Ability and Willingness to Pay for Family Planning in Vietnam

Prepared for the Enhancing Equity and Sustainability of Public-Sector Family Planning project

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Program for Appropriate Technology in Health

PATH
A catalyst for global health

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Acronym Key

EE:	Enhancing Equity and Sustainability of Public-Sector Family Planning project
FP:	Family planning
IUD:	Intrauterine device
PATH:	Program for Appropriate Technology in Health
RH:	Reproductive health
VMICS:	Vietnam Multiple Indicator Cluster Survey
Vnd:	Vietnam Dong
VSPS:	Vietnam Self-Paying Survey

Chapter 1: Introduction

A. Context

PATH's Enhancing Equity and Sustainability of Public-Sector Family Planning (EE) project aims to support the government of Vietnam as it plans how to coordinate the country's full range of family planning (FP) service providers—including the public and commercial private providers, social marketing groups, and nongovernmental organizations—to serve the diverse needs of their population.

Women in Vietnam have more access to contraceptives and reproductive health (RH) services than ever before. Thanks to the hard work of the government, a successful family planning program exists and free contraceptives are widely available, contributing to an impressive rate of social and economic development. It is because of this economic development that international donors of contraceptives are shifting their support to countries with greater need.

While external funding decreases, the demand for family planning services is increasing. The government must find a way to ensure access to these important services despite decreased external funding. PATH is helping the government of Vietnam to design a total market approach to family planning. A total market approach calls for a coordinated response by the full range of family planning service providers to meet a population's diverse needs. In other words, the public sector, social marketing groups, nongovernmental organizations, and the commercial sector are all part of one market working together to serve everyone—including those who require free or low-cost supplies and those who are able to pay. By acting as the steward for the country's family planning services and leading the coordination of a total market approach, the government is able to focus its limited resources on family planning service provision for the underserved. The remaining sectors can serve those who are able to pay, ensuring all segments of the family planning market have access to services and that there is a consistent supply of contraceptives available to those who need them. A key component of the project is to help the government draft an operational plan for public-sector contraceptive distribution to these targeted market segments.

To date, PATH has conducted interviews with a wide range of stakeholders to determine country readiness to implement a total market approach towards family planning. PATH, in partnership with the government, has also formed an advisory group of in-country stakeholders to provide technical input to the project. The next step is to assemble the evidence that will help to build the operational plan. This includes analyzing information about willingness to pay and segmentation opportunities.

This study offers policy analysis of data previously collected. The Vietnam Self Paying Survey (VSPS 2009) was conducted by the Vietnam Medical Military Institute. The Vietnam Medical Military Institute and their sponsors determined the scope of the survey, the sampling plan, and implementation of the survey. The PATH analysis built upon their excellent work but did not have input into the conduct or design of the study. This report also uses the data collected for the Vietnam Multiple Indicator Cluster Survey. Once again, PATH did not participate in the design or conduct of the original survey. Again, this report builds upon their excellent work.

B. Organization of report

This report is divided into three sections. The data and methods section of this report briefly describes the VSPS 2009. Because the VSPS 2009 used a non-random sample, we offer some cautions to the reader. A third subsection of the Data and Methods section describes the creation of two economic status variables. The Willingness to Pay section of the report presents the results of Vietnam Self-Paying Survey. The results are disaggregated by variables useful for policy making and program planning. The fourth and final section of the paper discusses the results briefly, and offers a few observations on how a user fees scheme might be implemented.

Chapter 2: Data and methods

A. Data

In 2009, the Military Medicine Institute conducted research into whether or not the government could expand a program to institute user fees for clinical methods of family planning. The research included qualitative and quantitative elements involving family planning users, potential family planning users, and providers of health services. This report is an analysis of the quantitative data regarding current and potential users of family planning data. This brief description provides only enough information to allow interpretation of the analysis that follows. For complete information on the survey, the reader should consult the *Evaluation of the self-paying ability to pay for clinical contraceptive* here referred to as the Vietnam Self-Paying Survey.[1]

The survey of current and potential family planning users consisted of two parts—Group A users of clinical family planning methods, and Group B women who were not using clinical methods. Group B consisted of women who used non-clinical methods and women who are not using family planning at all. Women in Group A and women in Group B were interviewed with different questionnaires. The questionnaires were very similar; therefore for the purpose of this report, most analysis combined the two groups of women.

The survey was conducted in five provinces (Hoa Binh, Ha Noi, Dong Thap, Gia Lai, Ho Chi Minh). The survey respondents were selected randomly among 4 communes from each province for a total of 20 communes. A total of 4,531 women were interviewed. This analysis limited itself to women less than 50 years old, of whom 4,470 were interviewed.

Given that there are 5 provinces represented in this survey and 63 provinces in Vietnam, the results of the survey should not be viewed as representative of Vietnam as a whole. Therefore, we caution the reader to view these results as being representative of the provinces included in the sample but not necessarily Vietnam as a whole. At the end of the report, we provide some results disaggregated by province. The reader may choose to extrapolate from an individual province to another province that s/he believes is similar. However with this we advise caution.

On the other hand, we believe that this report and the survey it is based upon are very useful for policy decisions. By disaggregating the results by province, user groups, occupation, etc., the reader of the report will have several vantage points on the willingness to pay for family planning services in Vietnam. A careful reading of these vantage points will provide policymakers and program managers with useful information for decisions about the future direction of cost-sharing.

B. Definition of user groups

An important aspect of willingness to pay for family planning services is the economic status of the current users and potential users. The VSPS asked respondents if their household is “poor” or “not poor.” About 11 percent of respondents said they were poor, and 89 percent said that they were not poor. The author of this report decided that finer distinctions were needed. The following two classification schemes were developed:

Location and poverty:

1. Urban not poor
2. Rural not poor
3. Poor

Occupation and education:

1. Government worker
2. Other formal sector workers (including sales, services, and craftsmen)
3. Educated informal sector worker
4. Uneducated informal sector worker:
   Informal sector workers include farm workers, workers, and houseworkers. Informal sector workers who have junior high education or better are considered educated.
5. Poor (all people who said they are poor, regardless of occupation or education)

C. Economic status of family planning users

Table 1 below presents the economic status of different types of family planning users interviewed in the VSPS 2009. The family planning use status is based upon the method women said that they are currently using. The far right column presents the average status of the respondents, and provides a useful comparison point for the different user categories. For example, in the row with government workers, the second column shows that government workers constitute 20.9 percent of intrauterine device (IUD) users. This is 5 percent higher than the far right column (15.5 percent), meaning that government workers are more likely to use IUDs than the general population. The comments below are based on such comparisons.

The first thing to note is that there are not large differences in the percentage of women who are poor across the different methods. Injectables have the highest percentage of women who are poor while those who are not using have the lowest percentage. On the other hand, there are big differences across the occupational groups. IUD users are disproportionately government workers and other formal sector workers. Implant and pill users are disproportionately from the ranks of the educated informal sector workers. In the second portion of Table 1, we see that IUD and pill users are disproportionately urban, not poor. We also see that implant users are much more likely to be among the rural not poor.

If we generalize about the relative economic status of different categories, we could say that IUDs are the method of choice for the relatively wealthy and the urban clients. Implants are the method of choice for those in rural areas or those in the informal sector. Finally, the category of poor does not seem to be distinguished across the methods.[*] A piece of speculation, in advance of the results of the next section, is the following. Since IUDs are disproportionately used by the relatively wealthy, the willingness to pay for IUD services should be higher than for implants or injectables.[†]

[*] This could mean one of two things: 1) the question asked in the VSPS concerning poverty status is not a useful category for distinguishing among women; or 2) location and occupation are much more important determinants of family planning use.

[†] This speculation ignores for the moment that different methods might have different prices, which would influence the willingness to pay.

Table 1: Economic status of family planning users from Vietnam Self-Paying Survey (VSPS) 2009

	Not using	IUD	Injectable	Implant	Pill	Condom	All women
Government worker	18.0	20.9	5.3	4.2	9.3	8.7	15.5
Formal sector worker	12.0	19.5	8.7	11.0	18.1	11.1	14.7
Educated Informal sector	37.5	26.3	47.7	47.4	44.0	39.7	35.6
Uneducated Informal sector	24.4	23.0	23.3	25.5	17.1	28.6	23.5
Poor	8.1	10.3	15.0	11.9	11.4	11.9	10.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urban not poor	42.6	49.9	35.1	22.3	50.8	41.3	43.3
Rural not poor	49.3	39.8	49.9	65.8	37.8	46.8	46.0
Poor	8.1	10.3	15.0	11.9	11.4	11.9	10.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of observations	1,217	1,869	755	310	193	126	4,470

D. Economic status of family planning users (according to VMICS 2006)

As mentioned above, the VSPS is not a random sample of all women in Vietnam. This section is written to orient the reader to the general socio-economic status of family planning users in Vietnam. This orientation will give the reader a point of departure for interpreting the willingness to pay results that follow.

The Vietnam Multiple Indicator Cluster Survey (VMICS 2006) is a random sample of all women aged 15 to 49 in Vietnam. Complete details on the survey methodology are available in the final survey report (GSO 2009).

Among many things, the VMICS 2006 asked questions necessary to establish wealth status of women (Poorest, Second, Third, Fourth, Richest). The establishment of the wealth status was based upon a wealth index derived from an accounting of assets held by the household where the woman lived at the time of the survey. Also included in the survey were questions about contraceptive use disaggregated by method. In the following, we present the levels of family planning use disaggregated by wealth status derived from the VMICS 2006.

Figure 1 shows that poor women in Vietnam are more likely to use modern family planning than wealthier women, while wealthier women are more likely to use traditional methods. This is in sharp contrast with almost all countries in the world, where wealthier women are more likely to use modern family planning than poorer women. In general, this means that policy decisions to charge for family planning services should be approached with caution, since poor women could be affected by the price increase leading to a reversal in the favorable usage pattern.

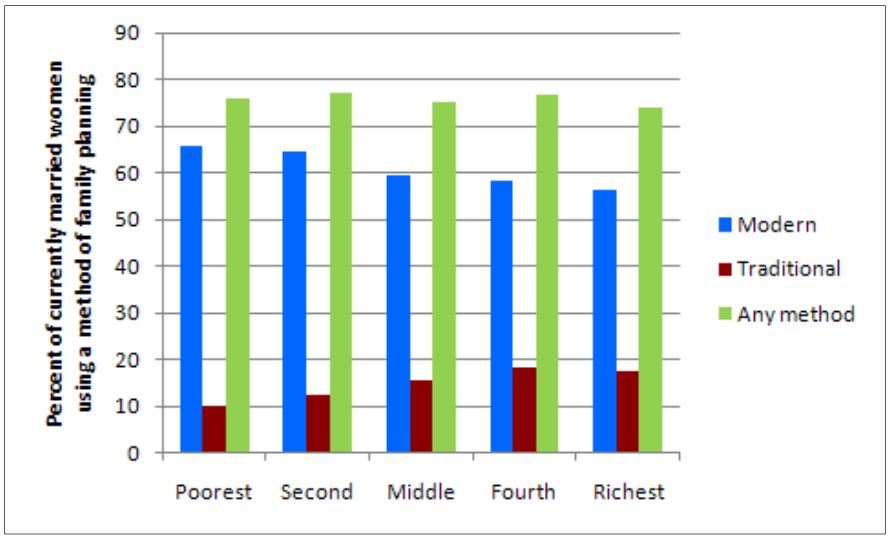

Figure 1: Percentage of currently married women who are using a modern method, a traditional method, or any method of family planning, currently married women aged 15–49, VMICS 2006.

The main concern of this report is willingness to pay for clinical methods of family planning. Figure 2 shows the percentage of women using IUDs and injectables across the wealth quintiles.[‡] Here the pattern of differences across the wealth groups becomes much clearer. Forty-three percent of the poorest women are using IUDs, versus only about 28 percent of the wealthiest women. Note that this is in direct contrast to what was seen in Table 1 where we saw that the women interviewed were in general "not poor". Great care must be taken before implementing any program of price increases. Note however, that these differentials in use patterns do not indicate that a user fee system should not be implemented, only that care should be taken to assure that the many poor users of IUDs are not discouraged from continued use.

[‡] Implants are not included in the graph because there are too few users to show robust results.

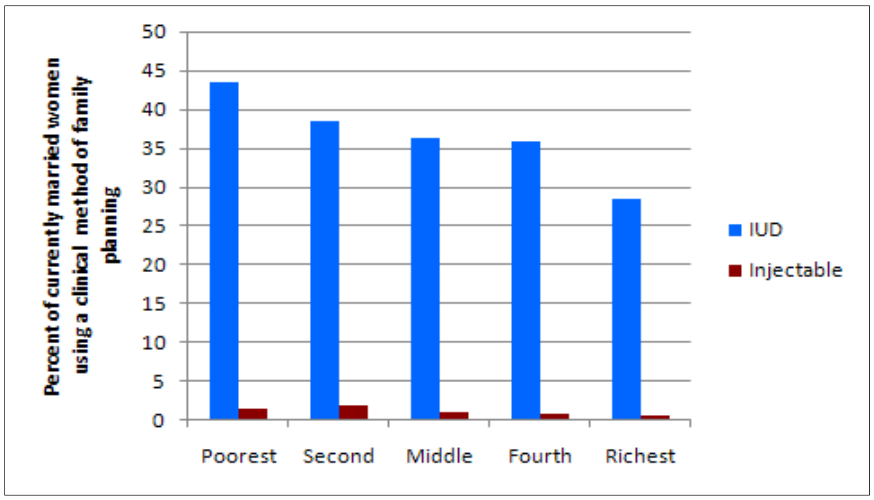

Figure 2: Percentage of currently married women who are using IUDs or injectables for family planning, currently married women aged 15–49, VMICS 2006.

E. Use of family planning disaggregated by location

Beyond economic status, a second axis along which users might be segmented is location—either urban versus rural or across the various geographic areas. This information is potentially useful as it is frequently easier to differentiate user fee policy by location rather than by economic status. Location is relatively fixed and unambiguous for a particular woman. Self-reported economic status has obvious limitations—women may under-report their economic status if they believe that benefits accrue to those who are poor. On the other hand, in the short run women stay in the same place and there are real economic costs (e.g., transportation) to purchase family planning products outside one's immediate location.

Figure 3 presents use of modern family planning disaggregated by urban-rural location and by geographic region. Rural women are more likely to use modern methods of family planning than urban women. However the differential is not large.

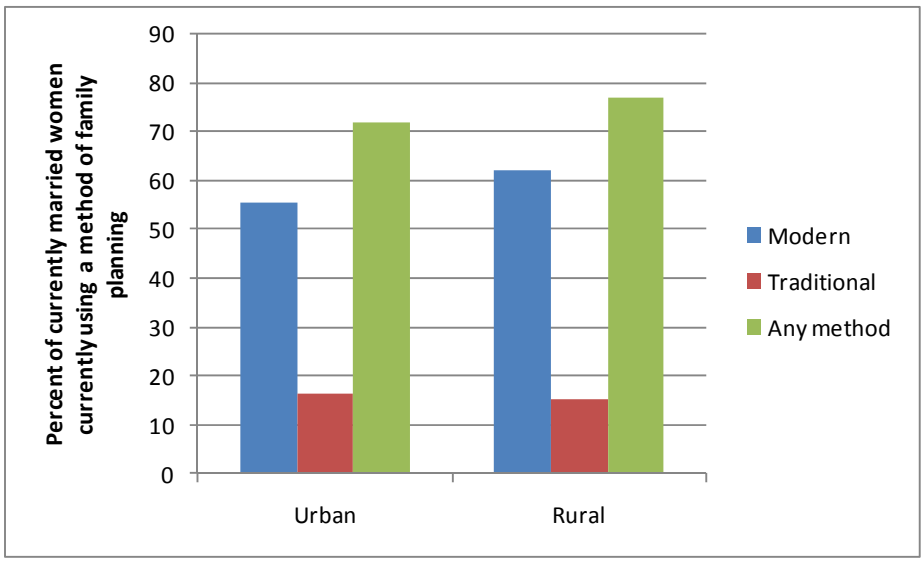

Figure 3: Percentage of women who are using a modern, traditional, or any method of family planning disaggregated by urban-rural status, currently married women aged 15–49, VMICS 2006.

In contrast to the lack of clear differentials based on urban and rural status, there are very large differences when looking at geographical areas. Women in the northern geographic regions are much more likely to be using modern methods of family planning than women in other geographic regions. Policy and program managers may need to differentiate their approach to user fees across the regions depending on whether the concern is discouraging current use where use is high, or discouraging potential users where use is low.

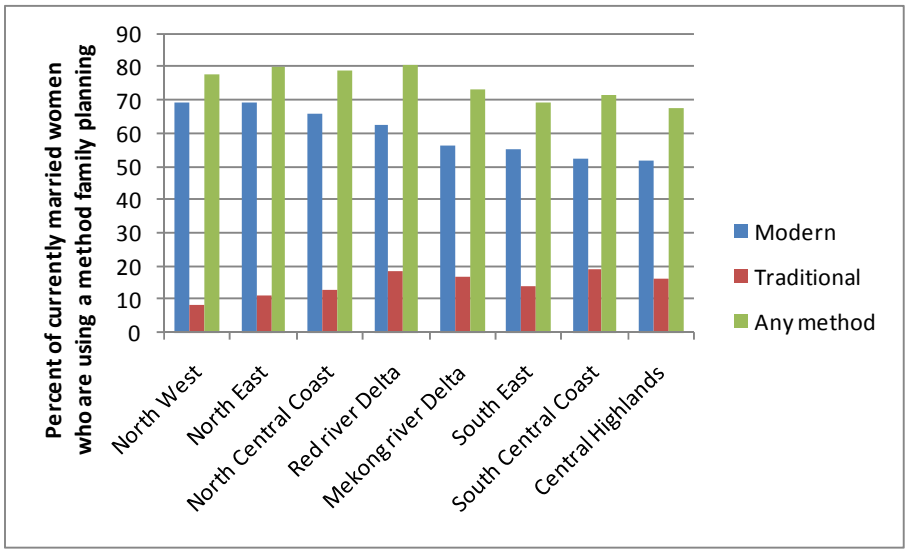

Figure 4: Percentage of women who are using a modern, traditional, or any method of family planning disaggregated by geographic region, currently married women aged 15–49, VMICS 2006.

The main clinical method being considered for user fees is the IUD. Figure 5 disaggregates IUD use by geography and by urban-rural status. Above, we saw that there are clear differentials by economic status of the users. In Figure 5, we see that there are also clear differentials in IUD use by geographic region and less so by urban-rural status. The women in the poorer north are much more likely to be using IUDs than women in other geographic regions.

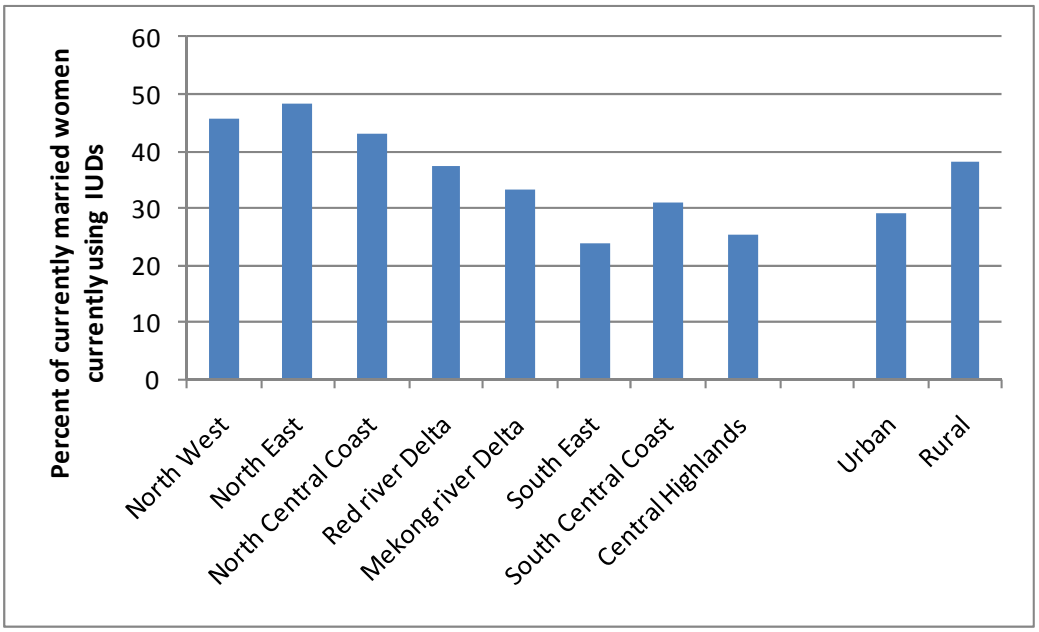

Figure 5: Percentage of women who are using IUDs disaggregated by geographic region and by urban-rural status, currently married women aged 15–49, VMICS 2006.

Chapter 3: Willingness to pay results

A. Current payments for family planning services

Paying for family planning services is not unknown in Vietnam. More than half of the respondents using non-clinical methods reported having paid for family planning. Figure 6 shows the percentage of women who paid across the different methods. More than half of women currently using pills or condoms have paid in the past for family planning services. On the other hand, less than 15 percent of clinical method users (IUD, injectable, and implant) have ever paid for their services. Interestingly, many women who report not currently using family planning have paid for family planning in the past.

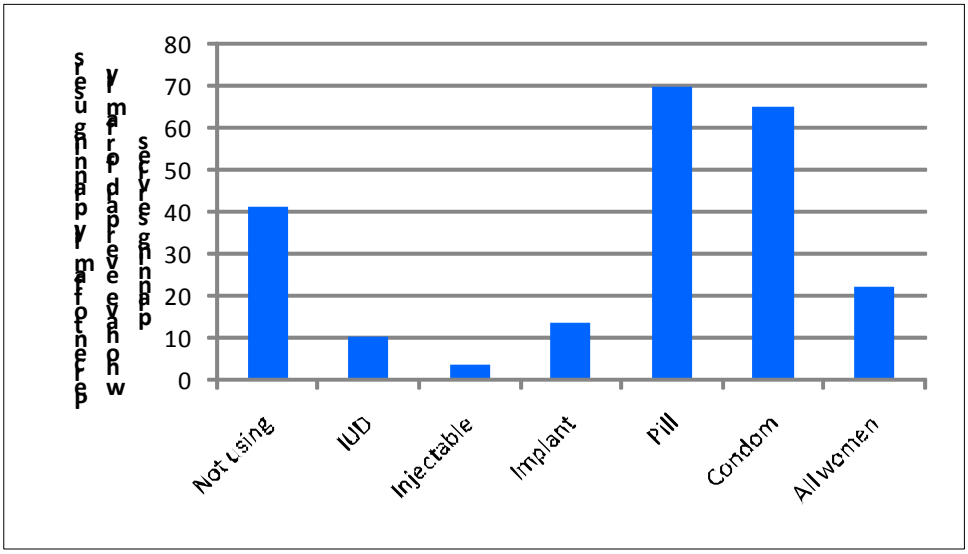

Figure 6: Percentage of family planning users who have ever paid for family planning services, VSPS 2009.

The prices that women have paid in the past are relatively high in the case of implants and less so for IUDs. The median prices paid are tabulated in Table 2. In the case of IUDs and implants, the median prices paid are similar to the social marketing prices in effect (i.e., 9,500 Vnd for IUDs and 495,000 Vnd for implants).

Table 2: Median price among current users of clinical methods who paid for family planning services, Vietnam Self-Paying Survey (VSPS) 2009

	Median price paid (Vnd)	Number of observations
IUD	10,000	83
Implant	515,000	30

B. Willingness to pay by method

The willingness to pay questions in the VSPS 2009 were organized as follows. First, all women were asked if they were willing to pay anything for contraceptives. This first question was not differentiated by method. If a woman said yes, she was then asked whether she would pay more

or less than a threshold price for IUDs, injectables, and implants. The threshold prices are based upon the current social marketing prices for contraception: 9,500 Vnd for IUDs, 16,500 Vnd for injectables, and 495,000 Vnd for implants. Appendix Tables 1, 2, and 3 present detailed information on willingness to pay. The discussion below refers to bar charts based on the Appendix tables.

Figure 7 presents the percentage of women who are willing to pay something for family planning services disaggregated by their current method of family planning. Please note that this assessment did not require that a woman say how much she would pay, only whether she would accept paying for family planning services. Almost 60 percent of IUD users are willing to pay something, while less than 40 percent of injectable users report willingness to pay something. About 42 percent of current implant users report willingness to pay for government services.

Less than 50 percent of current users of pills and condoms report a willingness to pay for government services. This contrasts starkly with Figure 6 above where it was shown that more than 60 percent of current users of both methods had paid in the past. This may be indicative of respondents answering in a way that that they believe will influence future policy in their favor. In other words, they say they would not pay, when in fact if presented with a choice of paying or not using family planning, they would choose to pay.

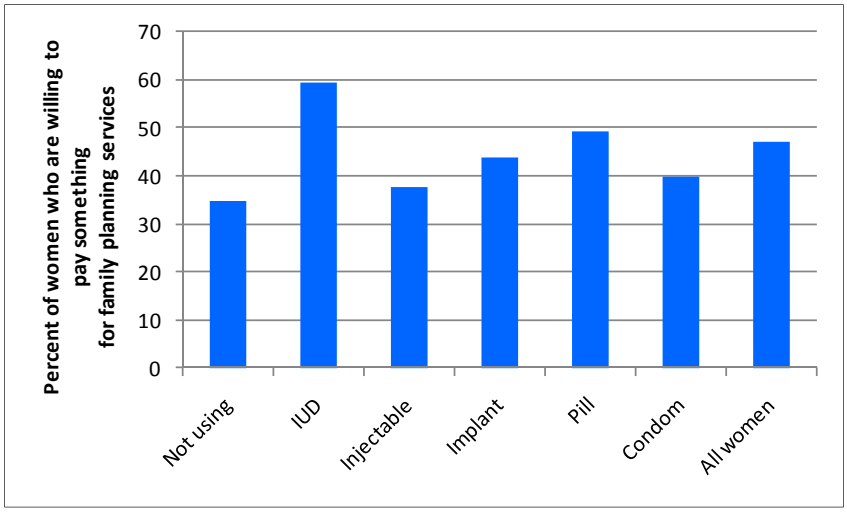

Figure 7: Percentage of family planning users who are willing to pay for family planning services at government clinics disaggregated by current method of family planning, VSPS 2009.

The social marketing price for contraceptives varies by method. For IUDs the price is 9,500 Vnd, for injectables 16,500 Vnd, and implants 495,000 Vnd. Figure 8 presents the percentage of all women who are willing to pay the social marketing price for the different methods. More than 30 percent of women are willing to pay the social marketing price for IUDs and injectables. In contrast, less than 20 percent of women state a willingness to pay the social marketing price for implants.

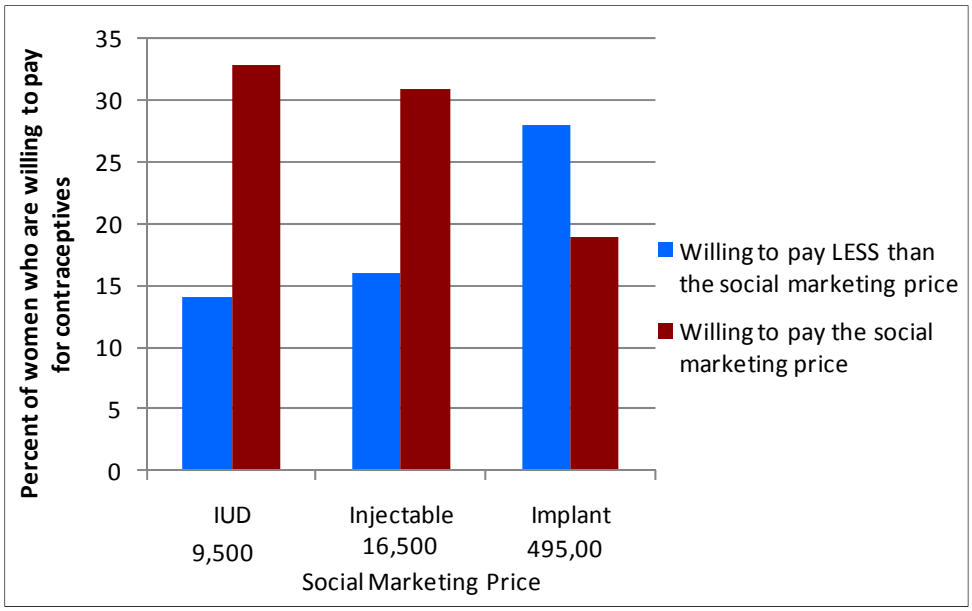

Figure 8: Percentage of family planning users who are willing to pay the social marketing price for family planning services at government clinics disaggregated by method, all women, VSPS 2009.

C. Willingness to pay by social and economic strata

In the previous section, we presented information on aggregate levels of willingness to pay for contraceptive services at government clinics. Figure 9 presents this information disaggregated by economic status. Little more than 30 percent of poor women, rural women, and uneducated women working in the informal sector are willing to pay for contraceptive services at government clinics. On the other hand, more than 80 percent of government workers and more than 50 percent of formal sector workers are willing to pay for contraceptive services.

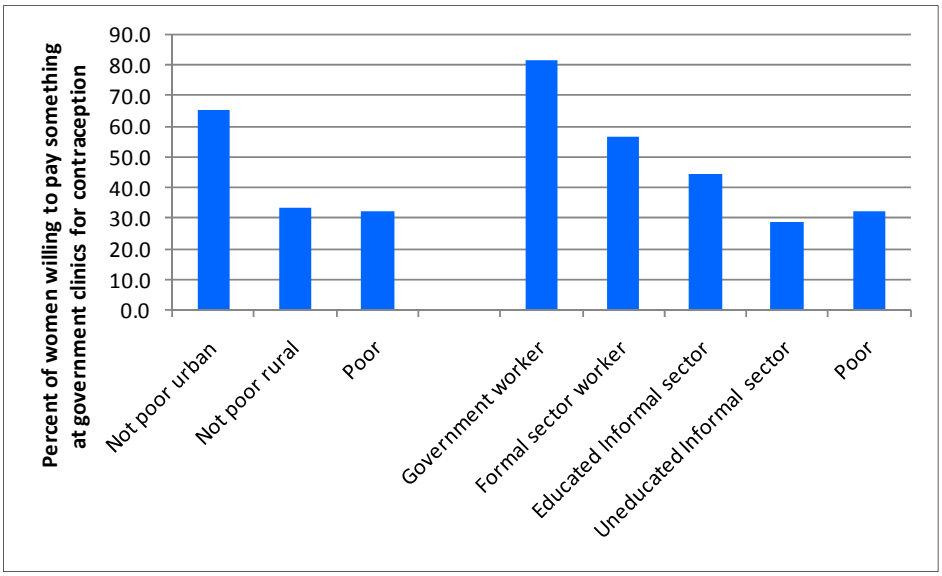

Figure 9: Percentage of family planning users who are willing to pay for family planning services at government clinics disaggregated by economic status, all women, VSPS 2009

The social marketing prices for IUDs, injectables, and implants are quite different. In fact, the price for implants is almost 50 times higher than that for IUDs. This is probably reflected in the large differences in willingness to pay for implants versus IUDs or injectables. Figures 10 and 11 present the percentage of women who are willing to pay the social marketing price for IUDs, injectables, and implants disaggregated by the two economic status variables. Across all of the groups, women are much less willing to pay the social marketing price for implants than for injectables or IUDs. Among the formal sector workers, government workers, and urban not poor women, there is little difference in willingness to pay the social marketing price for IUDs and injectables. On the other hand, there is a moderate difference between IUDs and injectables among less advantaged women.

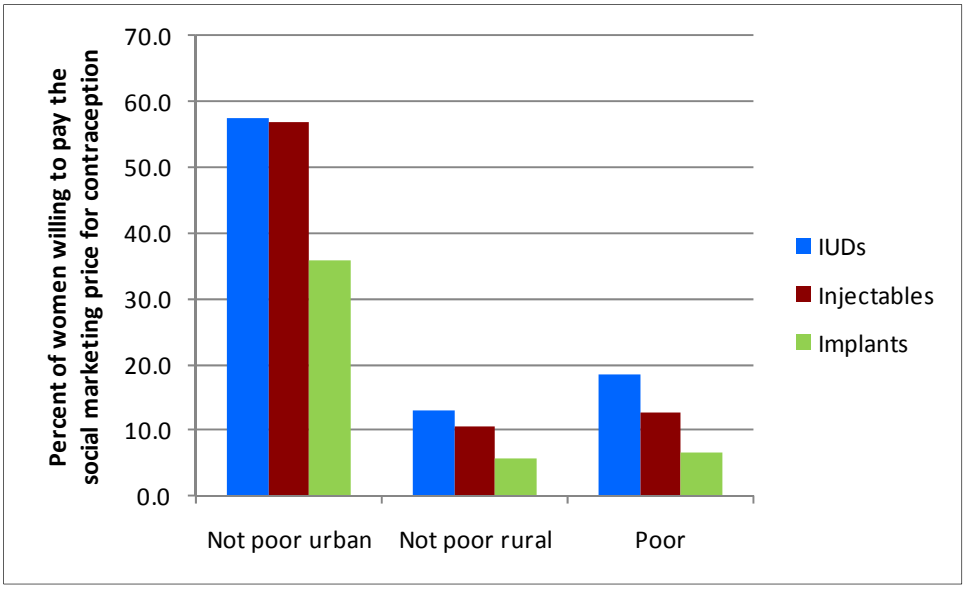

Figure 10: Percentage of family planning users who are willing to pay the social marketing price for family planning services at government clinics disaggregated by poverty status and location, all women, VSPS 2009.

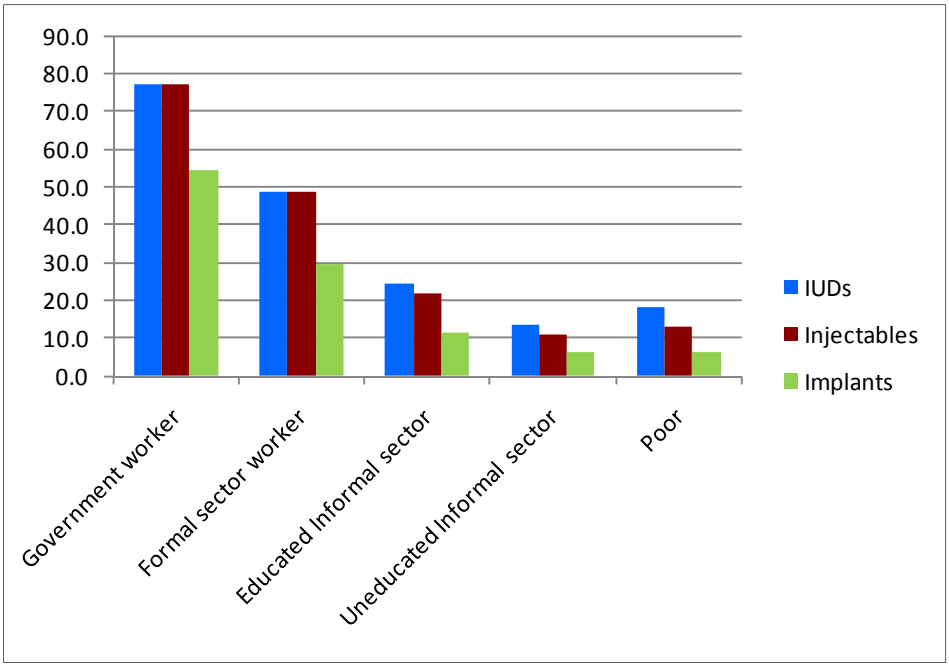

Figure 11: Percentage of family planning users who are willing to pay the social marketing price for family planning services at government clinics disaggregated by poverty status and job classification, All women, VSPS 2009

D. Intention to use family planning

The women using non-clinical methods or not using family planning were asked if they were willing to use clinical family planning methods in the future. Table 3 presents the preferred future clinical method of family planning among these women. Among all three groups of non-users of clinical methods, 60 percent say that they do not intend to use a clinical method in the future. Among non-users of family planning, there is a definite preference for IUDs. Among pill and condom users, the preference for IUD or injectables is about the same. Less the 10 percent of each of the three groups stated a preference for implants.

Table 3: Intention to use clinical methods of family planning among women not currently using clinical methods, Vietnam Self-Paying Survey (VSPS) 2009

	Not currently using family planning	Using pills	Using condoms
Do not intend to use a clinical method	60.3	57.0	59.5
Intend to use IUD	25.5	18.7	18.3
Intend to use injectables	6.2	15.5	18.3
Intend to use implants	8.1	8.8	4.0
Number of observations	1,217	193	126

Figure 12 presents the percentage of women who are willing to pay for family planning at government clinics. About 20 percent of the women who say they would use IUDs are willing to pay something. About 40 percent of women who do not intend to use clinical methods say that they would be willing to pay something for clinical services. Similarly, women who intend to use injectables or implants say they are willing to pay something for such services.

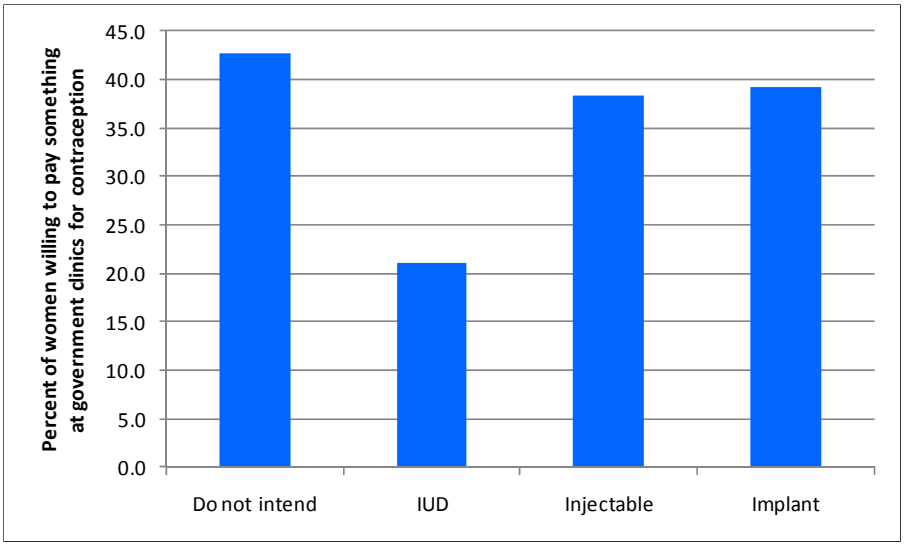

Figure 12: Percentage of women who are willing to pay for family planning services at government clinics disaggregated by intended method of use, among women NOT using clinical methods, VSPS 2009.

Figure 13 presents the percentage of women who are willing to pay the social marketing price for their intended method of family planning at government clinics. Less than 15 percent of women intending to use IUDs or implants say they would pay the social marketing price. About 22 percent of women intending to use injectables say they would pay the social marketing price. These are very small percentages and are perhaps indicative that user fees would discourage women from shifting to more effective methods of family planning.

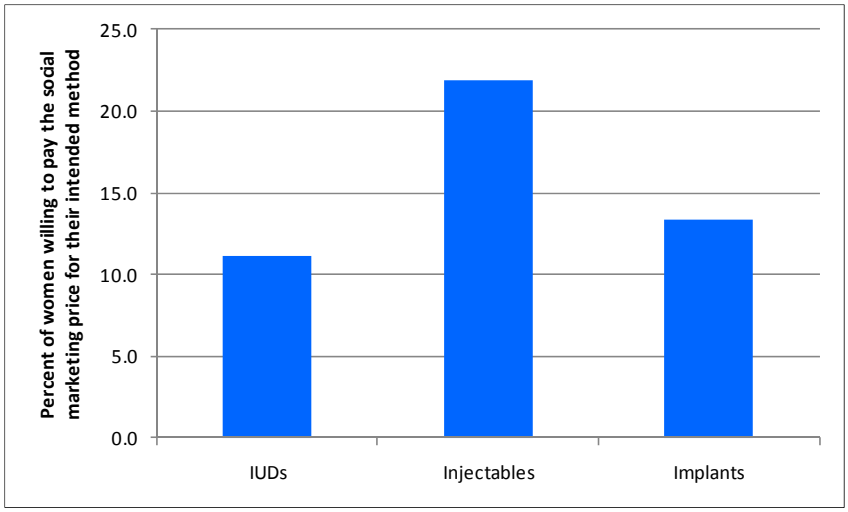

Figure 13: Percentage of women who are willing to pay the social marketing price for their intended method at government clinics, among women NOT using clinical methods, VSPS 2009.

Chapter 4: Discussion

The previous sections described in some detail the willingness to pay for contraceptive services at government clinics. Several observations were striking among the results:

- IUD users in the VSPS sample are relatively wealthy and are quite prominent among government workers and other workers in the formal sector. This contrasts with the VMICS 2006 which showed that poor women are more likely to use IUDs than wealthy women. The results of this analysis should not be extrapolated beyond the specific user groups interviewed.
- IUD users who are government workers and other workers in the formal sector would be good targets for instituting user fees. On the other hand, the great mass of poor users of IUDs needs to be investigated further.
- Many pill and condom users have paid for their services in the past. Also, it seems that many women who are not currently using contraception have paid for services in the past. This indicates that user fees might not lead to declining levels of use or that new users of clinical methods would not be averse to the idea of paying for their services.
- There is a high willingness to pay for contraceptive services among the urban not poor and women working in the government and other workers in the formal sector.
- Willingness to pay is much less among the rural, the poor, and women in informal sector jobs.
- Willingness to pay for clinical methods among women who intend to use clinical methods in the future is very low.

A perceived danger of implementing user fees in government clinics is that some women will discontinue use of family planning. If user fees were implemented and all of the women who said they are unwilling to pay in fact quit using, there would be a large decline in family planning use. The author of this report does not believe that all such women would quit using family planning. In Vietnam, the motivation to use family planning is strong and the inclination toward smaller, healthily spaced children is solid. On the other hand, use of more effective methods including IUDS, injectables, and implants may be discouraged by implementation of user fees. Again, as noted above, the VSPS 2009 interviewed IUD users who are disproportionately wealthy, and care should be taken with women who are not government workers or working in the formal sector.

There is valid concern for certain segments of the population. The findings of this report are perhaps instructive for how a phased implementation of user fees might be conducted. First, there seems to be a dichotomy in willingness to pay between women who have steady jobs with regular paychecks and those whose wages are less secure in the informal sector. If fees were implemented, clinics could potentially offer subsidies to women who are poor, are not working, or are working in informal sector jobs. Also, first time users of a clinical method might need a price break to incentivize their use.

Second, there seems to be a location dichotomy between women who live in rural areas versus those who live in urban areas. A scheme with differentiated fees based on location might be useful. One possibility would be to simply differentiate between urban and rural locations. Another possibility is to segment the population on a regional basis. Table 4 presents profiles of

women based upon their provincial/city location. Ha Noi and Ho Chi Minh are both extremely urban and have an economic profile consistent with a high willingness to pay (i.e., government and formal sector workers).

In the last three lines of the table, we see that almost all women in Ha Noi are willing to pay the social marketing price for IUDs and injectables. On the other hand, in Ho Chi Minh less than 30 percent of women are willing to pay the social marketing price for IUDs or injectables. In Hoa Binh, Dong Thap, and Gia Li the percentage of women willing to pay the social marketing price is low, as would be predicted by the urban/rural mix of the provinces and the economic status of the women.

A potential strategy based on this provincial analysis would be to implement the user fees first in Ha Noi and Ho Chi Minh. In Ha Noi, the user fees could be implemented without much fanfare. In Ho Chi Minh there could be some initial resistance, meaning that a communication strategy might be needed. Another point of concern is that in all of the provinces including Ho Chi Minh and Ha Noi, about 10 percent of the population identifies themselves as poor. Special allowances might be considered for this segment of the population.

Table 4: Ability and willingness to pay profiles of women by province (VSPS) 2009

	Hoa Binh	**Dong Thap**	**Ho Chi Minh**	**Gia lai**	**Ha Noi**
Socio-economic group (percent of total)					
Government worker	5.3	2.6	15.1	3.5	55.6
Formal sector worker	5.3	8.0	23.5	8.7	30.3
Educated Informal sector	59.0	24.5	36.9	50.7	6.5
Uneducated Informal sector	18.7	53.5	12.7	26.6	0.0
Poor	11.9	11.5	11.8	10.4	7.7
Total	100.0	100.0	100.0	100.0	100.0
Location by wealth status (percent of total)					
Not poor urban	0.1	0.1	87.7	46.8	91.2
Not poor rural	88.0	88.4	0.5	42.8	1.1
Poor	11.9	11.5	11.8	10.4	7.7
Total	100.0	100.0	100.0	100.0	100.0
Percent Urban	0.7	0.1	99.6	49.9	98.9
Percent willing to pay social marketing price					
IUD	13.5	17.4	29.1	15.1	95.5
Injectable	11.0	13.0	26.7	15.2	95.4
Implant	7.2	6.9	14.0	6.8	64.7
Number of observations	877	1010	881	883	819

References

1. General Statistics Office (GSO). *Viet Nam Multiple Indicator Cluster Survey 2006, Final Report*. Ha Noi, Viet Nam: GSO; 2006.

2. Population-Family Planning Department of GOPFP,Military Medicine Institute. 2009. “Evaluation of the self-paying ability to pay for clinical contraceptive.” Unpublished.

Appendix

Appendix Table 1 : Willingness to pay for IUDs (VSPS) 2009

	Not willing to pay anything	Below 9,500 Vnd	9,500 Vnd	Total	Observations
Not using	65.4	6.8	27.8	100	1217
IUD	40.7	14.8	44.5	100	1869
Injectable	62.4	17.6	20.0	100	755
Implant	56.1	23.6	20.3	100	310
Pill	50.8	22.3	26.9	100	193
Condom	60.3	16.7	23.0	100	126
Not poor urban	34.9	7.6	57.5	100	1935
Not poor rural	66.9	20.2	12.9	100	2056
Poor	67.9	13.8	18.4	100	479
Government worker	18.2	4.6	77.1	100	691
Formal sector worker	43.7	7.7	48.6	100	659
Educated Informal sector	55.7	20.3	24.1	100	1590
Uneducated Informal sector	71.6	15.0	13.4	100	1051
Poor	67.9	13.8	18.4	100	479
Method of intended use:					
Do not intend	57.3	7.9	34.7	100	919
IUD	78.9	10.0	11.1	100	369
Injectable	61.7	16.4	21.9	100	128
Implant	60.8	13.3	25.8	100	120
Ever paid for contraception	55.79	14.96	29.26	100	987
Never paid for contraception	43.87	10.94	45.19	100	3483
Ever paid for IUD	54.55	14.85	30.6	100	732
Never paid for IUD	46.04	10.11	43.85	100	3783

Appendix Table 2 : Willingness to pay for Injectables (VSPS) 2009

	Not willing to pay anything	Below 16,500 Vnd	16,500 Vnd	Total	Observations
Current use of family planning					
Not using	65.4	8.1	26.5	100	1217
IUD	40.7	16.6	42.6	100	1869
Injectable	62.4	22.1	15.5	100	755
Implant	56.1	24.5	19.4	100	310
Pill	50.8	22.3	26.9	100	193
Condom	60.3	16.7	23.0	100	126
Not poor urban	34.9	8.3	56.8	100	1935
Not poor rural	66.9	22.6	10.6	100	2056
Poor	67.9	19.4	12.7	100	479
Government worker	18.2	4.8	77.0	100	691
Formal sector worker	43.7	7.7	48.6	100	659
Educated Informal sector	55.7	22.5	21.9	100	1590
Uneducated Informal sector	71.6	17.4	11.0	100	1051
Poor	67.9	19.4	12.7	100	479
Ever paid for contraception	55.79	16.25	27.96	100	987
Never paid for contraception	43.87	15.3	40.83	100	3483
Method of intended use:					
Do not intend	57.34	9.14	33.51	100	919
IUD	78.86	11.38	9.76	100	369
Injectable	61.72	16.41	21.88	100	128
Implant	60.83	13.33	25.83	100	120
Ever paid for Injectable	53.71	16.22	30.07	100	180
Never paid for Injectable	40	11.67	48.33	100	4290

Appendix Table 3 : Willingness to pay for Implants (VSPS) 2009

	Not willing to pay anything	Below 495,00 Vnd	495,000 Vnd	Total	Observations
Current use of family planning					
Not using	65.4	18.7	15.9	100	1217
IUD	40.7	32.5	26.8	100	1869
Injectable	62.4	24.6	13.0	100	755
Implant	56.1	31.6	12.3	100	310
Pill	50.8	43.0	6.2	100	193
Condom	60.3	36.5	3.2	100	126
Not poor urban	34.9	29.2	35.9	100	1935
Not poor rural	66.9	27.3	5.8	100	2056
Poor	67.9	25.7	6.5	100	479
Government worker	18.2	27.4	54.4	100	691
Formal sector worker	43.7	26.6	29.7	100	659
Educated Informal sector	55.7	33.1	11.3	100	1590
Uneducated Informal sector	71.6	22.4	6.1	100	1051
Poor	67.9	25.7	6.5	100	479
Method of intended use:					
Do not intend	57.3	23.4	19.3	100	919
IUD	78.9	16.8	4.3	100	369
Injectable	61.7	38.3	0.0	100	128
Implant	60.8	25.8	13.3	100	120
Ever paid for contraception	55.8	27.2	17.1	100	987
Never paid for contraception	43.9	30.6	25.5	100	3483
Ever paid for Implant	53.5	27.9	18.6	100	70
Never paid for Implant	34.3	28.6	37.1	100	4400