

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C. 20523
BIBLIOGRAPHIC INPUT SHEET

FOR AID USE ONLY
TEMPORARY *Batch 43*

1. SUBJECT CLASSIFICATION	A. PRIMARY
	B. SECONDARY

2. TITLE AND SUBTITLE
DEIDS/Thailand project Quarterly report, July-Sept. 1976

3. AUTHOR(S)
(101) APHA

4. DOCUMENT DATE 1976	5. NUMBER OF PAGES 8p.	6. ARC NUMBER ARC
--------------------------	---------------------------	----------------------

7. REFERENCE ORGANIZATION NAME AND ADDRESS
APHA

8. SUPPLEMENTARY NOTES (*Sponsoring Organization, Publishers, Availability*)
(Activity summary: Lampang Health Development Project)

9. ABSTRACT

10. CONTROL NUMBER PN-AAC-767	11. PRICE OF DOCUMENT
----------------------------------	-----------------------

12. DESCRIPTORS	13. PROJECT NUMBER
	14. CONTRACT NUMBER CSD-3423 GTS
	15. TYPE OF DOCUMENT

PN-AAC-767
CSD-3423 GTS

LAMPANG HEALTH DEVELOPMENT PROJECT
EIGHTH QUARTERLY PROGRESS REPORT

(July 1 to September 30, 1976)

Introduction

July, August, and September comprise the last quarter of the Lampang Project's first two years. As final contract negotiations for the next phase took place, project activity intensified in order to complete all components as planned. At the same time, initial assessment of the first two-year's experience in Hang Chat continued so that adjustments may be made as implementation in the subsequent six districts of E₂ gets under way.

Thai/U.S. Inputs

A. Wechakorn

After the graduation ceremony on July 2nd, the fifteen wechakorn in the first class were deployed to their assignments. Seven midwife/sanitarian-wechakorn took up assignments in the Hang Chat Health Center and the Health Subcenters in each tambol of that district. Seven of the nurse-wechakorn were assigned to the hospital, working predominantly in the out-patient departments. And one nurse-wechakorn was assigned to teach (traditional midwives and others) at the Regional Midwifery School.

The transition to the new assignments was easiest for the hospital-based wechakorn whose new role expands and formalizes much of what they had been doing in the past. The transition is more difficult for the midwife/sanitarian-wechakorn who are assigned to the Rural Health Center and Health Subcenters of Hang Chat because their new set of skills and new role are strikingly different from that of the past. Moreover, health center-based wechakorn must establish their role and their credibility with local villagers, and this may require a period of time. As the new chief of the health center, the wechakorn is responsible not only for providing health care but for coordinating the work of all members of the health team, including the community health volunteers. There is considerable incentive to work closely with volunteer groups because they will be the source of referrals which will help to establish the reputation and credibility of the wechakorn. Reciprocally, the wechakorn will provide technical and administrative support. Ideally, the relationship between the wechakorn, other health workers, and the community health volunteers will be mutually beneficial.

Since the transition to the new role is greatest for the health center-based wechakorn, and because they are the most isolated from physicians, a great deal of attention must be given to their technical and logistical support, particularly during the initial deployment period. Shortly after reaching their assignments in mid-July, many health center-based wechakorn lacked supplies and equipment required for their new jobs. Also when the need arose for the consultation or advice of physicians and for the additional support necessary for them to carry out their responsibilities adequately, the Project began organizing a system of technical and administrative support for wechakorn in the field. This, emphasis was placed on developing a patient referral system between the rural health centers and the provincial hospital, a supervisory system for wechakorn, an expanded supplies logistical system, and a management information system.

The Community Health Department in the Provincial Hospital takes responsibility for coordinating technical support, in-service training, and medical/logistical support to the wechakorn in the field. This is coordinated with the physician in the District Health Center and the District Health Office.

B. In mid-July, the Project Director called a meeting of the Lampang Project's multi-agency Policy Committee in Bangkok to review the Project Paper (overall plan), a group of documents concerning planning and budgeting for the project. The Policy Committee Meeting was called to provide a forum for review of the documents by representatives of major Royal Thai Government agencies who are concerned with the Project. This permitted representatives to raise a variety of questions concerning the plans, operational methodologies, and administrative procedures employed by the Project.

C. During the third week of July, a multi-institutional seminar on community health development as related to the Lampang Project was held in Chiangmai. The objective of the meeting was to review and consider alternative concepts, approaches, strategies and methodologies of community health development particularly related to integration and management of wechakorn, community health volunteers, the hospital community health activity and personnel, and private sector providers. A variety of participants were invited representing Chiangmai University Faculty of Medicine, the Faculty of Public Health at Mahidol University, the Lampang Project, the Provincial Health Services, the University of Hawaii School of Public Health, the Government Pharmaceutical Organization, and private physicians and pharmacists. The meeting was chaired jointly by Dr. Somboon Vachrotai, Project Director, and Dr. Malee Thainuea, Assistant Director of WHO/SEARO. The meeting may have raised more questions than were answered, but it did provide insights on what is needed to improve the approaches and methods for community health development in the Lampang Project. Some of the major points discussed follow:

1. The meaning of Primary Health Care: Primary health care in rural villages may have three essential components: simple technology, low cost, and a base of village organization and participatory activity. It was recognized that health cannot be developed independently, but must be a coordinated part of a broader approach to development. The importance of developing self-reliance of villagers is the key, and it was acknowledged that this is quite compatible with Thai culture.
2. Community Health Volunteers: It was suggested that three factors are of great importance to maintaining the good performance of community health volunteers. These are (1) a system of supervision and support, (2) a set of incentives (not necessarily money), and (3) a bi-directional information system.
3. Private Hospitals: Private hospitals are basically of two types² profit and non-profit. It was suggested that private hospitals are sometimes preferred because of the frequent slowness of services at government hospitals, the greater availability of staff, and the extra efforts of private hospitals to win community support through mobile units, immunization programs, etc. Because of lower cost, the accessibility to the private non-profit type hospital is greater than to the profit hospital.

General areas of cooperation between private hospitals and the government health services were suggested: (1) In cases of poor patients coming to the private hospital, referrals could be made to the government hospital; (2) the government might share equipment with private hospitals on a rental basis; (3) government MDs might practice at private hospitals on a limited basis, thus supplementing the medical care staff which is usually limited at private hospitals; and (4) the government might also cooperate to provide professional training for private MDs, both in clinics and in private hospitals.

4. Drug Stores: It is well known that a majority of ill people in Thailand go directly to drug stores for health care. Therefore, it is desirable that they have an effective relationship to the government community health services. The head of the Government Pharmaceutical Organization was a participant in the seminar, and he observed that the drug stores are in great public demand for several reasons. There are many (perhaps over 10,000) registered drug stores throughout the country, and many others are not officially registered. Of the 10,000 that are registered, over 9,000 are outside the Capitol city. So they are numerous and easily accessible. When buying modern medicines, customers frequently bring a sample of the medicine purchased earlier from the hospital (at a higher cost) and ask the druggist to resupply these drugs (at lower cost). A larger group of people that utilize the drug stores are low-income patients who cannot afford to go to a private clinic or the hospital. At the drug store, they get not only medicine at a reasonable cost, but also receive free advice. The head of the Government Pharmaceutical Organization observed that it takes a long period for a pharmacist to train the people who actually sell the drugs at the drug stores, and he suggested that an important area of cooperation between the drug stores and the Lampang Project could be for the government health services to provide training to drug salespeople so that they will more appropriately dispense drugs. This could parallel the rural Health Post Volunteer's role for the more commercial centers with drug stores.
5. Community Medicine Department of the Provincial Hospital: It was noted that the role of a community medicine department in a provincial service hospital is quite different from that of the community medicine department commonly found in medical schools. Whereas the objective of the medical school department is to train medical students, the role of the provincial hospital's department is to coordinate government health services to the general population. Since there is limited experience with community medicine departments in service hospitals, the Project is developing a completely new model in Lampang. The Ministry of Public Health is now promoting a community medicine department for every provincial hospital and is therefore interested in the progress and results in Lampang. It was generally

agreed in the seminar that the community medicine department will be the key integrating unit for hospital and rural health center services. The community medicine department will have a major role in providing technical assistance and support to wechakorn at the subcenter and health center level, monitoring referrals, and providing other technical services needed by the rural health centers.

D. During July, the mobile kitchen supplied by the Ministry of Public Health Nutrition Division provided nutrition education in 12 villages of Hang Chat. The unit moved from village to village each day, and its staff gave educational demonstrations for food preparation and food choices.

E. A manual for Health Post Volunteers was completed and distributed to each volunteer. This manual covers the volunteer's role, use of a variety of drugs that are available to them, and outlines the care for a variety of problems that the Health Post Volunteers will face.

F. During the eighth quarter, Health Communicator groups 12 through 23 were trained. A total of 676 volunteers in these groups were trained for assignment in Muang District, the first district in the E₂ implementation area. Three groups of Health Post Volunteers, a total of 69, were trained for Muang District. One interesting observation from the training in Muang District was that, unlike Hang Chat where the sex ratio of recruits were about three women to one man, in Muang District the ratio was one woman to three men. Also, fewer traditional midwives were identified in the capital Muang District. These volunteers were trained by provincial health staff who have gone through the Training for Trainers Program which was organized several months ago.

G. In early August, a Workshop for Supervisors and Service Personnel was held in the MCH center in Chiangmai. These two groups (41 in the first group and 48 in the second group) were trained consecutively during the week. The objectives of the workshop were to discuss problems which are related to supervision from the supervisors' and service personnel's view-point, and to clarify supervisors' new responsibilities and roles. The participants first broke into small groups and discussed problems, and these were then presented in larger group sessions. Role playing sessions were held to demonstrate techniques of supervision (utilizing the videotape system) and group critique sessions reviewing the videotapes then followed. In addition, service targets for all types of health staff were presented and discussed.

H. In mid-August, several professors from the Mahidol University Faculty of Public Health, came to Lampang to discuss the possibility of collaborative involvement in the Lampang Project. The Project and provincial health staff were receptive but specified that student field training activities should be limited to specific areas. Further planning sessions have yet to be held.

I. In late August, the Lampang Project conducted the second Project Management Seminar in cooperation with faculty from the National Institute of Development Administration (NIDA) School of Business Administration. This was a follow-up to the earlier seminar held in February, 1976, which emphasized development of staff skills in project planning, control, evaluation, and preparation of "logical frameworks".

The second seminar was designed to improve staff interpersonal and communication skills, and to stimulate improved group functioning, decision-making, and cooperation. Three NIDA staff members, Professors Krit Ampoch, Kachornsak Hannarong, and team leader Nit Sammaphan, introduced a variety of group dynamics and feedback techniques aimed at developing individual self-awareness, group participation, and increased group achievement.

The NIDA staff were well prepared for the seminar and maintained a lively pace which held the participants' interest. Discussion of group behavior concepts and practice in role situations were well-received. Introduction of "sensitivity training" techniques, using direct and indirect individual feedback sheets, stimulated awareness of how members perceived each other's individual behavior. This is a novel approach in Thailand but did not seem to cause any problems.

J. During the last days of August and the first days of September, several project staff members participated in a MOPH-sponsored seminar on nation wide utilization of health volunteers. The seminar was designed to review the alternative roles of health volunteers and to work on details of establishing curricula for their training. This seminar follows a Ministry decision to train over 10,000 health volunteers nationwide during the next 5 years. The roles and curricula currently being planned follow closely those developed by the Lampang Project.

K. In early September, Dr. Thomas Hood of the APHA arrived in Thailand to finalize negotiations for the next contract period and to discuss the coming Annual Review and regional conference. The dates for the Annual Review are November 22nd to 26th. The dates for a regional conference have not yet been determined.

L. Preparations for training the second class of wechakorn were made. After a recruiting and testing period, training will begin on December 2 for the second group which includes 22 trainees. In order to complete training of all wechakorn groups by the end of 1979, a third training group will begin approximately six months after the second group begins. From June, 1977, there will be concurrent didactic and preceptorship training until all wechakorn for t province have completed training in 1979.

M. The last week of September, Dr. William Reinke and Mr. Pat Marnane arrived for a consultation visit with Project evaluation staff. Dr. Reinke of the Johns Hopkins University School of Public Health continued his long involvement in Project evaluation activities, and Mr. Marnane, a new evaluation staff person from the American Public Health Association, was introduced to the project evaluation activities. Formal reports from these consultants are not yet available, but some general observations and comments follow:

1. One major area of discussion was sampling of E_2 for the community health survey. The sample size for E_2 will be approximately 2,600 households, about five percent of the total number. Sampling will be carried out, as in E_1 , in two stages: in the first stage, the sample villages will be divided into two strata according

to the presence or absence of a government health facility. Half of the required villages for the sample will be drawn from each of the strata. In the second stage, households in each village selected will be divided into three strata based on the number of household members (1-3, 4-6, and >6 members) and the sample drawn to include more families representing the targetted population.

Dr. Reinke questioned the rationale to stratify by presence or absence of health facilities with selection on a 50-50 basis in the first stage, since this would "over-represent" villages with facilities present (only about 13% of villages in E_2 have a facility). He commented further that drawing equal samples (17% of households) from each household size stratum of the second stage may "over-represent" larger households (in order to include more of the target population) and questioned the utility of the household stratification. Project staff noted that the sample design was consistent with that employed in E_1 and, therefore, ensured comparability of data from the two areas over time.

The desirability of a Community Health Survey in E_3 was considered. Given the late opening of E_3 (1978) and the short interval in which change could be measured, Dr. Reinke suggested that the Community Health Surveys in E_1 and E_2 would generate sufficient data. However, he emphasized that Cost and Task Analyses may be very useful in E_3 .

2. After a preliminary review of the baseline Nutrition and Oral Health Survey data, Dr. Reinke observed that the number of sampled subjects of the target population of children under six was perhaps too small for meaningful analysis. He also questioned the need for the dental component of the survey. A simplification of the survey techniques was recommended and will be pursued by Project evaluation staff.
3. Dr. Reinke suggested that more attention be given to development of an overall data analysis plan and to interpretation of data already collected. He suggested this may be facilitated by a skilled, experienced evaluator who is not involved in day-to-day data collection/processing activities.

N. Project staff are currently examining information needs at each level in the delivery system as an initial step in establishing the Project Management Information System. The system should become operational during the ninth quarter.

O. During July, Dr. John Watson of the School of Medicine, University of Hawaii, and Dr. Jerome Grossman of the School of Public Health, University of Hawaii, consulted with the Project and the Department of Community and Social Medicine, Faculty of Medicine, Chiangmai University. They participated in a review of Project activities and participated as consultants during the Seminar on Community Health Development in Chiangmai.

P. During August, Dr. Athol Patterson from the Tulane University School of Public Health also consulted with the Project. His consultant report is also attached.

Q. In August, Dr. Allan Rosenfield, of the Center for Population and Family Health, Colombia University College of Physicians and Surgeons, consulted with the Project. His consultant report is attached.

R. Dr. Emmanuel Voulgaropoulos, Associate Dean, School of Public Health, University of Hawaii, visited the Project in July to review general project activities and the technical and management activities of the resident UHSPH staff.

S. During August, three Nepalese physicians from the Ministry of Public Health, Dr. K. Dixit, Dr. I. Khatri, and Dr. B. Prathan, accompanied by Mr. Allan Steffans of AID Nepal, travelled to the Project to observe project operations and to share the experiences of the Nepalese group.

T. In early September, Ms. Susan Minick, a staff member of the Solo Project (Dana Sehat) in Indonesia, visited the Project to compare activities in Lampang with those which she has been involved in Indonesia and to exchange experience. She also made a presentation of the community development approaches used in Solo and generated considerable interest among Project staff with a discussion of her concept of "social preparation". Social preparation, she explained, is the first major step in implementing any true community development project. This basically relates to methods of stimulating community initiative, interest and enthusiasm to organize themselves, identify their own needs, and take community action to resolve these problems.

U. In early August, a group of planners from the Southeast Asia region visited the Project as part of a Training Seminar on the Delivery of Social Services. The seminar was organized by the Asian Development Institute.

V. Dr. Drucker, a Social Science Consultant with the World Health Organization, visited the Lampang Project briefly in early September.

Problems Encountered and Anticipated

This period of overall Project review, contract and budget negotiation, and changing bureaucratic environments has exercised and strengthened communications between the many agencies concerned with the Lampang Project. Communications are improved between the Ministry of Public Health (responsible for the Lampang Project), the Department of Technical and Economic Cooperation, and USOM (USAID/Thailand). A better understanding of the Project's aim, process and administrative arrangements has been achieved. Communications are improving between the primary contracting parties (APHA and MOPH) regarding the many administrative constraints encountered during the transitions between contracts and budgets. All parties now seem satisfied with the Project's plan for development and expansion and with the renewed administrative and financial support committed through September 1979.

Recent logistical problems encountered in meeting the increased demand and distributions of medical supplies are now being solved through amplified supply channels and more active distribution logistics. Supply levels will be monitored and checked through the evolving Supervisory System and Management Information System.

The data processing backlog is a continuing problem due to a variety of administrative/managerial constraints. However, signs of improvement were not following recent actions of Project staff. Additional adjustments are also being considered.

Conclusion

A full review of the development and progress of the Lampang Project during the first two-year implementation period will be conducted at the Second Annual Review, November 22-26, 1976. Participants will also hear and review the plan for development and expansion of services during the forthcoming second implementation phase. A report of the Annual Review will be available to all participants and interested persons unable to attend the Annual Review who request a report.

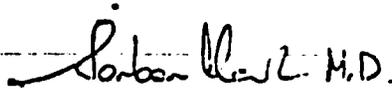
Signed:



Dr. Pricha Desawadi, Field Director



Dr. Ronald G. Wilson, Associate Field Director
and U.S. Counterpart



Dr. Somboon Vachrotai, Project Director