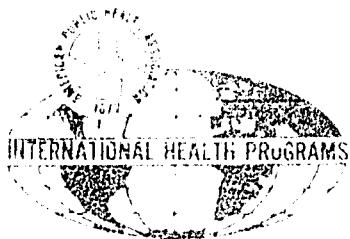


FD-340 (Rev. 1-15-60)

APHA-100



AMERICAN PUBLIC HEALTH ASSOCIATION
International Health Programs
1015 Fifteenth Street, N.W.
Washington, D.C. 20005

AN EVALUATION OF THE
FAMILY PLANNING HEALTH AND HYGIENE PROJECT
OF THE COMMUNITY-BASED
FAMILY PLANNING SERVICES, THAILAND

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During The Period:
March 23, 1981-April 3, 1981

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:
Ltr. AID/DS/POP: 6/23/81
Assgn. No. 582091

Draft ~~4/30/82~~; Family Planning of Community-Based Sites Thailand-
PS

ISN 614
PD-AAI-166

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Evaluates project to promote family planning (FP) and health services through Community-Based Family Planning Services (CBFPS) in Thailand. Evaluation covers the period 6/1/77-11/30/80 and is based on project records, interviews with project personnel, and a non-representative mini-survey of 2,463 project villages.

Initial free distribution of contraceptives failed to increase long-term sales and the inclusion of household drugs increased program costs without generating more income. A new CBFPS strategy--the project's fifth--was therefore developed, in which village distributors (VD): (1) provide FP services by selling contraceptives (especially oral contraceptives--OC) at subsidized prices and refer clients to the government for IUD and sterilization services; (2) sell and promote household drugs such as oral rehydration salts, vitamins, and anti-parasitics; and (3) promote breastfeeding, conduct certain economic development activities, and make referrals for immunization and curative care.

The mini-survey revealed that while delivery of services in the second and third categories was fairly low, there has been much success with the first category. OC sales in 11/80 were at 440,000/year, and have increased 14%/year each of the last 2 years. The project, expending \$7.87 per couple-year of protection, is cost-effective, although costs could be further reduced by using staff more effectively now that the project has passed the experimentation stage.

It is recommended that a full-scale feasibility study of a national subsidized contraceptive retail sales program be conducted; that the project be kept intact until the role of government village health volunteers in distributing contraceptives is clarified; and that the program be re^evaluated in 2 years in the context of the National FP Program. To solve operational problems, it is recommended to increase VD stocks by as much as 50%; have district supervisors and field officers reactivate inactive accounts; reduce staff where possible; take steps to increase cost-recovery from 25% to 50% within 2 years; compensate district supervisors for fuel costs; and provide further training to VD's, stressing referrals in addition to female sterilization and vasectomy and allowing VD's to meet referral personnel.

ACKNOWLEDGMENTS

The evaluation team is very thankful for the valuable assistance and cooperation it received from the staff of the Ministry of Public Health, Mahidol University, the Community-Based Family Planning Services, and the USAID. In particular, the team would like to thank Mr. David Oot of USAID, Dean Debhanom Muangman of Mahidol University, and Ms. Somchit Tipprapa of the CBFPS.

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C O N T E N T S

	<u>Page</u>
ACKNOWLEDGMENTS	i
MEMBERS OF THE EVALUATION TEAM	ii
LIST OF TABLES AND FIGURES	v
EXECUTIVE SUMMARY	vi
ABBREVIATIONS	vii
I. INTRODUCTION AND BACKGROUND	1
II. ACHIEVEMENTS OF THE PROJECT	3
Sources of Data.	3
A. Project Records	3
B. Interviews with Key Project Personnel	3
C. Mini Survey	4
Sales of Oral Contraceptives	4
Sales of Condoms and Neo Sampoo Tablets	7
Contraceptives and OC Prevalence Rates	7
Sales of Household Drugs	7
Promotion and Referral	11
III. STAFFING PATTERN	14
District Supervisors	14
Village Distributors	15
IV. FINANCIAL ANALYSIS OF THE PROJECT	18
Expenditure and Income	18
Cost-Effectiveness	18
V. DISCUSSION AND CONCLUSIONS	21
The Village Health Volunteers Program	21
Subsidized Commercial Retail Sales	21
Cost Recovery	22
VI. RECOMMENDATIONS	23
Short-Term Action	23
Long-Term Action	23
Operational Problems and Recommendations	23

APPENDICES

- Appendix A: Scope of Work
- Appendix B: Performance and Social-Economic Levels of Districts
- Appendix C: Distribution of Sales Proceeds From Condoms, Oral Contraceptives, and Household Drugs
- Appendix D: FPHH Organizational Chart
- Appendix E: FPHH Financial Analysis (June 1, 1977-November 10, 1980)
- Appendix F: List of Persons Interviewed on Field Trip
- Appendix G: List of Resource Persons
- Appendix H: Field Observations on Village Distributors

LIST OF TABLES AND FIGURES

<u>Table or Figure</u>	<u>Page</u>
Table 1: Oral Contraceptives Distributed Between FY 1978 and FY 1980 (Cycles)	5
Table 2: Condom Distribution During FY 1978-FY 1980 (Dozen)	8
Table 3: Relative Contribution of OCs, Condoms, and Foam Tablets	9
Table 4: Contraceptive Prevalence Rate from Mini Survey	10
Table 5: Household Drugs Sold During the Third and Fourth Years	12
Table 6: January 1981 Activities of the Village Distributors, By Region	16
Table 7: Cost Per CYP, FY 1977-FY 1980 (In U.S.\$)	19
Figure 1: OC Sales, By Brand, June 1978-November 1980	6

EXECUTIVE SUMMARY

The Family Planning Health and Hygiene (FPHH) Project of the Community-Based Family Planning Services (CBFPS) sells, at a subsidized price, oral contraceptives, condoms, and Neo Sampoo foaming tablets to a modest number (approximately 8 percent) of married women of reproductive age (MWRA) who live in 80 project districts in rural Thailand with a population of approximately 6.5 million.

The program is predominantly an oral contraceptive (OC) sales program. OC sales are increasing at approximately 14 percent annually. It is estimated that half of the project's clients once were drug store clients who switched to CBFPS sources; the other half are new clients. The project does not seem to have attracted the clientele of the government's free pill program.

Many other activities originally envisioned for the program, such as sales of household drugs, health promotion, and economic development, have not been successful. One exception is sterilization referral, which seems to be widespread.

Exclusive of contraceptives (which are donated to the CBFPS), the project costs approximately \$400,000 per year to operate. Income from the sale of contraceptives and drugs covers approximately 25 percent of the operating costs. Thus, the unrecovered cost per couple-year of protection (CYP) is approximately \$7.87. This compares favorably with similar programs in other countries; however, it should be possible to improve the program's cost-effectiveness by simplifying recordkeeping and using staff more efficiently. This action is possible because the program has passed beyond the research and experimental stage.

The evaluation team has made recommendations for both the program and its operation.

ABBREVIATIONS

AID/W	Agency for International Development/Washington
APHA	American Public Health Association
CBFPS	Community-Based Family Planning Services
CRS	Contraceptive Retail Sales
CYP	Couple-Years of Protection
DS	District Supervisor
DTEC	Department of Technical and Economic Cooperation
FPHH	Family Planning Health and Hygiene
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MCH	Maternal and Child Health
MOH	Ministry of Health
MOPH	Ministry of Public Health
MWRA	Married Women of Reproductive Age
NFPP	National Family Planning Program
OC	Oral Contraceptive
PDA	Population and Development Association
RTG	Royal Thai Government
USAID	United States Agency for International Development
VHV	Village Health Volunteer

I. INTRODUCTION AND BACKGROUND

I. INTRODUCTION AND BACKGROUND

The Family Planning Health and Hygiene (FPHH) Project is being conducted by the Community-Based Family Planning Services (CBFPS), under the direction of Mechai Viravaidya.

The FPHH Project began in June 1977. It has been in continuous operation for four years. External support to the project, which is provided by the Agency for International Development/Washington (AID/W), will terminate at the end of September 1981.

The background and evolution of the project have been described in other documents, such as the team evaluation report by Carlson and Potts (February 1979) and the trip report of Chen (February 1980). A brief description of the background of the project is contained in Appendix A.

During the project, five different community-based marketing plans for contraceptives and household drugs were used. A description of these models follows:

- Model A: The CBFPS provided only contraceptives. These were for sale at low prices.
- Model B: The CBFPS provided only contraceptives. However, a free, two-month introductory supply of pills and condoms was distributed throughout the village to those who were eligible and willing to use them.
- Model C: Both contraceptives and household drugs were sold by the CBFPS at low prices. In addition, community-based distributors were trained to provide health referrals.
- Model D: The same as Model C above; initially, contraceptives were distributed at no charge, as in Model B.

It was hypothesized that the free introductory supply of contraceptives and the inclusion of household drugs would improve the cost-effectiveness of the contraceptive distribution system. However, according to assessments conducted in February 1979 and February 1980, the initial distribution of free contraceptives did not result in a long-term increase in contraceptive sales. Moreover, the inclusion of household drugs in the program increased both the distributors' training costs and the cost of program maintenance without generating additional income. (However, it was noted in the 1979 evaluation report that the initial promotion of two free cycles of pills

(Models B and D) was not carried out uniformly by the village distributors. The promotion was more thorough in Model D, where 30 percent of the married women of reproductive age (MwRA) received free pills, than in Model B, where only 16 percent of MwRAs received the product.)

As a result of these findings, the four models were dropped and Model E was implemented. By May 1980, Model E had been applied in all 80 districts served by the FPHH Project. Three categories of services are provided under Model E.

1. Family Planning

Village distributors sell, at subsidized prices, three kinds of oral contraceptives: Norinyl, Ovostat, and Eugynon. They also sell condoms. In addition, Neo Sampoo foaming tablets are sold, primarily to postpartum nursing mothers and women who reject an oral contraceptive and the condom. Village distributors refer clients who are interested in the IUD and sterilization to the government service. However, if a village has many clients for sterilization, the CBFPS dispatches a mobile sterilization clinic.

2. Health and Hygiene

Village distributors sell and promote certain household drugs, including oral rehydration salts, multivitamin tablets, and anti-parasite drugs.

3. Promotion and Referral

With the assistance of CBFPS central office staff, village distributors promote breastfeeding, conduct certain economic development activities, and make referrals for immunization and curative care.

II. ACHIEVEMENTS OF THE PROJECT

II. ACHIEVEMENTS OF THE PROJECT

In discussing the achievements of the FPHH Project, the team focused on three activities. Special emphasis was placed on the family planning component.

Sources of Data

There were several sources of data for this evaluation. These sources are described below.

A. Project Records

The CBFPS has maintained a system of service records in the form of essential administrative reports and commodity logistics data. These data and the financial accounting records are the basis for quantitative evaluations.

B. Interviews with Key Project Personnel

The following persons were interviewed:

- CBFPS administrative and operational staff;
- 2 provincial chief medical officers and 6 district health officers;
- 9 district supervisors (DS) and 21 village distributors; and
- key staff of the National Family Planning Program (NFPP) of the Ministry of Public Health (MOPH).

For the field interviews, Thai and non-Thai members of the evaluation team were paired for three-day trips to separate destinations. One pair went to the Northeast Region, the other to the North Region. The sites in the south were not visited because an insurrection had been instigated there. The field visits included both high- and low-performance project districts, as well as a variety of rich and poor districts. Appointments were made by CBFPS personnel, but several unplanned visits were made also.

C. Mini Survey

Another source of data was the mini survey conducted by CBFPS district supervisors. Approximately 3,720 villages were targeted for the survey. By February 1981, 2,463 villages, or 65 percent of the target, had been surveyed. The mini survey was used not only as a research and evaluation tool (it provided contraceptive prevalence data for the project area); it also had a service function. When a district supervisor encountered an eligible woman who was not contracepting, he usually informed her of the methods available and told her where she could obtain the commodity or service.

Sales of Oral Contraceptives

Table 1 and Figure 1 present the sales statistics on oral contraceptives from June 1978 to November 1980. The FPHH Project sells approximately 440,000 cycles of oral contraceptives each year. Between FY 1978 and FY 1979, the volume of sales increased 14 percent. Between the first two quarters of FY 1979 and the first two quarters of FY 1980, sales again increased 14 percent.

The current market breakdown of oral contraceptives, by brand, is:

Norinyl	71.5%	sold for 5 Bhat (U.S.\$0.25) per cycle
Ovostat	17.2%	sold for 7 Bhat per cycle
Eugynon	11.4%	sold for 9 Bhat per cycle

The sales volume for Norinyl and Ovostat has stabilized; both OCs have been on the market since the beginning of FY 1978. Total OC sales increased with the introduction of a new, more expensive brand, Eugynon, in the second quarter of FY 1979 (see Figure 1). The availability of a variety of brands seems to stimulate sales.

Twenty-one village distributors were visited by the evaluators. The stocking patterns of the various contraceptive products were:

Norinyl	21 Distributors
Ovostat	19 Distributors
Eugynon	19 Distributors
Condoms	14 Distributors
Neo Sampoo	15 Distributors

Table 1
 ORAL CONTRACEPTIVES DISTRIBUTED BETWEEN FY 1978 AND FY 1980
 (Cycles)

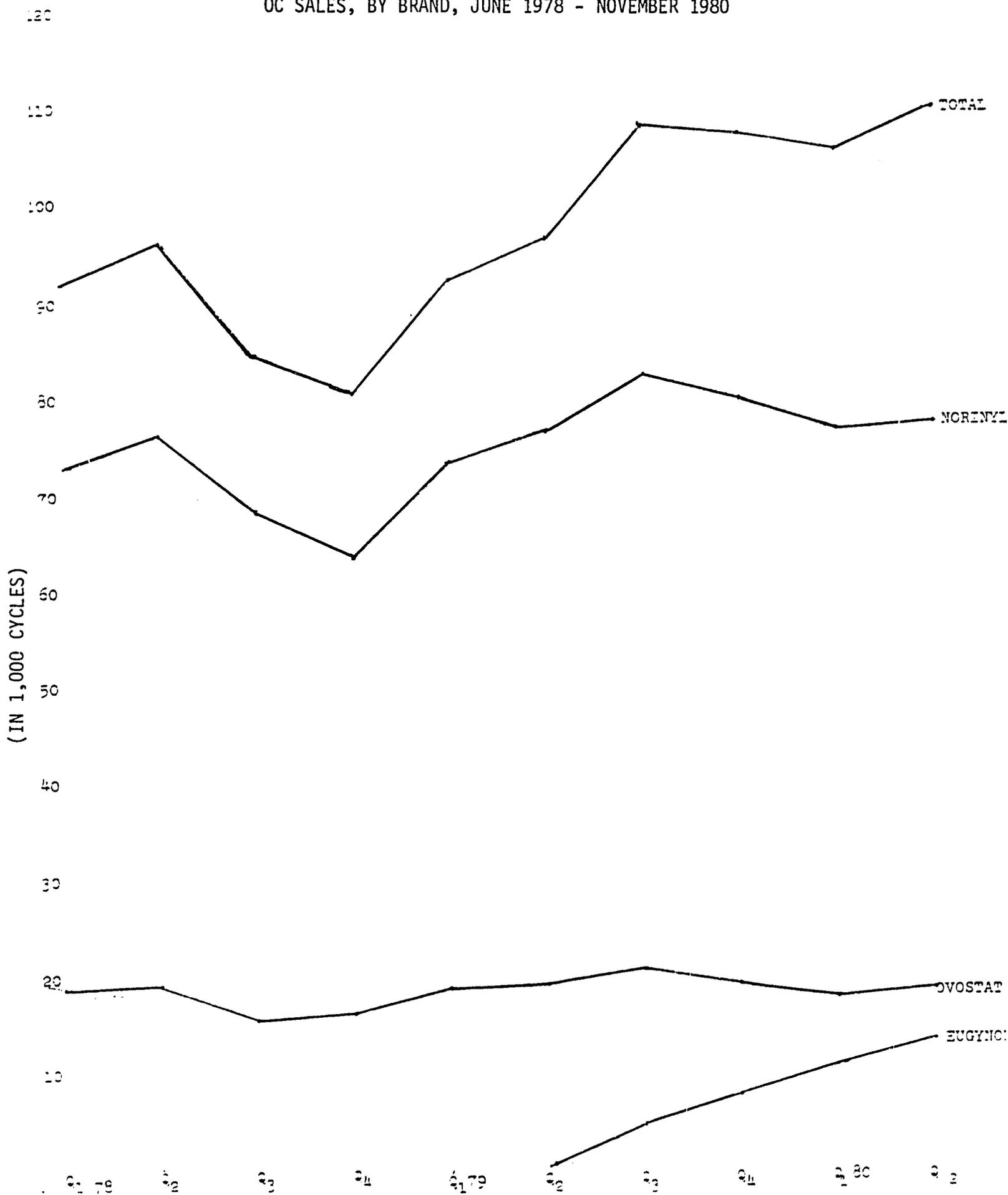
THAI FISCAL YEAR	MODEL A				MODEL B				MODEL C				MODEL D				TOTAL				
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
1978																					
Q1	26,016	7,104	-	33,120	17,142	3,804	1	20,947	14,651	3,801	-	18,452	15,524	4,415	-	20,009	73,403	19,124	1	92,528	
Q2	26,413	7,136	140	33,689	18,660	4,221	150	23,031	15,709	3,703	25	19,437	16,080	4,464	115	20,659	76,862	19,524	430	96,816	
Q3	26,123	6,915	-	33,038	13,939	3,026	-	16,965	13,016	3,320	-	16,336	15,801	2,754	-	18,555	68,879	16,015	-	84,894	
Q4	<u>22,902</u>	<u>6,115</u>	<u>-</u>	<u>29,018</u>	<u>15,103</u>	<u>3,401</u>	<u>-</u>	<u>18,504</u>	<u>13,100</u>	<u>3,922</u>	<u>-</u>	<u>17,022</u>	<u>13,138</u>	<u>3,206</u>	<u>-</u>	<u>16,344</u>	<u>64,244</u>	<u>16,644</u>	<u>-</u>	<u>80,888</u>	
TOTAL	<u>101,455</u>	<u>27,270</u>	<u>140</u>	<u>128,865</u>	<u>64,844</u>	<u>14,452</u>	<u>151</u>	<u>79,447</u>	<u>56,476</u>	<u>14,746</u>	<u>25</u>	<u>71,247</u>	<u>60,613</u>	<u>14,839</u>	<u>115</u>	<u>75,567</u>	<u>283,388</u>	<u>71,307</u>	<u>431</u>	<u>355,126</u>	
1979																					
Q1	26,016	7,104	-	33,120	17,142	3,804	-	20,946	14,651	3,801	25	18,477	15,514	4,415	-	20,009	73,403	19,124	25	92,552	
Q2	26,413	7,136	140	33,689	18,660	4,221	150	23,031	15,709	3,705	-	19,414	16,080	4,464	125	20,669	76,862	19,526	415	96,803	
Q3	26,778	7,889	1,812	36,479	21,579	4,804	1,326	27,709	17,553	4,102	715	22,449	16,647	4,214	1,088	21,949	82,557	21,088	4,941	108,586	
Q4	<u>27,079</u>	<u>7,426</u>	<u>3,245</u>	<u>37,750</u>	<u>21,447</u>	<u>4,300</u>	<u>2,046</u>	<u>27,793</u>	<u>15,657</u>	<u>3,380</u>	<u>1,544</u>	<u>20,581</u>	<u>15,904</u>	<u>4,469</u>	<u>1,105</u>	<u>21,478</u>	<u>80,087</u>	<u>19,575</u>	<u>7,940</u>	<u>107,602</u>	
TOTAL	<u>106,286</u>	<u>29,555</u>	<u>5,197</u>	<u>141,038</u>	<u>78,828</u>	<u>17,124</u>	<u>3,522</u>	<u>99,479</u>	<u>63,570</u>	<u>15,067</u>	<u>2,284</u>	<u>80,921</u>	<u>64,225</u>	<u>17,562</u>	<u>2,318</u>	<u>84,105</u>	<u>312,909</u>	<u>79,313</u>	<u>13,321</u>	<u>405,543</u>	
1980																					
Q1	24,507	6,504	3,948	34,959	19,387	4,025	2,310	25,722	16,237	3,233	2,241	21,711	16,765	4,258	2,408	23,431	76,896	18,020	10,907	105,823	
Q2	<u>25,686</u>	<u>6,591</u>	<u>4,416</u>	<u>35,695</u>	<u>18,672</u>	<u>4,223</u>	<u>2,858</u>	<u>25,753</u>	<u>17,255</u>	<u>4,051</u>	<u>2,800</u>	<u>24,106</u>	<u>15,931</u>	<u>4,184</u>	<u>3,620</u>	<u>23,735</u>	<u>77,546</u>	<u>19,049</u>	<u>13,694</u>	<u>110,289</u>	
TOTAL	<u>50,193</u>	<u>13,095</u>	<u>8,364</u>	<u>71,654</u>	<u>38,059</u>	<u>8,248</u>	<u>5,168</u>	<u>51,475</u>	<u>33,492</u>	<u>7,284</u>	<u>5,041</u>	<u>45,817</u>	<u>32,696</u>	<u>8,442</u>	<u>6,028</u>	<u>47,266</u>	<u>154,442</u>	<u>37,059</u>	<u>24,601</u>	<u>216,112</u>	

Code: 1 = Norinyl 2 = Ovostat 3 = Eugynon 4 = Total

Q1 = June - August Q2 = September - November Q3 = December - February Q4 = March - May

Figure 1

OC SALES, BY BRAND, JUNE 1978 - NOVEMBER 1980



Sales of Condoms and Neo Sampoo Tablets

Despite the 20 percent increase in sales between the first half of FY 1979 and the first half of FY 1980 (see Table 2), condoms account for a relatively small percentage of FPHH Project sales. They represent approximately 6.5 percent of the couple-years of protection (CYP) (see Table 3). Although it receives a lot of publicity, the condom has not been a popular method of contraception in Thailand. Nationally, condom users constitute only 4 percent of total current contraceptors, according to the 1978-1979 Contraceptive Prevalence Survey.

Table 3 shows that Neo Sampoo spermicidal tablets have not been a successful sales item in the project. They contribute less than 1 percent of the project's CYP.

Contraceptives and OC Prevalence Rates

Table 4 compares the contraceptive prevalence rates for the project area and rural Thailand in general. In the FPHH project area, which is predominantly rural, the rate of contraceptive practice is slightly higher than in rural Thailand (57.6 vs. 49). The OC practice rate is much higher in the project area than in rural Thailand (27.3 vs. 23.7).

Twenty-eight percent of the OC users in the project area buy their OCs from CBFPS distributors. Data from the initial mini survey (1978-1979) (see Table 4) suggest that half the project's clients were once government OC clients who switched to CBFPS sources; the other half are new OC users. However, data from the new mini survey (1979-1981) suggest that the composition of the clientele has changed: Half the project clients were once drug store customers; the other half are new OC users.

In interpreting Table 4, one must be aware that the mini survey conducted by the CBFPS in the project area did not include a representative sample of the project area. Furthermore, the survey was not taken in the same months in both the project area and rural Thailand. Thus, the results should not be regarded as scientifically rigorous.

Sales of Household Drugs

During the first year of the project, the MOPH provided 4,000 sets of household drug kits, at no cost, to the village distributors who, in turn, sold them to their clients. The money from these sales was used to buy drugs for future retail sales (see Appendix C).

Table 2
CONDOM DISTRIBUTION DURING FY 1978-FY 1980
(Dozen)

THAI FISCAL YEAR	MODEL				TOTAL
	A	B	C	D	
1978					
Q1 (June - August)	1,213	1,217	471	670	3,571
Q2 (September - November)	1,664	1,265	636	944	4,509
Q3 (December - February)	1,396	903	856	441	3,596
Q4 (March - May)	<u>1,190</u>	<u>1,113</u>	<u>678</u>	<u>738</u>	<u>3,719</u>
TOTAL	<u>5,463</u>	<u>4,498</u>	<u>2,641</u>	<u>2,793</u>	<u>15,395</u>
1979					
Q1	1,213	1,217	471	670	3,571
Q2	1,664	1,265	636	944	4,509
Q3	1,733	1,399	636	1,318	5,086
Q4	<u>1,877</u>	<u>1,441</u>	<u>704</u>	<u>909</u>	<u>4,931</u>
TOTAL	<u>6,487</u>	<u>5,322</u>	<u>2,447</u>	<u>3,841</u>	<u>18,097</u>
1980					
Q1	1,701	1,624	695	1,126	5,146
Q2	<u>1,856</u>	<u>1,138</u>	<u>735</u>	<u>882</u>	<u>4,611</u>
TOTAL	<u>3,557</u>	<u>2,762</u>	<u>1,430</u>	<u>2,008</u>	<u>9,757</u>

Table 3
RELATIVE CONTRIBUTION OF OCs, CONDOMS, AND FOAM TABLETS

	<u>June-November 1980</u>	<u>CYP Equivalent*</u>	<u>Percent CYP</u>
Oral Contraceptives (cycles)	216,112	16,624	92.6
Norinyl	154,442		
Ovostat	37,069		
Eugynon	24,601		
Neo Sampoo Spermicidal Foam Tablets (tubes of 20)	793	159	0.9
Condoms (dozens)	9,757	1,170	6.5
TOTAL		<u>17,953</u>	<u>100.0</u>

* 1 CYP = 13 cycles of OC, or 100 condoms, or 100 foam tablets.

Table 4
CONTRACEPTIVE PREVALENCE RATE FROM MINI SURVEY*

	FPHA PROJECT AREA, MINI-SURVEY DATA						1978-1979 Contraceptive Prevalence Survey	
	July 1978 - October 1979		November 1979 - February 1981		TOTAL July 1978 - February 1981		Rural Only	National
	No.	%	No.	%	No.	%	%	%
Total Number of MWRA's	63,936	100.0	65,618	100.0	129,554	100.0	100.0	100.0
Currently Contracepting	33,020	51.6	36,681	55.9	69,701	53.8	49.0	51.0
OC Users	17,423	27.3	17,427	26.7	34,850	26.9	23.7	21.9
IUD	2,843	4.4	4,153	6.3	6,996	5.4		
Male Sterilization	2,536	4.0	2,387	3.6	4,923	3.8		
Female Sterilization	6,720	10.5	9,086	13.8	15,806	12.2		
DMPA	2,535	4.0	3,036	4.6	5,571	4.3		
Condom	315	0.5	203	0.3	581	0.4		
Other	648	1.0	389	0.6	1,037	0.8		
Source of Supply for OC Users								
Government Health Center	8,850	13.8	11,599	17.7	22,127	17.1	17.3	16.0
CBFPS	4,609	7.2	5,071	7.7	9,634	7.4	0.8	0.7
Drug Stores and Others	3,964	6.2	757	1.2	3,089	2.4	5.6	5.2

* Number of villages to be surveyed (3,780), or 50 percent of total.

Number of villages completed July 1978 - October 1979: 1,159, or 30 percent of target.

Number of villages completed July 1978 - February 1981: 2,463, or 65 percent of target.

In Model E the role of household drugs was downplayed. However, drug sales increased 50 percent between the third and fourth years of the project. The volume of drug sales continues to be small, approximately \$6,570 a year.

The largest increases were in sales of aspirin tablets, A.P.C. tablets, and vitamin B complex. The sale of oral rehydration salt increased 42 percent (see Table 5).

During the field trip, the evaluation team observed that, of the 21 village distributors:

- 10 carried oral rehydration salt;
- 12 carried vitamins;
- 3 carried anthelmintes; and
- 7 carried other CBFPS drugs.

Fourteen distributors carried drugs that were not supplied by the CBFPS. These drugs ranged from analgesics to antibiotics.

Promotion and Referral

The majority of the 21 village distributors who were interviewed said they provided referrals. The services for which referrals were made, and the number of distributors who made those referrals, are:

<u>Referral</u>	<u>Number of Distributors</u>
Immunization	12
Sterilization	16
IUD	6
Health Care	12

There is little evidence that breastfeeding has been promoted and that economic development activities have been undertaken, although these activities are part of the Model E project design.

Table 5

HOUSEHOLD DRUGS SOLD DURING THE THIRD AND THE FOURTH YEARS

No.	Unit	Items	User Price in P ($\text{P}20 = \text{U.S.}\1)	Amount Sold		
				3rd Year, 6/79 - 5/80	4th Year, 6/80 - 1/81 (8 mos. only)	4th Year, Estimated for 12 months
1	Bottle	Stomach Mixture	4.50	3,361	1,986	2,979
2	Packet	Sodamin Tablets	0.50	3,889	2,934	4,401
3	Packet	Sulfagnamidine Tablets	5.00	1,655	1,374	2,061
4	Packet	Phthalysulfathiazoh Tablets	3.00	1,548	1,324	1,986
5	Packet	Coroquine Phosphate Tablets	2.75	1,213	1,415	2,123
6	Packet	Aspirin Tablet	0.50	3,962	7,641	11,462
7	Packet	A.P.C. Tablets	1.00	4,158	7,214	10,821
8	Bottle	Themerosal Tincture	1.50	1,367	1,019	1,529
9	Bottle	Merbromin Solution	1.50	1,548	1,317	1,976
10	Packet	Cotton Wool	2.00	1,476	1,353	2,030
11	Packet	Bandage	2.75	1,013	814	1,221
12	Bottle	Pinprazine Citrate Elixir	5.00	1,367	1,182	1,773
13	Packet	Vitamin B Complex	3.00	4,997	7,157	10,736
14	Tin	Analgesic Balm	1.50	1,501	1,664	2,496
15	Packet	Oral Rehydration	2.00	6,890	6,541	9,812
User Price x Amount Sold				$\text{P}87,430.5$ (U.S.\$4,371.5)		$\text{P}131,375.5$ (U.S.\$6,568.8)

The Population and Development Association (PDA), the parent organization of the CBFPS, owns two self-contained vasectomy buses which are deployed throughout rural Thailand. From August to October 1980, the two buses served 1,273 acceptors. When these acceptors were asked who or what motivated them to accept the vasectomy, 54 percent cited the village distributors of the CBFPS projects as the source of referral; 24.4 percent cited the government health worker as the source of referral.

III. STAFFING PATTERN

III. STAFFING PATTERN

The FPHH Project maintains a large staff: 42 staff in Bangkok and 80 district supervisors (see Appendix D, an organization chart). Because the project began as a research project, with emphasis on the collection and analysis of financial, sales, and client statistics, the project supports 18 people in financial, monitoring, and administrative offices. Field supervision also is well emphasized. This is reflected in the high supervisor-staff ratio. For example, each operation unit head supervises four field officers, and each field officer supervises four district supervisors.

Because the project has passed beyond the research and experimental stage, there is less need for complex financial and logistic statistics. For example, it is no longer necessary to record data separately for the four research models, or to count current users, because the sales statistics seem to provide a very good estimate of current users.

Salary costs constitute one-half of total project costs. By reducing the number of staff employed in research, monitoring, and financial management, and by decreasing the ratio of field officers to district supervisors, it is estimated that a 12-15 percent reduction in total program expenditure could be realized.

District Supervisors

The district supervisors each supply an average of 72 village distributors. A DS spends 7-18 days on the road; the average is 12 days. Time on the road varies according to the number and proximity of distributors. Some district supervisors think they can handle additional distributors in additional villages. Efforts to expand the number of outlets in villages already covered have been resisted, however.

District supervisors are resupplied when they attend the monthly meeting held in four regional offices. No problems with stock-outs have been reported.

District supervisors earn between 1,100฿ and 1,400฿ per month. With these funds they must pay for their gasoline and motorcycle maintenance. These two items consume approximately one-fifth of their pay. Many district supervisors complain about the high cost of transportation, which works as a disincentive, inhibiting them from going out to visit the distributors, particularly in remote areas. The CBFPS should consider reimbursing the district supervisors for the cost of gasoline, especially if they are to be encouraged to reactivate dormant accounts. Paying for gasoline would increase program expenditures by approximately 1.5 percent.

Village Distributors

The primary occupations of the 21 village distributors who were interviewed are:

Farmer	10
Shopkeeper	9
Weaver and Teacher	1 each

Ten have a second occupation. Ten also have other functions, including service as a village headman, royal scout, midwife, village health volunteer (VHV), village health communicator, malaria volunteer, traditional health attendant, and member of the civil defense.

The median distance from the village distributor to the closest health center is 5 kilometers; the median distance to the nearest drug store is 7 kilometers. The project has succeeded in penetrating villages that are not reached by either a source of free pills or the commercial market.

The CBFPS recommends that the village distributors keep only a one-month supply on hand and that the district supervisors visit the village distributors each month to keep them resupplied. In stock-checks during field visits and reviews of logistic statistics, the evaluators found that the recommended practice was prevalent, but certainly not universal.

Monthly data for November and December 1980 and January 1981 show that, for each month, between 51 percent and 58 percent of the village distributors ordered supplies from their district supervisors. The central and northern regions have the highest proportion of active village distributors; the southern and especially the northeastern regions have the lowest proportion of active village distributors (see Table 6). In any one month, more than 40 percent of the village distributors do not place orders. This does not necessarily mean that many are inactive, although district supervisors indicated that as many as one-quarter of the village distributors are inactive. The evaluation team has recommended that district supervisors and field officers attempt to reactivate inactive accounts. This can be done by calling less frequently on high-performance village distributors and more frequently on low-performance persons. Those village distributors who are not interested in continuing their work should be replaced.

Table 6 shows that the average monthly order of a village distributor is \$2.89; the range is from \$1.74 in the Southern Region to \$3.93 in the Northern Region. These figures correspond well with the team's field observation

Table 6
 JANUARY 1981 ACTIVITIES OF THE VILLAGE DISTRIBUTORS, BY REGION

	<u>North</u>	<u>Northeast</u>	<u>Central</u>	<u>South</u>	<u>TOTAL</u>
Total Number of Village Distributors	1,626	2,427	1,242	487	5,782
Number of Village Distributors Who Placed Orders in January 1981	1,090	1,043	926	275	3,334
Percent of Village Distributors Who Placed Orders in January 1981	67.0	43.0	74.6	56.5	57.7
Total Amount Ordered (in ₧)	85,590	51,736	45,462	9,583	192,371
Average Size of Order (in ₧)	₧ 78.52	₧ 49.60	₧ 49.10	₧ 34.85	₧ 57.7
Average Size of Order (in U.S.\$)	\$ 3.93	\$ 2.48	\$ 2.45	\$ 1.74	\$ 2.89

that an average village distributor serves approximately 10 women and sells approximately 10 cycles of oral contraceptives per month.

Because village distributors maintain so little stock, they run out of contraceptives frequently. Eleven of the 21 distributors who were visited reported that they run out of products on occasion. The team recommends that the inventories of the village distributors be increased, perhaps by as much as 50 percent.

In summary, the system of the CBFPS village distributors appears to be functioning as planned. Under Model E, specific tasks are being accomplished.

1. Family planning through the distribution of contraceptives is being accepted. Pills are distributed and sold widely. Condoms and foaming tablets also are distributed broadly (to village distributors), but current sales are low. The village distributors offer easy access and long hours to their customers at relatively low cost.
2. Efforts in health and hygiene, through the sale and promotion of oral rehydration salts, multivitamins, anti-parasitic products, and other household drugs, have been less successful.
3. Distributors are active in making referrals for female sterilization and vasectomies, but they are less active in other referral and health promotional activities. Economic development activities have not been undertaken.

Appendix H contains the team's other observations on village distributors.

IV. FINANCIAL ANALYSIS OF THE PROJECT

IV. FINANCIAL ANALYSIS OF THE PROJECT

Expenditure and Income

The sale of contraceptives, which are donated to the CBFPS, generates income for the CBFPS. One cycle of OC generates 3.5¢ - 7.5¢ for the CBFPS, depending on the brand; one condom generates 0.50¢; and 10 percent of the proceeds from sales of household drugs goes to the CBFPS (see Appendix C). The project expends annually approximately \$400,000. The income generated from the sale of contraceptives and household drugs is enough to cover one-quarter of the project's expenditures, up from one-fifth in previous years (see Table 7).

As sales of contraceptives and household drugs continue to grow, income will continue to increase. If at the same time the CBFPS can make more efficient use of personnel (through simplified recordkeeping and a more efficient supervisory structure), the project should become 50 percent self-sufficient in two years.

During the first six months of FY 1980, 44 percent of the total annual budget was expended. Although 52 percent of the AID grant budget was spent in these six months, only 22 percent of the CBFPS budget was used. This was the spending pattern recorded in the previous year. The CBFPS should correct the inequity in the rate of spending. (A detailed financial analysis of the FPHH Project is presented in Appendix E.)

Cost-Effectiveness

The FPHH Project is cost-effective. At this time, the cost subsidy per couple-year of protection is \$7.87 (see Table 7), down from \$43.35 in the first year, \$7.61 in the second year, and \$9.60 in the third year. Considering inflation, the real cost per CYP decreased in 1978-1980. The cost-effectiveness figures compare favorably to those for community-based contraceptive distribution programs in other countries. However, the cost-effectiveness of the FPHH Project can be improved substantially.

Cost-effectiveness in this report is measured by actual program expenditures, minus project income, divided by total couple-years of protection. The actual program expenditures include:

--salaries;*

--administration costs;

* Part of these costs are for research.

Table 7
COST PER CYP, FY 1977-FY 1980
(In U.S.\$)

	<u>FY 1977</u>	<u>FY 1978</u>	<u>FY 1979</u>	<u>FY 1980*</u>
Actual Program Expenditure (in U.S.\$)	280,341	282,623	411,088	187,919
Local Income	14,534	60,709	87,359	49,432
Percent Cost Recovery (2) ÷ (1)	5.2	21.5	21.3	26.3
Subsidy Required (1) - (2)	265,807	221,914	323,729	138,487
OC Sales (Cycle)	73,492	355,126	405,543	216,112
Condom Sales (Dozen)	3,982	15,395	18,097	9,757
Neo Sampoo (Tubes of 20)	0	0	1,761	793
Total Number of CYPs**	6,131	29,164	33,720	17,593
Subsidized Cost Per CYP (4) ÷ (8)	43.35	7.61	9.60	7.87

* First six months.

** 1 CYP = 13 cycles of OC, or 100 condoms, or 100 Neo Sampoo foam tablets.

- information, education, and communication costs;
- per diem costs;
- household survey* and Acceptors Recruitment Campaign;
- field development and support costs; and
- miscellaneous costs.

The cost of contraceptives is not included in the numerator; however, the income generated from sales of contraceptives and household drugs is used to offset the numerator. The denominator--CYP--includes protection afforded by OCs, condoms, and Neo Sampoo foaming tablets.

The FPHH Project is only one of several projects carried out by the CBFPS. There is evidence that resources are commingled among the various CBFPS projects. For example, FPHH field officers are involved, from time to time, in the advanced promotional activities of the vasectomy mobile clinics, and village distributors are involved in sterilization referral, but the sterilization acceptors are not counted among the achievements of the FPHH Project. It is probably safe to surmise that the FPHH Project is more cost-effective than the figures indicate.

*Part of these costs are for research.

V. DISCUSSION AND CONCLUSIONS

V. DISCUSSION AND CONCLUSIONS

The Village Health Volunteers Program

The FPHH Project seems to be a useful supplement to the National Family Planning Program of Thailand. Government officials, including the director general of the Ministry of Health (MOH), provincial chief medical officers, and district health officers, confirm this. These health officials believe that the program is well run and that it is at a more convenient location, provides more hours of service, and offers a greater variety of oral contraceptives than government outlets. They note that other health and hygiene functions either are irregular or absent. They stress that government village health volunteers and CBFPS distributors are chosen on the basis of different criteria, the former for their leadership potential and the latter for their marketing ability.

To achieve primary health care for all by the year 2000, the Thai government is proceeding vigorously with the village health volunteer training program. In addition to accomplishing nine health care tasks, the VHVs eventually will distribute contraceptives. Health officials at every level feel that the VHV system, when it is fully developed, will in fact replace the local contraceptive distribution activities of the CBFPS. However, they believe that the VHVs and CBFPS distributors can coexist at this time, with the latter concentrating on family planning activities only. Health officials are concerned that the VHVs may not be able to perform all their required tasks.

Given the prevailing sentiment, it is clear that the MOH does not favor the expansion of the FPHH program beyond the current CBFPS operating districts. However, the VHV program has had only limited success in delivering contraceptives, and it is questionable that the VHVs will succeed in providing family planning services to the deep rural areas. Therefore, the evaluation team recommends continued support of the CBFPS. It also recommends that the system be maintained until the role of the VHVs in the distribution of contraceptives becomes clear.

Subsidized Commercial Retail Sales

It now costs the commercial firms in Bangkok \$0.20-\$0.25 to move a cycle of oral contraceptives to drug stores, including drug stores in small towns. The corresponding cost for the CBFPS is \$0.56. One must bear in mind that the CBFPS operates a distribution system that penetrates deeply into the rural areas. In addition, its network of district supervisors and village distributors provides a structure for special campaigns, such as sterilization or economic development activities.

Several questions may be raised, however. For example, would subsidized contraceptive retail sales (CRS) through wholesalers lower the cost of contraceptive distribution and help the Thai government finance the purchase of contraceptives? Could subsidized CRS increase the already high rate of pill use? These are complicated questions; their answers depend on the presence of many factors, a discussion of which is beyond the scope of this report. The American Public Health Association (APHA) consultant, Professor John Farley, will address these issues in a separate document.

Cost Recovery

In general, the evaluation team believes that the FPHH Project is well-run but can be made more cost-effective. Project revenues now cover approximately 25 percent of total costs. The evaluation team recommends that the CBFPS set a goal of 50 percent cost recovery within two years. (See Chapter VI.)

Is this goal realistic? The director of the CBFPS, Khun Mechai, thinks it is. He suggests the following action:

1. Increase the price of OCs by 1฿ for each brand; increase the distribution of Eugynon, or add a fourth brand at 11฿ a cycle.
2. Consolidate the program by integrating the 80 former IPPF* districts with the 80 FPHH districts. The former cover more urbanized, more affluent districts and are recovering more costs.
3. Provide maternal and child health (MCH) care and full family planning services, including the injectables supplied by the Germans, using mobile clinics; charge for these services.
4. Increase commercial activities by helping the village distributors set up drug cooperatives. The coops should carry repeat items, such as soap powder, vegetable seeds, and fertilizers.

* International Planned Parenthood Federation.

VI. RECOMMENDATIONS

VI. RECOMMENDATIONS

The evaluation team met after the field trips and agreed on the following recommendations.

Short-Term Action

The evaluators recommend continued support of the CBPFS in the short term, because the village health volunteers system cannot cover every village. Some modifications should be made to make the system more cost-effective.

Based on Professor Farley's preliminary assessment of the feasibility of a national subsidized contraceptive retail sales program, the evaluators recommend that a full-scale feasibility study be carried out. This study should include a complete assessment of the economic and organizational issues peculiar to such a program.

Long-Term Action

The system should be kept intact until the role of the village health volunteers in the distribution of contraceptive products is made clear. If the VHV system provides pills either free or at low cost, the CBPFS program is likely to shrink.

The evaluators recommend that the Steering Committee reevaluate the program in two years in the context of the National Family Planning Program.

Operational Problems and Recommendations

The evaluators have identified the following as operational problems. Recommended solutions to these problems are provided.

1. Problem

Village distributors run out of stock frequently.

Recommendation

Increase the inventories of the village distributors, perhaps by as much as 50 percent.

2. Problem

Approximately two-fifths of all distributors did not order in the last month.

Recommendation

District supervisors and field officers should be instructed to attempt to reactivate inactive accounts. This can be done by calling more frequently on low-performance village distributors. Those village distributors who are not interested in continuing should be replaced whenever possible.

3. Problem

The net distribution costs for oral contraceptives require a subsidy of 56 cents per cycle.

Recommendation

Reduce staff where possible; reduce costs 12-15 percent, primarily by eliminating activities that were required earlier for research and experimentation.

4. Problem

Revenues cover approximately 25 percent of total costs.

Recommendation

Set a goal of 50 percent recovery within two years, and restructure the operation to achieve this result.

5. Problem

Transportation costs are a major difficulty for district supervisors.

Recommendation

Compensate district supervisors for fuel consumed in their work.

6. Problem

Referrals are not universal.

Recommendation

Provide additional training to the village distributors, stressing referrals in addition to female sterilization and vasectomy. The distributor should be allowed to meet the personnel to whom he refers his clients.

APPENDICES

Appendix A
SCOPE OF WORK

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

February 23, 1981

MEMORANDUM:

TO : Distribution

FROM : Marnie Chen, DS/POP/R *MC*

SUBJECT: SCOPE OF WORK FOR TEAM EVALUATION, FAMILY PLANNING HEALTH AND HYGIENE PROJECT, THE CBFPS, THAILAND

A. Background: The FPHH project is a community-based social marketing project which was begun in June of 1977. Four contrasting community based social marketing schemes have been carried out. They are referred to as the "four models":

Model A: Only contraceptives provided by CBFPS, for sale at low prices.

Model B: As above, but with two months free introductory supply of pills and condoms to be distributed throughout the village to those eligible and willing to try their use.

Model C: As in Model A above, but combined with household drugs and orientation for health services/referrals.

Model D: As in Model C above, with initial free distribution of contraceptives as in Model B.

It was hypothesized that free introductory supply of contraceptives and the inclusion of household drugs would increase the cost effectiveness of the contraceptive distribution system.

About 5,800 village distributors received one to two days training to become the depot holders. They sell oral contraceptives, condoms and a few household drugs at subsidized prices to a rural population of about 6.5 million.

Based on the accumulated experience from the various CBFPS projects, a "Model E" service delivery system was designed, and implementation started in December of 1979. Eventually Model E will be carried out in all the 80 FPHH project districts. In essence, three categories of services are provided by Model E:

(1) Family Planning: village distributors will sell three kinds of oral contraceptives: Norinyl, Ovostat and Engynon. They will continue to sell condoms. Neo Sampoo foaming tablets will be added to the contraceptive mix, aiming primarily at post-partum, nursing mothers and those who reject OC and condom. Village distributors will refer clients interested in IUD and sterilization to the government service. However, in villages where there are many clients, CBFPS will send out mobile clinics to perform sterilization.

(2) Health and Hygiene: Village distributors will sell and promote certain household drugs including oral rehydration salt, multi-vitamin tablets, and anti-parasite drugs.

(3) Promotion and Referral: Village distributors, with the assistance of CBFPS central office staff, will promote breast feeding, and certain economic development activities, and make referrals for immunization and sick care.

- B. Purpose and Rationale for Team Evaluation: The Pro Ag 932-0632-9003 has specified that there would be a team evaluation of the project in early 1981, prior to project termination date in September 1981. The purposes of this team evaluation are to (1) review the performance of CBFPS toward achievement of the programmatic and research objectives of the FPHH project, (2) identify potential modifications to FPHH system relevant to marketing, pricing, promotion and distribution, and (3) provide specific recommendations for the RTG and USAID regarding future utilization of CBFPS resources.

To do so will require (1) interview with key personnel of all concerned major parties to the FPHH project, (2) intensive review of both quantitative and qualitative information about the program inputs, outputs, and cost-effectiveness of the FPHH project, and (3) review of current planned evolution and possible future alternatives for CBFPS.

- C. Composition of the Team: As stated in the FY 80 Pro Ag, the evaluation team will be composed of the responsible AID/W technical officer, a U.S. based operations research specialist, and two Thai counterpart staff; one non-CBFPS evaluation specialist and one CBFPS staff member who will serve as a resource person.

I have invited Professor John Farley of Columbia University Business School to participate as a member of the evaluation team. Prof. Farley is a specialist in social marketing and is well respected in this field. The FPHH project is essentially a community based social marketing project. The project has been reviewed by specialist in community based family planning program (e.g., Dr. Malcolm Potts and Dr. Gary Merritt, team members of the February 1979 evaluation), but it

has never received scrutiny from a social marketing point of view. Since there has been manifestation of interest in a contraceptive retail sales (CRS) program in Thailand from various sources, it is time to explore the feasibility of CRS in Thailand. Prof. Farley's expertise will allow him, in addition to the primary responsibility of reviewing the FPHH project from a marketing point of view, to evaluate the organizational structure of CBFPS as a potential CRS intermediary and make an assessment in regard to market potential in rural and urban Thailand.

I have for more than a year been responsible for the AID/W administration and technical monitoring of the FPHH project. During a visit of 2 weeks to the CBFPS in February, 1980, I interviewed operational and administrative staff of the CBFPS, undertook one brief field visit to rural areas, and reviewed services statistics. I expect to focus on the quantitative analysis of the data from the FPHH experiment, including a cost-effectiveness appraisal.

The AID/Bangkok population officer will be responsible for selecting the two Thai members of the evaluation team.

D. Scope of Work:

(1) Review of quantitative information. The CBFPS has maintained a system of service records which provides essential administrative reporting and commodity logistic data. These data, coupled with financial accounting records, provide the basis for quantitative evaluation.

(2) Interview with key project personnel. Interviews by one or more team members should include at least:

1. CBFPS administrative and operations staff,
2. Members of project Review Committee,
3. Provincial chief and District Medical Officers (preferably from areas birth high and low in project outputs),
4. Village distributors and district supervisors,
5. Key staff of MOPH/NFPP.

It is proposed that for the field interviews, Thai and non-Thai members of the evaluation team be paired for separate destinations.

(3) Conduct a preliminary assessment of the desirability/potential of establishing a social marketing program in Thailand. In particular, the APHA consultant will make recommendations as to whether a Contraceptive Retail Sale program can be justified in terms of either increased contraceptive usage or in decreased program delivery costs as

compared with those of the government program or the community-based distribution program. In addition, a brief overview of the market dynamics relevant to a CRS program should be examined, particularly in terms of commodity prices and distribution costs. It is expected that the APHA consultant will also determine the current attitude of appropriate AID Mission personnel and MOPH/NFPP personnel vis-a-vis the establishment of a CRS program. Also, the consultant is expected to review, in consultation with AID Population Officer, proposed participants for the upcoming CRS regional conference in India to determine if the proposed candidates are the most appropriate attendees, and to make recommendations for alternative participants, if necessary.

E. Evaluation Agenda:

The evaluation exercise will start on the 23rd of March 1981, and will likely take two weeks. A briefing session will be undertaken with USAID/Bangkok on the initial day (probably A.M. March 23rd).

The evaluation exercise will probably require eight days, including perhaps three days for field site visiting. USAID/Bangkok will require a debriefing, at least on the part of the non-Thai members, proposed to be the tenth day after briefing (i.e. April 1), allowing sometime for post-debriefing follow-up in Thailand. It is expected that the final report should be submitted to APHA by May 15, 1981.

Main features of the agenda is as described above; however, the detailed agenda must be determined by USAID/Bangkok.

DISTRIBUTION:

DS/POP/FPSD: R. Haladay

DS/POP/FPSD: T. Seims

ASIA/TR: E. Muniak

AID/Bangkok: D. Oot

Appendix B

PERFORMANCE AND SOCIAL-ECONOMIC LEVELS OF DISTRICTS

Appendix B

PERFORMANCE AND SOCIAL-ECONOMIC LEVELS OF DISTRICTS

Code: H = High
M = Medium
L = Low

	<u>Performance Level</u>	<u>Social-Economic Level</u>
<u>Northeast Region</u>		
<u>Nakornrajasima Province</u>		
Pakthongchai District	H	H
Muang District	H	H
Nonsung District	L	M
Chakarat District	L	L
<u>Chaiyapoom Province</u>		
Chaturat District	L	H
<u>North Region</u>		
<u>Nakornsawan Province</u>		
Muang District	H	H
Krokpra District	L	M
<u>UthaiThani Province</u>		
Muang District	L	H
Banrai District	L	L

Appendix C

DISTRIBUTION OF SALES PROCEEDS FROM CONDOMS,
ORAL CONTRACEPTIVES, AND HOUSEHOLD DRUGS

Appendix C

DISTRIBUTION OF SALES PROCEEDS FROM CONDOMS, ORAL CONTRACEPTIVES, AND HOUSEHOLD DRUGS

Condoms

Condoms are sold for 1 β each. The distribution of the sales proceeds is:

- Village distributor receives .25 β .
- District adviser (government health officer) receives .25 β .
- CBFPS receives .50 β .

Oral Contraceptives

The per-cycle sale price of oral contraceptives is: Norinyl, 5 β ; Ovostat, 7 β ; and Eugynon, 9 β .

The distribution of the proceeds is:

- Village distributor receives 1 β .
- District adviser receives .50 β .
- CBFPS receives the balance, or 3.5 β -7.5 β .

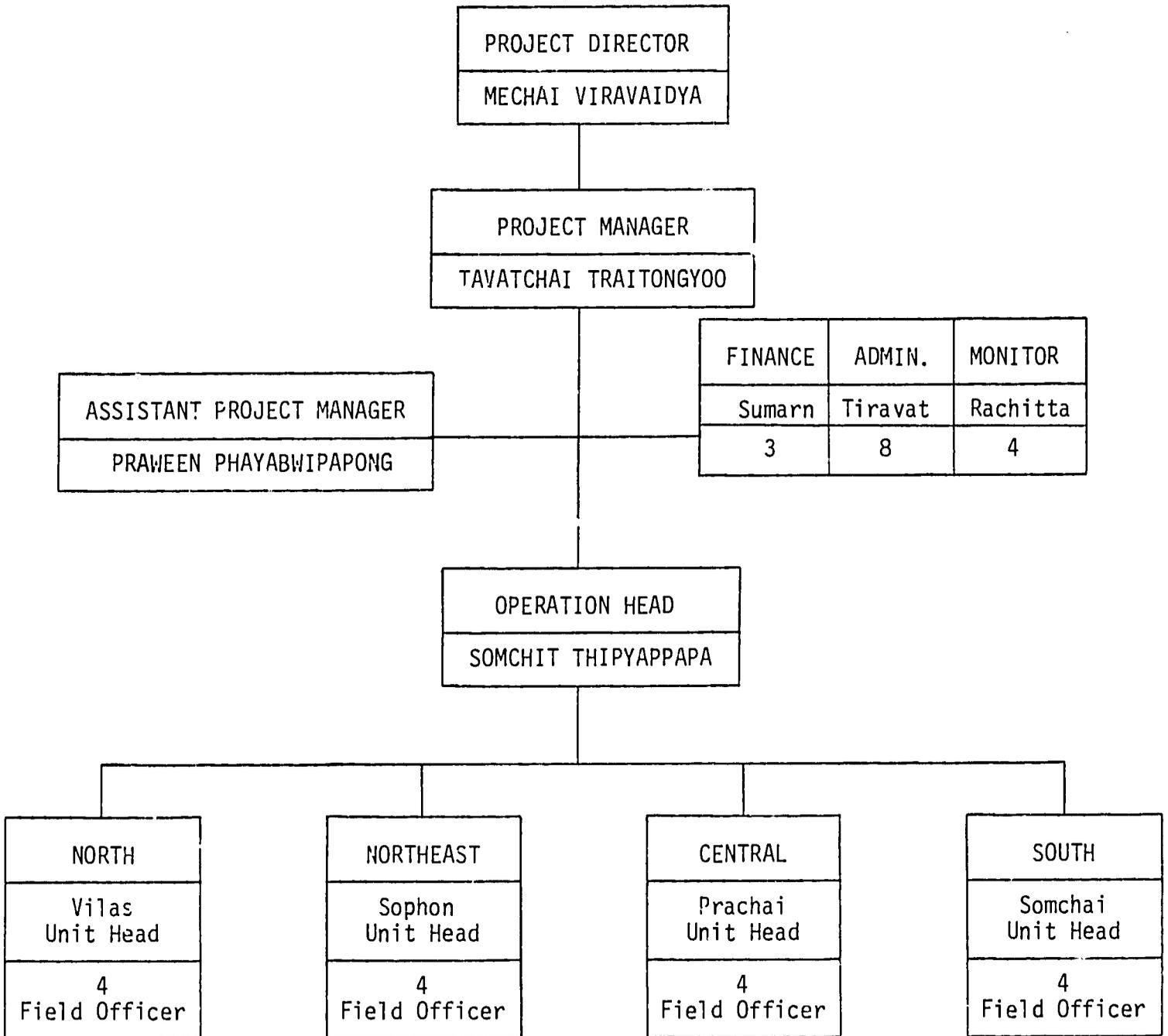
Household Drugs

For every 100 β of sale:

- Village distributor keeps 20 β .
- District supervisor keeps 5 β .
- CBFPS office keeps 10 β for packaging and other handling costs.
- The balance, 65 β , is placed in a revolving fund with which the CBFPS buys more household drugs.

Appendix D
FPHH ORGANIZATIONAL CHART

Appendix D
 FPHH ORGANIZATIONAL CHART



4 Unit Heads
16 Field Officers

1:4 Ratio

80 District Supervisors

1:72 Ratio

5,780 Village Distributors
(Non-Salaried)

Appendix E

FPHH FINANCIAL ANALYSIS
(June 1, 1977 - November 30, 1980)

FFHR PROJECT

FINANCIAL ANALYSIS

June 1, 1977-November 30, 1980

(U.S. Dollars) US\$ = 20¢

I. 1st Year
(June 1, 1977 thru
May 11, 1978)

	BUDGET			ACTUAL		
	AID	CFPS	TOTAL	AID	CFPS	TOTAL
<u>Income</u>						
AID	299,840		299,840	272,852		272,852
Salaries		77,760	77,760		14,534	14,534
TOTAL	299,840	77,760	377,600	272,852	14,534	287,386
<u>Expenditures</u>						
1. Salary	127,640	24,360	152,000	123,146	-	123,146
2. Administration Costs	28,400	-	28,400	31,204	-	31,204
3. Communications	44,700	17,400	62,100	42,722	-	42,722
4. Information & Education	15,000	-	15,000	29,893	-	29,893
5. Per Diem	41,800	18,240	59,840	43,335	7,458	50,793
6. Miscellaneous	12,300	3,200	15,500	12,664	-	12,664
7. Field Development & Support	-	14,760	14,760	77	42	119
TOTAL	299,840	77,760	377,600	272,842	7,500	280,342

II. 2nd Year
(June 1, 1978 thru May 11,
1979)

	BUDGET			ACTUAL		
	AID	CFPS	TOTAL	AID	CFPS	TOTAL
<u>Income</u>						
AID	205,670	-	205,670	205,670	-	205,670
Salaries	-	114,480	114,480	-	60,709	60,709
TOTAL	205,670	114,480	320,150	205,670	60,709	266,379
<u>Expenditures</u>						
1. SALARY	140,100	24,000	164,100	150,395	12,754	163,149
2. Administration Costs	19,200	14,000	33,200	23,497	7,846	31,343
3. Communication	18,000	20,100	38,100	18,400	17,666	36,066
4. Information & Education	8,400	17,600	26,000	9,465	2,194	11,659
5. Per Diem	15,170	16,070	29,440	15,173	10,987	26,160
6. Miscellaneous	8,600	7,750	16,350	8,173	5,912	14,085
7. Field Development & Support	-	14,930	14,930	-	1,057	1,057
TOTAL	205,670	114,480	320,150	222,007	60,616	282,623
AID	205,670	CFPS	TOTAL	222,007	CFPS	TOTAL

BEST AVAILABLE DOCUMENT

III . 3rd year (12 months) (June 1, 1979 through May 31, 1980)

	BUDGET (US\$)			ACTUAL (US\$)		
	AID	CBFPS	TOTAL	AID	CBFPS	TOTAL
<u>Income</u>						
AID	355,000	-	355,000	355,460	-	355,460
Local income	-	82,270	82,270	-	87,359	87,359
TOTAL	355,000	82,270	437,270	355,460	87,359	442,819
<u>Expenditure</u>						
Salary	149,582	44,988	194,370	160,057	8,881	168,938
Administration Costs	23,200	20,080	43,280	22,613	24,718	47,331
Communication	43,360	5,360	53,720	52,513	21,671	74,184
Information & Education	15,000	1,000	16,000	16,105	1,495	17,600
Perdiem	50,000	6,560	56,560	41,740	13,623	55,363
Miscellaneous	24,658	4,282	28,940	27,342	3,314	30,656
Field Development & Support	44,400	-	44,400	17,016	-	17,016
TOTAL	355,000	82,270	437,270	337,386	73,702	411,088

IV. 4th year (6 months) (June 1, 1980 through Nov. 30, 1980)

<u>Income</u>						
AID	173,105	-	173,105	148,416	-	148,416
Local Income	-	46,105	46,105	-	49,432	49,432
TOTAL	173,105	46,105	219,210	148,416	49,432	197,848
<u>Expenditure</u>						
Salary	78,570	20,640	99,210	76,257	15,546	91,803
Administration Costs	12,100	12,000	24,100	11,108	6,783	17,891
Communication	33,335	-	33,335	36,283	65	36,348
Information & Education	8,500	4,350	12,850	7,042	-	7,042
Perdiem	24,450	4,923	29,373	23,356	-	23,356
Miscellaneous	16,150	4,192	20,342	7,552	1,010	8,562
Field Development & Support	-	-	-	2,917	-	2,917
TOTAL	173,105	46,105	219,210	164,515	23,404	187,919
<u>Grand Total</u>						
Income	1,033,615	320,615	1,354,230	962,398	212,034	1,174,432
Expenditure	1,033,615	320,615	1,354,230	996,749	165,222	1,161,971
			Balance	(34,551)	46,812	12,461

Appendix F

LIST OF PERSONS INTERVIEWED ON FIELD TRIP

Appendix F

LIST OF PERSONS INTERVIEWED ON FIELD TRIP

Provincial Chief Medical Officers

Dr. Soonthan Thongkong, Nakornsawan

Dr. Pajit, Nakornrajasima

District Health Officers

Amnay Pipitgun, Nonsung

Sirilaorit, Pakthongchai Muang

Payont Sittinun, Krok Pra

Chais Kongping, Nakornsawan Muang

Thawyak, Utaithani Muang

Prasarn Parnduang, Banrai

District Supervisors

Sarin Pawpai, Utaithani Muang

Tawesin Binvekok, Banrai

Somyot Pong Chang, Nakornsawan Muang

Manus Yodbopius, Korkpra

Poj Puttaragsa, Pakthongchai

Permsakdi Wao-Kok-Sung, Muang Korat

Marakot Rimpingong, Chakkarat

Parton Intraumportn, Nonsung

Boonmee Samoadmoo, Chaturat

Village Distributors

Thanon -Yodboa, Nurnkwas
Boonyune Chattan, Hardthanong
Sawit Onehawe, Sakaekrung
Sanit Wanjapoh, Ban Thongchai
Boo Amutaku, Ban Prommarat
Kusol Chaisri, Ban Nonban
Seving, Sakakrung
Sod Hataborn, Murnkrao
Sampon Huttaboorn, Kakorn Sawan
Prasit, Nongkrot
Chalern, Bangmuang
Sawai Boonsume, Bangmuang
Pranorn Singbumrung, Watsai
Sakorn Sitisaruay, Huahang
Charas Putsiri, Huahang
Ampan Thipkaevee, Banrai
Darun Srathonglang, Ban Nongtayoy
Serng Runtalae, Ban Palai
Chan Pitkok, Ban Pradoke
Chanpen Harployklang, Ban Nongorh
Duang Mungsaklang, Ban Korhong

Appendix G
LIST OF RESOURCE PERSONS

Appendix G

LIST OF RESOURCE PERSONS

Ministry of Public Health

Dr. Amorn Nontasut, Director General, Department of Health

Dr. Somsak Vorakamin, Director, Family Health Division,
Department of Health

Mr. Tony Bennett, Adviser, Research and Evaluation, Family Health
Division, National Family Planning Program

U.S. Agency for International Development

Donald Cohen, Mission Director

David Oot, Population Adviser

Khun Karim, Program Officer

Community-Based Family Planning Services

Mechai Viravaidya, Director

Tavatchai Traitongyoo, Deputy Director

Tanothai Sookdhis, Acting Director, Asian Training Center;
Head, Urban Condom Sales Program

Somchit Tipprapa, Head, Operations Division

Rachitta Napattalung, Head, Monitoring and Research Unit

Sophon Sirivong, Head, Operation Unit I

Vilas Rohitakul, Head, Operation Unit II

Mahidol University

Dr. Debhanom Muangman, Dean, Faculty of Public Health

Appendix H

FIELD OBSERVATIONS ON VILLAGE DISTRIBUTORS

Appendix H

FIELD OBSERVATIONS ON VILLAGE DISTRIBUTORS

The following observations were made during the field trips:

- All but three shopkeeper-distributors displayed the pills.
- All but one distributor displayed the current CBFPS poster.
- Sterilization is having a major impact on sales, as is the opening of new health centers.
- Some distributors, especially shopkeepers, mentioned a lack of time for project activities other than contraceptive distribution.
- Some distributors asked for additional or refresher training.
- One distributor asked for more sales promotion stressing the social aspects of the program; he also suggested that pills be given free and that the other drugs be sold.
- Several distributors mentioned that their sales have improved because of short hours and expense in getting to the government health centers.
- One distributor said his only reliable source of (drug) supply was the provincial health center.

Eleven distributors reported stock-outs of products on occasion, although no stock-outs were observed. Only two distributors reported that customers were dissatisfied with the pill, primarily because of side effects. All considered the commission adequate; problems with records occurred in only three cases, two because of a misunderstanding and one because records were behind. The majority also showed evidence of a good understanding of the various products in the line.