ARTICLES

Measuring Family Planning Program Effort At the Provincial Level: A Vietnam Application

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Context: *Measures of family planning program effort have been obtained repeatedly in cross-country comparisons, but never for comparisons within a country. This method may be a valuable tool for tracing subarea program changes over time.*

Methods: *Family planning program efforts were assessed in 15 Vietnamese provinces that are part of a nationwide population and family health project. Thai Binh, a province with a strong program, was added to the study for comparison purposes. Eight officials in each selected province completed questionnaires from which various items were combined and scored on a scale from zero to four, resulting in 34 indices of program functioning. A single score for each index was calculated, based usually on the mean of the responses in each province.*

Results: *The mean program effort score across all 15 provinces and all 34 indices was 2.5, compared with a mean of 3.6 in Thai Binh, the comparison province. Standard deviations across the 34 indices ranged from 0.7 to 1.4 for the study provinces, compared with a standard deviation of only 0.6 for Thai Binh, indicating considerable variation within most of the provincial programs. Policy and administrative functioning was strong across provinces (mean score, 3.3), as were program operations such as information, education and communication activities and task execution (3.5 and 3.4, respectively). Contraceptive availability varied according to method: While the IUD was widely available across provinces (mean score, 3.3), access to methods such as the pill, the condom and male and female sterilization was limited. Private-sector involvement was weak in all provinces. Method choice was considerably broader in the South than in the North, but program effort in general was not strongly related to this division or to the overall level of provincial economic development.*

Conclusions: *This first within-country application of the program effort indices demonstrates the feasibility of provincial analysis of program effort for identifying program inputs and for comparing degrees of effort. It suggests that in Vietnam the primary determinants of effort strength concern leadership, administration and implementation methods, rather than environmental context.*

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The nature and strength of Vietnam's family planning program varies from province to province. The program is centrally administered from Hanoi, but there is no regional administrative structure to tailor directives or support their enforcement in the country's 63 provinces. Consequently, a certain amount of autonomy exists in the management and implementation of the national family planning program at the provincial level. It is therefore of interest to assess how the provincial family planning programs differ from each other and what the different patterns may suggest for program improvements.

While the family planning program efforts of some 100 developing countries have been measured and compared over time,[1] a similar analysis has never been applied within a single country. In 1995, the Institute of Sociology in Hanoi decided to examine the program efforts of 15 Vietnamese provinces selected for a World Bank project to strengthen their family planning and reproductive health programs. These 15 provinces represent nearly one-third of the population of Vietnam.

This within-country comparison of provincial family planning program efforts will provide a comprehensive picture of program functioning at the outset of the project. The profile of strengths and weaknesses that emerges from the assessment can guide changes in policies and in program administration. Moreover, repetition of the assessment in a few years can establish time trends useful for the project's overall evaluation. In addition, the methodological experience gained from this study may encourage applications in other countries.

Methods

The sample included 15 provinces identified by the Vietnamese government and the World Bank for the Population and Family Health Project. An additional province, Thai Binh, which is generally acknowledged to have an exceptionally strong family planning program, was added to this investigation to provide a standard for comparison. Data on the family planning program efforts of each province were collected in October and December 1996 from eight governmental officials in each provincial capital.*

A closed-ended questionnaire based upon a strict translation of the instrument used in the international studies[2] was employed for the within-country analysis. The original instrument included roughly 120 items. For the provincial study, several irrelevant items were deleted, and the remaining items were converted into 34 indices, covering six program effort areas: policy and administrative support; outreach; private-sector involvement; pro-

*The officials selected for interview in each provincial capital were two officers from the Provincial Committee for Population and Family Planning; one health officer and one staff member of the Family Planning Center in the Ministry of Health; one officer from the Interdepartmental Planning Committee; one from the General Statistics Office; one from the Education Ministry; and one from the Culture Ministry (the Ministry responsible for overseeing much of the mass media, including TV, radio and print materials).

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gram operations; evaluation and recordkeeping; and method availability. Measures of method availability included two items for each of six contraceptives: one item measuring the availability of the method through program facilities and one measuring the availability of the method through all sources in the province, including both program and private-sector sources.

Research staff met with respondents twice during data collection: once to give participants the written questionnaire and provide detailed instructions about how to complete it, and again three days later to collect the questionnaire. Research staff also used these follow-up meetings to clarify the objectivity of respondents' assessments. No officials refused to participate, although some individuals who were unavailable during field visits were replaced with other respondents.

Each index was generated from one or more items on the questionnaire and was scaled to range from zero to four. A rating of four indicated that the program's strength on that feature was at or near maximum. The availability of each contraceptive method was measured as the percentage of the population having reasonable access to that method, which was then divided by 20 to obtain the score. Any percentage of 80 or higher was scored as four.

Responses from participants in each province were combined to produce a single score, typically the mean value. If a particular response departed considerably from the others or was considered highly improbable, it was omitted. Respondents were asked to ignore questions for which they had no information; therefore, some scores were based on fewer than eight replies. Missing scores for individual provinces were imputed based on ratios of scores across all provinces; 4% of the total entries in the full matrix of scores were imputed.

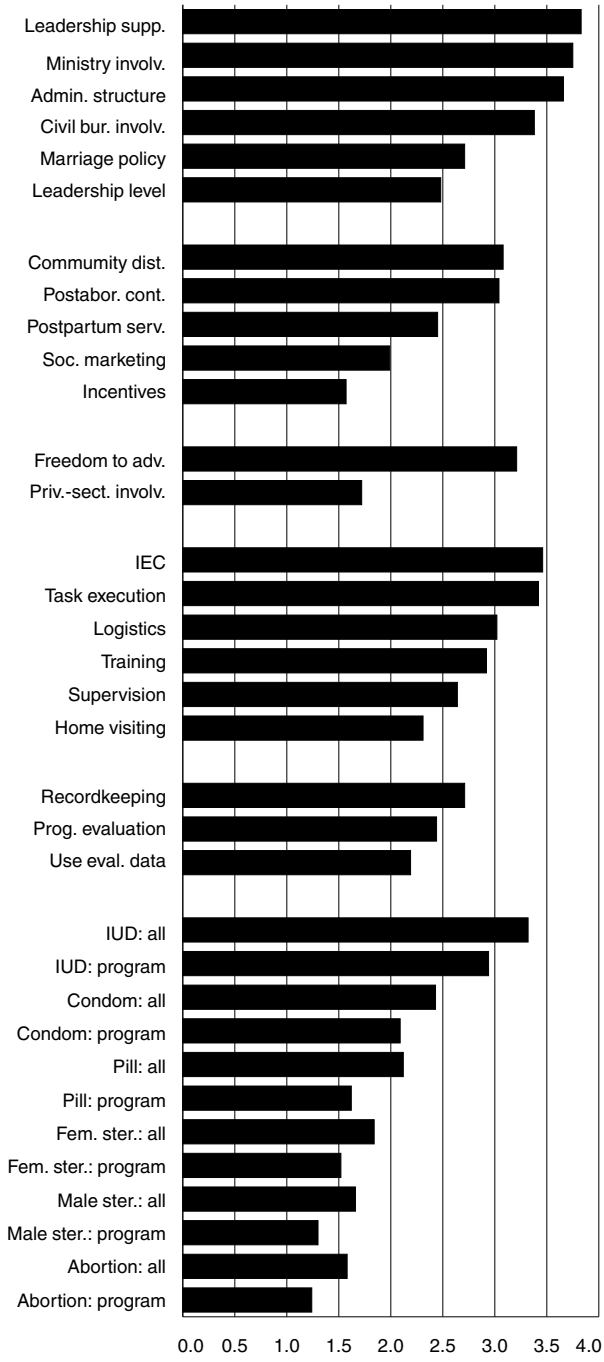
The questionnaire and the coding system included certain protections against potential biases in the data that might lead to over- or underestimation of program effort: For example, many questions, such as the formal position title of the program director or the list of ministries involved in the program, are objective in nature. In addition, the questionnaire contains some 120 items, and neither the respondents nor the interviewers knew which items would be grouped to produce each index. Moreover, neither interviewers nor respondents knew the coding rules for converting responses to scores. Finally, we discounted responses that departed significantly from the mean. While these protections cannot provide a full guarantee against bias, they proved useful in assuring accuracy in the international studies.[3]

Results

The overall mean program effort score for the 15 selected provinces was 2.5 (Table 1, page 6). Mean effort scores for the selected provinces ranged from 1.9 for Dac Lac province to 3.1 for Dong Thap. In comparison, the mean program effort score for Thai Binh province was 3.6.

Some provinces were more erratic in their efforts than others: The standard deviation of the program effort scores for each of the 15 provinces ranged from 0.7 in Lam Dong to 1.4 in Thanh Hoa. In contrast, the standard deviation of the effort score for Thai Binh province was 0.6, indicating greater uniformity in the generally high level of functioning of this program.

Figure 1. Mean family planning program effort scores of 15 selected Vietnamese provinces, by program index



Note: For complete program index labels, see Table 1.

Program Features

Among all provinces, family planning program effort varied considerably from one program feature to another (see Figure 1) In general, the provincial programs scored highest on measures of policy and administrative support such as leadership support, ministry involvement, adequacy of administrative structure and use of the civil bureaucracy (mean program area score, 3.3). Provincial programs varied more in outreach: Most programs scored moderately high in community-based distribution and the provision of postabortion contraception (mean scores, 3.1 and 3.0, respectively), moderately low on the provision of postpartum contraceptive information and services (2.5) and poorly on social marketing and the use of incentives* (2.0 and 1.6, respectively).

The provincial programs scored moderately high on freedom to advertise (3.2), but quite low on use of the private sector

* Several types of incentives exist in much of the Vietnam family planning program, but the wording of the questionnaire may not have led respondents to report on these specific types.

Table 1. Mean family planning program effort scores, by program area and index, according to selected provinces, Vietnam, 1996

Program area and index	Total mean	Northern provinces									Southern provinces								Thai Binh
		Mean	Tuyen Quang	Lai Chau	Lao Cai	Bac Thai	Hai Phong	Hai Hung	Nam Ha	Thanh Hoa	Mean	Thua Thien	Dac Lac	Lam Dong	Dong Thap	Vinh Long	Tra Vinh	Kien Giang	
Overall mean	**2.5**	**2.5**	**2.6**	**2.7**	**2.1**	**2.4**	**2.5**	**2.9**	**2.6**	**2.1**	**2.6**	**2.4**	**1.9**	**2.9**	**3.1**	**2.2**	**2.7**	**2.7**	**3.6**
Standard deviation	**0.99**	**0.90**	**0.94**	**0.81**	**1.27**	**1.15**	**1.22**	**0.75**	**0.91**	**1.36**	**0.67**	**1.00**	**0.94**	**0.72**	**1.13**	**0.90**	**0.82**	**0.89**	**0.58**
Policy/administrative support	**3.3**	**3.4**	**3.3**	**3.2**	**3.3**	**3.2**	**3.4**	**3.5**	**3.4**	**3.5**	**3.2**	**3.3**	**2.8**	**3.4**	**3.6**	**3.0**	**3.4**	**3.1**	**3.7**
Leadership support	3.8	3.9	4.0	4.0	4.0	3.5	4.0	3.8	3.8	4.0	3.8	4.0	3.3	4.0	3.8	3.8	3.8	4.0	4.0
Ministry involvement	3.7	3.9	4.0	4.0	4.0	4.0	3.6	4.0	3.3	4.0	3.6	3.9	3.9	3.4	3.9	3.7	3.5	3.1	3.9
Administrative structure	3.7	3.9	4.0	4.0	4.0	4.0	3.7	3.8	4.0	4.0	3.3	3.5	2.5	3.4	3.2	3.3	3.8	3.7	3.5
Civil bureaucracy involvement	3.4	3.6	3.6	3.5	3.8	3.6	3.6	3.6	3.6	3.4	3.2	3.3	3.1	3.2	3.3	2.2	3.5	3.6	4.0
Marriage-age policy	2.7	2.7	2.5	2.0	2.0	2.3	3.4	3.3	3.5	2.5	2.8	2.8	1.7	2.7	3.7	2.8	3.4	2.3	3.3
Leadership level	2.5	2.3	2.0	2.0	2.0	2.0	2.3	2.5	2.3	3.3	2.7	2.5	2.3	3.4	3.7	2.3	2.5	2.3	3.3
Outreach	**2.4**	**2.4**	**2.2**	**2.2**	**2.2**	**2.6**	**3.0**	**2.5**	**2.7**	**1.7**	**2.5**	**3.2**	**2.1**	**2.2**	**2.4**	**2.3**	**2.6**	**2.5**	**3.3**
Community-based distribution	3.1	3.1	2.7	4.0	2.4	3.6	3.0	4.0	3.2	1.7	3.1	3.4	3.1	2.5	4.0	2.6	3.8	2.2	4.0
Postabortion contraception	3.0	2.9	3.4	2.3	3.5	3.4	2.8	2.2	3.3	2.5	3.2	3.1	3.4	3.9	4.0	2.9	1.5	3.3	3.8
Postpartum services	2.5	2.4	2.3	1.5	1.9	2.9	3.5	2.9	2.7	1.8	2.5	3.1	1.3	2.3	3.5	2.2	2.6	2.4	3.9
Social marketing	2.0	2.0	1.4	1.0	1.5	2.0	4.0	1.5	3.4	1.2	2.0	3.8	0.7	1.0	0.1	2.7	3.2	2.5	3.0
Use of incentives	1.6	1.5	1.0	2.4	1.7	1.1	1.7	2.1	0.9	1.1	1.6	2.4	1.9	1.3	0.4	1.3	2.1	2.1	1.9
Private-sector activity	**2.5**	**2.4**	**2.3**	**2.5**	**1.9**	**2.0**	**1.7**	**2.6**	**3.4**	**2.6**	**2.6**	**2.4**	**2.6**	**2.8**	**2.2**	**2.7**	**2.6**	**2.7**	**2.7**
Freedom to advertise	3.2	3.0	2.8	3.3	3.1	2.3	2.3	3.3	3.8	3.7	3.4	3.7	3.3	3.4	2.7	3.3	3.8	3.8	4.0
Private-sector involvement	1.7	1.7	1.8	1.8	0.6	1.8	1.2	1.9	3.0	1.5	1.7	1.1	2.0	2.2	1.8	2.1	1.4	1.7	1.4
Program operations	**3.0**	**3.1**	**3.1**	**3.1**	**3.1**	**3.4**	**3.2**	**3.5**	**2.7**	**2.9**	**2.8**	**2.8**	**2.2**	**2.7**	**3.2**	**2.3**	**2.8**	**3.5**	**3.7**
Information, education and communication	3.5	3.6	3.4	3.8	3.4	3.9	3.8	3.6	3.5	3.5	3.3	3.3	3.4	3.2	3.3	3.0	3.2	3.6	3.9
Task execution	3.4	3.6	3.6	3.7	3.8	4.0	3.5	4.0	2.7	3.6	3.2	2.9	2.3	3.0	3.5	3.3	3.7	3.8	4.0
Logistics	3.0	2.9	2.8	2.4	2.5	2.8	3.9	3.1	2.9	2.9	3.2	3.1	2.0	3.6	3.8	3.7	2.6	3.3	3.8
Training	2.9	3.3	3.1	3.4	3.6	4.0	2.6	3.9	2.4	3.0	2.5	2.5	2.4	2.5	3.0	0.7	2.7	4.0	4.0
Supervision	2.6	2.9	3.4	2.8	2.6	2.9	2.7	3.8	2.9	2.4	2.3	2.4	2.1	1.7	3.0	1.7	2.2	3.3	3.3
Home visiting	2.3	2.5	2.4	2.3	2.3	3.0	3.0	2.6	2.0	2.0	2.1	2.6	1.2	2.3	2.6	1.1	2.3	2.9	3.3
Recordkeeping/evaluation	**2.4**	**2.5**	**2.2**	**2.5**	**1.8**	**2.2**	**3.1**	**2.4**	**2.7**	**2.8**	**2.4**	**2.8**	**2.0**	**3.1**	**3.2**	**1.4**	**2.4**	**2.2**	**3.4**
Recordkeeping system	2.7	2.6	2.3	2.9	1.9	2.7	2.8	2.8	3.1	2.6	2.8	3.0	2.3	2.8	3.3	2.5	2.9	2.8	3.3
Program evaluation	2.4	2.7	2.8	3.0	2.6	2.9	2.7	2.6	2.1	2.7	2.2	2.8	1.9	2.9	2.7	0.9	2.2	2.1	3.7
Use of evaluation data	2.2	2.1	1.4	1.4	0.9	1.1	3.8	1.8	2.8	3.3	2.3	2.5	2.0	3.7	3.6	0.7	2.0	1.9	3.3
Method availability	**2.0**	**1.8**	**2.2**	**2.5**	**1.0**	**1.8**	**1.2**	**2.6**	**1.9**	**0.9**	**2.2**	**1.4**	**1.2**	**3.0**	**3.3**	**1.8**	**2.4**	**2.3**	**3.8**
IUD																			
All sources	3.3	3.5	3.8	3.1	3.1	4.0	2.8	3.5	3.8	3.9	3.1	2.7	2.4	3.4	4.0	3.0	2.8	3.7	4.0
Program sources	2.9	3.1	3.7	2.8	2.7	4.0	2.4	3.3	2.6	3.1	2.8	2.1	2.2	2.9	4.0	2.6	2.4	3.4	3.9
Condom																			
All sources	2.4	2.0	2.1	3.2	1.2	1.1	2.6	3.0	2.0	0.9	2.9	2.1	1.6	3.9	4.0	2.3	3.6	2.9	4.0
Program sources	2.1	1.7	1.9	2.8	1.1	0.9	1.9	2.4	1.6	0.6	2.6	1.6	1.4	3.4	3.9	1.8	3.4	2.8	3.8
Pill																			
All sources	2.1	1.8	3.1	2.5	0.9	3.0	0.4	2.3	1.8	0.7	2.4	1.4	1.4	3.4	4.0	1.8	2.8	2.5	3.8
Program sources	1.6	1.5	2.8	2.2	0.8	2.8	0.3	1.8	1.1	0.2	1.8	0.6	1.5	2.6	2.4	1.4	2.1	1.8	3.5
Female sterilization																			
All sources	1.8	1.4	1.3	2.7	0.5	1.0	0.5	2.9	1.9	0.4	2.3	1.4	0.9	2.7	4.0	1.9	2.9	2.6	4.0
Program sources	1.5	1.1	1.1	2.5	0.4	0.8	0.5	2.0	1.0	0.3	2.0	0.9	0.7	2.5	4.0	1.3	2.5	2.3	3.9
Male sterilization																			
All sources	1.7	1.2	1.2	2.0	0.1	0.7	0.5	2.8	1.6	0.4	2.2	1.3	0.4	2.6	4.0	1.7	2.9	2.8	3.9
Program sources	1.3	0.8	0.9	1.7	0.1	0.5	0.2	2.0	0.9	0.1	1.9	0.8	0.4	2.1	4.0	1.1	2.3	2.4	3.8
Abortion																			
All sources	1.6	1.8	2.4	2.1	0.9	1.6	1.3	3.5	2.9	0.1	1.3	1.1	0.9	3.3	0.8	1.4	1.0	0.5	3.7
Program sources	1.2	1.4	2.2	1.9	0.6	1.5	1.2	2.3	1.8	0.1	1.0	1.0	0.7	2.8	0.8	1.2	0.6	0.3	3.5

(1.7). Program operations such as information, education and communication efforts and proper task execution by staff received high scores overall (3.5 and 3.4, respectively), but mean scores for logistics and training were moderate (3.0 and 2.9, respectively), and those for supervision (2.6), recordkeeping and evaluation (2.4) and home visits (2.3) were moderately low.

The most serious shortfall in nearly all of the provincial programs was the limited availability of contraceptive methods. Even when all public and private sources were considered, the IUD was the only method that women generally had reasonable access to (mean score, 3.3). The IUD historically has been the mainstay of Vietnam's national family planning program; it is used by nearly 40% of all couples, a level unmatched by most other countries.[4]

Effort scores for the availability of all other methods reveal Vietnamese women's limited access to a suitable range of contraceptive options. Mean availability scores for reversible methods such as the pill and the condom were low, both for program sources (1.6 and 2.1) and for all sources (2.1 and 2.4). Mean availability scores also were low for both male and female sterilization for program sources (1.3 and 1.5) and for all sources (1.7 and 1.8). Availability scores for abortion were lower than those for any of the contraceptive methods. However, this finding conflicts with national data indicating that abortion (including menstrual regulation) is used quite extensively.[5]

The 15 provinces differed considerably more on measures of contraceptive availability than they did on other indices of program effort: The standard deviations across provinces for nearly all measures of

contraceptive availability were well above those for the other indices (not shown). This is partly due to the surprisingly high method availability scores in Dong Thap; however, the other provinces still vary within a limited range of availability scores for all methods except the IUD.

The method availability scores for program sources compared with all sources differed little for most of the 15 provinces, indicating that private-sector involvement in the provision of contraceptives remains limited; methods in these provinces are available predominantly through clinic facilities, mobile teams and field workers. The difficult terrain and dispersed mountain settlements common in many provinces present obstacles to the development of commercial outlets and private medical practices; moreover, some ambivalence toward private initiatives persists in government circles.

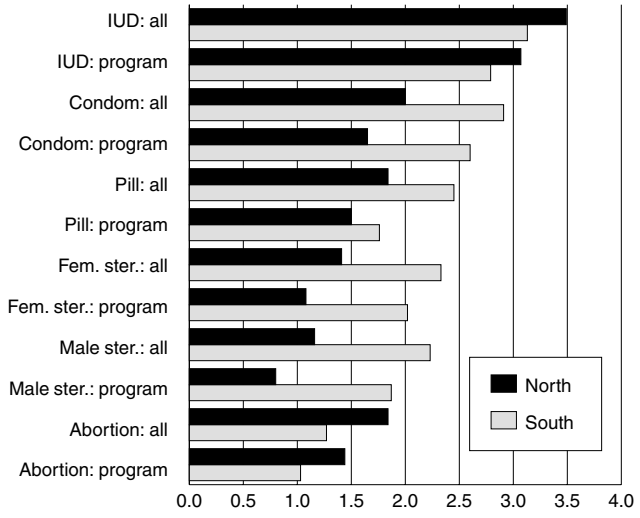
The pattern of program functioning characteristic of the 15 provinces corresponds with the overall functioning of the national family planning program, as described by a leading Vietnamese analyst:[6] Central policy features and basic implementation of the program through the administrative structure and the civil bureaucracy are strong, as are information, education and communications efforts; less emphasis is placed on training, logistics and supervision; outreach activities such as community-based service delivery and provision of postabortion contraception are relatively weak; and home visiting has not been implemented systematically. In addition, private-sector involvement is weak, and use of data for program evaluation and management is not very impressive. Thus, although the 15 provinces were selected because of their need for program revitalization, they share many characteristics of the overall functioning of the national family planning program.

North vs. South

Vietnam's national family planning program reflects a combination of the separate approaches that existed in the North and in the South before the country's unification in the mid-1970s. The family planning program that had been established in the North focused on use of the IUD, with abortion as a backup. After unification, this program was extended to the South, where traditional methods and commercial availability of modern contraceptives had always played a larger role.[7] The fundamental differences that characterized these programs persist to a degree today and continue to have an impact on contraceptive practice.

We compared program effort scores according to region to examine whether these differences would emerge within the selected group of 15 provinces. While patterns were similar between the two regions, there were important exceptions. The northern provinces were more likely than the southern provinces to score high on IUD and abortion availability, but the southern provinces scored much higher on other measures of contraceptive availability, notably provision of the pill, the condom and both male and female sterilization (Figure 2). Evidently, the southern provinces pursue a more even-handed approach to method availability, offering couples a more balanced set of options.

Figure 2. Mean program effort scores for contraceptive method availability, by method and method source, according to region



Note: For complete program index labels, see Table 1.

While the private sector has traditionally been stronger in the South, method availability scores do not show large regional differences in the ratio of all sources to program sources. Only for the pill does the South show a decided advantage over the North in the added availability that all sources afford.

The South provides a better balance of method choices than does the North. However, the North is somewhat stronger than the South on policy and administrative indices such as the involvement of multiple ministries, administrative structure and the use of the civil bureaucracy (not shown). Northern provinces also scored relatively high in the program operations area, particularly on supervision, on training and on information, education and communication efforts.

Provincial Subgroups

Apart from the historical influences on program functioning that continue to distinguish the northern and southern provinces, other factors may have an impact upon family planning program operations. Some of the 15 provinces, for example, lie in very poor, mountainous areas, where women cannot easily reach health centers and where mobile teams have difficulty going. Other provinces are located in the lowlands along the eastern coastline, where occupations, living conditions and even sexual customs are quite different from those in the highlands. In addition, some provinces are populated by diverse ethnic groups, while others are homogenous. Lastly, the country, which stretches some 1,000 miles in length, contains sharp climatic differentials that affect the seasonal operation of field programs.

In an effort to capture a small number of the most likely influences upon program strength, we categorized the 15 provinces into three groups according to their characteristic terrain and level of economic development. We then compared the program effort scores of each group. One group was composed of the five most mountainous and least developed provinces, another consisted of five provinces with a partly mountainous terrain and an intermediate level of development, and the third group included the five provinces that were located mainly in the lowlands and had the highest level of development. Northern and southern provinces were distributed across the three groups.

Table 2 (page 8) indicates that the total mean value of the indices for program effort were similar for the three groups (2.4–2.6). All groups scored high on policy and administrative support, as well as on program operations. The groups differed most sharply in the strength of their social marketing activities: The least developed group was the weakest in this area (mean score, 1.1), while the most developed group was the strongest (mean score, 2.8). This pattern was reversed, however, for oral contraceptive availability through program facilities, suggesting that social marketing may

be more vigorous where the provincial program is weakest.

Overall, the three groups were more similar than expected. In fact, effort scores varied substantially within each of the three groups (not shown). Furthermore, when we classified provincial scores according to both subgroup and region, we found that subgroup differences were not accounted for by the differential distribution of subgroup provinces by region. Thus, neither regional nor subgroup influences appear to have an overriding impact on family planning program functioning in these provinces. This suggests that the primary determinants of program effort concern leadership, administration and implementation methods, rather than environmental context.

Table 2. Mean family planning program effort scores, by program area and index, according to provincial subgroup

Program area and index	Least developed*	Intermediate†	Most developed‡
Overall mean (SD§)	**2.43(0.79)**	**2.57(0.82)**	**2.56(0.75)**
Policy/administrative support	**3.21**	**3.41**	**3.29**
Leadership support	3.85	3.80	3.85
Ministry involvement	3.87	3.84	3.54
Administrative structure	3.59	3.70	3.70
Civil bureaucracy involvement	3.41	3.41	3.31
Marriage-age policy	2.18	2.93	3.04
Leadership level	2.34	2.79	2.30
Outreach	**2.18**	**2.49**	**2.61**
Community-based distribution	2.94	3.30	3.01
Postabortion contraception	3.32	2.90	2.90
Postpartum services	1.85	2.78	2.72
Social marketing	1.12	2.03	2.82
Use of incentives	1.65	1.45	1.60
Private-sector activity	**2.42**	**2.37**	**2.61**
Freedom to advertise	3.16	3.22	3.25
Private-sector involvement	1.68	1.51	1.97
Program operations	**2.83**	**3.01**	**3.04**
Information, education and communication	3.44	3.44	3.49
Task execution	3.28	3.51	3.46
Logistics	2.66	3.03	3.37
Training	3.00	3.03	2.72
Supervision	2.50	2.57	2.85
Home visiting	2.11	2.49	2.33
Recordkeeping/evaluation	**2.32**	**2.68**	**2.34**
Recordkeeping system	2.44	2.92	2.79
Program evaluation	2.62	2.65	2.06
Use of evaluation data	1.90	2.49	2.18
Method availability	**1.96**	**1.98**	**1.97**
IUD			
All sources	3.13	3.48	3.34
Program sources	2.84	3.13	2.86
Condom			
All sources	2.40	2.33	2.55
Program sources	2.10	2.08	2.10
Pill			
All sources	2.25	2.35	1.76
Program sources	1.98	1.62	1.26
Female sterilization			
All sources	1.62	1.95	1.96
Program sources	1.43	1.69	1.43
Male sterilization			
All sources	1.24	1.86	1.88
Program sources	1.04	1.54	1.32
Abortion			
All sources	1.91	0.93	1.89
Program sources	1.61	0.77	1.35

*Includes Tuyen Quang, Lai Chau, Lao Cai, Dac Lac and Lam Dong. †Includes Bac Thai, Thanh Hoa, Thua Thien, Dong Thap and Tra Vinh. ‡Includes Hai Phong, Hai Hung, Nam Ha, Vinh Long and Kien Giang. §SD=standard deviation.

Discussion

This first within-country application of program effort indices provides information on both the level and the character of provincial activities. The overall picture presented here conforms well with observations about the functioning of Vietnam's family planning program.[8] Central policy direction and administration are firm and favorable; outreach features and internal program mechanisms can be strengthened; and the availability of methods, except for the IUD, is often poor. In addition, use of the private sector is quite weak in these largely rural provinces.

The findings of this study have clear implications for program improvement under the government's project with the World Bank: Program administration, more than environmental or economic circumstances, determines program strength, even in provinces where extreme conditions hamper the delivery of services. While the improved facilities and equipment that are part of the revitalization project are badly needed, enhancing internal management of the family planning program is equally vital. Training personnel, improving supervision and evaluation, and tightening supply lines all demand continual attention if substantial progress is to be made.

In addition, expanding the contraceptive method mix, especially in the North, will require ongoing effort. Vietnam's family planning program has a deeply imbedded subculture of bureaucratic levels and ministries that still strongly favors the IUD over other modern methods. Modifying this situation—a difficult and long-term project—is critical to correcting the imbalance in contraceptive availability, and must include encouragement of the private sector to expand its offerings and its geographic scope.

A subnational study of program effort performed at the provincial level requires somewhat different methods than an international comparison. It is essential that data be collected through personal contact rather than through the mail, so that research staff can explain the study, reassure respondents and collect replies without delay; also, provincial officials are less accustomed than national staff to objective studies and to formal questionnaires. Two visits by staff were feasible, given the modest number of provinces and their physical proximity.

To safeguard against program bias and to reduce courtesy replies by respondents, we found it best to utilize interviewers who were not program staff, and who were senior enough to establish rapport with provincial officials in the various agencies. The interviewer's approach should be nonthreatening so as to relax the respondents and elicit candid replies.

While there are a number of other useful methods (such as situation analysis[9]) for understanding program operations, provincial measures of program effort can be valuable in several ways. They can provide central personnel with basic information about how specific aspects of program operations differ province by province; furthermore, when repeated over time, they allow for the monitoring of changes in effort. The measures provide a management tool for diagnosing weaknesses and identifying areas in need of remedial action. Similarly, provincial measures of program efforts can identify exceptional performance and thereby facilitate the transfer of strengths across provinces.

Measures of program effort can be useful for assessing special projects as well. The method is appropriate where whole provinces are the unit of analysis for an action project, as the effort scores can serve as a baseline measure. Moreover, the measures can function as management guidelines for provincial officials themselves, and can supplement other information to better identify problem areas. Furthermore, data collection is relatively inexpensive, analysis can be done quickly and results can be presented simply and graphically to provincial leaders.

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Resumen

Contexto: *Se han desarrollado con frecuencia medidas del esfuerzo de los programas de planificación familiar para hacer comparaciones entre diversos países, pero nunca se han comparado estos esfuerzos a nivel nacional. Dicho método puede ser un mecanismo valioso para seguir los cambios que ocurren dentro de un país en el programa a través del tiempo.*

Métodos: *Se evaluaron los esfuerzos realizados en 15 provincias de Vietnam, como parte del proyecto nacional demográfico y de salud familiar. Una provincia adicional, Thai Binh, que cuenta con un sólido programa, fue incluida en el estudio para fines de comparación. Ocho funcionarios en cada una de las provincias seleccionadas completaron cuestionarios, de los cuales se combinaron varios temas y se asignó un puntaje sobre una escala de cero a cuatro, resultando en 34 índices de funcionamiento del programa. Se calculó un puntaje único para cada índice basado generalmente en el promedio de las respuestas de cada provincia.*

Resultados: *El puntaje promedio de los 34 índices en las 15 provincias fue de 2,5, en comparación con el promedio de 3,6 registrado en Thai Binh, la provincia que se usó como modelo para la comparación. Las desviaciones estándar en los 34 índices variaron de 0,7 a 1,4 para las provincias estudiadas, en comparación con una desviación estándar de solamente 0,6 correspondiente a Thai Binh, lo cual indica una variación considerable dentro de la mayoría de los programas provinciales. Las políticas y el funcionamiento administrativo en todas las provincias fue sólido (puntaje medio de 3,3), así como fueron las operaciones tales como actividades de información, educación y comunicación (3,5) y la ejecución de las tareas (3,4). La disponibilidad de anticonceptivos varió de acuerdo con el método: en tanto que el DIU estaba ampliamente disponible en todas las provincias (puntaje medio de 3,3), el acceso era limitado a métodos tales como la píldora, el condón y la esterilización masculina y femenina. La participación del sector privado en cada una de las provincias era débil. La posibilidad de elegir un método fue considerablemente más amplia en el sur que en el norte, aunque el esfuerzo del programa en general no estaba sólidamente relacionado con esta división regional o al nivel general del desarrollo económico de la provincia.*

Conclusiones: *Esta aplicación para evaluar los esfuerzos de un programa que se realiza por primera vez dentro de un país, demuestra que es factible realizar un análisis de los programas provinciales para identificar los insumos de los programas y para comparar los niveles de los esfuerzos realizados. Dicho estudio sugiere que en Vietnam los determinantes básicos de la solidez de los esfuerzos se relacionan con el liderazgo, y los métodos de administración y ejecución, más que el contexto ambiental.*

Résumé

Contexte: *Des mesures de líeffort des programmes de planning familial ont été obtenues dans le cadre de comparaisons transnationales, mais jamais au sein díun mÍme pays. Cette méthode pourrait síavérer utile au suivi des changements affectant les programmes de souszones au fil du temps.*

Méthodes: *Les efforts des programmes de planning familial ont été évalués dans 15 provinces vietnamiennes incluses dans un projet national d'étude démographique et de santé familiale. La province de Thai Binh, qui dispose d'un programme vigoureux, a été ajoutée à l'étude à des fins de comparaison. Dans chaque province sélectionnée, huit représentants officiels ont complété un questionnaire, dont plusieurs éléments ont été combinés et cotés sur une échelle de zéro à quatre, produisant 34 indices de fonctionnement des programmes. Une cote unique a été calculée par indice, sur la base, généralement, de la moyenne des réponses obtenues dans chaque province.*

Résultats: *La cote d'effort de programme moyenne, pour les 15 provinces et les 34 indices, a été calculée à 2,5, par rapport à une moyenne de 3,6 dans la province de référence de Thai Binh. Les écarts types, pour les 34 indices, se sont révélés variables, de 0,7 à 1,4, pour les provinces à l'étude, par rapport à 0,6 seulement à Thai Binh, soulignant une variation considérable au sein de la plupart des programmes provinciaux. Le fonctionnement politico-administratif s'est avéré robuste dans toutes les provinces (cote moyenne de 3,3), de même que les opérations de programme liées aux activités d'information, de sensibilisation et de communication et à l'exécution des tâches (3,5 et 3,4, respectivement). La disponibilité de la contraception s'est révélée variable suivant les méthodes: si le stérilet était largement disponible dans toutes les provinces (cote moyenne de 3,3), l'accès à la pilule, au préservatif et à la stérilisation féminine ou masculine était limité. La participation du secteur privé était faible dans toutes les provinces. Le choix de méthodes était nettement plus vaste dans le sud, mais l'effort général des programmes ne s'est pas révélé étroitement lié à cette division géographique, pas plus qu'au niveau général de développement économique des provinces.*

Conclusions: *La première application intranationale des indices d'effort de programme démontre la faisabilité de l'analyse provinciale de l'effort aux fins de l'identification des apports des programmes et de la comparaison des différents degrés d'effort. Elle laisse entendre, au Viet Nam, que les principaux facteurs de force de l'effort tiennent aux méthodes de direction, d'administration et de mise en œuvre plutôt qu'au contexte environnant.*