

WORLD HEALTH
ORGANIZATION

REGIONAL OFFICE FOR
SOUTH EAST ASIA

REPORT ON A VISIT TO THAILAND

SECOND PERIOD

6 JANUARY - 8 FEBRUARY 1977

BY

DAVID DRUCKER
SOCIAL SCIENTIST
(SEARO)

Introduction

The terms of reference for this first follow through visit grew directly out of the recommendations consequent upon the preliminary visit made in September/October 1976.*

Between times Dr V.T.H. Gunaratne, RD (SEARO) had attended the Second Annual Review of the Lampang (DEIDS) Project 22 - 25 Nov.'76

Relevant here are the Conclusions and Recommendations of that review:-

" ways and means of implementation
(of PHC) need to be clarified"

and

" it is recommended that a guide to
operationalising PHC in Thailand be pro-
duced" and elaborates upon this.

further

" it was also recommended that the project
extend its efforts to stimulate community
participation in PHC schemes....."

These conclusions (a copy of which was sent by the WR Thailand in
confirming the assignment**) were exactly in line with the recomm-
endations made by the Social Scientist earlier.

* See report on a visit to Thailand 23 Sept - 20 Oct. '76
D.Drucker (SEARO)

** SEARO Memo to WR to RD 1.12.'76

...../

In writing to Dr UTHAI SUDSUKH, Director, Rural Health Division, Karl Skansing, THA PHC 001 said:

"I strongly concur with his proposal to initiate the development of an "operational guide on primary health care care in Thailand". This is not so much for standardizing the approach to development of primary health care as to pull together and document the best experience we have in the country in this respect. It should also serve as a documentation of MOPH proposed strategy for supporting the development of primary health care schemes in an effort to co-ordinate technical inputs from various units in MOPH. In addition, it should serve as a starting point for adopting a plan for MOPH in promoting the development of the concept all over the country, in particular the 20 selected provinces scheduled for implementation in 1977 but also covering the period beyond 1977. A reassessment of training and other implementation targets as well as resource requirements should be made in this connection".*

The aspects of the terms of reference are clearly *part* of a *unified* assignment.

PURPOSE OF VISIT:

- (a) To "assist the government in writing up a summary documentation on the present experience of PHC schemes in Thailand to serve as a guideline for relevant units in the Ministry of Public Health in their efforts to implement PHC on a large scale" **

* Memo 20.12.'76

** Memo: K.Skansing to Dr Uthai, 7.1.'77

- (b) At the special request of Dr Soomboon Vachrotai, Director of the DEIDS project, To advise on the community participation aspect of the project..... That is, to be concerned with what he called the "Social Preparation" for organizing community efforts and "to reverse the planning implementation process that existed before and create a new process of 'upward planning, downward' support^{*}"

ACTIVITY

- (a) While the 'guideline team' was being assembled, it was proposed that a start should be made by a visit to Lampang Project which was expecting my arrival and Mr NIT SAMAPPAN of the National Institute of Development Administration was especially assigned as 'counterpart'^{*} for this part of the work.

Extensive discussions and visits took place with the staff members of the Lampang Project and with many villagers and organizations^{**}.

Suggestions were made regarding:

1. Village level organization and training in village level project management,
2. Development of "How to....guides"
3. Providing illustrations for 'a typical years work in health planning and project in a Thai village'

* New Horizons for Integrated Health Services and Primary Health Care in Thailand. The Lampang Health Development Project. Soomboon Vachrotai and R.G. Wilson 1976 Appendix....

** These included Min. of Interior (Community Development Centre No.5 Region) Northern Agricultural Development Centre (Min. of Agriculture) Friedrich Neumann Foundation, etc.

4. Need for illustrative detailed work schedules during 'start-up' and on-going phases of implementing PHC.
5. An examination and analysis of village committee activity.
6. § An examination and analysis of supervisory work
7. Collection of common attitudes and responses to PHC and some ways of dealing with these.....

The content of this visit and its suggestions were discussed fully with the staff at Lampang and in Bangkok with Dr Soomboon, Dr Wilson and others.

Later a written document was produced* and this was discussed at a subsequent visit to Lampang (Feb. 2 - 4th)

A full meeting around this report (which was excellently received) is scheduled for the full Lampang team when Dr Soomboon and Mr Nit return to Lampang (second week in February).

- (b) A beginning was made of the guidelines for Primary Health Care in three days of concentrated work at Sawan Kanewat. Mr Tirapol of Health Education (Korat) and Mr Narin Tima of the Health Training Division were assigned, supported by WHO's Mr K. Skansing, Rural Health Division and WHO Nurse, Miss Inge Bjorkroth.

* See, Lampang Health Development Project (DEIDS) visit by Mr D. Drucker and Mr Nit Saumapan - 12 - 18 January 1977.

Work included:

- a) identification of to whom the guidelines were to be addressed;
- b) identification of contents^{*}
- c) writing up of the preliminary drafts of the sections.

However, this undertaking was interrupted when it was found that a document existed in the Thai language which was a draft to the Provinces outlining their expected activity in implementing Primary Health Care. This document was hastily translated so that, we could examine its contents^{**}. In the light of the fact that our whole exercise was to pull together the Thai experience and the existence of the work on this document had not been known to us, a number of items were identified which seemed to us to require urgent discussion of a technical nature and for which some decisions would be required so as to make the most of the work already done and to utilise the available experience and expertise to the maximum.

In a memo of 26.1.'77 the WR Thailand¹ was informed about the 'guidelines' and it was suggested that discussion should take place regarding:

* See 'Draft on Primary Health Care' - Appendix -

** See 'Guidelines for the Implementation of VHC/VHV - Appendix -

1 See Memo Dr Drucker to WR Thailand - 26.1.'77 Appendix -

1. Selection(of volunteers)
2. Training (content, method and style) on a one-project at-a-time basis 'on demand'
3. Village Organization and Village Committees.
4. Community Technical Support Materials
5. Work Schedules

- (c) A number of internal meetings took place with the WR, Dr Chical, and Dr Stern, and it was suggested that a discussion paper should be prepared and a presentation made at a meeting to be arranged.
- (d) A discussion paper was prepared^{*} and a meeting took place attended by nationals from Divisions of Planning, Manpower Development, Health Education, Rural Health, the Chief sanitarian, WHO staff and chaired by ^{the} Dep. Under Secretary. A number of important issues were opened for discussion and a framework for examining and perhaps resolving some of the outstanding problems was tentatively suggested. In the expectation of a continuation of these discussions an illustrative outline of "milestones" and "time-scheduling" incorporating some of the ideas and approaches was prepared by Mr Drucker and Mr Skansing^{**}
- (e) Contact was made with Dr Patya Saihoo, Professor, Dept. of Sociology and Anthropology, Director Institute of Social Research, Chulalongkorn University Bangkok. Dr Patya has been commissioned to work with the Ministry of P.H. with WHO support. A very cordial exchange of views took place

* See 'D. Drucker: A discussion paper on the implementation of Primary Health Care in Thailand.

** See Appendix

and a review was made of the PHC situation as we saw it in Thailand. It seems that Dr Patya understands his current brief as making an evaluation of the work of 'communicators'

At the suggestion of Dr Stern

- (f) A further visit to Lampang was made to accompany Dr Prapont Piyaatn of the Faculty of Medicine, Chulalongkorn. He is contracted by WHO, Geneva to develop "evaluation instruments" for PHC. Extensive and wide ranging discussions regarding both concept and activity in PHC took place with the Lampang project staff and the staff of Chulalongkorn's Unit of Medical Education. Dr Prapont seemed to pinpoint his responsibility as devising ways for "evaluating the performance of Health Communicators and Village Health Volunteers" working in PHC.
- (g) The new film "the Lampang Project" was exhibited on two occasions to which I was invited. The first at the "Society for International Development" enabled discussions to take place informally regarding UNICEF's involvement in PHC, with the UNICEF Regional Director Mr Roberto Esguerra Barry. On the second occasion the Social Scientist was asked to speak to the senior staff of the Ministry of P.H. regarding WHO's interest in PHC and community participation (there are 4 copies of this film. It would be well worth borrowing a copy ^{to} show here at SEARO).

OBSERVATIONS

- a) Much of the substantive content of this assignment appear in the discussion papers prepared for the Min. of PH and the Lampang Project.
- § b) Much work still remains to be done in spelling out the new work content and time scheduling for the field-level staff in the initiation and promotion of the Provincial Primary Health Care Programme.
- c) More clarification and decision making is essential around the nature and detail of community involvement. For example How much can be expected and planned for in initiating what degree of village level planning? Should and could communication begin by collecting Base Line Data from the small group of householders, so releasing Public Health Staff for more skilled duties? How will a village support system be built up both for planning of activities and for related "training on demand?". etc., etc.
- d) If Community participation is to be seriously developed nation-wide, perhaps some kind of Thai 'Manual for Planning at the Village Level' needs to be desired. *desired.*
- e) The work of Dr Patya and Dr Prapont are clearly related in terms of the focus of their assignments. Operational relatedness would no doubt strengthen the work of both.
- f) The present status of the 'guidelines' needs to be clarified and the role of the Social Scientist in relation to this work re-defined.

- g) A request has already been made to RD (SEARO) regarding continued Social Scientist inputs into the important aspects of social preparation and village level planning.
- h) There is also a request for the Social Scientist to become involved in his next visit (and possibly in an on-going way) with a UN-funded attempt to establish a truly Integrated Rural Development Programme (Agriculture, Education, Health) to include PHC (see the project draft "The Songkla Integrated Population Development Model, September 1976).

COMMENT:

Community participation, clarity in conveying concept and method to implementing staff; and the proper place of health and PHC in overall rural development; are all very vital issues and constitute the core of the continued work to which the social Scientist could contribute in Thailand.

Lampang Health Development Project (DEIDS)

Visit by

Mr. D. Drucker W.H.O. (SEARO)

Mr. Nit Samnapan NIDA

^{Jan}
12 - 18th 1977

<u>Table of Contents:</u>	<u>Page</u>
Purpose	1
Approach	1
A. <u>Catalogue of Problems</u>	2
1. Selection Methods	2
2. Communicators	3
3. Health Post Volunteers	3
4. Health Committees	4
5. Supervision	5
B. <u>Some Observations and Suggestions</u>	5
Village Level Planning and Management	6
Village Committee Training	6
The Structure of Village Committees	7
Base Line Data	8
Village Plans	8
How to guides	9
<u>Conclusion</u>	10
Appendix: Some Suggestions for Mr. Nit Samnapan	

Visit to Lampang Health Development Project12 - 18 Jan 1977Purpose

Dr. Soomboon Vachrothai, Director of the project requested a look at the Community Participation aspects of the project. He is concerned with what he calls the "Social Preparation" for organizing community efforts and "to reverse the planning implementation process that existed before and create a new process of "upward planning, downward support". He seeks comment and help regarding the Lampang project in this respect.

A secondary purpose of this visit to Lampang was to contribute to a major responsibility to the Ministry of Public Health to help pull together the experience from the different Primary Health Care projects in Thailand in preparing a guide for the provinces to implement such a programme throughout the Kingdom. (20 provinces will begin in 1977)

Approach

Mr. Nit Samnapan, Assistant Professor, National Institute of Development Administration was assigned as a 'counter-part'. He accompanied me throughout my discussion with the staff at the Lampang project, and during extensive discussions in the villages where we were guided by Dr. Annuey. These village discussions took place with Village Headmen, Committee Members, Health Post Volunteers, Communicators, Tambon Councillors, Public Health Staff and Government Officials. Meetings were arranged with Niels Mulder, Social Anthropologist, Kurt Bettenhauser, Director of the Friedrich Neumann Foundation, and Garry Alton at the Northern Agricultural Development Centre. A meeting and exchange took place with the full staff of the Ministry of the Interior's Community Development Centre, Region 5.

A Catalogue of Problems emerging from the discussions

(1) Selection Methods

Selection of Volunteers has provided problems. To begin with, an elaborate socio-metric study was conducted in the villages by the Public Health Staff. The resulting socio-grams produced by a professional indicated the most likely volunteers. The project staff are not wholly convinced that the most effective persons for the particular job were identified by this method.

Doubt must be cast on this procedure when one hears on a number of occasions, for example, accounts of Health Post Volunteers being away from the village all day on their normal work activity. "But it is all right" we are assured "His wife (daughter) gives the medicine" "Question" why not have selected the wife/daughter and trained her in the first case? The project has abandoned this method ".... it has been found to be too expensive for nation wide replication" * It seems the sociogram method took 3 months to conduct and two months to analyse. Indeed a heavy call on staff time.

Village committees are now being asked to select the volunteers. But there are some misgivings about the present method. The project is designed to provide objective and sophisticated methods of selection and is clearly attempting to make the point that the selection and the volunteers belong to the community. Repeatedly, however, in discussions at the village, we were told that the volunteers had not volunteered but had been "drafted", "people will not volunteer, they have to be told to be a volunteer" Another view was that people "ought to apply, not be told they are to be the one" One wechakorn thought she could do the selection best.

What emerges here is a conflict of perception. One side, the "officials" genuinely seeing the procedure as community participation, the "participants" seeing it as a familiar manipulative directive from official to community member. Villagers said they had not understood the purpose of the selection and some of the Provincial Health Staff, who conducted the selection, said the same.

* It is therefore with concern that one finds in the guide prepared to introduce PHC in the Provinces that this method remains as the recommended approach.

(2) Communicators

The role of communicator in the villages is not being performed to the satisfaction of the Lampang project.

"Of 12 communicators only one has come to see me - and he came for care of his own wound" said one Health Post Volunteer. "There has never been any business for me to see the Health Post Volunteer", said a communicator, "They communicate as events strike the communicators. There are no meetings. Communicators are not given anything to communicate back to their household clusters".

One of the uneasy responses by the project staff is to question whether communicators are needed at all! "Perhaps no more than 1 in 3 is performing". A modifying suggestion is that the communicators functions should be performed by the village committee members, so cutting out the need for two persons where one would do.

(3) Health Post Volunteers

Health Post Volunteers seemed to raise the least number of problems. However, the following are some.

Health Post Volunteers who live in the same villages where sub-centres are located seem to be by-passed, - patients going directly to the sub-centre. Do we need HPVs in such villages at all? or could they be better employed assisting the often under manned sub-centres? ** If the latter course is taken, then job description, selection and isolated village patterns of service would need to be recognised.

I note in one HPV's referral book a patient who was referred to the sub-centre twice and then "because it didn't work" to the District Hospital. There seems to be no way in which the hospital or sub-centre refers back to the HPV. Possibly they could engage his energies in seeing that the patient keeps further appointments or ask HPV to provide certain medicines or some other simple patient management tasks. In addition there seemed to be no supervisory activity to help the HPV to improve his performance by, in this case, discussing the appropriateness or otherwise of referring as he did. ***

* If this idea should grow it has serious consequences, for the government has approved the selection and training of 220,000 Communicators in the next Five Year period.

** One Health Worker to whom this was proposed welcomed it as an innovative suggestion.

*** This is referred to again later.

One Health Post Volunteer had difficulty in collecting from patients payment for medicine, which he had dispensed on credit - with the consequent inability to pay for replacements.

Remuneration and the possible collection of support funds, to my mind should be on a committee's agenda for decisions to be made before HPV's are appointed and this area should be the subject of regular committee review.

(4) Health Committees

There are said to be 61 Health Committees in operation. It seems that some of these committee are revivals from an earlier programme of sanitary committees formed 10 - 15 (?) years ago. Some health committees are the same as the village general purpose committees, some have been set up in response to the project staffs efforts. The condition of the committees are not really known but seem certainly to give cause for concern. A review of the minutes of such committees might be useful. In relation to communicators and HPVs, the committee members and headmen we spoke to, seemed very hazy regarding the committees responsibility. "We don't know if the communicators are working". For example either there is no procedure for replacing communicators and HPVs (who move from their areas or are not performing satisfactorily) or the committee members had never heard of it.*

There is of course a description of the functions of these committees, and a standard agenda in general terms. It was commented that "sometimes the villages do not know how to conduct meetings".

The village headman and his committee(s) also seem to receive many other Ministries and agencies with their programmes and some of these also call for a system of volunteers.** Nowhere did one find a coherent village level health plan devised or understood by the village committee, certainly there is no over-all plan to accommodate the many mooted development programmes.

* We note that there is a procedure outlined in the guide being prepared for the Provinces.

** In one country, to my knowledge, a headman chaired 41 village committees which had been suggested by various Ministries. To imagine what all these suggestions look like from the perspective of a recipient village should be illuminating.

(5) Supervision

It was said that, the system of HPVs works where "there is supply and good supervision". The HPVs keep a supervisory register. It would be useful to make an analysis of the supervisors notes to see whether and how the supervisors cover the "30 items on the supervision pro forma".

Some attempt might be made to evaluate the quality of supervisory sessions.* One example of content and quality of supervision has already been indicated in the matter of referral.

This raises two sets of questions, one around the nature of supervision, and secondly, around the nature of 'feed-back' to the village. The matter of referral is not directly in my present brief, except that in order to keep volunteers interested and involved and to improve their performance, some continuing response to their actions from the medical hierarchy is required.**

The matter of supervision is a very important one and will be elaborated upon elsewhere.

The 'feed-back' needs to be examined in terms of what does the project 'feedback' to each village from the researchers collected data? To whom does information most effectively belong, how should it be supplied, to which 'consumers?' What could/should be supplied to the villages. Suggestions for the collection and utilization of data will be discussed later.

Some Observations and Suggestions

The comment quoted earlier regarding the necessity for 'supply and supervision' was given by the same person who stressed the essential requirement of 'village leadership' if the programme was to succeed.

* I note that the project is strong on quantitative evaluation processes and wonder if some qualitative items such as around supervision might be built into the research programme.

** As it is an objective of the project to test an integrated health programme - this example illustrates a failure in the link between HPVs and the medical facilities. It was said that the Doctors are too busy to write referral responses. In the long run such a procedure would lighten the load of patients coming to the hospital unnecessarily. Should not this function of referring back be a function of the Dept of Community Medicine in the Hospital? Or might the project offer for a trial period a clerical assistant to the Doctors in the hospital specifically for this re-referral function? It would put to the test the Doctors explanation and see whether it is a rationalisation of a non-acceptance of this kind of Community Programme.

Village Level Planning and Management

My opinion is that the success of this (or any other village-oriented) programme depends on the existing skills and climate for 'village level planning' and 'village level management'. Some such skills must exist (or villages would not have survived through the aeons of time). What is required is to draw out these latent skills, strengthen and sophisticate them, and build a planned health programme upon this common foundation which is necessary for all sectors. It is here at the village planning and management level that the often repeated 'integration' must take place.

Village Committee Training

Attention must therefore be specifically directed to the building of organization and general planning and management skills of the village. As Agriculture, Health, Education, Interior etc., are all Ministries who have a stake in such a result, perhaps a joint programme of practical training can be worked out both in an agreed structure for village organization of development activities, and joint content and exercises for learning developing and practicing the appropriate management skills.**

It seems that the Ministry of the Interior Community Development programme has had such a matter as village organization as an important focus of its work. It is likely that they already have much experience in this kind of effort.

* There must be a useful Thai word for such high sounding functions.

** Discussions took place precisely on such joint problems and possible approaches with the Foundations working with the NADC. as well as with the C.D. Regional Centre Staff.

The Lampang project might consider either arranging for the CD. people to move in to the villages in the E2 (?) E3 (?) areas ahead of the introduction of the Health Programme; or join with them in working out a village committee training programme; or consider a training procedure of their own for village committee building as the pre-requisite foundation for the Health Programme.* The Health Programme itself should be fashioned as a series of practical exercises and as a direct illustration of the general management skills taught to the village committee(s).

The Structure of Village Committees

The Health Committee itself might best be a sub-committee of the village committee (council), consisting of those who have shown themselves to be 'caring' people with some natural organizational ability. They should not necessarily be those who would ordinarily seek a status position or public office but are ready to belong and contribute to an activity (health activity) group. Of course such a group should be responsible to, and report to, the Headman and his committee at regular intervals.

I would suggest that the formation of a health committee should be quickly followed by a planned training programme centred round specific "How to guides" - in this case for example: "How to develop a village health plan"

"How to manage a community health project"

"How to manage committee meetings"

One part of the plan, and a specific project to illustrate and exercise this training, could centre round the need for, the functions, and the methods of selection of 'communicators' and HPVs. My view is that the method previously utilised is a useful tool if used properly and in the correct hands. I would submit that perhaps the method should be in the hands of the committee itself to use if it sees fit. This will involve the members directly and emphasise that it is their selection and so perhaps avoid the kind of misconception regarding whose volunteers they are - as we have described previously. The maps, clustering, and so forth should be placed in the hands of the community also. Perhaps the schoolteacher, the monk, the youth or elder schoolchildren or other person with skills of mapping etc. (whether on the committee or not) should be invited to do this work and be supervised by the committee as one of its early projects. The resulting diagrams etc. should be displayed in the village (copies can be given to the Health Centre). However, the point to be made is that these planning tools are produced by, belong to, and will be utilized by the village itself. It should also be stressed that those who volunteer are formally appointed by the Health Committee and are answerable to them.

* Dr. Soomboon has already suggested a multi-sectoral meeting presumably to discuss matters such as this, "...to integrate multi-sectoral development objectives, efforts, and interventions at the community level through a community oriented approach". In our discussions at the CD. Regional Centre they seemed most interested. I believe too that Mr. Bonyeam at the Sung Nern Training Centre of Mahidol University Sch. of PH. recently held a workshop on this subject.

Once the communicators are appointed, the committee, which will have planned for their training by the Health personnel, will immediately engage the communicators in tasks related to a village project which has also been planned and timetabled. Training for the communicators should always be task-oriented and timed to serve a specific planned project. Each village project should include in its programme of activity a spelling out of the appropriate skills for which training is required and a proper timetable of events to which the training is properly and immediately related. Training for communicators should be on a one-project (set of activities) at-a-time basis and should be seen as cumulative in the sense that projects are conducted one after another and are satisfactorily completed.

The earliest tasks of the communicators should be in communicating to their clusters, the nature and elements of the village health programme itself and, having introduced the idea of the HPV, they should ask for suggestions and nominations for that function.

Base Line Data

A second range of tasks (which will demonstrate the capacity of the communicator) should be to collect base-line data for the village committee so that the committee can plan appropriately. Until now the responsibility for collecting base-line data has been on the Health Worker. I am told that this is a heavy burden (taking as much as three months of their working time). This data then is sent to and 'belongs' to the Province and National planners. The suggestions here conceive each communicator collecting information from his own small cluster and it is primarily data for himself and his village committee, both of whom will utilize it, but it may be passed on and up for higher level utilization. The village committee plan will directly refer to this detailed cluster-collected data when devising its overall plan.

Village Plans

A village plan should consist of inaugurating and maintaining a collection of discrete projects, appropriately timetabled in relation to the pace and style of village life, and the necessary time it takes to perform the activities related to the technical requirements of the projects. Some activities will be on-going but at regular intervals such as the organizing of immunization for children at the appropriate age level. The Health Committee will 'campaign' with its communicators to set up such services and then review their functioning on a planned regular basis. They will of course be guided and assisted by the Health Workers regarding the technicalities, supplies etc. leaving the social aspects of organization to the village committee. (For example, in immunization

* as required such as the curative and referral work of the HPV. and some will be on-going...

the communicators would identify those in their clusters ready for immunization or needing re-immunization, alert the families both of the necessity for immunization and the date and the place where vaccines will be available and vaccination conducted. The communicators might also keep a simplified 'family folder' of such events for his particular cluster.*)

Apart from the setting up of on-going and maintenance activity and scheduling regular review, the Committee will consider which of a selection of discrete 'campaigns' it would like to take on in a given year - such things as latrine building, improved drinking water supply, elimination of small malaria breeding places etc etc.

A national** support programme would be necessary for such an approach. A major task would be the gradual development, accumulation and distribution of "How to guides"

How to guides

A guide on "How to develop a village health plan" would include examples in detail of a variety of illustrative annual or bi-annual village plans. Such guides, although including practical check lists, fill-in charts, and suggestions, might also include arresting and amusing "short stories" telling how things were done in a typical village and some of the common mistakes and solutions that took place - Fictionalized stories about a communicator, a HPV, a Health Worker, and a village and its Health Committee might be attempted. Creative writers, journalists or student journalists, given the outline of roles and project, might find it amusing and stimulating to write such stories sponsored by the Ministry of Public Health. "How toguides" should be written with the village life and the level of sophistication of villagers primarily in mind. They should concentrate on how villages can organize a specific activity. The technical aspects should only be introduced where it requires a particular task to be conducted by a villager. Each guide should be complete in itself, and must include a task breakdown and a training schedule and outline of content with a typical timetable attached directed to the particular project.

* In Bangladesh where problems of rural organization are particularly difficult judged by Regional standards, each family has a health card hanging on a nail in their houses or shelters.

** The Lampang project might pave the way for the National effort.

Armed with these guides as ingredients for village plans and project, the villages can respond by choosing what they feel the need for, and are ready to do, and the Health Workers can encourage them to broaden their range of possible activities one by one. The training, supplies, etc. can be planned for by the District/Province according to the conglomerate of village plans. This would be the "Downward support, upward planning" that Dr. Soomboon is seeking. It would give training and planning a diversity according to local needs and conditions, yet have a unified basis. It would be what might be called a "cafeteria" approach rather than the full scale "banquets" with many set courses we are more familiar with. Where the whole process was interlocked in a village-up planning approach, the community and volunteer training content and method would flow naturally from the projects planned, and supervision, would become directed to identifiable tasks and stages of implementation. Supervision would gradually free itself from a tendency to become a somewhat ad hoc line, 'inspection' tour to a truly supportive and educative activity - properly planned in advance. Of course differentiation must be made between technical/medical supervision which is the responsibility of the Health Worker, and the supervision of community and management activity which is the responsibility of the village health committee itself, with the Health Worker in an advisory role.

Conclusion

In summary, the suggestions made here involve the restructuring of the approach to the community rather than addressing the problems listed, one by one. These problems are to be seen as symptoms of a deeper set of problems centred around the crucial matter in P.H.C. of genuinely attempting to create "upward planning downward support" It will be seen that involved is a complex and extensive range of "social preparation" activities. Particularly these preparation require greater efforts in community building for development tasks, including a well thought through programme of health committee establishment and training in planning and project management. It requires a support system involving a whole range of community oriented "How to ... guides" and a radical change of relationships between health officials and communities.*

In one sense it might be argued that we will be exchanging one set of problems for another, but I believe that we will be moving in the right direction for the lasting implementation of Primary Health Care.

* For a discussion of role relationships which are related to our concerns, see: Herbert J. Rubin, Dynamics of Development in Rural Thailand, 1974 and
J.A. Niels Mulder, Monks, Merit and Motivation, 1973

Some Suggestions for Mr. Nit Sammanan

It might be of value to ask Mr. Nit to consider undertaking such tasks as:

- (1). Working out with appropriate officers in other sectors, a workable village level organization for development activity along with a training programme in village level project management.
- (2). Working on specific "How to guides" drawing out the management aspects of different projects.
- (3). Providing illustrations in detail of a series of "a typical years work in health planning and health project in a Thai village".
- (4). Some illustrative work schedules showing typical present work loads and timetabling for health workers; work schedules during the 'start up' phase of P.H.C.; work schedules once P.H.C. has been satisfactorily established. These work schedules must of course be directly related to the timetable of activity in the villages, with an appointment system for committee meetings and supervisory sessions.
- (5). A review and analysis of village committee minutes to clarify the nature and quality of their operation. This might lead to a paper along the lines of the "Life cycle of participation activities at the village level and the methods for continuing support and on-going stimulation".
- (6). An analysis of supervision as reflected in the supervisory register - with a view to improving supervisory performance.
- (7). Editing a collection of "Some common attitudes and responses to Primary Health Care efforts and some ways of dealing with these."

A Discussion Paper
on the Implementation of Primary Health Care
in Thailand

D. Drucker
WHO
Social Scientist
Bangkok, Jan 1977.

Table of Contents

or

Introduction
Some Observations and Suggestions
Village Level Planning and Management
Village Committee Training
The Structure of Village Committees
Base Line Data
Village Plans
How toguides
Conclusion

Introduction

In the course of many discussions with project staff and villagers during,

a) visits in Sept/Oct 1976 to

The Lampang Health Development Project (DEIDS)
The Chiang Mai Province Project (SURAPEE)
The Ban Phai District, Khon Kaen Province
The Korat Province Community Health Services
The Khon Kaen University Medical School
The Sung Nern Training Research Center of Mahidol University
School of Public Health

b) a longer visit to the Lampang project in January 1977 and

c) a review and discussion of the preliminary translation of 'Guidelines for the Implementation of Primary Health Care' with staff of the Ministry of Public Health.

it has been possible to identify areas of problems which warrant further technical examination and urgent discussion. The problem areas which have surfaced are discussed elsewhere* and include

1. Selection Methods
2. Communicators
3. Village Health Volunteers
4. Health Committees and
5. Supervision

The following are some observations and suggestions for discussion. They outline an approach to Primary Health Care which I believe would eliminate some of the problems and would strengthen the beginning of implementation of the nation-wide programme.

Some observations and suggestions

One experienced PHC. worker has communicated that with adequate "supply", "supervision" and "village leadership" the programme will succeed.

The framework for village leadership will be discussed first.

Village Level Planning and Management

My opinion is that the success of this (or any other village-oriented) programme depends on the existing skills and climate for 'village level planning' and 'village level management'. ^{*}Some such skills must exist (or villages would not have survived through the aeons of time). What is required is to draw out these latent skills, strengthen and sophisticate them, and build a planned health programme upon this common foundation which is necessary for all sectors. It is here at the village planning and management level that the often repeated 'integration' must take place.

Village Committee Training

Attention must therefore be specifically directed to the building of organization and general planning and management skills of the village. As Agriculture, Health, Education, Interior etc., are all Ministries who have a stake in such a result, perhaps a joint programme of practical training can be worked out both in an agreed structure for village organization of development activities, and joint content and exercises for learning developing and practicing the appropriate management skills.**

It seems that the Ministry of the Interior Community Development programme has had such a matter as village organization as an important focus of its work. It is likely that they already have much experience in this kind of effort.

* There must be a useful Thai word for such high sounding functions.

** Discussions took place precisely on such joint problems and possible approaches with the Foundations working with the NADC. as well as with the C.D. Regional Centre Staff.

PROVINCES

The ~~Health Committee~~ might consider either arranging for the CD. people to move in to the villages ~~in the (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)~~ ahead of the introduction of the Health Programme; or join with them in working out a village committee training programme; or consider a training procedure of their own for village committee building as the pre-requisite foundation for the Health Programme.* The Health Programme itself should be fashioned as a series of practical exercises and as a direct illustration of the general management skills taught to the village committee(s).

The Structure of Village Committees

The Health Committee itself might best be a sub-committee of the village committee (council), consisting of those who have shown themselves to be 'caring' people with some natural organizational ability. They should not necessarily be those who would ordinarily seek a status position or public office but are ready to belong and contribute to an activity (health activity) group. Of course such a group should be responsible to, and report to, the Headman and his committee at regular intervals.

I would suggest that the formation of a health committee should be quickly followed by a planned training programme centred round specific "How to guides" - in this case for example: "How to develop a village health plan"

"How to manage a community health project"

"How to manage committee meetings"

One part of the plan, and a specific project to illustrate and exercise this training, could centre round the need for, the functions, and the methods of selection of 'communicators' and HPVs. My view is that the ^{social practice} ~~method~~ previously utilised is a useful tool if used properly and in the correct hands. I would submit that perhaps the method should be in the hands of the committee itself to use if it sees fit. This will involve the members directly and emphasise that it is their selection and so perhaps avoid the kind of misconception regarding whose volunteers they are - as we have described previously. The maps; clustering, and so forth should be placed in the hands of the community also. Perhaps the schoolteacher, the monk, the youth or elder schoolchildren or other person with skills of mapping etc. (whether on the committee or not) should be invited to do this work and be supervised by the committee as one of its early projects. The resulting diagrams etc. should be displayed in the village (copies can be given to the Health Centre). However, the point to be made is that these planning tools are produced by, belong to, and will be utilized by the village itself. It should also be stressed that those who volunteer are formally appointed by the Health Committee and are answerable to them.

* Dr. Soomboon has already suggested a multi-sectoral meeting presumably to discuss matters such as this, "...to integrate multi-sectoral development objectives, efforts, and interventions at the community level through a community oriented approach". In our discussions at the CD. Regional Centre they seemed most interested. I believe too that Mr. Bonyeeam at the Sung Nern Training Centre of Mahidol University Sch. of PH. recently held a workshop on this subject.

Once the communicators are appointed, the committee, which will have planned for their training by the Health personnel, will immediately engage the communicators in tasks related to a village project which has also been planned and timetabled. Training for the communicators should always be task-oriented and timed to serve a specific planned project. Each village project should include in its programme of activity a spelling out of the appropriate skills for which training is required and a proper timetable of events to which the training is properly and immediately related. Training for communicators should be on a one-project (set of activities) at-a-time basis and should be seen as cumulative in the sense that projects are conducted one after another and are satisfactorily completed.

The earliest tasks of the communicators would be in communicating to their clusters, the nature and elements of the village health programme itself and, having introduced the idea of the HPV, they should ask for suggestions and nominations for that function.

Base Line Data

A second range of tasks (which will demonstrate the capacity of the communicator) should be to collect base-line data for the village committee so that the committee can plan appropriately. Until now the responsibility for collecting base-line data has been on the Health Worker. I am told that this is a heavy burden (taking as much as three months of their working time). This data then is sent to and 'belongs' to the Province and National planners. The suggestions here conceive each communicator collecting information from his own small cluster and it is primarily data for himself and his village committee, both of whom will utilize it, but it may be passed on and up for higher level utilization. The village committee plan will directly refer to this detailed cluster-collected data when devising its overall plan.

Village Plans

A village plan should consist of inaugurating and maintaining a collection of discrete projects, appropriately timetabled in relation to the pace and style of village life, and the necessary time it takes to perform the activities related to the technical requirements of the projects. Some activities will be on-going but at regular intervals such as the organizing of immunization for children at the appropriate age level. The Health Committee will 'campaign' with its communicators to set up such services and then review their functioning on a planned regular basis. They will of course be guided and assisted by the Health Workers regarding the technicalities, supplies etc. leaving the social aspects of organization to the village committee. (For example, in immunization

as required such as the curative and referral work of the HPV. and some will be on-going...