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MANAGEMENT DEVELOPMENT PLAN
FOR
FAMILY PLANNING MANAGEMENT TRAINING
IN THAILAND

Ken Heise
Ed de Jesus

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ACKNOWLEDGEMENTS

We would like to express our sincere thanks and appreciation to the many individuals at the central and provincial levels of the family planning program who made our visit to Thailand both pleasant and productive. We are indebted to them for their willingness to interrupt their busy schedules for meetings and discussions and for their patience in responding to questions from us in a language not their own. It was especially considerate of the Family Health Division staff to make travel and lodging arrangements and to accompany us on the trips to the provinces. Their insights and explanations added greatly to the value of the visits.

I. EXECUTIVE SUMMARY

At the request of USAID Thailand a team from the Family Planning Management Training Project (FPMT) visited Thailand from May 4-20, 1987 to design a proposal for FPMT activities with the National Family Planning Program. The team consisted of Mr. Ken Heise of Management Sciences for Health and Dr. Edilberto de Jesus of the Asian Institute of Management in the Philippines.

The focus of the team's visit was the management training needs of the Family Health Division of the Ministry of Public Health. This division is responsible for implementing the National Family Planning Program (NFPP). The team relied on meetings, discussions, and interviews to gain an appreciation of the structure and operation of the NFPP. At the central level, the team met with the director, section and unit heads of the Family Health Division (FHD), as well as with other divisions of the MOPH, e.g. the Rural Health Division, Health Statistics Division, and the Office of Primary Health Care. The team carried out field visits to Chiangmai, Ratchaburi, and Songkhla provinces to view the NFPP at the operational level. While in the provinces, visits were made to two tambon health centers, a district community hospital, two Maternal and Child Health centers, and two Provincial Chief Medical Offices.

To gain a broader perspective of the NFPP, meetings were held with officials from the Population and Community Development Association (PDA) and the Association for Strengthening Information on the

National Family Planning Program (ASIN), PVOs actively involved in family planning in the private sector. In addition, brief meetings were held with representatives of donor agencies. Both before and during the trip, the team benefitted from a review of the ample documentation available on the NFPP.

The NFPP has been extremely successful in reducing the rate of natural increase in Thailand. From a growth rate of over three percent just 25 years ago, Thailand's population is now growing at an estimated rate of 1.5 percent annually, with contraceptive prevalence on the order of 65% to 70%. Commitment to family planning remains high in both the public and private sector. Donor support, however, is decreasing and will play an ever smaller role in supporting the NFPP. The government appears both willing and able to assume greater financial responsibility for the program.

In a country with such a successful program the role that FPMT can play is somewhat limited. Many major issues facing family planning programs in other countries have long since been effectively dealt with in Thailand; those that remain, while important, cannot be considered urgent or critical in nature. FPMT interventions in Thailand will aim at making a very successful program even more efficient and effective.

In developing proposals for FPMT activities in Thailand, the team felt that several programmatic guidelines should be followed. These included:

- o FPMT activities should be consistent with and contribute to the policies and strategies of the government in health and family planning
- o Training and technical assistance activities should serve the needs of the NFPP and, whenever possible, have the potential to benefit programs in other countries as well
- o Activities should be mutually reinforcing, forming part of a coherent strategy for management development
- o FPMT should be prepared to adapt its proposed activities to changes in the family planning environment
- o FPMT activities should complement other interventions proposed or already underway
- o Emphasis should be placed on activities having a long-term benefit or impact on the NFPP

Proposed FPMT activities in Thailand fall into the categories of Case Development, Technical Assistance, Training, and Study and

Observation Tours. These are summarized briefly below.

1. Case Development: FPMT would work with the Family Health Division to develop one or more cases focusing on the management implications of a policy of decentralized planning in health and family planning. The work would be structured to build case writing and teaching skills among the training staff of the FHD.

2. Technical Assistance: FPMT would provide a consultant to work with the FHD to formulate a plan for staff development. This plan will identify staff persons needing training, identify opportunities for training, and help the FHD prepare to meet the challenges ahead.

3. Short- and Long-term Training: FPMT could contribute to strengthening FHD staff skills by supporting participants to several short- and long-term training courses.

a. Short-term:

1. Support for two participants to attend the MSH workshop Skills for Managing Effective Training Organizations

2. Support for two participants to attend an MSH workshop on managing drug supply

3. In-country training on micro-computer applications in the family planning program

4. Management training for provincial health and family planning officials. Skill areas will be identified during

the development of the case and in conjunction with ongoing operations research on decentralized health planning.

b. Long-term Training: FPMT will support two or more participants to long-term training in the U.S. Candidates for training will be identified during the process of formulating a plan for staff development. Long-term training will develop competencies in several of the following areas: health economics and financing, research design and analysis, monitoring and evaluation, MIS and microcomputers, and general management skills.

4. Study and Observation Tours: FPMT will collaborate with both the public and private sector to organize study and observation tours for family planning leaders and managers from other countries.

It is anticipated that during the course of FPMT activities in Thailand other opportunities for FPMT assistance will arise. While no guarantee of support can be made, FPMT will attempt to respond favorably to other requests for assistance.

II. THE NATIONAL FAMILY PLANNING PROGRAMME

A. Overview

Active and comprehensive involvement by the Thai government in family planning dates to 1970 with the advancement of a policy position advocating slower population growth through the adoption of voluntary family planning. The Cabinet stated that "The Thai Government has the policy to support voluntary family planning in order to resolve various problems concerned with the very high rate of population growth which constitutes an important obstacle to the economic and social development of the nation." At the same time, the National Family Planning Committee (NFPC) was created by the Cabinet in order to oversee planning, coordination, and evaluation of family planning and population activities. The NFPC is chaired by the Minister of Public Health and consists of representatives from the MOPH and other ministries (Interior, Agriculture, Education), the Bureau of the Budget, the National Economic and Social Development Board, the Department of Technical and Economic Cooperation, and private groups active in family planning.

Activities in support of family planning come under the National Family Planning Programme (NFPP), which came into existence at the beginning of the Third National Social and Economic Development Plan of 1972-1976. Within the Ministry of Public Health, it is the Department of Health which has oversight responsibility for the NFPP (Annex I). The Director General of the Department of Health

serves as the Director of the NFPP; the Deputy Director General of the Department of Health is the Deputy Director of the NFPP. Operational responsibility for the NFPP lies with the Family Health Division (FHD) of the Department of Health, created specially to coordinate and manage the NFPP. The Director of the FHD is also the Assistant Director of the NFPP. An organizational chart of the NFPP appears in Annex II.

The Family Health Division has a large staff of well-trained professionals and support personnel. The current director of the FHD assumed his position in 1985 following several years work in regional MCH centers. He is assisted by a four member Technical Advisory Board which meets regularly. The FHD is divided into six sections: Administration, Planning and Monitoring, Research and Evaluation, Public Relations and Information, Technical and Special Projects, and Training, Supervision, and Education (Annex ??). The activities of each Section are described below under III. D, Support Systems.

While the Ministry of Public Health plays the largest role in the management and delivery of family planning services, several other ministries and organizations are also involved. The Bangkok Metropolis Department of Health, under the Ministry of the Interior, offers family planning services through its 54 urban health centers. The Ministry of the Interior also has responsibility for the health stations maintained by the Border Patrol Police and, through the Department of Community Development,

supports community workers who provide family planning services. Under the direction of the Bureau of State Universities, six university hospitals provide family planning services and are often involved in clinical research. Family planning services are also available through health facilities maintained by other government branches, notably the Department of Public Welfare and the military. The Ministry of Education and the Ministry of the Interior play important roles in disseminating information about family planning, motivating couples to use services, and in population education in the secondary schools.

The NFPP benefits as well from close collaboration with private and non-governmental organizations. The principal organizations involved are the Population and Community Development Association, The Association for Strengthening Information on National Family Planning Program (sic), the Planned Parenthood Association of Thailand, the Thai Association for Voluntary Sterilization, the Thailand Fertility Research Association, and the Intensive Development of the the Quality of Life Association. Several missionary groups are also active in family planning in Thailand, most notably the McCormick Hospital in Chiangmai. A large number of pharmacies are also involved in the sale of contraceptives.

B. PLANNING

National development initiatives in Thailand are planned and implemented through sequential five year National Economic and

Development Plans. The National Economic and Social Development Board (NESDB) is responsible for coordinating each sector's plans with the overall National Economic Development Plan. In terms of family planning and population, national growth rate targets are established using data from a variety of sources, including census projections, contraceptive prevalence, vital events registries, fertility and mortality data, and migration information. The Third Plan of 1972-1976 set a target of reducing population growth to 2.5%. The Fourth, Fifth, and Sixth Plans set growth rate reduction targets of 2.1%, 1.5%, and 1.3% respectively. To date, the NFPP has always been able to achieve or surpass the national growth rate targets.

National growth rate targets form the basis for planning within the Family Health Division. Annual and longer-range targets are established by the FHD; progress towards these targets is measured in terms of new and continuing users broken down by method. The Research and Evaluation Section of the FHD works with the Provincial Medical Offices (PCMO) to set performance targets within the province, and by extension, to the district and sub-district levels. The target for a given province or district is based largely on past performance, adjusted for anticipated changes in numbers of service delivery points or changes in size of target groups.

Until recently, the provinces were given little role in determining targets for family planning. Targets were set by the FHD and

communicated downward to the PCMO who had little flexibility in modifying them. In one province visited by the FPMT team, it was noted that all 14 districts had the same target for contraceptive prevalence, despite the fact that several of the districts were heavily Moslem and had for years experienced lower levels of contraceptive use. Greater responsibility for planning and target-setting at the provincial and district level would help ensure that local factors are adequately considered. In addition, the population data available to local planners may be more recent and reliable than the estimates used by the FHD staff. In these instances, the FHD often accepts the figures and projections put forth by the provincial and district levels. Increasingly, as part of the trend towards increased decentralization in health planning, the PCMOs and districts will be given greater responsibility in determining performance targets. This is a welcome trend, and should lead to targets and plans that more accurately reflect the resources and demographic characteristics of the area. The shift towards decentralized target setting and planning will require additional skills and training on the part of the provincial and district health managers. Annex III shows the organization of the provincial administration for health services.

C. Service Delivery

The Thai NFPP has long been a pioneer in promoting new contraceptive methods, alternative delivery systems, and in allowing an expanded cadre of health personnel to provide

services. This propensity towards innovation and demedicalization is one of the reasons for the success of the NFPP. Another reason is the widespread availability of contraceptives through the public, private, and commercial networks.

The MOPH network of health facilities includes 15 regional hospitals, 72 provincial hospitals, 541 district community hospitals, and 7542 tambon (sub-district) health centers. Other public sector facilities offering family planning services include the University Hospitals, facilities run by the Ministry of the Interior (MOI) in metropolitan Bangkok, health stations of the Border Patrol Police (also MOI), and clinics maintained by the Defense Ministry. The MOPH has also trained over 45,000 village health volunteers and some 420,000 village health communicators who participate in motivation, referral, and distribution of some contraceptive methods. The VHV's cover an estimated 85% of all villages in Thailand.

The private and commercial sectors are also involved in providing family planning services. Although precise figures are not available, it is estimated that there are over 5,000 private facilities run by physicians in Thailand. An unknown, though important, number of these facilities serve as outlets for family planning services. Many physicians from private clinics and hospitals have been trained to perform sterilizations through a project funded by FPIA and implemented by ASIN. The Population and Community Development Association (PDA) supervises over 13,000

volunteer contraceptive distributors in some 16,000 villages, nearly a third of all villages in Thailand. Pharmacies are another source of contraceptives. Perhaps half of the country's estimated 17,000 pharmacies offer contraceptives. Overall, it is estimated that the public sector accounts for 80% of the family planning services, while the private and commercial sectors provide the remaining 20%.

Clinic-based family planning services are fully integrated into other maternal and child health and primary health care activities. In the hospitals and health centers visited by the FPMT team, nurses, auxiliary nurses, and midwives provided nearly all the family planning services. These same individuals were also responsible for running the well-baby and pre-natal clinics, immunization services, and providing general curative care. The use of nurses to fill a variety of roles has reduced the total manpower needs of the MOPH, but does put a strain on the nurses themselves. Many are forced to work overtime just to complete all the necessary reporting forms for the various services they offer.

Physicians are responsible for most of the IUD insertions and sterilizations performed. Recently, however, efforts have been made to train increasing numbers of nurses to perform insertions. These initiatives have been hampered somewhat by a low case load in some areas. Training of nurses to perform sterilizations is also underway. NORPLANT subdermal implants are available in a limited number of MOPH facilities and early indications are that they are well-received. The high cost of the implants may preclude greater

use of this effective product.

In addition to the family planning services offered through clinics and village distributors, the NFPP has made frequent use of mobile clinics as part of special promotional campaigns and to reach isolated, underserved locations. Both surgical and non-surgical methods of contraception are offered in the mobile clinics.

D. SUPPORT SYSTEMS

1. Logistics

The NFPP procures its contraceptives and related supplies from a variety of sources, both domestic and international. Throughout the 1970's and early 1980's, the donor community, and particularly USAID, provided most of the contraceptives used in the Thai family planning program. For the past several years, however, funds for the purchase of contraceptives have come almost entirely from the Thai Government. The current annual cost of contraceptives is approximately 138,000,000 baht, or roughly \$5,300,000. If the unit price of contraceptives remains constant, and there are no changes in the national method mix, the cost to the NFPP will increase substantially during the coming years as the cohort of MWRA grows from approximately 7 to 8.7 million.

The FHD is responsible for estimating contraceptive needs and

ordering contraceptives, most of which come from Europe. The FHD (Research and Evaluation Section) has developed computer software to help forecast contraceptive needs and monitor inventories. Technical assistance to improve this system is being provided through the CDC and Family Planning Logistics Management Project.

Contraceptives are cleared through customs in Bangkok and stored in national and regional warehouses. The supply system to the provinces is basically a "push" system, whereby the FHD (Administrative and Research and Evaluation Sections) determines when to send commodities to the field. This determination is made through an ongoing analysis of monthly user statistics and stock reports. The MOPH contracts with a government shipping company to send commodities to the field. This system has proven reliable, though lengthy delays are sometimes experienced as the shipping company waits to "fill orders" before sending out the supplies. None of the health facilities visited by the FPMT team had ever had a stockout and, by maintaining large stocks, were relatively immune from problems associated with the slow distribution system.

District health personnel frequently visit the provincial medical offices and take advantage of these contacts to pick up supplies of contraceptives. In a similar fashion, tambon health workers are able to resupply their clinics through regular contact with district level personnel. This somewhat informal supply system appears to work well in most instances.

2. Family Planning Service Statistics

The Research and Evaluation Section of the Family Health Division has developed and oversees a comprehensive family planning service statistics system. Information gathered through the system is used to monitor overall program performance, progress towards specific targets, contraceptive stock levels, and for planning and evaluation purposes. As conceived, the system includes information on both the public and private sectors, although information from the private sector is not as complete. It has proven even more difficult to obtain reliable and timely information from the commercial distribution network.

Information gathered on the family planning program at the service delivery level is passed upward on a monthly basis to the District Health Office where it is aggregated and sent onward to the Provincial Medical Office. Reports from all provinces are then sent to the Family Health Division for compilation and analysis (see Annex IV). The large volume of information received by the FHD, coupled with a long data processing and analysis time, result in lengthy delays in sending statistical reports back to the provincial level. By the time the reports reach the provincial and/or district level (three or more months after submission to the FHD) the utility of the data for monitoring and evaluation purposes has been severely reduced. Although not uniformly the case, many of the provinces and districts do use the data for program monitoring purposes before sending the reports to the FHD. Their

ability to make better use of the information is hampered by a lack of trained personnel and extremely limited access to computers for analysis. In addition, the provinces do not routinely receive information from the private sector directly. Private sector information is usually sent from the field to the private agency headquarters, and then shared with the Family Health Division where it is included with the public sector reports that are eventually sent back down to the provinces.

Perhaps the most common complaint expressed about the current service statistics system is the time and effort required of the service providers to comply with reporting requirements. The forms are long, occasionally redundant, and elicit information that may never be analyzed or used at any level of the system. As mentioned above, family planning services are delivered through the primary health care system by multi-purpose health personnel. The personnel therefore have reporting requirements not only for family planning but for other preventive, promotive, and curative services as well. As a result, they are frequently overwhelmed by the reporting requirements and are forced to consecrate long hours, frequently after official work hours, to complete the required forms. There is a general awareness of this problem and steps are being taken to simplify and consolidate the reporting systems for family planning and other primary health care interventions as well. Streamlining the reporting system should improve both the efficiency and the quality of the management information system.

The FPMT team was particularly struck by the plentiful and colorful

charts, tables, graphs, and other visual reporting and monitoring tools on display in health centers and hospitals. It was not clear whether these were kept on a voluntary or obligatory basis, but they certainly were useful displays and maintained in a neat and punctual manner. They also served to focus the attention of the health personnel on the progress being made towards achieving performance targets.

The MOPH in general and the FHD in particular are exploring ways of promoting a more decentralized approach to program planning and management. For a decentralized system to work, a management information system must be developed that will respond in a timely fashion to the needs of managers at all levels of the system, not just to the needs of the central staff. This was clearly recognized by the health personnel at the service delivery level as well as at the managerial/administrative level. Several studies are under way to test different approaches to decentralization. Once a model has been identified and a decision made to proceed, it will be necessary to develop training programs for the health managers to prepare them for their new, and larger responsibilities.

3. Supervision

The team was not able to gain an appreciation of the entire supervision system for family planning. Within the Family Health Division, responsibility for supervision rests with the Supervision

Unit within the Training, Supervision and Education Section. They coordinate closely with the Provincial Medical Office to supervise service delivery at the district and tambol level. Within larger health facilities, such as community hospitals, the nurses providing family planning services are supervised by the medical doctors on the premises. Nurses providing services in health centers are visited routinely by district and provincial teams and, in areas close to MCH Training Centers, by staff from those centers as well. Supervisory protocols are used for clinical supervision, and in the supervisory visit observed by the FPMT team, healthcenter records were reviewed and discussions were held over progress being made towards performance targets.

Supervision extends down to the level of the Village Health Volunteers and Communicators. Tambon nurses and sanitarians routinely visit the village workers to provide support, collect data, resupply contraceptives, and to handle any pressing medical problems. Many tambon health workers have access to motorbikes to facilitate their supervisory functions.

4. Information, Education, and Communication

IEC activities in the public sector are carried out by the Public Relations and Information Section of the Family Health Division. They are responsible for defining and developing IEC strategies and campaigns and, in theory, for gauging the impact or effectiveness of their efforts.

The IEC program takes full advantage of the variety of media available in Thailand. Village Health Communicators and health personnel promote family planning through person to person contact and in group discussions. These efforts are supplemented and complemented by a large number and variety of printed materials, including posters, brochures, flip charts, and booklets. The FHD funds the production of over 3,000,000 printed products annually. Films and slides have been developed, and extensive use is made of radio programs to disseminate family planning and population information. Radio shows make effective use of songs, discussions, drama, and soap operas to get the messages across. Television is not a frequently used medium for promoting family planning due to the limited number of viewers outside of the principal urban areas. The FHD maintains a fleet of over 80 mobile motivation units, covering all the provinces, to help reach difficult or remote audiences. For the most part, the FHD does not become directly involved in the production of IEC materials or mass media programs, preferring instead to contract with commercial advertising agencies. This arrangement has proven successful as attested to by the high quality of the materials and programs being produced.

IEC activities are characterized as belonging to one of two categories: maintenance activities or intensified activities. IEC maintenance activities are those which are intended to promote continued contraceptive use among those population groups which

have already achieved a high level of contraceptive prevalence. An estimated 30% of the IEC budget goes towards maintenance activities. Certain geographic areas and population sub-groups have been classified by the FHD as "low performance" and therefore targetted for intensified program activity. The Hill Tribe groups, several border provinces, some predominantly Moslem regions, adolescents, and slum dwellers all are the focus of intensified IEC activity. Similarly, special IEC activities are often organized to promote specific campaigns, such as those that promote a certain type of contraceptive method (IUDs, sterilizations). Funds to design and implement intensified IEC strategies and to develop new materials are often provided by donor agencies, whereas the FHD uses its own budget to support maintenance activities.

To the best of the team's knowledge, there have been few if any attempts to evaluate systematically the impact of specific IEC strategies or materials, nor have studies been carried out to determine the contribution made by IEC activities in achieving Thailand's remarkable contraceptive prevalence rate. Such studies, if carried out, might enable the FHD and NFFP to focus on those strategies and activities that yield the maximum benefit in terms of motivating new acceptors or promoting continuation among old acceptors. It seems likely that impact assessments, coupled with an analysis of cost effectiveness, could result in substantial savings to the FHD and donor agencies alike.

The Family Health Division Technical Section maintains an extensive

documentation center and clearinghouse of family planning and population materials. The center has over 8,000 books in Thai and English, subscribes to 460 national and international periodicals, and has a large microfiche collection. The center's resources are available to support the needs of the FHD staff, researchers from other ministries and Universities, as well as the general public. In addition to the standard library services it offers, the center provides translation services (from English to Thai) for selected materials. The center will soon receive a computer from ASEAN. The center hopes that the computer will lead to better referencing and retrieval systems and improve its national and international networking capacity.

5. Training for Family Planning

A) Public Sector

Within the Family Health Division responsibility for training lies with the Training, Supervision, and Education Section. Annex V, from the USAID Mid-Term Evaluation Report, shows the organizational structure and responsibilities of this Section. For a comprehensive discussion of the types of training programs undertaken by the FHD, the reader is referred to the Mid-Term Evaluation Report, pages 99-123. The 1987 calendar of FHD training activities is attached as Annex VI.

Training activities can be grouped into three general categories: basic training for auxiliary midwives, specialized pre-service training programs, and in-service/refresher training. The regional MCH Centers with their affiliated Schools of Midwifery are the key institutions providing training in family planning. These training institutions are part of the organizational structure of the Family Health Division, reporting to the FHD rather than the Provincial Medical Office.

The FPMT team visited the MCH Centers in Ratchaburi and Chiangmai which support MCH and family planning services in eight and nine provinces, respectively. The MCH Centers serve a host of important functions. The School of Midwifery offers a two year training program for high school graduates. The auxiliary midwives completing this program are typically assigned to work in sub-district health centers. Between 180 and 200 auxiliary midwives were being trained at the two MCH centers visited by the FPMT team. It is expected that this number will decrease in coming years.

The Centers provide support through supervision and referral services to the family planning and MCH program activities carried out in the provinces. The Maternal and Child Hospital at each Center offers a full range of MCH and FP services while serving as a practical training site for doctors and nurses. The Health Promotion Sections are responsible for undertaking a wide variety of community health activities. These include training for village health workers and public health nurses, designing and conducting

health education programs in the communities and the schools, carrying out home visits of pregnant women and followup of certain hospital cases. The Health Promotion Section is also responsible for the Mobile MCH Units which provide MCH and family planning services to areas not served by the health center network. Given the broad mandate of the Health Promotion Section, it is perhaps inevitable that requests for new types of training programs are addressed to them. The FPMT team was told that these requests were a source of some irritation as they often came with little advance notice and greatly taxed the quite limited human resources of the Section.

The MCH Centers also serve as research sites for new contraceptive methods. Studies undertaken to date include NORPLANT trials, comparative studies of new IUDs and oral contraceptives, and others.

B) Private Sector

Several private sector organizations offer training in family planning and related subjects. The most extensive training programs are offered by the Population and Community Development Association through its Asian Centre for Population and Community Development. Annexes VII and VIII show PDA's organizational structure and the Asian Centre's course offerings, respectively. The training activities of other private sector groups such as ASIN and PPAT are described below in Part V, Section B (2).

The Asian Centre was established in 1978 by PDA with financial assistance from the Pathfinder Fund and the Japanese Organization for International Cooperation in Family Planning. The Asian Centre offers courses for both national and international participants. In addition to the standard courses offered, the Centre conducts special seminars, workshops, conferences, and organizes study and observation tours.

PDA's initial focus and expertise was in community based family planning programs. Over the years, the success of these activities has encouraged PDA to apply similar approaches to a wide range of community development programs, such as integrated rural development, sanitation and parasite control, women in development, income generation, rainwater catchment and others. The course offerings of the Asian Centre reflect these broader interests of PDA.

6. Research and Evaluation

As discussed above, the Research and Evaluation Section of the Family Health Division plays the key role in the family planning service statistics system, from designing reporting forms to collecting and analyzing information to making programmatic recommendations based on the information received. This Section shares responsibility with the Administration Section for forecasting and ordering contraceptives and in assuring the correct

functioning of the contraceptive distribution system. The continual monitoring and evaluation functions of the Section are supplemented by periodic special studies and surveys.

The staff of the Research Unit are responsible for developing research proposals, securing funding, and implementing the activities, and also for coordinating the research activities of other groups studying various aspects of the NFPP. In the past, with relatively high levels of donor funding available for research, the Research and Evaluation Section was able to contract with many public and private organizations and institutions to carry out research. The Universities, the National Institute of Development Administration, the National Statistics Office, the Thai Development Research Institute and others have frequently been called upon to study both clinical and programmatic aspects of the family planning program. As donor funds become increasingly scarce, the Research and Evaluation Section will be forced to carry out a greater proportion of the studies in-house. This in turn may require further training in research methodology and analysis for several members of the the Research Unit staff. Priority research areas for the 1987-89 period are shown in Annex IX.

III. DISCUSSION

At the end of the Fifth National Economic and Development Plan (1982-86) the NFPP in Thailand appeared to have reached a new plateau. The Program has clearly achieved impressive gains. Experts credit the Program as the key to bringing down the rate of population growth in the country from over 3.0 percent in 1960 to approximately 1.5 percent 25 years later. The contraceptive prevalence rate (CPR) is currently between 65 percent and 70 percent.

The country visit confirmed for the Team the importance of three mutually reinforcing factors in the success of the NFPP:

1. Sustained commitment of the country's political and bureaucratic leadership, as demonstrated by the network of agencies established to plan, implement, and monitor the Program at national, provincial, district, tambon, and village levels, as well as by its willingness to allocate financial resources for the support of the NFPP.
2. The support of the PVO sector, not only in the delivery of family planning services but also in pioneering and promoting innovative IEC, community based, and social marketing efforts.
3. Generous assistance over the last two decades from international donor agencies extended both through bilateral and multilateral agreements.

But the Program's own success, coupled with a changing external environment, presents the government with a new challenge.

International donor agencies have begun to reduce their assistance for family planning activities in Thailand, whether undertaken by the government or the private sector. Partly for this reason, and partly because of the success of the government's outreach program, one PVO, the Population and Community Development Association (PDA) has stabilized its area of family planning coverage and has begun to shift its resources to rural development concerns.

While external financial support is declining, the cost of maintaining the Program and extending its reach is expected to rise. General inflationary pressures will raise the cost of contraceptive supplies and services. With the current high level of CPR, the NFPP will incur the higher expense of promoting family planning among the more resistant and/or more geographically remote segments of the population. Moreover, demographers expect a 25-30 percent increase within the next five years of the MWRA that the Program will have to serve.

The informants interviewed by the Team did not always agree on the implications of these trends and their potential impact on the NFPP. Some were confident that the government would be able to sustain whatever increased costs the Program will have to bear. Others were less certain that the government would be able to raise the NFPP budget as required given the pressure of other national priorities.

It was encouraging to note, however, that the government appeared to recognize the potential problems facing the NFPP. It has already initiated action on several fronts. At the policy level, it has moved to encourage greater inter-ministerial cooperation in the promotion of family planning. The Ministry of the Interior (MOI), in particular, has been mobilized to help the FHD maintain and increase CPR levels through motivation and awareness-raising campaigns conducted by the provincial governors, district officers, tambon chiefs, and village leaders.

Some policy issues still await resolution. Officials disagree, for instance, on when and to what extent the government should attempt to recover from the public the cost of providing family planning services. But the government has already initiated various research activities and field experiments to clarify the range of options it can take to cope with the likely situation of fixed or declining financial resources and rising costs in the coming years.

The Thailand Development Research Institute has just started a three-year project to study the price elasticity of demand for contraceptives. The government also wants to see the private sector become more actively involved in the NFPP. It is now exploring how private clinics can more effectively promote and deliver family planning services. A project being developed by the Medical Association of Thailand with USAID support is looking into how private medical practitioners can improve their own delivery of health care services. Though originating independently of government, this research should help it in formulating its own strategy for mobilizing private sector support for the NFPP.

The government is also collaborating with PVOs to market family planning in rural communities. The National Economic and Social Development Board (NESDB) has already authorized six million baht for a community based incentives program. The money will be used to set up a revolving fund from which villagers can borrow. The size of the fund allocated to a community depends on its CPR. Individual access to the fund and the amount of loans will depend on the borrower's own practice of family planning.

Like the issue of cost recovery, investment in social marketing efforts is a matter of some debate. There is no disagreement, however, on the need for insuring that the NFPP function in a more efficient, cost-effective manner.

The government has been moving towards a further integration of health services. A proposed reorganization plan for the MOPH would reportedly consolidate into one the many separate centers maintained by the Department of Health (DOH) at the regional level. The MOH Center would function as the main arm of the DOH in the region. Areas of activity such as dental health, nutrition, and school health, each presently served by its own center, would become the responsibility of separate sections working within the MCH Center. Family planning, at present only one of the areas attended to by the Health Promotion Section of the MCH Center, would become a separate section.

The move is expected to lead towards more efficient use of health facilities and manpower resources and to reduce the burden of

administration and supervision at the regional level. The reconstituted MCH Center would monitor health services in the provinces within the region and would report no longer to the FHD but directly to the Director General of the DOH. The reorganization plan is due for decision in August, 1987.

Attention has also focused on contraceptive logistics management as an area where an improvement in efficiency would yield substantial pay-offs. In at least one province, the responsible officer has to allow for as much as a three-month lead time for the resupply of contraceptives. The AID-funded Family Planning Logistics Management project has just completed a visit to Thailand and is due to return in June to continue work on possible modifications of the present FHD contraceptive logistics system. Although the work is just beginning, the FHD has already indicated that some staff from the Administration and Research and Evaluation Sections would benefit from training in logistics management.

There was also general agreement on the need to develop a more efficient and more effective Management Information System. Unlike family planning programs in other countries, Thailand's NFPP does not suffer from a lack of data. The FHD is able to obtain an enormous amount of data from the field. The tambon health centers visited by the Team maintained an impressive set of records, maps, charts, and tables of health statistics. But at various levels of the system, there was widespread concern over the MIS: first, over the time and effort tambon level personnel spend on collecting,

recording, and reporting data; second, over the quality of the data being passed up the system; third, over the usefulness of the data and reports to the provincial, district, and tambon level staff given the lag time of three to six months between the collection of the data and the analysis at the central level.

FHD officials agree that a more decentralized planning and monitoring process would help decongest the information pipeline. This conclusion coincided with the thrust of the project being implemented by the Management Improvement Unit (MIU) established recently in the Office of Primary Health Care. The MIU, with support from PRICOR, is testing a model of decentralized health planning and management at the provincial level. If successful, it will have great relevance to the NFPP's own delivery system. Both the MIU and FHD officials agreed that PCMO-level personnel would probably require training for the new responsibilities they would be expected to assume.

While supportive of the ministry's decentralization strategy, the Planning and Monitoring and the Research and Evaluation Sections of the FHD also hoped that access to computers and additional training would help them to cope better with the tasks of data collection and analysis. The FHD is, in fact, expecting to obtain microcomputers within the year, although it does not yet have all the information it needs about the ability of the hardware they will receive to run the software packages it expects to use. The FHD anticipates that staff from Administration, Planning and Monitoring, Research and

Evaluation, and the Technical and Special Projects Sections will need more training in microcomputer use and applications than the supplier will be likely to give.

In summary, the NFPP appeared to the Team to be in a process of transition. Officials at all levels of the organization seemed well aware of the need to respond to changing conditions. NFPP managers are looking ahead to problems and opportunities that may confront the Program ten years down the road. NFPP has already demonstrated its effectiveness in reducing the country's population growth rate. The new challenge is to prove that it can also be more efficient in the use of its resources.

The management issues that the NFPP must now address open up the possibility of FPMT involvement in support of the Program. On-going research and experimentation on management systems and processes will doubtless result in redefining the roles and responsibilities of people within the organization. Such a redefinition is likely to require upgrading of skills or developing new skills. FPMT can help with the training that may be demanded by changes in management systems and processes. But the range of training needs and options opening up for an operation as large and as complex as the NFPP also suggests the potential usefulness of FPMT technical assistance in developing a comprehensive staff development plan.

IV. RECOMMENDATIONS FOR FPMT ACTIVITIES IN THAILAND

In the relatively brief period of two weeks it has not been possible to define and elaborate an exhaustive list of management issues and problems facing the Thai NFPP. Many major issues facing family planning programs elsewhere have long since been effectively dealt with in Thailand; those that remain, though important, cannot be considered critical or urgent in nature. Management interventions in Thailand will aim at making a very successful program even more efficient and effective.

Several principles have served to guide the development of the proposed FPMT activities in Thailand. FPMT, as a project funded by the Agency for International Development (AID), must adhere to the Agency's priorities with respect to level of activity and funding for a given country and region. Thailand, because of its already advanced state of family planning program activities, is not one of AID's highest priority countries. With this in mind, FPMT has based its proposed activities on the following programmatic guidelines:

- o FPMT activities should be consistent with and contribute to the policies and strategies of the government in health and family planning.

- o Training and technical assistance activities should serve the needs of the Thai NFPP and, whenever possible, have the potential to benefit programs in other countries as well.

- o Activities should be mutually reinforcing, forming part of a coherent strategy for management development.
- o FPMT should be prepared to adapt its proposed activities to changes in the family planning environment.
- o Every effort should be made to ensure that FPMT activities complement, and not duplicate, other interventions proposed or already underway.
- o Emphasis should be placed on activities that will have a long-term benefit or impact on the NFPP.

The training and technical assistance recommendations made by the Team should be considered proposals, in preliminary form, that will require subsequent elaboration and refinement. All FPMT activities must be approved by the FHD, USAID Thailand, the central staff of FPMT, and AID Washington. As explained later, a Memorandum of Understanding between Management Sciences for Health and the Family Health Division will be drawn up providing a description of the activities to be undertaken and assigning responsibility for their successful implementation.

Proposed FPMT activities are discussed below by category: Case Development, Technical Assistance, Training, and Other Assistance.

A. Case Development

The case method has long been a popular and effective tool for training in business and management. There exists, however, a dearth of cases on the management of family planning programs. FPMT, over the five year life of the project, is to develop 24 cases for use in family planning management training. The Team feels that Thailand offers a particularly interesting opportunity for case development.

The development of appropriate cases in Thailand would serve several purposes. These include the following:

- 1) Cases could be used in management training for health and family planning managers at all levels of the health system.
- 2) Case development would serve to further identify and describe management problems in the delivery of health and family planning services, thereby aiding in determining the content and design of training workshops.
- 3) Information about the successful Thai family planning program could be effectively communicated to managers of programs elsewhere through the use of cases.

- 4) If developed in a time series, cases could help document and describe the effect of different policies and/or decisions on the management of health and family planning programs.

- 5) Skills in case development and case teaching could be built up among staff of the Family Health or other Divisions.

The Team identified several interesting case leads during its visit. Perhaps the most promising would be a case at the Provincial level focusing primarily on the implications of decentralization on the planning process. As greater authority for planning is shifted from the Central to Provincial level, management systems and responsibilities will necessarily change. A case could help describe the process of change and its implications to the health managers in the system and serve as an important teaching tool in subsequent management training for provincial health managers. It can also help decision-makers evaluate the effects of a policy of decentralization.

Subject to necessary clearance and approvals, FPMT would develop a case proposal outline for discussion with appropriate officials. If agreement to proceed is reached, FPMT would identify a case writer to investigate and develop the case. A Thai counterpart with a high level of English proficiency and familiarity with the case method would need to be identified to work collaboratively with the FPMT case writer. Ideally, this would be someone from within the FHD.

All aspects of the case writing activity, i.e. topic identification, location, protocol, and timetable, would need to be closely coordinated with the FHD and the Office of Primary Health Care. The latter is important as it is conducting operations research on the topic of decentralization and may request FPMT assistance in eventually developing a training curriculum, training strategies, and in conducting a training of trainers workshop for master trainers (see C1(d) below).

Part of the case development process could include a short seminar organized by FPMT to discuss the case writing and case teaching method. This seminar would provide a useful orientation to the participants and begin the process of building up skills in case writing and teaching in the FHD. A seminar of this kind would probably last two or three days.

B. Technical Assistance

Technical Assistance (TA) provided by FPMT is generally of two kinds: 1) as follow-up to training, and; 2) as a discrete activity in response to a specific need or request. This section deals only with the latter.

1. Plan for Human Resource Development

The FHD has a large staff with diverse backgrounds, training, and experience. Several sections of the FHD, though not all, have identified individuals requiring further training. There is not, however, an overall plan for staff development consistent with the goals and objectives of the FHD. Such a plan, if developed, would help prepare for changing responsibilities within the FHD as personnel move or are promoted, and would help ensure that the best possible use is made of all available opportunities for short- and long-term training, whether in Thailand or elsewhere. In a period of falling donor support, opportunities for staff development may decrease. It is therefore even more important that a rational and consistent plan be developed as soon as possible.

The Team recommends that FPMT allocate resources to training of FHD personnel. The proposed plan for staff development will help FPMT, other donors and cooperating agencies target their assistance in a timely and productive fashion. It is recommended that this TA be provided as quickly as possible to take advantage of upcoming training

activities of benefit to potential FHD participants. The FPMT consultant could meet with all sections and units of the FHD, and would coordinate his/her work with the Administration and Training Sections.

C. Training Activities

FPMT supported training may be of several varieties depending on the needs of the participants and the availability of existing courses and programs. In the case of Thailand, FPMT has identified several courses which respond well to the management training needs of certain persons. These are described below under Short-Term Training. The elaboration of a plan for human resources development will certainly identify other short-term needs and opportunities. FPMT is also able to fund participants to training of up to one year's duration, as described below under Long-Term Training. Finally, FPMT frequently organizes and conducts in-country training workshops. This would seem to be an appropriate format for proposed training in microcomputers and management training for provincial health officials as discussed below.

1. Short-Term Training

a. Management skills for training

The FHD, through its Training Section and MCH Centers, plays a major role in training for family planning personnel. A U.S. based course exists for training directors from development ministries and NGOs entitled "Skills for Managing Effective Training Organizations", or SMETO. The course is conducted jointly by Management Sciences for Health and the School for International Training from June 15 to July 29, 1987. The Team has learned that the Director of the Ratchaburi MCH Center has applied to attend, and may need financial support. Subject to necessary approvals, the Team recommends FPMT sponsor his participation, as well as a participant from the Training Section of the FHD central staff. English proficiency is a requirement.

FHD participation in the SMETO course this year would be especially appropriate, as there will be participants from several other family planning organizations in attendance. FPMT had hoped that the training director of PDA could also attend, but scheduling conflicts preclude this possibility in 1987. This idea can be reconsidered in 1988.

b. Training in commodity logistics

To the best of the Team's knowledge, there do not currently exist any regular training programs devoted specifically to the issue of commodity logistics for family planning. However, many of the issues faced in family planning logistics management are similar to those in drug management for health care programs. MSH offers a course once yearly called "Managing Drug Supply for Primary Health Care". Issues covered include planning and coordinating the supply system, forecasting requirements, managing procurement and distribution, management information and inventory systems, financing, and other issues. The three week course is followed by a technical seminar on revolving drug funds or microcomputers for drug supply.

Based on discussions with FHD personnel, the Team feels this course would be of benefit to selected staff of the Administration and Research and Evaluation Sections. The Team proposes that FPMT agree to sponsor two participants to the 1988 course in Boston. The need for training in this area may diminish if technical assistance and/or training is provided to the FHD through the Family Planning Logistics Management project. This will need to be followed closely in the coming months.

c. Training in microcomputers

There exist numerous microcomputer training courses in the U.S. and elsewhere. The need for microcomputer training was clearly expressed by FHD staff in numerous sections. However, given the large number of potential trainees and the language barrier, the Team recommends that microcomputer training be organized and conducted in Thailand. Although this needs to be confirmed, it appears possible to rent a sufficient number of computers for in-country training.

It is not possible at this time to specify the audience, timing, or content of the proposed training. This will depend on the details of the new NEC system due to be installed soon in the FHD, the training provided by the company, as well as the recommendations from an upcoming consultant visit by the Family Planning Logistics Management project.

To design a course in microcomputer training, the Team recommends that an FPMT expert in MIS/computers visit Thailand after the installation of the NEC system. The consultant will be able to conduct an in-depth assessment of the participants' needs and make all necessary arrangements for computer rental and workshop logistics. One or more Thai co-trainers for the course will also need to be identified. Trainers could come from within the FHD or possibly the Health Statistics Division. The latter are trying to develop their capacity to provide computer training to health workers.

d. Management training for provincial managers

The effective decentralization of health and family planning services is an area of key concern to the MOPH, and a topic of considerable discussion and research among many divisions of the Ministry. The Team, at USAID request, visited the Office of Primary Health Care to discuss research being undertaken by them (under a PRICOR project) on the management of primary health care at the provincial level. It is hoped that the research will lead to strategy for decentralized planning and management of health care activities in the provinces.

Owing to its mandate, PRICOR may not be able to fund curriculum development and training costs which might be called for as a result of the operations research. Management training for provincial and district level health officials will have a direct impact on family planning management, as family planning is integrated into the health planning and delivery system. FPMT, therefore, might be able to provide assistance in this effort.

FPMT's potential contribution would fall into three areas: 1) design of a management training curriculum; 2) development of training strategies for management training at the provincial level; and 3) help in the development of a Training of Trainers course for MOPH trainers responsible for management training in health. These ideas were discussed with USAID and the Management Improvement Unit of the Office of Primary Health Care. It was agreed to explore the idea further as more information becomes available on the likelihood of PRICOR being able to take on the training activities described above.

2. Long-Term Training

Both degree and non-degree training of up to one year's duration can be supported under the FPMT project. FPMT may also sponsor English language instruction for participants requiring increased proficiency prior to beginning long-term studies.

FPMT's ability to recruit long-term training candidates has been hampered in many countries by several factors, including the small applicant pool, newness and fragility of the family planning programs, and the large potential disruption to the programs caused by pulling staff for long-term training. These constraints do not apply to Thailand, opening up long-term training as a potential area for FPMT support to the NFPP.

During its stay, the Team was not able to identify specific persons who would benefit from long-term training. The selection of candidates must be made following a thorough analysis of needs and potential benefits to the NFPP of training. The selection process must also take into account opportunities for training through other donors, such as UNFPA. Such an analysis could be carried out as part of the proposed development of a plan for human resources development discussed above.

The Team anticipates that candidates for long-term training will be identified by the FHD, and recommends that FPMT consider supporting two or more participants to long-term training. A course of study would then be developed and all necessary arrangements undertaken for enrollment. Training would likely be designed to build competencies in several of the following areas: health economics and financing, research design and analysis, monitoring and evaluation, MIS and microcomputers, and general management skills.

Candidates for long-term training would need to be identified by November, 1987 for placement in programs beginning in August, 1988. Language instruction, if necessary, would take place in June and July.

D. Other FPMT Assistance

1. Study and Observation Tours

FPMT has already received proposals from PDA and ASIN for the design and conduct of study and observation tours in Thailand. These proposals were discussed with the organizations during the FPMT visit. The Technical and Special Projects Section of the FHD has expressed its strong interest in organizing study and observation tours as well. They have had considerable experience and feel that they may have better access to the public sector than either PDA or ASIN. The Team, in its final debriefing, encouraged the FHD to develop a proposal for submission to FPMT. Perhaps study tours sponsored by more than one organization can be undertaken, the choice of sponsor dependent on the profile of each group of participants (public vs. private sector, clinic based vs. community based, etc.)

2. Family Planning Library

The FHD has developed an impressive documentation center for population and family planning information. The materials serve the needs and interests of both national and international clients. FPMT is developing a library of family planning management resources to supplement and complement those already available to family planning programs in different countries. The Team recommends that a set of these resource materials be provided to the FHD documentation center.

The Team also feels that staff from the Technical and Special Projects Section, which maintains the documentation center, should be included in the microcomputer training proposed above. This training will help the Section in its attempts to develop a computerized reference and retrieval system for its materials.

V. COUNTRY PROFILE

A. Economic and Social Indicators of Development

1. Background

Thailand, formerly known as Siam, occupies 514,00 square kilometers (198,500 sq. mi.) in the heart of mainland Southeast Asia. Much of Thailand's history and politics are the result of its axial position in Southeast Asia. Although Thailand does not touch China or Vietnam, areas of both countries are within 100 kilometers of Thailand.

Thailand has four main topographical areas:

The rich agricultural central region is dominated by Thailand's most important river, the Chao Phraya which supports an extensive network of canals and irrigation projects. The central region has long been considered the "rice bowl" of Asia.

The northeast region, with the large Khorat plateau rising about 304 meters (1,000 ft.) above the central plain, comprises roughly one-third of the country. Much of this land is poor and suffers from seasonal droughts or floods. The topography makes irrigation and flood control difficult, but planned irrigation and flood control projects on the tributaries of the Mekong River along the Laotian border have improved agricultural potential.

The northern region, characterized by mountains and steep river valleys, covers about one-quarter of the nation's area. The thickly forested mountains, running north and south, provide valuable timber, while the narrow but fertile valleys, watered by the many rivers of the region, support intensive rice cultivation.

The southern region, a long sliver of land extending from central Thailand southward to Malaysia, is covered mainly by rain forest. Rubber and coconut cultivation and tin mining are the important economic activities in the region.

Thailand's tropical climate is dominated by monsoons, with high temperatures and humidity. Most regions have three seasons: rainy (June-October), cool (November-February), and hot (March-May).

2. Economy

Overall, Thailand's economy has grown steadily under the protection of conservative fiscal and monetary policies. Inflation is increasing, due in part to the high cost of energy and imported materials such as transportation and construction equipment, non-electrical machinery, textile fibers, and chemicals. In 1980 the trade deficit was \$4 billion annually, a sum equal to approximately 125 percent of total exports (\$3.2 billion). The principal export products are rice, sugar, rubber, maize, tin, pineapples, and finished textiles. Tourism is a major source of hard currency for Thailand.

A major economic obstacle, according to the Government of Thailand, is the growth in population which is currently estimated at 1.5 percent annually, a rate substantially below that of 15 years ago (3.2 percent). Each year, the country must create an additional 4 million jobs, and by 1992 the number will escalate to 5.8 million.

Population pressures have led the government to substantially subsidize food prices, especially rice.

3. Politics and Government

The government is a constitutional monarchy consisting of three branches: the Executive (King, chief of state), the Legislative (bicameral National Assembly), and the Judicial (three levels of courts).

Under the new constitution of December 22, 1978, the 14th constitution since 1932, the King is formally the head of state. Although he has little direct power, he is an important and popular symbol of national identity and unity. A 14-member Privy Council is appointed by the King to advise him and, under certain conditions, to appoint a regent for the exercise of royal powers.

Other state organs mandated in the constitution are the National Assembly, the Council of Ministers, the courts, and local government.

Thailand is administratively subdivided into 73 provinces and 642 districts. Officials are elected by a multi-party system; the Communist Party is prohibited.

4. Cultural and Religious Characteristics

Thailand's society is relatively homogeneous. More than 85% of the people speak a dialect of Thai and share a common culture. This core population is made up of the Central Thai (36% of the Population), Thai-Lao (32%), Northern (8%), and Southern Thai (8%). The Thai language of the Central Thai is the official language, taught in schools and used in government. Several other small Thai-speaking groups include the Shan, Lue, and Phutai. The largest minorities are the Chinese, about 8% of the population, and the Malay-speaking Muslims in the south (3%). Other groups include the Khmer, the Mon, who are substantially assimilated with the Thai, and the Vietnamese.

Theravada Buddhism is the religion of more than 90% of the Thai. The government permits religious freedom, however, and many other religions are represented. Spirit worship and animism are also important in Thai religious life.

5. Social Characteristics

Universal free public education is being expanded from 4 to 7 years. In 1986 education was the largest item in the Thai budget, accounting for more than 20% of the total. In 1979, 96% of primary and 29% of secondary school-age children were enrolled in school, and about 5% were in universities or colleges. The adult literacy rate had risen to 89.5% by 1984, as compared to 50% only 30 years earlier.

The legal system blends principles of traditional Thai and Western law. Law dealing with family and inheritance matters is rooted in traditional laws and custom, while criminal, civil, and commercial codes are adapted from British and European legal systems.

6. Health Characteristics

Health indices and demographic data for Thailand appear below:

Mid-1986 Population (thousands)	54,442
Average annual growth rate (1986)	1.5%
Crude birth rate	25.3
Crude death rate	7.4
Total fertility rate	3.0
Male life expectancy at birth	61.3
Female life expectancy at birth	67.3
Infant mortality rate	52
Percentage aged 0-14	35.6
Percentage aged 65+	3.6
Density (persons per square km)	102
Population projected by 2010 (thousands).....	73,057

In Fiscal Year 1986, the Royal Thai Government budget for health was approximately \$ 378,000,000, or about 4.33% of the national budget, a percentage that has held relatively constant over the past fifteen years.

B. History and Current Status of Family Planning

1. Origin of family planning efforts

Early population efforts were started by the private Family Planning Association in the late 1950's. Limited experimental projects were initiated in 1964 by the government, primarily as a response to a World Bank report identifying population growth as serious impediment to national economic growth.

On November 12, 1971, The Government of Thailand and the United Nations Fund for Population Activities (UNFPA) signed an agreement under which the UNFPA agreed to provide \$3.3 million in assistance to Thailand's national family planning program, initially for a three-year period. The UNFPA has continued its support on a consistent basis since this agreement, and current funding for a new four-year program has been allocated in response to UNFPA's most current (1981) comprehensive needs assessment, and the Royal Thai Government's Fifth Five-Year Plan.

Government Support

The first five-year family planning program was included in the Third National Economic and Social Development Plan (1972-1976), and had as objectives to reduce the population growth rate from over 3 percent to 2.5 per cent by the end of 1976; to inform eligible women, particularly those in rural and remote areas, about the concept of family planning and to make these services accessible; and to integrate family planning activities with the existing maternal and child health services.

Subsequent five-year family planning programs have been integral facets of the corresponding National Economic and Social Development Plans. The Fourth Five-Year Plan aimed to reduce the population growth rate to 1.5 per cent by the end of 1986 and the Fifth Five-Year Plan targets a 1.3 per cent population growth rate by the end of 1991. The current plan emphasizes the reduction of population growth rates through accelerated and intensified family planning services, particularly in remote areas. It also encompasses other aspects of population policy, such as health services, nutrition, and education.

Policy

For most of the present century, Thailand's policy on population was one of pro-natalism. The government felt that an increased population, up to 100 million, was necessary for national economic development and increased prosperity. It was not until 1970 that Thailand's policy with regard to population growth became one of intervention.

The statement of policy by the Cabinet in March 1970 declared that:

"The Thai Government has the policy to support voluntary family planning in order to resolve various problems concerned with the very high rate of population growth which constitutes an important obstacle to the economic and social development of the nation."

Thai Government support for the National Family Planning Programme has been a critical factor in the success of fertility reduction programs. The government has shown a consistent willingness to obligate sufficient

human and material resources to the NFPP, and has adopted policies allowing for service delivery from an expanded range of health personnel.

Laws Concerning Use of Auxiliary Personnel

A pilot study was initiated during the period of 1968-1970 in which auxiliary midwives, using a comprehensive check-list were allowed to prescribe oral contraceptives directly. The study was a success, showing that auxiliary midwives did well when compared with physicians: there was a definite increase in the number of acceptors, no increase in complications, and improved continuation rates. Due to the success of this pilot study, the Ministry of Public Health ruled in 1970 that midwives throughout the country could distribute oral contraceptives, using the same check-list. This ruling enabled an additional 3,400 clinics without physicians to provide contraceptive services. Approximately 80 per cent of the new acceptors lived in rural areas, and over two thirds were from agricultural households.

2. Family Planning Service Delivery System

Ministry of Public Health

Family planning activities in Thailand are being conducted by a large number of organizations, public and private. The Ministry of Public Health plays the most important role by providing family planning services through its nationwide delivery system of hospitals and health centers. The family planning activities within the Ministry of Public Health fall under the Family Health Division (FHD), Department of Health.

The Director-General of the Department of Health is also Director of the National Family Planning Programme. The Family Health Division's role is to monitor the NFPP, provide contraceptive services, manage foreign assistance , provide logistical support, conduct training, supervision, IEC activities, and research and evaluation.

The Ministry of Public Health (MOPH) has the responsibility for the organization and administration of public health services and most of the medical services of the government. The MOPH is organized into six major components: The Office of the Permanent Secretary of State for Public Health; the Department of Medical Services; the Department of Health; the Department of Communicable Disease Control; the Department of Medical Science; and the Office of the Food and Drug Committee.

Other organizations within the Government having activities related to family planning include the Ministry of Interior, which provides health services to specified population groups, such as the population of the Bangkok Metropolis through the Bangkok Metropolis Authority. The Department of Public Welfare is concerned with health services to resettlement groups, hill tribes, etc. The Ministry of Education is involved in population education, and Government hospitals outside the Ministry of Public Health provide services. A number of private organizations are also involved.

The Population and Community Development Association (PDA) is a private non-profit organization, actively engaged in family planning service delivery, parasite control, sanitation, primary health care, emergency relief programs and community-based development. PDA grew out of the

Community-Based Family Planning Services (CBFPS) which was founded in 1974.

With over 600 staff members and more than 13,000 volunteers working in 17,200 villages throughout the country, PDA is currently implementing some 47 projects, the majority of which are community based family planning, health and fertility-related development programs. These programs also include family planning services for factory workers and marginal urban populations.

Operating funds of PDA come from several donor agencies, contributions from the public and income generated by PDA itself through various activities.

Presently, PDA consists of four operating branches, namely: the Rural Population and Health Bureau, The Urban Population and Health Bureau, The Community-Based Appropriate Technology and Development Services Bureau and the Asian Centre for Population and Community Development. The first three branches are directly responsible for project implementation and management.

The Asian Centre serves as a technical resources pool, providing training services to its staff as well as family planners from many countries. The Asian Centre has trained over 800 participants from some 37 countries. Also operating under the Centre is the Research and Evaluation Division (RED), which engages in designing and implementing evaluation programs. RED is also providing services to several other organizations.

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

ASIN is a non-profit organization founded in 1975. ASIN's activities include:

-Voluntary Sterilization in Private Institutions Project (VSPI), a project which is supported by the Thai Government and FPIA. There are a total of 1,250 ASIN affiliated medical institutions throughout the country.

-VSPI also organizes national and regional seminars for its members and multidisciplinary persons involved in family planning. These seminars act as a forum for updating technical information and for exchanging ideas among VSPI's members.

-IEC Projects

-ASIN also provides vasectomy services in collaboration with the Planned Parenthood Association of Thailand, the Thai Association for Voluntary Sterilization, the Rotary Club of Kampaengphet Province (mobile vasectomy units), Paolo Memorial Hospital, and the Lions Club of Singhaburi Province.

-3 microprojects under the title of "Strengthening of Family Planning in Private Medical Institutes (PMI)", aimed at underserved areas.

The Planned Parenthood Association of Thailand (PPAT), the Thai IPPF affiliate, was established in 1970 and supports the national program through promotion of knowledge and information about planned parenthood, training of personnel, extension of services using the organized sector outlets, and experimental work in the industrial community and other organized special sectors of the population such as refugee camps.

Pharmacies and Private Doctors

In addition to the above-mentioned organizations, commercial pharmacies and private doctors are important delivery channels of family planning services.

There are 17,000 pharmacies in Thailand which are divided into three classes according to the kind of drugs they are permitted to dispense. Only "A" pharmacies are supposed to sell prescription drugs, which include oral contraceptives. The pharmacy network is limited to cities and towns where they cater to a class of people with more cash income. If oral contraceptives are removed from the "dangerous drug" list, the markets for distributors who handle them will be considerably widened.

It is estimated that there are about 5,000 private doctors offices or clinics, some with in-patient facilities, distributed over the country. A large proportion of these private doctors' offices are run by physicians who are also in Government service: MOPH rules permit Government doctors to engage in private practice outside Government hours, and in fact a very high proportion do so, including most doctors who serve in rural areas. While private doctors constitute a great resource for family planning service delivery, they have to date played a fairly small role.

3. Financing and Donor Support

Multilateral

The UNFPA funded program (refer to Origin of Family Planning Efforts), which was approved in 1983, includes projects in the areas of improving delivery of family planning services and management; formulation of a manpower development plan and training of maternal health care and family planning personnel; improvement of population information, education and communication strategies; in-school and non-formal population education; operations research; and policy and program formulation and evaluation.

The proposed UNFPA assistance is to be \$5,903,929 with an estimated Thai Government contribution of \$12 million. The Government coordinating agency is the Department of Technical and Economic Cooperation, and the Government implementing agencies are the Ministries of Public Health, Agriculture, Interior, and Education.

The executing agencies for this program are FAO, UNESCO, and the World Health Organization (WHO). In 1984-1985, WHO also supported service in psychosocial research in family planning, research on oral and injectable contraceptives, implants for fertility regulation, the safety and efficiency of current and new intrauterine devices, current methods of female sterilization, long-acting methods, methods for the regulation of male fertility, and research into the prevalence and causes of infertility.

Bilateral Assistance

Several countries offer bilateral assistance to Thailand in an effort to support the National Family Planning Programme.

U.S.A.I.D. has funded a four year project since 1982 at an estimated total cost of \$18,385,00. The main components of the project include 1) increasing the availability of contraceptive services and information in those provinces where acceptance levels are well below average; 2) providing the commodity support and technical assistance needed to train, deploy and monitor the use of auxiliary midwives to insert IUDs; 3) developing a problem-oriented operations research unit; 4) strengthening fertility-related maternal and child health services (prenatal nutrition and promotion of breast feeding) delivered through the rural health system; 5) providing voluntary surgical contraception through medical institutions and mobile teams below the provincial level; and 6) providing oral contraceptives at a gradually reduced rate. U.S. bilateral assistance is scheduled to end in June, 1989, and no plans currently exist for further assistance.

The Federal Republic of Germany supported family planning through primary health care services in the period 1977-1985, with an amount of about DM 5 million.

The Japan International Cooperation Agency initiated a fifteen year project in 1974 to strengthen MCH centers and IEC activities.

In 1978, the British Overseas Development Administration funded a four year study which examined the causative factors in the rapid fertility decline in the Chiang Mai region of Thailand.

Non-Government Organizations

There are various non-governmental organizations which actively support family planning. The Thai Association for Voluntary Surgical Contraception (TAVS) funds a variety of projects to improve the quality of the voluntary surgical contraception program; strengthen the effectiveness of educational activities; conduct research on various aspects of contraceptive methods and reproductive health; and to coordinate and analyze studies on oral contraceptives, IUDs, and female sterilization acceptors. Total grants from 1983 through 1986 amounted to \$697,865.

Family Planning International Assistance (FPIA) has provided a cumulative total of \$3,807,729 in family planning commodities to 76 institutions in Thailand as of June 30, 1985. FPIA supports projects which monitor and reimburse private medical institutions for performing voluntary sterilizations; support the training of youth volunteers; and identify the extent to which family planning is practiced in low-income metropolitan areas. For 1984 and 1985, a total of \$1,180,300 was provided, with projected funds for 1986 of \$527,800.

The Ford Foundation has awarded a grant of \$153,400 to Chiang Mai University for research in developing countries on issues of contraceptive

safety. The International Development Research Centre awarded a grant to Chulalongkorn University for \$48,810 to investigate the return of fertility among Thai women who have been IUD users for varying periods of time. Johns Hopkins University Department of Population Dynamics co-sponsored a 1983-1986 cohort study with Chiang Mai University to evaluate the effects of in-utero and lactational contraceptive steroid hormone exposure on long-term child growth, development, sexual maturation and health. Total funding from Johns Hopkins was \$300,000.

VI. FPMT MISSION TO THAILAND:

SCHEDULE OF MEETINGS AND PERSONS CONTACTED

4 May 1987

USAID Thailand: Health, Population and Nutrition Office

Mr. Edwin McKeithen (Director)
Mr. Karoon Rugbanichje

Ministry of Public Health: Family Health Division

Dr. Vira Niyomwan (Director)
Ms. Chusie Sujpluem (Chief, Training Supervision and Education Section)
Ms. Linda S. Andrews (Univeristy of Michigan Fellow in Training Section)
Ms. Patama Bhiromrat (Chief, Public Relations and Information Section)
Ms. Yindee Charanasomboon (Public Relations and Information Section)
Mr. Suthon Panyadilok (Chief, Research and Evaluation Section)

6 May 1987

Ministry of Public Health: Family Health Division

Ms. Sumalee Permpangpun (Head, Evaluation Unit)
Ms. Porsinee Amornwichet (Head, Research Unit)
Ms. Chantararat Rabiabloke (Chief, Technical Section)
Mr. Suthon Panyadilok (Chief, Research and Evaluation Section)

7 May 1987

Ministry of Public Health: Family Health Division

Ms. Varaporn Devaphalin (Chief, Planning and Monitoring Section)
Dr. Wanee Kolasartsenee (Director, USAID Population Project)
Ms. Jaruwun Angsuwon (Technical Section)
Ms. Supaje Suphantavang (Technical Section)

Ministry of Public Health: Rural Health Division

Ms. Ponsuk Hingkanont (Chief, Personnel Development)
Dr. Thawat Suntrajarn (Chief, Community Public Health)

8 May 1987

USAID Thailand: Health, Population and Nutrition Office

Mr. Edwin McKeithen
Mr. Karoon Rugbanichje

Family Planning International Assistance

Ms. Mary McGovern (Regional Director, Asia/Pacific)
Mr. Promboon Panitchpakdi (Associate Regional Director, Asia/Pacific)

12 May 1987

Dr. Soysaang Sethavanit (Acting Director, MCH Chiangmai)
Dr. Anusorn Sitdhirasdr (Deputy PCMO, Chiangmai)
Dr. Patsamee Rukskulkarn (Director, Sanpatong District Community
Hospital, Chiangmai)
Dr. Taweechai Yangcharoen (Sanpatong District Community Hospital)
Ms. Chantira (Health Promotion Section, PCMO Chiangmai)

13 May 1987

Population and Community Development Association

Mr. Pairojana Sornjitti (Director, Asian Centre)
Ms. Guia Morales Yomokgul (Head, Training Division, Asian Centre)

Lunch Meeting

Mr. Tony Bennet (Consultant, FHD)
Dr. John Laing (Population Council)

Office of Primary Health Care

Dr. Peerasit Kamnuansilpa (Director, Management Improvement Unit)
Ms. Peeungjun Sweatsriskul (Unit Manager, MIU)

14 May 1987

Maternal and Child Health Centre, Ratchaburi

Dr. Pradit Sukumol (Director, Maternal and Child Hospital)
Ms. Nimnuan Thawisomboon (Chief, Health Promotion Section)
Ms. Patcharee Ritneungoung (Health Promotion Section)
Ms. Komkai Kitvatanachai (Director, Midwifery School)

Vungyen Health Centre, Banpae District, Ratchaburi

Ms. Oracharn Watawee
Dr. Duangmanee Lachaprasittiporn (Siriraj Hospital)

15 May 1987

Office of the PCMO, Songkhla

Dr. Kanistha Tharavanich (Director, Technical Promotion and Health
Services)
Ms. Chitra Promdej (Chief, Health Promotion Section)
Ms. Kanitha Vanichanon (Chief, Planning Section)
Ms. Prapai Yimprasert (Priy Health Centre, Sadao District)

18 May 1987

Debriefing Session with FHD and USAID

Dr. Vira Niyomwan
Ms. Chusie Sujpluem
Ms. Linda S. Andrews
Ms. Jaruwan Angsuwon
Ms. Porsinee Amornwichet
Dr. Nanta Auamkul (Technical Advisory Board, FHD)
Dr. Sirikul Isaranurug (Technical Advisory Board, FHD)
Mr. Edwin McKeithen

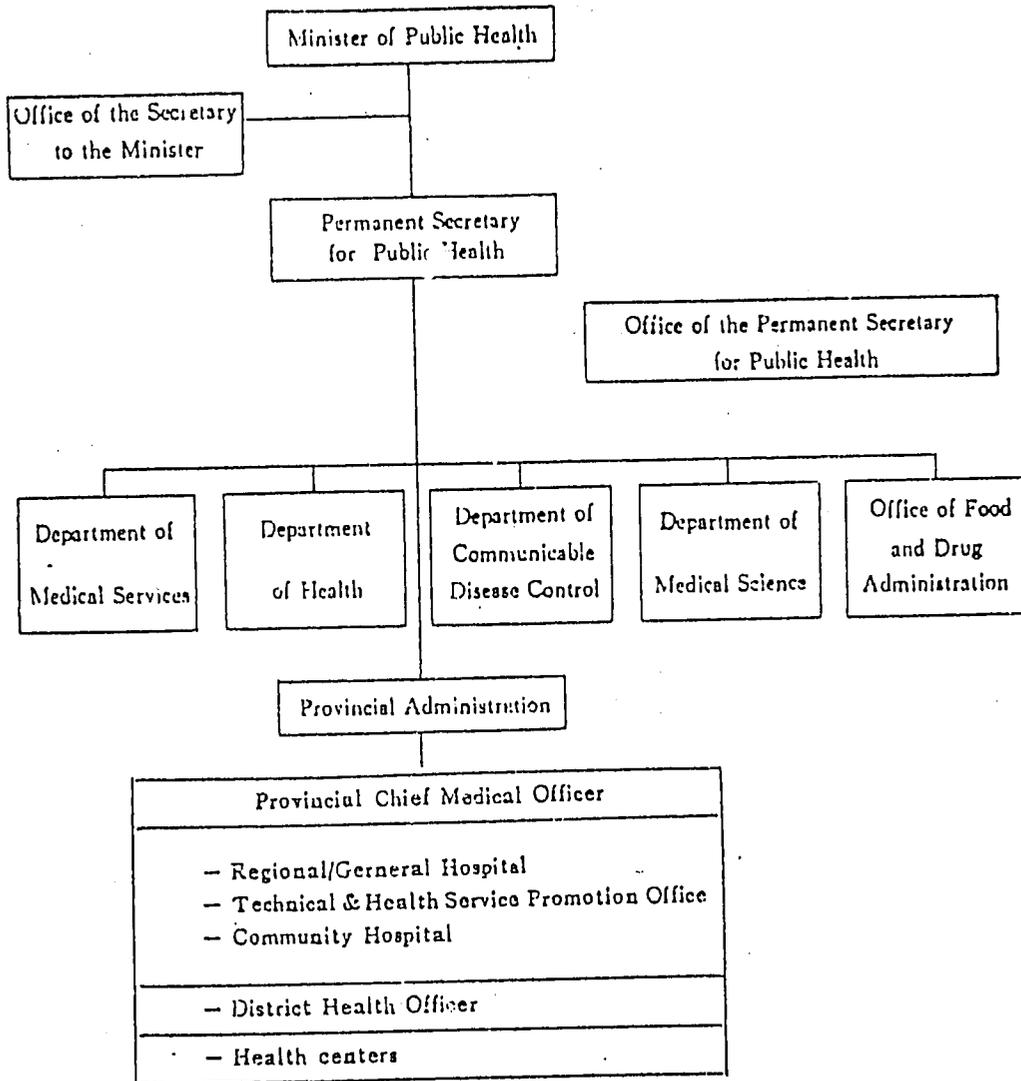
Health Statistics Division

Dr. Kanchana Kanchanasinith (Director)
Mr. Somkiat Wungkobiat (Chief, Scientific Instrument Center, National
Institute of Health)
Dr. Narong Kasitipardith (Epidemiology Division)
Ms. Phandhipaya Dharmasarojn (Data Processing Sub-section)

19 May 1987

Association for Strengthening Information on National Family Planning
Program (ASIN)
Mr. Arry Sriburatham (Acting Executive Director)

ORGANIZATION OF THE MINISTRY OF PUBLIC HEALTH



ANNEX II

THE NATIONAL FAMILY PLANNING PROGRAMME
 MINISTRY OF PUBLIC HEALTH
 FAMILY HEALTH DIVISION

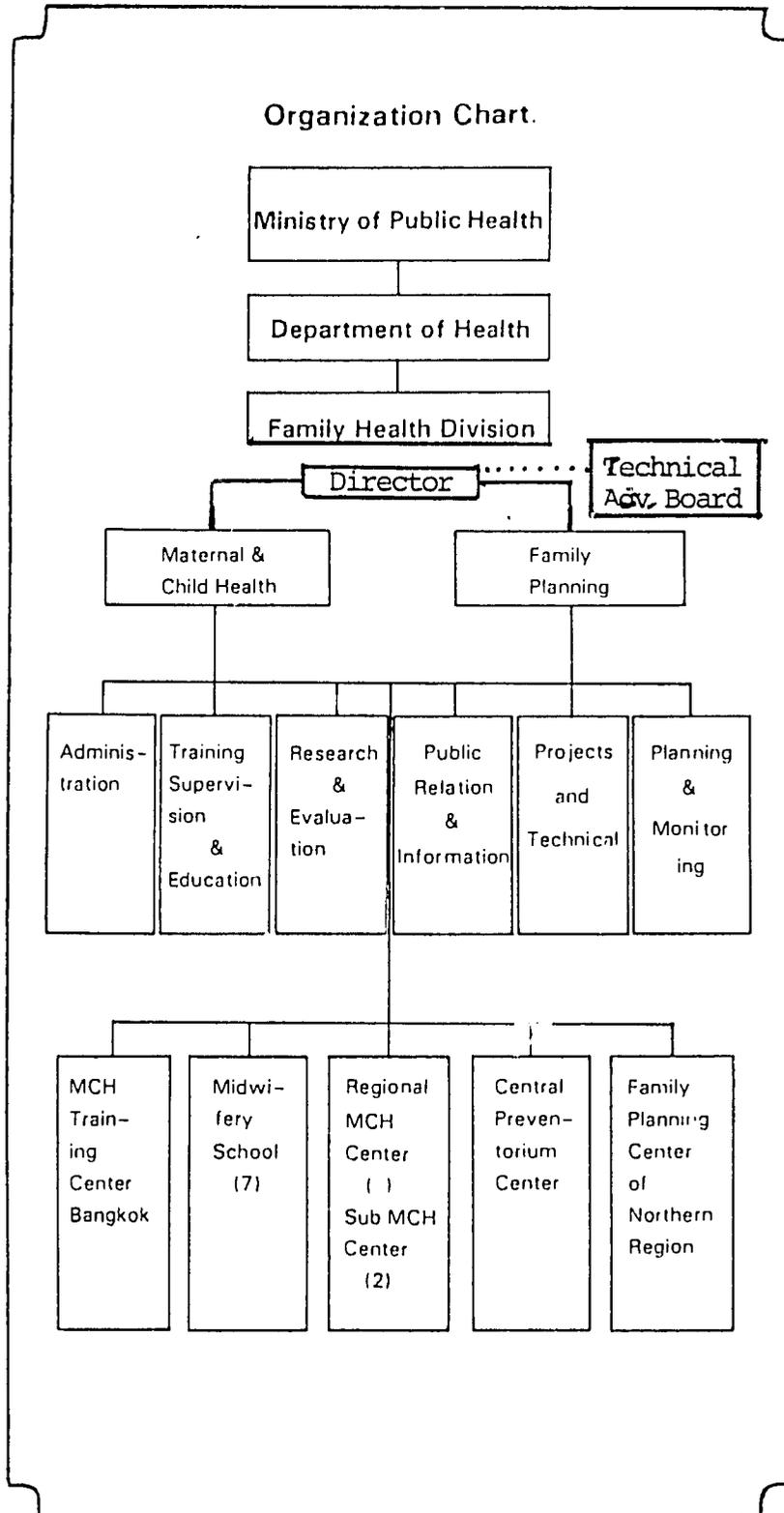
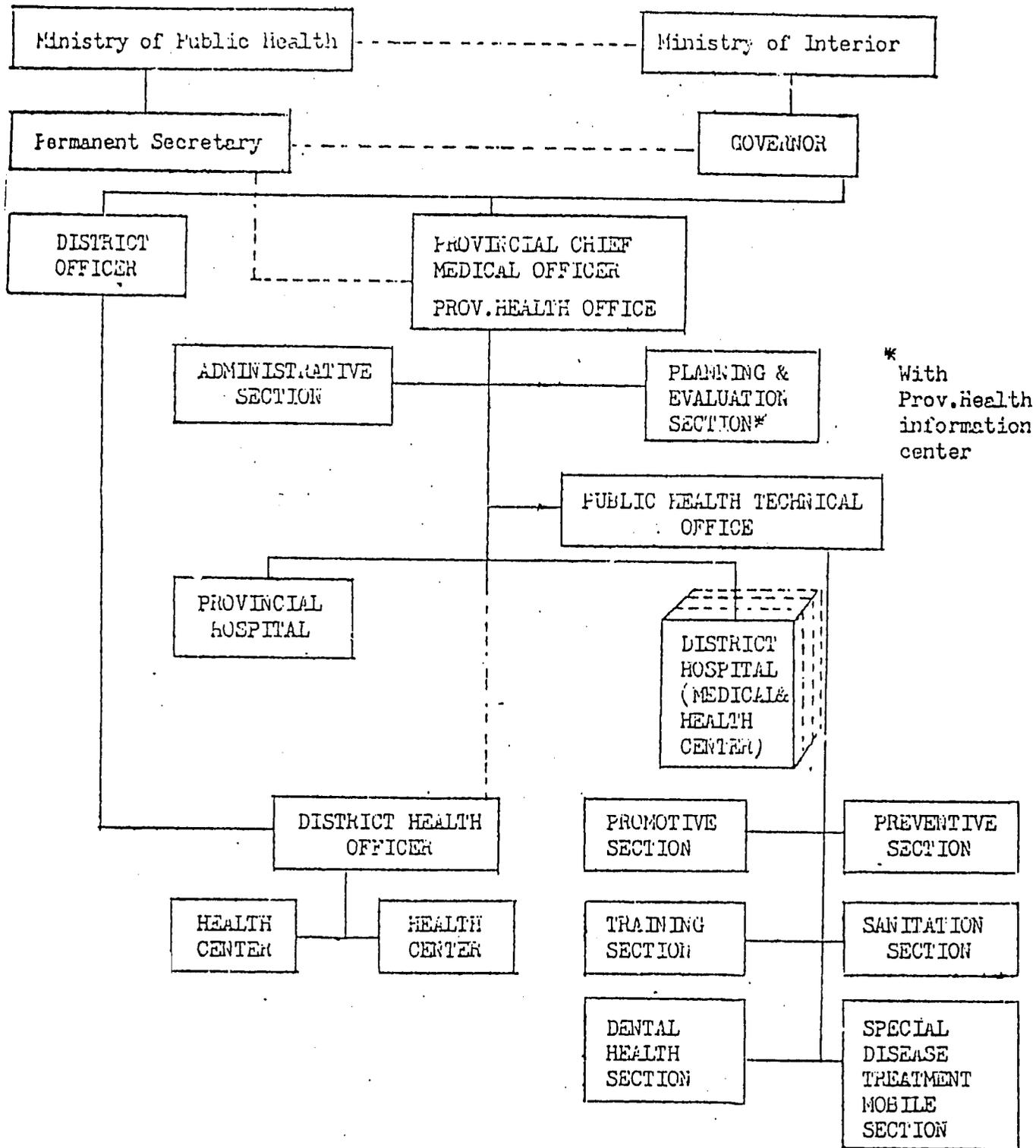


Figure 2.3 Provincial Administration

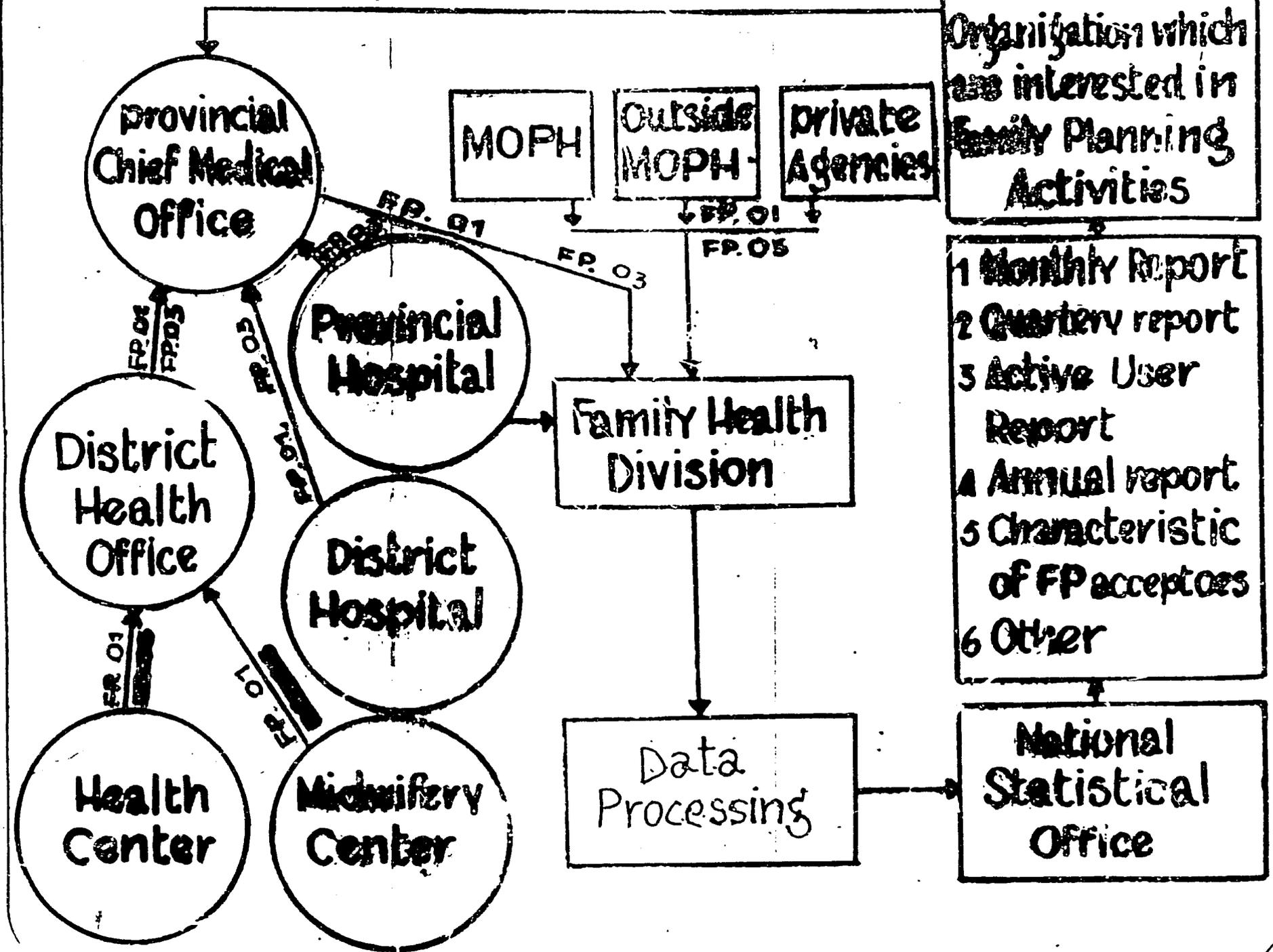


————— Line of Administration

- - - - - Line of Cooperation/technical supporting

FP Report Flow Chart

20



Organization which are interested in Family Planning Activities

- 1 Monthly Report
- 2 Quarterly report
- 3 Active User Report
- 4 Annual report
- 5 Characteristic of FP acceptors
- 6 Other

National Statistical Office

III. TRAINING AND SUPERVISION

A. Organizational Locus and Responsibilities for Training and Supervision

Within the Family Health Division, the planning and technical support locus for training and supervision is the Training Supervision and Education Section, organized into four sub-sections as follows:

Training Sub-Section
(about 24 training staff)
Responsible for:

- . Special emphasis training
- . Refresher courses
- . TOT and other special topical courses.

Education Sub-Section
(12 staff)
Responsible for:

- . Standardizing the curriculum and assuring maintenance of teaching standards in the 7 Schools of Auxiliary Midwifery.
Distributing information about and managing applications to continuing education courses for FHD personnel.

Orientation to FHD and family planning (one week) for new nurses who will be employed in provincial hospitals and MCH Centers.

Special projects: development of curricula for in-service training courses.

Supervision Sub-Section
(9 supervisory staff)

Responsible for:

- . Field supervision (with provincial staff) of midwives and nurse/midwives who have been trained in IUD insertion.
- . Field-based problem identification that flows into basic and in-service training needs assessments, supervisory needs, and field level technical or other support needed from central and provincial levels.

Technical Support Sub-Section
(18 staff, many without professional background)

Responsible for:

- . Distribution of audio-visual equipment for training programs.
- . Preparation of slide-shows, hand-outs, training manuals and training materials for in-service training courses.
- . Training data collection, presentation and reporting to FHD, UNFPA, and USAID.
- . Evaluation study of the multi-purpose competent training program.

ANNEX VI

Seminar/Workshop/Training Course in 1987.

<u>Title</u>	<u>Trainees</u>	<u>Days</u>	<u>Place</u>	<u>Bid</u>
1 Seminar "IUD insertion trainers at the provincial level"	5 doctors + 20 nurses/class from 20 provinces (4 Classes)	5 days	Siriraj Hospital. Chulalongkorn Hospital	USAID (Loan)
2 Training "IUD insertion for auxiliary midwives" (at provincial level)	25 midwives/class 1 class/province (20 Classes)	6 weeks	- PHO (2 wks) - District Hospital (2 wks) - Health Center (2 wks)	USAID (Loan)
3 Training "IUD insertion for nurses"	10 nurses/class - instructors of Midwifery School and nurse supervisors (2 Classes)	3 weeks	Khon Khan MCH Center	FHD
4 In-Service Training for auxiliary Midwives Course I	900 midwives graduated over 3 years (45 Classes)	5 days	- 6 MCH. Centers - Midwifery Schools	FHD
5 In-Service Training for auxiliary Midwives course 2	200 midwives Chief of the H.C (8 Classes)	5 days	Chonburi province (Bangsaen Beach Resort Hotel)	FHD
6 In-Service Training for nurses Course I	250 nurses work at District Hospital, District Health Office, MCH Centers (10 Classes)	5 days	"	FHD

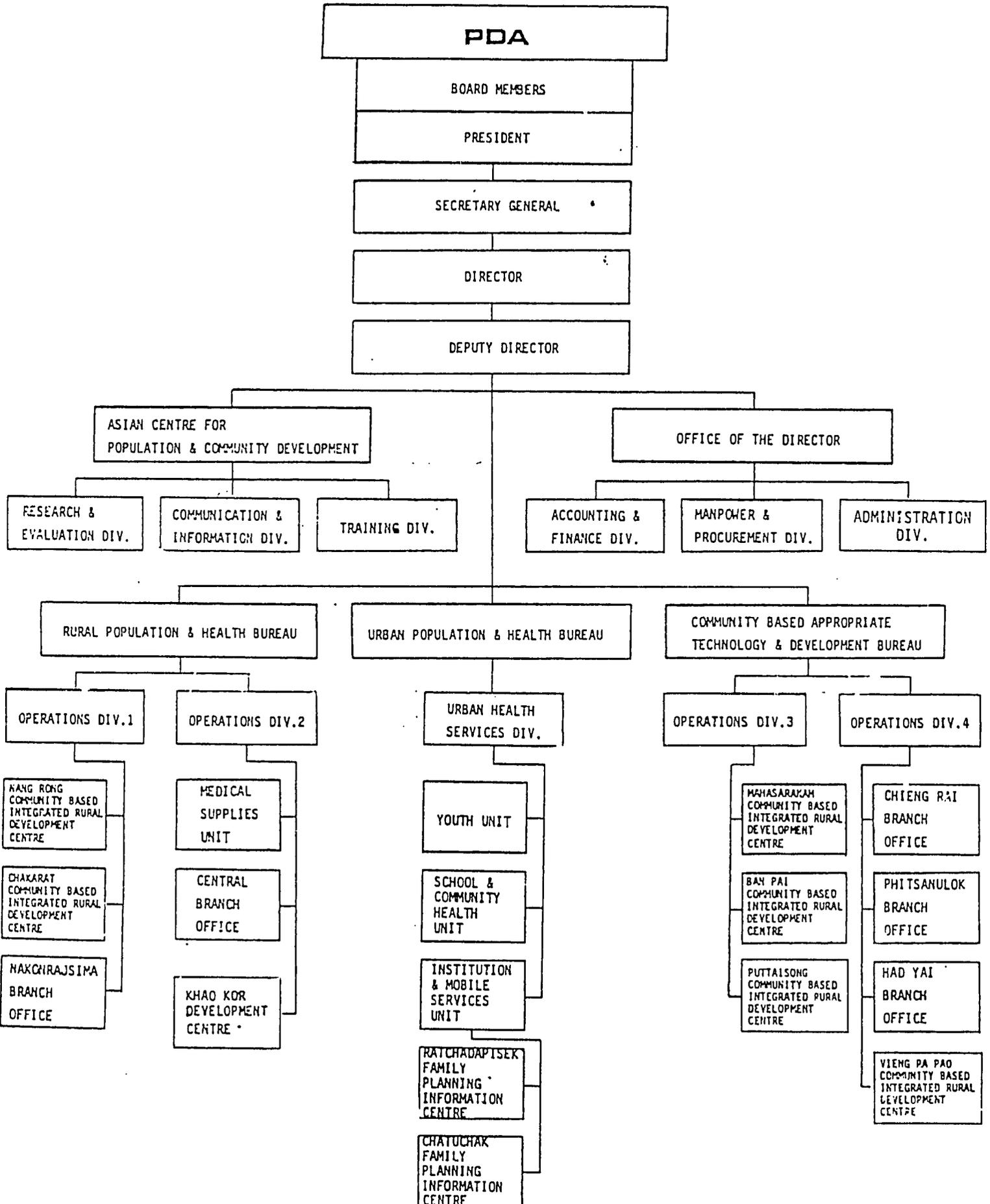
<u>Title</u>	<u>Trainees</u>	<u>Days</u>	<u>Place</u>	<u>Budget</u>
7. In-Service Training for nurses Course 2	100 administrative nurses as Chief of sections a Supervisors (4 Classes)	5 days	Chonburi province (Bangsaen Beach Resort Hotel)	FHD
8. Training of Trainers for adoles- sent Counseling	25 doctors, nurses and Social workers from MCH. Centers (1 Class)	5 days	Siriraj Hospital	UNFPA
9 Training "Family Health for sanitarians in 4 Southern provinces (Lower than 30 % of Prevalence rate of Contraceptive acceptance)	350 Nurses & Sanitarians (10 Classes)	4 days	Yala MCH. Center	UNFPA
10. Training "Family Health for sanitarians in 7 Southern provinces (Lower than 50 % of Prevalence rate of Contraceptive acceptance)	585 nurses (15 Classes)	4 days	Yala MCH. Center	UNFPA

<u>Title</u>	<u>Trainees</u>	<u>Days</u>	<u>Place</u>	<u>Budget</u>
11. Training of Trainers on Delivery Technique for TBA	660 auxiliary Midwives in 39 provinces (provinces (1 class) provinces)	3 days	PHO	UNICEF and FHD
11.1 Training "Delivery Technique for TBA"	3,150 TBAs. (39 provinces)	5 days	Health Centers	UNICEF and FHD
12 Training in MCH & FP for Model Mothers	2304 Model mothers (72 provinces)	3 days	District H.O.	FHD
13 Training in MCH & FP for Village H.V. in 4 Southern provinces	650 VHV (20 groups)	3 days	H.C.	UNFPA
14 Seminar on "Improvement of Well Child Clinic"	MCH Committee	1 day	MCH Center Bangkok	REDD BARNA
14.1 (Setting of Standard Clinic)				
14.2 Meeting of Evaluators	Evaluation Team (F.H.D. Staffs)	1 day	FHD	
14.3 Orientation on Project "Improvement of Well Child Clinic"	- PCMO - Chief of Health Promotion Section 9 provinces - Directors of MCH Centers	2 days	MCH Center Bangkok	

<u>Title</u>	<u>Trainees</u>	<u>Days</u>	<u>Place</u>	<u>Budget</u>
14.4 Training for Trainers	Pediatricians & Pediatric Nurse of MCH Centers	2 days	MCH Center Bangkok	
14.5 Training for Auxiliary Midwives to perform in well child clinic	36 Auxiliary Midwives (Redd Barna) 24 AMW	10 days	MCH Centers	Redd Barna UNICEF
14.6 Training of VHV, model mothers & TBA in Motivation for attending WCC	240 VHV 120 TBA 240 Model Mother	2 days	Health Centers	REDD BARN & UNICEF
15 Seminar on Means of problem Solving in MCH & FP in 4 southern provinces	- PCMO - Chief of Health Promotion Section - District Health Officer - Director of MCH (87 persons)	3 days	Hadyai District, Songkla Province	UNFPA
16 Training of Community health worker in FP	90 Community health workers (12 southern provinces)	3 days	Yala MCH Center Nakorn Sithamaraj Ranong Province	UNFPA

<u>Title</u>	<u>Trainees</u>	<u>Days</u>	<u>Place</u>	<u>Budget</u>
17. Training of Evaluation in Education	25 trainees/group 3 groups - Staffs from - Midwifery School - Training Section - MCH Centers	5 days	MCH Centers of Region 5	FHD
18 Workshop on "Improvement of training/Education materials for teaching in Midwifery School	Staffs from Midwifery Schools 30 per group 2 groups	5 days	MCH Center Bangkok	FHD
19 Seminar on "Teaching & Learning Issue for Intensive course for auxiliary midwives (Before attending BS degree program at School of P H)	35 Staffs of FHD and Midwifery Schools	5 days	FHD	FHD
20 Seminar on "Evaluation and operation of Health Midwifery course"	BS Staffs of FHD , Midwifery Schools and MCH Centers	5 days	Yala MCH Centers	FHD
21 Training on "Management of Audio-Visual aids"	30 Staff from MCH Center (15 per group)	14 days	FHD	FHD

Organization Structure of the PDA



ANNEX VIII

THE ASIAN CENTRE FOR POPULATION AND COMMUNITY DEVELOPMENT

1987 Course Schedule

Course No.	Date	Course Title	Length	Fee US\$
1	March 30 - April 11	Family Planning, Health and Community Development Participation and Observation Programme	2 wks.	650
2	June 1 - June 20	Incentives in Family Planning, Health and Fertility Related Development Programmes	3 wks.	850
3	June 29 - July 11	Family Planning, Health and Community Development Participation and Observation Programme	2 wks.	650
4	July 27 - August 8	Development and Management of CB Family Planning Health and Development Programmes	2 wks.	550
5	August 24 - September 12	Women in Community Development, Income Generation and Fertility Management Programmes	3 wks.	850
6	September 28 - October 10	Monitoring, Research and Evaluation of Community-Based Programmes	2 wks.	550
7	October 26 - November 14	Development and Management of CB Family Planning, Health and Development Programmes	3 wks.	850

Application Deadline : 3 wks. before the start of the training.

Language : English

* Fee : covers tuition, documents, internal transportation and general medical care.

ANNEX IX

Family Health Division

Priority for Research Topics for Family Planning and MCH

1. Long and short-term follow-up of contraceptive acceptors.
2. User perspective of different contraceptive methods.
3. Attitudes of provincial health officials toward the FP/MCH work of village volunteers.
4. Factors affecting contraceptive method - switching and its impact on the NFPP.
5. Evaluation of various family planning service models.
6. Study of family planning service strategies for different population sub-groups.
7. Evaluation of the provision of the injectable contraceptive by auxiliary midwives and female sterilization by nurses and auxiliary midwives.
8. Cost Benefit and cost effectiveness of family planning.
9. The impact of family planning on various development sectors.
10. Study of birth weight and ways to prevent low birth weight.
11. Study of factors which promote MCH and immunization service acceptance.
12. Study of knowledge transfer away trained and untrained village volunteers.
13. Study of maternal morbidity and mortality and preventive.
14. Study of infant mortality and interventions to reduce it
15. Study of strategies to promote the health development of women.