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87

THAILAND'S POPULATION PLANNING PROJECT II (1982-1987)

MID-TERM PROJECT EVALUATION

Project No. 493-0325

August 3, 1984

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PP II Mid-Term Evaluation

TABLE OF CONTENTS

Acknowledgments

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A report in handwritten form would be indecipherable (as the team became all too aware). For typing support above and beyond the call of duty, we thank Khun Charunee Bejrakashem and Khun Kanda Lochaya. For her magnificent and sustained response to the vast flow of barely-legible narratives, tables, figures and lists we are indebted to Khun Vinie Sunthanarangsun who is responsible for bringing the report into its current form.

ABBREVIATIONS

AFPH	Accelerated Family Planning and Health Baseline Study
AM	Auxiliary Midwife
AID	Agency for International Development
ASIN	Association for Strengthening Information in Support of the National Family Planning Program
AVS	Association for Voluntary Sterilization
BMN	Basic Minimum Needs
CBD	Community Based Distribution of Contraceptives
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHW	Community Health Worker
CPS	Contraceptive Prevalence Survey Conducted by the National Institute for Development Administration
DHO	District Health Officer
DMPA	Injectable Contraceptive
DTEC	Department of Technical and Economic Cooperation
EOP	End of Project
FHD	Family Health Division
FLE	Family Life Education
FP	Family Planning
FPIA	Family Planning International Assistance
FP/MCH	Family Planning and Maternal & Child Health
FY	Fiscal Year (October 1-September 30)
IEC	Information/Education Communication
IPR	Information and Public Relations Section, FHD
IPS	Institute of Population Studies, Chulalongkorn University
IPSR	Institute for Population and Social Research, Mahidol University
IUD	Intrauterine Device
JICA	Japanese International Cooperation Agency
MCH	Maternal and Child Health
MCH/FP	Maternal and Child Health and Family Planning
MIS	Management Information System
MOI	Ministry of Interior
MOPH	Ministry of Public Health
MWRA	Married Women of Reproductive Age
NESDB	National Economic and Social Development Board
NGO	Non-Governmental Organization
NIDA	National Institute of Development Administration
NLS or LS-1 & LS-2	National Longitudinal Study of Economic and Demographic Change - Chulalongkorn University, Institute for Population Studies
NM	Nurse Midwife
OC	Oral Contraceptives
OR	Operations Research or Operating Room
PCMO	Provincial Chief Medical Officer
PDA	Population and Community Development Association

PHC	Primary Health Care
PP	Project Paper (for PP II)
PP II	Population Planning II (USAID-assisted project)
PPAT	Planned Parenthood of Thailand
R/E	Research and Evaluation Section, FHD
RPEP	Rural Poverty Eradication Program
RTG	Royal Thai Government
SOFT	Survey of Fertility in Thailand, conducted by IPS and NSO
SSS	Service Statistics System
TAVS	Thai Association for Voluntary Sterilization
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TR	Tubal Resection (female sterilization)
T/S/E	Training Supervision and Education Section, FHD
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAS	Vasectomy (Male Sterilization)
VHC	Village Health Communicator
VHV	Village Health Volunteer
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

Currency Equivalent
US$1 = Baht 23

Table of Figures

Table of Tables

Table of Tables

Table of Annexes

EXECUTIVE SUMMARY

The mid-term evaluation of the Population Planning II project was conducted from June 18 - July 20, 1984. The evaluation team, comprised of Thais and Americans, represented 9 pertinent public health disciplines: demography; biostatistics; program and project management, administration and coordination; reproductive health; MCH/FP; health planning; evaluation; training and supervision; and information, communication and education. Almost two-thirds of the team had served on previous USAID/Thailand population project evaluations.

The scope of work for the evaluation -- provided in the Introduction to this report -- aimed at broader objectives than the usual mid-term assessment of project progress. It directed the team to look ahead to the next development plan period and to forecast needs for USAID and other assistance, based on targets set or being set for the 6th Economic and Social Development Plan. Although time did not permit in-depth coverage of every item in the scope of work, the team has attempted to identify strengths, problem areas and needed mid-term project corrections of PP II, and to forecast demographic and general resource needs for the 6th Plan period. The observations and recommendations contained in this report are a result of analysis and synthesis of information obtained from briefings, field visits, reviews of documents and materials, team discussions, and team members' professional experiences and backgrounds.

The following summarizes data and major perceptions elaborated on in the report:

1. A continuing fertility decline -- from a CBR of 26.9/1000 in 1981 to 21/1000 in 1984 -- is attributable to increased contraceptive prevalence which is largely a result of the NFPP. This has affected the population growth rate which has declined from 1.8% to an estimated 1.6% over the 1981-1984 period.

2. PP II is appropriately focused and adequately funded; however, there is need to strengthen certain components -- research and evaluation, the MIS, intersectoral coordination and training impact assessment -- and to add several elements consistent with the objectives in the Project Paper. These include: increased availability of services to special groups (hilltribes, residents of the Northeast region, slum-dwellers and factory workers); extension of services and support systems through additional resources and technical support; MOPH implementation of existing service policies; increased involvement of and collaboration with NGO providers; provision of participant training and study tour opportunities, particularly for provincial-level family planning personnel, and other means which are detailed in the report.

3. The targets set in PP II for the annual growth rate, service facilities, contraceptive prevalence, new acceptors and active users are on-stream and in some cases, have already been achieved. For example:

a. The PP II target of new acceptors for the 5th Plan is 5.3 million. From 1982 - April 1984 (with 2/3 of the year remaining) there were 2,594,898 new acceptors. According to the PP, by this time there should be 2,320,000 new acceptors.

b. The PP II target for active users is 4.2 million. From 1982-1983, the reported number of active users was 7,405.7 million. Thus, the PP II target has already been exceeded -- by 76%.

c. The annual growth rate target by 1986 (the original end-date of PP II) is 1.5%. Already, the estimated annual growth rate is 1.6% which is expected to decline to at least 1.5% by 1986, and further by 1987, the current EOP.

d. Tamboi (sub-district) level static facilities offering IUD services number 561 of the 7,169 service points. This target is on-stream if: (1) training of AMs proceeds as planned; (2) there is total implementation of MOPH policy; and (3) IUD kits are promptly provided to trained auxiliary midwives.

e. Village-level availability of orals and condoms is estimated at 85% coverage; the PP II calls for 60%.

f. Contraceptive prevalence is, according to preliminary CPS 3 data, over 60%. There are regional variations but even with these, the PP II target of 45% in "lagging provinces" will have been exceeded by 1987 and is already exceeded in the "lagging" Northeast region.

g. Vasectomy and IUD acceptance has much exceeded the modest 5% annual increase targeted in the PP: in 1983, IUD acceptance increased 51% over 1982; vasectomy acceptance increase for the same period was 16%. Data for the first part of 1984 indicate greatly increased acceptor levels for IUD and vasectomy over 1983 -- in the 60-70% range if current momentum is sustained.

4. With 35% pf PP II project time elapsed, 32% of the total project funds have been committed and 21% have been expended.

5. The Ministry of Interior has established policy guidelines that direct provincial and district administrators to promote and support family planning. This initiative, not anticipated by the PP II planners, adds a large and influential promotional system to the NFPP's decentralized service system. However, there are several emerging issues that the team feels should be resolved in order to improve and strengthen both short and long-term policy and working relationships. The team has also recommended that a portion of funds available for re-programming be used to support provincial-level MOPH/MOI initiatives.

6. USAID bilateral and AID intermediary and other donor support will be required during the 6th Plan period. The precise amount and nature of external assistance that will be required must reflect (a) an expected increase of 30% in the number of married women of reproductive age in the next seven years; (b) a growing number of active users that far exceeds the 5th Plan expectations in the Project Paper; and (c) a realistic appraisal of RTG's funding commitments.

The extent of external assistance that will be required to achieve a 1.2% annual growth rate target will emerge during preparation for the 6th Plan. The team has recommended that the preparatory phase be initiated immediately and receive financial and technical support under PP II.

Overall, the evaluation team gives high marks to the NFPP and to PP II. The recommendations made by the team are intended to make a very good program even better, and to provide a context for discussions by NFPP and USAID about desired and necessary changes and future USAID participation in Thailand's widely chronicled reproductive revolution.

PART ONE

I. Introduction

Fourteen years ago, the National Family Planning Program (NFPP) was established in recognition of the adverse effect of rapid population growth on social and economic development objectives. At that time, USAID's assistance to population/family planning began, and over the years has increased and diversified in response to the growth and program complexity of the NFPP.

The subject of this report is a mid-term evaluation of PP II which represents USAID's financial and programmatic assistance to the NFPP for the period of the 5th Economic and Social Development Plan (1982-1986). The evaluators also looked ahead, as requested, to the 6th Plan to assess the probable adequacy of resources required to achieve its demographic targets.

The scope of work for this evaluation contained the following elements:

I. Review and assess the performance to date of all PP II financed activities with special emphasis on the following:

A. Manpower development and supervision: Assess adequacy of current Project training programs, particularly IUD insertion training and the sterilization training for district physicians.

B. Information, education, and communication: assess current performance and determine relevance of planned IE&C strategy for the remaining life of the project.

C. VSC and IUD services: Assess adequacy of current coverage as well as qualitative and quantitative aspects of this service.

D. Contraceptive and related medical supplies: Assess current stock situation, and future requirements.

E. Assess reasons for low contraceptive continuation rates and make recommendations for improvement.

F. Program, operations and biomedical research: Assess current performance, identify unmet needs for research, review organizational arrangements needed to ensure effective overall coordination of research activities, and make recommendations for improvement.

G. Review mix of contraceptive methods offered in the NFPP including proposed new methods such as sub-dermal implants, together with alternative service delivery strategies now employed. Identify weaknesses in current service delivery practices and make recommendations for optimal delivery of family planning services.

H. Determine if the NFPP is meeting its targets as proposed in the 5th Plan and in the Project Log Frame.

I. Identify the contraceptive needs and nature of special emphasis programs required to reach potential acceptors in different geographic regions, age groups, ethnic and religious minorities.

II. Review and assess the organization and management of the NFPP as it affects the Population Planning II Project with special attention to policy formation, manpower utilization, program planning, management information systems, internal coordination and coordination with key outside agencies and the private sector, supply management and financial management. Special attention should be given to long term cost effectiveness issues, (e.g., What are the long-term cost implications of current NFPP approaches to fertility reduction). Make recommendations for improved organization management and financing of the NFPP.

III. Assess the demographic impact of the NFPP. Determine contraceptive continuation rates and impact on fertility reduction. Determine contraceptive prevalence requirements by method to reach the established and proposed targets in the 5th and 6th Five Year Plans.

IV. Assess the current and potential future contribution of other external donors to the NFPP, including AID-intermediary organizations such as the Population Council, FPIA and IPAVS. Assess the extent to which the RTG and other donors will be able to provide the necessary resources to meet demographic targets proposed for the 6th Five Year Plan. Determine the gap in RTG resources necessary to meet the 6th Five Year Plan targets upon the expiration of the Population Planning II Project and make specific recommendations for filling the gap through centrally-funded projects of AID-intermediaries operating in Thailand, and bilateral assistance.

V. On the basis of the foregoing analysis of the performance, needs and priorities of the NFPP, make specific recommendations for those project funds which should be reprogrammed for other uses, and identify, prioritize and describe those other uses in detail.

VI. Prepare and present to the RTG and USAID before leaving Thailand a detailed written report of the findings and recommendations of the evaluation team.

Specific outcomes of the evaluation were detailed as follows:

I. <u>PP II Project Performance</u>

a. Strengths and weaknesses of current project
b. Detailed recommendations for improving project peformance
c. Outline of suggested 3rd year implementation plan
d. Suggestions for $ reprogramming

II. Analysis of Future Needs: (6th 5-Year Plan Period)

a. Demographic trends
b. Gaps in services
c. RTG and other donor roles
d. Proposed USAID support

A total of one month was allotted to the evaluation. A Thai/American team, led by Dean (Dr.) Debhanom Muangman and co-led by Dr. Donald Minkler, held briefings in Bangkok followed by tandem team visits to the North, Northeast, Central and Southern regions. Pertinent documents were reviewed and team discussions were held to share and review information and points of view, and to determine, by reaching consensus, the response of the team to crucial issues raised during briefings and field observation. A preliminary presentation of findings and recommendations was made to the Minister of Health, senior members of his staff, and NFPP administrators and managers. A similar presentation was given to USAID's Acting Director and members of her staff. Several discussions were held by the team and individual team members with Mr. Terrence Tiffany, USAID's H/P/N Officer, in order to clarify and obtain his perceptions on various elements in the scope of work.

The magnitude of challenge presented by the scope of work may even exceed the challenge to be faced by the NFPP as the MWRA increases by 30% in the next seven years. It is unnecessary to state (albeit true) that time was insufficient to provide in-depth coverage of all items in the scope of work, and to sufficiently differentiate between the NFPP's program and PP II which, by design, was quite properly integrated with, not extraneous to, ongoing activities of the national program. The team hopes that its reviews and recommendations will serve as a basis for discussion and change, and that the report has accorded proper recognition to the public and private sector efforts that support, promote and invigorate family planning activities in Thailand.

II. MAJOR FINDINGS

A. The NFPP is a mature, innovative, and successful program which, assuming its present momentum is maintained, is certain to exceed its Fifth Development Plan target of a 1.5% population growth rate.

B. The team's demographer and biostatistician updated the current demographic situation, revealing the following salient evidence;

1. The growth rate which was estimated by the evaluators in 1981 at 1.8% has declined to a currently estimated 1.6%.

2. The crude birth rate has declined from approximately 27/1,000 in 1981 to a currently estimated 21/1,000.

3. Preliminary tabulations of the Third Contraceptive Prevalence Survey just concluded indicate that prevalence now exceeds 60% of MWRA, compared with an estimated 58.2% in 1981.

4. A 30% increase in the MWRA can be expected between 1983-1991.

C. The decline in the population growth rate can be attributed to a continuing decline in fertility for which the NFPP is largely responsible.

D. The policy guidelines of the Ministry of the Interior have contributed to accelerated progress toward Fifth Plan targets to the extent that the guidelines have thus far been implemented.

E. The evaluation team finds that the PP II project is appropriately focused and is making a significant contribution to the overall success of the NFPP. However, there are areas which need to be strengthened and improved in the future.

F. Private sector (NGO's) have provided a significant, unique, and complementary contribution to the NFPP serving to extend and strengthen the RTG program.

G. MOPH policy permitting trained AMs and NMs to insert IUD's and administer DMPA is not being evenly implemented.

III. MAJOR RECOMMENDATIONS TO THE NFPP

A. Need for New Strategies and Extension of Services

The number of family planning acceptors continues to increase. However, increasing contraceptive prevalence will require new strategies to reflect the age and parity of continuing acceptors. Significant extension of services will also be required to accommodate the expected 30% increase in MWRA during 1983-1991.

Increased attention and support should be given to the further extension and improvement of family planning services. This includes:

1. Implementation of MOPH policy permitting trained AM's and NM's to insert IUD's and administer DMPA injections;

2. Provision of additional resources and technical support for both male and female VSC and IUD insertion;

3. Increased availability and access to IUD, sterilization and DMPA services particularly in the Northeast provinces;

4. Extension of services to hilltribes;

5. Expansion of activities in the private sector, particularly those in VSC and IUD insertion, services to slum-dwellers and factory workers, and in family life education;

6. Provision of added support services, including transport, more timely and useful management information and improved management practices;

7. Addition of Norplant to the method mix, if approved by the FDA, and on the basis of findings from clinical trials;

8. Major emphasis and support for improving continuation rates of temporary method users, and promotion of permanent methods among those who have achieved desired family size;

9. Investigation of the potential for family planning training of nurse aides assigned to health centers in provinces that have demonstrated capability for IUD insertion training.

10. Provision of third country or U.S. based short-course training opportunities or observational study visits for provincial-level personnel.

B. Strengthening of Training and Supervision Systems to Increase Capability and Utilization of the Service System

The following assessments, reviews, studies and systems need to be initiated during the next year:

1. Provincial-level manpower needs assessments and review and development of training plans in "lagging provinces" first, and other provinces, subsequently.

2. An efficiency study to determine whether health centers with trained AM's working under supportive provincial family planning policies are being used at optimal levels and identification of barriers that impede optimal use.

3. Development of a comprehensive and systematic training evaluation and monitoring system that is keyed to provincial-level manpower needs assessments and training plans.

4. A needs assessment of family planning teaching and training materials, aids and models in all Schools of Midwifery and MCH Centers, and assessment of needs for transportation for students' and trainees' field practica.

5. Feasibility review of MCH Centers as sites or staff trainers for health center team training and if feasible, design and piloting of a curriculum emphasizing team training in family planning service delivery.

6. Establishment of several pilot areas for demonstration of a peer review supervisory system, and comparison of AM performance and achievement in those areas with AM performance and achievement in similar service areas using a traditional supervisory system.

7. Conduct an AM task analysis in preparation for a review of the basic curriculum for AMs.

C. Planning and Support Should Be Provided for Enhanced Coordination of the MOPH with the MOI. This includes:

1. Joint policy formulation between MOI and MOPH in which the technical staffs of both provide more substantive input.

2. Formal machinery to insure coordination of policy implementation at technical levels, centrally and provincially.

3. Financial support and technical assistance as needed for a joint MOPH/MOI exercise in target setting which reconciles the "campaign" strategy with the MOPH's ongoing service program.

4. Support for an orientation program for MOI officials, including an I&E publication from the MOPH, possible workshops/seminars for MOI provincial and district officers, and consideration of block grants, for promotional and coordinating activities, preferably related to performance targets and mediated through MOPH channels.

D. Increased Coordination of the NFPP with Other Population-Related Government and Non-Governmental Activities

1. USAID and the RTG should jointly support a National Population Seminar for representatives from the universities, the concerned Ministries and the private sector to be held before the end of 1984 to discuss the implications of CPS 3 and other topics relevant to the preparation of the population component of the Sixth Economic and Social Development Plan.

2. The School Health Division and FHD of MOPH, and the primary, secondary and Non-Formal Education Divisions of MOE should determine the feasibility of introducing and/or extending Population Education and FLE into formal and non-formal education systems.

3. Increased coordination of the NFPP with the Social Preparation Program and Basic Minimum Needs/Primary Health Care program should be achieved through:

a. Assurance of appropriate family planning content in the Social Preparation, BMN, and PHC programs particularly at district and tambol levels, and in training programs; and

b. Improved coordination of the NFPP with the RHD management system.

4. Development of a common data base for use of multisectoral development personnel at village, tambol and district levels to achieve improved coordination and complementarity in performance target setting and other activities.

5. Greater emphasis on information-sharing and education among the development sectors at the provincial level to promote complementary objectives and mutual support, (e.g., continuing education, orientation, and reference materials).

6. Addition of a Sub-Committee or Working Group on Population Policy to assist the National Family Planning Committee in review, analysis and updating of Ministries' policies and strategies in support of the achievement of the target growth rate.

7. Assure that the private sector is a participant in the RTG's preparation for the 6th Plan.

E. Promote and Support Preparation for the 6th Plan:

1. Conduct a detailed demographic analysis, assess organizational development needs, and conduct a policy review.

2. Support regional and other selected contraceptive prevalence studies to follow CPS 3.

3. Forecast internal and external financial and technical resources that will be required to achieve the demographic targets of the Sixth Plan.

4. Forecast manpower, commodity, and other needs that will be required to achieve targets.

5. Study financing alternatives for the delivery of family planning services, including the role of the private sector and MOPH recovery of supplies' costs from acceptors.

6. Follow-up on the proceedings of the National Population Seminar by requesting the participating Ministries to develop policy frameworks and plans that complement, reinforce and extend FHD's proposed plan.

7. Support the proposed "Population Policy Background Paper" and assure that it is disseminated and discussed by relevant Ministries, coordinating agencies, universities and private representatives, perhaps through a follow-on seminar to the National Population Seminar, in 1985.

F. Reduce Fragmentation of PP II by Reorganizing Project Components Into a More Cohesive Package With a Sharper Focus and Impact.

1. Continue to expand improved access, availability and management of services:

   a. USAID should support a hill tribes project designed by FHD which reflects the lessons learned and needs identified in the UNFPA-financed project managed through the Rural Health Division. To the extent possible, the expertise, experience and resources of the Chiang Mai hill tribes project team should be carried over into the new PP II Project component.

   b. Special priority should be given to the Northeast provinces in resource allocation for increased availability of services, training, and support services, and IE&C.

   c. The delivery of services should be expanded through increased availability of trained personnel, transport, IE&C and mobile units, commodities, and uniform implementation of the MOPH policy to permit trained AM's to provide the full range of temporary methods including IUD insertion and injectable contraception.

   d. IE&C prototypes development and revision of existing materials on temporary methods should be supported that will strengthen client counseling to improve continuation rates.

   e. Redirection of research funds toward studies aimed at efficiency and cost-effectiveness should be encouraged.

2. Preparation for the population component of the Sixth Plan needs to be supported during the third year of PP II to generate initiatives and a data base for informed policy formulation among the concerned Ministries and private sector.

3. Strengthening of PP II Performance.

   Program areas that will require increased attention in the near future are:

a. research and evaluation;
b. management information;
c. intersectoral coordination;
d. continuing disparities in regional performance; and
e. review and strengthening of the FHD management system.

G. Future Role for USAID

A possible PP III should be weighed against provision of population assistance through EPD II supplemented by centrally-funded (AID) projects. If it appears that the EPD II priorities of the RTG would not permit a sufficient level of bilateral support for population/family planning, a new project, PP III, might be considered.

PART TWO

I. Institutional Framework of the National Family Planning Program (NFPP)

The NFPP is under the direction of the Permanent Secretary for Health, and the members of the NFPP Committee are appointed by the Minister of Health. The membership changes when the Minister changes. There are two sub-committees: one on coordination and one on research and evaluation. Their membership is also appointed by the Minister and changes when the Ministerial incumbent changes. (See Annexes 2.1, 2.2 and 2.3 for the memberships and responsibilities of the Committee and Sub-Committees).

The Ministry of Public Health (MOPH) plays the most central role in the NFPP by providing family planning services through its nationwide delivery system of hospitals and health centers. Other governmental organizations are also a part of the family planning network including the Ministry of Interior (MOI), and the Ministry of Education (MOE) which is involved in population education. (The Ministry structure, and its provincial network are shown in Figures 2.1 and 2.2, and its relationship to MOI is shown in Figure 2.3. Annex 2.4 provides a detailed organization chart.)

The family planning activities within the MOPH are under the direction of the Family Health Division (FHD) of the Department of Health. The Director-General of the Department is also director of the NFPP. The Division's role is to manage, coordinate and monitor the NFPP, to provide contraceptive supplies, manage foreign assistance, provide logistical support, and conduct training, supervision, IE&C activities and research and evaluation. The Division is headed by a Director who is also the Assistant Program Director of the NFPP. (The FHD organization is shown in Figure 2.4).

A number of private organizations are also involved in the national program. These include: PPAT, PDA, TAVS and ASIN. The McCormick Hospital in Chiang Mai in addition to other private hospitals also contribute to the promotion and delivery of services. (The relationship of the private sector to the NFPP is shown in Figure 2.5.)

In 1984, the network of MOPH operated rural health facilities included the following:

Provinces (73)	73 Provincial Health Offices 89 Provincial Hospitals 8 MCH & sub-centers
Districts (611) (excluding Bangkok Metropolitan and districts with large hospitals)	470 District Community Hospitals 611 District Health Offices
Tambols (6,084)	7,169 Tambol Health Centers

16

Figure 2.1

ORGANIZATION OF THE MINISTRY OF PUBLIC HEALTH

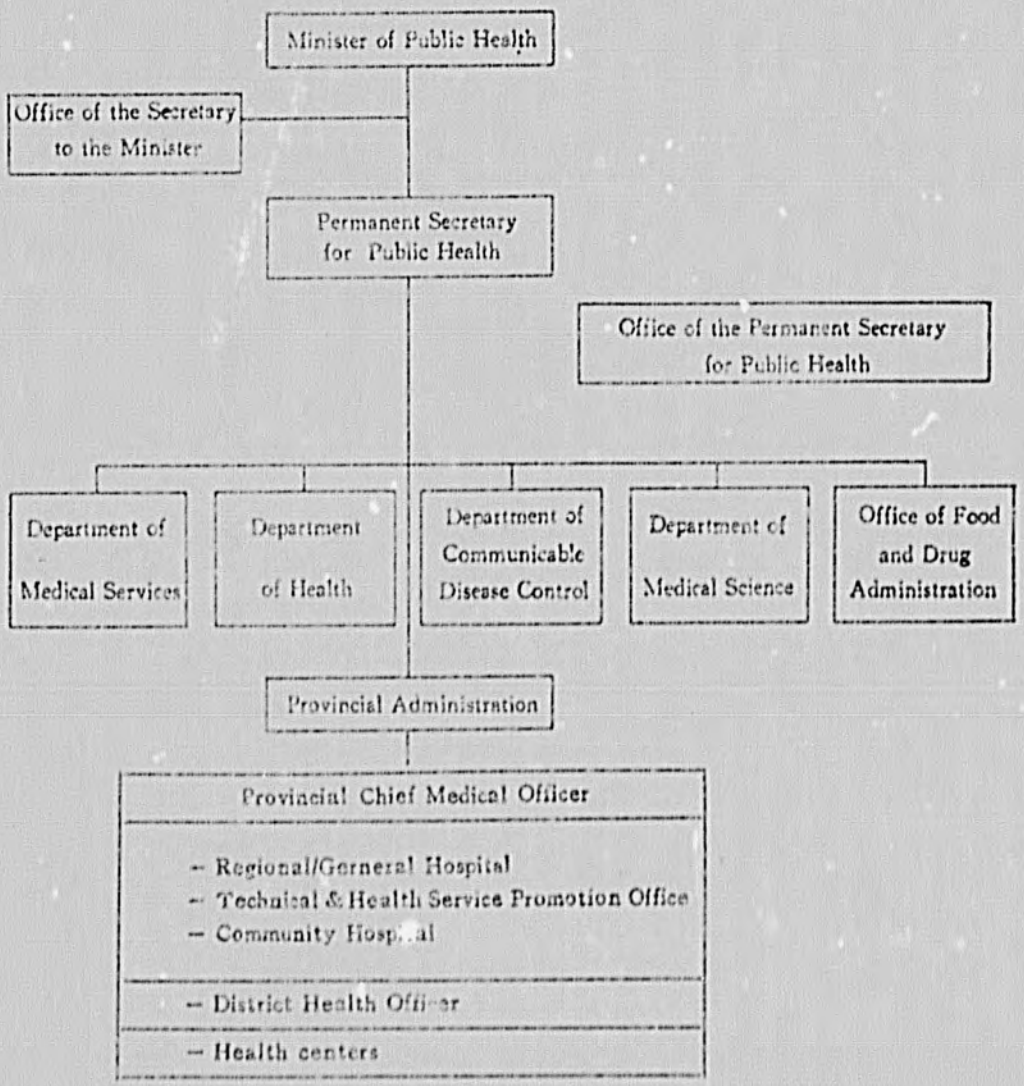


Figure 2.2
CURRENT MINISTRY OF PUBLIC HEALTH FACILITIES
AT THE PROVINCIAL LEVEL

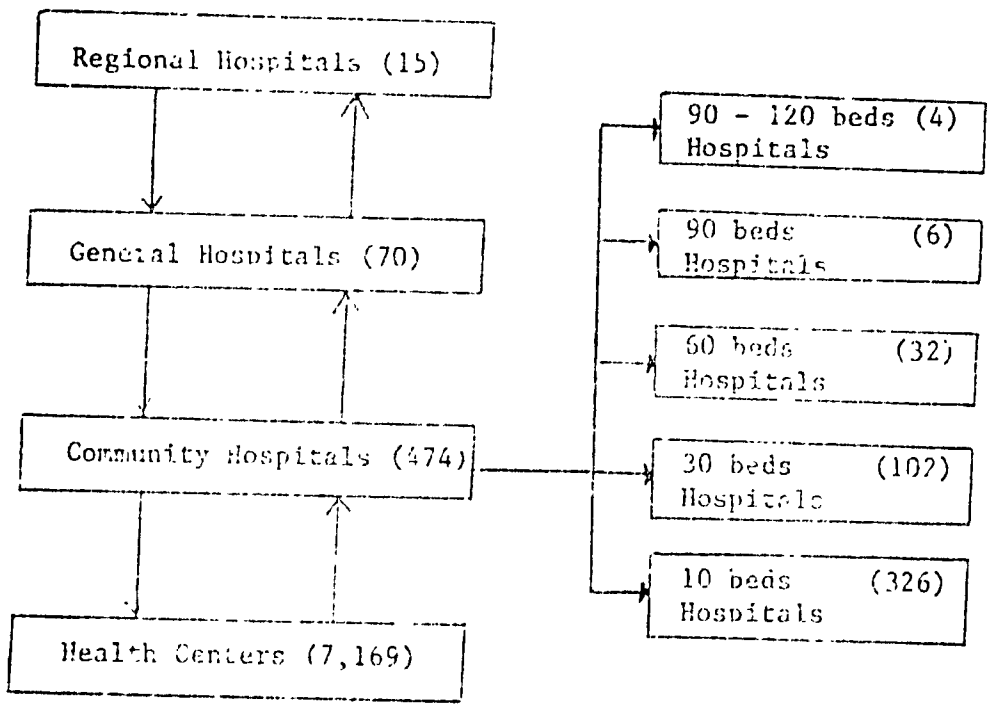
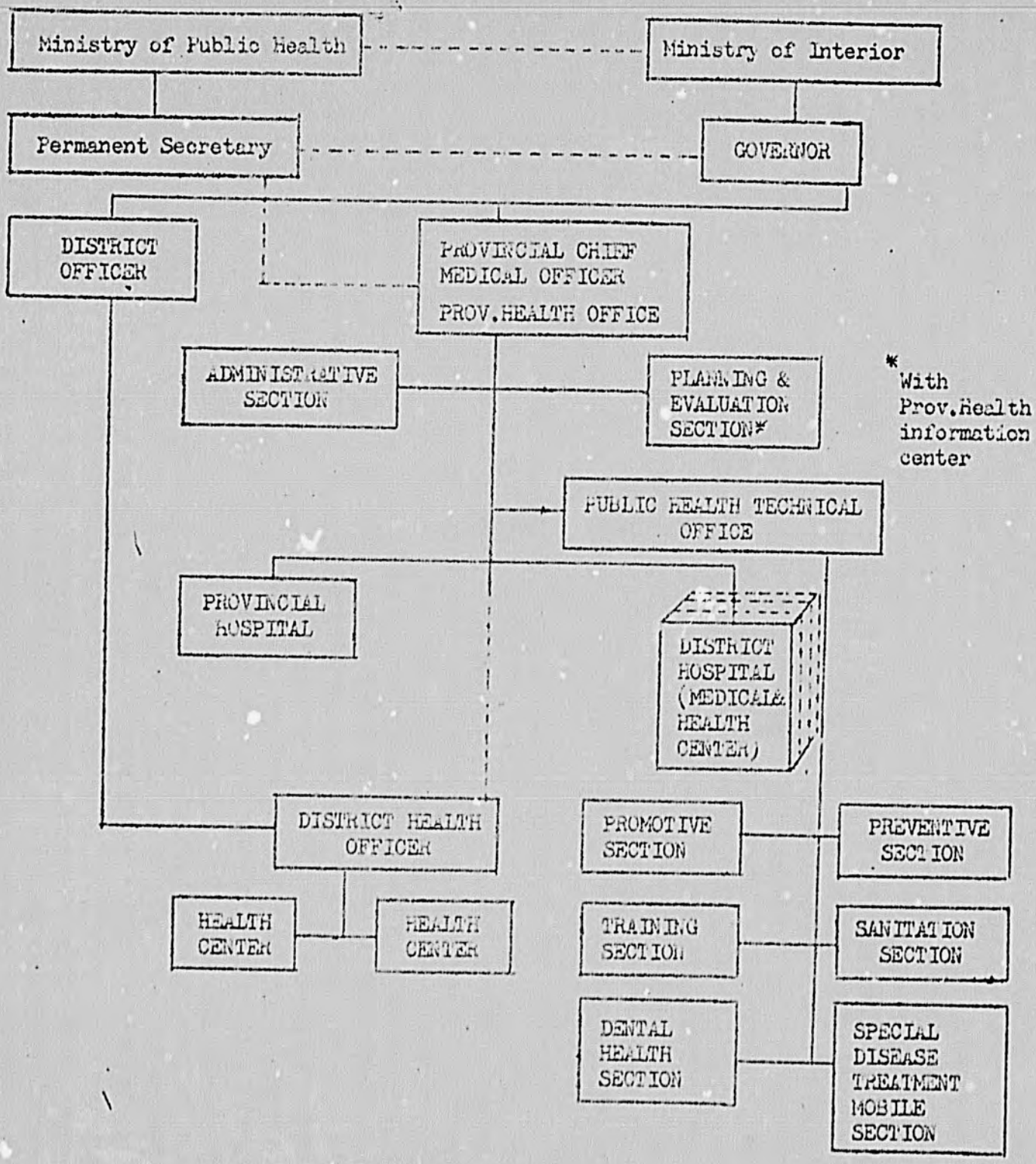


Figure 2.3 Provincial Administration



———— Line of Administration

---------- Line of Cooperation/technical supporting

Figure 2.4
THE NATIONAL FAMILY PLANNING PROGRAMME,
MINISTRY OF PUBLIC HEALTH
ORGANIZATIONAL CHART

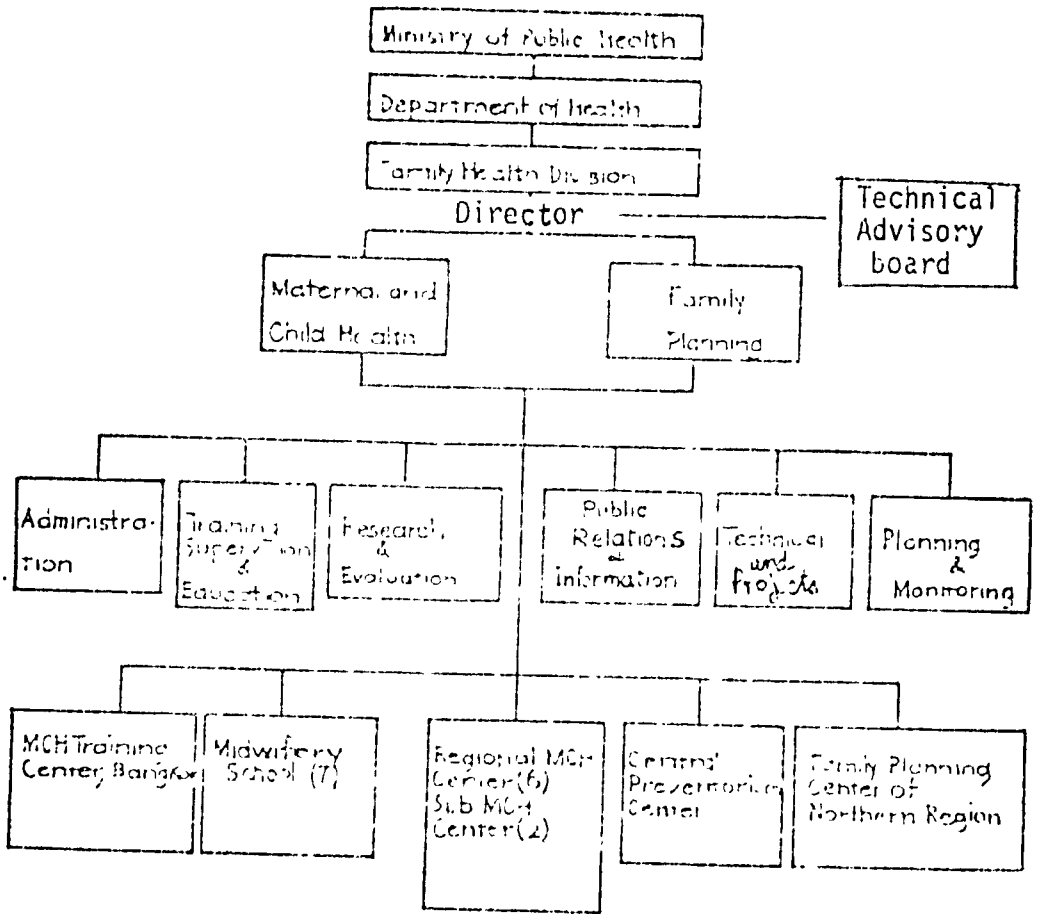
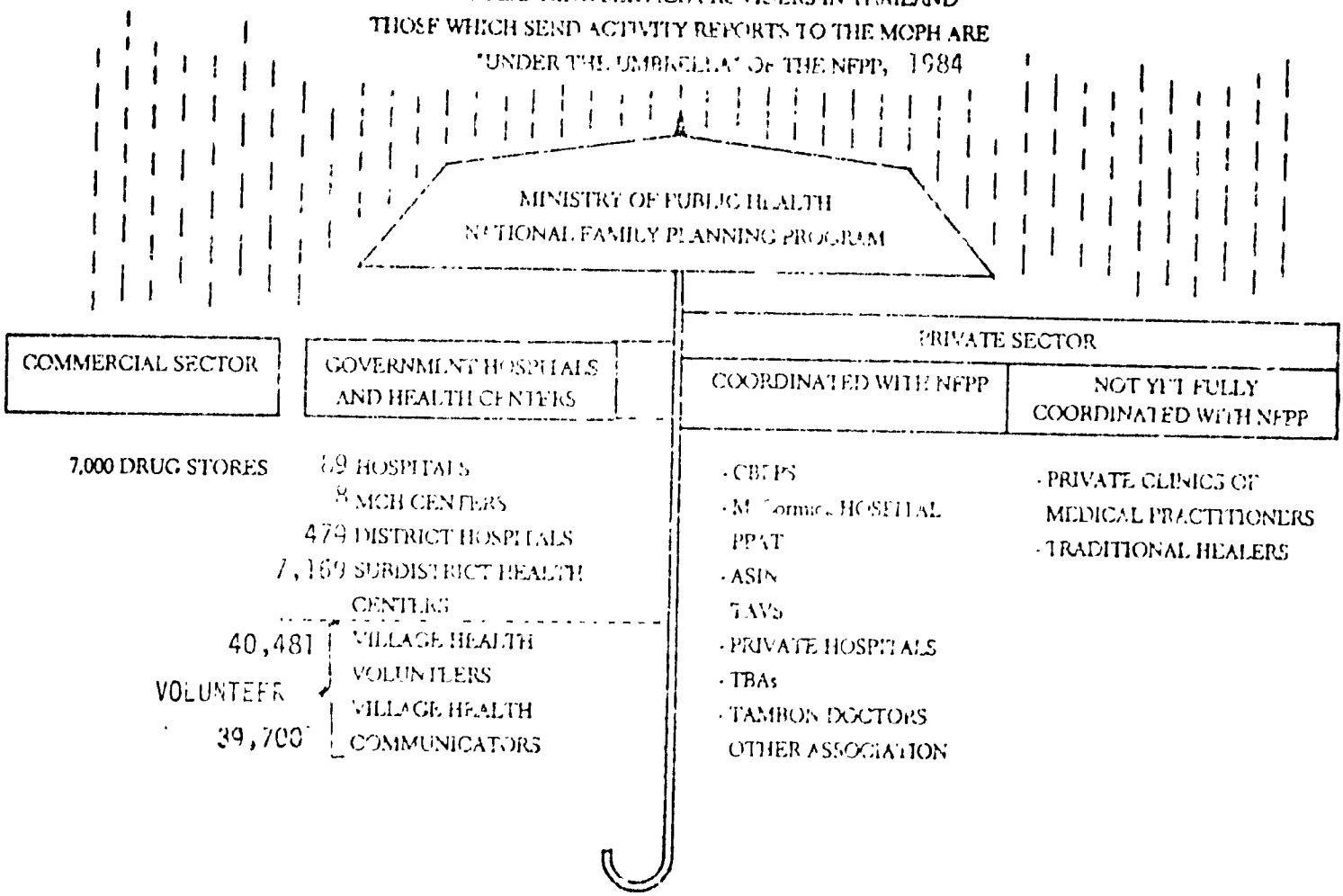


Figure 2.5

FAMILY PLANNING SERVICE PROVIDERS IN THAILAND
THOSE WHICH SEND ACTIVITY REPORTS TO THE MOPH ARE
"UNDER THE UMBRELLA" OF THE NFPP, 1984



A brief description of each service level is provided below.

Provincial Health Office. All of the nation's 73 provinces have a Provincial Health Office, headed by a physician, the Provincial Chief Medical Officer (PCMO), who is nominally responsible for both the Provincial Hospital and Provincial Health Office. In practice, the day-to-day running of the Provincial Hospital is conducted by a hospital director and the PCMO tends to focus on the supervision of rural health facilities and support for the various health programs for which he is responsible. For technical and policy matters, the PCMO is responsible to the Permanent Secretary of the MOPH, but he also is directly responsible to the Governor, the senior civil administrator of the province (who reports to the Ministry of the Interior).

Privincial and Regional Hospitals. Most provincial hospitals have 150 to 500 beds, but regional referral centers (14) have 500 to 1,000 beds and provide training for a variety of medical and paramedical workers. Provincial hospital services are predominantly curative, but a full range of maternal and child health and family planning services are also offered. Except for the large, regional referral hospitals, provincial hospitals are predominantly utilized by people in the immediate area of the provincial capital.

District Community Hospitals. Almost two-thirds of the nation's districts have a District Hospital (now renamed District Community Hospital). Although these hospitals normally have 10 to 30 beds (a few have 60 beds), they are predominantly out-patient facilities, providing a relatively limited range of in-patient care. The hospital normally has one physician, but there may be two or three in 30 bed facilities and up to five in a 60 bed facility. The District Community Hospital also provides full preventive and promotive health services (e.g. MCH and family planning services and immunizations) and has official responsibility for the supervision and technical support of tambol health center workers and programs in the tambol in which the hospital is located. District Hospital physicians are generally recent medical graduates with little experience in managing rural health programs and are usually serving a mandatory two-year commitment of rural service.

District Health Offices. The District Health Office refers to the place where the District Health Officer (DHO) is located. The DHO is normally a senior sanitarian worker who is responsible for all health centers and health programs in the tambols outside of the one where the District Community Hospital is located. The DHO is directly responsible to the District Officer (who is responsible to the Ministry of the Interior). In practice however, most of the DHO's technical and managerial support and supervision comes from the Provincial Health Office.

Tambol Health Centers. Every tambol has a tambol health center and some have more than one. Each tambol health center is normally

staffed by an auxiliary midwife and a junior sanitarian. (A practical nurse is being added to many tambol health centers). All of the major preventive and promotive health services are integrated into the tasks of the two health center workers. The midwife and sanitarian are responsible for prenatal, delivery and postnatal services, child immunizations, nutrition, family planning, and water supply and sanitation activities. Health centers also provide limited treatment for emergencies or minor illness and referral to distri or provincial hospitals for more serious problems. In theory, these activities are to be centered in the community, (e.g. home visiting, and supervision/ support for village health volunteers).

II. Policy Formulation

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

> "The Thai Government has the policy to support voluntary family planning in order to resolve various problems concerned with the very high rate of population growth which constitutes an important obstacle to the economic and social development of the nation."1/

The 1974 Constitution contains the following paragraph:

> "The State is to formulate population policy to suit the natural resources of the nation, social and economic conditions and technical progress for the interest of economic and social development and security of the State."2/

These policy statements have been given expression through RTG budget allocations to the NFPP (since 1972), and the setting of growth rate targets for the third (1972-1976) and subsequent Five Year Plans. The targets are set on the basis of data from a variety of sources including the census, vital and civil registration, contraceptive prevalence studies, and projections of fertility, natality, mortality, migration and population.

The goal of the current (1982-1986) Five Year Plan is a reduction from the 1981 growth rate estimated at 1.8% to a growth rate of 1.5%, which is to be achieved primarily through increased contraceptive prevalence.

1/ Basic Facts in Family Health in Thailand. FHD, MOPH, 1984.

2/ Population and Family Planning in Thailand, 1982, Population Clearinghouse/Documentation Centre, NFPP, MOPH, 1982.

The national growth rate target is translated into annual and long range family planning performance targets by the Family Health Division of the Ministry of Public Health expressed in terms of new and continuing acceptors by method. Provincial targets are in turn converted into district and sub-district performance targets by a process which is being increasingly decentralized with progressively increasing local participation in target setting. This process is described in further detail in the section of the evaluation report dealing with Organization and Management issues.

As the scope and extent of the NFPP continues to expand and decentralization progresses there will be need for increasing clarity in policy guidelines, more timely and accurate feedback from the field on the impact of implementation, and increased attention to policy adjustment and refinement. The complex nature of the NFPP, with service delivery highly decentralized, and subject ultimately to consumer preference for services, requires continuing special attention to the policy formulation function. Policy guidelines should be written with increasing clarity to minimize variations in interpretation while maximizing flexibility of application. Policy guidelines covering technical standards should become more rigorous and precise, while administrative and program management standards should maintain a high degree of flexibility to accommodate the diverse cultural and environmental conditions in the field. The role of FHD should become increasingly more substantial in technical backstopping, monitoring, technical quality control and supervision of technical standards. Concerns about the management of multi-purpose resources, coverage and access should increasingly shift to lower organizational levels where program operations management decisions are being made and reviewed.

The evaluation team noted certain weaknesses in policy linkage between the central level and provincial levels, and wide variations among provinces in both the interpretation and application of FP policy guidelines issued by both MOPH and MOI. Rejection of central policy by some administrators, (e.g. failure to use trained AMs to provide IUD services) suggests a need for more rigorous monitoring, education and enforcement of policy guidelines. This may require shifting emphasis to the concept of "standards setting" for certain areas lagging in implementation.

While some headquarters officials expressed satisfaction with the amount of time and attention devoted to policy formulation, others felt that it was too ad hoc and/or infrequent, that too little initiative and time were being devoted to it; that the service delivery system was too often running ahead of policy formulation, that there was some "catching up" to do; and, that policy guidelines needed to be more complete and supported by improved dissemination and education.

III. Financial Support

A. RTG

The NESDB Sub-committee on Population Policy and Planning is responsible for ensuring that adequate attention is given to population in the RTG development plans. The rapid expansion of the NFPP to meet the challenge of the Fifth Plan population target has necessitated not only increased RTG financial support but heavy dependence as well on external donor/lender financing, see Table 2.1.

B. USAID and Other Donors

The allocations and estimated budget for NFPP for the 1982-83 period, both for the RTG and the various external donors, appears in Table 2.1. (See Part Four, I.E. for the current and proposed budget of PP II, revised as of June 30, 1984).

The future financial implications of RTG population policy should be carefully analyzed in the near future. This requires that demographic targets be translated into service requirements by the estimated type, number, location and staffing of services needed to achieve demographic targets, and then these data must be converted into projected cost data. It is only then that the RTG can accurately assess its capability to provide the increasing resources needed in the future, and the extent to which the RTG must rely upon (1) external assistance, (2) the private sector, (3) and/or change its policies to increase revenue generation from service delivery systems and place even greater emphasis on permanent methods of contraception. Unfortunately, the evaluation team did not have adequate time, data or resources to execute this much needed assessment. Therefore, accurate prediction at this time about the extent of future needs for USAID financial assistance (as contrasted to technical assistance) is difficult to make. It is likely, however, that a target growth rate of 1.2% which will require a prevalence rate exceeding 70% at a time when the MWRA will increase by approach 30%, will require major resource increases beyond the capability of the RTG if past performance is an accurate indicator. This then suggests that unless there is a policy shift to greater reliance on the private sector and very significant increases in revenue generation from public sector services (which could inhibit the achievement of demographic targets), continued reliance upon bilateral external assistance will be needed through the 6th Five Year Plan (1987-91).

IV. Other Donors (USAID is specifically addressed in Part Five of this report)

1. Japan International Cooperation Agency (JICA)

Since 1974, JICA has contributed grant aid of 85 million baht ($3,695,652) to the Family Health Division for MCH/FP activities. From 1974-78, 7 million baht ($304,347) were contributed annually; the

TABLE 2.1: ALLOCATIONS AND ESTIMATED BUDGET FOR NFPP (INCLUDING FP AND MCH IN POVERTY AREAS)
(IN $1000'S)

SOURCE	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY 198/
INTERNAL - RSG	8,602	10,015	11,223	12,436	13,743[3/]	15,117[3/]
EXTERNAL - AID GRANT	1,000.0(?)	2,399.3[1/]	1,239.3[2/]	1,626.2	1,626.2	1,626.2
AID LOAN	2,000.0(?)	1,197.6[1/]	1,588.2[2/]	2,360.8	2,360.8	2,360.8
JAPAN	659.1	395.2				
CANADA	36.4	30.0				
GERMANY	536.0	1,475.0	1,475.0	1,475.0	1,475.0	
UNFPA	820.3	1,361.4	1.8	1.3	1.3	N/A
PCP COUNCIL	-	450.0				
IPPF	666.9	550.4	880	880[3/]	880[3/]	880[3/]
EMPIRE	19.6	35.5				
FHI	84.6	80	80	100	100[3/]	100[3/]
RESEARCH TRIANGLE INST.	-	16.7				
JHAVS	175.1	380	230	200[3/]	200[3/]	200[3/]
FAMILY PLANNING INT.	-	7.5				
OTHER	-	-				
SUB-TOTAL	6,782.0	7,675.8				
TOTAL						

1/ 1st Year of FP II Project.
2/ Based on earmarked funds as of June 30, 1984.
3/ Estimate.

contribution was raised to 10 million baht ($434,782) per year from 1979-1983. Japanese policy directs emphasis to the North and Northeastern regions.

The Japanese contribution through 1983 has been expended on:

. 1,560 motorcycles distributed to: Health Centers (1,060) MCH Centers (435), District Hospitals (25), CBFPS (30) and Border Police (10).

. 66 Mobile IE&C Units/Vans: PCMO's (16), MCH Centers (17), District Hospitals (2), NFPP (15), Department of Health (3), CBFPS (11), and Medical Schools (2).

. 572 copies of three family planning educational and motivational films which were distributed to PCMO's, MCH Centers, Provincial and District Hospitals, and the NFPP.

. Condoms

Special emphasis was placed in Nakorn Sawan (Northern Region) through in-service training programs in MCH/FP for midwives, sanitarians, DMO's primary school teachers and tambon Council chairmen, secretaries and tambol doctors. Equipment including a microbus, 70 motorcycles and 250 delivery kits were provided, and a midwife consultant was assigned to the Provincial Hospital from 1981-83.

The JOICFP has its own activities in Thailand with funding provided through JICA. These have included equipment and audio visual equipment and supplies purchase (motor bikes, vehicles, cassette and video tapes, films, color slides, condoms (13,000 gross) and midwifery kits (400 sets)).

The Japanese contribution to the FHD from 1984 to 1987 is not yet finalized, but is expected to be in the range of $1.5 million per year. FHD has requested funds for: training, medical equipment, condoms, vehicles and motorbikes, audio visual equipment and supplies, the construction of additional MCH Centers, and technical assistance.

Since 1980, JICA health sector financing has supported a Nursing Education Project which included: construction of the Srimahasarakham College of Nursing (Mahasarakam Province), a team of Japanese short and long-term experts to design curricula and materials for pre-service and in-service education, to design an audio-visual program for the audio-visual center, to provide consultation to the 21 Colleges of Nursing, to assist in support of evaluation of nursing education, and to conduct in-service short courses for 971 participants on a variety of topics. 13 Thai nurses have been sent to Japan for training in nursing and audio visual education.

Through 1987--and probably 2 to 3 years after that--a major initiative to strengthen the primary health care program is being

provided through three related components: One, the ASEAN PHC Training Center (Salaya campus of Mahidol) and four Regional Training Centers: Khon Kaen (completed), Chonburi, Nakorn Sawan, and Nakhon Sitamarat (all under construction). One-week PHC training courses will be offered to VHV's, VHC's midwives and sanitarians. JICA will support the trainees' tuition, transportation and per diems, and machinery for the production of textbooks. Teaching faculty for the Mahidol courses are drawn from the School of Public Health, and that center will become a training facility for the ASEAN countries. The faculty for the 4 regional centers will be drawn from among provincial health personnel. Included in the training curriculum are family planning and MCH.

The second component, linked to the Centers, are model development areas which are intended to be demonstrations of application of course content by trainees. Consultative assistance is to be provided by Mahidol faculty to VHV's, midwives and sanitarians. Teaching materials are an expected product of this assistance. Bang Pai near Khon Kaen is one of 5 areas to be supported.

Research in a variety of primary health care topics is the third component of the JICA project. Forty-two research projects have been approved through 1985; two have potential applicability to the family planning program:

RES/1/2525/15: Situation analysis of MCH and Family Planning Activities within PHC (has been completed by March 1984).

RES/2/2526/10: The Cost-Effectiveness of Contraceptive Methods in Rural Communities (to be completed by April 1985).

In order to strengthen the linkage between research and the model development areas (and thereby promote application of research findings), a Japanese advisor, Dr. Iwamura, will be assigned to the project. He has spent 20 years in Nepal in field-based program operations.

B. United Nations Fund for Population Activities (UNFPA)

Total UNFPA input for 1979-82 (the third phase of their assistance) was approximately $10 million. Proposed inputs for 1983-86 are $5.9 million: assistance in 1983 was $1,361,390; approximately $1.5 million will be spent annually between 1984 and 1986. Of the total 1983-86 budget, 61%, or $3,600,000, will be spent on family planning programs.

Projects being and to be undertaken between 1983-1986 are:

1. Short and long-term support for overseas training in population/fp.

2. MOE Population Education: reading materials for primary and secondary students; secondary school level teachers' manual, lesson plan and learning package; orientation seminars for local educational administrators and other education personnel; training of trainers and refresher training, and training of elementary, lower secondary and lower vocational school teachers; training for extension workers (agriculture, health, education, community development); production of radio programs, sound slide shows and newsletters; and, technical support, study tours, fellowships, and operating equipment to the agencies working in population education.

3. Health Service Project for Hill Tribes (Rural Health Division): Train hill-tribe AHW's and VHV's to provide primary health care; construct simple village health centers and lodging for AHW's and VHV's; provide medical supplies and equipment, vehicles, office and A-V equipment; provide administrative personnel; conduct seminars on the health problems of hill-tribes and on future health care/FP guidelines for hill-tribes.

4. NFPP Improved FP Program Management and Expansion of Family Planning and Contraceptive Delivery Service: Train 250 medical students per year (1983-86) in sterilization at weekend clinics at Chulalongkorn Hospital and Wat Thard Thong, and Khon Kaen medical students at district hospitals; conduct annual seminars for PCMO's and MOPH staff to review target-setting, staff performance, supervision, training and other matters; provide in-country study tours for provincial, district and tambol staff from low-performance provinces to observe MCH/FP programs in high performance provinces; improve target setting and data management by conducting two workshops on target-setting and provincial-level seminars on data collection for provincial health personnel; conduct an analysis of the supervisory system; provide two fellowships for master's degree and 3 short term fellowships in health care and family planning management; and, investigate illegal abortion and provide adolescent counseling programs (peer-counseling, establishment and operation of an adolescent counseling clinic and other support).

5. Improvement and Evaluation of the NFPP Training Unit: Conduct curriculum design workshops to redesign the training curriculum for multi-purpose trainers, AM's, nurse/midwives, DHO's and other health workers; conduct intermediate and advanced TOT courses for 250 multi-purpose trainers in family planning; conduct intermediate-level family planning clinical services training for 1,000 paramedical personnel; design, implement, evaluate and report on a training impact monitoring and evaluation system in Surin and Pattani provinces; document training activities for applicability to other developing countries; and, evaluate inputs, activities and outputs of the project and each training activity.

6. Population Education Through Rural Agricultural Development Networks (through Kasetsart University): Institutionalize the earlier project in the nine participating line agencies at national, regional and

provincial levels; conduct basic workshops for 80% of all agricultural extension personnel in 20 provinces; develop, procure and distribute manual kits to supervisors, trainers and extension workers; develop radio programs, a quarterly newsletter and slide-set cassette sets; and provision of data processing equipment rental and software.

7. Communication Support to NFPP Family Planning Activities: Design and test prototype mass media materials (posters, radio spots) (with the sub-contractor) that promote vasectomy, IUD's and the two child family norm, amd provide two short-term fellowships in communication planning and management. In the Southern Region: develop materials to be used in 8 provincial level workshop and 1 mass media regional workshop; conduct 8 provincial-level workshops that develop communication plans for each province and train PCMO's in management and implementation of the plans; conduct a mass media workshop to obtain cooperation of local radio stations; produce low-cost materials; and, provide audio-visual equipment ($190,000).

8. FHD Expansion of MCH and Birth Spacing Activities in the Four Southern Provinces: Revise the FP/MCH curriculum for training of TBA's by AM's; prepare a glossary of FP/MCH terms in Yawee language to be used by the AM's in TBA training; develop training materials and conduct TOT for AM's; support AM training of 646 TBA's in 4 border provinces; provide refresher training for VHV's in FP/MCH; establish 4 new mobile motivation and service systems (teams, vehicles, equipment, supplies, motivational materials), and train 8 teams for field operations in Yala, Satun, Pattani and Narathiwat provinces; provide travel allowance to AM's for MCH/FP service provision in villages and for supervision and backstopping of village health personnel; prepare forms to be used by AM's and TBA's in high risk pregnancy detection; prepare, collect and analyze village-level baseline data on MCH/FP; expect that village health workers will motivate for pre-natal, attended delivery, post-natal care and family planning; support VHV and TBA distribution of pills and condoms; distribute forms for contraceptive re-supply; use model mothers from 1,037 villages as promoters of MCH/FP by training them and holding a regional conference; and, provide study tours for Muslim leaders to a neighboring Muslim country.

9. Support of Population Training and Other Population Related Activities in the Southern Region (through Prince of Songkla University): Conduct motivational training (for adoption of birth spacing for family health) for: 75 Islamic Provincial Committee members from 5 border provinces, 460 Muslim leaders from 46 districts in the 5 border provinces, 230 teachers from religious secondary schools in 46 districts, and 337 local government administrators; produce adapted materials from the Kasetsart University population education project targeted to Muslim leaders and teachers; conduct a study tour for 5 governors, the Director of CASBP, Muslim leaders, and Prince of Songkla University staff to a neighboring Muslim country; conduct a planning and design workshop for the training programs; conduct a training activity assessment workshop; field-train 210 undergraduate PSU students in rural

services; provide equipment and a vehicle; and develop a planning and monitoring system for the CASBP and the governors' offices.

The UNFPA also supports other small projects including one with PDA that will provide guidelines for governors in implementation of family planning activities and another with the National Housing Authority to examine problems in urban slums.

UNFPA has encouraged a broader base for examination of, commitment to and work on population issues and is awaiting a proposal from Ministry of Interior. Of interest are the fertility consequences of development activities and the demographic components and proposed demographic impact of development plans.

3. United Nations Children's Fund (UNICEF)

UNICEF cash assistance, technical assistance and equipment and supplies in 1983 totalled $2,663,900. Over ten percent of that amount was directed toward Social Preparation courses and other suppport for government officials and village leaders in 123 districts of Thailand's 38 poverty provinces. Although UNICEF does not contribute directly to the NFPP, elements of support are directed toward MCH/FP goals.

The Social Preparation Program emanates from the Prime Minister's Office and is coordinated and managed by a Committee that includes Ministry representatives from: Agriculture and Cooperatives, Education, Public Health, and Interior; and, from NESDB, DTEC, Bureau of the Budget and the Prime Minister's Office. The program started in 1982 with the purpose of piloting a "rice-roots up" approach to the development of integrated basic services. The idea is to train village leaders to know about the government-sponsored services that are available to them and how to obtain and use those that are needed and wanted. Recognition and encouragement of local capabilities to adapt or develop appropriate development technologies are central features of the approach.

UNICEF's particular interest in the program is both philosophical and practical: inter-sectoral planning and multi-sectoral programming best serve the goal of integrated child development, and the more aware, informed and knowledgeable villagers are about child health and development needs, the more effectively they will use UNICEF inputs in nutrition, health, water and sanitation, training of VHC's and VHV's, and pre-school and non-formal education all of which comprise 87% of UNICEF's program budget activities.

Training is the major means for creating Social Preparation. District-level trainers from the 4 Ministries are trained for two days in technical and sectoral inputs and group dynamics. They are then responsible for the training of 1% of the total district population (6-9 persons for each trainer), to include 50% "natural" (including monks) and appointed village leaders, 20% youth, and 30% women. The village-based courses they conduct focus on 4 areas: health, mental and intellectual

development, vocational promotion and community participation. Trained villagers are then expected to train others with the assistance of their district-level trainers. Participating districts are selected through the Prime Minister's Office which submits a training plan for each district to the Committee and UNICEF. After village-level training is completed, UNICEF makes available: scales, growth charts, special nutrition training, vegetable and other seeds, poultry, materials for making toys and other pre-school educational materials, vaccines, water pumps, water catchment devices, latrine construction designs, manuals and texts for literacy training, and health posters and booklets.

The results of this approach are still being examined. In one northern district, within one year, third degree malnutrition was reduced from 3.55% to 0.62%, 2nd degree from 13.8% to 8.5% and normal nutritional status increased from 58.05% to 61.98%. It has been reported in another district that immunization coverage has increased to 90% and school absenteeism has decreased. In support of the health component, sixty self-instructional lessons on PHC were developed by UNICEF for VHV's and VHC's for post-training use, 24 training tapes have been developed, and village-based monitoring tables for child health and pre-natal care are being prepared for introduction into villages where social preparation training has taken place and UNICEF inputs have been made. A modification of the Child-to-Child program will be introduced into the primary schools using the growth-monitoring chart as the major tool for nutritional surveillance.

By 1986, 6-9 persons in each village of the 123 districts are expected to be trained. It is also expected that RTG will completely support an expanded training program in Social Preparation after 1986. UNICEF GOBIFF inputs (growth monitoring, oral rehydration, breast feeding, immunization, food supplementation, family spacing and female education) are expected to continue.

It was noted that local education officials are concerned that family planning has contributed to a reduction in school enrollment. Since merit increases or promotions currently are linked to school enrollment, this is not an insignificant point of view. UNICEF has promoted and will continue to promote the idea that quality of education should be a guiding principle, but also that schools--if closed--can be used for pre-school, women's and other development activities. (Currently, the Ministry of Education is providing bicycles to students who must commute because their school has closed owing to low enrollment).

RECOMMENDATIONS (2.IV)

A. Re. JICA

1. Since the PHC Training Centers will be training AM's, VHV's, and VHC's in PHC topics including family planning and MCH, pertinent aspects of the MIS, the new targeting approach, and a team approach to information/education/communication about family planning and access to services should be pursued for inclusion in the one-week course.

2. If there are research topics of interest to MOPH that could be developed, conducted and documented through the PHC project, there is good potential for village-based, micro-level studies that could involve provincial, district and tambol-level personnel in design, implementation, analysis, reporting and application. Suggested areas of research include: selected program approaches to non-users of family planning could be field-tested and evaluated, IE&C materials for the village-level could be pretested, and tested for applicability to family planning method acceptance; appropriate family planning method selection according to the age and parity of the client might be promoted and acceptance from the provider and user points of view studied; family planning within PHC could be studied from the point of view of perceived benefit (by villagers) as a health service, whether family planning loses or gains prominence within an integrated system, and how family planning can best be linked to nutrition, immunization, and diarrheal disease control programs. Since monitoring of PHC components should include family planning acceptance and continuation, a simple monitoring system could be designed, piloted and evaluated in one or two of the model demonstration areas.

3. AM IUD kits and midwifery kits may be available through JICA or JOICFP. USAID may be advised to investigate the proposed kit contribution of the Japanese during the period 1984-86 before procuring additional kits. A related opportunity is review with JICA or JOICFP and PHD of the proposed distribution (priority service sites, campaign areas) of the kits purchased through Japanese or USAID funds.

B. Re. UNFPA

1. Examine the potential for and possibility of building on the UNFPA supported work with hill tribes: review the lessons learned, the needs that have been identified and the approaches that have been successful, and consider possible use of the UNFPA-developed hill tribe team to assist in design of a carefully-phased project, and to manage and technically support a hill tribe project in family planning at provincial and local levels.

C. Re. UNICEF

1. Support FHD involvement with PCMO's and DHO's in promotion of family planning within Social Preparation training, and in the development and provision of family planning educational and informational materials within the literacy, health and women's development components of the village-level basic services program.

2. Pilot and evaluate the effectiveness and use of a village-level monitoring chart on family planning using mini-survey data collected by AM's and VHV's (available in DHO's offices) and targets established by Village Committees.

3. The USAID/H/P/N Officer should meet with the UNICEF Programme Officer, UNFPA Population Advisor, FHD, and the Rural Health Division to discuss possible collaboration on implementing the family spacing components of GOBIFF,* and on areas of mutual research and evaluation interests concerning family planning within the village-level PHC context.

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*A UNICEF-coined acronym that represents the major UNICEF program emphases: growth monitoring, oral rehydration, breast-feeding, immunization, family spacing, female education.

V. The Private Sector

From the beginning, the NFPP has been distinguished for the close cooperation that exists between the government program and the private sector. The collective contribution of non-government organizations active in family planning promotion and service delivery far exceeds the roughly 20% of acceptors attributed to direct NGO service delivery, as much of their activity supports motivation and referrals to NFPP service sources, as well as to private sources of care.

A number of donors provide financial or technical assistance for specific projects which support the activities of NFPP, and four major Thai organizations' efforts complement the RTG's NFPP. These include:

A. PPAT

The Thai affiliate of IPPF is particularly active in the development of IE&C resources, youth development, and training of teachers and resource persons for Family Life Education. In addition it operates two service delivery clinics in the Bangkok area and provides contraceptive distribution by project volunteers in Bangkok and forty provinces. A project designed especially for five southern provinces involves community based distribution of contraceptives and IE&C. and annual seminars for religious and community leaders in those provinces are planned, starting in 1985. PAAT has brought clinical and family life education services to six refugee holding centers in Thailand and supports several local family planning, PHC and workers development projects. Altogether, PPAT accounted for 144,579 acceptors in 1983.

The evaluation team, recognizing that PPAT faces diminishing levels of IPPF support and recognizing the innovative approaches which it adds to the overall family planning program, has recommended that PPAT:

1. Participate as a private sector participant in NFPP preparations for the Sixth Plan and determination be made of a role for PPAT in the Sixth Plan family planning agenda;

2. Be considered as a potential recipient of private sector initiative funds, particularly for FLE, slum-dwellers and youth activities, which the team has recommended as a reprogramming priority.

B. PDA

A great deal has been written in the world family planning literature about the Population and Community Development Association (PDA, formerly "CBFPS"). Accordingly, it is not felt necessary to reiterate its history or accomplishments in this report. The evaluation team agrees that its wide recognition for inauguration in family planning

promotion and innovations in integrating family planning with local community development activities is richly deserved.

The social marketing activity which was the major activity of the earlier CBFPS, now consumes only about 15% of PDA's overall budget. The evaluation team had an opportunity to observe a PDA distributor in the field, and confirmed the performance of this role as a useful extension of the rural network of contraceptive supply and referral channels. The team also observed some of the rural development activities (latrine building, water cisterns) in which the revolving loan fund mechanism brings these useful products within the financial reach of many households which could not otherwise afford them. PDA consistently links for the projects to family planning acceptance, and stresses their contribution, along with family planning practice, to family health and rural development.

USAID no longer provides commodities to PDA. Currently, USAID supports any PDA's community-based VSC project (CBVSC). The evaluation team believes that this organization has the requisite leadership, experience, and dynamism to play larger role in the overall family planning program as the RTG looks increasingly to the private sector for innovative ways to expand contraceptive prevalence, and is deserving of continued USAID support.

C. ASIN

The Association for Strengthening Information on National Family Planning Program was created in 1975 in an effort to enlist the resources of the private sector in support of the NFPP. It uses the more than 3,800 privately owned institutes (hospitals and medical clinics registered under the public health law) to extend the availability of both public information and fertility services throughout the country. Its IE&C project uses a variety of media to supply health and family planning education through the private medical institutions. Its VSPI (voluntary sterilization in private institutions) project, supported by the RTG and FPIA since 1977, accounted for 72,381 sterlizations in 1978-1981. It provides cost compensation of 300 baht per sterilization, along with sterilization medical kits. Other FP commodities are supplied to member clinics for public distribution without cost. ASIN has also conducted seminars and research to advanced knowledge and acceptance of voluntary sterilization. Especially noteworthy is ASIN's educational effort to dispel rumors and misunderstandings about vasectomy which are often cited as accounting for the generally low ratio of vasectomy to TL. The total ASIN program had a male:female VSC ratio of 1:3.0 in 1980-81 compared to 1:5.4 for the NFPP (excluding ASIN), and the ratio in its "one doctor ASIN Institutes" was 1:1.8.

ASIN is one of five projects in Thailand supported by FPIA. The others are more narrowly focused projects involving conferences, invitational travel, refugee services, slum areas. The RTG's commitment of funds for certain ASIN services represents an indicator of its

recognition of the importance of public-private sector collaboration to further insure the success of the NFPP. From the standpoint of USAID, ASIN and the other FPIA supported projects illustrate the value of centrally funded projects which lend an added measure of variety and innovativeness which effectively complements the bilateral AID project.

D. TAVS

The Thailand Association for Voluntary Sterilization, supported by IPAVS, works in close collaboration with PDA and with ASIN (in fact, its headquarters now occupy new quarters shared with ASIN and ICARP). In addition to its educational and clinical services, it has helped in the development of a national leadership group of specialists working on medical safety standards for VSC, quality of VSC services and counseling for VSC, and further promotion of vasectomy. On the basis of a 1982 evaluation, IPAVS is emphasizing the effort to seek other sources of funding for TAVS in keeping with an IPAVS policy shift toward a higher priority in Africa, resulting in a 30% cut in its Asia budget. The take over of the responsibility for the RAM Center by the MOPH and an NFPP commitment of 200,000 baht annually in support of TAVS starting in 1984 are steps toward institutionalization, but it is doubtful whether the pace of progress toward self-sufficiency will be sufficient to compensate for the reduction in IPAVS funding. The evaluation team feels that continued support of TAVS is justified by its past performance, the prospect of an anticipated larger role of VSC in the mix of methods required to meet the demographic goals of the Sixth Plan, and its role in promoting safety and quality in VSC services.

F. The Commercial Sector

While the contraceptive private sector market is outside the scope of PP II inputs, it is nevertheless worthy of note in any evaluation of the diffusion of contraceptive availability in Thailand.

The commercial oral contractive market is estimated at over 3 million cycles per year. Altogether 14 formulations of pills (supplied by 6 manufacturers) are available. It is noted elsewhere in this report that NFPP acceptors sometimes purchase commercially marketed pills for reasons of personal preference or when preferred government pills are not locally available. Several brands of condoms are also available. There are almost 750 grade "A" pharmacies in the country, almost 700 of which are in Bangkok, with the others concentrated largely in the main towns. Thus the importance of the NFPP contraceptive services network, supplemented by community based distribution of contraceptives to availability in the rural areas is clear. The feasibility study called for in PP II, of a proposed expanded commercial marketing and promotion effort in keeping with NFPP's plan to further increase the availability of oral contraceptives and condoms at the village level, was completed in March 1984. Discussions between USAID and the NFPP regarding its findings are under way, but to this date no conclusion has been reached regarding USAID participation in the expansion of social marketing during

the remaining period of PP II. Careful thought should be given to the proposed service constituency for a project and whether the current service network is capable of responding through new or different strategies.

RECOMMENDATION (2.V)

The evaluation team concurs fully with the NFPP's expressed intent to encourage expanded involvement of the private sector in the pursuit of Thailand's demographic goals. We therefore strongly recommend that support of the private sector activities be continued both in the reprogramming of remaining PP II funds and by encouraging the supoort by AID/W of centrally funded intermediaries whose projects in Thailand are supportive of NFPP goals.

Annex 1.1

Officially Appointed of the Ministry of Public Health

No 433/2527
(1984)
On Official Appointment to the NFPP committee

The Ministry of Public Health authorized by the Cabinet-Council has officially appointed new members to the National Family Planning Programme according to the letter of the Cabinet-Secretariat No.NR.0202/10076 dated July 29,2526 as follows:

1. Minister of Public Health	Chairman
2. Deputy Minister of Public Health	Vice-Chairman
3. Permanent Secretary, Ministry of Public Health	Committee
4. Permanent Secretary, Ministry of Interior	"
5. Permanent Secretary, Ministry of Agriculture and cooperatives	"
6. Secretary-General of the National Economic and Social Development Board	"
7. Director of Bureau Budget	"
8. Director of the NFPP	"
9. Director-General of the Department of Medical Services	"
10. Director-General of the Department of Technical and Economic Cooperation	"
11. Director-General of Public Relations Department	"
12. Director of the Institute of Population Studies, Chulalongkorn University	"
13. Director of the Institute for Population and Social Research, Mahidol University	"
14. Director of National Statistical Office	"
15. Director-General of Non-Formal Education Department	"
16. President of the Planned Parenthood Association of Thailand	"
17. President of Population and Community Development Association	"
18. President of Thai Association for Voluntary Sterilization	"

19. President of Association for Strengthening Information on National Family Planning Program — Committee

20. Director of the Family Health Division — Committee and Secretary

The Committee has responsible to:

1. consider and set up policy concerned NFPP's activities
2. consider and recommend the idea concerned family planning projects that have been proposed by other sectors
3. consider the out-come of family planning activities of other sectors in services, training, IE&C, research and evaluation and etc. including recommendations to improve the activities
4. consider and solve some problems in family planning activities of other sectors.
5. If necessary, the NFPP committee has been authorized to set up the sub-committee to assist the activity

October 24, 2526
(1983)

(Narut Sunnag)
Minister of Public Health

Annex 1.2

Officially Appointed of the Ministry of Public Health

No 93/2527
(1984)
Official Appointment of the Sub-Committee on

Cooperation between government and private sectors

2 1982

The Ministry of Public Health, authorized by the Cabinet-Council has officially appointed the members to be the member of the sub-committee on cooperation between government and private sectors that is responsible for considering and setting up policy and is to recommend some problems concerned family planning activities including considering of the out-come of the private sectors activities in services, training, IE&C, research and evaluation and etc.. in order to improve the activities to be effective.

The members are as follows:

1. Deputy Minister of Public Health	Chairman
2. Director-General, Department of Health	Vice-Chairman
3. Deputy Director-General, Department of Health (Dr.Somsak Verakamin)	Sub-committee
4. Director of Family Health Division	"
5. Secretary-General of the Planned Parenthood Association of Thailand	"
6. Secretary-General of the Population and Community Development Association	"
7. Secretary General of Thai Association for Voluntary Sterilization	"
8. Secretary-General of the Association for Strengthering Information on National Family Planning Program	"
9. Chief of Social Developrent and Professional Promotion Section Office of Policy and Planning Ministry of Interior	"
10. Director of Technical Division Department of Technical Economic Cooperation	"
11. Director of Health Department Bangkok Metropolitan Administration	
12. Dr. Suvanee Satayapan Family Health Division	

1. Chief of Planning Section
   Family Health Division — Sub-committee and Secretary

March 8, 2507 (1954)

(Marut Bunnag)
Minister of Public Health

Annex 1.3

Officially Appointed of the Ministry of Public Health

No 93/2527
(1984)
on

Technical Sub - Committee on Family Planning

The Ministry of Public Health, authorized by the Cabinet-Council has officially appointed the Technical Sub-Committee of the NFPP for coordination and development of the technique, research and evaluation as the standard level

The members are as follows:

1. Dr.Suporn Koetsawang Department of Obstetrics and Gynaecology, Siriraj Hospital	Chairman
2. Dr.Nibhon Debavalya Institute of Population Studies Chulalongkorn University	Vice-Chaiman
3. Dr.Nikorn Dusitsin Department of Obstetrics and Gynaecology Chulalongkorn University	Committee
4. Dr.Dedhanom Muangman Mahidol University	"
5. Dr.Somsak Varakamin Department of Health, Ministry of Public Health	"
6. Dr.Pramote Prasartkul Institute for Population and Social Research, Mahidol University	"
7. Dr.Subarn Panvisavas Mahidol University	"
8. Mr.Manoot Watanakomen Ministeriel Plan and Provincial Development Plan Division Office of Policy and Plan, Ministry of Interior	"
9. Dr.Kanchana Kanchanasinith International Health Division Ministry of Public Health	"
10. Dr.Mornkot Kornkasem Family Health Division, Department of Health Ministry of Public Health	"

11. Dr.Suvannnee Satayapan — Sub-Committee and Secretary
Family Health Division, Department of Health, Ministry of Public Health

This sub-committee has been responsible for

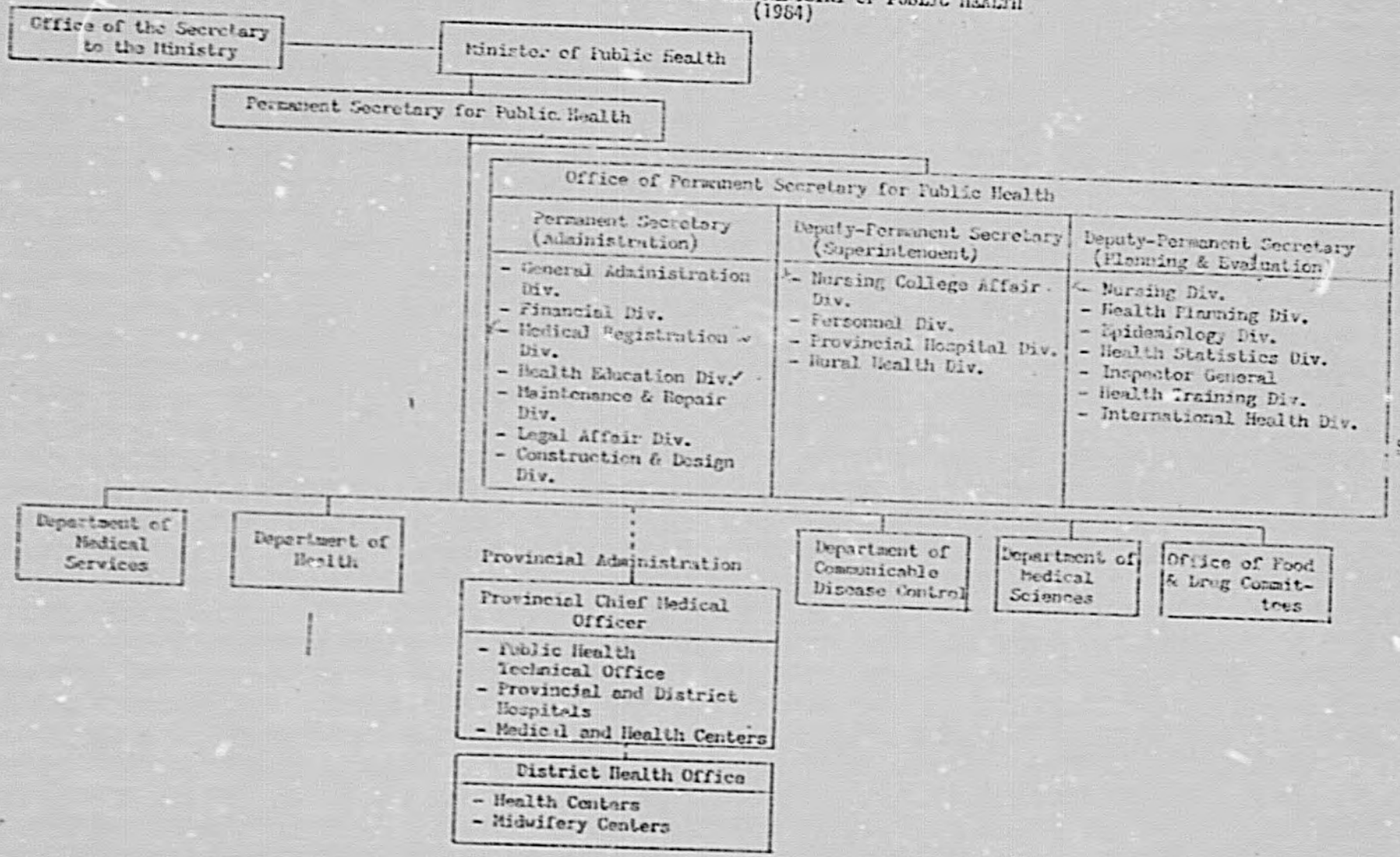
1. Coordination in technique, population research family planning and technique in family planning services.
2. Coordination between government and private sectors for using of some resources and exchanging in technique.
3. Exchanging and distribution of technical knowledge to the other sectors to improve and develope the family planning activities.

March 8, 2527
(1984)

(Marut Bunnag)
Minister of Public Health

Annex 1.4

ORGANIZATION OF THE MINISTRY OF PUBLIC HEALTH
(1984)



Department of Medical Services	Department of Health	Department of Communicable Disease Control	Department of Medical Sciences	Office of Food and Drug Commitees
-Office of the Secretary -Financial Div. -Personnel Div. -Technical Div. -Mental Health Div. -Children's Hospital -Thanyarak Hospital -Prasart Neurological -Hospital and Institute -Mental Deficiency Hospital -Lerd Sin Hospital -Srithanya Hospital -Buddhist Monk's Hospital -Somdej Chaophraya Hospital -Women's Hospital -Institute of Pathology -National Cancer Institute -Institute of Dermatology	-Office of the Secretary -Financial Div. -Personnel Div. -Dental Health Div. -Rural Water Supply Div. -Nutrition Div. -Sanitation Div. -Family Health Div. -School Health Div. -Environmental Health Div. -Occupational Health Div.	-Office of the Secretary -Financial Div. -Personnel Div. -V.D.Control Div. -Malaria Eradication Div. -General C.D.C.Div. -Filariasis Control Div. -Leprosy Control Div. -T.B.Control Div. -Bamrasnaradura J.D.Hospital -Leprosy Hospital -Chest Hospital	-Office of the Secretary -Entomology Div. -National Health Laboratories Project Div. -Radiation Protection -Clinical Pathology Div. -Toxicology Div. -Drug Analysis Div. -Food & Beverage Analysis Div. -Medical Research Div. -Virus Research Institute	-Office of the Secretary -Public Relation and Advertisement Control Div -Cosmetic Control Div. -Drugs Control Div. -Psychotromic Substance Control Div. -Food & Beverage Control Div. -Technical Div. -Inspector Div.

PART THREE

Demographic Background, Impact of the NFPP, and Forecasts

I. The Current Demographic Situation and the Impact of the National Family Planning Program

A. The Demographic Situation in 1984

Based on civil registration and data and various methods of projecting population estimates (NESDB and PLATO), the 1984 mid-year population is 50 million. Among the four regions of the country, the Northeast, the Central, the North, and the South, the percentage distributions of population are 34.8, 32.4, 20.4, and 12.4 respectively. It should be noted that the hill-tribe population which consists of approximately 500,000 to 1 million persons is not included in this estimate.1/

The third evaluation of the National Family Planning Program2/ concluded that the population growth rate in 1981 was 1.95 percent, a steep decline from the 3.2 to 3.4 percent of the early 1960's. It was also concluded that the principal cause of this sharp decline in the growth rate had been a remarkable decrease in fertility. The crude birth rate in 1981 as estimated by the NFPP was 26.9 per 1,000.

The trend of fertility decline has continued since 1981. Crude birth rates calculated from vital registration data have been consistently decreasing. Based on vital statistics, it is estimated that, in 1984, the crude birth rate is 21 per 1,000 and the crude death rate is 5 per 1,000. Thus, the rate of population growth in 1984 is 1.6 percent (see Table 3.1).

B. Fertility

Table 3.2 shows the rapid decline of total fertility rates (TFR) betweens 1975 and 1981. Comparing the SOFT's TFR of 4.74 with the CPS2 and the AFPH2 rates of 3.85 and 3.84 respectively, there has been a reduction of almost 20 percent during the six-year interval.

Table 3.3 shows that urban-rural differentials in the TFR are diminishing. Comparing the TFR of the 1979 AFPH survey with that of the 1981 survey, the more rapid decline in TFR of the rural population is evident. The Table also shows regional differentials in TFR with the highest level in the South despite a remarkable decline during the survey interval.

1/ 1980 Thai census and civil registration data.
2/ Thailand's Population Planning Project, 1979-1981: Report of a Joint Thai/U.S. Assessment, June 1981.

Table 3.1: Vital Rates Calculated from Registration Data, 1979-1984

Year	Mid-Year Population	Number		Rate/1,000		Population Growth Rate (%)
		Births	Deaths	Births	Deaths	
1979	45,667,000	1,130,907	236,091	24.8	5.2	2.0
1980	46,537,547	1,108,759	230,992	23.8	5.0	1.9
1981	47,418,170	1,082,641	220,522	22.8	4.7	1.8
1982	48,360,964	1,097,340	228,522	22.7	4.7	1.8
1983	49,181,000	1,063,094	238,398	21.6	4.9	1.7
1984*	49,993,000	1,049,850	249,960	21.0	5.0	1.6

*Estimates based on past trends.

Table 3.2: Total Fertility Rates (TFR), 1975-1981

Survey and Date		TFR
SOFT	1975	4.74
CPS 1	1978/79	3.64
AFPH 1	1979	4.11
CPS 2	1981	3.85
AFPH 2	1981	3.84

Note: The TFR's are calculated from age specific fertility rates of women aged 15-44.

Table 3.3: Total Fertility Rates (One Year Prior to the Survey Dates), by Residence and Region, GFPR Survey 1979 and 1981

Residence and Region	1979	1981	Percent Change
Whole Kingdom	4.11	3.84	-6.6
Urban	3.60	3.48	-3.3
Rural	4.15	3.87	-6.7
Central	3.61	3.71	+2.8
North	3.30	3.11	-5.8
Northeast	4.57	4.20	-8.1
South	5.97	4.93	-17.4

Note: Since the sample size of the Southern region was rather small as compared to other regions i.e. 295 and 282 in the 1979 and 1981 round respectively, the estimates for this region are more susceptible to deviations.

Table 3.4 shows that the pregnancy rates of married women have declined by 22 percent during the period 1975 to 1981. The rate of decline in rural areas is steeper than that in urban areas, i.e. 27 percent as compared to 5 percent, and urban pregnancy rates are somewhat higher than rural rates as revealed in recent surveys. It should be pointed out that the pregnancy rate of the North is lowest among all the regions, and has remained at about 7 percent for several years.

C. Contraceptive Prevalence

Among those factors accounting for the fertility reduction, it is universally accepted that contraception and sterilization are major contributors. Knowledge of contraceptive methods and contraceptive use are important factors determining the prevalence of contraception.

The CPS 2 conducted in 1981 revealed that almost 100 percent of ever-married women knew about at least one contraceptive method. It can be said that contraceptive knowledge is almost universal among Thai couples and, excluding the Southernmost provinces, it is apparent that there are no negative attitudes towards the use of contraception. Married women seem to know which methods should be used for spacing and which one should be used for cessation of childbearing. Furthermore, the small family norm seems to prevail among the younger cohort of women.

Table 3.5 shows the remarkable increase in contraceptive use over the past decade. Both the CPS and the AFPH surveys reinforce each other and establish that more than 50 percent of married women ages 15 to 44 were practicing contraception in 1981. Although there is a discrepancy in contraceptive prevalence rates estimated by the two surveys due to the difference in sampling frames, the rates of increase between the 1979 and 1981 rounds of both surveys are similar at about 10 percent. In addition, the studies revealed a much greater increase in contraceptive prevalence rates among the rural population which is also reflected in the data displayed in Tables 3.3 and 3.4. If this trend of linearly-increasing contraceptive use persists, it is estimated that the contraceptive prevalence rate will be approximately 65 percent in 1984.

Table 3.6 shows regional variations in contraceptive prevalence. This pattern has persisted during the last decade; the North and Central maintain the highest prevalence rates and the South still has the lowest. It should be pointed out, however, that the South has had the largest increase in contraceptive prevalence during the past few years.

As noted in the previous evaluation report, the marked increase in contraceptive prevalence among the Southern population might be due to the inclusion of the withdrawal method in survey estimates. The most recent studies related to fertility and family planning in the South

Table 3.4: Percent Currently Pregnant Among Currently Married Women Aged 15-44, by Residence and Region, 1975-1981

	SOFT 1975	CPS 1 1978/79	AFPH 1 1978	CPS 2 1981	AFPH 2 1981
Whole Kingdom	11.8	10.1	10.1	9.1	9.2
Rural	12.2	10.0	9.2	-	8.9
Urban	9.7	10.2	10.2	-	9.2
Central	-	-	9.5	8.3	8.9
North	-	-	8.3	7.6	6.9
Northeast	-	-	12.4	9.3	11.1
South	-	-	8.7	11.0	9.6

Note: Standardized for age.

- denotes data are not available.

Table 3.5: Percent of Currently Married Women Aged 15-44 Who Are Currently Practicing Contraception, by Residence, 1975-1981

	SOFT 1975	CPS 1 1978/79	AFPH 1 1/ 1979	CPS 2 1981	AFPH 2 1/ 1981
Whole Kingdom	36.8	53.1	48.3	50.2	52.8
Rural	34.9	51.2	47.0	57.1	52.4
Urban	49.2	62.5 2/	58.9	54.7 1/	59.7

1/ Excluding Bangkok Metropolitan Area.
2/ Bangkok Metropolitan Area.

Note: Standardized for age.

Table 3.6: Percent of Currently Married Women Aged 15-44 Who Are Currently Practicing Contraception, by Region, 1975-1981

	SOFT 1975	CPS 1 1973/79	AFPH 1 1979	CPS 2 1981	AFPH 2 1981
Whole Kingdom	36.0	53.1	45.0	58.2	52.8
Central	42.0	56.3	53.4	63.8	60.7
North	33.0	53.5	54.8	64.9	61.4
Northeast	25.0	43.6	43.1	54.3	44.8
South	16.0	23.6	30.9	42.4	40.9
Bangkok	48.0	59.4	-	64.0	-

confirm that withdrawal is a popular method practiced among both Buddhists and Muslims.1/

Table 3.7 indicates that oral contraception and female sterilization are the most popular methods. Though the proportion of injectable contraceptive users is relatively small, there has been a remarkable increase in the use of this method.

The continued increasing trend in use of permanent methods is also indicated in Table 3.7. Permanent methods have increased from 26 percent in 1975 to 39 percent (see 3) in 1981 with a concomitant decrease in temporary methods [illegible] (87 percent in 1975 to 59% of 1981).

Table 3.8 reveals that contraceptive prevalence in 1981 was highest (at nearly 75 percent) among women aged 30-39. Although the contraceptive prevalence rate among the youngest group of women aged 15-19 remained lowest, it is of interest to note that about 30 percent of them are practicing contraception. Nearly 50 percent of women aged 20-24 (the age group of [illegible] in Thailand) are using a contraceptive method. Such a high permanent vs. temporary method use among women aged 20-24 may be called for in order to formulate strategies to lower the prevalence rate of sterilization among this age group to the lowest possible level.

B. NFPP Contributions to Fertility Decline

The primary reason for explaining impressive fertility reduction is a remarkable increase in contraceptive use. To what extent has the NFPP contributed to this success story?

1. New Acceptors

Table 3.9a shows the number of new acceptors reported to the NFPP from [illegible] between the first quarter of 1984 and Table 3.9b shows percentage of [illegible] methods adopted since 1982. It is apparent that the total number of acceptors has increased steadily, but method choice has changed somewhat since the beginning of 1982. The oral pill, the most popular method, has dropped as a proportion of new acceptors even though the target has been exceeded. Sterilization acceptor targets have not been achieved. The steady rise in IUD acceptance has increased remarkably as demonstrated in Figure 3.1.

Concerning the number of new acceptors reported to the NFPP, two problems were observed during field visits to service outlets that new acceptors seem to be over reported. Evidence of switching methods (such

1/ IPS and IPPF: Proceedings of the Seminar on Fertility, Family Planning and Development Issues of Population in the South of Thailand, March 1983.

Table 3.7: Percent of Currently Married Women Aged 15-44, by Specific Method of Contraception, 1975-1981

Specific Method	SOFT 1975	CPS 1 1978/79	AFPH 1 1979	CPS 2 1981	AFPH 2 1981
Pill	15.2	21.9	17.9	20.2	18.2
IUD	6.5	4.0	4.6	4.2	3.8
TR	7.4	13.0	12.3	18.7	14.9
VAS	2.2	3.5	5.0	4.2	4.7
DMPA	2.1	4.7	5.8	7.1	8.2
Others	3.4	6.3	2.4	4.6	2.9
All Methods	36.8	53.4	48.0	59.0	52.8
Temporary Methods	64.67	57.30	58.96	53.39	57.39
Permanent Methods	26.09	30.90	36.04	38.81	37.12
Others	9.24	11.80	5.00	7.80	5.49
Total	100.	100.	100.	100.	100.

Table 3.6: Percent of Currently Married Women Aged 15-44 Who Are Currently Practicing Contraception, by Age, 1975-1981

Age Group	SCFT 1975	CPS 1 1978/79	AFPH 1 1979	CPS 2 1981	AFPH 2 1981
15-19	18.1	31.3	21.9	29.2	29.1
20-24	30.9	44.2	38.3	47.5	39.6
25-29	41.9	54.4	49.5	60.4	54.5
30-34	44.0	61.1	60.8	57.7	64.9
35-39	42.3	62.6	57.4	68.0	65.0
40-44	30.5	49.5	47.1	56.4	53.2
Total, 15-44	36.7	53.4	48.1	-	-
Standardized for Age, 15-44	36.8	53.1	48.2	58.2	52.8

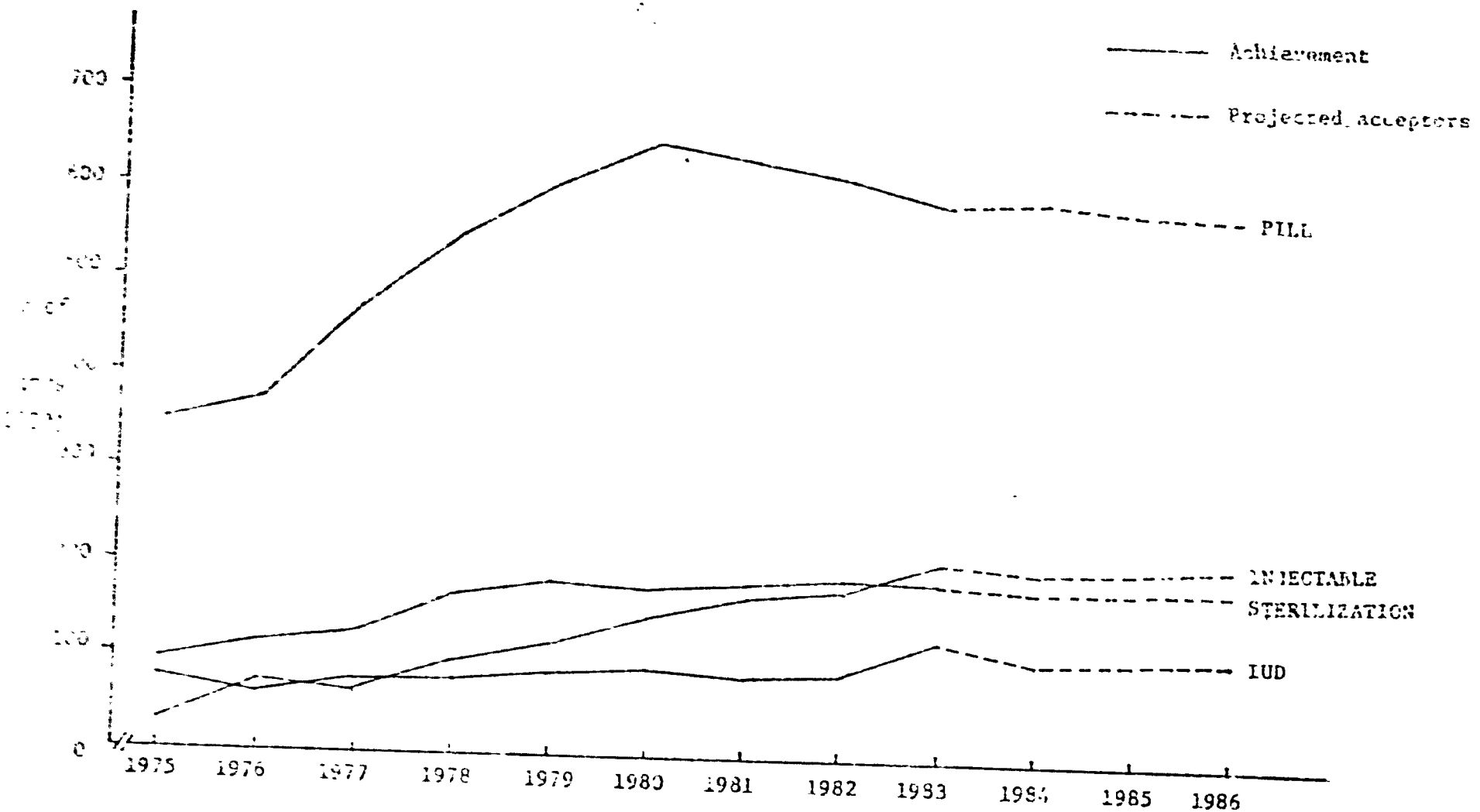
Table 3.9a: New Acceptors Reported to the NFPP, 1975 through April 1984

Year	PILL	IUD	TR	VAS	DMPA	TOTAL
1975	345,117	75,163	82,650	7,534	24,559	535,023
1976	376,707	71,894	95,131	10,150	73,357	627,239
1977	488,765	74,794	106,816	19,123	68,714	758,212
1978	557,857	77,775	124,205	44,256	86,620	890,713
1979	614,525	78,082	138,732	35,300	117,951	984,590
1980	653,610	79,378	151,681	31,105	149,744	1,065,518
1981	634,902	80,134	149,338	28,404	170,491	1,063,269
1982	622,320	83,899	143,561	23,405	177,855	1,051,040
1983	597,775	126,933	146,448	27,076	206,226	1,104,458
1984 (Jan-Apr)	212,404	72,132	59,786	14,782	80,296	439,400

Table 3.9b: Methods Adopted by New Acceptors, January 1982 Through April 1984, and Projected Method Targets, May 1984 Through December 1986

Year	PILL	IUD	TR	VAS	DMPA
1982	59.2	8.0	13.6	2.2	16.9
1983	54.1	11.5	13.3	2.4	18.7
1984 (Jan-Apr)	48.3	16.4	13.6	3.4	18.3
1984 (May-Dec)	55.6	9.7	15.6		18.5
1985	54.6	10.2	15.7		19.4
1986	56.3	10.6	15.7		20.2

Figure 3.1 Number of New Acceptors Reported to the NFPP, 1979-1983, and Projected Acceptors, 1984-1986, By Method.



Source : NFPP Service Statistics, 1975-1983.

as from pill to IUD, or pill to DMPA, or vice versa) was observed especially in the Northeast where massive IUD campaigns have been conducted.

Table 3.10 shows the percentage of new acceptors who were new to the program, from January through March 1984. Although this is fragmentary evidence, it is an indicator of the extent to which method switching and changing from a private to a public service site inflates new acceptor data.

Table 3.10: Sample Number and Percent of New Acceptors Who Are New to the NFPP, By Method, January Through March 1984

Method	All Types of New Acceptors (Sample Number)	% New to the NFPP
Pill	897	66.3
IUD	312	62.8
Injectable	386	59.8

Source: NFPP: 1:120 sample drawn of FP 01 forms.

In reviewing the trend data from 1975-1983, the NFPP has revised the percentage of new acceptors by method for 1984 to 1986 as shown in Table 3.11.

2. Active Users

Table 3.11 also shows the number of actual and projected active users by method and Table 3.12 summarizes NFPP active users as a percentage of married women aged 15-44 for the period, 1982-84. In 1984, the NFPP plans to recruit 54.8 percent of MWRA. Assuming that 80% of couples will receive services through government outlets similar to tne 1981 CPS2 data, (see Table 3.13), the contraceptive prevalence rate among Thai couples in 1984 could reach as high as 67 percent.*

It is worth noting that the numerical estimate of NFPP active users is derived from the number of new acceptors and continuation rates for each method. The estimated CPR, therefore, may be over or under estimated because of these two factors.

Table 3.11: NFPP Targets and Target Achievements by Method, 1982-1983, and Revised Targets of New Acceptors and Estimated Active Users, 1982-1986 (in 000s)

Year		IUD	PILL	Steriliz.	INJECT	TOTAL
1982*	New Acceptors	83.9	622.3	167.0	177.8	1,051.0
	Active Users	323.4	1,823.5	1,105.3	352.0	3,604.2
1983*	New Acceptors	127	598	174	206	1,105
	Active Users	361.5	1,779.1	1,252.2	408.7	3,801.5
1984**	New Acceptors	105	600	168	200	1,073
	Active Users	376.2	1,738.6	1,395.1	441.1	3,951.0
1985**	New Acceptors	110	590	170	210	1,080
	Active Users	392.1	1,702.7	1,537.2	470.3	4,102.3
1986**	New Acceptors	115	580	171	220	1,086
	Active Users	409.1	1,669.7	1,677.5	497.5	4,253.8

*NFPP achievement
**Revised estimates

Table 3.12: Estimates of NFPP Active Users, 1982-1986

Year	MWRA 15-44* (in millions)	Active Users (in 000s)	Percent of MWRA
1982	6.8	3,604.2	52.9
1983	7.0	3,801.5	54.3
1984	7.2	3,951.0	54.8

*From the projection of MWRA, Table 16 of this chapter.

Table 3.13: Source or Contraception, 1981

	CPS 2	AFPH2
Government Outlets	78.2	77.2
Private Outlets	21.8	18.9
Others	-	4.0

3. Continuation Rates

Firm conclusions on reasons affecting low continuation rates cannot be made because of insufficient current data.

Table 3.14 and Figure 3.2 summarize the most recent national continuation rates for the pill, IUD and injectable and add the results of a pilot trial of Norplant. A discussion on Norplant will be excluded from this section of the report since it is provided only in pilot study areas and its acceptors are recruited on a selective basis.

a) Pills

Table 3.14 shows that pill continuation rates, even though higher than those of other other neighboring country estimates seem to be lower than those of the previous NFPP surveys (1977 and 1981).

b) IUDs

The 12-month 75% continuation rate for IUD shown in Table 3.14 is identical to the 1971 NFPP survey. No current data are available. Some studies related to the IUD continuation rate, especially for IUD's inserted during mass campaigns, are under way. It should be noted here that this issue is most important for the future development of an IUD strategy.

The continuation rates discussed here are derived from single method and first segment of single method use which may not reflect switching of temporary methods and discontinuation/switching during a pregnancy interval.

c) Injectables

It was stated in the section on quality of contraceptive use in Thailand Population Monograph (p. 133): "There is much more

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*The prevalence rate cited earlier (65%) is projected from CPS data. The estimate of 67% is derived from extrapolations of user-data from NFPP.

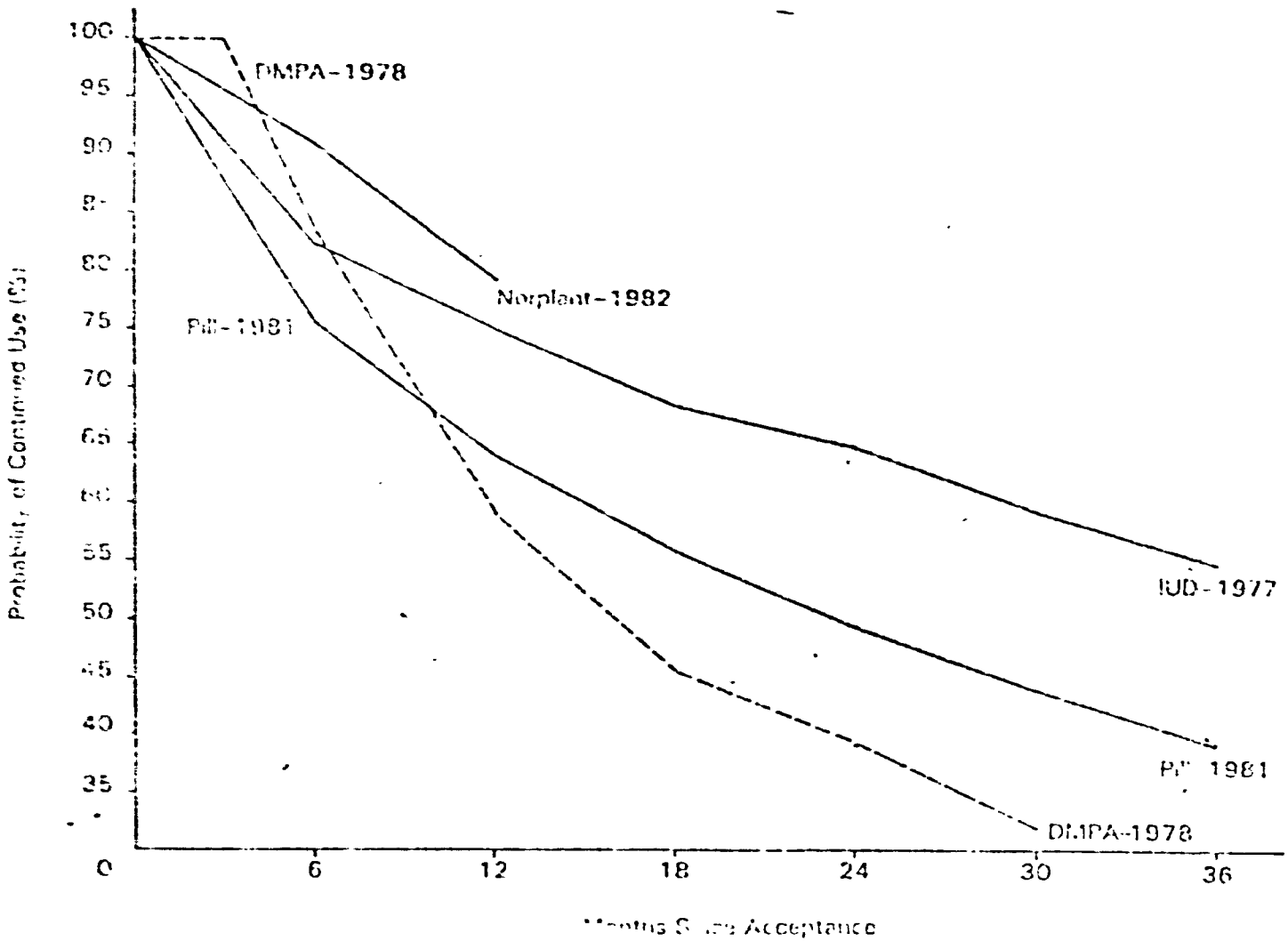
Table 3.14 Recent Continuation Rates for Thailand and International Rates for the Pill, Injectable and IUD

Country & Method	Date of acceptance	year of study	Continuation rate by Ordinal month in percentages								Study Characteristics
			6	12	18	24	30	36	42	48	
Thailand											
Pill	1974-76	1977	82	72	62	56	52	45	-	-	NFPP; N=1043; National
Pill	1977-79	1981	76	64	56	49	44	38	33	27	NFPP; N=1545; National excluding Bangkok
Philippines - Pill	1970-72	1974	66	53	43	35	29	24	18	14	N=2987; National
Singapore - Pill	1966-72	1973	59	48	40	35	31	29	27	25	N=3564; National
Java-Bali - Pill	1971-75	1975-76	75	64	-	47	-	32	-	-	N=2160
Mojokerto, E. Java - Pill	1971-73	1973-74	72	59	48	44	-	-	-	-	N=661
Sri Lanka - Pill	1966-67	1969	49	40	35	30	-	-	-	-	N=322; 2 provinces
Morocco - Pill	1968-71	-	63	45	-	27	-	16	-	-	
Tunisia - Pill	1969-72	-	61	44	-	27	-	17	-	-	
Thailand - DMPA	1976-77	1978	84	59	48	40	31	25	-	-	NFPP; N=624; National
Mexico - DMPA	1969-76	-		56	54	-	-	-	-	-	
Jamaica - DMPA	Pre-1974	1974	-	57	-	-	-	-	-	-	
USA - DMPA	1967-69	-	-	57	49	-	-	-	-	-	
Thailand - IUD	1974-76	1977	82	75	68	65	59	54	-	-	NFPP, N=520; National
Morocco - IUD	1968-71	-	82	71	-	-	-	-	-	-	
Tunisia - IUD	1969-72	-	84	72	-	-	-	-	-	-	

Source: Thailand Population Monograph, Bangkok, Ministry of Public Health and Mahidol University, 1983, p. 125.

Figure 3.2

Most Recent Net Continuation Rates for 4 Temporary Methods



Source: Thailand Population Monograph, Bangkok, Ministry of Public Health and Mahidol University, 1983, p. 139.

diversity in the continuation rates for the injectable contraceptive. Although only the 1981 survey is national in scope, there is reason to believe that mode of service delivery and client education are significant determinants of continuation because the injectable almost always changes the pattern of menstrual bleeding, ..." Observations made during the team's field visits confirm this statement. Some of the dropouts from injectables are a result of lack of supply, which forces the injectable user to switch to the pill. A study of factors affecting injectable continuation use has been undertaken by the R & E unit of the FHD. The results will shed further light on the reasons for the diversity in DMPA continuation reports from selected clinics.

d) General Comments

Some fraction of discontinuation is attributable to medical recommendations to terminate or switch methods. There are a host of other factors that contribute to discontinuation by the user, and the team observed the following factors during their field visits:

. Evidence exists of switching contraceptive methods either from temporary to permanent or from one temporary to another temporary method. As has been mentioned, some pill or injectable users have changed to the IUD and thereafter changed from the IUD to pill. The switching may be the result of mass campaigns which includes incentives and intense recruitment activity.

. There is also evidence of temporary absence of husbands from home which causes their wives to temporarily discontinue their method because they feel no need to protect themselves against pregnancy. The husband's absence could be due to employment in other countries (approximately 300,000 Thai men working in the Middle East) or seasonally migrating within the country.

. The aging of contraceptive users causes some to become acceptors of sterilization.

These impressions should be confirmed by field studies and review of existing data.

II. Forecasts for Future Population Planning

A. Contraceptive Prevalence

With reference to the analysis made by Dorothy L. Nortman,[1/] the correlation between the CBR and the contraceptive prevalence rate

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1/ Dorothy L. Nortman, Population and Family Planning Programs; A Compendium of Data through 1981, 11th edition, New York, Population Council, 1982, p. 22.

(CPR) in various countries is very high (R^2 equals 0.89). The analysis showed that those countries which have a CPR in the range of 70 to 80 percent have a CPR of 15 to 20 per thousand. Applying this finding to the target-setting for Thailand, a CPR of about 75 percent in 1991 will need to be reached in order to reach a CBR at or below 20 per thousand.

Projections of the number of women in the reproductive ages and the number of currently married women aged 15-44 from 1981 to 1991 are presented in Tables 3.15 and 3.16. These projections reflect a changing age structure that is related to fertility reduction. The proportion of women entering the reproductive age in the next decade will be larger than the cohort who entered 10 years ago.1/ As can be seen from Table 3.16 the percent of MWRA in the total population2/ in 1981 was 13.7, and has increased annually. It will reach 16.7 percent in 1991. This changing age structure must be kept in mind during target-setting and when dealing with the components of population change.

If the target of the CPR in 1991 is set at 75 percent and assuming that the CPR in 1984 is 65 percent,3/ the number of active users required each year to reach a 1.5 percent growth rate by the end of 1986 and 1.2 percent by the end of 1991 are shown in Table 3.17. Contraceptive prevalence targets by method set by the NFPP for 1984 to 1986 were shown in Table 3.11. It should be noted that the percentage of users of permanent methods is estimated to increase from 35.3 in 1984 to 39.4 in 1986. The remainder are pill, IUD and injectable users.

It should be recomended for the Sixth Plan that the prevalence by methods required to reach the target growth rate should be set in terms of a proportion of permanent to temporary methods aiming at 45 percent of active users to be users of sterilization, especially among eligible women aged 30 and over. The appropriate proportions of temporary methods should be taken into serious consideration before the decision is made about the proportion of temporary to permanent methods.

1/ The team's demographers used the age structure in the 1970 Census and compared it to and projected from similar data in the 1980 Census.

2/ It must be noted that various demographers have mentioned a factor of undercounting which has differed from census to census. Accordingly, there is room for speculation about the accuracy of estimates of total population.

3/ Regarding the number of active users by the NFPP which is estimated as 54.8 percent in 1984 and after adjustment to include acceptors from private outlets, the NFPP's CPR becomes 67 percent as mentioned before. Realizing that the NFPP new acceptors are somewhat over-reported and the continuation of use is relatively higher than the present estimate, the CPR in mid-1984 should be confirmed as 65 percent (since the results of CPS 3 have not yet been published, 65% will be used for further estimations and projections in this report).

Table 3.15: Projection of Number of Women Aged 15-44, 1981-1991
(in 000s)

Age	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
15-19	2,850	2,898	2,946	2,993	3,041	3,089	3,076	3,064	3,051	3,039	3,027
20-24	2,379	2,468	2,557	2,646	2,735	2,824	2,872	2,920	2,967	3,015	3,063
25-29	1,861	1,959	2,057	2,155	2,253	2,351	2,440	2,528	2,617	2,706	2,795
30-34	1,413	1,498	1,582	1,666	1,751	1,835	1,933	2,030	2,128	2,225	2,323
35-39	1,225	1,258	1,291	1,324	1,357	1,390	1,474	1,558	1,641	1,725	1,809
40-44	1,131	1,145	1,159	1,173	1,187	1,200	1,233	1,266	1,299	1,332	1,365
TOTAL	10,859	11,226	11,592	11,957	12,324	12,689	13,028	13,366	13,703	14,042	14,382

Sources: (1) Registered population at the end of 1980 and 1981.
(2) Sex ratio calculated from registered population data.
(3) Age-structure as enumerated in the 1980 Census.
(4) Mortality assumption as used for the "Population Projections for Thailand: Whole Kingdom and Regions, 1970-2005".

Table 3.16: Projection of Number of Currently Married Women Aged 15-44, 1981-1991 (in 000s)

Age	1981	1982	1983	1984	1985	1986
15-19	488	496	504	512	521	529
20-24	1,385	1,437	1,489	1,541	1,593	1,645
25-29	1,465	1,542	1,620	1,697	1,774	1,851
30-34	1,198	1,270	1,341	1,413	1,484	1,556
35-39	986	1,083	1,111	1,139	1,168	1,196
40-44	956	968	980	991	1,003	1,015
TOTAL	6,478	6,796	7,045	7,293	7,543	7,792
% of total population	13.7	14.1	14.3	14.6	14.8	15.1

	1987	1988	1989	1990	1991
15-19	527	525	522	520	518
20-24	1,672	1,700	1,728	1,756	1,784
25-29	1,921	1,991	2,061	2,131	2,201
30-34	1,639	1,721	1,804	1,887	1,969
35-39	1,268	1,340	1,412	1,484	1,556
40-44	1,043	1,071	1,099	1,126	1,154
TOTAL	8,070	8,348	8,626	8,904	9,182*
% of total population	15.5	15.7	16.0	16.4	16.7

Sources: (1) Projection of women aged 15-44, 1981-1991.
(2) Proportion of currently married women as enumerated in the 1980 census (assuming the same age pattern at marriage throughout the period).

*Represents 30% increase in number of MWRA during period 1983-1991.

Table 3.17: Estimated Levels of Selected Demographic Indices and Numbers of Active Contraceptive Users Required to Achieve A Growth Rate of 1.2% at the End of the 6th Development Plan

	Contraceptive Prevalence Rate (%)	Estimated Birth Rate (Per 1,000)	Estimated No. of Livebirths (Million)	Population Growth Rate (%)	No. of Active Users Required (Million)	No. of Active* Users Required By NFPP (Million)
1984	65	21	1.05	1.60	4.74	3.79
1985	67	20	1.016	1.55	5.05	4.04
1986	69	19	0.98	1.50	5.38	4.30
1987	71	18.5	0.97	1.40	5.73	4.58
1988	72	18.0	0.95	1.30	6.00	4.80
1989	73	17.5	0.94	1.25	6.30	5.04
1990	74	17.25	0.94	1.225	6.59	5.27
1991	75	17.0	0.94	1.20	6.89	5.51

Note: . Assume constant CDR at 5 per 1,000.

. All estimates are roughly calculated at the minimum levels of all variables. With regard to the TFR, the highest estimated achievement is 2.2 by 1991.

*Assume 80% of active users will obtain service through government outlets.

Table 3.18: Projected Total Population, CPR, CBR, and Growth Rates, 1984-1991

Year	Total Population (in 000s)	CPR (%)	Birth Rate (Per 1,000)	Growth Rate (%)
1984	50.0	65	21	1.60
1985	50.8	67	20	1.55
1986	51.56	69	19	1.50
1987	52.28	71	18.5	1.40
1988	52.99	72	18	1.30
1989	53.68	73	17.5	1.25
1990	54.35	74	17.25	1.225
1991	55.02	75	17.0	1.20

B. Population Growth Rate

By the end of 1986, the mid year population of Thailand will be an estimated 51.6 million. The population growth rate will be 1.5 percent, with an estimated 980,000 livebirths, provided that the active users of contraception will be recruited as estimated in the previous section. Thus, the target of a 1.5 percent growth rate by the end of the Fifth Plan will be achieved (see Table 3.18).

As mentioned earlier, the sharp fertility reduction during the last decade has resulted in a changing age structure. It should be kept in mind that the large cohort of females born during the 1960's just before the fertility decline is entering the peak age-group for reproduction. Thus, during the next decade, this large cohort may produce an unusually large number of births which will probably result in fluctuation of the fertility trend measured by the crude birth rate.

After carefully reviewing the demographic trends, the team concluded that a target of a 1.2 percent growth rate by the end of the Sixth Plan is the most reasonable and feasible one.1/ However, a 1.2 percent target will not be achieved automatically by the end of the Sixth Plan under a do-nothing condition. The possibility of a 1.2 percent growth rate is conditional upon a persistence of current trends in contraceptive prevalence with the full support of all related agencies and under the management of an active and effective family planning program. Furthermore, a vigorous family planning program alone may not be enough to sharply reduce the fertility of the Thai population. Social and economic measures to generate small family size norms are needed.

Recommendations (3)

1. Study permanent vs. temporary method use and preference among women 30 years old and above as a basis for formulating strategies to increase permanent method use in this age group.

2. Study/confirm team findings on factors contributing to continuation rates such as: switching, campaign pressure, temporary absence of husbands, aging child-spacers who discontinue temporary methods for a permanent method, and other user behaviors.

1/ A Sixth Plan target of 1.0% growth, which has been discussed, is mathematically conceivable only if the CBR is at or below 18-19 per thousand and the CDR rises to 8 or 9 per thousand, (for example, by aging of the population, or through more complete registration of deaths in the next 6 years). However, the evaluation team felt that these criteria are unlikely to be one, and that a target below 1.2 is not now scientifically justifiable. It is recognized that the decision on the target to be announced will depend on other than purely scientific considerations.

3. Consider a scientifically justifiable rate of 1.2% as the growth rate target for the 6th Plan.

4. Study and establish a justified ratio of permanent to temporary methods and the optimal distribution of temporary methods among new acceptors for the 6th Plan period.

5. Maintain awareness of the large cohort coming into the reproductive age group in planning for services and method-mix during the 6th Plan period.

6. Document actual costs for a new and a continuing acceptor for each temporary method and actual cost for providing a permanent method/per acceptor. These per unit costs need to be reflected against desired method mix and method prevalence to achieve growth rates of 1.2 and 1.0%, and contraceptive prevalence rates of 70, 75, and 80%.

Annex 3.1

The data on contraceptive prevalence and fertility presented in this 1984 evaluation report were drawn from the following sources:

SOFT (1975). Survey of Fertility in Thailand conducted by IPS Chulalongkorn University and the National Statistical Office (NSO).

CPS 1 (1978/1979) and CPS 2 (1981). Contraceptive Prevalence Survey conducted by the National Institute for Development Administration (NIDA) in cooperation with Westinghouse Health Systems.

AFPH 1 (1979) and AFPH2 (1981). The Impact of Accelerated Family Planning and Health programs conducted in 20 provinces by Mahidol University's Institute for Population and Social Research (IPSR). Although the data are limited to 20 lagging provinces the study is considered representative of rural Thailand.

Thailand Population Monograph, Ministry of Public Health and Mahidol University, 1983.

Informal discussions by the team with Dr. Peerasit and Dr. Apichat about preliminary CPS 3 data.

PART FOUR

I. Organization and Management of Services by the FHD

A. Communication and Coordination

While responsibility for FP service delivery and operations management resides at the provincial level and below, the Family Health Division (FHD) has responsibility for policy formulation, overall program administration and management, coordination, quality control, and for providing technical support services to the decentralized service delivery system. The evaluation team found that the existing organizational structure of the FHD continues to be appropriate to support its mission; however, there may be need to examine the relative role and status of the FHD in the overall structure of the MOPH, given the increasing importance of both FP and MCH in the long-term development strategy of the RTG, and the PHC responsibilities of the Rural Health Division.

Internal communications within the FHD appeared to be adequate; however, there were indications that communications and coordination between FHD and other components of the MOPH may need strengthening as the NFPP further develops; e.g., between FHD and: (1) Rural Health Division, (2) Health Education Division, (3) Health Statistics Division, (4) Health Planning Division, and (5) Health Training Division.

A need was also expressed for improved communications and coordination between MOPH and MOI, at both the policy and technical implementation levels. The present arrangement for coordinating policy formulation activities between the two Ministries may not adequately suffice in the future, as the MOI becomes more involved in supporting family planning and population activities in the field including the design and central management of special development projects having direct and indirect impact on FP and other health services. Similarly, at the technical planning and implementation level there is need for a more formal on-going mechanism to improve communications and coordination among headquarters' technical-level staff involved in project design, management, monitoring and evaluation, and the special support services that may be required from FHD and MOI to support development initiatives in the field, particularly those supervisory services aimed at maintaining and improving technical program standards and technical quality control.

Recommendation (4.I.A)

1. A special MOPH/MOI technical level working group should be established for the purpose of joint planning and coordination of policy implementation matters including centrally initiated and/or directed development projects impacting upon the field service

delivery system and the central provision of technical and administrative support for the field. Regularly scheduled (and ad hoc) meetings should be held throughout the year to ensure close collaboration and coordination between the two Ministries.

2. MOPH in collaboration with the private sector should provide provincial-level presentations to development Ministries' personnel on the contribtion of family planning to demographic change, and on other elements that affect population growth.

B. Program Management

Within the overall NFPP (program) are various projects for which special funding and persons with special responsibilities are assigned. These projects have a vertical texture which is one issue, but another related issue concerns seeming fragmentation within projects: persons/Sections are assigned to pieces of the project creating potential for uneven and sometimes overwhelming workloads.

The various vertical management responsibilities within PP II, for example, are expressed in the Implementation Plans provided to the evaluation team. While these do provide sufficient sub-project and budget detail, they do not give a sense of how each sub-project's activities will affect the specific, quantifiable objectives contained in the Project Paper or those of the NFPP. It is believed that this is a reflection of current deferred attention to a cohesive, coordinated and internally consistent plan in favor of administering and managing fiscal and sub-project activities of projects.

Centrally-vertical sub-project management responsibilities also have implications for the field. The FHD's service program is implemented through the public health service system. A number of persons at the central-level have particular pieces of PP II and other projects to promote and implement perhaps resulting in less than optimally coordinated field activities and potentially creating a set of vertically-managed mini sub-projects in the field.

The team questions whether multi-project and sub-project experience and data can be shared, used, multiplied or built-on for the benefit of the overall program under the current management pattern of project, sub-project and Section-by-Section responsibilities and implementation activities.

The MOI's involvement in family planning introduces yet another possibility for fragmentation. In this regard the Burirum campaign model[1/] should be examined and the service data reviewed. It is not

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1/ The Burirum campaign is decribed in the Service Delivery Section (Part Four II.B.3) of this report.

clear, at present, who within FHD would be responsible for knowing about and drawing attention to the potential that the Buriram model appears to present or whether R/E Section's service data from campaigns would be used as one source of information combined with process information for creating ideas for campaign strategies.

Recommendations (4.I.B)

1. The team has recommended that a management review be made. It is hoped that the effects of seemingly vertical sub-project management will be studied, and that the process for actively sharing and using experience and data across projects, sub-projects and sections will be examined.

2. The format of FHD's annual implementation plans for PP II require revision in order to show more clearly: the PP II EOP objective that is being addressed by each pertinent sub-project description and the means for coordinating these discrete pieces; the achievement toward the EOP objective that has already been made, and any departures from or proposed changes to PP II that are indicated in the proposed implementation plan. This conceptual change in format together with the proposed administrative format changes (to be described in Part 5) should lead to greater ease in monitoring and annual internal evaluation.

C. Target Setting and Program Planning

Planning of FP services occurs at all levels of the NFPP and is based primarily upon performance targets measured in terms of new and continuing acceptors by method. The use of performance targets to stimulate vigorous program activity as well as to monitor national provincial and local performance is deeply rooted in NFPP history. In general the national population growth rate targets reflect the demographic goals of the current five year plan, the demographic characteristics of the population, and service statistics indicating prior program performance. National, provincial and local service targets for new and continuing acceptors are established to accelerate service delivery.

1. Target Setting

The FHD presently establisnes annual and long-range performance targets for or with every province, with the expectation that as provincial capability in target setting develops in the future, the role of target setting will be decentralized to the provincial level and lower levels of the system. These targets will reflect annual and longer-term national level policy guidelines on performance target needs and expectations. Under the currently funded UNFPA project, workshops are being held to train provincial level officials in target setting procedures and skills; however, it was reported to the evaluation team that difficulties are being encountered with the procedures being used

for target setting, and that they are possibly too complex for use at lower organizational levels of the service delivery system.

During field visits, the evaluation team noted wide variations in the extent to which centrally set performance targets were accepted and used by provincial and district level officials. Various degrees of field-level participation in the target setting process were reported. They ranged all the way from unquestioning acceptance of the targets set at the central level, to active participation in the revision of centrally-set provincial targets, based on data obtained at the district and tambol levels. The process of translating provincial into local targets for district, tambol and village level units also varies considerably. Prior performance, vital registration data, and village surveys were all mentioned as factors in the final determination of local targets, expressed as numbers of new and continuing acceptors by methods. The variability in derivation of local targets and in the perception of their functional significance by various levels of NFPP personnel is compounded by the existence of local incentives (e.g. accelerated promotion for target achievement) and further compounded by additional targets superimposed by the added involvement of the MOI in the promotion of family planning service activities and campaigns. A review of actual performance compared to targets indicated wide variation: there were locations where targets had been exceeded by 300%, and locations where less than 10% of the annual target had been achieved by the 9th month of the year.

The evaluation team feels that further rationalization of the construction and use of performance targets is both desirable and feasible. And as the NFPP further matures, a shift is needed to greater use of contraceptive prevalence data for target setting. The growing impetus to increase community participation in development planning could also contribute significantly to the target setting process. Contraceptive prevalence is more understandable to workers with limited education than the currently tabulated acceptor data, and would be analogous, for example, to their reporting of immunization prevalence, which they appear to comprehend and do without difficulty. Moreover, contraceptive prevalence rates would be more useful in adapting targets to the eligible non-contracepting population.

The increasing use of village-level mini-surveys and maintenance of more complete family/household records is promising and illustrates the potential for accurate enumeration of household and village data needed for more realistic target setting. However, many village and tambol-level health workers do not yet understand how to use the enumeration forms or how to maintain complete family/household records.

The evaluation team believes that added attention should be given to the training and supervision of fieldworkers in the use of village surveys and improved health center record keeping. Training and work activity should be closely coordinated with the emerging Basic

Minimum Needs/Primary Health Care concept (of which family planning is an integral part) in the new system of local development committees being established in 285 poverty districts and sub-districts in eight provinces under the Rural Poverty Eradication Program (RPEP). A model for identification of community problems (including health) has already been developed, with coordination among the concerned sectors of the four ministries (Public Health, Agriculture and Cooperatives, Education, and Interior). Discussion and recommendations on further development of the FP information system, elsewhere in this report, call for a future shift in focus of the information system to a village "bottom-up" approach to information generation and a shift to measurement of continuation and prevalence.

2. Program Planning

Performance target setting is only one aspect of program planning which also must necessarily focus on the process of achieving targets (outputs), and on the right mix, quality and timing of resources (inputs) required to maximize outputs. The evaluation team found that those other aspects of program planning were generally quite weak at provincial, district and tambol levels. The planning and evaluation sections of provincial health offices are, for the most part, understaffed and underqualified with junior staff to perform and/or coordinate and supervise program planning including the planning of training activities that could significantly improve the rationalization and development of resources and services throughout a province. Similarly at district and tambol levels there is need for skills upgrading and standardized procedures for planning resource use and service delivery. Until improved capability exists at provincial and lower levels, there will not be adequate capacity to utilize the results of past, present and future research studies aimed at identifying more effective, efficient and cost-effective approaches to FP service delivery.

Recommendations (4.I.C.)

1. The NFPP should encourage greater community participation in the program planning and target setting process, with emphasis on the training and supervision of fieldworkers in the use of household/family and village data.

2. The NFPP should consider shifting to the use of contraceptive prevalence rates instead of only acceptor rates as performance targets in the future.

3. Mini-management studies of program management policies, procedures and practices at provincial, district and tambol levels of the service delivery system be funded under the PP II Project and conducted by qualified public sector management analysts, organization and methods specialists or industrial engineers, to identify and document the higher quality management practices that

have evolved among the many "natural experiments" in management practice occurring throughout Thailand, and that such studies produce management policy and procedure guidelines in the form of a reference manual for use in management training and supervision, and for the purpose of upgrading management practices among those districts and provinces where such practices remain weak.

4. A procedures reference manual (or sections of a PHC procedures manual) for planning the use of FP resources and the provision of FP services at the district level and below, should be developed, field tested, published, and used in the future for orientation, training and supervisory quality control purposes; the development of this manual should be a joint project of MOPH and MOI, and placed under the direction of qualified provincial level officials.

5. Investigation should be made of the most adequate, efficient, effective and affordable staffing pattern of health centers, particularly in the lowest performance districts.

D. Management Information

Better management information is required to achieve RTG's 5th Development Plan objectives of improving operations, increasing efficiency, and reducing costs. The output of program research and evaluation helps to meet these objectives if it is properly directed at the on set of the research studies. But the key prerequisite (and long-term solution) lies in further development of an institutionalized on-going information collection, processing and distribution system to serve the program planning and management needs of the NFPP at all organizational levels of the service delivery system, headquarters and field alike.

Significant progress has been achieved by FHD in recent years in strengthening its Research and Evaluation Section. Numbers of staff have increased, quality of staff has improved through training and experience, and hardware and software resources have been added. This has resulted in a more comprehensive and accurate information collection and processing function and has laid the ground work for further development of information system capability in keeping with the emerging needs of a maturing NFPP.

During field visits of the evaluation team, it was evident that the continued development of the Primary Health Care service delivery system, particularly at peripheral levels, was resulting in more substantial record keeping, reporting and use of information in monitoring and supervisory activities. Pressure to carry out complete village mini-surveys and/or maintain complete family/household records was being exerted by various other program areas besides the NFPP. Consequently, the amount and quality of data, and the extent of record keeping and reporting were most impressive at some tambol health centers. Current and historical information on fertility, and

contraceptive use and non-use was readily available and being used in management of promotive and other services at the higher performing health centers. This is as it should be in a highly decentralized service delivery system. It was also evident that where contraceptive prevalence rates were high, i.e. over 70%, service providers and supervisors were shifting their attention from new acceptors to monitoring continuation and prevalence, and focusing more on the non-user. This has significance for future development of the NFPP management information system.

The evaluation team also noted the difficulty being experienced by provincial health offices in compiling, processing and using data for program planning and management purposes due to shortages in resources and expertise. Planning and Evaluation Sections were notably weak as discussed elsewhere in this report. When significant data collection, processing and use were in evidence, technical personnel responsible for FP services were doing it; however, this function was usually being done without the benefit of all available data including service statistics from the private sector in the province. It was reported that private sector information arrives from FHD too late and in a format too difficult to be used by the provincial office.

The nation-wide development of the FP Service Statistical System (SSS) in recent years has been most impressive. The development approach has served well to set national priorities for data collection and build a standardized system to meet national level monitoring and planning needs. There are a number of significant problems in the present SSS which need to be resolved before further conceptual and structural development of the system is undertaken. For example, the feedback of processed data to the field in a format more useful and in a more timely fashion is needed. There is double-counting of new acceptors who have switched methods resulting in overly optimistic measurements of service performance in terms of new acceptors. The Service Statistics System shifted from counting new and continuing acceptors to estimating temporary method active users by counting the number of oral contraceptive cycles and injectables distributed. Unless this approach is backstopped by carefully conducted periodic audits to confirm accuracy and adjust for discrepancies between supplies distributed and actual use, the counting of temporary method active users could be also overly optimistic and very misleading. The supplies are subject to some degree of illegal leakage, hoarding and/or non-use by recipients who either drop out or switch methods. This potential problem will be avoided as the NFPP MIS is developed in the future, with a village "bottom-up" prevalence measurement focus.

As the NFPP further matures and as the decentralized PHC service delivery system further develops, a more decentralized "bottom-up" approach to information systems development will be required to provide:

1. Timely planning and management information to supervisors and program managers at lower echelons of the service delivery system wherein data are used as it flows up the system from the target population rather than on the way from headquarters.

2. Different and more sophisticated information, i.e. continuation and prevalence in addition to counts of new and old acceptors, and measures of service efficiency which relate service outputs to resource inputs.

USAID Contribution to Management Information

Under the PP II Project, assistance is being provided to the NFPP to develop a computerized management information system and to improve use of service statistics. The Project Paper appears overly optimistic in expecting that a Management Information System (MIS) could be designed and installed for a program as complex as the NFPP in the limited lead-time and with the limited amount of resources provided. The original schedule called for data processing software to be developed and tested by June 1983 and the new system to be completely operational by January 1984. During the second project year, the existing Service Statistics System (SSS) was to be incorporated into the MIS as well, which suggests that the original intent was to develop a comprehensive MIS that would serve the management information needs of the FHD as well as program managers responsible for FP services at lower organizational levels of the service delivery system, a rather large undertaking.

A contract for technical assistance services was awarded by USAID TO NIDA on March 25, 1983 for the period through March 31, 1984. The MIS consultants were to:

1. Assist Planning and Management Section Staff of FHD in inventorying all management information being collected by FHD, and deciding upon future information needs and priorities.

2. Design a computerized MIS including appropriate measures, indicators, information specifications and formats.

3. Prepare, test, debug and install appropriate software, and train FHD staff in use of software.

The sub-contract was later amended in August 1983 to include information on progress of externally-funded projects.

Considerable delays have been experienced and continue to be expected in designing, testing and installing the initial MIS:

1. NIDA consultants previously requested that the scope of the MIS be limited to the area of commodity management only,

although the objective of the MIS was to serve the overall management needs of the NFPP. A compromise was reached in focusing the initial MIS on work activities of the FHD only.

2. Certain key steps in the MIS design process were given too little attention or omitted entirely, e.g. inventorying all management information being collected by the FHD to identify that which would be needed or not needed, the additional requirements, and setting priorities on future information needs.

3. The MIS model was designed and the software package developed based on general classifications of data and indicators, a theoretical approach which remains untested at the present time. Normally specific program management information outputs and pre-requisite data input specifications are determined before, not after, the MIS model is designed and tested, which suggests that considerable difficulty may be encountered in real life application of the present model. A review of the initial data collection form, suggests that the system design may be overly cumbersome for practical use.

There is a high priority need for information to improve the planning, coordination, management and evaluation of FHD activities. The MIS being developed to serve this need will be tested through real life application in the near future. It is the judgment of the evaluation team that the system design will fall short of needs and expectations.

There also remains the broader and more significant need for an MIS to support FP program planning, management and evaluation at all organizational levels of the service delivery system. The existing FP Service Statistics System (SSS) should serve as a solid foundation for future development of this NFPP MIS which because of its complexity, will require a long-term development strategy. There is a tendency by donors and host governments alike, to underestimate the lead-time and resources required to develop an appropriate and viable MIS to serve a nation-wide hierarchial service delivery system. Thus it is important to carefully and realistically design a development strategy that clearly identifies, lead-time and resource requirements. A high degree of practical technical expertise in MIS application and design is also normally needed for this task.

Recommendations (4.1.D)

1. A thorough review be conducted as soon as possible of the NIDA MIS design proposal for FHD including some limited testing of it using real work activity data in a program management situation, to assess relevance and utility of the proposed system before wide scale introduction occurs.

2. Technical assistance be provided to the NFPP, either through the PP II Project or through centrally funded AID contracts, to assist the NFPP and FHD in developing a comprehensive strategy and long-term development plan for a comprehensive nation-wide MIS to adequately serve the future needs of the NFPP; that such plan include detailed time-line and resource requirements.

3. At least 4 pilot projects be funded under the PP II Project to design and test hierarchal decentralized approaches to FP information system development including:

   a. Utilization of a village and tambol "bottom up" approach to data gathering and reporting, which includes a re-orientation from counting new and old acceptors, to monitoring continuation and prevalence, and; utilization of data at each organizational level of service delivery by supervisors and managers for planning, target setting managing and evaluating FP services.

   b. A pilot project be conducted in each of the following diverse situations to properly test and assess the appropriateness and practically of a "bottom up" approach to information system development:

      1) A high performance district in a high performance province.

      2) A high performance district in a low performance province.

      3) A low performance district in a high performance province.

      4) A low performance district in a low performance province.

4. Technical assistance, training and other resources be given to the Planning and Evaluation Sections of PCMO offices to upgrade capability in data processing, analysis and use of data to improve and further develop the information system needed for planning, management and evaluation of FP service delivery.

5. A sub-section for data processing be formally organized and started within the existing Research and Evaluation Section of FHD to provide for: improved management and accountability over central data processing for NFPP; additional resources as needed and appropriate specialization; quality control and oversight for NFPP MIS development.

6. The R/E Advisor's tour of duty be extended through the remaining life of the PP II Project, to assist with the design and management of the pilot projects recommended above, and to implement a long-term development strategy for a comprehensive MIS and a program evaluation system to serve NFPP needs.

E. Financial Management

Table 4.1 provides information on financial allocations and estimated budgets for the NFPP during the period FY 1982 through FY 1987. Although the RTG receives financial assistance from a variety of donors, USAID support continues to be a major element of the NFPP.

Table 4.2 provides information on current financial commitments, estimated budget, and uncommitted balances for the USAID contribution to the PP II Project: 35% (21 of 60 months) of project time has elapsed, 37% of grant funds and 28% of loan funds have been committed. Overspending of grant funds is mainly attributable to an acceleration in spending to support mobile teams and intensive services -- 71% of the originally allocated funds have already been committed and 48% expended. If spending for this component continues to escalate or merely levels off at the present rate, either significant additional funds will be needed during the remaining project life, or the component must be phased out earlier than originally planned.

Significant underspending of loan funds is attributed to a decision taken by RTG not to utilize loan funds for procurement of contraceptives, and to a lag in spending for training in sterilization. Underspending has been partially offset by a major increase in procurement of medical kits to support IUD and sterilization services, wherein 127% of the original budget for kits has been committed to date, and 42% actually expended. There has also been some escalation in spending for IUD training, with 50% of original budget presently committed, although only 22% has been expended.

A review of USAID funds presently uncommitted indicates that approximately $ six million is available for reprogramming during the remainder of Project life due to changes that have occurred in project implementation planning since the project was originally designed in 1982. Among these changes is the decision by the RTG to become self-sufficient more rapidly in the procurement of contraceptives thereby reducing the percentage of USAID funding for commodities under the Project from 40% to about 12%. Priorities for reprogramming of available uncommitted funds during the remaining Project life are contained in the section on USAID Reprogramming Priorities.

Table 4.3 provides information on financial allocations and estimated annual fiscal year budgets for the remaining life of the project, which reflect the recommended priorities for reprogramming.

It should be noted that due to some delay in initiating project implementation and spending in 1982, that FY 1983 is considered to be the first project year, thereby extending the Five Year Project through FY 1987, or into the next Five Year plan period of the RTG.

TABLE 4.1: ALLOCATIONS AND ESTIMATED BUDGET FOR NFPP (INCLUDING FP AND MCH IN POVERTY AREAS)
(IN $1000'S)

SOURCE		FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987
INTERNAL - RTG		8,602	10,015	11,223	12,486	13,743[3/]	15,117[3/]
EXTERNAL - AID GRANT		1,800.0(?)	2,399.3[1/]	1,239.3[2/]	1,626.2	1,626.2	1,626.2
	AID LOAN	2,000.0(?)	1,197.6[1/]	1,588.2[2/]	2,360.8	2,360.8	2,360.7
	JAPAN	659.1	395.2				
	CANADA	36.4	30.0				
	GERMANY	520.0	1,475.0	1,475.0	1,475.0	1,475.0	
	UNFPA	820.3	1,361.4	1.8	1.3	1.3	N/A
	POP COUNCIL	-	450.0				
	FPIA	666.9	550.4	880	880[3/]	880[3/]	880[3/]
	JHPIEGO	19.6	35.5				
	FHI	84.6	80	80	100	100[3/]	100[3/]
	RESEARCH TRIANGLE INST.	-	16.7				
	IPAVS	175.1	380	230	200[3/]	200[3/]	200[3/]
	FAMILY PLANNING INT.	-	7.5				
	OTHER	-	-				
	SUB-TOTAL	6,782.0	7,675.8				
TOTAL							

1/ 1st Year of PP II Project.
2/ Based on earmarked funds as of June 30, 1984.
3/ Estimate.

TABLE 4.2: CURRENT AND PROPOSED BUDGET - POPULATION PLANNING II PROJECT
(AS OF JUNE 30, 1984)
(IN US$000's)

PROJECT COMPONENTS	TOTAL PP BUDGET	COMMITMENTS TO DATE	COMM. % OF PP	EXPENDITURES TO DATE	EXPEND % OF PP	UNCOMMITTED BALANCE	PROPOSED REDISTRIBUTION OF BALANCE	REVISED LIFE OF PROJECT BUDGET
A. GRANT								
1. CONTRACEPTIVES	3,503	1,236.0	35%	1,236.0	35%	2,267.0		
2. MOBILE UNITS/INTENS	1,283	909.5	71%	614.4	48%	373.5		
3. HEALTH & HYGIENE	595	357.0	60	357.0	60	238.0		
4. COM BASED VSC (PDA)	910	202.2	22	104.7	12	707.8		
5. SOCIAL MKTG	164	-	0	-	0	164.0		
6. COMMODITY MGT	67	69.1	103	8.4	13	0		
7. MGT INFOR	68	29.5 2/	43	26.1	38	38.5		
8. PROG RESEARCH	681	78.3 1/	11	51.2	8	602.7		
9. PROJ EVAL	416	221.0	53	46.6	11	195.0		
10. VSC & IUD AVGT	55	18.0	33	7.4	13	137.0		
11. OTHER	-	51.9	-	20.9	-	0		
CONTINGENCY	775	-	-	-		721.0		500
SUB-TOTAL	8,517	3,172.5	37%	2,472.7	29%	5,344.5		8,517
B. LOAN								
1. CONTRACEPTIVES	3,274	-	0	-		3,274.0		
2. KITS	686	869.6	127	286.6	42	0		
3. INSTITUTIONAL S	3,032	1,029.5	34	658.7	22	2,002.5		
4. IUD TRG	1,661	833.2	50	366.2	22	827.8		
5. STERIL TRG	319	26.3	8	4.6	1	292.7		
CONTINGENCY	896	-	0	-	0	712.4		712
SUB-TOTAL	9,868	2,758.6	28%	1,316.1	13%	7,109.4		9,868
GRAND TOTAL	18,385	5,931.1	32%	3,788.8	21%	12,453.9	12,453.9	18,385

1/ Earmarked funds for 10 Research Projects @ $137,000 not included here as commitment.
2/ Earmarked funds for NIDA follow-on OR Applic. ($7,100) and MIS ($12,600) not included have as commitment.

TABLE 4.3: ALLOCATIONS AND REVISED ESTIMATED BUDGET FOR PP II PROJECT
(IN $1000'S)

PROJECT COMPONENT	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	TOTAL
GRANT						
1. CONTRACEPTIVES	1,236.0	-				
2. MOBILE UNITS/INTENSIVE	327	582.3				
3. HEALTH & HYGIENE	357					
4. COM BASED VSC (PDA)	-	202.2				
5. SOCIAL MKTG	-	-				
6. COMMODITY MGT	12	57				
7. MGT INFORMATION	29.5	19.7				
8. PROG RESEARCH & EVAL	78.3	137				
9. PROJECT EVL	-	221				
10. VSC & IUD AUDIT	9	9				
11.						
12.						
13. OTHER		51.9				
14. CONTINGENCY	-	-	-	-	-	500.0
SUB-TOTAL	2,048.8	1,280.1				8,517.0
LOAN						
1. CONTRACEPTIVES	-					
2. KITS	296.4	573.2				
3. INSTITUTIONAL SUPPORT	546.3	483.2				
4. IUD TRG	331.7	501.4				
5. STERIL TRG	9.6	16.7				
6.						
7.						
8.						
9. CONTINGENCY	-	-	-	-	-	700.0
SUB-TOTAL	1,184	1,574.5				9,868.0
PROJECT TOTAL	3,232.8	2,854.6				18,385.0

F. Commodity Management

The NFPP currently requires approximately US$ 4.5 million a year for procurement of commodities (primarily contraceptives and medical kits), to support service delivery throughout Thailand, with costs escalating each year. Consequently, efficient management of commodities is a high priority need. Prior to the start-up of the PP II Project, numerous deficiencies had been identified in the management of commodities including wide variations in stock levels with central storage warehouse overloaded and stock shortages elsewhere in the system, stocks poorly organized for inventory control, record keeping systems unreliable, and supply management procedures at all levels of the distribution system in need of upgrading.

Under the PP II Project, commodity management was to be improved at all levels of the FP service delivery system, while the quantity of FP commodities supplied by AID would decrease in both absolute terms and as a percentage of the total NFPP requirement, from approximately 50% under the previous AID project to less than 15% under the present project.

During the past several years considerable progress has been made by the NFPP in improving commodity management. Semi-annual and subsequent annual inventories have been conducted, security of stock has been improved, and 4 regional warehouses have been established. During the first Project Year, technical consultants from the CDC completed the design of an inventory reporting system including a new reporting form and computer software for data processing and management. A micro-computer and related equipment were procured and installed. During the second Project Year, the new reporting form and related procedures are being tested in 4 Provinces with full country-wide implementation presently scheduled as follows:

By end of July: All provinces in central and southern regions.

By end of September: All provinces in northern region.

By end of December: All provinces in northeastern region.

Some delays have been experienced in the testing of the new system due to staff time shortages in the FHD Research and Evaluation Section, and delay in finding and appointing an appropriately qualified manager for the overall system. Continued workload pressures in the Research and Evaluation Section could result in further delays; however, the new system appears to be well designed and with continued assistance of the CDC consultants should provide a sound basis for upgrading the entire FP commodity management system.

The Project Paper estimated the budget for developing the commodity management system at $67,000. Due to the unanticipated need

for a micro-computer and related equipment, estimated to cost $18,109, this project component is now projected to exceed budget by that amount. Also, the system implementation delays being experienced will push more training and related system installation costs into the 3rd Project Year than was originally planned. (See Figure 4.1 for commodities budget.)

More than adequate inventory of commodities was reported at regional warehouses as protection against possible stock outages at lower levels of the system. It was estimated that approximately 1.5 years supply of contraceptives was being maintained in the system as previously committed by the RTG. After the new commodity management system becomes fully installed on a nation-wide basis with standardized minimum-maximum stock levels for all organizational levels of the system, the amount of stock on hand nation-wide may be reducible to one year or less at considerable financial savings without jeopardizing the adequacy of supply at any organizational level of the system.

It should also be noted that the original budget of the PP II Project provided for USAID procurement of contraceptives in the amounts stated below. The NFPP has expedited the phasing out of USAID funds for procurement of contraceptives as the following indicates:

	Project Budget	Proposed Revision
Grant	$3,503,000	$1,236,000
Loan	$3,274,000	$ -0-

The RTG is to be congratulated on achieving a more rapid self-sufficiency in contraceptive financing and procurement than previously planned or expected.

Recommendations (4.1.F)

1. The following recent recommendations of the CDC Consultants be implemented by FHD at the earliest possible time in order not to lose the development momentum now established for the commodity management system:

   a. A ranking official should be given overall responsibility and accountabilty for operation of the entire logistics system. Logically, this individual would have training in business administration with experience in logistics and distribution systems.

   b. An individual should be given clear responsibility for implementation of the computerized logistics monitoring system.

   c. Following the proposed tentative implementation schedule described above, USAID should schedule meetings at milestone dates to assess the progress in implementation, modify the schedule as needed, and schedule needed additional technical assistance from CDC and other outside consultants.

d. A plan for making provincial level staff aware of the uses of output data should be developed. This could be accomplished through (a) formalized training, (b) presentations at meetings, (c) on-site training, and/or on-the-job training through mailed critiques of monthly outputs.

2. An additional $16,000 be earmarked for further development of the Commodity Management System during the 3rd Project Year, which would increase the total Project Plan amount needed for this component by $14,422, from $56,000 to $81,422.

3. CDC consultants should continue to be used in further design of the commodity management system, including the application of economic order quantity methods in establishing guidelines for procurement scheduling and supply re-distribution among the various echelons of the national system. They should also assist in preparation of a procedures reference manual for use in training and supervisory quality control of supply management staff at all appropriate levels of the commodity management system.

4. FHD should follow-up its December 1983 directive to PCMO's on the availability and use of the approved 3 formulations (and 4 brands) of oral contraceptives, by preparing and distributing the proposed manual of instructions on the use of the various formulations (and brands), and by monitoring the commodity supply system to ensure the storage availability and use of the different formulations (and brands) at all appropriate service outlets and storage points.

5. A review be conducted of present and future needs for medical kits (IUD and sterilization) and efforts be made to initiate additional procurement actions during the 2nd Project Year if necessary to ensure full availability as early as possible in the 3rd Project Year. Consideration should be given to the direct assignment of kits to personnel at the time they are trained to use them, rather than the allocation of kits to Provincial Health Offices for use by personnel at lower levels of the system.

6. Funds be reallocated to increase the $686,000 of PP II Project Loan funds previously budgeted for procurement of medical kits for use during the remainder of the 2nd Project Year and during the 3rd Project Year to increase kit procurement to a level more commensurate with need. As suggested earlier, USAID may wish to confer with JICA and FHD on this matter before committing funds.

7. The NFPP, either through the PP II Project or other donors, or both, provide additional transportation and IEC equipment support to district and health center workers; and, make contribution to the RTG's revolving fund to support the purchase and provision of additional motorcycles and other types of transport vehicles to district, and health center workers involved in FP services, and which are subsequently purchased by the workers through pay check deductions which replenish the revolving fund.

Figure 4.1 Commodities Budget

Project Year	Original PP Budget	Project Implementation Plans To Date	Actual Commitments To Date
1	US$12,000	US$12,000	US$12,000
2	US$43,000	US$47,179 1/	US$53,422 1/
3	US$12,000	-	US$16,000 2/
4	-	-	-
5	-	-	-
Total	US$67,000	US$69,179	US$81,422

1/ Included $18,188 for micro-computer and related equipment not previously budgeted.

2/ Estimated requirements for 3rd Project Year.

II. Service Delivery

Both the qualitative and quantitative aspects of contraceptive service delivery are heavily influenced by the NFPP's IE&C effort and the training and supervision of family planning service providers. Accordingly, these program elements are inevitably intertwined with the team's evaluation of access to and delivery of contraceptive services. This portion of the evaluation considers the strategy underlying service delivery, the expansion of access to various services, and selected qualitative aspects of each service modality in the current NFPP.

A. Quantitative Aspects:

1. Expansion of Service Points

Progress in the expansion of services, particularly those providing IUD insertion and sterilization as emphasized in PP II, is evidenced both by the reported increases in service outlets and trained personnel and the favorable trends in acceptor rates recently reported.

By the start of 1984 (FY) the number of district community hospitals had increased to 470 and the number of tambol health centers had grown to 7,169. All of the district hospitals now provide the full range of modern contraceptives. The concomitant expansion in personnel trained in IUD insertion and others utilized in pill/condom distribution is described in the comments on the various service modalities to follow.

The degree of utilization of the absorptive capacity of service outlets varies widely. Many provincial and district hospitals were observed to be at or near capacity and some were overextended by virtue of demand for medical services. Others exhibit FP service gaps either because they lack personnel trained in certain FP methods or lack sufficient equipment.

At the sub-district level, underutilized capacity remains, either because of limited demand for services, insufficient IE&C and outreach activity, or local restriction on the use of auxiliaries in delivery of DMPA or IUD services. Facility utilization is a potential area for an efficiency study.

2. Availability of Commodities At Service Points

During field visits to 12 provinces by the evaluation team, it was learned that commodities were currently in adequate supply at all levels of the service delivery system except in the following cases:

a. Some health centers carried a supply of only one or two brands of oral contraceptives, and it was reported that some clients preferring other brands formerly obtained from health centers, were now purchasing these brands from private sources rather than accept the free but different brand from the health center.

b. There were widespread shortages of kits for sterilization and IUD insertion. Various MOI campaigns had necessitated provincial officials borrowing and returning supplies of kits from FHD. Kits were also not always available for newly trained-personnel which served to inhibit the provision of services at a time when these personnel needed to give services in order to sustain their skill levels and build their confidence.

c. Injectables were usually not available at health centers staffed by personnel not formally trained in use of injectables; however, there were situations where injectables were in full supply and being used, but not reported by such personnel; and other situations where personnel were provided injection supplies by their clients, or where clients provided funds and health center staff purchased supplies in order to give the desired injections. (See more complete discussion under training section of this report.)

B. Qualitative Aspects

1. Management of Service Delivery

The NFPP relies upon the multi-purpose PHC system for service delivery. The extent to which the PHC system provides coverage and develops the capability to deliver FP services, determines the extent to which there is availability and access to FP services. Success in achieving NFPP objectives therefore depends heavily upon the increased viability and further development of the PHC delivery system. While the use of special mobile teams and intensive campaigns can expedite availability and access to services, the long-term cost-effective solution to delivery of services lies in further development of the regular PHC service delivery system extending full coverage and access to all villages.

During field visits, the evaluation team was most impressed with the continuing development of the PHC system including support infrastructure, supervision and expanding coverage. There remains however, great variation in the quality of program management and supervision, and in the capability of multi-purpose health workers to deliver an appropriate mix of FP services. Consequently much remains to be done in strengthening and extending the service delivery system for FP.

Findings of the recently conducted Health Sector Assessment study sponsored by USAID, were generally confirmed by the evaluation team:

a. "A high drop out rate of Village Volunteers and Communicators;"

b. "Weakness of management system at district level and below;"

c. "Inadequate budgetary support for personnel, transport, per diems, and equipment at district level and below;" and

d. "At all levels, the need for management training ..., especially for workers at district level and below."1/

The evaluation team learned that there was less attrition of VHV's in areas where health center staff devoted more time and attention to outreach activities and working with the volunteers. Contraceptive prevalence rates appeared to be much higher in areas served by health centers having more than one female health worker, permitting more time for village outreach services and providing more complete female health worker coverage at the health center during regular working hours. It was reported that women acceptors were unhappy when arriving at the health center to find only a male sanitarian present to serve them.

The recent Health Sector Assessment study reported "conflicts between the physician-in-charge of the district hospital and the district health officer" and that "some clarification of management responsibilities at the district level is needed."2/ The evaluation team found that where the District Health Office was located physically adjacent to the district hospital, good collaboration on FP service was occurring, even to the extent that the hospital nursing staff had been allowed to take over complete supervision of FP and MCH services at nearby health centers. In other situations, communications and coordination needed improvement.

The evaluation team was quite impressed with the commitments to and knowledge of FP policies and services by district health officers. The dual reinforcement of FP policy and objectives by MOPH and MOI appeared to be having a pronounced effect on the attitude and work activities of DHO's some of whom were extremely articulate in FP and quite active in community promotive activities. They are, for the most part, in need of more training in planning, management and evaluation skills, and lack adequate resources, including transport, fuel, IEC materials, and operating budgets to effectively fulfill their functions. Despite these deficiencies, some DHO's appear to be doing a very excellent job.

At the provincial level the evaluation team again found wide disparities in the quality of service program management. The presence of a highly committed and dynamic PCMO was a major factor influencing the quality of management and service delivery. Another key factor was the extent to which senior managers had systematized and standardized management procedures and practices, and incorporated these in reference

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1/ Thailand Health Sector Assessment. AID, 1983.

2/ ibid.

manuals and management training activities. Still another factor was the extent to which training in program management and supervision was being conducted including adequacy of curricula and the frequency of formal and informal in-service training activities. While better managed provinces were spending more of their allocated funds and thereby more effective in generating increases in funding levels, other provinces have been experiencing less success in obtaining funding increases. Consequently, the evaluation team found wide variations in available resources among provinces, particularly in transportation and equipment availability and quality. In some provinces and districts, all tambol health center staff were equipped with motorcycles or another type of vehicle, or 2-way radios even at close in locations, and IEC materials. In other locations health center staff had little or none. Similarly at district level, some DHO's had adequate transportation and other resources and others had little or none.

Provincial level supervisors in some provinces complained that their function was seriously inhibited by the need to travel with a group of supervisors for lack of vehicles, and this resulted in poor supervisory coverage and inadequate amounts of available time to perform the supervisory function in the field. There appeared to be a direct correlation between the availability of transportation at health centers, districts and provincial offices, and performance levels in FP service delivery.

The evaluation team also found wide variations at the provincial level and below, in communications and coordination practices. Well-managed provinces had established policies and procedures, even elaborate visual aids used in orientation and training activities. Other provinces had little or no systematic approach to communications and coordination, or orientation and training on the subject. In some provinces there was little communication between the Provincial Health Office and the provincial hospital, and in other provinces excellent communications and close coordination existed. Similarly, relationships between provincial hospitals and district hospitals varied greatly, as did communications and coordination between the Provincial Health Office and private sector FP agencies and activities.

Since the delivery of NFPP services to the people of Thailand is so heavily dependent upon a decentralized multi-purpose system which serves many masters, and which obtains its resources from many sources, there is always a question as to how far the NFPP should go in providing assistance to development of common elements of the system.1/ This question is particularly relevant to areas where FP service delivery is either pushing ahead of the service system capability, e.g. where technical supervision of FP services is inadequate, or where Auxiliary Midwives are giving injections without required training and without an

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1/ Program management and supervision, equipment, transportation, communications, etc., that support all programs.

authorized supply of DMPA; or where other deficiencies in the PHC delivery system (e.g. resource mal-utilization or unavailability) are seriously obstructing further development of FP services. The evaluation team believes that each of the special program areas being served by the PHC system should contribute to the development of the common elements of the service system, and that the NFPP should therefore continue to provide support using internal and external funding sources including Japanese and American aid assistance.

2. Delivery of Temporary Methods

a. Oral Pill

The continued popularity of oral contraceptives (212,404 new acceptors in January-April 1984) is attributable in large part to the progressive increase in access to pills through a variety of channels. Pills are available free through over 40,000 VHV's who have been trained and who cover approximately 85% of the villages of the country. They are also sold through the network of community-based PDA distributors operating in some 16,000 villages in 48 of the country's 73 provinces A wider variety of pill formulations than those offered by MOPH is also available at retail prices (generally 20-25 Baht/cycle) in approximately 7,000 drug stores throughout the country.

While some providers in the course of our field observations indicated some client preference for certain formulations, and occasional shortages of specific pill brands among health center stocks were noted, the pill supply and distribution program seems generally adequate. There has been discussion of introducing lower-dose combination pills and progestin-only minipills, (the latter for lactating mothers) but to date these are not part of the regular MOPH formulary.

Reports of complications, and even of side effects, of oral contraception continue to be very infrequent, compared to the experience of other, particularly western countries. Nevertheless, screening for contraindications to pill use and training in the management of pill complications and side effects remain important ingredients in the quality of oral contraceptive service delivery. The evaluation team is concerned that the valuable and highly publicized pill "checklist" which was developed and validated in Thailand in the 1970's is not being applied routine to potential new pill acceptors at the village level. Moreover, the performance of VHV's is open to question, as evaluations have shown many of them to be inadequately trained for the responsibilities they assume.

b. IUD Services

In order to make IUD services more accessible, nurse midwives and auxiliary midwives are being trained in IUD insertion. Pilot studies began in 1976. By the end of 1983 a total of 1,060 nurse midwives and 558 auxiliary midwives had been trained.

The intent of IUD training is to extend IUD service to rural or remote areas. Although the reported increase in IUD acceptors indicates progress in this direction, the objective of fully operational IUD services down to the sub-district level has not been achieved to the extent expected.

Service outlets below district level providing IUD insertion number 661, at present. Our field observations revealed that a large number of health centers are still without this service. In some cases, this is because they either have no trained auxiliary midwife (AM), or a trained AM has no insertion kit. In others there has been no local promotion or campaign, or "No acceptors" is reported.

The "multiload" copper bearing device was added to the NFPP IUD program in 1983. While this device is generally reported to be preferable to, it is considerably more expensive than the Lippes Loop, and its recommended three year duration of use introduces a new dimension in IUD counseling, follow-up, and re-insertion service. Complications are reportedly infrequent, but anecdotal reports of explusions are generally felt to reflect errors in insertion techniques rather than an inherent property of the device. Observations and recommendations on the training implication of the change to multiload IUD are to be found in the Training section of this report.

c. DMPA

Acceptors of injectable contraception increased by 23% in the first four months of 1984 compared to the corresponding period in 1983 with the largest increase in new acceptors occuring in the Central and Northeast regions. Data on continuation indicates that about 60% of acceptors have maintained their injection schedule at one year.

In the course of field visits the evaluation team encountered significant variations in the availability of DMPA at the tambol levels. The result is that DMPA acceptors now have to travel to district or provincial level hospitals for this service.

The potential for expansion of access to this highly effective and relatively popular method of temporary contraception is addressed in the section of the evaluation dealing with training. The unique attributes of this method make it particularly acceptable to special sub-populations such as hill tribes of the North with logistics problems of ready access to services, or Muslim women of the South who, reportedly, find it easier to maintain secrecy about their contraceptive practice with this method. Accordingly, the evaluation team feels that the issue of training of auxiliary midwives in DMPA injection should be addressed without further delay. The recommendation pertaining to this issue is found in the training section of the report.

d. Condom

While condom (generally included in a "condom and other" category in MOPH acceptor tables) occupies a relatively minor role among the mix of methods, it nevertheless remains the only modern reversible method available to males. Hence, its distribution at no cost by VHV's and at minimal cost by PDA distributors continues to be important. A variety of condom brands, both domestic and imported, are available. According to CPS 2 about 30% of condoms dispensed in 1981 were obtained from government outlets and 77% from private outlets. The CPS 3 data on condoms are not yet available, nor is their net contribution to fertility control determined.

e. Withdrawal

While the practice of withdrawal is not reflected specifically in the service statistics of the NFPP, its frequent use, particularly in the southern provinces by Muslims and to a lesser extent, by Thai Buddhists, is acknowledged. Survey data have suggested that its prevalence may be as high as 20% in one province (Satun). In view of its apparent acceptability among groups known to be relatively resistant to the adoption of modern contraceptive methods, the evaluation team agrees with the investigators participating in CPS 3 that a study of the use-effectiveness of withdrawal as practiced by this sub-population would be valuable.

f. New Methods

In a project supported by the Population Council, the MOPH is conducting a study of the Norplant subdermal contraceptive implant. Altogether 1,000 women are enrolled in the study, which is being conducted in four locations: The Khon Kaen MCH Center, the Suan Dok Hospital, the MCH Center in Chiengmai, and the MCH Center in Yala. A separate more recent study is taking place at Siriraj Hospital under the direction of Prof. Suporn Koetswang. The implant consists of silastic capsules containing the hormone inserted subcutaneously in the arm, where they slowly release the levonorgestrel, producing highly effective contraception for over five years. The studies are not yet completed, but early reports indicate promising results in Thailand, as in other countries, with a high (79% at 1 year) continuation rate. (The possibility of a selection bias in the pilot studies may inflate this figure, since acceptors are screened for motivation to practice contraception for a moderate length of time). The Yala study, conducted at the MCH Center, was begun four years ago, and includes 359 women, representing both Muslim and Buddhist acceptors. All are between the ages 25 to 35 with parity one to four. The "six capsule" version of Norplant was utilized. Altogether 135 had discontinued by June 1984; seventy of these were "completed" cases (3 1/2 years), others wanted restoration of fertility, discontinued because of weight gain, or spontaneously expelled the capsules (presumably due to improper insertion).

The MOPH is interested in the potential contribution of Norplant to the future mix of tempoarary methods. There is also interest in training NMs and AMs to provide it. However, all must be held in abeyance--outside of ongoing studies--until the method is approved as a commodity.

3. Delivery of Permanent Methods

a. General Comments

The increased emphasis on sterilization in the NFPP in recent years has continued to result in substantial increases in VSC acceptance. New acceptor data comparing January-April of 1984 with the corresponding period in 1983 show an increase in vasectomies from 7,663 to 14,782 and in female sterilization from 47,428 to 59,786. Data on the rate of VSC increase relative to rates for other contraceptive methods are not yet available from CPS 3, but the preliminary tabulation of users by region indicates that female sterilization represents the highest percentage of users (age 15-49) in every region, and that VSC is being accepted at a younger age than in previous surveys.

Undoubtedly a number of factors have contributed to these trends. Increased access to sterilization at district hospitals has resulted from the training of new district hospital physicians (for example, 150 district-level physicians have been given a one-week course in VSC during PP II, thus far). Expanded media coverage, the district hospital mobile education/motivation campaign, and the support provided by the MOI through the Provincial Governors have all contributed, as has the private sector. The general expansion in trained family planning personnel to provide motivation and referrals at the subdistrict level must also have had some effect.

Acceptors of vasectomy in the first four months of 1984 (14,782) are nearly double the number for the corresponding period of 1983. If this level of activity is sustained throughout the year, the 1984 target of 30,000 vasectomies in the Intensified (nationwide) Vasectomy Promotion program will be exceeded. A full evaluation of the January to June 1984 campaign is expected by September, 1984.

In two of the three Northeastern provinces visited (Nong Khai and Surin), great resistance to vasectomy was reported for various reasons: fear of effects on sexual potency and/or the ability to do hard work; local occurrences of hematoma; lack of confidence in local medical personnel; program completion with female methods; and in the case of Surin, difficulty in reaching ethnic Khmers.

Buriram, however, was successful in promoting vasectomy. There the PCMO, with the support of the Governor, was able to organize and hold a short-term campaign that successfully recruited new acceptors for both male and female sterilization and IUD insertion. This

successful campaign seems to contradict the negative experiences of other provinces in motivating vasectomy acceptors, especially when IUD's were available simultaneously.

The Buriram success in the promotion of three methods at once appears to be attributable to:

1. Strong leadership from the Governor and PCMO.
2. Good organization and recruitment of acceptors through local government channels (district officers, village headmen).
3. Close coordination and hard work by all levels of provincial medical/health staff.
4. Incentives for acceptors and health personnel.
5. Training for all personnel prior to the campaign.
6. An integrated multi-media information campaign.

The team feels that judgement of the extent of the contribution of campaigns to overall NFPP performance must be withheld until a full assessment can be made of such factors as the substitution phenomenon, the extent of method switching occasioned by a campaign approach, and the anecdotal evidence of cases of very short continuation in reported instances where the incentive appeared to be the sole reason for acceptance of the IUD. Moreover, the need for close intersectoral synchrony and full mutual understanding of the philosophy and principles of voluntarism and the "cafeteria approach" to which the NFPP has been dedicated from the outset, are required in order to forestall any possibility of overzealous promotion, such has occurred in other countries where a "campaign" approach augmented by incentives has been utilized.

The contribution of ASIN, PDA and TAVS is substantial and illustrates the vast potential in the private sector for help in the diffusion of family planning service delivery. In our discussion with an ASIN representative it was acknowledged that this potential could well be extended to greater assistance in training medical students, post-graduate physicians, and/or selected MOPH personnel in surgical F.P. procedures. The extent of this that has occurred to date is not fully documented.

While surgeons responsible for VSC service show commendable ingenuity with regard to instrumentation and sterilization of equipment, a number of instances of inadequate supplies of surgical kits to meet the VSC case load were reported to us, especially where campaigns have produced larger number of acceptors in a short time. Additionally, there were numerous complaints about the quality of surgical instruments,

particularly those manufactured in Pakistan, which frequently rust, break, or otherwise malfunction.

b. Special Strategies

1. The Pattalung Province Mobile Sterilization Service

This USAID supported project was begun in 1981 by Dr. Sumroen, Deputy PCMO, with the full cooperation of the PCMO, Dr. Charoen, who has committed 800 man hours of provincial staff time to the project. The mobile van, donated in 1982 by the M.C. Piya Rangsit (Vibhavadee Rangsit) Foundation, provides vasectomy and laprocator sterilization service at the village level once or twice weekly to acceptors who request the service at prior visits to the village by a mobile team. The mobile team gives IE&C for all family planning methods. This year the demand has been accelerated by the multisectoral IE&C campaign mounted in response to the MOI's commitment of support to family planning through the cooperation of the governors and district officers. The project has greatly exceeded its target of fifty cases per month, accounting for 1,550 sterilizations between March '83 and June '84. The majority of these have been female sterilizations as expected. However, Dr. Charoen noted that he has performed 917 vasectomies since 1977, and the team had an opportunity to observe his personal motivational talk to a village meeting at which he effectively used a satisfied vasectomy acceptor to assure the audience that male sterilization is not harmful.

This project, successful in a province which has historically ranked among the lowest in new family planning acceptors in general, with a very modest level of sterilization acceptance in particular, illustrates the potential for improving performance with the right combination of dedicated personnel, quality service, and the commitment of resources to bring services directly to the people at village level.

The evaluation team concurs fully with the MOPH policy of training district level physicians in mini-laparotomy and the major reliance on this procedure for female interval sterilization. However, the successful demonstration of mobile laparoscopy service and the observation of effective use of laparoscopy in our field visits at provincial hospitals where physicians suitably trained and experienced in this modality are posted, appear to justify further extension of this well established female VSC modality.

2. Provincial Sterilization/IUD Campaigns

The female sterilization/IUD campaigns which began in February, 1984 in the 34 North and Northeast provinces were scheduled to be completed by June of this year, but have been extended to August. A full evaluation of their impact will be available by September 1984.

The campaigns use mobile units to inform and motivate acceptors. IUD insertions are done by mobile service units while female sterilizations are referred to district or provincial hospitals.

The Ministry of Interior through the Provincial Governors gives strong support to these campaigns. The support to IUD campaigns from Provincial Governors has been important in organization and promotion through district officers and village headmen, in providing funds for incentives and prizes, and in terms of the leadership and influence of the Office of the Governor.

3. The Intensified Vasectomy Promotion campaign emphasizes the use of tambol health center personnel as motivators. The health workers receive an incentive for vasectomy referrals to district hospitals. Mobile service is provided in districts without a hospital. The campaign has national coverage with the exclusion of Bangkok. It began in March of this year and has been extended until December. An estimated 30 to 40 percent of the target has been achieved to date, but formal reports have not been received in Bangkok as yet.

4. Use of Incentives

MOPH policy from the beginning has avoided direct payment of incentives to acceptors of family planning services. Its policy instead has been to reward individuals who refer acceptors of VSC and IUD insertion. The level of compensation has consistently been higher for male and female sterilization than for IUD insertion.

The entry of the MOI into the areas of active promotion of family planning with emphasis with a "campaign" approach has introduced a new dimension into the incentive framework, namely direct payment of an "in-kind" reward to the acceptor. The form which this takes varies from one province to another, and is not universally applied, depending on the availability of a provincial allocation of funds to meet the cost. In many instances the incentive is a new garment, perhaps augmented by an inexpensive but valued household item such as a water jug or blanket. In addition, some localities have given acceptors lottery tickets for prize such as a pig, egged goose, etc. Usually the acceptor of sterilization receives more tickets than the IUD acceptor, presumably to enhance the motivational effect of a chance to win a significant prize. Community incentives, such as cash prizes, for tambols meeting campaign targets were also described to the evaluation team, adding a further element of competition to the campaign strategy.

It cannot be denied that the campaigns have focused attention and mobilized heretofore inactive resources in the pursuit of NFPP goals with measurable success. Nevertheless, the anecdotal evidence that at least some of the reported increase in acceptor rates attributed to the campaigns represents method switching and the fact that the campaign strategy departs from an MOPH policy which precludes payments to acceptors, merits careful evaluation and closer coordination to insure

that the complementary activities do not work at cross purposes. This imperative is implicit in the recommendations we have made elsewhere in this report regarding the need for closer intersectoral coordination.

Recommendations (4.II.B)

A. Management of Service Delivery

1. As a goal, efforts should be continued in promoting more adequate staffing of tambol health centers to achieve a minimum of 2 female health workers for every health center at the earliest possible time, particularly in the lowest performance districts, but the financial and staffing implications are considerable and should be studied as should the existing utilization of health centers.

2. Greater utilization be made of district hospital nursing staff in the technical supervision of FP and MCH services delivered by tambol health center staff and a more formal matrix supervisory structure should be established at the district level to accommodate joint MOI administrative and MOPH technical supervisory responsibility for delivery of FP and MCH services.

3. Mini-management studies of program management policies, procedures and practices at provincial, district and tambol levels of the service delivery system be funded under the PP II Project and conducted by qualified public sector management analysts, organization and methods specialists or industrial engineers, to identify and document the higher quality management practices that have evolved among the many "natural experiments" in management practice occurring throughout Thailand. Such studies should produce management policy and procedure guidelines in the form of a reference manual for use in management training and supervision, and for the purpose of upgrading management practices among those districts and provinces where such practices remain weak.

4. The NFPP, either through the PP II Project or other donors, or both, should provide additional transportation and IEC equipment support to district and health center workers; and make contribution to the RTG's revolving fund to support the purchase and provision of additional motorcycles and other types of transport vehicles to district and health center workers involved in FP services, and which are subsequently purchased by the workers through pay check deductions which replenish the revolving fund.

Recommendations (4.II.B)

B. Temporary Methods

1. Greater attention should be paid to the quality of oral contraceptive service in general, and to the training and supervision of VHV's and other village level distributors in

screening of clients and instructing in oral contraceptive practice.

2. Norplant, when available as a commodity, should be added to the method-mix. High priority is accorded commodity purchase through USAID loan funds.

3. Investigation should be made of the perceptions and attitudes of service providers that affect uptake and continuation of services by ethnic minorities. These findings should be disseminated and discussed within FHD, and if negative should be acted on.

C. Permanent Methods

1. Replication of the successful mobile laparoscopy service in Pattalung should be considered in other areas where a suitably trained physician is available and the demand for female sterlization justifies its provision at the village level.

2. In addition to procurement of adequate numbers of VSC kits, special attention should be given to the reliability and source of procurement of instruments in order to assure high quality and safety in VSC services.

3. Training and equipment for laparoscopic VSC should be provided to those provincial and regional hospitals which have physicians with the requisite experience and training in obstetrics and gynecology.

4. The MOPH should explore the potential of NGO's involved in VSC service delivery for a larger role in the training of physicians in surgical contraception.

5. NGO increased participation in services and training could be guided by FHD's information on VSC service and training gaps. Likewise, NGO's training outputs should be documented and forwarded to FHD as to location and numbers of trainees to assure complementarity with FHD's monitoring of training and service projections.

6. Variability in the effectiveness of the intensified Vasectomy Promotion Campaign in different provinces should be carefully evaluated to ascertain the relationship of client resistance and the effectiveness and cost of the various IE&C promotion strategies on program performance.

III. TRAINING AND SUPERVISION

A. Organizational Locus and Responsibilities for Training and Supervision

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

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

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

Education Sub-Section
(12 staff)
Responsible for:

- Standardizing the curriculum and assuring maintenance of teaching standards in the 7 Schools of Auxiliary Midwifery.
- Distributing information about and managing applications to continuing education courses for FHD personnel.
- Orientation to FHD and family planning (one week) for new nurses who will be employed in provincial hospitals and MCH Centers.
- Special projects: development of curricula for in-service training courses.

Supervision Sub-Section
(9 supervisory staff)

Responsible for:

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

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

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

The Section Head reports to the Assistant Director of FHD. There appears to be no formal linkage of the Section with counterpart sections in the Health Training, Nursing, Health Education and Rural Health Divisions within the Office of the Permanent Secretary.

The Section is responsible for planning, technical support to, monitoring and evaluation of three types of training:

1. Basic training of auxiliary midwives: is conducted by 7 Schools of Midwifery (Khon Kaen, Chieng Mai, Yala, Ratburi, Nakorn Sawan, Lampang and Bangkok (Vachira)) and the MCH Centers that are affiliated with them. Since 1983, the course duration has been extended to two years, and there are 900 auxiliary midwives who graduate each year.

2. Pre-service training (orientation): a one-week course at FHD for new nurses who will work at MCH Centers and district and provincial hospitals. 381 were oriented at FHD in CY 1983.

3. In-service training: USAID-funded IUD insertion training for auxiliary midwives and nurse midwives; UNFPA-funded intermediate (297 trained in CY 83) and master-level (training of trainers 191 trained in CY 83) (TOT): military-funded training of military staff (two-week courses in FP/MCH/PHC) with 40 in each of 5 groups per year; Navy-funded training of Navy personnel in FP/MCH (4 groups per year); international training (a 5-week course) funded by Thai AID once a year for 20 Asian mid-level family planning managers; and a series of RTG-funded refresher courses for auxiliary midwives and nurse midwives (the step I course for auxiliary midwives is a one week update in FP/MCH, PHC, and sex education and is offered at the six MCH Centers to about 200 AM's who are in their third year of service. The step II course for AM's covers supervision, administration, FP/MCH policy, a TOT and sex education, and is offered to 100 participants each year. The step I course for nurse midwives is a one-week refresher offered after three years of service and is an update in FP/MCH services, and a TOT. Five groups of between 25-30 are trained each year. The step II course is designed for provincial and district senior-level nurse midwives, 3 groups each year, and covers evaluation, target-setting, monitoring, counseling and sex education).

Training of TBA's is underway. In CY 1983, 1,462 were trained by AM's in 10 provinces during 5-day courses. Preceding TBA training, ten two-day TOT's were held for tambol-level auxiliary midwives. This is not the first time that the Department of Health has trained TBA's: from 1977-81, 6,693 were trained in FP/MCH/PHC. The Training and Supervision Section has obtained external assistance, starting in June 1984, to train 310 TBA's in the Southern Region. The 5 day TBA courses will be conducted at tambol health centers by AM's who will have received a 5-day TOT. Each of 65 AM's will train 4 to 5 TBA's, and each TBA will receive a family planning flip chart, a delivery manual and a delivery kit.

In addition to regularly-scheduled training courses, the Section has offered special workshops on: curriculum development; family planning administration for mid-level managers; development and planning of monitoring and evaluation system for family planning and MCH activities; a workshop on media and artwork design for documentation: and a workshop on a planning and management sequence in the community health curriculum of Schools of Auxiliary Midwifery.

Not only the T/S/E Section of FHD conducts training which raises a management issue: training, supervision and education (and technical support) are functional, supportive components of a service program. Yet, in FHD the T/S/E Section has its own large agenda, and other Sections also have training, technical support, and education agendas. It is not clear whether there is a training management focal point that guides and plans the overall FHD manpower development and supervision components. As will be noted subsequently, this is also reflected at the provincial-level where there were, in all provinces visited, no Training Sections. The function was combined with another Section resulting in lack of provincial-level updated training master plans, training needs assessments, and training projections based on service requirements.

It appears that a review should be made of the training and supervision system (centrally/provincially/district-level/tambol level) as it exists, and based on this review, recommendations be made to clarify the locus of management of the system and to more fully integrate T/S/E centrally and provincially.

B. IUD Insertion Training for Nurse Midwives and Auxiliary Midwives

1. Background

The training of paramedicals in IUD insertion is expected to contribute significantly to increased availability of IUD services at the tambol level and strengthened services at provincial and district hospitals. The End of Project Status section of the Project Paper enumerates these expected increases:

. 1,500 sub-district service points

. 500 provincial and district service points;

and specifies the number of auxiliary midwives (AM's) and nurse/midwives (N/M's) who will be trained to staff the service outlets:

. 1,520 AM's
. 500 N/M's

Financial assistance specific to IUD training from USAID loan funds is $1,660,340, to support training courses ($1,630,660), training materials ($4,600), and follow-up and evaluation of AM's ($25,080).

Other program elements funded by USAID contribute to the post-training functions of AM's and NM's including IUD kits, IE&C and mobile service campaigns, and research and evaluation.

2. Training Targets and Process for Achieving Them

PP II calls for annual training targets, as follows:

	1982	1983	1984	1985	1986
NM's	100	100	100	100	100
AM's	240	320	320	320	320

It was assumed that all who will be trained will thereafter provide IUD insertions. That assumption and other issues pertinent particularly to AM's IUD insertion training, were raised by the evaluation team and will be discussed in sub-sections of this portion of the report.

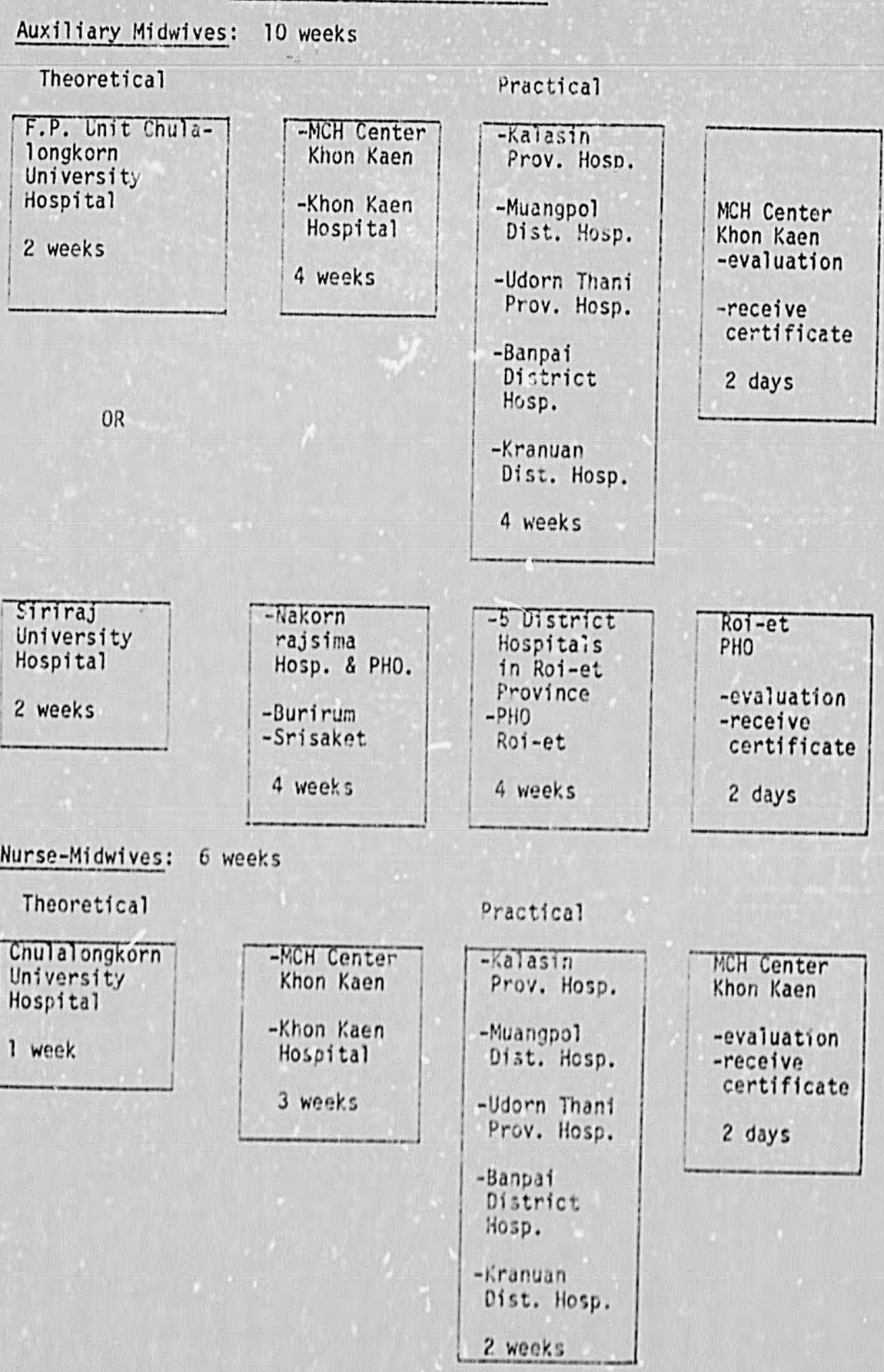
In FY 1983, the FHD training targets were 240 AM's and 80 NM's. The targets were achieved at a cost of ฿3,442,947 ($149,693) for the AM's and ฿783,574 ($34,068) for the AM's. Per trainee costs (using trainees and expenditures as factors) were: $624 for AM's, and $426 for the nurse midwives. The difference in cost per trainee derives from the differential duration of training (see Figure 4.1). Comparing these per trainee costs with those in the Project Paper, AM and NM per trainee costs are currently less expensive than projected ($870 and $615 respectively).

In 1984, the targets are 320 AM's and 110 nurse midwives. However, starting in February 1984 with USAID grant funds and RTG support, a pilot project began for IUD insertion training at the provincial level for AM's. Course duration has been reduced from 10 to 6 weeks (1 week theoretical, 5 weeks practical). To date, the pilot target of 60 trained AM's has been achieved: 20 AM's per class in Ubon Ratchthani, Nakhon Ratchasima and Nakorn Patom. Field follow-up of trainees (by central and provincial staff) began in mid-July.

Pilot decentralization and shortening of the IUD insertion training course for AM's is expected to: increase the number of trained AM's; decrease the costs of training, and institutionalize training capability at the provincial level under the general supervision of PCMO's. Training impacts are expected to: produce a training model that can be used in other provinces, increase the number of IUD service points and IUD acceptors, and contribute to national growth rate reduction goals.

If the pilot project can demonstrate feasibility and efficiency of IUD insertion training at the provincial level, the PP II target of 1,520 trained AM's can be exceeded. This, however, will also depend on availability of IUD acceptors at provincial and district level

Figure 4.2: IUD Insertion Training Site Sequence for Auxiliary Midwives and Nurse Midwives



training sites to the extent of 25 practice insertions per trainee. Thus, only provinces with a high or increasing level of IUD activities are likely candidates for pilot replicability.

The Supervision sub-section's highest priority is follow-up of IUD insertion training. However, the supervisory evaluation form that is used includes pill distribution, palpation technique during antenatal examinations, organization of antenatal, post partum and family planning services, and review of service goals and plans. A recently-returned central supervisor reported that she had visited 35 AM's and nurse midwives during one week, spending about one hour per supervisory visit. She observed problems of overcrowding in the clinics, insufficient health education and counseling, improper sterile technique, and plans that were not consistent with household and community data. Supervisees had requested more information on the pill, but she had no time to provide it. She had recommended that the provincial-level supervisor follow-up on the problems observed, and that pamphlets and other educational materials be provided to improve the health education component. (Subsequent to field visits, reports are prepared for the Head of the Supervision sub-section who submits a report to the Head of the Training Supervision and Education Unit).

3. Evaluations and Studies

In discussions by the team with the Training/Supervision/Education Section, need was acknowledged for a systematic, comprehensive evaluation system which will become particularly critical as and when decentralized target-setting and training take place. However, there have been efforts to examine the subject of IUD training.

There has been no systematic study of training impact on meeting service needs and requirements, or an in-depth study of the effectiveness and efficiency of AM training, but there have been several attempts to assess the quality of training, the relevance of training to on-the-job service situations and on post-training contributions to IUD service. The following is a summary of these findings:

a. USAID grant funds were expended on an "Assessment of the Short-term Effectiveness of the Training of AM's in IUD Insertion." This study was conducted by the R/E section of FHD at a cost of B98,238 ($4,271). The Training and Supervision Section was not involved in the study. Fifty-three health center-based, trained AM's from two regions were divided into low achievement and high achievement (with regard to new acceptors, not continuation clients) focus groups. The results of focus group discussions showed that:

1) Upon returning to their health centers after IUD training, the low performance midwives did not promote IUD acceptance any more strongly than the pill or injectable. The high performance midwives made a special effort to promote acceptance of the IUD.

2) While both groups specified one day of the week for IUD service, the high performance midwives prepared their insertion equipment everyday and provided IUD services daily. The low achievement group did not prepare their equipment daily and therefore had to turn clients away.

3) The low achievement group believed (incorrectly) that the pill and injectable are more efficient contraceptives than the IUD. The high achievement group felt that the methods were equally efficient but that the IUD is more convenient for the users since it does not require resupply.

4) Finally, the high achievement group felt that they should be trained in IUD removal (not a part of the current curriculum)* to maintain their credibility with clients when discontinuation is desired. The low achievement midwives, however, felt no need to be trained in IUD removal.1/

b. In an FY 83 post-card follow-up by the Training and Supervision Section, the following information was obtained from 160 of 240 FY 1983 trained AM's (a 67% response rate):

1) 5,842 IUD's had been inserted by the 160 respondents.

2) 340 IUD's had been removed by the respondents.

3) The highest reported number of IUD insertions by one AM was 311, and the lowest number was 1.

Among 51 trained nurse midwives (59% of those trained in FY 83), 4,785 insertions and 851 removals were reported. The highest reported number per nurse/midwife was 551, and the lowest was 3.

The continuation data for AM-inserted IUD patients have not been studied recently.

c. Documentation on observations made during the supervisory visits (dates unspecified) of Supervision sub-section staff revealed that:

1) Some trained auxiliary midwives and nurse midwives were not providing IUD service due to transfer to another unit, or to promotion. Supervisors were advised to consider better methods of selection of trainees to solve this problem.

1/ Preliminary abstract provided by R/E Section of FHD.

*This assertion was disputed by both the Khon Kaen MCH Center and the Training/Supervision/Education Section.

2) Some of the trained auxiliary midwives and nurse midwives who completed the training course before 1983 were not able to insert the Multiload 250. They were advised to go for training at the district hospital.

3) Improper sterile technique, and acceptor follow-up were observed problems (sterile technique was again reported as a problem during a recent supervisory visit, and by a member of the evaluation team.

4) Since the start of nurse midwife training in 1976, the percentage of nurse midwives who are providing IUD service is 46.9% (from a sample of 153). The main reasons given for non-provision of service were transfers and promotions.

5) The percentage of auxiliary midwives who are providing IUD services since training started in 1980 is 74.2% (from a sample of 92). The main reasons given for not providing IUD services were transfers, promotions, or no acceptors.

d. Pre and post test means scores on theoretical knowledge for groups trained in FY 1983 were:

Nurse midwives:	pre test	60.9%	
	post test	78.6%	17.7% gain
Auxiliary midwives:	Chulalongkorn sequence		
	pre test	42.8%	
	post test	72.4%	29.6% gain
	Siriraj sequence		
	pre test	45.7%	
	post test	68.4%	22.7% gain

e. Practical training experience was reviewed from the perspective of case numbers only, for groups trained in FY 1983. Mean numbers of cases for each trainee for each practical component are displayed in Figure 4.3, following.

The numerical variations between Chulalongkorn and Siriraj initiated training experiences (the major portion of the practicum is not in Bangkok--see P. 103 of this section) were not explained, but may be attributable to less site variation inthe Chula groups' first four week practicum which is conducted entirely at Khon Kaen MCH Center and Hospital.

Figure 4.3: Mean Number of Practice Cases During Training perNM and Am

	Nurse Midwife	Auxiliary Midwife (Begun at Chula)	Auxiliary Midwife (Begun at Siriraj)
Insertion of Lippes Loops	20.0	26.6	20.4
Insertion of Multiload Cu. 250 mg.	12.5	20.4	12.6
Reinsertion of IUD	5.1	6.4	3.3
Removal of IUD	9.7	15.8	7.9
Pelvic Examination	106.9	177.4	109.0
IUD Check Up	33.6	71.4	63.2
Pap Smear	14.1	21.4	9.9
Breast Examination	31.4	42.4	107.7
Refer to MD	8.7	4.8	3.3
Change of Method	2.7	1.9	18.3
Pills	4.5	3.7	3.3
Injection	5.6	13.3	3.3
Motivation Time	23.2	45.1	14.1
Persons	281.5	36.1	16.8

These data when contrasted with the percentage gains in pre and post test scores (see previous page) indicate that there is unexplained (and unstudied) variation between the Siriraj and Chulalongkorn training sequences which may or may not have an effect on the AM's post-training performance, achievement and quality of service being provided.

6) In October 1983, a two-day workshop was held in Khon Kaen by the Training Supervision and Education Section for lecturers and trainers (but no trainees) who participated in FY 1983 courses. USAID supported the per diems for the workshop (B22,450: $976). The purpose was to review experience from 1983 in order to make necessary adjustments and revisions to the FY 1984 courses. Content was provided on family planning policy during the 5th Plan, acceptor targets by method, and information on the Multiload IUD. Problems encountered by the lecturers and trainers were raised including the entry-level quality of trainees. Other topics discussed were: training sites and facilities; training materials; the process of training in each training center; and, coordination among central, provincial and district levels.

The participants divided into four discussion groups:

1. The Technology and Technique of Teaching were discussed with regard to content and methods of teaching. Revision of the training manual was considered and it was suggested that the practicum for nurse midwives be decreased from 5 to 4 weeks and for auxiliary midwives from 8 to 6 weeks.

Training location and materials were discussed. Although all training sites were acceptable, some lacked lodging for trainees who then had to stay in a hotel. The Family Health Division agreed to provide training materials to centers that had an insufficient supply. The group suggested that FHD should develop alternate training models in order to decrease training duration. No action was reported on the lodging situation.

Trainees and Trainers were discussed. With regard to the selection of trainees, a recommendation was made to adopt former selection criteria of FHD that trainees should be chosen by the provincial and district committees and the trainees should be under 35 years of age. It was recommended that trainers should fully understand FHD policy, should prepare lesson plans, should have refresher training every 2 years, and should have successfully completed a training for trainers' course.

Ways to increase numbers of trainees were identified: reduce the duration of practical training; prepare trainees by sending self-instructional modules prior to the course; and, conduct training in the provinces using the standard curriculum.

The Training and Supervision Section has already implemented some of the recommendations made at the Khon Kaen meeting.

4. Issues

During field visits and in discussions with FHD personnel, a number of observations emerged that have bearing on some of the assumptions made in the Project Paper, and more immediately, on the effective and efficient use of trained AM's in promoting greater availability of IUD services.

a. Currently, only about 10% of AM's assigned in each of the Northeastern provinces are trained in IUD insertion. Since the Northeast region is of high priority, data from it are of special significance. It has been observed that training of AM's in IUD insertion currently bears little relationship to data on IUD acceptors as a percent of all new acceptors. Illustrative data are shown in Figure 4.4.

While several explanations may account for the lack of a direct relationship, the T/S/E Section, field personnel and evaluation team members agree that promotive PCMO's are key to the factors that enable AM's to play a significant role in IUD insertion. Among these factors are: appropriate selection of AM candidates for training; implementation of MOPH policy that permits trained AM's to insert IUD's; management of and guidance to AM supervision and support systems; management of the distribution of kits and other necessary supplies to trained AM's; and, IE&C campaigns for and routine promotion of IUD acceptance.

The evaluation team observed that there are variations by province in implementation of the MOH policy permitting trained AM's (and nurse midwives) to insert IUD's. It was also observed that few if any provinces had set targets for manpower needs, training needs by number, personnel category and service site of personnel, or devised a monitoring system to inusre that (1) trained personnel are meeting expectations or "quotas" with regard to service delivery targets, and (2) service facility use is at optimal levels, particularly at service points where AM's trained in IUD insertion are posted.

b. Another issue is the multiload IUD now in use. AM's and nurse midwives trained in IUD insertion prior to January 1983 were not trained in multiload insertion. This may be a barrier to full confidence and commitment of provincial-level supervisors, and the service personnel.

It has been recommended that Multiload demonstrations be conducted at the provincial level either by a provincial-level or central trainer. At the same time, training in removal of IUD's that have been in place for some time could be conducted since this, too, has been mentioned as a skill-training need.

c. Some AM's interviewed by the evaluation team expressed lack of confidence about pregnancy detection prior to IUD insertion. This is of particular concern during campaigns, but is also felt during

Figure 4.4: Comparison of AM's Assigned, AMs Trained and IUD as A Percent of New Acceptors

Province	Number of AM's Assigned*	Number of AM's Trained in IUD Insertion**	IUD as a Percent of New Acceptors***
Nongkhai	169	19 centrally-trained 20 trained by province	10.4
Surin	253	23	1.4
Burirum	231	26	2.5
Khon Kaen	330	32	5.5
Mahasarakam	222	54	16.2
Nakorn Ratchasima	593	23 centrally-trained 20 pilot-trained	2.0
Chayapoom	202	21	1.0
Srisaket	316	24	2.1
Ubon R.	356	23 centrally-trained 20 pilot-trained	2.4
Yasothon	89	10	1.8
Udorn	327	23	3.0
Roi-et	283	26	3.6
Sakon Nakorn	219	19	3.3
Nakorn Panom and Mukdahan	201	11 centrally-trained 20 pilot-trained	1.6
Loei	149	15	1.7
Kalasin	108	21	1.3
Total	4,048	450	$\bar{X}$ = 3.7375

Sources: *Rural Health Division, **Training and Supervision Section, ***FHD Statistical Summary for 1983.

provision of routine IUD insertion service. Pregnancy tests, at B50, are not widely-used in rural areas, and bimanual pelvic examination prior to the sixth week of prenancy does not, apparently, reveal pregnancy. As a training topic, this problem needs to be more fully addressed.

d. With regard to IUD campaigns, those who train AMs are skeptical about IUD (and sterilization) service campaigns feeling that:

- There are short-cuts taken in counseling, screening, procedures/techniques, pregnancy detection, and client follow-up;
- AM's are under time-pressures and may make mistakes that result in method discontinuation; and,
- Method-mix and appropriateness of method to the client's profile are disregarded in favor of meeting campaign targets.

However, there is support for provincially-sponspored IUD educational and informational campaigns because these result in a steady flow of IUD acceptors who are more carefully managed and followed-up.

e. Lack of IUD kits for trained AM's is an obvious impediment to provision of IUD services. While the evaluation team was in Nong Khai Province, they visited the district with the lowest percent of target achievement. The DHO felt that the targets set by the PCMO were reasonable, but he was just unable to meet them. The district--really a king-amphoe--does not have a hospital which accounts in part for low achievement, but perhaps provision of IUD kits to health centers is a more remediable factor: all 6 IUD kits had been diverted to the provincial IUD campaign. Another factor also merits mention: AM's there are not permitted to administer DMPA injections and must refer clients to adjacent districts' hospitals. The DHO cited provincial policy as the reason for this, but said that since his district was credited with the referral, he did not feel there was a need to change the policy.

f. During field visits, the team observed that there were wide variations in the nature and quality of supervision received by AM's working at health centers. Some health centers located near district hospitals were being provided both technical and administrative supervision by hospital nursing staff, other health centers received technical supervision from district hospital nurses and provincial staff in coordination with administrative supervision by the District Health Officer. More remote health centers were being supervised by DHO's visits up to 12 or more times a year supplemented by occasional (0-4 times per year) visits by supervisory nursing staff from the provincial level and less occasionally from headquarters level; however, very little supervisory evaluation and remedial counseling on technical matters was occurring. Supervisory visits are usually perfunctory and occur at times when the AM is not engaged in the delivery of FP service. Often a

"textbook" rather than a practical approach to supervision was being followed, mainly administrative review and completing a standard supervisor's protocol form by recording and comparing work achievement against annual work output targets. (See Figure 4.5 for Northern region's standard supervisor's protocol covering FP services.) The use of this protocol has contributed to service delivery planning and monitoring, and has had a beneficial effect in reinforcing the setting of work activity targets. But, shifting workers' perspective to output and building accountability at peripheral levels of the service delivery system are taking much of the very limited supervisory time available at the expense of evaluation and remedial problem-solving on technical matters by supervisors. The absence of a technically qualified supervisor at the District Health Office compounds this problem. As FP services are further developed at peripheral levels of the system, technical supervisors at the provincial level increasingly will become spread far too thin to carry out effective supervision. Under present organizational arrangments, district hospital nursing staff are normally not expected to exercise direct supervision over health center staff.

C. Opportunities

The team's discussions with central and field-based health personnel about AM's and IUD insertions raised a number of related needs, centrally and in the field.

These are:

1. The job of the AM is changing and expanding in response to accelerated implementation of the PHC program. It is time for a task analysis, and for a training (basic, pre-service, in-service and refresher) and supervisory plan that responds to the actual roles, responsibilities and functions expected of the AM. Overall, such plans appear to be lacking as are manpower needs assessments and targets. The provincial level in all provinces visited by the evaluaton team lacked a Training Section (training is combined with the Health Promotion or Publicity section). Thus, the responsibility for preparing training plans and projections that are consistent with service goals and objectives may not be assigned to someone who has the skill and time to develop them.

2. Increasingly, nurse aides are being assigned to work with AM's and sanitarians at health centers. This is commendable because it (almost) assures that a service provider will be at the center when one or the other is on village visits. However, the nurse aides--if they are to provide family planning services in the absence of the AM--will require MCH and family planning training perhaps including IUD insertion. Concomitantly, the AM should be trained to provide diagnosis and treatment of simple illnesses, and in ORT, immunization and other basic PHC techniques. It may be very timely to conduct task analyses of the health center teams and to then review their training needs individually and as a team. DHO's supervisory visits might then

FIGURE 4.5: STANDARD SUPERVISORS PROTOCOL FORM - (TRANSLATION)

Supervision	Quantity of Work: Annual Target	Quantity of Work: Achievement	Quantity of Work: % of Target	Score: Quantitative	Score: Qualitative	Problems and Constraints	Recommendations
FAMILY PLANNING							
1.1 New Acceptors - IUD							
1.2 - TR							
1.3 - VASECTOMY							
1.4 - INJECTION							
1.5 - PILLS							
1.6 Continuing Acceptors - IUD							
- INJECTION							
- PILL							

emphasize a team approach and team problem-solving rather than be directed exclusively toward the performance and problems of one category of health center worker. Examination might be made of the potential of the Regional MCH Training Centers for piloting team training.

3. Supervision of AM's continues to be a problem. Scheduling of visits when technical supervision can be provided during client/AM interactions is difficult, and supervisors cannot spend much time with the AM either at the Health Center or in villages. Lack of transportation and petrol hamper frequent supervisory visits.

The quality of time spent and the content and process focus for supervisory visits are ultimately the most essential features. There is no completely satisfactory supervisory system that could be studied. Emerging ideas include a peer review: bringing midwives together with their technical supervisor on a quarterly basis to, as a group, review their performance by examining each health center's MCH and FP service achievement data (number of pregnant women obtaining prenatal care/number who are pregnant, number of AM-attended deliveries/non-attended deliveries, outcomes of assisted and non-assisted deliveries, number of women making post partum visits/number who should have made post partum visits, number of family planning acceptors by method/acceptor target numbers, number of continuation clients/number of clients scheduled for continuation visits) so that each midwife can assess her achievements and performance in relation to her peers. The meeting can emphasize joint problem-solving, targets can be set by the supervisor for the next meeting, good performance can be acknowledged by peers and the supervisor, and some in-service training can be provided keyed to informational and skill needs that appear during the review or that has been requested. This idea might be piloted in one or two districts in an experimental study to see if AM performance and achievement are higher in the districts using this method for supervision than they are in districts using conventional supervisory visits.

4. DMPA administration policy appears to vary by province. Some PCMO's permit AM's to screen clients and administer the injections, others insist that clients be referred to the district or provincial hospital. Cases were observed where the client brought DMPA to the AM for an injection because supplies were not available at the health center or the AM was not officially authorized to administer injections. Based on a study of 15 service points, the NFPP has developed and provided a two-day DMPA training curriculum and training funds to every province as inducements to implement MOPH policy that permits trained AM's to administer injections. Since DMPA is offered under the NFPP and is desired by clients, AM training and availability of quality supplies should be encouraged by the FHD. It may also be reasonable to include DMPA training in the basic curriculum of AM's.

5. Kits and other supplies and equipment. IUD kits are given to the Province, not to the AM trainee. Instances of unavailability of kits were not infrequent: either they had not arrived or they had been diverted to campaigns. It was also found at health centers that

teaching, training, and client education materials were in short supply although in some places, nurses and AM's had developed their own client educational materials. Teaching and training aids and models, up-to-date family planning posters, brochures and pamphlets, reference textbooks, and a modest set of audio visual equipment should be made available after an inventory and needs assessment are taken. The Schools for Auxiliary Midwives need teaching aids and models, a sufficient number of textbooks in Thai, and transportation for their students to get to practicum sites.

6. The Technical Support sub-section of the Training and Supervision Section acknowledged need for expertise in transforming ideas for visuals into pictorials for use in training and teaching materials and manuals. It was noted that the DTCP project* had been the source and resource for visuals and instructional materials, but with the conclusion of their assistance (funded through UNFPA), no residual capacity currently exists, and most staff are not professionally trained or experienced. It was suggested that someone from the IE&C program be assigned to the Section or that a visuals/instructional designer be hired by the Section. Since the Section cannot currently respond to its own needs and feels equally unable to respond to requests from the Schools of Midwifery, this matter requires resolution. An option is to seek consultation from the IE&C program manager in sub-contracting (as the IE&C program does) for visual presentations and production requirements. Another option is to review overall FHD training and teaching materials needs (including those not under the aegis of the T/S/E section) and to devise an internal mechanism, with outside technical assistance, if necessary, to meet these on an ongoing basis.

7. The team did not determine whether health centers with trained AM's working under supportive provincial policies were being used at optimal levels of service, and the team also did not determine indicators for optimal levels. However, in other sections of the this report there are recommendations for efficiency studies, and it is suggested that this matter be investigated as an efficiency topic.

D. Basic Preparation of Auxiliary Midwives

1. Schools of Auxiliary Midwifery

Of the 7 Schools for Auxiliary Midwives, two were visited by the evaluation team. In each School, there are 15 faculty; one school has 196 students and the other has 58 each term. The directors of both schools cited needs for a 100% faculty increase, teaching aids (models, overhead transparencies, movies, movie and slide projectors) and textbooks. The teaching models and aids are not in good condition and some cannot be used at all. The number of textbooks is insufficient for

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*The Development Training and Communication Planning programme (of UNDP) provided assistance until 1982. In addition to materials production, DTCP consultants developed a training master plan, a training management proposal, and assisted in conducting training courses.

the number of students. Although students could buy their own copies, some editions are not available and many students cannot afford to buy those that are. With reference to the two-year curriculum, in one School a community practicum is heavily emphasized starting in the first term. Community diagnosis and problem-solving are covered in the third semester. In the last semester, students are sent to their own province for eight weeks. The team was told that the community component is additional to the basic curriculum. In the other School, the Director felt the new two-year curriculum was too theoretical and recommended a 3 month internship (under provincial supervision) for the newly-graduated auxiliary midwife and an additional 4 month's course in community health nursing.

There are also differences between Schools in the family planning component of the basic curriculum. One gives practice in bimanual and speculum examinations, and administration of DMPA injections. The other does not. Neither provides IUD insertion training in the basic curriculum because, the Directors said, there was no time to give theoretical and practical components consistent with current standards.

Review of the basic curriculum for AM's is not planned, but the evaluation team encourages FHD to examine the possibility of introducing theory and practice of IUD insertion including all components now a part of IUD insertion in-service training, and to include DMPA administration, as well.

In discussions about the quantity and quality of students who enter the Schools, it was observed by both Directors that there was always a 100% fill-rate, but one Director observed that the basic science and chemistry backgrounds of her students were inadequate. She felt that although there are entrance examinations (differing from province to province), the Provincial Health Officers could be more careful in screening of those who take the examination and of those who pass it and are nominated. In one of the Provinces that nominates candidates for that School, a Provincial staff member acknowledged that the brighter 12th grade women students would prefer to take the practical nursing course rather than midwifery. This may have to do with placements after graduation: midwives are placed in rural areas; must work at night and in villages; and, are not accorded the prestige of a nurse.

2. MCH Centers

Both Schools visited have MCH Centers attached that provide the AM basic practicum in MCH/FP. Only one of the Centers provides in-service IUD insertion training. Both provide one-week refresher training courses for their auxiliary midwife graduates, sending out a questionnaire in advance to assess training needs. Both Centers have active MCH and family planning programs which includes family planning education for prenatal patients and for women who deliver in hospital. One Center reported that 70% of the post partum patients accept family

planning. This Center will be providing supervision of UNFPA-funded TBA, VHV and VHC training--300 TBA's and 2,000 VHV's and VHC's--which is expected to increase the number of pregnant women who enroll in prenatal care, who have an attended delivery, and who become family planning acceptors.

The assistant director (a physician) of one Center observed that physicians were not being adequately trained in IUD insertion and therefore could not give the necessary backup to auxiliary midwives and nurse midwives. She said that the insertion training of newly-graduated M.D.'s was insufficient, and many practicing physicians were in need of an update. She estimated that there were 400 physicians in her region, the Northeast, who should be trained. While the MCH Center could provide the practicum, she felt the theoretical component should be given at Chulalongkorn.

It is evident from discussions with the School and Center personnel, and from observation of their interactions with clients, students and trainees that the teaching, training and service being provided are of a high standard.

Several observations of the team, and needs expressed by the Schools and Centers merit discussion within FHD and at provincial level. As a general comment, the basic curriculum for auxiliary midwives (content, duration, emphases) should be reviewed and reflected against the post-training functions and roles they are now expected to perform. These may vary from region to region and may also be in a period of transition depending on regional priorities, service targets, number of service sites, and manpower needs and projections.

PCMO's will need to review their needs for AM's to insure that an appropriate number with strong entry-level qualifications are nominated each year. At current levels of faculty and facilities the schools cannot expand enrollment; thus, if demand for AM's increase the schools could not meet it. Priorities will have to be assigned according to need if this situation develops.

As a final observation on the basic and in-service training of AM's, the constituents' view was sought by the team during field visits. In every case, AM's were very positive in their evaluation of the training they had received, citing confidence and skill-building as major contributions.

E. Sterilization Training for OR Nurse Midwives, and AM's

The Project Paper calls for surgical sterilization training of 150 nurses (nurse midwives) in female sterilization and 80 AM's in vasectomy. The schedule is as follows:

	1984	1985	1986	Total	USAID Loan Assistance
NMs	50	50	50	150	$ 96,750
AMs	-	40	40	80	$108,000
Total	50	90	90	230	$205,000

The justification for an expanded role for NM's and AM's was that physician shortage and limited availability of VSC services at the district level were hampering extension and uptake of VSC services.

In preparation for this initiative, the FHD conducted three studies on OR Nurse Midwives' training in post-partum sterilization (minilaparotomy under local anesthesia) and one study on AM's training in vasectomy. The studies did not directly involve the Training Supervision and Education Section. The studies and their implications will be discussed separately.

1. Nurse midwives' training in post-partum minilaparatomy

The WHO-assisted studies began in 1979 and concluded in 1982. Initially 5 nurse midwives from Khon Kaen MCH Center with at least one year of OR experience were trained for 12 weeks. That study and the two subsequent to it had the following sequence:

Phase 1 (8 weeks)
- Theoretical background and demonstrations
- 3-5 assisted cases
- 20 cases with physician supervision

Phase 2 (4 weeks): 20 cases under the supervision of an Ob/Gyn

Phase 3: Client follow-up: 1 month, 3 months, 1 year

The initial and subsequent studies (9 NM's in the second study and 19 NMs in the third study) demonstrated that (1) trained nurse midwives could safely provide post partum sterilization to screened clients; (2) NMs were well-received by both patients and physicians; (3) the provincial-level was an appropriate choice for training; (4) in comparison with physicians, the nurse midwives (from the initial study) were as effective, in terms of operative difficulties, post operative follow-up and level of client satisfaction.

All trainees completed their participation in the studies and many exceeded the case-standard levels. There was no information available on whether the 23 trained NMs are currently providing post-partum sterilizations, but the way has been cleared for them to do so: until mid-1984 they could not legally perform sterilizations on their own; however, in mid-1984 the MOPH gave approval to the utilization of trained NM's to perform post partum sterilizations (Pomeroy technique) in government hospitals if a physician is proximate (but not supervising).

The FHD plans to train 50 NM's each year starting in October 1984. Large provincial hospitals--and MCH Centers--with currently high numbers of sterilizations will be used as training sites. Trainees, as in, the past, will have OR experience and will be 35 years or younger.

This initiative appears to be well-justified and is properly supportive of the increasing demand for female sterilization. It should be noted that there are, at present, continuing restrictions on trained NM's with regard to type of sterilization (post partum only) site (government hospital only) and degree of supervision (physician proximate). It appears that unless these restrictions are lifted, NMs could not perform non post-partum sterilizations and work in mobile VSC units. It should also be noted that the studies' cases had all been screened to exclude candidates who had poor health histories and who had Caesarian or other delivery-related complications. If the effectiveness demonstrated in the studies is to be carried forward in a Kingdom-wide program, the evaluators assume similar screening procedures will be employed.

A minor but somewhat pertinent factor is the duration of NMs training which obviously affects cost. (The cost-effectiveness of already studied training NMs has been studied).* Whether the training duration are sufficient, insufficient or too long is not known. Whether the training content and practica are well-suited to actual post-training experience is not known. The study protocol and documentation available to the evaluators did not contain this information although the protocol specified that a cost-benefit analysis would be conducted.

2. AM training in vasectomy

One study of 20 AM's training in vasectomy was conducted in 1981.

The training program was conducted in three phases:

Phase 1: conducted at Ramathibodi Hospital for six weeks. It included theoretical background, assistance in the procedure, performance of the surgery, pre and post op. care and interviews, client follow-up and performance of sperm analysis.

Phase 2: Conducted at district hospitals for six weeks. It included motivation and recruitment of acceptors, successful performance of 20 procedures, pre and post op. interviewing and correct recording on forms of interview and surgery data, follow-up of clients after one and three months; and, performance of sperm analysis at one and three months post-op.

Phase 3: Follow-up of cases, and recruitment of acceptors.

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*These findings were not reviewed by the evaluation team.

The evaluators were not provided with a copy of the results of this study, but were told that there had been no difference in performance level of AMs compared with that of physicians. Currently, there is no legal sanction for AMs to perform vasectomy without direct supervision by a physician.

At the time the Project Paper was written, the number of vasectomy cases had been declining (see p. 15 of the Paper). It is not clear why it was thought that AMs (many are single, youthful if not young, and women) were the appropriate category of personnel to help reverse the trend by recruiting and serving men who, as is noted in the Service section of this report, fear loss of sexual potency is a result of vasectomy, and feel lack of confidence in some local medical personnel.1/ It should not be surprising that FHD and field personnel are not, currently, enthusiastic about the implementation of this initiative (scheduled to start in 1985).

While it is true that vasectomy acceptance has been reassuringly on the increase since the Project Paper was written--notably during the 1983-84 period--it is not at all clear that AMs are the most likely source for increased availability of vasectomy services given both a lack of legal sanction, their gender, and their status in the medical hierarchy. Only one study of 20 AMs has been conducted which is hardly compelling evidence on which to base a change in the prevailing legal restriction--in contrast to the extensive documentation established on nurse midwives. Additionally, if motivation and recruitment of men--and their attitudes about local medical personnel--are indeed the problems the team was told they are, AM's are not the solution.

This initiative should be reviewed by USAID and FHD well before October 1, 1985. Unless there is a sharp, persistent increase in vasectomy acceptors accompanied by a measurable change in men's attitudes, the initiative should probably be delayed, or deleted from the PP II program.

1/ The team's observations do not contradict the 1982 study conducted by the R/E Unit, FHD on Factors Affecting the Operation of Mobile Vasectomy Teams. That study identified fear of loss of working capacity as the primary impeding factor. The 1982 study should probably be updated to identify current attitudes toward vasectomy.

Recommendations (4.III)

1. Immediate

   a. The FHD should heavily promote implementation of the MOPH policy permitting trained AM's and NM's to insert IUD's and administer DMPA injections.

   b. IUD kits should be provided to every trained AM.

      1. A review should be conducted of present and future needs for kits (IUD and sterilization) and efforts be made to initiate additional procurement actions during the 2nd Project Year if necessary to ensure full availability as early as possible in the 3rd Project Year; and consideration should be given to the direct assignment of kits to personnel at the time they are trained rather than allocating kits to Provincial Health Offices for use by personnel at lower levels of the system.

      2. AM IUD kits and midwifery kits may be available through JICA or JOICFP. USAID may be advised to investigate the proposed kit contribution of the Japanese during the period, 1984-86, before procuring additional kits. A related opportunity is review with JICA or JOICFP and FHD of the proposed distribution (priority service sites, campaign areas) of the kits purchased through Japanese or USAID funds.

   c. Provincial-level update training on insertion of the multiload IUD and removal of IUD's should be scheduled for AM's who received IUD insertion training prior to 1983.

   d. Provincial-level two-day DMPA injection demonstrations should be scheduled for AM's.

   e. Review should be made of the AM basic curriculum for potential of including IUD insertion and DMPA training.

   f. A needs assessment of teaching and training materials, aids and models should be conducted in all Schools of Midwifery and MCH Centers. USAID loan funds should be made available for purchase of items that are directly related to strengthening of the family planning teaching and training programs in the Schools and Centers if Japanese funds are not available for this purpose. Similarly, transportation needs for AM students and for AMs and NMs who are trainees should be made to facilitate full use of practica sites.

   g. An inventory of AM's and AM's technical supervisors' transportation needs should be made and funds should be sought to support purchase of motorcycles for AM's, and vehicles for technical supervision, perhaps through JICA.

h. The instructional design/visuals preparation needs of the Training Supervision and Education Section should be examined by the IE&C program manager, and USAID funds should be made available to support a sub-contract for development and preparation of necessary materials if that is the recommended option for meeting existing and projected needs.

i. Health Centers with an insufficient supply of family planning client education materials should be stocked with the most recently developed posters, brochures, pamphlets and flip charts.

2. Over the Next Year

a. Conduct the following and if technical assistance is necessary, USAID should seek to provide it (through intermediaries) in:

1. Provincial-level manpower needs assessments and review and/or development of training plans in "lagging provinces" first, and other provinces, subsequently. These should be updated on an annual basis, thereafter.

2. An efficiency study to determine whether Health Centers with trained AM's working under supportive provincial family planning policies are being used at optimal levels and, where appropriate, identification of barriers that impede optimal use.

3. Development of a comprehensive and systematic training evaluation and monitoring system that is keyed to provincial-level manpower needs assessment and training plans and to training impacts on service availability.

4. Review of the use of MCH regional training centers for health center team training and if feasible, design and piloting of a curriculum emphasizing a team approach to family planning service delivery.

5. Establishment of several pilot areas for a peer review supervisory system, and comparison of AM performance and achievement in those areas with AM performance and achievement in similar service areas using a traditional supervisory system.

6. Conduct an AM task analysis that can be used during development of comprehensive training plans.

b. Investigate the potential for family planning training of practical nurses assigned to health centers in provinces that have demonstrated capability for IUD insertion training.

c. Review the proposed initiative to train 80 AMs in vasectomy: are they the appropriate, acceptable source of service? does the demand for vasectomy indicate that AMs should be trained? will the legal restriction be lifted on the basis of one study of 20 AMs?

d. Since the PHC Regional Training Centers will be training AM's, VHV's, and VHC's in PHC topics including FP/MCH, aspects of the MIS, the new targeting approach, and a team approach to provision of information/education/communication about family planning and access to services should be pursued for inclusion in the one-week course.

e. Greater utilization be made of district hospital nursing staff in the technical supervision of FP and MCH services delivered by tamboi health center staff.

f. A more formal matrix supervisory structure be established at the district level to accommodate joint MOI administrative and MOPH technical supervisory responsibility for delivery of FP and MCH services.

g. Participant training opportunities should be identified for provincial-level staffs, and -- if appropriate -- for staff of the T/S/E Section in development of training evaluation systems, and management of training systems.

IV. IE&C

Comprehensive analysis of the motivational strategies and IEC materials used in USAID-supported activities was not possible during the course of this evaluation but observations on some problems with the vasectomy campaign and some reasons for high performance in IUD campaigns were given in the Service Delivery section of this report. Many IE&C mass media materials that promote these campaigns are still in prototype form. Interestingly, two vasectomy radio spots developed under the project which have been in use for just a few months were in the top ten radio commercials of 1983 in an advertising industry contest. This tribute to the quality of the media developed under the project justifies USAID support for the involvement of commercial agencies in IE&C materials development.

A. Vasectomy

Vasectomy mass media materials based on research done by McCann Erikson and funded by USAID have been developed and tested in prototype form. These prototypes are now ready for mass production. They include 3 new leaflets, 4 radio spots, one TV spot and 3 posters. The radio spots are now in use and the TV spot will be broadcast soon.

B. IUD/Female Sterilization Campaigns

This campaign in the Northern and Northeastern provinces uses mobile units to inform and motivate acceptors. IUD insertions are done by mobile service units while female sterilizations are referred to district or provincial hospitals. The Ministry of Interior through the Provincial Governors has lent strong support to these campaigns. Major emphasis is on IUD insertion.

The current challenge facing the NFPP is the development of appropriate working relationships and approprate operating strategies with the Ministry of Interior. That Ministry has announced a strong supporting policy for family planning. Provincial Governors have already began to organize and implement family planning campaigns. The problems facing the FHD are: (1) how to harness the energy of the MOI into appropriate family planning activities; (2) how to avoid problems related to excessive zeal in the promotion of family planning; and (3) how to deal with the needs of individual provinces as MOI activities and regional and provincial differences require greater decentralization of central support. These problems present particular challenges to the IPR Section of FHD.

C. Recommended Priorities for IE&C Support for the NFPP

1st Priority

	Suggested NFPP Objective	Target Group	Area
1.	To support and cooperate with MOI on provincial family planning activities	Determined by province	Province by province
2.	To support continuation of temporary methods	Current users of temporary methods with less than two children	National
3.	To promote permanent methods	Current users of temporary methods or new acceptors with 2 or more children	National
4.	To supplement family planning activities in the Northeast	New acceptors, current users of temporary methods	Regional
5.	To supplement family planning activities in the South	New acceptors	8 provinces

2nd Priority

6.	To promote general MCH and child-spacing	Newly married couples, pregnant women, mothers with less than two children	National
7.	To provide family life information including family planning to adolescents	Adolescents, Pre-marriage age group especially in rural areas	National
8.	To promote the two child family norm	Pre-marriage age group; married couples with 2 children or less	National
9.	To support and cooperate with MOI Departments and Parastatals in targeted family planning activities	As determined by Dept. or Agency	Determined by target group
10.	To develop special information programs for hilltribes	Hilltribe current users and new acceptors	Northern provinces
11.	To support the development of family planning and MCH training aids by the FHD Training Section	Health personnel	National aids by the FHD

D. Recommended IE&C activities in support of the achievement of these objectives are as follows (by objective):

1. Two activities are recommended for immediate implementation: organization of joint observation visits to provinces with MOI-sponsored campaigns with OPP/MOI staff, and documentation of campaign experience in five or six provinces in summary form for circulation to Governors and PCMO's. Further, support inthe form of supplementary funds for provincial campaigns initiated by Governors should be channelled through the FHD to PCMO's. The preparation of a handbook for MOI officials on population and development issues and basic demography is also strongly recommended.

2 . and 3. Recommended activities include: the revision of all materials on temporary methods, except the IUD, to provide up-to-date problem-oriented information; strengthening of the counselling function at the Health Center level by the preparation and distribution of a handbook for health personnel on problems of temporary methods, screening procedures to identify potential switchers to permanent methods, and the child-spacing concept; revision of materials on permanent methods and the IUD, all of which have been recently revised, in three years' time; a contingency for the possible promotion of Norplant.

4. The development of an overall strategy for empahsis on the Northeast is recommended to the FHD. IE&C aspects of this emphasis would include additional funds for MOI campaigns in the Northeast, technical assistance for the planning and implementation of campaigns, development of radio spots in the Northeastern dialect, and television spots that support the strategy to be developed.

5. The special emphasis on the South has two components: four Thai Muslim provinces and four low prevalence Thai Buddhist provinces. The Thai Muslim provinces are the subject of a comprehensive project which has already been funded by UNFPA. The plan calls merely for implementation of that project. For the Thai Buddhist provinces, increasing assistance from FHD staff for the implementation of district level campaigns is recommended. These campaigns will emphasize female sterlization and injectables.

6. All existing MCH materials will be reviewed and revised for inclusion of the child-spacing concept.

7. To begin to reach the large pre-marriage age group that will become the young married couples of the Sixth Plan period, a handbook on family life will be prepared for adolescents that includes the basics of human reproduction and contraception and promotes the two-child family and delaying the age of marriage.

8. The two-child family concept will be integrated into all media and materials under revision and recommended for promotion by the MOI.

9. Emphasis will be placed on developing working relationships with the Departments of Labour and Public Welfare which have factory workers, slum dwellers, and hilltribes as their target groups.

10. IE&C activities for the hilltribes are currently being discussed in the context of a USAID-supported project for the hilltribes. The nature of such activities has not been clearly defined as yet, but funds will be made available for special information programs for hilltribes through this proposed project.

11. The IPR section will assist the FHD Training Section to facilitate the commercial production of training aids in strengthen training programs for health personnel.

The financial implications of this list of activities for donor assistance are summarized in Annex 4.1. Requests for assistance from foreign donors are for prototype development or materials revision by commercial sources, purchase of broadcast time, suport for the new initiatives of the MOI, or the hilltribes. The two former items are difficult to fund within the context of existing Government regulations and the two later items are high priority Government activities.

In addition to activities carried out by the NFPP directly, support for private and voluntary organizations is recommended: namely, continued and increased support for the successful program of vasectomy promotion and service delivery by PDA; support for PPAT to develop further its program of in-school family life education; and support for TAVS to participate in provincial MOI campaigns.

Recommendations (4.IV)

Recommendations for USAID Support to Other Organizations

1. The Population and Community Development Association has had notable success in the promotion of vasectomies. These successful efforts should be encouraged. As an aspect of USAID's present support for NFPP vasectomy campaigns, funds could be allocated to PDA for vasectomy IEC and service delivery.

2. The Planned Parenthood Association of Thailand is in the vanguard on sex education for adolescents. This initiative could be extended and expanded to a program of in-school family life education. USAID support for the development of such a program is recommended.

3. The Thai Association for Voluntary Sterilization can lend some publicity and service delivery support to sterilization activities that are part of MOI campaigns. USAID funding for such support is recommended.

Recommendation for Evaluation of IE&C Messages

1. By adding to regional CPS (4) or through conducting special message studies, the impact of targeted IE&C messages should be examined, by age cohort, especially on the topics of: the small family norm; child spacing as a health benefit; the acceptability of sterilization at the completion of desired family size; and, which sterilization (vasectomy or T.L.) method is more acceptable. Men's attitudes toward vasectomy as acceptable for themselves and as a method to stabilize desired family size should also be examined.

Annex 4.1: IE&C External Assistance Needs Summary
(Baht)

Activity	Year 1	2	3	4	5	Total	Remarks
1. Provincial MOI Campaign Support	2,550,000	2,500,000	2,200,000	-	-	7,250,000	
2. Temporary Methods	1,000,000	1,000,000	1,500,000	-	-	3,500,000	- include ₿500,000 for Norplant promotion.
3. Permanent Methods	50,000	-	1,000,000	1,000,000	-	2,050,000	
4. Northeastern Emphasis	3,050,000	3,150,000	2,050,000	2,050,000	12,050,000	12,450,000	
5. Southern Emphasis	-	-	-	-	-	-	
6. MCH/Child Spacing	-	50,000	50,000	-	-	100,000	
7. Family Life Information	100,000	-	-	-	-	100,000	
8. Two Child Family Norm	-	-	-	-	-	-	
9. Support for MOI Departments Family Planning Activities	-	-	-	-	-	-	
10. Hill Tribes	10,900,000	2,700,000	-	-	-	13,700,000	
11. Training Aids	-	-	-	-	-	-	
Totals	17,650,000	9,400,000	7,900,000	3,090,000	2,050,000	28,950,000	

V. Research and Evaluation

One of the important PP II strategies in is to conduct program research and evaluation to improve the efficiency and cost-effectiveness of FP activities. It was anticipated that required increases in output of services to meet the 1.5% growth target would exceed expected increases in resource inputs over the Fifth Plan period, thereby necessitating greater efficiencies in the use of available resources. PP II provided US$681,000 in grant funds to support program research and evaluation, and an additional $20,000 to provide for the application of operations research methodology, and training for the staff of FHD.

The evaluation team found that the FHD Research and Evaluation Section continues to be overwhelmed with workload, short of available staff partly due to long leaves of absence for educational purposes, subjected to shifting priorities and instructions, and generally lacking the absorptive capacity to execute its present responsibilities under the PP II Project. The Section appears to have little input in guiding FHD research priorities despite the R/E staff's knowledge of issues and operational problems that could or should be studied.

A. The Research Program of PP II

Project Implementation Plans for both the first and second years included a provision for program research which "should be focused on improving operations, increasing efficiency and reducing costs". During the first Project Year, four research studies were initiated:

(1) Factors Affecting Continuation Rate of Injectable Contraceptive. (Current Status: report being written.)

(2) Assessment of the Short-Term Effectiveness of the Training of Auxiliary Mid-Wives in IUD Insertion. (Current Status: report being written.)

(3) Study of Community Participation in Support of the National Family Planning Program. (Current Status: ongoing.)

(4) Follow-Up of Two IUD's. (Current Status: ongoing.)

It should be noted that none of the above studies directly satisfy the need to address problems of efficiency and cost effectiveness.

During the second Project Year, a Research Working Group[1/] of 12 experts in the field of FP/Population research was established. FHD and this group developed and issued priority guidelines for research, and

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1/ Annex 4.2 provides the list of members on the Working Group and its responsibilities.

solicited research proposals from both public and private agencies. The following 21 proposals were subsequently received:

1. Factors Affecting the Use and Non-Use of Family Planning Services Among Thai-Muslim Population in Rural Narathiwat: by Mr. Sompart Fuangchan, Prince of Songkla University.

2. The Impact of Sexually Transmitted Diseases (STD) on Fertility and the Outcome of Pregnancy: by Dr. Chaninthorn Suvongse, Armed Forces Research Institute of Medical Science, Thai component.

3. Potential Program Intervention to Reduce Adolescent Fertility: by Ms. Chira Sakornpan, Thammasat University.

4. Sterilization, Desire for Sterilization Among Current Married Women in Rural Northeast of Thailand: by Dr. Picnit Pitaktepsombati, Institute of Population Studies, Chulalongkorn University.

5. Social and Economic Factors Influencing Use and Non-Use of Family Planning Program Among the Southern Thai Moslems: by Ms. Saranya Bunnga, Prince of Songkla University.

6. Factors Affecting Contraceptive Non-Use: The Case of Northeastern Thailand: by Dr. Pramot Prasatkul, Institute for Population and Social Research, Mahidol University.

7. Child Mortality Perceptions as a Determinant of Fertility Behavior, A Study in Thai Communities in the Northeast: by Dr. Santhat Sermsri, Institute for Population and Social Research, Mahidol University.

8. Role of Model Mother in Promoting MCH/F.P. in the Community: by M.C.H. Bangkok, Family Health Division.

9. Effects of Reducing Infant Mortality and Morbidity on Family Planning Acceptance: by Suphanburi Provincial Hospital.

10. Availability and Accessibility and Vasectomized Males Services by "Semi-Mobile" Unit in Udornthani: by Dr. Chin Yuvachit, Provincial Chief Medical Officer, Provincial and Public Health, Udornthani.

11. Study of IE & C Model on Vasectomy in Nong Khai Province: by Dr. Thongchai Termprasit, Provincial and Public Health, Nong Khai.

12. Operation Research on Expanding and Distribution of Family Planning Services to the Eligible Non-Users: by Dr. Unnop Samathiwat, Provincial of Public Health, Rayong.

13. Users and Non-Users of Family Planning Program Among the Special Target Group in Five Year Plan: by Mr. Surapong Sothanasathien, Prince of Songkla University.

14. A Comparative Study of the Effectiveness of Family Planning Motivation on the Two Different Social Behavior Hilltribe Leaders: by Dr. Poungpol Patrakorn, Provincial and Public Health, Petchabun.

15. Study Factors Affecting Use and Non-Use of Sterlization's Services in Songkla: by Dr. Prasit Banitcharoont, Provincial and Public Health, Songkla.

16. Factors Influencing on the Activities of Women's Leaders in Promoting Family Planning and MCH in Ubonratchathani: by Mr. Naowarat Ploychai, Mahidol University.

17. Study of Female Sterilization Services: by Wapipathum District Hospital, Mahasarakam.

18. Comparison Study of Psychological Sequella of Women Who Received Sterilization During Post Abortion/Post Partum/Interval: by Dr. Manut Kanawong, Phranolpolpayuha Hospital, Kanchanaburi.

19. Policy and Problems of Family Planning Administration and Services in Four Southern Muslim Provinces: by Mr. Tawee Soanmalee, Office of Research NIDA.

20. The Impacts of ther Different Family Planning Methods on Fertility Among the Thai-Muslims in the Sonthurn Border Provinces: by Mr. Teeracnai Pcopaibool, Prince of Songkla University.

21. Study of The Characteristics of Hard-Core Resistors to Family Planning: by Dr. Suvanee Satayapan, Family Health Division.

The Research Working Committee reviewed the above proposals and selected the following 13 of them for submission to USAID for review and approval: Proposals number 1, 4, 6, 7, 8, 9, 10, 11, 14, 15, 18, 19 and 21. USAID approved seven of these conditional upon them being redesigned to strengthen the research methodology: proposals number 4, 6, 8, 10, 11, 14 and 21.

It should be noted that of the 21 research proposals received, 13 initially selected and 7 finally accepted, most were again directed at questions of program effectiveness and few at questions of efficiency and cost-effectiveness as originally intended. From the experience to date, it is clear that the research interests and expertise of those involved on the Working Group and those also involved in preparing research

proposals were, for the most part, in the area of research on questions of effectiveness, not efficiency or cost-effectiveness. While there is continuing need for research on effectiveness, particularly to support policy formulation as NFPP moves to address "second generation" issues, there is also a pressing and high priority need to develop research expertise in, and to address, questions of efficiency and cost effectiveness, particularly if the RTG's current Fifth Development Plan objectives are to be realized. There already have been more than 300 studies since 1977[1/] on population and FP issues in Thailand although many of the findings have yet to be implemented.

Designing and conducting appropriate and useful research is a unique challenge in and of itself; however, such activity only represents the initial phase of an effort that should result in improved policy, program management and service delivery. This requires that research findings be rapidly and effectively disseminated and used by administrators, program managers and supervisors throughout the service delivery system. The distribution of published research results is not enough to attract the attention, improve the knowledge and change the behavior of personnel who should be benefitting from the results of current "state of the art" research. As research activity and findings escalate in the future, more effective and formal mechanisms will be required to transmit and teach the new knowledge and to identify program areas to which the findings can be applied.

There has been an expression of concern by USAID that the management of research, the quality and salience of research proposals, and the process for applying research findings require strengthening. The team considered this issue at some length. Subsequent discussion about how to achieve this included consideration of the Population Council's idea to establish a small technical secretariat (a Thai Ph.D. sociologist, a coordinator and a secretary) to be an "arm" of the FHD and the Research Working Group for a three year period. Functions identified, included: identification of research needs; pre-review of proposals; organization of workshops and seminars for dissemination; and, assisting peripheral universities to build research capacities in order to widen the circle of competent research institutions.

The team, after lengthy deliberation, found this idea unacceptable. Team members felt that (1) the proposed secretariat, working outside FHD premises, would not be familiar with operational and other program issues; (2) if it worked inside, it could be co-opted into promoting the FHD agenda rather than remaining objective; (3) capacity would not be built within FHD although arms and legs would be grafted on the organization; (4) other more basic institutional issues around agenda-setting, proposal development and review, and dissemination and application would not be adequately addressed.

1/ See Thailand Population Research Inventory 1983, MOPH, the Population Clearinghouse/Documentation Centre of NFPP, 1983.

Attention was by DTEC drawn to provision in PP II's grant fund Implementation Plan (October 1983-September 1984) for technical assistance and funds to support Thai consultants to design, review, and monitor R/E activities; to prepare summary translations; and, to hold dissemination conferences. Thus, there are funds for technical assistance to improve the quality and direction of proposals and to support FHD in disseminating and considering application of research findings. The team could not reach consensus on from whom or how technical assistance should be sought, but agreed that it was needed to improve the efficiency of the proposal review process and the quality and relevance of the research program.

B. Biomedical Research

The evaluation team did not explore and examine the biomedical research projects being undertaken on benalf of the NFPP. USAID does not directly support biomedical research in family planning, although AID, through intermediary assistance -- FHI -- supports clinical trials. The Thai Fertility Research Association funded by FHI carries out biomedical research studies.1/

FHI representatives were recently in Thailand, and it is assumed that their report together with the Population Council's reports when read in conjuction with this evaluation report, can assist the NFPP in identifying gaps in the necessary interface of social sciences research with clinical investigations concerning the safety, efficacy and effectiveness of new and currently-used family planning methods. The NFPP Technical Committee may be the appropriate group to address this matter.

C. Evaluation

As the NFPP further matures, there will be a need to shift from numerous topical research projects of a non-recurring nature to a permanently institutionalized program evaluation system that provides capability to monitor changes in program effectiveness, cost-effectiveness, productivity and efficiency on an on-going basis. Discussions and recommendations contained elsewhere in this report on the further development of the FP information system, are directly related to this need. The development of institutionalized program evaluation capability is not only needed at the central level of the NFPP, but at lower organizational levels as well. The nature of ongoing program evaluation is considerably different from the design and conduct of topical research studies, and requires the development of special expertise through training and on-the-job practical experience which

1/ See Annex 4.3 for an inventory of studies and other activities conducted by the Thai Fertility Research Association.

should include the actual design and management of an ongoing program evaluation system.

RECOMMENDATIONS (4.V.1 and 3)

1. During the remaining life of the PP II Project, USAID funds not be used to support the conduct of topical research studies aimed at questions of effectiveness only.

2. The number of desired research studies under the PP II Project should be reduced and focused more on questions of efficiency and cost-effectiveness.

3. The process for engendering and reviewing research proposals should be lengthier and more detailed in recognition of the time-consuming tasks that are involved.

4. The NFPP should set a policy agenda for research and specify the areas of research that are of high priority.

   a. Research ideas should be sought from FHD Sections (based on their needs) and from provincial-level staff, as well as from other sources; and

   b. The R/E Section, especially, should be used as a resource during the construction of the research agenda.

5. The Research Working Group's role, its decision-making boundaries, and its placement on the organizational chart should be clarified.

6. Consideration should be given to the addition of two PCMO's to the Group.

7. Technical assistance in proposal development and research from Thai consultants' methods should be provided to interested and pertinent peripheral university units and sections of provincial-level offices or other related entities in order to widen and deepen the pool of research capability, and to obtain a greater number of sound proposals from provinces outside Bangkok. At a minimum, this technical assistance should be given at the work-site of the prospective research investigator, and could be preceded by a workshop to present the annual research agenda, introduce the required protocol/forms, and give practice in translating operational problems and issues into research questions.

8. FHD capability to document, store, retrieve, transmit and/or teach the knowledge derived from research findings should be strengthened. PCMO's should be requested to include in their training and staff meeting activities essential information disseminated by the FHD on research findings; and when appropriate, the Training Section in collaboration with the Research and

Evaluation Section of FHD should prepare teaching aids for use by provinces and lower organizational levels in transmitting the results of research studies.

9. The FHD Research and Evaluation Section should continue to be strengthened through additional resources including additional authorized permanent positions and further in-service training of its staff to develop the competence needed to shift its orientation from topical research and evaluation to the design, implementation, technical backstopping and management of a comprehensive national program evaluation system serving all organization levels of the NFPP, from the village level upwards.

10. Standardized procedures for conducting on-going FP program evaluation at all organizational levels of the NFPP should be prepared, published and distributed for use in training and supervisory quality control. The production of these materials should be funded under PP II.

11. If there are research topics of interest to the MOPH that could be developed, conducted and documented through the Regional PHC Training Centers there is good potential for village-based, micro-level studies that could involve provincial, district and tambol-level personnel in design, implementation and analysis, reporting and application. Suggested studies include: selected program approaches to non-users of family planning could be field-tested and evaluated; IE&C materials for the village-level could be pretested, and tested for relevance to family planning method acceptance; appropriate method selection according to age and parity of the client might be promoted and acceptance from the provider and user points of view studied; family planning within PHC could be studied; from the point of view of perceived benefit (by villagers) as a health service; whether family planning loses or gains prominence within an integrated system; and how family planning can best be linked to nutrition, immunization, and diarrheal disease control programs. Since monitoring of PHC components should include family planning acceptance and continuation, a simple monitoring system could be designed, piloted and evaluated in one or two PHC model demonstration areas Staffing patterns and cost issues might also be studied.

12. The R/E advisor's tour of duty should be extended through the remaining life of PP II to assist with the design and management of pilot projects and implementing a long-term development strategy for a comprehensive MIS and a program evaluation system to serve NFPP needs.

13. The R/E staff and senior staff in FHD should review the range of findings across all studies to identify linkages among findings, and use service and evaluation data to amplify/elaborate on, confirm or raise questions about study findings. This review may also serve to identify needs for further research.

14. Consideration should be given to providing funds to the Population Council for the purpose of conducting key research studies to support future NFPP policy formulation aimed at "second generation" issues.

D. Application of Operational Research (OR) Techniques

This new activity was intended to assist the NFPP in solving operational problems involving questions of efficiency and cost-effectiveness through the application of modern mathematical models/techniques. A sub-contract was given to NIDA on March 25, 1983 to:

a. Identify operational issues/problems facing the NFPP which lend themselves to the application of operations research techniques;

b. Select priority issues and problems to be addressed; and

c. Develop, test, and establish the use of OR applications within the Family Health Division.

The Project Paper called for development of the first OR model by the end of 1982, with the assistance of a consultant who would also provide training to FHD staff, and continue developing and testing new models through 1984. The following topics were suggested by the Project Paper as appropriate for OR application:

Logistics:	Optimal size of oral contraceptive order and optimal distribution schedule.
Networks:	Shortest/least expensive route for mobile units and most efficient route for field supervisors.
Maintenance:	Optimal schedule for maintenance of equipment (laparescopes, AV equipment).
Pricing:	Optimal pricing policy for contraceptives.
Production:	Optimal production schedule for posters.
Resource Allocation:	Optimal allocation of NFPP resources among hospitals, health centers and mobile units.

NIDA in collaboration with FHD and USAID selected as the initial topic for OR application, the first topic listed above: "Logistics." Although this topic most easily lends itself to mathematical model building, serious delays in its development are being experienced. The evaluation team was informed that:

1. NIDA staff-time was not as available as originally planned.

2. Design problems were encountered in applying OR theory to a complex real life situation, necessitating additional work and redesign activity.

3. Standard EOQS (Economic Order Quantity Systems) packages which provide pre-tested standardized methodology for managing procurement, storage and distributing of supplies were not used or adapted, necessitating the design of an entirely new model and software.

In addition to concerns expressed about delays in OR application, other issues have surfaced. In designing the OR application for "Logistics," a number of over-simplifications were introduced which seriously weaken its utility as an exemplary application:

a. The model was limited to managing the supply of one commodity, oral contraceptives, only;

b. The model does not differentiate among different pill formulations and brands, but treats all oral contraceptives as one commodity and therefore cannot control for the separate procurement, storage and distribution of the various types of pills now in use;

c. The model addresses only central, regional and provincial levels of the national commodity management system; and

d. The model will not presently accommodate the need for special fluctuations in demand resulting from special campaigns and intensive services.

Moreover, the OR application overlaps the tasks of the CDC consultants in designing and installing a comprehensive commodity management system for all family planning supplies of the NFPP.

As part of the NIDA sub-contract, training in OR techniques was also to be provided to FHD staff. A short-course was attended by 2 personnel from the Research and Evaluation Unit. However, it was reported that the short-course was highly theoretical, very complex in mathematic calculations, and provided little knowledge or skills that could be transferred to the job.

It is a difficult task for relatively young inexperienced teachers/academics to translate theory into practice, particularly when the application of theory also requires a thorough understanding of the technical sector or sub-sector for which application is sought, in this case family planning and/or commodity management. Even in the best of situations, where valid and reliable data are readily available for use in mathematical model building, OR techniques have very limited applications in a public sector human services program like family planning.

It is the judgment of the evaluation team that more practical and useful applications of OR techniques should be considered in the future, and that OR techniques should be utilized only when there are not simpler and more cost-effective approaches to problem solving, e.g. use and/or adaptation of existing pre-tested mathematical models in lieu of building new models, and the use of qualitative research methodology in lieu of quantitative methodology, particularly when quantitative data are scarce, too expensive to produce, invalid or unreliable.

RECOMMENDATIONS (4.V.4)

1. The utilization of NIDA to provide technical assistance to FHD in applying and using OR techniques, and in training of FHD staff in application of OR techniques, should be discontinued upon completion of the existing sub-contract which is already funded.

2. Population Council, after translating its excellent and practical Operations Research training manual into Thai, should provide a series of one-week workshops for FHD and provincial level officials to train them in basic OR knowledge and skills sufficient to enable them to design and conduct unsophisticated OR studies. Remaining uncommitted funds for OR application should be made available for this purpose.

3. Hereafter a broader definition of "Operations Research" should be used in order not to exclude simple, more practical and cost-effective research methods (as contrasted to classical OR mathematical modeling) which often have wider application and greater utility in solving problems involving the improvement of service delivery efficiencies and cost-effectiveness, e.g. management analysis, organization and methods techniques, and industrial engineering.

Annex 4.2

Department of Health

No. 271/2527 (1984)

On

Working Group on Considering of

Family Planning and Maternal

and Child Health Research

The Department of Health has set up the members of working group on considering of family planning and maternal and child health research to cousider the family planning and maternal and child health research as follows:

1. Dr. Suvannee Satayapan	Family Health Division	Chairman
2. Prof Dr. Nikorn Dusitsin	Institute of Health Research Chulalongkorn University	
3. Dr. Orapin Singhadaj	Faculty of Public Health Mahidol University	
4. Dr. Promote Prasartkul	Institute for Population and Social Research Mahidol University	
5. Dr. Pichit Pitaktepsombati	Institute of Population Studies, Chulalongkorn University	
6. Dr. Apichat Chamratsitirong	Institute for Population and Social Research Mahidol University	
7. Dr. Peerasit Kamnuansilpa	Research Center National Institnte at Development Administration	
8. Dr. Santad Sermsri	Faculty at Socialogy and Anthropology Mahidol University	
9. Representative	Department of Technical and Econonic Coorperation (DTEC)	
10. Dr. Kanchana Kanchanasinith	Ministry of Public Health	
11. Dr. Wannee Kolasartsenee	Family Health Division	

12. Dr. Nanta Auamkul	Family Health Division	
13. Mr. Suthon Panyadilok	Family Health Division	
14. Miss Yupa Taralup	Family Health Division	Secretary

This working group has been responsible for considering of research topics which useful and upplicable to the NFPP, reviewing the research proposals, consulting for research designing and research implementing to institutions, helping interested institutions to do reseaches. Also find cut the donor sources to fund the approved reseaches.

February 17, 2527
(1984)

Pirote Ningsanonda

Director-General, Department of Health

Annex 4.3

Thai Fertility Association

III. Activities

a. Research project conduction under TFRA coordination.
b. Information Dissemination and Conferences.
c. Training Program in Research.

a. Research project conduction under TFRA coordination.

1. Systemic Contraceptive Study (May 1980 - March 1982) - 600 cases

A total of 600 women using the injectable contraceptive called DMPA were studied for changes in menstrual patterns, side effects and continuation. Four participating centers agreed to fill in the standard forms when subjects were first admitted to the study and four scheduled follow-ups were completed in the second year of this project. Data analysis was done by FHI.

2. Hospital Abortion Study (May 1980 - December 1980) - 720 cases

Thirty three district hospitals in rural Thailand were asked to record information about incomplete abortions, its treatments and type of patients etc. Approximately 720 forms were completed and sent back to TFRA for data processing. Finally, data analysis is being done.

3. TBA Record Study (May 1980 - February 1981) - 2,000 cases

TBAs in eight provinces were monitored of their experience in the provision of delivery services in rural areas. Most of these TBAs received some training by the government health personnel. Since almost all of TBAs were illiterate, the very clear and pretested pictorial form were distributed to them for checking. They were assisted by the local government midwives in the form filling. All completed TBA Records were forwarded to the TFRA where data processing and analysis were done.

4. Female Sterilization Study (July 1980 - September 1982) - 200 cases

Data about the open and closed laparoscopy techniques were compared in four major university hospitals in the ease of performances and safety of the open procedure as against the tradition laparoscopy technique of female sterilization. Data collection and processing were completed while data analysis will be reported soon.

5. A Comparative Trial of Standard vs. Low Dose OCs (January 1982 - August 1983) - 600 cases

Two oral contraceptives - standard and low dose - were being evaluated for their safety, effectiveness and acceptability among women in three centers using standard forms to collect data. All data were sent back to the TFRA for editing, coding and punching.

6. Micro-dose OCs : Microlut vs. Exluton (April 1983 - present) - 600 cases

Two brands of micro dose oral pills (progestogen only) were being studied for their acceptability and efficacy among postpartum mothers who needed contraception during lactation. Data collection has not been completed yet.

7. A Maternity Care Monitoring Project (December 1981 - present)

All births attended by health personnel and TBAs in Sukhothai Province were monitored to find out the major maternal and child health problems so that measures could be taken to improve and strengthen MCH care which could be duplicated for use in other provinces of the country. Second year round data collection is being done.

8. A Comparative Trial of Postpartum IUDs and Lippes Loops (February 1982 - January 1983) - 300 cases

The postpartum Delta Coop device was evaluated against the Lippes Loop in immediate postpartum women in one regional MCH Center to determine expulsion rates, six-month continuation rates and users satisfaction. Data processing and tables have already been prepared for analysis.

9. A Comparative IUD Trial of the TCu 380 Ag vs. Multiload 375 (June 1982 - present) - 660 cases

The effectiveness and acceptability of the two new developed IUDs - TCu 380 Ag and ML 375 - were being studied in three active hospitals using the standard forms for data collection. This study is now on the process of follow-up of cases recruited.

10. A comparative Trial of Mini IUDs : Mini Gravigard vs. Nova T vs. Multiload Short (July 1983 - present) - 450 cases

Three types of Mini IUDs - Mini Gravigard, Nova T. and Multiload Short are being compared among nulliparous women to detemine the acceptability and effectiveness of the devices at Nang Rong District Hospital, Chieng Mai MCH Center, Khon Kaen MCH Center, Cholburi Provincial Hospital and Siriraj Hospital, Bangkok using standard forms as data collection tools. Case-recruitment in each center is being on the process.

New Studies

11. A Follow-up Study of the IUD Acceptors in Mahasarakham Province (March 1984 - present) - 1,000 cases

This study will attempt to determine the continuation rate, major reasons for discontinuation, side-effects, failure rate and attitude towards the campaign. A sample of ten percent of all the acceptors will be randomly drawn from the hospitals' records and interviewed by a group of well-trained interviewers using a TFRA developed form.

12. An IUD Perforation Study (July 1984 - June 1985) - 400 cases

This study will attempt to determine the extent of the health problem concerning a perforation of the uterus among IUD users throughout the MOPH nationwide network of hospitals to find out the need for improve training of IUD insertion practitioners, to find any pathological change caused by the perforation and to determine the appropriate treatment of those cases. By canvassing the nation's 445 district and provincial hospitals for a period of one year it is expected that at least 400 cases of diagnosed perforations of the uterus will turn up. A simplified client record form locally prepared will be the data collection instrument.

13. *Female Sterilization Study : Filshie Clip vs. Ring using Laparoscopy technique (November 1983 - present) - 300 cases*

A total of 300 cases of interval women will be recruited for a comparative study of tubal occlusion by Filshe Clip using laparoscopic applicator and Ring using a laprocator applicator at Siriraj Hospital with the aim of evaluating effectiveness and side-effects. Three scheduled follow-ups at 1, 6 and 12 months are planned in addition to the usual visit at one week after the procedure.

14. *Reproductive Parameters of Thai Mothers (A Nationwide Study of Infant Birthweight in Thailand) - February 1984 - present*

This study will attempt to obtain a country data on reproductive parameters to crystalize the regional problems in MCH care. A sample of 15-25 percent (a total of 7,000 - 8,000 cases) of patients is selected from four MCH Centers, eight provincial hospitals and 24 district hospitals. From the Labour room log book, all necessary and previously defined parameters will be extracted and transferred onto computer cards for processing and analysis. The data will be presented to the provinces concerned as well as the nationwide.

15. *A Long-term Follow-up Study of IUD Acceptors (from the Two Comparative IUD Studies Implemented in SIN 725 and 1125) (August 1984 - July 1986) - 650 cases*

A long-term follow up study is proposed of the acceptors of four of the devices on trial in the SIN 725 and 1125 subgrants: Delta Loop and Lippes Loop for the postpartum study and the Multi load 375 and Copper T 380 Ag. The IUD may be the most suitable method for most of the Thai women needing temporary methods who are in the lower income group because of its cost-effectiveness and durability. This proposed study is designed to follow up acceptors of the two mentioned studies at twelve month intervals up to three years to assess effectiveness and continuation as well as the reasons for drop out.

b. *Information Dissemination and Conference*

An annual General Investigators' Meeting is planned research review and reporting. TFRA also planned for the publishing and distribution of a quarterly newsletter, conference proceedings and research findings for its network of investigators all over the country.

c. *Training Program in Research*

Each year at least one participating investigator who is a physician is invited to attend a two-week Research Methodology Workshop at FHI. TFRA also encourages its staff to attend periodically organized research training/workshop to enhance and sharpen their knowledge and capabilities in the field of research.

IV. Budget

Under successive subgrants, IFRP/FHI has provided the following assistance for

(a) research (clinical trails and maternity care monitoring studies) through research "forms payment" reimbursement, and for

(b) the institutional development of TFRA through a budget for "core support", in the form of staff salaries/benefits, general administration including office equipment and supplies, travel for supervisory and training purposes, travel/per diem/ organizational expenses of training courses and conferences as well as TFRA committee meetings:

Subgrant	Dates	Total
SIN 925	2/80-4/81	$ 38,479
SIN 725	5/81-9/82	95,287
SIN 1125	10/82-9/83	65,318
SIN 1225	10/83-9/85	180,000

From October 1983 through September 1985, a period of two years, FHI has made a commitment to TFRA of $180,000 of which $85,000 is to be committed in year one of the subgrant and $95,000 in year two. Some ongoing studies will be completed during this period, five new studies will be initiated and one ongoing study will be extended and duplicated.

V. TFRA Advisory Committee Members

1983 - 1986

1.	Dr. Debhenor Muangman	President
2.	Dr. Subarn Panvisavas	Vice President
3.	Dr. Supern Kootsawang	Executive Secretary
4.	Dr. Somsak Varakamin	Treasurer
5.	Dr. Moraket Kornkasem	Registrar
6.	Dr. Prayoon Klinchom	P.R. Officer
7.	Dr. Nanta Auamkul	Editor
8.	Dr. Suwanee Satayapan	Member
9.	Dr. Nikorn Dusitsin	"
10.	Dr. Chana Kumboonrat	

PART FIVE

PP II PERFORMANCE AND PROPECTS

I. Log Frame Analysis

(Sub) I. The Sector Goal (A-1)
To assist the RTG in reducing the rate of population growth to 1.5% by the end of the Fifth Plan (1982-86).

Progress:

As has been stated in this report, the current estimated growth rate is 1.6% which -- if present momentum is sustained -- will be reduced to at least 1.5% by 1986.

See: Part Three for detailed information

A. Objectively Verifiable Indicators (A-2)

1. Number of new acceptors during the 5th Plan totals at least 5.3 million using the pill, IUD, injectable, and male and female sterilization.

Progress: From 1982 to April 1984, the number of new acceptors by method was:

		PP II projections for this period
Pill :	1,432,499	1,404,000
IUD :	282,964	158,000
DMPA :	464,377	254,000
TR :	340,795	499,000
VAS :	65,263	
Total:	2,594,898	2,320,000

If the pattern for the first four months of 1984 can be projected to the next 8 months, 1984 will be a landmark year with the highest number of new acceptors in the history of the NFPP. FHD strategy has shifted since 1983, and the non-governmental sector, particularly PCD, has been very active in service promotion and delivery. If the NFPP continues to be responsive to signals for strategy change, and if MOI continues its support of family planning activities, it is likely that the current 1986 NFPP revised estimate of 5.3 million new acceptors can be exceeded.

See: Part Three for new acceptor data and a discussion of its definitional perils.

2. Number of active users increases from 3.0 million to 4.2 million by EOP.

Progress: From 1982 through 1983, the reported number of active users was 7,405,700 NFPP (revised) estimates for 1984-86 are 12,307,100 Both totals currently exceed the PP's expectation.

See: Table 3.11 in Part Three.

3. Fertility declines to a level necessary to result in a 1.5% annual growth rate.

Progress: The current growth rate is estimated to be 1.6% and is expected to reach 1.5% by 1986. An examination of fertility trends and preliminary data from CPS 3 gives assurance that fertility decline is currently the primary contributor to reductions in population growth.

See: discussion in Part Three.

B. Assumptions (A-4)

All of the assumptions made in the PP are currently valid:

1. RTG support to the NFPP in FY 1984 is the baht equivalent of $11,223,000, a 30% increase since 1982. The NFPP has expedited the phasing-out of USAID funds for contraceptive procurement, as follows:

Source	Project Budget	Proposed Revision
Grant	$3,503,000	$1,236,000
Loan	$3,274,000	$ -0-

Self-sufficiency in contraceptive financing and procurement has been achieved more rapidly than planned.

2. International donor assistance does supplement RTG financing, providing 28% of the total NFPP budget in FY 1983 (in FY 1982, external assistance provided 44% of the actual budget). The primary donors are USAID, UNFPA and JICA (see Table 2.1 for detail on RTG and donor assistance). The team learned that both FPIA and AVS will reduce the level of their assistance to Thailand, but it is hoped that the recommended PP II re-programming priorities of the evaluation team on private sector involvement will be adopted and will thereby offset these reductions.

3. Demand for services has increased. CPS 3 preliminary findings indicate that the CPR has increased since 1981 and may be as high as 65%. Further evidence is provided by the new acceptor numbers

which have increased since 1982 and are expected to reach a record-high this year. IE&C efforts will emphasize the two-child family norm and the health benefits of child-spacing, particularly in the Southern region. The team has recommended that MCH IE&C materials be reviewed for attention to these subjects, and strengthened or revised to promote them.

4. So far as is known, the RTG has never adopted or promoted coercive policies to encourage smaller families. If, however, the intention underlying this assumption was that policy additional to the Cabinet statement of 1970 and the statement in the 1974 Constitution would be forthcoming, it has not. However, both are deemed supportive and promotive of voluntary family planning. The MOI has issued policy guidelines which, the team believes, should be supplemented in order to underline the voluntary concept (see Appendix E for a translation of these guidelines).

In addition, the team has recommended that more effective collaboration be sought by the MOPH with MOI and with Ministries of Agriculture, Education and Public Welfare at central and provincial levels. Also recommended were more extensive collaborative work among the planning and policy staffs of these Ministries and a policy review. This should be augmented by USAID-funding of a Population Policy Background Paper in preparation for the 6th Plan, and a National Population Seminar and follow-on for representatives from Ministries, and others.

(Sub) II. Project Purpose (B-1)
To assist the RTG in extending and strengthening FP information and services nationwide, with particular emphasis on the sub-district level and low performance provinces and districts

The progress toward achieving the Project purpose will be identified within the context of EOP conditions.

A. EOP Status (B-2)

1. Contraceptive information and services are [unreadable] nationwide, from both public and private sources down to and including the village level. [Unreadable] will be:

a. Sub-district (tambol) outlets providing IUD services increased from 60 to 1,500

Progress: There are, currently, 7,169 health centers at tambol-level. All provide pills, and condoms; 561 provide IUD services and an unknown number provide DMPA. None provide sterilization. The team has recommended a number of ways to increase availability of IUD (and DMPA) services including: (1) Immediate implementation of MOPH policy permitting trained NMs and AMs to insert IUDs and administer DMPA; (2) FHD should provide IUD kits directly to trained AMs rather than to provincial health offices; (3) the two-day

DMPA training curriculum training and the funding that have been provided to every province to support DMPA training costs should be used; (4) review of the basic AM curriculum should be made to assess feasibility of including IUD insertion and DMPA training; (5) AMs trained before 1983 should receive training in insertion and removal of the multiload IUD.

b. IUD and VSC services strengthened at 500 provincial and district outlets.

Progress: Altogether, there are 1,238 IUD service points, 570 female sterilization service points and 639 male sterilization service points, as follows:

Type of Facility	Number Providing Service		
	IUD	Female VSC	Male VSC
Provincial hospitals	89	89	89
PCMO's clinics, excluding Bangkok	72	0	0
District hospitals	470	470	470
Health Centers	561	0	0
Mobile units	38	3	72
MCH centers and sub-centers	8	8	8
Total 1984	1,238	570	639
[Total in PP	568	411	481]

Since 1981, the number of outlets and providers of IUD and VSC has grown considerably, and certain constraints have been lifted. However, as mentioned in A.1.a above, IUD service availability can be improved if the team's recommendations are adopted. Both IUD and VSC services have been publicized and made more available through a new FHD strategy and the participation of the MOI. This is discussed in the Service section and other portions of the evaluation report. Studies and service data on the process and outcomes of the MOI/MOPH campaigns should be carefully monitored to assess the effectiveness (and costs) of this approach to service availability.

The FHD is conducting a pilot study to strengthen sterilization and IUD services at 10 district hospitals, which started in January 1984. The study includes IE&C materials and counseling clinics. An evaluation will be conducted in January 1985 comparing numbers of acceptors before and after the pilot study.

c. Village-level availability of orals and condoms will have increased from 25% to 60% of Thailand's villages

The estimated coverage is currently 85%.

d. Percent of married couples of reproductive age currently using modern contraception has increased from less than 10% to over 45% in the "lagging" provinces

Progress: Although CPS 3 findings are not yet available, the team discussed the very preliminary findings with Dr. Peerasit and Dr. Abichat, the CPS 3 research investigators. Although neither they nor the NFPP use "married couples" as their subjects, by using currently married women in the reproductive age group a surrogate is acceptably established. Currently, in the Northeast, contraceptive prevalence and numbers of new acceptors indicate usage much higher than 45%. The South, however, is still "lagging" compared to other regions, though there is discernible positive change. In 1981, prevalence in the South was 42.4% (CPS 2); thus it can be expected that by 1986, the 45% target will be exceeded. UNFPA-assisted projects in the South can also be expected to promote prevalence. Worth noting is Dr. Peerasit's observation that withdrawal, a not uncommonly employed method of child spacing in the South, may be a fairly effective method as practiced by couples who are highly motivated and used to the method. He has recommended further study on the subject.

e. Both vasectomy and IUD acceptance will increase by at least 5% annually beginning in year 0

Progress: The number of new acceptors of these two methods and the percent increase or decrease are:

Year		IUD		VAS
1981		80,134		28,404
1982	(+ 5%)	83,899	(- 17%)	23,405
1983	(+ 51%)	126,933	(+ 16%)	7,076
1984 (Jan-April only)		72,132		14,782

As has already been mentioned, if the January-April pattern persists throughout 1984, the increases should be well above the expectations of the PP. Increased IE&C efforts together with mobile and static-service campaigns have contributed significantly to the increase experienced in 1983 and the first third of 1984; however, study data should give more precise information on the contribution.

2. Management information, program research and evaluation are integrated into the management and planning of the NFPP

Progress: These are problem areas. There are many and detailed recommendations in this report that are directed toward improvement in these three components. Until they are improved, planning and management functions will be inpaired.

3. Cost-effective ways of delivering FP services are being developed, tested and implemented

Progress: So far as is known, cost-effectiveness studies have not been conducted during PP II. This evaluation report contains documenation of the need to focus attention on cost-effectiveness, and recommendations for improving the MIS, Operations Research, and research and evaluation processes and content.

In the absence of documentation from cost-effectiveness studies, it is not known whether campaigns, mobile units, use of paramedical personnel to delivery IUD, DMPA, post partum sterilization and vasectomy services, and accelerated media efforts have contributed and are contributing to lowered costs and/or to what extent the inputs of these efforts singly and in combination contribute to effectiveness and are efficient. The team has recommended that efficiency questions also be investigated to enable the NFPP to make informed decisions about strategies keeping cost, effectiveness and efficiency in mind.

B. Assumptions (B-4)

The first assumption is unquestionably still valid. The second assumption can be questioned. The team has recommended greater attention to logistical support for technical supervisors, and study of the optimal staffing pattern at health centers. Provincial-level technical section staffs have been especially targeted for participant training to increase their skills in their specialty areas. Training Sections at the provincial-level were absent in provinces visited by the team; a recommendation has been made to establish them, and several functions have been suggested.

The third assumption is invalid, to date. Recommendations have been made to improve the MIS, research and evaluation, and to address cost-effectiveness--and efficiency.

(Sub) III. Outputs (C-1)

A. Family Planning Information and Services (C-1) Magnitude of Outputs (C-2)

1. All existing government hospitals (391) and facilities added (216) during the project period supplied with VSC (1,430) and IUD (2,200) kits, plus vasectomy (100 kits for mobile teams

Progress: There are 559 provincial and district government hospitals and 7,169 health centers, in addition to 8 MCH centers and sub-centers, 72 mobile units, and 72 PCMO's clinics. For service availability data, refer to II.A.1.a. and b. of this section of the report.

The team visited 12 provinces. Although family planning commodities were in adequate supply, there were widespread shortages of sterilization and IUD kits. Until the commodities management system is strengthened, shortages and/or maldistribution can be anticipated. Recommendations have been made to improve commodities management, and to provide kits directly to trainees prior to their return to post. One of the disbenefits of campaigns is that kits are diverted from health centers for use in campaigns, or when sent by FHD to provincial officers, are distributed for campaign use rather than being sent promptly to health centers.

Increased funding for kits has been recommended if it is found that the shortages have been exacerbated by lack of supply. However, before PP II loan funds are reprogrammed: (1) the current inventory and proposed distribution points should be identified by FHD and communicated to USAID; (2) JICA's plans for kits purchase should be discussed; then, (3) USAID and FHD should determine the number and types of kits that are needed and where they will be distributed. If the commodity management system is improved by that time, this can be more certainty about both needs and receipt.

The team has also drawn attention to the VSC instruments, recommending that some changes be made.

2. Orals and condoms available at all NFPP outlets (7-18) and through the network of 48,000 VHVs and 6,000 CBFPS distributors

Progress: Pills and condoms are currently available at 7,880 outlets (100%) above the village-level. At village level, it is estimated that these is 85% coverage. PDA has 16,200 distributors in 16,200 villages in 48 of the country's 73 provinces.

However, the team found that some health centers carried a supply of only one or two brands of pills resulting in disappointed continuation clients who, rather than accept an unfamiliar brand, dropped out of the MOPH system to purchase their brand from a commercial or another private source. There seemed to be no problem with condom supply except transport of boxes from the district to the heatlh centers -- only motorcycles are issued to the DHOs.

3. 598 RTG fixed and mobile facilities receiving institutional support (subsidy) for VSC services

Progress: To date, 559 hospitals and 75 mobile facilities have received support for VSC services. The budget does not break-out VSC from IUD, but the combined total expended through June 30, 1984 is $658,675.51, or 21.7%, of the total obligated ($3,032,000) for institutional support.

According to data given to the team by FHD, VSC institutional support (B150/acceptor) from October 1983-February 1984, was provided for 27,127 female VSC cases and 4,456 male cases ($205,976 total).

4. Subdistrict level health facilities receiving institutional support for IUD services

Progress: Todate, 561 health centers and 38 mobile facilities have received IUD service institutional support.

Data provided to the team by FHD cites institutional support for IUDs (B20/acceptor) during the period October 1983-February 1984 for 26,892 cases ($23,384 total).

5. Selected mobile vasectomy and communication teams receiving travel and per diem support

Progress: This was a problem in 1981. However, the team heard no complaints about non-receipt of travel and per diems. To date, of $155,305 earmarked for VSC mobile team support, $74,060.38, or 48%, has been disbursed. This budget item should be monitored and if necessary, increased.

Of the total provided for intensified vasectomy promotion and service, $257, 141, or 74%, of the $343,260 committed has been expended. The media package commitment is $65,217 which by June 30, 1984 was not disbursed although McCann Erickson has developed and pre-tested the prototypes which are ready for mass production (3 leaflets, 4 radio spots, one TV spot and (3 posters).

6. CBFPS recovers at least 50% of operating costs by the end of Project Year 02 and assumes total costs in year 03

Progress: The Health and Hygiene Project concluded on September 30, 1983. There is currently no USAID support to CBFPS. According to material provided by PDA to the team, CBFPS is self-supporting.

7. SMP feasibility study completed by end of Project Year 01. If feasible, SMP being implemented by end of year 02

Progress: The feasibility study was completed by the Futures Group in March 1984. Feasibility and need for social marketing are being discussed within USAID and the NFPP. The team did not see a clear need for a SMP, and has recommended that until a clearly established, verifiable and definite constituency for SMP services is identified, the project should be tabled.

B. Commodity Management: Improved logistics and supplies system established

1. At least 80 [or 90?] Percent of service outlets complying with maxi-mini stock level system

Progress: As has already been noted, commodity management is a problem area. Recommendations have been made for improvement, including additional technical assistance from CDC and an increase in PP II support for further development of the system.

2. Staff trained, records maintained and warehouse management improved in accordance with revised logistics and supply manual by end of Project Year 02

Progress: See Progress under 1. above.

C. Training: The use of non-physicians to perform sterilizations and insert IUDs increased. Number of physicians at district-level performing sterilizations increased

1. 500 nurse midwives and 1,250 auxiliary midwives trained and providing IUD services

Progress: In FY 83, 240 AMs and 80 NMS were trained. The target for 1984 is 320 AMs and 110 NMs. If the pilot project in decentralized training at the provincial-level can be replicated, the PP target for AMs will be exceeded. There are, however, barriers to provision of IUD services, and recommendations have been detailed in II.A.1.a. of this section. (See also the Training and Supervision section of this report).

2. 250 district level physicians, 200 hospital nurse [nurse midwives], and 60 auxiliary midwives trained and providing VSC services

Progress: At present, 100 new physicians (who are assigned to district hospitals) are being trained at provincial hospitals and MCH centers. Only pilot study training of NMs and AMs has taken place. The future prospect for success of NM and AM VSC sterilization service provision are discussed in the Training and Supervision section of this report. It is recommended that NM TR training proceed as planned: 50 each in 1984, 1985 and 1986. However, until there is more and clearly established documentation on need and acceptability, the proposed vasectomy training of 40 AMs per year starting in 1985 should be tabled, or deleted from PP II.

D. Management Information/R&E: Management information system developed. Program research and evaluation improved

1. MIS established and used at central level and selected provincial levels

Progress: The evaluation team believes that the PP

writers were overly optimistic in their expectations. In addition, the sub-contract with NIDA has experienced considerable delays which are anticipated to continue.

There is a tendency by donors and host governments alike, to under-estimate the lead-time and resources required to develop an appropriate and viable MIS to serve a nationwide hierarchial service delivery system. Thus it is important to carefully and realistically design a development strategy that clearly identifies lead-time and resource requirements. A high degree of practical technical expertise in MIS application and design is also normally needed for this task.

The team has recommended a thorough review, technical assistance, pilot projects and several other remedies for the current problems.

2. Service statistics system (SSS) simplified and incorporated in the MIS

Progress: The nationwide development of the FP Service Statistical System (SSS) in recent years has been most impressive. The development approach followed has served to set national priorities for data collection and build a standardized system to meet national level monitoring and planning needs. A number of significant problems remain to be overcome in design of the present SSS, before further conceptual and structual development of the system should be undertaken. The feedback of processed data to the field in a format more useful and in a more timely fashion is needed. Problems in double counting of acceptors when switching methods that result in overly optimistic measurements of service performance in terms of new acceptors, need to be addressed. As the SSS has shifted from counting new and old acceptors to an attempt to count active users, it has shifted to the measuring of temporary method active users by counting the number of oral contraceptive cycles and injectables distributed. Unless this approach is supported by carefully conducted periodic audits to confirm accuracy and adjust for discrepancies between supplies distributed and actual use, the counting of temporary method active users could be overly optimistic and very misleading. The SSS should serve as a solid foundation for future development of the NFPP MIS which because of its complexity, will require a long term development strategy.

3. At least two operations research techniques developed, applied and used each year

The Project Paper called for development of the first OR model by the end of 1982, with the assistance of a consultant who would also provide training to FHD staff, and continue developing and testing new models through 1984.

NIDA (the sub-contractor) in collaboration with FHD and USAID selected as the initial topic for OR appliation, "Logistics."

Although this topic most easily lends itself to mathematical model-building, serious delays in its development are being experienced. Moreover, the OR application overlaps the tasks of the CDC consultants in designing and installing a comprehensive commodity management system for all family planning supplies of the NFPP.

As part of the NIDA sub-contract, training in OR techniques was to be provided to FHD staff. A short-course was attended by 2 personnel from the Research and Evaluation Unit. However, it was reported that the short-course was highly theoretical, very complex in mathematic calculations, and provided little knowledge or skills that could be transferred to the job.

It is the judgment of the evaluation team that more practical and useful applications of OR techniques should be considered in the future, and that OR techniques should be utilized only when there are not simpler and more cost-effective approaches to problem solving, e.g. use and/or adaptation of existing pre-tested mathematical models in lieu of building new models, and the use of qualitative research methodology in lieu of quantitative methodology, particularly when quantitative data are scarce, too expensive to produce, invalid or unreliable.

The team has recommended that the NIDA sub-contract not be renewed, and that Population Council provide a series of one-week workshops based on their OR training manual, using PP II funding for this purpose. (See OR section of this report for detailed recommendations).

4. Two Management Information Dissemination and utilization seminars held each year

Progress: To date, no seminars have been held. However, the Detailed Implementation Plan for FY 84 includes a budget item for a workshop in utilization which, the team believes, should be postponed until the MIS is more carefully thought-through.

5. At least five program research studies completed each year

Progress: During the first project year (FY 83) four studies were initiated. Of these, two are currently being written-up and two are "ongoing." During the second year (FY 84), 7 studies have been approved by USAID pending re-design of the methodology.

The team reviewed the process for setting a priority research agenda and for soliciting input into it, the role, boundaries and positioning of the recently-formed Working Group on Research, and the content focus of research studies. Recommendations for improvement in management of research are contained in the Research and Evaluation section of this report. In addition, this report underlines the importance of re-orienting research topics toward cost-effectiveness as

intended in the PP, and has gone further to suggest that efficiency topics should also be studied in view of the demographic and continuation acceptor challenges that will be faced during the 6th Plan.

6. At least five program evaluation studies completed each year

Progress: Unless the four research studies conducted by R/E Section in FY 83 are also considered to be program evaluation studies, the team is not aware of other evaluation studies conducted in FY 83.

7. Two regional research and evaluation dissemination and utilization conferences need each year

Progress: These conferences, as far as is known, have not been conducted.

E. Assumptions (C-4)

Of the 8 assumptions, current status is as follows:

1. Contraceptive supplies do not appear to be a problem in a general sense. However, stock levels of the approved 3 formulations (and 4 brands) of oral contraceptives and DMPA although perhaps adequate at the central level, are insufficient at the provincial level perhaps as a result of lack of supply monitoring and/or PCMO lack of full awareness about use. Other items (kits, gloves) are in short supply, but not uniformly.

2.

3. A final decision about the SMP is pending. The issue is not one of feasibility, in the evaluators' opinion; rather, it is need and by whom and how the need is demonstrated.

4. This assumption is, in part, valid with some provisos: local authorizations are variable re. IUD and DMPA; and, authorization for VSC provision is somewhat restricted for nurse midwives and very restricted for AMs.

5. This assumption is valid. The evaluators believe, however, that NIDA is not qualified to provide OR assistance.

6. Other than the R/E technical advisor, Tony Bennett, technical support from international agencies was not sought for the MIS, OR or program research components. (Mr. Bennett is affiliated with Columbia University). Commodities and logistics management consultation has been provided by CDC. Population Council provides support for research and has provided technical assistance to university-based and other research investigators.

7. This assumption is not yet valid.

8. There has been no problem in obtaining the full cooperation of MCH centers and medical schools in implementing the training programs.

LOG FRAMEWORK
F. Financial Analysis

D-1 Inputs

	Target	Objectively Verifiable Indicators Commitments to date (% of PP)	Expenditures to date (% of PP)	Analysis
Grant				
1. Contraceptives	3503	1236 (35%)	1236 (35%)	1. Although this item is chronologically on target, the RTG's decision not to use these funds for additional contraceptive purchase is not reflected. This money will be available for reprogramming.
2. Mobile Units/ Intensified F.P.	1283	909.5 (71%)	614.4 (48%)	2. Originally planned as support for mobile VSC activities at the provincial level only, this item now also includes VSC promotion and services at the district level and female sterilization/IUD promotion and services. Additional funds will need to be added for this line item from available reprogramming funds. Future plans include support to over 700 districts.
3. Health and Hygiene Project	595	357 (60%)	357 (60%)	3. This project which supported PDA's community based distribution services (CBFPS) was completed at the end of the second year of PP II. RTG may provide contraceptives to CBFPS with part of the remaining funds.
4. Community based VSC (PDA)	910	202.2 (22%)	104.7 (12%)	4. Gross underspending in this item is due to a late start. Originally, the program was to be supported by USAID at the beginning of PP II. However, other sources of funding were available until the final quarter of the first project year. Also, PDA is slightly behind target for this year's implementation plan for VSC acceptors in rural areas due to government emphasis on RTG health services meeting VSC targets. PDA has met with USAID and the FHD to discuss duplication of services. At present, PDA will limit its rural services to those provinces where government units are inactive.

D-1 Inputs

	Target	Objectively Verifiable Indicators: Commitments to date (% of PP)	Objectively Verifiable Indicators: Expenditures to date (% of PP)
5. Social Marketing	164	-	-
6. Community Management	67	69.1 (103%)	8.4 (13%)
7. Management Information	68	29.5 (43%)	26.1 (38%)
8. Program Research	681	78.3 (11%)	51.2 (8%)
9. Project Evaluation	416	221 (53%)	46.6 (11%)

Analysis

5. This was to provide funds for a social marketing program. After assessing the need for and feasibility of such a program, the RTG and USAID have decided to use these funds to support other activities.
6. This item was originally scheduled to be completed during the first two project years (thus, 103% committed through 1st and 2nd annual implementation plans). However, a great many delays have occurred and expenditures (13%) are very much under the target (103%). This is due to problems in the FHD R&E unit, such as lack of staff and a low priority given this item.
7. According to the implementation plan in the PP, 62% of these funds were to be used in the first two project years. Under-spending is due to numerous problems experienced in the NIDA subcontract. Original OR methodology to be used had to be redesigned for real life use; computer software took longer to develop than expect.
8. This item is grossly underspent and discussions between USAID and MOPH should be held subsequent to receipt of the evaluation report about the management and focus of future program research.
9. This item supports two contraceptive prevalence surveys and the mid-term and final project evaluation. Funding appears to be adequate and on-stream.

D-1 Inputs	Target	Objectively Verifiable Indicators Commitments to date (% of PP)	Expenditures to date (% of PP)
10. VSC & IUD Audit	55	18 (33%)	7.4 (13%)
Loan			
1. Contraceptives	3274	-	-
2. Kits	686	869.6 (127%)	286.6 (42%)
3. Institutional Support	3032	1029.5 (34%)	658.7 (22%)
4. IUD Training	1661	833.2 (50%)	366.2 (22%)

Analysis

10. This item is for audit of per diem and travel in connection with VSC recruitment and services. Price Waterhouse was subcontracted to determine if services were actually provided free of charge and that service data for accounting are correctly collected. Expenditure is below target (13:30%) because the subcontract for the second year of the project has not been awarded.

1. It is anticipated that commodities under the loan agreement will be deleted as an item.

2. Additional funds were added to procure more kits than originally planned as a result of the intensified IUD campaign (2 above). Originally scheduled for completion of procurement by year three, this is behind target in expenditures due to AID/W delay in awarding a contract in the second project year. Additional funds will be needed for 3rd year procurement.

3. This item for reimbursing institutions for VSC services is underspent and should be reviewed for possibility of reprogramming a portion of it.

4. Underspending is due to an overestimate of training costs. Originally DIEC per diem rates were used as the basis of calculating cost estimates. However, because these are loan funds, MOPII guidelines (with lower rates) are used. AM training is on schedule, NM only slightly behind.

D-1 Inputs

	Target	Objectively Verifiable Indicators Commitments to date (% of PP)	Expenditures to date (% of PP)
5. Sterilization Training	319	26.3 (8%)	4.6 (1%)
Project Total	18385	5931.1 (32%)	3788.8 (21%)

Analysis

5. This is to provide training for physicians, NMs and AMs. However, as in 4 above, use of loan funds restricts per diem levels and thus the item may be overestimated. However, since training of NMs has not yet begun and AM training is not scheduled until next year this item should be monitored. The team has recommended review of the proposed training of AMs in vasectomy.

Overall, PP II is only slightly below funding target at this point because loan funds for contraceptives were not used during the first two project years. However, this somewhat offset by overspending in the intensified family planning and medical kits line items.

II. Strengths and Problem Areas of PP II

Strengths

1. Strong, sustained, decisive program leadership and clear RTG support.
2. Adequate budget with room for flexibility in response to emerging needs of the national program.
3. PP II targets are on-stream: some have already been achieved or exceeded.
4. Private sector collaboration is evident and NGO activities are complementary and appropriately additive to the RTG's efforts.
5. FHD is a strong implementing agency drawing on a wide network of MOPH and private sector service resources.
6. Participation of the MOI and new strategies adopted by FHD in 1983 are contributing to a significant increase in IUD and sterilization acceptance.
7. Intermediary assistance has been used prudently and has been well-targeted.

Problem Areas

1. Uneven provincial-level implementation of MOPH policies permitting trained AMs and NMs to insert IUDs and administer DMPA is an obstacle to increased service availability and is a waste of training resources and skills.

2. Shortages of IUD kits hamper full utilization of trained AMs.

3. Lack of transportation hampers provision of technical supervision to and on-the-job training of AMs.

4. The commodity management system and the MIS are not on-stream.

5. The research and evaluation management function is weak as are the quality and relevance of proposed research projects, especially Operations Research.

6. Collaboration and coordination with MOI at policy and operational levels needs strengthening in order to provide greater clarity to field-level service priority-setting and performance target-setting.

7. Collaboration by USAID with JICA, UNFPA and UNICEF needs to be strengthened.

8. FHD implementation plans do not refer explicitly to PP II EOP conditions or progress toward reaching them.

III. PROJECT IMPLEMENTATION PLANNING AND MANAGEMENT

The complexity of PP II is due to the number of components, activities and sub-activities which makes implementation monitoring, coordination and project management particularly difficult and time consuming.

The Family Health Dvision has prepared annual project implementation plans for PP II. The current 2nd project year plans are more extensive in detail and format than were the 1st year plans and thus are easier to use in assessing current project implementation status. However, further improvements in the content and format of annual plans will be needed if project monitoring is to be adequately performed in the future.

Recommendations (5.III)

1. Project components, activities and sub-activities under both grant and loan categories should be systematically code numbered for easy reference and control purposes, and that identical code numbers should be retained from year to year to provide a reliable audit trail for project implementation monitoring and financial management that will relate project activities back to the original Project Paper, subsequent amendments, if any, to that paper, and to annual project implementation plans;

2. Further improvements in content and format of the Annual Project Implementation Plan should be introduced with the 3rd Project Year, to ease the burden of subsequent year plan preparation, and to facilitate monitoring and coordination of project implementation activities. (See Annexes 5.1 and 5.2 for proposed formats.)

3. Written quarterly progress reports should be routinely prepared by persons assigned responsibility for implementation of various project activities and sub-activities for use by senior officials in monitoring implementation progress; and the reports should be standardized in a format compatible with the detailed Annual Project Implementation Plan to facilitate review and analysis of implementation progress. (See Annexes 5.3 and 5.4 for proposed formats for quarterly reports.)

4. Quarterly project financial reports prepared by USAID should be re-formated according to the code numbering system and implementation planning formats recommended above, in order that monitoring of actual financial performance against planned financial performance can be simplified for both USAID and RTG officials, at considerable savings in staff time and resources.

disappointed continuation clients who, rather than accept an unfamiliar brand, dropped out of the MOPH system to purchase their brand from a commercial or another private source. There seemed to be no problem with condom supply except transport of boxes from the district to the heatlh centers -- only motorcycles are issued to the DHOs.

3. 598 RTG fixed and mobile facilities receiving institutional support (subsidy) for VSC services

Progress: To date, 559 hospitals and 75 mobile facilities have received support for VSC services. The budget does not break-out VSC from IUD, but the combined total expended through June 30, 1984 is $658,675.51, or 21.7%, of the total obligated ($3,032,000) for institutional support.

5. Regularly scheduled project implementation progress review meetings should be held on a quarterly basis for the purpose of reviewing written quarterly reports, sharing information among key implementation officials, senior administrators and donor representatives, and resolving issues and problems on a timely basis.

6. All technical advisors/consultants serving the PP II Project however employed should be required to prepare and submit to FHD and USAID a monthly (or trip) technical assistance report using the following format:

(1) Past month (or trip) technical assistance activities and output.

(2) Delays in Project Implementation (if any).

(3) Other Issues/Problems in Project Implementation.

(4) Next month (or trip) proposed technical assistance activities and output.

EXHIBIT NO. _____

ANNEX 5.1 ANNUAL PROJECT IMPLEMENTATION PLAN - SUMMARY

ACTIVITY CODE	ACTIVITY AND SUB-ACTIVITIES	MEASURABLE UNITS/TARGETS	PERSON RESPONSIBLE	START DATE	COMPLETE DATE	BUDGET		FOR DETAILS SEE PAGE
						BAHT	US$	

EXHIBIT NO. _____

ANNEX 5.2 ANNUAL PROJECT IMPLEMENTATION PLAN - QUARTERLY TARGETS AND BUDGETS

ACTIVITY CODE	ACTIVITY AND SUB-ACTIVITIES	1ST QUARTER (OCT-DEC)		2ND QUARTER (JAN-MAR)		3RD QUARTER (APR-JUN)		4TH QUARTER (JUL-SEP)	
		MEASURABLE TARGET	BUDGET	MEASURABLE TARGET	BUDGET	MEASURABLE TARGET	BUDGET	MEASURABLE TARGET	BUDGET

EXHIBIT NO. _____

ANNEX 5.3 QUARTERLY PROJECT IMPLEMENTATION PROGRESS REPORT
FOR QUARTER ENDING _____ 19____

PREPARED BY: _____
DATE: _____

A. ACHIEVEMENTS DURING QUARTER:

ACTIVITY CODE	ACTIVITY AND SUB-ACTIVITIES	MEASURABLE TARGETS PLAN	ACTUAL	%	COMMENTS:

B. IMPLEMENTATION DELAYS, EXPECTED FUTURE DELAYS, OTHER ISSUES:

ACTIVITY CODE	ACTIVITY OR SUB-ACTIVITY	PROBLEM DEFINITIONS:	SUGGESTED REMEDIAL ACTIONS:

EXHIBIT NO. _____

ANNEX 5.4 SUMMARY - QUARTERLY PROJECT IMPLEMENTATION PROGRESS REPORT
FOR QUARTER ENDING _____ 19___

ACTIVITY CODE	ACTIVITY AND SUB-ACTIVITIES	QUARTER:						YEAR TO DATE:					
		MEASURABLE TARGET			BUDGET			MEASURABLE TARGET			BUDGET		
		PLAN	ACTUAL	%	PLAN	ACTUAL	%	PLAN	ACTUAL	%	PLAN	ACTUAL	%

IV. PP II Reprogramming Priorities

The recommendations for reprogramming priorities reflect the judgment of the evaluation team regarding current strengths and weaknesses of PP II, mid-course corrections based on observed NFPP performance since the inception of PP II, and targets of opportunity.

For the third year of PP II, reprogramming should be limited to not more than $3.5 to $4.0 million of the six million estimated to be available. Further reprogramming should be contingent on the remaining balance and opportunities for new initiatives as well as increased needs for support of the ongoing programs.

A. Grant

High priorities

- Family Health Care for the Hill Tribes (10% of total needed).
- Block grants to FHD administered for PCMO's collaboration with MOI or campaigns.
- Management review to reduce fragmentation at the central level and between the central and the periphery.
- Mini-management studies and manuals, and extension of the commodities management system.
- Pilot MIS projects.
- Evaluation manuals and evaluation training.
- National Population Seminar, 1984 and follow-on in 1985.
- Preparation for the 6th Plan: demographics; organizational development; review of existing data; policy review.
- Extension of R/E Advisor.

Intermediate priorities

- Studies on second generattion issues.
- FLE initiatives: support of assessment of need at primary, secondary, and non-formal education levels (with School Health and FHD Divisions of MOPH, MOE and PPAT).

High priorities

- Private sector initiatives including slum-dwellers and factory workers, and support for vasectomy promotion and community-based distribution of contraceptives.

- Alternative financing: policy study, pending result of the USAID study on health sector financing (Fall 1984).

- Northeast initiatives, including IE&C

- Participant training and study tours for family planing personnel with special emphasis on provincial-level personnel.

- IE&C prototypes development and revisions of existing material.

B. Loan

High priority

- Family Health Care for the Hill Tribes (90% of total needed).

- Training and teaching materials, aids and models.

- Kits, if necessary.*

- Norplant purchase, if the commodity is approved by FDA.

- Transportation.

*According to an FHD inventory report obtained on July 24, 1984, there are 361 IUD kits, 97 vasectomy kits and 149 combined vasectomy/minilap kits. An additional 195 combined kits are to be cleared at the port on August 3.

V. Special Emphasis Programs

The evaluation team travelled to all regions of the Kingdom. More importantly, the Thai members of the team had made many prior visits in connection with their ongoing work, research interests, or as members of earlier evaluation teams. Thus, although the team's visits were too brief for the purposes of a precise identification of needs in each region, two special emphasis programs appear well-justified and currently under-financed:

Family Health Care for the Hill Tribes; and

A special set of initiatives for the Northeast.

Before providing more detail on these recommendations, it should be noted that the team was aware of low contraceptive prevalence and the special cultural constraints to family planning acceptance in the Southern Region, but believes that the two projects being financed by UNFPA are comprehensive enough to properly address the unique situation in the Southern border provinces.

A. Family Health Care for the Hill Tribes

Over the past 4 1/2 years, UNFPA has supported a project to develop health care services, with emphasis on MCH/FP, for hill tribes in Chiang Mai province. The Rural Health Division of MOPH was the implementing agency. One of the objectives of the project was to prepare guidelines and identify future collaborative projects relted to health care and family planning services for ethnic minority populations.

In this regard, the FHD/MOPH has submitted to USAID a proposal entitled, "Family Health Care for the Hill Tribes." It has been reviewed by the team who felt that the FHD was not fully aware of the lessons learned by and needs identified in the UNFPA-supported project. While the team is supportive of FHD's intention to improve family planning services in hill tribes areas, they felt that further discussions should be held with the Rural Health Division, USAID, and possibly the UNFPA-supported hill tribes team in order to become more fully apprised of successful approaches -- and pitfalls -- to service delivery in the north and northwest.

The team also suggests that consideration be given to the following approaches:

1. FP services to hill tribes should be integrated with primary health care and not singled out as a special emphasis service or by way of special campaigns. Consequently, the development of FP services should run in tandem with development of MCH and other PHC services.

2. Hill tribe villages should participate fully from the beginning with provincial and other government program managers, in planning and implementing the new health services delivery system to serve the village; this should include the setting of service delivery and health status impact priorities, targets and schedules.

3. The pilot service delivery system supported by UNFPA, using a Community Health Worker (CHW) as coordinator and linkage between the formal RTG system and village health workers should be retained with all incumbents of these positions selected from among appropriate and eligible Hill Tribe people. This will require the RTG to reduce existing educational requirements for CHW appointees from Grade 10 to Grade 8 to ensure that adequate numbers of eligible candidates are available for appointment to CHW posts. It has been suggested that additional educational credit be awarded candidates for their indigenous language capability and cultural knowledge, since these qualifications for a CHW job should rank well above general educational attainment.

4. Whenever possible to do so, RTG should recruit and train hill tribe people who are appropriately qualified with Grade 12 education, to serve as back-up supervisors to CHW's, i.e. Sanitarians and Auxiliary Midwives assigned to back-up health centers.

5. FP services made available to Hill Tribe people should include all contraceptive alternatives offered by the NFPP elsewhere, whether or not the hill tribe people initially elect to use them or not.

6. The current hill tribes project team should be considered as a special resource to be retained during the course of a USAID-supported project.

B. Initiatives for the Northeast

As a result of the team's site visits, discussions with the CPS 3 research investigators, and after a review of family planning, demographic and economic data, a special initiative in the Northeast appears well-justified. Even a cursory review of information in the Thailand Population Monograph indicates that it is the poorest, most populous rural region of the Kingdom, and though moving up in contraceptive prevalence, it still lags behind the Central and Northern regions. The team feels that increased use of family planning methods will accelerate the progress of other RTG development programs in the Northeast, but that special approaches may need to be taken that reflect the size and composition of the population, including Khmer and Lao minorities, and the lack, currently, of an adequate resource base which might provide sufficient local support of an accelerated family planning program.

Though the team did not develop a comprehensive list of activities that should be undertaken in the Northeast, they agree that priority should be given in allocations of resources, training, infrastructural support, IE&C and, when appropriate, participant training. The MOI is active in family planning in some provinces in the region and, therefore, close coordination by MOPH with MOI -- and other Ministries' development programs -- will need to be planned and achieved. Likewise, coordination with PDA and other pertinent private sector organizations needs to be undertaken with the possibility of strengthening and extending their efforts through financial and programmatic assistance.

It may also be prudent to review approaches that will be undertaken in the South to see if any lend themselves in a general way to the Northeast. For example, an ethnic language glossary will be developed in the South for use of service providers. This may also be a proper approach in the Northeat so that service providers know the Lao and Khmer equivlents of Thai terms.

The results of recent research studies and research underway should also be examined for possible use in the design of initiatives in the Northeast.

Recommendation (5.V)

1. FHD and USAID reprogramming of PP II grant and loan funds should reflect the high priority accorded by the team to hill tribes and the Northeast.

PART SIX

I. Beyond Family Planning

The current population policy is directed toward increased voluntary family planning support and, as has been documented in this report, the NFPP has been extremely competent in establishing and implementing a successful Kingdom-wide voluntary family planning program. Private and voluntary organizations have often pioneered approaches to informing, educating, recruiting and serving family planning acceptors, efforts which have also contributed to an extension and strengthening of the RTG's program. Recently, the Ministry of Interior added its considerable influence, manpower and other resources to further expand access to and availability of services under the aegis of the provincial administrators.

The evaluation team, having reviewed population projections and other preliminary relevant data, believe that new demographic challenges will confront the RTG during the 6th Plan period. To meet these effectively and successfully, resourcefulness, innovativeness, and full understanding of the demographic implications will be required of policy makers and high-level administrators, so that managers and service providers can be guided appropriately.

As has been described in detail, the MWRA will increase by 30% during the remainder of this and over the 6th Plan period. In addition, services for continuing acceptors must be provided--and that group grows larger each year.

The evaluation team believes that the magnitude of the challenge will require the technical and operational resources of Ministries in addition to MOPH and MOI. The current policy framework will need to be expanded to embrace measures beyond the provision of family planning services in order to influence positive demographic change.

Even now, there is an agenda of what have been termed "second generation issues"[1/] which, unless taken up in the remainder of the 5th

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1/ This list includes: services to peripheral areas and recruitment of "hand-core" non acceptors, and, unmarried, sexually active young women and young men; the quality of services; desired method-mix consistent with the age and parity distribution of the MWRA; recruitment strategies appropriate to socio/cultural, demographic, and geographic characteristics; program operations and program management that acknowledge an increasingly more prominent and widespread PHC program; capacity to identify, conduct and use research that is pertinent to important program and service informational needs; capacity to effectively and completely collect census data; and, commodities' needs and how these might be met in Thailand with effective quality control.

Plan period, will persist and perhaps adversely influence 6th Plan target achievement. The team recommends that these issues be studied, and the findings applied during strategy selection discussions of the NFPP.

As a further step, the team recommends policy coordination among Ministries who ought to be concerned with a reduction in population growth because their own development programs are or will be adversely affected if growth is not controlled. These Ministries include, but are not limited to: Interior, Agriculture and Cooperatives, Education, Public Welfare, and Public Health. A possible means for achieving better coordination is to invigorate the National Family Planning Committee through addition of a Sub-Committee or Working Group on Population Policy staffed by policy and planning representatives from the Ministries, and from NESDB and DTECH. It is also recommended that the private sector be represented. The Sub-Committee's (or Group's) main agenda would be to review and analyze current Ministries' policies that have population/family planning implications and to recommend to the NFPC new/revised/modified/additive policies and policy strategies showing the individual and combined effects of these on, and the resources needed to implement them in 6th Plan target achievement.

The evaluation team also recommends that the National Family Planning Committee should request that a review be made of existing legislation that (1) promotes and (2) impedes or will impede improved population policy and strategy implementation.

If the evaluation team's recommendations are favorably considered, the staff work of the Sub-Committee or Working Group on Population Policy can be considerably augmented by timely and coordinated input from the study groups and research investigators who are involved in development of the population policy background paper for the 6th Plan.

II. The Future Role of USAID Beyond PP II

As noted elsewhere in this evaluation, FY 1983 is considered to be the first year of PP II in view of delays in initiating project implementation and spending in 1982. Thus, the five year project extends through FY 1987, which overlaps the first year of the Sixth Development Plan.

The evaluation team concurs fully with the expressed position of the USAID Mission that USAID bilateral assistance and AID-supported intermediary assistance will be needed during the Sixth Plan period for perhaps a more limited population/family planning agenda that will emerge during RTG preparation for the Sixth Plan and USAID experience during the remaining years of PP II. Several of the team's recommendations are addressed to the very necessary preparatory work that must begin in the immediate future in order to establish the demographic bases for setting goals and resource and programmatic requirements within the framework of overall national social and economic development.

After the determination of the 6th Plan population growth rate target, the contraceptive prevalence level that will be required, and specification of internal and external resources necessary to achieve them are made, it is the team's speculation that a unique and significant role for USAID will emerge, although it may be more limited in scope and cost than PP II. Preliminarily and informally, the MOPH has indicated that it will request USAID assistance (50% loan, 50% grant) for sterilization and IUD services, training and equipment, and for support of NGO's and intermediaries. There may also be opportunities for assistance to follow-on activities of initiatives developed in the third and subsequent years of PP II.

The team recognizes that a direct linear relationship between the demand for increased resources and the estimated 30% increase in MWRA (1983-1991) need not necessarily be assumed. Nevertheless, even the full exploitation of yet unused service capacity in the current NFPP system, anticipated increases for family planning in the RTG budget and prospects for additional external assistance may be inadequate to meet the resource requirements occasioned by a demographic challenge of this magnitude. This evaluation suggests that the assumption that a bilateral population project following PP II will be unnecessary is premature.

During deliberations about the level and scope of future assistance to Thailand, the team urges USAID and AID to consider factors in addition to a comparison of Thailand's resource needs with those of developing countries less advanced in reducing their fertility levels. The ongoing monitoring and evaluation that is implicit in USAID involvement in bilateral population assistance here permits gaining insights and experience at a level of program maturity and demographic challenge which AID is certain to encounter elsewhere in its experience of assistance to countries less developed than Thailand.

Recommendation (6.II)

A possible PP III should be weighed against provision of population assistance through EPD II, supplemented by centrally-funded (AID) projects. If it appears that the EPD II priorities of the RTG would not permit a sufficient level of bilateral support for population/family planning, a new project, PP III, might be considered.

The rationale for this recommendation rests in part upon the demographic challenge which Thailand faces in the Sixth Plan period detailed elsewhere in this report and an admittedly intuitive assessment of the realities of political and budgetary prospects for significantly increased commitment of resources by the RTG.

APPENDICES

Appendix A: Persons Contacted

Ministry of Public Health

Honorable Marut Bunnag, Minister

Department of Health

Dr. Somsak Varakamin, Deputy Director, Department of Health
Dr. Pramook Chanthavimol, Chief Medical Officer, Department of Health
Dr. Prasert Suvannus, Chief Medical Officer, Department of Health

Family Health Division

Dr. Morakot Kornkasem, Director
Dr. Suvanee Satayapan, Assistant Director
Dr. Nonglak Bunnag, Medical Officer
Ms. Patama Bhiromrat, Chief, IE&C Section
Mr. Suthon Panyadilok, Chief, Research & Evaluation Section
Mr. Tony Bennett, Advisor, R&E, Columbia University
Ms. Chusie Sujpluem, Chief, Training & Supervision Section
Ms. Thawisomboon Nimnutren, Head, Supervision Sub-section
Ms. Piengchai Sattayut, Head, Training Sub-section
Ms. Penpan Rugsanon, Head, Education Sub-Section
Ms. Nongnuch Boonyakiat, Head, Technical Support Sub-Section

Provincial, District and Tambol Health Personnel

Nongkhai Provincial Office

Dr. Pichaiyo, PCMO
Dr. Tongchai, Deputy PCMO
Ms. Kanchana Sookpanich, Chief of Health Promotion
Ms. Varaporn, Chief of Family Planning Activities
Ms. Satjee, Chief of Publicity

Nongkhai Provincial Hospital

Dr. Supa, Director
Ms. Pojanate, FP Section

Pak Kat District Office

Mr. Kai Phajimtid, DHO
Ms. Ratchinee Kamwanga, Auxiliary Midwife, Nongyong
Ms. Notchiya Ganjana Wongsa, Practical Nurse
Ms. Sompra Tana Kamsaisang, Auxiliary Midwife

Boong Karn District Hospital

Dr. Kriengsak, Director
, Director, Health Promotion Section

Khon Kaen

Ms. Choompol Polnara, Director, School of Auxiliary Midwifery
Dr. Vanida, Assistant Director, MCH Center
Dr. Kawee Chaisiri,
Ms. Chirasak, Chief of Planning

Ratanaburi District Hospital

Dr. Anchalee, Acting Director

Ban Kae Yai Health Center

, Health Assistant

Buriram Provincial Office

Dr. Sujchasit, PCMO
Dr. Prasert, Deputy PCMO

Nang Rong District Hospital

Dr. Samran, Director
Ms. Sanit, Head, Promotion Section

Don Mafai Health Center, Ta Pek Tambol

Ms. Srivilai, Auxiliary Midwife

Pang Nga Provincial Health Office

Dr. Uthai Chindapal, PCMO
Ms. Ratri Nanakorn, Head of Family Planning Activities
Ms. Imjai, Head, Health Promotion
Mr. Anek, Head Planning Section
Ms. Malee Sanitphem, Publicity and Training

Pang Nga Provincial Hospital

Dr. Sanchit, Director

Bang Sai Community Hospital

Khun Chawewan, Nurse
, Medical Director
, Director, V.D. Clinic

Cm Kamol Health Center

Nobbring Health Center

, Assistant AM

Songkla Provincial Health Office

Dr. Prasit Wanichananda, PCMO
Dr. Kanitta Tarawanich, deputy PCMO
Ms. Chittra Promdej, Health Promotion
Ms. Kanitta Nawichananda, Planning and Evaluation
Mr. Phol, Acting Publicity and Training
Mr. Banchong, Nutrition Section

Songkla Provincial Hospital

Dr. Pai Boon, Director
Dr. Praprut, Head of OB/GYN

Songkla P.D.A. Branch Office

Mr. Cheep Kachornwongs, Coordinator
Mr. Suriya Yeekhun
Mr. Thomchit

Haad Yai Regional Medical Center

Dr. Wanno, Acting Director
, OPD Director
, FP Nurse
, Delivery Nurse

Chana District Hospital

Dr. Amorn Sansuk, Director
Mr. Teanchai, DHO
Ms. Prasarnsuwan, Nurse

Fa Ching Health Center

Khun Somlak, Auxiliary Midwife

Pattani Provincial Office

Dr. Trivitya Temahivong, PCMO
Dr. Chalermchai Chumeong, Provincial Hospital
Mr. Prasit Namsai, DHO, Kokpo District

Na-Pradee Health Center, Kok-po District

Ms. Panee Namsai, AM
Ms. Voranuch, AM

Yala

Dr. Anan Suleiman, MCH Center Director
Ms. Chinda Thiraphun, Director, School of Auxiliary Midwifery
Ms. Chairi Jinakul, Family Planning Services Director, MCH Center
Ms. Pannoy Teepasapun, Head, Health Promotion

Pattalung Provincial Office

Dr. Charoen Boonchai, kPCMO
Dr. Sumroun, Deputy PCMO
Mr. Supap, P.D.A. Coordinator

Ban Po Village

VHV ( )
VHC's
Mobile Funds Sterilization Team
Khun Op, PDA distributor

Central Region
Saraburi Province

1. Provincial Health Office	-	Dr. Prakorb Meesomboon, PCMO Dr. Kittisak Klapdee, Technical Assistant Mrs. Sri-u-rai Prakongsaard, Chief, Health Promotion Division
2. Provincial Hospital	-	Dr. Sermsap Damrongrat, OB/GYN
3. District Hospital Nongkae Sub-District Hospital	-	Dr. Soonthorn Sritha Director of the District
4. Health Center Boaloy Sub-District	-	Mr. Thawat Thongbai Health worker at the Boaloy Health Center

Lopburi Province

1. Provincial Heath Office	-	Dr. Prasop Palpai, Technical Assistant
	-	Mr. Chutharat, Chif, Health Promotion Division
	-	Dr. Panya Choenvongse, PCMO
2. District Hospital (Chaibadan District)	-	Dr. Jesda
3. Health Center Kongthanu Sub-District	-	Mr. Krasae Midwife

Cholburi Province

1.	Provincial Health Office	- Dr. Amnuay Uthangkorn, PCMO
2.	Cholburi Provincial Hospital	- Dr. Kanchana Nimannit, Acting Director of the Hospital - Dr. Kanchana Kusalasai, OB/GYN Dept.
3.	Panasnikom District Hospital	- Dr. Panya Kiratipatayakorn - Mrs. Krisni Sananthong, Chief, Health Promotion Division
4.	District Health Office Panasnikom District	- Mr. Prakorb Siripon, District Health Officer
5.	Banchang Health Center	- Mrs. Panjit Karnchanawat

Northern Region
Chiangmai Province

1.	Provincial Health Officer	- Dr. Mongkol Na Songkhla, Deputy PCMO
2.	MCH Center, Region 5	- Dr. Pratarn, Director MCH Center Region 5 - Dr. Suwat, Director of MCH Hospital
3.	McCormick Hospital	- Dr. Boonchom, Director of the Hospital - Dr. Mc. Daniel - Mr. Paul Lewis
4.	Banpung Health Center	- Mrs. Somboon, Midwife
5.	Provincial Hospital	- Dr. Sunandha, OB/GYN Department

Phitsanuloke Province

1.	Provincial Health Office	- Dr. Payao, Deputy PCMO - Mrs. Duangjan, Health Promotion Division
2.	Phitsanuloke Regional and Provincial Hospital	- Dr. Ratana, OB/GYN Department
3.	Watboat District Hospital	- Dr. Wajarin
4.	Health Center	- Mrs. Sakorn, Midwife

Petchaboon Province

1.	Provincial Health Office	- Mrs. Samran, Chief, Health Promotion Division
2.	Provincial Hospital	- Dr. Bongkot Jiramethakorn, Director of the provincial hospital
3.	Crown Prince Lomkao District Hospital	- Dr. Jirasak Mrs. Supan Chindangeon, Health Promotion Division
4.	Nasarn Health Center	- Mrs. Srisuda, midwife
5.	Village Health Volunteer	- Mr. Young Keoyam

Ministry of Interior

Mr. Suchan Pongnud, Deputy Chief of Policy and Planning

Songkla, Ministry of Interior

Mr. Pranet To-trakul, Deputy Governor

Pattani, Ministry of Interior

Mr. Pan Chantraparn, Deputy Governor

Ministry of Education, Department of Non-Formal Education

Dr. Kowit Worapipat, Director General
Dr. Somprasong

DTEC

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UNICEF

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Ms. Wilda Campbell, Regional Representative
Mr. Shyam Lama, Program Officer

AVS, International Project

Mr. Russell Vogel, Director, Asia Office

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Nibhon Dibavalya, Deputy Secretary General

PDA

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Dr. Boonlert
Members of Board and Staff of ASIN

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Mr. Edward Muniak, Asia Bureau
Mr. Bill Nance, Thailand Desk Officer

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Appendix C

Country Description

A. Overview

Thailand's land mass is 514,000 square kilometers located on the Indo-Chinese peninsula. Topographical characteristics divide the country into 4 regions: the North, the Northeast, Central, and South.

. The country is heavily rural (over 80%) and agrarian (77%). The mid-year 1984 total population is estimated to be 50 million, of whom:

. 95% are Buddhists, and 4% are Muslim;

. 82% are literate;

. 75% live above the poverty line;

. most speak Thai, but there are also ethnic dialects and language reflecting Muslim, hill tribe, Khmer, Lao and other minority representation in the population;

. 25% live in dwellings with electricity;

. 22% have access to safe water;

. 15% are under 5 years of age, 42% are under 15 years of age and 3% are aged 65 or older;

. over 60% of the MWRA practice contraception.

Regional desparities in resources, population size, and other characteristics are evident: the Northeast, the poorest region (with 50% of the poor living there), contains 35%, the largest proportion, of the Kingdom's population. The South contains 12% of the population and in 4 of it 14 provinces is 75% Muslim.

The estimated crude birth rate in 1984 is 21 based on an estimated 1.05 million live births. The crude death rate is estimated to be 7 per thousand population. These data contribute to an estimated 1.6% growth rate at the present time.

B. Government Structure and Political Subdivisions

Thailand is a constitutional monarchy. Until recently, most of the political authority was centralized and government plans and budgets were developed and programs administered through the Office of the Prime Minister. At present, attempts are being made to decentralize responsibility for development planning and resource allocation decisions to villages which are the lowest level of political organization (see Figure 1.1 for a representation of this decentralized process).

Political Subdivisions

Level of Political Organization	Number of	Population Size	Means of Selecting Administrators
Province (Changwat)	73	0.5-1.5 million	Governor appointed by Ministry of Interior
District (Amphoe)	700		District Officers appointed by Ministry of Interior
Sub-district (Tambol)	5,777	5,000	Kamnan-elected by village headmen
Village	53,163	200-5,000 ($\bar{x}$ = 750)	Headmen-elected by village population

Source: World Health organization (1983) Thailand Country Presentation, WHO Southeast Asian Regional Conference on Primary Health Care, Pyongyang, DPR Korea, 7-16 September, 1983, p. 2 (mimeo).

RECOMMENDATIONS

Appendix D

Collection of Recommendations

Recommendations (2.IV)

A. Re. JICA

1. Since the PHC Training Centers will be training AM's, VHV's, and VHC's in PHC topics including family planning and MCH, pertinent aspects of the MIS, the new targeting approach, and a team approach to information/education/communication about family planning and access to services should be pursued for inclusion in the one-week course.

2. If there are research topics of interest to MOPH that could be developed, conducted and documented through the PHC project, there is good potential for village-based, micro-level studies that could involve provincial, district and tambol-level personnel in design, implementation, analysis, reporting and application. Suggested areas of research include: selected program approaches to non-users or family planning could be field-tested and evaluated, IE&C materials for the village-level could be pretested, and tested for applicability to family planning method acceptance; appropriate family planning method selection according to the age and parity of the client might be promoted and acceptance from the provider and user points of view studied; family planning within PHC could be studied from the point of view of perceived benefit (by villagers) as a health service, whether family planning loses or gains prominence within an integrated system, and how family planning can best be linked to nutrition, immunization, and diarrheal disease control programs. Since monitoring of PHC components should include family planning acceptance and continuation, a simple monitoring system could be designed, piloted and evaluated in one or two of the model demonstration areas.

3. AM IUD kits and midwifery kits may be available through JICA or JOICFP. USAID may be advised to investigate the proposed kit contribution of the Japanese during the period 1984-86 before procuring additional kits. A related opportunity is review with JICA or JOICFP and FHD of the proposed distribution (priority service sites, campaign areas) of the kits purchased through Japanese or USAID funds.

B. Re. UNFPA

1. Examine the potential for and possibility of building on the UNFPA supported work with hill tribes: review the lessons learned, the needs that have been identified and the approaches that have been successful, and consider possible use of the UNFPA-developed hill tribe team to assist in design of a carefully-phased project, and to manage and technically support a hill tribe project in family planning at provincial and local levels.

C. Re. UNICEF

1. Support FHD involvement with PCMO's and DHO's in promotion of family planning within Social Preparation training, and in the development and provision of family planning educational and informational materials within the literacy, health and women's development components of the village-level basic services program.

2. Pilot and evaluate the effectiveness and use of a village-level monitoring chart on family planning using mini-survey data collected by AM's and VHV's (available in DHO's offices), and targets established by Village Committees.

3. The USAID/H/P/N Officer should meet with the UNICEF Programme Officer, UNFPA Population Advisor, FHD, and the Rural Health Division to discuss possible collaboration on implementing the family spacing components of GOBIFF,* and on areas of mutual research and evaluation interests concerning family planning within the village-level PHC context.

RECOMMENDATION (2.V)

The evaluation team concurs fully with the NFPP's expressed intent to encourage expanded involvement of the private sector in the pursuit of Thailand's demographic goals. We therefore strongly recommend that support of the private sector activities be continued both in the reprogramming of remaining PP II funds and by encouraging the supoort by AID/W of centrally funded intermediaries whose projects in Thailand are supportive of NFPP goals.

Recommendations (3)

1. Study permanent vs. temporary method use and preference among women 30 years old and above as a basis for formulating strategies to increase permanent method use in this age group.

2. Study/confirm team findings on factors contributing to continuation rates such as: switching, campaign pressure, temporary absence of husbands, aging child-spacers who discontinue temporary methods for a permanent method, and other user behaviors.

3. Consider a scientifically justifiable rate of 1.2% as the growth rate target for the 6th Plan.

4. Study and establish a justified ratio of permanent to temporary methods and the optimal distribution of temporary methods among new acceptors for the 6th Plan period.

5. Maintain awareness of the large cohort coming into the reproductive age group in planning for services and method-mix during the 6th Plan period.

6. Document actual costs for a new and a continuing acceptor for each temporary method and actual cost for providing a permanent method/per acceptor. These per unit costs need to be reflected against desired method mix and method prevalence to achieve growth rates of 1.2 and 1.0%, and contraceptive prevalence rates of 70, 75, and 80%.

Recommendation (4.I.A)

A special MOPH/MOI technical level working group be established for the purpose of joint planning and coordination of policy implementation matters including centrally initiated and/or directed development projects impacting upon the field service delivery system land the central provision of technical and administrative support for the field and that regularly scheduled (and ad hoc) meetings be held throughout the year to ensure close collaboration and coordination between the two Ministries.

2. MOPH in collaboration with the private sector should provide provincial-level presentations to development Ministries' personnel on the contribtion of family planning to demographic change, and on other elements that affect population growth.

Recommendations (4.I.B)

1. The team has recommended that a management review be made. It is hoped that the effects of seemingly vertical sub-project management will be studied, and that the process for actively sharing and using experience and data across projects, sub-projects and sections will be examined.

2. The format of FHD's annual implementation plans for PP II require revision in order to show more clearly: the PP II EOP objective that is being addressed by each pertinent sub-projects description and the means for coordinating these discrete pieces; the achievement toward the EOP objective that has already been made, and, any departures from or proposed changes to PP II that are indicated in the proposed implementation plan. This conceptual change in format together with the proposed administrative format changes (to be described in Part 5) should lead to greater ease in monitoring and annual internal evaluation.

Recommendations (4.I.C.)

1. The NFPP should encourage greater community participation in the program planning and target setting process, with emphasis on the training and supervision of fieldworkers in the use of household/family and village data.

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*A UNICEF-coined acronym that represents the major UNICEF program emphases: growth monitoring, oral rehydration, breast-feeding, immunization, family spacing, female education.

2. The NFPP should consider shifting to the use of contraceptive prevalence rates instead of only acceptor rates as performance targets in the future.

3. Mini-management studies of program management policies, procedures and practices at provincial, district and tambol levels of the service delivery system be funded under the PP II Project and conducted by qualified public sector management analysts, organization and methods specialists or industrial engineers, to identify and document the higher quality management practices that have evolved among the many "natural experiments" in management practice occurring throughout Thailand, and that such studies produce management policy and procedure guidelines in the form of a reference manual for use in management training and supervision, and for the purpose of upgrading management practices among those districts and provinces where such practices remain weak.

4. A procedures reference manual (or sections of a PHC procedures manual) for planning the use of FP resources and the provision of FP services at the district level and below, should be developed, field tested, published, and used in the future for orientation, training and supervisory quality control purposes; the development of this manual should be a joint project of MOPH and MOI, and placed under the direction of qualified provincial level officials.

5. Investigation should be made of the most adequate, efficient, effective and affordable staffing pattern of health centers, particularly in the lowest performance districts.

Recommendations (4.I.D)

1. A thorough review be conducted as soon as possible of the NIDA MIS design proposal for FHD including some limited testing of it using real work activity data in a program management situation, to assess relevance and utility of the proposed system before wide scale introduction occurs.

2. Technical assistance be provided to the NFPP, either through the PP II Project or through centrally funded AID contracts, to assist the NFPP and FHD in developing a comprehensive strategy and long-term development plan for a comprehensive nation-wide MIS to adequately serve the future needs of the NFPP; that such plan include detailed time-line and resource requirements.

3. At least 4 pilot projects be funded under the PP II Project to design and test hierarchal decentralized approaches to FP information system development including:

   a. Utilization of a village and tambol "bottom up" approach to data gathering and reporting, which includes a re-orientation from counting new and old acceptors, to monitoring continuation and

prevalence, and; utilization of data at each organizational level of service delivery by supervisors and managers for planning, target setting managing and evaluating FP services.

b. A pilot project be conducted in each of the following diverse situations to properly test and assess the appropriateness and practically of a "bottom up" approach to information system development:

1) A high performance district in a high performance province.

2) A high performance district in a low performance province.

3) A low performance district in a high performance province.

4) A low performance district in a low performance province.

4. Technical assistance, training and other resources be given to the Planning and Evaluation Sections of PCMO offices to upgrade capability in data processing, analysis and use of data to improve and further develop the information system needed for planning, management and evaluation of FP service delivery.

5. A sub-section for data processing be formally organized and started within the existing Research and Evaluation Section of FHD to provide for: improved management and accountability over central data processing for NFPP; additional resources as needed and appropriate specialization; quality control and oversight for NFPP MIS development.

6. The R/E Advisor's tour of duty be extended through the remaining life of the PP II Project, to assist with the design and management of the pilot projects recommended above, and to implement a long-term development strategy for a comprehensive MIS and a program evaluation system to serve NFPP needs.

Recommendations (4.I.F)

1. The following recent recommendations of the CDC Consultants be implemented by FHD at the earliest possible time in order not to lose the development momentum now established for the commodity management system:

a. A ranking official should be given overall responsibility and accountabilty for operation of the entire logistics system. Logically, this individual would have training in business administration with experience in logistics and distribution systems.

b. An individual should be given clear responsibility for implementation of the computerized logistics monitoring system.

c. Following the proposed tentative implementation schedule described above, USAID should schedule meetings at milestone dates to assess the progress in implementation, modify the schedule as needed, and schedule needed additional technical assistance from CDC and other outside consultants.

d. A plan for making provincial level staff aware of the uses of output data should be developed. This could be accomplished through (a) formalized training, (b) presentations at meetings, (e) on-site training, and/or on-the-job training through mailed critiques of monthly outputs.

2. An additional $16,000 be earmarked for further development of the Commodity Management System during the 3rd Project Year, which would increase the total Project Plan amount needed for this component by $14,422, from $56,000 to $81,422.

3. CDC consultants should continue to be used in further design of the commodity management system, including the application of economic order quantity methods in establishing guidelines for procurement scheduling and supply re-distribution among the various echelons of the national system. They should also assist in preparation of a procedures reference manual for use in training and supervisory quality control of supply management staff at all appropriate levels of the commodity management system.

4. FHD should follow-up its December 1983 directive to PCMO's on the availability and use of the approved 3 formulations (and 4 brands) of oral contraceptives, by preparing and distributing the proposed manual of instructions on the use of the various formulations (and brands), and by monitoring the commodity supply system to ensure the storage availability and use of the different formulations (and brands) at all appropriate service outlets and storage points.

5. A review be conducted of present and future needs for medical kits (IUD and sterilization) and efforts be made to initiate additional procurement actions during the 2nd Project Year if necessary to ensure full availability as early as possible in the 3rd Project Year. Consideration should be given to the direct assignment of kits to personnel at the time they are trained to use them, rather than the allocation of kits to Provincial Health Offices for use by personnel at lower levels of the system.

6. Funds be reallocated to increase the $686,000 of PP II Project Loan funds previously budgeted for procurement of medical kits for use during the remainder of the 2nd Project Year and during the 3rd Project Year to increase kit procurement to a level more commensurate with need. As suggested earlier, USAID may wish to confer with JICA and FHD on this matter before committing funds.

7. The NFPP, either through the PP II Project or other donors, or both, provide additional transportation and IEC equipment support to district and health center workers; and, make contribution to the RTG's revolving fund to support the purchase and provision of additional motorcycles and other types of transport vehicles to district, and health center workers involved in FP services, and which are subsequently purchased by the workers through pay check deductions which replenish the revolving fund.

Recommendations (4.II.B)

A. Management of Service Delivery

1. As a goal, efforts should be continued in promoting more adequate staffing of tambol health centers to achieve a minimum of 2 female health workers for every health center at the earliest possible time, particularly in the lowest performance districts, but the financial and staffing implications are considerable and should be studied as should the existing utilization of health centers.

2. Greater utilization be made of district hospital nursing staff in the technical supervision of FP and MCH services delivered by tambol health center staff and a more formal matrix supervisory structure should be established at the district level to accommodate joint MOI administrative and MOPH technical supervisory responsibility for delivery of FP and MCH services.

3. Mini-management studies of program management policies, procedures and practices at provincial, district and tambol levels of the service delivery system be funded under the PP II Project and conducted by qualified public sector management analysts, organization and methods specialists or industrial engineers, to identify and document the higher quality management practices that have evolved among the many "natural experiments" in management practice occurring throughout Thailand. Such studies should produce management policy and procedure guidelines in the form of a reference manual for use in management training and supervision, and for the purpose of upgrading management practices among those districts and provinces where such practices remain weak.

4. The NFPP, either through the PP II Project or other donors, or both, should provide additional transportation and IEC equipment support to district and health center workers; and make contribution to the RTG's revolving fund to support the purchase and provision of additional motorcycles and other types of transport vehicles to district and health center workers involved in FP services, and which are subsequently purchased by the workers through pay check deductions which replenish the revolving fund.

Recommendations (4.II.B)

B. Temporary Methods

1. Greater attention should be paid to the quality of oral contraceptive service in general, and to the training and supervision of VHV's and other village level distributors in screening of clients and instructing in oral contraceptive practice.

2. Norplant, when available as a commodity, should be added to the method-mix. High priority is accorded commodity purchase through USAID loan funds.

3. Investigation should be made of the perceptions and attitudes of service providers that affect uptake and continuation of services by ethnic minorities. These findings should be disseminated and discussed within FHD, and if negative should be acted on.

C. Permanent Methods

1. Replication of the successful mobile laparoscopy service in Pattalung should be considered in other areas where a suitably trained physician is available and the demand for female sterlization justifies its provision at the village level.

2. In addition to procurement of adequate numbers of VSC kits, special attention should be given to the reliability and source of procurement of instruments in order to assure high quality and safety in VSC services.

3. Training and equipment for laparoscopic VSC should be provided to those provincial and regional hospitals which have physicians with the requisite experience and training in obstetrics and gynecology.

4. The MOPH should explore the potential of NGO's involved in VSC service delivery for a larger role in the training of physicians in surgical contraception.

5. NGO increased participation in services and training could be guided by FHD's information on VSC service and training gaps. Likewise, NGO's training outputs should be documented and forwarded to FHD as to location and numbers of trainees to assure complementarity with FHD's monitoring of training and service projections.

6. Variability in the effectiveness of the intensified Vasectomy Promotion Campaign in different provinces should be carefully evaluated to ascertain the relationship of client resistance and the effectiveness and cost of the various IE&C promotion strategies on program performance.

Recommendations (4.III)

1. Immediate

a. The FHD should heavily promote implementation of the MOPH policy permitting trained AM's and NM's to insert IUD's and administer DMPA injections.

b. IUD kits should be provided to every trained AM.

1. A review should be conducted of present and future needs for kits (IUD and sterilization) and efforts be made to initiate additional procurement actions during the 2nd Project Year if necessary to ensure full availability as early as possible in the 3rd Project Year; and consideration should be given to the direct assignment of kits to personnel at the time they are trained rather than allocating kits to Provincial Health Offices for use by personnel at lower levels of the system.

2. AM IUD kits and midwifery kits may be available through JICA or JOICFP. USAID may be advised to investigate the proposed kit contribution of the Japanese during the period, 1984-86, before procuring additional kits. A related opportunity is review with JICA or JOICFP and FHD of the proposed distribution (priority service sites, campaign areas) of the kits purchased through Japanese or USAID funds.

c. Provincial-level update training on insertion of the multiload IUD and removal of IUD's should be scheduled for AM's who received IUD insertion training prior to 1983.

d. Provincial-level two-day DMPA injection demonstrations should be scheduled for AM's.

e. Review should be made of the AM basic curriculum for potential of including IUD insertion and DMPA training.

f. A needs assessment of teaching and training materials, aids and models should be conducted in all Schools of Midwifery and MCH Centers. USAID loan funds should be made available for purchase of items that are directly related to strengthening of the family planning teaching and training programs in the Schools and Centers if Japanese funds are not available for this purpose. Similarly, transportation needs for AM students and for AMs and NMs who are trainees should be made to facilitate full use of practica sites.

g. An inventory of AM's and AM's technical supervisors' transportation needs should be made and funds should be sought to support purchase of motorcycles for AM's, and vehicles for technical supervision, perhaps through JICA.

h. The instructional design/visuals preparation needs of the Training Supervision and Education Section should be examined by the IE&C program manager, and USAID funds should be made available to support a sub-contract for development and preparation of necessary materials if that is the recommended option for meeting existing and projected needs.

i. Health Centers with an insufficient supply of family planning client education materials should be stocked with the most recently developed posters, brochures, pamphlets and flip charts.

2. Over the Next Year

a. Conduct the following and if technical assistance is necessary, USAID should seek to provide it (through intermediaries) in:

1. Provincial-level manpower needs assessments and review and/or development of training plans in "lagging provinces" first, and other provinces, subsequently. These should be updated on an annual basis, thereafter.

2. An efficiency study to determine whether Health Centers with trained AM's working under supportive provincial family planning policies are being used at optimal levels and, where appropriate, identification of barriers that impede optimal use.

3. Development of a comprehensive and systematic training evaluation and monitoring system that is keyed to provincial-level manpower needs assessment and training plans and to training impacts on service availability.

4. Review of the use of MCH regional training centers for health center team training and if feasible, design and piloting of a curriculum emphasizing a team approach to family planning service delivery.

5. Establishment of several pilot areas for a peer review supervisory system, and comparison of AM performance and achievement in those areas with AM performance and achievement in similar service areas using a traditional supervisory system.

6. Conduct an AM task analysis that can be used during development of comprehensive training plans.

b. Investigate the potential for family planning training of practical nurses assigned to health centers in provinces that have demonstrated capability for IUD insertion training.

c. Review the proposed initiative to train 80 AMs in vasectomy: are they the appropriate, acceptable source of service? does the demand for vasectomy indicate that AMs should be trained? will the legal restriction be lifted on the basis of one study of 20 AMs?

d. Since the PHC Regional Training Centers will be training AM's, VHV's, and VHC's in PHC topics including FP/MCH, aspects of the MIS, the new targeting approach, and a team approach to provision of information/education/communication about family planning and access to services should be pursued for inclusion in the one-week course.

e. Greater utilization be made of district hospital nursing staff in the technical supervision of FP and MCH services delivered by tambol health center staff.

f. A more formal matrix supervisory structure be established at the district level to accommodate joint MOI administrative and MOPH technical supervisory responsibility for delivery of FP and MCH services.

g. Participant training opportunities should be identified for provincial-level staffs, and -- if appropriate -- for staff of the T/S/E Section in development of training evaluation systems, and management of training systems.

D. Recommended IE&C activities in support of the achievement of these objectives are as follows (by objective):

1. Two activities are recommended for immediate implementation: organization of joint observation visits to provinces with MOI-sponsored campaigns with OPP/MOI staff, and documentation of campaign experience in five or six provinces in summary form for circulation to Governors and PCMO's. Further, support inthe form of supplementary funds for provincial campaigns initiated by Governors should be channelled through the FHD to PCMO's. The preparation of a handbook for MOI officials on population and development issues and basic demography is also strongly recommended.

2. and 3. Recommended activities include: the revision of all materials on temporary methods, except the IUD, to provide up-to-date problem-oriented information; strengthening of the counselling function at the Health Center level by the preparation and distribution of a handbook for health personnel on problems of temporary methods, screening procedures to identify potential switchers to permanent methods, and the child-spacing concept; revision of materials on permanent methods and the IUD, all of which have been recently revised, in three years' time; a contingency for the possible promotion of Norplant.

4. The development of an overall strategy for empahsis on the Northeast is recommended to the FHD. IE&C aspects of this emphasis would include additional funds for MOI campaigns in the Northeast, technical assistance for the planning and implementation of campaigns, development of radio spots in the Northeastern dialect, and television spots that support the strategy to be developed.

5. The special emphasis on the South has two components: four Thai Muslim provinces and four low prevalence Thai Buddhist provinces. The Thai Muslim provinces are the subject of a comprehensive project which has already been funded by UNFPA. The plan calls merely for implementation of that project. For the Thai Buddhist provinces, increasing assistance from FHD staff for the implementation of district level campaigns is recommended. These campaigns will emphasize female sterlization and injectables.

6. All existing MCH materials will be reviewed and revised for inclusion of the child-spacing concept.

7. To begin to reach the large pre-marriage age group that will become the young married couples of the Sixth Plan period, a handbook on family life will be prepared for adolescents that includes the basics of human reproduction and contraception and promotes the two-child family and delaying the age of marriage.

8. The two-child family concept will be integrated into all media and materials under revision and recommended for promotion by the MOI.

9. Emphasis will be placed on developing working relationships with the Departments of Labour and Public Welfare which have factory workers, slum dwellers, and hilltribes as their target groups.

10. IE&C activities for the hilltribes are currently being discussed in the context of a USAID-supported project for the hilltribes. The nature of such activities has not been clearly defined as yet, but funds will be made available for special information programs for hilltribes through this proposed project.

11. The IPR section will assist the FHD Training Section to facilitate the commercial production of training aids in strengthen training programs for health personnel.

The financial implications of this list of activities for donor assistance are summarized in Annex 4.1. Requests for assistance from foreign donors are for prototype development or materials revision by commercial sources, purchase of broadcast time, suport for the new initiatives of the MOI, or the hilltribes. The two former items are difficult to fund within the context of existing Government regulations and the two later items are high priority Government activities.

In addition to activities carried out by the NFPP directly, support for private and voluntary organizations is recommended: namely, continued and increased supoort for the successful program of vasectomy promotion and service delivery by PDA; support for PPAT to develop further its program of in-school family life education; and support for TAVS to participate in provincial MOI campaigns.

Recommendations (4.IV)

Recommendations for USAID Support to Other Organizations

1. The Population and Development Association has had notable success in the promotion of vasectomies. These successful efforts should be encouraged. As an aspect of USAID's present support for NFPP vasectomy campaigns, funds could be allocated to PDA for vasectomy IEC and service delivery.

2. The Planned Parenthood Association of Thailand is in the vanguard on sex education for adolescents. This initiative could be extended and expanded to a program of in-school family life education. USAID support for the development of such a program is recommended.

3. The Thai Association for Voluntary Sterilization can lend some publicity and service delivery support to sterilization activities that are part of MOI campaigns. USAID funding for such support is recommended.

RECOMMENDATIONS (4.V.1 and 3)

1. During the remaining life of the PP II Project, USAID funds not be used to support the conduct of topical research studies aimed at questions of effectiveness only.

2. The number of desired research studies under the PP II Project should be reduced and focused more on questions of efficiency and cost-effectiveness.

3. The process for engendering and reviewing research proposals should be lengthier and more detailed in recognition of the time-consuming tasks that are involved.

4. The NFPP should set a policy agenda for research and specify the areas of research that are of high priority.

   a. Research ideas should be sought from FHD Sections (based on their needs) and from provincial-level staff, as well as from other sources; and

   b. The R/E Section, especially, should be used as a resource during the construction of the research agenda.

5. The Research Working Group's role, its decision-making boundaries, and its placement on the organizational chart should be clarified.

6. Consideration should be given to the addition of two PCMO's to the Group.

7. Technical assistance in proposal development and research from Thai consultants' methods should be provided to interested and pertinent peripheral university units and sections of provincial-level offices or other related entities in order to widen and deepen the pool of research capability, and to obtain a greater number of sound proposals from provinces outside Bangkok. At a minimum, this technical assistance should be given at the work-site of the prospective research investigator, and could be preceded by a workshop to present the annual research agenda, introduce the required protocol/forms, and give practice in translating operational problems and issues into research questions.

8. FHD capability to document, store, retrieve, transmit and/or teach the knowledge derived from research findings should be strengthened. PCMO's should be requested to include in their training and staff meeting activities essential information disseminated by the FHD on research findings; and when appropriate, the Training Section in collaboration with the Research and Evaluation Section of FHD should prepare teaching aids for use by provinces and lower organizational levels in transmitting the results of research studies.

9. The FHD Research and Evaluation Section should continue to be strengthened through additional resources including additional authorized permanent positions and further in-service training of its staff to develop the competence needed to shift its orientation from topical research and evaluation to the design, implementation, technical backstopping and management of a comprehensive national program evaluation system serving all organization levels of the NFPP, from the village level upwards.

10. Standardized procedures for conducting on-going FP program evaluation at all organizational levels of the NFPP should be prepared, published and distributed for use in training and supervisory quality control. The production of these materials should be funded under PP II.

11. If there are research topics of interest to the MOPH that could be developed, conducted and documented through the Regional PHC Training Centers there is good potential for village-based, micro-level studies that could involve provincial, district and tambol-level personnel in design, implementation and analysis, reporting and application. Suggested studies include: selected program approaches to non-users of family planning could be field-tested and evaluated; IE&C materials for the village-level

could be pretested, and tested for relevance to family planning method acceptance; appropriate method selection according to age and parity of the client might be promoted and acceptance from the provider and user points of view studied; family planning within PHC could be studied; from the point of view of perceived benefit (by villagers) as a health service; whether family planning loses or gains prominence within an integrated system; and how family planning can best be linked to nutrition, immunization, and diarrheal disease control programs. Since monitoring of PHC components should include family planning acceptance and continuation, a simple monitoring system could be designed, piloted and evaluated in one or two PHC model demonstration areas Staffing patterns and cost issues might also be studied.

12. The R/E advisor's tour of duty should be extended through the remaining life of PP II to assist with the design and management of pilot projects and implementing a long-term development strategy for a comprehensive MIS and a program evaluation system to serve NFPP needs.

13. The R/E staff and senior staff in FHD should review the range of findings across all studies to identify linkages among findings, and use service and evaluation data to amplify/elaborate on, confirm or raise questions about study findings. This review may also serve to identify needs for further research.

14. Consideration should be given to providing funds to the Population Council for the purpose of conducting key research studies to support future NFPP policy formulation aimed at "second generation" issues.

RECOMMENDATIONS (4.V.4)

1. The utilization of NIDA to provide technical assistance to FHD in applying and using OR techniques, and in training of FHD staff in application of OR techniques, should be discontinued upon completion of the existing sub-contract which is already funded.

2. Population Council, after translating its excellent and practical Operations Research training manual into Thai, should provide a series of one-week workshops for FHD and provincial level officials to train them in basic OR knowledge and skills sufficient to enable them to design and conduct unsophisticated OR studies. Remaining uncommitted funds for OR application should be made available for this purpose.

3. Hereafter a broader definition of "Operations Research" should be used in order not to exclude simple, more practical and cost-effective research methods (as contrasted to classical OR mathematical modeling) which often have wider application and greater utility in solving problems involving the improvement of

service delivery efficiencies and cost-effectiveness, e.g. management analysis, organization and methods techniques, and industrial engineering.

Recommendation for Evaluation of IE&C Messages

1. By adding to regional CPS (4) or through conducting special message studies, the impact of targeted IE&C messages should be examined, by age cohort, especially on the topics of: the small family norm; child spacing as a health benefit; the acceptability of sterilization at the completion of desired family size; and, which sterilization (vasectomy or T.L.) method is more acceptable. Men's attitudes toward vasectomy as acceptable for themselves and as a method to stabilize desired family size should also be examined.

Recommendations (5.III)

1. Project components, activities and sub-activities under both grant and loan categories should be systematically code numbered for easy reference and control purposes, and that identical code numbers should be retained from year to year to provide a reliable audit trail for project implementation monitoring and financial management that will relate project activities back to the original Project Paper, subsequent amendments, if any, to that paper, and to annual project implementation plans;

2. Further improvements in content and format of the Annual Project Implementation Plan should be introduced with the 3rd Project Year, to ease the burden of subsequent year plan preparation, and to facilitate monitoring and coordination of project implementation activities. (See Annexes 5.1 and 5.2 for proposed formats.)

3. Written quarterly progress reports should be routinely prepared by persons assigned responsibility for implementation of various project activities and sub-activities for use by senior officials in monitoring implementation progress; and the reports should be standardized in a format compatible with the detailed Annual Project Implementation Plan to facilitate review and analysis of implementation progress. (See Annexes 5.3 and 5.4 for proposed formats for quarterly reports.)

4. Quarterly project financial reports prepared by USAID should be re-formated according to the code numbering system and implementation planning formats recommended above, in order that monitoring of actual financial performance against planned financial performance can be simplified for both USAID and RTG officials, at considerable savings in staff time and resources.

5. Regularly scheduled project implementation progress review meetings should be held on a quarterly basis for the purpose of reviewing written quarterly reports, sharing information among key

implementation officials, senior administrators and donor representatives, and resolving issues and problems on a timely basis.

6. All technical advisors/consultants serving the PP II Project however employed should be required to prepare and submit to FHD and USAID a monthly (or trip) technical assistance report using the following format:

   (1) Past month (or trip) technical assistance activities and output.

   (2) Delays in Project Implementation (if any).

   (3) Other Issues/Problems in Project Implementation.

   (4) Next month (or trip) proposed technical assistance activities and output.

Recommendation (5.V)

1. FHD and USAID reprogramming of PP II grant and loan funds should reflect the high priority accorded by the team to hill tribes and the Northeast.

Recommendation (6.II)

A possible PP III should be weighed against provision of population assistance through EPD II, supplemented by centrally-funded (AID) projects. If it appears that the EPD II priorities of the RTG would not permit a sufficient level of bilateral support for population/family planning, a new project, PP III, might be considered.

The rationale for this recommendation rests in part upon the demographic challenge which Thailand faces in the Sixth Plan period detailed elsewhere in this report and an admittedly intuitive assessment of the realities of political and budgetary prospects for significantly increased commitment of resources by the RTG.

Appendix E

Policy Guidance for
Family Planning Promotion and Support Project
of the Ministry of the Interior

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1. Principle and Rationale

The Government has recognized the importance of the rapid population growth problem as being a serious obstacle in the national development and included the population planning in the national economic and social development plan since the third one. In 1976 family planning work was included in the National Family Planning Program under responsibility of the Ministry of Public Health. The implementation of the program has been found successful in accordance with the targets set. However, the need for family planning to slow down the population growth still exists and the work must be carried out in an accelerated manner in every locality, because the reduced population gorwth rate is not commensurate with the national economic and social growth.

Therefore, the Ministry of the Interior has established the family planning work as part of the Ministry's policy which reads "Promote and support to have family planning widely practiced so that rural people will have families of appropriate sizes which is another way of lessening the poverty problem."

The MOI family planning promotion is intended to increase the effectiveness of planned parenthood in terms of number of acceptors and contraception of high efficiency so as to enable rural people to achieve the proper size of family and to make it lead to the real ability of boiling down the poverty problem.

2. Objectives

2.1 To promote and support the family planning operation so that it is in harmony with the population policy under the 5th National Economic an Social Development Plan (1982-1986) in the light of reducing the population growth rate to 1.5 percent when the plan comes to an end in 1986.

2.2 To promote and support the family planning service operations of the Ministry of Public Health and the private sector organizations in terms of increasing the number of service acceptors thoroughly in every area.

2.3 To encourage and support rural people to have knowledge and understanding which will lead to family plannning practice, inclusive of the development of quality of life.

2.4 To encourage and support people to be fond of having only 2 children.

3. Roles and Duties of Agencies under MOI

To achieve the objectives of family planning operation the roles of agencies under the Ministry of the Interior may be divided into 2 levels as follows:

3.1 Central Level: The agencies are charged with duties to establish policies, principles and broad operational guidelines and to provide information support for the effectiveness of planning. Agencies directly concerned are: Office of the Permanent Secretary of the Interior, Department of Local Administration, Department of Community Development, Office of Accelerated Rural Development, Department of Public Welfare, Department of Police (Border Patrol Police) and Office of Policy and Planning. Agencies indirectly concerned are other departments and state enterprises under the direction of the Ministry of Interior.

3.2 Provincial Level: Provincial governors and district officers play direct roles in being responsible for improvement of the program at the provincial and district levels, mobilization of all forces and funds from both the public sector and private sector for use in motivating and seeking persons to accept contraceptive services according to the target, assignment of health personnel to deliver services in remote areas and specific rural zones as well as mobile service units with definite target, and direction to have the operation carried out in accordance with the program and target at the district, tambon and village levels in a thorough manner.

4. Target Group of Population

Fecund women (aged 15-44 years) and husbands.

5. Area of Operation

The Family Planning Promotion and Support Project will be implemented all over the country with area divided into 3 categories:

5.1 General rural area

5.2 Specific rural area comprising:

5.2.1 Population groups dwelling in remote rural area.

5.2.2 Population group having specific characteristics, different in respect to belief, i.e., Thai Muslim group in southern border provinces.

5.2.3 Population group having different way of life, i.e., hill tribal people.

5.3 Urban and slum area

6. Guidelines for Operation

1. Guidelines for Operation in General Rural Area

Family planning is determined to be an important part of the rural development with operating plan formulated in harmony and integration with the economic and social development to suit conditions of the area.

1.1 Survey to collect data in target areas by family in order to learn economic status, number of children, opinion and needs for family planning so that they can be used in setting target in the plan formulation.

1.1.1 Hold meeting of related persons of all levels.

1.1.2 Clearly designate target areas where the project will be launched.

1.1.3 Appoint operating committees at the provincial, district and subdistrict levels.

1.1.4 Determine duration and target of the operation at every level in a definite manner.

1.1.5 Determine duration of monitoring and evaluation.

1.2 Give basic knowledge concerning family planning and its benefits towards development of quality of life to general people with emphasis stressed on target groups per paragraph 4.

1.2.1 Encourage people, e.g., women groups, voluntary housewives groups, Lion clubs, Rotary clubs, provincial red cross societies and other related private associations, etc., to play roles and participate in the program as much as possible.

1.2.2 Constitute integrated activity, such as rendering health care services along with assistance in various forms at the same time.

1.3 Do all types of public relations to give knowledge and understanding in family planning to the people for the purpose of encouraging the attitude of acceptance which will lead to voluntary adoption along with public relations of family planning services of the Ministry of Public Health and private sector organization, covering all areas of operation.

1.3.1 Request for cooperation from local mass media and broadcasting stations in diffusing knowledge and braodcasting radio programs that emphasize essential points on population and planned parenthood with a stress on situation of the province.

1.3.2 Insert article on population and planned parenthood at various meetings as well as the training course designed for the people under every project.

1.3.3 Charge personnel of the 4 major ministries with duties to diffuse information and knowledge of family planning as well as motivate people in target groups to accept the services.

1.3.4 Ask for cooperation from local entertainers/actors to insert in their local performances some essential points to support the family planning and population operations.

2. Guidelines for Operation in Specific Rural Area

2.1 Population Groups Dwelling in Remote Rural Area

2.1.1 Promote and support village development committee and tambon council to take part in formulating family planning service delivery plan in an earnest manner, surveying to find service acceptors, giving information and motivating people to accept the services.

2.1.2 Promote accessibility to primary health care service with emphasis on family planning by providing for village health post volunteers and health communicators and regard them as mechanisms in the village-level organization for the development and administration.

2.1.3 Provide mobile service units from public and private sector organizations to visit the area from time to time.

2.1.4 Push and support integration of family planning work with other development projects with clear target and activities, offering opportunity for people's participation in the promotion, e.g. in pond excavation - size of pond or budget for excavation should depend on the collective rate of contraception of such village, in case of funding support the applicant must practice contraception or belong to a family practicing, etc.

2.1.5 Promote dissemination of family planning knowledge to build up concept of acceptability and adoption thru folk entertainment programs with emphasis on fun, e.g., Moh Ram, Manohra, etc.

2.2 Thai Moslem Group in Southern Border Provinces

2.2.1 Encourage religious leaders and people to have understanding in policy, principle and method of family planning by means of public relations, psychological operations as well as to exchange ideas with leaders of the same religion in other localities who achieve success in family planning.

2.2.2 Develop people's organizations with emphasis on participation of tambon council and village committee members in playing earnest roles in attacking problems on primary health care and family planning.

2.2.3 Encourage Thai Moslem women to turn to practice modern contraceptive methods which are of high effectiveness and not in conflict with their belief, in lieu of the traditiona' ones.

2.2.4 Initiate diffusion of knowledge and motivation of target group population to adopt longer childbirth intervals to cope with the families' economic and social conditions.

2.3 Hill Tribal People

2.3.1 Take drastic action to require hill tribal people to dwell stationarily and stop moving around by means of improving agricultural system and giving knowledge on modern farming so as to increase production on the same land cultivated.

2.3.2 Change value on having many children for use as farm hands, working thru social leaders or hill tribe group leaders.

2.3.3 Promote primary health care services with emphasis on family planning to be thoroughly promoted by encouraging public and private organizations to provide such service, using volunteers and mobile units.

7. Method of Operation

Under the Family Planning Promotion and Support Project of MOI gidelines are determined at 3 levels:

1. Provincial Level

Appoint a provincial level committee on family planning operation chaired by the provincial governor with chiefs of related provincial agencies as members. The committee has duties to:

1.1 Study and analyze statistical data concerning population and attitude towards family planning for development into part of the provincial rural development plan;

1.2 Set target regarding population and family planning operations at the provincial level, e.g., population growth target and acceptors number target to be set in agreement with each other, etc.;

1.3 Formulate work plans to achieve the target of number of acceptors on the bases of district, tambon and village in harmony with one another;

1.4 Establish measures and strategies for motivating not only the people to support and accept family planning service but also all staff who should be motivated by high ranking superiors as well;

1.5 Determine public relations strategies in wide scope to be conducted thru mass media, radio and television on a regular basis as well as stage exhibition from time to time and use folk entertaining facilities as media to promote people's understanding;

1.6 Work in coordination and cooperation with operational personnel at the district level and encourage the private sector to earnestly participate, particularly health care services;

1.7 Develop plan to attack the problems inadequate services and inaccessibility to target groups of people, by mobilizing and dispatch mobile units from public and private sector organizations in response to requests of district level agencies and to slum areas;

1.8 Mobilize funds to support the project by means of setting aside funds in the localities, e.g., provincial administrative organization, municipality, sanitary district, support from the private sector, etc.; and

1.9 Monitor and evaluate the project to make sure that the operation by the district office is carried out in a continual manner -- the monitoring and evaluation being required to be carried out regularly or every month.

2. District Level

Assign the district officer to be responsible for the family planning project at the district level ahd to have duties to study and analyze statistical data regarding population, target population groups and conditions of place of operation for development into part of the district rural development plan. He shall be required to:

2.1 Hold meetings of chiefs of district agencies, officials as well as Kamman and village headmen to explain the policies and operating guidelines for further implementation of the policy towards target population groups in tambon and villages;

2.2 Formulate project and set target for each year's operation in a clear manner;

2.3 Mobilize manpower resources for the opearation to be thoroughly carried out in all localities in terms of motivating target group population to visualize the importance of family palnning and accept the services;

2.4 Arrange a central point where people can accept the services, not less than once a month, if at all possible, a family planning service center should be set up at very tambon to facilitate acceptors;

2.5 Dispatch mobile units regularly to specific rural areas which, in addition to family planning service delivery, other services as may be deemed appropraite can be provided to the people at the same time;

2.6 Carry out other development activities in an integrated manner, e.g., occupation promotion, medical service, welfare services, activities which may lead to development of quality of life of people in Tambon and villages, etc.; and

2.7 Collect data concerning family planning at the tambon and village level and render on progress, problems and obstacles to the province onthe monthly basis.

3. Tambon and Village Level

3.1 Promote and support the Tambon council and village committes to take part in planning, disseminating information and play role in motivating target group population to accept family planning services in a serious manner until the tambon development plan can be formulated with coverage of population and family planning operations.

3.2 Encourage local leaders to initiate and coordinate work in organizing women groups and occupational groups in order to receive family planning knowledge and to play actual role in attacking basic health problems in their tambon and villages.

8. Funding Support

Funding support is derived from 3 sources:

8.1 From local administrative budget, provincial administrative organization, municipality and sanitary district to be allocated in accordance with their capabilities and appropriateness;

8.2 From directly related government agencies as per paragraph 3.1; and

8.3 From fund set up by contributions of the private sector and foreign organizations.

9. Project Evaluation

In order to know the progress, problem, obstacles and continuation of the project as well as to facilitate the improvement of targets of population and family planning collectively the following actions shall be taken:

1. Assign the provincial office or provincial public health office to collect data on family planning at the provincial level.

2. Assign the Office of Policy and Planning to collect data concerning this project from all provinces and to take responsibility in coordinating work between the provinces and MOI and between MOI and MOPH.

3. Arrange to have a research and evaluation of the overall family planning project conducted by universities.

10. Expected Outcome

1. Family planning practice will be widely adopted thereby increasing effectiveness of the family planning operation, both in terms of number of acceptors and highly efficient means of contraception.

2. Families in rural areas will arrive at appropriate size of family thereby leading to actual reduction of poverty problem.

3. The National Family Planning Program will be strengthened thereby lowering the national population growth rate down to 1.5 per cent in late 1986.