THE WORLD BANK INDEPENDENT EVALUATION GROUP

Vietnam
Population and Family Health Project

Project Performance Assessment Report

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INDEPENDENT EVALUATION GROUP

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Summary

In the early 1990s, Vietnam was increasingly open to the world economy and entered a period of rapid socio-economic change, poverty reduction, and sustained growth. Vietnam already had a longstanding commitment to reducing population growth and high fertility because of its negative impact on economic development. The government had promulgated a "one or two child" population policy, with mass mobilization to promote a small family norm and material and social incentives for couples and family planning providers to comply. It also had aimed to make methods of modern contraception widely available, with an emphasis on the IUD, while abortion and menstrual regulation were legal and widely available in the event of contraceptive failure. However, by the early 1990s the extensive primary health care infrastructure through which family planning services were delivered had deteriorated, in part due to the collapse of communal sources of finance. Total fertility rates were declining but the principal method of family planning – the IUD – did not address households' needs for modern, highly effective temporary methods of fertility regulation. The high share of women using less effective traditional methods of family planning led to high rates of abortion.

The Population and Family Health Project (PFHP) was one of the World Bank's early operations in Vietnam with objectives to: (a) improve the quality and range of family planning and related family health services; (b) increase utilization of modern methods of family planning and related health services; (c) enhance the capabilities of the National Committee for Population and Family Planning (NCPFP) in management, planning, and policy formulation; and (d) expand the knowledge base as the basis for policy and technical guidelines. The implementing agency was the NCPFP. The project was a part of a broader effort to support the government's strategies to revitalize the primary health care (PHC) system to improve the health status of the population and bring about a further reduction in fertility and population growth. The project was designed concurrently with a National Health Support Project (NHSP) that also focused on improving PHC, although with a different geographic focus and a greater emphasis on communicable and childhood disease.

The PFHP's design was complex, involving activities at the national level to increase the demand for family planning services and, in 20 provinces, to improve the quality and range of family planning and reproductive health services. In addition to the World Bank, the project had cofinancing from the Asian Development Bank (ADB) and Germany (KfW). There were initial delays in implementation, and with the availability of new information from surveys and studies as well as substantial unanticipated savings to some components, project financing was reallocated after the mid-term review. The most notable among the changes were: a dramatic increase in the number of facilities financed for civil works; financing of additional equipment, including for information campaigns; replacement of "information, education, and communications" for smaller families by "behavior change communication" to improve reproductive health; a new emphasis on the reproductive health of adolescents and on preventing HIV/AIDS; and launching of reproductive health campaigns in poor and more remote areas. The management information system to be developed for the NCPFP at all levels was eventually dropped, however. Leadership of the project management unit (PMU) within the NCPFP and Bank supervision of the Project remained constant throughout the project. The credit was nearly entirely disbursed with only a three-month extension of the completion date.

Project investments to improve the quality of services contributed to increased use of antenatal care and of health facilities for delivery and broader immunization coverage. The reproductive health campaigns and HIV/AIDS activities began to address concerns related to the high prevalence of sexually-transmitted infections. A socially marketed low-dose oral contraceptive, with intensive marketing in urban areas, was successfully introduced. However, while fertility continued to

decline at an unprecedented rate, the percent of women using modern contraceptive methods did not change, the use of oral contraceptives rose only slightly, and resort to less effective traditional family planning methods actually rose. Recourse to abortion and menstrual regulation was unchanged. The project's outcome is rated as moderately satisfactory, institutional development as substantial, sustainability as likely, and overall Bank and Borrower performance as satisfactory.

The PFHP produced lessons for Vietnam and the Bank that may be relevant for lending in countries with similar initial conditions:

- **Efforts to raise contraceptive use and improve method mix need to: (a) take into account pre-existing incentives, sanctions, and targets within the population program that may not be compatible with this objective; and (b) ensure that demand-generating activities and other "software" investments proceed in parallel with efforts to improve physical access**.

- **Population policy and family planning programs in countries undergoing the transition to a market economy need to adapt to the increasing role of the private sector as a service provider.** The potential complementarities and comparative advantages of the public and private sectors need to be exploited, while appropriate regulations and policies need to be put in place to ensure the quality of both.

- **It is critically important that population and reproductive health programs reach out to unmarried young adults, in order to promote highly effective temporary methods of birth control, prevent unwanted pregnancy and recourse to abortion, and prevent HIV/AIDS and other sexually transmitted disease.**

- **The effort to improve institutional performance can be undermined by lack of institutional analysis, weak articulation of institutional objectives, mis-identification of the main constraints for improvement, and omission of appropriate indicators to measure success.** In the PFHP, this affected not only the ability to strengthen capacity of the NCPFP, but also the ability to re-orient the population program toward a reproductive health approach.

- **In order to attribute changes in outcomes to public policy, programs need to document their inputs and outputs over time and to monitor other factors outside of the program that plausibly could account for those outcomes.** Lacking this information for the PFHP, one cannot be certain that continued fertility decline and the increased use of family health services in Vietnam was in fact due to improved service quality, as opposed to increases in education and family income.

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Evaluation

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Currency Equivalents (annual averages)

Currency Unit = Vietnamese Dong (VND)
US$1.00 VND 10,700 (1996)
US$1.00 VND 15,566 (April 2004)

Abbreviations and Acronyms

ADB	Asian Development Bank
AIDS	Acquired immune deficiency syndrome
BCC	Behavioral change and communication
CHC	Commune Health Center
CPR	Contraceptive prevalence rate
DHS	Demographic and Health Survey
EMW	Ever-married women
FP	Family Planning
HIV	Human immunodeficiency virus
ICR	Implementation Completion Report
IDA	International Development Association
IEC	Information, education and communication
IEG	Independent Evaluation Group (formerly Operations Evaluation Department)
IMR	Infant mortality rate
IUD	Intrauterine device
KfW	Kreditanstalt fur Wiederaufbau Entwicklungbank (development bank)
MCH	Maternal and child health
MIS	Management information system
MOH	Ministry of Health
MTR	Mid-Term Review
NCPFP	National Committee on Population and Family Planning
NHSP	National Health Support Project
OC	Oral contraceptives
PEP	Primary education project
PFHP	Population and Family Health Project
PHC	Primary health care
PMU	Project Management Unit
PPMU	Provincial Project Management Unit
PPAR	Project Performance Assessment Report
RH	Reproductive health
SAR	Staff Appraisal Report
SDR	Special Drawing Rights
STD	Sexually transmitted disease
TAR	Total abortion rate
TFGI	The Futures Group International
TFR	Total fertility rate
UNFPA	United Nations Population Fund
VLSS	Vietnam Living Standards Survey

Fiscal Year

Government: July 1 – June 30

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Principal Ratings

	*ICR**	*PPAR*
Outcome	Satisfactory	Moderately Satisfactory
Sustainability	Likely	Likely
Institutional Development Impact	Substantial	Substantial
Bank Performance	Satisfactory	Satisfactory
Borrower Performance	Highly Satisfactory	Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible operational division of the Bank.

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Preface

This is a Project Performance Assessment Report (PPAR) for the Vietnam Population and Family Health Project (PFHP, US$126.9 million). The PFHP was the first World Bank-supported population project in Vietnam. It was approved on January 16, 1996 and became effective on May 24, 1996. It provided financing of SDR 33.6 million (Credit 28070, US$50 million equivalent), with co-financing from the Asian Development Bank (ADB, $41 million) and Kreditanstalt fur Wiederaufbau Entwicklungbank (KfW, $20 million), and a government counterpart contribution of $18.6 million. The credit was closed on September 30, 2003, following a three-month extension of the original closing date, with 99 percent of the credit and 83 percent of the total project funding disbursed.

This PPAR was prepared by Martha Ainsworth, IEG, drawing from a field assessment in May 2005 by Dayl Donaldson, consultant. The findings are based on review of: project files; the end-of-project evaluation; the Implementation Completion Report (ICR) of the World Bank project team; the Project Completion Report of the ADB; published and unpublished literature on population, family planning, reproductive health and development in Vietnam; data from the Demographic and Health Surveys (DHS) and Vietnam Living Standards Surveys (VLSS); and interviews with the project task manager, staff of the Project Management Unit (PMU) in the National Committee for Population, Family and Children (NCPFC) and of the National Health Support Project (NHSP), and representatives of donor and NGO organizations contributing financially and/or technically to the project or to family planning and reproductive health in Vietnam more generally. During the two-week mission to Vietnam, government staff were interviewed and ongoing HIV/AIDS activities launched by the project were observed in Thanh Hoa province; both a Village Health Post and Commune Health Center were visited in Thai Nguyin province. A list of those consulted is in Annex B. IEG would like to express appreciation to those interviewed and to the PMU and World Bank Resident Mission staff who helped make appointments, arranged for translation and transportation, and assembled key documents.

The mission for the PFHP occurred concurrently with a mission to evaluate the Primary Education Project, with an interest in understanding the complementarity of investments in the population and education sectors. The findings from this PPAR will serve as input for a forthcoming IEG evaluation of the World Bank's support for the health, nutrition, and population sector.

Following standard IEG procedures, copies of the draft PPAR were sent to government officials and agencies for their review and comment. These are presented in Annex E. To the extent that IEG is in agreement with any of the comments, they have been taken into account in the final report.

1. Introduction and Background

Government and Bank Development Strategy

1.1 In 1986, Vietnam began an economic reform program, known as *Doi Moi,* and by 1989 was undertaking structural reforms that reduced the budget deficit, current account deficit, and inflation (from 400 percent in 1988 to 5.2 percent in 1993). Exports increased on average by 30 percent per annum. To achieve these measures the government sharply reduced public expenditures and growth in the wages of civil servants. The provision and maintenance of public services suffered as a result.

1.2 As a result of Vietnam's opening and the end of the United States' embargo, the World Bank launched a number of sectoral studies and financed a Vietnam Living Standards Survey (VLSS, 1992-3) to inform policy- and project-based lending. The first IDA credits – primarily focused on infrastructure rehabilitation in productive and social sectors – were approved in 1993. The Country Assistance Strategies of the Bank, dated 1994 and 1995, highlighted five goals of government policy: (i) to maintain macroeconomic stability; (ii) to make a steady transition to an open market economy; (iii) to improve basic infrastructure; (iv) to alleviate poverty and address regional inequalities; and (v) to preserve the nation's natural resource base. By 1998 the Prime Minister and senior leadership of the government had changed and, following the East Asian financial crisis, the government expressed concern about the high social costs of rapid reform, the widening of urban-rural disparities, and that capital-intensive growth was not giving rise to sufficient jobs. The World Bank's strategy shifted to strengthening the linkages between projects and policy dialogue; deepening the focus on poverty, social issues, and integrated rural development; decentralizing management to the Resident Mission; and increasing efforts to aid coordination and move to program lending.

1.3 Over the decade of the 1990s, Vietnam's economy doubled in size and the rate of poverty was halved. The Ninth Party Congress in March 2001 endorsed a 10-year development strategy based on continued transition to a "market economy with a socialist orientation", modernizing the system of governance, increasing openness to the global economy, and heavier investment in rural and lagging regions to ensure pro-poor development. The Comprehensive Poverty Reduction and Growth Strategy provides an "umbrella" under which aid from all sources can be coordinated. The World Bank continues to co-chair the Consultative Group including government, donors and NGOs, and it provides support to the program through a series of Poverty Reduction Support Credits.

Demographic and Family Health Indicators and Trends

1.4 Demographic change in Vietnam is closely linked to economic, environmental, gender, and social considerations. The government first articulated a policy to reduce population growth in 1963 with the Ministry of Health (MOH) in North Vietnam as the main agency for delivering family planning services. In the south of the country, family planning was not promoted until the early 1970s and was still not extensive at the end of the war, in 1975 (NCPFP 2003). Following unification, in 1981 the Council of Ministers at the Fourth

Party Congress set three guidelines: each couple should have only 2 children; children should be spaced 5 years apart; and women should be 22 years old before marrying and having a child. In 1984, the National Committee on Population and Family Planning (NCPFP) was created, with the objective of coordinating all population and family planning activities in the country and implementing nationwide social mobilization to promote family planning. However, delivery of family planning and abortion services remained the responsibility of the MOH. In 1986, the Sixth Party Congress set the goal of reducing population growth to replacement-level fertility by 2005. In 1988, the government officially adopted a "one child or two child" policy, including guidelines on age at first pregnancy, spacing intervals, and associated incentives and disincentives (Goodkind 1995), and it formalized a system of vital events registration with local authorities.

1.5 By 1989, Vietnam was a county of some 64.4 million people, the second most populous country in Southeast Asia after Indonesia and the 14th most populous country in the world. With one of the highest population densities in the world, Vietnam's natural environment faced population-related pressures, such as deforestation, land issues arising from the intensity of rice production, limited availability of national sources of power for electrification and industrialization, and declining water quality. That year, the NCPFP was elevated to being the sole advisory body to the Government on population policy and program development and was also tasked to facilitate intersectoral coordination and conduct population-based studies. By 1993, the NCPFP set up its own nationwide cadre of hamlet-level outreach workers ("collaborators") who received a small allowance plus performance-based incentives for the promotion of family planning, including the distribution of condoms and oral contraceptives.

1.6 By the mid-1990s Vietnam's population was in the process of a rapid demographic transition (Table 1.1). Over the previous decade, the total fertility rate (TFR) fell from 3.98 to 2.67 children per woman.[1] The contraceptive prevalence rate (CPR) among currently married women rose from 54 to 75 percent, including an increase in the use of modern methods from 38 to 55 percent.[2] Child health improved dramatically, due both to rising incomes and the use of antenatal care and maternal and child health (MCH) services. The infant mortality rate (IMR) and low birth weight deliveries declined substantially. As a result, although Vietnam's population grew from 64.4 million to 75.4 million between the 1989 and 1999 censuses, its intercensal population growth rate slowed from 2.1 percent (1979-89) to 1.7 percent (1989-99).

1.7 Despite this demographic success, the total abortion rate (TAR), which is the average number of abortions a woman would have during her lifetime if she experienced current age-specific abortion rates, was among the highest in the world,[3] an indication of high unmet

1. The total fertility rate is the number of children a woman would have over her lifetime if she gave birth at the prevailing age-specific fertility rates.

2. The contraceptive prevalence rate is the percent of women currently using any contraceptive method, including both modern (e.g., pill, condom, IUD, sterilization) and traditional methods (periodic abstinence, withdrawal). The modern method CPR is the percent of women using a modern method.

3. Goodkind (1994) estimated a TAR of 2.5 children per woman for 1992, using the reported number of abortions from the public health system. He assumed the same age distribution of abortions for all provinces as was found in a study of Hanoi

Table 1. Demographic and Health Trends, 1987 – 1997

	1987	1997
Demographic outcomes		
Total fertility rate (TFR)[a]	3.98	2.67
Contraceptive prevalence rate (CPR, percent)	54	75
Prevalence of modern methods (percent)	38	56
MCH utilization and outcomes		
Deliveries for which modern antenatal care was consulted (percent)	55	71
Deliveries occurring at a health facility (percent)	46	62
Births with low birth weight (percent)	14	5
Children receiving at least 2 doses of tetanus toxoid (percent)	40	55
Infant mortality rate (IMR, deaths per 1000 live births)	45	27

Source: Vietnam Demographic and Health Survey (DHS) data, as reported in NCPFP 1999, 2003.
Note: a. The 1997 TFR is an average over the previous five years (e.g., 1992-96)

demand for more effective contraceptive methods. There was an overwhelming reliance on the IUD,[4] yet one in five women were using traditional family planning (FP) methods, like rhythm and withdrawal. The high resort to menstrual regulation (MR) and abortion was a result of the failure of traditional contraceptive methods and unwanted pregnancies.[5]

Structure and Evolution of the Health Sector

1.8 Until the late 1980s health services were provided entirely by the public sector. Health facilities were structured in a pyramid with a Commune Health Center (CHC) at the base providing primary care services, supported by more sophisticated procedures available at district and provincial hospitals. The CHCs depended for their financing on agricultural work brigades, but with the collapse of the communal production system, the availability of funds for infrastructure, equipment, training, and even the salaries of commune health workers dried up (World Bank 2001). The extensive community-based health network, which was in large part responsible for Vietnam's relatively strong health outcomes for a country of its level of income, deteriorated dramatically.

1.9 *Doi Moi* reforms also applied to the health sector. After 1989, user fees were introduced at government hospitals. A decree on decentralized decision-making for state-owned enterprises included those manufacturing pharmaceuticals and condoms. Private medical practice and the commercial sale of medicines, drugs and contraceptives were legalized. The number of private providers, particularly drug outlets and private pharmacies,

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and Thai Binh and then "divid[ed] the resulting age-specific abortion totals by the population from Vietnam's 1989 census, aged forward by three years." (p. 351). This estimate includes reported abortions for all women, irrespective of their marital status. However, there is no TAR calculated in a similar way from service statistics for any subsequent year. The 1997 Demographic and Health Survey (DHS), estimated a TAR over the period 1992-96 of only 0.54, based on reports of a representative sample of *ever-married* women 15-49. While abortions are likely to be under-reported in surveys, this statistic is also lower than expected because never-married women (a third of the population of women 15-49 at that time) were included in the TAR calculation, with an assumption that they had no abortions (A. Cross, personal communication). Neither the 1997 nor the 2002 DHS collected abortion or contraceptive use information on never-married women.

4. Of the overall modern CPR of 56 percent, 38.5 percentage points was accounted for by the IUD.

5. In Vietnam, menstrual regulation (MR) refers to vacuum aspiration less than 6 weeks from the start of the last missed period, while abortion is used for procedures after 6 weeks' gestation (Hien and others 1999).

grew rapidly, quickly outstripping the ability of government to regulate and monitor their quality (World Bank 2001).

1.10 After the fall of the Soviet Union in 1991 and the elimination of contraceptive aid from Eastern countries, the United Nations Population Fund (UNFPA) provided most of Vietnam's contraceptive supply. Vietnam had its own condom production capacity, although there were quality issues. As of 1996, all women had a CHC in their commune and almost 90 percent had IUD insertion services available at their CHC (Behrman and Knowles 1998). However, only 77 percent of women had access to oral contraceptives (OC) at the CHC, ranging from 65 percent among women in the lowest income quintile to 85 percent in the highest quintile. Almost all women (95 percent) had access to OC at the nearest district hospital, but the poorest women lived an average of 20 km away. Only about 65 percent of the poorest women had a pharmacy in their commune, compared with 84 percent of women in the richest income quintile. Availability of OC at pharmacies was low, however, for both the poorest women (25 percent) and the wealthiest (46 percent).[6]

1.11 Aside from the FP services provided by CHCs and district hospitals, mobile units provided FP services in rural areas, including gynecological examinations, IUD insertions, distribution of pills and condoms, and performance of menstrual regulation/abortion and sterilization. By the early 1990s, reliance on the mobile units was declining as each of the district hospitals had a complete family planning unit (World Bank 1992).

2. Project Objectives and Design

2.1 The Population and Family Health Project (PFHP, $127.6 million equivalent, 1996-2003) supported the Government of Vietnam's strategies to strengthen and revitalize the current primary health care (PHC) system and programs in order to improve the health status of the population and bring about a further reduction in fertility and population growth. The project was designed concurrently with a National Health Support Project (NHSP, $127.3 million equivalent, 1996-2006) that also focused on improving PHC, although with a different geographic focus and a greater emphasis on communicable and childhood disease.

2.2 The specific objectives of the PFHP were to:

- increase utilization of family planning and related family health services;
- improve the quality and range of family planning and related family health services;
- enhance NCPFP's management, planning and policy formulation capabilities; and
- expand the knowledge base on which policy and technical guidelines would be founded.

2.3 At the time that the project was approved, it was expected to contribute to lowering the TFR from 2.9 to below 2.5 and the IMR from 40 to 25 and to raise the contraceptive prevalence rate (CPR) for modern methods to 56 percent by 2002. However, the 1997 baseline survey revealed that these had already been reached or nearly reached before the

6. Similar information on the availability of contraceptive supplies, especially temporary methods, at CHCs, district hospitals and pharmacies at the end of the project is not available.

project started. The targets were then revised: the TFR was to decline from 2.7 to 2.1 and the IMR from 28 to 25 per 1,000 live births, by 2002. The revised target for family planning was to raise the modern CPR from 56 to 65 percent. In addition, the share of temporary modern methods (pills, condoms, and injectables) among contraceptive users was to increase from 10 to 25 percent, and the total abortion rate (TAR) decline by 30 percent, from 0.54 to 0.38 (Annex Table D.1).

2.4 Activities were grouped under five components (Box 1). The first component supported strengthening the PHC system at the commune and district levels, particularly MCH and FP service delivery, in 15 (later 20) of the country's 53 provinces.[7] The

Box 1. Population and Family Health Project Components

Provincial Service Delivery (US$ 61.7 million, 49 percent of baseline cost). Provincial PHC service delivery was to be improved in 15 provinces by providing: (a) upgraded facilities; (b) furniture, equipment, and vehicles; (c) essential drugs and supplies; (d) in-service training; and (e) strengthened outreach services. Drugs and medical supplies were to be provided to set up revolving drugs funds, although in mountainous and remote communities they were to be provided at no charge.

Information, Education and Communication (IEC, US$ 12.9 million, 10 percent). IEC programs and activities of the NCPFP, both interpersonal outreach of FP collaborators and mass and print media, were to be strengthened and expanded. A social marketing program for oral contraceptives in urban areas was to be launched through pharmacies in better-off neighborhoods, coupled with community-based door-to-door promotion and resupply program in poor neighborhoods.

Contraceptive Supplies (US$ 24.2 million, 19 percent). This component was to fund the bulk of modern contraceptive commodities for a broadened method mix over the years 1997-2000, including OCs for the social marketing program, but excluding condoms, which were to be financed through the NCPFP budget.

Family Planning Management and Institutional Development (US$ 5.5 million, 4 percent). The management and planning capabilities of the NCPFP and its committee network were to be strengthened through training and the development of a management information system (MIS) that would track changes in project provinces and facilitate strategic planning.

Service Delivery Model Initiatives (US$ 6.0 million, 6 percent). Pilot studies were to be conducted to identify cost-effective approaches for expansion to appropriate areas.[a] Studies were proposed on: (a) strengthening the community-based FP collaborator system; (b) village health posts; (c) private sector support for family planning and reproductive health; (d) user fees for contraceptives; (e) improved approaches to safe motherhood; and (e) improved access for ethnic minorities.

a. Scaling up of successful pilot activities in the PFHP provinces was to be financed through the first component.

provinces were selected based on: their low health and FP status; adequate management capacity; absence of other substantial donor FP assistance; and regional spread. Many provinces were among the poorest and nine had significant ethnic minority populations. The other four components focused on strengthening the family planning program nation-wide.

7. Soon after effectiveness, some of the 15 selected provinces subdivided, resulting in 18 project provinces: Lam Dong, Dong Thap, Thai Nguyen, Bac Kan, Hai Duong, Nam Dinh, Hung Yen, Thua Thien Hue, Lao Cai, Nam Ha, Hai Phong, Dac Lac, Tuyen Quang, Lai Chau, Vinh Long, Thanh Hoa, Tra Vinh and Kien Giang. The NHSP supported a similar package of inputs in 15 (later 16) additional provinces, selected on similar criteria. By 2002, these two projects covered 36 of Vietnam's (then) 61 provinces.

2.5 In designating the NCPFP as the Executing Agency, the project expanded the scope of the NCPFP's activities to include delivery of family planning and reproductive health services, normally provided by the MOH.[8] Average annual levels of project funding (US$ 18.5 million) added about 40 percent to the NCPFP's estimated budget of US$ 45.6 million in 1996 from government sources. Implementation was managed by a Project Management Unit (PMU), consisting of a Project Director, a Deputy Director seconded from the MOH, and 13 other staff. Provincial Project Management Units (PPMUs) managed project implementation in the provinces participating in the first component. Oversight was provided by an inter-ministerial Project Steering Committee with representatives of the PMU, MOH, Ministry of Planning and Investment, Ministry of Administrative Services, and Ministry of Human Resources Development.

2.6 The project received technical and financial contributions of three donors – the Bank, ADB, and KfW. There were 7 preparation and appraisal missions over a period of 25 months. Project planning meetings were conducted at the provincial level, a facilities survey was fielded in 5 provinces, and consultant input was supported by a Population and Human Resources Development grant. The project became effective on May 24, 1996.

2.7 It is striking that the project design did not explicitly address the strong incentives embedded in Vietnam's population policy, given that these factors that could potentially affect the success of efforts to expand method mix and support contraceptive choice.[9] The Staff Appraisal Report (SAR) notes that among the strategies necessary to reach the objective of voluntary participation, freedom of choice, and a reproductive health approach, are "improved remuneration, training, and working conditions for collaborators and motivators, coupled with a gradual phasing-out of incentives" (World Bank 1995, p. 16). However, there is no evidence that the Bank entered into any policy dialogue with government on the issue of targets, incentives, or provider remuneration in conjunction with this project, nor are these policies addressed in the assessment of risks or in any of the covenants or agreements.

3. Implementation

3.1 The PFHP made significant up-front investments in training project staff in Bank processing procedures at the outset, to avoid the extensive delays experienced with the earlier approved Primary Education Project (PEP). However, even with this training the project had

8. The NHSP financed a substantially similar set of family health services in 16 additional provinces through the MOH.

9. The Staff Appraisal Report (SAR) notes, for example, that contracts between the MOH and the NCPFP typically specify targets to be achieved by the service providers, in terms of "numbers of acceptors for a given method or of different types of procedures to be performed annually" and that the budget is calculated based on these targets. It also notes that the NCPFP and CPFP network at sub-national levels include "incentives for adoption of a method (paid to both acceptors and the collaborators who motivate them)" (p. 12). This is not to suggest that the fertility reduction objectives of the population program are inappropriate, but rather that to the extent that these incentives or targets favor more permanent, highly effective methods (like the IUD or sterilization), they are not likely to be conducive to greater use of temporary modern methods by women who have not yet started a family or who are spacing births. A 1999 report by WHO, other UN agencies and the Bank suggested that the remuneration system for abortion providers at that time created an incentive for unnecessary procedures (Hien and others 1999).

an overly ambitious disbursement schedule. The complexity of the project (which grew over time as savings were reallocated), high staff turnover in the PMU, and over-estimation of the costs of some activities also contributed to lower than anticipated disbursement rates at the outset. At the time of the mid-term review (MTR) in December 1999, 11.8 percent of the credit had been disbursed and about half had been committed. However, disbursements were more rapid during the second half of the project, and it closed on September 30, 2003, with only a 3-month extension. Ultimately, 99.3 percent of the IDA credit and 83.0 percent of the original project budget in US dollars were disbursed.[10]

3.2 Substantial savings were experienced in some components, which provided an opportunity to reallocate resources and expand the scope (and complexity) of activities. Competitive bidding dramatically reduced the costs of civil works, furniture and equipment.[11] Further, following the initial procurement of essential drugs, it was found that CHCs already had adequate supplies, releasing roughly $10 million for other activities.

3.3 There were also developments in government policy that shaped the activities actually implemented. First, population and FP policy shifted from a family size limitation approach, emphasizing IEC for smaller families, to a behavior change communication (BCC) approach, promoting FP and reproductive health (Socialist Republic of Vietnam 2000). Second, concern was mounting about the need to thwart the rapidly spreading HIV/AIDS epidemic by integrating HIV/AIDS prevention into the population program and health system. Third, following severe flooding, in April 1998 the government requested that the provinces of Bac Lieu and Ca Mau, at the far southern tip of the country, be added, raising the number of "project provinces" to 20, from the original 15-18.

3.4 As a result, although the objectives of the PHFP remained unchanged:[12]

- About 60 percent more CHCs were upgraded than planned and 12 provincial education centers were built, though the latter had not been planned in the project design. Ninety-two village health posts were constructed on a pilot basis.[13]
- Communications equipment and vehicles, not originally planned, were financed at the province, district, and commune levels in both project and non-project provinces.
- An integrated package of investments in IEC and supervision systems was introduced at the district level in the 36 provinces supported by the PFHP and the NHSP, as well as additional equipment for district hospitals, including anesthesia, ultra-sound and X-ray machines.[14]

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10. The final disbursement in dollars was lower than planned largely because the IDA credit was denominated in SDR and the dollar appreciated against the SDR over the lifetime of the project. Thus, the available budget in US dollars was lower than the amount at appraisal.

11. This also might have been anticipated by the time that the PFHP was approved, based on the experience of the PEP.

12. See Annex C for a detailed list of planned and actual expenditures and commodities.

13. The SAR advocated construction of a maximum of 440 health posts, assuming that the model was found to be sustainable by the activities of the fourth component.

14. The district package was to be based on the re-oriented government population policy that included family planning, safe motherhood, RTI/STD/HIV prevention, safe abortion and information and counseling.

- IEC was replaced by BCC,[15] and a new activity aimed at adolescents –family and reproductive health education in upper secondary schools (grades 10-12) – was added for the 36 PFHP and NHSP provinces, albeit late in the project (2002-3), building on curricula development supported by UNFPA.
- The project, initially relying solely on government funds for condoms, spent $2-3 million on additional condom procurement toward the end of the project in anticipation of future unmet need, for free distribution to the provinces.
- Roughly $1.5 million from the studies component was allocated to support local responses to HIV/AIDS in seven provinces with 33 cities. This was intended to be an investment in learning more about local conditions and constraints, as the basis for planning future culturally appropriate, larger scale efforts to prevent HIV. [16]

3.5 Eight "service delivery model initiatives" were piloted, most for less than $400,000 each (see Annex Table C.6). However, twice the planned amount was spent on the component because of a single activity – the "Campaign on Reproductive Health Services for Disadvantaged Areas". These campaigns provided FP/RH counseling and services, antenatal services, gynecological examinations and treatment of STIs. A total of five rounds of this campaign were launched from October 2000 – September 2002 over most of the country.[17] Far from being a "pilot", the campaign was effectively one of the major activities of the project to increase outreach of reproductive health services to remote areas.

3.6 Because of the decision to discontinue drug procurement, only 17 percent of the budgeted amount for essential drugs was expended, releasing about 15 percent of the total project budget for reallocation. This and other savings resulted in expending twice as much on service delivery models as was planned, and more than twice the budgeted amount for furnishings, equipment, and vehicles.

3.7 The activities addressing the supply and demand for FP and reproductive health services were not implemented in parallel. Most of the improvements in infrastructure were completed by 2001. The efforts to raise demand did not occur until the end of the project. There was one spurt of IEC activity in 1999. The RH campaign in underserved areas was

15. Specific BCC activities introduced at the mid-term review included: developing management capacity for BCC at the national and provincial levels; BCC research; development of client-centered counseling skills in 36 provinces; two national campaigns, one for married couples and one for adolescents and unmarried adults, with mass media and provincial-level market-segmented approaches.

16. The seven provinces were Binh Duong, Soc Trang, Binh Phuoc, Long An, Thanh Hoa, Nghe An, and Ha Tinh. The three stated objectives of these activities were: (a) to increase awareness and full ownership of the local risks of HIV/AIDS among local political leaders; (b) to create basic technical capacity in the provincial health service; and (c) to demonstrate key elements of effective community actions to reduce vulnerability and risk to HIV infection. The activities, including IEC and peer educators, diagnosis and treatment of STDs and serological and behavioral surveillance, particularly of sex workers and their clients, paralleled those financed by a $3-million, 3-year ADB pilot community-based HIV/AIDS prevention project in five provinces that focused on "hot spots" of high-risk activity financed by the Japanese Poverty Reduction Fund.

17. They were carried out in five stages, reaching 5,541 communes in 54 provinces in the first two stages, 4,702 communes in 57 provinces in the third stage, and 8,064 communes in all 61 provinces in the fourth and fifth stages.

launched in 2000-2002. The BCC program was not launched until 2003 (*after* the second DHS to evaluate the project).[18]

3.8 The baseline survey for the PFHP – a national Demographic and Health Survey (DHS) – was conducted in July-October 1997, more than a year after the project became effective. The results were not published until February 1999, shortly before the MTR, at which time it was learned that many of the project's outcome targets had been reached or nearly reached before the project's launch. New targets were adopted (though not all were defined).

4. Outcomes by Objective

4.1 In assessing the contribution of the PFHP to population and family health outcomes, it is important to recognize the possible influence of other contemporaneous developments. Over the period 1993-2002, per capita income grew by 5.9 percent per year, halving the poverty rate, from 58 to 29 percent (ADB and others 2003). Between 1991 and 2002, State Budget health spending per capita more then tripled, from VND 20,000 to VND 64,000 in real terms.[19] This understates the increase in government health spending, however, because the share financed by the central government declined from about 35-40 percent in the mid-1990s to 25 percent in 2002. Over the four-year period 1998-2002, the gross enrollment rate in lower secondary school rose from 62 to 72 percent and the share of workers earning a wage rose from 19 to 30 percent. The demographic transition was already underway, and Vietnam's continuing socio-economic transition, in terms of rising female education and labor force participation and declining poverty, surely influenced the demand for children, FP/RH and family health services.

4.2 Vietnam's demographic transition continued over the course of the PFHP. Between 1997 and 2002, the TFR declined from 2.67 to 1.87 children per woman – below replacement level (see Figure1a). Considering the already relative low level of fertility in Vietnam, the rapid fertility decline in the first half of the 1990s, and compared with other countries, the VDHS Final Report concluded that the country's rate of fertility decline was "unprecedented". The infant mortality rate also declined dramatically, from 28.2 to 18.2 per thousand, although the confidence intervals around both statistics are sufficiently large that this drop is not statistically significant (Figure 1b).[20]

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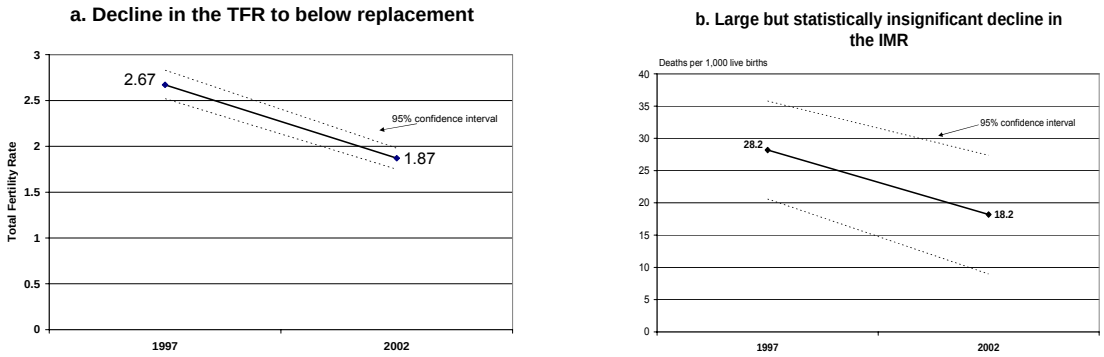
18. A new Director of the IEC Department was appointed in 2002. The major substantive shift to combining reproductive health and family planning messages and targeting audiences with specific messages was not adopted until that time. It was not possible for the end-of-project evaluation to assess the impact of the new BCC strategy on demand generation given that it was implemented so late in the project.

19. Socialist Republic of Vietnam and World Bank 2005, p. 57. The increase in per capita spending is in constant 1994 terms. From 1991-2002, State Budget spending on health rose from 1 to 1.6 percent of GDP and from 6 to 6.5 percent of the overall budget. Other important developments in the health sector included shift of payment of CHC workers from commune to the state and a dramatic expansion in privately-provided health care, including private pharmacies and drug vendors. Government attempted to increase the posting of medical doctors at CHCs, although IEG could not document the extent to which this effort succeeded.

20. Trends in key demographic and service utilization outcomes from 1997-2002 for which confidence intervals were calculated, are in Annex Table D.3. The 2002 DHS Final Report admits that the IMR estimate of 18.2 deaths per thousand live births is much lower than would have been predicted and that the true number is probably somewhat higher.

Figure 1. Vietnam's continued demographic transition, 1997-2002



4.3 The PFHP set demographic targets that were exceeded, but there were many changes in Vietnam's economy and society beyond the project outputs that could have brought this about. Improved quality and availability of FP/RH services and other outputs of the PFHP – both national and in the project provinces – may have contributed. However, given that the project provinces were not randomly selected, that similar FP/RH services were being financed by the NHSP and the government in all of the non-project provinces, and that many of the PFHP interventions were national in scope, [21] there is no simple or straightforward way of attributing even that part of demographic change to improved quality and range of FP/FH services or better IEC due to *this* project. Thus, in this section we review the evidence that each of the project's four objectives were achieved and that the achievements plausibly could be attributed to these *collective* efforts, particularly for the first and second project objectives of improving the quality and range of FP/RH services and increasing utilization of these services. Did these efforts raise the share of modern family planning methods, reduce traditional methods and the number of abortions? The evidence for achievement of the third and fourth objectives of improving NCPFP management and the knowledge base, respectively, are more easily linked to specific PFHP investments.

Improve the Quality and Range of FP/RH Services

4.4 The project made substantial investments, mainly through the first component, in improving the quality and range of FP/RH services in the 20 PFHP provinces, although it also financed some of these investments (training, equipment) in the 16 NHSP provinces. The quality and range of FP/RH services at the end of the project were relatively high, and

21. The NHSP financed a package of services that included communicable disease control, MCH, FP/RH, and other basic care, for example, in 16 provinces. According to the Final Evaluation Report, the government population budget per capita was 65 percent higher and the government health budget 54 percent higher in the non-PFHP provinces. Including the value of PFHP investments, total spending was still 21 percent higher in non-PFHP provinces, and this appears to exclude resources expended by the NHSP (TFGI and others 2003, pp. 30-31).

sometimes higher than in non-PHFP provinces, according to the Final Evaluation report (TFGI and others 2003):[22]

- An exemplar sub-set of the FP/RH/MCH *equipment* provided by the project was available at over 90 percent of CHCs in project provinces.[23] This generally matched the availability of the same items in non-project provinces, with the exception of infant and adult scales and pelvic rulers.
- Over 90 percent of workers in project provinces received *training* in 10 of 16 topics. In all 16 subjects a higher percent of workers in project provinces had received training within the past 5 years (Figure 2).[24] The extent of training in counseling on FP generally and on specific methods in both project and non-project provinces is particularly significant, as the concept of counseling as part of FP/RH services was uncommon in Vietnam prior to the launch of the project.
- As of the end of the project, the share of CHCs in PFHP provinces having each of 20 essential *drugs* in stock usually equaled or exceeded the share in non-project provinces. Over 80 percent of CHCs in project provinces had 12 of the 20 drugs, and over 90 percent of the CHCs had 7 of the 20 drugs. However, no specific essential drug was available at all CHCs.[25]

4.5 While it is likely that these represented *improvements over time* in the quality and range of publicly provided FP/RH services in both the project and non-project provinces, the magnitude of the improvement has not been systematically assessed.[26] The availability at CHCs of effective modern methods – the pill, the condom, and injectables – was not tabulated in the DHS final report or in the end-of-project evaluation. There is some evidence from the DHS of improved availability of the pill and condom in rural areas of PFHP

22. The Final Evaluation Report undertook a comparison of results in 2003 for 5 project provinces matched to 5 non-project provinces in the same regions. Comparisons in the DHS final reports, however, are for all project and all non-project provinces.

23. Surveyed items available at fewer than 60 percent of project CHCs were ENT equipment sets, microscopes, refrigerators and telephones – although these had not been included as part of the project's standard equipment. Communal leaders complained, however, that the electrical dryer for dry sterilization was too power consuming for a CHC with limited budget for electricity and too large for the capacity of the communal electrical system. This raises questions about whether the ability of CHCs to conduct more sophisticated procedures was accompanied by adequate means to reduce iatrogenic infections.

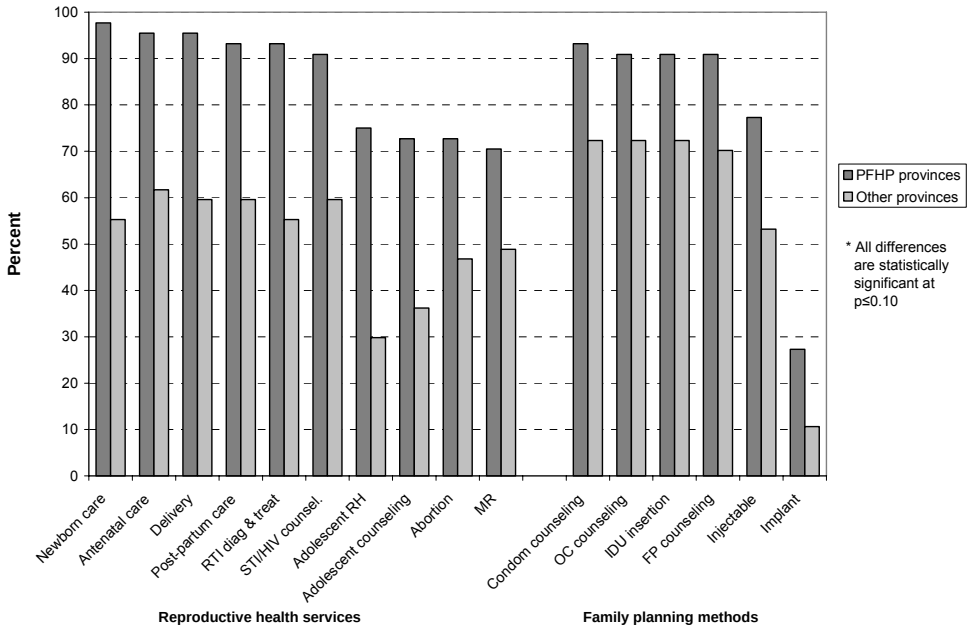
24. The training assessment scores of CHC RH staff in project provinces were not statistically different than for staff in non-project provinces, however, according to the end-of-project evaluation. Information about the initial levels of subject mastery by the PFHP and non-project groups is not available, although the fact that the PFHP provinces are considered more disadvantaged is a consideration. Areas of weakness in clinical knowledge in all provinces in the end-of-project evaluation included: (a) clients' RH rights; (b) condom use demonstration; (c) abnormal delivery scenarios; (d) abortion services; (e) STI counseling; (f) treatment of cervicitis and vaginal candida; and (g) syndromic treatment of STIs. Low scores for counseling were attributed by the Training Management Committee to the low value trainers gave to counseling. The questions on STI treatment were based on newly developed standards that had not been disseminated to the local level.

25. The PFHP provided only an initial procurement of essential drugs to the project provinces; it is plausible that the training provided by project resources contributed to better management of drug stocks in these CHCs, but there is no evidence that this was a result of the project.

26. Neither the Final Evaluation Report, nor the ICR presented an analysis of changes in quality of services over time, although such an analysis would have been possible using the results from the health facility surveys in both the 1997 and 2002 DHSs. Instead, both evaluations drew almost exclusively on evidence from a single round of the National Health Survey (NHS), conducted in 2002.

provinces from FP fieldworkers, and of better availability of pills and injectables from mobile FP clinics in both project and non-project areas from 1997 to 2002 (see Annex Table C.4).[27]

Figure 2. Percent of FP/RH workers who received at least one training in the past 5 years, by subject and province grouping*



Source: TFGI and others 2003.

4.6 The project supported social marketing of the first low-dose OC, *New Choice*, nationwide, with an emphasis on urban markets.[28] While OC had been socially marketed in Vietnam by DKT International since mid-1995, DKT was contracted by NCPFP to develop a brand name and social marketing campaign for an OC to be priced substantially below the prices of those available in private pharmacies in Vietnam. The social marketing program discontinued the previous brand, *Choice*, at the end of 1999, and *New Choice* replaced it nationally in January 2000. It was first marketed in Danang, Hanoi, and Ho Ch Minh City in 2000. The subsidized price was VND 1,000 per cycle, considerably below the prices of other commercially available products of up to VND 50,000 per cycle. In 2004, the marketing of *New Choice* was extended to Hai Phong. These efforts likely improved the access of urban married and unmarried women to a highly effective and temporary method of birth control, with the potential to reduce recourse to abortion. Although the price of *New Choice* doubled to VND 2,000, sales of OC increased over 50 percent from 1.9 to 3.2 million cycles.

4.7 Finally, the civil works financed by the project substantially improved the physical quality of 55 to 92 percent of CHCs in 75 percent of the communes in the 20 project

27. Access to mobile clinics declined in rural areas during the project, though this may represent a substitution of CHC for mobile FP services.

28.The DKT social marketing program provides OCs over the counter, without need for a doctor's prescription.

provinces, and from 78 to 92 percent of the CHCs in mountainous areas (TFGI and others 2003). However, there were shortcomings in the design of the CHCs noted by community leaders and health workers in the end-of-project evaluation: (a) the procedure room, used for clinical family planning and gynecological services is too small; (b) there is no separate room for injections or examinations or for retained patients who need to stay at the CHC; and (c) the roofs are too low for sufficient ventilation and often leak. The national standard for CHCs issued in 2002, after the PFHP civil works were completed, requires 8-9 rooms with a floor area of at least 90 m^2, while the CHCs renovated by the project have 5-7 rooms and an area of only 70m^2 (TFGI and others 2003, p. 39).[29]

Increase the Use of Family Health and FP Services

4.8 Over the period 1993-98, during which time much was invested in improving the physical quality of CHCs, the annualized contact rate of the population with CHC staff rose from a level that was 60 percent of the contact rate for public hospitals to near equality – 0.57 annual contacts, compared to 0.60 for public hospitals (see Annex Table D.5). Analysis of the 1992/93 and 1997/98 Vietnam Living Standards Survey (VLSS) found that CHCs are far more likely to be used by the poor and that as incomes rise (as they did over this period), use of public hospitals increases (Trivedi 2004). Thus, the relative increase in contact rates for CHCs compared to hospitals signals relatively greater utilization by the poor by 1997/98 of services supported by the PFHP, the NHSP and other government programs.[30]

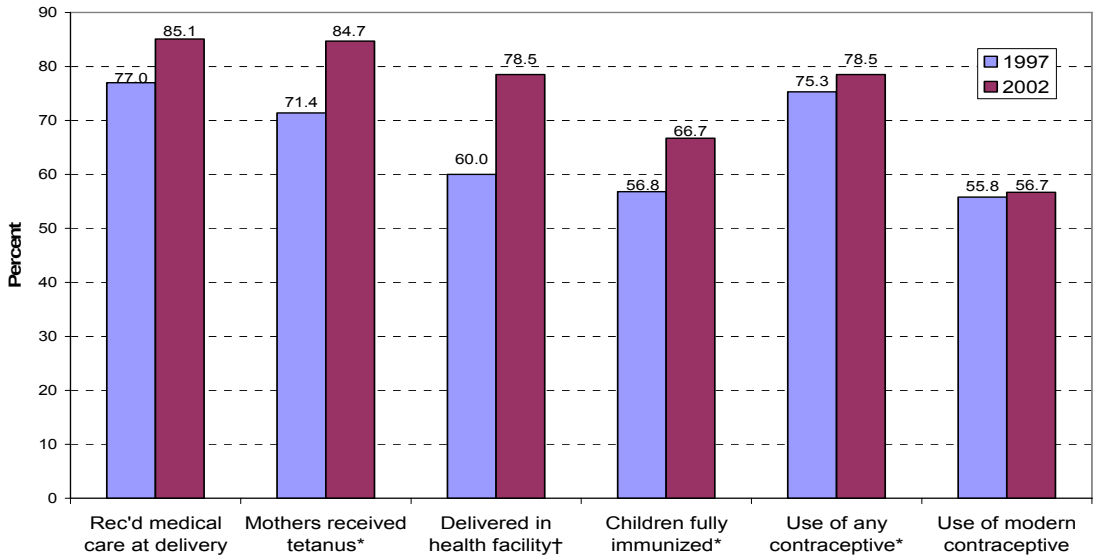
4.9 Use of a number of specific family health services increased over the life of the project: the share of women receiving tetanus and of children fully immunized, the share of deliveries in a health center, and the share of women receiving medical care at birth all increased (see Figure 3). Though the project did not provide inputs to the immunization program, the improvement in the quality of health infrastructure supported by the project and any increase in the number of physicians posted to CHCs by government may have supported the observed increases in use of family health services provided through CHCs.

4.10 In contrast, the anticipated outcomes for contraceptive use among currently married women were by and large not realized. The CPR rose about 3 percentage points (from 75.3 to 78.5 percent, statistically significant), which is remarkable given the already high percentage of women using contraception at the start of the project. However, the CPR for modern methods was unchanged, at roughly 56 percent, and the goal of increasing short-term, highly-effective supply-based contraceptive methods to 25 percent was not met. Use of the pill rose modestly from 4 to 6 percent, though this was not statistically significant, but so did use of less effective traditional methods, from 19 to 22 percent (see Annex Table D.6).

29. In a few communes, the PFHP CHCs were as large as 95m2. The procedure room of the upgraded CHCs was only 10m2, compared with the new standard of 16m2. Complaints about the small size of the CHCs were most frequent in heavily populated communes, while less frequent in remote areas (TFGI and others 2003).

30. Unfortunately, comparable data for 2003, the end of the project, are not available. The contact rates for 1992/93 were 0.19 for CHCs and 0.32 for public hospitals, but the data from the two surveys are not strictly comparable. The 1997/98 survey had a less restrictive question to capture more contacts. See the footnote to Annex Table D.5.

Figure 3. Use of family health services increased among married women, but not modern contraceptive use



Notes: * Increase is statistically significant. † Statistical significance not computed.

Source: DHS Final Reports 1997, 2002.

The small absolute increases in pill use nevertheless were observed among married women in both urban and rural areas and particularly among women 20-29. For both urban women and women 20-24, there was evidence of modest substitution of pills and/or condoms for IUDs, reflecting greater choice for some women, which was an objective of the PFHP. It is also notable that the CPR for rural women rose from 74 to 78 percent, almost reaching the same level as in urban areas (79 percent). Women 20-24 also raised their all-method CPR (from 55 to 58 percent). However, for both of these groups the increase in the CPR can be largely accounted for by increased use of traditional methods. One of the objectives of promoting the pill was to reduce the substantial reliance on traditional methods, which have a high failure rate. Yet recourse to them continued to rise and the overall use of modern methods was flat in almost all cases.[31]

4.11 Given the continued high recourse to traditional family planning methods, it is perhaps not surprising that the abortion rate (including both abortion and menstrual regulation, or MR) for *ever-married women* was also constant over the life of the project (Annex Table D.7).[32] Eighty-five percent of women undergoing a pregnancy termination

31. Annex Table D.6 also shows evidence of substitution of the pill and female sterilization for the IUD within project provinces (although with no change in the modern method or total CPR). However, the number of project provinces increased over the life of the project, from 15 to 20. Three of the original provinces were sub-divided, but two others were new, so the results for "project provinces" are not strictly comparable over time.

32. The Staff Appraisal Report proposed monitoring the "Total Abortion Rate" (TAR), which is the number of abortions and MRs that a woman would have in her lifetime if she had them at the current age specific rates over her entire reproductive lifetime. However, the two DHS did not collect data on unmarried women. To calculate the TAR they added never-married

previously were using a traditional method of contraception or no method. However, the share of induced abortions among all procedures declined from 38 percent to 21 percent and the share of MR increased. This pattern would be consistent with an improvement in services at CHCs (where MRs can be performed if staff have been trained to do so, but not later-term procedures), leading women to seek services earlier at the CHC rather than later at public hospitals.[33] While the total number of procedures was unchanged, a substantial share of MRs – 18 percent of them in a study of rural Thai Binh province – are performed on women who are not actually pregnant (Vach and others 1998).[34] Thus, with the relative increase in MR, the number of actual pregnancy terminations in ever married women may have declined. However, unless pregnancy tests have come into greater use, this would also imply that an even greater number of procedures was being performed on women who are not pregnant.

4.12 What can account for the modest results for the pill, continued high resort to the IUD, stagnation in the modern method CPR and the abortion rate, and the increase in traditional methods?

4.13 One hypothesis is that the demand-generating activities occurred too late in the project to register an impact, and/or that the project under-estimated the influence of entrenched provider attitudes and incentives. Previous studies suggested that supplies of the pill and condoms were not the binding constraint to raising their use (Knodel and others 1995). Rather, there was a need for a re-orientation of provider information, attitudes, and incentives to provide better counseling and freer choice, to emphasize less family size and more reproductive health, and to better inform consumers of the advantages of these other methods. However, the PFHP focused first on the supply side and only on the demand side much later. The population education program in upper secondary schools was implemented in 2002-3 and BCC was not introduced until March-June 2003, *after* the final DHS survey (TFGI and others 2003). Trends in the sale of socially marketed condoms and pills support this hypothesis (see Figure 4). Over the life of the project, condom sales increased steadily though not as rapidly, while pill sales were fairly flat, on average. But there was a surge in the sale of both methods the year after the launch of the BCC campaign in 2003, especially sales of the pill. The results might also suggest that entrenched provider attitudes are difficult to change quickly and/or that within the decentralized family planning infrastructure there are still pressures, targets, or provider and client incentives that operate against the new

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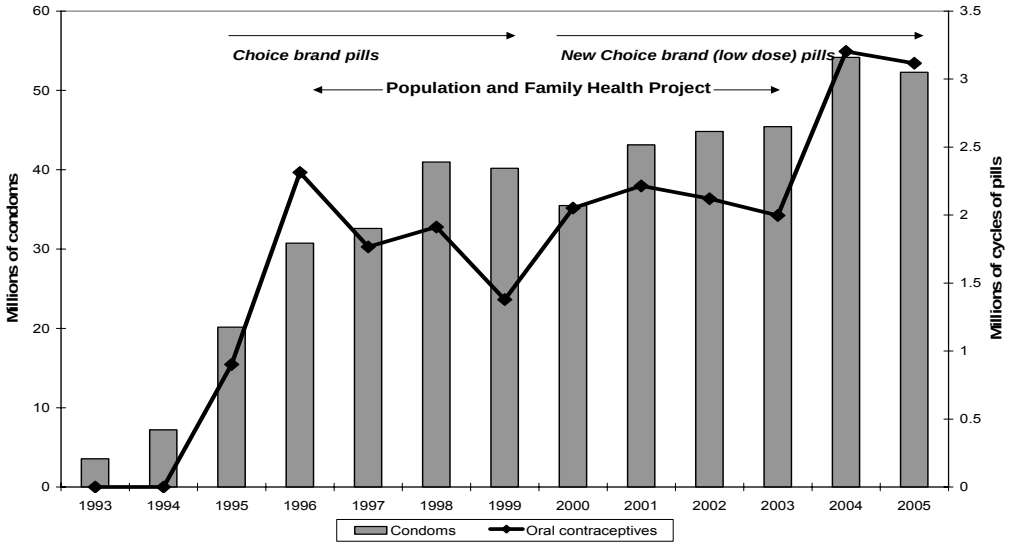
women to the denominator, assuming that they had *no* abortions or MR. This results in an underestimate of the true TAR, but even more important, it distorts any trend because the TAR will be affected by the share of never-married women in the population. Between 1997 and 2002, this share of never-married women actually decreased, from 33.5 to 32.0 percent. Thus, the increase in the TAR reported in the DHS is in part due to a larger share of ever-married women in 2002. A more accurate indicator of the trend among ever-married women would be the annual abortion rate per 1,000 ever-married women (TFGI and others 2003).

33. However, between 1997 and 2000, the share of procedures for which a health problem was reported rose from 33 to 48 percent, and the increase in health problems was particularly great for MRs (29 to 47 percent, Annex Table D.8). This could indicate that practitioners need additional training on sterile procedures. The share of those reporting a procedure and who sought medical advice or treatment increased dramatically, from 17 to 69 percent, but the sample size is small. This could indicate an increase in serious complications or, alternatively, better counseling of clients and greater access to health care. This is an area warranting urgent analysis.

34. A study in Cao Bang and Ninh Binh provinces in 2000 found that more than 90 percent of women presenting for abortions or MR are not given pregnancy tests (Anh and Dzung 2002).

approach. The final evaluation report attributed the lack of change in method mix to continued high commitment by providers to the IUD.

Figure 4. Trends in the sale of socially marketed contraceptives, DKT international



Source: DKT International.

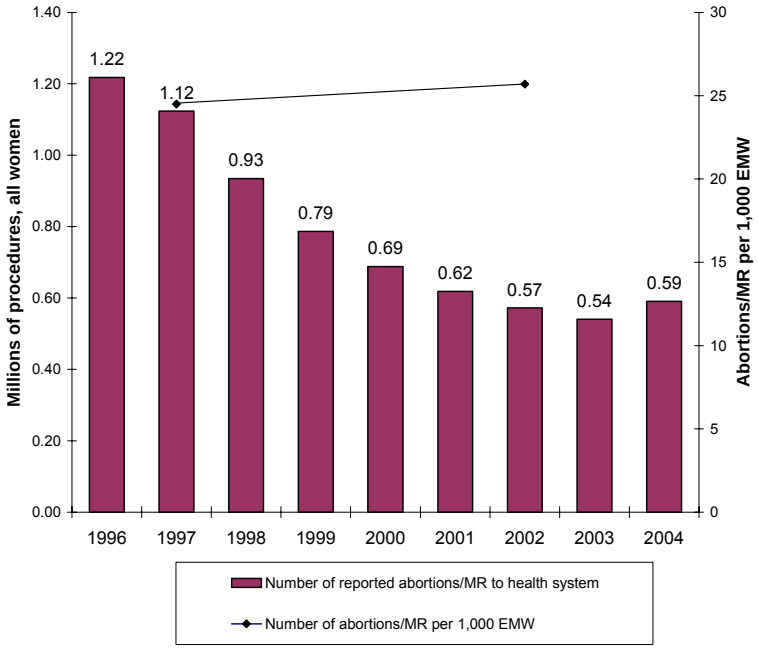
4.14 A second hypothesis is that some of the impact of the project has been missed because contraceptive use and abortion were not monitored among *unmarried women*, who were roughly a third of all women 15-49 in both DHSs.[35] A recent survey of premarital sexual activity among individuals married during three different time periods – 1963-71, 1977-85, and 1992-2000 – showed clear increases over time in the percent of men and women engaging in pre-marital sex, in seven provinces in the Red River Delta and six provinces and Ho Chi Minh City in the Mekong Delta (Ghuman and others 2005). In the Red River Delta, premarital sex among men rose from 7 to 13 to 31 percent in these three cohorts, reaching levels in the Mekong Delta. Among women, they rose from 0.5 to 12 percent in the Red River Delta and from 3 to 8 percent in the Mekong Delta between the first and last cohort. Unfortunately, there are no trend data on sexual behavior among the unmarried over the life of the project. A survey of adolescent behavior conducted in 1999 in six provinces found that 10 percent of males and 5 percent of females age 15-22 had engaged in premarital sex before the age of 21 (Mensch and others 2003). In Lai Chau, Quang Ninh, and Kien Giang provinces, the figure for young women was 8-9 percent. More recently, a survey of young adults 15-24 in Gialam, a suburb of Hanoi, found that 17.1 percent of males and 4.5 percent of females had ahd premarital sex (Le and others 2006). This is a group with potentially high demand for effective yet reversible modern methods,

35. Indeed, in 2002, 96 percent of women 15-19 and 52 percent of women 20-24 were unmarried. None of the previous demographic surveys (1988 DHS, 1992/93 LSS, 1997/98 LSS, 1994 Inter-Censal Demographic Survey, ICDS) collected contraceptive use for never-married women.

like the pill, and for whom contraceptive failure is highly likely to lead to MR or abortion. Estimates of the percentage of abortions and MR accounted for by unmarried women range from 10-30 percent, but the true level is uncertain because social stigma often leads unmarried women to lie about their marital status (Goodkind 1994, DHS Final Report 2002).

4.15 If one impact of the project was to raise modern contraceptive use among unmarried couples, we might expect to see a decline in abortions and MR in that group. Indeed, the number of abortions and MR reported from the public health system for all women (married and unmarried) declined by half over the life of the PFHP, in contrast to the constant abortion/MR rate for ever-married women (EMW, see Figure 5). The results are not definitive evidence of a decline in abortion/MR among never-married women, however, since a switch in demand from public to private providers of abortion and MR would produce a similar effect.[36]

Figure 5. Decline in reported abortions in the public health system (all women), but constant self-reported abortion rate among ever-married women



Source: Reported abortions in the public health system: Health Statistics Yearbooks, 1996-2004, and as reported in Nghia and Khe 2001. Abortion/MR rate per 1,000 ever-married women: authors' calculations based on DHS data, as reported in Annex Table D.7.

36. Unfortunately, the DHS did not ask women where obtained an abortion or MR, so it is not possible to assess the extent to which this decline represents a switch to private providers. Another factor that could lead to this decline in public sector abortions is increased use of emergency contraception, which is available in pharmacies.

Enhance the NCPFP's Management, Planning, and Policy Formulation Capabilities

4.16 The project aimed to strengthen the management, planning and policy formulation skills of the staff of the NCPFP and its provincial, district, and commune committees primarily through improved training of staff and implementation of a Management Information System (MIS) to monitor activities.

4.17 It is difficult to assess the extent to which this objective was achieved.[37] There were no baseline measurements taken of NCPFP management capacities at any level. The indicator proposed in the SAR – a 13-point "management information score" – was never constructed and in any event focused only on monitoring of deliverables, not management capacity (World Bank 1995, p. 82-83).

- By the time of the MTR, management training had been provided to 10,000 commune-level population workers and 1,200 district population staff.[38] The Final Evaluation Report notes that planning capacity at the national and provincial level improved steadily over the life of the project, with provincial plans "increasingly more practical and better tailored to the needs of the individual provinces." (TFGI and others 2003, p. 20). However, district-level planning capacity was not much affected.

- One of the major vehicles for improving management and planning – the MIS – was never implemented. Thus, to the extent that management and planning capacity improved, it cannot be attributed to the project's MIS.

- Evidence that management improved decision-making through the use of information generated by monitoring and evaluation activities – notably the two national DHSs as well as the evaluations of many individual project activities – is weak.[39] The 1997 DHS "baseline" results were not available until the MTR. They were used to define the baseline and targets. It is not clear whether other information from the survey fed into programmatic decision-making. The 2002 DHS was conducted with enough lead time to use for project evaluation purposes a year later, so was not timed to help fine-tune the program. A planned mid-term survey was not conducted. The "Campaign on Reproductive Health Services for Disadvantaged Areas" was expanded nationwide before it was evaluated – a missed opportunity to learn and improve.

- The Final Evaluation Report highlights improvements in NCPFP capacity to conduct and use research results, but notes that: "the PMU was challenged by poor capacity among PPMU staff to define their research needs."(p. 18)

37. The performance of the PMU – which is not included in the assessment of this objective – is discussed in the "Borrower's performance" section of the ratings.

38. The coverage of these training programs is not documented in the Final Evaluation Report, nor are results presented to document their effectiveness.

39. According to TFGI and others (2003), evaluations were conducted of: the impact of IEC on targeted population groups; health care training activities; the national AIDS program; training activities for local population and family planning staff; and the reproductive health services campaign for difficult areas.

- There is very little evidence to document improvement in strategy development over the life of the project. The initial emphasis was on service delivery, not on strategy, and there were major difficulties in obtaining the expertise to develop and implement the new BCC strategy, leading to its adoption very late in the project.

Expand the Knowledge Base for Policy/Technical Guidelines

4.18 The PFHP significantly expanded the knowledge base for improving policy and developing technical guidelines, particularly with respect to the two national demographic surveys and the community-based HIV/AIDS prevention activity launched toward the end of the project. Pilot studies were carried out in all of the areas indicated in the SAR, most costing less than $0.4 million. The NCPFP did not find them to be sufficiently cost-effective to scale-up to the provincial level, but understanding what doesn't work does expand the knowledge base.[40] So the knowledge based was in fact expanded by these efforts. However, there is a compelling and urgent need for deeper analysis of existing demographic and FP/RH data and improved technical design of action-oriented research.

4.19 The 1997 and 2002 DHS provided essential information on demographic trends – which were found to be changing more rapidly than expected – and the continued high persistence of abortion and traditional methods. A major shortcoming is that the surveys neglected to collect information on unmarried women, who constituted a third of women of reproductive age and a group that was greatly influenced by rapid social and economic changes. The omission of recording whether women sought abortions from public or private providers also limited its usefulness in assessing trends and policy actions. The data could also have been mined in greater depth to assess the relation between increased availability and quality of services and their use, particularly among the poor. There has been scant analysis of the impact of increased availability, quality on use of services by the poor, ethnic minorities and those in remote locations.

4.20 The community-based HIV/AIDS prevention activities launched in 2002 provided important experience for design of the follow-on World Bank financed HIV/AIDS Prevention Project ($38.5 million). Because the activities were launched so late in the project, only a baseline survey was conducted in the 7 provinces. However these results were disseminated promptly to program managers before the end of the project. Further, the design, which focused on reducing transmission in "hot spots", closely paralleled the ADB-financed pilot in five provinces, which was evaluated and found successful in raising condom use (see Box 2). The model provided experience with peer approaches to counseling and educating intravenous drug users and sex workers about risk reduction; it also developed guidelines for voluntary counseling and testing.[41]

4.21 In contrast, much less was learned from the Integrated RH Campaigns for Remote Areas, which were expanded nationwide without rigorous evaluation. Given their scope and scale, one cannot conclude that the campaigns were pilot efforts to build the knowledge base

40. Many of the study reports were only available in Vietnamese, so the quality of the reports could not be assessed.

41. The pilot areas also received laboratory equipment and training for HIV testing by provincial health personnel.

for policy/technical guidelines. Concerns were expressed with respect to: whether mobilization for sterilization and treatment for STIs would encourage the free and informed choice of method by FP clients; the efficacy of mass vs. syndromic treatment for STIs; the extent to which the campaigns strengthen or detract from regular service delivery; whether patient follow-up for side-effects, complications, and identified high-risk cases can be assured; whether this mode of delivery is cost-effective relative to alternatives; and whether this approach could be sustained by government over the long run.

Box 2. Focusing on "hot spots" to reduce HIV transmission

The PFHP supported expansion to 7 additional provinces of an approach launched through the parallel ADB "Community Action for Prevention HIV/AIDS Project" in 5 provinces. These efforts supported HIV prevention in "hot spot" situations and groups where transmission is most likely to occur – street-based female sex workers (FSW), karaoke-based sex workers, injecting drug users (IDU), migrant construction workers and traders, long-distance truck drivers, fishermen, sailors, and people living with HIV/AIDS (PLWHA). Interventions included peer education, STI treatment, condom promotion, harm reduction activities (for IDU), and voluntary counseling and testing (VCT).

An evaluation of the activities in the five ADB-supported provinces found substantial increases in consistent (100%) condom use in commercial sex from 2002-2004: among street-based FSW with non-regular partners from 18 to 58 percent; among IDU from 22 to 54 percent; and among migrant workers from 28 to 67 percent. Prevalence of gonorrhea and/or chlamydia declined from 20 to 11 percent among FSW.[a] However, the prevalence of syphilis and needle-sharing behaviors were not much changed. And although condom use more than doubled to about 60 percent among PLWHA who frequented FSW, more than 90 percent of PLWHA had contact with FSW at both the baseline and final survey.

a. The evaluation also monitored changes in HIV prevalence in these groups. However, since both mortality and out-migration from these groups can affect HIV prevalence trends, the latter is not a useful indicator of the trend in new HIV infections, which is the objective of the project.

Source: ADB 2005.

5. Ratings

Outcome

5.1 The project's overall outcome rating is **moderately satisfactory** based on the relevance of each of the project's objectives and efficacy and efficiency at meeting them. The ratings are summarized by objective in Table 2.

5.2 **Relevance**. The first two of the project's objectives remain *highly relevant.* Reduction of the rate of population growth has continued to be a high priority of the Government and the Bank for reasons of economic growth and poverty reduction, gender considerations related to women's choice, and reduction of the rate of environmental degradation. While the Government's objective to reach replacement fertility levels by 2005 has been achieved, the plateau in use of modern contraceptive methods and continued high reliance on traditional methods and abortion indicate the need to increase the utilization, quality and range of modern FP services. The third and fourth objectives remain *substantially relevant*. Effectively responding to rapidly changing needs, especially with

greater decentralization, requires continued strengthening of the NCPFP's management capabilities and policy and planning formulation at all levels. The need for developing new and more targeted public and private sector approaches to FP/RH for sub-populations such as adolescents and those living in poor urban and remote areas remains.

Table 2. Summary of Outcome Ratings by Objective

	Objective	Relevance	Efficacy	Efficiency	Outcome
1	Increase in quality and range of services	High	Substantial	Substantial	Satisfactory
2	Increased utilization of:				
	(a) RH services	High	Substantial	Substantial	Satisfactory
	(b) FP services and modern methods	High	Negligible	Modest	Moderately unsatisfactory
3	Strengthen NCPFP capabilities	Substantial	Substantial	Modest	Moderately satisfactory
4	Enhance the knowledge base	Substantial	Substantial	Modest	Moderately satisfactory
	Overall Project				**Moderately satisfactory**

5.3 **Efficacy.** Based on the analysis in the previous chapter, the project was *substantially efficacious* in improving the quality and range of FP/RH services, increasing the utilization of RH services, enhancing the NCPFP's capacities in policy, planning and management. capacity, and generating new knowledge. However, efficacy was *negligible* in terms of raising use of modern contraception among married women, shifting the method mix to temporary and highly effective modern methods, and reducing recourse to abortion.[42] The neglect of addressing the needs of adolescents and unmarried couples was a missed opportunity to enhance the efficacy of the program in meeting its overall objectives.

5.4 **Efficiency.** The project was *substantially* efficient in increasing the utilization of RH services and in increasing the quality and range of FP/RH services overall, particularly with respect to the savings for civil works and equipment due to competitive bidding and the widespread investments in training. Allocative efficiency was enhanced to the extent that the project focused on improving the quality of basic PHC services in rural and remote areas, where they can be provided more cost-effectively than through expansion of hospital services. An important caveat is that the basic design of the CHC improvements was not well tuned to local needs and led to sub-optimal allocations of space. Ultimately, the model supported was less than the national standard adopted toward the end of the project. There were, thus, unnecessary technical inefficiencies introduced through the limited variability in construction design and equipment "packages" and a "blanket" geographic approach that would not have targeted specific project expenditures to areas of greatest need.

42. As noted earlier, there is a strong possibility that overall modern contraceptive use, including use of modern temporary methods, might have increased in the population of all women of reproductive age (including unmarried women), particularly in light of the sharp decline in the reported number of abortions in public facilities. However, without other corroborating evidence that this is the case, IEG concludes that the efficacy of the FP objectives was modest.

5.5 The efficiency with which the remaining objectives were achieved was *modest*. While support for social marketing of the pill and involvement of the private sector improved efficiency over a purely public-sector approach, the lag in demand generation activities and the neglect of adolescents until late in the project, the scant efforts to promote injectables, and the lack of attention to unmarried women's FP/RH needs are evidence if important inefficiencies. The repeated difficulties in developing and implementing the MIS suggest that the efficiency of efforts to enhance the NCPFP's capabilities in policy, planning and management were also modest. Finally, the nation-wide expansion of RH campaigns before evaluation of their design and impacts, problems in orienting pilot research toward programmatic priorities, the omission of unmarried women and adolescents from the two DHSs, and lack of analysis of the relation between improved services and their use, using those data, suggest that the efficiency of expanding the knowledge base was modest as well.

Sustainability

5.6 The sustainability of project activities and achievements is rated as **likely**. The probability of project activities being sustained administratively is high. FP and RH continue to be priorities of the Government. The project supported new programmatic efforts – HIV/AIDS prevention, treatment of STIs, and FP/RH/STI education for adolescents at upper secondary schools – that will be continued by the government or with donor financing. Economic growth, urbanization, and increased education will contribute to a sustained demand for small families, birth spacing, and women's interest in reproductive health services, and the services that support them. With respect to financial sustainability, the total recurrent costs of the project activities are estimated at US$ 17 million, representing 5.2 percent of the NCPFP budget (for the RH campaigns) and 2.6 percent of the MOH budget (for maintenance). Assuming the economy of Vietnam continues the growth trends of the previous 10 years these levels of additional recurrent costs will likely be sustainable. After the end of the PFHP, the NCPFP provided limited financing to DKT to continue the social marketing effort. DKT's marketing efforts are now financed solely from sales revenue, with the continued donation of product from Germany. A Vietnamese firm is working in a joint venture with the German firm donating the cycles to produce them within Vietnam.

Institutional Development

5.7 The institutional development impact of the project, considering both public and private sector inputs, is rated as **substantial**.

5.8 *Public Sector*: The project substantially changed both the scope of activities within the NCPFP and they way that they are done. It developed the capacity of the NCPFP and other levels of FP institutions to supply FP/RH services that were previously (and subsequently) the responsibility of the MOH. As was the case for projects in other sectors, the project introduced the practice of competitive bidding and contracting for services at the national and provincial level. The HIV/AIDS model developed in the last years of the project set the course for emphasis on efficient, highly targeted approaches for HIV prevention that was adopted in the HIV/AIDS Prevention Project. The mechanisms for a continued program of operational research were put in place, although those mechanisms

were not always followed[43] and there is a continued need to ensure that these activities address programmatically relevant and high-priority issues.

5.9 *Private Sector*: Aside from investment in expanding social marketing of the pill and piloting of private physicians associations in one province, institutional development for the private delivery of population and family health services was weak, even as this share of the market was expanding dramatically. More could have been invested in understanding the capacity and barriers of private sector delivery of temporary modern methods and of the quality of privately provided FP/RH services (including abortion and MR), as a basis for strengthening institutional development relative to the private sector.

Bank Performance

5.10 The Bank's performance is rated as **satisfactory**, based on assessments of quality at entry and supervision.

5.11 *Quality at entry*: The quality at entry of the PFHP was satisfactory, though with some major shortcomings. Early Bank experience with significant implementation delays with the PEP should have led to a simplified project design and modest expectations for initial implementation progress and disbursements. Instead, the project design was comprehensive, geographically dispersed and thus inherently complex. Early training in Bank procurement procedures for staff in the PMU resulted in far fewer delays in implementation than experienced by the PEP. But the project's activities were over-budgeted; the team should have anticipated the considerable savings from competitive bidding based on the experience of the PEP and either scaled back the resource requirements or programmed the additional funds based on an analysis of programmatic priorities and their cost-effective use.

5.12 The project design included components to address both demand- and supply-side factors affecting FP/RH outcomes, and recognized the need to target poor women and ethnic minorities. However, important policy issues were overlooked. For example, changing the method mix was treated as a matter of simply improving client information, increasing the supply of temporary methods, and improving the quality of infrastructure and services.[44] There was no analysis in appraisal documents of the implications on the method mix of fees for temporary contraceptive methods, coupled with continued incentives for accepting IUDs or sterilization, particularly among low-income groups, despite a significant literature pointing to these issues.[45] In another example, oral contraceptives were listed as a Toxic B drug, requiring a physician's prescription for dispensing by a pharmacy. Project design also did not address the high prevalence of sexually transmitted infections or the need to provide training in sterilization of needles and other medical equipment and proper disposal of

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43. While management of a competitive process for study identification had been sub-contracted to the Institute of Sociology, there was little evidence to suggest that this mechanism was used. In one case, the NCPFP effectively blocked the acceptance of a safe motherhood study developed by Save the Children Federation over budgetary issues after the protocol had been developed with extensive input from the Institute of Sociology.

44. Fees and incentives to users and providers of different methods were also not discussed in the mid-term evaluation or reported as a topic of policy dialogue in supervision reports.

45. See Allman and others 1991; Goodkind 1994, 1995; and Knodel and others 1995.

medical waste. Preparation also did not undertake institutional analysis that might have allowed better understanding of the roles of the NCPFP and the MOH in the upgrading and management of the health delivery system.[46] Finally, the Bank should have pressed harder for a systematic field assessment of existing infrastructure and equipment prior to embarking on renovations and construction in the PFHP (and NHSP) projects.[47] An initial plan to develop all project inputs in 5 "pilot" provinces was later dropped in favor of a plan to complete the construction and equipment of all CHCs in the first three years of the project. This decision was responsible in part to the late implementation of components related to IEC/BCC, in-service training, and studies.

5.13 The decision at the design stage for the NCPFP to manage the provision of family planning and reproductive health services, including civil works, instead of the MOH, was poorly justified and had important negative repercussions for the effectiveness of the project. There is remarkably little discussion of the rationale or potential consequences in the SAR. The MOH is responsible for providing these services and the NCPFP in fact initially requested that these elements of the project be implemented by the MOH. The CHC package for the PFHP was identical to that for the NHSP, in a similar number of provinces, but the latter was managed by the MOH in a parallel operation. While the PMU and the NCPFP excelled in this task, the overwhelming effort in the first years of the project was on hardware. The demand-side efforts (like IEC/BCC and in-service training) that were key to changing the method mix and reducing reliance on abortion were delayed, many of the policy issues constraining them were never addressed, and inputs like the MIS that are important for improved management of population and family planning activities – which *is* the long-run responsibility of the NCPFP structure—were dropped. Capacity was developed in procurement and civil works, but following closure of the project, responsibility has reverted back to the MOH.

5.14 *Supervision*: Overall, supervision was satisfactory. Supervision missions worked closely with the NCPFP to identify solutions to issues in project implementation and provided subsequent follow-up. They were facilitated by high continuity of the Bank TTL, who changed only once in eight years. The Resident Mission provided continued guidance assistance on Bank procurement requirements and important adaptations were made at the MTR to adapt the project to changing government strategy. In three areas, supervision could have been improved. First, early supervision missions focused on the level and rate of financial disbursement at the expense of technical issues.

5.15 Second, the substantial savings early in the project coupled with the decision not to continue the drug supply sub-component led to a continuous process of reallocation of funds, often to new activities and an expanded number of provinces. This raised the complexity of the project over time and ensured that even after the initial packages of civil works and equipment were provided, a focus on hardware and how to use up the money (a moving

46. The decision to place the facility upgrading component under the NCPFP rather than the MOH was rationalized by the Bank in order to keep implementation of the comprehensive set of FP/RH inputs together. However, the operation and maintenance of these facilities is normally the mandate of the MOH and similar services to the PFHP were provided by the MOH for the sister project, the NHSP.

47. A survey of the facilities in 5 provinces was financed during project preparation, using grant funds (World Bank 1995).

target) – even if consistent with the project's objectives—would continue to divert attention from the project's "software" activities, particularly BCC and strengthened management capacity. With the benefit of hindsight, one option at the MTR would have been to cancel that part of the credit that was surplus, to focus efforts on the software, and to complete the project on or ahead of schedule. Based on internal correspondence, it does not appear that this option was ever seriously discussed. This might have substantially improved the project's performance with respect to the family planning and capacity improvement objectives.

5.16 Finally, better coordination between the three donors would have substantially reduced demands on the PMU. World Bank and ADB supervision missions were being coordinated by the end of the project, but KfW worked directly with the PMU. There was no harmonization of procedures between the Bank and the ADB – the PMU had to master both organizations' processing rules.

Borrower Performance

5.17 Borrower performance is rated **satisfactory,** based on the performance of the government and NCPFP/PMU on preparation, implementation, and compliance.

5.18 *Preparation:* The Borrower's involvement and contributions during project preparation were satisfactory. The high level of commitment to the project's objectives was reflected in strong ownership throughout the design and implementation phases. Trust funds for project preparation were fully utilized. However, the lack of a baseline inventory of CHC deficiencies and inadequate involvement of local authorities in providing feedback on the design of improvements in the CHC led the project to invest in sub-optimal improvements in civil works in some cases.

5.19 *Implementation*: Overall, implementation performance was satisfactory. The implementation schedule developed by the Borrower and the Bank proved overly ambitious during the early phases of the project. Additionally, delays were inherent in the political system in Vietnam (for example, the lengthy time for MOF approvals) and there was high turnover of PMU staff due to low wages, a problem not reconciled until late in the implementation. These delays led to unsatisfactory project performance ratings from September 1996 to December 1997. The initial heavy central control over project activities evolved into more decentralized management through the PPMUs.

5.20 Component 4 received unsatisfactory project component ratings from June 1997 through November 2000. With the exception of the DHSs, the NCPFP relied almost entirely on Vietnamese technical assistance for the conduct of the pilot studies.[48] Greater use of complementary international technical assistance in the design of the pilot studies might have facilitated the transfer of knowledge and skills related to action-oriented research. It is

48. Only 426 out of 2,301 person-months of domestic and 9.5 out of 61.6 person months of external technical assistance budgeted in the SAR to support the conduct of the pilots and studies was actually used.

unclear what efforts were taken on the part of the Borrower to ensure that women in the RH campaigns in underserved areas were fully informed of their contraceptive options.[49]

5.21 Nevertheless, the leadership and work effort of the PMU and its staff was exceptional. The project management structure was clear and the PMU director was highly capable and remained with the PMU through the life of the project. Aggressive use of competitive bidding for construction resulted in significant savings, which were used to renovate more CHCs than were originally planned.[50] The NCPFP was proactive at suggesting priority uses for reallocating funds, and these reallocations often further increased the complexity of activities. Despite initial delays and the constant changes in the number activities and expansion of their geographical coverage, the Borrower spent 99 percent of the credit with only a three-month extension of the closing date.

5.22 *Compliance*: The PFHP credit included 22 covenants. The Government complied with all of them, although three covenants relating to baseline studies/surveys or studies of drug financing/targeted free provision were fulfilled after the June 1997 covenant date. Three other covenants related to scaling-up specific pilot studies were only partially met in that the pilot efforts were carried out but some that were found to be not particularly cost-effective were nevertheless taken to scale. Overall, compliance was satisfactory.

Monitoring and Evaluation[51]

5.23 The M&E design called for monitoring of outcomes through three national population-based surveys – baseline, mid-term, and end-of-project – and tracking of project outputs. However, the SAR did not anticipate the need to account for: (a) other socio-economic factors affecting the demand for children and thus family planning and reproductive health services; (b) service delivery outputs in non-project provinces (which were influenced by NHSP and parallel government investments); and (c) the availability and price of FP/RH services in the private sector, where demand has been growing fastest. In light of the emphasis of the project on improving provider-client interactions (by more counseling on other methods) and the longstanding role of various financial and non-financial provider and client incentives for adopting different methods, it is surprising that the M&E strategy did not include any type of qualitative monitoring of client-provider exchanges. Finally, there were no baseline or final indicators (beyond outputs) to measure outcomes for the objectives of improving the management, planning, and policy formulation capacity of the NCPFP and expanding the knowledge base.[52]

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49. Principles of informed choice should be included in IEC/BCC training and supported by supervision as well as included as part of print and radio/TV media spots on FP/RH subjects.

50. The NCPFP was able to complete CHC construction and at a lower cost than the same facilities under the NHSP of the MOH.

51. This section evaluates the design and implementation of the project's monitoring and evaluation (M&E). However, IEG does not yet formally rate it.

52. This is indicative of a lack of specificity in the project design of exactly in what dimensions capacity needed to be built, which would have been strengthened by an institutional assessment and baseline survey during project preparation.

5.24 In implementing the M&E design, there were both successes and shortcomings. Two national DHSs were conducted to measure baseline and end-of–project outcomes. The questionnaires were identical, improving the comparability of results over time. However, the baseline survey did not occur until 1997, a year after project effectiveness, with results forthcoming only shortly before the mid-term review in 1999. This revealed that many demographic targets set at the beginning of the project had been surpassed as the project was being launched, leading to revised targets. The mid-term survey that might have pointed to successful and problem areas was not fielded. The final DHS was timed to produce results to feed into the completion report. Both DHSs were deficient in excluding unmarried women from the sample and collecting insufficient information on private sources of contraception, RH services, and abortion.

5.25 In analysis of the DHS, the approach of using "non-project provinces" as the counterfactual was fundamentally flawed, in light of similar investments being made by the NHSP and government in these provinces and the fact that many of the PFHP interventions were national in scope. Furthermore, the project provinces were selected based on specific characteristics, which affect not only their baseline outcomes but the rate of improvement in outcomes relative to other provinces. These issues might have been addressed in the final evaluation by multivariate analysis of contraceptive and RH service use, controlling for individual characteristics and access to and quality of services, and using both the 1997 and 2002 data. However, this apparently was not done. Although the emphasis of the project was on improving the access to and use by disadvantaged groups, including ethnic minorities, the poorest of the poor, and people in remote areas, neither of the evaluation reports (TFGI and others 2003, World Bank 2004) mined the available data to show that outcomes had improved for these groups. The available data were thus under-exploited and could have been used with far greater effect to improve the project. [53]

5.26 With respect to other dimensions of the project's M&E design, a number of individual project activities were evaluated in the course of the project. Evaluation of several of the models piloted as part of the fourth component revealed that they were not cost-effective. They were not scaled up as a result, which indicates that in some instances evaluation results were used to improve decision-making. Baseline data for the seven HIV/AIDS provinces were also used to inform subsequent program design. However, the Reproductive Health Campaign model was scaled up rapidly, nation-wide and at great expense without evaluating early efforts.

5.27 Finally, the MIS, which was to be used to track outputs and serve as a planning tool, was dropped from the project. It could have provided information to inform supervisory review of technical issues in project implementation. In its absence, there is little evidence of a consistent effort to monitor and evaluate the project outputs against project design.

53. Analysis of the 1997-98 VLSS, which included fertility and contraceptive use as well as many more socioeconomic variables than the DHS, could also have helped to inform population and family planning activities during the life of the project.

6. Lessons

6.1 Over the period 1996-2003, Vietnam's demographic transition continued as fertility dropped below replacement levels. Infant mortality may also have declined, but the data are not precise enough. The commitment of the government to the national population policy and demographic objectives remained consistently high throughout this period, with multiple policies in effect to promote continued fertility decline. Investments by the PFHP and other government programs raised the quality of family and reproductive health services, which, coupled with other socioeconomic developments in Vietnam, contributed to increases in their use. However, it is not clear whether these improvements disproportionately reached the poor and ethnic minorities, as was intended, and some of the other objectives of the PFHP, particularly those concerning the family planning method mix and reduction in abortion, were elusive. A number of lessons emerge from the experience of the PFHP which may inform future operations in Vietnam and elsewhere, both for population and family planning activities and for improving the effectiveness of programs more generally.

6.2 **Efforts to raise contraceptive use and improve method mix need to: (a) take into account pre-existing incentives, sanctions, and targets within the population program that may not be compatible with this objective; and (b) ensure that demand-generating activities and other "software" investments proceed in parallel with efforts to improve physical access.** The experience of the PFHP demonstrates the difficulty of transitioning from an approach that emphasized family size limitation – a "one or two child policy", backed up by incentives, sanctions, and targets – to one oriented toward reproductive health and free choice of contraceptive method. In such an environment, increasing the supply of alternative contraceptive methods, improving information to clients, and providing better training for FP staff alone are necessary but not sufficient to overcome deeply entrenched attitudes and misconceptions by both providers and the public.

6.3 **Population policy and family planning programs in countries undergoing the transition to a market economy need to adapt to the increasing role of the private sector as a service provider.** The potential complementarities and comparative advantages of the public and private sectors need to be exploited, while appropriate regulations and policies need to be put in place to ensure the quality of both. Future surveys in Vietnam urgently need to collect data on the availability, quality, and use of private, as well as government-financed reproductive and family health services.[54]

6.4 **It is critically important that population and reproductive health programs reach out to unmarried young adults, in order to promote highly effective temporary methods of birth control, prevent unwanted pregnancy and recourse to abortion, and prevent HIV/AIDS and other sexually transmitted disease.** There was an increased emphasis and reorientation of Vietnam's population program on adolescent reproductive health and new investments in HIV/AIDS prevention toward the end of the PFHP. The focus

54. In a similar vein, it will be important to obtain more information about the demand for abortion/MR, including whether the woman had a pregnancy test prior to the procedure, the number of weeks since the last period, whether the procedure was performed by a public or private provider, the type of institution, any out-of-pocket costs associated with the procedure, and post-procedure counseling on contraceptive methods.

of the program almost exclusively on married couples in the 1990s was a missed opportunity to improve reproductive outcomes among young adults and to understand their unmet need for family planning.[55]

6.5 **The effort to improve institutional performance can be undermined by lack of institutional analysis, weak articulation of institutional objectives, mis-identification of the main constraints for improvement, and omission of appropriate indicators to measure success.** IEG's 1999 evaluation of the World Bank's population, health, and nutrition support world-wide found that completion of physical objectives is often high, but performance on institutional and capacity objectives is much weaker.[56] In the case of the PFHP, the objectives for capacity building of the NCPFP were not articulated in terms of performance, but rather in terms of training and other inputs. It wasn't clear what the desired outcome would be or how one could know whether it had been reached. Further, the effort to re-orient the family planning program toward a reproductive health approach represented an institutional reform of the way that things are done, not just at the national level, but for committees on population and family planning at the provincial, district, and commune levels. Institutional analysis during project preparation might have led to a more accurate assessment of the constraints underlying current performance.

6.6 **In order to attribute changes in outcomes to public policy, programs need to document their inputs and outputs over time and to monitor other factors outside of the program that plausibly could account for those outcomes.** In the case of the PFHP, monitoring of health and population outcomes was achieved through the two DHSs, but inputs and outputs were not well tracked, nor were other factors (like individual socioeconomic status or the availability of private services) that might have influenced the phenomenal fertility decline and increase in use of RH services over the life of the project. Lacking this information, one cannot be certain that continued fertility decline and the increased use of family health services in Vietnam was in fact due to improved service quality, as opposed to increases in education and family income.

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55. Future population-based demographic and health surveys should ensure that all women are questioned on fertility, sexual behavior, contraceptive use, and pregnancy termination, including women who are not currently married. Male sexual behavior and contraceptive use also deserves much greater study.

56. Johnston, Timothy and Susan Stout. 1999. *Investing in Health: Development Effectiveness in the Health, Nutrition, and Population Sector*. World Bank Operations Evaluation Department: Washington, D.C.

References

Allman, James, Vu Qui Nhan, Nguyen Minh Thang, Pham Bich San, and Vu Duy Man. 1991. "Fertility and family planning in Vietnam". *Studies in Family Planning* 22(5):308-317.

Anh, Nguyen Quoc, and Hoang Kim Dzung. 2002. "Induced abortion in Vietnam: Fact and resolution". CICRED seminar on Reproductive Health, Unmet Needs and Poverty, Chulalongkorn University, Bangkok, November 2002.

Asian Development Bank, AusAID, DFID, GTZ, JICA, Save the Children UK, UNDP, and World Bank. 2003. *Vietnam Development Report 2004: Poverty*. Joint Donor Report to the Vietnam Consultative Group Meeting, Hanoi, December 2-3, 2003.

Asian Development Bank. 2004. *Project Completion Report on the Population and Family Health Project (Loan 1460-VIE[SF]) to the Socialist Republic of Viet Nam.* Manila: Asian Development Bank (PCR: VIE 26378), November.

Asian Development Bank. 2005. *Evaluation of the project "Community Action for Preventing HIV/IDS" in 5 provinces in Vietnam*. ADB Project JFPR: REG-9006. Hanoi, Vietnam, December.

Behrman, J.R. and J.C. Knowles. 1998. "The Distributional Implications of Government Family Planning and Reproductive Health Services in Vietnam". Mimeo. Philadelphia: University of Pennsylvania.

Desai, J. 1998. "Poverty and Fertility in Vietnam", in D. Dollar, P. Glewwe, and J. Litvack, eds., *Household Welfare and Vietnam's Transition.* Washington, D.C.: World Bank, pp. 277-330.

Desai, Jaikishan. 2001. "Vietnam through the lens of gender: Five years later". Results from the second Vietnam Living Standards Survey, prepared for the FAO Regional Office for Asia and the Pacific. Processed.

Gertler, P. and J. Litvack. 1998. "Access to Health Care during Transition: the Role of the Private Sector in Vietnam", in: D. Dollar, P. Glewwe, and J. Litvack. *Household Welfare and Vietnam's Transition.* Washington, DC: World Bank, pp. 235-255.

Ghuman, Sharon, Vu Manh Loi, Vu Tuan Huy, and John Knodel. 2005. "Continuity and Change in Premarital Sexual Behavior in Vietnam". *Population Studies Center Research Report*, no. 05-585. University of Michigan Population Studies Center, December.

Glewwe, P., S. Koch, and Bui Linh Nguyen. 2004. "Child Nutrition, Economic Growth and the Provision of Health Care Services in Vietnam", in: P. Glewwe, N. Agarwal, and D.

Dollar, eds., *Economic Growth, Poverty and Household Welfare in Vietnam.* Washington, D.C.: World Bank, pp. 351-389.

Goodkind, Daniel. 1994. "Abortion in Vietnam: Measurement, Puzzles, and Concerns". *Studies in Family Planning* 25(6): 342-352.

Goodkind, Daniel. 1995. "Vietnam's one-or-two-child policy in action". *Population and Development Review* 21(1):85-111.

Goodkind, Daniel, and Phan Thuc Anh. 1997. "Reasons for rising condom use in Vietnam". *International Family Planning Perspectives* 23(4):173-178.

Gwatkin, D.R. Shea Rutstein, Kiersten Johnson, Rohini P. Pade, and Adam Wagstaff. 2000. "Socio-economic Differences in Health, Nutrition and Population in Vietnam." *HNP/Poverty Thematic Group Working Paper.* Washington, DC: World Bank.

Hien, Do Trong, Pham Thuy Nga, Do Phuong Mai, Dao Khanh Hoa, Do Than Nhan, Nguyen Hoa Binh, Hua Thanh Son, Nguyen Quoc Chinh, Sally Girvin, Vu Quy Nhan, Peter Fajans, and Gabrielle Ross. 1999. "Abortion in Vietnam: An Assessment of Policy, Programme, and Research Issues". Report WHO/RHR/ITT/99.2. Geneva: WHO.

Hoang Van Minh, Nguyen Khang, and Nguyen Viet Dung. 2003. "Health Care Financing for the Poor in Vietnam", *Working Paper Series* 2004-8. Washington, D.C.: World Bank.

Knodel, John, Phan Thuc Anh, Truong Viet Dung, and Dao Xuan Vinh. 1995. "Why is oral contraceptive use in Vietnam so low?" *International Family Planning Perspectives* 21(1):11-18.

Le, Linh Cu, Robert W. Blum, Robert Magnani, Paul C. Hewett, and Hoa Mai Do. 2006. "A pilot of audio computer-assisted self-interview for youth reproductive health research in Vietnam", *Journal of Adolescent Health.* Forthcoming, June.

Mensch, Barbara S., Wesley H. Clark, and Dang Nguyen Anh. 2003. "Adolescents in Vietnam: Looking beyond reproductive health". *Studies in Family Planning* 34(4):249-262.

Mukherjee, N. 2001. *Achieving Sustained Sanitation for the Poor, Policy and Strategy Lessons from Participatory Assessments in Cambodia, Indonesia and Vietnam*, Jakarta: Water and Sanitation Program.

NCPFP. 1997. *The Costs and Benefits of Vietnam's National Investment in Population and Family Planning from 1979 to 2010.* Hanoi: Center for Population Studies and Information, in collaboration with the Futures Group International.

NCPFP and ORC Macro. 1999. *Vietnam: Demographic and Health Survey 1997.* Final Report. Calverton, Maryland: Committee for Population, Family and Children and ORC Macro.

NCPFP and ORC Macro. 2003. *Vietnam: Demographic and Health Survey 2002.* Final Report. Calverton, Maryland: Committee for Population, Family and Children and ORC Macro.

Nghia, Dang Thi and Nguyen Duy Khe. 2001. "Vietnam abortion situations: Country report". Paper for the Conference on "Expanding Access: Midlevel Providers in Menstrual Regulation and Elective Abortion Care". South Africa, December 3-6, 2001.

Phai, Nguyen Van, John Knodel, Mai Van Cam, and Hoang Xuyen. 1996. "Fertility and family planning in Vietnam: Evidence from the 1994 Inter-censal Demographic Survey". *Studies in Family Planning* 27(1):1-17.

Ponce, N., P. Gertler, and P. Glewwe. 1998. "Will Vietnam Grow out of Malnutrition?", in: D. Dollar, P. Glewwe, and J. Litvack, eds., *Household Welfare and Vietnam's Transition*. Washington, DC: World Bank, pp. 257-276.

Prescott, N. 1997. "Poverty, Social Services, and Safety Nets in Vietnam", *World Bank Discussion Paper,* no. 376. Washington, D.C.: World Bank.

Socialist Republic of Vietnam and World Bank. 2005. *Vietnam: Managing Public Expenditure for Poverty Reduction and Growth.* Public Expenditure Review and Integrated Fiduciary Assessment, Volume 2, Sectoral Issues. Hanoi: Financial Publishing House.

Socialist Republic of Vietnam, National Assembly Standing Committee. 2003. "Ordinance on Population". Ref: 06/2003/PL-UBTVQH11. (Unofficial translation from Vietnam Commission for Population, Family and Children website, www.vcpfc.gov.vn.)

Socialist Republic of Vietnam. 2000. "Vietnam Population Strategy, 2001-2010", approved by the Prime Minister by decision no. 147/2000/QD-TTg. December 22, 2000. Hanoi: Ministry of Health. (Translation from Vietnam Commission for Population, Family and Children website, www.vcpfc.gov.vn.)

Thang, Nguyen Minh and Vu Thu Huong. 2001. "The Oral Contraceptive Pill in Vietnam: Situation, Client Perspectives and Possibilities for Promotion." *Asia-Pacific Population Journal* 16(4): 31-48.

The Futures Group International (TFGI), Center for Social and Development Studies (CSDS) and Market and Development Research Center (MDRC). 2003. "Evaluation Report for the Family Health Project", submitted to the Program Management Unit, National Committee for Population, Family, and Children (NCPFC).

Trivedi, P.K. 2004. "Patterns of Health Care Use in Vietnam: Analysis of 1998 Vietnam Living Standards Survey Data", in: P. Glewwe, N. Agrawal, and D. Dollar, eds., *Economic Growth, Poverty and Household Welfare in Vietnam.* Washington, DC: World Bank, pp. 391-423.

Vach, Trinh Huu, Amie Bishop, Vuong Thi Hoa, Luong Xuan Hien, Tran Dinh Chien and Tuong I. Nguyen. 1998. "The potential impact of introducing pregnancy testing into menstrual regulation services in Vietnam". *International Family Planning Perspectives* 24(4): 165-169.

Wagstaff, A. 2001. "Measuring Equity in Health Care Financing: Reflections on (and Alternatives to) the World Health Organization's Fairness of Financing Index", *Policy Research Working Paper,* no. 2550. Washington, D.C.: World Bank.

Wagstaff, A. and Nga Nguyet Nguyen. 2004. "Poverty and Survival Prospects of Vietnamese Children under Doi Moi", in Glewwe, P., N. Agrawal, and D. Dollar, eds., *Economic Growth, Poverty and Household Welfare in Vietnam.* Washington, D.C.: World Bank, pp. 313-350.

Wagstaff, A. and E. van Doorslaer, E. 2001. "Paying for Health Care, Quantifying Fairness, Catastrophe, and Impoverishment, with Applications to Vietnam, 1993-98", *Policy Research Working Paper,* no. 2715. Washington, D.C.: World Bank.

Wagstaff, A. and N. Watanabe. 2000. "Socioeconomic Inequalities in Child Malnutrition in the Developing World", *Policy Research Working Paper,* no. 2434. Washington, D.C.: World Bank.

Wagstaff, A., E. van Doorslaer, and N. Watanabe. 2001. "On Decomposing the Causes of Health Sector Inequalities with an Application to Malnutrition Inequalities in Vietnam", *Policy Research Working Paper,* no. 2714. Washington, D.C.: World Bank.

World Bank. 1992. "Vietnam: Population, Health and Nutrition Sector Review", Report no. 10289-VN. Washington, D.C.: World Bank.

World Bank. 1995. "Staff Appraisal Report: Socialist Republic of Vietnam: Population and Family Health Project", Report No. 14966-VN. Washington, D.C.: World Bank.

World Bank. 2000. *Vietnam: Managing Public Resources Better, Public Expenditure Review 2000,* Vols. I & II. Report no. 21021-VN. Washington, D.C.: World Bank.

World Bank. 2001. "Vietnam: Growing Healthy: A Review of Vietnam's Health Sector", Report no. 22210-VN. Washington, D.C.: World Bank.

World Bank. 2004. "Implementation Completion Report on a Credit in the Amount of SDR 33.6 Million (US$44.9 Million Equivalent) to the Socialist Republic of Vietnam for a Population and Family Health Project", Report no. 28400. Washington, D.C.: World Bank.

Annex A. Basic Data Sheet

Key Project Data

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project cost (US$ millions)	129.70	107.55	82.9%
Credit amount (SDR millions)	33.60	33.36	99.3%
Cancellation		0.24	

Project Dates

	Original	*Actual*
Board approval	01/16/1996	01/16/1996
Signing	02/26/1996	02/26/1996
Effectiveness	05/24/1996	05/24/1996
Closing date	06/30/2003	09/30/2003

Staff Inputs (staff weeks, actual or latest estimate)

Stage of Project Cycle	*N° Staff weeks*	*US$('000)*
Identification/Preparation	NA	1,242
Appraisal/ Negotiations	NA	NA
Supervision	NA	666
ICR	NA	
Total	NA	1,908

Mission Data

	Date (month/ year)	*No. of Per-sons*	*Specializations represented**	*Performance rating*	
				Implementa-tion progress	*Development objective*
Identification/	05/22/1993	7	PS, PS, MN, MC, OO EC, ES		
Preparation	11/01/1993	6	PS, EC, PH, PO, PS, MC		
	02/22/1994	8	PS, EC, CS, PH, PH, HE, HS, ED		
	08/14/2004	6	PS, PS, DE, PH, PH, PF		
	11/14/1994	6	EC, PS, PH, FM, AR, PH		
	03/17/1995	9	EC, PS, PH, HR, PR, AR, OO, AR, TR		
Appraisal/ Neg.	06/29/1995	10	PS, PH, EC, CA, PO, DO, ME, PR, PS, OO		
Supervision	06/29/1996	6	PS, AR, PO OO, IE, PH	S	S
	11/23/1996	6	PS, AR, IE, OO, PH	S	S
	05/19/1997	5	PS, AR, IE, OO, PH	U	S
	11/25/1997	5	PS, AR, OO, PH, IE	S	S
	07/13/1998	5	PS, AR, OO, PH, IE	S	S
	07/01/1998	5	PS, AR, OO, PH, IE	S	S
(Mid-term Review)	12/17/1999	4	OO, OO, HS, BE	S	S
	06/26/2000	3	OO, OO, HS	S	S
	10/20/2000	4	OO, II, HS, OO	S	S
	02/21/2001	3	OO, OO, HS	S	S
	10/22/2001	4	OO, OO, HS, OO	S	S
	05/20/2002	3	OO, OO, HS	S	S
	12/06/2002	5	OO, OO, PO, HS, FM	S	S
	06/30/2003	2	OO, OO	S	S
ICR	01/31/2004	2	SS, EC	S	S

- AR = Architect; BC = Behavioral Change Communications Specialist; CA = Cost Analyst; CS = Communications Specialist; DE = Demographer; DO = Disbursement Officer; EC = Economist; ED = Early Childhood Development Specialist; ES = Education Specialist; FM = Financial Management Specialist; HE = Health Economist; HR = Human Resources Specialist; HS = Health Systems Management and Delivery Specialist; IE = Information, Education and Communication Specialist; MN = Management Development Specialist; MC = Maternal and Child Health Specialist; ME = Monitoring and Evaluation Specialist; OO = Operations Officer; PF = Public Finance Specialist; PH = Public Health Specialist; PO = Procurement Officer; PR = Pharmaceutical Specialist; PS = Population Specialist; SS = Social Scientist; TR = Training Specialist.

Annex B. Persons Consulted

Hanoi

GOVERNMENT OF VIETNAM

Mrs. Tran Thi Thanh Mai, Vice Director, Communication & Education Department, VCPFC
Dr. Long, Director, National Health Support Project, Ministry of Health

WORLD BANK

Mr. Samuel S. Lieberman, Sector Coordinator, Human Development
Mrs. Nguyen Thi Mai, Senior Operations Officer, Health, Nutrition and Population

NGOS AND OTHER DONORS

Mr. Duong Van Dat, National Programme Officer, UNFPA
Mrs. Tran Huong Giang, Project Manager, KfW
Mr. Larry Holzman, Country Director, DKT International, Vietnam
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Thai Nguyen Province

Dr. Dam Khai Hoan, Deputy Head, Community Medicine Department, Thai Nguyen Medical College
Nguyen Thanh Trung, Rector, Thai Nguyen Medical College and Vice Director, Thai Nguyen General Hospital

Thanh Hoa Province

Dr. Nguyen Dang Ngoan, Director, Center for Preventative Medicine, and other members of the Center's staff

Washington, D.C.

Ms. Anne Cross, Country Manager for Vietnam, ORC/Macro, Calverton, Maryland
Mr. Jaikishan Desai, Researcher, Field manager for the 1992/93 VLSS
Mr. Daniel Goodkind, U.S. Bureau of the Census
Mr. L. Richard Meyers, Lead Operations Officer, PFHP Task Manager, World Bank
Ms. Maryam Salim, Task Team Leader, HIV/AIDS Prevention Project, World Bank
Ms. Gilda Sedgh, Senior Research Associate, Guttmacher Institute, New York (via phone)

Annex C. Inputs and outputs

Table C.1. PFHP Budget and Expenditures

Component/activity	Budget Amount ($US million)	%	Expenditure Amount ($US million)	%	Actual as % of budgeted
Provincial Service Delivery					
Facility Upgrading	20.5	15.8	15.57	14.3	76.0
Equipment	17.6	13.6	39.79	36.5	226.1
Essential Drug Supply	13.7	10.6	2.27	2.1	16.6
In-Service Training	3.5	2.7	3.77	3.5	107.7
Outreach Strengthening	6.5	5.0	0.0	0.0	0.0
National Program					
Strengthening IEC	12.9	9.9	9.97	9.1	77.3
Contraceptive Supply	24.2	18.7	20.35	18.7	84.1
Management/Institutional Development	5.5	4.2	3.84	3.6	69.8
FP Service Delivery Model	6.0	4.6	11.99	11.0	199.8
Contingencies	19.3	14.9			
TOTAL	129.70	100.0	107.55	100.0	82.9

Sources: World Bank 2004.

Table C.2. Procurement of equipment and vehicles

Type	Planned (Project provinces)	Actual	
		Project provinces	Non-project provinces
Medical equipment			
Commune Health Centers (sets)	3,190[a]	3,795	
District Health Centers (sets)	184	232	
Provincial MCH/FP Centers (sets)	15	20	
District Hospital equipment			
Air conditioner		799	
Dehumidifier		574	
Stabilizer		526	
Vehicles			
Ambulance cars	199	252	
Ambulance boat		30	
Communication car		20	44
Communication boat		165	
Service boat		301	
Motorbike		211	99
Communication equipment			
Commune (sets)		1,970	3,792
Province and district (sets)		230	453
Office equipment (sets)		20	41

Source: Planned: World Bank 1995, Annex 5. Actual: ADB 2004, Table A3.2.

Notes: a. Represents all CHCs in the 15 original provinces.

Table C.3. Civil works

Type of facility	Planned	Actual	Actual as percent of planned
Village Health Post	440[a]	92[b]	21
Commune Health Center	1,616	2,611	162
District Health Center	184	136	74
Provincial MCH/FP Center	15	15	100
Provincial Education Center	0	12	-

Source: Planned: World Bank 1995, Annex 5. Actual: ADB 2004, Table A3.2.
Notes: a. To be built on a pilot basis, according to World Bank 1995, p. 87. As the health post study later concluded that this intervention should not be replicated, fewer were built than planned. b. Of which 60 in project provinces and 32 in non-project provinces.

Table C.4. IEC/BCC outputs

Type of output	Planned	Actual
Brochures	24 million	12 million
Rolling books	125,000	25,000
Billboards	3,600	1,750
Radio programs	312	18
TV programs	84	12
Provincial campaigns	318 (prov + dist)	250
District campaigns		"thousands"

Source: TFGI and others 2003, p. 53.

Table C.5. IEC/BCC Training

Type of training	Number trained	Type of trainee	Year
IEC	600	District workers	1999
	>10,000	Commune workers	1999
BCC management	24	National trainers	2003
	500	National workers	2003
BCC skills	196	Provincial trainers	2003
	1,100	District communication officials	2003
	11,000	Population workers	2003
Population education in secondary schools	12	National trainers	2002
	34	Leaders of provincial education departments	2002
	296	Provincial trainers	2002
	1,100	Headmasters	2002
	3,400	Teachers	2002

Source: For IEC and BCC data: TFGI and others 2003, p. 53. For population education data: internal project memoranda.
Note: The IEC/BCC component also financed a BCC strategy, a Population Counseling Center Model, and counseling materials.

Table C.6. Studies financed in Component 5

	Study/model	Dates	Cost	Location/coverage	Report in file
1	Health posts	12/1998-6/2001	$399,000	75 health posts in 9 provinces	Thai Nguyen Medical College, "Village Health Station Model", December 2001
2	Population and family health workers	9/1999-6/2002	$244,000	43 communes in 10 districts of 7 provinces	"Population and Family Health Staff model", November 2002
3	Safe motherhood	11/1999-12/2000	$400,000	150 communes in 5 provinces	Institute of Maternal and Child Health Protection, "Safe motherhood model", 2002
4	Integrated population program in poor communes of Da Bac	1/2000 – 5/2002	$360,000	16 communes of Da Bac District in Hoa Binh province	None noted in the Final Evaluation Report
5	Mobile team	3/2000-4/2002	$190,000	58 communes in 4 provinces	None noted in the Final Evaluation Report
6	Integrated RH campaigns	*Stages 1 & 2:* 10/2000 – 5/2001 *Stage 3:* 9/2001-12/2001 *Stages 4 & 5*: 1/2002-9/2002	$10 million	*Stages 1 & 2*: 5,541 communes in 54 provinces *Stage 3*: 4,702 communes in 57 provinces *Stages 4 & 5:* 8,064 communes in 61 provinces	"Evaluation report for phases 3-5" "Final evaluation, 5 phases of the campaign"
7	Private sector health services association in Hai Duong	12/2000-5/2003	$200,000	11 districts of Hai Duong Province	None noted in the Final Evaluation Report
8	Community-based HIV/AIDS prevention	2001-2003	$1 million	"Hot spots" in 7 provinces.	"Research results on approximation of HIV/AIDS risk in 7 provinces", 2003

Source: ADB 2004, Appendix 8 for the first 4 columns, and TFGI and others 2003, References, for the last column.

Note: The sum of the costs of these studies amount to $12,793,000. However, according to Annex Table C.1 only $11.99 million was spent on this component. IEG could not reconcile this discrepancy.

Annex D. Outcomes

Table D.1: Selected PFHP monitoring and impact indicators

Indicator	Target	National/project	1997	2002
Demographic and health outcome				
TFR	2.1	National Project provinces	2.7 2.8	1.9 1.8
IMR (deaths per 1,000 live births)	25	National Project provinces	28.2[a] 28.5[a]	18.2[a] 21.8[a]
Contraceptive use				
Raise CPR for modern methods	65	National Project provinces	55.8 56.1	56.7 56.2
Lower TAR	0.38[b]	National Project provinces	0.54[c] 0.67[c]	0.62[c] 0.67[c]
Increase share of temporary contraceptive methods	25	National Project provinces	10.2 3.0	12.1 9.8
Service Performance/Quality				
Percent of women receiving prenatal care from MD/RN/midwife	none	National Project provinces	70.1 66.0	85.4 83.1
Percent of women delivering at a health facility	75	National Project provinces	60 60.1	78.5 74.9
Percent of infants fully immunized	none	Country Project provinces	51.4 50.1	66.7 n.a.

Source: World Bank 1995, ADB 2004, and DHS Final Reports 1997, 2002.
Notes: a. The national IMR is measured over the 5 years preceding the survey, while for project provinces it is measured over the 10 years preceding the survey because of sample size limitations. The national IMR calculated over the 10 years before the DHS was 34.5/1000 in 1997 and 24.8/1000 in 2002. b. The target was a 30 percent decline from an initial value of 0.54, measured in the 1997 DHS. C. The TAR is computed over the five years before the survey, so the statistic for 2002 is actually an average for 1997-2001 (i.e., *during*, not at the end of the project) and for 1997 the average for 1992-96, five years *before* the project.

Table D.2: Distribution of currently married women using specific contraceptive methods, by source of method, 1997 and 2002

	Public fieldworker or mobile unit		Commune health center (CHC)		Public hospital		Other public source[b]		Private pharmacy		Other private source[c]	
Method[a]	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002
Pill	**17.2**	**33.1**	**38.6**	**28.3**	**3.3**	**1.2**	**1.7**	**2.4**	**32.9**	**30.0**	**6.4**	**4.8**
Condom	**21.7**	**17.9**	**24.6**	**18.0**	**1.2**	**1.1**	**7.0**	**3.5**	**40.6**	**52.6**	**4.9**	**6.7**
IUD	**13.4**	**11.5**	**53.0**	**58.5**	**23.1**	**18.6**	**4.4**	**5.4**	**0.5**	**0.0**	**5.7**	**5.9**

Source: DHS Final Reports 1997, 2002.
Notes: a. Sample sizes: pill (1997: 232; 2002: 337); condom (1997: 315; 2002: 310); IUD (1997: 2,056; 2002: 2,015).
b."Other public source" includes delivery house, FP clinic, and other. c. "Other private sources" include private hospital/clinic, private doctor, friends/relatives, and other.

Table D.3. Trends in key outcome measures and their confidence intervals, 1997 and 2002 VDHS

Variable	1997 Value	1997 Confidence interval	2002 Value	2002 Confidence interval
Total fertility rate (TFR, last 5 years)*	2.67	[2.52 – 2.83]	1.87	[1.75 – 1.98]
Infant mortality rate (IMR, last 5 years)	28.2	[20.6 – 35.8]	18.2	[8.97 – 27.38]
Proportion of children fully immunized*	0.568	[0.522 – 0.614]	0.667	[0.614 – 0.720]
Proportion of mothers who received medical care at birth	0.770	[0.706 – 0.834]	0.851	[0.816 – 0.886]
Proportion of mothers who received tetanus injection*	0.714	[0.681 – 0.746]	0.847	[0.815 – 0.880]
Proportion of currently married women using:				
-any contraceptive method*	0.753	[0.737 – 0.770]	0.785	[0.771 – 0.800]
-any modern method	0.558	[0.553 – 0.583]	0.567	[0.543 – 0.591]
-oral contraceptives	0.043	[0.033 – 0.054]	0.063	[0.052 – 0.074]
-IUD	0.385	[0.356 – 0.414]	0.377	[0.353 – 0.401]
-condom	0.059	[0.049 – 0.069]	0.058	[0.051 – 0.066]

Source: DHS Final Reports, 1997 and 2002, Annex Tables B.2.
Note: * denotes variables with non-overlapping confidence intervals from 1997-2002. Confidence intervals were not calculated for current use of injectables as a contraceptive method or for the total abortion rate.

Table D.4. Percent of currently married women 15-49 with access to contraceptive methods through community-based family planning services[a]

	Rural				Urban			
	Project Provinces		Non-project provinces		Project provinces		Non-project provinces	
Availability of:	1997	2002	1997	2002	1997	2002	1997	2002
From FP field worker:								
- oral contraceptives	77.6	92.0	94.8	96.0	95.3	100.0	100.0	89.5
- condoms	83.0	92.0	97.5	97.6	100.0	95.9	100.0	89.5
From mobile FP clinics								
- oral contraceptives	88.3	95.1	86.8	93.6	91.6	76.7	91.3	100.0
- IUDs	100.0	85.1	96.3	84.3	100.0	82.8	82.1	75.5
- female sterilization	46.4	15.8	38.5	24.7	14.3	23.5	12.7	17.7
- injectables	7.5	18.0	8.3	27.7	6.9	27.7	4.5	31.6
Number of survey clusters[b]	44	50	95	90	25	26	40	39

Source: DHS Final Report 1997, pp. 121-122; DHS Final Report 2002, pp. 113-114.
Note: a. The availability of methods from field workers and mobile clinics is based on reports by a community informant, and was not confirmed with the providers of sources. . Access to a community-based worker was virtually universal in both 1997 and 2002 (not shown), as was access to a FP fieldworker in the community. However, access to mobile FP clinics was considerably lower in all areas and provinces, though in rural areas this could have been as the result of greater reliance on availability of services at CHCs. b. Health services data are the same for all women in a sample cluster. As a result of the relatively small number of independent observations at the cluster level (see the last row of the table), these estimates have relatively large sampling variance.

Table D.5. Annualized Health Service Contact Rate, by Provider and by Per Capita Expenditure Quintile, VLSS[a]

	Total		Bottom quintile		Top quintile	
Health facility	**1993**	**1998**	**1993**	**1998**	**1993**	**1998**
Public Hospital	0.32	0.60	0.16	0.25	0.56	1.09
CHC	0.19	0.57	0.24	0.58	0.12	0.20
Other public	0.03	0.25	0.02	0.16	0.07	0.33
Total public	**0.54**	**1.43**	**0.42**	**0.99**	**0.75**	**1.62**
Private pharmacy/drug vendor	2.14	6.78	2.02	5.45	1.96	6.78
Pvt. Health care	0.66	1.76	0.46	1.17	0.88	2.44
Traditional	0.03	0.36	0.02	0.25	0.04	0.58
Total (public and private)	**3.37**	**10.33**	**2.50**	**6.87**	**2.88**	**8.80**

Source: World Bank 2001, Table 3.1, based on VLSS data.

Notes: a. The absolute increase in the contact rate is exaggerated by changes in the way that the data were collected in 1993 and 1998. The 1993 VLSS asked only about use of health care for an illness in the preceding 4 weeks and only a single contact for that illness, while the 1998 VLSS asked about all use of health care in the past 4 weeks, without conditioning on an illness. If the 1993 conditions are imposed on the 1998 data, the overall contact rate (public and private) for 1998 is 4.35 per capita, an increase in the service contact rate of 29 percent. Of interest here is that the CHC contact rate approached the public contact hospital rate (despite the fact that rising incomes might have led an even larger share of the population to consult public hospitals) and that the CHC contact rates increased the most in the lowest quintiles (represented by the bottom quintile).

Table D.6. Trends in contraceptive use among currently married women 15-49, 1988-2002

Year	Source	Modern methods					Any modern method	Any tradi-tional[a]	Any method	Sample size
		IUD	Condom	Pill	Injec-tion	Female Ster.				
Previous national demographic surveys										
1988	DHS	33.2	1.1	0.4	n.a.	2.7	37.7	15.5	53.2	3,896
1992-93	VLSS	35.9	2.9	2.1	0.4	[b]	43.8	25.3	55.1	2,927
1994	ICDS	33.3	4.0	2.1	0.2	3.9	43.8	21.2	65.0	10,400
1997-98	VLSS	40.9	6.5	3.9	0.2	6.5	58.3	24.9	81.0	4,064
PFHP baseline and final surveys – all women										
1997	DHS	38.5	5.9	4.3	0.2	6.3	55.8	19.2	75.3	5,340
2002	DHS	37.7	5.8	6.3	0.4	5.9	56.7	21.8	78.5	5,338
Women 20-24										
1997	DHS	34.0	3.6	5.6	0.0	0.0	43.3	11.8	55.1	716
2002	DHS	30.9	4.1	9.0	0.4	0.1	44.5	13.2	57.7	536
Women 25-29										
1997	DHS	42.4	6.0	6.3	0.2	1.9	57.0	16.2	73.4	988
2002	DHS	42.2	5.4	8.0	0.4	0.7	56.9	16.9	73.4	977
Urban women 15-49										
1997	DHS	32.5	11.8	4.1	0.0	5.3	54.0	24.9	79.3	997
2002	DHS	30.3	12.6	6.9	0.2	6.6	54.9	24.1	79.1	1,005
Rural women 15-49										
1997	DHS	39.9	4.5	4.4	0.2	6.6	56.2	17.9	74.4	4,343
2002	DHS	39.5	4.2	6.2	0.5	6.2	57.1	21.2	78.4	4,333
Project provinces										
1997	DHS	41.6	4.8	2.8	0.2	5.6	56.1	20.9	77.0	1,601
2002	DHS	38.3	4.8	5.0	0.5	6.8	56.2	21.2	77.5	1,752

Source: VLSS data (tabulated courtesy of J. Desai); Phai and others 1996 (1988 DHS and ICDS); DHS Final Reports 1997, 2002.

Notes: a. Includes rhythm, withdrawal, and periodic abstinence. b. Male and female sterilization combined was 3.4 percent.

Table D.7. Trends in abortion and MR in the DHS sample and their relation to contraceptive use

	1997			2002		
	MR	Abortion	Both	MR	Abortion	Both
Number of procedures in past 3 years, DHS sample	259[a]	127[a]	416	344	92	437
(percent of all procedures)	(62)	(38)	(100)	(79)	(21)	(100)
Annual number of procedures per 1,000 ever-married women[b]	15.2	9.2	24.5	20.2	5.4	25.7
Number of women who terminated pregnancy in the past 3 years, DHS sample	252	148	400	327	88	415
Percent of women undergoing procedure who were using:						
Modern method	21.1	30.0	24.4	13.7	20.7	15.2
Traditional method	27.0	22.0	25.2	53.5	32.7	49.1
No method	51.9	47.9	50.4	32.7	46.5	35.6

Source: DHS Final Report 1997, Tables 4.23 and 4.24, DHS Final Report 2002, Tables 4.21 and 4.22, and author's calculations of the procedures per 1,000 ever-married women.

Notes: a. The numbers of MRs and abortions in Table 4.24 in the 1997 DHS are reversed (personal communication, Anne Cross, ORD/Macro). This table reflects that correction. b. Calculated as the number of procedures over the past 3 years, divided by 3, divided by the total number of ever-married women who were interviewed (5,664 in 1997, 5,665 in 2002), and multiplied by 1,000. These rates have not been weighted with sampling weights.

Table D.8. Trends in reported health problems and treatment following pregnancy terminations in the 3 years before the survey, DHS sample

	Menstrual regulation		**Induced abortion**		**Total**	
	1997	**2002**	**1997**	**2002**	**1997**	**2002**
Number of procedures in past 3 years, DHS sample	259[a]	344	127[a]	92	416	437
Number reporting a health problem, DHS sample[b]	75	162	52	47	137	210
(As a percent of all procedures)	(28.8)	(47.0)	(40.7)	(51.4)	(33.0)	(48.0)
Number who sought medical advice or treatment, DHS sample[b]	11	114	11	30	23	145
(As a percent of those reporting a problem)	(14.4)	(70.6)	(20.4)	(63.4)	(16.8)	(69.0)

Source: DHS Final Report 1997, Table 4.24, and DHS Final Report 2002, Table 4.22.

Notes: a. The numbers of MRs and abortions in Table 4.24 in the 1997 DHS are reversed (personal communication, Anne Cross, ORD/Macro). This table reflects that correction. b. Approximate number, based on multiplying the percentages in the source tables by the number of procedures.

Annex E. Borrower Comments

June 23, 2006

In general, the Report is very careful in all aspects of the project with a lot of supporting data and figures from various surveys. I have some comments as follows:

Page 6, para 2.7: You think that the program in Vietnam has strong incentives: We do not call it incentives, as in the true sense, it is not incentive at all. As you know, each collaborator gets 20.000 VND/month ($1.50), just a pack of sweets for their children when they come home. The calculation of the budget based on targets of acceptors is the right thing in a very poor country with very limited recourse while the birth rate at that time was still very high.

Page 11, para 4.4, dot 3: The last sentence: *However, none of the essential drugs was available at all CHCs: I do not fully understand this sentence*, because, you wrote that 90% of CHCs had 7 of the 20 drugs.

Page 12, para 4.6: You compared New Choice at price of 1,000 NVD and another pill at 50,000 NVD in the free market. I don't really understand this comparison. One is a subsidized price for poor people, the other is for the rich ones. Therefore, you should write something to clarify to show out the true nature of the price difference.

Page 13, para 4.7: *There is no room for staff housing:* all staff in CHCs are living in the communities, why do they need housing?

Page 21, para 5.3: FP services and modern methods; *outcome is unsatisfactory:* If you compare DHS 1997 and 2002, you can see a big rise in oral pills and condoms and a decline in IUD; this is an achievement in national program because for many years, the program in Vietnam has been regarded as a one method program. So I propose the outcome is modest.

Page 22, para 5.5: *Finally, the nation wide expansion of RH campaigns without evaluation of their design and impacts:* We had a very serious evaluation of these campaigns done by an independent agency, sent it to the government, made it a standard and now, they have become a government means to provide services to people in the difficult areas. We regarded this model as the most successful. It sustained in terms of continuing supported by the Government as well as the support from the poor people.

I hope these comments will help in one way or another in finalizing your report.

Yours sincerely,

Tran thi Thanh Mai
Project Vice Director