are now on track and meeting the planned target. It was discussed during the 2015 Joint appraisal and annual work plan for 2016, to extend the programme duration to 2017, to be able to implement the large number of trainings.

### **Fund utilization**

Of the 24.4 million disbursed from Gavi the PMU reports utilization of 80% (May 2016). Cumulative utilization from 2012-2015 was \$17,867,094 and estimated utilization in 2016 is \$4,133,698.

There is a balance of unspent funds after 2016 due to some activities that were not implemented (provinces cannot do all trainings at once (therefore only 60-70% of planned activities for 2016), there are also some savings from procurement and reduction of allowances of PMU MoH staff, and reduction in cost norms, bank interest and difference in exchange rates has also led to some increase in available funds. Funds expected to be carried over to 2017 is \$2,787,208.

### **Achievements**

The HSS PMU reports good progress on implementation of key activities in 2015 and achieved close to 100% of their implementation targets in the year:

#### Equipped facilities:

Implementation over the last two years achieved delivery of equipment, and people were trained on use. The target for procurement of essential equipment and kits have been achieved: 30 district health facilities were equipped with essential equipment; 500 community health centers have been equipped with essential equipment; Routine supervision and monitoring found that equipment is in use, which gives promise of improved quality of service delivery (No formal assessment has been done yet).

#### Strengthened capacity:

The HSS grant has contributed to improve management capacity for provincial and district health workers on health statistics, health planning, health financing, information management and monitoring, health target program management and health human resources. All trainings planned for 2015 have been completed as per the plan; 3424 (3268 planned) village health workers were trained on 6-9 month course; 663 (608 planned) district level health workers and 5845 (5396 planned) commune health workers were trained on immunization practice. 751 (684 planned) health workers were trained on planning and M&E.

#### Improved access to immunization services:

2297 out of 2319 planned outreach sessions in the project provinces were held (99%) in 2015. Since the beginning of the HSS grant implementation, the number of children vaccinated reaches 572,110 times, including 175,100 visits in 2015. Of these, children of ethnic minorities accounted for 53% in averaged of whole 10 project provinces, in many provinces, this proportion accounted for 90% or more, such as Ha Giang, Lao Cai, Bac Kan, Kon Tum. 41,688 women are injected tetanus vaccination in 2015. Accumulated numbers of women had been injected tetanus vaccine in beginning of the project are 141,288 visits of women; of which, women from ethnic minorities accounted for 63.4%. Communication and counseling activity is also integrated at outreach spots of immunization.

With the additional immunization outreach sessions for hard to reach areas, the project has helped children and women get easier access to EPI services, increase immunization rates and increase proportion of children with fully immunization and coverage. As a result, immunization coverage in 10 provinces reaches 96%, compared to the national immunization coverage that is 97.1%. The HSS grant has contributed to improve access to immunization services in difficult areas. According to a study

conducted in 2014; "Evaluation of outreach immunization spot situation in some project communes funded by GAVI": The proportion of fully immunized children increased as a result of support outreach immunization spots (4 provinces and 16 disadvantaged project communes in 2014) have improved but remains still lower than the national average. Immunization target groups were better managed leading to lowering the vaccine wastage. More than 90% of the trained HWs can perform properly immunization steps. Most of health workers commented that support to outreach immunization spots is critical in improving people's access to health service, increasing on schedule vaccination rate and coverage as well as reducing drop-outs.

Strengthened health care services in target provinces:

Vietnam reports that knowledge and skills of VHWs and CHWs on primary health care, essential reproductive health and newborn care, initial treatment, first aid and normal delivery have been improved through the Gavi supported trainings; Capacity of health workers at grassroots level has been improved in terms of the management of target programs, early detection of epidemics, health education and communication and technical qualifications as required.

The supply of essential medical equipment (ultra-sounds, ECG, bio-chemical machines, laboratory, patient beds, and set of general and specialized medical kits, etc.) to 30 District Health Centres and 500 CHC's has contributed to standardize primary health care service delivery at facilities in accordance with current criteria and regulations of the localities and health sector. The equipment will also be used for long-term at grassroots level contributing to solve difficulties in delivery of medical services in remote, far and mountainous areas.

Policy development and JAHR:

Gavi HSS contributed (along with other resources) with funding to the MOH to develop study and Decree development 117/2014/ ND-CP (issued by prime minister): Organization and personnel of commune, ward and township health centers. This affects communes nationwide.

The HSS grant has also contributed to the development and dissemination of the Joint Annual Health Review (JAHR) for health managers, officers, researchers, development partners and stakeholders. The JAHR provide an overview, scientific evidence, rationale and current situation of Vietnam health system by different thematic focus each year.

**Results:**

The indicators committed in the project document and some other MCH indicators are collected and compared annually to evaluate project achievements with results as follows:

- 5 activity indicators over 4 years are achieved and exceeded compared to the set targets in the project document.
- 3 output indicators including proportion of infants fully immunized, proportion of CHCs accredited with the national benchmark standards and proportion of villages/hamlets with active VHWs which are assessed basing on the national data source are also achieved.
- Two impact indicators are assessed basing on the national data source. The maternal mortality ratio is estimated to be achieved and the children mortality rate is estimated to be achievable.
- Other indicators on MCH care are also collected by the project: Proportion of pregnancy management, tetanus vaccination is as equal for the target provinces and the national average. Proportion of underweight children is not much lower than the national proportion. Proportion of fully immunization in 10 project provinces is 96%, though a little lower than the national proportion of 97.1%.

**Output and impact indicators according to the Project Documents:**

No.	Activities	Plan 2012		Plan 2013		Plan 2014		Plan 2015	
		2011	Primary Survey	Project document	Reach (%)	Project document	Reach (%)	Project document	Reach (%)
	<b>2. Output Indicator</b>								
6	Percentage of children <1 year of age are fully	>90	96	>90	91,4	>90	97,1	>90	97.2

	vaccinated (%)								
7	Percentage of communes reaches national criteria on health (%)	40	76,8*	45	74,1*	50	55	60	60
8	Percentage of villages / hamlets have VHWs available (%)	85	82,9	87	81,2	88	96,9	90	98 (10 project province reports)
	<b>3. Impact Indicator</b>								
9	The maternal mortality per 100,000 live births ratio	68	68	66	66	64	49	58,3	58,3
10	Child mortality <5 years / 1,000 live births ratio	25	23,3	23	23,2	22	22,4	19,3	22,1

### Implementation challenges

The PMU raises various challenges related to the implementation of activities under the HSS grant, some reflect the situation since the beginning of the grant till present, and others are challenges to consider in transitioning out from Gavi HSS support.

#### Implementation challenges related to trainings of village health workers:

There is disparity in age, qualification and ethnic of participants. Most of them live in disadvantaged and poor areas with low monthly allowances, hence many VHWs have other part-time work (farming) to earn a living, most VHW have young children and the majority of them are women. Thus long-term attendance to training is a challenge for them when they decided to attending and studying training courses. Most of trainees attended and completed the training courses as requirement. Training needs to standardize qualifications of VHWs are still high, yet there is insufficient government (central and provincial) budget available.

#### Implementation challenges related to trainings of commune and district health workers:

According to the Circulation No. 12/TT-BYT dated 20/03/2014, Decision No. 3982/QD-BYT dated 10/03/2014 and the Decision No. 4673/QD-BYT dated 11/10/2014 of the Ministry of Health, health workers at grassroots level need to be retrained every two years to guarantee the skillful practices of immunisation and MCH services in health facilities. However there is insufficient funding in government budget to meet this need. In addition, there is a real need of training on health planning, management and operation at commune level but no funding resource is identified.

#### Implementation challenges related to Support to immunization activities:

Due to some emerging problems in immunization safety and changes in MoH's guidelines, several provinces are less confident or restrictive in the operation of outreach immunization spots causing its fewer number as planned. Although the project has supported the operation of outreach immunization spots, trained staff and provided equipment for vaccines storage, there are still areas in disadvantaged districts and communes with low immunization rates that need more than the current effort and investment to maintain the overall outcomes and achievement. Vaccines utilization rate is a little bit higher at outreach spots as compared to that at CHSs (last doses). Distribution and long-term storage of vaccines at commune level remains a major challenge.

Implementation challenges related to Procurement

Changes in government procurement regulations and mechanism make it more difficult to implement and manage project activities. Management, supervision and utilization of resources in provinces should be strengthened since this area is often neglected during supervision trips. The project covers a large geographical area of 500 CHSs and 30 district health centers in 10 provinces including difficult communes that make it very difficult to access and supervise problematic issues. At present the project has fund for the maintenance and repair of equipment, however the provinces need to propose for other funding sources to guarantee the implementation of activities in future, including establishing mobile teams for repairing and maintenance of equipment at health facilities.

Challenges related to financial management:

GAVI's fund transfers have often been disbursed at the end of the fiscal year in Vietnam, so financial and spending plans have needed to be adjusted accordingly. Additionally, financial reports to local bodies are also different. Project financial officers sometimes hold concurrent jobs and sometime do not prepare and submit reports on time as requirement.

Challenges related to reporting and monitoring:

The project is deployed in several mountainous and disadvantaged provinces with shortage of health personnel, thus makes it difficult to collect data, information and needs. There is challenge in getting timely reporting, especially when vaccination data is aggregated from village, CHS, district and province to report to PMU. The data is requested by different entities at different points of time and frequency. This becomes challenging in terms of data collection at multiple times.

**3.2.3. Describe any changes to HSS funding and plans for future HSS applications**

*[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]*

Vietnam is implementing its final tranche of HSS2. This grant was approved for a four year duration 2012-2016 with a total value of \$24.4 million. The first tranche was disbursed in November 2012, and the final tranche was received in January 2016. In previous years there were some delays in procurement of essential equipment and kits, which have now been completed. The HSS grant has continued steady implementation, however some activities have not been completed and it is expected that \$2.5 million will be carried over to 2017 for a no-cost extension, keeping the same 3 objectives from the original proposal. The no cost extension was also discussed during last year joint appraisal, and at that time the HSS PMU was strongly encouraged to develop a proposal for this final tranche of funds in collaboration with NEPI and partners. Concerns were raised about the sustainability of current activities and continued value / need of these in comparison to other potential investments.

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). The HSS PMU presented a proposal for no cost extension, which was endorsed by the HSCC (1 June 2016). The no-cost extension proposal is largely focused around continuation of the original activities with the addition of one activity to train provincial level health staff on immunisation and M&E.

The following reasons were presented for a need for the no cost extension:

- Training needs in 2016-2017 remains high. However there is a need to roll out health worker trainings in a phased manner, therefore more time is needed.
- Capacity of the provinces to implement the project yearly: Experience in the possibility of joint annual disbursement from PMU reached a maximum of \$3 million (not including procurement package). The ability to implement activities in 2016 projected to reach 60-70% of the budget at the maximum;
- Due to emerging needs the government proposes to add new activities to train provincial health workers and teachers of medical Schools of the 63 provinces in immunisation. It is expected to achieve 60% of total target in 2016, and will need to also be implemented over 2017.
- Ensure the project sustainability by advocating with provincial health authorities to take over and fund the additional outreach sessions for hard to reach areas (more than 3km from community health centers) on a monthly basis, and for provincial health authorities allocate \$12 per session across these target districts.

- The provinces want to maintain intervention models to take advantage of the project technique and project resources. The project required additional intervention to assess and draw lessons: an appropriate independent evaluation will be conducted and lessons learned will be disseminated.
- The targeting of the 10 provinces under the HSS grant is still considered relevant and is proposed to continue during the no cost extension, in light of the updated health policy context; Completed 5-year plan of health sector for period 2011-2015 and a new 5-year plan of health sector period 2016-2020; implementation of the Millennium Development Goals; People health care and protection Strategy in period 2011-2020 and the other priority tasks of the sector.

The proposal for a no cost extension was presented by the HSS PMU during the Joint appraisal mission. The workplan and budget for implementation in 2016 and 2017 has been provided and the performance framework has been updated with revised targets and new indicator for the new activity to train provincial level.

The HSCC discussed the need for the no cost extension action plan to consider what will happened after the HSS grant and how to maintain the gains of the HSS grant in the ten provinces. Good practice and lessons learned should be captured and used for higher level discussions in future with MoH and provincial health departments. The action plan will also include an in depth assessment of the trainings implemented with support from Gavi. There will also be workshop in 2017 to disseminate the learnings.

**Survey and end of grant evaluation**

The next MICS survey will be conducted in 2018/2019. End of grant evaluation was discussed during the Joint Appraisal, and a TOR for the evaluation was shared with Gavi for input. The independent evaluation is a requirement also for the MoH in closure of grants. The project needs more time to intervene and final evaluation of the project's investment, through which draw the lessons learned and similar models of intervention in Vietnam for the future.

**Data quality**

Vietnam presents a picture of little data quality/consistency issues. There is congruence among the administratively reported coverage, WHO-UNICEF estimates and periodic population surveys. The real discrepancy is seen relates to population estimates – country versus UN Population data. This is seen across several countries and creates a risk for a potential vaccine short supply, for example IPV.

**3.3. Transition planning (if relevant)**

*[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]*

A transition assessment was carried out in March 2016. The transition assessment covered activities in the following priority areas (1) financing of immunization, (2) procurement of vaccines- focused on operationalizing and providing capacity for the centralized procurement system under MOH, (3) equity and "hard to reach" areas coverage and AEFIs, and (4) legislation for immunization. The initial findings and recommendations for the transition action plan was developed, presented and endorsed in the Inter-agency coordinating committee for immunization (ICC). A debriefing on the results of transition assessment and plan was presented at the ICC meeting.

Since March 2016, consultations have been made between WHO, UNICEF and EPI to review, refine and finalize the transition action plan. To date, the transition plan is nearing completion including technical assistance by WHO, UNICEF, Sabin Institute and World Bank. The priority transition activities consist of developing a tailored co-financing ramp-up in line with Vietnam's request, stepping up advocacy at all levels, and reviewing potential financing options for EPI in order to secure Government financing for the transition period and beyond, use of UNICEF for procurement of quality vaccines at lower prices, strengthening vaccine regulatory system, consolidation of Government procurement capacities, building vaccine confidence and developing tools/guidance for improving coverage in hard to reach areas where majority of the ethnic minority population reside. The expected Gavi investment for transition plan is \$2.8 million, incorporating the annual technical assistance by development partners, mainly WHO and UNICEF. Any other new issue that could come up during the transition period will be addressed through the annual joint appraisal and periodic monitoring processes.

WHO and UNICEF in Viet Nam will continue to provide technical assistance to National Immunization program in Viet Nam. As in 2016 the Gavi supported 50% of salary cost for WHO international immunization staff and one UNICEF national immunization staff. It is proposed to continue these positions through the transition plan for 2017-2019.

**3.4. Financial management of all cash grants (e.g. HSS, VIG, campaign operational cost grant, transition grant)**

*[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]*

HSS provided details of fund utilization at the time of this appraisal. It is estimated that approximately \$2.8 million is likely to be the balance at end of December 2016. This has been proposed to be utilized during 2017 for which a no-cost extension proposal has been presented. It has been communicated, also reiterated at the HSCC that the Gavi HSS would close in end-December and unspent resources, if any, will have to be returned to Gavi.

The Government is expected to provide six monthly financial statements due by 15<sup>th</sup> August and 31<sup>st</sup> March respectively. In addition, an audit report is expected by end June 2016.

EPI financial reporting – Vietnam has sent the financial report for year 2015 to Gavi through the online portal. It is aware of the timelines for six monthly reporting as well as the annual audit report.

**4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL**

*[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]*

Recommended Actions	Responsibility (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	Timeline	Current status
Conduct the EVM assessment, develop and cost the Improvement plan including cold chain expansion	Government, <u>UNICEF</u> , WHO	October 2015	Completed
Develop a new c-MYP and application for Gavi support should the Government decide so	Government, <u>WHO</u> , <u>UNICEF</u>	September 2015	Completed
MR campaign – provide final reports, fund utilization report and plan for utilization of unutilized vaccine stocks/funds	Government	August 2015	Completed
Introduction of IPV in routine EPI	Government, <u>WHO</u> , <u>UNICEF</u>	May 2016	Due to non-availability of IPV delayed to the Q4 2017
Switching from tOPV to bOPV.	Government, <u>WHO</u> , <u>UNICEF</u>	May 2016	Use of tOPV stopped on 1 May, bOPV planned to be used starting from June 2016
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	TORs provided. Evaluation to be completed by December 2017
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	Completed
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	Ongoing
Introduce policy/regulation for reporting of vaccination in private health care facilities	<u>Government</u> , WHO, <u>UNICEF</u>	June 2016	Pending

## 5. PRIORITISED COUNTRY NEEDS<sup>1</sup>

*[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]*

<sup>1</sup> Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

Prioritised needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* (yes/no) If yes, indicate type of assistance needed
End of grant evaluation of HSS grant. It includes end-line survey for the performance indicators	Q3-4, 2017	WHO, Gavi in design of the evaluation and presentation of draft report/results (main responsibility is PMU)
A plan to scale up the training for VHWs and CHWs for Vietnam based on experiences from HSS grant (optional).  Project closure - PMU and 10 provinces to agree on how to maintain the project's results/experience. This will include solutions on HR, fund mobilization and other lessons learned	June 2017	
EPI related priorities have been included in the attached transition plan	2016 to 2019	The transition plan includes activities by WHO, UNICEF, World Bank and Sabin
Remove all tOPV from entire cold chain system	As soon as possible	

\*Technical assistance not applicable for countries in final year of Gavi support

\*Note: EPI related needs are embedded in the transition plan (attached)

## 6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS



*This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.*

<b>Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism</b>	HSCC and ICC meetings were organized with the JA mission to present, discuss and obtain endorsement on major recommendations as per prescribed process for the JA.
<b>Issues raised during debrief of joint appraisal findings to national coordination mechanism</b>	<p><u>HSCC meeting:</u></p> <ol style="list-style-type: none"> <li>1) Endorsement of no-cost extension till December 2017</li> <li>2) Evaluation of impact of training programs, training curriculum, worker performance and retention</li> <li>3) Use of lessons learnt for a new much larger World Bank project on training and HR capacity building at district level</li> </ol> <p><u>ICC meeting:</u></p> <ol style="list-style-type: none"> <li>1) Self-Procurement of Pentavalent vaccine through UNICEF</li> <li>2) Increased co-financing requirement presented to the Finance Ministry</li> <li>3) Choice of JE vaccine for the campaign and Gavi support</li> <li>4) Impact of long delay in IPV introduction and mitigation measures</li> </ol>
<b>Any additional comments from:</b>	<u>HSS project-MOH</u>
<ul style="list-style-type: none"> <li>• Ministry of Health</li> <li>• Gavi Alliance partners</li> </ul>	The project propose to GAVI the extension for 2017, in 12 months accompany with the project proposal

<ul style="list-style-type: none"> <li><b>Gavi Senior Country Manager</b></li> </ul>	<p>on objectives, activities, budget lines, project mechanism.</p> <p>Propose conducting the training evaluation and End of grant evaluation in Q3-4/2017, and final reports will be submitted in December 2017.</p>
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## 7. ANNEXES



*This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary*

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

The team consisted of WHO (Regional Coordinator for EPI, EPI officer and HSS officer from country offices), UNICEF (MCH officer from Country office) and Gavi (Senior Country Manager, HSS programme officer) working closely with NEPI and HSS officials of the Government.

The sources of information were latest JRF, updated data from the portal, inputs from respective teams in Gavi, meetings with HSS and EPI teams and observations during the field visit to a province/district/commune health centres.

The mission was divided into two parts – HSS and EPI. For HSS, a presentation was made on the progress and future plans, including the activities proposed during 2017 (extension period), end of project evaluation and impact assessment of the training activities. The support will close in December 2017.

The EPI meeting consisted of four presentations including the progress on EPI, future applications, MR campaign and contents of the transition plan.

Separate HSCC and ICC meetings were organized with participation of the mission members to present major findings/observations and obtain endorsement of two bodies as prescribed for JA process.

On last day of the mission, a debrief meeting was held with the Vice Minister. Issues of priority/concern with the Government included limitation of domestic resources for introduction of more new vaccines, application for Gavi support for Cold chain, impact of delayed IPV introduction and timelines for JE vaccination.

The JA report has been prepared jointly by JA participants and was shared with Government officials before its review by the HLRP.

### **Annex B: Changes to transition plan** (if relevant) *Plan presented for endorsement by the government*

Changes proposed	Rationale for changes	Related cost (US\$)	Source of funding for amended activities	Implementation agency	Expected result