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THE COMMUNITY-BASED FAMILY PLANNING SERVICES
FAMILY PLANNING HEALTH & HYGIENE
(FPHH)
PROJECT

A Report Prepared By:

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I. EXECUTIVE SUMMARY

In 1977, Community-Based Family Planning Services (CBFPS) began an operation research project, the Family Planning Health and Hygiene (FPHH) Project, to test the hypothesis that family planning services, when combined with health services, will be more cost effective and more acceptable to the community than when family planning is offered in isolation. A Team evaluated the FPHH Project in February, 1979, to review the performance of CBFPS and to make recommendations to the Royal Thai Government and USAID.

By December, 1978, 5,800 village distributors had been trained in 80 districts, which were divided into four model areas designed to test the above hypothesis. The experiment also compared free introductory contraceptive pills with the sale of every cycle.

The project was well implemented and accurate records are available. A base line survey was conducted in 1977. Service statistics demonstrate that the inclusion of household drugs approximately doubles the cost of providing services, but is not associated with any increased contraceptive usage. Neither the CBFPS distributors nor the Village Health Volunteers (VHV) of the Ministry of Public Health are offering primary health care. Rather, they are helping ameliorate a number of common, non-life threatening complaints.

It is recommended that USAID continue to support a modified operations research program, and that the RTG and CBFPS consider this report as a point of reference for determining alternative ways in which the CBFPS can best complement the government's family planning services. CBFPS has a unique contribution to make to village development, and it is important that their work is linked to the existing government structure at the provincial and district level.

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II. INTRODUCTION

A. OBJECTIVES AND SCOPE OF WORK

1. The official documentation for the FPHH operations research project specified that there would be an intensive team evaluation of the project prior to consideration of scheduled funding for project years three and four: "The project will make decisions which can significantly alter the status and the plans of operations of the project. The first will be at the end of the first year, and the second at the ninth month of the second year at which time all facets of the project will be closely analyzed to determine the progress. For each delivery system, the following categories of decision will be made: continue the system(s) unchanged; continue the system(s), modified; expand the system(s), modified; terminate the system(s)."
2. The purposes of the current evaluation were to (1) review the performance of CBFPS and Mahidol University toward achievement of the programmatic and research objectives of the investigation, and (2) provide specific recommendations for the RTC and USAID regarding future utilization of CBFPS resources.
3. The evaluation was undertaken by the American Public Health Association (APHA) under contract with USAID. The two members from APHA, Bruce D. Carlson and Malcolm Potts, joined with seven others to form the Evaluation Team (See List). Dr. Debhanom Muangman, Dean of the Faculty of Public Health of Mahidol University, served as the team leader.

B. METHODOLOGY

1. The Evaluation Team reviewed the FPHH Project in Thailand between February 12 and 24, 1979. The Team interviewed key resource persons from the MOHP, Mahidol University, CBFPS and USAID at the central level (Appendix II) and made site visits to representative project and control areas (Appendix III).
2. An intensive review was made of both quantitative and qualitative information about the family planning outputs and comparative cost-effectiveness of the four experimental models within the FPHH. The Team reviewed budget and performance figures to assess cost effectiveness and made a critical appraisal of the accuracy and validity of the data. The Team reviewed the current evolution of the project and assembled options for future developments in FPHH and CBFPS.
3. The Team met frequently throughout the two-week evaluation to compare notes and review various drafts of the report. By the end of the second week, the Team was able to reach a consensus regarding the Major Findings and Recommendations and to make an oral presentation to both the USAID Mission in Thailand and to CBFPS.

III. MAJOR FINDINGS

- A. The Community-Based Family Planning Services (CBFPS) has achieved most of the objectives of the Family Planning Health & Hygiene (FPHH) Project as outlined in the agreement signed between the Royal Thai Government (RTG) and the U.S. Agency for International Development (USAID):
1. The CBFPS has selected, trained and made operational 80 district supervisors and 5,800 village distributors in 29 provinces, covering 6.5 million people.
 2. As of December 30, 1978 the FPHH had reached 65,072 new pill acceptors.
 3. In the four model areas combined, the FPHH project attained an estimated 80 percent of the acceptor targets. The target for acceptors was achieved only in Model A (contraceptives only).
 4. The total expenditure, as of November 30, 1978, was \$406,000. The income (\$40,914) from all areas is now reaching 60 percent of the targets. However, in Model A the target has been exceeded, attaining 50 percent more income than the next highest model area.
 5. The introductory promotion of two free cycles of pills in Models B and D was not uniformly carried out by the village distributors. Nevertheless, the CBFPS did distribute two free cycles to 82,000 households.
- B. The FPHH was implemented with sufficient precision and adherence to experimental requirements to provide information on which to make management decisions about the best use of resources. The results clearly indicate that, at least in the context of CBFPS village distributor systems, the inclusion of household drugs approximately doubles the cost of providing services, but is not associated with any increased contraceptive usage.
- C. In addition, it is noted that the household drugs treat minor ailments but are unlikely to provide demonstrable improvements in health.
- D. The FPHH project is one of the first and perhaps best-documented projects studying the combinations of family planning and simple health care. The FPHH data indicate that the provision of family planning by village volunteers is likely (by reducing the risks associated with unplanned pregnancy) to make a more significant contribution to lowering rural morbidity and mortality rates than the distribution of household drugs.

- E. Despite the achievements of the FPHH in the sale of contraceptives and household drugs at modest prices, the CBFPS cannot expect to become self-sufficient by the end of 1981. CBFPS will likely require continued support, particularly with respect to the supplies.

- F. The "free pill" policy of the MOPH has undoubtedly resulted in a lower rate of increase in the number of acceptors under the FPHH project, thereby lowering the level of income anticipated by CBFPS.

- G. Although the Ministry of Public Health (MOPH) has authorized CBFPS to operate the FPHH project in 80 districts, many government officials at the provincial level remain either confused or uncertain regarding the role of CBFPS. The situation is exacerbated by the gradual implementation of the primary health care worker program under the MOPH's Population Project.

- H. The Faculty of Public Health of Mahidol University successfully carried out the baseline survey during 1977.

IV. RECOMMENDATIONS

A. GENERAL

1. That the RTG and USAID continue support to CBFPS for operations research on the cost-effectiveness of variations in family planning delivery systems.
2. That the RTG and CBFPS consider the Evaluation Team's report as a point of reference for identifying and discussing alternative ways in which the CBFPS can best complement the government's existing and planned family planning services, particularly the Village Health Volunteer (VHV) program, in order to avoid what could possibly become an either/or "no win" situation with respect to expansion of integrated health and family planning services.
3. That the findings of the FPHH Project be widely disseminated by the RTG and USAID in Thai and English.
4. That, unless documentation to the contrary is forthcoming from some other source, any decisions regarding support for projects involving simple health care and family planning deal with each type of service on a separate analytical basis rather than rely on assumptions that any component of health care when linked with family planning services will increase the acceptance of contraception and voluntary sterilization.

B. ORGANIZATION AND MANAGEMENT OF FPHH PROJECT

1. That the CBFPS, in consultation with the Project Review Committee, continue and modify the FPHH contraceptive delivery and operations research strategy:
 - a. By managing the 80 CBFPS-designated districts (ABCD) as a common experimental area in which new and modified models can be tested next in order to determine the most appropriate supervisory and logistical systems for CBFPS to adopt in order to complement the RTG program in simple health care and family planning.
 - b. By deciding on the use or non-use of household medicines within the context of public health needs and the policy set by the RTG and not on the basis of an operationally desirable need to combine contraceptive distribution with simple health care models.
 - c. By combining the FPHH and former IPPF project review steering committees into one. The new Committee should meet at least twice per year to review progress reports and set guidelines and be charged with the responsibility of establishing liaison with a representative of the Ministry's Population Project.

2. That a decision on the follow-up survey be deferred until early 1980, contingent upon the practical utility of such a survey both to the RTG and National Family Planning Program (NFPP) as well as the CBFPS. In order to meet the requirements of AID's budgetary cycle, the Project Review Committee must make the decision prior to March 30, 1980.

C. CONTENT OF FPP4 PROJECT

1. That, since, the baseline survey indicates 80 percent of rural contraceptive acceptors are practicing family planning in order to limit pregnancies:
 - a. Consideration be given to the supply of additional family planning methods appropriate for extending the pregnancy interval, including attention to the selection of appropriate steroids for women who are lactating.
 - b. CBFPS village distributors be more effectively used as referral agents for voluntary sterilization, in order to serve the needs of the majority of couples who wish to end childbearing.
2. That, since the training and supervisory systems could be designed to manage the use of more effective therapies, the Project Review Committee review the type of drugs distributed by CBFPS village distributors (and MOPH village health volunteers) and make recommendations to the RTG regarding the pharmaceuticals on the statutory dangerous drug list.

D. BEYOND THE FPHH PROJECT

1. That the CBFPS explore ways, under the guidance of the RTG, in which the private sector can complement the government's voluntary sterilization services, particularly with respect to male sterilization.
2. That the RTG use the experience of CBFPS to complement government family planning activities throughout the country by developing a network, particularly among village shopkeepers, to widen the mix of contraceptive services to that portion of the population who can, or prefer, to pay. In addition to the pill and condom, CBFPS could explore the design, packaging and marketing of additional low-cost, non-permanent methods of contraception, including a distinctive brand for use through both government and private sector outlets.

V. BACKGROUND

A. FAMILY PLANNING IN THAILAND

1. The Royal Thai Government (RTG) adopted a national family planning policy in 1970. During the Third Five-Year Plan (1972-1976) the population growth rate fell from over 3 percent per annum to approximately 2.55 percent by the end of 1976.
2. Currently, the country is in an important transitional stage. With 45 percent of the population under the age of 15 and an average completed family size of 6.4, it still faces serious demographic problems. However, the desired family size has fallen from 4 in 1973 to 3.7 in 1975. There appears to be a strong desire for family planning in many areas. A recent prevalence survey of contraceptive use estimated current use of contraception to be near 50 percent of eligible Thai couples. Nearly 1 out of 5 are using the pill and 1 out of 6 have received a sterilization procedure (preliminary tabulations of the Westinghouse Contraceptive Prevalence Survey, November, 1978).
3. The RTG has always sought frank analysis of the problems facing the country and has consistently provided an environment in which innovations in village health and family planning services could be tested.
4. In the early 1970's two key test programs were launched. In 1974, the Ministry of Public Health (MOPH) began a health delivery system in the villages of Lampang Province partly designed to test the appropriateness of using village health volunteers (VHVs) in primary health care. In the same year, Community-Based Family Planning Services (CBFPS) was founded in order to supplement and extend government services. CBFPS work was initially confined to the distribution of oral contraceptives and condoms through a variety of outlets. Like the Lampang Project, CBFPS relied greatly on trained and supervised part-time village workers. CBFPS set out to test:
 - a. The possibility of markedly expanding access to and information about contraceptive methods.
 - b. The possibility of creating new and increased demand for family planning at the village level so as to increase the total number of couples practicing family planning and in turn bring about a measurable decrease in the pregnancy rate.

CBFPS sought to become partially self-sufficient as a result of funding generated in exchange for contraceptives and by the sale of promotional items such as T-shirts.

5. The second half of the 1970's has been a time of building nationwide services on the pilot projects of earlier years. The RTG invited the World Bank to consider assistance in health and family planning for the Fourth Five-year National Economic and Social Development Plan which began in 1977. A U.S. \$66.0 million package was put together, one component of which was to intensify health and family planning services in rural areas, including the use of VHV's in the distribution of household drugs and the resupply of oral contraceptives. Based on data collected in 1974, the RTG and World Bank selected 20 provinces of the 71 provinces in Thailand where health services and contraceptive use was low in which to implement the Population Project.

Between May and September of 1976 CBFPS entered into negotiations with the RTG and USAID to fund contraceptive services in 80 rural districts. The Family Planning Health and Hygiene (FPHH) that developed is the basis of this evaluation.

B. OTHER PATTERNS OF CONTRACEPTIVE, DRUG DISTRIBUTION AND MEDICAL ADVICE IN RURAL THAILAND

1. Thailand was the first country in the world to encourage oral contraceptive distribution through auxiliary medical workers. In late 1970 midwives, after screening women with a checklist of medical questions in an attempt to eliminate those who might have any contraindication to pill use, were permitted to distribute pills. Nationwide use increased rapidly in the following months. A second important step in policy evolution occurred in 1974 when CBFPS initiated the system of delegated-medical distribution described above. During the planning and execution of the FPHH project additional experiments in the non-medical distribution of oral contraceptives have occurred. By January, 1979 the following groups either had been or were distributing contraceptives in at least some villages:
 - a. Village Health Volunteers (VHVs), under the Ministry of Public Health, are delegated the responsibility of resupplying contraceptive pill users free of charge.
 - b. Members of the Thai Nurses Association initiate and resupply pill users free of charge.
 - c. CBFPS distributors (mostly shopkeepers) distribute pills at 5 Baht and 7 Baht a cycle (1 Baht = 25¢ U.S.).

*Tambon doctors and T.B.A.'s trained in family planning had authority to distribute pills until late 1978 when that authority was withdrawn.

- d. Pills are available de facto without prescription in most drug stores for up to 18 Baht a cycle. (See Appendix I)
- e. Village stores and traditional village healers (quack doctors) invariably hold stocks of medicine and carry out an impressive range of clinical procedures as evidenced in Tables 1 and 2.

Table 1.

Types of Drugs Used by Village Healers in Medical Treatment at Po Thong District, Angthong Province, Thailand*

Type of Drugs Used	% Village Healers
1. Combination of Western and Traditional Medicines	62
2. Western Medicines Only	38
3. Traditional Medicines Only	10

Table 2.

Treatment Techniques of "Village Healers" at Po Thong District, Angthong Province, Thailand*

Treatment Technique	Medical Performance			No Performance	No Answer
	Frequent	Infrequent	Total		
1. Intramuscular injection of drugs	35(83%)	7(7%)	42(100%)	0	0
2. I.V. Injection of drugs	31(74%)	11(26%)	42(100%)	0	0
3. I.V. saline administration	20(48%)	21(50%)	41(98%)	1(2%)	0
4. Lancing boils	22(52%)	14(33%)	36(86%)	0	6(14%)
5. Suturing of wounds	26(62%)	0	26(62%)	13(31%)	3(7%)
6. Sell government's household drugs	-	-	9(21%)	24(57%)	9(21%)
7. Perform vasectomy	-	-	5(12%)	30(71%)	7(17%)
8. Delivery of babies	-	-	3(7%)	36(86%)	3(7%)

*Debhanom Muangman, M.D., Dr. P.H., Knowledge, Attitudes and Practices of "Village Healers" at Po Thong District, Angthong Province, Faculty of Public Health, Mahidol University, Bangkok, Thailand, 1976.

2. It should be emphasized that about 50 percent of CBFPS volunteers are also village shopkeepers who almost without exception, carry traditional and modern drugs, balms and household remedies. Most also carry emmenogues (drugs supposed to bring on a delayed period). In some cases, CBFPS volunteers are also malaria eradication volunteers, or traditional doctors.
3. A survey in 1970 by the MOPH found that 51.6 percent of the people in Thailand turn to drug stores and self treatment and 6.6 percent to health centers if they are sick. A quarter use private doctors and 7.7 percent use "injection doctors" or indigenous midwives. Among the reasons stated for not using health centers are "too much time wasted" or "inconvenient to reach" (20 percent) and "personnel spoke rudely" (7 percent). In the rural fringe areas of Bangkok, families spend 66 Baht a month on medical care (26 Baht on medicines and 40 Baht on services) or 4.8 percent of their total income.
4. While the diversity of contraceptive outlets is welcomed and contributes to the high use of oral contraceptives found in the country (estimated to be 19 percent of MWRA, nationwide, November, 1978) it has preempted some of the experimental aims of the original FPHH project. Some areas planned as controls now have access to village depot holders for contraceptives. The availability of alternative sources of household drugs is even wider and may present hazards as well as benefits to the village user.

VI. FAMILY PLANNING HEALTH AND HYGIENE (FPHH) PROJECT

A. HYPOTHESES

1. The FPHH Project was conceived as a piece of action research to test the relative cost effectiveness of various types of family planning delivery systems in rural Thailand. The hypotheses to be examined were:
 - a. Family planning services combined with health services will be more cost effective than delivery systems offering only family planning services.
 - b. Family planning services combined with health services will be more likely to be self-sufficient than family planning services alone.
 - c. The availability of free introductory supply of contraceptives will be more cost effective than delivery systems not offering introductory supplies.

B. SUPPORT

1. The Ministry of Public Health agreed to oversee the project and participate in training, supervision and provision of medical facilities at the district level.
2. The Faculty of Public Health, Mahidol University has provided technical assistance to CBFPS, especially in the areas of health and evaluation. Specifically Mahidol University:
 - a. Assisted CBFPS in the training of the project's trainers with particular emphasis on health and hygiene components to enable the trainers to train village agents.
 - b. Developed the technical aspects of visual materials to train agents in their health component responsibilities.
 - c. Took the leading role in the evaluation of the project in terms of surveys including the sample design, questionnaire development, analysis of survey data, and reports of surveys.
 - d. Assisted the Project in the recruitment and training and supervision of interviewers, quality control procedures for the survey instruments.

C. ORGANIZATION

1. CBFPS is responsible for the management of the project through the CBFPS Deputy Director (Tavatchai Traitongyoo) who was appointed as the Project Manager. The Director of the CBFPS (Mechai Viravaidya) acts as the Project Director. The CBFPS is responsible for the overall day-to-day management of program implementation including financial accountability and all accounting systems. SGV-NA Thalang and Co. has been appointed the financial auditors.
2. A Project Review Committee was established. The members of the Committee, apart from the Project Manager, include one representative from each of the following organizations:
 - National Family Planning Program (NFPP)
 - Ministry of Public Health (MOPH)
 - Faculty of Public Health, Mahidol University
 - Department of Technical and Economic Cooperation (DTEC)
 - Community-Based Family Planning Services (CBFPS)

In addition, the relevant Provincial Chief Medical Officers participate in Committee meetings when the activities discussed concern their province.

D. MODEL AREAS

1. The project was designed to be implemented in 80 districts of Thailand covering a population of approximately 5.6 million. Twenty-six districts each from North and Northeastern Thailand, twenty districts from Central and eight districts from Southern Thailand were selected. (See Table 3)
2. Four contrasting operational models for community-based distribution of contraceptives were devised (all are quasi-commercial):
 - 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.

Table 3.

Number of Districts under the FPHH Project

Model	Number of Districts				Total
	Central	North	Northeast	South	
A	5	7	6	2	20
B	5	6	7	2	20
C	5	6	7	2	20
D	<u>5</u>	<u>7</u>	<u>6</u>	<u>2</u>	<u>20</u>
Total	<u>20</u>	<u>26</u>	<u>26</u>	<u>8</u>	<u>80</u>

E. IMPLEMENTATION

1. Each type of delivery system was placed in twenty districts, each with an approximate population of 70,000. In addition to these 80 treatment districts, four districts in the Northeast were used for control purposes, the study population totalling approximately six million. As far as possible, clusters of districts were selected in order to minimize transportation costs and logistical problems. The delivery systems built upon the experience the CBFPS had gained under its earlier Village Distribution Program and drew upon the experiences of other innovative projects such as the Lampang district project of the Ministry of Public Health..
2. CBFPS central staff spent an average of 15 days in each district developing contacts with Provincial Chief Medical Officers (PCMO's), and local government officers and selecting village distributors. The training program for distributors who would handle household drugs (C & D) was two days compared with areas A & B which was one day only.
3. The "Health and Hygiene" component was related to the basic complaints of Thai villages and evolved around the simple diagnosis and treatment of parasites, headache and fevers, stomach aches, cuts, burns, simple first-aid, certain skin conditions and environmental sanitation. The health training input was directly related to the drugs to be supplied in the kit, which consisted of:

Supplies for Health Kit (Initial Consignment)

(The first seven were said to be the most-frequently purchased drugs in villages)

- | | |
|---------------------------------------|-------------------------------|
| 1. Aspirin | 14. Tincture Merthiolate |
| 2. Expectorant | 15. Ear Drops |
| 3. Sulfaguanadine | 16. Sulfa Ointment |
| 4. Bismuth et Soda | 17. Sulphur Ointment |
| 5. Cough Syrup | 18. Benzil |
| 6. Mis-histomacha
(liquid antacid) | 19. Lotion for Burns & Scalds |
| 7. Sodamint | 20. Tincture of Iodine |
| 8. Antacid pills | 21. Mercurochrome |
| 9. Vitamin B 1 | 22. Acriflavine |
| 10. Vitamin B Complex | 23. Methyl Ointment |
| 11. Tincture of Camphor | 24. Gauze |
| 12. Eye Drops | 25. Cotton |
| 13. Whitfield's Ointment | 26. Adhesive tape |

Total Cost US\$ 25 per kit

4. Upon completion of the training the distributors return with their supplies and begin work. A depot sign is posted in front of their place of work, house or shop. They are requested to inform the villagers through village meetings, or by word of mouth.

F. BASELINE SURVEY

1. Mahidol University designed, tested and implemented the baseline survey between March and August, 1977. The results were published in September, 1978. The sample of 1,000 villages (8,000 households) covered 32 districts of the Northeast region. It did not include villages with government health centers. The following general conclusions were reached as a result of the baseline survey:
 - a. The average age of women of reproductive age in the household was 29-31 years and the average age of marriage was 19 to 21 years old.
 - b. The average number of living children (3.3-3.7) closely approximated the ideal number of children desired (3.5-3.9). Respondents in the five types of districts reported prevalence of pregnancy ranging from 9.8 to 11.6 percent. Desire for more children was reported by 35.7 to 39.4 percent across the five groups of experimental and control districts.

- c. Among the sample of respondents, virtually 100 percent knew of at least one method of contraception. Prevalence of contraceptive practice ranged from 31 to 42 percent across treatment and control district groups. Most were using the pill, while the second most popular method was female sterilization.
 - d. An additional 37 to 45 percent intended to practice birth control mostly for reasons of birth limiting once ideal family size is reached.
2. Based on data from 1974 the RTG and World Bank selected 20 provinces where contraceptive use was low in which to implement the above-mentioned Population Project. In the interim CBFPS concluded the FPHH project development and began work. Dr. Amorn Nonthasut, Deputy Under-Secretary of State, Ministry of Public Health requested all Governors (3rd November 1977) to ask "All PCMOs not to implement the HPV-PHC project in those villages or districts in which CBFPS is implementing its village volunteer program." However, although PCMO's are trying to avoid overlap of the various volunteer projects, by the end of 1978, 19 of the 32 districts chosen for the baseline survey also had VHV's.

VII. GENERAL FINDINGS

A. ORGANIZATION AND MANAGEMENT OF FPHH PROJECT

1. Structure

- a. In broad terms, the FPHH experiment investigates the organizational and administrative problems posed in taking needed modern technologies into traditional village societies. It helps determine the best way to use what are always limited resources, and to set priorities for the sequence of technologies that can and need to be introduced.
- b. The project is one area of activity in the broad and expanding scope of work of an organization called The Population and Community Development Association (PDA). The PDA grew out of the work of the Community-Based Family Planning Services (CBFPS) which was established in 1974 with funding and contraceptives from the International Planned Parenthood Federation (IPPF). The CBFPS is the major bureau and implementation arm of the PDA. Other bureaus include The Asian Center for Population and Community Development and The Community-Based Appropriate Technology and Development Services (CBATDS). Affiliated with the PDA, but a separate, legal entity is the Population and Development Company, a non-profit agency.
- c. The Population and Development Company (PDC) was established in 1975, as a non-profit agency, to provide an additional flexible dimension to PDA with the potential of becoming a resource development arm for needy services to be rendered by PDA. The Patpong Clinic, the first medical arm, was established to provide clinical methods of fertility regulation. With further resources developed by the Company, a second clinic was opened in 1977 and in September 1978, a Sterilization Clinic Center was added at PDA headquarters to provide facilities to an expanding demand of fertility limitation. In January 1979, a small farm was purchased to initiate appropriate technology and village livelihood activities.
- d. The Asian Center for Population and Community Development was established under the umbrella of the PDA in mid-1978 to facilitate the transfer of experience in community-based and community-action concepts in population management and development activities within the region and other developing countries. International training courses and seminars will begin in May, 1979.

- e. The Community-Based Appropriate Technology and Development Services (CBATDS) was established in December, 1978 as a special arm to add a development and appropriate technology component to villages where CBFPS change agents have been successful in providing family planning and primary health care. The CBATDS serves as a specialist staff function arm to the CBFPS which is the Association's major line function arm.

2. Manpower

- a. Forty-two staff members in Bangkok (Table 4) contribute to the work of the FPHH project, although nearly all share their skills with other CBFPS projects.

Among the 37 Bangkok-based professional staff, one of the two division managers and two of the seven unit heads are women, as well as 12 of the 26 field officers. Thus 40 percent of the professional staff in Bangkok are women.

Table 4.

FPHH Project Personnel

A. Bangkok-Based

Office of the Director

Director	1	
Project Manager	1	
Secretary	<u>2</u>	= 4

Operations Division

Division Manager	1	
Unit Heads	4	
Field Officers	15	
Secretary	<u>1</u>	= 21

Finance and Administration Division

Division Manager	1	
Unit Heads	3	
Officers (Monitoring)	11	
Secretary	<u>2</u>	= 17
		42

B. Provincial Level

<u>District Supervisors</u>		<u>80</u>
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TOTAL		<u>122</u>
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- b. Tasks are well defined and good team work is apparent. The Director of CDA, Mr. Mechai Viravaidya, is well known for his leadership and organizational capabilities.
- c. As the organization chart on the following page indicates the ratio of the links in the supervisory chain are as follows:

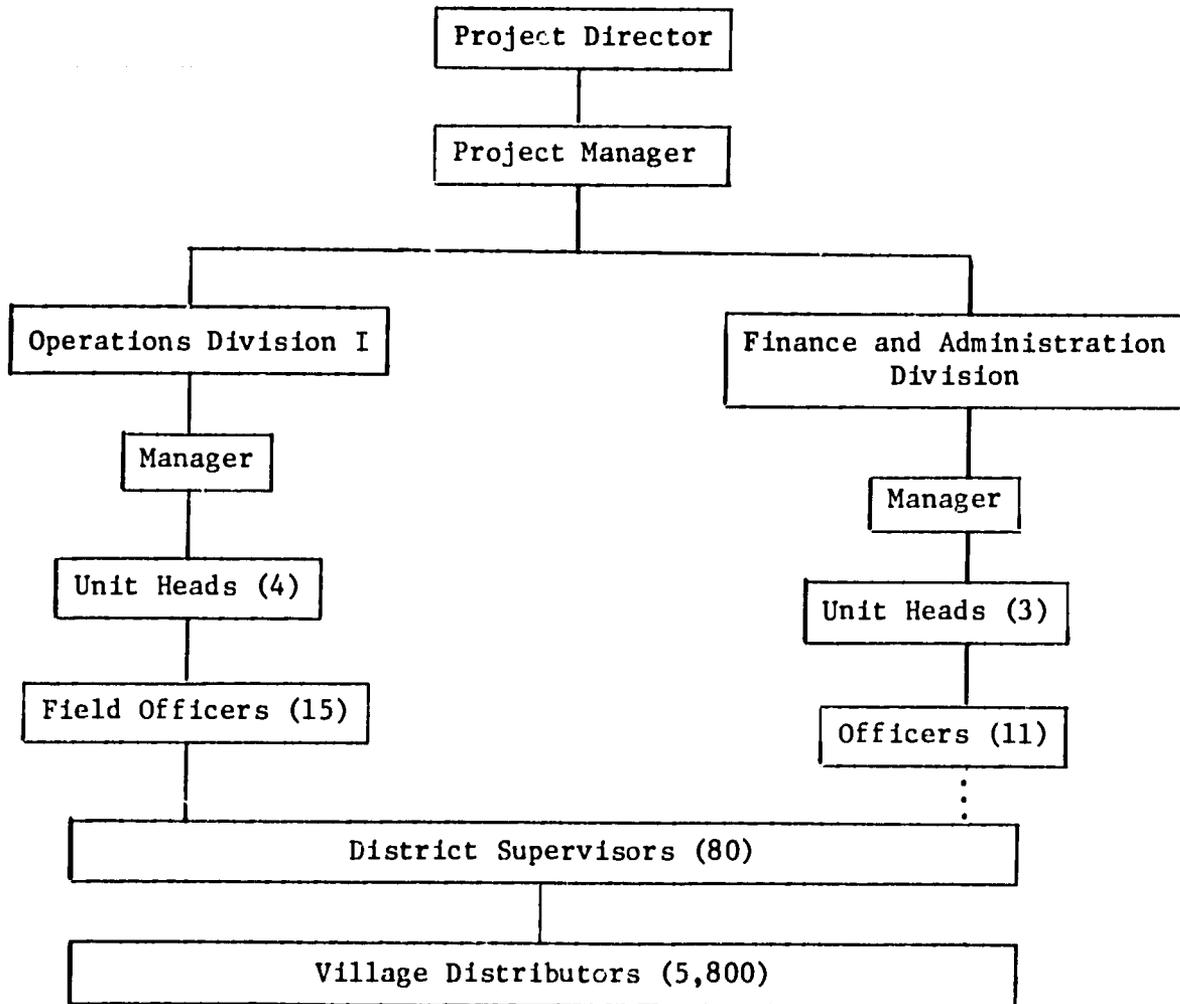
1 Unit Head : 4 Field Officers
 1 Field Officer : 5 District Supervisors
 1 District Supervisor: 15 Village Distributors

3. Supervisors

- a. The key organizational link in any form of rural development lies with the selection, training and supervision of those personnel whose function is to join the central body with the local community worker. In the case of CBFPS, this is the District Supervisor. It is at this locus that the traditional, pragmatic, diffuse, work-a-day level of village affairs is fused to the modern, centralized, capital city organization that plans, programs and receives governmental or international resources.
- b. The CBFPS District Supervisor is not only the organizational link which can be subject to the greatest tension but the Supervisor is the critical relay point in the transmission of information from the periphery to the center, which is both the basis of effective management and essential to the evaluation of the experimental aspects of the project.
- c. The supervisory structure chosen for the FPHH project is based on the already-tested system in the IPPF-funded CRD project. There are three levels of supervision. The local CBFPS supervisor who visits and resupplies the village distributors at least once a month and also collects records and helps the agents with questions or difficulties which may have arisen during the previous month. The supervisor sometimes refers questions to the local midwife or doctor. The monitoring of the district supervisor is the direct responsibility of the field officer. The field officer is normally responsible for five district supervisors and spends five days every three months in the field with each district supervisor. The field officer also meets monthly with the district supervisors to collect income, distribute contraceptives and household drugs and to review progress and problems in the field. Supervision of the field officers is the responsibility of the four unit heads, each of which is responsible for a geographical region including some four to six field officers.

CBFPS Organization Chart

FPHH Project



N.B. All officers and above are Bangkok-based.

- d. In addition to the direct field supervision, the CBFPS has designed indirect control on the activities of the district supervisors, particularly their visits to the village distributors. The visit of the district supervisor to the village distributor is indicated by the date and signature of both parties on distributor-held documents. Village distributors are also given pre-stamped postcards addressed to the CBFPS offices in Bangkok which are to be mailed by the village distributor if the district supervisor fails to visit. (To date, this practice has only been used in the Northeast and has yielded 40 postcards. Since the information from the villagers includes comments on the program as well as the district supervisor, it provides additional feedback to the CBFPS staff.)
- e. The selection process for district supervisors involves posting an advertisement and an announcement on radio. Applications are received and candidates interviewed by the unit head, a field officer, and district health officer. Each candidate must own a motorcycle and offer a guarantor for 5,000 Baht. Ten years of schooling are required. To date, all supervisors have been men and most have come from the district concerned.
- f. The district supervisor receives 15 days on-the-job training in the process of selecting village distributors and participates in the one-day formal training of village distributors. He then spends one week with a district supervisor in another area.
- g. At the end of four to six months, the district supervisor receives one (1) week of training at CBFPS offices in Bangkok. He also attends monthly meetings for district supervisors which are managed by the field officers.
- h. District supervisors are paid somewhat less than comparable government employees. The district supervisor is a salaried staff member of CBFPS with a monthly salary ranging from US\$ 45-65, depending on the size of the district. The salary does not begin until the formal one-day training of village distributors is complete.

During the initial 15 days on-the-job training the district supervisor receives a per diem of 30 Baht per day and transportation costs but no salary. During the one-week training with a counterpart supervisor, he receives 30 Baht per diem in addition to his salary. For the monthly meetings, he receives 30 Baht per diem plus transport (bus and taxi) and one meal. During the one-week training in Bangkok, he receives 60 Baht per diem plus hotel costs.

- i. District supervisors may receive an additional 60 Baht if they conduct a village mini-survey. Those working with household drugs receive five (5) percent of sales.
- j. There is no probationary or trial period, but the district supervisor is subject to dismissal at any time. Seventeen out of 80 district supervisors have left or needed to be replaced. When the differing duration of implementation is taken into account, there is no marked difference between the experimental areas (a = 20%; b = 35%; c = 25% and d = 5%). Five supervisory staff had to be fired, 10 left for other jobs and sadly two died: one in an accident and one was beaten up. Another was shot when someone attempted to steal his motorcycle, but survived. The district supervisors are all male.

4. Distributors

- a. Village distributors fall into two broad categories: those who are shopkeepers and the rest. Fifty-two (52) percent of the distributors are shopkeepers, 38 percent are rice farmers, and 10 percent are in produce gardening (3%) or other (7%). Most of the distributors who list rice farming as a principle occupation indicate "dry goods retail" as a secondary source of income. Three out of five village distributors are men, and four out of five have attained an educational level of grades 1-4.
- b. Under models B and D the village distributors were to visit every household in their area to provide two cycles of pills free of charge, plus free condoms if indicated. The evaluation team found that the concept of making house to house visits was not closely adhered to, especially in the case of shopkeepers. Rather, the availability of two free cycles of pills was announced at village meetings or by word of mouth. It is questionable, therefore, how much effect can be attributed to this promotional effort.

5. Record keeping

- a. The FPHH/CBFPS service statistics system is designed to provide the central headquarters with a simple record of new and continuing acceptors of the pill and to contribute to the Ministry of Health's NFPP report for government provincial health authorities which includes the CBFPS family planning input in their respective provinces. The Ministry also distributes a feedback report ranking districts within the region which is sent to the district health officer.
- b. The district supervisor is the backbone of the system and tabulates all the information on new and continuing acceptors and on stocks from the records of the village distributors. A copy of the monthly tally of acceptors and users is sent to Bangkok CBFPS headquarters for forwarding to the MOPH service statistics system. Logistics record, submitted monthly, provide details on pill and condom sales and household drugs as appropriate.
- c. In the current system the village distributor is required to write the name of new acceptors and fill out a short form when a referral is made. While all distributors are capable of writing, some have not acquired the fluency in reading to absorb the small-print guidebook and pamphlets given out at the completion of training.
- d. At CBFPS headquarters, extensive use is made of the family planning and logistics service statistics. The Monitoring and Research Unit is replete with graphs, bar charts, wall charts, pie diagrams, ranking systems, cost-effectiveness analysis, and notebooks full of other detailed information. It is noteworthy that all this information is hand-tabulated. Following the suggestions of distributors and district supervisors, CBFPS is testing a simplified record-keeping system. In this system, packets of three-piece, tear-off coupons are kept by the distributor and segments are detached and given to the district supervisor on his monthly visit as a tally of new acceptors, and the supervisor determines the number of continuing users by subtracting the total new acceptor coupon segments from the total cycles of pills sold during the month. This system eliminates the literacy requirement and reduces to a minimum the amount of clerical activity of the distributor.
- e. It must be emphasized that the CBFPS system involves a flow of cash to the central office and operates on the reasonable assumption that a village distributor is not going to give of his or her income to artificially inflate the statistics. Some cycles are given away as promotional items but the cash flow provides a record of minimum usage. Allowing for a few transcription errors, the data recorded in Bangkok is consistent and judged to be reliable.

6. Voluntary participation

The Team confirms to the extent that CBFPS has referred patients for sterilization that all procedures have been without coercion. Indeed, the philosophy of CBFPS to strive for at least partial self-sufficiency reinforces the voluntary nature of all aspects of family planning.

7. Abortion-related activities

It is evident to the Team that no abortion-related activities are carried out under the FPHH Project, and that no element of the FPHH Project is any way associated with the procurement or distribution of equipment for induced abortion or to promote such services.

B. FACULTY OF PUBLIC HEALTH, MAHIDOL UNIVERSITY

1. The Faculty of Public Health had primary responsibility for the baseline survey which was carried out in the Northeast region during 1977. This met the goals set out and provides useful information. There was a six months delay from the schedule of publishing the results.
2. As a result of external events, and in view of data available at CBFPS, the decisions regarding "go/no-go" (i.e. the future direction and management of the FPHH) need not await the results of the follow-up survey originally planned for 1980. Moreover, it is anticipated that the focus of such a survey would be somewhat altered. In any case, a decision regarding the follow-up survey should be made in early 1980.

C. RELATIONSHIP WITH RTG

1. DTEC

The external resources which CBFPS receives are released by USAID to DTEC, which is responsible for subsequent release of funds to CBFPS; DTEC monitors the progress of the project and is accountable to USAID for the proper utilization of the grant funds. Satisfactory relationships exist.

2. Commodities from MOPH

The MOPH provided 4,000 sets of household medical supply kits as well as condoms and oral contraceptives. Although there were delays in receiving the medical kits and problems with packaging which delayed the start up of the project in areas C and D, these have now been overcome.

3. Project review and coordinating committee

- a. The Project Review and Coordinating Committee of the FPHH is chaired by the Director General of the Department of Health of the MOPH. The members of the Committee include representatives from each of the following organizations: National Family Planning Program (NFPP); Faculty of Public Health, Mahidol University; Department of Technical and Economic Cooperation (DTEC) and Community-Based Family Planning Services (CBFPS). The Committee is one of four committees which link the activities of the CBFPS to the RTG, particularly to the MOPH.*

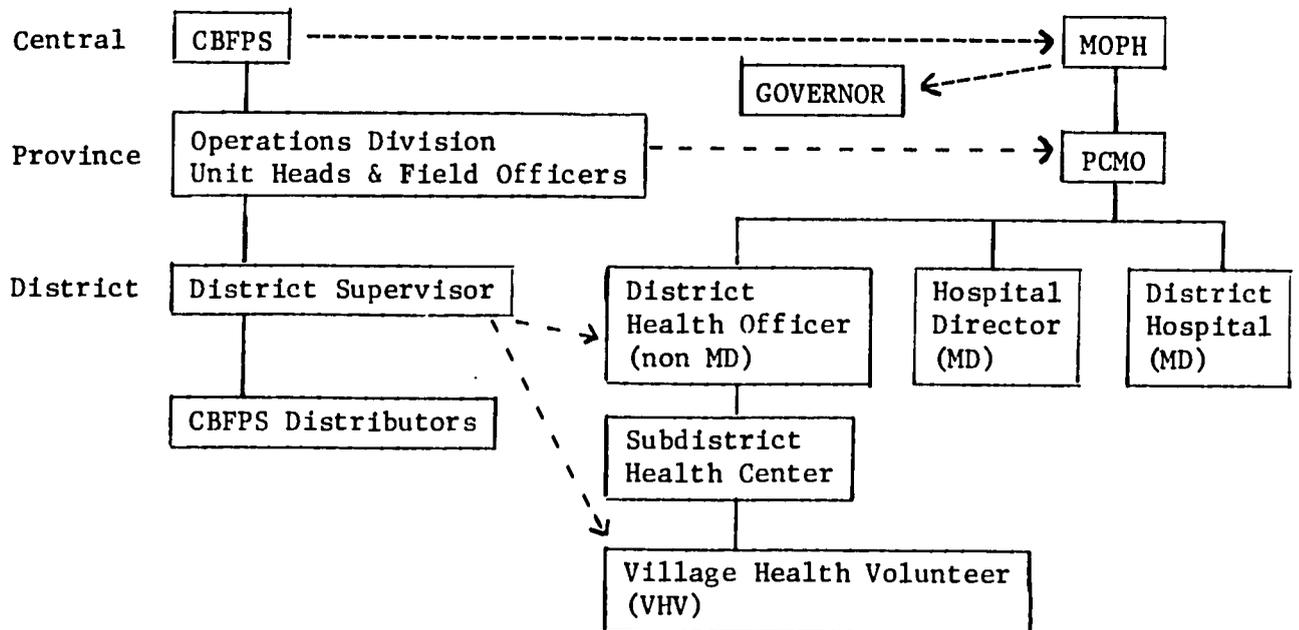
*The other committees include those for CBFPS' IPPF-supported activities, the Parasite Control Project and the subcommittee for private sector organizations of the National Family Planning Coordinating Committee. All four committees are chaired by Dr. Somboon Vachratai, Director General of the Department of Health.

- b. The FPHH Committee has had four formal meetings to date, in June, September and December 1977 and in July 1978. The 1977 meetings focused on the selection and approval of the 80 districts in the project and the official authorization and support of the MOPH in implementing the program. The 1978 meeting reviewed the first year's progress and developments of the FPHH project. In addition to these formal meetings, the CBFPS project manager, Mr. Tavatchai Traitongyoo, and the Ministry of Public Health appointed project coordinator, Dr. Chana Kamboonrat, Deputy-Director General of the Department of Health, frequently meet to discuss problems and developments which require special attention.
- c. While the Evaluation Team did not meet formally with the FPHH Project Review and Coordinating Committee, it met with the Committee Chairman, Dr. Somboon Vachratai. Moreover, separate discussions were had with most of the other committee members with the exception of the MOPH project coordinator.

4. Organizational relationship with MOPH

- a. CBFPS maintains cooperative relationships with government officials of the MOPH at the central, provincial and district levels.

Organizational Relationship between CBFPS and MOPH



- b. The Evaluation Team found that those PCMO's who gave greatest priority to family planning and preventive medicine and who had the best records of achievement, enthusiastically supported the complementary extension of government services which CBFPS offers. However, those PCMO's who interpreted their role in narrower administrative terms sometimes viewed CBFPS as a potential competitor. The monthly acceptor data, which the MOPH distributes and which was originally designed as a management tool has come to be interpreted as a series of targets, and many PCMO's complained that they did not receive CBFPS data until after it had been processed in Bangkok. They felt the ranking of their district's performance suffered if CBFPS gathered numerous acceptors that were not counted towards the district achievements.

D. INTEGRATION OF HOUSEHOLD DRUGS WITH FAMILY PLANNING

1. General

- a. The administration of rural development programs is partly influenced by the distribution of population. Most Third World villages have about 1,000 inhabitants. While the people are talented and can be taught many tasks, the resources available for training and the costs of supervision make it uneconomical to attempt to solve anything but common problems. Unlike a city, the population is too scattered to carry the capital costs involved in creating infrastructures, whether electricity or comprehensive health skills.
- b. Family planning services are achievable because a significant proportion of village adults want, and have, a recurrent need for services which happen to be technically easy to supply. The family planning consumer, unlike the sick person, normally makes his/her own diagnosis. In addition, illness takes many forms and has many degrees of severity and complications requiring greater skill in treatment than the unified pattern of dose schedule and level needed to use the pill or supply a condom.
- c. Clinically the FPHH project is not a family planning and health program in the sense that deaths are being prevented in the way births are being controlled. It could be argued that the distribution of toothpaste, sanitary towels or soap would be as relevant to health as most of the drugs included in the FPHH (or VHV) kits. This is not to degrade the usefulness of either household medicines or soap--both add to the quality of life; but neither provides benefits as significant as the public health benefits of preventing an illegal abortion or of saving a maternal death.

2. Cost effectiveness

- a. In the FPHH project cost effectiveness in the original project design was defined as: "the quantitative examination of alternative prospective systems as to the potential trade-offs with regard to the benefits, or effectiveness, to be gained and a cost to be incurred among the alternatives for the purpose of identifying the preferred system."
- b. Some of the more important outputs which the project analyzed are:
 - Contraceptive acceptors
 - Period prevalence of contraceptive use

It is more difficult to measure quantitatively the improvement in health standard or period prevalence of morbidity.

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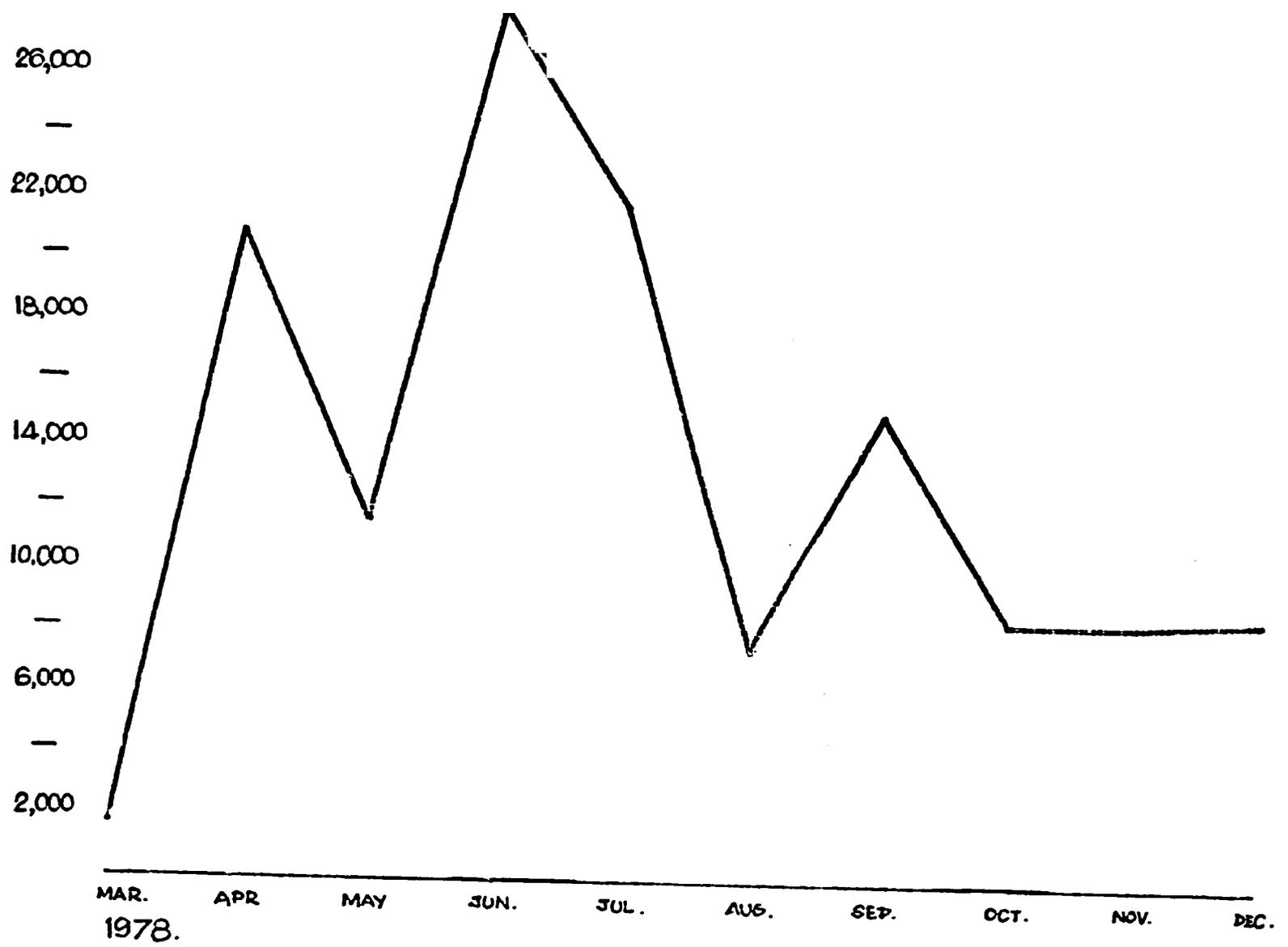
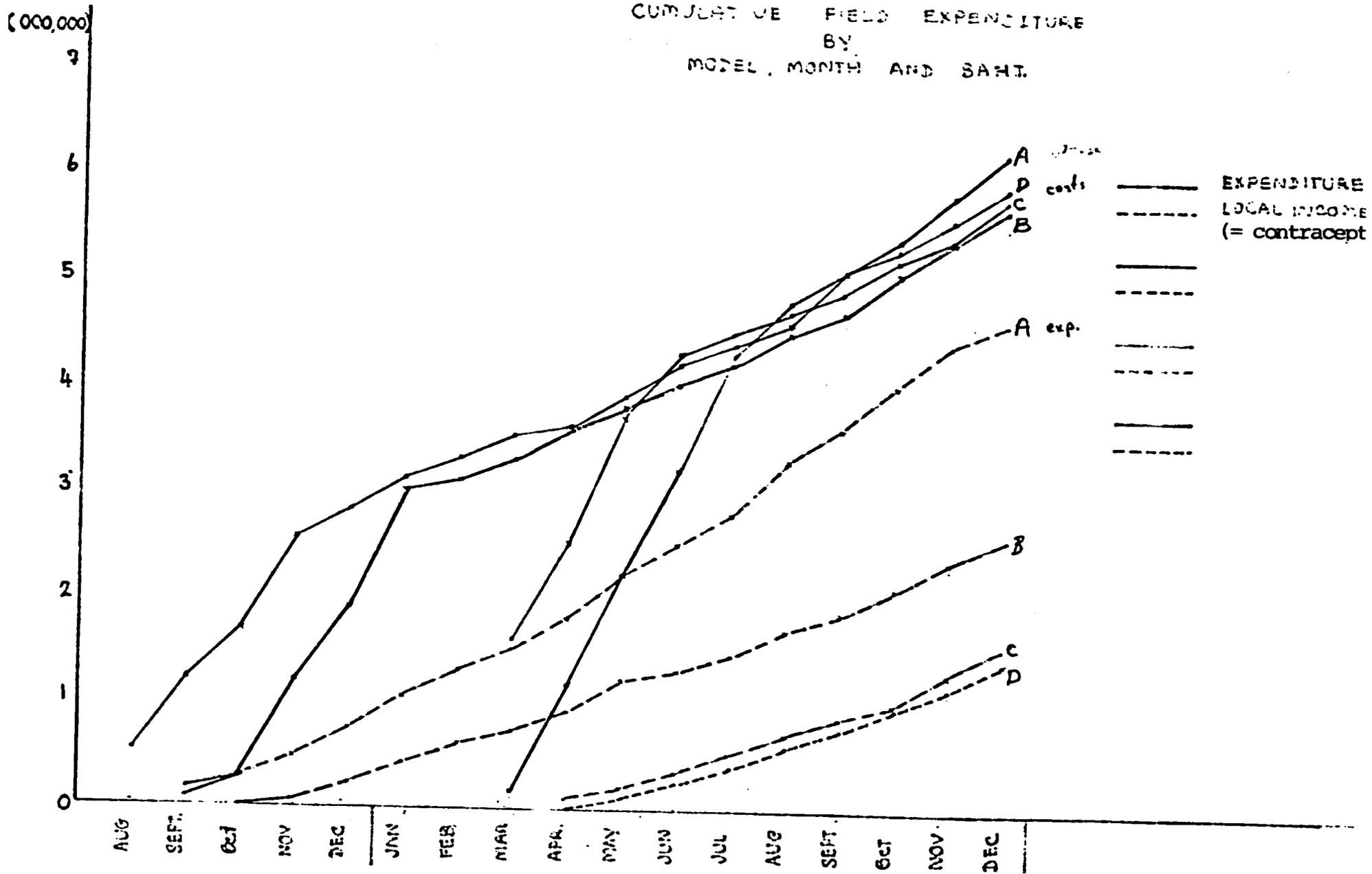


FIGURE B

CUMULATIVE LOCAL INCOME FROM CONTRACEPTIVE DISTRIBUTION
AND
CUMULATIVE FIELD EXPENDITURE
BY
MODEL, MONTH AND SAHT.



- h. Expenditure and income results of the experiment to date are shown in Tables 5 and 6. Table 5 simply describes the cumulative cost information for all the subsystems as of the latest date for which data are available, December 30, 1978. Comparing the four Models in Table 6--an ordinal cross-section--we see that Cumulative Expenditures are remarkably similar for A and B and for C and D. Income shows interesting variation by Models, and hence, the Cumulative Net data show significant variation. Model A performs significantly better than the others. Models C and D are almost identical and are considerably less effective--at least in this time span--in defraying the costs for subsystem implementation and maintenance.
- i. Notice particularly in Table 6 the contrasts between those subsystems with household drugs and those without (CD vs. AB). The latter perform over twice as efficiently as do those systems which involve household drugs. The difference between subsystems with and without initial free distribution is negligible.
- j. Figure C shows that all four subsystems reach a steady state trend of gradual decrease in unit costs (costs per actual monthly acceptor levels) by the fifth ordinal month of operation. The visual contrasts are obvious, even dramatic. There can be little doubt that the most cost effective system is Model A, nor that Models A and B together are more cost effective than C and D combined. Similarly, the combination of A and C is more cost effective than Models B and D combined.
- k. In view of the biases that would seem to inflate rather than decrease the costs of implementing the program in areas A and B, it is concluded that the two-fold difference of costs observed in the areas with household drugs probably represent a lower limit. Therefore, while the utility of distributing household drugs of the type used seems questionable, it is worthwhile to teach and supervise a contraceptive distribution system of the type CBFPS has pioneered.
- l. But once a contraceptive distribution system is in place, it is exceptionally valuable and relatively easy to add other needed technical innovations one by one. CBFPS, in areas apart from the FPHH project, is experimenting with adding parasite control, credit systems and agricultural innovations, as well as the distribution of household drugs to the contraceptive distribution system. Reviewed in this context, decisions concerning the addition of household drugs can become justifiable, not on a philosophy that health and family planning must necessarily be linked, but as one choice from among many of improving the quality of life in a village. Thai society, like many others, spends a considerable

Table 5.

Cumulative Income Expenditure and Net Balance by
Distribution Model as of December 30, 1978

(000 Baht)

Models	Cumulative Expenditures	Cumulative Income	Cumulative Net
A	624	460	-164
B	570	260	-310
C	580	155	-425
D	590	140	-450
(sub- total)			
A&B	1,194	720	-474
C&D	1,170	295	-875
A&C	1,204	615	-589
B&D	1,170	400	-760
TOTAL	2,364	1,015	-1,349

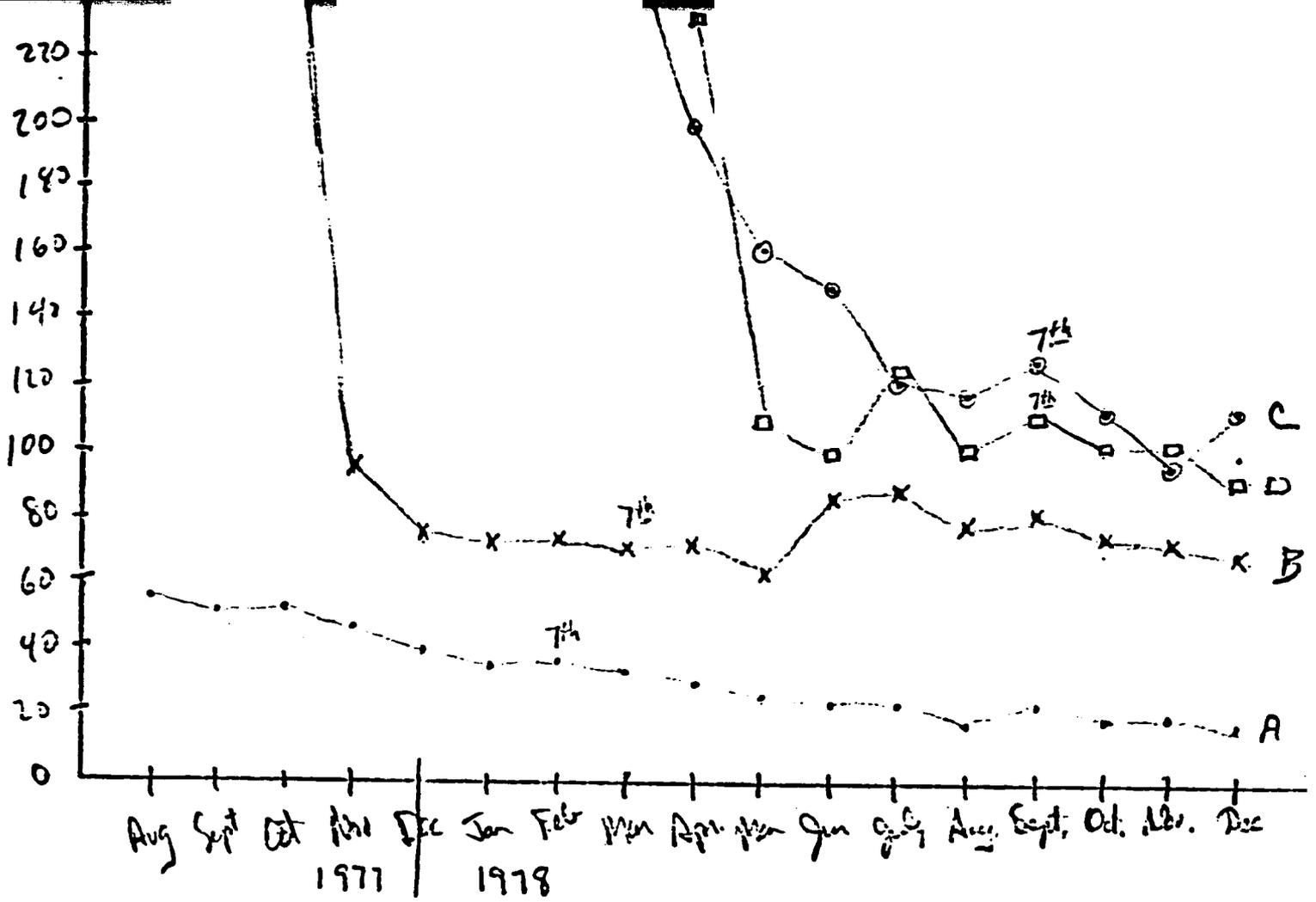
Table 6.

Comparison of Cumulative Income, Expenditures and Net Balance

Standardized to the seventh ordinal month of operation by
Distribution Model* (000 Baht)

Models	Cumulative Expenditures	Cumulative Income	Cumulative Net
A	326	180	-146
B	326	124	-202
C	523	127	-396
D	526	122	-404
(sub- total)			
A&B	652	304	-348
C&D	1,049	249	-800
A&C	849	307	-542
B&D	852	246	-606
TOTAL	1,701	553	-1,148

*The seventh month of operation was chosen because that is the time period within which most all districts have been operational.



CD = 9%

AB = 45.

proportion of its disposable income on medicines. Household drugs are appreciated daily domestic items often sold at considerably above cost. For CBFPS (and the VHV) to distribute selected, efficacious, safe household drugs at non-exploitive prices and by-passing the middle man is helpful to the villager.

- m. A planned system of household drug distribution could also be one way of avoiding the type of dangerous drugs that currently often reaches the village supplier. For example, one distributor in Sukothai Province has been visited recently by a sales representative and persuaded to buy a hormone (ethinyl estradiol) for delayed menstruation which is known not to work and could have a teratological effect on the embryo. The same distributor was also offering an intravenous infusion called Stamina, imported from Taiwan, which is simple saline with a homeopathic dose of vitamins.
- n. It is important to note that the conclusions reached about the lack of association between the availability of household drugs and the acceptance of family planning concerning the mechanical differences between person-to-person systems of village health care and family planning are no way peculiar to CBFPS. It merely happens that the carefully documented CBFPS experience allows the logistics leading to technical innovation at a village level to be documented more thoroughly than elsewhere. Indeed the conclusions are potentially useful in many countries and many settings.
- o. The picture can be changed if the policy determining the type of drug distributed was to be altered. Then the extra costs of training and supervision would be justified and the goals of the RTG in taking primary health care to rural areas achieved.
- p. In summary, there is no evidence that the addition of the household drugs chosen adds significantly to the acceptance of family planning. There is, of course, no argument that the needs of the community are best served by access to health care as well as family planning. However, in terms of the level of demand for household drugs and the relative simplicity of contraceptive services, household drugs have not proved a cost-effective addition to the CBFPS program. The balance of advantages and disadvantages, however, would be altered if it proved possible to use volunteers to handle life-saving medicines or procedures.

3. Referral for sterilization within FPHH districts

- a. In recent years voluntary sterilization has become an increasingly significant factor in the total family planning picture in Thailand. The 1978 contraceptive prevalence survey provides a nationwide estimate of 16.9 percent male and female sterilization among married women of reproductive age.

- b. The actual health achievements of the CBFPS distributors, therefore, should be measured in their potential to refer people for sterilization, as well as in contraceptives distributed. No systematic record of sterilization referrals is kept but, on questioning, some distributors acknowledged that they were asked about sterilization and did refer individuals. No gross difference was apparent between areas with and without household drugs.
- c. Recent NFPP data on the numbers of male and female sterilizations during the period January thru October, 1978 indicate performance rates within the 80 FPHH districts. The findings are summarized in Table 7 by region.

Table 7.
Sterilization Data for 80 CBFPS Districts
National Family Planning Program -- January-October, 1978

Region	MWRA	# Steril.	% of Total MWRA	Districts	FREQUENCY CATEGORY				
					No. sterilizations	per district			
					None	1-100	100-500	500-1,000	1000+
North	210,920	6,284	2.9	26	8	9	5	1	3
North East	321,433	7,460	2.3	26	7	8	7	1	3
Central	157,210	4,633	2.9	20	5	6	7	0	2
South	69,661	3,262	4.7	8	0	4	2	0	2
TOTAL	759,424	21,639	2.8	80	20	27	21	2	10

- d. The data indicate that the NFPP program is not very active in over half of the districts (47 districts with fewer than 100 sterilizations), leaving a considerable portion of the population still without services. The latter observation buttresses the Team's recommendation that CBFPS explore ways to implement a system for the availability of surgical sterilization (perhaps with mobile services) to help the NFPP to meet the existing community demand. The current FPHH operations research project would be utilized for the monitoring and evaluation of impact and cost-effectiveness.

* Although a number of variables may be operable (location, greater availability of services, etc.), areas where other CBFPS programs have been running a number of years, the average sterilization referrals are 402 per district (2,740 maximum) compared to the more recently-opened CBFPS/FPHH areas only 270 (1,548 maximum), or a 47 percent difference.

E. ADVANTAGES AND DISADVANTAGES OF FREE CONTRACEPTIVE DISTRIBUTION

1. It is the RTG's current policy to provide free medicines at the village level and philosophically it is logical to include oral contraceptives in this category. After the pill became free through all government outlets in October, 1976 the increase in nationally recorded new pill acceptance was 50 percent. This level of increase has been maintained more than two years, to the present. Although most of the increase in new pill acceptance after October, 1976 can be attributed to never-users of contraception, substantial and significant transfer took place of active users from the CBFPS pill outlets to the government health centers. Further, it is certain that a part of the flow of newly-motivated pill acceptors after October, 1976 was diverted to government outlets; had the pill not been free, they would have chosen CBFPS distributors out of convenience.
2. From the policy point of view a number of arguments can be mounted against the free distribution of oral contraceptives (or common home remedies). The resources for health care are limited and any step towards self-sufficiency frees up resources for other, perhaps even more forceful demands, on government funds. As Thailand progresses it must plan to make less call on international aid, which is currently supplying oral contraceptives free of charge.
3. When a product is given free, the consumer may use the disposable income they would have otherwise spent on purchasing pills to acquire less useful consumer items, such as soft drinks. At the village level, it is the almost unanimous opinion of government health workers and CBFPS workers that those things which are received free are seldom valued. It is interesting that the most common response to any immediate side effect that a woman may experience on the pill is to recommend the use of a more expensive brand. The perception that the more expensive must be better is not only one which distributors hold, but which users mention spontaneously and with approval.
4. Even though some distributors work near primary health centers and have relatively few clients it could be argued that those clients are particularly important as some aspect of the available government service may have been perceived (for valid reasons or as the result of misunderstanding) to be unacceptable to these individuals. It is also appreciated that some CBFPS distributors may prove an unacceptable choice for some individuals who will prefer to travel to a health center. For example, some primary health centers, although open six days a week will only supply women with the pill two days a week. Also the health center is not open early in the morning or late at night when the clients are most likely to be free to go for resupply.
5. When pill distribution is done for a fee, the cash flow to the central administration becomes an automatic, accurate and highly satisfactory record of program achievement. As users

frequently shift from government to CBFPS or to commercial sales and back again, a record of total usage combined with an opportunity to collect sample surveys on the details of use would be sufficient to manage any program.

6. Many of the provincial level and health center staff felt that charging for the pill is the better policy. Two reasons were cited:

- charging a small fee causes the client to place higher value on the supply;
- charging helps generate local income for health center equipment, furnishings, drugs and maintenance.

Indeed, some health centers seek a donation or charge \$0.25 for 3 cycles of pills. Other government staff made the point that they believe the free pill policy is responsible for a greater number of acceptors.

7. The Second Evaluation Report of NFPP (1977) commented that government pills "were found to be sold quite freely in several drug stores (6 Baht/cycle) during our provincial visits." It also emphasized the loss of revenue to health centers, the fact that surveys suggest most people could afford to purchase pills and the tapering off of external assistance that can be expected, increasing the financial burden that falls on the RTG. The Report recommends "NFPP should reconsider its pricing policy for family planning supplies. . . ."
8. It seems unlikely that AID bilateral support in family planning to Thailand will continue after the end of the fifth five-year plan (1986).
9. If the government free pill policy were reversed then family planning use in CBFPS outlets would increase significantly. If women are currently purchasing CBFPS pills out of convenience then the additional women who travel to the health center for the free pill out of economic need would surely conserve their transportation costs, if not drop out. It is certain that the use and acceptance through government outlets would drop. In addition, health center staff might be suspected by some clients of duplicity in suddenly imposing a fee.
10. The disruption caused by a policy about-face, affecting between one to two million women, would be formidable. Nevertheless, the increasing share of the cost of pill purchase that is falling to the MOPH will eventually have to be borne by the bulk of consumers. If the NFPP policy were reversed, a nationwide orientation campaign would have to be carried out to inform and explain the change in order to minimize any public outcry.

11. Another option would be to phase in a low price pill with a distinctive brand image for use in both government and CBFPS programs and to appeal to the emerging class of rural and urban women who can and should pay for their contraceptives. The demand for free pills might then decline as people get richer. (It should be noted that CBFPS has, in an internationally competitive market, developed, in 1977, the package design for condoms being used in Nepal and has been asked to develop a similar package design for Sri Lanka.)

VIII. IMPLICATIONS

A. FUTURE DIRECTION AND MANAGEMENT OF FPHH PROJECT

1. As experience is gained from the FPHH project it seems likely that the optimum form of primary health care and family planning program to which CBFPS can contribute to the RTG's efforts will not simply be an extension of one selected model. Rather it will be built upon the experience of test areas A, B, C, and D, while incorporating some new features. In a sense, the final outcome of this interesting project is likely to be the widespread use of a **new model identified as "Model E" type program.**
2. In view of the changes that have overtaken the project and control areas since its inception, the many important findings that have come out of the survey in the Northeast conducted by Mahidol University, and the usefulness of the routine service statistics, a follow-up survey of the type originally envisaged is no longer appropriate. It may be that as the project evolves an additional study will become appropriate but it will be impossible to make such a decision until 1980. If any additional survey takes place, then the experience now accumulated makes it likely that useful questions of a behavioral and perceptual type can be asked.

B. IMPACT OF CBFPS ON RURAL HEALTH AND DEVELOPMENT

1. Problems of national security
 - a. The FPHH project deals with two issues (health and family planning) that impinge on the quality of life at the village level. Currently, certain limited areas are administered by the Army and the loyalty of over half of the villages is at least partially exposed to competing political ideologies. The Evaluation Team is aware that battles which sometimes end in being fought with guns can be won or lost many years earlier in response to the way in which villagers see alternative systems offering to solve their everyday problems.
 - b. It is known that the insurgents use medical auxiliaries to offer immunizations, certain aspects of curative medicine and acupuncture. The Team is convinced that the RTG can and must offer a more attractive alternative. To do so it needs to (1) set bold and practical medical policies and (2) use all the organizational and administrative resources at its disposal, including maximizing the potential of non-governmental organizations such as CBFPS working under government supervision. A failure to follow

through on any element in this combination of factors could seriously, and perhaps irreversibly, weaken the effort to bring about a significant improvement of the quality of village life in relationship to the areas under discussion.

2. Village outreach

- a. The RTG sees clearly the need to simplify health services and ensure they are by the people and for the people. It is interested in low cost, rapidly implemented services and appreciates the significance of the link between the local community and central government. The CBFPS distributor, with their pattern of supervision, along with the TBA, VHV, traditional practitioner and tambon doctor is regarded by the RTG as one important experiment in building and maintaining this linkage. In addition to health-related activities the same concerns regarding out-reach and coverage apply to other RTG efforts to develop rural areas.

The government is well aware, from the Lampang project and other surveys, that villagers when sick turn to local drug-gists more frequently than they turn to primary health centers. An independent evaluation of the Lampang project presented at the Lampang Annual Review in 1978 highlighted a number of lessons the RTG saw as connected with that experiment:

Recruitment:

- hasty training resulted in insufficient review of candidate qualification and the selectors did not always fully appreciate the guidelines for selection and the criteria of acceptability
- selectors desired per diem and some officials were unenthusiastic about the work
- cases of favoritism occurred and there was lack of community interest and understanding in some sub-districts.
- candidates were selected whose work took them outside the village too frequently
- candidates for HPV say the job is more of a means for them to earn a living and greater status than as a means to serve the community

Supervision:

- field supervisors at various levels lacked close follow-up of activities
- some health officials imposed too many MOPH regulations on the activities of the HPV rather than letting a more appropriate service arrangement determine itself

Criticisms were also made of the scheduling and details of training courses. Some HPV's wanted to resign because of the limited returns which they perceived to come from their work. Others went beyond their training, for example, giving injections. Conflicts arose between government staff and HPV over such things as the resupply of oral contraceptives. The management of the revolving fund to purchase household drugs presented particular problems and in the logistics of supply. Finally, the record keeping was unsatisfactory.

- c. It is notable that CBFPS was asked to take over the selection, training and supervision of HPV in one district of the Lampang project. In this district CBFPS distributors are selling pills at 5 Baht per cycle and it will be important to compare the performance of this district in comparison with those where pills are free.

3. Strategies for village family planning and related services

- a. Having reviewed the problems of village outreach faced by the RTG, and taking into account the findings of the Evaluation Team, it is concluded that the selection, training and supervision of CBFPS distributors has gone a long way toward solving many of the major problems associated with any type of village outreach work. The aim of this section is to answer the question: How Can CBFPS more effectively assist the RTG in making the maximum contribution to village welfare? Within this broad question, the specific topic of the future CBFPS contribution to village family planning and health services is of primary concern.
- b. The Evaluation Team concludes that the system of village outreach CBFPS has created is an exceptionally valuable resource. It may prove appropriate for the transfer of a number of technologies relevant to village development, and, as a result, it can go wider than family planning and have nationwide implications.
- c. The frequent use of shopkeepers in the CBFPS system is notable and their handling of cash transactions has been satisfactory. In addition, they are of proven social appropriateness.
- d. In many areas the RTG program of VHV is moving forward rapidly. It would seem reasonable for CBFPS to continue to work with those distributors who are shopkeepers and whose work is limited to contraceptives, even in villages where a government VHV is in place or is to be placed. Our evaluation shows that this additional channel can appeal to certain villagers for whom other services have

not proven acceptable and who, although limited in number, may represent an important addition to total family planning usage. However, it seems redundant for CBFPS to recruit or supervise non-shopkeeper distributors in villages where VHV is operating. In villages where VHV are not planned then the CBFPS policy of recruiting a variety of distributors who could also handle household drugs could continue and expand.

- e. The original plan to recruit and supervise VHV's in some districts and CBFPS volunteers in others, has proved difficult to implement. One option for future development would be to issue new directives and ensure they were adhered to at the district level, although a rigid policy of this type might be felt to be unnecessarily restrictive both to PCMO's and CBFPS. More realistically, the precedent set in the Lampang project could be enlarged and RTG subcontract to CBFPS for training and, as appropriate, the supervision of VHV's, in the same way as the RTG contracts with builders to construct health centers. Our evaluation suggests that work undertaken by CBFPS would be conducted in a cost-effective way and adhere to a defined schedule. Pilot activities in this area could be undertaken in selected districts in the near future.
- f. CBFPS itself feels it has a unique contribution to make to the organization of the work at the village level and any contribution they might make could be linked to existing government structures at the district and provincial level.
- g. The Team notes that in the event that charges were re-imposed for government supplies of contraceptives, then the balance of achievable programs CBFPS could undertake with its present resources would change, automatically relieving government services of part of the burden of health and family planning work, thereby making available resources for other aspects of village development to which the RTG could contribute.

C. RELEVANCE TO NATIONAL HEALTH AND FAMILY PLANNING POLICIES

1. The FPHH project has implications which relate to the work of the RTG and to AID policy beyond Thailand and which may prove of interest to other international agencies. These relate to the policy of linking family planning and health delivery systems and to the potential of non-government organizations to complement and extend governmental services, particularly to villages.
2. Policies relating health and family planning have been vigorously debated over the past decade. On the one hand, it has been asked: Can family planning be integrated with health care? Some commentators have had a cautious approach to this question,

arguing the implementation of family planning work might take second place to the greater complexity and immediacy of health problems. On the other, it has been suggested that family planning is best integrated with health care, as in this way family planning services gain in credibility and work more effectively.

3. The FPHH project is one of the few large programs designed to directly explore if family planning objectives are best served by combining health and family planning services. Although the concept is ideologically acceptable it remains an empirical question. The documentation from CBFPS turns what can be seductive words into a real experience about which management decisions can and should be made. Everyone wants good health and the mixture of health and family planning sounds attractive, but words must be used carefully.
4. It needs to be recognized that the VHV and CBFPS distributors with household drugs are not offering health care, but the amelioration of a number of fairly common, but in no way inclusive, sample of non-life threatening complaints. By contrast, the village depot holder for family planning is doing more than preventing babies. The availability of pills makes a positive contribution to health, which the drive towards demographic goals sometimes misleadingly overshadows. Indeed, the most powerful life-saving medicine in the kit of household drugs distributed in experimental localities C and D is the oral contraceptive. Therefore, by virtue of the contraceptives put around, districts A and B are also receiving combined health and family planning services.
5. In 1974 the maternal death rate for all regions of Thailand was recorded as 1.7/1000 live births, but adjusted for under-reporting, it is thought to be 2.6/1000. In rural Thailand more than half of the births are still attended by granny midwives and in the Northeast, for example, reported maternal deaths are 70 percent above the national average. Deaths from abortion are likely to be particularly seriously under-reported. Therefore, in the regions where the FPHH is active it may well be that one in 250 women pregnant will die. Since the total number of active acceptors is over 18,000 and assuming that without contraception, the average Thai woman falls pregnant every 3.25 years then contraceptive use achieved by the program may be preventing over 20 maternal deaths a year at the village level.
6. Contraceptive use prevents death in childbirth, the risks of illegal abortion and the morbidity of pregnancy and its sequel. They do so differentially, because they are often used to prevent births by the women of highest parity and in older age groups. More than one-third of maternal deaths in Thailand occur to women over 35. Additionally, by allowing women to achieve the optimum spacing of pregnancies, contraceptives make a real contribution to infant welfare and lead to a

measurable decline in the infant death rate. Family planning is the practice of good obstetric care even before a society can afford to provide access to the skills of a physician. In a sentence: contraceptive distribution, of itself, is an integrated health program.

7. It is interesting to note that malaria eradication programs, like family planning programs, began as single purpose services. In the long term, the most significant contribution of the CBFPS distributor to primary health care is likely to be in referral and in preventive medicine.

A P P E N D I C E S

THAILAND: COMMERCIAL DISTRIBUTION OF
CONTRACEPTIVES 1964-1978

<u>Year</u>	<u>Cycles of Pills Distributed (000)</u>	
	<u>Total</u>	<u>Average per month</u>
1964	432	36
1965	1,328	111
1966	1,639	137
1967	1,438	120
1968	1,956	163
1969	3,242	270
1970	2,893	241
1971	3,275	273
1972	3,212	276
1973 (1st half)	1,770	295
1974	-	-
1975 (4th quarter)	754	251
1976 (2nd & 4th quarters)	1,434	222
1977	2,889	241
1978 (1st three quarters)	2,439	271

Source: Since 1967, Quarterly Reports, Price-Waterhouse, compiled from reports of major pill dealing firms in Thailand. Before 1967, figures from Government import records.

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Dr. Amorn Nontasut
Deputy Under-Secretary

Dr. Somsak Vorakamin
Director
Family Health Division
Department of Health

Community-Based Family Planning
Services

Mechai Viravaidya
Director

Tavatchai Traitongyoo
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Praveen Payapvipapong
Head
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Tanothai Sookdhis
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Director
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Dr. Boonlert Liewprapai
Director
Institute of Population and Social
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U.S. Agency for International
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Mission Director

Vernon Scott
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Health/Population and Nutrition

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1. Muang District, Prae Province

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2. Swankalok District, Sukhothai Province

Mr. Prom Chiebleam

3. Muang District, Nakornswan Province

Mr. Somyos Pongchang

E. CBFPS DISTRIBUTORS

1. Muang District, Prae Province

Mrs. Nongkarn Banlung	Hair Dresser
Mr. Boonsong Suntornmuang	Shopkeeper
Mrs. Sri-ouin Prommase	Dress Maker/Hair Dresser
Miss Nanthiya Chaiyanan	Hair Dresser/Life Insurance
Mrs. Panchit Yamao	Shopkeeper/Dress Maker

2. Swankhalok District, Sukhothai Province

Mr. Rung Sork-Pha	Shopkeeper
Mr. Booncho Ban-Klue	Farmer
Mr. Chumrat Bau-Tong	Shopkeeper
Mr. Kham Khamkhun	Shopkeeper
Mr. Prapan Oa-Gnam	Farmer

3. Muang District, Nakornswan Province

Mrs. La-Ong Chawechan	Shopkeeper
Mr. Suchod Muansri	Farmer
Miss Saithip Promcharoen	Shopkeeper
Mr. Prod Tasanee	Shopkeeper/Fisherman
Mr. Samraeng Tasakarn	Farmer/Shopkeeper

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2. Muang Nakornrajasima District, Nakornrajasima Province

Mrs. Tavee Saetung	Shopkeeper
Mrs. Samlit Phamchanthuig	Farmer

3. Pak-Thongchai District, Nakornrajasima Province

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3. Singburi Province (Model B)

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Nurse, District Health Office

Mrs. Charam
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2. Pamok District, Angthong Province

Mr. Likit Pautrakul

3. In-Buri District, Singburi Province

Mr. Prayoon Noisathis

E. CBFPS DISTRIBUTORS

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Mrs. Chanma Pornphasit	Shopkeeper
Mr. Tongoma Ku-larb	Shopkeeper
Mrs. La-or Chitsangut	Shopkeeper
Miss Sri-Prai Sarika	Shopkeeper

DOCUMENTATION

I. PROJECT RELATED DOCUMENTS

- A. Project agreement (493-0283-01) Family Planning Health and Hygiene
- B. Project agreement (932-0632-80007) Family Planning Health and Hygiene
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LIST OF ABBREVIATIONS

Community-Based Family Planning Services	CBFPS
The Family Planning Health and Hygiene Project	FPHH
Village Health Volunteers of the Ministry of Public Health	VHV
U.S. Agency for International Development	USAID
Royal Thai Government	RTG
Ministry of Public Health	MOPH
National Family Planning Program	NFPP
Department of Technical and Economic Cooperation	DTEC
Provincial Chief Medical Officers	PCMO's
International Planned Parenthood Federation	IPPF
The Population and Community Development Association	PDA
The Asian Center for Population and Community Development and The Community- Based Appropriate Technology and Development Services	CBATDS
The Population and Development Company	PDC
American Public Health Association	APHA