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 PD-APP-709-A1

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT PAPER FACESHEET**  
 TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE (EX: APPROPRIATE DOC)  
 ORIGINAL     CHANGE  
 ADD     DELETE

2. COUNTRY/REGIONAL ENTITY/GRANTEE  
**THAILAND**

3. DOCUMENT REVISION NUMBER  
 3 86p

4. PROJECT NUMBER  
**493 02**

5. BUREAU  
 A. SYMBOL **EA**    B. CODE **02**

6. ESTIMATED FY OF PROJECT COMPLETION  
 FY **82**

7. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS)  
 **POPULATION PLANNING**

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION  
 MO. YR.  
 A. INITIAL **12/75**    B. FINAL FY **81**

9. SECONDARY TECHNICAL CODES (MAXIMUM SIX CODES OF THREE POSITIONS EACH)

10. ESTIMATED TOTAL COST (\$000 OR EQUIVALENT, \$1=20-25)

A. PROGRAM FINANCING	FIRST YEAR			ALL YEARS		
	B. FY	C. L/C	D. TOTAL	E. FY	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	2,908	235	3,143	7,155	1,185	8,340
(GRANT)	(2,908)	(235)	(3,143)	(7,155)	(1,185)	(8,340)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER 1.						
U.S. 2.						
HOST GOVERNMENT	500	1,250	1,750	7,000	14,082	21,082
OTHER DONOR(S)	200	750	950	800	2,500	3,300
TOTALS	3,608	2,235	5,843	14,955	17,767	32,722

11. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)

A. AID APPROPRIATED BY PURPOSE/TECH. CODE	B. PRIMARY TECH. CODE	FY 76		FY 77		ALL YEARS	
		D. GRANT	E. LOAN	F. GRANT	G. LOAN	H. GRANT	I. LOAN
Commod.		2,800		510		963	
Training		93		52		217	
Research		150				50	
Travel (VEI)		100					
TOTALS		3,143		562		1,230	

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS)  CHECK IF DIFFERENT FROM PID/PRP

To reduce Thailand's annual rate of population growth to 2.1% or less by the end of 1981.

14. WERE CHANGES MADE IN THE PID/PRP FACESHEET DATA NOT INCLUDED ABOVE? IF YES, ATTACH CHANGED PID AND/OR PRP FACESHEET.

Yes     No    No PID/PRP prepared.

15. ORIGINATING OFFICE CLEARANCE

SIGNATURE  
 s/ J. E. Williams

TITLE  
 James E. Williams, Acting Director

DATE SIGNED  
 Aug 1, 1975

16. DATE RECEIVED IN AID/... OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

NO. DAY YR.    NO. DAY YR.

B. Recommendation

It is recommended that funds be approved for the Thailand Population Planning Project as follows:

<u>Grant:</u>	:	<u>\$ 8,340,000</u>
Commodities	:	6,928,000
Training	:	862,000
U.S.	:	\$127,000
Local:		735,000
Research (local):		450,000
Other (WFI Contract) :		100,000
Life-of-Project:		FY 1976-81

C. Description of Project

1. Introduction

The Royal Thai Government (RTG) has a national population policy to reduce the country's population growth rate by promoting the voluntary practice of family planning. A Cabinet decision in 1970 announced this policy, established the National Family Planning Program (NFPP), and authorized the inclusion of family planning activities in the RTG Third Five Year Plan (1972-76). Performance during the current Third Plan period has been good; it would have been better if not constrained by the limited population and geographic coverage of the Ministry of Public Health (MOPH) rural health network--the primary delivery system for clinical and non-clinical family planning services in Thailand.

Recently the NFPP<sup>1/</sup> prepared a general but comprehensive statement for inclusion in the Fourth Five Year Plan, outlining RTG plans for implementing a population program during the period 1977-81. This statement ("1977-81 Family Planning Development Plan of the National Family Planning Program,

<sup>1/</sup> The NFPP is both a program and an organization. The NFPP Director is the Under-Secretary of State for Health, MOPH; primary program design, coordinating and management responsibility for the NFPP is assigned to the Family Health Division of the MOPH.

Ministry of Public Health," April, 1975) is included as Annex C.

Briefly, the thrust of the new NFPP plan is to expand availability of family planning (F.P.) services "out and down" to virtually all areas of rural Thailand. To achieve this, the NFPP plans to: a) expand the F.P. service "carrying capacity" of the primary F.P. delivery system--the rural health network of the Health Ministry--by providing family planning training to all current and future MOPH personnel in the RTG rural health system; b) expand the use of mobile F.P. units in remote areas; c) utilize or create additional channels for distribution of F.P. information and services into areas not covered, or inadequately covered, by the RTG health network; and d) increase potential acceptors' choice of (effective) F.P. methods by introducing new contraceptive technologies (Depo-Provera, mini-laparoscopy) and by broadening availability of methods in existing F.P. service facilities (IUD-insertions by nurse-midwives and auxilliary midwives).

In support of the F.P. program's effort to expand service availability, three secondary areas are mentioned for further development during the Fourth Plan: a) improved quality of F.P. services; b) expansion of Information, Education and Communication (IE&C), including population education, activities; and c) conduct and utilization of applied programmatic research.

The primary RTG unit responsible for implementing these activities will be the MOPH which has been assigned, since 1970, overall planning, operational, and coordinative responsibilities for the RTG National Family Planning Program. The central staff of the NFPP are employees of the Health Ministry, and most administrative, management, logistic and research/evaluation functions of the NFPP are oriented towards the F.P. activities of the Ministry of Public Health. This is an appropriate arrangement in view of the operational role of the MOPH rural health network as the overwhelmingly dominant source of (public sector) F.P. services in Thailand. However, the NFPP also acts as the coordinative unit for the family planning and population activities of other RTG agencies: private and missionary hospitals, and non-government service organizations, including the local IPPF-affiliate, the Planned Parenthood Association of Thailand (PPAT). This coordinative function is facilitated by a National Family Planning Coordinating Committee chaired by the Minister of Health and including representatives from the NFPP and several RTG and non-government organizations participating in the Thai

population program. The NFPP prospectus mentioned above thus represents the planning framework for a broad-based national population program. Although F.P. services available through commercial channels present a special case, contraceptive supplies distributed by pharmacists or other commercial agents are also regulated by the MOPH.

## 2. Project Activities

The specific elements of this project include activities designed to increase the geographic and population coverage of the F.P. delivery system. Concomitant to expansion of the system itself will be efforts to energize the system by equipping it (through training and provision of contraceptive supplies) to actually extend F.P. services to the rural Thai community. These project activities include:

a. Contraceptives procurement and distribution through an expanded delivery system for F.P. services. Elements of the distribution system will include:

i. The hospital and rural clinic network of the MOPH. (Current network: approximately 5,000 hospitals and clinics; FY 1981: 5,500<sup>2</sup>/ hospitals and clinics.)

ii. Non-MOPH, RTG field workers from the Ministry of Interior, primarily Border Patrol Police (BPP), and tambon doctors;

2/ Capital costs for expansion of the hospital and clinic system will be borne by the RTG, MOPH. (See pp. 40-43, World Bank Draft Population Sector Report, April 28, 1975 - Annex A). U.S. assistance will include provision of a portion of the contraceptive supplies (orals, F.P. kits to be issued through the current and expanded clinical system).

- iii. Traditional midwives;<sup>3/</sup>
- iv. Mobile family planning units.
- b. Local family planning training for:
  - i. Ministry of Interior field workers (BPP and tambon doctors);
  - ii. Traditional midwives;
  - iii. MOPH nurse-midwives and auxilliary midwives (IUD-insertion training).
- c. Procurement and activation of forty (40) mobile family planning units.
- d. Improvement of NFPP program management, research and evaluation capability through use of short-term technical assistance, on-the-job training, and programmatic research.
- e. Population education training and materials development to stimulate an increased level of future utilization of the expanded F.P. service delivery system.

3/ There are approximately 18,000-20,000 traditional "granny midwives" currently active in Thailand's rural villages. These women--similar in function to the dais of South Asia--assist in deliveries, administer post-natal care, and occasionally sell some simple medicines to the mother for herself and/or the new baby. They are generally highly-respected members of the rural village, learned their skill from a relative, perhaps with some assistance from the local MOPH midwife, and accepts payment in cash or kind from her patient. Auxilliary midwives of the MOPH are formally trained for 18 months in MOPH medical/clinical facilities. The 7,000 (approx.) currently employed by the MOPH work in hospitals and rural clinics, the latter having "outreach" responsibilities for villages in the vicinity of the clinic. MOPH midwives are encouraged by the Ministry to cooperate closely with "traditional" midwives in their area. It is not unusual for both the village and the government midwife to jointly assist in the same delivery.

Of these above project activities<sup>4/</sup>, USG participation will include support for the following:

i. Provision of contraceptive supplies (orals, F.P. kits, medical equipment) on a decreasing basis;

ii. Provision of mobile family planning units on a 50-50 cost-sharing basis with the RTG;

iii. Grants for local family planning training. The share of these training costs supported by AID would also decrease annually.

iv. Short-term, specialized technical assistance in program management, evaluation, new contraceptive technologies, population education;

v. Research grants to support F.P. program-related studies conducted by the NFPP, local universities and research institutions;

vi. AID/W-funded resources as necessary and appropriate to furthering the objectives of the NFPP. These resources include short-term consultant and/or research support available through AID/W institutional contractors; support for project activities such as WEI, DEIDS, etc., grants for specialized training in U.S. or third countries.

### 3. End-of-Project Status

The end-of-project status expected in 1981 is, in quantifiable terms, an annual population growth rate of 2.1%. Also of importance, will be the demographic condition consequent to attainment of this objective: a sustained and

<sup>4/</sup> These components of a distribution system for family planning services do not represent all or even most of the existing formal or informal conduits for health care in rural Thailand (see Paul O. Wooley, Jr., Syncrisis, The Dynamics of Health, Vol. XII, D.H.E.W., June, 1974; and James N. Riley, Santhat Sermsri: Working Paper No. 6, "The Variegated Thai Medical System as a Context for Birth Control Services", Mahidol University, June, 1974). The distribution system elements indicated herein do, however, represent an optimum selection as determined by their potential population coverage and by their amenity to training, contraceptive re-supply, and routine professional supervision.

continuing downward trend of Thailand's population growth rate toward a rate commensurate with the country's broader economic and social development objectives. The mechanism for achieving this condition will be a nationwide distribution system for delivering basic contraceptives services to virtually every rural village in the country.

#### D. Summary Findings

The National Family Planning Program of the RTG has established a tentative Fourth Five-Year Plan target of 2.1% annual population growth by the end of 1981. The primary mechanism by which the RTG expects to achieve this target is an expanded and extended delivery system for family planning services. (This strategy has also been suggested by the World Bank). The central elements of this system will be additional contraceptive distribution agents and re-trained clinical personnel (RTG & non-government) and contraceptive supplies. Supportive elements will be mobile F.P. units, programmatic research to test various service "mixes" and orientations, and technical assistance in program management and monitoring areas temporarily over-extended by the growing program. Long-term impetus toward fertility reduction will be encouraged through support for population education activities in the formal and non-formal RTG educational system.

The RTG and Mission view, recently reinforced by a World Bank population sector review team, is that the current limited availability of F.P. services in rural areas represents the primary constraint to a continuing decline in Thai fertility. The Mission further believes that the action program outlined by the NFPP for extended F.P. services during the Fourth Plan period represents a feasible and potentially effective program to resolve this basic deficiency of F.P. service availability. The Mission is also convinced that the specific USG contributions identified in this paper are essential to the NFPP effort, are within the capacity of AID to deliver, and are within the capability of the RTG to effectively manage and utilize. Further, USG assistance being proposed herein is intended to be incremental, rather than substitutive, to an increased level of RTG investment in an expanded F.P. program. This factor is discussed in more detail in the project description and financial analysis sections below.

The FY 1976 elements of the project are appropriate to immediate implementation. Later components of the project are contingent

on final RTG approval of the NFPP submission to the Fourth Five Year Plan. Approval of this submission, or a revised version, is expected by early winter, 1976.

The project meets all applicable statutory criteria (See Annex F, Statutory Checklist).

### E. Project Issues

#### 1. Procurement of Oral Contraceptives

An AID/W review of the FY 1975 PROP for health, nutrition and population planning noted that the RTG had ample and growing reserves of foreign exchange (due in large measure to the rising value of rice--and other commodities produced in Thailand--in world markets). This relatively comfortable foreign exchange position put to doubt the suitability of continued USG support for oral contraceptives, a major foreign exchange cost component of the RTG family planning program.

This issue is dealt with in Part II of this Project Paper. Our conclusion is that continuing U.S.-financed oral contraceptives through the RTG Fourth Five Year Plan--on a declining share basis--will add a dynamic character to RTG pill budgets and will enable the NFPP to enter its fifth plan with an established and much increased funding level.

#### 2. USG Assistance Level for FY 1976

The level of assistance specified in this paper for FY 1976 is substantially higher than the level indicated in the DAP (\$3.7 million<sup>5/</sup> in this paper vs. \$1.5 indicated in the DAP). This higher level is the result of two factors: a) RTG/NFPP program decisions to vigorously expand the distribution network for F.P. services in rural areas of Thailand; and b) USOM proposal to fund sufficient oral contraceptives to meet AID/PHA/POP pipeline standards. This issue is also covered more thoroughly in Part II of this Project Paper.

#### 3. Duration of the Project

The time-frame of the project is also extended to six years, FY 1976-81 inclusive, to match up closely with the project-life of U.S.-assisted elements of the NFPP Fourth Five Year Plan (1977-1981).

5/ Including interim quarter.

In view of the congressional limitation restricting project duration to five years, the final year (FY 1981) of this project is included tentatively, and will be implemented subject to future congressional approval and availability of funds.

#### 4. Local Currency Generations

MOPH clinic personnel typically receive five baht (25¢) per cycle of oral contraceptives distributed, as a "client donation" or "service charge" (in some areas the charge is 15¢/cycle); indigent clients--perhaps 10% of all users--receive pills free. Thus, a substantial amount of funds--up to \$8 million--may be generated by pill donations over the next six years. The Mission and the RTG agree that a procedure must be established to manage the collection, reporting and disposition of this extra budgetary resource. The Mission's recommendation, to be explored with the MOPH and the RTG Bureau of the Budget, is to use these revenues to establish a revolving fund for RTG purchase of orals. This issue is also discussed in Part II.

5. The Ministry of Interior (MOI) has not yet formally approved the NFPP proposal to utilize MOI personnel (tambon doctors, BPP) as part-time family planning agents. This approval will be specified as a condition precedent to U.S. assistance for local training activities.

6. The pill is still on the RTG "dangerous drug list" and cannot be dispensed initially without a doctor's prescription (or instead, without a "checklist screening" of the potential acceptor by a government midwife). A possible solution to this would be to utilize the additional F.P. workers as "re-supply agents" following initial physician or midwife prescription.

7. The RTG has not yet specified RTG budgetary contributions to the NFPP for the Fourth Plan period. The program budget included in the NFPP Fourth Plan submission (Annex B) represents a total of RTG plus all donor contributions, with the result that actual RTG contributions will be a function of donor support levels. In view of the vagaries of long-term donor commitments at this time (particularly UNFPA support), a firm RTG statement of Fourth Plan funding levels will be required before mid-FY 1976 to enable appropriate donor adjustments. USOM assistance strategy is to support, on a

declining share basis, incremental NFPP efforts. Thus a rising level of RTG commitment over the life of the project is a necessary pre-condition to continued U.S. support.

8. The recent family planning evaluation (Annex B) pointed out other existing weaknesses and problems in the family planning program. These include:

a. A weak data base from which to plan program targets and to evaluate future program effectiveness. A survey of Population Change, now being conducted by the RTG National Statistical Office (NSO) is expected to produce baseline demographic data by early February, 1976. On receipt of these data, the demographic indices indicated in this and RTG program documents will be amended to establish benchmarks for future project evaluations.

b. Unavailability of regular budget funding/permanent RTG Civil Service Commission sanction for approximately 50% of the 200 MOPH personnel working at NFPP headquarters in Bangkok. However, subsequent to issuance of the evaluation report, the RTG has taken action to establish 65 NFPP headquarters positions as permanent RTG positions, and has assumed RTG budgetary responsibility for 150 temporary positions which had previously been funded largely by donors (Population Council and UNFPA).

c. Inadequate field supervision of the F.P. activities of MOPH field personnel. Also subsequent to issuance of the evaluation report, the NFPP has prepared a plan to improve field supervision. Improvement will be effected partly through training of personnel at the provincial and district levels in supervision techniques (already completed in a number of provinces), and the use of monthly service statistics as a supervisory tool. In addition, the headquarters staff at the provincial level will be increased to include two nurse-supervisors who will analyze performance by area and type of service activity. The Provincial Chief Medical Officer (PCMO) will be notified by the NFPP of low performers and will be empowered and requested to take corrective action.

PART II: Project Background and Detailed Description

A. Background:

The most extensive description available of the RTG and associated Thai population programs is the recent report of a World Bank population sector review team which visited Thailand in February - March, 1975. The Bank's report, plus a separate summary volume, are still in draft form, and, in keeping with Bank practice, are not yet available for general distribution. It is expected that a final version of the Bank report will have been published by the time this Paper undergoes review in AID/Washington. In the meantime, the Bank draft report dated April 28, 1975--copies of which were distributed by the Bank to AID/W, the Mission and the RTG--will serve as a temporary but unofficial annex to the P.P., and will stand as the primary background statement for the project paper. A brief summary statement follows, but the reader is urged to read the comprehensive IBRD report.

1. The National Family Planning Project, 1970-1975:

In March 1970, the RTG announced a formal national population policy which states, "It is the policy of the Thai Government to support voluntary family planning in order to help to resolve various problems related to the very high rate of population growth, which constitutes an obstacle to the economic and social development of Thailand".

The policy statement, in fact, followed by three years the Ministry of Public Health's commencement of a "Family Health Project" (1968) which integrated family planning services into the Ministry's rural health services. During this period, however, services were limited to those clinics and hospitals (about 250) which had a doctor in residence. The policy announcement was of major importance, however, for it: a) enabled the Ministry of Public Health, plus other appropriate RTG ministries and agencies, to submit budgets and population proposals for inclusion in the Third Five-Year Plan (1972-76); b) established the NFPP within the Ministry of Public Health; and c) set a Third Plan demographic target of 2.5% annual population growth rate by the end of 1976 (the 1972 rate was estimated to be approximately 3%).

The years following the policy announcement and creation of the NFPP have witnessed rapid progress toward development of a national population program. At present, near the end of FY 1975, family planning services are available through approximately 5,000 clinics and hospitals of the Ministry of Public Health; twenty-one health centers of Bangkok Municipality; various hospital and health facilities of the Army, Police, national railways; private and missionary hospitals; and a local IPPF-affiliate--The Planned Parenthood Association of Thailand--supports an active family planning information/motivation campaign plus an experimental "Community-Based Family Planning Services (CBFPS)" project designed to deliver non-clinical contraceptives at the village level. In addition, the commercial sector is an important source of oral contraceptives in more urbanized areas of the country, with pill distribution through retail outlets currently totally about 40% of national pill usage.

To date almost two million women have accepted family planning services through the national program, and many others have received services through private and commercial sources. A survey conducted by Chulalongkorn University (Longitudinal Survey of Social, Economic and Demographic Change, 1972) reveals that almost 25% of all eligible married women between the ages of 15 to 45 are practicing contraception or have been sterilized (in urban areas alone the percentage of eligible women practicing may be as high as 45 to 50%). This performance lends considerable likelihood to the possibility that the Third Plan target of a 2.5% growth rate may be achieved by the end of 1976.

Over the past year, however, there has been evidence that the RTG family planning program is "plateauing" in the sense that new acceptors are roughly equalling continuing users in number (i.e., annual program drop-outs are roughly the same as the annual number of new acceptors). Sterilizations, which have enjoyed a rather remarkable upsurge this year, are an exception, but overall, the family planning program seems to have largely reached--within the areas covered by the delivery system--much of the "early acceptor" pool, and is now dealing with couples who are lesser motivated to continue family planning practices. Regretably, this condition is prevailing even while basic family planning services are not routinely and continuously available to perhaps 60% of Thailand's rural population, including the potentially large number of these under-served - 60% (3,000,000 couples) who are highly-motivated to accept family planning services.

Thus, the DAP and the recent World Bank Sector Review Mission draft report have both identified the limited "reach" of the existing (largely MOPH clinical) family planning delivery system as a primary constraint to significantly increased levels of family planning practice in Thailand. In the Bank's phase, the family planning program is "supply-constrained" from achieving significant further advances in rural areas largely because the primary delivery network for family planning services--the MOPH rural health system--regularly reaches only 35-40% of the rural population. (The commercial sector, currently selling orals in urban areas holding approximately 15% of the population, is not impacting to any great degree on the overall "availability" problem).

NFPP planning for the upcoming Fourth Five Year Plan (1977-1981) has consequently focused on means to extend the family planning service delivery system outward. Elements of this plan will be discussed in detail below, as will the components of USG assistance proposed to support the expanded family planning program. First, however, it would be useful to briefly note the status of USG assistance provided to the Thai population program during the on-going Third Plan period.

## 2. USG Assistance, 1968-1975

USG assistance for RTG family planning activities began in FY 1968 in support of the MOPH Pilot Family Health Project. Following publication of the NFPP Third Five Year Plan in FY 1972, U.S. assistance was linked closely to the action program outlined in the NFPP plan. Through FY 1975, over \$10 million in technical assistance, participant training and commodity assistance (primarily pills, vehicles and medical supplies), was provided to the NFPP and associated organizations such as Mahidol and Chulalongkorn Universities, Bangkok Municipality Health Bureau, and the Ministry of Education. As noted by the World Bank team on their recent visit, the AID assistance provided during the formative years before and during the Third Plan period was absolutely essential to the rapid and successful development of the family planning program.

Population assistance provided in FY 1975 has been somewhat of a special case in form, if not substance. For reasons specified in the FY 1975 PROP, USG assistance for health, nutrition and family planning was consolidated into a one-year assistance program. This procedure was considered necessary to maintain continuity of essential assistance

elements, while the RTG, the USG and other donors collectively decided on a long-term assistance strategy for the Thai population program. Key inputs to this prospective were to be the World Bank population sector review, recently completed in draft form, a comprehensive RTG-USOM evaluation of the NFPP (report submitted in June, 1975), and an RTG population program plan to be prepared for inclusion in the Fourth Five-Year Plan. These documents are included in the attached annexes.

Because the expiring FY 1975 PROP covered USG population assistance for only one fiscal year, the long-term U.S. assistance program described below is out of synchronization by one year with the long-term plan (Fourth-Year Plan submission 1977-81) recently prepared by the NFPP. That is, FY 1976 assistance will be in support of population activities conducted during the final year of the current (Third) Five-Year plan, while subsequent assistance will be in support of Fourth Plan programs. This approach is not expected to present procedural problems in implementation of project assistance because the Fourth Plan program represents more of an expansion and extension of the NFPP, rather than a radical new direction in program methods and priorities.

### 3. Evaluation: The Program to Date

During February - April, 1975 the RTG and USOM conducted a joint evaluation of the RTG National Family Planning Program. This evaluation is attached as Annex B. A large part of the evaluation discusses aspects of the operational family planning program, manpower needs, budget requirements, and management issues such as commodity monitoring and control, personnel supervision, etc. The most significant portion of the report discusses the demographic effects which can be attributed to the family planning program through CY 1974. Noting that the Thai data-base is weak, and that the statistical and evaluation instruments needed for firm assessment of the program's demographic impact are less than satisfactory, the evaluation did tentatively identify a real and substantial effect on Thai fertility. Measured in terms of "births averted", this demographic impact was determined to be approximately 250,000 averted births since 1971 (the base-year of the evaluation), or up to 650,000 births averted since any F.P. services became available in 1965. The effect of contraceptive sales

through the commercial sector was estimated for an additional number of averted births, though the report does not seem to have considered the full impact, since 1968, of the commercial sector. Nonetheless, depending on the crude birth rate actually prevailing in 1971 (studies have put it between 36 and 41 per thousand population), the assessment estimated that the population growth rate may already be at or even under the Third Plan target of 2.5%, largely as a consequence of the NFPP.

#### 4. RTG (NFPP) Assistance Request

The NFPP has requested USG assistance for the period FY 1976-1981. The time-frame covered by the NFPP request includes FY 1976--the final year of the RTG Third Five-Year Plan (1972-1976), and 1977-1981--the period covered by the next (Fourth) Five-Year Plan.

The FY 1976 assistance request is for continuing oral contraceptive requirements of the F.P. program (computed on the basis of AID/W guidelines specified in the FY 1977 Annual Budget Submission) plus support for new program needs and innovations, training of nurse-midwives to insert IUD's, emphasis on sterilization (F.P. kits) and programmatic research.

Assistance to be provided over the FY 1977-81 period is comprised of support for those elements of the NFPP Fourth Plan submission which were jointly determined by the RTG and USOM to be most consistent with USG population assistance strategy outlined in the DAP (i.e., that they represent high-priority program activities involving incremental RTG efforts/expenditures to achieve more widespread coverage of the F.P. delivery system and a higher level of continuing contraceptive usage in rural areas). Components of the FY 1977-81 program for which U.S. assistance is requested therefore includes contraceptive supplies and equipment (linked with a schedule of gradually-increasing RTG purchases of contraceptives), mobile F.P. units (provided on a 50-50 matching basis with the RTG), training grants for local training of additional RTG and non-RTG family planning field workers and re-training of existing MOPH clinical staff in new F.P. skills (IUD insertions), research grants to study program innovations in the F.P. delivery system, and technical assistance in new methods of program management.

evaluation and contraceptive methodologies. In addition, support will be provided for population education activities selected from a recently completed Ministry of Education "Master Plan for Population Education" including teacher training and development/testing of population materials for use in the RTG formal and informal education system.

B. Detailed Description (See Logical Framework Matrix, Annex D).

1. The population Sector Goal is to reduce Thailand's population growth rate to a rate consistent with national economic and social development objectives. This reduced rate is expected to be below the interim(1981) target growth rate of 2.1% established by the RTG Fourth Five-Year Plan (1977-81). Two major assumptions related to this goal statement are:

a. Continuation of the present population growth rate, estimated to be approximately 2.5-2.7%, will result in population pressures exceeding the long-term resource availabilities of Thailand.

b. Family planning programs can contribute to a significant reduction in fertility.

2. Toward the sector goal, the Purposes of this project are: (a) the attainment of an annual population growth rate of not more than 2.1% by the end of 1981. (This is the tentative demographic target for the RTG Fourth Five-Year Plan 6/); and (b) the creation of a broad-based, functioning delivery system for F.P. information and services, including the active participation of the MOPH; the Border Patrol Police (BPP); the Community-Based Distribution Program; tambon doctors; and village midwives.

6/ Achievement of this target assumes successful attainment of the Third Five-Year Plan (1972-76) target growth rate of 2.5%. In the absence of reliable estimates of the current (summer, 1975) growth rate, the 1977 starting point is obviously not known. The recently completed F.P. project evaluation (see Annex B) of acceptor and continuing user total to date, however, suggest that the NFPP, along with the commercial sector, is having a significant impact on the growth rate. It is hoped that a number of studies in progress, among them the post-censal Survey of Population Change (National Statistical Office), the Longitudinal Survey of Social, Economic and Demographic Change (Chulalongkorn University); and the Thailand and Demographic Change (Chulalongkorn University) will help provide a reliable estimate of the 1976 growth rate. Most observers (NFPP, USOM, World Bank) believe, however, that if the rate is not 2.5%, it will indeed be very close, i.e., +2.6%.

Just as important as attainment of the demographic objective however, will be whether or not the project purpose--a 2.1% growth rate--is in fact an indicator of a new demographic condition in Thailand: a continuing and sustained downward trend in fertility and the population growth rate. A part of the dynamic element needed to sustain the reduction may very well be some kind of re-ordering of traditional rewards and sanctions currently affecting family-size decisions; but another basic element needed for the existence of this condition is availability of the means to limit fertility. This availability is established by successful attainment of the second project purpose.

Achievement of the project demographic purpose will be possible if approximately 45% of all eligible couples are practicing some form of family planning in 1981. 7/ Current practice (contraceptive prevalence) is about 25% of eligible couples. Thus, the number of contraceptive users in Thailand must roughly double (allowing for population growth in the eligible couples category) by 1981.

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7/ The natural growth rate of a nation is a result of the interaction between people being born and people dying over a specific period of time. Family planning programs are concerned with reducing the number of people being born by inducing a sufficiently large segment of the population to adopt contraception in order to attain this reduction. A method of translating this growth rate goal into family planning targets has been developed and is in use in many developing countries including Thailand. This is computed by taking a base year population and a level of fertility grossly measured as the Crude Birth Rate (CBR - the number of births per 1,000 population occurring during one year) as a starting point. To project family planning targets an equation is required that links the level of fertility during a given year to the prevalence of contraception produced by the population during the preceding year. A direct relationship is evident and can be expressed as a simple linear regression curve which links percentage of women who are to be protected to the CBR. The end points of the curve are maximum and zero fertility. The coordination of this relationship provides an estimate of the number or proportion of eligible women who must be protected in order to reduce fertility to pre-determined levels (Bogue - Edmonds, "An Empirical Model for Demographic Evaluation of the Impact of Contraception and Model Status on Birth Rates). This formula as used here indicates that a growth rate of 2.1 in 1981 requires a reduction of the CBR to 30 and a proportion of women practicing contraception of 45% of eligible couples.

In order to reach and continually service this high number of contraceptive users under prevailing patterns of Thai family planning acceptance and use, a distribution system for family planning services must attain near-universal population coverage. The current, primary distribution system for family planning services -- the rural health system of the MOPH -- regularly reaches about 35-40% of the rural population, which in turn comprises 85% of the total population of Thailand.

In determining how to significantly expand availability of family planning services out and down to the rural villagers within the short time-frame of the Fourth Plan, the RTG has considered the potential effectiveness of various elements which are or might be included as components of an expanded F.P. delivery system. These elements include:

a. The existing MOPH family planning delivery system, expanded by:

i. increasing the number of MOPH clinics/ personnel;

ii. increasing the scope of F.P. services provided by the existing MOPH family planning delivery system; and

iii. increasing use of mobile family planning units.

b. Other (non-MOPH) RTG personnel already in place in rural areas, incorporated into the NFPP as part-time F.P. agents;

c. The commercial sector;

d. Non-RTG, formal and informal service systems or organizations in rural areas, (e.g., teachers' associations, co-ops, religious organizations) enlisted as participants in the F.P. program;

e. Traditional practitioners currently providing health services in rural areas; 8/

8/ (See Riley, James N., and Sermsri, Santhat: "The Variegated Thai Medical System as a Context for Birth Control Services," June 1974 Working Paper, Mahidol University).

f) Other channels for rural health services, as described in the (James Riley and Paul Wooley, Jr.) papers cited earlier, e.g.. drug stores, private clinics, "magic" healers, etc.

The F.P. program described in the NFPP's Fourth Plan sub-mission acknowledges all of these channels, but concentrates its development program on items (a), (b), and, to a limited extent (traditional village midwives), (e). These elements were selected primarily because they are a) in place; b) likely to ensure broadest population coverage at least cost; and c) amenable to NFPP training, re-supply and supervision. Together, all components of the expanded delivery system are expected to result in near-universal coverage, by a functioning, hierarchal network, of Thailand's rural population.

The MOPH intends to continue its long-term efforts to expand the rural health system, which will continue to be the primary operational and supervisory component of the overall F.P. delivery system. At present, MOPH facilities and personnel are responsible for recruiting more than 80% of all non-commercial acceptors. When the 1976-81 delivery system expansion program is completed, the MOPH clinical share will probably decrease to perhaps 60% -- though this will involve a larger number of total acceptors. The RTG expansion plan for MOPH facilities and personnel is described in the World Bank Report (pp. 41-45) cited earlier.

The commercial sector cannot be discounted as a major provider of non-clinical contraceptive services in Thailand. (Commercial outlets currently serve approximately 40% of oral contraceptive users and over 80% of condom users). At present, however, the market for commercially-distributed contraceptives is primarily urban and semi-urban--a consequence of both the limited "reach" into rural areas by Bangkok-based manufacturers, wholesalers, and detail agents, and of a multi-tiered pricing system which prices commercial contraceptives beyond the budgets of most rural couples. (One cycle of orals costs \$.60 to \$1.00 in a pharmacy or general store; condoms cost about \$.25 for three. Through NFPP/MOPH outlets orals and condoms cost no more than \$.25/cycle and \$.25/doz. respectively).

Knowledge of the larger potential of the commercial sector in rural Thailand is nonetheless incomplete and in the absence of additional study, this possibly important conduit for non-clinical F.P. services remains an important area for future research and possible broader participation in the national F.P. program. During FY 1976 the NFPP will conduct, with AID consultant assistance, a study of the mechanics of the commercial distribution system in rural Thailand. The results of this study may lead to the development of project initiatives which might require future amendment/additions to this Project Paper.

### 3. Project Outputs

The major outputs of this project are the central elements of a pervasive F.P. delivery system. The F.P. systems - expansion program will therefore run down several "tracks":

- a) An expanded MOPH clinic/personnel program, as outlined in the IBRD report;
- b) Stocks of contraceptives and contraceptive equipment needed to supply the expanded F.P. clinic delivery system;
- c) An effective program policy, management, and supervisory staff, able to determine program needs and innovations, order and deliver contraceptives and assess the demographic impact of various population programs;
- d) Trained family planning workers to staff and implement a village-level F.P. delivery system;
- e) Other basic requirements or accountments of an expanded F.P. service system including informational and motivational (IE&C) programs to acquaint potential acceptors with and possibly induce them to use F.P. services; and population education activities which attempt to instill a population awareness or orientation conducive to family planning practice at some later time.

The schedule and estimated magnitude of project outputs are as follows:

Expanded Clinic Program

Availability of clinical family planning services is planned through 2,000 health facilities of the MOPH (current availability for sterilization and IUD-insertions: 350 facilities), and availability of non-clinical F.P. services through all 5,500 MOPH rural health facilities plus over 12,000 additional F.P. agents (1,200 BPP, 4,000 tambon doctors, 7,000 traditional village midwives) by the end of 1981. (Current rural availability of pills and condoms through 5,000 MOPH health facilities and 25 distribution centers of IPPF-funded Community Based Distribution System. No rural F.P. field agents).

Schedule: Increasing availability of IUD-insertions and non-clinical F.P. services (orals and condoms):

	<u>IUD-Insertions</u>		<u>Non-Clinical Services</u>	
FY 1976	400	Clinics	5,000 clinics	400 agents
FY 1977	600	Clinics	5,100 clinics	2,100 agents
FY 1978	1,000	Clinics	5,200 clinics	4,500 agents
FY 1979	1,300	Clinics	5,300 clinics	7,500 agents
FY 1980	1,700	Clinics	5,400 clinics	10,300 agents
FY 1981	2,000	Clinics	5,500 clinics	12,700 agents

Contraceptive Supplies and Equipment

Achievement of the project purpose of an annual population growth rate of not more than 2.1% by the end of 1981, and annual targets tentatively established in the RTG Fourth Five Year Plan result in the following projections of

total annual (not cumulative) contraceptive requirements:<sup>9/</sup>

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>
Orals (millions of cycles)	8.2	9	10.3	11.6	12.7	13.8
IUDs (units)	90,000	95,000	100,000	105,000	106,500	106,500
Condoms (gross)	30,000	30,000	50,000	65,000	80,000	90,000
Depo Provera (units) <sup>10/</sup>	120,000	143,200	245,200	340,000	430,000	511,000
Family Planning Kits	400	400	800	500	300	200
Mobile F.P. Units	-	20	20	-	-	-

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<sup>9/</sup> - Annual requirements for oral contraceptives, IUDs, and Depo-Provera based on acceptor/continuing users projections (for FY 1976) of the RTG/USOM project evaluation - Annex B; and (for FY 1977-81) on the NFPP Five-Year Development Plan - Annex C.

- Projections of annual condom requirements are a NFPP-USOM estimate based on observations of current clinical/distributor performance, through both the MOPH and CBFPS distribution systems.

- The annual number of F.P. kits required is consistent with annual "production" of qualified nurse-midwives and auxiliary midwives (IUD-insertions) and physicians (sterilizations) being trained to perform these clinical services.

- Annual numbers of mobile F.P. units indicated above assumes that in each of the two years FY 1976 and FY 1977 twenty units will be ordered, but delivered the following FY.

<sup>10/</sup> One continuing user requires four units (injections) of Depo-Provera.

Improved NFPP management, monitoring and research/evaluation capability.

The following are projected indicators of the output:

FY 1976:

- a. Two members of the NFPP Research and Evaluation Section trained in data management methodology;
- b. Two studies (contraceptive cost incentives; Muslim attitudes toward F.P.) completed;
- c. NFPP logistics staff trained;
- d. Revised service-statistics report prepared and produced at Bangkok Computer Center or National Statistics Organization;
- e. Province-level targets established for 31 "low-performance" provinces.

FY 1977:

- a. Study completed on means to increase participation of commercial distribution: findings incorporated into action plan if greater commercial sector participation feasible.
- b. Cost-effective analysis of mobile F.P. units completed: findings used for MOPH determination with regard to expanded utilization of mobile F.P. units.
- c. Feasibility study on utilizing auxiliary midwives to insert IUD's: MOPH decision with regard to formal authorization.
- d. Two members of NFPP headquarters staff receive training in F.P. program management.

FY 1978:

- a. Study completed on contraceptive continuation rates: findings used for program evaluation, cost-analysis, estimation of demographic impact.

b. NFPP sponsored study on "beyond family planning" incentives to contraceptive practices: findings used to design pilot project of specific incentives.

c. "Personnel-performance tracking system" installed at NFPP headquarters.

FY 1979:

conducted; a. Five year (1975-1979) program evaluation

needed. b. Other research/training activities as

FY 1980:

completed; a. Pilot study on new contraceptive methodologies

b. Other research and training as needed.

FY 1981:

completed; a. Survey to assess NFPP demographic impact

b. Action plan/program prepared for inclusion if Fifth Five-Year Plan (1982-86).

Trained family planning workers:

a. Participation of 5,100 additional RTG employees (BPP and tambon doctors) not currently active in the NFPP.

Total: approximately 4,100 tambon doctors and 1,000 BPP trained and operational by end of 1981.

FY 1976:	200 BPP
FY 1977:	200 BPP 500 Tambon Doctors
FY 1978:	200 BPP 800 Tambon Doctors
FY 1979:	200 BPP 1,000 Tambon Doctors
FY 1980:	200 BPP 1,500 Tambon Doctors
FY 1981:	200 BPP 1,200 Tambon Doctors

b. Participation of approximately 7,000 traditional midwives not currently active in the NFPP.

FY 1976:	None
FY 1977:	1,000 +
FY 1978:	1,400 +
FY 1979:	1,800 +
FY 1980:	1,600 +
FY 1981:	1,200
	<u>TOTAL: 7,000</u>

c. MOPH nurse-midwives and auxilliary-midwives trained to perform IUD-insertions (Total: 2,400 by end of 1981).

FY 1976:	100
FY 1977:	400

FY 1978	:	500	
FY 1979:		500	
FY 1980:		500	
FY 1981:		400	<u>TOTAL: 2,400</u>

Formal and non-formal education curriculae revised to include population education content.

a. Population-education materials included within standardized curriculae

FY 1976-77: Prototype materials developed at Ministry of Education.

FY 1978: Prototype materials pre-tested and evaluated.

FY 1979: Population education materials revised and re-tested as needed.

FY 1980: Population education materials introduced into standardized curriculae of formal and informal education systems.

b. Teachers trained in population theory, concepts, instructed in use of population education materials.

FY 1976: Population education workshops for teacher trainers.

FY 1977: Teacher-training workshops at regional levels.

FY 1978: Trained teachers pre-test prototype population education materials.

FY 1979-80: Local-level teacher training workshops.

FY 1981: Teachers in place at local school and non-formal educational facilities.

c. Family-life planning content incorporated into the adult education program of the Ministry of Education.

Thru FY 1975 303 teachers trained  
6762 adults in five educational regions reached and taught

FY 1976: 10,145 teachers trained  
434,000 adults reached and taught in eleven educational regions.

#### 4. Project Inputs

The predominant project monetary input is targeted on the supply element of the family planning supply and demand equation. This joint USOM-RTG decision arises from the Mission and IBRD observation mentioned earlier that the current RTG family planning delivery system is "supply constrained" rather than "demand constrained". This implies that the major returns to additional family planning investments in Thailand will be from expansion of the F.P. delivery system, rather than from investments in programs to alter basic fertility-related norms and motivations. Indeed, the supply-demand issue will not be particularly relevant in Thailand until basic F.P. services are available to considerably more than the 35-40% of population currently reached by RTG and commercial family planning services.

To achieve the above outputs project inputs will be required as follows:

##### a. Contraceptive Supplies and Equipment

###### Orals

In FY 1973, the RTG agreed to provide an annually increasing budget for the RTG purchase of orals. Thus, the MOPH purchased in accordance with their agreement, one million cycles in FY 1974 and two million cycles in FY 1975. However, as is evident from the above usage projections, purchases of additional 11/ increments of one million cycles each year will not result in a decrease in U.S. purchases because projected incremental usage equals or exceeds one million cycles each year. It is therefore proposed that the RTG extend its FY 1973 agreement with the added provision that: in addition to the additional increment of one million cycles each year, it also purchase 50% of each year's increase pill usage (using 1974 as the base year). It is also proposed that (a) should requirements be less than proposed in this paper, decrease would be shared between the RTG and USG on a 50-50 basis, and (b) that FY 1981 will be the final year for the financing of orals by USG.

Under this revised arrangement then, the USG would pledge to purchase 50% of each year's increased requirements for oral contraceptives. A rapidly expanding program would therefore elicit from USG a larger contribution of funds for oral contraceptives, while a static or (though unlikely) declining program would have little or negative effect on U.S. assistance levels.11/

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11/ Precise U.S. contributions made on the basis of usage projections would be adjusted yearly via the contraceptive requirements tables forwarded to AID with the Annual Budget Submission (ABS).

Under this revised arrangement, orals financing would be approximately as follows (millions of cycles, and thousands of \$):

Estimated Financing Requirements<sup>12/</sup>

<u>Fiscal Year</u>	<u>Total</u>		<u>RTG</u>		<u>AID</u>	
	<u>Cycles</u> (millions)	<u>\$</u> (000)	<u>Cycles</u> (millions)	<u>\$</u> (000)	<u>Cycles</u> (millions)	<u>\$</u> (000)
1976	22.5	3,960	5.0 <sup>13/</sup>	900	17.5 <sup>14/</sup>	3,150
1977	12.0	2,520	8.0	1,680	4.0	840
1978	13.0	2,730	9.5	1,995	3.5	735
1979	14.0	2,940	11.0	2,310	3.0	630
1980	15.0	3,300	12.5	2,750	2.5	550
1981	<u>16.0</u>	<u>3,520</u>	<u>14.0</u>	<u>3,080</u>	<u>2.0</u>	<u>440</u>
TOTAL	92.5	18,970	60.0	12,715	32.5	6,345

The Mission believes that this gradual turn-over of pill procurement responsibility to the RTG will help ensure that a) sufficient quantities of orals are available and in the pipeline; and b) that a budget category for orals is permanently "built-in" to the RTG-NFPP budget. A premature transition to 100% RTG purchase of orals could, on the other hand, result in fixed budgetary allotments which would create an effective "ceiling" on oral contraceptive supplies. Continuing provision of U.S.-provided orals (or other contraceptives)--donated on a declining-share basis--can add a dynamic character to RTG pill budgets by linking USG and RTG pill procurement schedules.

Within this conceptual framework a number of procedural options are also being studied:

a) The RTG could purchase their pills from AID. Because of its practice of consolidating worldwide USAID, IPPF,

<sup>12/</sup> Except for FY 1976, when purchases are increased to provide for the build-up of the orals pipeline (on hand, enroute, or on order) to an acceptable level, financing is provided in each year for the projected total usage two years hence, i.e., 1977 financing is provided for projected usage in 1979.

<sup>13/</sup> RTG financing shown for 1976 includes 2 million cycles for 1975 and 3 million cycles for 1976.

<sup>14/</sup> This estimated USG funding will be divided, 15 million cycles for FY 1976 and 2.5 million cycles for the interim quarter. Quantity determined by application of AID/W contraceptive requirements guidelines provided in FY 1977 Annual Budget Submission (ABS).

etc. pill requests into single orders, USG has been able to obtain preferential prices from U.S. pill manufacturers. If the RTG purchased their pills (on a multi-year schedule) from AID, the RTG might thus realize savings which could be used either to increase the total quantity of pills purchased (beyond the amount specified in the budget) or release excess contraceptive funds for other project activities such as training, research, technical assistance, purchase of Depo-Provera, etc. Procurement mechanisms might include establishment by the RTG of a dollar trust fund or simple reimbursement to AID for orals purchases.

b) Earlier assumption, by the RTG, of total responsibility for pill purchases might also be achieved if the F.P. program contraceptive "mix" included a greater emphasis on sterilizations and IUDs <sup>15/</sup>, thereby reducing the proportional requirement for orals under the NFPP budget item "contraceptive supplies".

c) Either in addition to, or in lieu of this shift in the service "mix", the NFPP might establish a revolving fund for RTG orals purchases, using funds locally generated from "service charges" or "client donations" for oral contraceptives distributed at MOPH clinics. The NFPP is planning a study to determine an optimum (in terms of F.P. acceptance and continuation) charge for orals, but the current return of 15¢-25¢ per cycle--approximately the total USG or RTG purchase price--suggests that a revolving fund would be a viable long-term solution to the program's insufficient orals budget. The specific terms and methods of this procedure remain to be reviewed within the RTG and between the RTG and USOM.

#### Other Contraceptive Supplies & Equipment

Estimated costs for other contraceptive supplies and equipment are as follows (in thousands of U.S.\$):

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<sup>15/</sup> The current cost-effectiveness of the NFPP contraceptive mix is very favorable compared to other developing countries in Asia, primarily because the longer-lasting sterilization and IUD methods available here are so inexpensive. (Couple-Year Protection cost for a male sterilization is \$0.83; for a tubal ligation \$1.56; for an IUD-insertion \$0.34).

<u>Fiscal Year</u>	<u>IUDs</u>	<u>RTG-funded</u>		<u>AID</u>	<u>AID-RTG (50-50)</u>	<u>TOTAL</u>
		<u>Depo-Provera</u>	<u>Other Contraceptive</u>	<u>funded F.P. Kits</u>	<u>funded Mobile F.P. Units</u>	
1976	13	93	70	130	60	371
1977	14	156	80	90	65	405
1978	15	233	95	100	--	443
1979	16	300	105	30	--	451
1980	16	380	115	20	--	531
1981	17	436	135	--	--	583
TOTAL	91	1,603	500	370	125	2,789

Although IUDs were in earlier years financed by the Population Council, the RTG has assumed their full cost starting in 1975. Except for injectables used in the highly successful program conducted by the McCormick Hospital, Depo-Provera costs will also have to be funded by the RTG. This is particularly significant because of the start of its use in 1975 by the MOPH.

"Other contraceptives" include condoms, foams, and jellies and assumes 100% funding from the RTG budget. Their use is not expected to grow vigorously, despite an attempt with supplies funded by USG, to popularize the condom.

USG will provide 100% of the funds required for F.P. kits (primarily IUD-insertion and sterilization kits).

USG and the RTG will each provide 50% of the funds needed to purchase 40 mobile F.P. units. In addition to their 50% contribution, the RTG will also provide maintenance and operating costs for the mobile units. For reasons of operating economy and compliance with Thai law and custom (traffic is on the left side of the road). U.S.-made vehicles are not appropriate vehicles for this purpose. Justification for a procurement source waiver (for 10 vehicles to be procured in FY 1976) follows:

Request for procurement source waiver from geographic code 000 (U.S. only) to geographic Code 899 (free world and to issue a type "O" PIO/C designating mission as procurement agent).

- a. Cooperating country: Thailand.
- b. Authorizing document: Type "O" PIO/C (to be issued).
- c. Project: Health and Population Planning (493-11-580-266.1).
- d. Nature of funding: Family Planning Grant.
- e. Description of Goods: Ten (10) each Japanese mini-bus, 12 passengers, right hand drive (RHD), 4 or 6 cylinder, approx. 1600 cc.
- f. Approximate value: \$40,000.
- g. Probable source: Through manufacturers local representative/dealer: Geographic Code 493 (Thailand) from Code 488 (Japan).

h. Source waivers granted for commodity procurement:

1. Current quarter (Oct. - present, 1975): None.
2. Previous quarter (Aug. - Sept. 1975): None.
3. Total this FY (July, 1975 - Present): None.

Discussion:

The Thai National Family Planning Program, MOPH will purchase mini-bus type vehicles to provide clinical family planning services such as IUD insertions and sterilizations to populations in remote areas. The RTG and USOM plan to purchase vehicles on a matching 50-50 basis. The vehicles must be economical to operate and right hand drive to comply with the laws and customs of Thailand where the traffic is the left side of the road. Fleet maintenance is cheaper and motorchangability better if all vehicles are the same make. Past experience was shown that U.S. vehicles were available on 8 cylinder and left-hand-drive instead of 4 or 6 cylinder, right-hand-drive as required. Also U.S. vehicles with high compression engines require use high octane fuel raising operating costs. Further, Japanese made are much cheaper than those of the U.S. estimated U.S. cost \$8,000/unit versus 4,000), and delivery time from Japan is about 120 days compared to 180-360 days from the U.S. Family Planning Mobile Clinic is a high priority project. It is essential that the vehicles arrive in country as soon as possible.

Justification:

1. Initial cost is less and vehicles are more economical to operate.
2. Vehicles are right-hand-drive which confirms to the customs and laws of Thailand in that the traffic pattern is the left side of the road.
3. Spare parts and services are readily available in Thailand.

Certification:

Exclusion of procurement from the source requested in the waiver will seriously impede attainment of U.S. foreign policy objectives of the Foreign Assistance Act.

b. Training

Costs of the local training programs will be shared by the RTG and USG 16/. For 1976 and 1977, costs will be shared on a 50-50 matching basis; the AID share will decrease in subsequent years, as follows (in thousands of U.S. \$):

	<u>Total</u>	<u>RTG</u>	<u>USG</u>
1976 <u>16/</u>	170	85	85
1977	300	150	150
1978	440	240	200
1979	480	330	150
1980	474	374	100
1981	<u>454</u>	<u>404</u>	<u>50</u>
TOTAL	2,318	1,583	735

In addition to these local training grants, USG will provide \$200,000 in FY 1976 to fund extension of the participant program begun in prior years.

c. Research

(1) In support of the "improved NFPP management, monitoring and research/evaluative capacity" output, USG will on a 50-50 matching basis share with the RTG costs for specific local research and evaluation activities. Following is an illustrative list of research and study activities contemplated for this project:

- Contraceptive cost incentives.
- Muslim attitudes toward family planning.
- Use of auxiliary midwives to insert IUD's.
- Cost effectiveness of F.P. mobile units.

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16/ Two factors determine the annual levels of USG support for local training costs: 1) total number of persons to be trained each year (no. increase annually through FY 1980; declines in FY 1981); and 2) the assumption, by the RTG of an annually increasing share of total training costs. Thus, the increasing numbers of people being trained (600 in FY 1976; 1,800 in FY 1977; 2,900 in FY 1978; 3,500 in FY 1979; 3,900 in FY 1980; and 3,000 in FY 1981) require increasing amounts of USG assistance through FY 1978, even though the USG support represents a smaller proportion, each year, of total costs of the training program. By FY 1979, when USG assistance starts to decline, the drop in the USG proportion will have acted to decrease absolute funding amounts even though the actual number of people being trained in FY 1979 is greater than previous years.

- Commercial sector F.P. activities
- F.P. "method-mix" cost effectiveness analysis
- Contraceptive continuation rates
- F.P. trainee follow-up

(2) University of Chaing Mai: "Social and Psychological Barriers to the Adoption of Family Planning in Northern Thailand" - In FY 1976, \$50,000 will be provided by the USG to support a study conducted by Chaing Mai University in Northern Thailand. The 18 month study, to be conducted jointly by the Faculties of Medicine and Social Science, will:

- (a) measure past and current levels of fertility and practice of contraception in northern Thailand;
- (b) examine the social, cultural and psychological determinants of fertility in the region; and
- (c) evaluate the adequacy and availability of family planning services in the northern region of the country.

d. Consultant Services

Short-term consultant services from USG will be derived from centrally funded capabilities. An illustrative list of consultant requirements follows:

	<u>Work-Months</u>
<u>1976</u>	
Data management	2
Population Education	3
Commercial distribution of contraceptives	1
<u>1977</u>	
Project Evaluation	2
Population Education	2
F.P. Program Management	1
F.P. Logistics	1

<u>1978</u>	<u>Work-Months</u>
F.P. Personnel Management	2
Research Consultant: Incentives	3
Project Evaluation	1
<u>1979</u>	
Project Evaluation	2
<u>1980</u>	
Research Consultant - New F.P. Methodologies	3
Population Program Planning	3
Population Education	3
<u>1981</u>	
Population Program Planning	3
Demographic Assessment	2
e. <u>World Education, Inc. (WEI)</u>	

In FY 1976 the USG will provide \$100,000 for the final year of a three-year Ministry of Education/WEI project to integrate family planning knowledge into the functional literacy training program of the MOI Adult Education Division. During the first two years (funded by AID/W) of this project, the program was developed and field-tested in five of Thailand's twelve educational regions. This final year (FY 1976) of the project will expand the activity country-wide, to include eleven of the country's educational regions. The \$100,000 USG contribution, channeled through WEI, will fund salaries for: one full-time WEI advisor assigned to the MOE; seven supporting Thai staff; five Thai staff members of the Thai National Population Education Committee; will cover two to five international consultants as needed; and will pay for teacher training workshops, field surveys, development of educational materials, and evaluation instruments.

f. DEIDS

Special note should be given to the DEIDS (Development and Evaluation of Integrated Delivery Systems) project currently underway in Lampang Province in Northern Thailand. This AID/W-funded activity is testing innovative methods to deliver low-cost integrated health, nutrition, and family planning services to Thailand's rural villages. The methods and results of the DEIDS project are therefore of considerable significance to the NFPP, which has identified expanded rural availability of F.P. services as a primary Fourth Plan objective. Over the next several years the NFPP and the MOPH in general will be closely studying the DEIDS experience for examples of DEIDS-tested manpower, management, or other operational innovation which might be introduced into the national family planning program.

A summary of USG inputs over the project period is shown in the table below:

SUMMARY OF USG INPUTS

(In Thousands of US \$ )

	<u>1976</u>	<u>I.Q.</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>TOTAL</u>
<u>Contraceptive Supplies/Equip.</u>								
Orals	2,700	450	840	735	630	550	440	6,345
F.P. Kits	70	60	90	100	30	20	---	370
Mobile F.P. Units	30	---	33	---	---	---	---	63
Other Methodologies	---	---	---	---	50	50	50	150
<u>Local Training</u>	85	---	150	200	150	100	50	735
<u>Participant Training in U.S.</u>	8	52	67	---	---	---	---	127
<u>Local Research/Evaluation</u>	150	---	50	100	50	50	50	450
<u>World Education Inc. Contract</u>	100	---	---	---	---	---	---	100
<u>TOTAL</u>	<u>3,143</u>	<u>562</u>	<u>1,230</u>	<u>1,135</u>	<u>910</u>	<u>770</u>	<u>590</u>	<u>8,340</u>

## Other Donors

### UNFPA

A description of UNFPA-supported F.P. activities is contained in Annex H-5 of the attached IBRD report on the NFPP. Support has largely been for the expansion of F.P. services such as Maternal and Child Health (MCH) facilities, subsidies for the sterilization programs, IE&C activities and transportation support. The RTG provides both in kind and budgetary support for UNFPA activities, as also indicated in Annex H-5 to the IBRD report.

Budget constraints are expected to reduce the level of UNFPA support for F.P. activities during the Fourth Five Year Plan period. In purposes of this Project Paper, we are projecting UNFPA inputs of \$750,000 each year through 1979, leaving open any extension of UNFPA funding beyond that date.

### Population Council

The Population Council has supported the RTG family planning efforts since 1963, when it sponsored the first National Population Seminar. In 1974, their support totalled approximately \$400,000 for technical advisory services, support of local evaluation and research activities, support for the Institute of Population studies at Chulalongkorn University, and support for family planning efforts of the National Economic and Social Development Board (NESDB).

Because of funding constraints, the Council expects to reduce the contributions of the NFPP to a level of approximately \$200,000 in 1976 and \$100,000 in 1977. It is expected that 1977 will be the last year that financing will be provided by the Council.

### Japan

The Japanese Government made its initial contributions to the NFPP in FY 1975 when it donated, through the Colombo Plan, approximately \$60,000 for mobile audio-visual units and other A-V equipment for use by the NFPP IE&C unit.

The Japanese Government has made no further commitments of support for the family planning program, though the NFPP is preparing a request for transportation assistance. Primary elements of this possible support could be motorbikes (approximately 1,500) being dropped from the UNFPA program because of UN funding constraints, and utility vehicles (possibly 45 jeep - type) for field supervision and transport of MOPH clinicians.

IBRD

The World Bank recently sent a population sector review team to Thailand (draft Report Annex A.) preparatory to consideration of possible loan support for the F.P. program. It is premature to speculate on the availability of the loan, or on RTG reaction to a specific loan offer.

It appears, however, that capital costs for a clinic expansion program may be an important element of an IBRD loan offer.

IPPF

Although formally not within the scope of the RTG National Family Planning Program, a footnote is required on F.P. support provided by IPPF.

IPPF support is provided in the form of commodities and staff/administrative support to the Planned Parenthood Association of Thailand (PPAT), the Community-Based Family Planning Services project (CBFPS), and to two permanent hospitals, the McCormick Missionary Hospital in Chiang Mai and Chulalongkorn Hospital in Bangkok. Projected levels of IPPF support are as follows:

1976	\$600,000
1977	400,000
1978	300,000
1979	300,000
1980	300,000
1981	<u>300,000</u>

TOTAL \$2,200,000

RTG Budget Support

The proposed RTG Family Development Plan for 1977-81, attached as Annex B, contains estimated total budget requirements to achieve the plan targets. Total budget requirements are also treated in some detail in the IBRD report, Annex A (pp. 80-85). Since the plan budget includes total requirements, including external assistance, the table on the following page indicates the effect of assistance levels included in this paper on RTG budget requirements--which is calculated as the residual.

The budget categories contained in the plan appear reasonable and adequate. It should be noted, however, that the NFPP budget does not represent total RTG investment in the family planning program. Because the primary delivery system for family planning services is the MOPH rural health system, most operational costs are covered elsewhere in the regular MOPH budget (field staff salaries, clinic overhead, POL, etc.) It has been estimated (NESDB, 1971) that the MOPH provides an additional \$1.5 million per year in indirect support for the family planning program. It should also be noted that the NFPP budget is substantially higher than projections included in the IBRD report.

TOTAL NFPP PROGRAM COSTS

(Thousands of US\$)

<u>Fiscal Year</u>	<u>Total Program</u>	<u>RTG(Direct Budget plus Counterpart Funds)</u>		<u>U.S.G.</u>		<u>UNFPA</u>		<u>Pop Council</u>	
		<u>Amount</u>	<u>%</u>	<u>Amount</u>	<u>%</u>	<u>Amount</u>	<u>%</u>	<u>Amount</u>	<u>---</u>
1976 *	6,405	1,750	28	3,705	57	750	12	200	
1977	4,667	2,587	55	1,230	26	750	17	100	
1978	5,200	3,315	64	1,135	22	750	14	--	
1979	5,300	3,640	69	910	17	750	14	--	
1980	5,400	4,630	86	770	14	Open		--	
1981	<u>5,750</u>	<u>5,160</u>	<u>90</u>	<u>590</u>	<u>10</u>	<u>Open</u>	<u>---</u>	<u>---</u>	
<b>TOTAL</b>	<b>32,722</b>	<b>21,082*</b>	<b>64</b>	<b>8,340</b>	<b>26</b>	<b>3,000</b>	<b>9</b>	<b>300</b>	

\* Includes Interim Quarter.

\*\* RTG total does not include approximately \$6 million RTG indirect F.P. program support to be provided through the regular budget of the MOPH, e.g., salaries for health workers and supervisors, clinic construction and maintenance, POL etc. The \$6 million figure is derived from an NESDB estimate, made in 1970, of the proportion of MOPH resources expended for F.P. activities.

PART III: PROJECT ANALYSIS

A. Technical Analysis

Local studies<sup>17/</sup> of rural Thai fertility preference/behavior and five years' performance of the national family planning program strongly indicate that family planning--conceptually and technically--is popularly accepted by the Thai people. This research and practical experience demonstrates that rural Thais will accept family planning services if they are available.

The central elements of this project--contraceptive supplies and a functioning delivery system (comprised of clinics and clinicians, outreach personnel, mobile units)--represent the components of F.P. services' availability in rural Thailand. (Population education activities serve to stimulate future demand for these services).

The utility of specific USG project inputs<sup>18/</sup> will be a function of whether and how effectively they contribute to the creation of a F.P. service structure capable of regularly delivering contraceptive services to most of Thailand's rural population. Considerations of this utility follow:

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<sup>17/</sup> See "The Potharam Study", Institute of Population Studies, Chulalongkorn University, 1971.

- "Studies of Health Problems and Health Behaviour in Saraphi District, North Thailand", Chiang Mai University, 1970.

- Workshop Papers (No. 1,2,5,6,13) of the "Longitudinal Study of Social, Economic and Demographic Change in Thailand, Institute for Population Studies, Chulalongkorn University, 1973, 1974.

<sup>18/</sup> USG inputs follow the recommendations of the recent F.P. project evaluation (Annex B). The NFPP will concurrently move to increase service availability in additional areas suggested by the evaluation. These include 1) filling vacant personnel positions at rural health facilities; 2) requiring auxilliary midwives to carry oral contraceptives and condoms with them during their village and home visit activities; 3) increasing the number of family planning "service days" at rural clinics; and 4) improving field emphasis and supervision of MOPH clinician family planning activities.

1. Commodities

a) Oral contraceptives proposed as elements of USG assistance have been extensively proven in clinical and mass distribution programs throughout the world. In Thailand oral contraceptive users represent over 60% of all family planning clients and thus represent the backbone of the entire program. Pills will constitute the primary family planning method to be made available by the 12,000 additional F.P. agents to be trained under this project by 1981 -- with the result that anticipated annual pill usage in 1981 will be almost double the 1976 figure (See Table, page 22).

Further, the procedural arrangement under which USG-provided orals are to be ordered--USG purchases linked to an accelerating schedule of RTG purchases--is intended to have the important developmental effect of ensuring RTG self-reliance in this important resource area by the termination date of USG assistance to the project.

b) The family planning kits (IUD-insertion kits, male and female sterilization kits) proposed for this project have been field-tested in several developing countries, including Thailand. They will be used to support NFPP efforts to move toward a higher proportion of the relatively more cost-effective clinical F.P. methods. Service outlets for these methods will be 84 provincial hospitals (sterilizations, IUD-insertions), and all health clinics staffed by nurse-midwives or midwives trained to perform IUD-insertions (2,000 clinics by 1981).

c) The practical utility of mobile F.P. units has been demonstrably high in Thailand, where mobile units attached to Chulalongkorn Hospital, Khon Kaen MCH Center and McCormick Hospital have successfully reached over 100,000 contraceptive users since 1970. The cost-effectiveness of mobile units to be provided to the MOPH (on a 50-50 cost-split basis) is expected to be particularly high because the new units will be intended primarily for delivery of clinical contraceptive methods (IUD-insertions, sterilizations) which have much lower client protection costs than non-clinical contraceptive methods such as orals and condoms.

d) Condoms are not being proposed as an element of U.S. assistance. In FY 1975 the USG delivered approximately a three year's supply of condoms (149,999 gross) to the NFPP. Future requirements will be purchased by the RTG.

Note: Condoms are produced in Thailand.

## 2. Training <sup>19/</sup>

During the FY 1976-81 period, the NFPP plans to train approximately 400 nurse-midwives and 2,000 auxiliary midwives to perform IUD-insertions at MOPH clinics, and 1,000 Border Patrol Police (BPP), 4,100 tambon doctors and 7,000 traditional ("granny") midwives as village-level agents for family planning information and service (primarily pills and condoms).

### a. IUD-insertion training.

Training for 150 nurse-midwives (IUD-insertion training) was funded in FY 1975. These initial trainees are being trained at Chulalongkorn Hospital in Bangkok and will in turn train the next 400 nurse-midwives at provincial hospitals and MCH centers in rural areas. Training for 2,000 auxiliary midwives will not commence until FY 1977, but will follow the pattern established by the nurse-midwife training program, i.e. an initial class of trainers will be prepared, probably in Bangkok, to train other auxiliary midwives in the provinces. Trained nurse-midwives and auxiliary midwives will then provide IUD-insertion services at the 2,000 clinics where they work. At present, IUDs are available only at provincial hospitals and First Class Health Centers staffed by physicians (1975 total: 350 facilities). Availability of IUD-insertions by female practitioners is expected to have a particularly strong impact in the Muslim South, where women have been reluctant to have IUDs inserted by male physicians.

### b. Border Patrol Police (BPP)

In most of Thailand's border regions the BPP represents the primary--and often the only--regular RTG presence. As part of its overall social service responsibilities in these areas, the BPP has provided field medical services to police, police families, and to civilians (1974 treatment: 199,204 policemen, 107,298 members of police families, and 420,539 civilians. The BPP commenced

19/ The major effect expected from the participation of additional non-MOPH F.P. field personnel is not necessarily a dramatic increase in the annual number of new F.P. acceptors. Rather, the ready and routine availability of non-clinical contraceptives in rural villages is expected to have more of an impact on continuing usage--retention of users who may have initially accepted F.P. services at a MOPH clinic, pharmacy, etc. Continuing contraceptive users, rather than new acceptors represent the "dynamic" element in a contraceptive program and typically represent over 90% of the total demand for oral contraceptive supplies.

provision of family planning services in 1974, in the context of their field medical services. During the period October 1974-August 1975 a total of 12,339 family planning cases were served by the initial group of 200 BPP family planning trainees. This project will support the training of an additional 1,000 BPP -- in equal annual installments of 200 trainees into Bangkok for five days F.P. training at BPP headquarters and the MOPH.

c. Tambon doctors

The "Tambon" in Thailand is an RTG administrative unit comprising several villages, and having a population of between 5,000 and 10,000. The "tambon doctor" is a RTG Ministry of Interior<sup>20/</sup> official--often trained previously as an Army medic--who is responsible for observing and reporting outbreaks of epidemic disease in his jurisdictional area, and for dispensing simple remedies, pharmaceutical supplies, etc. to persons not necessarily requiring more professional medical care. (In such cases the Tambon doctor is supposed to refer difficult cases to a nearby hospital or MOPY health clinic).

During the 1977-81 period the MOPH plans to train approximately 4,000 tambon doctors--in areas not covered by MOPH health facilities--as family planning information and service agents. This new responsibility would be an "add-on" to the other, similar services already being provided by the Tambon doctors.

Training would be for five days, and would be provided by provincial MOPH personnel who would also supervise the F.P. activities of the tambon doctor.

d. Traditional ("Granny") midwives

The NFPP plan to provide F.P. training for traditional village midwives (similar to the "dais" common in Pakistan, India, Bangladesh) represents a major effort of the NFPP to extend the F.P. delivery system outside the formal MOPH delivery network and into the informal village health service system. The traditional midwives would be trained as F.P. agents by MOPH auxiliary midwives, who would also provide contraceptive supplies and supervise the performance and record-keeping records of the village midwives. Trainees will be recruited on a volunteer basis by the MOPH auxiliary midwives.

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<sup>20/</sup> The RTG is currently studying the feasibility of transferring tambon doctors to the MOPH.

e. Teacher training: population education

During the Fourth Plan period (1977-81) the Ministry of Education (MOE) will conduct a series of population education workshops--to include materials development and teacher training functions--for approximately 5,000 MOE teachers from rural areas. These teachers will return to their local areas and conduct further population education programs for local teaching staff. The workshops will take place through the entire period of the Fourth Plan, and provide population education training for approximately 1,000 teachers per year during 1977-81.

The general descriptions of training activities outlined above have been provided by the NFPP, and are firmly planned for implementation during FY 1976-81. However, with the exception of a training plan and budget for the IUD-insertion program for nurse-midwives, precise training schedules and budgets have not yet been prepared and submitted by the RTG. Numbers of trainees, costs, and annual training targets specified herein represent the best NFPP estimates available at this time. When firm training plans are submitted the Project Paper will be amended if necessary, to reflect actual cost/personnel/timing elements of the training programs.

3. Technical/Research Assistance

a) Programmatic Research: Since its commencement in 1970 the NFPP has conducted an orderly high-utility series of program-related research activities. Typical of most of the research--carried out either by the NFPP itself or local universities and research institutes under NFPP contract--has been the practical application of research findings. Examples include a study of oral contraceptive usage and possible linkages to liver-fluke disease prior to broad-scale distribution of orals through the national F.P. program; a pilot study of oral contraceptive distribution by auxiliary midwives prior to granting of MOPH authorization to the midwives to dispense orals; a pilot study of IUD-insertions of nurse-midwives; a study of the comparative effectiveness of different kinds of F.P. field workers; and the Depo-Provera study now in progress.

During the last year of the Third Five-Year Plan (1976) and throughout the next Plan period the NFPP intends to continue this practice of conducting practical research. However now that the basic elements of the F.P. service system have been defined--though still inadequate in number and distribution--future programmatic research will include more emphasis on "high risk" studies, e.g., experimentation with fertility incentives,

commercial sector and other non-government contraceptive distribution channels, etc. USG support for selected high-risk studies will be provided to help create the informational base needed for RTG decisions affecting possible major shifts in or additions to the structure of the F.P. delivery system.

As indicated above, historical research experience of the NFPP and its contractors demonstrates both a sound local competence to conduct research, as well as a willingness to apply research findings to the operational family planning program.

b) Technical Assistance: Technical assistance being provided by the U.S. will include skills-resources required by the NFPP, in areas in which AID has particular competence to provide, e.g., project management, commercial sector research and market analysis, research design, contraceptive technology, and program evaluation. AID/W maintains agreements with a number of potential resources (PVO's, PASA's and institutional contractors) for support in these areas. The NFPP will also draw on the DEIDS experience for guidance in applying new operational modalities in its field program.

Environmental implications of the project:  
The project will have no negative impact on the physical, economic or social environment of Thailand. Indeed, excessive population growth is generally considered to be a primary factor contributing to environmental deterioration (See The Limits to Growth, Meadows, et al, 1972, among others).

## B. Financial Analysis

### 1. Financial Rate of Return/Viability

With the exception noted below, family planning services provided by the RTG do not generally result in any financial returns to the government. Economic returns of the family planning program are nonetheless substantial; these will be discussed in Section D., below.

The project input which does generate a return to project costs is oral contraceptives. Typically, clients give a five baht (25¢) "donation" or service charge for each monthly cycle of orals they receive from an auxiliary-midwife, nurse or other MOPH distributor. The CBFPS project sponsored by IPPF, similarly requires a client-charge, with the expected donation under the CBFPS generally ranging from 15¢ to 45¢ per cycle. Both distribution systems provide pills free to clients who claim to be poor (MOPH distributors often require a confirming statement from the client's village headman), but very few clients actually request free pills. In some instances, MOPH distributors charge less for a cycle, e.g., 15¢/cycle.

Funds collected in this manner by MOPH clinicians are kept in special accounts at local-level banks and used, on permission from the District Health Officer or Provincial Chief Medical Officer, for general clinic overhead, repurchase of clinical supplies, repairs, etc. Thus, up to 32 million cycles of orals could be donated by the USG over the FY 1978-81 period, approximately \$ 5 million to \$ 8.8 million <sup>21/</sup> might be generated as a form of extra-budgetary support to the MOPH health and population planning services delivery system.

These generations are partially offset by RTG contributions to a Counterpart Fund controlled jointly by the U.S. Mission and the RTG Department of Technical and Economic Cooperation -- the RTG agency responsible for coordinating all donor-assistance to various RTG and non-government development activities. The Counterpart Fund provides extra-budgetary support for donor-assisted projects on a short-term basis, either for time-limited activities, or for cost items which will eventually be assumed by the regular budgets of RTG ministries/agencies conducting the assisted projects. MOPH purchases of oral contraceptives in FY 1974 and FY 1975, for example, were funded partly from counterpart funds.<sup>22/</sup>

Because RTG Counterpart Fund contributions to the project over the 1976-81 period are unlikely to approach the amount of baht generations derived from oral contraceptive client donations, the U.S. Mission and the RTG will devise a new method for controlling and utilizing these generated funds (or their equivalent). Possible approaches include the establishment of a revolving fund for RTG contraceptive purchases, or establishment of a fund for other population program activities such as research, TA reimbursement, evaluation, special projects, etc. Discussions with the RTG on this project are only at a very preliminary phase; a more definite outline of an eventual baht-utilization scheme is therefore not being presented in this Paper but will be submitted for AID/W review in mid FY 1976.

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<sup>21/</sup> Depending on the standardized price (e.g. 15¢/cycle, 25¢/cyc to be established by the NFPP, number of cycles distributed free, etc.

<sup>22/</sup> For additional discussion of Counterpart Funds see page 22 and Table 10, p. 50, F.P. Project Evaluation Report, Annex B).

## 2. Recurrent Budget Analysis

Details of the impact of this project on the RTG budget are included in the Project Inputs section of Part II, above. There clearly is an awareness, on the part of the RTG, of the budgetary implication of this project, and the gradual decline in external assistance. There is also increasingly the conviction that project levels must be maintained or increased.

One issue which remains is the mix of regular MOPH budget resources and Counterpart Project Account resources (also RTG budget, but funds are allocated to DTEC for DTEC/donor management). This is basically an internal RTG issue which will need resolution as each budget year approaches.

One aspect of this issue relates to the funding of the NFPP central staff.

Over 50% of the NFPP central staff (in Bangkok) are currently being funded by UNFPA, Population Council and RTG-provided Counterpart Funds. The NFPP is attempting to obtain RTG Civil Service Commission sanction for these temporarily-funded positions, and thereby establish them as a permanent, regular-budget category of the NFPP. Failure to obtain and fund these positions on a permanent basis will cause severe dislocations in management capability of the NFPP. The US Mission supports the NFPP request to the CSC and will work with the NFPP, CSC and DTEC towards an early resolution.

## 3. Financial Plan/Budget Tables

Tables showing cost estimates for the project, including inputs from the RTG and from other donors as well as from USG, are included in the Project Inputs section of Part II of this paper.

## 4. Summary Opinion

Based on the analyses provided in this paper, our conclusion is that the project is technically and financially sound. The RTG has the resources to fund their projected requirements. The gradual "building in" of RTG contraceptive purchases will enable the project to enter the ensuing five-year-plan with an established and much increased funding level.

C. Social Analysis<sup>23/</sup>

Thailand is overwhelmingly rural, with rural areas containing 85% of the population. Bangkok is the dominant city, containing almost 33 times as many people as Chiang Mai, the second largest city. Four-fifths of the Thai people live in villages of about 200 to 3,000 people. It has been observed that the whole of rural Thailand seems to have a basic general cultural pattern, with regional differences as variations on common themes. Essentially the same language is spoken throughout the country except among the Malay-speaking Muslims of Southern Thailand. Only 3% of persons five years of age or older cannot speak Thai. Literacy (defined as the ability to read and write in any language) of persons 10 years of age and older was 81% among males and 61% among females in 1960. There was no appreciable difference between the sexes in the younger age groups. Most rural Thais earn their living through rice farming. Nearly everyone is Buddhist. The 1½ million Muslims of the Southern provinces bordering Malaysia constitute the only significant religious minority. In short, Thailand is ethnically, culturally, and religiously homogeneous.

The status of women is remarkably high in Thailand. According to a 1969 National Statistical Office sample survey, 73% of women aged 15 and over participated in the labor force. Although the 1969 survey reported that 82% of the female labor force was in agriculture, large numbers of women also run businesses, become physicians, teach in college, and otherwise demonstrate their economic and occupational equality with men. Rural women vote and attend village governmental meetings. Both urban and rural women have considerable power in the home through control of family finances including buying and selling.

Thai government agencies conducted six knowledge, attitude and practice (KAP) studies during 1964-68. The most salient message conveyed by these studies undertaken in various locations throughout Thailand is that most Thai couples are ready for birth control. In Potharam, 72% of all interviewed women said that they would like no more children. At present approximately 25% of Thailand's married couples aged 15-44 are using some form of contraception. A 1970 national sample survey undertaken among women who had accepted a contraceptive method revealed that 80% were from rural areas, 70% had husbands who were farmers, and 90% had had four years or less of education. The National Family Planning Project is

<sup>23/</sup> See also IBRD Sector Report, pp. 17-27 (Annex A).

apparently responding to a felt need of the rural masses. Ordinary Thai people are demonstrating that they will utilize family planning services when they are readily available. (The NFPP had 479,000 new acceptors in 1974. This is the highest number since the inception of the program.)

The Thai NFPP has been a relatively successful family planning program. The NFPP has made good quality services available through 4,929 health facilities. The Thai culture has not proven resistant to family planning. The number of new acceptors has grown in every year but one since the inception of services. The acceptor profile has indicated that the NFPP is benefiting the poorest majority of the population.

There are no obvious social impediments which require major changes in beneficiaries' values, social organizations and motivations before they will utilize the services. They are utilizing them in substantial and ever-increasing numbers at present, in areas where F.P. services are regularly available. It appears that the concept and practice of family planning is being rapidly diffused throughout all levels of Thai society. There is no organized resistance to the NFPP, although service statistics reveal that there has been less acceptance among the Malay-speaking Muslim population than among the general population. There will be studies undertaken of Muslim attitudes so that more acceptable services can be offered to that segment of the population. It appears extremely unlikely that any group other than the intended beneficiaries would be able to divert the project to their own benefit.

Earlier mention was made about the role of women in Thailand. Thai women are already well-integrated in the national economy. The high status of Thai women has unquestionably contributed to their ready acceptance of family planning. This project should especially benefit women. Female paramedicals are delivering most of the family planning services to other females. The female recipients are freed from unwanted pregnancies and are more able to retain their energy and health. They are more able to contribute to the development of Thailand through greater access to education and employment instead of a traditional commitment to only child-bearing and child-rearing. There are few cultural barriers to the advancement of women in Thailand. Thai women have perceived that family planning will allow them greater freedom to develop themselves and in so doing, to participate in greater measure in the economic and social development of Thailand.

D. Economic Analysis

The economic analysis of this project will concentrate on the benefit-cost ratio with results from the investment required to avert a birth in Thailand. At this stage the analysis must unfortunately omit any considerations of the economic costs of "crowding" and the psychic income accruing to parents, friends and relatives because of children. Current data on these issues are entirely too speculative for inclusion in this analysis.

The cost of averting a birth has been calculated from the projected total expenditures of the NFPP during the years from 1976 to 1981. The targets of these expenditures are expressed in terms of woman years of contraceptive protection and appear on Table I. The annual number of births averted has been calculated from the generally accepted rule that three woman years of contraceptive protection are required to avert one birth. The projected annual costs also appear in Table I. From this, the average cost of birth averted in Thailand has been calculated as \$31.96. Since the Thai family planning program is generally considered to be supply constrained rather than demand constrained, the average cost of a birth averted represents the cost necessary to fill an essentially existing distribution system with the required supplies and worker motivation. Little has to be spent at the present and in the next few years to either construct a system or stimulate public demand for family planning. Therefore, the average cost is considered to be essentially equal to the marginal costs of averting a birth.

TABLE I

<u>Year</u>	<u>Woman Years of Protection</u>	<u>Births Averted</u>	<u>Total Program Costs (\$000)</u>
1976	380,740	126,913	\$ 6,405
1977	400,065	133,355	4,667
1978	470,276	156,759	5,200
1979	539,152	179,717	5,300
1980	606,184	202,061	5,400
1981	<u>668,257</u>	<u>222,752</u>	<u>5,750</u>
Total	3,064,674	1,021,557	\$32,722

Total cost of program - \$32,722,000

Total births averted - 1,021,557

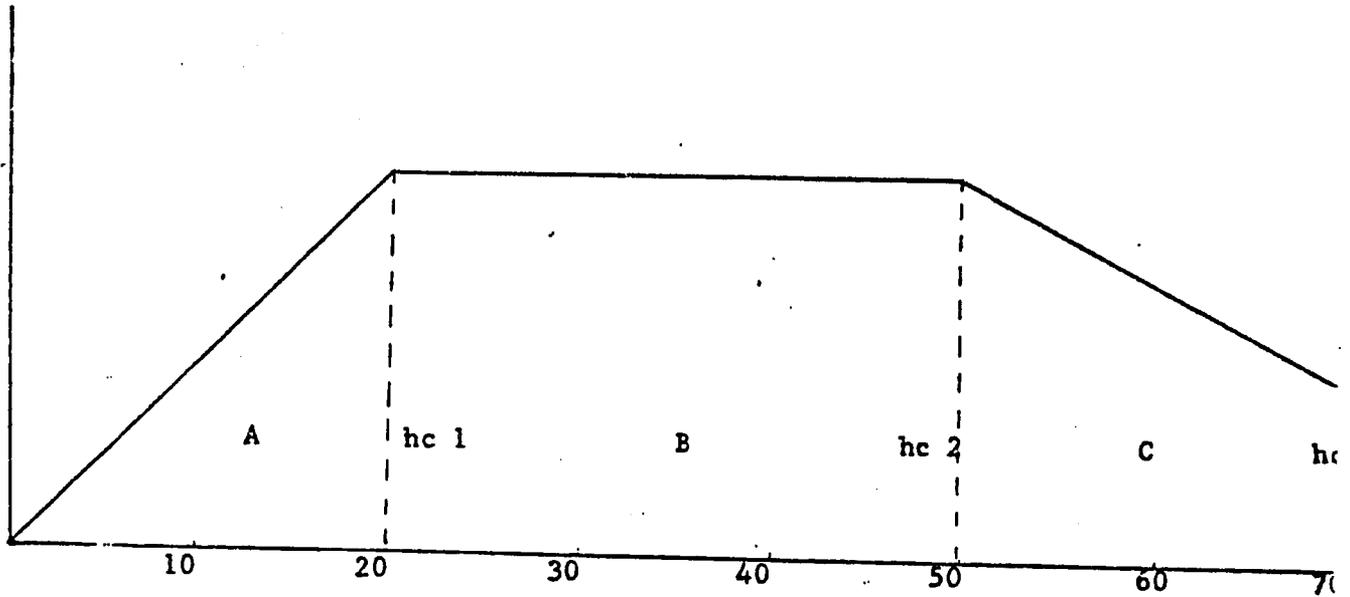
Average cost per  
birth averted = 32.03

The cost side of the benefit-cost ratio is therefore the marginal cost of a birth averted. The benefit side must now be considered.

The consumption pattern of a typical rural Thai can be described by Diagram I on the following page. This "average" Thai is considered to have a life span of 70 years and a consumption pattern which can be grouped into three phases. Phase A is from birth to age 20 and is a period of rising consumption. Phase B covers the years from age 20 to age 50 and is the period of maximum consumption. Phase C reflects the decline in consumption which occurs after the age of 50. The diagram uses linear relationships in each phase to simplify the calculations.

Diagram I

Lifetime Consumption Pattern



Annual income per capita = \$ 166

saving ratio 5%

Annual consumption per capita = \$166 x .95 = \$ 157.7

Life time consumption = \$ 157.70 x 70 years = \$11039.00

A+B+C = \$11039

$$\frac{1}{2} \cdot 20 \cdot hc_1 + 30 \cdot hc_1 + \frac{hc_1 + hc_2}{2} \cdot 20 = \$ 11039$$

Where  $hc_2 = \frac{2}{3} hc_1$

$$56.7 hc_1 = \$ 11039$$

$$hc_1 = \$ 194.7$$

$$hc_2 = \$ 129.8$$

The area under the curve (A+B+C) represents total lifetime consumption and is calculated as the product of average consumption per capita outside of Bangkok in 1973 and the life span of the "average" rural Thai. These consumption figures represent a total from income received from both cash sources and in kind. The level of consumption has been taken as 95% of total income indicating a savings ratio of 5%. Recent data calculated by the Thai Department of Agricultural Economics in the Ministry of Agriculture indicates that this represents a high estimate of the savings rate for personal income received by rural Thai. The pattern uses the most recently available data from the non-Bangkok area in order to most accurately reflect the target population of the family planning project.

The consumption pattern described in Diagram I allows us to calculate consumption by five year intervals as shown in Table II on the following page. From this, the present value of the future consumption has been calculated using three different discount rates. Calculations are based on the assumption that the consumption for the period must be available at the beginning of the period. That is, the \$121.8 dollars worth of consumption in the first five years of a person's life must be available at age zero. This has been done for calculation convenience and does not drastically alter the outcome of the analyses. An analogous assumption has been made for production.

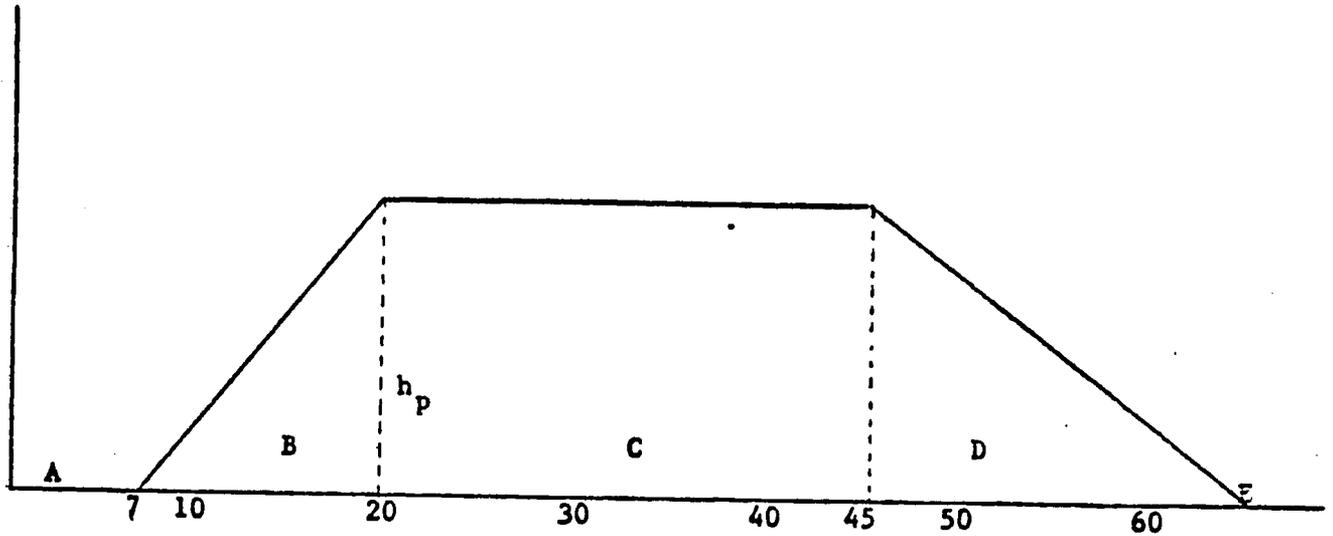
The discount rates used in the calculation of the present value of future consumption (and later, future production) have been selected from a number of the important interest rates in Thailand. The 8% rate is considered the basic government borrowing rate, however, in practice, discounting of par values occasionally occurs which raises this rate somewhat. The 10.5% rate is the commercial banks' prime rate. This rate is available essentially to Bangkok-based enterprises for loans secured by real assets worth 200% of the value of the loan. The 12% is perhaps the most useful for this analysis since it represents the minimum interest rate available in the rural sector for all agricultural, home and farm construction and consumption purposes. The bulk of the people in the rural sector must pay a higher interest rate as the majority of loan activity occurs in the unorganized financial markets. Therefore, 12% represents an absolute minimum rate, with the average closer to 20% or 30%.

TABLE II

Age	Consumption	Present Value		
		8%	10.5%	12%
0-5	121.80	121.80	121.80	121.80
6-10	365.30	248.60	221.70	207.30
11-15	608.50	281.90	224.20	195.90
16-20	851.80	268.50	190.50	155.60
21-25	973.50	208.90	132.20	100.90
26-30	973.50	142.10	80.20	57.30
31-35	973.50	96.70	48.70	32.50
36-40	973.50	65.80	29.60	18.40
41-45	973.50	44.80	17.90	10.50
46-50	973.50	30.50	10.90	5.90
51-55	933.00	19.90	6.30	3.20
56-60	852.00	12.40	3.50	1.70
61-65	770.80	7.60	1.90	.90
66-70	689.50	<u>4.60</u>	<u>1.00</u>	<u>.40</u>
		1,554.10	1,090.40	912.30

Diagram II

Lifetime Production Pattern



$$\text{Production} = \text{annual income per capita} = \$166$$

$$\text{Lifetime production} = \$166 \times 70 = \$11620$$

$$A + B + C + D + E = \$11620$$

$$0 + \frac{1}{2} 13 h_p + 25 h_p + \frac{1}{2} 20 h_p + 0 = \$11620$$

$$41.5 h_p = \$11620$$

$$h_p = \$280$$

On the production side, Diagram II illustrates the pattern of production for an average Thai, again simplified by the use of linear relationships in the five separate phases. Phase A represents the zero production of childhood. Phase B reflects the period of entry into the work force at the age of 7 and the rise of full productivity at age 20. Phase C is the period of maximum production which ends at or about the age of 45. After 45 the individual's contribution to output declines and reaches zero at about age 65, after which the individual is considered to be making no contribution to output.

The total lifetime production of an average non-Bangkok Thai is considered to be the average per capita rural income. The use of this figure may understate the true value of production since the rice premium tax has depressed the price of rice which is the chief commodity produced in the rural sector. However, this understatement also occurs on the consumption side. The non-consumed agricultural surplus whose value is understated in production is balanced on the consumption side, on the average, by the undervalued goods and services provided by the government.

Table III presents the lifetime production of an average Thai by five year intervals. These five year amounts have then been converted into their present value using the same discount rates that were applied to the consumption data.

TABLE III

Age	Production	Present Value		
		8%	10.5%	12%
0-5	0	0	0	0
6-10	96.90	65.90	58.80	55.00
11-15	592.30	274.30	218.20	190.70
16-20	1130.80	356.50	252.90	206.60
21-25	1400.00	300.40	190.10	145.10
26-30	1400.00	204.40	115.40	82.40
31-35	1400.00	139.10	70.00	46.70
36-40	1400.00	94.70	42.50	26.50
41-45	1400.00	64.40	25.80	15.00
46-50	1225.00	38.40	13.70	7.50
51-55	875.00	18.70	5.90	3.00
56-60	525.00	7.60	2.20	1.00
61-65	175.00	1.70	.40	.20
66-70	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
		1,566.10	995.90	779.70

A comparison of the production and consumption of an average individual yields the following results:

	<u>Present Value of Production</u>		<u>Present Value of Consumption</u>		<u>Net Present Value of Individual</u>
@ 8%	\$ 1,566.10	-	\$ 1,554.10	=	\$ 12.00
@ 10.5%	995.90	-	1,090.40	=	-94.50
@ 12%	779.70	-	912.30	=	-132.60

The appearance of the negative sign when the social rate of discount is taken to be 10.5% or 12% infers that at these and higher rates, a net loss would be incurred if another individual was added to the society. Viewed in another way, the aversion of a birth would yield a savings of \$94.50 and \$132.60 at a 10.5% and 12% respectively social rate of discount.

The benefit-cost ratios can now be calculated as follows:

$$\begin{array}{l}
 8\% \quad B/C = \frac{\$12.00}{\$32.03} = -.4 \\
 10.5\% \quad B/C = \frac{94.50}{32.03} = 2.9 \\
 12\% \quad B/C = \frac{132.60}{32.03} = 4.1
 \end{array}$$

Since this project is aimed at the rural sector and there is evidence which indicates that even the RTG has difficulties with the 8% level, the minimum appropriate social rate of discount should be taken at 10.5%, with 12% being the most likely.

These benefit/cost ratios can be considered in relation to alternative yields for an investment of the \$32.03 required to avert a birth. While the national increments capital output ratio is approximately 3, the ratio which results from government administered programs is probably closer to twice the national average. Therefore a \$32.03 investment by the RTG should yield a stream of income equal to \$5.31 per year which

is worth \$51 and \$44 at 10.5% and 12% interest rates respectively. These values indicate that if the social rate of discount is 10.5%, an investment in family planning is almost twice as profitable as a typical alternative program initiated by the government. At 12% discount a family planning investment is over three times as productive.

This analysis has relied on averages calculated from aggregate data and reflects the situation in the society at large. It does not distinguish between sex or the present number of children in a particular family and as such it does not represent the preferences and economic needs of the individual decision making couples except in situations where the couples have determined that they wish no more children. The analysis shows that there may be a conflict between the economic needs of the society at large and the economic needs of the individual child producing couples.

The conclusion on the aggregate level is that an investment in another individual is only productive if the society forces itself to accept a considerably longer time period for realizing the returns from this individual than it is willing to accept in any other investment. This condition could be changed by an increase in productivity and, therefore, the savings ratio; however, the continued expansion of the Thai population is bringing about a reduction in the per capita levels of existing resources which makes productivity increases even more difficult and costly. Trends in agricultural productivity reflect this crowding by the increasing use of unproductive land as good arable land becomes more scarce.

On the individual level the economic conditions may yield a different outcome. At this level the decision to have children reflects the desired economic security of the parents after they have reached the age when they can no longer work. Parents need enough children so that the sum of the net production of their children provides for the parents consumption after the parents have stopped working. Their preference function therefore puts a low value on the present consumption of their young or to be born children, and a high value on the future production of these children. Typical rural couples in LDCs, therefore, view the consumption and production patterns of their offsprings with significantly different discount rates so that all children up to a desired family size have a positive present value. It is only after the desired family

size is reached that the proceeding aggregate analysis represents the situation on the micro level.

However, the situation in the rural sector in Thailand is currently one where a considerable number of couples appear to have exceeded their own desired size of family and are therefore willing to accept family planning as it becomes available. As other government programs raise the economic condition of the rural sector and provide the necessary economic security previously found only in children, the desired size of family will be reduced.

PART IV. IMPLEMENTATION PLANNING

A. Analysis of the Recipients and AID's Administrative Arrangements

1. Recipient

a. Organization of the official program:

At the central level, the National Family Planning Program is located in the Ministry of Public Health. Its activities and implementing units include several Departments of the Ministry. The Director of the National Program is the Under-Secretary of State for Public Health.

Overall operations of the NFPP are coordinated in the Family Health Division, one of the components of the Department of Health, MOPH. This Division is responsible for research, evaluation, supervision, logistic support, training and public information--related to family planning. Since MCH is also a responsibility of the Family Health Division, integration of MCH with family planning is facilitated.

At the provincial level, the Provincial Chief Medical Officer is responsible for all programs of the Ministry within his province including the provision of family planning services. He is aided by two principal assistants, one in charge of hospital programs and the other in charge of public health programs. Supervisory staff, particularly in nursing and midwifery, are available at the provincial and at the district level. Since the family planning program is integrated with health services, these supervisory personnel are not exclusively concerned with family planning, but priority is given to family planning and MCH.

b. Organization of major voluntary agencies

The major voluntary agency in this field is the Planned Parenthood Association of Thailand (PPAT). This organization, an affiliate of IPPF, is constituted in a manner similar to IPPF affiliates in other countries. The IPPF also operates a Community-Based Contraceptive Distribution Project currently active in about 25 of Thailand's 570 amphurs(counties)

c. Institutional arrangements for coordination:

i) Interministerial: Overall policy decisions are, of course, vested in the Cabinet and responsibility for coordination of economic and social development is in the hands of the NESDB. Population education is being carried out by the Ministry of Education.

For some time an interministerial committee on population and family planning, the National Family Planning Coordinating Committee, has existed. It is now being reconstituted and includes representation from the NESDB, DTEC, the Ministries of Interior, Education, and Health, the Institute of Population Studies of Chulalongkorn University, the Centre for Population and Social Research of Mahidol University, the National Statistical Office and PPAT. In addition to intersectoral coordination, the Committee deals with coordination of external financial assistance.

ii) Coordination and Supervision: Field Level

The family planning project evaluation teams (Report, pp.9-11 - Annex B) noted that supervision of the operational F.P. program is not adequate at the provincial and lower levels. Specifically, supervision of clinic personnel has been assigned to senior MOPH nurse-midwives and physicians; but because of their concomitant administrative responsibilities in hospitals, clinics and provincial health offices, these working doctors and nurses have insufficient time to effectively supervise, advise and re-train field personnel in areas of family planning service delivery, management, reporting, etc.

Quite obviously, the anticipated introduction into the F.P. program of 12,000 additional (part-time) F.P. field workers over the next six years will require a rapid solution to this problem. Particular attention will have to be given to record keeping and reporting, client motivation, re-supply and follow-up.

The Evaluation Report cited above makes two recommendations which the Mission strongly endorses: (1) The MOPH should assign public health nurses at the provincial level as full-time supervisors. These supervisors would not be required to share their time among other professional responsibilities at hospitals, clinics or administrative offices; and (2) scheduled supervisory visits to operational units should be made regularly at least once a month. (This second recommendation would of course be facilitated by implementation of the first). Still unclear, however, are the linkages between the tightened supervision of MOPH clinical personnel and the mode of continuing supervision to be provided by these clinicians for 4,100 tambon doctors and 7,000 traditional midwives. The Mission would therefore add to the Evaluation Report's suggestion the recommendation that trained tambon doctors and village midwives be included on a name/geographic roster which will be the specific responsibility of identified clinicians to supervise on a regularly-scheduled basis.

BPP personnel present a special case in that BPP jurisdiction often covers geographic areas not served by other RTG agencies. In this instance, MOPH supervisory personnel from neighboring provinces, or from provinces having border areas under BPP jurisdiction, should plan regularly scheduled supervisory visits to BPP trained as F.P. agents. In all cases, however, the central need is for a formalized system of routine, recurring, competent supervision of F.P. personnel at the operational level of the distribution system. Identification and implementation of this working-level supervisory system will be specified as a condition precedent to U.S. assistance for local training activities of the F.P. program.

iii) Voluntary agencies: Coordination is achieved through the above-mentioned National Family Planning Coordinating Committee, of which local voluntary agencies are members.

## B. Management Analysis

### 1. RTG

The organizational structure of the MOPH formerly was an impediment to the forceful implementation of family planning activities at the local level because of the lack of direct line relationship between the central unit responsible for family planning policy and the local units responsible for implementation. This is greatly improved with the strengthening of the Under-Secretary of State's ability to delegate resources to local health and family planning operational units combined with the structuring of the provincial health authority to allow it to operate more efficiently. This has been reflected in higher acceptance rates during the past year. The recent evaluation of local level operations by a joint RTG-USAID team while revealing some deficiencies in supervision, client counselling and record keeping, did not find a single case where supplies were not reaching the end-point of the system, or where workers were not being paid in a timely fashion. The health infrastructure, while still inadequate in remote areas and underutilized in certain areas, is in place with operational staff of reasonable competence. Active steps are underway including a combined USAID-WHO-RTG Country Health Team analysis of the systems strengths and weaknesses to identify areas needing improvement and to recommend appropriate corrective action.

## 2. AID

AID assistance focuses on the role of provider of contraceptive commodities on a matching basis, encouragement of RTG private and public sector initiatives to improve management and coordination of current operations through small operational grants; support for in-country training of personnel; increased mobility of MOPH hospital and health center staff in taking F.P. services to villages; and stimulation of public awareness and participation in F.P. through Population Education. This educational effort is targeted on young adults.

Staff requirements will be met by a project officer located in the Mission with monitoring responsibilities supported by technical expertise from either AID/W or other centrally funded population organizations. Central funds will also be used as needed to support new program initiatives.

### C. Evaluation Arrangements for the Project

#### 1. General

a. The NFPP has as one of its major headquarters units a Research and Evaluation Section which is responsible for routine collection and interpretation of service statistics and for design and implementation of special studies pertinent to efficient operations of the project. This unit's activities are also reinforced by two Population Institutes located in the major universities in Thailand. Measurement on demographic impact of the project as well as special studies requiring expertise not present at the project are available through a special Sub-Committee on Population Research which reviews proposals and makes recommendations on priority needs.

b. Project baseline data are available through the National Statistical Office which carries out periodic national surveys on changes in vital rates in Thailand. In 1975-76 a study of population change is being carried out. The results will serve as a base for the fourth five-year plan 1977-81.

c. Monthly reports on project progress are sent to the NFPP by each unit for collating and analysis. These reports include numbers of new acceptors by method, usage of contraceptives and number of home visits made by F.P. personnel, clinic case loads and a comparison with the same month a year ago to measure project momentum. These data are

fed into a computer and the output is used in program management and analysis. Periodic studies to determine contraceptive continuation rates, and studies on acceptance of new procedures and introduction of new methods of contraception are coordinated by the R&E Unit.

d. In addition to these routine procedures the project establishes national targets and norms of clinic performance. Local targets are established for provinces having a history of falling below norms. The baselines used are the number of eligible women to be reached by the program divided by the number of women currently contracepting. These indices are later applied to demographic targets to determine impact of the project on fertility and growth rate.

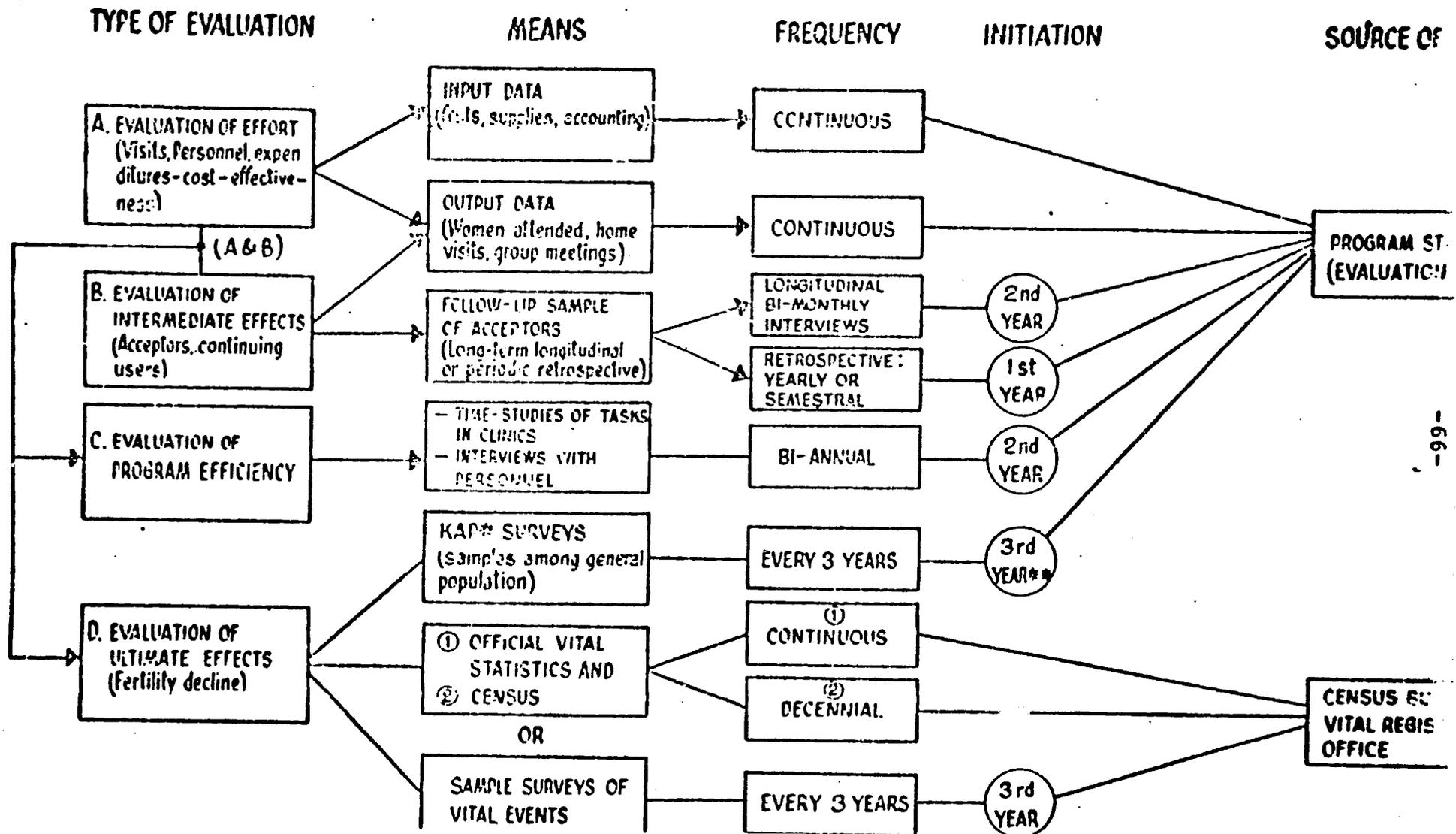
## 2. Project Evaluation Plans.

The schedule and elements of project evaluation for FY 1976-81 are illustrated on the diagram, following page. The two essential perspectives of the project's recurring evaluation methodology are (1) project management, including cost-effectiveness of different service mixes and modalities; and (2) analyses of the demographic impact of the program. Sources of data for these studies are indicated on the diagram.

In addition, comprehensive project evaluations will be conducted biannually by the NFPP, possibly with assistance from the U.S. and other major donors. These evaluations will include analyses of project performance specifically in areas receiving USG support, and in areas crucial to effective implementation of U.S. assisted elements of the project. Foci of these studies will include inter alia:

- a. Trends in acceptance and continuation of oral contraceptive usage;
- b. Performance analysis of nurse-midwives and auxiliary midwives as IUD-inserters;
- c. Performance analyses of tambon doctors, BPP, and traditional village midwives as F.P. information and service agents;
- d. Cost-effectiveness analysis of mobile F.P. units;
- e. Adequacy of RTG inter-agency coordination in F.P. program planning, reporting and field operations;

# Proposed Evaluation Schedule for NFPP 1976-1981



b. RTG agreement to match USG contributions for procurement of mobile F.P. units. Schedule as follows:

FY 1976:

USG purchase - 10 vehicles  
RTG purchase - 10 vehicles

FY 1977:

USG purchase - 10 vehicles  
RTG purchase - 10 vehicles

c. RTG agreement to match USG contributions for research activities. Tentative USG/RTG contributions, by fiscal year, are as follows:

	<u>USG</u>	<u>RTG</u>
FY 1976	100	100
1977	50	50
1978	100	100
1979	50	50
1980	50	50
1981	50	50

d. RTG authorization of 1,000 BPP, 4,000 tambon doctors and 7,000 traditional midwives to undergo F.P. training and to dispense non-clinical contraceptives and F.P. information.

e. RTG agreement to the cost-sharing formula indicated on page 30 for local training programs for BPP, tambon doctors, traditional midwives, MOPH nurses and auxiliary midwives, and MOE teachers.

f. The Civil Service Commission will review NFPP (headquarters) personnel requirements with MOPH and prepare a recommendation and schedule for transfer of appropriate Counterpart funded positions to CSC-sanctioned permanent MOPH positions.

g. MOPH will prepare a supervision plan for family planning field operations, reporting, and re-training. The plan will include identification of specific family planning supervisory responsibilities of doctors, public health nurses, and

auxiliary midwives, noting particularly the supervisory relationships between these personnel and non-MOPH personnel (BPP, tambon doctors, village midwives) proposed for training as family planning agents.

h. The RTG will consult with USOM regarding the establishment of a system of collection, accounting and utilization of fees and service charges collected by MOPH and non-MOPH distributors of oral contraceptives. The primary objective of these consultations will be the creation of an RTG revolving fund to enable future RTG purchase of 100% of NFPP oral contraceptive requirements. Establishment of a suitable system satisfactory to AID and the RTG will be a condition precedent to disbursement of funds under Project Agreements signed consequent to approval of this Project Paper.

i. As a condition precedent to project disbursements, the NFPP and USOM will jointly prepare a schedule for program expansion, relating AID and RTG support in a given functional/geographic area to that area's adherence to the expansion criteria (supervision, training, contraceptive outlets, etc.) outlined in the schedule.

j. The RTG/NFPP will assure the availability of adequate RTG personnel to conduct recurring evaluations of the family planning program.

k. FY 1981 will be the final year of USG funding of oral contraceptives.

l. Other conditions as included in Standard Provisions Annex to Project Agreements.

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

ANNEX 1

Life of Project:  
From FY 1976 to FY 1981  
Total U. S. Funding \_\_\_\_\_  
Date Prepared: \_\_\_\_\_

Project Title & Number: Population Planning

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>Program or Sector Goal:</b> The broader objective to which this project contributes: To reduce Thailand's population growth rate to a rate consistent with national economic and social development objectives (the ultimate rate to be established below 2.1%).</p>	<p><b>Measures of Goal Achievement:</b></p> <p>1. The actual population growth rate will equal the desired growth rate as specified in RIG policy statements and Five-Year Plans.</p>	<p>-Census -RIG policy statements -Five-Year Plan -Fertility surveys</p>	<p><b>Assumptions for achieving goal targets:</b></p> <p>As the rate of population growth decreases, the RIG will be able, in the future, to more clearly determine the ultimate rate of population growth which is presumed to be below 2.1%.</p>
<p><b>Project Purpose:</b></p> <p>1) Attainment of an annual population growth rate of not more than 2.1% by the end of 1981, as specified in the Fourth RIG Five-Year Plan.</p> <p>2) Creation of a broad-based, functioning delivery system for FP information and services, including the active participation of the MPM, BPP, the Community-Based Distribution Program, tambon health centers &amp; traditional village midwives.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>1) Declining share of MPM new acceptors in face of rising overall FP acceptance rates. Increased share of acceptors will be obtained by additional elements of the FP delivery system (BPP, tambon doctor, traditional midwives). FY 1975: total new acceptors: 500,000 MPM share: 400,000 FY 1981: total new acceptors: 700,000 MPM share: 420,000; 2) Crude Birth Rate (CBR) of not more than 30 per 1,000 pop. by end of 1981 (1975 CBR approx. 36-38 per 1,000); 3) 45% of eligible couples practicing some form of family planning (by 1975 prevalence: 25%); 4) the FP distribution system encompasses MPM and other FP agents whose combined jurisdiction will approximate universal coverage of the population.</p>	<p>-ISO -Census (1980) -Survey -Evaluation team report -MPP statistics service</p>	<p><b>Assumptions for achieving purpose:</b></p> <p>1) Substantially increase FP services availability will lead to increased FP practice. 2) There will be no unforeseen decline in demand for FP services. 3) Any possible future governmental reorganization will not negatively effect the FP delivery system. 4) Private sector channels (drug stores, private clinics, etc.) will continue to at least maintain, and hopefully increase present level of FP services.</p>
<p><b>Outputs:</b></p> <p>1. Trained part-time FP workers to staff an expanded FP delivery system. 2. Availability (stocks) of program-selected contraceptive methods in each tambol. 3. New management, logistic, operational techniques tested and adopted. 4. Forty mobile FP units, staffed and operating in remote rural areas. 5. Revised RIG educational curricula. 6. Expanded MPM clinic/personnel system.</p>	<p><b>Magnitude of Outputs:</b></p> <p>1. 12,000 additional part-time FP field workers. 2. Regional and provincial warehouses all clinics, and FP distribution agents supplied with contraceptives (see schedules pp. 21-22 of FP). 3. Four management studies, operational research studies conducted per year. 4. Mobile FP units each spending ten days per week in remote field areas. 5. Population education taught in RIG formal and informal education system and in teacher training schools. 6. 500 additional clinics staffed and funding by 1981.</p>	<p>1. MPP/MPM service statistics. 2. AID, GSA, and RIG contraceptive purchase and delivery data. 3. Research and administrative reports. 4. Mobile Unit acceptor data.</p>	<p><b>Assumptions for achieving outputs:</b></p> <p>1. USG and RIG project inputs will be timely. 2. Non-MPM organization will continue to participate in the FP program. 3. Appropriate research proposals will be developed by the RIG, universities to address priority needs. 4. Demand for clinical FP services in remote areas will continue at a sufficiently high rate to make use of mobile units cost-effectiveness.</p>

USG:

- 1) Contraceptive supplies and equipment.
  - a) oral contraceptives
  - b) FP medical kits
- 2) Twenty mobile FP units
- 3) Local training support
- 4) Research grants
- 5) World Education, Inc. (WEI)
- 6) Short-term consultant assistance (37 man-months through FY 1981)

FY 1976:  
 Commodities \$2,800,000  
 Consultants (6 mm) 93,000  
 Training 150,000  
 Research 100,000  
 WEI  
TOTAL: \$3,143,000

INTERIM QUARTER  
 Commodities \$ 510,000  
 Training 52,000  
TOTAL: \$ 562,000

FY 1977:  
 Commodities \$ 963,000  
 Consultant (6 mm) 217,000  
 Training 50,000  
 Research  
TOTAL: \$1,230,000

FY 1978:  
 Commodities \$ 835,000  
 Consultants (6 mm) 200,000  
 Training 100,000  
 Research  
TOTAL: \$1,135,000

FY 1979:  
 Commodities \$ 710,000  
 Consultants 150,000  
 Training 50,000  
 Research  
TOTAL: \$ 910,000

FY 1980:  
 Commodities \$ 620,000  
 Consultants (9mm) 100,000  
 Training 50,000  
 Research  
TOTAL: \$ 770,000

FY 1981:  
 Commodities \$ 490,000  
 Consultants (5 mm) 50,000  
 Training 50,000  
 Research  
TOTAL: \$ 590,000

PROJECT TOTAL: \$8,340,000

- 1) Project Agreements
- 2) Bills of lading
- 3) Consultant reports
- 4) Training sessions
- 5) Research projects
- 6) Contractors reports

- 1) FIC will assemble candidates for FP training programs.
- 2) Availability of USG resources for project assistance will continue through FY 1981.

ORG:

- 1) Contraceptive supplies and equipment.
  - a) oral contraceptives
  - b) FP medical kits
- 2) Twenty mobile FP units
- 3) Local training support
- 4) Research grants
- 5) World Education, Inc. (WEI)
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<u>FY 1976:</u>	
Commodities	\$2,800,000
Consultants (6 mm)	
Training	93,000
Research	150,000
WEI	100,000
<u>TOTAL:</u>	<u>\$3,143,000</u>
<u>INTERIM QUARTER</u>	
Commodities	\$ 510,000
Training	52,000
<u>TOTAL:</u>	<u>\$ 562,000</u>
<u>FY 1977:</u>	
Commodities	\$ 963,000
Consultant (6 mm)	
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Research	50,000
<u>TOTAL:</u>	<u>\$1,230,000</u>
<u>FY 1978:</u>	
Commodities	\$ 835,000
Consultants (6 mm)	
Training	200,000
Research	100,000
<u>TOTAL:</u>	<u>\$1,135,000</u>
<u>FY 1979:</u>	
Commodities	\$ 710,000
Consultants	
Training	150,000
Research	50,000
<u>TOTAL:</u>	<u>\$ 910,000</u>
<u>FY 1980:</u>	
Commodities	\$ 620,000
Consultants (9mm)	
Training	100,000
Research	50,000
<u>TOTAL:</u>	<u>\$ 770,000</u>
<u>FY 1981:</u>	
Commodities	\$ 490,000
Consultants (5 mm)	
Training	50,000
Research	50,000
<u>TOTAL:</u>	<u>\$ 590,000</u>
<u>PROJECT TOTAL:</u>	<u>\$8,340,000</u>

- 1) Project Agreements
- 2) Bills of lading
- 3) Consultant reports
- 4) Training sessions
- 5) Research projects
- 6) Contractors reports

- 1) PTO will assemble candidates for FP training programs.
- 2) Availability of USA resources for project assistance will continue through FY 1981.

UNITED STATES GOVERNMENT

# Memorandum

Proj. No 4930266  
PN

✓

TO : See Distribution

DATE: October 5, 1976

FROM : PHA/PROG, C. D. McMakin *Hoche*

SUBJECT: Thailand Population Planning Project

Attached are copies of the approved Action Memorandum, dated December, 1975 and the Project Paper for the subject project for your files. Also attached is a copy of the Action Memorandum approved in April, 1976, which revised the schedule of obligations of grant funds for this project.

If you require additional copies, please call PHA/PROG, Betty Roche, extension 632-8985.

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OCT 5 1976



ACTION MEMORANDUM FOR THE ADMINISTRATOR

THRU: EXSEC

DEC 23 1975

FROM: AA/PPC, Phillip Birnbaum *Phillip Birnbaum*

Problem: To obtain approval of the population planning Project Paper (PP), Thailand. Issues involved in the proposed project include:

- (1) Determination of the source (AID/W or bilateral) of project funding for FY 1978-81.
- (2) A USOM/Thailand Request for a Procurement Source Waiver for Vehicles.
- (3) Life of Project (six years).
- (4) Local cost funding.

These issues are discussed below,

Discussion:

A. Background. During the period FY 1968 - FY 1970 AID provided training, technical, and primarily commodity assistance to support a Royal Thai Government (RTG) pilot "family health program". This was primarily a trial family planning project wherein F.P. services were offered through about 330 municipal and rural health clinics of the Ministries of Health (MOPH) and Interior (MOI). In March, 1970 the RTG announced voluntary family planning as a national policy, and authorized the Ministry of Public Health to make F.P. services available through all of the Health Ministry's 4500 rural clinics. Similarly, the Interior Ministry -- which administers health clinics in Thailand's urban areas -- was authorized to provide services at all of their clinics. The policy announcement also:

- (1) created the National Family Planning Program (NEFP) -- a new organizational unit within the MOPH -- to coordinate the national FP program; and
- (2) sanctioned family planning as a development effort for inclusion in the RTG Third Five-Year Plan (1972-1976). This latter decision further enabled the MOPH to request RTG budget support specifically

*FY 68-78  
11/22/75*

OCT 5

for the family planning program. (Up to this point, the cost of providing F.P. services had been assumed within overall MOPH health services budgets); and established as a 1976 demographic target an annual population growth rate of 2.5%. (The 1970 rate was estimated to be approximately 3.0%).

AID and other donors (primarily UNFPA and Population Council) provided substantial assistance to the MOPH/NFPP through FY 1975. AID support for this period totalled approximately \$10.8 million, about 44% of which was for contraceptives. Other donors provided about \$6 million. RTG direct support for the program totalled approximately \$2.6 million, or 13.4% of program costs. In addition, the MOPH provided indirect financial support (salaries, facilities, medical supplies, etc.) having a value of \$8-9 million.

By the end of fiscal year 1975 over two million clients had accepted some form of family planning through the national program; and about 25% of eligible couples were practicing family planning (approximately 60% of whom were using oral contraceptives). According to estimates of the RTG and the AID Mission in Thailand, the 1976 target population growth rate of 2.5% would probably be met.

B. Current Situation. In the perspective of the program to date, then, the family planning project has been relatively successful. More recently, however, the program has begun to exhibit some signs of "peaking": numbers of couples dropping out are increasing as the number of monthly new acceptors stabilizes. The primary reason for this development\*, according to the USOM Mission and a recent IBRD population sector team report (Annex A of the PP), is that the RTG family planning program is "supply-constrained" in its efforts to reach and hold new F.P. users. This means that the 5,000 clinics of the MOPH, MOI and various affiliated RTG agencies have already reached most potential acceptors in these clinics' radii of operations, and that an additional "outreach" effort will be required if the NFPP is to reach current non-practicers. This finding is not unexpected in view of the World Bank's observation that the existing MOPH/MOI health services system regularly reaches only 35%-40% of Thailand's rural population.

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\* An exception is sterilizations, the number of which has been increasing dramatically over the past two years. At present, over 15% of all new acceptors choose tubal-ligations or vasectomies. (In 1974, there were 494,479 new acceptors of whom 80,482 chose sterilizations.)

0.8  
8.3  
19.1

C. PP Rationale. The project described in the PP represents the RTG's response to this supply-constraint problem. Briefly, the RTG's intention is to supplement the existing, clinic-based F.P. services distribution network with additional personnel and facilities which would carry F.P. services farther out and down to rural Thai villages. These add-on elements include:

- (1) 12,100 part-time F.P. agents including
  - (a) 4,100 tambon (township) doctors
  - (b) 1,000 Border Patrol Police; and
  - (c) 7,000 village midwives

who will receive family planning training from the NFPP, and act as supply-agents for non-clinical contraceptive methods (pills and condoms) in rural areas. In addition, they would act as referral-agents for sterilizations, IUD-insertions, and injectable contraceptives. ]

- (2) Forty (40) mobile family planning units, to deliver clinical F.P. services (IUD-insertions, sterilizations, injectables) to rural populations not served by health clinics; and

- (3) IUD-insertion training for 2,400 nurses and auxiliary nurse-midwives, thereby increasing availability of this method from a current 400 clinics (staffed by physicians) to over 2,000 clinics staffed by nurses and auxiliary nurse-midwives.

As further encouragement to rural populations to utilize these expanded F.P. services the RTG will also conduct training and materials development programs to introduce population concepts and family planning information into, respectively, the formal school curriculum and the adult literacy training program of the Ministry of Education. A continuing series of operations-related programmatic research is also being planned to permit testing and rapid introduction of F.P. program innovations. Short-term technical consultants will be utilized in such specialized fields as new contraceptive methodologies, data processing, commercial marketing of contraceptives, and program management.

AID's contribution to this effort is outlined on page 35 of the PP. Assistance includes

- oral contraceptives and F.P. kits (IUD-insertion and sterilization kits) to supply the clinic-based distribution system as well as the new elements (12,000 F.P. agents and mobile F.P. units of the distribution network)
- grants to partially cover the training costs of the new agents and population training of teachers
- twenty mobile F.P. units
- U.S. training in specialized F.P./population fields for a small number of Thai participants
- research/evaluation grants and
- a one-year (FY 1976) extension of contract assistance--through World Education, Inc.--for a MOE family planning/adult literacy project.

A contingency item -- "other methodologies" has been included to permit U.S. assistance in the introduction of new or innovative contraceptive methods (such as the intra-uterine membrane, injectable contraceptives), should they become practical in the future. Most assistance items are matched by RTG contributions. The RTG will provide, over the life of the project, 65% of the program's oral contraceptive requirement; 50% of the purchase cost for forty mobile F.P. units; 58% of local training costs; and 50% of research costs. The RTG share of program costs for the FY 1975-81 period will be 69% of total costs. Respective funding burdens of the RTG, AID and other donors are detailed on page 39 of the Project Paper.

The RTG has estimated that, as a result of the expanded population coverage attained under this supplemented distribution network, approximately 45% of Thailand's eligible couples will be practicing some form of family planning by the end of 1981. The RTG has further estimated that this degree of contraceptive prevalence will result in a 1981 population growth rate of 2.1%. This figure has been established as the RTG's Fourth Five-Year Plan (1977-81) target for the national family planning program. The AID Mission to Thailand and the reviewing offices in AID Washington concur that this is a reasonable target, and is attainable in the context of the six-year project outlined in the Project Paper.

Issues:

A. Source of Project Funding FY 1978-81. The AID Mission to Thailand has noted the Agency's decision to bring an end to fresh starts in Thailand, both loan and grant funded, after FY 1977. Exceptions to this decision are limited to (1) support for family planning and narcotics suppression activities (the latter funded from sources other than development assistance); and (2) AID grants to U.S. and Thai PVO's. This posture is set forth in the approved Thailand DAP (pp 21-25). The Mission therefore believes that as a matter of general policy any funding to flow to Thailand after FY 1977 should be incorporated in AID/W functional budgets and Congressional Presentations. As a matter of practice this would mean, for AID, provision for funding principally for contraceptive requirements, grants to PVO's and related expenses, and possible recourse to Section 661 financing for development of reimbursable technical assistance or for cost sharing thereof. The Mission also notes the possibility of using the Housing Investment Guarantee (HIG) authority. The Mission suggests that the rationale for this position can and should be fully explained to the Committees of the Congress during the course of the FY 1977 presentation and could be an object of exploration by AA/Asia and others on an informal basis prior to that time.

No!

The PHA and Asia Bureaus have studied the Mission's position on this issue and do not agree. Our joint belief is that the Congressional and public misunderstanding or misperceptions potentially consequent to this action are not worth the small gain. The net plus is mostly cosmetic -- the absence of a specific page in the Congressional Presentation for Thailand after FY 1977, because Thailand program costs would be subsumed in other AID/W functional presentations. We do not believe this tactical maneuver is worth the conceivable charges that AID is attempting to hide or bury a country program of considerable size from close congressional scrutiny.

Good

Your approval of the PP as now drafted would constitute agreement with PHA and Asia Bureau positions that the Thailand program for FY 1978 and beyond should continue to be reflected in separate Thailand CP's. \*

OK

B. USOM/Thailand Request for Procurement Source Waiver for Vehicles: USOM/Thailand has requested a procurement source waiver from geographic code 000 (U.S. only) to geographic code 899 (free world; Mission as procurement agent) to enable the Mission to purchase, in Thailand ten (10)

\* A third alternative is to shift U.S. program assistance for the final three years of the project (FY 1979-81) to loan financing. This option will be explored with the RTG in the future as RTG fiscal planning and development funding availabilities for the post FY-1978 period become more clear.

Japanese-made vehicles for use as mobile F.P. units - (Value: \$40,000). The procurement waiver request is presented on pp 30-31 of the PP. PHA and the Asia Bureaus concur in the request. Your approval of the PP will constitute your approval of the waiver.\*

C. Life of Project: The duration of the project described in the PP is six years. These six years include (1) the final year of the current RTG Third Five-Year Plan (1972-76), and (2) the entire period of the upcoming Fourth Five-Year Plan (1977-81).

The rationale for a six-year assistance program is that:

- (1) The project is Thai-designed. Project requirements and targets (and respective achievement schedules) have been established by the Thais in the context of their two Five-Year plans.
- (2) Specific USG project contributions are the result of RTG-USOM/Thailand joint identification of those project components most likely to result in an incremental RTG contribution to the F.P. program. Therefore most USG assistance (contraceptives, vehicles, research and training grants) will be provided on a cost-sharing -- and thus coterminous -- basis with RTG project contributions through the Fourth Plan period.

Additionally, it should be noted that RTG project evaluations over the next several years will be conducted with a view toward measuring project accomplishments against development targets specified in the Third and Fourth Plans. Whereas U.S. and RTG participation in the project is so closely linked, it would not be particularly useful to overlay a different U.S. timeframe for project (contributions or) evaluations. The RTG has demonstrated competence (see Annex B of the PP) to conduct project evaluations responsive to the Agency's requirements in this area.

*but AID must participate!*

Staff participants to the PP review agree with the rationale for a six-year project. Project design and implementation are host country initiatives, to be supported in a collaborative fashion by incremental USG contributions.

Approval of the PP will constitute your approval of a six-year project.

\* SER/COM has raised several points in connection with this issue. See Tabs 1 and 2 attached.

*pp 64*

D. Local Cost Funding: Approximately \$1.3 million (16%) of the \$8.3 million USG project contribution will be for local (baht) costs. Local cost items include training (\$735,000); mobile F.P. units (\$40,000-80,000); and re-search/evaluation (\$450,000).

Participants to the PP review recommend your approval-- indicated by approval of the PP -- of these local cost contributions.

Funding Data: Below is a comparison of project (dollar) totals for FY 1976, IQ and FY 1977 outlined in the PP, the Thailand Congressional Presentation (p. 75 of the CP), and AID's October 1975 submission to OMB:

	<u>CP</u>	<u>OMB</u>	<u>PP</u>
FY 1976	4,229,000	3,185,000	3,143,000
IQ	1,058,000	510,000	562,000
FY 1977		2,000,000	1,230,000

← 5,287 73,7057 3615

With one exception, the PP totals are less than both the CP and the OMB. The exception is the difference between the OMB IQ of \$510,000 and the PP IQ of \$562,000. The \$52,000 increase is the result of a rescheduling by USOM/Thailand of anticipated obligations in the IQ for participant training extensions.

Recommendation: That you approve the attached Thailand Population Planning Project Paper.

APPROVED: [Signature] \*

DISAPPROVED: \_\_\_\_\_

DATE: 12/24/74

PHA/POP/EA GBowers:hhk:12/8/75

Clearance:  
AA/PHA:HCrowley [Signature] Date: 12/11/75  
ASIA/EA : AGardiner [Signature] Date: 12/15/75  
GC:CGladson [Signature] Date: 12/15/75

\* Subject to conditions as follows:  
1. No grant existence beyond FY '78  
2. AID must participate in biannual evaluations (See)

Apr 26 4 58 PM '76

DEPARTMENT OF STATE  
EXECUTIVE SECRETARIAT AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D.C. 20523

7-5A

26 APR 1976

ACTION MEMORANDUM FOR THE DEPUTY ADMINISTRATOR

FROM: AA/ASIA, Arthur A. Gardiner, Jr.

SUBJECT: Grant vs. Loan Funding - Thailand Population Planning Project

Problem: On December 24, 1975 you approved the Thailand population and family planning Project Paper for FY's 1976-1981. Your approval of the PP was subject to two conditions: (1) the U.S. would be a participant in any evaluations conducted on the project; and (2) FY's 79-80-81 would be loan-funded rather than grant-funded. The Mission has requested that AID/W reconsider this decision and has proposed a method for utilizing grant funds which would negate the utilization of DL funds while at the same time allowing for the reassessment of U.S. assistance in 1978.

Discussion: At the request of the Royal Thai Government's Ministry of Public Health, the United States began providing assistance to a Population/Family Planning effort in 1968. In 1970 the RTG as part of their Five-Year Development Plan promulgated a National Population Policy and thus began a full scale program to reduce fertility levels. The U.S. has continued to provide assistance to this program. Through FY 1975 the U.S. has obligated a total of \$10,854,000 for support of the Thailand Population Program.

The Project Paper covers the period FY's 1976-81, in order to bring our assistance effort into line with the next Thailand Five-Year Development Plan. The planned total program costs for this six-year period amount to \$32,766,000, broken down as follows:

(\$000's)

<u>FY 76 CP</u>	<u>I.Q. (CP)</u>	<u>FY 77 CP</u>	<u>FY 1978</u>	<u>FY 1979</u>	<u>FY 1980</u>	<u>FY 1981</u>
U.S.G. Inputs						
3,187 <sup>1/</sup>	562	1,230	1,135	910	770	590
Total U.S.G. Inputs \$8,384						
<hr/>						
Other Inputs (UNFPA, Pop Council)						
950		850	750	750	--	--
Total Other Inputs \$3,300						
<hr/>						
RTG Inputs <sup>2/</sup>						
1,750		2,587	3,315	3,640	4,630	5,160
Total RTG Inputs \$21,082						

1/ The original FY 76 CP figure of \$4,229,000 was revised downward to \$3,187,000 per Mission request in PP.

2/ RTG total does not include approximately \$6 million RTG indirect F.P. program support to be provided through the regular budget of the MOPH, e.g., salaries for health workers and supervisors, clinic construction and maintenance, POL, etc. The \$6 million figure is derived from an NESDB estimate, made in 1970, of the proportion of MOPH resources expended for F.P. activities.

The steady decrease in U.S. funding of this project is coupled to a steady increase of RTG funding from their own resources. This pattern represents a collaborative effort undertaken by the USG with the cooperation of the RTG, which, in fact, epitomizes the new bilateral relations we plan with the Thai through FY 1981, as outlined in the DAP submission.

This collaborative style which the DAP conveys can be best described as a "formal meeting of the minds" in terms of our new relationship. While it can be argued that this approach does not signify an "agreement" designed to bind both parties, it does represent an arrangement or plan entered into in good faith. Thus for either party to renege or deviate in a material way from the proposed course of action would obviously raise questions as to the feasibility of the undertaking. I wish to emphasize that the Project Paper (PP) for this activity was prepared in close consultation with the Thai Ministry of Public Health and the general arrangement reflected was worked out to govern all our aid with the Head of the Thai National Planning Board: to wit, a shift from grants to loans with the principle exception in the field of population, and sequential absorption of all project costs by the Thai with commensurate reductions in U.S. AID inputs. I consider these understandings to reflect an important degree of success by USOM/Thailand in converting our aid relationships to the new style and as markers on the road to non-concessional aid.

We believe there is a realistic option which would permit us to terminate grant funding in FY 1978 without departing from our understanding with the Thai that our contributions to the population program would be exclusively on a grant basis. The option is to provide our contributions in the first three years of the project, leaving later year funding to the Thai. Specifically, we could obligate the \$2.3 million planned for FY's 79-81 as follows: an additional \$1.0 million in FY 76, with the balance of \$1.3 million to be obligated in FY 78. The FY 76 Title X program would thus total \$4,187,000 which is below the \$4,229,000 requested in the FY 76 CP, and therefore requires no prior notification.

This raises the question of the safeguards we would have to assure continued Thai project contributions after funds are obligated. As pointed out by Roger Ernst during our discussion with you on this subject, the best assurance we have that the Thai will contribute as required is the momentum behind the program itself. But we also believe that we should propose to the Thai an evaluation schedule wherein we will jointly scrutinize their proposed budgetary allocations with the critical year being FY 1979. As you know, the Thai fiscal year extends from October 1 through September 30 thus coinciding with our fiscal year. An evaluation in FY 78 would be appropriate in that the RTG could provide us with an estimate of budgetary resources planned for FY 79. Should we determine that slippage was likely on the Thai part, we could exercise control by withholding the "call forward" date for planned delivery of FY 79-80 cycles of oral contraceptives or perhaps hold back other inputs. The FY 79-80 shipments are financed by FY 78 funds.

We noted on page two a total USG input of \$8,384,000 for the life of the project. The Thai input for FY 76-78 alone totals \$7,652,000 which more than satisfies Section 110(a) legislative requirement that a country provide at least 25 percent of the costs for the entire project. Thus withholding disbursements on shipments in FY 78 would still leave the Thai in the position of having met our legislative requirement.

Recommendation: That you agree to the proposed schedule of obligations of grant funds set forth above which would result in our completing our funding commitment to this project at the end of FY 1978.

Approved John E. [Signature]

Disapproved \_\_\_\_\_

Date 5/6/76

**Attachments**

- A - Ravenholt to Gardiner memo dated 3/24/76
- B - BANGKOK 4772 dated 3/3/76
- C - BANGKOK 5695 dated 3/12/76

ASIA/EAA/T:ERhatigan:PHA/POP/EA:JCummiskey

THAILAND  
POPULATION PLANNING PROJECT

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## ANNEXES

- A. Draft IBRD Sector Report (2 Vols)  
"The National Family Planning Program" April 28, 1975.
- B. "Thai National Family Planning Project Evaluation,  
Preliminary Reports and Recommendations", May, 1975.
- C. "2520-2524 (1977-1981) Family Planning Development Plan  
of the National Family Planning Project, Ministry of  
Public Health", April, 1975.
- D. Critical Program Indicators - Narrative Sheet Project  
Performance Tracking Networks.
- E. Logical Framework Matrix.
- F. Statutory Checklist.