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.

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