GAVI Alliance

Annual Progress Report 2014

Submitted by

The Government of

Viet Nam

Reporting on year: **2014**
Requesting for support year: **2016**
Date of submission: **18/05/2015**

Deadline for submission: 27/05/2015

Please submit the APR 2014 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavi.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2014**

Requesting for support year: **2016**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Preventive Campaign Support	MR, 10 dose(s) per vial, LYOPHILISED	Not selected	2014
Routine New Vaccines Support	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2015

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

1.2. Programme extension

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2016	2019

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2014	Request for Approval of	Eligible For 2014 ISS reward
COS	Yes	Not applicable	No
HSFP	Yes	Next tranch of HSFP Grant No	No

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

There is no APR Monitoring IRC Report available for Viet Nam from previous year.

2. Signatures

2.1. Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government of Viet Nam hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Viet Nam

Please note that this APR will not be reviewed or approved by the High Level Review Panel (HLRP) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Nguyen Thanh Long, Vice Minister	**Name**	Truong Chi Trung, Vice Minister
Date		**Date**	
Signature		**Signature**	

<u>This report has been compiled by</u> (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Nguyen Van Cuong	Deputy NEPI Manager	+84 4 39725745 or +84 915342223	cuongepi@yahoo.com
Nguyen Hoang Long	Director, Vietnam Administration of HIV/AIDS Control; Director, HSS Project	+84 913503255	longmoh@yahoo.com
Duong Duc Thien	Officer, Department of Planning and Finance (Ministry of Health) Vice Director, HSS Project	+84 904393705	dducthien@yahoo.com

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Name/Title	Agency/Organization	Signature	Date

Mohamed Cisse, Chief, the Child Survival and Development Programme	UNICEF		
Toda Kohei, EPI Medical Officer	WHO		
Toda Kohei, EPI Medical Officer	PATH		
Dorothy Leab, Country Director, Human Resourcer for Health Programme – Programme Leader	AMP		

ICC may wish to send informal comments to: apr@gavi.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), MoH (Leaders of MoH, Representatives from involved departments), NIHE, WB, WHO, UNICEF, UNFPA, , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organization	Signature	Date
Prof., Dr. Nguyen Thanh Long, Vice Minister	Ministry of Health, Chair of HSSCC		
Dr. Nguyen Hoang Long, Director	Vietnam Administration of HIV/AIDS Control, MOH		
Dr. Dang Viet Hung, Leader	Planning and Finance Department, MOH		
Dr. Pham Van Tac, Leader	Personnel and Organization Department, MOH		

Assoc.Prof., Dr. Luu Thi Hong, Leader	Maternal and Child Health Department, MOH		
Dr. Tran Thi Mai Oanh, Leader	Health Strategy and Policy Institute, MOH		
Prof., Dr. Nguyen Cong Khan, Leader	Administration of Science, Technology and Training , MOH		
Assoc.Prof., Dr. Tran Dac Phu, Leader	General Department of Preventive Medicine, MOH		
Prof., Dr. Dang Duc Anh, Leader	National Institute for Hygiene and Epidemiology		
Dr. Dao Lan Huong, Health System Specialist	World Bank (WB) in Viet Nam		
Dr. Socorro Escalante, Team leader, Health Systems	World Health Organization (WHO) in Viet Nam		
Dr. Nguyen Huy Du, Maternal and Neonatal Specialist	United Nations Children's Fund (UNICEF) in Viet Nam		
Dr. Duong Van Dat, Team Leader, Reproductive Health	United Nations Population Fund (UNFPA) in Viet Nam		

HSCC may wish to send informal comments to: apr@gavi.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

Viet Nam is not reporting on CSO (Type A & B) fund utilisation in 2015

3. Table of Contents

This APR reports on Viet Nam's activities between January – December 2014 and specifies the requests for the period of January – December 2016

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Please also note that if the country applies the WHO multi-dose vial policy for IPV, the maximum indicative wastage rates are 5%, 15% and 20% for the 1-dose, 5-dose and 10-dose presentations respectively.

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 thereafter (%) for DTP	0	5	0	0		5		5		5
Wastage*[5]* factor in base-year and planned thereafter for DTP	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 be vaccinated) with 1st dose of DTP-HepB-Hib	1,631,026	1,669,008	1,650,597	1,650,597		1,670,405		1,752,039		1,773,063
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 thereafter (%)	5	5	5	5		5		5		5
Wastage*[5]* factor in base-year and planned thereafter (%)	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	90 %	0 %	90 %	90 %	0 %	0 %	0 %	0 %	0 %	0 %

Number	Targets (preferred presentation)	
	2019	
	Previous estimates in 2014	Current estimation
Total births		188,779
Total infants' deaths		0
Total surviving infants		188,779
Total pregnant women		188,879
Number of infants vaccinated (to be vaccinated) with BCG		1,794,340
BCG coverage*[1]*	0 %	950 %
Number of infants vaccinated (to be vaccinated) with OPV3		1,794,340
OPV3 coverage*[2]*	0 %	950 %
Number of infants vaccinated (to be vaccinated) with DTP1*[3]*		1,794,340
Number of infants vaccinated (to be vaccinated) with DTP3*[3][4]*		1,794,340
DTP3 coverage*[2]*	0 %	950 %
Wastage*[5]* rate in base-year and planned thereafter (%) for DTP		5
Wastage*[5]* factor in base-year and planned thereafter for DTP	1.00	1.05
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib		1,794,340
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib		1,794,340
DTP-HepB-Hib coverage*[2]*	0 %	950 %
Wastage*[5]* rate in base-year and planned thereafter (%)		5
Wastage*[5]* factor in base-year and planned thereafter (%)	1	1.05
Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of		1,794,340

Measles		
Measles coverage*[2]*	0 %	950 %
Pregnant women vaccinated with TT+		1,699,901
TT+ coverage*[7]*	0 %	900 %
Vit A supplement to mothers within 6 weeks from delivery		0
Vit A supplement to infants after 6 months	N/A	4,500,000
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	0 %

[1] Number of infants vaccinated out of total births

[2] Number of infants vaccinated out of total surviving infants

[3] Indicate total number of children vaccinated with either DTP alone or combined

[4] Please make sure that the DTP3 cells are correctly populated

[5] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

[7] Number of pregnant women vaccinated with TT+ out of total pregnant women

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2014 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2014.** The numbers for 2015 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  The number of surviving infants reported in 2014(1,750,358) in JRF are slightly lower than 2013 (1,782,720) and higher thanestimate for 2014 in APR 2013 (1,716,869). It is note that number of surviving infantsreported in 2014 from 63 Preventive Medicine Centres of 63 provinces in VietNam.

- Justification for any changes in **surviving infants**

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.** For IPV, supporting documentation must also be provided as an attachment(s) to the APR to justify ANY changes in target population.

  In thedecision letter on GAVI support to Viet Nam for IPV introduction dated 11February 2011.

  The Ministryof Planning and Investment of Viet Nam, General Statistics Office , states thatthe population of children under one year of age in 2013 was 1,704,084. The National Expanded Programme onImmunization (NEPI) estimates that the 2015 target population of children underone year of age is 1,737,471. This number has already been reported in the 2013Annual Progress Report to GAVI , and the 2013 Joint Reporting Form for WHO andUNICEF. In your letter of 11 February, you quote the number of doses to besupplied to Viet Nam in 2016 as 1,242,900.

  It is hope that there will be aupward revision in the estimates of the IPV requirements base on number oftarget population estimates by NEPI for Viet Nam as soon as possible.

- Justification for any changes in **wastage by vaccine**

  The national immunization policy of Viet Nam does not include the use of the multi-dose vialpolicy (MDPV) for any vaccine. Viet Nam takes the greatest care in applying immunization safety standards, which include a documented medical examination for everychild before vaccination. The estimated wastage rate for IPV in 10 dose vial presentation in Viet Nam is 35% which is consistent with DTP in 10 dose vial presentation.

5.2. Monitoring the Implementation of GAVI Gender Policy

5.2.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls
EPI Review in Viet Nam 2009	April 2009	99%	98%

5.2.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

In Viet Nam, both boys and girls have equal rights forhealth care, education and other basic rights. Findings from many EPI programreview evaluation show that no significant difference for boys and girls fortheir access to vaccination. Results from 2009 EPI review indicated that genderis not a significant factor affecting immunization service utilization, i.e 1%is the difference in DPT3 and FIC coverage between boys and girls (99% for boysand 98% for girls and 96%for boys and 95% for girls respectively). A New EPIReview include coverage survey will be conducted in third quarter 2015.

5.2.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Not selected**

5.2.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

5.3. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.3a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 20713	Enter the rate only; Please do not enter local currency name

Table 5.3a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2014	Source of funding						
		Country	GAVI	UNICEF	WHO	JICA	No	No
Traditional Vaccines*	4,989,388	4,989,388	0	0	0	0	0	0
New and underused Vaccines**	13,402,487	2,871,707	10,530,780	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	3,502,468	1,897,748	1,604,720	0	0	0	0	0
Cold Chain equipment	500,924	500,924	0	0	0	0	0	0
Personnel	0	0	0	0	0	0	0	0
Other routine recurrent costs	4,711,401	2,955,309	1,357,500	0	398,592	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	35,652,412	2,142,000	33,300,575	31,307	78,530	100,000	0	0
No		0	0	0	0	0	0	0
Total Expenditures for Immunisation	62,759,080							
Total Government Health		15,357,076	46,793,575	31,307	477,122	100,000	0	0

Traditional vaccines: BCG, DTP, OPV, Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support

5.4. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2014? **2**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2015 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.3 Overall Expenditures and Financing for Immunisation

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
PATH
AMP

5.5. Priority actions in 2015 to 2016

What are the country's main objectives and priority actions for its EPI programme for 2015 to 2016

Following are in brief main objectives and priority actionsfor 2015 to 2016 :

1) Maintain more than 95% coverage of the eligible population with all thevaccines included in the national immunization program with special effortsmade to increase the coverage in HRDs.

2) Maintain polio-free and Maternal Neonatal TetanusElimination status

3) Maintenance system for coldchain equipment at all levels

4) Maintain high HepB birth dose vaccination coverage and reduce missedopportunity for HepB vaccination in hospitals and health facilities.

5) Conduct MR campaign for target children from 1 to 14years old and introduction MR vaccine in routine EPI instead of MCV2 forchildren 18 moths.

6)Introduction of one dose of IPV for children 4 months at the same time withOPV3 in routine EPI and switching fromtrivalent OPV (tOPV) to bivalent OPV (bOPV).

5.6. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2014

Vaccine	Types of syringe used in 2014 routine EPI	Funding sources of 2014
BCG	Single use syringe	Gov.
Measles	AD syringe	Gov.
TT	AD syringe	Gov.
DTP-containing vaccine	AD syringe	Gov. + GAVI
IPV		
DPT4	AD syringe	Gov.
Typhoid	AD syringe	Gov.
JE	AD syringe	Gov.

Does the country have an injection safety policy/plan? **Yes**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

Not all of health facilities follow safety Plan. One of reagen for that is limited budget support from local government

Please explain in 2014 how sharps waste is being disposed of, problems encountered, etc.

The practice for disposal of immunization waste in 2014 were: incineration for urban area, open burning for rural area and burial in mountainous area.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2014

Viet Nam is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.2. Detailed expenditure of ISS funds during the 2014 calendar year

Viet Nam is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.3. Request for ISS reward

Request for ISS reward achievement in Viet Nam is not applicable for 2014

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2014 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2014 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2014 vaccinations against approvals for 2014

Please also include any deliveries from the previous year received against this Decision Letter

	[A]	[B]	[C]	
Vaccine type	**Total doses for 2014 in Decision Letter**	**Total doses received by 31 December 2014**	**Total doses postponed from previous years and received in 2014**	**Did the country experience any stockouts at any level in 2014?**
DTP-HepB-Hib	4,793,200	4,793,200	0	No

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  Quinvaxem vaccine was stop to use for 5 months(from May to September 2013) because AEFI cases. 354,264 doses of Quinvaxem wasdestroyed from mould during 2013. The coverage of Quinvaxem (DPT3) in 2013 isonly 59.36%. It is note that the coverage of children under one received threedoses of Quinvaxem vaccine in 2014 was high (95%).

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

  Closed to work with UNICEF

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

7.2. Introduction of a New Vaccine in 2014

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2014, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		
Nationwide introduction	Yes	01/06/2010
Phased introduction	Yes	01/06/2010
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	Yes

When is the Post Introduction Evaluation (PIE) planned? **December 2019**

7.2.2. If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

PIE will be done in September 2015. It will be reported to GAVI late.

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **Yes**

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **Yes**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

Sentinel surveillance for rota virus was setup in 04 health facilities for children under 5 years old. Total 2,222 caseswith specimen tested in the Lab in 2014. Number of cases with positive testsare 936. Sentinel surveillance for Bacterial meningitis was set up in 03 healthfacilities for children under 5 year old. Total 352 cases with specimen testedin the Lab in 2014. Number of cases with positive tests with Hib is 7; with pneumococcusis 45 and Meningococus is 7.

7.3. New Vaccine Introduction Grant lump sums 2014

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2014 (A)	0	0
Remaining funds (carry over) from 2013 (B)	1,348,562	28,368,370
Total funds available in 2014 (C=A+B)	1,348,562	28,368,370
Total Expenditures in 2014 (D)	320,849	6,749,383
Balance carried over to 2015 (E=C-D)	1,027,713	21,618,987

Detailed expenditure of New Vaccines Introduction Grant funds during the 2014 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2014 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

Training courses for EPI staff and other healthworkers at all levels on new vaccine introduction in EPI. It is includeproduction of guidelines and EIC materials for community and other targetpopulation. Monitoring and supportive supervision were conducted at alllevels.

Please describe any problem encountered and solutions in the implementation of the planned activities

Funds was received for introduction of MRvaccine on May 2013. However, MR campaign was conducted in 2014 and 2015.It was take time for prepare a lot of activities before conduct the campaign includeregister of MR vaccine in Viet Nam.

Please describe the activities that will be undertaken with any remaining balance of funds for 2015 onwards

1. Training: Dissemination workshops on MR introduction in routine immunization for national and regional levels. Training courses for new EPI staff and cold chain management staff and training on supportive supervision for EPI staff from provincial and distric levels;

2. Social Mobilizabion, IEC and advocacy: Development of IEC messages for introduction of MR vaccine into routine immunization and IEC works on news papers, social media and other mass medias about introduction of MR vaccine in routine immunization;

3. Surveillance and Monitoring: Conducting supportive supervision visits of national, regional, provincial and district levels and Transportation for supervisions activities;

4. Support localities: Providing Individual immunization books, recording books, reporting forms for provincial, district and commune levels. Supporting some difficult and mountainous areas on introduction of MR vaccine into routine immunization. Renting of cold stores at national and regional levels for MR vaccine and distribution of the vaccine and logistic to provincial level;

5. Assessment of output and effectiveness of the MR introduction activities;

6. Technical assistance: Hiring technical experts, advisors and financial experts;

7. Programme Management: management fee for National and regional levels, record, report, analysis, datafeedback, review activities for the MR introduction, office equipments, transportation and stationaries.

7.4. Report on country co-financing in 2014

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2014?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		760,000
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2014 from the following sources?	
Government	Yes	
Donor	No	
Other	No	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		760,000
	Q.4: When do you intend to transfer funds for co-financing in 2016 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2016	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	October	Gov.
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Inthe decision letter from GAVI dated 29 October 2013, ref:VNM-2013.02(xaxa)M Vietnam will procure 908,900 doses of Pentavalent vaccine for co-financing in 2014. However, with limited fund from the Government for EPI in 2014 we were only procured 760,000 doses. 148,900 doses of Pentavalent vaccine was not yes procurement for co-financing in 2014 will be procured in 2015.	

*__Note:__ co-financing is not mandatory for IPV

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at
http://www.who.int/immunization/programmes_systems/supply_chain/evm/en/index3.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **April 2012**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Are there any changes in the Improvement plan, with reasons? **No**

If yes, provide details

When is the next Effective Vaccine Management (EVM) assessment planned? **August 2015**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2014

7.6.1. Vaccine Delivery

Did you receive the approved amount of vaccine doses for MR Preventive Campaigns that GAVI communicated to you in its Decision Letter (DL)?

[A]	[B]	[C]
Total doses approved in DL	**Campaign start date**	**Total doses received (Please enter the arrival dates of each shipment and the number of doses of each shipment)**
27048940	15/09/2014	Shipments at Hanoi: 26/08/2014: 749,900 doses; 27/08/2014: 1,499,700 doses; 16/10/2014: 1,799700 doses; 24/10/2014: 1,799,700 doses; 31/10/2014: 2,024,700 doses; 23/12/2014: 4,297,800; Shipments at Ho Chi Minh City: 26/08/2014: 1,374,880; 27/08/2014:1,374,820; 17/09/2014: 2,195,820 doses; 18/09/2014: 2,203,820 doses; 17/10/2014: 2,474,760 doses; 09/12/2014: 2,627,820; 10/12/2014: 5,253,520.

If numbers [A] and [C] above are different, what were the main problems encountered, if any?

If the date(s) indicated in [C] are after [B] the campaign dates, what were the main problems encountered? What actions did you take to ensure the campaign was conducted as planned?

7.6.2. Programmatic Results of MR preventive campaigns

Geographical Area covered	Time period of the campaign	Total number of Target population	Achievement, i.e., vaccinated population	Administrative Coverage (%)	Survey Coverage (%)	Wastage rates	Total number of AEFI	Number of AEFI attributed to MenA vaccine
Nationwide	15/09/2014-15/05/2015	19931350	19551071	98	97	20	8	0

*If no survey is conducted, please provide estimated coverage by indepenent monitors

Has the campaign been conducted according to the plans in the approved proposal?" **No**

If the implementation deviates from the plans described in the approved proposal, please describe the reason.

The Decision letter from GAVI approuved for conducted the MR campaign on 08 April 2013. The plan for implement of campaign was in 2013 and 2014. However, vaccine register take more time as we expacted and it was register on May 2014. The campaign was stafrom 15th September 2014.

Has the campaign outcome met the target described in the approved proposal? (did not meet the target/exceed the target/met the target) If you did not meet/exceed the target, what have been the underlying reasons on this (under/over) achievement?

Targetchildren for MR campaign from 1 year instead of 9 months because MR vaccineregister in Vietnam used for children from 12 months of age. Total number oftarget children from 1 to 14 old for MR campaign is 19931,350. This is exactlynumber of children for the campaign from survey before the campaign. It isdifferent from estimated for target children from 9 months of age to 14 yearold for the campaign in application form to GAVI.

What lessons have you learned from the campaign?

Involvementof different organizers include of the central and local government.
The plan for the campaign at all levels was prepared well.
The role of medical people in the army will be very useful for remote areas andhard to reach areas.
Safe injection through training and monitoring will be very importance forreach high coverage.

Monitoring beforeduring and after campaign.

7.6.3. Fund utilsation of operational cost of MR preventive campaigns

Category	Expenditure in Local currency	Expenditure in USD
Total	**0**	**0**

7.7. Change of vaccine presentation

Viet Nam does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2015

If 2015 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2016 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby requests an extension of GAVI support for the years 2016 to 2022 for the following vaccines:

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**

At the same time it commits itself to co-finance the procurement of the following vaccines in accordance with the minimum Gavi co-financing levels as summarised in section 7.11 Calculation of requirements.

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**

The multi-year support extension is in line with the new cMYP for the years 2016 to 2022, which is attached to

this APR (Document N°**16**). The new costing tool is also attached (Document N°**17**) for the following vaccines:

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**

The country ICC has endorsed this request for extended support of the following vaccines at the ICC meeting whose minutes are attached to this APR. (Document N°**18**)

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**

7.9. Request for continued support for vaccines for 2016 vaccination programme

In order to request NVS support for 2016 vaccination do the following

Confirm here below that your request for 2016 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigen	Vaccine Type	2011	2012	2013	2014	2015	2016	2017
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID				2.60 %	2.70 %	2.80 %	3.30 %
MR, 10 dose(s) per vial, LYOPHILISED	MR, 10 dose(s) per vial, LYOPHILISED				12.70 %			

Vaccine Antigen	Vaccine Type	2018	2019
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	3.30 %	3.30 %
MR, 10 dose(s) per vial, LYOPHILISED	MR, 10 dose(s) per vial, LYOPHILISED		

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

ID		Source		2014	2015	2016	2017	2018
	Number of surviving infants	Parameter	#	1,716,869	1,737,471	1,758,321	1,844,251	1,866,382
	Number of children to be vaccinated with the first dose	Parameter	#	1,631,026	1,650,597	1,670,405	1,752,039	1,773,063
	Number of children to be vaccinated with the third dose	Parameter	#	1,631,026	1,634,091	1,670,405	1,752,039	1,773,063
	Immunisation coverage with the third dose	Parameter	%	95.00 %	94.05 %	95.00 %	95.00 %	95.00 %
	Number of doses per child	Parameter	#	3	3	3	3	3
	Estimated vaccine wastage factor	Parameter	#	1.05	1.05	1.05	1.05	1.05
	Stock in Central Store Dec 31, 2014		#	760,000				
	Stock across second level Dec 31, 2014 (if available)*		#	291,441				
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#	605,559				
	Number of doses per vial	Parameter	#		1	1	1	1
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes
	Reconstitution syringes required	Parameter	#		No	No	No	No
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes
cc	**Country co-financing per dose**	Parameter	$		0.46	0.76	1.06	1.36
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	0.0448	0.0448
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	0	0
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	0.0054	0.0054

fv	**Freight cost as % of vaccines value**	Parameter	%		2.70 %	2.80 %	3.30 %	3.30 %

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

Total stock in country include stock in one central store, regional stores and 63 procincial store were physical count by 31 December.

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

Not defined

Co-financing tables for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

Co-financing group	Graduating

	2014	**2015**	**2016**	**2017**	**2018**
Minimum co-financing	0.40	0.46	0.76	1.06	1.36
Recommended co-financing as per APR 2013			0.76	1.06	1.36
Your co-financing	0.40	0.46	0.76	1.06	1.36

	2019
Minimum co-financing	1.67
Recommended co-financing as per APR 2013	1.67
Your co-financing	1.67

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2014	**2015**	**2016**	**2017**	**2018**
Number of vaccine doses	#	3,884,300	4,578,600	4,234,800	3,745,300	2,689,500
Number of AD syringes	#	4,054,600	4,812,400	4,467,200	3,977,200	2,856,000
Number of re-constitution syringes	#	0	0	0	0	0
Number of safety boxes	#	45,025	52,975	46,600	41,200	29,600
Total value to be co-financed by GAVI	$	8,194,000	12,135,500	10,487,500	7,839,000	5,629,000

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2019
Number of vaccine doses	#	1,570,700
Number of AD syringes	#	1,667,900
Number of re-constitution syringes	#	0
Number of safety boxes	#	17,300
Total value to be co-financed by GAVI	$	3,287,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

2014	**2015**	**2016**	**2017**	**2018**

Number of vaccine doses	#	908,900	961,600	1,875,000	3,843,300	4,990,200
Number of AD syringes	#	948,800	1,010,700	1,977,900	4,081,200	5,299,100
Number of re-constitution syringes	#	0	0	0	0	0
Number of safety boxes	#	10,550	11,125	20,625	42,300	54,900
Total value to be co-financed by the Country *[1]*	$	1,917,500	2,548,500	4,643,500	8,044,000	10,444,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2019
Number of vaccine doses	#	6,201,200
Number of AD syringes	#	6,585,100
Number of re-constitution syringes	#	0
Number of safety boxes	#	68,225
Total value to be co-financed by the Country *[1]*	$	12,979,000

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 1)

		Formula	**2014**	**2015**		
				Total	**Government**	**GAVI**
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,631,026	1,650,597		
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,631,026	1,650,597		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	4,893,078	4,928,518		
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.05		
F	**Number of doses needed including wastage**	*D x E*		5,174,944		
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*				
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*				
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	1,500,000	760,000		
H3	**Shipment plan**	*Approved volume*		5,540,200		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		5,540,200		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*				

O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*				
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*				
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*				
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*				
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	**Total fund needed**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / T*				

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 2)

		Formula	2014		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*			
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,670,405	512,626	1,157,779
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,670,405	512,626	1,157,779
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	5,011,215	1,537,876	3,473,339
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	5,261,776	1,614,770	3,647,006
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*	32,563	9,994	22,569
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*	- 815,346	- 250,218	- 565,128
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*	1,125,257	345,327	779,930
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	6,109,700	1,874,987	4,234,713
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	6,445,037	1,977,897	4,467,140
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	67,207	20,625	46,582
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	14,437,222	4,430,593	10,006,629
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	288,738	88,610	200,128
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	366	113	253

R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	404,243	124,057	280,186
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	15,130,569	4,643,372	10,487,197
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	4,643,372		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	30.69 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 3)

		Formula	2017		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*	50.65 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,752,039	887,332	864,707
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,752,039	887,332	864,707
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	5,256,117	2,661,995	2,594,122
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	5,518,923	2,795,095	2,723,828
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*	2,069,597	1,048,161	1,021,436
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*			
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*			
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	7,588,550	3,843,271	3,745,279
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	8,058,286	4,081,172	3,977,114
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	83,475	42,277	41,198
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	15,025,329	7,609,677	7,415,652
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	361,012	182,837	178,175
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	455	231	224
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	495,836	251,120	244,716
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	15,882,632	8,043,863	7,838,769
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	8,043,863		

V	**Country co-financing % of GAVI supported proportion**	*U / T*	50.65 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 4)

		Formula	2018		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*	64.98 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,773,063	1,152,125	620,938
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,773,063	1,152,125	620,938
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	5,319,189	3,456,374	1,862,815
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	5,585,149	3,629,193	1,955,956
G	**Vaccines buffer stock**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** = • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*	2,094,431	1,360,948	733,483
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*			
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*			
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	7,679,600	4,990,153	2,689,447
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	8,154,983	5,299,054	2,855,929
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	84,476	54,892	29,584
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	15,205,608	9,880,502	5,325,106
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	365,344	237,399	127,945
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	460	299	161
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	501,786	326,058	175,728
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	16,073,198	10,444,256	5,628,942
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	10,444,256		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	64.98 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 5)

		Formula	2019		
			Total	Government	GAVI
A	Country co-finance	*V*	79.79 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	1,794,340	1,431,719	362,621
B1	Number of children to be vaccinated with the third dose	*Table 4*	1,794,340	1,431,719	362,621
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	5,383,020	4,295,155	1,087,865
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	5,652,171	4,509,913	1,142,258
G	Vaccines buffer stock	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** = • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*	2,119,565	1,691,218	428,347
H	Stock to be deducted	*H1 - (F (2015) current estimation x 0.375)*			
H1	Calculated opening stock	*H2 (2015) + H3 (2015) - F (2015)*			
H2	Reported stock on January 1st	*Table 7.11.1*			
H3	Shipment plan	*Approved volume*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	7,771,750	6,201,141	1,570,609
J	Number of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	8,252,844	6,585,010	1,667,834
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*	85,490	68,214	17,276
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	15,388,065	12,278,260	3,109,805
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	369,728	295,009	74,719
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	466	372	94
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	507,807	405,184	102,623
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	16,266,066	12,978,823	3,287,243
U	Total country co-financing	*I x country co-financing per dose (cc)*	12,978,823		
V	Country co-financing % of GAVI supported proportion	*U / T*	79.79 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

8. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2014**. All countries are expected to report on:

   a. Progress achieved in 2014

   b. HSS implementation during January – April 2015 (interim reporting)

   c. Plans for 2016

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2014, or experienced other delays that limited implementation in 2014, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2014 fiscal year starts in January 2014 and ends in December 2014, HSS reports should be received by the GAVI Alliance before **15th May 2015**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2015, the HSS reports are expected by GAVI Alliance by September 2015.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavi.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 8.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2014

   b. Minutes of the HSCC meeting in 2015 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2014 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

8. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

8.1. Report on the use of HSS funds in 2014 and request of a new tranche

Please provide data sources for all data used in this report.

8.1.1. Report on the use of HSS funds in **2014**

Please complete Table 8.1.3.a and 8.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 8.1.3.a and 8.1.3.b.

8.1.2. Please indicate if you are requesting a new tranche of funding **Yes**

If yes, please indicate the amount of funding requested: **3562452** US$

These funds should be sufficient to carry out HSS grant implementation through December 2016.

Table 8.1.3a (US)$

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)				3689552	12900284	4247712
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)				3689552	12900284	
Remaining funds (carry over) from previous year (*B*)					3604962	13939900
Total Funds available during the calendar year (*C=A+B*)				3689552	16505246	13939900
Total expenditure during the calendar year (*D*)				84590	2565346	5599645
Balance carried forward to next calendar year (*E=C-D*)				3604962	13939900	8340255
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	4186000	0	3689552	12900284	4247712	7810164

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	3562452			
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the	4247712			

calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)	8340255			
Total Funds available during the calendar year (*C=A+B*)	12587967			
Total expenditure during the calendar year (*D*)	1107557			
Balance carried forward to next calendar year (*E=C-D*)	11480410			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	3562452	0	0	0

Table 8.1.3b (Local currency)

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)				76846	268687	88471
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)				76846	271370	
Remaining funds (carry over) from previous year (*B*)					75084	293023
Total Funds available during the calendar year (*C=A+B*)				76846	346454	293023
Total expenditure during the calendar year (*D*)				1762	53431	117565
Balance carried forward to next calendar year (*E=C-D*)				75084	293023	175458
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	77634456	0	76845989	268687	88471	163411

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	76443			
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)	91147			
Remaining funds (carry over) from previous year (*B*)	175458			
Total Funds available during the calendar year (*C=A+B*)	266605			
Total expenditure during the calendar year (*D*)	23211			
Balance carried forward to next calendar year (*E=C-D*)	243294			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	76443	0	0	0

Report of Exchange Rate Fluctuation

Please indicate in the table Table 8.3.c below the exchange rate used for each calendar year at opening and closing.

Table 8.1.3.c

Exchange Rate	2009	2010	2011	2012	2013	2014
Opening on 1 January	16106	16973	18544	20813	20828	21036
Closing on 31 December	16973	18544	20813	20828	21036	21036

Detailed expenditure of HSS funds during the 2014 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2014 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2015 period are reported in Tables 8.1.3a and 8.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Has an external audit been conducted? No

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

8.2. Progress on HSS activities in the 2014 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 8.2. It is very important to be precise about the extent of progress and use the M&E framework in your original

application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 8.2: HSS activities in the 2014 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Objective 1: Support Human Resource Development for Health			
Act 1. Provide 6-9 month training courses for VHWs	Organize 24 training courses for 912 VHWs	93	Report of 10 PHDs
Act 3. Training courses on EPI in Practice for CHWs	Organize 40 training courses for 1600 CHWs	98	Report of 10 PHDs
Act 4. Training courses on MCH for CHWs	Organize 40 training courses for 1600 CHWs	98	Report of 10 PHDs
Objective 2: To strengthen management capacity to deliver basic health services through ensuring adequate supply of essential equipment for health facilities			
Act 5. Supply of essential equipment to DHCs, CHCs and VHWs	Provide essential equipment to 30 DHCs, 500 CHCs Provide 10,000 VHW kits	80	Report of 10 PHDs and the PMU
Act 6. Support outreach immunization spots in mountainous communes	Support 2230 outreach immunization spots	97	Report of 10 PHDs
Objective 3: To strengthen capacity in response to the needs for health sector reform and development in the new situation			
Act 7. Training courses on health planning and M&E for provincial and district health managers	Organize 15 training courses for 600 health managers	93	Report of 10 PHDs and the PMU
Act 8. Support for Joint Annual Health Review (JAHR)	Support the development of JAHR 2014	100	Report of the PMU
Act 9. Support for M&E and supervisory visits	Promote M&E visits of central level, provincial level and district level	95	Report of 10 PHDs and the PMU
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	100	Report of the PMU
Act 11. International workshops, training, study tours01 trip organized to support staff of line ministries, sectors to attend	01 trip organized to support staff of line ministries, sectors to attend international conferences, workshops and short-term study visits		Report of the PMU

international conferences, workshops and short-term study visits overseas	overseas		
Act 12. Local training/ workshops	Support annual project workshops in the central and provincial levels.	100	Report of 10 PHDs and the PMU
Project management			
Office equipment and supplies	Office equipment and furniture purchased	100	Report of 10 PHDs and the PMU
Running cost	Telephone, photocopy, stationery	100	Report of 10 PHDs and the PMU
Salary for project staff	Salary for 9 PMU full-time staffs paid on monthly basis	100	Report of 10 PHDs and the PMU
Allowance for PMU	Allowances for 5 PMU members paid on monthly basis	100	Report of the PMU
Annual Financial Audit	An independent auditing company recruited	100	Report of the PMU
International and national consultants	Hire consultants to support the implementation of the project (M&E, training, procurement of equipment etc…)	90	Report of the PMU

8.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Objective 1: Support Human Resource Development fo	
Act 1. Provide 6-9 month training courses for VHWs	22 training courses for 884 VHWs were conducted, achieving 93% against set target, in which, 12 courses were accomplished in 2014 and the remaining have been going on. Trainees after graduated from the courses have taken over job as VHWs in their resident areas. Only 2 courses did not take place in 2014 due to delay in recruiting trainees, but they were conducted in early 2015.
Act 3. Training courses on EPI in Practice for CHW	38 training courses were conducted for 1533 CHWs, obtaining 98% against set target. Trainees were granted with EPI certificates that increase number of qualified CHWs performing EPI tasks at CHCs and outreach immunization spots. Only 2 courses did not take place in 2014 due to delay in recruiting trainees, but they were opened and completed in early 2015.
Act 4. Training courses on MCH for CHWs	38 training courses were conducted for 1522 CHWs, obtaining 98% against set target. Trainees were updated with MCH knowledge and skills, contributing to improvement of MCH care at grassroots level. Only 2 courses did not take place in 2014 due to some delay in recruiting trainees, but they were opened and completed in the early 2015.
Objective 2: To strengthen management capacity to	
Act 5. Supply of essential equipment to DHCs, CHCs	Essential medical equipment and VHW kits are divided into 7 bid packages and in 2 stages: Stage 1 includes 3 bid packages, stage 2 includes 4 bid packages. Contracts of 3 bid packages in stage 1 were signed in December 2014. In April-May 2015, equipment will be delivered to beneficiary facilities. Contracts of 4 bid packages in stage 2 were signed in May 2015 and equipment will be delivered in October and November 2015. Reasons for slow progress: i) Amendment and supplementation in the Bidding Law led to re-development of procurement plan and bid documents. That

	procedure long time in 2014. ii) Careful and thorough review of needs for equipment to ensure equipment is effectively and efficiently used
Act 6. Support outreach immunization spots in moun	2265 outreach immunization spots were supported in 2014. Compared to the plan of 2330 outreach spots to be supported, this activity achieved 97%. Around 274843 children (85% come from ethnic groups) were immunized and approximately 64408 women (75% are ethnic) were vaccinated against tetanus at the outreach spots.
Objective 3: To strengthen capacity in response to	
Act 7. Training courses on health planning and M&E	14 courses were organized for 523 health managers at provincial and district level, achieving 93% against the set target. Trainees were facilitated and updated with new knowledge and practical skills on health planning, monitoring, supervision and evaluation that they can apply daily and effectively in their routine work.
Act 8. Support for Joint Annual Health Review (JAH	Topic of JAHR2014 is "Promoting Prevention and Control of Non-Communicable Diseases. JAHR 2014 was developed and published as planned with major financial support from the project. The report was disseminated via distribution of reports in annual meeting of Consultative Group, workshops and seminars of MoH and other relevant ministries/agencies, on website of MoH and JAHR. The report is widely used for health planning and policy dialogues between MOH and development partners.
Act 9. Support for M&E and supervisory visits	All project provinces received supportive monitoring and evaluation visits from central level on the periodical basis. The provincial level paid regularly supervised health care performance at district and commune levels. Monitoring and evaluation team comprises officers from relevant health departments/units (preventive health department, maternal and child health department, department of disease control…). Apart from supervising project activities, the supervision team specially focuses on monitoring and evaluation of health care activities at grassroots level, including: CHCs accredited with national health benchmark standards, health manpower, equipment and infrastructure, EPI, MCH care, performance of VHWs, ….
Act 10. Support for initiatives and policies to st	In 2014, 8 researches and initiatives on health care at grassroots level were carried out by PMU, MoH department and research institutions. The topic of researches and initiatives are: 1. Situation of service delivery at CHCs in some regions and associated factors (conducted by PMU and Hanoi Medical University) 2. Initiative for policy development: Research and proposal for regulations on organization and personnel of commune/ward/township health centres by Department of Personnel and Organization– MoH 3. Evaluation of results of training for CHWs and VHWs in some provinces funded by GAVI project by Health Strategy and Policy Institute 4. Evaluation of outreach immunization spot situation in some project communes funded by GAVI by PMU 5. Studying current situation and proposal for solutions to improve quality of EPI in Bac Kan province by Bac Kan Provincial Department of Health. 6. Situation of human resources and capacity to provide immunization and health care services at CHCs in Hoa Binh provinces by Hoa Binh Provincial Department of Health 7. Situation of health care and treatment and affecting factors at grassroots level in Nghe An province by Nghe An Provincial Department of Health. 8. Evaluation of immunization for children under one year of age in Ha Tinh in 2013 by Ha Tinh Provincial Department of Health.
Act 11. International workshops, training, study t	This activity was not conducted in 2014. The PMU have been working with WHO and relevant departments and institutions to select reasonable place and themes for the study tour.
Act 12. Local training/ workshops	11 workshops was conducted (one by PMU and 10 by project provinces) to review project progress, achievement, shortcomings

	and and the implementation plan in 2014. In addition, PMU organized 01 training workshop on project and financial management, 01 bi-annual workshop.
Project management	
Office equipment and supplies	Office equipment and furniture were purchased and provided to PMU and PHDs
Running cost	Overhead support was provided
Salary for project staff	Paid on monthly basis without interruption
Allowance for PMU	Paid on monthly basis without interruption
Annual Financial Audit	External audit was conducted in April-May 2014. Audit report was submitted to GAVI.
International and national consultants	Local consultants were recruited to assist the PMU in conduction of researches. Besides, consultants were hired to support the process of supply of essential equipment (develop technical specifications of equipment, evaluate bids, supervise the delivery and use of equipment).

8.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Most of the project activities were conducted as planned and achieve set target. *The supply of essential medical equipment (activity5)* was a slightly slower in progress. This activity was planned to be carried out in 2014. However due to both subjective and objective reasons, this activity experienced slow progress than scheduled. The progress of this activity in 2014 achieved 80%. By numerous efforts,the PMU conducted procurement of equipment cautiously and efficiently. Whole list of equipment was carefully reviewed regarding needs for quantity and variety, including immunization equipment (cold chain), MCH care equipment and specialized equipment. Procurement of equipment follows procedures as regulated by Vietnam government. 7 bid packages are procured in 2 stages: 3 bid packages in stage 1 and 4 bid packages in stage 2. Nevertheless, in mid of 2014, new bidding law (Bidding Law No. 43/2013/QH 2013) was put into effects with many supplemented and amended articles affecting the progress of the activity implementation. As a result, contracts of 3 bid packages of stage 1 were rewarded in December 2014 and have been ongoing with supply of VHW kits and equipment (April – May 2015), 4 bid packages of stage 2 have been moved to be implemented in 2015 (tentatively quarter 3/2015, equipment of these 4 bid packages will be delivered to 10 project provinces). Therefore, this activity has somehow affected overall disbursement of the project as well as receipt of budget for 3rd and 4th year of the project. By the end of 2015, the project will provide essential equipment to 30 DHCs, 500 CHCs and 10,000 VHW kits.Supplied with equipment under the project support, capacity for EPI performance,quality of vaccines preservation, health care services at grassroots level will be improved. That escalates and increases quality of medical services and primary health care for people of 10 project provinces.

Activity 11 (International workshops, training, study tours) was not conducted in 2014 because the PMU need more time to work with WHO and relevant departments/institutions to find reasonable place and themes for the study tour.

8.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

The GAVI HSS activities have greatly strengthened the human resource for health sector in Vietnam. The project provides short-term and long-term trainings (6-9month training for VHWs; short-term trainings on immunization practice and maternal and child health care for district and commune health workers; training courses on planning, management, monitoring, evaluation and supervision for provincial and district health managers). All these above mentioned training activities are in-line and support current guidelines, policies and regulations of the government of Vietnam, Ministry of Health and National EPI program. Practically, these activities directly help increase qualified and standardized man power at grassroots health system and the health sector as a whole. For example, according to the circular No.07/2013/TT-BYT dated 8 March 2013, VHWs should have elementary standards upwards and finish at least a three-month training course following programs regulated by the MoH. The 6-9 month training courses supported by the project has helped increase standardized VHWs for grassroots health system. In addition, as regulated in the MoH's guidelines, CHWs must have training certificate on EPI practice to be able to provide immunization services. Under the project framework, 5 day training courses for CHWs are conducted. After the training, CHWs are granted with certificates that facilitate them with required standards to perform EPI tasks. Thus, the project has promoted development of qualified EPI staff at local level, leading to improvement in quality and safety in immunization.

8.3. General overview of targets achieved

Please complete **Table 8.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2013 from your original HSS proposal.

Table 8.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2014 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2010	2011	2012	2013	2014		
Impact indicators											
1. Maternal mortality ratio (per 100,000 lbs)	68	2010	58.3	64					49	Estimation by UNICEF, WHO, World Bank, UN Population Division in an analysis of maternal mortality trend. The official data is released by GSO in 2019.	
2. Under five mortality rate (per 1,000 lbs)	25	2010	19.3	22					22.4	GSO	
Outcome indicators											
3. Percentage of <1 yr children fully vaccinated	96	2011	>90	>90					97.1	EPI/NIHE	
4. Percentage of communes achieving new national benchmark of commune health care	76.8	2011	60	45					55	Primary health care report 2015, MoH	
5. Percentage of villages with VHWs	82.9	2011	90	87					95.9	Health Statistic Yearbook	
Process indicators											
6. Number of Village Health Workers having under gone 6-9 month training	0	2012	3268	2508					2660	Reports from project provinces	
7. Number of Commune Health Workers having undergone update training on EPI in practice	0	2012	5396	4180					4389	Reports from project provinces	
8. Number of Commune Health Workers having undergone update training on MCH	0	2012	5396	4180					4350	Reports from project provinces	

9. Number of District Health Centers (DHCs) and Commune Health Centers (CHCs) having received additional essential equipment	0	2012	530	30DHCs, 500 CHCs					0	Reports from project provinces and PMU	Budget was transferred in November 2013. The activity has been carried forward 2014 and 2015.
10. Number of health managers having undergone update training on health planning and M&E	0	2012	684	646					600	Reports from project provinces and PMU	01 training course has not been implemented

8.4. Programme implementation in 2014

8.4.1. Please provide a narrative on major accomplishments in 2014, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

The overall objective of HSS project is to strengthen health care system,especially at grassroots level, in order to contribute to sustained and increased high coverage of quality basic health services, particularly EPI and MCH outcomes in difficult areas. In order to achieve the project object, PMU classified project activities under three main themes: 1) development of human resources for health in difficult 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.

1) 1) Support development of human resources for health in difficult provinces

To support development of human resources for health in project provinces, long-term and short term training courses are organised to build capacity for HWs at grassroots level. Long term training courses are provided for VHWs in six to nine months. Short-term courses cover training on EPI in practice for district and commune HWs, and MCH training for commune HWs.

Regarding training for VHWs, the project supports either 6 or 9 month training courses for VHWs in10 project provinces depending on actual needs of each province. About 38 VHWs participate in a training course. Trainees were selected based on criteria set by provinces to ensure sufficient and skilled health workforce at grassroots level. The criteria include: trainees must have age ranging from 17 to 45 years old regardless of gender; own secondary educational standards upwards;currently work as VHWs or are going to work as VHWs; sign a commitment to work as VHWs after being trained; have their curriculum vitae endorsed by local authority; have good health; are able to serve in the village from two years upwards

Department of Health in ten project provinces was delegated to act as focal point to organize training courses for VHWs. The DoH signed responsibility contract/memorandum of understanding with local medical college/secondary medical school to conduct the training courses.Depending on local context, the courses were delivered: (i) full-time in school;(ii) one semester in school and one semester at district hospital. Training curriculum endorsed by Ministry of Health was used by the project in training courses for VHWs.

In 2014, 22 training courses for 884 VHWs were held achieving 93% against the set target. By the end of 2014, accumulatively the project has trained 2660 VHWs, around 72% of trained VHWs come from ethnic minority groups and more than 60% are female. Under the project's support, by the end of 2014, VHWs in 87% of the districts and 70% of the communes in the project provinces were trained. After graduated, trainees continue their work as HWs at their villages. In ten project provinces, the proportion of villages having active VHWs is 95.3%, same as the national proportion of 95.9%.

It is noted that contribution of the project to the standardization of VHWs are considerable. In 2003, MoH enacted Circular No.07/2013/TT-BYT re-regulating standards, functions and responsibilities of VHWs. Under the circular VHWs should have primary educational standards upwards and finish at least a three-month training course following MoH guidelines. However, national budget is quite limited to standardize all VHW staff as regulated by MoH. Thus, this activity of the project has significantly built up competent VHWs to provide basic health care services in the community.

Findings from an independent research done by the Health Strategy and Policy Institute to evaluate results of

training for CHWs and VHWs in provinces funded by GAVI HSS project reveal that theoretical and practical sections are properly allocated in training for VHWs. Returning to work after being trained, VHWs can perform well their responsibilities as identified by MoH including: conducting IEC activities in the community, provide basic health care services in the community, detecting epidemic diseases, and participating in activities of CHC. Moreover, the percentage of VHWs be able to identify dangerous signs during pregnancy is97.6%. Detection of epidemic diseases and IEC skills are considered the two strongest points of and have been most applied by VHWs in the community. Approximately 74% of VHWs can identify infectious diseases in the community that need to be reported to CHCs. Communication via conversations and group discussions are most used by VHWs (89.2% and 78.3%). Furthermore, all VHWs have proactively involved in EPI activities. They play a vital roles in management of immunization targeted groups, mobilization of mothers to take children to get immunized as schedule, support CHWs in arranging immunization sections and provide EPI communication and counseling. Apparently, improved knowledge and skills of VHWs after trained by the project are significant factors of strong and quality health care system at grassroots level.

Not only emphasizing on the standardization of VHWs, the project has paid due attention to strengthen capacity of HWs at district and commune levels through training courses on EPI in practice and MCH care. EPI training for district HWs was accomplished in 2013, achieving the target as set in the project document. Thus, as 2014 workplan, the project conducted EPI training for CHWs. Totally in the year 2014, 38 training courses were conducted for 1533 CHWs (65% are female and 30% are ethnic).

Due to some cases of AEFI causing suspicion about immunization quality and safety, the immunization coverage was dropped out in 2013. For maintaining and sustaining immunization coverage, in 2014 MoH enacted guidelines on management of immunization and vaccines, usage of vaccines and biologicals. Following these guidelines, HWs must be properly trained to be able to provide immunization services. Therefore, EPI training courses supported by the project efficiently build up resources for EPI. The project trained CHWs on EPI in practice so that any CHW can provide immunization services. After training,commune health workers have better knowledge and skills on: diseases in EPI and requirements for diseases supervision; vaccines in EPI; cold chain for vaccines preservation; immunization groups and schedule; planning for immunization at commune level; estimation of vaccines and supplies; safety in immunization; organisation of a immunization day; monitoring adverse effects after immunization; MoH regulations on usage of vaccines and health products and updated policies; statistics,reports and management of EPI data.

Although as regulated by the MoH, localities shall allocate their local budget to provide continuous training for grassroots HWs, almost all localities do not have sufficient fund for training on EPI in practice for CHWs. Thus, EPI training for CHWs of the project is very crucial to improve capacity of HWs, especially help the EPI achieve targets on coverage, quality and safety of immunization. Training on EPI for CHWs directly contributes to EPI activities to be conducted monthly inthe commune (at CHCs and at outreach spots). Furthermore, trained CHWs actively participate in IEC and counseling activities at the communities. In immunization days at CHC, all CHWs are mobilized to organise immunization activities.

In 2014, the Health Strategy and Policy Institute conducted a research in 2014 to evaluate results of training for CHWs,. Findings from the research show that: more than 90% of trained CHWs have accurate knowledge on immunization schedule, times, dosage. 95% of trained CHWs have knowledge on immunization screening, counseling and more than 90% of trained CHWs implement immunization sessions properly. Knowledge of CHWs after being trained (regarding immunization planning, receipt and preservation of vaccines, consultation and counseling, responses to AEFI...) are improved.Training program used by the project is appraised as appropriate and meet local needs. Training courses have effectively contributed to EPI activities at commune/village level.

Furthermore, results of “Evaluation of outreach immunization spot situation in some project communes funded by GAVI“ show that CHWs have good knowledge and skills to execute immunization activities at outreach spots. From 90 to nearly 100% of CHWs follow required steps in provision of immunization services. In addition, almost all CHWs perform well injection technical procedures, including: sterilization, right vaccines and dosage, accurate identification of immunized position, not touching needle, not putting the lid on technical container after injection. After vaccinated, all children are recorded in immunization book (immunization date, name of vaccines) monitored 30 minutes, counseled by CHWs and given dates for the next immunization shot.

Via evaluation of CHWs’ knowledge and skills after being trained, it is seen that EPI training courses for CHWs under the project’s support has significantly improved capacity of HWs at grassroots level. That directly leads to improvement of immunization quality which is a foundation for increasing and maintaining

immunization coverage.

The project has not only helped improve provision of immunization services but also increased quality of MCH care services at grassroots level through organization of training on maternal and child health care for HWs at commune level because MCH care is a vital priority of the health sector.

Despite of achievements in reduction of maternal mortality rate and expanded MCH care system, there are big gaps in maternal mortality ratio in different areas in Vietnam (JAHR 2014). In mountainous area,maternal mortality ratio is 3 times higher than that in plain areas. Besides, qualifications of HWs at commune level to provide quality MCH care in disadvantaged districts and communes are quite low. Additionally, though the proportion of deliveries assisted by professional HWs and deliveries at health facilities is high, that proportion is greatly different amongst various regions. More than 99% of women in the red and mekong river delta have their deliveries assisted by HWs, meanwhile that proportion is 78.9% and 79.7% in the northern mountainous and central highland areas respectively. Especially, only 63.4% of ethnic women give births with assistance from professional HWs.Proportion of home deliveries stays high: 22% in the northern mountainous midland; 20.7% in the central highland and 33.8% from ethnic women, compared to the national proportion of 7.4%.

In many health facilities, including newborn units in the district hospitals, there are insufficient medical equipment, medical supplies, drugs or essential skills to ensure interventions when needed to save newborns. MoH and EPI have made great efforts to promote vaccination of Hepatitis B at birth at the hospitals and qualified CHCs. However, HepB at birth coverage is not as expected.

Confronting the problem, MoH regulates that annually budget should be allocated to provide new and refresh training for HWs on MCH with emphasize on the importance of HepB vaccination at birth. Nevertheless, local authorities can spend very limited budget for those trainings. Number of CHWs who have not been re-trained for 2 years in ten project provinces account for a large proportion With support from the project, CHWs receive essential and updated MCH training in to provide quality MCH services. The project provided training courses on MCH care for CHWs covering contents on: essential obstetric care, essential newborn care,pregnancy check, delivery, referral, prevention of obstetric complications,immediate skill-to-skill contact and delay cord clamping, necessity of tetanus vaccination for newborns, linkage between MCH, HepB vaccination at birth, and immunization for under one year children... Trainees are CHWs in charge of MCH who have not received refresh trainings in the last two years. In addition, leaders of CHCs, nurses and midwives were also invited to the training so that they can provide MCH services when the staff in charge is away.

In 2014, the project held 38 courses for 1522 CHWs .62% of trainees are female and 34% are ethnic). Proportion of districts and communes have HWs trained on MCH in project provinces account for 100% and 90% respectively.

According to findings from valuation of results of training for CHWs in some project provinces, knowledge and skills of CHWs graduated from MCH training courses were significantly improved: more than 90%of CHWs have accurate knowledge on testing assignment, identification of pregnant status in each period and identification of symptoms of mothers and children to be monitored an hour and a day after delivery. Around 79% of trained CHWs know proper treatment of bleeding navel in newborn. It can be said that the project have contributed to improvement of capacity for HWs at grassroots level, leading to improved quality of MCH services and health management.

2) 2) ***Strengthening management capacity to deliver basic health services through ensuring adequate supply of essential equipment for health facilities***

Recognizing the importance of strengthening service delivery capacity to provide good basic health care services, the project supplies essential medical equipment to 30DHCs, 500 CHCs and 10000 VHW kits. List of supplied equipment is developed basing on standard list of MoH. Supplied equipment include: cold chain equipment to support the implementation of EPI, MCH care equipment and equipment for the health services at village, commune, district levels and VHWs' kits. Adequate supply of equipment plus qualified and competent HWs are main factors for the quality of basic health care at grassroots level

In 2014, the PMU and10 project provinces reviewed, updated and identified needs for equipment as well as list of supplied DHCs and CHCs. The main activities include:development of process for implementation of procurement plan; recruitment of procurement officers who have wide experiences in managing procurement activities of projects funded by GF, WB, GAVI; recruitment of national consultants to develop technical specifications, develop bidding documents and monitor the usage of equipments upon delivery; reviewing standard list of essential equipments; assessment of needs and capacity of beneficiary facilities to receive

equipment; procurement packaging; development of technical specifications; and development of bidding invitation. Especially, PMU greatly concentrated on the needs of DHCs, CHCs and VHWs. Thus, the assessment process were done thoroughly. The assessment has been done 3 times. Assessment focuses on the capacity of HWs to use equipment(certificates of HWs to be able to use equipment or commitment from Provincial Departments of Health to train HWs to use the supplied equipment) and facilities to install them (beneficiary facilities well prepare in advance infrastructures for equipment installation and utilization). The project has closely worked with EPI, MCH department, related stakeholders and beneficiary facilities to avoid overlapping, ensure effectiveness and efficiency of supplied equipment and invest in disadvantaged areas.

According to the study on ”Situation of service delivery at CHCs in some regions and affecting factors”, in 2014 no CHCs had sufficient basic medical equipment. Only around 70% of CHCs own more than 50% of essential medical equipment. The proportion is lower in far and mountainous areas. Thus, the supply of equipment sufficiently and timely to 30 DHCs and 500 CHCs is one of the sustainable conditions that strengthen provision of people health care services including immunization and MCH services and reduce inequity in accessing health care services in remote,far and disadvantaged areas.

Apart from supply of equipment to health facilities for quality improvement of health care services, the project brings immunization services to hard to reach areas. GAVI HSS project continued support outreach immunization spots outside CHCs. The arrangement and organization of outreach spots are in accordance with guidelines of the MOH.Only mountainous and very difficult communes where immunization services are hard to reach received this support. The support has helped 10 project provinces improve coverage and quality of immunization, especially in the hard-to-reach communes and villages.

In 2014, the project supported 2256 outreach immunization spots. Around 274,843 children were immunized and cared at the outreach spots and 64,408 women were vaccinated against tetanus. The majority of beneficiaries of the activity of support outreach immunization spots are ethnic children and women. Proportion of ethnic children makes up 85% and 75%of women vaccinated against tetanus at outreach spots are ethnic. With this activity, the project assists children and women to easily access to EPI services, increase fully immunization for children under one and to increase immunization coverage. As a result, proportion of immunization coverage in ten project provinces is 96%, just 1% lower than the national coverage of 96.1%.

To review situation of outreach immunization spots in 2013-2014, PMU coordinated with national consultants to conduct an evaluation of outreach immunization spot situation in some project communes funded by GAVI. Findings of the evaluation show that37.9% of households in areas where outreach spots are organised under the project’s support are poor and near-poor, which is one of the barriers for local people to access to health care services in general and immunization services in particular. Additional barriers preventing mothers taking their children to CHCs for immunization are difficult travelling (55.8 %), busy working schedule(23.3%) and limited understanding about importance of immunization (23.3%). Thus,outreach immunization spots help to ease their difficulties in accessing to immunization services. The study results also reveal that almost all local people say that it is easier for them to access outreach spots than to CHCs and they are satisfied with services at the outreach spots.

Furthermore,surveyed CHWs claim that outreach immunization spots help: i) increase proportion of children immunized as scheduled (74.7% of interviewed CHWs); ii)increase immunization coverage (73,6%); iii) reduce dropping out rate(72,4%). These figures show that outreach immunization spots have greatly contributed to the success of EPI and benefited children and families in disease prevention.CHCs have better managed immunization targeted groups thanks to outreach spots that are closer to local people. Thus, 92% of interviewed CHWs recommend that itis important to maintain and sustain outreach spots because of the convenience in accessing services.

CHWs share their opinions in in-depth interviews under the study survey as follows:

“If immunization services are only provided in CHCs,the immunization coverage may decrease due to long traveling for local people to access to CHCs”

“It is vital to maintain outreach immunization spots because the farthest village to CHC is 20 kilometers. If HW don’t go to the village to provide immunization services, people will not take their children to CHC. It hard for HWs but HWs are willing to bring immunization services to people otherwise children will not be immunized. That will lead to epidemic outbreaks and the decrease in immunization coverage”.

Mothers in disadvantaged and far communes/villages where outreach immunization spots are implemented trust capacity of CHWs, know about importance of immunization and do not worry about side effects and AEFI as they are counseled by CHCs. They affirm to have their children immunized as EPI schedule. Support

outreach immunization spots helps ensure equity in accessing immunization services for under 1 year children and pregnant women. Particularly, organization of immunization activities at outreach spots has partially pushed immunization coverage up and brought about success of EPI campaigns. For example, in the conduction of measles and rubella campaign in 2014 & 2015, outreach immunization spots are places where children in mountainous, disadvantaged and hard to reach communes and villages can access to measles and rubella vaccines. That contributes to the achievement of MR campaign and increases immunization coverage as a whole.

3) ***3) Strengthening capacity in response to the needs for health sector reform and development in the new situation***

Strengthening health management capacity is one of the key contents in the health sector reform in the current context. To contribute to that process in the grassroots level, the project supported training courses on health planning and M&E for both provincial and district managers. In 2014, 523 health managers at provincial and district level were trained on health planning, health financing, monitoring, supervision and evaluation in health sector.... that helps heath managers at local level execute their job effectively. This activity of the project has strengthened capacity of local health planning officers following updated MoH template and capacity of supervising health performance at grassroots level in particular and the country health system in general.

On one hand the project facilitates health staff at grassroots level with theory of health planning, monitoring and evaluation as mentioned above.On the other hand, the project equip them with practical skills on M&E through activity to support for M&E and supervisory visits, aiming at strengthening heath sector at lower level. Monitoring and evaluation were regularly paid with a focus on professional performance of EPI, MCH care,consultation at grassroots level. Monitoring and evaluation team comprises officers from relevant health departments/units (department of preventive medicine, maternal and child health department, department of disease control…). Apart from supervising project activities, the supervision team specially focuses on monitoring and evaluation of health care activities at grassroots level, including: CHCs accredited with national health benchmark standards, health manpower, equipment and infrastructure, EPI, MCH care,performance of VHWs. Monitoring and evaluation use forms, checklists, direct observation, records, reports and meeting documents.

So as to investigate situation of health system, problems of health sector at grassroots level to develop health initiatives and policies, 8 studies were funded by the project in 2014. The studies include: 1) Situation of service delivery at CHCs in some regions and associated factors; 2) Research and proposal for regulations on organization and personnel of commune/ward/town health centres; 3) Evaluation of results of training for CHWs and VHWs in some provinces funded by GAVI-HSS project; 4) Evaluation of outreach immunization spot situation in some project communes funded by GAVI; 5) Studying current situation and proposal for solutions to improve quality of EPI in Bac Kan province; 6) Situation of human resources and capacity to provide immunization and health care services at CHCs in Hoa Binh province; 7) Situation of health care and treatment and affecting factors at grassroots level in Nghe An province; and 8) Evaluation of immunization for children under one year of age in Ha Tinh in 2013. The studies supported localities to identify shortcomings and challenges in EPI implementation so as to develop concrete solutions to improvement of immunization quality and coverage. The studies supported localities to identify shortcomings and challenges in EPI implementation so as to develop concrete solutions to improvement of immunization quality and coverage.

Basing on results of the research for regulations on organization and personnel of commune/ward/town health centres, proposal was made by MoH to develop a decree on commune/ward and township health. The decree was endorsed by the Government of Vietnam on 8 December 2014 (Decree No.117/2014 regulating commune/ward and town health).

Furthermore, annually the project gives major financial support for development of Joint Annual Health Review (JAHR). The JAHRs are used to assess the progress, determine problems, priorities and follow-up performance of health sector in Vietnam on an annual basis. This is also a forum for dialogue on key issues in health sector development, including basic health care network, public health programmes as well as the M&E tool for health system performance.

JAHR 2014 with the topic “Strengthening Prevention and Control of Non-Communicable Diseases” was published and distributed to relevant agencies inside and outside health sector. JAHR 2014 report is organized in three parts with eight chapters. Part 1 is the updates on the health system, the main part is part 2 on strengthening prevention and control of non-communicable diseases,and part 3 discusses conclusions and recommendations. JAHR 2014 report was published and distributed to relevant agencies inside and outside

health sector.

In 2014, workshops/meetings were conducted as planned. PMU and DoH in the project provinces organized 11 workshops to review project progress, achievement,shortcomings and develop implementation plan in 2014. PMU also organized 01training workshop on project and financial management, 01 biannual workshop. In the workshops, regulations on project and financial management, supply of equipment, updates on health care policies, health care system as a whole and health care at grassroots level in particular and reporting activities were presented.

Notably, the Health Systems Strengthening Coordination Committee (HSSCC) is re-consolidated in Decision No.1538/QD-BYT dated 23 April 2015. Following the decision, leader of General Department of Preventive Medicine is a member of HSSCC to closely monitor and coordinate immunization activities. HSSCC has proactively coordinated and monitored project activities at central and local level contributing to the efficiency and effectiveness of the project impacts.

Overall, HSS project has significantly contributed to sustained immunization coverage, quality and safety of immunization and equity in accessing immunization services via specific activities for capacity building for HWs, supply of essential medical equipment, strengthening supportive monitoring and evaluation, networking and mobilizing participation of relevant agencies and development partners and directly bringing immunization services to villages/hamlets. Impacts of the project has been highly appraised local people and authorities in the supported provinces and for the health system of the country.

8.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

Due to amendments in procurement policies in 2014, progress of activity of essential medical equipment supply is slower than planned. To solve this problem, PMU recruited experienced procurement officers and leading procurement consultants to implement procurement procedures. The activity has been now smoothly ongoing. By the end of 2015, all equipment will be supplied to beneficiary facilities.

8.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

At central level:

M&E activities are implemented on regular basis. The PMU has issued a set of M&E indicators, reporting templates and tables sent to all 10 project provinces. These indicators are linked with Health Management Information System set by the Ministry of Health. Quarterly, PHDs send a progress report which describes project activities, process indicators, achieved outputs, and financial statement to the PMU. In addition to reports, the implementation of project activities at the project provinces also monitored and supervised in regular M&E visits organized by the PMU, HSSCC and MOH.

Apart from bi-annual and annual workshops which are participated by related stakeholders, HSSCC members and PHDs, PMU also organizes workshops/meetings on special contents on finance, planning, MCH, EPI and management to update health regulations and policies as well as to help participants share experiences in project implementation and management of grassroots health care activities.This helps build capacity of health workers at local level.

At local level:

M&E activities are assigned as functions and responsibilities of the PHDs and district health centers to make sure that the project activities are implemented according to the guidance of current regulations and mechanism and the funds are used efficiently.Besides, the PMU conducted series of M&E training for provincial and district health authorities to strengthen their capacity in supportive monitoring of health activities at basic level.

HSSCC also monitors project implementation to ensure that activities are delivered at the set objectives and approved budget. Quarterly, PMU send progress and financial reports to HSSCC for review. The HSSCC holds regular meetings every 6months or unscheduled meetings when issues arise. The Department of Planning and Finance (DPF) acts as the focal point to coordinate meetings, seminars as guided by the head of the committee.

Since the commencement of GAVI-HSS project, the above mentioned arrangements for monitoring and evaluating GAVI-HSS activities have shown effectiveness and proven positive progress in managing project

activities (systematic reporting mechanism, skills to implement project activities, regular update of project indicators), contributing to the strengthening of health system at grassroots level. Thus, PMU continues to apply this management mechanism.

8.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

The PMU develop internal M&E system that includes indicators for project monitoring and evaluation. All GAVI-HSS impact and output indicators are from essential health indicators,e.g. Percentage of children under one year of age fully immunized, percentage of villages with a VHW, percentage of CHCs meeting national health benchmarks,child and maternal mortality… These indicators are also the current M&E indicators of the health system, included in the 5-year health sector plan(2011-2015) and in the health management information system (HMIS) of Vietnam.These indicators are assessed and included in the Joint Annual Health Reviews(JAHRs), which has been developed jointly by the MOH and development partners,discussed and shared among stakeholders, including national and international agencies since 2007. These indicators are reported to the central Government for monitoring performance of the health sector as well.

Furthermore, PMU revised tools for internal M&E. Forms, checklists, tables are developed to collect data of all activities under the project framework. Specifically, data on gender,ethnicity are gathered for training related activities. For outreach immunization activity, proportion of ethnic children and women benefited are also collected. In addition, the PMU revised and divided the project indicators into four main groups: 1) Input indicators (long-term training for VHWs;short-term professional training on EPI, MCH, planning, M&E; supply of medical equipment; health services), intermediate indicators (professional skills of HWs, supply of medical equipment), output indicators (EPI proportion,proportion of CHCs accredited with the national benchmark standards, proportion of villages with active VHWs) and impacts indicators (under 5 mortality rate,maternal mortality rate, suffering and death cases induced by diseases related to expanded immunization). These groups of indicators were collected and maintained annually to monitor the project progress by years and will be used for comparison with mid-term and final indicators to evaluate the achievements made by the project.

PMU have maintained internal M&E system with existing tools and indicators. Moreover, in 2014, PMU coordinated with research institutes/agencies (Health Policy and Strategy Institute, Hanoi Medical University, Organization and Manpower Department) to conduct studies and health initiatives on health system strengthening. The studies focus on: situation of health care activities at commune level and proposing policies for health system strengthening; capacity of provision of health care services at commune level; evaluation of HSS training activities; and assessment of situation and results of out-reach immunization spots. Results of the studies are valuable evidences to assess the project’s achievements and serve as scientific references regarding grassroots health system in Vietnam.

8.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

GAVI HSS implementation is supervised by both Governmental and non-governmental organizations at central and local levels, as follows:

Name of organization

Participation

Maternal and Child Health Department (Ministry of Health)

- Develop training curriculum on MCH for district and commune health workers
- Participate in the training courses as key trainers/facilitators on MCH
- Participate in field M&E visits

Other related MOH Departments, including: Planning and Finance Department; Manpower and Organisation Department; Science, Technology and Training Department; Health Strategy and Policy Institute, National Institute of Hygiene and Epidemiology, Hanoi Medical University.

- Monitor and evaluate the HSS implementation

- Review and recommend for the project annual workplan, procurement plan
- Participate in meetings/workshops of the project to provide comments and recommendations for project implementation.
- Participate in field M&E visits
- Involve in researches on HSS

National EPI Programme

- Develop training curriculum on EPI for district and commune health workers
- Participate in the training courses as key trainers/facilitators on EPI
- Participate in field M&E visits
- Review and recommend studies on EPI

WHO, WB, UNICEF, UNFPA

- Participate in the HSSCC (see the detailed TORs of the HSSCC)

Heath Partnership Group

(HPG)

- Be informed and discuss about implementation of the HSS as well as other support for the health sector

Provincial EPI Program

- Participate in TOT courses organised by the PMU and National EPI Program
- Participate in the training courses for district and commune health workers as key trainers/facilitators on EPI
- Participate in field M&E visits to district, commune and village levels

Provincial Secondary Medical Schools

- Organise 6-9 month training courses for village health workers

Provincial People Committee

- Approve action plan, procurement plan and monitor HSS implementation in the project provinces

Provincial Department of Health

- Comprehensively responsible for implementation of the HSS in the province

Local Civil Society Organisation, e.g., Fatherland Front, Women's Union, Farmers Association, Youth Union, etc.

- Participate in the process of decision making for socio-economic development strategies, including health sector.
- Join the monitoring and supervision of performance of the health sector, including HSS.
- Collaborate with health workers at grassroots level to implement public health care communication activities and social mobilization.

8.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

Under the framework of HSS project in the period 2012-2016, CSOs did not receive funding from HSS

project. CSOs have voluntary been co-implementers of the project activities as follows:

CSOs have proactively integrated their activities in encouraging people to protect environment for a healthy life,prevent diseases, and use safe water… In addition, representatives from CSOs(Women's Union, Youth Union, Farmers' Association…) are members of People Health Care Committee at commune level. The Committee mobilizes participation from local authorities and organizations into social and health work.Activities of the committee are steered by the local health sector.

EPI activities at the commune and village level are focally managed by health sector. Depending on special local circumstances, health sector consult communal authority to mobilize participation from Women's Union, Youth Union, Fatherland Front, Farmers' Union, village/hamlet leaders and community in immunization sessions/campaigns.

CSOs have actively supported project activities under the main guidance and instruction from health sector at grassroots level. For example, for organization of immunization activities at outreach spots, members of Women's Union, Farmers Association, and Youth Union,etc,.. are mobilized to go to households to give the EPI invitations and encourage mothers and children to go to CHCs or outreach spots for immunization. In addition, members of CSOs provide supports such as preparing spaces for immunization, welcoming mothers and children, mobilizing participation of local residents and authorities to support immunization activities in the locality.

IEC activities on immunization, MCH and other HSS activities receive strong support and involvement by Red Cross Association,Women's Union, Fatherland Front and Youth Union. Different health care activities, especially the accomplishment of national health targeted programs at the community level, were implemented with active participation and support from private health facilities and retired physicians.

In addition to the involvement of various civil society organizations, the GAVI HSS project also benefits from the inputs of key stakeholders through the Health Partnership Group (HPG). The ongoing policy discussions and programme reviews have provided guidance and direction in the implementation of the project.

8.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

GAVI HSS funds are managed according to the Decree no. 93/2009/ND-CP of the Government about management regulation of INGO support. At central level, Department of Planning and Finance (DPF) will be focal point for HSFP implementation.Existing PMU for GAVI-HSS phase 1 continues to help MOH to implement GAVI-HSS project.

HSS fund sare managed systematically by PMU and 10 PHDs. Annually, basing on the approved HSS proposal, the PMU and 10 closely work on the implementation and financialplan for activities carried out to meet practical needs and actual progress ofPMU and project provinces. The PMU synthesize and develop implementation and budget plan of whole project to submit to the Minster of Health for approval.Basing on the approved plans of MoH, Provincial People's Committees endorse implementation and financial plan for activities carried by 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.

In order to disburse the funds, basing on cost norms of the project's Financial Management Manual that was developed, reviewed and agreed by the Ministry of Finance and approved by the Minister of Health in the Decision Number 365/QD-BYT dated 30January 2013 and annual approved plans, PHDs prepare estimated detailed budget for each activity and send to the PMU for review. The PMU verifies the contents and transfers funds from PMU accounts that are opened in a commercial bank toPHDs through an account at Provincial State Treasury. Treasury office checks information and releases funds for implementing activities.

Quarterly,basing on data from the accounting software, 10 PHDs prepare financial reports the project funding sources and utilization of fund by activities to submit to the Provincial Finance Departments for control and approval, and send the reports to PMU. The PMU collects all quarterly financial reports from provinces and reports to HSSCC, Ministry of Health and GAVI.

The BRAVO software, which was developed in accordance with national accounting standards,is used by the

PMU and all 10 PHDs. All GAVI-HSS transactions are uniquely coded, cross-referenced for documentation and retained for external audit purposes and accounting controls.

Regarding procurement, the PMU collects all the needs of 10 PHDs. PMU prepares the procurement plan, and then submit to the HSSCC. After this plan is reviewed and approved by HSSCC, the PMU and PHDs submit procurement plans to the Ministry of Health and Provincial People's Committee respectively to be officially endorsed.Whole procurement process is conducted in accordance with the Law on Public Procurement of Vietnam.

Health Systems Strengthening Coordination Committee (HSSCC) was established to support, provide technical assistance, monitor and endorse project activities.The HSSCC has an important role to review and approve annual HSS work plan and financial plan, review quarterly financial statements of the PMU, follow-up actions after external audit reports. HSSCC also reviews and endorses the APR to be submitted to GAVI each year, monitors, oversees project activities to ensure that the project activities are carried out in compliance to the government regulations and GAVI requirements.

8.5. Planned HSS activities for 2015

Please use **Table 8.5** to provide information on progress on activities in 2015. If you are proposing changes to your activities and budget in 2015 please explain these changes in the table below and provide explanations for these changes.

Table 8.5: Planned activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2015 actual expenditure** (as at April 2015)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
Objective 1: Support Human Resource Development for Health						
1. Provide 6-9 month training courses for VHWs	Organize 21 training courses for 800 VHWs	753600	50675			
2. Training courses on EPI for district hospital staff						
3. Training courses on EPI in Practice for CHWs	Organize 34 training courses for 1292 CHWs	352000	40856			
4. Training courses on MCH for CHWs	Organize 34 training courses for 1292 CHWs	352000	40781			
Objective 2: Capacity to deliver basic health services through ensuring adequate supply of essential equipment for health facilities						
5.1. Supply of essential equipment to DHCs (Health products and health equipment)			352235			
5.2. Supply of essential equipment to CHCs (Health products and health equipment)						
5.3. Supply of essential			217627			

equipment kit to VHWs						
6. Support outreach immunization spots	Support 2319 outreach immunization spots	409680	77104			
Objective 3: To strengthen management capacity in response to the needs for health sector reform and development in the new situation						
7. Training courses on health planning and M&E for provincial and district health managers	Organize 2 training courses for 76 health managers	31200				
8. Support for Joint Annual Health Review (JAHR)	Support the development of JAHR 2015	100000	1048			
9. Support for M&E and supervisory visits	Promote M&E visits of central level, provincial level and district level.	254052	42426			
10. Support for initiatives and policies to strengthen the basic health network	Support conduction of 2 studies/researches on health systems strengthening	80000	16618			
11. International workshops, training, study tours	Support staff of line ministries, sectors to attend international conferences, workshops and short-term study visits overseas	50000				
12. Local training/workshops	Support annual project workshops in the central and provincial levels.	401945	174668			
Project Management						
Office equipment and furniture		4075	1548			
Running costs		225600	37400			
Salary for project staff		260400	50944			
Allowances for PMU		62400	1627			
Annual Financial Audit		62000				
Baseline and post-project surveys		65000				
International consultant		40000				
Local consultants		58500	2000			
		3562452	1107557			0

8.6. Planned HSS activities for 2016

Please use **Table 8.6** to outline planned activities for 2016. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 8.6: Planned HSS Activities for 2016

Major Activities (insert as many rows as necessary)	**Planned Activity for 2016**	**Original budget for 2016** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2016** (if relevant)
Objective 1: Support Human Resource Development for Health					
1. Provide 6-9 month training courses for VHWs		116511		Leftover budget after accomplishment of set target	(116511)
2. Training courses on EPI for district hospital staff	Organize 12 training courses for 456 DHWs	30635	Supplement 12 courses on EPI for district HWs	Further targets to meet demands of the local needs	120565
3. Training courses on EPI in Practice for CHWs	Organize 71 training courses for 2698 CHWs	119187	Supplement 71 courses on EPI for commune HWs	Further targets to meet demands of the local needs	661813
4. Training courses on MCH for CHWs	Organize 48 training courses for 1824 CHWs	109380	Supplement 48 courses for commune HWs	Further targets to meet demands of the local needs	418620
Objective 2: Capacity to deliver basic health services through ensuring adequate supply of essential equipment for health facilities					
5.1. Supply of essential equipment to DHCs (Health products and health equipment)		150000		Accomplished	(150000)
5.2. Supply of essential equipment to CHCs (Health products and health equipment)		450000		Accomplished	(450000)
5.3. Supply of essential equipment kit to VHWs		189000		Accomplished	(189000)
6. Support outreach immunization spots	Support 2320 outreach immunization spots	711037		Left-over budget	(42877)
Objective 3: To strengthen management capacity in response to the needs for health sector reform and development in the new situation					
7. Training courses on health planning and M&E for provincial and district health managers	Support 2330 outreach immunization spots	23093	Supplement 12 courses for district level and 2 courses for provincial level		208107
8. Support for Joint Annual Health	Support the development of	229584		Left-over budget	(169584)

Review (JAHR)	JAHR 2016				
9. Support for M&E and supervisory visits	Promote M&E visits of central level, provincial level and district level.	330772			
10. Support for initiatives and policies to strengthen the basic health network	Support studies/researches on health systems strengthening	166271			
11. International workshops, training, study tours	Support staff of line ministries, sectors to attend international conferences, workshops and short-term study visits overseas	50000			
12. Local training/workshops	Support annual project workshops in the central and provincial levels.	784956		Left-over budget	(318956)
Project Management					
Office equipment and furniture		117129			
Running costs		449587			
Salary for project staff		173540	Supplemented for extension period		104260
Allowances for PMU		152826			
Annual Financial Audit		33855			
Baseline and post-project surveys		73669			
International consultant		40000			
Local consultants		174500		Left-over budget	(76437)
		4675532			

8.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavi.org

8.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 8.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
The Global Fund	70763824	01/01/2012 - 31/12/2016	Strengthening Health Systems to improve and sustain outcomes for HIV/AIDS, TB Malaria and MCH programmers in Vietnam

8.8.1. Is GAVI's HSS support reported on the national health sector budget? **Yes**

8.9. Reporting on the HSS grant

8.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 8.9.1: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Annual report of Ministry of Health	This report was verified by MOH departments	
Baseline survey report	The data sources of the report use MOH statistics and government data	
Development Partners (WHO, UNICEF)	Reports, estimates are standardized and referenced in the globe.	
General Statistics Office (GSO	GSO is responsible for provision of official data of the country.	
Health Statistics Yearbook	This yearbook was compiled by DPF in MOH and validated by General Statistics Office	
Joint Annual Health Review (JAHR)	This report was verified by MOH.	
Quarterly and annual report of PHDs Available study reports conducted by PMU and consultants/institutions	The information is validated by M&E team of the PMU/MOH Researches apply scientific tools in data collection. Research consultants and institutions are those working in Medical University and Health Strategy and Policy Institute.	
Vietnamese expanded Program on Immunization/National Institute Of Hygiene And Epidemiology (EPI/NIHE)	EPI/NIHE is responsible for data collection and management of immunization activities nationwide and report to MOH	

8.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

There are no difficulties in putting this report together. APR2014 template is appropriate and easy to use.

8.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2014?2

Please attach:

1. The minutes from the HSCC meetings in 2015 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

9. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

9.1. TYPE A: Support to strengthen coordination and representation of CSOs

Viet Nam **has NOT received GAVI TYPE A CSO support**

Viet Nam is not reporting on GAVI TYPE A CSO support for 2014

9.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

Viet Nam **has NOT received GAVI TYPE B CSO support**

Viet Nam is not reporting on GAVI TYPE B CSO support for 2014

10. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

COMMENTS FROM HSSCC CHAIRS

Actions taken following recommendations of HSSCC meetings:

i) *The PMU should guarantee immunization safety in outreach spots; specially support for women and children in disadvantaged and mountainous areas; increase the coverage of hepatitis B vaccines for newborns within 24 hours after birth and immunization coverage through EPI training courses for district and commune HWs and support disadvantaged provinces/localities where the immunization coverage remains low.*

Outreach immunization spots are organized in accordance with MoH's guidelines. The PMU requests Department of Health in project provinces report regularly the implementation of EPI in the outreach spots. The PMU has closely worked with the National EPI to get latest information on safety and quality of immunization. In the training courses on EPI, updated guidelines on immunization safety are specially emphasized to facilitate HWs with required knowledge and practical behavior to perform EPI tasks.Furthermore, the importance of immunization for children and HepB vaccines for newborns within 24 hours after birth is the main topic in the EPI and MCH training courses.

All the provinces benefited from the project are those facing immunization difficulties. The project has particularly given priorities to district and communes with low immunization coverage. Targeted groups of the project are women and children. Majority of beneficiaries from outreach immunization spots are ethnic and mountainous women and children.

ii) Strengthening MCH care activities towards achievement of MDGs: The project should continue to carryout capacity building activities via short-term and long-term training courses,supply of medical equipment for DHCs and CHCs, mobilization of participation from stakeholders and related sectors to socialize health care activities.

MCH training courses for CHWs is a focal activity of the project. The project has closely worked with MCH Department (MoH) to organize MCH training courses for provincial, district and commune HWs. The courses use WHO's training curriculum which highly focusing on practical skills for HWs to provide better care for the mother and children at the local level. The PMU also procured one separate package of MCH equipment to deliver to DHCs and CHCs.

iii) The project should speed up this activity so that by the end of 2014, equipment and VHW kits will be provided to DHCs, CHCs and VHWs.

In order to make sure that equipment after supplied will be used effectively and efficiently, the PMU reviewed local needs for equipment carefully and thoroughly. Assessment of DHCs and CHCs (on capacity of HWs to use equipment,infrastructure to install the equipment) was done thoroughly in three times.These review and assessment steps took quite long time. Thus, in 2014, the PMU accomplished procedures to procure equipment. In 2015, equipment will be delivered to beneficiary facilities. The PMU will develop guidelines on the receipt, utilization and management of supplied equipment.

iv) Upon the completion of researches supported by the project, the project should share research results to related stakeholders and MoH for development of initiatives to strengthen health system at grassroots level.

Results of researches done in 2014 under project's support are shared with project provinces. Recommendations from researches are studied and followed up by the project. Lessons from evaluation on implementation of project activities are shared and learned. In 2015, the PMU plans to organize a workshop to share research results nationwide.

v) The project should standardize training curriculum and synthesized experiences to share with related stakeholders. The project can utilize products (research results, training curriculum…) of other similar projects for adaptation.

Training curriculum used by the project are standard curriculum of WHO (for MCH training courses), national EPI (for EPI training courses), and MoH (for VHWs training courses and training on health planning and M&E).

In2014, a representative of PMU attended national workshop on sharing experiences in EPI. In the workshop, project activities and experiences in project implementation were presented. Project's achievements and contributions to strengthen health system at grassroots level and to increase immunization coverage were highly appraised.

The HSSCC has reviewed and endorsed:

i)Annual Progress Report 2014 of the project (APR2014);

ii)Proposal on extension of the project in 2016-2017, as follows:

- Duration of project extension is from July 2016 to December 2017;
- The project objectives and 10indicators are kept the same as in the period 2012 – 2015
- Activities of the project are maintained as in the period 2012-2015

iii) Recruitment of one more project accountant.

The next tranche: PMU requests GAVI to make the next tranche of US$ 3,562,452 to actively and timely carry out activities under 2015 workplan.

11. Annexes

11.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2014 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS *1*

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

11.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2014 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

11.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2014 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	1&2. Signature page of MoH and MoF.pdf **File desc:** Signature page of MoH to endorse APR2014 **Date/time :** 13/05/2015 04:30:47 **Size:** 187 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	1&2. Signature page of MoH and MoF.pdf **File desc:** Signature page of MoF to endorse APR2014 **Date/time :** 13/05/2015 04:30:59 **Size:** 187 KB
3	Signatures of members of ICC	2.2	✓	Signature ICC_2014.pdf **File desc:** **Date/time :** 14/05/2015 09:31:12 **Size:** 125 KB
4	Minutes of ICC meeting in 2015 endorsing the APR 2014	5.4	✓	27 ICC meeting note_5 May 2015.docx **File desc:** **Date/time :** 14/05/2015 10:13:50 **Size:** 38 KB
5	Signatures of members of HSCC	2.3	✓	5. SIGNATURE PAGE_endording APR 2014.pdf **File desc:** HSSCC members signed in the signature page to endorse APR2014. **Date/time :** 10/05/2015 11:02:51 **Size:** 359 KB
6	Minutes of HSCC meeting in 2015 endorsing the APR 2014	8.9.3	✓	6. Minutes of HSSCC meeting to endorse APR2014.pdf **File desc:** Minutes of HSSCC meeting to endorse APR2014 of the project **Date/time :** 13/05/2015 10:20:27 **Size:** 52 KB
7	Financial statement for ISS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	No file loaded
8	External audit report for ISS grant (Fiscal Year 2014)	6.2.3	✗	No file loaded

9	Post Introduction Evaluation Report	7.2.1	✗	No file loaded
10	Financial statement for NVS introduction grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	Financial statment for NVS introduction grant 2014.docx **File desc:** **Date/time :** 18/05/2015 09:59:46 **Size:** 21 KB
11	External audit report for NVS introduction grant (Fiscal year 2014) if total expenditures in 2014 is greater than US$ 250,000	7.3.1	✓	External audit report for NVS troduction grant.pdf **File desc:** **Date/time :** 18/05/2015 10:00:09 **Size:** 1 MB
12	Latest EVSM/VMA/EVM report	7.5	✓	EVM 2012 - Summary report.doc **File desc:** **Date/time :** 15/05/2015 08:02:49 **Size:** 1 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	IMPROVEMENT PLAN.doc **File desc:** **Date/time :** 15/05/2015 08:03:31 **Size:** 46 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	Improvement plan based on EVM in VNM 2012.doc **File desc:** **Date/time :** 15/05/2015 08:04:03 **Size:** 43 KB
16	Valid cMYP if requesting extension of support	7.8	✓	cMYP for EPI 2010-2015_VNM.doc **File desc:** Attached file is cMYP for EPI 2011-2015. New cMYP for 2016-2020 will be prepared and submit the end of 2015. **Date/time :** 15/05/2015 09:56:10 **Size:** 877 KB
17	Valid cMYP costing tool if requesting extension of support	7.8	✓	MYP Costing tool for EPI 2011-2020.xls **File desc:** Attached file is cMYP costing tool for 2011 - 2015. The cost and financing of routine vaccine supplies include pentavalent is estimate up to 2020. The new one will be prepare and submit the end of 2015.

				Date/time : 15/05/2015 10:00:48 **Size:** 248 KB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✓	27 ICC meeting note_5 May 2015.docx **File desc:** **Date/time :** 14/05/2015 10:14:23 **Size:** 38 KB
19	Financial statement for HSS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	19. Income and expenditure HSS in 2014.pdf **File desc:** Financial statement for HSS grant in fiscal year 2014 **Date/time :** 10/05/2015 11:04:19 **Size:** 559 KB
20	Financial statement for HSS grant for January-April 2015 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	20. Income and expenditure HSS from 1 Jan to 30 Apr 2015.pdf **File desc:** Financial statement for HSS grant from Jan to Apr 2015 **Date/time :** 10/05/2015 11:05:20 **Size:** 561 KB
21	External audit report for HSS grant (Fiscal Year 2014)	8.1.3	✓	21. Financial Audit GAVI-HSS (pending).pdf **File desc:** An external firm was recruited to audit GAVI – HSS project. The audit has been ongoing at present. External audit report will be available and sent to GAVI by the end of June 2015. **Date/time :** 13/05/2015 10:57:31 **Size:** 13 KB
22	HSS Health Sector review report	8.9.3	✓	Joint annual health review 2014 (EN).pdf **File desc:** Topic of JAHR2014 is Strengthening prevention and control of non-communicable diseases **Date/time :** 05/05/2015 03:19:47 **Size:** 4 MB
23	Report for Mapping Exercise CSO Type A	9.1.1	✗	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2014)	9.2.4	✗	No file loaded

25	External audit report for CSO Type B (Fiscal Year 2014)	9.2.4	✗	No file loaded
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2014 on (i) 1st January 2014 and (ii) 31st December 2014	0	✓	26. Bank statements (1 Jan to 31 Dec 2014 and 1 Jan to 30 April 2015).pdf **File desc:** Bank statements for year 2014 and from 1st Jan to 30th April 2015 **Date/time :** 10/05/2015 11:14:46 **Size:** 492 KB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✗	No file loaded
28	Justification for changes in target population	5.1	✗	No file loaded
	Other		✗	1. Summary report_ Study on the current situation of service delivery of CHCs in some regions and associated factors.pdf **File desc:** **Date/time :** 13/05/2015 10:42:36 **Size:** 141 KB
				10.a. Minutes_HSSCC meeting_ 20 Nov 2014 to endorse 2015 workplan.pdf **File desc:** **Date/time :** 14/05/2015 10:32:28 **Size:** 64 KB
				10.b. Signature Page - endorsing 2015 worplan.pdf **File desc:** **Date/time :** 14/05/2015 10:32:45 **Size:** 894 KB
				11. Workplan2015_ GAVI-HSS.pdf **File desc:** **Date/time :** 14/05/2015 10:33:03 **Size:** 573 KB
				12. APR2014.VNM PRO (HSS Section).docx **File desc:** **Date/time :** 14/05/2015 10:33:20

Size: 203 KB

3. Summary report_Evaluation of results of training for CHWs and VHWs in some provinces funded by GAVI project.pdf
File desc:
Date/time : 14/05/2015 10:30:23
Size: 115 KB

4. Sumary repport_Evaluation of outreach immunization spot situation in some project communes funded by GAVI.pdf
File desc:
Date/time : 14/05/2015 10:30:41
Size: 76 KB

5. Sumary report_Studying current situation and proposal for solutions to improve quality of EPI in Bac Kan province.pdf
File desc:
Date/time : 14/05/2015 10:30:58
Size: 70 KB

6. Summary report_Situation of human resources and capacity to provide immunization and health services at CHCs in Hoa Binh province.pdf
File desc:
Date/time : 14/05/2015 10:31:16
Size: 63 KB

7. Summary report_Situation of health care and treatment and affecting factors at grassroots level in Nghe An province.pdf
File desc:
Date/time : 14/05/2015 10:31:31
Size: 104 KB

8. Summary report_Evaluation of immunization for children under one year of age in Ha Tinh in 2013.pdf
File desc:
Date/time : 14/05/2015 10:31:44
Size: 88 KB

9.a. Minutes of HSSCC meeting to endorse APR 2013.pdf
File desc:
Date/time : 14/05/2015 10:31:57

				Size: 60 KB
				9.b. Signature page to endorse APR 2013.pdf **File desc:** **Date/time :** 14/05/2015 10:32:12 **Size:** 867 KB
				2. Decree 117 regulation on commune, ward, township health.pdf **File desc:** The project supported research and proposal for development of the decree No.117 regulating commune, ward, township health **Date/time :** 13/05/2015 10:42:50 **Size:** 32 KB