

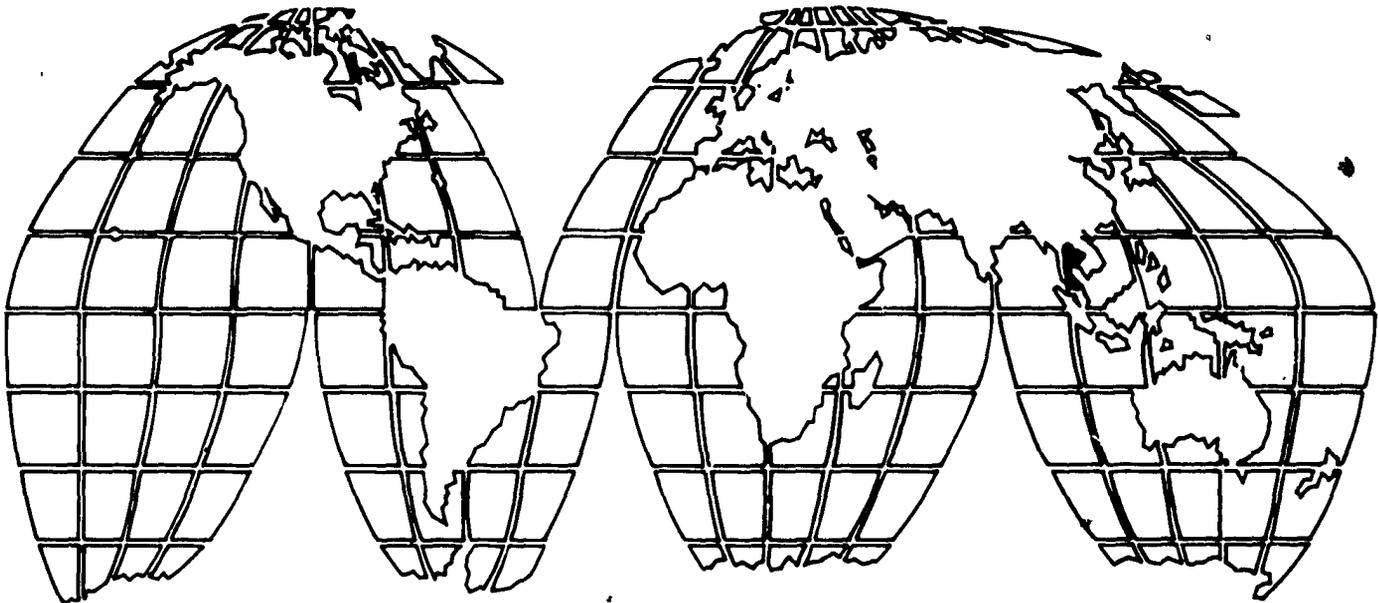
4930 209
4930 283
291
325

PN-AAH-006
ISN 39803

A.I.D. Program Evaluation Report No. 3

Third Evaluation of the Thailand National Family Planning Program

17



February 1980

Agency for International Development

000116

4930269

A.I.D. EVALUATION PUBLICATIONS

PROGRAM EVALUATION DISCUSSION PAPERS

- No. 1: Reaching the Rural Poor: Indigenous Health Practitioners Are There Already (March 1979)
- No. 2: New Directions Rural Roads (March 1979)
- No. 3: Rural Electrification: Linkages and Justifications (April 1979)
- No. 4: Policy Directions for Rural Water Supply in Developing Countries (April 1979)
- No. 5: Study of Family Planning Program Effectiveness (April 1979)
- No. 6: The Sociology of Pastoralism and African Livestock Development (May 1979)
- No. 7: Socio-Economic and Environmental Impacts of Low-Volume Rural Roads -- A Review of the Literature (February 1980)

EVALUATION REPORTS

PROGRAM EVALUATIONS

- No. 1: Family Planning Program Effectiveness: Report of a Workshop (Forthcoming)
- No. 2: A.I.D.'s Role in Indonesian Family Planning: A Case Study With General Lessons for Foreign Assistance (December 1979)
- No. 3: Third Evaluation of the Thailand National Family Planning Program (February 1980)

PROJECT IMPACT EVALUATIONS

- No. 1: Colombia: Small Farmer Market Access (December 1979)
- No. 2: Kitale Maize: The Limits of Success (December 1979)
- No. 3: The Potable Water Project in Rural Thailand (December 1979)
- No. 4: Philippine Small Scale Irrigation (January 1980)

SPECIAL STUDIES

- No. 1: Afghanistan Basic Village Health (Forthcoming)

PROGRAM DESIGN AND EVALUATION METHODS

- Manager's Guide to Data Collection (November 1979)

THIRD EVALUATION OF THE
THAILAND NATIONAL FAMILY PLANNING PROGRAM

A.I.D. Program Evaluation Report No. 3

Bureau for Asia
U.S. Agency for International Development

February 1980

This report was prepared by a joint Thai/U.S. evaluation team. The U.S. evaluators participated under the auspices of the American Public Health Association, supported by the Agency for International Development contract AID/pha/C-1100. The views and interpretations in this report are those of the authors and should not be attributed to the Agency for International Development.

INTRODUCTORY NOTE

This series is devoted to evaluation reports that examine development activities from a program, national, or comparative inter-country perspective. The series is coordinated by the Office of Evaluation, Bureau for Program and Policy Coordination (PPC/E).

The third report in this series, the Third Evaluation of the Thailand National Family Planning Program (NFPP), was prepared under contract at the direction of AID's Bureau for Asia, which is attempting to identify policy implications from its extensive experience in assisting population programs in that region. The third Thailand NFPP evaluation is of particular interest because it provides documentary evidence of the demographic change that has recently occurred and its impact in Thailand. It addresses the various factors that have contributed to the success of the program, including the impact of outside donor support. An important facet of the report is that it represents a joint evaluation. The evaluation team included members of the Royal Thai Government (RTG) (but not personnel directly involved with program operation), AID and the United Nations Fund for Population Activities (UNFPA). This helped to ensure an unbiased evaluation, but more important, enhanced the chances of acceptability and implementation of its recommendations.

The evaluation examines the achievements of the entire national program, including but not focusing on the supporting activities of bilateral and multilateral donors. Among these donors, AID has played an important role in the program. Beginning with the inception of the initial Family Planning Project in the Ministry of Public Health in 1968--prior to the adoption of a population policy by the RTG in 1970--AID bilateral population assistance, through fiscal year 1979, has totaled about \$23 million. The focus of this assistance has been on increasing the availability of voluntary family planning information and services. Specifically, AID bilateral assistance has been concentrated in three areas: support for training of various categories of personnel to provide family planning services--from administrators to physicians to village volunteers; primary support for the voluntary sterilization program; and the provision of oral contraceptives.

From the beginning, AID, along with the UNFPA and the RTG, has constituted one substantial leg of a tripartite effort to provide the resources--both human and financial--necessary for the NFPP to achieve its objectives. Over the years AID has been instrumental in getting the RTG to assume an ever increasing proportion of the program budget. Though the program has grown substantially in size and resource allocation, the RTG has become the largest contributor--over 40% in direct contributions--while AID, still a major contributor, provides a decreasing percentage of total program resources. Thus, another measure of the impact of AID upon the success of

the NFPP is not just the financial support provided but also the increasing ability of the RTG to internalize financial support for the program. At the present rate it is anticipated that the changeover from AID bilateral assistance to RTG support for the program should occur in the next five-year plan period (1982-1986).

In addition to direct support to the RTG, AID has contributed to the support of non-governmental and private sector organizations which have played a significant role in the national effort. The Planned Parenthood Association of Thailand (PPAT) and Community-Based Family Planning Services, Inc. receive support from International Planned Parenthood Federation which in turn receives support from AID. In 1977, AID began providing direct support to an expansion of the Community-Based Family Planning Services effort and enlisted the participation of the medical community in extending the availability of voluntary surgical contraception through support for the Association for Strengthening Information on National Family Planning Program. Others receiving AID support include McCormick Hospital, the Thai Nurses Association, and the Thai Association for Voluntary Sterilization.

* * * * *

Readers are invited to comment on both the substance and methodology involved in the report. Comments, as well as requests for additional copies, may be forwarded to the Office of Evaluation, Bureau for Program and Policy Coordination, Agency for International Development, Washington, D.C. 20523.

PREFACE

This report of the Third Evaluation of the Thailand National Family Planning Program was prepared by the entire joint Thai-American evaluation team. The members of the evaluation team are listed on pages 1 and 2 of the report.

Co-Team Leaders:

Donald Minkler, M.D., MPH
Debhanom Muangman, M.D., Dr.PH

TABLE OF CONTENTS

	Page
PREFACE	i
I. INTRODUCTION	1
II. SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS	3
III. ACHIEVEMENTS OF THE NATIONAL FAMILY PLANNING PROGRAM	6
A. Historical Background	6
B. Impact of the NFPP on Contraceptive Prevalence and Demographic Trends	7
C. A Review of Recent Evidence on Contraceptive Prevalence, Fertility and Population Growth in Thailand	10
D. Factors in the Success of the NFPP	17
E. Fertility Decline in Thailand Compared With That of Other Asian Countries	19
F. Assessment of Unmet Family Planning Needs	19
IV. SERVICE STATISTICS, OPERATIONAL RESEARCH, AND EVALUATION.	22
A. NFPP Service Statistics Findings	22
B. Summary of Operational Research Studies in the Field of Population/Family Planning Conducted in Thailand During 1977-1979	24
C. The Impact of the NFPP on the Quality of Life	26
V. CURRENT STATUS OF SPECIFIC PROGRAM COMPONENTS	27
A. Information, Education, and Communication	27
B. Manpower Development and Supervision	28
C. Contraceptive Services	32
D. Expanded Sterilization Program	37
VI. SOURCES OF SUPPORT FOR NFPP	45
A. RTG Support	45
B. Sources of External Support	45
C. Support to NFPP	46
D. Private Sector Support	47
E. USAID Support: The Population Planning Project	51
VII. IMPLEMENTATION OF RECOMMENDATIONS OF THE 1977 EVALUATION	62
VIII. REPORT OF CONSULTATION WITH USAID/T, JULY 23- JULY 26, 1979.	64

APPENDICES

- Appendix A - Glossary
- Appendix B - Sites Visited During Field Trips
- Appendix C - Organizations Visited by Evaluation Team
- Appendix D - Tables 1-15
- Appendix E - The Impact of the Free Pill Policy on Contraceptive Prevalence
- Appendix F - New Pill Acceptors and Acceptors of Other Methods
- Appendix G - New Acceptors: Thai National Family Planning Program
- Appendix H - Impact of Reduced Population on Per Capita GNP 1970 - 1978
- Appendix I - Contraceptive Knowledge Table
- Appendix J - N.F.P.P. Training Activities 1977 - 1981
- Appendix K - Tables 1-12

I. INTRODUCTION

The third biannual comprehensive project evaluation of the RTG National Family Planning Program (NFPP) was conducted from June 25 through July 20, 1979. The evaluation was conducted by a joint Thai-U.S. member team sponsored jointly by the RTG and AID. The main objectives of the evaluation were:

- A. To determine the demographic impact of NFPP since the previous evaluation.
- B. To determine if the NFPP has met all of its targets as indicated in the 4th plan.
- C. To determine what difficulties, if any, the NFPP will have in attaining its goals for the 4th Plan (1977-81) and to give NFPP some guidelines for the preparation of the 5th Plan.
- D. To examine the inputs being provided by the Royal Thai Government and all foreign donors to ascertain their effectiveness and needs for further inputs in the future.

The evaluation team was multidisciplinary, with representation from Thai institutions including Faculty of Public Health, Mahidol University DTEC, NESDB, and the BOB. The American participants included a demographer, a physician specialist in MCH/FP, a nurse health educator and a family planning management consultant, all of whom had prior professional experience in Thailand. The list of participants and their professional affiliations is as follows:

Faculty of Public Health, Mahidol University

1. Dr. Debhanom Muangman Co-team Leader, Dean of Faculty of Public Health
2. Dr. Yawarat Porapakham Head, Biostatistics Department
3. Dr. Orapin Singhadej MCH Department

DTEC (Department of Technical and Economic Cooperation, Prime Minister's Office)

4. Mr. Pichet Soontornpipit T.S. Division
5. Mrs. Sumontha Thanyapon Ext. Coop. Officer (AID Program)

NESDB (National Economic and Social Development Board, Prime Minister's Office)

6. Mr. Visuth Kanchanasuk Chief, Health Planning Section
7. Mr. Surajit Kaewchingdoug Plan & Policy Analyst

Bureau of the Budget

8. Mr. Poonsup Piya-Anant Chief, Public Health Sector
9. Mr. Aroon Anukrakanond Budget Analyst

U.S.A. Consultants

10. Dr. Donald Minkler Asso. Prof. OB-GYN, Lecturer MCH,
Univ. of California, Co-team
Leader
11. Mr. Bruce D. Carlson Management Consultant, Princeton,
New Jersey
12. Dr. John Knodel Assoc. Prof., Dept. of Sociology,
Research Associate, Population
Studies Center, University of
Michigan
13. Miss Kate Lorig Research Associate, Stanford
University, School of Medicine

Following an orientation and review of documents pertinent to the evaluation, the team was given an initial briefing at the MOPH, at which the officials responsible for various elements of the NFPP reviewed the work of their respective departments and assisted in planning the itinerary and agenda of the field visits. Visits were then made by subcommittees of the team in all regions of the country, in the course of which delivery of family planning services was studied and observed at the provincial, district, and local levels. (See Appendix B for list of sites visited). Members of the team also visited institutions and representatives of the numerous organizations involved in the NFPP. (See Appendix C for organizations visited). The entire team then convened in Bangkok to review and analyze its findings and prepare its recommendations. On July 20, a final meeting was held at the MOPH at which a summary of the evaluation and its major recommendations was presented to the Deputy Minister of Public Health, the Director of the Family Health Division and the Director of the NFPP.

The team wishes to acknowledge with deep gratitude the hospitality, cooperation, and assistance of the many individuals who gave freely of their valuable time and energy to insure that a complete and accurate evaluation took place. The MOPH staff at all levels, the representatives of the private and commercial sectors, and of the international donor community were all extremely helpful in this regard. We are indebted to the faculty of Public Health at Mahidol University and the USAID staff for providing needed office and conference facilities, transportation, access to relevant materials, and invaluable secretarial assistance.

Finally, the cordial and constructive working relationship among the Thai and American representatives on the team is cited as yet another example of the value of cross-fertilization of ideas that results from sharing an experience such as this across national and cultural boundaries.

II. SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS

While the complete findings and recommendations are detailed in the text to follow, the essence of this evaluation may be summarized in a few words.

It is clear that the NFPP has successfully achieved its targets to date, and that the resulting reduction in the population growth rate is virtually certain to reach the goal of 2.1 percent per annum set by the Fourth Economic and Social Development Plan. The evaluation team feels, moreover, that if this record of achievement is to be continued through the Fifth five-year plan (1982-86) increasing levels of support both from the RTG and the international donor community will be required.

The major recommendations arising from this evaluation (with reference to the relevant text in each instance) are as follows:

- | | <u>REPORT
SECTION</u> |
|---|---------------------------|
| A. <u>General</u> | |
| 1. The NFPP should continue to focus its efforts on all regions of the country, including Bangkok. | III. |
| 2. The NFPP should give priority to those geographic areas and segments of the population where family planning acceptance is low and/or availability of information and services are not fully developed. | III. |
| 3. Targets should be set in terms of a combination of new and continuing acceptors in the next five-year plan. (With emphasis on percent of eligible couples practicing contraceptives). | IV. |
| 4. Greater emphasis should be given to management and supervision at the village and health center levels. | V. |
| 5. The international donor community should give full recognition to the necessity of maintaining a level of direct support for the NFPP to assist the RTG in achieving the goals of the Fifth National Economic and Social Development Plan (1982-1986). | VI. |
| B. <u>Information Education and Communication</u> | |
| 1. IE and C activities of the NFPP should be extended from the present emphasis on providing information to an approach which combines information-giving with a focus on interpersonal communication and assistance in decision making. | V. |

2. Health education provided in context of primary health care services should include family planning related IE&C. V.

C. Training

1. There should be more emphasis on training of at least one supervisor at the provincial level in proper procedures for reporting service statistics. This person should ensure that persons in charge of service statistics at all service units are properly trained in reporting and recording procedures. V.
2. The training department of the Family Health Division should undertake operations research on the effectiveness of its various programs, especially those for lower level paramedical personnel, i.e., TBA's, Tambol Doctors, etc. V.
3. The Family Health Division, Training Division, and the Rural Health Division of MOPH should coordinate their training courses, materials, and other efforts in order to maximize effectiveness. V.
4. Formal training in the theory, practice and planning of health education should be assured for all personnel responsible for health education in the expanded rural health and family planning delivery network. V.

D. Voluntary Surgical Contraception

1. The RTG and international donor agencies should continue to support each component of the present package of combined public and private sector activities in the field of voluntary sterilization. Moreover, given anticipated higher annual VSC acceptance in the 1980s, the levels of total support should be increased. V
2. The subsidy to health facilities for Voluntary Surgical Sterilization should be continued, as well as a subsidy differential between urban and rural sterilizations. The subsidy for both male and female sterilization should be the same. Hence, the additional subsidy for vasectomies beyond the target should be dropped. V.

E. Evaluation and Research

1. Frequent assessment of fertility and contraceptive prevalence should continue to be made and greater attention be given to dissemination of the findings. III.
2. Evaluation of the impact of the NFPP should be extended from a largely demographic focus to an analysis of its micro- and macro-level effects on the quality of life in Thailand. IV.
3. The impact of the NFPP on the health status of the people should be investigated. Specifically, the effect on maternal and infant mortality and morbidity attributable to alterations in fertility resulting from family planning practice should be ascertained. V.
4. The evaluation team supports the MOPH policy of carrying out pilot projects in order to determine the use of various categories of non-physician personnel in the delivery of certain family planning services. The team recommends that pilot projects be continued and that careful selection of trainees in reasonable numbers and adequate precautions regarding supervision and medical consultation be given high priority. V.

III. ACHIEVEMENTS OF THE NATIONAL FAMILY PLANNING PROGRAM

A. Historical Background of the NFPP

Awareness of the need for government action to curb rapid population growth in Thailand grew during the 1960s. During that period, three national seminars were held, and the interest of the academic community as well as government and private institutions was stimulated.

By 1970, the RTG had declared a population policy, although no family planning budget ensued until two years later. The decision in 1970 to allow paramedics to dispense oral contraceptive pills enabled the expansion of service units from about 300 to over 3,000 in one year. From the start family planning services were delivered by existing health personnel through the MOH services. Although the oral contraceptive pill remained on the dangerous drug list, the restriction of its sale was not enforced and pills were in fact sold quite freely in over 10,000 drugstores.

The initial "Family Planning Project" in the MOPH, began in 1968, evolved into the National Family Planning Project which was implemented in 1971 and subsequently came under the aegis of the Division of Family Health. Currently, there are three organizations responsible for family planning policy formation and coordination. They are:

1. The NESDB subcommittee on Population Policy and Planning.
2. The MOPH National Family Planning Committee, and
3. The National Family Planning Coordinating Committee.

From the beginning, non-government organizations have played a significant role in the national effort, and coordination between them and government institutions has evolved.

The Planned Parenthood Association of Thailand (PPAT) was founded in April, 1970 and subsequently accepted under the Royal patronage of H.R.H. The Princess Mother. PPAT became an associate member of IPPF in 1970 and a full member in 1975. PPAT is a non-profit organization.

In 1974 the CBFPS, with support from IPPF, was established as a private non-profit agency. It expanded within four years to cover villages in 155 districts with its program of contraceptive education and village distribution. Since 1976, the CBFPS program has expanded its horizons to include parasite control measures, simple health care and rural development activities with its village family planning program. The FP/HH project, arising from this expansion, was the subject of a separate evaluation in February, 1979. Details of the further evolution of a regional Asian population and community development organization from these beginnings are provided in the section of this evaluation dealing with the private sector.

From the beginning, the academic community has had an active role in the evolution of the national family planning effort. Considerable biomedical research was done in the early 1970s by the medical schools, establishing the safety and efficacy of pills, DMPA, IUD, etc. in Thailand. In 1972, the Ramathibodi method of minilaparotomy for female sterilization was introduced. The method is now widely used throughout the world. Many pilot projects involving use of paramedics for delivery of family planning services were also carried out during this period and active research is continuing. Numerous international donor organizations, both public and private, have contributed increasingly to the work of the academic institutions involved in social and demographic as well as biomedical research.

In 1976, the mobile vasectomy program was initiated. Its purpose was twofold, namely to improve the ratio of male to female sterilizations under the NFPP, and to extend the availability of male sterilization to the large rural population of Thailand.

In 1977, the participation of the medical community was enlisted in extending the availability of VSC in private medical clinics and hospitals. The ASIN project (Association for Strengthening Information on National Family Planning Program) provides a support payment to providing institutions. (See section on the private sector for further details).

Further integration of family planning with the expanding rural health infrastructure is now underway with implementation of the Rural Primary Health Care Program adopted in 1978. The program involves the cooperative effort of the RTG and a number of international donors under the aegis of the IDA. While the Population Project itself is beyond the scope of this evaluation, it nevertheless represents a further effort by the RTG to expand the resources for the control of fertility to its rural as well as urban population.

This summary clearly covers only the highlights of this complex and multifaceted national effort. Further details and reference to the specific inputs into the NFPP in particular, are to be found in the remainder of this evaluation.

B. Impact of the NFPP on Contraceptive Prevalence and Demographic Trends

In order to highlight the impact of the NFPP, which is the major focus of this evaluation, a brief summary of recent data indicating the important trends is presented here.

While there are some areas of inconsistency in these data, there is sufficient concurrence to merit several conclusions. In Section 3, which follows this summary, the extensive information available in Thailand on recent trends in contraceptive prevalence, fertility, and population growth are reviewed in greater detail. For the sake of ready reference, all of the tables pertinent to these two sections are included in Appendix 4 of the report.

1. Contraceptive Prevalence (See Appendix D, Table D-1)

a. Contraceptive practice has increased substantially since the beginning of the NFPP and probably at an accelerated rate since 1975. A series of national surveys reveal that the percent of currently married women, age 15-44, practicing contraception increased from 15 percent in 1969/1970 to 53 percent in 1978/1979 for the country as a whole. There has been a 17 percentage point gain between April, 1975 and the end of 1978.

b. The largest gains since 1975 have been first of all, in the use of the pill, most likely reflecting the change to a free pill policy by the MOPH in October 1976 and second in use of surgical sterilization (especially female sterilization), probably due in part to the MOPH's new emphasis on permanent methods (Table D-2). The only major method to show a decline in use is the IUD.

c. Regionally, the northeast has experienced a disproportionately large share of the increase in prevalence in contraceptive use increasing from 25 percent of MIRA in 1975 to 45 percent in 1978 with 93 percent of current users practicing an efficient method (Table D-3). While the northeast still lags behind the north and central regions in prevalence, the gap has closed considerably since 1975. Data for the south, where prevalence is lowest, are less clear. While an increase in contraceptive usage is indicated by the surveys, over a third of the users interviewed in the 1978/1979 CPS survey indicated they were relying on non-modern methods, especially withdrawal (Table D-4). Thus the gap between the south and the remainder of the country remains very substantial.

d. Increases in contraceptive practice have been disproportionately concentrated among married women with no education (from 27 to 47 percent) and least among women with secondary or higher education (up from 52 to 60 percent) (Table D-6). This may be in part related to the free pill policy which probably helped reach the poorest and least educated women. While educational differentials in contraceptive practice still exist, the gap is clearly closing and indeed the 1978/1979 CPS survey indicates only a small difference remaining in the extent of practice between women with no education and those with primary education.

2. Source of Contraception

a. Government outlets (including some private hospitals but excluding CBFPS) are by far the most important source of contraception, accounting for 77 percent of reported use in the 1978/1979 CPS (Table D-7). The second most important source is drugstores.

b. The number of active users of all methods reported by the NFPP in 1978 (excluding the commercial sector) agrees reasonably well on a national level with estimates of prevalence from the CPS based on users who report as sources units contributing to the NFPP effort. Regionally, agreement is also fairly clear except for the south where the NFPP estimate of active users exceeds considerably that reported in the CPS (Table D-8).

c. Approximately three-fourths of all pill users obtain their supply from government outlets (including some private hospitals but excluding CBFPS) (Table D-9). Most of the remainder obtain their supplies through the drugstores. In rural areas 80 percent report the government as their source while in Bangkok less than one-third do. The majority of Bangkok women buy their pills in drugstores. CBFPS accounts for only 3 percent of pill use as reported in the CPS. This is in contrast to service statistics reported by the MOPH and CBFPS themselves which indicate that CPFPS accounted for 12 percent nationally of all pill cycles distributed by government outlets and CBFPS combined. A probable explanation of this discrepancy is that users misreported CBFPS supply units as either drugstores or as government outlets although there is no direct evidence to substantiate this interpretation.

3. Trends in Fertility

a. There is a wide variety of evidence that the decline in fertility for the period between the mid-1960s and 1975 has continued and probably accelerated since 1975 (Table D-11). While not all sources agree on the exact amount of the decline, they all indicate that fertility is continuing to fall (Table D-12).

b. Fertility is probably falling in all four major regions of the country with the greatest declines probably in the northeast and the least decline in the south, although there is some inconsistency in the data, especially concerning the south. In the north where fertility is now lowest (especially, if we consider rural areas) the decline seems to be slowing down and this may also be true in the central region although there is little evidence of fertility leveling off in either region yet.

c. There is also some indication that fertility is falling faster in rural areas nationally than in urban areas. The urban areas still have lower fertility but the gap seems to be closing.

4. Assessment of Recent and Future Growth

a. After a thorough evaluation of a large variety of sources, the Thailand Panel of the National Academy of Sciences (U.S.), determined last year that the growth rate in Thailand by 1975 was very likely in the range of 2.3-2.6 percent per annum -- down from 3.2-3.4 percent in the early 1960s. Since it seems reasonably clear that fertility declined by another 10 to 20 percent between 1975 and 1978 the growth rate by the end of 1978 probably is in the 2.0-2.3 range. This means that the target of reaching a 2.1 percent growth rate by the end of the current five-year plan in 1981 seems assured. While the success in reaching the targeted reduction in the growth rate is to be commended, it is necessary to keep in mind that a growth rate of 2.0 percent is still rapid and would lead to a doubling of the population within 35 years if not reduced further.

b. While it is difficult to make regional estimates of population growth both because the fertility data for regions are less certain and because migration can have an important influence on growth rates, it seems fairly clear from the fertility trends that growth rates are declining in most regions with

the possible exception of the south. Most importantly, the populous northeast region now seems clearly to have experienced fertility decline and hence lowered population growth rates after having lagged behind the national trends until quite recently.

c. Considering the large proportion of contraceptive usage that derives from government sources, it seems clear that the NFPP made a major contribution to the reduction in the growth rate. The substantial amount of foreign assistance (including that of AID) has no doubt been an important contributor to the program's success in terms of its demographic impact. The free pill policy, which has probably been an important part of the recent fertility and growth rate reduction (See Appendices 5 and 6) is facilitated considerably by foreign assistance. While a further reduction in the growth rate to a level of 1.5 by the end of the next five-year plan in 1986 clearly seems feasible if present trends are extrapolated, such an extrapolation is based on an assumption of continued assistance from foreign donors.

RECOMMENDATIONS:

1. THE NFPP SHOULD CONTINUE TO FOCUS ITS EFFORTS ON ALL REGIONS OF THE COUNTRY, INCLUDING BANGKOK.
2. THE NFPP SHOULD GIVE PRIORITY TO THOSE GEOGRAPHIC AREAS AND SEGMENTS OF THE POPULATION WHERE FAMILY PLANNING ACCEPTANCE IS LOW AND/OR AVAILABILITY OF INFORMATION AND SERVICES ARE NOT FULLY DEVELOPED, SUCH AS THAT FUNDED UNDER THE CURRENT USAID/RTG PROJECT AGREEMENT.
- C. A Review of Recent Evidence on Contraceptive Prevalence, Fertility and Population Growth in Thailand

Thailand is fortunate among developing nations in having a number of capable institutions actively involved in the collection and analyses of demographic and related data. Thus, there is an unusually extensive amount of information available for assessing recent trends in contraceptive prevalence, fertility and population growth. In the Appendix, we draw on a variety of this material in order to piece together, as best we can, recent national and regional trends. The major focus will be on trends since 1975 although it will be useful to place recent changes within the somewhat longer perspective of the last decade.

1. Sources of Data

The present review draws on a number of sources kindly provided by the institutions responsible for them. These sources are listed below with brief descriptions:

- a. National Longitudinal Study of Social Economic and Demographic Change (L.S.) -- conducted by the Institute of Population Studies (IPS), Chulalongkon University.

The survey consisted of two rounds, with separate rural and urban phase during the following dates:

April-May 1969 - Rural Round I
April-May 1970 - Urban Round I
April-May 1972 - Rural Round II
April-May 1973 - Urban Round II

The sample excluded some sensitive areas and the four predominantly Muslim provinces of the south.

- b. Survey of Fertility in Thailand (SOFT) also conducted by IPS in connection with the National Statistical Office (NSO). SOFT is part of the World Fertility Survey and the field work took place in April-May 1975. The sample was national.
- c. The Survey of Population Change (SPC) - This was a large sample survey conducted by NSO in order to assess demographic rates utilizing a dual record methodology which incorporated both use of the registration systems in sample areas and repeat household surveys. Field work was conducted from mid-1974 to mid-1976. The sample was national.
- d. The Family Planning/Health and Hygiene Project Baseline Survey (FP/HHP) was a survey conducted in the northeast region jointly by the Biostatistics Department of Mahidol University and the MOPH research and evaluation unit of the NFPP. Fieldwork took place during August-October, 1977.
- e. The Contraceptive Prevalence Survey (CPS) conducted by the Research Center at the National Institute of Development Administration (NIDA) in cooperation with the Westinghouse Health Systems. Interviews of a national rural sample and a sample of Bangkok took place during December, 1978 and January, 1979. Note that the sample excluded provincial urban places.

Comparisons among the results of these surveys, especially SOFT and CPS provide considerable information on recent trends and enable us to make a very up-to-date assessment of fertility and family planning prevalence. In addition, it is particularly fortunate that the FP/HHP survey is available for the northeast region for a period more or less midway between the SOFT and CPS since there is considerable interest in demographic developments in this region. The interest stems both from the fact that the northeast region contains about one-third of the

country's entire population and from earlier findings which indicated the fertility decline and increase in contraceptive prevalence evident for the country as a whole was lagging far behind in the northeast as of the first half of this decade.

In addition to data from the surveys listed above, we also examined data on birth registration from the Health Statistics Division of the MOPH and the service statistics of the NFPP.

While an effort has been made to make results from the various surveys as comparable as possible, given the existing tabulations to which we had access, it was not possible to achieve perfect comparability. While results in a given table generally refer to a base population delineated in the same manner, different tables refer to different base populations especially with respect to age groups covered (15-44, 15-49, 20-44) and to marital status (currently vs. ever married). Thus special care should be given to the description of the base population included in the heading of the Tables and to the footnotes which call attention to problems of comparability.

2. Contraceptive Prevalence

Table D-1 indicates trends in contraceptive prevalence (all methods), from four national surveys from 1969 to 1978/1979. Whether or not the results are standardized for age, a clear trend towards rapid increase is apparent with some acceleration in the increase in rural areas evident after 1975. Between 1969 and 1975, contraceptive prevalence increased at an average of just under 4 percentage points a year but since 1975 (taking into account the exact dates of the surveys), the rate of increase has increased at 4 1/2 percentage points a year. While sampling error or other extraneous factors might account for this change, the increased prevalence accords well with the increased acceptor rate reported by the NFPP especially after the introduction of the free pill policy in October 1976.

Table D-2 indicates increases in the reported prevalence by specific methods. Not only is the pill by far the most common method reported by current contraceptive users but pill users account for the largest increase in prevalence since 1975. This again accords with the sharply increased acceptor rates for the pill reported by the NFPP. Surgical sterilization and in particular female sterilization (TR) follow pill use in terms of prevalence. A substantial increase in TR is evident since 1975 again in agreement with increases indicated in service statistics from the NFPP. Other methods except the IUD have also increased. The drop in IUD usage since 1975 is undoubtedly genuine as service statistics indicate a substantial drop in acceptors over the last five years.

Regional trends in contraceptive prevalence (all methods) are shown in Table D-3. Perhaps the most striking finding is the substantial increase in prevalence in the northeast region which had lagged considerably behind up to 1975. While prevalence in the northeast is below the national average, the gap between it and the rest of the country is narrowing. The results of rapid increase in prevalence in the northeast between 1975 and 1978/1979 is given added credence

by the figures from the 1977 FP/HHP baseline study which fits quite well in the trend indicated by the 1975 SOFT and the 1978/1979 CPS results.

Table D-3 also indicates a substantial increase in contraceptive prevalence in the south. These results, however, must be treated with particular caution and indeed may be somewhat misleading. The sample size for the south in both SOFT and CPS is small since the south contains a small proportion of the country's population. Perhaps more importantly traditional methods of contraception (especially the use of withdrawal) accounts for a large proportion of contraceptive as reported in the CPS for the south. This is not true for any of the other regions as is clear from Table A-4. The south is clearly well behind the other regions in the adopting of modern, more efficient methods of the contraception. Most of the 13 percent of southern respondents reporting use of less efficient methods reported use of withdrawal. The more prevalent use of traditional contraceptive methods in the south does agree with some impressionistic information provided by persons familiar with the south. Unfortunately, it was not possible from existing tabulations to determine if the increase in overall prevalence in the south was due to an increase in reported use of traditional methods since cross-tabulation of method by region have yet to be done for the 1975 SOFT survey. In any event, it is clear that the prevalence rate of modern contraception is quite low in the south by 1978/1979 and the figures for prevalence of all methods need to be interpreted with this in mind.

Table D-5 shows the trends in current practice by age of woman. The results indicate that even younger married women are practicing contraception to a substantial extent probably reflecting an increasing use of birth control for spacing births as well as for limiting the ultimate family size. (This trend was already apparent in an earlier analysis comparing the LS and SOFT results).

Trends in current birth control practice by educational level are shown in Table D-6. These results indicate the largest increase in practice since 1975 for women with no education and the least increase for women with more than a primary education. While educational differentials still exist and current practice is inversely related to educational levels, the gap is closing and as of 1978/1979, there appears to be only small difference remaining between the extent of contraceptive prevalence among women with no education and those with primary education (note, however, that the results are not standardized for age in Table D-6 and hence may underestimate the difference between these two categories since women with no education are disproportionately concentrated in the later reproductive ages where birth control use tends to be higher). The contraction of educational differentials is undoubtedly the result of the extension of the NFPP services throughout rural areas and may in part reflect the results of the free pill policy which could have facilitated acceptance among the poorest (and least educated) women.

3. Source of Family Planning Methods

The CPS included a series of questions about the source of contraceptive services among users of birth control. Table D-7 shows the results for the national sample by method. Government outlets (including some private hospitals) are clearly the major supplier. A little more than three-fourths of all users of modern methods reported receiving their supply (or service) from the government sponsored outlets. Drugstores account for a little more than one-tenth of all reported use but are a much more important source of supply for condoms (50 percent) and pills (21 percent). Regionally, there is some variation in the importance of government outlets as a source of family planning as seen in Table D-8. The most striking, but not unexpected finding, is that the government is a considerably less important source in Bangkok than in rural areas. However, even in Bangkok over two-thirds of users report their source of family planning as sources associated with the NFPP. The importance of the government as chief supplier of modern contraception in the south must be tempered with the consideration that overall prevalence of these methods is quite low in that region.

Table D-9 indicates the source of pill supply by region. In rural areas of all regions, government outlets are by far the predominant source of supply (80 percent of all rural pill users). In Bangkok, however, the government provides only about a third of users of the pill with over half reporting they purchase their cycles in drugstores. The results regarding the role of CBFPS in supplying pills are rather surprising in light of official service statistics provided by the NFPP indicating that in 1978 CBFPS contributed to 12 percent of all pill cycles distributed by the government and CBFPS combined. A probable explanation of this discrepancy is that users misreported (or interviewers misrecorded) CBFPS supply units as either drugstores, government outlets or some other category of supply. Unfortunately, it is not possible to directly confirm this speculation with existing data. (It should be noted that a reasonably large proportion of the sample villages in the CPS are officially indicated as having a CBFPS distributor).

Table D-10 presents results of an exercise which attempts to compare the results of the CPS with the service statistics of the NFPP in active users. For the comparison only respondents who reported using a method provided by a government outlet or CBFPS (which also reports to the NFPP) are included. Table D-10 presents the results. For the national level there is reasonable agreement between the estimates of prevalence from the CPS and the results issued by the NFPP on active users. Regionally, agreement is also fairly good with the exception of the south where the NFPP estimate of active users exceed considerably that reported in the CPS. The discrepancies for Bangkok and the central region excluding Bangkok are probably attributable to some acceptors who live in neighboring provinces coming to Bangkok for services where they are attributed to Bangkok but being interviewed back in their provinces of residence for the CPS.

Fertility Trends

There is considerable evidence from a variety of sources indicating that the decline in fertility which began in the 1960s, continued and may have accelerated since 1975. Moreover, this decline which had previously been limited largely to the Northern and Central regions, and which now may be slowing down in those regions, has spread to the populous northeast region where fertility now appears to be falling more rapidly than elsewhere. Results for the South region are less consistent although they generally indicate some fertility decline there as well.

A comparison of the two years of the SPC is shown in Table D-11 and indicates a decrease in fertility between the first and second year in all regions except the North. Moreover, a greater decline in fertility during those two years is indicated for the rural than for the urban areas. Since the SPC is a sample survey and Table-11 refers to changes during only a two-year period, the results cannot be given great weight in themselves especially for any single region but they are helpful when put together with findings from other sources.

Total fertility rates for the two years of the SPC combined (mid 1974 - mid 1976) are compared in Table D-12 with total fertility rates calculated from the C.P.S. for 1978. Results from the FP/HHP for the Northeast are also included. Since the rates from the C.P.S. (as well as for the Northeast from the FP/HHP) are based on a retrospective question on the date of last birth while the SPC rates are derived from a dual record system designed to correct for underreporting of births, the results in Table D-15 may exaggerate the amount of change. Since any such bias would presumably operate on the results for all regions, comparison among the regions should not be affected in any systematic way. The results indicate a 17 percent decline in fertility for the rural areas as a whole which is larger than the decline indicated for Bangkok where fertility was at a considerably lower level at the onset of the period. The largest decline is found for the rural Northeast and the least decline (excluding Bangkok) for the rural South, which by 1978 has apparently replaced the Northeast as the higher fertility area. Results for the FP/HHP help confirm the substantial decline for the Northeast although, as indicated above, there are some problems of comparison with the SPC due to the different methodologies used.

Trends in marital fertility based on a comparison of CPS and SOFT (and the FP/HHP for the Northeast) are shown in Table D-13. The rates refer to married women aged 20-44 and are standardized for age thus controlling for differences in age distributions between the samples. The comparison indicates declines in fertility for the rural populations in all regions. Fertility in the Northeast registers a substantial decline larger than for any other region. The decline in the Northeast is confirmed by the intermediate values of fertility for that region indicated by the FP/HHP.

In both SOFT and CPS, as well as FP/HHP women were asked if they were currently pregnant. This data is derived in the interview separately from information about

births and this provides an independent measure of fertility change. Results are shown in Table D-14 and indicate a decline in the percent pregnant among rural women in all regions. The decline is largest for the Northeast and least for the South. The striking decline in percent pregnant in the Northeast as evident between the SOFT and CPS results is confirmed by the FP/HHP results which fit into the trend well.

While registration data on births are incomplete in Thailand and thus underestimate the true level of fertility, data on birth order help substantiate the continuing fertility decline. It is commonly observed that as couples reduce their fertility, the proportion of lower order births increases. Changes in the distribution of registered births can be expected to reflect real changes in the actual distribution even with under-registration unless changes in completeness are birth order specific. Table D-15 indicates the percent of all registered births of known birth order that are of third or higher order. In other words, it indicates what percent of births are above second births. Since the late 1960s, the birth order distribution changed systematically with higher order births representing a decreasing share of all births. This trend is evident for every single year from 1975 to 1978 supporting the evidence from sample surveys that fertility has continued to decline since 1975.

Assessment of Recent and Future Growth

After a thorough evaluation of a large variety of sources, the Thailand Panel of the National Academy of Science (U.S.), determined last year that the growth rate in Thailand by 1975 was very likely in the range of 2.3 - 2.6 percent per annum -- down from 3.2 to 3.4 percent in the early 1960s. Since it seems reasonably clear that fertility declined by another 10 to 20 percent between 1975 and 1978 the growth rate by the end of 1978 probably in the 2.0 - 2.3 range. This means that the target of reaching a 2.1 percent growth rate by the end of the current third-year plan in 1981 may have already been reached and is virtually certain to be somewhat exceeded by then. Most importantly, the populous Northeast region now seems to clearly have experienced fertility decline and hence lowered population growth rates after having lagged behind the national trends until quite recently.

Considering the large proportion of contraceptive usage that derives from government sources, it seems clear that the NFPP has made a major contribution to the reduction in the growth rate.

RECOMMENDATION:

FREQUENT ASSESSMENT OF FERTILITY AND CONTRACEPTIVE PREVALENCE SHOULD CONTINUE TO BE MADE AND GREATER ATTENTION BE GIVEN TO DISSEMINATION OF THE FINDINGS.

D. Factors in the Success of the NFPP

It is readily apparent that a multiplicity of factors have contributed to the substantial decline in Thailand's population growth rate in the 1970s. Undoubtedly, the constellation of forces encouraging fertility declines throughout the world are operative here as well. In Thailand, however, such influences operate in the context of a socio-cultural and religious heritage which is conducive to change and the diffusion of progressive ideas. They have been further enhanced by an enlightened national leadership which faced and recognized the problem of rapid population growth early and resolved to meet it with a bold and innovative plan of action. It would be presumptuous for this evaluation to attempt a thorough discourse on all of the factors responsible for the demographic change. We are convinced, however, that the extent of fertility decline documented in this report would not have occurred without the conscious national effort embodied in the NFPP. The strengths and limitations of each ingredient of the program are evaluated in detail in the report. However, an attempt was also made to identify those aspects of the total national effort that are unique to Thailand and those which may be replicable in other developing countries.

The conclusions in the following section were drawn after the use of a modified delphic procedure in which 14 members of the joint Thai-American Evaluation Team participated.

The results of this exercise show that success factors can be roughly divided into six categories: service, cultural, financial, governmental, managerial and other.

1. Service Factors

- a. The widespread availability of contraceptives.
- b. The involvement of health personnel at all levels in family planning.
- c. The delegation of family planning tasks to non-physicians.
- d. The integration of family planning with MCH from the start of the program.
- e. The use of pilot projects to test and then integrate innovative family planning delivery systems.
- f. Utilization of vehicles and equipment at the provincial and local level.

2. Cultural Factors

- a. The people of Thailand want family planning.
- b. Cultural tolerance of the subject of family planning which in part is responsible for the success of a widespread IE&C program.

- c. Relatively good status of women.
 - d. The neutrality of the Buddhist religion and philosophy regarding contraception.
3. Financial Factors
- a. Commitment of RTG budget and in-kind support.
 - b. Substantial foreign aid and technical assistance.
4. Governmental Factors
- a. Key government officials give active support to the program at every level.
 - b. Ministry of Public Health officials see the implementation of the family planning program as a duty.
5. Managerial Factors
- a. Strong coordination between the governmental and non-governmental family programs. The NFPP takes a key role in this coordination.
 - b. Personnel at every level of the program have incentives for taking an active FP role (i.e., vehicles for provincial offices and promotions for health center workers who meet and/or exceed FP targets).
6. Other Factors
- a. The existence of an extensive network of transportation and communications.
 - b. The existence and cooperation of a large number of excellent health/medical educational institutions.

In examining these perceptions, there are two important considerations.

First, it is apparent that several of the factors are specific to Thailand and thus cannot be transferred to other countries.

Even more important, the actual success of the program is not so much as a result of individual factors as it is of the interaction of factors. It is this interaction which creates a continual spiral of cause-effects-cause reactions.

Thus, while it is possible to enumerate the factors in success of the Thai family planning program, these factors must be considered as an integrated whole and not in isolation.

E. Fertility Decline in Thailand Compared with that of Other Asian Countries

In order to view Thailand's demographic change in the larger context of East and Southeast Asia as a whole, the following Table of growth rates is quoted from the estimates published in 1979 by the Population Reference Bureau. The disclaimers noted in the PRB publication regarding limited accuracy and comparability of the data must be kept in mind. Nevertheless, the list provides an opportunity to view Thailand's growth rate in rough comparison with those of its neighbors.

TABLE 1

Population Growth Rates
East and Southeast Asia
1979

Burma	2.4
Cambodia	2.6
China	1.2
India	1.9
Indonesia	2
Hong Kong	.9
Korea	1.7
Malaysia	2.5
Philippines	2.4
Singapore	1.1
Sri Lanka	1.8
Thailand	2.3*

F. Assessment of Unmet Family Planning Needs

With the present population of slightly over 45 million, Thailand still faces unmet family planning needs in various population sub-groups as follows:

1. Adolescent Group

In 1978,** the population projection of medium fertility showed that Thailand had a total population in the age group of 15-19 equivalent to 4.98 million with the total number of males slightly higher than those of females. This group, as indicated by the study, contributes to the increasing prevalence of premarital sex, unwanted pregnancy and criminal abortions. About 25 percent of them are in schools and the remainder are largely either in the

*It should be noted that this evaluation estimates Thailand's growth to be between 2.0 and 2.3. It is given here as 2.3 as this is the figure used by the Population Reference Bureau.

**"Adolescent Fertility Study in Thailand" by Debhanom Muangman, M.D., Dr. Ph. 1979.

factories or on the farms. The family planning services available to them in terms of IE&C and contraceptives are still very limited. Although population education and health education including some sex education are taught in schools it is still inadequate and does not reach a large number of students. Similar teaching in the adult education program is still quite limited although some excellent material has been developed in the adult functional literacy curriculum. More resources and more attention in terms of research and services should be directed to this large potentially high fertility group.

2. Hill Tribes

A study on hill tribes in Thailand by a UN Research Team in 1966 revealed that the total population numbered 275,249. Their number is currently estimated at about 500,000. These are nomadic people with different cultures and dialects, and they move frequently. Although family planning services are provided to them by various public and private agencies, their fertility control needs remain largely unmet.

3. Religious Groups

Buddhist Monks. The population census carried out in Thailand in 1970 showed that 95.3 percent were Buddhist, 3.9 percent Muslims, 0.6 percent Christians, and 0.2 percent others. In 1977, it was found that there were 218,779 Buddhist monks, 110,421 novices. Although the monks are not permitted to marry, the rate of turnover of active monks is high, estimated at about 80 percent. Often, adult Thai men will enter the monkhood for three months. More research should be done in this area to explore the potential for utilizing this large group of people for social development.

Muslims. According to the statistics from the Department of Religion, Ministry of Education in 1977, there were 1,736,300 Muslims. Large numbers of Muslims are still not receptive to modern contraception. Therefore, more study of factors in acceptance and practice of family planning should be done in this area, especially in the Southern provinces of Thailand.

4. Indo-Chinese Refugees

Because of political conflict in recent years in Vietnam, Laos, and Cambodia, large numbers of refugees have been pouring into Thailand at an alarming rate. The statistics from the Ministry of Interior in April, 1979 showed that there were about 149,000 registered refugees. If the total number unregistered are included, the figure may go up to about 250,000. The refugees still walk in daily along the 1,000 mile border between Thailand and Cambodia, or Thailand and Laos. The Thai government has recently requested the private organizations (CBFPS, PAAT and TAVS) to assume responsibility for planning the appropriate services to meet this problem. In the interim, the MOPH is assisting wherever possible in providing general health services, including family planning. Clearly defined policy on family planning for these people should be established including the most appropriate methods of IE&C and contraception for their special circumstances.

5. "Service Girls" at High Risk for Pregnancy

Before the end of the Vietnam War, bars, nightclubs, and massage parlors sprouted in Bangkok and many big towns in Thailand where U.S. troops were stationed. Since the end of the Vietnam War, these service places still exist, serving both the tourists and the local Thais. According to the statistics of the Police Department of Thailand, there are at the present time about 400,000 bars, nightclubs and massage parlor girls whose age varies from 13-45. The majority of these girls come from the farms in rural Thailand. This large group of people cannot be overlooked, and family planning and IE&C services should be readily available to them. More study of the special characteristics and needs of this group should be done.

6. Factory Workers

At the present time, there are about 80,000 large and small factories in Thailand. The total number of factory workers are young and come largely from the farms. Although PPAT and CBFPS have provided some family planning services to them their coverage is still inadequate, i.e., less than 500 factories. More services should be available to them.

7. Military Personnel

It is estimated that there are about 240,000 soldiers in Thailand. The total number of their families is quite large. More family planning services should be provided to them especially in rural military camps.

8. Premarital Couples

While education on family planning has become more generally available, specific premarital counselling is performed only to a limited extent. More emphasis should be placed on the expansion of such counselling to couples before marriage.

9. Women Undergoing Criminal Abortions

The subject of abortion is understood to be outside the scope of this evaluation. The evaluation team is assured that no U.S. government funds are being used in Thailand for the provision of abortion services or for the promotion of abortion. In view of the integration of family planning with health services, however, the team was told in the course of visits to hospitals and health centers throughout Thailand that the prevalence of criminal abortion is high. Moreover, admissions to hospitals for serious complications of such abortion cases are a formidable public health problem and a serious drain on the scarce resources allocated to health services. Physicians and others concerned with delivery of MCH/FP services are trying very hard to substitute the practice of family planning for abortion wherever possible. In addition, the consensus is growing among leading Thai physicians encountered in this evaluation that modification of Thailand's restrictive abortion law will become necessary in order to reduce the present high toll in morbidity and mortality attributable to criminal abortions.

IV. SERVICE STATISTICS, OPERATIONAL RESEARCH, AND EVALUATION

A. NFPP Service Statistics Findings

1. The NFPP service statistics system is probably the most efficient one in the health sector, as indicated by their production of up-to-date evaluations and internal feedback:

- The annual report of NFPP new acceptors and active users for 1978 came out in May, 1979 - only four months after the year ended - and was immediately disseminated to all PCMO's (as observed by our visits) across the country, as well as to other potential users. (See Appendix G).
- The computer printouts of "NFPP Active Users of Contraception by Method by Province and by Month" is distributed month-by-month to potential users, indicating the efficiency of the staff of R&E units (for example, the March printout was already available in early July).

2. There is evidence that some of the 1977 recommendations regarding the client record forms have been adopted -- although some still remain to be implemented.

3. A significant amount of arithmetic errors seem to occur at almost every level, PCMO or service unit, within the NFPP service statistics because of weak and inadequate supervision (from both NFPP HQ's and the PCMO's).

We also observed some midwives at the service units still have misunderstandings about proper reporting and recording procedures.

- Filling out the form 01 incorrectly for one reason or the other.
- Because of increasing demand for DMPA, there is not always adequate supply to the service unit. Some midwives are instructed to give pills if no DMPA is available, but they do not report the case as changing of method -- or vice versa, etc.

4. From the 1978 annual report - new acceptors are distributed as follows:

	72	73	74	75	76	77	78
From Rural	74.1	74.9	71.5	69.6	69.5	67.2	64.0
From Urban	13.0	12.4	13.9	13.9	12.2	13.4	13.8
	<u>87.1</u>	<u>87.3</u>	<u>85.4</u>	<u>83.5</u>	<u>81.7</u>	<u>80.6</u>	<u>77.8</u>
Assumed Unknown Residence	12.9	12.7	14.6	16.5	18.3	19.4	22.2

The remainder as shown represents the "unknown" category under "place of residence" on reporting forms, and has been progressively increasing in percentage of all acceptors. It is not clear from these statistics if the rural proportion of acceptors is actually declining but it appears that they have not been increasing. This is inconsistent with the findings of demographic studies noted earlier in this report, and suggest that further attention to the reporting function is needed. The supervisor at the provincial level should be either (a) the head nurse in charge of health promotion division or (b) the person in charge of the research and evaluation unit within the PCMO office (in the Population Project). All persons working in recording and reporting need instruction and supervision regarding the procedures for indicating new and continuing family planning services, especially newly recruited personnel such as assistant health workers who are to be aides to the midwives in the Population Project. Included in the training should be a stress on checking for arithmetic errors whenever data are summed to larger aggregates.

The line of supervision of the R&E unit of NFPP headquarters to the PCMO office to the local service units should be strengthened. Procedures for recording continuing (active) users at the local level should be reviewed. Personnel at all levels should be instructed on how to follow these procedures, in order to make reporting of active users more uniform and systematic, especially if targets for continuing users are to be incorporated in the next five-year plan. Some system of rewards (perhaps involving a promotion policy) should be established based on performance in recording and reporting of service statistics as well as other activities.

The planned management training for PCMO's and other relevant personnel should include material covering target setting procedure and allocation of targets within each province.

Finally, considering the increase in the proportion of acceptors in the NFPP that have previously received a method from the government program, the R&E unit of the NFPP should review the adjustment factor of 20 percent currently used to discount duplication or misreporting of new acceptance.

RECOMMENDATION :

TARGETS SHOULD BE SET IN TERMS OF A COMBINATION OF NEW AND CONTINUING ACCEPTORS IN THE NEXT FIVE-YEAR PLAN. (WITH EMPHASIS ON PERCENT OF ELIGIBLE COUPLES PRACTICING CONTRACEPTION).

**B. Summary of Operational Research Studies in the Field of Population/
Family Planning Conducted in Thailand During 1977-1979**

1. "Comparative Program Demonstration of the Use of Depo-provera by Medical and Paramedical Personnel in Thailand". This study was done by the staff of Research and Evaluation Unit of the NFPP. The final report came out in April, 1977. The main objectives of this pilot study were to assess the acceptability of DMPA in rural areas and its effect on overall clinic family planning activity, and to evaluate the effectiveness and consumer satisfaction associated with midwife administration of DMPA as compared with that of physicians. Acceptors were overwhelmingly rural. There was no anecdotal information to suggest increased risk to health by midwife injection of DMPA.

2. "A Pilot Study on the Training of Nurse-Midwives for Postpartum Female Sterilization". The study was jointly carried out by the Obstetric and Gynaecology Department of Siriraj Hospital Medical School, Mahidol University and the NFPP during 1977-1978. The final report dated June, 1979 concluded that a well-trained nurse can perform safe and high quality postpartum sterilization. The result of a follow-up of various stages of the training at 24 hours, 1 week, 6 weeks and a year after the operation showed that nurse and physician performance was not significantly different. The study emphasized that in the selection of the nurses a number of criteria are required, such as a minimum of two years experience in an operating theater, sound knowledge of operating instruments, experience assisting at operations, special interest in female sterilization and most of all a sense of dedication to this work.

A survey of physician's opinion was carried out in the hospitals under this pilot study on the use of trained nurse-midwives for postpartum sterilization. The physicians in these hospitals were of the opinion that nurses were capable of performing such operations well, provided that there is adequate and proper training with close supervision by a physician, and that proper procedures are applied in the selection of nurses.

3. "Pilot Study on Training of Paramedical Personnel for Male Sterilization". A joint project was carried out in 1977/1978 by the NFPP and Ramathibodi Hospital Medical School of Mahidol University. The 20 paramedical personnel were selected by the MOPH. The six-week training to perform vasectomy was given by staff of the Urological Section, Department of Surgery of Ramathibodi Hospital. The program proved to be successful in training paramedicals to perform vasectomy safely and effectively.

A follow-up of vasectomies performed by these 20 paramedics was done by the Institute for Population and Social Research, Mahidol University, one year after they finished the training and were placed in service outlets. Each paramedic had, on the average, performed over 100 cases of vasectomy during the one-year period, thus demonstrating consumer acceptability. Rates of negative side-effects, both medical and non-medical were no higher than those of medical interns and physicians. Two most important key elements seem to be adequate training and supervision.

4. "After Effects of Male Sterilization, Metabolic and Psychological Effects". Dr. Verasing Muangman of Ramathibodi Hospital medical school, has reviewed ten papers dealing with metabolic and psychological effects of vasectomy. The results were presented in the Seminar on Recent Research in Family Planning in Thailand, Haadyai, June 18-20, 1979. The author concluded that post-vasectomized men showed no significant alteration in metabolic and psychological functioning. With improved surgical technique this operation is now considered a semi-reversible procedure despite the fact of high incidence of antisperm antibody following vasectomy and vaso-vasostomy which may lead to functional failure in some cases.

5. A comparative study of Midwifery Knowledge, Attitude and Practices of Trained and Untrained Traditional Birth Attendants in Thailand 1978/1979 (done by NFPP staff).

6. Metabolic Effects of Injectable Contraception -- A review of the literature.

7. Vaso-vasostomy Using Microsurgical Techniques by P. Gojaseni, 1979.

(No definite conclusions but initial results were encouraging).

8. The 1977 continuation Rate Survey for Pill and IUD Acceptors During 1974 to 1976, August, 1978 (R&E Unit, NFPP).

9. Second Report 1977 Continuation Rate Survey for Pill and IUD Acceptors During 1974 to 1976, December, 1978, (R&E Unit of the NFPP).

10. The Maternal and Child Health Project, MOPH, 1979-1981 -- A proposal to the RTG

11. Adolescent Fertility Study in Thailand, 1979, D. Muangman -- A preliminary report presented at the Seminar on Family Planning Research, Haadyai, June 18-20, 1979.

12. Project for Strengthening of Nutrition and MCH -- FP Activities in Java District, Songkhla province. (Here is the subproject of Songkhla integrated Development Project or "Songkhla Model" 1977-1981) starting 1979 to 1980.

13. Family Planning/Health & Hygiene Project (See Evaluation of the FP/HH Project, APHA February, 1979).

14. Contraceptive Prevalence Survey, 1978/1979, Westinghouse sub-contracted to NIDA. (In process of publication).

15. Abortion Study - R&E Unit.

C. The Impact of the NFPP on the Quality of Life

The evaluation of how family planning programs affect the quality of life is a complex issue which involves both a variety of macrolevel and microlevel implications. Consideration needs to be given not only to the social and economic impact on the national or provincial level but equally importantly on the day-to-day lives of the individual families. It is often difficult to measure these impacts precisely especially with regard to the microlevel effects which can range from more concrete results such as reductions in numbers of maternal deaths to high parity women to much more subjective matters such as feelings of well being among family members. There have been and continue to be considerable efforts made to estimate the past and future macrolevel impact in Thailand especially using a variety of economic and demographic models. An analysis of the influence of the reduced population growth rate on per capita GNP from 1970, the year the NFPP officially began, and 1978 suggests that the increased per capita GNP associated with a slowing of population growth have already become evident. (See Appendix H). Projections comparing the effect on per capita GNP based on high and low fertility assumptions indicate the impact will be substantial in the coming decades.

Research on microlevel impacts is much less common and should be encouraged in order to expand our knowledge of the impact of the NFPP on the quality of life as it affects individuals and their families.

RECOMMENDATION:

EVALUATION OF THE IMPACT OF THE NFPP SHOULD
BE EXTENDED FROM A LARGELY DEMOGRAPHIC FOCUS
TO AN ANALYSIS OF ITS MICRO- AND MACROLEVEL EFFECTS
ON THE QUALITY OF LIFE IN THAILAND.

V. CURRENT STATUS OF SPECIFIC PROGRAM COMPONENTS

A. Information, Education, and Communication

1. Findings

To date the IE&C unit has concentrated its efforts in disseminating family planning knowledge. In 1978, two million pieces were printed and distributed. These materials were prominent in every health facility visited. By keeping the themes simple and repetitive this knowledge campaign can be judged to be successful. The 1977 Thailand Contraceptive Prevalence Survey showed that only 0.4 percent of the women interviewed had no knowledge of contraceptives and that 90 percent of currently married women had heard of each method except vasectomy where the figure was 87 percent. (See Appendix I).

During the past two years, there has been an expanding use of audiovisual materials for motivation at the village level. Mobile motivation teams from the control unit have reached more than 170,000 persons and more have been reached by mobile teams stationed in various provinces.

At the present time 15 provinces have complete mobile IE&C units which include a complete range of A-V equipment and films. It is expected that every province will have such units before 1981. In addition, the central office has 10 mobile IE&C units which travel to various provinces.

The major thrust of these units is to hold large group meetings for 50 to 300 people during which both entertainment and family planning films are shown with emphasis on vasectomy. In addition, posters and pamphlets are left at each village. During 1978, the mobile units from the central office reached 419 groups (villages).

2. Problems

a. To date the IE&C program has concentrated heavily on the giving of family planning information. Now, as the family planning program is trying to reach more difficult acceptors (i.e., males for vasectomy, hilltribes people, less motivated women) it is important to widen the IE&C effort to emphasize the decision to accept contraception. To date, there has been very little emphasis on decision-making. While there is still some room for improvement of knowledge about contraception especially about vasectomy and side effects of various methods, this area should receive less emphasis and more effort should be made to develop and disseminate health education methods and media which emphasize behavior change (i.e., the decision to accept contraception). Consultants from the School of Public Health would probably be helpful in this effort.

b. The slide series on vasectomy and female sterilization seems to heavily emphasize anatomy, physiology, and the surgical techniques. While this series may be excellent for training purposes, it seems a bit complicated for uses with the general public. In addition, some of the slides of actual surgery may, because of the fear factor, actually deter potential acceptors.

c. Several provinces were found where slide projectors were available but no slides. Nowhere was the local production of slides considered.

d. Although there seems to be a fair amount of locally produced health education materials, there do not seem to be attempts to locally produce family planning materials.

e. The family planning motivation kits were examined in several health centers and sanitarians and auxiliary midwives questioned about their usefulness. From this cursory survey it seems that the flip charts are being heavily utilized. There is a mixed reaction to the pelvic model, in some places it is used and in others it had not been removed from its original plastic wrapping. Finally, the cloth and paper posters do not seem to have been used.

In our discussions, we heard complaints that the kit was difficult to carry and that the materials were not good for groups of more than about 10.

A follow-up survey of the utilization of the motivation kits is planned by the IE&C unit of the NFPP.

f. Although the 1977 evaluation recommended the development of IE&C materials for special groups, (i.e., hilltribes, Moslems) there is no evidence of activity in this area. In several provinces, we heard requests for such materials. One special project was carried out in the South. (The use of shadow puppets to motivate for vasectomy). The results of this project showed it not to be cost effective.

RECOMMENDATIONS:

1. IE&C ACTIVITIES OF THE NFPP SHOULD BE EXTENDED FROM THE PRESENT EMPHASIS ON PROVIDING INFORMATION TO AN APPROACH WHICH COMBINES INFORMATION-GIVING WITH A FOCUS ON INTERPERSONAL COMMUNICATION AND ASSISTANCE IN DECISION MAKING.
2. FAMILY PLANNING IE&C SHOULD BE INTEGRATED INTO THE HEALTH EDUCATION PROVIDED IN THE CONTEXT OF EXPANDED PRIMARY HEALTH CARE SERVICES, SUCH AS THAT FUNDED UNDER THE CURRENT USAID/RTG PROJECT AGREEMENT.

B. Manpower Development and Supervision

For a full tabulation of NFPP training activities for the 1977-1981 period, see Appendix 10.

The 1975 project agreement called for the training of Tambon doctors (usually former army medics who supply a mix of western and traditional medicine at the village level), traditional birth attendants (TBAs), nurse midwives and auxiliary-midwives. To this a fourth category, border patrol police (BPP) were added in 1977.

Table 2 Training Activity 1977-1979

	<u>Project Agreement</u>	<u>Actually Trained</u>
<u>1977</u>		
Tambon doctors	500	-
TBAs	1,000	-
Nurse midwives	{ 400	163
Auxiliary-midwives		20
BPP	200	200
<u>1978</u>		
Tambon doctors	800	750
TBAs	1,400	1,400
Nurse midwives	{ 500	220
Auxiliary-midwives		-
BPP	200	800
<u>1979</u>		
Tambon doctors	1,000	1,000
TBAs	1,800	1,400
Nurse midwives	{ 500	120
Auxiliary-midwives		100
BPP	200	200

From this it can be seen that the original agreement is roughly on schedule.

All of the above training is carried out by the training department of the family health division. It should be noted that in addition to the AID funded training this department is responsible for a large number of other training programs funded by the RTG, UNFPA, Pathfinder, and others.

In the 1977 evaluation, it was obvious that this department was understaffed and not capable of carrying out all the training asked of it. Since that time, several of the 1977 recommendations have been adopted. The training staff has increased from 22 to 40. In addition, the majority of the MOPH training responsibility in the World Bank Population Project is held by the Training Department of the MOPH and not by the Family Health Division.

In general the FHD training department continues to do an excellent job. Its greatest area of weakness is the supervision of regional trainers, once the training of trainers courses are completed.

Because of the massive amount of training being carried out by this department, the decentralized training plan seems appropriate, (i.e., central staff train

regional staff who in turn train district and health center staff who train traditional birth attendants.

However, because of the weakness of supervision at all levels, there is little control on the implementation of training, especially at the lower levels.

RECOMMENDATION:

GREATER EMPHASIS SHOULD BE GIVEN TO MANAGEMENT AND SUPERVISION AT THE VILLAGE AND HEALTH CENTER LEVELS.

Although the FHD is responsible for family planning training, this cannot be looked at in isolation from the population project and other MOPH efforts. During the fourth Five-Year Plan (1977-1981), the MOPH plans to train:

900 nurses to become nurse practitioners

2,500 auxiliary midwives in primary curative care

750 health assistants to work at the midwifery centers

500 health assistants to work at the MCH and family planning centers

22,800 village volunteers to work at the village level

228,000 village communicators

and a variety of support and supervisory staff to work at the provincial and district levels.

The responsibility for the majority of the training is held by the Training Division of the Rural Health Division. This division has developed training materials, uses experiential methodologies and a decentralized training scheme similar to that of the Family Health Division. Unfortunately, there seems to be little communication between the two training departments. (It should be noted that within the MOPH there are several other training units: malaria, nutrition, etc. which are also not coordinated).

While the scope of this evaluation did not cover the training aspects of the World Bank Population Project, we were able to observe the impact of this project on family planning training. The problems seem to stem mainly from lack of coordination between the Family Health Division training department and the training department of the Rural Health Division. Some of the problems encountered were:

1. In some cases, the same provincial staff members receive training of trainers' courses from both departments.

2. In some health centers the staff has recently been trained in curative health care. They are also expected to assist with the recruitment and training of traditional birth attendants, village health volunteers, and village communicators. Thus, at the same time, they are assuming new roles as curative service providers, trainers of three types of personnel, and supervisors.

3. Although the population project calls for an increase of district and provincial staff to offer support to the health center staff, these new positions are often not filled, although training is progressing at the lower levels.

4. In some cases, the same village level people are trained for two or more of the following roles: tambon doctor, traditional birth attendant, village health volunteer, health communicator, CBFPS volunteer. While there is nothing inherently wrong with one person filling several roles, there are several actual and potential problems:

- a. Non-maximization of health manpower resources.
- b. Redundant training as many of the training programs contain some similar material, (i.e., family planning).
- c. Potential role conflicts. (A tambon doctor and/or village volunteer gives away government pills free, but the same person as a CBFPS volunteer sells pills. Health communicators cannot distribute pills, but TBAs supply continuing acceptors).

Probably the biggest problem with the large increase of lower level manpower is lack of supervision. At the village level, it is possible for one to three personnel at the health center to have upwards of 120 persons to supervise (10 villages with 10 health communicators, one village health volunteer and one traditional birth attendant each). At the health center level, supervision is given by the district health officer or the assistant district health officer and the provincial nursing staff. Under the best of conditions, supervisory visits are made monthly and usually much less frequently. In addition, now that health center staff are being trained in curative services, the district supervisory staff does not have the technical skills to give medical supervision. Nurse practitioners at the district hospital are well suited to assist in supervision of health center staff. However, this deters from their role as primary service providers.

Finally, there is very little data to indicate that the training of lower level health workers has any effect on family planning acceptance. In most places visited, no or incomplete statistics are being kept on new categories of health workers. Those statistics we were able to find indicate that TBAs were each distributing an average of 18 cycles of pills a month to continuing acceptors. However, they were averaging less than one referral a month of new acceptors.

The 1977 evaluation report recommended that the FHD evaluate the family planning effectiveness of lower level workers. Because of training demands, this recommendation has not yet been implemented. However, the evaluation team was informed

that MOPH has planned an evaluation of in-service training of peripheral health workers, in collaboration with Chiangmai University Faculty of Medicine and Faculty of Social Sciences. The evaluation, under the Rural Primary Health Care Program, is to be implemented in August, 1979 in the 20 provinces covered by the IBRD project. It is to be followed by a further evaluation in collaboration with Mahidol University of the performance of village health volunteers.

RECOMMENDATIONS:

1. THERE SHOULD BE MORE EMPHASIS ON TRAINING OF AT LEAST ONE SUPERVISOR AT THE PROVINCIAL LEVEL IN PROPER PROCEDURES FOR REPORTING SERVICE STATISTICS. THIS PERSON SHOULD ENSURE THAT PERSONS IN CHARGE OF SERVICE STATISTICS AT ALL SERVICE UNITS ARE PROPERLY TRAINED IN REPORTING AND RECORDING PROCEDURES.
2. THE TRAINING DEPARTMENT OF THE FAMILY HEALTH DIVISION SHOULD UNDERTAKE OPERATIONS RESEARCH ON THE EFFECTIVENESS OF ITS VARIOUS PROGRAMS, ESPECIALLY THOSE FOR LOWER LEVEL PARAMEDICAL PERSONNEL.
3. THE FAMILY HEALTH DIVISION, TRAINING DIVISION, AND THE RURAL HEALTH DIVISION OF MOPH SHOULD COORDINATE THEIR TRAINING COURSES, MATERIALS, AND OTHER EFFORTS IN ORDER TO MAXIMIZE EFFECTIVENESS.
4. FORMAL TRAINING IN THE THEORY, PRACTICE AND PLANNING OF HEALTH EDUCATION SHOULD BE ASSURED FOR ALL PERSONNEL RESPONSIBLE FOR HEALTH EDUCATION IN THE EXPANDED RURAL HEALTH AND FAMILY PLANNING DELIVERY NETWORK.

C. Contraceptive Services

1. Biomedical Impact of Changes in "Mix" of Methods in the NFPP Program.

Along with the rapid increase in the prevalence in contraceptive practice in Thailand, there has been a significant increase in reliance on the most effective and modern contraceptive methods. (See Table A-2, Appendix D). While this has the desired effect of reducing the proportion of unintended births, it implies at the same time increased exposure to the various negative sequelae which are known to occur when potent pharmaceuticals and surgical procedures are employed to control fertility.

a. Oral Contraceptives

Fortunately, both empiric and research evidence suggest that the serious cardiovascular and metabolic complications attributed to oral contraceptive use in the western industrialized societies are relatively rare in the Thai experience. Moreover, the relatively higher maternal mortality and morbidity compared to those of more developed countries must be weighed in the considerations of risks vs. benefits in the use of contraceptive steroids. Nevertheless, the

increasing prevalence of oral contraceptive use, the de facto availability of these potent drugs as over the counter drugstore purchases, and the policy (in which the evaluation team concurs) of delegating oral contraceptive distribution to village-level paramedical workers renders careful surveillance all the more necessary if serious complications, albeit rare, are to be minimized. In the rapid "outward and downward" expansion of the health/FP delivery network, the NFPP must assure that continued importance is given to adequate screening of new acceptors for contraindications, monitoring of continuing users for pill-induced health hazards, and education of acceptors regarding the importance of reporting possible complications.

b. Injectable Contraceptives

The injectable contraceptives, despite their known prevalence of side effects (chiefly irregular bleeding and amenorrhea) have assumed an important role in the NFPP program because of their high acceptability and practicality. The evaluation team observed on each field visit that local demand exceeds the supply. It is apparent that the prevalence of DMPA among contraceptive choices, if allowed to, could increase even more rapidly than it already has. Whereas some provincial and local level health officials reported actively encouraging DMPA, the MOPH appears to be taking a more cautious approach, as reflected both in NFPP targets and the local supply figures which we studied. The evaluation team concurs in this attitude of caution. Despite the lack of evidence of serious deleterious effects in humans in follow-up studies to date, the longest continuing observations (from the Chiangmai experience) are still limited to 13-14 years, and the potential for delayed harmful sequelae currently under intensive study in animals mitigate against the vigorous promotion of this method, particularly in populations hard to reach for follow-up. In the meantime, the careful surveillance and active clinical research on injectable contraception, in which the physicians and institutions of Thailand have had a prominent and valued role, is commendable and should be continued. The evaluation team agrees in principle with the MOPH plan to train 400 auxiliary midwives in the administration of DMPA (see recommendation IV-D), assuming that careful selection, supervision, and follow-up are assured.

In a meeting with representatives of the commercial sector, the team was informed that a new long acting injectable contraceptive containing a formulation other than DMPA will soon be marketed in Thailand. The existence of alternative products for the injection method will pose both new problems and new opportunities for the family planning program. Closer coordination between the NFPP, the commercial sector, and the research community will be required if the potential offered by new and improved pharmaceuticals is to be realized.

c. Sterilization

The demographic, administrative, and logistical aspects of VSC are considered elsewhere in this evaluation. The following findings and analysis are, therefore, limited to the biomedical implications of the rapid increase in reliance on VSC in Thailand.

It is apparent to the evaluation team that progress has been made in extending the availability of both male and female VSC to the rural areas. A number of factors have contributed to this success, including the increase in VSC service units providing VSC from 290 in 1976 to 430 in 1978. This was accomplished chiefly by an increase in district hospitals and first class health centers from 168 in 1976 to 264 in 1977, and an increase in mobile units from six in 1977 to 46 in 1978. The mobile units, in particular, have made vasectomy available to the rural areas, resulting in a significant decrease in the ratio of female to male sterilizations in rural areas.

From the beginning of the NFPP program, Thai authorities have demonstrated a willingness to explore new and innovative approaches to achieve wider access to VSC in areas short of physicians. The MOPH and Chulalongkorn University, with assistance from WHO, have studied the training of medical students in vasectomy techniques and of surgical theater nurses in the performance of postpartum sterilization (using a modified minilaparotomy approach). Another study is being carried out by Ramathibodi Hospital in collaboration with the MOPH to use sanitarians to perform vasectomy. Further innovations at Chulalongkorn Hospital include a special weekend vasectomy clinic beginning in July, 1976 and routine immediate postpartum tubal ligation in the delivery room resulting from a 1973-75 study. Evaluation of these pilot projects has been generally favorable.

In the case of the female operation, the trend toward decentralization of VSC facilities has had an inevitable impact on the mix of surgical techniques employed for VSC. While laparoscopes have been distributed and are in use throughout the country at the provincial hospital level (as well as in large urban and private institutions), postpartum TR and interval mini-laparotomy clearly dominate the range of methods. District medical officers, trained in six of the provincial hospitals, and providing VSC in the 264 district hospitals and health centers where laparoscopy is not available, account for a significant portion of this trend. Even in the provincial hospitals which the team visited, however, mini-laparotomy was generally, although not universally, the preferred method. Reasons given for this ranged from logistics (scheduling easier where a larger roster of doctors trained in mini-laparotomy available), to more certain availability of equipment (occasional breakdown of laparoscopic equipment and delay in obtaining replacement parts). In those locations where a surgical technician has been trained in the special project at Ramathibodi Hospital in maintenance and repair the contribution of this project was considered valuable.

The distribution of kits containing surgical instruments for vasectomy and TR has kept up with the training of personnel for VSC in mobile units, district hospitals and health centers. However, in several instances the team was informed of local objections to specific items in the kits, notably retractors and clamps which were deemed too large for the vasectomy and TR techniques in use and obsolete suture material.

Although the incidence of sterilization regret or requests for reversal are reportedly rare, some foresight is necessary in view of the trend toward increasing

reliance on surgical methods of contraception in Thailand. It is widely acknowledged that sterilization is occurring increasingly among younger acceptors and women of lower parity. In the future, it will, therefore, be important to study whether sterilization targets or decisions earlier in the childbearing era result in significant sterilization regret.

d. Intrauterine Devices

The decline in acceptance of IUD contraception stands out in contrast to the increasing acceptance of modern methods generally. It parallels, however, similar trends in most other countries.

In spite of its relatively declining popularity, however, the IUD still occupies an important place in the total NFPP effort, with 77,775 new acceptors reported in 1978. The policy permitting IUD insertion by nurses has made this modality available in many areas where contraceptive choices would otherwise be limited for practical purposes to pills and condoms. The MOPH is currently in the process of extending this policy to an additional group of 400 suitably trained auxiliary midwives. As the family planning program increasingly reaches the acceptors with completed families desiring permanent contraception more attention is given to spacing methods among younger and lower parity acceptors, the results of these policies are likely to be reflected in a leveling, if not an increase, in the rate of acceptance of intrauterine contraception.

e. Condom

The evaluation team found that condom stocks are sufficient at all levels of the delivery network. While the condom is clearly not a prominent element in total NFPP performance, the team feels that it is being appropriately used as an entry point to family planning at the village level, as an interim method in conjunction with acceptance of more modern methods, and as an adjunct to vasectomy. With the implementation of the expanded rural health network involving delivery of primary health care by VHV's and VHC's the distribution of condoms is expected to increase somewhat, although the impact of this on fertility in general is not expected to be great.

RECOMMENDATION:

TARGETS SHOULD BE SET IN TERMS OF A COMBINATION OF NEW AND CONTINUING ACCEPTORS IN THE NEXT FIVE-YEAR PLAN. (WITH EMPHASIS ON PERCENT OF ELIGIBLE COUPLES PRACTICING CONTRACEPTION).

2. Training of Non-Physicians for IUD Insertion and Sterilization

Since the early 1970s, Thailand has been noted for its leadership in testing the validity of paramedical personnel in the delivery of family planning services. Its early and successful experience with distribution of oral contraceptives by non-physicians has since been extended to more sophisticated procedures.

a. IUD Insertion

The role of nurse midwives in IUD insertion has become so widespread as to be the accepted norm throughout the country. IUD insertion and practice is part of the standard curriculum in most if not all schools of nursing. In short, this is no longer considered a "new role".

In 1977, a pilot study was conducted assessing the effectiveness of auxiliary midwives in IUD insertion. Again the project was successful and since that time 100 more auxiliary midwives have been trained. At the present time, a policy which authorizes the extension of this expanded role on a nationwide basis is under consideration. If approved, it is expected to provide a total of 400 auxiliary midwives with this added skill.

At the present time, IUD insertion is available at most district hospitals and at some health centers. All health centers are able to do IUD checks. In addition, we found at least one example of a mobile IUD insertion team.

Despite an increase in number of service sites and personnel able to insert IUDs, the IUD acceptor rate has decreased. Thus, in view of the expense of special training projects, and the inclusion of IUD insertion training in nursing curricula, it may not be necessary to mount further large programs for IUD insertion training. Small programs may be considered for areas and/or populations of special need.

b. Female Postpartum Sterilization

A pilot project was carried out in 1977/78 to train 20 surgical nurses for postpartum sterilization. The results of this program show that the performance of the nurses one year following training compares favorably with that of physicians, according to several criteria.

c. Male Sterilization

On the basis of successful pilot studies, the training of medical students in the techniques of vasectomy has been institutionalized in the regular medical school curriculum. Also in 1977, 20 junior sanitarians were trained to perform vasectomies. Again, after one year, their performance compared favorably with that of physicians.

There are also many isolated anecdotal reports of nurses, sanitarians, army medics and border patrol police who have been trained to perform vasectomies with generally good results.

In a 1977 study of 140 vasectomized* rural men, it was found that 39 percent of the operations had been done by physicians, 37 percent by army medics, 18 percent by village healers, 4 percent by nurses and 2 percent by junior sanitarians.

*Debhanom Muangmon "Acceptance and Non-acceptance of Vasectomy in Rural Thailand" May 30, 1977. (Pop. Council Grant No. T 76.901/ICARP/UNRA-1).

If this is not an isolated example, it would seem that vasectomy by paramedics is not only acceptable to Thai men but also that the vasectomy acceptance rate may be greatly underreported. This latter finding bears further investigation.

RECOMMENDATION:

THE EVALUATION TEAM SUPPORTS THE MOPH POLICY OF CARRYING OUT PILOT PROJECTS IN ORDER TO DETERMINE THE USE OF VARIOUS CATEGORIES OF NON-PHYSICIAN PERSONNEL IN THE DELIVERY OF CERTAIN FAMILY PLANNING SERVICES. THE TEAM RECOMMENDS THAT PILOT PROJECTS BE CONTINUED AND THAT CAREFUL SELECTION OF TRAINEES IN REASONABLE NUMBERS AND ADEQUATE PRECAUTIONS REGARDING SUPERVISION AND MEDICAL CONSULTATION BE GIVEN HIGH PRIORITY.

D. Expanded Sterilization Program

1. Major Findings

The impressive growth of VSC services and the growing acceptance of permanent contraception are among the most striking changes observed since the 1977 evaluation. They reflect both the wisdom of key policy decisions of the NFPP and the appropriate use of considerable external assistance planned specifically to strengthen this element of the program. Progress in VSC is summarized briefly as follows:

The number of new VSC acceptors has increased from 23,546 in 1971 to 168,461 in 1978. The percent of total new acceptors in terms of VSC services has increased from 7.2 percent in 1972 to 18.9 percent in 1978. The ratio of male to female sterilization acceptors has changed from 1:10 in 1976 to 1:2.8 in 1978. The provision of VSC services has shifted from 80 percent urban in mid-1976 to 60 percent in mid-1979. The number of male sterilizations has increased from 10,150 in 1976 to 44,256 in 1978.

While the significant contribution of organized units in the private sector (CBFPS, PPAT, TAVS and the ASIN program) to the total VSC performance is known and reported, the sterilizations performed by private physicians and other unreported sources cannot be accurately determined. At least one study* has indicated that a substantial number of vasectomies are done by army medics, village healers, nurses and junior sanitarians.

In addition to the important gains observed, the evaluation team finds evidence of continuing unmet need and opportunity for further strengthening of VSC services. The performance on a province by province basis shows wide variation, with many areas where the percent of couples protected by VSC remains very low.

*Ibid.

Obviously, this is in part a reflection of the newness of the mobile unit program and the incomplete implementation which will be remedied by the end of this year when the full complement of units become operational. Nevertheless, the locations showing poor performance do not necessarily correspond to the geographic distribution of mobile units, and other factors are clearly important in the wide variations in performance that we have seen.

During the field visits, one of the major explanations given for poor vasectomy statistics was that rural men had a general lack of information and irrational fears, among other factors, which lowered acceptance. However, the statistics and studies of the CBFPS have shown that a properly executed IE&C effort, emphasizing an interpersonal approach, have been able to dispel the fears and dramatically raise vasectomy acceptance. It would appear that greater emphasis on the IE&C aspects of sterilization services, especially for the male, would be productive. Many health units are allocated VSC targets by the PCMO's, and the setting of achievable targets is being utilized as an important management tool. All health facilities are aware of the VSC reimbursement scheme, and there is general agreement on its value, although there were some complaints of late payments. Therefore, it is important that a greater effort be made to insure prompt reimbursement.

The role played by the NFPP mobile units is an important consideration in the projection of anticipated VSC requirements for the future. Of the 25,133 increase in vasectomy acceptors from 1977 to 1978, 11,473 or 45 percent were the results of the work done by mobile units. Based upon targeted rates of national increase, and the assumption of 25 percent VSC among total NFPP acceptors beyond 1980, it is clear that well over 300,000 VSC's per year will be required by the mid-1980s if the anticipated decline in PGR is to be achieved. To this end, the evaluation team believe that support for extension of the mobile vasectomy program should be continued.

At the present time, the NFPP pays a subsidy to health facilities for all VSCs performed. There is a differential between urban and rural VSC in order to encourage rural acceptors, which has occurred. (See Table 8).

Subsidies are increased for vasectomies performed after the NFPP target has been met in both rural and urban areas. However, this increased subsidy does not seem to provide for an increase in acceptance.

Finally, a greater subsidy is paid for female than for male sterilizations.

A preliminary review of the most recent monthly reports of NFPP service statistics gives some cause for concern, insofar as vasectomy performance for March and April of 1979 for all regions except Bangkok show declines in vasectomies and the central and south regions plus Bangkok show declines in female sterilizations compared with the corresponding months of 1978. Whether these figures represent temporary fluctuations or indicate more significant problems in the program cannot be ascertained within the scope of this evaluation. It is to be noted that characteristically the acceptance rate in recent years has been greater in the second half of the fiscal year. In addition to ordinary seasonal factors (rainfall,

planting times, etc.) the fact that this is the first year that the PCMO's have been given full responsibility for the implementation of the mobile unit program may account for some fluctuation in performance. Whatever the reasons, the monthly figures serve as a reminder that sheer momentum alone cannot be expected to carry the VSC program to the levels which will be required if the NFPP's goals for the coming decade are to be realized.

2. Administrative and Fiscal Aspects of the Expanded VSC Services

The MOPH initiated an "Expanded Sterilization Project" in November, 1972 with financial assistance from the UNFPA. The objective was to improve and enlarge male and female sterilization activities throughout the country by providing reimbursement to health facilities for VSC procedures performed. By the end of the third National Economic Social Development Plan in 1976 there were 358,221 new VSC acceptors against an original program target of 170,000. Despite the success of the program, two limiting factors were identified: 1) 80 percent of the VSC procedures were performed in urban or semi-urban based facilities, and 2) approximately 90 percent of the acceptors were female. Thus the RTG-MOPH requested USAID to assist in redirecting efforts away from the urban-based hospital system toward the rural population served by rural health stations and mobile units. The strategy also called for more emphasis on male sterilization and the provision of VSC procedures free of charge, male and female, in district hospitals, health centers, MCH sub-centers and mobile units.*

At present, over 600 MOPH facilities, other government agency health facilities, university hospitals and private institutions offer VSC services. In addition, the MOPH supports 46 mobile units for male sterilization, with 20 more to be added during 1979.

Table 3
NFPP
VSC Service Units

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>
1. Mobile Units	3	6	46	66
2. Service units in Bangkok	20	20	20	20
3. Provincial Hospitals	70	70	71	71
4. District Hospitals (more than 60 beds)	23	23	23	23
5. District Hospitals (less (than 60 beds) and First Class Health Centers	168	264	264	264
6. M.C.H. Centers	4	4	4	4
7. M.C.H. Subcenters	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>
Total	290	389	430	450**

*Free VSC services for rural population became effective October 1, 1976. The provincial hospitals, PCMD clinics and MCH Centers have the option of charging clients.

**Plus approximately 200 private institutions which collaborate in a voluntary sterilization project sponsored by ASIN. (Source: NFPP, Ministry of Public Health).

The VSC new acceptor rate has continuously increased from 23,546 in 1971 to 168,461 in 1978. As a result, the percent attributed to VSC procedures of all new acceptors has increased from 5.8 in 1971 to 18.9 in 1978. In addition, the number of vasectomy procedures has increased such that the ratio of male VSC to female VSC has dropped from 1:10 in 1976 to 1:2.8 in 1978, with the ratio in rural areas less than 1:2.5.

Table 4
Incidence of Male and Female
Sterilization in Thailand

Year	Male	Female	Male to Female Sterilization Ratio
1976	10,150	95,131	1:10
1977	19,123	106,816	1:6
1978	44,256	124,205	1:2.8

The number of vasectomy acceptors increased more than fourfold from 10,150 in 1976 to 44,256 in 1978. Of the 25,133 increase in vasectomy acceptors from 1977 to 1978, 11,473 or 45 percent, were the result of the work done by mobile units. Moreover, the percent of vasectomy acceptors serviced by the mobile units increased from 3.2 percent in 1976 to 61.9 percent in 1978. The increasing importance of the mobile units is illustrated in the following table.

Table 5
Mobile Units

Year	No.	NFPP Target	Actual	Percent of Total Vasectomies	Percent of All VSC Cases
1976	3	2,100	3,344	32.9	3.2
1977	6	5,000	5,921	30.9	4.7
1978	46	20,000	<u>27,394*</u>	<u>61.9</u>	<u>16.3</u>

*Excludes December 1978 vasectomies by UNFPA-supported units.

The targets of the NFPP for VSC services and the actual number of acceptors by sex since 1972 are found in the following table:

Table 6
NFPP
VSC Services

1972 - 1979*

Year	Female	<u>Actual</u> Male	Total	NFPP target
1972	31,386	1,282	32,668	25,000
1973	46,804	2,802	49,606	30,000
1974	73,702	6,780	80,482	35,000
1975	81,888	7,453	89,341	40,000
1976	95,131	10,150	105,281	40,000
1977	106,816	19,123	125,939	90,000
1978	124,205	44,256	168,461	95,000
1979*	33,148	9,455	42,603	100,000

*January-March

Although the NFPP has exceeded the annual target by a substantial margin each year, the RTG-MOPH has found it important to maintain the targets for at least three reasons: 1) the targets are those established per the corresponding five-year plan; 2) it has been important to keep the program target at 2.1 percent by the end of 1981; and 3) the NFPP view targets as a minimum threshold and has effectively used them as a management tool to reward the PCMO's for achieving and even surpassing the targets.

In the process of increasing the total of new VSC acceptors, the NFPP has also succeeded in shifting more of the VSC services to the rural areas. The percent of urban and rural VSC procedures has changed from 80:20 in mid-1976 to approximately 60:40 as of mid-1979.

The total number of VSC procedures projected for FY 1980 (October 1979-September 1980) is 180,000. This figure includes the NFPP target of 105,000,* plus an estimated 75,000 over target. The overall projections indicate a 1:3 ratio of male to female VSC acceptors and an urban-rural distribution of 56-44 percent. The ratio of male to female is expected to be 1:15 in rural areas and 1:6 in the urban centers.

*78,750 female and 26,250 male.

Table 7
Projected VSC Services
For FY 1980 By Service Unit

Rural Health Centers & Mobile Units

	<u>Male</u>	<u>Female</u>	<u>Total</u>
Target	18,000	28,000	46,000
Over target	<u>13,000</u>	<u>20,000</u>	<u>33,000</u>
Sub-total	<u>31,000</u>	<u>48,000</u>	<u>79,000</u>

Hospitals/MCH Centers

Target	8,250	50,750	59,000
Over target	<u>5,750</u>	<u>36,250</u>	<u>42,000</u>
Sub-total	<u>14,000</u>	<u>87,000</u>	<u>101,000</u>
TOTAL	<u>45,000</u>	<u>135,000</u>	<u>180,000</u>

The operational costs for VSC procedures are approximately $\text{฿}600$ (\$30) for female and $\text{฿}300$ (\$15) for male. The current reimbursement plan of the NFPP for VSC procedures covers one-half the cost of female VSC acceptors both urban and rural. For male VSC acceptors the NFPP pays one-fifth to one-half in urban areas and two-thirds to full cost in rural areas. The reimbursement schedule to MOPH facilities is summarized as follows:

Table 8
NFPP Reimbursement to Health Facilities
For VSC Procedures
By Male/Female & Urban/Rural

	<u>Urban</u>		<u>Rural</u>	
	Baht	US\$	Baht	US\$
Female	150	7.50	300	15.00
Male				
Up to NFPP target	50	2.50	200	10.00
Over target	150	7.50	300	15.00

The FY 1979 project agreement for 1980 operations between the RTG-MOPH and USAID/T continues support for the VSC reimbursement plan at the current level of payment. As before, USAID/T's support is limited to rural areas up to the NFPP target level, while the RTG support covers urban and rural only up to the target.

Table 9
Funding of VSC
Reimbursement Plan
By RTG and USAID

(US Dollars)

	<u>USAID</u> <u>Female/Male</u>		<u>RTG</u> <u>Female/Male</u>	
Up to 105,000*				
Urban	- -		7.50 2.50	
Rural	7.50 7.50		7.50 2.50	
Beyond 105,000				
Urban	7.50 7.50		- -	
Rural	15.00 15.00		- -	

*On June 1, 1977 USAID/T increased its support for the reimbursement of male vasectomy at rural health centers and mobile units from ₪50 to ₪150, which, together with the ₪50 from the MOPH, resulted in a payment of ₪200. Likewise, USAID/T increased its contribution to support costs from ₪50 to ₪150 for all vasectomies beyond the NFPP target.

The total cost of the VSC reimbursement plan in FY 1980 is projected to be slightly less than \$4.0 million plus about \$1.0 million for support of the mobile teams, or some \$5.0 million.

	<u>USAID</u>	<u>USG</u>	<u>Total</u>
VSC Support	\$1,155,000	\$2,728,125*	\$3,883,125
Nibuke teams	<u>686,616</u>	<u>300,000</u>	<u>986,616</u>
Total	<u>\$1,841,616</u>	<u>\$3,028,125</u>	<u>\$4,869,741</u>

*This figure includes an in-kind contribution of \$2,025,000.

RECOMMENDATIONS:

1. THE RTG AND INTERNATIONAL DONOR AGENCIES SHOULD CONTINUE TO SUPPORT EACH COMPONENT OF THE PRESENT PACKAGE OF COMBINED PUBLIC AND PRIVATE SECTOR ACTIVITIES IN THE FIELD OF VOLUNTARY STERILIZATION. MOREOVER, GIVEN ANTICIPATED HIGHER ANNUAL VSC ACCEPTANCE IN THE 1970s, THE LEVELS OF TOTAL SUPPORT SHOULD BE INCREASED.
2. THE SUBSIDY TO HEALTH FACILITIES FOR VOLUNTARY SURGICAL STERILIZATION SHOULD BE CONTINUED, AS WELL AS A SUBSIDY DIFFERENTIAL BETWEEN URBAN AND RURAL STERILIZATIONS. THE SUBSIDY FOR BOTH MALE AND FEMALE STERILIZATION SHOULD BE THE SAME. HENCE, THE ADDITIONAL SUBSIDY FOR VASECTOMIES BEYOND THE TARGET SHOULD BE DROPPED.

VI. SOURCES OF SUPPORT FOR NFPP

A. RTG Support

Appendix K, Table K-1 indicates the levels of RTG support of the NFPP for the period 1976-1981. It must be noted that the figures in Table K-1 do not include the RTG indirect contribution to the NFPP, which is significant. Its indirect support consists of health facilities, equipment, personnel, drugs, etc., equivalent to approximately two to three times the annual totals indicated in the table.

The totals indicated for 1979 through 1981, must be considered in the light of the RTG's budgetary participation in the population project initiated in 1977. While the entire project is designated as the Primary Health Care Program by the MOPH, it affects family planning both directly and indirectly in a number of ways. These are not apparent in the NFPP budget figures (a further reflection of the functional integration of health and family planning in Thailand). Table K-2 represents an attempt to depict those ingredients of the RTG's budget for the Primary Health Care Program which supports its family planning components. Insofar as they are complementary to the 1978-1981 totals in Table K-1, the continuing commitment of the RTG to achievement of its population goal is evident.

B. Sources of External Support

The total external assistance in support of the NFPP and related programs in the public and private sector during 1979-1981 is projected in U.S. \$34.0 million, double the amount of the previous three-year period. (See Table K-3).

Most of the increase is the result of increased support from the multilateral and private sector organizations, particularly the increase in expected funding from UNFPA from \$5.1 to \$12.0 million.

The breakdown by source (see Table K-4) shows \$13.9 million in bilateral support, \$13.0 million in multilateral, and \$7.132 million from others. The number of international donor agencies totals 22, consisting of four bilateral, two multilateral, and 16 private organizations. The latter are predominantly private non-profit institutions, foundations, or universities, most of which are based in the United States.

As is evident from Table K-5 and Figure K-6, virtually all of the bilateral and multilateral assistance is directed to the public sector. The converse is true of the assistance from international private organizations, of which 89 per cent goes to support private sector activities.

The private organization (other) support is expected to total \$7.132 million, coming from three services: FPIA (\$1.82 million), IPAVS (\$1.8 million), and IPPF (\$1.5 million), Canada (\$5.4 million), Germany (\$1.0 million), and Japan (\$0.45 million).

The multilateral support includes \$1.0 million from IDA and \$12.0 million from the UNFPA (for details of donors and recipients, see Tables K-7 and K-8).

C. Support to NFPP

Of the \$34 million in external assistance, the actual amount to support the NFPP is approximately \$20 million, which is increased about one-third from the 1976-1978 level (see Table K-9).

The increase, however, consists of loan funding rather than grants. The apparent decline in the grant figure is explained by the front-end funding by USAID during the last two years. It is important to point out that two-thirds of the support to the NFPP is for the subsidy for VSC and for oral contraceptives. USAID is the principal donor supporting the sterilization program. As indicated in Table K-9 although the UNFPA has increased its total funding by \$7 million during the 1979-1981 period, its support of the NFPP per se remains at the 1976-1978 level.

It appears clear from the available evidence that the NFPP will obtain the necessary funding through 1981. However, given the above facts and the probability that the population growth rate will fall below 2.0 percent during the fifth development plan, the implications of the foregoing data are that:

1. The RTG additionally faces the prospect of increasingly obtaining support from the international donor community in the form of loan instead of grant funding.
2. If the donor community continues to prioritize countries eligible for assistance based upon their current criteria, Thailand may in fact experience a reduction in aid.

Conclusions

This evaluation points to the success of the Thai NFPP, the need to maintain and build on its momentum, the proven efficacy of the free pill policy and sterilization subsidy both of which depend upon external support, and the continuing commitment of Thai leadership to further the already impressive reduction in its population growth rate. In view of these facts, it is essential that the international donor community continue policies and practices which make external assistance of the kind that Thailand has had to date readily available. It would be a cruel irony if successful programs such as Thailand's were not rewarded with continuing needed support as they approach their demographic goals.

RECOMMENDATION:

THE INTERNATIONAL DONOR COMMUNITY SHOULD GIVE FULL RECOGNITION TO THE NECESSITY OF MAINTAINING A LEVEL OF DIRECT SUPPORT FOR THE NFPP TO ASSIST THE RTG IN ACHIEVING THE GOALS OF THE FIFTH NATIONAL ECONOMIC AND SOCIAL DEVELOPMENT PLAN (1982-1986).

D. Private Sector Support

1. Non-government Organizations

In most countries, developed as well as developing, the private sector has played a key role in the initial stages of promoting family planning information and services and of encouraging the government to adopt an official population policy and to mount a national family planning program. In Thailand, however, it was the Thai Government itself, namely the MOPH, which took the initiative to extend family planning services nationwide.* The formal RTG national population policy statement announced in March, 1970, in fact, followed by three years the commencement of the MOPH's "Family Health Project," which integrated family planning services into the Ministry's rural health services.

Due to the rather unusual historical development and the general pervasiveness of the government infrastructure, including the university medical schools, the development of the private sector in family planning did not really occur until the mid-1970's. Today, there are four major non-government organizations which, along with the commercial sector, play an important role in complementing the activities of the RTG's National Family Planning Program. They include ASIN, PDA, PPAT and TAVS.

a. ASIN

The Association for Strengthening Information on National Family Planning Program (ASIN) is a private organization founded in 1977. ASIN's principal project, which is entitled "Voluntary Sterilization in Private Medical Institute" (VSPI), began on October, 1977 with financial support from FPIA.

The purpose of the project is to recruit members among private clinics and hospitals and to provide a subsidy to the institutes for each VSC procedure performed. The present subsidy is ฿200 (\$10) per procedure, and the "informed consent" forms are checked by the NFPP to avoid duplication.

There are some 200 active institutions among the approximately 600 members representatives, 70 of the 72 provinces in Thailand. The total number of VSC procedures in the first year was 13,244 cases (with a male to female ratio of 1:1), and the target for the year ending September 30, 1979 is 27,000, or 2,225 cases per month. Based on the figures to date, ASIN is likely to be near the target by year-end. The number of acceptors are included in the NFPP service statistics, along with the other private organizations. ASIN also sponsors seminars for its members, provides special training and publishes 2,000 issues of a bimonthly magazine called "New Life".

*There were, of course, a number of valuable pioneering efforts in the mid-sixties led by individual clinics such as the Red Cross Clinic at Chulalongkorn Hospital and McCormick Hospital in Chiang Mai.

b. PDA

The Population and Community Development Association (PDA), a registered tax-exempt non-profit organization, grew out of the work of the Community-Based Family Planning Services (CBFPS), which was founded in 1974. With assistance from IPPF the CBFPS initiated community-based family planning services in 1974 in rural areas. By the end of 1978 the activities had reached 7,200 villages in 75 districts and became self-sufficient in cash, with continued contraceptive support from IPPF.

In late 1976, the CBFPS launched an "Integrated Family Planning and Parasite Control Project" in five selected districts with financial assistance from JOICFP. The objectives are to increase family planning acceptance and to lower the high rate of parasite infection.

In mid-1977, USAID funded an operations research project, "Family Planning Health and Hygiene," which expanded the community-based family planning activities into 80 more districts. The districts were divided into four model areas to test the integration of family planning with simple health care (household drugs). By the end of 1978 the CBFPS had selected, trained and made operational 80 district supervisors and 5,800 village distributors in 29 provinces, and reached 65,072 new pill acceptors. Based on the recommendations of an evaluation team in February this year, the CBFPS is now consolidating the 80 districts into one operational research model.

To facilitate the transfer of experience in community-based and community-action concepts in population and development among developing countries, the PDA has recently established the Asian Center for Population and Community Development. The first international training course was conducted in June, 1979.

The PDA established the Population and Community Development Company, a non-profit agency, in 1975, to become a resource development arm for needy services to be rendered by PDA. A number of fertility regulation services are carried out under PDC, including voluntary sterilization, IUD insertions, injectables, and the commercial distribution of condoms in 3,000 outlets throughout the country.

c. PPAT

The current role of PPAT is to focus on IE&C activities and provide services only in remote areas, refugee camps in the Northeast, and other special target groups which might be identified in consultation with the RTG. PPAT is also planning to place more emphasis on youth groups.

d. TAVS

The Thai Association for Voluntary Sterilization (TAVS) is a private, non-profit organization, which was founded in May, 1975, by key people from prominent medical schools, the Ministry of Public Health and the NFPP. Its purpose is to promote sterilization techniques and research on sterilization for both sexes. TAVS receives basic financial support from IPAUS.

TAVS serves as a catalyst to stimulate the inclusion of voluntary sterilization in the national health delivery system. In addition, it promotes understanding of voluntary sterilization as one of the important contraceptive methods within family planning programs among government agencies, private organizations and the public.

Its activities include public education on voluntary sterilization, manpower development, clinical services in Bangkok, and two mobile units in the Northeast. The Association also publishes and distributes 5,000 issues of a monthly newsletter. TAVS has been operating a repair and maintenance center for laparoscopy equipment which will be transferred to the MOPH in 1980. Additional projects pending include a community-based educational program and a surveillance center. The latter would keep detailed data on male and female sterilization throughout the country.

TAVS is sponsoring the first annual meeting of its male vasectomy club, numbering some 5,000 males, in November this year in Bangkok. The two-day program will include seminars, mass media coverage, and festive activities at the Parade Grounds.

Coordination

Coordination among the private organizations and between the private and public sectors is achieved through both formal and informal systems. The formal system consists principally of the National Coordinating Committee, a subcommittee of the National Family Planning Committee. The coordinating committee includes members from the MOPH, DTEC and the four major private organizations (ASIN, PDA, PPAT and TAVS). Participation from the MOPH includes the Director-General of the Department of Health, one of the two deputies, and the director of the Family Health Division, which is responsible for the NFPP. The committee is chaired by the Director-General of Health and meets monthly on a rotating basis, meaning each organization takes turns hosting the committee.

The informal system involves a rather intricate pattern of active participation on the part of a number of key civil servants in the employ of the MOPH, other government agencies, medical schools and academic institutions in the activities of the non-government organizations, either as board members, officers or special advisors. For example, the chairman of the National Coordinating Committee also serves as president of three of the four private organizations (ASIN, PDA, and TAVS). The resulting relationships contribute to greater communication among the members of the Committee and help to minimize any conflicts or problems that may arise. Given the government's interest in strengthening further the role of the private sector, however, it is important that the Committee members take steps to develop joint planning efforts, as well as continue the current process of information sharing.

2. Commercial Sector

About 11 percent of the currently married women, age 15-49, use the drug-store outlets as a source of family planning methods, particularly the pill and condom.* One in five (one in two in Bangkok) buy oral contraceptives and one-half purchase condoms in drugstores. Although the "free pill" policy created a drop of some 10 percent in commercial sales during 1977, the commercial sale of oral contraceptives has maintained an annual level of approximately 3.0 million cycles over the past decade.**

Some of the pharmaceutical firms supplement their sale of pills through drugstores by selling directly to the MOPH. In fact, this type of sale is indicative of a worldwide pattern which is developing with respect to the servicing of contraceptives in general, government purchase and the policy of international donors.

- a. With the active participation of governments in delivery of family planning services, a general decline in commercial sales (unlike the experience in Thailand) is occurring. There is the tendency, therefore, toward concentrating production facilities on a regionalized basis.
- b. Concomitant with the above trend is the gradual transfer in the cost of contraceptives, particularly pills and injectables, from the population (acceptor) to their respective governments.
- c. At the same time that governments are assuming increasing financial responsibility for the purchase of contraceptives, some of the international donor agencies are shifting their assistance from grant to loan funding, thereby increasing still further the cost of contraception to the governments.

The net effect of these three trends is that governments with large family planning programs such as the RTG's are faced with three options. Either they must absorb the added costs by increasing their budgetary support for the program, or shift the added burden to the acceptors in the form of charges for contraceptive services and supplies, or seek more external assistance, an increasing portion of which is likely to be in the form of loans.

Table K-9 lists the participants in a meeting conducted for the evaluation team in order to discuss the role of the private sector in the total family planning effort.

*C.P.S. 1978/1979.

**Based on Quarterly Reports prepared in Price-Waterhouse, compiled from reports of the major pill dealing firms in Thailand.

E. USAID Support: The Population Planning Project

1. The 1970-1975 Project

Shortly after the establishment of the Royal Thai Government's (RTG's) NFPP in 1970, USAID began its first Population Planning Project (493-0266). This was a five-year project which ended in 1975. Its primary purpose was to support development of the basic services delivery system. These joint efforts helped to reduce the population growth rate from over 3.0 percent in 1970 to 2.5 percent by the end of 1976. This project was also instrumental in introducing innovations such as authorizing paramedical personnel to dispense oral contraceptives, training nurses to insert IUD's, and utilizing traditional healers to motivate and provide services. By 1975, there were 5,928 family planning clinics in operation under the Ministry of Public Health, 149 under other Ministries and 16 under private auspices for an overall total of 6,093 clinics. Thailand exceeded its 1975 target for acceptors by 50 percent and by the end of that year, 23.3 percent of the married women of reproductive age were active users of family planning.

The first USAID-financed five-year family planning project involved the expenditure of \$8,292 million in the following categories:

Oral Contraceptives	\$5.265 million
Participant Training	1.865
U.S. Technicians	.595
Contracts	.367
Medical Kits	.204
Other Contraceptives	<u>.046</u>
Total	\$8.292 million

2. The 1976-1981 Project

a. Policy Decisions Affecting the Project

Progress made by the NFPP during the first five years of USAID's involvement led to the decision that support to the NFPP was warranted at least through the end of Thailand's Fourth Five-Year Plan (FFYP) in 1981. Accordingly, the documentation for USAID's second and current Population Planning Project (493-0283) was prepared in 1975. Further USAID support was based on the revised goals of the NFPP as outlined in the fourth plan. The objective of the NFPP revision was to extend the availability of family planning services to virtually all areas of rural Thailand by:

- (1) Expanding the family planning activities of the rural primary health delivery system, including the training and retraining of health personnel in family planning;
- (2) expanding services (including sterilization) in remote areas through the use of mobile family planning units;

- (3) utilizing and/or creating additional channels for distribution of population information and services (including the expanded use of traditional healers);
- (4) increasing the available choices of family planning methods by introducing new contraceptive technologies (including injectables and minilaparotomy) and by increasing the availability of methods in existing facilities.

The 1975 documentation called for a life-of-project funding level over six years of \$8.34 million. However, a number of internal AID/Washington decisions resulted in modification of the original plan. Eventually, the Asian Bureau in 1976 obtained the Deputy Administrator's approval of a plan to "forward fund" some of the last three years' activities by increasing funding levels for the earlier years. Thus, funds totalling \$1.0 million were moved to FY '76 and \$1.27 million to FY '78.

During the summer of 1976, a further alteration of the project budget resulted from an RTG request to USAID for assistance in financing its rapidly expanding program of voluntary sterilization. The RTG's financial situation was made somewhat critical at this time because of a decision by the United Nations Fund for Population Activities (UNFPA) to decrease its funding for Thailand, due to reportedly higher priority demands in other countries. Since there was a critical need to help maintain and expand on the earlier successes of the voluntary sterilization effort, USAID allocated \$3.3 million for support of this activity. However, the project was not amended to show this new development. In an Audit Report of October, 1976, the AID Area Auditor General recommended that AID/Washington act to correct the documentation. Efforts to revise the documentation to reflect this and other proposed changes were delayed by internal reviews of overall assistance strategy relative to Thailand's demonstrated progress in reducing its PGR. The decision was made to continue USAID support of the Thailand NFPP. An Advice of Program Change to the Congress covering the related revisions in USAID support was submitted on August 9, 1977, and the proposed changes were reflected in the FY '78 Congressional Presentation which reflected a new total budget of \$12,215,000.

A 1977 evaluation of the AID project and the continued success of the sterilization program contributed to a decision by USAID to continue its support for an expanded effort. The situational review showed that:

- (1) Voluntary sterilization continued to show strong acceptance by both Thai men and women. The number of cases had grown from 32,668 in 1972 to 105,281 in 1976 for a cumulative total of 358,221 cases for 1972-1976.
- (2) Even better results were expected with the continued expansion of training for medical and

paramedical personnel, provision of medical kits to the personnel trained, and procurement and delivery of special vehicles so that each of the 72 provinces would have a mobile unit by 1980.

- (3) Information, Education and Motivation (IEM) activities and personnel were strengthened so that these could precede visits of the mobile service units.
- (4) Planning was underway for a new expanded multi-donor effort which would upgrade health and family planning services in the 20 most underserved provinces. This new IBRD/RTG/AID project would build on the established successful practices of the RTG/AID Population Planning Project and further enhance the RTG's prospects for achieving or exceeding its target of a population growth rate of 2.1 percent by the end of 1981.

The various changes described above produced a new life-of-project figure of \$16.607 million. The various budget alterations leading to this recommended final figure are shown in Appendix K, Table K-11 (Breakdown of Components financed by AID from Initial Proposal through current PP recommendation). Table K-7 (Components financed by AID and Contributions by RTG, UNFPA and intermediary agencies) breaks the USAID figures down by fiscal year for the six years of the project (FY 1976- FY 1981). Table K-7 also summarizes the assistance provided to the Thai NFPP by the RTG, UNFPA, and intermediary agencies. Support provided by these other entities is expected to total about \$33 million for FY 1976 - FY 1981.

b. Specific Program Components of the 1976-1981 Project

The project was designed to assist the RTG's intent to supplement the clinic based family planning distribution network with additional personnel and facilities in order to extend services "outward and downward" to the rural villages.

Specifics of the project included:

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

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

- (2) Forty (40) mobile family planning units, to deliver clinical FP services (IUD-insertions, sterilizations, injectables) to rural populations not served by health clinics; and
- (3) IUD-insertion training for 2,400 nurses and auxiliary nurse-midwives, thereby increasing availability of this method from a current 400 clinics (staffed by physicians) to over 2,000 clinics staffed by nurses and auxiliary nurse-midwives.
- (4) Other, including a) training and materials development programs to introduce population concepts and family planning information into, respectively, the formal school curriculum and the adult literacy training program of the Ministry of Education; b) a continuing series of operations-related programmatic research to permit testing and rapid introduction of FP program innovations; c) short-term technical consultants in such specialized fields as new contraceptive methodologies, data processing, commercial marketing of contraceptives, and program management.

AID's contribution to this effort originally consisted of:

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

c. Revisions and Amendments of the Project

- (1) The original Population Planning Project was approved in 1975 for life-of-project grant funding of \$8,340,000 subject to the condition that no grant assistance be provided the RTG under the project beyond FY 1978. In 1978, an increase in life-of-project funding to \$9,569,000 was approved.
- (2) The Population Planning Project was revised in June, 1976 (FY 1976 ProAg) to include USAID support for two new project components, a) the expansion of voluntary sterilization services and b) the expansion of family planning training and services in hilltribe regions and resettlement areas.
- (3) In February, 1979 USAID approved an amendment in the Population Planning Project which included an increase in the life-of-project funding by \$8,267,000. Virtually all the increase is to provide support to VSC procedures. The new total level is now \$16,607,000 including \$1,580,000 of bilaterally-funded commodities to be provided during FY 1979-1981 and an estimated \$3,900,000 of centrally-funded commodities which were provided during FY 1976 through FY 1978, as well as \$11,127,000 of other bilateral assistance over the life-of-project. At the same time, USAID also authorized \$2,700,000 in grant funding in FY 1979.

The Thai commitment to the program includes RTG financing of about two-thirds of total financing in FY 1979-1981. In addition, the RTG has borrowed approximately \$33 million (\$28 million from the World Bank and \$5 million from the Canadian government) in support of its family planning and primary health care activities.

3. Relationship to the IBRD/RTG/AID Project

The IBRD/RTG/AID Project was initiated in 1978 to further improve the delivery of health and family planning services. USAID is contributing \$5.5 million to an overall budget of \$68.6 million equivalent for the new joint IBRD/RTG/USAID effort. USAID's \$5.5 million contribution is being made through the new Rural Primary Health Care Expansion Project (493-0291) which was approved in April, 1978. The success of the USAID Population Planning Project was a key factor in attracting these additional resources to improve population and health services in rural Thailand.

4. The Current Population Planning Project (ProAg 1979)

The current RTG-MOPH and USAID/Thailand Population Planning Project includes the following family planning activities: 1) Voluntary Surgical Contraceptive (VSC) Services; 2) Commodities; 3) Training; 4) Operational Research and Evaluation; and 5) Intensified Information, Education and Communication in selected provinces. The total USAID/T grant, based on the Project Agreement signed in mid-1979, which

covers primarily FY 1980 (October, 1979 to September, 1980), is \$2.7 million. The resources provided by the RTG total \$5,310,805, not including costs borne on an "in-kind" basis. (See Table K-12).

a. Voluntary Surgical Contraceptive (VSC) Services

The basic strategy is to continue redirecting program support away from the urban-based hospital system toward the rural poor population served by rural clinics and mobile units which offer VSC procedures free of charge. Thus, USAID/T support is:

(1) VSC Subsidy:

(a) To cover client charges for VSC procedures performed at rural health centers or by mobile units.

(b) To provide institutional support for VSC procedures performed beyond FY 1980 target of 105,000.

USAID provides reimbursements of \$7.50 for each VSC procedure performed at district hospitals, health centers (2nd class), mobile units, and MCH sub-centers; and \$7.50 for each VSC performed beyond the FY 1980 NFPP target of 105,000 at any MOPH facility, including provincial hospitals, PCMO clinics, and MCH centers.

The RTG support includes \$7.50 for female and \$2.50 for male VSC acceptors up to the target of 105,000.

The total reimbursement paid by the NFPP to MOPH facilities is summarized as follows:

	<u>Urban</u>	<u>Rural</u>
Female	\$ 7.50	\$15.00
Male		
Up to VSC Target	2.50	10.00
Over Target	7.50	15.00

Estimated RTG costs based on ratio of 3:1 (female to male) acceptors at \$7.50 and \$2.50 respectively up to 105,000 VSC procedures total \$656,250. In addition, based on the total operational costs for VSC procedures which are approximately ₦600 (\$30) and ₦300 (\$15) for female and male respectively, the RTG "in-kind" contribution is \$2,025,000 (135,000 x \$15) for female acceptors and \$46,875 (18,750 beyond target of 105,000 x \$2.50) for male acceptors.

IE&C Support for Mobile VSC Units. The Equipment for the 20 additional IE&C teams can be supported from prior year funding, with the RTG funding the personnel for the 66 IE&C teams.

(2) Personnel Support

USAID will provide compensation in the form of per diem for all members of mobile teams for the 60 USAID/T supported teams.

Cost: \$687,000

(3) Funding Summary - VSC Program

	<u>USG</u>	<u>RTG</u>	<u>Total</u>
1. VSC Support	\$1,155,000	\$2,728,125	\$4,883,125
2. Pers. Support	<u>686,616</u>	<u>300,000</u>	<u>986,616</u>
Total	\$1,841,616	\$3,028,125	\$4,869,741

(4) NFPP VSC Target

The NFPP target for VSC procedures during FY 1980 (Oct. 1979-Sept. 1980) totals 105,000 -- 78,750 females and 26,250 males. For purposes of calculating RTG and USG support, the total number of VSC procedures projected for FY 1980 is 180,000.

Table 10
FY 1980 VSC Procedures
Distribution by Service Unit

Rural Health Centers & Mobile Units

	<u>Male</u>	<u>Female</u>	<u>Total</u>
Target	18,000	28,000	46,000
Over Target	<u>13,000</u>	<u>20,000</u>	<u>33,000</u>
Sub total	<u>31,000</u>	<u>48,000</u>	<u>79,000</u>

Hospitals/MCH Centers

Target	8,250	50,750	59,000
Over Target	<u>5,750</u>	<u>36,250</u>	<u>42,000</u>
Sub total	<u>14,000</u>	<u>87,000</u>	<u>101,000</u>
TOTAL	<u>45,000</u>	<u>135,000</u>	<u>180,000</u>

(5) Additional Centrally Funded Support for the VSC Program

A separate centrally funded agreement has recently been approved by the JHPIEGO program. It consists of a two-year \$357,070 program which will provide training and equipment for 60 physicians yearly in female sterilization using the "Laprocator" technique. This program is designed to expand the availability of modern female sterilization technology in the provincial hospitals. Since this program has yet to be implemented, it is not included in this evaluation.

b. Oral Contraceptives

Since 1973, the RTG has increased its purchase of oral contraceptives each year. During 1979, RTG will purchase 6,350,000 cycles and in FY 1979 the USG will provide \$522,000 for approximately 3,200,000 cycles.

c. Family Planning Training

NFPP will train non-MOPH personnel as follows:

(a) Tambon Doctors:

One-week training for 1,000 tambon doctors in 15 provinces, to serve as motivators, referral agents and distribute family planning services.

(b) Border Patrol Paramedics (BPP)

Two-week course for 200 BPP at National Family Planning Training Center in Lampang Province.

(c) Traditional Birth Attendants (TBA)

One-week training for 12,000 TBA's in small groups (3-4), training by MOPH public health nurses and auxiliary midwives, also train 400 trainees (auxiliary midwives).

Special priority will be given to the training of TBA's and Tambon Doctors in the 20 AFPH designated provinces.

USG: \$176,548

RTG: \$162,680

Assuming these fundamental premises for the planning of a USAID role in the 1980s, this evaluation made a special effort to analyze and report the diverse inputs of all donors (bilateral, multilateral and private) who currently contribute to the support of the NFPP. It is hoped that this assessment will be of value as a detailed point of reference in the planning of AID's role among donors in support of the next five-year plan.

It would be presumptuous to attempt at this juncture a projection of the total amount of aid that will be required through the fifth plan period. The rapidity with which Thailand becomes self-sufficient depends to a great extent upon factors not under direct control of the RTG. Not only economic forces (world economic trends, oil prices, inflation, markets for Thai exports, etc.), but the need for budgetary adjustments to meet National defense requirements are certain to affect the pace at which the RTG can be expected to assume the cost of inputs that will be required if its population targets are to be met. Moreover, the relative contribution among the numerous donors who now share in the sum total of external assistance is likely to change, particularly, if individual donors prioritize countries eligible for assistance according to criteria based on demographic achievements. The aforementioned assessment is revealing, in that it illustrates the multiplicity and diversity of donor agencies who participate directly or indirectly in assistance to the NFPP.

For these reasons, this evaluation does not attempt to recommend specific inputs, and instead suggests the following as guiding principles as the next phase of development assistance to Thailand evolves:

1. The major thrust of Thai social and economic strategy is basically compatible with the underlying philosophy of current U.S. development assistance.
2. In the overall development strategy for Thailand, family planning continues to deserve a high priority in view of its contribution to the quality of life in addition to its demographic impact.
3. The diversity of the multifaceted NFPP is enhanced by its access to a variety of donors. Planning for future external assistance should preserve this diversity, with a well-coordinated effort by the donor community, including the U.S., to tailor their combined effort according to the legal, economic, and technological strengths and constraints peculiar to each donor.
4. A long history of cooperation exists between USAID and the RTG. Effective working relationships between American and Thai officials have developed, and the resulting trust and mutual respect is a valuable resource on which to build.

The ramifications of U.S. assistance to the NFPP transcend the demographic targets of the RTG. Its continuance is clearly in the best interests of both countries.

5. Institutional and personal contacts between academic and research institutions in Thailand and the U.S., many of which antedate the bilateral aid relationship, continue to contribute to the program in a number of ways. The technical assistance, training, and research that emanates from these established contacts is mutually advantageous and should continue. As a result of Thailand's recognized and growing capability in training and both social and biomedical research, more of these activities should be based in Thai institutions. At the same time some short term technical assistance to Thai institutions where needed, and participation of Thai professionals in short term training opportunities and professional meetings in the U.S. should continue, in order that Thailand may participate fully in new developments in this rapidly changing field.

VII. Implementation of the Major Recommendations of the 1977 Evaluation

The report of the second evaluation of the NFPP, conducted in 1977, was circulated widely among the individuals and institutions who participate in the NFPP. In particular the 14 major recommendations were given careful consideration and for practical purposes 11 of them have either been acted upon, or at least the recommended action is in progress. The following comments refer to the three recommendations which the present evaluation team feels still warrant serious attention.

Recommendation #4: "Policies and Regulations which are still in conflict with the national population policy should be reviewed and revised by the NFPP with the appropriate RTG agency".

In our 1979 meeting with representatives of the commercial sector the opinion was again expressed that agencies other than those directly concerned with the NFPP still have policies and regulations whose effect may be to inhibit indirectly the wide distribution of contraceptives which the NFPP seeks to achieve. The present evaluation team still feels that serious discussion and review across administrative boundaries among the agencies involved in the importing, manufacture, and distribution of contraceptives would help to correct such unnecessarily conflicting policies and regulations.

It is noted that since the 1977 evaluation, the RTG policy of giving educational subsidy has been limited to three children per family.

Recommendation #5: "There should be more frequent meetings of the NFPP committee as well as the NFPP coordinating subcommittee".

It is to be noted that the meetings of the NFPP committee itself have indeed increased in frequency following the second evaluation. However, the increase amounts only to a change from meeting once to meeting twice each year. It is further noted elsewhere in the present evaluation that overlapping memberships on the governing bodies of a number of the agencies represented in the total NFPP effort does in fact make for a considerable degree of useful informal communication and coordination. Nevertheless, it is the opinion of this evaluation team that in view of the rapid changes taking place in the program as well as in the country's demographic situation as a whole, meetings should be held at least four times per year.

Subcommittees (Research and Private Sector Coordination) are now appointed and expected to meet on a monthly basis.

Recommendation #9: "A comprehensive operational planning process should be adopted by the NFPP".

The present evaluation team is fully aware of, and sympathetic with, the great demands upon the time and energy of the central NFPP staff. Nevertheless, the NFPP does not function in isolation, and to the extent that it is increasingly interwoven into the expanding rural primary health care network, an overall operational plan, phased appropriately with the plans of the other related agencies is necessary. The evaluation team observed that planning for the coordination among specific projects and between the NFPP and other administrative entities can still be improved.

VIII. REPORT OF CONSULTATION WITH USAID/T, JULY 23-JULY 26, 1979

TO: Vernon Scott

From: Donald Minkler

Subject: USAID Assistance to the VSC Program of the NFPP

In response to USAID's request, I remained in Bangkok following the June 25-July 20 evaluation, in order to provide consultation regarding the VSC program assisted by AID. Between July 23 and July 26, I have had visits with Dr. Suporn Koetsovang (Director, Family Planning Research Unit, Siriraj Hospital), Dr. Suvanee Satyapan (Director of Sterilization Program, NFPP), Dr. Vilay (Chief of Obstetrics and Gynecology, Ramathibodi Hospital), and Dr. Kamheang Chaturachinda (Department of OB/GYN of Ramathibodi Hospital). Discussions were also held with the USAID project staff, and the documents related to the VSC program were reviewed. The following observations summarize the findings of this consultation.

1. The Mobile Unit Program

Dr. Suvanee noted that of the 42,353 sterilization cases (both female and male) reported in the first three months of the current fiscal year, 9,869 were vasectomies reported by the USAID supported Mobile Units, and 400 by the UNFPA supported Units. It would appear that the momentum added to the program by the Mobile Units will continue through the 1979 fiscal year, even though she acknowledged that some of the northern provinces with high previous contraceptive acceptor rates are beginning to report that the "ready acceptors" are now largely covered, so that target will be more difficult to achieve henceforth.

The reported downturn in VSC acceptors in the March and April statistics reported by the MOPH bears close watching. MOPH officials note that such a fluctuation is not inconsistent with the performance of previous years, and are still projecting a total of 170,482 VSC acceptors for FY '79, based upon the first three months' figures. They also point to the fact that this is the first year that PCMO's have full responsibility for the deployment of Mobile Units in their prospective provinces. If the March/April downturn is sustained over several months, a further review of the VSC program at the provincial level will be needed.

2. The Laproscator Training Agreement

There are widely divergent views among Thai gynecologists concerning the utility of laparoscopic sterilization in Thailand. In particular, the Faculty of Ramathibodi Hospital are skeptical about the practicality of laparoscopic training, pointing to the acquisition and maintenance costs of the equipment and the need for specialized training of physicians already experienced in gynecology and obstetrics as its chief disadvantages. It is understandable that the Ramathibodi faculty are

partial to the minilaparotomy, which was developed at their institution. They are justly proud of its relative simplicity, with no special instrumentation required, other than the simple and inexpensive Ramathibodi uterine elevator. Moreover, the fact that basic surgical training is the only prerequisite to training in minilaparotomy extends its usefulness to locations where District Medical Officers can provide VSC service.

It must be noted that in the course of our evaluation field trips we encountered provincial hospitals where the obstetrician trained in laparoscopy had been transferred to other locations, while the necessary instruments remained the property of the hospital they left behind. Others had laparoscopes inoperative due to delays in obtaining replacement parts (although the RAM program of maintenance and training of operating room staffs was generally praised and felt to be effective).

In contrast to the generally pessimistic view of laparoscopy expressed by Dr. Kamheang, Dr. Suporn feels that the laprocator project will add measurably to Thailand's capability in VSC. He acknowledges some of the difficulties already cited, but attributes them to the early and sporadic introduction of laparoscopy, which produced inevitable gaps in equipment, maintenance, and trained personnel. He feels that the new laprocator project benefits from the prior experience in that it is better conceived, involves simpler and less expensive equipment, and has provisions for follow-up of trainees and maintenance of equipment more securely built into the project. It will enable a practical alternative for cases in which minilaparotomy is contraindicated (obese women, women with pelvic adhesions, etc.), and will provide the additional benefit of a valuable diagnostic instrument in provincial hospitals. In the hands of a properly trained and equipped team, it is generally acknowledged that laparoscopy can be done more quickly than minilaparotomy, enabling a larger VSC schedule on a given day. It is also generally more comfortable than minilaparotomy, thus adding to acceptability of VSC.

This consultant tends to agree in principle with the "simpler is better" argument in planning a large-scale VSC program extending into rural areas in a generally under-doctored country. I must concede, however, that Dr. Suporn's arguments have merit, and that the laprocator project as currently constituted is a vast improvement over the previous JHPIEGO pattern of U.S. based training of participants in a sporadic fashion. While this consultation did not go into the details of the IPAVS agreement which supports the RAM project of training and equipment for the VSC program, I nevertheless would stress the importance of continuing this project hand-in-hand with the laprocator training, and until Thailand is fully self-sufficient in VSC technology and capability.

3. The Subsidy for VSC Services

The current status of the subsidy program is dealt with in detail in the just completed third evaluation of the NFPP. In brief, the evaluation disclosed that the subsidy does appear to lend additional motivation to the providers of VSC and has contributed to the diffusion of VSC services in more peripheral service outlets. My discussions with Dr. Suvanee after the evaluation have given rise to

some doubts about the recommendation made by the evaluation team that the subsidy for both male and female sterilization should be the same. I believe the intent of the recommendation was simply to reduce administrative confusion. However, Dr. Suvanee feels that this is not a problem, and that the higher subsidy for vasectomies beyond the target has contributed significantly to the increased acceptor rates for vasectomy.

4. The ASIN Program

In general, ASIN is regarded as a useful adjunct to the NFPP program, and cooperation between the public and private sector seems to be adequate. This consultation did not deal in depth with the question of adequacy of the present incentive payment to providers under the ASIN program. However, in the course of these visits a few observations were made that may be of interest to USAID. It is generally understood among providers that the incentive payment does not meet the cost of providing the service. In most instances the difference is made up by the physician's fee charged to private patients. In addition, some providers refer to their participation in ASIN as a public service. One observation which appears to have merit, is that the present level of payment works a hardship on those who have operated mobile units under the ASIN program, and those who provide the service in sensitive areas, where acceptors are hard to reach by regular NFPP resources. It was suggested that an increase in payment in such selected circumstances might be considered without necessarily resorting to an across the board increase.

5. Some Concluding General Observations

Assuming a PGR target of 1.5 percent for the fifth development plan, the estimates of need for VSC services (by Vitoon and others) at levels of 300,000 per year and above in the 1980s appear correct. In order to achieve and maintain such levels, the combined effort of regular MOPH health services plus the array of special VSC programs will need to continue. It is apparent from this consultation that the externally supported mobile units, the VSC subsidy, CBFPS, ASIN, TAVS and the various pilot projects (Training, Maintenance, etc.) each contribute measurably to the achievement of VSC targets, with no observable evidence of unnecessary duplication of services. While there may be areas in which the majority of ready acceptors have been reached and more intensive motivational effort will be needed to achieve targets, these are still the exception to the general rule that demand exceeds supply. The wide variation in VSC performance among districts (demonstrated especially in the CBFPS mini-surveys) points to the need for attention to the quality and effectiveness of education/motivation effort as well as the availability of clinical services.

In view of the target-oriented NFPP and the zeal of Thai officials responsible for achieving targets, this consultant gave special attention to the level of compliance with the requirements of voluntarism in VSC services. It is gratifying to note that in spite of the stimulus to achieve targets, the principle of voluntarism seems deeply imbued in the minds of providers and acceptors alike, and the appropriately designed consent forms and procedures are being utilized both in the public and private sectors.

It is inevitable that, as the demand for VSC becomes increasingly met, and as average family size continues to decline, acceptors of lower age and parity will be increasingly reached. While this consultant found no evidence of reports of significant levels of sterilization regret, this phenomenon will inevitably appear in Thailand as it has elsewhere where these trends in age-parity structure of the VSC acceptors have occurred. It is not too early for the medical leadership in Thailand to prepare for this eventuality. It would be in the best interests of the credibility of the NFPP if attention were given to the selection of operative techniques that avoid irreversible damage to reproductive tissues (fallopian tube, vas deferens), and if the training of Thai gynecologists and urologists included techniques of reversal of VSC for the occasional instances of sterilization regret that will eventually appear.

APPENDIX A

GLOSSARY OF ABBREVIATIONS USED IN THE REPORT

BILATERAL ORGANIZATIONS

CIDA	Canadian International Development Agency
GTZ	German Agency for Technical Cooperation
JAPAN	Japanese Government
USAID	United States Agency for International Development (Former designation was USOM - United States Operations Mission)

MULTILATERAL ORGANIZATIONS

IDA	International Development Association (IBRD) (World Bank)
UNFPA	United Nations Fund for Population Activities

OTHER

RTG	Royal Thai Government
MOPH	Ministry of Public Health
NESDB	National Economic and Social Development Board
DTEC	Department of Technical and Economic Cooperation
NFPP	National Family Planning Program
NFPC	National Family Planning Committee
CBFPS	Community-Based Family Planning Services
PPAT	Planned Parenthood Association of Thailand
VHV	Village Health Volunteer
VHC	Village Health Communicator
VSC	Voluntary Surgical Contraception

IE&C	Information, Education, and Communication
DMPA	Depo-Medroxyprogesterone Acetate
SOFT/WFS	Survey of Fertility in Thailand/World Fertility Survey
NSO	National Statistical Office
APHA	American Public Health Association
TAVS	Thailand Association for Voluntary Sterilization
TFRP	Thailand Fertility Research Project
ASIN	Association for Strengthening Information on National Family Planning Program
PDA	Population and Development Assistance
CAP	Contraceptive Prevalence Survey
AID/W	United States Agency for International Development/Washington
E-W CENTER	East-West Center, University of Hawaii
FORD	Ford Foundation
FPIA	Family Planning International Assistance
HEW	United States Department of Health, Education, and Welfare
ICARF	International Committee on Applied Research in Population
IFRP	International Fertility Research Program
IPAVS	International Project Association for Voluntary Sterilization
IPPF	International Planned Parenthood Federation
JOICFP	Japanese Organization for International Cooperation in Family Planning
NORTH CAROLINA	Poplab/University of North Carolina
PATHFINDER	Pathfinder Fund

PIACT

Program for the Introduction and Adapta-
tion of Contraceptive Technology

POP COUNCIL

Population Council

SPH/UH

University of Hawaii

APPENDIX B

Sites Visited During Field Trips

<u>Province</u>	<u>PCMO Office</u>	<u>Provincial Hospital</u>	<u>District Hosp. Crown Prince Hospital</u>	<u>Health Centers</u>	<u>Refugee Camp</u>	<u>Midwifery Center</u>
<u>North</u>						
Chiang Rai*	X	X	XX	XX	X	
Phitsanulok	X	X	XX	X		
Sukhothai	X	X	X	X		
<u>South</u>						
Songkhla	X	X	X	X		
Phuket	X	X	X	X		
Phang-nga	X	X	X	X		
<u>Central</u>						
Karachanaburi	X	X	X	XX		
Suporuburi	X	X	X	X		
Prachinburi	X		X			
<u>Northeast</u>						
Udonrathani	X	X	X	X		X
Nonkhai	X	X	X	X	X	X
Ubon	X	X	X	X	X	X

* Other sites: Mobile Vasectomy Unit, Hilltribes Development Center,
School of Nurse-Midwifery

APPENDIX C

Organizations Visited By Evaluation Team

Ministry of Public Health

Director of Family Health Division

Evaluation and Research Section Family Health Division

IE&C Section Family Health Division

Training Section Family Health Division

Health Planning Division

Ministry of Education

Deputy Minister of Education

Non-Formal Education Section

Bilateral Organization

USAID

Multinational Organizations

UNFPA

World Bank

Private Voluntary Organizations

Population Council

Ford Foundation

Association for Strengthening Information on National Family
Planning Programs (ASIN)

Thailand Association for Voluntary Sterilization (TAUS)

Planned Parenthood Association of Thailand

Community-Based Family Planning Services (PDA/CBFPS)

International Family Planning Project

American Home Economics Association

Nurses' Association of Thailand

Statistical/Demographic Organizations

International Committee on Applied Research in Population
of Asia (ICARP)

Institute of Population and Social Research - Mahidol
University

Institute of Population Studies - Chulalongkorn University

National Statistics Office

Others

Representatives of five commercial drug companies

APPENDIX D

Table D-1

Percent by Currently Married Women Aged 15-44 Currently Practicing any Method of Contraception as Reported in Four National Surveys, Unstandardized and Standardized for Age of Woman

		Unstandardized For Age		Standardized For Age ^a	
		Rural	National	Rural	National
L.S.	1969 (1969/70) ^c	10.9	14.8	10.5	14.4
L.S.	1972 (1972/73) ^d	22.8	26.3	22.8	26.0
SOFT	1975	34.8	36.7	34.9	36.8
C.P.S.	1978/79	51.3	53.4	53.1	55.4 ^b

^a The age distribution of currently married women for the whole kingdom as reported in the 1970 census was used as the basis of the age standardization.

^b Excludes provincial urban but includes Bangkok in twice the relative proportion of the rural areas.

^c Rural round in 1969; urban round in 1970.

^d Rural round in 1972; urban round in 1973.

APPENDIX D

Table D-2

Percent of Currently Married Women Aged 15-44 Practicing Specific Methods of Contraception from Four National Surveys

	<u>Pill</u>	<u>IUD</u>	<u>TR</u>	<u>VAS</u>	<u>INJECT</u>	<u>CONDOM</u>	<u>OTHER^a</u>
<u>Rural</u>							
L.S. 1969	2.8	2.2	3.1	2.0	0.4	0.0	0.5
L.S. 1972	9.6	4.6	4.8	2.7	0.8	0.0	0.4
SOFT 1975	14.3	6.7	6.5	2.2	2.1	0.3	2.7
CPS 1978/9	23.7	3.8	10.8	3.6	5.0	1.5	4.2
Change 1969-78/9	20.9	1.6	7.7	1.6	4.6	1.5	3.7
Change 1975-78/9	9.4	-2.9	4.3	1.4	2.9	1.2	1.5
<u>National</u>							
L.S. 1969/70	3.8	2.2	5.5	2.1	0.4	0.8	
L.S. 1972/73	10.4	4.6	6.8	2.9	0.9	0.1	0.5
SOFT 1975	15.2	6.5	7.4	2.2	2.1	0.5	2.9
CPS 1978/9 ^b	21.9	4.0	13.1	3.5	4.6	2.1	4.6
Change 1969/70-78/9	18.1	1.8	7.6	1.4	4.2	n.a.	n.a.
Change 1975-78/9	6.7	-2.5	5.7	1.3	2.5	1.6	1.7

Notes: Results from the CPS are tentative since minor adjustments had to be made to estimate the number of currently married users aged 15-44 from data on the number of currently married users 15-49 and the number of ever married users 45-49.

^a Since use of other methods was specifically asked in SOFT and CPS but not in the L.S., the apparent increase between the L.S. and the other surveys is probably exaggerated.

^b Excluding provincial urban but including Bangkok in twice the relative proportion of the rural areas.

D-2

74

APPENDIX D

Table D-3

Percent of Currently Married Women Aged 15-49
Currently Practicing Any Method of Contraception
by Region 1975 to 1978/79

	<u>SOFT</u> <u>1975</u>	<u>FP/HHP</u> <u>1977</u>	<u>CPS</u> <u>1978/79</u>	<u>Increase</u>
<u>Rural</u>				
North	43		55	+12
Northeast	25	36 ^c	45	+20
Central	42		57	+15
South	16		37	+21
All Rural	33		49	+16
<u>Bangkok</u>				
<u>Bangkok</u>	48 ^a		63	+15
<u>National</u>	35		51 ^b	+16

^a All urban places in central region.

^b Excludes provincial urban residents but includes Bangkok on twice the relative proportion of the rural areas.

^c Recalculated to exclude municipal areas (by deleting entire "amphoe muangs" from the sample). However, results including municipal areas are identical.

15

APPENDIX D

Table D-4

Percent of Currently Married Women 15-49
Practicing More Efficient and Less Efficient
Methods of Contraception by Region
According to the 1978/79 C.P.S.

	<u>More Efficient Methods</u>	<u>Less Efficient Methods</u>
<u>Rural</u>		
North	53.5	1.6
Northeast	43.8	3.5
Central	56.3	0.3
South	23.6	13.1
All Rural	45.3	4.1
Bangkok	59.4	4.1
National ^a		

^a Excludes provincial urban but includes Bangkok in twice the relative proportion to the rural areas.

APPENDIX D

Table D-5

Percent of Currently Married Women Aged 15-44
Currently Practicing Any Method of Contraception
by Age 1975 - 1978/79

	<u>Rural</u>			<u>National^a</u>		
	<u>SOFT</u>	<u>CPS</u>	<u>Increase</u>	<u>SOFT</u>	<u>CPS</u>	<u>Increase</u>
	<u>1975</u>	<u>1978/79</u>		<u>1975</u>	<u>1978/79</u>	
15-19	16.7	30.0	13.3	18.1	31.3	13.2
20-24	28.5	44.6	14.1	30.9	44.2	13.3
25-29	39.9	53.5	13.6	41.0	54.4	13.4
30-34	42.4	58.4	16.0	44.0	61.1	17.1
35-39	40.3	59.4	19.1	42.3	62.8	20.5
40-44	27.6	45.8	18.2	30.5	49.5	19.0
15-44	34.8	51.3	16.5	36.7	53.4	16.7

^a The national figures for the C.P.S. exclude provincial urban areas but include Bangkok in twice the relative proportion of the rural areas.

APPENDIX D

Table D-6

Percent of Currently Married Women 15-49
Currently Practicing Contraception by Years of Schooling

<u>Rural</u>	<u>SOFT</u> <u>1975</u>	<u>CPS</u> <u>1978/9</u>	<u>Increase</u>
0	27	47	20
1-7	34	49	15
8+	52	60	8
<u>National</u>			
0	28	49 ^a	21
1-7	35	51 ^a	16
8+	52	66 ^a	14

Notes: The results for the C.P.S. are tentative since the percent currently using among currently married women was estimated from the percent using among ever married women.

^a Excludes provincial urban but includes Bangkok in twice the relative proportion to rural.

APPENDIX D

Table D-7

Source of Family Planning by Method, C.P.S. 1978/79
for Currently Married Women 15-49

	<u>PILL</u>	<u>CONDOM</u>	<u>IUD</u>	<u>T.R.</u>	<u>VAS</u>	<u>INJECT</u>	<u>ALL METHODS</u>
Government Outlet	73.2	31.5	80.4	95.3	66.7	76.5	77.1
Drugstore	21.2	50.0	0.0	0.0	0.0	0.8	11.3
CBFPS	3.2	9.3	0.0	0.0	1.0	0.0	1.8
Other	2.5	9.3 ^a	19.6	4.7	32.3	31.7	9.7
Total Percent	100	100	100	100	100	100	100
Number of Users^a	567	54	107	359	99	123	

^a Excluding cases of unknown source.

APPENDIX D

Table D-8

Percent of Current Users of Methods Included
in the NFPP WHO Report Receiving Method from
Government Outlet by Region, C.P.S. 1978/79

Rural

North	79.8 ^a
Northeast	76.1
Central	74.7
South	91.9
All Rural	78.8
Bangkok	68.1
National ^b	70.4

Note: Methods provided in the NFPP are pill, IUD, condom, male and female sterilization and injection. Results based on couples who were currently married and in which the wife was between ages 15-49.

^a Acceptors in Chiang Mai from the McCormick Hospital and mobile clinic are included in the government outlet category.

APPENDIX D

Table D-9

Source of Pills by Region, C.P.S. 1978/79
for Currently Married Women 15-49

	Rural				All Rural	Bangkok	National
	North	NE	Central	South			
Government Outlet	81.3	81.3	70.2	81.8	79.8	31.2	73.2
Drugstore	15.8	11.0	24.5	9.1	15.5	57.1	21.2
CBFPS	2.4	5.2	2.1	9.1	3.7	0.0	3.2
Other	0.4	0.6	3.2	0.0	1.0	11.7	2.5
Total	100	100	100	100	100	100	100
Number of Users	209	154	84	33	490	77	567

APPENDIX D

Table D-10

Active Users of NFPP Supplied Contraception as Percent
of Currently Married Women 15-44: Comparison to NFPP
Statistics and Results from the C.P.S.

	<u>Active Users 1978 as Indicated by NFPP^a</u>	<u>Estimated from C.P.S. 1978/79^b</u>
North	48.4	46.1 ^c
Northeast	36.7	33.9 ^c
Central (excluding Bangkok)	38.9	45.8 ^c
Bangkok	43.4	39.5
South	33.5	21.6 ^c
National	39.2	37.6 ^d

Notes: NFPP supplied contraception including pill, IUD, condom, TR, vasectomy and injection.

^a Unweighted averages of provincial level statistics in active users per 100 MWRA

^b Estimated by multiplying the prevalence rate for the combined appropriate methods by the proportion of users who reported the source of contraception to be a government outlet or a private outlet which reports acceptors to the NFPP.

^c Excluding provincial urban.

^d Excluding provincial urban but including Bangkok in twice the relative proportion of the rural area.

APPENDIX D

Table D-11

Total Fertility Rates by Region, Comparison of the
First and Second Year of the Survey of Population
Change (SPC)

	<u>1974/75</u>	<u>1975/76</u>	<u>Change</u>
North	3.79	3.79	0.00
Northeast	6.59	6.15	-0.44
Central	4.67	3.60	-1.07
Bangkok	3.65	3.29	-0.36
South	6.28	6.05	-0.23
National	5.17	4.63	-0.54
All Rural	5.31	4.67	-0.64
All Urban	4.58	4.40	-0.18

Appendix D

Table D-12

Comparison of Total Fertility Rates from the SPC
1974/76 and the CPS 1978/79

	S.P.C. 1974/76 ^a	FP/HHP 1977 ^e	C.P.S. 1978 ^b	Change
North	3.74		3.18 ^c	-0.61
Northeast	6.25	5.29 ^e	3.66 ^c	-2.59
Central (excluding Bgk)	4.11		3.41 ^c	-0.70
Bangkok	3.46		3.18	-0.28
South	6.12		5.58 ^c	-0.54
National	4.90		3.68 ^d	-1.22
All Rural	4.98		3.79	-1.19

Notes: Because of the different methodologies used in the derivation of total fertility estimates from the S.P.C. and C.P.S., the comparison of results should be treated with utmost caution. The amount of decline is almost certainly exaggerated since the dual record methodology of the S.P.C. would normally lead to higher estimates of fertility than fertility rates based in retrospective reports of the date of last birth as was used in the C.P.S.

^aFertility for the period from mid 1974 to mid 1976.

^bFertility during the year prior to the survey which took place in December 1978 - January 1979.

^cExcluding the provincial urban population.

^dExcludes provincial urban but includes Bangkok in twice the relative proportion of the rural areas.

^eFertility for the year prior to the survey which took place in August - September 1977.

64

Appendix D

Table D-13

Marital Fertility Rates Standardized for Age to
Currently Married Women 20-44 from SOFT and CPS

	Standardized for Age to Women 20-44			Change
	SOFT 1973/5 ^a	FP/HHP ^c	CPS 1978	
<u>Rural</u>				
North	.152		.126	-.026
Northeast	.315	.255 ^d	.176	-.139
Central	.185		.177	-.008
South	.352		.252	-.100
All Rural	.216		.175	-.041
Bangkok	n.a.		.181	n.a.
National	.210		.177 ^b	-.033

^aThe rates in this column refer to fertility during the 24 months prior to the survey expressed as an annual rate and are adjusted for periods of exposure of less than 24 months for women married less than two complete years.

^bExcludes provincial urban but includes Bangkok in twice the relative proportion of the rural areas:

^cThe rate from the FP/HHP refers to the 12 months prior to the survey which took place in August - September 1977.

^dIncludes provincial urban.

85

Appendix D

Table D-14

Percent Pregnant Among Currently Married Women Age 15-44 by Region of Residence Standardized for Age

	SOFT 1975	FP/HHP 1977	CPS 1978/79	Change
<u>Rural</u>				
North	7.7		7.3	-0.4
Northeast	15.7	11.0 ^a	11.5	-4.2
Central	11.2		9.2	-2.0
South	11.6		13.2	-1.6
All Rural	12.2		10.1	-2.1
Bangkok	n.a.		10.2	n.a.
National	11.8		10.1 ^b	-1.7

Notes: The age distribution of currently married women as reported for the whole kingdom was used as the basis for standardization.

^aUnstandardized for age and including a small number of women aged 45-49. Results recalculated to exclude municipal areas (by deleting entire "amphoe muangs" from the sample). However, results including municipal areas are identical.

^bExcludes provincial urban but includes Bangkok in twice the relative proportion of the rural areas.

APPENDIX D

Table D-15

Percentage of All Registered Births of Known Birth
Order that are Third or Higher Order Births:
1961 - 1978

1961 - 65	60.5
1966 - 70	59.5
1971 - 74	54.3
1975	47.6
1976	45.2
1977	41.2
1978	40.0

APPENDIX E

The Impact of the Free Pill Policy on Contraceptive Prevalence

While there is considerable debate about the desirability of the free pill policy of the NFPP, often based on philosophical differences between those approving and those opposing the policy, the available evidence from survey data, and, more importantly from service statistics, seems to indicate that the policy has had a substantial effect in increasing contraceptive practice among the rural population.

To briefly review the relevant results from the surveys, increases in pill usage account for more of the increase in contraceptive prevalence between 1975 and 1978 than all other methods combined. Moreover, the rate of increase in contraceptive prevalence accelerated during this period compared to others. The increase has been especially large among the more disadvantaged segment of the population (as indicated by educational levels) which is what we might expect from the free pill policy since it should have larger appeal among the poorer women.

Data from service statistics of the NFPP document the dramatic increase in new acceptors. As is apparent in the accompanying graph, new pill acceptors were reasonably constant between the first quarter of 1975 until the third quarter of 1976 just before the introduction of the free pill. Between the third quarter of 1976 and the first quarter of 1977, new

pill acceptors increased from 80,631 to 118,123 or by 46 percent. This increase in new acceptors was sustained at a more or less constant rate through the second quarter of 1978 after which a further increase occurred which has been sustained through the latest figures (1st quarter 1979).

With such a dramatic increase in new pill acceptance, questions naturally arise concerning (a) the extent to which the free pills have simply caused women to switch method or to switch from the commercial sector to the government program and (b) whether the continued increase in new pill acceptors occurred at the cost of taking new acceptors away from other methods. Data from the service statistics on new acceptors of methods from the NFPP other than the pill are also plotted on the graph. A slight drop in the number of new acceptors for methods other than the pill is evident for the fourth quarter of 1976 but this is immediately reversed and instead of declining or leveling off, new acceptors of methods other than the pill generally increase at an even faster pace than prior to the introduction of the free pill policy. If anything, the free pill policy, perhaps in relation to the general policy of free medicine at health centers, seems to have increased acceptors of all methods and not just the pill. Of course, many other factors were operating and probably had an influence on the method mix but at least it is clear that the increase in new pill acceptors was not at the expense of new acceptors to

other methods offered by the NFPP.

1975	3,633,416
1976	2,923,339
1977	2,889,746
1978	3,204,441

They suggest a slight drop associated with the free pill but probably only of the order of 10 percent or less and involving a very small percentage of women who were active pill users at the time.

The CBFPS, whose statistics are included in the NFPP statistics and thus in the new acceptors shown in the graph, appears to have lost some new pill acceptors to the program as indicated by a report from the NFPP but the net change is already taken into account by the figures in the graph. In sum, the free pill policy resulted in a net gain in acceptance despite switching CBFPS and some minor loss from the commercial sector.

Finally, it should be noted that continuation rates of usage after the introduction of the free pill policy are at least as good as prior to it despite arguments by opponents that giving the pill free would "devalue" it in the minds of the acceptors and reduce acceptance. According to the 1977 continuation rate survey which included women who started on the pill both before and after free pill distribution began,

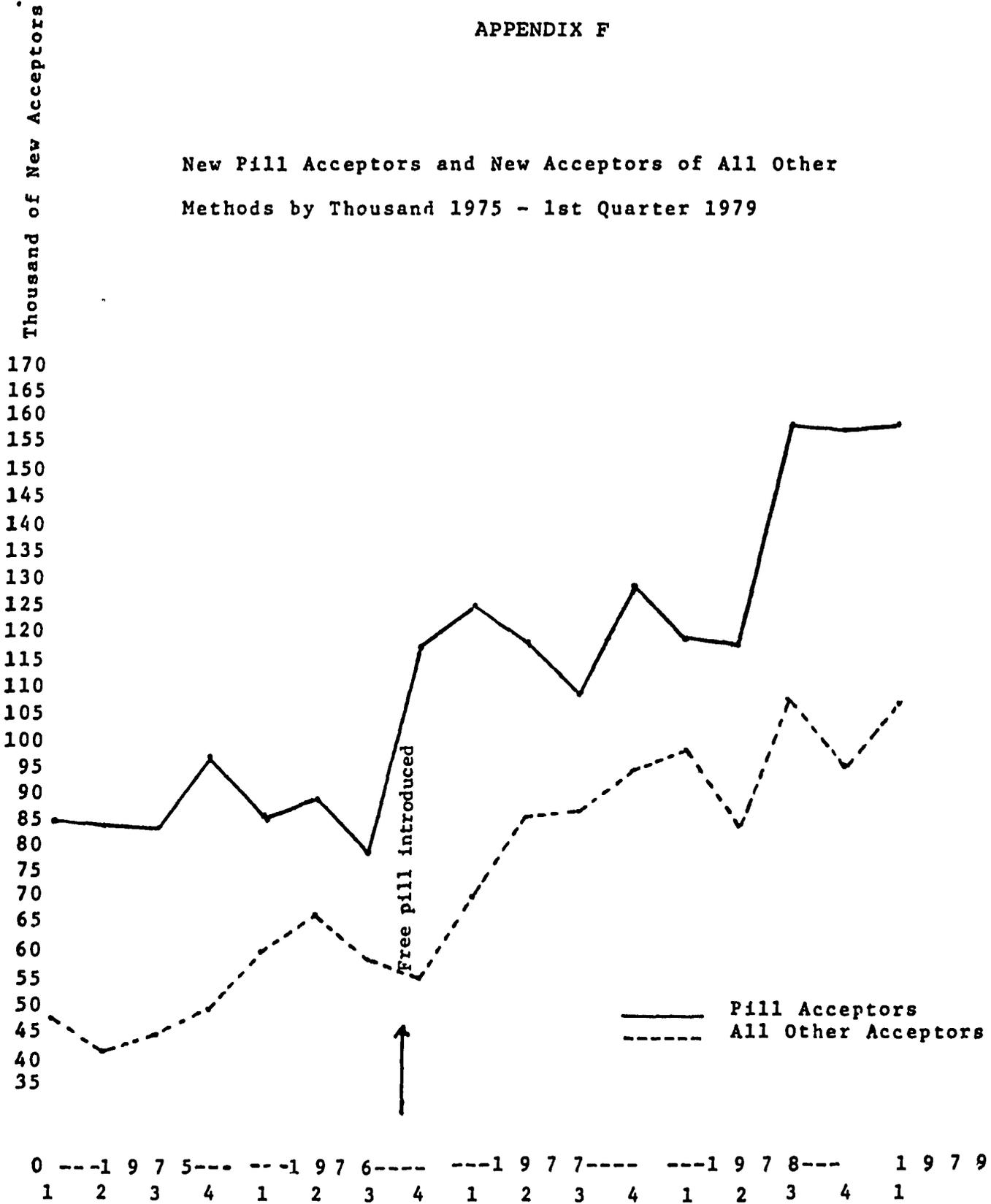
the following continuation rates are observed:

<u>Months Since Acceptance</u>	<u>Post-Oct. 1976 Acceptors</u>	<u>All Pill Acceptors</u>
3	91.2	98.8
6	84.6	81.8
9	78.0	76.6
12	74.9	72.2

The somewhat higher continuation rates of the post-October 1976 acceptors may reflect the greater willingness to continue on the pill if there is no cost for resupply. This was mentioned by a number of primary suppliers during the field trip to the Northeast.

APPENDIX F

New Pill Acceptors and New Acceptors of All Other Methods by Thousand 1975 - 1st Quarter 1979



92

APPENDIX H

IMPACT OF REDUCED POPULATION ON PER CAPITA GNP 1970 - 1978

	1970	1978 ^e	1970-78
GNP (Millions of Baht)	134,439	441,950	
Number of Population (in thousands) without FP	36,370	45,185	
% Actual Growth Rate Per Year	2.75	2.05	
Number of Population (In thousands) with FP	36,370	44,278	
Per Capita GNP at 2.5% Constant Growth Rate	3,751	9,781	160.75% ^a 20.09% ^b
Per Capita GNP (Actual Growth with FP)	3,751 3,751	9,981 9,981	166.08% ^c 20.76% ^d

- a Total increase during 1970-78 is 160.75%]without FPP
- b Average increase during 1970-78 is 20.09%
- c Total increase during 1970-78 is 106.08%]with FPP
- d Average increase during 1970-78 is 20.76%

The difference of per capita income by the end of 1978 between F.P.P. and without is 2.04%.

APPENDIX I

Percent of Women* in Thailand with Specific Knowledge
of Contraceptives by Type of Knowledge

<u>Method</u>	<u>Knowledge Not Prompted</u>		<u>Ever Heard of With or Without Reminder</u>	
	1975 ⁺	1978/79	1975	1978/79
PILL	78%	88%	93%	99%
IUD	51	51	87	93
FEMALE STERILIZATION	45	61	88	96
MALE STERILIZATION	24	36	72	87
INJECTION	22	42	73	90

* 1975 Currently married women, 15-44
1978/79 ever married women, 15-49.

+ 1975 Source: Survey of Fertility in Thailand 1975.
1978/79 Source: Thailand Contraceptive Prevalence Survey.

95

APPENDIX J

N.F.P.P.

Training Activities 1977 - 1981

<u>Number of Trainees</u>	<u>Type of Trainees</u>	<u>Funding Agency</u>	<u>Year/s</u>	<u>Cost (US\$)</u>
56	Regional Task Force Tainers	UNFPA	1977	18,000
2,238	Service Level Personnel	UNFPA/UNICEF	77	102,755
743	Nurse Midwives IUD Insertion	USAID/FH.Div. UNFPA/FH.Div.	77 79-81	224,910
320	Aux. Midwives IUD Insertion	Pathfinder UNFPA	77 79-81	29,175 252,075
3,000	Refresher Course Aux. Midwives	UNFPA	79-81	510,375
	-	UNFPA	79-81	83,250
600	Pre-Service Trng. Nurse Midwives	UNFPA	79-81	97,500
500	Aux. Midwives Students in F.P.	RTG	77-81	
750	Nurse Assistants	RTG	77-81	
150	Workshop Staff FHD	UNFPA	79-81	31,332
35	Workshop Trng. Staff FI & D	UNFPA	77	20,280
40	Workshop on Org. Dev. for Improve- ment of Community Based Trng. Prog.	UNFPA	78	10,000
390	TOT Tambon Drs. and TBAs	USAID	76-78	61,425

<u>Number of Trainees</u>	<u>Type of Trainees</u>	<u>Funding Agency</u>	<u>Year/s</u>	<u>Cost (US\$)</u>
3,500	TOT Aux. Midwives TBA Training	USAID	78-81	131,600
14,000	TBA Training	USAID	78-81	129,750
4,400	Tambon Doctors	USAID	78-81	100,000
1,000	Jr. Sanitarians Field Workers	UNFPA	80-81	72,720
200	Personnel Outside MOPH	UNFPA	80	35,468
60	Field Workers Bangkok Metropolitan	UNFPA	79-81	3,150
240	Mobile Hilltribes Welfare	USAID	77	41,314
1,086	Self-Help Land Settlement Workers	USAID	77	4,174
1,650	Border Patrol Police	USAID/UNFPA	77-81	194,240
1,200	Military Male Nurses	UNFPA	79-81	138,624
300	Govt. Enterprise & Private Clinic Nurses	UNFPA	79-81	60,720
38	Group Leaders Refugee Camps	RTG	78	
90	Paramedics Refugee Camps	RTG	78	
189	Housewives Refugee Camps	RTG	78	
20	International Trng. in FP. Admin.	RTG	78-81	
48	Personnel Outside MOPH - Yala Prov.	UNFPA	78	1,680
70	Sea Tribes	UNFPA	78	1,500
80	Prov. Chief of Agri. Officers	UNFPA	78	10,000

<u>Number of Trainees</u>	<u>Type of Trainees</u>	<u>Funding Agency</u>	<u>Year/s</u>	<u>Cost (US\$)</u>
80	Regional & Prov. Educ. Supervisors	UNFPA	78	1,500
200	Factory Medical Doctors	UNFPA	79-81	28,762
200	Factory Managers	UNFPA	80-81	24,762
240	Factory & Industrial Nurses	UNFPA	80-81	29,640
40,000	Factory & Industrial Workers	UNFPA	80-81	161,000 (Acceptors)
30	Home Economics Community Dev. Workers	UNFPA	79	3,280
120	M. OS in Bangkok Metropolitan	UNFPA	79,81	1,040
460	Nurses Bangkok Metropolitan	UNFPA	79,81	5,890
110	Social Workers Bkk Metropolitan	UNFPA	79,81	420
415	Refresher Course Field Workers Bkk Metropolitan	UNFPA	79-81	1,965
80	Seminar on Integration of FP. into other Health Progs.	UNFPA	78	<u>10,000</u>
				\$2,634,255*
78,518				
38,516	Providers		* \$2,473,255	$\bar{x} = 64.21$
40,000	Acceptors		\$ 161,000	$\bar{x} = 4.03$

* Not including RTG contribution or training staff salaries

Yearly average budget	\$ 526,851.00
Yearly average number of trainees	15,703.00
Yearly average number of Provider trainees	7,703.00

APPENDIX K
Table K-1

RTG BUDGET FOR THE NFPP
(1976-1981)
(\$00's)

<u>Regular Budget</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>
1. Salaries & Wages	247.8	362.3	427.0	476.8	825.9	
2. Remuneration	4.0	7.0	11.8	13.3	10.0	
3. General Expenses (Per diem, travel, repair costs, etc.)	135.0	229.7	252.2	280.3	300.0	
4. Commodities & Supplies (including O.C.)	750.0	1,144.3	1,244.5	596.7	652.6	
5. Equipment	7.2	80.7	211.9	127.4	5.14	
6. Land & Construction	-	106.1	171.8	136.8	5.0	
7. Sterilization Subsidies	-	550.0	550.0	800.0	800.0	
Sub-Total	<u>1,144.0</u>	<u>2,480.1</u>	<u>2,869.2</u>	<u>2,431.3</u>	<u>2,598.6</u>	<u>2,780.0</u>
<u>Project Counterpart Funds</u>						
1. Salaries	14.3	28.3	•			
2. Per diem, travel, Hotel allowance, etc.	22.0	52.7				
3. Transportation of things & Maintenance	5.0	5.0	7.1			
4. Commodities & Supplies (including O.C.)	231.0	239.0	467.5			
5. Equipment	50.0	190.0	54.6			
Sub-Total	<u>322.3</u>	<u>515.0</u>	<u>529.2</u>	<u>500.0</u>	<u>500.0</u>	<u>500.0</u>
Total	1,466.3	2,995.1	3,398.4	2,931.3	3,098.6	3,280.0*
* Estimate						

K-1

99

APPENDIX K

Table K-2

RTG SUPPORT OF FAMILY PLANNING FOR FY 1978-1979
IN THE NFPP AND THE PRIMARY HEALTH CARE (IBRD) PROGRAM
(BAHT)

CATEGORY	NATIONAL FAMILY PLANNING PROGRAM		FAMILY PLANNING COMPONENTS PRIMARY HEALTH CARE PROGRAM			
	FY 1978	FY 1979	FY 1978		FY 1979	
			Thai	Loan & Grant	Thai	Loan & Grant
Salaries	2,306,300	2,820,000	-	-	-	-
Permanent Wages	4,785,500	5,245,300	-	-	1,614,000	-
Temporary Wages	1,448,700	1,469,700	-	-	-	-
Remuneration	235,000	265,000	-	-	69,500	-
Ordinary Expense	5,200,000	5,604,900	-	-	11,287,900	-
Materials	24,890,000	11,934,200	-	-	3,542,300	-
Equipment	4,237,200	2,548,000	-	-	4,453,860	8,271,410
Land & Construction	3,436,000	2,736,000	3,000,000	-	1,449,300	3,726,900
Subsidies	11,000,000	16,000,000	-	-	-	-
	<u>57,538,700</u>	<u>48,623,300</u>				
TOTAL	57,538,700	48,623,300	3,000,000	-	22,416,860	-
DIRECT PAYMENT	-	-	-	-	-	12,857,533
GRAND TOTAL	<u>57,538,700</u>	<u>48,623,300</u>	<u>3,000,000</u>	<u>-</u>	<u>22,416,860</u>	<u>24,855,843</u>

K-2

109

APPENDIX K

Table K-3

External Assistance
for Two Three-Year Periods
1976-1981 by Source
(\$000's)

Source	1976-1978*	1979-1981**	Increase (%)
Bilateral	9,500	13,900	+146
Multi-lateral	5,100	31,000	+256
Other	3,100	7,132	+230
Total	<u>17,700</u>	<u>34,032</u>	+192

* Possibly slightly underestimated.

** Estimate

APPENDIX K Table K-4
External Assistance (Estimate)
NFPP & Related Programs
1979 - 1981
(\$ 000's)

SOURCE	PUBLIC			PRIVATE				TOTAL	
	BILATERAL	MOPH	OTHER	ASIN	PDA/CBFPS	PPAT	TAVS		OTHER
CIDA		5,400*							5,400
GTZ		1,000			250				1,250
JAPAN		450							450
USAID		6,800							6,800
Sub-total		<u>13,650</u>	<u>-</u>	<u>-</u>	<u>250</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>13,900</u>
<u>MULTILATERAL</u>									
IDA		1,000*							1,000
UNFPA		6,400	4,300		1,300				12,000
Sub-total		<u>7,400</u>	<u>4,300</u>	<u>-</u>	<u>1,300</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>13,000</u>
<u>OTHER</u>									
AID/W					700				700
E-W Center		6							6
Ford			200						200
FPIA				1,200	350			270	1,820
HEW			220						220
ICARP			50						50
IFRP		50						150	200
IPAVS					550		1,200	50	1,800
IPPF						1,500			1,500
JOICFP					100				100
No. Carolina			6						6
Patrinder					100				100
PIACT					100				100
Pop. Council			200					50	250
SPH/UH		50							50
Westinghouse		30							30
Sub-total		<u>136</u>	<u>676</u>	<u>1,200</u>	<u>1,900</u>	<u>1,500</u>	<u>1,200</u>	<u>520</u>	<u>7,132</u>
TOTAL		<u>21,186</u>	<u>4,976</u>	<u>1,200</u>	<u>3,450</u>	<u>1,500</u>	<u>1,200</u>	<u>520</u>	<u>34,032</u>

* Contraceptives via Population Project

102

APPENDIX K

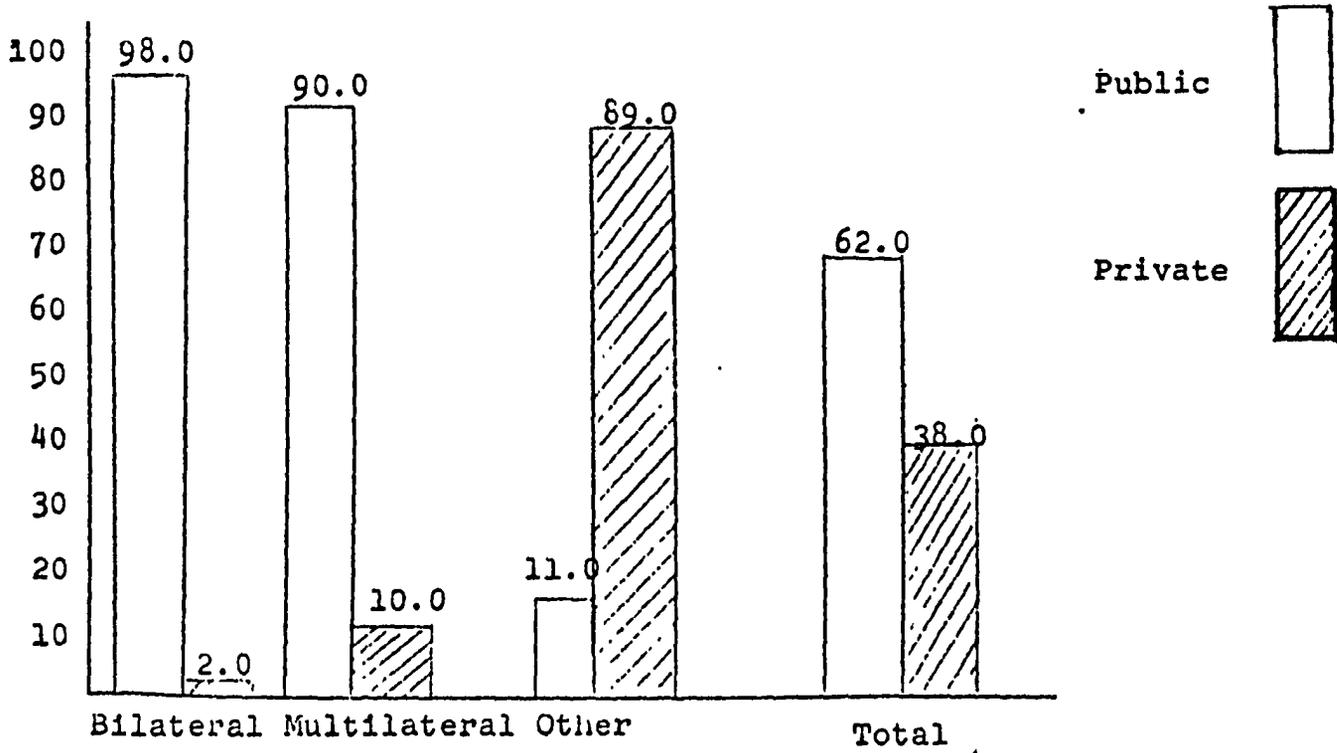
TABLE K-5

External Assistance (Estimate)
 In Population/Family Planning
 To Public and Private Sector
 By Source
 1979 - 1981
 (US\$ 000's)

<u>Source</u>	<u>Public</u>		<u>Private</u>		<u>Total</u>	
	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>
Bilateral	13,650	98.0	250	2.0	13,900	100
Multilateral	11,700	90.0	1,300	10.0	13,000	100
Other	<u>812</u>	<u>11.0</u>	<u>6,320</u>	<u>89.0</u>	<u>7,132</u>	<u>100</u>
Total	<u>21,186</u>	<u>62.0</u>	<u>7,870</u>	<u>38.0</u>	<u>34,032</u>	<u>100</u>

APPENDIX K
FIGURE K-6

Percent of External Assistance
(Estimate) in Population/Family Planning to Public and
Private Sector by Source: (1979-1981)



104

APPENDIX K

Table K-7

THAILAND NATIONAL FAMILY PLANNING PROGRAM
Components Financed by AID
and
Contributions by RTG, UNFPA, and Intermediary Agencies

FYs 1976-1981
(\$000's)

	<u>FY 76</u>	<u>TQ</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>FY 81</u>	<u>Totals</u>
<u>AID-Funded Components</u>								
VSC Services ¹	729	-	1,604	1,500	1,800	1,500	1,400	8,533
<u>Commodities</u>								
Oral Contraceptives*	2,745	241	14	900	522	540	518	5,480
Family Planning Kits	238	71	157	50	-	50	-	566
Mobile Units	40	-	125	-	-	-	-	165
Local Training	154	-	300	160	148	150	100	1,012
Research & Evaluation	118	-	28	-	100	40	40	326
IE&C Improvement ²	143	-	50	-	130	-	-	323
Participants	51	41	59	-	-	-	-	151
Other	9	-	42	-	-	-	-	51
AID TOTALS	4,227	353	2,879	2,610	2,700	2,280	2,058	16,607
<u>All Financing by Sources</u>								
Royal Thai Government**	1,500	-	2,387	3,800	4,300	4,200	4,660	21,047
UNFPA	1,359	-	2,500	1,200	2,500	unk	unk	7,559
Intermediary Agencies	801	-	1,065	1,226	1,350	unk	unk	4,443
AID	4,227	353	2,379	2,610	2,700	2,280	2,058	16,607
GRAND TOTALS	7,887	353	8,532	8,836	10,850	6,480	6,718	49,656

* AID oral contraceptives were centrally-funded and centrally-obligated, FY 1976-1978. Beginning FY 1979, contraceptives are bilaterally-funded and obligated.

** Does not include in-kind contribution estimated at \$7,000,000 annually.

¹ "VSC" - Voluntary Surgical Contraception

² "IE&C" - Information, Education and Communication

Revised 11/24/78

105

APPENDIX K

Table-8
 External Assistance (Estimate)
 NFPP & Related Program
 By Source, Grantee and Activity
 (1979 - 1981)
 (US\$ 000's)

<u>Source</u>	<u>Grantee</u>		
<u>Bilateral</u>			
CIDA	MOPH	Population Project (Orals)	5,400
GTZ	PDA/CBFPS	Services	250
	MOPH	Pop. Project (orals)	1,000
JAPAN	MOPH	NFPP (Equipment & vehicles)	450
USAID	MOPH	NFPP (VSC, orals)	6,800
		Sub-total	<u>13,900</u>
<u>Multilateral</u>			
IDA	MOPH	Population Project (DMPA)	1,000
UNFPA	MOPH	NFPP (4 projects)	5,200
	MOPH	Training Division	1,200
	MOE	Population Education	1,700
	NSO	Preparation 1980 Census	400
	Kasetsart U.	Pop. ed. in agricultural sect.	1,000
	Other	Welfare/FP of minority groups	1,200
	CBFPS	VSC motivation/general support	1,300
		Sub-total	<u>13,000</u>
<u>Other</u>			
AID/W	PDA/CBFPS	Family Planning Health/Hygiene	700
E-W Center	MOPH	Preparation of 1980 Census	6
Ford	IPS	Doctoral training abroad	100
	IPS/NESDB	Population & Dev. Project	50
	Other	Research	50
FPIA	McCormick	Services	70
	ASIN	VSC Private Institutes Proj.	1,200
	TNA	Mobile Services/referral	200
	PDA/CBFPS	Adolescent program	350
HEW	MOPH/MOI/NSO	Vital statistics registration	220
ICARP	Other	Applied research	50
IPAVS	McCormick	VSC Services	50
	PDA/CBFPS	Mobile VSC services	550
	TAVS	General support/services	1,200
IFRP	TFRP	Special research program	150
	MOPH	DMPA studies	50
IPPF	PPAT	General Support	1,500
JOICFP	PDA/CBFPS	Parasite Control	100
NCarolina	NSO	Technical assistance	6
Pathfinder	PDA/CBFPS	Regional training center	100
PIACT	PDA/CBFPS	Operations research	100
Pop Council	IPS	Micro-level studies	150
	Other	Research (Public & private)	100
SBH/UH	MOPH	Training of nurses, DHO's	50
Westinghouse	MOPH	CPS Survey (NIDA) 1980	30
		Sub-total	<u>7,132</u>
		Total	<u><u>34,032</u></u>

APPENDIX K

Table K-9

Comparison of External Assistance (Estimate) to NFPP By Source: 1976-1978 and 1979-1981 (\$000's)

Source	1976 - 1978	1979 - 1981	1979 - 1981 Breakdown		
	Total	Total	Contraceptives	VSC	OTHER
<u>Grants:</u>					
GTZ	-	1,000	1,000 (orals)	-	-
Japan	-	450	-	-	450
UNFPA	5,100	5,200	-	-	5,200
USAID	<u>9,500</u>	<u>6,800</u>	<u>1,580</u> (orals)	<u>4,550</u>	<u>670</u>
Sub-total	<u>14,600</u>	<u>13,450</u>	<u>2,580</u>	<u>4,550</u>	<u>6,320</u>
<u>Loans:</u>					
CIDA	-	5,400	5,400 (orals)	-	-
IDA	-	<u>1,000</u>	<u>1,000</u> (orals)	-	-
Sub-total	-	<u>6,400</u>	<u>6,400</u>	-	-
TOTAL	<u>14,600</u>	<u>19,850**</u>	<u>8,980</u>	<u>4,550</u>	<u>6,320</u>
(Precent)	(100)	(100)	(45)	(23)	(32)

* Support provided as part of World Bank's Population Project.

** This amount represents 58 percent of the total estimated external assistance for population/family planning during 1979-1981.

107

APPENDIX K

Table K-10

MEETING WITH REPRESENTATIVES OF THE COMMERCIAL SECTOR
 AT THE
 POPULATION AND COMMUNITY DEVELOPMENT ASSOCIATION
 TUESDAY, JULY 17, 1979

NAME	POSITION	ORGANIZATION
1. TECHIN C.	SALES MANAGER	UPJON
2. W. MACHOLD	G.M.	ORGANON
3. A. WEE	MANAGER	WYETH
4. BOONCHUB	SUPERVISOR	WYETH
5. DONALD H. MINKLER	CO TEAM LEADER	EVAULATION TEAM
6. DEBHANOM MUANGMAN	TEAM LEADER	"
7. YAWARAT PORAPAKHAM	MEMBER	"
8. ORAPIN SINGHADEJ	MEMBER	"
9. VISUTH KANCHANASAK	MEMBER	"
10. BRUCE CARLSON	APHA CONSULTANT	"
11. PICHET SOONTORNPIT	DTEC	"
12. SUMONTHA THANYAPON	DTEC	"
13. KATE LORIG	TEAM MEMBER	"
14. AROON ANAKRAHANOND	BUDGET ANALYST	BOB
15. TIMOTHY ANSCOMB	MARKETING MANAGER	SCHERING BANGKOK LTD.
16. MARK GRAHAM	MANAGING DIRECTOR	G. D. SEARLE
17. MECHAI VIRAVAIIDYA	CBFPS - DIRECTOR	CBFPS

108

APPENDIX K

Table K-11

Thailand National Family Planning Program

Breakdown of Components Financed by AID
From Initial Proposal through Current PP Recommendation
(\$ 000's)

	<u>Original PP Proposal</u>	<u>(Changes)</u>	<u>Project Approval 12/24/75</u>	<u>(Changes)</u>	<u>Interim Proposal 1/1/77</u>	<u>(Changes)</u>	<u>Current PP Proposal</u>
VSC Services <u>1/</u>	-	-	-	4,520	4,520	4,013	8,533
Commodities							
Oral Contraceptives	6,345	(1,620)*	4,725	78	4,803	677	5,480
Family Planning Kits	370	(50)	320	529	849	(283)	566
Mobile Units	63	-	63	89	152	13	165
Local Training	735	(300)	435	311	746	266	1,012
Research & Evaluation	450	(150)	300	-	300	26	326
IE&C Improvement <u>2/</u>	250	(150)	100	30	130	193	323
Participants	127	-	127	-	127	24	151
Other	-	-	-	10	10	41	51
TOTALS	8,340	(2,270)	6,070	5,567	11,637	4,970	16,607

* (1,620) = Reduction of \$1,620

1/ "VSC" = Voluntary Surgical Contraception

2/ "IE&C" = Information, Education and Communication

K-11

APPENDIX K

Table K-12

SUMMARY

POPULATION PLANNING

1979 PROJECT AGREEMENT

(US\$)

<u>Project Component</u>	<u>USG</u>	<u>RTG</u>	<u>TOTAL</u>
VSC Services			
VSC Support Costs	1,155,000	2,782,125	3,883,125
Personnel Support Costs	686,616	300,000	986,616
Oral Contraceptives	522,000 ¹	2,120,000	2,642,000
Local Training	(176,548) ²	162,680	162,680
Operational Research & Evaluation			
Research	98,000	"In Kind"	98,000
Evaluation	5,000	"In Kind"	5,000
IE&C Improvement Campaign in Lagging Provinces	233,384	"In Kind"	233,384
TOTAL	<u>2,700,000</u>	<u>5,310,805</u>	<u>8,010,805</u>

¹ "In Kind" - Contraceptives to be purchased and delivered by WID/W.

² From prior year funds.