ASIAN DEVELOPMENT BANK **PCR: VIE 26378**

PROJECT COMPLETION REPORT

ON THE

POPULATION AND FAMILY HEALTH PROJECT
(Loan 1460-VIE [SF])

TO THE

SOCIALIST REPUBLIC OF VIET NAM

November 2004

CURRENCY EQUIVALENTS

Currency Unit – dong (D)

		At Appraisal	At Project Completion
		(20 Aug 1996)	(21 June 2004)
D1.00	=	$0.00009	$0.00007
$1.00	=	D11,005	D15,485

ABBREVIATIONS

ADB	–	Asian Development Bank
AIDS	–	acquired immunodeficiency syndrome
BCC	–	behavior change communication
CHC	–	commune health center
CPR	–	contraceptive prevalence rate
DHC	–	district health center
FP	–	family planning
HIV	–	human immunodeficiency virus
ICB	–	international competitive bidding
IDA	–	International Development Association
IEC	–	information, education, and communication
IMR	–	infant mortality rate
IUD	–	intrauterine device
JFPR	–	Japan Fund for Poverty Reduction
KAP	–	knowledge, attitude, and practices
KfW	–	Kreditanstalt für Wiederaufbau
MCH	–	maternal and child health
MIS	–	management information system
MMR	–	maternal mortality ratio
MOH	–	Ministry of Health
MTR	–	midterm review
NCPFP	–	National Committee for Population and Family Planning
NGO	–	nongovernment organization
PHC	–	primary health care
PM	–	person-month
PMU	–	project management unit
RH	–	reproductive health
SDR	–	special drawing rights
STI	–	sexually transmitted infection
TTV	–	tetanus toxoid vaccine
UNFPA	–	United Nations Populations Fund
VCPFC	–	Viet Nam Commission for Population, Family, and Children
VHW	–	village health worker (MOH)
VPC	–	village population collaborator (VCPFC)

NOTES

(i) The fiscal year (FY) of the Government ends on 31 December.
(ii) In this report, "$" refers to US dollars.

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BASIC DATA

A. Loan Identification

1.	Country	Viet Nam
2.	Loan Number	1460
3.	Project Title	Population and Family Health
4.	Borrower	Socialist Republic of Viet Nam
5.	Executing Agency	National Committee for Population and Family Planning
6.	Amount of Loan	SDR29.501 million
7.	Project Completion Report Number	VIE 844

B. Loan Data

1.	Appraisal	
	– Date Started	27 May 1996
	– Date Completed	7 June 1996
2.	Loan Negotiations	
	– Date Started	19 August 1996
	– Date Completed	20 August 1996
3.	Date of Board Approval	19 September 1996
4.	Date of Loan Agreement	28 November 1996
5.	Date of Loan Effectiveness	
	– In Loan Agreement	26 February 1997
	– Actual	11 March 1997
	– Number of Extensions	1
6.	Closing Date	
	– In Loan Agreement	30 June 2003
	– Actual	11 December 2003
	– Number of Extensions	0
7.	Terms of Loan	
	– Service Charge	1.0% per year
	– Maturity	40 years
	– Grace Period	10 years

8. Disbursements

a. Dates

Initial Disbursement	**Final Disbursement**	**Time Interval**
31 July 1997	11 December 2003	77 months
Effective Date	**Original Closing Date**	**Time Interval**
11 March 1997	30 June 2003	78 months

b. Amount ($ million)

Category or Subloan	Original Allocation	Last Revised Allocation	Amount Canceled	Net Amount Available	Amount Disbursed	Undisbursed Balance
01- Civil Works	12.80	8.83	3.97	8.83	8.83	0.00
02- Equipment & Vehicles	10.80	20.07	(9.27)	20.07	20.07	0.00
03- Drugs & Medical Supplies	8.90	1.49	7.41	1.49	1.49	0.00
04A-Health Worker Training Consultants	0.25	1.17	(0.92)	1.17	1.17	0.00
04B-Health Worker Training-Other Training Expenses	1.45	0.57	0.88	0.57	0.57	0.00
05A-Studies & Pilot Programs Consultants	0.14	0.93	(0.79)	0.93	0.93	0.00
05B-Studies & Pilot Programs-Pilot Test Costs	2.76	4.16	(1.40)	4.16	4.16	0.00
06- Service Charge	1.80	1.28	0.52	1.28	1.28	0.00
07- Unallocated	4.10	0.00	4.10	0.00	0.00	0.00
Total	**43.00**	**38.51**	**4.50**	**38.51**	**38.51**	**0.00**

9. Local Costs (Financed)
- Amount ($ million) 10.81
- Percent of Local Costs 84.56
- Percent of Total Cost 28.07

C. Project Data

1. Project Cost ($ million)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	29.10	27.70
Local Currency Cost	13.90	10.81
Total	**43.00**	**38.51**

2. Financing Plan ($ million)

Cost	Appraisal Estimate	Actual
Implementation Costs		
Borrower-Financed	17.20	10.84
ADB-Financed	41.20	37.23
Other External Financing	66.00	59.61
Total	**124.40**	**107.68**
IDC Costs		
Borrower-Financed	0.00	0.00
ADB-Financed	1.80	1.28
Other External Financing	0.00	0.00
Total	**126.20**	**108.86**

ADB = Asian Development Bank, IDC = interest during construction.

3. Cost Breakdown by Project Component ($ million)

Component	Appraisal Estimate	Actual
A. Provincial Level Service Delivery		
1. Facility Upgrading	21.10	15.58
2. Equipment Provision	20.10	39.73
3. Essential Drug Supply	14.40	2.34
4. In-Service Training	4.20	3.76
5. Outreach Strengthening	6.50	0.00
Subtotal Provincial Level Service Delivery	**66.30**	**61.40**
B. National Level Program		
1. Strengthening FP IEC	12.90	9.97
2. Contraceptives Supply	24.20	20.35
3. Management & Institutional Development	5.50	3.97
4. FP Service Delivery Model Initiative	4.60	11.99
Subtotal National Level Program	**47.30**	**46.28**
Total Baseline Costs	**113.60**	**107.68**
Physical Contingencies	4.10	0.00
Price Contingencies	6.70	0.00
Total Project Costs	**124.40**	**107.68**
Service Charge During Project Life	1.80	1.28
Total	**126.20**	**108.96**

FP = family planning, IEC = information, education, and communication.

4. Project Schedule

Item	Appraisal Estimate	Actual
Date of Contract with Consultants	June 1997	June 1997
Completion of Engineering Designs	December 1998	June 2000
Civil Works Contract		
Date of Award	June 1997	November 1997
Completion of Work	June 1998	June 2001
Equipment and Supplies		
Dates		
First Procurement	September 1997	August 1997
Last Procurement	December 1998	October 2002
Completion of Equipment Installation	June 2002	November 2002
Start of Operations		
Completion of Tests and Commissioning	June 2002	November 2002
Beginning of Start-Up	June 2002	November 2002

5. Project Performance Report Ratings

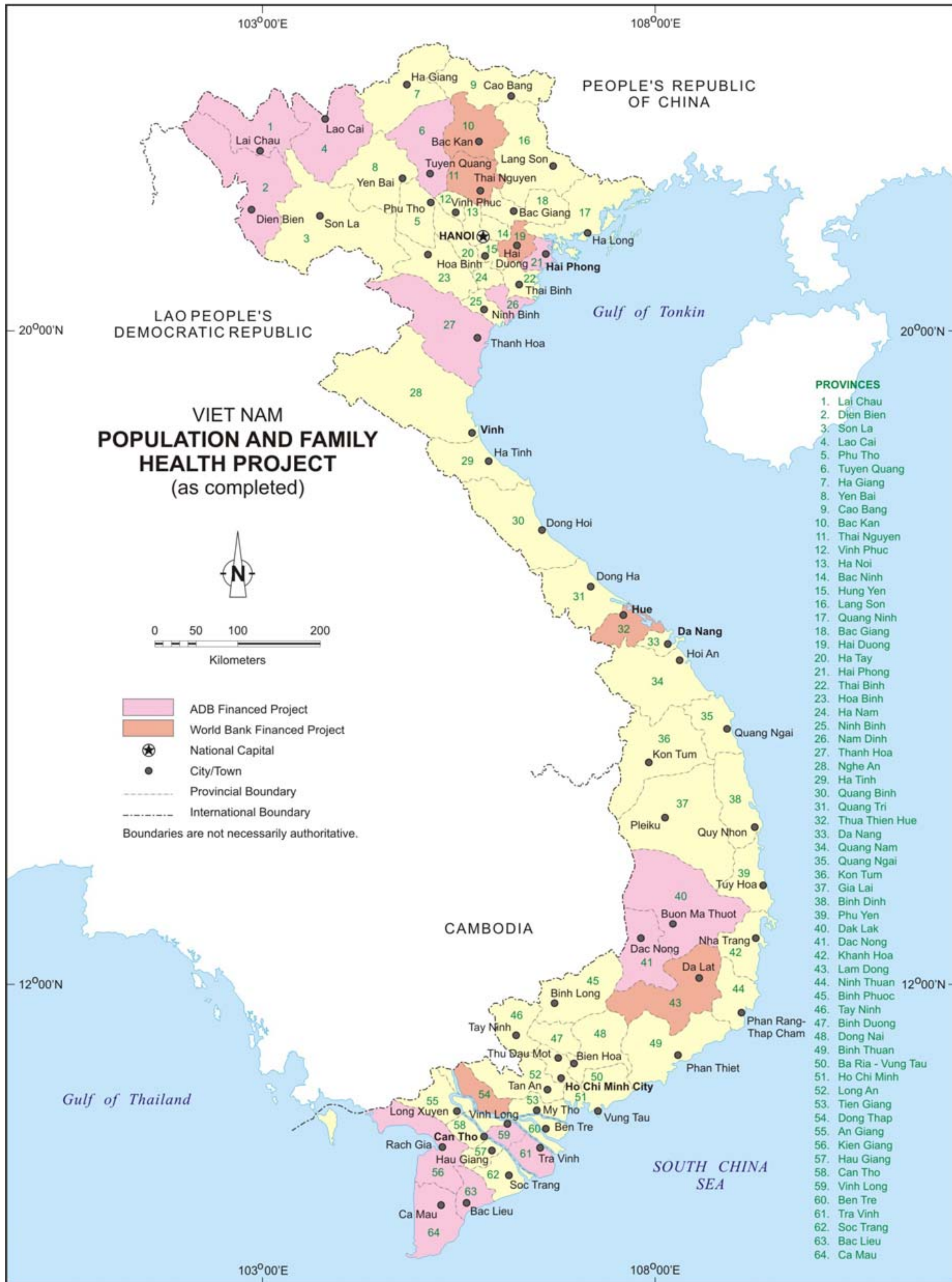
Implementation Period	Ratings	
	Development Objectives	**Implementation Progress**
From 19 September 1996 to 31 December 1996	Satisfactory	Satisfactory
From 1 January 1997 to 31 December 1997	Satisfactory	Satisfactory
From 1 January 1998 to 31 November 1998	Satisfactory	Satisfactory
From 1 December 1998 to 31 December 1998	Satisfactory	Highly Satisfactory
From 1 January 1999 to 30 June 2003	Satisfactory	Highly Satisfactory

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members[a]
Fact-Finding	3–21 March 1996	5	80	a, e, i, k
Appraisal	27 May–7 June 1996	4	48	e, k
Inception	6–11 July 1997	3	18	d, e, g
Review 1	11–19 February 1998	1	9	e
Review 2	23–30 October 1998	1	8	e
Consultation	26–30 October 1998	1	5	a
Review 3	1–6 March 1999	1	6	e
Special Loan Administration 1	20–27 August 1999	1	8	c
Midterm	12–20 October 1999	5	29	d, f, g, c, h
Review 4	29 May–6 June 2000	1	9	d
Special Loan Administration 2	22–28 September 2000	1	7	c
Review 5	10–22 October 2000	1	13	d
Review 6	19–21 February 2001	1	3	d
Review 7	20–24 May 2002	1	5	d
Review 8	18–20 September 2002	1	3	d
Review 9	24–26 September 2003	2	6	b, g
Project Completion Review[b]	1–9 July 2004	3	49	j, g, k

[a] a - manager, b - principal project economist, c - senior project specialist, d - senior project economist, e - project economist, f - senior executive officer, g - assistant project analyst or project administration assistant, h - deputy resident representative, i - health specialist, j - senior health specialist, k - consultant.

[b] The Project Completion Report was prepared by V. de Wit, Senior Health Specialist; and V. Cabio, Assistant Project Analyst.



04-3026 HR

I. PROJECT DESCRIPTION

1. From 1996 to 2003, the Government of Viet Nam implemented the Population and Family Health Project (the Project). The purpose of the Project was to strengthen and revitalize family health and family planning programs, so as to improve the health of the population, and reduce fertility and population growth. The Project had three broad objectives: (i) to improve the quality and range of family health and family planning services, and increase their utilization; (ii) to enhance the management, planning, and policy formulation capabilities of the National Committee for Population and Family Planning[1] (NCPFP); and (iii) to expand the knowledge base on which policy and technical guidelines for family planning and family health will be founded. The Project was estimated to cost $126.2 million equivalent. It was cofinanced by the World Bank's International Development Association (IDA), for $46 million; the Asian Development Bank (ADB), for $43 million; Kreditanstalt für Wiederaufbau (KfW), for $20 million; and the Government, for $17.2 million equivalent. The project framework is in Appendix 1, and the evaluation methodology, including list of reference documents is in Appendix 2.

2. The project objectives were to be achieved through one provincial service delivery component (component 1) and four national program support components. ADB supported component 1 and the initiatives for mobilizing the private sector, under component 5. The original components were

(i) improving the delivery of provincial public health services, including (a) upgrading facilities; (b) providing furniture, service vehicles, and equipment; (c) supplying essential drugs and supplies; (d) training commune, district, and provincial health staff; and (e) strengthening outreach systems, for $66.3 million (ADB in 10 provinces; and IDA in 5 provinces).

(ii) providing information, education and communication, and social marketing, for $12.9 million (IDA).

(iii) supplying of contraceptives, for $24.2 million (KfW).

(iv) developing management and institutions, including surveys, management information systems (MIS), and management training, for $5.5 million (IDA).

(v) supporting service delivery model initiatives, consisting of (a) private sector mobilization, including regulatory reform, training of private practitioners, social marketing, and mobile clinics (ADB); and (b) public sector models, including reproductive health (RH) campaigns, health posts, safe motherhood, and training of village population collaborators (IDA); for $4.6 million total.

3. The NCPFP was the Executing Agency for the Project. Headed by the minister of NCPFP, it was responsible for project planning and coordination with the Ministry of Health (MOH) and provincial governments. The inter-ministerial Project Steering Committee included representatives from the Project Management Unit (PMU), MOH, the Ministry of Planning and Investment, the Ministry of Finance, the Ministry of Administrative Services, and the Ministry of Human Resource Development. Provincial project management units were established in all project provinces to work closely with the provincial health and civil works departments.

[1] The NCPFP became the Viet Nam Commission for Population, Family, and Children (VCPFC) in 2002, reflecting an expanding mandate that included childcare and rights.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

1. Formulation

4. ADB provided project preparatory technical assistance in June 1995 for a feasibility study, which included consultations with stakeholders during field visits and workshops.[2] The World Bank also consulted extensively on the preparation of the project design in the first half of 1995.[3] For loan fact-finding and appraisal, ADB staff visited selected provinces to consult with provincial governments, health staff, clients, nongovernment organizations (NGOs), and the private sector. During those visits, ADB staff also assessed the facilities and services in the provinces. Ethnic minorities were identified as a priority group with special needs, and special strategies were identified to reach them under the IDA part of component 5.

2. Relevance of Design

a. Supporting the Country Strategy

5. The Project supported the Government's population strategy for 2001–2010, and its comprehensive primary health care (PHC) approach that aimed to provide all communities of Viet Nam with access to PHC. The Project also was in line with ADB's operational strategy for Viet Nam, which emphasized efficient economic growth with equity, poverty reduction, and environmentally sound development. Finally, it also supported ADB's Population Policy, which promoted the integration of family planning and health services as part of PHC.

b. Addressing Family Needs

6. At appraisal in 1996, population growth was putting considerable pressure on Viet Nam's natural resources and development. The population had increased to 74 million, and the population growth rate was estimated at 2.5% per year, with a total fertility rate of 3.1 per woman. The contraceptive prevalence rate (CPR) was estimated at 65%, though half of this was through traditional methods. The common use of intrauterine devices (IUDs), abortion, and menstrual regulation was of major concern. The maternal mortality ratio remained above 100 per 100,000 live births, and was even higher among poor ethnic minorities. Child mortality (at 60 per 1,000 live births) and malnutrition remained high due to common health problems, such as malaria, diarrheal diseases, and acute respiratory infections, in particular among poor children.

c. Approach and Scope

7. In the 1980s, Viet Nam built an extensive PHC network and achieved health indicators that were very good relative to its economic level. The rural poor relied primarily on commune health centers (CHCs) that were managed and financed by cooperatives. However, the cooperative system collapsed due to economic reforms in the 1990s. Low public health spending of about $2 per person per year threatened past health gains, although some priority programs (such as family planning) remained well-financed. Some health indicators showed signs of reversal. Gains in health status were unevenly distributed between rich and poor. Recognizing these imbalances, the Government proposed investing in PHC and integrating

[2] ADB. 1995. *Technical Assistance to the Socialist Republic of Viet Nam for Population and Family Health Project.* Manila.

[3] The IDA Board approved the Project on 16 January 1996, and the IDA credit became effective on 24 May 1996.

family planning and health services. The project design was comprehensive with an emphasis on family planning. Demand and supply components, sector management, and the quality of public and private services were appropriately reflected in the design.

8. The Project scope was changed several times during implementation in response to new information and circumstances (Appendix 3). Some activities were outside project provinces. The four major changes in scope were:

(i) **Adding Provinces.** Under component 1, the number of participating provinces rose from 15 to 21, including an increase from 10 to 13 for ADB and from 5 to 8 for IDA.[4] Four provinces were added when provinces around Hanoi were split because of population size. Following floods in the southern tip of the Mekong Delta, Ca Mau and Bac Lieu provinces were added for post-flood reconstruction, meaning geographical expansion was limited to two provinces. Furthermore, many communes were divided, requiring additional project inputs.

(ii) **Reducing Drug Allocations.** The Government requested the cancellation of most of the procurement of drugs because (a) international competitive bidding was more expensive than locally produced medicines; (b) the Government had introduced a new drug revolving fund policy, which required patients to pay for drugs; and (c) the Government had adequate budget to procure drugs for the poor (all ethnic minorities and a proportion of other poor). This change of scope increased the share of spending on hospital services rather than CHCs. However, the majority of clients in these hospitals were also poor. An effort was made to ensure that free drugs for the poor were indeed available (para. 18).

(iii) **Shift to Reproductive Health.** As fertility targets had been reached (see para. 9), the Project was reoriented toward integrated RH services, in particular targeting populations with high levels of fertility. This included (a) improving the contraceptive mix; (b) switching from information, education, and communication approaches to behavior change communication (BCC) to increase the demand for RH services; (c) introducing adolescent RH education in schools; and (d) deepening the involvement of the private sector.

(iv) **Expanding Sexual Health Promotion.** A Japan Fund for Poverty Reduction (JFPR) project with a $3 million grant was added for community action to prevent the spread of HIV/AIDS[5] in five targeted provinces.[6] This was more the addition of a major component to the Project than a true change of scope. IDA reallocated $1million for an HIV/AIDS prevention model initiative. The JFPR components were condom promotion, BCC, and treatment of sexually transmitted diseases.

9. The results of the 1997 Demographic and Health Survey became available in the first year of project implementation. The data showed that project fertility and CPR targets for 2002

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[4] Lai Chau province was split into Lai Chau and Dien Bien provinces (ADB), Bac Thai province into Bac Kan and Thai Nguyen (WB) provinces, Hai Hung province into Hung Yen and Hai Duong provinces (WB), and Nam Ha province into Ha Nam and Nam Dinh provinces (WB). Buon Ma Thuot province was split into Buon Ma Thuot and Dac Nong province after project completion, and is still counted as one province.

[5] human immunodeficiency virus/acquired immunodeficiency syndrome.

[6] ADB. 2001. *Grant Assistance (Financed by the Japan Fund for Poverty Reduction) to the Kingdom of Cambodia, Lao People's Democratic Republic, and Socialist Republic of Viet Nam for Community Action for Preventing HIV/AIDS.* Manila.

already had been achieved. The national total fertility rate had fallen to 2.3 during 1994–96, while the CPR had increased to 75% of married couples (56% by modern methods). This highlighted the Government's commendable strides in promoting small families as the norm, and in providing effective family planning services to the people. Achieving demographic targets before the Project took off did not diminish their importance or relevance. Rather, the success helped the Project to focus on the important second generation issues. Project activities were reoriented to (i) increase access to RH services for ethnic minorities and people living in poor and remote areas, (ii) improve the quality of services, and (iii) promote sustainability of services. Accordingly, the Project focused on RH with the aim of creating specific capacities considered important to attaining Viet Nam's desired population and family health outcomes.

10. The private sector model initiative was also highly relevant. Research had shown tremendous growth in the private sector's provision of services in the past decade, with public sector employees providing a large proportion of these services. The issue was not how to promote private sector services, but how to ensure that they provide high-quality services. The Project's pilot efforts were appropriate, particularly for setting up medical associations and training private practitioners.

d. Implementation Plan

11. The Project supported the NCPFP, which was established in 1984. The NCPFP has units at the provincial, district, and community levels, allowing village population outreach workers to link with the health system of MOH under the coordination of the People's Party at each level. While this provided a strong policy framework and structure for implementation, the Project was challenging for several reasons. First, it concerned 2 sectors, 2 ministries, 5 layers of services, and 3 external funding agencies. Second, though the Borrower had United Nations experience, it lacked experience in implementing projects with the banks. Third, the NCPFP had a background in family planning services, rather than integrated maternal and child health (MCH) and family planning services. Fourth, the health services were under MOH, not NCPFP. Finally, ADB's involvement concentrated mainly on strengthening provincial health and population services (component 1) and on private sector model initiatives (component 5). ADB did not have direct control over three other essential project components—information, education, and communication (IEC); contraceptive supply; and management. However, the Project was implemented jointly.

B. Project Outputs

12. The project outputs were compared to outputs anticipated at appraisal.

1. Component 1: Provincial Service Delivery

13. The Project aimed to improve the quality and utilization of services by (i) supporting civil works for construction and renovation of selected health facilities; (ii) providing equipment, vehicles, and furniture; (iii) providing essential drugs and supplies throughout the Project; and (iv) training commune- and district-level health staff, including training of trainers at the national and provincial levels. The project outputs were:

a. Improving Health Facilities

14. The Project was to support the replacement, renovation, or upgrading of selected CHCs, district health centers (DHC)—including emergency obstetric and surgical wards—provincial

MCH/FP centers, and village health posts in 15 provinces (10 by ADB, 5 by IDA). The Project initially focused on improving CHCs. Later, several new CHCs were included in the Project to cover new communes that had been formed. To reach remote populations, one health post was planned for each district. However, following a reassessment of accessibility, the number of health posts constructed was reduced from 440 planned to 92. Some of these health posts, which are mainly used for mobile clinics, are not in targeted provinces. Village health workers, however, preferred working from home. No resettlement issues were reported.

15. ADB was to fund 1,697 health facilities. The Project's scope was increased considerably, with nearly 3,000 health facilities upgraded in 20 provinces (11 by ADB, 9 by IDA) at project completion, including 2,606 CHCs, 192 DHCs, 15 MCH/FP centers, 15 population centers, and 92 health posts. ADB funded 1,825 of these health facilities (110% of planned ADB-funded civil works), including 1,682 CHCs, 68 DHCs, 9 provincial MCH/FP centers, 6 population centers, and 92 health posts at sub-commune level (38 in ADB provinces; 22 in IDA provinces; and 32 in Hoa Binh, a non-project province for a model initiative). This subcomponent represented 20% of the Project at completion, compared to 12% at appraisal. Appendix 4 compares the planned and actual civil works.

b. Providing Equipment, Furniture, and Service Vehicles

16. Medical equipment, furniture, and service vehicles were delivered to ADB-funded provinces as follows: 2,153 CHCs (about 73 kinds of equipment each), 128 district hospitals, 14 provincial hospitals, and 11 provincial MCH/FP centers (about 68 varieties of equipment for each facility). More equipment than originally planned was supplied to the facilities, because additional funds were made available through cost savings on medicines. Equipment provided to CHCs was mainly for gynecological procedures, minor surgery, childcare, and sterilization. Districts and provincial hospitals were provided with x-ray, ultrasound, and anesthesia machines, as well as ventilators and surgical equipment. ADB expenditures on equipment totaled $20.4 million (53% of the total ADB budget) at project completion, more than double the appraised estimate of $9.8 million (23% of the ADB budget). A list of procured equipment is Appendix 5.

c. Providing Essential Drugs

17. Essential drugs were to be provided to 2,153 CHCs, 128 district hospitals, 14 provincial hospitals, and 11 MCH/FP centers. However, the subcomponent was canceled in 1998 after the Government noted that health facilities had adequate drugs, and a Government program was providing free drugs to the poor. Of the $14.4 million planned for this component (12% of the project budget at appraisal), only $2.3 million (2% of the project budget) was spent. The savings were used for the purchase of supplies, particularly for hospitals. Details are in Appendix 6.

18. The cancellation of this subcomponent in the context of the overall supply of drugs and the possible project impact was examined in some detail. As many as six drug supply systems are operating in parallel in the sector. Ethnic minorities and poor people were eligible for free drugs. The system apparently worked well, though several drawbacks were noted. First, the social welfare service had to confirm eligibility, thus creating some degree of social control. This could be a hurdle for ethnic minorities to access free services. Second, many non-eligible people had to pay for drugs, but were often too poor to do so. Third, users reported that the availability of free drugs was inadequate, causing stocks to run out. The cancellation of this subcomponent did not affect funding for drug programs. As reported by ADB missions, the Government budget compensated for the canceled drugs allocation under the Project. However,

a distribution problem might have had some impact, possibly resulting in local shortages and incomplete treatment. That, in turn, could lead to drug resistance. The importance of supplying drugs for the poor was reflected in the 2003 Decree 139, which established an equity fund to ensure easy access to drugs for all the poor. Donors are supporting this initiative.[7]

d. Training of Health Workers

19. The Project invested about $3.7 million in ADB and IDA provinces for medical retraining, less than the $4.5 million envisaged at appraisal. In the 11 ADB-financed provinces, hundreds of retraining courses were conducted for around 12,000 heath staff at all levels. The retraining included (i) 110 provincial core trainers' courses, (ii) 384 ultrasound courses, (iii) 228 anesthetic courses, (iv) 264 x-ray courses, (v) 447 district supervisor courses, and (vi) 9,680 training courses for commune health staff. See Appendix 7 for a list of training courses.

20. The training programs generally were considered successful. This subcomponent was the most appreciated of the Project, perhaps because it provided a welcome subsidy and opportunities to meet peers. A few participants complained that the curricula were not appropriate for certain levels, though these were minor. Based on survey data and interviews, staff appeared to be competent in most routine procedures. However, they still could benefit from additional training in basic work management, counseling, and specialized procedures.

2. Component 2: Information, Education, and Communication

21. This component, supported by IDA, was to strengthen and expand IEC channels, programs, and activities for family health programs nationwide. It also was to include launching an expanded social marketing initiative for pills. The Project was to finance the costs of (i) the development, production, and air or screen time for IEC media; (ii) training of IEC trainers; (iii) IEC training for healthcare providers and IEC staff; (iv) transport and equipment for collaborators; and (v) IEC training for special campaigns, workshops, and other events, as well as social marketing program costs (other than for pills, which would be supplied under component 3). Some villagers interviewed near CHCs and a health post said they knew about HIV/AIDS, with their knowledge ranging from knowing that it is a bad disease to knowing how to prevent it. However, many other villagers said they had never heard about it. Obviously, more HIV/AIDS education is needed.

3. Component 3: Contraceptive Supplies

22. This component, supported by KfW, was to finance the purchase of most of the contraceptive commodities required for an increased modern-method CPR and a broadened method mix. The aim was to shift from IUDs to oral pills, injectables, implants, and condoms from 1997 to 2000. This was in line with increasing the use of effective methods of contraceptives, and expanding contraceptive choice. As survey data showed, couples apparently did not shift contraceptive practices in project areas despite having more choice. More social analysis is needed to understand this finding. A second observation is that the trend in CPR between project and non-project areas was similar. One possible factor is that the NCPFP adopted a flexible approach, and used other funds to assist non-project provinces.

[7] ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for Health Care in the Central Highlands.* Manila. It includes cofinancing from the Swedish International Development Cooperation Agency for an equity fund of $5 million for the poor in the central highlands.

4. Component 4: Family Planning Management and Institutional Development

23. This component, supported by IDA, aimed to strengthen management, planning, and policy formulation capabilities in NCPFP and its subsidiary committee network. During loan fact-finding, ADB initially proposed a major management component. However, the Government didn't agree to this during appraisal. The component included identifying organizational needs, and developing appropriate curricula for training of trainers and training of staff. Overall, the implementation of this component was satisfactory. However, according to the PMU's final project report, the management training did not cover commune-level training. The PMU also did not contract international technical assistance. To cut costs, the planned overseas post-graduate training for building sector development know-how also was canceled.

24. An MIS was envisaged to support strategic planning at the national and provincial levels, coordination at the district level, and operational activities at the commune level. The Project supported (i) procurement of computers, other equipment, and software; (ii) workshops; (iii) development of training curricula, and training for management and MIS trainers; and (iv) MIS training courses for NCPFP staff at all levels. The component also was to cover the costs of the project management structure, and monitoring and evaluation activities. This subcomponent was delayed, partly because of the failure to hire an international consultant. The MIS subcomponent eventually was canceled due to these implementation delays.

5. Component 5: Service Delivery Model Initiatives

25. This component aimed to provide funds for developing models, and pilot testing new and innovative approaches to family health service delivery. If the tests were considered successful, component 1 would extend these models to all project provinces. ADB was to support the mobilization of private and NGO participation in family health service delivery, while IDA was to support public initiatives. Proposals were developed during project implementation. A summary of the model service delivery initiatives is in Appendix 8. To strengthen PHC service delivery, ADB supported a network of village-level health posts in remote mountainous areas in all project provinces. This subcomponent was discontinued, however, when the model was deemed unsustainable. Similarly, IDA tested a model for strengthening hamlet-based network of family health workers in remote areas in all project provinces, which involved upgrading village population collaborators to full-time heath staff. The model also was canceled.

26. Several integrated outreach programs were tested, such as (i) the MCH program, (ii) the mobile team program, (iii) the integrated population program, and (iv) the integrated RH campaigns. The capacity of staff to develop these different models was limited, and the remaining project time was too short for these initiatives to materialize fully and demonstrate impact. However, these models generally were found to be effective in reaching the poor, and the Government plans to expand the integrated RH campaigns. Similarly, the JFPR project, which covered community-based HIV/AIDS prevention, BCC, condom promotion, and treatment of sexually transmitted diseases, was considered successful.

27. ADB eventually supported only a few private-sector initiatives. One of the most successful involved setting up a medical association in one province at very low cost. This showed great potential for expansion and sustainability nationwide. This was to be expanded, according to a loan covenant. Other initiatives such as social marketing, mostly in urban areas, were less successful.

C. Project Costs

28. The Project cost was estimated at $126.2 million equivalent. ADB was to finance $43.0 million equivalent for (i) provincial services delivery (component 1) in the ADB provinces, (ii) the private sector mobilization subcomponent of the service delivery model initiatives (component 5), and (iii) the service charge on the ADB loan during the project life. IDA financing was to be $46.0 million equivalent, while KfW was to provide a $20.0 million equivalent grant. The Government was to contribute $17.2 million equivalent. Appendix 9 summarizes and compares the cost estimates at appraisal and actual costs at project completion.

29. During the Project, changes in the exchange rate between special drawing rights (SDR) and $ reduced the budget by more than 10%. However, changes in the exchange rate between the $ and Viet Nam dong increased the budget expressed in local currency.

30. In 1998, $3 million of the ADB loan was reallocated from the drugs and medical supplies component for the purchase of equipment and vehicles. Following the midterm review (MTR) in 1999, a major reallocation of $7 million of the ADB loan was made from civil works and drugs and medical supplies to equipment and vehicles. As a result, nearly 90% of the original budget for essential drugs was reallocated following the cancellation of the essential drugs component. The splitting of provinces and communes did not require a reallocation. However, the flood emergency response in 2000, which added two provinces in the Mekong Delta, and RH campaigns in the highlands required a reallocation of $3.2 million from the unallocated budget to purchase drugs, equipment, boats, and operational costs of medical camps. For the IDA loan, the MIS subcomponent was canceled in 2001, and $9 million was reallocated to other activities. IDA also reallocated $2.6 million to cover the increased requirement for contraceptives generated by RH campaigns. For ADB and IDA combined, more than $10 million was reallocated to carry out five RH campaigns in remote areas.

31. Savings from competitive bidding, favorable exchange rates, and overly generous estimates of original costs totaled more than $18 million, which was reallocated to meet project needs. These included (i) upgrading more than 1,000 additional facilities (580 funded by ADB); (ii) increasing medical equipment from 60% to 80% in project CHCs; and (iii) increasing medical equipment, such as x-ray and ultrasound machines and ambulances, for DHCs. These doubled the equipment budget from $17.6 million to $34.6 million. ADB inputs increased by nearly $8 million, and IDA agreed to similar increases in the IDA provinces.

D. Disbursements

32. Proceeds of the ADB loan for $38.51 million equivalent were disbursed in accordance with ADB guidelines. Loan proceeds were fully utilized by the end of the Project. The Government provided timely counterpart funds as per the Loan Agreement, averaging 9% for the Project. Annual disbursements by source, component, and category are in Appendix 10. Disbursements initially were slow due to (i) the need for careful planning, (ii) difficulties in arranging suitable mechanisms for flows of funds, (iii) building understanding of the disbursement procedures of the two banks, and (iv) high turnover of project staff. The highly capable and determined PMU overcame these difficulties. The initial imprest account of $1 million was increased to $2 million in 1998, and to $3 million in 1999. This helped maintain a smooth flow of funds and project momentum. The turnover ratio of the imprest account varied from 2.2 in 1999 to 1.0 in 2002, with an average of 1.8. Annual contracts awarded continued to increase, reaching $10.48 million in 1999. However, the momentum slowed due to the 5-month delay in obtaining Government approval of the 1999 annual plan. The main reasons for good

disbursement performance were the PMU's leadership, PMU staff's effective guidance on ADB procedures, detailed planning by the PMU, and NCPFP's strong support and supervision. Appendix 10 also includes a comparison of planned and actual disbursements by source.

E. Project Schedule

33. ADB's portion of the Project was to be implemented from March 1997 to June 2003 (for 75.7 months). Instead, it was implemented from July 1997 to December 2003 (for 76.3 months). Appendix 11 shows the planned and actual implementation schedules. The large number of stakeholders, project sites, and activities caused some initial delays in implementation. In addition, the three cofinanciers had their own sets of procedures, and the Borrower was not familiar with multilateral bank procedures. This was the first social sector project ADB financed in Viet Nam since resuming lending operations in 1993. IDA had funded only one social sector project in Viet Nam previously. Government procedures were also being developed at the time, which presented additional challenges for the Borrower. The increase in the number of facilities to be upgraded and medical equipment to be procured also delayed project completion. Access to remote facilities was difficult, as was the recruitment of international consultants. However, implementation proceeded satisfactorily and almost all project activities were completed within the original project period.

F. Implementation Arrangements

34. The NCPFP, as a central committee aligned directly under the central government, was established to work across sectors. As such, it had considerably more autonomy, administrative flexibility, and scope for cross-agency coordination than regular line ministries. To ensure interagency coordination and guidance for the Project, the NCPFP established an inter-ministerial steering committee for the Project. The committee comprised representatives from the ministries of Health, Finance, Planning and Investment, and Communication and Works; as well as the Women's Union and the Youth Union. In FY2000, the Viet Nam Commission for Population, Family, and Children (VCPFC) replaced NCPFP, reflecting a new institutional orientation with broader functions and mandate. However, the institutional change affected the functioning of the steering committee over a period of 2 years.

35. A PMU was set up within NCPFP to coordinate and administer day-to-day project implementation. The PMU had strong leadership and clear authority. However, it fell somewhat short on technical capacity, which affected project adjustments according to emerging needs, design work, and monitoring. The PMU's capacity initially was affected by high turnover of staff, and the numerous procedural and administrative hurdles presented by the donors and the Government. Once these hurdles were overcome, project implementation and disbursements moved forward more efficiently.

36. The Project was to be implemented through MOH. The NCPFP had some initial coordination and communication problems with provincial health departments. However, NCPFP and MOH built a strong relationship, allowing the Project to be implemented on time. Compared with other projects in Viet Nam and elsewhere, this collaboration was among the best, for which the Government should be congratulated. Management challenges included decentralization of responsibilities for civil works to the provinces, planning and reporting procedures, flow of funds, and limited capacities and experience in the provinces.

G. Conditions and Covenants

37. The NCPFP basically complied with the covenants in the Loan Agreement with few exceptions. No covenants were canceled, modified, or waived. The audited financial statements (Loan Agreement, Section 4.06[b]) were satisfactorily complied with up to FY2002. The reports mentioned the quality of civil works and equipment, and the problems of documentation at the provincial level. The surveys and studies for developing strategies for ethnic minorities were delayed somewhat, and the cost-recovery strategy for drugs was delayed for about 1 year. The development of professional associations, although a successful model, was not replicated, as called for by a loan covenant (Loan Agreement, Schedule 6, para. 16). The assessment of compliance with loan covenants is summarized in Appendix 12.

H. Related Project

38. The JFPR was added to strengthen community action for preventing HIV/AIDS (footnote 6). The use of project structures was expected to facilitate JFPR startup—an innovative approach. The Project is doing well, and is to be closed in December 2004.

I. Consultant Recruitment and Procurement

1. Recruitment of Consultants

39. Under the Project, 61.6 person-months (pm) of international consulting services were planned, including 6 pm with ADB support and 55.6 pm with IDA support. ADB actually supported 9.5 pm of international consulting services, while IDA supported did not support any. Domestic consulting services totaling 2,301 pm also were planned, with ADB supporting 545 pm and IDA 1,756 pm. ADB actually supported 426 pm of domestic consulting services, while IDA did not support any. Consultants were engaged in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB for the engagement of domestic consultants. Appendix 13 provides a list of consulting services.

2. Procurement of Civil Works, Equipment, and Supplies

40. Procurement of civil works, equipment, and supplies was carried out in accordance with ADB's *Guidelines on Procurement*. During the Inception Mission, the Government requested to discontinue the use of the prequalification procedure as stipulated for ADB-financed procurement. This request was made because civil works (i) were small and simple, (i) had location-specific designs for repairs or renovations of CHCs and DHCs, and (iii) were scattered over the provinces. Unit costs were about $3,000 for 440 health posts, $6,700 for 1,697 CHCs, $11,600 for 103 DHCs, and $21,000 for 10 provincial MCH/FP centers. CHCs came in three types for different climatic conditions and workload.

41. Civil works initially were delayed during the preparation and approval of the plans. In ADB provinces, 131 bidding packages were tendered, including 121 by national competitive bidding. The bidding process, which was delegated to the provinces, was generally competitive, transparent, and fair to bidders. Despite the large increase in the number of facilities upgraded (nearly 1,000 more than at appraisal), only two thirds of the estimated ADB budget at appraisal was spent ($8.6 million versus $13.9 million). The design—and perhaps the large number of bidders (521 for 131 packages)—saved 7% on estimated civil works.

42. Local leaders and health workers generally appreciated the new facilities. However, staff complained about lack of space, including small rooms and low roofs (some earlier buildings reportedly were larger), and combined examination and treatment rooms. The separate obstetric and family planning rooms are too small to be practical, and should be combined given their modest use. Despite extensive consultations, the design did not optimally balance workload, climate, quality, and costs. The Government already has developed a new, larger design for CHCs, which is expected to meet requirements. The quality of CHC construction, as reported and observed, was mixed. Leaking roofs were a common problem. For hospitals, a similar low budget approach caused some design problems. Given the state of some hospital buildings, replacing them may have been more appropriate. The districts are facing budget constraints for maintenance. ADB will need to follow up on the civil works.

43. The project vehicles, ambulances, and motorcycles were appreciated and properly used. Boats also were provided to some districts to deal with emergency floods, though some were underused and should be relocated. Given the supervision constraints, hospitals and CHCs could have been provided with more motorcycles or bicycles. Most equipment and furniture were satisfactory and being used. However, some imbalances were apparent: (i) standard autoclaves were too small for district hospitals and too large for CHCs; (ii) operating theater lights and ventilators were undersized; and (iii) too many bed cupboards were supplied, while not enough beds were provided. Some equipment also overlapped, such as blood analyzers and ultrasound machines. Consultations with users before purchasing equipment appeared to have been inadequate. Maintenance of equipment, including after-sales services, appeared to be satisfactory. Staff training and instructions, especially for more complicated equipment, could have been better. The Government was asked to decentralize the procurement of equipment to the provinces, and ensure the concurrence of users such as surgeons and nurses before proceeding with procurement. Appendix 14 provides a summary of supply contracts.

J. Performance of Consultants, Contractors, and Suppliers

44. The overall performance of consultants engaged under the ADB loan was satisfactory. Contractors for civil works were often small firms with limited capacity and experience in civil works. A combination of design features, low-cost contracts, and limited construction supervision resulted in substandard construction. The performance of suppliers of medical equipment also was mixed.

K. Performance of the Borrower and the Executing Agency

45. The performance of the NCPFP as the Executing Agency was highly satisfactory. NCPFP provided exemplary leadership in project implementation in a relatively new administrative environment. Working closely with MOH, the NCPFP developed a successful multisectoral approach. The NCPFP also delegated civil works to the provinces, and enhanced participation of stakeholders and beneficiaries. Since the Project started, the NCPFP's mandate was revised to focus on advocacy for RH, HIV/AIDS, and children's rights. To strengthen the capacity of other agencies, lessons learned in project implementation should be shared. (MOH is implementing a similar ADB project.[8]) As the NCPFP stated in its final project report, the Project "has contributed to an open-minded policy toward cooperation with other institutions, which has been rare in Viet Nam and deserves imitation."

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[8] ADB. 2001. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for the Rural Health Project*. Manila.

L. Performance of the Asian Development Bank

46. ADB's performance was rated as satisfactory. ADB provided high-quality support, though less frequently than desirable. The Project was supported from headquarters. ADB staff conducted 10 review missions (1–2 per year), including regular field visits. Placing a local health staff in the Viet Nam Resident Mission in Hanoi would have facilitated project implementation and monitoring, sector work, and donor coordination. However, ADB staff remained in close contact with the NCPFP during project implementation, and the Viet Nam Resident Mission was responsive to requests from the NCPFP. ADB approvals of terms of reference, tender documents, bid evaluation reports, contracts for international procurements, and requests to increase the limit for the imprest account were handled in a timely fashion. ADB procedures were carefully explained and problems were solved jointly. ADB, NCPFP, and PMU showed excellent cooperation throughout the Project.

III. EVALUATION OF PERFORMANCE

A. Relevance

47. The Project is assessed as highly relevant. During the Project, Viet Nam's population increased from 74 million to 81 million. The Government and ADB had prioritized population control and family health in Viet Nam. The project design was appropriate based on the information available at that time. However, events during the Project required design changes that shifted the focus from fertility reduction for the general population to RH, particularly for ethnic minorities. The Project was suitably adjusted following the MTR, probably increasing the impact on high-fertility populations, although this has not been demonstrated yet.

48. The project design adequately reflected the understanding of the governance, capacity constraints, and social challenges in the sector. The MTR noted that increased local participation had improved ownership, appropriateness of design, quality of civil works, and service delivery. More user inputs would have benefited project implementation. The changes made during reviews strengthened the Project. When the budget for drugs was reduced, the Government provided adequate financial compensation. However, this might have decreased the Project's leverage to facilitate the timely procurement of drugs, and ensure that mechanisms are in place to make these available to the poor. Technical expertise also could have avoided some of the inappropriate procurement. The implementation arrangements, which were appropriate, were adjusted as needed over time, including a substantial change in scope and delegation of authority to the provinces. The NCPFP was prepared to make adjustments to improve project performance.

B. Efficacy in Achievement of Purpose

49. The Project is assessed as efficacious. Project targets were met in 1997 before the Project started, requiring new national targets to be followed for fertility and CPR. Because fertility targets had been met, the Project was reoriented towards RH services and ethnic minorities. The implementation of the ethnic minorities strategy is in Appendix 15. ADB project provinces showed a 77% increase in new acceptors of modern family planning methods.

50. During the Project, Viet Nam reduced population growth from 2.0% to 1.2% per annum. In addition, the total fertility rate fell from 2.1% to 1.9% children per woman, mainly because of fertility reduction in rural areas. The infant mortality rate, which was at 25 per 1,000 live births in 1997, declined to 18 per 1,000 live births in 2002. The reduced population growth was

estimated to have increased per capita income from $270 to $380 during this period. While the Project succeeded in improving access to noninvasive RH services, the CPR and contraceptive mix changed little. The abortion rate remained high, particularly among educated women. These were national statistics, and indicators for the direct impact on the project areas were not available. The new directions, implemented halfway through the Project, have not been evaluated. However, major progress was made in developing more integrated RH services, and expanding these services to ethnic minorities through RH campaigns. To realize the full impact of these investments, further improvement in CHC services and support for village health workers might be needed. The Project had a major impact on overall development goals, and succeeded in building the RH system and strengthening institutional and staff capacity. Appendix 16, project outcome, shows the baseline, original, and adjusted targets, as well as achievements at project completion. It also compares changes in CPR between project and non-project provinces, and presents nationwide change in contraceptive mix between 1997 and 2002.

C. Efficiency in Achievement of Outputs and Purpose

51. The Project is assessed as efficient. The Project initially focused on delivering highly cost-effective interventions through CHCs. This focus was diluted during implementation as hospitals were increasingly emphasized. The original focus was on civil works and equipment, with inadequate attention given to operating CHCs and reaching communities. The budget for medicines was cut for a variety of reasons (paras. 17 and 18). This should not have affected funding of drugs, which was adequate. However, the distribution of drugs might have been affected, causing inefficient service delivery. The numerous small pilots and interventions also affected project implementation. Coordination among external funding agencies was excellent. The project team made some important policy changes for drugs and ethnic minorities. Throughout the Project, the Government and ADB management were pragmatic. The PMU was generally efficient, including in financial management. The high turnover of staff, which was attributed to low pay and an increase in alternative job opportunities, was a major issue. As staff settled in, staff turnover stabilized.

D. Preliminary Assessment of Sustainability

52. The project achievements are likely to be sustainable. The Government has demonstrated its commitment by increasing budget allocations for the health sector, releasing funds on time, and assuring a continuation of financing for the expanded services. The provincial governments have demonstrated their ownership and commitment through regular contributions for project implementation and allocations for the new facilities. However, an adequate budget still needs to be secured for training and maintenance.

E. Environmental, Sociocultural, and Other Impacts

53. Other project impacts are substantial. The Project made a major contribution toward building the capacity of the Government and the provinces in project implementation and health system development. Project implementation did not generate any significant negative environmental, sociocultural, and other impacts. The management of medical waste at hospitals and health centers showed some improvement, mainly by using incineration. However, this should be improved using clear guidelines, regular inspection, staff training, and community involvement. Medical waste was handled well in locations with strong community participation.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

54. The Project was considered satisfactory in terms of relevance, design, implementation, institutional development, and sustainability.

55. The project objectives and scope were generally sound, though they required reorientation after loan effectiveness as fertility and contraceptive prevalence targets already had been met. In consultation with ADB, the Government adjusted the targets, and these national targets were met. Coverage data showed no significant difference between project and non-project provinces, perhaps in part because the project provinces were less developed. However, the Government also switched its own resources to non-project provinces—to the extent that these were receiving more funds than project provinces—in a sense making this a nationwide sector program. This was acceptable.

56. The lack of improvement in contraceptive mix before and after the Project was a major concern. Given the vastly improved network of health services, quality of health staff, and demand generation, more use of noninvasive services would have been expected. However, reliance on IUDs and menstrual regulation as methods of contraception continues to be high. It is possible that substantial impact will materialize. However, in light of their gender implications, more efforts should have been made to change the contraceptive mix.

57. The overall focus of the Project was on family planning rather than family health. The original scope of the Project covered (i) improving the network of health facilities, (ii) public health education, (iii) services management, (iv) contraceptive supply, and (v) testing several innovative and promising strategies in the public and private sector. The scope did not change until MTR. After achievement of the general fertility targets became known, the Project was refocused on RH and health care for the poor, especially ethnic minorities who had high mortality and fertility rates. However, implementing the revised objectives and scope in full within the remaining project period—particularly reaching ethnic minorities—was difficult.

58. Project implementation generally was good. With a strong Executing Agency and good cooperation with the World Bank and KfW, ADB was involved fully in the other components to facilitate synergy. Coordination between the NCPFP and MOH was very good, helping to complete the Project on time and demonstrating the NCPFP's capacity. Implementation of the MIS component by IDA was less successful, a typical problem for many projects. Specific problems in project implementation included (i) inadequate participatory planning to help improve the quality of civil works and appropriateness of equipment; (ii) inadequate support for operating CHCs, and (iii) ensuring easy access to free drugs for the poor.

B. Lessons Learned

59. Project design would have benefited from more preparatory sector work, including updated information on key indicators and detailed understanding of issues at field level. This would have allowed the planning of second generation RH activities upfront.

60. Project impact cannot be assumed based on a broad design, reflecting all major elements of the health system. Rather, it depends on participatory planning and strategy adjustments based on changes in health behavior and quality of care. The NCPFP demonstrated flexibility to adjust the Project as required.

61. The management structure made establishing a link to field performance difficult. However, the project demonstrated valuable lessons for good project management, including clear assignment of responsibilities, intensive coordination, and flexibility in implementation.

62. Cofinanciers should harmonize their requirements in advance, to the extent possible.

63. The construction and maintenance of health centers was much better in locations where communities participated strongly. Communities should be involved in the planning of health centers, and agree with the authorities on the maintenance of the facility. The issue of medical waste should be addressed early in project preparation, included in loan covenants, and followed up during reviews. Health projects should provide clear guidelines, regular inspection, staff training, and community involvement for the handling of medical waste.

C. Recommendations

1. Project-Related

64. The Government will prepare and implement a plan to address shortcomings in civil works and equipment, and this will be reported to ADB. The Government also will continue monitoring the utilization of upgraded CHCs, address problems in service delivery and supply of free drugs for the poor, and make adjustments as necessary. This also will be reported to ADB, which requested quarterly progress reports from the Government until the end of 2005. Additional technical assistance would be useful in improving the operations of CHCs with involvement of local communities to increase the impact on the poor, including ethnic minorities.

65. In terms of follow-up actions on loan covenants, the Government should prepare a plan to expand innovative, successful strategies initiated in component 5, particularly the formation of medical associations for private doctors. Further technical assistance also is needed to expand private sector initiatives.

66. The project performance audit report should be carried out after July 2005 to derive a better sense of the Project's impact, particularly on ethnic minorities. Ideally, the report should wait until the next major household survey that covers mortality, fertility, and service coverage indicators.

2. General

67. Sector analysis and sector capacity in resident missions for the design and implementation of health projects should be strengthened (para. 59).

68. Advance action for civil works is recommended to speed up project implementation and allow more time to make services operational.

69. Perhaps most important, the Mission recommends full participation of end users and beneficiaries as the basis for future project design and implementation.

PROJECT FRAMEWORK

Design Summary	Project Targets	Monitoring Mechanisms	Project Achievements
Goal To support the Government's achievement of its demographic and family health goals.	To strengthen the NCPFP's contributions to the Government's overall objectives.	Baseline, midterm, and final surveys Socioeconomic surveys	The Government is fully committed to the achievement of population and family health objectives.
Objectives 1. To improve the quality and range of family planning services and increase their utilization. 2. To enhance NCPFP's management, planning, and policy formulation capabilities. 3. To enhance the knowledge base on which policy and technical guidelines for family planning and family health will be founded.	By the end of the Project - reduction in fertility rate from 2.9 to below 2.5 - increase modern method CPR from 4% to 56% - increase supply-based methods from 10% to 25% - increase access to family planning methods - increase need for life-saving obstetric care - reduce abortion rate by 30% - increase utilization of CHCs for antenatal care - increase immunization of 1-year olds - reduce infant mortality rate from 4.0% to 2.5% - improve management information availability	 Baseline, midterm, final surveys Baseline, midterm, final surveys Baseline, midterm, final surveys Baseline, midterm, final surveys ; facility records Facility records Baseline, midterm, final surveys Household survey, facility surveys Baseline, midterm, final surveys Baseline, midterm, final surveys Program planning and assessment documents, interviews and managers	 Achieved, 1.9% Achieved, 56.7% Not achieved, 16% Achieved Not achieved Achieved, 83% in project Provinces Achieved, 66.7% fully immunized in project Provinces Achieved, 18 per thousand
Project Components and Outputs 1. Provincial Service Delivery In 15 provinces, enhance population and family health resources to enable provision of agreed set of basic primary health care services, including family planning.	- Renovation or replacement of 2,340 CHCs, 184 DHCs, 15 MCH/FP centers - 3,207 CHCs, 184 DHCs, 15 MCH/FPs suitably equipped and furnished	Facility records, surveys of usage Baseline, midterm, and final surveys	2,606 CHCs, 192 DHCs, 15 MCH/FP centers ADB: 2153 CHCs, 128 DHCs, 14 provincial hospitals, 11 MCH/FP centers

Continued on next page

Design Summary	Project Targets	Monitoring Mechanisms	Project Achievements
	- Adequate annual supplies of essential drugs and medical materials to all facilities - Clinical and outreach skills of all CHC personnel refreshed - Clinical skills of all middle and senior personnel enhanced - Agreed basic services delivered	Program planning and assessment of documents; interviews and managers Training evaluation and skills assessment	Same ADB: 968 training courses for CHC staff ADB: 612 technical training courses; ADB: 110 core training courses
2. Information, education, and communication	- 90% of eligible couples in plains/delta areas (60% in other areas) will know of at least three modern contraceptive methods , and should have tried at least one modern method. - 90% of women of reproductive age in plains/delta areas (60% in other areas) should know how to prevent and recognize reproductive tract infections. - 90% of pregnant women in plains/delta areas (60% in other areas) should know the benefits of antenatal care, should have sought such care at least twice during pregnancy, and should be aware of the steps to be taken in case of an obstetric emergency.	Baseline, midterm, and final surveys Service records, management interviews	91% of adult women know at least five family planning methods (80% in lowest income quartile) 88% of adult women use any method (74% in lowest income quartile) 78% of adult women use antenatal care (46% in lowest quintile) Not successful
Social marketing program (oral contraceptives)	- Increase the availability and usage of modern contraceptives, while improving sustainability.	Baseline, midterm , and final surveys	Not successful
Outreach by collaborators	- Enhance outreach skills and practices by all collaborators.	Supervision records Skills assessment	

Continued on next page

Design Summary	Project Targets	Monitoring Mechanisms	Project Achievements
3. Contraceptive Supplies	- Increase availability of a wider range of modern contraceptive methods to reach 65% prevalence, and improve service quality	Service records Baseline, midterm, and final surveys	Achieved
4. Family Planning Management and Institutional Development Management Development Strengthening of program planning and reporting systems	- Increase trained managers, following agreed assessment of needs - Increase management skills of workers - Develop management information system - Review and strengthen organization	Supervision records Skills assessment Management information system functioning	56.7% prevalence
5. Medical Service Delivery Tests of private and nongovernment organization sector mobilization Pilot tests of outreach systems Studies to improve quality of service Operations research	- Increase quality and volume of population and family health services provided through the private sector - Design, implement, and evaluate tests, with follow-on action plans agreed - Improve quality and cost effectiveness	Research reports, supervision missions, project missions Baseline, midterm, and completion reports	See Appendix 8
Inputs Gov't: $17.20 million ADB: $41.20 million IDA: $46.00 million KfW: $20.00 million Total $ 126.20 million			Gov't: $10.85 million ADB: $38.42 million IDA: $44.59 million KFW: $15.03 million Total $ 108.89 million

ADB = Asian Development Bank, CHC = commune health center, CPR = contraceptive prevalence rate, DHC = district health center, KfW = Kreditanstalt für Wiederaufbau, Gov't = Government, IDA = International Development Association, MCH/FP= maternal and child health/family planning, NCPFP = National Committee for Population and Family Planning.

Source: Viet Nam Commission for Population, Family, and Children.

EVALUATION METHODOLOGY

A. Method

1. A team comprising an Asian Development Bank (ADB) senior health specialist, an international public health consultant, and a local research associate carried out the evaluation in July 2004 with the assistance of the project management unit. ADB staff was in Viet Nam for 10 days, while the consultant and associate spent 20 days in the field.

2. Following sources of information were used:

(i) Desk review of ADB project documentation, such as the Report and Recommendation of the President, aide memoires of missions, the midterm review, and project administration data; and other documentation, including surveys, studies, and project reports. The Demographic and Health Surveys of 1997 and 2002 provided good baseline and outcome data, respectively. The 2003 Evaluation Report for the Population and Family Health Project of the Futures Group International and others provided good project analysis. A list of reference documents is in Section B of this appendix.

(ii) Field visits to four provinces: Lao Cai, Tra Vinh, Dak Lak, and Hai Phong. These trips included discussions with the respective Population, Family and Children Committee in the province, health staff, and local people; and visits to provincial hospitals, secondary medical schools, district health centers, commune health centers, and health posts. Field observations were documented and are available on request. The visits focused on the quality of project inputs, the use of upgraded services, and the views of local leaders and potential beneficiaries on the services.

(iii) Discussions with the Viet Nam Commission for Population, Family, and Children (VCPFC), which was the Executing Agency; the Ministry of Health, the main implementing agency; and other stakeholders in Hanoi, including an exhaustive wrap-up meeting with the VCPFC steering committee on 9 July 2004.

3. The Mission could not ascertain the revised targets and activities, which have not been evaluated. A revised project framework was not prepared for these. Within this short period, an assessment of the quality of staff was impossible, as was a more comprehensive assessment of civil works and equipment. A more quantitative analysis of project benefits was similarly impossible. The evaluation by the Futures Group International was particularly helpful in this respect.

4. ADB and International Development Association (IDA) had separate accounts. However, the VCPFC followed a program approach, sometimes distributing ADB and IDA expenditures across provinces. Hence, ADB paid for some expenditure in IDA provinces, and vice versa.

5. The findings of the Mission did not disagree fundamentally with the views of VCPFC and the steering committee regarding project performance and issues. Certain findings, such as the similarity in fertility rates between project and non-project areas, and the popularity of invasive contraceptive methods, could not be explained fully and require further analysis.

B. List of Reference Documents

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CHANGE OF SCOPE

Table A3.1: Major Changes in Scope

Year	Project Category	Major Changes in Project Scope	Justification	Reallocated
March 1998	Civil Works to Civil Works	Surplus civil works funds were reallocated to build and/or renovate an additional 262 CHCs and 10 DHCs under the existing contracts. Surplus funds resulted from (i) competitive bidding, (ii) favorable exchange rates, and (iii) costs estimates that might have been overly generous.	The additional civil works (i) met project criteria, but they could not be accommodated under the previous budget; and (ii) covered facilities in new communes and districts that were created since the Project was approved.	$3.4 million
December 1998	Essential Drugs to Equipment and Service Vehicles	Surplus drugs funds reallocated for procurement of additional equipment and vehicles. Surplus drugs funds were from (i) competitive bidding, (ii) favorable exchange rates, and (iii) the establishment of a Government cost-recovery policy for drugs.	The Government established a revolving fund and cost recovery policy for procurement of essential drugs at the provincial level. Therefore, estimated allocations for essential drugs were no longer required.	$3.0 million
December 1999	Civil Works and Essential Drugs to Equipment and Service Vehicles at District Levels	Surplus essential drugs and civil works funds were reallocated for additional medical equipment and training to 141 DHCs (i) to meet the increased demand for DHC services resulting as their improved quality of services and provision of ambulances led to more referrals from CHCs, and (ii) to reduce the pressure on provincial hospitals.	Due to (i) inefficiency of centrally procured drugs to variable health priorities in different provinces, (ii) sufficient drugs from other sources, (iii) project drugs fund represented only about 10% of the demand of each province, (iv) Government preference to use own budget for recurrent expenditures.	$7.0 million
November 2000	Unallocated Project Funds to Emergency Flood Relief Assistance	Savings from lower-than-expected bids for equipment were reallocated to finance additional costs for about 120 ambulance boats, medicines, and other emergency relief medical services in 27 provinces, including 18 non-project provinces.	To respond to the increased incidence of waterborne diseases in the 27 flood-affected provinces; reaffirming Asian Development Bank's commitment to assist Government in mitigation of damage from natural calamities.	$3.0 million
October 2000 –September 2002	Five Integrated Reproductive Health Campaigns	Reach remote, mountainous, underserved areas with free reproductive health/family planning services, examinations, and treatment.	Popular and successful service delivery model; generate demand, increase service utilization	$10.0 million
August 2001 –December 2004	Japan Fund for Poverty Reduction (JFPR)	Community Action for Preventing HIV/AIDS Project under the JFPR grant funds implemented in conjunction with the Population and Family Health Project	A separate regional project, but integrated into the existing Project. The project management unit is the Executing Agency and the AIDS division of the Ministry of Health is the national Implementing Agency.	$3.0 million

CHC = commune health center, DHC = district health center, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, JFPR = Japan Fund for Poverty Reduction.
Source: Viet Nam Commission for Population, Family, and Children.

Table A3.2: Distribution of Population and Family Health Project's Physical Investments (Asian Development Bank and International Development Association)

Item	Project Provinces	Non-Project Provinces	Total
Infrastructure			
CHC	2,611	0	2,611
DHC	136	0	136
Provincial MCH/FP Center	15	0	15
Population Education Center	12	0	12
Village Health Post	60	32	92
Transportation Means			
Ambulance Cars	252	0	252
Communication Cars	20	44	64
Ambulance Boat	30	0	30
Communication Boat	165	0	165
Service Boat	301	0	301
Motorbike	211	99	310
Communication			
Communication Set for Province and District	230	453	683
Communication Set for Commune	1,970	3,792	5,762
Office Equipment Set	20	41	61
Electric Equipment			
Air Conditioner	799	0	799
Dehumidifier	574	0	574
Stabilizer	526	0	526
Medical Equipment			
Set for CHC	3,795	0	3,795
Set for DHC	232	0	232
Set for MCH/FP Center	20	0	20
Essential Drugs Package	3,190	0	3,190
Total	**15,169**	**4,461**	**19,630**

CHC = commune health center, DHC = district health center, MCH/FP= maternal and child health/family planning.
Source: Viet Nam Commission for Population, Family, and Children.

SUMMARY OF CIVIL WORKS

Province	Total				CHC			DHC			MCH/FP Center			Population Center			Health Post	
	Planned	Done			Planned	Done		Planned	Done		Planned	Done		Planned	Done		Planned	Done
		New	Upgraded	Cost ($mil)		New	Upgraded		New	Upgraded		New	Upgraded		New	Upgraded		
ADB-Funded	**1,894**	**959**	**866**	**8.57**	**1,699**	**891**	**791**	**113**	**0**	**68**	**11**	**7**	**2**	**11**	**1**	**5**	**60**	**60**
1. Lao Cai	188	65	115	0.91	167	54	112	9	0	2	1	1	0	1	0	1	10	10
2. Lai Chau	161	82	70	0.74	145	76	65	8	0	4	1	0	0	1	0	1	6	6
3. Tuyen Quang	139	53	83	0.53	126	46	80	5	0	2	1	1	0	1	0	1	6	6
4. Hai Phong	135	21	113	0.62	123	20	102	10	0	10	1	1	0	1	0	1	0	0
5. Ha Nam	93	42	50	0.39	85	41	44	6	0	6	1	1	0	1	0	0	0	0
6. Nam Dinh	202	91	111	0.75	191	90	101	9	0	9	1	0	1	1	1	0	0	0
7. Thanh Hoa	512	433	53	2.67	480	426	52	24	0	0	1	1	0	1	0	1	6	6
8. Dak Lak	213	67	138	0.93	183	56	122	18	0	16	1	1	0	1	0	0	10	10
9. Vinh Long	71	26	41	0.26	63	26	36	6	0	4	1	0	1	1	0	0	0	0
10. Tra Vinh	78	30	45	0.38	69	29	38	7	0	7	1	1	0	1	0	0	0	0
11. Kien Giang	80	27	47	0.36	67	27	39	11	0	8	1	0	0	1	0	0	0	0
12. Bac Kan*	5	5	0	0.01	0	0	0	0	0	0	0	0	0	0	0	0	5	5
13. Thai Nguyen*	5	5	0	0.01	0	0	0	0	0	0	0	0	0	0	0	0	5	5
14. Thua Thien Hue*	6	6	0	0.02	0	0	0	0	0	0	0	0	0	0	0	0	6	6
15. Lam Dong*	6	6	0	0.01	0	0	0	0	0	0	0	0	0	0	0	0	6	6
IDA Funded	—	505	540	5.55	—	465	455	—	0	81	—	5	1	—	3	3	32	32
Total		**1,464**	**1,406**	**14.12**		**1,356**	**1,246**	**113**	**0**	**149**		**12**	**3**		**4**	**8**	**92**	**92**

ADB = Asian Development Bank, CHC = commune health center, DHC = district health center, IDA = International Development Association, MCH/FP = maternal and child health/family planning.

* ADB funded health posts in some provinces otherwise supported by the World Bank.

Source: Viet Nam Commission for Population, Family, and Children.

PROCUREMENT OF EQUIPMENT

Item		Quantity	IDA	ADB
District and Provincial Level				
1.	Ambulance boats	30	15	15
2.	Ambulance vehicle	252	97	155
3.	Drug wardrobe	984	388	596
4.	Trolley first-aid stretcher	494	194	300
5.	Gynecological examining table	492	194	298
6.	Trolley instrument table	492	194	298
7.	Delivery table	492	194	298
8.	Operating table	247	97	150
9.	Infant's scale	247	97	150
10.	Portable anesthesia	247	97	150
11.	Electric cauterizer	247	97	150
12.	Light operating emergency mobile	494	194	300
13.	Water filter machine	247	97	150
14.	Sterilizer dressing pressure, electric	1,235	485	750
15.	Incubator	247	97	150
16.	Electric generator	247	97	150
17.	Examination light	494	194	300
18.	Fluid suction machine	247	97	150
19.	Centrifugal angle head machine	247	97	150
20.	Intrauterine device insertion kit	1,235	485	750
21.	Female sterilization kit	1,235	485	750
22.	Vasectomy set	2,470	970	1,500
23.	Cervical expander sets	2,470	970	1,500
24.	Instrument tray	1,482	582	900
25.	Instrument tray with cover	1,482	582	900
26.	Drum sterilizer	2,470	970	1,500
27.	Boiling type sterilizer instrument	494	194	300
28.	Boiling pot syringe	494	194	300
29.	Instrument table	741	291	450
30.	Examination table	494	194	300
31.	Stretcher	494	194	300
32.	Stool	1,562	582	980
33.	Oxygen cylinder	1,235	485	750

Continued on next page

Item		Quantity	IDA	ADB
34.	Oxygen flow meter	988	388	600
35.	Sphygmomanometer	1,235	485	750
36.	Resuscitator (neonatal)	494	194	300
37.	Adult scale (metric)	247	97	150
38.	Caesarian section/hysterectomy instrument set	494	194	300
39.	Electrocardiograph machine	247	97	150
40.	Centrifugal machine	247	97	150
41.	Karmann syringe (single valve)	2,050	750	1,300
42.	Electric dryer machine	741	291	450
43.	Oxygen bag	1,235	485	750
44.	Cupboard	494	194	300
45.	Syringes	494	194	300
46.	Intrauterine device removal forceps	1,235	485	750
47.	Hemoglobinometer Shali-set	494	194	300
48.	Tracheotomy set	247	97	150
49.	Blood test instrument set	494	194	300
50.	Ophthalmoscope	247	97	150
51.	Ultraviolet sun-lamp	494	194	300
52.	Ultrasound machine	247	97	150
53.	Photo meter measurement machine	232	130	102
54.	Microscope	232	130	102
55.	Respirator	232	130	102
56.	Blood analyzer	232	130	102
57.	Emergency bed	232	130	102
58.	Patient's monitor	232	130	102
59.	Electric bistoury	232	130	102
60.	Ceiling operating light	232	130	102
61.	Minor surgery instrument	464	260	204
62.	Major surgery instrument	464	260	204
63.	Labor monitoring equipment	232	130	102
64.	Uterine scanner with TV monitor	310	208	102
65.	X-ray machine	152	63	89
66.	Oxygen creater machine	232	130	102
67.	Patient’s bed	20,036	4,412	15,624
68.	Bedside cabinet	11,786	4,412	7,374
69.	Airconditioner	814	316	498
70.	Humidifier	574	246	328
71.	Voltage stabilizer	526	206	320

Continued on next page

Item		Quantity	IDA	ADB
Commune Level				
1.	Delivery table	2,705	1,009	1,696
2.	Trolley instrument table	2,695	999	1,696
3.	Gynecological examination table	2,695	999	1,696
4.	Drug and instrument wardrobe	5,218	1,826	3,392
5.	Water filter	2,725	1,009	1,716
6.	Infant's scale	2,735	999	1,736
7.	Karmann syringe	10,192	3,400	6,792
8.	Cervical dialator sets	2,725	1,009	1,716
9	Urine protein paper test	2,725	1,009	1,716
10.	Tray instrument	2,725	1,009	1,716
11.	Tray instrument with cover	5,450	2,018	3,432
12.	Drum sterilization	5,450	2,018	3,432
13.	Stretcher	2,725	1,009	1,716
14.	Stool	5,450	2,018	3,432
15.	Water container with tap	5,450	2,018	3,432
16.	Pail waster	2,725	1,009	1,716
17.	Sphygmomanometer	2,725	1,009	1,716
18.	Electric stove (small)	2,725	1,009	1,716
19.	Autoclave	2,725	1,009	1,716
20.	Instrument boiler	2,725	1,009	1,716
21.	Adult scale	2,725	1,009	1,716
22.	Slanted bandage cutting scissors	2,725	1,009	1,716
23.	Curved blunt scissors	5,450	2,018	3,432
24.	Curved sharp scissors	2,725	1,009	1,716
25.	Straight surgical scissors	2,725	1,009	1,716
26.	Straight, sharp surgical scissors	2,725	1,009	1,716
27.	Straight, blunt surgical scissors	2,725	1,009	1,716
28.	Uterine curved scissors	2,725	1,009	1,716
29.	Clamping forceps	5,450	2,018	3,432
30.	Forceps sterilizer	5,450	2,018	3,432
31.	Forceps dressing	5,450	2,018	3,432
32.	Cervical forceps	5,450	2,018	3,432
33.	Intrauterine device removal forceps	2,725	1,009	1,716
34.	Surgical forceps	10,900	4,036	6,864
35.	Needle holder	2,725	1,009	1,716
36.	Speculum (small)	13,625	5,045	8,580
37.	Fetus heart stethoscope	2,725	1,009	1,716
38.	Surgical knife blade	2,725	1,009	1,716
39.	Knife handle, surgical	2,725	1,009	1,716
40.	Pelvicmeter	2,725	1,009	1,716

Item		Quantity	IDA	ADB
41.	Uterine measuring instrument	2,725	1,009	1,716
42.	Measuring tape	2,725	1,009	1,716
43.	Torch	5,450	2,018	3,432
44.	Catheter (for woman)	2,725	1,009	1,716
45.	Catheter (for men)	2,725	1,009	1,716
46.	Baby bath	2,725	1,009	1,716
47.	Tongue depressor	8,175	3,027	5,148
48.	Catgut suture	5,450	2,018	3,432
49.	Peclon suture	2,725	1,009	1,716
50.	Surgical gloves (small)	40,875	15,135	25,740
51.	Surgical gloves (medium)	40,875	15,135	25,740
52.	Basin kidney (small)	2,725	1,009	1,716
53.	Basin kidney (large)	2,725	1,009	1,716
54.	Acupuncture needle	8,175	3,027	5,148
55.	Needle suture (3/8 circle, cutting assorted)	2,725	1,009	1,716
56.	Needle suture (uterine, 1/2 circle)	5,450	2,018	3,432
57.	Breast pump (hand, rubber bulb, glass/plastic bell)	2,725	1,009	1,716
58.	Aspirator (nasal, infant)	2,725	1,009	1,716
59.	Bowel spinge, stainless steel	5,450	2,018	3,432
60.	Dropper (medicine, straight tip, not graduated)	2,725	1,009	1,716
61.	Irrigator (bowel)	2,725	1,009	1,716
62.	Cup solution	5,450	2,018	3,432
63.	Measuring aid (graduated with hand)	5,450	2,018	3,432
64.	Basin solution (deep, 6 liters)	2,725	1,009	1,716
65.	Thermometer (clinical, oral)	13,625	5,045	8,580
66.	Hand pump irrigator for child	2,725	1,009	1,716
67.	Rubber bag for hot water or ice	2,725	1,009	1,716
68.	Stethoscope	2,725	1,009	1,716
69.	Blood pressure cuff for child	1,451	1,009	442
70.	Motorbike	310	310	0
71.	Vehicle	64	64	0
72.	Ambulance boats	897	30	867
73.	Cassette player	6,465	6,465	0
74.	Amplifier	5,782	5,782	0
75.	Microphone	5,782	5,782	0
76.	Loud speaker	5,782	5,782	0
77.	Television	683	683	0
78.	Video cassette player	683	683	0
79.	Conference amplifier	61	61	0
80.	Overhead projector	37	37	0

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Item		Quantity	IDA	ADB
81.	PC viewer	1	1	0
82.	Personal computer	98	98	0
83.	Voltage stabilizer	98	98	0
84.	Uninterrupted power supply	98	98	0
85.	Air conditioner	24	24	0
86.	Fax machine	18	18	0
87.	Laser printer	94	94	0

ADB = Asian Development Bank, IDA = International Development Association.
Source: Viet Nam Commission for Population, Family, and Children.

PROCUREMENT OF DRUGS

Item	Unit	Total	Fund Resources	
			World Bank	ADB
1. Gentamicin	vial	258,800	90,000	168,800
2. Ferrous Sulphate	tablet	74,676,000	0	74,676,000
3. Penicillin	tablet	8,534,400	0	8,534.400
4. Baneocin Ointment	vial	21,336	0	21,336
5. Metronidazole	tablet	9,799,800	3,399.000	6,400,800
6. Nystatine	packet	11,759,760	4,078,800	7,680,960
7. Cotrimoxazole	tablet	7,600,000	2,266,000	5,334,000
8. Paracetamol	tablet	6,533,200	2,266,000	4,267,200
9. Erythromycin	tablet	1,520,000	453,200	1,066,800
10. Hydroclorothiaze	tablet	1,066,800		1,066,800
11. Mebendazole	tablet	39,199,200	13,596,000	25,603,200
12. Magnesium	tablet	7,600,000	2,266,000	5,334,000
13. Chloramphenicol	ampule	373,200	120,000	253,200
14. Benzyl Penicillin	vial	2,013,300	679,800	1,333,500
15. Oxytoxine	tablet	61,322	45,320	16,002
16. Tetracyline eye ointment	tube	195,996	67,980	128,016
17. Prostigmine	ampule	7,260	6,000	1,260
18. Ergometrine	tablet	407,880	407,880	0
19. Neomycin+Bactracine	tube	11,330	11,330	0
20. Benzyl Benzoate Emulsion	tablet	2,266	2,266	0
21. Panthenol	tube	4,532	4,532	0
22. Penicillin V	tablet	4,532,000	4,532,000	0
23. Hydrochlorothiazine	tablet	453,200	453,200	0

ADB = Asian Development Bank.
Source: Viet Nam Commission for Population, Family, and Children.

LIST OF TRAINING COURSES

Training Course	Total		Central Level Training		Local Level Training		ADB	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Training of Trainers for Province	203	203	203	203	0	0	0	0
Training of Trainers for Ethnic Minority Groups	72	72	72	72	0	0	0	0
Training of Trainers for Monitoring and Supervision	58	58	58	58	0	0	0	0
Training for Ethnic Minority Health Staff on MCH/FP	3,830	3,323	0	0	3,830	3,323	2,400	1,924
Refresher Training on MCH/FP for All Levels	16,096	15,061	0	0	16,096	15,061	10,090	9,250
Master Training on Family Planning Technical Skills	2,349	2,107	0	0	2,349	2,107	1,470	1,347
Monitoring Supervision Training at District Level	1,013	977	0	0	1,013	977	635	622
Patient Monitor Machine Training	233	195	0	0	233	195	137	123
Obstetric Monitor Machine Training	229	203	0	0	229	203	135	126
Training on Using X-ray Machine	533	474	91	91	442	383	223	210
Training on Using Anesthetic Machine	519	437	81	81	438	356	206	167
Training on Using Ultrasound Machine	723	647	217	217	506	430	279	239
Training on Using Blood Test Analysis Machine	249	211	0	0	249	211	143	133
Training on Using Electronic Surgery Knife	232	198	0	0	232	198	134	118
Training on Using Respirator	452	375	0	0	452	375	238	216
Total	**26,791**	**24,541**	**722**	**722**	**26,069**	**23,819**	**16,090**	**14,475**

ADB = Asian Development Bank , MCH/FP = maternal and child health/family planning.
Source: Viet Nam Commission for Population, Family, and Children.

MODEL SERVICE DELIVERY INITIATIVES

Model	Objective	Area	Scale	Time	$ million	Achievements	Comment
1. Health Post	1. Make VHWs responsible for community mobilization and education on personnel hygiene and environmental sanitation. 2. Provide RH and FP services.	Thai Nguyen, Bac Kan, Tuyen Quang, Lao Cai, Lai Chau, Thanh Hoa, Thua Thien Hue, Lam Dong, Dak Lak	75 health posts	December 1998–June 2001	$0.286 (IDA) $0.113 (ADB for civil works)	- Trained 130 VHWs - Medical equipment, drugs supplied to 75 health posts - Dramatic changes in KAP in hygiene, RH care and FP - Civil works (ADB)	- For highland and remote areas - VHW should be trained to become community nurse with regular refresher training - Should be integrated into other health duties - Strengthening monitoring and supervision
2. Safe Motherhood	1. Reduce MMR and IMR. 2. 70% PW received at least 3 examinations at CHC. 3. 95% PW received TT injection. 4. 90% PW give birth at CHC. 5. 70% of complications are referred in time. 6. Improve MCH. 7. Provide FP information and services.	Hai Duong, Tuyen Quang, Thua Thien Hue, Dak Lak, Kien Giang	150 communes	November 1999–December 2000	$0.40 (IDA)	- Pregnancy care network set up at 95% of CHC. - Normal delivery available at 100% CHC. - 93.3% of complications were referred in time. - Reduction in IMR - 100% PW received TT injection, folic acid, and Vitamin A.	- IEC promotion on behavior change - Increase new and refresher training for health staff at community level. - Improve monitoring & supervision - Priority community level investment - The model should be extended in remote areas.

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Model	Objective	Area	Scale	Time	$ million	Achievements	Comment
3. Population and Family Health Workers	1. Set up population family health collaborator network. 2. Set up appropriate organization and management structure. 3. Integrate collaborator's activities into other health care activities.	Hai Duong, Nam Dinh, Thanh Hoa, Thai Nguyen, Bac Kan, Dong Thap, Dak Lak	10 districts with 43 communes	September 1999–June 2002	$0.244 (IDA)	- Set up effective model and operating - Appropriate for mobilization and communication - Increased use of FP and RH care services -Improved knowledge - Change behaviors in RH care and FP	- Replicate model in remote areas. - Increase materials, equipment, and budget for IEC. - Select PFH workers, training, and updating. - Strengthen monitoring and supervision.
4. Integrated Population Program in Poor Communes of Da Bac	1. Raise awareness on population and FP. 2. Improve management and technical capacity. 3. Construct health posts, provide medical equipment. 4. BCC RH care and FP	Da Bac District, Hoa Binh province	16 communes	January 2000 –May 2002	$0.36 (IDA)	- Trained 16 VHWs - Provided 18 IEC sets - Drug and equipment provision - Two campaigns on environmental hygiene - 43,800 leaflets and 6,640 handbooks; 64 poster boards - Constructed 32 health posts with essential equipment	- Appropriate to this area - Should be replicated - Increasing materials, equipment and budget for communication - More training - Increase FP/RH video cassettes

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Model	Objective	Area	Scale	Time	$ million	Achievements	Comment
5. Private Sector Health Services Association in Hai Duong Province	1. Situation analysis 2. Regulatory reform 3. Mobilize private health service providers for health care program. 4. Assist health department in management of private health service providers. 5. Association members share and exchange professional experiences	Hai Duong	11 districts	December 2000–May 2003	$0.2 (ADB)	- Established 11 branches with 513 members - Organized one training on improving knowledge of law - Organized eight professional trainings - Provided examination and treatment	- Sustain and improve quality of the association. - Provide regular professional training for members. - Replicate this model in other provinces and establish association at the central level.
6. Mobile Team	1. Strengthen knowledge in RH, FP for women aged 15–49 years. 2. Provide services and counseling on RH and FP. 3. Decrease rate of third child.	Thanh Hoa, Phu Yen, Kon Tum, Binh Phuoc	58 communes	March 2000 –April 2002	$0.19 (ADB)	- Reduced CBR and third child - Examination and treatment for 70% of women aged 15–49 years - Improved health staff capacity	- Replicate model in remote areas - Identify appropriate services for different areas - Provide drugs and gynecological examination instruments

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Model	Objective	Area	Scale	Time	$ million	Achievements	Comment
7. Integrated RH Campaigns	1. Provide RH/FP counseling. 2. Provide FP services. 3. Safe motherhood: ANC, folic acid, TT injection, clean delivery kit provision 4. STI prevention: Gynecological examination and treatment	Stages 1 & 2: 54 provinces or cities Stage 3: 57 provinces Stages 4 & 5: 61 provinces or cities	5,541 communes 4,702 communes 8,064 communes	October 2000–May 2001 September–December 2001 January–September 2002	$10 (ADB and IDA)	- Nearly 100% of women received 3 packages - KAP on RH/FP significantly increased - Investment went to community. - Saved time and money with services valued at more than D60 billion.	- Sustain the campaign. - Mobilize contributions from different sources. - Requires close and careful monitoring and supervision. - Mobilize community participation.
8. Community-based HIV/AIDS Prevention	1. HIV/AIDS prevention, BCC 2. Set up model. 3. Increase percentage of STI patients receiving examination and treatment, 4. Strengthen management and supervision skills,	Thanh Hoa, Nghe An, Ha Tinh, Binh Duong,Binh Phuoc, Soc Trang	Hot spots for HIV and AIDS	2001–2004	$1.0 (IDA)	- Attracted participation of many people - Improved capacity of HIV/AIDS preventative staff	- Sustain model in HIV/AIDS hot spots. - Replicate the model to other areas with high risk of HIV/AIDS. - Resource mobilization from community and Government

ADB = Asian Development Bank; ANC = antenatal care; BCC = behavior change communication; CBR = crude birth rate; CHC = commune health center; DHC = district health center; FP = family planning; IDA = International Development Association; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; IEC = information, education, and communication; IMR = infant mortality rate; KAP = knowledge, action, and practices; MCH = maternal and child health; MMR = maternal mortality ratio; PFH = population and family health; PW = pregnant women; RH = reproductive health; STI = sexually transmitted infection; TT = tetanus toxoid; VHW = village health worker.
Source: Viet Nam Commission for Population, Family, and Children.

PLANNED AND ACTUAL PROJECT COST
($ million)

Item	Appraisal Estimate			Actual			
	Foreign Exchange	Local Currency	Total Costs	Foreign Exchange	Local Currency	Total Costs	Appraisal Percentage
A. Provincial Level Service Delivery							
1. Facility Upgrading	6.20	14.90	21.10	14.12	1.45	15.58	73.80
2. Equipment Provision	15.90	4.20	20.10	35.42	4.31	39.73	197.60
3. Essential Drug Supply	12.80	1.60	14.40	2.12	0.21	2.34	16.20
4. In-Service Training	1.20	3.10	4.30	3.56	0.20	3.76	87.40
5. Outreach Strengthening	0.80	5.70	6.50	0.00	0.00	0.00	0.00
Subtotal (A)	**36.90**	**29.50**	**66.40**	**55.23**	**6.17**	**61.40**	**92.50**
B. National Level Program							
1. Strengthening FP IEC	3.70	9.20	12.90	7.15	2.82	9.97	77.30
2. Contraceptives Supply	21.60	2.60	24.20	19.28	1.07	20.35	84.10
3. Management & Institutional Development	2.60	2.90	5.50	3.66	0.31	3.97	72.20
4. FP Service Delivery Model Initiative	0.90	3.70	4.60	11.52	0.47	11.99	260.70
Subtotal (B)	**28.80**	**18.40**	**47.20**	**41.61**	**4.67**	**46.28**	**98.10**
Total Baseline Costs	65.70	47.90	113.60	96.84	10.84	107.68	94.80
C. Contingencies							
1. Physical Contingencies	2.00	2.10	4.10	0.00	0.00	0.00	0.00
2. Price Contingencies	3.10	3.60	6.70	0.00	0.00	0.00	0.00
Subtotal (C)	**5.10**	**5.70**	**10.80**	**0.00**	**0.00**	**0.00**	**0.00**
D. Service Charge	1.80	0.00	1.80	1.28	0.00	1.28	71.10
Total Project Costs	**72.60**	**53.60**	**126.20**	**98.12**	**10.84**	**108.96**	**86.30**
Percentage of Total (%)	57.50	42.50	100.00	90.00	10.00	100.00	100.00

FP IEC = family planning information, education, and communication.
Source: Viet Nam Commission for Population, Family, and Children.

DISBURSEMENTS

TableA10.1: Annual Disbursement by Source and Year
($ million)

Year	ADB Component				IDA Component				KfW Component				Total			
	*ADB Share	Gov't Share	Total	% Gov't Financing	IDA Share	Gov't Share	Total	% Gov't Financing	KfW Share	Gov't Share	Total	% Gov't Financing	Donor Share	Gov't Share	Total	% Gov't Financing
1997	1.18	0.24	1.42	16.90	2.76	0.99	3.75	26.40	0.00	0.00	0.00	0.00	3.94	1.23	5.17	23.80
1998	9.64	0.68	10.32	6.60	8.25	2.30	10.55	21.80	0.08	0.06	0.14	42.86	17.97	3.04	21.01	14.50
1999	7.58	0.66	8.24	8.00	3.46	0.18	3.64	4.94	0.68	0.04	0.72	5.55	11.72	0.88	12.60	7.00
2000	8.08	0.66	8.74	7.60	6.11	0.91	7.02	12.96	4.12	0.06	4.18	1.43	18.31	1.63	19.94	8.20
2001	9.94	0.95	10.89	8.70	4.66	0.67	5.33	12.57	4.65	0.02	4.67	0.42	19.25	1.64	20.89	7.90
2002	0.97	0.41	1.38	29.70	11.05	0.91	11.96	7.60	3.66	0.35	4.01	8.72	15.68	1.67	17.35	9.60
2003	1.12	0.10	1.22	8.20	8.29	0.51	8.80	5.79	0.84	0.15	0.99	15.15	10.25	0.75	11.00	6.90
2004	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	1.00	0.00	1.00	0.00
Total	**38.51**	**3.70**	**42.21**	**8.80%**	**44.58**	**6.47**	**51.05**	**12.67%**	**15.03**	**0.68**	**15.71**	**4.32%**	**98.12**	**10.84**	**108.96**	**9.90%**

ADB = Asian Development Bank, Gov't = Government, IDA = International Development Association, KfW = Kreditanstalt für Wiederaufbau.
* Including service charges totaling $1.28 million.
Source: Viet Nam Commission for Population, Family, and Children.

Table A10.2: Planned Versus Actual Disbursement by Source and Category
($ million)

Component	Total			IDA		ADB		KfW		Counterpart	
	Planned	Actual	%	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
I. Investment Costs											
Civil Works	22.00	15.83	72.00	5.90	5.55	13.90	8.83	0.00	0.00	2.20	1.45
Equipment	30.50	35.08	115.00	14.70	14.21	12.00	20.07	0.00	0.80	3.70	0.00
Drugs	15.00	2.34	15.60	4.80	0.85	10.10	1.49	0.00	0.00	0.00	0.00
Contraceptives	22.90	19.28	84.20	2.90	5.30	0.00	0.00	20.00	13.98	0.00	0.00
Training	5.70	11.45	200.90	3.80	7.61	1.90	0.57	0.00	0.24	0.00	3.03
Consulting Services	4.30	6.27	145.80	4.30	4.17	0.00	2.10	0.00	0.00	0.00	0.00
Studies and Pilot	6.80	10.96	161.20	3.70	6.33	3.10	4.16	0.00	0.00	0.00	0.47
II. Recurrent Costs	17.10	0.88	5.10	5.80	0.57	0.00	0.00	0.00	0.00	11.30	0.31
III. Logistics	0.00	5.58		0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.58
IV. Service Charges	1.80	1.28	71.10	0.00	0.00	1.80	1.28	0.00	0.00	0.00	0.00
Total	**126.20**	**108.96**	**86.30**	**46.00**	**44.59**	**43.00**	**38.51**	**20.00**	**15.02**	**17.20**	**10.84**

ADB = Asian Development Bank, IDA = International Development Association, KfW = Kreditanstalt für Wiederaufbau.
Source: Viet Nam Commission for Population, Family, and Children.

Table A10.3: ADB Contract Awards and Disbursements
($ million)

		ADB[a]					
		Contract Awards			Disbursement		
Year	Quarter	Amount	Cumulative	Amount Per Year	Amount	Cumulative	Amount Per Year
1997	I	0.00	0.00		0.00	0.00	
	II	0.00	0.00		0.00	0.00	
	III	0.00	0.00		1.00	1.00	
	IV	6.71	6.71	6.71	0.18	1.18	1.18
1998	I	1.40	8.10		2.75	3.93	
	II	0.56	8.66		4.22	8.15	
	III	0.00	8.66		1.46	9.61	
	IV	2.00	10.66	3.95	1.22	10.83	9.64
1999	I	1.82	12.48		4.00	14.83	
	II	0.13	12.61		0.73	15.56	
	III	1.20	13.81		1.33	16.89	
	IV	7.34	21.14	10.48	1.51	18.41	7.58
2000	I	0.00	21.14		2.73	21.13	
	II	0.10	21.24		0.72	21.85	
	III	0.17	21.40		1.39	23.24	
	IV	7.50	28.91	7.76	3.24	26.48	8.08
2001	I	0.68	29.59		0.63	27.11	
	II	1.57	31.16		5.62	32.72	
	III	0.61	31.77		1.32	34.05	
	IV	1.62	33.39	4.48	2.37	36.42	9.94
2002	I	0.43	33.82		0.61	37.03	
	II	0.44	34.26		0.18	37.21	
	III	0.61	34.87		0.00	37.21	
	IV	1.35	36.22	2.83	0.18	37.39	0.97
2003	I	0.27	36.49		0.35	37.74	
	II	0.43	36.92		0.67	38.41	
	III	0.00	36.92		0.41	38.82	
	IV	0.31	37.23	1.01	(0.31)	38.51	1.12
Total		**37.23**	**37.23**	**37.23**	**38.51**	**38.51**	**38.51**

ADB = Asian Development Bank.
[a] Including service charges totaling $1.28 million.
Source: Asian Development Bank estimates.

IMPLEMENTATION SCHEDULE

DESCRIPTION	IMPLEMENTATION PERIOD (YRS)							
	1996	1997	1998	1999	2000	2001	2002	2003
	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
1. Provincial Service Delivery								
- Facility Upgrading								
- Equipment								
- Essential Drugs								
- In-service Training								
Training of Trainers								
Clinical Refresher Training								
Remote/Mountain Training								
2. IEC (IDA)								
3. Contraceptive Supplies (KfW & IDA)								
4. Program Management (IDA)								
5. Service Delivery Models								
- Private Sector (ADB)								
Situation Analysis and Regulatory Reform								
Training								
Professional Associations								
Mobile Teams								
Equipment								
- Reproductive Health Campaign (ADB & IDA)								
- Other Initiatives (IDA)								

IDA - International Development Association, IEC - information, education, and communication, KfW - Kreditanstalt für Wiederaufbau.

As planned | Actual | Start of Bank Operations

COMPLIANCE WITH LOAN COVENANTS

	Covenants	Reference	Status
1.	The Borrower shall cause the Project to be carried out with due diligence and efficiency and in conformity with sound administrative, financial, engineering, environmental, and educational practices.	Loan Agreement Section 4.01(a)	Complied with
2.	In carrying out the Project and operation of the project facilities, the Borrower shall perform, or cause to be performed, all obligations set forth in Schedule 6 of the Loan Agreement.	Loan Agreement Section 4.01(b)	Complied with
3.	The Borrower shall make available, promptly as needed, the funds, facilities, services, land, and other resources that are required, in addition to the proceeds of the loan, for carrying out the Project and for the operation and maintenance of the project facilities.	Loan Agreement Section 4.02	Complied with
4.	In carrying out the Project, the Borrower shall cause competent and qualified consultants and contractors, acceptable to the Borrower and Asian Development Bank (ADB), to be employed to an extent and upon terms and conditions satisfactory to the Borrower and ADB.	Loan Agreement Section 4.03(a)	Complied with
5.	The Borrower shall cause the Project to be carried out in accordance with plans, design standards, specifications, work schedules, and construction methods acceptable to the Borrower and ADB. The Borrower shall furnish, or cause to be furnished, to ADB, promptly after their preparation, such plans, design standards, specifications and work schedules, and any material modifications subsequently made therein, in such detail as ADB shall reasonably request.	Loan Agreement Section 4.03(b)	Complied with
6.	The Borrower shall ensure that the activities of its departments and agencies in carrying out the Project and operating the project facilities are conducted and coordinated in accordance with sound administrative policies and procedures.	Loan Agreement Section 4.04	Complied with
7.	The Borrower shall make arrangements satisfactory to ADB for insurance of the project facilities to such extent and against such risks and in such amounts as shall be consistent with sound practice.	Loan Agreement Section 4.05(a)	Complied with
8.	Without limiting the generality of the foregoing, the Borrower undertakes to insure, or cause to be insured, the goods to be imported for the Project and to be financed out of the proceeds of the loan against hazards incident to the acquisition, transportation, and delivery thereof to the place of use or installation; and for such insurance any indemnity shall be payable in a currency freely usable to replace or repair such goods.	Loan Agreement Section 4.05(b)	Complied with
9.	The Borrower shall maintain, or cause to be maintained, records and accounts adequate to identify the goods and services and other items of expenditure financed out of the proceeds of the loan, to disclose the use thereof in the Project, to record the progress of the Project (including the cost thereof) and to reflect, in accordance with consistently maintained sound accounting principles, the operations and financial condition of the agencies of the Borrower responsible for carrying out the Project and operation of the project facilities, or any part thereof.	Loan Agreement Section 4.06(a)	Complied with

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	Covenants	Reference	Status
10.	The Borrower shall furnish, or cause to be furnished, to ADB all such reports and information as ADB shall reasonably request concerning (i) the loan, and the expenditure of the proceeds and maintenance of the service thereof; (ii) the goods and services and other items of expenditure financed out of the proceeds of the loan; (iii) the Project; (iv) to the extent relevant to the Project, the administration, operations and financial condition of the agencies of the Borrower responsible for carrying out the Project and operation of the project facilities, or any part thereof; (v) financial and economic conditions in the territory of the Borrower and the international balance-of-payments position of the Borrower; and (vi) any other matters relating to the purposes of the loan.	Loan Agreement Section 4.07(a)	Complied with
11.	Without limiting the generality of the foregoing, the Borrower shall furnish, or cause to be furnished, to ADB semi-annual reports on carrying out the Project and on the operation and management of the project facilities. Such reports shall be submitted in such form and in such detail and within such a period as ADB shall reasonably request, and shall indicate, among other things, progress made and problems encountered during the 6-month period under review, steps taken or proposed to be taken to remedy these problems, and proposed program of activities and expected progress during the following 6-month period.	Loan Agreement Section 4.07(b)	Complied with
12.	Promptly after physical completion of the Project, but in any event not later than 3 months thereafter or such later date as may be agreed for this purpose between the Borrower and ADB, the Borrower shall prepare and furnish to ADB a report, in such form and in such detail as ADB shall reasonably request, on the execution and initial operation of the Project, including its cost, the performance by the Borrower of its obligations under the Loan Agreement and the accomplishment of the purposes of the loan.	Loan Agreement Section 4.07(c)	Complied with
13.	The Borrower shall enable ADB's representatives to inspect the Project, the goods financed out of the proceeds of the loan, and any relevant records and documents.	Loan Agreement Section 4.08	Complied with
14.	The Borrower shall ensure that the project facilities are operated, maintained, and repaired in accordance with sound administrative, financial, engineering, environmental, vocational education and skills training, and maintenance and operational practices.	Loan Agreement Section 4.09	Complied with
15.	It is the mutual intention of the Borrower and ADB that no other external debt owed a creditor other than ADB shall have any priority over the loan by way of a lien on the assets of the Borrower. To that end, the Borrower undertakes (i) that, except as ADB may otherwise agree, if any lien shall be created on any assets of the Borrower as security for any external debt, such lien will *ipso facto* equally and ratably secure the payment of the principal of, and interest and other charges on, the loan; and (ii) that the Borrower, in creating or permitting the creation of any such lien, will make express provision to that effect.	Loan Agreement Section 4.10(a)	Complied with
16.	The provisions of paragraph (a) of this Section shall not apply to (i) any lien created on property, at the time of purchase thereof, solely as	Loan Agreement	Complied with

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	Covenants	Reference	Status
	security for payment of the purchase price of such property; or (ii) any lien arising in the ordinary course of banking transactions and securing a debt maturing not more than 1 year after its date.	Section 4.10(b)	
17.	The term "assets of the Borrower" as used in paragraph (a) of this Section includes assets of any political subdivision or any agency of the Borrower, and assets of any agency of any such administrative subdivision, including the Viet Nam Bank for Agriculture and any other institution performing the functions of a central bank for the Borrower.	Loan Agreement Section 4.10(c)	Complied with
18.	Except as ADB may otherwise agree, the Borrower shall establish immediately after the Effective Date, an imprest account at SBV or a commercial bank acceptable to the Borrower and ADB. The imprest account shall be established, managed, replenished, and liquidated in accordance with ADB's *Guidelines on Imprest Fund and Statement of Expenditures Procedures* dated November 1996, as amended from time to time, and detailed arrangements agreed upon between the Borrower and ADB. The initial amount to be deposited into the imprest account shall not exceed the equivalent of $2.0 million.	Loan Agreement Schedule 3, para.8	Complied with Bank approved the Executing Agency's request to increase ceiling of the imprest account from $2.0 million to $3.0 million
19.	The NCPFP shall be the Executing Agency for the Project. The minister, chairman of NCPFP shall have overall responsibility for project planning, organization and implementation.	Loan Agreement Schedule 6, para. 1	Complied with
20.	The Project Steering Committee, which has been established for the Project, shall be responsible for providing overall direction and guidance to the Project and shall be chaired by the minister, chairman of NCPFP. Other members of the Project Steering Committee shall include vice-minister level representatives from MOH, MPI, and MOF, together with high level representatives from SBV. The Project Steering Committee shall be responsible for ensuring interagency coordination, in particular between NCPFP and MOH. The Project Steering Committee shall meet as often as required, and at least once every 6 months.	Loan Agreement Schedule 6, Para. 2	Complied with
21.	The Executive Committee, which has been established for the Project, shall be responsible for coordinating the technical implementation of the individual components of the Project. The Executive Committee shall be comprised of the directors of the relevant departments of NCPFP, including the Service Delivery Department, and shall be chaired by the minister, chairman of NCPFP. The Executive Committee shall meet once every 2 months.	Loan Agreement Schedule 6, para. 3	Complied with
22.	The PMU, which has been established for the Project, shall be responsible for the coordination and administration of the day-to-day implementation of the Project. The director of the PMU shall have been seconded from NCPFP and carry the rank of department director; the deputy director shall have been seconded from MOH to ensure appropriate inter-ministerial coordination. At least one person in the PMU shall be responsible for the private sector mobilization subcomponent within Part A of the Project. The PMU shall also designate and identify staff to be responsible for ethnic minority issues	Loan Agreement Schedule 6, para. 4	Complied with

Continued on next page

	Covenants	Reference	Status
	in connection with the Project. The PMU shall be responsible for all BME activities and the MTR for the Project.		
23.	The PPMUs, which have been established for the Project, shall be responsible for day-to-day implementation of the project activities in their provinces, including the management of civil works. Each PPMU shall be composed of four staff, who shall be seconded from within the provincial CPFP or hired as contractual staff. The PPMUs shall be responsible for ensuring close coordination with the corresponding provincial health bureaus, including the civil works departments. In all provinces where ethnic minorities constitute at least 15% of the population, at least one person in the PPMU shall be responsible for overseeing the coordination and implementation of project activities relating to the ethnic minorities.	Loan Agreement Schedule 6, para. 5	Complied with
24.	The Borrower shall ensure that additional baseline studies and surveys will be undertaken for certain key indicators, and their results used to determine specific targets for these indicators by 31 December 1997.	Loan Agreement Schedule 6, para. 6	Complied with late
25.	The Borrower shall ensure that the baseline surveys and other additional studies required to develop appropriate strategies for ethnic minorities will be carried out, and, with appropriate participation of representative communities, initial strategies for ethnic minorities will be designed for discussions with ADB by 31 December 1997.	Loan Agreement Schedule 6, para. 7	Complied with late
26.	The Borrower shall ensure that the CHCs to receive facility upgrading will be selected in accordance with the criteria agreed with ADB.	Loan Agreement Schedule 6, para. 8	Complied with
27.	The Borrower shall ensure that all CHCs, DHCs, and provincial MCH/FP centers in the 15 project provinces will be appropriately staffed and all CHCs will be provided with adequate funding to pay staff salaries.	Loan Agreement Schedule 6, para. 9	Complied with
28.	The Borrower shall ensure that all CHCs, DHCs, and provincial MCH/FP centers upgraded under the Project will be adequately maintained during and after project implementation in accordance with guidelines agreed with ADB.	Loan Agreement Schedule 6, para. 10	Complied with
29.	The Borrower shall furnish ADB by 30 June 1997 for discussion with ADB a comprehensive description of the policy and implementation guidelines it will employ to ensure, as agreed with ADB, the effective implementation of: (i) cost recovery with respect to the essential drugs to be provided by the Project, and (ii) provision of essential drugs free of charge in mountainous and remote communes in the project provinces. The Borrower shall commence implementation of the policy and guidelines by 31 December 1997, and the policy and implementation guidelines shall be reviewed by the Borrower and ADB each year and will be the explicit focus of the MTR.	Loan Agreement Schedule 6, para. 11	Complied with late
30.	The Borrower shall ensure that the Model Services Initiatives Committee will be established by 31 December 1996 to foster,	Loan Agreement	Complied with

Continued on next page

	Covenants	Reference	Status
	develop, and implement model service delivery initiatives. All activities to be financed under the service delivery model initiatives component of Part A of the Project shall be submitted, through the committee, to ADB for prior review and approval, and thereafter shall be promptly implemented as approved.	Schedule 6, para. 12	
31.	If the pilot test of a strengthened community-based outreach system for family planning and family health is evaluated as successful by ADB, the other cofinanciers, and the Borrower, the Borrower shall prepare and submit to ADB for its approval a time-bound action plan for its implementation in the project provinces (within 6 months of the test evaluation and in no case later than 31 December 1999), and then promptly implement the plan as approved.	Loan Agreement Schedule 6, para. 13	Pilot was implemented, but not yet taken to scale.
32.	If the pilot test of village health posts is evaluated as successful by ADB, the other cofinanciers, and the Borrower, the Borrower shall prepare and submit a time-bound action plan for its implementation in the project provinces to ADB for approval (within 6 months of the test evaluation and in no case later than 31 December 1999), and then promptly implement the plan as approved.	Loan Agreement Schedule 6, para. 14	Pilot was implemented, but not yet taken to scale.
33.	The Borrower shall ensure that the pilot tests of private sector mobilization initiatives to be undertaken that are evaluated as successful by the Borrower and ADB be extended as funding is available.	Loan Agreement Schedule 6, para. 15	Pilot was implemented, but not yet taken to scale
34.	Before 31 December 1998, the Borrower shall ensure that financing, in the amounts agreed to with ADB, for the development of professional associations for doctors, assistant doctors, and nurse midwives, through budgetary allocations, from other sources on a grant basis, or a combination thereof shall have been obtained.	Loan Agreement Schedule 6, para. 16	This activity has been modified during the MTR.
35.	The Borrower and ADB shall undertake the MTR by 31 December 1999. The MTR shall begin with a three-part review encompassing the following: (i) a comprehensive internal assessment by the PMU based largely on the project MIS; (ii) an external assessment, by either an agency of the Borrower or a private consultant, of progress in meeting project objectives; and (iii) a synthesis by the PMU in the MTR report.	Loan Agreement Schedule 6, para. 17	Complied with ahead of schedule

ADB = Asian Development Bank, BME = benefit monitoring and evaluation, CHC= commune health center, DHC = district health center, CPFP = Committee for Population and Family Planning, MCH/FP = maternal and child health/family planning, MIS = management information system, MOF =Ministry of Finance, MOH = Ministry of Health, MPI = Ministry of Planning and Investment, MTR = Midterm Review, NCPFP = National Committee for Population and Family Planning, PMU = project management unit, PPMU = provincial project management unit, SBV = State Bank of Viet Nam.

CONSULTING SERVICES

Project Components	International						Domestic					
	RRP			Actual			RRP			Actual		
	Person-Months	ADB	IDA	Person-Months	ADB	IDA	Person-Months	ADB	IDA	Person-Months	ADB	IDA
National Level Strengthening of IEC												
- International Trainers on IEC	7.0		7.0			0						
- Long-Term IEC Agency	6.5		6.5			0						
- Long-Term Consultants							18.0		18.0			0
- Consultants' Travel							4.0		4.0			0
Management and Institutional Development												
- Management Training	18.0		18.0			0						
- MIS Software Application Development	3.0		3.0			0	18.0		18.0			0
- Teachers for MIS							3.0		3.0			0
- Central-Level Project Management							21.0		21.0			0
Provincial-Level Service Delivery												
1. MCH and FP Training for CHC Staff												
- Training Needs Assessment	2.0		2.0			0						
- Materials Development	2.0		2.0			0						
- Core Trainers	3.0		3.0			0						
- Evaluations	1.5		1.5			0						
- Master Trainers							444.0		444.0			0
- Administrators							84.0		84.0			0
- Secretaries							84.0		84.0			0
2. District Supervisor Training												
- Training Needs Assessment	2.0		2.0			0	3.0		3.0			0
- Training of Trainers	1.0		1.0			0	2.0		2.0			0
3. Clinical Upgrading												
- Training of Trainers	0.8		0.8			0						
- Competency Assessment	0.8		0.8			0						
4. Provincial Management of Training												
- Technical Assistance	4.5		4.5			0	10.0		10.0			0
- Courses for Trainers in 15 Project Provinces							45.0	30.0	15.0		0	0
- Courses for Trainers in 15 National Health Support Project Provinces							45.0		45.0			0

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Project Components	International						Domestic					
	RRP			Actual			RRP			Actual		
	Person-Months	ADB	IDA	Person-Months	ADB	IDA	Person-Months	ADB	IDA	Person-Months	ADB	IDA
5. Specialist Training												
- Protocol Development							1.0		1.0			0
- Teachers in 15 Project Provinces				0.5	0.5		750.0	500.0	250.0		0.0	0
- Teachers in 15 National Health Support Project Provinces							750.0		750.0		0.0	0
6. Training in Remote Areas												
- Material Design	2.0		2.0			0	2.0		2.0			0
- Training of Trainers	1.5		1.5			0	2.0		2.0			0
Private Sector Mobilization												
- Training Needs Assessment	1.0	1.0		9.0	9.0					66.0	66.0	
- Professional Associations	2.0	2.0			0.0					240.0	240.0	
- Regulatory Reform	1.0	1.0			0.0		6.0	6.0		120.0	120.0	
- Evaluation and Market Analysis	2.0	2.0			0.0		9.0	9.0			0.0	
- Program Management												
Total	**61.6**	**6.0**	**55.6**	**9.5**	**9.5**	**0**	**2,301.0**	**545.0**	**1,756.0**	**426.0**	**426.0**	**0**

ADB = Asian Development Bank; CHC = commune health center; FP = family planning; IDA = International Development Association, IEC = information, education, and communication; MCH = maternal and child health; MIS = management information system; RRP = report and recommendation of the President.
Source: Asian Development Bank estimates.

SUMMARY OF SUPPLY CONTRACTS

Materials and Supplies

Procurement Mode	Contract Signing (dd-mm-yy)	Source	Amount ($)	Approval Date (dd-mm-yy)	Nature and Quantity of Goods
ICB	23-10-99	Japan	1,806,335	24-09-97	100 ambulances
ICB	22-11-97	Japan	77,542	28-10-97	Gasoline generating set
ICB	18-11-97	Germany	57,879	28-10-97	Obstetric instrument set
ICB	20-11-97	Hong Kong, China	203,254	20-10-97	Light operating mobile
ICB	21-11-97	Japan	199,724	28-10-97	Electrocardiograph set
ICB	20-11-97	Hong Kong, China	465,830	28-10-97	390 units hot air sterilizer
ICB	06-12-97	France	81,358	28-10-97	130 units incubator oven laboratory
ICB	02-12-97	Viet Nam	1,330,591	28-10-97	Cupboard/stretcher/exam and delivery table
ICB	12-12-97	France	428,082	06-11-97	Operating table, water filter
ICB	12-12-97	Spain	83,220	06-11-97	7,670 syringes
ICB	05-12-97	Singapore	686,331	06-11-97	Dressing sterilizer, electric
ICB	12-12-97	United Kingdom	77,937	06-11-97	Still water, electric
ICB	22-12-97	Korea	403,000	28-10-97	Portable adult/infant anesthesia apparatus
ICB	25-12-97	France	808,550	05-12-97	Therm/Scale infant/adult dressing sterilizer
ICB	12-12-97	Denmark	119,285	04-11-97	Boiling-type sterilizer instrument
ICB	15-12-97	Denmark	65,255	04-11-97	Medicines
IS	10-09-98	Hong Kong, China	1,013,186	26-08-98	Medical equipment (packages 1, 5, & 6)
IS	10-09-98	Hong Kong, China	383,602	26-08-98	Medical equipment (packages 3,4,7,9, & 10)
IS	09-09-98	Viet Nam	21,372	26-08-98	Medical equipment (Package 8)
IS	12-09-98	Viet Nam	220,193	26-08-98	Medical equipment (package 2)
ICB	11-09-99	Japan	1,409,862	04-08-99	55 ambulances
ICB	20-10-99	Viet Nam	275,653	17-09-99	Medical equipment (packages 1 & 2)
ICB	19-10-99	Hong Kong, China	119,079	17-09-99	Medical equipment (packages 3,10, & 15)
ICB	20-10-99	Viet Nam	1,898,234	17-09-99	Medical equipment (packages 5 & 9)
ICB	18-10-99	Viet Nam	144,382	17-09-99	Medical equipment (package 6)
ICB	20-10-99	Viet Nam	31,700	17-09-99	Medical equipment (package 7)
ICB	18-10-99	Viet Nam	198,998	17-09-99	Medical equipment (packages 8, 12, 13, 14, 16, 17, 18, & 19)
ICB	18-10-99	Japan	13,663	17-09-99	Medical equipment (package 11)
ICB	10-10-99	Viet Nam	79,281	08-10-99	9 ambulance boats & 6 ambulances
ICB	30-10-99	France	108,272	17-09-99	Medical equipment (package 4)
ICB	29-10-00	Italy	94,945	27-10-00	Package 1-cColorimeter photoelectric

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Procurement Mode	Contract Signing (dd-mm-yy)	Source	Amount ($)	Approval Date (dd-mm-yy)	Nature and Quantity of Goods
ICB	28-11-00	Viet Nam	225,615	27-10-00	Package 6-bedside cabinet
ICB	27-22-00	Viet Nam	623,927	27-10-00	Package 5-patient beds
ICB	30-11-00	Germany	271,667	27-10-00	Package 12-ceiling operating light
ICB	30-11-00	Viet Nam	653,231	27-10-00	Packages 11 & 16-electrosurgery & colposcopes
ICB	30-11-00	Hong Kong, China	314,289	27-10-00	Packages 13 & 14-major & minor instruments
ICB	20-12-00	Cambodia	713,176	27-10-00	Package 4-portable respirator
ICB	11-12-00	Japan	1,763,354	27-10-00	Package 7-x-ray machine
ICB	07-12-00	France	419,505	27-10-00	Package 8-blood analyzer
ICB	21-12-00	Netherlands	371,402	27-10-00	Package 10-patient monitor
ICB	15-12-00	United Kingdom	248,370	27-10-00	Package 15-labor monitoring
ICB	12-09-01	Viet Nam	136,372	17-08-01	82 ambulance boats for DHCs
ICB	12-09-01	Viet Nam	415,003	17-08-01	785 ambulance boats for commune health centers
ICB	12-08-02	Viet Nam	299,136	09-07-02	383 service boats
ICB	15-11-02	Viet Nam	597,473	09-10-02	7,250 patient's beds

DHC = district health center, ICB = international competitive bidding, IS = international shopping.
Source: Loan Financial Information System.

IMPLEMENTATION OF ETHNIC MINORITIES STRATEGY

1. Ethnic minorities, who live mainly in the highlands, accounted for 50–80% of the population in three provinces, and 15–30% in another six provinces at the time of project appraisal. However, due to rural resettlement and rural-urban migration, this percentage might have declined in the highlands. The Loan Agreement required that at least one person from the Project Management Unit be assigned to coordinate and implement project activities relating to ethnic minorities in all provinces with an ethnic minority population of at least 15%. Following a baseline survey, a national family planning strategy for ethnic minorities was approved about 1 year later than expected. The one- or two-child policy was softened for ethnic minorities, while efforts were made to improve access to family planning services.

2. This strategy became even more important following the outcome of the 1998 Demographic Health Survey (DHS), which showed a major discrepancy between rich and poor (Table A15.1).

Table A15.1: Reproductive Health Status in Viet Nam

Expenditure Quintile	**Total Fertility Ratio**	**Average Age at First Marriage** (years)	**Pre-natal Care** (%)	**Delivery Supervised by Qualified Health Professional** (%)	**Delivery at Health Facility** (%)	**Mother Knows at Least 5 Methods of Family Planning** (%)	**Contraceptive Prevalence Rate** (all methods)
1(poorest)	4.0	20.5	46	56	37	80	74
2	2.5	20.8	59	72	56	90	87
3	1.7	21.1	64	80	65	93	87
4	1.6	21.2	67	84	72	94	90
5 (richest)	1.2	22.2	79	92	85	95	98
Total	**2.2**	**21.2**	**63**	**77**	**63**	**90**	**87**

Source: Demographic Health Survey 1998.

3. During the midterm review in 1999, the Project was refocused to give more attention to these disadvantaged groups. Various strategies were tried to reach the ethnic minorities. Establishing village-based health posts in remote communities did not work well, partly because it was not implemented based on health zoning. The expansion of village workers proved more successful. Reproductive health campaigns, while costly and difficult to sustain, also were useful. Special efforts were made to recruit and train ethnic minority staff to be posted in these remote areas, and to develop education material in local languages. The Government made an important decision to provide free drugs for ethnic minorities. Regular meetings were held with ethnic minority representatives to follow up on the development of services. Overall, the services for ethnic minorities improved considerably during the Project, not only in the project provinces but throughout the country.

4. To capture the trend in family planning services, the change in new acceptors of contraceptives was compared in project and non-project provinces (Table A15.2). This is a proxy indicator of family planning services that captures many events in the provinces, such as demographic changes due to declining fertility rates and migration, and development and stabilization of projects. New acceptors of modern contraceptives could be old and new couples. A negative trend might not necessarily mean declining performance. A new project would initially increase acceptance among older couples, while a longer-established project would serve proportionally fewer new acceptors. With these qualifications in mind, Table A15.2 shows that the number of new acceptors in 2002 was almost 1 million more than in 1997. It also shows

that the trend was more favorable in rural provinces compared to the three cities, suggesting that rural areas are catching up. This could be due to the fact that services were available earlier in the urban areas, but urban areas are growing faster. ADB-supported provinces showed a more positive trend than World Bank-supported provinces, partly, perhaps, due to migration. In general, provinces showing more acceptors in 2002 than in 1997 were located in the central region and the Mekong Delta. Acceptors declined in the northern region, while elsewhere showed a more mixed picture. Provinces with proportionally more ethnic minorities showed a much higher number of acceptors in 2002 compared to 1997. However, this might have been caused by resettlement of people from the lowlands into these areas. In any case, the results imply that services are increasingly available in these provinces with a higher proportion of ethnic minorities.

Table A15.2: Change in New Acceptors of Modern Contraceptives in Project and Non-Project Provinces

Acceptors	1997	2002	Difference	Trend[a]	% Positive Provinces
Total	3,407,053	4,324,738	917,685	43(8)	70
Rural provinces excluding project provinces	1,870,326	2,361,405	491,079	27(11)	71
Urban provinces excluding project provinces	351,913	490,148	138,235	2(1)	67
ADB project provinces	755,008	997,034	242,026	10(3)	77
World Bank project provinces	429,806	476,151	46,345	4(3)	57
Project provinces with higher proportion of ethnic minorities	341,822	460,258	118,436	7(1)	88
Project provinces with lower proportion of ethnic minorities	842,992	1,012,927	169,935	7(5)	58

[a] Percentage of provinces showing an increasing trend in new acceptors (or decreasing trend in acceptors).
Source: Government of Viet Nam. Health Statistical Yearbook, 1997. 2002. Hanoi. A correction was made for the 1997 use of condom and pills in Nam Dinh province.

PROJECT OUTCOME

A16.1: Project Baseline, Targets, and Outcome

	Indicators	Baseline Value[a] (1997) (%)	Original Targets (%)	Adjusted Targets[b] (%)	At Project Completion[c] (%)	Remarks
1.	National Decline in TFR	2.4	2.5[d]	2.1	1.9	Achieved
	- National Decline in TFR in Urban Area	1.6		1.4	1.4	Achieved
	- National Decline TFR in Rural Area	2.9		2.3	2.0	Achieved
2.	National Increase of CPR (Modern)	55.8	56	65	56.7	Not Achieved
3.	National Decline in Total Abortion Rate	0.54	30	30	0.62	Not Achieved
4.	National Decline in Infant Mortality Rate	29/1,000	25/1,000	25/1,000	18/1,000	Achieved
5.	National Increase in the Share of Temporary Short-Term, Supply-Based Contraceptive Methods	19	25	25	16	Not Achieved
6.	National Improvement in Access to FP Services	88% for non-clinical and 44% for clinical methods		95% for non-clinical and 60% for clinical methods	1. FP field worker present in community: 98.4% NNP; 94.2% PP[e] 2. Mobile FP clinics visiting community: 77.3% NPP; 60.2% PP 3. FP campaign: 86% NPP; 96% PP 4. Distribution of married women aged 15-49 years by distance to nearest FP provider: a. < 1 km: 66.8% NPP; 58.8% PP b. 1–4 km: 23.7% NPP; 31.5% c. 5–9 km: 5.9% NPP; 8.8% PP d. 15–29 km: 0.0% NPP; 1.2% PP	Achieved Note: 86% of married FP users are served by the public sector (DHS 2002).

[a] Based on the Demographic and Health Survey (DHS) 1997.
[b] Adjusted during midterm review in 1999.
[c] Based on DHS 2002 data, and quoted from the project management unit final report.
[d] At project appraisal the national total fertility rate in the country was estim ated to be 3.1.
[e] Project provinces and non-project provinces.

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Indicators	Baseline Value (1997) (%)	Original Targets (%)	Adjusted Targets (%)	At Project Completion (%)	Remarks
7. Utilization of CHC for Prenatal Care in Project Provinces; Provider is Doctor, Nurse, or Midwife	71.7		80	86% of pregnant women received examination, 15% increase	Achieved
8. Life-saving Obstetric Care	11,000 with 2.5% deaths		Reducing: 10% of obstetric complication cases, and reducing 20% deaths per year[f]		
9. Decrease Maternal Mortality Ratio in PP	70/1,000			50/100,000	Achieved
10. Immunization of Infants in PP	50.1		63.9	66.7% fully immunized in PP[g]	Achieved
11. Knowledge of Five or More Modern Contraceptives	86.40		90	Increased by 8%	Achieved

CHC = commune health center, CPR = contraceptive prevalence rate, FP = family planning, km = kilometer, NNP = non-project provinces, PP = project provinces, TFR = total fertility rate.

[f] Ministry of Health, 1997: 2.5% dead among obstetric complications.

[g] DHS Survey lists 66.7% nationwide, and states that there is little difference between project provinces and non-project provinces.

Source: Viet Nam Commission for Population, Family, and Children.

Table A16.2: Changes in Contraceptive Prevalence in Project and Non-Project Provinces

Region		Prevalence in 1997 Modern (%)	Prevalence in 1997 Traditional (%)	Prevalence in 2002 Modern (%)	Prevalence in 2002 Traditional (%)
Viet Nam	Project	56.1	20.9	56.2	21.3
	Non-Project	55.7	18.9	56.9	22.1
Northern	Project	45.0	24.0	55.6	21.4
	Non-Project	53.6	17.1	56.8	21.8
Red River Delta	Project	65.3	18.9	59.5	23.9
	Non-Project	67.3	14.5	59.3	22.9
North Central Coast	Project	63.9	18.9	60.1	15.8
	Non-Project	63.0	14.7	54.6	28.8
Central Highlands	Project	43.8	19.8	43.1	28.8
South Central Coast	Project	54.4	15.4	56.9	20.4
Southeast	Project			39.4	18.6
	Non-Project	52.9	21.5	55.0	21.0
Mekong River Delta	Project	48.8	24.8	54.1	19.9
	Non-Project	48.3	25.1	58.1	21.1

Source: The Futures Group International.

Table A16.3: Change in Contraceptive Mix 1997 and 2002 For Married Women Aged 15–49 years

	1997	2002
Any method	75.3	78.5
Any modern method	55.8	56.7
Oral contraceptive (pill)	4.3	6.3
Intrauterine device	38.5	37.7
Injection	0.2	0.4
Condom	5.9	5.8
Female sterilization	6.3	5.9
Male sterilization	0.5	0.5
Any traditional method	19.2	21.8
Periodic abstinence	7.3	7.5
Withdrawal	11.9	14.3
Other methods	0.3	0.1

Source: Viet Nam Commission for Population, Family, and Children.