Report Number: ICRR0023077

1. Project Data

Project ID P131825	**Project Name** Health Prof. Edc and Trg (HPET)
Country Vietnam	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	**Closing Date (Original)**	**Total Project Cost (USD)**
IDA-54410,TF-A1658	31-Dec-2020	43,412,960.81
Bank Approval Date	**Closing Date (Actual)**	
06-May-2014	31-Dec-2021	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	106,000,000.00	8,066,608.15
Revised Commitment	54,608,163.03	4,448,877.99
Actual	44,362,950.67	4,908,965.44

Prepared by	Reviewed by	ICR Review Coordinator	Group
Salim J. Habayeb	Judyth L. Twigg	Eduardo Fernandez Maldonado	IEGHC (Unit 2)

2. Project Objectives and Components

a. Objectives

The objectives of the project were to improve the quality of health professionals' education, strengthen management competencies of the Recipient in the health sector, and improve the competencies of primary health care teams at the grass-roots level (Financing Agreement, p. 4).

This ICR Review applied a split evaluation, as there was a downward revision of an associated outcome target in July 2018, at which time disbursement was at 27 percent.

In January 2021, one year before the closing date, the project scope was reduced in terms of numbers of training institutions, clinical training sites, and commune health stations. This was undertaken in conjunction with a decrease in project commitments through partial cancellation of credit proceeds (see Section 2e). Therefore, this ICR Review did not apply a second split rating for the 2021 revision, because the reduced scope was commensurate with the lower commitment size.

b. Were the project objectives/key associated outcome targets revised during implementation?
Yes

Did the Board approve the revised objectives/key associated outcome targets?
No

c. Will a split evaluation be undertaken?
Yes

d. Components

I. Improving the Quality of Health Professionals Education (Appraisal: US$61.6 million; Actual: US$13.4 million)

1a. Improving the Quality Assurance System of Health Professionals Education: (i) establishment of standards for health professionals' education; (ii) establishment of a quality assurance council within the Ministry of Health (MOH); and (iii) provision of support to the said quality assurance council to set up a peer review assessment system and a standardized examination system.

1b. Supporting Measures to Meet the Standards of Health Professionals Education: provision of grants to selected education and training institutions to scale up their performance and achieve national standards established under section 1a, above.

II. Strengthening Management Competencies in the Health Sector (Appraisal: US$11 million; Actual: US$6 million)

2a. Strengthening Health Management Training: support to Hanoi School of Public Health and Ho Chi Minh City Institute of Public Health to strengthen their capacity in health management training, including: (i) training of trainers, health managers and other officials; (ii) minor renovation and repair of existing facilities; (iii) provision of training equipment, office equipment, and furniture; (iv) development of training materials; and (v) enhancement of health management learning resources.

2b. Improving Policy Making in Human Resources for Health: (a) carrying out of studies, dissemination, and knowledge exchange activities leading to improvement in the policy environment for human resources in the health sector; and (b) launching of a pilot program to improve the distribution of human resources in disadvantaged areas, including: (i) carrying out of physician needs assessments in the targeted disadvantaged areas; (ii) carrying out information campaigns to relevant stakeholders; and (iii)

supporting selected teaching institutions and/or hospitals to encourage freshly graduated and/or trained physicians to volunteer to work in disadvantaged areas.

III. Improving Competencies of Primary Health Care Teams at the Grass-roots Level (Appraisal: US$29 million; Actual: US$17.5 million)

3a. Training Primary Health Care Teams at the Grass-roots Level: (i) carrying out of needs assessment and curriculum review and development; (ii) provision of support to selected training institutions to carry out training to health professionals in primary health care through a combination of long-term and short-term modular training courses and on the-job training; and (iii) provision of support for an independent organization to carry out post-training evaluation of the primary health care teams' performance.

***3b. Improving Trained Primary Health Care Teams Access to Basic Equipment According to the National Benchmarks*:** provision of laboratory and medical equipment and furniture to primary health care teams and clinical training sites.

IV. Project Implementation Support and Coordination (Appraisal: US$4.4 million; Actual: US$1.8 million), including provision of support for project management activities, supervision, procurement, financial management, disbursement, audits, and monitoring and evaluation.

Note: The components did not change (ICR, p. 13), but there were revisions in component costs with cancellations along with an increased focus on competency-based training (as explained in Section 4).

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

At appraisal, the project cost was estimated at US$121 million consisting of an International Development Association (IDA) Credit of US$106 million equivalent, a World Bank Grant of US$10 million (from a Single Donor Trust Fund supported by the European Union), and a Borrower contribution of US$5 million to finance salary allowances for government staff seconded to the project (PAD, p. 11).

The project had three fund cancellations that aggregated at US$56.1 million:

- The first cancellation of US$20 million was made in April 17, 2017, 2.5 years after project effectiveness when only US$3.8 million had been disbursed. The cancellation was related to weak project implementation progress at that time. The cancellation reduced Component 1 (Improving the Quality of Education). The project was among a number of operations that were targeted by the

Ministry of Planning and Investment for reallocation of IDA resources to other projects prior to the country's graduation to the International Bank for Reconstruction and Development.

- The second cancellation of US$21.1 million was made in January 2021 based on a reduction in anticipated expenditures that were needed during the one-year extension of the closing date. The cancellation was associated with a reduction in project scope, as the number of training institutions, clinical training sites, and commune health stations was reduced from 2,300 sites to 736 sites.
- The third cancellation of US$15 million was carried out around the project closing date of December 31, 2021 to remove funds that would not be required for eligible expenditures incurred prior to closing.

Actual disbursement amounted to US$44.4 million. The originally planned Borrower contribution of US$5 million was revised to US$2.1 million in 2018, and the actual contribution was not reported.

3. Relevance of Objectives

Rationale

Development objectives were responsive to challenges in human resources that affected health sector performance, access to care, and service quality. According to the Project Appraisal Document (PAD, p. 3), the quality of health professionals' education was lagging not only in content but also in teaching methods. According to the PAD (p. 3), clinical practice sites were limited to central hospitals and some provincial hospitals. There was a need to shift from conventional to more active teaching methods and problem-based learning. Also, the PAD (p. 4) noted that, in general, medical training was hospital-based, with little focus on developing skills and competencies that were needed at the primary health care level.

At entry, the overall rationale was consistent with the Country Partnership Strategy for the period FY12-FY16 that aimed at supporting government efforts to improve the delivery of public services, including a well-trained and motivated health workforce (ICR, p. 16). In parallel to improving educational aspects, the project intended to strengthen management competencies, justified by the fact that, in 2013, only 30 percent of hospital administrators were trained in management. The project also intended to strengthen human resources at the grassroots level to facilitate the provision of quality health services in a decentralized system where only one third of Commune Health Stations (CHS) had a physician. Such support at the primary health care (PHC) level was also intended to contribute to implementation of the national master plan for the development of grassroots health networks.

At project closing, the objectives remained consistent with the Country Partnership Framework (CPF for the period FY18-FY22), specifically in "Focus Area 2: Invest in people and knowledge" that had three objectives: improve access to quality public and private health services and reduce malnutrition; improve integration and efficiency of social assistance, pension, and health insurance systems; and strengthen the relevance and quality of tertiary education and labor market institutions. The ICR (p. 16) noted that, with Vietnam's graduation from IDA in July 2017, project objectives were in line with the CPF approach that intended to assist the country's efforts to succeed as a middle-income country by developing a stronger and more competitive labor force with relevant in-demand skill sets.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
Improve the quality of health professionals' education

Rationale
The theory of change held that improving quality assurance in the education of health professionals through standards, policies, and new curricula supported by grants to medical/nursing/pharmacy schools would lead to a competency framework for health professions and strengthened institutional capacity to implement competency-based curricula, plausibly contributing to improved quality of health professionals' education.

Outputs and intermediate results

MOH established a Professional Council to assess the implementation of competency-based curricula developed under the project. The Council was chaired by a senior official in charge of health professionals' education and comprised of senior educators and managers from universities, the Ministry of Education and Training, and professional associations.

The Professional Council used scorecards acceptable to the World Bank in this process. Scorecards included 10 areas/standards, 36 criteria, and 96 indicators. Covered areas covered included required competencies, syllabi, learning and teaching methods, adequacy of human resources, appropriate allocation and use of resources as per agreed budget, facilities and infrastructure, and quality enhancement. The 19 grant-recipient schools (medicine, nursing, dental, and pharmacy) developed new curriculum frameworks, 1,184 modules or detailed lectures, 2,778 Objective Structured Clinical Examination questions, 185,090 multi-choice questions, 6,509 checklists for evaluation of practice, and 1,807 teaching and learning documents.

If a school met at least 70 percent of its respective scorecard, then the education program was accepted, and the school was acknowledged as "successfully implementing a competency-based curriculum" (ICR, p. 18). Grant-recipient schools completed 76.2 percent, 82.3 percent, and 85 percent of activities in their annual work plans for 2018, 2019, and 2020, respectively.

The methodology used for measuring structural and process quality was in line with international standards, including standards of the World Federation of Medical Education and education quality accreditation practices (TTL clarifications, September 7, 2022).

In addition, a supportive regulatory environment was further strengthened through the development and approval of 34 regulatory and technical documents. According to the ICR (p. 21), these documents guided and facilitated the implementation of the National Education System Structure and the National Qualifications

Framework of Vietnam in Human Resources for Health training, and served as an elaborative tool for government decisions on specific training needs and professional regulation in the health sector.

Outcomes

The number of grant-recipient schools that successfully implemented their competency-based curriculum reached all 19 grant-recipient training schools, exceeding the target of 12 grant-recipient schools. The results were measured by an independent peer review mechanism through the Professional Council.

The reported progress in advancing qualitative aspects in health professionals' education was noteworthy as it reflected the advancement of structural and process aspects of quality, based on scorecards encompassing a wide range of standards and criteria in accordance with international practice as discussed above under outputs. Also, this approach that promotes and measures structural and process quality aspects through scorecards is commonly used for assessing the quality of care in Performance-Based Financing operations because of its feasibility and overall reliability.

Rating
High

OBJECTIVE 2
Objective
Strengthen management competencies in the health sector
(original outcome target)

Rationale
The theory of change held that supporting institutions to strengthen their capacities in management training and improving policy making through studies, dissemination of knowledge, and financing a pilot to incentivize adequate distribution of human resources would increase the number of health managers and inspectors who had at least one management course and, under the pilot, would increase the number of young volunteer physicians completing CK1 training (first level specialist training) and increase the percentage of young volunteer physicians working in disadvantaged districts after CK1 training. The theory of change suggested that these results would reflect strengthened management competencies in the health sector and would lead to a more equitable distribution of PHC physicians in disadvantaged areas.

The theory of change was weak in assuming that completing at least one management course would reflect sufficient evidence on strengthened management competencies in the health sector. Also, the pilot aiming at more equitable distribution of physicians in disadvantaged areas had important merits in testing an approach for promoting equitable distribution of physicians, but not as a full-fledged outcome reflecting achievement of the stated objective.

Outputs and intermediate results

A total of 2,450 professionals completed at least one management course. This number encompassed 1,407 leaders of the Provincial Departments of Health and other health units, including 93 health inspectors, 722 managers at the division/unit level, 111 health policymakers, and 117 Trainers of Trainers for CHS staff.

The project supported a pilot program that financed training of physicians in a specialty field for a district hospital (surgery, pediatrics, and obstetrics/gynecology) leading to CK1 training for medical doctors who volunteered, upon graduation, to work in a disadvantaged location. The project also provided support to volunteering physicians. The number of young volunteer doctors who completed CK1 training program was 354 volunteer doctors, 40 percent of whom were female.

Outcomes

The ICR reported that the number of managers and inspectors who completed at least one management course reached 2,450 officials in 2021, considerably short of the original target of 4,000 managers and inspectors.

Under the pilot program for more equitable distribution of physicians in disadvantaged areas, the ICR reported that the percentage of young volunteer physicians who worked in disadvantaged districts during the year following completion of CK1 training reached 100 percent, exceeding the target of 90 percent. This successful pilot provided an important message that improved policy making in human resources can contribute to promoting equitable distribution of physicians in disadvantaged areas where it is scaled up.

Rating
Modest

OBJECTIVE 2 REVISION 1
Revised Objective
Strengthen management competencies in the health sector
(revised outcome target)

Revised Rationale
The theory of change and intermediate results were the same as under the original Objective 2, above.

Outcomes

In addition to the pilot results on promoting equitable distribution of physicians as shown above under the original Objective 2, the number of managers and inspectors who completed at least one management course reached 2,450 managers, exceeding the revised target of 2,300 managers and inspectors. The target

reduction from 4,000 to 2,300 managers and inspectors was requested by MOH because of increased unit cost of training and delayed implementation (ICR, p. 73).

Nevertheless, the number of health managers who have completed at least one management course did not constitute sufficient evidence reflecting strengthened management competencies in the health sector. Therefore, the revised objective (with revised outcome target) was assessed as partly achieved.

Revised Rating
Modest

OBJECTIVE 3
Objective
Improve the competencies of primary health care teams at the grass-roots level

Rationale
The theory of change held that training of PHC teams at the grassroot levels in 15 selected provinces through long- and short-term modular training courses and on-the-job training, the provision of basic equipment as per national benchmarks, and the provision of laboratory and medical equipment would contribute to improved competencies of PHC teams at the grassroots level and improved health infrastructure at the PHC level.

Outputs and intermediate results

The number of health staff enrolled in the PHC training program reached 24,639 staff, exceeding the original target of 8,500 staff and the revised target of 16,500 staff. The ICR (p. 26) noted that 56.9 percent of all health workers who were trained by the project were female.

The project provided a set of basic equipment to 793 training institutions, clinical training sites, and CHS, short of the original target of 2,300 but exceeding the revised target of 736 training institutions and sites.

Outcomes

The percentage of CHS staff who reported improvement in their knowledge and clinical skills in the management of selected conditions reached 96 percent in 2021, exceeding the target of 80 percent. The result was based on a final evaluation conducted in 54 CHS in six of the 15 project provinces. Other competency improvements that were reported by PHC team members included communication, teamwork, decision-making, and planning/organization skills (ICR, p. 20).

The project faced some challenges in measuring the above results, as the definition of the indicator changed as a result of government restrictions on the use of IDA Credit for recurrent expenditures. MOH was unable to contract independent evaluators to measure the indicator under its original version: “Percent of CHS staff per province that have improved their clinical skills in the management of selected conditions by at least 25% after training." The percentage element of the definition was modified from 25 percent to 20 percent in 2018 and was dropped in 2021 (ICR, p. 74) to simplify the assessment of staff-reported improvements.

In addition, the ICR appropriately explored potential effects of PHC training that could have contributed to changes in service utilization (ICR, p. 20). Pre-training utilization in 2016 was compared with post-training utilization in 2019. The ICR (p. 66) reported an uptake in the number of patients utilizing CHS for preventive services, increasing from 80,935 to 101,780 examinations. There were substantial increases in ultrasound visits, laboratory testing, and the number of patients with non-communicable diseases managed by CHS, such as hypertension and diabetes (ICR, pp. 67-68). The improved utilization pattern was not uniform, as the number of curative visits decreased from 311,208 in 2016 to 249,909 visits in 2019.

Rating
Substantial

OVERALL EFFICACY
Rationale
The objective to improve the quality of health professionals’ education was fully achieved; the objective to strengthen management competencies in the health sector was partly achieved; and the objective to improve the competencies of primary health care teams at the grass-roots level was almost fully achieved. The aggregation of achievements is consistent with a substantial overall efficacy rating.

Overall Efficacy Rating

Substantial

OVERALL EFFICACY REVISION 1
Overall Efficacy Revision 1 Rationale
The same achievements as under the original overall efficacy were observed.

Overall Efficacy Revision 1 Rating

Substantial

5. Efficiency

The economic analysis at appraisal justified the investment by the public good nature of gains in the quality of education and positive externalities associated with improved health outcomes. The analysis reviewed empirical evidence on links between quality assurance of health professionals' education and better quality of care, but did not attempt to quantify the impact of improved health professionals' education (Component 1) in view of the difficulty of assigning a monetary value to expected improvements in health outcomes. The economic analysis quantified expected benefits of increased allocative efficiency and cost containment in the health sector under Components 2 and 3 (improving competencies) and estimated that the project would generate significant cost savings from increased utilization of health care services at the lowest levels of care, and estimated a net present benefit of around US$260 million, yielding a gross benefit ratio of 15.2.

The ex-post economic analysis explored the likely impact of higher quality training of health personnel on improving the quality of care and attempted to assign a monetary value to the expected improvements in health outcomes. It employed a macroeconomic approach in its analysis; specifically, the "health outcome" was measured based on a health index used in the construction of the World Bank's Human Capital Index, where results of growth regression suggested that a unit increase in the health index was associated with a 0.421 percentage point increase in the country's average long-run GDP per capita growth rate per annum. The benefit of project interventions was calculated as the present value of the difference between the simulated and the baseline GDP paths until the year 2055.

Among the assumptions, the analysis assumed that quality improvement in training led to a 7.1 percent increase in core competencies for physicians and physician assistants, and a 2.4 percent increase for nurses, midwives, and pharmacists. The efficiency gain was estimated under two scenarios. In the first scenario, it was assumed that the increase in recurrent costs after the training interventions would be equal to the increase in personnel productivity after the training. Using a discount rate of 5 percent, the net present value (NPV) of the project was estimated at US$1,070 million. The corresponding internal rate of return (IRR) was estimated at 18.25 percent and the benefit-cost ratio at 4.1. In the second scenario, it was assumed that the increase in recurrent costs would be equal to 50 percent of the increase in personnel productivity after the training. Under the second scenario, the NPV of the project was estimated at US$1,220 million, with a corresponding IRR of 21.5 percent and a benefit-cost ratio of 7.3. The underlying assumption of causal linkages between the quality of health professionals' education and improved health outcomes reflects potential contributions to health outcomes, but the assumption has uncertainties, as health outcomes are influenced by numerous other determinants.

Implementation shortcomings reported by the ICR (pp. 29-31) significantly reduced overall efficiency. The project suffered from major delays throughout its implementation period. From the start, it faced a challenging regulatory and institutional environment, including a change in leadership. The signing of the Trust Fund Grant Agreement was delayed by two years, hindering the start of related activities. The decision to introduce competency-based education and the newly approved National Education Framework impacted the structure and pathways of the health professionals' education, and necessitated re-setting the stage to implement the new approach. There were changes in the governance of provincial colleges. The requisite legal framework was insufficient at the health sector level where only seven schools were managed by MOH. These factors

introduced an unanticipated level of complexity in project implementation, including by affecting approvals, timing, and resources to be provided for grants to schools to scale up performance. The slow rate of disbursement led to the cancellation of US$20 million from the project in 2017 (ICR, p. 29). That year, Vietnam graduated as an IDA country, and a new policy on public debt management was enforced, thus impacting the use of project funds, including all external development assistance, including World Bank projects. This constrained the project's ability to use financing for recurrent expenditures. As of 2019, the government did not allow the use of project financing for education and training activities, further affecting core project activities. Along with various delays, the above challenges contributed to additional cancellations of project funding, aggregating at a total of US$56.1 million by project closing. Equipment procurement was also hampered by delays in approvals. Equipping of CHS supported by the project required more than ten approvals. This in turn led to a delay in the centralized procurement of equipment for various CHS supported under the project.

The COVID-19 pandemic and necessary responses had a negative impact on project progress. In June 2021, the country experienced another rapid surge in COVID-19 cases and deaths, and the government imposed stringent restriction measures during which MOH was pre-occupied in handling pandemic-related emergencies, leading to further project implementation delays, including in the delivery of equipment and in assessing education grants.

Efficiency Rating

Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐ Not Applicable
ICR Estimate	✓	18.25	80.00 ☐ Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives across the entire project is rated high, as there was full alignment between the objectives, country programs, and the Country Partnership Framework at closing.

Efficiency, also rated across the entire project, is rated modest in view of negative aspects of implementation that significantly reduced efficiency.

Efficacy: (i) Under the original objectives, efficacy is rated substantial, as the project almost fully achieved its objectives; and (ii) after restructuring, efficacy is also rated substantial, as the project almost fully achieved its objectives.

According to IEG/OPCS guidelines, when a project's objectives/associated outcome targets are revised, the final outcome is determined by the weight of Bank disbursements under each set of objectives. Since the efficacy rating was the same under the original and revised objectives, a formal calculation is unnecessary. The aggregation of ratings encompassing high relevance, substantial efficacy, and modest efficiency is consistent with an overall outcome rating of moderately satisfactory, reflecting moderate shortcomings in the project's preparation, implementation, and achievement.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

Project approaches and interventions are expected to be sustained, and this would contribute to maintaining development outcomes that were realized. Training institutions, relevant ministries, and provincial authorities are expected to pursue competency-based training. A variety of supportive measures such as decrees and circulars, training materials, and assessment tools will continue to be applied to training activities after the project period. Capacity building efforts resulted in a large number of skilled personnel, including lecturers, trainers, health managers, and PHC staff. Training institutions and health facilities are expected to continue utilizing the assets that were developed by the project. According to the ICR (p. 36), a number of training institutions have committed to either allocating their own resources and/or mobilizing resources from other funding sources to continue project-initiated activities in the near and medium term.

Project investments in training and equipping CHS will likely continue to help in improving health services at the grass-roots level. This will ultimately contribute to alleviate the burden of overcrowding at district and provincial hospitals, although such a desirable pattern may be diminished by the policy on health insurance payments that allows patients to bypass the CHS level and to go directly to district hospitals (ICR, p. 36).

8. Assessment of Bank Performance

a. Quality-at-Entry

Preparation was collaborative and included various MOH departments and representation from the Ministries of Planning and Investment, Finance, Education and Training, and Internal Affairs. A Project Steering Committee at MOH, the main implementing agency, was formed. The Central Project management Unit (CPMU) prepared to enter into Memorandums of Understanding with training institutions. Preparation included key stakeholders, namely universities/schools/colleges, and provincial and district authorities for aspects related to PHC staff. Preparation also drew upon international expertise already being provided through other support, including Health Advancement in Vietnam (a partnership with selected foreign universities), which was providing support to participating schools in

building training programs at medical universities and colleges, including for on-the-job training approaches.

Institutional arrangements for implementation were clearly defined (ICR, p. 35). Technical, financial, and fiduciary aspects were adequately prepared. A procurement plan was developed and approved. Preparation took into consideration poverty, needs of disadvantaged areas, gender, and social aspects. Safeguard Policy OP 4.01 on Environmental Assessment and Safeguard Policy OP 4.10 for Indigenous Peoples were well prepared. Risks were adequately identified and mitigated. These included the fact that the Department for Administration of Science, Technology and Training within MOH had had no prior experience with World Bank-financed projects, thus necessitating the engagement and support of other MOH departments; challenges related to transforming health professionals' education; and the scope of services and competencies of staff at the PHC level (PAD, p. 14).

At the same time, significant shortcomings were reported. Preparatory arrangements appear to have proceeded without an indication of concrete commitment to reforms. The ICR (p. 35) stated that the absence of any official pronouncement necessary to underpin/indicate broader commitment to the reform elements proved to be problematic moving forward in implementation. According to the ICR, indications of such support were needed prior to effectiveness. While Vietnam's desire to showcase medical education reform for the 21st century was praiseworthy, reforms could not effectively advance without consensus and partnership with related sub-sectors dealing with health professionals' training, notably medical education, where reforms are often contentious and require extensive consultations, ownership, and implementation readiness (ICR, p. 37). During the first three years of the project, implementation and disbursements were minimal. The ICR noted that the project would have benefited from an extended preparation phase to allow the formulation of explicit policy positions and regulatory frameworks in order to proceed with the proposed reforms. Also, the ICR stated that, at entry, the project had modest M&E design to monitor outcomes (ICR, p. 31).

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision
The ICR noted that the Task Team was focused on development impacts, and that, in collaboration with the CPMU, it was pro-active in addressing initial implementation constraints, resulting in turning around a problem project (ICR, p. 35). The Task team worked closely with its counterparts in: (a) conducting systematic monitoring of project activities and early identification of issues; (b) providing technical support and capacity building, notably on project management; (c) supporting compliance with environmental and other safeguards; and (d) working with the government team to address bottlenecks.

According to the ICR (p. 30), the Task Team was candid in its reporting to Bank management, while seeking appropriate solutions. A total of 23 supervision and implementation support missions were undertaken during the seven-year implementation period, including interim missions that were introduced after the Mid-Term Review. Missions benefited from the participation of staff experts in various areas. Reviews during the latter half of the project benefited from having almost all participating staff based within the country, thus facilitating timely responsiveness and support. According to the ICR, supervision missions focused not only on project implementation, but also on broader system-building aspects to promote

sustainability of project interventions. The task team reportedly extended substantial effort to ensure that the CPMU provided adequate support in capacity building to beneficiary training schools and provinces. During the COVID-19 pandemic, the Task Team promoted the use of digital platforms to maintain continuity of training and information sharing. Therefore, the Quality of Supervision is rated satisfactory.

Note: The satisfactory rating for Quality of Supervision puts it in an opposite direction from that of Quality-at Entry that was rated moderately unsatisfactory. In such cases, the rating for overall Bank Performance depends on the outcome rating; therefore, overall Bank Performance is rated Moderately Satisfactory.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The project's objectives were clearly specified. Selected indicators were largely in line with stated objectives, although with a frequent output-orientation that did not directly measure intended outcomes. For example, the number of health managers enrolled in a management course did not directly measure improved management competencies in the health sector (ICR, p. 31). The expected improvement of clinical skills competencies by 25 percent among CHS staff trained was not based on any baseline information (ICR, p. 31). The ICR (p. 32) noted that, wherever possible, indicators were planned to be disaggregated by gender. These were not included in the results framework, but relevant results were adequately reported by the ICR. Data sources and definitions were established. The design included semi-annual reporting and a final evaluation. The CPMU clarified data collection instruments, recording, and reporting systems. Project auditors were to certify the numbers of trained professionals and amounts to be paid.

b. M&E Implementation
During implementation, the results framework was significantly improved and revised to capture the change in government approach toward achieving the intended improvement in health professionals' education. This entailed a change from standardized examinations to tracking the implementation of competency-based education, notably through scorecards. Following this shift, M&E implementation improved, and the ICR (p. 32) reported that the results framework was implemented rigorously, with results being tracked and updated on a regular basis. M&E coordination was reportedly smooth between the CPMU, departments, provincial levels, and the World Bank Task Team. Project staff were trained to further strengthen M&E skills.

c. M&E Utilization

M&E findings were used for regular project monitoring and evaluation. The use of scorecards left valuable tools for medical institutions to continue applying in their pursuit to improve the education quality of their graduates. The ICR (p. 33) noted that experience gleaned through the project helped to inform another project prepared in the region.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

Overview: The project complied with safeguard policies and with Vietnam's environmental regulations. It also complied with Safeguard Policy OP 4.10 on Indigenous Peoples. The overall Safeguard Rating recorded in the Operations Portal was satisfactory.

The project triggered Safeguard Policy OP 4.01 - Environmental Assessment – and was classified under category B in view of small-scale rehabilitation works in medical and nursing schools and some risks related to medical waste. An Environmental and Social Management Framework was developed and disclosed. Implementation aspects highlighted by the ICR included the following: (a) an Environmental Code of Practices was implemented by contractors during repairs and infrastructure improvement activities; (b) a Waste Management Plan was implemented by clinical training institutions and commune health stations; and (c) training courses included topics on COVID-19 pandemic prevention and control. The ICR stated that the project followed the World Bank's environmental safeguards policies and Vietnam's environmental regulations. Contractors complied with the environmental health and safety requirements outlined in bidding and contract documents. The ICR reported that implementation of safeguard policies was satisfactory. There were no incidents of environmental health and safety reported.

The project also triggered Safeguard Policy OP 4.10 - Indigenous Peoples. According to the ICR (p. 33), activities were fully aligned with the Safeguard Policy. Government priorities relating to women and ethnic minorities were encouraged and prioritized for participation in training courses. Communication materials were produced in Thai and Muong languages in order to reach ethnic minorities. The latter accounted for 78 percent of volunteer doctors who were trained and went to work in mountainous/remote areas, 37 percent of primary health care staff trained by the project, and 15 percent of health managers who were trained.

b. Fiduciary Compliance

Although financial arrangements during preparation were adequate overall, financial performance was low during the initial three years, but it improved to a satisfactory level in the remaining four years of implementation. Disbursements were affected by extrinsic factors, including the requirement for an annual budget allocation without which no disbursements were allowed, and new Ministry of Finance regulations associated with the country's graduation from IDA to IBRD that aimed at minimizing the use of official

development assistance funds for recurrent expenditures, resulting in partial cancellations of funds (see Section 2e).

There was variability in procurement performance. Related weaknesses were addressed, including those pertaining to delayed approvals of provincial procurement plans. The final rating for procurement performance was satisfactory.

The project complied with all external audits, including the last audit for fiscal year 2021, that was submitted on time (ICR, p. 34).

c. Unintended impacts (Positive or Negative)

The ICR (pp. 27-28) reported two unintended positive impacts:

1. In the context of the COVID-19 pandemic and increased use of digital solutions to maintain training continuity, project infrastructure was used to quickly roll out virtual COVID-19 training programs for students who were then deployed to support Vietnam's COVID-19 emergency response. With increasing demand to promote knowledge among PHC workers, development partners offered to support the utilization of e-learning modalities for workforce training and peer learning in the country, including a focus on disseminating knowledge on COVID-19. Also, improved skills and physical resources that resulted from equipping 600 CHS supplemented Vietnam's COVID-19 emergency response. Improved knowledge and clinical skills in emergency care, elderly care, and communicable disease control, as well as the availability of equipment such as respiratory care equipment, autoclaves, and refrigerators for vaccines, were an important complementary ingredient for the pandemic response.

2. The project helped the country's health workforce to position itself as a competitive workforce in the Association of Southeast Asian Nations (ASEAN) Economic Community. Also, two grant-recipient schools gained accreditation by A*SEAN University Network.* Historically, Vietnam has had little engagement in external health services trade. This pattern may change, as the project provided an example for other countries in the region on what it might take to transform health professionals' education (ICR, p. 28).

d. Other

--

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	

Bank Performance	Moderately Satisfactory	Moderately Satisfactory
Quality of M&E	Substantial	Substantial
Quality of ICR	---	High

12. Lessons

The ICR (p. 37) identified some lessons and recommendations, including the following lessons moderately re-stated by IEG Review:

In countries undergoing decentralization, strong collaboration in planning and implementation among central and subnational level stakeholders promotes the potential for improved health professionals' education and its sustainability. The project benefited from collaboration between the Central Project Management Unit, several ministries, training institutions, and Provincial Departments of Health. Various bodies were involved in the transfer of new medical techniques and the installation and operation of new equipment. Local project implementers were medical and pharmaceutical colleges staff who would contribute to the sustainability of project outcomes beyond the project life.

Medical education reforms are facilitated by extensive consultations and by leveraging international expertise. The project stimulated consultations and used existing support from other partners, including international expertise. The project linked with ongoing efforts to build training programs at medical universities and colleges. This contributed to shortening the time required for developing and implementing competency-based training programs.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a thorough and clear overview of the project. It was candid and aligned to development objectives. Some of the evidence was at the output-level, but this weakness was rooted in the project design rather than in the ICR, which aptly highlighted related gaps. The analysis referred to the project's theory of change and helped the reader understand how project activities were linked to observed results. The ICR was remarkable in its data presentation and in providing a clear storyline distilled from a complex situation. Lessons were derived from project experience. The ICR was internally consistent and followed established guidelines, except for two relatively minor lapses. It was lengthy and had an error in applying the split rating methodology: efficacy was assessed by time phases rather than by considering the achievement of each objective across the entire duration of the project, i.e., the assessment of achievement of a given objective should not end at restructuring. This error was inconsequential to the determination of overall outcome in this case. The overall quality standards of the ICR were high.

a. Quality of ICR Rating
High