Request for Health Systems Strengthening Support based on a jointly assessed National Health Strategy

Funding Request Template - Pilot Version, 10 May

Applicant Details

Country	VIETNAM	
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Funding requested from GAVI only	x☐
Funding requested from Global Fund only?	☐
Funding requested from the Global Fund and GAVI	☐

Government endorsement (for requests to GAVI only)

Please note that this application will not be reviewed or approved by GAVI without the signatures of both the Minister of Health & Finance or their delegated authority.

Minister of Health
Name: Nguyen Quoc Trieu
Signature:
Date:

Minister of Finance
Name: TRƯƠNG CHÍ TRUNG
Signature:
Date: 8/8/2011

Background

HSCC Signatures Page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), endorse this proposal on the Health Systems Strengthening Support. 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/Organisation	Signature
Pham Le Tuan Director	Planning and Finance Department, MOH	
Tran Duc Thuan Vice Director	Training and Science Department, MOH	
Nguyen Duy Khe Director	Maternal & Child Health Department, MOH	
Nguyen Tuan Hung Vice Director	Manpower & Organization Department, MOH	
Nguyen Manh Cuong Vice Director	International Cooperation Department, MOH	
Tran Quy Truong Vice Director	Curative Care Administration, MOH	
Vu Thi Minh Hanh Vice Director	Health Strategy and Policy Institute, MOH	
Nguyen Tuan Thien Director	National Institute for Hygiene and Epidemiology	

Background

Duration of the National Health Strategy	
From (Month and year)	**To (Month and year)**
Jan 2011	Dec 2015
Planned Start and End dates for HSS support (please note that the funding duration is until the end of the National Health Strategy for GAVI, and up to a maximum of five years for Global Fund)	
From (Month and year)	**To (Month and year)**
Jan 2012	Dec 2015
Describe how the dates above were selected and how they contribute to alignment with national fiscal and/or program review cycle/s. Mid-term plans have been developed for the health sector every five years. Current health sector 5-year plan is for 2011-2015. Based on the five-year plan, annual health plans are developed. GAVI-HSFP will be integrated into annual planning cycles of the health sector and aligned priorities set in the 5-year health plans.	

Currency: 'Tick' (✓) which currency is used throughout this application.	x☐ USD or ☐ EURO Note that GAVI will disburse in USD only.

Period	HSS Funding Request					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
	Jan–Dec 2012	Jan -Dec 2013	Jan – Dec 2014	Jan – Dec 2015		
Funds requested from the Global Fund						
Funds requested from GAVI	3,689,552	12,900,284	4,247,712	3,562,452		24,400,000
					Total Funding Request	24,400,000

ELIGIBILITY

If this application includes a request to the Global Fund, applicants are requested to verify their eligibility for Global Fund support by filling out this eligibility section [insert link].

For more information on Global Fund eligibility, please refer to the Global Fund's policy and practical guidance on the six minimum requirements for CCM eligibility [insert link].

If this application includes a request to GAVI, applicants are requested to verify their eligibility for GAVI support by filling out this eligibility section.

For more information on GAVI eligibility, please refer to the following document

http://www.gavialliance.org/support/who/index.php .

NOTE: In filling out the sections below please cross-reference as much as possible to the existing documentation of the National Health Strategy

SECTION 1: EXECUTIVE SUMMARY

Please provide a high level summary of the National Health Plan and explain:

1) How funds requested for cross-cutting HSS interventions will help achieve expected outcomes and impact as described in the National Health Strategy/Plan.
2) How the elements of the overall national health strategy for which HSS support is requested are expected to contribute to:
   - Improved outcomes in at least two of the three diseases (HIV/AIDS, Malaria, Tuberculosis) – for Global Fund support
   - Strong links to immunisation outcomes – for GAVI support

If the application includes a request to GF please also provide the following:

3) For which elements of the National Health Strategy HSS support is requested

Response:
Please limit your response to two pages maximum

1. Summary of National Health Plan, 2011-2015

Vietnam has 63 provinces with a population of 87 millions. GDP per capita is about 1,200 USD. Vietnam health system is a mixed public-private provider system, in which the public system plays a key role, especially in prevention, in-patient care, research and training. The private sector has grown since the 'reform' of the health country in 1989, but is mainly active in simple outpatient care. Total health expenditure in 2008 was about 7% of GDP, including tax-based budget (23%), social health insurance (18%), ODA/NGO support (2%), out-of-pocket payment and others (57%).[1] Share of public health expenditure among total health expenditure has increased from about 20% in 2000 up to 43% in 2008.

Income per capita is still low, however, Vietnam has made good achievements in improving health status. All targets for 2010 of the health-related MDG goals have been achieved. During last decade 2001-2010, life expectancy at birth has increased from 69.1 to 72.8; infant morality from 30‰ to 16‰; under-5 mortality from 58‰ to 25‰; maternal mortality from165 to 69/100 000 live births.[2]

Vietnam 5-year health sector plan has identified priority issues for the next 5 years as follows: (i) Increasing disparities in health status across regions and income groups; (ii) Grass-roots health care network is still in difficulties, especially in mountainous, remote, isolated areas; district preventive health network remains weak; (iii) Capacity and quality of the curative care network is limited; (iv) Risk of increasing fertility rate, increasing imbalance of sex ratio at birth; low quality of MCH care; (v) Inadequate health workforce quantity, structure and distribution, low quality of health workforce especially the rural and mountainous areas; (vi) Health information system is incomplete; (vii) Low domestic production of drugs, high drug price, common irrational and unsafe use of drug; (viii) Low domestic production of medical devices; (ix) Low total health expenditure, low public health spending (<50%); inappropriate financial allocation and payment mechanisms; low coverage

[1] National Health Account, MOH, 2010.
[2] Health Statistics Yearbooks, MOH

of health insurance (60%); (x) Insufficient management capacity for policy-making, planning, policies implementation and M&E.

Overall health sector goal for 2011-2015 is to further strengthen the health care system towards equity and efficiency, improving quality of care, meeting the growing and diverse needs for health care of the people; reducing morbidity and mortality, promote health, increase life expectancy, and improve quality of life.

The 5-year health sector plan 2011-2015 include eight objectives: (i) To consolidate and further develop the health care network, especially grass-roots level, mountainous, remote and isolated areas; (ii) To promote preventive medicine and PHC to ensure equitable access to quality basic health care services; (iii) To improve quality of hospital care services; (iv) To enhance performance of population and family planning activities, reproductive health, securing stable population with rational population growth and quality, and gradually mitigate imbalance of sex ratio at birth; (v) To develop human resource for health both quantity and quality, especially in the rural, mountainous, remote and isolated areas; (vi) To enhance health financing reforms, increase public health expenditure, develop universal health insurance, adjust budget allocation and increase its efficiency; (vii) To develop pharmaceutical and medical equipment industry, promote health technology assessment; (viii) To strengthen health system management capacity in response to the needs for health sector reform in the new situation.

The EPI cMYP 2011-2015 and recent assessment of EPI programme (2009) has identified major EPI-related challenges to 2015 including: sustaining high immunization coverage, especially in hard-to-reach areas; responding effectively to adverse events for immunization; strengthening collaboration between preventive and hospital sectors, in particular hepatitis B birth dose; building capacity and mobilizing resources to motivate the health workforce especially in remote areas; building links with health systems planning in order to sustain operational finance and human resource capacity in rural and remote areas. Key activities for EPI 2011-2015 include to strengthen routine immunization through micro-planning workshops, supervisory follow-up in priority districts, training of staff at different service delivery levels, including AEFI for communes health workers, replace cold chain, build financial planning and management capacity at all levels, supportive supervision, etc.

The 5-year health plan and JAHRs[3] have highlighted key health system bottlenecks and prioritized areas where intervention programs may have a significant impact on improving access to and quality of services, particularly in more disadvantaged and remote areas. The most critical strategic intervention areas include the consolidation and strengthening of (i) health workforce (ii) inadequate supply of essential equipment and (iii) management capacity.

2. HSFP contribution to immunisation outcomes

Based on priorities, objectives and key activities set in the health sector 5-year plan and cMYP for EPI Programme 2011-2015, JAHRs, experience from other HSS projects and GAVI priorities, HSFP will focus on three key objectives: (i) support human resources development for health in rural, mountainous and difficult areas through various training activities on EPI, MCH care, health system management, health planning and M&E etc; (ii) strengthen capacity to deliver good basic healthcare services, especially for mothers and children, through ensuring adequate supply of essential equipment, outreach services to hard-to-reach populations; (iii) strengthen management capacity in response to the needs for

[3] Joint Annual Health Sector Reviews, which have been jointly carried out annually since 2007 by MOH and development partners to provide information for health planning, health policy dialogue and monitoring health system performance.

health sector reform and development in the new situation. Interventions will be focused in 10 difficult provinces with low EPI and DPT coverage, high drop-out rate, high poverty rate, and high under-5 mortality.

These 3 objectives of HSFP are fully in-line with objectives number 1 and 2 (strengthen basic health care network and PHC), objective number 5 (human resource for health), and objective number 8 (management capacity) in the 5-year health sector plan 2011-2015. Proposed HSFP activities are also selected from section 4 (key tasks) of the health sector 5-year plan. HSFP will mainly focus on three out of six building blocks of health systems, namely human resource, governance and stewardship, and service delivery which are highly prioritised by the Government.

The 5-year health plan also includes 19 essential health indicators assigned by National Assembly and Government for the health sector. Among these 19 indicators, HSFP will significantly contribute to indicators number 3 (percentage of villages with VHW), number 7 (% of children under 1 year fully vaccinated), number 8 (% of commune achieving national benchmarks for commune health), numbers 10, 11, 12 and 13 about life expectancy at birth, MMR, IMR and U5MR.

As regards EPI outcomes, HSFP objectives and activities are in-line with priorities, objectives and activities stated in the EPI assessment and EPI cMYP 2011-2015. HSFP activities will contribute to improve and sustain EPI coverage, quality and equity in EPI and in health care. *About coverage*, The HSFP will support training on EPI, MCH, health system management for health workers who directly involve in EPI campaigns (commune health workers, VHWs, district EPI staff, hospital staff related to vaccination, etc); support outreach EPI and mobile immunization teams, etc. These will help to increase coverage of EPI, including children fully vaccinated, DPT and hepatitis B birth dose, especially in the hard-to-reach areas. *About quality,* strengthened staff capacity and supply of essential equipment will help to improve service delivery, quality of immunization, MCH and other PHC services. *About equity*, HSFP focuses in basic healthcare network of difficult provinces with high poverty rates, poor districts, communes and hard-to-reach populations. This will improve access of people, especially the poor and ethnic minorities, to basic and essential health care services, therefore, improve equity in EPI and in health care in general. These are also fully in-line with basic principles for health sector development in Vietnam, to build an equitable and efficient health care system in order to provide health care services to all people, especially the poor, people living in mountainous, remote and difficult areas.

SECTION 2: PROGRAMMATIC INFORMATION

Based upon currently known and planned funding available to support the National Health Strategy, please describe the HSS goals, objectives and key activities which have been prioritized for additional funding through this application.

Explain how these objectives link to the national strategy and any other relevant plans, such as annual or sub-sector (for example, human resources management) plan.

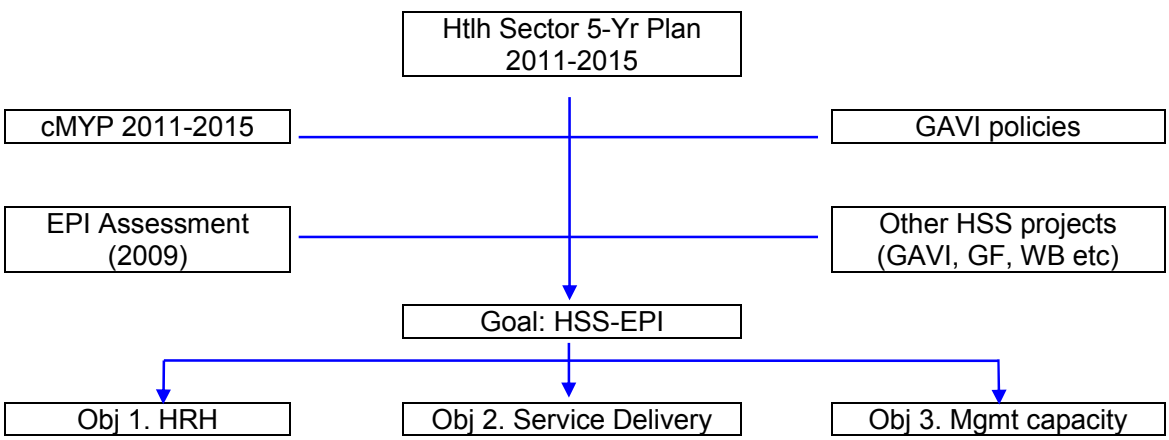
Explain how these objectives link to previous Global Fund and/or GAVI HSS support.

Response:
Please limit your response to six pages maximum

1. HSFP goal:

Background for the proposed goal, objectives and key activities includes 5-year health sector plan 2011-2015, JAHRs, EPI cMYP 2011-2015, EPI assessment (2009), GAVI priorities and lessons from previous and on-going HSS projects funded by GAVI, WB, GF etc.

Goal of GAVI-HSFP is to strengthen health care system, especially at basic level, through support to development of health workforce, improved service delivery capacity and strengthened management capacity, which will contribute to sustained and increased high coverage of quality basic health services, especially EPI and MCH outcomes in difficult areas of Vietnam.



2. Objectives

(i) To support development of human resources for health in rural, mountainous and difficult areas through various short and long-term training activities.

(ii) To strengthen health systems capacity to deliver good basic healthcare services, especially for mothers and children, through ensuring adequate supply of essential equipment and outreach services to hard-to-reach populations.

(iii) To strengthen management capacity in response to the needs for health sector reform and development in the new situation.

These GAVI-HSFP objectives are fully in line with specific objectives number 1 and 2 (strengthen basic health care network and PHC), objective number 5 (human resource for health), and objective number 8 (management capacity) of the 5-year health plan 2011-2015. They are also in line with key issues and objectives of the National EPI programme (e.g., building capacity and mobilizing resources to motivate the health workforce especially in remote areas, regular training of all health workers engaged in delivery of immunization services; Increase coverage of birth dose of hepatitis B vaccine; maintenance of a functioning national adverse events following immunization (AEFI) monitoring system; better planning and financial sustainability for EPI programme, etc).

3. Key activities

GAVI-HSFP will focus in 10 difficult provinces selected with following criteria: (i) provinces with low EPI coverage (low DPT3, low rate of fully immunized children and high number of districts with DPT3 less than 80%, high drop-out rate; (ii) high poverty rate; (iii)

high infant mortality; (iv) geographic location (north, center and south); (vi) no other similar projects, e.g., GF-HSS (as activities are quite the same). Following provinces have been selected for GAVI-HSFP: *Hà Giang, Bắc Kạn, Tuyên Quang, Lào Cai, Hòa Bình, Nghệ An, Hà Tĩnh, Kon Tum, Đăk Nông, and Kiên Giang*. Among these 10 provinces, there are 3 provinces from GAVI-HSS Phase 1 (Ha Giang, Bac Kan and Kontum).

Key activities for GAVI-HSFP are selected from section 4 (key tasks) of the health sector 5-year plan and key activities for EPI cMYP 2011-2015. HSFP activities focus at basic health network (district, commune and village) in difficult provinces, address health system bottlenecks of EPI in Vietnam. Key activities by objective are summarised as follows:

HSFP GOAL	OBJECTIVES	KEY ACTIVITES
To strengthen health care system, especially at basic level, which will contribute to sustained and increased high coverage of quality basic health services, especially EPI and MCH outcomes in difficult areas of Vietnam.	Human Resource Development	1.1. 6-9 mth training courses for VHWs 1.2. Training courses on EPI for district hospital staff 1.3. Training courses on EPI in Practice for CHWs 1.4. Training courses on MCH for CHWs
	Service delivery	2.1. Supply of essential equipment for DHCs, CHCs and VHWs 2.2. Support outreach immunization spots in mountainous communes
	Management capacity	3.1. Training courses on health planning and M/E for provincial and district health managers 3.2. Support for Joint Annual Health Sector Reviews (JAHRs) 3.3. Support for M/E and supervisory visits 3.4. Support for initiatives and policies to strengthen basic health network 3.5. International workshops, training, study tours

Objective 1: Human Resource Development for Health

Human resource development for health (HRH) is among high priority issues of the MOH. Major HRH strategy is to increase health staff quantity with more balanced structure and distribution, improve staff quality and efficiency. Quite many interventions should be carried out, as stated in the 5-year health plan, including: (i) Training measures: upgrade training facilities, improve training materials and methods, set standards for training outputs in order to improve training quality; expand new and refresh training for assistant doctors, midwives, nurses, pharmaceutical staff, village health workers, especially for rural and disadvantaged areas; strengthen post-graduate training; (ii) Non-training measures: Issue licenses for health professionals; policies, incentives to develop health workforce in the difficult regions (e.g., financial incentives, house or land support, staff rotation, technical transfer to lower levels, etc); strengthen HRH management capacity... Among strategies and priorities set by MOH and EPI cMYP, GAVI-HSFP will mainly focus on training of health workers at basic level, who directly involve in immunization activities at hospitals and community.

1.1. Provide 6-9 month training courses for VHWs: In 2009, Vietnam has 98,529 Village Health Workers (VHWs), working in 75.8% of villages. The main responsibilities of VHWs include: (i) Carry-out health education and communication activities; (ii) Community

hygiene and health prevention (food safety, clean water, hygiene latrine, participate in immunization activities, nutrition, etc); (iii) MCH care (pregnancy checks, support normal delivery, child home-care, family planning, etc); (iv) First aid and basic curative care (accidents and injuries; simple and common diseases, home care for tuberculosis, HIV/AIDS, leprosy, etc; (v) Other public health programs (TB, malaria, malnutrition, EPI, etc) and vital registrations (births, deaths).

VHWs play important roles in EPI campaigns, especially in mountainous and remote areas. VHWs are responsible to get names of all mothers and children in immunization age in the villages, gather children to immunization spots, help CHWs to give immunization, follow-up children after immunization and carry out IEC activities for EPI programme. These issues will be also included in the training curriculum for VHWs.

Five-year health plan set a target that by 2015, 90% of villages in the country should have (VHW), at least one VHW for each village. MOH requires VHWs to be trained at least for 9-months. However, most of VHWs are trained only for 3 months or less. Only few percents of VHWs have been sufficiently trained as required by the MOH (except in 10 provinces supported by GAVI-HSS phase 1). Sufficient training for VHWs (6-9 months) is among key tasks in the health sector 5-year plan (section 4.1). Therefore, 6-9 month training courses are highly needed for VHWs to be fully trained as required by the MOH (6-month course is for VHWs who have already undergone for 4-6 month training; 9-month course is for new VHWs or VHWs with 3 months training or less).

GAVI-HSS Phase 1 has supported to train over 8,000 VHWs with 6-9 month programmes with very positive outcomes, increasing number of VHWs, improving quality of VHWs and their services, etc. GF-HSS has planned to train 6,000 VHWs in 15 provinces. This GAVI-HSFP will provide this training for CHWs in newly participating provinces, and limited number of courses for provinces already included in the GAVI-HSS phase 1.

The training courses will be organised by Provincial Secondary Medical Schools (one school in each of almost provinces). Training curriculum already approved by relevant authorities will be used, including EPI Programme, as well as other issues related to functions of the VHWs (as mentioned above). Training programme can be divided into 2 or 3 semesters, including field practice in trainees own community. After training, participants will be provided with a Certificate by training schools which allows them to practice as a formally trained VHW.

1.2. Training courses on EPI for district hospital staff (2-days): Vietnam is a country with high prevalence of Hepatitis B positive in the population (about 8-16%). Therefore, HipB birth dose is very important. However, only about 30% of newborns have been vaccinated during first 24 hours. Main reasons of this include insufficient training for health workers in the hospitals (without training certificate on immunization safety, they cannot give vaccination) and poor awareness among hospital staff, poor information and communication, etc. EPI cMYP has identified the need to strengthen collaboration between preventive and hospital sectors, especially for surveillance and immunization services (in particular Hepatitis B birth dose). Iinvolvement of hospital in early detection and care of AEFI also need to be strengthened. One of the important EPI targets is to increase coverage of Hip B birth dose. Therefore, GAVI-HSFP will support 2-day training courses for district hospital MNCH staff, e.g., doctors, assistant doctors and nurses working at obstetrics and paediatrics departments so that they have better awareness about importance of Hip B birth dose, and have certificate to give vaccination as required by the MOH. Each hospital, about 6 staff will be trained. This is also among priority activities requested by the National EPI programme.

1.3. Training courses on EPI in Practice for CHWs (5 days): With support from WHO, the EPI Program in Vietnam has developed a detailed technical and practical guideline on immunization and EPI (EPI in Practice). This guideline has been widely distributed to CHCs. According to Article 5 of the Decision 23/QD-BYT dated 7 July 2008 of the MOH about the use of vaccines, health workers who give vaccination must be trained and get a certificate of

attending a training course on Immunization Safety. However, due to shortage of budget, each CHC there are only about 2 staff (CHW head and EPI-in-charge staff) trained. Every month, on vaccination day, one CHC may give vaccination to about 60-100 children. Also CHC has to carry out out-reach in about 4-6 vaccination spots. Therefore, two trained staff is not sufficient for CHC to give vaccination. GAVI-HSS phase 1 already organised about 192 courses for over 7,000 health workers in 10 provinces with very good outcomes to improve immunization quality. National EPI programme strongly requests to have more courses in order to improve immunization coverage and quality. The GAVI-HSFP will support short-training courses (5 days) on "EPI in Practice" in order to update CHWs with latest practices according to guidelines of the national EPI programme. Each CHC, about 3 health staff will be trained.

1.4. Training courses on MCH for CHWs (5 days): The maternal and child health program has been implemented in Vietnam for many years. However, in some provinces especially in the disadvantaged areas CHWs have not received adequate refresh training on MCH and Reproductive health, which has resulted in poor MCH related indicators. The GAVI-HSFP will support short training courses for CHWs on updates of MCH programmes, as well as management of common health problems of the community. These courses will be organized by provincial DOHs and DHCs.

Objective 2: Strengthen capacity to deliver basic health services through ensuring adequate supply of essential equipment for health facilities

2.1. Supply of essential equipment to DHCs, CHCs and VHWs: After improving staff capacity through training, availability of equipment is a crucial element for service delivery. In a district of about 100,000-150,000 population, there are three healthcare organisations: (i) District Health Office is a division with about 3-5 officers belonging to District People Committee to be overall responsible for healthcare in the district; (ii) District general hospital with about 100-200 beds; and (iii) District Health Center (DHC), with about 30-50 staff, taking care of preventive medicine, focal point to implement all public health programmes in the district, including EPI, TB, malaria, HIV/AIDS etc.

Among these three organizations, HSFP will support essential equipment for DHC, as this is the focal point for EPI and other public health programmes, directly related to mother and child healthcare. DHCs have been newly created (since 2006). A Decision was signed by the Prime Minister (No.1402, year 2007) to strengthen DHCs. However, due to lack of funding from the Government, DHCs are still in difficult situation with serious lack of essential equipment. Within the selected provinces, about 70% DHCs do not have enough essential equipment for their work performance.

In a commune of about 10,000-20,000 population, there is one Commune Health Center (CHC) with about 5-7 health workers, including one medical doctor, responsible for healthcare in the commune, including both primary curative and preventive health services. CHC is also responsible for all vertical public health programmes, including EPI. Similarly, about 60% of CHCs lack of essential equipment, such as refrigerator, cold box, other laboratory and reproductive health materials, surveillance equipment, etc., as defined in the standard lists of the MOH. EPI assessment report and cMYP also strongly emphasised urgent equipment needs for basic health care network, especially cold boxes and refrigerators.

In the 10 difficult provinces selected for GAVI-HSFP, there are 110 districts and 1,886 communes. Among these, only 30 DHCs and 500 CHCs which are among poor and most disadvantaged ones will be supported with essential equipment. The standard lists of equipment for DHC and CHC issued are used to assess the needs with the following steps: (i) MOH will select a number of essential equipment items with following selection criteria: Essential items for technical performance of the facilities; closely related to implementation

of EPI, MCH and other public health programmes (e.g., TB, malaria, and HIV/AIDS); (ii) MOH send to provinces and then to every selected DHC and CHC. Using the list suggested by the MOH, DHCs and CHCs check their current equipment items, health staff capacity to use the equipment, future needs to make their equipment proposal and submit to Provincial Department of Health (DOH); (iii) Provincial DOH collect, review, approve the needs and submit to MOH; (iv) MOH reviews and compiles needs from all provinces.

MOH has also issued a standard equipment kit VHWs. This kit consists of basic and essential items to serve the work of VHWs, in accordance with their roles. This kit will be provided to all VHWs in the project provinces who do not have yet the equipment kit.

GAVI-HSFP only provide equipment; costs for running, maintaining and repairing equipment (if any) will be borne by beneficiary health facilities using their annual recurrent budget financed by the Government.

2.2. Support outreach immunization spots in mountainous communes: Overall immunization coverage is high in Vietnam (over 90%). However, coverage of DPT3 and the hepatitis B birth dose are still very low in remote, mountainous and difficult areas. On the vaccination day, in addition to CHCs, about 4-6 vaccination spots need to be organised outside CHC for children in remote villages. The MOH's Decision 23/QD-BYT above has specified necessary conditions as regards health staff, facilities, equipment for an immunization spot outside CHC. There should be at least 3 staff for each spot, including one CHW for examination and follow-up after immunization, one CHW to give vaccination and one VHW to check mothers and children lists, contact households to get mothers and children to the spot and provide administration support for organising the spot. During outreach immunization, members from mass organizations (e.g. Women Union, Farmer Union, Youth Union) also participate in order to help children and mothers to the immunization spots, monitor the immunization and provide other support when needed. In addition to immunization services for mothers and children, teams also provide information and consultation about pregnancy, maternal, reproductive and child care, nutrition, etc.

National EPI programme has a policy to increase EPI coverage in mountainous and remote areas through these immunization spots and outreach EPI. However, due to shortage of budget, it is difficult to expand and improve the quality of immunization spots outside CHC.

A project to support health care for the poor (HEMA) supported by EC has also provided similar support to immunization spot outside CHCs 253 communes of 33 districts selected in five difficult provinces with good outcomes for EPI in mountainous and remote areas.

The GAVI-HSFP will support outreach immunization spots outside CHCs organised in accordance with guidelines of the MOH (Decision 23) in *mountainous and very difficult communes*[4] of the project provinces (not all communes). For each commune, HSFP will support *up to 5 outreach immunization spots*, priority given to the spots furthest from CHC. The support includes travel cost and per-diem for health staff, approximately about 15 USD/spot/month.[5] Commune with similar support from other projects (e.g., HEMA) will not be supported by HSFP. This support will help increase coverage and quality of immunization in the hard-to-reach communes and villages, and also contribute to equity in immunization and healthcare in general.

[4] There are Decisions of the Government about the very difficult communes.

[5] This is similar to current cost-norm supported by HEMA project for outreach vaccination spots.

Objective 3. To strengthen management capacity in response to the needs for health sector reform and development in the new situation

3.1. Training courses on health planning and M&E for provincial and district health managers (5 days): At different levels in the health care sector, doctors tend to have the most education, and are appointed to be responsible for management tasks. Therefore, most of management posts in the health care network are responsible by persons with medical background and with inadequate management training (especially at lower levels).

Manager competency strengthening is considered a key component of the MoH-initiated program of sector wide financial and operational mechanism reforms. Placed high on the policy agenda of the MOH and with potential strong impacts on health services delivery, management capacity strengthening is also taken on as the key emphasis in Joint Annual Health Review (JAHR, 2009).

The five-year health plan and EPI cMYP give particular importance to planning and M&E activities as they play an essential role in providing insight into the effectiveness and efficiency of the health system and the public health care programs in particular. The refinement of health plans relies a large part on results from M&E activities. To the other end, and as result from the relatively weak M&E system, health programs have in many cases not been well implemented despite a substantial amount of planning has been undertaken.

This GAVI-HSFP will provide short training courses on health system management (especially health planning and M&E) for health managers at provincial and district levels. Health system building blocks and key issues of the health system will be introduced in the courses, (i.e., human resource development, health financing, health information system, service delivery, quality management, management of PHC and basic health care network, etc). Current health policies and reforms will be also introduced to the participants.

3.2. Support for Joint Annual Health Review (JAHR): JAHR has been jointly developed by MOH and Health Partnership Group (HPG) since 2007. JAHRs are used to assess progress, determine problems, priorities and follow-up performance of the health sector (M&E) 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 (e.g., EPI), human resource development, health financing issues, etc. The MOH also uses JAHRs for the health planning and M&E. Donors increasingly use JAHRs to align their assistance to the health sector. Other stakeholders find JAHRs useful for teaching and research. From 2011, JAHR has become an M&E tool for health system performance for both MOH and HPG. Some donors have used JAHR as a tool to monitor and supervise performance of the health sector, and do not require additional performance assessment for funding (e.g., EC). The JAHR has received enthusiastic technical and financial support from stakeholders (Atlantic Philanthropies, WHO, UNICEF, AusAID, USAID/PEPFAR, EC, UNFPA, Pathfinder, GTZ/KfW, Netherlands Embassy, Rockefeller Foundation etc...). Each year, budget for JAHR is about 200,000-250,000 USD. Main expenditure items include: local and international consultants; data collection; consultation workshops/meetings; translation and editing; printing and publication; dissemination, including development and running of JAHR website; and some office supplies, administrative support and other costs. However, funding commitment is not clear and not sufficient for coming years.

JAHR is an important M&E tool for health system performance, as well as HSFP implementation. Therefore, GAVI-HSFP is requested to partially support the JAHRs for coming years, together with other partners. All financial support from different donors will be put in a transparent funding matrix presented to Health Partnership Group each year for information and fund mobilization.

3.3. Support for M&E and supervisory visits: EPI cMYP 2011-2015 has identified the need to strengthen the system of supportive supervision at all levels for EPI. In addition to training courses on planning and M&E above, GAVI-HSFP will support basic expenses for field M&E visits, including travel and per-diem. Support for monitoring and supervisory visits will include daily allowances, accommodation and transportation for supervisory staff. With HSFP support, CHCs will be supervised every quarter by district level; and district level will be supervised every 6 months by provincial level; provincial level will be supervised every year by central level. Supervisors can be from MOH, CPMU, NIHE and related institutions, Provincial Department of Health, Provincial Preventive Health Center, District Health Center, district hospitals and District Health Offices. Supervisory visits will cover HSFP implementation, as well as other major areas of health system performance, e.g., preventive medicine, implementation of national target programmes (TB, malaria, HIV/AID, EPI, nutrition, NCDs, etc), curative care, food safety, family planning, etc.

3.4. Support for initiatives and policies to strengthen the basic health network: An innovative fund will be reserved to support operational research and promote new policies, initiatives and mechanisms to strengthen basic health care system. All project provinces and relevant institutions will be informed and encouraged to submit proposals. An application form and a guideline will be developed and distributed to project provinces and other relevant organizations to call for proposals. The initiatives and innovative policies will help strengthening basic healthcare network, especially about sustainable human resources development for rural and difficult areas, equitable healthcare financing, equity in healthcare, basic health service packages, how to improve quality of health services and access of the poor, ethnic minorities to basic health services, etc. Local ideas and initiatives will be encouraged. These studies and operational research will help provinces and health sector further strengthen basic health network, successfully implementation of health sector 5-year plan and EPI cMYP 2011-2015.

3.5. International workshops, training, study tours: HSFP budget is requested to support participants from Vietnam to attend international workshops, short-training, study-tours to learn and share experiences about development of health care systems with other countries.

4. Links with the five-year health plan, cMYP and other HSS support

- *Link with the 5-year health sector plan*: Key activities proposed in this GAVI-HSFP is fully inline with priorities, objectives and key tasks identified in the 5-year health sector plan, 2011-2015. The five-year plan clearly set priorities for the health sector as follows: Grass-roots health care network is facing difficulties, especially in mountainous, remote areas; preventive medicine network (especially district level) remains weak. Quality of care at basic level remains poor; health workforce is inadequate; quality of health workforce remains limited especially in the mountainous areas and ethnic minorities; health system management and M&E is still weak. The 5-year plan includes 8 specific objectives. Three GAVI-HSFP objectives (HRH, service delivery, management capacity) are fully in-line with specific objectives number 1 and 2 (strengthen basic health care network and PHC), objective number 5 (human resource for health), and objective number 8 (management capacity) in the 5-year health sector plan 2011-2015. Proposed key activities for GAVI-HSFP are also selected from section 4 (Key tasks) of the health sector 5-year plan.

- *Link with cMYP of EPI programme, 2011-2015 and most recent EPI programme assessment:* The most recent assessment of EPI programme (2009) has identified major EPI challenges to 2015 including: Maintaining high immunization coverage (especially in hard to reach areas); responding effectively to adverse events for immunization; strengthen collaboration between preventive and hospital sectors, especially for surveillance and immunization services (in particular hepatitis B birth dose); building capacity and mobilizing resources to motivate the health workforce especially in remote areas; building links with health systems planning in order to sustain operational finance and human resource

capacity in rural and remote areas. Key activities for EPI 2011-2015 include to strengthen routine immunization through micro-planning workshops, supervisory follow-up in priority districts, training of staff at different service delivery levels, including AEFI for communes health workers, replace cold chain, build financial planning and management capacity at all levels, supportive supervision, etc. GAVI-HSFP key activities are fully in line with these EPI challenges and key activities.

- *Link to the previous GAVI HSS support*: GAVI-HSS 2007-2011 has over-achieved it targets. Good lessons and interventions from this phase have been expanded by the GAVI-HSFP. A number of provinces from phase 1 will also continue to receive HSFP support in order to sustain its outcomes. Project management team and mechanism which function well in phase 1 will continue to manage the GAVI-HSFP.

- *Link to GF-HSS support (Round 10) and other HSS projects:* A number of interventions for HSS are quite similar between GF and GAVI (e.g., 6-9 month training for VHWs, equipment for DHCs, CHCs and VHWs, M&E visit support, etc), although special focus is different between GF (TB, malaria, HIV/AIDS) and GAVI (vaccination). Because of similar activities, there is no geographic overlap of provinces between the two projects. In addition, good lessons from other HSS projects (e.g., funded by WB, ABD, EC, etc) have been considered to identify key activities for this GAVI-HSFP.

SECTION 3: WORKPLAN, BUDGET AND FINANCIAL GAP ANALYSIS

Outline the sums of money being requested from GAVI and/or the Global Fund, presented by program area and by cost category (refer to the National Health Strategy budget, requested amounts need to be consistent with the National Health Strategy budget).

Explain how the amounts requested were calculated. Explain links, as appropriate, to the medium term expenditure framework, National Health Strategy budget, previous financial gap analyses and annual plans. Applicants may attach relevant spread-sheets or extracts from the national strategy budget which support the funding request.

Please provide an updated financial gap analysis (with an estimation of current and anticipated domestic and external funding. Describe how contributions from various sources of funds were estimated, and assumptions made, including reference to:

a. any changes in contributions anticipated over the period of support and the reason for any identified reductions over time; and

b. any current delays in accessing the funding that should be explained, including the reason for the delay, and plans to resolve the issue(s).

Please attach the most recent annual operational plan and budget for the National Health Strategy. The format for submission should be the same as currently used by the country. If the annual budget breakdown is contained in a separate document from the operational plan, please submit the relevant documentation together with the operational plan. For requests to GAVI, in addition, please attach the latest approved and fully costed **cMYP** that covers the duration of the requested HSS support.

The estimate cost of the approved five year plan and the financial gap analysis indicate relatively large financial gap for the five year plan to be successfully implemented.

Response:

1. Sums of budget requested from GAVI: Workplan and budget calculation is attached.

2. Calculation: Quantities for each activity (e.g., number of training courses) are based on the need assessment from each province. Budget calculation is based on detail assumptions

using existing GAVI-HSS cost-norms adjusted by inflation rate and current GF-HSS cost-norms.

3. Financial gap analysis (attached).

SECTION 4: FINANCIAL MANAGEMENT ARRANGEMENTS

Outline the financing channel to be used and specific financial management arrangements. Use of existing country-level financial management arrangements is encouraged. Reference should be made to any relevant Financial Management Assessment (FMAs) and to relevant sections of the JANS report.

Detail any relevant actions which will be taken to ensure that sufficient capacity exists for financial management of the requested funds.

Response:
Please limit your response to two pages maximum

1. Financing channels (Fund flowchart)

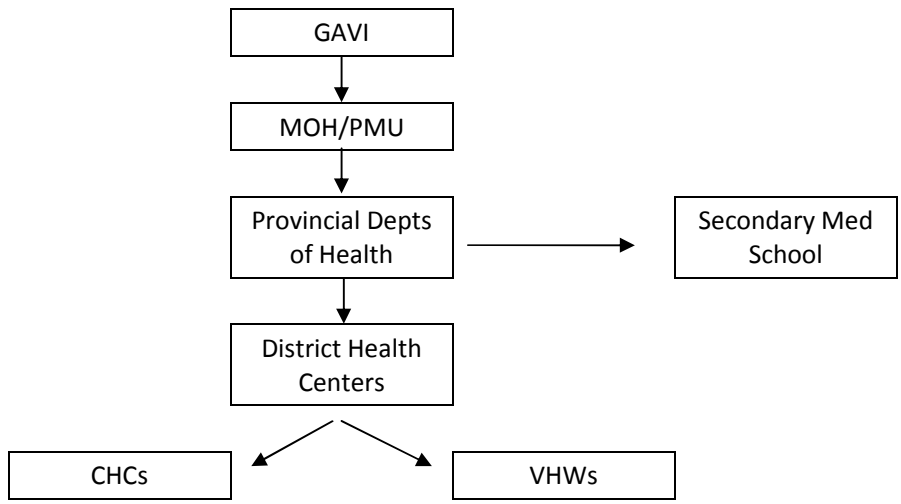


Diagram 1. Flow of funds

2. Specific financial management arrangements

HSFP grant is managed in accordance with current regulations of the Government, including the Decree no. 93/2009/ND-CP dated 22 October 2009 of the Government about management regulation of INGO support and Circular no. 225/2010/TT-BTC, dated 31 December 2010 of the Ministry of Finance about financial management regulation of external grants.

At central level, the project management unit (PMU) for GAVI-HSS phase 1 will continue to help the MOH implement HSFP. Bank accounts for USD and VND within MOH management system used for GAVI-HSS will be also used for HSFP. PMU director and chief accountant are appointed by the MOH to manage the project.

HSFP budget from PMU will be transferred to the bank accounts of provincial DOH. DOH will use existing financial management system to manage the HSFP fund in accordance with Government regulations.

Internal audit will be performed regularly by MOH, MOF and State Audit as regulated. External audit will be done annually by an independent international audit firm competitively selected.

3. Financial management capacity

At central level, DPF/MOH is now managing 14 projects, with a total amount of 470 millions USD, supported by different donors, e.g., WB, ADB, JICA, EC, WHO, Unicef, GF, etc. Project director and chief accountant has many years managing projects, including GAVI HSS phase 1. In addition, a number of experienced accountants will be contracted to work for the project. At provincial level, existing financial management mechanism will be used to manage the project fund. The DPF is also Principle Recipient (PR) of GF-HSS. During preparation of GF-HSS project, GF and LFA carried out capacity assessment of the DPF, including financial management capacity. The DPF has fully met requirements of GF to be a PR of GF-HSS.

SECTION 5: IMPLEMENTATION ARRANGEMENTS

Briefly explain the implementation arrangements for the National Health Strategy/Plan, and how coordination between the different elements will occur.

If the application includes a request to GF please describe the implementing institution(s) with responsibility for ensuring that the activities are successfully implemented and performance is monitored. Include for each implementer details of past experience, technical, managerial and/or financial arrangements and capacities, and any relevant actions which will be taken to ensure necessary capacity.

If there are multiple lead implementers (Global Fund only), describe how co-ordination will occur to ensure timely and transparent performance updates and disbursement requests, on separate and joint reporting.

For requests to the Global Fund, please provide the same information for sub-implementers with responsibility for implementing activities. In addition, describe how they were selected, and which activities will be conducted by them.

Response:
Please limit your response to two pages maximum

1. Implementation arrangements for the National Health Strategy/Plan

After approval, the five-year health plan was distributed to Government Office, other ministries, all provinces, departments, institutions under MOH, donor community, etc. Provinces and institutions regularly prepare annual plans in line with this five-year plan.

At the health sector level, DPF is the MOH focal point to coordinate the development and follow-up implementation of the five-year plan and annual health sector plans. The DPF is responsible to collect inputs from related organisations at central and provinces to develop annual health sector plans in line with 5-year strategic health plan, with reference to guidelines of the Government, MPI and MOF for annual planning. Participation and rich consultations with managers, implementing partners, provinces, HPG members, different stakeholders, etc are required. A series of meetings with MPI and MOF are organised to discuss about key targets, activities and budget allocation.

About health financing, according to National Health Account, financial resources for health in Vietnam (2008) include tax-based budget (23%), social health insurance (18%), ODA/NGO support (2%), out-of-pocket payment and others (57%). Every year, the MOH submits annual health plan to MPI and MOF. These ministries make budget allocation to all sectors and submit to the Government. After reviewing, the Government submits to National Assembly for approval. Health budget approved by National Assembly is divided into two parts: The MOH controls about one-third state health budget, which is used for MOH and its central hospitals, medical schools, other central institutions, and national health target programmes (including EPI). The MOH is responsible to allocate and control this part, including ODA and NGO projects, for its central institutions and also for provinces.

The other part is directly allocated to provinces. At provinces, provincial people committee and people council has right to allocate budget from central level to different sectors in the province, including provincial health sector. Normally, provinces remain or increase budget for the health sector, especially in the better-off provinces.

Management of budget and procurement in health sector is managed in accordance with State Budget Law, Procurement Law, and other regulations of the Government, Circulars of the MPI, MOF. Although there are some differences, Vietnam procurement law and policies are in general adequate, accountable, transparent and compliant with common international practices (WB, ADB, etc).

After approval, the plan is distributed to all related institutions, ministries, and provinces for implementation. DPF is responsible to follow-up overall plan implementation, prepares 6-month and annual progress reports, and reports to Government, MPI and MOF about performance of the sector. Other MOH departments are responsible for specific elements of the health plan, e.g., Department of Science and Training, Department of Organization (human resource for health), Medical Service Administration (hospital services), Department of Preventive Medicine (health prevention), Food Administration, Drug Administration, Population and Family Planning, etc.

During recent years, Vietnam has carried out a number of measures to improve aid effectiveness in health sector: (i) After Paris Declaration, Vietnam Government and donor community endorsed “Hanoi Core Statement”, and then the MOH and HPG endorsed “Statement of Intent” with 10 milestones to improve aid effectiveness in the health sector; (ii) The Health Partnership Group (HPG) has been established since 2005, with participation of donors and partners working in the health sector. HPG organises quarterly meetings, co-chaired by Minister or Vice-Minister and a representative from donor community, to discuss health strategies, policies, plans, HSS and other issues. Technical Working Groups under HPG are also created, e.g., Planning and Financing, MCH, HIS, etc; (iii) Joint Annual Health Sector Reviews (JAHRs) have been developed annually since 2007; (iv) Vietnam has joined IHP+ and carried out JANS for its 5-year national health sector plan, 2011-2015. Vietnam Government has also issued sufficient regulations to manage external aid, e.g., Decree 131, Decree 93, procurement law, budget law, financial management regulations, etc. These mechanisms have improved effectiveness and coordination for the implementation of health sector plan, including GAVI-HSFP and other HSS projects.

2. GAVI-HSFP implementation arrangements

As stated above, GAVI-HSFP will be managed according to the Decree number 93/2009/ND-CP of the Government about management regulation of INGO support. At central level, Department of Planning and Finance (DFP) will be focal point for HSFP implementation. Existing PMU for GAVI-HSS phase 1 will continue to help MOH implement GAVI-HSFP. This is a small PMU integrated in the DPF, with participation of some key Departments related to HSS (e.g., MCH) and National EPI Programme. HSFP implementation will be guided by HSCC and Minister or a Vice-Minister.

At provincial level, provincial Department of Health will be focal point for HSFP implementation, with involvement of Provincial EPI Programme, Provincial Preventive Health Centers. Existing organization of Department of Health and financial management structures will be used to implement and manage funding from HSFP. Each year, HSFP provinces will prepare annual health plan, including HSFP activities and budget, submit to MOH/PMU to develop overall HSFP plan which will be approved by the MOH, and integrated in the overall health sector plan. Financial and procurement management will basically follow Vietnam laws and regulations.

Implementation of GAVI-HSFP will be highly decentralised and integrated in the existing system at local level. Majority of activities will be carried out by local levels. MOH/PMU will play main roles in HSPF planning, implementation coordination, and M&E. EPI programme at different levels will play important roles in implementing HSFP activities, especially EPI technical aspects, EPI training activities, EPI related M&E, outreach EPI spots, etc. More details about HSFP oversight, M&E and financial management will be described in the below parts.

SECTION 6: GOVERNANCE AND OVERSIGHT ARRANGEMENTS

Describe the body (CCM and/or the relevant Health Sector Co-ordinating Committee) with responsibility for oversight of Global Fund and/or GAVI supported activities. Include a description of how this will include a broad range of stakeholders in oversight processes (CCM requirements will continue to apply).

Outline how the Committee(s) will perform this oversight function, including monitoring implementation and budgets.

Describe any relevant actions which will be taken to ensure that the Committee(s) has sufficient capacity for this role.

Response:
Please limit your response to one page maximum

- Meetings: The HSCC includes the Health Minister/Vice-Minister and directors/ representatives of key MOH departments (DPF, Organization and Manpower, Science and Training, MCH, Administration for Medical Services, Health Strategy and Policy Institute, etc. Every week, the MOH has weekly meeting chaired by Minister (or a Vice-Minister) with participation of HSCC members and leaders of MOH Departments. In the meeting, urgent issues of the each Department, including about HSS and projects implementation if necessary, are reported to get guidance/direction of the Minister, Vice-Ministers and HSCC members. Implementation of major health projects will be also briefly reported at some of these meetings.

The HSFP PMU will organize weekly internal meetings to monitor and supervise the HSFP implementation; quarterly meeting with Minister or Vice-Minister in-charge to report HSFP progress; 6-month and annual review workshops with Minister or Vice-Minister, HSCC, implementing agencies, all HSFP provinces and National EPI Programme. In the meetings of HPG, in addition to overall issues (e.g., health policies, strategies, plans, HSS, etc), implementation progress of HSFP will be updated for HPG to monitor.

- **Reports**: HSFP PMU prepares quarterly and annual reports on project implementation progress, financial disbursement and management, etc, to submit to HSCC, Minister or Vice-Minister, MPI and MOF. Annual report submitted to GAVI will be also reviewed and approved by the Minister and HSCC members.

- **JAHRs**: Joint Annual Health Sector Reviews have been developed by MOH and HGP members since 2007. JAHR is used to provide information for health policy, strategy making, health planning, and also for health system M&E. JAHR includes a list of essential health indicators assigned by National Assembly, Government and MOH to provide information about performance of the health sector. JAHR reports have been distributed to all HSCC and HGP members. More and more donors use JAHRs as M&E tool. This will be also used as M&E tool for GAVI-HSFP.

- **Site visit**s: MOH/HSCC can also carry-out M&E visits to provinces to monitor HSFP implementation. Representatives from MPI, MOF, HPG, National EPI programme are welcome to join the field visits. In the field visit, HSFP progress and financial management will be supervised.

- **Audits**: The HSFP will be audited according to Vietnam regulations, including internal audit, independent audit and State audit. Audit reports will be submitted to HSCC.

- **Involvement of stakeholders**: HSFP implementation will be supervised by MOH/HSCC, other ministries (MPI, MOF), HPG. At local level, performance of the health sector, including HSFP, is supervised by People Committee, People Council and other social organization, e.g., Fatherland Front, Women Union, Farmer Union, etc.

- **Actions to ensure sufficient capacity for oversight role**: In order to ensure capacity for HSCC and other to monitor and oversight implementation, HSFP funding is requested to use for the following actions: Support for development of JAHRs; support for field visits of HSCC, other ministries and PMU; support for M&E visits at local levels; 6-month and annual review meetings of PMU, HSCC and provinces; payment for independent audit, etc.

SECTION 7: MONITORING AND EVALUATION

Briefly explain the expected contribution the requested support will make towards achieving the national indicators and targets contained in the national M&E plan. For GAVI, it is essential to demonstrate a clear linkage to immunisation outcomes. For Global Fund, it is essential to demonstrate a clear linkage to the three disease outcomes.

Explain how performance of the funded activities will be measured – what indicators will be collected and what will be the data sources. Please present this using a Performance Framework and refer to relevant national documents.

Describe how existing monitoring activities (e.g. joint annual reviews, HMIS systems) will be used to monitor the program.

Please list relevant actions which will be taken to ensure that the capacity exists to collect and analyse the necessary information. Requested support should be included as part of a technical assistance plan, which should be attached to the funding request.

Response:
Please limit your response to two pages maximum

1. GAVI-HSFP contribution to national health targets and linkage to immunisation outcomes:

The HSS will significantly complement the overall efforts towards the strategic health outcomes measured with the national set of indicators with targets. Specifically, the HSS

project has direct contribution to 7 out 19 essential indicators in the health sector 5-yr plan, 2011-2015 (# 3, 7, 8, 10-13) as elaborated in the table below.

No	Indicators in the 5-yr health plan, 2011-2015	2010	Target for 2015	Contributions of GAVI-HSFP activities
	Input indicators			
3.	Percentage of villages with VHW (%)	85	90	GAVI-HSFP will support to train VHWs for 6-9 months. This training activity will not only increase the VHWs quantity, but also improve quality of VHWs.
	Performance indicators			
7.	Percentage of children under 1 year fully vaccinated (%)	>90	>90	GAVI-HSFP strongly focuses on health system bottlenecks related to EPI, especially at basic level where immunization services are mainly provided. It will contribute to increase and sustain EPI outcomes, including high coverage and high quality immunization services through strengthening capacity of health staff (long and short-term training), supply of essential equipment (including refrigerators and cold boxes), immunization for hard-to-reach areas, strengthened management capacity and M&E, etc.
8.	% of commune achieving national benchmarks for commune health	-	60	Commune health benchmarks include 50 indicators, with many indicators related to GAVI-HSFP activities, e.g., immunization, VHWs, refresh training for CHWs, MCH, etc. Therefore, GAVI-HSFP will significantly help communes to achieve the commune health national benchmarks.
	Outcome indicators			
10.	Life expectancy at birth (years)	73.0	74.0	Reduced mortality will contribute to better LEB.
11.	MMR (p100,000)	68	58.3	Improve staff capacity through training activities (especially about EPI and MCH), adequate supply of basic equipment and better management capacity will contribute to reduction of mortality, especially among mothers and children.
12.	IMR (p1,000)	<16	14,8	
13.	U-5MR (p1,000)	25	19.3	

2. Performance Framework: (Attached)

3. Monitoring activities:

- **Health Management Information System - HMIS**: Vietnam has a good and wide health management information system (HMIS) from commune up to central level. HMIS, including health indicators, registers, reporting forms, etc has been developed in the 1960s, and most recently adjusted in 2009. Data sources for health statistics include routine data collection, household sample surveys, civil registration, health facility records, etc. Every 10 years there is a population census; every 2 years there is a Living Standards Measurements Survey (VLSS), and every few years there is a Demographic and Health survey (DHS),

Multi-Indicator Cluster Survey (MICS), and Survey Assessment of Vietnamese Youth (SAVY); every year there is a Survey of Population Change and Family Planning. In addition, the justice sector keeps statistics on birth and death as part of the civil registration system. The regulations on patient records are implemented in all hospitals.

The HMIS covers the entire country, starting from CHC up to MOH. CHC is the first level to collect health statistics, using 8 registers and more than 15 reporting forms. CHCs submit quarterly reports to district health centers. At the district level, district health center compile reports from all CHCs, district hospitals and other health programmes, then submit to provincial department of health every quarter. Similar, provincial DOHs submit quarterly reports to the MOH. In addition, vertical programmes have also requested health facilities to report programme specific statistics and indicators. At all levels, in addition to submitting to higher levels, data is analysed and used for management and decision making to its own level. HMIS statistics software has been developed and web-based reporting system is under development.

At the MOH, DPF has regularly published annual Health Statistics Year Books (HSYB) with essential health statistics and indicators for all 63 provinces, including health status, health financing, human resource for health, health services provision, health determinants, performance of public health programmes, health system performance, etc. Data and indicators are disaggregated by province and ecological region. HSYB is widely disseminated to all provinces, other sectors, training and research institutions, donors, etc. Almost all HSFP indicators will be collected using the routine and existing data collection systems of HMIS. No additional data collection mechanisms will be created for HSFP, at both central and local levels.

- **JAHR**: Since 2007, the Health Partnership Group (HPG), including international and foreign organizations providing support to the Vietnamese health sector, and the MOH has agreed to implement a Joint Annual Health Review (JAHR) on an annual basis. Main objectives of the JAHR include: (i) To provide overall annual update of the health sector situation, including progress in meeting MDGs and Vietnam's development goals related to health; (ii) To assess in detail various building blocks of the health system to identify priorities and recommend solutions; (iii) To monitor health system performance and assess progress in implementing recommendations of the JAHR in previous years.

The JAHRs have been developed under the direction of the MOH and HPG. Organizational structure for preparing the JAHR included: *JAHR working group*, including members of the MOH and HPG, with responsibility for guiding and supervising the process of developing JAHR and ensuring resources are available for related activities. *JAHR Secretariat*, including representatives of the DPF, an international coordinator, a national coordinator, and support staff, is responsible for resolving daily management and administrative problems, organizing workshops, synthesizing feedback, ensuring that the process of writing the report involves participation from many stakeholders; compiling, editing, revising and finalizing the report. *Consultants*, consisting of national and international experts are responsible for drafting JAHR chapters, collecting feedback and comments from stakeholders and completing the chapters as appropriate.

Main steps to develop JAHRs include: (i) Identify topics and overall outline of JAHR for each year, get comments and approval of the MOH and HPG; (ii) Develop chapters outline and recruit consultants for each chapter; (iii) Chapters consultation process with HPG members, experts, stakeholders through technical workshops, sending draft for comments, etc; (iv) Compile chapters in whole JAHR report, get comments through series of consultation workshops and other methods; (v) Finalise, get approval from HPG and MOH for publishing and disseminating.

The JAHR 2007 report comprehensively covered the basic components of Vietnam's health system, including: i) Health status and determinants; ii) Organization and management of the health system; iii) Human resources for health; iv) Health financing; and v) Health service delivery. The JAHR 2008 report, in addition to overall updates of the health system, focused on Health financing in Vietnam. The JAHR 2009 report focused on Human resources for health; The JAHR 2010 report again included all building blocks of the health system in order to provide analysis for development of 5-year plan for 2011-2015. The JAHR 2011 focuses on health financing reforms and health system governance and stewardship. Although each year JAHR may focus on certain topics, it still contains an important part to provide rich updates of all health system building blocks. Since 2010, JAHR has included a list of essential indicators for health system performance M&E. These include indicators required by the National Assembly, Government and MOH. More and more development partners also consider as an M&E tool to assess performance of the health sector. Therefore, JAHRs will be also used as an M&E tool to monitor and supervise performance of the HSFP.

4. Actions to ensure capacity to collect and analyse the necessary information

Most of indicators and data collection for HSFP will be integrated in the existing health system M&E framework. Within HSFP, a number of activities will be carried out to support M&E. Short training courses on health system management will be organised to improve health planning and M&E for health managers at different levels. HSFP will also support M&E and supportive supervisory visits at different levels to ensure good implementation of HSFP, as well as implementation of the health sector 5-year plan 2011-2015. HSFP will provide partial financial support, together with other donors, for development of JAHRs, including for consultants, some data collection, consultation workshops, etc.

APPLICATION ANNEXES

LIST OF ATTACHMENTS (TEMPLATES)

The following should be submitted with the completed funding request template:

Document
Attachment 1: Summary Funding Request (Excel worksheet)
Attachment 2: Financial Gap Analysis (Excel worksheet)
Attachment 3: Results framework based on a national template

LIST OF SUPPORTING DOCUMENTS

A number of supporting documents need to be annexed to this application (see the table below). Additional documents which applicants believe are essential for the review of the request should be included in this table (add rows as needed and clearly name and number annexes**)**

LIST OF DOCUMENTS SUBMITTED FROM VIETNAM:

Documents	File name
1. Cover letter signed by Minister Nguyen Quoc Trieu, on behalf of HSCC	1-Cover letter
2. Funding Request signed by Minister of Health and Vice-Minister of Finance	2a-Funding request (PDF) 2b-Funding request (Word)
3. Summary Funding Request (Excel worksheet)	3-Summary Funding Request
4. Financial Gap Analysis (Excel worksheet)	4-Financial Gap Analysis 2011-2015
5. Results Framework	5-Results Framework
6. JANS report (including an assessment how feedback received during the JANS has been reflected in the final national health strategy)	6-JANS report
7. Five-year Health Sector Plan, 2011-2015 with budget estimates	7a-5year Health Plan 7b-5year Health Plan-Budget
8. Annual Health Sector Plan 2012 with budget allocation *(in Vietnamese, to be translated if requested)*	8a-Annual Health Plan 2012 8b-Annual Health Plan 2012-Budget
9. EPI cMYP 2011-2015	9a-EPI cMYP 2011-2015 9b-EPI cMYP 2011-2015-Budget
10. Recent Health Sector Assessment documents: Joint Annual Health Sector Reviews 2007-2010	10a-JAHR 2007 10b-JAHR 2008 10c-JAHR 2009 10d-JAHR 2010
11. Most recent EPI Programme assessment, 2009	11-National EPI Review 2009
12. Statement of Intent between MOH and HPG	12-Statements of intent
13. List of equipment supported by HSFP for District Health Centers	13-Equipment list of DHCs
14. List of equipment supported by HSFP for Commune Health Centers	14-Equipment list of CHCs
15. VHW equipment kit	15-VHW equipment kit

List of Acronyms

ADB	Asian Development Bank
AEFI	Adverse Events Following Immunization
CHC	Commune Health Center
CHW	Commune Health Worker
DHC	District Health Center
DOH	Department of Health
DPF	Department of Planning and Finance
GF	Global Fund
GSO	General Statistical Office
HIS	Health Information System
HMIS	Health Management Information System
HPG	Health Partnership Group
HSFP	Health System Funding Platform
HSS	Health System Strengthening
ICC	Inter-Agency Coordinating Committee
IMR	Infant Mortality Rate
JAHR	Joint Annual Health Sector Review
JANS	Joint Assessment of National Strategy
MCH	Maternal and Child Health
MCH	Mother and Child Health
MMR	Maternal Mortality Rate
MOF	Ministry of Finance
MOH	Ministry of Health
MPI	Ministry of Planning and Investment
MTEF	Medium-term Expenditure Framework
NIHE	National Institute of Hygiene and Epidemiology
PHC	Primary Health Care
PMU	Project Management Unit
SOI	Statement of Intent
TWG	Technical Working Group
VHW	Village Health Workers