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HOW THAILAND'S

FAMILY PLANNING PROGRAM

REACHED REPLACEMENT LEVEL

FERTILITY:

LESSONS LEARNED

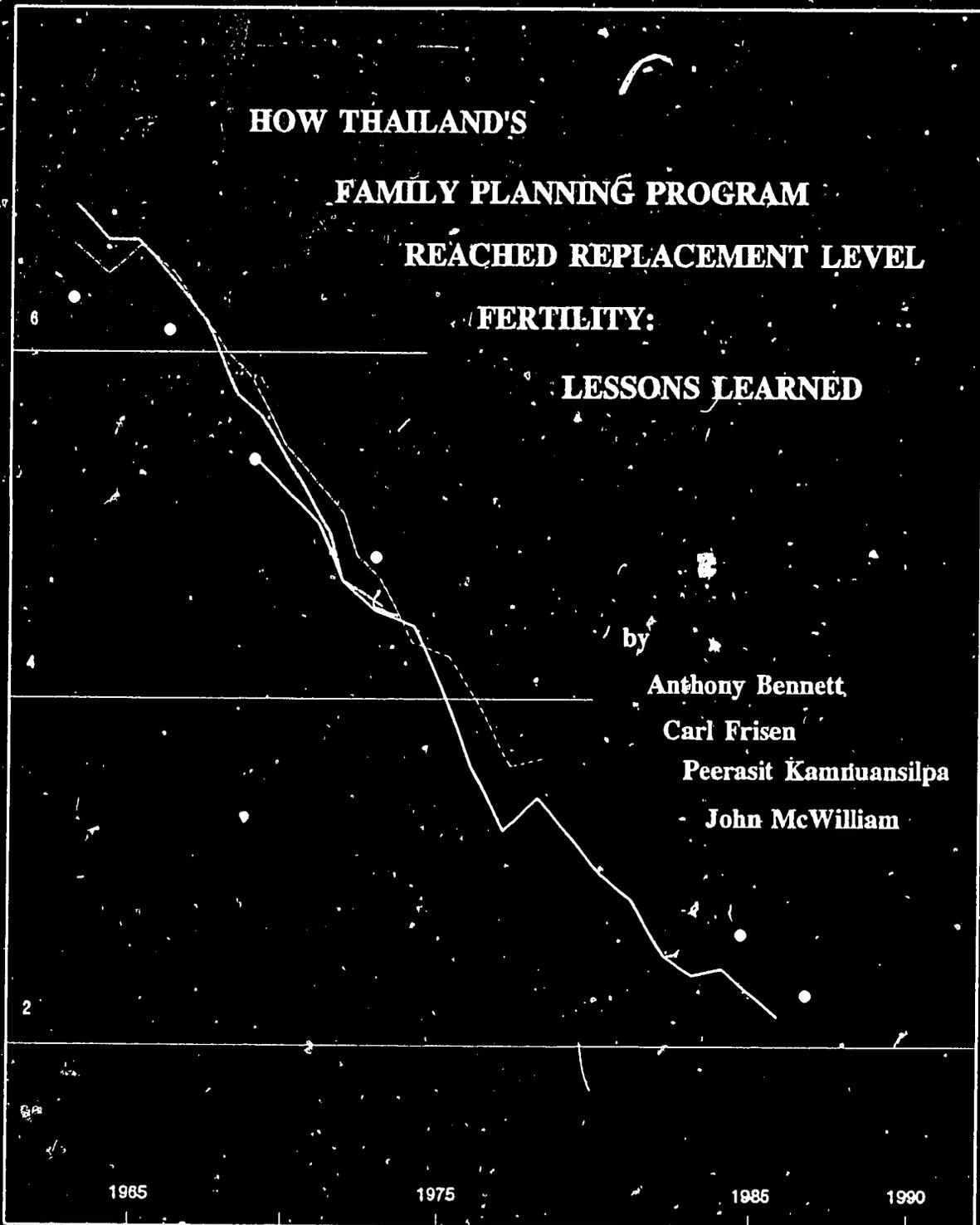
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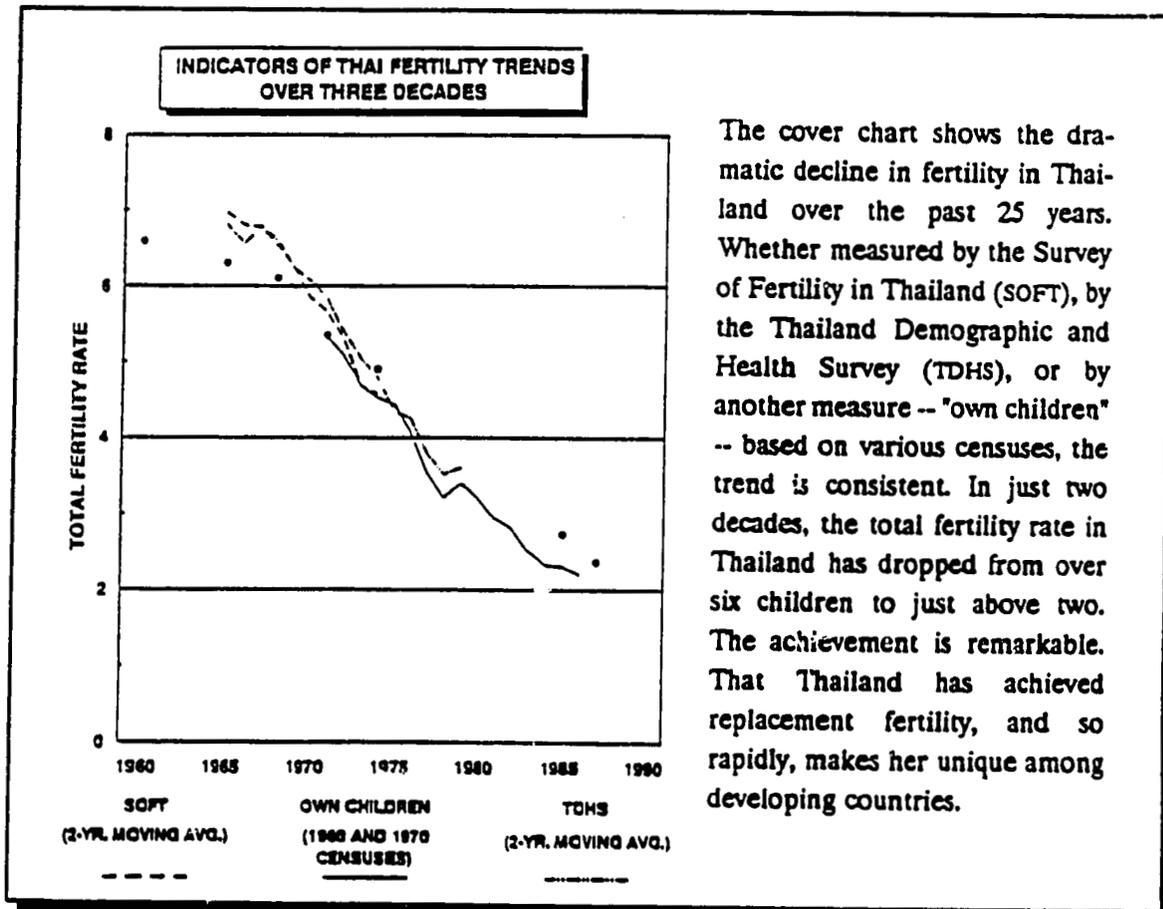
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HOW THAILAND'S FAMILY PLANNING PROGRAM REACHED REPLACEMENT LEVEL FERTILITY: LESSONS LEARNED

by

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Preface

This is the fourth in a series of Occasional Papers published by the Population Technical Assistance Project (POPTECH). Like its predecessors, this paper focuses on an issue of special interest to the population community -- in this case, the lessons learned from the successful Thai family planning program that might be applicable elsewhere.

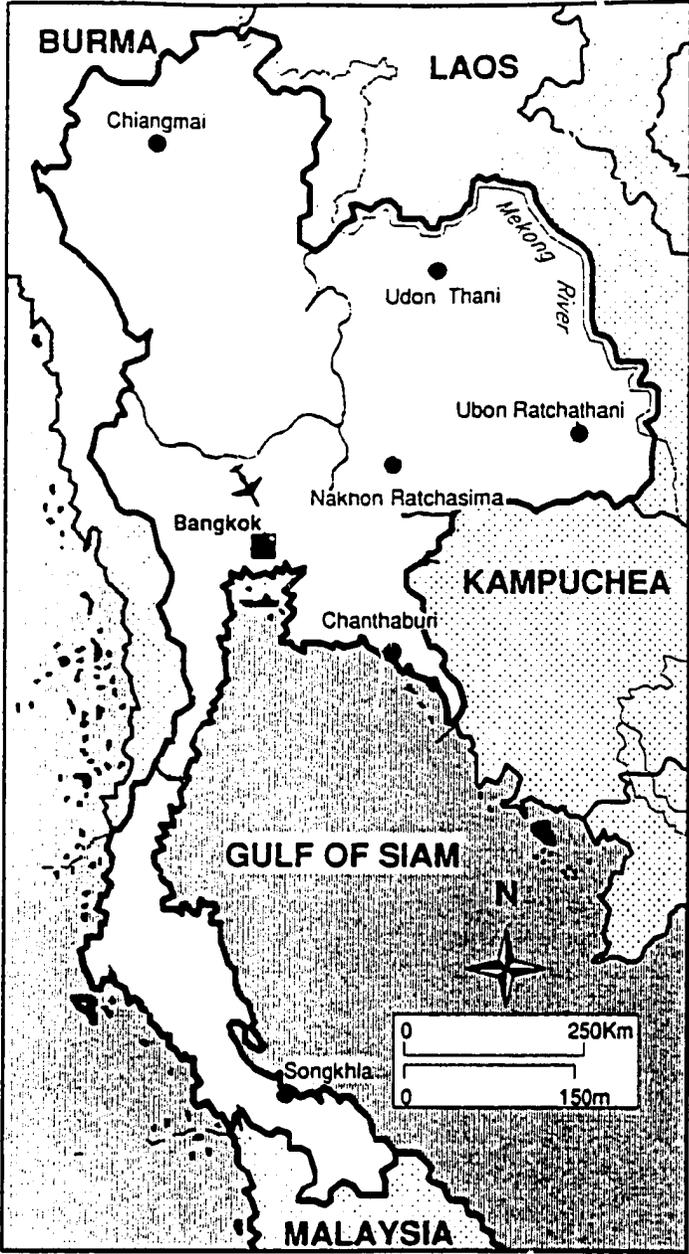
The paper was written at the request of the Office of Health, Population and Nutrition of USAID/Thailand with the purpose of analyzing "the most influential program factors (in the evolving socio-cultural context of Thailand) that...account for the dramatic success of the family planning program." Coming at the end of nearly two decades of assistance, the paper serves as the final summing-up of the USAID experience. USAID selected this approach, rather than the more traditional project evaluation, because the Thai family planning program stands virtually alone in the developing world in the degree of success it has enjoyed. A series of national seminars was held in conjunction with the preparation of this report, also focusing on the lessons learned from the Thai program.

The report takes an historical approach to the question at hand: How did Thailand's family planning program achieve its unprecedented successes? Using a framework developed by A.I.D.'s Office of Population, it separates the evolution of the Thailand experience into five stages according to the level of contraceptive prevalence at each period. Based on this framework, the report analyzes the program factors that were pivotal at each level in bringing a greater proportion of the populace into the ranks of contraceptive users and thus bringing the program to the next stage. The hope is that the history of the Thai program and lessons learned from it may be useful to other programs in their pursuit of increasing contraceptive prevalence.

The report was prepared principally in Thailand by three individuals with extensive experience in the Thai demographic and family planning setting. Dr. Peerasit Kamnuansilpa is a professor at the National Institute for Development Administration in Bangkok and a principal investigator of the country's four most recent contraceptive prevalence and fertility surveys including the Thailand Demographic and Health Survey. Anthony Bennett is the country representative to Thailand for Family Health International and formerly field representative of Columbia University's Center for Population and Family Health to the Thai National Family Planning Program. Dr. Carl Frisen is a lecturer and research associate at the Institute of Population Studies at Chulalongkorn University in Thailand. Additional work was done by John McWilliam, technical director of the Population Technical Assistance Project.

The authors wish to thank USAID/Thailand and particularly the Chief of the Office of Health, Population and Nutrition, Edwin McKeithen, for asking them to undertake this project.

Thailand Country Map



Country Profile

Thailand is a tropical country in the Indo-Chinese Peninsula of southeast Asia. Bordered on the north and east by the Lao People's Democratic Republic and Cambodia, on the west by Burma and on the south by Malaysia, it covers approximately 198,500 square miles or 514,000 square kilometers. The Kingdom's length from north to south is about 1,000 miles or 1,650 kilometers and its width is 500 miles or about 900 kilometers.

The country is comprised of two main parts: One is the valley of the Chao Phya River and the Korat plateau, which together make up the north, northeast and central regions of the Kingdom; the other is the narrow extension of the Malay Peninsula, in which is located the southern region of Thailand. The total population in mid-1989 was estimated at 54 million.

Nineteen percent of the nation's population live in the northern region, which includes both sparsely settled mountainous areas and densely settled river valleys where rice is grown. Most of Thailand's hilltribes reside in this region.

The northeast, with 35 percent of the Thai population, is the country's poorest region economically. It is dry with relatively infertile soil and lacks adequate irrigation. Principal crops are glutinous rice, maize, kenaf and tapioca.

Second in population size is the central region with an estimated 33 percent of the national total. It includes the Bangkok metropolitan area with over one-third of the region's population. Most of Thailand's industrial activity is concentrated in the Bangkok metropolitan region, which includes both the metropolitan area and five adjacent provinces. Rice is the region's major agricultural crop.

The southern region, located in peninsular Thailand, has 13 percent of the country's population. Principal commercial crops are rubber, coconuts and fruit. There is also tin and wolfram (tungsten) mining. Residents of the four southernmost provinces are predominately Malay-speaking Muslims.

The Muslims, of whom 80 percent live in the south, are Thailand's largest religious minority group. The 1980 Census reported that about 95 percent of the population professed Buddhism, and that 4 percent were Muslim.

From an ethnic standpoint, the Chinese are an important minority, especially in urban areas, but no data are available on their numbers. As a result of extensive inter-marriage and assimilation, there are no ready means of defining Chinese ethnicity.

1. Introduction

Introduction

Thailand's is a family planning success story. In 25 years, its people have moved from being pronatalist, with fertility levels between 6.3 to 6.6 births per woman, to a society of contraceptive users, with fertility almost at replacement levels. Contraceptive prevalence as of 1987 was high -- about 67.5 percent of currently married women of reproductive age, 15 to 44 years (modern method prevalence 65.5 percent).

The dramatic decline in births and fertility levels started in the early 1960s when government policy-makers learned that the expected population growth would seriously retard the country's economic development plans. These individuals shared their concerns with groups that could help -- the Ministry of Public Health (MOPH), private sector organizations and international donors -- and together, these bodies initiated a demographic revolution that relatively quickly began to limit the population size of Thailand. It is estimated that had the Government of Thailand not implemented its National Family Planning Program (NFPP), the population of Thailand today would be 67 million, rather than the 54 million estimated for mid-1989.

The magnitude of this demographic revolution and the way it took place are discussed in the following chapters. The analysis is made in the context of a new framework developed by A.I.D.'s Office of Population, which classifies countries in terms of their contraceptive prevalence and the stage of their family planning program. Thailand's remarkable fertility decline is divided into five levels or stages: the emergent stage, pre-1963; the launch stage, 1963-1969; the growth stage, 1970-1975; the consolidation stage, 1976-1984; and the mature stage, 1985 to the present. During each of these stages, different types of program activities took place which were important in gaining a greater acceptance of family planning by the Thai population. The most important of these activities, and the lessons learned from them, are summarized in the final chapter of this paper, in anticipation that they may provide guidance to other countries pursuing similar demographic and family planning goals.

Population Change in Thailand

Pattern of Growth

During the nineteenth century, the population of Thailand remained at a level of 5 to 6 million, stabilized by the nearly balanced high crude birth and death rates.

The first census, taken in 1911, showed a population of about 8 million, increasing slowly to 9.2 million in 1919 (see Table 1 on page 2). The total had increased to 11.5 million in 1929, 14.4 million in 1937, and 17.4 in 1947. The average annual rate of population growth during this period was not very large (about 2.2 percent per year) because of the still high level of

mortality. The population, however, had doubled in approximately 30 years, having grown from 8 million in 1911 to 16 million sometime between 1937 and 1947.

Table 1

Enumerated Population for Census Years 1911-80
Adjusted Population for Census Years 1960-80
and Average Annual Intercensal Growth Rates

Census date	Enumerated population (in 1000s)	Intercensal annual growth rate (percent)	Adjusted population (in 1000s)	Adjusted annual growth rate (percent)
04-01-1911	8,266.5	-	-	-
04-01-1919	9,207.4	1.3	-	-
07-15-1929	11,506.2	2.2	-	-
05-23-1937	14,464.1	2.9	-	-
05-23-1947	17,442.7	1.9	-	-
04-25-1960	26,257.9	3.2	27,357.0	-
04-01-1970	34,397.4	2.7	36,825.0	3.0
04-01-1980	44,824.5	2.6	46,269.5	2.3

Source: John Knodel, Aphichat Chamratithirong and Nibbon Debevalya, *Thailand's Reproductive Revolution: Rapid Fertility Decline in a Third-World Setting*. Wisconsin: The University of Wisconsin Press, 1987, p. 28.

The population began to increase even more rapidly after the end of World War II when death rates began a rapid and steady decline and birth rates remained high. The reduction in mortality rates was primarily the result of the introduction of modern medical treatment and sanitation practices developed in the industrialized nations. The Thai government also implemented a number of important disease control programs which had a telling impact on mortality rates and life expectancy. The most dramatic was the malaria eradication program, which was implemented in the 1950s and which significantly reduced infant and child mortality.

The 1960 census came as a major surprise to Thai demographers. The total count of 27 million was nearly 3 million above what had been expected and revealed that population was now growing at a very high rate of 3.3 percent. Ten years later, in 1970, the Thai population had increased another 9 million and stood at 36 million. This time, it had taken just over 20 years for the population to double.

The momentum that had been created by decades of accelerating growth, however, meant that the number of newborns would continue to increase for many years to come as more couples reached the child-bearing age. Thus by 1980, the Thai population was still growing at an estimated annual rate of between 2.3 and 2.6 percent. The 1980 census revealed that the Thai population had reached 46 million. This was an increase of 10 million over 1970, an even greater jump than during the previous decade (9 million between 1970 and 1980). Projections based on this total and estimates of fertility and mortality suggest that the mid-1989 population stands at 54

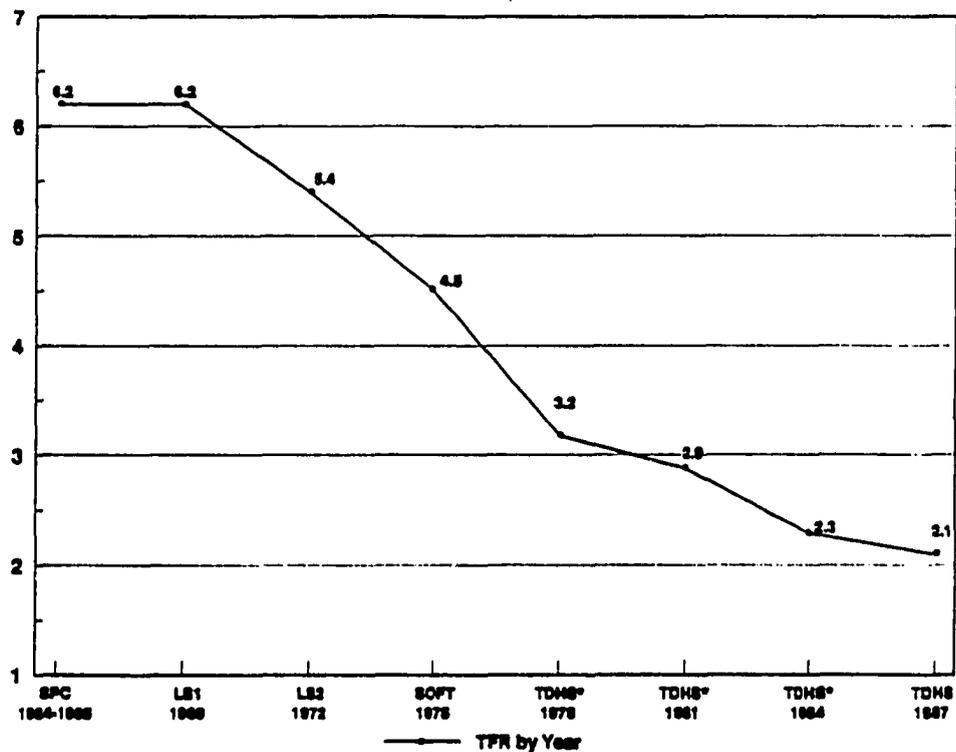
million. This increase, although still a substantial 8 million, is lower than that of either of the preceding two decades and demonstrates that the NFPP has begun to have an important effect on reducing fertility (see below).

Trends in Fertility

The decline in total fertility rates is evident from Figure 1. In the early 1960s, according to a study conducted by the National Research Council (1980), the total fertility rate was in the range of 6.3 to 6.6 births per woman. From this level it declined to 5.4 and 5.1 in 1972 and 1975, respectively. The decline started to accelerate in the mid-1970s. By 1978 the total fertility rate had dropped to 3.7, still well above the replacement level. By 1987, however, the total fertility rate in Thailand was virtually at a replacement level of 2.1 births per woman. The pace of fertility decline in Thailand has been documented as among the most rapid ever experienced by any developing country.

Figure 1

Total Fertility Rates in Thailand
1964 - 1987



* These rates are derived from the fertility histories collected in the Thailand Demographic and Health Survey, 1987.

Fertility in urban Thailand started to decline first and proceeded more rapidly than in the rural areas (see Figure 2). There is evidence that urban fertility was already declining by the 1960s, whereas rural fertility remained relatively constant until the second half of the 1960s. By 1975, the differentials in fertility by urban and rural area were beginning to decrease and by 1982, the difference was less than one birth.

Figure 2
Total Fertility Rates
by Residence by Year

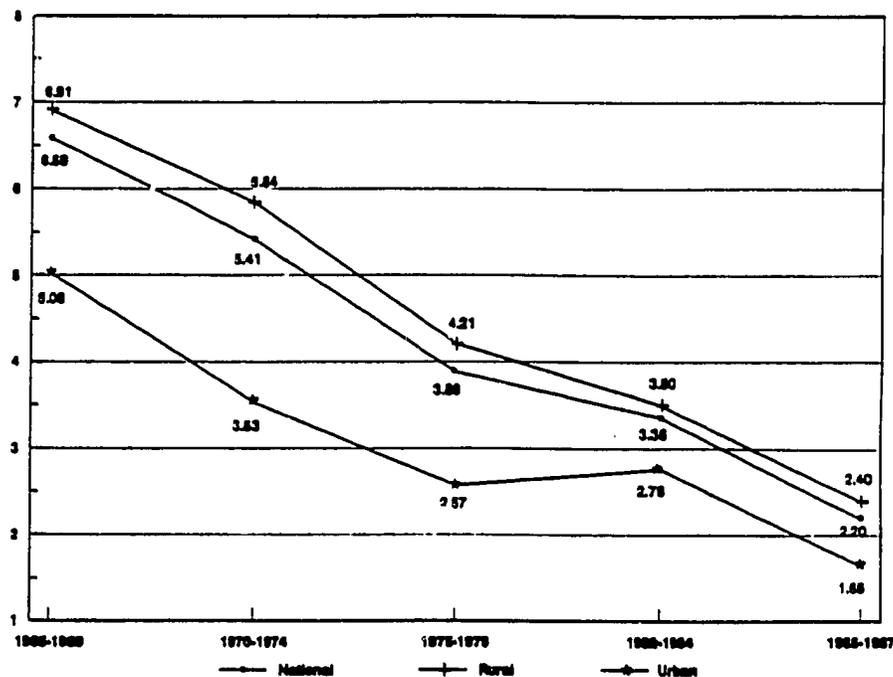


Figure 3

Total Fertility Rates
by Region by Year

Regional variations persist in fertility (see Figure 3). In Bangkok, the north and central regions are characterized by relatively low fertility levels. Total fertility is greater by about one child in the northeast and by almost two children in the south.

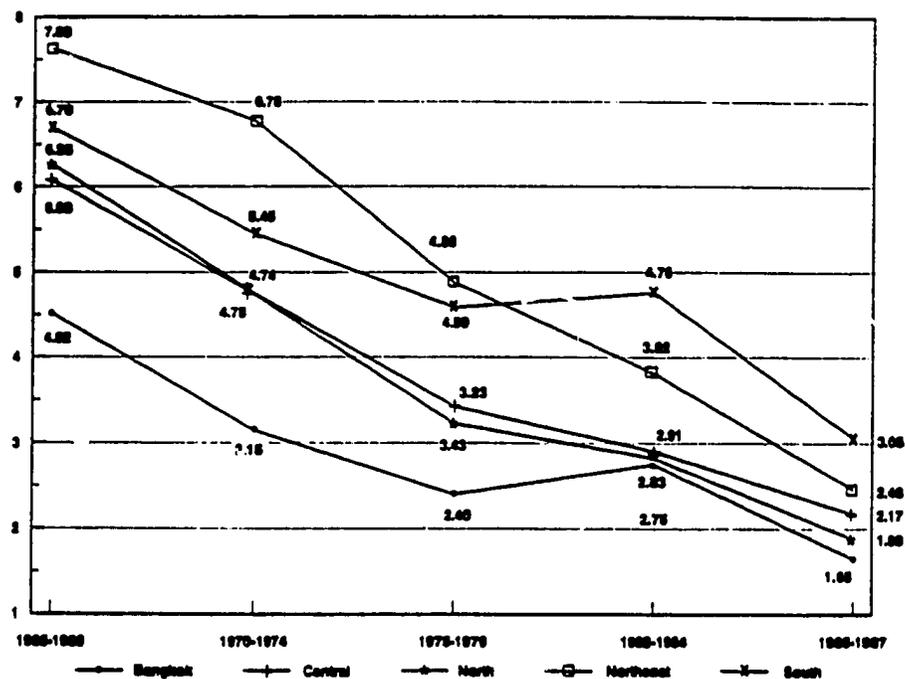
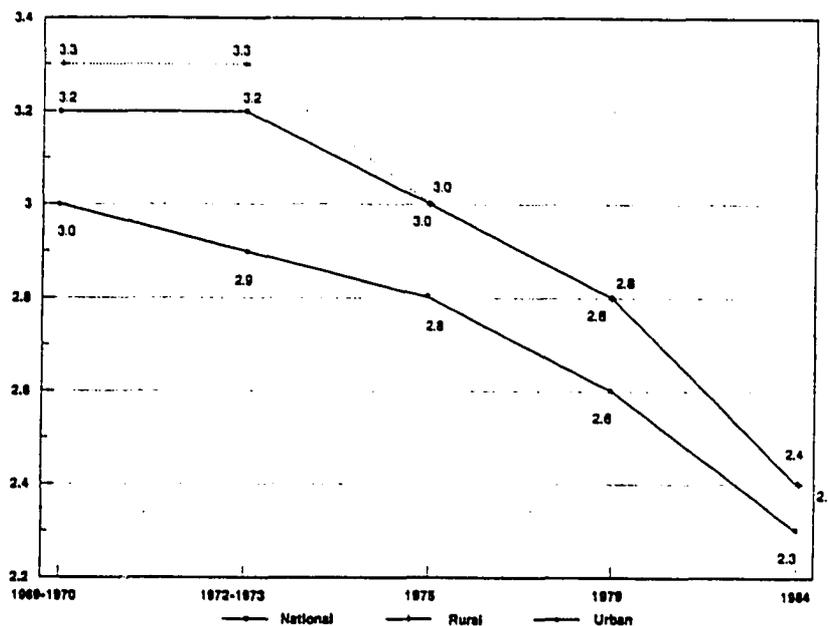


Figure 4

Preferred Number of Children among Currently Married Women Aged 15-44 and Married Less Than Five Years

The decline in desired family size has been parallel to the decline in fertility rates (see Figure 4). Rural women consistently expressed a preference for a higher number of children than their urban counterparts throughout the period. By 1984, however, the rural-urban difference had almost disappeared.



Source: John Knodel, Aphichat Chamratitrong and Nibhon Debevalya, *Thailand's Reproductive Revolution: Rapid Fertility Decline in a Third-World Setting*, Wisconsin: The University of Wisconsin Press, 1987, p. 28.

National Family Planning Program

Development of the NFPP

The year 1970 can be seen as the turning point in Thai demographic history. This was the year that the Thai cabinet approved an official policy to reduce the population growth and that the NFPP was formally established under the auspices of the MOPH. By 1972, the NFPP was fully operational, leading to the beginning of the decline in fertility that, in turn, would make possible a decline in the population growth rate.

The initial goal of the NFPP was to provide quality family planning services to those who voluntarily requested them. The NFPP set achievement targets to aid planning and presented these in five-year installments to the National Economic and Social Development Board (NESDB). The first family planning plan was included in the third NESDB plan (1972-76). The target was to achieve a population growth rate of 2.5 percent per annum by year 1976 through the recruitment of 2.5 million new family planning acceptors. In the fourth NESDB plan (1977-81), the growth rate target was set at 2.1 percent with 3.0 million new acceptors. By the fifth five-year plan (1982-86), the target was 1.5 percent growth and 4.9 million new acceptors. The current plan period (1987-91) has as its target achievement a population growth rate of 1.3 percent by 1991 and 6.6 million new acceptors. The current plan also puts more emphasis on continuing users: to achieve the current target, at least 5.7 million continuing users will have to be maintained throughout the period.

The Contribution of the NFPP

The impact of the NFPP on reducing fertility in Thailand has indisputably been significant. Calculation of this impact has varied, however, depending on the different assumptions made about potential fertility, the actual amount that fertility was assumed to decline, and the contraceptive continuation rates incorporated in the model [1] [2].

Nonetheless, in all cases, the contribution appears to have been substantial, with the highest an estimate that the program should be credited for 80 percent of the decline in the total fertility rate (TFR) between 1964 and 1975. This estimate was based on the calculation of number of births averted through use of program-supplied contraception. Another analysis, also based on calculations of births averted but using a different methodology, indicates that about 75 percent of the amount that marital fertility was suppressed in 1975 compared to 1970 was attributable to family planning program clients [3] [2].

The method of multivariate regression analysis was also employed for estimating the impact of the NFPP. According to Chao and Allen's study (1984), 53 percent of the decline in the TFR during 1962 to 1980, and 68 percent of the decline during 1972 to 1980, were attributable to program activities [2].

The significant role and contribution of the NFPP may also be judged from reviewing service statistics showing the number of new acceptors (see Table 2 on page 7). The number of new family planning clients officially attributed to the program (which includes most acceptors affiliated with private programs) has grown steadily since its inception. The number of new acceptors grew from 225,439 in 1970 to 1 million in 1979, and surpassed the 1.5 million mark in 1986. The figures are somewhat inflated in the sense that persons classified as new acceptors include those switching methods, as well as several other categories of persons who were previously using contraception. Nevertheless, these statistics imply that a large proportion of contraceptive users obtain their method from the national program.

The striking increase in the number of new acceptors derived from service statistics is consistent with the results from more or less equivalent surveys conducted in Thailand over the last two decades (see Table 3 on page 8). According to the Thailand Demographic and Health Survey (TDHS) conducted in 1987, total contraceptive prevalence among currently married women aged 15-44 has reached 67.5 percent. This represents an increase, consistent with previous trends, over the equivalent prevalence rate of 64.6 for 1984 found by the Third Contraceptive Prevalence Survey (CPS3).

Table 2
New Acceptors Reported to the Thai National Family Planning Program, 1965-1988

Years	Pill		IUD		Sterilization		Injectables		Other		Total			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
1965-68	17,861	25.5	121,158	64.9	47,574	9.6	-	-	-	-	186,893	100.0		
-69	60,459	46.5	54,495	41.8	15,264	11.7	-	-	-	-	130,219	100.0		
-70	132,387	58.7	74,404	33.0	18,648	8.3	-	-	-	-	225,439	100.0		
-71	294,607	72.9	86,034	21.3	23,546	5.8	-	-	-	-	401,187	100.0		
-72	327,582	71.7	90,128	19.7	32,668	7.2	-	-	-	-	456,694	100.0		
-73	268,674	63.6	93,449	22.1	49,606	11.8	6,316	1.4	-	-	422,176	100.0		
					Female		Male							
					No.	%	No.	%						
-74	305,244	61.7	89,739	18.1	73,702	14.9	6,780	1.4	19,014	3.8	-	-	494,479	100.0
-75	345,117	61.4	75,163	13.4	82,650	14.7	7,534	1.3	24,559	4.4	26,671	4.7	561,694	100.0
-76	376,707	56.6	71,894	10.8	95,131	14.3	10,150	1.5	73,357	11.0	37,656	5.7	664,895	100.0
-77	488,765	58.9	74,794	9.0	106,816	12.9	19,123	2.3	68,714	8.3	71,193	8.6	892,405	100.0
-78	557,857	57.3	77,775	8.3	124,205	13.2	44,256	4.7	86,620	9.2	50,006	5.4	940,719	100.0
-79	614,525	59.1	78,082	7.5	138,732	13.3	35,300	3.4	117,951	11.5	55,184	5.3	1,039,774	100.0
-80	653,610	58.3	79,378	7.1	151,681	13.5	31,105	2.8	149,744	13.4	55,448	4.9	1,120,966	100.0
-81	634,902	56.4	80,134	7.1	149,338	13.3	28,404	2.5	170,491	15.1	62,547	5.6	1,125,816	100.0
-82	622,320	55.7	83,899	7.5	143,561	12.8	23,405	2.1	177,855	15.9	65,441	5.9	1,116,481	100.0
-83	597,775	50.5	126,933	10.7	146,448	12.4	27,359	2.3	206,226	17.4	78,757	6.6	1,183,198	100.0
-84	581,882	44.2	190,291	14.4	164,511	12.5	45,173	3.4	249,624	19.0	84,873	6.4	1,316,354	100.0
-85	587,196	41.3	184,627	13.0	160,330	11.3	37,377	2.6	373,669	26.3	76,778	5.4	1,419,977	100.0
-86	613,121	39.6	199,880	12.9	162,314	10.5	35,787	2.3	450,776	29.1	85,127	5.5	1,547,005	100.0
-87	691,512	44.2	150,936	9.7	142,511	9.1	16,626	1.1	475,011	30.4	87,435	5.5	1,564,031	100.0
-88	636,200	41.5	153,666	9.7	138,759	8.8	16,447	1.0	518,823	32.8	116,237	7.4	1,580,132	100.0

Source: Data for 1965-1987 are from Family Health Division, *Annual Report*, 1988.
 Data for 1988 are from service statistics.

Table 3

Percentage of Currently Married Women Aged 15-44,
Practicing Specific Methods of Contraception
1969-87

Year	Survey	Pill	IUD	Sterilization		Injection	Condom	Others	All Methods
				Male	Female				
1969/70	LS1	3.8	2.2	2.1	5.5	0.4	0.0	0.7	14.7
1972/73	LS2	10.6	4.7	2.8	6.8	0.9	0.1	0.5	26.4
1975	SOFT	15.2	6.5	2.2	7.5	2.1	0.5	2.8	36.8
1978/79	CPS1**	21.9	4.0	3.5	13.0	4.7	2.2	4.2	53.5
1981	CPS2	20.2	4.2	4.2	18.7	7.1	1.9	2.7	59.0
1984	CPS3	19.8	4.9	4.4	23.5	7.6	1.8	2.6	64.6
1987	TDHS	20.0	7.2	5.5	22.4	9.2	1.2	2.0	67.5

Notes: LS1 and LS2 refer to rounds 1 and 2 respectively of the National Longitudinal Study of Social, Economic and Demographic Change; SOFT refers to the Survey of Fertility in Thailand; CPS1, CPS2, and CPS3 refer respectively to the first, second and third Contraceptive Prevalence Surveys; and TDHS refers to the Thailand Demographic and Health Survey. Results for LS1 and LS2 are derived by combining separate rural and urban surveys taken one year apart and weighing the results to reflect the different sampling fractions used.

Predisposing Factors for the Fertility Decline

The Thailand of today is outstanding in the developing world, from both an economic and a demographic standpoint. Economic growth is impressive and the country is now reaching the replacement level in population growth.

To explore the relationship between Thailand's socioeconomic and reproductive revolutions, Table 4 on the opposite page presents data for Thailand, five other Asian countries and five African countries.¹ All of the countries chosen lacked official population policies before 1960. All of the countries, including Thailand, were predominantly agricultural with low incomes per capita (see the early figures on gross national product [GNP] per capita and the percentage of the labor force engaged in agriculture).

Although TFRs for 1955-60 were indicative of high fertility levels in all of the countries, two other demographic variables -- life expectancy at birth and crude death rates -- show three countries to be different from the others. These countries -- Thailand, Republic of Korea and the Philippines -- had higher life expectancies and lower death rates than the remainder. These differences contributed to intercountry variations in the growth rate, for birth rates in 1955-60 were uniformly high. Most of the countries showed rates in the mid- and high-40s, with Kenya and Nigeria exceeding 50.

¹In a 1988 article, John and Pat Caldwell discussed the suitability of applying Asian family planning program experience to countries in Africa. In doing so they have compared mid-1970s data for seven African and four Asian nations, including Thailand [4]. Five of the same African countries have been selected for inclusion in Table 4. Problems of reliability and comparability of data restrict the conclusions that can be drawn from this table.

Table 4

Socioeconomic and Demographic Indicators around 1955-60 and 1985-90, Selected Asian and African Countries

	YEAR	THAI	INDO	KOREA	NEPAL	PAK	PHIL	GHANA	KENYA	NIGERIA	SENEGAL	ZAMBIA
Total Population (millions)	1960	26.4	92.2	25.0	9.4	50.0	27.6	6.8	8.3	42.3	3.0	3.1
	1987	53.6	171.4	42.0	17.6	102.5	58.4	13.6	22.1	106.6	7.0	7.2
GNP Per Capita (US\$)	1963	110	-	110	70	90	140	230	90	100	170	160
	1987	850	450	2,690	160	350	590	390	330	370	520	250
% Labor Force in Agriculture	1960	84	75	66	95	61	61	64	86	71	84	79
	1980	71	57	36	93	55	52	56	81	68	81	73
% GDP from Agriculture	1960	40	54	40	65	46	26	41	38	63	24	11
	1987	16	26	11	57	23	24	51	31	30	22	12
% of Age Group in Primary School												
	Total											
Total	1960	83	71	94	10	30	95	38	47	36	27	42
Male	1960	88	86	99	19	46	98	52	64	-	36	51
Female	1960	79	58	89	1	13	93	25	30	-	17	34
Total	1986	99	118	94	79	44	106	63	94	92	55	104
Male	1986	-	121	94	104	55	106	75	97	103	66	112
Female	1986	-	116	94	47	32	107	59	91	81	44	101
Life Expectancy At Birth	'55-'60	51	40	53	38	42	51	44	43	38	36	40
	'85-'90	65	56	69	51	56	64	54	58	50	46	53
Crude Death	'55-'60	15.9	24.3	14.9	26.2	25.0	16.1	20.1	23.5	25.3	28.0	23.6
	'85-'90	7.0	11.2	6.2	14.8	12.6	7.7	13.1	11.9	15.6	18.9	13.7
Crude Birth Rate	'55-'60	44.3	45.4	45.9	46.0	48.8	47.4	47.9	52.9	51.6	48.3	49.9
	'85-'90	22.3	27.4	18.8	39.6	47.0	33.2	44.3	53.9	49.8	45.7	51.2
Total Fertility Rate	'55-'60	6.4	5.7	6.1	5.7	6.8	7.1	6.9	7.8	6.8	6.7	6.6
	'85-'90	2.6	3.3	2.0	5.9	6.5	4.3	6.4	8.1	7.0	6.4	7.2
Gov't F.P. Program		1970	1968	1961	1966	1960	1970	1969	1967	1970	1976	1974

Sources: World Bank. World Development Report. The World Bank, Washington, D.C., various years.

United Nations. World Population Prospects 1988.

Population Studies No. 106. United Nations, New York, 1989.

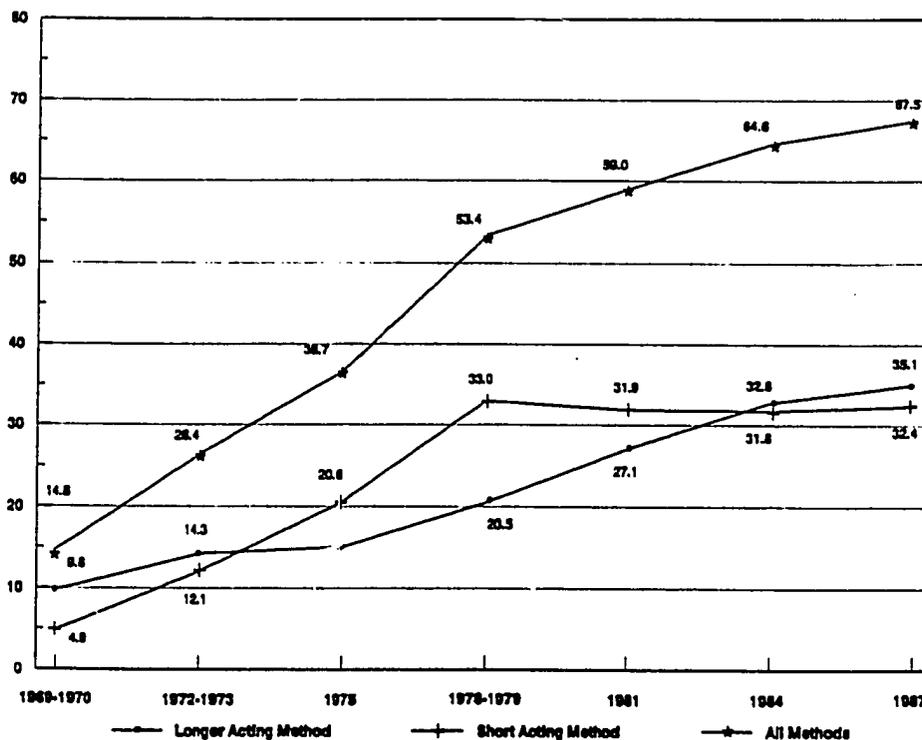
Dorothy Nortman. Population and Family Planning Programs.

11th edition. Population Council, New York, 1982.

(A = 1965 B = 1984 C = 1985 D = Year not indicated)

In figure 5, data from Table 3 are combined to analyze efficiency of method. Longer-acting methods (the IUD, female sterilization and male sterilization) were first accepted by a higher percentage of users than were short-term methods. From 1975 to 1983, however, the shorter-acting methods (pill, injectable, condom and others) were used more widely than longer-acting methods. After 1984, longer-acting methods again surpassed short-term methods. This latter phenomenon signified the increasing cost-efficiency and maturity of the Thai NFPP.

Figure 5
 Percentage of Currently Married Women Aged 15-44
 Currently Practicing Contraception
 1969-1987



The same three countries stood apart from the others with regard to the proportion of children enrolled in primary school. Thailand, the Republic of Korea and the Philippines showed total enrollment rates of 83, 94 and 95 percent respectively in 1960. Levels of total enrollment were influenced by differences in the proportionately large number of girls attending school. African percentages were more consistent but at a relatively low level.

It is tempting to hypothesize about the relationship of primary school enrollment and infant and child mortality to the reduction of fertility, but the data shown here are too crude to provide guidelines for projecting 1960-1990 fertility trends. The following detailed examination of the Thai experience, however, suggests that both factors were critical in enabling Thailand to achieve its transition to low fertility in less than three decades.

2. Five Stages of the Thailand Family Planning Effort

Overview

This report's analysis of the implementation of Thailand's NFPP is based on a conceptual framework or typology that has been developed, for use in its strategic planning, by the Family Planning Services Division of the Office of Population of A.I.D. The framework groups countries according to current levels of the modern contraceptive prevalence rate (CPR) among married women of reproductive age (MWRA) [5]. The groups are the following:

- **Emergent**, with less than 8 percent prevalence;
- **Launch**, with prevalence between 8 and 15 percent;
- **Growth**, with prevalence between 16 and 34 percent;
- **Consolidation**, with prevalence between 35 and 49 percent;
- **Mature**, with prevalence of 50 percent or higher.

Interestingly, countries in these groupings are found generally to have similar socioeconomic and family planning program characteristics. Therefore, countries may be grouped not only according to their prevalence but also according to their socioeconomic characteristics and the types of family planning activities that can be expected at each level of prevalence. The latter is not surprising, since each stage or level of prevalence brings common situations and problems that call for similar solutions. The grouping methodology is expected to prove a useful program tool since the use of the prevalence level as a yardstick should make it possible to project the types of interventions that are appropriate at a given level to advance family planning efforts.

The Thailand case is seen as particularly instructive since the NFPP has progressed through all five stages, from the emergent stage in the early 1960s to the mature stage in the 1980s. In the process, it has faced and overcome many of the problems that are still being experienced by countries still in earlier stages throughout the world. Due to the large number of variables that come into play, it may not be possible to extrapolate lessons that will in every instance be applicable to every country. Nonetheless, the path taken by Thailand toward replacement level fertility may provide some new insights to countries pursuing similar goals, and analyzing that path should also help those in the Thai program better to understand the reasons for their remarkable achievement.

On the following pages is found a brief synopsis of the typology developed by the Office of Population, together with an analysis of the Thai experience at each corresponding level.

Level 1: Emergent

Level 1 - Emergent

(0-7 percent modern method prevalence)

Socioeconomic Characteristics. Countries in this category have high TFRs (6.4); low life expectancy (49); and high infant (116) and maternal (645) mortality rates. The per capita GNP is low (\$295), and the GNP per capita growth rate is non-existent (0.0). The percentage of GNP in agriculture is relatively high (37 percent). The percentage of the population that is urban is low (26 percent) as is female school enrollment. The transport and communications infrastructure is often limited, which makes the cost of doing business high.

Program Characteristics. At the emergent level, less than 8 percent of the MWRA use modern contraceptive methods. Those who do are mostly the urban elite. An example is Burundi with total modern method prevalence level of 1 percent, through injectables. An additional 8 percent of the populace uses traditional methods. A small number of individuals make family planning services available through government clinics or private associations. Contraceptive knowledge is limited and often inaccurate. The availability of services is not widely known.

Program Needs. The most important need is to build support and credibility for family planning. Special studies, observational study tours and special analyses can all contribute to enlarging the circle of those who support or provide family planning and the development of national policies and strategies. Private non-profit programs may play a key role in demonstrating the feasibility and acceptability of family planning. Service delivery should target potential early adopters of family planning such as women with large families, urban couples and women right after delivery. Good information and good services are critical since satisfied users play an important role in recruiting others. Technical assistance in planning, management and training is needed to develop clinical facilities, standards for care and basic data collection systems.

The Thai Experience

The emergent stage in the Thailand reproductive revolution began in the 1950s and ended in about 1963. There are no figures on contraceptive prevalence, but several of the major demographic and socioeconomic indicators conform to the model presented above: The TFR from 1955-1960 was 6.4; a high percentage of the labor force was in agriculture -- 84 percent (1960); and per capita GNP was low -- \$110. As indicated above, however, three other socioeconomic indicators do not conform with the model. Life expectancy at birth was 51 years, higher than the average; the crude death rate was very low for this stage -- 15.9 (1955-1960); and female school enrollment was very high at 79 percent.

The high level of female school enrollment and the consequent high level of female literacy contributed to improvement of the status of women in Thai society. Female education and literacy tend also to be closely related to acceptance of family planning.

Transportation and communication infrastructure during the 1950s were limited in Thailand; however, this was to change in the 1960s, when an extensive road-building program began.

Availability of contraceptives was very limited, primarily through private clinics in urban areas. The government had not, as yet, become involved in family planning; the need for it had not been fully recognized.

The program need at this time was to learn more about the actual demographic situation in Thailand and the consequences of population growth. Policy-makers required a better understanding of the population situation. Once informed, they were prepared to develop a family planning policy and program strategy.

Countries in Emergent Stage: 1988 (United Nations Data)	
Afghanistan	Mauritania
Benin	Myanmar
Burkina Faso	Niger
Burundi	Nigeria
Cameroon	Papua New Guinea
Central Afr Rep	Rwanda
Chad	Senegal
Congo	Sierra Leone
Cote d'Ivoire	Somalia
Ghana	Sudan
Guinea	Tanzania
Guinea-Bissau	Togo
Haiti	Uganda
Liberia	Yemen Arab Rep
Madagascar	Zaire
Malawi	Zambia
Mali	

Level 2: Launch

Level 2 - Launch

(8-15 percent modern method prevalence)

Socioeconomic Characteristics. In these countries, the TFR remains high (6.4); life expectancy low (51); and the maternal (460) and infant (118) mortality rates, high. The per capita GNP is still low (\$338), the GNP per capita growth rate remains flat (0.0 percent), and the percentage of GNP in agriculture is dropping (24 percent). The percentage of the population that is urban (25 percent) is low, as are the female school enrollment rates.

Program Characteristics. Countries with programs at the launch level are either those in the early stages of program development or those whose programs have not grown much over time. Bolivia is typical with 11 percent modern method prevalence (5 percent female sterilization and pills, 4 percent IUDs, 1 percent injectables and vaginal), and 15 percent traditional. The number of pill users is increasing rapidly. The government or private associations provide almost all clinical methods and most temporary ones.

Program Needs. These include removing legal or procedural barriers to family planning service delivery; broadening training opportunities; developing management capacity; implementing a national information, education and communication (IEC) strategy; and increasing the availability of services. The institutional base for family planning service delivery needs to be broadened. It is important to work with community and women's groups, social service agencies and private employers to identify viable, acceptable institutions with an existing infrastructure and the potential to provide services to large numbers of clients. Demand generation continues to be important, with IEC efforts centered in the urban and peri-urban areas. Program managers need to be aware of alternative ways to deliver services and to move beyond clinics and make services more broadly available. There may be a latent demand for sterilization from couples who have never practiced contraception and are now ready to stop having children. Operations research is needed to test new approaches. Increased local support, together with stronger management, coordination, training and evaluation systems, is required to launch programs and move into the growth level.

The Thai Experience

The launch stage in Thailand began around 1963 when contraceptive prevalence had reached an estimated 8 percent. This coincided with the holding of the first national seminar on population. Contraceptive prevalence had reached nearly 15 percent of currently married women by 1970 (14 percent CPR, modern methods), to end the launch stage. Nineteen seventy was also highly significant as the year a national population policy was announced.

The socioeconomic characteristics of this stage were similar to the emergent stage. Family planning acceptors during the period 1965-68 chose the IUD over the pill or sterilization, since this was the method most likely to be offered in various experimental programs, but the pill and female sterilization were to increase in popularity by the end of this stage.

Perhaps the most important activity during this period was building a consensus that government action was necessary to address the population growth issue. Drawing in part on the findings from research that had been undertaken during the emergent stage, the 1963 national population seminar sounded the alert that the high population growth rate would retard development efforts.

Although it took a long seven years for consensus-building activities to lead to the adoption of a government policy advocating family planning, the time was put to good use. Specifically, the MOPH and other concerned organizations had an opportunity to lay the foundation for the family planning program. As anticipated in the model, crucial among the activities were efforts to train medical and paramedical staff to provide family planning services, development of an institutional base that would enable health centers around the country to introduce family planning services, and pilot studies which, although they were not properly speaking operations research, served the same purpose by testing various strategies in the delivery of family planning services. The pilot studies were particularly significant for two reasons. One related to the specific finding that arose from a 1969 study that paramedical personnel could successfully prescribe oral contraceptives, a discovery that, when implemented during the growth stage, led almost immediately to a significant increase in contraceptive prevalence. The second was that all these studies highlighted the high demand for family planning services among women and thus helped to spur on the acceptance of a population policy and the formal initiation of the National Family Planning Program. Another aspect of institutional development was the establishment of two demographic/population research centers.

The Thai experience varied from the model in that no national level IEC activities took place during the launch stage. The government prohibited publicity for family planning until adoption of the population policy. Even without formal IEC activities, however, women were finding out about contraceptives through word-of-mouth; and many women would travel considerable distances in order to receive services. The expanding road construction program aided in the mobility of women.

Countries in the Launch Stage: 1968 (United Nations Data)
Bolivia Nepal Pakistan Swaziland

Level 3: Growth

Level 3 - Growth

(16-34 percent modern method prevalence)

Socioeconomic Characteristics. These countries have a moderately high TFR (5.3); increased life expectancy (60); and moderately high maternal (275) and infant (76) mortality rates. Per capita GNP has risen (\$437), the GNP per capita growth rate has begun to show gains (1.9), and agriculture accounts for a lower proportion of the GNP (19 percent). Over one-third (38 percent) of the population is urban and female school enrollment rates have risen.

Program Characteristics. Modern contraceptive prevalence ranges between 16 and 34 percent. Prevalence is high among elite groups and is beginning to spread among all urban and educated groups. Zimbabwe is typical of growth countries, with 27 percent modern method prevalence dominated by a rapidly growing use of pills (24 percent), the start of use of female sterilization (2 percent), 1 percent use of other methods (injectables, IUDs and condoms), and 13 percent traditional. The private sector plays an increasing role in providing family planning services, especially in the supply of oral contraceptives.

Program Needs. These include programs to stimulate the private sector and increase the supply of contraceptives to meet growing demand, particularly in urban and peri-urban areas. Particular attention needs to be paid to management capabilities and evaluation systems as the numbers of providers and service outlets expand. A more rural focus may be required, both in terms of demand generation through IEC and service delivery through community-based distribution (CBD).

The Thai Experience

The model anticipates that contraceptive prevalence will surge during the growth stage, more than doubling from a relatively low 16 percent to a rate in the mid-range of some 34 percent. Though in the Thai experience the starting point was a little lower (14 percent), prevalence had more than doubled, reaching 34 percent modern CPR, in a remarkably short five years (1970-1975). Consequently, the TFR dropped from 6.2 in 1969 to an expected 5.1 in 1975. In accordance with the model, it was an increased use of the pill that was responsible for the fertility decline, which stemmed in turn from the decision to allow auxiliary midwives (AMW) the authority to prescribe oral contraceptives. Overnight the number of outlets providing government pills increased from 250 to 3,500, and the percentage of currently married women using oral contraception increased from 3.8 percent in 1970 to 15.2 in 1975.

Although a national family planning program was in place by the start of this stage, additional resources would be needed to provide services to a ready population of women. The encouragement of the private sector foreseen in the model was a hallmark of this stage in Thailand, and the MOPH made major efforts to draw in the major non-governmental organizations (NGO). An unanticipated, but highly significant, aspect of the MOPH's approach was its readiness to allow others to run their programs without government interference or control.

Once a population policy was in place, it was possible to develop an IEC strategy. Newspapers were important for the urban population, but during this stage, the Thai program was pursuing another program activity predicted in the model -- that of intensifying its rural penetration. From an IEC standpoint, this meant the use of radio -- a highly practical strategy in Thailand where, in 1970, 64 percent of rural households had radios. The radio, and then television, strategy continued throughout the 1970s and proved successful. A 1977 study showed that over 50 percent of men and women received their information on family planning from the radio or TV. Less successful were initiatives to include population education in the school system.

With an expanding service delivery system, the need for a management information system (MIS) was felt by the MOPH. In 1974, the NFPP inaugurated a monthly computerized print-out of new acceptors by contraceptive method and administrative area. This would also give the government enhanced capabilities to evaluate its program efforts, an important dimension of any program during the growth stage.

Countries in Growth Stage: 1988 (United Nations Data)	
Algeria	Kenya
Bangladesh	Lesotho
Belize	Mauritius
Botswana	Morocco
Guatemala	Paraguay
Honduras	Peru
India	Philippines
Jordan	Turkey

Level 4: Consolidation

Level 4 - Consolidation

(35-49 percent modern method prevalence)

Socioeconomic Characteristics. These countries have a lower TFR (3.7); high life expectancy (67); and lower maternal (218) and infant (50) mortality rates. The per capita GNP (\$738) is rising, the GNP per capita growth rate has risen (2.3) and the percentage of GNP in agriculture has fallen (17 percent). The majority of the population is urban (52 percent), and female school enrollment has risen.

Program Characteristics. Countries with programs at the consolidation level have achieved high CPR among urban and educated groups. The method mix is changing from a primary reliance on oral contraceptives to rapid increases in female sterilization and steady increases in use of IUDs. Prevalence may still be low among rural, uneducated, poor segments of the population. Typical of this grouping is Mexico, with modern method prevalence of 45 percent (including 19 percent female sterilization, 11 percent IUDs, 10 percent pills, and the remaining injectables, condoms, male sterilization and vaginals). Traditional methods are used by 8 percent. The private sector is the primary source for oral contraceptives and condoms, and the public sector, for IUDs and sterilizations.

Program Needs. These include maintaining the quality of the programs to retain present acceptors and to help them switch methods as their status changes from spacers to limiters; reaching out to rural, uneducated and poor segments of the population; and testing and implementing ways to expand local support for programs. Increasing levels of demand for and consumption of contraceptives require that an increasing share of the consumers be served by the private sector. Ways to increase donor resources through currency conversion and corporate donations need to be explored.

The Thai Experience

In the eight-year period between 1976 and 1984, the CPR (modern methods) in Thailand rose again, this time by an impressive 28 percentage points -- from 34 to 62 percent -- accompanied by a significant decline in the TFR from 5.1 to about 3.5. The A.I.D. typology considers the consolidation stage that period during which contraceptive prevalence increases from 35 to 49 percent. In the Thai case, however, the classification was based on the programmatic strategies used during the period 1976-84, rather than contraceptive prevalence.

Specifically, a dramatic increase in the relative importance of female sterilization as a contraceptive method is a key indicator that a program is in the consolidation stage and in Thailand, just such a surge took place over

this period. Efforts to improve access to female sterilization resulted in a threefold rise in the percentage of prevalence attributable to voluntary surgical contraception (VSC), from 7.5 percent in 1975 to 23.5 percent in 1984. The change in method mix is typically also characterized by a stabilization in the use of the pill, and this too occurred in Thailand. During this period, the use of oral contraceptives increased to a high of about 22 percent (in 1978/79) and then leveled off at about 20 percent for the rest of the period. During this period, also typically, other methods increased in usage, particularly injectables and vasectomies. The high increase in sterilization meant that increases in IUD use were lower than expected at this stage in the model (only 5 percent vs. 11 percent).

The Thai program undertook another initiative typical of the consolidation stage. It made a major effort to reach out to the rural populace and also to concentrate on hard-to-reach groups, in particular the hilltribes in northern Thailand, the Muslim population in southern Thailand, and adolescents. Domestic and international resources were marshalled, and different strategies to reach these groups were developed, such as mobile units for service outreach and community development approaches.

Not emphasized in the A.I.D. typology is the need identified in Thailand for better data from surveys and censuses. These served both to enable program managers to improve targeting of populations that had been identified for increased attention and to improve planning and programming capabilities at the local level.

Countries in Consolidation Stage: 1983 United Nations Data	
Costa Rica	Sri Lanka
Dominican Republic	Trinidad/Tobago
Ecuador	Tunisia
El Salvador	Venezuela
Egypt	Zimbabwe
Indonesia	

Level 5: Mature

Level 5 - Mature

(Over 50 percent modern method prevalence)

Socioeconomic Characteristics. These countries have a relatively low TFR (3.4); life expectancy is high (67); and maternal (108) and infant (45) mortality rates low. Per capita GNP has more than doubled (\$1,680) and the GNP per capita growth rate is relatively high (2.4). The proportion of the GNP in agriculture is low (11 percent). The population has become increasingly urban (60 percent).

Program Characteristics. Countries with programs at the mature level have succeeded in reaching a majority of their populations with family planning services. The most popular method is female sterilization followed by oral contraceptives and IUDs. Thailand ranks as a mature country, with 66 percent modern method contraceptive prevalence (22 percent female sterilization, 20 percent pill, 9 percent injectables, 7 percent IUDs, 6 percent male sterilization and 1 percent condoms). Traditional methods are used by only 2 percent. In Asia, the public sector is the largest source of family planning services although the private sector makes an important contribution. In Latin America the private sector is the primary supplier.

Program Needs. These include ensuring the continued availability of contraceptives and improving the quality of information and services to improve continuation rates for temporary methods. Decisions on which sectors should receive continued government and donor support will be required. Attention to the diminishing returns of subsidized services will help planners decide on where to put resources for the maximum return. Local production of contraceptives needs to be considered.

The Thai Experience

Thailand was selected by A.I.D. to exemplify a country at the mature stage in family planning development primarily in recognition of its very low TFR. In 1987, two years into the mature stage, the TFR in Thailand was estimated to be 2.1, compared with A.I.D.'s yardstick for mature countries of 3. Rural fertility is higher than urban -- 2.4 compared to 1.65. Regional variations in fertility still exist: the south and northeast remain above the average (3.06 and 2.46). Probably the best indicator that a society has reached the mature stage is that the preferred number of children has begun to match the numbers being born. In 1984, the preferred number of children in Thailand was about 2.4, compared with a national average of 2.2 being born.

Although in A.I.D.'s typology the mature stage is seen as a time when responsibility for providing services should increasingly be shifted to the private sector, this transfer has not yet begun in Thailand. In fact, just the opposite has taken place. In the early 1980s, the MOPH welcomed a second

government agency, the Ministry of the Interior (MOI), as a participant in the effort to increase use of family planning. To help keep the MOI approach (IUD insertion camps) on track, other government officials were enlisted, specifically a number of provincial and district governors who were given study tours and training that provided insights on preferred approaches to provision of family planning services.

Although there has been no appreciable increase in the reliance the Thai government has placed on the private sector, the MOPH has continued to allow private providers to operate more or less as they see fit. During this period, the MOPH has allowed private providers to experiment with offering incentives, although this approach has never been sanctioned in Thailand nor was it envisioned as playing a role in any of A.I.D.'s five stages. The most successful of the experiments relied not on individual incentives, but on community rewards that provided community development funds in return for improvements in the community CPR. This approach has enabled villagers to understand the link between CPR and the size of the loan fund for their village, and this scheme has been replicated in low CPR areas in the northeast region.

In many family planning programs at the consolidation or mature stages, great attention is paid to decreasing the public subsidy for contraceptive services. Thailand is an exception to this rule; here, the government has increased its funding for family planning every year since 1982. It is the understanding of the government that its investment in family planning offers a better return than does any other type of social service spending and that the introduction of a cost-recovery scheme might result in loss of users and loss of NFPP momentum toward its goals.

Countries in Mature Stage: 1988 (United Nations Data)
Barbados
Brazil
Chile
Colombia
Jamaica
Mexico
Panama
Thailand
Uruguay

3. Emergent (prior to 1963)

3. Emergent (prior to 1963)

Overview

No figures are available on contraceptive prevalence during this initial stage of the Thai family planning effort, but there was evidence that fertility was falling in the 1960s in urban areas: as of 1965, total fertility in urban areas was 5.03 compared with 6.91 in rural areas. The assumption is that some kind of contraception was being practiced, at least in the cities (see Figure 2).

The need to address nationally the problem of a rapidly growing population dawned only gradually on Thai policy-makers during the early 1960s. They were influenced to some degree by international factors (some of their neighboring Asian countries had adopted government policies favoring family planning and a World Bank report pointed out that population growth would surely become a hindrance to Thailand's economic growth). It took the 1960 census, however, with its surprise revelation that the growth rate was considerably higher than had been anticipated, to convince policy-makers to move toward open discussion of the problem.

Lack of Awareness of Population Situation In Thailand

In the early 1950s, it was evident that many Asian countries were experiencing unprecedented increases in population growth rates as result of continuing high fertility and declining mortality rates. The implications of this growth for economic development became a subject for discussion at sessions of the United Nations Economic Commission for Asia and the Far East (later renamed the Economic and Social Commission for Asia and the Pacific, ESCAP). A regional Conference on Population and Development was held in Bandung, Indonesia, in 1955 and in that same year the Commission secretariat, with the assistance of the United Nations headquarters, began a three-year study on population trends and related problems of economic development in the region.

A report of the study was submitted to the 1959 Commission session. It provided a demographic picture of the region up to 1956 with projections to 1980 and discussed some of the implications of population growth [6]. It reported that the three most populous countries of the region had already adopted government policies favoring family planning: Japan in 1948, India in 1951, and China in 1955. A similar policy was announced in Pakistan in 1958. Aside from Japan's, the early programs were modest in scale and their impact was not clear. Nevertheless, they showed that governments were reacting to the implications of rapidly rising population growth rates for their plans to expedite economic development.

In some of the smaller countries of the region, the governments were providing encouragement or support for family planning activities without taking the lead in their promotion. Thailand's position had long been essentially pronatalist, and there was no indication up to 1958 that a change was contemplated. At the same time there were no restrictions on the

import or use of contraceptives, and one doctor reported having started the insertion of the IUD in 1931. Sterilization was the most widely known method of contraception. Condoms were available but their association with prostitution limited their acceptability.

One difficulty in Thailand was the lack of accurate statistics on which to base an assessment of trends. Data in the major areas of concern -- economic, social and demographic -- were either nonexistent or of a quality that impeded a satisfactory analysis of change during the decade of the 1960s [7] [8]. Concern about population growth appears to have been limited, and an MOPH official later pointed out that the government had not been aware of the rapid growth rate until the 1960 census revealed a population about 3 million higher than had been expected.

First Indication of Population Growth Problem

A nine-member mission from the World Bank undertook a 12-month comprehensive study of Thailand's economy, beginning in July 1957. The report identified a number of economic and social problems that the government was expected to face in the future. Lack of adequate demographic data led the mission to refer only to a population growth rate of "over 2 percent a year"; later analysis suggested that by 1957 it may already have exceeded 3 percent. The mission proposed that, in view of the rapid increase in the population, "a responsible attitude toward the size of families should be encouraged" through making birth control information "available" at public health centers [7, p. 160].

The mission's report was submitted to the Council of Ministers in 1959. Interestingly, although this was basically an economic report, it was referred to the MOPH for comment on whether the mission's recommendations were suitable. The Ministry indicated they were. Its position was that if the economy could not keep pace with the increase in population, consideration should be given to the dissemination of information on fertility control and birth spacing. The Ministry recommended that the report be submitted to the National Research Council and the National Economic Development Board to obtain their views on appropriate future operational policies. The Council and Board are important policy-making bodies in the government.

The Political Science and Public Administration Committees of the National Research Council took a pronatalist stance, arguing that population increase would expand trade and industry. Its other concerns were that the promotion of family planning might cause a deterioration in public morals and that the non-Thai ethnic groups might not practice birth control, thus increasing their numbers in relation to the ethnic Thai population. The National Economic Development Board took an opposite stand, citing the economic and social problems that would result from continued rapid population growth. It recommended that further studies be carried out and suggested that the MOPH might be allowed to provide information on contraception to those who sought it voluntarily, while avoiding undue publicity.

First Cabinet Decision on Family Planning

After considering both reports, the Cabinet in 1961 sided cautiously with the National Economic Development Board's position supporting provision of family planning information. Although it affirmed that giving advice on matters of birth control should be both permitted and initiated, the Cabinet added this "should not yet be done in an open manner." The Cabinet also noted the "voluntary" nature of birth control, pointing out that "people ...should be aware of their own status and how many children they should have." [9, p. 36].

The Cabinet's decision did not constitute an operational policy as no government agencies were assigned responsibility for implementation. It did, however, clear the way for studies, surveys and pilot projects, whether by government or private agencies, that would give the appropriate government agencies, especially the MOPH, the opportunity to prepare for an anticipated national operational policy based on the knowledge and experience gained from the research and experimental projects. It also represented the first step in achieving the recommendation of the World Bank mission.

When the 1960 census data became available in 1962, the Prime Minister ordered the Economic Science and Social Science Committees of the National Research Council to carry out further studies focused on problems concerned with economic and social development. Their findings supported those set forth earlier by the National Economic Development Board.

Up to this point, only the Council and the Board had participated in the research and discussions. In view of the increasing demands of the government for information on which to base an operational policy, the National Research Council decided to sponsor a technical seminar that would discuss the role of population in national development and propose means of resolving the wide differences in opinion regarding the content of a government policy. This was the First National Population Seminar, which ushered in the launch stage in March 1963.

Conclusion

The emergent stage in the development of Thailand's family planning program was directed toward data gathering and consensus building. Family planning was available in the urban areas through private physicians, but the government was not yet ready to implement a family planning program. A consensus was needed among government policy-makers and academics on the population problem and ways to deal with it before the government would act. Reaching this consensus would take the next seven years.

4. Launch (circa 1963-69)

4. Launch (circa 1963-69)

Overview

From the time that public officials began to appreciate fully the implications of population growth on national economic and social goals, it took seven years and three national-level seminars before the government officially agreed to adopt a national policy supporting the provision of family planning. This period saw a profusion of small-scale isolated family planning activities whose experiences fed back into the policy process. The evidence these gave of a national receptivity to use of contraception expedited development of the policy. The activities also provided a wealth of knowledge as to how best the services might be offered.

Toward a National Population Policy

First National Population Seminar

In Thailand, the first serious consideration of family planning on a national level took place at the First National Population Seminar in 1963, held with the financial assistance of The Population Council. This was a technical meeting and brought together qualified persons from governmental agencies and academic institutions and others with professional interest in population matters. The discussions, however, went beyond scientific considerations, with "cultural, religious, political and even emotional values" all having an influence over the deliberations [10].

This meeting took place shortly after analysis of the 1960 census had shocked many public officials with the unexpectedly high population growth rate that was revealed (see Chapter 3) [11]. Not surprisingly, in light of the different opinions voiced in the earlier reports to the Cabinet, there was no consensus on the content of a government policy with regard to fertility or even whether there should be such a policy. Some felt that it was not advisable to "disturb the people," especially in rural areas, with new ideas such as family planning. Other participants emphasized the voluntary aspect of family planning and suggested that a first step would be to provide services for families in poor economic circumstances.

In fact, the only point of agreement was that more information was needed on how the people of Thailand viewed the subject. Answers were lacking on such fundamental questions as these: What was the preferred size of the Thai family? Was the public willing to accept and practice contraception? How would people react to different approaches to family planning? There was a consensus that answers to these and related questions were basic to the formulation of a government policy on population.

The most significant outcome of this seminar was its recommendation that a pilot project be carried out in a rural area to measure the extent of knowledge and interest and to evaluate an experimental family planning program. The resulting Potharam pilot project is discussed on page 30 below.

Second National Population Seminar

A Second National Population Seminar was convened in 1965, following shortly after the first. This one no longer skirted the issue of whether the government should take a role in family planning. Rather, it came out with a proposal that, under the supervision of the MOPH and other agencies concerned, "family health" services should be provided to the general public on a voluntary basis.

The government's response was mixed. The MOPH was prepared to take action but the Cabinet was still reluctant to take a public stance supporting a policy of carrying out family planning. The Ministry's readiness to act was in part based on the findings at Potharam (see below), which confirmed that the problem in Thailand was not so much one of motivation as it was of supplying correct information about contraception. Indeed, the Ministry was already anticipating the personnel shortages it would face when called upon to implement a national program. With two-thirds of all physicians living and practicing in the Bangkok area, the Ministry was proposing other ways to bring services to the public. One of its ideas was to explore the feasibility of using paramedical personnel for IUD insertions. Another was to use mobile clinics operating from provincial health facilities. It was evident that the Ministry intended to use the Potharam and other experimental projects to identify problems and to test solutions [12]. It is significant that these plans were well under way while there remained a lack of consensus within the Cabinet regarding the government's support of family planning.

Third National Population Seminar

The Third National Population Seminar took place three years after the second, in 1968. Considerable progress had been made in the intervening years. Perhaps most important, the Cabinet had just issued a statement indicating that contraception should be made available to persons with four children who did not desire more. It had also agreed that the experimental activities of the Potharam project could be expanded to other areas. These pronouncements came in response to a report from the Family Health Research Committee, which had recommended that knowledge of family planning should be disseminated through hospitals and health clinics to those who wished to space or limit the number of children. This Committee had been established in 1964 after the First National Population Seminar to supervise research activities and serve as a coordinating agency. Its report was based on the studies and action programs that had been conducted during the previous three years.

Also by 1968, a considerable number of isolated service delivery activities had taken place and a substantial infrastructure had been established for a larger national program (see next page). Although the numbers of acceptors were few in comparison with the total population of the country, they were impressive indicators of contraceptive acceptance when the limited

accessibility of services was taken into account. The most important fact, however, was that population growth rates continued high and that the implications of these rates for national economic and social development remained bleak.

The most significant recommendation from this meeting was a call for the Cabinet to take urgent action in formulating and adopting a definite policy to reduce the population growth rate. This time, the Cabinet referred the matter to the National Economic Development Board for its views and authorized the Board to make recommendations on policy regarding population problems.

Adoption of a Population Policy

On the basis of its analysis of the impact of population growth on economic and social development in Thailand, the National Economic Development Board strongly recommended the adoption of a national population policy. Its report convinced the Cabinet, which in March 1970 issued a statement formally supporting voluntary family planning. Its rationale was economic and social. The statement pointed out that the policy was being adopted "to resolve...problems concerned with the very high rate of population growth, which constitutes an important obstacle to the economic and social development of the nation."

The cabinet assigned to the MOPH the responsibility for implementing the policy [13].

Toward Development of A Family Planning Program

For the decade preceding the launch of Thailand's NFPP, the groundwork was being laid for a government program through a series of studies and field research activities touching on program administration and implementation.² Initiatives included a pilot study at Potharam district, a family planning clinic at McCormick Hospital, surveys and clinical program at Potharam, and government and private hospital cooperation in studies of the quality of medicine and the various kinds of equipment used in family planning clinical activities.³

Although very significant as learning experiences, these pilot studies/services were unable to serve the real needs of an expanding population that was to be shown to be very receptive to the use of contraception. As best as can be ascertained without a systematic record-keeping system, it appears that as of

²Perhaps the only major area excluded was the use of mass media in providing information and motivating potential clients. It was prohibited by a 1961 Cabinet directive forbidding publicity.

³A number of others, including research in the field of reproductive physiology and in the clinical evaluation of contraceptive methods, are not reported on here. Some of these were conducted as a part of large experimental projects such as the postpartum programs at four Bangkok hospitals.

1968, contraceptive acceptance was high in areas of intense program activity. The Bangkok hospitals involved in The Population Council postpartum program were inserting about 30,000 IUDs annually. Approximately 10,000 female sterilizations per year were being performed (there were no data on the number of vasectomies). Acceptors of injectable contraceptives were in the order of 4,000 annually. There is very limited information regarding the use of oral pills.

These operations were accompanied by the establishment of two training and research institutes, the initial training of physicians, nurses and midwives to provide family planning services, and study tours for senior-level MOPH staff to observe the family planning programs in other countries.

During the initial period, funds from external donors played an essential role. The Population Council provided financial assistance, starting in 1963, for the surveys and action program in Potharam district, for the postpartum program in Bangkok, and later, for provincial hospitals and for in-service training, scholarships and travel grants. It also provided resident advisors and supplied most of the contraceptives needed prior to 1968 when USAID funded a grant for clinical equipment, vehicles and oral contraceptives. Other contributors during the latter part of the decade included the United Nations Children's Educational Fund (UNICEF), International Planned Parenthood Federation (IPPF), and the Ford and Rockefeller Foundations. The strong external support made possible the training of field staff and conducting of research in universities, hospitals, and other institutes and agencies [13] [14]. These private funding sources were essential to establish the blueprint for the Thai program. Only after the government established a policy and program in 1970 was it possible for the Thai government and bilateral and multilateral donors to provide the large sums of money necessary to build the program.

Studies and Experimental Programs

Research Project in Potharam

Based on the consensus view of the first National Population Seminar that more information was needed about public views on family planning, the Cabinet moved to launch a pilot family planning project. The proposed site of the project was Potharam district in Ratchaburi, some 85 kilometers west of Bangkok. The actual title of the activity was Family Health Research Project, to ensure its integration into the maternal and child health (MCH) program of the MOPH. Responsibility was shared by the National Research Council in cooperation with the MOPH, and funding was secured primarily from The Population Council [12].

Potharam district is a largely rural area with a population of about 70,000. A baseline survey in August 1964 showed that 5 percent of the families had ever used contraception and that the most common method was sterilization.

For 30 percent of the eligible women, the only known method was sterilization, and only 5 percent knew of any modern, *reversible* method of contraception [15].

After this baseline data had been collected, clinical services were started, offering a choice of IUDs, pills, condoms and foam tablets. During the year and one-half that the project was operational, 30 percent of the eligible women in the district had accepted a contraceptive method. Although the only publicity was through person-to-person communication, word spread beyond the district about the availability of birth control methods and by the end of the project, almost three times as many women had come to the clinics from outside the district as from Potharam district itself [16].

These results were highly significant, showing a considerable receptivity to use of family planning in what was viewed as a fairly typical part of rural Thailand. The conclusions were fed back to the Second National Population Seminar by an MOPH official who stated that "We think we have demonstrated the existence of a high degree of readiness to engage in family planning in Thailand" [12, p. 338]. The conclusion had an important bearing on the resulting recommendation from the seminar in support of a government role in the provision of family planning services.

McCormick Hospital

In 1963, McCormick Hospital, a missionary-operated hospital in the northern city of Chiangmai and a major medical facility in Thailand, began the first bona fide service provision program in the country. It was begun on the strength of the Cabinet's 1961 directive that indicated that providing advice on family planning would be permissible. The hospital's program consisted initially of provision of IUDs, and in 22 months it had provided contraceptives to about 1,400 acceptors. Testing of an injectable contraceptive, Depo-Provera, started in 1965 as an alternative for women who could not tolerate or would not accept an IUD. The new contraceptive proved satisfactory and soon became the first choice of new acceptors in preference to the IUD and oral contraceptives [17].

In the mid-1960s, McCormick Hospital initiated mobile family planning services to reach more remote rural areas. As in the Potharam experiment, the Hospital selected a pilot area and surveyed residents to determine initial levels of contraceptive knowledge and use. Results mirrored those in Potharam. In the survey area, Ban Pong (a rural village with about 250 eligible women), only five percent of the women reported practicing contraception, most of them having been sterilized, and only 10 percent could mention a modern method of contraception. The receptivity of villagers to contraceptives proved to be as positive as it had been in Potharam. Following two years of visits by a mobile unit, 37 percent of the eligible women were current users [18].

Vachira Hospital

Organized family planning services were initiated in Vachira Hospital in Bangkok with insertion of IUDs in 1963 and then expanded to areas outside of Bangkok such as in Chiangmai and Lumpoon. During this period, data continued to be collected and research on other methods of family planning were carried out by an increasing number of clinical outlets.

Chulalongkorn Hospital/The Population Council International Postpartum Project

Another initiative, also hospital-based, was that of the Chulalongkorn Hospital, which for a number of years been providing sterilization for women who had four or more living children and had given birth at the hospital. In 1965, it began a more comprehensive family planning service, offering IUDs, oral pills, and injectables. The reception was overwhelming. Women from 90 percent of the country's 71 provinces flocked to the Chulalongkorn clinic on the strength of word-of-mouth communication that contraceptives could be gotten there.

In 1966, Chulalongkorn joined Siriraj, Vachira and Rachvithi Hospitals in the international postpartum program of The Population Council. This was a project to study the acceptance and effectiveness of IUDs while women were in the hospital following delivery. A variety of educational and motivational methods were tested and the results became the basis for postpartum programs in a number of other hospitals [19] [20].

MOPH Clinics

In 1965 and 1966, the MOPH opened its first experimental family planning clinics. Two hospital-connected clinics were opened, both in the northeast. The first was attached to the provincial hospital in Khon Kaen, which established an outpatient clinic for the insertion of IUDs in 1965. The following year the Roi-et provincial health office, through its network of health clinics, also began to provide IUDs. In the first two years, each province served more than 8,000 acceptors annually. As had been the case at Potharam, each program drew many women from outside its service area. A number of clinics were established in other provincial hospitals as qualified staff members completed training.

Research Facilities

The National Population Seminars had called attention to the need for training of demographers to carry out research in the population field and to serve as teachers of demography in colleges and universities. They also called for the promotion of demographic research basic to economic and social development planning. The Thai climate was receptive to research. In addition to the pilot projects described above, the two medical schools in

Bangkok (Siriraj and Chulalongkorn) had undertaken a number of clinical studies on oral and injectable contraceptives and on IUDs. In addition, at McCormick Hospital, the popularity of injectable contraceptives made possible a large-scale and long-term field study.

The establishment of two population research and training centers (later designated as institutes) in Bangkok in 1966 and 1967 served to institutionalize the capability for in-country research. The Institute of Population Studies at Chulalongkorn University (1966) received support and advisory assistance from The Population Council. The Institute for Population and Social Research of Mahidol University (1967) was assisted by the University of North Carolina and the Rockefeller Foundation. Both institutes offered graduate training in demography and initiated strong research programs.

The Chulalongkorn Institute, a faculty of the Department of Political Science, tended to be policy-oriented in its research. Its first major research project was the Longitudinal Study of Social, Economic and Demographic Change in Thailand. Launched in 1969, it involved two rounds of interviews separated by a four-year interval. The study included the first comprehensive analysis of fertility patterns and family planning practice in Thailand. Though unplanned, its timing coincided with the inauguration of the country's national family planning program, thus providing benchmark data against which to evaluate change over time.

The Mahidol Institute, associated with the University of Mahidol, was more program-oriented in its research. In 1967-68, it conducted a survey of a suburban area, Bangkhen, in the Bangkok metropolitan area. In contrast to rural Potharam, 97 percent of the women interviewed here had some knowledge of family limitation methods and 42 percent said they were current users of contraception. Of those practicing family planning, over 35 percent were sterilized and another 20 percent had husbands who had had vasectomies. The widespread knowledge and acceptance of contraceptive methods at this early stage and the predominance of sterilization as a method doubtless reflected the close proximity of Bangkok and its service facilities [21].

Human Resources Development

At the time of the Second National Population Seminar in 1965, there was an acute shortage of physicians, especially in rural areas. Experience (e.g., in Potharam and at Chulalongkorn Hospital) had shown that many women would travel to other districts and provinces and even to Bangkok to reach family planning clinics, but the great majority were unable to do so. Of the 3,000 facilities offering health care services in 1963, only about 300 were staffed by physicians. Most of the remaining facilities, located primarily in rural areas, were staffed by AMWs.

In the latter part of 1967, the MOPH prepared a three-year strategy -- the Family Health Project of 1968-1970 -- for the expansion of family planning services in Thailand. This was designed to serve as the basic structure for the provision of family planning services upon the adoption of a national population policy. It was an ambitious plan, adding another major responsibility to the tasks assigned to the multipurpose workers in MCH.

The plan called for giving basic training to one doctor and one nurse in each of the provincial hospitals and to the doctors, nurses and AMWs in the health department of each province. The doctors were responsible for prescribing oral pills, inserting IUDs and performing sterilizations. Paramedical personnel were trained in person-to-person motivation. Over the three-year period, 330 physicians, 700 nurses and 3,090 midwives received the one-week training course [13]. With external support, a number of officials had been sent abroad to study and to observe on-going programs. Family planning was integrated into the existing health services, through utilizing existing facilities and personnel.

During this period, the MOPH decided to take a major innovative step by testing the feasibility of using paramedical personnel to provide family planning services, a task previously restricted to doctors. A pilot study was carried out in four provinces in 1969 in which AMWs made use of a simple checklist of contraindications to prescribe oral contraceptives. The test proved successful and the Ministry's decision in 1970 permitting AMWs to prescribe pills would make possible a tenfold increase in the number of health facilities offering modern contraceptives, most of them located in rural areas [13]. (For a fuller discussion, see Chapter 5.)

The AMWs, most of whom were posted in rural areas, were to provide family planning information and motivation through person-to-person communication at clinics and through home visits. The existing structure and functions of the MOPH were maintained, and its hospitals, health centers and midwifery centers served readily as family planning clinics. By the end of the three-year program, there would be clinical services in at least every provincial center.

The Family Health Project was a prototype, the first step toward a country-wide program encompassing MCH care and family planning services. The Cabinet's decision to adopt a population policy before the completion of the three-year program shifted it from a preparatory to an operational phase. The value of the knowledge gained through the many studies, surveys and action programs was to be tested in the implementation of the National Family Planning Program.

Conclusion

In the context of the rapid growth and maturation of Thailand's family planning program, the six years between the Potharam pilot project in 1964 and the approval of a formal policy in 1970 represented a substantial time span. In some ways, however, the timing was just right. By the time the cabinet was ready to provide official backing to family planning, most of the key staff who would implement the NFPP had already been trained in family planning.

Likewise, the service infrastructure had had time to develop. Primarily with domestic funding, the MOPH had gradually built up the critical mass of peripheral service outlets, together with necessary trained staff, equipment and supplies, so that by 1970, contraceptives were widely available throughout Thailand.

Thus, although Potharam had provided the mandate for a policy and program as far back as 1964, launching the program that early might have been a serious mistake by creating a demand for services that could not be met. By the end of the decade of the 1960s, however, all the pieces were in place and the built-up demand could be satisfied with accessible and continuous services.

The three national population seminars, held between 1963 and 1968, had created an atmosphere of acceptance of voluntary family planning at the highest policy levels. It has generally been the case in Thailand that, before national policy is promulgated, there must be credible, concise documentation in support of the proposed policy and that this must be presented by respected and unbiased institutions. In the case of population, that support came in late 1969 and early 1970 from the National Economic Development Board, together with the MOPH and the Institute of Population Studies, which together prepared a comprehensive report for the cabinet on the adverse effects of the high rate of population growth on economic and social development and strongly recommended adoption of a population policy [13].

Although family planning services had been provided since the mid-1960s, the advantages of a public policy included the following: (1) It allowed the government to speak openly about the family planning services available throughout the country; (2) It led directly to the establishment of the NFPP and to the creation of the Family Health Division (FHD) within the MOPH, which would administer the NFPP in the years to come; (3) It enabled foreign governments to provide bilateral assistance directly to the NFPP; (4) It promoted coordination of family planning activities by focusing on a single entity (the NFPP) as the authority for the nation; and (5) It legitimized family planning services and the declaration of national targets.

The question arises whether family planning would have succeeded even without a policy and an NFPP, given the tremendous demand for services that existed at the time. According to Dr. Somsak Varakamin, the MOPH

permanent secretary and former head of the FHD (see below, Chapter 6), the population policy was "indispensable" to the success of the Thai program. In the 1980s, he pointed out, existence of the policy enabled the MOPH to request increased, direct support from the Thai Bureau of the Budget. National budget support, in turn, helped to institutionalize funds for the basic commodities and equipment and also served to free the NFPP management from total dependence on "unpredictable" foreign sources [Personal interview, March 1990].

In sum, a population policy was a critical factor to the Thai family planning success because it gave rise to a national program operated through a staffed FHD and served to attract, coordinate and funnel resources to areas of program need. The policy was promulgated at an appropriate time: after adequate infrastructure had been established both to nourish demand and to link it with supplies and services.

5. Growth (circa 1970-75)

Overview

During the five-year period, 1970-1975, contraceptive prevalence in Thailand rose by 20 percentage points -- from 14 percent to 34 percent modern methods. This swift increase can be attributed in part to the groundwork for service delivery that had been laid during the previous decade. Of greater significance, however, were the steps taken by the government to make a variety of methods of contraception -- the pill, the IUD, and sterilization -- widely available throughout the country. The pill became accessible to rural women throughout Thailand following the government decision to allow AMWs to prescribe this method and thereafter, to allow drugstores to sell some pills without prescription. By midway through this period, the pill had become the dominant method in the country (used by 10.6 percent of currently married women in 1972/73 [see Table 3] and remained the most popular method through 1984). IUDs, although used by less than half as many women as the pill, doubled in popularity between 1969/70 and 1972/73, again as a result of government efforts to make this method more easily available by training nurses and then AMWs, to insert the device. Contraceptives also became increasingly available through the private and NGO sectors, thanks primarily to government policy encouraging and endorsing the contribution of these potentially rival sources.

An idiosyncratic and uniquely Thai asset during this period was the charismatic family planning publicist, Mechai Viravaidya, who -- through his village-based pill distribution program -- drew the attention of people both inside of Thailand and out, to the cause of family planning for Thailand. Typical of the Thai approach, Mechai was allowed to carry out this private sector effort, although NFPP policy did not officially endorse village-based distribution of the pill. Mechai's IEC success to some degree may have counteracted the one weak spot of this period -- the lack of an extensive mass media IEC effort and the lack of formal population education in the schools.

Contrary to conventional wisdom, a final important characteristic of the program during this phase was that family planning service delivery remained essentially independent of the MCH services of the government. Funds poured into the national family planning program, all but eclipsing MCH efforts.

Not Requiring a Medical Prescription for the Pill

AMWs as Providers

One of the first actions taken by the newly formed NFPP was to authorize AMWs in peripheral health centers to prescribe the pill. A pilot study had demonstrated the feasibility of training AMWs to prescribe the pill and, essentially overnight, AMWs throughout the nation were empowered to do so. No other action, before or since, has had a more dramatic effect on the success of the Thai NFPP. This policy made effective contraception easily

accessible to rural women throughout the country: Almost immediately the number of outlets providing government pills increased 14-fold from 250 to 3,500 [22]. In addition, an important related management decision was to allow the AMW to collect a "donation" of \$0.25 for each cycle of pills distributed (to be used as the AMW saw fit).

These policies also had more profound implications, some of which are enumerated below:

1. Allowing government midwives to provide a prescription drug sent the message that the peripheral government workers were medically competent and that they could be trusted.
2. The monetary donation increased the importance of family planning for the midwifery center.
3. Making the pill more easily accessible to rural women implied recognition of the intelligence of villagers to take this method correctly and to report any severe side effects on a self-referral basis. This is in contrast to other countries in Asia (notably India and Japan), which have restricted women's access to the pill.
4. Allowing non-physicians to prescribe the pill encouraged the introduction of community-based pill distribution, which followed three years later.

Pharmacists as Providers

The pragmatic attitude of the Thai MOPH is usually cited in reference to its authorization of government paramedics to provide clinical services. Another significant policy, however, was the lack of control of the drugstore pill market. Drugstores have long been present in provincial and district towns in Thailand, and they do a brisk business in antibiotics, analgesics and palliatives. The MOPH also allows these drugstores to market a wide variety of oral contraceptive formulations without medical prescription. Although these pills were sold at twice the price of the government pills in the early 1970s, drugstore oral contraceptives were an important alternative source of service in urban areas for the following reasons:

1. Women could select from a much wider range of dosages and preparations and thus potentially minimize side effects;
2. The woman's confidentiality was protected by the anonymity that Thai pharmacies offered; and

3. A new cadre of distributors (i.e., the commercial pharmacists) materialized at no cost to the government. In 1978, approximately one out of five pill users obtained their last cycle from a commercial pharmacy [23].

Training of Physicians, Nurses and Auxiliary Midwives

With the success of the pilot program to train AMWs to prescribe the pill and the successful national expansion of that model, attention turned to the expansion of the number of practitioners of more sophisticated clinical procedures. Although the pill soon became the dominant method in the Thai NFPP, the MOPH was also gradually building up an army of clinicians skilled in IUD insertion, female sterilization and vasectomy, because of the substantial array of government and private outlets that needed staffing. In the early 1970s, Thai physicians were still concentrated in Bangkok (50 percent worked there) and most of the rest were in provincial urban centers [24]. Thus, if the NFPP was rapidly to expand clinical and surgical contraception, the only option was to train nurses and AMWs in these techniques.

By 1972, every active physician, nurse and AMW employed by the MOPH had received basic training in family planning concepts and methods, which, at that time, included sterilization, the IUD and the pill. That year, the NFPP invited an outside expert to develop a curriculum in IUD insertion for Thai nurses. As with the introduction of the pill, a small demonstration project was conducted to test this curriculum and carefully evaluated. The evaluation of the local training demonstrated that nurses could perform as effectively as physicians in this area and that client satisfaction was higher with nurse providers. On the basis of this finding, in 1975 the MOPH established a policy that permitted all nurses who had received the NFPP training program to insert the IUD. This is another example of the policy formation model in the Thai NFPP: small exploratory research, followed by a pilot study that is documented and evaluated, leading to a national policy.

Despite the successful training program, the NFPP continued to follow up the trainees and found that many of the nurses had been transferred to non-clinical positions. This led to another policy cycle resulting in the authorization of AMWs to insert the IUD in health centers. At present, AMWs are trained at regional and provincial centers throughout Thailand. Recent survey data indicate that 20 percent of AMWs in health centers have been trained in IUD insertion [25].

Another benefit of the training of non-physicians to provide clinical family planning was to increase the number of females who could provide services to a largely female clientele. Although only approximately one-fourth of Thai medical students were female in the 1970s, almost all nurses and midwives were women. By authorizing non-physicians to prescribe the pill, to give the injectable contraceptive (1975), and to insert IUDs, the NFPP was creating a women-to-women service network as a de facto policy. Consistently,

Community- Based Family Planning and Mechai Viravaidya

follow-up evaluations comparing physicians and non-physicians have found that client satisfaction is greater with the (female) non-physician service providers [26]. This aspect of the Thai program is one of the factors that helped propel the acceptance of contraception in the 1970s to the saturation level witnessed today.

The Community-Based Family Planning Services Project (CBFPS) launched in 1974 by Mechai Viravaidya was a village-based pill distribution program. CBFPS village agents were a convenient source of pills when the local health center was closed. Survey data show that the CBFPS contribution never exceeded 10 percent of pill users in a given year [2]. This modest contribution is understandable since AMWs were already prescribing pills in remote rural areas throughout Thailand.

The contribution of Mechai to the family planning program, however, was much greater than his involvement in the CBFPS project. More than any other individual, Mechai has been associated by the *international media* with the success of Thailand's program. Mechai's popularization of the condom through the media and public events gave the impression that the condom played a direct role in the fertility decline in Thailand. In truth, the condom played an extremely minor role in preventing pregnancy among Thai couples (see Table 3). Instead, Mechai used the condom as a prop to desensitize the population on the topic of family planning.

The CBFPS and Mechai had three additional, more profound, effects on the national population program which are often overlooked:

1. Personally, Mechai helped to orient primary school teachers throughout Thailand to family planning and its importance for the future development of the country. This message was transmitted to students and their parents through songs and slogans, the most quoted of which is "Many Children / Make You Poor" (which, in the Thai version, is a clever rhyme).
2. More important than the slogans, however, was the attraction of the print media toward Mechai and his iconoclastic outspokenness. Mechai served as a type of "media ambassador" for the NFPP, ensuring that the media were knowledgeable and supportive of family planning during the growth years of the program.
3. A third indirect but substantial contribution of Mechai to the NFPP was that he attracted the attention of international donors and politicians to Thailand. Mechai addressed the World Population Conference in Bucharest in 1974 and was featured in countless international publications and symposia during that decade. It is not possible to quantify this contribution to the total flow of resources to the NFPP, but the amount is certainly substantial.

Encouragement of the Private Sector

Although the MOPH was solely responsible for organizing family planning services for the country, it never attempted to exercise this authority to the exclusion of the private sector. The Thai government's generosity in encouraging and endorsing private sector and NGO involvement deserves mention because not all governments are so inclined.

During the first half of the 1970s, the NFPP invited representatives of the major NGOs to join the National Family Planning Coordinating Committee. In addition, the NFPP provided contraceptive supplies and equipment -- free -- to any NGC that agreed not to charge for services. An increasingly large number of private service providers began sending monthly activity reports to the MOPH, and the data from these forms were incorporated into the monthly computer report of the NFPP. Thus, in print, in policy, and in substance the NFPP expressed its acknowledgment and appreciation of the private sector's support for the national demographic goals.

It is difficult to quantify the contribution of the private sector to the success of the Thai program but it is clear that individual projects have received considerable recognition for their pioneering work: (1) The McCormick Hospital in Chiangmai was the first place to offer organized family planning services in Thailand and grew to become the world's largest mobile service for the injectable contraceptive (see above, Chapter 4); and (2) Mechai's CBFPS project became a model for other programs throughout the world. The significant aspects of the NFPP's relationship with these programs were that it allowed them to operate, although they did not conform to the accepted program norms, and that it even supplied them with contraceptives. For example, the MOPH did not approve the injectable contraceptive (for government outlets) until 1975, and, therefore, could have terminated the mobile injection clinic of McCormick Hospital after its inauguration in 1965. Similarly, the MOPH could have withheld approval for village volunteers to distribute the pill, effectively destroying the community-based distribution (CBD) program of Mechai Viravaidya. The MOPH did neither and, instead, through the NFPP, ensured the viability and growth of these two pioneering programs by supplying them with pills and injectables.

The private sector in Thailand prospered and drew increasing international attention, often at the expense of the MOPH itself. Although it unquestionably provided the vast majority of services to the rural population, the MOPH did not resent the lack of publicity for its work. Rather, it accepted that other groups were being credited with success as long as financial support was adequate to maintain the expansion of the program.

The MOPH was also not pursuing a practice that is standard for many developing countries -- allowing the private sector to explore innovative approaches that are later incorporated into the government program. For example, the MOPH never introduced mobile injectable units, and its expansion of injectable services was very cautious, extending over the period of a decade. Similarly, the MOPH did not authorize its national cadre of

village health volunteers to dispense the pill although only one-fourth of the nation's villages were covered by Mechai's distributors. In short, the MOPH was not using the private sector to experiment with new service delivery approaches. Rather, it supported the private sector in its own right, most likely secure in the knowledge that the NFPP would always control the majority of population resources.

Shortcoming: The Failure of Formal Population Education

Not all aspects of Thailand's population program have been successful. Although population communication, through the media and person-to-person channels, rapidly created a national awareness of family planning, little was done to provide formal population education in the schools. Instead, population communication and population education have evolved independently, were implemented by separate and uncoordinated agencies, and have addressed radically different topic areas. Early on, the Ministry of Education adopted UNESCO's very broad definition of population education, which encompasses social studies, ecology and civics. Population communication, on the other hand, was narrow and applied, focusing on family planning education and adolescent sexuality (as it relates to responsible parenthood). The population educators refused to incorporate sensitive topic areas of family planning and sex education while the population communication groups resisted taking a broader, more theoretical approach to population topics.

When formal population education was introduced in 1978, it was implemented in the secondary school grades and not the primary grades, which represent the totality of education for most of the rural population. The vast majority of Thais complete four years of education and over three-quarters complete six years (now compulsory). The proportion completing higher grades diminishes dramatically, however (see Table 5 on page 43).

The decision of the Ministry of Education to adopt the conservative approach of UNESCO and to limit population education to the upper grades meant that the opportunity was lost to reach young people at a time that the demand for smaller families was spreading throughout Thailand. If a primary school population education curriculum had been developed, some Thai experts argue that present-day adolescents and young adults might have a more practical awareness of reproduction and social responsibility [27]. This gap has been filled by the non-formal population education sector and private organizations such as the Planned Parenthood Association of Thailand and Mechai's Population and Community Development Association (CBFPS's new name, as of the early 1980s). This is typical of the success of Thailand's NFPP, however. When one sector was inadequate, another was always there to back it up.

Table 5

School Enrollment by Age and Grade: 1980

Age	Percent in School	# Grade
6	24	
7	66	1
8	87	2
9	91	3
10	91	4
11	88	5
12	78	6
13	58	7
14	42	8
15	33	9
16	30	10
17	27	11
18	24	12
19	19	
20-24	8	

Source: National Statistical Office, 1980

6. Consolidation (circa 1976-84)



6. Consolidation (circa 1976-84)

Overview

In the eight-year period between 1976 and 1984, modern method contraceptive prevalence once again rose rapidly -- from 34 to 62 percent -- although the rate of increase had slowed somewhat from the immediately preceding stage. During the growth stage, the average rate of increase was an astonishing 4 percentage points a year, compared with a rate of increase during consolidation of 3.5 percentage points. Nonetheless, an increase of 28 percentage points over an eight-year period is extremely impressive.

Throughout this period, the Thai government consciously attempted to reach all elements of the population, including indigenous hilltribes, resistant southern Muslims, and the unmarried adolescent, a particularly sensitive group to approach. Other aspects of the NFPP's outreach strategy included development of a far-reaching network of mobile units which, although to some degree duplicating the existing rural network of facilities, ensured access to services for far-flung rural groups; promoting the widespread availability and dependability of the minilaparotomy technique, which contributed to a three-fold increase in use of female sterilization during this time; special radio programs targeted to rural populations that spread the family planning message; and the national surveys and censuses that allowed the program to identify underserved geographic areas and target them for program interventions.

More traditionally, efforts continued to build the rural infrastructure, made possible in part during the consolidation stage through a major World Bank loan. This infusion of funds, typical of many such investments, reflected the readiness of the international community to contribute to development efforts in Thailand. Thailand was attractive to donors for a number of reasons, not the least of which was the leadership of Dr. Somsak Varakamin. Dr. Somsak, holding key positions in the family planning program during this period, lobbied effectively for both domestic and international funds; placed a premium on infrastructure development and quality services; and continued the program of training that fed into the infrastructure and services.

Focus on Population Sub-Groups

By the end of the 1970s, the NFPP was well on its way to providing a complete array of family planning services for the majority of the rural population. The needs of urban residents were increasingly being met by the private clinics of (mostly) government physicians and by an ever-expanding number of drugstores. The Thai government, however, recognized that important segments of the rural population were being left out of the demographic revolution and therefore called for intensified service strategies directed to two major groups: hilltribes and southern Muslims [28]. With assistance from the United Nations Population Fund (UNFPA), the NFPP developed and expanded innovative service models for these two groups.

Hilltribes

The high mobility, mortality and ethnic diversity of the hilltribes demanded a unique approach to services. Unlike the NFPP service model, the strategy that was developed for the hilltribes integrated family planning with primary health care. Indigenous hilltribesmen were recruited and trained to provide basic medical and health care. In addition, referral and supply links were emphasized to ensure that hilltribe couples had relatively easy access to modern contraception. The result of this so-called "Mae Chaem" model was an increase in the CPR from 5 percent in 1981, before the pilot project, to 41 percent in 1988. The model was expanded (using USAID and Thai government funds) to cover hilltribes in 11 provinces of northern Thailand. This represents one more example of successful pilot testing, evaluation, documentation and replication.

Southern Muslims

Although NFPP service statistics had historically recorded low acceptance rates in the predominantly Muslim provinces of the deep south, analysis of health center density indicated that lack of *access* to government service outlets was not a barrier to use of family planning. Rather, both religious and southern cultural features were contributing to low prevalence levels. The NFPP and UNFPA were interested in testing new service strategies that might help draw this minority into the mainstream of service delivery. UNFPA convened a regional seminar to tap the wisdom of local leaders and researchers as to the needs and obstacles for greater contraceptive prevalence. The service model that was developed (and which is still evolving) consists of five activities: (1) Orientation for village health volunteers in motivating couples to accept family planning; (2) Production and distribution of cassette tapes on MCH and family planning in the local dialect to be used by health center workers when conducting outreach; (3) Arrangement of meetings of MWRA in all villages with less than 60 percent CPR to motivate for acceptance of family planning; (4) Construction of large, road-side billboards in every *Tambon* to advertise contraceptive methods; (5) Orientation for radio station representatives to ask for their cooperation in airing the family planning radio programs and spots at prime time.

What is significant in this instance is not the success or failure of the special strategies that were developed; it is that the NFPP took a special interest in minority groups and devoted more per capita resources to them than were being directed to the mainstream rural population. In many societies, minorities are regarded with suspicion by the majority. In Thailand, groups are also marked by their ethnicity, but this did not prevent the MOPH from pursuing a nationally inclusive strategy for family planning.

Approaching the (Single) Adolescent Population

Until the mid-1970s, the NFPP was directed exclusively to the married population, even requiring the name of spouse on all new acceptor forms. This policy neglected mounting evidence of sexual activity among single adolescents. Official data on cases of incomplete abortion throughout Thailand and informal statistics from extralegal abortion clinics in Bangkok indicated that many single women were sexually active and were not effectively preventing unwanted pregnancies. Interviews with 1,000 single women for the 1978 National Contraceptive Prevalence Survey discovered only one person who admitted ever using a contraceptive. A variety of surveys of adolescents in the 1980s indicated that approximately 10 percent of female teens were sexually active [29].

In the early 1980s, working with the reputable Siriraj Hospital in Bangkok and using funding from the UNFPA, the NFPP began a pilot program of adolescent counseling in which junior and commercial college students were trained as peer counselors. The success of the pilot led to a large-scale replication by the MOPH in all regions of the country. At the same time, the private sector was active in providing sex education directly to high school students through the training of Boy Scout and Girl Scout leaders. (This approach was particularly effective during the first year of high school: the Scouts program is mandatory through the 9th grade of school.) Through this program, it is estimated that the Planned Parenthood Association of Thailand has reached one million Thai youth with sex education messages [30].

Although reluctant to begin an overt program of sex education, the FHD is producing video and printed materials through its dynamic Information and Public Relations Section which address the risk of unwanted pregnancy and sexually transmitted disease (STD). In fact, Thai youth had been exposed to family planning messages ever since the 1970s when the NFPP mobile units showed popular films with inserted messages about contraception. Because adolescents were not the target audience and because of the decreasing popularity of outdoor films (compared with home video), this activity had limited impact [31].

Of all components of the NFPP, the adolescent programs are the most difficult to evaluate because of the reluctance of single youth to disclose information about sexual intercourse and because of the difficulty in creating a sampling frame for a scientific survey. The experience in Thailand shows that even with a progressive and successful program for married couples, it was not until the program had reached the consolidation stage that it was ready to address the needs of single, but sexually active, youth. The advent of AIDS, and the growing realization that most heterosexual infection occurs in the teen years, should accelerate sex education (and contraception) for this group.

Mobile Units for Service Outreach

One of the NFPP's most striking characteristics is that it continued to make efforts to increase service coverage, even during the consolidation stage when the program was progressing well. Despite an excellent infrastructure and ubiquitous public transportation, the NFPP consistently sought and received support for mobile coverage that eventually covered all 72 provinces. The mobile strategy came in a number of guises described below.

The first, mobile motivation and service units, was initiated by the UNFPA in 1975 for use in the NFPP. Between 1977 and 1981, with USAID funding, their number grew until 110 units were providing increasingly decentralized services to populations in peripheral areas. The provincial health office scheduled mobile trips each month, with the emphasis on motivation for sterilization. For vasectomy, the mobile unit would attract crowds of villagers by showing popular films on an outdoor screen. When at least 10 men had agreed to accept sterilization, a second mobile unit would travel to the local area where the vasectomies were performed. The same recruitment strategy was used for female sterilization, except that potential acceptors were transported to the medical facilities for the procedure.

Although these mobile motivation and service units have become the most numerous in the Thai NFPP, a variety of other mobile strategies were also used during the growth and consolidation stages. The first, and today the best known, is the McCormick Hospital injectable mobile service, which travels to remote areas on a three-month circuit. Remarkably, the unit has never missed an appointment in over 20 years of service. At some service units, over 1,000 women have received the injectable contraceptive on a single morning.

In the late 1970s, the MOPH tested a multi-method mobile service in 15 provinces that provided vasectomy, IUD insertion, and the injection in the village setting. The evaluation of this approach found that it was not as cost-effective as the single-service mobile vasectomy unit, which had fewer acceptors but higher couple years of protection per dollar spent [32].

Perhaps the most unusual mobile unit was a creation of Mechai's Population and Community Development Association. This unit was a self-contained vasectomy operating room bus. The van had two air-conditioned operating tables and traveled to villages throughout rural Thailand, averaging 22 acceptors per day.

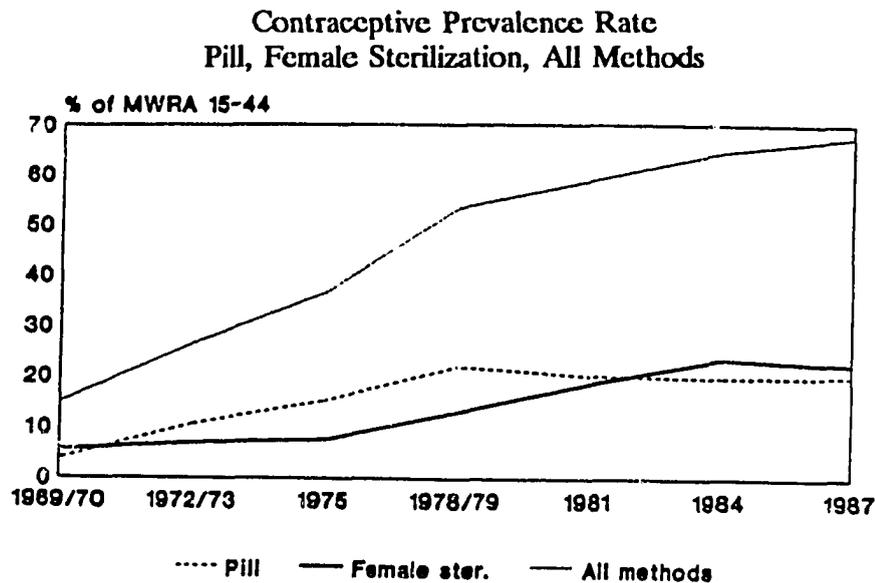
Thailand's only mobile female sterilization unit was developed by a rural surgeon. This doctor performed hundreds of sterilizations in rural health centers, using the minilaparotomy procedure. Staff and equipment were transported by the mobile unit to these centers, enabling clients to have the procedure only 10 minutes away from home. Because of the surgeon's skill and the small incision of minilap, no cases of infection were ever recorded.

Thailand is one of the least likely settings for a wide network of mobile units. With its well-distributed service outlets, excellent transportation and highly motivated clientele, there would seem to be little need for staff-intensive mobile outreach. Nevertheless, mobile services became a popular link between villager and service provider. This redundancy of effort is one of the many factors that helped sustain the momentum of the NFPP.

Minilaparotomy and the Role of Female Sterilization

Thailand has one of the highest rates of female sterilization in the world. In an inventory of 76 developing and developed countries for 1981, only 6 other nations had as high a rate of female sterilization prevalence as Thailand [33]. During the consolidation stage, the popularity of female sterilization increased rapidly; in 1975, only 7.5 percent of the contracepting women had been sterilized compared with 23.5 percent in 1984. Since then, female sterilization has remained the most common method of contraception for Thai couples (see Figure 6 below).

Figure 6



Various national sample surveys

The NFPP's ability to provide this high level of female sterilizations arises from the high quality of its family planning organization, which is competent to train practitioners and offer a public information program, client counseling, logistics support, and acceptor surveillance. In turn, the extensive number of physicians (and even nurses) trained in sterilization and the widespread availability of this service can be largely attributed to use of the minilaparotomy technique.

In an effort to make sterilization simpler and safer, physicians at Ramathibodi Medical School helped to pioneer the minilaparotomy technique. Requiring only a small incision and local anesthesia, female sterilization became an out-patient procedure which could be performed in any hospital with an operating room [34]. Indeed, as indicated above, minilaparotomy was even performed successfully in rural health centers. The proportion of interval (i.e., non-postpartum) sterilizations increased as well. Sterilization now became a year-round option for rural women and spur-of-the-moment decisions could be made.

For example, in one village in northeast Thailand, three sterilization acceptors convinced some 17 women in their village to have sterilizations. One described the experience as follows:

"I had been thinking about sterilization for a while. My husband had just returned from abroad and I did not want to get pregnant again but I was afraid of the operation. I knew the local hospital could do the sterilization any day I wanted but I was still ambivalent. Finally, I talked to two friends and we decided to go together. We all had a general anesthetic but returned home together in the evening. During the ride home we made a pact to tell all the other village women that the procedure didn't hurt at all. In fact, it hurt a darn lot after waking up [from the anesthesia]. But we wanted the other village women to go through it too."

Over the next five days 17 women from that village went to the district hospital for the procedure, an extraordinary event made possible by out-patient female sterilization.

National Sample Surveys and Censuses

By the late 1970s, Thai surveys and enumerations began describing important sub-groups of the population which were perceived to be in special need of development programs. An extremely important use of the census was the disaggregation of population data to the provincial and district levels. Specifically, these sub-national tabulations enabled program agencies to calculate the size of the target population (e.g., MWRA, children under five years old) to serve as denominators in the calculation of coverage and service achievement rates. Without these denominators, no meaningful comparison among areas could be made and thus it was difficult to allocate resources effectively. After 1978, MWRA were tabulated by district and province, enabling managers to compare family planning output with the target population. These tabulations led to efforts by donors and programs to target specific sub-groups for additional coverage.

The 1980 census made another significant contribution to the NFPP by including two questions on family planning: (1) Is the woman of reproductive age in the household using a contraceptive method; and (2) If so, what method? The Research and Evaluation (RE) Unit of the Family Health Division took advantage of these data by requesting district-level tabulations

of MWRA by contraceptive use status. This was a unique move in Thai history. From this base, the RE Unit derived estimates of contraceptive prevalence by method, by month, for every district and province in the country. These data made possible the calculation of contraceptive prevalence for small administrative areas and, combined with service statistics, provided month-by-month estimates of prevalence in these locations. These data were critically important in the 1980s in directing UNFPA and USAID population resources to areas of lowest coverage.

The national contraceptive prevalence surveys in 1978 and 1981 provided detailed family planning and fertility data by region for the first time. From these data, the NFPP and donors targeted the northeast region and the south region as the top priorities for project activities based on their higher fertility and lower contraceptive prevalence as compared with other regions.

Several large donor-assisted projects used existing survey and census data to identify needy groups: the World Bank's Accelerated Family Planning and Health Project in 20 provinces, the UNFPA program for southern Muslims (see above), and, during the mature stage, the Lagging Provinces Project funded by USAID in 15 provinces (see below, Chapter 7).

Radio Broadcasts

Another method by which the Thai national family planning program extended its reach was through an extensive radio campaign designed to spread the family planning message throughout rural Thailand. Although it had its beginnings during the previous growth stage, the media campaigns peaked during this period.

Although the print media (i.e., newspapers) were important sources of family planning information in urban areas in the first half of the 1970s, their penetration in the rural areas where 80 percent of the population resided was minimal. Instead, the NFPP relied on radio broadcasts to reach the semi-literate couples of reproductive age in these areas. Rural coverage by transistor radios increased dramatically between 1970 and 1980 (see Table 6 on the following page).

In 1970, the majority of rural households had radios even though less than 10 percent had electricity. This reflects the popularity among the farming population of transistor radios, a cheap information source that could be taken to the rice fields. The NFPP took advantage of this technology with a barrage of radio programs that used primarily the "entertainment-education" approach. This consisted of interspersing family planning messages between musical selections in music programs and incorporating family planning messages in radio dramas. These programs were generally very popular with the population. Because family planning was national government policy, the MOPH was able to obtain free radio air time from the Air Force (which controlled all provincial radio air waves at that time).

Table 6

Percent of Households with a Radio and Electricity
1970 and 1980

	Rural	Urban	National
% Households with a Radio			
1970	64	86	66
1980	86	94	87
% Households with Electricity			
1970	9	86	19
1980	32	94	43

Between 1976 and 1978, three different radio strategies were used to spread family planning messages:

1. **Music Program.** The NFPP produced tapes of country music with five intermissions. Each of these short intermissions featured one of the five family planning methods available in MOPH outlets. These programs lasted 30 minutes and were aired once a week (at different times of the day) by 40 radio stations in 32 provinces.
2. **Drama.** Popular radio drama teams were given contracts to adapt stories from well-known local writers. Each drama consisted of 30 to 45 half-hour installments and each installment contained three spots on contraceptive methods. Each week, three to five installments were aired on 36 stations in 32 provinces.

Both the music and drama programs were produced centrally, duplicated and sent to the provinces. Both were in the central Thai dialect.

3. **Local Programs.** To accommodate persons who use primarily one of the four major regional dialects, the NFPP allocated block grants to the provincial health offices to develop 15-minute programs on family planning. The NFPP supplied a demonstration program featuring integrated health and family planning messages which were adapted to the local culture and dialect. Fully 65 of Thailand's 72 provincial radio stations aired this program once a week.

In addition to the broadcasts, the radio programs invited listeners to send in questions to the NFPP. During the late 1970s, an average of 200 letters per month were received by the NFPP.

Sample survey data confirm that the radio broadcasts were an effective strategy. A survey of reproductive age couples in north Thailand in 1977 found that radio and television were the predominant sources of knowledge of contraception and were more than twice as important as any other listed channel of information on family planning including family planning workers and other media, e.g. magazines, posters, etc. (see Table 7 on page 54). It must be assumed that radio was more influential than television at that time because of the low level of electrification in the country-side and scarcity of televisions in the rural areas.

Infrastructure Development of the MOPH (for Population)

International funding was always an important enabling factor for the NFPP, and in the consolidation stage, a \$60 million three-year package of assistance from the World Bank made possible a substantial increase in the rural infrastructure. The package included a substantial amount of funds for construction of district hospitals and health centers and training of physicians, nurse practitioners and AMWs. The loan was based on a series of needs assessments conducted by the Bank during the mid-1970s to identify how it might contribute to the Thai NFPP. The Bank was primarily seeking ways to increase availability of services in rural areas, both through the development of rural facilities and the training of more persons to staff them.

In itself, the World Bank assistance was small compared to the needs of the country. The Bank's action, however, stimulated a surge in government-funded construction and staffing of rural health centers, the most important sources of modern contraception up to that point.

Senior Management: Program Budgeting and Management

Thailand's development efforts have long attracted international donors, but for the NFPP in the consolidation stage, even more important were the entrepreneurial skills of the program managers. These were pivotal in creating an effective donor-recipient relationship. Dr. Somsak Varakamin, since 1988 Permanent Secretary of the MOPH, may best exemplify this breed of manager.

Dr. Somsak served as Director of the Family Health Division from 1975 to 1980.⁴ During that period, not only did domestic and international assistance to the NFPP increase dramatically, but, more important, the program's ability to manage the resources increased significantly as well. The organization

⁴Prior to this post, Dr. Somsak had served as the provincial health chief in the south, after which -- in the early 1970s -- he was promoted to Chief of the Research and Evaluation Unit in the Family Health Division. From there, he went to the U.S. where he completed a Doctorate in Public Health.

Table 7

Source of Information of Contraception among a 1977 Sample
of Wives and Husbands in Northern Thailand
Methods of Communication

Part 1: Family Planning Worker

Amount Learned	Home Visit	Small Group Meetings	Public Meeting
Wife:			
No contact	82.5	97.1	86.7
Nothing	2.6	0.1	0.6
A little bit	8.9	0.8	3.2
Quite a bit	6.0	2.1	9.5
Sub-total	100.0	100.0	100.0
Husband:			
No contact	-	93.1	82.3
Nothing	:	0.1	0.6
A little bit	:	4.4	7.6
Quite a bit	-	2.3	9.5
Sub-total	-	100.0	100.0

Part 2: The Media

	Radio-TV	Magazines	Posters	Movies	Leaflets
Wife:					
No contact	39.9	85.1	65.2	79.4	90.1
Nothing	7.1	2.3	6.3	4.1	1.1
A little bit	26.7	6.2	15.9	8.8	3.2
Quite a bit	26.9	6.4	12.6	7.7	5.5
Sub-total	100.0	100.0	100.0	100.0	100.0
Husband:					
No contact	34.5	73.2	64.4	82.2	87.0
Nothing	8.8	2.0	7.3	2.0	2.1
A little bit	29.2	11.9	18.7	7.6	4.2
Quite a bit	27.4	11.9	9.7	8.2	6.2
Sub-total	100.0	100.0	100.0	100.0	100.0

Source: Shevasunt, Sompong and Dennis Hogan. Fertility and Family Planning in Rural Northern Thailand. Faculty of Social Sciences and Faculty of Medicine, Chiang Mai University. 1979

was broadened from four sections in 1974 to six sections and four regional MCH hospitals by 1980. Notwithstanding the proliferation of personnel required to serve in this expanded program, Dr. Somsak exerted strong control over the day-to-day management of the NFPP.

He found ways to attract and interest donors in projects that he wanted financed (e.g., through awards to donor representatives), and the international community proved eager to have a role to play in the successful Thai family planning effort.

Dr. Somsak was also an effective lobbyist for increased domestic support to the NFPP. In 1982, when USAID began a phasing out of its support for contraceptive commodities, he convinced the National Planning Board and National Budget Bureau to increase the government budget for contraceptives from \$750,000 to \$6 million annually. This rapid transition to government support is truly exceptional in view of Ministry of Finance regulations, which limit the annual budget increase for any division to no more than 15 percent. (The increase in the commodities budget had the effect of increasing the entire FHD budget over 200 percent -- from \$2.6 million in 1981 to \$8.1 million in 1982.)

Dr. Somsak's description of his management approach of the NFPP confirms several of the lessons already pointed out in this report: namely, the importance of allowing the private sector to complement public sector efforts; the key role of a well-developed infrastructure; and the value of training. In Dr. Somsak's words:

"In administering the NFPP directly, I adopted a hierarchy of priorities. First comes the national goal, which in this case was the acceptance of family planning services. Viewed this way, it did not matter whether it was more private sector or public sector but whatever contributed to the common goal that should be supported. Second priority in the hierarchy goes to the organization, which in this case was the MOPH. I tried to manage the program in such a way to achieve lasting improvements to the MOPH infrastructure and ability to provide quality services to the public. Finally comes the individual goal. In this respect I took a personal interest in the development and advancement of the staff who were administering the NFPP at all levels. I made an effort to see that all key program managers received advanced training in the relevant public health disciplines and this enabled me to make promotions according to ability and qualifications and not based on seniority alone." [Personal interview in March, 1990]

Shortcomings

During the growth and consolidation stages, the NFPP has suffered from a number of notable, though minor, shortcomings.

Stockouts

Stockouts occurred as a result of too rapid growth. In 1975, for example, the NFPP authorized the provision of the injectable contraceptive Depo-Provera

in all hospitals throughout the country. In a rare case of mismanagement, the NFPP severely underestimated demand for the three-month contraceptive and rapidly ran out of stock. It took three years and emergency support from the UNFPA and the Canadian International Development Agency to achieve a stable state of supply and demand. A 1973 research study had given evidence of the popularity of the injectable, but the report was in English and probably was not read or taken seriously by NFPP managers. This oversight was a result of the second shortcoming.

Lack of Utilization of Program Research

The 1973 research study cited above is one example of the underutilization of research results in the Thai program. Although funding for research proliferated in the Growth and Consolidation stages, program research was largely an end in itself. Many factors that contributed to the failure to use research results in the Thai case may apply to other programs as well: (1) Donors generally approached the NFPP research unit, rather than program managers, to assess research needs; (2) Research reports were almost exclusively produced in English to meet donor requirements; (3) NFPP managers were rarely given oral briefings of the research results; (4) Program managers were too impatient to delay a decision for the months (or perhaps years) that normally elapse until research results were known; and (5) Most management decisions in the Thai program produced good results (or at least did no harm) even without the benefit of a controlled research design.

These are all valid reasons, but they do not justify the vast amount of domestic and international resources spent on research that was never used to help set the course for the evolution of the NFPP.

Weak Management Information System

Very early in its history (1974), the Thai NFPP inaugurated a monthly computerized print-out of new acceptors by contraceptive method and administrative area. Computerization may have been a mistake at that stage for a variety of reasons: (1) Computer time and programming skill had to be purchased at considerable cost from the private sector; (2) The print-out was in English and used cryptic abbreviations which managers had difficulty interpreting; (3) The emphasis of the report was on new acceptor totals, and did not include dropouts or their impact on contraceptive prevalence.

Over the years these deficiencies have been corrected, but they could have been avoided if a more appropriate design had been employed -- for example, bilingual, hand-typed reports. At the time, however, the senior management of the NFPP defended the bulky computer printout, taking the position that "a large multi-million dollar program" should not have its work reflected in "a slim activity report."

7. Mature (circa 1985-90)

Overview

As of 1984, Thailand had achieved a high 62 CPR (modern methods) or an even higher total CPR of 64.6 percent. Predictably, at this juncture, additional increases would be very difficult to achieve. Nonetheless, during this mature stage (1985-90), the program was able to attract additional users, so that by 1987, total contraceptive prevalence had risen another 3 percentage points -- to 67.5 (modern methods, 65.5). This was well within striking range of achieving a replacement fertility rate -- which was estimated in the Thai setting to require a CPR in the low 70s.

For any family planning program, the effort to sustain the considerable progress that enabled it to reach the mature stage may be its greatest challenge. In a programmatic sense, what becomes essential is a switch in emphasis from attracting new acceptors to retaining existing users. The Thais understood this, incorporating a target of a high 75 percent CPR into the current Five-Year Plan.

Since it entered the mature stage, the NFPP has not abandoned efforts to attract new users but rather has continued its strategy, begun during the consolidation phase, of outreach to low CPR areas. At this stage, however, other government bodies have also attempted to recruit new users, and, although at times their tactics have contravened accepted approaches, the NFPP has allowed, and even supported, their efforts.

One of the most surprising aspects of the program during this late stage is that, despite the availability of family planning services in the private sector, the government has not relinquished in the least its commitment to funding the family planning program. The degree to which this is a reason for the success of the NFPP is one of the unanswered questions in the Thai experience.

National CPR Target

The series of contraceptive prevalence surveys (1978, 1981, and 1984), in combination with a new report that gave a province-by-province report on CPR nationwide (see below), had a significant impact on how central policy-makers evaluated the progress of family planning in Thailand. In the mid-1980s, the NFPP made an important shift from viewing new acceptors as the premier measure of achievement to recognizing users as the quality indicator. In a young program, counts of new acceptors are an appropriate barometer of demand and method preference. When the majority of the eligible population accepts family planning, then contraceptive prevalence becomes the indicator of choice. Finally, the ultimate indicator of program achievement will be total fertility, which should converge with the national goal for average family size.

By 1985 the Thai government was considering replacement fertility as an attainable (and desirable) goal for the Sixth Five-Year Plan period (1987-1991). To this end, the RE Unit applied the Bongaarts TARGET model to estimate the contraceptive prevalence level required to achieve a TFR of two. It was found that, with the age structure and mortality levels at that time (1984-5), a CPR in the low 70s would be adequate to achieve a TFR of 2.2, i.e., replacement fertility. As a consequence of this analysis, the Thai family planning program introduced a (conservative) target of 75 percent contraceptive prevalence to be achieved by the end of 1991.

This CPR target was incorporated into the Five-Year Plan, complementing the crude birth and death rate targets that had regularly been a feature of the plan. From a programmatic standpoint, the effect should be to encourage program managers to be increasingly zealous about the quality of the services being provided, with the end result of increasing client satisfaction and thus reducing any possible loss of acceptors.

Targeting of Low-CPR Areas

One of the reasons that a CPR target was incorporated in the most recent Five-Year Plan was that, by the mid-1980s, it had become both practically possible and well accepted to assess program performance in terms of CPRs. The capability grew out of the 1980 census (see above, Chapter 6), which allowed calculation of estimates of CPRs by method, by month, for every district and province in the country. In 1984, the FHD began producing a Thai-language report based on the census findings. These reports were distributed to senior management within the NFPP and MOPH and to every provincial health office throughout Thailand.

The most significant use of these new data was for the Lagging Provinces Project, funded by USAID over a four-year period (1986 to 1989). In this project, the districts with the lowest CPR were targeted for intensive family planning case recruitment. This approach contrasted with that used during the consolidation stage, when program planners focused on underserved population sub-groups (e.g., hilltribes, southern Muslims). Now, the NFPP was able to use *performance* as a criteria for resource allocation. By virtue of this project, the CPR report of the NFPP grew in importance as a management tool for central and provincial managers and the term "CPR" became well understood throughout the hierarchy of the MOPH.

Ministry of Interior Involvement in Family Planning

From the beginning of the NFPP, family planning activities were the clearly established responsibility of the MOPH. Thus, it was an unlikely scenario that brought the MOI into the national family planning arena. The MOI is the largest and most important ministry for the running of government affairs in Thailand. The police, rural development, provincial administration and numerous other agencies fall under the MOI. All government activities in a province are overseen by the governor, an official of the MOI.

In 1982, the governor of one province in the northeast region was determined to reduce the population growth rate of his province to zero within two years. This governor strongly believed that the development programs he was pursuing could not be achieved unless the population were stabilized. He instructed the local health office to calculate how many IUDs would be needed to achieve zero population growth in two years and began organizing IUD insertion camps.

This mass approach to the promotion of a single method was contrary to NFPP strategy. Instead of contradicting the governor, however, the MOPH supported him through provision of supplies and publicity. Thousands of women had IUDs inserted during the two years. Many were undermotivated, however, and the campaign fell far short of its goal because of high removal rates [35]. Surprisingly, the IUD camps were copied by other governors and the MOI became increasingly involved in demographic target setting and case recruitment.

The NFPP position was that more government agency support was welcome but that the program could be damaged if senior MOI managers were not fully knowledgeable about basic population dynamics. It therefore requested the UNFPA to fund a multi-year program of training and study tours for provincial and district governors. This program began in 1987 and ended in July 1990.

The experience of the MOI initiative in population is instructive on a number of points: (1) Without proper education on the relationship between population and family planning variables, authoritative officials may resort to unrealistic targets which can result in unmotivated acceptors; (2) At the same time, the NFPP tolerated the MOI role because it brought more resources into the program and drew many couples into the NFPP service network who had not participated before; (3) The involvement of the key development ministry in support of family planning reflected widespread acceptance of the notion that rural population growth can be detrimental to numerous development programs.

Incentives

The MOI's experiments with family planning targets paved the way for the first use of material incentives for acceptors in the government service program. Use of acceptor incentives was never sanctioned by the MOPH and the NFPP, but these organizations also could not forbid the provincial governor from compensating acceptors. The action brought the issue of incentives into the open and led to provincial experimentation with various approaches to attract clients using token gifts (e.g., wash cloths), lucrative raffles (e.g., first prize of a TV set or buffaloes), and service benefits (e.g., free medical insurance for one year).

The private sector had been bolder in exploring the use of acceptor incentives and was refining its approaches in the mid-1980s when the Thai

NFPP entered the mature stage. One of the most successful private sector incentives programs was the Community-Based Incentives project of Mechai's Population and Community Development Association [36]. In this project, village development funds were compensated in proportion to the increase in CPR of the entire community. In this way, villagers could benefit only from collective action. The project was able to raise the CPR very rapidly, loan funds were distributed equitably and local income was raised at the same time. The mechanism by which the project succeeded was the activism of the village loan fund committee members, who were local villagers. It was these individuals who fully understood the link between CPR and the size of the loan fund and, consequently, they became an effective lobbying force for family planning. USAID and the FHD were sufficiently impressed by the success of the project that it was replicated in a low CPR area of the northeast region.

In the context of the prevailing high demand in Thailand for family planning, it is puzzling why both the public and private sectors felt the need to resort to incentives to accelerate increases in prevalence that were occurring naturally. One risk was that incentives would inflate demand temporarily but then would recede after the incentives were discontinued. Another potential risk (one true for all incentives programs) was the danger of producing involuntary acceptance. Thailand's NFPP seemed impervious to any of these risks, however. No popular backlash has ever occurred in response to (the rare occurrence of) forceful case recruitment, and the momentum of increasing prevalence has not slowed over the years.

Instead of playing a galvanizing role, incentives appeared relatively late in the history of the Thai program and acted primarily as an expensive supplement to an already mature service delivery system.

Sustainability and Domestic Support

As a country develops economically, as Thailand has, the government might be expected gradually to reduce its role in service provision, allowing the private sector to assume greater responsibility. In Thailand, the reverse has been true. National sample surveys show that the proportion of users whose source of contraception is a government outlet *increased* during 1981 to 1984 and from 1984 to 1987 (see Table 8 on page 61).

Instead of decreasing the public subsidy for contraceptive services, the Thai government has increased its investment every year since 1982. The managers of the NFPP and senior MOPH officials justify this policy on the grounds that the return on investment in family planning is better than in practically any other area of social services; that the government is actually saving money by underwriting family planning services; and that introducing cost-recovery would result in loss of users and loss of NFPP momentum toward its goals.

Table 8

Percent of Users (all methods) Obtaining Their Contraceptives from a Government Outlet (four national surveys)

1978 (CPS1)	76.9%
1981 (CPS2)	78.2%
1984 (CPS3)	79.2%
1987 (DHS)	81.9%

In fact, the sample surveys also show that couples are paying for contraceptives even at the government outlets. The latest national survey to ask about cost per service shows that the average price per pill cycle from government outlets is \$0.16 even though the MOPH policy is to provide pills free-of-charge [37]. This breach of policy reveals several points: (1) The public is willing and able to pay for contraceptive supplies; (2) Health center and hospital staff feel it is appropriate to charge for services; and (3) NFPP managers are unofficially tolerating fee-for-service.

Nevertheless, even in cases in which service fees are allowed (e.g., injectables, implants), the funds are not used to purchase new supplies but are retained by the local health outlet for any health service support expense. Not only does the Thai government resist privatization, but it is not even ready for the intermediate step of cost-recovery. This policy is not likely to change in the near future.

8. Issues and Lessons Learned

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8. Issues and Lessons Learned

Introduction

It is possible to isolate a number of key ingredients in the 20-year success story of the Thai family planning program. Some appear obvious, features necessary to ensure the success of any family planning program, whereas others are surprising. Some have exerted a particularly strong influence during one of the five stages of the program, although most have continued to be important throughout. Some are program-related and easily documented, whereas others are more nebulous, stemming rather from special characteristics of the Thai population and its leadership.

The following analysis views the NFPP's performance from six perspectives:

- 1) policy, its importance and its manifestations;
- 2) demand for services, its extent and government efforts to generate additional demand;
- 3) supply of services, i.e., the broad range of activities that have made family planning widely accessible throughout the country;
- 4) demographic research and its practical uses;
- 5) financial resources available to support services; and
- 6) special characteristics of Thai leadership.

As will be seen below, these factors are so closely interrelated that it is difficult to identify which ones deserve greatest credit for Thailand's success in family planning. In this paper, therefore, no effort is made to rank these factors in this way. Rather, the conclusion is that Thailand's success story reflects the country's own unique blend of national, societal, and programmatic influences.

On the other hand, a number of lessons have been learned from the Thai experience that may have broader applicability. The following discussion focuses on these lessons, distinguishing insofar as possible the general lesson from its particular manifestation in Thailand.

Population Policy Issues

The Need for a Policy

One of the more intriguing questions in the field of population is the extent to which a government policy that specifically supports family planning is essential to the popular acceptance and use of contraceptives. The Thai experience suggests two answers. On the one hand, a program may not

need the endorsement of an explicit policy to be launched successfully. In Thailand, in fact, the seven years it took to promulgate a policy provided time for a firm foundation to be laid for the NFPP. On the other hand, over the long term, the existence of a strong formal population policy has been indispensable to the success of the Thai family planning program. The policy legitimized family planning and provided the basis for the development of a national program with its own budget.

Particular attention should be directed to how, on an operational level, the Thais made use of the pre-policy period. While publicly debating population issues at national seminars, Thai officials were quietly allowing an informal system to evolve that resulted in formulation of operational policies. The system, which involved exploratory research on possible program interventions followed by pilot studies that were evaluated, virtually guaranteed that no program would be undertaken nationally unless its success seemed fairly certain. This approach also helped avoid confrontations on the issue of legal barriers. For example, legal barriers such as the prescription of drugs by non-physicians were reviewed in pilot studies, and any recommendations for changes in the policies could then be made on the basis of practical evidence.

Use of this experimental approach has been characteristic of the Thai program throughout its history. Its mark was perhaps greatest during the 1963-70 period, since that was when the foundations of the government program were laid. Experimental efforts were particularly influential in providing evidence that rural demand for services existed (the Potharam experiment) and that this demand could actually be met if AMWs were to be given authority to dispense pills. This evidence in turn paved the way for the government and donors to embrace a national family planning program. Later experiments were also important to the program, however (e.g., another demonstration project paved the way for nurses and AMWs to insert IUDs and use of multi-method mobile service was ruled out on the basis of evidence that the single-service mobile vasectomy unit was more cost effective).

Lessons Learned

A population policy need not be in place to support initial family planning service provision efforts, and indeed, lack of public attention to the population problem may offer a good opportunity for laying a foundation for a national program.

Over the long term, however, an explicit government policy supporting family planning is an invaluable asset. The Thai NFPP could not have been fully successful without a formal population policy and the government resources that this brought.

Testing various service delivery approaches before full-scale implementation is always a sound approach and in Thailand represented one of the principal reasons for the program's overall success.

The Rationale for a Policy

Economic Justification

The Thais have consistently responded to the economic arguments for family planning. In particular, it was the consequences of population growth on economic development, rather than the health rationale for family planning, that was the primary motivating force for establishing a population policy.

This perspective appears to have strengthened the program in two ways. The first is that the emphasis on the economic ramifications of population growth has had an appeal to a wide range of government policy-makers (e.g., a provincial governor became involved in various family planning efforts because he believed that population growth was endangering various rural development programs), and thus national support for the program has been forthcoming throughout its history.

A second ramification of the downplaying of the health issues is that the NFPP has not been accorded the relatively obscure status of a subsection within an MCH effort. Rather, the government has allowed the program to operate independently, with considerable public acclaim and ample budgetary resources. The importance of this is discussed below.

Vertical vs. Integrated Family Planning Program

That the NFPP is a vertical program may seem surprising since it has been widely reported that the reason for the success of the Thai program was the integration of family planning with MCH. This is incorrect. For most of the history of the Thai program, family planning has been pursued almost to the exclusion of MCH.

The Family Health Division (FHD -- the name given to the MOPH's MCH Division after the NFPP was created) has increasingly become a family planning agency. It has responsibility for logistics, training, information dissemination and research for all government family planning activities throughout the nation. Because all bilateral and multilateral funding for population activities passes through the FHD, and because the amounts of funding allocated to this activity in Thailand have continued to mount, this division has become increasingly powerful and its dedication to family planning activities has grown accordingly, at the expense of MCH. Indeed, the rapid growth of family planning has all but eclipsed the development of MCH services.

Although family planning and MCH services themselves are not integrated, the family planning efforts continue to depend on MOPH facilities for

delivery of services, using the existing infrastructure of hospitals and health centers. As the health system has expanded, family planning service points have also increased. No parallel infrastructure has been established. This approach has been very cost-efficient for the family planning program, as well as for the government.

The popularity of family planning has also served to revitalize some government MCH facilities -- in particular, midwifery centers. The MOPH constructed and staffed a considerable number of these in rural areas in the 1950s and 1960s.⁵ They were intended to be places for ante-natal care and delivery services, with additional health promotion activities in health education, nutrition and vaccination. Utilization of these centers was negligible, however, because rural women preferred traditional birth attendants or, if necessary, delivery by a physician in the hospital setting [38]. In the period before the NFPP, the midwives who staffed these centers were essentially idle.

The use of these midwifery centers changed dramatically after government midwives were given a role in family planning in 1970. As suggested, the management decision to de-hospitalize contraception represented a major departure at the time and was possibly the most important program action ever taken. Because of the enormous reservoir of demand for birth control, the AMWs had merely to announce the availability of the new service to a few innovative village women to begin a flow of acceptors that lasted a decade. From underutilized facilities with little or no business, these centers became busy family planning facilities in which pills were readily available, IUDs were inserted, and contraceptives were freely discussed between client and provider.

Lessons Learned

Economic arguments for the need for family planning programs may have greater appeal to a wider range of government officials than do arguments based on the health benefits of controlling fertility.

A family planning program within a ministry of health structure can have maximum effect if it can retain its budgetary and management authority while using the ministry's infrastructure to deliver services.

Demand for Family Planning

Importance of Pre-Existing Demand

This paper provides multiple examples of the strong and widespread demand for family planning that existed throughout the country before there was any IEC effort to awaken or cultivate it. The enthusiastic response to early

⁵The midwifery center consisted of a one-room building located in a village and staffed by an auxiliary midwife. All these centers have since been upgraded to three-person health centers.

experimental and pilot service delivery efforts indicated that even the most remote Thai villager was ready to take steps to limit the size of her family as soon as the opportunity presented itself. This lesson was repeated when AMWs were given the authority to dispense the pill; once again, it was simply necessary to make known that a new contraceptive service would be available and women flocked to utilize it. The story of the 17 village-level women who went for minilaparotomies after hearing of the successful experience of their fellow villagers once again demonstrates the proposition: Thai women were ready to avail themselves of family planning services once they learned about them from their peers.

Without doubt, existence of this demand was an indispensable ingredient of the swift rise in contraceptive prevalence in Thailand over the past 20 years. Just how important, it is impossible to measure, but it is safe to say that it was key to ensuring that virtually all program efforts that were initiated would be utilized fully.

It is equally difficult to establish definitively why demand in Thailand was so strong. There is no reason to disbelieve the crude socioeconomic indicators that appear to credit women's readiness to use contraception to low infant and childhood mortality and the high educational level that improved their status. The monograph on Thailand's reproductive revolution by Knodel, Chamratrithirong and Devbavalya points out that the demand for smaller families among rural women was present at least a generation before modern contraception was available and fertility actually began to decline. The mystery of this advance demand may never be solved, however, and is probably so interwoven with the cultural fabric of Thai society as to be unreplicable.

Lessons Learned

The existence of a strong demand for family planning is an essential ingredient of any successful family planning services program.

Improvements in women's status and the lowering of the mortality rate, particularly infant and child mortality, most likely play an important role in providing the impetus for women to recognize the need for family planning and seek services.

Increasing the Demand for Family Planning

Because of the already high demand for family planning when the NFPP had started in 1970, the strategy of the program was to begin by increasing access to family planning services as quickly as possible. Major efforts in demand creation took place later in the program when different groups of acceptors needed information and motivation to accept family planning. It was accompanied by a variety of outreach efforts to underserved populations,

even if those populations represented minorities who were outside the mainstream of Thai culture.

Mass media

In the 1960s, family planning information was primarily conveyed by satisfied users and clinic personnel. It was not until the late 1970s that mass media techniques were fully utilized. The delay stemmed in part from government realization that IEC efforts were not needed originally; the concern was with meeting existing demand, not generating new. When mass media efforts peaked, it was during the consolidation stage, when much of the government effort was directed to extending the program to sub-groups who were difficult to reach and hard to convince of the value of contraception. The mass media approach represented one way of reaching these populations.

The radio was the key medium for informing the population about family planning during the late 1970s, due to the high level of radio listenership in both urban and rural areas. The "entertainment-education" techniques used were found very popular. Since family planning was national government policy, free air time was given to the NFPP. By the late 1970s, the radio was the single largest source reported by the women for information on family planning.

Lessons Learned

If a high level of demand for services exists when a family planning program is inaugurated, it may be wise to postpone any IEC efforts until the initial demand is satisfied.

Depending on the media habits of the population, the use of either radio or television can generate widespread interest in, and knowledge about, family planning among the general population. If the media is under the control of the government and the family planning program can arrange for free air time, the mass media approach can be even more cost effective.

Formal Population Education

The adoption by the Ministry of Education of UNESCO's broad approach to population education was possibly a mistake. UNESCO's approach does not deal with how family planning and adolescent sexuality relate to responsible parenthood. These are, however, issues of particular importance as younger men and women are exposed to the risks of childbearing and STDs, including AIDS. In addition, the Ministry missed an opportunity to reach the vast majority of the young population by its decision to introduce population education in the secondary grades with diminishing numbers of students attending each year rather than in the primary grades that are attended by most of the youth population.

Lessons Learned

The effectiveness of in-school population education may be increased by 1) taking a direct approach in dealing with family planning and other important topics concerning reproductive health and 2) introducing the curriculum in the primary school system in order to reach more students at an earlier age.

Incentives

Client and community incentives were introduced in the Thai program relatively late, in the 1980s when prevalence was high. Community-based incentive programs that linked development funds for the village with the CPR of the entire community were successful in some low-prevalence communities in raising the CPR and increasing local incomes at the same time. On balance, however, these incentives appear to have been unnecessary at so late a stage of the Thai program. The use of contraception was already widely accepted and would more than likely have spread to these low-prevalence communities in time, without the use of costly incentive schemes.

Lessons Learned

Incentives schemes for family planning may not always be cost effective. In Thailand, instead of playing a galvanizing role for contraceptive acceptance, the incentives acted more as an expensive supplement to an already mature service delivery program.

Mass Promotion of Single Method

The Thai program has had only isolated experience with a mass approach to the promotion of a single method -- IUD camps involving demographic target setting and case recruitment. These were initiated through the MOI and, although they had the NFPP's support, proved that the NFPP was correct in never having itself adopted this approach. Lack of understanding on the part of both the target groups and the officials in charge doomed the first of these efforts, with the campaign falling far short of its goals. It remains to be seen whether efforts to educate officials in family planning issues will change the situation.

Lessons Learned

Mass promotion of a single method has the potential for inflating demand temporarily and for inducing involuntary acceptance. Therefore, great care should be taken before a program decides to use such an approach to increase prevalence.

Outreach

The NFPP has been vigorous in its efforts to attract into the family planning fold such hard-to-reach groups as hilltribes, Muslims, and adolescents. The success of these efforts is not as important as the government's willingness to make the effort. The significance is that, when the contraceptive prevalence in Thailand had reached the mid-30s -- a point at which many family planning programs tend to stagnate -- the NFPP was not content to rest on its laurels. Rather, it recognized that some groups remained underserved and turned its attention to bringing them into the program. Unlike some other countries, Thailand was willing to work with these groups although they did not fall into the mainstream ethnically (hilltribes and southern Muslims) and although they presented very sensitive societal issues (adolescents).

Lessons Learned

To increase prevalence past the median level (mid-30s), it may be necessary for the national program to make special efforts to attract groups that lie outside the mainstream contraceptive public (i.e., MWRA from predominant ethnic groups).

Increasing Access to Family Planning

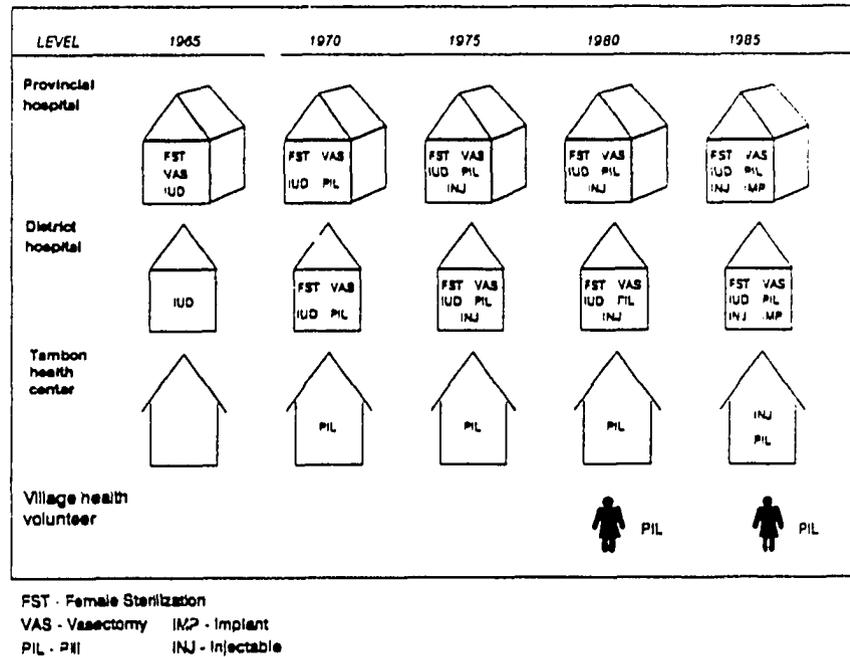
Thailand boasts an extensive and reliable infrastructure for delivering family planning services, ensuring reasonable access to services to nearly everyone in the country. The infrastructure includes a widespread network of facilities, but its effective functioning relies on three other factors: (1) trained, credible staff in every outlet; (2) a broad mix of methods whose supply is reliable; and (3) good, year-round road access to outlets and frequent public transport. This last aspect was beyond the control of the NFPP, but proved to be a critical component to the success of the family planning program.

Health Facilities

Before the national program began, family planning services, consisting of female and male sterilization and IUD insertion, could be obtained only in provincial hospitals in the public health service; some district hospitals could insert IUDs. By the time the program had been initiated, service outlets had increased -- some district and private hospitals could provide sterilization and IUD services and peripheral health centers could provide oral contraception. By 1980, village health volunteers could provide oral contraceptives in the community. Mobile services have also been provided by both the MOPH and NGOs to provide family planning services in rural areas. The increase of access points for provision of contraceptives has multiplied many times over and some type of service is readily available to every person (see Figure 7 on following page).

Figure 7

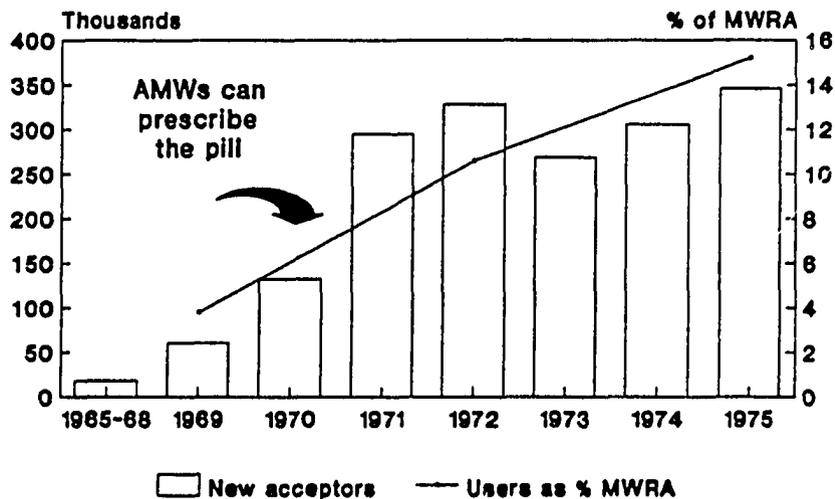
Thai Public Health Service Infrastructure and Family Planning Services, 1965-1985



An important aspect of the increase of access points was the MOPH's policy to allow non-physicians to take an active part in the provision of pills, the giving of injections and in the insertion of IUDs. The MOPH willingly delegated authority for clinical procedures to nurses and AMWs out of a genuine appreciation of their skills and competence (see Figure 8 below).

Figure 8

Acceptance and Current Use
Oral Contraceptives, 1969-1975



NFPP data and national sample surveys

The NFPP's heavy reliance on women providers -- AMWs and nurses -- began as a means of increasing the availability of pills, injectables, and IUDs in the rural area, but it proved to have the added benefit of being very popular with clients. External evaluations have repeatedly identified the large number of women providers as an important ingredient of the success of the Thai program.

The Thai government's open acceptance of multiple provider efforts represents another reason for the program's success -- a redundancy of effort that has served to sustain the momentum of the program. Even with a well-established network of rural health centers, the government promoted mobile units so vigorously that they eventually covered all 72 provinces. It also supported Mechai's village-level pill distribution program even though AMWs could also prescribe the pill in remote areas.

Lessons Learned

Extending responsibility for the provision of family planning to paramedics increases access to family planning. This was particularly true in Thailand, where paramedics have provided the overwhelming bulk of services, particularly in rural areas.

Female providers of family planning services are usually preferred, a proposition definitely proved in Thailand.

Multiple service delivery points for services increase usage. Indeed, in Thailand, duplication of family planning services, while not always efficient, has had a positive effect on increasing coverage.

Training

The primary reason that the NFPP got off to a successful start was that trained personnel were in place to provide services at the moment the program was launched. MOPH officials deserve considerable credit for their foresight in this regard.

Throughout the program's life, training has remained a predominant feature of the NFPP. All key program managers receive advanced training in relevant public health disciplines, thus enabling promotions to be based on ability and qualifications, not only on seniority. At the services level, all the different categories of staff receive training, and special in-service training has been provided as new contraceptives have been brought into the program or as new cadres of family planning staff have been enlisted to provide services. In-service training has become a regular part of the FHD's program, and it has been systematized through the development of a comprehensive training plan for all categories of service personnel. To support these various approaches, Thailand has had access to a large amount

of foreign aid for training (e.g., from USAID, UNFPA, Program for International Training in Health, Pathfinder, etc.).

An underlying factor in this picture is the high priority that Thai civil servants have always placed on continuing education. Additional training, especially training that confers a new skill or certificate, is seen as contributing to advancement potential and is viewed as a status symbol, reflecting the prestige conferred on an individual who is selected from among his or her peers.

Training has, in fact, been overemphasized at times. For example, when NORPLANT[®] sub-dermal implants were introduced into the NFPP in the mid-1980s, one physician from every district hospital in the country was trained and given 10 sets of implants. Demand rapidly exceeded supply (because the NFPP was unable to purchase adequate stocks of the costly implants), leading to some consumer dissatisfaction.

In general, however, the training experience of the Thai program has been positive, justifying the policy of offering as much training as possible to all cadres. The most radical (and effective) aspect of the training policy was the willingness of the medical administrators to delegate authority for clinical procedures to nurses and AMWs. In this regard, Thailand is more progressive than "developed" countries, where physicians still control clinical services.

Lessons Learned

To ensure a successful launch of a new family planning program, it is essential that trained personnel be in place.

The development of a training system that provides for regular upgrading of skills of all program staff, from top management to service providers to motivators, is a basic requirement to increase access to quality family planning services.

Training works best among individuals who are ambitious and who look to such opportunities to lead to professional advancement. Thus, the Thai civil service has been particularly receptive to training programs.

Ready Supply of Appropriate Contraceptive Methods

Although there was never an explicit policy in this area, the NFPP has consistently promoted as wide a selection of contraceptive methods as possible and avoided promotion of one method at the expense of another. A review of the history of method preference (based on prevalence) shows that different methods have predominated at different times over the years.

Specifically, in succession, the most popular methods have been the IUD (1965-69); female sterilization, (1970); the pill (1972-1984); and female sterilization (1984 to present). Over the most recent five years, the most rapidly increasing method in terms of acceptance and prevalence has been the injectable, reflecting most likely the authorization of AMW injection in 1985 (see Table 9 below).

Table 9
Contraceptive Prevalence by Method and Era

	Percent of Currently Married Women 15-44 Using:				
	IUD	Pill	Sterilization		Injection
			Female	Male	
1969/70	2.2	3.8	<u>5.5</u>	2.1	0.4
1972/73	4.7	<u>10.6</u>	6.8	2.8	0.9
1978/79	4.0	<u>21.9</u>	13.0	3.5	4.7
1984	4.9	19.8	<u>23.5</u>	4.4	7.6
1987	7.2	20.0	<u>22.4</u>	5.5	9.2

Source: Derived from Table 3 in this report

Between 1965 and 1969, when IUDs were the most commonly used method, there were 175,000 new IUD acceptors compared to 78,000 pill and 63,000 female sterilization acceptors.⁶ The IUD was receiving emphasis in the post-partum project, but sterilization and pill services were given equal attention, and by 1970, sterilization had become the most popular method. This was in turn quickly surpassed by the pill after AMWs were authorized to prescribe oral contraceptives. The pill reigned for a decade as the most used method until expansion of sterilization services brought female sterilization to the forefront.

Although the number of new acceptors of female sterilization was only one-fifth of the total pill acceptors, the nearly 100 percent continuation rate and declining age at acceptance (currently 29 for female acceptors) created an increasingly large group of users of this method. By the early 1980s, female sterilization had surpassed the pill as the most common method of family planning for Thai couples.

These trends reflect two factors: method availability and the needs of different groups of women. It is not difficult to trace the influence of the first: IUDs were popular in Thailand when they were virtually the only method available; the pill gained rapidly as soon as it was easy to get; and

⁶These figures came from service statistics of the Family Health Division.

sterilization became popular when the government improved the delivery system for that method. With respect to women's needs, the obvious holds true in Thailand as it does everywhere: women's contraceptive needs change as they proceed through their reproductive cycles from a desire to space births to a preference for limiting births.

Lessons Learned

Promotion of as wide a selection of contraceptive methods as possible may well be a factor in increasing prevalence. The availability of multiple methods ensures that women in all phases of their reproductive lives will be able to find an appropriate method. In Thailand, the introduction of new methods has tended consistently to attract new groups of acceptors.

Transportation System

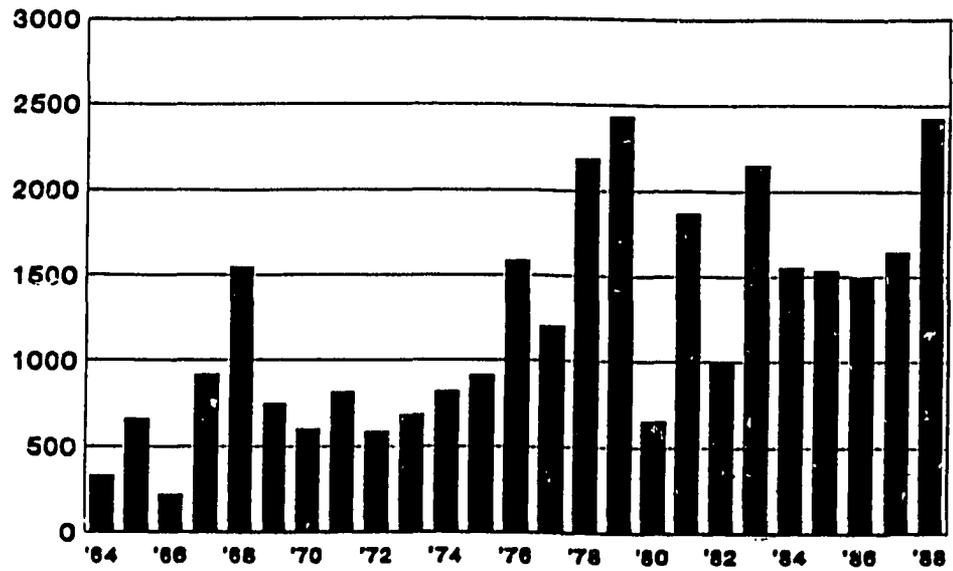
The growing MOPH infrastructure could be steadily developed and maintained in the 1960s because the communications network of the country was developing rapidly, primarily through the development of year-round roads. USAID was a principal source of funds in road construction. These links would prove indispensable to the success of the NFPP by promoting the following: (1) access to contraceptive service outlets; (2) access to markets for women and exposure to new ideas; and (3) access to more schools and, thus, perceived opportunities for their children. A reliable road system also facilitated the delivery of contraceptives and helped prevent health center-level stockouts as well as allowing mobile family planning clinics to provide services in disparate villages (see Figure 9 and Table 10 on the next page for information on the developing transportation infrastructure).

Access to a wide range of outlets reduced the dependency on a single outlet that might suffer from a variety of deficiencies (e.g., impolite staff, occasional stock-outs, limited choice of methods.) A multivariate analysis showed that, even as late as 1987, mobility was an important determinant of contraceptive prevalence. Rural women who had taken at least one trip to town in the past month were significantly more likely to be practicing contraception than were women who did not travel to town [39].

This was probably because the construction of year-round roads and the development of a public transportation system opened a number of doors for women. As they traveled afield from their villages, they began to be exposed to new ideas. They learned of educational opportunities for their children and discovered goods for sale in the marketplace. Such exposure led many to begin to consider the cost implications of raising large families. For those concerned, information on how modern family planning could help control family size was available in larger towns, as was better access to a variety of contraceptive methods.

Figure 9

Provincial Roads
Kilometers Constructed by Year



Source: Department of Highways

Table 10

Budget Spent on Roads as Percent of National Budget

Year	Percent	Year	Percent
1965	8.3	1977	6.5
1966	10.9	1978	6.6
1967	12.2	1979	6.7
1968	11.3	1980	6.3
1969	10.9	1981	6.3
1970	10.7	1982	5.5
1971	10.7	1983	5.2
1972	9.0	1984	4.7
1973	9.0	1985	4.2
1974	8.5	1986	4.1
1975	7.8	1987	3.8
1976	7.4	1988	4.1

Source: Department of Highways.

Note: The decrease in the percentage of funds allocated to roads reflects the increasing size of the national budget, rather than any real decrease in the amount allocated to roads.

Lessons Learned

A good transportation system can be an important factor in the success of the family planning program. This has been true in Thailand, and not only for such obvious reasons that it helped guarantee commodity availability and made possible mobile services. It has also served to increase the mobility of women, and this both gave them access to a wider range of outlets and exposed them to new ideas that increased their receptivity to using modern contraception.

Demographic Research and Its Practical Uses

Thailand has one of the most extensive sets of data on population and family planning indicators of any country in the developing world, and these have been unusually influential in helping to shape the family planning program.

Very important in the overall evolution of the Thai NFPP are the decennial censuses, which provided evidence of rapid population growth. More than any other item of data, the estimates of the population growth rate gave force to proposals to formulate a population policy: The 1960 census shocked policy-makers into realizing that steps were needed to control population growth and the 1970 census reinforced this message, finding that the country's population had doubled in 20 years. The 1980 census, on the other hand, provided convincing evidence that the growth rate had slowed and that the family planning program was having an effect.

During the 1960s and 1970s, censuses and sample surveys produced primarily national tabulations. By the late 1970s, surveys and enumerations began describing important sub-groups of the population that were perceived to be in special need of development programs and this helped make possible the various outreach efforts that characterized the consolidation stage of the Thai program. Later, thanks to the inclusion of family planning questions in the 1980 census, it became possible to target districts with the lowest CPR for special program interventions. The existence of solid CPR statistics, together with their proven usefulness as a programming tool, led to the government's incorporating a CPR target in the sixth Five-Year Plan.

Taken together, census and survey data have been essential ingredients in the Thai success story. They provided sufficient data for formulation of Thailand's population program policy and maturation of the program. They helped steer NFPP managers to regions of greatest need. Censuses allowed calculation of contraceptive prevalence in small administrative areas, thus allowing for more efficient resource allocation to underserved populations.

MIS data are also collected, but they have not been as important in decision making as the data collected from the various surveys. This was particularly true early on when new acceptor data alone was generated by the MIS, which tended to inflate estimates of achievement because method- and clinic-switchers were counted as new acceptors (as they are in most programs).

Both MIS and survey data have proved useful as monitoring and evaluation tools. MIS data were particularly relevant when the focus was on new acceptors, but as the program matured and attention was turned to retaining continuing users, CPR data from surveys that counted continuing users was more useful. The interest in continuing users meant that service delivery techniques would increasingly focus on quality of service and client satisfaction issues, and the availability of CPR data gave program managers information by which they could assess provider performance.

Lessons Learned

Developing strategies to meet the specific needs of various population groups require the periodic collection of population data through surveys and censuses. In Thailand, the information collected helped officials understand the target population and thus enabled them to develop appropriate strategies to meet the needs of these groups. These data can also serve as monitoring and evaluation tools.

Sample surveys and the census are the key data collection instruments when the need is for major strategic decision making. MIS data were clearly not as important.

Financial Resources

Availability of International Funding

Throughout its history, inadequate funding has never been a constraint for the NFPP. On the contrary, a wide variety of donors have been attracted to Thailand. Reasons include that (1) Thailand encourages donor investment by limiting the bureaucratic procedures to give and receive a grant; (2) Thais are eager to work and cooperate with foreigners; (3) Thailand has a high level of absorption of donor funds; (4) Projects in Thailand have a reputation for being successfully completed.

From the earliest days (1959), international donors were eagerly exploring possibilities to support family planning activities in Thailand. In the emergent stage, it was the World Bank that first alerted Thailand that economic progress could not be significant unless steps were taken to curb population growth. During the launch stage, thanks to the ready availability of funds from United Nations and private sources, it was possible to launch the multiplicity of experimental efforts that convinced policy-makers that family planning was wanted and would be successful. Funds and technical assistance continued to be available during the growth and consolidation stages to allow for the acceleration of training and infrastructure building. The World Bank's \$60 million loan in the mid-1970s had a synergistic effect, stimulating increased government spending for rural health centers.

An important sidelight in this picture is that the NFPP, while eagerly accepting assistance, never abdicated management control to the donor

community. Throughout, this has remained a Thai-run effort, designed by Thais to suit the Thai setting.

A shift from donor to government financial support for the program began in 1982, late in the consolidation stage, when the government took over from A.I.D. the major responsibility for purchasing contraceptives. The result was that it quadrupled its budget for the program, expanding the program substantially with government resources well before donors pulled out. By 1990, the government was receiving minimal foreign aid for population.

Overall, A.I.D. has provided about half of the foreign assistance funds to the Thai program; since 1972, close to \$120 million in grants and loans were provided through all sources, of which A.I.D. provided about \$57 million (see Table 11 on following page).

Lessons Learned

Allowing, indeed encouraging, many donors to be contributors/partners in a national family planning program can help assure a strong resource base. In Thailand, openness to donor support represented an important strategic decision, making possible the large and frequent infusions of both financial and technical assistance that underlay the NFPP's rapid and impressive growth.

In attracting international assistance, it helps if a country minimizes procedural problems for donors and offers prospects that the assistance will be successfully absorbed.

As countries reach the consolidation and mature stages, international assistance will start to dry up and it is important that government find new sources of funding. In Thailand, the NFPP understood that donor assistance would not last forever and was able to increase substantially the government's allocation to the program even while donor assistance was still at a high level.

Government Policy on Cost Recovery

The Thai government's strong commitment to providing family planning services meant that it could reject solutions for new revenues offered in other settings. Specifically, the NFPP turned neither to the private sector to increase its role in the provision of services, nor did it look to cost recovery schemes to help support its own activities. Rather, it remains the policy of the NFPP not to charge for contraceptives, except for injectables and implants. Although there is evidence that couples are paying a small charge for contraceptive pills at some government outlets, the Thai program has eliminated any financial barrier for couples to accept family planning.

Table 11
Estimated Budget for NFPP (in \$1,000:) from 1972 - 1990

Source	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	Total
Thai Govt.	476.1	523.8	595.2	771.4	1,000.0	2,228.5	2,542.8	2,314.2	2,052.1	1,756.5	7,995.6	8,456.5	7,978.2	7,856.0	8,420.0	8,924.0	9,664.0	12,816.0	17,588.0	103,958.9
% of Total Budget	15.6	16.0	14.7	17.9	19.9	23.5	15.3	14.8	18.1	17.7	51.5	53.0	50.4	44.8	49.8	70.6	68.6	77.1	97.8	737.3
Foreign Donors																				
A.I.D. Grant	1,052.3	1,242.8	1,433.3	1,433.3	1,433.3	4,361.9	2,261.9	2,485.7	2,347.8	1,982.6	1,900.0	1,356.5	1,852.1	2,284.0	1,676.0	500.0	948.0	1,160.0		31,711.5
A.I.D. Loans												1,256.5	1,456.5	1,852.0	2,168.0	1,452.0	2,056.0	1,748.0		11,969.0
A.I.D. Central							1,950.0	1,865.0	2,156.0	1,508.0	1,082.0	1,438.0	1,256.0	1,338.0	736.0					13,329.0
UNI-PA	847.6	1,123.8	1,147.6	1,104.7	1,095.2	1,209.5	1,928.5	2,080.9	1,973.9	1,452.1	878.2	478.2	434.7	736.0	396.0	140.0	524.0	640.0	332.0	18,522.9
JICA	42.8	114.2	380.9	380.9	476.1	380.9	380.9	476.1	652.1	434.7	434.7	434.7	434.7	400.0	400.0					5,823.7
Pop. Council	76.1	76.1	76.1	76.1	76.1															380.5
ASBAN/ Australia											91.3	78.2	43.4	88.0	48.0	128.0	68.0			544.9
World Bank Loan							8,019.0	6,395.2	404.3	513.0										15,331.5
Other	380.9					9.5		204.7				43.4	39.1	48.0		156.0	92.0	256.0	56.0	1,285.6
PPAT	166.6	190.4	214.2	238.0	280.9	357.1	390.4	390.4	408.6	408.6	534.7	582.6	656.5	736.0	796.0					6,351.0
PDA			190.4	304.7	666.6	914.2	719.0	733.3	860.8	782.6	926.0	1,191.3	1,208.6	1,476.0	1,656.0					11,629.5
TAVS						14.2	119.0	223.8	186.9	126.0	200.0	156.5	173.9	304.0						1,504.3
ASIN						14.2	257.1	323.8	439.1	513.0	352.1	347.8	369.5	256.0						2,872.6
TFRA							39.1	65.2	65.2	69.5	86.9	80.0	88.0							493.9
Total	3,042.4	3,271.1	4,037.7	4,309.1	5,028.2	9,490.0	16,618.6	15,628.1	11,314.7	9,899.3	15,533.8	15,959.7	15,816.1	17,544.0	16,904.0	12,638.0	14,088.0	16,520.0	17,976.0	225,728.8

Lessons Learned

Although charging for contraceptives may be acceptable to some clients, it may also represent a barrier to usage, even in a mature family planning program. Program managers need to weigh this in considering whether to initiate cost recovery efforts. In Thailand, the regard for the importance of maintaining the highest possible rate of contraceptive use outweighed any financial considerations.

Special Characteristics of Thai Leadership

Outstanding Individuals

Few family planning programs have been associated in the international mind with specific leaders in the way that the Thai program has been linked to the two individuals described in this paper -- Dr. Somsak Varakamin and Mechai Viravaidya. They played very different roles -- the one in the public and the other in the private arena of the family planning program. Each, however, conveyed a sense of enthusiasm and competence that impressed the international community and was contagious within Thailand, not only among co-workers but also within the larger population of family planning users.

In the public domain, the NFPP's manager, Dr. Somsak, understood that to build an infrastructure capable of dealing with the population situation, certain political and bureaucratic realities had to be accepted: The program would have to win the support of the larger government bureaucracy in order to get an increasing share of the national budget for capital and recurrent expenditures; foreign financial and technical assistance would be required to build the infrastructure, e.g., training of staff, construction of buildings, and supply of commodities; and cooperation with the private sector would be required. Through his management of the program, each program success was shared by all participants -- the government, donors, the private sector, and his staff. Together, they reinforced each others' efforts and resolve, and the ultimate effect was to strengthen the total program immeasurably.

The private sector produced one of the world's best-known advocates for family planning, Mechai Viravaidya. Officially, he is known for having established a community-based family planning program. More important, however, he served as a sort of "family planning media ambassador," both within Thailand and beyond. In the national setting, he oriented primary school teachers to the importance of family planning and ensured that the news media was knowledgeable and supportive of the program. Internationally, he attracted the attention of donors who eventually contributed substantial funds to the national program.

Lessons Learned

The prospects for success in a family planning program are considerably enhanced if a leader or leaders come forth with a high level of bureaucratic

and entrepreneurial skills and a pragmatic philosophy on how to reach program goals. It represents a bonus if these leaders also have the flair for attracting public attention and for selling the family planning message.

Pragmatism

The pragmatism that marked the efforts of both Dr. Somsak and Mechai is a characteristic that has pervaded the program itself from start to finish. It has been manifested in the willingness of program leadership to accept the implications of the experimental research programs that have been undertaken throughout the program's course. Moreover, program leadership has consistently put the goal of service provision above any territorial concerns about who will deliver those services or how they will be provided. It has been equally generous in its attitude toward the private sector, towards paramedics, and toward other government organizations that have joined the effort to enlist new family planning acceptors.

For example, although the MOPH was solely responsible for organizing family planning services for the country, it never attempted to exercise this authority to the exclusion of the private sector. The Thai government's generosity in encouraging and endorsing private sector and NGO involvement deserves mention because not all governments are so inclined. In the earlier stages, the NFPP gave the private sector wide latitude to undertake new activities, although none was entirely in conformance with its standard operating procedures: It allowed pharmacies to dispense oral contraceptives without a prescription; it supported the McCormick Hospital outreach program; and it backed Mechai's village-level pill program.

Likewise, the government was very pragmatic when it came to involving paramedics in the program, and the importance of using AMWs to dispense the pill and to insert IUDs has been discussed abundantly above. Later, during the mature stage, the NFPP allowed other government officials to experiment with targets and incentives, though neither was viewed as an appropriate ingredient of the NFPP's own program. Clearly, the NFPP was more concerned with bringing new resources into the program than it was in dictating a doctrinaire approach to family planning.

With respect to NGOs, this sector's involvement in the family planning program is currently small in comparison to the public sector program. In the early stages of the program, however, it was international and national NGOs that hosted policy seminars, provided contraceptives, and tested family planning strategies. More recently, the NGO community carried out innovative family planning programs that complemented the public sector program. The laissez-faire approach of the NFPP in working with NGOs fostered their growth and their ability to try new approaches.

Lessons Learned

The pragmatic attitude of the family planning program that allowed the private sector and other government units to try out various approaches in the provision of family planning has been a "silent" population policy that has increased the types/brands of contraceptives available in the country, the distribution channels for contraceptives, and the motivational efforts for family planning.

Conclusions

As is clear from the above, the factors responsible for Thailand's success are very closely interwoven. Indeed, it is virtually impossible to disentangle cause from effect, or to be certain which elements were indispensable and which peripheral to the NFPP's success. Instead, all that can be said is that Thailand's remarkable record in the area of family planning arises from its own unique blend of national, societal, and programmatic influences.

Of course, all countries represent their own particular mix of characteristics. Where Thailand differs is in the unusually high number of individual characteristics and influences that have predisposed it to, and abetted in, its rapid adoption of family planning. Some of its program initiatives, too, have been distinctive, made possible in part because of the existence of the various predisposing factors mentioned above.

This analysis has suggested that, with respect to family planning, Thailand stands apart from many other countries in two fundamental ways:

- the unusually high demand for contraceptives that greeted the NFPP at its start and that has continued unabated throughout its history; and
- the extraordinarily strong commitment of the government to supporting the program throughout.

This paper has not attempted in any depth to probe the Thai "national character" in order to explain why these two essential characteristics should be in place. It has made passing reference, however, to certain characteristics that tend to be strikingly strong throughout Thai society and its government:

- the advanced status of women, which has made this pivotal segment of the population unusually receptive to family planning;
- the receptivity, particularly of the national leadership, to the economic arguments for controlling the national fertility rate;
- the ability of national leadership to utilize international donor assistance with maximum effectiveness and a minimum of bureaucratic ado;

- the pragmatism of those running the NFPP;
- the high regard for training within the civil service; and
- the emergence on the family planning field of two unique leaders, who captured both national and international attention with their commitment and imaginative approaches to the issues.

The paper has also identified a number of external influences which have come into play, and without which it is unlikely that the program would have enjoyed the unprecedented success it has:

- the extraordinarily large amount of external donor support, which has allowed for development of a solid program infrastructure;
- the existence of good demographic data; and
- the country's strong transportation system, which has contributed both to the mobility of women and to support of program activities.

Finally, the NFPP has operated in ways that are not common in family planning programs elsewhere -- but that have been in considerable part instrumental for the Thai program's success. Prime among these are

- the early use of experimental pilot projects to pave the way for national program initiatives;
- the willingness of the NFPP to enlist the participation of all parties in the family planning effort, both allowing groups to follow unorthodox paths and giving credit where credit was due;
- the willingness of NFPP leadership to have paramedics provide pills, IUDs, and injectables; and
- NFPP's continuing efforts to increase prevalence, in particular among groups that represent difficult challenges for the program.

To be sure, not every country offers so rich an array of favorable factors. Unique though Thailand is, however, it does not follow that Thailand's success in the area of family planning need remain unique. An equally valid conclusion is that particular weight should be given to Thailand's experience, for its very success suggests its strategies and solutions may well be relevant for other countries that hope to make progress in the journey that Thailand has successfully completed.

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Glossary

A.I.D.	U.S. Agency for International Development
AMW	Auxiliary midwife
ASIN	Association for Strengthening Information on the National Family Planning Program
CBD	Community-based distribution
CBFPS	Community-Based Family Planning Services Project
ESCAP	Economic and Social Commission for Asia and the Pacific
FHD	Family Health Division
GNP	Gross national product
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JICA	Japan International Cooperation Agency
LS (1 and 2)	Longitudinal Study of Social, Economic and Demographic Change (rounds 1 and 2, conducted by the Institute for Population Studies)
MCH	Maternal and child health
MIS	Management information system
MOPH	Ministry of Public Health
MWRA	Married women of reproductive age
NESDB	National Economic and Social Development Board
NFPP	National Family Planning Program
NGO	Non-governmental organization

NORPLANT®	A method of contraception which releases the synthetic hormone levonorgestrel through capsules inserted beneath the skin of the upper arm
NSO	National Statistical Office
PDA	Population and Community Development Association
PPAT	Planned Parenthood Association of Thailand
RE	Research and Evaluation (unit)
SOFT	Survey of Fertility in Thailand
SPC (1, 2, and 3)	Survey of Population Change (rounds 1, 2, and 3, conducted by the National Statistical Office)
STD	Sexually transmitted disease
TAVS	Thailand Association for Voluntary Sterilization
TDHS	Thailand Demographic and Health Survey
TFR	Total fertility rate
TFRA	Thailand Fertility Research Association
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U. S. Agency for International Development (mission)
VSC	Voluntary surgical contraception

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