(2) 国際セミナー (International Consultative Meeting)

Date	Title of Seminar/Training Program	No. of Participants
Mar. 28-31, 1985	First Regional Consultation on AT/PHC Development	20
Mar. 6-8, 1984	Second International Consultative Meeting on PHC Development	15
Feb. 19-22, 1985	Third International Consultative Meeting on the Role of Hospitals in PHD Development	15

各回のテーマ

第1回 a) to exchange experiences among ASEAN member countries in the development of primary health care specifically in the areas of training and manpower development, and in research for PHC development;

b) to review and discuss-strategies and mechanisms for technical collaboration among ASEAN countries in PHC development activities;

c) to formulate recommendations and guidelines for the future role of the ATC/PHC in promoting and facilitating collaborative activities among ASEAN countries specifically in training and research for PHC development.

第2回 the formulation of the International Board Advisors
the formulation of International Training Programme in PHC Development
the Development of a work plan for the International Consultative meeting

第3回 the role of hospitals for PHC development

第1回セミナー参加者

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(3) ASEAN 域内訓練(International Training)

Date	Title of Seminar/Training Program	No. of Participants
Oct. 1-31, 1984	First International Training Program: Advanced Course in PHC Development	15

(4) 研　究　（Research）

	Title	Principal Investigator
	Series 1/1982	
1.	Situation Analysis of Food & Nutrition Programs in PHC	Mrs. Vena Veravaitaya MOPH
2.	Situation Analysis of Safe Water Supply and Basic Sanitation Programs in PHC	Mr. Udom Kompayak Faculty of Public Health, MU
3.	Situation Analysis of Health Education Programs in PHC	Dr. Banyat Atiburanagarn PCMO, Nakhon Phanom Province
4.	Situation Analysis of Maternal & Child Health and Family Planning Programs in PHC	Dr. Orapin Singhadej Faculty of Public Health, MU
5.	Situation Analysis of Essential Drugs Provision Programs in PHC	Mr. Romsai Klasoontorn Faculty of Public Health, MU
6.	Situation Analysis of Immunization & Control of Local Endemic Diseases Programs in PHC	Dr. Porapan Boonyarattapan Faculty of Public Health, MU
7.	Situation Analysis of Care & Treatment of Simple Wounds & Minor Ailments in PHC	Dr. Surakiet Archananupaph Faculty of Medicine, Ramathibodi Hosp., MU
8.	Situation Analysis of Community Mental Health in PHC	Dr. Supattana Dechatiwongse Na Ayutthaya Somdej Chao Phya Hosp., MOPH
9.	Situation Analysis of Community Dental Health in PHC	Dr. Udom Tumkosit MOPH

	Title	Principal Investigator
10.	Compilation and Analysis of Research Papers in PHC	Dr. Pricha Deesawadi MOPH
11.	Nutrition Management Programs in Densely Populated Urban and Suburban Communities	Dr. Rujira Mangkalasiri Maharaja Hosp. Nakhon Ratchasima Province
12.	Study of the Role of VHC/VHV in Health Education	Dr. Anan Menaruji Ban Phai Hosp. Khon Kaen Province
13.	Study of Methods and Approaches for Effective Community Participation in PHC	Dr. Paichit Pawabutr PCMO Nakhon Ratchasima Province
14.	Evaluation of VHC/VHV's Performances in Bang-Pa-In District, Pranakon-Sri-Ayuttaya Province	Dr. Orathai Sakdiswadi Faculty of Medicine, Ramathibodi Hosp., MU
15.	Preliminary Study of the Role of "Paet Tambol" in PHC	Mr. Chairat Patanachareon MOPH
16.	Effectiveness of Training and Follow-Up Programs for Village Health Communicators	Dr. Tongchai Termprasith PCMO Office Nong Khai Province
17.	Role of Community Hospital Personnel in PHC	Dr. Samreung Yangkratoke Soong Nern Hosp. Nakhon Ratchasima Province
18.	Practice in MCH and PHC among Married Women of Reproductive Age in Kalasin Province	Dr. Uthane Jaranasri PCMO Kalasin Province
19.	Development of Provincial Health Information Model for PHC through Community Health Volunteers	Dr. Thana Earkarnna PCMO Samut Songkhram Province
20.	Role & Public Acceptance of VHV/VHC in PHC Projects in Nakhon Sawan Province	Dr. Soonthorn Tongkong PCMO Nakhon Sawan Province
21.	Screening, Follow-Up and Promulgation of Research Projects	Dr. Orapin Singhadej Faculty of Public Health, MU

Title	Principal Investigator
Series 2/1983	
1. Effectiveness of Cable Broadcasting in Nutrition and Health Education : A Case Study of a Village in Ubon Ratchathani Province	Ms. Karnikar Omunae Inst.of Nutrition, MU
2. Comparative Study of Health Education through Mass Media and Personal Communication	Dr. Paungpol Patrakorn PCMO Phetchabun Province
3. Result of Primary Orientation for VHV/VHC in PHC Training Programs in Kabinburi District, Prachin Buri Province	Dr. Somsak Narischat Kabinburi Hosp. Prachin Buri Province
4. Effect of Fat Supplementation on Nutritional Status of Pre-School Children in Rural Southern Thailand	Ms. Sauvanit Ong-Roongruang Faculty of Medicine, PSU
5. Study of Excreta Disposal by Twin Chamber Digesters with Sand-Bed	Mr. Chaiwath Anantarungsee Saraburi Province
6. Identification of Simple Indicators for Use in PCM Surveillance at the Local Level	Dr. Mandhana Prateepasaen Faculty of Public Health, MU
7. Study of Alternative Nutritional Supplementary Programs	Dr. Wiput Pulcharoen Community Hosp., Dansai District, Loei Province
8. Current Situation of Thai Mothers and Children in the Poverty Area of Ampher Doi-Saket, Chiang Mai Province	Mrs. Suntaree Panutat Faculty of Medicine,Ramathibodi Hosp., MU
9. Cost-Effectiveness of Contraceptive Methods in Rural Communities	Mrs. Kusol Soonthornthada Inst.for Population and Social Research, MU
10. Campaign for Basic Immunization Program in Ratchaburi Province	Dr. Pramate Chaichinda PCMO Ratchaburi Province
11. Campaign to Broaden PHC Concept through National Broadcasting	Dr. Supat Vanichakarn Faculty of Medicine,Siriraj Hosp.,MU
12. Impact of Mobile Health Unit on PHC in Some Densely Populated Communities of Bangkok	Dr. Prapasara Pisalpong Rajvithi Hosp.

	Title	Principal Investigator
13.	Study of Referral System for Primary Health Care in Nakhon Ratchasima Province	Dr. Wichai Kattiyawitayakul Community Hosp., Jakkaraj District, Nakhon Ratchasima Province
14.	Pilot Production and Distribution of Essential Drugs at Local vs. Central Levels	Mr. Somporn Utissampanthakul Prakonchai Hosp., Buriram Province
15.	Pilot Production and Distribution of Antiflatulents at Local vs. Central Levels	Ms. Nanthana Pruckkumvong Faculty of Pharmacy, MU
16.	Surveillance of Common Endemic Diseases in Nakhon Pathom Province	Dr. Pleng Thongsom PCMO Nakhon Pathom Province
17.	Management of PHC Programs at the Village Level in Sisaket Province	Dr. Chaichana Suwanavej PCMO Sisaket Province
18.	Monitoring of Community Mental Health Service in Nakhon Ratchasima Province	Dr. Supol Rujirapipat
19.	Appropriate Models and Technology for Controlling Common Intestinal Worms in Villages of Haad Yai District, Songkhla Province	Dr. Deelok Puvanan

	Title	Principal Investigator
	Series 3/1984	
1.	Acceptability and Nutritional Assessment of Supplementary Foods Prepared from Bananas and Legumes	Mrs. Parichart Boonpikum Faculty of Public Health, MU
2.	Effectiveness of Health Education in Changing the Knowledge, Attitude and Practice of Post-Partum Sterilization	Ms. Pranee Soonthornsaduog Faculty of Public Health, MU
3.	Measles Immunity after Vaccination in Thai Children at 9 Months vs. 13 Months of Age	Dr. Pagakrong Lumbicanon Faculty of Medicine, KKU
4.	Evaluation of Basic Immunization and Motivation Techniques for High Coverage of Immunization	Dr. Sanga Boon-Umrung Paholpolpayuha-Sena Hosp., Kanchanaburi Province
5.	Appropriate Models for Controlling the Anemic States of Hook-Worm Infested Children	Dr. Sri Srinophakun Faculty of Public Health, MU
6.	Study of Malaria Vector Control by Improving Sanitary Environment	Dr. Chirasak Rojanapremsuk Faculty of Public Health, MU
7	Control of Liver Fluke Infestation through Community Participation in Kalasin Province.	Dr. Boonyium Trakoolwong Faculty of Public Health, MU
8.	Effectiveness of Training Para-Medical Personnel and Village Health Volunteers in Wound Care by Surgeons in a General Hospital	Dr. Vara Rojanahasdin Ban-Pong Hosp. Ratchaburi Province
9.	Development of Essential Drugs from Traditional Services (Canum Seeds as a Bulk Laxative)	Dr. Chantra Shaipanich Faculty of Pharmacy, MU
10.	Herbal Extracts for Diarrheal Treatment	Dr. Malin Choolsiri Faculty of Pharmacy, MU
11.	Study of the Health Information System of the Sub-District Council	Dr. Samak Srichariya PCMO Loei Province
12.	Study of Basic Minimum Needs as An Indicator for Development of Urban Community	Dr. Rujira Mangkalasiri Maharaj Hosp. Nakhon Ratchasima Province

	Title	Principal Investigator
13.	Development of a Paper Strip for Cholinesterase Activity in Blood Sample	Dr. Chin-Osoth Husbumroe MOPH
14.	Role of Health Volunteers in Immunization Programs	Dr. U-Thai Chindapon PCMO Phang-nga Province
15.	Promotion of Herbal Plant Cultivation in School Grounds	Mrs. Oranuch Puapatanakul MOPH
16.	Study of the Effectiveness and Efficiency of IUD Campaign in Nong Khai Province	Dr. Pichaiyo Wanasiri PCMO Nong Khai Province
17.	Screening, Follow-Up and Promulgation of Research Projects	Dr. Orapin Singhadej Faculty of Public Health, MU
18.	Study of the Effectiveness of Training Programs for "Paet Tambol" in PHC Service	Dr. Prakrom Woothipongse MOPH
19.	Study of the Appropriate Methods in Surveillance of Diseases for Village Health Volunteers	Dr. Prakrom Woothipongse MOPH
20.	Development of Information, Education and Communication Systems in PHC	Dr. Prakrom Woothipongse MOPH
21.	Case Study of Community Participation in PHC Programs	Dr. Samroeng Yang-Kratoke Soong Nern Hosp. Nakhon Ratchasima Province
22.	Development of Teaching Module for the Promotion of Breast Feeding in Songkhla Province	Ms. Permsiri Nitimanop PSU

NOTE: IUD = Intra-Uterine Device
KKU = Khon Kaen University
MCH = Maternal and Child Health
MOPH = Ministry of Public Health
MU = Mahidol University
PCM = Protein Calorie Malnutrition
PCMO = Provincial Chief Medical Officer
PHC = Primary Health Care
PSU = Prince of Songkhla University
VHC = Village Health Communicators
VHV = Village Health Volunteers
"Paet Tambol" = Officially-appointed traditional healers in a sub-district of a province

Report on

SITUATION ANALYSES OF 10 PRIMARY HEALTH CARE ELEMENTS IN THAILAND 1983

By

ASEAN Training Centre for Primary Health Care Development

Mahidol University & Ministry of Public Health

Preface

This paper presents the studies on Situational Analysis of 10 Primary Health Care elements in Thailand. The inverstigators were 9 teams of public health persons. Each team consisted of both Mahidol University and Ministry of Public Health personnels whose names are listed below. The studies were conducted during June to December 1983 which were financially supported by The Japanese Government; JICA through ATC/PHC (Asean Training Center for Primary Health Care Development) project. Their first presentation was held at Faculty of Public Health in Bangkok on December 8-9, 1983 by the ATC/PHC. The second presentation was among the SEAMEO/TROPMED member countries met in Jakarta on May 15-18, 1984. The author would like to thank JICA for sponsoring the research grants and SEAMEO/TROPMED for kindly inviting her to present the paper in the 26th SEAMEO TROPMED Seminar.

Orapin Singhadej M.D, Dr. P.H.

May 1984.

CONTENT

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- Mr. Pratheep Siribhoti
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- Mr. Poonsak Poonviset
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- Mr. Udom Kompayak
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IV. Situational Analysis of MCH/FP element.

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V & VI. Situational Analysis of Immunization and Control of Locally Endemic Diseases Elements.

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VIII. Situational Analysis of Treatment of Minor Ailments and Simple Wound Element.

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Situation Analysis of Health Education Element in PHC context

(RES /1/2525/14)

The Study consists of two parts :

1. assess Health-Education implementation in general and
2. assess Health-Education in PHC context.

Performances :

1. Community Health Education :

   improving Community H.Ed to meet a standard 90 villagest province/year

2. School Health Education :

   improving to meet a standard 90 schools/province/year.

3. Establishing H.Ed. in every hospital and health center.
4. H.Ed through mass media
   - radio program 48 times or over/area/year
   - television program 6 times/year
   - newspapers 12 times/year
   - Press release 2 times/year
   - Mobile H.Ed team 2 times or more/year
   - Other public relation channel in the villages 1 place/year
5. Training of Personnel such as school teachers, VHV and VHC.

6. Production and Provision of appropriate audio-visual materials
7. Supervision and Evaluation.

The popular methods for giving Health Education in the villages :-

PHC element	Method	Percent
1. Control of local endemic disease	1. group process	72.2
	2. group meeting	38.8
	3. Mobile team	16.6
	4. local radio program	16.6
	5. individual discussion	16.6
2. Food and Nutrition	1. Group Process	88.8
	2. Demonstration of food preparation	61.1
3. Safe water Supply and Basic Sanitation	1. Group Process	94.4
	2. Group Meeting	22.2
	3. Individual discussion	38.8
	4. Demonstration	16.6
4. Immunization	1. Group Process	83.3
	2. Individual	55.5
	3. Group meeting	33.3
5. MCH/FP	1. Group Process	94.4
	2. Individual	83.3
	3. Group Meeting	16.6
6. Drugs and Nursing care	1. Individual	88.8
	2. Group Process	61.1

In terms of giving health education to every type of workers and population, there is a need for improving the materials and methods to make more effective.

The PHC subjects that the people have heard most were durg used, basic nursing care and immunization. The other subjects are heard less mostly people gained knowledge from individual contact with health - personnels, and VHV, VHC respectively. Secondly from group meeting and radio. By newspapers and mobile units were very minute.

II. Situation Analysis of Food and Nutrition Element in PHC context

(RES /1/2525/12)

Objective :

To assess the current situations of Food and Nutrition development in PHC context in terms of scope, problems, constraints and possibly - appropriate strategies for future program implementation.

Material and Methods of study :

1. Literature review
2. Assess and Analyse the current situation by using a standard questionnaire to collect data.

Findings :

The Food and Nutrition development in PHC context has been implemented since the middle of the Fourth-National Economic and Social Development Plan (by the year 1978). The multi-sectorial co-operation between 4 main ministries has been applied (i.e. Ministries of Public Health, Education Agriculture and Interior). The methods of implementations are : Nutritional Survey for diagnosis, Nutrition education to mothers emphasizing on proper feeding and correction of malnourishments.

The assessment of performances during the period of 1977 to 1979 were as follows :

1. Establishment of 9 regional nutrition centers
2. Establishment of Child Nutrition Centers
3. Providing Nutrition educations to mothers and married woven at reproductive (MWRA).
4. Training the nurses.

   All of the above performances were exceeded the targets.
5. Production of healthed salt : acheived 70 % of the target
6. Providing supplementary food to children : achieved 17 %
7. Training of midwives : achieved 44 %
8. Training of child care taker : achieved 30 %

Impact :

1. Child mortality (0-4 year-old) reduced by 8.27 %
2. Reduction of malnourishment grade 1* but small increased of grade 2** in some regions and increased grade 3*** in every region. It implied that :

   1. the nutrition program network was not cover the vulnerable children or else.

   2. the second sample survey in 1979 represented more population than the survey in 1977.

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* Grade 1 = mild degree of malnourishment.

** Grade 2 = moderate degree of malnourishment.

*** Grade 3 = severe degree of malnourishment.

The Strategies of operating Food and Nutrition Development Program in PHC context are :

1. Stimulate & Motivate the VHC and VHV to be aware of and participate in solving nutritional problems.

2. Train the health personnels at grass-root level to teach and supervise VHC and VHV

3. Produce self-learning package on Nutrition education

4. Produce teaching materials such as posters and booklets etc. for VHV and VHC.

5. Periodically evaluate the VHV's and VHC's performances and organize appropriate refresher courses.

Table 1 : The Performances during 1982 to 1983 :

1.1 Anthropological measurement (0-60 months-old)

Region	Percent of total villages by Health centers	Percent of total villages by District Hospital
North-east	53.0	68.7
North	43.0	84.0
South	39.0	59.0

1.2 Production of local supplementary food

Region	Percent of total villages by Health Centers	Percent of total villages by District Hospital
North-east	23.0	26.0
North	13.0	40.0
South	7.0	21.0

1.3 Nutrition revolving fund

Region	Percent of total villages by Health Centers	Percent of total villages by District Hospital
North-east	13.0	18.0
North	10.0	27.0
South	5.0	3.0

1.4 Nutrition education

Region	Percent of total villages by Health Centers	Percent of total villages by District Hospital
North-east	62.0	72.0
North	46.0	65.0
South	39.0	44.0

Table 2 : Co-operation with other sectors

Region	Percent of total villages by Health centers	Percent of total villages by District Hospital
1. North-east		
MOPH	3.0	9.0
MOPH & Agriculture + Education + Interior	9.0	22.0
2. North		
MOPH	3.0	20.0
MOPH & Agriculture	12.0	14.0
MOPH + Agriculture + Education + Interior	69.0	23.0
3. South		
MOPH	4.0	17.0
MOPH + Agriculture	12.0	14.0
MOPH + Agriculture + Education + Interior	38.0	14.0

The full co-operation among 4 main ministries were mostly established in the North-eastern and the Northern regions especially in the areas responsible by the health centers.

The workers considered that the establishment of Nutritional revolving fund is the most difficult job in terms of supportive resources from central level, community participation, co-ordination with and enthusiasm of the government officials.

The launching of main activities occurred most in the North-east and secondly in the North due to the high prevalence of malnourishment in those two regions.

The production and distribution of supplementary food :

The housewives took major role in producing the supplementary food and the VHV, VHC responsible for its distribution.

In the areas of district hospitals, the governmental officials took the same role as the VHV, VHC and community leaders.

The supplementary food was given free of charge to the grades 2 & 3 malnourished children on every area. For the others the food was sold in order to collect money to pay back the revolving funds.

Problems and Constraints

1. Inadequate equipments and audio-visual aids
2. Inadequate well trained personnels
3. Inadequate multi sectorial co-operation especially due to shortage of budget and the government red-tape.
4. Inadequate follow up, supervision and evaluation in some remote areas due to poor communication and transportation.
5. There were several forms to be filled in which caused confusion among the workers.
6. Poor economic status of the population in some areas caused a delay in producing supplementary food.
7. Inadequate community preperation and public relations

III. Situation Analysis of Safe water Supply and Basic Sanitation Element in PHC context (RES /1/2525/13)

Objective :

To analyse the current situation and future trends of Safe Water Supply and Basic Sanitation development in PHC context.

Scope : The study covered :

- Safe water supply
- Feces disposal
- Gabage and wastes disposal.
- Food Sanitation
- Household Sanitation

Sources of data collection

- Institutions concern
- Literature review
- Some Sampled rural communities
  (i.e. Choom-porn and Nakorn-Rajsima Provinces) and etc.

Findings : The provisions of safe water supply are responsible by several sectors those are :

Governmental : - Dept.of Health, Minstry of Public Health

- Mistry of Interior
- Ministry of industry
- Ministry of Agriculture and Co-operative

  Such as Irrigation Dept. & Land Development Dept.
- Prime Minister' s Office
- Ministry of defense

Non Governmental :

- The Population Development Association
- Women's Council
- LIONS

The rural sanitation developments are mainly responsible by the Dept. of Health, Ministry of Public Health. The activities consist of

- Bio-gas
- Community waste-burning furnace
- Closed toilet in the households, temples, and schools
- Garbage disposal recipient in the households and communities.
- Garbage well in the households.

The Perfonmances :

1. Training VHC and VHV
2. Training Village Sanitary workers
3. Community development by :
   - 3.1 encourage to producing toilet
   - 3.2 Suggest on garbage disposal and household cleaning
   - 3.3 Suggest and help on producing Rain-Water containers
   - 3.4 Demonstrate the productions of containers.
   - 3.5 Suggest on waste water drainage
   - 3.6 Suggest and help on producing Sanitary Tank.

The Situation Analysis :

I. Drinking and Cleaning Water :

About two-thirds of rural population used safe water for drinking. But only one-third used safe water for cooking cleaning purposes. In case of drinking rain water only half of them have enough water all year round. Mostly the people did not treat the water properly before use.

II. Feces disposal :

Only 60 % of rural population had and used toilet . The ones who claimed that they had toilet, half of them were in good sanitary condition.

III. Waste disposal :

There was 70 % of rural population who had gabage cans in their households. The disposals were mainly through out to low-land area, burn down, made fertilizer etc.

IV. Waste Water disposal :

Only one-fifth had made proper drainage.

V. Insect and Vector Control :

Half of the population had one-way or another to control insects and vectors.

VI. Food Sanitation :

- Seventy-five and 92 % of population appropriately preserved fresh and ready made food respectively.
- To take food ; 79 % still using hand.
- Before eating ; 17 % regularly washed their hands.
  78 % randomly washed
  5 % no answer.

IV. Situation Analysis of Maternal and Child Health and Family Planning (MCH/FP) element in Primary Health Care Context. (RES /1/2525/15)

The Maternal and Child Health and Family Planning (MCH/FP) development in Thailand has aimed at providing medical and public health services to all population. The services include Promotion of health, - Prevention of diseases, delivery, care for sick family members, prevention of unwanted pregnancy and etc. The target population of MCH/FP development program cover 2/3 of total population. The MCH/FP services had been started in the "mother & child welfare " context more than 50 years ago. In March 1970, the national population policy was stated and followed by definie targets and implementation plans. So that the Family Planning Development program has step ahead of MCH.

However, the idea of integrated PHC with Overall community development have initiated the socall " Basic Minimum Need (BMN) " to be a standard measure. Within 52 indicators of BMN, MCH/FP are greatly involved.

Objectives of the study :

1. To review the MCH/FP development in PHC context.

2. To analyse and assess the situation whether which strategies support or obstruct the development such as :

- community participation
- effective management system
- appropriate technology
- man power development
- utilization of resources
- multi-sectoral co-operation.

3. To seek for future MCH/FP model development in PHC context.

Material & Method

This is a socio-anthropological research. The team of investigators went to observe and discuss with all level of health personnel and village health volunteers (VHV), Village health communicators (VHV), Model Mothers and community leaders.

Results

1. Coverage of the implemented program :

The villages which health centers are located can manage very well in terms of communication and supervision to the VHV and VHC. But the out-skirt areas still have rather small development due to - difficulties in transportation and supervision.

2. Community Participations : depend on the community's structures (such as Tambon Council and village development committee), and the leadership of the grass-root health personnel in co-ordinating with the community leaders.

3. Managerial System : the success of the program depend on a settled managerial system e.g. : -

3.1 a definite appointment date for health education, Immunization, Nutrition surveillance and MCH/FP services.

3.2 a grouping of VHV and VHC to play different roles and functions according to their capability and interest such as in - Nakorn-Sawan Province, the VHV and VHC were made into 3 groups :

Group 1 : Sanitation, Household drugs co-operative, Basic Treatment and health education.

Group 2. : MCH/FP and health education

Group 3. : Immunization, Nutrition Surveillance and health education.

4. Training : more training of grass-root level health personnel and VHV,VHC is needed in order to collect and present data such as Infant and Maternal mortality rates, high-risk mothers and children etc.

5. Human Resources : the socalled " model-mothers " can be good motivators and health educators to their neighbors. They can perform better than male VHV and VHC . Also the adolescent, housewife and - occupation promotion groups should be recruited to be VHC.

Other suggestions :

The integrated MCH/FP and rural health development must aware of the following factors :

1. community preparation to accept PHC and community development concept especially through "Risk Approach"

2. Strengthen the co-operation between health personnel and community leaders

3. Improve a management system and man-power development as stated above.

V & VI. Situation Analysis of Immunization and Control of Locally Endemic Diseases Elements in PHC context. (RES /1/2525/17)

Objectives :

1. to assess a current situation of Immunization and Control of Locally Endemic diseases.

2. to study the involvement of PHC concept which had been applied.

3. to seek for the appropriate strategies in developing those two elements.

Materials and Methods :

1. review literature
2. interview health personnel

Findings :

1. The problems occurred in the past :
   - no definite target population
   - Cold chain system
   - low coverage especially DPT & OPV.
2. Current trend
   - The Expanded Programme on Immunization started in 1976 - 1977 to cover the whole infants of Thailand.

- The evaluation of EPI showed 80 % coverage in urban and 60 % in rural areas.

- The Oral Polio vaccination was distributed to cover the remote area in 1978 - 1979.

- The pregnant women received 2 doses of Tetanus Toxoid was about 60 %.

Impact :

- The incidence of Tetanus Neonatorum, Poliomyelitis and Diphtheria had signficantly decreased.

VHV's participation in EPI :

- The VHV & VHC did not fully participate in recruitment and motivation of the target population.

- The VHV, VHC must receive more training and close supervision.

Problems :

- Problems in Cold Chain system still exist.

- not enough surveillance for infectious diseases.

Priority setting according to the severity of Immunizable and Preventable diseases :

1. Diphteria, Pertussis, Tetanus, Tuberculosis and Poliomyelitis.

2. Typhoid, Diarrhea and Dysentery

3. Rabies

4. Haemorrheagic fever

5. Encephalitis

Roles of VHV

- Inform the neighbors on epidemic diseases
- Report the diseases to P.H. personnel
- Report birth, death, immunization, sanitation and other P.H. problems.
- give health education
- give simple treatment
- able to refer the patients to health centers, hospitals or other sepcific institutions
- Collect blood smear for Malarial check up

Suggestions :

1. Regarding the efficiency of VHV & VHC, they need more knowledge on dosage of immunization and schedule at different age especially the danger of non-immunized children. Therefore regular meeting with the health personnel must be set up.

2. More budget must be allocated to cover more population and encourage surveillance of diseases.

3. Cold chain system must be emphasized and closely supervised in order to keep potency of vaccines.

4. More equipments and audio-visual aids for health education are needed.

5. Community preparation must produced.

6. Policy on setting up target population especially high risk groups must be revised.

7. More frequent immunization services are needed.

8. Providing enough vaccines.

9. Integrated EPI with MCH/FP program.

VII. Situation Analysis of essential Drugs Element in Primary Health Care Context in Thailand (RES /1/2525/16)

Objectives :

1. to study corrent concept and strategies of Providing Essential drugs at village level.
2. to study factors support or obstruct its implementation
3. to study appropriate essential drugs that should be provided at village level.
4. to seek for proper management and supply of essential drugs.

Materials and Methods

1. Review literature and documents
2. Interview the provincial chief medical officers (PCMO) and district public health officers.
3. Interview and observe 100 Drugs co-operatives by random sampling. The interviewees were :
   - Sub district public health officers
   - 1 or 2 members of Drugs co-op committee
   - manager or sellers of Drugs co-op committee
   - local residents both who were or were not members
   - local small dispensaries in the villages.

Findings :

The first Essential drugs co-operative in Thailand was established by Dr. Preecha Deeswasdi in October 1977 at Ban-Mog Champhae, Muang district, Mae-hong-Sawn Province. After that the model was modified and implemented in several other provinces in every region such as Khon-Kaen, Loey , Chiengmai, Nakorn-Rajsima, Khan-jana buri, Suphan-buri, Maha-Sarakham, Pang-Nga and Nakorn-Sri-Thamrat.

In 1981 the team who evaluated PHC project suggested that Essential Drugs Co-operative should be a good core structure leading to the development of other PHC elements.

So far (by the end of 1983) about 10,000 Ess. drugs co-op, have been established in $60,000^{+}$ villages; an average of Ess. drugs co-op per 6 villages in Thailand.

There are 8 Steps in establishment of Ess. Drugs Co-op :

1. Health Personnel in co-ordinating with VHV communicate with and motivate the villagers.
2. Set up 5 to 7 villagers to be committee members.
3. Admission of members who are willing to buy 10 or 20 Baht bond.

4. The Ministry of Public Health (MOPH) or any private agencies grants 700-1,000 Baht in form of money or drugs to encourage the co-operative settlement.

5. The committee members meet to select the types of household drugs which are needed and consider on suitable site of dispensary, seller and accounting.

6. Set up the place, price list, name list of the members etc.

7. The health personnels at village level visit and supervise the co-op once or twice a month.

8. At the end of the year the committee meet to share the benefit in form of money or put it into the village's revolving fund.

The Analyses of efficiency of the Co-op management.

1. Human Resource :

- About half of district public health officers had been trained in Ess. Drug Co-op. The P.H. officers in the North and North-east were trained more than in the Central and the South.

- about 82 % of P.H. officers had correct concept of setting the Ess. drug Co-op.

- the opinion future management 91.5 % of the officers stated that it should be expanded into multipurpose Co-operative and selling more items.

4.1 the personnel and committee must be trained and operate the co-op correctly.

4.2 The members should consist of at least 70 households in the village.

4.3 Drug sellers must have knowledge and good judgement in selecting drugs for each person.

4.4 The co-op which operated more than one year had put its benefit or surplus into public development.

4.5 The management still running good.

The assessment showed that about half of the co-op in every region had made moderately performances, 23 % had excellent and 28 % had poor performances.

Problems and Obstacles.

1. The Committee members do not have enough time to meet often
2. The members did not pay debt.
3. 16 % complaint on managing the accountant.

Suggestions :

1. More training on Co-operative management and selection of drug use are needed.

2. Drug sellers must be the ones who had run business for sometimes in order that they can manage the co-op.

3. Close supervision from the higher level P.H. officers is necessary.

4. The government pharmaceutical department must improve the system of production and distribution of drugs to serve rural need in time.

5. Community preparation before setting up the co-op is necessary.

VIII. Situation Analysis of Treatment of Minor Ailments and Simple Wound in PHC Context : (RES/1/2525/18)

Objectives :

1. to study pattern of sickness in rural villages and seek for care.
2. to study VHV and VHC's roles and Essential Drugs Co-operative in medical care of the population.
3. to study referral system.
4. to make some suggestions for treatment at grass-root level.

Findings :

1. Mostly people need basic treatment of sickness only small proportion need to consult the physicians.

2. Whenever simple sickness occurred the villagers treated themselves by purchasing drugs at nearest dispensaries.

Belief in traditional and superstitious treatment randomly exist.

3. District Hospitals can give good care to the patients. Only 1 % need to be referred to the provincial hospitals or others.

4. Referral system still not well established. The VHVs can not fill the form. Mostly the VHVs took the patients to the hospital by themselves. No referral form in the health centers.

5. People who had more access to the hospitals are the ones who live nearly.

6. The VHVs who resided in the Essential drugs co-operative areas have more knowledge on drug usage and treatment more than others.

IX. Mental Health Element in PHC Context (RES /1/2525/19)

First-Five year Plan : 1962 to 1966 2505 2509	- Clinically-oriented emphasized on increasing capability and improving quality of care
Second Five year Plan : 1967 to 1971 2510 2514	- Started Community Mental Health Services; - set up mobile unit and community mental health centers.
Third-Five year Plan : 1972 to 1976 2515 2519	- Improved Standard of Care and Services in Mental Hospitals as well as increasing community mental health centers.
Fouth-Five year Plan : 1977 to 1978 2520 2524	- Started Integration between Curative and Preventive care but rather curative than Preventive.
Research topics :	- School Mental Health Child to Child Care
Fifth-Five Year Plan : 1982 to 1986 2525 2529	- Community Mental Health is included in the National Plan for PHC development (4 years after Thailand started PHC development plan.)

So far Mental Helath Care has been introduced to the community level but Rehabilitation is still institutionalized. The authority has made a future plan to develop Social Rehabilitation since 1979 in which the community participation is expected.

The Perfomances of the Non-governmental Organizations related to communities Mental Health are as follows :-

1. The Population Development Agency (PDA) :
   - Youth Development center
   - Rape Crisis Center
   - Family Planning Councelling Center
2. National Pilot Project on PHC for the Prevention and Reduction of Drug Abuse in the Community.
3. SAMARITAN Project : telephone councelling on mental problems including Committed Suicide.

Evaluation of Integrated Program

Community Mental Health in PHC context

1. Knowledge Attitude and Practice (KAP) on Mental Health of Village Health Volunteers (VHV) and Village Health Communicators (VHC) who were trained on Mental Health Care were not significantly different from those who were not trained.

The investigators made 3 remarks on the observation above :

1.1 The training was in a short period of time; only 2 to 3 days so that it can increase only cognitive domain but not affective domain.

1.2 The VHV and VHC could not change their attitude towards mental health due to their own believes, culture and tradition.

The short training course could not change the trainee's attitudes.

1.3 Even though the trainees gained knowledge but there are still other factors involve in practice such as motivation own benefits and habits etc.

2. The trends on implementing community Mental Health in PHC context is rather optimistic due to the positive attitudes of the VHV and VHC.

3. There was an evidence that more and more screening for mental health patients is applied to the Community Mental Health.

X. Dental Primary Health Care (D.PHC) (RES /1/2525/20)

General Dental Health Situation in Thailand

A rapidly increasing dental caries problem, a stable, high perio-dental disease problem and a scarcity of manpower in Thailand are the big problem among other health problem.

Dental Caries

1. Percentage of affected person and serverity of the disease are very high in children below 14 years of age
2. Prevalance of the disease is high in Urban area than in rural area.
3. Dental caries is a preventable disease. Dental Health education and Fluoridation should be implemented.
4. Curative Dental caries should go together with dental health education.

Gingivitis and Perio-dental Diseases

1. Percentage of affected person of disease is high in teenagers and severity of the disease increases in old-age.

2. Prevalance of the disease is higher in rural than Urban area,

3. They are preventable diseases, Proper-tooth-brushing technic should be emphasized.

Distribution of Manpower

Male-distribution and inadequacy of dental health personnels are the big problems in Thailand, Majority of dental health personnels (dentist, dental hygienist) work in Bangkok or other big cities.

Dental Public Health Services have faded out only at the district level, there are no activities of Curative dental caries at sub-district and lower level, the situation of Dental Public Health Problem should be improved, other,wise severity of the disease will increase to 4.5 times in the near future 9by the year 2000).

So Dental PHC has been implemented.

Dental PHC (D.PHC) APPROACHES.

According to the objective of PHC development WHO aimed that children at 12 year-old should have average D.M.F index 3.0 (Having decay + Missing + Filling + 3 teeth/Person) by the year 2000.

Research of ATC/PHC in " Situation Analysis of Dental Health Element in PHC Activities (RES /1/2525/20) was perfomed in 4 regions of Thailand (Northern, Southern, North-eastern, and Middle part). The - objectives of this research are to study the prevalance, trend of dental caries and Perio-dental disease, causes of the disease,namely determinant

and predisposing causes. Besides, to study need demands, attitude and community's potential in improving Dental PHC as well as its future prospect. The research was conducted in 4 villages of each region of Thailand.

Acitvities of D.PHC

1. To train public health officials at sub-district level on Basic Dental Health Care for prevention and simple curative (such as using analgesic drug, superficial dealing of the germ) and referring the patients to a district hospital near by.

2. To train village health volunteers, Village Health Communicator in the village trough trained public health officials.

3. Providing tooth-brush revolving fund within household drug co-operative.

4. At the present time, Dental PHC has been implemented in only 14 villages as research models, and will be enlarged into 40 provinces during the years 1985-1986.

The research results are as follows :

1. Only 15.18 % of the people has had knowledge positive attitude and proper practice in oral health.

2. Average oral hygiene Index of the communities is not good,i.e. 96.44 % of the people have had poor-oral hygiene.

3. 89.08 % of the people have oral disease

i. 84.62 % in North-Eastern part of Thailand, the children have caries of deciduous teeth.

ii. 49.68 % of the children in the Middle and Southern part of Thailand have Dental Caries of Permanent teeth.

iii. 62.93 % of the people in Southern and Northern part of Thailand have a periodontal disease.

4. Prevalance of dental caries is high in children and low in elderly. In contrary Prevalence of Periodontal disease is high in elderly but low in children.

Service Needs are as follows :

1. Dental Health education = 100 % of the population
2. Dental Health education + Preventive dental care = 100 %
3. Dental Health education + Preventive dental care + Curative Dental care ; 50 % permanent teeth, 90 % in deciduous teeth, 80 % of people for perio-dontal disease.

Treatment Demands.

1. 55% stated that they have treatment demands, among those only half of them could receive dental services.

2. There are 71.03 % of the population who used the government dental health services the rest received care from Private Clinics and indigenous personnel.

3. The services which people received were extraction (55.3 %), Symtomatic treatment by using drug (22.3 %) and the rest were filling and scaling.

Potential of community to develop Dental Primary Health Care.

Following the Hypothesis of Implementing PHC development Program; The community participation for community diagnosis, planning and implementation to solve their own problems must follow :-

1. acceptability and awareness of the problems (dental health)
2. readiness to develop their own community.

Results of the study :

1. 24 % and 57 % of the population and the community leaders respectively have dental health problems.

2. only 37 % of the community leaders stately that they are ready to participate in the community dental health program.

More importantly 15 % of those leaders are sure to seek for supportive resources.

3. 22 % of the volunteers who have participated in community public health were satisfied with the job and showed their willingness to continue it.

Conclusion & Suggestion (made by research team)

1. Urgent and serious concern at the high level of governmental authorites in dental health problem should be stimulated by :

- resetting priorities beginning with promotive, preventive and then curative.
- setting target group ; such as dental caries in school children, periodontal disease in old-age population.
- area of endemic, and distribution of the diseases are :- Southern part-Dental caries and Periodontal disease Should be stressed. Middle part-Dental caries.

Middle part - Dental caries.

Northern part - Periodontal disease.

North - eastern part - Dental caries in school children.

2. Stimulating and increasing the level of Needs and Demands of the people in community and improving curative elementary services.

3. Preparing the communities to helping themselves in Dental PHC work.

4. Closing supervision in continuity of Dental PHC work.

5. Improving the communication technic for better and quicker diagnosis and effective treatment.

6. More research works are needed.

ABSTRACT
OF
RESEARCH REPORT
ON
SERIES 1/2525

BY

ASEAN Training Centre for Primary Health Care Development

Mahdol University & Ministry of Public Health

1, Title : Nutrition Managemention Densely Populated Urban and Subrub Communities

2, Location : Nakornrajsima Province

3, Sponsoring : Asean Training Centre Primary Health Care

4, Principal investigator (s)
(name and address) : Dr. Rujira Mangkalasiri
Department of Social Medicine
Maharaj Hospital
Nakornrajsima Province

5, Starting date : May 1, 1983

6, Completion date : May 1, 1984

7, Total cost: 31,200 ฿

Title : Nutrition Managemention Sensely Populated Urban and Subrud Communities

Abstract

The study was done in urban and suburb slum area, Nakornrajasima Province. It was done during May 1983-April 1984. The main rusults were as follow:-

1, For urban community it was clearly different from suburb and rural in/terms/of population, way of life socio-economic and political pattern.

2, Urban Public Health problems both type and size of problems were not different from rural. Health Services connot cover all of the population, especially prevention and promotion of services.

3, The Nutritional program in urban community success only some activities for example and supplementary food production. The other activities got community participation not regularly. Because of the occupation pattern and the way of life. In suburb community the activities which succeeded were nutritional surviellance and Supplementary food Program. The most important thing that both communities haven't emphasize was Nutrition Education.

4, Community participation in suburb were better than in urban. For suburb community, there were community develpment committee which is most accepted by the people. This committee is very effective in management and respected by the people there.

5, Result of changing nutritional status in target population during study were to improve better status in both of the communities. Suburb community was changed significantly.

6, Role of government staff which stimulate the activities in the community, they felt that they didn't have role in planning activities of the community.

1, Title : Study on the Role of Village Health Communicators in Health Education

2, Location : Ban-Phai District, Khon-Kaen Province

3, Sponsoring : ATC/PHC Mahidol University

4, Principal investigator(s) (name and address) : Dr. Anan Menaruji
Director of Ban-Phai Community Hospital
Khon-Kaen Province

5, Starting date : May 1,1983

6, Completion date : May 1,1984

7, Total cost : 35,300 ฿

8, CODE : ees/1/2525/02

Abstract

This study's objcetive wasto assess the performance of health education element in the PHC field of VHV_s and VHC_s. How it progress and its components-promoting factorsand factors that interfere the performance. By studying case study from 2 studied villags, with succes-ful PHC programmes in Banphai district, KhonKaen province. The researchers utilized a case study method and anthropological method as tools and methods for collecting information and data. By the research assistants who were assigned to live in the study villages for 8 week's. The research assistants could gather information through a "participation observation" an"indepth interview"where by they gather information from the groups of VHV_s and VHC_s, Community leaders and villages, And they can participated in various activities and events.

The result is that VHV_s/VHC_s have low performance in health education only 3 out of 29-have self confidence and educate the people, The performance is limited to individual education, during campaign of each activity of PHC. The principal function of health education belongs to the health personnels. They showed this role during social preperation, while the VHV_s and VHC_s did not have chance to practice this role, the rest of VHV_s and VHC_s loss confidence to educate the people and were satisfied with their limited role. The effective health education depends upon its leadership of VHV_s and VHC_s. There have been many factors that haven't been contributed to the role of health education more efficiently that is VHV_s/VHC_s didn't understand the health education concepts clearly and thoroughly . There haven't had appropriate model or process of health education that is suitable to the health behavior in each subject and agree to the reality of social, community. They didn't realise the importance of their role of education. This due to the training curriculum, supervision and continuation of training. In spite of the improvement of curriculum of Banphai Hospital.

1, Title	:	A Study of Methods And Approaches for Effective Community Participation in Primary Health Care
2, Location	:	Karmsakaesang District, Nakorn-rajsima Province
3, Sponsoring	:	ATC/PHC Mahidol University
4, Principal investigator (s) (name and address)	:	Dr. Paichit Pawabutr Chief Medical Officer, Office of the Permanent Secretary, MOPH
5, Starting date	:	May 1,1983
6, Completion date	:	May 1,1984
7, Total cost	:	36,000 ฿

Title : A Study of Methods and Approaches for Effective Community Participation in Participation in §Primary Health Care

Abstract

This operational research was conducted specifically in the villages of Amphur Kamsakaesang, Nakhonrachasrima Province. The objective is to study the basic information of community participation in primary health care performance and analysed the problems. Then take the study result to use in the experimental level. The evaluation was conducted every month at provincial level and every three months at the field. The quantitative data were collected by using questionaire and the qualitative data were collected by using the depth interview and sociological observation. The quantitative and qualitative data collection were made by using the travelling seminar.

Otherwise the data were collected by the supervision and the workshop.

From the study, we found that problems and important factors related to community participation promotion are as follows:

1. The management system of village development are lack of efficiency. According to the potential of the community organization, is very low without the management relation and village development between village committee and family leader. Although the VHV do not have the ability to give the village development as the mentioned point.

2. The community lacks of idea frames and guidances to solve the problems and the needs of himself which effected on the community participation.

3. Governmental staff lacks of the idea frame and the ability to support the village development. The community should participate in the problem and the basic minimum needs of the community.

1, Title	:	Evaluation Study of the Impact of VHV's and VHC's Performance on Health Status of the Population
2, Location	:	Phanakornsriayudhaya Province, Nakonrajsima Province
3, Sponsoring	:	ATC/PHC Mahidol University
4, Principal investigator (s) (name and address)	:	Assoc. Prof. Dr. Orathai Sakdiswadi Department of Medicine Faculty of Medicine, Ramathibodi Hospital
5, Starting date	:	May 1,1983
6, Completion date	:	May 1,1984
7, Total cost	:	36,000 ฿

Title : Evaluative Study of the Impact of VHV's Performance on Health Status of the Population

The performance of VHC & VHV has been found to be very useful in PHC development. The impacts were measured by 1, changing of practice during pregnancy and post-partum 2, breast feeding and 3, Immunization coverage. The real impacts occurred due to the co-operation among public health officials, VHV, VHC and the villagers. However, there still some problems exist such as drug misuse among the villagers. The pain relieving drug especially APC is regular used by 66.2% of the people and 52.5% still taking "packaged drugs".

Affter giving health education the use of "packaged drug" was substantially decreased but the proportion of villagers who regularly take APC was almost the same as before.

The objectives of PHC development has not been fully attained due to the rush selection of VHC. The community participations were less than expected because there were no and motivation of the villagers, VHC & VHV.

Among the village headmen, 314 of them realized the roles and benefit of VHC & VHV, but almost 40% of the villagers did not know the VHV & VHC in their community.

The villagers who requested the assistance of VHV & VHC were only 25%. Of these they asked for some essential durgs, birth control and simple treatment of common diseases.

Training of VHC&VHV : the VHC & VHV stated that their Training were sufficient but they did not have time to study the manual. It was found that the VHC & VHV have medium knowledge in health but not enough knowledge in community diagnosis. Therefore further training is needed.

Co-ordination : 3/4 of VHC & VHV had chance to contact with public health officials, but the rest did not.

Problems & Constraints :

1, Not enough communication between VHV, VHC and public health officials. Some VHVs reside so far away.

2, The villagers not yet accepted nor co-ordinated with VHV & VHC.

3, VHV could not leave their main job to fully participating in PHC .

4, The villagers wanted to get the government essential drugs free of charge .

Performance of VHV & VHC : mostly the VHCs did not perform full activities nor continuity. They had participated in weighing children, doing some surveys and some of them did help in essential durgs distribution. Many VHCs & VHVs did motivated the villagers for immunization, family planning and MCH. The other PHC activities were performed very little.

There are more needs from the village headmen to further educate the VHV in treatment of common diseases especially in the villages that have many old people and children.

Title	:	Role of "Pat-Tambon"in PHC involvement
Researchers	:	Mr. Chairat Patanachareen et al
Location	:	Khon-Kaen Province ;
		Nong-Roue, Phu-Wieng and Nunjakiri districts
Duration of study	:	May 1983 to April 1984
CODE	:	RES/1/4505/05

Title : Role of " Pat-Tambon " in PHC involvement.

Researchers : Mr. Chairat Patanacharoen et al

Location : Khon-Kaen Province ; Nong-Roue, Phu-Wieng and Munjakiri districts

Duration of study : May 1983 to April 1984.

Abstract

The study aimed at defining roles of "Pat-Tambon" in PHC involvement. The attitudes of all types of personnel in the formal community organizations towards "Pat-Tambon" were also studied by interviewing them. There were 28 "Pat-Tambons" who worked in 3 Sampled districts and 558 personnel were also interviewed.

The "Pat-Tambons" are the part-time workers in health related field. They have been appointed under the auspices of Ministry of Interior. Their work and responsibility were not linked with public health personnel.

Most of the "Pat-Tambons" did not play an active role in PHC activities. Their performances in general public health was very minimal. However large proportion of the "Pat-Tambons" indicated their interest in participating in PHC activities. They requested for more training and be given more clearly defined roles in PHC activities.

All types of personnel in the formal community organizations except District health officers and head man of the villages had rather positive attitudes towards "Pat-Tambon's role in PHC activities. Those personnel wanted to have "Pat-Tambons" to be supporters and co-ordinators of PHC activities at Tambon level.

There were some village health volunteers and communicators (VHV & VHC) who had rather negative attitude towards "Pat-Tambons". Those personnel did not want to collaborate with "Pat-Tambons" neither wanted them to act as chief of VHC & VHV.

A suggestion was made that "Pat-Tambons" should be trained and persuaded to involve in PHC activities.

Title : Role of District Hospital Personnel in PHC.

Researchers : Dr. Samroeng Yangkratoke et al

Location : All 400 district hospitals in Thailand

Duration of study : May 1983 to March 1984

code : RES/1/2525/01

Title : Role of District Hospital Personnel in PHC

Researchers : Dr. Samroeng Yangkratoke et al

Location : All 400 district hospitals in Thailand.

Duration of study : May 1983 to March 1984,

Abstract

The purposes of the study are: 1, to survey the situation of district hospital personnel in PHC implementation 2, to draw some suggestions in order to improve collaborative roles of district hospital personnel in PHC.

The mailed questionnaire were responded from 265 district hospitals which are distributed in every region of Thailand. Also 10 hospitals were visited and discussed in detail.

The findings infered that district hospital personnel are suitable to be supporters in PHC implementation because they are qualified and accepted by the people . Besides, the distric hospitals have enough resources and facilities to participate in PHC development in their Communities. The doctors can go out to villages and the directors can participate in planning at provincial level as well .

However, there were only 25 % of the respondents who indicated their real interest in PHC implementation. The suggestion to improve the situation is that the Ministry of Public Health (MOPH) should aim at expanding 10 bed hospital to be 30 bed hospital . So that they will have more personnel to be

able to take serious role in PHC. Besides, more co-operation between hospital personnel and district health officers must be strengthen. The MOPH policy on launching PHC elements should be flexible according to various situation in the communities by region.

To create awareness and positive attitude of doctors towards PHC concept must be initiated in the medical schools. The medical students must be convinced that Public Health is as important as Clinical services. After graduation the doctors should be frequently refreshed and stimulated on PHC.

1. Title	:	Utilization of MCH Services by Married Women of Reproductive Age in Kalasin Province According to PHC Projects
2, Location	:	Kalasin Province
3, Sponsoring	:	ATC/PHC Mahidol University
4, Principal investigator(s) (name and address)	:	Dr. Uthane Jaranasri Provincial Public Health officer of Kalasin Province
5, Starting date	:	May 1, 1983
6, Completion date	:	May 1, 1984
7, Total cost	:	36,000 ฿

Abstract

Research: Practice in MCH and Primary Health Care of Married Women of Reproductive Age, Kalasin Province Primary Health Care Project, Ministry of Public Health

The objectives of the research study are to:

1. study MCH/PHC knowledge, attitude, and practice of married women of reproductive age;

2. analyze the correlation between MCH knowledge/attitude, and the acceptance of MCH services;

3. study factors related with a use of MCH services, and the satisfaction of the acceptors as well.

The study was launched in Kalasin Province, one of the northeastern provinces, and 310 interviewes were made with married women aged 15-44 years whose youngest children were between 0-5 years old.

The results of the study were summarized as follows:

1. MCH knowledge and attitude of the interviewees were acceptabed (good), but their practice was not so good as it should be.

2. Maternal care knowledge had a relationship with attitude and practice of maternal care as well as a practice of child care.

3. MCH knowledge and attitude were factors related with the practice.

4. The samples were satisfied with the provision of MCH services.

1, Title	:	Provincial Health Information system Development and Provision of Primary Health Care Services through Health Volunteer System
2, Location	:	Samuthsongklarm Province
3, Sponsoring	:	ATC/PHC Mahidol University
4, Principal investigator(s) (name and address)	:	Dr. Thana Earkarnna Provincial Public Health officer of Samuthsongklarn Province
5, Starting date	:	May 1,1983
6, Completion date	:	May 1,1984
7, Total cost	:	36,000 ฿

"Development of Provincial Health Information Model for Primary Health Care by Community Health Volunteers"

Thana Earkarnna, Prawit Soonthornsima, Pichit Skulbhram

Abstract

This research project was implemented in the areas of all 3 districts of Smutsongkarm Province. The 57 villages in 20 Tambols with the population of 22,948 were selected to be used as experimental areas. As the criteria of one Village Health Volunteer is elected by 10 households. So there were 370 V.H.V. had been elected to work in the areas. All V.H.V. were sent to be trained at Tambol health offices for 2 days. These V.H.V. were assigned to be responsible for 2 significant functions : health information reporting and providing of primary health care services. Each V.H.V. was assigned to be responsible for his 10 households only. All health informations were reported by filling up in the forms and sent to Tambol health personnels every month. Finally, those forms will be sent to the Provincial Health Office as the center for collection and analysis. The main functions of primary health care services of V.H.V. were : providing of essential drugs to patients, taking the patients to get the appropriate medical services, providing health education, motivation and helping the villages to develop environmental sanitation activities etc. This research project was done in January 1 to December 31 , 1983, the results were as follows. The V.H.V. were able to report health informations with completeness, rapidity, up-to-date effectiveness and realiable especially the data on population e.g. birth, death, immigration, health data e.g. sickness, immunization, environmental health data e.g. water supply, disposal of excreta and wastes etc. Besides, it was found that the V.H.V. became important persons as the middlemen to advise the villagers and to coordinate the works with the health personnels to be able to perform the new public health service project in the community such as drug cooperative project.

The research project was funded by ASEAN Training Center for Primary Health

1, Title : Study of Role Acceptance in Association with Role Performance Among VHV's in PHC Project of Nakornsawan Province

2, Location : Nakornsawan Province

3, Sponsoring : ATC/PHC Mahidol University

4, Principal investigator(s) (name and address) : Dr. Soonthorn Tongkong
Provincial Plublic Health officer
of Nakornsawan Province

5, Starting date : May 1, 1983

6, Completion date : May 1, 1984

7, Total cost : 36,000 ฿

8 CODE : RES/1/3505/10

Abstract

Research: Factors Influencing The Role Performance of Village Health Volunteers in Nakhonsawan Province Primary Health Care Project, Ministry of Public Health

The Objectives of this research are to study the factors influencing the role performance of village health volunteers the other is to study the VHV's personnel-characteristics, the VHV's community-characteristics, the VHV's satisfaction to the government supports and the role acceptance of VHVs' those were associated with the role performance

There were 190 VHVs participated in the study, which trained and work during the period of 1978-1982 and 47 tambol health personnel, together,

The data were collected by interview the VHV_s using questionnaires and evaluated the VHV's role performance by using forms. The results were as follow:

1. Most VHV_s's role performance were medium level, and high level was at least.

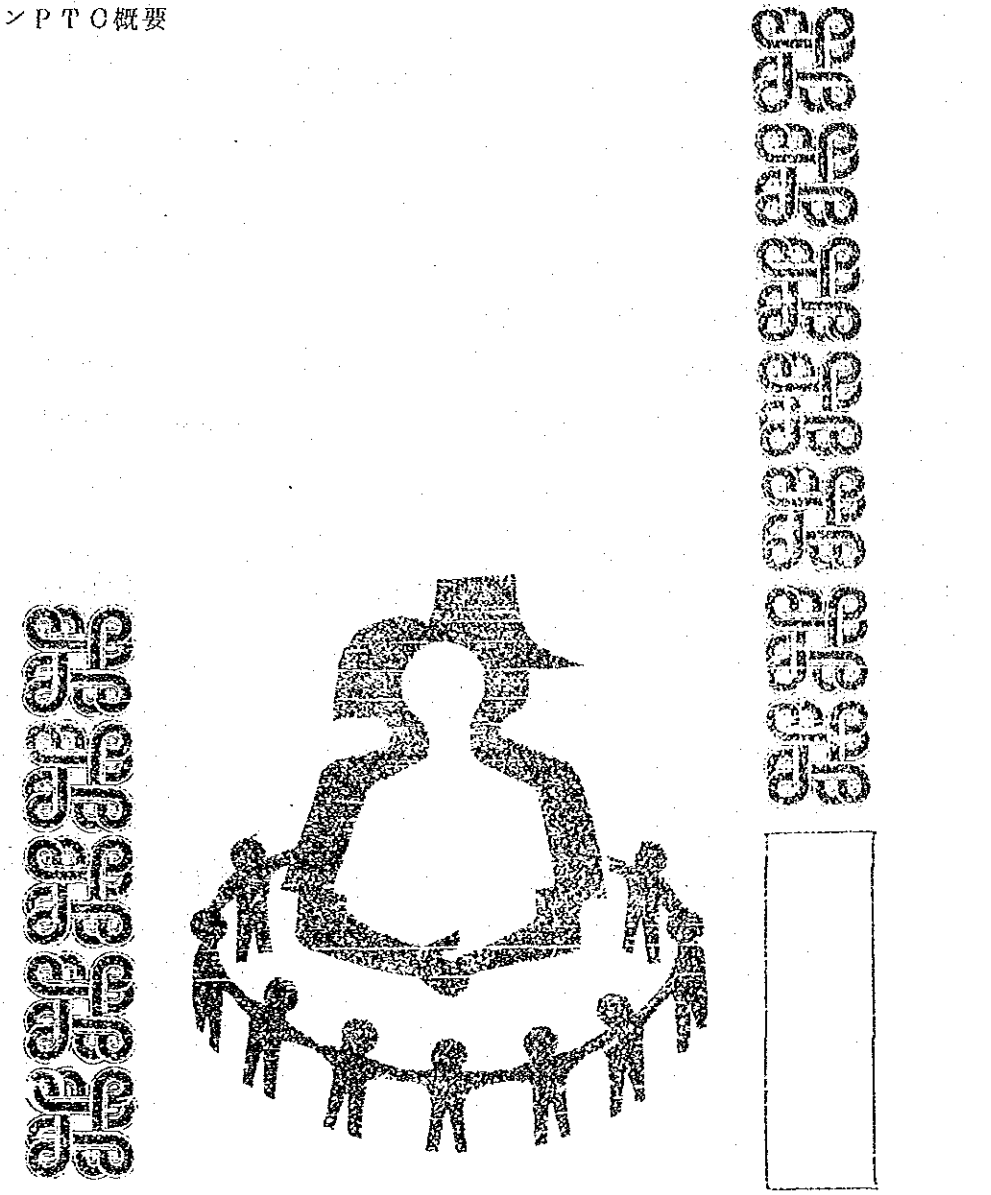
2. Non significant association was found at the level of 0.05 between the most VHV_s's characteristic and the VHV_s's role performance. Sex and the thinking of VHV's retirement, however, affected their role performance.

3. The level of the community's characteristic was medium. But non significant association with the VHV_s's role performance.

4. Most VHV_s were satisfy to the government's supports. The adequacy of VHV's drugs, the training for VHV's and the refreshing course were significant association with the VHV_s's role performance.

5. Non significant association was found at the level of 0.05 between the role acceptance and the role performance. And the level of role acceptance was medium.

5. コンケンＰＴＣ概要



NORTHEASTERN
REGIONAL TRAINING CENTER
FOR PRIMARY HEALTH CARE DEVELOPMENT
Tel. 239505,239659

Regional Training Center for

Primary Health Care Development

BACKGROUND

The ASEAN Training Center For PHC Development Project will be another important progressive step for improvement of the living status of the ASEAN rural community. It is a five-year project (1982-1986) supported by the Government of Japan in term of grant in aid and technical cooperation. The main purpose of the program is not only to concentrate on training activities but also to stress strategic devlopment activities,and studies of modelling process and development

According to the principle of Primary Health Care, community participation is the core concept of all activities. Full community participation will exist after community acceptance of health problems,self,identification of the causal factors, self analysis of the information,self planning and testing of innovative procedures.Therefore, in the training program, emphasis will be placed or community understanding of these activities. Research studies and modelling activities of the people in the community will also be emphasized. The ATC at Salaya is suitable for international and national conceptual orientation and training. The Regional Training Centers for PHC Development will be responsible for practical experiences, field studies, and modelling and research on PHC management.

Four RTCs will be built in the rural provinces. One for each region are as:-

RTC at Khon-Kaen is reponsible for PHC activities in 17 provinces of Northeastern region

RTC at Chonburi is responsible for PHC activities in 24 provinces of Central region.

RTC at Nakornsawan is responsible for PHC activities in 17 provinces of Northern region.

RTC at Nakorn-Srithamarat is responsible for PHC activities in 14 provinces of Southern region.

Construction of the first RTC of Khon Kaen was completed in February 1984; the other three RTCs will be completed in 1985

Objectives.

1) To extend the functions of ATC (Salaya) to the district tambon and village levels particularly in the area of field study
2) To conduct training courses in Primary Health Care for PHC trainers of volunteers, PHC managers, at district, tambon and village level.
3) To conduct studies of and development for Primary Health Care in local area.
4) To collect and disseminate information on Primary Health Care
5) To act as a focal point of regional PHC activities providing coordination and technical support

Activities

The RTCs as a part of the PHC system have 3 major activities.

1. Orientation and Training

The RTCs are responsible for orientation and training programs for administrators, technical officers, health staff and village community health workers from district leval down to the community level. The RTC will also to arrange field training programs for ATC field training courses, Orientation and Training will follow the following framework

A)Training content

-To define the PHC concept and activities.

-To introduce and encourage the concept multisectoral collaboration

-To develop intersectoral planning and management ability within the scope of primary Health Care.

-To create consciousness and willingness to work for the community

b) Target groups

1.Above district level: those in the ATC/PHC training program.

2.District level. the District Development Committee and District PHC Committee members (app.13 persons for one district) :

-District officer(1)
-Deputy district officers(2)
-Community Development Officer (1)
-Agriculture Officer (1)
-Co-operative Officer (1)
-Education officer (2)
-Health officer(2)
-District representative tothe Provincial Council (1)
-Delegate from DDC

3) Tambon level: 5 governmental Officers (2 Health Officers,1 CD Officer, 1 Agriculture Officer and 1 Teacher) and 12 Elite group (Tambon Chief, Village Chiefs and the Village Sages per each tambon.

4) Village level:Approximately 20 villagers (9 Village Development Members, 1 VHV and 10 VHCs) per each village.

c) Course duration

The training courses for district and tambon officers will be 2 weeks for each course, for tambon and village elite group the courses, will be 1 week.

d) Curriculum outline

Details in table 1

e) Teaching staff and lecturers

The core teaching staff will be the existing central and Provincial PHC trainers who work near the RTCs, Lecturers and Resource Persons will be invited from the nearby university,Public Health College, Nursing College, Provincial officers and from other related sections.

Table 1 Curriculum Subject and training method.

Subjects	District Level [1]	Tambol Level		Village Level [4]	Remark
		Gov's Offices [2]	Elite Group [3]		
1. Nature of Rural Community	L	L	-	-	L=Lecture
2. Basic Needs	L/G	L/G	G	G	G=Group Discussion
3. Basic Community Services	L/G	L/G	L/G	L/G	
4. Community Development					F=Field work
5. social Preparation for Development	L/G	L/G	-	-	
6. PHC concept and Philosophy	L	L	L	L	
7. PHC Strategies and Implementation	L/G	L/G	L/G	L/G	
8. PHC Plan and Management	L/G	L/G	L/G	L/G	
9. Planning (Village investigation/synthesis and analysis in relation to ECS/PHC)	F	F	-	-	
10. Planning (Problem identification and Priority setting)	G	G	G	G	
11. Planning (Program/Project Formulation	G	G	G	G	
12. Program (administration and management	L/G	L/G	L/G	L/G	
13. Field Observation	G	G	G	G	
Period of Training	2 weeks	2 weeks	1 week	1 week	

2) Research and Model Development

a) Research

RTCs will have responsibility for two areas oof research

1) RTCs will act as the operational bases for the field work of research on PHC initiated by ATC. The research and development section staff will act as field coordinators for ATC studies. They will contribute to. Rne research design step for implementable purpose on the respective circumstances.

2) RTCs will act as the core centers for local PHC studies 10 PHC studies for each RTC will be carried out each year using the district hospitals and the district health office as the operational bases. Researchers from the health staff of the Ministry of Public Health will be encouraged and supported directly by the RTCs.

The research projects will cover the following areas:

1. Collection and analysis of data PHC activities.
2. Methods of and approaches to for effective community participation in PHC.
3. Training modules for Health Volunteers.(Evaluation of)
4. Effective supervision and provision of continuing education for Health Volunteers.
5. Evaluation of education aids in PHC.
6. Methods of improvement of knowledge and educational skill of district and tambon trainers.
7. Managing and coordinating PHC activities.
8. Proper referral system for better patient care at community level
9. Role of district and provincial hospitals in supporting PHC.
10. Evaluation of Health Volunteers performance in PHC.

Special research topics will be those related to community organization, community financing, continuing training for PHC and multisectoral collaboration strengthening programs. At the begining, a training course on research methods will be essential for peripheral health staff This can be carried out as one of the training lessons in all of the training programs of RTCs.

b) Model Development

Each RTC will be responsible for developing sites in rural areas, The urban model will be managed by the ATC. Meeting for planning, monitoring and evaluating the models will be organized with ATC staff and related sectors. The result of the ATC and RTC Studies will be fully utilised in inplementing the model deyelopment The characteristics of the tambon chosen in the program should include

1. Consisti of at least 10 villages with an average of 1,000-1,500 households
2. No previous intensive Primary Health Care program or similar activities.
3. Located Within easy reach of the RTCs.

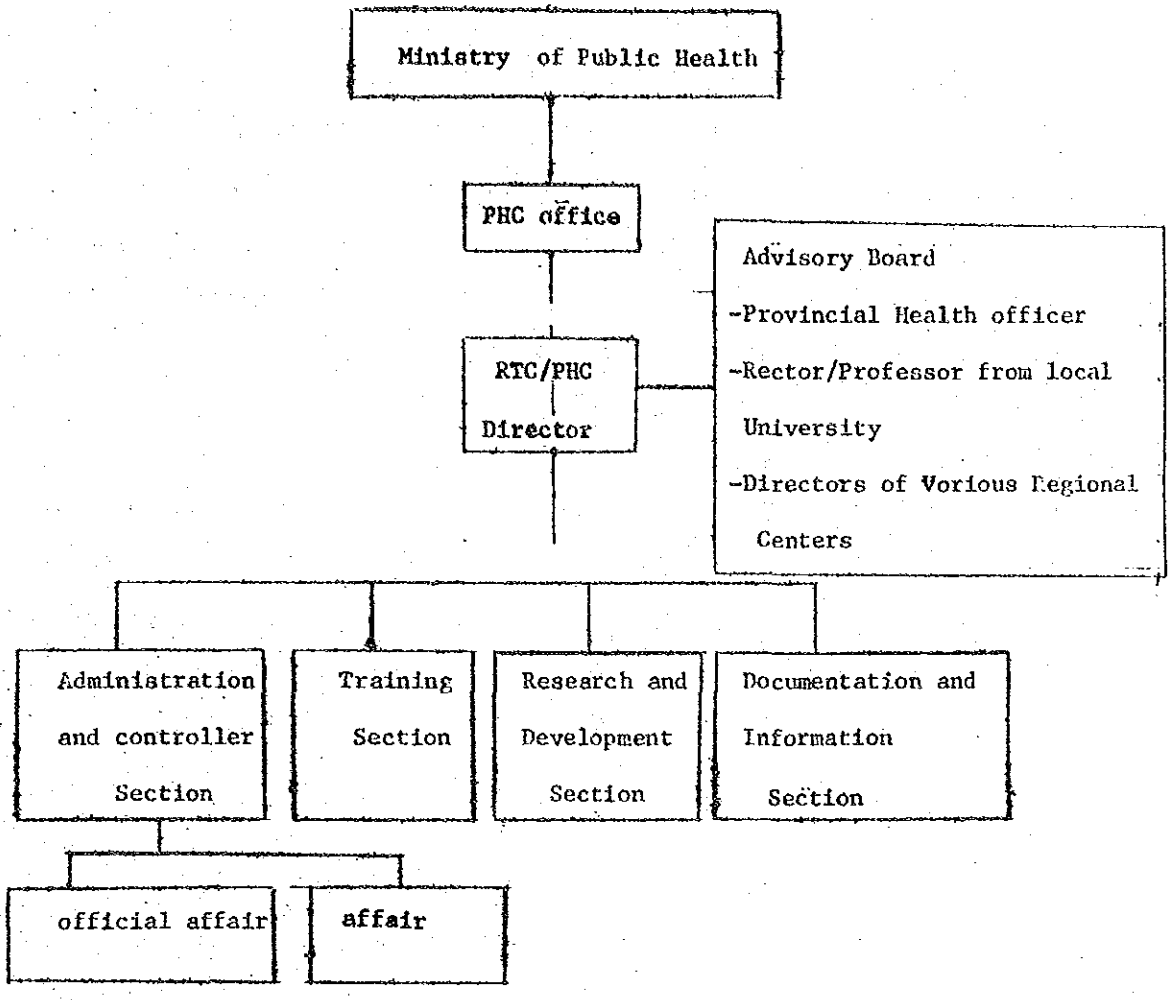
The activities in the model tambon should be oriented to organizing a community self reliance system based on the 8 PHC elements with a appropriate community organization of services, referral system, information system, monitoring and evaluation system, with the tambon health office acting as a center for intersector collaboration activities documentation, information and technical supports. 4 Tambons will be implemented in 1984 and another 12 tambons will begin in 1985 The model tambons will be used as a training sites for field experience as part of the training program content of the ATC and RTCs.

3. Documentation and Information

RTCs will be responsible for the following activitie

1) PHC data collection, analysis, compilation and documentation. Among the data to be available are data on trainers, workers, the percentage of PHC coverage by province within the corresponding region as well as information on PHC training, development models, and integrated rural development projects.
2) In connection with the ATC Documentation and Information, RTCs will serve as a focal point for information exchange between the central and the peripheral level
3) In connection with the community, RTC's will dissemminate PHC information through a number of approaches: i.e.distribution of newsletters, a/v presentations, periodic displays are exhibition, etc.
4) RTCs will maintaina small library to be utilized by trainers, trainees, PHC scholars,and researchers.

Organization of RTC



6. 我国の技術協力投入実績

(1) 調査団派遣

第1次予備調査　1981. 8. 3 ～ 8. 9

団長	(総括)	中沢幸一	国際協力事業団医療協力部長
団員	(公衆衛生)	橋本正己	国立公衆衛生院衛生行政学部長
	(技術協力)	平賀慶暉	外務省経済協力局技術協力第2課々長補佐
	(公衆衛生)	南沢孝夫	厚生省社会局老人保険課課長補佐
	(業務調整)	熊倉晃	国際協力事業団医療協力部医療協力課

第2次予備調査　1981. 11. 30 ～ 12. 11

団長	(総括)	橋本正己	国立公衆衛生院衛生行政学部長
団員	(公衆衛生)	平良専純	国際協力事業団医療協力部医療協力課長
	(疫学)	豊川裕之	東京大学医学部保健学科助教授
	(技術協力)	平賀慶暉	外務省経済協力局技術協力第2課課長補佐
	(〃)	宮内義	東京大学庶務部国際主幹
	(公衆衛生)	佐柳進	厚生省医務局国立病院課課長補佐
	(業務調整)	熊倉晃	国際協力事業団医療協力部医療協力課

事前調査　1982. 3. 16 ～ 3. 26

団長	(総括)	橋本正己	国立公衆衛生院衛生行政学部長
団員	(公衆衛生)	百井一郎	日本ツーリストクリニック院長
〃	(〃)	広田良夫	厚生省公衆衛生局難病対策課課長補佐
〃	(技術協力)	佐々木修	外務省経済協力局技術協力第2課
〃	(業務調整)	熊倉晃	JICA医療協力部医療協力課

(注) 上記5名の他に無償資金協力関連で，当事業団基本設計課の今津武及び石本建築事務所の藪前栄一の両名が参加した。

実施協議　1982. 9. 27 ～ 10. 7

団長	橋本正己	埼玉県立衛生短期大学学長
団員	小泉明	東京大学医学部公衆衛生学教授
〃	豊川裕之	東京大学医学部保健学科助教授
〃	橋爪章	厚生省児童家庭局母子衛生課主査
〃	岩本渉	文部省大学局医学教育課企画係長
〃	杉山長	外務省経済協力局技術協力2課
〃	近藤芳久	国際協力事業団医療協力部医療協力課参事

計　画　打　合　　1983. 10. 23 ～ 10. 29

団　長（総　　括）	橋　本　正　己	埼玉県立衛生短期大学長
団　員（疫　　学）	豊　川　裕　之	東京大学医学部助教授
〃　（公衆衛生）	松　本　信　雄	東京大学医学部助教授
〃　（技術協力）	谷　崎　奏　明	外務省経済協力局技術協力第２課首席事務官
〃　（業務調整）	近　藤　芳　久	国際協力事業団医療協力部医療協力課参事

(2) 研修員受入

氏名（研修科目）	来日時職位	受入期間
昭和57年度		
Prof. Natth Bhamarapravati （視察・協議）《高級》	Rector, Mahidol University	1982.7.18 ∿ 7.24
Dr. Pirote Ningsanonda （視察・協議）《高級》	Deputy Uncer-Secretary of State for Public Health Ministry of Public Health	1982.7.18 ∿ 7.24
Dr. Anong Nondasuta (PHC)	Faculty of Medicine, Ramathibodi Hospital, Mahidol University	1983.2.17 ∿ 3.23
Ms. Chandavimol Pisamai (PHC)	Policy and Planning Analyst, Health Planning Division, Ministry of Public Health	1983.2.17 ∿ 3.23
昭和58年度		
Dr. Anchern Israngkura Na Ayudhya （公衆衛生学）	Director of Training ATC/PHC, Associate Professor in Physiology, Faculty of Medicine, Siriraji Hospital, Mahidol University	1984.1.19 ∿ 2.18
Dr. Prakarsna Chaovanapricha （公衆衛生行政）	Khon Kaen Provincial Chief Medical Officer Ministry of Public Health	1984.1.19 ∿ 2.18
Dr. Pichit Skulbhram （PHC）	Associate Dean, Faculty of Public Health Mahidol University	1984.1.19 ∿ 2.18

Dr. Manoj Vamananda (PHC)	Chief of Supervisory Section, Primary Health Care Division Ministry of Public Health	1984.1.19 ∿ 2.18
Mr. Nopadol Klaikiew (視聴覚教育)	Chief of Audio Visual Education Section ATC/PHC	1984.1.19 ∿ 2.18
Dr. Pramukh Chandavimol (公衆衛生行政)《準高級》	Chief Meical Officer Department of Health, Ministry of Public Health	1984.11.29 ∿12.9
Dr. Paichit Pawabutr (公衆衛生行政)《準高級》	Chief Medical Officer, Office of Permanent Secretary, Ministry of Public Health	1984.11.29 ∿12.9
Dr. Orapin Singhadej (PHC 開発)	Director of Research Division, ATC/PHC, Associate Professor, Faculty of Public Health, Mahidol University	1984.11.29 ∿12.23
Ms. Chirapa Jieraphan (PHC 開発)	Training Office, ATC/PHC	1984.11.29 ∿12.23
Mr. Wirat Kamsrichan (視聴覚教育)	Audio Visual Officer, ATC/PHC	1985.2.21 ∿ 4.17

(3) 専門家派遣

昭和57年度

(公衆衛生学)	百井　一郎	1982. 11. 20 ～ 12. 14 1983. 3. 1 ～ 4. 4	元恩賜財団済生会理事
(〃)	松本　信雄	1983. 3. 23 ～ 4. 23	東京大学医学部公衆衛生学教室助教授

以下は国際セミナー出席のための専門家チーム

(公衆衛生学)	橋本　正己	1983. 3. 25 ～ 3. 30	埼玉県立衛生短期大学学長
(〃)	小泉　明	1983. 3. 27 ～ 3. 31	東京大学医学部公衆衛生学教授
(〃)	豊川　裕之	1983. 3. 24 ～ 3. 31	東京大学医学部疫学教室助教授
(医療協力)	太田　新生	1983. 3. 25 ～ 3. 31	(財)日本国際医療団専務理事
(技術協力)	長谷川正男	1983. 3. 27 ～ 3. 29	国際協力事業団理事
(〃)	近藤　芳久	1983. 3. 22 ～ 4. 5	国際協力事業団医療協力部医療協力課

昭和58年度

(業務調整)	長谷川　謙	1983. 6. 3 ～ 1986. 6. 2 (当初任期を1年延長)	国際協力事業団医療協力部
(衛生教育)	小林　基弘	1983. 8. 1 ～ 1985. 7. 31 (当初任期を1年延長)	神奈川県衛生部上足柄保健所主事
(公衆衛生学)	百井　一郎	1983. 6. 21 ～ 7. 24	元恩賜財団済生会理事
(視聴覚教育)	岩梨　一博	1984. 3. 30 ～ 4. 15	カメラのきむら

国際セミナー参加専門家チーム

石幡　輝保	1984. 3. 5 ～ 3. 10	川崎市川崎保健所長全国保健所長会副会長
小泉　明	1984. 3. 5 ～ 3. 10	東京大学医学部公衆衛生学教室教授
豊川　裕之	1984. 3. 5 ～ 3. 10	東京大学医学部疫学教室助教授
近藤　芳久	1984. 3. 5 ～ 3. 10	国際協力事業団医療協力部医療協力課

昭和59年度

(公衆衛生学)	岩村　昇	1984. 7. 5 ～ 7. 18	神戸大学医学部付属国際交流センター教授
(〃)	丸井　英二	1984. 7. 13 ～ 8. 12 1984. 12. 16～85. 1. 12	東京大学医学部疫学教室助手
(計画調整・公衆衛生学)	橋本　正己	1984. 9. 11 ～ 9. 15 1985. 2. 19 ～ 2. 21	埼玉県立衛生短期大学学長 (国際セミナー) 〃
(計画調整)	伊藤　清臣	1984. 9. 11 ～ 9. 15	国際協力事業団医療協力部医療協力課長
(チームリーダー，公衆衛生)	寺尾浩明	1984. 12. 3～1985. 12. 2	帝京大学医学部公衆衛生学科講師

(4) 機 材 供 与

昭和57年度　　C.I.F バンコック　¥22,257,471

番号	品名及び仕様	メーカー名	数量	単価	金額
1	OHP				
	オーバーヘッドHP-3000 220V	コルモ	2	107,350	214,700
	TPアートキット	〃	2	14,250	28,500
	ライティング ロールアタッチメント(ロールフイルム付)	〃	2	6,650	13,300
	ブランクシート250用100入	〃	4	3,325	13,300
	マーカー6色セット　油性	〃	4	855	3,420
	〃　〃　水性	〃	4	855	3,420
	スペアランプ220V-650W	〃	4	4,220	16,880
	ロールフィルム250用20m	〃	5	1,900	9,500
	紙枠　〃　50入	〃	5	3,800	19,000
2	トランスペアレンシー				
	サーモFAX-45型220V	住友3M	1	250,000	250,000
	TPフィルム174　100入	〃	5	13,900	69,500
	TPフィルムA4　100入	〃	5	14,500	72,500
3	スライドプロジェクター				
	AS-3000A 220V	エルモ	2	150,000	300,000
	オートキャリア　横型	〃	2	7,220	14,440
	〃　縦型	〃	2	7,220	14,440
	トレーⅡ型　直進	〃	10	1,425	14,250
	トレー　円型	〃	10	2850	28,500
	コンバージョンレンズ	〃	2	14,400	28,800
	予備ランプ24V-250W	〃	4	1,900	7,600
	キャリングケース	〃	2	11,400	22,800
4	スライドコーダー				
	801　220V	エルモ	2	93,100	186,200
5	ラジオカセットレコーダー				
	CFS-46S	ソニー	2	30,800	61,600
6	カメラ				
	F3　50mm F1.4W/C	ニコン	1	171,950	171,950
	スピードライトSB-12W/B	〃	1	21,000	21,000

番号	品名及び仕様	メーカー名	数量	単価	金額
	52m/m フィルター	ニコン	1	2,090	2,090
7	スクリーン				
	HW-2 125×125	エルモ	1	24,000	24,000
	HS-4 180×180	〃	1	43,000	43,000
8	16m/m 映写機				
	16CL-MO 220V	エルモ	1	300,200	300,200
	予備ランプ24V-250W	〃	2	3,990	7,980
	エキサイターランプ4V-0.75A	〃	2	1,045	2,090
9	アンプリファイアー				
	WA-740 トランス付	ナショナル	2	94,000	188,000
	マイクロフォンWM-363マイクW/スタンド	〃	2	23,000	46,000
	オーディオミキサー410Aトランス付	〃	2	57,000	114,000
10	ワイヤレスマイク				
	WM-200	東亜	2	24,800	49,600
	アンテナ YA402	〃	2	12,000	24,000
	ユニット式ワイヤレスチューナーWT-06	〃	2	118,500	237,000
	アンプ15×トランス付	〃	2	51,600	103,200
	スピーカーBS6/WT 固定金具付2個1組	〃	2	30,800	61,600
11	電動タイプライター				
	ET-221 5ケ国語メモリートランス付	オリベッティ	2	498,000	996,000
	カセットリボン6入	〃	4	8,500	34,000
	修正リボン 4入	〃	4	2,800	11,200
12	複写機				
	DT5700R	リコー	1	1,050,000	1,050,000
	トナー(タイプ1700)1本0.75ℓ 4入	〃	5	16,000	80,000
	現像液(〃)1本6ℓ3入	〃	15	12,000	180,000
	ペーパーA3 1250枚/箱	〃	5	5,950	29,750
	〃 B4 2500枚/箱	〃	10	6,350	63,500
	〃 A4 〃	〃	10	5,950	59,500
	〃 B5 〃	〃	5	4,500	22,500
	パーツセット(A3用)	〃	1	200,000	200,000
	テーブル(タイプE)	〃	1	40,000	40,000

番号	品名及び仕様	メーカー名	数量	単価	金額
13	謄写輪転機				
	RM−350	ウチダ	2	350,000	700,000
	インク黒	〃	30	1,200	36,000
	原紙　100入	〃	20	5,000	100,000
14	ミニテープレコーダー				
	WA-55	ソニー	2	40,000	80,000
	(AC-4A(JE)ACアダプター付)	〃			
15	関数電卓				
	FX-502P	カシオ	2	29,000	58,000
16	ポータブルデッキ(パル方式)				
	ビデオカセットCR4400	ビクター	2	812,500	1,625,000
	バッテリーパックPBP-1	日立	2	12,500	25,000
	ACアダプターAA-P44	ビクター	2	75,000	150,000
	ビデオテープKCS-20	日立	50	6,250	312,500
18	モニターテレビ				
	CMT-2060	日立	2	225,000	450,000
19	ビデオカメラ				
	FP-10	日立	1	1,025,000	1,025,000
	マイクロフォンMC-30B	〃	1	26,250	26,250
	バッテリィベルトPB-20A	〃	1	181250	181,250
	VTRケーブルC-501VB5m	〃	1	25,000	25,000
	バッテリィチャージャーBC-20B	〃	1	187,500	187,500
20	三脚				
	T−4D	日立	1	168,750	168,750
21	パーソナルコンピューター				
	CX−1型　トランス付	キャノン	1	1,600,000	1,600,000
	<プリンターPW-80, MP216(12ケース) PI-520(2ケース)>				
24	編集機				
	8200E	ビクター	1	1,506,440	1,506,440
	ケーブル含む エディティングコントローラーRM88	〃	1	625,000	625,000
	モニターテレビCMT2060	日立	1	225,000	225,000

番号	品名及び仕様	メーカー名	数量	単価	金額
26	カッター				
	G－100	ウチダ	1	108,500	108,500
	替刀	〃	2	27,000	54,000
	受木	〃	10	1,100	11,000
27	製本機				
	T－323（各2セット付表紙A4，B5）		1	470,000	470,000
29	オートプリンター				
	AP-2600	リコー	1	1,447,500	1,447,500
	製版機S－3	〃	1	980,000	980,000
	ファックスマスターLSサイズ(L)	〃	10	6,000	60,000
	〃 〃 〃 (S)	〃	10	3,600	36,000
	プリンターペーパー（100入）	〃	10	1,800	18,000
	現像剤（4ℓ）	〃	5	20,000	100,000
	トナー（1ℓ）	〃	3	20,000	60,000
	リムバー（500cc）	〃	5	1,500	7,500
	H液S－3用（4ℓ）	〃	2	14,000	28,000
	インキ（1kg）	〃	5	20,000	100,000
	クリーナーNA	〃	3	10,000	30,000
	H液ファックス	〃	2	14,000	28,000
	クリーナL1	〃	5	2,200	11,000
	ハンドクリーナ	〃	2	14,000	28,000
	ゴムローラーエッチングモルト ゴムブランケット下敷	〃	2	8,000	16,000
30	三菱フォルテ1600ピックアップ1ton積トラック右ハンドルAMラジオ，シガライター付				
	LO25PE型　FOB横浜		1輌		740,000
	三菱パジェロメタルトップディーゼル2,300右ハンドルエアコン，AMラジオ付				
	2043GVFD型　FOB横浜		1輌		1,660,000
31	オートバイ		2台		232,000

（昭和58年度に繰越実施分）ＣＩＦ　バンコク　　¥18,288,582

番号	品名及び仕様	メーカー名	数量	単価	金額
1	編集機	ビクター	1式		1,730,000
	モデル8200E				
	エディテングコントローラー	〃	1式		640,000
	モデルRM88				
	ケーブル含む				
	モニターテレビ	日立	1式		230,000
	モデルCMT−2060				
2	スライドプロジェクター	キャビン	2式	192,700	385,400
	サウンドキャビンSP				
	標準付属品一式				
	携帯ケース付				
	特別付属品				
	交換ランプ　10ケ				
3	オペークプロジェクター	ウチダ	1式		740,000
	教材提示装置CW−40				
	カラービデオカメラCV−590				
	クローズアップレンズP×58S#1				
4	ラジオカセット	ソニー	2台	70,500	141,000
	モデルCFS88S				
5	スクリーン	エルモ			
	モデルHW−2　125×125cm		1式		24,000
	モデルHS−4　180×180cm		1式		42,000
6	16mm映写機	エルモ	1式		308,500
	モデル　16CL−MO				
	守備ランプ　24V　250W		2ケ	4,100	8,200
	エキサイターランプ　4V　0.75A		2ケ	1,050	2,100
7	電動タイプライター	オリベッティ	2台	410,000	820,000
	モデルET−225 下記付属品付				
	コレクションリボン		10ケース	8,800	88,000
	リフトオフリボン		4　〃	2,975	11,900
	タイプスタンド		2台	18,450	36,900

番号	品名及び仕様	メーカー名	数量	単価	金額
8	オートバイク モデルC-50　排気量50cc	ホンダ	2式	131,000	262,000
9	NISSAN CIVILIAN STANDARD BODY HIGHROOF ED33 ENGING MODEL：MW40CSFHU with 26-seaters,Air- Conditioner, AM Radio,	日産自動車㈱	2units	3,022,000	6,044,000
10	NISSAN PATROL STATION WAGON P-40 ENGINE MODEL：WG160GFUC with Air-Conditioner, AM Radio,Mud & Snow Tyres, Clock,Fender Mirrors, ACCESSORIES： STANDARD SPARE TYRE 1pc./UNIT TOOLS & JACK	日産自動車㈱	2units	1,705,500	3,411,000

番号	書　　名	数　量	単　価	金　額
1.	Leaveil.- Preventive medicine for the Doctor in His community: An epidemic approach. '79 (Krieger)	3 vols.	1 ,600.-	¥31,800.-
2.	Nichols, P.J.R.- Rehabilitation Medicine: The management of physical disabilities. (Butterworth)	2 "	15,980.-	31,960.-
3.	Barber, J.H.- Towards Team care. (Churchill Livingstone)	2 "	3,080.-	6,160.-
4.	Carr, P.J.- Community Psychiatric Nursing: Caring for the mentally ill and handicapped in the community. (Churchill Livingstone)	3 "	12,670.-	38,010.-
5.	Jansen, E.- The Therapeutic Community: Outside the hospital. (Croom Helm)	3 "	4,510.-	13,530.-
6.	Wing, J.K.- Community Care for the mentally Disabled. (Oxford U.P.)	2 "	13,000.-	26,000.-
8.	Abramson, J.H.- Survey Methods in Community Medicine: An introduction to epidemiological and evaluative studies. (Churchill Livingstone)	3 "	4,060.-	12,180.-
9.	Alderson, M.- An Introduction to Epidemiology.	3 "	3,860.-	11,580.-
10.	Barmer, D.J.P.- Epidemiology in Medical Practice. (Churchill Livingstone)	3 "	2,920.-	8,760.-
12.	Knox, B.G. (ed.)- Epidemiology in Health Care Planning: A guide to the uses of a scientific method. (Oxford O.P.)	3 "	6,500.-	19,500.-
13.	Langman, M.J.S.- The Epidemiology of Chronic Digestive Disease. (Edward Arnold)	2 "	9,100.-	18,200.-

番号	書　　名	数　量	単　価	金　額
15.	Irwin, V.L.- Basic Health Education (Longman)	3 vols.	4,030.-	¥12,090.-
16.	Sutherland, I. (ed.)- Health Education: Perspectives and Choices. (Allen & Unwin)	3 "	9,750.-	29,250.-
17.	Fry, J. (ed.)- Primary Care. (Heineman Medical)	3 "	13,000.-	39,000.-
18.	Wynn, M.- Prevention of Handicap and the Health of Women. (Routledge)	2 "	6,980.-	13,960.-
19.	Duffus, J.H.- Environmental Toxicology. (Edward Arnold)	2 "	3,230.-	6,460.-
20.	Bennett, F.J.- Community Diagnosis and Health Action: A manual for tropical and rural area. (Macmillan Press)	3	4,510.-	13,530.-
21.	Dunn, P.D.- Appropriate Technology: Technology with a human face. (Macmillan Press)	3 "	3,210.-	9,630.-
22.	Christie, A.B.- Infectious Diseases: Epidemiology and Clinical. (Churchil Livingstone)	3 "	29,250.-	87,750.-
23.	Clark, C.C.- Enhancing Wellness '81 (Springer Pub. Co.)	2 "	10,780.-	21,560.-
24.	Caplan, A.L.- Concept of Health and Disease. '81 (Addison-Wesley)	3 "	16,200.-	48,600.-
25.	Harvey, A. Mc.- Research and Discovery in Medicine. '81 (John Hopkin Univ. Press)	3 "	11,000.-	33,000.-
26.	Leathor, D.S. Health Education and the Media. '81 (Pergamon Press)	3 "	36,000.-	108,000.-

番号	書　　名	数　量	単　価	金　額
27.	World Conference on Medical Information. 35d. 1980. (North-Holland Pub.)	1 vol.		¥72,000.-
28.	Medley, E.S.- Common Health Problems in Medical Practice. '82 (William & Wilkins)	3 vols.	10,000.-	30,000.-
29.	Winefield, H.R.- Behavioral Science in Medicine. '80 (Univ. Park Press)	2 vols.	7,980.-	15,960.-
30.	Craig, R.J.- Drug Dependent Patients Treatment and Research. '81 (C.C. Thomas)	2 "	15,500.-	31,000.-
31.	Gogoll, A.H.- Primary Care Medicine. '81 (Lippincott)	3 "	15,800.-	47,400.-
32.	Smitherman, C.- Nursing Actions for Health Promotion. '81 (Davis Co.)	3 "	5,580.-	16,740.-
33.	Jarvis, L.L.- Community Health Nursing. (Davis Co.)	3 "	9,180.-	27,540.-
34.	Grant, M.- Handbook of Community Healthy. 3rd od. '81 (Les & Febiger)	3 "	4,800.-	14,400.-
35.	Dupont, H.L.- Travel with Health. '82 (Appleton Gentury Crafts)	2 "	5,580.-	11,160.-
36.	Foder, J.T.- Health Instruction. 3rd ed. '81 (Lea & Febiger)	2 "	3,900.-	7,800.-
37.	Anderson, S.V.D., et al.- Chronic Health Promblems. '81 (Mosby)	3 "	7,180.-	21,540.-
38.	Edward, B.R.- Biomedical Innovation. '82 (MIT Press)	3 "	14,000.-	42,000.-

番号	書　　名	数　量	単　価	金　額
40.	Schottenfeld, D.- Cancer Epidemiology and Prevention. '81 (Saunder)	3 vols.	39,200.-	¥117,600.-
41.	Attkinsson.- Evaluation Human Service Programs. '78 (Academic Press)	2 "	15,600.-	31,200.-
43.	Bennett, C.A.- Evaluation and Experiment: Some critical issues in assessing social problems. '75 (Academic Press)	2 "	19,000.-	38,000.-
44.	Berkowitz, L.- Group Processes. Papers from Advances in Experimental Social Psychology. '78 (Academic Press)	2 "	9,000.-	18,000.-
45.	Foster.- Long-term Field Research in Social Anthroplogy. '78 (Academic Press)	2 "	15,800.-	31,600.-
46.	Van, D.- The Eco System Concept in Natural Resource Management. '69 (Academic Press)	2 "	17,400.-	34,800.-
47.	Purdom, P.W.- Environmental Health. 2nd ed. '78 (Academic Press)	2 "	14,000.-	28,000.-
48.	Perring, M.- Ecological Effects of Pesticides. '77 (Academic Press)	2 "	15,800.-	31,600.-
49.	Lee, D.H.K.- Environmental Factors in Respiratory Disease. '72 (Academic Press)	2 "	15,800.-	31,600.-
50.	Lee, D.H.K.- Metallic Contaminants and Human Health. '77 (Academic Press)	2 "	15,800.-	31,600.-
51.	Chai, W.A.- Programming Standard COBOL. '76 (Academic Press)	2 "	7,500.-	15,000.-

番号	書　　名	数　量	単　価	金　額
52	Tsichritzic, D.C.- Data Base Management. '77 (Academic Press)	2 vols.	10,000.-	¥20,000.-
53.	Stanley, N.F.- Changing Disease Patterns and Human Behavior. '81 (Academic Press)	2 "	39,400.-	78,800.-
54.	Barna, A.- Introduction to Microcomputers and Microprocessors. '76 (John Wiley)	2 "	7,980.-	15,960.-
55.	Barnett, E.H.- Programming Time-Shared of Computer in Basic. '72 (John Wiley)	2 "	11,180.-	22,360.-
56.	Bibbero, R.J.- Microprocessors in Instrument and Control. '77 (John Wiley)	2 "	11,180.-	22,360.-
57.	Moulton, P.- Foundations of Programming Trough BASIC. 1079 (Wiley)	2 "	8,380.-	16,760.-
58.	Mullish, H.- A Basic Approach to Structured BASIC. '76 (Wiley)	2 "	7,180.-	14,360.-
59.	Stern, N.B.- Structured COBOL Programming. 2nd ed. '75 (Wiley)	2 "	10,380.-	20,760.-
60.	Chassan, J.B.- Research Design in Clinical Psychology and Psychiatry. 2nd ed. '78 (Wiley)	2 "	7,800.-	15,600.-
61.	Waterson, N.- The Development of Communication. '78 (Wiley)	3 "	25,980.-	77,940.-
62.	Hobbs, D.A.- Sociology and the Human Experience. 2nd ed. '78 (Wiley)	2 "	6,780.-	13,560.-
63.	Hayes, R.M.- Handbook of Data Processing for Libraries. 2nd ed. '74 (Wiley)	2 "	21,980.-	43,960.-

番号	書　　名	数　量	単　価	金　額
65.	Ashley, R.- ANS COBOL '4 (Wiley)	2 vols.	3,800.-	¥7,600.-
66.	Williamson, Y.M.- Research Methodology and It's Application to Nursing. '81 (Wiley)	2 "	7,800.-	15,600.-
67.	Kendall, P.C.- Handbook of Research Methods, in Clinical Psychology. '82 (Wiley)	2 "	22,000.-	44,000.-
69.	Johnson, F.N.- Clinical Trial. '77 (Blackwell Scientific Publication Ltd.)	2 "	8,930.-	17,860.-
70.	Alexander,- Natural Selection and Social Behavior: Recent Research and New Thoory. '80 (Blackwell Scientific Publication Ltd.)	2 "	22,750.-	45,500.-
72.	Anderson, F.- Practical Management of the Elderly. '76 (Blackwell Scientific Pub.)	2 "	6,855.-	13,710.-
74.	Armitage, P.- Sequential Medical Trial. 2nd ed. '75 (Blackwell Scientific Pub.)			
75.	Armitage, P.- Statistical Methods in Medical Research. '71 (Blackwell Scientific Pub.)	3 "	4,760.-	14,280.-
77.	Rubenstein, D.- Multiple Choice Questions on Lecture Notes on Clinical Medicine. '78 (C.V. Mosby)	2 "	1,395.-	2,790.-
78.	Sommer, A.- Nutrition Blindness. '82 (Oxford Univ. Press)	3 "	7,620.-	22,860.-
79.	Kaplan, F.M.- Encyclopedia of China Today. '79 (Macmillan Press, UK)	2 "	5,690.-	11,380.-

番号	書　　名	数　量	単　価	金　額
80.	Webb. C.- Communication Skills, Take Yourself into a Job. '79 (Macmillan Press, UK)	2 vols.	1,120.-	¥2,240.-
81.	Bentley, T.J.- Making Information System Work. '79 (Macmillan Press, UK)	2 "	7,620.-	15,240.-
82.	Barnds, W.J.- Japan and the United States Challenges and Opportunities. '79 (Macmillan Press, UK)	2 "	4,570.-	9,140.-
83.	Whsley, R.F.- Health. '82 (Prentice Hall)	3 "	3,970.-	11,910.-
84.	Bedwarth, A.E.- Health for Human Effective. '82 (Prentice Hall)	2 "	6,785.-	13,570.-
85.	Kratz, C.R.- The Care of the Long-Term Sick in the Community. '78 (Churchill Livingstone)	3 "	2,180.-	6,540.-
86.	Grant, C.- Hospital Management. '72 (Churchill Livingstone)	3 "	2,760.-	8,280.-
87.	Petrio, J.C.- The Problem Oriented Medical Record. '79 (Churchill Livingstone)	2 "	3,430.-	6,860.-
88.	Roper, N.- Element of Nursing. '80 (Churchil Livingstone)	3 "	6,660.-	19,980.-
90.	Medical Dictionary. end ed. (Butterworths)	3 "	27,000.-	81,000.-
92.	Schilling, R.S.F.- Coccupational Health Practice. 2nd ed. '81 (Butterworths)	3 "	11,480.-	34,440.-

番号	書　　名	数　量	単　価	金　額
93.	Glew, G.- Multiple Choice Questions in Psychiatry. '81 (Butterworths)	2 vols.	2,565.-	¥5,130.-
94.	Tuma, M.- Handbook for the Practice of Pediatric Psychology. '82 (John Wiley & Sons Inc.)	3 "	9,409.-	28,227.-

昭和58年度　　CIFバンコック　¥5,291,000

（59年度に繰越実施分）

番号	品名及び仕様	メーカー名	数量	単価	金額
1	パーソナルコンピューター（本体） （220V 50Hz）	キャノン AS-100M	1台		450,000
	キーボード	A－1111	1ケ		45,000
	フロッピーディスク	A－1300	1台		300,000
	ドットインパクトプリンター	A－1200	1台		130,000
	オプショナルメモリーボード	A－1020	1台		60,000
	オペレーションシステム（解説明書付）	CP/M	1セット		40,000
	〃　〃	MS-DOS	1　〃		40,000
	ソフトウェア		一式		250,000
	キャノンBASIC				
	G　W　BASIC				
	英文ワードプロセッサー				
	簡易言語				
	フロッピー		1ケース		25,000
	インクリボン		1　〃		1,500
	用　紙		2　〃	8,000	16,000
2	ポータブルカメラ	FP－15B	一式		1,100,000
	ACアダプタ				
	レンズケーブル付				
	チャージャーAB－61				
3	複写機（220V 50Hz）	リコー FT4060	1台		928,000
	複写機台		1台		50,000
	現像剤		1袋		86,000
	トナー　250g		4本	6,000	24,000
	シリコンオイル		1本		4,000
	用　紙　A3		2ケース	5250	10,500
	〃　A4		4　〃	5,250	21,000
	〃　B4		4　〃	7,000	28,000
	〃　B5		4　〃	4,500	18,000
	パーツセット		一式		45,000

番号	品名及び仕様	メーカー名	数量	単価	金額
4	カメラ 1.4 レンズケースフイルターフラッシュ付	ニコンF3	一式		210,000
5	ビデオモニター	VM-906B	1台		60,000
6	ステンシルカッター（220V 50Hz）	ES-1000S	1台		330,000
	光源ランプ		10ケ	600	6,000
	記録計　20本入		5ケース	1,490	7,450
	原稿押フィルム		1束		7,000
	原稿台紙		1束		4,000
	集塵フィルター		1束		2,000
	原紙		3束	10,000	30,000
7	ワイヤーレスマイク	AIWA WM-240	2ケ	3,800	7,600
8	カセットイレーサー	BE－9H	1ケ		7,000
9	フィルムドライヤー（220V）		1ケ		150,000
13	メスカップ	LPL	1セット		550
14	電動タイマー　ハンザ		2ケ	11,600	23,200
15	タイマー　（220V　50Hz）		1ケ		14,600
16	計算機　（220V　50Hz）	キャノン P－1230	4台	70,000	280,000
	ロールペーパー（5巻入）		8本	750	6,000
17	工具セット	S－10	2セット	9,800	19,600
18	マイクロフォン	ECM-150T	6本	15,000	90,000
19	ラッセル（イーゼルマスク）		1セット		7,000
20	カッター用マット　90×60		3枚	7,000	21,000
21	カッター（裁断幅1000m／m）		1台		

昭和59年度　　ＣＩＦ　　¥ 21,117,392

番号	品名及び仕様	メーカー名	数量	単価	金額
1	綴機 丸山式 種突下　21 ～ 22　　3組 23 ～ 28　　5〃 ツブシ蝶々　　3〃 クラッチスプリング　　10本 イチョウ型柳スプリング　30本 小ネジ　　1式 ワイヤー (21, 23, 25) 各2 kg 1式	徳河文具店	1式		1,310,000
2	裁断機 イトー　100SD 最大断裁巾　1,016mm 〃　高さ　145mm 〃　奥行　1,016mm 包丁　SKH-2　　2枚 定木　　5本 工具・給油セット　1式	徳河文具店	1式		6,887,000
3	製版機 大日本スクリーン　C−660−C コンパニカ660 （オンライン濃度計DM310含む） 撮影サイズ 線画最大　51×61 cm 網かけ最大　51×61 cm 自動露光制御 スケールフィーカシング 標準レンズ倍率 f = 260mm　(1／2～2倍) f = 150mm　(1／5～5倍) 標準付属品一式	カメラのきむら	1式		2,667,600

番号	品名及び仕様	メーカー名	数量	単価	金額
	特別付属品				
	反射用ハロゲンランプ 100V 500W		4ケ		
	透過用螢光灯 100V 20W		6ケ		
	フラッシュ露光用タングステン				
	ランプ 5W		1ケ		
	フジ製版フィルム				
	ネガ 10″×12″ 100枚入4箱				
	ポジ 〃 〃 4〃				
	コンタクトスクリーン				
	ND 85 1台				
	ND 100 1〃				
	ND 120 1〃				
	現像液 5ケ				
4	簡易製版機	カメラのきむら	1式		96,600
	コダック P−112				
	ヒーター付				
5	真空焼付機	カメラのきむら	1式		1,473,000
	大日本スクリーン P−703DL				
	刷版，フィルム兼用				
	焼付有効サイズ 65×55cm				
	専用キャビネット含む				
	特別付属品				
	積算光量計 L1−100 1台				
	メタルハライドランプ 1ケ				
	Gマーク750				
	タングステンランプ 1ケ				
	6V 20W				
	安全灯 黄色4W 1ケ				
	赤色5W 2〃				
6	ポータブルビデオセット（ビクター）	カメラのきむら			
	1）ポータブルVTR HR−2650EG		1台		178,800
	2）チューナー TU−26EG		1〃		76,100

番号	品名及び仕様	メーカー名	数量	単価	金額
	3）アダプター　AA-P26EG		1台		11,300
	4）バッテリー　NB-P1		1〃		7,200
	5）ビデオカメラ　GZ-S3E		1〃		226,200
	6）カメラケース　CB-P4U		1ケ		7,200
	7）非指向性マイク（ソニー）F-115A		1式		29,200
	8）マイク用プラグアダプター（ソニー付）PCI-M				
	9）延長ケーブル　VC-235-10U		1本		7,200
	10）VTRキャリングケース　CB-P26		1ケ		10,300
7	オートバイ C-90型（青色） 86cc 4ストローク単気筒　3速	ホンダ	6台	151,100	906,600
8	フジマイクル1200用ケミカル マイクルキット　F-4 フィルム　4本入	カメラのきむら	5式	20,680	103,400
9	フジNewリーダープリンター用フィルム 257×150m　2本入	カメラのきむら	5箱	12,340	61,700
	フジFMRP30Au用ペーパー 297×150m　2本入		5箱	14,600	73,000
10	現像液　トナー60g　10本入	〃	5箱	14,400	72,000
11	パナコピーKV-500用フイルム KV-50FM	〃	5ケ	21,600	108,000
12	パナコピーKV-500用現像液KV-50TK		5〃	9,260	46,300
13	パナコピーKV-500用定着剤KV-10XE	〃	5〃	2,060	10,300
14	住友3M　45用フィルム	〃			
	T-174		5〃	15,000	75,000
	T-389		5〃	15,940	79,700
15	スペアランプ	〃			
	エルモ16mm　LX-1100用		1〃		99,700
	〃　〃　LX-2200用		1〃		129,800
	〃　AS-3000用　24V　250W		1〃		2,230
	〃　16mmクセノン250W		1〃		34,950
	〃　スライドXS-55用		1〃		59,620

③ 書　籍

10.	Davis, G.B.- Management Information Systems. '74 (McGraw-Hill)		15,730.-
12.	Schroeder, R.- Operations Management. '81 (McGraw-Hill)		13,0390.-
13.	Hicks, H.G.- Organizations: Theory & Behavior. '75 (McGraw-Hill)		12,710.-
14.	Hicks, H.G.- The Managment. 4th ed. '81 (McGraow-Hill)		15,970.-
15.	Likert, R.- The Human Organization: It's management value. '67 (McGraw-Hill)		14,380.-
16.	Fox, J.- Primary Health Care for the Young. '80 (McGraw-Hill)		16,630.-
20.	Pritchard, P.- Manual of Primary Health Care. 2nd ed. '82 (Oxford U.P.)		4,770.-
28.	Drummond, M.F.- Principles of Economic Appraisal in Health Care. '80 (Oxford U.P.)		4,500.-
29.	Coombs, P.H.- Meeting the Basic Needs of the Rural Poor. '80 (Pergamon Pr.)		24,300.-
30.	United Nations.- Popular Participation in Decision Making for Development. '75 (U.N.)		2,250.-
32.	Barker, D.J.- Practical Epidemiology, Medicine in the Tropics. '82 (Churchill-Livingstone)		6,680.-
34.	McLaren, D.S.- Nutrition in the Community. '83 (Wiley)		24,730.-
35.	Britanica, Encyclopedia. Brown ed.	(set)	262,000.-
40.	Brocklehurst, J.C.- Progress in Geriatric Day Care. (Oxyford U.P.)		5,400.-
41.	Milliken, M.E.- Understanding Human Behavior. 3rd ed. '81 (Delmer)		6,300.-
42.	Lansky,- Succhessfull Dieting Tips. '81 (Meadowbrook)		2,230.-
47.	Wood, C.- Health Policies in Developing Countries. (Grune)		12,380.-
50.	Bronfen,- Nutrition for a Better Life. '80 (Capra Pr.)		4,030.-

53.	Potts, M.- Society and Fertility. '79 (Macdonald & Evans)	5,970.-
56.	Strubs, G.- A Woman's Health. '80 (Croom Helm)	6,900.-
57.	Chang, R.S.- Preventive Health Care. '81 (G.K. Hall)	15,750.-
62.	Pilsworth, R.- The Control and Management of Communicable Disease: A short guide for nurses, doctors and environmental health officers: Lewis. '80 (H.R. Lewis)	3,300.-
65.	Gchlbach, S.H.- Interpreting the Medical Literature. '82 (Health)	5,830.-
66.	Slome, et al.- Basic Epidemiological Method and Biostatistics. '82 (Brooks-Cole)	8,890.-
67.	Lenihan, J.-Environment and Man. '85 (Academic Pr.)	
	Vol. I.	17,550.-
	Vol. II.	15,750.-
	Vol. III.	17,550.-
68.	Cairncross,- Evaluation for Village Water Supply Planning. '80 (Wiley)	17,710.-
72.	Stanley, N.H.- Changing Disease Patterns and Human Behavior. '81 (Academic Pr.)	44,320.-
75.	Stern, N.B.- Structured Cobol Programming, 3rd ed. '80 (Wiley)	12,580.-
84.	Davidson, P.O.- Behavioral Medicine Chaning Health Lifestyle. '79 (Brunner Mazel)	11,250.-
87.	Davies, J.B.- Community Health, Perventive Medicine and Social Services. 5th ed. '83 (Saunders)	6,730.-
91.	Barten,- Progress in Community Mental Health. Vol. II. '75 (Grune)	17,550.-
93.	Barger, M.- Working with People Called Patients. '77 (Brunner-Mazel)	5,380.-
94.	Brown, W.- Psychological Care during Pregnancy and the Postpartum Period. '79 (Raven Pr.)	9,680.-
98.	Horton, P.B.- Sociology. 6th ed. '84 (McGraw-Hill)	11,230.-

100.	Labovitz, S.I.- Introduction to Social Research. '81 (McGraw-Hill)	6,280.-
101.	Deikelmann, N.- Primary Health Care of the Well Adult. '77 (McGraw-Hill)	7,630.-
103.	Miller,- Family Focussed Care. '80 (McGraw-Hill)	9,880.-
104.	Scheider, W.L.- Nutrition: Basic Concepts & Application. '82 (McGraw-Hill)	8,980.-
105.	Becker, H.B.- Information Integrity: A structure for its definition management. (McGraw-Hill)	12,130.-
107.	Blakiston,- Blakiston's Gould Medical Dictionary. '79 (McGraw-Hill)	15,750.-
109.	Johns, E.B.- Health for Effective Living. '75 (McGraw-Hill)	11,250.-
115.	Hoffman, N.S.- A New World of Health. '75 (McGraw-Hill)	10,350.-
119.	The New Oxford Illustrated Dictionary.	30,000.-
120.	Webster's New Colligiate Dictionary. (4,900.- x 2 sets)	9,800.-
125.	Michaels, D.- Diagnostic Procedures: The Patient and the Health Care Term. '83 (Wiley)	8,080.-
129.	Milio, N.- The Care of Health in Communities: Access for outcasts. (Macmillan)	9,430.-
131.	Mechanic, P.- Medical Sociology: Second ed., The Free Press. (Collier Macmillan)	9,880.-
132.	Hammond, P.B.- An Introduction to Cultural & Social Authropology. 2nd ed. (Macmillan)	13,480.-
135.	Mechaic, D.- Handbook of Health, Health Care, and the Health Professions. (Free Pr.)	22,480.-
136.	Fischer, R.A.- Statistical Methods for Research Workers: 14th/E, CMI. (Hafner)	8,980.-
138.	Wood, C.-Human Health and Environmental Toxicants. (Grune)	17,780.-

139.	Miler, B.F. & Keane,- Encyclopedia and Directionary of Medicine, Nursing and Allied Health, 3rd ed. (Saunders)		10,780.-
143.	Gray, J.A. & Fowler,- Essentials of Preventive Medicine. '83 (Blackwell Sci.)		5,100.-
144.	Baker, A.A.- Comprehensive Psychiatric Care. '76 (Blackwell Sci.)		7,500.-
146.	Busvine, J.R.- Insects and Hygiene, Third ed. '83 (Methuen)		7,950.-
147.	Cooper, J.I.- Viruses and the Environment. '83 (Methuen)		9,000.-
148.	Hobson, W.- The Theory and Practice of Public Health, 5/E. '79 (Oxford U.P.)	(42,000.- x 2 sets)	84,000.-
149.	Pritchard, P.- Manual of Primary Health Care, 2nd ed. '81 (Oxford U.P.)		5,370.-
150.	Williams, C.D.- Mother and Child Health. '72 (Oxford U.P.)		6,000.-
151.	Hornby,- Guidelines for Health Manpower Planning: A course book. (W.H.O.)	(5,200.- x 3 sets)	15,600.-
162.	Personnel for Health Care: Case studies of educational programmes. Vol. 2. (W.H.O.)	(2,800.- x 3 sets)	8,400.-
164.	Educational Handbook for Health Personnel, Revised ed. by Guilberg. '81 (W.H.O.)	(5,600.- x 3 sets)	16,800.-
165.	Guidelines for Training Community Health Workers in Nutrition. '81 (W.H.O.)		2,400.-
166.	Fulop,- International Development of Health Manpower Policy. '82 (W.H.O.)	(3,000.- x 3 sets)	9,000.-
175.	Hardy, M.E.- Role Theory: Perspectives for health professionals. (A.-C.-C.)		7,880.-

(5) ローカルコスト負担

	技術者養成対策費	プロジェクト運営費		合　　計
		研　　究	モデル開　発	
昭和 57 年度	26,905,920 円	0	0	26,905,920 円
昭和 58 年度	25,868,510 円	6,607,000 円 (11,376,000)	0	32,475,510 円 (11,376,000)
昭和 59 年度	31,006,100 円	10,415,000 円 (3,635,000)	2,387,000 円	43,808,100 円 (3,650,000)

注：カッコ（　）内の金額は，前年度に実施を計画したがタイ側の事業進捗の遅れのため当該年度に支出したもの。従ってこの金額を上段の額に加えたものが当該年度の支出総額である。

(6) プロジェクト投入実績表

	昭和 56 年度	昭和 57 年度	昭和 58 年度	昭和 59 年度
調査団派遣	第一次予備調査団 第二次予備調査団 事前調査団	実施協議調査団 基本設計調査団 （無償資金協力）	計画打合せ調査団	巡回指導調査団
専門家派遣（新規）		9 人（4.5MM）	8 人（20.5MM）	7 人（3.1MM）
MAN・MONTH		6.3	長谷川　（業務調整）	～ 60. 6. 2
長期専門家		8.1	小林基弘（衛生教育） 寺尾浩明（リーダー，公衆衛生）	～ 60. 7. 31 12. 3.～ 60. 12. 3
研修員受入	0 人	4 人（3MM）	5 人（5MM）	5 人（5MM）
携行機材	0	0	3,841,058 円	5,826,660 円
機材供与		22,257,471 円	0	21,117,392 円
（）内繰越分			(18,288,582)	(5,291,000)
ローカルコスト負担	0	26,905,920 円	43,851,510 円	47,458,100 円
支出額		（概算）		
(1)センター協力費	8,792,979 円	56,000,000 円	97,092,488 円	
(2)保健医療協力費	0 円	0 円	476,480 円	
(3)開発調査費	1,844,783 円	26,173,529 円	0 円	0 円
(4)研修員受入事業費	0	（概算） 3,000,000 円	（概算） 4,500,000 円	（概算） 4,500,000 円
(1)＋(2)＋(3)＋(4)	10,637,762	85,173,529	102,068,968	

注　1）プロジェクトに関する支出予算は以下のとおり

(1)　センター協力費：技術協力に係る調査団の派遣，専門家派遣，機材供与，ローカルコスト負担の経費

(2)　保健医療協力費：学術情報サービス，チームリーダー会議に係る経費

(3)　開発調査費：無償資金協力のための調査に必要な経費

(4)　研修員受入事業費：カウンターパートの受入に必要な経費

Ⅲ　調査団派遣後のプロジェクトの動き

昭和 59 年 11 月　Mahidol 大学学長 Dr. Natth と ATC 所長 Dr. Krasae が来日。国内委員，関係者とモデル開発その他について協議。タイ側からモデル開発を効果的に実施するための Gradnate Health Voluntffr (GHV) 訓練の要請あり。医療協力部長と Dr. Natth との懇談ではローカルコストの支出・精算について JICA より申し入れを行う。（別紙(1)参照）

昭和 59 年 12 月　順天堂大学医学部公衆衛生学教室講師寺尾浩明専門家（リーダー，公衆衛生学）を１年間の予定で派遣。

昭和 60 年２月　第３回国際セミナー開催。期間中の２月 20 日に ATC／PHC 開所式がタイ国皇太子 Preeda Patanathabutr 殿下を迎えて行われる。
（別紙(2)橋本委員長報告書）

別紙

医療協力部長からNatth学長への申入れ事項

26.11.84

DR. Y. HASEGAWA
JICA/HQ. TOKYO

NOTES TO PROFESSOR NATTH BHAMARAPRATI

1. The provisions mentioned under section V (Provision of Special Measures) of the R/D are special arrangements only for the Thai PHC Project and are not given to other project-type cooperation programmes.

2. The JICA's accounting rules and procedures are also applied to the expenditures of the above-mentioned provisions.

3. Only a part of expenditures are borne by JICA as mentioned in section V of R/D.

4. The JICA's budget cycle is one single year (from April to next March) and the annual budget becomes effective on 1 April every year. The accounts of the local costs have to be settled at the end of March every year. It is not possible to carry them over to the next fiscal year.

5. In order to secure a necessary budget or to be able to increase it, it is essential for us to convince the Finance and Accounting Department of JICA as to how efficiently and usefully the appropriated budget has been spent.

6. Unless the Thai side provides us with necessary materials concerning the expenditures of the local costs, we are unable to convince our Finance and Accounting Department, which might lead to the decrease in the budget for the next fiscal year.

7. In order to be successful in getting a budget for new proposals, it is indispensable for us to submit to the Finance and Accounting Department a very detailed explanation of the proposals together with solid budget estimates calculated on the basis of the unit costs of all items to be used.

8. As regards the development of PHC models, the JICA office or the Coordinator of the Project will disburse the necessary costs within the appropriated budget, without being subjected to the accounting procedures of the Mahidol University.

   At the end of the fiscal year, the accounts have to be settled with the relevant vouchers.

9. JICA can bear the local costs only in such a way as mentioned above, that is, the direct payment from the JICA Office or the Coordinator.

10. If the both sides agree on the budgetary items and unit costs in the beginning, the way of the disbursements as mentioned in 7 above is a simple procedure, which does not at all imply any control of the Project by JICA.

11. In the case of the JICA's other projects in Thailand such as the projects on the nursing education and the family planning, where a much more limited amount of local costs are provided, JICA disburses the costs directly, without transferring them to the accounts of the Thai Ministry of Health.

12. If the above-mentioned procedures are taken, there is a good chance that the local costs for the next year may be increased.

BUDGET FOR DEVELOPMENT
OF PHC MODELS (draft)

1. Personnel

Typists	฿ 2500	x	months
Interviewers	฿	x	days

2. Expendable equipment

Stationery and other consumable goods.

The non-expendable equipment has to be bought by the "Equipment Budget".

3. Travel

a. Transportation

Gasoline ฿ / litre x km/5km

b. Daily allowance, accommodation costs, etc.

	Daily allowance	Accommodation costs
ATC staff	฿ 150.-	฿ 250.-
Drivers	฿ 100.-	฿ 150.-

4. Printing

Costs for printing and book-binding of materials for workshops, conferences, etc.

Costs for translation.

5. Costs which JICA cannot bear

* Revoluing funds ; because of JICA's rules and regulations.
* Training costs for recent graduate volunteers cannot be borne by the budget for the Model Development. These may be met from the travel allowance and stipend for trainees under section V of R/D.

別紙(2)　報告書

ＪＩＣＡ（ＡＴＣ／ＰＨＣ）短期専門家
橋　本　正　己

1. 旅行の目的及び日程

第３回ASEAN International Consultative Meeting における基調講演及びASEAN・PHC・Training Centre の開所式に出席のため，1985年２月19日（火）より同21日（木）までBangkokに赴いた。

2. スケジュール及び業務の概要（別紙1.参照）

２月19日（火）：TG741にて1750成田発2230 Bangkok着。（当初CX703 の予定であったが，都合によりTG741に変更）長谷川調整員，寺尾，小林専門家の出迎えを受け，Siam Inter-Continental Hotelに投宿。（時間の関係で前記Consnltatiue Meeting の Reception は欠席）

２月20日（水）：0830-0930 ATC／PHCにおいて開催中の第３回ASEAN International Consultatiue Meeting on the Role of Hospitals in Primary Health Care Development に出席，Special key Note Address として，“Hospitals and PHC Development”を行う。

0930-1200：同上セミナーにおいて，返題講演２題を聴く。

1200-1500：昼食の後，寺尾，小林専門家及び長谷川調整員と打合せを行い，また本プロジェクトModel Development（Chanthaburi province）のタイ側担当者Dr.Som Archによる Chanthaburi の実地調査状況及び今後の研究実施プランについて，説明を受け意見交換，指導を行った。

1530-1730：ATC／PHC大講堂における Royal Inauguration Ceremony（出席者約200名）に出席，His Royal Highness Crown Prince Maha Vajiralongkon に拝謁ATC／PHC 記念章を授与される。（式次第は別紙２参照）

式典後Receptionに暫時出席，Dr.Natthはじめタイ側の要人と歓談する。

２月21日（木）：JL474にて0925 Bangkok発。同1650成田帰着

3. 総括的所見

(1) 建設の過程で若干の曲折があったようであるが，ATC／PHCのMain Building と Facilities が完成し，タイ国皇太子を迎えて盛大なRoyal Inauguration Ceremony が挙行されたことは，1981年８月の予備調査以降，事前調査，実施調査，巡回指導等のＪＩＣＡの Mission の Leader として本プロジェクトに係って来た小生としては，大きな喜びであった。開所式後の Reception の席上でも，Dr.Natth をはじめタイ側の関係要人からも深甚の謝意が表明された。

また，日本側では当初やや難色のあったコンケン，チョンブリ，ナコンサワン，ナコンシタマラートの4 Regional Centresの完成も，本プロジェクトの将来に大きな戦力となるものと確信する。

(2) 今回のATC/PHC開所式の日程は，第3回Consultative Meetingとも関連し，タイ国Royal Familyの臨席を得るため設定されたものであるが，日本側にとっては大学関係者，各省関係者，JICA関係者ともに最悪の時期となった。このため日本からの公的な出席は小生のみとなり，また小生としても前日が入学試験であり，公務の制約のため2泊3日の短期滞在となり，本年度計画案についても時間がとれなかったことは残念であった。

(3) タイ側より特に依頼のあった第3回ASEAN Consultative Meeting の基調講演については，今回の会議の主題に即し，"Hospitals and PHC Development"と題してfull-paper のコピーを準備して約1時間の講演を行った。但し，このKey Note Aadressに対するDr.Krasaeよりの私信の依頼が届いたのは出発4日前であり，小生としては昨年11月Dr.Natth来日の際の打合せから"Social Involvement in Health and Welfare : The Final Goal of PHC Development"の講演を準備した後となったので，新しい基調講演の準備に徹夜の状態となった。なお，今回はWHO事務総長Dr.H.Mahlerが出席の予定で，本プロジェクト及び日本のPHCの状況等について直接話しあえるものと期待したが，都合により訪タイされなかったことは残念であった。なお，Consultative Meetingの開会式へのDr.Mahlerの祝辞（別紙3参照）では，本プロジェクトが国際的にもきわめて高く評価され，国際的に強い期待がよせられていることがわかる。

(4) この度grant-in-aidによるATC／PHC及び4か所のRTCs／PHCの完成により，本プロジェクトは新しい段階に入った。また1982年10月に正式に発足したJICA の技術協力プロジェクトも，早くも第3年目に入っているが，Dr.Mahlere の祝辞にもくり返して述べられているように，本プロジェクトは国連WHOの今日の最高政策"Health for All by the Year2000" のための世界で最初のRegional base のInstitutionであり，日本のinitiativeと資金援助，技術協力により，ASEAN諸国間の国際協力をベースとして異色のあるプロジェクトとして，WHOは最高の評価を示し，今後の発展に全世界の期待がよせられていると申しても決して過言ではない。これまでの経緯の中で，日・タイ両国間の予算等の制度上の相違，事務処理パターン等の相互理解の不足等のため，また本プロジェクト自体が本来multi-disciplinary，horizontal のアプローチを必須とし，単なる技術移転に期待できるものではないため，なお今日developmental な諸問題を残している。しかし，前述のような本プロジェクトの世界的，歴

史的な意義と期待を正しく認識し，日本側としても今後の対応については，本プロジェクトの基本的needsに対し，最大限の努力をなすべきものと確信する。なお，公衆衛生省ベースで本年度に新しく導入されたナコンサワンにおけるWHOのPHC研究プロジェクト（1984年10月～1987年12月）との関連も慎重に検討すべきものと考えられる。

(5) 今回は短期間のため，討議の時間がなかったが，本プロジェクトの当面の重要課題として，次の各項目の早急な検討を要するものと考える。

① Chanthabariにおける Model Development の研究計画の開始に間に合うよう早急に経験のある短期専門家を派遣すること。

② 近く任期満了予定の調整員，専門家等に対する対応を早急に行うこと。

③ 本プロジェクトのmasterplanの再検討を考慮すること。

④ ATC／PHCのタイ側スタッフの academic staff の status の改善

⑤ 来日中の audio-vidual の counterpart の効果的訓練。