

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

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Batch 73

1. SUBJECT CLASSIFICATION	A. PRIMARY Serials	Y-ND00-0000-G750
	B. SECONDARY Health--Delivery systems--Thailand	

2. TITLE AND SUBTITLE
DEIDS/Thailand project quarterly report, July-Sept., 1977

3. AUTHOR(S)
(101) Am. Public Health Assn., Washington, D.C.

4. DOCUMENT DATE 1977	5. NUMBER OF PAGES 28p. 21p	6. ARC NUMBER ARC
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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-AAF-060	11. PRICE OF DOCUMENT
12. DESCRIPTORS Delivery systems Health Thailand	13. PROJECT NUMBER
	14. CONTRACT NUMBER CSD-3423 GTS
	15. TYPE OF DOCUMENT

LAMPANG HEALTH DEVELOPMENT PROJECT
TWELFTH QUARTERLY PROGRESS REPORT

(July 1 thru September 30, 1977)

Introduction

The end of the twelfth quarter also brought to a close the third fiscal year of project operations. In terms of total manpower trained, the Project is ahead of its timetable, as is the case with most other field operations.

The fourth fiscal year begins with some changes in key personnel, and with increased effort to overcome operational problems and implement all remaining elements of the planned integration model. At the same time, project staff are giving emphasis to producing detailed descriptions and guidelines of operational methods developed and the experiences gained in the first phases of project implementation. This is to enable the Ministry of Public Health to more fully incorporate the Lampang experience into Ministry plans for broad extension of primary health care in Thailand.

Project Inputs and Progress

	<u>Number in Training</u> <u>During Quarter</u>	<u>Total Number Trained</u> <u>(Cumulative)</u>
Health Post Volunteers	97	469
Health Communicators	175	4,374
Traditional Midwives	-	171
<u>Wechakorn</u>	52	67

A. Health Volunteer Training

Training of health post volunteers, health communicators and traditional midwives continued on schedule. As planned, training for these groups in the six E₂ districts will be completed in fiscal year 77-78, permitting training to begin in the remaining four E₃ districts late in the same period.

As the Ministry of Public Health proceeds with plans to train health volunteers in at least 20 more provinces in the next five years, there has been increased interest in the experience of the Lampang Project.

The Project had developed and field-tested a small Health Post Volunteer Manual which was distributed to all Health Post Volunteers; and, the time has come for the manual to be strengthened. In order to improve the manual, project training staff organized a workshop to review the Health Post Volunteer Manual and make whatever improvements and revisions deemed necessary. The working group consisted of participants from the Ministry of Public Health, the Faculty of Public Health, the Community-Based Family Planning Services Organization, the Lampang Project, and the University of Hawaii School of Public Health. The participation from such groups insured that viewpoints and experience from a broad base of private sector, government service agencies, and government

education institutions would be incorporated into the new, revised Health Post Volunteer Manual. The workshop proved to be very useful, and the soon-to-be-published Health Post Volunteer Manual is clearly an improvement over its predecessor. The Health Post Volunteer Manual will be available in large quantities before the end of the year, and an English-language edition is under preparation.

B. Wechakorn Training and Deployment

Wechakorn group II are now in the final stages of their one-year training program, and they will graduate at the time of the third Annual Review in late November. Wechakorn group III - composed of 2 graduate nurses, 14 midwives, and 8 sanitarians, and 2 nurse aides - began their training schedule on August 1. Wechakorn group IV, the fourth and last group of wechakorn, will start training sometime in mid-1978 and graduate in 1979, which completes wechakorn training in Lampang.

C. Family Planning Extension

During the quarter, all arrangements were finally accomplished to enable the wechakorn at the health sub-centers to insert IUDs and provide Depo-provera injections. Although wechakorn are trained to perform these tasks, they lacked official permission to carry out such activities - and this affected the supply and logistical support observed earlier. Now each wechakorn in the rural health sub-centers of Hang Chat (the district hospital already had these services) is equipped with the instruments and supplies necessary to extend these family planning services.

Family planning services of all types continue to be emphasized in the health services for Lampang. Nationwide, and particularly in the north, family planning services seem to have had substantial impact on fertility, and this no doubt accounts for the high rate of family planning acceptance found in Hang Chat and other districts of the province. The demand for family planning services has been high and constant, representing a real need in the population. Project emphasis continues to be directed at completing coverage of family planning services and stimulating the adoption of more permanent methods, such as sterilization.

D. Nutrition Activities

The problem of under-nutrition has not been recognized by the population in general, and the magnitude and nature of the problem may not be fully appreciated by high level government planners. As the Project began in 1974, the extent of the problem in Lampang was not known, and the level of direct nutrition activity by the provincial health services was limited, consisting mostly of a number of Child Nutrition (day-care) Centers. This may reflect a low level of awareness that rural populations have nutritional problems - particularly among young children - and also that the problem is complex, requiring interventions to embrace not only health services but also agricultural production, education, community development and cultural habits which have great influence on nutrition status.

In order to learn more about the extent of the problem in Lampang, and to apply a broad approach in developing effective solutions, the Project is

inaugurating a nutrition surveillance program in Hang Chat District. The program is being organized as part of the normal range of extended rural health services, employing community health volunteers. The nutrition surveillance program began in Hang Chat with the weighing of all children under 6 years of age. 4,094 children in this age group were identified in Hang Chat District using the health post volunteers. Each child was weighed monthly for a period of three months, and their weights and ages recorded on a simple form. This extensive surveillance activity could not be carried out routinely by government health workers because of the demands on their time, but employing the Health Post Volunteers who work under the supervision of wechakorn and other health workers, and the use of an appropriate technology (eg. local Chinese market scale) greatly decrease the costs involved and facilitate installment of a community-based nutrition program. Of the more than 4,000 pre-school children weighed, about 1,800 children fell into the various categories of under-nutrition adopted by the Ministry of Public Health Nutrition Division. About 1,200 were classified as first degree under-nutrition, 500 were second degree under-nutrition, and 84 were third degree under-nutrition.

As the results of the surveillance were analyzed and as the extent of the problem became known, program components were established to deal with the problems on a priority basis. The first priority group was, of course, the children who showed signs of third-degree under-nutrition. As this group was identified in each tambol, a team of health staff composed of wechakorn and physicians from the district and provincial hospitals travelled to each of the effected areas and (1) reweighed the identified children to assure the initial assessment was accurate, (2) recorded the family and child history, (3) provided a physical exam of each child, (4) provided medication for any apparent infection, including intestinal parasites, (5) provided nutrition education and food supplements to the mothers, and (6) provided immunizations needed. At the same time, a simplified and improved growth chart (similar to the road-to-health chart) and a child health card were tested. The community-based nutrition program has generated considerable interest among the villagers, and attempts are being made to involve the Community Development and Agricultural officers in the area, as well as the local health committee members. The program is also useful in bringing the hospital and health center staff, and local volunteers together in cooperative activities.

E. The Project Management Information System is being finalized in Hang Chat District. The working group, composed of Provincial, Project, and District health staff members, has reviewed the current reporting system and is developing simplified forms and procedures which will be tested on a trial basis and evaluated. Preliminary results may be available in the next quarter.

F. Private Sector Involvement

An agreement was completed between the Provincial Health Office and the local drug distributors to resupply health post volunteers with the simple medicines produced by the Government Pharmaceutical Organization. This reduces the burden placed on local health workers to act as distributors and money collectors, and puts the distribution network on a private-sector, commercial basis. There are also discussions being initiated now to identify agents at the district level to more easily facilitate distribution to volunteers in more remote locations.

The Lampang Project staff and members of the Food and Drug Administration have agreed to pursue plans for the Lampang Project to orient and train the druggists in Lampang, an important step when one recognizes that over 50% of people seeking medical care consult the druggist. A meeting of the FDA and Lampang Project is set for October 28th.

G. Project Evaluation

1. Baseline data collection for Task and Cost Analysis in E₂ health facilities, organized by the NIDA staff, and using project data collectors, began during the quarter.
2. Coding of the E₂ Community Health Survey Data continued.
3. The final summary report of baseline data in E₁, C₁, and C₂ is being completed and will be available at the Third Annual Review.
4. Dr. William Reinke of the Johns Hopkins University School of Hygiene and Public Health, and Mr. Patrick Marnane of APHA, spent four days with the evaluation staff to review project evaluation progress. (Their reports have not been received as of this writing.)

H. During the quarter, Dr. Yonglaab Panjavan was appointed Field Director to replace Dr. Pricha Desawasdi, who was promoted to Provincial Chief Medical Officer in Mae Hongson Province. Dr. Yonglaab, the Provincial Chief Medical Officer in Lampang, brings many years of rural health experience to the Project.

I. During the quarter, the new out-patient wing of the Provincial Hospital was completed. The official opening is set for October 15. The new wing should greatly improve the overcrowded conditions in the former out-patient department. The construction of a new in-patient facility which will double the bed capacity of the hospital is due to follow.

J. Late in the quarter, the Project jointly sponsored a National Seminar on Primary Health Care which was held in Chiangmai. This meeting was a national review for developing a report and contributions for the SEARO Regional Meeting on Primary Health Care to be held in Delhi, India November 21-26, 1977. Staff members reviewed project activities, and compared their work with that of other projects employing primary health care approaches in other parts of the country.

K. A team of four project training staff, Dr. Nopadol Somboone, Dr. Wannarat Channukul, Mr. Nart Charoenchai, and Mrs. Ampai Komolrat, travelled to the North-east province of Nongkhai to assist in developing a paramedical training program for Indochinese refugees and remote Thai villagers. The para-medical workers will serve their own communities, which are currently underserved medically.

L. Dr. Chaichana Suvanavejh, Deputy Chief of the Planning & Programming Division, travelled to Indonesia to observe community nutrition activities.

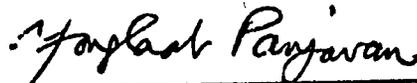
M. Visitors to the Project during the quarter:

1. Dr. Athol Patterson, Professor of International Health, Tulane University.
2. Drs. Aree Varayaseewee and Prem Buri from the Faculty of Medicine, Ramathibodi Medical School.
3. Dr. V. Ramakrishna, School of Public Health, University of Hawaii (Report attached) and Professor Varunee Surasiti, Deputy Dean, Faculty of Public Health, Mahidol University.
4. Dr. Michael O'Byrne, Health Manpower Development Staff, University of Hawaii, enroute to the Pakistan Rural Health Development Project.
5. Mr. Erland Heginbotham, Deputy Assistant Secretary of State, Mr. William Toomer, Economic Officer, U.S. Embassy, Bangkok, Mr. Charles Gladson, Director of USAID to Thailand, Mr. Vernon Scott, USAID to Thailand.
6. Fifty members of the Thai press observed Project activities.

Conclusion

With the completion of three years' work, Project staff are anticipating a full discussion of all aspects of operations during the approaching Third Annual Review (November 29-December 3). This year's meeting will be of special importance within Thailand since senior health leaders will attend from 20 other provinces which have been designated for implementation of primary health care approaches similar to those of Lampang.

Signed:



Dr. Yonglaab Panjavan, Field Director



Dr. Ronald G. Wilson, Chief-of-Party, UNSPH Resident Staff



Dr. Somboon Vachrotai, Project Director, and
Director-General
Department of Health, MOPH

Encl: Dr. Ramakrishna's Report

10/25/77

REPORT ON THE VISIT
TO THE
LAMPANG HEALTH DEVELOPMENT PROJECT
July 16-22, 1977
Dr. V. Ramakrishna, Consultant

1. INTRODUCTION

This report was written to serve as a tool for stimulating continuing discussion, decision and action at different levels of the Project and the provincial health delivery system. Therefore, there are more questions in it than answers. The Project has many highly competent and experienced staff led by an outstanding leader. It is utter presumptuousness on the part of any consultant to pretend to know all the problems and solutions better than them in a few days or weeks. The best assistance a consultant can render is to focus on priority problems, facilitate communications, exchange experiences, and stimulate discussions to find solutions. It is hoped that the report will form the basis for discussions in cycles above-downwards and below-upwards. What emerges out of these discussions are much more realistic and vital than whatever a consultant can offer at any time.

2. TERMS OF REFERENCE

The terms of reference for the consultation were finalized in discussions with the Project Director, Dr. Somboon Vachrotai, Director General of the Department of Health and the Associate Field Director, Dr. Ronald G. Wilson. They were:

- 2.1 To assist in reviewing, revising and refining a Health Post Volunteer (HPV) manual (for training and field reference) for immediate application in the LHDP and the MOPH/FPH/CBFPP Family Health Project and, later, for nationwide application.
- 2.2 To assist in developing plans for a provincial health communications system directed toward village-level health education by Health Communicators (HC) for testing in the Lampang Project.

The initial discussions at Bangkok were very valuable as they provided clarifications, laid emphasis on certain current concerns and outcomes, and revised the work schedule of the consultant. The schedule was modified as the work progressed and identified other problems and needs.

3. METHODOLOGY AND ACTIVITIES

- 3.1 Studying the documents provided by the project staff and discussions with them.
- 3.2 Working closely with a counterpart and/or a group.
- 3.3 Studying the program/activities in the field as well as the role of different workers and their supervisors.
- 3.4 Participating in meetings and presenting different possible approaches.
- 3.5 Examining in detail the HPV manual and relevant materials with the group and raising questions.
- 3.5 Reviewing and testing the impressions gained and observations made with the project staff.

The plan of activities and work may be seen in Appendix A. But for the utmost cooperation and zeal of all the staff this heavy schedule of activities could not have been accomplished.

4. HEALTH POST VOLUNTEER MANUAL

It would have been impossible to review the manual without the faculty of Public Health, Mahidol University, who translated the manual and worked closely with the consultant.

- 4.1 Observation of the functioning of the HC, HPV and their supervisors in the field gave an insight into the problems and needs of the workers. Questions like--"Did the HPV use the manual? Did they really need a manual and for what purposes? What were their feelings? If the manual was a felt need, how can it be made an effective working tool?" bothered me while I was talking with these functionaries. They needed time to think about these and other basic questions which go to the very roots of field operations at the community level. Their involvement in the process of developing the manual seemed essential.
- 4.2 Working with the group convened to revise the manual, indicated that the task had to be completed in a few days and a selected member of the group would draft a chapter each. "Reviewing, revising and refining" of the manual was handled as an emergency task. Since the manual had already passed through two editions, it was felt that the third edition could be done in a very short period by a group of senior officers of the Project, members of the Faculty of Public Health, and representatives of the Family Planning Association. However, it was considered useful to pretest the draft of the manual in the field involving as many HPV and their supervisors as possible before it is finalized for printing.

4.3 The following concepts, ideas and questions were either raised or considered and emphasized during the review of the manual:

- * The manual was an important, dynamic instructional instrument to support and to guide him or her in various activities. It encouraged the HPV to acquire more and more knowledge, and improve skills by furnishing interesting, attractive and useful educational materials (packages of self-instructional materials) which became part of the manual. The manual also served as a guide for supervisors and on-the-job training.
- * The manual gave essential philosophic foundations in tune with Thai culture, religion, lifestyle, and the concepts and principles of LHDP. It described the vital role of the HPV and its implications to achieve the objectives of the Project. In other words the manual recognized his key role and motivated the HPV to attain merit through continued service to the people.
- * In the performance of his/her tasks, the manual emphasized that the HPV was not alone but worked as a member of the health (and welfare) team. The HPV was assured of the support of the team. The manual defined the relationships among the team members with others.
- * The most important section of the manual described each of the functions and told what to know, what to do, how to do, when and where for each of the activities in simple, easy to understand, local Thai dialect. It had illustrations to clarify emphasis and to assist in stepwise action. The manual format helped for quick reference and was not an impersonal, factual mini-textbook.
- * During training and supervision, the HPV learned how to maintain the manual 'evergreen' and demonstrated how to use it as a guide.
- * The value and use of the HPV manual was enhanced by considering it as an integral part of the total educational, training and supervision system of the project. Therefore, it had to be closely related to the other manuals of health workers, supervisors, etc.

4.4 While examining the format and analyzing the content of the manual, the following concerns were expressed:

- * The thirteen chapters of the second edition of the HPV manual were mostly of textbook type. Should they be grouped and re-organized according to the functions and tasks to be performed? For example when a person having diarrhea/fever/injury goes to the HPV what has to be done and how, what has to be known, and what information should be given to the patient and how.

* The content and format of the manual related and reinforced the stepwise action to be taken in carrying out the functions.

* Could the manual be in parts or volumes?

Introduction: Basic philosophy, concepts and principles.

Role of HPV/HC

(Messages)?

Function and Task: What to do, how, when and where.

Subjects and Topics: Factual/scientific information with why the actions to be taken. Reinforced by periodical supply of brochures, pamphlets, etc.

Case Reports: Work of HPV/HC; story of excellence of the month.

* Since the target population of the Project is the mother and child, does the manual give adequate emphasis to the tasks related to this group? What priority activities need better attention? Who is responsible for what in the health team for MCH and FP. How about immunization, nutrition, worms, sanitation in the MCH and FP program? Does Health Education form an integral part of each task?

* Education of the individual, family, and community for better health and quality of life is basic to the principles and concepts of the project. Educational inputs by the HPV/HC are crucial. Does the manual help the HPV to perform his educational role adequately? Does it guide him to identify opportunities for education in different functions and use them effectively? How can he plan with the HC and guide her in conducting health education in the families? What educational activities can HPV plan and undertake in the community, with the monks, school teachers, TBA and others, and during fairs and festivals? How to use local musicians, poets and other artistic talent for educational purposes? Answers to these could be included in the second and third part of the manual.

* Should the HPV report in seven prescribed forms? Does this tally with the philosophy and concept of volunteering? For what purposes is the data in these forms used? What could be a realistic usable report?

4.5 Some thoughts to enhance the value of the manual:

* Will it be feasible to include messages from:

- the head monk of Thailand and/or the province.
- their Majesties the King and Queen.
- others respected in the community.

- * Will it be useful to include some appropriate quotations, sayings, etc. which the people value (at the beginning and end of each section)?
- * Continuous improvement and enrichment of the manual depends on the feedback from the field operations at the individual, family and community levels. What machinery and mechanism need to be established (or entrusted) to collect, analyze and use the feedback information for CHV system? Which problems need specific field studies (operational/ action research)? Will it be useful to undertake a quick comparative study of the working CHV system (background; selection; role description and relationships; supervision; expectations and outcome; support, supplies and incentives; reporting and records; training) currently used by different agencies in Thailand?

5. TOWARDS VILLAGE LEVEL HEALTH EDUCATION

5.1 Education:

A live dynamic HPV manual and other manuals are essential parts of the education system of the project. Information, communications and media are integral components of education. It is not unusual to mistake a component for the whole, as the components appear more attractive, easy to handle and demonstrate. With the advent of the family planning era, confusion between I, C and E has been aggravated. Would it be useful and worthwhile to arrive at a common understanding and consensus about education and the terms and concepts used in the Project? Does the "re-orientation and re-education of all health service personnel" include discussions on education, educator, education system, and education for what?

5.2 People Centered and Field-Oriented Training:

* A quick glance of the LHDP reveals concepts like effective low-cost integrated health delivery system; self-help and self-reliance; upward planning-downward support; community health volunteer, wechakorn and competency-based curriculum, etc. What are the common ingredients of these basics? People? Education?...? Documents and discussions indicated that adequate inputs have not been made so far with regard to people and education. Observations in this field, though quick and perfunctory, gave clues that preparation of health workers and volunteers must have been mostly skill and technology centered. It is hoped that this impression proves to be incorrect and the training is people and community centered and field-oriented.

5.3 Education in Training:

* One of the functions of HPV, HC and TBA is "extending health education and health information from the health delivery system to villagers through HC, "facilitating communications from and between villagers, HPV's and health officials" and "extending health, information and communications to and from the HC's" respectively. The basis of all these functions is to learn how to work with people and help them to help themselves. Does the training given prepare these community health volunteers adequately to perform this educational function effectively? Does the faculty teaching this aspect of the curriculum have sound experience of working as educators at the rural community level and with the Thai village and Tambol institutions.

Of the 20 training modules for wechakorn, should there be one on 'education for better health'? Similarly, in the training of the midwife and other workers should there be emphasis on their educational role and how to perform it? In the faculty team should there be at least one who is competent in different aspects of community and school health education? Thailand has specialists in these areas.

5.4 Responsibility for Education:

One of the major innovations in the LHDP is the establishment of the Department of Community Health in the Provincial Hospital, the Department has "full responsibility for the hospital's new community health activities" including "health education and health communities for the hospital and the rural health centers." Observations and discussions at the Department focussed on the need for:

- * Defining the role, responsibilities, and relationships of the department and make them known to all concerned.
- * Defining the health education policy as a part of the policy of the Community Health Department, Provincial Health Services and the LHDP and entrusting the Chief of the Department with the responsibility of implementing that policy on behalf of the PCMO.
- * Providing essential resources like transport, personnel, etc., to plan, implement and supervise the programme of the Department which will include community health education, School Health Education and Special education programs related to problems like Population, Nutrition, etc.
- * Forming a task force to formulate a master plan for education for better health which may include programmes of education in the community,

family, school, vat, drug store, provincial and district hospitals, health centers and sub-centers, CHC, HPV stations, etc. The task force may be chaired by the PCMO or his representative and the chief of the community health department as convener. Members of the task force may have specialized knowledge and experience in community health education; school health and population education, communication and AV education, mass media and social scientists in Thai culture, rural sociology and experts in Thai indigenous media and communication. Expertise in these areas are available in Thailand.

In case the task force approach is not suitable at this juncture, it may be useful to get the help of one or two members of the Faculty of Public Health, Mahidol University who had or are having community education experience to develop a plan working with the chief of the Community Health Department and the health educators in Lampang Province.

- * Strengthening of the AV section of the Project and the provincial hospital may form a part of the total educational plan and strategy. Acquiring hardware and producing software will have to fit into this overall plan.

5.5 Nutrition Education:

A nutrition survey had been completed and compilation of data was in progress. It was suggested that assistance be given to develop a nutrition education plan. The following questions have to be considered to formulate the plan: Will the survey yield such data and information for planning nutrition education? Does it help in defining the prevailing nutrition problems and needs as perceived by people (consumers), as perceived by the providers of health services and as perceived by producers and distributors of food and administration? Does it help in pinpointing the causes or precursors of the major nutrition problems including those like economic, production, distribution, storing, utilization, social and cultural, etc.? Which of these causes are vulnerable for educational interventions? What additional data may be required to form the baseline of current lifestyle of food and nutrition practices? Answers to these questions clarify the real problem and their educational component. This important step is the one that is generally ignored or neglected.

5.6 Nutrition Education Program Components:

To mount the nutrition education program the next successive steps could be:

- * Define nutrition programme objectives and their educational objectives- short and long term.
- * Determine target populations' knowledge, feelings, values practices regarding the specific nutritional problem and its causes; identify community communication channels, leadership patterns, media and resources; and the attitudes and practices of the staff.
- * Formulate education strategy, select methods and media, define educational role of staff and volunteers, specify time schedule, activity locations, plan coordinating machinery and procedures, allocate resources.
- * Train staff, volunteers, leaders, etc., prepare educational aids and mass medial programme and supply materials.
- * Implement the educational strategy of the nutrition programme-supervise and support.
- * Set up feedback and concurrent appraisal mechanism and improve the strategy.

The above questions and outline are not uncommon to those who are involved in developing educational strategies. However, the task force proposed may wish to consider them among others. A plan evolved by those who are to implement it is likely to succeed. Therefore, active participation of the provincial and Project staff in the work of the task force is crucial. Further, inclusion of appropriate members of the Faculty of Public Health, Mahidol University, and the Ministry of Public Health would enrich the task force. The task force may also suggest setting up of suitable coordinating, implementing, and evaluating machinery and propose procedures to be followed.

5.7 Need for Intersectoral Approach:

If the nutrition problem defined has the causative factors related to production, distribution, cooking methods, etc., it may be useful to seek the assistance of agencies (agriculture, animal husbandry, cooperation and home service) concerns with those causes. Nutrition education like sex education has been found to be a complex long-range process requiring careful planning synchronized efforts by all community workers and coordinated supervision and support. Experience shows that success of

nutrition education depends on these elements as much as on technical education and nutrition inputs.

6. ACKNOWLEDGEMENT

The consultant received much, gave very little except questions and problems. Everyone from simple rural people, village health communicators to the distinguished chiefs of the divisions and directors of the Project and the provincial health services gave their time, extended courtesies and assisted the consultant in every way. That helped him immensely to assist them better. To everyone of them the consultant tenders his sincere thanks and expresses his indebtedness to Dr. Somboon Vachrotai. Sincere thanks are due to the Deputy Dean of the Faculty of Public Health, Mahidol University, Mrs. Varunee Surasiti, for helping the consultant to surmount language barriers and to understand rural Thai life. Dr. Emmanuel Voulgaropoulos provided this opportunity and the consultant expresses his deep sense of gratitude.

APPENDIX A

PROPOSED WORK SCHEDULE
FOR
DR. VENKATARAN RAMAKRISHNA
PROFESSOR OF PUBLIC HEALTH, UNIVERSITY OF HAWAII
CONSULTANT TO FACULTY OF PUBLIC HEALTH AND THE LAMPANG PROJECT

Itinerary

<u>Dates</u>		<u>Counterparts</u>
July 11	Arrive Bangkok, Thailand	
July 12 AM	Meet with Dr. Somboon Vachrotai, Director-General, Department of Health, MOPH and Lampang Project Director	
PM	Meet with Dr. Debhanom Muangman, Dean, Faculty of Public Health, and Mrs. Varunee Surasiti, Associate Dean, Faculty of Public Health, Mahidol University	
July 13-15	FPH: Curriculum development and review/revision of overall public health curriculum, with special emphasis on Health Education Unit, Continuing Education and Graduate Programs	
July 16	0730 Depart Bangkok by TAC 0910 Arrive Chiangmai 1000 Meet with Dr. Somboon Vachrotai	
July 17	Open	
July 18-20	LHDP: Meeting with Lampang Project staff to discuss and assist in development of a provincial health education/communication plan oriented towards village-level nutrition/health education, implemented through supervisors, HPV, and health communicators and village health committees	Dr. Amnuey - LHDP Dr. Jumroon - LHDP Mr. Suwit - LHDP Mr. Samrarn - Prov. Mr. Sa-nga - Prov. Ms. Varunee - FPH
July 20-22	LHDP: Meeting with Lampang Project staff, FPH staff and CBFPF staff to discuss and assist in review/revision and improvement of HPV Manual (for training and field reference)	Dr. Choomnoom - LHDP Dr. Chaichana - LHDP Dr. Jumroon - LHDP Ms. Amphai - LHDP Ms. Varunee - FPH Mr. Boonyium - FPH Mr. Praween - CBFPF Mr. Tawatchai - CBFPF Mr. Royitta - CBFPF
July 23-24	Travel Lampang/Bangkok and free time	

Itinerary

July 25-26 FPH: Continue curriculum development activity

July 27-29 FPH: Visit to Soongnern Training Center, Korat Province

July 30-31 Open

August 1-2 Reveiw of work, report writing and debriefings with Dr. Somboon Vachrotai, Director-General, Department of Health and Dr. Debhanom Muangman, Dean, Faculty of Public Health

August 3 Depart Bangkok. Return to University of Hawaii, Honolulu

TENTATIVE AGENDA
FOR THE
THIRD ANNUAL REVIEW
LAMPANG PROJECT, MINISTRY OF PUBLIC HEALTH

Conference Room, Railway Hotel, Chiangmai

Tuesday, 29 November 1977

- 08:30-10:00 Opening Ceremony; Presentation of Wechakorn Diplomas
and Awards to Outstanding Health Volunteers
- 10:00-10:30 Coffee/Tea Break
- 10:30-16:30 Review of Lampang Project Progress, Problems, and
Constraints

Session Chairman: Dr. Sombun Pong Aksara
Rapporteur: Dr. Samli Plienbangchang
- 10:30-12:00 Reorganization of Provincial Health Infrastructure
and Implementation of Integrated Health Services

Panelists: Dr. Yonglaab Panjavan, Dr. Jumroon Mikhanorn,
Dr. Sommai Yasamut
- 12:00-13:30 Luncheon Break
- 13:30-14:15 Development of Wechakorn

Panelists: Dr. Choomnoom Promkutkao, Dr. Nopadol Somboon,
Dr. Okas Plangkun & Wechakorn Spokesman
- 14:15-15:00 Implementation of Village Health Volunteers, Health
Communicators, and Traditional Midwives

Panelists: Dr. Chaichana Suvanavejh, Dr. Choomnoom
Promkutkao, Dr. Pien Chiowanich, and
Spokesman for Village Health Volunteer,
Health Communicator
- 15:00-15:15 Coffee/Tea Break
- 15:15-16:00 Implementation of Primary Health Care as Part of
Community Development

Panelists: Dr. Annuey Utthangkorn, Mr. Term Thongsukchote,
Mr. Prasopsuk Phanprayura

Thursday, 1 December 1977

09:00-16:30

Group 1. (Provincial Chief Medical Officers and
Hospital Directors;

Separate into three small groups by region:
North, South+ Northeast, and Central.)

Provincial Implementation of Integrated Health
Services and Primary Health Care (cont'd)

Group 2 (Remaining Participants)
(Continued) of Review of Evaluation Activities
Chairman: Dr. Boonserm Weesakul
Rapporteur: Dr. Anumongkol Sirivedhin

(10:30-10:45

Coffee/Tea Break)

(12:00-13:30

Luncheon Break)

(15:00-15:15

Coffee/Tea Break)

20:00-21:00
(Special Session)

Panel Discussion: "Family Planning in Thailand: Future
Outlook"

Panelists: Dr. Somsak Vorakamin, Dr. Suporn Kerdsawang,
Dr. Nikorn Dusitsin, Dr. Vitura Ostanond,
Mr. Mechai Viravaidya

Friday, 2 December 1977

09:00-12:00

Group 1 (Provincial Chief Medical Officers and
Hospital Doctors; small group discussions
Provincial Implementation of Integrated
Health Services and Primary Health Care
(cont'd)

Group 2 (Remaining Participants)
Evaluation Review (cont'd)

(10:30-10:45

Coffee/Tea Break)

12:00-13:30

Luncheon Break

13:30-16:30

Panel Discussion: "Appropriate Technology for Health"

Panelists: Dr. M. Sathianathan, Dr. San Hadtirat
Dr. Narong Sadudee, Dr. J. Sulianta,
Dr. Katherine Elliott, Mr. Walter Malhann
Mr. John Rogosch (Moderator)

Saturday, 3 December 1977

Plenary Session

Chairman: Dr. Emmanuel Volgaropoulos

Rapporteur: Dr. Ronald Wilson

09:00-10:30

Group Discussion Reports

10:30-10:45

Coffee/Tea Break

10:45-12:00

Future Plans

12:00-13:30

Luncheon Break

13:30-15:00

Conclusions & Recommendations

Closing Remarks

Nov. 7, 1977