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Report No: PAD2619

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF US$80 MILLION

AND

PROPOSED GRANTS

IN THE AMOUNT OF

US$17 MILLION (GLOBAL FINANCING FACILITY IN SUPPORT OF EVERY WOMAN EVERY CHILD MULTI-DONOR TRUST FUND),

US$5 MILLION (INTEGRATING DONOR-FINANCED HEALTH PROGRAMS MULTI-DONOR TRUST FUND), AND

US$3 MILLION (TACKLING NON-COMMUNICABLE DISEASES CHALLENGES IN LOW- AND MIDDLE-INCOME COUNTRIES MULTI-DONOR TRUST FUND)

TO THE

SOCIALIST REPUBLIC OF VIETNAM

FOR AN

INVESTING AND INNOVATING FOR GRASSROOTS HEALTH SERVICE DELIVERY PROJECT

May 29, 2019

Health, Nutrition, and Population Global Practice
East Asia And Pacific Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2019)

Currency Unit =	Vietnamese Dong (VND)
VND 23,204 =	US$1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Victoria Kwakwa
Country Director:	Ousmane Dione
Senior Global Practice Director:	Timothy Grant Evans
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ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
CCE	Cold Chain Equipment
CCEOP	Cold Chain Equipment Optimization Platform
CDC	Centers for Disease Control and Prevention
CHS	Commune Health Station
CNRHS	Central North Region Health Support
COPD	Chronic Obstructive Pulmonary Disease
CPF	Country Partnership Framework
CPMU	Central Project Management Unit
DA	Designated Account
DALY	Disability-adjusted Life Year
DH	District Hospital
DHC	District Health Center
DOH	Department of Health
ECOP	Environmental Codes of Practice
EMPF	Ethnic Minority Planning Framework
EPI	Expanded Program on Immunization
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
EU	European Union
FA	Framework Agreement
FM	Financial Management
GBV	Gender-based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GoV	Government of Vietnam
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
GSO	General Statistics Office
HCW	Health Care Waste
HMIS	Health Management Information System
HPET	Health Professionals Education and Training
HWMSP	Hospital Waste Management Support Project
ICR	Implementation Completion and Results Report
IEC	Information, Education, and Communication
IFR	Interim Financial Report
JAHR	Joint Annual Health Review
M&E	Monitoring and Evaluation
MDR-TB	Multi-drug-resistant Tuberculosis
MDTF	Multi-Donor Trust Fund
MOF	Ministry of Finance
MOH	Ministry of Health

MPI	Ministry of Planning and Investment
MTIP	Medium-Term Investment Plan
NCD	Noncommunicable Disease
NGO	Nongovernmental Organization
NORRED	North East and Red River Delta Region Health Support Project
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-Pocket
PDO	Project Development Objective
PHC	Primary Health Care
PHGF	Pharmaceutical Governance Fund
POM	Project Operations Manual
PPC	Provincial Peoples' Committee
PPMU	Provincial Project Management Unit
PPSD	Project Procurement Strategy for Development
RBF	Results-based Financing
SA	Social Assessment
SDG	Sustainable Development Goal
STEP	Systematic Tracking of Exchanges in Procurement
TB	Tuberculosis
TS	Transitional Support
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNICEF-SD	UNICEF-Supply Division
VIA	Visual Inspection with Ascetic Acid
VHLSS	Vietnam Household Living Standards Survey
VNEPS	Vietnam E-Procurement System
WA	Withdrawal Application
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Vietnam	Investing and Innovating for Grassroots Health Service Delivery	
Project ID	**Financing Instrument**	**Environmental Assessment Category**
P161283	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Disbursement-linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
19-Jun-2019	31-Dec-2024

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The Project Development Objective is to improve the quality and utilization of grassroots health services, with a focus on the commune level, in the Project Provinces.

Components

Component Name	Cost (US$, millions)

Component 1: Upgrading of CHS Infrastructure	81.25
Component 2: Improving the Readiness of CHS to Manage Tracer Conditions	22.00
Component 3: Creating an Enabling Policy Environment, Piloting Innovations, Evaluation, and Project Management	6.00

Organizations

Borrower:	Ministry of Finance
Implementing Agency:	Ministry of Health Ha Giang Department of Health Bac Kan Department of Health Son La Department of Health Tra Vinh Department of Health Hoa Binh Department of Health Bac Lieu Department of Health Hau Giang Department of Health Ninh Thuan Department of Health Quang Binh Department of Health Quang Ngai Department of Health Quang Tri Provincial Project Management Unit for Industrial and Civil Works Long An Department of Health Yen Bai Department of Health

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	109.25
Total Financing	109.25
of which IBRD/IDA	80.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	80.00
IDA Credit	80.00

Non-World Bank Group Financing

Counterpart Funding	21.25
Local Govts. (Prov., District, City) of Borrowing Country	20.55
National Government	0.70
Trust Funds	8.00
Integrating Donor-Financed Health Programs	5.00
Pharmaceutical Governance Fund	3.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Transitional Support	80.00	0.00	0.00	80.00
Total	**80.00**	**0.00**	**0.00**	**80.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022	2023	2024	2025
Annual	0.00	2.00	8.00	16.00	22.00	22.00	10.00
Cumulative	0.00	2.00	10.00	26.00	48.00	70.00	80.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Moderate

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓

Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10	✓	
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description
Institutional Arrangements

Financing Agreement: Schedule 2 Section I.A
Recurrent, Continuous

Obligation of the Recipient, (i) through the MOH, to maintain, and cause to be maintained a Central Project Management Unit (CPMU) responsible for: the overall and day-to-day implementation, coordination, reporting, environmental and social safeguards, financial management, procurement and monitoring and evaluation of the activities under Parts 2.2, 2.3 and 3 of the Project, and for coordination with the Provincial Project Management Unit (PPMU) for the implementation of the Project activities within the Project Provinces; (ii) through each Project Province, to maintain a PPMU to be responsible for: (a) the day-to-day implementation of the activities under Parts 1 and 2.1 of the Project within the respective Project Province, including environmental and social safeguards management, financial management and procurement; and (b) coordination with the CPMU for the implementation of the Project activities within the respective Project Province; all with composition, powers, functions, staffing, facilities and other resources acceptable to the Association.

Sections and Description
Subsidiary Agreements

Financing Agreement: Schedule 2, Section I.B
Recurrent, Continuous

Obligation of the Recipient to make the proceeds of the Credit available to the Project Provinces under a subsidiary agreements between the Recipient and the Project Provinces, under terms and conditions acceptable by the Association; exercise its rights under the Subsidiary Agreements in such manner as to protect the interests of the Recipient and the Association and to accomplish the purposes of the Credits.

Sections and Description
Annual Work Plans

Financing Agreement: Schedule 2, Section I.C.1
Recurrent, Continuous

Obligation of the Recipient, through the MOH and the Project Provinces, to: (a) prepare and furnish to the Association by October 1 in each year during the implementation of the Project, a draft Annual Work Plan for review and comment, summarizing the implementation progress of the Project for the said year and the Project activities to be undertaken in the following calendar year, including the proposed annual budget for the Project; (b) taking into account the Association's comments, finalize and furnish to the Association no later than December 1 in each year, during the implementation of the Project, the Annual Work Plan, acceptable to the Association; and (c) thereafter ensure the implementation of the Project during the following calendar year in accordance with the Annual Work Plan agreed with the Association and in a manner acceptable to the Association. The Recipient shall not amend, suspend, abrogate, or waive said Annual Work Plans or any provision thereof without the prior written agreement of the Association.

Sections and Description
Project Operations Manual

Financing Agreement: Schedule 2, Section I.C.2
Recurrent, Continuous

Obligation of the Recipient, through MOH and the Project Provinces, to carry out the Project in accordance with the Project Operations Manual; and not amend, suspend, or waive the Project Operations Manual or any provision or schedule thereof unless the Association otherwise agrees in writing.

Sections and Description
Safeguards

Financing Agreement: Schedule 2, Section I.D
Recurrent, Continuous

Obligation of the Recipient, through MOH and the Project Provinces, to ensure that the Project is carried out in accordance with the Safeguards Instruments; and not amend, revise or waive, nor allow to be amended, revised or waived, any of the provisions of the Safeguards Instruments unless the Association agrees otherwise in writing; and regularly collect, compile, and furnish to the Association as part of the Progress Reports information on the status of compliance with the Safeguards Instruments; and maintain policies and procedures adequate to enable it to so monitor and evaluate implementation.

Sections and Description

Midterm Review

Financing Agreement: Schedule 2, Section II.2
Due Date: 30 months after the Effective Date

Obligation of the Recipient, through MOH and the Project Provinces, to carry out jointly with the Association a midterm review to assess the status of Project implementation, as measures against the performance indicators set forth in the Project Operations Manual.

Conditions

Type	Description
Effectiveness	Financing Agreement, Article 4.01 (a) and Grant Agreement, Article 5.01 (a) The Project Operations Manual has been duly adopted by MOH.
Type	Description
Effectiveness	Financing Agreement, Article 4.01 (b) and Grant Agreement, Article 5.01 (b) The Financing Agreement and the Grant Agreement have been executed and delivered and all conditions precedent to their effectiveness or to the right of the Recipient to make withdrawals under them have been fulfilled.

I. STRATEGIC CONTEXT

A. Country Context

1. **Vietnam has achieved tremendous poverty reduction over the last couple of decades through distributing the gains of strong economic growth equitably.** By 2016, the incidence of poverty had fallen to 9.8 percent (national General Statistics Office [GSO]-World Bank poverty line),[1] down from nearly 60 percent in 1993. Inequality has remained largely unchanged, with the Gini coefficient even dropping slightly (from 35.7 to 35.3) over 1992 to 2016.[2] Over the past half-decade (2010 to 2016), the average consumption level of the bottom 40 percent has grown by 5.2 percent annually. Vietnam's success in reducing poverty is attributed to rapid economic growth and economic restructuring that has also been accompanied by job growth and government investments to improve public infrastructure and service delivery. The economy has transformed from a largely closed and centrally planned one to a dynamic and market-oriented one, integrated and connected to the global economy. Economic growth has also been fairly resilient to a challenging global environment, with recent annual gross domestic product (GDP) growth in excess of 6 percent and only moderate inflation. Vietnam reached middle-income status in 2009.

2. **Poverty reduction has also been accompanied by broader welfare gains and improved living standards.** This is evidenced by the fact that Vietnam achieved most of the Millennium Development Goals faster than targeted—and welfare improvements have continued. From 1993 to 2017, the infant mortality rate decreased from 32.6 to 16.7 (per 1,000 live births),[3] while stunting prevalence fell from 61 percent to 24.2 percent.[4] The net enrollment rate for primary school increased from 78 percent in 1992–1993 to 93 percent in 2014, for lower secondary school from 36.01 percent to 84.4 percent, and for upper secondary school from 11.39 percent to 63.1 percent.[5] Access to household infrastructure improved dramatically: by 2016, 99.4 percent of the population used electricity as their main source of lighting (up from 48.6 percent in 1993),[6] 77 percent of the rural population had access to improved sanitation facilities (compared to 33.8 percent in 1993),[7] and 69.9 percent of the rural population had access to clean water in 2016[8] (from 62.9 percent in 1996).[9] Access to all of these services in urban areas is well above 90 percent. Vietnam has also closed gender gaps along a wide range of social and economic measures (including bringing female labor force participation within 11 percentage points of that of men),[10] but the high and widening sex ratio at birth (115 in 2018)[11] shows that fundamental gender discrimination

[1] World Bank. 2019. World Development Indicators 2019.
[2] Ibid.
[3] United Nations Inter-Agency Group for Child Mortality Estimation 2018.
[4] GSO of Vietnam. 2017. Statistical Yearbook. Hanoi: Statistical Publishing House.
[5] Vietnam Living Standards Survey 1992–1993; Vietnam Household Living Standards Survey (VHLSS) 2014.
[6] Vietnam Living Standards Survey 1992–1993; VHLSS 2016.
[7] World Bank. 2018. *Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam*. Washington DC: World Bank.
[8] Ibid.
[9] World Health Organization (WHO)/United Nations Children's Fund (UNICEF). 2015. *Joint Monitoring Program for Water Supply and Sanitation. Estimates on the Use of Water Sources and Sanitation Facilities*. https://www.wssinfo.org/documents/?tx_displaycontroller[type]=country_files.
[10] Vietnam Labor and Employment Survey 2018 (quarter 2).
[11] GSO 2018. Socioeconomic situation 2018 https://www.gso.gov.vn/default.aspx?tabid=621&ItemID=19037. Accessed February 9, 2019.

persists. The 2018 Human Development Index ranked Vietnam at 116 out of 189 countries, in the 'medium' category with a score of 0.694,[12] while the World Bank's 2018 Human Capital Index ranked Vietnam 48th out of 157 countries with a score of 0.67 (exceeding the global, regional, and even upper-middle-income country averages).[13]

3. **Looking ahead, Vietnam is expected to go through further social transformation and may face mounting economic and environmental pressures.** First, Vietnam is one of the most rapidly aging countries and the 65+ age group is expected to increase 2.5 times by 2050.[14] Second, while the population still largely lives in rural areas (64.8 percent in 2017), it has been steadily urbanizing (at about 0.7 percentage points per year).[15] Expectations of the population in terms of access to quality public services are also changing because of increasing incomes, access to information, and more spatial integration (global and urban-rural). Risks to development include the fragility of poverty gains, as well as the concentration of poverty in ethnic minority communities and rural, mountainous areas;[16] environmental sources of vulnerability (such as climate change, natural disasters, and unsustainable exploitation of natural resources); rising fiscal pressures, including a growing fiscal deficit[17] and a debt-to-GDP ratio that, although having fallen back from its 2016 high (of 63.7 percent) to 61.4 percent is still close to the 65 percent statutory limit; structural constraints in the growth model, including an overreliance on factor accumulation (compared to productivity growth); and limited private sector development. Balancing economic prosperity with environmental sustainability, promoting equity and social inclusion, and strengthening state capacity and accountability—all within a constantly evolving global and domestic context—will be challenging.[18]

B. Sectoral and Institutional Context

Health Outcomes, Access to Services, and Emerging Health Challenges

4. **Vietnam has made remarkable progress in health outcomes over the past 25 years and access to basic health services is good**. Between 1990 and 2016, life expectancy increased from 70.5 to 76.3 years, and is the highest in the region for countries at a similar income level.[19] Between 1990 and 2017, the child mortality rate fell from 51 to 21 per 1,000 live births,[20] while the maternal mortality ratio fell from 139 to 54 per 100,000 live births between 1990 and 2015.[21] In 2014, the proportion of births assisted

[12] United Nations Development Programme (UNDP). Human Development Indices and Indicators. 2018 Statistical Update. New York: UNDP http://hdr.undp.org/sites/default/files/2018_human_development_statistical_update.pdf.
[13] World Bank. 2018. The Human Capital Project. https://openknowledge.worldbank.org/handle/10986/30498. License: CC BY 3.0 IGO.
[14] GSO and United Nations Population Fund (UNFPA). 2016. Population Projections for the Period 2014–2049. Hanoi: Thong Tan Publishing House.
[15] World Bank. 2019. World Development Indicators 2019.
[16] World Bank. 2018. *Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam*. Washington, DC: World Bank.
[17] The fiscal deficit averaged 5.6 percent of GDP during 2011–2015 and 2.2 percent of GDP during 2006–2010.
[18] World Bank Group and Ministry of Planning and Investment (MPI). 2016. *Vietnam 2035: Toward Prosperity, Creativity, Equity and Democracy*. Washington, D.C: World Bank.
[19] World Bank. 2019. World Development Indicators 2019.
[20] UN Inter-Agency Group for Child Mortality Estimation (UN-IGME) in 2018. Downloaded from http://data.unicef.org.
[21] Alkema, L., et al. 2016. "Global, Regional, and National Levels and Trends in Maternal Mortality between 1990 and 2015, with Scenario-based Projections to 2030: A Systematic Analysis". *The Lancet* 387.10017 (2016): 462–474.

by a trained staff was 93.8 percent[22] and the proportion of pregnant women receiving four or more antenatal care visits was 73.7 percent. [23] In 2017, the nationwide full immunization rate was 96.4 percent and reached or exceeded 95 percent in 54 out of Vietnam's 63 provinces.[24] In 2016, 7.9 percent of people (8.4 percent in rural and 7.0 percent in urban areas) had at least one inpatient visit, while 36.0 percent (34.4 percent in rural and 39.4 percent in urban) had an outpatient visit in the previous 12 months.[25]

5. **However, disadvantaged groups—and especially ethnic minorities and those living in poor, remote, and mountainous provinces—have substantially worse access and outcomes.** In 2016, the child mortality rate in rural areas (26.0 per 1,000 live births) was more than double that in urban areas (12.7); child mortality rates in some remote mountainous provinces exceeded 50 but were generally less than 20 in the delta provinces.[26] Similarly, while the national under-five stunting prevalence was 24.2 percent in 2017, it reached over 35 percent in some remote mountainous provinces.[27] Survey-based estimates of full immunization rates fall to as low as 70 percent among disadvantaged groups, such as ethnic minority children (69.4 percent), the poorest quintile (72.2 percent), and those in mountainous provinces (such as the Central Highlands, 70.5 percent, and Northern Midlands and Mountains, 71 percent).[28] The proportion of births assisted by a trained staff was 68.3 percent among ethnic minority women and 73.4 percent among the poorest quintile, compared to over 95 percent among women in the remaining quintiles.[29] The proportion of pregnant women having four or more prenatal care visits was only 32.7 percent among ethnic minorities and 38.6 percent among the poorest quintile but rose to 67 percent in the second poorest quintile and to 96 percent in the richest quintile.[30] The sex ratio at birth worsened to 115 in 2018,[31] up from 112 the previous year, and is now, together with China, the highest in the world.

6. **Population aging, a disease burden increasingly dominated by noncommunicable diseases (NCDs), and a growing middle class will present a new set of challenges to the health system.** As previously indicated, Vietnam's population is aging faster than most other Asian countries.[32] This is contributing to a rapid shift in Vietnam's burden of disease toward NCDs, which increased from 46 percent of the disease burden (measured in disability-adjusted life years [DALYs]) in 1990 to 74 percent in 2017.[33] In 2017, cervical cancer accounted for 19 times more deaths than maternal causes[34] (and 3.8 times more deaths than maternal causes among women of childbearing age). The single leading contributor to the disease burden is stroke, accounting for 14 percent of all DALYs.[35] The leading risk factors associated with

[22] GSO and UNICEF. 2015. *Vietnam Multiple Indicator Cluster Survey 2014, Final Report*. Ha Noi, Vietnam.
[23] Ibid.
[24] GSO. 2018. Statistical Yearbook of Vietnam 2017. Hanoi: Statistical Publishing House.
[25] GSO. Result of the VHLSS 2016. Hanoi: Statistical Publishing House. 2018.
[26] GSO. 2018. Statistical Yearbook of Vietnam 2017. Hanoi: Statistical Publishing House. (Tables 34 and 36).
[27] Provincial estimates from National Institute of Nutrition. 2016. Statistical data on child malnutrition 2015. http://viendinhduong.vn/news/vi/106/61/0/a/so-lieu-thong-ke-ve-tinh-trang-dinh-duong-tre-em-qua-cac-nam.aspx.
[28] GSO and UNICEF. 2015. *Vietnam Multiple Indicator Cluster Survey 2014, Final Report*. Ha Noi, Vietnam.
[29] Ibid.
[30] Ibid.
[31]GSO. Socioeconomic situation 2018 [Tình hình kinh tế - xã hội năm 2018]. *https://www.gso.gov.vn/default.aspx?tabid=621&ItemID=19037*. Accessed February 9, 2019.
[32] Ministry of Health (MOH) and Health Partnership Group. 2018. *Joint Annual Health Review 2016 - Towards Healthy Ageing*. Hanoi: Medical Publishing House.
[33] Institute for Health Metrics and Evaluation (IHME). Global Burden of Disease Results Tool. Data downloaded November 20, 2018.
[34] Ibid.
[35] Ibid.

stroke (as well as with other major contributors to the disease burden) are uncontrolled hypertension, high cholesterol, diabetes, smoking, and an unhealthy diet. In 2015, only 13.6 percent of hypertension cases and 28.9 percent of diabetes cases were being managed (but not necessarily controlled) by a health care provider.[36] As Vietnam grapples with the shifting disease burden, it will also face the challenge of the rising expectations of a growing middle class which will demand better quality and more technological sophistication in health care (typically with a preference for hospital and specialist care).

Health Financing and Financial Protection from Health Costs

7. **The government's current health spending is high in Vietnam, contributing to high total health spending as a share of GDP.**[37] The Government of Vietnam (GoV) has committed to keep the annual rate of increase of government health spending higher than the rate of increase of the general government budget (National Assembly Resolution 18/2008/NQ-QH12), with the result that current health spending grew from 8.1 percent of general government expenditure in 2008 to 8.9 percent in 2016. This is higher than any other low-to-middle income country in the region except China and Thailand. Combined with increasing out-of-pocket (OOP) health spending (see next paragraph), rising public spending means that overall health spending has also increased steeply: between 2000 and 2016, the per capita current health expenditure increased more than threefold, from US$98 to US$356 in purchasing power parity-adjusted terms. As a share of GDP, the total health expenditure (capital and current) rose from 5.4 percent to 4.9 percent over the same period; this share is higher than all other low-to-middle-income countries in the region, except Cambodia and Nepal.

8. **OOP health spending has been rising, but increased incomes and the expansion of health insurance coverage have mitigated the financial impact on households.** From 2000 to 2016, real per capita OOP health spending tripled, from US$37 to US$159 in purchasing power parity terms. As a share of current health expenditure, OOP spending increased from 37 percent to 45 percent. GDP per capita rose almost as rapidly as OOP health spending, increasing 2.3 times in this period, with the result that OOP as a share of GDP increased only a little from 1.8 percent in 1995 to 2.5 percent in 2016. Health insurance coverage has also grown rapidly, from 13.4 percent in 2000[38] to 87 percent by 2017,[39] through a series of legal decrees to fully subsidize the health insurance coverage of the poor (2002), children (2006) and other vulnerable or meritorious groups (for example, social assistance beneficiaries or people who had participated in the revolution) and provincial decisions to partially or fully subsidize the near-poor. Consequently, financial protection from health spending has been improving: the incidence of catastrophic health spending declined from 20.2 percent in 1992 to 9.5 percent in 2016 (when measured with a 10 percent threshold defined in total household spending), while impoverishment due to health spending fell from 2.3 percent to 1.1 percent when using the US$3.20 per day poverty line (and 4.6 percent

[36] MOH, General Department of Preventive Medicine. 2015. Vietnam National Survey on the Risk Factors of NCDs (STEPS).
[37] Unless otherwise noted, all estimates in this and the subsequent paragraph are from the WHO Global Health Expenditure Database (updated December 3, 2018). http://apps.who.int/nha/database.
[38] MOH. 2007. *Vietnam Health Report 2006*. Hanoi: Medical Publishing House.
[39] MOH and Health Partnership Group. 2018. *Joint Annual Health Review 2016. Towards Healthy Ageing*. Hanoi: Medical Publishing House.

to 0.31 percent when using the US$1.90 per day poverty line).[40] With these improvements, Vietnam now has similar levels of financial protection to other middle-income countries.[41]

9. **The country is no longer highly dependent on external financing for the health sector.** In 1995, 3.5 percent of total health expenditure came from external assistance, but this had fallen to 1.8 percent in 2013—although it was back up to 2.7 percent in 2014.[42] As Vietnam has achieved middle-income country status, a number of major development partners—including the European Union (EU), Gavi the Vaccine Alliance and the Global Fund for HIV/AIDS, Tuberculosis, and Malaria—have completed or are reducing the scale of their assistance, necessitating a shift of previously externally financed programs to government budget or health insurance. There is a need to ensure and sustain the gains made with development assistance, particularly for vertical programs (like immunization, tuberculosis [TB], HIV/AIDS, and others).

10. **Another important health financing transition, driven by fiscal pressures, is the shift from the use of government budget for health care, resulting in fee increases that threaten the financial sustainability of the health insurance fund and the financial protection of uninsured patients.** In 2012–2013 and again in 2016, following the introduction of the road map to phase in full cost recovery for government health services (Decree No. 85/2012/ND-CP), government-administered fees for health services were raised dramatically. As a result, consumer prices for medical services and pharmaceuticals rose by 45 percent in 2012[43] and, in 2013, by a further 19 percent. In 2016, they rose by 56 percent. These high price increases constitute a shift in the responsibility to pay for government health services from the government budget (through reduced provider subsidies) to the health insurance fund and uninsured patients. For the 13 percent of the population that was still not covered by health insurance by 2017, these policies present a financial risk. For the health insurance fund, the combination of price increases and a largely fee-for-service payment mechanism pose a threat to financial sustainability. Premiums have not been raised to cover the price increases and Vietnam Social Security, which is currently in deficit, has few instruments at its disposal to effectively curb inefficient service provision and cost escalation.

11. **The incentives inherent in Vietnam's health financing system may be leading to overprovision of curative care at the expense of essential and ultimately cost-saving preventive and promotive services.** The fee-for-service payment method for curative care (whether paid for by the health insurance fund or OOP by patients) creates strong incentives to order large volumes of tests and treatments and retain patients in hospitals when they could be effectively cared for at the commune health station (CHS). Preventive and promotive services are paid from the state budget but now largely at the provincial level rather than through centrally-managed national target programs. In many localities, this consists largely of payment for material inputs (drugs, vaccines, and consumables), while staff are remunerated with a fixed government salary. In the centrally-managed national target programs of the past, additional

[40] Teo, H. S., S. Bales, C. Bredenkamp, and J. S. Cain. 2019. *The Future of Health Financing in Vietnam*. Washington, DC: World Bank.
[41] Comparison across middle-income countries from WHO and World Bank. *Tracking Universal Health Coverage. First Global Monitoring Report*. http://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2015_financial_indicators_country.pdf?ua=1.
[42] WHO. Global Health Observatory data repository. Health expenditure ratios, by country, 1995-2014 Vietnam. http://apps.who.int/gho/data/view.main.HEALTHEXPRATIOVNM?lang=en.
[43] GSO. Consumer price index. Data are from the statistical yearbook for each year, as well as monthly statistical information on the website for recent years. http://www.gso.gov.vn/default_en.aspx?tabid=622.

payments were made to health workers to incentivize performance, such as completion of full immunization, monitoring of patients through full treatment protocol for TB, or for implementation of information, education, and communication (IEC) campaigns. Decentralizing these payments to the discretion of local governments facing many competing spending priorities may threaten program sustainability, particularly without verifiable and timely performance monitoring.

Service Delivery

12. **Over-reliance on hospital-centered care and over-servicing are major sources of health system inefficiency.** Vietnam's rate of hospital admissions and average length of stay are higher than regional averages[44] and the total inpatient spending is 1.42 times higher than outpatient spending.[45] Bypassing lower levels of care is common because people generally do not have a primary provider who acts as a care coordinator to guide them through the system to get effective and appropriate care in line with their needs. Despite higher co-payment rates at higher-level hospitals to discourage bypassing, the deterrent effect has not been very strong because service prices have been substantially subsidized. With user fees now increasingly aimed at full cost recovery, disincentives to bypassing are likely to be stronger than in the past.[46] Public hospitals are also encouraged to raise capital from the private sector (including from their own staff)[47] to invest in new medical technologies and are allowed to charge higher fees for the use of the private equipment. In addition, the financial autonomy policy allows hospitals to top up staff incomes from operating surplus, encouraging over-servicing.[48] These factors create powerful incentives for hospitals to offer expensive, high-tech services, some of which may be medically unnecessary,[49] but are also interpreted by patients as a signal of quality, further exacerbating bypassing and overcrowding.

13. **Primary care is the responsibility of the grassroots health system.** The 'grassroots health system' refers to the health system at the district (population of about 100,000), commune (5,000–8,000), and village (about 1,000) levels. CHSs, which are responsible for the implementation of vertical programs and increasingly the first point of contact for some services financed by health insurance, are under the management of the district preventive medicine centers (responsible for preventive and public health). Health insurance reimbursements flow to CHS through district hospitals (DH) which provide both primary and basic secondary care. DHs and preventive medicine centers are in the process of being merged into one facility (henceforth referred to as district health center/hospital [DHC/DH]). Village health workers are managed by the CHS.

[44] OECD (Organisation for Economic Co-operation and Development)/WHO. 2016. *Health at a Glance: Asia/Pacific 2016: Measuring Progress towards Universal Health Coverage*. Paris: OECD Publishing. DOI: http://dx.doi.org/10.1787/health_glance_ap-2016-en.

[45] Health Finance and Governance (United States Agency for International Development) and MOH. 2016. *Vietnam 2013 General Health Accounts and Disease Expenditures with Sub-Analysis of 2013 HIV/AIDS Expenditure*.

[46] For inpatient care, health insurance reimbursement is reduced to 60 percent if bypassing is to provincial level and to 40 percent if bypassing is to central level. For outpatient care, bypassing to any level results in zero reimbursement.

[47] According to Decree No. 69/2008/ND-CP, "Units implementing social mobilization are permitted to mobilize capital through sales of stocks, capital contributed by workers in the unit…to invest in construction of physical facilities."

[48] Decree No. 16/2015/NĐ-CP on the autonomy mechanism in government service provider units.

[49] For example, the C-section rate has risen rapidly from 20 percent in 2011 to 27.5 percent in 2014, while the share of births in government hospitals increased from 69.9 percent to 78.6 percent over the same period. Data: GSO and UNICEF. 2011/2014. Vietnam Multiple Indicator Cluster Surveys.

14. **While relatively well-used in the more disadvantaged parts of the country, CHSs are not yet sufficiently equipped or enabled to tackle the shift in the disease burden, while health financing arrangements fail to incentivize effective and coordinated care.** On average, only 23 percent of outpatient contacts are at the CHS or regional polyclinic,[50] but this share reaches well over 50 percent in most mountainous provinces. However, the basic infrastructure, equipment, and competencies are lacking in many communes. In 2016, only 69.76 percent of rural communes met the 2014 national commune health benchmarks.[51] Moreover, those largely structural benchmarks do not provide any assurance that the CHSs are capable of appropriately dealing with specific medical conditions in line with diagnostic and treatment guidelines for those conditions and in close coordination with higher-level facilities. The capacity to prevent, detect, and manage chronic NCDs;[52] identify pregnancy risks during antenatal care; and provide timely response and transport in case of obstetric emergency, for example, is weak. Creating a stronger primary care function based on a strong health professional team-patient relationship is needed to ensure continuity of care and better patient case management while also encouraging more patients to seek care at this level rather than bypassing. Another challenge is that current provider payment arrangements do not provide the appropriate incentives to the CHS health workers to make more effort to keep patients healthy or manage diseases effectively. Staff are paid by salary, drugs are provided in kind from the DH, and health insurance reimbursement at the CHS level is only for a small set of medical services and paid on a fee-for-service basis.

15. **The multiple transitions—demographic, epidemiological, health financing—through which Vietnam is going, coupled with a shift toward more horizontal integration of care, could pose some risks to the sustainability of essential public health services.** The epidemiological transition toward a disease burden dominated by NCDs, spurred by a rapidly aging population, will demand more resources for combatting conditions such as cancers, hypertension, and diabetes. This may limit further expansion of public health programs in this area of health care where success is perceived to be largely achieved. The domestic financing transition, whereby the Government is quickly shifting from supply-side subsidies to demand-side financing (through the expansion of health insurance coverage and moving different 'cost components' of care from government budgets to health insurance) will increase resources provided for curative care, possibly reducing the incentivize for providers to focus on preventive services. Finally, while solid transition plans are generally in place, there remains a risk that the reduction in external financing may be challenging for those conditions/services that have traditionally been very reliant on donor support (for example, immunization where, in 2016, only 64 percent of financing was sourced domestically). The sustainability question is not only fiscal, that is, whether domestic resources can fill the gap without jeopardizing access to care but also programmatic, that is, related to the integration and harmonization of the systems used by the donor-financed programs (which often have different procurement, financial management (FM), human resources, and reporting arrangements).

Government Strategies and Plans

16. **Recent government strategies and masterplans, as well as ongoing policy development, reflect an increasing awareness of these challenges and an emphasis on strengthening the grassroots health**

[50] Regional polyclinics are government primary care facilities intended to provide services to multiple communes, particularly those far from DHC/DH, or in remote districts (MOH Decision No. 1327/2002/QD-BYT), but not all provinces have them.
[51] Central Steering Committee for the Census of Rural areas, Agriculture and Aquaculture. 2016. Preliminary report of the Results of the Census of Rural areas, Agriculture and Aquaculture. Hanoi: Statistical Publishing House.
[52] MOH, General Department of Preventive Medicine. 2015. Vietnam National Survey on the Risk Factors of NCDs (STEPS).

system. The MOH and development partners' recent Joint Annual Health Reviews (JAHRs) have focused on the challenges related to the NCD burden (2014), strengthening primary health care (PHC) (2015), and healthy aging (2016). The five-year health sector plan for 2016–2020 includes a significant focus on strengthening the grassroots health system (MOH Plan 139/KH-BYT of 2016). The Government's Masterplan for Easing Hospital Overcrowding includes actions at the primary care level, including developing a family practice model, bolstering preventive medicine, and strengthening CHSs (Prime Ministerial Decision 92/QD-TTg of 2013). Both the National Strategy to prevent and control cancer, cardiovascular disease, diabetes, chronic obstetric pulmonary disease, asthma, and other NCDs for 2015–2025 (Prime Ministerial Decision No. 376/QD-TTg of 2015) and the National Strategy for Population and Reproductive Health for 2010–2020 (Prime Ministerial Decision 2013/QD-TTg of 2011) emphasize the importance of strengthening the grassroots level to prevent and manage NCDs as well as to improve maternal and child health outcomes. In 2016, the Government approved the masterplan for building and developing the grassroots health care network in the new situation (Prime Ministerial Decision 2348/QD-TTg of 2016) which includes plans for investment (in infrastructure and equipment) and reforms to address the abovementioned problems, and also identifies overseas official development assistance (ODA) as one of the potential sources of financing. In 2018, the new 10-year Central Party Resolution on Health Care (Resolution No. 20 NQ/TW, October 25, 2018) emphasized that priority should be given to strengthening of the grassroots health system, also referring specifically to the role of the CHS in managing NCDs. The MOH has issued action programs to implement both of these high-level policies.[53] The MOH has also been operationalizing reforms at the commune level through piloting a new CHS model that is currently being implemented in 26 CHSs.[54] A new basic essential service package for health insurance reimbursement at the commune level has been issued, expanding the scope of services to include NCD interventions.[55] The principles of family medicine[56] are being promoted for the CHS and private primary care facilities.[57] As reforms in the organization and financing of service delivery proceed, and the system attempts to address new challenges related to NCDs, care will also need to be undertaken that coverage of basic health services (such as immunization and maternal care) is sustained—and further improved.

C. Higher Level Objectives to which the Project Contributes

17. **The project contributes to the attainment of the GoV's socioeconomic goals and the strategic directions of Vietnam's health sector.** The GoV's 2010–2020 Socio-Economic Development Strategy and the more recent 2016–2020 Socio-Economic Development Plan stress the importance of addressing the changing health needs of the population through a strengthened PHC system, highlighting that this is an efficient means to improve health outcomes. The 2018 Central Party Resolution on Health Care (Resolution No. 20 NQ/TW, October 25, 2018) also pointed to the need to strengthen the grassroots health system, highlighting the need for a new role of the CHS in managing NCDs. The project also serves

[53] MOH Program 1379/CTr-BYT on developing the grassroots health network according to Decision 2348/QD-TTG during 2018–2020; MOH Decision 1624/QD-BYT on implementing Resolution 20-NQ/TW on strengthening protection, care, and promotion of the people's health.
[54] MOH Guidelines 1383/HD-BYT on implementing the CHS model in 26 CHSs during 2018–2020
[55] Circular 39/2017/TT-BYT regulating the essential health care services package at the grassroots level.
[56] These principles include continuity, comprehensiveness, coordination, preventive orientation, and reliance on community and family.
[57] MOH Decision No. 935/QD-BYT of 2013, approving the development of the family doctor model during 2013–2020; MOH Decision No. 1568/QD-BYT of 2016, approving the scaling up and further development of the family doctor model during 2016–2020.

the specific objectives of the MOH's PHC-related strategies and plans such as the Grassroots Masterplan, the Masterplan for Reducing Hospital Overcrowding, various disease-specific strategies (for example, for reproductive health and for NCDs), and ongoing reforms related to the benefit package and health financing arrangements (referred to in section I B).

18. **The project is also aligned with the objectives set out in the World Bank Group's Vietnam Country Partnership Framework (CPF) FY18–FY22,[58] in particular Objective 6 which is to 'improve access to quality public and private health services and reduce malnutrition'**. This objective explicitly focuses on the quality of PHC, including 'strengthening the grassroots (district and commune) health system in terms of availability/access, quality, integration, and transparency and voice'. The project also supports one of the five strategic shifts envisaged under the CPF, namely improving 'financial sustainability of public services and transfers', by reducing the over-reliance on hospital care, improving the efficiency of service delivery arrangements, and supporting health financing reform. In addition, the project contributes to CPF Objective 5, on ethnic minority poverty reduction, by targeting its health and human capital investments at poor provinces which have large ethnic minority populations. Taken together, the investments in human capital made by this project will contribute to the World Bank Group's overarching goals of reducing poverty and promoting shared prosperity.

19. **Finally, the project contributes to Vietnam's aspiration for Universal Health Coverage (UHC), which is not only the unifying health-related Sustainable Development Goal (SDG 3.6), but also the overarching strategic direction for the World Bank's Health, Nutrition, and Population Global Practice.** UHC is defined as a situation where all people have access to essential health services (preventive, promotive, curative, rehabilitative, and palliative) that they need, of sufficient quality to be effective, without risk of financial hardship. It is monitored across two dimensions: first, a set of indicators[59] that measure access to essential quality services (including a number of the services addressed by this project) and a set of indicators measuring financial protection (that is, share of the population not impoverished by OOP spending on health care).[60] PHC stands central to the attainment of UHC. Indeed, in October 2018, the Astana Declaration reaffirmed the commitment to PHC as the cornerstone of UHC and the health-related SDGs, emphasizing services that are "high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed."[61]

[58] World Bank. 2017. *Vietnam - Country Partnership Framework for the Period FY18-FY22 (English)*. Report No. 111771. Washington, D.C.: World Bank Group.
[59] Sixteen essential health services in four categories are monitored: reproductive; maternal; newborn; and child health (family planning, antenatal and delivery care, full child immunization, health-seeking behavior for pneumonia); infectious diseases (TB treatment, HIV antiretroviral treatment, hepatitis treatment, use of insecticide-treated bed nets for malaria prevention, adequate sanitation); NCDs (prevention and treatment of raised blood pressure, prevention and treatment of raised blood glucose, cervical cancer screening, tobacco [non-]smoking); and service capacity and access (basic hospital access, health worker density, access to essential medicines, health security, that is, compliance with the International Health Regulations).
[60] WHO and World Bank. 2017. *Tracking Universal Health Coverage: 2017 Global Monitoring Report on Universal Health Coverage*.
[61] https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf.

II. PROJECT DESCRIPTION

20. **The project aims to improve the efficiency of the grassroots health system and address the unmet need for care, by improving the quality and utilization of commune-level health services.** The project will enable the CHS to take on a new role in detecting and managing NCDs (including hypertension, diabetes, and cervical cancer) while strengthening its existing role in controlling infectious diseases (including through immunization and early detection of TB) and providing essential newborn and child health care services. It also aims to strengthen vertical and horizontal integration, patient-centeredness, and continuity of care to improve quality while shifting care toward the most appropriate level and the most effective interventions to improve peoples' health and overall system efficiency.

21. **These improvements will be guided by family medicine principles and enabled by information technology.** Family medicine principles, which emphasize continuity of care and collaboration across different levels, now form the basis of training for grassroots health professionals in Vietnam. In line with these principles, the project will seek to build stronger teamwork within facilities, horizontal integration across services, and vertical integration across commune (health center) and district (hospital) levels. The project's interventions (and innovations) will also exploit the widespread availability of computers and internet access in the CHS which, combined with recent developments in the grassroots electronic health information system (including policies to implement electronic health records at the commune level) will help to enhance the quality of care. One example is providing vaccine fridges to disadvantaged communities and integrating the birth and immunization information systems of the DHC/DH and CHS to help ensure that children who are not born in facilities (hospitals) also get timely immunizations (especially birth doses). Another example is expanding capacity for early detection and treatment of TB (including multi-drug-resistant tuberculosis [MDR-TB]) through training in differentiating symptoms of lung diseases, increased availability of GeneXpert testing, and enhanced GeneXpert network connectivity allowing cloud-based monitoring across levels of care.

22. **Project support is organized around a set of 'tracer conditions'.** These 'tracer conditions' represent priority diseases or conditions that have been, or can be, detected and managed at the commune level, with appropriate support from the district level. The tracer conditions supported by the project reflect the priorities of the GoV, which are well-justified in various sector strategies,[62] and also the priorities of the donors who have contributed significant grant resources to this project. Within each tracer, the selected interventions are based on national strategies, plans, and international guidelines. The following five tracer conditions and associated services are at the core of the project's activities[63].

(a) **Hypertension (new CHS role).** This includes IEC, early detection, diagnosis, development of a treatment plan, and continuous management of uncomplicated primary hypertension.

(b) **Diabetes (new CHS role).** This includes IEC, identification of suspected cases, referral to the

[62] Priorities are articulated in the Grassroots Masterplan (PM Decision No. 2348), MOH action plan for implementing Decision 2348 (MOH Decision No. 1379 of 2017), MOH action plan for the health care of the elderly (MOH Decision No. 7618), the National Strategy for NCD control (PM Decision No. 376), the National Population and Reproductive Health Strategy to 2020 (PM Decision No. 2013/QD-TTg), and the National Strategy to combat Tuberculosis (PM Decision No. 374/QD-TTg), among others.

[63] Additional tracer conditions may be added during project implementation.

DHC/DH for diagnostic confirmation and treatment plan, and continuous management and glucose monitoring of non-insulin dependent (type 2) diabetes based on the treatment plan developed by the DHC/DH.

(c) **Cervical cancer (new CHS and DHC/DH role).** This includes IEC, both opportunistic and population screening of eligible women (aged 30 to 54) for cervical cancer using visual inspection with ascetic acid (VIA) or visual inspection with Lugol's Iodine and referral to an appropriate facility for cervical cancer diagnostic confirmation and treatment.

(d) **Immunization and other early childhood interventions (existing CHS role).** This includes enhanced availability of vaccine cold chain and IEC, the CHS services related to early essential neonatal care, and management of child health, nutrition, and illness (fever, respiratory infections, or diarrhea).

(e) **TB and other lung diseases (existing and new CHS and DHC/DH role).** This includes IEC, differential diagnosis based on symptoms of presumptive TB, chronic obstructive pulmonary disease (COPD)/asthma and acute respiratory infections, treatment and/or referral of presumptive TB or chronic lung disease cases to the DHC/DH for confirmatory diagnosis (including by GeneXpert), and development of treatment plan, followed by disease management by the CHS in line with the treatment plan.

23. **To achieve the project's objectives, the project's financing will be used to:**

(a) Upgrade the CHS infrastructure by new construction, expansion, or renovation to help the targeted CHS meet national standards related to facility infrastructure (Component 1);

(b) Improve CHS service readiness in the management of tracer conditions, by providing equipment, training, and quality management tools (scorecard) (Component 2); and

(c) Support policy reforms to improve the financial sustainability and technical quality of the CHS services, pilot innovations in primary care delivery, undertake monitoring and evaluation (M&E) and implementation research activities, and strengthen project management (Component 3).

24. **The project is financed by a credit from the IDA transitional support (TS) window, two co-financing grants, and counterpart financing.** Specifically, the project financing is as follows: an IDA-TS credit of US$80 million, a co-financing grant of US$5 million from the Integrating Donor-Financed Health Programs Multi-Donor Trust Fund (MDTF) (henceforth 'MDTF grant'),[64] a co-financing grant of US$3 million from the Tackling Non-Communicable Diseases Challenges in Low- and Middle-income Countries

[64] The contribution from the MDTF (with Australia Department of Foreign Affairs and Trade as the contributing donor for this project) is provided to help ease the transition from external to domestic financing, especially with respect to immunization.

MDTF (henceforth Pharmaceutical Governance Fund [PHGF grant]),[65] and US$21.25 million in counterpart financing.

25. **An additional grant of U$17 million from the MDTF for the Global Financing Facility (GFF) in Support of Every Women Every Child will be made available to Vietnam for the purpose of 'buying down' a portion of the IDA-TS credit.**[66] The GFF grant will be used for debt service of the IDA-TS credit, including payment of interest charges and principal as they become due. The Government will provide irrevocable instructions to the World Bank, as administrator of the GFF, to use the GFF grant to make debt service payments to IDA, while the Government will remain obligated for any debt service payments under the IDA-TS credit not covered by the GFF grant.

26. **The project implementation time line and disbursement projections take the planning cycles of the GoV into consideration.** Partly because of the high debt-to-GDP ratio and partly because of the lack of room in the current Medium-term Investment Plan (MTIP) 2016–2020, it is possible that the GoV will only be able to allocate a small amount of budget to this project during the current MTIP. Consequently, only modest implementation and disbursement of credit-financed activities (construction and equipment) are anticipated in the project's early years.

A. Project Development Objective

27. The Project Development Objective (PDO) is to improve the quality and utilization of grassroots health services, with a focus on the commune level, in the Project Provinces.

28. **The following are the PDO-level results indicators for the project:**

(a) Percentage of CHS in the project provinces meeting national standards/benchmarks for structural quality

(b) Number of NCD cases screened or being managed at the CHS level in project provinces:

(i) Number of hypertension cases being managed at CHS level

(ii) Number of diabetes cases being managed at CHS level

(iii) Number of eligible women screened for cervical cancer at CHS level

(c) Percentage of project provinces maintaining a full immunization rate above 90%

[65] Contributions to the Pharmaceutical Governance Trust Fund (umbrella fund of the Tackling Non-Communicable Diseases Challenges in Low- and Middle-income Countries MDTF) are from the Access Accelerated Initiative hosted by the International Federation of Pharmaceutical Manufacturers and Associations.

[66] The GFF is a broad financing partnership to assist countries in setting the trajectory to achieve the health-related Sustainable Development Goals under government leadership. The GFF objectives are to (a) support the identification of a clear set of priority reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) results that all partners commit resources to achieving; (b) get more results from existing health resources and increase the total volume of financing for health; and (c) strengthen systems to track progress, learn, and course-correct for reductions in preventable maternal and child deaths and improved health and wellbeing for vulnerable women, children, and adolescents.

(d) Number of presumptive TB cases referred for GeneXpert testing in project provinces

(e) Population utilization rate of CHS in the project provinces

(f) (Core Results Indicator) Number of people who have received essential health, nutrition, and population (HNP) services, including:

(i) Number of people who have received essential health, nutrition, and population (HNP) services - Total

(ii) Number of people who have received essential health, nutrition, and population (HNP) services - Female

(iii) Number of children immunized

(iv) Number of women and children who have received basic nutrition services

(v) Number of deliveries attended by skilled health personnel

B. Project Components

Component 1: Upgrading of CHS Infrastructure (US$65 million IDA credit, US$16.25 million provincial counterpart financing)

29. **This component will improve the quality of CHS infrastructure in the project provinces so that the CHSs meet the national standards for CHS infrastructure.** The targeted CHSs will be upgraded through either new construction, expansion, or renovation to reach the infrastructure-related standards of the MOH for CHS.[67] The component will also allocate a small amount of resources to the construction and renovation of the DHC/DH, but this will be limited to cases of special need (for example, recently bifurcated districts which lack district health facilities) and where provinces can demonstrate that the CHS infrastructure needs of the province can be adequately funded through other sources. The project will only finance the actual cost of construction, while the associated non-construction costs will be financed by provincial counterpart funding.[68] The architectural design of the CHS will take into consideration the need for access for the disabled, environmental waste management, and climate resilience.

30. **A needs-based formula was used for the initial allocation of funds across project provinces.** The amount allocated is proportional to the number of rural and disadvantaged CHS in each province, with

[67] The current commune health benchmarks are described in MOH Guidelines 4667/HD-BYT of 2014, the CHS's functional space requirements are in MOH Decision 6070/QD-BYT of 2018, and the minimum architectural standards are in MOH Decision 2271/QD-BYT of 2002. If new CHS infrastructure standards are approved during project implementation, then the new standards will apply.

[68] Non-construction costs include consulting services for investment planning, design, costing, and procurement documents (before investment); insurance costs and supervision of construction (during investment); and audits (and other post-construction costs).

rural communes assigned a weight of 1 and disadvantaged[69] communes assigned a weight of 1.9.[70] The coefficient of 1.9 reflects the ratio of the per capita health budget norm of remote areas to that of rural delta areas (VND 469,100: VND 246,900).[71] Also, for reasons of equity and economies of scale in implementation, no participating province receives less than US$2.5 million for construction.[72] See annex 2, figure 2.1, for the initial allocation of funds across project provinces.

31. **Within each province, the targeting of specific CHSs for construction/renovations is based on provincial plans and complemented by a set of criteria that will help to improve the efficiency and equity of project investments.** The provincial grassroots health investment plans, prepared in line with the Grassroots Health Masterplan (Prime Ministerial Decision 2348/QD-TTg of 2016), serve as the basis for identifying the CHSs eligible for project support within each province. Complementary criteria for selecting a CHS for upgrading include the following: the CHS has not yet met the infrastructure-related standards of the MOH; the province is willing to make complementary investments in equipment (through project or own resources) and human resource availability (through own resources) necessary for the CHS to deliver quality services; priority is given to the CHS in rural areas (Zones 2 and 3);[73] the CHS meets, or has plans to meet, requirements for health insurance reimbursement (and, in so doing, ensure sufficient operating budget for the facility); and the CHS is willing to commit to improving service delivery in line with the tracer conditions. Finally, the CHSs financed under the project should not require new land acquisition, land clearance, or resettlement, and the land area should also be large enough to meet the MOH standards.[74]

Component 2: Improving the Readiness of CHS to Manage Tracer Conditions (US$15 million IDA credit, US$4 million from MDTF and PHGF co-financing grants, US$3 million provincial counterpart financing)

Subcomponent 2.1: Equipment for tracer conditions (US$15 million IDA credit, US$3 million provincial counterpart financing)

32. **The project will provide the essential equipment needed to enable the CHS and DHC/DH to manage the tracer conditions in an integrated way.** A list of eligible CHS and DHC/DH equipment, aligned with the five tracer conditions, has been developed as part of project preparation (see annex 2, table 2.1). The project will only provide the equipment if it is not yet available or needs replacement. The allocation of funds for equipment across provinces is in proportion to the number of CHS and districts in each province. Once the participating provinces have ensured that all the CHSs and DHCs/DHs have the

[69] Prime Ministerial Decisions 131/QD-TTg (2017) and 900/QD-TTg (2017) list the disadvantaged communes in coastal/island areas and mountainous areas, respectively.
[70] Different options for resource allocation were presented to the project provinces during consultations (July 6, 2018, Hanoi) and this one was preferred (over the alternatives of one that factored in the percentage of CHS in the province that have already met benchmarks/standards and one that was purely based on the number of communes without weights for remoteness or disadvantage).
[71] Prime Ministerial Decision 46/2016/QD-TTg, Article 9.
[72] Allocations to Ninh Thuan, Bac Lieu, and Hau Giang were increased to reach the minimum, with other provinces' allocations reduced proportionately.
[73] The CHSs in urban/peri-urban areas (Zone 1) are only supported if all the CHSs in other zones currently meet (or will meet through investments funded by other sources) the infrastructure benchmarks. According to the Prime Minister's decision, Zone 1 facilities are defined as those that meet at least one of the following criteria: within 3 km of a hospital, in an urban ward or district capital, or in other locations with convenient transport to easily access such facilities.
[74] Land requirements are 500 m^2 for CHS in Zones 2 and 3, and 60 m^2 for CHS in Zone 1 (urban).

equipment needed to deliver services related to the tracer conditions, the remaining project funds may be used to purchase other equipment on the official list of equipment and furniture for CHSs,[75] with the exception of x-ray, ultrasound, and nasal endoscopy. On a limited basis, and subject to the prior review of the MOH and the World Bank, select other equipment may also be purchased for the DHC/DH level.

33. **Among the equipment financed by the project are two specialized pieces of equipment, linked to the TB and immunization tracer conditions.** To help provinces comply with the national TB program guidelines, which state that by 2020 all presumptive TB cases must be tested by GeneXpert machines, the project will provide GeneXpert machines to select DHCs/DHs. To ensure allocative efficiency, the number and placement of GeneXpert machines at the district level was informed by spatial and mathematical modelling (see section II F). The project will also finance specialized fridges for vaccine storage in the CHSs in disadvantaged areas and in the obstetric wards of DHs, along with other items related to the vaccine cold chain (for example, cold boxes and vaccine carriers). Project support to the vaccine cold chain will serve as the Government's share needed to leverage a matching in-kind grant from Gavi through its Cold Chain Equipment Optimization Platform (CCEOP),[76] thus effectively doubling the impact of the project's investment in the vaccine cold chain. Funds for GeneXpert machines and the vaccine cold chains, of around US$1 million each, were set aside before funds for other equipment were allocated to provinces. See annex 2, figure 2.1, for the initial allocation of equipment funding across provinces.

Subcomponent 2.2: Training for tracer conditions (US$3 million from MDTF and PHGF co-financing grants)

34. **This subcomponent will improve the competencies of PHC teams to provide integrated preventive and curative services and better manage tracer conditions.** The project will support the development of training curricula, where needed, and e-learning modules; training of trainers and training of PHC teams, both through short-term modular training and on-the-job training; and on-the-job supervision (clinical mentoring) of PHC teams' performance after training. Training will follow the approach used by the ongoing Health Professionals Education and Training (HPET) Project and the two projects will efficiently synergize their training investments. Medical education institutions will use the training curricula on family medicine principles and PHC that was developed by the MOH under the HPET Project and, under this project, further customize it to include additional training related to the tracer conditions.[77] In the project provinces that are also part of the HPET Project (for example, Ha Giang, Son La, and Yen Bai), the HPET Project will bear most of the cost of training, while this project will emphasize on-the-job supervision of the PHC teams' performance and training in the management of tracer conditions and help ensure that training-related capacity requirements for health insurance reimbursement are met.

[75] MOH Decision 4389/QĐ-BYT in 2018 issued the standard list of equipment and furnishings for the CHS for each of the three zones. All equipment items needed for the tracer conditions are also included on this list.
[76] Up to a certain agreed value, countries that are in accelerated transition from Gavi, like Vietnam, can benefit from matching in-kind grants from the Gavi CCEOP in the form of free cold chain equipment (CCE). The MOH, Gavi, and the World Bank have agreed that the project financing will serve as the 50 percent government share needed to trigger the 50 percent Gavi CCEOP contribution. Purchase, installation, and related training in the bundled price and eligible equipment must be procured through the UNICEF-Supply Division (UNICEF-SD).
[77] The family medicine curriculum does not yet include training modules related to cervical cancer and TB (screening, detection, and management), and the child health-related curriculum needs strengthening (particularly with respect to nutrition and immunization). The project will also support health worker training on Civil Registration and Vital Statistics (CRVS), including verbal autopsy.

Subcomponent 2.3: Quality scorecards (US$1 million from MDTF and PHGF co-financing grants)

35. **The project will support the implementation of quality scorecards at the CHS and DHC/DH levels to monitor and improve the quality of care.** At the CHS level, the scorecard will cover various quality dimensions related to the tracer conditions including, for example, availability of equipment; availability of essential drugs; staff compliance with technical guidelines (such as clinical practices guidelines and appropriate referrals) related to the tracer conditions and other services; internal quality management processes; outreach; patient follow-up; interactions with the DHC/DH; maintenance of family health records; planning and FM; information reporting; and so on. At the DHC/DH level, the scorecard will emphasize (a) providing supportive supervision to the CHS and (b) strengthening the integration and continuity of care through downward patient referral and information exchange with the CHS. The CHS and DHC/DH scorecards will be visualized on an online dashboard and integrated into the MOH's ongoing digitization of its health statistics system and implementation of electronic health records and will build on the experience of the MOH's results-based financing (RBF) pilots. Training of staff on how to interpret the scores and implement facility action plans to improve scores will be needed. It is expected that the project will support the implementation of scorecards in all project provinces but only a subset of the districts in each province. The MOH envisages that the quality scorecards will be expanded to other districts later by regulation and financed by the provinces' own resources.

Component 3: Creating an Enabling Policy Environment, Piloting Innovations, Evaluation, and Project Management (US$4 million from MDTF and PHGF co-financing grants, US$700,000 central counterpart financing, and US$1.3 million provincial counterpart financing)

36. **First, the component will support the development and evaluation of relevant policies, regulations, and guidelines related to the management of the tracer conditions as well as broader grassroots health financing and service delivery issues.** Policies, regulations, and guidelines to be supported and evaluated by the project will be identified by the MOH, in consultation with other agencies, and reviewed and agreed with the World Bank on an annual basis. Areas include, but are not limited to, reforms to better enable and incentivize the CHS to manage NCDs and other services (for example, policies on scope of service/benefit package, drug dispensing, conditions for health insurance reimbursement, other provider payment arrangements); addressing the fragmentation of financing; correcting incentives to ensure a more effective upward and downward referral system; better integrating the activities of private providers; and developing and refining evidence-based clinical guidelines.

37. **Second, the component will support the design, implementation, and evaluation of innovative pilots at the grassroots level.** Criteria for selection of innovations include alignment with the PDO, potential to go to scale, and the priorities of the MOH and the project provinces. Pilots will have one of the following goals: improving health promotion, improving the clinical quality of care, improving patient care-seeking behaviors and treatment compliance, improving the organization of service delivery (including through better integration of care and through engaging the private sector), and reforming the CHS-level health financing mechanism(s). The component will also support research and evaluation of the project's pilots and innovations, covering both the effectiveness of these pilots/innovation in achieving their goals and the operational aspects of implementation.

38. **Third, the component will finance the incremental costs associated with project management at the central and provincial level.** At the central level, this will include additional MOH staff and/or

consultants hired to staff the Central Project Management Unit (CPMU), financed by central counterpart financing and co-financing grant. At the provincial level, it will include the additional staff and/or consultants hired to supplement the Provincial Project Management Unit (PPMU), financed by provincial counterpart financing.

C. Project Beneficiaries

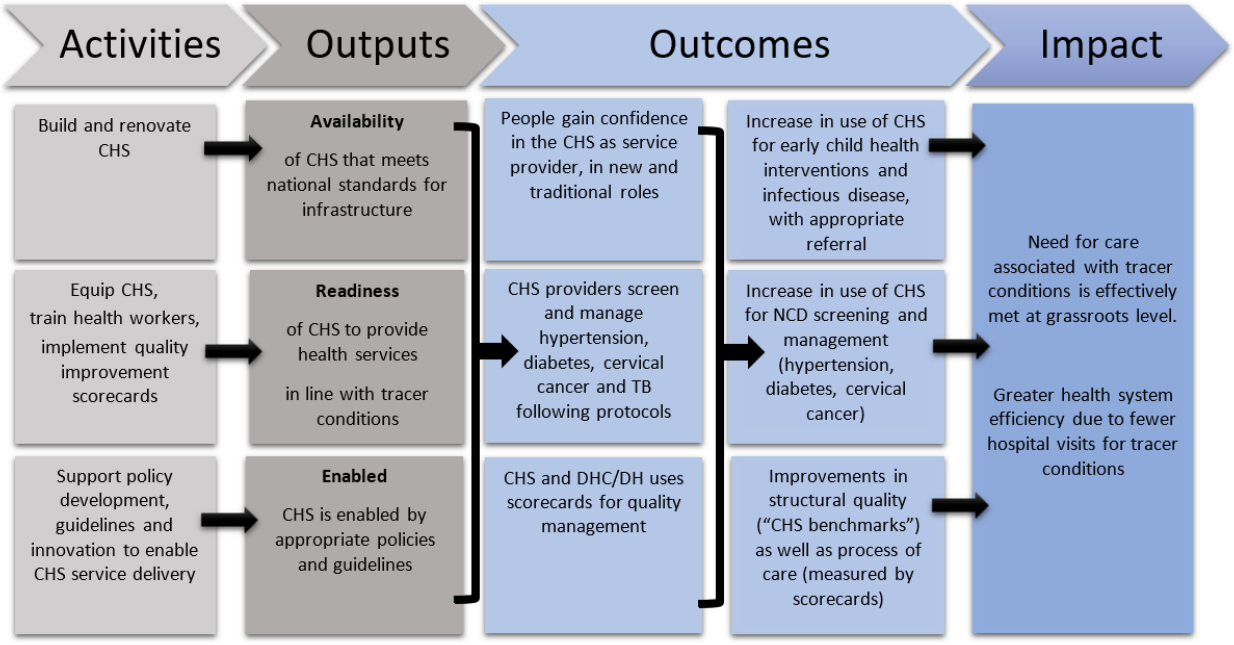
39. **The project covers all regions of Vietnam and is pro-poor in terms of its geographic scope, both across provinces and within provinces.** The identification of project provinces took into consideration the following criteria: poverty rates, representation of all three geographic regions of Vietnam, whether provinces had sufficient borrowing room relative to their debt thresholds (according to the requirements of Government decrees and Ministry of Finance (MOF) implementation guidelines), and that the selected provinces were not included in the concurrent grassroots-strengthening project of the Asian Development Bank (ADB). The 13 project provinces are Ha Giang, Bac Kan, Yen Bai, Son La, and Hoa Binh (in the north); Quang Binh, Quang Tri, Quang Ngai, and Ninh Thuan (in the central region); and Long An, Tra Vinh, Hau Giang, and Bac Lieu (in the south). Nine of the provinces are in the poorest third of all provinces, three are in the middle third, and one (Long An) is in the top third, with its inclusion justified as a 'front-runner' province able to implement innovations. All but one of the project provinces have poverty rates above the national average and four of the project provinces have poverty rates exceeding 2.5 times the national average (see section IV A on Technical, Economic, and Financial Analysis). Within each of the selected provinces, the project prioritizes investment in rural and remote communes (that is, Zones 2 and 3) over urban and peri-urban locations (Zone 1), further enhancing its pro-poor focus.

40. **The project will benefit all population groups in the selected project provinces, but children, women, the elderly, ethnic minorities, and the poor are expected to benefit more than others.** This is both because of the nature of the project interventions and because of the targeting of poor project provinces and communes. Looking across the life cycle and by gender, the grassroots health system tends to be used mainly by women of childbearing age and young children (because the CHSs have historically focused on reproductive and child health services) and also by the elderly (because the CHSs' community-based location makes them convenient for older, less-mobile people to access). That said, by expanding the CHS's role to also include the management of NCDs, the project should lead to increased utilization of the CHSs by men (and even more elderly people), thus helping to reduce the gender gap in utilization of basic CHS-level primary care services. The project will also disproportionately benefit ethnic minority populations. This is partly because the project provinces and communes have higher concentrations of ethnic minority populations than most other provinces and partly because ethnic minorities tend to use the CHS for a greater share of their outpatient health visits than the majority of the Kinh or Hoa population. Finally, the use of pro-poor criteria in selecting project provinces, as well as communes within the project provinces, and the fact that poor people are more likely to use the CHS services than better-off people, means that the project is expected to benefit the poor more than other groups. Approximately 9.2 million people are expected to benefit from the project's activities in the 13 provinces (under components 1 and 2), while its support to policy development (under component 3) will have nationwide impact. More details on utilization patterns, including by the poor and ethnic minorities, are provided in the Technical, Economic, and Financial Analysis (section IV A).

D. Results Chain

41. **The project activities are expected to contribute, through a chain of inputs, outputs, and outcomes, to improving the quality and utilization of commune-level health services and, in so doing, address the unmet need for basic PHC services and health system inefficiencies.** The theory of change is represented in figure 1. The project activities will contribute to ensuring the *availability* of CHSs that meet national standards (through building and renovating of CHS facilities); the '*readiness*' of the CHSs to deliver services associated with the tracer conditions (through equipment, training, and introducing quality monitoring mechanisms), and that CHS service delivery is *enabled* (by appropriate policies and guidelines). The improved infrastructure of the CHS, its ability to deliver an expanded scope of services (through its new role in screening and managing hypertension and diabetes and cervical cancer), and the improvements in the quality of existing services (immunization and early child interventions, TB) will give people greater confidence in using the CHS as their first point of care. Training, equipment, quality management procedures, and revised policies/guidelines will enable the CHS providers to treat diseases according to the protocols for better clinical outcomes. As a result, more people will use the CHS for care and be appropriately referred to the higher level as needed. This, in turn, will have two system-level impacts. First, the unmet need for health services (especially for NCD services) in the CHS catchment area will be addressed. Second, with the shift of the locus of care for relevant conditions from higher levels to lower-cost CHS, overall health system efficiency will be improved.

Figure 1. Project Theory of Change



42. **The theory of change relies on some critical assumptions that are beyond the influence of the project.** The theory of change assumes that (a) *health workers* have the necessary complementary resources—including sufficient remuneration, supervision and support, and the drugs needed—which, together with the facilities, equipment, and training provided by the project, will enable them to provide

quality services; (b) *patients* will regain trust in primary care facilities and alter their care-seeking behavior, despite having gotten used to seeking care at hospitals; and (c) *higher-level facilities* will appropriately fulfil their role as a referral facility (including downward referral of patients) and take on a clinical support function for the CHS. For the latter to happen, the Government would need to change the current financial incentive structure which encourages retention of patients at the hospital level, does not require referral from the lower level before specialized care is provided, and does not remunerate the higher-level facilities for the clinical support /mentoring of CHS staff. The project's support for policy development and innovations can go some way toward addressing these issues, but these critical assumptions will remain.

E. Rationale for Bank Involvement and Role of Partners

43. **The World Bank's involvement in this project is justified on the grounds of efficiency, equity, and human capital development.** From a technical and economic perspective, the World Bank's involvement is for reasons of efficiency (that is, strengthening prevention and early disease detection and rebalancing the delivery of basic care toward the commune-level); human capital development (that is, addressing the unmet need for health services, especially those related to the tracer conditions); and equity (that is, reducing deficits in service utilization and outcomes among the poor by targeting poor provinces and poor localities within those provinces), all of which contribute to the World Bank's overarching goals of reducing poverty and promoting shared prosperity. As described in section C, the scope of the project is strongly aligned with the World Bank's country and sectoral strategies, as well as the GoV's priorities. The rationale for World Bank involvement is further elaborated in section IV A on the Technical, Economic, and Financial Analysis.

44. **Various partners co-finance this project.** The GFF contributes US$17 million to 'buy down' a portion of the credit, while the MDTF and PHGF grants together provide US$8 million in co-financing. The project also leverages in-kind financing from Gavi, the Vaccine Alliance (approximately US$1 million) for strengthening the vaccine cold chain.

45. **Partners have provided, and will continue to provide, technical assistance to strengthen the project.** The project design has been informed by consultations with, and analysis undertaken by, the WHO, UNICEF, United States Centers for Disease Control and Prevention (CDC), UNFPA, EU, ADB, and various nongovernmental organizations (NGOs) (such as PATH, Marie Stopes, HelpAge). Examples include collaborating with the WHO to update the WHO-MOH health facility database that was then used in the planning of CHS investments; adoption of training and IEC materials developed by the WHO, PATH, EU, and Marie Stopes International; collaboration and coordination with CDC, Global Fund, and the WHO to determine the optimal location of GeneXpert machines; and replication and modification of pilots implemented by PATH as project innovations. It is expected that these partners will continue to provide technical support to project implementation and evaluation of project interventions.

46. **There are also other projects, financed both by the World Bank and other partners, that share common objectives with this project, resulting in opportunities for synergies.** An ADB project, approved in late 2018 with a similar level of financing (US$80 million credit and US$15 million grant), also aims to strengthen the grassroots health system but in a different set of provinces. Province selection for the World Bank project was coordinated with the ADB project and, together, they cover more than 40 percent of Vietnam's provinces. The World Bank and ADB projects are the main external sources of financing for

realizing the vision of the MOH's Grassroots Masterplan. There are also important synergies with the World Bank's HPET Project which will cover most of the training costs in those provinces which are beneficiaries of both the HPET Project and this project. Coordination with the ongoing World Bank North East and Red River Delta Region Health Support Project (NORRED), which provides equipment and training to the DHC/DH and provincial hospitals (but not the CHSs) in 13 northern provinces, presents an opportunity to pilot initiatives related to vertical integration of care. Other recent projects that focus on strengthening grassroots' infrastructure and human resources include those of Atlantic Philanthropies (in Thai Nguyen, Khanh Hoa, and Thua Thien Hue provinces), the EU (75 CHSs nationwide), and an ADB project in the Central Highlands, but these will have been completed by the time this project starts.

F. Lessons Learned and Reflected in the Project Design

Technical

47. **The technical design of the project is informed by analytical work, both existing research and analysis undertaken specifically to inform project preparation.** A 2016 survey and report by the MOH and World Bank highlighted the need to improve the quality of care provided by staff at the CHS level, highlighting both inadequacies in diagnosis and 'know-do' gaps in treatment and prescribing.[78] Additional analysis of that survey, undertaken as part of project preparation, showed that better facility infrastructure, equipment availability, and the ability to manage NCDs were associated with higher utilization rates, especially in poor areas, thus justifying the project's emphasis on these investments.[79] Investment decisions regarding the most expensive equipment to be procured by the project are data driven. For example, a combination of mathematical modelling and application of geospatial techniques was used to determine the optimal number and placement of GeneXpert machines within project provinces.[80] Several assessments undertaken by development partners and the GoV inform the approach that the project will take to NCD management, including assessments of NCD pilots in Ha Nam province (by the WHO and MOH), in Soc Son (by the MOH), and in Bac Giang (by provincial health authorities).

48. **The technical design is also informed by closed and ongoing World Bank projects.** The training modalities adopted in Component 2 will follow those currently used by the HPET Project. The inclusion of a quality scorecard in Component 2 is informed by a RBF pilot in the Central North Region Health Support (CNRHS) Project, P095275. An evaluation of this pilot (undertaken as part of project preparation) found that the combination of scorecard and incentives improved CHS quality scores (from 78 percent to 88 percent in two years),[81] that the scorecard was continued even after the incentives were no longer paid, and that non-intervention districts also voluntarily started to implement the scorecard. The Implementation Completion and Results Reports (ICR) of the Northern Upland Health Support and CNRHS Projects emphasize the importance of complementing supply-side infrastructure investments with measures to stimulate utilization (demand-side). Therefore, this project will use some of its grant co-financing for select demand-side innovations in Component 3. Finally, the ongoing NORRED, which

[78] World Bank. 2016. *Quality and Equity in Basic Health Care Services in Vietnam*. Washington DC: World Bank.
[79] Vu, L., S. Bales, and C. Bredenkamp. 2019. "What Drives Utilization of Primary Care Facilities in Vietnam? Evidence from A Facility Survey." Health Nutrition, and Population Discussion Paper. Washington, DC: World Bank.
[80] Quiroga, M. D., S. Bales, D. Wilson and C. Bredenkamp. 2019. Optimizing GeneXpert Deployment in Vietnam. Unpublished manuscript.
[81] Nguyen, H. T. H. 2018. "The Experience of a Results-based Financing in Vietnam: A Case Study from A Pilot in Nghe An Province." Health, Nutrition, and Population Discussion Paper. Washington, DC: World Bank.

involves providing lower-level hospitals with select skills and equipment, helps illustrate the usefulness of focusing investment and training on very specific priority health conditions (lending support to this project's focus on tracer conditions).

Operational

49. **The ICRs of the recently completed Northern Upland Health Support Project (2008–2016, P082673) and CNRHS Project (2010–2016, P095275) yield important operational lessons.** The ICRs concluded that the success of these projects was facilitated by the fact that they were regional projects with investments in geographically contiguous provinces, suggesting that the proposed project's multi-region scope may pose a risk to implementation. Success was also attributed to the fact that project investments were closely aligned with provincial health plans and also further strengthened elements of the plans; this project will take a similar approach. With both projects experiencing some early challenges in M&E (including data collection), the ICRs stressed the importance of relying, to the extent possible, on the existing information systems (as this project will), as well as the importance of ensuring that the M&E system and reporting mechanisms are in place well before effectiveness. Finally, the ICRs point to the capacity of the CPMUs and PPMUs as being pivotal to implementation success, citing in particular the importance of having national consultants to boost capacity and ensuring that staff hired to these units have adequate project management skills. With loans no longer permitted to be used for project management, ensuring sufficient resources (whether through grant co-financing or counterpart financing) to fund the CPMU and PPMUs will be a challenge in this project that was not faced by previous projects.

50. **The ongoing projects in Vietnam, both in the health and other sectors, provide additional operational lessons.** The Hospital Waste Management Support Project (HWMSP) provides at least two operational lessons that have been reflected in the institutional design and plans of this project. First, aligning project investment plans with provincial plans, preparing them up-front, and having them reviewed by multiple provincial stakeholders increased provincial ownership and, thus, implementation speed. In a similar vein, this project bases its infrastructure investments on the existing provincial plans for facility investment and then applies additional filters to ensure the efficiency and equity of the subset of facilities supported by the project. The HWMSP also highlighted the effectiveness of using the PPMUs under the provincial Departments of Health (DOH) for project coordination: when project management was changed from the PPMUs under the DOH to the provincial project management board, there were implementation delays that were so challenging that eventually the PPMU was moved back under the DOH. In this project, all but one of the PPMUs will be under the DOH. Another cross-cutting lesson from the ongoing health projects is that implementation of project activities should not rely on the passage of policies and development of guidelines at the national level. To this end, the project has ensured that no provincial-level project activities are contingent on new national decisions or policies. Finally, the estimated disbursement profile reflects the experience of other recent World Bank projects in the Vietnamese health sector which have historically been slow to disburse in the early years.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

Project Management

51. **The project will be implemented by a CPMU and 13 PPMUs.** The MOH will constitute a new CPMU or assign an existing CPMU to implement the activities funded by grant co-financing—Subcomponent 2.2 on training, Subcomponent 2.3 on quality scorecards, and Component 3 on Policy, Innovation, Evaluation, and Project Management—and also provide overall coordination of all project activities (including the credit-financed activities implemented by the provinces). The Provincial Peoples' Committee (PPC) of each project province will establish or assign a PPMU to manage the credit-financed activities of that province. The PPC will decide whether to use an existing PPMU (such as the province's Specialized Management Unit), establish a new PPMU under the provincial DOH, or make other arrangements. The PPMUs will directly implement the credit-financed activities related to construction and renovation (Component 1) and equipment (Subcomponent 2.1). The PPMUs may also implement some of the grant-financed activities (under Subcomponents 2.2 and 2.3 and Component 3), based on a workplan approved by the CPMU.

52. **Responsibilities and staffing.** The CPMU will have responsibility for implementing the grant-financed activities of the project, monitoring implementation progress of the entire project, and reporting on project implementation to the MOH, World Bank, and other ministries. It will also be responsible for project audit (at both central and provincial levels), overall project M&E, ensuring compliance of the grant-financed activities with fiduciary and safeguards requirements, and reporting on compliance of both central (grant-financed) and provincial (credit-financed) activities to the MOH, World Bank, and other ministries. Each PPMU will be responsible for implementing the credit-financed activities within its province, ensuring compliance of its activities with fiduciary and safeguards policies, carrying out M&E activities for its province, and reporting on implementation progress and compliance to the PPCs, DOHs, CPMU, and World Bank. The CPMU and PPMUs will have staff/consultants with the expertise needed to implement project activities. This expertise includes, but is not limited to, construction, equipment, training, quality assurance, health systems and policy, and cross-cutting aspects of operational management (planning, procurement, FM, M&E, safeguards, and so on). The detailed organizational structure, responsibilities, and functioning of each of these units will be further described in the Project Operations Manual (POM).

Financial Management

53. **The implementing agencies will use the Government's FM policies and procedures in the implementation of the project.** These policies and procedures have been assessed as acceptable to the World Bank. Under the decentralized implementation arrangements of this project, the provincial implementing agencies are solely responsible for the FM function at the provincial level, including, but not limited to, reporting, internal control, planning and budgeting, contract management, and payment. The CPMU will appoint an external auditor for the whole project. An FM action plan with time-bound actions and an implementation support plan have been prepared to improve the FM capacities, as well as to address the FM risks that have been identified as part of the FM assessment of the project.

54. **The project will use the GoV's treasury system for both the credit and the co-financing grants.** The credit will be channeled directly from the World Bank to the provinces through 13 Designated Accounts (DAs) opened by the PPMUs at the Provincial State Treasuries. The two co-financing grants will be channeled from the World Bank to the CPMU of the MOH through two DAs opened at the Central State Treasury. Co-financing grant funding may be transferred from the CPMU to the PPMUs through provincial sub-accounts denominated in U.S. dollars at Provincial State Treasuries for the grant-financed activities implemented in provinces, based on work plans approved by CPMU. Disbursement arrangements will be established for each source of funds and the DAs using the typical major disbursement methods, including advances, reimbursement, special commitment, and direct payment. The details of the institutional arrangements for FM, including flow of fund diagrams, can be found in the Appraisal Summary on FM (section IV B).

Procurement

55. **Procurement will be carried out by the CPMU and PPMUs.** The CPMU will conduct procurement for most activities financed by grant co-financing. The CPMU will also be responsible for establishing Framework Agreements (FAs) under which the provinces will procure equipment for the CHS and DHC/DH (where feasible) and provide assistance to the PPMUs for the procurement of GeneXpert machines and CCE. Procurement activities to be implemented by the PPMUs include new construction or renovation of the CHS and DHC/DH under Component 1; procurement of equipment for the CHS and DHC/DH, including call-off contracts under FAs, under Subcomponent 2.1; and procurement of consultancy services (and management of contracts ensuing from procurement conducted on the province's behalf by the CPMU) related to grant-financed activities under Components 2 and 3. More details of the institutional arrangements for procurement, including the results of the procurement capacity assessment, can be found in the Appraisal Summary on procurement (section IV B).

Safeguards

56. **Arrangements for monitoring environmental and social safeguards implementation are as follows:** Institutional responsibility for environmental and social safeguards performance, including monitoring safeguards implementation, lies with the CPMU and PPMUs. Safeguards monitoring will need to take place in coordination with local authorities and communities. The CPMU and PPMUs will report regularly to the World Bank on the status of safeguards implementation and the World Bank will regularly assess the compliance of the project with safeguards policies. The World Bank will also provide implementation support to help ensure adequate performance of the project on environmental and social safeguards issues. More details of the institutional arrangements for safeguards, including the results of environmental and social assessments (SAs), can be found in the Appraisal Summary on social and environmental safeguards (section IV C).

B. Results Monitoring and Evaluation

57. **Indicators in the Results Framework will rely primarily on the routine Health Management Information System (HMIS).** All but one of the PDO indicators are drawn from indicators on which the CHS is routinely required to report to higher levels. This will help ensure that the information needed to measure attainment of the PDOs is available on a regular and timely basis. The indicator on cervical cancer screening is not yet routinely collected in the HMIS because this service is not yet regularly provided. For

the intermediate indicators, which capture progress on implementation of project activities, information will need to be collected directly from the implementing entities (that is, the CPMUs or PPMUs). The PDO indicators will be updated at least annually, while the intermediate results indicators will be updated semi-annually. The intermediate indicator on patient satisfaction is the only one which will likely require specialized data collection (for example, household surveys or patient exit interviews).

58. **The evaluation activities of the project will focus on those issues where there is a need to generate an evidence base to further inform policy or policy implementation.** Consequently, it is unlikely that the project will carry out a general (household or facility) survey at the beginning of the project to form the baseline against which to measure the entire project's impact on the PDOs. Rather, any survey will be carefully focused on specific research questions and undertaken in locations appropriate to those questions. The evaluation activities may include, for example, assessments of the project's innovations and pilots, the effect of core project interventions (for example, hypertension, diabetes and cervical cancer screening at CHS level) on patient- and system-level outcomes, and operational research into the project's implementation modalities.

59. **Institutional responsibility for data collection and reporting on project indicators will lie with the CPMU and PPMUs.** The CPMU and PPMUs will be responsible for monitoring project results, collecting data on project indicators, reporting the values of these indicators to the World Bank, and taking action (to inform implementation) in response to these indicators. The CPMU and each PPMU will assign or hire someone qualified in M&E to take on this role. For any surveys or specialized assessments, the CPMU will hire consultants who will complete the activities with technical oversight by the CPMU and World Bank.

C. Sustainability

60. **The institutional sustainability of the reform directions supported by the project is ensured by strategies and policies that create a strong enabling environment.** Most notably, the 'Grassroots Masterplan' (Prime Ministerial Decision 2348 of 2016) includes plans for investment and reforms to strengthen the grassroots, and these have been further developed in a 2018 draft action plan. Earlier, the Masterplan for Reducing Hospital Overcrowding (Prime Ministerial Decision 92 of 2013) stressed the need for action at the grassroots level—including developing a family medicine model, bolstering preventive medicine, and strengthening CHSs. The MOH's current health sector plan (2016–2020) includes a significant focus on the grassroots health system (MOH Plan 139 of 2016). Disease-specific strategies relating both to the CHS's existing role and its new envisioned role (for example, on reproductive health, nutrition, NCDs, and health of the elderly) are in place. The new 10-year Central Party Resolution on Health Care (Resolution No. 20 NQ/TW of 2018) also emphasizes the strengthening of the grassroots health system and particularly the role of the CHS in managing NCDs. A new basic essential service package for health insurance reimbursement at the commune level (included for NCDs) has just been developed.

61. **The financial sustainability of the project's activities is significantly enhanced by its support to enabling the CHSs to meet the requirements for health insurance reimbursement for a broader primary care package.** Strengthening the capacity of the CHS to provide primary curative care (including for NCDs) will expand the number and type of services that are eligible for health insurance reimbursement. Also, as more patients turn to the CHS for care, the CHS revenues from health insurance will increase, reducing their dependence on the state budget. The project will also support the development of policies and guidelines to incorporate more preventive services into the curative care packages paid by health

insurance, thus further contributing to the financial sustainability of preventive care and availability of services at the CHS level (although generally preventive services will continue to be paid by the state budget, in line with Prime Minister Decision No. 1387 of 2016).

62. **The project also supports the financial sustainability of externally financed (donor-financed) programs, especially for immunization and TB.** As discussed in the section I B on Sectoral and Institutional Context, Vietnam no longer relies substantially on external financing for health, but some specific health programs (like immunization and TB) are still dependent on external financing for a relatively large share of their costs. There is a need to ensure and sustain the gains made with external financing, especially as Vietnam transitions away from supply-side subsidies toward more demand-side financing through social health insurance. While the HIV program has made substantial progress in shifting to domestic financing sources, the TB program has not yet made this transition. Policy development activities under the project will help it do so, including ensuring sustainable financing for the recurrent costs associated with GeneXpert testing. The expanded program on immunization (EPI) is beginning a transition toward using provincial budgets to pay for recurrent costs (excluding vaccines) and is also in accelerated transition from Gavi support. The project's investment in vaccine cold chain will facilitate the immunization financing transition by enabling Vietnam to benefit from the Gavi CCEOP for countries in accelerated transition.

63. **The physical sustainability and climate resilience of project investments (especially infrastructure) are important considerations**. The MOH standards for the CHS construction and CHS equipment take into consideration the need for sustainability and climate resilience, and the construction and equipment procured under this project will at least be equal to those standards. Larger equipment purchases (specifically vaccine fridges and GeneXpert machines) will meet the international standards used for Gavi and Global Fund procurements. The use of World Bank procurement guidelines and a record of good compliance with those guidelines in previous health projects in Vietnam gives confidence that equipment procured under the project will be sufficiently durable. While climate and weather (especially flooding adjacent to rivers and due to ocean level rise, as well as excessive precipitation and high humidity) pose risks to the physical sustainability of infrastructure, the project will mitigate these through measures to enhance climate resilience (for example, building on stilts in flood-prone areas). Increasing the number of facilities contracted by health insurance, which the project will help support, should further help ensure resilience by increasing the availability of operating budgets for facility and equipment maintenance. More details can be found in section V (climate and disaster risk screening).

IV. APPRAISAL SUMMARY

A. Technical, Economic, and Financial Analysis

Technical Analysis

64. **Project interventions support the GoV's plans for the health sector which, in turn, are in line with sectoral needs.** Vietnam's current health service delivery model is hospital-centric and tends to focus on episodic treatment of acute conditions rather than the prevention and management of early conditions and risk factors. It is also fragmented with little coordination across different levels. The GoV has developed various strategies and plans to address these challenges. Project interventions will help operationalize these plans, especially the 2016 Grassroots Masterplan. Built on the principles of family

medicine and people-centered care, the Masterplan is technically sound. It aims to (a) strengthen service delivery at the frontline; (b) introduce a new model of care that is better suited to the health needs of the population, especially given the rise of chronic (and often co-morbid) conditions; and (c) regain the people's trust in the CHS and, in so doing, reduce bypassing to and overcrowding of hospitals.

65. **The five tracer conditions prioritized by the project are appropriate.** They capture the new role that the MOH envisages for the CHS in managing NCDs, as well as the CHS's more traditional role in infectious disease control and maternal and child health. Together, the tracer conditions account for a significant share of the disease burden in Vietnam.

66. **TB and other lung diseases.** Overall, infectious and chronic lung diseases accounted for 8.7 percent of total DALYs and nearly 12 percent of all deaths.[82] Among these, COPD, acute respiratory infections, and TB account for the highest burden. Vietnam aims to eliminate TB by 2030 and test all presumptive cases of TB with GeneXpert by 2020, but case detection is still quite weak. In 2017, the health system detected 105,733 cases of TB out of an estimated 124,000 cases.[83] The case fatality rate is estimated at 10 percent. In 2017, 4,900 cases of multidrug resistant TB were detected. However, only 26 percent of cases were tested with rapid diagnostics at the time of diagnosis. The treatment success rate in 2016 was 92 percent, including new and relapsed cases. The prevalence of COPD in people aged over 40 years is estimated at 4.2 percent[84] and the prevalence of asthma is estimated at 5 percent.[85] Acute respiratory infections account for three of the top ten reasons for hospital contact while pneumonia is one of the top ten causes of death recorded in hospitals.[86] Lack of capacity for differential diagnosis, particularly between acute respiratory infections and TB, may lead to delays in treatment. Therefore, project activities related to the detection and control of TB and other lung diseases, as well as project investment in GeneXpert machines, are needed.

67. **Hypertension and diabetes.** In a 2015 survey, the prevalence of hypertension in adults aged 18 to 69 in Vietnam was estimated at 18.9 percent.[87] The prevalence of impaired fasting glycaemia was 3.6 percent, while raised blood sugar was found in 4.1 percent of individuals. In Vietnam, both hypertension and diabetes are characterized by under-diagnosis and lack of disease management. Among those detected with raised blood pressure, only 43.1 percent reported being previously diagnosed by a doctor while only 13.6 percent reported that their hypertension was currently being managed at a health facility. Hospital statistics indicate that primary hypertension is one of the most common reasons for hospital visits.[88] Among those detected with raised blood glucose/diabetes, only one-third (31.1 percent) reported a previous diagnosis by a doctor and only 28.9 percent were being managed at a health facility. Through equipment, training, and continuous quality improvement, the project will enable the CHSs in project provinces to manage these diseases for the first time.

[82] IHME. GBD Results Tool. Data downloaded February 4, 2019.
[83] TB estimates in this paragraph are from WHO. 2018. *Global Tuberculosis Report 2018*. Annex 2. Vietnam Country Profile.
[84] MOH. 2018. *Diagnostic and Treatment Guidelines for COPD.* Hanoi: Medical Publishing House.
[85] MOH. 2009. *Diagnostic and Treatment Guidelines for Asthma 2009.*MOH Decision 4776/QĐ-BYT.
[86] MOH. 2015. *Health Statistics Yearbook 2015*.
[87] Unless otherwise stated, estimates are from MOH, General Department of Preventive Medicine. 2015. Vietnam National Survey on the Risk Factors of NCDs (STEPS).
[88] MOH. 2015. *Health Statistics Yearbook 2015*.

68. **Cervical cancer.** In 2017, the prevalence of cervical cancer was estimated at 57,000 per year. Cervical cancer accounts for about 16 percent of all cancer cases among women and 25 percent of the seven cancer types with the highest survival rates.[89] It can be prevented by the HPV vaccine, but cost is a barrier to widespread use. However, since cervical cancer usually develops from precancerous changes in the cervical cells over a long period, from one to two decades, there is ample opportunity for early detection before cancer develops.[90] Precancerous lesions on the cervix can easily be detected through simple techniques (such as VIA) performed by midwives, nurses, or doctors at the community level during gynecological examinations and at very low cost. Detection of suspected lesions can be followed up by treatment of precancerous lesions using inexpensive treatment techniques such as cryotherapy or Loop Electrosurgical Excision Procedure (LEEP) or by cancer treatment for confirmed cancer cases.[91] The project aims to increase provision of VIA screening during gynecological exams and possibly routine population screening of women in the target age of 30 to 49 following national guidelines. Project interventions include health worker training, provision of basic gynecological exam equipment at the commune level, and colposcopy and cryotherapy equipment for treatment of precancerous lesions at the district level.

69. **Immunization.** Most vaccine-preventable diseases are under control and immunization coverage rates are high. According to administrative data, the nationwide full immunization rate was 96.4 percent in 2017 and reached or exceeded 95 percent in 54 out of Vietnam's 63 provinces.[92,93] However, as external financing for vaccine-preventable diseases declines and as local (subnational) budgets take on a greater share of vaccination costs and anti-vaccination movements gain ground, there is a risk of decline in immunization rates. Also, some specific vaccine-preventable diseases remain an important threat. Japanese encephalitis is endemic, with 450 reported cases in 2014 despite an 80 percent immunization rate. The Hepatitis B vaccination has high coverage but low timeliness, with only 77 percent of newborns receiving their first dose within 24 hours.[94] More generally, immunization rates in remote and mountainous areas lag behind the national average. The project's investment in the vaccine cold chain (which is one of the top eight priorities of the MOH's EPI program for 2016–2010) and IEC can help maintain, or even further improve, immunization coverage rates. Because Japanese encephalitis requires vaccinations at a 2-week interval, having well-functioning vaccine fridges at the CHSs outside of urban areas will avoid the high cost of transporting vaccines from districts to the CHSs in between the monthly immunization days.[95] Fridges at the CHS level will also help ensure access to the Hepatitis B birth dose for babies that are delivered at home and in remote areas, enable a stock of vaccines to be kept for outreach to far-flung vaccine posts. Vaccine fridges in obstetric wards of the DHs will increase the likelihood that the Hepatitis B birth dose is given on time.

[89] IHME. 2018. *Global Burden of Disease Study 2017*. http://ghdx.healthdata.org/gbd-results-tool. https://www.medicalnewstoday.com/articles/322700.php.
[90] WHO. 2014. World Cancer Report. Chapter 5.12
[91] WHO. 2019. *Fact Sheet on Human Papillomavirus (HPV) and Cervical Cancer.* https://www.who.int/news-room/fact-sheets/detail/human-papillomavirus-(hpv)-and-cervical-cancer.
[92] GSO. 2018. *Statistical Yearbook of Vietnam 2017*. Hanoi: Statistical Publishing House.
[93] By contrast, latest household survey data from the Vietnam Multiple Indicator Cluster Survey 2014 show a full immunization rate of 82.4 percent.
[94] WHO. 2018. WHO Vaccine-Preventable Diseases: Monitoring System. http://apps.who.int/immunization_monitoring/globalsummary/coverages?c=VNM [Updated September 18, 2018].
[95] MOH, EPI Program. 2016. *Comprehensive Multi-Year Plan for Expanded Program on Immunization 2016–2020*.

70. **Early child health interventions.** Nearly one in four children under age five in Vietnam suffers from stunting.[96] Only 26.5 percent of women initiate breastfeeding within the first hour of life. While 62.4 percent of breastfed children aged 6 to 23 months have a minimum acceptable diet, this rate was only 54.5 percent among non-breastfed children. Diarrhea and acute respiratory infections are common illnesses among children, requiring maternal knowledge of symptoms, home treatment, and danger signs requiring medical intervention. In 2014, 42 percent of children with diarrhea did not receive proper home treatment by oral rehydration and continued feeding, and 10 percent received no treatment. While over 80 percent of children with cough and fever were taken to a health care provider, maternal knowledge about danger signs requiring immediate care was quite low, and many mothers brought their children to a health care provider when home care would have been sufficient.[97] Early essential neonatal care, integrated management of childhood illness, and child nutrition programs have been developed and implemented in most provinces. However, resource limitations mean that training has not taken place in all communes. These programs have also not yet been integrated into performance monitoring systems.

71. **The substantial investment that the project makes in construction and equipment to enable the CHS to meet national benchmarks for structural quality will increase patient trust in, and utilization of, the CHS and, in so doing, help rebalance the service delivery model toward primary care settings**. A key feature of the government's 2016 Grassroots Masterplan is ensuring that all the CHSs in the country meet the national benchmarks. The hypothesis that improvements in facility infrastructure and equipment availability will attract patients is also grounded in evidence. A recent study using the 2015 Health Facility Survey suggests that if all facilities could be raised from their current level of quality to that which is planned under the project—that is, having infrastructure that meets government standards, at least 70 percent of equipment in place, and able to effectively manage hypertension and diabetes—utilization in remote areas could increase from the current 0.5 visits per capita to 1.8 visits.[98] Even if only infrastructure and equipment could be improved, visits could increase to 1.1 per capita.[99]

72. **Training the CHS health workers to manage tracer conditions and improve the quality of care is also critical.** While improving structural benchmarks of quality (such as infrastructure and equipment) is important, it does not provide the assurance that the CHSs workers will deliver quality care, that is, manage conditions according to clinical guidelines and in close coordination with higher levels. For this reason, training the CHS health workers to manage the conditions within their scope of service, practice according to family medicine principles, and improve the overall quality of care is prominently featured in the Grassroots Masterplan, the Masterplan for Reducing Hospital Overcrowding, and various disease-specific strategies. Yet, as highlighted in a 2016 World Bank report, there remain substantial deficits in the knowledge and skills of the CHS health workers when it comes to the management of even the most common conditions.[100] Improving the ability of CHS health workers to deliver quality care is especially important for the health of poor people; as shown in the Economic and Financial Analysis, the poor are

[96] GSO. 2018. Statistical Yearbook of Vietnam 2017. Hanoi: Statistical Publishing House.
[97] GSO and UNICEF. 2015. Vietnam Multiple Indicator Cluster Survey 2014, Final Report. Hanoi, Vietnam.
[98] Vu, L., S. Bales, and C. Bredenkamp. Forthcoming. "What Drives Utilization of Primary Care Facilities in Vietnam: Evidence from a Facility Survey." HNP Discussion Paper. World Bank, Washington, DC.
[99] Ibid.
[100] World Bank 2016. *Quality and Equity in Basic Health Care Services in Vietnam: Findings from the 2015 District and Commune Facility Survey*. Washington, DC: World Bank.

more likely to use the CHS than others, relying on it for a third of their outpatient curative visits and two-thirds of their preventive care visits.

73. **There is evidence that using scorecards for performance monitoring can improve the quality of care.** An assessment of an RBF pilot in Nghe An Province, which was introduced as part of the World Bank CNRHS Project and combined scorecards with financial incentives, found that the quality scores of the CHS included in the pilot improved by 10 percentage points, from 78 percent to 88 percent, over two years.[101] This project will fine-tune that scorecard and scale up its use but without the performance-based incentives. Still, even without incentives, evidence from elsewhere suggests that there can be a significant independent effect of scorecards on quality.[102] Also, the fact that some districts in Nghe An continued to use the scorecard after the financial incentives ended, while other nonparticipating districts voluntarily adopted it, suggests that facility administrators think it makes a difference. [103]

Economic and Financial Analysis

74. **The project's expected contribution to development is to improve the access of poor people to quality primary health services and, in so doing, address unmet health needs and improve the efficiency of the health system.** Specifically, the project will improve the quality and utilization of health services at the commune level in disadvantaged provinces. This will, in turn, contribute to reducing morbidity and premature mortality resulting from inadequate continuity and integration of preventive and curative care between primary level (CHS) and secondary level (DH) facilities for conditions that account for a large share of the burden of disease in Vietnam. It will also reduce the costs to society and households of managing and improving health by obviating the need to travel to DHs for basic primary care. At the systemwide level, this will also help facilitate a shift from a health care delivery model that is very hospital-centric (with patients going to hospital for primary curative care), and thus expensive, to a more efficient lower-cost model of delivering more (primary and secondary) preventive care at the CHS level.

75. **Increasing the effectiveness of disease prevention, early detection, and management of NCDs can reduce the economic cost of disease to society.** Currently, Vietnam faces a substantial burden of disease due to NCDs, with NCDs accounting for 74 percent of all DALYs in 2017. Further, 28.7 percent of this burden is attributable to only two risk factors, namely high systolic blood pressure and high fasting blood glucose, both of which are among the tracer conditions targeted by this project. As noted in the Technical Analysis, nearly one in five adults (18.9 percent of people aged 18 to 69 years or about 12 to 15 million people) has high blood pressure, yet inadequate detection and management means that only 13.6 percent are being managed at a facility and fewer than one in ten of them (9.7 percent) has properly managed blood pressure.[104] Similarly, 3.6 percent of the adult population has impaired fasting glycaemia (pre-diabetes) and 4.1 percent has diabetes (about 3.5 million adults aged 20 to 79), but less than one-

[101] Nguyen, H. T. H. 2018. "The Experience of Result-Based Financing in Vietnam: A Case Study from a Pilot in Nghe An Province under the Central North Region Health Support Project." HNP Discussion Paper, Washington DC: World Bank.
[102] In an RBF pilot in the Kyrgyz Republic, after 2.5 years a score of 63.1 was achieved by the group that used a balanced scorecard and 80.2 by the group that used both a balanced scorecard and incentives, compared to a control group score of 13.6.
[103] Nguyen, H. T. H. 2018. "The Experience of Result-Based Financing in Vietnam: A Case Study from a Pilot in Nghe An Province under the Central North Region Health Support Project." HNP Discussion Paper, Washington DC: World Bank.
[104] MOH, General Department of Preventive Medicine. 2015. Vietnam National Survey on the Risk Factors of NCDs (STEPS).

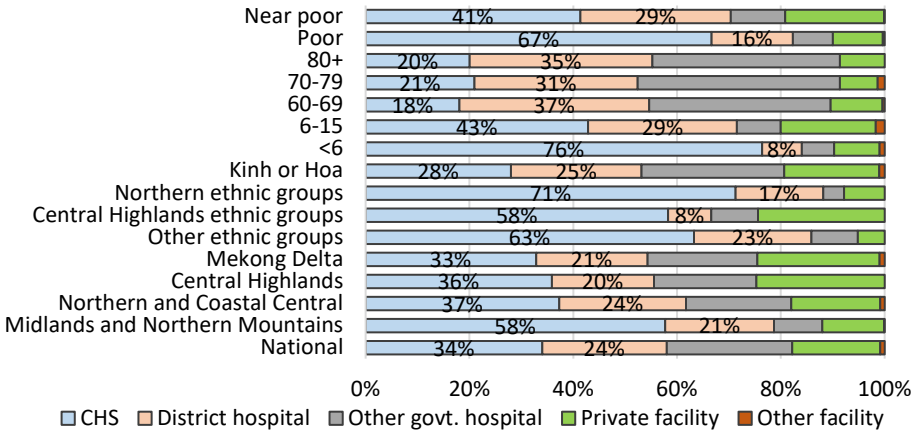
third of diabetics are being managed by a health care provider.[105] The social cost of not managing these conditions is high: in 2017, it was estimated that 129,000 deaths in Vietnam were due to high systolic blood pressure and 99,000 deaths were due to high fasting blood glucose. The economic losses are also large: already in 2005, it was estimated that the economic losses caused by chronic diseases in Vietnam was about US$20 million (0.033 percent of annual national GDP)[106], and this figure is likely to be substantially higher by now (as a result of the increased prevalence of NCDs and rising health care costs).

76. **Shifting the locus of care for NCD prevention and management from hospitals to the CHS can transform the health care delivery model into a lower cost one, saving the resources of the health system and of patients.** In 2015, only 20.3 percent of hypertensive patients and 6.2 percent of diabetics under doctor's supervision had their disease managed at the CHS.[107] Most patients sought care at hospitals (even central-level hospitals). The cost of hospitalization for primary hypertension in Vietnam has been estimated at US$53 per episode, much higher than the estimated cost of management of hypertension at the CHS level of US$9.4 per patient per year.[108] In 2017, the mean diabetes-related expenditure per diabetic, aged 20–79, was US$217, including care in secondary and tertiary facilities.[109] Providing more of the care associated with the management of NCDs at the commune level is a more efficient and less expensive way for the health system to deliver care, and also reduces the costs currently incurred by households, especially in terms of travel (both financial and time cost) to reach hospitals at the district level.

77. **The pervasiveness of market failures, externalities, and spillover effects bolster the efficiency rationale for investment by the GoV in primary care.** The *public good* nature of preventive health services (such as immunization and basic preventive care) leads to under-provision by the private sector (see figure 2). The high *transaction costs* that patients face in terms of information-gathering about the quality of care leads them to choose hospitals (which are perceived as higher quality) over primary care providers even if the CHS has the capacity to manage their medical problems. *Information asymmetry* and misaligned incentives (*principal-agent problem*) created by the fee-for-service payment mechanism contributes to overprovision of (often unnecessary) services, especially when care for common medical conditions is sought in a hospital setting. Investment in the CHS can help to alleviate these market failures. At the same time, while private facilities currently account for a small share of preventive visits, they have the potential to play a more important role—which is why the project will pilot some innovations to engage the private sector in primary care delivery.

[105] Ibid.
[106] Minh, H. V., D. L. Huong, K. B. Giang, and P. Byass. 2009. "Economic Aspects of Chronic Diseases in Vietnam." *Global Health Action* 2(1): 1965.
[107] MOH, General Department of Preventive Medicine. 2015. Vietnam National Survey on the Risk Factors of NCDs (STEPS).
[108] Nguyen, T. B. Y., T. T. Nguyen, H. H. Le, C. C. M. Schuiling-Veninga, and M. J. Postma. 2014. "Direct Costs of Hypertensive Patients Admitted to Hospital in Vietnam: A Bottom-up Micro-Costing Analysis." *BMC Health Services Research* 14(1): 514.
[109] International Diabetes Foundation. 2017. "Diabetes Atlas." https://www.idf.org/aboutdiabetes/what-is-diabetes/facts-figures.html.

Figure 2. Share of Preventive Care Visits (Immunizations, Health Checkups, and Reproductive Health Care) at Different Types of Facilities, by Characteristics of Individuals or Households, 2016

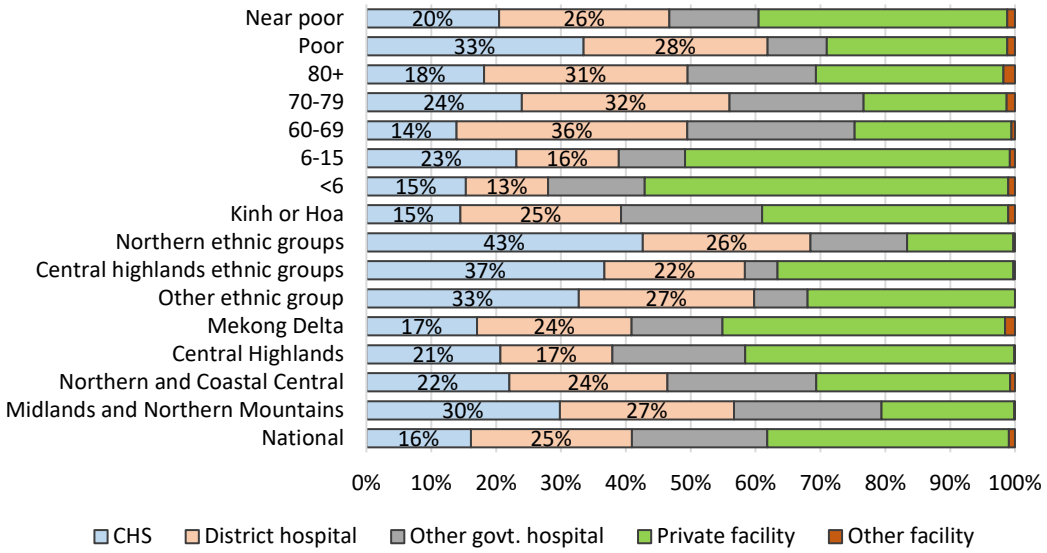


Source: VHLSS 2016.

78. **Attainment of equity objectives is another economic argument for investment in the CHS.** The CHS services are disproportionately used by poor people, ethnic minorities, children, older persons, and people living in more remote areas (especially in those locations where hospitals and private sector outpatient care alternatives are less geographically accessible). In addition, benefit incidence analyses show that government health spending at the CHS level tends to be strongly pro-poor whereas at the district, provincial, and hospital level, it is not.[110] The design of the project is also strongly pro-poor. First, it focuses its interventions and financing on the CHS which, compared to other types of health facilities, is disproportionately used by the poor (and, thus, potentially contributes to making the overall incidence of government health spending more pro-poor). Second, it targets provinces that are among the poorest in the country (see table 1). Third, within provinces, it focuses its investments on the administrative zones that are more likely to be poor (Zones 2 and 3). Fourth, the resource allocation formula used to allocate project funds for construction to provinces is pro-poor, effectively allocating more resources to those provinces with a larger number of disadvantaged communes. Fifth, several of the project's tracer conditions occur disproportionately among the poor (for example, TB and other infectious diseases). That said, the project also addresses NCDs which are currently concentrated among the better-off.

[110] Calculations by the Health Strategy and Policy Institute, 2006 (unpublished).

Figure 3. Share of Outpatient Curative Care Visits at Different Types of Facilities, by Characteristics of Individuals or Households, 2016



Source: VHLSS 2016.

79. **Related to the equity objective is the project's potential for enhancing financial protection, especially among the poor.** Improving access to primary care will help to prevent disease and slow disease progression, thus protecting patients from the (potentially impoverishing) impact of spending on health care and the broader financial burden of coping with the consequences of ill health (for example, unemployment, reduced employment, and time cost to family caregivers). While Vietnam's performance on financial protection goals has improved dramatically over time, with the incidence of impoverishing health spending down to around 1 percent and catastrophic spending (at the 10 percent threshold) now below 10 percent (see section I B Sectoral and Institutional Context), the impact on affected households can be substantial, including for diseases that are associated with the project's tracer conditions. In 2016, 63 percent of households affected by TB and 98 percent of households affected by MDR-TB reported total costs pre- and post-diagnosis exceeding 20 percent of annual household income.[111] A study of the financial impact of cancer treatment in Vietnam found that the average treatment cost for reproductive tract cancer (including cervical cancer) was over VND 40 million, leading to 85 percent of households facing catastrophic spending (at 20 percent threshold).[112] Another study found that the catastrophic health expenditure and impoverishment rates among households who have at least one member with a chronic disease were 14.6 percent and 7.6 percent, compared to only 4.2 percent and 2.3 percent, respectively, in households whose members did not suffer from these diseases.[113] Detecting diseases early and

[111] Vietnam National Target Program for Tuberculosis. First National TB Patient Cost Survey in Vietnam.
[112] Minh, H.V., C.P. Pham, Q. M. Vu, T.T. Ngo, D.H. Tran, D. Bui, X. D. Pham, D. K. Tran, and T. K. Mai. 2017. "Household Financial Burden and Poverty Impacts of Cancer Treatment in Vietnam." *BioMed Research International* 2017 Article ID 9350147.
[113] Minh, H. V. and B. X. Tran. 2012. "Assessing the Household Financial Burden Associated with the Chronic Non-Communicable Diseases in a Rural District of Vietnam." *Global Health Action* 5 (1): 1892.

ensuring that they are adequately treated at the primary care level can help to enhance financial protection.

80. **A substantial health financing gap exists at the grassroots level.** While the 2016 Grassroots Masterplan did not include a cost estimate or indicative budget allocation, costing exercises carried out during the drafting of the Masterplan estimated that VND 18,002 billion (equivalent to just over US$800 million) would be needed between 2014 and 2025 to cover the costs of capital construction, procurement of medical equipment, staff training, health education and information, and interagency monitoring needed to strengthen the grassroots health system.[114] The Masterplan also listed ODA as an important source of capital for its implementation. This project, as well as the one that will be implemented concurrently by ADB, aims to help fill this financing gap, with priority being given to the disadvantaged provinces. Without external financing, the opportunities for provinces to mobilize additional resources for the CHS would be limited. Unlike hospitals, which are increasingly attracting financing or capital from private investors (in line with the 'socialization'/'social mobilization' policy of the GoV), the CHS is less attractive to investors because the amount needed per commune is low and the potential for profit-sharing is minimal.

81. **The project's financing is likely to be affordable to the MOF and the provinces.** With national debt close to the 65 percent statutory limit, the GoV is being cautious when it comes to taking on additional debt. However, the overall fiscal impact of this project should be small. At the national level, an US$80 million credit would be equivalent to 0.06 percent of the 2017 national public debt of US$140 billion. The amount for which each of the 13 provinces is responsible depends on the on-lending share required by the MOF (mostly between 30 percent and 50 percent) and the amount allocated to each province (see Table 1). However, the amount borrowed seems affordable: over a five-year project implementation period, the additional annual provincial debt would vary from around US$0.3 million (in Bac Kan, Ninh Thuan, Hau Giang, and Bac Lieu) to around US$1 million (Quang Ngai). These amounts should be easily repayable through provinces' own revenues. The US$17 million GFF buy-down also substantially softens the debt service obligation. A detailed repayment schedule for each province, considering on-lending and interest rate (including buy-down), was developed as part of project preparation, and the Provincial People's Committees and the MOF have confirmed the affordability of the credit and the ability of the provinces to repay. In general, fiscal space for health spending (including loan-financed health spending) at the provincial level should be larger than in years gone by; with an ever-greater share of the cost of care being shifted away from government budget to health insurance (under government's cost recovery policies),[115] provinces have to spend much less on curative care than in the past.

[114] MOH assessments show that, nationwide, 3,200 CHSs need to be rebuilt, while 3,597 CHSs need renovation. The project will address around 10 percent of that need.

[115] These policies pertain to increasing curative care service fees to a level considered sufficient to cover all costs and removing direct supply-side subsidies previously used to cover the part of costs not collected in the form of user fees.

Table 1. Characteristics of Project Provinces

Province	Region	Poverty Rate[a] (%)	% Communes that Meet Benchmarks	Total Communes	Number of Resolution 30a Districts[b]	On-lending Share	Initial Credit Amount (US$, millions)
Ha Giang	North East	36.9	75.1	177	7	30	9.54
Bac Kan	North East	27.7	76.4	110	2	30	5.33
Yen Bai	North East	23.6	33.8	157	2	30	7.47
Son La	North West	41.0	38.8	188	4	40	9.42
Hoa Binh	North West	15.4	47.6	191	1	40	9.08
Quang Binh	North Central	12.1	81.6	136	1	40	6.10
Quang Tri	North Central	14.3	86.3	117	1	40	5.28
Quang Ngai	South Central	12.2	73.5	166	5	70	7.75
Ninh Thuan	South Central	12.6	46.8	47	1	10	3.18
Long An	Mekong	3.6	51.8	166	0	50	6.52
Tra Vinh	Mekong	12.0	83.5	85	1	40	4.01
Hau Giang	Mekong	9.4	92.6	54	0	50	3.18
Bac Lieu	Mekong	11.5	85.7	49	0	50	3.14
National average		7.9					

Notes: a. The poverty rate is the 2017 multidimensional poverty rate which includes all poor households plus households whose monthly average per capita income is above the income-based poverty line but below the minimum living standard and the household is deprived of at least three indices for measuring deprivation of access to basic social services.
b. Resolution 30a districts are the 61 poorest districts in the country.

82. **The financial sustainability of the project's activities has two dimensions.** First, strengthened primary care reduces total health care costs to society by preventing disease and averting complications that require more costly hospital and specialist care, and ensuring that curative care for common conditions is provided in primary care facilities, rather than in more expensive specialist facilities that are prone to over-servicing. The lower costs of care make services more affordable to patients and to the health insurance fund. Second, strengthening the capacity of the CHS to provide primary curative care expands the scope of primary curative care services that are eligible for health insurance reimbursement. This will encourage more patients to stay at the CHS for care, thus increasing revenues of the CHS from health insurance and reducing their dependence on the state budget. The project will also contribute to policy and guideline development to incorporate more (secondary) preventive services into the packages paid by health insurance (for example, for TB treatment), thus further contributing to the financial sustainability of preventive care and availability of services at the CHS level).

B. Fiduciary

Financial Management

83. **The institutional arrangements for FM are as follows:** the CPMU will be responsible for (a) project annual financial statements and external audit, (b) management of the two designated accounts (DA) for the activities funded by the two co-financing grants, including providing funds to provincial-level project

accounts, (c) project financial reporting including interim and periodic reports, and (d) FM of activities funded by grant co-financing that are implemented by the CPMU. The PPMUs will be entirely responsible for the FM function of the activities implemented in provinces, including expenditures approval, contract management and payments, maintenance of accounting records, and working with auditors/inspectors, among others. These FM arrangements meet the World Bank's minimum FM requirements at both the central and provincial level.

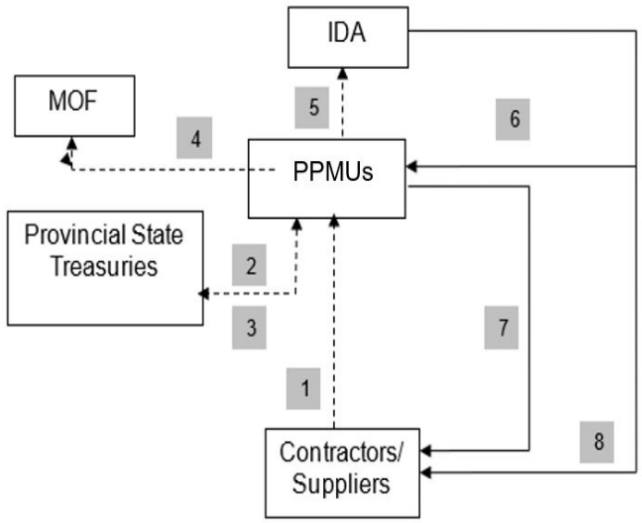
84. **Planning and budgeting.** Expenditures for project activities funded by the credit need to be included in the MTIP approved by the National Assembly and in the budget allocated annually by the MPI and MOF to each province (MOF for the on-lending amount and MPI for the remainder [central transfer]). When funds are available, a budget notice will be issued for the respective amounts. After the budget notice is issued, the PPCs will issue a detailed budget allocation to project activities, which will serve as the basis for the Provincial State Treasury to approve expenditure payments. For the activities funded by grant co-financing, a budget notice is also needed. Then, the MOH will approve the annual work plan for these activities, and the CPMU will transfer the money to PPMUs for grant-financed activities implemented by PPMUs. The responsibility for preparing the budget proposal lies with the CPMU and PPMUs, regardless of the financing source.

85. **Accounting policies, systems, and procedures.** The project will adopt accounting policies and procedures acceptable to the World Bank. The current accounting system used is the Accounting System for Investment Owner which is based on circulars issued by the MOF and is acceptable to the World Bank. Accounting records will be maintained in a computerized accounting system.

86. **Internal controls.** The CPMU and each of the PPMUs are responsible for ensuring that an adequate internal control framework and internal controls are in place and operating for the components/ subcomponents for which they are responsible. Adequate internal control systems are already in place in all implementing and oversight agencies in Vietnam, in accordance with government regulations, including authorization of payments and transactions, segregation of duties, asset management, cash management, budget formulation and variance analysis, and financial reporting. Payments made for all kinds of expenditures will be verified by the State Treasury before payment, following GoV procedures. The State Audit of Vietnam and Inspectorate will perform examinations on regular and ad hoc bases. Given the amount of the credit and the number of provinces, internal audit is not required for this project.

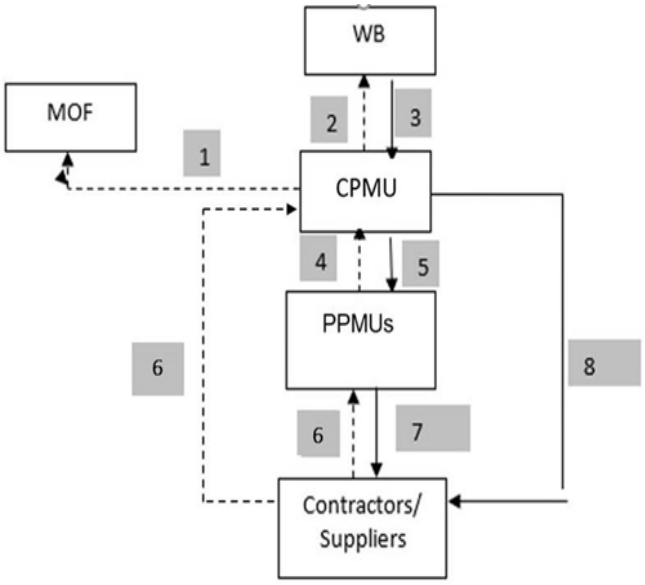
87. **Fund flow for credit and co-financing grant:** The credit will be channeled directly from IDA to the provinces through DAs opened by PPMUs at the Provincial State Treasury. Funds will be released upon co-signature of a withdrawal application (WA) by the MOF. For co-financing grants, there will be two DAs managed by the CPMU at the Central State Treasury. For grant-financed activities implemented by the provinces, funds will be transferred from the CPMU to the PPMUs through provincial subaccounts denominated in U.S. dollars at Provincial State Treasuries, based on a workplan approved by the CPMU.

Figure 4. Fund Flow for Credit



1. Contractors/suppliers submit payment requests, invoices, and other documentation to PPMUs.
2. PPMUs review, certify, and then submit to the Provincial State Treasury for its verification.
3. Provincial State Treasuries check, approve, and send back to PPMUs.
4. PPMUs prepare the WAs and send to the MOF for co-signature.
5. PPMUs submit the WA signed by the MOF to IDA.
6. IDA disburses money to the PPMU's DAs opened at the Provincial State Treasury.
7. PPMU pays the contractors/ suppliers.
8. IDA pays directly to contractors in case of large payments.

Figure 5. Fund Flow for Co-financing Grants



1. The CPMU prepares the WA and sends to the MOF for co-signature.
2. The CPMU submits the WA signed by the MOF to the World Bank.
3. The World Bank disburses money to the CPMU's DAs opened at the Central State Treasury.
4. PPMUs send requests for payment to the CPMU, with supporting documents.
5. The CPMU requests the Central State Treasury to make payment to project accounts of PPMUs at the Provincial State Treasury.
6. Contractors/suppliers submit payment requests, invoices, and other documentation to the CPMU/PPMUs.
7. The CPMU/PPMUs review, certify, and make payments to contractors/suppliers.
8. The CPMU also makes payments to its suppliers or on behalf of PPMUs if needed.

88. **Financial reporting arrangements.** The PPMUs, who are the ultimate spending units at the provincial level, will be responsible for the preparation of financial reports for all project expenditures

incurred at the provincial level and will submit them to the CPMU on a quarterly basis. The CPMU will then prepare the interim financial reports (IFRs) based on the information provided by PPMUs and submit to the World Bank within 45 days of the end of the semester. The unaudited IFRs will cover all project activities and include the following forms: IFR1 on Sources and Uses of Funds, IFR2 on Disbursement by component and province, and IFR3 on Statements of Designated Accounts Reconciliation.

89. **External audit.** Project financial statements will be prepared by each PPMU and then submitted to the CPMU for consolidation and audit. The project's annual financial statements will be audited in accordance with international auditing standards and in compliance with the independent auditing regulations of Vietnam. The CPMU will be responsible for the appointment of the auditor for the entire project, in accordance with the World Bank's guidelines.

90. **FM action plan.** The action plan to strengthen FM at central and provincial levels includes (a) having a POM with detailed FM guidelines; (b) ensuring that qualified experienced FM staff are hired in all project implementing agencies; and (c) ensuring that adequate budget is allocated for both credit and counterpart funding by all PPCs, MOF, and MPI.

Table 2. FM Actions, Completion Dates, and Responsibility

	Actions on FM	Expected Date of Completion	Entity Responsible
1.	POM with detailed FM guidelines	Effectiveness	CPMU and PPMUs
2.	Appointment of qualified experienced officers for FM at all implementing agencies	Disbursement	CPMU and PPMUs
3.	Adequacy of budget allocation for both credit and counterpart financing	Annually	CPMU and PPMUs

91. **Disbursement arrangements.** The primary disbursement method will be advances to DAs. The fixed ceiling for the CPMU's two DAs for activities funded by grant co-financing is US$500,000 per account and the ceiling for each of the PPMU DAs for credit-financed activities is US$1 million. The ceiling for the PPMUs' subaccounts for activities funded by grant co-financing is US$50,000. Supporting documentation required for eligible expenditures paid from the DAs and subaccounts are Statement of Expenditures and Records with the format and contents defined in the POM. The frequency of reporting of eligible expenditures paid from the DAs and subaccounts is quarterly. The Reimbursement, Special Commitment, and Direct Payment disbursement methods will also be available. Reimbursements will also be documented by Statement of Expenditures and Records. Direct Payments will be documented by Records. The minimum application size for Reimbursement, Special Commitment, and Direct Payments will be US$200,000 of the DA ceiling.

Procurement

92. **Procurement for the proposed project will be carried out by the CPMU and PPMUs.** The project will be executed in accordance with the World Bank's 'Procurement Regulations for IPF Borrowers: Procurement in Investment Project Financing' (hereinafter referred to as 'Procurement Regulations"), dated July 1, 2016, revised November 2017 and August 2018, and the provisions stipulated in the project's Procurement Plan and the POM.

93. **The World Bank's Systematic Tracking of Exchanges in Procurement (STEP) will be used to prepare, clear, and update Procurement Plans and conduct all procurement transactions for the project**. Accordingly, all the procurement activities under the proposed project will be entered, tracked, and monitored online through the STEP system. For procurement involving the national market, including National Competitive Bidding and Shopping, the CPMU and PPMUs will conduct the procurement using the Vietnam E-Procurement System (VNEPS) (www.muasamcong.mpi.gov.vn) to enhance procurement transparency, competition, and efficiency. To this end, the CPMU and PPMUs will have accounts opened on the VNEPS and will encourage all their potential suppliers to register on the system. More detailed guidance will be provided in the POM. If there are any updates on e-procurement implementation arrangements, the World Bank will notify and provide implementation guidance to the CPMU and PPMUs on time.

94. **The CPMU will be responsible for procurement related to many of the grant-financed activities and support some of the procurement activities of the provinces.** The CPMU will directly undertake procurement (mainly consultant services) under Subcomponents 2.2 and 2.3 and Component 3 and provide assistance to the participating provinces in procuring two major pieces of equipment, GeneXpert and CCE under Subcomponent 2.1. The CPMU will also be responsible for establishing FAs, where feasible. PPMUs will then, through a secondary procurement process, award call-off contracts and sign and manage the ensuing contracts directly. The CPMU will maintain adequate staffing with the relevant expertise needed to implement these activities.

95. **Each PPMU will be responsible for procurement related to project activities in its own province.** This includes (a) procurement related to new construction or renovation of the CHS or DHC/DH under Component 1; (b) procurement of equipment, including call-off contracts for equipment, where FAs are in place, under Subcomponent 2.1; and (c) management of contracts ensuing from the procurement conducted on their behalf by the CPMU under Components 2 and 3. The PPMUs will maintain adequate staffing with the relevant expertise needed to implement project activities at the provincial level.

96. **A Procurement Capacity and Risk Assessment of the CPMU and each of the PPMUs has been conducted.** The assessment concluded that, generally, the PPMUs have sufficient expertise for the needs of the project and, hence, there is no need for the provision of hands-on extended implementation support. They have all implemented several World Bank-funded projects in the past, including projects in the health sector. However, several key risks were identified that could lead to delays in project implementation and/or noncompliance if not properly mitigated, including (a) gaps in knowledge and experience of CPMU and PPMU staff with the new features allowed by the World Bank's Procurement Regulations such as FAs; (b) lengthy internal procurement reviewing and approval processes; and (c) governance risks associated with conflict of interest, fraud and corruption, and collusive practices.

97. **A series of measures will be implemented to further strengthen existing capacity and mitigate identified risks to ensure the satisfactory performance of procurement functions within the CPMU and the PPMUs.** These include (a) preparing a simple and common code of conduct for procurement officials, (b) instituting measures to have members of the Evaluation Committee sign a transparency statement, (c) training and strengthening internal controls of procuring entities to detect corruption, and (d) organizing training workshops in the use of the World Bank's STEP and the application of the Procurement Framework. The procurement and contract management training will be extended to the staff of the MOH, PPCs, CPMU, PPMUs, members of Bid Evaluation Committees, and relevant technical specialists

from related agencies who will participate in the preparation and/or appraisal of procurement documents.

98. **A Project Procurement Strategy for Development (PPSD) was carried out and identified the appropriate market approaches, selection methods, and type of review by the World Bank.** Most of the activities for works contract packages that will be procured under the project are simple, small value, and of low risk with several capable contractors in the local market available to participate in the bidding process. Procurement will be carried out in the national market through open competitive bidding or request for quotation procedures, as captured in the approved Procurement Plan. The CPMU and PPMUs will use harmonized standard bidding documents agreed with the Vietnam Public Procurement Agency for the implementation of ODA projects when approaching the national market and the World Bank's standard procurement documents when using FAs and when conducting international competition. Contracts with cost estimates less than US$200,000 and US$100,000 for works and goods, respectively, will be procured using request for quotations procedures.

99. **The GeneXpert and CCE will be procured using the Direct Selection method.** The GeneXpert will be procured directly from the only WHO-approved manufacturer (namely the Foundation for Innovative New Diagnostics, a partner organization for fighting TB in highly endemic countries, including Vietnam) to take advantage of the negotiated price. With regard to the procurement of the CCE, and under a special agreement with Gavi to leverage matching in-kind financing to achieve twice as much coverage for the GoV, UNICEF-SD will serve as the sole procurement agent. The scope of the contract for the CCE will include supply, delivery, installation, and training of beneficiaries in the use and maintenance of the equipment. From the PPSD recommendations and discussions with relevant stakeholders, the World Bank finds this arrangement acceptable as it delivers value for money for the client. During implementation, the CPMU and the PPMUs will work with UNICEF-SD to determine the final pricing, equipment model selection, and delivery time lines based on recommendations from Gavi's CCEOP's indicative pricing mechanism. For both the GeneXpert and CCE, each participating PPMU will sign separate contracts with the suppliers, receive goods, confirm conformance to the requirements of the contract, and make payment to the suppliers accordingly.

100. **FAs will be used for the procurement of the CHS and DHC/DH equipment (where feasible) to take advantage of potential savings derived from economies of scale and to ensure quality.** The CPMU, acting on behalf of the PPMUs, will conduct the primary procurement to select suppliers under the FAs for the CHS and DHC/DH equipment. Then PPMUs will, through a secondary procurement process, award call-off contracts as defined in the FAs and sign and manage the contracts directly. PPMUs will keep and manage records from the call-off supplies diligently and share pertinent information on completed supplies with the CPMU for collation and overall M&E of the FAs. Initial terms for the FAs will not exceed two years with the possibility of extension for a maximum two years. Given that this is the first FA to be conducted under the World Bank's new Procurement Framework in Vietnam, the World Bank will provide technical assistance to the CPMU and PPMUs.

101. **The cost of consultancy services for the design and supervision of infrastructure procured by the project will be borne by the participating provinces, using counterpart funds.** Given the risk that this arrangement poses, the following risk mitigation measures are recommended. Provinces will identify and plan for the infrastructure to be built a year ahead of implementation and include the same in their budget. Information regarding the budget should be shared with the World Bank. For consultancy

assignments that might be required, the most appropriate method (Quality- and Cost-Based Selection [QCBS], Quality-Based Selection [QBS], Selection Under a Fixed Budget [FBS], Least-Cost Selection [LCS], Selection Based on the Consultants' Qualifications [CQS], and Individual Consultant), based on the complexity, value, most appropriate market, and fit-for-purpose considerations will be used.

102. **Based on the PPSD, an initial 18-month Procurement Plan has been prepared by the CPMU and the PPMUs and agreed to by the World Bank.** The Procurement Plan, which also identifies the review type for each activity set based on performance and risk rating, will be updated at least annually to (a) reflect performance of project implementation, (b) accommodate any necessary changes, and (c) add new packages. All Procurement Plans, as well as any revisions to the Procurement Plans, will be subject to the World Bank's prior review and no-objection. The World Bank will carry out procurement post reviews on an annual basis with an initial sampling rate of 20 percent, which may be adjusted during project implementation based on the performance of the project. Details for the procurement arrangements and procedures are provided in the POM.

C. Safeguards

Indigenous Peoples

103. **The project triggers OP 4.10 on Indigenous Peoples.** The project is expected to bring positive health care benefits to local people in the project sites, especially poor people in difficult and remote areas. OP 4.10 on Indigenous Peoples is triggered because many of the project provinces have relatively high concentrations of ethnic minority populations and these groups are also beneficiaries of the project. OP 4.12 on Involuntary Resettlement is not triggered because the construction of the CHSs, financed by the project, will not require new land acquisition, land clearance, or resettlement; the CHSs will be constructed within the existing land of the CHS or commune.

104. **A SA conducted in Son La, Quang Tri, and Tra Vinh Provinces found that the project has broad support from various stakeholders and communities, including those from the ethnic minority groups.** The ethnic minority groups of the H'mong, Thai, Xinh Mun, Paco, Bru Van Kieu, and Khmer were among those consulted and overall feedback was very positive. Generally, respondents value the role of the CHS in the care of their health, noting that (compared to other facilities) the CHS is located more conveniently, is of lower cost, and has faster service and that they feel more comfortable around the CHS health staff (who are familiar to them and often share a common language). However, in some communities, local people still prefer to go to a DH for checkups, especially when the hospital is not too far away from their communities. Respondents think that DHs have better capacity to deliver services and stock better-quality medicines. In addition, for birth deliveries, DHs are very much preferred over the CHSs; respondents think that the CHS lacks the staff and facilities to handle complicated deliveries.

105. **The SA also examined the need for health services among ethnic minority groups.** Gynecological diseases and child malnutrition were cited as common diseases among ethnic minority groups, while home delivery remains common and hypertension and diabetes are emerging concerns. During a field trip to Dak Rong District in Quang Tri Province, it was found that 70 percent of women who came to the CHS for checkups were found to have a gynecological disease. Local health staff believed that gynecological diseases are caused by a lack of knowledge of hygienic practices and unsanitary working conditions. Meanwhile, the common causes of child malnutrition, some of which are related to social norms, include

under-age marriage, premature delivery, mothers' malnutrition, lack of breastfeeding (due to returning to work soon after delivery), inadequate feeding practices, and poor sanitation. Home deliveries remain common in the remote mountainous areas of Quang Tri and Son La. In Son La, the rate of home delivery was 30 percent and most predominant among Hmong women.[116] In Quang Tri, the Bru Van Kieu and Ta Oi women give birth in tents erected next to their homes. Hypertension and diabetes are considered emerging diseases and appear to not yet receive much attention among many rural people. Local people attributed this to a lack of awareness of the health risks associated with these diseases and the lack of availability of NCD monitoring and management services at the CHS.

106. **Based on the findings of the SA and public consultations, an Ethnic Minority Planning Framework (EMPF) has been prepared to guide the preparation of province-specific Ethnic Minority Development Plans.** The EMPF will help ensure that (a) affected ethnic minority peoples receive culturally appropriate social and economic benefits and (b) where there are potential adverse effects on ethnic minority peoples, the impacts are identified, avoided, minimized, mitigated, or compensated for. Public consultations were carried out during the preparation of the SA and will be continued throughout the project cycle. Based on these inputs, a draft EMPF was prepared. The draft EMPF was disclosed on the World Bank's internal and external websites on March 5, 2018, and on the MOH's website on February 28, 2018.[117] No comments were received from the public. The final EMPF was disclosed on February 15, 2019, on the World Bank's internal and external websites,[118] and on February 28, 2019, on the MOH's website.[119]

Gender

107. **The project will contribute to closing gaps in women's endowments in health.** The objectives and activities of the project are in line with the directions described in the World Bank's gender-related strategies. These include the World Bank Group Gender Strategy FY16–23, the East Asia Pacific Regional Gender Action Plan FY18–23, and the draft Vietnam Country Gender Action Plan FY18–22 which identifies maternal mortality and childhood stunting among poor and ethnic minority women and children as a key area of focus. Indeed, ethnic minority women face not only the current challenge of exclusion but also the future risk of being left behind by the rapid changes in Vietnam's economy. On several measures, they fare worse than their Kinh majority peers, and enabling them to participate more equitably in a changing economy will require reducing these gender gaps, including gaps related to access to health care services.[120] As analysis in section I B (Sectoral and Institutional Context) shows, while much progress has been made at the national level in Vietnam, utilization of reproductive and child health services is lower among poor women, especially those of ethnic minority groups. Cervical cancer risk is also a growing concern. The sex ratio at birth is among the highest in the world—and has worsened in recent years.

108. **The project will finance activities to overcome the supply-side barriers to accessing evidence-based reproductive, maternal, and child health interventions, as well as address the burden of cervical cancer in Vietnam.** The focus on strengthening CHS services in poor and rural areas, which also have a

[116] Reports of the provincial Departments of Health, provided in March 2018.
[117] http://moh.gov.vn/LegalDoc/Pages/OpinionPollInfo_V2.aspx?CateID=394
[118] http://projects.worldbank.org/P161283/?lang=en&tab=documents&subTab=projectDocuments
[119] http://moh.gov.vn/news/Pages/TinKhacV2.aspx?ItemId=2389
[120] Committee for Ethnic Minority Affairs. 2015. *Survey on the Socio-economic Situation of 53 Ethnic Minority Groups in Viet Nam.*

high concentration of ethnic minority populations, is expected to have a disproportionately positive impact on women and children (especially those who are poor and from ethnic minorities) because they use the CHS more than other demographic groups. The infrastructure investments provided under Component 1 will ensure that basic physical quality standards are met for health services and provide a foundation for adequate service delivery; the investment in equipment, training, and quality monitoring under Component 2 will help strengthen adherence to clinical guidelines for priority maternal and child health services that can have a measurable impact on reducing maternal and child mortality.[121] The inclusion of an 'immunization and early childhood intervention' tracer condition will provide the opportunity to strengthen delivery of commune-level interventions across the continuum of reproductive, maternal, newborn, and child health services. The 'cervical cancer' tracer aims to provide access to essential screening services that are currently not available to most women in Vietnam.

109. **The gender-related dimensions of the project's results will be monitored, at project level (through the Results Framework) and at the facility level.** The Results Framework includes PDO indicators that capture gender gaps. These include indicators on utilization of cervical cancer screening, deliveries, and nutrition services. At the facility level, the project's quality scorecards will enable the monitoring of select facility/commune-level outcomes related to gender, such as gender differentials in birth outcomes (including sex ratio at birth), child and adult health, and service utilization. A gender-based violence (GBV) risk assessment has been undertaken (see section V on Key Risks) and will be updated by the MOH every two years.

Environment

110. The project is classified Category B and triggered the safeguard policy on Environmental Assessment (OP/BP 4.01) because of its potential environmental and social impacts.

111. **The project's overall impact is assessed as positive, but the physical investments may have minor adverse environmental and social impacts, especially during the construction phase.** The civil works associated with the construction and renovation of the CHSs may involve dust, noise, vibration, waste, traffic disturbance, communicable disease transmission (due to the crowded living conditions of construction crews), and accident and incident risks. In addition, construction activities may also cause a temporary interruption in local people's access to health care services. Given the small scale and simplicity of the civil works financed by the project, construction-related impacts are considered small, temporary, localized, and can be mitigated. During operation, some adverse impacts are also anticipated, such as the generation of health care waste (HCW), including hazardous HCW, arising both from the operation of the CHSs and exposure to infection and diseases. According to the MOH's surveys, the amount of HCW generated from a CHS is small, approximately 0.5 kg of solid hazardous HCW and 0.4–0.95 m^3 of wastewater (with characteristics similar to domestic wastewater) per day.

112. **An Environmental and Social Management Framework (ESMF) has been prepared by the MOH in accordance with OP 4.01.** An ESMF is used because the project involves a large number of small subprojects whose exact location and other details will not all be known by project approval. The ESMF sets out the principles, rules, guidelines, and procedures to be used to assess the environmental and social

[121] Chou, D., B. Daelmans, R. Rima Jolivet, M. Kinney, and L. Say. 2015. "Ending Preventable Maternal and Newborn Mortality and Stillbirths." *British Medical Journal* 351: h4255.

impact of the subprojects. It contains measures and plans to reduce, mitigate, and/or offset adverse impacts and enhance positive impacts; provisions for estimating and budgeting the costs of such measures; and information on the agency or agencies responsible for addressing project impacts. The ESMF also includes Environmental Codes of Practice (ECOP) that provide a set of mitigation measures to address generic construction-related impacts associated with upgrading and construction of the CHSs. It also includes a description of the grievance redress mechanisms (GRMs); people affected by subprojects may submit complaints via the local grievance mechanisms that will be established by the PPMUs or the World Bank's corporate Grievance Redress Service (GRS) (see below). The ESMF also mandates that if a subproject may have potential moderate adverse impacts, an Environmental and Social Management Plan (ESMP) must be developed. The ESMP is subject to the World Bank's review and clearance and must be publicly disclosed before the subprojects' appraisal. The ESMP or ECOP and site-specific mitigation measures must then be incorporated into bidding documents and construction contracts. Construction contractors are required to comply with the contract provisions and the environment, social, health, and safety requirements set out in the standard procurement document. Measures to mitigate a temporary interruption of the provision of care during construction must be developed, based on consultations with the CHS manager, project technicians, and local authorities.

113. **Public consultation and information disclosure.** During project preparation, consultations on the ESMF were conducted by the MOH with key stakeholders at central and provincial levels, including the Health Environment Management Agency and the provincial DOHs. Comments and recommendations from stakeholders were reflected in the ESMF and the project design. The draft ESMF was publicly disclosed on the World Bank's external website in English on February 28, 2018,[122] and on MOH's website in Vietnamese on March 5, 2018.[123] No comments were received. The final ESMF was disclosed on February 15, 2019 on the World Bank's internal and external websites,[124] and on February 28, 2019 on the MOH's website.[125] At the subproject level, consultations with locally affected people, local NGOs, and authorities will be carried out by PPMUs during the technical preparation of the subprojects. Comments and recommendations received will be considered in subproject design. Environmental Assessment instruments prepared for any subproject during project implementation will be disclosed on the project's website and at public places accessible to locally affected people and local NGOs in Vietnamese before subproject appraisal.

Grievance Redress Mechanisms

114. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to

[122] http://documents.worldbank.org/curated/en/445821519877139497/pdf/SFG4088-EA-P161283-PUBLIC-Disclosed-2-28-2018.pdf.
[123] http://moh.gov.vn/LegalDoc/Pages/OpinionPollInfo_V2.aspx?CateID=394.
[124] http://projects.worldbank.org/P161283/?lang=en&tab=documents&subTab=projectDocuments.
[125] http://moh.gov.vn/news/Pages/TinKhacV2.aspx?ItemId=2389.

the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. *For* information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

V. KEY RISKS

Systematic Operations Risk-Rating Tool Analysis

115. **The overall risk rating is Moderate.** The most significant areas of risk are related to macroeconomic factors, institutional capacity, and fiduciary concerns. These three risk areas are all rated Substantial and are discussed in more detail in the paragraphs that follow. Political and governance risk is Moderate. Sectoral strategies/policies risk is Moderate because all the relevant strategies and policies on which the implementation of credit-financed project activities will depend are already in place. However, the tendency for the MOH to take a long time to develop policies and guidelines may have an impact on some of the policy development activities under Component 3 (funded by grant co-financing). Technical design risk is Moderate because the credit-financed investments in infrastructure and equipment are not complex and training activities will rely mainly on established training modalities. Environmental and social risk is Moderate as the MOH is very familiar with World Bank safeguard policies, and safeguards compliance in existing health operations is Satisfactory. Stakeholder risk is also Moderate, owing mainly to the non-controversial nature of the project objectives and design. The large number of donors contributing co-financing grants to the project adds some complexity and expands the group of interested stakeholders, but this is mitigated by the fact that grant co-financing is from existing Trust Funds managed by the World Bank with established reporting procedures.

116. **Macroeconomic risk is rated Substantial.** While macroeconomic performance has been strong, fiscal constraints associated with the high public debt-to-GDP ratio (which at 61.4 percent is close to the 65 percent statutory limit, even if down from the 2016 high of 63.7 percent) pose some risk to the attainment of PDOs. Over the last year, the GoV has cut back its budget allocation to World Bank projects to avoid taking on further debt—to the point that allocations have in some cases been insufficient to implement project activities. In addition, the current MTIP 2016–2020 of the Government has scant room to accommodate additional activities, further constraining the allocation of budget for credit-financed project activities (at least until 2021). However, the potential impact of these risks should be relatively short-lived and confined to the first few years of the project.

117. **Institutional capacity for implementation and sustainability is rated Substantial.** Although the central MOH team has considerable experience implementing projects, the capacity for project implementation at the provincial level is weaker. Moreover, the project will be targeting poorer provinces, where capacity tends to be lower. Allocation of MOH staff time and difficulty in hiring good-quality local consultants, as well as being able to pay sufficient rates for international consultants, have been constraints in the past. Recent changes in the regulations on ODA management exacerbate implementation risk. First, credit resources may no longer be used to finance project management and there is a risk that counterpart financing and co-financing grants allocated for this purpose may be insufficient. Second, the elimination of so-called 'umbrella projects' means that the MOH no longer has direct management of, and accountability for, activities implemented at the provincial level. In addition,

innovative approaches (which are included in Component 3) are not always easy for the MOH and the provinces to adopt, and pilots undertaken in previous ODA projects (whether financed by the World Bank or others) have seldom been sustained. Finally, the fact that two of the three ongoing World Bank-financed health projects in Vietnam spent significant time in problem status in the early stages of implementation underscores the institutional capacity risk. The mitigation measures to address these risks include (a) a comprehensive and detailed POM to be adopted by project effectiveness; (b) prior review by the World Bank of key personnel in the CPMU and PPMUs, as well as their terms of reference; (c) monitoring by provincial authorities of project implementation progress; and (d) capacity-building and implementation support before and during project implementation

118. **Fiduciary risk is rated Substantial.** Although the procurement assessment concluded that the 13 participating provinces generally have sufficient expertise to serve the needs of the project, government staff lack experience in the use of the new Procurement Framework and the STEP that were recently introduced by the World Bank. The use of FAs will also be novel; it is the first time that this is being applied in a World Bank project in Vietnam. In addition, experience points to the risk of procurement delays arising from procurement-related decision-making/approval processes due to complex government requirements, inefficient coordination among implementing and beneficiary agencies, occasional non-compliance with the World Bank's procurement policy/procedures, and the possibility of corrupt and fraudulent practices in the implementation of the project activities. FM risk is substantial due to (a) a high level of decentralization of the project whose credit-financed activities are managed by as many as 13 provinces which, moreover, have different capacities and (b) recent history of delayed and inadequate budget allocation (including for projects), especially in poorer provinces. The mitigation measures include (a) inclusion of detailed FM and procurement guidelines in the POM; (b) ensuring appointment of qualified experienced FM and procurement staff, acceptable to the World Bank, in the CPMU and PPMUs; (c) preparing a simple code of conduct for fiduciary officials and members of Bid Evaluation Committees; and (d) organizing training workshops and providing implementation support with respect to the World Bank's fiduciary policies and procedures and the application of the Procurement Framework. These measures are elaborated in the Appraisal Summary (section IV B).

GBV Risk Assessment

119. **A GBV risk assessment has been carried out.** The project was rated in the lowest category, that is, 'lower risk' (with a score of 10 out 25). Of the risks examined the main concerns stem from country context factors, specifically the high national prevalence of intimate partner violence and sexual violence, low incidence of help-seeking in case of GBV, and the absence of national referral protocols. Among project-specific risks, the main concerns relate to the fact that the project will invest in poor and remote areas (where it may be more difficult to supervise the behavior of construction workers). Measures to minimize these risks will be further elaborated in the POM. At minimum, these will include: (a) organizing orientation workshops to sensitize all stakeholders to GBV issues; (b) including measures to address GBV risk in the Code of Conduct for contractors; and (c) strengthening the GRM by including contact details of a GBV focal person as part of the project information on the project-related website(s). The GBV risk assessment will be updated by the MOH every two years.

Climate and Disaster Risk Screening

120. **The project was screened for climate and disaster risk and found to be at Moderate risk, mainly due to exposure to extreme precipitation and flooding as well as storm surges.** Much of Vietnam's coastline is exposed to typhoons and is struck an average of six to eight times per year, resulting in nearly US$4.5 billion in damage over the past century. Rainfall has increased over time causing frequent episodes of river flooding and flash flooding, while rising sea levels contribute to increased coastal flooding. This poses a risk to the project's investments in CHS and DHC/DH infrastructure, especially in the coastal provinces which are prone to coastal flooding and in some inland provinces where there is a flooding risk from run-off or rivers overflowing their banks. Analysis of the results of predictive models show that the project provinces of Quang Binh, Quang Tri, Quang Ngai, Bac Lieu, and Tra Vinh will likely be affected by sea level rise, while Long An and Hau Giang will likely be affected by flooding from the Mekong River. The gradient of the land around health facilities may also be inadequate to ensure drainage away from the facilities during the rainy season, thus exacerbating flood damage and also potentially blocking access to facilities for patients. Mold is a persistent challenge in facilities, especially in damp and humid conditions. Together, these factors mean that the project's infrastructure investments might degrade more quickly than they otherwise would.

121. **Risks will be mitigated by existing government policies and practices, as well as project-specific measures.** Risk mitigation related to climate change is a priority for the GoV. Moreover, the health sector already considers such hazards in the official standards that are used for health facility infrastructure.[126] In line with these standards, Component 1 will incorporate climate resiliency into infrastructure development, including building facilities on stilts in flood-prone areas, using reinforced concrete, and aiming for construction to last at least 40 years. In line with climate smart healthcare principles, there may also be an opportunity to innovate (in select facilities) with measures that are currently uncommon in CHS and DHC/DH in Vietnam – such as solar panels, energy efficient lighting, passive cooling and thermal insulation of walls. Under Component 2, the project's investments in specialized vaccine fridges (which are able to keep essential vaccines protected from heat even during power outages) will be certified energy-efficient to a standard specified by Gavi, replacing the older, less energy-efficient fridges[127] currently in use in most DHs. The POM will describe the measures that can be taken to increase the climate resilience of the project's infrastructure investments in more detail. The potential impact of climate and natural disasters on other project activities (such as training, policy development, and piloting of innovations under Component 3) is low. Consequently, the impact of climate change risk on the outcome of the project is considered Moderate.

[126] The commune health benchmarks are described in MOH Decision 4667/QD-BYT of 2014, the CHS's functional space requirements are in MOH Decision 6070/QD-BYT of 2018, and the minimum architectural standards are laid out in MOH Decision 2271/QD-BYT of 2002.

[127] Most of the vaccine fridges in use in the DHs in the project provinces were procured 18 years ago (under a development assistance project of the Luxembourg government)

VI. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Vietnam

Investing and Innovating for Grassroots Health Service Delivery

Project Development Objectives(s)

The Project Development Objective is to improve the quality and utilization of grassroots health services, with a focus on the commune level, in the Project Provinces.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Improve the quality and utilization of grassroots health services, with a focus on the commune level							
Percentage of CHS in the project provinces meeting national standards/benchmarks for structural quality (Percentage)		78.00	78.00	79.00	81.00	83.00	85.00
Number of NCD cases screened or being managed at the CHS level in project provinces (Number)		0.00	0.00	0.00	80,000.00	120,000.00	180,000.00
Number of hypertension cases being managed at CHS level (Number)		0.00	0.00	0.00	50,000.00	70,000.00	100,000.00
Number of diabetes cases being managed at CHS level		0.00	0.00	0.00	20,000.00	30,000.00	50,000.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
(Number)							
Number of eligible women screened for cervical cancer at the CHS level (Number)		0.00	0.00	0.00	10,000.00	20,000.00	30,000.00
Percentage of project provinces maintaining a full immunization rate above 90% (Percentage)		100.00	100.00	100.00	100.00	100.00	100.00
Number of presumptive TB cases referred for GeneXpert testing in project provinces (Number)		7,860.00	8,253.00	8,665.00	9,098.00	9,553.00	10,000.00
Population utilization rate of CHS in the project provinces (Number)		0.56	0.56	0.58	0.60	0.62	0.65
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	0.00	95,000.00	215,000.00	352,000.00	485,000.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		0.00	0.00	70,000.00	140,000.00	232,000.00	270,000.00
Number of children immunized (CRI, Number)		0.00	0.00	50,000.00	150,000.00	240,000.00	330,000.00
Number of women and children who have received basic nutrition services (CRI,		0.00	0.00	75,000.00	240,000.00	400,000.00	580,000.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Number)							
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00	0.00	45,000.00	135,000.00	225,000.00	310,000.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Component 1: Upgrading of CHS Infrastructure							
Number of CHS built (new) or renovated with project support (Number)		0.00	22.00	88.00	198.00	330.00	440.00
Number of new CHS built (Number)		0.00	7.00	27.00	61.00	101.00	135.00
Number of CHS renovated (Number)		0.00	15.00	61.00	137.00	229.00	305.00
Component 2: Improving Readiness of CHS to Manage Tracer Conditions							
Number of CHS in the project provinces with the basic package of equipment needed to manage the tracer conditions (provided by the project) (Number)		0.00	55.00	220.00	495.00	825.00	1,100.00
Number of grassroots facilities in the project provinces with a functioning vaccine cold chain (fridges) (provided by the		0.00	36.00	142.00	320.00	533.00	710.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
project) (Number)							
Number of CHS in the project provinces with a functioning vaccine cold chain (fridges) (provided by the project) (Number)		0.00	30.00	120.00	270.00	450.00	600.00
Number of DHC/DH in the project provinces with a functioning vaccine cold chain (fridges) (provided by the project) (Number)		0.00	6.00	22.00	50.00	83.00	110.00
Number of DHC/DH in the project provinces with a GeneXpert machine (provided by the project) (Number)		0.00	0.00	0.00	35.00	35.00	35.00
Number of health professionals at CHS level who have received in-service training (through the project) on the management of the tracer conditions. (Number)		0.00	350.00	1,400.00	3,150.00	5,250.00	7,000.00
Number of CHS in the project provinces authorized by the provincial DOH and provincial VSS to manage at least one of the new NCD tracer conditions (hypertension or diabetes) in the project provinces (Number)		0.00	0.00	0.00	100.00	200.00	300.00
Percentage of CHS using quality monitoring and management practices (in the form of a quality scorecard) (Percentage)		0.00	3.00	5.00	10.00	15.00	20.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Percentage of beneficiaries in project provinces reporting that they are satisfied with the quality of services at the CHS (Percentage)		40.00	42.00	45.00	47.00	50.00	55.00
Component 3: Creating Enabling Policy Environment, Piloting Innovations, Evaluation and Management							
Satisfactory progress on policy development and implementation (Text)		No	Yes	Yes	Yes	Yes	Yes
Number of districts in project provinces piloting at least one innovation (Number)		0.00	10.00	20.00	30.00	40.00	50.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Percentage of CHS in the project provinces meeting national standards/benchmarks for structural quality	Number of CHS in the project provinces who fully meet (11 points) of the infrastructure criteria (Criteria 3) of the National Benchmarks on health stipulated in the Decision 4667/QD-BYT dated November 07, 2014/Total number of communes in the	Annual	HMIS	Administrative report	CPMU, PPMUs

	project provinces				
Number of NCD cases screened or being managed at the CHS level in project provinces	This indicator counts the number of NCDs patients that are registered for management and/or screening at the CHS in the project provinces. "Management" means the patient has a disease profile at the CHS, is monitored regularly, and receives treatment.	Annual	Project specific	Administrative report	CPMU, PPMUs
Number of hypertension cases being managed at CHS level	This indicator counts the number of hypertension patients that are registered for management at the CHS in the project provinces. "Management" means the patient has a disease profile at the CHS, is monitored regularly, and receives treatment.	Annual	Project specific	Administrative report	CPMU, PPMUs
Number of diabetes cases being managed at CHS level	This indicator counts the number of diabetes patients that are registered for management at the CHS in the project provinces. "Management" means the patient has a disease profile at the CHS, is monitored regularly, and receives	Annual	Project specific	Administrative report	CPMU, PPMUs

	treatment.				
Number of eligible women screened for cervical cancer at the CHS level	This indicator counts the number of women aged 30 – 49 who have been screened for cervical cancer at the CHS level during the year in the project province.	Annual	Project specific	Administrative report	CPMU, PPMUs
Percentage of project provinces maintaining a full immunization rate above 90%	Project provinces are able to maintain the EPI immunization rates above 90%	Annual	HMIS	Administrative report	Department of Health/National Expended Immunization Program
Number of presumptive TB cases referred for GeneXpert testing in project provinces	This indicator counts the number of cases that are referred for tested using GeneXpert in project provinces.	Annual	Project specific	Administrative report	Provincial Project Management Units
Population utilization rate of CHS in the project provinces	The indicator is calculated as the number of consultations at the CHS level per person per year. The data are taken from CHS A1 book.	Annual	HMIS	Administrative report	Provincial Project Management Unit
People who have received essential health, nutrition, and population (HNP) services		Annual	Provincial Health Bureau Provincial VSS	Administrative report	Provincial Project Management Unit
People who have received essential health, nutrition, and population (HNP) services - Female (RMS		Annual	Provincial VSS	Administrative report	Provincial Project Management Unit

requirement)					
Number of children immunized		Annual	HMIS	Administrative report	Provincial Project Management Unit
Number of women and children who have received basic nutrition services		Annual	Provincial VSS	Administrative report	Provincial Project Management Unit
Number of deliveries attended by skilled health personnel		Annual	HMIS	Administrative data	Provincial Project Management Unit

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Number of CHS built (new) or renovated with project support	The indicator counts the number of CHS that are newly built or renovated with the project support in the project provinces.	Bi-annual	Project specific	Administrative report	CPMU, PPMUs
Number of new CHS built	The indicator counts the number of CHS that are newly built with the project support in the project provinces.	Semi-annual	Project specific	Administrative report	CPMU, PPMUs
Number of CHS renovated	The indicator counts the number of CHS that have been renovated with project support in the project provinces	Semi-annual	Project specific	Administrative report	CPMU, PPMUs

Number of CHS in the project provinces with the basic package of equipment needed to manage the tracer conditions (provided by the project)	This indicator counts the number of CHS in the project provinces which receive the basic package of equipment from the project to manage the tracer conditions. The list of equipment is identified in the project document.	Semi-annual	Project specific	Administrative's report	CPMU, PPMUs
Number of grassroots facilities in the project provinces with a functioning vaccine cold chain (fridges) (provided by the project)	This indicator counts the number of CHS and DH in the project provinces which receive and operate the functioning cold chain (fridge) provided by the project.	Annual	Project specific	Administrative report	Provincial Project Management Unit
Number of CHS in the project provinces with a functioning vaccine cold chain (fridges) (provided by the project)	This indicator counts the number of CHS in the project provinces which receive and operate the functioning cold chain (fridge) provided by the project.	Semi annual	Project specific	Project administrative report	CPMU, PPMUs
Number of DHC/DH in the project provinces with a functioning vaccine cold chain (fridges) (provided by the project)	This indicator counts the number of DH/DHC in the project provinces which receive and operate the functioning cold chain (fridge) provided by the project.	Semi-annual	Project specific	Administrative report	CPMU, PPMUs
Number of DHC/DH in the project provinces with a GeneXpert machine	This indicator counts the number of DHC/DH in the	Semi-annual	Project specific	Administrative report	CPMU, PPMUs

(provided by the project)	project provinces which receive and operate a GeneXpert machine provided by the project.				
Number of health professionals at CHS level who have received in-service training (through the project) on the management of the tracer conditions.	This indicator counts the number of health staff at the CHSs who have received in-service training (through the project) on the management of the tracer conditions. The list of training courses is defined in the POM.	Semi-annual	Project specific	Administrative report	CPMU, PPMUs
Number of CHS in the project provinces authorized by the provincial DOH and provincial VSS to manage at least one of the new NCD tracer conditions (hypertension or diabetes) in the project provinces	The indicator measures the number of CHSs in the project provinces which are authorized by the provincial DOH and provincial VSS to provide services to manage at least one of the new NCD tracer conditions (hypertension or diabetes) in the project provinces. This is a comprehensive assessment on the conditions and capacity of the CHS, including infrastructure, equipment, human resources, etc to provide health care services for NCD management and control. The authorization	Semi-annual	Project specific	Administrative report	CPMU, PPMUs

	procedure will be developed during the project implementation.				
Percentage of CHS using quality monitoring and management practices (in the form of a quality scorecard)	This indicator measures the percentage of the CHS that apply the Balanced Scorecard to manage the quality of care among the total number of CHSs in the project provinces.	Semi-annual	Project specific	Administrative report	CPMU, PPMUs
Percentage of beneficiaries in project provinces reporting that they are satisfied with the quality of services at the CHS	This indicator measures the percentage of the patients in project provinces reporting that they are satisfied with the quality of services at the CHS. This indicator is collected through patient satisfaction survey.	Baseline, Mid-term, End-project	Project specific beneficiary survey	Patient satisfaction survey	Independent Evaluation team
Satisfactory progress on policy development and implementation	This indicator measures the policy development progress qualitatively. It is assessed by comparing the progress in policy development against the project plan. The unit of measurement is yes/no to evaluate whether it is achieved or not.	Semi-annual	Project specific	Administrative report	CPMU, PPMUs
Number of districts in project provinces piloting at least one innovation	This indicator counts the number of districts in project provinces piloting at	Semi annual	Project specific	Administrative report	Provincial Project Management Unit

	least one innovation as stipulated in the Project Document.				

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Vietnam
Investing and Innovating for Grassroots Service Delivery Reform

1. **The World Bank's implementation support will focus on** (a) helping the MOH and the 13 participating provinces to unblock operational bottlenecks; (b) ensuring compliance across fiduciary, social, and environmental domains; and (c) providing advice and undertaking analytics to strengthen the technical quality of implementation. The extent of implementation support that can be provided will depend on the mobilization of complementary resources.

2. **Within the operational domain, the largest share of the World Bank's implementation support will go to the credit-financed components on construction and equipment.** In light of the new ODA regulations that eliminate the 'umbrella project' approach (where projects are managed by a hierarchical structure of a CPMU and PPMUs), the World Bank will need to provide direct implementation support to each of the 13 provincial 'project owners' which implement the credit-financed activities and are responsible for (a share of) credit repayment. Because this project is one of the first to be approved under these new regulations, it is not certain exactly what the implications for implementation support will be, but the demand for implementation support is expected to be greater than in previous projects, with corresponding implications for team size (which may need to be bolstered by consultant support), field travel, and supervision costs.

3. **In terms of strengthening compliance, technical assistance will be needed as described in the relevant sections of the Appraisal Summary.** With fiduciary risk rated as Substantial, technical assistance to procurement and FM will be prioritized, especially with respect to the two innovations of this project (the use of FAs for procurement and the use of State Treasury for fund flow). The use of FAs is new not only to the MOH but also to World Bank projects in Vietnam (because it was only recently included as an option under World Bank procurement policies). There will also be training in the use of the STEP and the new World Bank Procurement Framework. Implementation support for FM will be undertaken mainly during, and in response to the findings of, the semi-annual FM supervision reviews. In addition, there will be specialized training for the State Treasury through which funds will flow for the first time in a World Bank project. For environmental and social safeguards, the World Bank will monitor compliance through the reports submitted by the CPMU and PPMUs and take remedial and supportive action as needed.

4. **Within the technical domain, the focus for the World Bank's implementation support will be related to the grant co-financed subcomponents.** This will include technical assistance to, among others: (a) the technical design and use of the quality scorecards and related quality management approaches, as well as assessment of their effectiveness (under Subcomponent 2.3); (b) curriculum development (related to the tracer conditions) and e-learning approaches (under Subcomponent 2.2); (c) policy development, assessment of policy impact, updating of guidelines, and regulatory strengthening in line with the PDOs (under Component 3); (d) design, implementation, and evaluation of pilots and innovations (under Component 3); and (e) M&E and operational research activities, including quantitative surveys and qualitative approaches, as needed (under Component 3).

5. **Development partners are expected to provide technical assistance, and occasionally operational support, to strengthen the implementation of select project activities, in line with their respective mandates.** The WHO, with its in-country expertise across a wide range of relevant topics (including NCD management, various communicable diseases, information systems, and health systems) will continue to be an important technical partner. The United States CDC and Global Fund will support implementation of activities related to TB (including GeneXpert placement and use), UNICEF and Gavi will have both a technical and an operational role with respect to the procurement of CCE and the use of the CCEOP, and UNFPA will partner to support activities related to cervical cancer screening. NGOs, including PATH and HelpAge, can provide technical support for NCD management. There is also potential to benefit from, and contribute to, technical assistance activities related to the concurrent ADB project that is focused on grassroots health system strengthening in a different set of provinces. The World Bank team will coordinate its implementation support with these partners to get the most value-for-money, avoid duplication, and exploit synergies.

6. **While implementation support will be provided throughout project implementation, it is anticipated that more intense support will be needed at two points in time**: during the first 12 months (from approval to effectiveness and through early implementation) and at midterm review. With only a limited allocation of budget to the project expected in 2020, implementation support in the first year of the project will focus on creating project implementation momentum through institutional capacity strengthening, preparation for first construction packages and CCE and GeneXpert procurement, and technical assistance for pilot design and policy development.

Table 1.1. Type of Implementation Support

Time Line	Focus	Skills Needed	Resource Estimate
0–12 months	Creating project implementation momentum through institutional capacity strengthening, preparation for first construction packages and CCE and GeneXpert procurement, and technical assistance for pilot design and policy development	Project management, operational, technical (including M&E), fiduciary, environment, and social	At minimum, 3 formal implementation support missions. All provinces to be visited at least once. Just-in-time technical assistance.
12–24 months	Continued institutional capacity enhancement, implementation monitoring, operational and technical assistance to support implementation	Project management, operational, technical (including M&E), fiduciary, environment, and social	Two formal implementation support missions; just-in-time technical assistance
Midterm review	Midterm review and identification of midcourse adjustments	Project management, operational, technical (including M&E), fiduciary, environment, social	Comprehensive Midterm review mission
24–60 months	Implementation monitoring, operational and technical assistance to support implementation	Project management, operational, technical (incl. M&E), fiduciary, environment, social	Two formal implementation support missions; just-in-time technical assistance
Completion phase	ICR and final payments	Project management, fiduciary	ICR mission

Table 1.2. Team Skills and Time Allocation (Annual)

Skills Needed	Weeks	International Trips	Comments
Team leadership and cross-cutting implementation support	24	0	Country based
Technical specialists	12	2	Country and HQ based
FM specialist	4	0	Country based
Procurement specialist	4	0	Country based
Environmental specialist	4	0	Country based
Social specialist	2	0	Country based
Consultants (technical) Consultants (procurement)	16 4	2 0	Country based
Administrative Support	6	0	Country based

ANNEX 2: Project Components - Additional Tables and Figures

COUNTRY: Vietnam
Investing and Innovating for Grassroots Service Delivery Reform

Figure 2.1. Initial Allocation of Credit, by Project Province and Investment Type

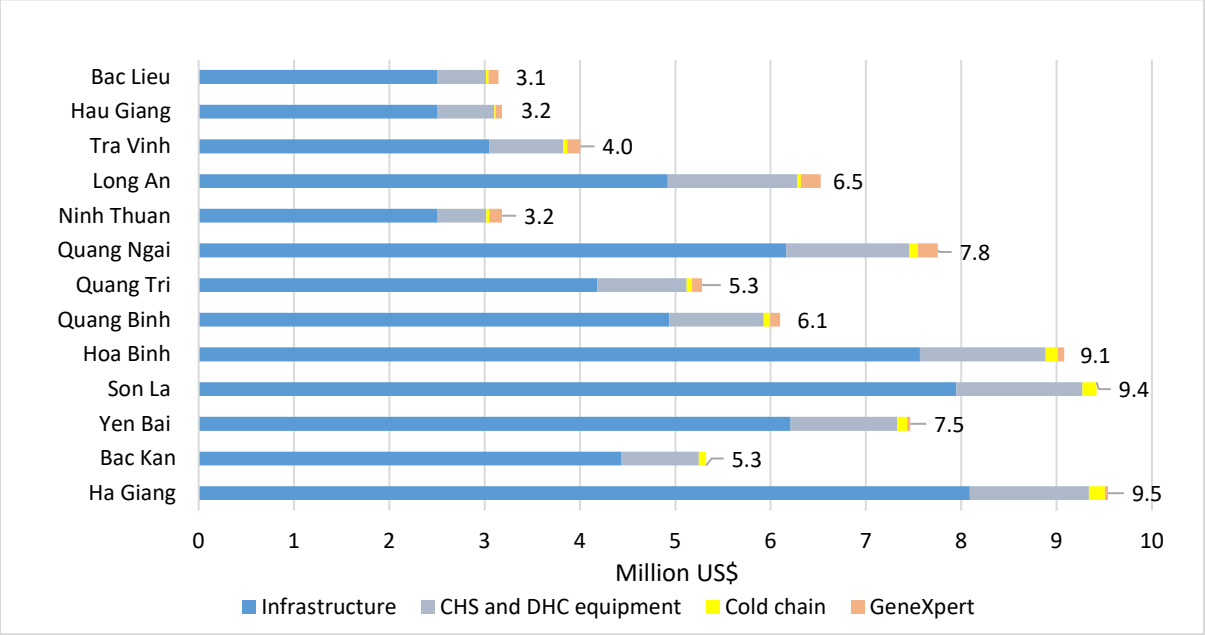


Table 2.1. List of Equipment to Support the Five Tracer Conditions

CHS	DHC/DH
Electronic blood pressure cuff	ECG
Glucometer	HbA1c testing equipment
Pulse oximeter, simple peak flow meter, nebulizer, oxygen tank, and masks	Pulse oximeter, peak flow meter, spirometer, x-ray, and microscope (for sputum testing)
Gynecological exam bed, cervical exam instruments, standing LED lamp	Gynecological exam bed, colposcopy and cryotherapy equipment
Newborn and child weighing scales	GeneXpert machine (including cartridges)[a]
Computer and printer	
TV, projector and screen, amplifier for IEC work	
Vaccine fridge[a]	Vaccine fridge[a]

Note: a. Select districts and communes only, as identified during project preparation and in consultation with the National Institute for Hygiene and Epidemiology (national EPI program) and National TB and Lung Hospital (national TB program).