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APHA CONSULTANT REPORT ON
THE SECOND EVALUATION OF THE
NATIONAL FAMILY PLANNING PROGRAM
IN THAILAND, 1972-76

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(Additional Evaluators are identified in text)

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REPORT OF
THE SECOND EVALUATION OF
THE NATIONAL FAMILY PLANNING PROGRAM (NFPP)
IN THAILAND, 1972-76

Introduction

The Royal Thai Government and USAID had agreed to conduct the Second Evaluation of the NFPP from June 22 to July 23, 1977. The First Joint Evaluation was carried out *in 1975*.

A. Objectives of Evaluation

The evaluation objectives were as follows:

1. To determine whether or not the National population growth rate of 2.5% had been achieved at the end of the Third Five-year National Socio-Economic Development Plan of Thailand (1972-76).
2. To determine if the NFPP had met all of its targets in the Third Plan.
3. To determine if the NFPP had met all of its targets in the Third Plan.
4. To examine closely the inputs being provided by the Royal Thai Government (RTG) and all foreign donors to ascertain the adequacy of these inputs relative to the program purposes and the coordination among donor agencies.
5. To determine what difficulties, if any, the NFPP will have in attaining its goals for the Fourth Plan (1977-81), especially in the light of the possibility of reduced U.S. funding.

B. The Evaluation Team

The Thai-American team was multidisciplinary, composed of representatives from Mahidol University, DTEC, NESDB, BOB, *APHA*, and Columbia University. The name and institution of each team member is as follows:

<u>Name</u>	<u>Institution</u>
1. Dr. Debhanom Muangman (Team leader)	Dean of Faculty of Public Health Mahidol University
2. Dr. Donald Minkler (Co-team leader)	Associate Professor OB/GYN Department University of California School of Medicine, USA (APHA)

- | | | |
|-----|--------------------------|--|
| 3. | Mrs. Saowaros Tongkom | National Economic and Social
Development Board (NESDB)
Prime Minister's Office |
| 4. | Mr. Virat Damrongphol | NESDB |
| 5. | Mr. Poonsup Piya-Anant | Bureau of the Budget (BOB)
Prime Minister's Office |
| 6. | Mr. Sittipan Sripen | BOB |
| 7. | Miss Sumontha Thanyapon | Department of Technical Economic
Cooperation (DTEC)
Prime Minister's Office |
| 8. | Mr. Pichet Soontornpipit | DTEC |
| 9. | Dr. Yawarat Porapakham | Head of Biostatistics Dept.
Faculty of Public Health
Mahidol University |
| 10. | Dr. Orapin Singhadej | MCH Department
Faculty of Public Health
Mahidol University |
| 11. | Miss Kate Lorig, PHN | President of Human Education
Association, USA
APHA |
| 12. | Mr. Terrance Tiffany | Public Health Administration
Consultant
APHA |
| 13. | Dr. Henry Elkins | Social Scientist
Center for Population and
Family Health
Columbia University, USA |

Thus, in the above group, there are Public Health Physicians, Public Health Nurse, Public Administrator, Economists, Biostatisticians, Social Scientist, totalling 13.

C. Methods of Evaluation

The evaluation methodology was as follows:

1. Collection of existing statistical data concerning population and family planning from the public and private sectors.
2. Interviews and meetings with responsible population and family planning personnel in both sectors in urban and rural areas.
3. Site visits by the Evaluation Team to provinces in four regions of Thailand.

The criteria for selection of provinces for site visits were as follows:

1. Visits should cover at least 10% of the total provinces in Thailand and reflect rural communities of each region.
2. Visiting areas for the Evaluation Team should be safe from communist guerrillas and bandits.
3. Transportation and communications in visiting areas should be good.
4. Hotel and food accommodations in the visiting areas should be adequate.
5. Family planning activities in the visiting areas should reflect activities in the region (Appendix 2).

After the team made the decision on the provinces to be visited based on the above criteria, the Family Health Division, Department of Health, Ministry of Public Health was informed and all of the selected provinces were approved with excellent cooperation. In addition, the Family Health Division confirmed its sincere appreciation of the proposed evaluation and gave its assurance of the team's complete freedom for the conduct of the evaluation. The itinerary and dates of provincial site visits by the Team are listed in Appendix 2, and the provinces visited are illustrated in the map, Appendix 3. The categories of the various levels of administrative, service, and training institutions visited are detailed in Appendix 4.

In addition to the above itinerary, various members of the Evaluation Team met with personnel from sections of the Family Health Division of the Ministry of Public Health from four Medical Schools, from the National Statistics office and other relevant organizations.

I. BACKGROUND

A. General Country and Population Information

The Kingdom of Thailand, formerly known as "Siam," is situated in the center of continental South-East Asia. It occupies the total area of 200,000 square miles with a 1976 population of slightly over 43 million. It is one of the few countries that has never been colonized. Eighty-five percent of the population live in rural areas with an average annual per capita income of US\$ 378. Thailand has 71 provinces and is divided geographically into four regions (Appendix 3). The most heavily populated area is the Northeastern Region. In addition, this is the poorest region with the smallest increase in the annual per capita income. (See Appendix 5 for table of the Number of Provinces, Population, and Average Annual Per Capita Income in the four regions of Thailand, 1976.)

Forty-five percent of the Thai population is under 15 years of age, and the average family size is 6.4, and the male is the dominant figure in rural extended families. Ninety-four percent of the Thai are Buddhist with 5 percent Moslem, mostly living in the Southern Region. In terms of education, the primary school enrollment is 95 percent with the majority of children never going beyond the fourth grade. The main occupation is agriculture. The adult literacy rate is about 70 percent. The growth of GDP is about 6.5-7 percent per year. At present the crude birth rate is estimated to be about 35/1,000 with crude death rate of 9/1,000, and the crude growth rate at the end of 1976 approximately 2.6 percent. The urban annual growth rate is 6.5 percent. A population census was carried out for the first time in Thailand in 1911. At that time, it was found that the total population was about 8.2 million. Following this, more country-wide population censuses were done. The last census, accomplished in 1970, showed the population to be about 34.4 million. (See Appendix 6 for table of population censuses and intercensal increase from 1911-1970.)

B. Health Care System in Thailand

The present health care system in Thailand is divided into health agencies in the Public and Private Sectors as follows (see Appendix 7 for table of agencies and their service from Provincial to Village Level):

1. Public Sector (Government or Semi-Government Agencies)

- a. Ministry of Public Health. This ministry was established in 1942 and is responsible for the health of the entire nation. The present organization chart of the Ministry of Public Health is shown in Appendix 8. (See Appendix 9 for table of the present number of hospitals and health centers which belong to the Ministry of Public Health.)

- b. Other Ministries. The major ministries are: Ministry of Defense; Ministry of Interior; Ministry of University Affairs, etc. These ministries are also involved in health service delivery and training of various categories of health workers not under the jurisdiction of the Ministry of Public Health.
- c. State Enterprises. A large number of semi-government organizations have their own hospitals and clinics. In addition, some train their own health workers and offer services to the public.

2. Private Sector (Non-Governmental Agencies)

There are a large number of non-government agencies which offer health services to the population. The 1970 country-wide health survey,¹ revealed that only 17 percent of the people interviewed utilized the government's health services when sick. In addition, in 1976, the Ministry of Public Health officially proclaimed that its health delivery system could cover only 30 percent of the total population. The important health and health-related agencies of the private sector are:

- | | |
|-----------------------------|-----------------------------------|
| (1) Drug companies | (approx. no.= 1,800) ² |
| (2) Drug Stores | (approx. no.=13,000) |
| (3) Private Medical Clinics | (approx. no.= 3,000) |
| (4) Private Hospitals | (approx. no.= 90) |

A 1972 country-wide survey carried out by the Westinghouse Population Center revealed that there are about 30,000 quacks in Thailand. In 1970 it was estimated that the Thai population paid the Public Sector for health services about 1,000 million bahts (US\$ 50 million). The amount paid to the Private Sector was about 5,000 million bahts (US\$ 250 million).³

C. Previous Evaluation of NFPP in 1975

In 1975, a Thai-American Evaluation team composed of representatives from the Institute of Population and Social Research, Mahidol University, DTEC, BOB, NESBD, and USOM/USAID carried out the first evaluation of NFPP. The evaluation team visited nine provinces and gave several recommendations concerning family planning services, and medical supplies and equipment, foreign assistance, record statistics, coordination, demographic impact, etc. The report was then submitted to the MOPH. However, it is noteworthy to report that action was taken on only a few of these worthwhile recommendations up to the present time.

¹ A joint study of the MOH and the Faculty of Public Health.

² MOH figures.

³ Health Planning Division, MOH figures.

RECOMMENDATION:

IN ORDER NOT TO REPEAT SIMILAR MISTAKES, IT IS STRONGLY RECOMMENDED THAT THIS EVALUATION REPORT BE SUBMITTED TO RESPONSIBLE PERSONNEL IN THE MOPH AND EVERY MEMBER OF THE NFPP COMMITTEE FOR SERIOUS CONSIDERATION AND THAT A SPECIAL MEETING BE ARRANGED FOR THE EVALUATION TEAM TO REPORT TO THEM.

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II. MAJOR FINDINGS AND RECOMMENDATIONS OF THE NFPP EVALUATION, JULY 1977

Section I. National Population Policy in the Third Plan (1972-76)

Finding 1. Achievement of the Demographic Goal

The Demographic Goal of the Third Plan has been achieved with a reduction in the population growth rate from over three percent per annum in 1972 to a level which fell in a range of 2.4-2.7 percent per annum by the end of 1976. For purposes of programming and public information, the figure of 2.55 percent is a reasonable approximation of the actual growth rate at the end of 1976.

Finding 2. NFPP Major Achievements

Based upon the achievement of the Demographic Goal in the Third Plan, the Evaluation Team regards the National Family Planning Program (NFPP) as a success, especially noteworthy are (a) NFPP accomplishment in extending family planning services to over 2 million fertile Thai women in over 5,000 service units throughout Thailand, (b) development of innovative mechanisms for a service delivery, and (c) ^{an}increased level of concern for rapid population growth as a high priority for government action.

Finding 3. NFPP Demographic Impact

Of the total number of NFPP acceptors, about 75 percent can be counted as having a direct impact on reducing the population growth rate, since this is the percent of clients who have never before practiced family planning.

RECOMMENDATION: FOR PURPOSES OF PLANNING, ONLY THOSE NEW ACCEPTORS WHO HAVE NEVER BEFORE PRACTICED FAMILY PLANNING SHOULD BE COUNTED AS HAVING A DIRECT IMPACT ON THE REDUCTION OF THE POPULATION GROWTH RATE.

Finding 4. NFPP Achievement of New Acceptor Targets

Although the actual number of new acceptors were found to be approximately 18 percent less than that reported (due to duplication errors in the reporting system) the total new FP acceptor targets were, nevertheless, exceeded in the third plan.

RECOMMENDATION: THE REPORTING SYSTEM SHOULD BE REVISED TO ELIMINATE DUPLICATION OF NEW ACCEPTORS. UNTIL THIS IS DONE, CURRENTLY-REPORTED ACCEPTOR RATES AND TARGETS SHOULD BE DISCOUNTED BY 20 PERCENT.

Finding 5. Conflicting Policies and Regulations

Certain Policies and Regulations are still in conflict with the National Population Policy. Examples are as follows:

- (a) Advertising of contraceptives through the mass media is still prohibited.
- (b) Oral contraceptives still remain on the "Dangerous Drug List" in Thailand. In addition, their availability to the population will be much restricted next year by new regulations concerning the dispensing of dangerous drugs by pharmacists in drug stores throughout the country.
- (c) ^{An} Economic incentive which encourages Thai Government officials to have large families (extra 50 bahts/child/month) still continues.
- (d) Import duties on contraceptives and contraceptive raw materials contribute to high contraceptive cost in the local market.

RECOMMENDATION: POLICIES AND REGULATIONS WHICH ARE STILL IN CONFLICT WITH THE NATIONAL POPULATION POLICY SHOULD BE REVIEWED AND REVISED BY THE NFPP.

Finding 6. NFPP Policy-making Process

The NFPP policy-making process is not functioning adequately.

RECOMMENDATION: THERE SHOULD BE MORE FREQUENT MEETINGS OF THE NFPP COMMITTEE AS WELL AS THE NFPP COORDINATING SUBCOMMITTEE.

Finding 7. NFPP Coordination with Commercial Sector.

There is no definite policy regarding coordination of the NFPP with the commercial sector; i.e., big drug companies.

RECOMMENDATION: A POLICY FOR COORDINATION OF THE NFPP WITH THE COMMERCIAL SECTOR SHOULD BE ESTABLISHED.

Finding 8. NFPP Policy on Free Contraceptive Pills

The policy of providing FREE oral contraceptives by the NFPP since October 1, 1976 has resulted in a higher pill acceptors rate. However, this *policy* still remains controversial.

RECOMMENDATION: THE PRICING POLICY FOR CONTRACEPTIVES SHOULD BE SUBJECTED TO INTENSIVE STUDY PRIOR TO A REVIEW BY NFPP.

Section II. Financial Support in the Third Plan

Finding 9. Financial Support

Total funding of the NFPP for the Third Plan period was adequate with *when foreign assistance is* included.

RECOMMENDATION: FOREIGN ASSISTANCE MUST CONTINUE IN THE FOURTH PLAN (1977-81), BUT THE LEVEL OF THE ROYAL THAI GOVERNMENT SUPPORT SHOULD CONTINUE TO INCREASE TOWARD ACHIEVEMENT OF SELF-SUFFICIENCY DUE TO REDUCED FOREIGN ASSISTANCE IN THE NEAR FUTURE.

Section III. NFPP Program Management and Administration.

Finding 10. NFPP Comprehensive Operational Planning

There is insufficient *comprehensive operational planning* by the NFPP.

RECOMMENDATION: A COMPREHENSIVE OPERATIONAL PLANNING PROCESS SHOULD BE ADOPTED BY THE NFPP.

Section IV. NFPP Research

Finding 11. Bio-Medical, Operational, and Social Science Research

Research in Family Planning in Thailand during the Third Plan is plentiful but not well coordinated.

RECOMMENDATION: A NFPP RESEARCH COORDINATING BODY SHOULD BE REESTABLISHED.

Section V. NFPP Program Implementation

Finding 12. Demand and Supply for Sterilization Services

The demand for voluntary sterilization exceeds the available supply of sterilization services.

RECOMMENDATION: EXTERNAL SUPPORT FOR VOLUNTARY STERILIZATION PROGRAM SHOULD CONTINUE WITH EVALUATION ON A CONTINUING BASIS.

Finding 13. Mobile Sterilization Units

Mobile sterilization units have greatly extended the availability of vasectomy in rural areas in Thailand.

RECOMMENDATION: ONE MOBILE STERILIZATION UNIT SHOULD BE BASED IN EACH PROVINCE.

Section VI. NFPP Training

Finding 14. Services, I.E. & C., Management Training

Training of family planning personnel by the NFPP in the Third Plan was *effective and of high quality*. However, the training plans for the Fourth Plan (1977-81) Period outstrips the capacity of the present NFPP Training Unit.

RECOMMENDATION: NFPP SHOULD CONSIDER ANY OR ALL OF THE FOLLOWING ALTERNATIVES:

- (a) INCREASE THE NUMBER OF NFPP STAFF.
- (b) ASSIGN FULL-TIME NURSE TRAINERS/SUPERVISORS TO EVERY PROVINCE.
- (c) UTILIZE NON-MOPH SOURCES FOR TRAINING SUCH AS UNIVERSITY, PRIVATE FAMILY-PLANNING ORGANIZATIONS, ETC.
- (d) *REDUCE THE TRAINING PLAN FOR THE FOURTH PLAN PERIOD.*

Section VII. Prospect for the Fourth Plan (1977-81)

Finding 15. Projected Fourth Plan Targets

Projected Fourth Plan Targets are consistent with the Third Plan performance except those for IUD's which appear excessively high, and for DMPA's, which appear excessively low.

RECOMMENDATION: FOURTH PLAN TARGETS SHOULD BE MADE CONSISTENT WITH THE THIRD PLAN PERFORMANCE FOR ALL CONTRACEPTIVE METHODS.

III. NATIONAL POPULATION POLICY*

There are three organizations responsible for Family Planning policy formulation and coordination.

1. The NESDB Subcommittee on Population Policy and Planning which is responsible for planning national population policy.
2. The Ministry of Health National Family Planning Committee (NFPC) which is responsible for establishing and coordinating family planning policy and programs.
3. The National Family Planning Coordinating Center, established by the NFPC as its functional coordinating arm.

A. Subcommittee on Population Policy and Planning

The National Economic and Social Development Board has been established to formulate the National Economic and Social Development Plan.

The Board, which has been appointed by the Cabinet, acts as a secretariat to the Executive Committee of the RTC Cabinet. The committee members are the Secretary General of the NESDB, Director of the Bureau of the Budget, Governor of the Bank of Thailand, and Director General of the Department of Technical and Economic Cooperation.

In 1974 the Executive Committee of the NESDB appointed a Subcommittee on Population Policy and Planning. The Secretary-General of the NESDB acts as the Chairman. The major roles of this sub-committee are:

1. To improve and broaden the population policy including promotion of the quality of the population.
2. To draft the Population Master Plan which consists of targets, guidelines, and measures to be incorporated into the National Plan.
3. To draw up programs concerned with policy implementation and plans for resource allocation.

Seven working groups were formed under the Sub-committee on Planning of Population Policy. Each of these working groups has taken into account the various problems concerned with population, such as:

1. The problem of rapid growth ^{of population} and labor force which will have an impact on the economic, social and political situation in the country. Hence, recommendations were made that the government has to concentrate on promoting family planning and population education.

* See Appendix 10 for diagram of Family Planning Organization

2. The problem of the quality of the population, including food and nutrition, health, and manpower development.
3. In addition to the above concerns, the problems of labor, employment, increase in level of income, labor welfare and human settlement.

D. The National Family Planning Committee

Since the declaration of the Population Policy by the Thai Government in 1970, the main responsibility for implementation has been given to the Ministry of Public Health. The family Planning structure is shown in Appendix 10.

The National Family Planning Committee was established by the Ministry of Public Health to assure that the National Family Planning program activities would be coordinated with the activities of other governmental and private agencies.

The responsibilities of the National Family Planning Committee are:

To establish policies and control the implementation of family planning activities in accordance with the specified objectives and targets,

To coordinate the policies and the strategies of the implementation of family planning activities among various concerned agencies, and

To solve various problems and impediments.

The composition of The National Family Planning Committee is as follows:*

1. Minister of the Ministry of Public Health	Chairman
2. Assistant Minister of the Ministry of Public Health	Deputy Chairman
3. Under-Secretary of State of the Ministry of Public Health	Member
4. Under-Secretary of State of the Ministry of Interior	Member
5. Under-Secretary of State of the Ministry of Agriculture and Cooperative	Member
6. Secretary General of the National Economic and Social Development Board	Member
7. Director of the Budget Bureau	Member
8. Director of the National Family Planning Program	Member
9. Director General of the Department of Health	Member
10. Director General of the Department of Medical Services	Member
11. Director General of the Department of Technical and Economic Cooperation	Member

* as of 1976

- | | | |
|-----|--|----------------------|
| 12. | Director General of the Department of Public Relations | Member |
| 13. | Director General of the Population and Social Research Institution, Mahidol University | Member |
| 14. | Director of the Institute for Population Studies, Chulalongkorn University | Member |
| 15. | Director of the Population Research Division, National Statistical Office | Member |
| 16. | Head of Adult Education, Ministry of Education | Member |
| 17. | President of the Planned Parenthood Association of Thailand | Member |
| 18. | Director of the Community-based Family Planning Services | Member |
| 19. | Director of the Family Health Division, Ministry of Public Health | Member and Secretary |

Activities of the National Family Planning Committee

During the initial stage, the activities of the National Family Planning Committee were carried out in accordance with the objectives (i.e., the NFPC determined the strategies of implementation for the National Family Planning Project such as the pilot project for graduate nurses to perform IUD insertions, acceleration of the vasectomy program, etc.). In addition, the NFPC has specified the coordination of operational plans of various agencies concerned in family planning activities e.g., it specified that the Planned Parenthood Association place major emphasis on IE&C activities, and that the faculties of Medicine of various universities assume a large role in research studies, etc. However, it is evident here that later NFPC activities have slowed considerably. There are long gaps between meetings (i.e., instead of holding the meetings twice a year, the NFPC has met only once a year, and in some years has not met at all). The causes may be summarized as follows:

The National Family Planning Committee is appointed by the Cabinet. Therefore, when the Cabinet which appointed the National Family Planning Committee dissolved, the NFPC also automatically dissolved.

The appointment of a new National Family Planning Committee must await the formation of a new Cabinet. Furthermore, the preparation and submission of a proposal requesting the appointment of a new NFPC requires a long period of time. The reasons stated above are the main causes for no NFPC meetings being held during some years. The NFPC is presently in the process of being re-appointed.

The NFPC is composed of high ranking officials of various departments and ministries, and the Chairman is a Minister. It is therefore difficult to call meetings and they are held only infrequently.

Because of the constraints mentioned above, it was not possible for the NFPC to closely control or follow up the implementation of the National Family Planning Project. Therefore, in order to solve the aforementioned problems and constraints, it was necessary for the NFPC in 1975 to establish a "National Family Planning Coordination Center" as the authorized coordinating representative agency of the NFPC.

Findings

At the national level, the Evaluation Team found that NFPC members changed everytime there was a change in the government. Moreover, NFPC and the two sub-committees met infrequently.

Several important family planning policies which should be formulated or reviewed by this committee were made elsewhere. During our provincial visits, it was found that several policies (i.e., number of children prior to sterilization, condom distribution, and family planning advertisement in mass media, etc.) were not clearly-defined. This resulted in various interpretations and actions by PCMO's and Hospital Directors. Further, we observed some conflicts between district hospitals and the District Health Officers. Such lack of a ^{Coordination} between the MOPH and Ministry of Interior may hinder family planning services.

RECOMMENDATIONS: THE NATIONAL FAMILY PLANNING COMMITTEE SHOULD BE MADE MORE STABLE WITH MORE FREQUENT MEETINGS, SUCH AS FOUR TIMES PER YEAR. IN ADDITION, NEW FAMILY PLANNING POLICIES SHOULD BE REVIEWED AND FORMULATED BY THIS COMMITTEE. CONFLICT BETWEEN MD'S UNDER MOPH AND THE DISTRICT HEALTH OFFICERS UNDER THE MINISTRY OF INTERIOR AT DISTRICT LEVEL SHOULD BE NEGOTIATED AS SOON AS POSSIBLE. THERE SHOULD BE A DEFINITE PLAN FOR MORE FREQUENT MEETINGS OF THE TWO SUB-COMMITTEES.

C. The National Family Planning Coordination Center

The National Family Planning Coordinating Center was established in 1975 by the National Family Planning Committee. It is the authorized coordinating agency of the NFPC.

1. Purposes

- a. To accept policies for implementation from the NFPC ~~and~~ to submit policy recommendations to the NFPC for their consideration.
- b. To coordinate activities in education, information and communication.
- c. To coordinate raising of funds for the implementation of family planning services of various agencies of the public as well as private sectors.
- d. To solve various problems, impediments or constraints preventing the implementation of family planning activities.

- e. To study policies, regulations, and laws affecting population and to make comments and/or recommendations as appropriate.
 - f. To assist in the dissemination of family planning activities.
2. The members of the Executive Committee of the National Family Planning Coordinating Center represent the implementing level of various public and private organizations concerned with family planning. They include:
- | | |
|---|-----------|
| 1. Director General, Department of Health | Chairman |
| 2. Representative of Bureau of the Budget | Committee |
| | Member |
| 3. Representative, DTEC | " |
| 4. Representative, NESDB | " |
| 5. Representative, Thai Women Physicians' Association | " |
| 6. Representative, Medical Unit, Teachers' Council | " |
| 7. Representative, McCormick Hospital, Ghangmai | " |
| 8. Representative, Community Based Family Planning Service | " |
| 9. Representative, Planned Parenthood Association of Thailand | " |
| 10. Representative, Family Health Division | " |

Findings

1. The concept of a National Family Planning Coordinating Center is important as it is not possible for any one governmental department or private organization to have access to all the information necessary to coordinate a thoroughly integrated family planning program.
2. The National Family Planning Coordination Center has not been fully utilized. For example, after two meetings in 1976 further meetings have not been held. The reasons for lack of further meetings is unclear.

RECOMMENDATIONS:

1. FAMILY PLANNING IS THE CONCERN OF MANY AGENCIES AND ORGANIZATIONS IN BOTH THE PUBLIC AND PRIVATE SECTORS. THE DETERMINATION OF POLICIES, CONTROL OF OPERATIONS, AND THE COORDINATION OF ACTIVITIES ARE MATTERS OF GREAT IMPORTANCE AND HAVE DIRECT IMPACT ON THE SUCCESS AND FAILURE OF THE NATIONAL FAMILY PLANNING PROJECT. FAMILY PLANNING OPERATIONS ARE COMPLICATED, AS MENTIONED ABOVE. THEREFORE, CONTROL AND COORDINATION SHOULD BE CARRIED OUT BY A COMMITTEE COMPOSED OF REPRESENTATIVES FROM ALL AGENCIES AND ORGANIZATIONS CONCERNED.

2. THE OPERATION OF THE NATIONAL FAMILY PLANNING COMMITTEE HAS MANY CONSTRAINTS AND IMPEDIMENTS WHICH ARE SOMETIMES DIFFICULT TO REMOVE DUE TO GOVERNMENT REGULATIONS. IT IS THEREFORE RECOMMENDED THAT THE OPERATION OF THE NATIONAL FAMILY PLANNING COORDINATION CENTER BE RESTORED:

- a. IMPROVING THE REPRESENTATION OF THE EXECUTIVE COMMITTEE OF THE NATIONAL FAMILY PLANNING COORDINATION CENTER TO INCLUDE MEMBERS OF AGENCIES AND ORGANIZATIONS IN ALL FIELDS CONCERNED WITH FAMILY PLANNING.
- b. INCREASING THE AUTHORITY OF THE EXECUTIVE COMMITTEE TO INSURE A BROADER ROLE. IT IS RECOMMENDED THAT ALL FAMILY PLANNING PROJECTS FROM PUBLIC AND PRIVATE ORGANIZATIONS BE COORDINATED BY THE EXECUTIVE COMMITTEE TO PREVENT REPETITION AND OVERLAPPING, AND ENCOURAGING COOPERATION.
- c. ESTABLISHING OPERATIONAL PROCEDURES (e.g., SPECIFYING THE NUMBER OF ANNUAL MEETINGS, METHODOLOGIES FOR FOLLOW-UP, AND CRITERIA FOR EVALUATION OF VARIOUS OPERATIONS AND POLICIES).

IV. FINANCIAL SUPPORT

A. Royal Thai Government Support

The Thai government has given its support for family planning since the Third Economic and Social Development Plan. The budget allocation for this purpose has increased progressively since 1972 and in 1976, the final year of the Third Plan, the budget was 22.8 million baht (see Appendix 11). The total budget provided by the government during 1972-1976 was 75.06 million baht which is very close to the government budget requirement as stated in the Plan.

However, such *funds* provided for the family planning project are only one part of the contribution of the government towards family planning activities. Apart from the 220 million baht of Thai counterpart funds to match foreign assistance in family planning, the government also provides a budget for overall health services through the Provincial Health Administration Project, the Provincial Hospital Project, and the Provincial Public Health Service Project. Parts of the budget for such projects are spent for the operation of family planning activities, primarily in the form of salaries for personnel who are also delivering other health services. Though no precise figures are available on these costs, this "hidden" contribution of the RTG to the national family planning effort no doubt equals the aforementioned allocation to the RTG, NFPP, and may even exceed it one or more times over. Hence, if all the *funds* utilized for family planning activities are added together the amount is quite substantial.

The Need for Foreign Financial Support

In the Third Plan financial support for the project derived from three sources: the government's 75.07 million baht, foreign assistance valued at about 220 million baht, and 220 million baht from the Thai counterpart fund budget. The total amount from the three sources is about 565 million baht to which the US contributed about 180 million baht or 33.6 percent. Since the US aid plays an important role in financing the project, the reduction of US funding would undoubtedly have a great impact on the achievement of targets set for the Fourth Economic and Social Development Plan. This is because even though the Thai government has increased the financial support for the project the acceptor targets also increase requiring even greater financial support. The Thai government cannot provide a sharp increase in the budget to make up for the reduced US funding because it has many projects to carry out for the economic and social development of the country and for national security and defense which require budgets.

RECOMMENDATIONS:

1. THE RTG SHOULD ASSUME A PROGRESSIVELY INCREASING FRACTION OF THE EXPENDITURE FOR FAMILY PLANNING AS THE LEVEL OF FOREIGN AID DECLINES.
2. SINCE THE RTG ~~HAS~~ ^{ACHIEVED} NOT YET ^{SELF-SUFFICIENT} ^{CY} IN FINANCE ^{ING} THE NFPP THROUGH THE FOURTH PLAN, FOREIGN FINANCIAL ASSISTANCE SHOULD CONTINUE.
3. ALTERNATIVE SOURCES OF INTERNAL ASSISTANCE SHOULD BE ENCOURAGED SUCH AS USE OF THE COMMERCIAL SECTOR FOR IE&C AND SELF-HELP PROJECTS.

B. USAID Support

The Ministry of Public Health first received financial support for family planning from the United States Government in 1968. At that time the Royal Thai Government had not accepted family planning as a national policy. Therefore, the Family Planning program was in the form of a pilot project and its operations were implemented with great success. Since the RTG *adopted a* - population policy in 1970, the Ministry of Public Health has received long-term support for the program during the Third Five Year Development Plan and for the current Fourth Development Plan.

Components of the USAID Assistance

The USAID assistance is comprised of four main categories:

1. Supply and Equipment
 - a) Male and female sterilization equipment, b) IUD insertion equipment, c) oral contraceptives, d) condoms, and e) vehicles.
2. Fellowships and Local Training
 - a) Academic Masters Degree training, b) Local training of multipurpose health personnel, c) Short term training including observation tours in the United States, Korea, Philippines, Singapore, and Malayasia, etc. (See Appendix 12 for table of Overseas Training of NFPP Staff According to Source of Support.)
3. Technical Experts

The Family Planning Program has been provided with experts in family planning research and training. USAID employs two US experts in family planning. An additional expert is employed from Columbia University.

The amount of financial assistance in the Third Five Year Development Plan totalling US 9,116,988 was divided into:

- | | | |
|----|------------------------|---------------------|
| 1. | Supplies and Equipment | - \$4,118,238 |
| 2. | Experts | - - - - - 396,000 |
| 3. | Fellowships- | - - - - - 1,004,850 |

C. Support from Other Donors

Besides USAID, the National Family Planning Project has received assistance from other donors in the form of multi-lateral, bilateral and non-government organization agreements.

1. UNFPA is a very important source of assistance of the NFPP. UNFPA provides assistance in the form of consultants, fellowships, training, supplies and equipment, and funds for in-country training and research.

During the Third Plan period of 1972-1976 UNFPA's assistance to the Thai Family Planning Program totalled US 5 to 9 million, broken down by percentage of assistance as follows:

Technical assistance	- - - - - 7%
Local personnel	- - - - - -14%
Sub-contract	- - - - - -15%
Training, Seminars, Research	-14%
Equipment	- - - - - -50%

During the Fourth Plan UNFPA has budgeted approximately US 3 million to assist the National Family Planning Program. As a matter of fact, the RTG needs additional UNFPA assistance during the Fourth Plan, especially in training, equipment and vehicles.

2. Japan

Japan has given assistance to the Thai National Family Planning Project under the Columbo Plan. It started to assist the Project in 1974 in the form of audio-visual equipment and vehicles with a value of about US 350,000 during 1974-1975.

3. The United Kingdom has been providing DMPA to the Thai National Family Planning Project and also providing funds for training and observation study tours. A total of \$14,706 has been given during the period 1974-75.

D. Non-Government Organizations

The NFPP has also received assistance from several non-government organizations such as

- American Home Economics Association

- American Public Health Association
- The Asia Foundation
- Columbia University-Institute of Population Studies
- Association for Voluntary Sterilization
- Pathfinder Fund
- World Fertility Fund
- University of Hawaii, etc.

The assistance received from non-government organizations is mainly in the form of funds for research, seminars and observation study tours abroad, as well as provision of various kinds of family planning equipment.

Moreover, there are several other non-government organizations, such as International Planned Parenthood Federation, IPRC, Church World Services, Population Council, Rockefeller Foundation, etc. that provide funds in connection with family planning to other agencies than the NFPP, such as Mahidol University, Planned Parenthood Association of Thailand, the Community Based Family Planning Services, and Institute of Population Studies, Chulalongkorn University, etc.

Findings and Recommendations

1. Supplies, equipment, and support of specific program elements.

(Findings and recommendations in these categories are discussed under "Program Implementation" in Section VII of this evaluation.)

2. Coordination among donor agencies.

In the past, some overlapping and duplication has resulted from insufficient coordination among the numerous donor agencies.

RECOMMENDATION : DONOR AGENCIES SHOULD NOT ONLY COORDINATE THEIR ACTIVITIES WITH ONE ANOTHER, BUT SHOULD ALSO CONSULT REGULARLY WITH THOSE RTG AGENCIES CONCERNED WITH FOREIGN ASSISTANCE (NESDB, BOB, DTEC, ETC.) IN ORDER THAT EXTERNAL ASSISTANCE TO THE NFPP MAY BE PROPERLY COORDINATED.

3. Training fellowships

Evaluation of the cost-effectiveness of short-term vs. long-term fellowships is difficult, the evaluation team nevertheless concluded on the basis of informal dialogue with numerous Thai professionals that sufficient in-country capability exists in the acquisition of knowledge and skills important to the NFPP to indicate a shift in emphasis toward short-term training fellowships rather than long-term (such as masters degree) overseas training.

RECOMMENDATION: EXTERNAL ASSISTANCE FOR OVERSEAS TRAINING FOR NFPP PROFESSIONALS SHOULD EMPHASIZE SHORT-TERM FELLOWSHIPS, OBSERVATION STUDY TOURS, SEMINARS, WORKSHOPS, ON THE JOB TRAINING, ETC. RATHER THAN LONG-TERM ACADEMIC TRAINING.

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4. Technical Assistance Experts

The need for long-term foreign experts has diminished as in-country capability of Thai professionals has been achieved.

RECOMMENDATION: THE PROVISION OF FOREIGN EXPERTS IN SUPPORT OF THE NFPP IN THE FUTURE SHOULD EMPHASIZE SHORT-TERM CONSULTATION FOR SPECIFIC PROGRAM NEEDS.

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What about implementation rather than just a function of advisors?

V. PROGRAM MANAGEMENT AND ADMINISTRATION

A. General

Using the criterion of goal attainment, the management system of the NFPP can be said to be functioning adequately.

Nevertheless, review of written data together with field investigations indicate some important areas of weakness and needed improvement in the management system.

There are actually two management systems in operation within NFPP at both the national and provincial level: the formal and informal systems.

The informal system of program management refers to that inter-related network of personal, kinship, and political relationships that is used to accomplish objectives. It is used extensively and is at least as important to success or failure as the formal system. The NFPP is fortunate to have several well-placed individuals within this informal system, many of whom possess outstanding personal leadership capabilities. In addition, the program benefits from widespread approval and priority ranking both within the Ministry of Health and the government at large.

Extensive reliance on the informal management system has, however, hindered development of useful formal mechanisms for efficient operation, such as implementation plans, ad hoc task forces and coordinating committees.

B. Planning

1. Finding

There has not been and does not now exist an operational plan within NFPP to carry out the overall population objectives of the Third and Fourth National Economic and Social Development Plan. As a result of this deficiency there are inadequate guidelines to judge which mix of inputs are necessary to meet desired objectives. Lack of such a comprehensive operational plan has, in the past, led to over-extension of the training department, neglect of needed areas of operations research and a haphazard method of allocating targets and resources among provinces.

RECOMMENDATIONS:

- a. AN AD HOC PLANNING TASK FORCE SHOULD BE APPOINTED COMPOSED OF SENIOR STAFF AT NFPP HEADQUARTERS. THIS GROUP SHOULD DEVELOP A DETAILED PLAN OF OPERATION FOR NFPP ON AN ANNUAL BASIS. THE MAJOR ELEMENTS OF SUCH A PLAN WOULD CONSIST OF: AN ASSESSMENT OF FAMILY PLANNING NEEDS

*Not valid conclusion
no concrete findings*

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AND RESOURCES AVAILABLE THROUGHOUT THE COUNTRY; A FORMULA DESIGNED TO ALLOCATE NFPP RESOURCES AMONG THE PROVINCES BASED UPON NEEDS AND RESOURCES; A DEPARTMENT BY DEPARTMENT WORK PLAN WITH SPECIFIC TASKS AND TIME FRAMES APPROPRIATE TO MEETING STATED OBJECTIVES; A MECHANISM FOR ONGOING INTERNAL EVALUATION AND REVISION OF THE INTERNAL PLAN OF OPERATION.

THE PLAN OF OPERATION SHOULD SERVE AS THE TOUCHSTONE FOR ALL NFPP ACTIVITIES. NEW TRAINING ACTIVITIES, RESEARCH PROJECTS OR OTHER PROGRAMS SHOULD NOT BE ENTERED INTO UNLESS JUSTIFIED BY THE OPERATION PLAN AS FEASIBLE MEANS OF ACCOMPLISHING PREVIOUSLY ESTABLISHED NFPP OBJECTIVES.

- b. SIMILAR OPERATIONS PLANS SHOULD ALSO BE DEVELOPED AT EACH PROVINCE BY THE PCMO, FAMILY PLANNING NURSE SUPERVISOR, DISTRICT HEALTH OFFICERS AND OTHER KEY PROVINCIAL PERSONNEL INVOLVED IN FAMILY PLANNING PROGRAM MANAGEMENT. SUCH PLANS SHOULD PROVIDE THE BASIS FOR ALLOCATION OF ACCEPTOR TARGETS, FAMILY PLANNING RESOURCES AND NEW PROGRAMS AMONG HOSPITALS, HEALTH CENTERS, MIDWIFERY CENTERS AND OTHER SOURCES OF FAMILY PLANNING SERVICES WITHIN THE PROVINCE.

C. Supervision

Findings

1. At the present time second-class health centers and midwifery centers are visited for supervisory purposes three to four times a year.
2. There is no clear-cut supervisory authority. Often supervision visits to the same sites are made by the provincial nurses, district nurses and district health officers. Furthermore, most supervisory personnel have little authority to enforce changes of discipline.
3. There is a limited feedback system for mid-level supervisors to report findings and/or problems to the appropriate administrative personnel.
4. The fourth plan¹ calls for the addition of 57,300 non-professional personnel¹ involved in family planning. This means that on the average each second class health center and midwifery center will be responsible for supervision of 16 additional persons.

¹ 44,800 village health communicators and village health volunteers, 7500 traditional birth attendants, 4400 Tambon doctors, 600 family planning workers.

RECOMMENDATIONS

1. THERE SHOULD BE REGULAR SUPERVISORY VISITS TO SERVICE UNITS. IDEALLY THESE SHOULD TAKE PLACE ONCE A MONTH. SUPERVISION SHOULD STRESS CORRECTION OF DISCREPANCIES AND DEFECTS. EXAMPLES COULD BE DISCREPANCIES IN RECORDING AND REPORTING OR LACK OF FOLLOWUP OF CONTRACEPTIVE USERS WHO HAVE MISSED SCHEDULED REVISITS, ETC.
2. IN LIGHT OF FINDINGS TWO, FOUR AND FIVE, A CLEAR-CUT SUPERVISORY POLICY NEEDS TO BE WRITTEN AND IMPLEMENTED AT EVERY LEVEL. THIS IS ESPECIALLY NEEDED IN LIGHT OF THE GREATLY INCREASING SUPERVISORY RESPONSIBILITIES. THIS POLICY SHOULD INCLUDE: LINES OF AUTHORITY AND RESPONSIBILITY, FEEDBACK MECHANISMS, OBJECTIVES FOR SUPERVISION AT EVERY LEVEL AND A DEFINITION OF SUPERVISORY FUNCTIONS.
3. ONCE THIS POLICY IS WRITTEN, ALL PERSONNEL AT THE PROVINCIAL, DISTRICT, SECOND-CLASS HEALTH CENTERS, AND MIDWIFERY CENTER LEVELS, SHOULD RECEIVE TRAINING IN ITS USE.
4. AS MIDWIVES AND JUNIOR SANITARIANS WILL HAVE SUPERVISORY RESPONSIBILITY FOR VILLAGE VOLUNTEERS, TBA'S AND TAMBON DOCTORS, CONTENT ON SUPERVISION SHOULD BE ADDED TO THEIR BASIC CURRICULUM.

D. Resource Utilization

1. Personnel

Adequacy and Availability of Personnel. The trained personnel in the program include physicians, nurses, auxiliary midwives, sanitarians, village health volunteers, and personnel at the central office of the Family Health Division. The number of service units to reach the population in need of family planning services is inadequate. At present the service units cover only 10 percent of Thai villages. Furthermore, the number of personnel at the operational level where service units exist (i.e., auxiliary midwives and junior sanitarians) are insufficient for making home visits to more than about one-half of the population in their area of jurisdiction:

At the district and provincial levels there is a shortage of doctors. For example, the MCH Center visited by the team can accommodate 150 in-patients but there are only six physicians who are responsible not only for delivery and family planning services but also for training the midwives and family planning workers. In this center there was no trained physician to do laparoscopy. These shortages of personnel adversely affect the delivery of some contraceptive methods such as vasectomy and tubal resection. Furthermore, only about 20 percent of personnel time is spent on family planning since personnel working in the medical and health facilities in the

provinces are responsible for comprehensive and multi-purpose health services (ten basic health services) of which family planning services are only one part.

The number of project personnel who are responsible for the training and supervision and to give advice to the operations of various provinces are inadequate. The village health volunteer program does not exist in all service areas and where it does exist the number of volunteers are still inadequate to meet the needs. Within the NFPP headquarters staff, less than half are permanent civil service positions. The remainder are funded primarily from foreign sources which are by nature temporary in nature. This situation has led to poor staff morale and promotes high staff turnover.

RECOMMENDATIONS

1. THE PERSONNEL WHO PERFORM FAMILY PLANNING ACTIVITIES SHOULD BE GIVEN THE OPPORTUNITY TO BE RETRAINED ON A REGULAR BASIS AND TO ATTEND SEMINARS OR WORKSHOPS TO EXCHANGE KNOWLEDGE AND SKILLS. TRAINING SHOULD EMPHASIZE MOTIVATION, FOLLOWUP RECORDING AND REPORTING.
2. POSITIONS NEED TO BE ESTABLISHED IN THE RESEARCH AND EVALUATION DIVISION FOR PERSONNEL WHOSE PRIMARY FUNCTION IS DATA ANALYSIS.
3. MORE SUPERVISORY AND TRAINING PERSONNEL SHOULD BE SOUGHT AT THE PROVINCIAL AND DISTRICT LEVELS.

E. Financial Management

Findings

1. Funds for family planning service in the provinces come from four sources. The PCMO offices and the district health offices receive *funds* from the Provincial Health Administration Project; the provincial hospitals are financed from the Provincial Hospital Project; other health service offices receive budget allocations from the Provisional Public Health Service Project; and, finally, all these offices receive both financial assistance, supplies, and material concerning family planning from the National Family Planning Project. The first three projects are under the management of the Office of the Under-Secretary of State, while the Family Planning Project is under the jurisdiction of the Department of Health. This fragmentation of funding from several sources makes the management of the family planning project more difficult. A financial management function does not exist at the provincial level due to the fact that Provincial Chief Medical Officers do not control health and family planning budget for their provinces. This makes planning and resource allocation quite difficult.

RECOMMENDATION: THE OFFICERS WHO ARE DIRECTLY RESPONSIBLE FOR THE PROJECT SHOULD RENDER MORE ATTENTION TO REPORTS FROM THE HEALTH OFFICES IN ORDER TO IDENTIFY AND SOLVE ANY PROBLEM THAT MAY ARISE.

2. Although adoption of the "Free pill policy" in October 1976 resulted in a very significant increase in new acceptors to NFPP (see Appendix 13,14), the policy remains controversial. This policy should now be reconsidered quite seriously because of the following reasons:

- a. Government Oral Pills, ^{normally only} brands distributed by NFPP in Thailand, were found to be sold quite freely in several drug stores (6 bahts/cycle) during our provincial visits. This finding raised several questions, e.g., (i) how many new pill acceptors really used the pills for contraception? In addition, the duplication factor of 21 percent in the reporting of new pill acceptors reported elsewhere in this evaluation must be taken into consideration, (ii) what is the extent of the leakage, and from what sources does most of it occur? (iii) has the "free pill" policy thereby provided a new source of profit to these drug stores?
- b. "Free Pill" policy has affected the health service operation throughout Thailand, especially at those health centers at subdistrict and village levels. This is illustrated by the example in Appendix 15. Data here shows that the annual income of 13 subdistrict health centers derived from oral pills was 53.4% of the total income. PCMO's and other health workers generally complained quite bitterly about the loss of this income resulting from the "free pill" policy, which has affected the health service operation significantly. Since family planning service is a part of the 10 basic health services, its operation will also be affected.
- c. Several community surveys conducted by the Faculty of Public Health, Population Institutes, CBFPs, etc. have shown that over 95 percent of the Thai population could afford to pay 5 bahts/month for contraception. Since most of them could afford to help to bear the pill cost of 20 million bahts per year, they could thereby be allowed to participate in this self development process.
- d. Reduced foreign assistance in family planning will certainly occur in the very near future. The payment of a modest price for pills helps to teach the Thai people to help themselves and their government to be self-sufficient. Of course those who cannot afford to pay will get free service as before the "free pill" policy. National development will never occur in any country where people never know how to help themselves.

- e. Another great concern over the distribution of free pills focused on the recording system. Before the "free pill" policy, after each pill cycle was sold, the pill acceptor was given a legal receipt with a retained copy in a receipt book at the health center. Legal action could be taken against any health worker who mishandled the pills. After the pills became free, no receipt was needed. The record of pill distribution was written in a simple notebook. Anyone who mishandles the pill cannot be prosecuted in court because of lack of legal evidence. Should 20 million bahts of scarce Thai Government funds in the form of oral pills be handled this way yearly?

RECOMMENDATION: THE NFPP SHOULD RECONSIDER ITS PRICING POLICY FOR FAMILY PLANNING SUPPLIES AND SERVICES IN TERMS OF ITS IMPACT ON NEW AND CONTINUING ACCEPTOR RATES, RELATIONSHIP TO ESTABLISHED PRICING PRACTICES IN THE COMMERCIAL SECTOR AND LONG-TERM EFFECT ON THE ACHIEVEMENT OF SELF-SUFFICIENCY FOR THE THAI NFPP.

F. Supplies, Equipment and Logistics

Field investigations reveal that hospitals and health centers are fairly well equipped, with the following exceptions. Lack of specula at midwifery centers, shortage of DMPA in some areas, shortage of client record forms (01) and monthly report forms (03) at some service units, lack of audio-visual equipment, shortage of vehicles and motorcycles to cover the entire service area.

Findings

1. Most offices of Provincial Chief Medical Officers appear to lack sufficient space to keep adequate stocks of contraceptive supplies and equipment on hand. In addition, procedures for inventory control are lacking which might avoid problems of over or under stocking of supplies.
2. At the present time there is an over supply of oral contraceptives due largely to excess supplies obtained from the Philippines. However, as USOM has delayed further shipment from the U.S. until 1978, this condition should correct itself by the end of 1978 when supplies on hand will approximately equal one year's needs.
3. During the Fourth Plan approximately 62,000 new non-professional motivators and distributors will be trained. *Not very effective*
If each of these workers recruits three new pill acceptors a year, this will mean an increased need for approximately 2.5 million cycles a year. This is above and beyond any normal growth in pill usage. This may create *power needs*

the need for additional pill stocks in 1980-81. While the nature of the evaluation precluded an exact audit of existing pill stocks, data was obtained from the USAID Project Officer on present and projected stocks through 1981 (see Appendix 16).

RECOMMENDATIONS

1. WHEN PLANNING PILL STOCKS, THE NFPP SHOULD ALWAYS HAVE ON HAND AN ESTIMATED SIX MONTHS SUPPLY.
2. THE EFFECTIVENESS OF PARAMEDICAL PERSONNEL IN RECRUITING PILL USERS SHOULD BE MONITORED CAREFULLY IN ORDER TO PREDICT ANY SUDDEN CHANGE IN PILL USAGE WHEN NEW SUPPLY POINTS ARE ESTABLISHED AT THE VILLAGE LEVEL.

G. Evaluation and Internal Feedback

Findings

1. Aside from comparison of new acceptor totals against established targets, program evaluation is almost non-existent within the NFPP, since there is no detailed standard against which to measure performance. The situation is further complicated by the fact that family planning is thoroughly integrated with other health service delivery at the service unit level, this making it difficult to measure efficiency of family planning activities. At NFPP headquarters and at the PCMO level, almost no use is made of the client reporting system for purposes of evaluating areas of weakness or change in the program.
2. The NFPP has a good service statistics system. However, much useful data seems to be merely collected with little analysis and interpretation. For example, the average parity of women enrolled in the program has increased steadily from 3.3 in 1973 to 4.0 in 1976. This fact will obviously have an adverse impact on population growth reduction, especially if women with low parity are not receiving services elsewhere. Yet the NFPP has not attempted to analyze this data and assess its implications for the future of the program.
3. Although new client acceptor targets are established for the country and for individual Provinces, it does not appear that targets have significant operational validity. Total new acceptor targets are established by the NFPP and allocated among the various provinces by the NFPP. There does not appear to exist a precise formula based upon needs and resources to serve as a basis for this allocation. As a result, resources are not always utilized to the maximum extent in reaching potential acceptors in need of family planning services.

Targets, moreover, appear to mean different things to different decisionmakers. For some, they are minimums to be reached and exceeded to the maximum extent possible; for almost none are targets seen as a tool for program management (e.g., redirect family planning personnel and supplies elsewhere once target goals are attained in a certain area). Finally, little attention is given to individual targets by method at the service unit level. Usage is much more likely to reflect client preference (i.e., sharp rise in DMPA acceptors rates) than staff efforts to meet specific method targets.

why not

RECOMMENDATIONS:

1. SINCE THE PRESENT USE OF TARGETS BY NFPP IS AN EXCELLENT METHOD FOR MOTIVATION AND CONTROL, ITS USE SHOULD BE CONTINUED WITH THE FOLLOWING MODIFICATIONS:

Where necessary to meet the target... report mobilization... not for allocation... monthly statistics

a. ESTABLISHMENT OF A FORMULA FOR ALLOCATION BASED UPON A NEEDS/RESOURCE ANALYSIS OF EACH PROVINCE.

b. ADJUSTMENTS OF TARGETS TO REFLECT MORE ACCURATELY CURRENT PRACTICE AND ESTIMATED FUTURE USE (E.G., INCREASE IN DMPA TARGET). AT PRESENT MOST PROVINCIAL TARGETS ARE SET FAR TOO LOW, A SITUATION WHICH MAY LEAD TO LESS EFFORT BEING PUT ON FAMILY PLANNING SERVICES ONCE THEY ARE MET.

c. ESTABLISHMENT OF TARGETS FOR TOTAL ACCEPTORS OF INDIVIDUAL METHODS AT THE SERVICE UNIT LEVEL. THIS WOULD HELP AVOID THE POSSIBILITY OF FAMILY PLANNING STAFF FEELING THE NEED TO ADVOCATE ONE METHOD OVER ANOTHER IN ORDER TO MEET THE TARGET.

total acceptor... cases... monthly

2. SERVICE STATISTICS SHOULD BE MORE CLOSELY AND MORE FREQUENTLY ANALYZED IN TERMS OF THEIR IMPLICATIONS FOR THE NFPP. SPECIAL STUDIES SHOULD BE CONDUCTED IN AREAS WHERE SERVICE STATISTICS REVEAL GAPS AND WEAKNESSES IN THE PROGRAM OR INDICATE CHANGES IN CONTRACEPTIVE PRACTICE.

4. A significant amount of reporting error occurs within the NFPP service statistics because of widespread misunderstanding of proper reporting procedures at the service unit level. Moreover, at the NFPP headquarters level, monthly acceptor totals are calculated at the end of the following month, regardless of the fact that as much as 20 percent or more of the service units have not reported in by that time.

RECOMMENDATIONS:

1. BOTH THE CLIENT RECORD FROM (01) AND THE MONTHLY REPORT FORM (03) SHOULD BE MODIFIED TO CREATE A

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"CONTINUING ACCEPTOR" CATEGORY WHICH WOULD INCLUDE ALL THOSE CLIENTS WHO ARE, OR HAVE BEEN, ENROLLED IN THE NFPP BUT WHO HAVE CHANGED THEIR CLINIC, METHOD, OR BOTH.

UNTIL THIS STEP IS TAKEN, NEW ACCEPTOR RATES SHOULD BE ADJUSTED DOWNWARD BY APPROXIMATELY 20 PERCENT TO ALLOW FOR DUPLICATION.

IN ADDITION, THE MONTHLY REPORT FORM (03) SHOULD BE MODIFIED TO INCLUDE A CATEGORY OF "TOTAL CONTINUING ACCEPTORS" BY METHOD. THIS WILL ALLOW SUPERVISORY PERSONNEL AT THE PROVINCIAL AND HEADQUARTERS LEVEL TO MONITOR CONTINUATION RATES ON A MONTH-TO-MONTH BASIS. A SECTION TITLED "PROBLEMS AND OBSTACLES" SHOULD ALSO BE ADDED TO THE FORM.

2. THE RESEARCH AND EVALUATION DIVISION OF THE NFPP SHOULD TRAIN ALL NURSE SUPERVISORS (OR THEIR DESIGNEES) AT THE PROVINCIAL LEVEL IN PROPER PROCEDURES FOR REPORTING SERVICE STATISTICS. PROVINCIAL NURSE SUPERVISORS SHOULD, IN TURN, ENSURE THAT PERSONS IN CHARGE OF SERVICE STATISTICS AT ALL SERVICE UNITS ARE PROPERLY TRAINED IN REPORTING PROCEDURES.
3. MEASURES SHOULD BE TAKEN BY THE OFFICE OF THE UNDER-SECRETARY OF STATE FOR PUBLIC HEALTH TO EARNESTLY ADVISE THE DELINQUENT REPORTING UNITS TO FILE THEIR REPORTS ON TIME.

VI. RESEARCH

The research studies in the field of population/family planning conducted in Thailand are of a vast variety. Operations research, bio-medical studies, and clinical trials started as early as in 1964. Because institutions and research centers are conducting the studies independently, and the funds come from various agencies (the major sources are WHO, UNFPA, and USAID), research studies in the field are not always coordinated.

In the past, a research coordinating subcommittee, an assisting body of the NFPP committee, was set up to coordinate all family planning research activities. However, this subcommittee was dissolved along with the NFPP Committee, and has not been reappointed since. This circumstance has resulted in duplication and lack of coordination of academic, private, and government research. It is felt that this represents ineffective utilization of the limited funds available for research.

A. Operational Research

This type of research is concerned with the evaluation of different program activities and results to gain better understanding of what works and what does not work, so that the program can be improved. Most of these studies have been conducted wholly or partly by the MOPH itself and some by staff members at Mahidol and Chulalongkorn Universities.

Considerable use has been made of such studies, starting with the exploratory field study in Potharam District in 1964-66. Another key experiment was the 1969/70 study of whether health auxiliaries could safely be given authority to dispense pills if there were no negative replies upon administration of a simple check-list. There have been studies on the use of different kinds of field workers, on the use of the traditional birth attendant (Moh-tam-yae), and a few studies on communications.

The Research and Evaluation Unit (R&E) in the NFPP is the agency which has the direct concern for research on program operations. The R&E unit has conducted some high priority projects and these studies include: pilot projects for auxiliary midwives inserting IUDs, abortion attitude survey, contraceptive follow-up surveys (every two years), and a pill incentive study.

The introduction of village volunteers can be a very low cost strategy, depending on their success as recruiters and how much of the costs of supervision are charged. There was a pilot study starting in one district (Po-thong) 85 miles north of Bangkok in 1974. Single purpose village volunteers devoted themselves exclusively to family planning. The experiment was conducted by staff in the Faculty of Public Health at Mahidol University. The result of the study was remarkably successful.

The Community Based Family Planning Services (CBFPS) project has been implemented under the guidance and supervision of a tri-partite steering committee made up of representatives from the MOPH, PPAT and CBFPS. The program is designed to test new methods of significance by expanding access to and information about contraceptive methods, particularly in the rural areas, by utilizing local villagers, shopkeepers, farmers, village headmen and teachers as channels of communication and distribution.

Starting in 1974, the CBFPS experimental areas now cover 68 districts across Thailand.

Another large-scale experiment based on utilizing the village volunteers will be implemented in 1977 by the joint efforts of the MOPH, CBFPS, and the Faculty of Public Health at Mahidol University. CBFPS will be taking the major lead in its operation. "The Family Planning, Health/Hygiene Project" is designed to test the efficiency of the volunteer's performance when some primary health care services are to be given along with the family planning. The volunteers will be assigned to augment health centre personnel by providing family planning services (pills and condoms) in villages, thereby increasing the coverage of the family planning program.

The list of research topics is appended for further consideration (see Appendix 17).

B. Biomedical Research

This category includes both basic research in physiology of human reproduction and clinical trials to test the effectiveness of various contraceptive methods among different populations in Thailand. Major studies of this type have been conducted by staff members at the Medical Schools, for instance, Siriraj Family Planning Unit, WHO Research Unit at Chulalongkorn Hospital, and Research center at Chiangmai Medical School.

The results of studies on various contraceptive methods, for example, oral contraceptives, IUDs, injectable and different techniques of sterilization are of great help to the NFPP management in choosing effective and appropriate methods for the program.

A representative list of research studies of this type is attached (see Appendices 18, 19 and 20).

C. Major Studies Assessing the Demographic Status of Thailand

It is clearly important for ^{the} Thai government to make periodic estimates of national fertility and mortality in order to derive estimates of the natural rate of increase. The major studies for assessing these demographic rates are:

1. The Survey of Population Change (SPC) 1964-65, 1974-75, 1975-76 of the National Statistical Office (NSO).

2. **The Survey of Fertility in Thailand/World Fertility Survey (SOFT/WFS) 1975** conducted by the Institute of Population Studies, Chulalongkorn University.

Because of the discrepancy of the results from the two surveys, after investigating through the methodology and results of the above surveys, the team members prefer to follow the lead of the Thai demographers in placing primary emphasis on SPC data in terms of estimating the number of events. From our estimates by the end of 1976 a range for the growth rate was of 2.4 to 2.7. The detailed discussion is as follows:

The Survey of Population Change (SPC) 1964-5, 1974-5, and 1975-6 of the National Statistical Office

Thai demographers unanimously judged the Survey of Population Change (SPC) to be the most accurate source for estimating vital events. Results of the 1974-5 SPC were recently published. The National Statistical Office has not yet released data on an SPC 1975-6. The SPC (1974-5) was a dual record investigation including both household survey and registration. The survey consisted of a series of successive quarterly household interviews for a large sample of both rural and urban households. Data collected in the survey were matched with registered events, and for non-municipalities registered events were also matched through survey. The final count was adjusted for events estimated to have been missed by both mechanisms. Data collected for a period of nine months beginning July 1974 were adjusted to represent a period of one year, with a midpoint of January 1, 1975. The sample covered about 47,800 married women of reproductive ages in some 38,000 households. The households were located in 35 provinces, 83 districts, 249 villages and 91 municipal areas. Some 135 NSO employees engaged full time but with additional assignments carried out the interviewing.

The 1964-5 SPC was similar to the 1974-5 SPC but excluded Bangkok-Thonburi. The data collection for the yet to be published 1975-6 SPC covered a full 12 months but otherwise resembled the 1974-5 SPC.

The Survey of Fertility in Thailand/World Fertility Survey (SOFT/WFS) 1975, The Population Institute of Chulalongkorn University

The SOFT/WFS was a subsample of the 1974-5 SPC. The subsample included about half of the 91 municipal areas but all of the rural areas in 35 provinces and 249 villages. University undergraduates served as interviewers. Field work began in March and ended in May 1975. A supervisor and assistant supervisor for every five or six interviewers did field editing for all interviews and sent interviewers back for reinterviews where schedules were incorrectly completed. However, the survey utilized no systematic reinterviews to measure response reliability or control for interviewer performance. The ample experience of the Population Institute of Chulalongkorn University in conducting sample surveys

would indicate that the quality of interviewing was excellent. The survey identified 4002 ever married fertile age women, 94.4 percent of whom completed the interviews. Three thousand four hundred and thirty-eight husbands were identified and 96.0 percent interviewed. Although SOFT/WFS utilized de facto residence requirements slightly different from those of SPC, fewer than one percent of respondents would not have been eligible under the SPC requirements.

Results

SOFT/WFS and SPC differ markedly in measures of current fertility. For the five-year period 1970-74, the SOFT/WFS yielded a Total Fertility Rate of 4.85, whereas SPC 1964-5 produced a Total Fertility Rate of 6.299 and SPC 1974-5 a Total Fertility Rate (TFR) of 5.167. If one utilizes July 1, 1972 as the midpoint of the SOFT/WFS period of 1970-4 and linearly interpolates to that point for the SPC data, the TFR of 4.85 of the SOFT/WFS compares with a TFR of 5.41 for SPC, i.e., the SPC estimate is 11.5 percent higher than the SOFT/WFS estimate.

Thai demographers familiar with SOFT/WFS are quick to point out that SOFT/WFS had multiple purposes and that SPC is the preferred means for estimating current fertility. Nonetheless at least one non-Thai demographer has preferred the SOFT/WFS data and in some other countries, notably Colombia, recent fertility surveys similar to SOFT/WFS have produced estimates of current fertility closely approximating estimates from census data. It is therefore worthwhile to comment upon possible reasons for such a large discrepancy between SPC and SOFT/WFS and suggest reasons for our own preference. First, the methodological differences between a one-time retrospective study such as SOFT/WFS and the dual record system of SPC might be expected to differ in the direction of higher SPC estimates. The multiple visits of SPC at close intervals allow little time for memory loss, and vice versa. In contrast, women queried in a retrospective survey might be expected to forget births, particularly those live born who died later or moved away. Eligible women identified but not interviewed (5.6 percent in SOFT/WFS) might possibly have higher fertility than those interviewed.

Secondly, SOFT/WFS obviously incorporated a much smaller sample than did SPC, but on the other hand because of the large number of primary samplint units including all of the 249 rural villages of the SPC sample, the quality of the SOFT/WFS sample appears to have been very good. One would certainly not expect sampling error alone to account for the 11.5 discrepancy.

Although one commentator has suggested that the upward adjustment of the SPC (to account for events that may have been missed by one or both mechanisms) may have produced an overestimate of the number of events, NSO claims to have conducted a sensitivity study that confirms the estimates of vital events as quite

accurate. Other Thai demographers insist that problems of over-estimating because of mismatching of names and addresses are not present in the Thai context.

Our own judgement is to follow the lead of the Thai demographers in placing primary emphasis on the SPC data, at least in terms of estimating the number of vital events. Although both NSO and the Institute of Population Studies at Chulalongkorn University have demonstrated high technical capacity in executing the studies, the inherent methodological advantages of the most costly dual record system and the larger sample give the advantage to SPC. However, as detailed below, even if one grants priority to the SPC for the estimation of vital events, the estimation of the denominators (where matching is not involved) and the derivation of crude birth and death rates are open to alternative approaches. One alternative described below would lead to a slightly lower crude birth rate than that of 37.0 calculated by NSO.

The calculation of denominators for SPC was straightforward. For non-municipal areas the denominator was simply the number of people enumerated in the survey. At each successive visit the interviewer asked whether or not anyone had moved into or out of the household. The number of enumerated persons, 192,305, and the number of births, 7,063, yielded a crude birth rate of 36.73. One thousand seven hundred ninety-five deaths produced a crude death rate of 9.33. For the population living in municipal areas, NSO projected a population of 6,542,002 by interpolating from registration data, 255,481 estimated births produced a crude birth rate of 39.05. The crude death rate for municipal areas was 6.19. NSO applied weights of .14 for municipal areas and .86 for non-municipal areas to calculate for the whole kingdom a crude birth rate of 37.05 (reported as 37.0) and a crude death rate of 8.89.

An alternative to the above method is to assume that SPC correctly estimated both the number of births and the number of women in reproductive age (and therefore accurate general fertility rates (GFR) but to infer a different number of males and females outside the reproductive ages. In fact, the proportion of females in reproductive ages that may be inferred from quotient of the 1974-5 SPC crude birth rate and general fertility rate ($37.0/157.5 = .235$) is at variance with NSO's own projections for 1974-5, and suggests that NSO may have slightly underestimated the denominators. NSO's medium fertility projections for 1974 and 1975 yield an interpolated proportion of women in the reproductive ages for January 1, 1975 of .229. Since the general fertility rate is equal to the number of births divided by women in the reproductive ages 15-49, we may infer a crude birth rate by multiplying the general fertility rate by the proportion of women in the reproductive ages. In this case, the 1974-5 SPC general fertility rate of 157.5 multiplied by the NSO projected proportion of women in the reproductive ages of .229 produces a crude birth rate of 36.1

and 49 high

The implications of such a slight downward adjustment are to produce a slightly lower estimate of the growth rate both at the end of 1974 and by extrapolation at the end of 1976. By NSO's estimates of a crude birth rate of 37.0 and crude death rate of 8.9, the growth rate (excluding migration) was 2.8 percent at the end of 1974. The alternative crude birth rate of 36.1 would yield a growth rate of 2.7 percent at the end of 1974. Linear extrapolation from the 1964-5 SPC and the 1974-5 SPC to the end of 1976 would produce growth rates of 2.7 for the higher estimated 1974 crude birth rate of 37.0 or 2.6 for the lower estimate of 36.1.

Unpublished data from the SOFT/WFS calculated for two year periods rather than five year periods indicate that fertility decline has not been linear but accelerated rapidly in the period 1972-74. Similarly, preliminary unpublished data for the 1975-6 SPC indicate more rapid decline than one would obtain from linear extrapolation from the 1964-5 SPC and 1975-6 SPC. It seems wise therefore to estimate for the end of 1976 a range for the growth rate of 2.4 to 2.7.

RECOMMENDATIONS

1. AN NFPP RESEARCH COORDINATING BODY SHOULD BE ESTABLISHED TO COORDINATE FAMILY PLANNING RESEARCH PROJECTS TO BE FINANCED BY DOMESTIC AS WELL AS FOREIGN SOURCES.
2. THE NFPP SHOULD PUT MORE CONSIDERATION ON THE RESULTS OF THE RESEARCH STUDIES ACCOMPLISHED IN THAILAND AND ADOPT SOME GUIDELINES FOR THE IMPLEMENTATION OF THE PROGRAM BASED UPON THESE STUDIES. (FOR EXAMPLE, THE FEASIBILITY OF TRAINING PARA-MEDICAL PERSONNEL IN PERFORMING VASECTOMY OR TUBAL LIGATION, SHOULD THE USE OF VILLAGE HEALTH VOLUNTEERS BE ENCOURAGED? SHOULD INJECTABLE CONTRACEPTIVES BE PROMOTED AS A MAJOR METHOD WITHIN THE NFPP?)
3. THE RESEARCH AND EVALUATION UNIT SHOULD CONDUCT STUDIES TO DETERMINE THE CONTINUATION RATES OF VARIOUS METHODS USED IN THE PROGRAM AT MORE FREQUENT INTERVAL AND EMPHASIS SHOULD BE PUT ON THE SURVEY DESIGN.
4. THE R&E UNIT SHOULD PUT MORE EMPHASIS ON THE ANALYSIS OF THE SERVICE STATISTIC RETURNS IN TERMS OF THEIR IMPLICATIONS FOR THE NFPP PROGRAM. SPECIAL STUDIES SHOULD BE CONDUCTED IN AREAS WHERE SERVICE STATISTICS REVEAL GAPS AND WEAKNESSES IN THE PROGRAM OR INDICATE CHANGES IN CONTRACEPTIVE PRACTICE.
5. A SURVEY OF PRIVATE SECTOR COMMERCIAL DISTRIBUTION OF CONTRACEPTIVE METHODS SHOULD BE CARRIED OUT UNDER THE AUSPICES OF THE NFPP ON A REGULAR BASIS IN ORDER TO ASSIST THE PLANNING AND IMPLEMENTATION OF THE PROGRAM, I.E., TARGET RESETTING, ETC.

VII. PROGRAM IMPLEMENTATION

A. Services

Progress in service delivery during the Third Plan.

The organization of the National Family Planning Program in 1970 established the MOPH as the principal planning, coordinating, and operational instrument of national population policy. The planning and coordination functions, which relate family planning to the larger multi-sectoral policies and programs affecting population growth, are dealt with elsewhere in this evaluation (see Section III, National Population Policy).

Recognizing certain limitations in the statistical data base for assessment of the program, the evaluation nevertheless concludes that the accomplishments during the Third Plan indicate that the basic strategy underlying the NFPP is sound. It's demographic impact during the Third Plan was in large part achieved by a substantial increase in rural family planning services, utilizing an expanded rural health delivery network. During the plan period the number of rural service units (1st class H.C., 2nd class H.C. and midwifery center) was increased from 4,297 in 1972 to 5,464 in 1976. An extensive training program with increasing emphasis on delegation of more family planning tasks to non-physicians simultaneously enhanced the effectiveness of these units. The results are reflected in the table of estimated couple years of protection (see Appendix 21) which indicates an approximately six-fold increase in contraceptive protection between 1970 and 1976.

The "mix" of methods reflecting trends in contraceptive practice in Thailand is summarized in Appendix 22, and a comparison of achievement with regional acceptor targets, by methods, in Appendix 23. The following comments on acceptor rates by method reflect the consensus of the evaluation team based upon direct observation and discussion with MOPH staff during our field visits to all levels of service units in a sample of provinces representative of all four regions of Thailand. For a tabulation of family planning performance by percentage of eligible females in those provinces visited by the evaluation team, see Appendix 24.

B. Oral Contraception

Undoubtedly the predominance of oral contraception has resulted from the increased access to pills which was brought about through increased technical competence and responsibility given to lower level health workers. Experience in Thailand has amply demonstrated the safety and effectiveness of oral contraceptive distribution by suitably trained nurses and auxiliary midwives.

1. The Community Based Family Planning Service Program

That this delegation can be further extended to various categories of non-medical personnel is now being demonstrated (and simultaneously evaluated) in the Community Based Family Planning Services Program (CBFPS). Under its village program, at least one local family planning volunteer distributor per village is trained to provide information, motivation, and contraceptive supplies (pill, condom) and to function as a resource for referral to government health centers and hospitals for contraceptive services (IUD, sterilization, and management of contraceptions) not provided directly by CBFPS.

The CBFPS village program now operates in 68 districts scattered throughout the country of Thailand. In June 1977, the program was expanded to include 83 additional districts which will ~~extend~~ coverage to more than 25 percent of the districts in Thailand.

The preliminary results of the most recent annual impact and effectiveness survey showed that in the two years since the village program began, the pregnancy rate has dropped by 40 percent in the villages.

In addition to the village programs, two additional major distribution programs have been initiated by CBFPS. These are (a) a Public Institution Program, which includes the enlistment and training of Teachers factory workers, and military personnel as motivators and distributors, and an integrated Family Planning and Parasite Control Program, and (b) a Private Sector Program which concentrates on distribution in heavily populated areas and major transport terminals.

The net result of these innovations in both public and private sectors adds up to a continuing dominant role for the oral contraceptive method for the foreseeable future.

Problems

MOPH personnel at several of the sites visited in rural areas complained that changes of pill brands provided in the past in the external assistance program have hampered continued acceptance and accounted for preventable dropouts from oral contraception. Others had only one brand of pill in stock, and were accordingly unable to treat side effects by changing to an alternative formulation.

RECOMMENDATIONS

1. EACH SERVICE SITE SHOULD BE PROVIDED WITH TWO ALTERNATIVE PILL FORMULATIONS TO ALLOW FOR CHANGING BRANDS WHERE INDICATED.

2. EXTERNAL ASSISTANCE PROGRAMS, AS WELL AS THE RTC, SHOULD BE CONSISTENT IN THE FORMULATION, PACKAGING AND BRAND NAME OF PILL SUPPLIES IN ORDER TO ASSURE SUSTAINED ACCEPTANCE.
3. PILL DISTRIBUTION SHOULD BE INCLUDED AS A MATTER OF POLICY AMONG THE REGULAR FUNCTIONS OF HOME VISITS BY MIDWIVES AND JUNIOR SANITARIANS IN ORDER TO MAXIMIZE THE ROLE OF THE SECOND CLASS HEALTH CENTER AS A SOURCE OF CONTRACEPTIVE SERVICE.

C. Intrauterine Contraception

While the IUD still accounts for a significant fraction of overall contraceptive protection in Thailand, its popularity among methods has declined here as it has elsewhere. A total of 424,738 new IUD acceptors were reported over the Third Plan Period (see Appendix 25). Annual new IUD acceptors declined from 90,128 in 1972 to 76,259 in 1976. Data from the sample of service sites visited in this evaluation indicate that this trend is continuing.

The relative contribution of the IUD to the total family planning effort in Thailand has suffered from its dependency upon trained professional personnel for insertion and followups. Clinical studies of IUD performance in Thailand (using both Lippies Loop and Copper-T) have reported rates of protection, continuation, complications and side effects similar to (and in some cases, better than) those in other parts of the world. Recognizing the shortage of physicians in the rural areas, and having demonstrated in pilot studies, the ability of suitably trained nurses to provide intrauterine contraceptive service, the NFPP undertook an ambitious and successful program to utilize nurses in this capacity. Utilizing nurse-midwives specially trained as trainers in Downstate Medical Center, New York, and Chulalongkorn Hospital, Bangkok, training capacity was rapidly extended to the Regional MCH Centers and other institutions, and the evaluation team found ample evidence of second and third generation trained nurses deployed throughout the rural family planning delivery network.

Since 1975 nurses have been officially authorized by the MOPH to insert IUDs. The shortage of rural health personnel persists, nevertheless, and extension of training in IUD insertion to the next echelon, the auxiliary midwife, was begun on a pilot basis in 1976. Two groups of 20 midwives each have been trained and are being evaluated by the Family Planning Unit at Chulalongkorn in collaboration with NFPP. While it appears likely that further extension of IUD service capability to the level of the rural second-class health center and midwifery station can be achieved without sacrificing safety, the net contribution of this diffusion of accessibility will depend on the relative acceptability of the IUD among methods, which has unquestionably been declining in recent years. Despite low rates of complications and side effects in earlier published reports, the evaluation team encountered evidence of decreasing enthusiasm for intrauterine

contraception as alternatives (pill, DMPA, sterilization) become increasingly available. Complaints of pain, bleeding, disagreeable discharge, spreading rumors of IUD failures, and a disinclination by rural women to expose themselves to pelvic examinations were mentioned among reasons for preference for other methods.

Findings and Recommendations

1. Although there have been delays in the continuing supply of IUD inserters in the field, this appears to have been corrected recently. There are, however, inconsistencies in the provision of loops and insertion equipment which should be adjusted to local needs. For example, the large size vaginal speculum is considered unnecessary and rarely used, and the size "C" Lippes Loop is strongly preferred over the size "D" which is available in larger quantities.

RECOMMENDATION: LOCAL IN-COUNTRY PREFERENCES AMONG INSTRUMENTS AND DEVICES SHOULD BE CONSIDERED IN THE PROVISION OF KITS AND SUPPLIES FOR INTRAUTERINE CONTRACEPTIVE SERVICE.

2. Current MOPH planning, pending evaluation of the pilot projects training of midwives to insert IUDs, calls for a commitment during the Fourth Plan to train 1,000 additional midwives for IUD insertion in the peripheral service units. This extension of services to a larger rural pool of potential acceptors involves risks to the program as well as benefits. In view of the findings of the evaluation regarding the importance of negative rumors, and the impression gained from field interviews that discontinuation rates appear to be higher than those of earlier published studies, it is necessary that all service centers where IUD insertion is provided be adequately assured of a system of medical backup and supervision. Moreover, the preparation of staff for this function must include training in techniques of counteracting negative rumors and in educating acceptors about the side effects and complications.

RECOMMENDATION: WHILE THE EVALUATION AGREES WITH THE RATIONALE FOR TRAINING MIDWIVES FOR IUD SERVICE (PENDING EVALUATION OF THE PILOT PROJECT), PROVISION OF THIS SERVICE IN PERIPHERAL RURAL UNITS SHOULD ONLY BE PERMITTED WHERE ADEQUATE SAFEGUARDS IN THE FORM OF MEDICAL BACKUP AND SUPERVISION CAN BE ASSURED.

D. Voluntary Surgical Contraception (VSC)

The growing acceptance of sterilization in Thailand is evidenced by the NFPP data which shows an increase from 32,688 acceptors in 1972 to 105,281 in 1976. Several factors have contributed to this increase, including an effective motivational effort, extension of service by mobile teams, expanded training of both physician and non-physician (the latter on a pilot project basis) personnel, and a national sterilization subsidy program. More-

over, improved surgical techniques have contributed not only to greater acceptance, but to changes in the ratio of male to female operations over the years. Female sterilization, once confined largely to puerperal tubal ligation in the small percentage of women who deliver in hospitals, is now more widely available as an interval ambulatory procedure using either the laparoscopy or "mini-laparotomy" technique. Thus, the ratio of male to female operations, which had been 1:2 less than a decade ago, had become 1:10 by 1976. This trend is now being reversed by the active promotion of vasectomy, in particular by the mobile sterilization units.

In 1972 a national sterilization subsidy program was implemented with assistance from UNFPA. Upon expiration of the UNFPA funding in 1976, a revised project agreement was implemented by the USG and RTG under which acceptors obtain free sterilization services at subsidized rural non-hospital health facilities. The subsidy covers the client costs to the clinic, viz: 150 baht for female sterilization and 50 baht for vasectomy (since June 1, 1977 the subsidy for client cost for vasectomy is 150 baht). In addition, the program provides the resources to cover the increased costs of sterilizations performed beyond the NFPP target of 90,000 procedures in FY 1977. The agreement includes, in addition to the subsidy payment, funds for vehicles and equipment for mobile-unit vasectomy service. A revision of the FY 1976 project agreement provides funds for training 140 physicians, plus institutional support for sterilization training.

Mobile Vasectomy Teams

USAID has allocated counterpart funds for purchasing 20 mini-buses in 1976 (on a 50-50 basis with the RTG) and 20 mini-buses in 1977. The mobile vasectomy teams help to increase the number of rural vasectomy acceptors. The NFPP now has 17 mini-buses in operation, and it is expected that the remaining mobile vasectomy clinics will be in service as soon as the mini-buses, equipment, and supplies are available.

The evaluation team paid special interest to the provision of informed consent for sterilization procedures. While informed consent for all surgical procedures has been an established practice in Thailand for many years, a new and expanded informed consent form for sterilization has been initiated by the NFPP in recent months. The new form specifies that the procedure will make the acceptor sterile, that it is permanent, and that it is voluntary and obtained without any material reward or inducement. It must be witnessed and endorsed by the spouse in the case of female sterilization. It also includes a signed statement by the practitioner attesting to the above mentioned conditions. Although circulation of the new forms in triplicate (one copy for the acceptor, one for the service unit, and one for NFPP) is not yet complete, the evaluation found the form in use in all but one service unit, and in the latter case, an older version but equally informative consent procedure was used. Based upon our

first hand observations, including interviews with acceptors in some sites, the evaluation team is satisfied that volunteerism is strictly observed, and that proper informed consent is provided by the NFPP. (See Appendix 25 for English translation of the current NFPP consent form.)

Training for sterilization in Thailand deserves special mention. While the number of trained physicians and the resources for sterilization are still insufficient to meet the demand in the immediate future, the quality of training in all procedures for permanent contraception is excellent, and the precedent for in-country training is established by the Ramathibodi Fertility Termination Training Program, under which physicians from 100 of the 250 district hospitals have been trained. This demonstrated capacity, along with the innovative pilot projects under which surgical nurses, paramedics, and undergraduate medical students have been trained to perform sterilization procedures, indicates that Thailand has achieved self-sufficiency in training capability for surgical contraception. The evaluation foresees a continuing need for surgical equipment, vehicles, IE&C materials, etc., but does not feel that participant training overseas for sterilization procedures will be needed in the future.

Findings and Recommendations

1. In all parts of the country, demand exceeds supply for sterilization services. Moreover, recent surveys and special studies ("Acceptance and Non-acceptance of Vasectomy in Rural Thailand" by Dr. Debhanom Muangman, Mahidol S.P.H., May 1977 and unpublished studies of CBFBS and NFPP mobile vasectomy projects) indicate the potential for still greater demand, given an appropriate motivational effort.

Accordingly, some external assistance will continue to be needed if the requisite number of sterilizations to meet anticipated demand is to be met.

RECOMMENDATION: USG ASSISTANCE TO THE NFPP PROGRAM IN VOLUNTARY SURGICAL CONTRACEPTION SHOULD CONTINUE AT APPROXIMATELY THE FY 1977 LEVEL (US \$1.8 MILLION) WITH EVALUATION ON A CONTINUING BASIS.

2. The sterilization subsidy not only contributes to increased acceptors in rural non-hospital health facilities, but also provides clinic income needed for other family planning services.

RECOMMENDATION: THE VARIOUS GOVERNMENT AGENCIES CONCERNED, SUCH AS MOPH, NESDB, DTEC, AND BOB, SHOULD DEVELOP PLANS IN PREPARATION FOR THE EVENTUAL PHASING OUT OF THE SUBSIDY IN THE FUTURE.

3. While most service units observe the requirement of two living children as a pre-requisite for male or female sterilization, exceptions to this practice were encountered. A uniform policy in this regard would serve the best interests of acceptors and the NFPP alike.

RECOMMENDATION: THE NFPP SHOULD IMPLEMENT AND ENFORCE A UNIFORM POLICY REGARDING ELIGIBILITY FOR STERILIZATION ON THE BASIS OF LIVING CHILDREN.

4. Medical School output (currently at about 500 graduates per year) and in-service training of practicing physicians, will not sufficiently meet the demand for sterilization services for the next several years. Therefore, existing efforts to seek non-physician alternatives should continue.

RECOMMENDATION: A THOROUGH SURVEY AND EVALUATION OF ALL PILOT PROJECTS INVOLVING PROVISION OF STERILIZATION SERVICES BY NON-PHYSICIANS SHOULD BE UNDERTAKEN, AND ITS RESULTS UTILIZED IN THE FORMULATION OF NEW POLICIES AND PLANS FOR ACHIEVING STERILIZATION TARGETS IN THE REMAINDER OF THE FOURTH PLAN.

5. While mobile sterilization units have demonstrated their value in increasing acceptance of vasectomy in rural areas, they are not yet readily available to all provinces.

RECOMMENDATION: ONE MOBILE UNIT FOR STERILIZATION SERVICE SHOULD BE BASED IN EVERY PROVINCE.

6. The Laparoscope, although very useful in performing female sterilization rapidly and effectively, is, nevertheless, expensive and difficult to maintain. While the Ramathibodi Hospital has made available a repair and maintenance resource for those institutions employing laparoscopy in rural areas, some delays in repairs and maintenance are inevitable.

RECOMMENDATION: FOR PRACTICAL AND ECONOMICAL REASONS, LAPAROSCOPIC STERILIZATION SHOULD BE PROVIDED CHIEFLY TO LARGER HOSPITALS. IN MOST RURAL AREAS, EMPHASIS SHOULD BE GIVEN TO TRAINING AND EQUIPMENT FOR STERILIZATION BY MINI-LAPAROTOMY AND VASECTOMY.

E. Injectable Contraception (DMPA)

While injectable DMPA continues to be provided on a "pilot project" basis, its acceptance and prevalence is increasing rapidly. Even though targets were not established until 1977 by the NFPP, DMPA acceptors increased from 6316 in 1972 to 66,991 in 1976 and a total of 127,327 new acceptors were reported over the Third Plan period (see Appendix 25).

In many instances this rapid increase has required local purchase by service outlets, since NFPP supplies reflect the modest targets set for 1977.

A high degree of protection against unwanted pregnancy, a cultural preference for injections in general over other routes of administration, and freedom from fear of forgetting to take daily pills or unpopular coitus-related methods are the principle reasons the evaluation team encountered for growing acceptance of DMPA. At the same time, a high incidence of side effects were reported, and while heavy bleeding is seldom encountered, irregular bleeding and amenorrhea account for most discontinuations.

While the biomedical questions regarding long-term effects of DMPA are beyond the scope of this evaluation, it is noted that in Thailand, where some of the largest followup and widest experience in clinical use of DMPA has been studied, no serious sequelae have been encountered, and confidence in the safety and effectiveness of this method is increasing.

Finding and Recommendation.

The pilot project status of DMPA inhibits, somewhat, its ready incorporation into the mainstream of family planning service. In particular, the training of lower-level family planning personnel in management of DMPA contraception and the planning of budget and targets on a realistic basis would be enhanced by a clarification of the status of DMPA in the family planning armamentarium.

RECOMMENDATION: THAT COMPLETION OF EVALUATION OF PILOT STUDIES AND EARLY ACTION BY THE THAILAND FOOD AND DRUG ADMINISTRATION SHOULD BE SOUGHT BY THE MOPH IN ORDER TO CLARIFY THE STATUS OF DMPA AMONG APPROVED CONTRACEPTIVE METHODS.

F. Condom Contraception

Condom usage is extremely limited in Thailand. Locally manufactured condoms are readily available at low cost in drug stores, and the NFPP has made condoms available at all service outlets. Nevertheless, the most recent survey of knowledge and practice of birth control by eligible women (reported in "First Round of the Household Survey to Evaluate the Impact and Effectiveness of the CBFPS program in Thailand," 1977), less than 1 percent of the households sampled in the control areas knew about condom contraception although nearly all had knowledge about one or more birth control methods.

While condom acceptors are not currently considered in the setting of targets or the calculation of demographic effects of contraception in Thailand, the importance of condom distribution and availability is nevertheless acknowledged. In particular, its use as an "interim" method, as an adjunct to vasectomy, and as an "entry point" into contraceptive practice deserves mention. The condom is included in IE&C materials and family planning education, and is made available at the most peripheral health units by junior sanitarians and auxiliary midwives.

More recently, the incorporation of non-professionals into the family planning diffusion network (including tambon doctors, community health volunteers, etc.) has extended the potential for rural condom distribution.

The effort by the CBFPS to change the "image" of the condom has attracted considerable attention and is noteworthy. While the major emphasis of this program has been on community-based pill distribution, its ingenious and popular advertising methods featuring such attention-getting items as balloon (condom) blowing contests or promotion of condoms as "multipurpose" items, and its effective multi-media approach has given a new "visibility" to the condom and enhanced its recognition as a form of contraception planning method.

Finding and Recommendation

Although condom distribution is widespread in NFPP service units, there is as yet no standard policy for the role of the condom in the overall family planning program.

RECOMMENDATION: ACCOUNTABILITY FOR ISSUE OF CONDOMS TO SERVICE UNITS AND GUIDELINES FOR THEIR DISTRIBUTION SHOULD BE STANDARDIZED AS A MATTER OF NFPP POLICY. }

G Information, Education and Communication (IE&C)

The IE&C Division of the NFPP has a staff of 37. Of these, 24 are members of eight mobile IE&C units which **serve** eight **areas** of the country to support the IE&C activities of the provinces in that **area**. During 1973-76 the staff of the IE&C unit had direct contact with

6,503	health personnel
9,202	community leaders
1,197,457	members of the general public

They also produced and distributed a wide variety of materials including, but not limited to:

5	40 minute films
3,361	half-hour radio programs
232	sets of slides
13,000	motivation kits
4,263,000	pieces of printed matter

Finally they carried on a variety of research programs in relationship to IE&C. A second IE&C effort which merits discussion is that of the Community Based Family Planning Services. This private non-profit organization has used many community-based IE&C methods including poster coloring contests for children, loan of stud pigs to family planning acceptors and condom blowing contests for school children.

Findings

1. The poster and pamphlet distribution system is excellent. There was ample evidence of these materials at all health sites visited.
2. The audio-visual efforts of the IE&C program seem excellent in their effectiveness in recruiting new acceptors. However, because of lack of equipment and materials, these efforts cannot be duplicated at the provincial level.
3. The development and distribution of family planning motivation kits is a substantial effort at bringing family planning motivation materials to a local level.
4. During the Fourth Plan, IE&C priorities will be given to sterilization.
5. There is a need at all levels of government for population education. This is especially true among government officials outside of the MOPH.
6. There is some expressed need for culturally specific IE&C materials and methodologies.

RECOMMENDATIONS

1. THE PROVINCES SHOULD BE PROVIDED WITH AUDIO-VISUAL EQUIPMENT AND SUPPORTED BY REGIONAL AND/OR NATIONAL MEDIA RESOURCE CENTERS.

AS AN ALTERNATIVE, NON AUDIO-VISUAL IE&C METHODOLOGIES SHOULD BE DEVELOPED FOR USE AT THE PROVINCIAL AND LOWER LEVELS.
2. CAREFUL FOLLOWUP STUDIES AND EVALUATION SHOULD BE MADE OF THE VARIOUS COMPONENT PARTS OF THE FAMILY PLANNING MOTIVATION KITS. SUCH STUDIES SHOULD BE UTILIZED IN THE DEVELOPMENT OF FURTHER MATERIALS TO BE USED AT THE SERVICE LEVEL.
3. BECAUSE OF THE NEW EMPHASIS ON MOBILE VASECTOMY UNITS BASED IN THE PROVINCES, THE IE&C DIVISION SHOULD PUT EMPHASIS ON DEVELOPING MALE STERILIZATION MOTIVATION MATERIALS AND METHODOLOGIES.
4. FOR PROVINCES WITH DISTINCT CULTURAL GROUPS (E.G. HILLTRIBES MUSLIMS) THE IE&C DIVISION SHOULD DEVELOP CULTURE-SPECIFIC MATERIALS AND METHODOLOGIES IN COOPERATION WITH PROVINCIAL STAFF MEMBERS.
5. THE IE&C DIVISION IN CONJUNCTION WITH THE TRAINING DIVISION SHOULD DEVELOP PROGRAMS IN POPULATION EDUCATION. SUCH PROGRAMS SHOULD BE AIMED AT OTHER RTG MINISTRIES, AND GOVERNMENT OFFICIALS AT ALL LEVELS. IN ADDITION, TEACHERS SHOULD RECEIVE POPULATION EDUCATION ALONG WITH FAMILY PLANNING EDUCATION.

VIII. TRAINING

A. Background

1. Training Division

Training is one of five divisions of the National Family Planning Program. It is staffed by 22 nurse-midwives who are divided into two sections, training and supervision. During the Third Health Plan the division was responsible for the training of the following MOPH personnel:

766 physicians
 2,020 nurses
 8,945 midwives
 4,152 sanitarians
 100 clinic workers
 15,943 total (for further details
 see Appendix 26)

The largest single number of personnel trained in one year was 1975 when 3,225 were trained

2. IE&C Division

The IE&C division has been responsible for training personnel at the provincial level in motivation and communication techniques. This has been accomplished by sending one of eight mobile IE&C teams composed of three persons to each province for a period of one week of training followed by three to five weeks of motivational activities. As of July 1977, personnel in 69 provinces had received this IE&C training.

B. Training of Nurses and Paraprofessionals

1. The biggest single thrust during the Third Health Plan was a program to train 5 to 10 senior nurses from each province in family planning methodology, record-keeping and motivation. These nurses then returned to their provinces where they were responsible for training midwives, sanitarians and other nurses in their province. Two members of the NFPP training staff gave assistance to these efforts in each province.

Finding

Based on the observation that personnel at all levels were involved in, and knowledgeable about, family planning, this training seemed to be successful.

RECOMMENDATION: DURING THE THIRD AND FOURTH PLANS, 5,357 SANITARIANS WILL BE TRAINED IN FAMILY PLANNING. THIS MEANS THAT BETWEEN 500 AND 1,000 REMAINING SANITARIANS WILL HAVE

RECEIVED NO FORMAL FAMILY PLANNING TRAINING. IN LIGHT OF THE INCREASED EMPHASIS ON VASECTOMY AND MALE PARTICIPATION IN FAMILY PLANNING, AND THE INCREASED NUMBER OF PERSONNEL TO BE SUPERVISED FROM THE DISTRICT, AND SECOND-CLASS HEALTH CENTERS (VILLAGE HEALTH COMMUNICATORS, VILLAGE HEALTH VOLUNTEERS, AND TAMBON DOCTORS) EMPHASIS SHOULD BE PLACED ON SUPERVISORY AND MOTIVATION TRAINING FOR SANITARIANS.

2. To date, 200 nurses have been trained in IUD insertion and as nurse trainers through Chulalongkorn University

Finding

This program is a success as there are IUD trained nurses functioning throughout the country at the provincial and district levels. There is ample evidence of second and even third generation training occurring in the provinces. An additional 400 nurses are presently being trained in IUD insertion. We have also seen evidence of individual physicians taking the initiative to train nurses in IUD insertion. Thus, the role of the nurses as IUD inserters is well established and accepted.

RECOMMENDATION: ALTHOUGH THE NUMBER OF PERSONNEL QUALIFIED TO INSERT IUDS HAS INCREASED, THE NUMBER OF IUD ACCEPTORS IS DECREASING. THEREFORE, CAREFUL STUDY IN TERMS OF ACCEPTOR INCREASE SHOULD BE MADE BEFORE MANY ADDITIONAL PERSONNEL ARE TRAINED IN IUD INSERTION.

3. Ten nurses have recently completed training in post-partum sterilization. It is too early to evaluate the results of this training. We did note that there is some hesitation on the part of physicians to allow these nurses to operate without a doctor in the operating room.

There is currently underway a pilot study at Ramathibodi Hospital to train 20 male nurses and sanitarians to perform vasectomies. We also observed a nurse and sanitarian trained by a chief provincial medical officer performing vasectomies with a rural mobile unit.

RECOMMENDATION: IF THE ABOVE PILOT STUDIES PROVE SUCCESSFUL, EMPHASIS SHOULD BE PLACED ON TRAINING PARA-PROFESSIONALS TO PERFORM STERILIZATIONS. SPECIAL EMPHASIS SHOULD BE GIVEN TO VASECTOMY TRAINING.

4. The Fourth Health Plan calls for the training of 1,000 midwives in IUD insertion.

Finding

IUD acceptors are declining despite increased providers of service. Based on field observations, the one-year retention rate is less than 70 percent and may be as low as 50 percent. IUD insertion training is relatively long and expensive requiring a high trainer to trainee ratio.

RECOMMENDATION: BEFORE LARGE NUMBERS OF MIDWIVES ARE TRAINED IN IUD INSERTIONS, CAREFUL STUDY BE MADE OF THE COST EFFECTIVENESS OF SUCH TRAINING.

5. DMPA is the most rapidly increasing method utilized by acceptors.

RECOMMENDATION: ONCE THIS METHOD IS APPROVED BY THE RTG, ALL PERSONNEL IN ALL SECOND CLASS HEALTH CENTERS AND MIDWIFERY STATIONS SHOULD BE TRAINED IN ITS USE.

C. Physician Training

Eight hundred twenty-one physicians are included among professionals trained under the NFPP over the Third Plan period. Special training programs for physicians include:

1. One hundred forty physicians trained in male and female sterilization techniques in six training centers established by the MOPH.
2. Two hundred seventy-six physicians trained in interval sterilization techniques under an IPAVS assisted project (84 physicians trained at Ramathibodi Hospital, plus 192 second and subsequent generation trainees).
3. Approximately 100 physicians trained in vasectomy techniques under the Fertility Termination Training Program (a project aimed at decentralization and satellization which aims toward availability of vasectomy in 250 district hospitals).
4. Fifteen physicians trained in the U.S. under the Program for International Education in Gynecology and Obstetrics (PIEGO). Training of physicians has been further enhanced by the provision (IPAVS, PIEGO) of laparoscopic equipment and of sterilization kits (USAID).

While a detailed analysis is beyond the scope of this evaluation, additional training of physicians in other medical schools and in the private sector, such as the McCormick Hospital program, have contributed measurably to increased capacity for delivery of family planning services by physicians. It is evident from this evaluation that sufficient capability in physician training exists within Thailand to preclude the necessity for further overseas training, except for updating of selected trainees as new advances in fertility control technology emerge.

D. Non-professional Training

1. The NFPP has recently embarked on a massive plan to train non-professionals as distributors of non-clinical family planning methods and/or as family planning communicators. Reports from various sources list the following as types and numbers of non-professionals to be trained during the Fourth Plan.

Traditional Birth Attendants	7,500	plus an additional 1,410 trainers
Tambon Doctors	4,400	
Family Planning Workers	600	
Border Patrol Police	400	
Mobile Hilltribe Personnel	550	
Self-help Land Settlement Per- sonnel	1,000	plus an additional 93 trainers
Total	18,850	

In addition, the NFPP Training Division is scheduled to participate in the training of 44,800 village health volunteers and village health communicators.

Present plans include having the NFPP Training Division train directly or train trainers of non-professionals. They will also be responsible for monitoring training at provincial level, providing technical assistance and training evaluation.

A large part of the actual training responsibility will fall on sanitarians and nurses at the provincial, district, and second class health center levels.

Findings:

There is evidence of limited communication to the provinces about the future scope of their training responsibilities.

There is extremely limited capacity in terms of the training and mobilization on the part of provincial, district, and second class health center personnel, to supervise this massive influx of new personnel.

There have been doubts expressed at all levels about the effectiveness of using traditional healers for family planning. One pilot study sponsored by the International Development Research enter indicated each trained TBA accounted for three new acceptors a year. Extrapolated by 7,500 this would account for 22,500 new acceptors a year, a 3.5 percent annual increase.

RECOMMENDATIONS: CAREFUL EVALUATION BASED ON INCREASED ACCEPTORS AND CAPACITY TO PROVIDE (1) TRAINING, (2) SUPERVISION, AND (3) SERVICE, BE MADE IN PILOT AREAS. THIS EVALUATION SHOULD BE CARRIED OUT BY AN OUTSIDE AGENCY SUCH AS THE SCHOOL OF PUBLIC HEALTH.

COMPARISON SHOULD BE MADE OF THE EFFECTIVENESS OF EACH TYPE OF NON-PROFESSIONAL.

2. The NFPP Training Division has always had a limited program of providing family life education and family planning train-

ing to institutions outside of the MOPH. That this program has been successful can be seen by the fact that the NFPP currently has plans to provide training in the next 18 months to 15 such diverse groups as pharmacists, military personnel, agricultural extension workers and nursing instructors.

Findings

The interest in and need for family planning training outside of the MOPH is increasing.

The quality of training offered by the NFPP training division is acceptable based on increasing requests.

RECOMMENDATIONS: FUTURE PLANS FOR FAMILY PLANNING TRAINING OUTSIDE THE MOPH MUST TAKE INTO CONSIDERATION THE INCREASED DEMANDS ON THE TRAINING CAPACITY OF THE NFPP REFLECTED IN THE FOURTH TRAINING PLAN. (SEE G, RECOMMENDATION 2.)

E. IE&C Training

The IE&C division carries out training by the use of 8 mobile teams of three people. Each team is provided with a vehicle equipped with a complete range of audio-visual equipment. As of July 1977 all but two provinces have received IE&C training. When a team enters a province it provides one week of training and then supports provincial staff for three to five additional weeks during mobile family planning campaigns.

Finding

The IE&C effort is heavily based on the use of media and audio-visual materials. Once the team has left, these materials are not available in the provinces, so much of the training received cannot be utilized.

RECOMMENDATION: SINCE THE IE&C EFFORTS SEEM TO BE EXTREMELY EFFECTIVE WHEN CARRIED ON BY THE NFPP STAFF, THE PROVINCES SHOULD BE GIVEN MEDIA EQUIPMENT AND MATERIALS TO EXPAND THIS EFFORT.

AN ALTERNATIVE WOULD BE A NEW IE&C TRAINING EFFORT AT THE PROVINCIAL AND DISTRICT LEVELS TO CREATE A NON MEDIA-DEPENDENT IE&C PROGRAM.

F. Quality of Training Given by NFPP Training Division

The overall quality of training in the past seems to be excellent. There is ample evidence of the use of needs assessments, innovative learning methodology and a concern for evaluation. In addition, the large numbers of personnel working effectively in family planning attests to the quality of the program.

Finding

The new training center at Lampang should add to the quality of training.

In recent months the quality of training has begun to suffer and will probably continue to do so because of the overburden on the central NFPP training staff. The press of training is so great that there is little time for needs assessments or curriculum planning. Complete evaluation can only be done on high priority pilot training projects such as the use of midwives for IUD insertion.

The program has been so successful that it has created a demand that is damaging the quality of training.

RECOMMENDATION: (SEE G, RECOMMENDATION 2)

G. Quality of Training

It seems evident that the NFPP Training Division is being asked to produce more than its capable staff is able to accomplish.

The 1975 National Family Planning Project Evaluation stated "The Training ... will be implemented effectively only when the NFPP has an adequate number of personnel to conduct training..."

The 1977 WHO report on Achievements of the National Family Planning Program 1972-1976 states "The training capacity of the Family Health Division is stretched to the maximum with its present staff. Any further expansion of training activities would be to the detriment of the managerial tasks of the insufficient staff."

Despite the recommendations of these two reports, the 1977-78 plans call for the NFPP to:

1. Provide training to 2,034 personnel.
2. Conduct an additional 13 training programs of several days each for a variety of organizations.
3. Supervise, give technical assistance, and evaluate the training of an additional 13,950 personnel. This is to be accomplished with a staff of 22 (17 in the Training section and five in the supervision section). At the present time there are no full-time supervisors as supervisory staff is being used to provide training.

Findings

The front loading of funds by USAID has seriously overloaded the capacity of the NFPP training program.

There is evidence of lack of coordination between donor agencies and NFPP priorities. See Appendix 27.

Due to training pressures, there is a lack of planning and evaluation.

RECOMMENDATIONS:

1. THE FOURTH TRAINING PLAN ^{SHOULD} BE REVIEWED AND REVISED BY THE RTG AND ALL DONOR AGENCIES WITH THE INTENT OF (1) SETTING PRI-

ORITIES, (2) SETTING REALISTIC TRAINING GOALS, (3) DOVE-TAILING SIMILAR PROGRAMS (E.G., TRAINING OF TRAINERS FOR TBPS, TAMBON DOCTORS, VILLAGE HEALTH VOLUNTEERS AND VILLAGE HEALTH COMMUNICATORS).

2. IN VIEW OF THE LIMITED MANPOWER CAPACITY OF THE NFPP TRAINING DIVISION ONE AND/OR ALL OF THE FOLLOWING ALTERNATIVES SHOULD BE CONSIDERED:
 - a. GREATLY INCREASING THE STAFF OF THE TRAINING DIVISION.
 - b. ASSIGNING A FULL-TIME FAMILY PLANNING NURSE TRAINER/SUPERVISOR TO EVERY PROVINCIAL OFFICE.
 - c. UTILIZING NON-MOPH ORGANIZATIONS FOR PORTIONS OF THE TRAINING. POSSIBLE RESOURCES INCLUDE THE CBFPS, PLANNED PARENTHOOD ASSOCIATION OF THAILAND AND/OR COMMERCIAL DRUG COMPANIES.
 - d. REDUCING THE AMOUNT OF FAMILY PLANNING TRAINING TO BE DONE DURING THE FOURTH HEALTH PLAN.
3. THE SUPERVISION SECTION OF THE NFPP TRAINING DIVISION SHOULD BE STRENGTHENED AND MADE RESPONSIBLE FOR QUANTITATIVE, QUALITATIVE, AND COST EFFECTIVENESS EVALUATION OF ALL TRAINING. A SPECIFIC PERCENTAGE OF THE TRAINING BUDGET SHOULD BE UTILIZED FOR EVALUATION.

H. Other In-service Training

1. Finding

There will be a great influx of new health workers 1977-81. Plans call for supervision of these personnel to be done at the provincial, district second class health center and midwifery station levels. At the present time, no one below the district level is trained in supervision. Supervision capacity and skill at the provincial and district levels is limited. (Each health station received three to four supervisory visits a year.)

RECOMMENDATION: HEALTH PERSONNEL AT THE PROVINCIAL, DISTRICT, SECOND CLASS HEALTH CENTER AND MIDWIFERY CENTERS SHOULD RECEIVE SUPERVISION TRAINING WITH EMPHASIS ON PERFORMANCE ANALYSIS, UTILIZATION OF RESOURCES, PRIORITY SETTING, AND PROBLEM SOLVING.

2. Finding

There is evidence that the statistics and record-keeping system is not well understood or utilized by personnel at the service level. This results in faulty statistics throughout the system.

RECOMMENDATIONS:

1. A MANUAL ON RECORD-KEEPING SHOULD BE DEVELOPED FOR SERVICE PERSONNEL.
2. ALL SERVICE PERSONNEL SHOULD RECEIVE ANNUAL OR BI-ANNUAL TRAINING ON RECORD KEEPING. THIS SHOULD BE A PART OF ALL OTHER IN-SERVICE TRAINING PROGRAMS.
3. SPECIFIC TRAINING MATERIALS SHOULD BE DEVELOPED (E.G., PROGRAMMED LEARNING) WHICH WOULD ASSURE AND DEMONSTRATE UNDERSTANDING AND CORRECT USAGE OF THE RECORD-KEEPING SYSTEM.

I. Pre-service Education

Finding

Family planning is presently included as part of the basic training of most health personnel. This education is aimed heavily at the knowledge and attitudes level. In many schools not enough family planning skills are taught to make the graduates functional without further training.

RECOMMENDATIONS

1. AS PART OF THE BASIC CURRICULUM ALL JUNIOR SANITARIANS BE TAUGHT (1) FAMILY PLANNING MOTIVATION, ESPECIALLY VASECTOMY, (2) TO DISTRIBUTE PILLS AND CONDOMS, (3) TO DEAL WITH QUESTIONS ABOUT THE SIDE EFFECTS OF ALL FAMILY PLANNING METHODS AND TO MAKE REFERRALS WHEN APPROPRIATE.
2. AS PART OF THE BASIC CURRICULUM ALL MIDWIVES AND NURSE MIDWIVES SHOULD BE TAUGHT 1, 2, and 3 ABOVE. IN ADDITION THEY SHOULD GRADUATE WITH THE SKILLS NECESSARY TO GIVE DMPA AND TO INSERT IUDS WITHOUT FURTHER TRAINING.

IX. COORDINATION WITH OTHER AGENCIES

Within the NFPP, about 97 percent of the family planning activities are implemented by various family planning clinics of the Ministry of Public Health. Only about three percent are implemented by other agencies which help the NFPP to achieve the targets. The agencies outside the Ministry of Public Health may be classified into two categories, viz;

A. Government Agencies Outside MOPH

These include the University teaching hospitals, military hospitals, municipal health centers of the Ministry of Interior, and Border Patrol Police outpost clinics. These health facilities outside MOPH are responsible for 2.3 percent of all family planning clinics.

B. Private Sector

Besides the non-MOPH and MOPH clinics, the private sector also plays a very important role in family planning activities.

1. McCormick Hospital, Chiangmai, has been delivering multiple health services to the people in Northern Thailand and it is widely known for its research on the use of DMPA for the past ten years.
2. Community Based Family Planning Services is a private organization established in 1974. Its main objective is to support the NFPP in pill and condom distribution and motivation. The CBFPS operations cover the remote areas where the government health services are not available. It is operating in 68 districts throughout Thailand and USAID has presently given support to the CBFPS to operate in 80 additional districts established by lay outreach workers as agents to distribute pills and condoms and motivate the remote villagers to accept family planning services.
3. Planned Parenthood Association of Thailand (PPAT) is a private association affiliated with the NFPP. Its objectives are to provide IE&C and to motivate the people to accept family planning services.
4. Drug stores play quite an important role in family planning. Many people in the urban areas purchase oral contraceptives from the drug stores. Approximately 3 to 5 million cycles of oral contraceptives are distributed through drug stores every year.

Except for the drug stores, most of the non-MOPH agencies and private organizations are coordinating with the NFPP in operational planning and reporting.

C. Operational Planning

The organizations of the private sector, such as the CBFPS, the PPAT, and McCormick Hospital, before implementing their operations, submit their plans of operations to the Family Planning Committee for consideration and approval in advance, in order to avoid overlapping of the delivery of family planning services.

D. Reporting

The private organizations report their achievements to the NFPP. They use the same forms used by the government family planning clinics for reporting. They submit their reports once a month.

Findings

Although it has been agreed that the private organizations and non-MOPH agency family planning clinics must send their reports to the MOPH, it has been observed that some private organizations do not report their family planning achievements to local MOPH officials. For example, in Phuket and Songkhla Provinces, the PCMOs informed the Evaluation Team that they did not receive family planning reports from the Christian hospitals in their provinces. If this is so, the data available for planning at the provincial level are incomplete.

The Evaluation Team also found that other organizations of the private sector, such as the CBFPS, have not submitted reports to the PCMO's of the provinces where they are operating, but the CBFPS reports its activities directly to the NFPP Central Headquarters in Bangkok. This creates a gap of coordination between the provincial chief medical officers and the private organization, and will affect provincial planning. An example of this was found in the CBFPS operations in Songkhla Province.

E. Referral Systems

The village health volunteer or the village agent at the CBFPS whose scope of responsibility is to deliver oral pills and condoms, will also motivate and refer the family planning acceptors to receive services from the government clinics. They also collect and submit data and statistics to the MOPH through the district health officer.

Findings

1. The acceptors who are referred for sterilization procedures at the district hospitals or provincial hospitals must wait for a long period of time before they get the services because the physicians have a long list of acceptors waiting for sterilization. Another problem is that the

private organizations do not return the referral cards to the hospitals when the acceptors have received the services.

RECOMMENDATIONS:

1. THE NFPP SHOULD ESTABLISH A POLICY TO ALLOW THE PRIVATE ORGANIZATIONS TO PARTICIPATE IN THE MOTIVATION PROGRAM OF THE MINISTRY OF PUBLIC HEALTH. A DEFINITE PLAN OF COORDINATION SHOULD BE ESTABLISHED AS TO HOW AND TO WHAT EXTENT THE PRIVATE ORGANIZATIONS WILL PLAY A ROLE IN THE NFPP.
 2. THE NFPP SHOULD ASSIST THE PRIVATE ORGANIZATIONS IN TECHNICAL ASPECTS TO IMPROVE THE PRIVATE ORGANIZATION'S CAPABILITY TO CARRY OUT THE ACTIVITIES IN THE SAME WAY AS GOVERNMENT AGENCIES. THE ASSISTANCE SHOULD BE IN THE FORM OF SEMINARS, CONFERENCES, TRAINING OF PHYSICIANS IN STERILIZATION PROCEDURES, ETC.
 3. *SHOULD BE HELD*
DISCUSSIONS BETWEEN THE PRIVATE ORGANIZATIONS AND MOPH REGARDING THE REFERRAL SYSTEM, SO THAT IT WILL BE MORE EFFECTIVELY CARRIED OUT.
 4. AS SOME CLINICS OF THE PRIVATE ORGANIZATIONS HAVE NOT SENT THEIR REPORTS TO THE MOPH, IT IS RECOMMENDED THAT FOLLOWUP AND STUDY OF VARIOUS STATISTICS OF ACHIEVEMENT BE DONE PERIODICALLY TO RENDER THE MOPH REPORTS MORE ACCURATE AND COMPLETE.
2. Though it plays by far the largest role in nationwide fertility reduction, the NFPP is not truly a "national" program in the broadest sense.

Discussion

None of the commercial sector and substantial numbers of hospitals providing family planning services in Thailand are included within the NFPP. It has been estimated that NFPP clients comprise from 30 to 50 percent of all persons practicing contraception in Thailand. Of the remainder, most receive services through the commercial sector (drug stores) followed by private clinics and programs. Even within the NFPP, service units which lie outside the Ministry of Public Health are also outside the operational control of the NFPP.

RECOMMENDATION:

SINCE THE PRIMARY OBJECTIVE OF THE NFPP IS REDUCTION OF THE OVERALL NATIONAL BIRTH RATE UPON WHICH OTHER PROGRAMS ALSO IMPINGE, THE NFPP SHOULD ATTEMPT TO DEVELOP MUCH CLOSER RELATIONSHIPS WITH THESE PROGRAMS THAN NOW EXISTS, SPECIFICALLY:

AN ONGOING WORKING COMMITTEE COMPRISED OF COMMERCIAL DRUG COMPANY AND NFPP REPRESENTATIVES SHOULD BE FORMED TO EXCHANGE DATA ON ACTIVITIES, ENTER INTO JOINT VENTURES WHERE APPROPRIATE, EXPLORE INNOVATIVE MARKETING AND SERVICE DELIVERY TECHNIQUES AND TO EXPLORE NEW AREAS OF CONTRACEPTION USE, OPERATIONAL RESEARCH, AND STANDARDIZATION OF COMMODITIES AND PHARMACEUTICALS. THE NFPP SHOULD ALSO TAKE AN ACTIVE ROLE IN HELPING TO MODIFY OR ELIMINATE BARRIERS TO CONTRACEPTIVE PRACTICE, SUCH AS NEW REGULATIONS RESTRICTING THE SALE OF CONTRACPTIVES THROUGH DRUGSTORES.

WITH REGARD TO ORGANIZED NON-MINISTRY OF HEALTH FAMILY PLANNING PROGRAMS, THE NFPP SHOULD ATTEMPT TO ACHIEVE CLOSER COOPERATION IN PROGRAM PLANNING AND IMPLEMENTATION THROUGH COORDINATION OF ALL ORGANIZATIONS DELIVERING FAMILY PLANNING SERVICES IN THAILAND.

X. PROSPECTS FOR THE FOURTH PLAN

A. Demographic Goals

There is reason to be optimistic that the Fourth Plan goal of reducing the national population growth rate of from 2.5 to 2.1 percent per annum will be achieved by 1981. A major reason for this optimism is that there apparently exists a firmly established countrywide downward trend in birth rates. Furthermore, family planning is rapidly growing in popularity and availability throughout the country. On the other hand, factors which could restrain progress toward this goal are restrictive government policies on the dissemination of contraceptives through the commercial sector or reduction in the level of financial support to the NFPP. Moreover, the extent to which family size preference is being influenced by the NFPP remains uncertain. So long as family size preference remains high, the population growth rate will likewise remain high.

With regard to new acceptor targets of the NFPP, there is more concrete evidence to suggest that they will be met. In 1976, the last year of the Third Plan, a total of 664,895 new acceptors came into the program. The 1977 target, the first year of the Fourth Plan is only 575,000. New acceptor rates to date suggest that this target will be exceeded by as much as 20 percent.

B. Role of External Assistance

The findings of this evaluation clearly indicate that a continuation of external assistance will be required if the goal of decline in the population growth rate to 2.1 percent per annum is to be achieved. In particular, increased extension of services to rural areas (including remote areas, border areas, hilltribes, etc.), enhanced IE&C in rural areas, extension of sterilization services by mobile teams, and an ambitious training program including training of non-physician personnel to deliver services are areas of emphasis in which assistance will be sought. Current DTEC estimates call for approximately Baht 310 million (US\$ 15.5) for the family planning program, of which US\$ 9.5 million will be sought from USAID (Title X), 3.0 million from UNFPA, and the remaining 3.0 million from other donors (including perhaps additional UNFPA assistance). Specifics of funding levels, categories of assistance, and the time frame for requested assistance have not yet been determined. The evaluation team has observed and been informed of problems when donor agencies including USOM discussed plans and commitments to RTG individuals and/or agencies without prior consultation with DTEC. Therefore, close cooperation between USOM staff and DTEC is essential in the handling of assistance matters which come under DTEC jurisdiction.

In regard to the planning of external assistance, it is noted that with the exception of USAID, bilateral agreements are

generally on a year-by-year basis. This short-term nature of bilateral assistance agreements introduces a degree of uncertainty into the planning process.

Negotiations for assistance from non-government organizations generally occur directly between donors and a variety of recipient agencies. This works a hardship on the RTG agency (DTEC) responsible for monitoring such assistance and leads to duplication. For these reasons attention is directed to the evaluation's recommendations dealing with strengthening the National Family Planning Committee and the National Family Planning Coordination Center, whose functions should include the monitoring of non-government along with government activities. Regular reporting to DTEC by agencies receiving assistance from external non-government organizations would also contribute to better coordination.

Current USOM estimates for Title X funding call for continuing support for the VSC program (including subsidy payments, IE&C, vehicles, equipment, and per diem), and declining levels for training, research, and equipment through FY 1979. In addition, centrally funded commodity support of approximately \$1.2 million, spread over a three-year period to prevent overstocking, will be needed to assure continued supply of contraceptives through 1981. The personal interest and support shown by the US Ambassador and the USOM Mission Director in continuing US assistance to Thailand in family planning and health is noted in this evaluation as a significant factor in the constructive cooperation between the USG and the RTG as its progress toward self-sufficiency continues.

In view of the integration of family planning with health services, a \$60 million rural health and family planning expansion project, currently under negotiation (as a loan) with the World Bank, is relevant to this evaluation. USAID, as well as other donors (as yet unspecified) are being requested to join in this project which aims to extend primary health care to the rural population. ↵

If this degree of expansion comes to full fruition, its impact, not only on the achievement of Fourth Plan demographic targets, but on the ultimate achievement of self-sufficiency by Thailand in the provision of basic health/family planning services to its rural population, will be major.

Appendix 1

Glossary of Abbreviations Used in the Report

RTG	Royal Thai Government
MOPH	Ministry of Public Health
NESDB	National Economic and Social Development Board
DTEC	Department of Technical and Economic Cooperation
NFFP	National Family Planning Program
NFPC	National Family Planning Committee
CBFPS	Community Based Family Planning Service
IPPF	International Planned Parenthood Federation
UNFPA	United National Fund for Population Assistance
PPAT	Planned Parenthood Association of Thailand
USOM	United States Operations Mission
USAID	United States Agency for International Development
VHV	Village Health Volunteer
VHC	Village Health Communicator
VSC	Voluntary Surgical Contraception
IE&C	Information, Education, and Communication
DMPA	Depo-Medroxyprogesterone Acetate
SOFT/WFS	Survey of Fertility in Thailand/World Fertility Survey
NSO	National Statistical Office
IPAVS	International Project, Association for Voluntary Sterilization
APHA	American Public Health Association

Appendix 2

Provisional Site Visits by the Evaluation Team

<u>Date</u>	<u>Activities</u>
June 22, 1977	Meeting of the Evaluation Team at the Faculty of Public Health
June 23, 1977	Briefing at Family Health Division, Ministry of Public Health
June 24, 1977	Meeting with representatives from Community Based Family Planning Services Agency (CBFPS)
June 26-July 1, 1977	<u>Northern Provincial Visit</u> to Chiangrai Province, Chiangmai Province, Lampang Province, Nakorn Sawan Province
July 5-8, 1977	<u>Northeastern Provincial Visit</u> to Khon Kaen Province and Nakorn Ratchasima Province
July 9, 1977	Meeting with Commercial Sector
July 11-15, 1977	<u>Southern Provincial Visit</u> to Songkhla Province, Phuket Province, and Phangnga Province.
July 18, 1977	Meeting with Population Institute, Chulalongkorn University
July 19-24, 1977	<u>Central Provincial Visit</u> to Chantaburi Province and Chonburi Province
July 25, 1977	Report to NEFP .

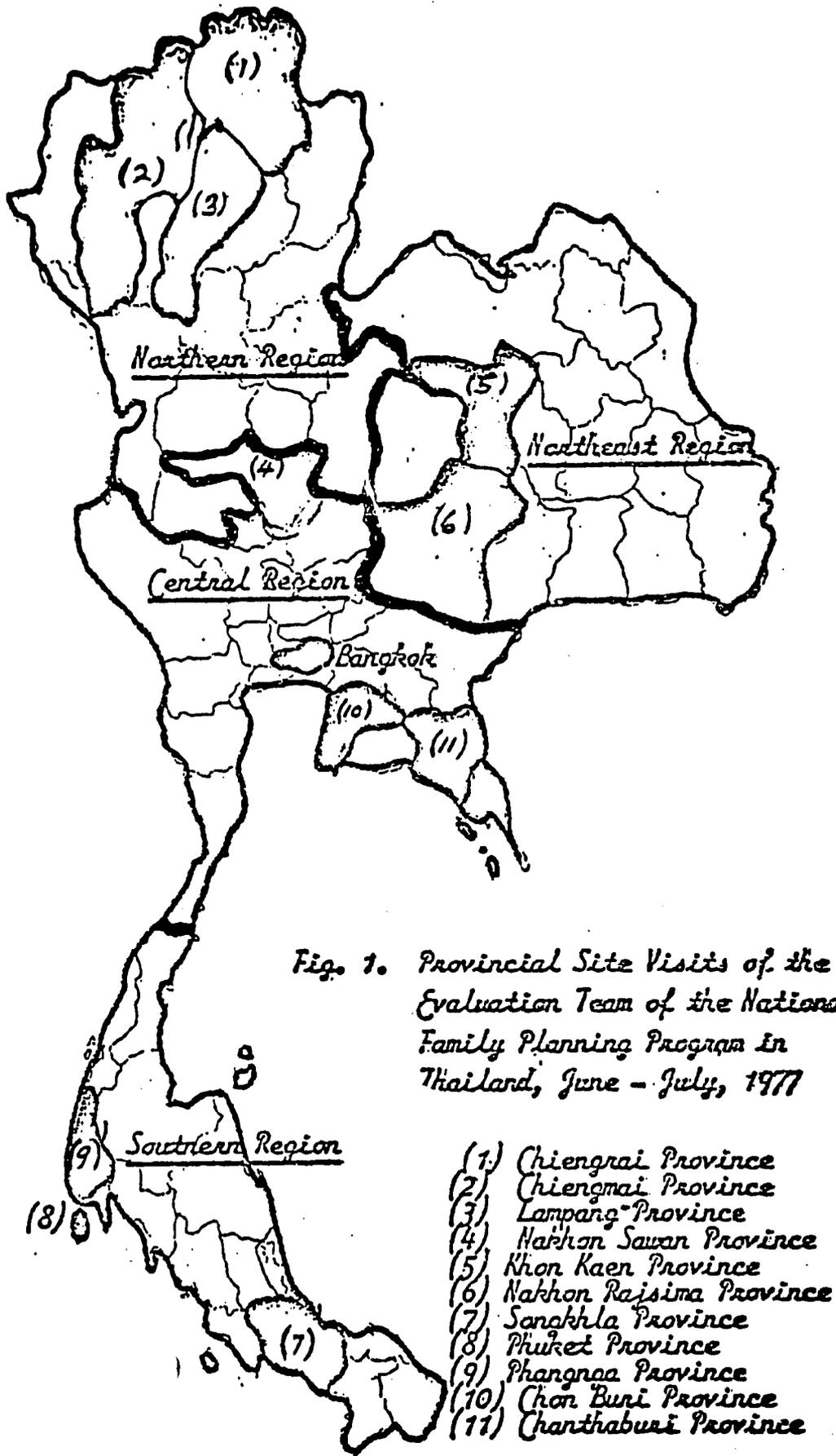


Fig. 1. Provincial Site Visits of the Evaluation Team of the National Family Planning Program in Thailand, June - July, 1977

Appendix 4

Details of Provincial Visits of the Evaluation Team
June-July, 1977

Province	Visits by Evaluation Team						Other
	PCMO Office	Provincial Hospital	District Hospital	Sub-district Health Center	Midwife Center		
<u>Northern Region</u>							
1. Chiangrai Province	x	x	x	x	-		*
2. Chiangmai Province							**
3. Lampang Province							***
4. Nakorn Sawan Province	x	x	x	XX	x		****
<u>Northeast Region</u>							
1. Khon Kaen Province	x	x	x	XX	XX		*****
2. Nakorn Ratchasima Province	x	x	x	XXX			
<u>Southern Region</u>							
1. Songkhla Province	x	x	x	XX	x		
2. Phuket Province	x		x				
3. Phang Nga Province	x		x	x			
<u>Central Region</u>							
1. Chonburi Province	x						
2. Chantaburi Province	x		x	x			*****

- * Local drug stores, 2 village volunteer posts of CBFPS
 ** Chiangmai Christian Clinic, McCormick Hospital
 *** Northern FP Training Center, Family Health Division, Dept. of Health, MOPH
 **** Local drug stores
 ***** MCH Training Center
 ***** Cambodian Refugee Camp, Thai Family Resettlement Camp from Cambodian border.

Appendix 5

Number of Provinces, Population, and the
Average Annual Per Capita Income in
the Four Regions of Thailand,
1976

Region	Number of Provinces	Approximate Population	Average Annual Per Capita Income** (in Bahts)	Average Income Increase since 1975 (in bahts)
Bangkok*	1	4.3 x 10 ⁶	20,000 (\$ 1,000)	1,082 (\$ 54)
Central	24	12 x 10 ⁶	11,373 (\$ 568)	1,423 (\$ 71)
Southern	14	5 x 10 ⁶	7,237 (\$ 362)	396 (\$ 20)
Northern	16	9 x 10 ⁶	5,471 (\$ 273)	326 (\$ 16)
Northeast	16	13 x 10 ⁶	3,141 (\$ 157)	169 (\$ 8)
Total	71	43.3 x 10 ⁶	7,568 (\$ 378)	845 (\$ 42)

* Bangkok, a capital of Thailand, is located in the Central Region

** Approximate foreign exchange rate: US\$ 1 = 20 bahts

Sources of Data: (1) In terms of income at the end of 1976, from survey of NESDB, 1977
(2) In terms of number of provinces and the population from the Department of Local Administration, Ministry of Interior, 1977

Appendix 6

Population Census and the Inter-Censal
Increase in Thailand from 1911-1970

Census Year	Total Population	Inter-Censal Increase	Annual % Increase
1. 1911	8,266,408	-	-
2. 1919	9,207,355	940,447	1.4
3. 1929	11,506,207	2,298,952	2.2
4. 1937	14,464,105	2,957,898	3.0
5. 1947	17,442,689	2,978,584	1.9
6. 1960	26,257,916	11,467,727	3.2
7. 1970	34,397,374	11,860,542	2.7

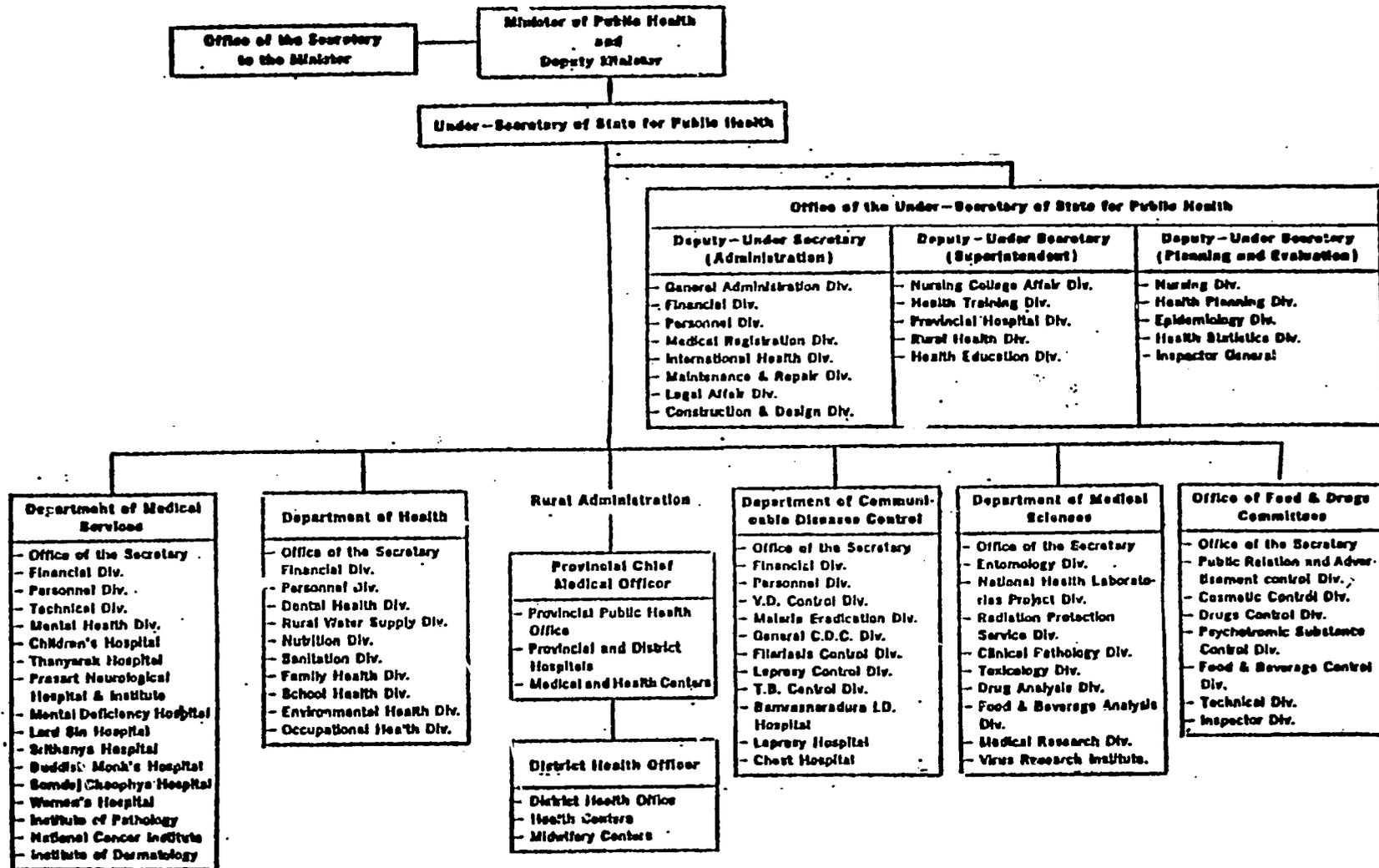
Appendix 7

Present Public and Private Health Agencies and Their Services
from Provincial to Village Level in Thailand

	Private Sector (Non-Governmental)				Public Sector (Governmental)			
	Drug Companies	Drug Stores	Medical Clinics	Hospitals	Mobile Medical Teams	Clinics	Health Center*	Hospital
	(1,800)	(12,000)	(3,000)	(90)	(38)			
<u>Provincial Level</u>	xxx	xxx	xxx	xx	x	x	xxx	xxx
<u>District Level</u>	x	x	x		x		x	x
<u>Subdistrict Level</u>					x		x	
<u>Village Level</u>					x		x	

* Include District Hospital

Organization of the Ministry of Public Health



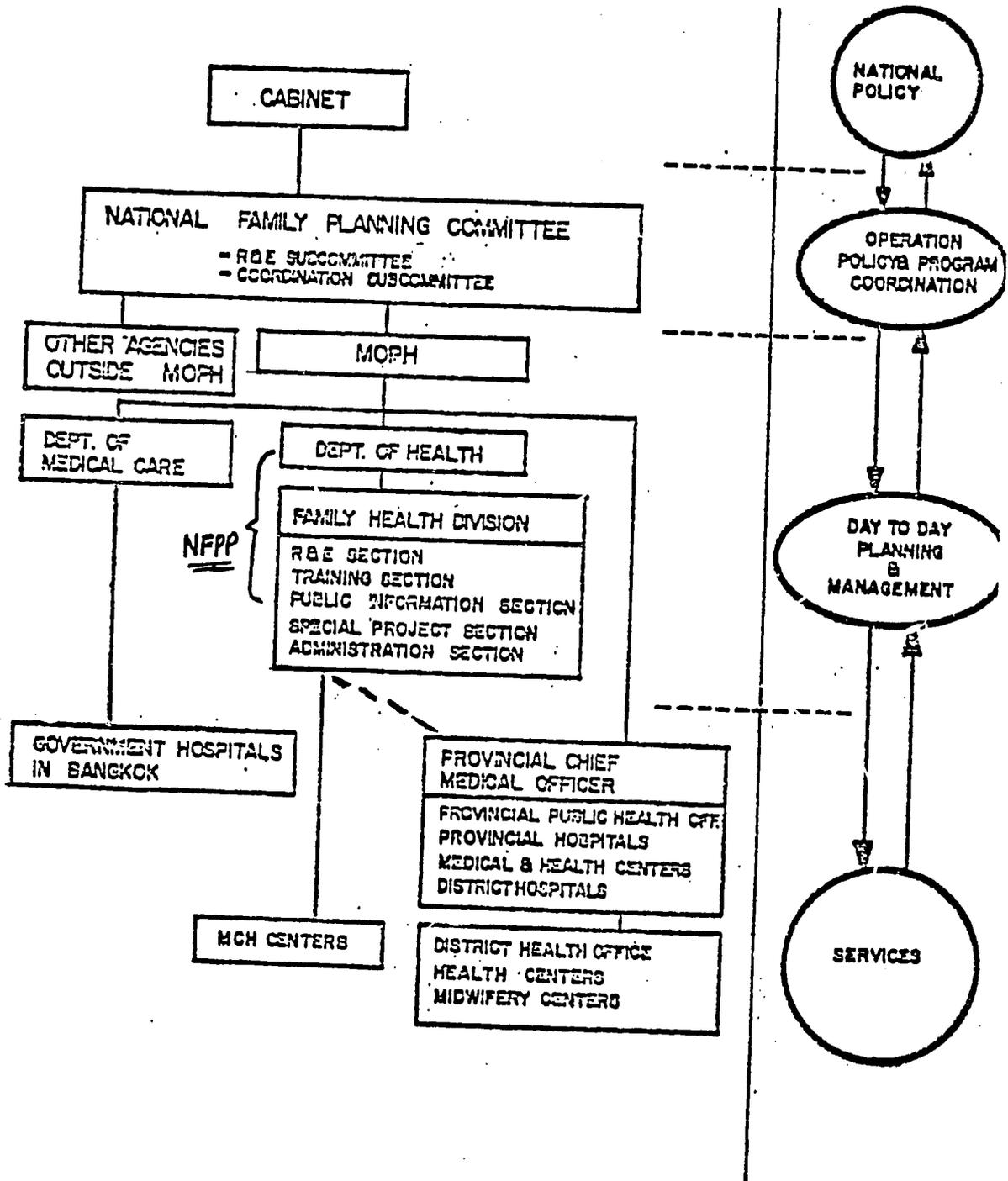
Appendix 9

The Present Number of Hospitals and Health Centers which
Belong to Ministry of Public Health, Thailand

	Number	Percentage Coverage
1. Provincial Hospital (# Provinces)	88 (17)	124
2. District Hospital/Medical and Health Center (# Districts)	270 (556)	49
3. Subdistrict Health Center (#Subdistrict or Tambons)	3,200 (5,115)	63
4. Midwifery Center (# Villages)	1,500 (46,000)	3

Source of Data: Ministry of Public Health, 1977

FAMILY PLANNING ORGANIZATION STRUCTURE



Appendix 11

Royal Thai Government Budget for the
National Family Planning Project
(in bahts)

	1972	1973	1974	1975	1976	1977
Salaries	447,400	447,400	456,400	799,800	1,016,900	1,992,500
Permanent Wages	209,600	668,200	1,186,600	2,954,500	2,588,700	3,903,500
Temporary Wages	300,000	750,000	900,000	1,350,000	1,350,000	1,350,000
Remuneration	231,400	221,400	221,400	200,000	80,000	140,000
Ordinary Expenses	2,200,000	2,200,000	2,250,000	2,300,000	2,700,000	4,593,000
Materials	5,611,600	5,611,600	7,300,000	11,000,000	15,000,000	22,885,200
Equipment	-	101,400	182,200	87,500	143,200	1,614,800
Land and Construction	1,000,000	1,000,000	-	-	-	2,122,000
Subsidies	-	-	-	-	-	11,000,000
Other Expenses	-	-	-	-	-	-
Total	10,000,000	11,000,000	12,496,600	18,691,800	22,878,800	49,601,000

Appendix 12

Overseas Training of NFPP Staff (including Bangkok Metropolis
with Long-term and Short-term Fellowships Classified
According to Sources of Funds, 1972-1976

Sources of Funds	1972	1973	1974	1975	1976	Total
1. UNFPA	-	11	22	15*	25**	73
2. WHO	3***	3	3	6	8	23
3. USAID	70	57	46	55	12	290

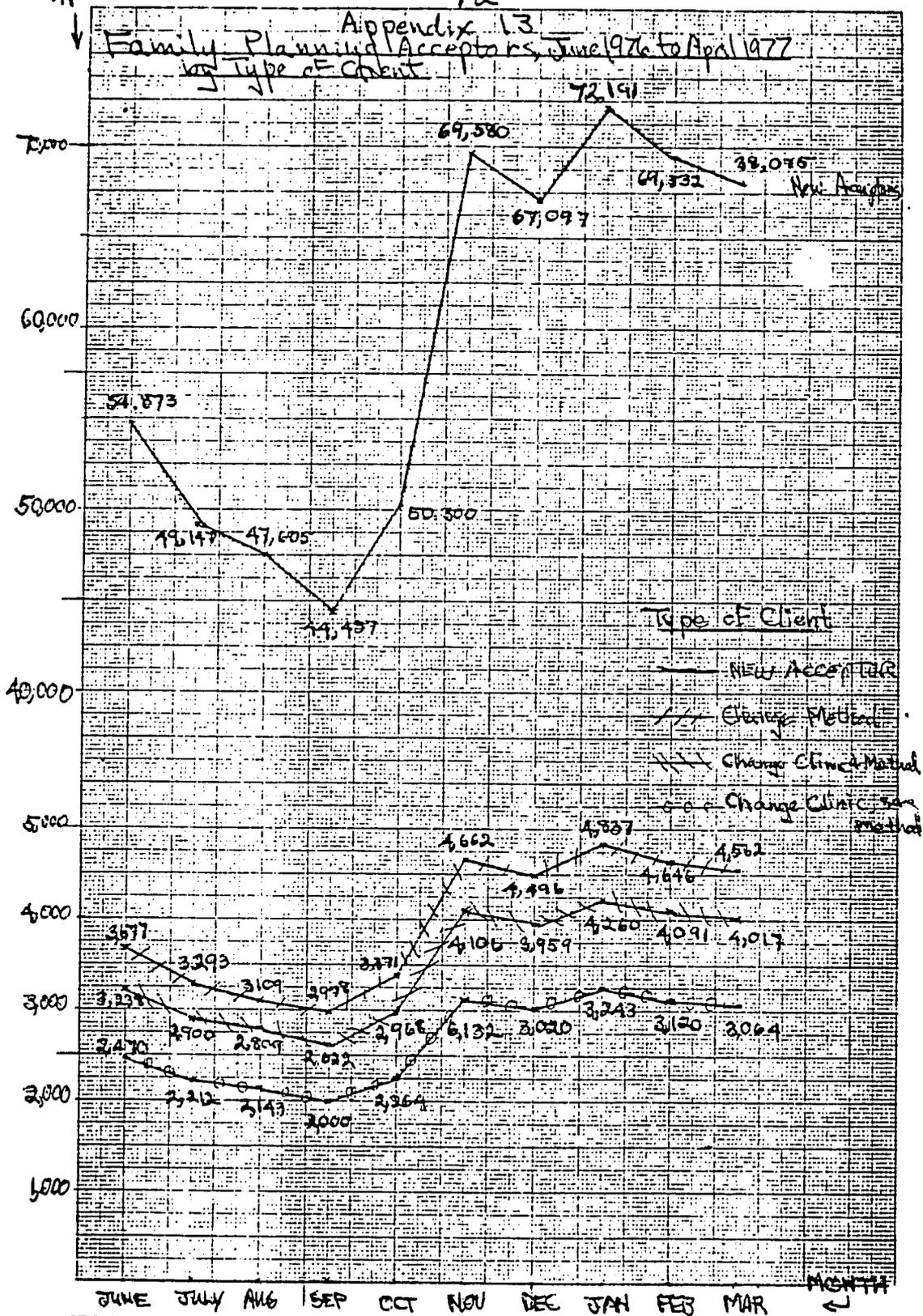
- * Include 1 long-term fellowship
 ** Include 3 long-term fellowships still available
 *** Include 1 long-term fellowship

Source of Data: 1) WHO Final Report for UNFPA-Supported
 Projects, March 1977
 2) USAID, Thailand, 1977

Type of Client (#s)

72

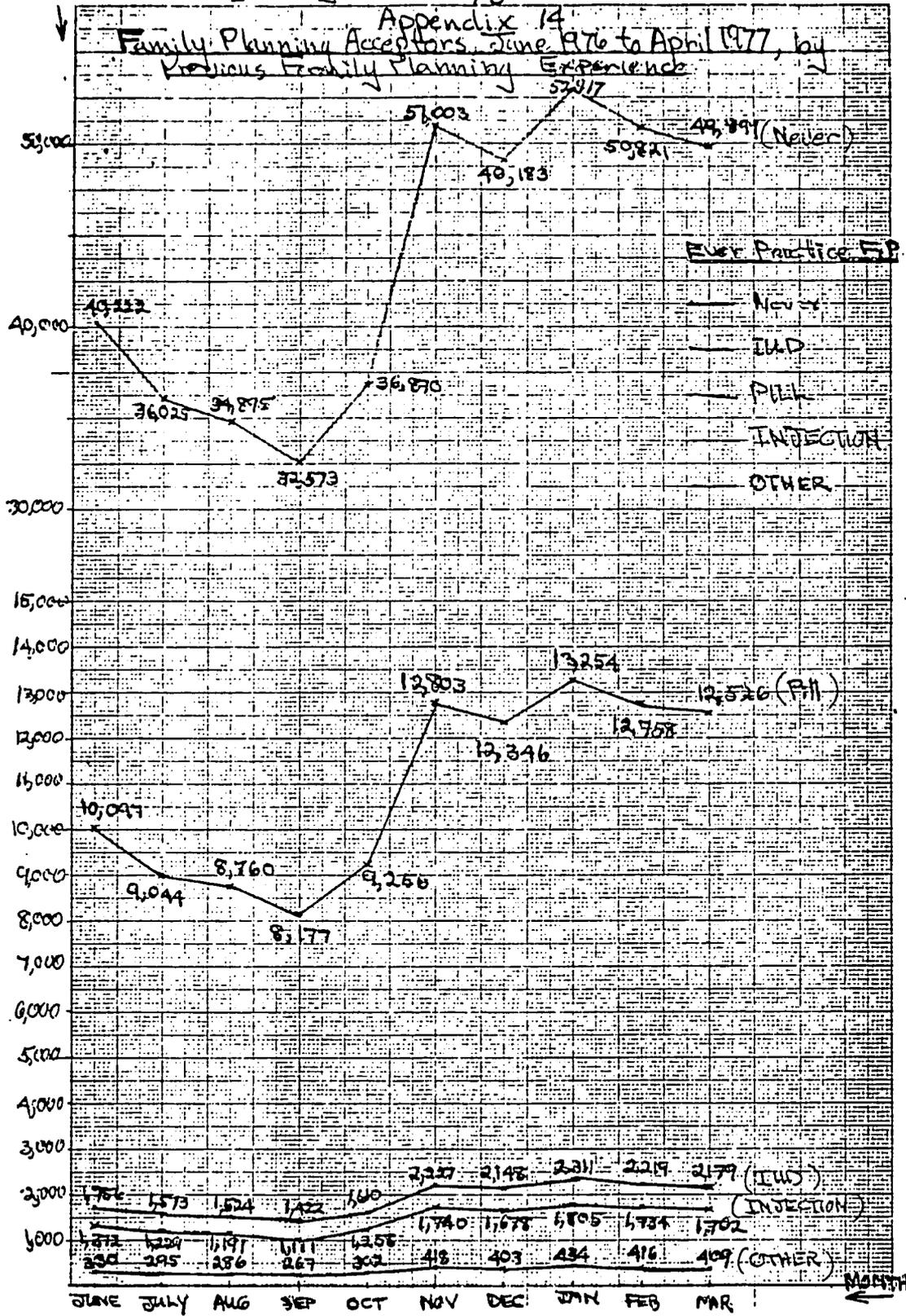
Appendix 1.3
Family Planned Acceptors, June 1976 to April 1977
by Type of Client



Ever-Practice Family Planning

73

Appendix 14
 Family Planning Acceptors June 1976 to April 1977, by
 Previous Family Planning Experience



Appendix 15

Real Incomes and Expenditures of Thirteen
Subdistrict Health Centers in
Po Thong District, Angthong Province,
January to December 1975

<u>Annual Incomes of 13 Subdistrict Health Centers</u>			<u>Expenditures***</u>
<u>Medical Treatment*</u>	<u>Oral Pills***</u>	<u>Total</u>	<u>(in bahts)</u>
39,820	45,634	85,454	53,592

- * This includes the selling of Government's household drugs.
 ** 1 pill cycle costs 5 bahts (prior to free pill policy).
 *** The expenditures include the repair of health center, buying more drugs, etc. since the budget of each subdistrict health center was only 5,000 baht (US\$ 25) per year.

Source of Data: District Health Office, Po Thong District, Angthong Province, 1976

Appendix 16

Oral Contraceptive Supplies
Pill Data Chart

	<u>Arrivals</u>	<u>Dispensed</u>	<u>On Hand</u>
<u>June 31, 1977</u>			
Central Warehouse			13,000,000
Provinces			3,000,000
1st and 2nd class Health Centers and Midwifery Centers			<u>+1,500,000</u>
			17,500,000
Arrival: UNFPA	<u>1,800,000</u>		+ 1,800,000
Dispensed: CBFPS		2,000,000	
Usage		<u>4,200,000</u>	<u>- 6,200,000</u>
Estimated End of Year Stock			<u><u>13,100,000</u></u>
<u>January-December 1978</u>			
Arrival: USAID	4,120,000		
RTG	<u>4,500,000</u>		+ 8,620,000
Dispensed: CBFPS		2,000,000	
Usage		<u>8,500,000</u>	<u>-10,500,000</u>
Estimated End of Year Stock			<u><u>11,220,000</u></u>
<u>January-December 1979</u>			
Arrival: USAID	3,500,000		
RTG	<u>16,000,000</u>		+ 9,500,000
Dispensed: CBFPS		2,000,000	
Usage		<u>10,980,000</u>	<u>-12,980,000</u>
Estimated End of Year Stock			<u><u>7,740,000</u></u>
<u>January-December 1980</u>			
Arrival: USAID	4,000,000		
RTG	<u>7,500,000</u>		+11,500,000
Dispensed: CBFPS		2,000,000	
Usage		<u>12,000,000</u>	<u>-14,000,000</u>
Estimated End of Year Stock			<u><u>5,240,000</u></u> <u><u>4,740,000</u></u>
<u>January-December 1981</u>			
Arrival: USAID	4,500,000		
RTG	<u>8,000,000</u>		+12,500,000
Dispensed: CBFPS		2,000,000	
Usage		<u>12,000,000</u>	<u>-14,000,000</u>
Estimated End of Year Stock			<u><u>2,740,000</u></u> <u><u>2,240,000</u></u>

Appendix 17

I. List of Operational Research in
Family Planning/Population Conducted in ThailandA. Research Studies Already Completed

1. Potharam Project, 1964-1966, National Research Council and Ministry of Public Health.
2. Oral Contraception and Liver Fluke Disease, 1969-1971, MOPH.
3. Auxiliary Midwife Prescription of Oral Contraception, 1969-1970, NFPP.
4. National Follow-up Survey of Acceptor, 1971, NFPP.
5. Family Planning Mass Communication Pilot Project, Khon Kaen Province, 1971, NFPP.
6. Analysis of Family Planning Acceptor's Characteristics, 1972-76, NFPP.
7. Evaluation Study on Training Course of Midwifery School, 1971, Family Health Division, MOPH.
8. Post-partum Programme in Thailand, 1966-1973. The Population Council and NFPP.
9. Comparative Study on Side-effect, Complication and Discontinuance of Use of Oral 28 and Norlestron Contraceptive Pills, 1972, NFPP.
10. Field Worker Evaluation Project, 1971-73, Institution for Population and Social Research, Mahidol University and NFPP.
11. Granny Midwife Study, 1973-74, Faculty of Public Health, Mahidol University and NFPP.
12. Evaluation of National Family Planning Achievement, 1968-1975, NFPP.
13. Research to determine content and style of planned communication materials, 1973, DSCS and NFPP.
14. Condom Acceptability Study, 1974-75, Faculty of Public Health and NFPP.
15. National Follow-up Survey of Oral Contraceptive Use, 1974, NFPP.
16. Copper T-200 Study: Urban and Rural Trial, 1971-72, The Population Council and NFPP.
17. Study on Nurse to Insert Cu-T Device Rural Health Program, 1972-73, NFPP.
18. Unsuspected Pelvic Injection Discovered at Tubal Ligation: Relationship to Use of Intra-Uterine Contraception, 1974, The Combined Bangkok Hospital Group, The Population Council and NFPP.

Continued

Appendix 17 (Continued)

1. List of Operational Research in
Family Planning/Population Conducted in Thailand

B. Research Studies Underway

1. Research Study in Accelerated Development of Maternal Child Health and Family Planning Services, Taylor-Berelson's Study, 1973, MOPH.
2. Research Studies in Expanded Sterilization Project, 1977, NFPP.
3. Comparative Study on the Use of Depoprovera by Medical and Paramedical Personnel, 1977, NFPP.
4. Analysis of Family Planning Acceptor's Characteristics 1972-76, NFPP.
5. Abortion Study: Attitude of Medical Students and Physicians toward Abortion and its Legal Status, 1976, NFPP.
6. Evaluation of Impact of Family Planning Communication Inputs on Rural Couples, 1976, NFPP.
7. Increased Mobility for Health Personnel in National Family Planning Programme (Motorcycle project), 1976, NFPP.
8. A Pilot Project to Prevent Incomplete Abortion through Contraceptive Services, 1976, NFPP.
9. Follow-up Study of Vasectomized Cases Performed by Physicians and Paramedics, 1977, NFPP.
10. Pilot Study on the Utilization of Village Volunteer in Family Planning in 60 Districts (CBFPS), 1974.
11. Health and Hygiene Project in 80 Districts, 1977, CBFPS, NFPP and Faculty of Public Health, Mahidol University.

Appendix 18

II. Biomedical Research Conducted by Siriraj Family Planning Research Unit Mahidol University

- Comparative Female Sterilization Study Cautery versus Spring Loaded Clip.
Start: June 1974
- Comparative Female Interval Sterilization Study Cautery versus Silastic Ring.
Start: August 1975
- Comparative IUD Study: Lippes versus Ypsilon.
Start: December 1975
- Clinical Study of Copper T and 7 IUD
Start: December 1971
- A Comparative Study of Pethidine, Droperidol versus Pethidine, Droperidol, Atrophine versus Morphine, Droperidol, Atropine.
Start: October 1976
- Clinical Study of Continuous Microdose ProgestinLutisan 0.75 mg.
Start: 1973
- The Study of Effects of Methyleyanocrylate (MCA) on Tubal Occlusion.
Start: August 1976
- Clinical Study of Continuous Microdose Progestin, Lynestrenol 0.5 mg.
Start: March 1974
- Effects of Medroxyprogesterone Acetate Inadequate Lactating Condition.
Start: June 1974
- Clinical Study of a Monthly Injectable Contraceptive Containing 25 mg. Medroxy Progesterone Acetate and 5 mg Estradiol Cypionate.
Start: July 1973
- The Study of the Outcome of Pregnancy with IUD.
Start: January 1968
- Pregnancy Termination Study.
Start: 1972
- Comparison of Culdosopic and Laparoscopic Sterilization.
Start: January 1972
- Laparoscopic Female Sterilization Using Spring Loaded Clip.
Start: August 1973
- Study of Effects of Exluton on Lactation.
Start: August 23, 1976

Appendix 18 (continued)

II. Biomedical Research Conducted by
Siriraj Family Planning Research Unit
Mahidol University

- The Study of MPA Level in Sacrum of Patient Treated with Cyclo-Provera.
Start: July 1974
- The Study of Absorption and Metabolism of Ethinyl Estradiol, and Mestranol.
Start: May 1974
- The Study of a Low Dose Oral Contraceptive Containing 0.4 mg Norethindrone and 0.0375 mg Ethinyl Estradiol.
Start: January 1973
- The Study of a Low Dose Oral Contraceptive Containing 1 mg Lynestrenol.
Start: July 1973
- The Comparative Study of Two Oral Contraceptives, Biphasil versus Oral.
Start: May 1975
- The Study of Threatened, Inevitable, and Complete Abortions Treated in Hospital.
Start: June 1977
- The Effect of Various Techniques of Tubal Occlusion on Ovulation and Menstrual
Start: September 1977
- The Study of Pelvic Infection Relationship to the Use of IUD.
Start: May 1974
- Comparative Oral Contraceptive: Norinyl 1-50 versus Norestrin 1 versus Brevicon versus Lo-Estrin 1.50/30.
Start: September 1977
- A Comparative Study of Three Intrauterine Devices in Multiparous Women.
Start: November 1976
- Comparative Evaluation of the Contraceptive Effectiveness of DMPA Given Every Three Months and Net.-Oen Given Every Two Months.
Start: June 1976
- A Comparative Study of Two Combination Oral Contraceptives, One Containing Synthetic Oestrogen and the Other Natural Oestrogen.
Start: July 1975
- Comparative Evaluation of Surgical Sterilization Procedures by Mini-incision Laparotomy, Colpotomy, Culdoscopy and Laparoscopy.
Start: January 1977
- Concentration of Steroids in Milk of Lactating Women Using Injectable Contraceptives
Start: February 1977

Appendix 18 (continued)

II. Biomedical Research Conducted by
Siriraj Family Planning Research Unit
Mahidol University

- Followup Study, Comparative Clinical Trials of Medroxyprogesterone Acetate and Norethisterone Oenanthate.
Start: September 1975
- Measurement of Half-life of Ethynyl-oestradiol and Norethisterone in Different Populations in Women.
1977
- Effect of Varying Doses of DMPA on Ovarian Functions.
1977
- Concentration of Steroids in Milk of Lactating Women using Injectable Contraceptives.
1977
- Comparison of Metabolism of DMPA and Net-Oen in Obese and Thai Women.
1977

Appendix 19

III. Research Projects on the Clinical Evaluation of Fertility Regulating Agents at Chulalongkorn Hospital Medical School (by the support of the World Health Organization since 1972)

A. Completed Projects

1. Luteinising Hormone, Oestradiol and Progesterone Levels in the Serum of Menstruating Thai Women.
The Journal of Obstetrics and Gynecology of the British Commonwealth Vol. 81, No. 2; February 1974.
2. Human Growth Hormone (HCG), Thyroid Stimulating Hormone (TSH) and Cortisol Levels in the Serum of Menstruating Thai Women.
The Journal of Obstetrics and Gynecology of the British Commonwealth Vol. 81, No. 7, July 1974.
3. Incidence of Post-partum Deep Vein Thrombosis in the Tropics.
British Medical Journal, Vol. 1, 9 February 1974.
4. Incidence of Post-partum Thromboembolism in Thai Women: Comparison with Western Experience.
Journal of the Medical Association of Thailand, Vol. 57, No. 12, December 1974.
5. Post-operative Thrombosis in Thai Women.
The Lancet, June 21, 1975, p. 1357.
6. The Effect of Medroxyprogesterone Acetate, Administered to the Lactating Rat, on the Subsequent Growth, Maturation and Reproductive Function of the Litter.
The Journal of Reproduction and Fertility, Vol. 46, 1976.
7. The Effect of d-Norgestrel, 30 mg on the Oral Glucose Tolerance Test, including Insulin Levels, in Thai Women.
Fertility and Sterility, Vol. 27, No. 5, May 1976.
8. A Study of Glucose Tolerance, Serum Transaminase and Lipids in Women using Depot-Medroxyprogesterone Acetate and a Combination-Type Oral Contraceptive Contraception, Vol. 14, No. 2, August 1976.
9. A Study of the Use of Intermittent Serum Luteinizing Hormone, Progesterone and Oestradiol Measurements for the Detection of Ovulation.
British Journal of Obstetrics and Gynecology, Vol. 83, No. 8, August 1976.
10. Simple Smear Method to Identify the Vas Quickly.
 - 1) IPPF Medical Bulletin, Vol. 10, No. 4, August 1976.
 - 2) Journal of the Medical Association of Thailand, Vol. 60, No. 2, August 1977.
 - 3) Chulalongkorn Medical Journal, Vol. 21, No. 2, April 1977 (in Thai).

Appendix 19 (continued)

III. Research Projects on the Clinical Evaluation of Fertility
Regulating Agents at Chulalongkorn Hospital Medical School
(by the support of the World Health Organization since 1972)

11. Effects of DMPA on Milk Secretion in Lactating Women and on Hormonal Levels with a View to Determine its Mechanism of Action.
Chulalongkorn Medical Journal, Vol. 21, No. April 1977 (in Thai).
12. Comparative Trial of Three IUDs in Rural Thailand.
13. Effect of d-Norgestrel 30 meg on Milk Secretion in Lactating Women.
14. Liver Function in Thai Women Using Different Contraceptive Agents.
15. Long-term Effects of Medroxyprogesterone Acetate (150 mg) on the Intravenous Glucose Tolerance and Liver Function Tests in Thai Women.
16. The Return of Ovulation after Cessation of DMPA Administration.
17. Effect of DMPA on the Adrenal and Thyroid Function.
18. DMPA Contraception and Liver Fluke Infection.
19. Acceptance, Use and Continuation Pattern of New Contraceptive Acceptors of Oral Contraceptives and IUDs in Bangkok.
20. A Field Trial of the Acceptance Pattern and Continuation Rates of Three Methods of Contraception in a Rural Family Planning Program with Sociological Evaluation.

B. On-going Projects in 1977

1. Effects of Medroxyprogesterone Acetate (150 mg) and a Combination-Type Oral Contraceptive on Oral Glucose Tolerance Test, Serum Transaminase and Lipids in Thai Women. WHO.
2. Effect of a Combined Oestrogen-Progestogen Contraceptive on Blood Clotting System in Thai Women. WHO.
3. Effect on Progesterone Levels of DMPA at Lower than Conventional Dose in Thai Women. WHO.
4. Ovulation and Metabolic Studies of Daily d-Norgestrel 30 meg. in Thai Women. WHO.
5. Clinical and Metabolic Studies of a Low-estrogen-dose Combined Oral Contraceptive in Thai Women. WHO.
6. Effect on Progesterone Levels of Starting DMPA at Other Than the Standard Time of the Cycle in Thai Women. WHO.
7. A Study of the Training of Non-Physicians (Medical Students) to Perform Vasectomy. WHO.

Appendix 19 (continued)

III. Research Projects on the Clinical Evaluation of Fertility
Regulating Agents at Chulalongkorn Hospital Medical School
(by the support of the World Health Organization since 1972)

8. A Study of Contraceptive Choice and Use in Bangkok Metropolitan Municipal Clinics. WHO.
9. Clinical Study of Combined Medroxyprogesterone Acetate and Testosterone Enanthate in Thai Males. WHO.
10. The Provision of Post-partum Sterilization Service by Operating-Room Nurses. WHO.

Appendix 20

Biomedical Research: New Projects for 1977-1978

1. Multicentered Double Blind Controlled Trial on the Effects of Low Dose Steroid Oral Contraceptive on Established Lactation. WHO.
2. Task Force on Long-acting Systemic Agents for the Regulation of Fertility. Phase I Trial of a Biodegradable Implant Delivery System for Norethisterone (BIDS-NET) Developed by Alza Corporation. WHO.
3. Task Force on Intrauterine Medication for Fertility Case Control Study on the Relative Risk of Ectopic Pregnancy and Pelvic Inflammatory Disease Associated with IUD Use. WHO.
4. Task Force on Long-acting Systemic Agents for the Regulation of Fertility. Determination of Bleeding Patterns in Women Receiving a New Monthly Injectable Preparation (Norethisterone Oenanthate 50 mg and Oestradiol Valerate 5 mg). WHO.

Appendix 21

Estimated Couple Years of Protection
Provided by NFPP (cumulated)*

Year	Pill	IUD	Sterilization	DMPA	All Methods
1970	89,427	118,164	62,619	1,475	271,685
1971	233,151	169,960	79,612	4,100	486,823
1972	398,063	220,329	102,904	7,780	729,076
1973	514,551	267,672	137,507	13,870	933,600
1974	619,132	307,646	192,942	24,630	1,144,350
1975	736,789	338,104	264,775	39,590	1,379,258
1976	847,272	360,284	344,055	77,278	1,628,889

* Calculated using NFPP continuation rates and NFPP definition of acceptor--therefore there is some duplication--overestimation for change of method & clinic.

Appendix 22

Number of Family Planning Acceptors
by Method, 1976

Month	IUD	Pill	Sterili- zation	DMPA	Total	Other	Grand Total
January	6,712	30,260	7,564	5,049	49,585	2,599	52,184
February	7,388	30,349	8,306	5,869	51,912	3,396	55,308
March	7,004	29,905	9,196	6,779	52,884	2,813	55,697
April	6,170	26,857	8,592	6,466	48,085	2,062	50,147
May	5,993	27,319	8,281	6,791	48,384	2,344	50,728
June	7,007	28,991	8,708	7,656	52,362	2,884	55,246
July	5,589	25,945	8,663	6,744	46,941	2,917	49,858
August	5,123	27,589	9,258	6,520	48,490	4,047	52,537
September	5,493	22,628	8,430	5,112	41,663	2,774	44,437*
October	3,358	32,097	7,599	4,522	47,576	2,724	50,300*
November	5,816	44,064	9,663	5,852	65,395	4,185	69,580*
December	5,526	41,962	9,682	5,240	62,410	4,687	67,097*
Whole Year	71,894	376,707	105,281	73,357	627,239	37,656	664,895

Remark: Include the delayed reports.

* Do not include the delayed reports.

Appendix 23

Comparison of the 1976 Achievements of the
Thai NFPP by Region and Method

1976	Target Population	I.U.D.			Pills			Sterilization			Total		
		Real Acceptors	Target	% R.A. T	Real Acceptors	Target	% R.A. T	Real Acceptors	Target	% R.A. T	Real Acceptors	Target	% R.A. T
Bangkok	4.3 x 10 ⁶	10,966	9,225	119%	34,341	26,936	128%	21,077	4,264	494%	66,414	40,425	164%
Central Region (Exclude Bangkok)	12 x 10 ⁶	7,443	20,070	37%	82,644	62,972	131%	24,261	9,064	268%	114,348	92,106	124%
Southern Region	5 x 10 ⁶	2,928	10,645	27%	33,821	33,824	100%	10,740	4,960	216%	47,489	49,629	96%
Northern Region	9 x 10 ⁶	10,921	18,891	58%	109,345	61,152	179%	18,722	8,316	225%	138,988	88,359	157%
Northeast Region	13 x 10 ⁶	39,606	30,969	125%	116,566	95,116	122%	30,481	13,396	227%	186,643	139,481	134%
TOTAL	43.3 x 10⁶	71,894	90,000	80%	376,707	280,000	134%	105,281	40,000	263%	553,882	410,000	135%

Source of Data: National Family Planning Project, Ministry of Public Health

Appendix 24

Family Planning Performance by Percentage of
Eligible Thai Females in Provinces
Visited by the Evaluation Team
(Program Year 1976)

Total Population	F.P. Ranking by MOPH***	Percent Eligible Females Using (Age 15-44)				
		IUD	Pills	Sterili- zation	Total	
<u>Northern Region</u>						
1. Chiangrai Province	1,312,064	5	0.8	9.7	2.1	12.5
2. Chiangmai Province*	1,096,243	2	0.9	10.0	1.8	12.7
3. Lampang Province**	643,260	19	1.6	7.6	0.9	10.1
4. Nakorn Sawan Province	935,176	28	1.2	6.6	1.7	9.4
<u>Northeast Region</u>						
1. Khon Kaen Province	1,238,894	7	4.7	4.2	3.2	12.2
2. Nakorn Ratchasima	1,778,547	43	1.3	4.5	1.3	7.2
<u>Southern Region</u>						
1. Songkhla Province	778,386	65	0.2	3.9	1.2	5.3
2. Phuket Province	118,601	12	0.5	7.6	2.9	10.9
3. Phang Nga Province	157,213	8	0.5	9.1	2.5	12.1
<u>Central Region</u>						
1. Chonburi Province	669,213	19	0.7	6.7	2.7	10.1
2. Chantabuti Province	288,423	1	1.6	9.7	2.8	14.0

* Visit only Chiangmai Christian Clinic, McCormick Hospital.

** Visit only the Northern Family Planning Training Center, Family Health Division, Department of Health, Ministry of Public Health.

*** By the end of 1976, the Family Health Division has ranked the family planning performance of each of 71 provinces in Thailand according to the percentage of eligible females coming to receive family planning services at the Government's family planning service units.

Source of Data: Family Health Division, Department of Health, Ministry of Public Health, 1977.

APPENDIX 25

Report Initial Acceptors as a percent higher or lower than the Target by Method, 1971 - 1976

Year	Pill			IUD			Sterilization			DMPA			All Methods		
	Target	Acceptors	% Higher + Lower -	Target	Acceptors	% Higher + Lower -	Target	Acceptors	% Higher + Lower -	Target	Acceptors	% Higher + Lower -	Target	Acceptors	% Higher + Lower -
1971	200,000	24,607	+47.3	80,000	86,034	+7.6	20,000	23,546	+17.8	-	-	-	300,000	407,835	+36.0
1972	235,000	327,582	+39.4	90,000	90,128	+0.2	25,000	32,668	+30.7	-	6,316	-	350,000	456,694	+30.5
1973	280,000	268,674	- 4.0	90,000	93,449	+3.9	30,000	49,606	+65.4	-	10,447	-	400,000	422,760	+ 5.6
1974	280,000	305,244	+ 9.1	90,000	89,739	-0.2	35,000	80,482	+130.0	-	19,014	-	405,000	494,479	+22.1
1975	280,000	345,117	+23.3	90,000	75,163	-16.4	40,000	90,181	+125.5	-	24,529	-	410,000	535,023	+30.5
1976	280,000	344,779	+23.2	90,000	76,259	-15.2	40,000	104,449	+161.2	-	66,991	-	410,000	592,472	+44.5
Total, 1971-1976	1,555,000	1,886,003	+21.3	530,000	510,772	-3.6	190,000	380,935	+100.5	-	127,327	-	2,275,000	2,906,685	+27.9

- Remarks :
1. The total of all Methods is higher than the sum of individual Methods because the total of All Methods in 1971 includes acceptors using methods other than those listed (e.g., Foam, Diaphragm, Condoms etc.)
 2. For the 1976 Acceptor Totals, stylized projections were used to obtain figures for November and December of 1976 which were not available at the time of preparation of this report.