MINISTRY OF HEALTH
No. *2169/QD-BYT*

Social Republic of Vietnam
Independence – Freedom – Happiness

Hanoi, June 27, 2011

DECISION
Re: Issuing Operational Plan for Contraceptive Total Market In the National Population and Family Planning Program

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THE MINISTER OF HEALTH

Based on the Government's Decree numbered 188/2007/ND-CP dated December 27, 2007 regulating functions, tasks, responsibilities and organizational structure of the Ministry of Health;

Based on the Prime Minister's Decision numbered 18/2008/QD-TTg dated January 29, 2008 regulating functions, tasks, responsibilities and organizational structure of the General Office for Population and Family Planning;

Based on the Decision numbered 2331/QD-TTg dated December 20, 2010 issuing the list of national targeted program in 2011;

To implement the National Strategy for Population and Reproductive Health in the period of 2011 – 2020;

With a proposal of General Director of the General Office for Population and Family Planning,

DECIDE:

Clause 1. Issue this Decision together with "Operational Plan for Contraceptive Total Market in the National Targeted Population and Family Planning Program".

Clause 2. The Decision has taken effective since the date of signed and promulgated.

Clause 3. General Director of the General Office for Population and Family Planning, Director of the Department of Planning and Finance, leaders of departments under the Ministry of Health and other relevant units are responsible for executing this Decision.

SIGNED FOR MINISTER
DEPUTY MINISTER

Nguyen Ba Thuy

Recipients
- As Clause 3
- Minister (for reporting)
- Save: Director, GOPFP (5 copies)

MINISTRY OF HEALTH

Social Republic of Vietnam
Independence – Freedom – Happiness

OPERATIONAL PLAN FOR CONTRACEPTIVE TOTAL MARKET
The National Population and Family Planning Program

Issued together with Decision No. 2169 /QD-BYT of the Ministry of Health on June 27, 2011

I. Rationale for a total market operational plan

As of April 1st 2010, the contraceptive prevalence rate is 78.0% and this of modern contraceptive methods is 67.5%. This reflects that a majority of the married couples have accepted contraceptive methods to prevent unexpected pregnancy and this rate helps maintain total fertility rate at 2.0% (data as of April 1st 2010). However, the supply and use of contraceptives still have the remaining gaps as follows:

- Most of the contraceptives are provided free of charge from the state budget (except condoms and a portion of combined oral contraceptives), so it doesn't ensure sustainability of the population and family planning program.
- Income levels and gaps of wealth among different social strata have been increasing. At the same time, there is an increasing demand in qualified and diversified contraceptive methods. Therefore, free provision of contraceptives to most of the clients becomes an inequity in using state budget.
- As Vietnam transitions to middle-income status, donors have ceased provision of clinical contraceptive supplies, causing a large projected shortfall in the family planning budget.
- The need in new contraceptive devices of current users to replace the devices no longer effective or of the newly emerging client groups continues to increase in the period 2011 – 2015. Multiplicity in clients' needs is also increasing according to income levels. At the same time, the number of women of reproductive age is expected to peak at approximately 27 million in 2015 and remain at that level until 2025. This is the largest-ever generation of reproductive aged women, especially young people (20 – 29 aged) in the demographic history of Vietnam, resulting in the highest-ever demand in diversified and high quality contraceptives.

To solve these gaps, it is necessary to develop a contraceptive total market operational plan so as to meet the needs in diversified and high quality contraceptives of various client groups by ensuring clients' access to contraceptives through free supplies, social marketing, and commercial markets, which is appropriate with their desires, ability to pay and status. A contraceptive total market approach has been defined as "a coordinated approach" that responds to the multiplicity of high quality family planning needs of different client groups and ensures a "rational balance between roles" that each market sector plays and targets to different client groups in the market.

II. Foundations for development of the operational total market plan

1. Legal foundation

Politics Ministry's Resolution numbered 47-NQ/TW dated March 22, 2005 on continuously strengthening the implementation of population and family planning policy indicated tasks and key solutions for the population and family planning program, including *"improving the reproductive health and family planning service system to fully address needs of contraceptive users, strengthening investment and upgrade of facilities and equipments, enhancing health staff capacity to provide reproductive health and family planning care services, and encouraging social organizations and private service units to contribute to provision of these services, as well as enhancing social marketing and sales of contraceptives in the free market." (Bullet 5, Item C, Section II)*

The Prime Minister's Instruction numbered 23/2008/CT-TTg dated August 4, 2008 about continuously strengthening the population and family planning program requested the ministries, sectors and provincial people's committees to *"increase investment from the domestic budget to ensure contraceptive security" (Bullet 6, Item b, Section 1)* and require the Ministry of Planning and Investment to "include request on fundraising and receiving funding for the family planning program into the priority list of ODA funds." *(Section 5)*

The Prime Minister's Decision numbered 2331/QD-TTg dated December 20, 2010 on issuing the list of national targeted programs in 2011 included a project "Family Planning Logistics and Service Security". This project followed closely objectives, tasks and solutions of the National Target Program for Population and Family Planning in the period 2006 – 2010, approved by the Prime Minister's Decision numbered 170/QD-TTg dated November 08, 2007, and the project "Contraceptive Logistics Assurance and Social Marketing Promotion" under the National Target Program for Population/FP in the period 2006–2010, approved by the MOH's Decision numbered 2287/QD-BYT dated June 25, 2008.

At the same time, the National Strategy for Population and Reproductive Health and implementation guidance documents identified continued implementation of the objectives and tasks in contraceptive commodity and service provision to meet the needs of various client groups in quantity, method mix and high quality of family planning methods. *"The State to take the lead role in coordinating supplies in response to needs for contraceptives of the family planning service providing network;…prioritize free or subsidized supplies of contraceptives for poor, socially and economically disadvantaged and especially disadvantaged areas and, at the same time, enhance social marketing and sales of contraceptives in the free market."*

Based on the fact of contraceptive supply until 2010 as well as its management and organization not achieving the targets yet, implementing total contraceptive market approach is to strengthen socialization of population and family planning, to optimize financial resources from different economic sectors, and to meet the increasing needs in quantity, diversification and high quality of contraceptives for different groups of clients.

2. Situation of the contraceptive use and supply

a. Use of contraceptive methods

Contraceptive prevalence rate has been increasing rapidly from 53.2% in 1988 to 72.7% in 2000 and 78.0% in 2010, and this of modern contraceptive methods has been also increased

from 37.7% in 1988 to 67.5% in 2010. In the mean time, this of traditional methods tends to reduce from 15.5% in 1988 to 10.5% in 2010.[1]

At the contraceptive prevalence rate would be a basis for maintaining a replacement total fertility rate (TFR), which was 2.11 on April 1st 2005 and 2.0 on April 1st 2010. Reasons for having not used contraceptive methods among married 15-49 aged women were being pregnant (accounting for 2.8%) and desire to be pregnant (counting for 9.4%). Therefore, the other reasons such as limited knowledge about contraception, opposition from relatives, bad health condition accounted for only 9.8%. Almost married 15-49 aged women have accepted and had a good understanding about contraceptive methods. This reflected effectiveness of the Population and Family Planning Program.

b. Supply of contraceptives

Free provision of contraceptives, mostly IUDs and condoms, was initiated in 1963 for all people in needs. So far, this free provision has been maintained for a large proportion of users with almost contraceptive methods. In 1993, social marketing of condoms was piloted. This approach was replicated for oral contraceptive pills in 1998 and for clinical methods in 2006. The social marketing contributed to a significant increase in number of users paying for their contraceptive methods. Among 67.5% of married 15-49 aged women who are currently using modern contraceptive methods in 2010, the percentage of women receiving free the products is 54.0%; the percentage of women using social marketing products is 40.0%; and the percentage of women using commercial products is 6.0%.

By the year 2010, different approaches in contraceptive supply such as free supply, social marketing and sales in commercial markets are all implemented simultaneously in all provinces and cities nation-wide. However, the shares of each approach in different provinces and cities are varied. The rate of sales in free markets and free supply are higher in urban in compared with rural areas. Overall, free provision has been still accounted for the major share at 54%. This of social marketing (mainly of condoms and pills accounting for 64.5% and 56.1% respectively) has not reached 40% and of the commercial sales is still low at 6%.

	Shares in the market in 2010 (%)		
	Free	Social marketing	Commercial market
Total	54.0	40.0	6.0
- Condom	25.5	64.5	10.0
- Pills	36.1	56.1	7.8
- Injectable	92.5	7.0	0.5
- Implant	99.9	-	0.1
- IUD	97.5	2.4	0.1
- Sterilization	100	-	-

[1] Data sources: DHS 1988 and Population Change Surveys on Apr 1st 2000 and on Apr 1st 2010

3. Situation of management and organization of contraceptive supply

Management and organization of contraceptive supply are practiced through three channels, i.e. free supply, social marketing and commercial market. Each channel is managed and organized differently.

a. Free supply

The GOPFP is responsible for making plan of quantity and types of contraceptives in needs and estimating state budget for procurement, transportation, storage and distribution of contraceptives to the provincial level (This include the contraceptives donated by ODA funds from the international organizations and other countries governments).

The Offices for Population and Family Planning at provincial and district levels are responsible for projecting quantity and types of contraceptives in needs and making plan of distribution of these contraceptives to the reproductive health/family planning facilities through the respective management lines in accordance with the technical regulations. At the same time, these Offices estimate state budget (from the central sources for target based supports to local areas, and from the local sources) needed for transportation, storage and distribution of contraceptives to the RH/FP service delivery points.

The public-sector reproductive health/family planning service delivery points include commune health centers, regional hospitals, obstetric units of district preventive medicine centers, district population and family planning centers, provincial hospitals, and provincial reproductive health care centers provide free clinical contraceptives and oral contraceptive pills. Population and family planning staff at commune level and population and family planning collaborators provide free condoms and oral contraceptive pill to the users who register to use.

b. Social marketing

By the year of 2010, there have been four institutions involved in social marketing, including DKT, VINAFPA, MSI and CSI. Main methods for social marketing are non-clinical methods such as condom and OCs. Social marketing of the clinical methods such as IUD, injectables, implants and emergency pills is being piloted by DKT and MSI. Management and organization of social marketing is practiced in two ways based on two funding sources:

- For DKT: This is financial donor cum implementer of social marketing. So it purchases contraceptives or receives donated contraceptives; then manage to implement social marketing. Therefore, DKT's management of social marketing follows internal mechanism for distribution, advertisement, behavior change communication, product promotion and commercial incentive to implement social marketing and sell the products at retail price approved by the Ministry of Health (MOH). For the donated contraceptives, DKT signs a contract with a division of GOPFP and implement social marketing based on the terms of the contract.
- For VINAFPA, CSI, MSI: They implement contraceptive social marketing with the state budget. They are social marketing implementers under the contract with a unit of the GOPFP. The activities and cost norms follow the MOH's regulations. Evaluation is conducted quarterly and annually. Budget is reimbursed based on the sold contraceptive quantity.

c. Commercial market

As the current regulations, the brands circulated in Vietnam must have license from the MOH. The companies in different economic sectors with business license are allowed to import contraceptives initiatively. However, there are certain contraceptive brands which are not included in the list of the allowed commodities, and contraceptives of a manufacturer with the same brand name for free product and social marketing have been still sold at the same time in the market.

III. Goal and objectives

1. Goal

The ultimate goal of the operational plan is to support the Strategy on Population–Reproductive Health for 2010–2020 by promoting equitable access to contraceptives, coordinating a total contraceptive market to meet the diversified needs in high quality family planning of different client groups, and mobilizing financial and experience resources for family planning from the public service sector, NGOs, private sectors to sustain the national population and family planning program.

2. Objectives

a. **Objective 1:** Strengthen behavior change communication, improve quality of contraceptive commodities and services, ensure contraceptive security and enhance management forces to address increasing needs of contraceptive methods and to reach the objective on reducing TFE from 2.0 in 2010 to 1.9 in 2015
   - Contraceptive prevalence rate increases from 78.0% in 2010 to 82% in 2015
   - Modern contraceptive prevalence increases from 67.5% to 73% in 2015

b. **Objective 2:** Promote equitable access to free, social marketing and commercial market contraceptives to be concordant with the desire, ability to pay and status of each client group so as to meet their increasing needs in quantity, diversity and high quality of FP methods. Following is the targets s up to 2015.
   - Decrease the market share of free condom to 12.3% and increase the market share of social marketing and commercial condom to 97.7%
   - Decrease the market share of free OCs to 30.9% and increase the market share of social marketing and commercial OCs to 69.1%
   - Decrease the market share of free injectables to 75.9% and increase the market share of social marketing and commercial injectables to 24.1%
   - Decrease the market share of free implants to 45.1% and increase the market share of social marketing and commercial implants to 54.9%
   - Decrease the market share of free IUD to 70.4% and increase the market share of social marketing and commercial IUDs to 29.6%

c. **Objective 3:** Optimize financial sources, experience and engagement for family planning from public sectors, NGOs, private companies and retail pharmacies by incentive regulations and competitive environment in the total market
   - Increase the number of organizations implementing social marketing from 4 to 6 in 2015

- Public sector and non-public sector coordinate to provide contraceptives in the total market, and ensure availability of at least 3 types for each contraceptive in the commercial market.

In order to achieve these objectives, a key principle is rationally matching public and private providers to their market segments to ensure that clients receive contraceptives appropriate to their needs and ability to pay.

A basis for this matching is to optimize the financial resources from different market sectors with government resources focused on serving the targeted clients including the poor and the isolated communities (such as ethnic minority, handicapped and people living in the remote or disadvantaged areas).

Tools for implementing the contraceptive total market operational plan is the master and specific plans with detailed action steps, timelines, responsible parties, and milestones for capacity building, financing and procurement, demand generation and communications, and regulatory issues.

IV. Scope, area and timeline for implementation

1. Scope

Scope of the plan covers contraceptives used in the population and family planning program via free supply channel, and social marketing and commercial sector products to meet the increasing needs in diversified and high quality family planning methods, including implant, injectables, pills, emergency contraceptives, contraceptive films, IUD, and condom for only purpose of contraception (projection for condom demand for comprehensive purposes including STI and HIV prevention, gynecological exams, pregnancy prevention will be addressed in another separate master plan).

2. Timeline

Implementation period is from June 2011 to end of 2015.

3. Areas

At central level and in 63 provinces/cities nation wide

V. Leadership, collaboration and coordination

1. **Management agencies: the** MOH (GOPFP, Maternal and Child Health Department, Planning and Finance Department, Administration of AIDS Control, Pharmaceutical Management Department. Equipment and Medical Facility and Construction Department) coordinates with the Ministry of Planning and Investment, Ministry of Finance and other relevant Ministries and Institutions.
2. **Implementing agencies:** GOPFP, the MOH
3. **Collaboration organizations:**

- Provincial level health departments
- Mass Organizations: Women's Union, Youth Union, Vietnam Labor Union
- Donors: UNFPA
- NGOs: PATH, Marie Stopes, DKT, Pathfinder, VINAFPA

- Commercial: Interested contraceptive manufacturers and distributors.

VI. Activities and outputs

1. Activities to achieve objective 1

a. Projection of contraceptive users and methods

The targets set for up to 2015 are a decrease in TFR from 2.0 in 2010 to 1.9 and an increase in the contraceptive prevalence rate from 78% in 2010 to 82%. These mean an increase in contraceptive prevalence rate by 4% in comparison with this rate in 2010, and an average increase of 0.8% per year in 2011– 2015 period, that are equivalent to the increase during 2006 – 2010 period. The targets also include a 5.5% increase in modern contraceptive rate, that is higher than the target in 2006 – 2010 period, and an 1.5% decrease in traditional contraceptive p rate in compared with this rate in 2010.

	Apr 1st /2010	2011	2012	2013	2014	2015
Contraceptive prevalence rate (%)	78.0	78.6	79.4	80.2	81.1	82.0
Modern contraceptive rate (%)	67.5	68.2	69.2	70.5	80.8	73.0
Traditional contraceptive rate (%)	10.5	10.4	10.2	9.7	9.3	9.0

Projection of number of the contraceptive users in 2011–2015 period is based on actual user trends and socio-economic condition. Trends of the method mix in 2011–2015 period are projected as follows: long-term and high-effectiveness contraceptive methods keep reducing; implants tends to increase as this method has just been introduced and current usage level is still low; other short-term contraceptive methods such as condoms, OCs continue an increasing trend. The structure of contraceptive use has been changed but still remained high rate of contraceptive users, so it would enable to achieve the target as the TFR at 1.9 in 2015.

	2011	2012	2013	2014	2015
Total of new contraceptive users	6,838,707	6,948,917	7,062,242	7,175,088	7,287.310
Condom	1,522,540	1,582,571	1,641,795	1,700,782	1,759.931
Female sterilization	30,357	29,175	28,234	27,444	26,655
Injectables	275,556	282,383	290,028	297,596	305,163
IUD	1,538,020	1,520,847	1.505,095	1,490,314	1,475,124
Male sterilization	2,636	2,616	2,611	2,615	2,620
Implants	32,275	36,980	41,725	46,520	51,349
Ocs	1,816,133	1,874,664	1,932,090	1,989,091	2,046,148
Other	1,621,190	1,619,681	1,620,664	1,620,726	1,620,320

Notes: The number of annually new contraceptive users in 2011 – 2015 period includes contraceptive users replacing the contraceptive devices no longer effective, but excludes emergency contraceptive users.

Identification of annually contraceptive demand in the period of 2011 – 2015 is based on annual new contraceptive users and the current regulation on use norm of each type of contraceptive.

	2011	2012	2013	2014	2015
Condom (million units)	183	190	197	204	211
Ocs (1,000)	27,242	28,120	28,981	29,836	30,692
Injectables (1.000)	1,098	1,130	1,160	1,190	1,221
Implants (1,000)	32	37	42	47	51
IUD (1,000)	1,692	1,673	1,656	1,639	1,623

Notes: The above contraceptive demand doesn't include contraceptive used for other purposes 9such as condom used for STI and HIV/AIDS prevention and gynecological exams, OCs used for hormonal treatment,…)

b. Effective implementation of projects under the national targeted population and family planning program

- Effectively implement project "Behavior Change Communication", project "Family Planning Logistics and Service Security", and project ""Enhancing organization capacity" under the National Targeted Population and Family Planning Program
- Implement on-going and synchronous family planning IEC activities and counseling through direct and non-direct communication, traditional performance and integrated entertainments to promote individuals, family and communities to voluntarily change behavior of using free products to using social marketing and commercial products
- Provide contraceptive product safely and timely to the people in need through channels of free supply, social marketing and commercial sectors; and high-quality family planning services through formal and mobile service teams
- Develop and implement incentive policy and mechanism to contraceptive providers and users
- Capacity building for staff on government management of family planning product and service provision, and social marketing, and contraceptive side- effect management

2. Activities to achieve objective 2

a. Projection of contraceptive total market from 2011 to 2015

Projection of contraceptive total market in 2011– 2015 period is based on characteristics of contraceptive types, actual brand names of social marketing product and anticipated new band products in the market in 2011– 2015.

Disclosure of the projection is to create competitive opportunities for providers with different channels of supply to understand about the market and prepare for their business.

	Free	Social marketing	Commercial marketing
1. Common characteristics of contraceptives	Particular brands are regulated to be supplied free or there is a statement on the pack such as "free product".	• Particular brands are regulated for social marketing • There is a statement on the pack such as	• The brands of particular producers allowed to be circulated in Vietnam.

	Free	Social marketing	Commercial marketing
		"retail price is…VND" or "this is the subsidized product" or "this is a social marketing product"	• The brands which have not been officially approved to be circulated in Vietnam
2. Condom			
Male condom	Happy brand	• OK brand • Yes brand • Hello brand • Add other new brands	Various brands from manufactures
Female condom	None	None	
3. Pills			
Combined OCs	Ideal brand	• Choice brand • Newchoice brand • Add other new brands	Various brands from manufactures
Progestin-only OCs	The brands with the statement "free product"	None	
4. Injectable	The brands with the statement "free product"	• Sil brand • Add other new brands	Brands from manufactures
5. Implant		• Sil brand • Blue star brand • Add other new brands	Brands from manufactures
6. IUD	• Tcu 380A and Cu 375 SL • The brands with the statement "free product"	• Sil brand • Blue star brand • Add other new brands	Brands from manufactures
7. Emergency pills	None	Introduce new brands	Brands from manufactures
8. Contraceptive film	None	None	Brands from manufactures

b. Projected shares in the contraceptive total market

Currently, free contraceptives have a large share. The social marketing channel only supplies condom, pills and is piloting to supply the clinical methods. The unpopular contraceptives are being supplied through the commercial market such as female condom, sponge, contraceptive film, and pills for lactating mothers.

The contraceptive total market in the period 2011-2015 is defined to increase the share of the social marketing and reduce that of the free supply, grow quickly the share of social marketing for the clinical or high price contraceptive methods.

The proposed shares of different channels in the total market in 2011-2020 are presented below:

Contraceptives	Share out of total (%)		Annual quantity (1,000 units)	
	2011	2015	2011	2015
1. Condom	100	100	183,000	211,000
Free	*14.2*	*12.3*	*26,000*	*26,000*
Social marketing	*13.7*	*7.6*	*25,000*	*16,000*
Commercial market	*72,13*	*80,09*	*132,000*	*169,000*
2. Pills	100	100	27,241	30,693
Free	*47.6*	*30.9*	*12,967*	*9,484*
Social marketing	*34.5*	*41.4*	*9,398*	*12,707*
Commercial market	*17.9*	*27.7*	*4,876*	*8,502*
3. Injectable	100	100	1,097	1,220
Free	*88.7*	*75.9*	*973*	*926*
Social marketing	*8.6*	*15.9*	*94*	*194*
Commercial market	*2.7*	*8.2*	*30*	*100*
4. Implant	100	100	33	51
Free	*69.7*	*45.1*	*23*	*23*
Social marketing	*18.2*	*31.4*	*6*	*16*
Commercial market	*12.12*	*23.53*	*4*	*12*
5. IUDs	100	100	1,692	1,624
Free	*78.8*	*70.4*	*1,333*	*1,144*
Social marketing	*14.4*	*19.1*	*244*	*310*
Commercial market	*6.8*	*10.5*	*115*	*170*

c. Market segments

The market segmentation is to match public and private providers to a targeted market segments so that they could be engaged in the contraceptive supply initiatively in an appropriate coordination in contraceptive use of the entire population of WRA (15-49 aged).

There are various ways to segment based on different criteria such as client group, income level, regions, contraceptive method users or decentralized levels in contraceptive supply and reproductive health/family planning services. In each method, there may be more concrete criteria which can be overlap or interact with each other.

This plan applies the segmentation by wealth, region, difficulty in accessing to family planning and contraceptive method. Please see the Table 2. Market segments.

The segmentation by wealth in different areas is an important basis for defining and developing the market shares of contraceptives. The poor and para-poor in disadvantaged areas are prioritized segments for free products. The para-poor in urban areas, middle income group in wherever and high income group in disadvantaged areas are targeted clients of social marketing sectors. The group with middle income level and above is targeted segments for commercial sectors.

The segments defined by difficulty in family planning access include handicapped, ethnic minority, youth and adolescent and new users. Mass and community organizations would be appropriate providers for these segments.

The segmentation is also based on contraceptive method users to match the market shares of each type of contraceptives to supply channels including subsidized, social marketing and commercial ones. A decreasing trend of subsidized channel will affect on other channels to fill the gaps.

Estimate of segment size is important for the market segmentation to project users and financial sources.

Data were not available to develop segments based on psychological and attitudinal variables, which are obviously important to develop marketing strategies. These data may be worth collecting in future.

3. Activities to achieve objective 3

- Engage mass organizations such as the Women's Union and private companies to social marketing. Otherwise, GOPFP establishes a social marketing unit to strengthen contraceptive social marketing in the period of 2011 – 2015
- Communicate and advocate for involvement of all economic sectors in producing and importing various types of contraceptive, which meet the technical standards regulated by the MOH's Decision 714/QD-BYT on Mar 2nd 2010 and used for the National Targeted Population and Family Planning Program
- Enable companies from all of economic sectors to produce, get import license and circulate contraceptive products in the market, particular for type of contraceptive with less than three types in the market. Expand external collaboration to attract capital investment, and technological and technical transfer from international private sectors.

VII. Proposed amount of investment and capital sources

Based on the projected contraceptives needs by years in the period 2011–2015, and the proposed market shares of contraceptives and market segmentation in the total market, the investment amount and capital sources are estimated as follows:

Unit: million dongs

	Total	State budget			Commercial/ Free market chanel
		Sum	Free	Social marketing	
Total	**1,427,496**	**829,817**	**505,903**	**323,915**	**607,652**
1. Condom	**590,948**	**140,975**	**77,696**	**63,279**	**449,974**
2011	109,623	30,695	15,457	15,238	78,928
2012	113,945	29,626	15,497	14,129	84,319
2013	118,209	28,371	15,604	12,767	89,839
2014	122,456	26,940	15,552	11,388	95,516
2015	126,715	25,343	15,586	9,757	101,372
2. Pill	**536,129**	**413,027**	**209,217**	**203,809**	**123,102**
2011	100,794	82,752	47,978	34,774	18,042
2012	104,148	82,923	45,259	37,664	21,225
2013	107,232	82,783	42,142	40,641	24,449
2014	110,394	82,464	38,748	43,716	27,930
2015	113,561	82,105	35,090	47,014	31,456
3. Injectable	**120,036**	**113,422**	**98,566**	**14,856**	**6,642**
2011	22,733	22,097	20,142	1,955	614
2012	23,381	22,446	19,991	2,455	959
2013	24,014	22,718	19,764	2,954	1,321
2014	24,641	22,965	19,491	3,474	1,676
2015	25,267	23,196	19,178	4,018	2,072
4. Implant	**117,407**	**95,724**	**65,939**	**29,786**	**21,657**
2011	18,144	16,093	12,955	3,139	2,068
2012	20,789	17,754	13,409	4,345	3,014
2013	23,456	19,281	13,534	5,747	4,152
2014	26,152	20,686	13,311	7,375	5,466
2015	28,866	21,910	12,730	9,180	6,957
5. IUD	**72,976**	**66,669**	**54,485**	**12,185**	**6,277**
2011	14,907	13,893	11,746	2,147	1,014
2012	14,740	13,590	11,306	2,285	1,135
2013	14,588	13,318	10,882	2,436	1,255
2014	14,444	13,058	10,472	2,586	1,372
2015	14,297	12,810	10,079	2,731	1,501

The above estimated amount and capital sources of investment only include procurement cost of contraceptive devices, transportation, storage and distribution of the devices to the family planning service facilities (for clinical methods) and to clients (for non-clinical methods), but exclude cost of technical service procedure such as expenses for essential medicine, consumable supplies, and procedures.

VIII. Solutions

1. Identification of prioritization and implementation

a. Addressing needs of contraceptive

Effectively implementing the National Targeted Population and Family Planning Program and addressing contraceptive needs of users are to reach the target of increase in the contraceptive prevalence rate. During implementation of total market approach, contraceptive users might have been willing to pay social marketing or commercial products. Thus, behavior change communication and facilitation for clients would be necessary.

Temporary local incentive policy for contraceptive users might help the transition period to avoid contraceptive dropping users.

b. Prioritized groups

Priorities should be given to a number of groups to access contraceptives conveniently and safely so that their needs in family planning will be met equitably and effectively. These groups are:

- Poor and para-poor groups: Free provision of contraceptive to the poor and the para-poor is the first priority. However, the poor and the para-poor are scattered in all regions of the country provinces and cities. To simplify financial management, organization and implementation, and to ensure that the targeted users are covered, some type of mechanism such as service card or voucher, and direct provision of non-clinical contraceptives through public sector to the poor and para-poor need piloted.
- Handicapped faced difficulties in accessing family planning products and services. Also, most of them are not able to pay by themselves for the products and services. This group should be prioritized and have appropriate measures via public sector, mass organizations and professional associations to meet their need of contraceptive (for those concentrated in an area).
- Ethnic minority groups and those in the isolated areas who are not able to access family planning products and services. Traffic is difficult, and there are not many public-sector facilities and limited number of private-sector family planning service outlets in these areas. Therefore, it is necessary to have convenient channels, to provide support to and to engage public and private providers, as well as to use mobile family planning teams.
- Adolescents and youth, especially unmarried youth are not commonly served in public-sector clinics and present significant unmet need and demand. This group lives in all regions of the country. To solve unmet need, appropriate approaches including product and service provision in concentrated sites such as high school, vocational school and other units are necessary to address their contraceptive needs.
- New contraceptive users usually are lack of knowledge, experience and mind about contraceptive methods. They will need incentives to begin using contraception.

c. Prioritized channels of supply

During the period of 2011 – 2015, there will be the strongest transition to shift from free provision of contraceptives to paying partly price of contraceptive by users via social marketing. After 2020, the market shares of social marketing products will be reduced to make room for the commercial market. Therefore, social marketing is the prioritized channel in the period of 2011 – 2015.

The MOH issued incentive policy for contraceptive social marketing in the National Targeted Population and Family Planning by the Decision numbered 2062/QD-BYT on June 22, 2011. This decision regulated components of social marketing, retail price, expense items for social marketing, and the government management of social marketing. This is a legal basis for contraceptive social marketing implementers to carry out and expand scope of social marketing in the nationwide.

The commercial market shares have been larger and larger in the total contraceptive market, in accompany with growth of the socio-economy and improvement of the people living standards. The government's decree numbered 69/2008/ND-CP dated May 30, 2008 on socialization of education, health, culture, sport and environment fields and implementation guidance documents is a legal basis and fair opportunities for non-public sectors.

2. Pilots and scale-up for the total contraceptive market

Transition from free provision to intermediate channel (social marketing) and commercial market is a process in which awareness creation and behavior change communication are done in parallel with organization of the provision channels of family planning products and services to be appropriate with psychology, desire, economic and health condition of each target group. Therefore, it is necessary to pilot and scale up the total contraceptive market in order to achieve the set targets.

Provision of free package family planning services and products to the poor users should be piloted. At the same time, piloting introduction of a fee structure in public service delivery points targeted for those who can afford to pay serves to improve the competitive environment between public and private providers. It is also necessary to pilot the social marketing for injectables, implants and IUDs with a package fee including costs of essential drugs, consumable supplies and technical procedures. In addition, testing contraceptive provision via social marketing and commercial market to those face difficulties in service and product access should be done.

3. Communication and management capacity building

IEC activities for contraceptive use in the national population and family planning program advertisement for social marketing product brands should be carried out effectively. Communication for behavior change from using free product to using social marketing and commercial products to reduce a heavy load of the state budget and to promote equitability in family planning should be paid special attention.

Being trained and learning international experience are to enhance capacity of the management staff, to improve effectiveness of management, and to facilitate public and private sectors to well serve in the total contraceptive market.

4. Promotion policy development, promulgation and implementation

Policy for the subsidized groups should be developed, promulgated and implemented. Targeted groups for free family planning (the poor and para-poor, the people supported by social policy, those are difficult accession family planning in need) are specified by contraceptive methods. Level of subsidization is applied according to using norm and standards of each type of contraceptive. Mechanism to provide products and services to the users certified for free is needed piloting for each contraceptive method to prevent from complex and expensive reimbursement procedures and papers. The providers matching to the segments are population collaborators, commune-level population and family planning staff and public-sector service delivery points.

Concrete guidance about social marketing structure, retail price, expense items for social marketing and a subsidized rate for each social marketing product brands needs to be made and issued to serve social marketing implementers to carry out social marketing in practice.

Specific guidance documents on promoting socialization under the Decree number 69/2008/ND-CP are in need of development to guide non-public sector to produce, import, provide and distribute family planning product and services, as well as to contribute to the total market.

5. Flexible coordination in the total contraceptive market

Based on the proposed market shares of contraceptive and annual implementation status of the total market approach, the MOH in collaboration with the Ministry of Planning and Investment, the Ministry of Finance and other relevant ministries and institutions annually review, update and revise annual plan for quantities of contraceptive by supply channels to catch up with actual situation and the state budget plan.

The total market is coordinated flexibly by engaging the relevant ministries, institutions, mass organization, donors, NGOs, and contraceptive manufacturers and distributors to solve difficulties and challenges during the process of total market approach implementation, and to integrate with socio-economic policies, as well as to support public and private providers.

6. Disclosure

Disclosure of the total market operational plan, cost norm and fee schedules of family planning services will improve the competitive environment between public and private providers. This is a significant measure for socialization so as to optimize financial sources from different sectors, which ensures enough funds for family planning products and services.

Disclosure also helps the groups who have ability to pay for contraceptives and family planning services to be more initiative and meet the increasing needs in high quality and safe contraceptives of these groups.

IX. Implementation plan

The implementation plan is developed to concretize carrying out the set priorities. Please see the Table 3. Implementation plan.

Launching this plan in the proposed progress ensures achievement of the objective on matching public-sector, social marketing and commercial-sector providers to targeted segments, and provides evidences for scaling up in the next period. Assigned parties are responsible for implementing this plan in the proposed progress.

X. Indicators for success

In addition to the milestones in each implementation plan, additional evaluation measurements are suggested for the overall operational plan. For example, these may include:

- Government monitoring of implementation of plan with the Reproductive Health Commodity Group of the Reproductive Health Affinity Group.
- Annual reviews and revisions of the plan.
- Non-state actors continue to be involved in plan monitoring and revisions.
- Incorporation of the plan into other national policy and/or budget plans.
- Government resources for clinical contraception are targeted to those who cannot afford to pay.

- Maintenance of modern contraceptive prevalence rate.
- Number of sources of supply (commercial, NGO, public) increased for each contraceptive method.
- Increase in share of commercially supplied products.
- Decrease in market share of subsidized/free products to those who can afford to pay.
- Increase in share of clinical contraceptive social marketing
- Improved method mix.
- Decrease in unmet need for contraception among youth.
- Plans are developed for remaining market segments and/or emergent prioritized segments not included in this plan.

The operational plan for contraceptive total market is used for the national population and family planning program, and an indispensable part of annual plan and long-term plan for the population and family planning program. GOPFP is responsible for monitoring and evaluation of the plan implementation and consult with the MOH about difficulties and challenges during the implementation.

Table 1: Contraceptive prevalence rate and the projected number of contraceptives in the perid of 2011-2015

	2011	2012	2013	2014	2015
1. Contraceptive prevalence rate (%)	78.6	79.4	80.2	81.1	82.0
- Modern methods	68.2	69.2	70.5	80.8	73
- Traditional methods	10.4	10.2	9.7	9.3	9.0
2. Total contraceptive users	13,071,568	13,162,019	13,245,459	13,322,281	13,396,094
- Condom	1,522,540	1,582,571	1,641,795	1,700,782	1,759,931
- Female sterilization	629,935	622,494	614,318	605,691	596,793
- Injectable	275,556	282,383	290,028	297,596	305,163
- IUD	7,109,941	7,067,699	7,017,678	6,963,029	6,905,752
- Male sterilization	39,222	39,504	39,750	39,976	40,192
- Implant	57,051	73,023	89,136	105,390	121,795
- Pill	1,816,133	1,874,664	1,932,090	1,989,091	2,046,148
- Others	1,621,190	1,619,681	1,620,664	1,620,726	1,620,320
3. New contraceptive users	6,838,707	6,948,917	7,062,242	7,175,088	7,287,310
- Condom	1,522,540	1,582,571	1,641,795	1,700,782	1,759,931
- Female sterilization	30,357	29,175	28,234	27,444	26,655
- Injectable	275,556	282,383	290,028	297,596	305,163
- IUD	1,538,020	1,520,847	1,505,095	1,490,314	1,475,124
- Male sterilization	2,636	2,616	2,611	2,615	2,620
- Implant	32,275	36,980	41,725	46,520	51,349
- Pill	1,816,133	1,874,664	1,932,090	1,989,091	2,046,148
- Others	1,621,190	1,619,681	1,620,664	1,620,726	1,620,320
4. The project number of contraceptives by years					
Condom (million units)	183	190	197	204	211
Pill (1,000 circles)	27,242	28,120	28,981	29,836	30,692
Injectable (1,000 vials)	1,098	1,130	1,160	1,190	1,221
Implant (1,000 doses)	32	37	42	47	51
IUD (1,000 devices)	1,692	1,673	1,656	1,639	1,623

Table 2. Market segments

Target group and segments	Service channels	Contraceptive product/ supply source
I. By wealth		
1. Segment 1. Poor households		
- Disadvantaged areas	Public Mass organizations No fee	All modern contraceptives Government budget
- Rural areas		
- Urban areas		
2. Segment 2. Para- poor households		
- Disadvantaged areas	Public service Mass organizations No fee	All modern methods Government's budget
- Rural areas		
- Urban areas	Public service Social marketing via mass organizations	All modern methods Government budget Social marketing product fee
3. Segment 3, 4. Middle-income households		
- Disadvantaged areas	Social marketing via mass organizations and NGOs	All modern methods Government budget Social marketing product fee
- Rural areas	Social marketing via mass organizations NGOs Commercial	All modern methods Government budget Social marketing product fee Out-of pocket
- Urban areas		
4. Segment 5. High income households		
- Disadvantaged areas	Social marketing via mass organizations NGOs	All modern methods Government budget Social marketing product fee
- Rural areas	NGOs Commercial	All modern methods Out-of-pocket
- Urban areas		

Target group and segments	Service channels	Contraceptive product/ supply source
II. By difficulty in access		
1. Handicapped	Public Mass organizations No fee	All modern methods Government budget
2. Ethnic minority	Public – no fee Social marketing via mass organizations	All modern methods Government budget Social marketing product fee
3. Adolescent and youth in rural areas	Social marketing via mass organizations NGOs Commercial	All modern methods Government budget Social marketing product fee
4. Adolescent and youth in urban areas		
5. New users	Free promoted products Social marketing by mass organizations, NGOs	All modern methods Government budget Social marketing product fee
III. By contraceptive methods		
1. Condom	Free supply quickly declined to 10% for the poor segment in the disadvantaged areas	Government budget for social marketing Expenditure from social marketing/commercial marketing product users
2. Pill	Free supply quickly reduced to 30% for the poor/para-poor in disadvantaged areas	
3. Injectable	Social marketing Commercial NGOs	Government budget for social marketing Expenditure from social marketing/commercial marketing product users Plan for promotion of private sector engagement
4. Implants		
5. IUD		
6. Emergency pills	Social marketing Commercial	Out-of-pocket
7. Other methods	Commercial	Out-of-pocket

The segments classified by wealth according to the Government's regulation (with household as the unit) include:

- Segment 1. Poor households
- Segment 2. Para-poor households
- Segment 3. Middle income households
- Segment 4. Above middle- income households
- Segment 5. Rich households

The segments classified by the areas include:

- Disadvantaged areas: The provinces in the Northern Mountainous and Central Highland regions
- Rural areas: The provinces in Northern Delta, Costal Central, Eastern South and Mekong River Delta regions.
- Urban area: The central or provincial cities

Table 3. Implementation plan

	Activity	Timeline	Responsible party	Milestones
1. Poor and subsidized populations (incl. disadvantaged, isolated, ethnic groups)				
Capacity building	Establish plan for where to locate pilot. Establish management mechanism to provide, monitor and supervise provision of exemptions to identified population. Conduct pilot	May 2011– November 2011 2012	GOPFP with provincial, district, commune level of selected pilot. GOPFP	Pilot plan developed. Mechanism identified. Pilot conducted, lessons assessed, program revised.
Financing	Estimate the number of WRA in quintiles one and two who are in need of contraception and method mix; use this as the basis of projected budget requirement. Estimate health worker incentives. Determine when exemptions will go into effect. Plan to include family planning in national health insurance by 2016.	June 2011 July 2011 September 2011 2012	GOPFP with GSO GOPFP, MOH GOPFP, MOH MOH, Health Insurance Dept.	Revised projection of budget need by July 2011. Incentives estimated. Plan scheduled. Health insurance pilot conducted in 2013. Budget estimated and requested by 2014.
Procurement/ supply/ logistics	Revise procurement estimate based on above.	October 2011	GOPFP	Revised product projections by November 2011.
Demand generation and communication	Determine health worker incentives and targets to be employed. Determine key messages and communication channels to notify health workers/ population of eligibility and exemptions.	May 2011 November 2011	GOPFP WU/YU	Incentives determined. Key messages and channels determined.
Regulatory	Determine if regulatory changes needed.	November 2011	GOPFP, MOH	Changes identified.

	Activity	Timeline	Responsible party	Milestones
2. Fee introduction in public sector				
Capacity building	Plan project to pilot fee introduction. Establish management mechanism to monitor and supervise fees to identified women. Address how quality improvements can maintain client utilization. Conduct pilot.	June 2011 November 2011 December 2011 2012	GOPFP with provincial, district, commune level of selected pilot. GOPFP GOPFP, MCH	Pilot plan developed and approved by November 2011. Mechanism identified. Quality plan developed for pilot Pilot conducted, lessons assessed, program revised.
Financing	Determine the fee structure based on cost data. Adjust budget estimates in government projections to include estimated number of women who will be charged fees, fee revenues, and possible decrease in service use as a result of those who seek services in private sector.	July 2011 September 2011	GOPFP with MOF GOPFP	Fee structure developed by September 2011. Revised estimates by October 2011.
Procurement/ supply/ logistics	Estimate women who may leave public sector if charged fees. Revise procurement estimate based on above.	October 2011	GOPFP	Revised product projections by November 2011.
Demand generation and communication	Determine key messages and communication channels to notify health workers/ women of start of fees.	November 2011	GOPFP with WU and YU	Key messages and channels determined.
Regulatory	Identify regulations on private-sector pricing that might impede growth in that sector.	November 2011	GOPFP, MOH	Regulations identified and plan made to address them.

	Activity	Timeline	Responsible party	Milestones
3. Injectable contraceptives				
Capacity building	Assess barriers to use and lessons learned from previous efforts. Train public and private providers on side-effect management and counseling.	August 2011 2012	GOPFP, MCH Social marketing MCH	Barriers identified. Providers trained.
Financing	Revise projections to include injectable use for new users. Incorporate training costs into state budget requests	May 2011 2012	GOPFP MOH	Revised projection of budget by July 1, 2011. Training costs funded.
Procurement/ supply/ logistics	Encourage distributors to provide injectables in private markets. Clarify definition of social marketing—purpose of projected government budget, which organizations receive funds, contractual requirements to achieve quality, availability and affordability to fund/commodity recipients.	October 2011 May 2011	GOPFP Injectable manufacturers, distributors GOPFP	Revised product projections by November 2011. Definition disseminated by June 2011.
Demand generation and communication	Determine key messages and communication channels to inform and counsel women on managing side-effects of product use. Develop key messages based on identified barriers.	November 2011	MCH, Private providers, NGOs, Product manufacturers WU	Key messages and channels determined. Increased percent provided through commercial sector.
Regulatory	Determine if providers can inject outside of clinic setting? Determine if new injectable products need to be registered. Address how advertising regulations can be adjusted in order to promote general	November 2011	MOH	Decision made. Plan developed.

	Activity	Timeline	Responsible party	Milestones
	method category. Address other regulatory barriers identified in the initial capacity-building step.			Barriers identified
4. Intrauterine devices				
Capacity building	Increase number of private sector access points for IUD provision by training service providers.	2012	MCH	New service delivery points by December 2012
Financing	Incorporate training costs into state budget requests	2012	MOH	Training costs funded.
Procurement/ supply/ logistics	Clarify definition of social marketing—purpose of projected government budget, which organizations receive funds, contractual requirements to achieve quality, availability and affordability to fund/commodity recipients.	May 2011	GOPFP	Definition disseminated by June 2011.
Demand generation and communication	Determine end-user communications plan to increase awareness of IUD availability in the commercial sector, including: o Key messages. o Communication channels. o Intensity and frequency of communication.	December 2011	Private providers, Product manufacturers.	Communications plan implemented in 2012 Increased percent provided through commercial sector.
Regulatory	Enable dispensing by private doctors. Extend licensing and accreditation systems to include quality and availability of private providers. Address how advertising regulations can be adjusted in order to promote general method category.	August 2011	GOPFP with MOH, Dept. of Pharmaceutical Management	Regulatory changes made by December 2011.

	Activity	Timeline	Responsible party	Milestones
5. Youth				
Capacity building	Assess barriers to use and lessons learned from previous efforts. Train service providers, including private abortion providers. Scale-up youth-friendly services in public-sector clinics.	September 2011 2012	MOH, provincial, district, commune levels.	Barriers identified. Providers trained. New service delivery points/times established with youth-friendly services by December 2012.
Financing	Determine if youth will be served for free in public sector clinics, regardless of income. Incorporate training costs into state budget requests	June 2011 2012	GOPFP MOH	Decision made. Training costs funded.
Procurement/ supply/ logistics	Develop/confirm projections that include unmarried youth.	September 2011	GOPFP	Projections confirmed by October 2011.
Demand generation and communication	Develop plan to increase general knowledge of contraception and its purpose. Design communication programs to target youth and inform them of need and youth-friendly services.	February 2012 February 2012	MOE MOH MOH, Youth Union	Plan developed by April 2012. Increased percent of youth served and using modern contraceptive method.
Regulatory	Ensure that over-the-counter list is up-to-date. Accredit youth-friendly sites in public sector.	August 2011 July 2012-	MOH, Dept. of Pharmaceutical Management MOH	List updated annually. Determine accreditation procedures. Performed continuously

	Activity	Timeline	Responsible party	Milestones
6. New users				
Capacity building	Determine eligibility criteria for new users. Establish management mechanism to monitor and supervise provision of exemptions to identified population.	July 2011	GOPFP with provincial, district, commune level	Criteria and mechanism identified.
Financing	Include new users in state budget requirements.	July 2011	GOPFP	Revised projection of budget need by September 2011.
Procurement/ supply/ logistics	Revise projections for new users to include OCs and injectables.	October 2011	GOPFP	Revised product projections by November 2011.
Demand generation and communication	Target abortion providers to counsel on contraceptive method use as part of post-abortion services. Determine if health worker incentives and targets will be employed. Determine is voucher will be used to identify new users. Determine key messages and communication channels to notify health workers/ new users of eligibility and need for contraception.	March 2012 January 2012 February 2012 April 2012	GOPFP GOPFP GOPFP GOPFP, MOH, WU	Targeting plan developed and providers trained. Decision made. Mechanism and implementation system identified. Programs designed by March 2012.
Regulatory				

Signed for Minister
Deputy Minister

Nguyen Ba Thuy