MEMORANDUM AND RECOMMENDATION

OF THE

PRESIDENT OF THE

INTERNATIONAL DEVELOPMENT ASSOCIATION

TO THE

EXECUTIVE DIRECTORS

ON A

PROPOSED CREDIT

OF SDR 33.6 MILLION

TO

THE SOCIALIST REPUBLIC OF VIET NAM

FOR A

POPULATION AND FAMILY HEALTH PROJECT

DECEMBER 22, 1995
CURRENCY EQUIVALENTS

October 1995

Currency Unit = Vietnamese Dong (VND)
US$1.00 = 11,018 VND

WEIGHTS AND MEASURES

Metric System

ABBREVIATIONS

ADB
Asian Development Bank

ADF
Asian Development Fund

CHC
Commune Health Centre

CPR
Contraceptive Prevalence Rate

FP
Family Planning

GDP
Gross Domestic Product

GNP
Gross National Product

GTZ
Gesellschaft fur Technische Zusammenarbeit

ICPD
International Conference on Population and Development

IDA
International Development Association

IFC
International Finance Corporation

IUD
Intra-Uterine Device

IMR
Infant Mortality Rate

KfW
Kreditanstalt fur Wiederaufbau

NCPFP
National Committee for Population and Family Planning

ICR
Implementation Completion Report

PPAR
Project Performance Audit Report

PHC
Primary Health Care

PHN
Population, Health and Nutrition

PHRD
Policy and Human Resource Development Fund

SAR
Staff Appraisal Report

TAR
Total Abortion Rate

FISCAL YEAR

Government: January 1 - December 31
IDA: July 1 - June 30
SOCIALIST REPUBLIC OF VIET NAM

POPULATION AND FAMILY HEALTH PROJECT

Credit and Project Summary

Borrower: Socialist Republic of Viet Nam
Implementing Agency: National Committee for Population and Family Planning and Local Governments of Project Provinces
Beneficiary: Not Applicable.
Poverty: Program of Targeted Interventions
Amount: SDR 33.6 million (US$50.0 million equivalent)
Terms: Standard IDA, with 40 years maturity and 10 years grace
Commitment Fee: 0.5 % on undisbursed credit balances, beginning 60 days after signing, less any waiver
Onlending Terms: Not Applicable
Financing Plan: See Schedule A
Net Present Value: Not Applicable
Staff Appraisal Report: No. 14966 VN
Map Numbers: IBRD 27336 and 27337
Project ID Number: 4841
MEMORANDUM AND RECOMMENDATION OF THE PRESIDENT OF THE INTERNATIONAL DEVELOPMENT ASSOCIATION TO THE EXECUTIVE DIRECTORS ON A PROPOSED CREDIT TO THE SOCIALIST REPUBLIC OF VIET NAM FOR A POPULATION AND FAMILY HEALTH PROJECT

1. I submit for your approval the following memorandum and recommendation on a proposed development credit to the Socialist Republic of Viet Nam for SDR 33.6 million, on standard IDA terms, with 40 years maturity and 10 years grace, to help finance a Population and Family Health Project.

2. **Country/Sector Background.** After several decades of war, Viet Nam was unified under socialism in 1975. In 1989, Government launched a successful program of adjustment and reform, aimed at macroeconomic liberalization and stabilization. Real annual GDP growth has averaged 7%, and exports have grown more than 30% per annum to become a leading sector in the economy. Prospects for the coming decade are bright. However Viet Nam is still one of the world's poorest countries, at a per capita GNP of under US$200. One quarter of the population is too poor to afford an adequate daily food intake and over half of young children are stunted. A combination of broad-based economic growth with continued access for the poor to basic social services will be essential for long-term economic development and poverty reduction.

3. **Reduction of population growth will make a vital contribution.** Viet Nam's population is now 73 million, the second largest in Southeast Asia. Pressure on agricultural and forest land is acute and dependency ratios are still high, resulting in heavy education and child health care costs relative to productive capacity. Despite recent declines, the total fertility rate (TFR) is still above 3 births per woman, much above replacement level. Because of Viet Nam's very low mortality, annual population growth is still over 2%, sufficient to double the population within 33 years.

4. **Viet Nam's family planning program has had a successful initial stage, reaching a contraceptive prevalence rate (CPR) for modern methods of 44% in 1994.** The small family norm is well entrenched, with preferred family size among young women close to replacement level at 2.3. The total CPR stands at 65%, indicating that couples are translating their desire for small families into action. However Viet Nam's program is no longer fully responding to their needs, as evidenced by little recent change in modern-method prevalence, high rates of pregnancy termination, and a rise in use of less-effective traditional methods (now at a CPR of 21%) whose failures contribute significantly to the demand for pregnancy termination. The major problem is the program's failure to provide short-term and reversible modern methods as alternatives to the IUD and sterilization, both methods with only limited acceptability in Viet Nam.

5. **At the same time, progress in women's health has lagged far behind.** Maternal mortality is anomalously high, at over 200 per 100,000 live births. The prevalence of anaemia and reproductive tract infections (RTIs) is very high, possibly linked to the high rates of IUD use and pregnancy termination. The deterioration of Viet Nam's primary health care system,
through which most FP and reproductive health services are delivered in a highly cost-effective manner, is another concern. Though comprehensive and well utilized in the past, its resources have dwindled with decollectivization and pressure on public expenditures. Quality and utilization rates have fallen, and substantial investment is needed to restore effective functioning.

6. In response to these concerns, Government has formulated a broader approach as set out in its Cairo International Conference on Population and Development statement. The principles include: voluntary participation in family planning; recognition of the right to reproductive health care; integration of family planning with maternal and child health care; and recognition of the need to reduce the incidence of pregnancy termination through improved FP services. The project is designed within this policy framework.

7. **Project Goals and Objectives.** The objectives of the Project are to assist Government in improving the health of the population of Viet Nam and achieving further reductions in fertility and population growth through: (a) an improved and increased utilization of family planning and related family health services; (b) enhancing NCPFP’s management, planning and policy formulation capabilities; and (c) expanding the knowledge base upon which NCPFP and MOH policy and technical guidelines are to be formulated.

8. Within the framework of these broad goals, ten key indicators will measure project impact and achievement, related to specific objectives for the year 2002 as follows: (1) a decline in the TFR to around 2.2; (2) an increase in the CPR for modern methods to 56%; (3) a decline of 30% in the total abortion rate (TAR); (4) a decline in the infant mortality rate to 25; (5) an increase in the share of short-term methods in the contraceptive method mix to 25%; (6) improved access to an adequate range of family planning services; (7) improved utilization of commune health centre facilities for pre-natal care in the 15 project provinces; (8) improvement in the met need for life-saving obstetric care in the 15 project provinces; (9) an increase in the percent of infants fully immunized in the 15 project provinces; (10) an improvement in the management information score. Specific values for objectives (6)-(10) will be set after a baseline survey.

9. **Project Description.** The major project components will be: (1) upgrading of primary health care service delivery (US$74.9 million or 57.8% of total project cost) at the commune, district and provincial level, to provide selected facility renovation, equipment, essential drug supplies, refresher training and support to outreach in 15 provinces in order to strengthen services for (i) family planning, (ii) maternal care including pre- and post-natal care, safe delivery, and tetanus toxoid immunization and micronutrient supplementation in pregnancy, (iii) reproductive tract infections and (iv) other primary health care including child health and minor curative care; (2) strengthening of information, education and communication (US$16.8 million or 13.0%) to improve awareness and demand for FP and family health services; (3) provision of contraceptive supplies (US$25.3 million or 19.5%) to support increased contraceptive use and a widened method mix; (4) development of the management, planning and policy formulation capabilities of NCPFP and its subsidiary committee network (US$6.7 million or 5.2%) by providing management training for FP program staff and strengthening management information systems; (5) strengthening of the capacity and quality of FP and family health service delivery (US$6.0 million or 4.6%) through studies and piloting.
cf new approaches in private sector development, services for ethnic minorities, community-based outreach, and quality issues in treatment of reproductive tract infections and other reproductive health care.

10. **Project Cost and Financing.** Total project cost is estimated at US$129.6 million equivalent including taxes, or US$125.3 million excluding taxes with a foreign exchange component of US$68.6 million (53% of project cost). The proposed credit of SDR33.6 million (US$50.0 million equivalent) will finance about 38.6% of the total project costs net of taxes. The remainder will be financed by an ADF concessionary loan from the Asian Development Bank of US$41.0 million, a grant from KfW of DM30 million (approximately US$20 million) and a Government contribution of US$18.6 million. A breakdown of costs and the financing plan are shown in Schedule A. Amounts and methods of procurement and disbursement and the disbursement schedule are shown in Schedule B. A timetable of the project's key processing steps and the status of Bank Group operations in Viet Nam are shown in Schedules C and D respectively. The Staff Appraisal Report (SAR No. 14966 VN dated December 22, 1995) is being distributed separately.

11. **Project Implementation.** The project will be implemented over a seven year period by the NCPFP and the local governments of the project provinces, in close coordination with the Ministry of Health and provincial health bureaus. Day-to-day project management will be the responsibility of a Project Management Unit within NCPFP reporting to the Chairman, NCPFP, and corresponding Provincial Project Management Units in the 15 project provinces. Overall guidance for the project will be provided by a ministerial-level Project Steering Committee including the Ministry of Health, Ministry of Planning and Investment, State Bank of Viet Nam and Ministry of Finance. Technical implementation of national family planning components will be the responsibility of corresponding departments in NCPFP under an Executive Committee.

12. **Project Sustainability.** For the strengthening of provincial PHC services, no issues of sustainability arise. The incremental cost burden generated by the project's upgrading package, comprising maintenance and essential drug costs for 15 provinces, would amount to well under 1% of the projected national health budget at project completion in 2002. Even the simultaneous upgrading of a further 15 provinces under the National Health Support Project, and any possible extension under Government funding to the rest of the country, could be sustained through earmarking of no more than 3% of the health budget. Under the National Health Support Project, issues of health financing and sustainability will be examined further and revisited at mid-term review. For the strengthening of the national FP program, the major issue is the increased volume and cost of contraceptive supplies generated by the project's investment in increasing contraceptive prevalence and the use of short-term commodity-based methods. The net increase in recurrent costs generated by the project is projected at around US$5 million per annum, and the total cost burden for contraceptive commodities would reach about US$7.5 million, or 13% of the projected national FP budget. This allocation for contraceptives is not excessive by world standards, and should be affordable even if Government were obliged to finance the entire amount. In practice, however, an increasing share of costs is likely to be borne through private sector services and charges for contraceptives in the public program. Substantial donor contributions are also expected to continue. The expanded FP program should therefore be financially sustainable. Institutional
sustainability of both upgraded provincial health services and the family planning program should not be an issue. No staff are being added, organizational structures and tasks are not changing, and there is ample spare capacity in the current systems to handle the increased workload generated by the project.

13. **Lessons from Previous Bank Experience.** IDA has experience with only one social sector project in Viet Nam, the Primary Education Project (Credit 2548-VN). A key lesson from early implementation has been the need to invest heavily in advance training of implementation agency staff in IDA procedures, and to provide follow-up assistance during the initial project period. Early preparation of first-year implementation plans would also be essential. In these respects, a PHRD grant to prepare the project has been of great value. Though executed by IDA, all local expenditures were handled through the Resident Mission in close partnership with the NCPFP Project Unit, which gained valuable experience in IDA procedures.

14. **Rationale For Bank Involvement.** IDA’s goal in Viet Nam, as outlined in the Country Assistance Strategy (discussed by the Board on November 21, 1995), is to promote broad-based economic development and to combat poverty. A key element of this strategy is to assist in developing sustainable social sector delivery systems as the basis for human capital accumulation and national social protection. The project contributes to the poverty alleviation strategy through: (a) development of effective and sustainable family health and FP systems; (b) targeting to particularly vulnerable groups; and (c) assistance to reducing rapid population growth.

15. The project will use IDA’s comparative advantage in addressing population issues in the context of a broad sectoral dialogue with Government based on the Cairo conference consensus. It will build on and complement work done for the PHN Sector Review, the Poverty Assessment and Strategy Report and the National Health Support Project, by sharpening sectoral priorities and broadening the scope of assistance to the PHN sector. In addition, it complements the Primary Education Project by reinforcing investment in female education through investment in women’s health. By reducing population growth, it will also contribute to sustainable use of natural resources.

16. A number of donors, notably UNFPA, UNICEF and GTZ, have been active in the population and family health sectors in Viet Nam for some time, and have made very valuable contributions. However IDA is uniquely able to provide a comprehensive national package of technical and financial resources for the core investments needed to strengthen and redirect the population sector in Viet Nam.

17. **Agreed Actions.** During negotiations, the following principal agreements were reached with Government: (a) selected key indicators will be used to monitor and evaluate implementation progress and project impact (see para.8); (b) baseline and final surveys and a Mid-term Review will be carried out, with contents linked to key indicators and project objectives; (c) an annual review of the project workplan and budget for the next fiscal year will be carried out with IDA; (d) all facilities upgraded under the project will be adequately maintained during the life of the project; (e) a study of the acceptability and impact of charges for contraceptives supplied through the public program will be carried out and its
results used to implement an appropriate phased program of charges; (f) proposals for all activities under the service delivery model initiatives component will be submitted to IDA for prior review and approval; (g) Government policy and implementation guidelines for cost recovery for essential drugs and medical supplies provided under the project, including an exemption for remote and mountainous communes, will be reviewed with IDA early in the project and implemented thereafter. As a condition of credit effectiveness, the Project Steering Committee, the Executive Committee, the Project Management Unit, and the Provincial Project Management Units would be established and key staff appointed.

18. Poverty Category. Viet Nam's GNP per capita of less than US$200 per capita ranks it as one of the poorest countries of the world. The project aims to improve family health and FP services at the grassroots through public sector programs. Hence it contributes to poverty alleviation and is self-targeted towards the rural poor. It also aims to improve access to services for disadvantaged and isolated ethnic minorities, who are among the poorest and most underserved groups in Viet Nam. The project is therefore poverty-focused and falls under the category "Program of Targeted Interventions".

19. Environmental Aspects. The project has been ranked "C" for environmental assessment purposes. In the long-term, an effective PHC system which includes adequate provision of FP and family health services will lower fertility and reduce environmental pressures associated with rapid population growth.

20. Program Objective Categories. The project will invest in improvements in FP and basic health services in provinces selected for unfavorable health and fertility indicators, with a particular focus on improved health services for women and children. These are not only least-cost and highly cost-effective public health interventions but will also support poverty alleviation and enhance the participation of women in development.

21. Participatory Approach. Through the PHRD grant, NCPFFP worked closely with provincial, district and commune Population and Family Planning committees, as well as local health bureaus and staff, in the design, planning and detailed preparation of the project. Provincial project management units will be set up in the 15 project provinces. In addition, participatory studies were carried out among ethnic minority communities, and their findings used to design a strategy for improving family health and FP services for disadvantaged minorities.

22. Project Benefits. By strengthening the FP program and integrating it into family health, the project will generate a range of benefits. Nationally, smaller family sizes, and reduced population growth would be achieved through improved knowledge of FP methods, a wider choice of methods and better quality FP services. Individually, women, children and families, including an average 7 million contracepting couples annually, would benefit from improved maternal, child and reproductive health and family welfare. Additional benefits to the economy and society of Viet Nam (82 million people by 2002) will include the reduction of pressure on natural resources and the environment, and of the need for social services.

23. At the provincial level, upgraded PHC services should produce a number of least-cost and cost-effective health benefits to the entire community (currently 21 million
people). Core beneficiaries (women needing maternal care, children under three years of age and contraceptors) would amount to 5.4 million annually. In addition, if the package of inputs provided by the project, and by the National Health Support Project, is successful in revitalizing the PHC system, it should provide a powerful stimulus and model for similar upgrading in the remaining third of the country.

24. Without the project (and the National Health Support Project), Government probably could not mobilize sufficient domestic or external funding for major upgrading of either the family planning program or provincial health services. Lacking such investment, the family planning program is likely to stagnate at current usage levels and method mix, driving couples to still greater use of ineffective traditional methods. Fertility decline could be slowed and abortion rates would remain undesirably high. The primary health care system would probably deteriorate still further, reducing coverage and quality of core public health interventions and risking increases in disease and death rates such as have been observed elsewhere in similar circumstances. In neither case is the private sector likely to substitute adequately for public services within the foreseeable future.

25. **Risks.** The technical packages of FP and PHC interventions to be delivered under the project present little risk. They are well-tested world-wide, and Viet Nam's ability to implement them efficiently and with commitment is not in doubt. However the project carries three major risks. First, as regards **provincial PHC services,** utilization rates have dropped because of deteriorating service quality. It has been assumed that they would recover as the result of the project's investments. There is a risk that it may be too late to retrieve public confidence even if services are dramatically upgraded. However experience elsewhere has shown that public systems continue to be attractive, particularly to the very poor, if access and quality of services can be assured. This risk will be minimized by providing a comprehensive package of inputs that should achieve good access and quality.

26. Second, as regards the **national FP program,** there is a risk that despite high-level commitment and the project's fresh inputs, the expected broadening of the method mix, and shift to a client-oriented approach, may not be achieved as rapidly as projected. It may prove difficult to change attitudes and practices among program managers and providers, to correct client misperceptions, and to shift client preferences towards less familiar methods. These risks will be minimized by: intensive information, education and communication activities; extensive training in counseling for providers and motivators; management strengthening to promote fresh thinking; and the use of findings from studies and pilot interventions to support new strategic approaches.

27. Third, there is a general risk that project implementation may be slow and unsatisfactory because of Viet Nam's inexperience with IDA and ADB project procedures, coupled with limited NCPFPP management capabilities. This risk will be minimized by management upgrading under the project. Extensive training in IDA and ADB procedures is also planned prior to implementation. The positive experience of NCPFPP's use of PHRD funds, combined with Viet Nam's past successful management of PHC and FP programs, suggests that this risk is not unduly high.
28. **Recommendation.** I am satisfied that the proposed credit would comply with the Articles of Agreement of the Association and recommend that the Executive Directors approve it.

James D. Wolfensohn  
President

Washington, D.C.  
December 22, 1995

Attachments
### Estimated Cost and Financing Plan

(US$ million)

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### Financing Plan:

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SOCIALIST REPUBLIC OF VIET NAM

POPULATION AND FAMILY HEALTH PROJECT

Summary of Proposed Procurement Arrangements
(US$ Million equivalent)

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1 Other includes shopping and consultancy services.
2 Not applicable as these amounts are not financed by IDA.
3 Figures in parentheses are IDA amounts only, and exclude the ADB amounts.
SOCIALIST REPUBLIC OF VIET NAM

POPULATION AND FAMILY HEALTH PROJECT

Disbursement Categories

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>IDA Amount in SDRs million</th>
<th>Percentage of Expenditures to be Financed by IDA Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Civil Works</td>
<td>4.03</td>
<td>90%</td>
</tr>
<tr>
<td>2. Equipment, Furniture, Vehicles, Drugs, Medical Supplies and Contraceptives</td>
<td>15.30</td>
<td>100% of foreign expenditures, 100% of local expenditure (ex-factory cost), and 85% of local expenditures for other items procured locally.</td>
</tr>
<tr>
<td>3. Training, Technical Assistance and Studies &amp; Pilots</td>
<td>8.54</td>
<td>100%</td>
</tr>
<tr>
<td>4. Outreach Workers Allowance</td>
<td>3.90</td>
<td>70%</td>
</tr>
<tr>
<td>5. Operating Costs</td>
<td>0.41</td>
<td>70%</td>
</tr>
<tr>
<td>6. Unallocated</td>
<td>1.42</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33.60</strong></td>
<td></td>
</tr>
</tbody>
</table>

Estimated Disbursement Schedule

(US$ million)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>4.3</td>
<td>12.0</td>
<td>8.0</td>
<td>6.8</td>
<td>6.0</td>
<td>8.2</td>
<td>4.3</td>
</tr>
<tr>
<td>Cumulative</td>
<td>4.3</td>
<td>16.3</td>
<td>24.3</td>
<td>31.1</td>
<td>37.2</td>
<td>45.4</td>
<td>50.0</td>
</tr>
</tbody>
</table>
SOCIALIST REPUBLIC OF VIET NAM

POPULATION AND FAMILY HEALTH PROJECT

Timetable of Key Project Processing Events

<table>
<thead>
<tr>
<th>Event</th>
<th>Date/Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Time taken to prepare the project</td>
<td>18 months (January, 1994 - June 1995)</td>
</tr>
<tr>
<td>(b) Prepared by</td>
<td>Government with assistance from IDA (including consultant services financed by a PHRD Grant)</td>
</tr>
<tr>
<td>(c) First IDA mission</td>
<td>March, 1993</td>
</tr>
<tr>
<td>(d) Appraisal Departure</td>
<td>June, 1995</td>
</tr>
<tr>
<td>(e) Negotiations</td>
<td>December, 1995</td>
</tr>
<tr>
<td>(f) Planned date of effectiveness</td>
<td>March, 1996</td>
</tr>
<tr>
<td>(g) Relevant ICRs and PPARs</td>
<td>None</td>
</tr>
</tbody>
</table>

This report is based on the findings of an appraisal mission that visited Viet Nam in June-July, 1995. The mission comprised Althea Hill (Task Manager and Mission Leader, EA1HR), Rama Lakshminarayanan (Public Health Specialist, EA1HR), Claudia von Monbart (Economist, Paris Office), Ji An Zhou (Cost Analyst, EA1HR), Mohinder Virdy (Procurement Specialist, ASTTP), S. Subramanian (Disbursement Specialist, New Delhi Office), Laura Shrestha (Monitoring and Evaluation Specialist, HDD), Ved Kumar (Pharmaceuticals and Logistics Consultant) and Dr. Alex Zinanga (Family Planning Consultant). Contributions to the report were also made by Nguyen Van Minh (Operations Officer, RMV), Maria MacDonald (Population Specialist, ASTHR) and consultants funded under Japanese Grants to the World Bank and Asian Development Bank for project preparation, including Pradeep Kakkar (IEC and Management Specialist), Mario Taguiwalo (Management Specialist), Rami Chhabra (IEC Specialist), Jennifer Huddart (Training Specialist), Susan Mitchell (Private Sector Specialist), Bruce Geisert (MIS Specialist) and Cyril Bowman (Architect). Peer reviewers for the project were Tom Merrick (Senior Population Adviser, HDD), James Socknat (Chief, ASTHR) and Willy de Geyndt (Public Health Specialist, ASTHR). The report was produced by Emily Mwai EA1HR), assisted by Joyce Bruce (EA1HR). Desiree Jessimy (EA1HR) coordinated report production. The report was cleared by Sven Burmester (Chief, EA1HR) and Callisto Madavo (Director, EA1).
### Schedule D

**STATUS OF BANK GROUP OPERATIONS IN VIET NAM**

**A. STATEMENT OF BANK LOANS AND IDA CREDITS (a)**

(As of September 30, 1995)

<table>
<thead>
<tr>
<th>Loan or Credit Number</th>
<th>Fiscal Year</th>
<th>Borrower</th>
<th>Purpose</th>
<th>IDA/b</th>
<th>Undisbursed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2548</td>
<td>1994</td>
<td>Viet Nam</td>
<td>Primary Education</td>
<td>70.00</td>
<td>68.94</td>
</tr>
<tr>
<td>2549</td>
<td>1994</td>
<td>Viet Nam</td>
<td>Highway Rehabilitation</td>
<td>156.50</td>
<td>160.72</td>
</tr>
<tr>
<td>2561</td>
<td>1994</td>
<td>Viet Nam</td>
<td>Agriculture Rehabilitation</td>
<td>96.00</td>
<td>36.92</td>
</tr>
<tr>
<td>*2657</td>
<td>1995</td>
<td>Viet Nam</td>
<td>SAC 1</td>
<td>150.00</td>
<td>61.85</td>
</tr>
<tr>
<td>2711</td>
<td>1995</td>
<td>Viet Nam</td>
<td>Irrigation Rehabilitation</td>
<td>100.00</td>
<td>100.09</td>
</tr>
<tr>
<td>2724</td>
<td>1995</td>
<td>Viet Nam</td>
<td>Power Sector Rehabilitation</td>
<td>165.00</td>
<td>165.22</td>
</tr>
</tbody>
</table>

**Total**

799.20 593.73

of which has been repaid 4.18

Total Now Held By Bank and IDA 795.02

Amount sold 0.00

Total Undisbursed 593.73

* Indicates SAL/SECAL loans and credits.

(a) The status of the projects listed in Part A is described in a separate report on all IBRD/IDA-financed projects in execution, which is updated twice yearly and circulated to the Executive Directors on April 30 and October 31.

(b) Principal amounts in US$ equivalent at date of negotiations, and undisbursed amounts in equivalent are valued at exchange rate applicable on the date of this statement.

**B. STATEMENT OF IFC INVESTMENTS**

(As of September 30, 1995)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Obligor Type of Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>Hanoi Sofitel Metropole</td>
</tr>
<tr>
<td></td>
<td>Tourism</td>
</tr>
<tr>
<td></td>
<td>8.5  -  17.5  26.0  8.5  5.3</td>
</tr>
<tr>
<td>1995</td>
<td>Baria Port</td>
</tr>
<tr>
<td></td>
<td>Industrial Services</td>
</tr>
<tr>
<td></td>
<td>3.0  -  2.0  5.0  3.0  5.0</td>
</tr>
<tr>
<td></td>
<td>Total Gross Commitments b/</td>
</tr>
<tr>
<td></td>
<td>11.5  -  19.5  31.0 - -</td>
</tr>
<tr>
<td></td>
<td>Less Cancellations, Terminations, Repayments &amp; Sales</td>
</tr>
<tr>
<td></td>
<td>-  -  -  - -</td>
</tr>
<tr>
<td></td>
<td>Total Commitments Now Held b/</td>
</tr>
<tr>
<td></td>
<td>11.5  -  19.5  31.0 11.5 10.3</td>
</tr>
</tbody>
</table>

**Pending Commitments**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Obligor Type of Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>Foremost Dairy</td>
</tr>
<tr>
<td></td>
<td>Dairy Products</td>
</tr>
<tr>
<td></td>
<td>8.0  -  7.0  15.0</td>
</tr>
<tr>
<td>1996</td>
<td>Vimaflour</td>
</tr>
<tr>
<td></td>
<td>Agribusiness</td>
</tr>
<tr>
<td></td>
<td>8.0  -  3.0  11.0</td>
</tr>
<tr>
<td>1996</td>
<td>Morning Star Cement</td>
</tr>
<tr>
<td></td>
<td>Cement</td>
</tr>
<tr>
<td></td>
<td>30.0  -  66.6  96.6</td>
</tr>
<tr>
<td></td>
<td>Total Pending Commitments</td>
</tr>
<tr>
<td></td>
<td>46.0  -  76.6  122.6</td>
</tr>
<tr>
<td></td>
<td>Total commitments held &amp; pending Commitments</td>
</tr>
<tr>
<td></td>
<td>57.5  -  96.1  153.6</td>
</tr>
<tr>
<td></td>
<td>Total Undisbursed Commitments</td>
</tr>
<tr>
<td></td>
<td>3.1  -  7.2  10.3</td>
</tr>
</tbody>
</table>

a/ Gross commitments consist of approved and signed projects.

b/ Held commitments consist of disbursed and undisbursed investments.
VIET NAM
POPULATION AND
FAMILY HEALTH PROJECT

Provinces with PHC Systems to be Upgraded:
Phase I, PFH Project Provinces
Phase II, PFH Project Provinces
National Health Support Project Provinces

Provinces:
1. Ha Giang
2. Tuyen Quang
3. Cao Bang
4. Lang Son
5. Lai Chau
6. Lao Cai
7. Yen Bai
8. Bac Thai
9. Son La
10. Hoa Binh
11. Quang Ninh
12. Vinh Phuc
13. Ha Bac
14. Ha Giang
15. Hai Phong
16. Ha Tay
17. Hai Hung
18. Thai Binh
19. Nam Dinh
20. Ninh Binh
21. Thanh Hoa
22. Nghe An
23. Ha Tinh
24. Quang Binh
25. Quang Tri
26. Thua Thien Hue
27. Quang Nam-Do Nang
28. Quang Ngai
29. Binh Duong
30. Phu Yen
31. Khanh Hoa
32. Ninh Thuan
33. Binh Thuan
34. Gia Lai
35. Kon Tum
36. Dak Lak
37. Lam Dong
38. Ho Chi Minh City
39. Song Ba
40. Tay Ninh
41. Dong Nai
42. Ba Ria-Vung Tau-Con Dao
43. Long An
44. Dong Thap
45. An Giang
46. Tien Giang
47. Ben Tre
48. Vinh Long
49. Tra Vinh
50. Can Tho
51. Soc Trang
52. Kien Giang
53. Ninh Thuan

Selected Cities
- National Capital
- Province Capitals
- Province Boundaries
- International Boundaries

The boundaries, colors, designations, and other information shown on this map do not imply, on the part of the World Bank Group, any judgment or acceptance of such boundaries.
VIET NAM
PROVINCES CLASSIFIED BY
UNICEF POVERTY CLASSIFICATION

Poverty Classification:
- Poor
- Average
- Above Average

Provinces:
1. Ha Giang
2. Tuyen Quang
3. Can Tho
4. Long Son
5. Lai Chau
6. Lao Cai
7. Yan Bai
8. Bac Thai
9. Son La
10. Hoa Binh
11. Quang Ninh
12. Vinh Phu
13. Ha Bac
14. Hanoi
15. Ha Phong
16. Ha Tuyen
17. Hai Phong
18. Thai Binh
19. Nam Ha
20. Ninh Binh
21. Thanh Hoa
22. Nghe An
23. Ha Tinh
24. Quang Binh
25. Quang Tri
26. Thua Thien Hue
27. Quang Nam Da Nang
28. Quang Ngai
29. Binh Dinh
30. Phu Yen
31. Khanh Hoa
32. Ninh Thuan
33. Binh Thuan
34. Gia Lai
35. Kon Tum
36. Dak Lak
37. Lam Dong
38. Hu Chi Minh City
39. Song Be
40. Tay Ninh
41. Dong Nai
42. Ba Ria-Vung Tau-Can Gio
43. Long An
44. Dong Thap
45. An Giang
46. Kien Giang
47. Tien Giang
48. Ben Tre
49. Vinh Long
50. Tra Vinh
51. Can Tho
52. Soc Trang
53. Kien Giang
54. An Phu
IMAGING

Report No: P- 6701 VN
Type: MOP