タイ王国家族計画・母子保健プロジェクト

実施協議調査団報告書

平成３年11月

国際協力事業団

医療協力部

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医 療 協 力 部

序　　文

タイ政府は、1970年から国家家族計画政策を実施し、同年３％であった人口増加率は1988年には1.5％まで減少した。

わが国は、1974年から1989年の間、同国の中西部において家族計画分野のプロジェクト方式技術協力を実施したが、その恩恵に浴さない地域はなお広く、地域による格差が著しいのが現状である。

特にタイ東北部は、家族計画・母子保健の立ち遅れがみられ、出生率、乳幼児死亡率共に他の地域に比べて高いものとなっている。

このような背景から、タイ政府は東北タイにおける家族計画および母子保健協力に係る新たな技術協力を要請越した。

当事業団は、本要請に基づき、1990年（平成２年）10月に、事前調査団を派遣し、要請内容、プロジェクトの背景等について調査を行い、プロジェクト方式技術協力実施の可能性等があることを確認した。事前調査団の報告をうけ、本年１月10日から同年１月19日の間、討議議事録および暫定実施計画を締結するために実施協議調査団を派遣した。

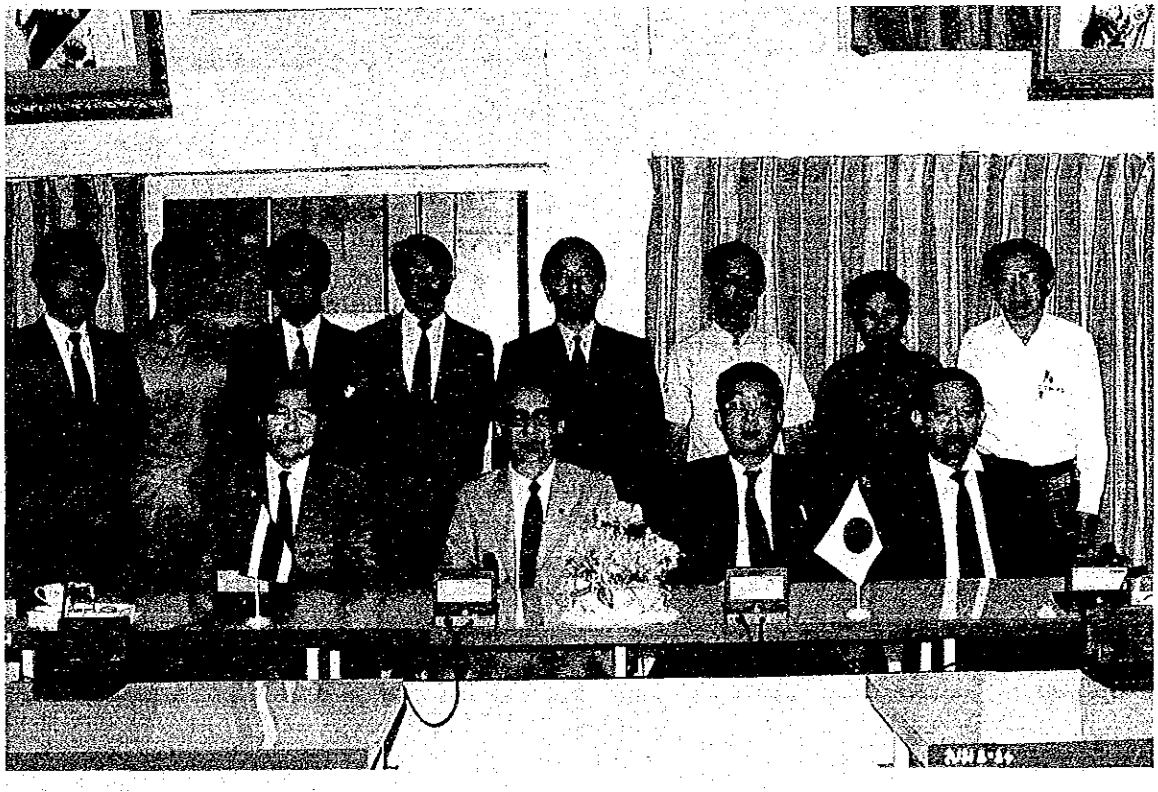
本報告書は、本調査団による調査結果を取りまとめたものである。

ここに本プロジェクト形成に尽力いただいた関係各位、本調査団の団員および調査団の派遣にご協力いただいた関係各位に対し深甚なる謝意を表するとともに、今後の本件プロジェクトの実施・運営にあたり関係各位の一層のご協力をお願いする次第である。

平 成 3 年 11 月

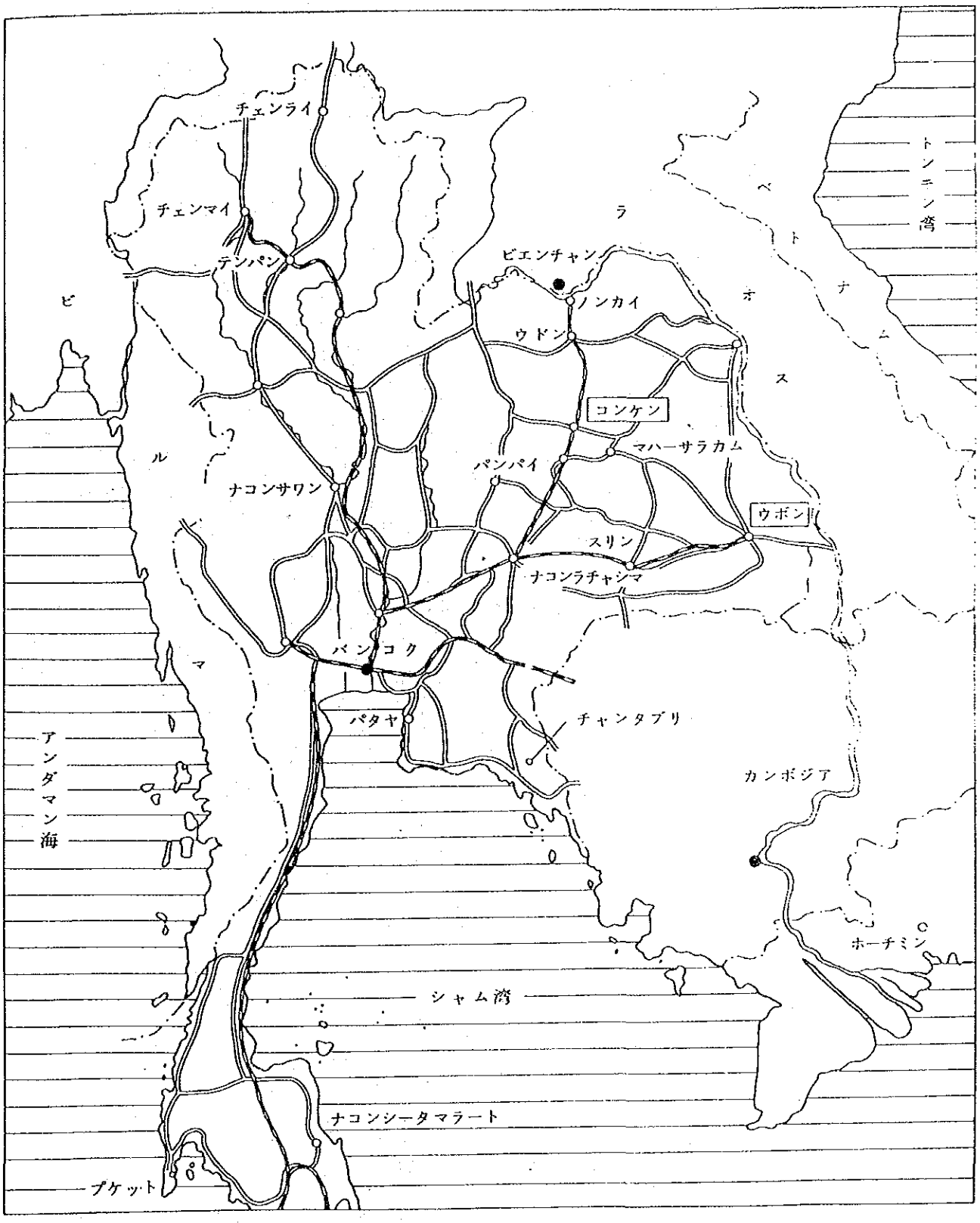
国際協力事業団

理 事　西 野 世 界



タ　イ　王　国

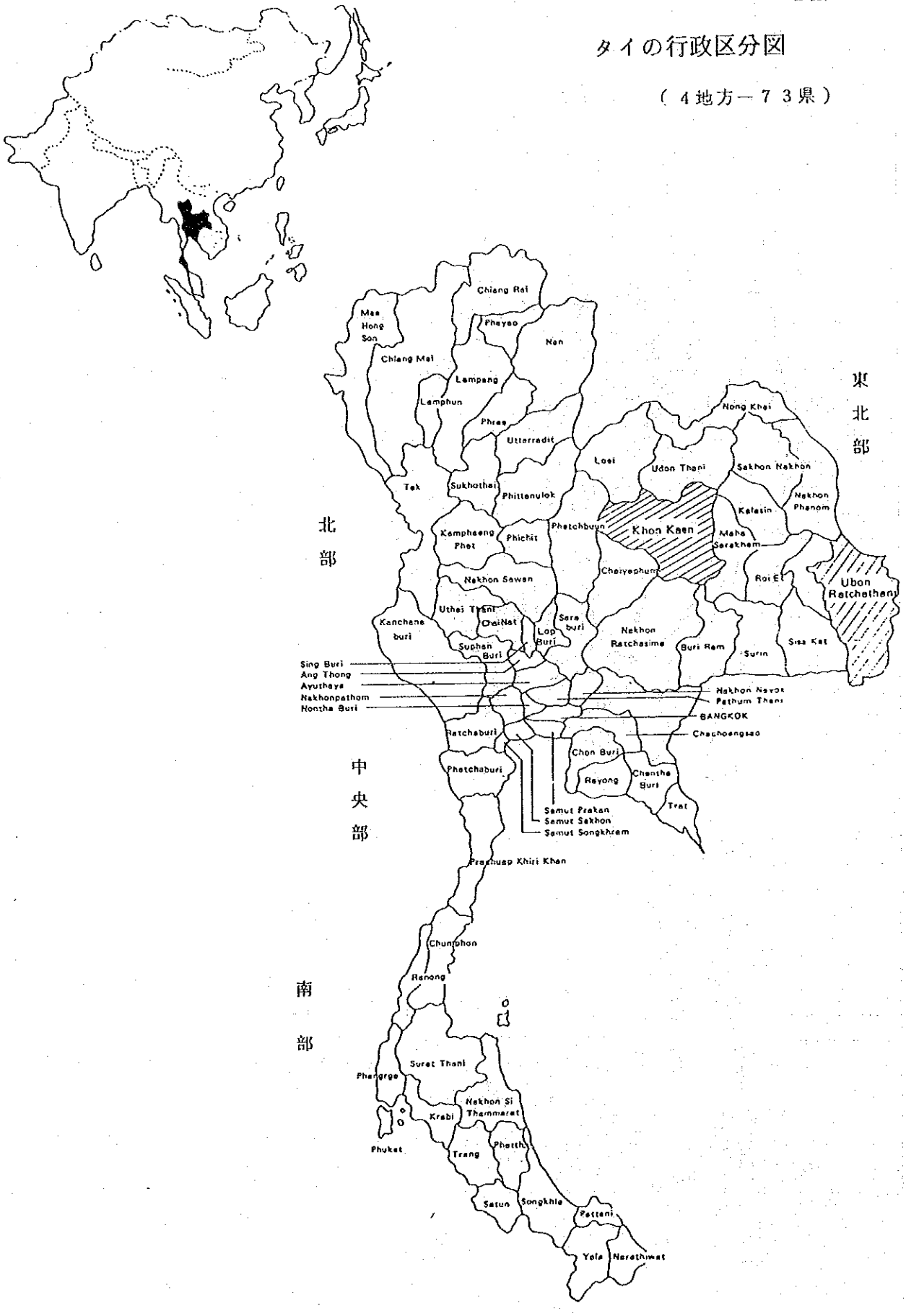
地図 1


チェンライ
チェンマイ
ランパン
ビエンチャン
ノンカイ
ウドン
コンケン
マハーサラカム
パンパイ
ナコンサワン
ウボン
スリン
ナコンラチャシマ
バンコク
パタヤ
チャンタブリ
カンボジア
ホーチミン
シャム湾
ナコンシータマラート
プケット
アンダマン海
トンキン湾
ベトナム
ラオス
ビルマ
マレー

地図 2

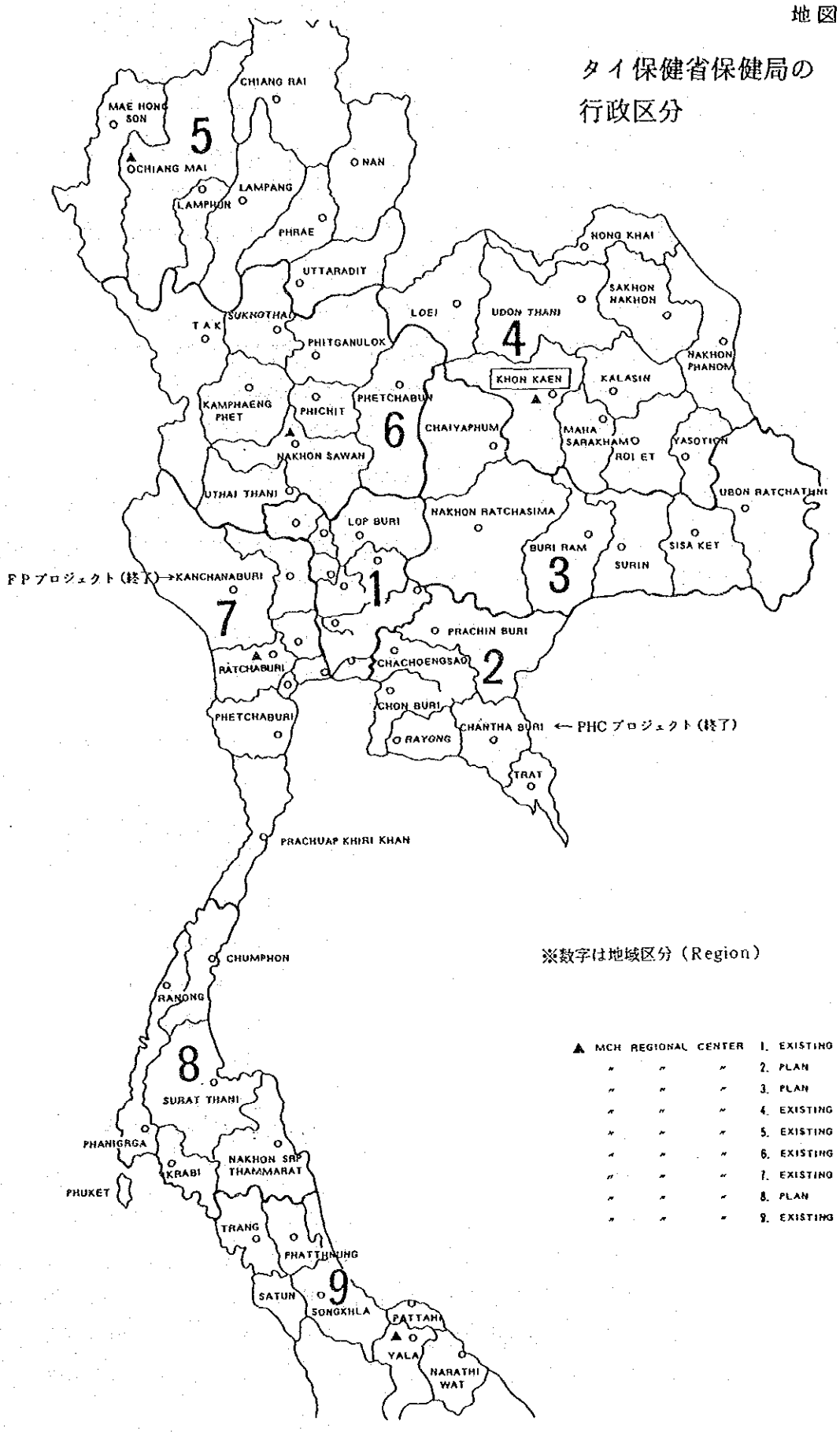
タイの行政区分図

（４地方－７３県）



地図 3

タイ保健省保健局の行政区分



※数字は地域区分（Region）

▲ MCH REGIONAL CENTER
1. EXISTING
2. PLAN
3. PLAN
4. EXISTING
5. EXISTING
6. EXISTING
7. EXISTING
8. PLAN
9. EXISTING

目　　次

1．　実施協議調査団派遣

1－1．　調査団派遣の経緯と目的

タイ政府は、1970年から国家家族計画政策を実施し、同年3.0％であった人口増加率は1988年には1.5％まで減少した。

家族計画は、現行の国家開発計画においても重点政策の一つとして取り上げられており、第6次国家保健計画においても1991年までに人口増加率を1.3％に縮小することになっている。

わが国は1974年から1989年の間、同国の中西部において家族計画分野のプロジェクト方式技術協力を実施したが、その恩恵に浴しない地域はなお広く、地域による格差が著しいのが現状である。

また、人口問題解決の前提となる母子保健の向上は、今後の大きな課題となっているが特に、タイ東北部は母子保健レベルが低く、家族計画・母子保健の立ち遅れが見られ、出生率、乳幼児死亡率共に他の地域に比べて高いものとなっていることから、タイ国政府は東北タイにおける家族計画および母子保健協力をわが国に要請越したものである。

本要請を受け、平成2（1990）年10月事前調査団を派遣し、要請の背景、協力内容、実施体制等の確認および候補対象地区の調査を行った。

事前調査の結果を踏まえ、今般、協力内容、協力方法、協力対象地域の特定と協力実施計画策定を行い、討議議事録（R／D）および暫定実施計画書（ＴＳＩ）の署名交換を行うことを目的として実施協議調査団が派遣された。

要請内容

(1) 協力期間：5年間

(2) 協力先機関：保健省保健局

(3) 対象地域：東北タイ南部

(4) 協力目的：家族計画・母子保健分野の(i)啓発活動の普及、(ii)サービスの向上、(iii)人材の養成

(5) 協力内容：(i) 専門家派遣

(ii) 供与機材

(iii) 研修員受入

1－2．調査団の構成

（担　当）	（氏　名）	（所　　属）
・団長　総括・母子保健	林　　謙　治	国立公衆衛生院保健人口学部長
・団員　計画協力	杉　山　亨　造	ＪＩＣＡ東京国際研修センター所長
・団員　衛生行政	藤　崎　清　道	厚生省大臣官房政策課課長補佐
・団員　技術協力	佐　藤　三　郎	外務省経済協力局技術協力課事務官
・団員　業務調整	森　谷　裕　司	ＪＩＣＡ医療協力部医療協力特別業務室

1－3．調査行程表（平成3年1月10日から同年1月19日まで）

日順	月日	曜日	移動及び業務
第1日	1／10	木	14時30分　JL 717　東京→バンコク （佐藤団員は13日出発）
2	11	金	JICA事務所にて調査打合せ、日本大使館表敬 保健省と協議
3	12	土	資料整理
4	13	日	バンコク→コンケン（杉山団員、藤崎団員、森谷団員） バンコク→ウボン（林団長） （佐藤団員：10時45分CX 501／ 751東京→バンコク）
5	14	月	現地調査 （佐藤団員：バンコク→コンケン）
6	15	火	現地調査 夜：コンケン、ウボン→バンコク。団内打ち合わせ
7	16	水	保健省と協議
8	17	木	DTEC表敬。保健省と協議
9	18	金	保健大臣面会。R／D署名。 日本大使館、JICA事務所に調査結果報告
10	19	土	11時15分TG 640　バンコク→東京

1－4．主要面談者

(1) 総理府技術経済協力局（DTEC）
Ms. Tipsuda Nopmoncol　Japan Sub Division
稲垣　富一　専門家

(2) MINISTRY OF PUBLIC HEALTH, Department of Health, Family Health Division
Dr. Dhatchai Mungkandi　Director－General
Dr. Vira Niyonwan　Director, Family Health Division
Mr. Patama Bhiromrut　Family Health Division
Mr. Sanit Maprachaub　Chief, IEC Section, Family Health Divisision
Mr. Rachaneewan Sirinawin　Staff, IEC Section, Family Health Division
Dr. Sompoth Borworsin　Chief, School Health Division

(3) KOHN KAEN HEALTH PROMOTION CENTER
Dr. Sompit　Deputy Director

(4) KOHN KAEN PROVINCIAL PUBLIC HEALTH OFFICE
Dr. Pishet Leelapanmetha　Deputy Director

(5) KOHN KAEN UNIVERSITY, RESEARCH DEVELOPMENT INSTITUTE
Dr. Krasae Chanawongse　Director

(6) 在タイ日本大使館
長門　利明　二等書記官

(7) JICAタイ事務所
阿部　信司　所長
谷川与志雄　次長
宮本　秀夫　所員

2．調査結果要旨および提言

2－1．総　　括

今回ミッションの本務はR／D署名にあるが、署名内容の一層の充実を目指し、また、プロジェクト開始後の具体的な実行が円滑に運営される基盤作りを目的としてタイ保健省と協議し、さらに東北タイ（コンケン県、ウボン県）を視察した。

昨年十月の訪問時に、すでに日本側の基本的な考え方を伝えたので実務レベルでは活動内容についてよく理解しており、今回の協議ではとくに大きな意見の違いがなかった。ただし、タイ側はＪＩＣＡプロジェクトの運営方法について本質的な理解ができていないために、過去の運営方法に固執し、若干のやりとりがあった。

R／Dに盛り込まれた活動の基本方針は次の四本柱から成り立っている。

1　県レベルにおける母子保健・家族計画活動およびこれに伴うＩＥＣ活動の強化

2　母子保健・家族計画活動に従事する技術者の教育訓練

3　同分野における情報システムの構築

4　同分野における調査研究の促進

1および2は過去日・タイ間で行なわれてきたプロジェクトの延長線上にあるようにも見えるが、3と4との関係で従来とはかなり異なる活動が展開できる見込みである。

3の「情報システムの構築」は地域保健活動に必要な基礎的な情報が正確にかつ迅速に収集ができ、ひいては保健計画にも役立つことを目的としている。4の「調査研究の促進」はオペレーションリサーチを中核とするも、この範疇に入らない調査も必要となるので「オペレーションリサーチ」という用語はR／D案から敢えて削除した。この方面の調査は病院、診療所、保健所、住民活動の意義が十分発揮されるための基礎資料となることが期待され、その結果に基づき供与機材の一部が順次決定されることと関連する。

プロジェクトサイトについては当面の間、コンケン県、ウボン県の二県に絞り、基盤が整備され次第、双方の協議により広げることにした。その場合においてもRegion 3，4内に限ることは言うまでもない。

なお、「情報システム」、「オペレーションリサーチ」についてはスタート時はウボン、コンケン両県内の数地区のみを対象にすることに合意した。

本プロジェクトは当初公衆衛生プロジェクトとのインテグレートで協議を進めてきたが、タイ側の実施体制が整わないことからとりあえず個別に行うこととなった。しかしながら、実施内容3、4を含めることによりプロジェクトサイトでは実質的に両プロジェクトがかなりの部分において協力関係が成り立つものと想像される。

本プロジェクトを成功させるためには周到な準備および専門家の大いなる努力が求められるところであり、そのためにも機材が供与される以前に少なくとも情報関係および公衆衛生関係の短期専門家の派遣により、専門分野の基本設計を綿密に行なっておく必要がある。

3．討議議事録の交渉経緯

3－1．交渉経緯

(1) 合意事項

タイ側プロジェクト関係者との討議、プロジェクトサイトの視察の結果、以下の点につき合意した

ア 専門家の活動拠点

専門家オフィスはコンケンの県健康増進センター（HEALTH PROMOTION CENTER)に置くこととし、執務スペース等はタイ側が提供することとなった。

イ プロジェクトエリア

当初は、コンケン県およびウボンラチャタニ県を中心にモデル地区を設置し、プロジェクトの活動地域を絞って協力を開始することで合意した。

ウ 専門家派遣

日本側は、専門家３名（リーダー、家族計画・母子保健、調整員）を1991年６月に派遣することとし、そのためにタイ側は、要請書を３月末日まで提出することとした。

なお、リーダーについては、協力計画の策定のために赴任当初１カ月位バンコクに滞在してほしい旨、タイ側より要望があった。

エ 研修員受け入れ

C／Pは、1991年度は２名程度とし、１名はバンコク、他の１名はコンケンから選抜することが好ましい旨申し入れた。人選については６月に専門家が赴任してから協議の上決定することとした。

オ 機材供与

予算額は、年間約３～４千万円程度とし、タイ側は機材要望リストを優先順位を付して早急にまとめ、ＪＩＣＡタイ事務所に非公式に提出し、日本側はこれをＪＩＡＣＡ本部で検討の上、再通報する。また、その後の機材供与計画については、専門家赴任後策定していく。

(2) 討議議事録（R／D）の変更点等

事前調査での協議結果から日本側から提示したR／D（案）に基づき討論した結果、以下の点につき変更・追加記入した。

① プロジェクト運営の総責任者を当初「保健大臣」としていたが、実質的にプロジェクトの総責任者は「保健局長」であり、プロジェクト運営上も問題がないためサイナーも「保健局長」に変更した。（(ATTACHMENT Ⅳ－Ⅰ)

② Region 3 およびRegion 4の健康増進センター（HEALH PROMOTION CENTER）所長の所掌業務に「調整業務」があたるため、タイ側の主張によりこれを追記した。（ATTACHMENT Ⅳ－3)

③ 保健省家族健康課長の所掌業務の明記が無かったため追加記入した。(ATTACHMENT Ⅳ－4)

④ 運営委員会のメンバーにＤＴＥＣの代表の記入がなかったためこれを追加した。（ANNEX Ⅳ－2－(2)－(d))

⑤ 現在形成中の公衆衛生プロジェクトとの混乱を避けるため、「ＰＨＣ」という文言はすべて削除した。(MASTER PLAN 等)

(3) タイ側主要面談者の発言概要

タイ側主要面談者からプロジェクト協力、R／Dの内容に関して以下のようなコメント等があった。

① DTEC

ア 調査団の来訪を歓迎する。

イ R／Dの「運営委員会」のメンバーDTEC代表を記入してもらいたい。

ウ 専門家として赴任後に、もし問題が生じた場合は、DTECに相談してほしい。（DTECが協力する。）

② 保健大臣

ア 日本の協力に感謝。家族計画の協力を通じて、日・タイ間の関係強化につながるだろう。

イ タイ国では、大学のレベルは高いが、地方での教育普及はまだ不十分。

ウ 本協力が終了する5年後も引き続き日本の協力を要望したい。

（林団長から大臣に対し、杉山団員が6月からチーム・リーダーとして赴任するとの紹介を行った。）

③ 保健省保健局長(DR.DHATCHAI)

ア 多くのC／Pが日本での研修を受けられることを要望。

イ 国内研修はタイ側で負担することが可能。中堅技術者養成対策経費を、機材経費に転用して全国の保健所に供与すれば母子保健の向上に資することができる。

ウ FPやPHCは、高い技術は必要ない。必要な場合には、（タイの）大学からサポートを得ることが可能。

エ 専門家の派遣経費は高額なので、特殊分野を除いて専門家経費を機材経費に転用してはどうか。

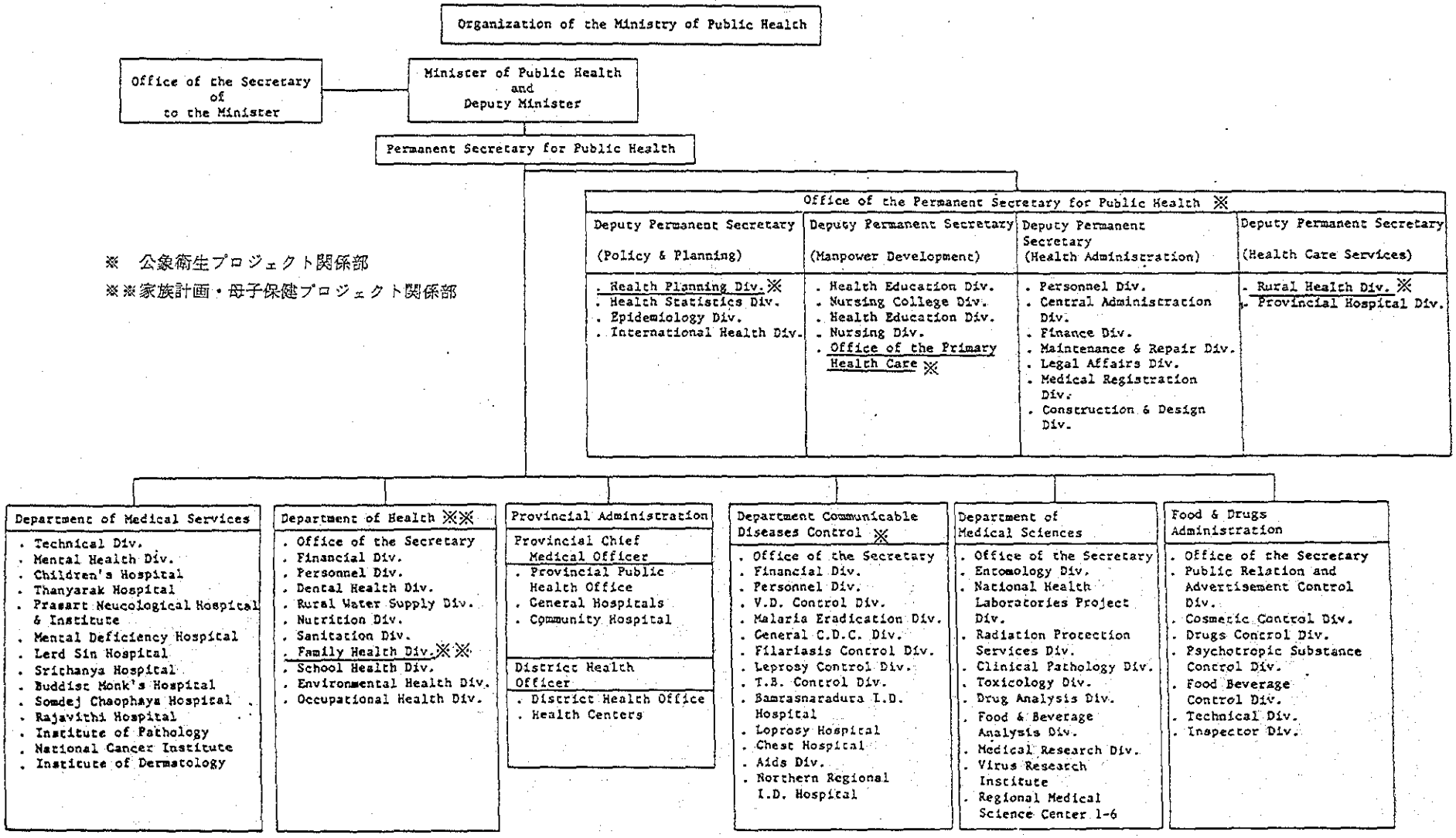
当方から イ．エに関し、必要に応じ検討のうえ派遣、供与を行っており、他に回すという考え方はできない旨を説明した。

ア 家族計画の活動主体は、ウボン県であるので、専門家もウボン県に滞在したほうがよい。

イ コンケン県衛生部は、スペース等十分でないので、コンケンに専門家の拠点を設けるとしたら健康増進センターがよい。

ウ タイ側が負担する予算、人員、執務スペース等は既存の予算、施設等から対応できる。

タイ保健省組織図


Organization of the Ministry of Public Health
Office of the Secretary of to the Minister
Minister of Public Health and Deputy Minister
Permanent Secretary for Public Health
Office of the Permanent Secretary for Public Health ※
Deputy Permanent Secretary (Policy & Planning)
. Health Planning Div. ※
. Health Statistics Div.
. Epidemiology Div.
. International Health Div.
Deputy Permanent Secretary (Manpower Development)
. Health Education Div.
. Nursing College Div.
. Health Education Div.
. Nursing Div.
. Office of the Primary Health Care ※
Deputy Permanent Secretary (Health Administration)
. Personnel Div.
. Central Administration Div.
. Finance Div.
. Maintenance & Repair Div.
. Legal Affairs Div.
. Medical Registration Div.
. Construction & Design Div.
Deputy Permanent Secretary (Health Care Services)
. Rural Health Div. ※
. Provincial Hospital Div.
※ 公衆衛生プロジェクト関係部
※※家族計画・母子保健プロジェクト関係部
Department of Medical Services
. Technical Div.
. Mental Health Div.
. Children's Hospital
. Thanyarak Hospital
. Prasart Neucological Hospital & Institute
. Mental Deficiency Hospital
. Lerd Sin Hospital
. Srithanya Hospital
. Buddist Monk's Hospital
. Somdej Chaophaya Hospital
. Rajavithi Hospital
. Institute of Pathology
. National Cancer Institute
. Institute of Dermatology
Department of Health ※※
. Office of the Secretary
. Financial Div.
. Personnel Div.
. Dental Health Div.
. Rural Water Supply Div.
. Nutrition Div.
. Sanitation Div.
. Family Health Div. ※※
. School Health Div.
. Environmental Health Div.
. Occupational Health Div.
Provincial Administration
Provincial Chief Medical Officer
. Provincial Public Health Office
. General Hospitals
. Community Hospital
District Health Officer
. District Health Office
. Health Centers
Department Communicable Diseases Control ※
. Office of the Secretary
. Financial Div.
. Personnel Div.
. V.D. Control Div.
. Malaria Eradication Div.
. General C.D.C. Div.
. Filariasis Control Div.
. Leprosy Control Div.
. T.B. Control Div.
. Bamrasnaradura I.D. Hospital
. Loprosy Hospital
. Chest Hospital
. Aids Div.
. Northern Regional I.D. Hospital
Department of Medical Sciences
. Office of the Secretary
. Entomology Div.
. National Health Laboratories Project Div.
. Radiation Protection Services Div.
. Clinical Pathology Div.
. Toxicology Div.
. Drug Analysis Div.
. Food & Beverage Analysis Div.
. Medical Research Div.
. Virus Research Institute
. Regional Medical Science Center 1-6
Food & Drugs Administration
. Office of the Secretary
. Public Relation and Advertisement Control Div.
. Cosmetic Control Div.
. Drugs Control Div.
. Psychotropic Substance Control Div.
. Food Beverage Control Div.
. Technical Div.
. Inspector Div.

3－2．討議議事録（R／D）および暫定実施計画（TSI）

RECORD OF DISCUSSIONS
BETWEEN THE JAPANESE IMPLEMENTATION SURVEY TEAM
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE KINGDOM OF THAILAND
ON THE TECHNICAL COOPERATION
CONCERNING
THE FAMILY PLANNING AND MATERNAL AND CHILD HEALTH PROJECT

The Japanese Implementation 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, Department of Public Health Demography, the Institute of Public Health, Ministry of Health and Welfare, visited the Kingdom of Thailand from January 10 to 19, 1991, for the purpose of working out the details of the technical cooperation program concerning the Family Planning and Maternal and Child Health Project (hereinafter referred to as "the Project").

During its stay in the Kingdom of Thailand, the Team exchanged views and had a series of discussions with the Thai authorities concerned in respect of the desirable measures to be taken by both governments for successful implementation of the Project.

As a result of the discussions and in accordance with the provisions of the Agreement on Technical Co-operation between the Government of Japan and the Government of the Kingdom of Thailand signed at Tokyo on November 5, 1981 (hereinafter referred to as "the Agreement"), both parties agreed to recommend to their respective governments the matters referred to in the document attached hereto.

Bangkok, January 18, 1991

Dr. Kenji Hayashi
Leader,
Japanese Implementation Survey Team,
Japan International Cooperation Agency,
Japan

Dr. Dhatchai Mungkandi
Director-General,
Department of Health,
Ministry of Public Health,
The Kingdom of Thailand

ATTACHMENT

I. TECHNICAL COOPERATION BETWEEN BOTH GOVERNMENTS

The Government of Japan and the Government of the Kingdom of Thailand will cooperate with each other in implementing the Project in accordance with the Master Plan in I of the Annex.

II. MEASURES TO BE TAKEN BY THE GOVERNMENT OF JAPAN

In accordance with the laws and regulations in force in Japan and the provision of Article III of the Agreement, the Government of Japan will take, at its own expense, the following measures through JICA according to the normal procedures of its technical cooperation scheme.

1. DISPATCH OF JAPANESE EXPERTS

The Government of Japan will provide services of the Japanese experts listed in II of the Annex. The provisions of Article IV, V, VI and VII of the Agreement will apply to the above-mentioned experts.

2. PROVISION OF EQUIPMENT

The Government of Japan will provide such equipment, machinery and other materials (hereinafter referred to as "the equipment") as listed in III of the Annex. The provision of Article VIII of the Agreement will apply to the equipment.

3. TRAINING OF THAI COUNTERPART PERSONNEL IN JAPAN

The Government of Japan will accept the Thai personnel connected with the Project for training in Japan.

4. SPECIAL MEASURES FOR TRAINING OF MIDDLE-LEVEL MANPOWER

(1) The Government of Japan will supplement a portion of the following local expenditures, necessary for the training programs for middle-level manpower conducted in the Kingdom of Thailand.

(a) Travel allowances to and from the place of training for training participants.
(b) Expenditures for preparation of teaching materials.
(c) Travel allowances for field trips for training participants.
(d) Expenditures for the purchase of supplies and equipment necessary for training programs.
(e) Travel allowances for instructors when they accompany training participants on field trips.
(f) Fees for instructors invited from institutions other than ones directly connected with the Project.

(2) Support for the above-mentioned expenditures will be reduced annually. The reduced portion of the expenditures will be replaced by the Thai side.

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Ⅲ. MEASURES TO BE TAKEN BY THE GOVERNMENT OF THE KINGDOM OF THAILAND

In accordance with the laws and regulations in force in the Kingdom of Thailand, the Government of the Kingdom of Thailand will take, at its own expense, the following measures:

1. THAI COUNTERPARTS AND ADMINISTRATIVE PERSONNEL

(1) In accordance with the provision of Article Ⅳ-(b) of the Agreement, the Government of the Kingdom of Thailand will secure services of suitably qualified Thai counterparts and administrative personnel listed in Ⅳ of the Annex.

(2) Knowledge and experience acquired by Thai counterpart personnel from technical training in Japan will be utilized effectively for implementation of the Project.

2. PROVISION OF BUILDINGS AND INCIDENTAL FACILITIES

In accordance with the provision of Article Ⅳ-(a) of the Agreement, the Government of the Kingdom of Thailand will provide buildings and incidental facilities as listed in Ⅴ of the Annex.

3. SUPPLY AND/OR REPLACEMENT OF EQUIPMENT AND MACHINERY

The Government of the Kingdom of Thailand will supply and/or replace equipment, machinery, vehicles, instruments, tools, spare parts and other materials necessary for the implementation of the Project except for the equipment referred to in Ⅱ.2 above.

4. ALL RUNNING EXPENSES

The Government of the Kingdom of Thailand will meet all running expenses necessary for the implementation of the Project.

IV. ADMINISTRATION OF THE PROJECT

Administration of the Project will be as follows:

1. DIRECTOR-GENERAL, DEPARTMENT OF HEALTH, MINISTRY OF PUBLIC HEALTH

The Director-General, Department of Health, Ministry of Public Health will bear overall responsibility for the successful implementation of the Project and administrative matters related to the Project.

2. DIRECTOR(S) OF PROVINCIAL PUBLIC HEALTH OFFICE

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

3. DIRECTOR(S) OF HEALTH PROMOTION CENTER

The Director(s) of Health Promotion Center(s) in Region 3 and 4 will be responsible for technical and coordination matters.

4. DIRECTOR OF FAMILY HEALTH DIVISION, DEPARTMENT OF HEALTH, MINISTRY OF PUBLIC HEALTH

The Director of Family Health Division, Department of Health, Ministry ofPublic Health will be responsible for program management and coordination matters related to the Project.

5. CONTRIBUTION OF JAPANESE EXPERTS

(1) The Japanese Team Leader will provide necessary recommendations and advice on technical and administrative matters concerning the implementation of the Project.

(2) The Japanese experts will give necessary technical guidance and advice to the Thai counterpart personnel on matters pertaining to the implementation of the Project.

6. JOINT COORDINATING COMMITTEE

For effective and successful implementation of the Project, a Joint Coordinating Committee will be established with the functions and composition as described in VI of the Annex.

V. MUTUAL CONSULTATION

There will be mutual consultation between the two governments on any major issues arising from or, in connection with this document.

VI. TERM OF COOPERATION

The duration of technical cooperation for the Project will be five (5) years beginning June 1, 1991.

ANNEX

I. MASTER PLAN

1. General objective of the Project

The general 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.

2. Activities of the Project

(1) Strengthening of family planning and maternal and child health care activities as well as related information, education and communication activities at provincial level

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

(3) Formulation of management system on health information in the field of family planning and maternal and child health.

(4) Promotion of research in the field of family planning and maternal and child health.

II. LIST OF JAPANESE EXPERTS

1. Leader
2. Coordinator
3. Experts in the following fields:
   (1) Family planning
   (2) Maternal and child health
   (3) IEC (Information, Education, Communication)
4. Other related fields mutually agreed upon as necessary

III. LIST OF EQUIPMENT

Equipment pertaining to:

1. Family planning
2. Maternal and child health
3. IEC (Information, Education, Communication)
4. Other related fields mutually agreed upon as necessary

Dhatelai

IV. LIST OF THAI COUNTERPART AND ADMINISTRATIVE PERSONNEL

1. Chief of the Project
2. Counterpart personnel in the fields of:
   (1) Family planning
   (2) Maternal and child health
   (3) IEC(Information, Education, Communication)
   (4) Others mutually agreed upon as necessary
3. Administrative personnel:
   (1) Secretaries
   (2) Clerks
   (3) Typists
   (4) Drivers
   (5) Other supporting staff(s) mutually agreed upon as necessary

V. BUILDINGS AND FACILITIES

1. Sufficient space for implementation of the Project
2. Office for the leader of Japanese experts
3. Offices and necessary facilities for Japanese experts
4. Facilities such as electricity, gas and water supply, sewerage syste telephone and furniture necessary for Project activities.

VI. JOINT COORDINATING COMMITTEE

1. Functions

The Joint Coordinating Committee will meet at least once a year and whenever necessity arises, and work;

(1) To review the overall progress of the Project as well as the achievements of annual work plan.

(2) To review and exchange views on major issues arising from or in connection with the Project.

2. Composition

(1) Chairman:

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

(2) Thai side;

(a) Director(s), Provincial Public Health Office(s) in Region 3 and 4

(b) Director(s), Health Promotion Center(s) in Region 3 and 4

(c) Director, Family Health Division, Department of Health, Ministry of Public Health

(d) Representative of Department of Technical and Economic Cooperation

(3) Japanese side;

(a) Leader of the Japanese expert team

(b) Coordinator

(c) Japanese experts

(d) Resident representative of JICA Thailand office

(e) Other personnel to be dispatched by JICA

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

TENTATIVE SCHEDULE OF IMPLEMENTATION

OF

FAMILY PLANNING AND MATERNAL AND CHILD HEALTH PROJECT

The Japanese Implementation Survey Team (hereinafter referred to as "the Team") and the Thai authorities concerned have jointly formulated the Tentative Schedule of Implementation of the Project as annexed hereto.

This schedule has been formulated in connection with the Attached Document of the Record of Discussions signed between the Team and the Thai authorities concerned for the Project, on condition that the necessary budget be allocated for the implementation of the Project and that the schedule is subject to change within the framework of the Record of Discussions when necessity arises in the course of implementation of the Project.

Bangkok, January 18, 1991

Dr. Kenji Hayashi
Leader,
Japanese Implementation Survey Team,
Japan International Cooperation Agency,
Japan.

Dr. Dhatchai Mungkandi
Director-General,
Department of Health,
Ministry of Public Health,
The Kingdom of Thailand.

TENTATIVE SCHEDULE OF IMPLEMENTATION

FAMILY PLANNING AND MATERNAL AND CHILD HEALTH PROJECT IN THE KINGDOM OF THAILAND

Japanese Fiscal Year (April-March)	1991/92 4 5 6 7 8 9 10 11 12 1 2 3	1992/93 4 5 6 7 8 9 10 11 12 1 2 3	1993/94 4 5 6 7 8 9 10 11 12 1 2 3	1994/95 4 5 6 7 8 9 10 11 12 1 2 3	1995/96 4 5 6 7 8 9 10 11 12 1 2 3	1996/97 4 5 6 7 8 9 10 11 12
1. Dispatch of Japanese Experts to Thailand	Project Leader Family Planning and Maternal and child health IEC Coordinator					
2. Training of Thai Personnel in Japan	← →	← →	← →	← →	← →	
3. Provision of Machinery and Equipment	← →	← →	← →	← →	← →	
4. Dispatch of Japanese Mission to Thailand	↔ Planning and consultation	↔ Advisory			↔ Evaluation	

The number of personnel and fields of training in Japan are subject to further discussion.

Note : This schedule is formulated tentatively on the assumption that necessary budget will be acquired both sides.

This schedule is subject to change within the framework of the Record of Discussions when necessity arises in the course of implementation of the Project.

3－3．討議議事録（R／D）等の訳文（主要点のみ）

(1) 両国政府は、マスター・プランに基づき本プロジェクトの実施に協力する。

(2) 日本側協力内容

ア　専門家派遣

(ア) 長期4名（リーダー、家族計画・母子保健、ＩＥＣ、調整員）

(イ) その他必要と認められる分野の専門家

イ．機材、器具等の供与

ウ．タイ側カウンターパートの日本における研修

エ．中堅技術者養成に必要な経費の一部負担

(3) タイ側協力内容

ア．カウンターパートおよび必要な事務職員の配置

イ．建物および付属施設等の供与

ウ．日本側が供与する以外の機械、車輌、器具、道具および部品等の供与

エ．プロジェクト業務の実施に必要なすべての運営経費

マスタープラン

(1)プロジェクトの目的

プロジェクトの目的は、東北タイにおいて、家族計画および母子保健活動を促進強化することにより地域住民の保健水準を向上する。

(2) プロジェクトの業務

ア．家族計画および母子保健活動を増進するとともに、ＩＥＣ活動を強化する。

イ．家族計画、母子保健分野の人材養成を促進する。

ウ．上記分野の保健情報管理システムを形成する。

エ．上記分野の調査研究を促進する。

4．プロジェクト実施上の留意点

4－1．実施体制

(1) 先方（タイ側）実施体制

タイ側C／P機関は、プロジェクトの総責任については保健省保健局長（家族保健課）であり、プロジェクトサイトにおいては、保健局直轄の健康増進センター（Region 4）である。また、地域における保健・衛生に関する末端組織はヘルスセンターであり、ヘルスセンターは、保健省次官室直轄の県衛生局の所管にある。すなわち、行政組織上（運営管理上）は、健康増進センターは第一次医療機関であるヘルスセンターを直接的には管轄していない。ただし、健康増進センターは、保健局が所掌する家族計画、母子保健、健康教育（ＩＥＣ）、栄養、学校保健、歯科等の事業実行上、県衛生局、県病院と調整・連携しながら技術的サポートを郡病院、ヘルスセンターに対して行っている。

したがって、プロジェクト実施にあたっては、プロジェクトサイトと本省（バンコク）との調整に留意することはもちろんのこと、保健局と次官室ないしは健康増進センターと県医務局についての調整にも十分配慮していく必要がある。また、今後次官室C／Pとした当事業団による「公衆衛生」プロジェクトも実施していく予定であり、東北タイをターゲットとした効果的な事業の実施にあたっては、日本人専門家チーム同士の情報交換、事業の協調にも十分配慮していく必要がある。

(2) 国内（日本側）実施体制

タイはある程度技術レベルが高く、家族計画の実施についてもかなりの成功を納めており、今後は、もっと家族計画の浸透率の低い東北タイ南部の家族計画対策のみならず母子保健分野をも重点的に活動強化していく必要があり、幅広い活動が予想される。そのため、幅広い分野に関しての技術的なサポートが可能な国内委員会等を組織化し、強力な技術支援、情報支援体制を確立してプロジェクトを運営していくことが必要である。　また、この国内委員会の形成による体制整備とあわせ、プロジェクト活動を進めていくにはＴＳＩに記されている以外の疫学や衛生統計等の分野の専門家の派遣も必要であり、適宜短期専門家を派遣しプロジェクトを支援していく必要もある。

4－2．実施計画

(1) 活動内容の方向性

タイは近年めざましい発展を遂げ、1988年現在の一人当たりＧＮＰは 1,000ｓドルに達した。

こういった経済的発展に伴いタイの家族計画も成功しており、人口増加率は1965年～1980年の平均2.7％から1980年～1989年の平均1.8％へと大きく改善された。

さらに、タイ政府は第７次５カ年計画（1992～1996年度。㊟タイの予算年度）では、人口増加率を 1.2％へと減少させることをかかげる予定である。（90年８月の事務次官共同審議による）

また、避妊法の普及率は1980年から1988年の平均66％であり、５歳未満児死亡率（U5MR）は35（1989年）、乳児死亡率（IMR ）は27（1989年）である。（いずれも全国平均。"THE STATE OF THE WORLD'S CHILDREN1991" による）

したがって、家族計画の促進を全面的な活動とするよりは、ＩＥＣ活動等の実施により母子保健レベルの向上を進めることにより家族計画を促進するといったアプローチが望まれる。

(2) 専門家の活動拠点と主要活動

専門家の執務室については、コンケンの健康増進センターの一室をタイ側は提供することで合意した。本センターは保健省保健局の出張所であり、REGION４全域の「健康増進」に関する業務を所掌する機能をもつものである。東北タイは区分でいうとREGION３およびREGION４で構成されるが、REGION３には健康増進センターの建物がないため実質的にREGION ４の健康増進センターが東北タイでの中心的センターとなっている。したがって、本センターのスタッフが保健省医務局等と連係をとりながら東北タイの保健衛生に関する指導を実施しているため、本センターの運営、事業計画の立案、活動強化等に関する技術指導が派遣専門家の主要活動の一つとなる。

(3) プロジェクトエリア（フィールド）

本プロジェクトの対象地域は、本調査団の調査・協議結果では東北タイのコンケン県およびウボンラチャタニ県の２県とした。

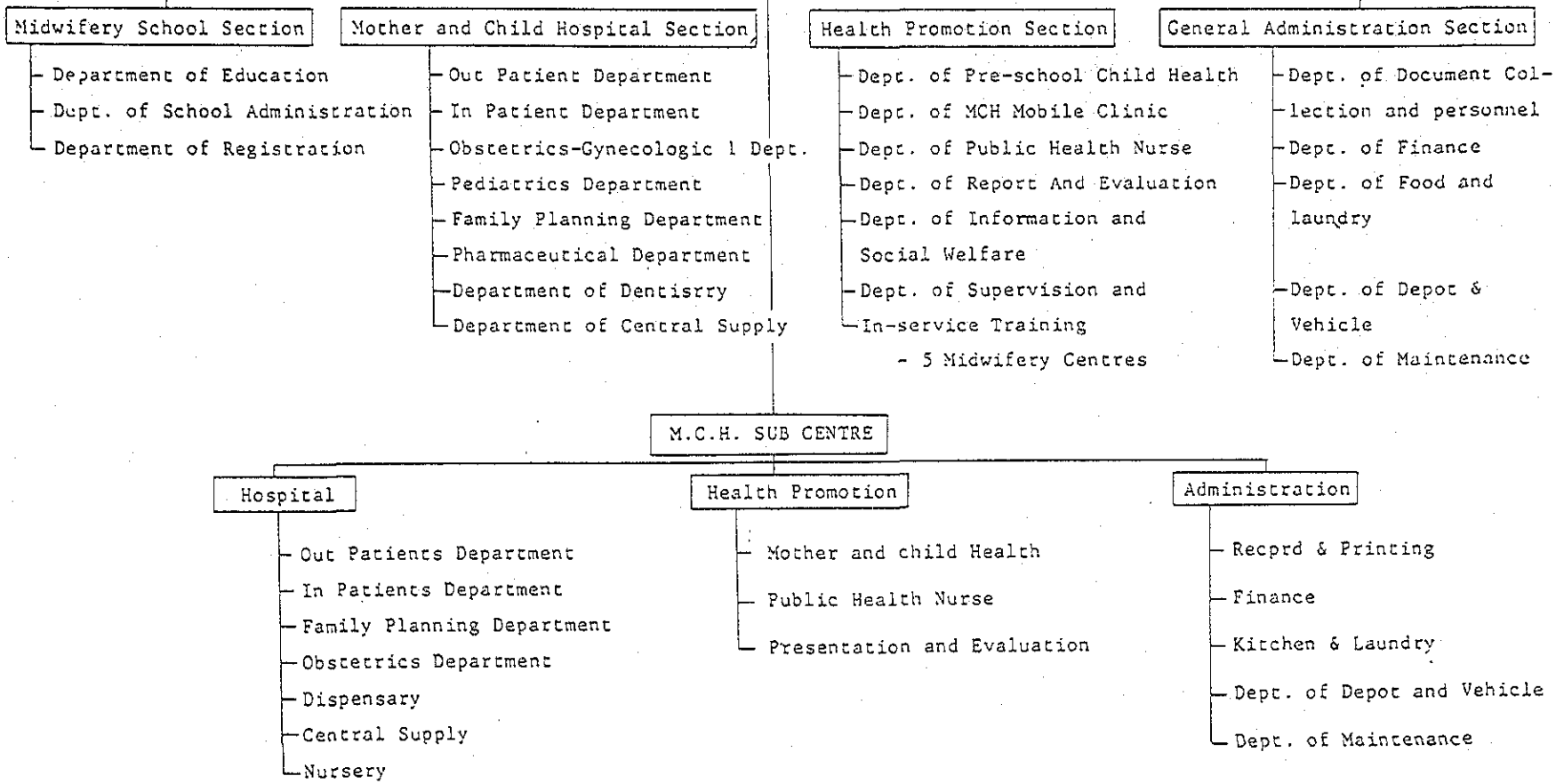
しかしながら、２県を視察してみて、正確なデータは得られなかったものの、インフラの整備状況、郡病院のスタッフの質、機材の質・量等の点で比較してみると、コンケン県よりもウボンラチャタニ県の方が家族計画の普及率も母子保健のレベルにおいてもかなり低いと思われる。（参考：病院出産は、コンケンで72.5%、ウボンラチャタニで20.4%（1988年、" PUBLIC HEALTH STATISTICS" MINISTRY OF PUBLIC HEALTH による）また、タイ側も東北タイ南部での協力を強く望んでおり、今後プロジェクトの進捗状況を見ながら協力フィールドの重点対象地域をウボンラチャタニ県に移行していくことも検討する必要がある。

また、先方から強い要望のあるコンケン県、ウボンラチャタニ県以外の地域へのプロジェクト活動の展開については、事業進捗（モデル事業の確立）を見ながら先方との協議により広げていくこととしたい。

健康増進センター組織図

Organization Chart

Maternal and Child Health Centre Region 4



附　　屬　　資　　料

1．FAMILY PLANNING IN THAILAND

2．BACKGROUND INFORMATION(KHON KAEN REGIONAL HOSPITAL)

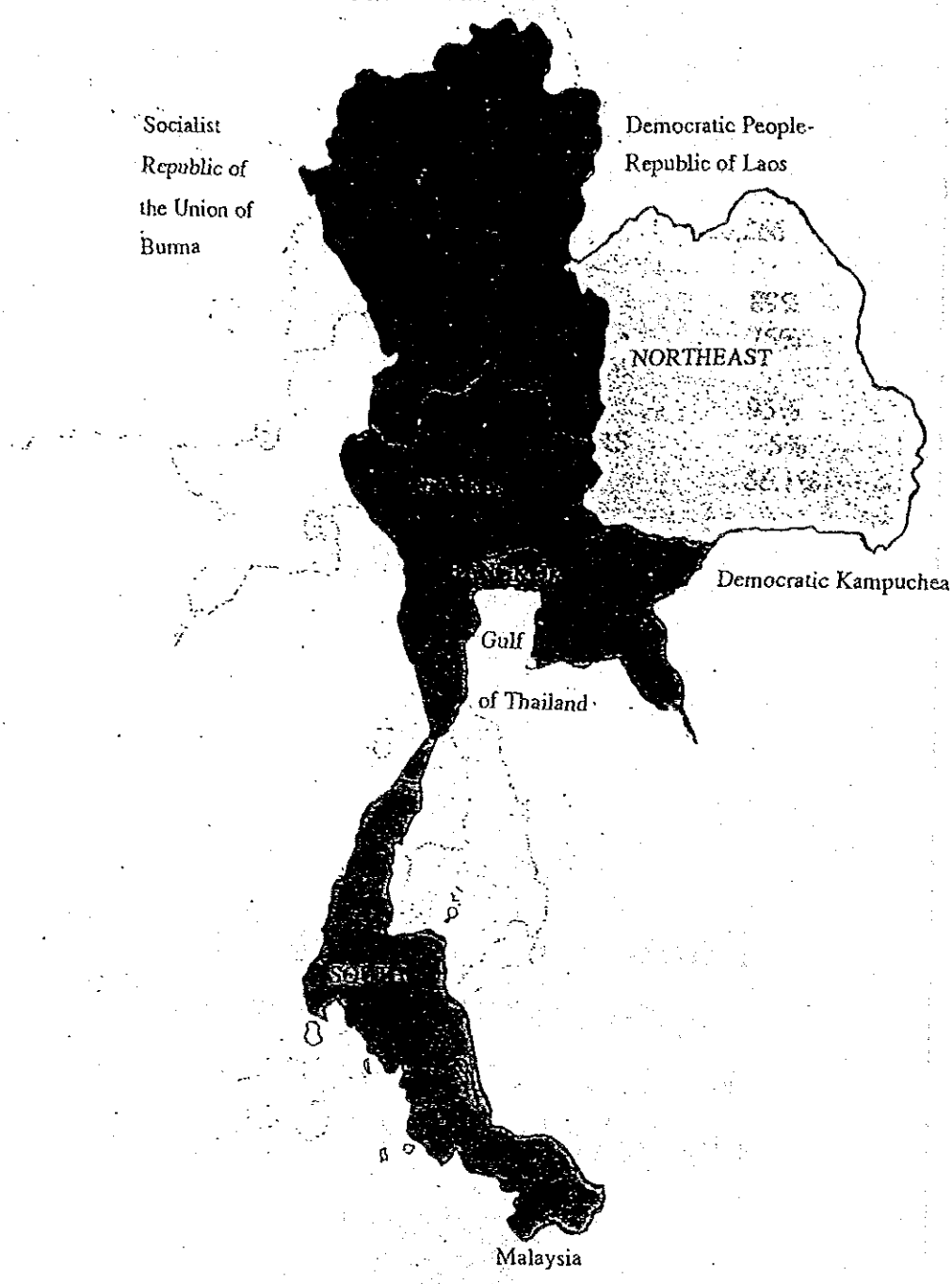
FAMILY PLANNING

IN

THAILAND

Family Health Division
Department of Health
Ministry of Public Health
Bangkok, 1989

MAP OF THAILAND



Region 1. Bangkok

Region 2 Chonburi

Region 3. Nakhonratchasima

Region 4. Khonkaen

Region 5. Chiangmai

Region 6. Nakhonsawan

Region 7. Ratchaburi

Region 8. Nakhonsithammarat

Region 9. Yala

BASIC HEALTH INFORMATION

1.	POPULATION	54,960,917 (100%)	1988***
	FEMALE	27,574,256 (50.17%)	
	MALE	27,386,661 (49.82%)	
	POPULATION IN BANGKOK METROPOLIS	5,719,779 (10.40%)	
2.	DENSITY (PERSON/1 KM ^{2})	105	1988***
3.	ANNUAL PER CAPITA INCOME	20,266 BAHT (US $ 810)*	
4.	LITERACY RATE		
	MALE	89%	1987****
	FEMALE	75%	
5.	RELIGION		
	THERAVADA BUDDHISM	95%	1987*
	CHRISTIAN, MUSLIM AND OTHERS	5%	1987*
6.	DEPENDENCY RATIO	56.1%	1988***
7.	EXPECTATION OF LIFE AT BIRTH		1987***
	MALE	61.75	
	FEMALE	67.50	
8.	ANNUAL RATE OF POPULATION GROWTH	1.5	1987**
9.	CRUDE BIRTH RATE	18.8/1,000	1987**
10.	CRUDE DEATH RATE	4.4/1,000	1987**
11.	INFANT MORTALITY RATE	35/1,000	1987****
12.	MATERNAL MORTALITY RATE	40/1 00000	1987**
13.	CONTRACEPTIVE PREVALENCE RATE	70.6	1987*****
14.	TOTAL FERTILITY RATE	2.21	1987****
15.	CHILDREN UNDER 5 WITH 1° MALNUTRITION:	20.4%	1988**
	2°+3°	2.3%	1988**
16.	CHILDREN UNDER 1 YEAR WITH IMMUNIZATION	51.1%	1987**
17.	PREGNANT WOMEN RECEIVED TETANUS TOXOID	59.5%	1987**
18.	PERCENTAGE OF THE NEWBORN BABIES		
	WEIGHED LESS THAN 2,500 GRAMS	10.1%	
19.	MEDIAN DURATION OF BREAST FEEDING		1987****
	RURAL	18.0 MONTHS	
	URBAN	9.8 MONTHS	
20.	NUMBER OF PHYSICIAN PER POPULATION	1 : 5,978	1987**
21.	NUMBER OF NURSE PER POPULATION	1 : 1,336	
22.	NUMBER OF HOSPITALS	661	

* Ministry of Interior
** Ministry of Public Health
*** National Statistic Office
**** Thailand Demographic and Health Survey
***** Determinants and Consequences of Contraceptive Use Patterns in Thailand

2

General Information

The Kingdom of Thailand occupies an area of close to 200,000 square miles of 514,000 square kilometres in the center of continental South-East Asia. Thailand lies between 6 and 21 north of the Equator which gives it a lush and tropical climate. The country's geographical location is bounded by Democratic Kampuchea on the South-East, People's Democratic Republic of Laos on the East and North-East, Socialist Republic of the Union Burma on the West and North-West and on the South by Malaysia. Thailand is divided by natural barrier into four geographical regions which differs significantly with regard to population density, cultural characteristics and socio-economic activities and ac cessibility.

The Central Region is the economic center of the nation, where situated the primate city of Bangkok Metropolis which is also the capital city. The region occupies a plain and alluvial low land most of which is farmed in rice, except for Bangkok and around Bangkok where industrial establishments are concentrated. The Northeastern Region is the large semi -arid plateau. Its saline and dry soils in combination with limited water supply allow no more than rain-fed subsistence farming. One-third of Thailand's population live in the Northeast which has density of 105 persons per square kilometre. Northern Thailand contains mountainous and forested areas with some furtile valleys where rice is grown. In the South where there is the longest rainy season, tin, rubber and fisheries are major sources of employment and wealth.

The predominant religion is Theravada Buddhism, which permeates the Thai arts, culture, tradition and learning. Ninety-five percent of the population is Buddhist and the 5% left are Christian, Muslim and others.

The country is constitutional monarchy. The King is under the law and accepts a constitutional form of the government. Nevertheless, he is greatly loved and respected by all his people as Head of state. In the Southeast Asia region, Thailand and Nepal are the only countries which were not colonised but maintained independence and strong national identity. One identity in the national language, Thai, which has its own set of alphabets.

The administration in Thailand is divided into 3 levels : central government, provin cial government, and local government. The country is divided into 73 Provinces or changwats each of which is headed by an appointed Governor. A province is further subdivided into districts (amphur), sub-districts (tambol), and villages (muban).

The conomy of Thailalnd is a mix of agriculture, manufacturing, mining and servic ing which is undergoing rapid industrialization. The economic growth in 1987 was over 7% and accelerated impressively in 1988 to about 11% GNP Per capita has increased from about 490 US$ in 1978 to US$ in 1987.

The country remains one of the world's exporters of diversified products which include rice, tapioca, canned fruits, canned fish, frozen seafood, textiles, toys and a range of other manufactured goods.

Health Administration

The Ministry of Public Health (MOPH) has the responsibility for organization, management and administration of medical care, disease control and perventive care, and health promotion in provinces other than Bangkok. In Bangkok and other municipal areas public-health services and facilities are mainly under the responsibility of the Ministry of Interior. The Ministry of Public Health is organized into six major components (Figure I) and administers a variety of public health facilities through an extensive network outlets including regional health centers, provincial and district hospitals, and local health stations at the sub-district level (Figure II)

ORGANIZATION OF THE MINISTRY OF PUBLIC HEALTH

Figure I

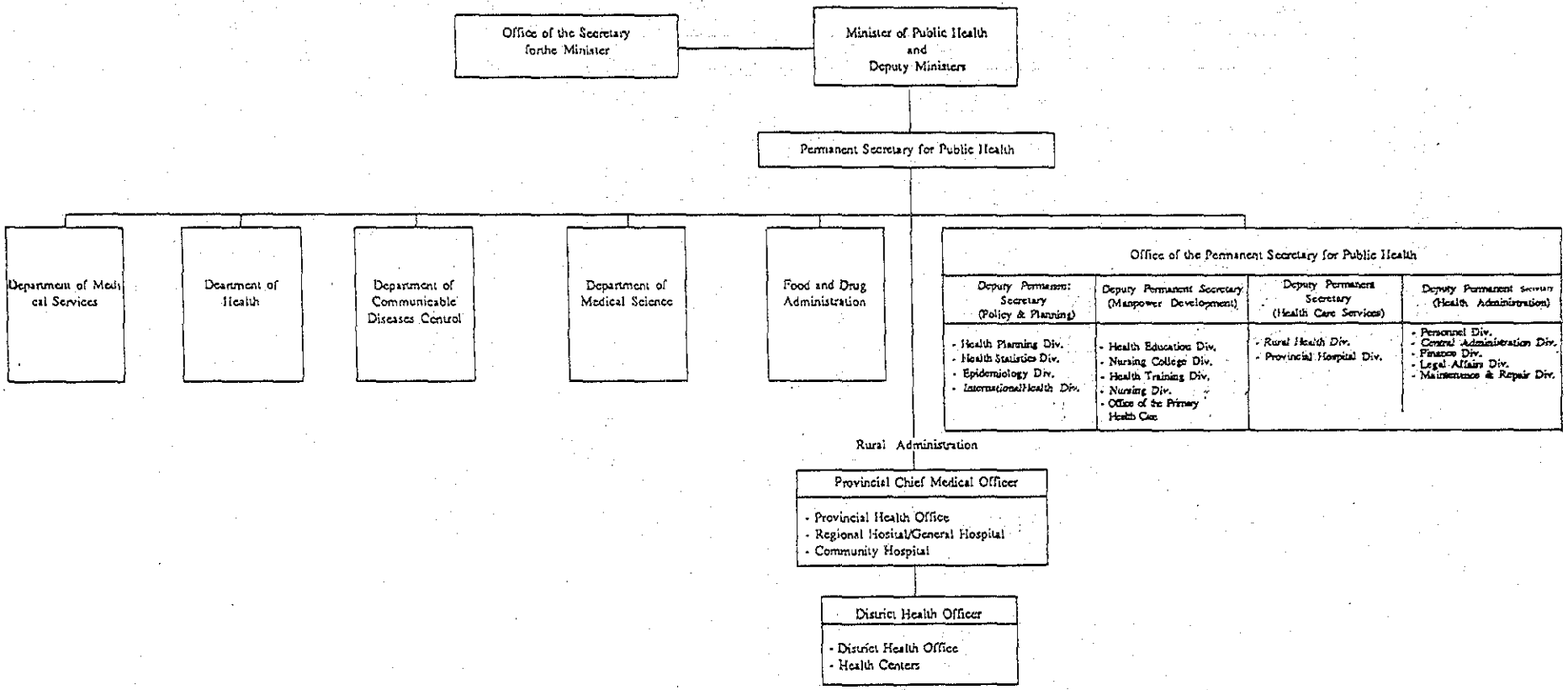
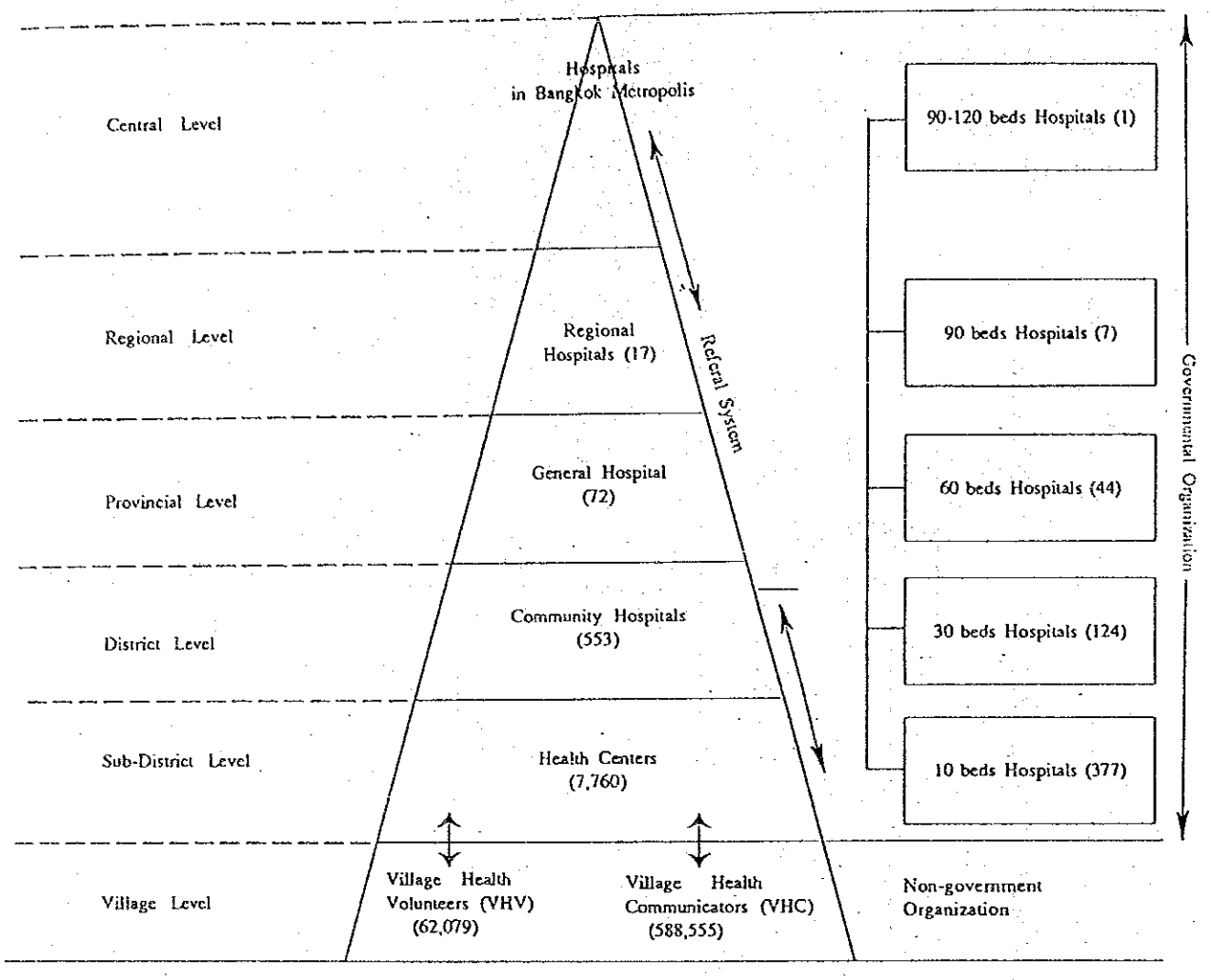


Figure II
The Structure of Rural Health Delivery System



Note: Numbers in parentheses refer to the number of hospitals in each level or the number of VHV or VHC

SOURCE : Ministry of Public Health : Year 1988

6

Population Policy and Family Planning Program

During the first half of the 20.th century, Thailand's official stance on population was predominantly pronatalist. When health services were first established, part of the justification stated was to lower mortality in order to increase the size of population. The Government did, however, begin sending young scholars abroad for training in Demography and related fields and in 1958 a World Bank Economic Commission to Thailand recom mended that the Government seriously considered the adverse effects of the population growth rate or economic development. The Office of the Prime minister established a series of committees to study the population problems and to make recommendations to the Cabinet. Additionally, between 1963 and 1968, three National Population Seminars were held.

In 1967, the Prime Minister affixed his signature to the United Nations World Leader' s Statement on population. Beginning in 1968, the Cabinet sanctioned the development of family services by the Ministry of Public Health on a research basis. During the 3 year period of 1968-1970 training on population and family planning were arranged for existing physicians and paramedical personnel so as to enable them to provide free family planning services to people in rural areas.

In late 1969 and early 1970, the National Economic and Social Development Board, together with the Ministry of Public Health and the Institute of Population Studies, prepared a comprehensive report for the Cabinet on the rapid population growth as a development problem, and strongly recommended the adoption of a population policy. In March 1970, the Cabinet accepted the report and declared "The Royal 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 eco nomic and social development of the nation."

The Cabinet also appointed a committee consisting of representatives of concerned public and private agencies to take action in study, over-all planning, coordination, and evaluation of the various activities connected with the implementation of the population policy. The National Family Planning Committee (NFPC) was chaired by the Minister of Public health, and his Ministry was assigned the responsibility for providing family planning services throughout the country. It was the intention of the Ministry to integrate family planning programs with other health activities for not only the economic reason but also for the maximum utilization of the existing health personnel and facilities.

In 1971 the National Family Planning Program (NFPP) was implemented. The members of the NFPP are appointed by the Minister of health and its membership is composed of

Program Director	- Director-General of the Department of Health
Deputy Program Director	- Deputy Director-General of the Department of Health
Assistant Program Director	- Director of the Family Health Division

Since the statement of the population policy, the five-year plans of the NFPP were developed in accordance with the National Economic and Social Development Plans starting with the Third plan (1972-1976). The main objective was to reduce the rate of growth of the population as shown in Table 1

TABLE 1 : Targets of the National Family Planning Program

Five-Year Plan	Target of Reduction of Population Growth rate	Target of New Acceptor
The Third Plan (1972-1976)	2.5	2.5
The Fourth Plan (1977-1981)	2.1	3.0
The Fifth Plan (1982-1986)	1.5	4.9
The Sixth Plan (1987-1991)	1.3	6.6

During the Third Plan the Policy was to emphasize the reduction of population growth rate in terms of quantity only. Starting with the Fourth Plan other aspects of a population policy have been encompassed. Population policy during the Fifth and the Sixth Plan period focuses on the quality of population as well as on population size and distribution.

The general objectives of the Sixth Plan (1987-1991) are to reduce fertility and the population growth rate, and consequently facilitate economic and social development and enable each family to improve the quality of life of its members. The specific objectives are as follows:

1. To reduce a total fertility rate from 2.95 in 1986 to 2.43 by the end of 1991.
2. To reduce a population growth rate from 1.6 to 1.3 per cent per year by the end of 1991.
3. To increase a contraceptive prevalence rate to be 75 per cent by the end of 1991.

The Family Health Division (Figure III)

The coordination of service delivery and day-to-day management of the family planning program necessitated the creation of an operating unit in the Department of Health. With regard to this reason the Family Health Division was assigned two main responsibili ties maternal/Child Health and Family Planning, and accordingly divided into 6 sections and two technical development groups as follows.

1. **Administrative Section**

The section handles routine administrative matters of which the main func tions are: budgeting most of the budget is allocated for contraceptives supplies and equip ment, salary of the staff, and other operating expense; logistics support-contraceptive meth

ods whether purchased or donated are received and delivered by this section: and personnel recruitment.

2. **Education and Training Section**

The NFPP includes provision for a continuous programme of in-service train ing to prepare Ministry of Public Health personnel of various levels. The Training and Education Section has organized the training/seminar for paramedical personnel such as nurses, midwives and other auxiliary personnel in the various methods of contraception due to the physician shortage in rural areas. The training is aimed to produce highly skilled practitioners capable of motivating, servicing and looking after complications of the family planning clients.

In addition to the regular training programme, refresher courses have been organized as the need arises. The maternal and child health and the primary health care content are also integrated in some inservice training courses.

The section is also responsible for organizing and developing a curriculum for 7 Nursing Midwifery Colleges that are under the Health Promotion Center in each part of the country.

3. **Research and Evaluation Section**

Research and evaluation activities have received particular attention from the very begining of the NFPP. The primary functions of this section are to carry out studies and evaluation of population and family planning Programmes aiming at the effective formu lation of policy, planning, implementation and administration of activities. Specifically, the staff conduct regular monitoring and evaluation of the activities of the NFPP. A Computer ized monthly report details statistics collected by each service unit throughout the Kingdom. Of the total reportion units 97.3% belong to the Ministry of Public Health, 2.3% belong to other public sector agencies while 0.4% are in the private sector. The analyzed data which indicate program progress of each service unit are evaluated and the results of the data have been periodically fed back for program implementation.

4. **Public Information Section**

Public Information Section is responsible for developing programs to stimu- late contraceptive acceptance of reproductive age groups based on factual information and understanding of the needs at both national and local level. Program strategies include : mass media approach (radio, printed materials, billboards and films); group and individual approach (systematic programs for meetings between health staff and target groups of indi- vidual); developing inventory of users and non-users in each village for individual visit; developing integrated programs to encourage acceptance of contraceptive among minority and hard core groups: launching different campaigns for promotion of specific contraception service; and designing advertising materials i.e. leaflet, poster, video, film, billboards.

5. **Family Health Documentation Section**

Family Health Documentation Section is responsible for provision and acqui sition of any of materials related to maternal and child health, family planning and popula tion, and for processing, storage and retrieval of these materials. Repackaging of selected in formation production in various forms of publications, and dissemination is done by Selec- tive Dissemination of Information (SDI) Program. Thai Population Information Center (TPIC) which offers a special library service is included in this section.

6. Technical Promotion Section

The section works in cooperation with other sections of the FHD and other related sectors in term of operational policies and programs of the NFPP and the Maternal and Child Health Program and ensuring that various projects are correlated with the National Health Policy and with the overall National Economic and Social Development Plan. Col lecting and analysing data of FP/MCH programs are also carried out by the section for the use of high rank officers. Besides, essays and papers on policy, planning, and progress of the FP/MCH Programs are provided to health personnel as a means of technical support in combination with the management of fellowships for the staff of Health Department who work in the field of FP/MCH. Another task is to arrange the observation tours for foreign guests.

7. Maternal and Child Health Technical Development Group

The Maternal and Child Health Technical Development Group is responsible for the medical and technical aspects of maternal and child health program including devel oping maternal and child health service system, coordinating and conducting clinical and non-clinical researches, setting standard for maternal and child health service as well as standard for medical supplies/equipment, writing and preparing technical materials and docu ment and handbooks for service providers, giving lectures on maternal and child health and also conducting technical conference concerning maternal and child health.

8. Family planning Technical Development Group

The Family Planning Technical Development Group is responsible for the medical and technical aspects of family planning programs. Its responsibilities include developing of family planning service system; coordinating and conducting clinical and non-clinical research for the development and improvement of contraceptive methods and family planning service; setting standard for family planning service as well as standard for contra ceptives and medical supplies/equipment; writing and preparing of technical materials and document, handbooks for service providers; giving lectures on family planning; conducting technical conferences, seminars and workshops in family planning; and conducting family planning technological training for physicians. In addition, it also offers technical consulta tion to other sections and organization on request.

Private Organizations

There are six major non-goverment organizations which play an imporiant role in complementing the family planning activities. These associations are described below :

ASIN

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

PDA

The Population and Community Development Association, a registered tax-exempt non profit organization grew out of the work of the Community-Based Family Planning Services (CBFPS) which was founded in 1974. With assistance from International Planned Parenthood Federation (IPPF) , the Japanese Organization for International Cooperation (JOICFP) , the U.S. Agency for International Development (USAID) etc, the CBFPS pio neered community-based family planning services in rural areas. Other activities include an integrated family planning and parasite control project and a family planning and primary health care project.

The PDA has recently established an international training center called the "Asian Center for Population and Community Development". The first international training course was conducted in June 1979 and 6-7 courses are held each year.

The PDA established the Population and Community Development company, a non-profit agency, in 1975, to become a resource development arm for meedy services to be ren dered by PDA. A number of fertility regulation services are carried out under PDA, includ ing voluntary sterilization, IUD insertion, injectables, and the commercial distribution of con dom which has 3,000 outlets throughout the country.

PPAT

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

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.

TFRA

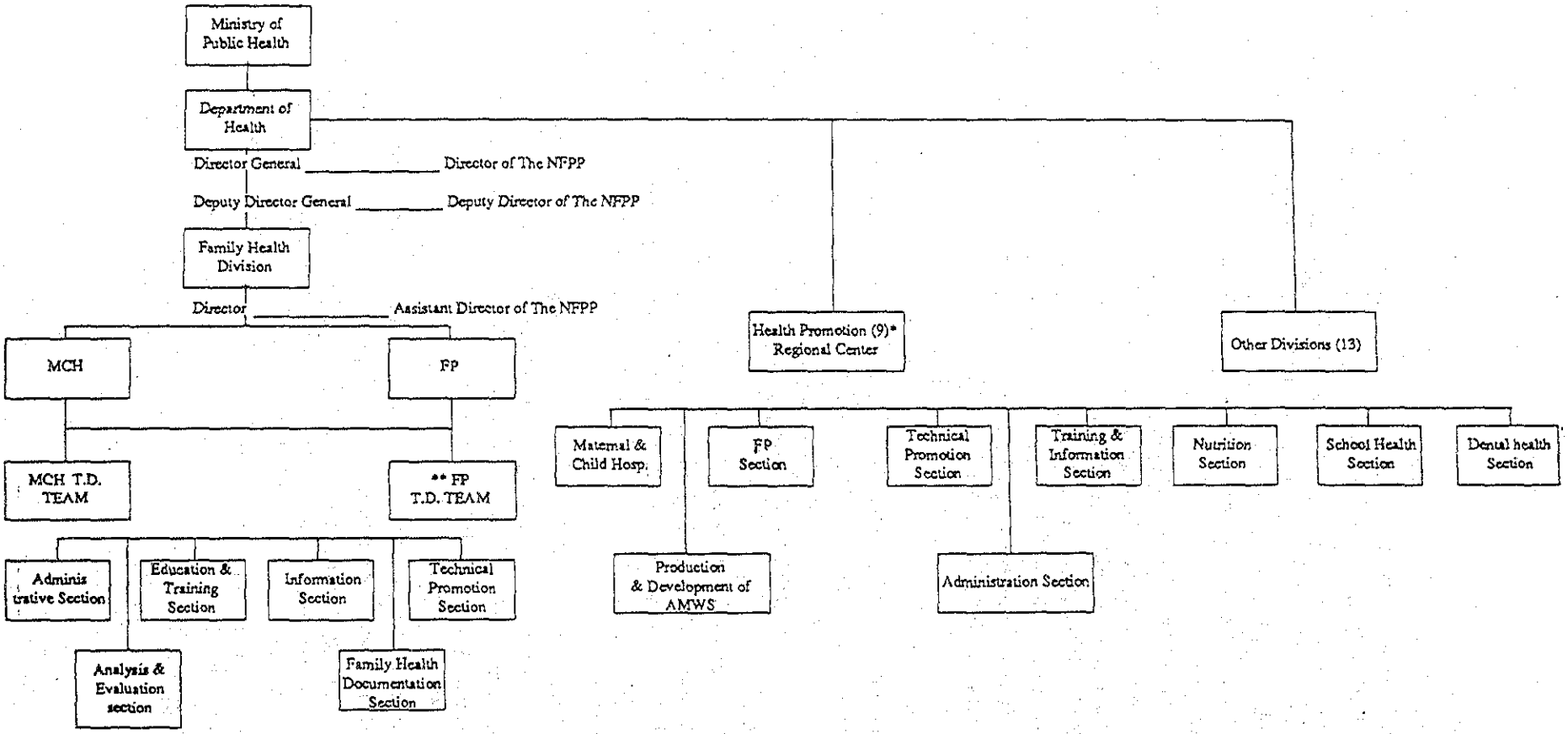
The Thailand Fertility Research Association was developed in 1979 as a national center for family planning research in Thailand. It conducts essential research concerning the effectiveness, safety and acceptability of various contraceptive methods and people's behavior and attitudes.

IQLA

The Intensive Development of the Quality of Life Association was eatablished in 1984 in order to support the NFPP to develop and solve the problems of poverty and illness of people. Its objective focus on the hard core groups both in urban and rural areas.

ORGANIZATION OF FAMILY HEALTH DIVISION, DEPARTMENT OF HEALTH

Figure III



Contraceptive Services

There are five effective methods used in the NFPP, namely oral contraceptives, intrauterine device (IUD), injectable contraceptives, subdermal implants and sterilization. By 1971trained auxiliary midwives could prescribe birth control pills. In 1972, IUD services were available in all provincial hospitals and by 1973, sterilization services were also available, In 1975 injectable birth control was available nationally through hospitals. In 1980 auxiliary midwives were trained to inject depomedroxy-progesterone acetate (DMPA) and insert IUDs. Norplant was introduced on a trial basis in 1981 and used nationwide in 1988.

Contraceptive Prevalence

The Third Contraceptive prevalence Survey revealed that the contraceptive prevalence in 1984 was 64.61% of MWRA compared with 59% in 1981. Currently, the results of the Survey of Determinants and Consequences of Contraceptive Use Patterns (CUPS) indicated that contraceptive prevalence in 1987 was 70.6%. Virtually all contraceptive use among married couples in Thailand is attributable to modern and potentially very efficient methods.

TableII Percentage currently practicing specific methods of contraception among currently married women aged 15-44, 1969-87

Year	Survey	Pill	IUD	Male steri.	Female steri.	Injection	Condom	Others	All methods
1969/70	LS1	3.8	2.2	2.1	5.5	0.4	0.0	0.7	14.8
1972/73	LS2	10.6	4.7	2.8	6.8	0.9	0.1	0.5	26.4
1975	SOFT	15.2	6.5	2.2	7.5	2.1	0.5	2.8	36.7
1978/79	CPS1**	21.9	4.0	3.5	13.0	4.7	2.2	4.2	53.4
1981	CPS2	20.2	4.2	4.2	18.7	7.1	1.9	2.7	59.0
1984	CPS3	19.8	4.9	4.4	23.5	7.6	1.8	2.6	64.6
1987	CUPS	19.9	6.2	3.8	25.4	10.9	1.9	2.6	70.6

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

Source: Knodel, Chamratritlirong and Debavalya, 1987.

Achievement of the National Family Planning Program

Thailand has nearly 2 decades of experience in implementing a national family planning program. The NFPP has put a lot of effort into reducing the growth rate which is regarded as way to improve the standard of living of the people. The rate of growth decreased from over 3% in 1970 to 2.5% in 1976 and to 1.7% in 1986. In addition, the total fertility rate gradually declined from 5.1% in 1972 to 3.4% in 1974 and to 2.1% in 1987 (TDHS).

The success of the NFPP also can be seen in the increase of the contraceptive prevalence rate; from 14.8 per cent in 1969-1970 to 70.6 per cent in 1987. The number of new contraceptive acceptors has increased from 0.2 million in 1970 to 1.5 million in 1986 and is still increasing steadily.

Factors contributing to the achievement in quantity control of population are as follows:

1. Availability and accessibility of family planning information and services organized by government and private sector under political commitment.
2. Quality of family planning services including choice provided and program follow-up.
3. Favourable social and cultural setting of Thai society, for example high literacy rate, women's employment and status, increasing age at marriage, together with rapid economic change make the two-child family norm acceptable.
4. The integration of family planning with maternal and child health with realization of the interrelation between fertility and mortality of mothers and children.
5. Close coordiantion and joint effort of related ministries and private associations are strongly accelerated.
6. Continuous assistance from external donors and strongly supported by Royal Thai Government.

Despite this success, a low level of contraceptive prevalence does pervail in certain parts of the country; particularly in the remote areas of the Northeast and the South, where people are reluctant to participate in this demographic transiuon. The provision of family planning services to these people has been difficult to carry out and has met with nominal success due to communication problems and cultural and language barriers.

To serve the needs of these particular groups, special programs have been initiated since the last Five-Year Plan (1982-1986). These include the Hilltribe Family Health Project and the Institutionalization of Maternal and Child Health and Birth Spacing Services in Selected Districts of the South. The goals are to improve service delivery and increase the national contraceptive prevalence rate.

Besides the aforementioned target groups, increased attention is also given to adolescents. The Expanded Family Life Education Counselling Program for Adolescents is being carried out to help educate them in contraception and reproductive health and to address their particular needs.

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During the Sixth Plan (1987-1991) besides those continuing program the National Family Planning Program has placed emphasis in the expansion of services to other special target groups, namely those in the fertile age groups working in factories and living in slum areas. The family planning program for factory workers is ready for implementation in 1988 -1989 with the cooperation of the private sector.

The NFPP is begining to face the hard core groups of resistor. Therefore more effective approaches have to be initiated. The quality of services is one approach being emphasized to make family planning more attractive to the target population. One activity created for serving this purpose is the pap smear screening program for the family planning acceptors and for other women at risk.

Simultaneously, other actions with a more immediate payoff are desirable. Carefully designed regulations, legal measures, and family planning information and services can en able married couples to plan and space pregnancies, to properly use the available contracep tive methods, and to accept permanent contraception when they want no more children. These well-designed measures can provide an additional mechanism to encourage lower fertility.

ANNEX 1

NUMBER OF BIRTH, NUMBER OF DEATH,

BIRTH RATE, DEATH RATE AND GROWTH BIRTH RATE

1964 - 1987

Unit : 1,000

YEAR	NUMBER OF POPULATION (MID-YEAR)	NUMBER OF BIRTH	NUMBER OF DEATH	BIRTH RATE (PER 1,000)	DEATH RATE (PER 1,000)	GROWTH RATE %
1964	29,016	1,212	249	41.8	8.6	3.3
1696	34,038	1,131	228	33.2	6.7	2.7
1974	40,642	1,186	247	29.2	6.1	2.3
1979	45,668	1,131	235	24.8	5.1	2.0
1984	50,049	926	238	18.5	4.7	1.4
1985	51,189	933	197	18.2	3.8	1.4
1986	52,382	869	219	16.6	4.2	1.2
1987	53,397	862	225	16.2	4.2	1.2

SOURCE : THE INSTITUTE OF POPULATION AND SOCIAL RESEARCH, MAHIDOL UNIVERSITY 1989

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ANNEX 2

PERCENTAGE OF POPULATION PER PUBLIC HEALTH

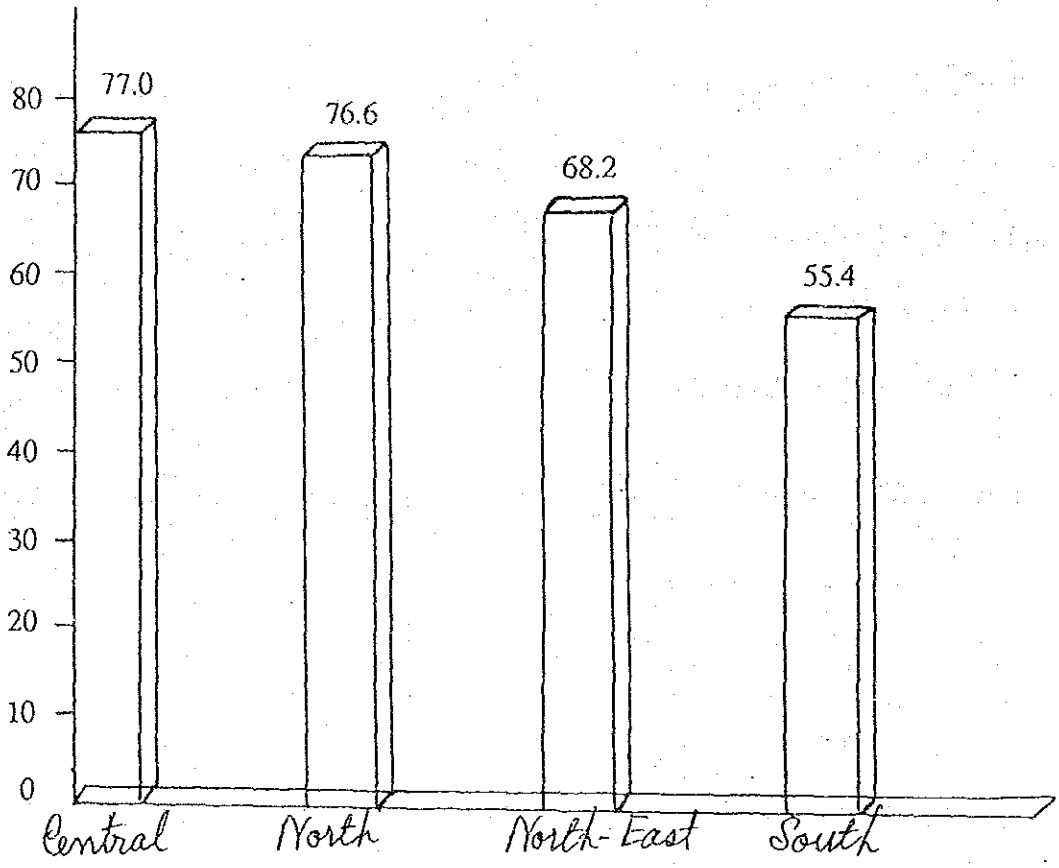
PERSONNEL (1986)	WHOLE COUNTRY	BANGKOK	REGION
POPULATION PER 1 DOCTOR	5,564	1,407	8,799
POPULATION PER 1 DENTIST	37,745	6,598	91,461
POPULATION PER 1 PHARMACIST	15,690	2,109	78,680
POPULATION PER 1 NURSE	1,284	443	1,684
POPULATION PER 1 MIDWIFE	8,262	15,015	7,824

SOURCE : PUBLIC HEALTH STATISTIC DIVISION, MINISTRY OF PUBLIC HEALTH

ANNEX 3

PERCENTAGE OF MARRIED WOMEN AT REPRODUCTIVE AGE (15-44 YEARS)

AND STILL USING CONTRACEPTIVE METHODS DISTRIBUTE BY REGION



SOURCE : INSTITUTE OF POPULATION AND SOCIAL RESEARCH, MAHIDOL UNIVERSITY 1987

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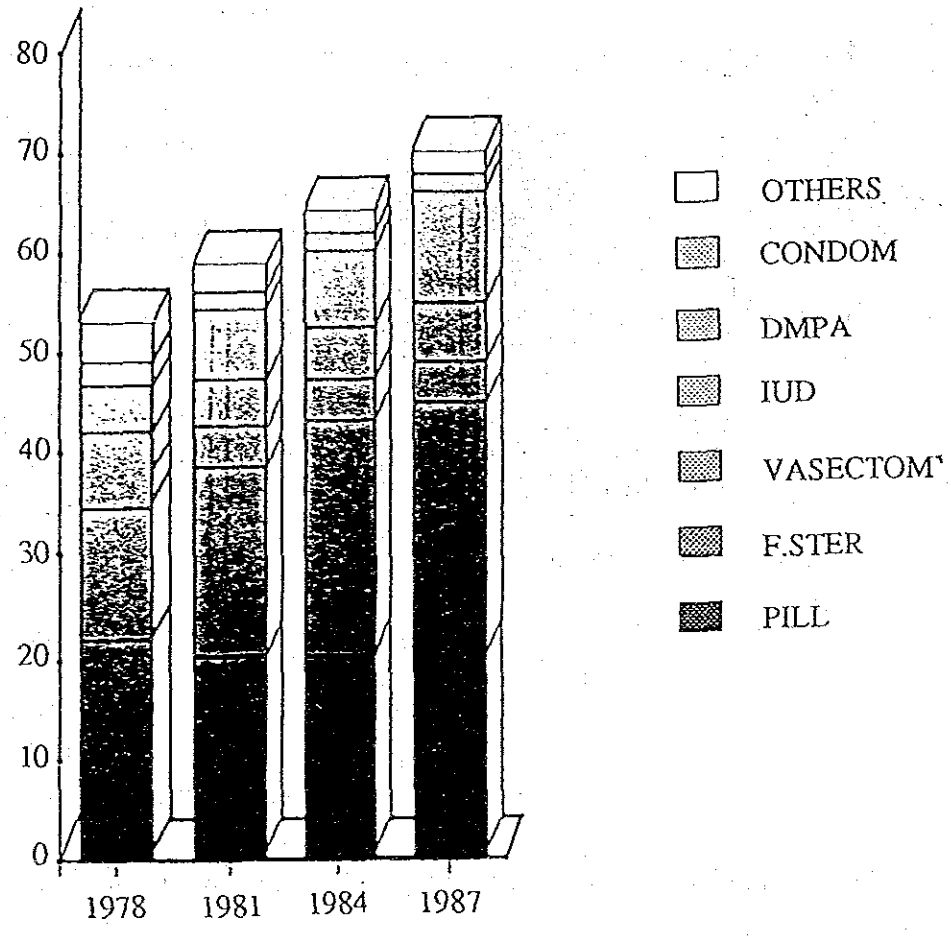
ANNEX 4

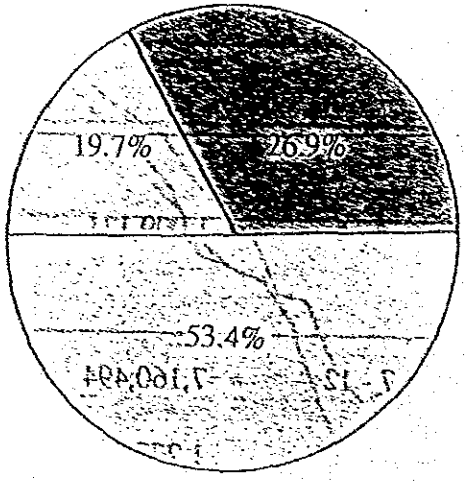
PERCENTAGE OF MARRIED WOMEN AT REPRODUCTIVE AGE (15 - 44 YEARS) AND STILL USING CONTRACEPTIVE METHODS DISTRIBUTE BY METHOD (1978 - 1987)



ANNEX 5

STRUCTURE OF POPULATION AND LABOUR FORCE

OF THAILAND (MID YEAR 1986)



ANNEX 6

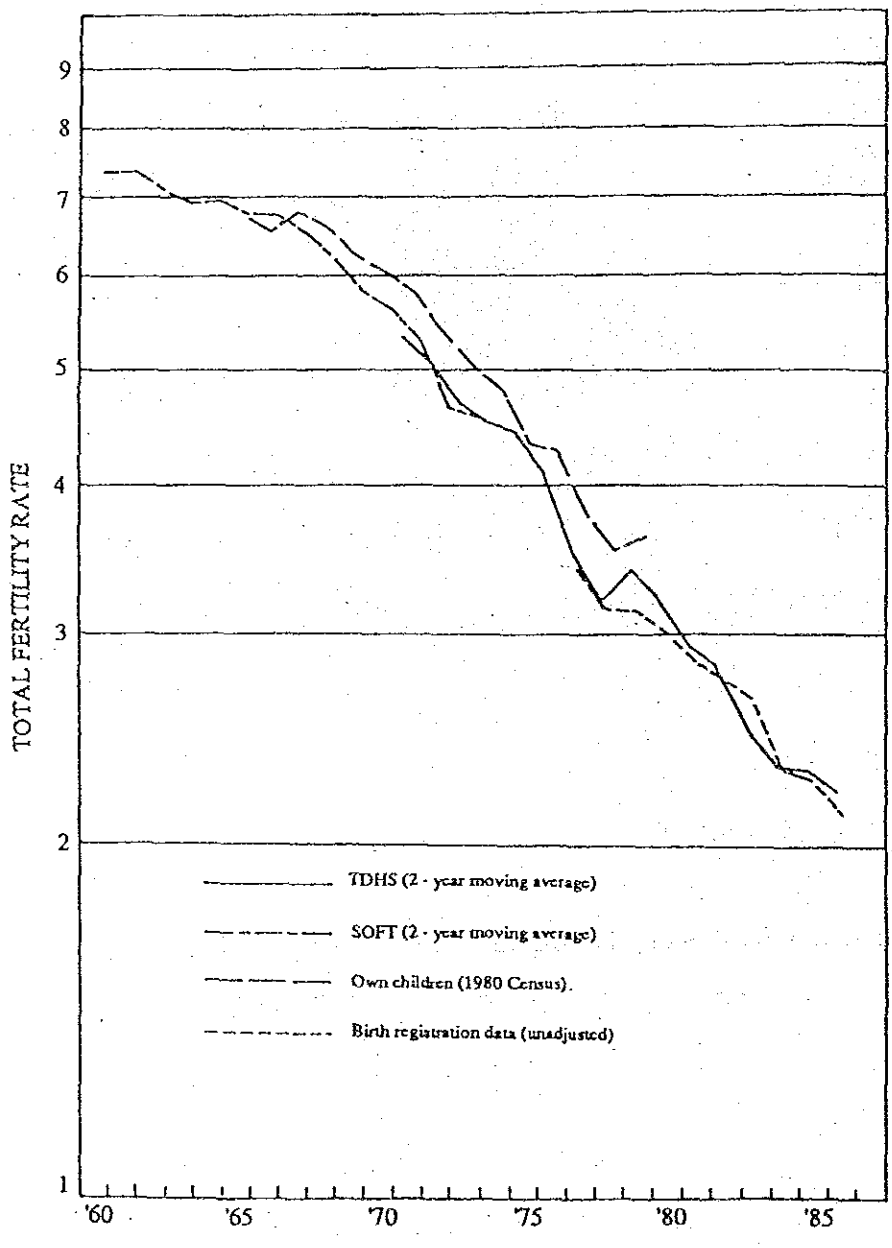
NUMBER OF STUDENTS (FROM PRIMARY SCHOOL TILL UNIVERSITY) WITHIN SCHOOL SYSTEM AND POPULATION AT SCHOOL AGE DISTRIBUTED BY CLASS AND LEVEL OF EDUCATION (1986)

LEVEL OF EDUCATION	DURATION AGE	STUDENTS	POPULATION AT SCHOOL AGE	% OF STUDENTS PER POP AT SCHOOL AGE
BEFORE PRIMARY SCHOOL	4 - 6	1,009,131	3,799,288	26.6
PRIMARY SCHOOL	7 - 12	7,160,494	7,477,338	95.8
SECONDARY SCHOOL	13 - 15	1,277,619	3,708,727	34.7
HIGH SCHOOL	16 - 18	907,231	3,671,463	7.7
UNIVERSITY (BACHALOR DEGREE)	19 - 22	348,487	4,537,550	

SOURCE : PLANNING DIVISION, MINISTRY OF EDUCATION, 1986

ANNEX 7

Comparison of the trend in the TFR based on TDHS with trends based on data from SOFT, the 1980 census, and vital registration



ANNEX 8

Percent distribution of women who know a specific method according to supply source named (if any)

Source	Pill	IUD	Injection	Vaginal methods	Condom	Female sterili-zation	Male sterili-zation	Periodic abstinence	Other
Government hospital	15.7	58.2	31.6	41.3	16.4	85.0	78.0	20.0	65.2
Govt" health center	59.3	27.8	49.6	25.0	48.7	5.6	7.9	24.8	4.9
Family planning clinic	0.3	0.2	0.4	0.6	0.3	0:1	1.2	1.0	0.2
Mobile clinic	0.0	0.2	0.4	0.0	0.2	0.2	2.5	0.2	0.5
Health volunteer	1.0	0.0	0.0	0.0	0.3	0.0	0.0	0.3	0.1
Reading	0.0	0.0	0.0	0.1	0.0	0.0	0.0	17.2	0.1
Private hospital or clinic	4.9	4.5	11.2	7.5	1.6	4.8	4.2	7.0	4.5
Pharmacy	12.1	0.0	0.5	3.3	17.7	0.0	0.0	0.1	1.6
Shop	0.9	0.0	0.0	0.2	0.9	0.0	0.0	0.0	0.6
MCH center or Bangkok health center	4.2	4.9	4.6	4.8	2.4	2.7	2.3	3.6	4.6
Friends, relatives	0.1	0.0	0.1	0.3	0.2	0.0	0.0	15.0	1.4
Other	0.3	0.0	0.1	0.0	0.2	0.0	0.0	2.3	1.7
Nowhere	0.0	0.0	0.0	0.1	0.0	0.0	0.0	1.7	0.0
Don't know*	1.2	4.1	1.5	16.8	10.9	1.5	3.9	6.5	14.6
Total percent	100	100	100	100	100	100	100	100	100
Weighted number of women	6,674	6,399	6,562	1,127	5,950	6,611	6,480	1,911	1,019

* Includes a small number of cases for whom no answer was recorded

BACKGROUND INFORMATION

KHON KAEN REGIONAL HOSPITAL

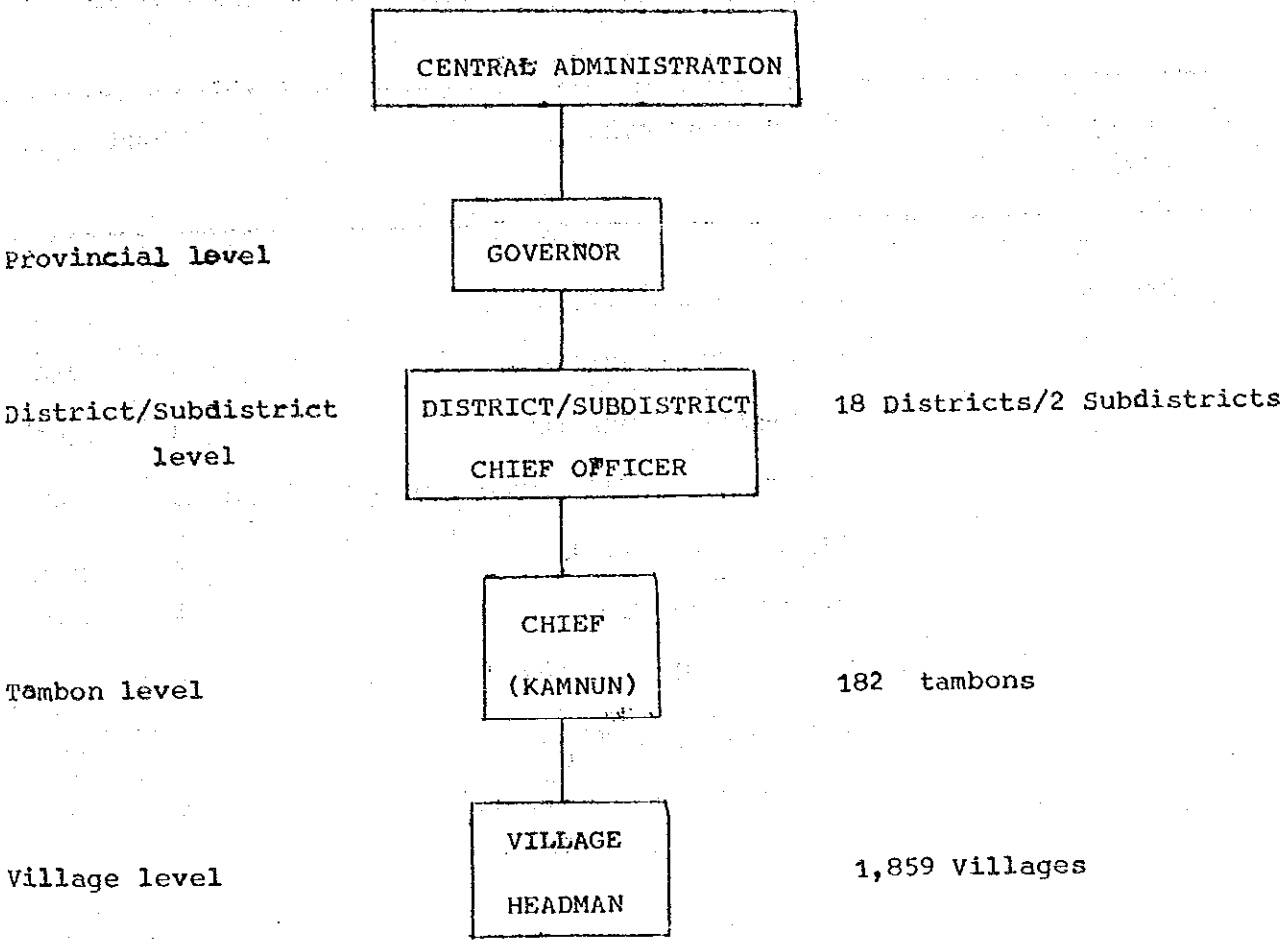
1990

TABLE OF CONTENT

PART 1 : INTRODUCTION TO KHON KAEN PROVINCE

Khon Kaen was founded by Rajkruluang or Lord Muangtan in 1783. It is approximately 445 kilometers from Bangkok and covers an area of 13,404 square kilometers with a population of 1,653,536 (Mid-year 1989). The population density is 123 per square kilometer. The majority of lands are dormant and unsuitable for agriculture due to an inadequate irrigation. Agriculture is the major source of income. Rice is the major agricultural product. In the recent years many kinds of industry have been introduced into the province, thus improving its economic condition. Despite all the effort, the living standard remains poor. The per capita income in 1988 was about 16,506 bahts annually.

ADMINISTRATIVE STRUCTURE OF KHON KAEN PROVINCE



PART 2 : HEALTH RESOURCE IN KHON KAEN PROVICE

2.1 MEDICAL AND HEALTH ESTABLISHMENTS IN KHON KAEN PROVINCE, FISCAL YEAR 1990

ADMINISTRATIVE LEVEL	ESTABLISHMENTS	NUMBER	BEDS
PROVINCE	REGIONAL HOSPITAL	1	614
	UNIVERSITY HOSPITAL	1	780
	PSYCHIATRIC HOSPITAL	1	300
	MATERNAL AND CHILD HOSPITAL (HPC)	1	200
	LEPROSY SANITARIUM	1	170
	MILITARY HOSPITAL	1	30
	MALARIA CONTROL CENTER	1	-
	T B CONTROL CENTER	1	-
	LEPROSY CONTROL CENTER	1	-
	VD CONTROL CENTER	1	-
	MCH CENTER	1	-
	ENVIRONMENTAL HEALTH CENTER	1	-
	MEDICAL SCIENCE CENTER	1	-
	KHON KAEN SKIN CLINIC	1	-
DISTRICTS	60 - BED COMMUNITY HOSPITAL	4	240
	30 - BED COMMUNITY HOSPITAL	2	60
	10 - BED COMMUNITY HOSPITAL	13	130
TAMBON	HEALTH CENTER	179	-

ADMINISTRATIVE LEVEL	ESTABLISHMENTS	NUMBER	BEDS
PRIVATE SECTOR	PRIVATE HOSPITAL	5	150
	PRIVATE CLINIC	153	-
	PRIVATE DENTAL CLINIC	35	-

TOTAL 2,674

REMARK POPULATION PER BED 618

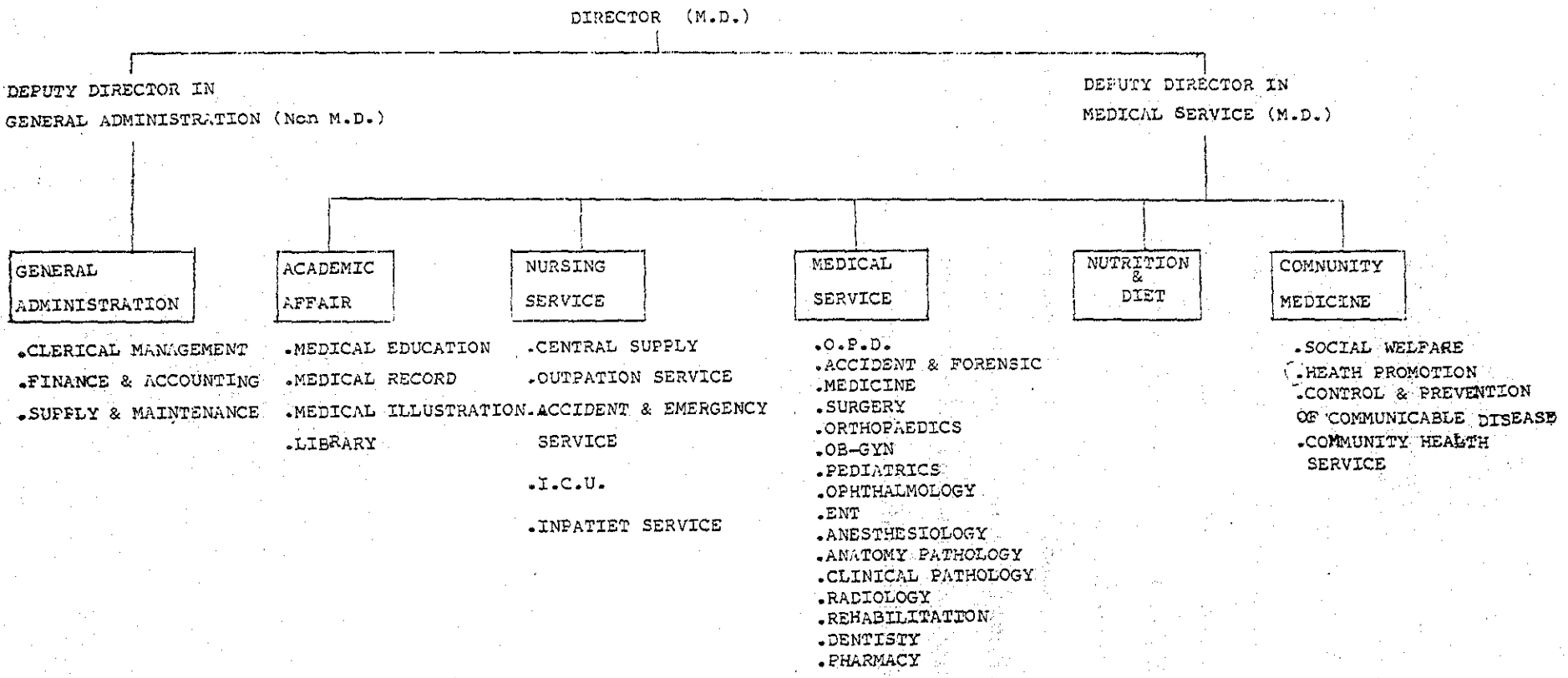
2.2 NUMBER OF SELECTED HEALTH PERSONNEL IN KHON KAEN (FISCAL YEAR 1990)

TYPES OF PERSONNEL	NUMBER	POPULATION/HEALTH PERSONNEL
PHYSICIAN	410	1 : 4,033
DENTIST	62	1 : 26,670
PHARMACIST	69	1 : 23,964
PROFESSIONAL NURSE	1,066	1 . 1,551
TECHNICAL NURSE	436	1 : 3,793
ASSISTANT NURSE	543	1 : 3,045
MIDWIFE	396	1 : 4,176
JUNIOR HEALTH WORKER	231	1 : 7,158
DENTAL NURSE	36	1 : 45,932

PART 3 : INTRODUCTION TO KHON KAEN REGIONAL HOSPITAL

Khon Kaen Hospital was founded in 1951 with only two doctors, three nurses and the facilities for 26 beds. At present, it is a regional hospital and medical center with 614 beds. It offers conventional and many specialized care to the people in this region. It serves as a referral and supporting center for community and general hospitals in the area. It participates in many teaching, training and research programs. The medical and nursing students from Khon Kaen University receive their teaching and training at the hospital.

3.1 ORGANIZATION STRUCTURE OF KHON KEAN REGIONAL HOSPITAL



3.2 NUMBER OF SELECTED MEDICAL AND ALLIED HEALTH PERSONNEL IN KHON KAEN REGIONAL HOSPITAL (PISCAL YEAR 1990)

TYPES OF PERSONNEL	MANPOWER FRAME	ACTUAL NUMBER	% OF MANPOWER FRAME
PHYSICIAN	128	48	37.5
RESIDENT	24	24	100.0
DENTIST	9	4	44.4
PHARMACIST	14	7	50.0
MEDICAL TECHNICIAN .	7	6	85.7
OCCUPATIONAL THERAPIST	3	1	33.3
PHYSICAL THERAPIST .	5	3	60.0
NURSE (ALL KIND)	625	429	68.6

REMARK TOTAL PERSONNEL 1,085

3.3 FINANCIAL STATUS (FISCAL YEAR 1989)

	GOVERNMENT BUDGET (BAHTS)	HOSPITAL EARNINGS (BAHTS)	TOTAL (BAHTS)
1. SALARIES	35,923,483.91	-	35,923,483.91
2. WAGES	14,183,580.00	2,880,255	17,063,835.00
3. ORDINARY EXPENSES	17,394,591.01	31,715,101.82	49,109,692.83
4. BUILDING AND CONSTRUCTION	1,714,900.00	7,561,502.00	9,276,402.00
5. PUBLIC UTILITIES	3,750,800.00	3,150,850.41	6,901,650.41
6. SUBSIDIES	8,701,000.00	-	8,701,000.00
7. OTHERS	141,890.00	232,311.50	374,201.50
TOTAL	81,810,244.92	45,540,020.73	127,350,265.60

PART 4 : SELECTED ACTIVITIES

4.1 SELECTED MEDICAL SERVICE (FISCAL YEAR 1989)

TOTAL BEDS	614
BED OCCUPANCY RATE (%)	96.5
BED PER PHYSICIAN RATIO	9.2
BED PER NURSE RATIO	1.4
OUTPATIENT NUMBER	
RATE PER YEAR	181,126
RATE PER DAY	633
INPATIENT NUMBER	
RATE PER YEAR	30,505
RATE PER DAY	593
DEATH RATE (PER 1,000 ADMISSION)	25.8
AVERAGE HOSPITAL STAY (DAYS)	7.09

4.2 TEN LEADING CAUSES OF ILLNESS IN OUTPATIENTS

RANK	CAUSES	NUMBER	% OF TOTAL OUTPATION
1.	DIGESTIVE DISEASE	30,921	17.1
2.	RESPIRATORY DISEASE	18,969	10.5
3.	ACCIDENT & POISONING	15,821	8.7
4.	NERVOUS SYSTEM	13,598	7.5
5.	ILL DEFINED CONDITION	12,245	6.8
6.	GENITO URINARY SYSTEM	11,895	6.6
7.	MUSCULOSKELETAL SYSTEM	11,757	6.5
8.	ENDOCRINE & METABOLISM	8,760	4.8
9.	INFECTIOUS DISEASES	8,533	4.7
10.	SKIN DISEASES	6,915	3.8
	TOTAL FOR 1-10	139,414	77.0
	ALL OTHER CAUSES	41,712	23.0

4.4 COMMON CAUSES OF DEATH IN HOSPITALS

DISEASE	NUMBER	% OF TOTAL DEATHS
1. HEART DISEASE	131	16.6
2. MOTOR VEHICLE ACCIDENT	93	11.8
3. ALL OTHER ACCIDENT	79	10.0
4. SEPTICEMIA	52	6.6
5. MALIGNANT NEOPLASM	50	6.4
6. PNEUMONIA	42	5.3
7. CEREBROVASCULAR DISEASE	34	4.3
8. TUBERCULOSIS	23	2.9
9. RENAL FAILURE	22	2.8
10. GASTROINTESTINAL HEMORRHAGE	18	2.3
TOTAL FOR 1-10	544	69.1
ALL OTHER CAUSES	243	30.9

4.3 TEN LEADING CAUSES OF HOSPITAL ADMISSION

CAUSES	NUMBER	% OF TOTAL ADMISSION
1. ALL OTHER ACCIDENT	2,353	7.7
2. MALIGNANCY	1,587	5.2
3. DELIVERIES & COMPLICATIONS OF PREGNANCY	1,572	5.1
4. TRAFFIC ACCIDENT	1,406	4.6
5. ILL DEFINED CONDITION	1,282	4.2
6. HEMORRHAGIC FEVER	945	3.1
7. ACCUTE APPENDICITIS	780	2.6
8. ANEMIA	693	2.3
9. ENTERITIS & DIARRHEAL DISEASES	633	2.1
10. BENIGN TUMOR	566	1.9
TOTAL FOR 1-10	11,817	38.7
ALL OTHER CAUSES	18,688	61.3