GAVI Health System Strengthening Support Evaluation

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Viet Nam Case Study

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Table of Contents

Abbreviations and Acronyms

CHC	Commune Health Center
CHW	Commune Health Worker
CoC	Code of Conduct
DOH	Department of Health (provincial level)
DOPF	Department of Planning and Finance
EPI	Expanded Programme on Immunisation
GBS	General budget support
GDP	Gross domestic product
GOV	Government of Viet Nam
HCS	Hanoi Core Statement
HMIS	Health Management Information System
HPG	Health Partnership Group
HRD	Human resource development
IMR	Infant mortality rate
JAHR	Joint Annual Health Review
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOH	Ministry of Health
MoHA	Ministry of Home Affairs
MPI	Ministry of Planning and Investment
MTEF	Medium Term Expenditure Framework
NGO	Non-governmental organisation
NTP	National Target Programme
ODA	Official development assistance
PMU	Project Management Unit
PRSC	Poverty Reduction Support Credit
SEDP	Socio-economic development plan
SWAp	Sector Wide Approach
TA	Technical assistance
UN	United Nations
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
WHO	World Health Organization

Summary of key findings and recommendations

This summary of the Viet Nam country case study answers the first two GAVI HSS evaluation questions, namely:

1. What has been the experience at country level with GAVI HSS in terms of each of the following aspects: design, implementation, monitoring, integration (harmonisation and alignment), management and outputs/outcomes;
2. What have been the main strengths and weaknesses of GAVI HSS at the country level, and what are the specific areas that require further improvement?

It also highlights some key issues related to how well the Viet Nam HSS intervention fits with GAVI's principles and values.

GAVI HSS Proposal Design, Focus and Rationale

The process of proposal design in Viet Nam was thoroughly and systematically conducted resulting in a well written proposal that clearly links needs and gaps with proposed GAVI HSS interventions. The design process included: a study assessing health systems wide barriers to EPI; a proposal preparation working group led by the MOH; well targeted support from the WHO country and regional offices, and from the UNICEF country office; a process of formal consultation between the MOH and the provinces; and a formal consultation and discussion of the original HSS proposal at the Health Partners Group.

The main objective of the Viet Nam HSS proposal is to strengthen the basic health care network through training, re-training, improved monitoring and supervision, recurrent cost support (linked to EPI activities) and cash incentives and allowances to promote better performance by Village Health Workers in ten selected provinces through explicitly defined criteria (socio-economic status, vaccination coverage, government spending).

Rather than being innovative in nature the HSS proposal complemented what the MOH and other health partners were supporting at the time. But does the HSS proposal deal convincingly with the issues raised at design and at sufficient scope and scale? Key findings which are elaborated upon in the main report include:

- While provision of training and cash incentives can improve VHW performance this depends on the right ones – the right VHWs, and the right incentives for the right services being selected. It is not clear that this is always the case as selection processes fall outside the remit of the HSS intervention;

- Coordination of training between HSS and other national programmes at commune and provincial level remains poor;
- Focus on improved supervision of VHWs (by CHCs) and of CHCs (by provincial authorities) is not receiving as much attention as expected at design and seems to have been lost in the APR reporting process;
- The proposal does not make sufficient acknowledgement of the fact (clearly highlighted in the initial assessment of system wide barriers) that limited government health expenditure on basic services, regressive out-of-pocket payments and inability to target government funding to the poorest areas remain the most significant barriers to uptake of basic health services. This means that HSS interventions may improve the situation to some extent, but only for a limited time and with limited health systems impact.

Our analysis of the counterfactual questions (What would have happened if the GAVI HSS funds had not been made available?) suggests that without the GAVI HSS support Viet Nam might not have been able to target resources for improved MCH outcomes in poorer provinces. As the MOH stated to us "GAVI is the only major project supporting Village Health Workers". However, as argued earlier evaluators are less convinced that training, incentives and some recurrent cost support provided during a limited period of time will attain the desired changes in the absence of concomitant efforts to increase and improve the targeting of government health spending in poorer, more remote provinces.

HSS Application and Approval Processes

From proposal submission in October 2006 to first disbursement in August 2007 there was a process of clarification based on observations by the IRC. The issues raised by the IRC were all very relevant and some were effectively dealt with by the MOH, such as the IRC request to avoid a heavy PMU as is traditional in Viet Nam. However, other substantial points were not addressed as effectively, such as the requests to ensure that the right VHWs would be selected, or to better link activities with the seven proposed HSS output indicators or, importantly for sustainability reasons, a guarantee that the funds paying VHWs incentives and recurrent costs to CHCs would be effectively taken over by the MOH.

The point to make here is not that the MOH did not attempt to respond to the concerns expressed by the IRC, but that dealing with those concerns would have required a much closer and stronger engagement between the IRC (or the GAVI Secretariat) and the MOH. This is due as much to the complex nature of the HSS intervention and of the clarifications raised, as to the unrealistic expectation that these matters can be discussed and resolved at distance (mainly) through written correspondence. The lesson is that the IRC model would

need to be substantially modified to enable it to deal with potentially complex HSS issues at proposal approval stage, and for it to do a more thorough reality check of the feasibility of both its clarifications and the potential remedial action. When issues are of substance but unlikely to be solvable the approach should be to incorporate these matters into the revised proposal in a constructive manner, recognising that the said matters are nothing but other "barriers" to health systems performance and immunisation and MCH services that it will take time and effort to overcome.

Start up and early implementation matters

As mentioned above the proposal approval process was quite lengthy and left some unanswered issues that could have been addressed as start-up interventions. Examples included: a clear, realistic set of progress indicators; dealing with sustainability concerns; ensuring the right selection and performance based financing of VHWs; etcetera. Other issues that, in our opinion should have been addressed at this stage include the lack of synchronization between disbursements and implementation (see main report) and the lack of fit between the annual reporting systems used by Viet Nam and the GAVI, discussed below.

Annual Progress Reporting on HSS

The quality of APR reporting in Vietnam was found to be excellent in terms of activity reporting, and the fact that the financial management systems are quite strong in the MOH made it easy to assess expenditure levels against activities. But several important issues were identified that merit discussion:

- The APR process is not at all aligned with country systems in terms of timing and format and they result in extremely high transactions costs (that can only be fulfilled thanks to funding of key PMU officers from the GAVI HSS grant). Alternative reporting methods do exist in Vietnam (the JAHR process and others) that should have been considered as alternative.
- Monitoring of the 7 HSS progress indicators cannot be done on an annual basis, so this part of the APR is not useful for assessing progress. There are also concerns about the sensitivity of these indicators and their realistic attribution to HSS interventions. This means that performance can neither be assessed annually prior to funding, nor will it be easy to measure impact of HSS interventions at the end of the project.
- Similar comments made earlier - about the impracticality of seeking clarifications from a distance at design stage - can be made in relation to the feasibility of monitoring progress on HSS interventions; through a distant IRC model using mainly information provided in a written report. In sum, the APR model that works quite well for other GAVI windows is quite constrained when applied to HSS grants.

Technical Support of the HSS Grant

While both WHO and UNICEF were actively involved in proposal design their involvement almost ceased at the time of supporting HSS grant implementation, to the point that they hardly play any role is overseeing the quality and accuracy of HSS-related APR reporting. This lack of engagement was perceived differently by the MOH and by the technical partners:

- The MOH seemed to be clear about what needed to be done (so why additional technical support?) and annually submits the APR report for signature by the WR;
- UNICEF officers felt that their lack of involvement on HSS matters was a result of the HSS grant being implemented by a part of the MOH that is not (unlike the EPI programme) a natural counterpart for UNICEF. This corresponds to the fact that ICC discussions do not include references to HSS matters;
- The WHO country office staff interviewed in turn expressed the view that because the MOH is used to leading and implementing the HSS programme in their own manner, with relative isolation from WHO or any other partner there is hardly any case for providing technical support even if WHO is indeed quite active on other health systems related interventions.

In any case, it was admitted by all that the role of the technical partners in supporting HSS grants is not clear or explicitly defined anywhere. None of them were familiar with the concept of the annual workplan that the GAVI signs with WHO and UNICEF very year.

How does HSS fit with the GAVI Principles and Values?

Our evaluation suggests that countries like Viet Nam are not fully aware of which are the "GAVI principles" or "GAVI values", and that it is not clear to them or to these evaluators the process by which the GAVI Alliance expects to achieve the said principles or values. A second interesting finding is that while our interviewees in Viet Nam particularly valued the flexibility of the HSS window and the relative simplicity of application these do not feature among either the principles or values. The following sections briefly summarises key findings in this particular area.

The HSS proposal was found to be fully **country driven**, with WHO and UNICEF playing an important facilitation and technical support role in putting the proposal together, after which the government took complete control and leadership for implementation.

In terms of **alignment** results are mixed, for while the HSS proposal can be seen to be on line and respond to expressed needs of Viet Nam (as per their own national policy) it is less clear

whether the grant fills a gap that the Viet Nam government had not been able to fulfil otherwise or that it had discussed with its health partners. In this sense the HSS support appears to be opportunistic (demand for resources is met by available funding window) rather than strategic (expected need is met when other options would not be available). Alignment to budget and reporting cycles was found to be minimum or non-existent, this being greatly influenced by the heavy and rather inconsequential APR reporting process.

Harmonisation with the planning, reporting and financing systems used by other donors was also found to be deficient, although it was the general weaknesses of donor harmonisation in Vietnam that were mainly responsible for this situation rather than a deficiency that can be linked to the GAVI HSS model.

Predictability of funding linked to the HSS grants was considered a big plus by the MOH, particularly in comparison to other sources of funding in a country dominated by donor drive activity delivered mainly in the form of projects. Another reason for perceived 'good predictability' was that respondents considered the discontinuation of funding unlikely unless a major disaster occurred. The possibility that funds might be discontinued as a result of poor performance was judged to be minimal by most respondents, and performance was seen to be linked to activity reporting rather than to the HSS established result indicators.

The GAVI HSS grant was found to be more **accountable, inclusive and collaborative** at design stage than at implementation, as discussed earlier.

The team did not find much evidence that the HSS proposal is **results oriented,** or that **HSS funding is performance based** because, as has been explained, the defined HSS results indicators cannot be measured on an annual basis (largely because this area received insufficient attention at design and start up phase). At the moment the IRC seems to base its recommendations for continued funding on the activities - rather than results - that countries report in their APR. If such is the case why continue to pretend that countries will be measured by their progress along defined indicators given the transactions costs these entail in the case of Viet Nam?

The **catalytic effect** of the HSS grant was often taken for granted or expected rather than being known or based on verifiable facts. This might be the result of the HSS grant being in its early implementation stages, but it is also possible that the catalytic effect is considered secondary to ensuring that more funding remains in poorer provinces. As discussed earlier the **additionality** of HSS funding (a key prerequisite in the GAVI HSS guidelines) was found

to be difficult to demonstrate and dependent largely on the assumption that provincial governments will maintain (or increase) health spending levels rather than reduce the same as a result of the additional HSS funds. As discussed in the main report even this assumption was put in question by some members of the PMU who admitted that cuts in the health budget by provincial governments were very common and a constant source of concern to maintain basic services operational.

The evaluators found cause for concern after a rather superficial assessment of **sustainability** issues at design stage. This is considered a serious matter in a grant providing both cash incentives and recurrent cost support to VHWs and CHCs respectively that provincial governments had "committed" to take up post GAVI HSS without explaining how they would eventually do so.

Finally, the focus on **equity** of the HSS proposal was found strong enough after a thorough and systematic process to focus the grant on the weaker provinces based on objective, verifiable criteria.

Conclusions and Recommendations

Viet Nam expects to apply for a second generation HSS grant. Evaluators would expect such application to be based on a similar level of consensus and joined-up work than demonstrated at the original HSS proposal design, and with equal level of government ownership. We would also expect that such grant, if approved, would build on the issues found in this evaluation. Specifically, we would recommend that:

a) **Improve proposal design and the process of clarifications through a revised IRC model**. The next HSS proposal be assessed through improved dialogue and understanding of the realities operating in Viet Nam that was possible by using a distant, far removed IRC model. When issues of substance are identified at design these should be either resolved or built into the proposal in a constructive manner. This should apply to areas such as: Monitoring of results and choice of realistic indicators; alignment of GAVI planning, reporting and funding cycles to those of the country; exploring the space for more progressive grant financing and implementation modalities; and greater attention to sustainability issues when recurrent cost support or cash incentives are provided from the HSS grant. These are just examples, not an exhaustive list.

b) **Improve results orientation and performance monitoring of the HSS grant**. If design and approval processes are improved (as above) then the need for a heavy, costly APR reporting process of the HSS grants would be substantially reduced. The

GAVI should aim at using existing country reporting systems instead or requiring parallel structures and processes. Where reporting systems are found to be weak or unspecific (in terms of the expected HSS results receiving sufficient attention) then the GAVI should endeavour to strengthen these rather than working around them.

c) **Not all HSS gaps are the same, neither are the risks comparable among different types of HSS proposals**. The GAVI should distinguish more clearly between opportunistic and strategic, innovative or complementary, upstream or downstream HSS proposals, and adjust the risk analysis (and the linked funding decision) to these realities. Countries taking innovative steps or targeting deeply rooted systemic matters should be treated differently - and the quantities and modalities of funding should be also adjusted - than when more traditional areas are being targeted (see upstream and downstream discussion in 3.1.4). There will always be unmet health needs, but the role of the GAVI HSS support should place greater attention to catalytic, strategic unmet health systems barriers.

d) **GAVI HSS is a new form of aid but GAVI is not a standard donor**. The GAVI - through its Secretariat - should stop relating to countries as if it was yet another bilateral agency, particularly on HSS matters where its lack of country presence represents a serious impediment for adequately assessing both opportunities and risks. This distinction is crucial at both design and implementation stages, and was found to be particularly lacking at the latter. Just like GAVI has used the ICC mechanism for vaccine-related matters. it should make more and better use of the right sector coordination structures, and these are likely to be different from country to country. Asking for signatures of the HSCC is not enough. In Viet Nam, for instance, the HPG and the JAHR may be too incipient for the purposes of ensuring proper sector coordination, but the solution is to work through them (not around them) and to ensure that the GAVI has some kind of “eyes and ears” at sector level. If this is the role that WHO should play (so seems to be implied in the annual workplans developed between the GAVI and WHO/UNICEF in Geneva) then this role should be made explicit, it should be costed and funded from the grant (WHO country offices critically rely on these incentives) and the performance of this mechanism should be externally and regularly reviewed.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Viet Nam in June 2009 as part of the GAVI HSS Evaluation Study. This is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Viet Nam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested from HLSP or the GAVI Alliance Secretariat. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 3.

1.2 Brief conceptual framework of the Evaluation

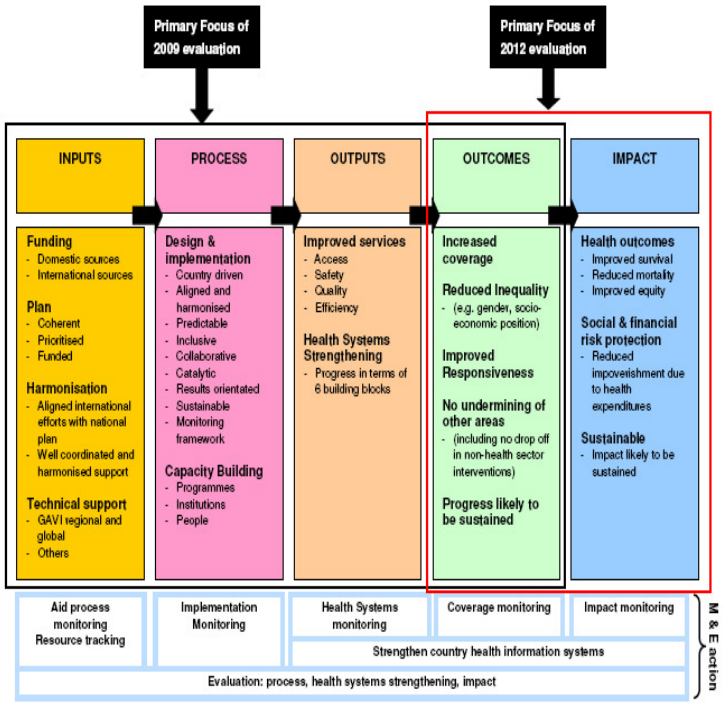
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation - the first one ever conducted on the GAVI HSS component - will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and

national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1 The conceptual framework - logical progression from inputs to impact



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

1.3 Approach to the Country Case studies

All 11 countries included for in-depth review underwent at least one country visit by the HLSP country lead consultant helped by one or more national consultants or national research institutions depending on the circumstances.[1] In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Viet Nam and Zambia) the HSS evaluation team were able to count on the invaluable support and previous work of another study team conducting the so called GAVI HSS Tracking Study in those countries. The Tracking Study -led by the JSI/InDevelop-IPM covers very similar areas (albeit form a different angle) to those aimed at in our HSS Evaluation study, so it was highly synergistic for us to be able to use the Tracking Study guidelines and their extensive network of contacts and country knowledge for the purposes of our own evaluation study. To all members of the Tracking Study team including their country collaborators we wish to express our most sincere thanks and appreciation for their generous collaboration.

In Viet Nam as in other countries the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called "Focal Points" based at either the World Health Organisation (WHO) or UNICEF.

Once the letters had been sent the Country Lead Consultants began the process of documentation (see list of documents reviewed in Annex 2), they approached potential country researchers to work with them and they began preparing the country visits with country and regional stakeholders. In the case of Viet Nam the country visit took place between the 30th May and the 6th June 2009. This relatively short visit was sufficient given that both authors of this report had previous work experience in Viet Nam and because they received the invaluable help of the JSI team who were in Viet Nam at the time of our visit undertaking their own Tracking Study.

A list of people met for this evaluation is included in Annex 1. All meetings took place in Hanoi. Field visits to any of the 10 provinces targeted for HSS support were not necessary or appropriate (transaction costs) since the JSI team had just undertaken several visits to

[1] The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etcetera.

provinces on the week prior to our arrival and de-briefed with us on those visits while we all met in Hanoi.

After the visit to Viet Nam a draft report was prepared that was shared with the Ministry of Health in Hanoi (Dr Nguyen Hoang LONG and Dr Duong Duc THIEN) and with colleagues from the Tracking Study. Feed back was received with thanks from the Ministry of Health and a few factual inaccuracies were corrected and suggestions gratefully incorporated into this final report. In general feed back on the report was very positive: respondents were keen to highlight that the MOH and all 10 provinces are "*very happy to have GAVI HSS support, which is the only major project supporting Village Health Workers in the difficult provinces".*

1.4 Acknowledgements

We would like to thank the Ministry of Health in Viet Nam in the person of the Deputy Director of Planning and Finance and his team in the MOH for the support received. Thanks are also expressed to colleagues from the World Health Organisation and from the UNICEF country offices for their invaluable support. Pär Ericksson (JSI) and Professor Chuc (Medical University of Hanoi) helped us cross notes with the ongoing GAVI HSS Tracking Study / we thank them for their views and support. The full list of people met for this study is included in Annex 1 / to all of them our most sincere gratitude.

2 Snapshot of the health system in Viet Nam

2.1 The country

With a population of more than 80 million people, Viet Nam is home to 54 different ethnic groups. The Viet (Kinh) people account for 87% of the country's population and live predominantly in the low land areas. The other 53 ethnic minority groups, amounting to over 8 million people, are scattered over mountainous areas covering two-thirds of the country's territory.

With regard to administration, Viet Nam is divided into 64 provinces/cities; 659 districts and 10,732 communes. It is notable that 5,156 communes are in mountainous and island areas with lower social and economical development. The North East, North West and Central Highland are in mountainous areas with difficult access, transportation and health delivery

Population (millions)	84.2
Population under 5 ('000)	7,969
Population under 18 ('000)	30,496
% Population growth rate	1.33
Land area ('000 sq.km)	329
Density per sq.km	252
GNI per capita (US $)	620
GDP per capita (US $)	636
Human development index	0.709
% Central gov't expend. allocated to health	6.44
% Central gov't expend. allocated to education	16.9
% Central gov't expend. allocated to defence	11
% population living below intl. poverty line	19.5
% of households having radio	29
% of households having TV	67
Internet users (per 100 population)	7.1
Telephones (per 100 population)	7.0
% Female (15+) economic activity rate	64.4
Official dev. assistance (% of GNI)	4
Debt service (% of exports)	5.5

Source: Unicef Official website 2009.

2.2 Progress towards MDGs

Viet Nam has adapted the MDGs to the country's specific conditions and integrated these goals into its socio-economic development strategies and programs setting up its own 12 development goals (referred to as Viet Nam's Development Goals (VDGs), which mainly focus on the social development and poverty reduction targets until 2010.

Viet Nam is considered one of the world leaders in MDG achievement, in which it has made remarkable progress in improving the living and health standards. Between 1993 and 2008 the number of people below the poverty line fell from 53% to 15%. This has resulted from economic growth stimulated by "Doi Moi" reforms, accelerated international integration, market liberalisation, private sector job creation, while the government also established targeted poverty programmes aimed at poverty alleviation in the poorest areas and communes.

Regarding health status, most of the basic health indicators such as an IMR (15/1000 in 2007) and life expectancy (72 years) are comparable to countries that have a substantially higher level of per capita income. Child health care has been improved. The child mortality rate of under-five fell dramatically from 58 per thousand live births in 1990 to 25 per thousand in 2007. Similarly, the infant mortality rate was 44 per thousand live births in 1990 to 15 per thousand in 2007. The rate of children getting vaccinated with 6 types of vaccines was 96.7%, relatively high in the region.

Table 1 Viet Nam's progress towards MDGs

	1990	2000	2005	2007/2008
Infant mortality	44.4/1.000	31/1.000		15/1.000
Under-five mortality	58/1.000	42/1.000	32/1.000	25/1.000
Maternal mortality	233/100.000	100/100.000	85/100.000	75/100.000
Deliveries with skilled attendant	-	85%		92.92%
Contraceptive Prevalence Rate	53.2%	75.3%		78%
Total fertility rate	3.98	2.33		2.09

Source: Health Book; Health MDGs in Viet Nam by Nguyen Hoang Long PowerPoint presentation made at the High-level forum on Health MDGs 2008; and Estimates by UNFPA, UNICEF

In spite of remarkable results in implementing the MDGs Viet Nam still faces challenges to reduce increasing disparities among population groups, with high poverty incidence and limited accessibility to maternal health care in rural, mountainous areas and Central Highlands. There are worrying signs that key groups are being left behind in the modernisation and expansion of the health system. Gaps in health status and access to

health care are increasing. This is despite the fact that equity and poverty reduction are key government policies[2].

2.3 The response from the health system

Viet Nam's health system retains its socialist basis, with the state health system playing a key role in health service provision. Services are delivered by both private providers and an extensive public network of village health workers, commune health stations, inter-communal polyclinics, district hospitals, district preventive health centres, provincial hospitals, and regional, central and specialist hospitals. Planning and management of the public network involves the national Ministry of Health, provincial departments of health and district health offices, which are responsible for village health workers and commune health stations.

One of the reasons for Viet Nam´s recent health improvements can be found in its well run, largely government-funded national programmes, of which EPI is a good example. Indeed, immunization coverage has remained very high since the late nineties, and although lower coverage figures can be found in poorer provinces Viet Nam continues to run one of the most successful EPI programs in the world.

Table 2 Immunisation Coverage Viet Nam 1986-2008

Vaccine type	1986	1990	1996	2001	2002	2003	2004	2005	2006	2007	2008
Tuberculosis (BCG)	54.5	89.9	95.4	96.7	96.7	97	96	95	95	94	97
Polio3	44.7	86.5	94.5	96.4	91.6	96	96	94	94	92	96
DTP3	42.6	86.7	94.4	96.2	74.8	99	96	95	94	92	96
Measles 1	38.8	86.6	96	97.6	95.7	93	97	95	93	83	97
Measles 2									98	18	97
TT 2 Plus						91	88	93	91	91	89
Birth Dose Hep B< 24 hrs						55	60	62	64	27	25
Hep B 3						78	94	94	93	67	89

Source: Viet Nam – National EPI Review Report. Draft May 6, 2009. Data sourced from 2005 EPI Review data subsequent to 2003 sourced from Joint Report Form reports

Total per capita health expenditure in Viet Nam is approximately USD 45 a person per year, an average amount compared with other countries in the region. The structure of health financing in Viet Nam in the past few years has experienced some changes for the better with higher proportions of public expenditure, increased state budget funding for health and broader coverage of health insurance. However, out of pocket payments at 70% of total

[2] Viet Nam Health Sýsem Assesment (WHO) 2006

health expenditure remain among the highest in the world and represent a key obstacle to progressive health financing. (JAHR 2007 and World Bank 2008)

3 The GAVI HSS proposal – inputs, outputs and progress to date

This section will review the main issues surrounding the GAVI HSS design and application processes and will attempt to summarise progress to date. It concludes with a reference to the issues that ought to be covered in the assessment of the HSS grant at completion in 2010.

3.1 HSS proposal design, focus and rationale

3.1.1 Design

The process of proposal design in Viet Nam was quite thorough, and resulted in a well written proposal that clearly pointed to needs and gaps as justification for the GAVI HSS support requested. Key elements of the proposal design process included the following:

- A study assessing health systems wide barriers to EPI was conducted in 2004 (Ministry of Health, 2004) pointing to areas, some of which were later targeted for support in the GAVI HSS grant.
- A Working Group was established to put together the HSS proposal. This group was led by the MOH. The Department of Planning and Finance of the MOH in the person of its Deputy Director (Dr Nguyen Hoang Long) took a very active role in the process of proposal development and became responsible for HSS grant implementation.
- The World Health Organisation (WHO) supported the proposal design process with its own country staff and hired an international consultant (Bo Stenson) to help put the proposal together. At Regional Level WHO also organised a Workshop in Manila to help countries prepare their HSS proposals.
- UNICEF supported the design process with its National EPI Project Manager.
- There was process of formal consultation between the MOH and the provinces, including a formal workshop held in the 10 selected HSS provinces, with participation of DOH leaders, deans of provincial secondary medical schools, representatives from district health offices, MPI, MOF, and concerned MOH's Departments. In addition several provinces provided comments on the final HSS proposal before it was submitted to the GAVI.
- Once prepared the draft HSS proposal was formally presented and discussed at the Health Partners Group (HPG – the formal coordination structure between the MOH and health partners)) and the Inter-Agency Coordination Committee (ICC). Written comments on the HSS proposal were received from these coordination structures and included in the final proposal.

3.1.2 Proposal focus and rationale

The main objective of the HSS proposal is to strengthen the basic health care network through training, retraining, improved monitoring and supervision, recurrent costs support and allowances to promote better performance of Village Health Workers (VHWs) in ten selected provinces. The focus of the project is on Commune Health Centres and VHWs as they play a critical role in the success of PHC and public health programs in Viet Nam, including MCH services.

The HSS grant - or project as it is referred to in Viet Nam - targeted 10 (out of 64) provinces in different parts of Viet Nam. Selection of the provinces, by regions, for the first phase (2007-2010) was based mainly on the following criteria: (i) Socio-economic status of the provinces, including the number of difficult to reach communes and extremely-difficult to reach villages[3]; (ii) Immunization coverage: priority was given to provinces with lower coverage of immunization; (iii) Current government spending and available human resources for health. Based on the above criteria the following provinces were selected for the first period of the project: *Ha Giang, Bac Kan, Cao Bang, Dien Bien, Bac Giang, Ha Tay, Binh Dinh, Kon Tum, Lam Dong and Tra Vinh*

The Goal of the HSS proposal is to improve the health status of people, in particular children, through sustained and increased coverage of quality basic health services, including immunization.

Specific objectives 1-3 below relate to the ten project provinces while specific objective no 4 is nationwide.

1. To increase the number of VHWs and improve the quality of their work.
2. To improve the quality of work of CHWs and expand the reach of the CHCs.
3. To strengthen health system management capacity
4. To develop and introduce new policies and innovative solutions to strengthen the basic health care system

[3] Identified according to Decision No 393/2005/QD-UBDT dated August 25th 2005 of the Ethnic Minority Committee of the Government.

HSS Inputs	Levels			
	Village level	Commune level	District and prov levels	National level
Human resources development	- Better training of VHWs - More VHWs trained	- Short-training of CHWs on "EPI in Practice" using materials jointly developed by National EPI Program and WHO	- Staff trained on health planning, health management, monitoring and supervision of CHCs and VHWs	- Planning staff trained
Management	- More regular and better quality supportive supervision of VHWs	- Simple tools for monitoring and supervision of VHWs	- Manual on Health Planning and Management - Manual on monitoring and supervision - HMIS	- Manuals on Health Planning and Management - Manuals on monitoring and supervision - HMIS
Supplies and recurrent budget	- Basic equipment kits for VHWs - Monthly incentives for VHWs	- Additional recurrent budget - Computers and EPI-HMIS software (pilot CHCs)	- Additional budget for monitoring and supervision - Computers	- A car for monitoring and supervision

3.1.3 Critical analysis

The proposal was thoroughly developed and involved the main sector stakeholders. Rather than being innovative in nature the proposal complemented what the MOH and other donors were supporting at the time i.e. the training and motivation (through cash incentives among other measures) of VHWs and the strengthening of the CHC level. But does the Viet Nam HSS proposal deal convincingly with the issues raised at design, particularly when the assessment of system wide barriers was undertaken? Is the HSS intervention of sufficient scale and scope so as to deal effectively with those barriers?

The following issues are identified that will be later discussed in this report:

- While training and cash incentives are known to improve performance this depends largely on whether the right VHWs have been selected. The proposal (section 1.5) makes reference to a significant proportion of VHWs being too old (for them to be able to change ways or learn), or simply not the right people selected for the job. It is not

clear how it will be ensured that training and incentives target the right VHWs at commune and village levels.

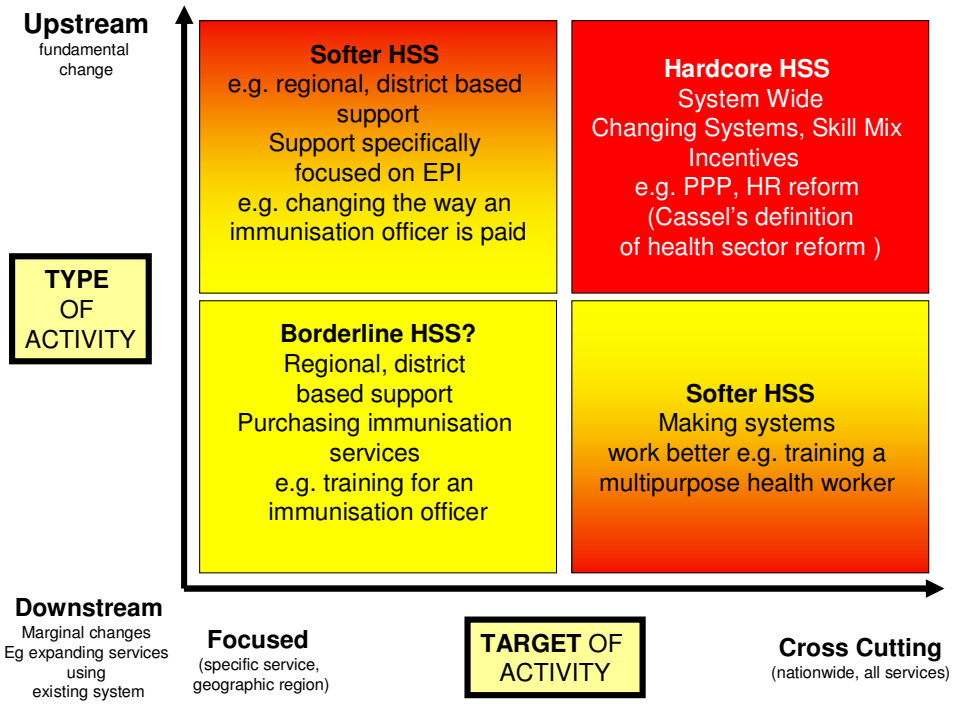
- The IRC spotted the previous issue (of targeting the "right" VHWs) and requested that training and cash incentives be provided on the basis of performance. However, performance-based financing at the level of VHWs had not (and has not to date) been developed in Viet Nam, so at the moment most provinces provide cash incentives to those VHWs who attend quarterly meetings, so attendance to these meetings has become the criteria rather than performance.
- While training of VHWs and CHC is very necessary, the HSS related training inputs will be just one more among many training inputs (most linked to the National Target Programs – NTP) that health workers will receive in Viet Nam. There is no discussion in the proposal about ways to better integrate training within the provinces, both for technical as well as for opportunity-cost reasons.
- The focus of the proposal was on training, incentives AND supervision. In the original proposal reference is made to the need to define what supportive supervision entails and to ensure that more and better supervision actually take place. Process indicators were also included in the proposal (such as setting a minimum standard of 2 supervision visits to every VHW per year). However, these process indicators for increased supportive supervision are not being reported in the APR and, in fact, there is no way to assess through the results framework whether supervision is receiving increased attention or improving as part of the HSS effort.
- It is not clear or explained in the proposal to what extent component 4 can be considered a barrier to immunisation, particularly as many health partners and projects in Viet Nam already include technical support components that could easily provide funds for policy development work. In sum, the focus of this component appears vague, and the low utilisation of funds for this component in 2007 and 2008 (see 3.5) might suggest that it was not really based on a real need or filling a specific gap.
- Finally, our impression as evaluators is that while the areas targeted by the HSS proposal are quite crucial to service delivery, other equally crucial issues identified in the assessment of system wide barriers, such as the fact that in many areas government financing is too low to ensure the delivery of a basic package of services in poorer provinces (pages 32-34 of MOH Assessment study) did not receive sufficient attention (or HSS funding being formula based could not possibly afford to deal with those issues). With that in mind one might question if training, recurrent costs and incentives alone can realistically achieve the intended changes, or indeed whether these changes will last beyond the HSS intervention.

3.1.4 The counterfactual

The evaluators made a commitment in our methodology to address some counterfactual questions, even if answer to these questions will be, by necessity, tentative and speculative only. What would have happened if the GAVI HSS funds had not been made available? Would other donors have picked up this need? Would the MOH have identified other sources of funding easily?

Our response to these questions would be that without the GAVI HSS support Viet Nam might not have been able to target resources for improved MCH outcomes in poorer provinces. This is partly because high national and provincial vaccination coverage easily disguise disparities and low performing areas to potential donors, and partly because most donors consider that immunisation receives sufficient support from the MOH (and from UNICEF and other GAVI windows!). An additional factor is that with Viet Nam being expected to shortly attain Middle Income Country status many bilateral donors are slowly pulling out of health or focusing their efforts on other more pressing health problems (such as the AIDS epidemic).

In sum, as argued by the MOH itself in the feed back to our report "GAVI is the only major project supporting Village Health Workers". In this sense GAVI HSS is clearly addressing a legitimate aspiration of the MOH. However, as argued by us in 3.1.3, we are less convinced that training, incentives and some recurrent cost support provided during a limited period of time will attain the desired changes in the absence of, for example, higher per capita government health spending in health in the poorer provinces that compensates for extremely high and regressive out-of-pocket health expenditure that hits the poor hardest. An effort on the latter would have represented an upstream, cross cutting intervention (according to the diagram shown on next page) with higher chances of fundamental health systems change. But this is not to say that current HSS interventions are either less legitimate or less important, since they too have the potential to influence broader systems change, but this depends on the extent to which HSS lessons really influence the policy context in the right manner. We are not sure if sufficient efforts are being placed for such policy change to take place in important areas like developing a more progressive health financing model that better targets resources according to need.



3.2 HSS application and approval processes

The following box summarises the key dates involved in the HSS proposal preparation and approval:

Box 3. Key dates in the Viet Nam HSS proposal

2004	Study on barriers to immunisation conducted (HESO)
2006	Proposal preparation: consultant is hired; consultations in provinces; ICC and HPG reviews and approval.
October 2006	Proposal submission: US$ 16,395,892 requested
November 2006	Conditional approval letter from GAVI Secretariat is received in Viet Nam.
February 2007	HSS proposal resubmitted: US$ 16,284,892 requested. Four year proposal 2007-2010
April 20th 2007	Second conditional approval letter received seeking one additional clarification and making 2 recommendations.
May 12th 2007	GAVI Board approval decision
August 7th 2007	First HSS Disbursement (for 2007) received
February 13th 2008	Second HSS Disbursement (for 2008) received
May 15th 2008	APR report produced by Viet Nam contains HSS section: reports on 3 months of 2008. IRC recommends continued HSS funding.
February 2nd 2009	Third HSS disbursement (for 2009) received

3.2.1 Clarifications sought on the proposal

After complimenting Viet Nam on a very well written and justified proposal the IRC identified several areas where additional clarification was requested. The following paragraphs briefly discuss what clarifications were sought and provided. Text in italics is taken from the letter November 2006) from the GAVI Alliance Secretariat, while the "actions taken" sections are explanations provided by us, the evaluation consultants in an attempt to summarise the responses or actions taken by the GOV (MOH 2007 - GAVI HSS Proposal Viet Nam – responses to the comments/conditions from IRC). The comments" section also belongs to the evaluation consultants on issues that we consider of significance that are discussed elsewhere in this report.

1. *There is a need to explain the role of the Ministry of Home Affairs in relation to the Village Health Workers (VHW) and its link to proposed activities.*

   Action taken: The DOPF explains this point emphasising that in a decentralised government structure different entities like the Ministry of Home Affairs (MHA), the MOH, the Communes Health Committees and the District Health Offices play different roles in relation to the selection, management, financing and performance monitoring of VHWs.

   Comment: the response suggests that the MOH is just one among several players, and implies that issues about performance monitoring of VHWs or incentives provided to them involve different government structures. This has important implications in terms of sustainability of VHW incentives and recurrent costs provided by the HSS grant, but it is unlikely that the IRC would be able to pick up such implications on the basis of the existing correspondence.

2. *The GAVI HSS guideline state that "support shall build on existing country systems and processes for planning, implementation and monitoring as much as possible" and support is not for a project. Project management through a Project Management Unit at different levels parallel to the existing health structures goes against the idea of strengthening health systems. Please clarify how the proposed project management fits in the overall health system management mechanism and why the GAVI HSS proposal cannot be managed through existing health structures.*

   Action taken: The re-submitted proposal explains how Article 25 of the Decree 131/2006/ND-CP of 9th November 2006 establishes that ODA funded projects should

establish a PMU at the central level after the project is officially approved, and therefore that the MOH would establish such a PMU.

Comment: PMUs are very common in Viet Nam and it is often the case that the PMU structure may reach the Provincial (or even District levels) where project specific staff may be recruited. In the case of the GAVI HSS funds and in response to the IRC comments a very small PMU structure made up of a total of 5-6 technical and administrative support staff was established at the DOPF level in Hanoi. However, in attention to the issues raised by the IRC this PMU structure was not replicated at provincial levels or below. This was a deliberate effort to integrate GAVI HSS implementation and financial management within existing structures and systems at provincial level and below.

3. *There is a need to establish health service output indicators and clarify the link between the targets and the activities. Indicators should show progress overtime. The district level performance should be included in the indicators and the annual progress report.*

   Action taken: 7 health service output indicators were included in the final proposal, and an additional annex 5 (the links between indicators/targets and project key activities) was included.

   Comment: The issue raised by the IRC was not fully resolved because while all of 7 service output indicators could in theory be related to increased activity levels by VHWs and CHCs –as a result or their increased numbers of competences- such link remains weak (elusive) for reasons of attribution and sensitivity of the indicators. More generally, our impression (and main point for this evaluation) is that the IRC assessment of feasibility and sensitivity of the results framework shown in the HSS proposal was rather superficial and should not have been made at a distance but through more direct assessment of the local situation. Insufficient assessment of these matters has important implications that are discussed in the sections on APR (in this section) and results orientation (section 4) of this report.

4. *Kindly explain how the recurrent costs, particularly for VHW incentives and Commune Health Centres supplemental funds, will be taken over for the 4 years. Also please describe the mechanism to ensure timely refill of consumables of the kits for VHW.*

   Action taken: the MOH required provincial governments to make a formal commitment to take up the costs of cash incentives and recurrent costs post GAVI HSS.

Comment: This is a crucially important observation by the IRC that was only partially addressed by the DOPF. In fact, whether a "commitment" is sufficient guarantee is an issue given that the persons who may have made such commitments will change, but also because such a commitment should have been more specific about the how, when and by what amounts would such commitment be honoured. Again, this issue emphasises the limitations of the IRC model in the case of complex HSS proposals. In this case the IRC rightly spotted the sustainability issues but the proposal was approved all the same in the absence of a guarantee that the said costs would be eventually taken over by provinces.

5. *Please explain how HSS support from other donors (WB, ADB, GFATM, NGOs and bilateral partners) is taken into account in the proposed coverage area. Further, please provide a mechanism to ensure active NGO partnership in implementation.*

Action taken and comment: On the matter of the HSS support from other donors we (the evaluators) have not found any explanation in the available correspondence on whether and how was this issue addressed in the resubmitted proposal. While HPG comments to the re-submitted proposal (Annex 6 – comments from stakeholders) do not suggest any duplication they do not explain any synergistic or related issues as requested by the IRC. There is also the issue that the original assessment of system wide-barriers identified low government funding (especially at provincial and communal levels) in the poorest provinces as a key barrier to immunisation and other services (page 33 Table 4.1), but this issue was not picked up in the HSS proposal at all[4].

The request to "provide a mechanism to ensure active NGO participation" is partly addressed in section 6.9 of the proposal (social mobilisation) where the potential for NGO involvement and for demand-side interventions are acknowledged. But there is not any specific or convincing explanation about how NGOs will be actually involved, if at all. The vagueness of the response is illustrated by 2 facts: one is the absence of any reference to working with local NGOs in the HSS project activities and another is the absence of reference to this in the 2007 and 2008 APR reports. The point of this observation by the evaluators is simply to highlight the limitations of the proposal review process based on questions raised by a distant IRC that are often not satisfactorily addressed at country level.

[4] This links once again to the issues of sustainability of GAVI HSS funding and to whether GAVI HSS is additional or just substitutes for (low) government funding, discussed in section 4.

6. *There is a need to revise the proposed budget to fit within the allowed amount (based on the birth cohort for the respective years of the proposal multiplied by US $ 2.5 per child).*

   Action taken: this was done and the final proposal included a revised, slightly smaller budget (from $16.3m to $16.2m).

There was a second (and last) conditional approval letter sent by the GAVI Secretariat on 25th April 2007 in February 2006 that - on the basis of the resubmitted proposal requested an additional clarification as follows:

> *The country needs to clarify how they will integrate performance-based incentive scheme and to ensure that incentives will only be provided after a VHW has completed the required 9-month training. In view of the proposed recruitment of new VHWs and the need to complete or conduct full training for existing VHWs, the budget per year for VHW monthly allowance would need to be revised to reflect the incremental number of VHWs completing the 9-month training and provide services over the four years.*

Comment: We have not seen an explicit response to these clarification and recommendations but based on the interviews held in Hanoi and on the information shown in the APRs for 2008 and 2009 the following comments can be made. It is our understanding that incentives began to be provided to all existing VHWs in the 10 provinces from 2008 (month not mentioned in APR) irrespective of whether or not they had received training.

3.2.2 The IRC proposal review when applied to HSS

The impression of the evaluation consultants is that the IRC process did identify the main issues of concern linked to the original proposal, but that many of them remained unresolved even after the process of clarifications was concluded. We do not suggest that there was a lack of compliance on the part of the Viet Namese government or incompetence on the part of the IRC. The issues raised by the IRC were legitimate, but these could not be possibly resolved within a short period or without causing substantial delays to project start up. Thus, while the issues raised by the IRC were of substance – for instance the need to reward the "right" VHWs on the basis of performance and only after receiving training, or the need to ensure that incentives and recurrent costs would be taken over post GAVI HSS- the responses by the MOH had to be, by necessity, partial or even superficial. Dealing with these issues satisfactorily would have required time, a very detailed and up-to-date understanding of the Viet Namese health system and a much closer engagement between bidders and reviewers than the current IRC review process permits.

The lesson is that the IRC model would need to be substantially modified for it to deal with potentially complex HSS issues at proposal approval stage, and for it to do a more thorough reality check of the feasibility of both its clarifications and the potential remedial action. When issues are of substance but unlikely to be solvable the approach should be to incorporate these matters into the revised proposal in a constructive manner, recognising that the said matters are nothing but other "barriers" to health systems performance and immunisation and MCH services that it will take time and effort to overcome.

In sum, addressing important health systems issues and IRC concerns would require a much deeper discussion and a closer engagement between the GAVI Secretariat (or IRC) and the proposed recipient of the HSS grants that the standard HSS approval process cannot possibly deliver.

3.3 Start up measures

3.3.1 Start up measures taken

Other than the setting up of the PMU within the DOPF and the opening of the bank account for GAVI HSS money it does not appear that other significant steps were required to start up the implementation of the GAVI HSS grant. The bank account was indeed established swiftly, managed by the DOPF and following standard government financial management and accounting procedures for ODA projects. HSS funds thus can be seen to be "on plan" although not technically on the MOH budget. External Audit reports are due to take place at the beginning of the third year (would this be 2009 or 2010 given only a few months of implementation in 2008?) and within one year after the close of project.

Special arrangements for the collection of HSS indicators were not necessary at start up since the seven GAVI HSS indicators are all routinely collected in Viet Nam (however please note the issues discussed earlier in relation to attribution and sensitivity issues of proposed indicators). The PMU was also established swiftly and it reported on progress at the APR submission in May 2008.

3.2.2 Lack of sync between disbursement and implementation

This section attempts to highlight an issue affecting Viet Nam that has also been observed in several other HSS countries in this study. This is the lack of synchronization between the HSS approval dates, the HSS disbursements and the financial years in which the HSS funds should be spent as per the HSS proposal.

In Viet Nam, the first implementation year for HSS was almost gone by the time the GAVI approval was received in May 2007 and the funds were disbursed in August 2007. Given this it would have been more logical to re-schedule the first year of implementation from 2007 to 2008, but this would have implied the elimination of one year worth of HSS grant since the GAVI will not fund beyond the last year of the country´s National Health Plan which ends in 2010. Thus it is not in the country interest to delay the beginning of implementation (in this case until January 2008) even though it may cause problems to spend the money by the expected dates. The first victim of this approach is the alignment of the GAVI HSS grant with the country´s Fiscal Year (FY) and budgeting cycle. If the idea is that the country will be allowed to use HSS funds beyond 2010 then this should be made explicit for the purposes of alignment, absorptive capacity and predictability of funding.

Just like the funding decision arrived "late" for implementation in 2007 the disbursement for 2008 was received in February 2008 only i.e. 2 months into the FY. This caused a delay in the approval of project activities by the MOH, affected the quality of planning and caused significant delays to implementation.

Would it be not be more appropriate for the purposes of alignment, predictability of funding, adequate activity planning and ultimate utilisation of funds to better align these processes to the country´s planning and budget cycle? So seem to think our MOH interlocutors for this evaluation that GAVI "should send the annual approval decision letters 3 to 4 months before the beginning of the FY when the monies are expected to be used[5]. Actual arrival of the funds is less of an issue (although it should be stated in the letter) because Viet Nam does have available (unspent) funds from the previous year in the Bank, but these delays and lack of synchronization complicate proper financial management of HSS funds quite considerably".

This evaluation study was not able to explore - due to lack of time - the implications of these issues at the levels of provinces, districts and communes. However it is at those levels that these issues may actually represent a more serious matter, since provinces - particularly the poorer, 10 HSS provinces - vitally depend on early warnings of fund availability, to allow them to plan and budget according to their own annual plans.

[5] To be fair the GAVI Secretariat confirmed through letter dated 6 September 2008 that the HSS fords for the following year had been approved on the basis of the APR review.

3.4 Annual Progress Reporting (APR) on HSS

In this section we discuss issues linked to the quality of APR reporting on HSS and to the relevance and alignment of APR HSS reporting in the context of Viet Nam´s established health reporting and accountability mechanisms.

3.4.1 Quality of APR reporting in Viet Nam

The team in the HSS PMU is integrated in the Department of Planning and Finance (DOPF) of the Ministry of Health (MOH) are responsible for the preparation of the APR. Viet Nam submitted on time the HSS section of the APR reports in May 2008 and 2009. In 2008 reporting covered barely four months of implementation (September to December 2007) and activities undertaken from January to April 2008. On 8 September 2008 the GAVI Secretariat communicated to Viet Nam that the HSS funds for the 2009 FY would soon be released based on the approved APR report. The Secretariat congratulated Viet Nam for a well written report and reminded it to attach ICC minutes and collect all the necessary signatures for the APR. The Deputy Director of the DOPF confided to us that the collection of APR signatures (a total of six for HSS alone!) is a significant burden and transaction cost on his department as collecting signatures is a time consuming, laborious process. He suggested that this was a somewhat disproportionate, unnecessary requirement.[6]

In May 2009 the APR for 2008 was submitted covering for the first time a full year of APR implementation. The report is in our opinion well presented, complete and provides good level of description on activities and expenditures against those incurred to date. There is also reporting against the seven progress indicators included in the proposal (discussed later). Perhaps we missed a reference to why expenditure reached only 54% against available budget for 2008. We sought clarification to the MOH on this matter and their response suggested that delays in the receipt of funds in 2008 and accounting procedures (money spent not yet reflected in MOH accounts because of lack of synchronization between GAVI and Viet Nam´s fiscal year) were responsible for this apparent low implementation.

ICC minutes were attached from two ICC meetings, one in 2008 and one in 2009, but none included any reference to the HSS grants as HSS matters are apparently discussed at HPG level only, not at ICC. The report also mentions that formal consultations were held with the

[6] We tend to agree with this observation. Signatures do not necessarily demonstrate that the report has been discussed. It might be netter to explain when it was discussed and what was said in the attached ICC or similar minutes.

provinces in order to compile the information for the report. The APR report was formally discussed with the HPG on April 2nd, but no minutes were found of such a meeting.[7]

3.4.2 APR alignment with country systems

The following issues were identified in relation to the alignment of the APR with national reporting mechanisms:

a) The timing of the APR in May is not ideal for the MOH as it takes place before the consolidated figures for the whole country become available by June/July of the year after. This implies that most information for the APR - both activities undertaken and progress against the seven progress indicators - has to be collected manually by the PMU in the provinces at considerable transaction costs.

b) Given the above our interlocutors in the DOPF wondered if the GAVI would be prepared to allow Viet Nam report in October instead of May in order to better integrate reporting and use the HMIS. However the concern was whether this might delay the funding decision - and the linked letter by the GAVI Secretariat - which would in turn affect the predictability of the HSS funds and the planning of HSS activities for the following year.

c) Given the choice, the DOPF would prefer the GAVI to use the national reporting mechanisms that include annual reviews and regular meetings between the DOPF and the health partners in the HPG in order to limit reporting related transaction costs.

3.4.3 Monitoring HSS indicators through the APR process

The HSS proposal expects Viet Nam to report on 7 service output indicators. Progress against these as per the May 2009 APR is shown in the table below.

[7] Evaluators had access to a presentation made by Dr Long to the HPG on progress with the GAVI HSS grant.

4.8 General overview of targets achieved

Table 4.8 Progress on Indicators included in application

Strategy	Objective	Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target	Current status	Explanation of any reasons for non achievement of targets
		Sexual and reproductive health										
		Contraceptive prevalence rate	The number of women of reproductive age who are using (or whose partner is using) a contraceptive method	Total number of women of reproductive age	Regular report on M&C care at CHCs	60%	Health Statistical Year Book	Qtr3, 2008	80% in all project provinces	2010	73.3*	
		Births assisted by skilled Birth attendant	The number of live births attended by skilled health personnel	Total number of live births	Regular report on M&C Care at CHCs	60%	HSYB	Qtr3, 2008	85% of delivery	2010	88% in all project provinces	Remark: The outcome is not even across province as the rate stayed around 65% to 75% in the poorest provinces
		TB										
		Cases detection of AFB (+):	The number of new smear positive cases notified	The number of new smear positive cases estimated	Regular report of TB program	60%	HSYB	Qtr3, 2008	75%	2010	57.2*	
		DOTS cure rate:	The number of new smear-positive TB cases registered under DOTS that successfully completed treatment	The total number of new smear-positive TB cases registered under DOTS	Regular report of TB program	70%	HSYB	Qtr3, 2008	80% of detected cases	2010	88.2	
		Nutrition										
		Malnutrition rate of children < 5 weight for age	The number of u5 having weight-for-age less than -2 standard deviations (SD) of the WHO Child Growth Standards median)	The total number of children aged less than 5 years	Regular report by provinces on nutrition status of children	24%	HSYB	Qtr3, 2008	reduced 4% in each project province	2010	22%	
		Utilization of CHCs			Regular report by CHCs				Increased utilization of health services at CHCs	2010		
		Immunization										
		Sustain high DTP3 coverage of at least 90% in each project provinces	The number of children receiving their third dose of DTP	The number of children surviving to their first birthday	Annual EPI report	75%	HSYB	Qtr3, 2008	at least 90% in each project provinces	2010	82	
		Routine 2nd dose of measles vaccine coverage of at least 90% in each project provinces	The number of children receiving their second dose of measles	The number of children surviving to their first birthday	Annual EPI report	75%	HSYB	Qtr3, 2008	at least 90% in each project provinces	2010	82	

As has been already mentioned, the collection of information to report progress on these indicators is very laborious given that (a) the information displayed in the tables relates to the 10 HSS provinces only – not the entire country; and (b) such information has to be produced three months before the HMIS would be able to present the same information just because of the timing of the APR. In addition, one might question whether those transaction costs are really worthwhile since none of the seven indicators has sufficient sensitivity to be influenced by GAVI HSS interventions, particularly on an annual basis. Sensitivity of the indicators is affected in this case by the difficult attribution of progress to the HSS interventions (other interventions and circumstances affect such link) and also because a minimum of two years would be needed to measure changes in service delivery that could be realistically (if

remotely) attributed to improvements in VHW availability or competence, to mention just Objective 1. Attribution in the case of Objectives 2, 3 and 4 would be even more difficult and elusive.

Why then, we asked at our meetings in Hanoi, were these indicators selected? Why ask the MOH to collect these indicators at high transaction costs at the time of the APR and not wait for later in the year when they would be available anyway? Where these the right indicators to monitor progress with the HSS intervention anyway? These seem to be the issues that made the IRC (see 3.2) request the MOH "…t*o establish health service output indicators and clarify the link between the targets and the activities. Indicators should show progress overtime. The district level performance should be included in the indicators and the annual progress report."*

We did not get very clear answers to our questions, and a common comment was that these indicators were selected because they were the ones that figured as examples in the HSS proposal template. A more likely explanation, however, might be that there was not sufficient engagement and dialogue between the GAVI Secretariat, the IRC and the Viet Namese proposal writers on any of these issues, and that considerations of alignment, transaction cost implications and others did simply not receive the attention they deserved. Again, the IRC assessment model based on requiring clarifications in writing could have done with a closer reality check of the Viet Namese HMIS, reporting and M&E systems.

3.5 HSS progress to date

We are unable to assess performance on the basis of the seven HSS result indicators given that (a) this is early stages of implementation, (b) for the issues of indicator sensitivity and attribution discussed in 3.4.3, and (c) because a more thorough analysis would be needed in any case comparing performance in HSS versus non HSS districts.

In terms of HSS activities progress to date has been affected perhaps by the decentralised nature of the Viet Namese HSS proposal where activities take place in the provinces, at commune and village levels. GAVI HSS implementation has been somewhat below plan in terms of both percentage completion of activities and expenditure levels. Progress has been slower in strengthening management capacity (5% of planned expenditure - Objective 3) and in policy development (14% of plan - Objective 4) than in supporting VHWs with training and incentives (58% of plan – Objective 1) and CHCs with training and recurrent costs (85% of plan – Objective 2). Expenditure versus budget is shown in the table below.

GAVI HSS Expenditure in FY 2008 (as per APR May 2009) – US$				
Row Title	**Budget**	**Spent (%)**	**%**	**Balance**
Objective 1 - VHWs	3,953,118	2,311,741	58	1,641,377
Objective 2 - CHCs	1,214,419	1,040,554	85	173,865
Objective 3 – Management Capacity	744,000	39,829	5	704,171
Objective 4 – Policy Development	417,816	61,010	14	356,806
Project Management costs	574,648	325,587	57	249,060
TOTAL	**6,904,001**	**3,778,721**	**55**	**3,125,279**

These evaluators do not consider under-expenditure a matter of concern since a significant part of it refers to ongoing activities that had not yet been paid at the end of the reporting period.

3.6 End of HSS Assessment

In Viet Nam it will be hard to demonstrate impact of the HSS funding at the end of 2010 for various reasons:

- If immunisation coverage is taken this is unlikely to experience much improvement given high immunisation coverage rates in Viet Nam that were already high at design stage. Visualising impact on other indicators would be equally problematic.[8]
- There may be a chance to see some modest improvements in each of the 7 progress indicators but, as discussed earlier, attribution and sensitivity of these indicators are likely to be problematic. It would be however interesting to measure progress in the indicators and then compare it with progress in the same indicators in a control group of provinces.

[8] In their comments to our first draft the MOH argued that "*other indicators rather than 7 routine progress indicators*" are used to evaluate the HSS impact, and that "*different methods are used to evaluate the impacts: HSS annual reports; pre- and post project surveys using different quantitative and qualitative data collection methods (including household survey, health facility survey etc); Field visits; Reports from provinces etc*". However, if other indicators and data sources are used for impact monitoring by the MOH then why select the existing 7 progress indicators in the HSS proposal, and why are the alternative indicators suggested by the MOH not included in the APR apart from the activity reporting?

However, the real impact of the HSS interventions should be seen have been on service and process indicators that are not being measured either by the HSS project or as per the National Health Plan, and for which we are unlikely to have sufficient baseline data. Some such indicators might include: Increased number of supervision visits to VHWs; evidence of use of tools for better supervision; increases in referrals from VHWs to CHCs or hospitals; uptake of MCH services in target areas; increased utilisation of CHCs after training to VHWs has been completed; etcetera. In sum, it is unlikely that measurable impact will be recorded at the end of the HSS support unless specific surveys are conducted.

3.7 Support systems for GAVI HSS

Technical support provided by various agencies can be divided into support provided: (a) at proposal design and approval stage; (b) at APR; (c) for HSS proposal implementation. These are briefly reviewed now.

3.7.1 Technical support for proposal design and approval

As described in sections 3.1 and 3.2 WHO and UNICEF made a considerable effort to support the preparation of the HSS proposal, and they did so in a very effective manner as the result was a well written, successful proposal. These agencies provided support through their own staff, through contracted consultants and through technical events (such as the Manila seminar.

3.7.2 Technical support to the APR and to HSS implementation

WHO admitted to not having been involved in the preparation of the 2008 APR and to having been merely asked to sign it. In 2007 WHO did take some part in completing the APR report, but mainly because the WR had made a point of signing it only after some mistakes had been corrected. UNICEF admitted to not having had any active involvement in the APR, in either 2007 or 2008. The MOH did report about progress with the HSS to these agencies in March 2009, at the time of the HPG meeting, where Dr Long made a presentation of progress. Given that both agencies had been very actively involved in the design and preparation of the HSS proposal, the evaluation consultants were keen to understand why these agencies had become far less involved at implementation.

The answers, as perceived by these agencies, varied slightly but not in essence. The MOH has taken complete leadership of the HSS implementation, and the MOH does not seem to need support from either WHO or UNICEF for either completing the APR or for its implementation. At the same time these agencies accepted that their stance had been somewhat passive, in the sense of helping when asked but not when not asked. This,

combined with what the agencies perceive as an unclear role for the agencies in support of HSS implementation further emphasised such a "passive" approach. When WHO officers were asked by these consultants whether they were familiar with the GAVI Annual Workplan (which among other things depicts expected involvement of WHO and other UN agencies in relation to GVI programmes) they claimed not to be aware of the existence of such a Workplan. They also considered that a more clear mandate for WHO in relation to the oversight of HSS would be useful both for clarifying roles as well as for giving them the mandate to scrutinise annual reports.

In relation to technical support to implementation neither agency, as said, has had any involvement in implementation for reasons similar to the ones stated above, and also perhaps - these consultants think - because the HSS proposal already includes (under Component 4) a generous amount for technical assistance that the MOH can use as need be. From the 2008 APR report it would appear that the MOH had not contracted any technical support - national or international - from Component 4 funds.

4 HSS Alignment with GAVI Values and Principles

This section will attempt to analyse the extent to which the Viet Nam HSS grant adapts to the GAVI "values" or "principles" listed below. Some of those principles have been slightly modified to accommodate specific questions and issues that the evaluation consultants considered important such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?
- Equity oriented

4.1 Country Driven

There is no question that the HSS proposal has been fully country driven and owned from design to implementation. On whether or not the right gaps had been identified, most respondents considered that the design process had been as thorough as can be, and that the MOH were implementing HSS with considerable leadership. Some respondents considered though that the HSS initial focus on systems and supportive supervision had been slightly lost and that there was too much emphasis on training.

4.2 Is GAVI HSS aligned?

In this section we consider several dimensions of alignment as discussed in the evaluation study guidelines: Alignment with broader development policies such as the PRSP and the national health plans and priorities; alignment with planning and reporting systems; alignment with budget and financial management systems.

4.2.1 Alignment with broader development and health policies

The focus of the HSS proposal is fully consistent with the Viet Namese Health Plan that prioritises Primary Health Care and Public Health to achieve expected outcomes. On the other hand, whether such alignment in the case of HSS implied a proper assessment of the role that HSS would play vis a vis the work that other health partners or NGOs were playing

in the 10 selected provinces is far less clear. Alignment in Viet Nam is a challenging concept, partly because the government is very clearly in control but its policies may not be sufficiently developed to enable alignment in the proper sense. A second problem is that while the government knows what most health partners are funding it may not be in a strong position to change their resource allocation decisions because the quality of the engagement and coordination at health sector level are still incipient (but improving very fast). For example, an independent assessment of the Hanoi Core Statement (HCS) undertaken in 2007 recognised that "*most donors have aligned their country programmes to the SEDP, or are in the process of doing so. However, alignment at this level is not a very onerous commitment, and has not involved any significant reorientation in donor programmes. Aligning at the sectoral level is a more difficult challenge, which depends on the state of planning and budgeting processes in the sectors, as well as on the quality of engagement by donors. There is significant variation across the sectors on the extent of alignment.*"[9]

Finally, the HSS process is quite aligned with the process of annual planning by the MOH but issues linked to the disbursement of HSS funds (discussed under 3.2.2) make real alignment or activities and budgets quite challenging.

4.2.2 Alignment with budget and reporting cycles

HSS reporting is clearly out of step with Viet Nam´s own monitoring and reporting systems, and this causes very onerous transaction costs to the MOH. For example:

- The timing of the APR is too early for the MOH to be able to use data from its own annual health report that is usually produced in May/June;
- Viet Nam reports on the 10 HSS provinces, which means that specific data collection systems had to be defined for that purpose in each province;
- Viet Nam runs Joint Annual Health Reviews that could be used with only slight modification for the GAVI purposes of assessing progress against the seven targets in the HSS proposal (some of which are common to Viet Nam´s own list of sector monitoring indicators).
- Activity reporting is particularly labour intensive - if the purpose is to account for expenditures the same information could be provided to the GAVI a couple of months later as part of the routine processes of financial reporting used by the MOH;
- Collection of so many signatures for the APR report is an unnecessary requirement since formal signatures do not in any case guarantee that the report has been either

[9] See reference in Cox et al, in Annex 3. The Hanoi Core Statement is the Viet Namese own agreement for improving the effectiveness of aid along the principles of the Paris Declaration.

properly reviewed or that those signing have had a role in putting together the report, as explained for WHO in section 3.

In terms of alignment with budget and financial management procedures, GAVI HSS money, as the rest of the GAVI funds are "on plan" and feature "on budget" even if they sit in a separate bank account. The same financial management principles applying to any government funds apply to the GAVI funds, and financial management procedures are generally perceived to be solid and reliable.

4.3 Is GAVI HSS Harmonised?

Several issues touching on harmonisation of planning and reporting and financing procedures have already been discussed in previous sections. In general GAVI HSS funds are quite harmonised within the limited framework offered by the health sector in Viet Nam where project type funding remains the main approach to health financing for donors. Other windows are being opened in the form of pool funds, sector budget support or general budget support, but none of these were available at the time of HSS project design.

Does the setting up of a PMU represent an issue in relation to harmonisation? We do not think so. As explained in section 3.2.1 the setting up of PMUs is a government requirement, and in fact it was the GAVI that requested the GOV to reduce the size of the PMU to the minimum necessary. The MOH complied and set a small PMU based within the Department of Planning and Finance and, contrary to practice in other projects, it did not prolong such PMU to the provincial level or below, which means that at those levels the HSS is using standards government structures and procedures.

4.4 Is GAVI HSS funding predictable?

When compared to other sources of funding the predictability of GAVI HSS funds appears quite high, particularly in a country where project aid from bilateral partners is the norm.[10] Government officers interviewed by the consultants also considered that GAVI HSS offered a relatively simple and reliable source of funding. They were less appreciative of the requirement to tailor the end of the HSS funds to the end of the health sector plan, as this also limited the ability of the government to prepare the resource envelope for the following

[10] For a deeper discussion on predictability of donor funding in Viet Nam please refer to Figure 2 in the UN document: *How external support for Health and HIV will evolve as Viet Nam becomes a Middle-Income Country. HLSP, September 2008.*

health plan knowing whether or not GAVI HSS funds would be available. A five-year timeframe was considered ideal for any HSS grant.

4.5 Is GAVI HSS accountable, inclusive and collaborative?

The GAVI HSS proposal is generally accountable to the designated health sector coordination structures such as the Health Partners Group (HPG) or the Inter-Agency Coordination Committee (ICC). Dr Long, the Deputy Director at the DOPF responsible for HSS implementation informed the health partners about progress, through a power point presentation, at the meeting of the HPG of March 2009.

In terms of inclusiveness and collaboration there is very little in the HSS proposal or in the APR reports to suggest that, for example, civil society or NGOs are involved at all in HSS activities at village or commune levels, as requested by the IRC at the time of the conditional approval (for example see 3.2.1, clarification 5). It is also quite clear that HSS implementation has not to date generated calls for technical support among technical agencies such as WHO or UNICEF.

4.6 Does GAVI HSS have a catalytic effect?

The catalytic effect of GAVI in areas such as immunisation and new vaccines was clearly recognised by all our interlocutors. However, in the specific case of HSS funding such a catalytic effect is harder to demonstrate, partly because this evaluation did not get to the level of provinces or communes where its catalytic effect might be better appreciated. In any case all the interventions supported by the HSS grant (training, recurrent cost support, cash incentives, technical support, etcetera) are fairly common in Viet Nam i.e. other health partners have been supporting similar activities for several years. The consultants found it surprising that they could not find evidence on the *efficacy* of these interventions in terms of improving service utilisation and health behaviour in Viet Nam. This emphasises a risk discussed in many reports on the health sector in Viet Nam; that many interventions of great potential are seldom rigorously evaluated, in part because of their donor driven nature.

4.7 Is GAVI HSS Results Oriented

While the HSS proposal includes clear activities and seven result indicators it is not clear to the evaluators whether the proposal as such is results oriented since (a) most reporting is activity reporting, and (b) there are several problems associated with considering changes in the seven result indicators to be related to the HSS activities, as discussed earlier in this report.

For this HSS grant to be truly results oriented a more thorough assessment of the feasibility and sensitivity of selected indicators should have been done at the onset, around the time of clarifications (since this issue was clearly picked up by the IRC – see Proposal Approval in section 3). But the model chosen by the GAVI to approve HSS proposals, that has served the GAVI well for immunisation purposes, did not seem to work so well for dealing with HSS interventions; where attribution is elusive and impact takes time and may be difficult or costly to measure.

4.8 GAVI HSS sustainability issues

As discussed under 3.2.1 the fact that the Viet Namese HSS proposal included the provision of recurrent costs for CHCs and the payment of cash incentives to VHWs raised a number of sustainability issues that were rightly picked up by the IRC. The consultants do not consider that the guarantee provided by the MOH in Viet Nam in the form of a "commitment" from provincial authorities to take up the costs at the end of the GAVI project was sufficiently robust. Nevertheless, the GAVI or the IRC or both seemed to think otherwise since final approval was granted. In the second round of clarifications the IRC also requested Viet Nam "t*o provide a mechanism for taking over the financial responsibility of recurrent costs before the allocation of the second tranche",* which has not happened.

In general, the consultants found that the assessment of financial and programme sustainability issues in the original proposal and then in the post-approval period was very superficial. This was caused - in our opinion - by a combination of factors linked to the GAVI HSS modus operandi based on IRC review conducted at a distance, lack of GAVI presence in countries and lack of involvement of country-based UN agencies around the approval and post approval stages; all of which preclude closer engagement between the GAVI Secretariat and the MOH in Viet Nam. In fact, the project proposal includes an interesting discussion and recognition of sustainability issues that should have been more clearly assessed by the GAVI Secretariat or the IRC. For example, the proposal states that "*sustainability is a key issue…even if recurrent costs constitute a relatively limited part of the total proposal …The recurrent costs amount to approximately $ 4.2 million or 25% out of the total project budget of $16.4 million. This constitutes no more than 0.13 percent of the total government recurrent health budget*". Even if that is the case indeed $4.2 million is a considerable amount of money that poor provincial governments may struggle to fund once the GAVI HSS support finishes.

Finally, financial sustainability issues in Viet Nam are mixed with the question of whether HSS funding will be additional as HSS funding is expected to be. For example, the HSS

proposal states that "the HSS fund will not displace any existing sources, but supplement the sources. All project provinces' authorities will be clearly informed about this". In reality this is hard to verify and even harder for the MOH to enforce since provincial authorities have considerable freedom (and autonomy from the MOH) for allocating financial resources that fall outside the close earmarking of NTPs. In fact, variations in health spending and PHC spending among provinces are one of the best documented causes of inequitable health spending among provinces in Viet Nam. The MOH was well aware of these matters when members of the PMU recognised to these evaluators that "*it is difficult for the HSS project to ensure that the local expenditure for health will not be reduced. The local support for health may not be in the priority list once it has already received additional funds from GAVI. Therefore, PC (the People´s Committee) in coordinating local resources may want to re-arrange the additional local budget. This, if it happens, will influence the results of interventions. The project is fully dependent on commitment of PC in not cutting down local budget for health".* (personal communication)

4.9 Does HSS funding help improved equity

The equity and poverty focus of the Viet Nam HSS proposal is quite clear given the government decision to focus the HSS support on the poorer provinces where health and immunisation indicators were worse.

Annex 1 List of people met

Ministry of Health

Dr Nguyen Hoang Long	Deputy Director, Department of Planning and Finance, and Head of the Health Policy Unit, MOH
Dr Nguyen Van Cuong	Deputy Manager, National EPI program, MOH
Dr. Vu Van Chinh	Program Officer, Department of Planning and Finance, MOH
Dr. Duong Duc Thien	Vice Head, Health Policy Division, MOH
Ms. Nguyen Mai An	Officer, Department of Planning and Finance, MOH
Ms. Hoang Thi Giang	Accountant, Department of Planning and Finance, MOH
Ms. Dinh Thanh Thuy	Accountant, Department of Planning and Finance, MOH
Ms. Duong Thu Hang	Administrator, Department of Planning and Finance, MOH

GAVI HSS Tracking Study

Prof. Nguyen Thi Kim Chuc	Associate Professor of Public Health, Medical University of Hanoi, Researcher at the GAVI HSS Tracking Study
Mr Par Ericksson	Consultant, GAVI HSS Tracking Study

WHO

Dr Jean-Marc Olivé	Representative, Country Office for Viet Nam
Dr Lokky Wai	WHO Senior Program Officer EPI
Rebecca Dodd	Technical Officer, Health Policy, Development and Services
Graham Harrison	Technical Officer, Health Systems Development
Dr Hiroshi Murakami	Former EPI-Officer, WHO
Amanda Tyrrel	

UNICEF

Cao Tran Viet Hoa	MCH Specialist, Child Survival and Development Program

Annex 2 List of Documents reviewed

Documents consulted provided by the GAVI Alliance:

- GAVI HSS Proposal Guidelines
- HSS original proposal submitted by Viet Nam
- Letter of conditional approval
- Letter of final approval
- Letter providing clarifications by the GOV
- APR 2007 and linked IRC report
- APR 2007 Consolidated IRC report
- APR 2008 and linked IRC report

JAHR 2009. Status report by the Joint Annual Health Review. 02 April 2009.

Marcus Cox, Sam Wangwe, Hisaaki Mitsui, Tran Thi Hanh. Independent Monitoring Report on the Hanoi Core Statement. Final report November 2007

Marjorie Dieleman, Pham Viet Cuong, Le Vu Anh anf Tim Martineau. Identifying Factors for job motivation of rural health workers in North Viet nam. www.human/resources/health.com

Ministry of Health. Rapid Assessment of country efforts to address system wide barriers to immunization. Ministry of Health, Viet Nam, with support from the GAVI Alliance, WHO Regional Office in Manila and Unicef Country Team. Hanoi, September-October 2004.

United Nations Viet Nam. How external support for Health and HIV will evolve as Viet Nam becomes a Middle-Income Country. Report prepared by Javier Martinez, HLSP, September 2008.

Annex 3 Summary GAVI HSS Evaluation Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **eleven In-depth country case studies**. These are structured in such as way that independent consultants teamed with local consultants pay a visit to the country and document country experiences. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these. In 6 out of 11 country studies our evaluation will be complemented by the on/going work taking place in **6 GAVI HSS Tracking Studies** being conducted by the JSI-InDevelop-IPM research group.

We will also undertake 10 additional desk studies in a sample of countries using information available through the GAVI Secretariat and via internet.

Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions mentioned above.

Annex 4 Typology of areas for HSS support.

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA ($50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	*Internal process*	IRC-HSS
IRC recommendations	*Internal process*	IRC-HSS
Decision on proposals	*Internal process*	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring