Project Information Document/ Identification/Concept Stage (PID)

Concept Stage | Date Prepared/Updated: 07-Jan-2021 | Report No: PIDC225322

BASIC INFORMATION

A. Basic Project Data

Project ID	Parent Project ID (if any)	Environmental and Social Risk Classification	Project Name
P174401		Moderate	JSDF - Strengthening Preparedness and Response to COVID-19 at the Grassroots level in Vietnam
Region	**Country**	**Date PID Prepared**	**Estimated Date of Approval**
EAST ASIA AND PACIFIC	Vietnam	07-Jan-2021	
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Institute for Social Development Studies	Institute for Social Development Studies	

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	2.85
Total Financing	2.85
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Counterpart Funding	0.10
Non-Government Organization (NGO) of Borrowing Country	0.10
Trust Funds	2.75
Japan Social Development Fund	2.75

B. Introduction and Context

Country Context

1. Vietnam has achieved remarkable poverty reduction over the last couple of decades through distributing the gains of strong economic growth equitably. By 2016, the incidence of poverty had fallen to 9.8 percent (according to the General Statistics Office [GSO]-World Bank poverty line)[1],

down from nearly 60 percent in 1993. During 2010 to 2016, the average consumption level of the bottom 40 percent grew by 5.2 percent annually. Inequality has remained largely unchanged, nonetheless, with the Gini coefficient dropping slightly (from 35.7 to 35.3) from 1992 to 2016[2].

2. Vietnam's success in reducing poverty is attributed to rapid economic growth and economic restructuring that has also been accompanied by job growth and public investment 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 relatively resilient to a challenging global environment, with recent growth of the annual gross domestic product (GDP) exceeding 6 percent with moderate inflation. Vietnam reached middle-income status in 2009.

Sectoral and Institutional Context

1. Vietnam has made remarkable progress in health outcomes over the past 20 years. Life expectancy, which increased from 72.1 to 75.8 years, is the highest in the region for countries at the similar income level[3]. Between 1990 and 2015, the child mortality rate dropped from 51 to 22 per 1,000 live births[4] and the maternal mortality ratio fell from 139 to 54 per 100,000 live births[5]. In 2014, the proportion of births assisted by a trained staff was 93.8 percent[6] and the proportion of pregnant women receiving four or more antenatal care visits was 73.7 percent[7]. In 2015, the nationwide full immunization rate was 97.1% and exceeded 95% in 53 out of Vietnam's 63 provinces[8]. In 2014, 7.5 percent of the people (7.8 percent in rural and 6.7 percent in urban areas) had at least one inpatient visit, while 33.5 percent (32.9 percent in rural and 34.9 percent in urban) had an outpatient visit in the previous 12 months[9].
2. The country's geographic location is particularly prone to infectious diseases, including zoonotic diseases that are the result of interactions between humans, livestock, wild animals, and the environment. With global flows of trade, finance, people, and data connecting the region to the rest of the world, the risks of cross-border endemic infectious diseases are more threatening than ever before. The emergence and spread of disease are facilitated by a wide range of socioeconomic, demographic, and environmental factors, including close contact between humans and animals (both domestic and wild), high-risk livestock and wildlife farming practices, expanding urbanization, high population density, and climate change. In recent years, Vietnam has encountered reoccurring outbreaks and public health emergencies, including severe acute respiratory syndrome-SARS (in 2003), avian influenza (H5N1 in 2003), influenza H5N6, and the pandemic strain of flu (H1N1 in 2009), among others. These threats demonstrate the continuing need to strengthen preparedness and response capacities to emerging infectious diseases and public health emergencies.
3. The COVID-19 situation has been evolving quickly and the Government of Vietnam (GoV) has been active on the preparedness and response fronts. With a long border and close trade relationship with China, Vietnam was among the first countries hit by the epidemic. The first case was confirmed as early as January 23, 2020 and as of September 8, 2020, Viet Nam reported 1,049 cases and 35 deaths; half of these were imported cases from China, South Korea, Europe, and the United States [10]. On January 30, 2020, the National Steering Committee for COVID-19 Prevention and Control was

established, chaired by a Deputy Prime Minister with leaders of all sectors as members; the Prime Minister declared the epidemic on February 1st, 2020. While many countries have been mired in the debate between health and economic choices, the Vietnam government made an unequivocal decision: prioritizing people's health over GDP growth. Such commitment from the highest level of leadership paved the way for the Ministry of Health and other relevant ministries to design and implement unprecedented measures for COVID-19 response, using a "whole of government" and "whole of society" approach. At the local level, the People's Committee led the inter-sectoral forces to implement prevention and response measures emergently. The slogan: "Combating the epidemic is like fighting against the enemy" is a call for the highest attention and effort of the whole country to fight the disease. Various strong mitigation measures have been applied with participation of all related sectors, such as health, police, army, and local authorities.

4. The GoV has implemented most of the recommended epidemic mitigation measures to contain COVID-19. All schools, colleges and universities were closed for 13 weeks starting in late January 2020. Travel restrictions were applied at first for specific countries with high infection rates (China, Republic of Korea, Iran and Italy), followed by blanket travel restrictions in late March. Mandatory institutional quarantine has been put in place for all travelers entering the country, including repatriated Vietnamese currently returning on charter flights. Close contact tracing and then institutional quarantine have been implemented for those who have had direct or close contacts with confirmed cases, while home quarantine has been applied for those at risk. In April, facial masks were required to be worn in all public places and social distancing was strongly recommended in big cities, while restaurants, services and entertainment facilities were required to close. Public gatherings, religious activities and festivals were suspended across the whole country. After two months of strict lockdown, the Government has gradually allowed the re-opening of services, schools and offices. However, Vietnam was hit by the 2nd wave of pandemic on July 24 after 99 days with no new community transmitted case of COVID-19.
5. At the global level, health systems are being challenged with rapidly increasing demand caused by the COVID-19 outbreak. When health facilities at all levels are overwhelmed, both direct mortality from an outbreak, and indirect mortality from vaccine-preventable and treatable conditions, increase dramatically. Analyses from the 2014-2015 Ebola outbreak suggest that the increased number of deaths caused by measles, malaria, HIV/AIDS, and tuberculosis attributable to health system failures exceeded the deaths from Ebola[11];[12]. The United Nations Children's Fund (UNICEF) also warned that COVID-19 containment measures can disrupt life-saving health services such as childbirth care, putting millions of pregnant mothers and their babies at great risk[13]. A recent study by the World Health Organization in 155 countries shows that more than half (53 percent) of the countries surveyed have partially or completely disrupted services for hypertension treatment; 49 percent for treatment for diabetes and diabetes-related complications; 42 percent for cancer treatment, and 31 percent for cardiovascular emergencies[14]. Even though data is not available in Vietnam to understand the impact of COVID-19 on the provision of health care services to patients of other diseases, general information shows a significant decrease on the numbers of health examination in health facilities at all levels as patients were scared of becoming infected with the virus at health facilities. The system's ability to maintain delivery of essential health services will depend on its

capacity and burden of disease, and COVID-19 transmission context (classified as no cases, sporadic, clusters, or community transmission).

6. The World Bank in Vietnam has engaged with the Government in supporting the country in the fight against COVID-19 through technical support and grants. At the early stage of the epidemic, through PHRD grant for Strengthening Pandemic preparedness, the World Bank supported the National Institute of Hygiene and Epidemiology (NIHE) to provide technical assistance to improve the surveillance, diagnostic, testing, treatment and care for COVID-19 pandemic. The training was provided to lab technicians, health staff, and quarantine officers in 28 provinces. A grant of US$ 6.2 million by the Pandemic Financing Facility was promptly proceeded to assist Vietnam to strengthen capacities for detecting and responding to COVID 19. Six months after the epidemic started, the World Bank Vietnam has issued six policy notes covering various areas of socio-economic and social issues to provide policy and technical advice to the Government.
7. Other Development Partners have also quickly provided their support to the Government given their competitive advantages. Key Development Partners are Japanese Government, USAID, USCDC, and WHO. These supports are mainly Personal Protective Equipment (PPE) and medical equipment to health facilities and technical assistance to the Ministry of Health (MOH). All supports have been mobilized and implemented in a timely manner to respond to the pandemic. However, there has not been a more long-term support to strengthen the country's response and preparedness to COVID-19, especially at community level.
8. The additional JSDF support will complement to the country's effort to strengthen the pandemic preparedness and response by focusing on interventions at community level. The country has received several IPF/JSDF grants and therefore has the experience and capacity to effectively implement the new project financed by the JSDF emergency response to COVID19. Non-governmental organizations (NGOs) are active and capable of supporting the implementation of JSDF projects. Currently, Vietnam has two JSDF projects, partnered with Save the Children and HelpAge International.

Relationship to CPF

1. The proposed operation will contribute to: (i) building a resilient health system at the grassroots level for current and future public health emergencies, (ii) improving the community's awareness and its prevention of COVID-19 and other emergency diseases in the selected provinces, and (iii) setting the model for replication nationwide. The Project was not included in the World Bank Group's Country Partnership Framework for Vietnam (2018–2022) or the Performance and Learning Review, however COVID-19 pandemic highlights the need to strengthen pandemic preparedness and response for Vietnam.
2. Within the above context, the JSDF support will focus on the improvements in pandemic preparedness and response at the grassroots level. These interventions will complement the current pandemic preparedness and responses by reaching communities and the most vulnerable groups that have not yet been covered by other programs of the GOV and concerned stakeholders. Further, these will enhance the participation of communities and frontline community leaders and health workers in

the country's efforts to combat the COVID-19 pandemic, with a vision for the country to be better prepared for possible future health emergency situations. Through the JSDF's focus on strengthening participatory monitoring systems and public education for health promotion, it will augment the overall effectiveness of the country's efforts to respond to the COVID-19 pandemic and also improve resilience among these communities against any similar outbreaks in the future.

C. Project Development Objective(s)

Proposed Development Objective(s)

The development objective is to strengthen the capacities of communities, including the community leaders, health and other sectors and civil society organizations, and vulnerable populations in their preparedness and response to the COVID-19 pandemic as well as for other health emergencies in the project's provinces.

Key Results

- 27 plans for inter-sectorial collaboration for COVID-19 and other health emergencies preparedness and response are developed and approved (baseline: 0, target: 27);
- Percentage of health staff at the CHSs who have good knowledge in COVID-19 and pandemic response and preparedness (baseline: 30, target: 50);
- Percentage of people who have good knowledge in COVID 19 and pandemics prevention and response (baseline: 20, target: 40);
- Number of people in the vulnerable groups, including the elderly, people ling with HIV/AIDS, female sex-worker, drug users, informal workers, and ethnic minorities, who participate in the project intervention activities (baseline: 0, target: 3500).

D. Preliminary Description

Activities/Components

The proposed project has four components:

Component 1. Building capacities at the grassroots level in preparedness and response to COVID-19 and other health emergencies (US$879,472)

This component will support the improvements of the inter-sectorial coordination and capacity of commune health facilities including health staff for preparedness and response to COVID-19 and future pandemics. Front-line workers who will receive capacity building trainings and workshops are those who are from local authorities and different sectors involving in the containment of virus and pandemic prevention, including local authorities, commune health care workers, police, army, people from mass organizations such as Women Union, Youth Union, Elderly Union, etc., people from different sectors such as information and communication function, labor, invalid and social welfare function, education function, etc.

There are 2 sub-components as below:

Sub-component 1.1. Improving inter-sectorial coordination capacity (US$ 237,132)

This sub-component aims at: (i) Development of an inter-sectorial collaboration plan to prepare and respond to COVID-19 and other health emergencies. The strategy of the Vietnamese government in the preparedness and responses to COVID-19 is to mobilize and coordinate available resources from different ministries and sectors in the fight against COVID-19. This strategy works relatively well at the central level, however, at the grassroots level, there is no available guideline on how local authorities can mobilize the participation of different local agencies, including primary health care facilities in the preparedness and response to COVID-19. In collaboration with policy makers at MOH and/or international experts, the project will assist with developing an inter-sectorial coordination plan in which it defines specific roles and responsibilities of each local entity and how the overall efforts to prevention and control of the virus should be best coordinated at different pandemic scenarios at local grassroots level. The plan will be developed using community participatory approach and in consultation with local government authorities and health authorities at ministerial, provincial and district levels. The plan will be widely disseminated to the stakeholders at provincial, district and commune level via: provincial level sensitization workshops for all district leaders in the project's provinces and district level training workshops for all commune leaders and related stakeholders in the project's implementing communes; (ii) Training of front-line workers at the commune level on how to operate community and home quarantine and isolation during pandemic. Together with Provincial Center for Disease Control (CDC) experts, Provincial Project Management Unit (PPMU) and ISDS's Project Management Team (PMT) will develop training materials based on the National Guideline for home and/or residence-based quarantine; and (iii) Development and implementation of simulation exercises for response with different epidemic/pandemic levels/scenarios.

The simulation exercises (SE) will be developed in intense consultation with technical experts from MOH, international organizations, local authorities and representatives from related stakeholders and communities. These SE are the opportunities for local authorities, health care leaders and workers and cross-sectional actors, including local police and/or army, mass organizations, communities and vulnerable populations to practice the response to COVID-19 and other health emergencies (epidemiological investigation, contact tracing, referral for testing and some extreme forms of community-level social distancing measures such as community lockdown, isolation, quarantine, support and protection of vulnerable populations) in a collaborated and well-coordinated manner. In each of the implementing provinces, one simulation exercise mimicking a real pandemic scenario will be implemented at the commune level. Each SE is estimated to last for one day. A half day is spared for all involved parties to debrief lessons learned. This exercise aims to let each player practice their assigned roles and responsibilities and to test the plans and procedures (operational guidelines and standard operating procedures) in the pandemic preparedness and response to Covid-19 and other infectious diseases. To foster cross and continuous learning, representatives from different groups of beneficiaries from the project's implementing provinces will be invited to observe the practice of simulation exercise in other provinces and participate in the lessons learned debriefing sessions.

This sub-component finances the following activities: (i) Development of an inter-sectorial collaboration plan for COVID-19 and other health emergencies preparedness and responses at commune level; (ii-a) Sensitization workshops at provincial level for all districts' leaders on this plan; (ii-b) Training workshops at district level for all commune leaders/local authorities and related stakeholders from implementing communes on this plan; (iii) Trainings for local authorities and related stakeholders in operating and monitoring home and residence-based quarantine; and (iv) Developing and practicing simulation exercises of COVID-19 mimics scenarios at commune level.

Table 2. Sub-component 1.1 outputs and indicators

Outputs	Indicators
Training on the inter-sectorial collaboration plan for COVID-19 and other health emergencies preparedness and response for local authorities and related stakeholders	Number of community leaders and stakeholders trained
Approval of the inter-sectorial collaboration plan for COVID-19 and other health emergencies preparedness and response	Number of communes approving the plan
Training on operating and monitoring home and residence-based quarantine	Number of front-line workers trained
Support for establishing a designated examination room for suspected COVID-19 and other communicable diseases for Commune Health Station (CHS)	Number of CHSs that receive project's support to establish a designated examination room for suspected COVID-19 and communicable disease patients
Practice of simulation exercise on emergency responses to COVID-19 at communities	Number of simulation exercises on health emergency response that are implemented at the community

Sub-component 1.2. Strengthening Commune Health Station's capacities in preparing and responding to COVID-19 and other epidemics (US$642,340)

In Vietnam, each commune has a Commune Health Station (CHS) normally staffed with one doctor or an assistant doctor and several nurses, equipped with basic health care equipment and a small pharmacy. The extended network of the CHS is village health workers, who receive basic training on health care and can support the CHS on preventive health care activities. The role of CHS is to provide essential health care services, including immunization, diagnosis and treatment of common diseases, management of chronic conditions and other national public health programs (prevention of malnutrition, tuberculosis prevention and control, management of mental health disorders, and protection of mother and child health, etc.). CHSs run under the direct management of District Health Centre and receive funding from both line MOH and provincial budget.

This sub-component aims at: (i) strengthening the capacity of CHSs, commune and village health workers in preventing and controlling infection at health facilities, (ii) ensuring the continuity of essential health care services provision to commune's people during the pandemic (this will support CHSs to develop a Manual in continuity of essential health service provision, train health staff on this Manual and adaptation of the Manual at each CHS), and (iii) providing equipment, minor repairs and upgrades of the facilities, as well as essential personal protection equipment to CHSs to establish triage arrangement and/or a separate consultation rooms for suspected patients with COVID-19 or other infectious diseases while still maintaining the provision of essential health care services to other patients or community's individuals; and (iv) building capacities of grassroots health staff working at CHSs and village health workers in early detection and reporting, epidemiological surveillance and contact tracing, testing and referral for patients with suspected COVID-19 infection and other health emergencies.

This sub-component finances the following activities: (a) Development of Guideline and Training on infection prevention and control at CHS facilities for CHSs' health care workers; (b) Upgrading CHS (minor repairs and purchase of basic equipment) to establish triage arrangement and/or a separate consultation rooms for suspected patients with COVID-19 and/or other infectious diseases' signs and symptoms; (c) Develop and train on Manual for developing a Plan of Continuity of Essential Health Service Provision during the pandemic and/or other health emergency events; and (d) Training for grassroots health care workers on COVID-19 early detection and reporting, epidemiological investigation and contact tracing, testing and patient referral. For this training, ISDS's PMT and PPMU will collaborate with Senior Technical Officers from provincial CDC to review and develop training materials based on the relevant National Guideline.

Table 3. Sub-component 1.2 Outputs and indicators

Outputs	Indicators
Training on infection prevention and control at grassroots health facilities	Number of health staff trained
Developing and training on Manual for continuity of essential health services provision for grassroots health care workers	Number of health staff trained
Support for establishing a designated examination room for suspected COVID-19 and/or other communicable diseases	Number of CHSs that receive project's support to establish a designated examination room for suspected COVID-19 and communicable disease patients
Training for grassroots health care workers in COVID-19 early detection, epidemiological investigation, testing and patient referral	Number of health staff trained

Component 2. Raising awareness and knowledge towards changing attitudes and behavior of the community through risk communication (US$648,676)

This Component will support outreach communication activities focusing on the awareness, knowledge, and attitudes for behavioral changes of citizen and community on health emergency preparedness and response against COVID-19 and other pandemics. There are two sub-components as below:

Sub-component 2.1. Improving risk communication capacity for front-line workers (US$226,726)

This sub-component will support the review, development, printing and dissemination of communication products, and training of trainers for health workers and community level workers on risk communication in the project's communes and other localities in the project's provinces.

Risk communication materials focus on providing knowledge and scientific, fact-based updated information in relation to COVID-19 transmission modes, suspected signs and symptoms, prevention measures which include mask wearing, hand washing and surface disinfection. Additionally, updated local, regional, national, and international epidemiological data is also provided periodically to communities residing in the project's locations during project implementation via community loudspeaker systems. Risk communication materials will be developed by the application of a participatory, community-based approach with significant inputs from experts from MOH and international organizations and key informants from communities for the cultural appropriateness of content and language and will be produced in several formats, including both printed versions and electronic version to enable wider sharing and dissemination. Once they are finalized, risk communication trainings will be delivered to front-line workers, including local authorities and related stakeholders, health care workers, communities' volunteers and vulnerable groups' volunteers. It is expected that people upon finishing these trainings will be able to communicate about risks of COVID-19 to their communities and most affected, vulnerable individuals so that they can make informed decisions to protect themselves and their families.

This sub-component finances the following activities: (i) Developing COVID-19 related communication materials and (ii) Training on COVID-19 risk communication skills for front-line workers in the project's implementing communes.

Table 4. Sub-component 2.1 Outputs and indicators

Outputs	Indicators
Developing of COVID-19 related communication material	Number of communication material developed and printed
Training on COVID-19 risk communication skills for front-line workers and community/vulnerable groups' volunteers	Number of front-line workers and community/vulnerable groups' volunteers trained

Sub-component 2.2. Implementing communication activities and initiatives in the community (US$421,950)

This sub-component will finance communication outreach activities at the community level. Community innovations, such as children drawing contests, community games, application of social media, etc. will also be implemented to improve community participation and engagement. Communication equipment, including loudspeakers, TV, radio, etc. will be provided to project communes.

Upon completing trainings on risk communication, local authorities, related stakeholders, health care workers, community volunteers and volunteers of vulnerable populations will deliver risk communication in relation to COVID-19 to communities in their neighborhood by various communication methods and via multiple channels. Currently, the Vietnamese government's communication activities have been carried out mainly via mass media channels and sending messages to mobile phones which might not be reachable to all people in the community, particularly vulnerable populations such as elderly people, poor informal migrant workers, ethnic people because of the inappropriateness of content and language and lacking of mobile phones. The project will complement this gap in a number of creative and innovative ways.

Communication delivering activities could be conducted flexibly in various ways, depending on the local context, COVID-19 pandemic situation and characteristics of communities and vulnerable populations, acknowledging government social distancing and mask wearing requirements. These activities may include (but not limited to) the followings: communicating and updating COVID-19 information and knowledge via community loud-speaker system which is usually used to disseminate information to communities, household outreach, face-to-face meetings or virtual meetings in mobile meeting applications, community group meetings, sending interactive, two-way messages in popular mobile-based social networks in Vietnam such as Facebook and Zalo. Wherever possible, communication events by a small group will be organized and communication of virus transmission could be done via group activity games. Besides communication and knowledge sharing, community and vulnerable groups' volunteers also demonstrate and instruct people the ways to correctly wear masks, wash hands and hygienically clean their homes and furniture. Particularly, the project will organize communication innovations such as drawing contest for children and art-based communication contest for adults to raise community awareness in COVID-19 preparedness and response. To enable communication at community level, the project will purchase basic communication equipment such as laptops, projectors, and loudspeakers for project's implementing communes.

This sub-component finances the following activities: (i) Communication outreach activities at community level; (ii) Painting/Drawing contest for primary and secondary school children; (iii) Art-based contest for adults; and (iv) Purchase of communication equipment (loudspeakers, laptops, screens, and projectors, etc.)

Table 5. Component 2.2 Outputs and indicators

Outputs	Indicators
Communication activities at community level	Number of people reached
Painting contest for school children	Number of children participated
COVID-19 related art-based communication contest for adults	Number of adults participated

Purchase of communication equipment	Number of communes received communication equipment

Component 3. Developing and piloting models to support the most vulnerable groups in the preparedness and response to COVID-19 (US$529,379)

This Component will support the development and piloting of three to four models to support different vulnerable groups in selected Provinces. Intervention models will be for elderly people in the cities, ethnic minorities in Long An province, informal workers in Long An and Khanh Hoa provinces, and HIV-related vulnerable populations, including people living with HIV/AIDS (PLHIV), people who use drugs and female sex workers, in Vinh Phuc province. Main activities include: (i) the establishment of the community volunteers' networks. ISDS PMT together with PPMU will organize introductory and consultation meetings with potential enthusiastic group's volunteers, provide them with brief introduction of the project and expected scope of work of a volunteer, and recruit those who are willing to contribute their efforts to support the most affected, vulnerable individuals in their groups. The work of networks' volunteers include the following activities: (ii) communication on signs and symptoms of COVID-19 and its impact on health, livelihood and mitigation measures carried out by volunteer networks; (iii) guidance for disease preventions, government-required health reporting and declaration; (iv) providing psychological support, raising their awareness on fundamental development issues such as gender equality, prevention of domestic violence and providing in-kind supports such as PPE, food, medication, etc. to support these hard-to-reach and vulnerable people in preparing, responding to and mitigating the impacts of COVID-19.

Using peers in implementing public health interventions is proved to be effective and efficient. People from community and/or vulnerable groups are those who best understand their issues and problems and can consult for the most appropriate interventions and reach the most hard-to-reach individuals in their communities. Currently, the GOV responses to COVID-19 target general population throughout the country and yet to have specific interventions to support several vulnerable populations. This project will use available volunteer networks of people living with HIV/AIDS, drug users and female sex workers in an on-going HIV project in Vinh Phuc, establish new volunteer networks for poor, informal migrant workers and rely on current network of elderly people in Khanh Hoa, empower community heads or respectful people of Khmer ethnic minority people in Long An to support the most affected, vulnerable individuals in the project's communes.

The project will build up capacity for communities' and vulnerable groups' volunteers in areas such as communication skills (already mentioned in Component 2), COVID-19 symptoms detection, case management of suspected or confirmed cases at home-based quarantine, COVID-19 preventive measures (mask wearing, hand washing, surface hygiene), health reporting form completion, psychological support and development-related cross-cutting topics such as gender equality, domestic violence in the context of COVID-19 pandemic. For groups such as elderly people, we train them in basic digital communication knowledge and skills with digital social networks, including Zalo, Facebook, Zoom, and Youtube, etc.

After TOT trainings, networks' volunteers will provide support to their members in: i) Communication about COVID-19 health related information (symptoms, notification to local health authorities, preventive measures); ii) Instructions on preventive measures practice, including mask wearing, hand washing and surface hygiene; iii) Instructions on and support for health reporting form completion. Depending on the characteristics of their networks, they can provide this information in either face-to-face meeting, household outreach, physical communication events/trainings, and/or digital communication. Network volunteers' roles also include psycho-socio support to mitigate impacts of COVID-19. Network volunteers will provide the following psycho-socio support to their network members:

a. Inform network's members about potential pandemic-associated risks with respect to their likelihoods, mental health, family violence and care access issues that are likely to occur during the pandemics and/or under extreme forms of social distancing measures such as lockdown, isolation, quarantine and confinement.
b. Update information about local administrative procedure and support accessibility to the government benefits and other resources such as financial supports, foods, accommodation, and transportation subsidies (if any).
c. Support network members to detect early psychological disorder signs by a user-friendly mental health screening scale and provide peer-psychological support and counselling and/or referral to health care facilities with severe cases (if any).
d. Provide support and counselling on gender inequality issues and domestic violence.

This component finances the following activities: (i) Introductory and consultation meetings with network volunteers of vulnerable populations for volunteer recruitment and establishing volunteers' networks purposes; (ii) trainings for recruited volunteers on COVID-19 signs and symptoms and prevention measures; (iii) trainings for network volunteers on psychological support, gender equality and domestic violence awareness and prevention; (iv) outreach support for members of vulnerable groups and (v) community-driven initiatives to support the most affected, vulnerable individuals in the communities and vulnerable groups.

Table 6. Component 3 Outputs and indicators

Outputs	Indicators
Supports in relation to COVID-19 preparedness and responses provided by volunteer networks of vulnerable populations to their groups' members	Number of community collaborators that participate in the project activities
Communities' initiative packages supporting the most affected and vulnerable members as results of COVID-19	Number of community innovation models for COVID-19 and other health emergencies

Component 4. Project Management and Administration, Monitoring and Evaluation, and Knowledge Dissemination (US$692,473)

This Component will support the following activities (i) project management and administration; (ii) project monitoring and evaluation; (iii) preparation of evaluation reports; (iv) environmental and social safeguards; (iv) dissemination of project activities and interventions; and (v) annual audits on the use of the proceeds of the Grant. This Component will support the Project implementing agencies to carry out the day-to-day activities of the Project, including the requisite procurement, financial management, auditing, participatory monitoring and evaluation, and knowledge management activities, in line with the Project Operations Manual (POM).

Sub-component 4.1. Project management and administration (US$358,848)

This sub-component includes the following activities: i) establishing a project management team, ii) forming advisory boards at central, provincial and district levels, iii) establishing project management units at provincial level; iv) developing a project operation manual (POM) based on regulations and guidelines of the WB; v) organizing training on POM for local partners; vi) daily project financial and implementation management; and (vii) launching and closing workshops. ISDS's PMT include assigned staff from ISDS, including a Project Director, a Chief Accountant, an Accountant and an Administration Officer and is supplemented by a team of long-term consultants, including: a Chief Technical Advisor, a Senior Monitoring and Evaluation Coordinator, a Planning and Procurement Specialist and a Social inclusion, Safeguard Specialist. For several project activities implementation, ISDS's PMT will recruit short-term consultants with diverse expertise (public health, communication, social work, coordination, etc.) to support PMT and PPMU to carry out the tasks.

In each implementing province, ISDS will establish a Provincial Project Management Unit (PPMU), staffed with a Provincial Project Director (PPD) who is expectedly a Senior Leader from the Provincial DOH, a Project Deputy Director who is expectedly a Senior Official from the Provincial CDC, and a Provincial Local Coordinator who is a full-time consultant. In collaboration with ISDS PMT, PPMU's overall responsibilities include (but are not limited to) annual project planning and review, coordination for project activity implementation at commune level, daily project operational and management, management of voluntary networks of vulnerable groups and periodical project activities' monitoring and reporting. For capacity buildings activities, consultation meetings, workshops, and trainings, while ISDS PMT is responsible for technical aspects and expenditure payment, the major responsibilities of PPMU is to coordinate the events and prepare needed logistics. PPMU is also responsible for coordination and logistic preparation for evaluation activities such as baseline surveys, mid-term, and end-of-project evaluation. PPMU has direct implementation management and reporting responsibilities for activities implemented at communities, i.e. simulated scenario practicing, communication activities and campaign, execution of community and vulnerable groups' innovations to support the most affected and vulnerable members because of COVID-19. Together with ISDS PMT, PPMU will review and approve submitted innovations' implementation plan and budget prior to implementation.

With each voluntary network of vulnerable groups, ISDS will assign a team leader who has the responsibilities in providing daily management and technical assistance to network's volunteers, developing proposal and budgeting for communication and support innovations, coordinating and implementing group's activities, organizing group's monthly meeting and preparing monthly reports. Networks' team leaders directly report to PPMU and correspondence provincial Project Officer. Further, in each participating commune, ISDS will establish a group of approximately 30 community volunteers who will support local health agencies in periodic active surveillance of COVID-19 cases and regular household-based risk communication on COVID-19 prevention and responses.

A Technical Advisory Group (TAG) at the Central level will be formed to provide insight technical advices to capacity building activities of the project. Members of the TAG include, but are not limited to, representatives from GDPM, concerned departments of MOH, CDC, DOH of project provinces. The committee members will be consulted as needed for the technical activities to ensure the alignment of the project's technical guidance/documents with the overall/national/provincial directions and orientations and secure immediate and/or future scale up and expansion.

ISDS will strictly apply all government and/or organization's social distancing requirement during project implementation. Project staff will be required to frequently clean hands and wear masks during fieldwork. Meetings will be organized so that the distance between people is at least one meter, all meeting participants are required to wash their hands and wear face masks during the meetings. ISDS also works with local PPMU during preparation and set up stages to ensure that local partners have sufficient access to and proficiently use of virtual meeting applications such as Zoom, Google meet, etc., to prepare for virtual working if the pandemic is transmitted in the community where the project is implemented. ISDS will develop an organizational regulation on COVID-19 organizational preparedness and responses in which it clarifies working mode during the pandemic. This regulation will include (but will not be limited to) the following requirements during pandemic: (i) working from distance via emails, phone calls, and virtual meeting applications; (ii) compulsory face mask wearing and frequent hand washing; (iii) at least one meter distance between people during meetings; and (iv) health status reporting as required by the government after each field trip.

This sub-component finances the following activities: (i) launching workshops at provinces; (ii) annual review and planning workshops; (iii) closing workshops; (iv) audit; (v) long-term consultant payment and staff salary; and lastly (vi) office expenses.

Sub-component 4.2. Participatory Monitoring and Evaluation (US$283,162)

The project will develop a log-frame to detail project outcomes, activities, and outputs, along with a set of indicators for each project outcome and key activities. A Monitoring and Evaluation (M&E) plan will be developed. It will incorporate the log-frame's features to detail who, when, and how often monitoring and evaluation will be conducted, and the log-frame will be updated, and where the report will be sent. The M&E plan will be using participatory approaches with involvement of community actors to ensure ownership, continuous learning and necessary adaption. Also, the result-based M&E approach will be used to inform

project management decision on project progress toward its proposed objects and measure results and impacts of the project. All of the M&E process will be oversighted by a Senior M&E Coordinator who, besides developing log-frame and M&E plan driven by participatory structures, will routinely oversee monitoring of the project activities undertaken and organize quarterly and annual meetings in order to review project progress with activities milestones and results against the approved work plan, PDOs and intermediate outcomes. Daily monitoring of project implementation is carried out by Provincial Local Coordinator and Planning and Procurement Specialist.

Data for M&E will be collected from both primary and secondary sources: training satisfaction reports, activity reports, needs assessments, stakeholder consultations, baseline and end-line surveys, and formative research. Data will inform discussions among the project team and local partners in periodical reflection meetings and planning workshops.

Monitoring and evaluation activities include:

Evaluation: a pre- and post-evaluation mixed-method design will be used to assess the effectiveness of the project. Qualitative and quantitative methods, including: i) desk review of availability of localized/contextualized guidelines/plan to prepared for and responses to COVID-19 at local authorities and health facilities; ii) in-depth interviews or focus-group discussions with key localities' actors exploring their perception of local capacity and readiness to COVID-19 ; iii) inventory checking of infrastructure, medical equipment and consumable readiness at health care facilities, and iv) surveys with health care workers, community members, members of vulnerable groups in COVID-19 associated knowledge, belief, attitude and behaviors (KBAP) will be employed to measure project's outcomes, significant changes and long-term impacts. Key impact indicators to be measured at baseline and/or end-line evaluation include:

a. Local authorities' capacity in exercising a comprehensive preparedness and response to COVID-19 and/or other infectious diseases through a proper inter-sectional collaboration and coordination plan.
b. Health care facilities at grassroot level capacity in preparedness and response to COVID-19 and/or other infectious diseases though well-prepared in-hospital infection prevention and control guidelines and plan for continuity of essential health services provision.
c. Frontline health workers and non-health workers technical capacity in COVID-19 symptoms, diagnosis, epidemiological surveillance for early case detection and notification, home or residence-based isolation and quarantine and risk communication
d. General community and vulnerable populations KBAP in COVID-19 symptoms detection and reporting and utilization of preventive measures.

Mid-term review. By the middle of project implementation and before the end of the second year of project implementation, ISDS will conduct a mid-term review. Mid-term evaluation will be conducted with in-depth-interviews and/or focus group discussions with key informants from all groups of project beneficiaries. This mid-term evaluation will provide the ISDS project management team, PMT and the Bank with a basic for identifying appropriate actions to: i) address particular issues or problems in design, implementation and management for project's interventions adjustment if needed and ii) reinforce initiatives that demonstrate

the potential for success. Mid-term review report will be sent to ISDS project Director/Senior Technical Advisor, PMT and the Bank for review and recommendations for the second half of project implementation.

Monitoring. Key monitoring activities include: 1) regularly reviewing project activities, using output indicators in the log-frame; 2) reviewing periodic activity reports submitted by project staffs, and project partners, 3) periodical quarterly field visits and meetings with local partners and volunteers; 4) monthly meeting with project staffs to review the project progress and results against the approved operation plan, and 5) midterm review will be undertaken at the Year 2.

This subcomponent finances the following activities: (a) a baseline survey, (b) monitoring and technical assistant trips, (c) mid-term evaluation and (d) end-line survey.

Sub-component 4.3. Knowledge sharing and dissemination (US$50,463).

We propose four main strategies for dissemination of our project result: i) though the project will be implemented in 9 communes of each implementing districts of 3 project provinces, we expand the scope of trainings to build capacity of local primary health care workers to all primary health care personnel who work in the districts where the project will be implemented. By this strategy, not only when the project is completed its results could be shared but capacity of all local health care workers in implementing districts are expected to be improved, resulted in a better preparedness and responses to COVID-19 at primary health care facilities at larger scale; ii) Mid-term lessons learned sharing workshop for representatives from project's beneficiaries; iii) Dissemination Workshop will be organized upon project completion, disseminating the project's outcomes, technical guidance and training materials and lessons learned to nation-wide related stakeholders who include representatives from beneficiaries groups from the implementing provinces, representatives from MOH, representatives from other provinces, representatives from international organizations working in Vietnam (WHO, CDC, etc.); and iv) Establish an internet-based, open knowledge sharing hub, integrated in ISDS website. All technical guidance, training materials and progress reports of the project will be uploaded in this hub for widely sharing with all related stakeholders.

This sub-component finances the following activities: (i) a mid-term lesson learned sharing workshop; (ii) dissemination workshop; and (iii) establishment of an open, online knowledge sharing and dissemination hub.

Environmental and Social Standards Relevance

E. Relevant Standards

ESS Standards		Relevance
ESS 1	Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10	Stakeholder Engagement and Information Disclosure	Relevant

ESS 2	Labor and Working Conditions	Relevant
ESS 3	Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4	Community Health and Safety	Relevant
ESS 5	Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6	Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7	Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
ESS 8	Cultural Heritage	Not Currently Relevant
ESS 9	Financial Intermediaries	Not Currently Relevant

Legal Operational Policies

Safeguard Policies	Triggered	Explanation (Optional)
Projects on International Waterways OP 7.50	No	The Project will not be implemented on or affect any international waterway
Projects in Disputed Areas OP 7.60	No	The project will not be implemented in any disputed area.

Summary of Screening of Environmental and Social Risks and Impacts

The project only finance capacity building, awareness, small upgrading, equipment, and development of operation manual. The project may cause limited environmental risks and impacts during the minor rehabilitation of existing CHSs i.e. the generation of small amount of waste, wastewater, and workers? safety. The main environmental risks during operation would be staffs and community health and safety due to the potential exposure to infected patients and improper handling of medical waste which could include infectious pathogen. The project itself does not bring about additional environmental risk, but rather reduce potential health risks associated with CHSs operation. Given the type, location, sensitivity, and scale of the project, the nature and magnitude of the potential environmental risks and impacts, and the capacity the implementing agencies to manage the environmental risks and impacts in a manner consistent with the ESSs, the environmental risk is assessed as Moderate. The social risk for this project is moderate because it will primarily involve communications, training, capacity building, which are unlikely to result in substantial adverse impacts. The project will require engagement with, and service provision to, vulnerable socio-economic groups, such as the elderly, informal workers, migrants, ethnic minority people, and people living with HIV/AIDS. The social risks have been anticipated in the design of the project. The main issue to consider will be the institutional capacity of the borrower to ensure the activities are fully and successfully implemented to address social risks. Strengthening the institutional capacity for ESF implementation of ISDS is necessary through training, technical support from the Bank task team and additional measures that will be identified during the preparation.

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