Vietnam
Case Study

The Global Alliance for Vaccination and Immunization
Health Systems Strengthening Tracking Study

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September 2009

Acknowledgements

This study was prepared by a team from Hanoi Medical University with the technical support of Bernt Anderson and Pär Eriksson from InDevelop-IPM (Sweden) and Birger Forsberg from Karolinska Institutet, Stockholm. We would like to extend our deep gratitude to all the specialists involved into the GAVI HSS implementation process at the national and provincial levels, including those from the provinces of Ha Tay, Binh Dinh and Tra Vinh, who assisted in the field research. In particular, we would like to thank Dr. Nguyen Hoang Long, Vice Director of the Planning and Financing Department of the Ministry of Health and Focal Point for GAVI HSS in Vietnam, for his participation and great contributions. Finally, we would like to thank the Global Alliance for Vaccines and Immunizations for their financial and technical support in strengthening the health system in Vietnam

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Acronyms

ADs	Appropriate Single-dose Diluents
CHCs	Commune Health Centers
CHWs	Commune Health Workers
CSOs	Civil Society Organizations
cYMP	Comprehensive Multi-Year Plan
DHO	District Health Office
DoPF	Department of Planning and Finance
DOTS	Directly Observed Therapy Short Course
EPI	Expanded Program on Immunization
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
HCS	Hanoi Core Statement
HMIS	Health Management Information System
HPG	Health Partnership Group
HSS	Health System Strengthening
ICC	Inter-Agency Coordinating Committee
IMR	Infant Mortality Rate
IRC	Internal Review Committee
ISS	Immunization Support Services
JICA	Japan International Co-operation Agency
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millenium Development Goals
MMR	Maternal Mortality Rate
MOF	Ministry of Finance
MoH	Ministry of Health
MPI	Ministry of Planning and Investment
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organization
NIHE	National Institute of Hygiene and Epidemiology
PDoH	Provincial Department of Health
PHC	Primary Health Care

PMT	Project Management Team
PMU	Project Implemention Unit
PPMT	Provincial Project Management Team
PSMS	Provincial Secondary Medical School
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
VHWs	Village Health Workers
VND	Vietnamese Dong
WB	World Bank
WHO	World Health Organization
WG	Working Group

Executive Summary

The Global Alliance for Vaccines and Immunization (GAVI) was launched in 2000 to increase immunization coverage and reverse widening global disparities in access to vaccines. The partnership includes governments in industrialized and developing countries, the United Nations Children's Fund (UNICEF), World Health Organization (WHO), World Bank, non-governmental organizations (NGOs), foundations, vaccine manufacturers, and public health and research institutions working together to achieve common immunization goals. Health systems strengthening (HSS) grants are a relatively new addition to GAVI's funding portfolio. The GAVI Alliance created this new funding window in 2005 based on a multi-country study that identified system-wide barriers to higher immunization coverage. Currently, US $800 million is available from GAVI for HSS to help countries address difficult health systems issues such as management and supervision; health information systems; health financing; infrastructure and transportation; and health workforce numbers, motivation and training.

The GAVI Secretariat, along with its inter-agency HSS Task Team, sought an interim assessment of the HSS application and early implementation experience, with a focus on how countries are planning, budgeting and implementing their programs. With this purpose, GAVI awarded JSI Research and Training, Inc. (JSI) a contract to work with its partner organization in Sweden, InDevelop-IPM, to jointly implement a tracking study. The HSS tracking study has been designed to provide real-time evidence from the country level regarding the technical, managerial, and policy processes of GAVI HSS grant implementation. The tracking study spanned a period of 13 months (August 2008 to September 2009) and produced Case Studies in six HSS-recipient countries.

One of the six HSS-recipient countries is Vietnam. Although Vietnam is one of the poorest countries in the world, its vital health indicators are comparable to those of middle-income countries. Life expectancy is 10 years longer for Vietnamese women than would be expected given the country's level of development. Infant mortality (16.0 per 1,000 live births) is at the same level as countries such as Brazil, Algeria and Turkey. Vietnam has been successful in providing preventive health services, in controlling communicable diseases and in achieving good health for its population. This success has been achieved partly thanks to its extensive health care delivery network, which focuses very strongly on Primary Health Care (PHC), with a large supply of health workers and well-organized national public health programs.

Many of the economic reforms at the end of the 1980s (doi moi) touched the health sector. The commune health centers that previously depended on the agricultural work brigades for their financing then had to rely on the People's Committees. Funding became insufficient, and the PHC system was close to collapse. In addition, the lack of resources had a negative impact on the hospitals. Faced with this situation and in view of the limited resources, the Vietnam Government (the Government) introduced important health sector reforms, including user fees for health services, legalization of private medical practice and the deregulation of the pharmaceutical market. The number of private providers increased rapidly, but the Government was not well prepared to regulate and monitor the quality of their services. This, in combination with an under-funded public sector, had serious negative consequences for access to care for a large part of the population and for the quality of care in general. To overcome these problems, in 1992 the Government took over the payment of the health workers at the commune level and created a social insurance.

Methods used in the Tracking Study included the collection of both qualitative and quantitative information to track the implementation of HSS activities. Specifically, the study methods included key informant interviews with (a) directors of the concerned central-level Government organizations and in-charges at the provincial level; (b) staff at district and community-level health facilities and training institutions; and (c) trained village health volunteers. Across levels, over 55 health professionals were interviewed. In addition, the study conducted an extensive review of documents: (a) program plan and implementation documents related to the activities; (b) existing monitoring and supervision systems and tools at the central, provincial and district levels; and (c) training material developed and/or used and resources for supervision. Structured observations were made of the activity implementation. Data collection sources included central-level institutions, provincial health offices, secondary medical schools or colleges in the selected provinces, district public health offices and commune health centers (CHCs).

In-depth implementation tracking was conducted in 3 of the 10 target provinces: Hatay, Binh Dinh, and Tra Vinh. Within these districts, two communes were purposively selected with the assistance of provincial and district health authorities as high-, middle-, and/or lower-performing communes with respect to GAVI HSS implementation.

The Government has formulated a 10-year socio-economic development strategy and a strategy for people's health care for the years 2001–2010 with ambitious goals and targets, including substantially improving the country's human development index, providing prevention and treatment to all people, and increasing life expectancy to 70-75 years.

Within the health sector, a Health Partnership Group (HPG) was established in 2002 with the participation of all donors in the health sector. An Inter-agency Co-coordinating Committee (ICC) that includes key Ministry of Health (MoH) departments and partners is responsible for coordinating the implementation of immunization activities.

In 1981, the national immunization program was established as the Expanded Programme on Immunization (EPI). Traditionally, it had been implemented through the epidemic control system under the leadership of the National Institute of Hygiene and Epidemiology (NIHE) and the Provincial and District Preventive Centers. Today, the large majority of children are taken to private providers when they become sick. Even though immunization services are usually not offered by the private providers, the continued high immunization coverage reported from Vietnam suggests that people continue to use public facilities for this particular service.

The main priorities and activities of the Multi-Year Program for Immunization (cMYP) are increasing the cover of immunization and improving the quality of vaccines. The relation between the GAVI HSS and the cMYP is strong, and some of cMYP's objectives are directly supported by the GAVI HSS.

Program achievements by the EPI have been quite remarkable over the years, with DPT3 coverage around 95 percent. The EPI is an important contributor to the reduced burden of disease on children in the country. Although coverage is very high in Vietnam, there is great disparity between coverage rates in urban and rural areas, although that gap is being reduced.

The MoH received information from WHO about the possibility of applying for GAVI HSS support. The Director of the Department for Planning and Financing at MoH was given the responsibility to develop and submit a proposal to GAVI.

The proposal was developed within the regular organization of the MoH, with consultations with stakeholders and other ministries. A working group was set up with members from the Department for Planning and Financing, the National Institute for Epidemiology and Hygiene

(NIHE) and the EPI, as well as from other relevant MoH departments and in consultation with the provincial health authorities. The provinces participated in the proposal development.

The working group had a broad representation from MoH but no participation from other ministries or civil society. Stakeholders, including provincial authorities, were involved. HPG, ICC and external partners reviewed the application and provided comments and input, which were taken into account in developing the proposal. Technical assistance in the development was provided by an experienced international consultant through WHO. The draft proposal was discussed in meetings, where again the HPG and the ICC and external partners provided input that was taken into account in formulating the final proposal, which was submitted in October 2006.

It took approximately six months to develop the proposal (from May to October 2006) and send it to GAVI. It then took another six months for the review process, interaction with the Internal Review Committee (IRC), and the revision and completion of the proposal before GAVI approved it in June 2007. The funds for the first transfer arrived two months later, in August 2007. Overall, the application process was well laid out and implemented.

The GAVI HSS grant is working to improve the capacity of the health system through interventions in four areas, as shown in the table below.

Table 1: Cost of Implementing HSS Activities (US$): Overall Project Budget

Objectives	2007	2008	2009	2010	TOTAL
1. Village health workers	1,788,608	3,360,508	3,253,608	2,498,608	10,901,332
2. Community health workers	731,840	671,840	671,840	671,840	2,747,360
3. Management capacity	574,000	170,000	-	-	744,000
4. Policy development	190,000	290,000	290,000	110,000	880,000
Project management costs	332,800	201,800	192,800	221,800	949,200
TOTAL	3,670,748	4,727,648	4,461,748	3,535,748	16,395,892

The total budget for the GAVI HSS grant is US $16,395,892, with 66 percent going to Objective 1, increasing the number of village health workers (VHWs) and improving the quality of their work. Another 16 percent goes to Objective 2, improving the quality of work of community health workers (CHWs) and expanding the reach of community health centers.

The proposal responds very well to the assessments of the barriers to immunization and the problems of the PHC system. It also addresses the lower levels in the system: VHWs and commune health centers that have not been addressed before with broad health systems projects. The application is fully integrated in the Master Plan for Health Sector Development 2006-10 (the Plan) and aims to support the achievement of the targets specified in the Plan.

Ten provinces have been selected that have relatively low immunization coverage and poor socio-economic conditions. It should be possible to demonstrate improved immunization coverage at the provincial level during the life span of the GAVI HSS grant. The other health service output indictors should be followed closely at the provincial level; it is not unreasonable to believe that they will also be improved.

The proposal addressed major identified weaknesses in the health system at the commune and village levels, with the exception of the inadequate physical infrastructure. The Government is addressing the latter issue through a program of construction and equipment of health facilities, supported primarily by the Asian Development Bank, the World Bank and Economic Union (EU), with a focus on disadvantaged areas.

All the data in the proposal and in reports for the health service output indictors chosen for the GAVI HSS apply to the national level, while actual HSS implementation support is directed to 10 of the 64 provinces. This lack of alignment between the monitoring and evaluation indicators and implementation is worth pointing out. It is, therefore, not very likely that changes at the national level can be attributed to the GAVI HSS grant. The main strengths of the HSS proposal are that:

- It is well coordinated with the national health plan.
- It addresses broad system issues.
- It gives priority to less-developed districts.
- It supports concrete activities that are feasible and quite possible to implement.
- Its activities can be monitored through clear monitoring mechanisms and indicators.

Because the proposal review was lengthy, and, as a consequence, disbursement was delayed, the GAVI HSS project actually started in September 2007, approximately one year after originally planned. In the first year, activities occurred mainly at the central level, focusing on planning and management. After receiving GAVI funds at the end of 2007 and approval of the Minister of Health on the Annual Action Plan for 2008, the GAVI HSS project worked in collaboration with related stakeholders and the 10 project provinces to initiate activities. In spite of the delay, almost all activities under the Action Plan are underway, and there have been no further delays in implementation. On the contrary, the training activities are being implemented quickly and catching up with the original timeframe.

At the central level (MoH), a GAVI grant Project Implementation Unit (PMU) was established with 10 staff working full or part time for the project. The PMU is headed by a Director and Vice Director (GAVI HSS coordinator), both of whom are from the Planning and Financing Department. Much of the implementation of the components is the responsibility of the provincial and district levels. Training is mainly the responsibility of the provincial level, together with provincial secondary medical schools. The PMU has recruited four national consultants to support the HSS project (training, Monitoring and Evaluation [M&E], project management and procurement of the VHW kit).

The MoH/PMU has opened a foreign currency account within the MoH account system for receiving US dollars from GAVI and a national currency account to exchange the dollars for Vietnamese Dong. Within the country, the existing financial management system is utilized. Based on the plans of the 10 project provinces, PMU transfers money to the account of these provincial health offices. The Director/Vice Director of the provincial health office is responsible for this money. The money is further transferred to secondary medical schools and all districts within the provinces. At the commune level, the head of the commune health station, under the supervision of the commune people's committee, is responsible for the money.

One of the problems during early implementation was the transfer of the project management role at the district level from the Health District Office to the District Preventive Medicine Center in accordance with the new organizational structure of Vietnam's health system. This led to a short interruption of payments for project activities at the communal level. Another problem

was that funds requested annually were often lower than the amount actually received from GAVI. It has also been a bit difficult to reallocate funds for each activity and each province receiving GAVI HSS grant support.

The proportion of spending in 2007 is very low (1.5 percent) because money transferred from GAVI to the MoH arrived only in August 2007. Many activities that were supposed to be implemented in 2007 were moved to 2008. During 2008, 55 percent of the funds were spent—almost exactly the amount that had been planned to be spent during 2007. This indicates that there has not been any increase in spending in 2008 to catch up for 2007, which suggests that the project may still need four years to implement all activities and spend all funds; this would be achieved by the end of 2011, one year behind schedule.

The GAVI HSS is perceived as catalytic and innovative for the health system since it is the only donor-supported project that is aimed at strengthening the village and commune level of the system. The experiences from this support will guide the MoH in further developing activities aimed at strengthening the village and commune levels. The development of guidelines and training courses will be used even after the project period, and their use can be extended to the whole country.

A weakness with the GAVI HSS proposal is that it does not address the major health system challenge of reaching out to target groups with public health interventions through the most utilized part of the health system, namely the private sector. It is essentially left to the provinces to engage the private sector and civil society, namely, the NGOs. There are no specific policies to do this, and there does not seem to be any strong incentives for provinces and districts to work with NGOs. It is therefore likely that those organizations will be little involved in the GAVI HSS grant implementation and immunization activities in general.

In spite of the delay and some problems mentioned above, almost all activities under components 1 to 3 in the Action Plan are underway:

A nine-month training curriculum for new VHWs has been updated and further developed. Unfortunately, up to now, training materials have not been finalized and distributed to provinces. Even so, training of CHWs and CHCs have started, and 2,380 people have been trained in this program so far. Participants and district managers have, in general, expressed satisfaction with the training program. In addition, more than 69 training courses on EPI in practice have been conducted.

- Procurement procedures for more than 15,000 kits for VHWs have been completed.

- An extra monthly allowance to CHWs and VHWs, based on a performance-related incentive scheme with assessment and classification on a three-graded performance scale, has been introduced by the GAVI HSS project. More than 16,000 VHWs have received the allowance. This scheme is expected to increase competitiveness among VHWs and promote better performance. The study shows, however, that all surveyed CHWs and VHWs considered the allowance rather a ”spiritual” reward than a benefit. Almost all of them also obtained the highest score and allowance.

- The MoH and a local consultant on M&E have developed a manual/guideline for VHW and CHC monitoring and supervision in 2008, which is available for use. Training of M&E trainers is planned for 2009.

- GAVI HSS pays for supervision work that integrates overall supervision, not only immunization activities. This is seen as an advantage by managers. In 2008, on average, five supervisory visits were paid to lower-level facilities from district and provincial level staff.

- The MoH and local experienced health managers have developed and updated health planning and management manuals for provincial and district levels. Using this material, two training of trainers courses on health planning and management were organized by the MoH for health managers and planners from 10 project provinces.

- The fourth component in the HSS project, which aims at developing and introducing new policies and innovative solutions to strengthen the basic health care system, has made less progress. Two study proposals have been drafted by the Planning and Finance Department of MoH, and intentions are to implement them in 2009. The MoH and provincial health departments have also organized some workshops and seminars to assist the MoH in developing policies and new solutions to strengthen the health care system. Implementation of this component needs to be accelerated.

Recommendations

- The component on policy and innovative solutions in the GAVI HSS in Vietnam needs to be given higher priority and should be further strengthened. Clearly operational activities are easier to implement than are policy-oriented activities.

- There is a growing willingness in Vietnam to include other stakeholders in public health planning and coordination. This willingness should be strengthened with more regular meetings that include the GAVI HSS on the agenda for HPG and ICC. Province health bureaus should be further encouraged to coordinate with all partners in the province.

- Unfortunately, there is a total lack of provincial-level data in reports to GAVI, although the HSS is directed to only 10 of the 64 provinces. The indicators at the national level will not likely show any changes attributable to the HSS grant monies, so the monitoring system should be reworked so that implementation is monitored through the use of provincial-level data.

- Along those same lines, the GAVI HSS grant should be closely monitored using the data from the 10 provinces as it provides an opportunity to compare the development in the 10 HSS provinces with the other 54 provinces.

- Since the dominating modality for donor assistance in the health sector is the project modality, donors should increasingly comply with the Hanoi Declaration and move away from the project modality and harmonize requirements for project planning, formats for project proposals, and requirements for financial accounting and reporting.

- GAVI should maintain its objectives with HSS support, aimed at improving immunization coverage and child and maternal health. Vietnam represents a clear example of how broad public health support at the village and commune levels results in better immunization coverage and improved child and maternal health in rural areas.

- The GAVI HSS in Vietnam is well integrated into the overall Government structures, both at the highest and lower levels. Other countries could learn from this implementation model. At the same time, the Vietnam case illustrates the importance of full integration in planning of all concerned parties, in particular the planning of a national immunization program.

- GAVI HSS in Vietnam has a strong training component that is of general benefit to the whole health system at the basic level. Immunization activities are very likely to be strengthened by this. Gains are likely to be more long term.

I. Introduction

a). Description of GAVI HSS funding

The GAVI Alliance was launched in 2000 to increase immunization coverage and reverse widening global disparities in access to vaccines. Governments in industrialized and developing countries, the United Nations Children's Fund (UNICEF), World Health Organization (WHO), World Bank, non-governmental organizations, foundations, vaccine manufacturers, and public health and research institutions work together as partners in the Alliance to achieve common immunization goals in recognition that only through a strong and united effort can much higher levels of support for global immunization be generated.

Health Systems Strengthening (HSS) grants are a relatively new addition to GAVI's funding portfolio. Based on analytical work that examined system-wide barriers to expanded immunization coverage, the GAVI Alliance Board made new HSS support available to all GAVI-eligible countries in late 2005. Currently, US $800 million is available from GAVI for HSS to help countries overcome system-wide barriers that constrain productivity and progress in providing immunization and other child and maternal health services. By December 2008, 45 of the 72 countries eligible for GAVI HSS funding had their applications approved. These approved HSS applications have an associated financial commitment of US $532 million.

The purpose of GAVI HSS is to address those bottlenecks and system-wide barriers that impede progress in improving and sustaining high immunization coverage and the delivery of other maternal and child health care interventions. This innovative and potentially catalytic use of funds for health systems strengthening makes it possible for recipient countries to address difficult health system issues such as management and supervision, health information systems, health financing, infrastructure and transportation, health workforce capacity and incentives, public-private partnerships and involvement of civil society. With this opportunity, however, comes the challenge of monitoring GAVI's investment and learning from past and ongoing proposal and implementation processes so as to continue to improve them.

b). Objectives of the HSS Tracking Study overall and in Vietnam

The overall objectives of the GAVI Tracking Study are the following:

- The primary objective is to improve the quality of project design/applications and strengthen implementation.
- A secondary objective is to develop responsibility for and ownership of the monitoring of GAVI HSS and to promote its integration into ongoing processes at the country level.
- A tertiary objective is to establish a network of countries implementing HSS—beginning with the countries in the case studies—and to facilitate cross-country learning and capacity building among them.

The Tracking Study has been designed to provide real-time evidence from the country level regarding the technical, managerial, and policy processes for the successful implementation of GAVI HSS grants. The end products of this work will be a set of six country case studies, a multi-country workshop and a multi-country synthesis paper.

The objectives of the HSS Tracking Study in Vietnam have been:

- To study the overall management and coordination mechanism during implementation, alignment, harmonization, sustainability/complementarities of HSS funding, financial management and flow of funds, and monitoring and evaluation practices.
- To track progress in human resource training and follow the outcome of financial incentives for Village Health Workers (VHWs), to increase their numbers and to improve the quality of their work, and to track the progress in human resource training, particularly Commune Health Workers (CHWs) to improve quality and expand the reach of CHW.

The objectives of the Vietnam GAVI HSS proposal are:

- Objective 1- Increase the number of VHWs and improve the quality of their work
- Objective 2- Improve the quality of work of CHWs and expand the reach of CHCs
- Objective 3 - Strengthen health system management capacity
- Objective 4- Develop and introduce new policies and innovative solutions to strengthen the basic health care system

The main focus for the GAVI HSS Tracking study in Vietnam has been on GAVI HSS objectives 1 and 2 since they represent the most advanced in implementation and more than two thirds of the budget allocated to these two objectives.

c). HSS Tracking Study methods used in Vietnam

A set of indicators have been developed to assess the effects of the HSS work. Indicator tracking has been done in all ten target provinces. More in-depth implementation tracking has been conducted in three of the ten target provinces, Hatay, Binh Dinh, and Tra Vinh. Within these districts two communes have been purposely selected with the assistance of provincial and district health authorities as high, middle, and/or lower-performing communes with respect to GAVI HSS implementation. Each of the communes has been visited and surveyed for more in-depth studies of HSS implementation at the field level.

The detailed methodology used includes the collection of both qualitative and quantitative information to track the implementation of activities related to the objectives mentioned above. More specifically, the study methods include:

- Review of all available program plans and implementation documents related to the activities;
- Review of existing monitoring and supervision systems and tools available at all levels: central, provincial and district;
- Review of training materials developed and/or used and resources for supervision;
- Key Informants Interviews with the directors of the concerned central-level government organizations and in-charges at the provincial level;
- Interviews with district and community-level health facilities and training institutions;
- Interviews with VHWs who have been trained; and

- Observations of field work.

Data collection sources include central-level institutions, Provincial Health Offices, Secondary Medical Schools or Medical Colleges in selected provinces, District Public Health Offices and Commune Health Centers. Study provinces included Ha Tay (Figure 1, labelled #2); Tra Vinh (Figure 1, labelled #21) and Binh Dinh. A list of persons interviewed is presented in Annex 1.

Figure 1

d). Description of the review process

The study team reviewed documentation and collected information at the central, provincial, district and commune levels. On 20 July a national workshop to review and discuss the findings with key stakeholders took place in Halong Bay.

II. Country Context

a). Health situation, priorities and programs

Although Vietnam is one of the poorest countries in the world, its vital health indicators are comparable to those of middle-income countries. Life expectancy is 10 years longer for Vietnamese women than would be expected given the country's level of development. Infant mortality (16.0 per 1,000 live births) is at the same level as that in countries such as Brazil, Algeria and Turkey. Vietnam has been successful in providing preventive health services, in controlling communicable diseases and in achieving good health for its population. This success has been achieved partly as a result of an extensive health care delivery network with a very strong focus on Primary Health Care (PHC). The country has 9,806 commune health centers and more than 600 district hospitals, a large supply of health workers, and well-organized national public health programs, such as the Expanded Program on Immunization (EPI).

Table 2: Population, Economics and Health in Vietnam (2007)

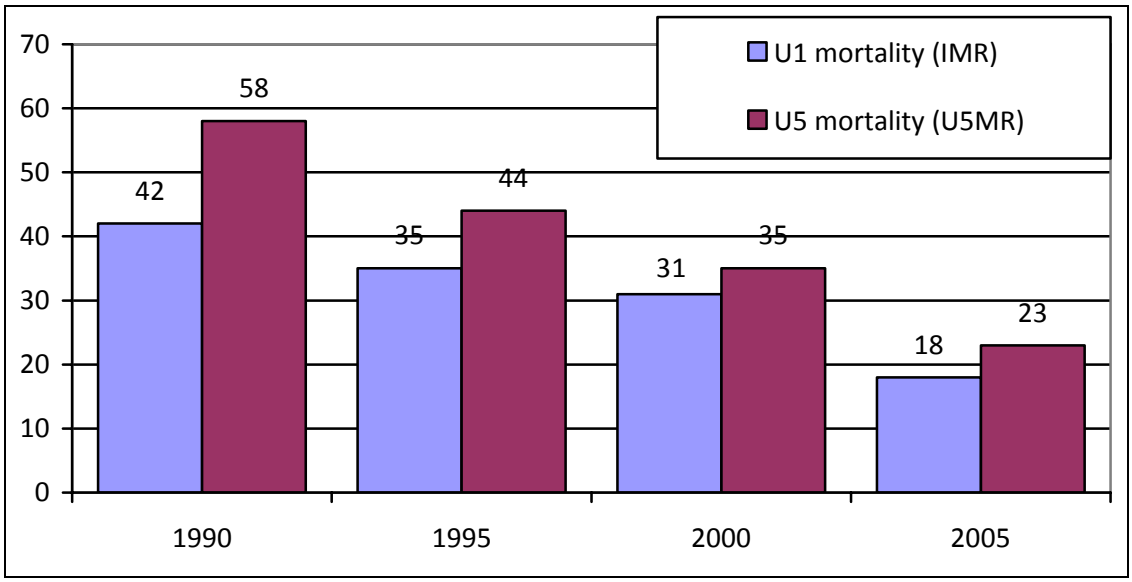
Population ('000)	84,155
GDP per capita (USD)	832
% of health budget in GDP	2.75
Health budget per capita (1000 VND)	370
Life expectancy	73.8
Infant mortality rate-IMR (%)	16.0
Under-five mortality rate-U5MR (%)	25.9
Maternal mortality ratio (per 100,000 live births)	75.0
% of commune health centers with a physician	67.4
% of villages having VHWs	84.9

Source: *Health statistic year book, MoH 2007*

Over the past two decades, Vietnam has seen remarkable improvements in overall mortality and child mortality. The under-five mortality rate decreased from 58 in 1990 to 23 in 2005, according to official MoH statistics (see Figure 2 below). According to a UNICEF survey in 2006[1], the under-five mortality rate was 27, and infant mortality was 18 in 2005, compared to 22 in 2006. There are large variations in under-five mortality between urban and rural areas: from 16 in urban areas to 30, on average, in rural areas. The country has seen a steady decline in overall mortality from deaths caused by communicable diseases compared to mortality levels from other causes of deaths, such a non-communicable diseases and injuries. In preventive work, the focus is increasingly placed on prevention of smoking, drug abuse and road safety. Still, the classic public health priorities, like immunization, are given due attention.

[1] MICS3 in Vietnam, Final report 2006

Figure 2. Infant and Under-five Mortality Rates in Vietnam (1990-2005)



Source: *Annual Health Statistics – MoH*

Structure of the national immunization program and recent Immunization coverage trends

The national immunization program was established as the Expanded Program on Immunization (EPI) in 1981. Historically, it has been implemented through the epidemic control system under the leadership of the National Institute of Hygiene and Epidemiology (NIHE), with Stations of Hygiene and Epidemic Control (now called Provincial and District Preventive Centers) taking responsibility for implementation at the provincial level. Those stations have been in charge of public health and have had little formal authority over curative services. Immunization services have, however, been part of regular public health service delivery and provided to all people free of charge. In particular, the well-penetrating primary health care services at the commune level have ensured high immunization coverage of children in Vietnam. With the introduction of new health policies at the end of the 1980s, which allowed for private practice, the system became less homogenous. Today, the large majority of children are taken to private providers when they fall sick. However, immunization services are usually not offered by private providers. The continued high immunization coverage reported from Vietnam suggests that people continue to use public facilities for this particular service. The Multi-Year Program for immunization (cMYP) has the following objectives:

- Strengthen the capacity and competence of EPI manpower at the basic level through regular training and retraining integrated into the training program at secondary health schools.

- Increase funding for immunization programs, ensuring an adequate supply of vaccines and basic resources for recurrent costs, with funding from Government and from external support (e.g., GAVI, UNICEF, JICA), which have introduced and expanded the use of new and underutilized vaccines such as the vaccine against Japanese encephalitis, the second dose of measles, and the booster for DPT vaccine and rubella.

- Further improve safe injection practices in order to achieve injection safety for the national EPI through the exclusive use of appropriate single-dose diluents (ADs) and safety boxes for all EPI injections.

- Strengthen data management, research and disease surveillance for more effective use of basic epidemiological information for planning of EPI activities and resource allocation, particularly for remote communities.

Relations between the GAVI HSS and the cMYP are very strong; in particular, GAVI GSS supports objectives number 1 and 4 of the cMYP. GAVI HSS will strengthen the basic health care system in order to increase immunization coverage and improve child and maternal health. The immunization program is under the direction of a National Manager, placed in the Ministry of Health (MoH). An Inter-Agency Coordinating Committee (ICC) for EPI Vietnam was formed in 2001. A Steering Committee for EPI exists at all four administrative levels: national, provincial, district and commune. Immunization coverage is shown in the following table.

Table 3: Estimated Immunization Coverage (percent of children 12-13 months immunized against the antigens)

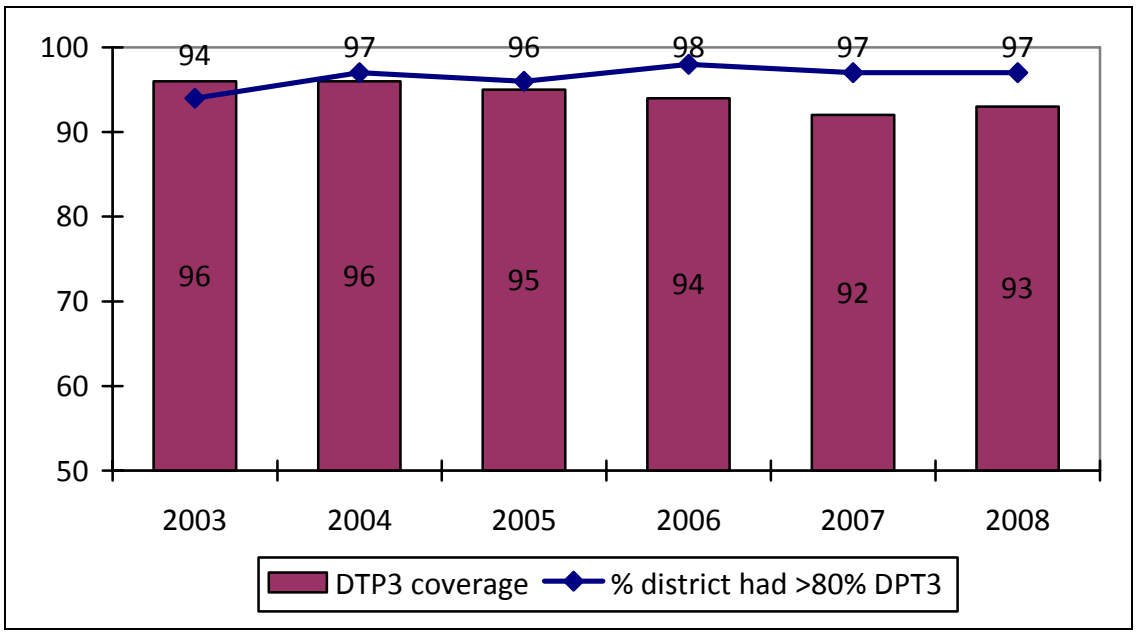
	2001	2002	2003	2004	2005	2006	2007	2008
BCG	97	97	97	96	95	95	94	92
DPT1	99	85	99	92	94	94	92	90
DPT3	96	75	99	96	95	94	92	93
Pol3	96	92	96	96	94	94	92	93
MCV	98	96	93	97	95	93	83	92
Hep B3	-	-	78	94	94	93	67	87

Source: *WHO/UNICEF Review of National Immunization Coverage - August 2008*

Program achievements have been quite remarkable over the years, with DPT3 coverage reaching approximately 95 percent (Table 3). EPI is an important contributor to the reduced burden of disease on children in the country. However, the coverage rate was lower than in previous periods. In 2000, there was a serious shortage of DPT vaccine due to the poor quality of vaccine imported from India (2 million doses were destroyed) and to problems of local production.

In 2007 and 2008, there were several severe adverse events following immunization in Vietnam that undermined the trust of the people in vaccinations and led to a decrease in vaccination coverage in general—and DPT 3 in particular—among children under the age of one in comparison to previous years. Nevertheless, the coverage rate remains over 90 percent (except for coverage of measles and HBV vaccinations). DPT3 coverage, which is very high in Vietnam, is shown in Figure 3. It must be noted, however, that immunization coverage differs between urban and rural areas, although that gap is narrowing.

Figure 3. Coverage of Children under 1 with DPT3 in Vietnam



Source: http://www.who.int/vaccines/globalsummary/immunization/countryprofileresult.cfm

Past GAVI Alliance Support, Achievements and Implementation Experience

Historically, Vietnam has received support from GAVI for Injection Safety (INS) in 2003-2006 and support of monovalent Hepatitis B vaccine for 2002-2007, including birth-dose.

In 2007, the first support for Immunization Services (ISS) investment, US $255,375, and the second tranche, US $255,375, were disbursed.

In 2007, Vietnam received support from GAVI for the following:

- A four-year ISS Phase 2 program (2007-2010)
- Measles second dose for 2008 to 2009, with the total amount of US $1,282,500 in cash, for the country's own procurement of WHO pre-qualified measles vaccines for catch-up of children under six years old
- Health Systems Strengthening for four years (2007-2010), with a total amount of US $16,285,000.

The total ISS receipt in 2007 was US $510,750, which was spent as follows:

- 43 percent at the district level,
- 38 percent at the provincial level,
- 12 percent at the central level, and
- 7 percent with the private sector for a training on the micro-planning workshop.

Figure 4. Summary of GAVI Support to Vietnam

GAVI support	2002	2003	2004	2005	2006	2007	2008	2009	2010
Monovalent Hepatitis B vaccine									
Injection Safety Support (INS)									
1st Immunization Service Support (ISS)									
2nd ISS									
Health System Strengthen Support									
2nd Measles Vaccine									

One ICC meeting was conducted in 2007 and two in 2008. Key discussions focused on the use of GAVI resources in measles immunization work in the Northern Provinces in 2007 and in the Highlands in 2008. The Health Partners Group and the Ministry of Health meet every quarter; ICC members are invited to these meetings.

b). Health care reforms and health systems strengthening efforts

Many of the economic reforms (*doi moi)* at the end of the 1980s touched the health sector. The commune health centers depended on the agricultural work brigades and the People's Committees for their financing. Funding then became insufficient, and the PHC system was close to collapse, negatively impacting the hospitals. Faced with this situation and in view of the limited resources, the Government introduced important health sector reforms, including user fees for health services, legalization of private medical practice and the deregulation of the pharmaceutical market. The number of private providers increased rapidly, but the Government was not well prepared to regulate and monitor the quality of their services. This had, in combination with an under-funded public sector, serious negative consequences for access to care and quality of care for a large part of the population. To overcome these problems, the Government took over the payment of health workers at the commune level and created social insurance in 1992. Still, many of the problems with access and use in the health sector during the last 10 years have still not been solved.

Developments in Health Sector Financing, Organization and Management

Health sector problems

The Government budget for health is low: US $3 per capita in 2000. This places Vietnam behind countries such as China and the Philippines. A large share of government health spending is on hospitals. Spending on public health services is greater in better-off provinces, as provincial health spending is partly financed by provincial governments. The budget allocated from the central level does little to address this inequality. The introduction of user fees in health facilities and the emergence of private practitioners and drug sellers have led to very high private spending on health (80 percent of total health spending). A significant part of this spending is concentrated on pharmaceuticals. The total annual health expenditure is between US $25 and

US $30 per capita and places Vietnam among those countries in Asia that spend the most on health care.

Since the exemptions system does not work properly and the social health insurance covers only a small portion of the population, there are increased inequalities between rich and poor in term of access to services. The poor utilize public health facilities less and spend less on health care in absolute terms, yet expenditure on health is a main cause of poverty. The low quality of care and the lack of patient-oriented and user-friendly approaches also prevent health services from reaching their full potential, even within the limited resources that exist. This situation is partly due to the low salaries of health staff. Finally, the lack of a strong legal framework for the private sector and of government enforcement capacity lead to an illogical use of resources; this is particularly true in the pharmaceutical sector, with large expenditures on unnecessary and sometimes useless drugs. In spite of this situation, preventive health programs continue to be delivered.

The Government's main challenge now is to protect the achievements gained in terms of health outcomes and health services and to ensure that the health system contributes fully to an improvement of the health of the population and a reduction in health inequalities. The Millennium Development Goals (MDGs) will be attained only if these two improvements happen.

Government Response

In its Ten-Year Socio-Economic Development Strategy and in the strategy for people's health care for the years 2001–2010, the Government has formulated ambitious goals and targets, including substantially improving the country's human development index, providing prevention and treatment to all people, and increasing life expectancy to 70-75 years.

The health strategy recognizes the important role of health and the need to invest in health for accelerated socio-economic development and for improving the quality of life of every individual. The strategy is based on four principles: (i) equity and efficiency of the health sector; (ii) the fight against the broad social determinants of bad health; (iii) integration of traditional and modern medicine; and (iv) an appropriate public-private mix with the Government in a position to protect the public interest.

Since 2007, the Ministry of Health—in collaboration with the World Bank, WHO, and other donors—annually convenes a "Joint Annual Health Sector Review," where the health strategy and progress are assessed. The Ministry of Health is developing a strategic plan for 5 years (2011-2015) as well as one for 10 years (2011-2020), both of which will be presented at the Joint Review later in 2009.

The broader policy initiatives have not affected immunization services over the years. The main vehicle for immunizing Vietnam's children remains the EPI.

On-going Health Systems Strengthening Efforts

The major sources of funding for health systems strengthening activities are presented in Table 4. The Government is by far the most important of those sources, followed by the Asian Development Bank (ADB).

Table 4. Sources of Funding (including Government, GAVI & Other Main Contributors) (Million USD)

Funding Sources	Year of GAVI applica-tion (2006)	Year 1 of implem enta-tion (2007)	Year 2 of implem enta-tion (2008)	Year 3 of implem enta tion (2009)	Year 4 of implem enta tion (2010)	Total
1. Government	1,538.6	1,797.4	2,025.8	2,289.0	2,587.0	10,237.8
2. GAVI (HSS proposal)	0.0	2.24	6.04	5.22	2.88	16.4
3. Others sources	97.91	111.42	90.00	75.00	51.00	425.3
▪ ADB	26.56	53.65	30.93	30.00	20.00	161.1
▪ WB	4.93	24.30	24.30	24.00	24.00	101.5
▪ EC	1.61	3.28	3.00	3.00	3.00	13.9
▪ Others	64.80	30.20	31.78	18.00	4.00	148.8
Total funding	**1,636.5**	**1,911.1**	**2,121.8**	**2,369.2**	**2,640.9**	**10,679.5**

Source: Data from *Evaluation and Projection of ODA and Loans, MoH – 2004*

Other global health initiatives active in the country with health systems focus

The Global Fund on AIDS, TB and Malaria (GFATM) has provided support to HIV/AIDS, tuberculosis and malaria control in Vietnam. As part of this effort, TB and malaria control projects have conducted numerous training courses for Commune Health Workers (CHWs) and VHWs. The TB control program has trained two to three health workers in each CHC, and one VHW in about 20 percent of the country's villages. The malaria control program has trained one to two health workers in each CHC and one VHW in each village in 23 project provinces. However, all these courses specifically target TB and malaria control, e.g., identification of TB and malaria suspects and diagnosis of cases, management of TB and malaria cases at CHCs and in the community, and IEC activities on TB and malaria control. No discussion of the health system has been included in these courses.

Coordinating bodies in the health sector

A Health Partnership Group (HPG) was established in 2002 with the participation of all donors in the health sector. As of 2006, the HPG was composed of the MoH, WHO, UNICEF, UNDP, World Bank, ADB, EC, Sida, JICA, Embassy of Luxemburg, Royal Netherlands Embassy Hanoi, and Save the Children US. The HPG meets every three months to discuss common priority issues and concerns related to the health sector. These meetings are normally co-chaired by a Vice-Minister and a representative selected by the donor community.

Donors align with Vietnam's strategies and commit to use strengthened country systems; Vietnam strengthens institutional capacity with support from donors; donors increasingly use government systems. *- Hanoi Core Statement*

In June 2005, the Government of Vietnam and the donor community in Vietnam approved the "Hanoi Core Statement" (HCS) on Aid Effectiveness, Ownership, Harmonization, Alignment and Results. Donors and the Government agreed to improve project management alignment. An Inter-agency Coordinating Committee (ICC), which includes key MoH departments and partners, is responsible for coordinating the implementation of activities in specific areas of the health sector. With regard to immunization support, major functions and responsibilities of the ICC are as follows:

- Review and endorse annual and four-year plans, country proposals and reports and other relevant documents prepared by the National EPI.
- Coordinate and manage the implementation of EPI/UCI and other EPI-related goals in the whole country to ensure that HSS-funded activities conform with national plans and the principles of harmonization and alignment.
- Mobilize funding and assist in planning and monitoring in priority areas as determined by the National Steering Committee for EPI.
- Steering Committees for EPI have also been established and are functioning at four levels, from the national to the communal level, to guide and monitor the implementation of EPI.

III. GAVI HSS Proposal Development and Application Process

a). Chronology of the country's GAVI HSS application

The history of Vietnam's GAVI HSS proposal is summarized in Table 5.

Table 5. Chronology of Activities during the GAVI HSS Application Process

Time	Activity
May 2006	MoH participated in the WHO-GAVI workshop in Manila on development of HSS proposals.
May 2006	MoH created a working group to prepare the proposal, with MoH's Departments (NIHE, EPI, MOF, MPI) as the focal point.
10-26 July 2006	A WHO-GAVI consultant visited Vietnam for two weeks, engaged in field visits and provided consultancy to the working group.
July 2006	A situation assessment was conducted in selected provinces.
August-September 2006	The Working Group produced draft proposals.
September 2006	Comments from HPG and others (ICC) were collected.
September 2006	The drafts were forwarded to GAVI for informal review.
September-October 2006	The MoH finalized the proposal with the WHO-GAVI consultant.
October 2006	The proposal was signed by the MoH and Ministry of Financing.
3 November 2006	The proposal was submitted to GAVI.
13 June 2007	GAVI, after review of the proposal, sent its official letter to the MoH, stating its approval of the VN HSS proposal with a total budget of US $16,285,000 for the 2007-2010 phase.
14 September 2007	The Prime Minister issued the official document 1322/TTg-QHQT, giving permission to the MoH to administer the GAVI-HSS project.
9 August 2007	The first funds arrived.
13 February 2008	The second funds arrived.
2 February 2009	The third funds arrived.

The MoH received information from WHO about the possibility of applying for GAVI HSS support. The Director of the Department for Planning and Financing at MoH was given the responsibility to develop and submit a proposal to GAVI.

The proposal was developed within the regular MoH organization, with consultations with stakeholders and other ministries. The proposal was submitted to GAVI in November 2006, finally approved in June 2007, and the first disbursement of funds was made in August 2007.

b). Coordination and decision-making

Roles of the Health Sector Coordinating Committee, MoH Divisions, National Immunization Program, ICCs and Other Stakeholders

To oversee GAVI HSS support, a Health Sector Strategic Committee was formed composed of the Minister of Health and representatives from departments and institutions of the Ministry of Health, including the Departments of Planning and Finance, Science and Training, Organization and Manpower, Reproductive Health, Treatment, and International Cooperation; the Health Strategy and Policy Institute; and the National Institute of Hygiene and Epidemiology.

An Inter-agency ICC for EPI Vietnam was formed in 2001. Currently, the ICC has the following members: EPI/MoH, UNICEF, WHO, JICA, and PATH. The ICC is responsible for coordinating and guiding the use of GAVI ISS support.

A group of core MoH departments and representatives from the Ministry of Planning and Investment (MPI) and Ministry of Finance (MOF) headed by the Health Minister (MoH Health System Core Group) participated in the project development process. This group includes key departments/institutions related to health system development, including the Departments of Planning and Finance; Organization and Personnel; Science and Training; International Cooperation; Reproductive Health; Health Strategy and Policy Institute; and National Institute of Hygiene and Epidemiology. All core group members have already provided comments on the HSS proposal and signed the HSS application form submitted to GAVI.

A Health Partnership Group (HPG) was established in Vietnam in 2002 with the participation of all key donors in the health sector (WHO and MoH Department of International Cooperation are the secretariat of the HPG). The HPG has scheduled meetings every six to eight weeks to discuss common priority issues and concerns related to the health sector. The HPG meetings are normally chaired by a Vice-Minister, co-chaired by a representative selected by the donor community, and attended by HPG members, representatives from MPI, and concerned MoH departments, among others. The HSS proposal (as well as these responses to GAVI Board conditions) was presented at the HPG meeting. In addition to useful technical comments for the proposal, the HPG members also provided the MoH with information about their projects and/or support to the project provinces.

During HSS project development, information from all donors was collected about their support related to HSS in the 10 project provinces through the mechanism of a form distributed to all concerned donors. Through this effort, overlaps in support from other donors in the coverage area were avoided. Specifically, major HSS projects during recent years and up to 2010 were identified and included in the application. At the local level, provinces are asked to invite NGOs associated with the health system to participate in project activities (e.g., sharing experiences, sharing materials, participating or conducting training courses).

Nature and Level of Technical Assistance (TA) during the Process

WHO contracted an experienced international consultant for a period of 2 + 2 weeks to develop the HSS proposal. The consultant had extensive previous experience in GAVI upper-level management. He was part of the working group that developed the proposal and advised the group and assisted in writing parts of the proposal. He was also instrumental in bringing in staff from both the EPI and the Training Department, thus widening the group and strengthening the links to both the EPI program and the training implementer. The working group's analysis of the barriers was based on a previous study by GAVI supported by Norway.

Process

Initially, a small working group with people from the Planning Department, Department of Therapy, the Maternal and Child Care Department and the International Cooperation Department was established to develop the proposal. EPI staff were disappointed with this approach since they were used to developing all GAVI applications themselves.

The activities were identified first through reviews of health system development strategies and policies, different health system assessment reports and EPI assessment reports, including health-system-wide barriers to EPI. The working group then discussed the activities with related departments of the MoH (Organization and Manpower, Science and Training and Treatment) and the National EPI Program. In addition, meetings about the proposed activities and priorities were held with experienced health staff at the provincial, district and commune levels. Finally, comments were solicited from HPG members, ICC members and other ministries to confirm and prioritize the activities.

Decision-making process

Participants in the HPG were highly supportive of the project and its proposed activities/content, which they thought were clearly in line with the strategy and priorities of the Government in health system strengthening. The following is summary of recommendations for improving the proposal from the HPG meeting:

- The personnel to be provided training should be appropriately selected to ensure participation by ethnic minority groups.
- Financial support, including incentives for VHWs and supplemental recurrent budgets for CHCs, should be coordinated to ensure that (1) the support will not create imbalances in payment among the primary health care staff across districts and provinces, and (2) the results gained through the proposed support are sustained.
- The project should have built-in mechanisms to promote collaboration among the various levels and two-way communication of information from the monitoring and supervision activities.
- There should be a broader policy analysis which reflects the Government's updated health system reform program, including health insurance and health financing issues, an analysis which will help develop alternative approaches to the problems identified.

When the proposal was discussed at the EPI ICC meeting, there were several comments and suggestions:

- Some information could be inserted on the presence and mandate of the collaborators at the village and commune level and the possible windows of opportunity to create synergies with the VHWs and CHCs.

- There should be some explanation as to how the replenishment and financing of the consumables in the kits will be organized.
- There should some refinement regarding the budget line for monitoring and supervision so that this type of budget would be more effectively linked to the uneven sizes and the traffic conditions across project provinces.

Participants from the 10 provinces who attended another workshop also provided important comments, some relating to incentives and training (below):

- A key policy issue that should be given due attention is how to make the VHWs stay in their jobs after training. There have been a number of occasions when VHWs have undergone three months of training and then left the job because of low allowances. Encouragement to remain in their jobs should be effective if the monthly financial support for VHWs were increased to approximately US $6.
- There should be a strong commitment to ensure that the VHWs go back to serve their communities after receiving the training. The commitment should come not only from the trainees themselves but also from local health authorities.

MoH response in developing the proposal

Most comments from the HPG, the ICC and all of the comments from the workshop with participants from the 10 provinces could be incorporated into the final proposal from MoH. Some comments were of a more general nature and dealt with issues that cannot be solved by this project; rather, they are best described as guidance to MoH for implementation and further policy development.

IRC comments and conditions regarding the proposal

The IRC had a number of comments and conditions relating to the proposal, which MoH responded to and developed in some parts of the application. (All comments and responses can be found in the application.) One question brought to the attention of the IRC related to the establishment of a Program Management Unit (PMU), a move not recommended by GAVI, which questioned why HSS support could not be managed through existing structures. The MoH responded that it is necessary for the MoH to establish a PMU at the central level for the GAVI-HSS project at this time since this is the established procedure for all external projects in all sectors. However, the MoH has established only a small and simple PMU with a high degree of integration with the current system of the MoH. The PMU is based in the Department of Planning and Finance (DoPF) of the MoH, using mostly the current DoPF staff. Planning, implementation and monitoring of the HSS project will be integrated into the existing system of the DoPF and the wider MoH.

Another question raised relates to the need to establish health service output indicators and clarify the link between the targets and the activities. Indicators should show progress over time. District-level performance should be included in the indicators and annual progress report. In response to this concern, the MoH developed and presented health service output indicators and expected progress over time in the 10 project provinces.

The MoH also explained that district-level performance will be evaluated using data from the Health Management Information System, which collects data from commune levels (by commune health centers), and is reported to the District Health Office, then to the Provincial Department of Health and the MoH annually. Therefore, district performance indicators of the project provinces will be included in the annual report of the HSS project.

A third question from the IRC was how the recurrent costs (particularly for VHW incentives and CHC supplemental funds) will be taken over in four years, and what the mechanisms are to ensure timely refill of consumables of the kits for VHWs.

The MoH responded that in the recent policy and strategy documents[2], the Government of Vietnam has clearly stated that it will increase state spending for health more rapidly in the coming years. According to the Medium-Term Expenditure Framework (MTEF) for the health sector, the share of Government spending for health among GDP will increase from 5.56 percent in 2006 up to 8.23 percent in 2009. At the same time, the five-year socio-economic development plan has set a target for annual GPD growth of 7.5 percent for the period 2006-2010. With high economic growth and Government commitment to higher spending for health, it is clear that Government spending for health—both in absolute terms (amount) and relative terms (share of health expenditures among total Government expenditures)—has been and will be considerably increased in the coming years. In absolute terms, the Government budget for health for 2007 is 21 percent higher than that for 2006 (while GDP growth is 7.5 percent).

c). Stakeholder perceptions

Persons interviewed were of the opinion that the most urgent health systems problem was the functioning of the Commune Health Stations, the lowest-level entity in the health system and the first contact point for the populace. The services they provide are under-utilized, their location is not always well selected, and the quality of service is often not sufficient to solve the health problems. Nevertheless, the EPI program may be the program that functions best at this level.

To strengthen the part of the health system that is aimed at achieving better immunization coverage, the chosen activities in the HSS proposal are probably the right ones, as they focus on the VHWs and partially on the Commune Health Stations. Participants in the HPG were highly supportive of the project and its proposed activities/contents, which they thought were clearly in line with the strategy and priorities of the Government in health system strengthening. No other donor support goes to the village or commune level, so the GAVI HSS is helping the MoH to break new ground.

Stakeholders also expressed the opinion that the quality of the current training must be assessed before more training is done. There is little information about the quality and results of the training courses, including the ability of VHWs to absorb the content of the training or the usefulness of the training to the participants. Stakeholders also expressed concerns about the sustainability of the strategy of increasing payments to VHWs, which could eventually turn them into health employees.

d). Suggestions for improving the proposal development and application process

Although no suggestions to this effect have been received from the persons interviewed, it is obvious that civil society organizations (CSOs) should participate. There was no participation by

[2] The Resolution number 46-NQ/TW dated 23 February 2005 of the Central Party; Decision number 153/2006/QDD-TTg, dated 30 June, 2006 of the Prime Minister on comprehensive master plan for health sector up to 2010, and with a vision to 2020.

the CSOs in the development of the HSS proposal. The review and the comments by the ICC, the HPG and IRC were useful for finalizing the proposal, and this kind of review should be continued.

e). Analysis of the GAVI HSS proposal development/application process

Overall, the application process was well laid out and implemented. Most stakeholders at the national level were involved. However, the EPI was less involved than they had wanted to be. Implementers at the provincial level were involved in a consultation process, which included a national meeting in Halong Bay.

It took about six months (from May to October 2006) to develop the proposal and send it to GAVI. It took another six months for the review process, interaction with the IRC, and the revision and completion of the proposal before approval by GAVI in June 2007. The funds for the first transfer arrived two months later, in August 2007.

The working group had a broad representation from the MoH, but no participation from other ministries or CSOs.

There seems to have been a very good and active review process, involving the HPG, ICC, a provincial workshop and the ERC. The three questions raised by the IRC seem to be very relevant; specifically, the need to develop health service output indicators for the monitoring of output from the health sector. It appears that the review process contributed significantly to the quality of the proposal.

On the topic of the sustainability of the proposed support, provincial representatives think that given the steady socio-economic development, it is quite feasible that local governments will be able to take over the support when the project is due to end.

The GAVI proposal development and application process followed the guidelines given by GAVI. Stakeholders—including provincial authorities—were involved, the application was reviewed by the HPG, and the ICC and external partners provided comments and inputs. All comments were taken into account in the development of the proposal. Technical assistance was provided by an experienced international consultant through WHO. The decision-making process in HSS involved several bodies in the following ways:

- The MoH Health System Core Group provided comments on the HSS proposal and signed the HSS application.
- The HPG provided technical support and received information about project implementation.
- GAVI ICC developed the proposal and was responsible for its implementation.

IV. Content and Characteristics of the GAVI HSS Application

a). Description of the country's GAVI HSS approach

Primary themes/objectives and budget allocation

The GAVI HSS funding aims to improve the health status of the population, in particular, children, through sustained and increased coverage of quality basic health services, including immunization. This will be achieved through an improvement of the health work force capacity and the health system at the district, commune and village levels, supported by improved management capacity at all levels to achieve measurable improvements in the output of the health services at the lower levels. Expected outcomes to be achieved on a provincial level have been identified, thereby improving equity between provinces at different socio-economic levels.

The capacity of the health system to achieve these outcomes will be improved through intensified efforts in four areas:

- Strengthening the capacity of VHWs,
- Strengthening the capacity of the commune health centres (CHCs),
- Reinforcing management, supervision and monitoring at all levels, and
- Developing and introducing new policies and innovative solutions.

For each of the areas above, targets have been established with process indicators and a monitoring system that will track these indicators and the achievements towards health services outputs on a regular basis.

In the health policy documents of Vietnam, consolidating and strengthening the basic health care network is always among the highest priorities. The strengthened basic health care network will contribute to overall improvements in the health care system in general. Therefore, the project has proposed a range of interventions, mainly to strengthen the basic health care network in Vietnam (commune and village levels), including training, retraining, monitoring and supervision, recurrent costs support, and allowances to promote better performance of VHWs. These interventions will improve the capacity of CHCs and VHWs in a comprehensive way.

The focus of the project is on CHCs and VHWs because they play a critical role in the success of PHC and public health programs in Vietnam. Most of these programs aim at improving the health status of children and women. Therefore, with reference to the functions of VHWs, strengthening CHCs and VHWs will contribute considerably to improvements in child and maternal health.

For the period 2007-2010, the project will be implemented in 10 (out of 64) provinces in different parts of Vietnam. Selection of the provinces, by regions, for the first phase (2007-2010) is based mainly on the following criteria:

- Socio-economic status of the provinces, including the number of difficult-to-reach communes and extremely difficult-to-reach villages[3].
- Immunization coverage (full-immunization, BCG, Polio, DPT and measles coverage) from Annual Health Statistics of the MoH (2005) are used to select project provinces. Priority has been given to provinces with lower coverage of immunization.
- 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 (see map in Figure 1).

This proposal addresses major identified weaknesses of the health system at the commune and village levels, not including the inadequate physical infrastructure. The Government is addressing this issue through a program of health facilities construction and equipment, supported primarily by the Asian Development Bank, the World Bank and the EU with a focus on disadvantaged areas. It has, therefore, been considered efficient and in line with GAVI principles for this proposal to address the other major constraints (including human resources development; management capacity strengthening, including HMIS; and basic supplies) and to coordinate closely with other projects and programs in the concerned provinces.

Although the focus of the project is on the basic health care level (village, commune and district levels), the project interventions will closely link to the broader health system and improvement of child health.

The budget is divided in the following way: 45 percent on human resources development, 4 percent on equipment, 27 percent on recurrent cost provision, and 24 percent on management, monitoring and policy development. The complete budget is as follows:

Table 6. Cost of Implementing HSS Activities (US$): Overall Project Budget by Year

Objectives	2007	2008	2009	2010	TOTAL
1. VHWs	1,788,608	3,360,508	3,253,608	2,498,608	10,901,332
2. CHWs	731,840	671,840	671,840	671,840	2,747,360
3. Management Capacity	574,000	170,000	-	-	744,000
4. Policy Development	190,000	290,000	290,000	110,000	880,000
Project Management	332,800	201,800	192,800	221,800	949,200
TOTAL	3,670,748	4,727,648	4,461,748	3,535,748	16,395,892

The total budget is US $16, 395,892, with 66 percent going to Objective 1, which is to increase the number of VHWs. Another 16 percent goes to Objective 2, which is to improve the quality of work of CHWs and expand the reach of CHCs. A more detailed budget is attached as Annex 4.

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

The budget is based on cost per item used in other projects and in the budgeting for the annual budget. Thus, costs for training are based on number of participants, remuneration for the trainers, costs for the training facility, etc., all well-known costs. Costs for procurement are based on the latest procurement of similar items. Payments to VHWs and CHCs are fixed sums and based on the actual number of VHWs and CHCs.

Key activities, their scope, selection of geographic areas/targeting, and expected results

Specific Objectives 1 to 3 below relate to the 10 project provinces while Objective 4 is nationwide.

1) Increase the number of VHWs and improve the quality of their work.
    a. Activities include updating and distributing curriculum and training materials for VHWs, organizing the training courses; providing basic equipment kits, raising the allowances and making supervisory visits.
2) Improve the quality of work of CHWs and expand the reach of the CHCs.
    a. Activities include organizing training courses for CHWs on reproductive, maternal and child health, on EPI in practice, and on supervisory visits; providing a cart; and providing CHCs with monthly support for recurrent costs.
3) Strengthen health system management capacity.
    a. Activities include developing Health Planning and Management Manuals for provincial and district health officers; organizing Training of Trainers (TOT) courses on Health Planning and Management; organizing training courses on Health Planning for district health officers; piloting and updating the EPI-HMIS software for CHCs; and providing computers, printers and accessories for districts and pilot communes.
4) Develop and introduce new policies and innovative solutions to strengthen the basic health care system.
    a. Activities include establishing an Innovation Fund and modality for planning, implementing, monitoring and gathering experiences; organizing workshops, seminars, and policy studies; and implementing policy-oriented studies.

Relationship to past assessment findings and recommendations of themes/activities

It is expected that the achievement of the targets will result in the improvement of the health system outputs and ultimately in health status improvements, especially for children. Some important past assessments, reviews and studies of the health system are listed in Annex 2.

The major recommendations in these assessments are:

- Stronger political and financial commitment: A significant increase in the proportion of Health budget/National budget; increase allowances for VHWs (with a revision or amendment of Circular No. 51).
- Investment in human resources in the framework of a comprehensive human resource strategy to strengthen EPI manpower and skills: The human resource strategy should encompass personnel management, training and the introduction of supportive supervision to facilitate in-service training and problem-oriented feedback in all aspects of EPI through supportive supervision, and setting up appropriate policies in the training and utilization of VHWs from the ethnic minorities in the localities.

- Improvement in the physical infrastructure and equipment/access to primary health care: This should be done by upgrading the infrastructure and technical skills for districts and CHWs, especially in difficult areas, to create more favorable conditions for the population to access PHC.
- Strengthening of management and monitoring and information systems: National and regional staff need to be trained in both the content and method of supportive supervision to transfer needed skills and practice; improvements in the quality and utilization of data collected; and the involvement of the private sector in the Health Management Information System (HMIS).
- Promotion of social mobilization/demand creation: Increased financial resources are needed for the EPI to cover new vaccines and relevant supplies and to facilitate the implementation of EPI by outreach where needed; annual plans should be developed at all levels of the EPI, including funding for transport, supplies, cold chain needs (including replenishment of ice if needed) and per-diem payments.

The areas for development within the HSS support are all well in line with the identified barriers and the recommendations. The HSS will address all of these recommendations except the one relating to infrastructure. The primary health system, particularly the functioning of VHWs and the CHCs, will be strengthened with training, equipment and some financial resources and supportive supervision to strengthen links to higher levels and make possible continuous training.

Management and financial arrangements proposed

The project implementation will be under the responsibility of the Planning and Finance Department of the MoH, which is monitored by the national-level health sector coordinating body, the HPG, key MoH departments and the ICC.

The HSS is managed by a Project Implementation Unit within MoH, reporting to the Director of Planning and Finance. The activities are implemented through the regular health organization in 10 provinces. The financial procedures of MoH are used for the HSS. MoH is responsible for reviewing and approving plans and budgets. At the central level, the Program Management Team (PMT) is responsible for preparing annual project plans and budgets and submitting them to the DoPF, the focal department for reviewing plans and budgets of the MoH. The DoPF will organize an appraisal meeting with the relevant departments and the PMT. After being reviewed, the plans and budgets will be submitted to the Minister of Health for final approval. Vietnam's financial year runs from 1 January to 31 December and the same time period is applied to GAVI funds.

In order to receive the funds, the MoH/PMU has opened a foreign currency account within the MoH account system for receiving US dollars from GAVI and a national currency account to transfer US dollars to Vietnamese Dong. Within the country, the existing financial management system is generally used. The budget from PMU's account is transferred to the existing account of the Department of Health for carrying out the project activities within provinces.

Reporting on the use of funds is done by collecting and analyzing data on the progress of the project implementation. The data will be collected within routines for health planning and monitoring in Vietnam. First, progress reports are done by provinces. After approval from the Provincial Department of Health, the reports are submitted to PMT/MoH. The PMT is then responsible for transforming province reports into a project report in accordance with requirements of the GAVI.

The project will be financially audited by an independent auditing company twice, once at the beginning of the third year (auditing the first two years of activities) and again within one year after the close of the project. Costs of auditing will be covered from project management costs.

b). Monitoring and evaluation plan

Key indicators, targets and processes

A base-line study was carried out (2008) and will be followed by a mid-term survey and an end-of-project survey. District-level performance will be (1) evaluated using data from the HMIS, which collects data from commune levels (by CHCs); (2) reported to the District Health Office; and (3) then reported to the Provincial Department of Health and MoH annually. In this manner, district performance indicators of the project provinces will be included in the annual report of the HSS project.

c). Attention in the HSS application to core GAVI HSS principles

Country-aligned and country-driven

The HSS plan is fully integrated into the Master Plan for health sector development 2006-10 and aims to support the achievement of the targets specified in the Plan. As described earlier, other donors are supporting health system strengthening, but most focus on higher levels than on specific interventions such as immunization. During HSS project development, in addition to the information from MoH, information was collected from all donors about their support related to HSS in the 10 project provinces. A form was created and distributed to all concerned donors to collect information. In this way, overlaps were avoided with support from other donors in the coverage area.

At the central level, NGOs are invited to participate in the review meetings of the project organized by the MoH. The NGO member in the HPG (only one) is informed about the GAVI-HSS project issues and progress in its meetings. At the local level, provinces are requested to invite NGOs related to health system strengthening to participate in project activities (e.g., sharing experiences, sharing materials, participating or conducting training courses).

Harmonization

At the central level, the HSS is managed by a PMU, but at the provincial level, the existing MoH organization and system (that is, the existing financial management system) are used. The budget from PMT's account is transferred to the existing account of the Department of Health for carrying out project activities within provinces.

Reporting on the use of funds is done by collecting and analyzing data on the progress of the project implementation. The data is collected within the routine system for health planning and monitoring in Vietnam. Other global and bilateral initiatives use the national systems to varying degrees.

Results-oriented

The areas for development within the HSS support are all well in line with the identified barriers and the recommendations. The primary health system, particularly the functioning of VHWs and the CHWs, will be strengthened with training, equipment and some financial resources; and supportive supervision will strengthen links to higher levels and provide continuous training.

Resources - predictable and additional

Funding from GAVI is additional to the MoH budget. Since the GAVI funds were delayed almost one year initially, predictability has been low to medium. Now funding may be more regular.

Inclusive and collaborative

All stakeholders have been informed about the HSS proposal and to some extent have participated in the proposal's development. Implementation will be the responsibility of the Government health system, but provinces are encouraged to inform civil society and other stakeholders at the provincial level and seek collaboration whenever possible.

Catalytic

The Ministry of Planning asked the HSS to include a PMU since this was standard procedure for foreign assistance. The working group for the HSS, having in mind the Paris Agenda, reached a compromise with a PIU that was integrated in the MoH structure. A PMU was thus created at the central level for the GAVI-HSS project according to the established procedures for all projects. Planning, implementation and monitoring of the HSS project will be integrated into the existing system of the Department of Planning and Financing.

At the provincial and district levels, no PMUs have been established. The existing health care systems at these levels will be used to plan, implement and monitor the HSS project activities. The Provincial Department of Health (at the provincial level) and the District Health Office (at the district level) will be responsible for project implementation.

Sustainability-consciousness

The overall policy of the Government of Vietnam is to increase expenditures on health in the coming years, both in absolute terms and in relative terms within the Government budget. The share of Government spending for health among GDP is expected to increase from 5.56 percent in 2006 to 8.23 percent in 2009. Government policy is to give higher priority in the coming years to preventive medicine, the basic health care network (communes and villages), and health care in difficult-to-reach provinces and for poor people. With the economic resources available to the Government and the political will to increase spending in health, it is not unreasonable to expect that the Government will be able to assume responsibility for the recurrent costs financed by the HSS, particularly the VHW incentives—and extend them to the whole country—and the supplementary funds to the CHCs.

d). Analysis of the application's strengths and weaknesses

The proposal accurately reflects the assessments of the barriers to immunization and the problems of the PHC system. It also addresses the lower levels in the system, VHWs and CHCs that have not been addressed before with broad health system projects.

Since the 10 provinces selected have relatively low immunization coverage, together with poor socio-economic conditions, it should be possible to demonstrate improved immunization coverage at the provincial level during the life span of the HSS. The other health service output indictors should be followed closely at the provincial level, and it is not unreasonable to expect that they will also be improved.

All data for the health service output indictors chosen for the GAVI HSS are given for the national level in the proposal and in reports, while the support is directed to 10 of the 64 provinces. It is not likely that any changes at the national level can be attributed to the HSS. It is strongly recommended that the HSS be monitored using provincial date for the 10 provinces.

The HSS also provides an opportunity to compare the development in the 10 HSS provinces with the other 54 provinces.

The GAVIHSS will support the Government in properly training VHWs in the 10 project provinces. In the existing system, VHWs should, ideally, be trained for nine months, but, so far, many have not yet received that training due to a shortage of funds. The GAVI HSS support is used to rectify this. There is no other donor project that provides support for this VHW training program. The functions and responsibilities of the VHW are broad and encompass most of the basic primary health care functions. GAVI HSS support, therefore, strengthens the entire PHC system.

The main strengths of the HSS proposal is that it is well coordinated with the national health plan, that it addresses broad system issues, that it gives priority to less-developed districts, and that it supports concrete activities which are feasible to implement. The activities can also be monitored through clear monitoring mechanisms and indicators although focus should be on the provincial level.

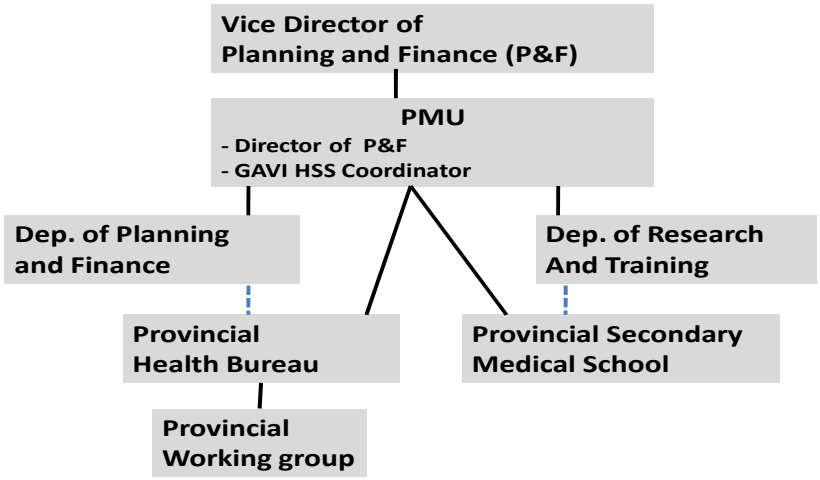
V. Implementation Experience

a). Management and coordination of the GAVI HSS in practice

Management and coordination mechanisms during implementation

GAVI HSS in Vietnam is supervised by the Vice Director of Planning and Financing Department. He serves as a focal point in the country. The HSS support is managed by the Planning Department at MoH. During implementation, there were indications from interviews and minutes from the EPI ICC that the links to the EPI are weak.

At the central level (Ministry of Health) an office for GAVI, the PMU, was established with 10 members working either full or part time for the project. The PMU is headed by a Director (Director of PMU) and Vice Director (GAVI HSS coordinator) of the Planning and Financing Department. The PMU also includes the Vice Director of the Research and Training Department, as well as two experts from the Planning and Financing Department. Other staff include a chief accountant and accountant of the project and three more permanent staff. The office, which is located within the MoH, has a very close relationship with the Department of Planning and Financing, as well as with the Department of Research and Education in implementing project activities. However, it seems there is no link between the office and the national immunization program. The PMU has direct responsibility for the planning, supervision and reporting of the project. The organization is illustrated below.



Much of the responsibility for implementing the components is at the provincial and district levels. Both training and the provincial secondary medical schools are mainly the responsibility of the provincial level. Provincial staff for implementation and coordination at the provincial level of project activities at the 10 provinces have been identified (including a leader of the provincial health bureau, a planning-coordinating officer and an accountant). Based on the project proposal, a memorandum of understanding between the MoH and Provincial People's Committee of the 10 project provinces on project arrangements was signed in 2009.

At the provincial level, every province has one working group led by either the Director or Vice Director of the Provincial Health Services. This person is in charge of implementing the project in the province. Other members are:

- The head or vice head of the Planning Department (coordinator)
- The head or vice head of the Financing Department (an accountant)
- The director or vice director of the medical secondary school
- A person who works full time for the project

The last person listed is responsible for the GAVI HSS activities and relations with the PMU at the central level and receives a monthly salary from the project, while the others are paid by the provincial health authority.

Decision-making process

Decisions about implementing the GAVI HSS is made when the budget for the health sector is approved, ultimately by the National Assembly since the funds are part of the MoH budget. Day-to-day decisions about implementation are made by the PMU. If necessary, issues are brought to the National GAVI Coordinator, the Vice Director of the Planning and Financing Department, the Director of PMU, or the Director of the Planning and Financing Department.

The health authorities at the provincial, district, and even commune levels work very closely with other administrative authorities and peoples committees at every level. After the proposal's approval, every level implements its tasks. The process of releasing funding is transparent, and all money is transferred from the top down to the account number of the district health office.

The process of recruiting trainees is decided not only by the health sector but also by the administrative authority. The selection of VHWs also involves the peoples committee. The relationship between the Provincial Health Services and the medical secondary school work closely to provide the training course for VHWs as well as specific courses on reproductive health or immunization.

A core activity of GAVI HSS is to organize training courses for VHWs. This activity is the responsibility of the medical secondary school. Teachers from the school and doctors working at district hospitals are involved in the teaching process and bring their knowledge and skills to their teaching. They are given some remuneration for their work.

Planning and budgeting process

Every year, the MoH starts to plan for the next year in the third quarter. All financial resources for the health sector are included in the planning, including all international aid, health insurance, and hospital fees (estimated). Included in the document submitted to the MOF and MOPI, the Government and the National Assembly were international aid and GAVI support.

At the provincial level, the same process of planning and budgeting exists. The HSS is included in the planning of the provincial health sector.

At the onset of HSS support, a workshop was held to introduce all project activities and to budget accordingly. Every year before the planning process, the MoH asks the provinces to include the GAVI HSS in their plans. The MoH can revise the national plan according the plans received from the provinces and the objectives of the GAVI HSS to achieve the expected results and outcomes.

Nature and source of any technical assistance (TA) received during implementation

PMU has recruited four national consultants to support the HSS project (training, M&E, project management and procurement of VHW kits).

b). Attention during Implementation to the Core GAVI HSS principles

Country-aligned and country-driven

As proposed in the GAVI HSS application, the implementation of the HSS plan is fully integrated into the Master Plan for health sector development (2006-10) and the Annual Operational plans. At the central level, the HPG has been kept informed about GAVI-HSS project issues and progress in its meetings, particularly during discussions of annual reports to GAVI. At the local level, provinces have coordinated implementation with other actors.

Harmonization

Like the GAVI HSS, most externally funded projects have a PMU, and the project modality is common for donor support to the Vietnam health sector.

Results-oriented

At focus group discussions in the three provinces visited, participants expressed very positive views about the HSS support. Opinions were that GAVI helps the entire health system, including CHCs and VHWs as the HSS focuses on improving staff knowledge and skills at the grass roots level. The training was seen as different from other courses and more practical (e.g., female trainee, VHW for three years in Ha Tay). In the words of the project secretary of the Tra Vinh province:

The GAVI HSS is invaluable because it targets the community. The VHW is the first contact person for the local people so it seems that everyone benefits from GAVI HSS.

Some expressed the opinion that most projects focus on material and facilities while the HSS focuses on human resources. Not only are VHW skills improved but also the planning and supervision skills of provincial, district and commune staff, according to the Director of the Preventive Center, Tra Vinh province. The positive views about GAVI HSS support, (i.e., that it is very much in line with the needs in the provinces) were repeated at the seminar.

Resources - predictable and additional

The GAVI HSS funding is part of the annual budget for MoH and covers the remaining time of the Master Plan for health sector development (2006-10). Although there may be delays in disbursement from GAVI, resources at the central level flowing into the MoH budget are predictable. At the provincial and district levels, the actual funds received have not always corresponded to what the provinces or districts expected (see Flow of funds and bottlenecks in section C.2).

Inclusive and collaborative

A weakness with the plan is that it does not address the major health system challenge of reaching out to target groups with public health interventions through the most utilized part of the health system, namely, the private sector. The involvement of non-NGOs essentially leaves it to the provinces to engage the NGOs. There are no obligations created by this step, and there does not seem to be any strong incentives for provinces and districts to work with NGOs. It is therefore likely that those organizations will be minimally involved in the GAVI HSS and immunization activities in general.

Catalytic

The GAVI HSS is perceived as catalytic for the health system since it is the only donor-supported project that is aimed at strengthening the village and commune levels of the system. The experiences from this support will guide the MoH in further development of supportive activities to these levels. The development of guidelines and training courses will be used even after the project period, and their use can be extended to the entire country. The studies that are being financed with GAVI HSS support will be of great value for the MoH in continuing to strengthen the health system at the lowest levels. It is also expected that innovative funds will provide the MoH with experiences from limited and piloted studies that will guide future work.

Sustainability-consciousness

It is assumed that Government spending for CHCs and VHWs will be clearly increased in the coming years and will, step-by-step, take over the supplemental support from GAVI for VHWs and CHCs. GAVI funding is enabling the MoH to proceed more quickly with strengthening the resources available for VHWs and CHCs than would otherwise be possible.

The MoH expects that the Government will continue to support the project if the project can be continued for some time and its effect at all levels can be demonstrated. It will be good for the Government to show such progress. People living in remote areas are the main target groups for GAVI. The Government is often unable to reach these groups. GAVI HSS may be able to show how these groups can be accessed with health services. If so, the GAVI HSS case will be strengthened, and GAVI will have a good chance of receiving continued Government support.

The issues of sustainability, as perceived by the study team, of the activities proposed in the GAVI HSS application after completion of GAVI HSS funds is presented in the Table 7.

Table 7. Approach to Sustaining Gains after Completion of GAVI HSS Funding

Component	Sustainability
1. To increase the number of VHWs and improve the quality of their work. Activities include updating and distributing curriculum and training materials for VHWs; organizing training courses; providing basic equipment kits; raising allowances; and making supervisory visits.	The recurrent costs of maintaining the equipment kits and allowances is a challenge for the MoH, but it is expected that Government spending for CHCs and VHWs will be increased in the coming years and gradually replace the supplemental support from GAVI for VHWs and CHCs.
2. To improve the quality of work of CHWs and expand the reach of the CHCs. Activities include organizing training courses for CHWs on reproductive, maternal and child health and on EPI in practice, supervisory visits, providing a cart and providing Commune Health Centres with monthly support for recurrent costs.	Providing the Commune Health Centers with monthly support for recurrent costs will also be a challenge for the MoH.
3. To strengthen health system management capacity. Activities include developing health planning and management manuals for provincial and district health officers; organizing TOT courses on health planning and management; organizing training courses on health planning for district health officers; piloting and	Most of the training and the development of the manuals are expected to be sustainable. Computers, printers, etc., must be maintained.

Component	Sustainability
updating the EPI-HMIS software for CHCs; and providing computers, printers and accessories for districts and pilot communes.	
4. To develop and introduce new policies and innovative solutions to strengthen the basic health care system. Activities include establishing an Innovation Fund and modality for planning; implementing monitoring and gathering experiences; organizing workshops, seminars, and policy studies; and implementing policy-oriented studies.	These activities are expected to be sustainable since they are part of the regular responsibilities of the MoH and the volume of developing studies and policies can be adapted according to the availability of funds.

Sustainability is a concern of the project, as reflected in following issues raised during the field visits:

- Before the GAVI HSS project, VHWs were trained for only three months and did not receive any certificates; their allowance was not significant; and VHWs were inactive and ineffective. Many of them withdrew from the work. By providing the training program for nine months and granting a certificate, VHWs now have become more professional. In addition, VHWs receive an additional allowance. Both changes mean they are more committed to their work. Attrition has now become less common.
- Capacity building for health workers at the commune health center, as well as at the district level, contributes to strengthening the whole system.
- Regarding allowances, many provinces have decided to add some money for VHWs, which are a part from the Central Government. Recently, the State increased the allowance for VHWs to 50 percent of the basic salary for remote areas and 35 percent for plain areas. This took effect 1 July 2009.

c). Financial management and flow of funds

Financial procedures, roles and responsibilities

As described previously, MoH/PMU has opened a foreign currency account within the MoH account system for receiving US dollars from GAVI and a national currency account to transfer from US dollars to Vietnamese Dong. Within the country, the existing financial management system is utilized. The budget from the PMU's account is transferred to the existing account of the Department of Health for carrying out project activities within provinces. MoH transfers funds to provincial health bureaus for the implementation of activities.

Reporting on the use of funds is done by collecting and analyzing data on the progress of the project implementation. The data is collected using routines for health planning and monitoring in Vietnam. First, progress reports are done by the provinces. After receiving approval from the Provincial Department of Health, the reports are submitted to PMT/MoH. The PMT is then responsible for compiling province reports into a project report in accordance with GAVI requirements.

Flow of funds and bottlenecks

The GAVI funds come to the Project account. PMU itself will use the funds for activities run at the central level, such as purchasing a car, purchasing basic bags for VHWs, providing allowances for PMU members, and covering the costs for the office. Based on the plans of the 10 project provinces, the PMU transfers funds to the account of these provincial health offices. The director/vice director of the provincial health office is responsible of these funds. The funds will further be transferred to the secondary medical schools and all districts within the provinces. In the secondary medical school, either the director or vice director of the school is in charge. At the district level, either the director of the district health office or the director of the preventive medicine center will be in charge. In some districts, the funds will be transferred to the communes monthly, but, mainly, funds are transferred quarterly. At the commune level, the head of the commune health station is responsible for all funds with supervision by the commune peoples committee.

One of the problems early in the project was the movement of the project management role at the district level from the Health District Office to the District Preventive Medicine Center according to the new organizational structure of the health system in Vietnam. This led to a short interruption of payments for project activities at the communal level. Another problem was that the funds requested annually were often lower than the funds actually received from GAVI. It has also been somewhat difficult to reallocate funds for each activity and each province in the HSS.

GAVI HSS allocation/spending compared to plan

Table 8. Spending for Implementing HSS Activities (US$): Overall Project Budget by Year

Major Activities	2007		2,008	
	Budget	Spent	Budget	Spent
Objective 1: Village Health Workers	1,788,608	0	3,953,116	2,311,741
Objective 2: Commune Health Workers	731,840	34,337	1,248,755	1,040,554
Objective 3: Management Capacity	574,000	Moved to 2008	744,000	39,829
Objective 4. Policy Development	187,500	14,684	432,500	61,010
Project Management	314,802	6,481	498,629	308,393
Technical Support	51,250		82,500	17,194
Total	3,648,000	55,502	6,959,500	3,778,721

The proportion of spending in 2007 is very low (1.5 percent) because the funds were not transferred from GAVI to the Ministry of Health until almost August 2007. As a result, many activities supposed to be implemented in 2007 were moved to 2008. The total amount for 2008 is a combination of the remaining amount from 2007 plus the amount for 2008. For this reason, the total amount for 2008 was higher than that in the application: US $6,959,000 compared to US $4,727,648. During 2008, 55 percent of the funds were spent, almost exactly the amount that had been planned to be spent during 2007. This indicates that there has not been any increase in spending in 2008 to catch up for 2007, which suggests that the project may still need four years to implement all activities and spend all funds and finish by the end of 2011.

Looking at spending per component, the component most in phase with the original plan is Component 2, *Commune Health Workers,* where spending is 83 percent of the combined funds available for 2007 and 2008. For Component 1, *Village Health Workers*, spending is 58 percent.

In Component 3, *Management Capacity,* only 5 percent of funds have been spent, indicating a very slow implementation, with manuals still in the process of being finalized before most of the training can start. Procurement of computers is more than 50 percent of the funds, and the computers will only be distributed—with the newly developed software—after the training courses, so it would be wise to do the procurement shortly before the distribution in order to purchase the most modern computers. In Component 4, *Policy Development,* only 15 percent of the funds have been spent, mostly on workshops. Proposals for the Innovative funds, which constitute the majority of the budget, are still being developed. Management costs and technical support has been just over 50 percent, as can be expected since costs are mostly salaries and office costs.

Attention to financial sustainability

It is assumed that Government spending for CHCs and VHWs will be clearly increased in the coming years, leading to a step-by-step takeover of the supplemental support from GAVI for VHWs and CHCs. The GAVI funding simply enables the MoH to proceed more quickly to strengthen the resources available for VHWs and CHCs than would otherwise be possible. The Vietnamese Government has already given more attention to the basic health care system, including human resources from the village level up to the district level and to the infrastructure of commune health centers and district hospitals. The allowance of VHWs since 1 July 2009 has increased substantially and is now 35 percent to 50 percent of the minimum salary in remote and areas.

d). Monitoring and evaluation practices

Indicators, information systems, procedures at each administrative level

PMU puts together a report every six months to MoH with data on the progress of the HSS. The reports provide the input to the annual reports to GAVI. Data collection for evaluating the service output and outcome indicators is done annually for GAVI based on the present health statistic system of the MoH and the provinces. The data is gathered through the regular HMIS from commune health centers up to district then provincial levels. The MoH synthesizes all data from the 10 GAVI provinces according to the indicators developed in the proposal. No provincial data is provided in the reports to GAVI, although the HSS is directed to only 10 out of 64 provinces.

The MoH/PMU carried out the baseline survey from the middle of 2008, and the final report is now completed.

Use of monitoring data for program management, planning or policy making

Monitoring indicators were used to adjust GAVI activities as well as the activities related to the EPI and to strengthen the health system at the district and commune levels.

GAVI support of monthly allowances for VHWs created the base for recommending that the Government increase the allowance for VHWs. Allowances for VHWs are classified into three levels—A, B, and C—based on the working performance and qualification of the VHW. Each VHW is periodically classified into one of these three levels and receives bonus payments according to his or her level. The bonus payment is not significant, but VHWs still strive to improve the quality of their work in order to move upwards and be recognized as good health workers.

e). Analysis of implementation experience

Although there is a PMU, the project seems to be well integrated into the structures of MoH, to a great extent because the Director and Vice Director of the Department of Planning and Finance are responsible for the GAVI HSS and are also members of the PMU.

There does not seem to be any collaboration between the Department of Planning and Financing and EPI, and EPI does not seem to be involved in any aspect of the HSS. At the ICC meeting in March 2008, there appeared to be no information available on HSS activities. The meeting participants expressed the opinion that the HSS activities should involve EPI and that the managers running HSS should collaborate with EPI. In ICC meetings, representatives of the Planning and Financing Department are often not present

The financial system and the flow of funds work as planned, and the funds seem to reach the units at the different levels responsible for implementation of activities, mainly the Provincial Health Bureaus. No problems with lack of funds at lower levels have been found.

During 2008, 55 percent of the funds were spent, almost exactly the amount planned to be spent during 2007. This indicates that there has not been any increase in spending in 2008 to catch up for 2007, which suggests that the project may still need four years to implement all activities, spend all funds and finish by the end of 2011.

The PMU is collecting data for the monitoring of the implementation of the HSS, mostly through the national HMIS, but also through direct contacts with provinces for the collection of process data. No provincial data is provided in the reports to GAVI, although the HSS is directed to 10 only out of 64 provinces.

VI. Country Performance against Plans and Targets

a). GAVI HSS-funded activities carried out as compared to plan

The proposal includes indicators for monitoring the progress of activities, objectives and specific targets. The tracking team has collected monitoring data from the Annual reports and from the PMU (Column 5, Progress May 2009). Progress has been verified during field visits to three provinces where quantitative and qualitative data was collected.

Because of the long period of time for the review of the proposal and, as a consequence, a delay in funds transfer into the account of the PMU at the Ministry of Health, the GAVI HSS project actually started in September 2007, about one year later than the plan. In the first year, activities occurred mainly at the central level and focused on planning and management. After receiving GAVI funds at the end of 2007 and the approval of the Minister of Health of the Action Plan for 2008, the HSS project worked in collaboration with related stakeholders and 10 project provinces to begin carrying out activities.

In spite of the delay and some problems mentioned above, almost all activities under the Action Plan are in progress, although many of them have not met the planned timeframe.

Component 1. "To increase the number of VHWs and improve the quality of their work"

To start the implementation, in October 2007, a kick-off workshop with 10 project provinces, some related Government agencies (such as MOF and MPI) and relevant stakeholders was organized in Lam Dong province. After the workshop, the proposal for a baseline survey was drafted, and training curricula for commune and VHWs were collected from project provinces and some other projects.

During 2008, the nine-month training curriculum for new VHWs was updated by the Science and Training Department of the MoH and national consultants based on curricula available from MoH and the local socio-economic contexts in 10 project provinces. The three- or six-month curriculum for VHWs was also upgraded to meet the requirements of the nine-month training program as regulated by the MoH. Based on the updated training curricula, major training materials for the nine-month program for VHWs were revised during 2008 and 2009. Unfortunately, as of yet, training materials have not been finalized and distributed to provinces.

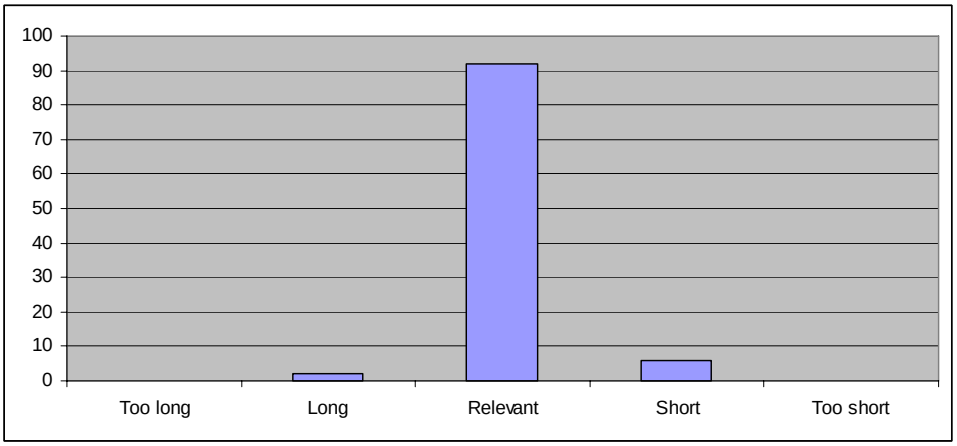
Provincial Health Departments and Provincial Secondary Medical Schools (PSMSs) offered 60 nine-month and six-month training courses for 2,380 VHWs; of those, 3 were completed in 2008 and 57 will be completed in 2009. Trainees are local people carefully selected from villages by local authorities according to selection criteria defined by PHDs. Trainers/facilitators from PSMSs take on the main tasks, in collaboration with invited lecturers and facilitators from provincial hospitals, provincial preventive health centers, district hospitals, district preventive health centers, the district health office, etc. Qualified trainees will be provided with a standard certificate allowing them to practice as formally trained and professional VHWs. With this certificate, the trained VHWs feel more secure and have a strong attachment to this work over a long time.

Most of VHWs are female (84.4 percent). Those in this study had completed at least grade 9 (65 percent); of those, 33 percent also had completed grade 12. Thirty seven and a half percent of VHWs had received training before being trained by the GAVI project, but just 20 percent had

taken the six-month or nine-month training course for VHWs. Most of the others were trained in one month.

About 92 percent of VHWs rated the length of training as fitting the reality of their work. Six percent thought that it was not long enough, and 2 percent reported that the training was too long.

Figure 5. Rating of Length of Course in Relation to Their Needs among Surveyed VHWs



The organization of the training was rated as good or very good by 98 percent of the VHWs. The content of the training was rated interesting by 57 percent and very interesting by 39 percent. Two percent of the participants thought that the content did not fit their work.

All interviewees were provided handouts, which they reported as relevant to the content of the course. Some opinions on the training are given below:

- *The content of the training could be different from place to place. For example, in Quinhon city, we need to learn about social diseases but not necessarily malaria.* (Female trainee, VHW for 12 years, Quinhon City, Binhdinh)
- *Theory and practice should be provided in parallel. We may forget theory before coming to practice.* (Female trainee, VHW for 12 years, Binhdinh)
- *We need to do real work, not just stand to observe people practice.* (Female trainee, 39 age, VHW for 4 years, Binhdinh)
- *The theory part is OK but time for practice at the hospital should be increased while time at the commune health center should be decreased.* (Male trainee, 44 years with 9 years as VHW, Travinh)
- *It is very difficult for minority people to take the course. They are not able to pass the examination and do not want to take the examination again.* (Head of CHC, Binhdinh)
- *Some trainees will not work for a long time, particularly when they are young females. They may marry somebody outside of their home village.* (Vice Dean of MSS, Tra Vinh)
- *Most of my concern is that some VHWs will give up their work due to the low salary. It's necessary to have a mechanism for charging course fees from those who give up work after taking the course.* (Director of Preventive Medicine Center, Travinh province)

After the need for VHW kits for 10 project provinces was identified, the MoH selected the kit's essential items, including syringe, stethoscope, and sphyromomanometer. The MoH then proceeded with the procurement of 15,012 kits for the VHWs. The supplier expects to distribute

all the kits in the 10 project provinces in June 2009. The kits will facilitate good performance of VHWs in their villages. However, due to a delay in the transfer of money and complicated bidding procedures, the basic kits were not available in provinces during the time surveyed. All basic kits were purchased at the central level. The ten provinces have now received the kits.

A total of 16,389 VHWs received the additional monthly allowance from the HSS project with three levels of support: 50,000 VND; 45,000 VND and 35,000 VND for three levels of performance, respectively, A (very good), B (good) and C (poor). The application of a performance-based incentive scheme with assessment and classification of CHC was expected to make the VHWs competitive, thus promoting better performance on their part. However, all surveyed CHWs and VHWs considered this rather as a "spiritual" reward than a benefit, and almost all received the highest level of additional allowance.

In addition to the support from the project, all VHWs received a monthly allowance from local authorities, although this varied by province. Binh Dinh paid 250,000 VND for VHWs, including 50,000 VND from the GAVI project while Tra Vinh's payment for VHWs was in the range of 90,000-165,000 VND per month, including 50,000 VND from the GAVI HSS. Most VHWs rated support from the project as too low. Only a third of them thought the support was important to their income (18 percent rated it important and 11 percent, very important).

Although, overall, the procedure for receiving money from the project was rated acceptable and good, about 20 percent thought that it was still complicated.

The manual/guideline for VHW and CHC monitoring and supervision was developed by the MoH and a local consultant on M&E in 2008 and is available for use. The MoH will organize TOT courses in 2009 for the provincial trainers responsible for training district and commune health workers.

Eighty-four percent of staff at the health facilities (73 staff) who were interviewed said that supervision was carried out, on average, five times last year, with a range of 1 to 12 times; 98 percent said that they received feedback from supervision. A Vice Head of the District People's Committee said that they have not carried out supervision for GAVI separately but rather with other projects. A Director of DHO said that a benefit of GAVI paying for supervision work is that other supervision can be carried out at the same time without additional costs.

There were more monitoring and supervision visits carried out from central, provincial and district levels to lower levels in 10 project provinces than before. Supervisors were expected to provide monitoring and supervision on the management, organization and performance of health facilities, including the implementation of training courses for VHWs and activities related to EPI. In addition, VHWs and CHWs will receive guidance/instruction from supervisors to better perform their tasks. As a result, the performance of VHWs and CHWs was improved considerably. However, because of the lack of training and manual/guidelines for supervision, the number of visits was increased while the quality of supervision did not improve proportionally.

Component 2. "To improve the quality of work of CHWs and expand the reach of the CHCs"

A total of 69 training courses for CHWs on EPI in practice were organized by PHDs with the support and coordination from the National EPI Program in 10 project provinces. The available guidelines jointly developed by the EPI Program in Vietnam and WHO were used for these training courses. Although not assessed during this study, in the opinion of the Study Team, these courses will likely improve the skill and capacity of the CHWs on EPI. .

The HSS project provided 1,674 CHCs in the 10 project provinces with additional recurrent costs of US $30 per month. These funds partly supported CHCs in the most disadvantaged provinces, especially in disadvantaged communes, to cover basic operational costs, e.g., consumables, water, telephone and electricity. Thanks to this support, CHCs had full electricity for freezers to keep vaccines and drugs in good condition.

Component 3. "To strengthen health system management capacity"

Health Planning and Management Manuals for provincial and district levels were developed and updated by the MoH and local experienced health managers with references from available materials from the MoH and the provinces, as well as those developed by other projects to meet the new context and policies of the health sector in recent years. The manuals seem to meet the local health planning and management needs in the disadvantaged provinces.

Two TOT courses on health planning and management were organized by the MoH for health managers and planners from the 10 project provinces. The training materials used in the TOT courses are the above-mentioned health planning and management manuals.

Although the HMIS software was updated, it has not been piloted as the purchasing of computers was completed only recently in just 5 of the 10 provinces.

Component 4. "To develop and introduce new policies and innovative solutions to strengthen the basic health care system"

Two proposals for innovating health village performance and evaluating the role and functions of CHCs in urban areas, as well as a study on the need for recurrent costs of CHCs, were drafted by the Planning and Finance Department of MoH. The proposals and the study are expected to be finalized in the second quarter of 2009.

The MoH and PHDs organized workshops and seminars to assist the MoH in developing policies and new solutions to strengthen the health care system.

Some official documents were developed and promulgated by the PMU and PHDs to facilitate the implementation of HSS activities (e.g., regulations on project management and financial management, selection criteria of VHW for training).

b). HSS inputs and outputs compared to targets

The proposal includes a table for monitoring inputs. The tracking team has collected monitoring data from the annual reports and from the PMU on the situation as of May 2009. Progress has been verified at field visits to three provinces, where quantitative and qualitative data were collected.

There are some activities that either were not done or not completed due to the delay in funding. Some activities cannot be completed before others; for example, computers must be purchased before training courses on computers for district and commune staff can take place. The pilot of HMIS can be done when the purchasing of computers is completed. Generally, the project is on track but delayed.

The proposal also includes the following table relating to the monitoring of output indicators over time as requested by the IRC. The tracking team collected this monitoring data from the annual reports and from the PMU.

Table 9. Expected Progress in Health Service Output Indicators over Time in Project Provinces

Expected outcomes		Year of GAVI application (2006)	Year 1 of implementation (2007)	Year 2 of implementation (2008)	Year 3 of implementation (2009)	Year 4 of implementation (2010)
Contraceptive prevalence rate	Target	60%	60%	65%	70%	80
	Achieved	-	-	73%		
Births assisted by skilled birth attendant	Target	60%	60%	70%	80%	85
	Achieved	-	-	88%		
Case detection of AFB (+)	Target	60%	60%	65%	70%	75
	Achieved	-	-	57%		
DOTS cure rate for AFB+	Target	70%	70%	75%	80%	80
	Achieved	-	-	88%		
Malnutrition rate children <5 (weight for age) (reduce 4% in each province)	Target	24%	23%	22%	21%	20%
	Achieved	-	-	22%		
DPT3 coverage	Target	75%	80%	85%	90%	90%
	Achieved	-	-	82%		
Routine 2nd dose measles	Target	75%	80%	85%	90%	90%
	Achieved	-	-	82%		

According to official MoH data, almost all targets have been achieved for 2008 with the exceptions being case detection of AFB(+), DPT3 coverage and routine 2nd dose of measles vaccine. Since program activities started only in late 2007, it is not meaningful to expect any changes in 2007. The study team, however, finds it difficult to verify and explain how assisted births could increase from 60 percent to 88 percent—a 50% increase—in just one or two years. It has also not been possible to verify any of the data from other sources.

VII. Conclusions

a). GAVI HSS proposal development and application process

Overall, the application process was well laid out and implemented. Most stakeholders at the national level were involved although the EPI was not involved as much as they had wanted. Implementers at the provincial level were involved in a consultation process that included a national meeting in Halong Bay.

It took about six months, from May to October 2006, to develop the proposal and send it to GAVI. It took another six months for the review process, interaction with the IRC, and the revision and completion of the proposal before approval by GAVI in June 2007. The funds for the first transfer arrived two months later, in August 2007.

The working group had a broad representation from MoH but no participation from other ministries or civil society organizations.

There seems to have been a very good and active review process, involving the HPG, ICC, a provincial workshop and the ERC review. The three questions raised by the IRC seem to be very relevant; specifically, the need to develop health service output indicators for monitoring output from the health sector. The review process appears to have contributed significantly to the quality of the proposal.

Strengths/Weaknesses of the HSS Application

The proposal responds very well to the assessments of the barriers to immunization and the problems of the PHC system. It also addresses the lower levels in the system, that is, the VHWs and commune health centers, which have not been addressed before by broad health system projects.

Since the 10 provinces selected have relatively low immunization coverage, together with poor socio-economic conditions, it should be possible to demonstrate improved immunization coverage at the provincial level during the life span of the HSS. The other health service output indictors should be followed closely at the provincial level, and it is not unreasonable to believe that they will also be improved.

All data for the health service output indicators chosen for the GAVI HSS are given for the national level in the proposal and in reports, while support is directed to 10 of the 64 provinces. It is not likely that any changes at the national level can be attributed to the HSS. It is strongly recommended that the HSS be monitored using data for the 10 provinces. The HSS also provides an opportunity to compare the development in the 10 HSS provinces with the other 54 provinces.

The GAVI-HSS will support the Government of Vietnam to properly train VHWs in the 10 project provinces. In the existing system, VHWs should ideally be trained for nine months, but so far many have not yet received that training due to a shortage of funds. GAVI HSS support is used to rectify this. There is no other donor project that provides support for this VHW training program. The functions and responsibilities of the VHW are broad and encompass most of the basic primary health care functions. GAVI HSS support, therefore, strengthens the entire PHC system.

The main strengths of the HSS proposal is that it is well coordinated with the national health plan, that it addresses broad system issues, that it gives priority to less-developed districts and

that it supports concrete activities that are quite possible to implement. The activities can also be monitored through clear monitoring mechanisms and indicators, although the focus should be on the provincial level.

b). HSS implementation experience/absorptive capacity

Capacity to implement HSS activities at national and sub-national levels as planned

Because of the long period of time required for the review of the proposal and, as a consequence, the delay in the funds transfer, the GAVI HSS project actually started in September 2007, approximately one year later than planned. In the first year, activities occurred mainly at the central level, focusing on planning and management. After receiving GAVI funds at the end of 2007 and the approval of the Minister of Health on the Action Plan for 2008, the HSS project worked in collaboration with related stakeholders and the 10 project provinces to begin carrying out activities. In spite of the delay, almost all activities under the Action Plan are in progress, and there have been no further delays in implementation. In fact, the training activities are catching up with the original timeframe.

Although there is a PMU, the project seems to be well integrated into the structures of the MoH, to a great extent because the Director and Vice Director of the Department of Planning and Finance are responsible for the GAVI HSS and are also members of the PMU.

There does not seem to be any collaboration between the Department of Planning and Financing and EPI, and EPI does not seem to be involved in any aspect of the HSS. At the ICC meeting in March 2008, there seemed to be no information available on HSS activities. The meeting participants expressed the opinion that the HSS activities should involve EPI, and the managers running HSS should collaborate with EPI. In ICC meetings, the representatives of Planning and Financing Department are not often present

Capacity to allocate, manage, account for and spend GAVI HSS funding as planned

The financial system and the flow of funds work as planned, and the funds seem to reach the units at the levels responsible for implementing activities, mainly the Provincial Health Bureaus. No problems with lack of funds at lower levels have been found.

During 2008, 55 percent of the funds were spent, almost exactly the amount planned to be spent during 2007. This indicates that there has been a small increase in spending in 2008 to catch up for 2007, which suggest that the project may still need approximately four years to implement all activities, spend all funds, and finish during the second half of 2011. The implementation of the HSS component was delayed due to financial and administrative procedures at GAVI and MoH. It also took some time for the MoH to establish mechanisms for the proper organization of the GAVI HSS.

The HSS project has successfully provided CHCs in the project provinces with additional recurrent costs of US $30 per month. These funds partly supported CHCs in the most disadvantaged provinces, especially in disadvantaged communes to cover basic operations and thanks to the support, those CHCs had full electricity for freezers to keep vaccine and drugs in a good condition.

Capacity to monitor HSS performance targets and use monitoring data to revise its HSS approach

PMU puts together a report on the progress of the HSS to the MoH every six months. The reports provide the input to the annual reports to GAVI. Data collection for evaluation of the

service output indicators and outcome indicators is done annually for GAVI based on the present health statistics system of the MoH and the provinces. The data is gathered through the regular HMIS, from the commune health center to the district and then the provincial level. The Ministry of Heath synthesizes all the data from the 10 GAVI provinces according to the indicators developed in the proposal.

No provincial data is provided in the reports to GAVI, although the HSS is directed to only 10 out of 64 provinces.

c). Application of Paris Declaration and other core GAVI principles during implementation

Inclusiveness/participation of a variety of public, private, multilateral, bilateral stakeholders

In the application process, the working group contained only MoH participants. Other development partners were involved through the Health partnership group and through the ICC for immunization. During implementation, the forum for involvement is through the health partnership group and the ICC, but so far the implementation of the HSS has not been a regular item on the agenda of these bodies. There is a growing awareness in Vietnam that other stakeholders should be included in public health planning. At the provincial level, health bureaus are encouraged to coordinate with all partners in the province.

Alignment/integration with national processes

The HSS organization is well integrated into the national health planning, the multi-year immunization plan and regular government functions. A small PMU has been set up at the national level in the MoH to coordinate the HSS. Much of the implementation is done at the provincial and lower levels within existing structures.

Complementarity/coordination of donor inputs

The HSS is the first comprehensive project for strengthening health systems directed to the village and commune level. It addresses several components of the health system, such as equipment, organization and—above all else—the training of health workers. Infrastructure improvements, complementary to the GAVI HSS, are addressed by the Asian Development Bank. Since there are no other donors implementing projects at the village and commune level, the only need is to coordinate with other development partners, mainly NGOs, in the project provinces. With the limited time for implementation, there are no experiences yet of this coordination.

Harmonization of donor requirements

In June 2005, the Government of Vietnam and the donor community in Vietnam approved the "Hanoi Core Statement" (HCS) on Aid Effectiveness Ownership, Harmonization, Alignment and Results. Among other issues, donors and the Government agreed to increasingly use Government systems. Within the health sector, two sub-sectors were selected to test better harmonized aid management mechanisms, namely, Tuberculosis Control and HIV/AIDS Control. A number of meetings and workshops have been organized to discuss how to practically implement a SWAp and/or budget support in the health sector. Still, the dominating modality for donor assistance in the health sector is the project modality, where there is little harmonization among donor requirements for project planning and formats for project proposals, requirements for financial accounting and reporting requirements.

d). Progress toward expected outputs and outcomes

A nine-month training curriculum for new VHWs has been updated and further developed. Unfortunately, up to now, training materials have not been finalized and distributed to provinces. Even so, training of CHWs and CHCs has started, and 2,380 people have been trained in this program so far. Participants and district managers have, overall, expressed satisfaction with the training program. In addition, more than 69 training courses on EPI in practice have been conducted.

Procurement procedures for more than 15,000 kits for VHWs have been initiated. Due to the delay in the transfer of funds and complicated procedures in bidding, the basic kits were not available in the provinces at the time of the tracking study.

An extra monthly allowance to CHWs and VHWs, based on a performance-related incentive scheme with assessment and classification on a three-graded performance scale, has been introduced by the GAVI HSS project. More than 16,000 VHWs have received the allowance. This scheme was expected to increase competitiveness among VHWs and promote better performance. The study shows, however, that all surveyed CHWs and VHWs considered the allowance rather a spiritual reward than a benefit. Moreover, almost all of them received the highest score and allowance.

A manual/guideline for VHW and CHC monitoring and supervision has been developed by the MoH and a local consultant on M&E in 2008 and is available for use. Training of M&E trainers is planned for 2009.

GAVI HSS pays for supervision work that integrates overall supervision, not only immunization activities. This is seen as an advantage by managers. In 2008, on average five supervisory visits were paid to lower-level facilities from district- and provincial-level staff.

Health planning and management manuals for provincial and district levels have been developed and updated by the MoH and local experienced health managers. Using this material, two TOT courses on health planning and management were organized by the MoH for health managers and planners from the 10 project provinces.

The fourth component of the HSS project, which aims at developing and introducing new policies and innovative solutions to strengthen the basic health care system, has made less progress. Two study proposals have been drafted by the Planning and Finance Department of MoH, and intentions are to implement them in 2009. The MoH and provincial health departments have also organized some workshops and seminars to assist the MoH in developing policies and new solutions to strengthen the health care system. This component needs to be accelerated.

VIII. Recommendations to Strengthen the GAVI HSS Application Process and Bolster Implementation

a). To country policy and program decision-makers

The component on policy and innovative solutions in the GAVI HSS in Vietnam needs to be given higher priority and should be further strengthened. Operational activities are easier to implement than policy-oriented activities, which should be given due consideration in the future so that relevant policy issues are addressed early on and due attention given to the need to strengthen policy development capacity.

There is a growing awareness in Vietnam of the need to include other stakeholders in the public health planning and coordination. The involvement of these stakeholders should be strengthened with more regular meetings and by regularly including the GAVI HSS on the agenda for HPG and ICC. At the provincial level, the health bureaus should be further encouraged to coordinate with all partners in the province.

The Department of Planning and Financing and EPI should collaborate, and EPI should be involved in every aspect of the HSS.

The HSS project has successfully provided CHCs in the project provinces with the additional recurrent cost of USD $30 per month. This support should continue after the project period and be extended to the whole country.

Since provincial data is not provided in the reports to GAVI and the indicators at the national level will not likely show any changes attributable to the HSS, implementation should be monitored through the use of provincial-level data.

b). To stakeholders in-country

Since the primary modality for donor assistance in the health sector is the project modality, donors should increasingly comply with the Hanoi Declaration, move away from the project modality, and harmonize project planning requirements, project proposal formats, financial accounting requirements, and reporting requirements.

Civil society organizations should continue to push for better coordination with all development partners in the health system.

c). To the GAVI Alliance

GAVI should require reports of process and health service outcome data from each of the supported provinces and should consider using more of the national systems for financial management and reporting, striving towards participation in a future SWAp. It should also maintain its objectives with HSS support, aimed at improving immunization coverage and child and maternal health. Vietnam will probably be a good case study for demonstrating how broad public health support to the village and commune levels results in better immunization coverage and improved child and maternal health in rural areas.

d). To other global actors in health systems strengthening

Global actors should follow the example of GAVI and develop modalities for increased and more coordinated support to planning and implementation of support to strengthen the health system in Vietnam, with a focus on lower levels and disadvantaged provinces.

e). To other countries planning to apply for or beginning to implement GAVI HSS

Delays in GAVI HSS procedures should be avoided so as not to discourage recipients of GFATM funds for HSS from mobilizing energy for HSS implementation. Realistic expectations should be created by learning from earlier experiences with project planning and initiation, including time taken for the establishment of accounts, financial transfers and accounting procedures. Plans should take such experiences into consideration.

The GAVI HSS in Vietnam is well integrated into the overall Government structure, both at the highest and lowest levels. Countries should learn from this approach. At the same time, the Vietnam case illustrates the importance of full integration in planning of all concerned parties, in particular the national immunization program.

GAVI HSS in Vietnam has a strong training component that is of general benefit to the entire health system at the basic level. Immunization activities are very likely to be strengthened by this focus on training, and gains are likely to be more long term. Countries should learn from Vietnam's consistency in this policy rather than placing a focus on investments that will have immediate impact on immunization coverage levels.

GAVI HSS in Vietnam also has a component of strengthening that is of immediate benefit to EPI. The investment provides broader support to health services as it includes a basic kit of utensils, drugs and tools to be used by VHWs as well as direct support to general operational funds for CHCs. Countries should learn from this integrated approach to structural support.

Countries should plan for an extensive review procedure as part of the application development process. There seems to have been a very strong and active review process in Vietnam, involving the HPG, ICC, a provincial workshop and the ERC review.

Annexes

ANNEX 1 – List of Interviewees

VIETNAM - GAVI - HSS TRACKING STUDY

List of interviewees

Central level and International organizations

No	**Full name**	**Position**	**Tel**	**Email**
1	Duong Huy Lieu	Director of Planning and Financing Dept Director of PMU	04.2.732266 0917.683.878	
2	Nguyen Hoang Long	Vice Director of Planning and Financing Dept PMU member	04.2.732.262 0913.503.255	longmoh@yahoo.com
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5	Hoang thÞ Giang	Chief accountant of the project	04.2.732.273 ext 27 0904.267.658	giangmhoh@yahoo.com
6	Duong Duc ThiÖn	Expert of Planning & Financing Dept., PMU member	04 8.461.386 ext27 0904. 393.705	ddthien@yahoo.com
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11	Nguyen Tran Hien	Director of NIHE	0913352524	nthiennihe@vnn.vn
12	Nguyen Tuong Son	Vice Director Department of Social, Cultural and Labor Affairs, Ministry of Planning and Investment		
13	Nong Thi Hong Hanh	Expert Foreign Economic Relations Department	8232042 91215 1234	anhhanhbi@yahoo.com

		Ministry of Planning and Investment		
14	Hoang Minh Thoa	Vice Director Department of Finance and Monetary Ministry of Planning and Investment		
15	Vu Thuong	Expert Department of Finance and Monetary Ministry of Planning and Investment		
16	Do Hong Phuong	Health and Nutrition Section UNICEF, Vietnam		dhphuong@unicef.org
17	Vu Minh Huong	PATH officer	0913213667	hvu@path.org
18	Hitoshi Murakami, MD, MPH, PhD	Expert Services Division, International Medical Center of Japan (formerly WHO officer in Vietnam)		STC@ WHO Viet Nam Office
19	Dr. Lokky Wai	Senior Program Management Officer, WHO, Vietnam		WaiL@wpro.who.int

Provincial level

TT	Full name	Position	Tel	Email
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2	Tran The Thao	Vice Dean Medical College Hanoi Province	0913598560 37347978	soytehatay@vnn.vn
3	Hoang Thi Phuong Thao	Director Dept. of Financing and Accounting Hanoi Health Office	0904001180	
4	Nguyen Van Cang	Director Binhdinh Health Office	056793120 0903504403	
5	Nguyen Van Chuong	Director Dept. of Planning and Financing Binhdinh Health Office	056791222 0913413706	chuongsyt@ yahoo.com.vn
6	Pham Thi Thu Hien	Contracted officer	0987028690	soytebinhdinh@ dng.vnn.vn
7	Le Thi Thanh Huyen	Accountant of Cabinet Office Binhdinh Health Office	0905407497	
8	Le Quang Liem	Vice Dean Secondary Medical School Binhdinh Province	0914035152	

9	Nguyen Y Khoa	Director Travinh Provincial health Office	0913891194	khthsyttv@ yahoo.com.vn
10	Nguyen Van Lo	Director Preventive Medicine Center Travinh Province	0919245945	bsnvlotv@gmail.com
11	Bui Van Minh	Vice Dean Secondary Medical School	0903337679	
12	Do Thanh Nam	Accountant of Cabinet Office Travinh Health Office	0919480719	

District level

1	Nguyen Hoang Linh	Manager of Cang Long District health center		
2	Duong Thanh Hieu	Vice director of Cang long District health center		
3	Nguyen Van Son	Vice director of Tieu Can district health center		
4	Nguyen van Hung	Director of Health Services		
5	Nguyen thi Chuc	Vice director of Qui Nhon health center		
6	Dao do My	Director of Qui Nhon health department		
7	Cao Hoang Mong Tien	Vice director of Tuy Phuoc health department		
8	Duong Ngoc Hung	Director of Tuy Phuoc district health center		
9	Ho Thi Hue	Specialist for project		
10	Nguyen Thanh Mai	Chief of accountancy Tuy Phuoc district health center		
11	Bach Cong Tien	Vice chair man of Ba Vi district committee		
12	Nguyen Danh Quang	Director of BaVi District Health center		
13	Vo Van Tan	Ba Vi district health center		

Commune level

1	Khuong van Long	Head of Tong Bat CHS		
2	Phung Van Duc	Head of Thai Hoa CHS		
3	Chu Thi Thanh Huong	Specialist of immunization in		

		Thai Hoa CHS		
4	Pham Van Dong	Specialist of Immunization in Tong Bat CHS		
5	Nguyen Thi Thanh Chuong	Head of Tan Binh CHS		
6	Nguyen Thi Tieng	Specialist of communization Tan Binh CHS		
7	Vo Thi Mong Thu	Head of Cang Long CHS		
8	Nguyen Thi Ngan	Head of Cau Quan CHS		
9	Tran Thi Hong Hue	Ex-Head of Cau Quan CHS		
10	Nguyen Van Son	Specialist of Communization in Cau Quan CHS		
11	Kim Thi Vi Thy	Accountancy of Cau Quan CHS		
12	Dao Thi Huong	Head Of Tran Phu CHS- Qui Nhon		
13	Do Hong Tuan	Head of Ghenh Rang CHS- Qui Nhon		
14	Tran Khanh Ngan	Head of Phuoc Loc CHS- Tuy Phuoc		
15	Nguyen Ngoc Thun	Head of Phuoc An CHS- Tuy Phuoc		

ANNEX 2 – Important Recent Health System Assessments

Some important assessments, reviews and studies of the health system in the past

Title of the assessment	Participating agencies	Areas / themes covered	Dates
Resolution No. 46 NQ/TW by the Politburo On people's health protection, care and promotion in new context	Government Office, MoH, MoF, MPI, provinces	Major features of health and health care in the new contexts	23 February 2005
Five year plan for protection, care and promotion of people's health for 2006-2010	MoH, MPI, MOF, Govt Office	General areas of health and health care	January 2006
Master Plan for the Development of Health Sector	MoH, MPI, MOF, Govt Office, provinces	Comprehensive aspects of health system development up to 2010 and 2020	June 2006
Five year Plan for the Expanded Program of Immunization for 2006-2010	MoH, EPI program	General and specific issues regarding the Expanded Program of Immunization	2006
Medium Term Expenditure Framework	MoF, MoH	Health financing	December 2005
Review of The Expanded Program On Immunization	EPI review team: NEPI, PATH/CVP, UNICEF, WB, WHO	Routine immunization coverage amongst children aged under one The status of management practices in the EPI including the reporting system, training and supervision.	16 - 27 November 2003
The GAVI barriers analysis 2004	WHO, GAVI (Mr. Ingvar Theo Olsen), MoH, MOF, MPI, provinces	The main characteristics related to the health sector in general and to immunization in particular System wide barriers with significant impact on immunization Recommendations on priority interventions	October 2004
Rapid Health System Assessment – The	Dr Graham Harrison (WPRO), Dr	The main areas/components of the	8 - 12 May 2006

Review by Graham Harrison at al.	Dominique Egger, Dr Brenda Killen (WHO)	health system in general	
Assessment of participation in EPI activities of private health sector in Ho Chi Minh city	Dr. Do Sy Hien, Dr. Nguyen Van Cuong (NIHE)	EPI Resources, including manpower and finance Health management information system (HMIS) EPI Communication	2004

ANNEX 3 – Indicators of Planned Activities

Indicators related to planned activities in the GAVI HSS component

	Training of VHWs	Allowances for VHWs	Equipment kit for VHWs	Training of CHWs & support to CHCs	Management, M&E
Contraceptive prevalence rate	Better performance of IEC activities	More active in family planning activities	More active and effective family planning activities	More active and effective family planning activities	Better mgt and M&E for family planning
Births assisted by skilled birth attendant	Better skills on maternal care, e.g., pregnancy checks	More active attendance to birth deliveries in community	More effective support to normal deliveries in community	Better quality maternal care services	Better mgt and M&E for maternal and child healthcare
Case detection of pulmonary AFB (+)	Better recognize TB suspects and advise them to go to hospital for a diagnosis	More home visits to recognize TB suspects	More effective checks/care for common health problems	Better knowledge and quality services for TB case detection	Better M&E from district and hospitals for TB control activities
DOTS cure rate	Better hold TB cases during continuous treatment phase (DOTS) in community	More active home visits to TB patients under DOTS	More effective home visits to TB cases	Better knowledge and quality services for TB control - DOTS	Better M&E from district and hospitals for TB control activities
Malnutrition rate of children <5	Better knowledge and IEC activities	More active in malnutrition control activities	More effective checks/care for common health problems	Better IEC activities and guidance on malnutrition control	Better guidance and support to CHCs and VHWs on malnutrition control
Sustain high DTP3 coverage	Better knowledge and IEC activities	More active involvement in EPI campaigns	More effective EPI campaigns	Better EPI services	Improved M&E for EPI
Routine 2nd dose of	Better knowledge	More active involvement	More effective EPI	Better EPI	Improved

measles vaccine coverage	and IEC activities	in EPI campaigns	campaigns	services	M&E for EPI

ANNEX 4 – HSS Implementation Costs

Cost of implementing HSS activities (US$): Overall budget by year

		2007	2008	2009	2010	TOTAL
	Obj. 1. VHWs	1,788,608	3,360,508	3,253,608	2,498,608	10,901,332
1.1	Training curriculum and materials update	25,000	-	-	-	25,000
1.2	Training materials printings	-	50,000	-	-	50,000
1.3	Nine-month courses for VHWs	755,000	1,510,000	2,265,000	1,510,000	6,040,000
1.4	Basic equipment kits for VHWs	-	641,900	-	-	641,900
1.5	Monthly allowance for VHWs	688,608	688,608	688,608	688,608	2,754,432
1.6	Supervisory visits for VHWs	-	-	-	-	-
1.6.1	Monitoring manual/guideline	20,000	-	-	-	20,000
1.6.2	TOT courses for provincial trainers	-	24,000	-	-	24,000
1.6.3	Short courses for district officers	-	146,000	-	-	146,000
1.6.4	Support for monitoring and supervision	300,000	300,000	300,000	300,000	1,200,000
	Obj. 2. CHWs	731,840	671,840	671,840	671,840	2,747,360
2.1	Short courses for CHWs on MCH	130,000	130,000	130,000	130,000	520,000
2.2	Short courses for CHWs on EPI in practice	130,000	130,000	130,000	130,000	520,000
2.3	Monitoring and supervision for CHCs	-	-	-	-	-
2.3.1	Monitoring manual/guideline for CHCs	25,000	-	-	-	25,000
2.3.2	A car to support	35,000	-	-	-	35,000

		2007	2008	2009	2010	TOTAL
	monitoring & supervision					
2.4	Recurrent costs for difficult CHCs	411,840	411,840	411,840	411,840	1,647,360
	Obj 3. Management Capacity	574,000	170,000	-	-	744,000
3.1	Health Planning and Mgmt. Manuals	30,000	-	-	-	30,000
3.2	Training for provincial and district officers	-	-	-	-	-
3.2.1	TOT courses for prov trainers	-	24,000	-	-	24,000
3.2.2	Courses for district officers	-	146,000	-	-	146,000
3.3	HMIS support	-	-	-	-	-
3.3.1	Pilot and update HMIS software	8,000	-	-	-	8,000
3.3.2	TOT course on Software for district staff	20,000	-	-	-	20,000
3.3.3	Training courses for CHWs	120,000	-	-	-	120,000
3.3.4	Computers for prov, districts and pilot CHCs	396,000	-	-	-	396,000
	Obj 4. Policy development	190,000	290,000	290,000	110,000	880,000
4.1	Innovative fund	100,000	180,000	180,000	40,000	500,000
4.2	Workshops, seminars	70,000	70,000	70,000	70,000	280,000
4.3	To implement policy-oriented studies	20,000	40,000	40,000	-	100,000
	Project Management costs	332,800	201,800	192,800	221,800	949,200
	- Office equipment and furniture	110,000	-	-	-	110,000
	- Allowances for Project Director	12,000	12,000	12,000	12,000	48,000
	- Allowances for Project	8,400	8,400	8,400	8,400	33,600

		2007	2008	2009	2010	TOTAL
	Vice-Director					
	- Contracted staff (3), admin staff, accountant	80,400	80,400	80,400	80,400	321,600
	- PCU/PPCU running costs	92,000	92,000	92,000	92,000	368,000
	- Financial audit (two times)	-	9,000	-	9,000	18,000
	- Baseline and post-project surveys	30,000	-	-	20,000	50,000
	Technical support (3 per-mths)	53,500	33,500	53,500	33,500	174,000
	- Local consultants (24 per-mths)	13,500	13,500	13,500	13,500	54,000
	- International consultants (6 per-mths)	40,000	20,000	40,000	20,000	120,000
	TOTAL	3,670,748	4,727,648	4,461,748	3,535,748	16,395,892

ANNEX 5 – HSS Implementation Spending

Spending for implementing HSS activities (US$): Overall project budget by year

Major Activities	2007		2,008	
	Budget	Spent	Budget	Spent
Objective 1: Village Health Workers	1,788,608	0	3,953,116	2,311,741
1.1. Training curriculum & materials update	25,000	Moved to 2008	25,000	12,535
1.2. Training materials printings	0			0
1.3. Long-term training courses for VHWs	755,000	Moved to 2008	2,065,000	1,404,910
1.4. Basic equipment kits for VHWs	0		641,900	0
1.5. Monthly allowance for VHWs	688,608	Moved to 2008	877,216	615,915
1.6. Supervisory visits for VHWs				
1.6.1. Monitoring manual/guideline	20,000	Moved to 2008	20,000	9,410
1.6.2. TOT courses for provincial trainers	0		24,000	0
1.6.3. Short courses for district officers	0		0	0
1.6.4. Support for monitoring & supervision	300,000	Moved to 2008	300,000	268,971
Objective 2: Commune Health Workers	731,840	34,337	1,248,755	1,040,554
2.1. Short courses for CHWs on MCH	130,000	Moved to 2008	130,000	393,401
2.2. Short courses for CHWs on EPI in practice	130,000	Moved to 2008	260,000	0
2.3. Monitoring and supervision for CHCs				
2.3.1. Monitoring manual/guideline for CHCs	25,000		25,000	11,874
2.3.2. A car to support monitoring & supervision	35,000	34,337		
2.4. Recurrent costs for difficult CHCs	411,840	Moved to 2008	798,755	635,279
Objective 3: Management Capacity	574,000	Moved to 2008	744,000	39,829
3.1. Health Planning and Mgmt. Manuals	30,000	Moved to 2008	30,000	12,510
3.2. Training for provincial and district officers				0
3.2.1. TOT courses for provincial trainers	0		24,000	27,319
3.2.2. Courses for district officers	0		146,000	0
3.3. HMIS support	0			0
3.3.1. Pilot and update HMIS software	8,000	Moved to 2008	8,000	0
3.3.2. TOT course on Software for district staff	20,000	Moved to 2008	20,000	0

Major Activities	2007		2,008	
	Budget	Spent	Budget	Spent
3.3.3. Training courses for CHWs	120,000	Moved to 2008	120,000	0
3.3.4. Computers for prov, districts & pilot CHCs	396,000	Moved to 2008	396,000	0
Objective 4. Policy development	187,500	14,684	432,500	61,010
4.1. Innovative fund	100,000	Moved to 2008	280,000	15,458
4.2. Workshops, seminars	67,500	14,684	92,500	40,274
4.3. To implement policy-oriented studies	20,000	Moved to 2008	60,000	5,278
Project Management Costs	314,802	6,481	498,629	308,393
Office equipment and furniture	110,000	Moved to 2008	110,000	99,007
Allowances for PMU	20,400	4,200	40,800	32,386
Contracted and admin staff	68,400	800	136,800	73,334
Running costs	86,002	1,481	172,029	84,638
Financial audit (two times)			9,000	0
Baseline and post-project surveys	30,000	Moved to 2008	30,000	19,028
Technical support	51,250		82,500	17,194
Local Consultants	11,250	Moved to 2008	82,500	17,194
International consultant	40,000	Moved to 2008		
Total	3,648,000	55,502	6,959,500	3,778,721

ANNEX 6 – Project Management Unit Members

VIETNAM - GAVI - HSS PROJECT

Project Management Unit (PMU) members

TT	Full name	Possition	Tel	Email
1	Dung Huy Liu	Director of Planning and Financing Dept Director of PMU	04.2.732266 0917.683.878	
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ANNEX 7 – Objectives and Activities Tracking

Tracking of specific objectives and activities as of April/May 2009

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
Specific objective 1 To increase the number of Village Health Workers (VHWs) and improve the quality of the work				
Curriculum of 9-month training program for VHWs updated	Department of Research and Training	Completion of the curriculum by quarter 2/2008	Not completed (70%)	- One year delay in starting - Training before the completion of curriculum (old version was used)
Major training materials (plans and procedures for administration) for 9-month training program for VHWs updated	Department of Research and Training together with Provincial Secondary Medical schools	Completion of the materials by quarter 3/2008	Not completed	- One year delay in starting - A frame of curriculum was developed - Training before the completion of materials
Training materials printed and distributed to all project provinces	PMU	Copies of the curriculum and materials distributed by quarter 4/2008	Not available at project provinces	Old materials were used for training Different versions at different provinces
Facilitate the employment of VHWS to get 99 percent of villages under the project having a VHW	District Health Bureaus	Completed by 2010	On going	

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
Providing 9 month training course for VHWs	Province Health Office together with Provincial Secondary Medical schools	6,040 VHWs having undergone 9 month training by 2010	On going	
Providing basic equipment kit for VHWs	PMU	All VHWs having received basic equipment kit (with continuous refill) by quarter 2/2008	The procurement procedure completed All kits expected to be distributed in August 2009	One year delay in starting
Monthly allowance for VHWs	Funds distributed through the salary system to provinces and further to districts that pay the salary	All VHWs receiving incentive of 50,000 VND per month every quarter during 2007-10	100% of VHWs receiving monthly incentive base on 3 levels of performance: A (very good)-50,000 VND; B (good)-45,000 VND and C (poor)-35,000 VND from Jan 2008	One year delay in starting Reduced incentive Positive points of performance classification
Monitoring manual/guideline for VHWs	PMU	Monitoring guideline developed for VHWs	The guideline was completed	
TOT courses for provincial trainers	PMU	1 TOT courses organized for provincial trainers	Has not been done	
Short courses for district officers	Provincial Health Offices	21 short courses organized for 751 district officers	Has not been done	
Support for monitoring and supervision	All levels	- At central level: 10 monitoring	On going	90%

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
		and supervision visits carried out in 10 project provinces - At provincial level: M&S visits carried out in all districts and communes - At district level: M&S visits carried out in all communes and villages		
Specific objective 2. To improve the quality of Commune Health Workers (CHWs) and expand the reach of the commune health centers (CHCs).				
Training materials on EPI in Practice and on MCH printed and distributed to all project provinces	Provincial Health Office together with the National Immunization Program	Completion of the material by the quarter 2/ 2007	Not available	
104 training course on reproductive, maternal and child health" for 4000 CHWs	Province Health Office together with Provincial Secondary Medical schools	Completed by 2010	On going 62 courses organised	Training without updated materials
104 training course on "EPI in Practice" for 4000 CHWs	Province Health Office together with Provincial Secondary Medical schools	Completed by 2010	On going 43 courses organised	Training without updated materials
Monitoring manual/guideline for CHCs	PMU	Monitoring manual/guideline for CHCs	Completed	
Provide a car to support monitoring and supervision	PMU	A car purchase and used	Purchased and used	
Recurrent cost for	District Health	1,144 CHC	Started since	The number

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
difficult CHCs	Bureau	received additional recurrent budget of 30USD per month during 2007-10	Jan, 2008	of CHCs is more than proposed
Specific objective 3. To strengthen health system management capacity				
3.1. Health Planning and Mgmt. Manuals	PMU	Health Planning and management Manuel developed for provincial and district health office	Completed (100%)	
3.2. Training for provincial and district officers	PMU			
3.2.1. TOT courses for provincial trainers	PMU	2 TOT courses organized for provincial trainers	Completed (100%)	
3.2.2. Courses for district officers	PMU	19 courses organized for 669 district officers	Not done	
3.3. HMIS support	PMU			
3.3.1. Pilot and update HMIS software	PMU	HMIS software updated and piloted	HMIS software updated	
3.3.2. TOT course on Software for district staff	PMU	A TOT course on HMIS organized for district staff	Not done	
3.3.3. Computer courses for CHWs	PMU	15 courses organized for 419 CHWs	Not done	
3.3.4. Computers for prov, districts and pilot CHCs	Province Health Office	316 computers purchased and provided to PHDs, district health centers and piloted CHCs	7/10 provinces have purchased computers	

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
Objective 4. Policy development				
4.1. Innovative fund	PMU and Department of Planning and Financing	Some proposals developed and approved	On going (70%)	
4.2. Workshops, seminars	PMU and Department of Planning and Financing	Workshops organized in the central and provincial levels	On going (70%)	
4.3. To implement policy-oriented studies	PMU and Department of Planning and Financing	Some studies carried out	On going (80%)	
Support and Management	PMU			
Office equipment and furniture	PMU	Office equipment and furniture purchased and used	Have done completed	
Allowances for PMU	PMU	Director, Vice Director, Coordinator and Chief Accountant received allowances	All got allowance (100%)	
Contracted and admin staff	PMU	An additional program officer recruited	All staff recruited	
Running costs	PMU	Running costs (telephone, photocopy, stationery, etc,) paid	All done	

ANNEX 8 – Progress and Impact Monitoring

Progress and impact monitoring under GAVI HSS in Vietnam

HSS inputs	Indicators: baseline and targets within 10 provinces under the project					
	Base-year	Year of GAVI application (2006)	Year 1 of implementation (2007)	Year 2 of implementation (2008)	Year 3 of implementation (2009)	Year 4 of implementation (2010)
Funds disbursed for PMT and the end users	Target	0	3,670,748	4,727,648	4,461,748	3,535,748
	Achieved		55,501	2,005,160	296,708	
Training curriculum and materials developed and provided to the end users	Target	NA	0	1	NA	NA
	Achieved		Not in progress	In progress	Expected to be completed	
Computer set & HMIS developed and provided to the end users	Target	NA	0	10 prov. 10 districts 164 comm.	7/10 provices purchased computors	NA
	Achieved		Not in progress	Not in progress	Com. Set purchased HMIS updated	
Number of equipment kits for VHWs	Target	NA	0	18,340	NA	NA
	Achieved		Not in progress	In progress	Completed (15,012 kits)	
Number of CHWs trained on EPI practice	Target	NA	500	1,500	2,000	
	Achieved		Not in progress	68 courses (41.3%)	Not yet available/ 36 planned	
Number of VHWs trained with 9-month course	Target	NA		1,000	2,500	2,540
	Achieved		Not in progress	2,313	2,580	
Percentage of village	Target	93.9	95	97	98	99

HSS inputs	Indicators: baseline and targets within 10 provinces under the project					
	Base-year	Year of GAVI application (2006)	Year 1 of implementation (2007)	Year 2 of implementation (2008)	Year 3 of implementation (2009)	Year 4 of implementation (2010)
with a VHW	Achieved		Not in progress	NA	NA	
Frequency of supervisory visits from higher levels to VHWs and CHWs	Target	NA	Every 6 months	Every 6 months	Every 3 months	Every 3 months
	Achieved		Not in progress	Achieved	Achieved	