Joint Appraisal Report 2017

Country	Socialist Republic of Viet Nam (Vietnam)
Full Joint Appraisal or Joint Appraisal update	Joint Appraisal update
Date and location of Joint Appraisal meeting	23 June 2017 and 3 July 2017
Participants / affiliation[1]	Duong Thi Hong, Deputy EPI Manger Nguyen Van Cuong, NEPI Team Nguyen Huy Du, UNICEF Hanoi IIJIMA Makiko, WHO Hanoi, PMU/HSS Unit, Hanoi
Reporting period	2016
Fiscal period[2]	January to December 2016
Comprehensive Multi Year Plan (cMYP) duration	2016 - 2020

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi**
Routine	Pentavalent vaccine	2019	2018	1,773,938	TBC	TBC
Routine	Inactivated Polio Vaccine	2018	2018	TBC	US$ 0	US$ 1,166,000 (100%)

Note:

*** This projection is subject to change, given Vietnam has yet to introduce IPV and the introduction date (while likely in 2018) will depend on supply availability.*

* *Not include vaccine requirement for catch-up vaccination of target children were eligible for one dose of IPV after the switch from tOPV to bOPV (from May 2016)*

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year
Routine	NA	NA	NA
Routine	NA	NA	NA

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	24,400,000
Duration of HSS grant (from…to…)	2012-2017
Year / period for which the HSS renewal (next tranche) is requested	NA
Amount of HSS renewal request (next tranche)	NA

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Total amount of CCEOP grant	US$	
Duration of CCEOP grant (from…to…)	2017-2020	
Year / period for which the CCEOP renewal (next tranche) is requested	2018	
Amount of Gavi CCEOP renewal request	US$ 794,285[3]	
Country joint investment	**Country resources**	US$ 794,285
	Partner resources	NA
	Gavi HSS resources[4]	NA

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[5]

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	NA	NA	NA

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

In December 2016, the Government approved a Master plan for building and developing the grassroots healthcare network (Decision No. 2348/QĐ-TTg), which includes both plans for concrete investment and reforms to strengthen primary health care. With this policy, HSS activities supported by Gavi over the past few years are expected to be maintained and sustained.

On 31 July 2017, the Health Programme Plan of Action for 2017 – 2020 including the EPI Plan of action was approved by the Government (Decision No. 1125/QĐ-TTg). It is noted that funding for EPI from the Government only covers the cost for EPI vaccines and injection equipment. Other requirements will be covered by local government (Province). Viet Nam has officially written to Gavi that they will no longer be requiring Gavi support for JE campaign, as the country is not able to meet the conditions included. The country is unable to meet the financing gap for the Sanofi product and also the manufacturer does not appear to be able to supply in the quantity needed. However, the country will use the mouse brain derived vaccine for the campaign for target population from 6 to 15 year old in high risk areas with funding from the government and support from PATH.

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunisation

Vaccination coverage reported in the 2016 Joint Reporting Form (JRF) surpassed the regional immunization targets, reaching 96% for the third dose of DTP-HepB-Hib vaccine (Penta3). 44 provinces reached >=95% and 19 provinces reached 90-<95%. However, 79 districts (11% of total districts) reached less than90%. Coverage for Polio (OPV3) was 95%and 99% for the first dose of the measles containing vaccine (MCV1). There are still 7 districts with MCV1 coverage <50% and 7 districts with coverage of 50-79% in 2016 (figure 2b). All these districts are in Ho Chi Minh City where data management is challenging. Viet Nam has had quite a few measles outbreaks, and so it is important to strengthen the routine or conduct PIRIs in these districts. There is no difference between the administrative data and WHO UNICEF estimates for 2016.

[3] Already approved

[4] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.

[5] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

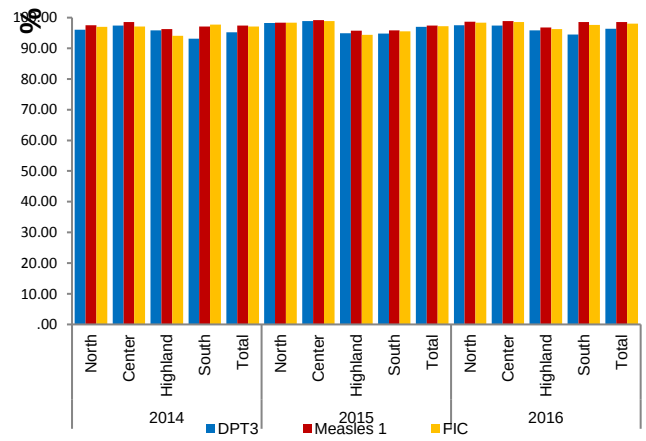


Figure 1. The rate of DPT3, MCV1 and Full immunization children, 2014 - 2016

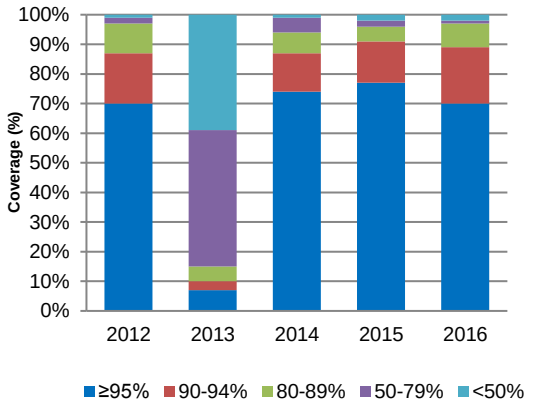


Figure 2a. Penta3 coverage by % of districts 2012-2016

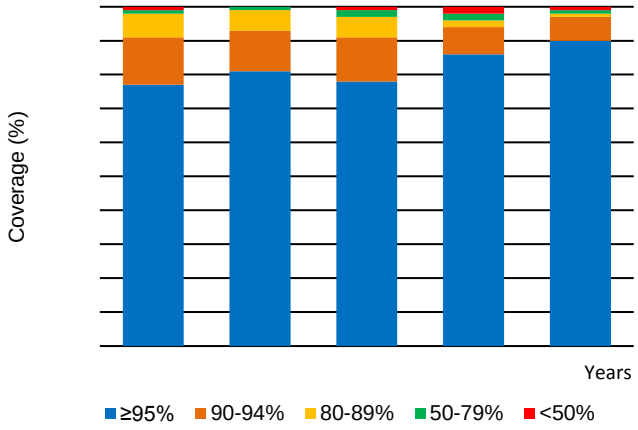


Figure 2b. MCV1 coverage by % of districts 2012-2016

Significant improvement is noted for the birth-dose of Hepatitis B vaccine. The country reported 68% in 2016 as compared to 70% coverage in 2015, 55% in 2014 and 56% in 2013. With exception of 2012, hepatitis B birth-dose has been below 60%.

In 2016 the coverage rate of Hepatitis B birth-dose was very different province by province (Figure 3):

- <50%: 14 provinces
- 50 - <80: 37 provinces
- 80 - <90: 9 provinces
- 90 - <95%: 2 provinces
- ≥ 95%: 1 province

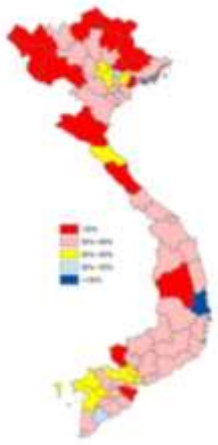
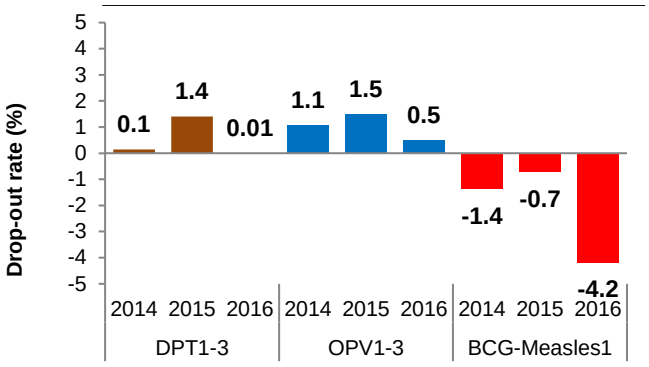


Figure 3. Hep B birth-dose coverage by province **2016**

All drop-out rates of DPT1-3 and OPV1-3 were less then 1.5% during 2014-2016. BCG-MCV1 has a reverse drop-out rate because of disparities between BCG uptakes (94.6% - 96.8%) and MCV1 uptake (97.4% - 98.6%). Improvement of MCV1 coverage is a result of improved communication during the MR campaign 2014-2016 (Figure 4).

However, in 2016, seventeen (17) hard to reach districts reported a DTP drop-out rate greater than 10%, an improvement compared to 35 districts in 2015 and 54 districts in 2014.



In Viet Nam, both boys and girls have equal rights to health care, education and other basic rights. Findings from many EPI program review evaluations show no significant difference for boys and girls regarding their access to vaccination. Results from 2015 EPI review indicated that gender is 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 boys and 98% for girls and 96% for boys and 95% for girls respectively). The Hepatitis B birth dose coverage is low in remote areas including mountainous areas where home delivery is very common. Commune health centers in this areas conduct immunization outreach.

3.2. Key drivers of low coverage/ equity

The inequities and the resulting disparities in health outcomes, including full immunization coverage, continue to persist and even seem to be widening particularly among the ethnic minorities in the hard to reach areas. It is evident that in general in Viet Nam, the key drivers of inequity in health are ethnicity and residence. The latest 2014 Multiple Indicator Cluster Survey (MICS) shows a significant difference between Diphtheria-Pertussis-Tetanus first dose (DPT1, 96.3) and DPT third dose (DPT3, 88.6). Immunization coverage disparity is persistent and prevalent amongst the ethnic minorities. In terms of demand generation, parents and child care givers still fear side-effects of vaccines especially amongst a few ethnic minority populations e.g. the H'Mong. In addition, there is a language barrier between immunization service providers and the parents of ethnic minorities. Regarding coverage data quality, Viet Nam has a comprehensive immunization information system at all levels. Main operational challenge with information is the limited use of data for planning and management at local level. Dropout rates are not well monitored with coverage monitoring charts at some commune health centres. In addition, the reporting system of vaccination data from the private sector has not yet been fully implemented nationwide.

Even though Viet Nam has an extensive network of health providers, the problem with geographical access still occurs in some hard-to reach areas (rural and mountainous areas), and immunization services still fail to reach the mothers and children there.

In general, the Government budget for health has increased but the share for preventive medicine activities, including immunization, has been limited. Recently, the state budget for the national health program has been cut down, creating more difficulties for preventive medicine activities including immunization; and thus, high outreach costs in hard to reach areas not supported by regular funding. District and commune health facilities have received very little budget from the health system to implement health activities especially outreach sessions, and they have to seek additional funding from the local government. However, financial contributions from local governments for health activities are very limited

3.3. Data

Immunization data management

In 2017, a web-based immunization registration system was launched in Vietnam. Information of each visit of every child was entered into the system, including date of getting vaccine, vaccine name, lot number, health facilities as well as general information (name, gender, age, date of birth, mother's/father's name, contact number, resident and temporary address, automatic generated ID number, etc). The system was rolled out nationwide in June 2017. A total of 11,000 commune health centers and 1,400 hospitals, private

immunization clinics/centers use the system. Since July 2017, there are approximately5 million children born 2015 in the system.

EPI intends to upgrade the system with a new component of vaccines and syringes management. The database will provide data on lot number, expired date, location supporting an effective vaccine distribution in accordance to approved vaccine usage factors that are categorized by geographical characteristics. Vaccine managers can generate a flow of vaccine distribution and find warning massages on lots with short expiry dates.

The system provides real time data and automatic summary reports on vaccine uptake by vaccine, health facility, birth cohort and supports HWs on planning immunization sessions (generation of list of eligible children/PWs by session). The user can access immunization history and follow every child for better management.

VPD surveillance

The vaccine preventable disease surveillance system is well functioning at all levels. Active surveillance is being conducted by preventive medicine center (PMC) staff at provincial and district levels regularly; however, the operational budget for active surveillance or supervisory monitoring is often limited which results in challenges of thorough investigation in some areas. In addition, the collaboration between hospitals and PMCs is sometimes not effective and there isn't a consistent understanding of the cases to be investigated, and a limited number of samples taken and cases investigated. Another point need to be strengthened is the limited attention and capacity for data analysis and usage at local levels.

Findings from 2015 EPI review:

VPD surveillance in Vietnam had been strengthened and is considered as one of the most systematic in the Western Pacific Region. However, some gaps were identified in some locations as described below:

- Limited number of samples taken and case investigation due to unawareness of taking samples and case investigation from hospitals.
- Attention and capacity for analysing surveillance data should be enhanced at provincial and district levels.

In 2016 there were 383 AFP cases, equivalent to 1.49/100,000 children under 15 years old, reaching WHO's requirement (1/100,000 children under 15 years old). 97.1% cases were taken specimens (requirement: ≥ 80%). 60/63 provinces reported AFP cases, in which 45 provinces met the indicator for case detection.

In 2016, Measles - Rubella surveillance was strengthened nationwide, in the context of both epidemiological and laboratory surveillance. In general, all measles surveillance indicators improved in comparison to 2015. The rate of discarded measles cases was 2.52/100,000; 82.1% of suspected cases were investigated and reported (in 2015: 50.2%). 92.7 % specimens with results within 4 days of collection. 50.8% of provinces met the indicator of detection of suspected measles/rubella case (≥2/100,000 pop.). 80.2% of suspected cases with adequate investigation (requirement: 80%).

Remaining challenges:

- 49.2% provinces did not meet the indicator of detection of suspected measles/rubella case (≥2/100,000 pop.). This needs to be improved in future.
- Percentage of suspected cases taken serum sample did not reach WHO's requirement (80%).

There are parallel preventive and treatment systems at provincial and district level. Doctors at hospitals are under pressure of health examination. HCWs at district preventive centres and clinicians at hospitals have not been trained on surveillance for years. So they are not aware of the importance of surveillance and don't know case definition, how to implement surveillance, taking samples and filling the investigation form. A surveillance assessment is planned in 2017 in Vietnam.

There is little supervision for data collection at the village-level and supervisors practically carried out no quality checks. In addition, health workers at the district are constrained by lack of training and lack of technology (e.g. computers and internet access) and they are under constant pressure to fill out forms and produce reports requested by multiple target programmes.

There is also an issue related to data quality that is political in nature. EPI is a highly political and successful government programme. Immunisation services are free of charge. Performance targets are set at the highest political levels and implemented with rigour. The people's committee at the commune-level has a strong influence on the reporting of EPI data. Local authorities set high immunisation targets, often above 90%. It is common for data to be fixed to match the desired result.

3.4. Role and engagement of different stakeholders in the immunisation system

- **Immunization Coordination Committee** (ICC): Members of ICC include WHO, UNICEF, PATH, MOH Department related (GDPM, Planning department and DAV) MOF, MPI and NEPI. ICC meetings are conducted every 3 to 6 months to review all EPI activities in the past and discus activities in future.
- **Civil society**: the role and engagement of civil society (Association of Women and Youth Association) in the immunisation system in the past year has been very important both for service delivery at commune level not only for routine EPI but also for SIAs.
- **Private sector**: The private sector gives non EPI vaccines to children and other target populations. In the big cities about 5 - 10% of target children receive immunisation through the private sector.
- **Cross-sectoral collaboration**: collaboration between EPI and education programmes for SIAs has been very good. In the plan this collaboration will be include routine EPI.

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

NVS:

As in 2015, no vaccine stock-outs were reported/registered in 2016. In 2016, the country received 4,961,600 doses of the Pentavalent vaccine (3,448,500 doses from Gavi 1,513,100 doses from co-financing for 2016), out of the 4,961,600 doses as per the Gavi decision letter.

Vaccination coverage reported in the 2016 Joint Reporting Form (JRF) surpassed the regional immunization targets, reaching 96% for the third dose of DTP-HepB-Hib vaccine (Penta3). 44 provinces reached more than 95% and 19 provinces reached 90-95%. Coverage was 95% for Polio (OPV3) and 99% for the first dose of measles containing vaccine (MCV1).

The Gavi supported Measles-Rubella catch up campaign for the 1 - 14 year age group in 2014-2015 was followed by the introduction of MR vaccine in to routine EPI for children 18 months of age with MCV2 funded by the Government. MR vaccine local production by POLYVAC will be introduction in EPI from 2017.

HSS

Up to 12/2016, the project has completed the target of 2016 and proposed an extension to 12/2017. This extension was approved by HSCC, MOH and GAVI. The main results of AWP2016 are:

1. Training for VHWs:

VHWs play a very important role in supporting commune health centres to provide health care services for local people, specifically: i) health communication; Ii) managing the target population, collecting lists of mothers and children in need of vaccination; Iii) coorperating implementation of immunization campaigns; Iv) Post Immunization Monitoring (AEFI); V) training / monthly meetings; Vi) Data management and reporting to commune health centres.

Number of VHW trained 6 months and 9 months to reach primary care measure according to MOH regulation is 3,424 people who met the target plan. The proportion of female and ethnic minority students is 67.9% and 52.1% respectively.

2. Training on EPI for district health workers:

Number of trained staff in 2016 is 717, accumulated up to 12/2016 is 1383, reaching 104% of the commitment. The percentage of female students: 67.2% and ethnicity: 33.2%. Participants include leaders / managers of district health centres, head / deputy department of obstetrics-pediatric district hospital / regional poly clinic; Doctors, NHS, and YS work in obstetrics and gynaecology department of district hospital / clinic, ... The health staff in the hospital / clinic is responsible for managing, guiding, directing and implementing immunization in the medical facility. Especially immunizing Hepatitis B vaccine, communication for mothers, relatives of mothers, patients on immunization benefits. For leaders and health workers at district health centres, they have the role of organizing the management of immunization activities in the whole district, supporting and supervising the commune level to carry out immunization. For disadvantaged communes, the human resources of the health centre are ready to send staff to support immunization.

3. Training on EPI in practice for commune health workers:

Number of trained staff in 2016 is 2731, accumulated up to 12/2106 to 8576, reaching 107.4% of the commitment. Female students and ethnic students are 65.4% and 35.8%. According to professional regulations, health workers in immunization must have certificates of training on immunization, so the project has very good support for commune and health sector on this resource. The proportion of district and commune having trained health workers is 100%. Knowledge and skills, handling immunization and effective management have been improved significantly.

4. Training on maternal and child health for commune health workers.

Number of trained staff in 2016 is 2861, accumulated from the beginning of the project to 12/2016 is 8622 trainees, reaching 108.5% of the commitment. Female students and ethnic students are 80.1% and 40%. Students are doctors, physicians, obstetric and gynaecological doctors, midwives, etc who play the role of health care for mother and child, management of pregnancy and deliveries at CHC.

5. Training on EPI for provincial health workers in 63 provinces (Department of Health, Provincial Preventive Medicine Centre, National and Regional Pasteur Institute (NIHE / RIHE)) achieved 193% of the plan. Participants have the role of managing, supervising, supporting district and commune level in immunization. Training on EPI for university / college teachers reached 38% of the plan. Teachers are updating knowledge, using this material to teach medical students.

6. Training in Health Planning and M & E

The content focuses on the new planning framework implemented by MOH, updating the overall health information system such as health sector overview, payment methods, information management, health monitoring and indicators, training for 440 students in 2016, accumulated to 12/2016 is 1229 students.

7. Management of equipment provided by the project.

According to the plan, the project provided equipment for 30 district health centres, 500 CHC and 10 000 village health bags that was completed in 2015. Total number of beneficiaries increased as planned, 48 district health centres, 555 CHCs and 10 000 YTB have been provided with basic medical equipment for professional purposes. Many devices are used effectively, serving people like ultrasound, electrocardiogram, tester, blood glucose meter, fatal hearing machine ...

8. Support outreach immunization spots.

In 2016, the project supported 2273 outreach spots. The implementation rate is 98.5%. Number of children has been vaccinated at outreach spots reached 772352 children, the proportion of male and female is equal, and the rate of ethnic children is 73.4%. 195 927 women were tetanus vaccinated at outreach spots, ethnic women accounted for 73.7%. Most of the rural areas are difficult to access, and health staff must bring services closer to people, thereby ensuring equity for vulnerable groups and gradually filling the gap in immunization.

9. Other activities:

- The project has supported the JAHR 2013-2016. The JAHR report is a useful reference for regulatory agencies inside and outside the Ministry of Health and Human Services and policy dialogue between MOH and development partners.

- The project has supported the completion of 10/13 research topics and policies, serving for the development and policy making of the health sector. For example, Decree 117 / ND-CP / 2014 of the Government on Commune and Ward Health Regulations have been issued with technical and financial support from the Project.

- Every year, the project supports provinces to organize monitoring visits in the field of grassroots health care.

- Every year, the project organizes workshops to review and finalize the project. Two study tours abroad (Australia, Cuba) on health systems and immunization were organized.

10. By the end of 2016, disbursement rate reached 86% and the Annual targets have been reached as the plan.

Lessons learned from HSS

1) Training for VHW, and training for commune health staff on EPI, MCH play key roles in strengthening EPI, MCH and primary health care services

2) Outreach immunization site is a good model to provide EPI services to far and remote areas

- On general policy, ND104 / 2016 / ND-CP allows outreach and home-based immunization in remote, inaccessible areas. This will provide a basis for local governments and national programs to pay attention and support investment in these priority areas.
- Vietnam has deployed outreach spots, so in remote areas medical facilities have set up maps and it is easy to re-enter the area.
- The model of outreach immunization has been implemented for 5 years so it is familiar and 10 province will be able to maintain this activity. The dissemination of the model is also expected to be integrated into project workshops to share experiences in implementation.

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

Grant	Start Year	End Year	Approved Grant	Disbursed	Cumulative Expenditure end 2016	Country Cash Balance End 2016	Utilisation	Source
HSS	2012	2017	24,400,000	24,400,000	21,359,226	3,378,530	86%	2016 Audit Report
VIG - IPV	2015	2015	1,111,000	1,111,000	72,535	1,045,737	7%	2016 Audit Report
OPC - MR	2013	2014	14,901,575	14,901,575	14,901,575	0	100%	2016 FR, 2016 Audit Report
VIG - MR	2013	2013	1,357,500	1,357,500	1,357,500	0	100%	2016 FR, 2016 Audit Report
ISS	2007	2013	1,930,500	1,930,500	1,419,750	510,750	74%	2014 Audit Report

OPC – MR campaign: Remaining funds from 2015 for OPC - MR were USD 1,261,722 and were fullyu spent in 2016.

MR VIG: Remaining funds from 2015 for Vaccines Introduction Grant - MR is USD 541,882 and were fullyt spent in 2016.

IPV VIG (2015): Remaining funds from 2015 for Vaccines Introduction Grant of IPV were USD 1,111,000 and balance carried over to 2017 is USD 1,045,737. Activities in 2016 included: Developing plan on polio outbreak response, developing handbook “Question and answer on polio disease, tOPV and bOPV vaccine” and organize events” Immunization week 2016” to include IPV introduction in Viet Nam.

ISS grant: Audit report in 2014 (attached file) showed that EPI received ISS funds twice: USD 510,734 (this funding transfer from MOH account to NIHE account on 23 June 2008) and USD 909,000 (this funding transfer from GAVI to NIHE on 20 April 2011). It did not include USD 510,750 transferred from GAVI to MOH account in 2008 that the EPI team was not aware of. These funds were transferred from MOH’s acount to EPI’s account on 15th January 2017 (see payment order enclose). Some EPI activities have been conducted with this funding in 2017 and the next report will be in 2018.

HSS

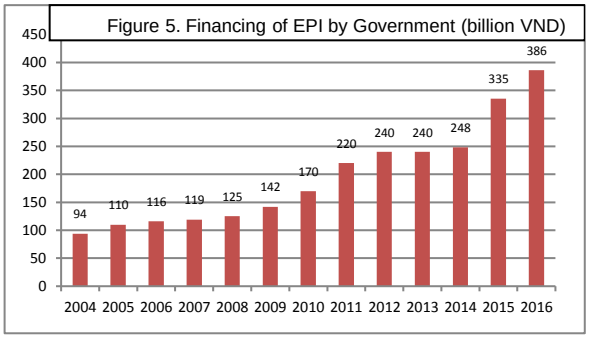
- In January 2016 GAVI disbursed the final amount of $ 3,562,452 bringing the total amount of funding to $ 24,400,000 as committed. In December 2016, GAVI approved the extension of the project implementation to 31/12/2017 and added $ 368,700 worth of project funding from bank interest and foreign exchange differences. In 2016, the project spent $ 3,492,054 and total accumulated expenditures from the beginning of the project were $ 21,359,226, equivalent of 86%.

- The project has completed the period of financial report for the first 6 months of 2016 (Periodic Financial Report) and the financial statements of 2015 and 2016 (Annual Financial Statement). From 2016 to present time, the project has done 2 independent audits for the fiscal year 2015 and 2016. All of the reports have been uploaded on the GAVI country portal system on time.
- Number of shortcomings described in the cash program audits such as advance management, bank reconciliation, cash expenditures excess of 5,000,000 VND, as well as late preparation of financial reports have been corrected.
- The financial management system has been maintained in a stable manner to meet the financial management requirements of GAVI as well as the Government of Vietnam.

4.3. Sustainability and transition planning

The national program is financed nationally through the MoH and increasingly through local government at the provincial and district level. Data in Figure 5 shows an increasing trend for financing of EPI by the national Government. It should be noted that funding for EPI from the Government only covers the cost for EPI vaccines and injection equipment. (the Decision No. 1125/QĐ-TTg approved for the Health Programme Plan of action for 2017 - 2020 include EPI July 2017)

Support from local government for EPI, 2012-2016						
		2012	2013	2014	2015	2016
Total	Million VND	12,459	13,116	14,877	22,287	62,739
	US$	$566,340	$596,160	$676,240	$1,013,040	$1,617,800
# provinces		24/63	26/63	20/63	38/63	38/63



In 2016 38 out of 63 provinces provided support for routine EPI to the amount of $1,617,800.

18 out of 63 provinces receive support from local government for routine EPI every year. 6 out of 63 provinces did not provide any provincial budget allocations for routine EPI during 2012 - 2016. From 2017 other requirements for EPI activities (not including vaccines and injection equipment) will be coved by local government (Province) (the Decision No. 1125/QĐ-TTg approved for the Health Programme Plan of action for 2017 - 2020 include EPI July 2017)

National EPI will develop a “costing of immunization package” which indicates all necessary budget of immunization programme implementation in order for central and local government to clearly understand their responsibility to sustain immunization programme.

Figure 6. Support from local government for routine EPI, 2012-2016

In March 2016, Viet Nam had a transition assessment in country by relevant stakeholders. Based on this assessment, a 3 year transition plan was developed which was agreed between Gavi and MoH. WHO and UNICEF are the main external partners who support its implementation.

UNICEF Viet Nam received the first allocation of 535,000 USD for implementation of the Gavi transition plan in May 2017 for Viet Nam. In line with the current Government regulations, in order to implement the transition plan, a programme of cooperation and an annual work plan between Ministry of Health (MOH) and UNICEF was developed and approved by the Government authority and MOH respectively. To date, 65,267 USD (12.2%) out of the 535,000 USD, has been utilized for technical assistance from UNICEF largely for one national staff to support the implementation of the transition action plan.

Process between WHO and GAVI took some times after the agreement between MoH and Gavi. It was signed by WHO Western Pacific regional office director and Gavi representative at the end of June 2017. Total budget allocated to WHO was 1,720,000 USD. The WHO Country office received the transition budget in July 2017. Several intensive discussion with Gavi, WHO and NEPI took place after the August Gavi DCEO in-country visit. All parties agreed to re-program some priority activities working with NEPI, and submitted to the Gavi team on 30 September 2017. The prioritized activities include the support of costing of immunization package and communication, the planned cost for activities in 2017 would be 130,000 USD out of the total budget, and the preparation of those activities is ongoing. Besides activity costs, 120,000 USD will be utilized for WHO CO EPI medical officer to support the implementation of the transition plan as well as EPI activity support. Further discussion will be continued to detail out the next two years of activities

4.4. Technical Assistance (TA)

The technical assistance is integrated with the transition grant for Vietnam.

In 2016, WHO provided intensive TA focused on polio switch, national measles-rubella elimination plan, and surveillance review guideline draft development, together with one WHO consultant in line with TCA.

With UNICEF TA, national EPI has conducted monitoring and supportive supervision in vaccine storage and supply management in 63 provinces and 521 out of 667 districts; trained and improved knowledge and skill of all national level staff in vaccine storage management and 89 national and provincial level EPI staff in cold chain equipment maintenance and rehabilitation. The reach every commune guideline was published and distributed in low coverage districts, There were 4 districts and 30 communes with low immunization coverage implementing the guideline which included training EPI staff and conducting micro-planning and outreach sessions.

National EPI organized 2 national level workshop on risk communication in immunization for journalists from relevant newspapers and mass media agencies, reviewed the communication in immunization training manual and trained provincial health staff from health education centres in communication in immunization. In addition, 322 village health staff in identified communes and villages will low immunization coverage were trained in immunization and communication in immunization and communication materials such as leaflets and Questions and Answerers for DTP-HepB-Hib were developed and disseminated.

UNICEF TA was provided for sufficient and timely procurement of vaccines (DTP-HepB-Hib) which were both financed and co-financed by Gavi and the Government.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Introduction of IPV in routine EPI	Due to non-availability of IPV delayed to the first half of 2018
2. Switching from tOPV to bOPV. Remove all tOPV from entire cold chain system	Use of tOPV stopped on 1 May, bOPV from June 2016
3. Communications: implement the national communication plans for EPI focusing on demand generation and vaccine hesitancy	Ongoing (UNICEF)
4. Introduce policy/regulation for reporting of vaccination in private health care facilities	Ongoing (WHO and UNICEF)
5. EPI related priorities have been included in the attached transition plan	The transition plan includes activities by WHO, UNICEF, World Bank and Sabin
6. Conduct an evaluation of HSS grant with end line survey, including lessons learnt for sustainability and scale up of the activities. In 2016, HSS PMU has provided the TORs for GAVI recommendation. Evaluation to be completed by December 2017.	The selection of consulting firm has been completed. The project signed contract with Vietnam Health Economic Research and Consulting Centre (VHERC) in June 2017. The draft report is expected to be sent to GAVI for review by 30 November 2017, the final report will be submitted by 31 December 2017.

7. Develop a plan for full utilization of HSS grant beyond June 2016 in close consultation and endorsement by the EPI program.	The plan has been completed and endorsed by EPI in December 2016
8. A plan to scale up the training for VHWs and CHWs for Vietnam based on experiences from HSS grant (optional). Project closure - PMU and 10 provinces to agree on how to maintain the project's results/experience. This will include solutions on HR, fund mobilization and other lessons learned in June 2017	The experiences and lesson learnt will be documented and shared with 10 local health department in the project closure conference and other dissemination workshops at local and central level.

5. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

Introduction of inactivated polio vaccine (IPV)

As part of global polio eradication initiative Viet Nam was planning to introduce one dose of IPV vaccine into the routine immunization schedule by October 2015, with support from Gavi. However, due to limited global supply of IPV the introduction of the vaccine has been postponed to spring 2018 (according to the latest available information from UNICEF). In the application submitted to the Gavi the country indicated 1,850,260 children under 1 year of age as target population for 2016. However, according to the Gavi's decision letter for 2016, the approved number was 1,242,900. No decision letter was issued for 2017 due to the global supply shortage. For 2018 approvals, the country estimate of 1,773,938 has been used.

Introduction of IPV vaccine is an important part of global polio eradication plan because after the switch from tOPV to bOPV, which took place in May 2016 in Vietnam, IPV is the only mean of protection of the population against type 2 poliovirus. For Viet Nam the current situation means that almost two birth cohorts will not have been protected against type 2 poliovirus until the IPV vaccine is introduced in the 2nd quarter of 2018. As part of mitigating activities, WHO recommends to the countries with delayed introduction of IPV, including Viet Nam, that catch-up vaccination of those who were eligible for one dose of IPV after the switch up to the date IPV should be made available. Gavi will be supporting Viet Nam with the required doses and devices to vaccinate the children missed since the Global tOPV-bOPV switch.

In line with vaccine supplying availability, according to information from UNICEF and WHO Vietnam proposes:

2018: Prioritized implementation in high risk areas of 30 provinces with criteria of prioritized areas:

a. High risk of existing VDPV in population –
    i. Low routine EPI coverage districts
    ii. areas where any outbreaks occurred of diphtheria or tetanus before (that indicated low routine coverage)
b. High risk of not realizing VDPV in population - Low performance districts of AFP surveillance
c. High risk of importing VDPV - bordering areas or areas with any port (airport, seaport)
d. High risk of circulation of VDPV - high population mobility and high population density areas

2019: Expand to remaining 33 provinces.

The proposal from NEPI is currently under review by WHO HQ and WPRO.

Implementation in 30 high risk provinces in 2018:

- Organizing catchup vaccination for children ≥ 5 months of age (children born from 1 March 2016 to 31 January 2018 who were not vaccinated with polio vaccine type 2). Expected about 1,228,216 children. To be launched in May - June 2018 once IPV will be available in Viet Nam.
- From July 2018, IPV vaccine will be introduced in routine immunization for 5-month-old infants in 30 provinces. It is expected that monthly vaccinated population (from July 2018 to the time of implementation in routine immunization nationwide - expected in April 2019) is about 418,777 children.

Implementation in the remaining 33 provinces in 2019

- Organizing catchup vaccination in March 2019 for children ≥ 5 months of age (children born from 1 March 2016 to 31 September 2018). Estimated about 2,755,072 children.

- From April 2019, IPV vaccine will be introduced in routine immunization for 5-month-old children nationwide. The estimated target population is about 140,000 children per month.

Vaccine needs

In 2018: 2,818,600 doses of vaccine, to be provided before March 2018
- 2,100,000 doses: catch up vaccination for children were not immunized with polio vaccine type 2 in the 30 high risk provinces in June 2018.
- 718,600 doses: to be used in routine immunization for 5 months of age children in 30 provinces from July 2018 to March 2019.

In 2019: 5,652,300 doses, supply needed in January 2019
- 3,753,300 doses: for catch up vaccination for children were not immunized with polio vaccine type 2 in the remaining provinces (33 provinces) in March 2019-1,899,000 doses: to be used in routine immunization for 5 months of age children in 63 provinces from April 2019 to December 2019

CCEOP

The CCEOP Operational Deployment Plan and project is currently under development to be submitted for government approval. The project will include a plan of equipment distribution to provincial and district levels in 2018, 2019 and 2020. The number of equipment required for each year is outlined in the Gavi CCEOP approval letter dated 11 August 2017.

HSS

Key activities of the project in 2017 approved by MOH and Gavi:

- Training on EPI for district health workers in 9 out of 10 provinces for about 722 students
- Training on EPI for commune health workers for about 3230 students (they are new health workers, health workers have exhausted training certificate on immunization).
- Training on MCH for about 1596 students (who have not been trained under the new MOH program).
- The training on health planning and M&E for 494 students at provincial and district levels.
- Training on safe immunization practices for 114 health workers at the provincial level and 114 teachers of medical schools in 63 provinces.
- Support outreach immunization,
- Strengthening the management of equipment of the project
- Activities on monitoring of primary health care, workshops / conferences, JAHR reporting support,
- Preparatory activities for closing the project.
- Research, Initiatives: (i) evaluation of health worker training / education, (ii) evaluation of health services utilization, (iii) assess the need for maternal and child (under 2 year) health care, and the ability of the Health centres to respond

The total cost for 2017 is $ 3.27 million.

The MOH proposal for the HSS project closure period (January-June 2018)

The Ministry of Health requests Gavi to extend some of its closure activities until 30 June 2018 for the following reasons:

1. According to the Government of Vietnam, the closing of the project should complete procedures for donors, ministries, provinces and government of Vietnam with duration of 6 months to 1 year.

2. If the project ends in December 2017, the HSS PMU will be dissolved and the project staff will no longer work, the part-time staff of the Ministry of Health will be unlikely to undertake the large workload of the PMU. As such, interconnection of project information is interrupted which greatly affects the completion of the project.

3. The sharing of results-lessons learned-model of the project, documentation should take time to prepare and implement. The way to carry out this activity will include hiring consultants to complete the materials, products and organize seminars with interested parties, sharing products and send to MOH, provinces. Materials and products are also the basis for local consultation and development of plans / programs to ensure sustainability after project closure.

Activities to be implemented from January to June 2018

1. Complete the procedures for closing the project:

According to the Government of Vietnam (Point d, Clause 3, Article 6 of Circular 07/2010 / TT-BKH of the Ministry of Planning and Investment guiding the implementation of Decree No. 93/2009 / ND-CP dated October 22, In 2009 the Government promulgated the Regulation on the management and use of foreign non-governmental aid), after finalizing the program within six months, the PMU must complete a number of specific contents as follows:

- Make the project completion report as prescribed and submit it to the competent authority for approval.
- Make reports on settlement of administrative and non-business capital for submission to the managing agencies / competent agencies for appraisal and approval according to the current accounting regime.
- Dispose of assets when the project is terminated in accordance with Circular No. 198/2013 / TT-BTC.
- The tax office shall examine and compare the fulfilment of the project tax obligation and the tax code-closing notice
- The insurance agency shall check and compare the deducted amounts, payment and payment of social insurance, health insurance, fixed assets and project insurance premiums and notify the insurance code number.

2. Record files, project documentation

3. Complete the independent audit report for 2017

4. Organize some conferences:
- Project Review Conference
- Conference for sharing results of research, dissemination lessons learned.

Cost for this period is about $ 259,000, taken from the project's balance (including bank interest and VND / USD exchange rate differences). Funds are used to cover the salaries and allowances of some key members of the PMU, administrative expenses, conferences, workshops etc.

Key finding 1	A key activity for 2018 is the phased introduction of IPV into routine EPI Starting with prioritized implementation in high risk areas of 30 provinces with low immunization coverage, difficult surveillance of AFP, mountainous provinces and provinces bordering with other countries. 2019: Expand to remaining 33 provinces
Agreed country actions	Need the official letter from UNICEF to inform about time and number of IPV doses will be supported.
Associated timeline	As soon as possible, dependent on IPV availability
Technical assistance needs	Support from WHO needed to calculate target population which may be different to the previously communicated DL figures.
Key finding 2	The CCEOP project is being developed for government approval. The project will include a plan of equipment distribution to provincial and district levels in 2018, 2019 and 2020. The number of equipment required for each year is outlined in the Gavi CCEOP approval letter dated 11 August 2017.
Agreed country actions	Need Government approval for the CCEOP project soon (may be December 2017).
Associated timeline	Implementation to start as soon as possible. Government approval takes time.
Technical assistance needs	For TA needs, it is essential for the EPI cold chain management staff and EPI staff at national and regional levels to be trained by equipment manufacturers on equipment maintenance and repairing which is specified for the refrigerators selected for CCEOP.
Key finding 3	Pentavalent (DPT-HepB-Hib) in routine EPI needs to move from Quinvaxem to ComBE Five product by Biological E. Limited, India, and MR vaccine product by SII, India to MRVAC product by POLYOVAC (local production)
Agreed country actions	Implement ComBE Five in 4 provinces in December 2017 and all country from March 2018, and

	Implement MRVAC in 4 provinces in September 2017 and all country from October 2017.
Associated timeline	ComBE Five will be used from December 2017 and MRVAC from September 2017.
Technical assistance needs	Receive 105,000 doses of ComBE Five support by Gavi for 2018 in October 2017 for use in 4 provinces before using in all country in March.
Key finding 4	Vaccine hesitancy is one of the key drivers of uneven coverage. Recent information from Anti-Vaccination Group on social media recently poses a =n increasing risk to EPI vaccine coverage.
Agreed country actions	Increase communication to community and improvement of AEFI system at all levels.
Associated timeline	As soon as possible.
Technical assistance needs	TA from WHO and UNICEF is needed to address information from the Anti Vaccine Group. Communication activities for immunization need to be implemented, including issues related to anti-vaccination which are identified in the transition plan and the national communication plan for immunization.

6. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

HSSCC members approved the JA report.

7. ANNEX

Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators			NA
Financial Reports			
Periodic financial reports	Yes (HSS)		NA
Annual financial statement	Yes (EPI&HSS)		
Annual financial audit report	Yes (EPI&HSS)		
End of year stock level report	Yes (EPI)		
Campaign reports			NA
Immunisation financing and expenditure information	Yes		
Data quality and survey reporting			
Annual desk review			NA
Data quality improvement plan (DQIP)			NA
If yes to DQIP, reporting on progress against it			NA
In-depth data assessment (conducted in the last five years)			NA
Nationally representative coverage survey (conducted in the last five years)	Yes (EPI)		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	Yes		
Post Introduction Evaluation (PIE)			NA
Measles-rubella 5 year plan			NA
Operational plan for the immunisation program	Yes		
HSS end of grant evaluation report			To be submitted in Dec 2017
HPV specific reports			NA
Transition Plan	Yes		