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Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 03-Oct-2017 | Report No: PIDISDSC22055



BASIC INFORMATION

A. Basic Project Data

Country Vietnam	Project ID P161283	Parent Project ID (if any)	Project Name Investing and Innovating for Grassroots Service Delivery Reform (P161283)
Region EAST ASIA AND PACIFIC	Estimated Appraisal Date Jan 08, 2018	Estimated Board Date Mar 27, 2018	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Socialist Republic of Vietnam	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

The development objective is to improve the quality and efficiency of the grassroots health system in the targeted provinces, with a focus on the management of selected non-communicable disease (NCD) and maternal and child health (MCH) tracer conditions.

This will be achieved by (i) enabling the commune-level facilities to take on the management of select non-communicable diseases, (ii) improving the utilization and quality of services already provided at commune level, and (iii) strengthening the capacity of the district to provide appropriate referral and support services..

Financing (in USD Million)

Financing Source	Amount
Borrower	5.00
Global Financing Facility	20.00
International Development Association (IDA)	80.00
Integrating Donor-Financed Health Programs	5.00
Pharmaceutical Governance Fund	3.00
Total Project Cost	113.00

Environmental Assessment Category B-Partial Assessment	Concept Review Decision Track I-The review did authorize the preparation to continue
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Other Decision (as needed)

B. Introduction and Context

Country Context

- Vietnam has achieved tremendous poverty reduction over the last decade through distributing the gains of strong economic growth equitably.** In 2014, the incidence of poverty was 13.5% (national GSO-WB poverty line), down from close to 60% twenty years earlier (in 1993), effectively lifting 40 million people out of poverty. Over the same period, the average consumption level of the bottom 40% grew by 6.8% annually. Inequality remained largely unchanged, with the Gini coefficient growing only slightly, from 32.6 to 34.8. Vietnam's success in reducing poverty has been largely the result of rapid economic growth and restructuring that was also 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 growth between 5% and 6% and moderate inflation. Vietnam reached middle income status in 2009.
- 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 (MDGs), including many of them ahead of time. From 1993 to 2015, the infant mortality rate decreased from 33 to 14.7 (per 1,000 live births), while stunting fell from 61% to 24.6%. The net enrollment rate for primary school increased from 78% in 1992-93 to 93% in 2014. Access to household infrastructure has improved dramatically: by 2014, 99.2% of the population used electricity as their main source of lighting (up from 48.6% in 1993), 74% of the *rural* population had access to improved sanitation facilities (compared to 33.8% in 1993), and 89% of the *rural* population had access to clean water (compared to 62.9% in 1996). Access to these services in urban areas is well above 90%. Vietnam has also closed gender gaps along a wide range of social and economic measures (including bringing female labor force participation within 10 percentage points of that of men). In 2015, the Human Development Index ranked Vietnam in the "medium" category with a score of 0.683.
- Looking ahead, Vietnam is expected to go through a rapid social transformation that will affect its outlook over the next 20 years, as well as face environmental and economic pressures.** First, Vietnam is one of the most rapidly aging countries and the 65+ age group is expected to increase by 2.5 times by 2050. Second, while the population still largely lives in rural areas (66.1% in 2015), it has been steadily urbanizing (at about 1 percentage point a year). Expectations of the population in terms of equity in access to quality public services are also changing due to 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; environmental sources of vulnerability (such climate change, natural disasters and unsustainable exploitation of natural resources); rising fiscal pressures, including a growing fiscal deficit and a debt-to-GDP ratio of 62% that is fast-approaching the 65% debt ceiling; structural constraints in the growth model, including an over-reliance 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.

4. **The Government of Vietnam is also entering a new phase in its relationship with the World Bank Group.** With graduation from the International Development Association (IDA) in June 2017, Vietnam now faces less-concessional lending terms and will have access to reduced volumes of World Bank financing. This will be compounded by the pressure of the national debt ceiling, which will reduce overall external and domestic borrowing capacity.

Sectoral and Institutional Context

Health outcomes, access to services, and emerging health challenges

5. **Vietnam has made remarkable progress in health outcomes over the past 20 years and access to basic health services is good.** Life expectancy increased from 72.1 to 75.8 years, and is the highest in the region for countries at a similar income level. Between 1990 and 2015, the child mortality rate fell from 51 to 22 per 1,000 live births and the maternal mortality ratio fell from 139 to 54 per 100,000 live births. In 2014, the proportion of births assisted by a trained staff was 93.8% and the proportion of pregnant women receiving 4 or more antenatal care visits was 73.7%. In 2015, the nationwide full immunization rate was 97.1% and exceeded 95% in 53 out of Vietnam's 63 provinces. In 2014, 7.5% of people (7.8% in rural and 6.7% in urban areas) had at least one inpatient visit, while 33.5% (32.9% in rural and 34.9% in urban) had an outpatient visit in the previous 12 months.

6. **However, disadvantaged groups – and especially ethnic minorities and those living in remote, mountainous areas – have substantially worse access and outcomes.** In 2014, child mortality rates in rural areas (26.5 per 1,000 live births) are more than double those in urban areas (12.9); child mortality rates in the remote mountainous provinces exceed 50 but are less than 20 in the delta provinces. Similarly, while the national under-five stunting prevalence is 24.6%, it reaches over 35% in some remote mountainous provinces. The proportion of births assisted by a trained staff is 68.3% among ethnic minority women and 73.4% among the poorest quintile, compared to over 95% among women in the remaining quintiles. The proportion of pregnant women having 4 or more prenatal care visits is only 32.7% among ethnic minorities and 38.6% among the poorest quintile, but rises to 67% in the second poorest quintile and to 96% in the richest quintile. Similarly, full immunization rates fall to around 70% among disadvantaged groups, such as ethnic minority children (69.4%), the poorest quintile (72.2%), and those in mountainous provinces (such as the Central Highlands, 70.5%, and Northern Midlands and Mountains, 71%).

7. **Population ageing, a disease burden increasingly dominated by non-communicable 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 ageing faster than most other Asian countries. This is contributing to a rapid shift in Vietnam's burden of disease towards NCDs, which increased from 46% of the disease burden (measured in DALYs) in 1990 to 73% in 2015. In 2015, cervical cancer accounted for 8.5 times more deaths than maternal causes. The single leading contributor to the disease burden is stroke, accounting for 14% of all DALYs. Leading risk factors associated with stroke (as well as with other major contributors to the disease burden) are uncontrolled hypertension, high cholesterol, diabetes, smoking, and an unhealthy diet. 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



8. **Government health spending in Vietnam is high and has been increasing over time.** Government of Vietnam 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 health spending grew from 7.9% of government budget in 2008 to 14.2% of government budget in 2014. As a share of the budget, government spending on health in Vietnam is higher than any other low-to-middle income country in the region except China. Combined with increasing out-of-pocket health spending (see below), rising public spending means that overall health spending has also increased steeply: between 1995 and 2014, total per capita health expenditure increased more than five-fold, from 73 PPP\$ to 390 PPP\$. As a share of GDP, total health expenditure rose from 5.2% to 7.1% over the same period; this share is higher than all other low-to-middle income countries in the region.

9. **Out-of-pocket health spending has been rising, but increased incomes and expansions in health insurance coverage have mitigated the financial impact on households.** From 1995 to 2014, real per capita out-of-pocket health spending tripled, from US\$46 to US\$144 in PPP terms, but as a share of total health expenditure, out-of-pocket spending declined from 63% to 37%. GDP per capita rose almost as rapidly as out-of-pocket health spending, increasing 2.5 times in this period, with the result that out-of-pocket spending as a share of GDP declined from 3.3% in 1995 to 2.6% in 2014. Health insurance coverage also grew rapidly during this period, from 13.4% in 2000 to 81.7% in 2016, 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 (e.g. 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% in 1992 to 9.8% in 2014 (when measured with a 20% threshold defined in terms of total household spending), while impoverishment due to health spending fell from 2.2% to 1.4% when using the US\$3.10 per day poverty line (and 4.6% to 0.35% when using the US\$1.90 per day poverty line). With these improvements, Vietnam now has similar levels of financial protection to other middle income countries.

10. **The country is no longer highly dependent on external assistance for the health sector.** In 1995, 3.5% of total health expenditure came from external assistance, but this had fallen to 1.8% in 2013 – although was back up to 2.7% in 2014. As Vietnam has achieved middle income country status, a number of major development partners – including GTZ, EU, the Global Alliance for Vaccines Initiative (GAVI), and the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GF) – have completed, or are busy, phasing out their assistance and working with the government to shift 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, HIV/AIDS and others), especially as the country transitions away from supply-side subsidies and toward more demand-side financing through social health insurance.

11. **Fiscal pressures are driving a shift away from the use of government budget for health care, resulting in fee increases which 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 roadmap 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% in 2012. In 2013, they rose by a further 19%; in 2016, by 56%; and, in the first 5 months of 2017, by another 18%. 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 one-fifth of the population that was still not covered by health insurance in 2016, 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 the Vietnam Social Security agency has few instruments at its disposal to effectively curb inefficient service provision and cost escalation.

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 and total inpatient spending is 1.42 times higher than outpatient spending. 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. Public hospitals are also encouraged to raise capital from the private sector (including from their own staff) 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. These factors create powerful incentives for hospitals to offer expensive, high-tech services, some of which may be medically unnecessary, but are also interpreted by patients as a signal of quality, further exacerbating bypassing and overcrowding.

13. **While relatively well-utilized in the more disadvantaged parts of the country, the grassroots health system¹ (including commune health stations) is 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% of outpatient contacts are at the CHS or regional polyclinic², but this share reaches well over 50% in most mountainous provinces. However, the basic infrastructure, equipment and competencies are lacking in many communes. In 2016, only 69.76% of *rural* communes met the 2014 national commune health benchmarks. Moreover, those largely structural benchmarks do not provide any assurance that the commune health stations are capable of appropriately dealing with specific medical condition in line with diagnostic and treatment guidelines for those conditions and in close coordination with higher-level facilities. Capacity to prevent, detect and manage chronic NCDs, 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 CHS health workers to make more effort to keep patients healthy or manage their diseases effectively.

¹ The "grassroots level" is terminology used in Vietnam. It refers to the health system at the district (population of about 100,000), commune (5,000-8,000) and village (about 1,000) levels. Commune health stations (which are responsible for the implementation of vertical programs and also 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), while health insurance reimbursements flow through district hospitals (responsible for primary and basic secondary care). Vietnam is currently undergoing a transformation to merge district hospitals and preventive medicine centers. This concept note will refer to the district hospital / district health center (DH/DHC) cluster. Village health workers are managed by the commune health stations.

² Regional polyclinics are government primary care facilities intended to provide services to multiple communes, particularly those that are far from district health centers, or in remote districts (MOH Decision No. 1327/2002/QĐ-BYT). However, de facto, 68 out of 544 regional polyclinics are in municipalities rather than remote areas. Some 14 provinces have no polyclinics (Health Statistics Yearbook 2014). Some 3.1% of all outpatient contacts and 3.9% of inpatient admissions were at regional polyclinics (VLHSS 2013/14).



Staff are paid by salary, drugs are provided in-kind from the district hospital, 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.

Government strategies and plans

14. **Recent government strategies and masterplans, as well as on-going policy development, reflect an increasing awareness of these challenges and an emphasis on strengthening the grassroots health system.** The Ministry of Health and development partners' recent Joint Annual Health Reviews (JAHR) have focused on the challenges related to the non-communicable disease burden (2014), strengthening primary health care (2015) and healthy ageing (2016). The five-year health sector plan for the period 2016-2020 includes a significant focus on strengthening of 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 commune health stations (Prime Ministerial Decision 92/QĐ-TTg of 2013). Both the National Strategy to prevent and control cancer, cardiovascular disease, diabetes, chronic obstetric pulmonary disease, asthma and other non-communicable diseases for the period 2015-2025 (Prime Ministerial Decision No. 376/QĐ-TTg of 2015) and the National Strategy for Population and Reproductive Health for the period 2010-2010 (Prime Ministerial Decision 2013/QĐ-TTg of 2011) emphasize the importance of strengthening the grassroots-level to prevent and manage non-communicable diseases and improving maternal and child health outcomes. Most importantly, in December 2016, the Government approved the Masterplan for building and developing the grassroots healthcare network in the new situation (Prime Ministerial Decision 2348/QĐ-TTg of 2016) which includes plans for both concrete investment and reforms to address the above-mentioned problems. A new basic essential service package for health insurance reimbursement at the commune level, intended to expand the scope of services to include non-communicable disease interventions, is currently under development. Principles of family medicine are being promoted for commune health stations and private primary care facilities. 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

Relationship to CPF

15. **The project will contribute to the attainment of the objectives set out in the (new) Vietnam Country Partnership Framework (CPF) FY18-22, in particular Objective 6 which is to “improve access to quality public and private health services and reduce malnutrition”.** This objective explicitly includes the intention to improve the quality of health care service delivery, especially at the primary care level, including “strengthening the grassroots (district and commune) health system in terms of availability/access, quality, integration, and transparency and voice”. This objective also includes the need to improve the efficiency and sustainability of health financing and service delivery arrangements, including (among others) reducing the over-reliance on hospital-centered delivery, supporting health insurance reform, enhancing financial protection from out-of-pocket health spending, and creating an enabling environment for private sector participation. In this regard, the project will also be relevant to bringing about one of the five strategic shifts envisaged under the CPF, namely achieving “the financial sustainability of public services and transfers”. To a lesser extent, the project will also contribute to the achievement of two other key strategic shifts envisaged in the CPF, namely the strategic shift towards more private sector development and participations across sectors and, also, ethnic minority poverty reduction.



C. Proposed Development Objective(s)

Note to Task Teams: The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet.

The development objective is to improve the quality and efficiency of the grassroots health system in the targeted provinces, with a focus on the management of selected non-communicable disease (NCD) and maternal and child health (MCH) tracer conditions.

This will be achieved by (i) enabling the commune-level facilities to take on the management of select non-communicable diseases, (ii) improving the utilization and quality of services already provided at commune level, and (iii) strengthening the capacity of the district to provide appropriate referral and support services.

Key Results (From PCN)

Key results (indicators) are still under discussion. Some possible result indicators include:

- (i) Number or percentage of CHS that are certified (and being used) for screening and management of at least one non-communicable diseases (e.g. hypertension, diabetes, cervical cancer screening)
- (ii) Ratio of outpatient consultations at commune-level versus district-level for select maternal and child health-related services (e.g. antenatal care, uncomplicated delivery, postnatal care)
- (iii) Percentage of children receiving the Hepatitis B vaccination within 24 hours of birth
- (iv) Number/percentage of DH/DHCs with centralized laboratories that are receiving and sending samples to the CHS
- (v) Overall quality of care at the commune level (as measured by a CHS balanced scorecard)

In all cases, an *increase* in the indicators signifies progress towards development objectives.

D. Concept Description

16. **The project will be implemented in around 10 provinces, prioritize poorer provinces, and also include a few higher-capacity provinces that can implement more ambitious reforms.** It has been agreed with the MOH that the provinces will include 7 poorer provinces and 3 “front-runner” provinces (i.e. wealthier, higher-capacity provinces that are willing and able to implement more ambitious reforms). Criteria for selection include: (i) willingness to participate, including accepting the on-lending requirements, (ii) relatively high poverty rate³ and/or reputation as forward-looking, innovative province, (iii) having a relatively low percentage of communes meeting the commune benchmarks for health, and (iv) that the provinces together give a reasonable geographic distribution across the country. Also, while health services delivered with the support of the project will benefit people of all ages, the nature of the interventions mean that they will likely disproportionately benefit young children, women, and the elderly. The fact that the project targets poorer provinces means that there will likely be a relatively high concentration of ethnic minority populations in the project provinces.

³ It is anticipated that at least two-thirds of participating provinces will be in the worst third of provinces in terms of poverty incidence.



17. **The main thrust of the project is to ensure that all commune health stations and regional polyclinics in the project provinces are able to deliver – with quality – the services that are within their current mandate, while also taking on a new role in the management of select non-complicated conditions (for which services are currently only available at the district level).** In addition to investments in infrastructure, equipment and competencies (“technical transfer” or training) at the commune level, achieving this new role will also require that the appropriate support be provided at the district hospital / district health center (DH/DHC) cluster. This support includes paraclinical support to the communes’ needs for diagnostic capacity (by establishing centralized laboratories that can receive and send samples – rather than patients – from the commune-level), emergency transfer of patients, technical back-up to the CHS to help them manage conditions, and referral services (for treatment of more complicated conditions). Realizing this new role for the CHS will also require certain policy changes at the national and provincial levels (e.g. policies regarding health insurance reimbursement and drug prescribing/dispensing guidelines). It may also require information/education campaigns to inform the public of the CHS’ new role and instill public confidence in using them. In addition, the project will selectively experiment with pilots and further innovations in grassroots service delivery and financing reform.

18. **The set of selected new conditions that will be taken on at the CHS level will be defined during project preparation, but will reflect the shifting disease burden and a vision for a new role for the CHS in the district health system.** This might include, for example, hypertension screening and management, diabetes screening and management, prevention and detection of treatable cancers (e.g. cervical cancer screening⁴), and basic health check-ups for the elderly. At the same time, the project will need to ensure improved, and better quality, delivery of basic services that are currently within the CHS’ mandate (such as immunization, tuberculosis control, and antenatal care).

19. **It is expected that the project will improve quality, efficiency, and patient confidence in the grassroots level.** The proposed investments and reforms will restore patient trust in the commune level, help make access to grassroots health services more convenient and cheaper for people (in terms of medical care, time, and travel cost), help to reduce the overcrowding at district level (to which patients currently go directly for these services), and enhance the overall efficiency of service delivery (by delivering new services in the lower cost environment of a CHS).

20. **Disbursement and fund-flow arrangements are still under discussion, but it has been agreed that Components 1 and 2 (and possibly also Component 3) will disburse against results (DLIs).** Components 1 and 2 will likely be implemented through a “fund” which provides financial support to each of the project provinces on the basis of a provincial grassroots health system investment plan geared towards the attainment of project results. Once the provincial investment plan has been approved, the project will transfer an advance (percentage to be determined during preparation) of the IBRD financing to the respective province. The next instalments and final payment would be made upon receipt by the MOH of satisfactory reports on the achievements of the agreed DLIs, and will be subject to third-party verification.

Component 1: Improving quality of care at the commune health stations and enabling them to take on a new role on disease management

21. Component 1 will strengthen the availability, quality, and continuity of care provided by the grassroots health system by (i) supporting commune health stations (CHS) to meet the national benchmarks for service-readiness and (ii) equipping and enabling the CHS to manage a new set of conditions (mainly non-communicable diseases), most of which are currently managed only at higher levels.

⁴ Screening would be using visual inspection with ascetic acid (VIA), not pap smear.



22. *Ensuring the basic readiness of CHS to deliver health services:* The project will finance the investments needed for the CHS in the project provinces to reach the national benchmarks for commune health. Investments will include mainly upgrading of existing CHS, but may also include construction of new CHS (either because there is no CHS⁵ or because it is better to demolish and rebuild the current CHS than to upgrade). Investments will also be made in regional polyclinics⁶. The national benchmarks for commune health care for the 2014-2020 period have been defined by the Ministry of Health and are described in Circular 4667/QĐ-BYT.

23. *Enabling the CHS to take on a new role in managing select health conditions that are not currently available at commune level:* This sub-component will finance the additional inputs needed for the CHS to properly manage select non-complicated conditions. These inputs could include infrastructure, equipment, drugs and materials, as well as the training of health workers (“technical transfer”) in the relevant competencies and information/education campaigns to inform the public of the CHS’ new role and build public confidence. Decision support technologies will be used to guide health care workers through the clinical decision-making process (from examination to diagnosis to treatment), as well as improve select information management functions (e.g. cause of death reporting). It is envisaged that a CHS will first achieve competency (marked by a process of certification) in the delivery of one of these services before moving to gain certification in others. Not all participating provinces (or districts) will necessarily take on management of all of the select conditions.

Component 2: Strengthening the district health services (DH/DHC cluster) to support the new role of the CHS and provide continuity of care

24. Component 2 will strengthen the double-function district health centers (DH/DHCs) to (i) serve as centralized diagnostic laboratories for the CHS, (ii) provide emergency transfer of patients, and (iii) improve their capacity to serve as referral facilities for specific clinical services needed to ensure continuity of care from the commune to the district level. Not all project provinces will necessarily undertake all of these investments.

25. *Strengthening the provision of diagnostic laboratory services:* One activity will be the establishment of a centralized laboratory service at DH/DHC level. This will involve enhancing the laboratory capacity at the DH/DHC level (to handle a greater volume and, possibly, broader type of diagnostic services) and a transportation system to send specimens (not people) to and from the DHC (from its CHSs) on a timely basis.

26. *Ensuring timely emergency transfer of patients:* Another activity will be enhanced capacity in the emergency transfer of patients from CHS to DH/DHC level, and from DH/DHC to provincial level, intended to instill in patients the confidence that if they use the grassroots health system, they will be transferred quickly and safely to higher levels of care if deemed medically necessary. This activity will likely involve the purchase of ambulances, but lease and public private partnership (PPP) alternatives will also be explored during project preparation.

27. *Improving clinical capacity in select referral services:* The project will also support district hospitals to build their clinical capacity in the delivery of select services that are linked to the tracer conditions being strengthened at the CHS level in order to complete the continuity of care. The component will need to support not only investment in infrastructure and equipment, but also the technical knowledge (“technical transfer”) needed to provide those services. It will also introduce decision support technologies to guide health care workers through the clinical decision-making

⁵ Per the latest Agricultural Census, there are only 19 communes in the country without CHS.

⁶ Polyclinics tend to serve multiple communes and are typically found in urban areas where they replace commune health stations.



process. Provincial health staff are expected to play an important role in the training of grassroots health staff, but may also themselves be the beneficiaries of training intended to enable them to better support the grassroots level.

Component 3: Enabling grassroots reforms, promoting quality improvement, piloting and scaling-up of innovations, implementation support, and results monitoring

28. *Enabling grassroots reforms through policy and capacity building:* To implement the reforms envisaged in this project, as well as to strengthen the grassroots health service delivery system (as envisaged in the Grassroots Master Plan) more generally, the MOH will need to develop enabling policies and build the capacity of provincial, district and local health staff. Policy actions specific to this project include, for example, the development of a certification process for each of the new conditions/diseases to be managed by the CHS. Broader reforms include the development and implementation of various policies, strategies and guidelines related to provider payment mechanisms, re-organization of service delivery, quality of care, governance and accountability, public-private partnership, etc. for the grass-roots system.

29. *Encouraging continuous quality improvement through quality scorecards:* Balanced Scorecards (BSC) will be developed by the MOH and introduced at the CHS and DH/DHC level in order to focus attention on the overall quality of facility service delivery and management, as well as the quality with which specific services are delivered. Ideally, the results of the Balanced Scorecards will be made available not only to district and provincial health authorities, but also to the public (at the facility) in order to promote accountability and patient trust by communicating the quality improvements. At the CHS level, the BSC could include, for example, compliance with technical guidelines for delivery of tracer services (including, for example, clinical practice guidelines, referrals, sending specimens to centralized labs as needed); internal quality management processes; outreach and follow-up with patients and the district hospital; completion of family health records; planning and financial management; health information system. At DH/DHC level, the BSC could capture items such as the completion of training of the CHS staff; quarterly supervision at the CHS and (internal) verification of CHS balance scorecard; ensuring the operationalization of the centralized laboratory; ensuring better two-way patient referral with the CHS; clinical practices with respect to the select referral conditions; and better information exchange. The design of the BSCs will be further elaborated during project preparation⁷.

30. *Piloting innovations:* This project envisages some health system innovations – including a new role for the CHS in NCD management, the use of centralized diagnostic laboratories, introduction of quality scorecards – and takes them to significant scale. The project is able to scale these innovations because they build on pilots that have been implemented and evaluated elsewhere in Vietnam. Component 3 will create space within the project to pilot, on a much smaller scale, additional innovative interventions envisioned in the Grassroots Masterplan – and evaluate them. At this concept stage, PPPs in grassroots health service delivery is one possible pilot area. Others are yet to be identified.

⁷ The design and implementation of the BSCs will draw on the findings of the evaluation of a pilot in Nghe An province under the Central North Region Health Support Project of the World Bank that used results-based financing mechanisms and quality scorecards.



31. *Implementation support, results verification, and evaluation:* This component will also ensure that the MOH and provincial DOH are able to provide sufficient implementation support to the local health authorities and facilities implementing the project. In addition, it will also support the independent verification of the attainment of the results envisaged under the project, and especially the DLIs, by a verification agent with appropriate qualifications as agreed between the Government and World Bank. Further, this component will cover the costs of the design, implementation and analysis of health facility (CHS and DHC) surveys intended to monitor progress in the quality of care at the grassroots level over the life of the project. It is anticipated that there will be a baseline survey undertaken early in the first year of the project, with follow-up surveys at mid-term and during the last year of the project.

Note to Task Teams: The following sections are system generated and can only be edited online in the Portal.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

While the provinces will be known by appraisal, the exact project locations (districts and communes) will likely not be. It is anticipated that at least two-thirds of participating provinces will be in the worst third of provinces in terms of poverty incidence. The fact that the project targets poorer provinces means that there will likely be a relatively high concentration of ethnic minority groups in the project provinces. Health facilities are typically located in populated areas (e.g. close to the center of a village or a town).

B. Borrower's Institutional Capacity for Safeguard Policies

Ministry of Health (MOH) will have the overall responsibility for ensuring safeguard compliance during project preparation and implementation. MOH has been managing a number of World Bank financed health projects. The most recent portfolio includes the Northern Upland Health Support Project, the Central North Region Health Support Project, the Northeast and Red River Delta Regions Health System Support Project, the Hospital Waste Management Support Project, and the Health Professionals Education and Training for Health System Reforms Project. MOH is familiar with World Bank Safeguard Policies and the compliance in recent projects has been satisfactory. At the national level, the existing policy and regulatory framework for environmental and social safeguards in the health sector is sufficient. Institutional capacity for healthcare waste management at the provincial and hospital levels has been improved significantly (including through the World Bank financed Hospital Waste Management Support Project and other MOH initiatives such as the "green, clean and beautiful health facilities" movement). However, healthcare waste management at the grassroots level (on which this project focuses) needs further improvement; the competency of primary healthcare teams in this area is still weak and financial resources are limited.

C. Environmental and Social Safeguards Specialists on the Team

Giang Tam Nguyen, Social Safeguards Specialist
Sang Minh Le, Environmental Safeguards Specialist

D. Policies that might apply



Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>This policy is triggered as the project includes investments which have potential adverse environmental and social impacts related to upgrading, new construction, and operation of commune health stations (CHSs), inter-commune polyclinics, district health centers; establishment of centralized laboratory services at district health center level; and use of medical equipment purchased for health facilities at the grass-roots level.</p> <p>The civil works for a standard CHS are expected to be around 60 m2 to 250 m2 depending its location and complexity. The amount of waste generated at a district hospital in a day per bed is about 0.15 kg of solid hazardous waste and 0.4 - 0.95 m3 of wastewater. A commune health station may generate about 0.5 kg of solid hazardous HCW and 1 - 2 m3 of wastewater per day. Since the various investments of the project are intended to increase utilization of health services, there will likely also be an increase in the volume of healthcare waste (HCW) at targeted health facilities.</p> <p>The overall impact of the project will be positive; it will improve the health status of the local people due to better management of selected non-communicable disease and improvements in maternal and child health care.</p> <p>During facility construction/upgrading, there will be some potential negative impacts in the form of noise, dust, vibration, construction wastes, wastewater, localized flooding and safety issues (all at a low level and over a short time period). During facility operation, potential adverse impacts are pollution of soil and water due to healthcare wastes, as well as human health risks associated with exposure to hazardous HCW and occupational injuries and infections (such as HIV, HBV). There is also public sensitivity to anatomical waste. Facility wastewater typically has a high content of enteric pathogens which are easily transmitted through water. However, these potential adverse impacts are expected to be moderate, localized, mitigatable and manageable through good design, appropriate mitigation measures</p>



		<p>and close monitoring during implementation and operation. Therefore, the project is proposed to be classified as a category B project.</p> <p>Since all the project districts and communes will not be identified during project preparation, and additional project provinces may be added during implementation, an Environmental and Social Management Framework (ESMF) will be prepared to guide preparation of the subproject specific safeguard instruments during project implementation. The ESMF will include an environmental and social assessment with a focus on HCW management to analyze and anticipate potential impacts of the proposed project on environmental and occupational health, and an analysis of health service access for women, the elderly, children, and vulnerable groups, including the poor. An Environmental and Social Management Plan (ESMP) or an Environmental Codes of Practice (ECOP) will be prepared for each subproject to assess the potential impacts and risks of the proposed mitigation measures in line with the government regulations and the Bank safeguard policies. The ESMP should follow the World Bank Group Guidelines on Environmental, Health and Safety. Public consultation will be carried out as part of ESMP preparation. The final draft ESMF and ESMPs will be disclosed on the Bank website and locally for public access prior to project appraisal.</p>
Natural Habitats OP/BP 4.04	No	Given the type and small size of the activities and the potential locations of the different subprojects, the project is not expected to involve natural habitats nor does it have the potential for any significant conversion or degradation of critical natural habitats, forests or other natural habitats. Therefore, the policy is not triggered.
Forests OP/BP 4.36	No	Given the location and the nature of activities, the project will not affect forests. Therefore, the policy is not triggered.
Pest Management OP 4.09	No	The project will not involve the production, procurement, storage, handling or transportation of any pesticide, nor will it result in an increased use of pesticides. Therefore, the policy is not triggered.
Physical Cultural Resources OP/BP 4.11	No	It is not expected that the project will require relocation of physical cultural resources (PCRs) such as monuments, temples, churches, religious/spiritual and



		cultural sites. However, there is a chance that civil works might result in chance finds. A chance find procedure will be included in the specific ESMP/ECOP and civil works contracts.
Indigenous Peoples OP/BP 4.10	Yes	It is anticipated that at least two-thirds of participating provinces will be in the worst third of provinces in terms of poverty incidence. The fact that the project targets poorer provinces means that there will likely be a relatively high concentration of ethnic minority groups in the project provinces. A social assessment (SA) will be conducted to understand gaps between various ethnic minority groups and other populations in the project sites with regard to access to health services, and measures to address these gaps. The SA will provide an in-depth analysis of health service access for women, the elderly, children, and vulnerable groups, including the poor. On a basis of this SA, an ethnic minority planning framework (EMPF) will be prepared before project appraisal. Once project districts become known, ethnic minority development plans (EMDPs) will be developed for the project sites having ethnic minority groups.
Involuntary Resettlement OP/BP 4.12	TBD	The trigger of OP4.12 has been changed to TBD as there is a possibility that the project may require land acquisition for new construction of CHS, although this possibility is very low. In all of Vietnam, there are only 19 communes without health stations; it is unlikely that all of these will be in the project provinces; if they are, first choice will be to build on public land. Lot size of commune health stations is small; civil works will likely be in the order of 60 m2 to 250 m2. The determination as to whether land acquisition will be needed will be made by appraisal stage. If land acquisition for new construction of CHS is needed, the related project province(s) will prepare a resettlement plan which will address the potential adverse impacts of the land acquisition upon the related local people and communities with adequate measures to mitigate and minimize these impacts.
Safety of Dams OP/BP 4.37	No	The project will not involve construction or rehabilitation of dams nor would it affect or depend on the safety of any existing dam.
Projects on International Waterways OP/BP 7.50	No	The project will not be implemented on any international waterways.
Projects in Disputed Areas OP/BP 7.60	No	No part of the project activities will be implemented in a disputed area.



E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Nov 30, 2017

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

All the project draft safeguard instruments including ESMF, EMPF, subproject ESMPs/ECOPs, EMDPs, and RAP(s), if any, will be completed and disclosed locally and at the Bank's websites in October 2017, well before project appraisal.

All the safeguards instruments prepared during project preparation will be completed by appraisal (scheduled for January 2018) with subsequent final disclosure locally at the project sites and the Bank's websites.

CONTACT POINT

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APPROVAL

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Note to Task Teams: End of system generated content, document is editable from here.