

THAI NATIONAL FAMILY PLANNING PROJECT EVALUATION
PRELIMINARY REPORTS & RECOMMENDATIONS

by The Thai-American Evaluation Team
May 1975

BEST AVAILABLE COPY

UNCLASSIFIED
CLASSIFICATION

For each address check one ACTION INFO

DATE REC'D.

TO - AID/W TOAID A 212

PROM - Bangkok

SUBJECT - Transmittal of Evaluation Report (PAR) for the Thai National Family Planning Project, 493-11-580-209

REFERENCE -

Attached is the evaluation report (PAR) for the Thai National Family Planning Project. A joint RTG/AID team conducted an intensive evaluation survey during February - March, 1975. RTG members of the team included representatives from NESDB, BOB, IPRS and MOPH. The USG was represented by a team USOM/T and AID/W.

The objectives of the evaluation were: to assess performance; identify problems; assess adequacy of resources; and to determine the feasibility of achieving the project's goals in the event that external support was withdrawn. The eleven Thai and three U.S. evaluators used national statistics and interviews with all administrative and program levels in nine provinces as the basis of their report. The time period covered by the report is 1972 - 1974.

The evaluation team's findings were written in Thai and circulated and discussed among key Thai agencies. The team also plans to utilize the report as a basis for a meeting with external donors within the next three months in order to better coordinate their support for the project. The report particularly addressed the problem of over reliance on external financial funding sources.

The scope of the evaluation was limited to the National Family Planning Project. Policy and the coordinative

Attachment: 10 copies of Evaluation Report

PAR Face Sheet

WRITTEN BY Scott W. Edmonds	OFFICE Edmonds Team	PH. NO. 351	DATE 7/2/75	APPROVED BY A/D: James D.
--------------------------------	------------------------	----------------	----------------	------------------------------

ALL D. AND OTHER CLEARANCES

O/PROG:RMellison (draft), 7/2/75

A/DB:McHartoll

D, DD, C, etc.

UNCLASSIFIED

CH...

ACTION OFFICE - When ACTION completed, return this copy to OFFICIAL FILE STATION or appropriate OFFICIAL FILE

NO ACTION NECESSARY	
DATE	SIGNATURE

BEST AVAILABLE COPY

aspects of a total national population program received little attention. However, it is felt by USOM that the report was consistent and constructive, indicating that the project has had considerable impact on fertility in Thailand and has fulfilled its objectives.

Action Requested

It is requested that AID/W distribute this report to interested agencies including the IBRD, which is currently considering a loan in support of RTG population activities.

If additional copies are needed, USOM will provide them.

WHITEHOUSE

BEST AVAILABLE COPY

TABLE OF CONTENTS

	page
Foreword	1
FINDINGS AND RECOMMENDATIONS	4-40
1. Target Attainment of the Project	4
2. Personnel and Training	7
3. Performance of the Personnel in Family Planning Activities	11
4. Family Planning Clinics	13
5. Medical Supplies & Equipment	15
6. Vehicles	19
7. Finance & Budget	20
8. Client Service Charge	23
9. Service Statistics Recording & Reporting System	24
10. Coordination with Other Agencies and Organizations that are Implementing Family Planning Activities	25
11. Demographic Impact of Family Planning Program	27
TABLE 1: Reported Initial Acceptors as a Percent Higher or Lower than the Target by Method, 1972-1976	41
TABLE 2: Projected Targets and Reported Initial Acceptors as a Percent of Married Women	42
TABLE 3: Numbers of Active Pill Users	43
TABLE 4: Numbers of Active IUD Users	44
TABLE 5: Number of Personnel who Perform F.P. Activities at the Provincial Level in 1973, Classified by Region.....	45
TABLE 6: Number of Personnel of Various Categories who have Received on-the-job Training in Family Planning During 1968-1973.....	45

	page
TABLE 7: Qualifications of Personnel at the NFPP Central Headquarters	46
TABLE 8: Number of Personnel at the NFPP Central Headquarters, Classified by Type of Work, 1973-1974	47 - 48
TABLE 9: Numbers of Active Pill Users and Initial Acceptors, and Number of Cycles of Pills Dispensed by Month in 1974....	49
TABLE 10: Foreign Assistance, Classified by Source of Assistance by Year (1972-1976).....	50
TABLE 11: Foreign Assistance, Classified by Source and Type of Assistance (1972-1976).....	51

FOREWORD

During the period February 11 - 28, 1975 a joint RTG-USOM (including representatives from DTEC, NESDB, BOB, IPRS, MOPH and USOM) conducted an evaluation of the National Family Planning Project operations, in order that the government agencies concerned with the National Family Planning Project operations will know the operations of the NFPP, both at the NFPP Central Headquarters and at the provinces, as well as to recognize the problems and develop suggestions on corrective measures so that the operations can be implemented smoothly and the Project will achieve its targets.

Due to time constraints, the Evaluation Team had to rely on statistic data of the NFPP and other organizations and agencies concerned and to collect additional data by going out to observe the NFPP operations in selected provinces, by region, which have indicated different levels of operational results. This approach was utilized in order to get the view of the Project implementation as much as possible. Therefore various information found in this evaluation report are those that the Evaluation Team found by their visits to provinces of those regions only. Eventhough the facts have not been obtained from visiting units all over the country, with the selective collection of data from the provinces of different levels of operational results as stated above, the Evaluation Team believes that these facts will be able to point out problems and ways to achieve success in accordance with the family planning program objectives as a whole.

The smooth implementation of evaluation within a limited period of time was due to the excellent cooperation that the Evaluation Team has received from the Ministry of Public Health, especially from the close cooperation of Dr. Somsak Varakamin, Director of Family Health Division, Department of Health, Dr. Suvanee Satayapan and other personnel of the Family Health Division as well as the provincial chief medical officers, hospital medical directors, medical officers, nurses, midwives and sanitarians of the following provinces, namely, Chiangmai, Lumphun, Lampang, Khon Kaen, Kalasin, Roiet, Udonthani, Chumphon, Phang-nga and Phuket. The Evaluation Team would like herewith to take this opportunity to thank all these people.

Moreover, this evaluation is limited to cover the family planning activities of the Ministry of Public Health only. It does not include the family planning activities of other government agencies or other private organizations.

The Thai-American Evaluation Team

THE NATIONAL FAMILY PLANNING PROJECT

1. Project background

The Ministry of Public Health initiated the family planning operations in 1968 under the name of "The Family Planning Project", implemented by Division of Maternal and Child Health, Department of Health, in collaboration with Rural Health Division, Department of Medical Services. The implementation of family planning operations at this period had a limited scope, aiming at rendering assistance to the poor families and the families with many children, especially in the rural areas, and the family planning information was given only to the mothers who had children.

The implementation of family planning activities in this period included the training of public health personnel at various levels, such as physicians, nurse midwives and health midwives concerning the family planning operational methods.

In 1970, the Cabinet had concurred with the recommendations of the National Economic Development Board (the present National Economic and Social Development Board) by announcing the national population policy. The Ministry of Public Health had therefore started the family planning activities seriously, and included the National Family Planning Project in the National Third Five Year Development Plan (1972 - 1976).

2. Objectives of the National Family Planning Project

The objectives of the National Family Planning Project are as follows:

2.1 To reduce the annual population growth rate from 3% to 2.5% at the year ending 1976.

2.2 To render family planning knowledge to women of fertility age groups, especially to those who live in the remote rural areas to motivate them to accept contraceptive methods, and to arrange to have family planning services throughout the nation.

2.3 To integrate family planning/maternal and child health services which have now been closely related, creating mutual support to increase efficiency.

3. Project implementation

The National Family Planning Project had officially initiated its implementation in 1971, having the Division of Maternal and Child Health, Department of Health; and Division of Provincial Hospitals, Department of Medical Services, as implementors and coordinators to coordinate activities with other government agencies concerned within the Ministry

of Public Health. However, at present, the National Family Planning Project is under the aegis of the Division of Family Health, Ministry of Health, only.

At the initial stage of the implementation, the Project tried to utilize existing public health personnel to operate the family planning activities and to utilize existing public health facilities to deliver the family planning services. However, the Administration of the NFPP Central Headquarters was formed to provide additional technical manpower to achieve the projected targets so that the activities of other health aspects would not be affected.

The various methods of contraception adopted by the Thai NFPP are as follows:

3.1 The distribution of oral contraceptive pills is implemented by provincial hospitals and health and midwifery centers. The health facilities charge 0-5 baht service charge per cycle of contraceptive pills distributed.

3.2 The delivery of IUD insertion service to the people in all provincial hospitals and health centers with physicians, charge not to exceed 20 baht for an IUD insertion service to a woman. Moreover, the Ministry of Public Health has approved a training program to train nurse-midwives to deliver IUD insertion service.

3.3 The delivery of sterilization services, both tubal ligation and vasectomy. The sterilization services have been implemented in all provincial hospitals for several years and later expanded to all health centers with physicians. A fee of 50 baht is charged for delivering vasectomy service to a man and 150 baht for a tubal ligation.

However, this year (1975) the National Family Planning Project has started to disseminate two additional contraceptive methods, namely, condoms and contraceptive injectables.

4. Budget for implementation

Regarding the budget for implementing the NFPP operations besides the regular budget allocated by the RTG, as the NFPP is an important project included in the National Economic and Social Development Plan, the NFPP has also received donations from foreign donors and international donor agencies and foundations, such as USAID, UNFPA, The Population Council, and other international foundations.

Objectives of the Evaluation

The evaluation of the NFPP operations, implemented by the Ministry of Public Health as specified in the RTG Third Five-Year Plan 1972 - 1976, has the following objectives:

1. To consider whether or not the implementation of the NFPP operations has achieved the targets set up in the operational plan since 1972.
2. To determine what problems exist, to what magnitude, and what resources are needed to resolve them.
3. To consider whether or not those various resources provided by the RTG and foreign donors are adequate and pertinent to the NFPP requirements and to what extent the utilization of those resources is in support and promotion of the NFPP activities.
4. To study the feasibility of the NFPP implementation to achieve the present objectives and targets as well as to achieve the future objectives and targets in the event of the withdrawal of foreign support.

The Evaluation Team

The Evaluation Team was composed of representatives of several RTG and foreign agencies concerned as follows:

- | | | |
|-----|----------------------------|---|
| 1. | Dr. Boonlert Leoprapi | Institute for Population and Social Research, Mahidol University
(Thai Co-Team Leader) |
| 2. | Miss Orathip Tanskul | National Economic and Social Development Board |
| 3. | Mr. Komol Chorbekmenchon | Social Project Division, NESDB |
| 4. | Miss Pathra Chor Sorapongs | Bureau of Budget |
| 5. | Mr. Kunyaphan Raengkhum | Bureau of Budget |
| 6. | Mr. Boonpong Wanapirom | Office of Under-Secretary of State,
Ministry of Public Health |
| 7. | Mr. Pichet Soontornpipit | Department of Technical and Economic Cooperation |
| 8. | Miss Ghantana Indragarjita | Department of Technical and Economic Cooperation |
| 9. | Mr. Cherdpong Siriwit | Department of Technical and Economic Cooperation |
| 10. | Mr. Achari Yuktanandana | Department of Technical and Economic Cooperation |

- | | | |
|-----|---------------------------------|--------------------------------|
| 11. | Mr. Scott W. Edmonds | USOM (American Co-Team Leader) |
| 12. | Mr. Gerard R. Bowers | USOM |
| 13. | Mr. J. Cumiskey | Representative, AID/W |
| 14. | M.R. (Miss) Chiravadee Kasemsri | DTEC (Co-ordinator) |

Methods of Evaluation

The evaluation has been implemented by:

1. Arranging to have the meetings between the Evaluation Team and the Project personnel at the Ministry of Public Health to listen to the briefing, to interview and to ask the personnel of various units and sections some questions as well as to collect statistic data and various documents concerned.
2. Travelling to observe the operations of the operational units at all levels in 9 provinces, as well as to participate in the meetings with and to interview the medical and health personnel at provincial level.

In order to achieve the objectives of the evaluation, the Evaluation Team has specified the following frame of reference for use in the evaluation implementation:

1. Target attainment of the Project.
2. Personnel.
3. Capability.
4. Acceptance of F.P. services.
5. Availability of services.
6. Equipment and supplies.
7. Finance and budget.
8. Satisfaction of acceptors, and
9. The impact of the NFPP on population change.

Findings & Recommendations

1. Target Attainment of the Project

The most important target of the NFPP to achieve the objective in reducing the birth rate is the target of the number of initial acceptors of various contraceptive methods. The NFPP has set the targets that during

the period 1972-1976 there must be total initial acceptors of 2.275 million, classified into 1.555 million initial pill acceptors; 0.530 million initial IUD acceptors; and 0.190 million initial sterilization acceptors. The targets of acceptors of each year had also been projected.

1.1 Number of acceptors

From the statistics of the NFPP operational results from 1971-1974, the number of contraceptive acceptors was higher than the target every year and in every contraceptive method, except in 1973 the number of pill acceptors was 4% below the target 1/ but the total number of acceptors of all contraceptive methods was 2.9% higher than the target 2/. Eventhough the number of contraceptive acceptors was higher than the target every year, the percentage had the declining tendency, i.e., in 1971 = +34.7%; in 1972 = +28.7%; in 1973 = +2.9%; in 1974 = +22.1%; 3/. The important factor that has created the change in the percentage higher than the target has been the decrease in the number of pill acceptors which is the main component of the combined target (68.4% of the total combined target).

It can be observed that from 1973 and 1974 statistics, the number of pill acceptors decreased by 60,000 acceptors and 20,000 acceptors respectively, even when the target of 1972 was projected lower than the targets of 1973 and 1974. Therefore, the change in this component affected the percentage higher than the combined target of all methods. Similarly, the percentage of the IUD acceptors has also tended to drop, but as for the number of the sterilization acceptors 4/ the percentage higher than the targets has tended to rise namely: 1971 = +17.7%; 1972 = +30.7%; 1973 = +28.7%; 1974 = +29.9%. This is because the people like the sterilization methods because they are permanent contraceptive methods. The acceptor has to come only once and it can protect him or her forever, however this method is only about 9.0% of the total acceptors of all methods throughout the period of 4 years.

It can be observed that the number of married women (15-44 years old) in 1971 was about 4.8 million people, and about 8.4% had already accepted family planning services. Therefore, the lowest target was set up for that year. It was only 6.5% of the number of eligible women. 1973 was the year that the highest target was set up. It was about 7.9% of the eligible women, and the NFPP was able to deliver services to 8.1% of the eligible women. 1972 was the year that the NFPP was able to deliver the highest percentage to the eligible owmen, i.e. about 9.1% followed by 1974 which was about 9%. 5/

-
- 1/ See Table 1 of the appendixes
2/ See Table 1 of the appendixes
3/ See Table 1 of the appendixes
4/ See Table 1 of the appendixes
5/ See Table 2 of the appendixes

1.2 Continuation Rates

As this projected targets are the numbers of initial acceptors, therefore when we computed the continuation rates of the pill and IUD acceptors of the Photharam Pilot Project we have found that:

1.2.1 Oral contraceptive pills. From the operational results of the NFPP during 1971-1974, the number of active pill users at the year ending 1974 was 546,256, and there will be 409,342 pill users at the year ending 1976. 6/

However, the NFPP has projected that during 1971-1976 there will be 711,742 active oral pill users at the end of 1976. 7/

1.2.2 IUD. During 1971-1974, the number of active IUD users at the year ending 1974 and 1976 would be 191,881 and 143,955 respectively. 8/

Moreover, it is estimated that from the operational result of the project during 1971-1976 there would be 257,355 active IUD users at the end of 1976. 9/

1.2.3 Sterilization. There will be no change in the continuation rate of sterilization method.

As there is discrepancy in the counting of initial acceptors, such as the acceptors who wish to switch from one method of contraception to another method are considered to be new acceptors, therefore, it is necessary to maintain the higher percentage than the target, the higher the better.

Briefly speaking, the operational results of the NFPP during 1971-1974 can be considered to be higher than the projected targets, even though we are unable to say definitely to what extent the annual population growth rate has been reduced, we can say that the population increase rate has been reduced. However, to solve the problem of discrepancy of the reports and the counting of initial acceptors during the period of last 2 years of the implementation, the NFPP must try to maintain a higher rate than the target achieved in 1974 to compensate for the problems of the discrepancy in the reporting system.

1.3 Recommendations.

1.3.1 In some provinces it has been found no projected targets for family planning operations. It is recommended that there should

6/ See Table 3 of the appendixes

7/ See Table 3 of the appendixes

8/ See Table 4 of the appendixes

9/ See Table 4 of the appendixes

be a projected target for every contraceptive method, based on the number of clinics and personnel existing in the province. The projected targets should be based on the ratio of the active contraceptive users to the number of eligible couples instead of using the ratio of the initial acceptors to the number of eligible couples.

1.3.2 The distribution of manpower and equipment has not been properly implemented. Some of the first class health centers (medical and health centers) have physicians but lack of equipment, but some first class health centers are well equipped but no doctors assigned to them. This poor utilization of manpower and equipment has created the situation of under utilization of manpower and equipment. There should be a corrective measure to assign doctors and equipment to the medical and health centers in proper proportion.

2. Personnel and Training

2.1 Personnel that work in the NFPP

The Ministry of Public Health is responsible for the family planning activities. According to the report of the Division of Family Health 1975 there are 4,647 public health facilities within the Ministry of Public Health, that render family planning services as follows:

- Hospital	90
- Office Provincial Chief Medical Officer	45
- First Class Health Center	264
- Second Class Health Center	2714
- Midwifery Center	1547
- MCH Center	5

Besides, there are also family planning clinics outside the Ministry of Public Health, such as Public Health Service Centers, Bangkok Metropolis, Municipal medical centers, and the government and private hospitals totaling 63 clinics. Therefore, there are 4,710 units in all that render family planning services and they submit reports to the NFPP regularly.

A total of 378 personnel hold full-time jobs both at the NFPP central and provincial units. They are 8 M.D.s; 9 executive medical personnel; 7 researchers/statisticians; 6 administrative assistants; 100 F.P. workers; 150 house visitors, and 91 clerical workers. 147 of these personnel are officials and permanent employees and represent 38.9 per cent of the total staff.

As for those who are implementing F.P. operations at the provincial level, they are classified to be 887 M.D.s and 11,026 paramedical personnel. The paramedical personnel are composed of 2,878 nurses, 4,745 health midwives and 3,473 sanitarians. In 1973 the total personnel working at the provincial level was 11,913.

Among these number are 220 doctors who are assigned to work in the first class health centers. When compared with the number of the existing 264 first class health centers, there is still a shortage of 44 doctors for the first class health centers throughout the country.

The personnel working in the medical and health facilities in the provinces are mostly responsible for comprehensive and multi-purpose health services, so it may be said that family planning services are only part of the whole comprehensive health services. The provincial hospitals are mainly responsible for male and female sterilization, and IUD insertion. The medical and health centers are mainly responsible for IUD insertion, vasectomy and distribution of oral contraceptive pills.

2.2 Training of Personnel

The training of personnel started in 1968. The training has been divided into 3 categories, namely, on the job training, the training prior to recruitment and the participant training in the U.S. and in the third countries. The purpose is to improve and upgrade the efficiency of the personnel at various levels as follows:

2.2.1 On the job training

From the report of the NFPP, 1973 it is found that since the start of the Project, the following personnel have been trained:

578	physicians
1,110	health nurses
5,338	health midwives
1,985	sanitarians
100	family planning workers

2.2.2 Training prior to recruitment

Besides on the job training, the NFPP has arrived at an agreement with the medical schools, the nursing schools, the midwifery schools and the Faculty of Public Health to include the family planning course in the regular curriculum.

The training of each category of personnel had been arranged to be relevant with the jobs that the personnel are going to perform. For example, the training of physicians has emphasized the family planning administration, IUD insertion, and male and female sterilization. As for the training of the nurses, it has stressed supervision of the work of the subordinates. The midwives have been trained to distribute pills and record keeping. The junior sanitarians have been trained to be health educators to motivate the villagers, and later, the junior sanitarians are allowed to distribute pills and condoms to the continuing users.

The NFPP is of the opinion that the family planning services should be expanded more extensively than it is now in order to be able to have better coverage. Therefore the Ministry of Public Health has decided to allow the nurses to deliver IUD insertion service so that the physicians will have more time to perform male and female sterilization services.

2.2.3 Participant Training Abroad

Since the start of the NFPP, the following personnel had been provided with participant training:

Long-term training (9 months and above)

Physicians	28
Nurses	3
Personnel of other categories	5
TOTAL	<u>36</u>

Short-term training (6 months)

Physicians	9
Nurses	9
Personnel of other categories	3
TOTAL	<u>21</u>

Third-Country

Physicians	114
Nurses	45
Midwives	5
Personnel of other categories	15
TOTAL	<u>179</u>

2.3 Findings concerning personnel and training

2.3.1 The number of personnel at the operational level (midwives, health midwives and junior sanitarians) is considered to be adequate to deliver family planning services, especially the pill distribution service, but there is the problem that the midwives also have to be responsible for many other aspects of health activities, such as maternal and child health, school health, prevention of diseases (immunizations) etc. Moreover, there is lacking of proper supervision and advice which may affect the F.P. operations of certain levels. Another problem is the shortage of doctors for medical and health centers, and the doctors assigned to work at the medical and health centers are changed very often. This adversely affects the delivery of some contraceptive methods such as vasectomy.

2.3.2 The project personnel who are responsible for the training and supervision and to give advice to the operations of various provinces are inadequate, even though the NFPP has endeavored to solve this problem by training the supervisors at provincial and district levels, the supervisory personnel have to bear too much responsibility. The health nurses are unable to supervise the jobs of their subordinates efficiently because their areas of responsibilities are too large both specially and functionally. The physicians have major responsibilities to deliver the medical and health services at the hospitals or medical and health centers and they have no time for supervision or to deliver medical services at the clinics of the lower levels or mobile medical teams.

2.3.3 The training is lacking refresher courses. There are many personnel who had received training only once for a short period of time many years ago and have no more opportunities to attend the refresher courses or to obtain additional new techniques and knowledge.

2.3.4 The training that has been conducted is considered to be quite successful measured by its ability to upgrade the capability of job performance of many personnel at various levels, especially the para-medical personnel but the number of the trainees is still small and inadequate.

2.3.5 Most of the personnel who have had the opportunity to get training abroad have come back to use the knowledge they obtained from the training to train other personnel quite well, but the Evaluation Team has observed that a number of personnel who are not doing any jobs directly connected with family planning activities were selected as participants to be trained abroad.

2.4 Recommendations

2.4.1 The NFPP should arrange to have in-service training for health personnel regularly by emphasizing on the upgrading of capability on operations, supervision, motivation and follow-up. If the trainees still perform the jobs in connection with family planning activities, they should be given the opportunity to be retrained every 2-3 years, and if possible, the NFPP should arrange to have seminars for their personnel at various levels at least once a year in order to allow them to exchange experiences, knowledge and ideas which will rouse interest and enthusiasm in performing their duties.

2.4.2 The training stated above will be implemented effectively only when the NFPP has an adequate number of personnel to conduct training in technical aspects of the jobs, administration, planning and follow-up, etc. The NFPP should consider increasing the number of qualified personnel who are responsible for conducting training, including the personnel who support the activities stated above.

2.4.3 The Ministry of Public Health should assign the public health nurses who have been trained in operational techniques or who have been trained abroad to work as supervisors at the provincial level instead of assigning them to work at the medical and health centers. This is to allow them to have the opportunity to transmit their knowledge and experiences more widely and extensively.

2.4.4 There should be regular supervisory visits of the operational units at least once a month. The nature of the supervision should be stressed on advising on correction the discrepancies and defects found, such as the discrepancy in the recording and reporting, the defects concerning the operational procedures, the follow-up of the active contraceptive users who have not come to get the service at the allocated time. It is recommended that the NFPP should experiment on having supervisors who are responsible for supervising family planning activities only in some provinces, especially in the provinces with a low operational result. These family planning supervisors should be specially trained in the management and in family planning supervision, including the analysis of records or statistical data and the setting up of operational plan.

3. Performance of the personnel in family planning activities

3.1 Findings

3.1.1 There is a great deal of variation in family planning performance from clinic to clinic, but the provincial health authorities are not analyzing the differences to explain their causes and to devise corrections.

3.1.2 Even though the combined number of initial acceptor's of all contraceptive methods is higher than the projected target, from observation in various provinces including the operational units at various levels, it was found that various operational units were lacking interest and enthusiasm in performing family planning activities, in several provinces the health personnel did not even know or have projected targets for their family planning activities. The operational units of almost every province did not try to bring the services to the acceptors. This might be because they had wrong attitude that in bringing the services to the houses of the acceptors, the acceptors would get used to that system and never visit the health centers.

From the information taken from the monthly reports of the pill initial acceptors and continuous users and the number of cycles of pills distributed monthly by some of the midwifery centers during a 12 months period, it was observed that even though there had been initial acceptors every month, the number of active continuous pill users did not change. It

seemed that the initial acceptors only replaced the number of the drop-outs (see Table 8 in the appendixes). In other clinics half of the number of the initial acceptors replaced the drop-outs.

3.1.3 The recording and reporting need improvement. Many clinic personnel were found to take no interest in these aspects of their work. In some cases there was no record of receiving repeated service in Form Wor Khor (F.P.) 01, so the operational personnel did not know the true condition of the continuous users. This might be the cause for not making follow up visits to drop-out pill users because the operational personnel knew nothing about them.

3.1.4 In some midwifery centers the house visitors were asked to perform as assistants to the midwives instead of going out to visit houses and motivate the women to accept the family planning services and to continue using the contraceptive methods. Some family planning workers at the medical and health centers did not know their own duties, operational procedures and their own responsibilities.

3.1.5 There is a great variation between province to province in the distribution and the charge of oral contraceptive pills. In some provinces in the North, the midwives and the junior sanitarians interpreted the instruction of the Ministry of Public Health "to charge not exceeding 5 baht for a cycle of oral contraceptive pills" as to charge a flat rate of 5 baht for a cycle of pills. Therefore it was found that only very few clinics distributed 3 cycles of pills to the active continuous pill users who revisited the clinics in the northern provinces. This might be because the acceptor had less than 15 baht when she came to get the pills. But in the southern provinces (such as Phuket and Phang-nga) the clinics charged 10 baht for 3 cycles of oral contraceptive pills. Therefore an active continuous pill user received 3 cycles of pills when she revisited the clinic. This can be compared with the acceptance of oral contraceptive averagely only 1.3 cycles per continuous user in the provinces of Chiangmai, Lamphun and Lampang. The impact of the variation in the pattern of distributing and charging, for oral contraceptive pills on the continuation rate of pill acceptors is the subject that should be further studied before a definite statement can be made, but from using common sense, it is possible that the distribution of many cycles of pills each time at a cheaper price will result in higher continuation rates.

3.1.6 Bringing family planning services to the acceptors is seldom done. For example, the midwives consider the midwifery center or second class health center as the base to deliver services, therefore the services are not taken to the people outside the health or midwifery centers.

3.1.7 The operational personnel do not make an effort to correct the harmful rumors concerning the side-effects of various

contraceptive methods. For example, in certain provinces in the south there was a rumor that the IUD insertion was the cause of cancer. The attempt to correct the rumors on an original basis was not done. Similarly, the acceptors usually received the methods that the acceptors already knew and requested. The personnel who deliver the services didn't consider the specific requirements of the acceptors (such as, age number of children that they had, number of children needed) or they didn't consider the effectiveness of various contraceptive methods (As for the present continuation rates of the contraceptive methods in Thailand, IUD is more effective than Pill, and sterilization is considered more effective than any other methods).

3.1.8 The personnel of various levels still have incorrect attitudes toward the F.P. operations carried out by other agencies and organizations outside the Ministry of Public Health. They thought that the operations implemented by other organizations would reduce the number of initial acceptors, instead of coordinating or encouraging other organizations to motivate the people to be interested in accepting more services.

3.1.9 Most of the acceptors did not mind paying the service charges of the contraceptive services.

3.2 Recommendations

3.2.1 The NFPP should arrange to have IUD insertion service on every working day at the hospitals and the medical and health centers, and once a week at the office of the provincial medical officer. All nurses should be trained to deliver IUD insertion service.

3.2.2 It is recommended that the standardization of operational procedures and principles be adopted by provincial health authorities as much as possible. The provincial health authorities should be encouraged to utilize the resources outside the public health sector for the benefit of family planning services.

4. Family Planning Clinics

Family planning clinics are organized within the public health facilities at various levels of the provinces, e.g., provincial hospitals, medical and health centers, health center and midwifery center. The MCH centers provide resource persons for training sessions and deliver family planning services at regional level.

4.1 Findings

4.1.1 Location of Service Units

Some health facilities are located too close to the other units providing more comprehensive F.P. services. For example, the medical and health centers are located too close to the provincial hospitals, the health centers are located too close to the medical and health centers. This is one of the causes that the number of the acceptors of those clinics are below the target, and the clinics are under-utilized. Moreover, the locations for health clinics are not generally chosen on the basis of user-convenience or traffic flow, but are instead often sites donated by local citizens. While this is a most admirable indication of popular desire and appreciation for the government's health services, and an obvious ameliorative to a strained MOPH budget, it does not always result in optimum placement or access to clinical facilities. Moreover, since this noteworthy tradition is not likely to change in the near future, it is additionally imperative that clinic staff expand and improve their efforts to carry F.P. services to the rural villagers.

The delivery of family planning services at the provincial level may be divided into various levels as follows:

- The provincial hospital delivers all approved methods of family planning services, namely, tubal ligation and vasectomy, IUD insertion, and distribution of oral contraceptive pills.
- The first class health centers deliver all approved methods of family planning services similar to the provincial hospitals.
- The second class health centers only deliver the oral contraceptive pill service.
- The midwifery centers also deliver only oral contraceptive pill service.

4.1.2 In the delivery of services it has been found that some medical and health centers are not assigned with proper and qualified personnel to deliver comprehensive family planning services.

4.1.3 The Ministry of Public Health has a program to train the nurses to deliver IUD insertion services to relieve the burden of the physicians, and to solve the problem of shortage of physicians. This is considered to be a good and appropriate idea, because the acceptors will be glad to have IUD insertion service delivered by the nurses who are of the same sex but it has been virtually found out that the progress of the said project has been very slow. The Evaluation Team had found only a new nurses who have been trained to deliver IUD insertion service. Due

to the slow progress of the training program, the provincial hospitals and medical and health centers of some provinces have started to train their own nurses to deliver IUD insertion service under the close supervision of the physicians at the initial stage.

4.1.4 Usually the F.P. services at F.P. clinics of the midwifery centers, health centers and medical and health centers are provided once a week (though clients can be re-supplied with oral contraceptive pill at the clinic any time if the clinician is present). To some extent, this scheduling of F.P. services is unavoidable since clinic staff must spend a substantial portion of their time on home visits. The tight scheduling of only one day, however, may discourage some potential new acceptors or continuous users from visiting the clinics at an inconvenient time (i.e., during the working hours) and thus negatively affect contraceptive acceptance and continuation rate.

4.2 Recommendations

4.2.1 The Ministry of Public Health should accelerate on filling the vacant posts of health facilities so that those health facilities will be able to operate according to the specified scope.

4.2.2 It should be specified as a rule that the midwives must take oral contraceptive pills and condoms with them when they go out on home visits.

5. Medical Supplies and Equipment

The medical supplies and equipment used in the family planning project operations consist of oral contraceptive pills, IUD, condoms, equipment for IUD insertion, for vasectomy and tubal ligation as well as other types of equipment such as currette and laboratory equipment, etc.

5.1 Findings

5.1.1 Oral contraceptive pill. Oral contraceptive pill is the most popular method and is considered to be the chief method of contraceptive of the NFPP, i.e., about 70% of the total number of acceptors of all methods. It has been found from the finding of the evaluation that:

1. there has never been any problem of shortage of oral contraceptive pills at the clinics visited by the Evaluation Team. The quantity of oral contraceptive pills received as assistance from foreign donors is adequate for the requirements of all clinics throughout the country.

2. however, the problem of side-effects of the oral contraceptive pills still exists, eventhough "Norestrin" which has the most side-effects, has been replaced by Norinyl.

3. the policy of the Ministry of Public Health concerning the service charge of oral contraceptive pills which is considered to be a contribution at the rate of not exceeding 5 baht per cycle, in actual practice, it has been found that some provinces do not seem to understand the policy. The clinic staffs have charged 5 baht flat rate for a cycle of pills distributed, or otherwise the oral pills are supplied to the acceptor free of charge when the acceptors show the letters issued by district administrative personnel. Similarly the policy of the disbursement of the said revenue which is considered to be a contribution to the health facilities, has been implemented differently in various provinces. The Ministry of Public Health should clarify this policy so that the personnel at all levels will clearly understand it.

5.1.2 IUD

IUD is the contraceptive method which is the second most important and popular to the oral contraceptive pills, i.e. about 20% of the method of all contraceptive methods.

1. there is no shortage of IUD's. The supply of IUD's by the international assistance agency is adequate for the distribution and utilization in various provinces.

2. the number of acceptors of this method is increasing but it has been found by the Evaluation Team that the rate of increase is decreasing every year. This may be due to the fact that some of the acceptors change to other methods or they stop using the method entirely.

3. there are side-effects in utilizing IUD and there are many types and sizes of IUD. This does not create confidence on the part of the acceptors regarding the safety of the device.

4. the Evaluation Team found that the majority of the women in the rural areas do not want male doctors to perform IUD insertion, they prefer the nurses who are of the same sex to perform the IUD insertion service.

5.1.3 Condoms

Condom service has just been started at the end of 1974. The main purpose is to use condoms for the men whose wives have problems of using pills or IUD. However, from the start in the dissemination of condoms, it has been found that:

1. The first lot of condoms distributed by the NFPP to various provinces was not accompanied by instruction of utilization and distribution. Therefore the condom service at the initial stage has been implemented according to whim and fancy of each individual and as a result the service has not met with the success it should have.

2. The people do not like to use condoms. They say the utilization of condom is controversial and it is difficult to dispose the condoms after using.

3. The attitude of most of the women in the rural areas is that the condoms are for use with prostitutes.

4. The first shipment of condoms received by the NFPP (manufactured in Korea) were of a size and quality not suitable to the Thai people in general.

5.1.4 Sterilization equipment

Tubal ligation and vasectomy are becoming more and more popular, this is because they are the permanent methods of contraception. They are cheaper in terms of length of protection, being cheaper than the oral pill in a long run. However, the expansion rate of sterilization service has not met the demand. This may be due to:

1. Sterilization equipment received under aid program is inadequate for the requirements of hospitals and medical and health centers.

2. Moreover, some health facilities having medical staff qualified to perform sterilization services, have not received sterilization equipment or have received incomplete sets of the equipment.

3. Some medical and health centers are not assigned with proper and qualified personnel or the number of qualified personnel assigned is inadequate to perform the comprehensive family planning services.

4. Lack of proper and adequate public relations and motivation to counter the old attitudes among the people concerning the sterilization.

5.1.5 Other supplies and equipment

Other types of supplies and equipment used in the support of the NFPP, such as supplies and equipment of mobile medical teams, laboratory equipment, or health education materials and audio visual aids are still inadequate for disseminating information. The supervision at the local level, is still at the unsatisfactory standard. All these bring about the result of low rate of contraceptive acceptance.

5.2 Recommendations:

5.2.1 All family planning equipment and supplies should be properly tested before putting them into use. They should be suitable to the physiology, psychology, as well as socio-economic conditions and culture of the acceptors.

5.2.2 The family planning clinic should be provided with at least 2 types of oral contraceptives for the users to choose the type that is the most suitable to them.

5.2.3 Research should be conducted to find a formula most suitable to the people.

5.2.4 A study should be conducted to find comparison data of advantages and disadvantages of the manufacture of oral contraceptive pills within the country, no matter whether by the government or by private sector.

5.2.5 The program of expansion of IUD insertion service to the health centers (second class health centers) should be accelerated. Even though at present oral contraceptive pill service is still the chief method of contraception of the NFPP, it is the most expensive method and the users are liable to forget to take the pills. Therefore in a long run the Ministry of Public Health should encourage more of the IUD service or sterilizations by allowing the agencies or private organizations to develop and disseminate more of the oral contraceptive pill service.

5.2.6 A survey should be conducted to find out the type and size of IUD that is the most suitable to Thai women, and develop standard and manual to be distributed to all family planning clinics.

5.2.7 There should be more information services to disseminate knowledge concerning the utilization and the benefits of condoms as well as to advise how to dispose of the used condoms. Moreover, the sizes and quality of the condoms should be of the same grade as those sold in the market.

5.2.8 Family planning clinics that have physicians should be provided with adequate sterilization equipment. This will help avoid the repeated use of equipment without proper clinical sterilization which is against good medical practice.

5.2.9 The equipment and supplies used in support of the NFPP should also be adequate for the requirements and scope of the Project operations.

5.2.10 The NFPP should arrange to have dissemination information, both in publication and radio broadcasts so that the general public will know more about the advantages of a various types of contraceptives, especially the sterilization services.

6. Vehicles

The vehicles received under the National Family Planning Project which consist of four-wheel vehicles, motorbikes and bicycles, have been distributed to all family planning clinics to be used for supervision and follow-up.

6.1 Findings

6.1.1 Four wheel vehicles which are assigned only to the medical and health centers, have all been received according to plan, but the problems concerning these four-wheel vehicles are the large budget for required fuel and the maintenance as these vehicles which are of too high horse power and with high compressure engines.

6.1.2 The four wheel vehicles possessed by the medical and health centers have mostly been used for many years. Therefore they have started to deteriorate and a lot of budget is necessary for the utilization and maintenance of these vehicles.

6.1.3 The nurses and midwives have all received motorbikes according to plan, except the midwives who have just been recruited. However, these new recruits will also get motorbikes after working for some time.

6.1.4 The motorbikes received under the NFPP help increase efficiency of the performance of the nurses and midwives considerably.

6.1.5 According to the former program, the midwives have been provided with bicycles, but the utilization of bicycles by the midwives has not been effective as they are unsuitable for the work of the midwives. Therefore the bicycles are given to the F.P. house visitors.

6.2 Recommendations

6.2.1 The allocation of budget for fuel and maintenance of vehicles should be sufficient to cover the actual costs as determined by examination of vehicle utilization and requirements so that the F.P. operations can be carried out regularly.

6.2.2 If possible, the four-wheel vehicles assigned to the medical and health centers should be vehicles of small size and low cost. Moreover, they should be the vehicles for which spare parts are readily available locally.

6.2.3 The four wheel vehicles that are not serviceable, should be replaced by the serviceable ones, because the vehicles are one of the important equipment for the delivery of services.

6.2.4 The motorbikes which are obtained as aid, should be allocated among health facilities on a priority-need basis.

7. Finance & Budget

Budget for the NFPP may be classified into 3 categories, namely, regular government budget, foreign assistance, and counterpart fund.

7.1 Findings

7.1.1 Regular RTG budget

The RTG has appropriated the budget in support of the NFPP since 1972 (The following figures which do not include indirect cost of maintaining and operating the health/F.P. delivery system) are as follows:

1972	10,000,000 baht
1973	11,000,000 baht
1974	12,496,600 baht
1975	16,691,800 baht

These figures indicate that the appropriation of government budget has increased every year, but when compared with the budget received as foreign assistance, the direct RTG budget was only 15% of foreign assistance in 1972, now the foreign assistance funds have been reduced, and the RTG budget has been increased, as agreed between RTG and foreign donor. This means that the RTG has to bear an additional financial burden year after year. For example, the RTG has to allocate government budget for purchasing one million cycles of pills in 1974 and increased to two million cycles in 1975.

Of the regular budget allocated to the NFPP, about half has been used for various supplies, such fuel, spareparts, motorbikes, bicycles, printed materials, and oral contraceptive pills. The RTG allocated four million baht for the purchase of one million cycles of oral contraceptive pills in 1974 and, increased it to eight million baht for the purchase of 2 million cycles of pills in 1975. The next most budget expenditure are for miscellaneous expenses, which includes mainly per diem, and lodging fees of the trainees at various levels.

7.1.2 Foreign assistance

The budget of the NFPP has been mainly obtained from foreign donors, such as USAID, UNFPA, UNICEF, Population Council, IPPF, and Ford Foundation etc. The assistance received from foreign countries has been mainly commodities, such as pills, IUD, medical equipment, vehicles, motorbikes, bicycles, etc. Besides these commodities the foreign assistance has also been in the form of experts and personnel, fellowships, and training for doctors, nurses, midwives and sanitarians, etc. Another category of foreign assistance has been in the form of donation for construction of office buildings and health facilities, such as the NFPP Central Headquarters Building in the MOPH compound, etc. (See Table 11 of the appendixes)

The direct and indirect sources of foreign assistance to the NFPP can be summarized as follows:

1. USAID started to assist the MOPH in population activities since 1968 under the Family Health Program, and when the MOPH had officially established the NFPP, USAID has continued its support. The assistance that the RTG has received from USAID is in various forms which can be summarized into 3 main categories:

1. Experts and Personnel
2. Fellowships and Training
3. Commodities

The total amount of USAID assistance to Thailand during 1972-1976 is US \$9,130,388 or the equivalent of 182,607,760 baht.

2. UNFPA started to have a role in providing assistance to Thailand in 1971. UNFPA is now supporting 5 population programs as follows:

1. Accelerated MCH/FP Development Program
2. Expansion of Sterilization Services Program
3. Dissemination of Information and F.P. Mass Communication to the People Program.
4. Mobile Medical Teams Program.
5. Motorbikes for Nurses and Midwives in Rural Areas Program.

3. Population Council of New York started to assist Thailand by supporting in the arrangement and organization of the National Technical Seminar on "Population of Thailand" in 1963 and assists the NFPP by providing experts and fellowships for training. Population Council also helps the NFPP in research work up to the present day. The total amount of assistance during 1972-1976 has been 782,300 US dollars or equivalent of 15,646,000 baht.

4. UNICEF has provided assistance in training public health personnel since 1969 and has provided motorbikes for the midwives throughout the country. The total amount of assistance provided by UNICEF during 1972-1974 has been 1,816,188 US dollars or equivalent of 36,423,700 baht (Total amount of UNICEF assistance is included in UNFPA assistance).

Moreover, there are also international organizations that provide indirect assistance to the NFPP at present, such as IPPF, Rockefeller Foundation, Ford Foundation, Population Center of North Carolina, University of North Carolina, etc.

7.1.3 Counterpart Funds

Counterpart funds are appropriated by the RTG, according to the Project Agreement with the donor agencies. The counterpart funds do not have the same characteristics as the regular budget. The counterpart funds consist of line items under 10 codes (code 01-10). They are salary and wages, lodging fees, transportation fares, per diem for training, per diem for traveling, cost of transport of commodities under aid program, office rent, cost of services under contract, cost of gasoline, and expendable supplies including cost of extension of buildings and offices, etc. Moreover, the counterpart funds in USAID projects do not include the cost of construction of buildings for the implementation of the Project activities, and the cost of land for the sites of the buildings. As for the assistance from other source i.e., UNFPA, besides the expenses, the counterpart funds also include land and buildings. Therefore it can be seen that the amount of counterpart funds in UNFPA projects is much higher than the amount of counterpart funds in USAID projects.

The total amount of counterpart funds in USAID Projects is about 22,084,026 baht. The total amount of counterpart funds in UNFPA Projects is about 129,346,450 baht (See Table 10 of the appendixes)

The counterpart funds in the projects of other sources of assistance, such as "WHO" and "UNICEF" are "in kind" category which will not be shown here.

7.2 Recommendations

If we consider the investment for the NFPP project implementation, it can be seen that the Project receives its budget from three main sources, namely, the regular RTG budget (During 1972-1976 the amount has been about 60 million baht); foreign assistance has been about 334 million baht during 1972-1976; and the counterpart funds from RTG have been about 150 million baht. The total investment from the three sources during 1972-1976 has been about 600 million baht, or averaged by year the NFPP has to use more than 100 million baht a year for project implementation.

From this rough figure, it can be seen that the RTG will have to accept the responsibility to appropriate a larger budget to implement the project after foreign support phases out, after a definite period of time according to the various commitments. The problem is to what extent will the RTG be able to accept this responsibility? If we look at the foreign assistance (See Table 2) which consists of about 5 categories, namely, commodities, technicians and experts, fellowships for training, donation for construction and expenditure for salary and wages of the staff and other miscellaneous expenses, it can be seen that the assistance for commodities and the salary and wages of the personnel have been more than other items and are the most important factors for the success of the NFPP. If the foreign assistance reduces gradually, the RTG should determine the time frame of aid reduction and determine the period of time of receiving assistance in accordance with the capability of the RTG to continue the NFPP operations after foreign assistance phases out.

Moreover, as the NFPP is the project at national policy level and it is a long term project, and the foreign assistance from various sources will phase out sooner or later, therefore what we should consider in connection with the budget for project implementation is to study what are the most essential things for the project implementation in the future, how much budget is needed in order to achieve the target projected, which means we have to utilize the existing resources to obtain the most benefit out of them.

8. Client Service Charges

8.1 Findings

8.1.1 Service charges at the health facilities where the family planning clinics are attached are found to be as follows: oral contraceptive pill, 5 baht per cycle; IUD insertion, 20 baht a case; vasectomy 50 baht a case; tubal ligation 150 baht a case. The health facilities spend the money received as service charges for maintaining and repairing the facility buildings, the personnel quarters, cost of electric light and water supply or purchasing medical supplies in some health facilities were found to have large deposits of money attained from service charges.

8.1.2 The service charges specified above are the highest rates that the family planning clinics should charge the clients. The health facilities in some provinces charge these flat rates without any exception, but the health facilities in some provinces charge flexible rates. For example, they charge 10 baht for 3 cycles of oral contraceptive pills and so on.

8.2 Recommendations

8.2.1 Rates of service charges or contributions for all contraceptive methods should be standardized.

8.2.2 The family planning clinics collect service charges from the people, and utilize the proceeds for other purposes which are not directly concerned with family planning. As the foreign assistance has definite time limits, it is recommended that future financial burden of the RTG be reduced by setting aside part of the proceeds derived from family service charges or contributions for costs of implementation of the NFPP in the future.

9. Service Statistics Recording and Reporting System

9.1 Findings

9.1.1 Family planning service statistics prepared by the NFPP Evaluation and Research Unit are not being utilized at the provincial and local level. Statistics data concerning drop outs, continuation rates and client characteristic data are not being analyzed or utilized to improve program operations or to solve operational problems.

9.1.2 The client record cards maintained in each clinic are excellent, readily available sources of operational data for provincial health administrators to assess program performance, but only a few provinces visited by the Evaluation Team, have been utilizing the client record cards to assess program performance.

9.1.3 Most of the health personnel who are performing family planning activities do not understand the methods of recording and reporting well, nor do they recognize the value of recording and reporting. Even in the family planning clinics to which family planning workers were assigned, the recording and reporting system was found not to be entirely satisfactory.

9.2 Recommendations

9.2.1 The NFPP and Office of Provincial Chief Medical Officers should compile client statistics data, classified according to different characteristics, into a year book or annual report to be used for planning and assessing program performance.

9.2.2 The operational units should collect statistics of continuation rates of the acceptors of various methods for the benefit of follow-up.

9.2.3. The NFPP should train the personnel who are concerned with recording and reporting system in order to assure the standardization of recording and reporting system of the NFPP. The NFPP should also develop an operational manual concerning the service statistics recording and reporting system.

10. Coordination with other agencies and organizations that are implementing family planning activities.

There have been other organizations and agencies outside the Ministry of Public Health, both government and private, which are delivering family planning services and promoting family planning activities. The NFPP and the Office of Provincial Chief Medical Officers should take positive steps to improve the coordination among various agencies and organizations by arranging routine meetings with them to discuss and get rid of any misunderstandings and to specify the scope of activities of each group or individual organization to mutual support each other. These organizations and agencies are:

10.1 Military and police medical hospitals and field clinics which have large number of people under their responsibilities. The cooperation and coordination with the military and police hospitals and field clinics may include the allocation of medical supplies such as oral contraceptive pills, IUD and condoms which the NFPP receives as assistance from foreign donors.

10.2 Other government agencies, such as the Department of Community Development, or the Ministry of Education where there is a program to use community development workers (C.D. workers) and teachers to distribute pills to the people. The cooperation with these two government agencies will certainly reduce the burden of the Ministry of Public Health. Besides helping to reduce the responsibility of the Ministry of Public Health, the cooperation will provide technical knowledge to the personnel of the two agencies to implement F.P. activities in accordance with right techniques.

10.3 Private organizations or various foundations, such as the Planned Parenthood Association of Thailand (PPAT) or the Office of the Community-based Family Planning Distribution System and so on. This sincere cooperation will provide the Ministry of Public Health with an image of coordinated effort and the actual consolidated statistic data, will enable the Ministry of Public Health to control and advise those organizations on the best ways to implement the family planning activities in accordance with proper techniques and principles, and to promote the government's job of improving health and welfare of the people at the same time.

10.4 There may be problems if the Ministry of Public Health which will benefit in the F.P. operations is assigned as coordinator. An agency that is not concerned with direct F.P. operations such as NESDB or BOB or both, should be assigned as coordinator.

10.5 Efficient family planning operations should conduct research and study activities to find better methods and techniques for implementing family planning operations at all times. Various universities within the country are capable of conducting research work. If there is close coordination, the research institutes of various universities within the country will be useful to the NFPP operations as a whole.

11. Demographic Impact of Family Planning Program.

11.1 Objectives and targets of the NFPP, 1972-1976.

One of the most important objectives of the NFPP during the Third Five Year Plan (1972-1976) of the Ministry of Public Health is "To reduce the annual population growth rate which is over 3% to 2.5% at the end of 1976.", and to achieve the said stated target of the reduction of population increase rate, the NFPP has specified the targets of initial acceptors by year and by method during 1971-1976 that during the period of six years, there must be 2,275,000 initial acceptors of all methods, to be classified as follows:

Table 1 Projected Targets of Initial Acceptors by method, 1971-1976

Year	Pill	IUD	Sterilization	All Methods
1971	200,000	80,000	20,000	300,000
1972	235,000	90,000	25,000	350,000
1973	280,000	90,000	30,000	400,000
1974	280,000	90,000	35,000	405,000
1975	280,000	90,000	40,000	410,000
1976	280,000	90,000	40,000	410,000
TOTAL	1,550,000	530,000	190,000	2,275,000

Source - Population Growth and Family Planning in Thailand, NFPP, MOPH, p. 57

In projecting the target, the NFPP has set up an assumption concerning continuation rates for oral contraceptive pills and IUD, based on baseline data of the Photharam Pilot Project and from family planning programs of other countries.

TABLE 2 Hypothesis of continuation rates for oral contraceptive pills and IUD.

Continuation Period after accepting F.P. services	Pill %	IUD %
(No. of Years)		
0	100	100
1	60	70
2	48	56
3	40	46
4	35	41
5	32	38
6	30	35
7	28	32

Source - Five Year Operational Plan, NFPP, MOPH, 1972-1976; (Final revised copy - undated), p. chor and sor.

From targets of initial acceptors in each year and from the hypothesis for the continuation rates, the NFPP has projected the Women Years of Protection 1/ that since the start of the Project (1971) until 1976 there will be 1,131,981 woman years of protection as shown in the following Table 3.

1/ Woman years of protection means the numbers of women who continue to use the services full year, such as a woman has accepted a contraceptive device for a period of one full year, it is equal to one woman year of protection. If a woman continues to use the contraceptive device for 6 months, it is equal to 0.50 woman year of protection. For example, in October, 12 women accept pill service; in November, 12 women accept the service and in December, 12 women accept the service. Supposing everyone of them accepts the service on the first day of the month, and everyone is still taking the pill, in the case like this, the number of woman years of protection is equal to 6.

TABLE 3 Number of Woman Years of Protection

Year	From Results of 1965-69 Performance	From Results of 1970 Performance	From Results of 1971-76 Performance	Total 1+2+3	Remarks
1971	197,938	106,604	7,324	311,867	
1972	174,718	120,600	155,525	450,843	
1973	160,186	98,199	350,003	608,308	
1974	150,120	84,861	544,336	779,317	
1975	142,145	76,941	744,175	963,261	
1976	134,217	71,834	925,929	1,131,981	

Source - Same as Table 2, p. Yor (Ying)

From the number of woman years of protection, the NFPP has projected the number of averted live births by using the data from the Survey of Demographic Change of the National Statistical Office, and the Survey on Fertility Status of Photharam Pilot Project. It then estimates the marital fertility rate of women aged 15-44, which was equal to 330 to 1,000 married women aged 15-44, if they are not accepting any method of contraception in one year, on the average will give birth to 330 babies, which means that if there are 3.03 woman years of protection, it will be able to prevent one birth in a year. For convenience's sake, the NFPP has used the ratio 3:1 as basis for projection of the births that can be averted, the result of which is shown in the following Table 4.

TABLE 4 Projection of Averted Live Births and the Reduced Birth Rate

Year	No. of Averted Live Births	Reduced Birth Rate per 1,000 population
1971	103,955	2.78
1972	150,279	3.88
1973	202,767	5.07
1974	259,770	6.29
1975	321,084	7.55
1976	377,323	8.61

Source - Same as Table 2, p. Dor Chada.

The natural increase rate can be estimated from data of the projection of the reduced birth rate per 1,000 population in 1976 which is equal to 8.6 per year and from the hypothesis that the population death rate will further reduce by 1.0 per 1,000 population. Therefore, the population increase rate reduce 7.6 per 1,000 population. In 1972, it had been estimated that the population increase rate was 33 per 1,000 population, the result of the NFPP operations will reduce the population growth rate in 1976 to only 25.4 per 1,000 population, or in other words, the annual population growth rate will be reduced from 3.3% to 2.54% at the end of 1976.

From various methods of projection as stated above, we can see that they are based on various hypotheses, such as:

(a) The hypothesis concerning the number of initial acceptors by method by year.

(b) The hypothesis concerning the continuation rates of the acceptors of non-permanent methods (pill, IUD)

(c) The hypothesis concerning the number of population (Projection of number of population at midyear and in each year), as well as the birth rate and death rate before the Project started and at the end of 1976.

11.2 Population Evaluation of NFPP

Even though there has been evaluation on the demographic impact of family planning program especially the fertility rate of the population in various countries that have implemented family planning program, in most cases the effort has not met with success because the family planning project of various countries cannot say with confidence that the reduced birth rate is solely the result of the family planning program "A major problem in measuring the impact of the family planning program on levels of fertility is the lack of reliable estimates on the post and current fertility". ^{2/} Even though the statistical services concerning birth rate is completely available, the reduced birth rate may also be influenced by various other factors, such as the change in the age at marriage, other social changes, such as urbanization of the suburbs of the city or township, improved education standards, women working outside their homes, or even the increase in abortion cases. As we are unable to evaluate the project by the controlled experiment method, the effort to evaluate the demographic impact of family planning program must therefore be based on hypotheses and various projections.

11.2.1 Demographic trend of Thailand

Even though the law on birth and death registration had been enforced since 1965, the vital statistics data were only printed for dissemination in 1937, but if we look at the crude birth rate (per 1,000 population), we can see that during the period of the past 40 years except 1964, 1965 and 1968, according to vital regulation figures, the natural annual rate of population growth of Thai people never reached 3%, especially during the period between the 1947 and 1960 censuses. The result of the two censuses indicates that during the stated period the population of Thailand increased at the constant rate of about 3.2%. Vital statistics for the corresponding period showed that only 6 years of the whole period had an annual rate of growth higher than 2%. ^{3/} Therefore it is undoubtedly a fact that the registration of births in Thailand at that time was very much incomplete. This statement had been confirmed by the demographic analysis of Das Gupta, et. al., ^{4/}

-
- ^{2/} Samuel Baum and William O'Leary, Problems in Interpretation and Projection of Fertility Changes in a Continuing Program of Population Projection (Washington, D.C.: The International Demographic Statistics Center, Bureau of the Census). Research Document No. 2, p. 1 Jack Reynolds, "Evaluation of Family Program Performance: A Critical Review", Demography, Vol. 9 No. 1 (Feb. 1972), pp. 69-86.
- ^{3/} Public Health Statistics, Thailand 1969 (Bangkok: Vital Statistics Division, Office of Under-Secretary, Ministry of Public Health).
- ^{4/} Das Gupta, et. al., "Population Perspective of Thailand" Sankhya (Indian Journal of Statistics) Series B., Vol. 27, 1965.

and various sample survey, such as the Survey of Population Change of the National Statistics Office in 1964-1965. It has been estimated that "the registration of birth was incomplete by about 15% and the registration of deaths was incomplete by about 30%. 5/

For the reason stated above, we are therefore unable to use the birth rates from the registration system as an indicator of the birth level. In view of the fact that the family planning acceptors since 1965 has continuously increased (from the program statistics), i.e., increasing from 35,000 acceptors in 1965 to about 400,000 acceptors annually since 1971, we may use the data from the survey in the said period to consider whether there have been any change in the birth rates of population of Thailand. The said data can be obtained from the Survey of the Population Change of the National Statistics Office and the Longitudinal Study of Social, Economic and Demographic Change in Thailand, conducted by the Institute of Population Studies, Chulalongkorn University (Data of the National Statistics Office and of the Institute of Population Studies may not be used for comparison for evaluating the change quite well because of the differences in procedures and universe, even though the samples of these two surveys have been selected to be the representatives of the population throughout Thailand. Due to lack of suitable data, however, we have to use the data of 1968-1969 and 1971-1972 of the Institute of Population Studies, Chulalongkorn University for evaluating the population change quite well because they interviewed the same households).

If we are to accept that the data shown in Table 5 below are quite accurate, it can be seen that during the past period of 7 years the birth rate of the population in Thailand has shown a downward trend.

5/ Report on Survey on Demographic Changes 1964-1965 (National Statistics Office, Office of the Prime Minister) Page 21.

TABLE 5 Estimate of fertility rates of Thai women, by age group in various years.

Mothers' Age Groups	Survey of Demographic Change of the National Statistical Office.	Longitudinal Study of the Institute of Population Studies, Chulalongkorn U.	
	1964 - 1965	1968 - 1969	1971 - 1972
15-19 years	.0664	.07196	.07126
20-24 years	.2589	.25550	.22837
25-29 years	.3026	.28569	.28648
30-34 years	.2731	.22907	.17759
35-39 years	.2224	.19767	.16559
40-44 years	.1123	.15211	.12253
45-49 years	.0251	.02882	.01441
Fertility Index	1.2068	1.22082	1.06619

Source of the data : Report of the Survey on Population Change 1964-1965 (National Statistical Office, Office of the Prime Minister) and "Tables on Fertility and Family Planning." Longitudinal Study of Social, Economic and Demographic Change in Thailand Rands I and II (Institute of Population Studies, Chulalongkorn University, August 1974), Table 13. Estimates of fertility rate by age group are made from marital fertility rate, using the ratio of the married women by age group from census 1970 as adjusting factor.

During the four years between 1964-1965 to 1968-1969, the fertility index (total fertility rates by age group.) shows a decrease of 3.2% but during the period of 2 years between 1968-69 and 1971-72 the fertility index shows a decrease of 3.7%. In terms of crude birth rate, calculating by using 1970 population census as "standard population", the age-sex adjusted birth rates will be as follows: 1964-1965 = 41.6 per 1,000

population; 1968-69 = 40.1 per 1,000 population and 1971-72 = 35.6 per 1,000 population, and it can be seen that the changing level of crude birth rate during the same period has the same rate as the change of the fertility index.

Since the data from these two surveys are obtained by means of sample survey, the change of the birth rate which may be simply sampling errors. As the two surveys did not compute the variance of birth rates, it is difficult to say that the change in the birth rates between 1964-65 and 1968-69 has really occurred or they are merely the variations between samples. If we consider samples sizes of the two surveys, they could be sampling variations. The birth rate that shows a decrease of a little more than 3% is not statistically significant.

As for the decreased birth rate of about 13% during the period of 3 years between 1968-69 and 1971-72, if a real change occurred could we be able to indicate that to what extent the decrease of birth rate was influenced by family planning operations, and to what extent it influenced by other factors. The reply is that we are unable to do that because the NFPP was not implemented in a pilot areas where there was control of various factors, but we may be able to estimate the decrease by relying on other statistic data, such as number of acceptors, continuation rates, etc.

During the 3 years period 1968 to the end of 1970, from the reports of the NFPP, it has been found that there were 413,000 initial acceptors, consisting of 164,000 pill acceptors; 203,000 IUD acceptors, and 46,000 sterilization cases, and the number of initial acceptors of all methods had increased from 57,000 cases in 1968 to 223,439 cases at the end of 1970, a 4 folds increase. Supposing that the initial acceptors in the period stated above had the same continuation rates as what had been obtained from the result of the follow up survey of the family planning acceptors in 1971, conducted by the Research and Evaluation Section of the NFPP, i.e., the IUD continuation rates were after accepting the service 6 months = 85%; 12 months = 76%; 24 months = 65% and 36 months = 57%. The pill continuation rates were : after accepting the service 6 months = 79%; 12 months = 69%; 24 months = 55%; and 36 months = 46%. Supposing no loss occurred, the number of initial acceptors from 1968 to the end of 1970 would be 413,000 cases, equal to 300,000 woman years of protection (excluded the result of operations before 1968) or equal to 100,000 cases of averted live births during the 3 years' period.

Now let us consider how many births must be decreased to have the age-sex adjusted birth rate changes from 40.1 per 1,000 population in 1968-69 to 35.6 per 1,000 population in 1971-72. If we take the number of population in mid 1968 to be equal to 34 million, and supposing that the death rate of the population was equal to 10 per 1,000 and it did not change, and supposing that the crude birth rate in 1967 = 38 per 1,000 population, the number of infants born in each year would be as follows:

1968	=	1,363,400
1969	=	1,330,889
1970	=	1,281,744

From the projection, based on the hypotheses stated above, when the crude birth rate decreased from 40.1/1,000 to 35.6/1,000, the number of infants born would be about 82,000. When we compare this with the projection of the averted live births (100,000 cases) affected by the NFPP operations, it can be seen that the number of live births' decrease was about 82% of the projected number of averted live births said to be affected by the operations of the National Family Planning Project.

From the result of all projections stated above, may we summarize with confidence that the NFPP during the stated period had a role in reducing the birth rate of the population? The answer is it is probable. This depends on the probabilities of various hypotheses used in the projection, such as:

1. All contraceptive methods are completely and immediately effective.
2. The same number of initial acceptors accept the services simultaneously on the first day of every month of each year.
3. The continuation rates of various contraceptive methods are reliable.
4. During the period of 6 or 12 months of each year, none of the acceptors discontinues using the services.
5. If a Thai woman of reproductive age practiced contraception for three years, she would avert one birth (i.e., 3 couples-years protection = 1 averted birth).
6. The statistic data concerning the initial acceptors are accurate, without repetitive counting, and the initial acceptors have never been the initial acceptors of other family planning clinics before.
7. Statistic data concerning birth rates from the surveys and the hypothesis concerning the number of population in the mid year and the death rates are accurate.

From the consideration of the hypotheses stated above it can be seen that some of them are improbable. The tests of these hypotheses must be based on various types of statistic data, for example, pill acceptors. If every pill acceptor continues to use the service for one full year, one woman will, on the average, have to use 13 monthly cycles of oral contraceptive pills. If we have accurate statistic data concerning pills, we will be able to project the number of active contraceptive pill users. Due to the lack of accurate data stated above and various other data, we can only say that the NFPP had a role in reducing the birth rate of the population. This again depends on the fact that the birth rate has really decreased.

11.2.2 The demographic impact of the operations of the NFPP (1972-1974).

From the targets of operations and the estimate of averted live births of the NFPP shown in 11.1 and from the statistics of results of operations which are higher than the targets, no matter on what basis we use to consider the target by year throughout the period of 4 years, or to consider the targets by contraceptive method (except the target of pill acceptors in 1973 which is 4% below target) or to consider the target of all contraceptive methods combined, the percentages of the results of operations are higher than the targets in various years as follows: 1971 = 34.7%; 1972 = 28.7%; 1973 = 2.9% and 1974 = 22.1%, over the period of 4 years, the result of operations is 21.1% higher than the target. (See appendix).

If the various hypotheses used in the projection of averted live births, and the statistic data of initial acceptors shown by the NFPP are accurate and reliable, the result of operations of the NFPP implemented so far have had an impact on demographic change, i.e., it caused the population birth rate to decrease in accordance with the objectives set up.

Now, let us turn to consider the conclusion stated above how far it is reasonable, using Project statistical data and the data of other surveys.

The operational monthly reports during 1971-1974 show the numbers of acceptors by method, and by assuming that the monthly discontinuation rate of pill acceptors is 7% every month, and the monthly discontinuation rate of IUD acceptors is 3% every month, (The hypotheses concerning the discontinuation rates of pill and IUD acceptors will cause the annual continuation rates to be higher, i.e., the annual pill continuation rate will be about 71%, and the annual IUD continuation rate will be about 85%, and the discontinuation rate will affect the estimate of woman years of protection to be higher than it should be) and the last hypotheses concerning sterilization, i.e., the acceptance of sterilization method will be immediately effective, we may estimate the number of woman years of protection from the NFPP operations in each year by using the following formula:

WYP	=	Woman Years of Protection
On	=	Number of Pill acceptors
In	=	Number of IUD acceptors
TLv	=	Number of Tubal ligation acceptors
Vn	=	Number of Vasectomy acceptors
a	=	Number of acceptors that changes in each month of the year.

By the formula stated above the numbers of women years of protection affected by the family planning operations in each year from 1971 through 1974 (without considering the results of operations of the past years) will be as follows:

1971

$$\text{WYP} = .4048 (294,607) + .4693 (86,034) + .5152 (23,516) = 131,372$$

1972

$$\text{WYP} = .4540 (327,582) + .5046 (90,128) + .5206 (32,668) = 211,208$$

1973

$$\text{WYP} = .4320 (268,374) + .5104 (93,449) + .5120 (49,606) = 189,032$$

1974

$$\text{WYP} = .4190 (305,204) + .4874 (89,739) + .5078 (80,482) = 212,488$$

If we compute the number of averted live births, we will get 43,791 averted live births in 1971; 70,403 averted live births in 1972; 63,011 averted live births in 1973; and 70,829 averted live births in 1974, or about 248,034 averted live births all together. This does not include the result of operations of the National Family Planning Project in the years before that, and it does not include the result of contraception carried out by the people themselves or the result of operations of private or voluntary organizations which do not submit operational reports to the National Family Planning Project to be compiled into the statistics.

Another method of projection of averted live births is the projection of the result of the maximum impact of the program, if we have the data concerning the number of cycles of pills used, number of IUD acceptors, and number of male and female sterilization acceptors, and know the IUD continuation rate and average age of the women sterilized. The rationale of this type of projection is that a number of all categories of family acceptors in each year have dropped out. Some of them may continue using the services, such as the pill users of 7-8 years ago and in the following years until the year we wish to project the impact, if they still continue using pills, it indicates the amount of pills that the Project distributed in that year (plus the amount of pills sold by the drug stores). As

for the IUD acceptors, from the continuation rate we are able to project women years of protection for each IUD acceptor, and/or for the sterilization acceptors, if the average age of the women is equal to 35 years and supposing that the women pass the fertility age groups at 45 years of age, and assuming that some die before passing fertility age, the number of years of protection from sterilization for each case is equal to 9 women years of protection etc. We may project the highest number of women years of protection of the NFPP at the end of 1974 (by including the result of operations since 1965) by using the formula modified from the formula of Dr. Samuel Wishik who prepared it for evaluating the Pakistan Family Planning Program, as follows:*

$$WYP = \frac{CO}{15} + 2.1 In + 9 (TLn + Vn)$$

When

- WYP = Women years of protection
CO_n = Number of cycles of pills distributed
In * = Number of IUD inserted
IL_n = Number of female sterilization
V_n = Number of male sterilization

* Samuel Wishik "Indexes for Measurement of Contraceptive Use" a unpublished paper written in April, 1968, quoted by Shirley J. Smith in Evaluation of Demographic Impact of a Family Planning Program (Washington, D.C.: The International Demographic Center, Bureau of the Census). Research Document No. 1, p.p. 5-7.

This equation indicates that 15 cycles of pills distributed will give one woman year of protection (usually it should be 13 cycles of pills) but when considering the loss as some of the pills distributed are not used, the computing of 15 cycles seems to be more realistic and one IUD inserted will give 2.1 women years of protection (calculated from the continuation rate of the survey and each sterilization case will averagely give nine women years of protection.)

Therefore the highest number of women years of protection of the NFPP at the year ending 1974 will be equal to:

$$\text{WYP} = \frac{4,000,000}{15} + 2.1 (471,286) + 9(76,989) = 1,949,268$$

and the number of averted live births as the result of NFPP operations at the end of 1974 will be about $1,949,268/3 = 649,756$. When compared with the protection in Table 3 it can be seen that this projection is lower than the NFPP projection by 12% even when the number of initial acceptors is 12% higher than the target.

In addition to the results of NFPP operations, some women did not accept the family planning services from the operational units that submit reports to the NFPP, this is noted in the report concerning the quantity of pills sold by the private sector, compiled by Price Waterhouse which stated that about 3,400,000 cycles of pills, sold by the private sector. In the case of pills sold by the private sector, we may use the principle that 13 cycles of pills will give one woman year of protection. Then we will get the number of women years of protection = 261,528 or 87,179 averted live births.

Therefore, if we wish to estimate the highest number of averted live births during the year ending 1974, it will be about 737,000 showing the impact of the NFPP to be about 88.2% and from the contraception initiated by the women themselves about 11.8%.

One thing that is worth observing is that if the result of operations of NFPP and the contraception initiated by the women themselves without accepting services from the NFPP, turn out to be as estimated above, and if the statistic data from the Longitudinal Study of the Institute of Population Studies indicating that the crude birth rate of Thai people in 1971-1972 was about 36 per thousand is considered to be accurate, at present, the birth rate as well as the rate of growth of Thai people must have been lower than the level which the NFPP hope to achieve at the end of 1976. The accuracy and the outcome all depend on the validity of various hypotheses stated above. As for the real birth rate death rate and population growth rate at present, we have to wait until the result of the survey of the demographic change being conducted by the National Statistics Office since 1974 is published.

However, in trying to estimate the averted live births based on statistic data of the actual result of operations (throughout the period of 4 years the number of initial acceptors is 21% higher than the target) even though the estimate is lower than the projection of the NFPP, when the number of initial acceptors is in accordance with the target, it can be concluded that the result of operations of the NFPP has a significant impact on the decreasing birth rate but we would like to emphasize ~~this~~ conclusion concerning the achievement of the target stated in the beginning of the report that "The National Family Planning Project should endeavor to maintain the number of initial acceptors to be at least 20% higher than the target, in order to get the needed number of averted live births".

11.3 Recommendation

In order to measure the contribution of the family planning program in reducing the rate of population growth, the result of which will be considerably useful to the planning of the program in the future, the controlled experimental study extending over the period of 4-5 years should be conducted. In addition, efforts should be made to improve the demographic statistics system with a view to obtaining more accurate and up-to-date data.

Table 1 Reported Initial Acceptors as a percent higher or lower than the Target by Method, 1972-1976

Year	Pill			IUD			Sterilization			All Methods		
	Target	Acceptors	% Higher+ Lower -	Target	Acceptors	% Higher+ Lower -	Target	Acceptors	% Higher+ Lower -	Target	Acceptors	% Higher+ Lower -
1971	200,000	294,607	+ 47.3	80,000	86,034	+ 7.5	20,000	23,546	+ 17.7	300,000	404,187	+ 34.7
1972	235,000	327,582	+ 39.4	90,000	90,128	+ 0.1	25,000	32,668	+ 30.7	350,000	450,960	+ 28.7
1973	280,000	268,674	+ 4.0	90,000	93,449	+ 3.8	30,000	49,606	+ 28.7	400,000	411,729	+ 2.9
1974	280,000	305,244	+ 9.0	90,000	89,739	- 0.1	35,000	73,702	+110.6	405,000	494,479 ¹	+ 22.1
1975	280,000	-	-	90,000	-	-	40,000	-	-	410,000	-	-
1976	280,000	-	-	90,000	-	-	40,000	-	-	410,000	-	-
Total 1971- 1974	995,000	1,156,107	+ 16.2	350,000	359,350	2.3	110,000	186,302	69.4	1,455,000	1,761,355	21.1

Remarks - The total of All Methods is higher than the sum of All Methods because the total of All Methods includes the acceptors using methods other than those listed. (e.g., Foam, Diaphragm, Condoms etc.)

Sources - NFPP Performance Reports 1973-1974. Research and Evaluation Unit, NFPP, MOPH.

Table 2 Projected Targets and Reported Initial Acceptors as a percent of Married Women.

Year	No. of Eligible Women aged 15-44 1/	No. of Married Women 2/	% Target/Married Women	% Reported Initial Acceptors/Married Women	Remarks
1971	7,768,000	4,800,600	6.3	8.4	
1972	8,005,000	4,947,100	7.1	9.1	
1973	8,250,000	5,098,500	7.9	8.1	
1974	8,507,000	5,257,300	7.7	9.0	
1975	8,775,000	5,423,000	7.6	-	
1976	9,049,000	5,592,300	7.3	-	

Remarks - 1/ Population Projection of Thailand 1960-2000, Table 12, p. 18, jointly prepared by National Economic and Social Development Board, the Institute of Population Studies, Chulalongkorn University, and the National Statistical Office.

2/ About 61.8% of the eligible women (aged 15-44) are married. Source - The Third 5-Year National Development Plan, 1972 - 1976, Thai National Family Planning Project, Appendix 1, p. 3, Line 8.

Table 3 Numbers of Active Pill Users.

Calendar Year	From Result of 1971 Performance 1/	From Result of 1972 Performance 2/	From Result of 1973 Performance 3/	From Result of 1974 Performance 4/	From Result of 1975 Performance 5/	From Result of 1976 Performance 6/	From Result of 1971-74 Performance	From Result of 1971-76 Performance
1972	176,764	-	-	-	-	-	176,764	176,764
1973	141,411	196,549	-	-	-	-	337,960	337,960
1974	117,843	157,239	161,204	-	-	-	436,286	436,286
1975	103,113	131,033	128,964	183,146	-	-	546,256	546,256
1976	94,274	114,654	107,470	146,517	168,000	-	462,915	630,915
1977	88,382	104,826	94,036	122,098	134,400	168,000	409,342	711,742

Remarks - 1/ - 4/ Family Health Division ; the projection of the number of active pill users is based on the result of the study of the continuation rates at Photharam District.

5/ - 6/ Acceptor targets ; the projection of the number of active pill users is based on the result of the study of the continuation rates at Photharam District.

Table 4 Numbers of Active IUD Users

Calander Year	From Result of 1971 Performance 1/	From Result of 1972 Performance 2/	From Result of 1973 Performance 3/	From Result of 1974 Performance 4/	From Result of 1975 Performance 5/	From Result of 1976 Performance 6/	From Result of 1971-74 Performance	From Result of 1971-76 Performance
1972	60,224	-	-	-	-	-	60,224	60,224
1973	48,179	63,070	-	-	-	-	111,249	111,249
1974	39,576	50,472	65,414	-	-	-	155,462	155,462
1975	35,274	41,459	52,331	62,817	-	-	191,881	191,881
1976	32,693	36,952	42,987	50,254	63,000	-	162,886	225,886
1977	20,112	34,249	38,314	41,280	50,400	63,000	143,955	257,355

Remarks - 1/ - 4/ Family Health Division ; the projection of the number of active IUD users is based on the result of the study of the continuation rates at Photharam District.

5/ - 6/ Acceptor Target ; the projection of the number of active IUD users is based on the result of the study of the continuation rates at Photharam District.

Table 5 Number of personnel who perform F.P. activities at the provincial level in 1973, classified by region.
(Data from Rural Health Division, Ministry of Public Health)

Region	Physicians	Nurses	Health Midwives	Sanitarians
Central	337	950	1,369	974
Northern	179	693	1,013	756
Northeastern	215	719	1,501	1,118
Southern	146	516	862	555
Total	887	2,878	4,745	3,403

1/ Includes physicians working in hospitals, offices of Provincial Chief Medical Officers, and First Class Health Centers within the Ministry of Public Health.

Table 6 Number of personnel of various categories who have received on-the-job training in Family Planning during 1968 - 1973

Categories	1968	1969	1970	1971	1972	1973
Physicians	87	102	141	100	148	-
Nurses	174	203	323	170	220	120
Health Midwives	928	1,003	1,139	729	129	1,390
Sanitarians	-	-	1,985	-	-	-
F.P. Workers	-	-	20	80	-	-
F.P. House Visitors	-	-	-	-	-	-
Personnel at Central Agency	-	-	-	-	-	41
Total	1,209	1,308	3,608	1,079	547	1,551

..... Table 7. Qualifications of personnel at the NFPP Central Headquarters.

Qualifications	1973	1974	Remarks
Ph. D.	1	1	
Master Degree	16	11	
Bachelor Degree	24	37	
Diploma	2	2	
Certificate	7	27	
Total	50	82	

Remarks - Both RTG officials (RTG-funded) and employees funded by international agencies or C.F. funds are listed in the table above. Drivers and other categories of service personnel are not listed.

Table 8 Number of personnel at the NFPP Central Headquarters, classified by type of work, 1973-1974.

No.	Type of work	Government Officials		Employees funded by International Agencies		Employees assigned on permanent basis		Remarks
		1973	1974	1973	1974	1973	1974	
1	Physicians	8	4	-	-	-	-	
2	Nurses	5	11	-	-	-	-	
3	Health Educators	4	5	-	-	-	-	
4	Researcher	1	1	1	2	-	-	
5	Statisticians	2	1	1	2	-	-	
6	Mass Communicators	-	-	7	9	-	-	
7	Administrative Officers	1	-	3	6	-	-	
8	Public Relations Officers	-	-	-	2	-	-	
9	Chief of Coders	-	-	-	2	-	-	
10	Resource Persons	1	-	-	1	-	-	
11	Journalists	-	-	-	1	-	-	
12	Research Workers	-	-	1	1	-	-	
13	Accountants	1	2	-	1	-	-	
14	Interpreters	-	-	1	1	-	-	
15	Draftmen	-	-	-	1	-	-	
16	Electronicians	-	-	-	1	-	-	
17	Printers	-	-	-	1	-	-	
18	Clerks	2	4	16	9	-	-	
19	Typists	-	-	1	2	-	-	
20	Coders	-	-	10	10	-	-	

Table 8 (continued)

No.	Type of Work	Government Officials		Employees funded by International Agencies		Employees assigned on permanent basis	
		1973	1974	1973	1974	1973	1974
21	Punching Clerks	-	-	1	1	-	-
22	Drivers	-	-	1	10	-	10
23	Mechanics	-	-	-	1	-	-
24	Electricians	-	-	-	1	-	-
25	F.P. Workers	-	-	-	-	-	100
26	Sanitarians	-	-	-	1	-	-
27	House Visitors	-	-	-	-	5	18
28	Laborers	-	-	1	7	10	-
29	Statistic Clerks	-	-	-	8	-	-
30	Janitors	-	-	-	-	2	-
31	C.F. Temporary Workers	-	-	-	-	37	-
Total		25	28	44	83	54	128

Remarks - 25. One hundred F.P. workers were stationed in the provinces in 1974.

26. Seventeen of house visitors are working at the NFPP Central Headquarters.

31. Total number of temporary workers in 1973 = 37

Total 1973 = 123

Total 1974 = 234

TABLE 9 Numbers of Active Pill Users and Initial Acceptors, and number of cycles of pills dispensed by month in 1974**

Month	No. of Acceptors		No. of Cycles of Pills dispensed		Remarks
	Active Users	Initial Acceptors	Active Users	Initial Acceptors	
January	819	84	1,542	84	Note that the number of active users did not show significant gains during the year
February	1,432	82	1,724	82	
March	900	87	1,587	87	
April	861	96	1,575	96	
May	1,004	91	1,875	91	
June	891	68	1,644	68	
July	962	84	1,791	84	
August	944	93	1,653	93	
September	1,006	71	1,837	71	
October	842	68	1,583	68	
November	1,030	79	1,872	79	
December	1,013	76	1,874	76	
Total	11,776	979	20,557	979	

**Performance of seven (7) first class health centers.

TABLE 10 Foreign Assistance, classified by Source of Assistance by Year (1972 - 1976)

Unit = U.S.Dollars

Sources	Total 1972-1976	Amount of Assistance					Remarks
		1972	1973	1974	1975	1976	
USAID	9,116,988	1,406,150	1,616,400	2,260,438	830,000 ^{1/}	3,004,000 ^{2/}	<u>1/</u> Project Budget Submission through Congress <u>2/</u> USOM Funding Estimates <u>3/</u> Estimated Figure.
UNFPA (WHO, UNICEF)	6,377,649	736,341	1,067,290	1,945,268	1,896,147	732,603	
Pop. Council	782,300	373,500	254,800	129,000	25,000 ^{3/}	-	
Denmark	460,400	443,600	16,800	-	-	-	
U. K.	17,165	-	-	17,165	-	-	
Total	16,754,502	2,959,591	2,955,290	4,351,871	2,751,147	3,736,603	
RTG Counterpart Funds:							
In USAID Projects	1,104,001	137,979	90,225	267,601	267,911	340,484	
In UNFPA Projects	11,933,452	N/A	2,146,330	2,865,635	3,925,700	2,995,787	

TABLE 11 Foreign Assistance, classified by Source and Type of Assistance. (1972-1976)

Unit = US Dollars.

		Categories of Assistance/ Costs (1972-1976)					
		Commodities	Experts	Funds for Training	Cost of Construction	Salaries & Wages.	Others
USAID	9,116,988	4,118,238	396,000	1,004,850	-	-	593,900 3,004,000 ('76)
UNFPA (UNICEF, WHO)	6,377,649	3,117,498	345,762	445,498	470,000	157,119	1,841,772
Pop Council	782,300	21,000	216,000	52,220	-	468,080	25,000 ('75)
Denmark	460,400	-	-	-	400,000	-	60,400
U.K.	17,165	17,165	-	-	-	-	-
Total	16,754,502	7,273,901	957,762	1,502,568	870,000	625,199	5,525,072

DTEC, May 20, 1975.