OVERVIEW REFLECTION OF PRIMARY HEALTH CARE IN THAILAND SUPPORTED FROM 1976 TO 1996 BY JAPAN - THAILAND PARTNERSHIP

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Abstract. The international health cooperation of Japan for developing countries has been mostly concentrated on matters such as improvement of hygienic environment, prevention of tropical infectious diseases, establishment of hospitals with modern medical instruments and devices, and dispatch of medical experts. PHC (Primary Health Care) activities based on voluntary participation of local inhabitants in developing countries have been largely neglected. In the field of health and medical care, sufficient effect may not be achieved unless the local health activity is based on voluntary participation of the inhabitants. The introduction of advanced modern medical technics may be beneficial to some of the inhabitants, while most of the local inhabitants may not have the chance to receive such benefits, and additionally it is difficult to propagate modern medical care and technics widely to rural areas.

In Thailand, PHC activity based on community participation was started in 1985, with the following three main themes:

(1) Training of Village Health Volunteers (VHV) and Village Health Communicators (VHC), and development of their activities.

(2) Establishment and operation of Health Centers.

(3) Establishment and operation of a Drug Cooperative System (DC).

Earlier, one of PHC activities developed by Japan, "Thailand Local Health Activity Improvement Project" based on the program of Thailand - Japan Partneship, was initiated in 1976 in rural areas of Chanthaburi Prefecture. From 1982, third country training programs have been carried out by the Japan International Cooperation Agency (JICA).

As 10 years have elapsed since the initiation of PHC activity in rural areas in Thailand under the cooperation of the Governments of Thailand and Japan, it seems to be time to reconsider how PHC activity should be developed in future based on a candid evaluation of achievements and results.

INTRODUCTION

Thailand is located at the center of the Indochinese Peninsula and has land area of 514,000 km^2, *ie* about 1.4 times as large as Japan. Climate is tropical, and there are three seasons: hot season (March - May), rainy season (June - October), and cool season (November - February). From topographical and social viewpoints, the country is divided into four areas: central, northern, northeastern and southern regions. In administrative division, the country is divided to 75 provinces and Bangkok Special Administrative District, Thailand has population of about 60 million, comprising many ethnic groups, of whom 8 million people live in the capital city of Bankok (National Statistical Office, Thailand, 1994).

Buddhism is the national religion, and 94% of the people are Buddhists. In the system of Government, Thailand is a constitutional monarchy with centralized administrative power. The head of state is King Rama IX (King Bhumibol Adulyadej). The Government consists of 1 office, 13 ministries and 1 agency. Local self-governing bodies are established under the control of the Ministry of the Interior. Administrative divisions are: Province District Sub-District (Tambon) Village (Wongkhomthong *et al,* 1986) (Fig 1).

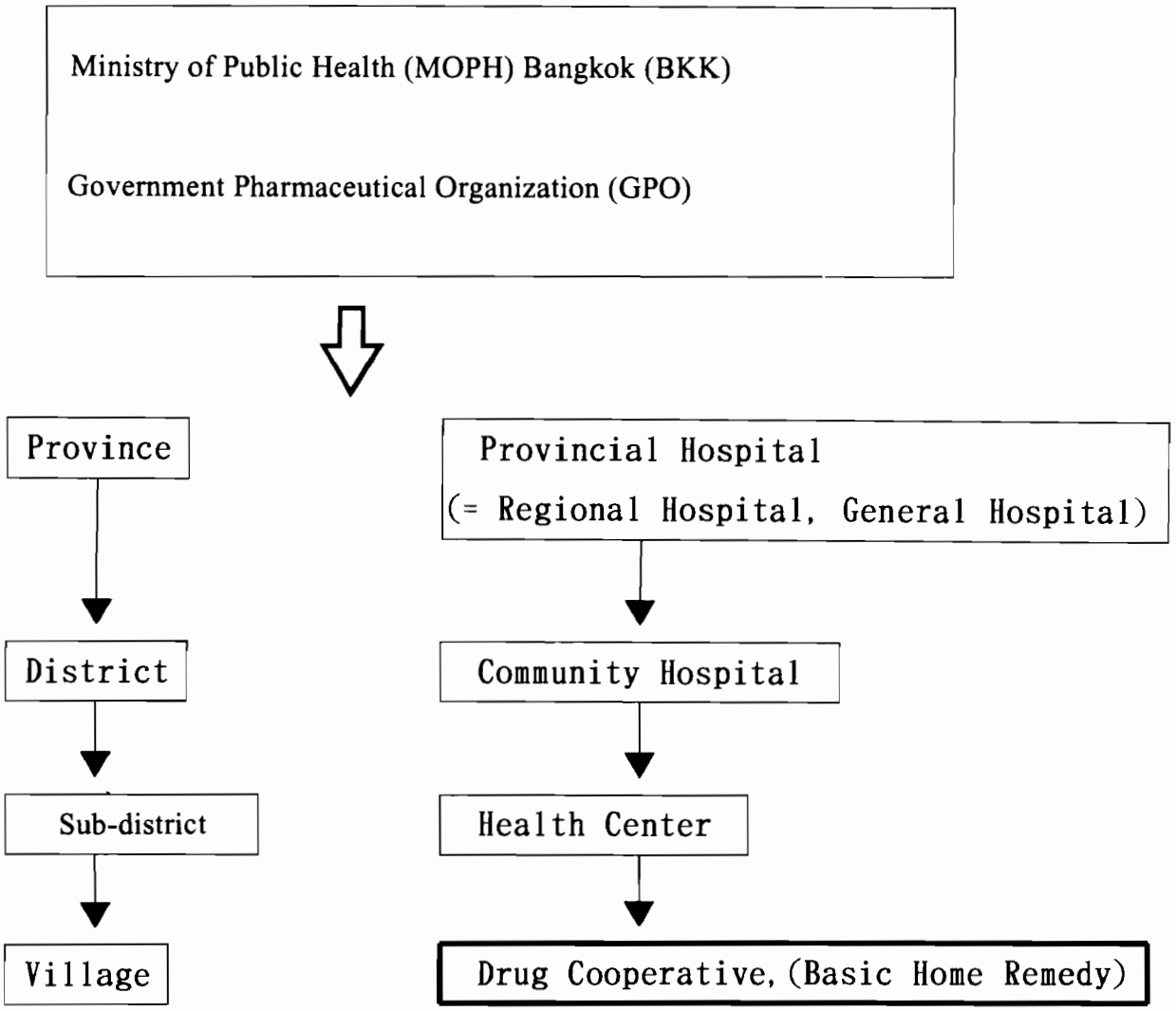

Fig 1–The management of Drug Cooperative System

PRIMARY HEALTH CARE (PHC)

Basic concept of PHC in WHO

In 1978, WHO and UNICEF established a global goal of "Health for all people by the Year 2000" and defined the basic concept of PHC (primary health care) as a method to achieve this goal. After the Alma Ata Declaration, a high priority has been given to PHC, with the aim to establish a system for health, medical care and hygiene in each area and to maintain and improve a high level of health (Kobayakawa, 1996). The basic concept is to incorporate PHC as one of the elements for social and economical development and to proceed toward social and economic progress under the principle of social fairness and justice. For this purpose, it is necessary to transfer central authority to local areas, to respect initiative of local inhabitants, and to encourage their positive participation (Umenai, 1996). Ichiro Kai (1996) proposed the following points as the basic conditions for PHC.

(1) Accessibility

PHC must be easily acceptable for local inhabitants in view of time, distance and economical viewpoints.

(2) Comprehensiveness

Comprehensive services must be provided from primary prevention to tertiary prevention including prevention, health promotion, early detection, treatment, rehabilitation.

(3) Coordination

To establish coordination between medical care and welfare or between hospitals and clinics.

(4) Continuity

To continue medical care at home after discharged from hospital and health care the over entire life.

(5) Accountability

To provide complete information to the patients, to maintain quality of medical care, and to offer adequate medical services from an economic viewpoint.

PHC in Thailand

In Thailand, PHC activities have been developed since 1950 under the slogan of "People's Participation". This is essentially a synonym of "Community Participation" as proposed by WHO. Major PHC projects executed in Thailand since 1950 are as follows:

(1) Community Health Development Project (1956-1959)

(2) Strengthening of Rural Health Service Project (1963-1967)

(3) Health Development Project (1964-1969) - Chiang Mai

(4) Health Development Project (1974-1981) - Lampang

(5) Drug Cooperation Project (1978-1980) - Mae Hong Son

In particular, the project (3) above is a prototype of the present PHC in defining people's participation as an element indispensable for local medical care. Project (4) was the first one to emphasize the importance of village health volunteers ("VHV") and village health communicators ("VHC"). In historical process, this is characteristic PHC movement including "the presence of VHV and VHC" and "drug cooperative system in village". Also, description will be given on the activities of "Thailand Local Health Activity Promotion Project (1976 - 1984)" developed by JICA (Japan International Cooperation Agency), which made remarkable contribution to PHC activities in Thailand (Hasegawa, 1985).

VILLAGE HEALTH VOLUNTEERS (VHV) AND VILLAGE HEALTH COMMUNICATORS (VHC)

Major PHC activities in Thailand in 1970s were the promotion of VHV and VHC. These were defined as the first local inhabitant health unit (health volunteers) in Thailand and various types of practical PHC activities have been developed. In principle, VHV is based on one-village one-person system, and the person is expected to fulfill the duty as the health volunteer leader. Major work is to cooperate with the staff of the Local Health Center, which is the forefront administrative organization of the government, and to play an important role in the following tasks:

(1) Immunization prograns (prophylactic inoculation)

(2) Recording of children's weight and height

(3) Public health and hygiene education

(4) Water supply and sanitary construction (arrangement of toilet facilities and water jars)

(5) Drug cooperative system in village

VHV is a system specific in Thailand for the supply of medical drugs indispensable for the establishment of PHC and to encourage participation of the inhabitants. On the other hand, the primary task of VHC is to keep close contact with the health centers in local communities.

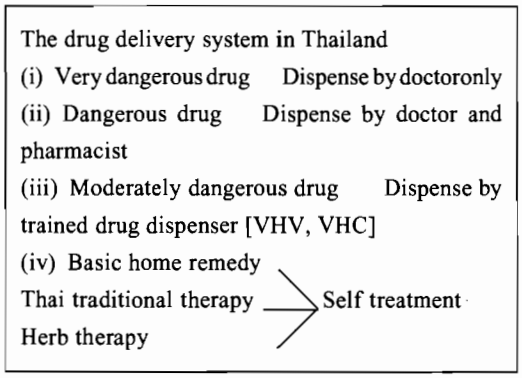

Fig 2–The drug delivery system in Thailand.

Much expectation had been placed on VHV and VHC. However, after reviewing of 7th National Health Development Organization (1992-1996), problems were pointed out as follows:

(1) VHV and VHC are selected by the intention of the health center and the village committee. The criteria for appointment is not clearly defined, and the selection is not based on voting by local inhabitants.
(2) The activities of the health volunteers are always under the control of the health center, and views of local inhabitants are restricted.
(3) Except those based on the decision by the health center, no budget is appropriated from the Government of Thailand. The time for the health volunteers are restricted and the volunteers often pay the expenses by themselves. In particular, in rural areas, there are problems of busy, farming seasons and moving of the workers to Bangkok during farmers' leisure season. Thus, it is difficult to perform continuous PHC activities. From the above reasons, the system of VHV and VHC was frozen or actually not practiced up to now.

DRUG COOPERATIVE SYSTEM IN VILLAGE

The first Drug Cooperative System ("DC") was started in Mae Hong Son Prefecture in 1978, and extensive development was seen in the 1980s. DC was established under the guidance of Thai Government, and it was not a system organized voluntarily by local inhabitants. The basic concept for the establishment of DC was as follows (Klasoontorn, 1996) :

(1) Community participation of local authorities, community leaders, and villages in general by representatives of the Ministry of Public Health: (self-consciousness of health volunteers based on inhabitant participation as administrative officials of the Ministry of Public Health).
(2) The establishment of a village drug committee for drug distribution and drug control: (Establishment of DC having essential drugs always in stock).
(3) The recruitment of shareholders for the cooperative.
(4) The opening of the village drug cooperative with daily services.
(5) The establishment of mechanism of DC for supervision from the Local Health Authority DC in Thailand is organized as shown in (Fig 2), and the foundation of DC is based on basic home remedy. However, the detailed circumstances of DC are as follows:

(1) Influenced by the propagation of commodity distribution via mass media (such as television, radio) inhabitants selected commercial drugs rather than the drugs of DC.
(2) DC was based on inhabitant participation system and more than one half of local inhabitants purchased the stocks of DC (10 Bahts per stock). However, VHV's management of drugs and accounting was carelessly controlled.
(3) Problems have risen such as embezzlement of funds by VHV or incomplete collection of credit account. As a result, local inhabitants began to distrust VHV who controls the management of DC. As described above, VHV and VHC were frozen, and this resulted in bankruptcy and closing of DC. As a result, DC was virtually swept away by branch offices of civilian pharmacies having head stores in Bangkok.

PUBLIC HEALTH AND PHC ACTIVITIES BASED ON AID FROM JAPAN

1. Thailand Local Health Activities Improvement Project.

This Project has been executed in Chanthaburi Province over a period of 8 years from April 1976 to March 1984. Thirty Japanese specialists were dispatched from Japan for this project, and equipment and tools offered exceeded 400 million yen in total amount. Also, 42 Thai researchers visited Japan for the accomplishment of this large-scale project. This was also a public health project, which was carried out for the first time by the Medical Cooperation Department of JICA (Japan International Cooperation Agency).

This project was not a conventional research type project, but it was "a general project concentrated on public health" by paying special attention on practices of local health activities. In other words, it was based on the principle that "the propagation of preventive medicine leads to enforcement of clinical medicine" and was executed by putting importance on local health activities. In Thailand where formal hierarchical administrative organizations prevail, the influence of agencies of the central government is strong. In this respect, the

principal base of this project was placed in Chanthaburi Province, and not in Bangkok Special Administrative District, in order to achieve "local health activities" to the full extent. This province is located about 330 km east of the capital city of Bangkok. It is a small province with population of about 39,000 (in 1996), has a border with Cambodia in the northeast and seacoast on the Gulf of Thailand in the south. Economically, it ranks at about 15th position in the country and was considered as the best suitable for execution by the local health activities.

What had to be reconsidered in this project was the dispatch of Japanese specialists. Specialists in parasitology, indispensable for the development of public health, were not sent, and the project was terminated. Also, the dispatch of epidemiologists was delayed. As a result, basic statistical data and materials were not collected adequately and computers could not be utilized to the full extent. However, enthusiasm and determination of Thailand for this project was evidenced by the fact that 152 researchers from Japan and 354 researchers from Thailand contributed articles and investigation reports relating to public health studies in this project. In the past, the researchers in Thailand have not always presented the results of their research and study in this field in the form of articles. This may be attributed to the fact that the place and the chance of presentation were limited and that there have been not very much interest in local PHC activities in Thailand. This project offered opportunities for them to summarize and present the results of their studies, and they became in turn more interested in local PHC activities. Many articles were also presented voluntarily by health volunteer staff of Thailand.

It should be highly evaluated that, for the promotion of PHC activities in local communities, a large-scale project relating to public health was developed with its basis in Chanthaburi Province under the direction of the cooperative agencies of the two countries for a period as long as 8 years.

2. The Third Country Training "Primary Health Care" of JICA.

JICA is carrying out the third country training "primary health care" in the ASEAN Institute of Health Development (AIHD) of Mahidol University. This training course is organized each year under the cooperation of JICA and DTEC (Department of Technical and Economic Cooperation). AIHD, where the training course is held, was established in 1982 with the cooperation funds from Japan. The third country training is a system of technical cooperation, in which an advanced country bears the expenses necessary for the training and a developing country accepts training staff from another developing country. The expenses and the participating staff are allocated between the advanced country and the developing country (Wada, 1992). In this connection, Japan and Thailand are in very close friendly relationship in PHC activities. In August 1994, Japan-Thailand Partnership Program (Japanese Ministry of Foreign Affairs, 1994) was concluded, and PHC activities of the "5-Year Plan of 8th International Economic and Social Development (October 1996-)" have been developed under the Japanese assistance.

Also, the two countries have reached agreement in the following points:

(1) Promotion of social center support on education and AIDS: "Human-Oriented Development", which will be the core of "5-Year Plan for 8th Internaional Economic and Social Development".
(2) Maintenance of environmental conditions: Priority is given to maintenance of environment, and cooperation is carried out with the loan on Japanese yen and development investigation.
(3) Development of local and rural areas: Consolidation of infrastructure in local and rural areas and promotion of community activities.
(4) Arrangement of economic foundation: Training of staff for consolidation of economic infrastructure and promotion of export.
(5) Support of community cooperation: Cooperation to support development of Indochinese countries based on "Japan - Thailand Partnership Program".

TIE-UP BETWEEN PHC AND PRIMARY MEDICINE CARE (PMC)

We are often apt to concentrate our efforts on therapeutic medicine rather than preventive medicine, and there are severe criticisms on this point. This may be attributed to the shortage of specialists on medical care in local communities. Because people and all other essential elements of society have moved from local communities all over Thailand to the capital city of Bangkok, there are many

underdeveloped, economically poor communities outside the Bangkok Special Adminitstrative District. People move to the cities seeking wealth, and, being infected with AIDS there, they go back home and cause secondary infection. The problem ofAIDS is closely related with the problem of poverty of local inhabitants. In future, to solve the problems of AIDS and others, positive promotion of PMC is needed, which is closely related with PHC as preventive medicine in Thailand.

CONCLUSION

Thailand has shown remarkable economic growth in recent years by adopting the economy-oriented policy of industrialization based on the introduction of foreign investment. While the economy has been successfully developed, it also created such problems as increase of regional difference between Bangkok and local areas, aggravation of living environment such as air pollution, traffic congestion, etc caused by rapid urbanization and industrialization, the problem of AIDS spreading to local communities. Therefore, PHC activites based on participation of local inhabitants are urgently needed in Thailand. Regrettably, VHV, VHC and DC originally planned in Thailand were practically frozen and did not lead to satisfactory results. In recent years, however, Thailand reinforced cooperative relationships with other Indochinese countries such as Lao PDR, Cambodia, Vietnam and Myanmar and is trying to develop PHC ativities further based on the reflections in the past failure. Japan is trying to make efforts for the accomplishment of PHC activities through participation of local inhabitants in other Indochinese countries through Japan-Thailand cooperation in the movement such as support of AIH for the reinforcement of PHC activities in Thailand or though the "Japan-Thailand Partnership Program". In future, PHC activities will be more concentrated on preventive medicine, and we may expect more on PHC activities in Thailand, which will establish guidelines and a model for other developing countries.

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