

WORLD BANK GROUP MULTI-DONOR TRUST FUND CONCEPT NOTE
Integrating Donor-Financed Health Programs
Window 2 (Immunization)

Objectives

The development objective of the recently-approved multi-donor trust fund (MDTF) for integrating donor-financed health programs (TF072424) is to support countries in strengthening their health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to universal health coverage (UHC) with a particular focus on assessing and supporting the financial and institutional sustainability of donor-financed health programs. The MDTF comprises four activity pillars: (i) *comprehensive health financing and institutional assessments (Bank-executed)*; (ii) *technical assistance and capacity building (Bank-executed)*; (iii) *knowledge generation and exchange activities (Bank-executed)*; and (iv) *implementation of health systems integration/strengthening interventions (Recipient-executed)*. The purpose of this “mini” concept note is to elaborate on support to selected countries in the East Asia & Pacific (EAP) region – possibly Cambodia, Indonesia, Lao PDR, Myanmar, Papua New Guinea, Philippines, and Vietnam -- specifically in the context of integrating donor-financed immunization programs and within the overarching umbrella of the MDTF.

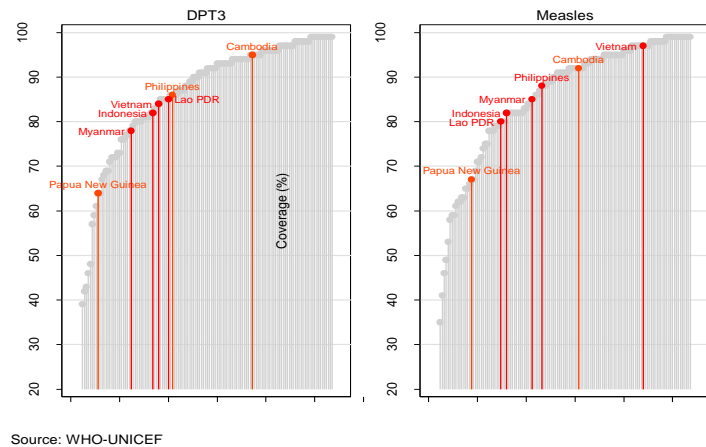
Background

Attainment of UHC varies significantly across EAP countries: countries such as Papua New Guinea provide almost universal breadth of coverage financed by general government revenues; others such as Indonesia, Philippines, and Vietnam cover relatively large proportions of their populations under social health insurance UHC programs; and progress has been made in some of the lower income countries such as Cambodia and Lao PDR in removing financial barriers for targeted sub-groups such as the poor and for certain services such as those related to maternal and child health (MCH). Challenges remain, however, with regard to depth and height of coverage, even in countries claiming high or universal breadth of coverage.

Despite notable progress in recent years, progress on immunization coverage – a key component of progress towards preventive/promotive UHC interventions -- varies significantly across EAP countries. For example, DPT3 immunization rates ranged from 65% in Papua New Guinea to 95% in Cambodia. Similar differences exist for measles vaccination rates (Figure 1). Many EAP countries, including middle-income ones such as Indonesia, have immunization rates that are lower than expected for their income levels indicating potentially fundamental problems in key aspects of health systems, including health financing and service delivery. Low coverage in these countries makes the region vulnerable to vaccine-preventable disease outbreaks such as measles and polio. Coverage of newer WHO-recommended vaccines such as the pneumococcal conjugate or rotavirus is much lower, in part because many EAP countries do not include them in their national immunization packages due to financial considerations. In some EAP countries, the prime challenge will remain attainment of decent levels of coverage, in particular for antigens other than DPT3, and these countries may remain eligible for donor financing in the

foreseeable future and the approach/focus of MDTF activities may thus be somewhat different in these countries.

Figure 1: DPT3 and measles immunization rates in developing countries, 2012-2014



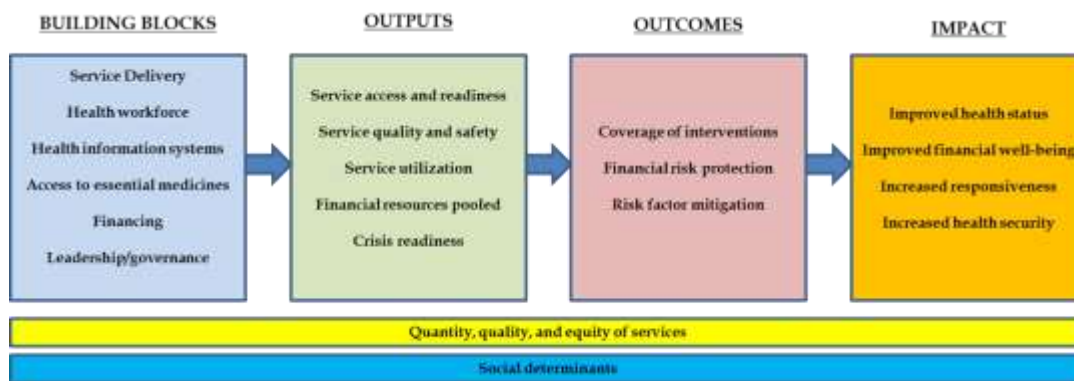
Large differentials in immunization are evident within countries as well, even in those with relatively high levels of national coverage: with significantly lower rates for the bottom 40% of the population, among those living in poorer and more remote geographic sub-regions, and – at least in some countries in the region – among girls. For instance, DPT3 coverage rates among the bottom 40% in Indonesia were only 61% compared to 85% among the top economic quintile of the population; in the Philippines, DPT3 coverage among the bottom 40% was 81% relative to 93% among the top quintile. Measles vaccination rates in the rich province of Yogyakarta in Indonesia were close to 100%, double those in the relatively poorer province of Papua; the province of Xayaburi in Lao PDR had a measles immunization rate of 88%, more than double that in the province of Savannakhet. Discrepancies in vaccination status between the poor and the better-off, and across social and ethnic groups, were also found in Vietnam: despite the overall high coverage, recent analysis has pinpointed 91 districts -- distributed across 26 provinces, including 12 in the north, 4 in central, and 10 in the south region -- with immunization coverage lower than 80% for DTP-HepB-Hib3 or MCV2 in 2014; geographically, these areas are also highly correlated (but not exclusively) with the areas of the country with high ethnic minority populations, highest levels of poverty, in highland or delta regions.

The other key immunization-related challenge has to do with the introduction of new vaccines where these have been assessed as cost-effective interventions for reducing morbidity and mortality in vulnerable populations (e.g., vaccines to protect against rotavirus and pneumococcal infections). Countries in the region have often been reluctant to introduce new vaccines without support from donors such as GAVI. And few countries in the region have adopted the inactive polio vaccine (IPV) to date.

1. In terms of understanding constraints to improving and expanding immunization coverage, WHO's "building blocks" conceptual framework health systems can be a useful starting point. WHO defines a health system as "...the sum total of all the organizations,

institutions, and resources whose primary purpose is to improve health.”¹ WHO conceptualizes health systems as comprising of six core building blocks: (i) *service delivery*; (ii) *health workforce*; (iii) *health information systems*; (iv) *access to essential medicines*; (v) *financing*; and (vi) *leadership/governance*.² These six building blocks represent inputs and processes that – when combined together – generate outputs, outcomes, and impact for attainment of desired objectives such as immunization coverage and other indicators for UHC, improved responsiveness, and enhanced health security (Figure 2).³

Figure 2: Results chain from building blocks to impact



Source: Adapted from WHO (2013a).

In countries implementing UHC using social health insurance modalities, there remain challenges of integration and complementarity of service delivery and financing of national immunization programs. Supply-side readiness to provide vaccine services is also key: vaccine stock-outs and cold chain problems can indicate systems issues, signaling insufficient investments and/or training; however, these issues can occur even when the national immunization programs are well-funded, and generally represent challenges as new vaccines are being introduced or as efforts are ramped up to deal with high-profile challenges such as polio campaigns. In the province of Papua in Indonesia, for instance, public health centers had on average only half of WHO’s recommended supply-side readiness indicators for delivery of immunization services (key deficiencies included lack of guidelines, training, and cold-chain elements). In a national sample of health centers in Lao PDR, only 60% had the polio vaccine, only 71% had the BCG vaccines, and only 65% had a reliable power supply. The decentralization context in countries can play a significant role in decision-making and resource allocations and variations in sub-national capacity often significantly influences service delivery. Greater emphasis on improving incentives and motivation among frontline health staff and use of innovative technologies is needed. Use of citizen accountability methods – such as “score cards” – can often help improve service delivery in poor-governance settings.

¹ WHO 2014, Health Systems Q&A. Available from: <http://www.who.int/topics/health_systems/qa/en/>. [March 2014].

² WHO 2010, Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies, WHO, Geneva.

³ WHO 2012, The World Health Report 2013: research for universal health coverage, WHO, Geneva.

In addition, there are myriad constraints to expanding vaccination coverage from the demand-side, ranging from social and cultural issues such as personal belief systems and integration into society to health systems issues such as access to and satisfaction with health services. In almost all countries, children without any vaccinations are more likely to come from the poorest quintile households, live in remote and/or rural areas, and have mothers with low levels of education. Low levels of awareness of the benefits of immunization, especially among vulnerable population sub-groups, are thus a key constraint in some countries.

With regard to health financing, EAP countries are at different stages with regard to the share to total health expenditure coming from external sources. Whereas in Indonesia, Philippines, and Vietnam less than 5% of total health expenditure came for external sources, the corresponding number was in excess of 20% in Lao PDR and Papua New Guinea (Figure 3). However, the situation with regard to external financing specifically for the case of immunization differs from that for health more generally. For example, in countries such as Cambodia, Lao PDR, Papua New Guinea, and Vietnam external financing for vaccines is more than domestic financing, sometimes significantly so, potentially increasing challenges related to integration and sustainability (Table 1).

Figure 3: External share of total health expenditure, 2012-2014

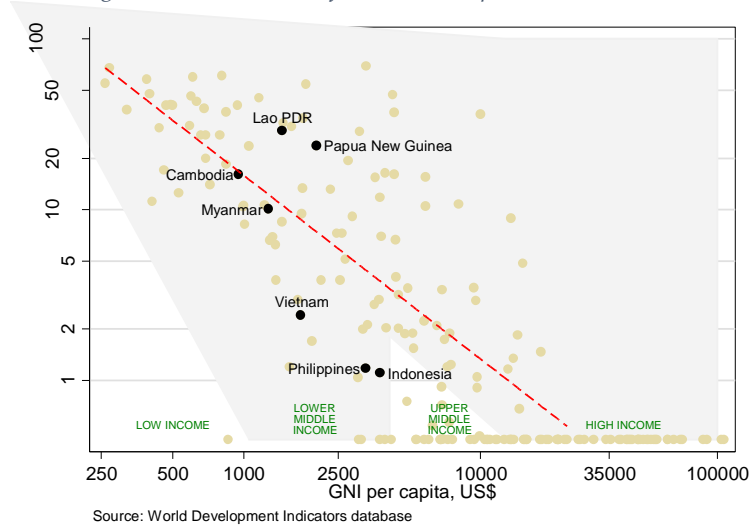


Table 1: Vaccine financing

Country	Domestic financing	External financing
Cambodia	US\$2 million	US\$10 million
Indonesia	US\$48 million	US\$18 million
Lao PDR	US\$0.2 million	US\$2 million
Myanmar	US\$1 million	US\$11 million
Papua New Guinea	US\$2 million	US\$7 million
Philippines	US\$40 million	US\$1 million
Vietnam	US\$7 million	US\$24 million

Source: IHME & JRF

Institutional issues play an important role in addressing the sustainability challenge for essential service historically dependent on external financing. Fragmentation of planning, financing flows, reporting, monitoring, management of services and human resources are part of this challenge. But it also goes broader, including the political economy of how countries make allocations of their scarce resources as well as of governance and relative power structures of existing public administration and regulatory institutions.

Strengthening health systems for improving immunization coverage supports the broader agenda of strengthening public health resilience and responsiveness as emphasized in EAP's *Regional Health Strategy for 2014-2019* and for enhancing regional health security as outlined in DFATs *Health for Development Strategy 2015-2020*. The EAP region has been the epicenter of emerging and reemerging infectious diseases especially those with pandemic potential. Over 30 new infectious agents have been detected in the last three decades, 75% of which have originated in animals (zoonoses). New pathogens, particularly viruses, remain unpredictable and contribute to emerge and spread across the world. Several emerging and re-emerging diseases have profoundly affected countries in the EAP region including dengue fever, MERS, Japanese encephalitis, leptospirosis, and the Nipah virus. The advent of SARS and avian influenza, in particular, underscore the importance of emerging diseases and their impact on health and economic development, as does the recent emergence of the H7N9 virus in China. Several socioeconomic, demographic, environmental, and ecological factors facilitate the emergence and spread of these diseases in the region, including the close contacts between humans and animals, high population density, urbanization, as well as climate change. A combination of prevention, improved surveillance, and responsive public health interventions are required to deal with challenges related to both immunization and for managing the impact of emerging infectious diseases in the region.

Proposed Activities

Given this background -- and within the overall objectives and pillars of the MDTF for integrating donor-financed programs -- the following activities are proposed within the specific context of expanding and improving immunization coverage. Equity -- including gender equity and collection and analysis of gender-disaggregated data -- will be a core focus of the work: both on the evidence and assessment sides, but also in the provision of targeted resources for strengthening capacity in lagging parts of countries. In addition, the MDTF will explicitly support activities that would strengthen the process by which countries adopt new vaccines such as the IPV and on integrating immunization within UHC programs. By keeping the focus on health systems strengthening, the MDTF will finance activities to strengthen country capacity and give them exposure to tools to assess fiscal space and institutional requirements for introduction of new vaccines, including health technology assessments (HTAs). The basic immunization system assessments under the HFIA would also look specifically at IPV (which is about restructuring rather than introduction of new vaccine per se, i.e., changing strategy of vaccine preventable disease that was in the package before). The MDTF could also encourage work on country case studies, including those that have adopted the OPV to IPV transition. Strengthening the availability of data and dialoguing on the importance of immunization coverage as a key metric of UHC progress will be emphasized where possible. The activities proposed

under this MDTF will complement GAVI co-financed activities promoting the sustainable financing of immunization programs within a sectoral and fiscal context (P150653).

Pillar I: Comprehensive Health Financing and Institutional Assessments: In some of the countries of focus – Cambodia, Lao PDR, Myanmar, Papua New Guinea, Philippines, and Vietnam – a comprehensive health financing and institutional assessment will be conducted with a specific focus on immunization using the recently-developed protocol by the health financing global solutions group of the World Bank’s HNP GP. Indonesia is already implementing this as part of ongoing engagement. In other countries, the assessments will add an immunization focus to ongoing or recently completed health financing assessments (e.g., in Indonesia, Lao PDR, Myanmar, Papua New Guinea, Philippines, and Vietnam). In others such as Cambodia, both the health financing and institutional assessment and the module on immunization (including a focus on assessing bottlenecks to restructuring of packages such as the transition from OPV to IPV) would be implemented. The assessment will include modules focused on assessing financial and institutional sustainability of support for specific diseases or programs, albeit these will be embedded within the broader assessment of the ability of health financing systems to facilitate attainment of UHC. In addition to financial sustainability considerations, the comprehensive analytical framework assesses health financing from a variety of perspectives including adequacy of resources; equity in health financing revenue generation and allocation; efficiency in how revenue are raised, pooled, allocated, and channeled; and predictability of financing, among others. With regard to financial sustainability considerations, several sets of issues are likely to be paramount: whether the financing needs of the health sector are being adequately met in order to help countries make progress towards attainment of UHC (including in countries transitioning away from donor-sourced financing); the macro-fiscal country context and its impact on health financing, including issues of prioritization for health in the government budget; and whether or not financing for health is crowding-out legitimate resource needs of other sectors and/or adversely impacting the economy in other ways. With regard to institutional sustainability considerations, the assessment will include a focus on issues related to public financial management, human resource management, procurement and strategic purchasing capabilities, monitoring and evaluation, supply-change management, and challenges related to decentralization, high level allocative decision making, and governance, including stakeholders and political economy of the health sector more generally. Activities will include collection of data as needed, consultation and dissemination seminars, as well as country and regional reports summarizing the findings. The teams will also consider integrating into assessments elements from Global Health Security Assessment tool that has been piloted and was discussed at the GHSA meeting in Korea on September 9, 2015.

Pillar II: Technical Assistance and Capacity Building: Activities under this pillar would include support for development of pathway options toward equitable and sustainable financing for immunization services within the context of UHC in each of the focus countries, including for addressing health financing transition challenges and for mainstreaming of donor-financed health programs. Resources will also be provided under this pillar for engagement with non-health sector actors at the national level (e.g., ministries of finance and planning, home affairs, public service, and executive offices) and

sub-national governments for dialoguing on health financing, information management, and service delivery, including with regard to financial and institutional implications of transitions from donor-financing of immunization programs in the context of UHC. Proposed activities would also include training of key stakeholders on the equitable and efficient generation and utilization of resources, including issues related to integration and/or optimizing the complementarity of donor-financed health programs, technical assistance and capacity building for enhancing the technical and allocative efficiency of programs as they undergo transition from donor-financing to domestic-financing, and capacity building for improving health system monitoring and evaluation systems, including for design of pilots and development of monitoring and evaluation mechanism including performance indicators. This pillar could include support countries to make rational decisions on utilisation of new immunisation technologies (e.g., where appropriate, support transition from OPV to IPV). Whereas the focus of Pillar I will be more on analytical and advisory work, the focus of Pillar II will be more explicitly on provision of technical assistance and capacity building.

Pillar III: Knowledge Generation and Exchange Activities: Under this pillar, resources will be provided for compilation and sharing of lessons learned from countries graduating from donor-financed immunization programs, including via financing of South-South and North-South knowledge exchanges to help provide exposure to policy-makers and other stakeholders to implementation of innovative integration strategies. Resources will also be provided for regional and global knowledge-exchanges, consultation, and dissemination activities including cross-country comparative analytical work and contributions to the global knowledge base related to immunization transition challenges.

Pillar IV: Implementation of Health Systems Integration/Strengthening Interventions: Under this pillar, resources will be provided for recipient-executed activities (including as additional financing) as part of ongoing and new operations planned in the target countries. Activities would include financing of health systems integration/strengthening immunization-focused interventions including potentially for strengthening surveillance-related monitoring and evaluation activities. This window can provide resources to governments to strategically help leverage IDA/IBRD-financed operations that could include financing for technical assistance, co-financing for IDA/IBRD financing, or financing of pilots. Some specific World Bank operations that could benefit from support include the recently-effective Lao PDR *Health Governance and Nutrition Development Project* which aims to increase coverage of reproductive, maternal, child health, and nutrition services in target areas in Lao PDR and has a focus on local service delivery that requires intensive implementation support and could possibly absorb additional co-financing in later years of implementation as Lao PDR graduates from IDA financing. Other financial support could be to ongoing operational and analytical support in Myanmar. For other potential focus countries, the World Bank currently has operations in the pipeline in the Philippines, Papua New Guinea, and Indonesia wherein MDTF financing could be used to support technical assistance and/or system strengthening interventions that can trace impact to immunization coverage. Proposed activities for new World Bank operation in decentralized countries such as Indonesia and the Philippines, which include results-based financing mechanism or incentives to sub-national levels to achieve agreed results, could potentially be supported with additional resources. Giving the limited amount of

resources that are available under this window, leveraging impact of existing financing will be a key guiding principle as would be piloting of innovative solutions to the problems of improving and expanding immunization coverage among hard-to-reach populations.

Most of the funds are expected to be spent under Pillars II and IV. Some of the proposed country-specific activities, including expected disbursements, are summarized in Table 2 below (these are tentative/indicative amounts for now). More detailed background on the countries and proposed activities is summarized in Annex A.

Table 2: Proposed country-specific activities and estimated disbursements

Country	Activities	Expected disbursements			
		FY16	FY17	FY18	Total
Indonesia	<i>Pillar I</i> Transition financing analytics including update of fiscal space assessment for absorbing current donor-financed programs related to immunization, incorporating the costs of introducing new vaccines; Assessment of human resource management issues, skill gaps, and supply-side readiness; Collection of health resource-tracking data at the sub-national level.				
	<i>Pillar II</i> Technical assistance for capacity building at the central level (planning cell, EPI cell, MNCH directorate, primary care services directorate), provincial level (planning and monitoring), and district level (planning, management, and monitoring). There would also be specific support to innovations in primary care and other community-based services (e.g., development of guidelines, ICT pilots, and accreditation). This would also continue or build upon some existing capacity-building work supported by other donors (such as under AIPHS by DFAT).	US\$0.50 million	US\$1.5 million	US\$1.5 million	US\$3.5 million
	<i>Pillar III</i> South-South exchange activities with countries relevant to Indonesia in terms of decentralization, reform of primary care, and expansion of social health insurance programs.				
Lao PDR	<i>Pillar I</i> Comprehensive health financing systems assessment, with a focus on immunization financing and service delivery, including introduction of new vaccines and restructuring of packages, and building on recent public health expenditure review.				
	<i>Pillar II</i> Capacity building at the central and sub-national levels to improve capacity to adopt new vaccines and restructure packages, surveillance, monitoring, and management capacity.	US\$0.50 million	US\$2.5 million	US\$2.5 million	US\$5.5 million
	<i>Pillar IV</i> Adoption of some co-financing for relevant interventions under the ongoing <i>Health Governance and Nutrition Development Project</i> .				
Papua New Guinea	<i>Pillar II</i> Technical assistance to design and implement pay-for-performance pilot.				
	<i>Pillar IV</i> Financing for pay-for-performance interventions to incentivize health facilities and health care authorities by provision of conditional and/or additional funding when set targets (disbursement-linked indicators) are met, targeting areas with poorest health indicators.	US\$0.05 million	US\$1.3 million	US\$4.15 million	US\$5.5 million
Philippines	<i>Pillar I</i> Comprehensive health financing systems assessment, with a focus on immunization financing and service delivery in a decentralized context.				
	<i>Pillar II</i> Build the capacity of the DOH Central Office and Regional Health Offices' staff to help them better play their role of providing technical assistance to local government units (LGUs) for planning and monitoring health service delivery. Areas of capacity development will include planning for immunization services, information/data analysis, financing, stock management, and reporting. Capacity-building (training, coaching) will be the responsibility of a contracted firm; In a selected number of LGUs (probably around 80-100 LGUs, i.e. 6-10 of 81 provinces) use a specialized contracted firm to directly build capacity of LGUs in implementing effective and	US\$0.5 million	US\$1.5 million	US\$1.5 million	US\$3.5 million

		efficient EPI programs, through hands-on support to the development of LGU health plans and budgeting, advice and training in effective systems of inventory management and reporting, developing outreach plans and campaigns, and review of coverage reporting.				
	Pillar IV	Leveraging of existing government financing for provision of a combination of financial incentives (to LGUs) and enabling data technologies to incentive LGUs to better plan for, manage, deliver, and report on immunization service delivery, targeting areas with poorest health indicators; Government buy-in for forthcoming IBRD project already in place.				
	Pillar I	Comprehensive health financing and institutional assessment, with a focus on immunization financing, including assessment of adoption of new vaccines and restructuring of packages; fiscal space for increased domestic financing over the next 5 year period also given the competing demands for other programs; the health financing and institutional assessment in a decentralized context, utilizing the assessment tool for drill down in particular provinces.				
Vietnam	Pillar II	Technical assistance and capacity building of the Ministry of Health, Provincial Departments of Health, NIHE, and other related stakeholders (i.e. National Assembly Social Affairs Committee) on: sustainable health financing including resource mobilization, pooling and purchasing with a particular focus on the public health programs like immunization that undergoing a transition from donor to domestic financing, introduction of new vaccines, and restructuring of packages; and undergoing a transition domestically from national funding of a vertical program to subnational or health insurance financing. Technical assistance and capacity building of the improved service delivery including a focus on outreach to difficult areas and population groups, and the improved efficiency and effectiveness of the service delivery.	US\$0.3 million	US\$1.5 million	US\$1.7 million	US\$3.3 million
Regional/Global	Pillar I	Systematic cross-country comparative assessment of health financing systems, health system characteristics, UHC progress, immunization-related integration including transition from GAVI financing, introduction of new vaccines and restructuring packages including IPV, financing, and service delivery challenges results of which will be shared with government counterparts; Annual workshop with relevant government counterparts for sharing of experiences and findings across countries; Case studies and compilation of findings with regard to political economy of prioritization for health and for immunization in government budgets.	US\$0.5 million	US\$1 million	US\$1 million	US\$2.5 million
	Pillar III	Annual knowledge-exchange activities, including South-South exchanges (possibly using the Joint Learning Network platform) and study tours to relevant developing countries in the region (e.g., Thailand).				
Total			US\$2.35 million	US\$9.3 million	US\$12.15 million	US\$23.8 million

Expected Impact

In order to identify progress towards attainment of the program objective, several indicators will be monitored that will provide the basis for monitoring results under the immunization sub-component of the MDTF. Indicators will be country-specific and developed under each of the four pillars of the MDTF depending on the nature of support that is provided. These indicators will be measured and reported at the country level and aggregated to assess results of the overall program. It is envisaged that a small number of additional indicators would be developed to capture intermediate outcomes and outputs of the different investments under the MDTF support – including reporting on gender-disaggregated indicators where relevant -- depending on the nature of support provided

across countries (e.g., where feasible: the number of health financing and institutional assessments with immunization focus completed and disseminated; indicators for measuring provision of technical assistance; strengthened government capacity to integrate and implement donor-financed immunization programs; generation, capture, and exchange of operational knowledge with regard to health system strengthening and integration of donor-financed immunization interventions; increased financing, including leveraging of government co-financing, and expanded coverage).

Table 3 summarizes the proposed results framework for the immunization sub-component of the MDTF, derived from the results framework of the umbrella MDTF.

Table 3: Expected impact and results indicators

Development objective	Indicators	Targets
Support countries in strengthening their health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to UHC with a particular focus on assessing and supporting the financial and institutional sustainability of donor-financed immunization programs.	<ul style="list-style-type: none"> Number of countries where MDTF-financed activities aimed at assessing and supporting the financial and institutional sustainability of donor-financed immunization programs have been implemented. Number of countries that have developed their strategy for integrating donor-funded immunization programs (transition plans). Number of countries where immunization-related supply-side readiness indicators have improved. 	<ul style="list-style-type: none"> At least three countries where MDTF-financed activities have been implemented by the end of year three, and at least five countries by the end of year five. At least three countries have developed strategies for integrating donor-funded immunization programs. At least two countries where MDTF funds are leveraged to complement IBRD/IDA operations.
Intermediate objectives	Indicators	Targets
Development financing informed	<ul style="list-style-type: none"> Government expenditure informed. 	<ul style="list-style-type: none"> Health financing and institutional assessments conducted and discussed with Ministries of Health, Finance, and Planning and other stakeholders in target countries by the end of year five.
Policy strategy informed	<ul style="list-style-type: none"> Government policy/strategy informed. Development community/partner policy/strategy informed. 	<ul style="list-style-type: none"> Pathway options and transition plans for integration of donor-financed immunization programs informed in five countries by the end of year five.
Client's capacity increased	<ul style="list-style-type: none"> Design capacity strengthened. Implementation capacity strengthened. Monitoring and evaluation capacity strengthened. 	<ul style="list-style-type: none"> Technical assistance and capacity building activities for integration of donor-financed immunization programs implemented in five countries by the end of year five.
Knowledge deepened	<ul style="list-style-type: none"> Facilitated exchange of best practice with clients. Facilitated exchange of best practice with partners. Disseminated best practices. 	<ul style="list-style-type: none"> Knowledge exchange activities implemented in five countries by the end of year five.
Innovative approaches & solutions generated	<ul style="list-style-type: none"> New innovative approach fostered. New innovative approach developed. 	<ul style="list-style-type: none"> Financing for immunization-related health system strengthening interventions implemented in two countries by the end of year five. Immunization supply-side readiness increased in at least two countries as a result of MDTF financing.

Governance

Governance, management, and program selection criteria will follow those outlined umbrella MDTF. Engagement with key relevant stakeholders, including donors, will be encouraged and clarified in country-specific child concept notes. Risks to implementation include: (a) lack of demand from client governments; (b) lack of integration of planned activities within the overall strategic context of the WBG's country and regional engagement work programs; and (c) "verticalization" of activity focus on immunization and disconnect with the overall context of health financing, service delivery, and

implementation of UHC. Risk mitigation activities will include consultations and reviews under the overarching umbrella of GHNDR's business line for health financing so as to ensure that assessments and policy dialogue occurs within the context of health systems strengthening and within the context of health financing systems for UHC more generally (as opposed to taking disease-specific and/or program-specific perspectives). Each child activity will do its own Grant Funding Request and concept review chaired by country and/or regional/global directors or designates, following standard WBG quality control procedures as well as management oversight and accountability measures, and will be embedded within overall country work plan agreements so as to ensure consistency with current WBG partnership frameworks. In order to ensure demand and buy-in from counterparts, country teams will be required to engage extensively with governments/donors/other relevant stakeholders including inviting their active participation formally and informally in review and implementation of activities. Periodic reviews will be conducted that will also allow for flexibility and adjustment in planned work should there be significant changes in overall context and prioritization.

Partnership Arrangements

The proposed expansion to immunization-focused support under this MDTF is expected to be finalized by 15 December 2015. Given that the planned work falls under the pillars of the umbrella MDTF, no additional internal WBG concept note reviews are needed to finalize an amendment to the existing administrative agreement with DFAT. Once the amended administrative agreement is signed, a call for funds and the availability of funds for initiation of work is expected to occur latest by 31 January 2016.

Where the planned work under this expansion can be conceptualized and subsumed under existing and ongoing WBG programmatic country and/or regional-specific analytical and technical assistance work, this will be reviewed annually as part of WBG country management program reviews that are held annually in December/January for the Pacific countries, Papua New Guinea, and Indonesia. The timings of such reviews may differ for some of the other focus countries. DFAT (and other relevant partners/stakeholders) will be invited to peer review and participate in each of these concept note and/or program reviews.

In addition to the country and/or regional-specific concept note and program reviews, there will be an annual MDTF review (chaired by WBG health global practice sector management) where DFAT (and other relevant partners/stakeholders) will be invited to participate in order to take stock of progress, assess opportunities to cross-fertilize work across countries/regions, and make adjustments to planned work as and if needed. These annual reviews will be held beginning in 2017 in January/February every year.

Where discrete outputs such as knowledge sharing and dissemination activities including conferences/workshops and policy reports/notes are envisioned as part of MDTF work, DFAT (and other relevant partners/stakeholders) will be invited to co-host, co-author, and peer review finalized products. For example, one of the first regional events financed by the MDTF will be a learning/consultation two-day workshop on health/transition financing to be held as a side event for the Prince Mahidol Conference in Bangkok in

January 2016, to which DFAT (and other relevant partners/stakeholders) have been invited to participate.

ANNEX A

COUNTRY-SPECIFIC PROPOSED IMMUNIZATION-RELATED ACTIVITIES

Multi Donor Trust Fund (phase 2): Indonesia

Diagnostics and sectoral context: Health outcomes and outputs in Indonesia (population~250 million; GDP per capita~\$3,500; \$1-a-day poor~15%; \$2-a-day poor~45%) have undoubtedly improved in recent years. Life expectancy has increased from 68 in 2002 to 71 in 2012. Under-five mortality has declined from 48/1,000 live births in 2002 to 31/1,000 live births in 2012 and Indonesia is projected to meet the child-health related MDG. Pregnant women receiving four or more antenatal care visits have also increased to 88% in 2012, up from 81% in 2002. Percentage of moderately/severely underweight under-five children has decreased from 23% in 2002 to 18% in 2012. Landmark legislations in 2004 and 2011 have helped realize a potential pathway to UHC. Health insurance coverage rates in Indonesia have increased significantly in recent years: from ~27% in 2004 and to ~65% in 2012. As of 2014, Indonesia has one of the largest single-payer social health insurance program, JKN, in the world. In 2019, everyone in Indonesia is supposed to have coverage under JKN.

Nevertheless, key challenges remain, especially with regard to inequalities in health outcomes and access to quality primary care services, including immunization as well as maternal health and chronic malnutrition. Maternal mortality continues to be a problem for Indonesia despite relatively high rates of antenatal care and skilled birth attendance. Almost a third of all of deliveries in Indonesia continue to occur at home, with associated delays in decision-making, delays in transportation to facilities in the event of emergencies, and delays related to management of complications in facilities contributing the problem. Quality of care -- including inadequate training of health professionals and poor supply-side readiness -- remains a challenge in many parts of the country. Inadequate feeding practices and poor sanitation are the primary determinants of stunting in Indonesia. Exclusive breastfeeding remains low despite many years of encouragement through participation in posyandu sessions as well as antenatal care messages. The existing community-based approach is in need of reform and more intensified interpersonal communication strategies are needed for stimulating behavior change.

Indonesia's population aged 0-1 years of age - the primary target group for immunization - was 4.3 million in 2013. This number has been declining ever since it peaked at around 4.7 million in 1998. It is projected to decline to 3.9 million by 2030. There are a variety of estimates of immunization coverage for Indonesia. IDHS data indicate that 60% of children 12-23 months were fully immunized in the country in 2012.^[2] Over the period 2012-2014, and depending on source, estimates of BCG immunization rates ranged from 89-97%; DPT ranges from 72-82%; polio immunization rates ranged from 74-83%; and measles immunization rates were 80-89%. Table 1 summarizes coverage information from different household surveys and other data for Indonesia. Despite increases in

^[2] According to WHO guidelines, children are considered fully immunized when they have received one dose of BCG, three doses each of the DTP and polio vaccines, and one dose of the measles vaccine.

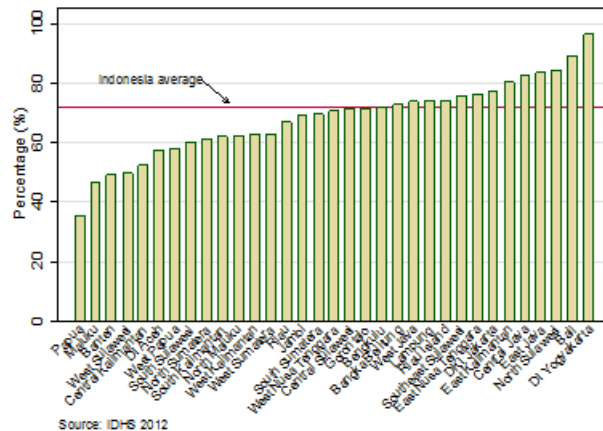
coverage rates in recent decades, Indonesia does not compare favorably to its peers and for its income level when it comes to immunization rates. For example, Indonesia is richer than Cambodia, Philippines, and Vietnam but has significantly lower coverage rates for DPT3 and measles immunization.

Table 4: Immunization coverage rates, 2012-2014^[3]

Vaccine	Source				
	IDHS	Riskesdas	SUSENAS	WHO-UNICEF	MOH
BCG	89%	88%	94%	97%	90%
DPT	72%	76%	73%	82%	77%
Polio	76%	77%	74%	83%	81%
Measles	80%	82%	89%	82%	84%

There is as much as a three-fold difference in immunization coverage rates across provinces in Indonesia. DPT immunization rates, for example, are almost 90% or more in Bali and Yogyakarta but only 35% in Papua and less than 50% in Maluku, Banten, and West Sulawesi (Figure 25).

Figure 4: DPT immunization rates by province, 2012



The World Bank is supporting the GOI to address some of these critical areas towards achieving UHC through different products: (i) ongoing programmatic AAA focused on analyzing the system of health financing, including transitional financing for donor supported programs (MDTF phase 1), supply side readiness and other institutional and systemic assessments; (ii) a proposed new operation focusing to support Government of Indonesia's primary health care reform and strengthen service delivery in priority districts to achieve better access to and quality of maternal, child health (including immunization) and nutrition services; and, (iii) ongoing support to community level behavior change and frontline delivery through other sector projects and AAA (PNPM Generasi and citizen accountability).

^[3] Average for 2012-2014 for SUSENAS, WHO-UNICEF, and Official MOH.

The proposed interventions under the MDTF will be closely aligned to ongoing activities and especially the new proposed operation. The new operation currently envisages 3 components: (i) strengthening the health financing framework on the supply side (by making the central transfer – DAK – more performance based and to districts with greater need) as well as necessary strengthening of BPJS on the demand side – this will include capacity building for planning and management of resources at the district, province and national level; (ii) strengthening access to and quality of primary care delivery in priority districts through accreditation of primary care facilities, improving measurement systems and addressing human resource management and skill gaps in health workers; and, (iii) strengthening community level frontline workers and programs to improve population promotive and health seeking behaviors for better health and nutrition. This will also include strengthening multi sectoral interventions for better health outcomes.

The interventions proposed are under pillar 1, 2 and 3:

Pillar 1	Studies related to transition financing, including fiscal space to absorb current donor financed programs related to immunization and cost of introducing new vaccines, HR management issues and skill gaps, planning and stewardship capacity at provincial and district level, frontline worker skills and plans to improve productivity through ICT and public sector management functions (public finance management and procurement and supply chain)
Pillar 2	Technical assistance in terms of capacity building at the central level (planning cell, EPI cell, MNCH directorate, primary care services directorate), provincial level (planning and monitoring) and district level (planning, management and monitoring). There would also be specific support to innovations in primary care and other community based services (development of guidelines, ICT pilots, accreditation). This would also continue or build upon some existing capacity building work supported by other donors (such as few components AIPHSS by DFAT)
Pillar 3	South-south exchange with countries relevant to Indonesia in terms of the reform context of decentralization, reform of primary care services and expansion of social health insurance programs

Expected disbursements:

FY 16	FY 17	FY 18	Total
USD 250,000	USD 1.5 million	USD 1.5 million	USD 3 million

The figures and activities would undergo some change based on agreements reached with GOI during project preparation. Most of the funds are expected to be used under pillar 2 and RETF under pillar 4 has not been included in the proposal, as funds are expected to be available to GOI under the project.

Proposal for the Integrating Donor-Financed Immunization Programs Trust Fund

Country: Papua New Guinea (PNG)

Title: Design and Implement a Pay for Performance Pilot to Improve Maternal and Child Health Service Delivery, including Immunization

Papua New Guinea context

The health outcomes in PNG have been stagnant, if not worsening. PNG has some of the worst maternal and child health outcomes in the region. It is one of only a handful of non-African countries on the list set to miss both Millennium Development Goals (MDG) targets 4 (reducing the under-five mortality rate by two thirds) and 5 (reducing the maternal mortality rate by three quarters) ⁴. The immunization rate in PNG is worse than most lower and middle-income countries, with only 53% for Polio and 62% for DPT3 and 65% for measles coverage.

Table 5: Immunization coverage and maternal and under 5 mortality rates

Country	Polio	DPT3	Measles*	Maternal mortality**	Under 5 mortality***
Cambodia	98%	97%	94%	170	31
Fiji	99%	99%	94%	59	23
Indonesia	79%	78%	77%	190	28
Lao PDR	88%	88%	87%	220	69
Myanmar	76%	75%	86%	200	52
Papua New Guinea	53%	62%	65%	220	59
Solomon Islands	94%	88%	93%	130	29
Timor-Leste	76%	77%	74%	270	55
Vietnam	96%	95%	97%	49	22

Polio and DTP3 – Source: WHO Global Health Observatory. (2014)

*Child immunization measures the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized against measles after receiving one dose of vaccine. (Source: WDI. 2014)

**per 100,000 live births (Source: WDI. 2013)

*** per 1000 live births (Source: WDI. 2014)

However, the health system in PNG is facing great challenges and even sustaining the current health outcomes is at a high risk. PNG is undergoing a rapid deterioration in its fiscal situation. The economic growth has slowed down in light of declining oil and commodity prices, the under-subscription of Treasury Bills and a reduction in tax receipts. The Government of PNG has had to revise its 2015 Budget downwards by K1.6 billion. A K1.2 billion further reduction will be required across Government in 2016. Financing of

⁴ Building a Future for Women and Children, World Health Organization, http://www.who.int/pmnch/knowledge/publications/countdown_2012_report/en/

the health sector has been unavoidably affected. To reduce the 2015 deficit, the Government identified K239 million or 19% in savings from the Health Sector Budget. The 2016 Health Sector Budget has declined by roughly 12% against the original 2015 appropriation.

The operating context is becoming more, not less, complex. The government has announced to establish District Development Authority (DDA) in 2014. However, the implementation has been slow and it is uncertain how this further decentralization will affect the health sector. The funding flow from central government to frontline facilities has been historically poor. The DDA may potentially add another layer and affect the effective operation of facilities.

Accountability for results is low at all levels. There is also ambiguity in the roles and responsibilities in service areas such as maintenance, patient transfer and the distribution of medical supplies, which are impinging the performance of health outcomes.⁵ Despite the shortage of health workers, absenteeism was prevalent in some areas. Adherence to good clinical practices is poor. There was some observational evidence that significant difference in the performance of public and church health facility providers. The NDOH publishes the annual health sector performance review, but there has been no follow up actions to reward the higher performers or further incentivize the lower performers to improve.

The decentralized funding and delivery system that has evolved with its various actors, parts and pathways provides challenges that impede basic health services delivery. These challenges include: (i) the absence of a designated budget for an activity or facility; (ii) a failure to inform the sector/facility of their budget; (iii) a failure to inform the sector/facility of the receipt of funds which may be due to poor communication between national and provincial levels of government, between the provincial treasury and provincial administration or provincial administration and the sector, or between the sector and facility; (iv) the possibility that funds may be diverted for other purposes; and (v) the slow and/or untimely release of funds which may be due to the inefficiency of the national agency or provincial administration.

Project Development Objective:

The project development objective is to improve the maternal, neonatal and child health services, including child immunization. The program will pilot Pay for Performance (P4P) in order to give stronger incentives to health facilities and healthcare authorities through providing conditional and/or additional funding when set targets are met – aiming to improve health outcomes. That is, payments are conditional on the results measured by agreed indicators, i.e. disbursement linked indicators (DLIs).

⁵ Financing the frontline: an analytical review of provincial administrations in Papua New Guinea's rural health expenditure 2006-2012. *World Bank*. <http://documents.worldbank.org/curated/en/2015/07/24819484/search-progress-financing-frontline-papua-new-guinea>

Pay for Performance in Papua New Guinea

The potential P4P operation would support the GoPNG to accelerate the reduction of maternal and neonatal and child mortality. It is also intended to tackle inefficiencies in resource delivery by highlighting where the greatest needs are and aligning funding to these places – i.e. shifting a greater share of resources towards frontline health services. The project would also aim to promote transparency and predictability of the operational budget and enhance efforts to strengthen financial management systems, by improving the communication and credibility of those responsible for funding channels and those responsible for service delivery. Payments to local provincial governments would be conditional on the results measured by agreed DLIs, thus strengthening the relationship between expenditure and performance.

These indicators would be linked with maternal and child health, including immunization. Examples of indicators include:

DLIs

- (1) Percentage of pregnant woman attending four or more antenatal care (ANC) visits
- (2) Percentage of deliveries with a skilled birth attendant
- (3) Percentage of HIV positive mothers who receive ART
- (4) Percentage of 3rd Dose Pentavalent Coverage
- (5) Percentage of 3rd dose pentavalent coverage in children under 1 yr.
- (6) Percentage of facilities with continuous availability of 10 tracer medicines in the past year

Note these indicators (1-5) were already collected by the National Department of Health through the National Health Information System and are used for the annual sector performance review. Building on these indicators will give an opportunity to further strengthen Government own data collection and progress monitoring.

Implementation timeline

	FY2016				FY2017				FY2018			
	1	2	3	4	1	2	3	4	1	2	3	4
Project Preparation			X	X								
Project Appraisal and Negotiation					X	X	X					
Project Implementation								X	X	X	X	X

Budget and disbursement schedule

	FY16 6mths	FY17 12mths	FY18 12mths	Total
Project Preparation and Supervision (BE)	50K	300K	150K	500K
Project Implementation		1 million	4 million	5 million

Proposal for the Integrating Donor-Financed Immunization Programs Trust Fund

Country: Philippines

Title: Addressing national-local disconnects in decentralized immunization service delivery

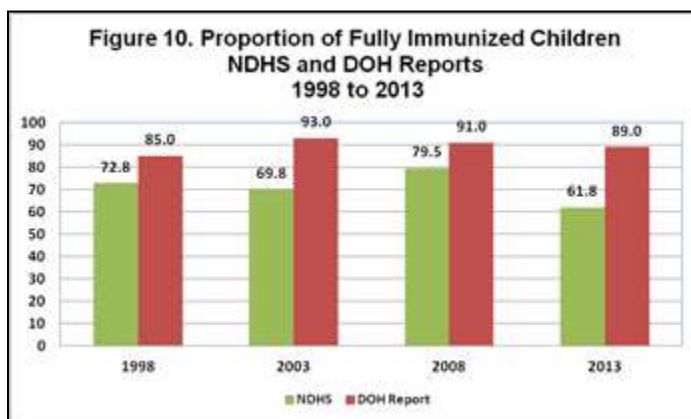
Motivation

The Philippine Expanded Program on Immunization (EPI) has five strategic objectives. They are: to immunize all infants/children against the most common vaccine-preventable diseases and pregnant women from tetanus; to sustain the polio-free status of the Philippines; to eliminate measles virus; to eliminate maternal and neonatal tetanus, and; the control of common vaccine-preventable diseases.

The Philippine National Demographic and Health Survey (NDHS) shows that Fully Immunized Child (FIC) coverage is at its lowest point in 10 years. In 2013, FIC was only 61.8% (see Figure), down from 79.5% coverage in 1998. The trend of decline from 2008 to 2013 shown by the NDHS is similar to the decrease observed when using Department of Health (DOH) data for the last 4 years prior to 2013. DOH reports, further, that target coverage of 95% for all vaccines has not been achieved since 2000.

There are also large inequalities in vaccination coverage by region. Per the NDHS, the conflict-affected ARMM region has the lowest FIC coverage (29 percent), while CAR has the highest (84 percent). According to DOH's 2013 EPI report, only 5 of the 17 regions reached the service coverage target of 95%. This has resulted in an increase in the number of children susceptible to vaccine-preventable diseases and deaths.

In the highly decentralized context of the Philippines, vaccine procurement is the responsibility of the central Department of Health (and its regional offices), while financing of all other inputs related to immunization (including staff, equipment and infrastructure), as well as actual service delivery itself, is the responsibility of local governments units (LGUs), composed primarily of municipalities. This system faces four key challenges, as identified by UNICEF in a recent review. First is the weakness of the DOH's weak vaccine procurement process that results in inadequate and irregular supply to LGUs despite an increasing health budget. Second are gaps in cold storage capacity at all levels of the supply chain which results in stock-outs at local level even when vaccines are successfully procured nationally. Third are limitations at the local level, including insufficient knowledge and capacity of the health staff hired by LGUs, insufficient commitment of LGUs to the EPI program, and limited supervision at the frontline facility level. Lastly, there is insufficient



demand due to the lack of an effective, sustainable and well-coordinated communication strategy to support behavior change of clients.

Proposal

This grant, with both BE and RE components, aims to address the national-local disconnects that arise in this decentralized system through capacity-building, financial incentives and new technology.

Component 1: Immunization Financing and Service Delivery Assessment

Undertake an assessment of the EPI program utilizing the EPI module of the Health Systems Financing Assessment tool, modified to suit the Philippines EPI program and taking into account areas of concern to DOH and LGUs. The assessment will look at the program through the lens of a decentralized health system and will highlight both national and local government features that contribute to the current coverage status. The assessment will be undertaken jointly by WHO, UNICEF and WBG, and will inform the design of Components 2 and 3, as well the implementation of the DOH's new EPI Strategic Plan (2015-2019).

Component 2: Local Government Capacity-building

1. Build the capacity of the DOH Central Office and Regional Health Offices' staff to help them better play their role of providing technical assistance to LGUs for planning and monitoring health service delivery. Areas of capacity development will include planning for immunization services, information/data analysis, financing, stock management, and reporting. Capacity-building (training, coaching) will be the responsibility of a contracted firm.
2. In a selected number of LGUs (probably around 80-100 LGUs, i.e. 6-10 of 81 provinces)⁶, use a specialized contracted firm to directly build capacity of LGUs in implementing effective and efficient EPI programs, through hands-on support to the development of LGU health plans and budgeting, advice and training in effective systems of inventory management and reporting, developing outreach plans and campaigns, and review of coverage reporting.

Critically, capacity-building activities will integrate EPI planning with broader health service delivery planning (and financing) in order to better ensure realism of targets and program sustainability.

⁶ The LGUs will be chosen in order to develop a model that would be suitable for scale-up across diverse regions. The selected areas may be in all or some of the following typologies: where Development Partners have existing programs that will be complementary to the TA to be provided or where the TA can easily be blended into an existing program addressing immunization; in the ARMM region where there is fragility and conflict; in Geographically Isolated and Disadvantageous Areas (GIDAs) where most Indigenous Peoples (IPs) can be found, or; in disaster-prone areas. These areas provide particular challenges to EPI program implementation.

Component 3: Results-based grants to LGUs for improving immunization service management and delivery

This component will use a combination of financial incentives (to LGUs) and enabling data technologies to incentive LGUs to better plan for, manage, deliver, and report on immunization service delivery. Key disconnects to be addressed include that DOH procurement suffers from lack of information on vaccine needs at LGU level, LGUs don't know when vaccines will arrive and so can't effectively make back-up plans for local procurement, LGUs fail to prioritize immunization, and existing health information systems results in tremendously delayed – and often inaccurate – reporting on immunization service delivery from LGUs to region and central DOH offices.

Central to the system will be a web-enabled platform (ideally Android/IOS app and phone-based) that will enable LGUs to (i) plan, schedule and map outreach activities, (ii) monitor vaccine stocks, including real-time reporting to central DOH on vaccine availability/use at local level, (iii) receive auto-updates from national level on expected vaccine shipments so that emergency local procurements can be started in time, and (iii) report real-time immunization service delivery to central and regional DOH offices, with aggregation across LGUs through the cloud. Good performance by LGUs (for example, on indicators of vaccine stock management, data reporting, and service delivery) will be rewarded with financial incentives to the health teams / facilities. Fund flow will (ideally) use an existing results-based fund download mechanism (such as that which exists between the Department of Interior and Local Government and LGUs). This part of the grant will therefore be recipient-executed, with the recipient being the government agency (like DILG) that is responsible for fund flow.

Implementation timeline

	FY2016				FY2017				FY2018			
	1	2	3	4	1	2	3	4	1	2	3	4
Comp 1: Immunization assessment			X	X								
Comp 2: Capacity-building			X	X	X	X	X	X	X	X	X	X
Comp 3: Results-based grant												
- Design mechanism and technology			X	X	X							
- Implementation, results-reporting					X	X	X	X	X	X	X	X
- Payment for results							X	X	X	X	X	X

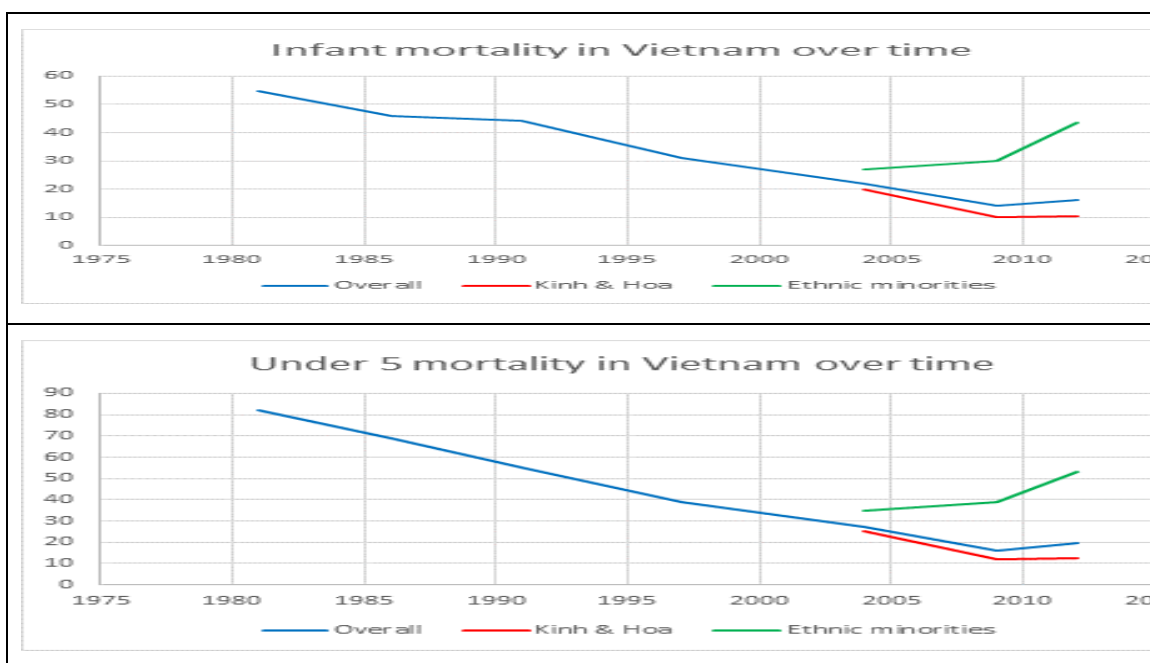
Budget and disbursement schedule

	FY16 6mths	FY17 12mths	FY18 12mths	Total
Component 1: Immunization assessment (BE)	60K			60K
Component 2: Capacity-building			X	
- Firm contract (BE or RE)	100K	175K	150K	425K
Component 3: Results-based grants (RE)				
- Grant payments		1mn	1mn	2,000K

- Development of android/IOS app for results reporting, dashboard monitoring etc	150K	75K	50K	275K
- Independent verification agent		75K	75K	150K
Bank staff (preparation and supervision budget)	50K	75K	75K	200K
Total	360K	1.4 million	1.35 million	~3.125 million

Multi Donor Trust Fund (phase 2): Vietnam

Vietnam has been very successful in improving basic health indicators for the majority of the population (one of the 10 ‘high-performer’ countries in meeting health-related MDG targets), while health indicators for the minority of the population remain a challenge. Infant mortality fell from 36.7 (2000) to 14.9 (2014) and under-five mortality from 42 (2000) to 22.4 (2014) deaths per 1000 live births; considerable progress has also been made in reducing maternal mortality from 130 (2001) to 60 (2014) deaths per 100,000 live births. The success of the extended program on immunization (coverage of DPT3 often 90% or greater) and policies to protect women’s health all contributed to these positive outcomes. However, these indicators have showed slow progress recently and the U5MR remains short of the MDG target. Child mortality in the most difficult regions (especially ethnic minority areas) remains hard to address, showing slowed progress or even potentially worsening results. Child and maternal mortality rates in mountainous rural areas are 3-4 times higher than in rural plains and urban areas. Child malnutrition rate is still high in areas with high concentration of ethnic minorities (i.e. 34% of H’mong children are underweight and more than 55% stunted as compared to 16.8% and 27.5% of Vietnamese children nationally).

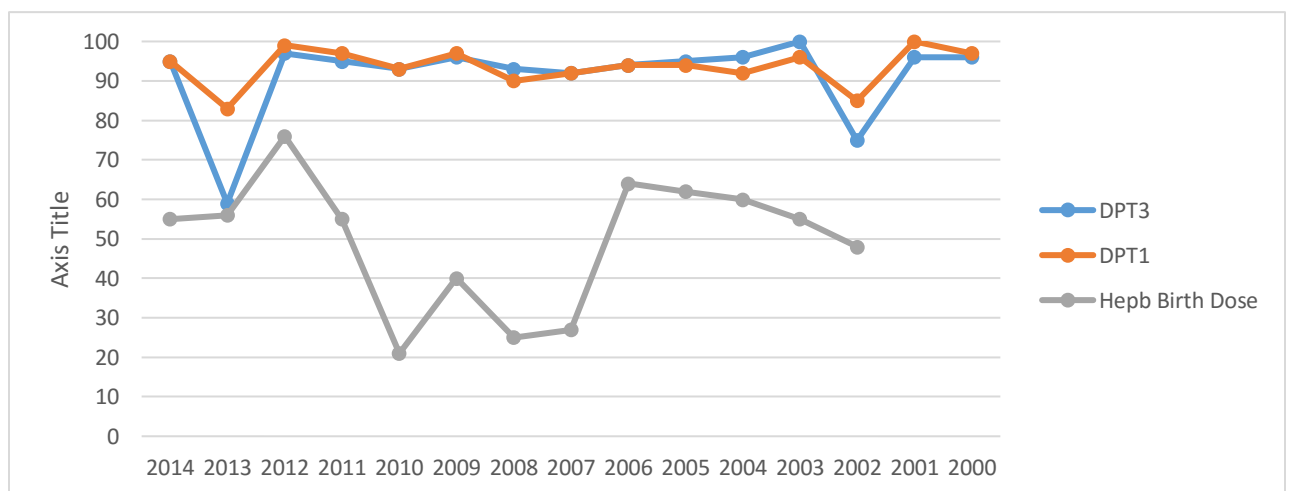


Note: Source: Multi-Indicator Cluster Survey (MICS) from UNICEF. It is important to note that these point estimates have large standards of deviation due to the sample size.

At best, though it shows a slowdown in recent progress and a widening gap between the ethnic majority and minority populations.

The trends in coverage of immunization remain generally high, but show gaps in time, for some specific vaccines and in geography. The figures below outline trends in immunisation coverage in Vietnam. High coverage has been maintained by most antigens for the last 10 years with a number of exceptions. There was a sharp drop in immunisation coverage for DPT3 in 2013, related to a nationwide suspension of pentavalent vaccine following several Adverse Events Following Immunization (AEFI) and media attention to those events. The other notable observation is the hepatitis B birth Dose coverage, which is lower than expected given the high facility delivery rate in Vietnam (92%). Although the rate has recovered from the decline during the previous planning cycle. The recent AEFI events may have also contributed to the moderate coverage, institutional delivery largely occurring in hospitals outside of the vertical control management and reporting structure the National Extended Program of Immunization (NEPI), as well as to the lack of attention on following consistent quality guidelines for delivery and other health care provision.

Immunisation Coverage (Official & WHO UNICEF Estimates) 2000-2014



Map showing distribution of 91 districts with coverage <80% in Viet Nam 2014



Despite the overall high coverage, analysis has pinpointed the areas of the country with immunisation coverage lower than 80% for DTP-HepB-Hib3 or MCV2 in 2014. This analysis identified 91 districts in the country distributed among 26 provinces including 12 are in the north, 4 in central regions and 10 in the south. A total of 68 out of these 91 districts reported measles cases in 2014. Geographically, these areas are also highly correlated (but not exclusively) with the areas of the country with high ethnic minority population, highest level of poverty, highland or delta regions.

The immunization program of Vietnam is a relatively well-managed vertical program and through an extensive network of service providers and an increasing level of national financing; there are,

however, gaps in management, quality, operational budget and uncertainty regarding the future financial sustainability. The national EPI program (NEPI) is situated nationally inside the National Institute for Hygiene and Epidemiology. Thereafter, the program management is decentralised to Regional EPI offices (4), Provincial Preventive Medicine Centers (63), and District Preventive Medicine Centers (704). Immunisation services are integrated into the health service delivery model of the Commune Health centres, where immunisation services are normally provided in sessions for 1 - 3 days per month, supplemented by mobile health strategies for remote areas, and immunisation campaigns for disease elimination and control activities. A fee for service model of immunisation for some vaccines also operates through public and private facilities. There is also a communication network of Village Health Workers, whose main responsibility is to communicate with families, mobilise communities for immunisation sessions at the CHC, and conduct community based surveillance. The national program is financed nationally through the MoH/NiHE (particularly the vaccines themselves) and increasingly through local government at provincial and district level (the operational costs for service delivery). The proportion of the national program funded by the government is 44% in 2014, which is an increase from 39% in 2010. GAVI financing is intended to phase out, presumably around 2020 which would mean a significant increase in necessary financing over a relatively short period of time. At the same time, the Government of Vietnam is reviewing the programs under its National Targeted Programs and reconsidering these programs, including increasing the financial responsibility of the national and sub-national authorities. The variability of available budget to finance the operational costs of the service delivery is one

of the key bottlenecks leading to the differences in coverage. A general review of other bottlenecks of improved immunization delivery, highlight many factors that are similar to other preventive and primary health care service delivery challenges such as lack of information of detailed service delivery planning, knowing the population and risk factors and making plans accordingly; variability in operational budget and lack of budget and incentives for outreach, particularly for hard to reach areas; limited monitoring and supervision; staff turnover and competencies; behaviour change communication with the community limited and not as sensitive to the needs of minority population; and shortages in inventory and need to upgrade outdated equipment.

The Government has a strategy for improved service delivery for immunization, particularly in the underserved areas. At the same time, the Government is reviewing its strategy for improved delivery of basic health care with a view towards a more integrated approach, at the point of service provider, to address the community and family.

With this situation analysis in mind, the MDTF (Phase 2) proposed for Vietnam proposes the following:

Country	Activities	Expected disbursements			
		FY16	FY17	FY18	Total
Vietnam	<i>Pillar I</i> Comprehensive health financing and institutional assessment, with a focus on immunization financing; the fiscal space for increased domestic financing over the next 5 year period also given the competing fiscal demands for other programs; the health financing and institutional assessment in a decentralized context, utilizing the assessment tool for drill down in particular provinces.				
	<i>Pillar II</i> Technical assistance and capacity building of the Ministry of Health, Provincial Departments of Health, NIHE, and other related stakeholders (i.e. National Assembly Social Affairs Committee) on: sustainable health financing including resource mobilization, pooling and purchasing with a particular focus on the public health programs like immunization that undergoing a transition from donor to domestic financing; and under-going a transition domestically from national funding of a vertical program to subnational or health insurance financing. Technical assistance and capacity building of the improved service delivery including a focus on outreach to difficult areas and population groups, and the improved efficiency and effectiveness of the service delivery through improved information and integration. Technical assistance in and capacity building in information management and quality assurance systems.	US\$0.3 million	US\$1.5 million	US\$1.7 million	US\$3.5 million
	<i>Pillar III</i> Selective south-south learning with other countries that have recently graduated from donor supported financing and increased domestic resources; have systems for motivating subnational delivery of public health programs through purchasing and other mechanism.				
	<i>Pillar IV</i> Finance a scale up of a regional Results Based Financing pilot for proposed Additional Financing of an IDA operation, focussing on maternal, child health and nutrition services, with increasing the focus on overall provincial level progress in meeting verifiable results including immunization coverage targets in the remote and hard to reach districts. The scaled up pilot would be used for demonstration for a larger IDA financed operation starting in FY18.				