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**THAILAND'S POPULATION PLANNING PROJECT, 1979-1981**  
**REPORT OF A JOINT THAI-US ASSESSMENT**

By

Debhanom Muangman, MD, Dr. PH

Jack Reynolds, Ph.D

Jarrett Clinton, MD

Visuth Kanchanasuk, MS

Donald Ostergard, MD

Poonsup Piya-Anant, MPA

Yawarat Porapakham, MD, MSPH

Sumontha Thanyapon, MPA

Pichet Soontornpipit, MS

Alton E. Wilson, MPH

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Debhanom Muangman, MD

Jack Reynolds, Ph.D

Co-team Leaders

**Best Available Document**

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THAILAND'S POPULATION PLANNING PROJECT, 1979-1981  
REPORT OF A JOINT THAI-US ASSESSMENT

Part One: Introduction and Summary

1. Summary of Major Findings and Recommendations.

This is a report of a brief assessment of the National Family Planning Program (NFPP), focusing particularly on USAID's contributions to various program components between 1979-1981. Over that three-year period USAID obligated \$6,880,000 of new funds to five NFPP components; 1) the Expanded Sterilization Program; 2) contraceptive services; 3) training and supervision; 4) IE&C in the 15 "lagging provinces", and 5) research and evaluation.

A. Fertility Down, Contraceptive Use Up

The rate of population growth has continued to decline, from 2.0-2.3 at the end of 1978 to under 2.0 at mid-1981. The principal cause of this decline has been a remarkable drop in fertility. The crude birth rate went from 36-38 per 1,000 in 1970 to 26.9 per thousand by mid - 1981. Total fertility rates dropped from 6.12 to 3.55 during this

period, a decline of 40 percent. Marital fertility dropped 39 percent and pregnancy rates dropped 40 percent. These changes have occurred in rural as well as urban areas, but there are significant regional variations. Fertility is higher in the Northeast and South than in the North and Central regions.

The principal causes of fertility decline have been increases in induced abortion and particularly, contraception. Fertility due to use of contraception including sterilization, is estimated to have declined by about 30 percent between 1972-1978.

Contraceptive use has increased remarkably over the last decade, going from 15 to 50 percent among married women 15-44 years of age. The increase has occurred in both rural and urban areas and in all regions, but prevalence is somewhat higher in urban than rural areas, and in the North and Central regions than in the Northeast and South. Contraceptive use is significant among all age groups, but it is higher and has gone up more among older women 25-44.

The most popular contraceptives are the pill and female sterilization, which together account for almost 70 percent of the contraception being used.

B. NFPP Has Impact

The number of new NFPP accentors has increased from 225 thousand in 1970 to 1.1 million in 1980. The number of active users has increased almost one-half million in the last year alone and is now estimated to be about three million, fully 50 percent of all the married women of reproductive age. The NFPP has calculated that in 1979 it was serving all but six percent of current contraceptive users, and surveys show that 80 percent of users receive their contraceptives from a government source.

The NFPP has exceeded its targets in every region and for all methods except the IUD - and even that was close (99 percent) to the target. Overall achievement has been greatest in Bangkok and the South (146 percent of the target in each area) and for pills (147 percent) and sterilization (140 percent).

All indications are that the NFPP has contributed significantly to the decline of fertility in Thailand.

C. NFPP Delivery System Loosely Structured but Extensive

A number of private agencies (ASIN, CBFPS, PPAT, TAVS)

and universities (Mahidol, Chulalongkorn) work directly and indirectly with the NFPP. The NFPP is administered by the Family Health Division (FHD) in collaboration with other Divisions in the Ministry of Public Health. The FHD has no direct line authority over the local facilities and personnel who provide services yet in spite of these constraints the program has managed to develop an extensive and effective delivery system.

Family planning services are available in practically all hospitals, health centers, midwifery centers and through 30-40,000 village-level volunteers.

All types of contraceptives are available, but not all outlets offer all services. Most provide pills and condoms, but IUDs, injections and sterilizations are provided mainly by hospitals. Mobile clinics perform vasectomies in all provinces. Data on new acceptors show that people are using these outlets and that the program is reaching younger, lower parity women who have not used contraceptives before.

D. USAID One of Several Donors to NFPP

Between 1979-1981 the three largest contributors to

the NFPP have been the RTG itself (\$8 million), USAID (\$ 6.9 million) and UNFPA (\$5.1 million), which provided grants; and CIDA (\$5.6 million), which provide a loan.

Almost half of the donor contributions have been used to purchase contraceptives, with over half of that coming from CIDA. UNFPA contributions have gone largely to training, IE&C and the VSC program. The principal components supported by USAID have been: 1) VSC; 2) contraceptives; 3) local training; 4) IE&C in the lagging provinces; and 5) operational research and evaluation.

E. Sterilization for Females Up, Down for Males

Almost 183 thousand sterilizations were performed in 1980, well over the target of 100,000. Female sterilization is going very well, but vasectomies have been declining since 1978.

Most female sterilizations are tubal resections, performed in hospitals during the post partum period, when both motivation and the procedure is relatively easy. Both the age and parity of female acceptors have been declining. The average woman is 29 year of age with 3.5 living children. As successful as this part of the program is, there are gaps. There have been few interval sterilizations, and outreach is

relatively weak.

Vasectomies are performed in hospitals and by mobile teams. The latter are having increasing difficulty recruiting male acceptors. There are a variety of reasons for this: fears and anxieties of potential acceptors; inappropriate targets; problems in reimbursing mobile team expenses.

The NFPP has successfully demonstrated that paramedical personnel can perform sterilizations, but paramedicals are still not widely used for this function.

#### RECOMMENDATIONS

-Further research should be undertaken to develop techniques to counter the fears men have of vasectomy.

-Vasectomy targets should be set individually for provinces, taking population size, unmet need and other relevant factors into account.

-Reimbursement for expenditures should be made promptly.

-The quota system of a minimum of five cases per day should be reviewed to determine if this is a disincentive to mobile unit activity.

-Actual costs of sterilization techniques should be determined and adjustments made in subsidies.

-Study the feasibility of paying transportation costs for those women requesting interval sterilization.

-Paramedicals should be trained to perform sterilizations and placed in facilities where they will be able to undertake these operations.

-More emphasis should be placed on motivation and referral for interval sterilization.

-The quality and appropriateness of <sup>old</sup>VSC kits should be upgraded.

-Laparoscopy should be limited to those larger medical facilities where adequately trained physicians are available.

-The VSC audit should be continued but adjusted to achieve a two percent response rate.

F. Contraception: Injections Up, Pills Steady, IUDs Declining

DMPA usage is increasing relative to other methods, even though it is rarely available outside of hospitals. For cultural reasons, this may be the preferred method in Thailand, but supplies are limited.

Pill usage is levelling off relative to other methods, but it remains the most popular and widely available method. There is a serious problem with maintaining adequate supplies, however, and this may be contributing to method switching with resultant side effects and dropouts. Also, the "free pill policy" is not universally applied - some outlets are selling the pills.

IUD usage is declining. The method is rarely available outside of hospitals and trained paramedical personnel are not always allowed to insert the device.

RECOMMENDATIONS

-Provide DMPA and IUDs at all Health and Midwifery Centers and Mobile Units.

-Conduct a brief study to determine if paramedical personnel who have been trained to insert IUDs are performing this task, and if not, what needs to be done to allow them to do so.

-Encourage PCMOs to utilize trained paramedicals to insert IUDs. A memo from the Ministry of Public Health could encourage as well as approve of this activity.

-Provide medical professionals with adequate technical information about side effects of the various contraceptives being dispensed.

-Ensure an adequate supply of oral contraceptives at all outlets.

-Standardize oral contraceptive formulations and packaging.

-Conduct a study of oral contraceptive distribution procedures, including pricing policies.

G. Training Quantitatively On Target but Need Follow-Up

Training continues to be a major component of the

family planning programme. The strategy relies on an untested concept that family planning personnel at all levels can become trainers. The rapid expansion of training capability has depended on this tier-on-tier training of trainers, designed to decentralize training down to the tambol level.

In 1980 the NFPP trained 3,814 Tambol Doctors, Traditional Birth Attendants, Auxiliary Midwives and Border Patrol Police using this strategy, close to its target of 4,400. Training of paramedicals to perform sterilizations and insert IUDs has been successful but has not been expanded.

Follow-up and evaluation of training has not been undertaken, thus there is little information available on the utility of the training and the application of skills learned.

#### RECOMMENDATIONS

-Provide transportation for nurse-supervisors so that they can carry out planned supervisory activities.

-Verify the validity of the precept that any trainee can become a trainer, and adjust the strategy accordingly.

-Undertake an external evaluation of the impact of training.

-Revise the target-setting procedures so that they focus less on numbers of people to be trained and more on needs for training.

-Consider training government officials who work with villagers (e.g., teachers, agricultural extension officers) in family planning.

-Consider training of paramedicals to perform VSCs and insert IUDs as the highest priority for NFPP training.

-Coordinate training activities with the Training Division of the Under-Secretary of Health.

H. IE&C in Lagging Provinces Underway but Effects Uncertain

During the period covered by this assessment, IE&C activities have been intensified in the 15 lagging provinces with low family planning achievement records. These activities have included 1) motivational and planning seminars for provincial and district staff, 2) mass media use of billboards in six provinces, and 3) use of mobile IE&C teams to inform villages of family planning services in advance of visits by mobile vasectomy teams.

Despite inevitable administrative, logistical budgetary and technical problems, the IE&C motivational impact has been considered crucial to achievement of program targets. There has been no formal evaluation of IE&C activities, but field reports indicate that without the educational/motivational efforts the VSC team visits have not been productive.

#### RECOMMENDATIONS

-Consider setting the target of mobile vasectomy team in terms of different factors e.g. number of population, equipment and manpower availability. Then the IE&C services should be designed accordingly.

-The implementation plan of IE&C services for the mobile vasectomy team in the province should be jointly undertaken between the PCMO and the district hospital to ensure that the IE&C services will be scheduled to meet each request.

-Continue to coordinate IE&C with private sector agencies e.g. PPAT, CBFPS, TAVS, and ASIN.

-Rely on more simple approaches, less on sophisticated audio-visual equipment.

-Continue decentralization of IE&C, including local development of materials and testing of alternative motivational approaches. A pilot study should be conducted at the provincial level.

-Continue support of IE&C activities with more emphasis on evaluating their effectiveness on "hard to reach" groups.

-Make a greater effort to deal with fears and anxieties men have about vasectomies; use vasectomized men as motivators.

-Place more emphasis on interpersonal communications with individual and small group counselling.

-Focus on reaching other specific target groups e.g. adolescents, males, young couples, to influence attitudes toward small family size.

-Consider scheduling intensive vasectomy campaign during the "off season".

-Consider disincentives for having more than two or three children since the present practices that medical charges

for the second or third child is less than the first one and totally free of charge for the poor family. Those practices are opposite to the objectives of the family planning program.

-Continue to use mass media as appropriate.

-We agree in principle with the proposal to expand the lagging provinces program, provided that a thorough evaluation of the current program is conducted first.

I. Research and Evaluation Needed but Limited

In 1979 and 1980 five specific operational research studies were funded by USAID, and in 1981 funds were provided for an unspecified number of studies on service delivery and creation of demand. So far, none of the studies have been completed, but all are in progress.

Four types of evaluation were planned, including periodic evaluations of the VSC program, the lagging provinces project, and training. Only two of the evaluations have been undertaken, and only one (this assessment) has been completed.

Research and evaluation activity has been constrained because of several factors: heavy workload, limited analytical

staff, lack of staff continuity, limited expertise in these areas in Thailand, limited funding, restrictions on honoraria, competition with other research projects, and lack of leadership.

#### RECOMMENDATIONS

-Operational research and programmatic evaluation are very much needed and should be undertaken.

-Studies are needed to find ways to improve efficiency, management, service delivery, and quality of services.

-Specific study topics need to be systematically identified and priorities set among them.

-Thai and USAID officials need to develop a realistic strategy for developing Thai capability to undertake operational research and evaluation.

#### J. USAID Assistance Significant

Although the RTG receives financial assistance from a variety of donors for the NFPP, USAID's contributions have been

significant in helping the RTG to develop a program that is oriented toward communities rather than clinics, relies on paramedical personnel rather than physicians, aggressively promotes and provides sterilization not just pills, and is beginning to focus on applied rather than academic research.

## II. INTRODUCTION

Prior to preparing a Project Design for Fiscal Year 1982, the RTG and USAID agreed to conduct a brief assessment of USAID's contributions to the National Family Planning Program since July, 1979, the date of the last evaluation of the NFPP. USAID contributions, while substantial, constitute only a portion of the inputs to the NFPP and, for administrative reasons, are known as the "Population Planning Project". Table 1 summarizes the contributions for the last three fiscal years.

Table 1

Population Planning Project, USAID Contributions

Fiscal Years 1979-81

USAID-Financed Components	FY 79	FY 80	FY 81
Expanded Sterilization Program	1,841,616	1,500,000	1,000,000
Contraceptive Services			
Oral Contraceptives	522,000	540,000	750,000
F.P. Kits/Medical Equipment		50,000	
Training and Supervision		150,000	100,000
IE&C Improvement/ Lagging Provinces Project	233,384		
Operations Research/ Evaluation	103,000	40,000	50,000
Total	2,700,000	2,280,000	1,900,000

Note: These are new funds appropriated for the project and do not include unutilized funds from prior years that were reprogrammed into the FY 79-81 Project Agreements.

Although the assessment focused on these components, the overall objective was to determine the effect of USAID'S contributions on the NFPP. Thus, the assessment had to view the USAID-financed project in the broader context of the overall program - its inputs, activities, outputs and impact on fertility.

Thus, the objectives of the assessment were to:

1. Update the findings of the most recent (July 1979) Population Planning Project Evaluation with respect to each of the major AID supported components. The update should assess qualitative as well as quantitative performance.
2. Determine the extent to which the NFPP has achieved its stated objectives regarding service delivery, contraceptive use and fertility reduction.
3. Determine the role of USAID in helping the NFPP achieve these objectives.
4. Update information regarding financial contributions to the NFPP from the RTG, AID/washington, and other donors/lenders.

Following a briefing by the staff of the NFPP, the team reviewed available documents and statistics, and made field visits to selected provincial and district hospitals, district and tambol health centers, and midwifery centers. Because time was limited, visits were made to only three provinces: Angthong (Central Region), Sisaket (Northeast), and Pitsanuloke (North).

The assessment was conducted by an independent, multi-disciplinary Thai-US team over a two week period (May 19 - June 1, 1981). The members and professional affiliations are shown below:

1. Debhanom Muangman, M.D., Dr.PH, Co-Team Leader, Dean, Faculty of Public Health, Mahidol University.
2. Jack Reynolds, Ph.D., Co-Team Leader, Evaluation Specialist, University Research Corporation, Washington, D.C.
3. Jarrett Clinton, M.D., Senior Representative, South and East Asia, the Population Council, Bangkok.
4. Visuth Kanchanasuk, B.A.(Econ), MS (Econ), Chief, Health Planning Section, National Economic and Social Development Board, Office of the Prime Minister.

5. Donald Ostergard, M.D., Associate Medical Director for Gynecology, Women's Hospital, Memorial Hospital Medical Center, Long Beach, California and Professor of Obstetrics Gynecology, California College of Medicine, University of California at Irvine, Orange, CA.

6. Poonsup Piya-Anant, B.A.(Econ), MPA, Chief, Public Health Branch, Bureau of the Budget.

7. Yawarat Porapakham, M.D., MPH, MSPH, Head, Biostatistics Department, Faculty of Public Health, Mahidol University.

8. Sumontha Thanyapon, B.A. (Pol. Sci.), MPA, External Cooperation Officer (AID Program), Department of Technical and Economic Cooperation, Office of the Prime Minister.

9. Pichet Soontornpipit, M.S., Assistant to the Director, Technical Service Division, Department of Technical and Economic Cooperation, Office of the Prime Minister.

10. Alton E. Wilson, MPH, Consultant, Education and Training, Medical Service Consultants, Inc., Arlington, VA.

Part Two: The National Family Planning Program

III POPULATION POLICY AND PROGRAM DEVELOPMENT  
IN THAILAND

Two decades have passed since the first expressions of concern regarding Thailand's population growth rate and its implications for long term economic and social development. Following special reviews, seminars, a field project and the initial Ministry of Public Health Family Planning Project in the 1960's, a national population policy was announced in 1970. The concepts were included in the Third Five-Year Plan (1971-76) and a National Family Planning Program was established.

The Cabinet declaration of March 1970 reads:

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.

Two events occurred in the early 1970's which contributed significantly to the program: 1) paramedical personnel were authorized to dispense oral contraceptives (a landmark decision for Thailand and for all of Asia); and 2) both nurses and nurse-midwives were trained and authorized to insert IUDs.

In the mid 1970's free sterilization services were made available; oral contraceptives were provided free in the government health system; and the Ministry of Public Health

approved use of the injectable contraceptive, DMPA.

The late 1970's brought wider availability of contraceptives services, particularly in the Northeast Region; authorization of government auxiliary midwives to insert IUDs and provide injectable contraceptives; a considerably expanded voluntary sterilization program; increased participation of private associations<sup>1)</sup> to assist in the delivery of family planning services; and the initiation of a population and development planning policy project (NESDB and Chulalongkorn University Institute for Population Studies) to examine long-term population and development dynamics.

Population policy in Thailand is formulated by the NESDB Committee (legally, a subcommittee) on Population Policy and Planning, and the National Family Planning Committee. The mandate of the Committee on Population Policy and Planning is as follows:

- Develop a comprehensive national population policy covering quantitative, qualitative and distributive aspects of population;

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1) These include Planned Parenthood of Thailand Population and Community Development Association Thai Association for Voluntary Sterilization, the Association for Strengthening Information in Support of the National Family Planning Program, the Thai Red Cross and private hospitals (for example, McCormick Hospital in Chiangmai).

- Draft and develop a master plan consisting of the targets and other details of the measures necessary to carry out a national population policy;
- Indicate projects and specify the resources, government budget, foreign assistance and manpower needed to successfully implement a national population policy; and
- Develop recommendations for appropriate ways to improve the coordination of population-related policies and programs and promote the evaluation of such policies and programs.

The National Family Planning Committee provides a specific focus on family planning information and services and contributes directly to the NESDB Committee on Population Policy and Planning.

The population policy of the Fourth Five-Year Plan (1976-81) established a target of 2.1 percent annual growth rate by 1981 (a reduction from 2.5 percent in 1976). Attainment of this goal appeared assured even at the time of the last joint USAID-Thai evaluation in 1979.

Population growth and fertility rates have been reduced in Thailand primarily because of the ready availability of family planning information and services (except abortion

which is illegal except under very restricted conditions) delivered primarily by the Ministry of Public Health.<sup>2)</sup>

Other government agencies and private associations contribute toward fertility reduction by providing information and services in particular areas, for particular target groups, or through specialized service delivery systems (for example, private practitioners who provide surgical sterilization).

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- 2) The Ministry of the Interior provides health services to specific populations in metropolitan Bangkok and sensitive border areas through the Border Patrol Police. The Ministry of Welfare and the Ministry of Education are two other important family planning program implementors in the public sector.

#### IV. FERTILITY AND CONTRACEPTION

The 1979 evaluation demonstrated that fertility declined markedly in the 1970s and that the NFPP made a significant contribution to that decline. This chapter presents additional data that reaffirm those findings.\*

The data presented in the 1979 evaluation were drawn from four sources:

- LSI (1969/1970). The National Logitudinal Study of Economic and Demographic Change, conducted by the Chulalongkorn University Institute of Population Studies (IPS).
- LS2 (1972/1973). Second round of same survey.
- SOFT (1975). Survey of Fertility in Thailand, conducted by IPS and the National Statistical Office (NSO).
- CPS (1978/1979). Contraceptive Prevalence Survey conducted by the National Institute for Development Administration (NIDA) in cooperation with Westinghouse Health Systems.

Two recent data bases can now be added:

- NS (1979). The National Study of Family Planning Practices, Fertility and Mortality conducted by IPS in April -

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\* The team is very grateful to John Knodel for recent data that he generously provided, to Thavisak Svetsreni for permitting us to use new data from the AFPH survey, and to Richard Moore, UNFPA Coordinator for sharing a draft report just prepared by a UNFPA Needs Assessment Mission to Thailand.

May 1979.

- AFPH (1979). The Accelerated Family Planning and Health Baseline Survey conducted in 20 provinces in October - November 1979 by Mahidol University's Institute of Population and Social Research (IPSR). Although limited to 20 provinces the study is considered fairly representative of rural Thailand.

The NS data have already been included in an article from which this discussion draws heavily (Knodel, Debavalya and Kamnuansilpa, 1980). A report on the 20 Provinces study is being prepared. Thus, data from six surveys are available for review of trends over the ten-year period 1969 to 1970.

A. Population Growth:

In 1978 the Thailand Panel of the National Academy of Science calculated that the growth rate in Thailand by 1975 was between 2.3 - 2.6 percent per year. That was a steep decline from the 3.2 - 3.4 percent of the early 1960's.

The 1979 Evaluation Team estimated that "the growth rate by the end of 1978 was probably in the 2.0 - 2.3 range." They concluded that the goal of reaching 2.1 by the end of 1981 "may already have been reached and is virtually certain to be exceeded by then." <sup>1/</sup> They were right. According to calculations made by the NFPP, Thailand's 1981 mid-year population

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<sup>1/</sup> Third Evaluation of the Thailand National Family Planning Program, AID Program Evaluation Report No. 3, AID/Washington, D.C., February 1980, p. 16.

is 48,179,000 and its current growth rate is 1.95 percent.

### B. Fertility

The principal cause of this decline in growth has been a remarkable decline in fertility. The crude birth rate is estimated to have declined by about 9 - 10 percent between 1970 to 1975 and about 15 percent between 1975 - 1980<sup>2/</sup>. In 1970 the crude birth rate was 36 - 38 per 1,000<sup>3/</sup>. The NEFP estimated the current rate at 26.9 per 1,000.

Table 2 shows that total fertility rates have declined rapidly between 1969/70 and 1979. Comparing the LSI rate of 6.12 with the NS rate of 3.55, there has been a reduction of over 40 percent in the last decade.

Table 3 shows that marital fertility has declined by about 39 percent nationwide between 1969/70 and 1979. The decline has been greater in rural areas (.77 to .44 = 43 percent) than in urban areas (.53 to .40 = 25 percent) and rural marital fertility is now close to that in urban areas.

Table 4 shows that pregnancy rates of married women have likewise declined, particularly in rural areas. Again, the decline has been about 40 percent over the last decade. Interestingly, urban pregnancy rates are now somewhat higher than rural rates, according to two of the three most recent surveys.

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2/ NEFP, "Draft Report of Mission on Needs Assessment for Population Assistance - Thailand", April 1981, p. 34.

3/ *ibid.*, p. 66.

TABLE 2

Total Fertility Rates (TFR)  
1969/70 - 1979

<u>Survey and Date</u>	<u>TFR whole Kingdom</u>
LS1 1969/70	6.12
LS2 1972/73	5.34
SOFT 1975	4.74
CPS 1978/79	3.64
NS 1979	3.55

Note: All yearly rates refer to levels during the year prior to the survey. LS1 and LS2 TFRs apply age specific marital fertility rates (ASMFR) to the proportions of currently married women reported in the 1970 census. SOFT, CPS and NS TFR's use the 2nd Survey of Population Change (1974 - 76) for the proportion of currently married women. See the prior notes and referenced articles for details of national sampling.

Source: (Preliminary and Draft) "Report on Determinants of Fertility in Thailand", by permission of authors:  
John Knodel, Apichat Chamrarithrong, and Nibhon Debavalya,

TABLE 3

Index of Marital Fertility (Ig') for currently  
married women aged 15 - 49, by Residence,  
1969 - 1979

<u>Residence</u>	<u>LS1</u>	<u>LS2</u>	<u>SOFT</u>	<u>CPS</u>	<u>NS</u>
	1969/70	1972/73	1975	1978/79	1979
National	.72	.64	.57	.44 <sup>1/</sup>	.44
Rural	.77	.67	.58	.44	.44
Urban	.53	.51	.50	.45 <sup>2/</sup>	.40

1/ Excluding provincial urban areas

2/ Bangkok metropolitan area

Source: Knodel, Nibhon Debavalya and Peerasit Kamnuansilpa,  
"Thailand's Continuing Reproductive Revolution", International  
Family Planning Perspectives, Vol. 6, No. 3, September 1980,  
p. 87.

TABLE 4

Percentage of Currently Married Women Aged  
15 - 44 Pregnant, by Residence, 1969-1979

	<u>LS1</u> <u>1969/70</u>	<u>LS2</u> <u>1972/73</u>	<u>SOFT</u> <u>1975</u>	<u>CPS</u> <u>1978/79</u>	<u>NS</u> <u>1979</u>	<u>AFPH</u> <u>1979</u>
National	15.3	14.3	11.8	10.1 <sup>1/</sup>	10.4	9.8 <sup>2/</sup>
Rural	16.2	14.9	12.2	10.0	10.3	9.9
Urban	12.2	10.7	9.7	10.2 <sup>3/</sup>	11.9	8.8

1/ Excluding provincial urban area

2/ Excluding Bangkok Metropolitan area

3/ Bangkok Metropolitan area

**Note:** Standardized for age among the distribution of currently married women at the time of the 1970 census.

**Source:** Knodel et al, 1980, p. 88, and unpublished data from the AFPH

TABLE 5

Percent of Current Married Women Aged 15-44  
Currently Pregnant by Region, AFPH Survey 1979

Age Adjusted Pregnancy Rate

North	7.6
Northeast	12.2
Central	9.3
South	9.0
All Regions	9.8

C. Determinants of Fertility

What has caused this decline in fertility and pregnancy?

A number of factors can account for changes in fertility: age at marriage, duration of marital unions, changes in fecundity (natural and artificial sterilization), abortion (natural and induced), frequency of intercourse, and, of course, contraception.

A recent report by a UNFPA Needs Assessment Mission concluded that four "proximate determinants of fertility" - age at marriage, induced abortion, breastfeeding (which reduces fecundability) and contraception (including artificial sterilization) have accounted for most of the variation in fertility.

TABLE 6

Estimated Effects of Four Proximate Determinants  
on Fertility, Thailand 1972 - 1978

	<u>1972</u>	<u>1974</u>	<u>1978</u>
Total Fecundity Rate	15.3	15.3	15.3
Fertility suppressing effects of			
Breastfeeding	5.20	5.05	4.44
Induced abortions	.41	.51	1.52
Contraception	2.42	3.12	4.30
Marriage	2.11	1.85	1.56
All four	10.13	10.53	11.82

Source: UNFPA Needs Assessment (April 1981).

1/ "Assumed maximum biological fecundity of 15.3 children per women."

The significant changes, however, have been in induced abortion (which was estimated) and contraception. "There has been virtually no changes in age at marriage in Thailand.... There has been a slight decrease in the duration of breast-feeding" which would "increase the fertility level by about eight percent during 1972 - 1978". The report concludes that "a tremendous increase in the use of contraception during 1972-1978 has been primarily responsible for the observed decline in the total fertility during this period. Fertility due to use of contraception, including sterilization, is estimated to have declined by about 10 percent during 1972 - 1974 and by about 20 percent during 1974 - 1978"

D. Contraception:

Table 7 demonstrates the remarkable increase in contraceptive use over the past decade. On a national level it has increased from 15 percent to approximately 50 percent among married women aged 15 - 44. Rural contraceptive use increased nearly five-fold from 11 percent to approximately 50 percent among married women aged 15 - 44. The data indicate that the rural-urban differences in contraceptive use are decreasing.

TABLE 7

Percentage of Currently Married Women Aged 15 - 44 Currently Using  
Any Contraceptive Method, by Residence, 1969-1979

<u>Residence</u>	<u>LS1</u> <u>1969/70</u>	<u>LS2</u> <u>1972/73</u>	<u>SOFT</u> <u>1975</u>	<u>CPS</u> <u>1978/79</u>	<u>NS</u> <u>1979</u>	<u>AFPH</u> <u>1979</u>
National	14.4	25.0	36.8	53.1 <sup>1/</sup>	48.5	48.2 <sup>2/</sup>
Rural	10.5	22.8	34.9	51.2	47.2	47.2
Urban	30.9	43.2	49.2	62.5 <sup>3/</sup>	53.9	59.3

1/ Excluding provincial urban areas

2/ Excluding Bangkok Metropolitan area

3/ Bangkok Metropolitan area

Note: Standardized for age

Source: Knodel, Debavalya, Kamnuansilpa, 1980 and preliminary  
AFPH data

The three most recent surveys (CPS, NS and AFPH) reinforce each other and firmly establish that the prevalence of contraceptive use was close to 50 percent nationwide in 1979.

Table 8 shows regional variations. The 1975 SOFT data demonstrated that wide differences existed between the North and Central regions (47 and 45 percent prevalence, respectively) and the Northeast and South (27 and 15 percent prevalence, respectively). Though regional differences continue today, the Northeast and South had the largest increases in contraceptive prevalence. In the Northeast, which has nearly one-third of Thailand's population, contraceptive prevalence has increased by nearly 20 percentage points (1975/SOFT = 27 percent prevalence and 1979/CPS = 48 percent prevalence).<sup>\*</sup> This trend toward rapid increases in contraceptive use in the Northeast was documented in the 1979 report. Newly available data now reconfirm this encouraging development.

Further, contraceptive prevalence in the most lagging region, the South, has also increased significantly.

Table 9 shows that most of the women who are practicing contraception are using modern methods (OC, IUD, DMPA and sterilization). At the national level 92 percent of all contraceptive users have adopted modern methods. At the rural level the figure is 88 - 89 percent. As noted earlier, the CPS and NS data have marked differences at the regional level. Further discussion of regional differences becomes

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\* We note, that the NS data for the Northeast and South show lower increases than the CPS and AFPH data

more complex and beyond the scope of this review. Earlier studies and a 1980 study (see Table 10) in Songkhla Province indicate that withdrawal is a popular method among Buddhists and Moslems in the South; and that while 29 percent of Buddhists use modern methods, only eight percent of Moslems do.

TABLE 8

Percent of Currently Married Rural Women Aged 15 - 44 Currently  
Practicing Contraception by Region, 1975 - 1979

	<u>SOFT</u> 1975	<u>CPS</u> 1978/79	<u>NS</u> 1979	<u>AFPH</u> <sup>1/</sup> 1979	<u>Change</u> (NS-SOFT)
North	47	59	61	56	+ 14
Northeast	27	48	40	41	+ 13
Central	45	60	58	53	+ 13
South	15	36	25	28	+ 10
All Rural	35	51	47	47	+ 12
Bangkok	48 <sup>2/</sup>	63	53	-	+ 15
National	35	51 <sup>3/</sup>	51	48 <sup>4/</sup>	+ 16

1/ Includes provincial urban areas, unstandardized

2/ All urban areas in the central region

3/ Excludes provincial urban areas but includes Bangkok

4/ Excludes Bangkok

**Note:** Standardized for age

**Source:** Knodel, Debavalya and Kammuansilpa 1980 and supplementary data from other reports and their authors

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TABLE 9

Percent of Currently Married Women 15 - 49 Practicing Modern  
Contraception\* by Region

	<u>CPS</u>	<u>NS</u>
	1978/79	1979
North	53.5	49.6
Northeast	43.8	42.9
Central	56.3	59.4 <sup>1/</sup>
South	23.6	22.6
All Rural	45.3	42.0
Bangkok	59.4	53.1
National	47.1	46.5

\*Modern contraception : Oral pills, IUD, Injectable DMPA  
and sterilization

1/ Includes the Bangkok Metropolitan area.

TABLE 10

Percent of Currently Married Women Aged 15 - 49 Currently Practicing Contraception, by Religion, Java District, Songkhla Province, 1980

	<u>Buddhist</u>	<u>Muslim</u>	<u>Total</u>
Oral (pill)	5.2	4.2	4.7
IUD	1.2	0	0.6
Female ster. (Tr.)	10.9	1.2	6.0
Male ster. (VAS)	8.9	0.6	4.7
Injection (DMPA)	2.5	1.2	1.8
Condom	0.4	1.2	0.8
Safe period	2.1	0.6	1.4
Withdrawal	15.0	14.0	14.5
Vag. supp.	0.4	0.2	0.3
All methods	46.7	23.0	34.8
Modern methods	29.7	8.4	18.6
N	514.0	521.0	1035.0

Source: Preliminary data from a family health status survey conducted in Java, Songkhla in June 1980 by the Biostatistics Department, Mahidol University and the Family Health Division, MOPH. These data have not been standardized for age.

Table 11 shows that contraception is used by all age groups. Prevalence increases by age, and is highest among women aged 30 - 34, and then begins to decline. Use was and remains lowest among younger women, aged 15-24, which may indicate a need for special education and services for these age groups. Likewise, the decline in use among women 40 years and older may reflect a false sense of security from the risk of pregnancy as they approach menopause. Further investigation of the fecundability of this age group may be called for.

TABLE 11

Percent of Current Married Women Aged 15 - 44 Currently Practicing Any Method of contraception by Age 1975-1979

<u>AGE GROUP</u>	<u>SOFT 1975</u>	<u>CPS 1978/79</u>	<u>NS 1979</u>	<u>AFPH 1979</u>
15-19	18.1	31.3	19.5	21.4
20-24	30.9	44.2	32.9	34.5
25-29	41.0	54.4	52.6	49.6
30-34	44.0	61.1	61.1	60.9
35-39	42.3	62.8	59.5	57.5
40-44	30.5	49.5	44.2	47.1
15-44	36.7	53.4	49.3	48.1
Standardized for Age*	36.8	53.1	48.5	48.2

Note: Age standardization based on age distribution of currently-married women at the time of the 1970 census.

As reflected in Table 12, the oral contraceptive is still the most popular method, used by approximately 40 percent of all current contraceptive users. However, the largest increase has been in female sterilization (TR) which roughly doubled between 1975 and 1979. Female sterilization now accounts for approximately 30 percent of all current contraceptive use. Use of male sterilization and the injectable contraceptive have also doubled, but the population base for each of these is only one-third of that for female sterilization. The percentage of married women aged 15 - 44 using the IUD has declined over the past five years. This deserves immediate attention.

In general, the prevalence of contraceptive use has increased remarkably over the last decade. Nationwide it has gone from 15 percent to <sup>about</sup> 50 percent among married women of reproductive age (MWRA). The increase has occurred in both rural and urban areas and in all regions, but prevalence is somewhat higher in urban than rural areas, and in the North and Central region than in the Northeast and South.

Contraceptive use is significant among all age groups, although it has increased more and is higher among older women 25 - 44. Use among younger women (15 - 24) is lower and has increased only slightly.

The most popular contraceptives are the oral pill and female sterilization, which together account for almost 70 percent of the contraception being used.

TABLE 12

Percent of Currently Married Women Aged 15 - 44 Practicing  
Specific Methods of Contraception, 1969 - 1979

	<u>PILL</u>	<u>IUD</u>	<u>TR</u>	<u>VAS</u>	<u>DMPA</u>	<u>Others</u>	<u>All Methods</u>
LS1 (1969/70)	3.8	2.2	5.5	2.1	0.4	0.8	14.8
LS2 (1972/73)	10.4	4.6	6.8	2.9	0.9	0.7	26.3
SOFT 1975	15.2	6.5	7.4	2.2	2.1	3.4	36.8
CPS 1978/79	21.9	4.0	13.0	3.5	4.7	6.3	53.4
NS 1979	20.6	2.8	16.6	4.2	5.1	2.2	51.6
AFPH 1979	18.0	4.6	12.3	5.0	5.9	2.3	48.1
Percentage Points Change Between SOFT (75) and NS (7a)	+5.5	-3.7	+7.8	+2.4	+3.5	-0.3	+14.8

V. THE IMPACT OF THE NATIONAL FAMILY PLANNING PROGRAM

It is clear that fertility has declined rapidly in Thailand and that increased use of contraception is the principal reason. The next question is: What role has the NFPP played in that decline? Figure 1 shows a very direct correlation between the decline in fertility, the increased prevalence of contraception and new acceptors of family planning services.

A. New Acceptors

Table 13 shows acceptor data by method from 1965 through 1980. Acceptance has increased steadily since the NFPP officially began in 1970.\* Pills have been and continue to be the preferred method. The number of IUD acceptors has remained about the same, but the proportion of acceptors who chose the IUD has dropped steadily. Female sterilization and injections have become popular.

B. Active Users

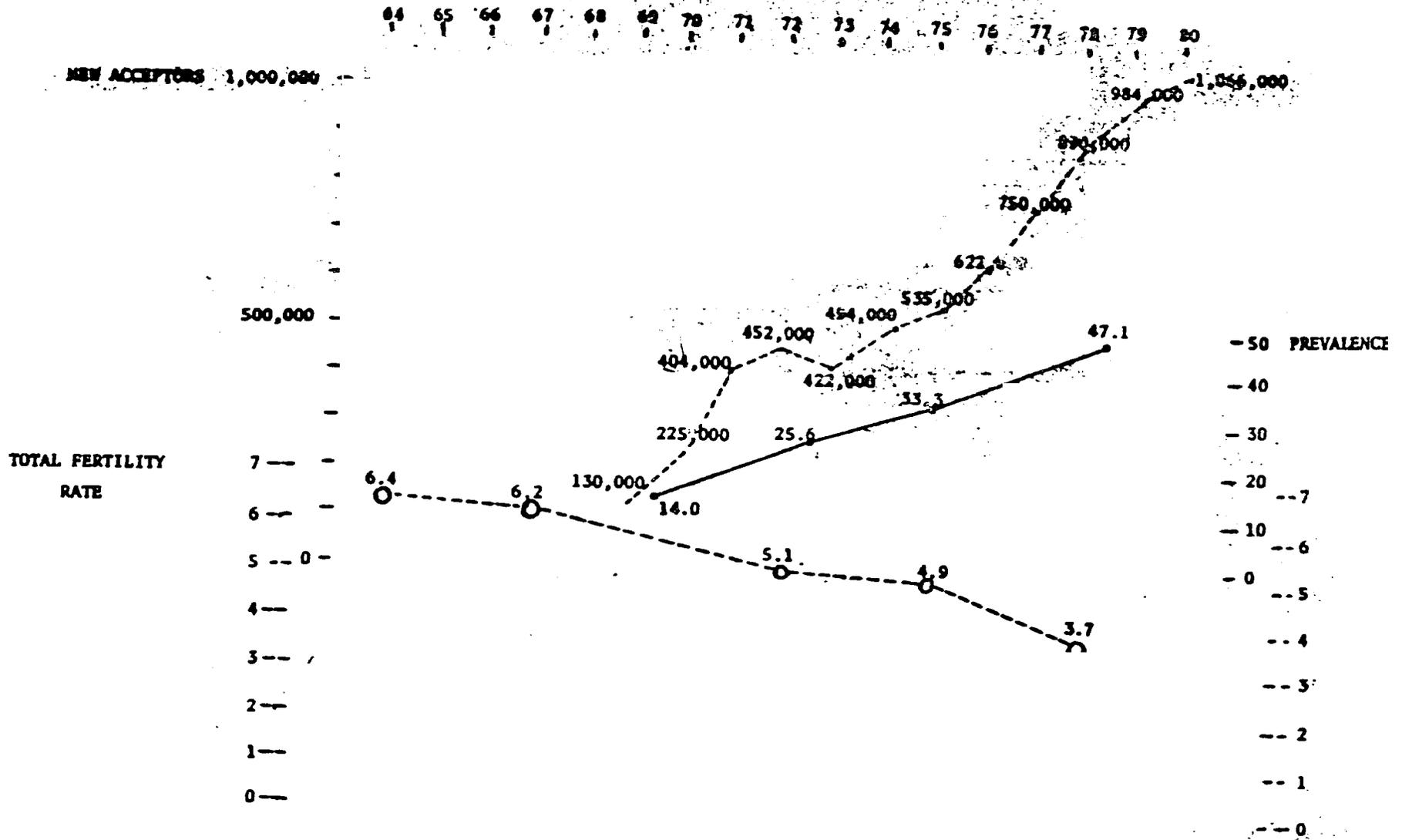
Table 14 summarizes recent NFPP data on active users. The number of active users is large and has increased almost one-half million in the past year alone (see Appendix for details). Perhaps more important, the proportion of married women of reproductive age (MWRS) who receive services through the NFPP is very high. Given that the prevalence of use was about 49 percent of MWRS in 1979 (See Table 7), that means the NFPP was serving all but six percent of current users.

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\* Training activities started in early 1968 and family planning had been available in urban government hospitals even before that.

Figure 1

TRENDS IN ACCEPTANCE, USE AND FERTILITY 1964-1980



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Table 14

Estimates of NFPP Active Users, 1978-1980

	Number	Percent MWRA*
December 1978	2,170,832	39.2
December 1979	2,499,009	43.4
December 1980	2,974,388	49.5

Source: NFPP

\* Married Women of Reproductive Age

C. Source of Supply

Since active users are estimated accordingly to a formula it is possible that there is some error. However, as Table 15 shows, survey data indicate that almost 80 percent of users received their contraceptives from a government source. The second most prevalent supplier was the drug store.

Table 15

Source of Contraception, 1978/1979

	CPS	Percent	
		Rural	Urban
Government outlet	77.1	79.0	62.9
Drugstore	11.3	10.6	19.0
Other*	11.6	10.4	18.1

\* Private hospitals and clinics, CBFPS

D. Achievement of NFPP Objectives

Table 16 shows that the NFPP has done very well in meeting its objectives. Nationally the program has exceeded its targets in every region and for all methods except the IUD - and even that was close to the target.

The highest individual achievements were sterilizations in the North (220 percent of target), DMPA in the Northeast (188 percent), and pills in Bangkok (183 percent). The lowest achievements were IUDs in the North (60 percent) and Central regions (82 percent).

Table 16  
NFPP Achievement of Program Objectives  
for New Acceptors by Methods, FY 1980  
Percent of Target Achieved

Region	IUD	Pill	Ster.	DMPA	National
Bangkok	110.8	182.7	94.7	150.7	145.7
Central	82.4	170.3	125.6	77.7	135.8
Northeast	117.9	128.9	156.2	187.9	138.0
North	59.8	130.8	220.4	93.3	124.2
South	169.3	172.0	112.6	105.1	146.0
National	98.8	146.8	140.2	113.5	135.3

Source: NFPP

E. Conclusion

In 1979 the Evaluation Team concluded "considering the large proportion of contraceptive usage, it seems clear that the NFPP made a major contribution to the reduction in the growth rate"<sup>1/</sup>. Last year Knodel and his colleagues concluded that "... the national family planning program undoubtedly contributed to the fertility decline which has occurred in Thailand."<sup>2/</sup> The data presented in the preceding tables seem to confirm those conclusions.

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<sup>1/</sup> Third Evaluation..., op.cit., p. 10

<sup>2/</sup> Knodel, op cit, p. 94

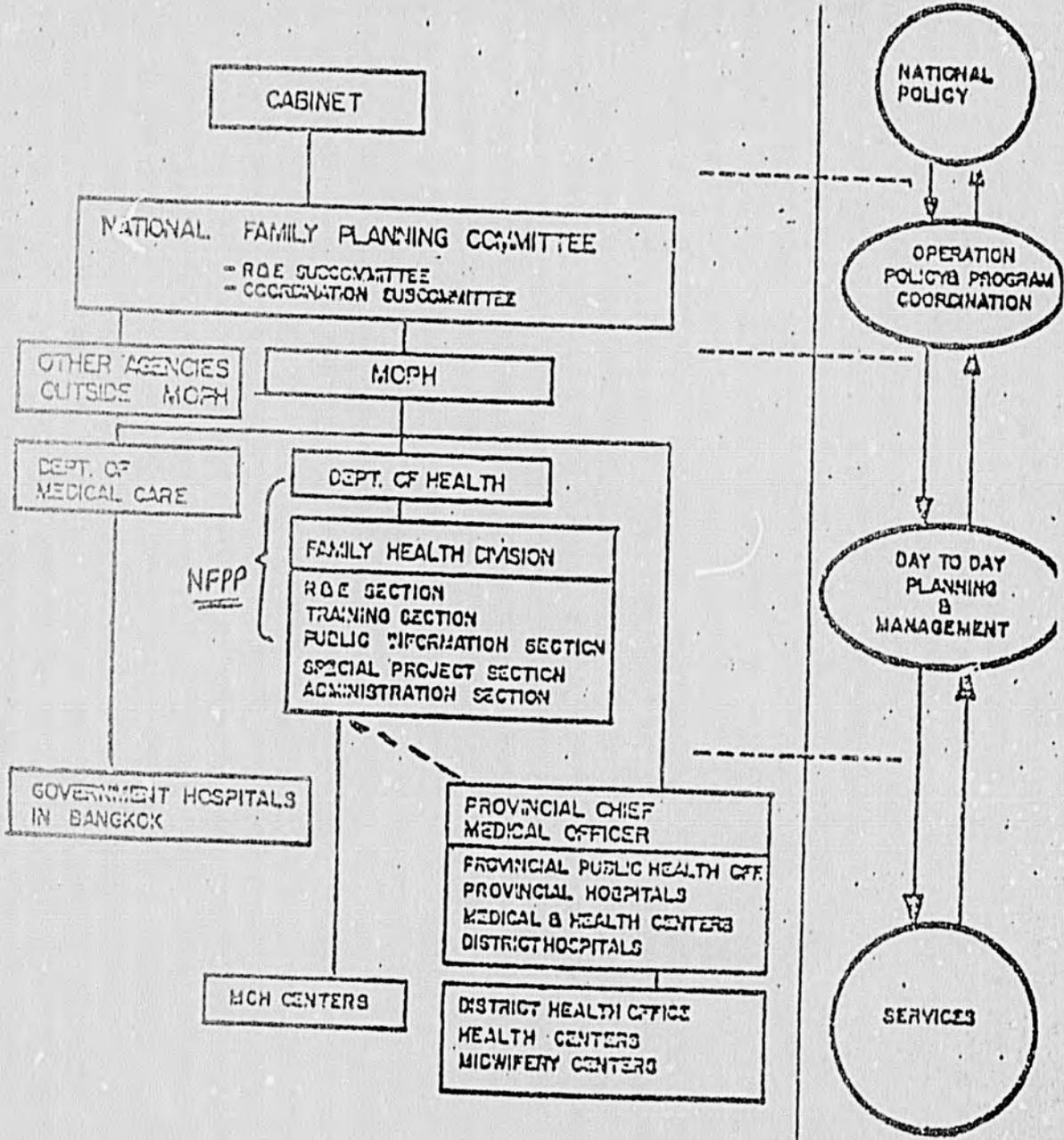
## VI. THE NATIONAL FAMILY PLANNING PROGRAM DELIVERY SYSTEM

### A. Background

The initial "Family Planning Project" in the Ministry of Public Health (MOPH) began in 1968. In 1970 the RTG declared a population policy and gave the MOPH responsibility for its implementation, although no family planning budget was approved until two years later. In 1971 family planning was given high priority in the third National Five Year Plan and the National Family Planning Program was implemented, and subsequently incorporated into the activities of the Division of Family Health (see Figure 2). In 1974 the National Family Planning Committee was formed which, together with two other committees - the NESDB Committee on Population Policy and Planning and the National Family Planning Coordinating Committee - is responsible for policy making, planning and coordination of family planning activities.

Coordination is an important issue because there are a number of public and private agencies involved with family planning in Thailand. The Planned Parenthood Association of Thailand (PPAT), which was founded in 1970, carries out IE&C activities but also provides services to special target groups: refugees, hilltribes, adolescents. The Community-Based Family Planning Services (CBFPS) was set up in 1974 and currently covers villages in 148 districts with its program of contraceptive education and distribution. During 1980, CBFPS initiated a program of mobile sterilization services, focusing initially on rural districts where the level of VSC acceptance has been low. ASIN, the Association for Strengthening Information on the National Family Planning Program was founded in 1977, and provides sterilization services through private medical

**FAMILY PLANNING ORGANIZATION STRUCTURE**



clinics and hospitals. The Thai Association for Voluntary Sterilization (TAVS) promotes sterilization, provides training, disseminates literature, and provides services through a clinic in Bangkok and two mobile units in the Northeast.

The academic community has also been very involved in the evolution of the family planning program. A large amount of biomedical research was conducted in the early 1970s by the medical schools, establishing the safety and efficacy of oral contraceptives, IUDs, DMPA and culminating in the development in 1972 of the Ramathibodi method of minilaparotomy. The method is now widely used in Thailand and around the world. Universities such as Mahidol and Chulalongkorn carried out a number of pilot projects which led to the expanded role of paramedical personnel. As a result of these projects midwives were authorized to distribute oral contraceptives in 1971; nurses were authorized to insert IUDs in 1975; and in 1978 a group of 20 nurses was trained to perform sterilizations. These and other innovations, such as the introduction of a mobile vasectomy program in 1976, resulted in rapid expansion of services. For example, in 1970 the decision to authorize paramedical personnel to distribute pills had the effect of expanding service outlets from 300 to 3,000 in just one year.

The innovative programming has continued with the implementation of the Rural Primary Health Care Program in 1978 and the "Lagging Provinces" project in 1979. Pilot projects are underway that could lead to even more innovations.

#### B. Structures of the Programme

The NFPP is difficult to describe partly because of the complexity of the public-private relationship, but mostly

because of the complexity of the NFPP structure.

Figure 3 shows the organization of the Family Health Division, which has six technical sections that contribute to family planning activities. Activities of the national program are administered by the division, with the collaboration of other departments of the Ministry of Public Health.

There are no direct lines of authority between FHD and the providers of services (Figure 4). Hospitals and health centers are administered by the Ministry of the Interior, not the Ministry of Public Health. For example, the Provincial Chief Medical Officers are paid by the Ministry of Public Health but are administratively responsible to the provincial governors.

Technical lines of "authority" from the Ministry of Public Health to the hospitals and health centers come from a number of divisions, but FHD is not one of them.

<u>Technical Authority</u>	<u>Services Provider</u>
Department of Medical Services	Specialized Hospitals in Bangkok
Provincial Hospital Division	Provincial and District Hospitals
Rural Health Division	Health and Midwifery Centers

In addition, the Office of Primary Health Care, which was created in 1980 to plan, organize and coordinate all PHC activity, is not located in FHD, but is directly under the Under-Secretary of State for Public Health. This program has a large family planning component.

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Figure 3

The National Family Planning Programme, Ministry of Public Health

Organizational Chart

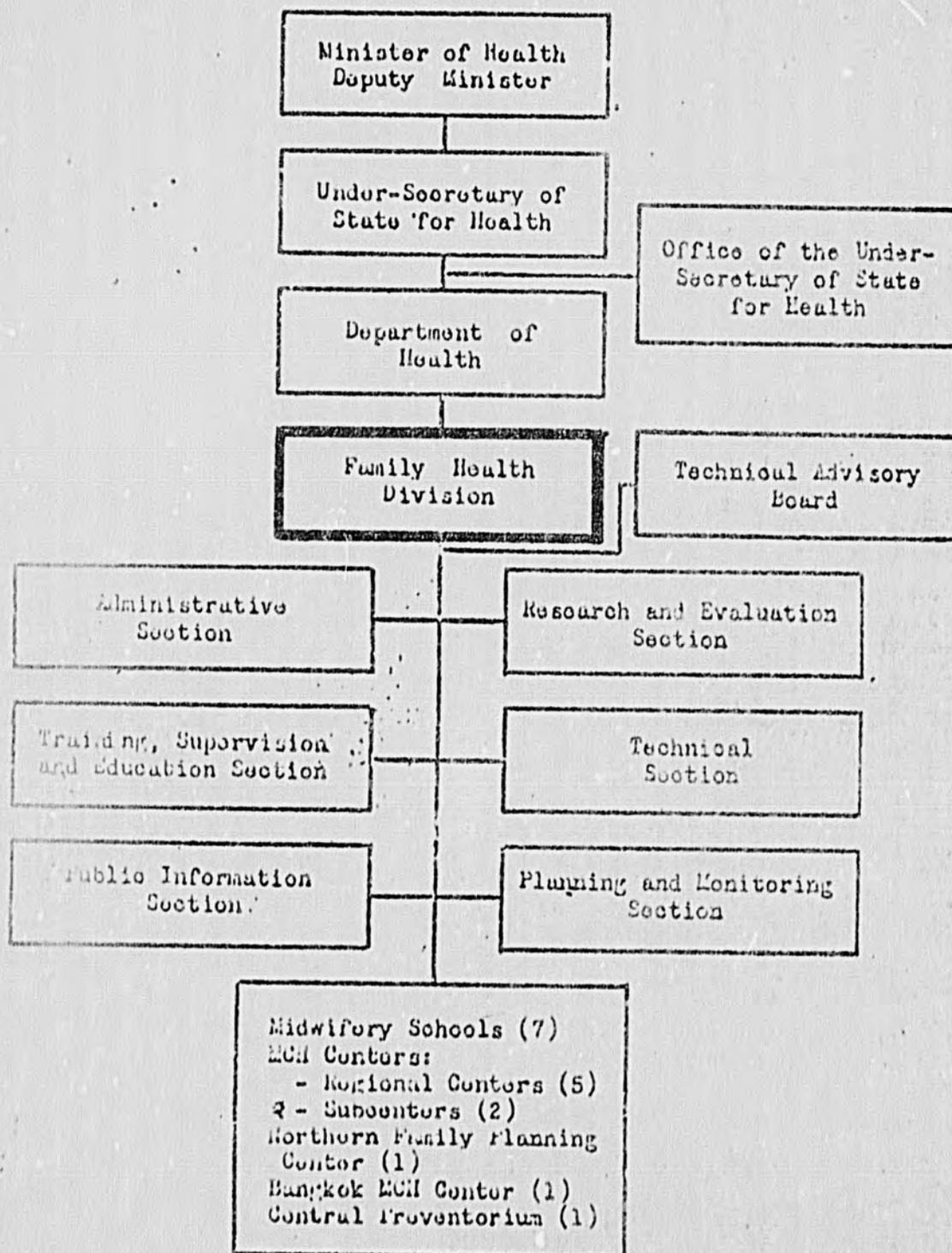
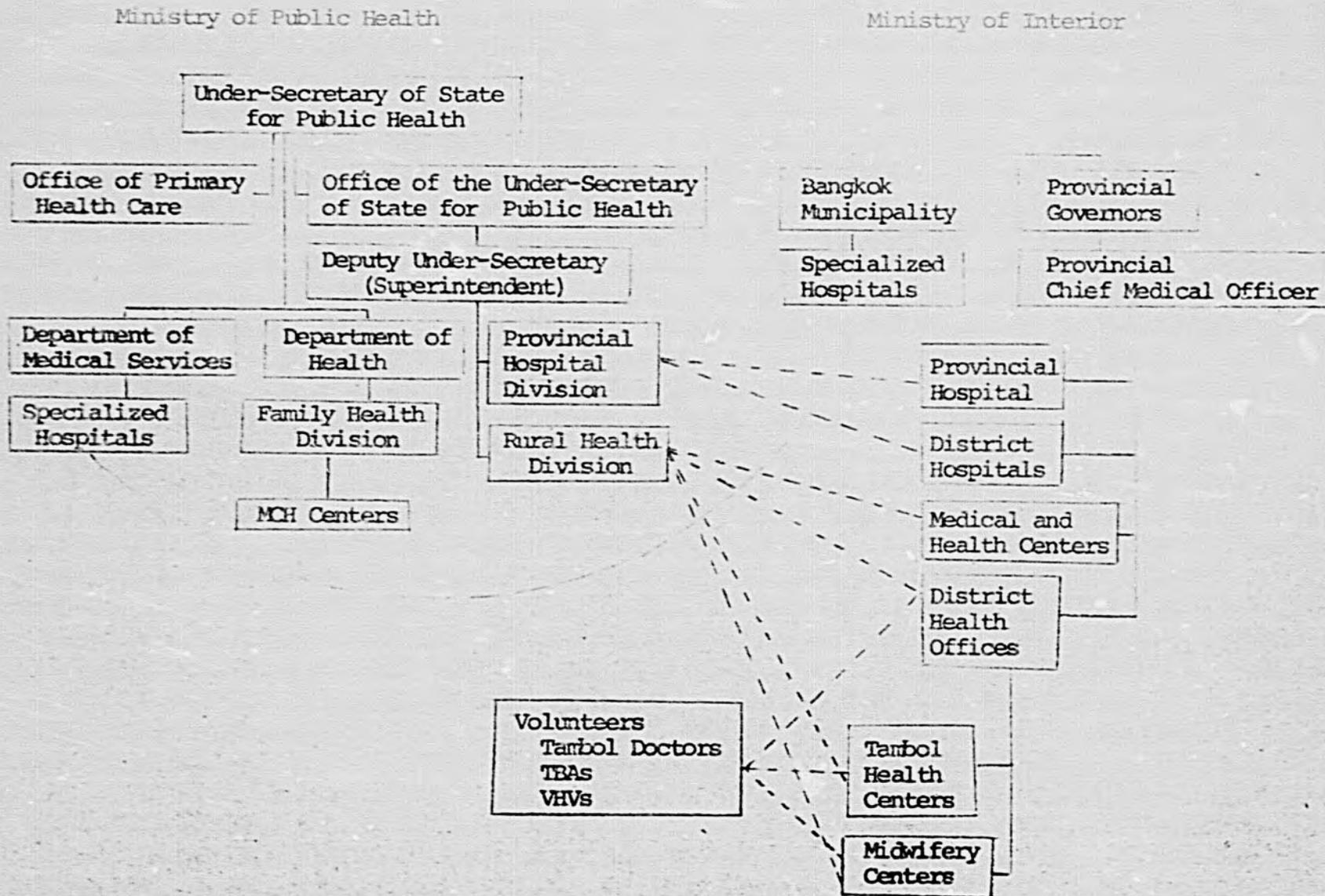


FIGURE 4

National Family Planning Program Lines of Technical and Administration Authority



The National Family Planning Coordinating Committee is the formal mechanism for coordinating activities among these various divisions and the private agencies. The Director-General of the Department of Health is chairman of the committee. Other members are the Directors of the FHD and representatives from DTEC, ASIN, PDP, PPAT, and TAVS. However, this committee rarely meets.

There is a good deal of informal coordination based on intricate networks of personal relationships, committees, and financial incentives (per diem for trips, grants for research, fellowships for study abroad). Thus, despite the lack of a formal structure, formal lines of authority, and formal coordination, the "program" has managed to develop an effective delivery system that has enrolled large numbers of acceptors, retained them for considerable lengths of time, and contributed significantly to the reduction of fertility.

C. Service Outlets

Family planning services are available from a large number of public and private agencies. Figure 5 summarizes these.

FIGURE 5

Family Planning Service Outlets

Public or Governmental Agencies (NFPP)

Bangkok Hospitals	=	11
Provincial Chief Medical Offices	=	71
Provincial Hospitals (over 60 beds)	=	89
District Hospitals (60 beds and less)	=	302
Subdistrict health centers	=	5,478
Midwifery Centers	=	1,111
Village Health Volunteer Posts	=	22,400

Private Agencies

1. Private Hospitals/Medical Clinics	=	3,000
2. Drug Stores	=	13,000
3. Planned Parenthood Association of Thailand (PPAT)	=	1
4. Population and Community Development Association (PDA) - with FP Village Volunteer	=	16,000
5. The Thai Association for Voluntary Sterilization (TAVS)	=	1
6. Association for Strengthening Information on National FP Program (ASIN) with total number of private hospitals/clinics which give sterilization services	=	741

D. Services Offered

All types of contraceptives services are offered, but not all outlets offer all services. Table 17 shows that almost all outlets provide pills and condoms, but IUDs, injections and sterilizations are provided mainly by hospitals. The provincial health office clinic also provides IUDs and injections and the mobile clinics perform vasectomies. A few mobile clinics (those in the "lagging provinces") provide all methods.

Thus, although a wide number of services are available, it is clear that there is still room for expansion.

Table 17  
Number of Outlets (N<sub>1</sub>) and Number Providing Service (N<sub>2</sub>)

	Pill		IUD		DMPA		F. Ster.		VAS		Condom	
	N <sub>1</sub>	N <sub>2</sub>										
Provincial Hosp	89	89	89	89	89	89	89	89	89	89	89	89
PCMO's Clinic	72	72	72	72	72	72	72	1	72	?	72	72
District Hosp	312	312	312	312	312	312	312	312	312	312	312	312
Health & Midwifery Ctr.	6,469	6,469	6,469	60	6,469	74	6,469	0	6,469	0	6,469	6,469
Mobile Unit	72	13	72	13	72	13	72	1	72	72	72	13
MCH Ctr.	8	8	8	8	8	8	8	8	8	8	8	8
Private Sector	11,500	11,000	11,500	14	11,500	4	11,500	425	11,500	425	11,500	-
All Sources	18,522	18,463	-	582	-	582	-	836	-	906	-	6,963

Source: NFPP

E. Acceptors of Family Planning Services

Table 18 shows that over half of the new acceptors who selected the pill were served at local health and midwifery centers. Close to half of those who chose IUDs got them at district hospitals, which also provided about 40 percent of the injections, performed about one-third of the female sterilizations and one out of five vasectomies. The mobile units performed two out of five vasectomies; the provincial hospitals did about one-third of the female sterilizations. Table 18 also shows the important contributions made by the private sector.

Table 19 provides information on selected characteristics of new acceptors. The average age and number of living children of new acceptors has been declining steadily since 1974. That is, the program is reaching younger, lower parity women. The length of open interval has fluctuated, however. The average acceptor enrolls in the program approximately one year after the birth of the second or third child.

The data also show that most new acceptors have never used contraceptives before. Although this percentage has declined over the years it is still high and indicates that the program is reaching a population that had been largely unserved.

Finally, the percent of acceptors who changed methods only went from 3.3 in 1974 to 4.8 in 1980. The percent of those who changed clinics only went from 6.5 to 7.2, which means that the clientele has been remarkably stable, with little method switching and few changes of clinic.

F. Conclusions

The delivery system of the National Family Planning

Table 18

NEW ACCEPTORS BY METHOD AND SOURCE

	<u>Pill</u>	<u>IUD</u>	<u>DMPA</u>	<u>F. Ster.</u>	<u>Vas.</u>	<u>Condom</u>
Provincial Hosp.	3.2%	14.8%	7.5%	32.1%	8.3%	6.6%
PCMO's Clinic	1.9	7.5	6.8	0.2	1.0	4.3
District Hosp	7.9	45.0	39.7	31.3	18.7	17.2
Health & Midwifery Centers	56.2	4.4	24.5	0.0 <sup>+</sup>	1.0	48.7
Mobile Unit	0.8	2.7	6.7	3.0	40.8	3.9
MCH Centers	0.9	9.8	3.3	4.8	0.5	6.5
Private Sector	29.0	15.9	11.4	28.5	29.7	12.7
All Sources	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

Source: NFPP

Table 19

Selected Characteristics of New Family Planning Acceptors,  
1974-1980

<u>Average</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
Age	28.3	28.3	28.2	28.1	27.7	27.3	27.1
No. of Living Children	3.3	3.1	2.9	2.8	2.6	2.6	2.4
Length of Open Interval (months)	12.1	12.7	12.7	12.4	12.7	12.6	11.9
<u>Percent</u>							
With no Prior Practice of Contraception	78.2	76.0	73.3	73.2	71.0	70.3	70.7
Who are New to the Government's NFPP	84.1	83.7	79.9	79.1	77.5	76.9	77.9
Who Changed Method Only*	3.3	4.0	4.5	4.2	4.6	4.4	4.8
Who Changed Clinic Only*	6.5	7.0	5.9	6.1	7.5	8.3	7.2
Who Changed Method and Clinic*	5.9	5.3	6.7	7.0	7.9	5.4	5.5

These data were obtained from a 1:60 sample of the F.P. 01 new acceptor forms.

\* These percents refer to new acceptors who were already in the government system but are counted as new acceptors again due to change of method or clinic.

Source: NFPP

Program is a complex amalgam of public and private sector outlets, mobile units, and volunteers, complimented by university researchers and trainers. Formally family planning is integrated into the activities of the Family Health Division, where the program is lodged. Although FHD has no direct authority over the people who are responsible for providing the services, through informal coordination, personal relationships and incentives the RTG has managed to develop a delivery system that is both innovative and extensive. Services are offered through a variety of outlets and many people now have access to a wide range of contraceptives. Data on new acceptors show that people utilize these outlets and that the program is reaching younger, lower parity women who have not used contraceptives before.

PART THREE: AN ASSESSMENT OF NFPP COMPONENTS SUPPORTED BY USAID

The USAID Mission is one of the major donors providing support to the Thai National Family Planning Program. Other large donors are the UNFPA, the World Bank, CIDA, FPIA, and government agencies of Japan and Germany. The largest single contribution, however, comes from the Royal Thai Government itself. In the following chapters we provide an overview of sources of support for the NFPP and then assess those components supported in whole or in part by USAID from 1979 through 1981.

VII . NFPP Sources of Financial Support

Table 20 summarizes the grant and loan contributions of the various donor agencies between 1979 and 1981. As the data show, almost half of the contributions have been for contraceptives. USAID has contributed less than one-fifth of the total; but the largest contributor has been CIDA. The second largest category has been the voluntary sterilization program. Most of the donated funds for this program have come from USAID. The remaining donor contributions have been for training, IE&C, supplies, equipment, research and evaluation.

Table 21 shows the RTG contribution to the National Family Planning Program, again from 1979-1981. These data show that the bulk of the funds for the NFPP go for personnel costs, subsidies, and materials.

Table 22 gives a breakdown of USAID contributions for the entire project. As these data show, the principal components supported by USAID from 1979-1981 were: 1) the Expanded Voluntary

Sterilization Program (VSC); 2) contraceptives; 3) Local Training;  
4) Research and Evaluation; and 4) IE&C in the "Lagging Provinces."

Table 20

External Assistance to NFPP by Source  
1979 - 1981  
(US \$000)

		<u>Contraceptives</u>	<u>VSC</u>	<u>Other</u>	<u>Total</u>
Grants	USAID	1,862	4,342	676	6,880
	UNFPA	16	1,200	3,908	5,124
	Japan	115	-	1,535	1,650
	ADAB	-	-	523	523
	FPIA	<u>900</u>	<u>-</u>	<u>-</u>	<u>900</u>
	Subtotal	2,893	5,542	6,642	5,077
Loans	CIDA	5,598	-	-	5,598
	IDA	<u>1,660</u>	<u>-</u>	<u>-</u>	<u>1,660</u>
	Sub Total	7,258	-	-	7,258
Total		10,151	5,542	6,642	22,335
Percent		45.5	24.8	29.7	100.0

\* Primarily for training and NFPP communications support

Source: Bureau of the Budget, UNFPA, USAID

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Table 21

RTG Support of NFPP For FY 1979-1981  
(Baht)

Category	National Family Planning Program			Total
	FY 1979	FY 1980	FY 1981	
Salaries	2,820,000	3,594,700	3,727,000	10,141,700
Permanent Wages	5,245,300	11,131,800	15,587,900	31,965,000
Temporary Wages	1,469,700	1,791,000	1,620,000	4,880,700
Remuneration	265,000	200,000	217,200	682,200
Ordinary Expense	5,604,900	5,241,000	4,429,500	15,275,400
Utilities	-	759,000	883,000	1,642,000
Materials	11,934,200	13,052,600	13,052,600	38,039,400
Equipment	2,548,000	102,800	10,000	2,660,800
Land & Construction	2,763,000	100,000	-	2,836,000
Subsidies	16,000,000	16,000,000	16,000,000	48,000,000
Sub-Total	48,623,100	51,972,900	55,527,200	156,123,200

Total  
(\$US=Baht 20)

Source: Bureau of the Budget

Table 22  
POPULATION PLANNING PROJECT  
FINANCIAL PLAN

AID-Financed Components	FY 76	TQ	FY 77	FY 78	FY 79	FY 80	FY 81	Totals
VSC Services 1/	705,000		1,313,579	1,416,304	1,841,616	1,500,000	1,000,000	7,778,499
Commodities								
*Oral Contraceptives	2,745,000	241,000	15,000	900,000	522,000	540,000	150,000	5,112,000
Family Planning Kits/ Medical Equipment	149,571	71,200	177,470	50,000		50,000		498,541
Mobile Units			60,000					60,000
IE&C Equipment	109,000		144,975	81,696				355,671
Local Training	184,128		301,092	160,000		150,000	100,000	895,220
Participants	51,350	40,800	57,550					149,700
Research and Evaluation	152,649		10,304		103,000	40,000	50,000	355,953
IE&C Improvement/Lagging Provinces 2/			230,000		233,354			463,354
Population Education	100,000							100,000
IUD Subsidy	30,000		50,000					80,000
AID Totals	4,226,998	353,000	2,379,000	2,610,000	2,700,000	2,280,000	1,900,000	16,448,998

\*AID oral contraceptives were centrally-funded and centrally-obligated between FY 76-78. Beginning in FY 79 contraceptives have been bilaterally-funded and obligated.

1/ "VSC" = Voluntary Surgical Contraception

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

Source: USAID/Thailand

VIII. THE EXPANDED VOLUNTARY STERILIZATION PROGRAM (VSC).

USAID began funding the VSC program in 1976.

Contributions to date total \$8.533 million. In the last three years USAID has contributed \$4.7 million which is two-thirds of the total USAID contribution to the NFPP between 1979-1981.

A. The VSC Program

In the two years since the last evaluation, targets were set at 100,000 sterilizations per year. The targets for both years were markedly exceeded. In 1979 174,032 were performed and in 1980 the total was 182,786. The average age and number of children of both male and female acceptors has decreased slightly during the last years (Figure 6). This trend supports those surveys indicating that Thais are now planning smaller families. Higher targets were not set annually based on the previous year's experience since the targets followed the Royal Thai Government's (RTG) Five-Year Plan. Targets will be adjusted in the new plan to reflect actual experience.

Even though sterilization procedures as a whole have increased steadily, absolute numbers of vasectomies have steadily declined during the last two years (Figure 7). This occurred in spite of increased AID funding for mobile communication and service teams. The total number of mobile teams has increased markedly during 1979-1980, going from 49 in 1978 to 64 in 1979 to 138 in 1980 (Table 23), and the mobile

Figure 6  
Age and Children of Sterilization Acceptors

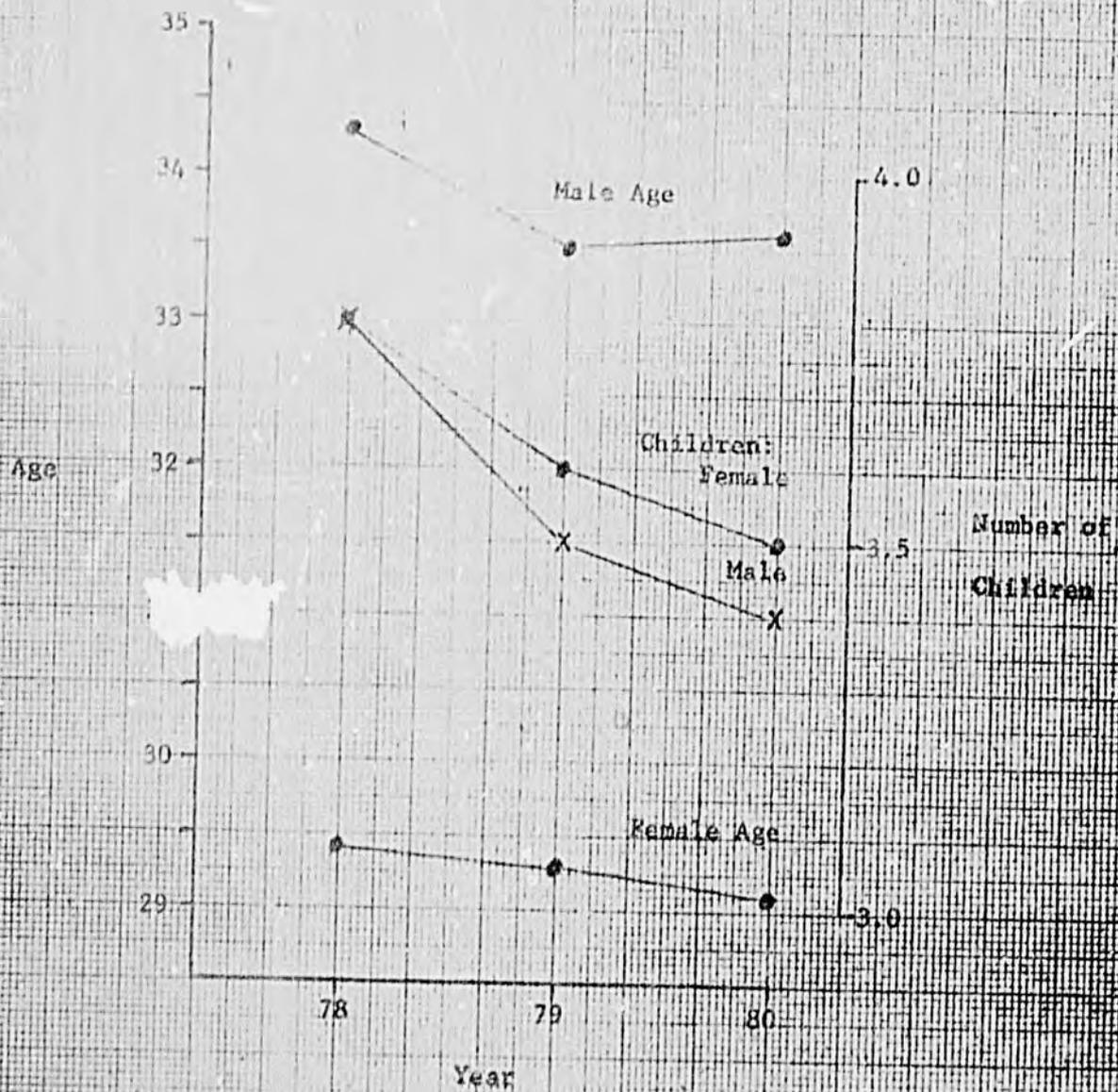


Figure 7

New Acceptors to the Thai NFPP Male and Female Sterilization Program

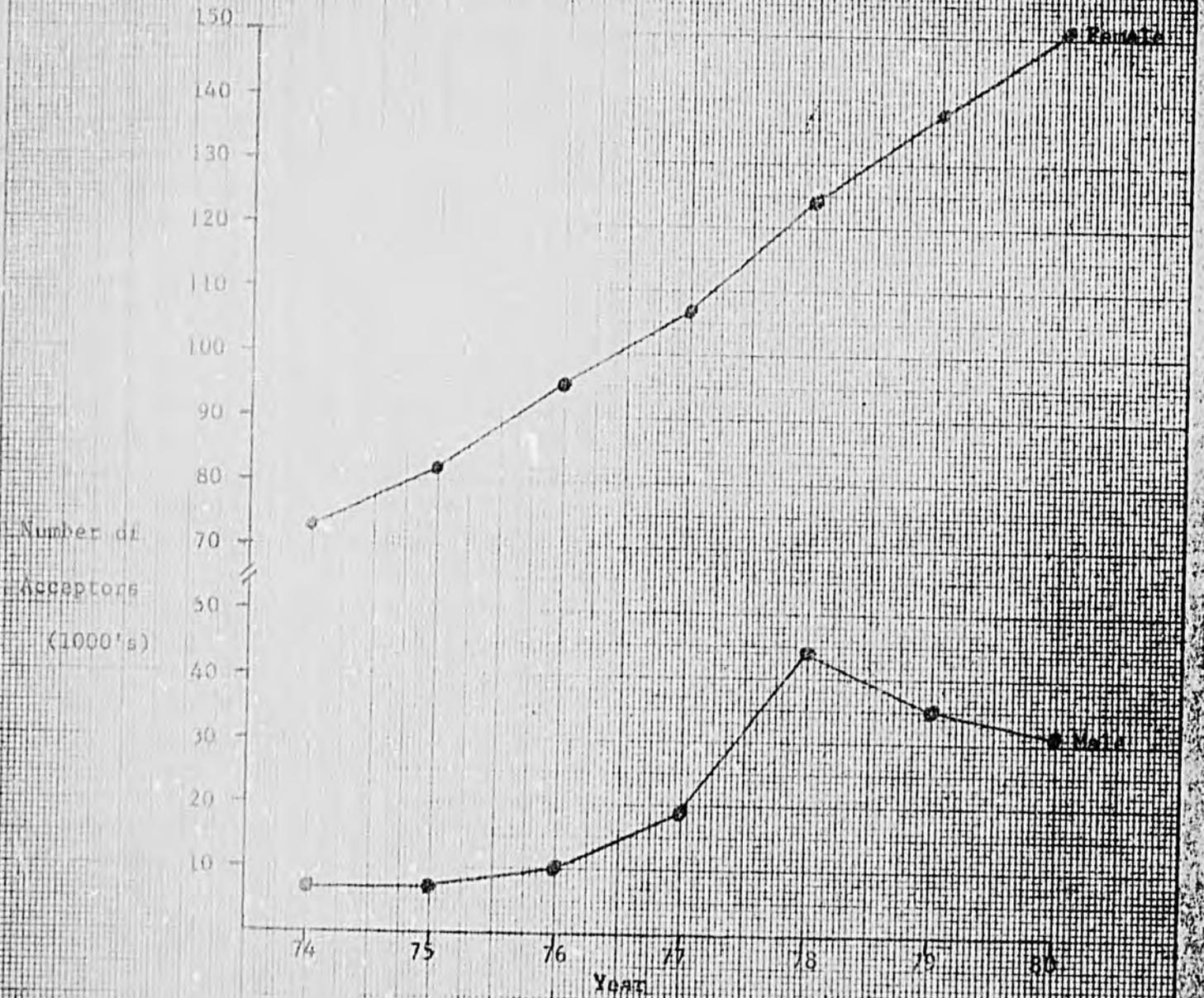


Table 23

Sterilization Service Units of NFPP

Government Sector

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
1. Mobile Units	3	6	49	64	138
					Provinc 62
2. Service units in Bangkok (Hospitals and Clinics)	20	20	20	20	22
					District 76
3. Provincial Hospitals	70	70	71	71	71
4. District Hospital (more than 60 beds)	23	23	23	23	24
5. District Hospitals (less than 60 beds) and First Class Health Centers	168	264	314	328	337
6. M.C.H. Centers	4	4	4	4	4
7. M.C.H. Subcenters	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>
	<u>290</u>	<u>389</u>	<u>483</u>	<u>512</u>	<u>598</u>

Private Sector

	<u>1978</u>	<u>1979</u>	<u>1980</u>
Hospitals and Clinics	476	604	662

Source: NFPP

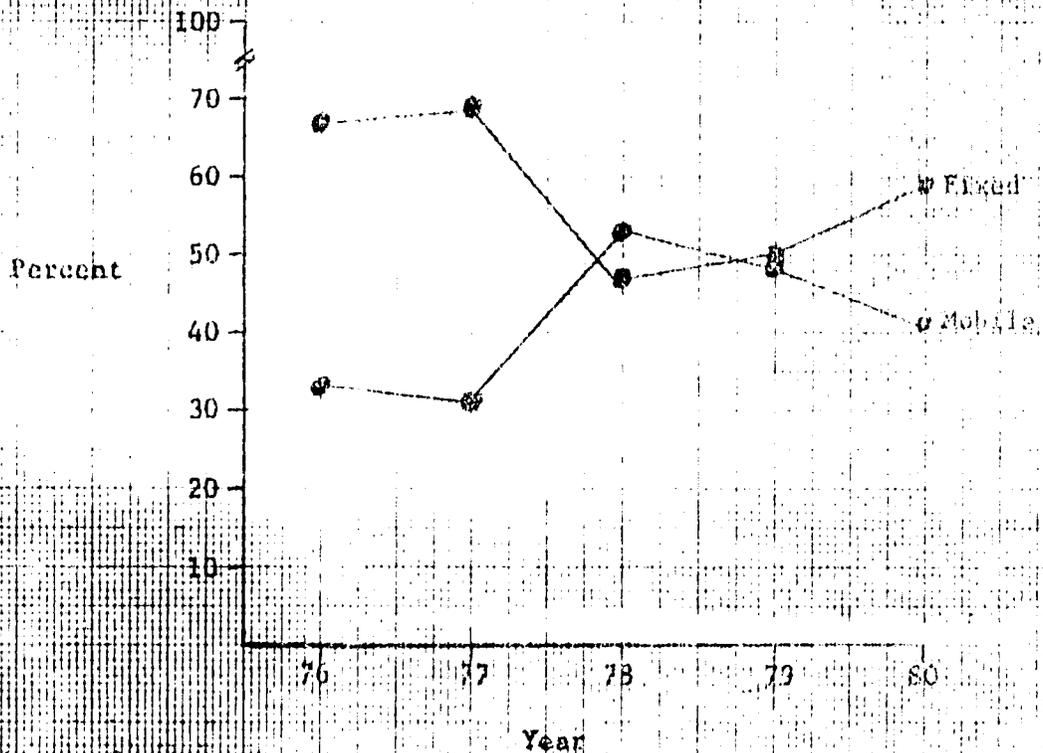
units have accounted for a significant proportion of the total male sterilization acceptors (Figure 8). However, the proportion of sterilizations performed by the mobile units has declined during the last two years. Updated motivational techniques will be required to increase the effectiveness of the mobile units.

Field interviews suggest that a variety of reasons may account for the lessened number of male sterilization procedures and the decreased proportion derived from mobile units. The men themselves state 3 reasons why they do not want vasectomies: 1) subsequent inability to do hard work; 2) impotence; and 3) post operative pain and other complications. Since all three concerns are mostly fictional, it is the job of the motivational teams to dispell these fears. At this point the teams seem unsuccessful in this regard, even though "satisfied local acceptors" are used to show that these concerns are not really problems.

A second problem is that targets are set for mobile teams by the central office at 100 vasectomies per province, regardless of the size of the province, the rate of growth, or the number of vasectomies already performed.

Figure 8

Proportion of Male Sterilization From Mobile  
and Fixed Units



A third problem is slow reimbursement of mobile team expenditures. The team (or provincial office) has to pay for gasoline, for example, submit a receipt to Bangkok, then wait for reimbursement. This procedure has lessened enthusiasm for making field trips..

Another financial problem is that the central office has set a quota for reimbursement. A mobile team must perform at least five vasectomies during a trip in order to be reimbursed and receive per diem. In some cases 10-15 men may have been recruited for vasectomies, but by the time the mobile team arrives there may be less than five and expenses will not be reimbursed.

RECOMMENDATION: Further research should be undertaken to develop techniques to counter the fears men have of vasectomy. Targets should be set individually for provinces, taking population size, past performance, unmet need, demographic growth and other relevant factors into account. Reimbursement for expenses should be made promptly, or a revolving fund should be established so that the provincial office and staff do not have significant out-of-pocket expenses. The quota system should be reviewed to determine if this is a disincentive to mobile activity.

Even though field interviews suggest that funds and gasoline are inadequate for more than eight motivational sessions per month and the districts are requesting more support, additional funds should not be used in support of increased motivational activities until the adjustments suggested here have been made.

B. VSC Subsidies

The RIG and USAID give subsidies to health facilities which perform sterilizations (See Table 24). There is no differential payment for female sterilizations performed post partum and those performed at intervals between gestation. Since post partum patients are much easier to motivate and the operative procedure is considerably easier due to the large size of the uterus, minimal effort is expended in motivating the patient and performing this procedure. Motivation for interval female sterilization is considerably more difficult and the surgical procedure is also more difficult. In addition, hindrances are placed in the way of women desiring the interval procedure. In field interviews it was determined that although transportation is provided for males desiring vasectomy, none is provided for females desiring tubal resection.

Table 24

Royal Thai Government and USAID

Sterilization Subsidies

	RTG		USAID		TOTAL	
	Female	Male	Female	Male	Female	Male
<b>Target</b>						
Urban	150 (\$7.50)	50 (\$2.50)	-----	-----	150 (\$7.50)	50 (\$2.50)
Rural	150 (\$7.50)	50 (\$2.50)	150 (\$7.50)	150 (\$7.50)	300 (\$15)	200 (\$10)
<b>Over Target</b>						
Urban	-----	-----	150 (\$7.50)	150 (\$7.50)	150 (\$7.50)	150 (\$7.50)
Rural	-----	-----	300 (\$15)	300 (\$15)	300 (\$15)	300 (\$15)

Source: NFPP

Another problem is that the reimbursement by RTG and USAID does not cover costs. Actual costs are now more than 600 Baht (\$30) for a female and 300 Baht (\$15) for a male sterilization procedure.

Recommendations: 1) Determine by a more current cost analysis the actual cost of sterilization procedures and adjust reimbursements accordingly; 2) conduct study of feasibility of providing for transportation costs for those women requesting interval sterilization; 3) more emphasis should be placed on interval sterilization.

C. VSC By Paramedicals

As mentioned in the previous report, paramedical personnel have been trained to do tubal resection and vasectomies. Adequate follow up now exceeds two years. One district hospital has utilized women trained in both procedures for more than two years and recommends that this service be made available to other hospitals where physicians are willing to allow these people to function. A male nurse aide was observed performing a tubal resection. His surgical skill was excellent. He has done in excess of 3,500 tubal resections and many vasectomies over the three years. Many facilities have more requests for post partum sterilizations than they can

perform due to other demands on physician time. The addition of a paraprofessional trained in VSC would be a very important addition to the health care team of such facilities. Several reports have evaluated the long term results of paraprofessional VSC's. Complications are rare and physician acceptance is good.

Recommendation: 1) Determine the location of those facilities where properly trained paramedicals would be allowed to perform tubal resections and vasectomies; 2) train sufficient personnel to staff these facilities.

This recommendation is strengthened by the knowledge that trained general surgeons would prefer to do other types of major surgical procedures than tubal resections and vasectomies. Trained paramedicals would relieve them of this burden while allowing them to be available in the unusual event of a complicated procedure. This would make more efficient use of scarce manpower.

D. VSC Kits

Generally, field discussions revealed satisfaction with the sterilization kits provided by AID. However, some personnel stated that the Pakistani instruments

rust prematurely and the size of certain instruments is inappropriate.

Recommendation: Upgrade the quality and appropriateness of instruments in the sterilization kits.

E. Laparoscopy

Laparoscopy is used very infrequently for female sterilization due to lack of training of physicians in this technique. Since the interval sterilization procedure is the only appropriate use for this technique, its lack of usefulness is apparent. Laparoscopy is, however, useful for other intraabdominal diagnostic and the therapeutic procedures.

Transfer of the responsibilities for repair of these instruments to the Ministry of Public Health is contemplated soon. Those in charge feel that this transfer is appropriate.

Recommendation: Limit the use of laparoscopy to those larger medical facilities where adequately trained physicians are available.

F. VSC Audit

An independent audit of sterilization reimbursement was contracted by USAID. The auditors were to sample two percent of those receiving sterilization services to verify that services were actually rendered. The survey is carried out by mail and the response rate has been 58 percent. Since the response rate is low, in actual fact less than one percent are actually surveyed. It is planned to increase the survey requirements to three percent to decrease the error involved in the small sample. So far no examples of misreporting of sterilization procedures have been found. The cost for this survey is minimal.

Recommendation: Continue the audit sample to reach an actual response rate of at least two percent.

G. VSC Expenditures

Under the FY 80 Project Agreement, USAID would make reimbursements of \$1,125,750 during the project year. The amount actually disbursed was \$758,267. Projected expenditures for personnel support for the VSC mobile teams during this same period were \$374,250, but only \$105,244 was actually disbursed.

In part, the lower than expected level of institutional reimbursements may be due to the increasing number of VSC acceptors who received services through the ASIN clinics. The level of disbursements for personnel supported continued to decline during this project year (1979-80), reflecting a decreased level of mobile team activity.

In an effort to address some of the constraints to greater mobile team activity, funds were budgeted for gasoline and additional field supervision in the FY 80 ProAg. Thus far, however, even these additional measures do not seem to have substantially altered the level of mobile VSC activity. Under the FY 80 ProAg, it was agreed that \$63,500 of unutilized prior year funds would be used to purchase additional medical kits needed by the program. As a result of this Agreement, 300 IUD kits and 600 sterilization kits have been purchased.

IX. CONTRACEPTIVE SERVICES

A. General

Contraceptive services continue as described in the last evaluation. Table 25 shows that IUD & DMPA services are low in two of these MOPH outlets.

Recommendation: Increase IUD and DMPA services in Health and Midwifery Centers and Mobile Units.

B. Paraprofessionals and IUD's

Certain training activities involving lower level health personnel now make oral contraceptives and condoms more available at subdistrict levels (Table 25). All MOPH outlets now provide these contraceptives. Only eight percent of centers do IUD insertions and this service is rarely available below the district hospital level. IUD training still lags and no effort has been made to determine if recently trained paramedical personnel will be allowed to insert IUD's when they return to their jobs.

Recommendation: Conduct a short study to determine whether paraprofessional who have been trained to insert IUD's are allowed to do so and if not, what needs to be

Table 25

Contraceptive Outlets Providing Specific Services

Government and Private Sectors

	N	OC	IUD	DMPA	Condom
Provincial Hospital	89	100%	100%	100%	100%
PCMO's Clinic	72	100%	100%	100%	100%
District Hospital	312	100%	100%	100%	100%
Health and Midwifery Center	6469	100%	1%	1%	100%
Mobile Unit	72	100%	18%	18%	100%
MCH Center	8	100%	100%	100%	100%
Percent of All Outlets (MOH)	7022	100%	8%	8%	100%
Private Sector	11500	90%	1%	1%	0
Combined MOH and Private	18522	99%	3%	3%	38%

Source: NFPP

done to make this possible.

C. Relative Contraceptive Usage

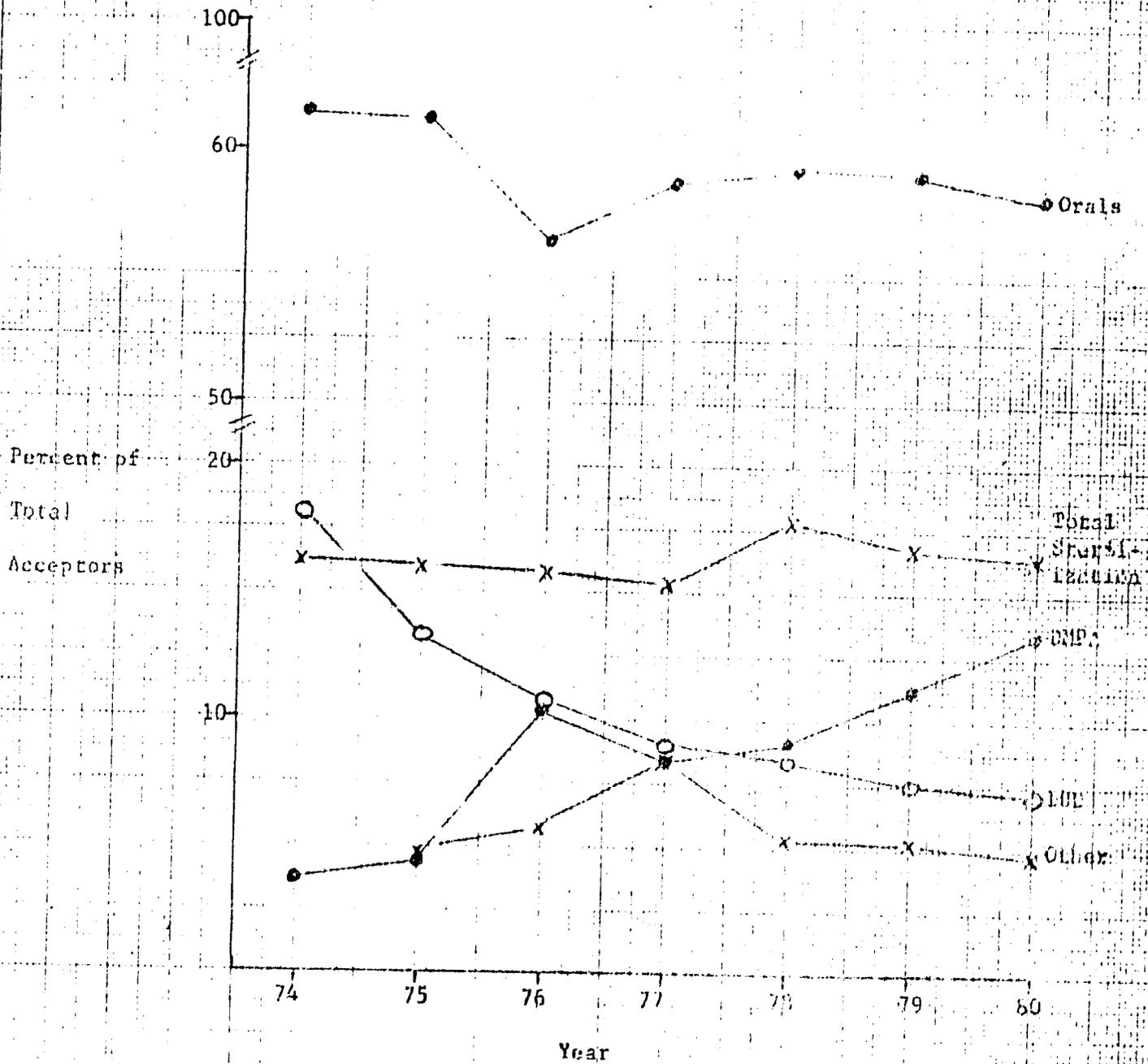
Contraceptive mix has changed over the years (Figure 9) particularly DMPA and IUD's DMPA usage is accelerating while IUD usage is declining. Several factors seem to account for this change. Firstly, IUD insertion is rarely available below the district level. Women desiring an IUD must, therefore, travel to the district hospital for this service. Secondly, even though trained paramedicals are available, many are not allowed to insert IUD's. Some midwives insert IUD's in their private practices even when not allowed to do so in their district positions. They feel that IUD use would increase if they could function with official approval. Their contention is borne out in U.S. experience where IUD usage increased markedly in several clinics when paramedicals were allowed to insert them.

Recommendation: Encourage PCMD physicians to allow trained paraprofessionals, particularly the auxiliary midwives to insert IUD's. A memo from the Ministry of Public Health could encourage as well as approve of this activity.

AID provided IUD kits are generally stated to be

Figure 4

New Contraceptive Acceptors by Method



satisfactory. The comment regarding rusting applies here also.

D. DMPA

DMPA usage is increasing even though only eight percent of the outlets provide it (Table 25). This is probably the result of the villagers' concept of "strong medicine" inherent in an injection as opposed to other forms of contraception. Since Thai women tolerate DMPA exceedingly well, its use should be encouraged and extended to the subdistrict level. Currently, providers state that they cannot be assured of a continued supply of DMPA and, therefore, do not encourage its use.

Misinformation was found amongst physicians in the field as to the serious side effects of DMPA. For example, one facility does not use DMPA because the physician thinks it causes cancer.

Recommendation: Increase the availability of DMPA at subdistrict levels and encourage its use. Augment the factual medical information available to physicians regarding DMPA

E. Oral Contraceptive Supplies

Several problems were identified with regard to oral contraceptive supplies. Firstly, supply does not always equal demand. Maintaining an adequate supply of oral contraceptives continues to be a serious problem. A 1980 AID analysis 1/ pointed out that NFPP supplies were well below minimal levels. A World Bank Mission spent considerable time reviewing this issue in early 1981 and "concluded that the situation has deteriorated even further. This unavailability of contraceptive supplies at service outlets could undermine the credibility and hence the accomplishments of the entire national program". 2/ The recent UNFPA Needs Assessment Mission also conducted that this remains a serious problem. A concerted effort must be made to ensure that all outlets have adequate quantities of the correct oral contraceptives to distribute. One midwife stated that she could not predict the type of pill that she would receive from one delivery to the next.

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1/ Anthony Boni, "Thailand, Forecasting of Contraceptive Requirements, 1981-1986", January 9, 1981.

2/ "Thailand Population Project: Review Mission Findings and Updated Status Report No. 6", April 1981, p.2.

Secondly, there are several formulations of contraceptives available as well as at least three different types of packages for one formulation. For several reasons an effort must be made to standardize the available oral contraceptives. Patients will have adverse symptoms if a different formulation is used due to medical reasons. If the same formulation is packaged differently, psychological factors may produce symptoms. Consistency is required to improve continuation rates.

Recommendation: Ensure an adequate supply of pills at all outlets. Standardize oral contraceptive formulations and packaging to maximize continuation rates.

F. Sale of Contraceptives

Field visits indicated a variation in understanding of whether oral contraceptives are to be sold or to be given free. A study should be undertaken to clarify this issue.

Recommendation: Solicit and fund a study to determine the pattern of oral contraceptive distribution in relation to costs to patients.

X. MANPOWER DEVELOPMENT AND SUPERVISION

A. General

Training continues as a major component of the Family Planning Program in Thailand. The strategy is based on the precept that any trainee may become a trainer, given the proper methods and motivation. Figure 9 shows the current training strategy which is designed to decentralize training activities. The University Medical Education Unit leads the sequence and trains Family Health Division personnel who subsequently become trainers themselves. This process is repeated until the auxiliary midwives become trainers of traditional birth attendants, who are the health educators in the villages. Training supervision, in theory, extends from one level to the next. However, field visits suggest that in practice this type of supervision is infrequent. A training course in Management Team Building was held in an attempt to address this problem.

Recommendation: Verify the validity of the precept that any trainee can become a trainer, and adjust the strategy accordingly. Develop<sup>a</sup>/realistic and functional follow up and supervision system.

B. Training Objectives

Personnel actually trained during 1980 are shown in Table 26 with a comparison to the target. Generally the training activities remain on target for TBAs and Auxiliary Midwives. Border Police training fell well

Figure 10

Training Strategies in Thailand (NFPP)

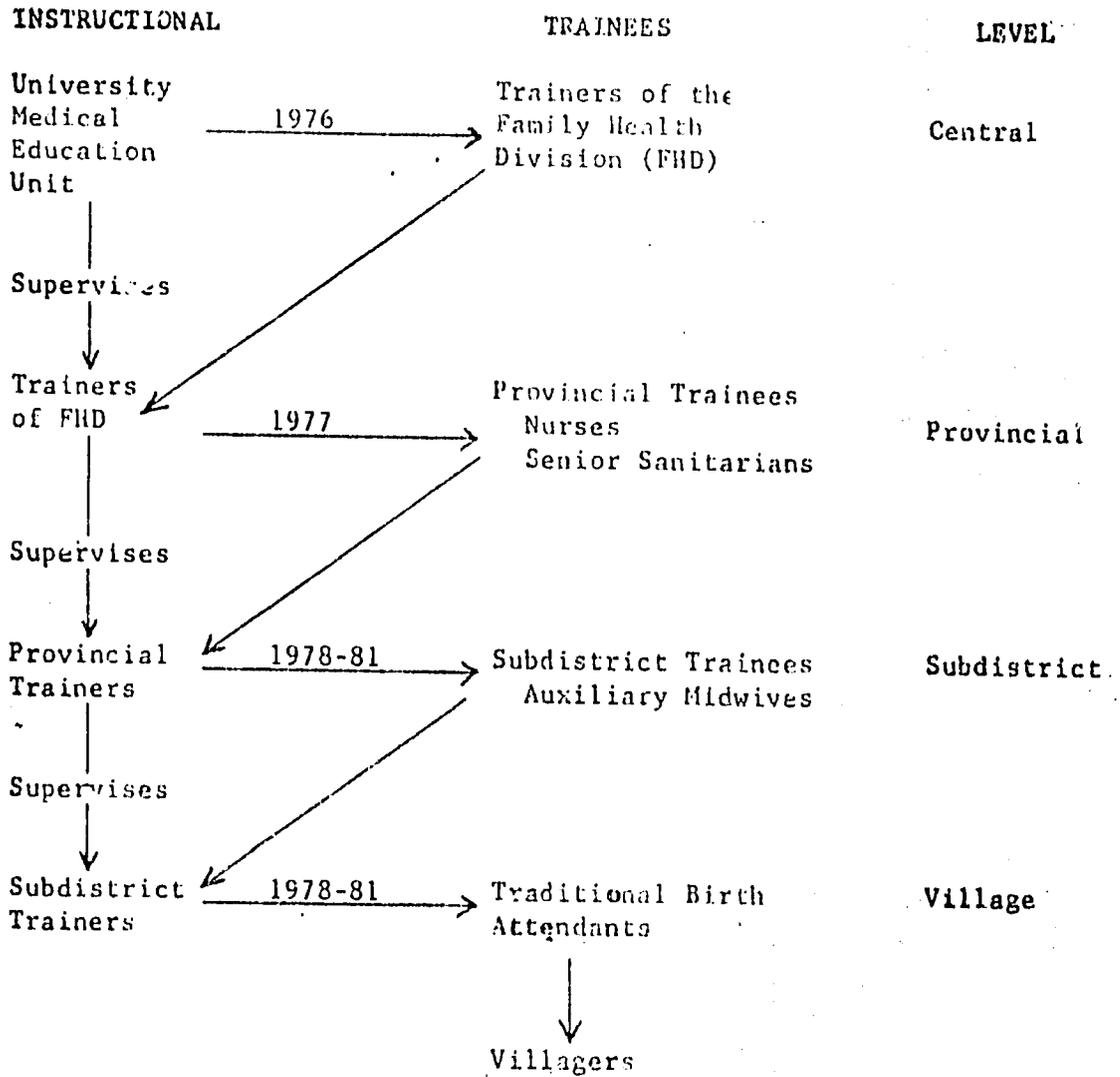


Table 26

Training Activities 1980 (NFPP)

	<u>Project Agreement</u>	<u>Actually Trained</u>	<u>Percent Achieved</u>
Tambon Doctors	1200	929	77.4
TBA's	2400	2271	94.6
Auxiliary Midwives	600	540	90.0
Border Patrol Police	<u>200</u>	<u>74</u>	<u>37.0</u>
Total	<u>4400</u>	<u>3814</u>	<u>86.7</u>

Source: NFPP

below the target. In general, training targets seem to focus on numbers of people to be trained regardless of variations in need.

Recommendation: Revise the target-setting procedure to meet actual needs for training.

#### C. Evaluation of Training

It is not possible to determine the results of training due to the absence of evaluation. It would be helpful to know if the information given to the trainees is useful to them in their work. A course in evaluation techniques has been developed for subcentral trainees to allow them to evaluate their own training activities. A definitive, centralized evaluation process has not yet been instituted by the Training Division.

Recommendation: Institute an ongoing, in-depth evaluation of the end products of these training activities with respect to the usefulness of the information presented in local job settings. Revise training curricula, as appropriate, to more adequately focus on job functions for which training is actually needed.

#### D. Paramedical Training in VSC and IUD

The training of paramedical to perform VSC and insert IUDs has been successful and remains one of the highest priorities as determined by this team. As described previously, significant increases in VSC acceptors will result from the presence of trained paramedicals in Provincial and District Hospitals.

Recommendation: Consider the training of paramedicals to perform VSC and insert IUD's as the highest priority for training activities in Thailand.

E. Compliance with Previous Recommendations

The previous evaluation recommended that a provincial supervisor be designated to ascertain that all individuals are properly trained in reporting and recording procedures. The training division has held meetings to educate the responsible individuals in these procedures.

It was further recommended that the Family Health Division and the Rural Health Division should coordinate their training efforts. Apparently, there is now some interaction, at least with each side inviting the other to participate in their respective activities.

Formal training in the theory, practice and planning of health education was also recommended for all personnel at all levels but the effectiveness of this training cannot be judged due to the lack of evaluation.

Recommendation: Further efforts should be made to coordinate training activities between those two divisions.

XI. INFORMATION, EDUCATION AND COMMUNICATIONS (IE&C)

A. Intensified, IE&C Campaign in the Lagging Provinces

In 1979 USAID provided \$233,380 to mount an intensive campaign in "15 provinces which chronically have had a low family planning achievement record."

Central

Chachoengsao

Lopburi

Nakorn Pathom

Petchburi

Samut Prakan

Northeast

Nakorn Panom

Sisaket

Surin

Yasothon

North

Petchaboon

South

Nakorn Si Thammarat

Naratiwat

Pattani

Phatalung

Satun

The objective of the campaign was to try a new approach that would increase family planning acceptance in these "lagging provinces". Three activities were planned:

project was delayed and the provinces did not all begin field work at the same time.

B. Findings

1. General

Implementation of IE&C activities generally has followed the project plan, but progress has varied considerably from province to province. To date there has been no formal attempt to measure the effectiveness of the IE&C campaign, except through review of monthly acceptor statistics. Some areas have performed well, but reports from many areas show low VSC results. The general view is that without an accelerated motivational program, the response of potential male vasectomy acceptors will continue to drop.

The capability to mount a full-scale IE&C program is constrained by a variety of administrative, logistic, budgetary and technical problems. In the 15 lagging provinces, many districts are short of qualified health workers; coordination between provincial and district offices in scheduling IE&C and VSC mobile units has not yet been well planned; mobile units and IE&C equipment are often out of

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order , or used by other program units; per diem reimbursement for mobile unit teams is not approved if the number of acceptors is below five; and lack of advance funding for purchase of gasoline has made scheduling more difficult.

Some people think IE&C is:

a. Too centralized (Bangkok) - should allow for more local development of materials and motivational approaches. The central IE&C Section has initiated several measures, for example, mobile IE&C units of the central office are being reassigned to selected provinces. Funds are also being allocated to the provinces for production of educational materials.

b. Too sophisticated (mobile units with tape recorders, projectors) - should rely on simple approaches. (Heavy duty 16 m.m. movie projectors provided with USAID support are replacing the older equipment. Movie projectors continue to be necessary for use in showing education/entertainment films for large village audiences. Single cassette recorders are considered adequate. Large cassette and reel recorders are not adequately maintained, nor are the mobile units supplied with tapes.)

c. Too abstract - should deal with individual, personal issues. (Greater emphasis is being placed on small group communications and use of satisfied vasectomy acceptors to appeal to potential acceptors attending large village educational/entertainment programs).

d. Too concerned with conveying facts and information - should concentrate on how to help potential acceptors in decision making - to use contraceptives. (The individualized, decision-making approach will be improved largely through better training and supervision of family planning service providers).

The assessment team members visiting Sisaket, one of the 15 "lagging" provinces reported:

"There is only one set of audio-visual equipment at the Provincial Medical Office. The movie projector is always out of order as it is over-used in training of village health volunteers/health communicators, used by the IE&C mobile team, and sometimes loaned to other government agencies of the province. Only one movie projector operator has been trained. When the projector is loaned to other agencies, it is operated by inexperienced operators."

Similar observations were made by the team which visited Pitsanuloke. The Provincial Health Office had three tape recorders, one of which was a reel recorder, for which there were no tapes. The machine used most was the hand-held cassette recorder.

2. IE&C Components

a. Motivational and planning seminars for key provincial and district staff

Seminars have been held in all of the provinces except Samut Prakarn. Central NFPP staff believe that provincial and district workers are now aware of their situations. A monthly comparison of acceptor statistics is used to motivate the provinces to reach targets. However, perhaps because of other program pressures, such as lack of technical personnel, the level of motivation has not remained high. New measures to raise performance levels need to be explored. Most provincial and district programs are overloaded with curative service requirements.

b. Billboards

The six provinces selected for billboard displays were Lopburi, Petchburi, Samut Prakarn , Naratiwat, Pattani and Pattalung. Interestingly, Samut Prakarn, which received billboards, but had no mobile component and held no siminars, showed the greatest increase in family planning acceptors during the two-year period (See Table 27).

To date no formal evaluation of the impact of billboards or of the mix of motivational methods has been conducted, although an action research project has been designed and funds requested from DTEC to conduct the field work.

The NFPP proposed to extend the billboard campaign to the other nine "lagging" provinces. Large size billboards for display in district and sub-district locations are being produced in the provinces. Small billboards for placement in villages are to be produced centrally.

Table 27. I E & C Inputs for the 15 "lagging" Provinces, 1978-80, with comparison of percentage of Active Contraceptive Users by year 1978-80.

	Input				% of Active User			Different		Remark
	No. of Billboard				(1)	(2)	(3)	78-79	79-80	
	S	M	Small	Big	Nov. 78	Oct 79	Sep. 80	<del>(78-79)</del>	<del>(79-80)</del>	
1. Chachoengsao	/	/	739	-	21.4	25.5	30.3	4.1	4.3	
2. Lopburi *	/	/	-	100	29.8	29.7	33.1	-0.1	3.4	
3. Petchaburi *	/	/		73	25.7	30.1	34.6	4.4	4.5	
4. Nakorn Pathom	/	/		-	25.8	28.2	35.8	2.4	7.6	
5. Samut Prakarn *	-	-		50	21.7	26.4	35.9	4.7	9.5 *	* received billboards only
6. Sisaket	/	/		-	21.5	21.6	29.3	0.1	7.7	
7. Surin	/	/		-	22.7	23.6	27.3	0.9	3.7	
8. Nakhon Phanom	/	/		-	27.6	32.6	36.5	5.0	4.0	
9. Yasothon	/	/		-	24.3	29.2	33.6	4.9	4.4	
10. Petchabun	/	/		-	28.6	32.3	35.7	3.7	3.4	
11. Nakorn Sitanarat	/	/		-	18.3	17.0	21.6	-1.3	4.6	
12. Narathiwat *	/	/		50	12.5	13.5	14.9	1.0	1.4	
13. Pattani*	/	/		50	11.0	13.0	15.2	2.0	2.2	
14. Pattalung *	/	/		102	21.9	24.1	31.1	2.2	7.0	
15. Satun	/	/		-	23.9	27.5	32.0	3.6	4.5	

\* Provinces where billboards are provided

S = Seminar

M = Mobile FP.

2. Mobile Units

Mobile IE&C teams routinely contact and work with village leaders, small village groups, and provide large group educational/entertainment programs. This is done in advance of the VSC team visit. There is evidence that VSC team visits without prior motivational efforts are not productive.

Satisfied male vasectomy users are recruited to participate in the village motivational efforts. This has been one of the most effective approaches. The mobile IE&C teams also distribute pills and condoms.

Because coordination between provincial and district offices in scheduling mobile IE&C and VSC team visits has not yet been perfected, there have been numerous instances where requests could not be met if two villages wanted the teams on the same date. Village workup by sanitarians and midwives, with expectations the mobile teams could be available, has led to disappointment by staff and loss of interest among potential acceptors.

C. Conclusions

The VSC program in the lagging provinces is falling short of target projections. Factors affecting performance are suggested in the findings noted above. In addition, the basic resistance, or lack of enthusiasm, of males to obtain vasectomies is not fully understood, particularly in terms of how to overcome this low response.

Careful research is needed to identify possible IE&C approaches, if the male vasectomy program is to reach acceptable target levels.

Other administration and program factors affecting provincial cost-effectiveness of various techniques also needs to be addressed, especially in the long range projection of resource utilization.

D. Recommendations

1. Develop better integration/coordination of IE&C activities between the NFPP and Primary Health Care, MCH, Nutrition.

2. Continue to coordinate IE&C activities with private sector family planning agencies, e.g., the Mechai Community Based Family Planning Services, PPAT, TAVS, and ASIN.

3. Continue decentralization of responsibility for IE&C activities, including local development of materials and the testing of alternative motivational approaches. A pilot study should be conducted at the provincial level.

4. Improve coordination between Provincial and District levels in scheduling planning and administrative support for mobile team activities.

5. Intensive IE&C and VSC service campaigns might better be scheduled for the "off season" when men are not engaged in heavy manual labor. This would probably be much more cost effective, and would result in less real or imagined after effects on the part of acceptors. Much greater effort should be made to dispell fears by men that vasectomy leaves them weaker. Use of "satisfied" acceptors is proving effective in areas where this has been tried.

6. Rely more on simple approaches, less on the use of sophisticated audio-visual equipment.

7. Place more emphasis on interpersonal communications and individual or small groups counselling.

8. Set more realistic targets to more closely fit the particular needs (e.g., population size) and resources (e.g., available equipment and personnel) in each province, and design IE&C activities accordingly.

9. IE&C should focus on reaching specific target groups (adolescents, younger couples, males) to influence attitudes toward smaller family size. Appropriate materials should be used with female target groups to motivate them to obtain tubal resections once desired family size is reached, and especially for interval sterilization.

10. Consider disincentives for having more than two or three children, e.g., non-payment for delivery of a fourth child.

11. Continue use of mass media, as appropriate.

12. Support of the IE&C component of the NFPP program should continue in the next Five-Year Plan. Greater emphasis should be placed on evaluating the effectiveness of IE&C activities on "hard to reach" contraceptive acceptors. IE&C

inputs will become increasingly crucial when the program reaches the stage requiring "demand creation." This stage may have been reached already in some highly receptive areas, as in the northern provinces.

13. The NFPP recommends that the intensified IE&C program in the 15 "lagging" provinces should be expanded to 10 more provinces whose rate of active users is lower than 40 percent of MWRA, to accelerate their achievement and the progress toward national demographic goals. The Assessment Team recommends that any expansion of this program be preceded by a thorough evaluation of the current program.

## XII. OPERATIONAL RESEARCH AND EVALUATION

The research and evaluations funded by USAID comprise only a portion of the total activity in this area. A recent "Population Research Inventory"<sup>1/</sup> lists 256 studies conducted by 31 Thai institutions since 1977. These studies deal with a wide variety of topics, including/reproductive physiology, the testing of new contraceptives, demographic analyses, and cost-effectiveness of various family planning components. In addition, a number of studies have been conducted by U.S. institutions. One that is currently going on is an analysis of the impact of family planning programs on such areas as fertility, per capita income, energy consumption, education, health services, infant and child mortality. This study is being conducted by the International Population and Development Program (University of North Carolina) and the Futures Group.

Studies specifically funded by USAID have focused on programmatic issues. In 1979 and 1980 five specific operational research studies were funded by USAID. In 1981 funds were provided for general "support for operational research focused on problems related both to service delivery and creation of demand for family planning services". Four types of evaluation were planned: a "periodic evaluation of the progress of the VSC program"; a "comprehensive project evaluation", which was scheduled for mid-1981; evaluation of the lagging provinces project, and evaluation of training.

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<sup>1/</sup> "Population Research Inventory", Thai Population Clearing House/ Documentation Center, Family Health Division, February 1981.

A. Operation Research

1. The Relation Between Oral Contraceptive Usage and Infections in Compromised Populations (FY 79 - Ramathibodi Hospital)

This study was designed to determine if there is any difference in the incidence of infection between "normal" women and women with a prior history of urinary tract infection who take oral contraceptives.

The study was proposed in late 1979, revised and submitted to USAID and DTEC for approval in early 1980. The Assessment Team could not get any information on the status of this study.

2. The Dynamics of Family Planning Acceptance in Northeast Thailand (FY 79 - Mahidol University)

This study was to identify the factors that influence decisions to use contraception. It was to be conducted in two stages among married couples in the Northeast, where fertility was comparatively high. The study began in October, 1979 and was expected to be completed by April, 1981.

The project experienced several delays and cost overruns. It was eventually discontinued after completion of the first stage. A preliminary report is expected by June.

3. User Perspective Study (FY 80, \$19,000 - Family Health Division).

This was to be an in-depth study of current and past users of temporary methods of contraception (orals, injectables, condoms, etc.) to identify factors that affect continuation.

The actual study design was modified and is now called a "continuation rate/user perspective study". Field work has been completed and a final report is expected in August, 1981. Results from the study will be used to adjust the formulas for calculating active users, to detect regional variations in continuation, and to identify factors that affect continuation.

4. Village Health Volunteer (VHV) Study (FY 80, \$2,400 - Family Health Division)

The purpose of this study was to determine the extent to which VHVs are providing information about family planning and resupplying users with oral contraceptives and condoms.

Funds for this study have just been approved by DTEC. A protocol and draft questionnaire have been designed. Field work has not been scheduled but may begin in Udorn later this year. Plans are to treat this as a pilot study, which can be the basis for designing a national study later on. Staff expect that the study will be useful because no other research has been undertaken on this subject.

5. Comparative Study of Information, Education and Communication (IE&C) Strategies (FY 80, \$10,000 - Family Health Division)

This "action research" project was to consist of small-scale experiments of alternative motivation techniques. The first was to be a comparative study of various motivational approaches, i.e., printed materials, traditional birth attendants, "satisfied users", and so forth.

A questionnaire has been developed. Funds have been approved by DTEC to undertake the field work.

6. Other Operational Research Studies (FY 81)

As noted previously, the FY 81 Project Agreement did not list any specific studies, but provided general support for studies that were expected to be submitted to the MOPH/NFPP research committee.

Three proposals have been received to date.

a. Drug Cooperatives and Family Planning - (Family Health Division) - an experimental study to test the feasibility of selling pills through drug cooperatives.

b. Pilot Study on Training Auxiliary Midwives to Perform Vasectomy (Ramathibodi Hospital and NFPP) - twenty auxiliary midwives would be trained to perform vasectomies; follow-up would compare midwife and physician performance.

c. Study on the Consequences of Mobile Sterilization Project. (Family Health Division and medical staff of Soongnern District Hospital, Korat Province).

This is a follow-up of men and women from five districts in Korat who were sterilized. The study was approved by USAID in January 1980. A questionnaire has been developed and funds have been requested from DTEC to undertake the field work.

### B. Evaluation

#### 1. VSC Program Evaluation

The Project Agreements called for "periodic evaluation of the progress of the VSC program", which was to be done by the Research and Evaluation Section of the Family Health Division. Program progress was to be measured "through close study and analysis of the NFPP monthly statistical reports, the MOPH Forms O-1, ES-2 and the informed consent form."

The "Study on the Consequences of Mobile Sterilization Project", mentioned above, will provide some evaluative information on the VSC Program. No other evaluation has been undertaken or is planned at this time.

#### 2. Project Evaluation

The RTG and USAID agreed to continue the bi-annual comprehensive evaluation of the Population Planning Project. The last such evaluation was conducted, as noted previously, in July, 1979. The next evaluation was scheduled for May or June, 1981. Since there had been few changes in either the national program or the USAID-supported Population Planning Project in the interim, the RTG and USAID agreed that a comprehensive evaluation was not required at this time; instead this brief assessment was undertaken.

#### 3. Evaluation of the IE&C Campaign in the Lagging Provinces

The FY79 Project Agreement also called for a specific evaluation of the Lagging Provinces campaign. The evaluation was to take place in three stages: 1) during the seminars; 2) during implementation of the plan; and 3) at the end of six months of activity.

Due to delays in the pre-implementation stage, the first project began operations only in April, 1980; the last one begin in October, 1980. No formal evaluation of this project has been conducted, although a preliminary analysis was made of service statistics from the 15 provinces. An estimate of cost-effectiveness was also made, comparing the IESc with the VSC mobile vans.

The data from the analyses indicate that this approach may be both effective and cost-effective. Changes were made in the original project design but staff do not believe that will affect the evaluation.

At this time the R&E unit has a minimum of six months of data for each province, although the data have not been completely tabulated. The analysis can begin, therefore. However, the schedule for completing the evaluation has not yet been set.

#### 4. Evaluation of Training

The Project Agreement called for the training of Tambol Doctors, Traditional Birth Attendants, and Border Patrol Police. A special "assessment" of these training programs was to be carried out "prior to the end of March 1981." The assessment was to determine the effects of the training on "family planning knowledge and practice, both among the trainees and the population they serve" and it was to be "carried out by staff from the training section of the Family Health Division (FHD) and at least one evaluation specialist from outside the Division. Small sample surveys, using personally administered questionnaires, will be one method employed...."

So far no evaluation has been conducted. A professor at Mahidol University submitted a proposal recently to do this evaluation and it is now under serious consideration.

Conclusions

So far, none of the planned studies have been completed, although several are underway or in the planning stage. Of the five specific operational research studies funded by USAID, one is nearing completion (continuation study), one is still underway (infection and oral contraceptives), two have been delayed but are about to begin (VHV and IE&C), and one was discontinued <sup>at the halfway stage,</sup> but a preliminary report is being prepared (dynamics). Three studies on service delivery and demand have been proposed for FY 1981, one of which has been approved. The others are under review.

Of the four evaluations, one was modified (from a "comprehensive evaluation" to an "assessment" of the Population Planning Project), one may be completed soon (lagging provinces), and two have not been undertaken as yet (VSC and training).

In the last year or so there have been three noticeable shifts in research and evaluation: 1) proposed projects have become more program and problem-oriented, less biomedical and demographically-oriented; 2) the proposed projects have become smaller in scope and budget requirements have decreased; and 3) a trend has begun toward contracting studies out rather than attempting to do them all "in house".

In general, the NFPP has not yet completed any of the research and evaluation studies funded by USAID since FY 1979, however, several studies and evaluations are either underway or in the planning stages. Since none of the projects have been completed, it is not possible to assess their quality, much less their utility for management decision-making.

D. Factors Affecting Performance

1. Workload

The R & E staff spends most of its time on service statistics and has only a limited amount of time available for special studies. The VHV study, for example, could not have been conducted even if DTEC had approved it sooner because the R & E staff was already overbooked. VSC and IE&C staff are also busy with programmatic activities and have little time for research. The Thai system encourages qualified researchers to take on several projects at once in order to receive honoraria from each project. This has resulted in most researchers taking on much greater workloads than they can handle.

2. Personnel

Although R & E consists of 31 persons, only six to eight have analytical skills, the majority of the staff is engaged in routine coding, key-punching and tabulation of service statistics. The VSC and IE&C staff are not researchers. USAID only provided funds for per diem, gasoline, printing and other ancillary expenses, not NFPP personnel to conduct the studies.

3. Continuity

R & E staff have been out of the organization for long periods of time - for training abroad, leaves of absence, etc. Turnover is also an issue - transfers, promotions, etc. The only person who has been with R & E Section continuously for the past five years is a foreign advisor.

4. National Capability

There are few trained and experienced researchers in Thailand, particularly in operational research and evaluation. Since the demand for research exceeds the supply of qualified researchers, many are overbooked, and quality suffers.

5. DTEC

Delays in approval of funds for projects have resulted in delays in implementation, but DTEC has taken steps to rectify this.

6. Language

English tends to be the language of USAID-funded studies and evaluation projects, and that slows down and even limits involvement of limited English-speaking Thais. It also limits the utility of those research reports that are published only in English.

7. Funding

Several projects had very limited funding given the breadth of the research topics, and USAID's policy limiting honoraria has discouraged researchers from working on such project.

8. Other Research Efforts

As noted, there are many other research studies undertaken, both by the FHD and other institutions. Thus, the USAID-funded studies both complement and compete with other studies.

9. Leadership

The Research Committee of the NFPP rarely meets and there is little interest in operational research and evaluation. Thus, there is no strategy or list of priorities in these areas.

## Recommendations and Issues

### 1. The Need for Operational Research and Evaluation

Although there have been many studies conducted in Thailand, the majority have focused on service statistics, demographic impact, and contraceptive knowledge, attitudes and use. While these studies are very useful, there is a need at this time to shift the emphasis to studies of program operations to determine which program components are effective and which are not; and to find ways to improve effectiveness and efficiency.

### 2. Topics for Operational Research and Evaluation

a. Improvement of Efficiency. The program appears to be effective (i.e., it is reaching its objectives), but costs are a concern to the Thais. Operational research and evaluation can provide information to show ways to provide the same level and quality of service at reduced cost. Studies of VHWS, tambol doctors, mobile units and the lagging provinces are all examples.

b. Improvement of Management. Productivity varies from province to province, planning, supervision and coordination also vary. Studies geared to improve management and administration should lead to better services, greater coverage, increased acceptors, and increased efficiency.

c. Service Delivery. There is a need to find and test better and cheaper ways to serve the current population, hard-to-reach populations, and individuals who are uncertain of the benefits of family planning.

d. Quality of Services. Medical and educational services seem highly variable. There is a need to study ways to reduce this variability and to improve quality overall.

### 3. Strategy

The Evaluation Team does not have a strategy to recommend. Several issues need to be considered, however in developing a strategy. **First,**

resource for operational research and evaluation are limited in Thailand. Few people have received formal training in these field, and there is a limited body of expertise in the universities, ministries and private sector. Second, leadership must be developed to encourage these types of studies and to set priorities. Third, a long-term solution to the apparent gap in skilled personnel might require academic training in operational research, evaluation, cost analysis, and related fields. Perhaps this could be done through special training programs at Mahidol, Chulalongkorn, Thammasat, and other universities outside of Bangkok, but university faculty would have to be given special training first. Fourth, there is no immediate crisis, so crash courses in operational research and evaluation do not need to be conducted at this time. Fifth, if provincial and district personnel are to be encouraged to carry out studies there will have to be a mechanism developed to train and provide technical assistance to these personnel. They cannot be expected to carry out research and evaluation studies without such assistance. Finally, a mechanism needs to be developed to produce and distribute study results.

#### 4. Activities and Inputs

The specific activities to be conducted in the future and the resources required from USAID can only be determined after the strategy is developed. It will be important to coordinate USAID contributions with those to be made by UNFPA, IDA, CIDA, the Japanese Government, other donors, and the RTC itself.

5. Recommended Studies

A number of operational research and evaluation studies have been recommended throughout this report. These and several others that the team recommends are summarized here.

a. Program Utilization

1. Patterns of program use, by region and target group.
2. Factors affecting acceptance and continued use, by region, target group, and method.
3. Continuation rates.
4. Factors affecting utilization of VSC mobile units.

b. Program Evaluation

5. Training: validation of the training strategy; evaluation of knowledge and skill gains; follow-up of persons trained, cost-effectiveness.
6. IE&C: effectiveness of messages and media; effects on target groups, cost-effectiveness.

7. Lagging provinces, effectiveness and cost-effectiveness of the program.

8. Contraceptive distribution system, effectiveness and cost-effectiveness.

9. Mobile Units: effectiveness and cost-effectiveness.

10. Analysis of NFPP inputs at provincial and district levels.

11. Evaluation system built into each program component (training, IE&C, etc.) to compare planned and actual performance.

c. Operational Studies

12. Pilot study of a vasectomy campaign in the "off season".

13. Pilot studies of IE&C directed toward specific target groups (males, young couples).

14. Tests of VSC motivation/service options.

15. Tests of alternative ways to recover costs.

d. Operations Research

16. Logistics: inventory control of contraceptives.

17. Scheduling: optimum scheduling of staff, mobile units.

18. Resource allocation: optimal allocation among different service units (mobile units, health centers, hospitals).

19. Maintenance: optional program for maintenance of equipment (vehicles, mobile units, AV equipment).

XIII. ROLE OF USAID POPULATION ASSISTANCE

Although the Thai Government receives financial assistance from a variety of donors for its population program, USAID support continues to be vital.

A specific area of importance is the monetary support provided to District Hospitals for the Expanded Voluntary Surgical Contraceptive Program (VSC). The incentives to the institution are important, but unfortunately do not cover costs. As recommended earlier, consideration should be given to providing support to cover the full costs of the procedure.

USAID support of the Mobile Service Teams, Motivation Teams and Supervisors has allowed this component to demonstrate its potential for motivation and service delivery. USAID support is vital for this important project component.

Another very significant AID contribution is contraceptive supplies, including oral contraceptives and sterilization kits. Although shortfalls in supplies have occurred in the past, timely AID financial assistance has diminished the effect on services of underpurchasing. Since usage is projected to increase significantly in the next few years, provisions should be made to increase purchases.

Family planning training activities in Thailand form the backbone of its effective contraceptive service delivery system. AID support of the training of tambon doctors, border patrol police and traditional birth attendants contributes significantly to the success of the non-traditional aspect of this program. AID should strongly consider providing support for training of non-physician personnel to perform sterilizations.

Information, education and communication (IE&C) activities of the NFPP have been directly enhanced under the USAID population assistance project, particularly in redirecting program emphasis toward reaching the "unserved" population in the 15 lagging provinces. IE&C mobile teams carry out motivational activities in target villages in advance of visits by the VSC mobile teams. The IE&C teams work with village leaders, small groups and large gatherings of villagers to provide basic family planning information, to distribute pills and condoms, and to sign up receptors for vasectomy service.

Plans to conduct comparative studies of various educational methods in reaching new acceptors, with USAID support are being implemented after considerable delay.

As noted previously, no formal evaluation to measure the impact of IE&C activities on the service delivery component has been built into the program. This issue will be addressed in program projections in the new five-year plan.

It is difficult to assess the effect of USAID contributions on operational research and evaluation since no studies have been completed. However, it appears that USAID is playing a significant role in stimulating the NFPP to place more attention on short-range, problem-oriented studies designed to improve program effectiveness and efficiency.

Finally, the provision by USAID and AID/Washington of resident advisors and short-term consultants has been very significant. In addition to providing technical assistance, such personnel stimulate discussion and action, encourage analysis and reflection provide different points of view, and act as bridges between staff and decision makers.

Overall, USAID's contributions have been significant in helping the RTG to develop a program that is oriented toward communities rather than clinics, relies on paramedics rather than physicians, aggressively promotes and provides sterilization not just pills, and is beginning to focus on applied rather than academic research.

Appendices

- A. List of Institutions Visited and Persons Interviewed
- B. Terms and Abbreviations
- C. NFPP Statistics
  - 1. Number of NFPP Active Users
  - 2. Recent Continuation Rates
  - 3. Miscellaneous Fact Sheet
  - 4. MOPH MCH Service Statistics Available
  - 5. Available FP and Fertility Data
- D. References

List of Institutions Visited and Persons Interviewed

NFPP

Research and Evaluation Section

Suthorn

Mr. Tony Bennett

Training, Supervision and Education Section

Ms. Chusie Sujpleum

Information, Education and Communication Section

Ms. Patama Piromrat

Mahidol University

Suporn Koetsawong, M.D., Professor and Director, Siriraj Family  
Planning Research Unit

Angthong Province

Dr. Banchob Yantadilok, Provincial Chief Med. Officer (PCMO)

Dr. Puangpol Patrakorn, Assistant PCMO

Dr. Charas Pemayodhin, Director of Provincial Hospital,

Dr. Payat Sintusaad, Director of District Hospital, Visetchaicharn  
District

Pitsanuloke Province

Dr. Jinasak, PCMO

Dr. Payao Donkannert, Asst PCMO

Dr. Panya Sorukom, Director of Provincial Hospital

Dr. Vibul Vacharapibul, Director of District Hospital, Bang Rakim  
District

Sisaket Province

PCMO's office

Dr. Buonying Watkaew, Provincial Chief Medical Officer

Mrs. Thongproey Aksornsri, Chief Health Promotion Section

Provincial Hospital

Dr. Salan Suktrakul, Hospital Director

Dr. Chanchai Chatsirimongkol (who briefed us) (in charge of FP  
Section)

Kantharak District Hospital (60 bed)

Dr. Tirapong Nasinbodi, Hospital Director

Nurse Aide who is able to perform Tubal Resection and Vasectomy:

Mr. Amnuay Thongplaew

Health Center Tambon Phayuh, Muang District, Si Sa Ket Province

Midwife, Mrs Sanguansri Chanthanasak

Kantharom District Hospital (10 bed)

Dr. Udomsak Imsawat, Hospital Director

## Terms and Abbreviations

AFPH	Accelerated Family Planning and Health Baseline Study
ASIN	Association for Strengthening Information in Support of the National Family Planning Program
BPP	Border Police Patrol
CIDA	Canadian International Development Agency
CPS	Contraceptive Prevalence Survey Conducted by the National Institute for Development Administration
DMPA	Injectable depo provera
FHD	Family Health Division
IDA	International Development Agency (World Bank)
IE & C	Information, Education and Communications
IPDP	International Population and Development Program (University of North Carolina)
IPS	Chulalongkorn University, Institute for Population Studies
IPSR	Institute of Population and Social Research, Mahidol University
IUD	Inter uterine device
MOPH	Ministry of Public Health
MWRA	Married Women of Reproductive Age
NESDB	National Economic and Social Development Board
NFPP	National Family Planning Program
NIDA	National Institute for Development Administration
NLS or LS-1 & LS-2	National Longitudinal Study of Economic and Demographic Change - Chulalongkorn University, Institute for Population Studies
NS	National Study of Family Planning Practices, Fertility and Mortality
NSO	National Statistical Office
OC	Oral Contraceptives
PCDA (PDA)	Population and Community Development Association
PPHT	Planned Parenthood of Thailand
R & E	Research and Evaluation
RTG	Royal Thai Government
SOFT	Survey of Fertility in Thailand, conducted by IPS and NSO

TAVS	Thai Association for Voluntary Sterilization
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
TR	Tubal resection (female sterilization)
UNFPA	United Nations Family Planning Association
USAID	United States Agency for International Development
VAS	Vasectomy (Male sterilization)
VHC	Village Health Communicators
VHV	Village Health Volunteers
VSC	Vasectomy Surgical Contraceptive Program

APPENDIX C - Page 1

NUMBER OF NEPP ACTIVE USERS

JULY, 1978 - AUGUST, 1980

	<u>Month</u>	<u>Total</u>	<u>IUD</u>	<u>Pill</u>	<u>Male and Female Sterilization</u>	<u>DMPA</u>	<u>TOTAL % MWRA</u>
<u>1978</u>	JUL	2,015,183	262,283	1,099,287	548,835	104,778	36.1 %
	AUG	2,044,004	265,169	1,113,441	559,736	107,658	36.9 %
	SEP	2,079,239	264,287	1,132,003	572,316	110,633	37.5 %
	OCT	2,105,711	265,033	1,145,446	582,122	113,110	38.0 %
	NOV	2,135,646	265,823	1,161,132	592,677	116,014	38.6 %
	DEC	2,170,832	266,633	1,182,470	602,959	118,770	39.2 %
<u>1979</u>	JAN	2,208,014	267,988	1,202,399	614,757	122,870	39.6 %
	FEB	2,241,787	268,861	1,220,539	624,836	127,051	40.2 %
	MAR	2,272,040	269,843	1,237,800	633,635	130,768	40.8 %
	APR	2,299,967	270,085	1,248,731	642,397	133,754	41.2 %
	MAY	2,325,304	270,860	1,265,669	651,465	137,510	41.7 %
	JUN	2,350,514	271,211	1,278,949	659,753	141,001	42.2 %
	JUL	2,376,940	271,998	1,291,253	669,093	144,596	40.8 %
	AUG	2,401,631	272,733	1,301,839	679,645	147,414	41.2 %
	SEP	2,424,776	273,400	1,310,145	690,362	150,869	41.6 %
	OCT	2,447,565	274,122	1,317,397	701,263	154,781	42.0 %
	NOV	2,477,212	275,033	1,322,199	710,796	159,179	42.5 %
	DEC	2,499,009	275,245	1,340,476	719,851	163,437	43.4 %
<u>1980</u>	JAN	2,538,659	277,284	1,359,982	732,339	169,054	42.7 %
	FEB	2,582,197	279,542	1,381,842	745,265	175,548	43.4 %
	MAR	2,622,662	280,705	1,404,134	756,919	180,904	44.1 %
	APR	2,652,530	282,034	1,416,857	768,243	185,396	44.6 %
	MAY	2,689,948	283,203	1,436,529	779,840	190,376	45.2 %
	JUN	2,722,299	283,716	1,454,816	787,163	196,604	45.8 %
	JUL	2,757,054	284,702	1,469,568	800,345	202,439	46.4 %
	AUG	2,788,728	284,972	1,484,651	811,772	207,333	46.9 %
	SEP	2,824,232	287,107	1,498,707	825,006	213,412	47.5 %
	OCT	2,851,872	288,712	1,508,722	837,233	217,155	48.0 %
	NOV	2,911,067	290,844	1,544,637	848,422	227,164	49.0 %
	DEC	2,944,514	292,590	1,537,235	862,163	232,526	49.5 %
<u>1981</u>	JAN	2,974,388	294,214	1,566,852	874,276	239,046	48.5 %

Decline in % due to adjustment for MWRA increase

## APPENDIX C

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## Recent Continuation Rates for Thailand and Some International Rates for DMPA

Country & Method	Date of Acceptance	Year of Study	Continuation Rate by Ordinal Month In Percentages						Study Characteristics
			6	12	18	24	30	36	
<u>Thailand</u>									
DMPA	1974	1975	75	50	-	-	-	-	NFPP (M.Ds); 550 Women 15 - Provinces
DMPA	1974	1975	86	69	-	-	-	-	NFPP (M.Ds); 555 Women 15 - Provinces
DMPA	1970 - 73	1975	84	73	65	57	51	46	McCormick Hospital; 4,876 - Women 62,110 Women years, 1 Province
DMPA	Pre 1974	1974	-	76	-	60	-	-	Sirirat Hosp. Bangkok 886 Women
DMPA	1976 & 77	1978	84	60	48	40	31	25	NFPP; 624 Women National
<u>Mexico</u>									
DMPA	1969 - 76	-	-	56	54	-	-	-	54,650 Women
<u>Jamaica</u>									
DMPA	Pre 1974	1974	-	57	-	-	-	-	12,565 Women Months
<u>U.S.A.</u>									
DMPA	1967 - 69	-	-	57	49	-	-	-	Emony Univ; 650 Women
<u>Thailand</u>									
Pill	Pre 1971	1971	79	69	-	55	-	-	NFPP; 1,495 Women: National
Pill	1970 - 73	1974	68	54	48	35	-	-	NFPP; 1,506 Women: National
Pill	1972 - 74	1975	77	66	54	48	-	-	IPSR; 720 Women: Bangkok
Pill	1974 - 76	1977	82	72	62	56	52	45	NFPP; 1,043 Women: National
<u>Thailand</u>									
IUD	Pre 1971	1971	85	76	-	65	-	-	NFPP; 1,087 Women: National
IUD	1971 - 72	1972	-	77	-	-	-	-	NFPP; 1,880 Women: Bangkok Hosp.
IUD	1972 - 74	1975	75	62	48	36	-	-	IPSR; 277 Women: Bangkok
IUD	1976 - 77	1977	82	75	68	65	59	54	NFPP; 520 Women: National

\* M. Ws = Midwives

MISCELLANEOUS FACT SHEET - 1981 UNLESS SPECIFIED

<u>TOTAL MID YEAR POPULATION:</u>	48,179,000	(100.0%)	
Female	23,970,000	(49.8%)	
Male	24,209,000	(50.2%)	
Under 15	19,432,000	(40.3%)	
<u>CRUDE BIRTH RATE</u>	26.9	per 1,000	
<u>CRUDE DEATH RATE</u>	7.4	per 1,000	
<u>GROWTH RATE</u>	1.95%		
<u>INFANT MORTALITY RATE (1975)</u>	68	per 1,000 Live Births	
<u>PREVALENCE OF PRESCHOOL MALNUTRITION (1980)</u>	1 <sup>0</sup> :41%	2 <sup>0</sup> :14%	3 <sup>0</sup> :2%
<u>AVERAGE DURATION OF BREAST FEEDING (1979)</u>	Rural:	18.7 Months	
	Urban:	10.0 Months	
<u>ANNUAL PER CAPITA INCOME* (1979)</u>	฿12,000	(\$600)	
<u>AVERAGE LANDHOLDING PER HOUSEHOLD* (1979)</u>	26 Rai	(1 Rai = 1,600 Sq. Met. or 0.4 Acres)	

NUMBER OF RURAL HEALTH OUTLETS

		<u>Theoretical Coverage</u>
District Hospitals	312	50,000 People
Tambon (Sub-District) Health Centers	4,688	5,000
Village Midwifery Centers	1,781	2,000
Assuming no overlap between Health Centers and Midwifery Centers, Coverage	=	56%

<u>MOPH BUDGET (1981 FY)</u>	฿5,428. Million	(\$271 Million)
- DEPT. OF HEALTH BUDGET	฿ 299. M.	(\$15 M.)
- FAMILY HEALTH DIVISION BUDGET	฿ 140. M.	(\$7 M.)
- FAMILY PLANNING BUDGET	฿ 55. M.	(\$2.75 M.)
- MCH BUDGET	฿ 85. M.	(\$4.25 M.)

\* Excludes Bangkok

MOPH MCH SERVICE STATISTICS (AVAILABLE BY PROVINCE)

RURAL HEALTH DIVISION 1980

1. NUMBER OF NEW REGISTRANTS FOR
  - A. ANTE-NATAL CARE
  - B. DELIVERY
  - C. POST-PARTUM CARE
  - D. WELL BABY UNDER 1 YEAR CARE
  - E. WELL BABY 1-4 YEARS CARE
  
2. NUMBER OF VISITS (SEPARATED BY CLINIC AND HOME)
  - A. ANTE-NATAL CARE
  - B. DELIVERY
  - C. WELL BABY CARE (1-4 YEARS)
  
3. NUMBER OF CLINIC/HOME DELIVERIES
  
4. NUMBER OF LIVE BIRTHS
  - A. NUMBER OF STILL BIRTHS
  - B. MORTALITY WITHIN 1 WEEK/4 WEEKS
  
5. NUMBER OF LIVING POST PARTUM MOTHERS
  - A. MATERNAL MORTALITY WITHIN 6 WEEKS
  
6. TOTAL HOME VISITS
  
7. NUMBER OF CONSULTANCIES AT 6 WEEKS POST PARTUM
  
8. NUMBER OF FOLLOW-UP VISITS

APPENDIX C - page 5

WHAT FAMILY PLANNING AND FERTILITY DATA ARE AVAILABLE?

A. NEW ACCEPTORS

1. NFPP SERVICE STATISTICS: THE MONTHLY REPORT  
(BY PROVINCE, DISTRICT, METHOD AND MONTH)

\*2. REPORTING UNITS THEMSELVES

B. CONTINUATION RATES

\*1. NFPP FOLLOW-UP SURVEYS

C. PREVALENCE OF PRACTICE

1. NFPP SERVICE STATISTICS: ACTIVE USERS REPORT  
(BY PROVINCE, METHOD AND MONTH SINCE JULY, 1978)

\*2. NATIONAL SAMPLE SURVEYS (LS, SOPT, CPS, NS)  
(BY REGION AND METHOD FOR 1969, 1972, 1975, 1978, 1979)

3. MINI-SURVEY OF MECHAT'S PDA  
(BY MECHAT DISTRICT AND METHOD SINCE 1979)

4. 1980 CENSUS  
(BY PROVINCE AND METHOD)

D. FERTILITY

1. VITAL REGISTRATION SYSTEM

\*2. NAT'L SAMPLE SURVEYS (LS, SOPT, SPC, CPS, NS)

3. NAT'L CENSUS

1  
\* MOST RELIABLE DATA

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