(3) Minutes of Meetings

THE MINUTES OF MEETINGS
BETWEEN
THE JAPANESE PRELIMINARY SURVEY TEAM
AND THE AUTHORITIES CONCERNED
OF THE GOVERNMENT OF KINGDOM OF THAILAND
CONCERNING TECHNICAL COOPERATION
FOR THE FAMILY PLANNING AND MATERNAL AND
CHILD HEALTH PROJECT

The Preliminary Survey Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr. Kenji Hayashi, Director of Public Health Demography, the Institute of Public Health, visited the Kingdom of Thailand from October 23 to November 2, 1990 for the purpose of conducting the feasibility study regarding technical cooperation for the Family Planning and Maternal and Child Health Project (hereinafter referred to as "the Project") on the request by the Government of Kingdom of Thailand.

The Team and the authorities concerned of the Government of Kingdom of Thailand had a series of discussions in respect of technical cooperation and agreed to the matters mentioned in the document attached hereto.

Bangkok, October 31, 1990

K. Hayashi

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ATTACHED DOCUMENT

1. Project title

The Family Planning and Maternal and Child Health Project

2. Objective of the Project

The objective of the Project is to improve the health status of communities in the northeastern part of Thailand by promoting and strengthening family planning and maternal and child health activities.

3. Activities of the Project

(1) Strengthening and development of information, education, communication and service delivery activities with regard to family planning and maternal and child health activities.

(2) Promotion of education for personnel in the field of family planning and maternal and child health.

(3) These activities will be implemented in close coordination with the Primary Health Care Project, which is under consideration as a cooperation project in future by both Governments.

4. Target Area of project implementation

The geographical target area of the Project will be the northeastern part of Thailand.

5. Japanese Technical Cooperation

The technical cooperation for the Project will consist of :

(1) dispatch of Japanese experts;
(2) acceptance of Thai personnel for training in Japan;
(3) provision of equipment and materials.

6. Thai organizations responsible for project preparation and implementation.

(1) The Ministry of Public Health will bear overall responsibility for successful implementation of the Project.

(2) The Department of Health, Ministry of Public Health, will be responsible for administrative and managerial matters of the Project.

(3) The Director(s) of Provincial Public Health Office(s) in Region 3 and 4 will be responsible for program implementation.

(4) The Director of Health Promotion Center in Region 4 will be responsible for technical and practical matters.

7. Measures to be taken by the Thai side

(1) Providing sufficient number of personnel for implementing the Project, including administrative staff and secretaries.

(2) Providing necessary working facilities for implementation of the Project.

(3) Establishing inter-ministerial coordinating committee including responsible departments of the Ministry of Public Health for family planning and maternal and child health, and primary health care.

8. Term of Cooperation

The duration of Japanese technical cooperation will be five(5) years from the date determined in the Record of Discussions (R/D).

9. Joint Coordinating Committee

The Joint Coordinating Committee will be established for successful implementation of the Project at the commencement of the Project.

Composition

(1) Chairman :

Director-General, Department of Health, Ministry of Public Health

(2) Members:

Thai side

a. Director(s), Provincial Public Health Office(s) in Region 3 and 4
b. Director, Health Promotion Center in Region 4
c. Director, Family Health Division, Department of Health, Ministry of Public Health

Japanese side

a. Leader of the Japanese expert team
b. Coordinator
c. Representative of JICA Thailand office
d. Japanese experts
e. Other personnel to be dispatched by JICA

Note : Official(s) of the Embassy of Japan may attend the Joint Coordinating Committee as observer(s).

(4) タイにおける家族計画概要

National Family Planning Programme in Thailand

National Family Planning Programme in Thailand

Introduction

Thailand is one of the ASEAN countries which is bounded by Burma in the North and West, Laos in the Northeast, Cambodia in the East and Malaysia in the South. Thailand has an area of approximately 514,000 square kilometres (200,000 square miles) and its population is 54,465,056 (1988). Bangkok is the capital with a population of about 5.7 millions in 1988. Because of locating near the tropical zone, the climate is rather warm and humid. There are 3 seasons, summer starting from March to May, rainy season during June to November and from December to February is winter

Agriculture has been the major sector in the Thai economy. Main production are rice, rubber and maize. However, the economic situation has been slightly changed to be semi-industrialized. A diversification approach has been utilized in order to expand the economic growth. Its growth rate in 1988 has been about 11 per cent as against 8.4 per cent growth recorded in 1987. It is due to the remarkable expansion of agricultural sector, manufacturing sector and other sectors including investment, exports, and tourism. With regard to the economic situation in 1988 and some major internal and extermal factors, the growth rate in 1989 has been foreseen to be sustainable at the rate of 8.5 per cent because of the dropping growth rates in many sectors.

2. Population Policy in Thailand

During the past two decades, Thailand has been systematically developed in both economic and social matters. The first National Devleopment Plan was started in 1961 which was mainly emphasized on the economic development and some of the social problems were simultaneously resolved that were -- a health condition and an education. This strategy was continuously operated in the Second National Development Plan (1967-1971). However, the outcomes of these Plans were unsatisfied by virtue of the retardation. The main problem was due to a high population growth rate which was about 3 per cent at that time. Consequently, in the Third Plan (1972-1976), specified policy of improving the social condition was formulated and had a major concern in the reduction of the population growth rate.

The measure that has been strengthened since the Third Plan is the family planning programme. As a result, the population growth rates has decreased from 3 per cent in 1970 to 1.5 per cent in 1988 while the contraceptive prevelance rate is about 70 per cent in 1986. The overall health condition has been enriched by providing health services and facilities throughout the country. Crude death rates has dropped from 12.8 per cent in 1960 to 5.7 per cent during the Sixth Plan. Life expectancy at birth has been higher for both men and women -- from 59 and 63 for men and women during 1975-1980 to 61 and 65, respectively between 1980-1985. Total fertility rate is 3.36 per thousand in 1984 while crude birth rate is 21.04 per thousand in 1988.

Apart from the policy of reduction of population growth rate, there are two more important policies -- improving quality of popul-aiton and distributing of population. For the improvement of quality of population, many measures have been formulated including encouragment of education and training innovations and emphasis on the higher participation of the population in their health concerns. The population distribution is another policy that needs more attention due to high rate of migration to Bangkok Metropolis. However, it has to be integrated with other policies in rural and urban development programmes.

3. National Family Planning Programme (NFPP)

3.1 Objective of the NFPP

Since the Third National Development Plan, the government has declared a 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. Therefore, the National Family Planning Programme (NFPP) has been established in the Ministry of Public Health in order to develop effective and economical FP services throughout the country.

3.2 Organization of the NFPP

The NFPP is under the responsibility of Department of Health. A Committee which is consisted of many members from concerning Departments in the Ministry of Public Health has been set up. The Director of the Programme is the Director-General of the Department of Health.

Integration of family planning into other services is the basic philosophy of the Department of Health. It is apparently that coordination of service delivery and the day-to-day management of the family planning programme needs a specific unit to operate these task in the Department. Consequently, the operating unit of the NFPP has well been established in the Family Health Division which its Director has been the Assistant Programme Director and member of the NFPP. An organization chart of the NFPP is presented in the Appendix.

3.3 Responsibilities of the NFPP

The NFPP has been responsible for many activities as follows:-

1) Expand and improve family planning services

- Improve capability and responsibilities of paramedical personnel at each level especially auxiliary midwives to provide all methods of family planning except sterilizations; sanitarians, junior health workers and community health workers to provide oral pills for new and current acceptors and injectable contraceptives for hilltribes.

- Promote government personnal outside the MOPH to provide FP services such as health personnel of the Ministry of Interior, border patrol police and health personnel of the Ministry of Defence.

- Promote the volunteers of both public and private organizations to provide oral pills and condoms.

- Accelerate FP services for special target groups which are :- newly married coupies, slum dwellers, hilltribes, adolescents, factory workers, couples with two living chidren and Moslems in the South.

- Procure adequate amount of supplies and equipment for regular services and during special occasions.

- Promote Pap Smear services for family planning acceptors

- Establish counselling and service units for adolescents

- Promote community participation in family planning activities.

2) Increase production and up-grade the capability of health personnel

- Increase the number of auxiliary midwives and assistants

- Train physicians and other health staff in sterilization techniques

- Train staff in the use and maintenance of sterilization equipment

- Train physicians to insert inplant contraceptives

- Train nurses and auxiliary midwives in IUD insertion

- Train auxiliary midwives to provide injectable contraceptives.

- Train VHVs, VHCs and TBAs to provide information and FP services in the rural community

- Participate and support FP training outside the MOPH

- Conduct seminars and short-term training for groups involved in community development in basic FP methods and motivation

- Improve the training curricula to be consistent with the national policy and plan

- Conduct meeting and seminars on FP and related topics to disseminate and exchange of information and experiences among FP practitioners

- Provide fellowships and observation tour for qualified staff.

- Supervise and evaluate activities of trained personnel in FP services

3) Expansion and improvment of public relations and information

- Promote the institutions concerned with population and family planning to publicize the two-child family norm.

- Increase the coverage of mass media in support of FP and MCH.

- Coordinate with the Ministry of Interior in supporting FP campaign in target districts and provinces.

- Support local leaders in effort to conduct group education and motivation in FP and MCH.

- Improve information, education and communication(IE&C) activities relevant to each of special target groups.

- Intensify IEC activities in the high priority areas in the Northeast and the South

- Promote public reactions and informations in practising of highly effective methods, such as, sterilizations and IUD.

- Improve coordination in planning and supervision of IEC activities among private and public sectors.

4) Research and Evaluation

- Conduct studies which investigate the time use providing FP services with the aim to improve the efficiency of personnel.

- Conduct cost-effectiveness studies of various aspects of the NFPP

- Identify the population groups which are in greatest need for FP services and design service strategies

- Study integrated strategies which use FP as a key service

- Improve the data collection and information systems of the NFPP

- Increase the efficiency of the evaluation activities of the NFPP

- Study the impact of FP services on socio-economic status of the population

- Study on bio-medical aspects of contraceptives currently use in the NFPP and conduct trial studies for the new and proper methods to be used in the programme.

5) Promotion of community participation in development of family planning programme

- Make awareness of socio-economic problems occurred from having big family to community leaders.

- Provide information for villagers about the advantage of family planning on the health of mothers and childern.

- Support community leaders in motivating the villagers to accept two-child family norm

- Promote the newly married couples to have a birth interval after bearing the first child

6) Beyond family planning

- Reform and reviso laws and regulations conflicting with the implementation of programmes in accordance with the population policies and goals of the country.

- Encourage the private sector to revise regulations so as to support the goals of the population policy

- Create incentives to encourage both public and private agencies to participate in population quality development and take action in balancing the distribution of population.

- Motivate people to have 2 children in the family by providing special benefits to small families.

3.4 Private Organizations

The Ministry of Public Health has encouraged private organizations to provide family planning services by giving monetary support, contraceptive equipment and supplies. The major non-government organizations which play an important role in complementing the activities of the NFPP are as follows:-

a) ASIN

The Association for Strengthening Information in Support of the NFPP is a private organization founded in 1977. ASIN principal project entitled "Voluntary Sterilization in Private Medical Institutions" began in October 1977. The purpose of this project is to recruit physicians in private clinics and hospitals to perform sterilizations. A subsidy is provided to the physicians for each

sterilization procedure performed. The number of acceptors are included in the NFPP service statistic reports. ASIN also sponsors seminars for its members, provides special training and publishes 2,000 issues of a bimonthly magazine.

b) PDA

The Population and Community Development Association a registered tax-except profit organization, was expanded from the work of the Community-Based Family Planning Services (CBFPS) which was established in 1974. With assistance from International Planned Parenthood Federation (IPPF), the Japanese Organization for International Cooperation (JOICEP), the U.S. Agency for International Development (USAID) etc., the CBFPS pioneered a community-based family planning and parasite control project and a family planning and primary health care project.

The PDA has recently organized an international training center called the "Asian Center for Population and Community Development". The first international training course was conducted in June 1979 and 6-8 courses are held each year.

The PDA also established the Population and Community Developemnt Company, a non-profit agency, in 1975, to become a financial source for services rendered by PDA. A number of fertility regulation services are carried out under PDA, including voluntary sterlization, IUD insertions, injectables, and the commercial distribution of condoms in 3,000 outlets throughout the country.

c) PPAT

The current role of the Planned Parenthood Association of Thailand is to focus on promotional activities and provide services in remote areas, refugee camps in the Northeast, and to other special target groups which are identified in consultation with the Government. PPAT is also planning to place more emphasis in youth groups.

d) TAVS

The Thai Association for Voluntary Sterilization is a private, non-profit organization which was founded in 1975. Its purpose is to promote sterilization skills and research on sterilization for both sexes. Its activities include public education on voluntary sterilization, manpower development, clinical services in Bangkok, and mobile units in the Northeast.

e) TFRA

The Thailand Fertility Research Association was established in 1979 as an independent and non-profit organization that brings together the support of capable researchers in the private and public sectors to assist the work of the Thai National Family Planning Program (NFPP). As a private organization, the TFRA is uniquely situated in the Ministry of Public Health (MOPH), where it could enjoy substantial Thai Goverment support and has excellent access to family planning decision makers and health facilities delivering family planning services.

f) There are few missionary hospitals (2-4 places) engaged in family planning field, especially the McCormick Hospital and Family Planning Clinic in Chiangmai.

Besides the above mentioned organizations there are some more channels which deliver family planning services. Those are as follows:-

f) Commercial Channels

There are about 17,000 pharmacies in Thailand. They are divided into three classes (A,B and C) according to the kinds of drugs they are permitted to dispense; only "A" pharmacies are supposed to sell prescription drugs, which up to now has included oral contraceptives. The pharmacy network is limited almost exclusively in cities and towns, where they cater to a class of people with more income than the great majority of villagers. There is, of course, a much more extensive network of non-pharmacy retail shops and stalls, which does extend to the village level. The (subsidized) Community-based Family Planning Services (CBFPS) program is also making selective use of the existing retail networks.

g) Private Doctors (modern)

It is estimated that there are about 5,000 private doctor clinics, some with in-patient facilities, distributed over the country. A large proportion of these private doctor clinics are run by physicians who are also in Government service: MOPH rules permit Government doctors to engage in private practice outside Government hours, and, in fact, a very high proportion do so including most doctors who serve in rural areas. The advantages are to extend the

hours during which medical services are available in a community; another may be to offer a greater degree of privacy than the Government hospital may offer. The important point is that there are almost as many private doctor clinics in the country as MOPH health centers and these clinics constitute a resource which might well be given an important role in the national family planning programme.

4. Impact of the NFPP on the Socio-Economic Conditions

4.1 Impact on population size and structure

If the family planning programme had not been created in Thailand, the number of total population would have been 60 million in 1985 which is 9 million persons more than the actual number in the same year. The changing population structure, which is manifested by the increasing number of children and youth, has increased the dependency burden for the people in economically active groups and necessitated more and more early entry of children and women into the labour market, thus, affecting the family institution with an eventual repercussion on the society as a whole.

TABLE 1 NUMBER OF POPULATION WITH AND WITHOUT THE FAMILY PLANNING PROGRAMME 1960-1990

Year	Number of population	
	Without family planning programme	With family planning programme
1960	26,257,860	26,257,860
1965	30,744,000	30,744,000
1970	36,611,000	36,370,000
1975	42,677,700	41,388,000
1980	50,725,800	46,961,338
1985	60,460,200	51,180,478
1990	72,249,500	55,207,977

TABLE 2 COMPARISION DISTRIBUTION OF THE POPULATION AGED 0-14 YEARS AND 60 YEARS AND OVER WITH AND WITHOUT THE FAMILY PLANNING PROGRAMME 1970-1990

(Per cent)

Years	0-14 years		60 years and over	
	Without FP. Programme	With FP. Programme	Without FP. Programme	With FP. Programme
1970	44.8	44.4	4.9	4.9
1975	45.5	43.0	4.7	4.9
1980	46.1	40.3	4.6	5.0
1985	46.5	36.5	4.6	5.4
1990	46.6	32.5	4.5	6.0

Source : Leoprapai B.: Impact of FP on Size and Structure of the Population, presented at the Seminar on "Impact of FP on the National Development" 1986.

4.2 Impact on provision of welfare services

The success of the family planning programme in reducing the growth rate consequently lessens the Government financial burden in providing welfare services to target groups including children and youth, women in certain categories, elderly, crippled and handicapped people as well as persons who suffer from natural calamities. The budget of approximately 21,000 million baht was saved during the Fifth Plan and about 51,000 million baht will be saved in the Sixth Plan.

TABLE 3 ESTIMATED BUDGET FOR PROVISION OF SOCIAL WELFARE SERVICES 1982-1991.

(million baht)

	Budget for Provision of Social Walfare Services		Savings
	Without FP. Programme	With FP. Programme	
The Fifth Plan			
1982	90,323	87,962	2,361
1983	96,116	92,916	3,200
1984	102,261	98,200	4,061
1985	109,270	104,143	5,127
1986	116,620	110,375	6,245
Total	514,590	493,596	20,994
The Sixth Plan			
1987	124,427	116,983	7,444
1988	132,721	123,990	8,731
1989	141,534	131,421	10,113
1990	151,159	139,489	11,670
1991	161,388	148,046	13,342
Total	711,229	659,929	51,300

Source : Report of the Seminar "Impact of FP on the National Developemnt, Family Health Division, 1986.

4.3 Impact on Education Management

The continuing implementation of the policy to reduce the population growth rate has brought about a decrease in the number of children at the compulsory and secondary educational levels, Therefore, the emphasis for development input will be on equal opportunities in education and on quality improvement.

5. Constraints and Problems

Despite its satisfactory results, the NFPP has still encountered some constraints in relation to the delivery of family planning services as follows :

1. Restricted availability of sterilization services in rural and remote areas.

2. Restricted availability of the IUD services due to inadequate personnel. Although trained auxiliary midwives have been allowed to insert IUD since 1981, the Family Health Division could train only 350 auxiliary midwives per year during 1983-1986. The number of trainees has increased to be 500 per year in 1987 but it still takes time to cover auxiliary midwives all over the country (approx. 7,000 auxiliary midwives in rural areas). The contraints of the training programme are the training centers and cases for trainees to practise.

3. Some groups of target population may not be achieved such as : ethnic and religious minorities, low-income groups, and slum dwellers.

5. The infant mortality rate has still considered high when compare with developed countries or some developing countries in the same region. Therefore, parents in rural areas do not have confidence to accept family planning.

6. Future Plan

Increasing contraceptive prevalence rate is more difficult to accomplish in a context where almost 60 per cent of eligible couples are already practising some form of contraception. Indeed, there is some evidence of a slight decline in the rate of new acceptors during 1991 to 1982. To increase the rate of acceptors or to reach currently underserved sectors of the population, Thailand has the following issues to encounter and consider for development of the future programmes :

- development of appropriate education and service programmes for the large numbers of adolescents entering the reproductive ages each year;

- development of more focused information, education and communication efforts for the special population groups that are currently underserved, including the urban poor, hilltribes, and refugees;

- improving the quality of service delivery in order to match user needs and preferences, and having available methods for those who wish to contracept but are not satisfied with their current methods;

- more attention to the demand factors affecting use of contraception and adoption of the small family norm; and

- greater need for interministerial cooperation in the formulation and implementation of policies in other development areas that may have a bearing on family size intentions and contraceptive use.

In its effort to expand services to underserved segments of the target population, the government should pay more attention to indirect measures or beyond family planning approaches for the programme.

(5) Health Statistical Report of Ubolratana District

HEALTH STATISTICAL REPORT OF UBOLRATANA DISTRICT (1 JAN 1990)

1) GENERAL INFORMATION
2) VITAL STATISTICS
3) NUTRITIONAL STATUS
4) IMMUNIZATION STATUS
5) MATERNAL AMD CHILD HEALTH STATUS
6) SANITATION
7) PRIMARY HEALTH CARE
8) BASIC HEALTH SERVICE
9) UBOLRATANA DISTRICT HEALTH PROBLEMS

1) GENERAL INFORMATION

1.1	AREA	=	418	SQUARE KILOMETRTS
1.2	NUMER OF SUBDISTRICT	=	6	SUBDISTRICTS
1.3	NUBER OF VILLAGE	=	57	VILLAGES
1.4	NUMBER OF HOUSE	=	6,459	HOUSES
1.5	NUMBER OF POPULATION	=	34,856	PEOPLE
	1.5.1) MALE	=	17,466	
	1.5.2) FEMALE	=	17.390	

1.6) OCCUPATION

1.6.1) AGRICULTURE
1.6.2) OFFICER
1.6.3) LABOR
1.6.4) FISHERY

1.7) AVERAGE OF INCOME PER YEAR = 31,501 BATH/FAMILY

1.8) EDUCATION (EXCLUDE PRESEHOOL AGE)

1.8.1) DIDN'T GO TO SCHOOL	=	4%
1.8.2) 4-6 YEAR IN SCHOOL	=	90%
1.8.3) MORE THAN 6 YEAR IN SCHOOL	=	6%

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2) VITAL STATISTICS

2.1)	- TOTAL LIVEBIRTHS	=	649
	- LIVE BIRTH RATE PER 1,000	=	18.65
	- GENERAL FERILITY RATE PER 1,000	=	74.2
2.2)	- TOTAL POPULATION DEATH	=	34
	- CRUDE MORTALITY RATE (PER 1,000)	=	0.98
2.3)	- TOTAL INFANT DEATH	=	5
	- INFANT MORTALITY RATE	=	7.70
2.4)	- MATERNAL MORTALITY RATE	=	0
2.5)	POPULATION INCREASE RATE (PER 1000)	=	17.67

2.6) TOP TEN OUT PATIENT DISEASES OF 1989
(DATA COLLECT FROM UBOLRATANA HOSPITAL)

DISEASE	CASES	%
1) ACUTE RESPIRATIRY TRACT INFECTION	4,243	22.03
2) INTESTINAL DISEASE	3,271	19.32
3) INFECTIOUS DISEASE ANDPARASITE	2,980	15.47
4) ACCIDENT	1,346	6.99
5) NEUROTIC DISORDER AND NONPSYCHOTIC MENTAL DISORDERS	1,175	6.10
6) INFLAMMATORY CONDITION OF SKIN AND SUBCUTANEOUS TISSUE EXCEPT INFECTION	1,104	5.73
7) DISORDERS OF MUSCULAR AND SKELETAL	1,035	5.34
8) DISORDERS OF GENITAL TRACT EXCEPT INFLAMMATORY	1,010	5.24
9) DISORDERS OF ENDOCRINE GLAND SYSTEM	859	4.46
10) OTHERS	1,786	9.29
TOTAL	19,258	100

2.7) TOP TEN DISEASES OF IN - PATIENT ADMISSIONS OF YEAR 1989
(DATA FROM UBOLRATANA HOSPITAL)

DISEASE	NUMBER OF CASES	%
1) FEVER (WITH COMPLICATION)	247	8.49
2) DIARREA	212	7.29
3) OTHER DISEASE OF DIGESTIVE SYSTEM	116	3.99
4) ACCIDENT	102	3.51
5) DENGUE HEMORRHAGIC FEVER	97	3.34
6) APPENDICITIS	86	2.96
7) COPD	65	2.24
8) TUBERCULOSIS	64	2.20
9) EOSINOPHILIC MENINGITIS	44	1.51
10) DIABETIC (WITH COMPLICATION)	44	1.51
11) OTHER	1,819	62.55
TOTAL	2,908	100

2.8) TOP TEN COMMUNICABLE DISEASE OF THE YEAR 1989

OF UBOLRATANA DISTRICT (FROM EPIDEMIOLOGY)

DISEASE	NUMBER OF CASE	INCIDENCE RATE/100,000
1) DIARRHEA	1,062	3,094
2) PYREXIA	260	752
3) DYSENTERY	175	506
4) CONJUNCTIVITIS	171	494
5) PNEUMONIA	132	382
6) HEMORRHAGIC FEVER	98	238
7) FOOD POISONING	75	217
8) SYPHILIS	48	138
9) CHICKENPOX	29	83
10) TUBERCULOSIS	27	78

3) NUTRITIONAL STATUS OF 0-5 YEAR

3.1) TOTAL CHILDREN	=	2,719	
3.2) WEIGHED CHILDREN	=	2,469/	90.81 %
3.3) NORMAL NUTRITIONAL STATUS	=	1,526/	61.81 %
3.4) 1 DEGREE PROTIEN CALORIE MALNUTRITION	=	897/	36.33 %
3.5) 2 DEGREE PROTIEN CALORIE MALNUTRITION	=	46/	1.86 %
3.6) 3 DEGREE PROTIEN CALORIE MALNUTRITION	=	0	

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4) IMMUNIZATION STATUS

4.1) COVERAGE OF VACCINE IN 0 - 1 YEAR

TYPE OF VACCINE	IMMUNIZED INFANTS	PERCENT COVERGE
1) BCG	588	85.84
2) DPT	602	87.88
3) OPV	604	88.18
4) MEASLE	583	85.11

NOTE TOTAL INFANTS = 685

4.2) COVERAGE OF TETANUS IN PREGNANCY

- TOTAL NUMBERS OF PREGNANCY = 654
- COVERAGE OF TETANUS TOXOID = 457 = 70

4.3) COVERAGE OF VACCINE ON SCHOOL AGE GROUP

TYPE OF VACCINE	IMMUNIZED	PERCENT COVERGAE
1) BCG (CLASS 1)	514	67.63
2) DT (CLASS 1)	636	83.68
3) TYPHOID (CLASS 1-6)	5228	99.68
4) T (CLASS 6)	956	100
5) RUBELLA (FEMALE CLASS 6)	477	96.95

NOTE 1) TOTAL NUMBER OF CLASS 1 = 760
2) TOTAL NUMBER OF CLASS 6 = 956
3) TOTAL NUMBER OF FEMALES CLASS 6 = 452
4) TOTAL NUMBER OF CLASS 1-6 = 5249

5) MATERNAL AND CHILD HEALTH STATUS

5.1) FAMILY PLANNING

5.1.1) TOTAL NUMBER OF MARRIAGED WOMEN = 4,479

5.1.2) COVERAGE OF CONTRACEPTION = 3,825 = 85.4%

- PERMANENT = 2,364 = 1.02%
- TEMPORLY = 1,461 = 38.2%

5.1.3) MODE OF PERMANENT CONTRACEPTION

- VASECTOMY = 24 = 1.02%
- TUBAL RESCTION = 2,340 = 98.98%

5.1.4) MODE OF TEMPORALY CONTRACEPTION

- IUD = 686 = 46.89%
- PROGESTERONE INJECTION = 462 = 31.62%
- ORAL PILLS = 308 = 21.08%
- OTHERS = 5 = 0.41%

5.2) COVERAGE OF ANTINATAL CARE

- TOTAL NUMBER OF DELIVERY = 649
- COVERAGE OF ANTINTAL CARE = 454
  (4 TIMES)

5.3) COVERAGE OF DELIVERY BY HEALTH PERSONAL OR TRAINED PERSONELS

- TOTAL NUMBER OF DELIVERY = 649
- COVERAGE OF DELIVERY = 475
  (BY HEALTH PERSONAL OR TRAINED PERSON)
  = 73.19%

5.4) BIRTH WEIGHT (COVER ONLY DELIVERY BY 5.3)

BIRTH WEIGHT (GMS)	NUMBER	%
< 2500	39	8.21
2500 - 2999	150	31.58
> 3000	286	60.21
TOTAL	475	100

5.5) COVERAGE OF POSTNATAL CARE

- TOTAL NUMBER OF DELIVERY = 649
- COVERAGE OF POSTNATAL CARE = 422
  (4 TIMES) = 65 %

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6) SANITATION

COVERAGE OF LATRINES OF UBOLRATANA DISTRICT IN THE YEAR 1989	=	71.47%
COVERAGE OF CLEAN DRINKING WATER OF UBOLRATANA DISTRICT IN THE YEAR 1989	=	66.52%

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7) PRIMARY HEALTH CARE

7.1) HEALTH COMMUNICATORS	=	560 PERSONS
7.2) COVERAGE OF HEALTH COMMUNICATORS	=	1 - 12 HOUSES
7.3) HEALTH VOLUNTEERS	=	55 PERSONS

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8) BASIC HEALTH SERVICES

8.1) SUBDISTRICT HEALTH OFFICES

8.1.1) SUBDISTRICT HEALTH OFFICES = 4 PLACES

8.1.2) DISTRICT HEALTH OFFICES = 4 PERSONS

8.1.3) COVERAGE OF DISTRICT HEALTH OFFICES
= 1: 8539

8.1.4) SUBDISTRICT HEALTH OFFICES = 11 PERSONS

8.1.5) COVERAGE OF SUBDISTRICT HEALTH OFFICES
= 1: 2196

8.2) PATIENTS

OUT PATIENTS = 2900 VISITS/YEAR

IN PATIENTS = 2908 ADMISSION/YEAR
= 7000 ADIMSSION DAY/YEAR

8.2.1) SURGERY

- APPENDECTOMY	=	86 CASES/YEAR
- TUBAL RESECTION	=	180 CASES/YEAR
- CESAREAN SECTION	=	8 CASES/YEAR
- HERNIOTOMY C HERNIORRHAPHY	=	6 CASES/YEAR
- OTHERS	=	20 CASES/YEAR

8.2.2) PERSONNEL

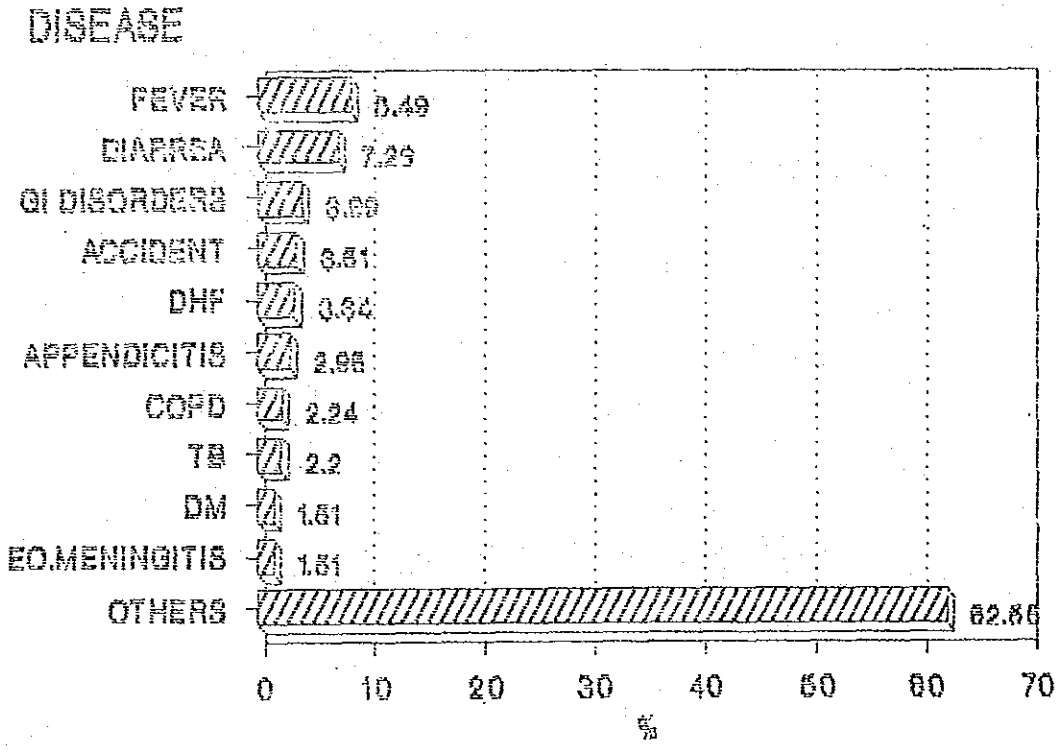
PERSONNEL	NUMBER	COVERAGE
A) DOCTORS	2	1 : 17428
B) PHARMACIST	1	1 : 34856
C) DENTAL NURSE	1	1 : 34856
D) GRADUATED NURSE	4	1 : 8714
E) TECHNICAL NURSE	8	1 : 8714
F) OTHERS	30	-
TOTAL	46	-

๙) TEN MAJOR HEALTH PROBLEMS OF UBOLRATANA DISTRICT

SET PRIORTY
1) PREVALENCE OR INCIDENCE
2) SEVERITY
3) CONCERN
4) CHANGEABLE

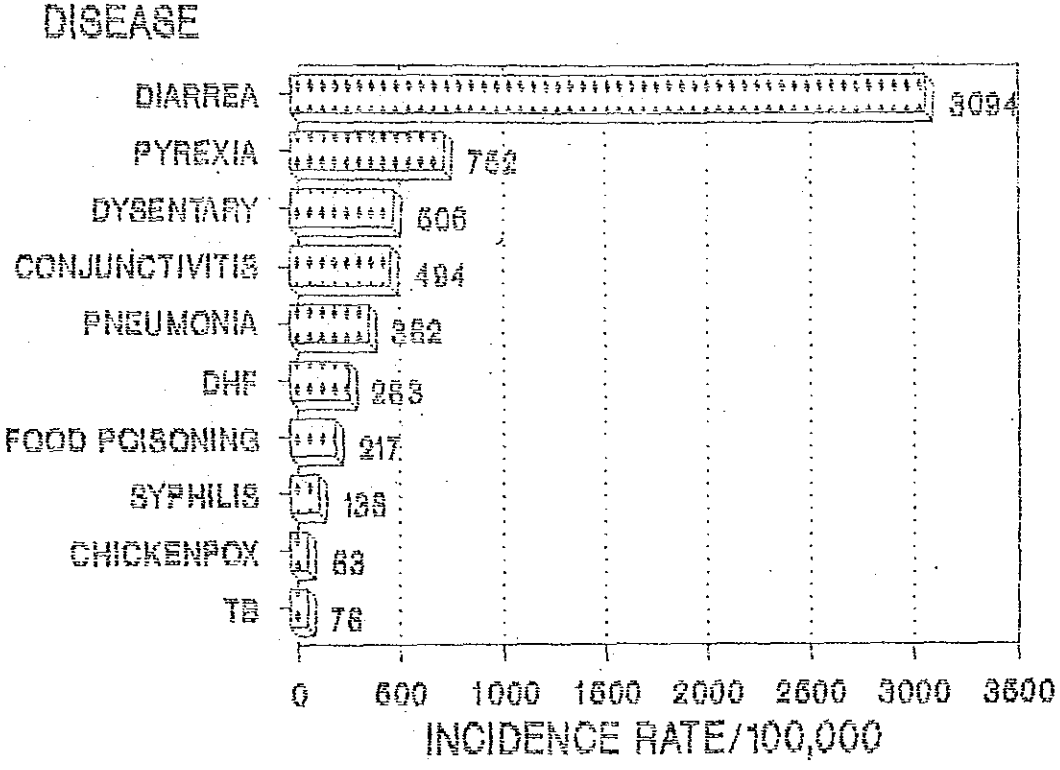
1) OPISTHORCHIASIS
2) ACCIDENT
3) DENGUE HAEMORRHAGIC FEVER
4) DIARRHEA
5) PNEUMONIA
6) DIABETIC MELLITUS
7) TUBERCULOSIS
8) DYSENTERY
9) UPPER RESPIRATORY TRACT INFECTON
10) RENAL CALCULI

TOP TEN IN PATENT DISEASE
IN UBOLRATANA HOSPITAL



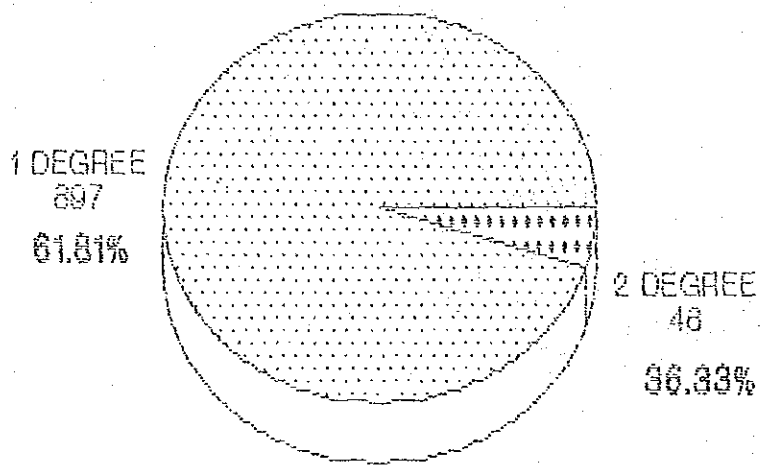
IN 1989

TOP TEN COMMUNICABLE DISEASE IN UBOLRAT DISTRICT IN 1989



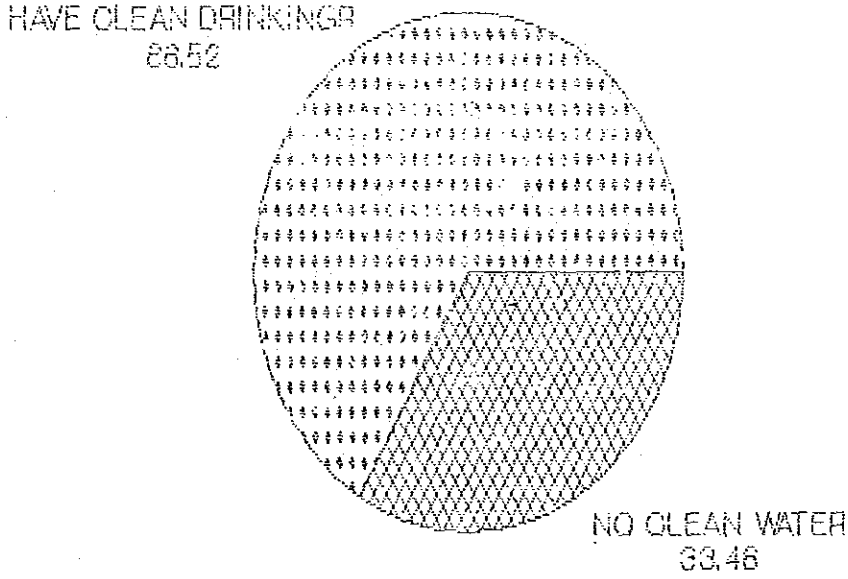
DATA FROM EPIDEMIOLOGY

NUTRITIONAL STATUS 0-5 YEAR OF UBOLRATANA DISTRICT



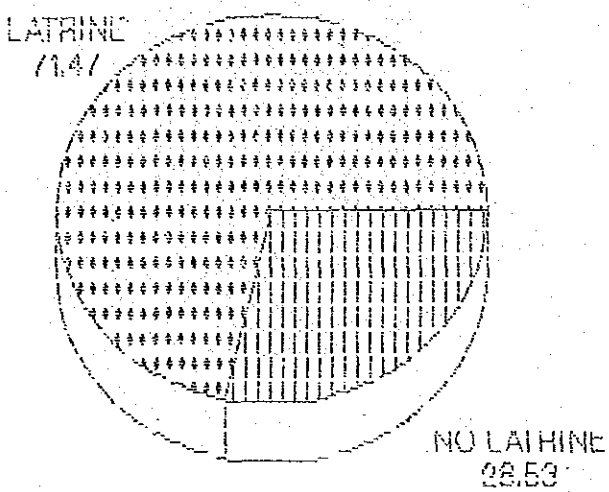
IN 1989

COVERAGE OF CLEAN DRINKING WATER IN UBOLRATANA DISTRICT



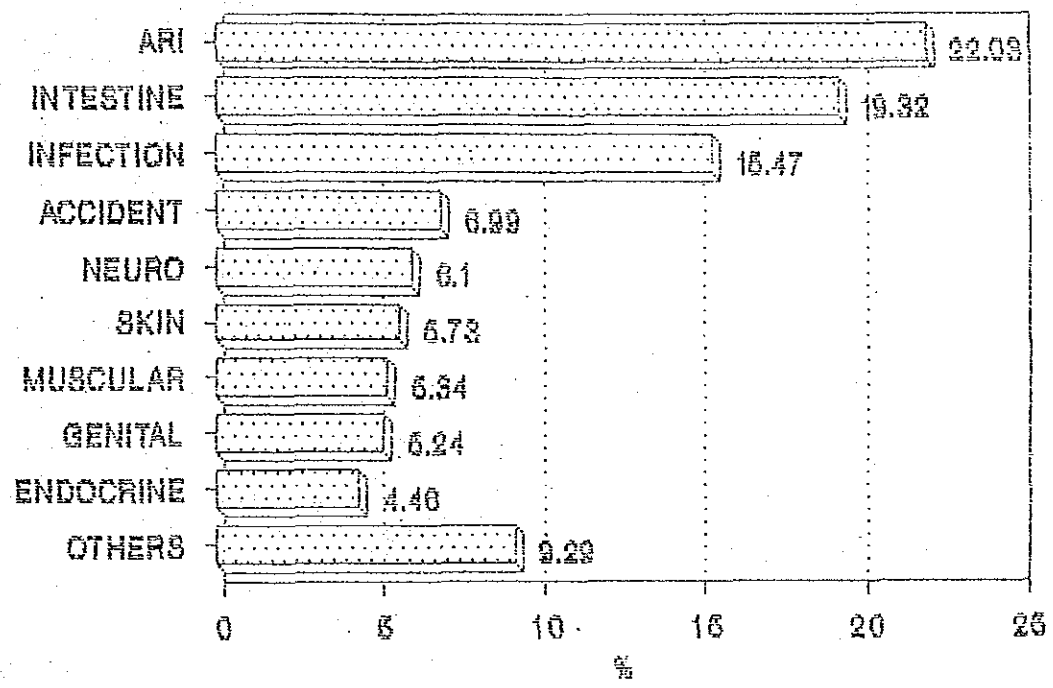
IN 1989

COVERAGE OF LATRINE
IN UBOLRATANA DISTRICT



IN 1989

TOP TEN OUT PATIENT DISEASE
OF UBOLRATANA HOSPITAL



IN 1989

(6) プロジェクト方式技術協力要請書

Form P.

PROJECT TITLE :	New Family Planning Project Family Planning in Total Rural Health Development in Region III
REQUESTING AGENCY :	Family Health Division Department of Health Ministry of Public Health THAILAND
SOURCE OF ASSISTANCE :	Japanese Government (Japan International Cooperation Agency)

PROPOSED PERIOD OF THE PROJECT : April 1989 - March 1994

A. JUSTIFICATION

Description of Problems

The seven border provinces in the North east comprise Nakohn ratchasima, Surin, Si sa ket, Yasothon, Chaiyaphum, Buriram, Ubon ratchathani with the total population of 9.3 million. In these area most of rural population are very poor, especially Surin, Srisaket and Buriram. Among the local ethenic groups in these areas, the fertility rate is still high. High fertility causes high mortality of infant. Unplanned birth contribute to high morbidity and low birth weigh baby. For mothers, frequent child bearing causes pregnancy related illness and death for example hemorrhage, sepsis and infection. In these area, The infant mortality rate and children under five-mortality rate is 44/1,000 L.B. and 53/1,000 L.B. respectively. One forth of pregnancies of mothers receive no antenatal care from neither health staff nor traditional birth attendance. The first three leading causes of death in infancy were conditions originating in the perinatal period, pneumonia and disease of digestive system. Nutrition is one of the important factor for the cause of low birth weight infant. The pregnant mothers who are still nursing infants are to face the great risk of health problems on anemia and under nutrition. The rate of low birth weight of infant and preterm is still very high. Children from low-income families bear more than their share of illness and death.

All diseases occured to mother and children are preventable. It is neccessary to increase birth spacing, pre natal care, delivery service and post natal care for adequate needs of the mothers and children which are two third of the total population in the target area.

Background

B. Detailed Description of Present Project Accomplishment and Work in progress

Before 1970 Thailand annual rate of population increase was around 3.3 % which is one of the highest rate in the world. The very rapid and high growth rate of population would give an unavoidable adverse effect to the national social and economic development of the country. The Thai Government announced its policy to support voluntary family planning in 1970 in order to resolve various problems concerned with the very high growth rate of population. Because of the great efforts of the National Family Planning Program, the rate of population growth has declined dramatically from 3.3 % in 1970 to only 1.5 % in 1988. From the contraceptive prevalence survey, it was found that the rate of current contraceptive use has risen sharply from 15 % to 70 % during 1970 - 1987. An increase of acceptance resulted in better health of mothers and the decline of the infant mortality rate which decrease from 84 to 35 per thousand live births during the same period.

During 1984 - 1989, inputs under the assistance of JICA include medical equipment, for the Regional Maternal and Child Health Centers, transportation for mobile information/service and home visit program ofprovincial and district health office, educational film and video-tapes for health education programs in rural areas, training and technical consultants. The program has been in good progress. All equipment, transportation, educational equipment and materials are being utilized for family planning and maternal and child health program. The received support in kind of approximate one hundred million yen/year has been utilized and implemented as planned. This greatly help to the capacity and efficiency of FP/MCH information and services. The contribution partly results the great increase the rate of contraceptive from 64.6 % in 1984 to 70.6 % in 1987 and help to reduce the infant mortality rate from 45 to 35 per thousand within five years.

The impact of the FP program has shown the great result in reducing the morbidity and the mortality of infants and mothers. With family planning, a mother would have her choices for long spacing between children in order that the best care for the existing child could be possible and the limitation of the number of children can be determined according to the potential support of each couple.

C. Major Problems and Obstacles Experiences during Project Implementation

All activities under JICA technical assistance during the period of 1980-1984 have been implemented according to schedules and found no crucial obstacles to the program activities. However, the ultimate goal to improve the health of mothers and children in some hardcore areas can not be reached. Most of these target groups belong to the very low economic status in the following areas :

1) Seven border provinces in the northeast.,

2) Hilltribe groups in the North,

3) The Muslim in the Southern border provinces.

The rate of contraceptive use in these areas is around 25-60 %. Number of children in each family is still high around 3-10 children as compared to the national average which is around 2.3 children.

The Government of Thailand has a plan to reduce National population growth rate from 1.5 % to 1.3 % during the year 1987-1991. At the same period, contraceptive prevalence rate was planned to increase from 70 % to 75 % and reduce the infant mortality rate from 35 % to 25 % To be able to reach its goals, special inputs are needed for these selected hard core areas where poor health status are still exited.

D. Description of the New Project

Project Objectives

1. To increase contraceptive use among couples in target area. The use of contraceptive should serve the purpose of delaying th mother age of first birth from 20 to 23 and spacing children at least 3-5 years. Stretilization should be accepted to limit the family size to two children.

2. To increase intensive pronatal care delivery services and post natal care by health personnel, at least 4 visits to health centers and hospitals for pre natal care & post natal care each is to be encouraged. Regular care could help to prevent children who are particularly vulnerable and subject to disease.

E. Conditions Expected at completion of the Project

1.By the end of 1994, the rate of contraceptive use in the project area will increase from average 55 % to 65 %

2.By the end off 1994 ,80 % of children 0-5 receive well baby check up and treatment annally.

F. Duration of the Project March 1989 - April 1995

G. Project Site Ubon rachathani, Surin, Sri sa ket and Buri rum.

H. Project Work Plan and Activities

1) Intensive information and service program

- Twenty districts in the 4 provinces will be selected.

- Intensive information and service programs will be organized by district hospitals and health centers. Scope of information and service will include the following areas;

H-1. Family planning services

- Oral contraceptive pill
- Injectable contraception
- IUD insertion
- Condom
- Norplant Implant
- Male and female sterilization

H-2. Maternal and child health services

- Antinatal care
- Delivery
- Postnatal care
- Well baby clinic
- Pap smear check up

H-3. Nutrition programs

- Nutrition surviillance
- Promotion of breast feeding and supplementary food

H-4. Dental program

- Dental survicilance in children under five
- Promote brushing teeth and fluoride rinsing
- Promote village fund raising for tooth brush and tooth paste

H-5. School Health Services

- Periodic health examination
- Immunization
- Vision screening
- Others,....

H-6. Treatment for diseases and injuries

- Increase co-ordination of district hospital and health center in providing health service and information to specific target groups.

- Develop primary health care program; increase community participation, increase the use of village volunteer, village communicator and other village resources.

- Organize orientation, seminar, training to review program activities and plan.

- Provide training program for key persons to improve management skill in Japan

- Provide neccessary equipment and transportation to some selected health centers and hospitals.

- Evaluate program achievement by analyzing service reports of health centers and hospital.

- Conduct research to find appropriate model of information and services and identify problem areas for future program development.

I. Assistance Requested for the Project

1. Medical equipment for MCH/FP service at hospital, health center and mobile units
2. Equipment for education programs and information system
3. Transportation
4. Training
5. Research
6. Consultant/expert/coordinator

Schedule of Project Activities

description of activities	1989-90				91-92				92-93				93-94				94-9		
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3
1) Provision of medical equipment, education equipment and transportation to some selected district hospital and health Centers.				-				-				-				-			
2) Field implementtation, comprehensive health information and service in 20 districts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3) Conduct training			-				-				-				-				-
4) Program evaluation			-				-				-				-				-
5) Research activities			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

J. Operating Agency

The family Health Division, Department of health will be responsible for the project management, resource allocation and monitoring. Field implementation of intensive information and services will be carried out by Provincial public Health office including 20 district hospitals and health centers. Staff members under the mentioned organization will be responsible for project activities. The Regional Health Promotion Center Region 4 (Khonkaen) will provide technical support, (If the health promotion center region 3 is constructed, the center will share the technical support to project in implementation)

K. Assistance Requested

K-1 Expert

Field of operation or activities	person/manmonth				
	1989	1990	1991	1992	1993
1) Project Coordinator	1/12	1/12	1/12	1/12	1/12
2) Public Health expert	1/1	1/1	1/1	1/1	1/1
3) Gynecologist	1/1	1/1	1/1	1/1	1/1
4) Pediatrician	1/1	1/1	1/1	1/1	1/1
5) Volunteer	2/24	2/24	2/24	2/24	2/24
6) Cytologist	-	2/4	2/4	2/4	2/4
7) Pathologist	-	2/4	2/4	2/4	2/4

Job Description

1. Project Co-ordinator

The project coordinator will be at the Family Health Division to organize all kinds of supports under the project agreement.

2. Public Health Official:

The public health official will help to organize health education programs to promote awareness of health needs of the target population under the project area.

3. Gynecologist

The gynecologist will assist to develop pronatal care, delivery service and post natal care systems including advise on appropriate equipment for maternal services.

4. Pediatrician

The prdiatrician will assist to develop infant and child care programs and determine medical equipment for infant & child health services.

5. Volunteer

Two Volunteers will work at district level to develop information and community self organization for health development.

6. Cytologist and pathologist

One Cytolelist and pathologist will help to train health staff and technician in screening slides under pap. smear program to lower the incidence of cervical cancer in women.

K-2 Equipment

- Basic medical equipment will be selected to provide to Health Promotion Center provincial offices, hospital and health centers in the project areas. All of equipment are for MCH/FP service. The equipment will help to extend hospitals, capacity to diagnose and treat MCH/FP client with reliable and valid facilities to promote health of mothers and children. Exact type and number of equipment will be determined by each district hospitals and health center with the assistance of expert provided under the project in each year.

- Educational equipment is to be supported to district hospitals and health centers. These equipment will make possible to each district hospital and each health center to provide comprehensive health education program for communities with in its districts. The health education program will help villagers to learn about health promotion and prevantation of communication deseases.

Equipment·

Description	No. of set				
	1989	1990	1991	1992	1993
MCH/FP Medical Equipment					
HP	2	2	2	1	-
DH	4	4	4	4	4
HC	40	40	40	40	40
MCH/FP Information &	No. of set				
	1989	1990	1991	1992	1993
Educational Equipment					
HP	1	1	1	1	1
DH	4	4	4	4	4
HC	40	40	40	40	40
Transportation					
HP (mobile unit)	-	-	2	2	-
DH (mobile unit)	4	4	4	4	4
I-HC (motorcycle)	40	40	40	40	40

- Transprtation will be provided to district hospitals and will be used as Mobile units for intensive information and services in co-operation with health centers. Motor cycles will be used for home visits by health staff working at each health center.

K-3 Training

Course Description	Duration (day)/No of trainee.				
	1989	1990	1991	1992	1993
A Local Training					
- Maternal health	5/50	-	-	-	-
- Child health	-	-	-	-	5/50
- Family Planning	-	-	-	5/50	-
- Cervical Cancerening	-	-	5/50	-	-
- Community Program	-	2/50	2/50	-	-
B Training in Japan	5/1	5/1	5/1	5/1	5/1

Health staff from 2 Hospitals and 20 District hospitals participate in the above meeting. The meeting will review technical subjects and programs planned for intensive services in MCH/FP. Nutrition school health and dental health subjects and programs are also added for training. Community Program Training will include subjects on information systems in communities, role of community participation and primary health care programs. Training Japan for approximate one month for 5 key officials is required for further program development and application.

k-4 Research

Each year 2 studies in health promotion areas are planned. The family Health Division will consult with Regional Health Promotion Center and District Hopitals regarding specific areas of studies. A total of 10 studies during the project year is proposed. Study areas include 1) maternal health, 2) child health, 3) Nutrition, 4) school health, 5) dental health, 6) Health Education models 7) Community involvement 8) Development of information system in villages 9) Hospital Health Education programs 10) Family planning

K-5. School health service

- Periodic health appraisal, medical examination
- Immunization
- Vision screening
- Others (nutrition and dental program

Description of Medical Equipment for

1) District Hospitals and Health Promotion Center

1. Infant Incarbator
2. Bilirubino meter
3. Infant respirator
4. Neonatal monitor
5. Infant warmer with resuscitator.
6. Microscope

2) Health Center

1. Gynecological examining table
2. Delivery set
3. Autoclave

Description of information and ducation equipment

Health Promotion Center

Micro computer

Word processor

District Hospitals

Electriet Scaner

Transparency Coppying machine

Photo copy machine

Electriet Typewriter

Mimeograph machine

Health Center

Teaching aid production kit

L. Expected Out Come

1) Approximate 5,000 pregnant mothers and infants will be served by 20 hospitals and 200 health centers for prenatal care, delivery and post natal care. Services include periodic health check up vaccination and consultation each year

2) Approximate 30,000 children of age 0-5 receive annual well baby check up and treatment annually

3) Approximate 70,000 primary school students receive annual health examination and treatment.

4) Approximate 60,000 new family planning acceptors receive and continue their use of contraception.

Prepared by Patama Bhiromrut

Ratchadawan Sirinawin

Information Section

Tel. 2823140 - 7 Ext. 62

Approved by Vira Niyomwan

Family Health Division

Department of Health

Ministry of Public Health