# Ⅵ. 第二次予備調査（昭和５６年１２月）

# Ⅳ　第二次予備調査

1. 目　　的

１９８１年８月に実施した予備調査及び１０月６日及び７日ジャカルタにおいて開催された第２回準備会議に提出されたプロジェクト計画書（P.※）を踏まえ，マヒドン大学Salaya キャンパスに建設予定のペライマリ・ヘルスケア訓練センターと地方センターの帰属問題等につき調査・協議し，プロジェクトの具体化に寄与する。

2. 構　　成

| | | | |
|---|---|---|---|
| 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課々長補佐 |
| （同　　上） | 宮 | 内 盈 | 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々長補佐 |
| （業務調整） | 熊 | 倉 | 晃 | 国際協力事業団医療協力部医療協力課 |

3. 日　　程（派遣期間：１９８１年１１月３０日～１２月１１日）

| | | |
|---|---|---|
| １１月３０日(月) | 東京 JL717 バンコック | |
| 12月　1日 (火) | 9：40 | 日本大使館表敬（久保田参事官） |
| | 10：00 | 伍藤書記官，河西ＪＩＣＡバンコック所長及び坂牧職員と日程等につき打合せ |
| | 15：00 | タイ側と第１回目協議（於：国立マヒドン大学公衆衛生学部） |
| 2日(水) | 9：00 | 第２回目協議（訓練事業に関し） |
| 3日(木) | 9：00 | 第３回目協議（研究開発事業に関し） |
| 4日(金) | 10：30 | CHONBURI NURSING COLLEGE 視察 |
| | 14：30 | CENTRAL REGION OF CHONBURI PUBLIC HEALTH COLLEGE 視察 |
| 5日(土) | | CHONBURI→BANGKOK |
| 7日(月) | 10：00 | BUDDHACHINARAJ NURSING COLLEGE 視察 |

| | | |
|---|---|---|
| | 13:45 | NORTHERN PUBLIC HEALTH COLLEGE |
| | 16:00 | PHITSANULOK 県の1村を訪問し，PHC事業の活動を視察する。 |
| 8日(火) | 10:40 | SUKOTHAI 県保健衛生局訪問 |
| | 11:30 | SUKOTHAI → BANGKOK |
| 9日(水) | 10:00 | 第4回目協議 |
| 10日(木) | 資料整理 | |
| 11日(金) | バンコック KL863 東京 | |

(注) 平良団員の派遣期間は11月30日から12月6日，また豊川団員は12月6日から12月11日までである。

4. 協議の概要

(1) 第1回目協議（12月1日午後3時，マヒドン大学公衆衛生学部）

出席者　NATTH学長，PRAWASE副学長，KRASAE講師，DUSANEE 助教授，KRAISID助教授，ROMSAI講師，ANUCHA企画課主幹（以上マヒドン大学）

PAIROTE次官補，DAMRONG企画課長，PRICHA PHC室長（以上公衆衛生省），SUTIN コロンボプラン担当官（DTEC）

1）マヒドン大学学長Dr. Natth（座長）より，ATC／PHC Project の主旨と，今回の日本側Mission の歓迎の開会挨拶が述べられ，タイ側の出席者の紹介が行われた。これに対し，橋本団長より，今回のMission の任務，限られた期間内の有効な討議，現地踏査への期待が述べられ，Mission メンバー及び日本側出席者の自己紹介が行われた。

2）次いで団長より，下記配布資料について，日本側としての"ATC／PHC Project のDraft shedule of plan of action"が説明され，若干の質疑応答が行われた。

THE TRAINING CENTER FOR PRIMARY HEALTH CARE, ASEAN HUMAN RESOURCES DEVELOPMENT PROJECT IN THAILAND

PLAN OF ACTION (draft) Nov. 25, 1981

| ACTIVITIES \ YEAR | | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 |
|---|---|---|---|---|---|---|---|
| Technical Cooperation by Gov. of Japan (five years) | | | | | | | |
| Construction of Training Center | | | | | | | |
| Field Research | | | | | | | |
| | No. of Project | | | | | | |
| Development | | | | | | | |
| | No. of Project | | | | | | |
| Training | National | | | | | | |
| | No. of Course | 3 | 10 | 14 | 14 | 14 | |
| | International | | | | | | |
| | 1 Course | | | | | | |
| | International Seminar | | | | | | |
| | 1 Seminar | | | | | | |
| Technical Materials Production & Dissemination | | | | | | | |

3）次いで団長より，事前に公電によって準備を求めた今回のATC／PHC Projectの基礎的な3つの問題

①Salaya キャンパスに建設予定のASEAN Traing Centerの施設の帰属

②ASEAN Traing Center とタイ側から要望のある4つのRegional Training Centers との関係

③ASEAN Training Center に必要なFull－timeスタッフの予定プラン

についてタイ側の回答を求め，次の諸点が明らかになった。

①について；討議の結果，施設はマヒドン大学に帰属することが確認された。

②について；ASEAN Training Center のtrainees のfield training の場として，また，公衆衛生省が実施中のNursing College，Public Health College の新しい卒業生（これはauxilliary レベルのSanitarian，Midwife，Nurse でPHCの中心的ワーカーとなるもの）に短期間のPHCの教育訓練のため，4つのRegional Training Centerがぜひ必要である旨が説明され，本Mission の2か所のRegional Training Center 予定地の視察の後，さらに討議することとなった。

③について；Dr. Nath より，3種類のStaff すなわち，ⓐCO－Staff（full time），ⓑ1983年度以降，公衆衛生省より，3か月交替の数名の業務のStaff 及びⓒマヒドン大学よりのpart－time（兼務）のStatf を予定している旨説明があった。（他に日本，WHO等からのExpert など）

4）団長より，現在予算編成に際し，①Training，②Research and Development，③Material production，に関するローカルコストの協力については，最大の努力をしているが，すでにくり返し確認されているとおり，タイ側から要望のあるAdministrative and Supporting cost については，技術協力の規則として認められておらず，この項目については将来ともに見込みのない旨が述べられた。

5）これに対し，Dr. Nath より，これは本project の不可欠の条件であり，対応としては①日本側又はタイ側負担，②本プロジェクトの断念，及び③WHO，USAID等国際機関よりの援助，以外の選択のないことが強調され，またⓐASEAN 諸国への貢献，ⓑ新5か年計画設定後にproject が提起されたため，タイ側の対応が不可能であることが述べられた。

(2) 第2回目協議（12月2日午前9時）

出席者　KRASAE講師，DUSANEE助教授，KURASID助教授，PRAWASE副学長（以上大学）RRICHA室長

第2回目は，訓練事業を中心に以下の通り討議した。

1）公衆衛生省官房ＰＨＣ室長Dr. Pricha より，タイにおけるNational Health Administrationの中央，地方を通ずる組織，機構の現状が詳細に説明されるとともに，１９６９年以降のＰＨＣに関するproyectの実績をふまえ，village レベルを中心に，現在の中央・地方を通ずるＰＨＣの推進のためのシステム及び，VHC，VHVsの選択，任務，監督等が具体的に説明された。またこれらをふまえて，これまで公衆衛生省が実施してきた，３つのレベルのＰＨＣ Trainingの現状，及びこれに関する第４次国家社会経済発展計画終了時（１９８１fiscal year）までのmanpwerの養成の実績と今後の課題が述べられ，ATC／PHCの役割と位置づけ，Regional レベルのTraing Centerの重要性が述べられた。

2）以上のOrientationをふまえて，午後のsessionにはDr. Natth も出席の下で，本日の主題について，ATC／PHC projectの初年度の実施計画について，きわめて積極的な意見交換と討議が行われた。主要な討議事項は次のとおりである。

①タイ側から提案のある，regional level のＰＨＣ Traingが，新しい構想であることが再確認された。

②前記第４次計画終了時（１９８１年９月）までに，ＰＨＣのtrainersとして，cevtral レベル（35），provincial & district レベル（1,016），及びTambon レベル（5,216）が養成されており，このうちcentral レベルの３５人は，既にprovincial レベルのtrainer養成の任務を完了している。

③以上により，Villagesの約５０％，populationの１8.5％がすでにＰＨＣ活動でカバーされている。

④ATC／PHCとしては，今後central レベルで公衆衛生省及びＰＨＣに関係のある農業省，教育省，内務省などの意志決定を行う行政官，及びprovincial & District レベルの公衆衛生行政，病院，農業，教育，内務行政等の責任者に対して，ＰＨＣについて理解を深めることが重要である。

⑤ＰＨＣ trainingのための視聴覚教材，器材として，ＶＴＲ，micro-computerなどの必要性がタイ側から述べられたが，日本の経験からは，地方とcommunityの現実に即したcolor slide や １６㎜フィルムの製作，活用が安価できわめて効果のあることを述べ，共感を得た。

3）以上の意見交換と討議の結果，タイ側より，ATC／PHC projectの初年度のtraining coursesとして，次のplanが提案された。タイ側基本文書の１４コースの案には拘泥していない様子であった。すなわち，provincial & Districtレベルの病院長，公衆衛生，農業，教育，地方行政の責任者のmulti-sectoralのグループ（１回３５人，期間２週間）のコースを６回実施したい。併せて，中央各省の

関係局長などを対象とする２－３日程度のＰＨＣの研修的プログラムを実施したい。

(3) 第３回目協議（１２月３日午前９時）

出席者　ＫＲＡＳＡＥ講師，ＤＵＳＡＮＥＥ助教授，ＤＥＢＨＡＮＯＭ学部長，ＫＲＡＳＩＤ助教授（以上大学），ＰＲＩＣＨＡ室長（公衆衛生省）

第３回目は研究・開発事業を中心に以下の通り協議した。

1）団長より，本日はこのproject の"Research and Development"について，初年度（１９８２年１０月～１９８３年３月）の実施計画を討議したい旨発言，またタイ側文書Appendix ２記載の１１の主要分野についての１７１の研究小課題はいずれもＰＨＣ推進に必要であることは理解できるが，それらの性格は多様であり，日本の経験からも，初年度の研究項目については，本project の目的を明確にふまえたcriteria を念頭において討議すべきである，と述べた。

2）次いで公衆衛生省ＰＨＣ室長Dr. pricha より，本プロジェクトのため，５つのRegion から比較的恵まれない条件にある５つのTambons（平均１０Villages）をモデル地区として選定することが報告され，"Health for" を目標に，従来の一連のタイにおけるＰＨＣの実践から導き出されたModel の組織，構造，機能について説明がなされ，これに基づいてＰＨＣの８つの基本分野における研究調査の必要性とその内容が述べられた。またマヒドン大学公衆衛生学部長Dr. Debhanom から最近の産業衛生における問題の説明がなされた。

3）ＰＨＣのstrategy と関連して，Dr. Debhanom より，タイの地方自治，地方財政の現状とhealth sector の問題点が述べられ，Tambon Development Council の課題，特に①農業，②教育，③経済，等の諸分野との連携，ＰＨＣの啓発の重要性が強調された。

4）以上タイ側（公衆衛生省及びマヒドン大学）の説明と問題提起を中心に，日本の経験をふまえて，各種の事例等について活発な討議が行なわれた。主な事項は次のとおり。

①社会資源の活用について（Village の寺院及びmonks，elementary school の教師など）

②他のセクターのVolunteer （あるsector では月＄３０.⁻をVolunteer に給している。）

③Model の開発については，そのSize を考慮する必要がある。

④Drug store には，３つのレベルがあり，それぞれの条件を考えて計画する必要がある。

⑤現在３０余のVillages で作られているVillage cooperations は，今後のＰ

HC推進のうえで注目すべきものと考えられる。（村民のcontributionが基金である。）

5）Dr.Debhanomより，１９７８年のWHOワークショップの討議の中から提起されたPHCに関する共通的な研究課題として，①needの識別，②受益者の反応の確認，③既存のhealth systemの評価，④managementの向上，⑤Villageレベルにおけるhealth以外のセクター間とのcoordination，⑥appropriate technology，など１１の課題について，projectorを用いて説明がなされた。

6）さらに，タイにおけるHSRの現状が述べられ，これまでに主としてWHO，world dank，VSAIDなど国際機関によるgrantによって，公衆衛生省及びマヒドン大学が関与して行われた研究調査の概要が説明された。

7）次に，マヒドン大学Dr.Kraisid（小児科専攻）より，本年１０月に開催されたマヒドン大学と公衆衛生省共同のPHCについてのワークショップについて報告があり，PHCの９つの基本分野に関する研究課題についての討議の結果，次の３つのgroupの研究の必要が明らかになった旨が述べられた。すなわち，①package of research，②common topics for all PHC，及び③General topicsであり，それぞれのgroupの研究項目が例示された。

8）タイにおけるPHCに関する研究調査の現状についての以上のような報告をふまえて，初年度の本プロジェクトによる研究調査実施計画について討議が行われた。主な事項は次のとおりである。

①タイ側から提起されている"contract research"方式については，既にかなり経験がある。

②ResearchとDevelopementの明確な概念を求め，Dr.Damrong（公衆衛生省官房企画課長）がその説明に当った。（inputとoutputの関係に類する）

③従来この種の研究調査の費用は，もっぱら前記の各種の国際機関に依存しており，公衆衛生省の費用としては，PHC室として精々年間２０,０００バーツ程度の研究費に過ぎない。

④health education，inter sectoral coordination等の課題について，具体的なresearchの方法，contrast設定の可能性などが討議され，本日冒頭に公衆衛生省側から報告された５つのModel Tambonsが活用されることが説明された。

9）以上，本日の午前・午后に亘る討議をふまえ，団長より，初年度の研究は，個々のcategoricalな項目ではなく，２年目以降の有効な研究実施のための必須の共

通課題をとり上げることが望ましい旨，提言され，タイ側も全面的にこの主旨に賛同し，例示として次の３課題があげられた。

①Assessment of present situation（situation analysis），②効果的なhealth care-network，③coordination及びTeam approach，など。

(4) 第４回目協議（１２月９日午前１０時）

出席者　学長，副学長，公衆衛生学部長，KRASAE講師，DUSNEE助教授（以上大学）

企画課長（公衆衛生省）

1）前週の２回に亘る主題別会議における①Training，②Research and Development に関する初年度（１９８２年１０月～１９８３年３月）の実施計画を再確認し，若干の討議を行った。

①Training については，Dr. Krasaeより，前回の討議の結果を整理した下記ペーパーが説明され，若干の討議修正を行った。（日本側予算は１９８２年１０月～８３年３月の分であること。）

②Dr. Dusaneeより，下記資料のTrainingについて，１３項目に及ぶobjectivesが提示された。

2）Dr. ナットの出席を得て，団長より，前週の３日間の会議後におけるchon Buri provine（Central Region），及びpithanulog province（Northern Region），Sukothai province の現地視察についての所見を報告するとともに，前回の会議で公衆衛生省から熱心な提案のあったRegional PHC Training Center については，当面モデル的な試みとして，バンコクから比較的近い場所（例えばChonburi province）に１か所を設置してはどうかとの提案を行った。

3）前記Regional PHC Training Centerについて，Dr. Damrongより，公衆衛生省としては，できれば，District及びTambon レベルの宿泊可能な多数のTraining Centersを希望する旨の説明があり，団長からそれは今回はじめてきく新しい構想であり，地方レベルに小規模な施設を多数作ることは，Grant Aid にはなじまない旨を説明し，これらをめぐって討議が行われた。

4）討議の結果，午前中に団長より提案した当面モデル的な試みとして，バンコクから比較的近い場所にRegional PHC Training Centerを建設することで，公衆衛生側も積極的な賛意を表した。なお，場所の選定は公衆衛生省が早急に行ない，日本大使館に連絡することとなった。

Nov. 9, 1981

# TENTATIVE OPERATIONAL PLAN
## ASEAN/PHC Training Program

Purpose:

1) To enable Thai officials to effectively cooperate in the training, supervision and support the PHC activities.

2) To generate intersectoral participation and commitment in the area of primary health care.

The Challenge:

Subject to the global goal of health for all by the year 2,000, it is essential that Thai officials be reoriented to realize the importance of primary health care as the key strategy for health for all. The ASEAN/PHC training programme for 1982 - 83 is planned accordingly.

Participants:

Directors of district hospitals and provincial hospitals (about 20 persons), and Government officials from other relevant sectors (education, local government, agriculture etc. about 10 persons)

Location:

Salaya Campus, Mahidol University

Faculty and Training Philosophy:

Faculty members are Mahidol University Specialists and Senior officials from the Ministry of Public Health which are professionally trained in their respective fields (Primary Health care and community development etc.) and experienced at adapting their specialties to tackle rurual problems.

The participants themselves play a key role in the training, through sharing of experiences and ideas, comparative analysis of problems, group discussions and joint responsibility for program management. Though the lecture method is frequently employed, sessions will be conducted through role-playing, debating, and workshops.

Action-oriented teaching and learning experience and active participation is fundamental to the success of the training, both in regularly scheduled programme activities and during free time.

Facilities:

The ASEAN/PHC training centre at Salaya Campus, Mahidol University is located at Nakorn Prathom Province, approximately a one-hour drive south from Bangkok. The facilities offered include conference rooms, library, and audio-visual equipment. Field demonstrating areas are available for a few days visit. Opportunities are available for recreational activities. Weekend field trips can also be organized.

Course Content

The objectives and content of PHC training course have evolved through close participatory planning among Faculty staff of Mahidol University and Ministry of Public Health. The team have identified and addressed key areas of concern for Primary Health Care worldwide as well as for Thailand. They include:

1. History and Philosophy of PHC

A series of lectures by the Rector of Mahidol University, Undersecretary of State for Public Health, Dean of School of Public Health and Director of Primary Health Care Division (MOP), etc., describing the conditions and the process through which the fundamental principles of PHC have been conceptualized, tested and applied during the last decade.

2. PHC Issues and Strategies

A survey, situational analysis and comparison of selected PHC programmes worldwide.

3. Primary Health Care System in Thailand

Introduction and analysis of an integrated, participatory development approach pioneered at the Ministry of Public Health, which utilizes three mutually supporting strategies: leadership development; technology transfer; and development of community organizations.

4. Primary Health Care Principles for Field Work

Socio - psychological approach in promoting change at the village - level, from group building to participatory problem - solving.

5. Village Round

An opportunity for each participant to live with a rural family and share the work of the village. Experiential learning and observation would stimulate participants to formulate insights directly applicable to their own work and to consider ways to inplement these insights.

6. Strengthening PHC through Inter - Agency Collaboration

Inter - agency collaboration, both between ministries and among private voluntary organizations, has been identified as a key component of effective PHC development efforts.

7. Other Topics

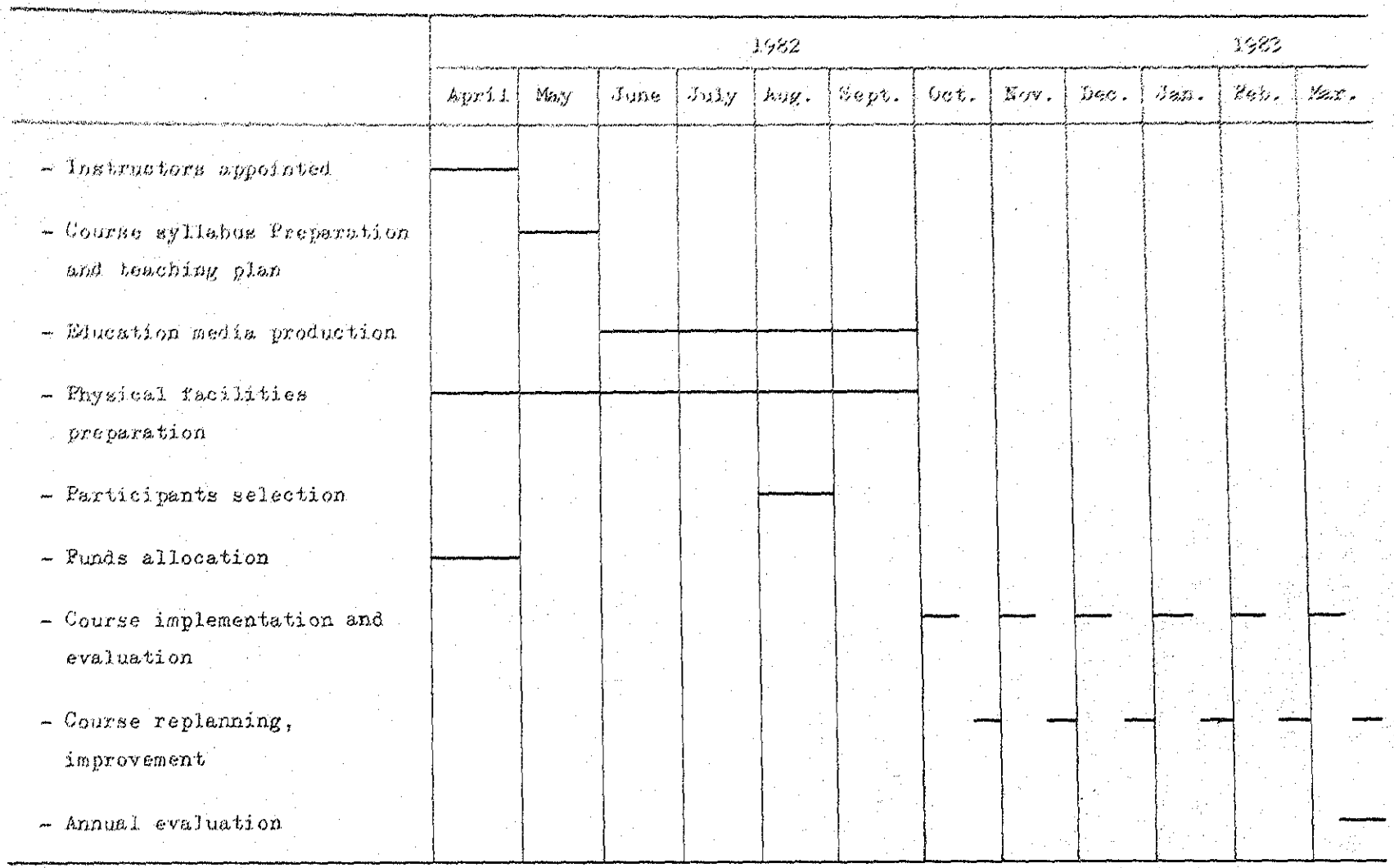
- Appropriate Technology
- Cooperatives and Financing
- Socio - Economic Problems to Health Development
- The Role of Physicians in PHC
- Research Studies and Design
- Woman and Development
- Health Issues in Rural Development
- Principle of Management

Program Dates and Duration

The 1st PHC Training Course will be conducted for 2 weeks in the beginning of October, 1982. Sufficient funds for participants are available which includes board and lodging, materials and travels.

There will be totally 6 courses during the time period Oct. 1982 - March, 1983. Each course lasts 2 weeks.

Time Scheduling of ASEAN/TEC Project 1982 - 83



5. 総括的所見及び要検討事項

(1) 本プロジェクトは，基本的にMahidol 大学と公衆衛生省の共同のものであり，その成否は両者の積極的な連携の如何にかゝっているといってよい。この点で第1次予備調査時（本年8月）に比べて，今回は公衆衛生省関係者の本プロジェクトに対する積極的な意欲が感ぜられた。

(2) 今回の討議，現地調査等を通じて，Mahidol大学，公衆衛生省ともに，本プロジェクトに関係の深いkey postsにきわめて有能かつ意欲的な人材が配置されている，という印象を受けた。

(3) 第1回会議での追求の結果，Salaya Campusに新設されるASEAN PHC Training Centerは，Mahidol 大学に帰属することが明らかになったが，この点からも公衆衛生省に帰属すべきRegional PHC Training Center の設置は，積極的に考慮すべきものと考えられる。

(4) 大学と公衆衛生省の連携により，本プロジェクトの具体計画・運営準備のための委員会を早急に組織して定期的会合を持つよう助言し，同意を得たが，その組織の実現方を見守ることが必要である。

(5) 無償供与，技術協力を通じて，日本側からの資金の具体的な流れ方，及びその手続などについて，事前に具体的に十分タイ側の理解を得ることが必要である。Lampang ProjectにおけるＵＳＡの援助資金は，かなりflexibleな使用がなされたようであるが，実施の段階で誤解を招くことのないよう，予め関係者によく説明する必要があろう。

(6) タイ側は，無償供与関係の調査団が，来年2月頃派遣されることを期待しているが，今回協議の結果Salaya Campus のASEAN PHC Training Centerと共に，Regional PHC Training Center 1か所の新設が予定された。候補地は早急に公衆衛生省が決定のうえ日本大使館に通知するとのことであるが，Dr.Nathは建築物の設計については，最終案となる前に，タイ側として2回の検討を希望している。なお，Dr.Nathは１９８２年2月6日～１６日の間は，国際学会のためオーストラリアに出張予定とのことであった。

(7) 今回の第1回会議要旨に記載のとおり，本プロジェクトに必要なソフト面の経費，特にadministrative and Supportive costの負担について日，タイ両国の意見は，残念乍ら全く対立した。

この問題については，本調査団の公式日程終了後（１２月１０日夕），Dr. Nathより橋本団長あての強い要望方の書翰が，大学よりの使者の手によって橋本団長に手交されている。

(8) 本プロジェクトは，タイ及びASEAN諸国のPHC推進のための指導的人材及び教師の教育訓練を目的とするものであり，その特質上，単にTraining Centerのハード面に対する援助のみでなく，ソフト面特に本プロジェクトの運営に要する経費の措置如何が，本プロジェクト自体の成否を左右するものというべきである。

(9) タイ側の事情は，Dr. Nathの書翰に述べられているとおりであり，この件については他のASEAN諸国の人造りプロジェクトについても，程度の差はあれ，同様の事情があるものと考えられる。ハード面のみならず，その特質上ソフト面の経費特に運営管理経費の確保は，必要不可欠の条件であり，本プロジェクト提案の経緯ならびに人造りプロジェクトの特質から見て，その成功を期するためには将来の慣行に捉われず，この問題の解決にあらゆる努力を払うべきものと思料する。

ナット学長発橋本団長宛書簡は以下の通り。

December 10, 1981

Dr. M. Hashimoto
Chief, JICA Planning Survey Mission
ATC/PHC Project
c/o Japanese Embassy
Bangkok

Dear Dr. Hashimoto,

Our negotiation on the ATC/PHC project appears to progress very nicely since the arrival of your team. The theme of our request for your assistance which could be broken down into six categories namely 1. Grant in Aid, 2. Technical Cooperation, 3. Research, 4. Development, 5. Training, and 6. Administrative service support have been reviewed by your group and we have the feeling that it may be possible for your government to render assistance to us for the first five types of assisrance but you may not be able to help with the sixth one for administrative support.

I am very much concerned about this and would like to ask you again to review this problem back in Japan. We feel very strongly that for this ATC/PHC project, a reasonable administrative service support from your government is very essential for the successful outcome for several reasons.

1. This project is an international project and the administrative machinery should be efficient enough to cope with the many requirement which would involve nationals from the other four Asean countries as well as from Japan and perhaps third countries. Therefore the administrative arrangement will have to be of international standard and will be bi-or even trilingual in communication i.e. Thai - English - Japanese. While we do not foresee a completely new administrative system of the UN type of agency, we could use the national framework, but we still require additional support to give us more operational flexibility and to give us an efficient operation. To cite just one example, we could not hire administrative staff who could meet international standard of service on the existing Thai government pay scale.

2. The beginning of this project has been very awkward from the standpoint of our fifth five year economic and social development plan which began October 1981. There has been no financial provision at all for the project in this plan because the project has only been started recently. We shall have to try to obtain a budget in fiscal year of 1983 which begins in October 1982. We have informed the NESDB on this matter and have received

no answer to this problem, except a suggestion that since this project has been initiated at the Asean - Japan level, the Japanese side should take more responsibility in seeing that this project receive reasonable administrative support from the Japanese government who intiates the project to assure a success.

3. Primary health care project, by nature, does not require big support from the Grant in Aid or Technical Cooperation standpoints. Its success could be measured by good research, development and training activities which not only would require development and training activities which not only would require adequate financial support for these three major activities but also be able to plan, implement, coordinate and evalute these funetions in the most efficient manner, which requires a good management system and needs reasonable financial support in this area.

In case that you could not immediately solve this problem I would suggest 3 options for your consideration.

1. Bring the matter up to the high political level of negotiation by both sides. We would have to emphasise the absolute need for administrative service support from your side and hope that the solution would be forthcoming.

or 2. Reconsider the whole project, and perhaps with the approval of other Asean countries, find a new project which would fit more the Grant in Aid, and Technical Cooperation scheme of assistance. This may be more in high science or technology area but probably would fit less, the human resource development aspect.

or 3. Permit us to explore a third party to obtain assistance from them just for this administrative service support. From preliminary and unofficial discussions, there is a strong possibility that this would be forthcoming if requested. There is a feeling that since the Japanese Government has aiready given a large part of the finance, the request for administrative support represents such relatively small part that any agencies concerned should love to get involved at such a small cost.

I would strongly urge you to consider this problem seriously and hope you could find way to solve this matter to our mutual satisfaction and to the success of the project.

Sincerely yours,

Natth Bhamarapravati, M.D., D.Sc.
Rector, Mahidol University

NB:si

# V. 資　　料

# 1 Primary Health Care in Thailand

March 1, 1981

Dr. Pricha besawadi
Director
Office of the Primary Health Care

Backaround

Primary Health Care in Thailand has started since 1969 as a pilot project in Sarapee District, Chiengmai Province in the Northern Part of the country. The project was initiated because of the problem of underutilization of the health centres. The health services delivery system is mostly functioned by the health officers with the following basic elements; curative, mothers and chield health and Family Planning, communicable disesses control, nutrition, school health, health education, sanitation, laboratory, health statistics and disemination of government producing house-hole remedies. At that time, these services were very low interms of population coverage, especially the treatment of minor diseases, sanitation, mother and child health, family planning and nutrition. Some analysis of the problems were done and it was found out that one of the most important cause was the lack of people's participation in the health delivery system. The decision makers of the Ministry of Public Health at that time decided to have some of the selected people from the community helping in carying out some health services activities, with concentration on MCH and family planning, nutrition, sanitation, communicable diseases control and treatment of some minor diseases. These selected people whom were chosen partly by the villagers perform the activities on voluntry basis. There were two kinds of volunteer called village health post (which is village health volunteer now) and the village health communicator. Each village health communicator was responsible for 8 - 15 households, their function was mainly on preventive and promotive while the main function of the village health post was the provision of curative as well as preventive.

The experiences gained from the study was evaluated and demonstrated that the health services coverage was increased obviously. From that time several tested pilot project have been carried out in several provinces of the country and the result was satisfactory.

Studies were also carried out to find out other maters of the volunteer services including the way to select the volunteers, what types of people will be the best to perform the health services on volunteer basis, etc. The experiences gained from these studies lead to the development of Nation - wide programme on Primary Health Care in 1977. The Primary Health Care (PHC) programme has started since 1977 until now.

Concept of PHC in Thailand

The concepts of the PHC in Thailand are develop-d from our own experiences gained in solving the health problems of the people in the rural area who are underserved of the health services delivery system of the government. The consept of community participation is the basic one which is the key to the sucess of the PHC programme. The community participation comprises of the contribution of ideas, manpower, money and materials which are available in the community. To develop the people in the community to be self-veliance or self supoort is th other basis concept which the programme is strongthened. The Ministry of Public Health awares that the strengthening of health services delivery system is essential as well as the referral system in supporting the PHC activities.

A National Seminer was conducted in December 1979, on "Health for All by the Year 2000". It has been decided that the primary health care activities should comprises of the following elements:

1. Health Educator.
2. Local Endemic Diseases Control.
3. Maternal and Child Care including Family Planning.
4. Immunization against Communicable Diseases.
5. Provision of Essential Drugs.
6. Treatment of Common Diseases.
7. Nutrition Promotion.
8. Sanitation and Safe Water Supply.
9. Drug abuscs.
10. Mental Health.
11. Dental Health.

Again, the participants of the seminar felt that the PHC activities could be added or changed according to the awareness of the problems which need to be solved by the community themselves. Since health is only one part of the community development, it should have some relationship with other sectors such as education, agriculture, community development, etc.

Objectives of the PHC Programme:

The objectives of the programme are formulated based on the concects which are as follows:

1. To expand the coverage of the health services, particularly among the underserved rural population and to help the people to help themselves.

2. To utilise community resources and to encourage community participation in order to solve individual health broblems and eventually to establish the self-help programmes at the village level.

3. To promote the dissemination of health information to local people, as well as to integrate all the data that will reflect the needs and health of the communities.

4. To make basic health services available, accessible and acceptable to the people.

5. To promote the health status of the people who live in the rural areas as well as their own awareness on health problems and problem solving.

Primary Health Care Workers - Who are they ?

In Thailand, according to the concept of primary health care and our own experiences, the primary health care workers should be the people in the community to promote the community participation and their performances should be on voluntary basis. We have recognized the potential the human resources that exist in the community and are waiting to be mobilized. We are developing a "grass - roots" primary health care manpower forces comprising of village health communicators (VHCs) and village health volunteers (VHVs) that will promote rural health and development efforts through organized community. The VHCs are responsible for a cluster of

8 - 15 houses whilst the village health volunteers are responsible for the whole village. Their function are emphasized on the health education (prevention and promotion) and dissemination and getting health information from the village. The VHVs have the same function as VHCs but they have additional training on curative aspect and learn how to manage simple accidents or injuries as well as the common illness in their own communities.

Therefore, the VHCs and VHVs villagers who are interested in health matters and are willing to help their fellow villagers without receiving any remuneration from the Government. However, the government will give some incentive such as certificate for recognition, free medical care services, and they might also receive some recognition from the villagers. This is one way of developing community self-reliance and increase the community participation in providing health services.

Selection of Primary Health Care Workers (VHVs and VHCs)

Selection of Primary Health Care has to be done very carefully because if unsuitable persons are selected, many problems will arise and rate of drop out is high.

The procedure for selection of VHCs is as follows: -

1. It is very important that there should be a community proparation before conducting the selection of PHCs. The health personnel at the peripheral centre (Tambon or subdistrict) will inform the villagers about the objective and the outcome of the PHC and asking them for the participation and cooperation.

2. In order to identify the right people, the health personnel will apply simplified sociometric method which is the method that has been tested and proved to be the best method in selection of PHC workers. It requres a house-by house survey to determine prevalent communication patterns between households; it is used to identify those to whom other most frequently turn for advice. This can be done with the following steps: -

a. Make a servey of the village and draw a map showing each houses.

b. Ask the head of the household or the best informed person in the household using the simple form and interview about the neighbors and problems (See the form in Annex 1).

c. As soon as the interview completed, mark on the map with arrows which household is contacted most often for advice and by whom.

d. The groups or cluster of house should be "organized" according to the "communication lines".

e. Count the number of arrows pointing to each house in a cluster. The villagers who has recieved the high number of arrow lines means that he or she should be the central of communication, or he/she will be most respected people within that community (See Annex 2).

f. Find out the persons who live in the house to which most arrows point are interested in volunteer work. If they are willing to spare their time helping their neighbors they will be selected as village health communicators. Village health communicators will be controlled not only by the village committee but the people in the community themselves as well.

After the VHCs have been selected, they will recieve one week training and performs their task and recive continuous education by self-teaching and learning modules under the supervision of the tambon health personnel. VHCs will work for about 6 months then they will be reselection to be VHCs. The village committee and the villagers will be responsible for the resolection. Criteria for selection of VHV are as follows: -

- has shown interest in working to help others and has enough free time to help the public,
- lives and works in the village,
- is trusted by the villages,
- must be a person who has occupation and earns his/her living and live in the house easily accesible to the villagers,
- should not be the government officer or headman.

Each village will have one VHCs or two according to the number households in that village. The VHVs will recieve additional training which will require about 15 days.

Responsibilities of PHC Workers:-

I. VHC

1. Inform the villagers in his/her area about news related to health.

2. Collect information from the public regarding health and other information, i.e. birth, death, migration, pregnancies, problems and needs.

3. Disseminate knowledge, advices and stimulate the public in the following 8 elements:-

3.1 Education concerning health problems and methods of preventing and control them.

3.2 Promotion of food supply and proper nutrition.

3.3 An adequate supply of safe water supply and sanitation.

3.4 Maternal and child health care including family planning.

3.5 Immunication against the major infections disesses.

3.6 Prevention and control of local endemic diseases.

3.7 Appropriate treatment of common disesses and injurious.

3.8 Provision of essential drugs.

The elements of PHC might be more or less than above according to the needs and problems of the community and it varies from country to country. In Thailand, according to the National Meeting held in Bangkok on December 1979, the members of the meeting stated that other elements should be added such as drug abuse, mental health, and dontal health.

4. Help carry out and coordinate health activities and join in other activities.

II. VHV

The responsibilities of the VHV are the same as VHCs with the following additional: -

1. Give services to the public, for exsample:

   a. Distribution of suplementary foods for children, weighing the pre-school children.

   b. Helps and gives simple symtomatic medical care by using home remidies or other medicines which the Ministry of Public Health has given permission to use.

   c. First aid treatments for fresh wounds, fractures, burns, etc.

   d. Distribution of birth control pills to the patients who have already been examined by the government health staff, and condoms.

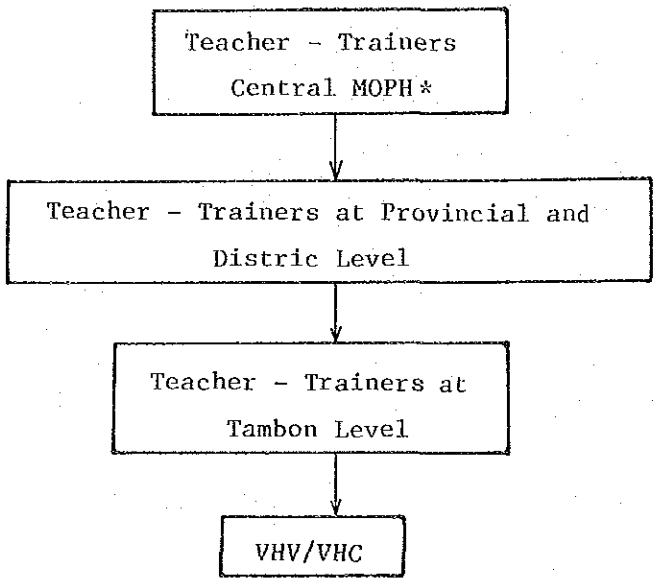
Training of PHC Workers

The objective of the training is to enable the VHCs and to know about the preventive, promotive and curative aspects of health including how to disseminate the health information to the villagers and how to get the information from the villagers. The training is very informal and organized in small groups or by individual instruction using the self-teaching-learning modules or packages. The packages contain the issues which are preventive, promotive and curative. These issues have been broken down to various items that need to be trained. The training is staggered over a period of time at a location convenient for the trainees. The priority of modules selected are based on the problems met in the village. There is a five-day orientation course for VHCs organized by tambon trainers (auxiliary midwives, junior sanitarians, and other tambon health staff). The VHCs are taught how to use the 35 modules, how to work as a group, how to identify health problems, etc. The VHVs take additional fifteen-day course also from tambon trainers to learn additional 17 modules on curative care. See Annex 3 for the topics of the selfteaching-learning modules.

Training for the Trainers

In order to facilitate the training of 22,400 VHVs and 224,000 VHCs within the year 1981, the Ministry of Public Health organized 3 levels of training the Trainers. There are Central trainers, Provincial/District trainers and Tambon Trainers (sub-district).

Plan for Training the Trainers at Different Levels




* MOPH = Ministry of Public Health

The teacher - trainers from the MOPH are staff from the Department and Divisions who are concerned with the scheme. They are trained by the team for 10 days. They learn about the principles of teaching and learning using 0-6 modules of self-teaching and learning;

Unit 0 - Motivation

Unit 1 - Training and Modules of Training

Unit 2 - Job Analysis and performance discrepency

Unit 3 - Objectives of Training and Methods of Evaluation during the period of Training

Unit 4 - Learning Activities and Planning Teaching-Learning Methods

Unit 5 - Implementation of Training

Unit 6 - Support - of Training and Evaluation at the end of Training Programme (sumative evaluation) and support the trainers.

This central trainers developed a simplified modules of the principle of teaching and learning for the Trainers at Provincial/District Trainers, and also involved in developing curiculum and training modules of VHCs and VHVs.

After completion of the training, the central level trainers are divided into 5 groups and go to the provinces to train the Provincial/District Trainers, it took 3 years to complete the training of all provinces.

The Provincial/District Trainers are the health staff responsible for training and supervision at provincial level, there are 5 from the Provincial Health Office (PHO) and one each from the District Health Office (DHO).

These Provincial/District Trainers will train the Tambon Trainers who are health personnel at tambon level. These Tambon trainers will be the trainers of VHCs and VHVs, this is suitable because they are front-live workers who stay close to the villagers.

Beside the training principle of teaching and learning, the concept and national policy on PHC are also explained.

Table 1 showing the training targets of the PHC programme in the Forth Five year Plan (1977-1981)

Table 2 showing the area and Population Coverage.

Table 1: Training Targest

| Item | 1977 | 1978 | 1979 | 1980 | 1981 | Total |
|---|---|---|---|---|---|---|
| 1. Central Trainers | 35 | - | - | - | - | 35 |
| 2. Provincial/ District Trainers | 316 | 350 | 350 | - | - | 1,016 |
| 3. Tambon Trainers | 216 | 1,000 | 2,000 | 2,000 | - | 5,216 |
| 4. VHVs | 2,000 | 5,100 | 5,100 | 5,100 | 5,100 | 22,400 |
| 5. VHCs | 20,000 | 51,000 | 51,000 | 51,000 | 51,000 | 224,000 |

Table 2: Area and Population Coverage

| | 1977 | 1978 | 1979 | 1980 | 1981 |
|---|---|---|---|---|---|
| 1. Area | | | | | |
| - Provinces | 23 | 48 | 68 | 68 | 68 |
| - Districts | 240 | 493 | 620 | 620 | 620 |
| - Tambons | 240 | 1,800 | - | - | - |
| - Villages | 2,000 | 7,100 | 12,200 | 17,300 | 22,400* |
| 2. Population (million) | 1.6 | 5.9 | 10.1 | 14.3 | 18.5 |

* Approximately 50% of Total villages.

Annex 1

QUESTIONNAIR FOR FINDING AND SELECTING VILLAGE HEALTH COMMUNICATOR (VHC)

Number of Hamlets ..... Village ..... Tambon ...

District ..... Province .....

| Interviewee | | Question: Who is the person in this cluster that you go to for advice most often and whom you respect? | | | |
|---|---|---|---|---|---|
| House Number | Name | Person | Name | House Number Owner of House | Hamlet Number |
| | | 1. | | | |
| | | 2. | | | |
| | | 3. | | | |
| | | 1. | | | |
| | | 2. | | | |
| | | 3. | | | |
| | | 1. | | | |
| | | 2. | | | |
| | | 3. | | | |

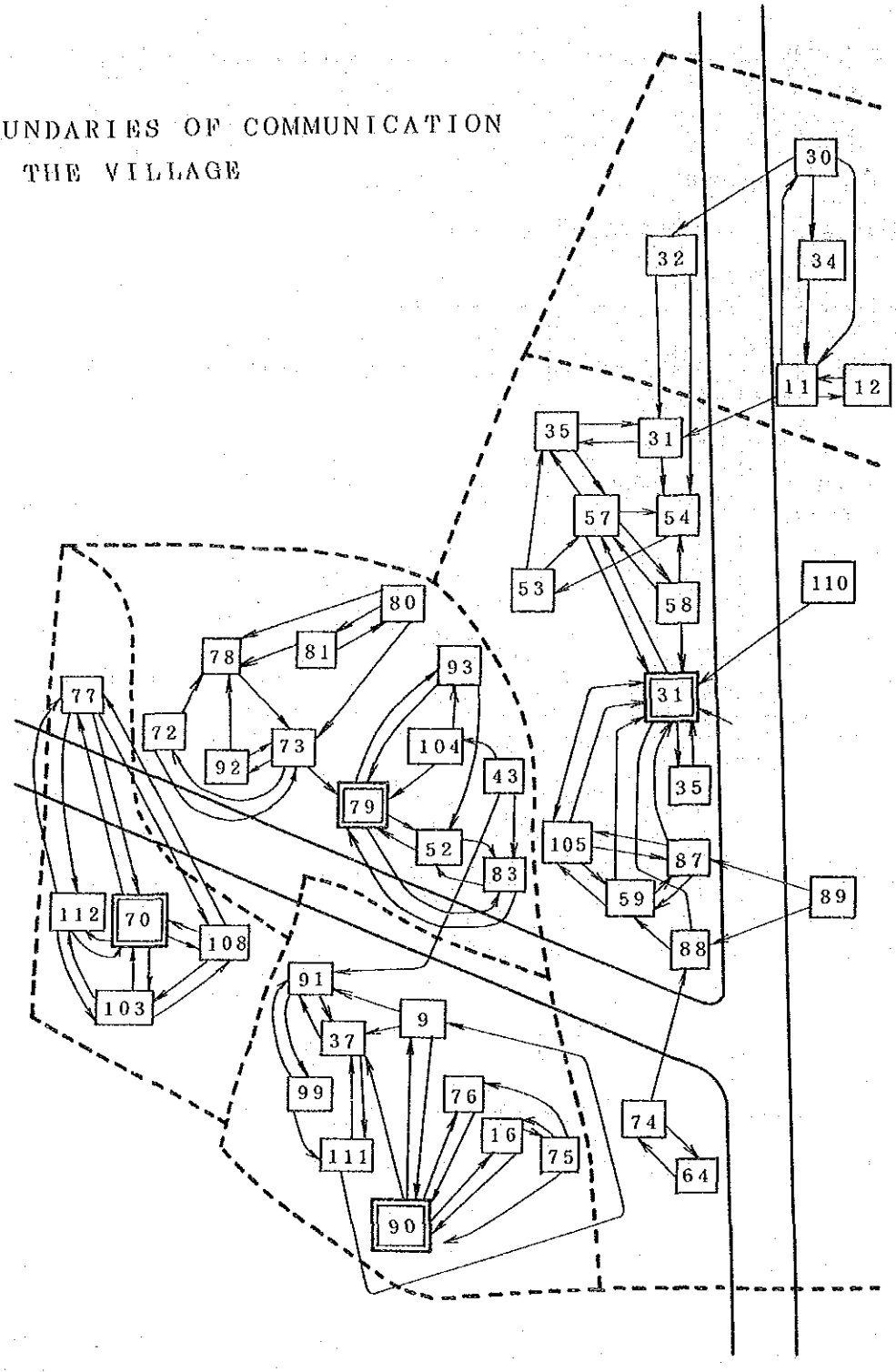
Signature of the Interviewer

Date .....

Note: This questionnaire is used for every household by asking the head of the household or the person who is most informed.

Annex 2

BOUNDARIES OF COMMUNICATION
IN THE VILLAGE




Village Boundary

VHC.

Annex 3

Titles of 52 Training Modules

| | | |
|---|---|---|
| C + V | A | Public Health Problems to be solved by Community. |
| C + V | $A_1$ | Identification of Problems in the Village. |
| C + V | $A_2$ | Group Activities/Communicaty Participation. |
| C + V | 1. | Utilization of Government Public Health Facilities. |
| C + V | 2. | Utilization of Household drugs. |
| C + V | 3. | Utilization of Traditional Herb Medicines. |
| C + V | 4. | Dressing of Fresh Wounds. |
| C + V | 5. | Assist the Persons with Fractures and Sprains. |
| C + V | 6. | Assist the Fainting Persons. |
| C + V | 7. | Assist the Persons with Burns and Scales. |
| C + V | 8. | Assist the Persons with Convulsion. |
| C + V | 9. | Assist the Drowning Persons. |
| C + V | 10. | Assist the Persons with Snake Bites. |
| C + V | 11. | Assist the Persons Bitten by the dogs. |
| C + V | 12. | Assist the Persons Taking in Poisons. |
| C + V | 13. | Providing Immunization Services. |
| C + V | 14. | Prevention of Tuberculosis. |
| C + V | 15. | Assist the Persons Suffering from Leposy. |
| C + V | 16. | Portable Water and Water for Household Use. |
| C + V | 17. | Construction of Sanitary Privies (latrines). |
| C + V | 18. | Garbage Disposal. |
| C + V | 19. | Sewage Disposal. |
| C + V | 20. | Mosquito, Fly and Cockroach Control. |
| C + V | 21. | House Mice and Rats Control. |
| C + V | 22. | Fool Poisoning and Contaminated (dirty) Foods. |
| C + V | 23. | Household Improvement. |
| C + V | 24. | Vegetable Preservation. |
| C + V | 25. | Fruit Preservation. |
| C + V | 26. | Kitchen Gardening. |
| C + V | 27. | Chicken Raising. |
| C + V | 28. | Duck Raising. |
| C + V | 29. | Fish Raising (fish ponds) |
| C + V | 30. | Big Raising. |

C + V 31. Personal Hygiene.

C + V 32. Daily Diets.

C + V 33.a Family Planning Knowledge.

V 33.B Oral Pills and Condoms.

V 34.A Maternal and Child Health.

V 34.B Postpartum Care.

V 34.C Infant Care.

C + V 35.A Assist Malnourished Children.

C + V 35.B Infant Foods.

C + V 35.C Infant Food Supplement.

C + V 35.D Foods for Preschool Children.

V 36. Assist the Persons with Fever.

V 37. Assist the Children with Fever and Rash and Red Dots.

V 38. Assist the Persons with Cough.

V 39. Assist the Persons with Headache.

V 40. Assist the Persons with Back Ache, Weist Ache and Ache all over the Body.

V 41. Assist the Persons with Constipation.

V 42. " " Stomach Ache.

V 43. " " Diarrhea.

V 44. " " Intestinal Parasite Worms.

V 45. " " Boils.

V 46. " " Skin Diseases.

V 47. " " Dental Caries.

V 48. " " Conjunctivities.

V 49. " " Ear Ache.

V 50. " " Beriberi.

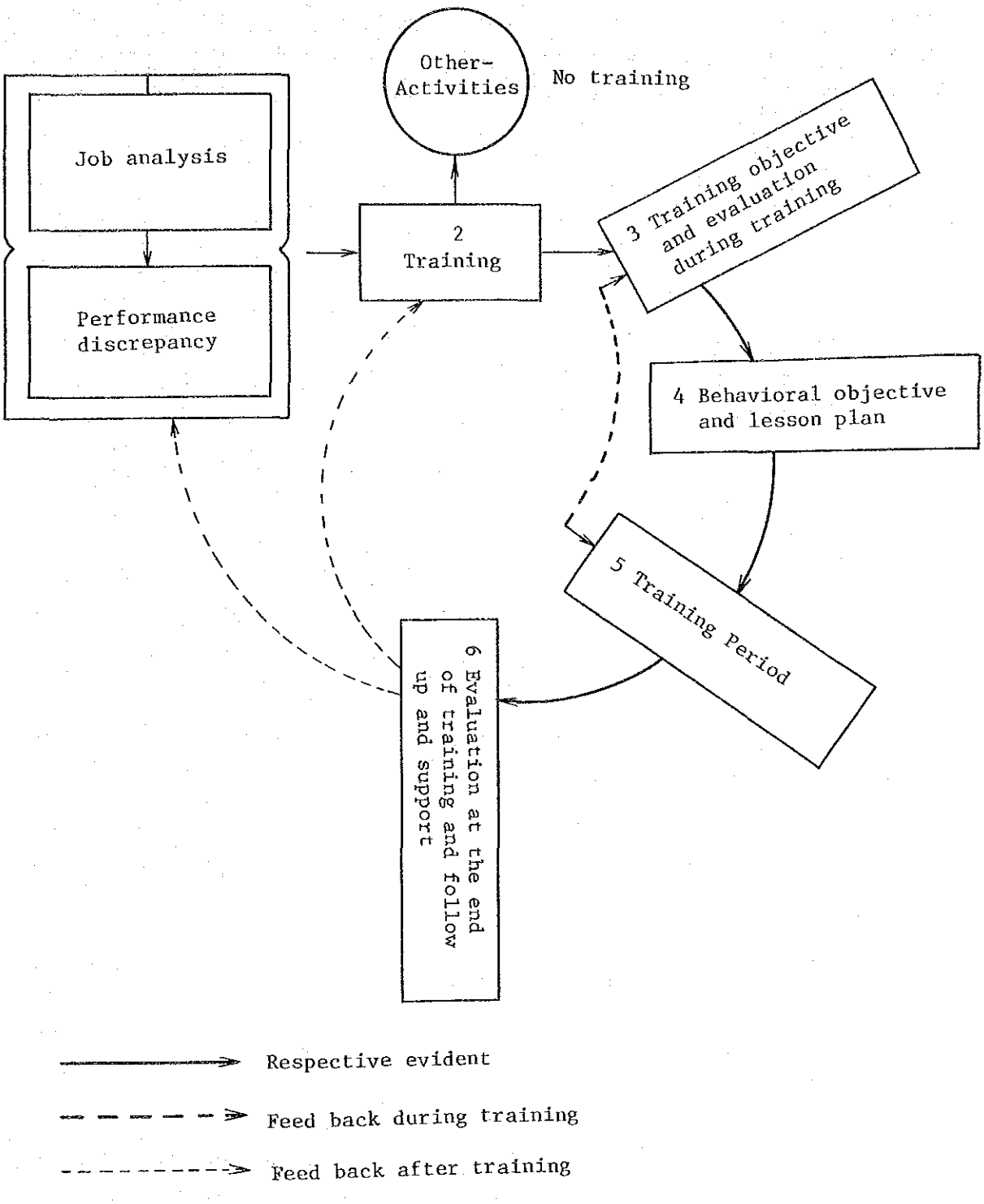
V 51. " " Anemia.

V 52. " " Malaria.

C = Village Health Communicator

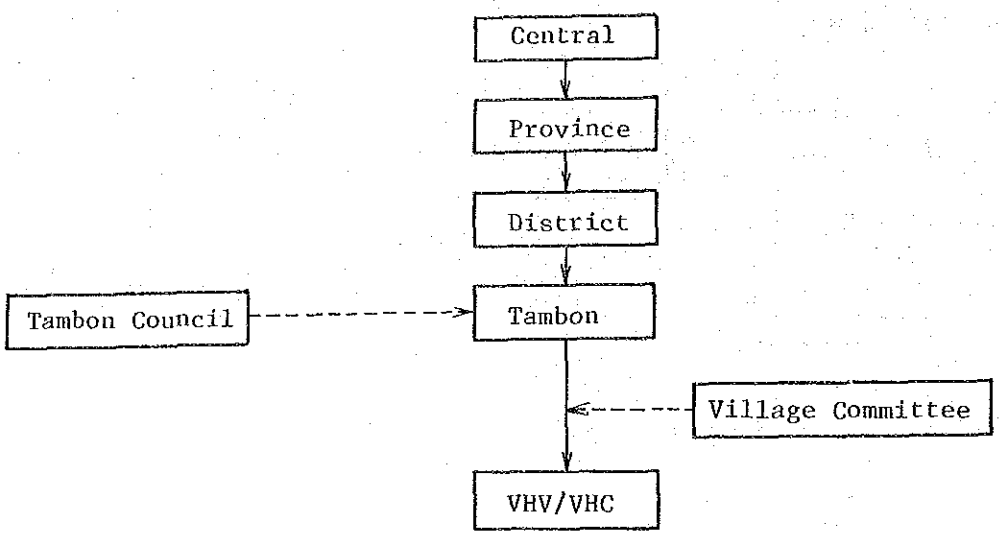
V = Village Health Volunteer

Training for the trainers model



Supervision and Support

The Ministry of Public Health by the Primary Health Care Division is responsible for supervision and support. The chanel of support follows through the existing health infrastructure; that means from the central to the provincials, districts, tambons and health centres respectively.




1. Objective of supervision

1.1 Follow up the plan of implementation

1.2 Follow up and supervise the management, recruitment, performance, administration, support etc.

1.3 To study the problems and finding the way to solve all of those problems, the problems may specify in selection, recruitment, training, and implementation.

2. The scope of supervision

There are three levels of supervision.

2.1 Provincial level

PHC supervision at the provincial health office has to supervise the district health office of district health assistant in the following.

- Target setting and planning
- Monitoring and controlling
- Training Program
- Medical supply such as medical kit.
- Community organization of community support such as health co-operative setting or other community participation activities
- Continuing education

2.2 District Level

District health offices or assistant will go with the supervisors. They will supervise subdistrict or tambon health centre as follow:

- Planning and target setting
- Promote community participation
- Promote community preparation
- Promote the rote of village commitee
- Recruitment and selection of PHC worker
- Training of village health volunteer and village health communicator
- Referal system
- Support-medicine and equipment
- Continuing education
- Performance information
- Close looking at the activities of village health volunteer and communicators

2.3 Subdistrict level (Tambon level)

Supervisor at subdistrict level are health personnel (junior health worker and midwife). They will supervise the followings:

- Performance or activity of the village health volunteer and village health communicators according to the context of PHC (8 elements).
- Technical aspect of providing services. (PHC)
- Organize and maintain community support of community participation
- Consulting to the village committee
- Support medical equipments
- Collect health activities which are performed by village health volunteer of village health communicator

- To link the primary health care services to the governmental health services
- Train the village health volunteer and health communicator though continuing education method
- Establish or stimulation the community self support, such as health-cooperative, or community medical bank, etc.

3. The Team of Primary Health Care Supervisors

3.1 Provincial level The group of supervisors in Provincial Health Office consists of Provincial Health Officer, Director of Provincial Hospital, Director of Technical and Health Service Promotion, Chief Nurse of Provincial Hospital, Chief of sections in Provincial Health Office, Technical and Health Section should be added in any provinces under Population Project,

3.2 District level District supervisors consist of District Health Officer, Assistant District Health Officer, Senior Midwife or District Supervisors assigned by provincial level.

3.3 Tambol supervisors Consist of health workers in Health Centers or Midwifery Center.

4. Frequency of supervision

4.1 From province to district the supervision should be at least 3 times a year.

4.2 From district to subdistrict should be at least 3 times a year and should have another supervision direct to the village health volunteers by sampling method not less than three village volunteers.

5. Methodology of supervision

Supervision in PHC as similar to the kind of supervision. It is two-way communication system the enphasissing is on the PHC concept especially on the basis of community participation. Planned supervision is also include technical supervision is more emphasised on the appropriated are than the sophisticated one.

6. The responsible persons

6.1 Primary Health Care Division is the major source of supervisors.

6.2 General supervisors of MOPH

6.3 Provincial, District, District Officer Assistance and the peripheral health personnel.

7. Evaluation

7.1 Will be based on supervision reports indicating the result of changes and progress of implementation, the procedure of supervision comparing to the former one.

7.2 Will be conducted from the quality and quantity of workload of health workers and the progress of the outcome of VHC/VHV.

7.3 Will be from the research of evaluation.

8. Reaponsible group for supervision plan

8.1 Primary Health Care Coordinating Committee

8.2 Provincial supervisors/district supervisors/tambol supervisors

8.3 Primary Health Care supervisors in Training section (Provinces under Population Project)

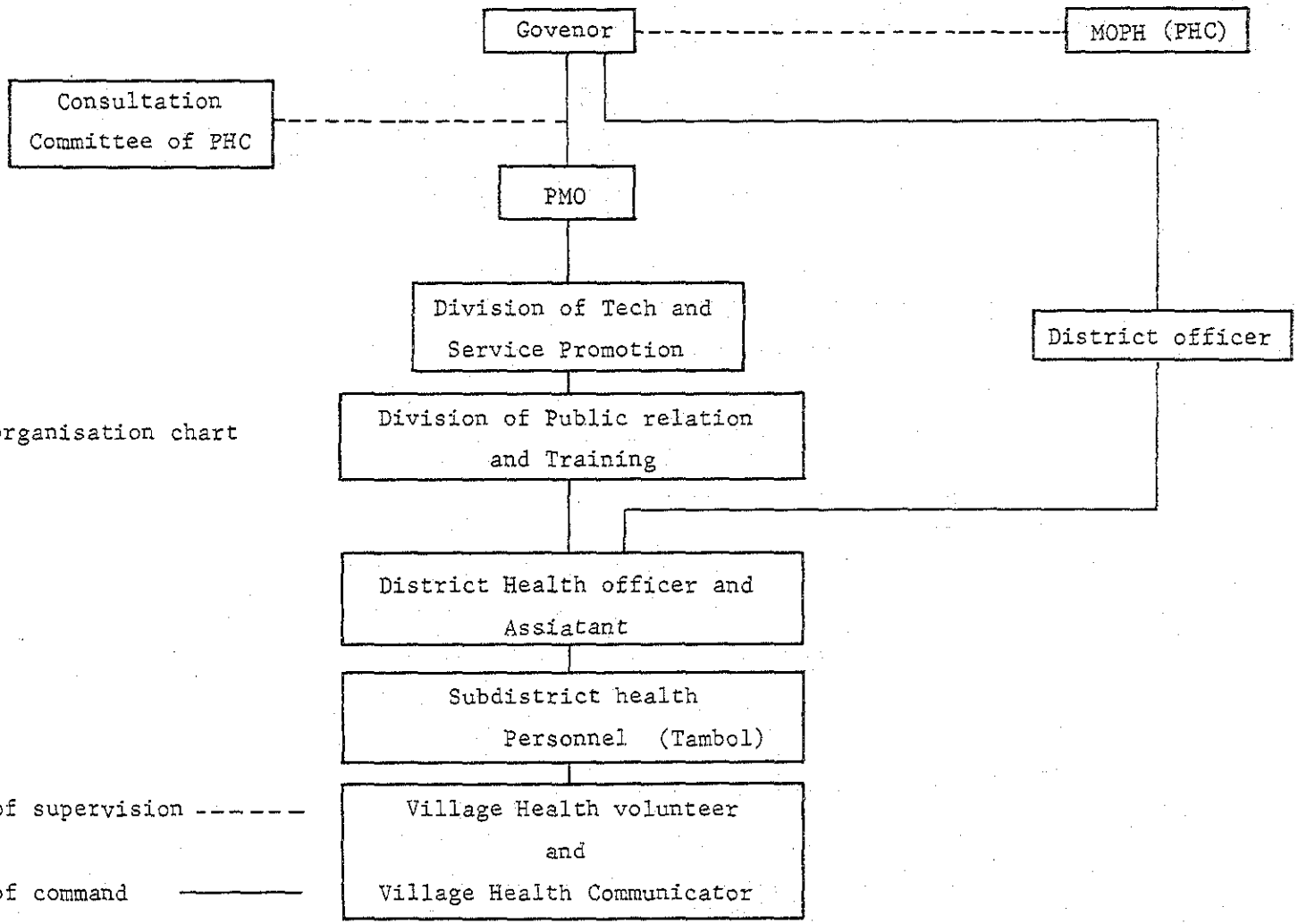
9. Expected outcome

9.1 According to Provincial supervision, the administration and implementation of Primary Health Care will be more efficient and the operation of curative services will be safe for people and correct technically.

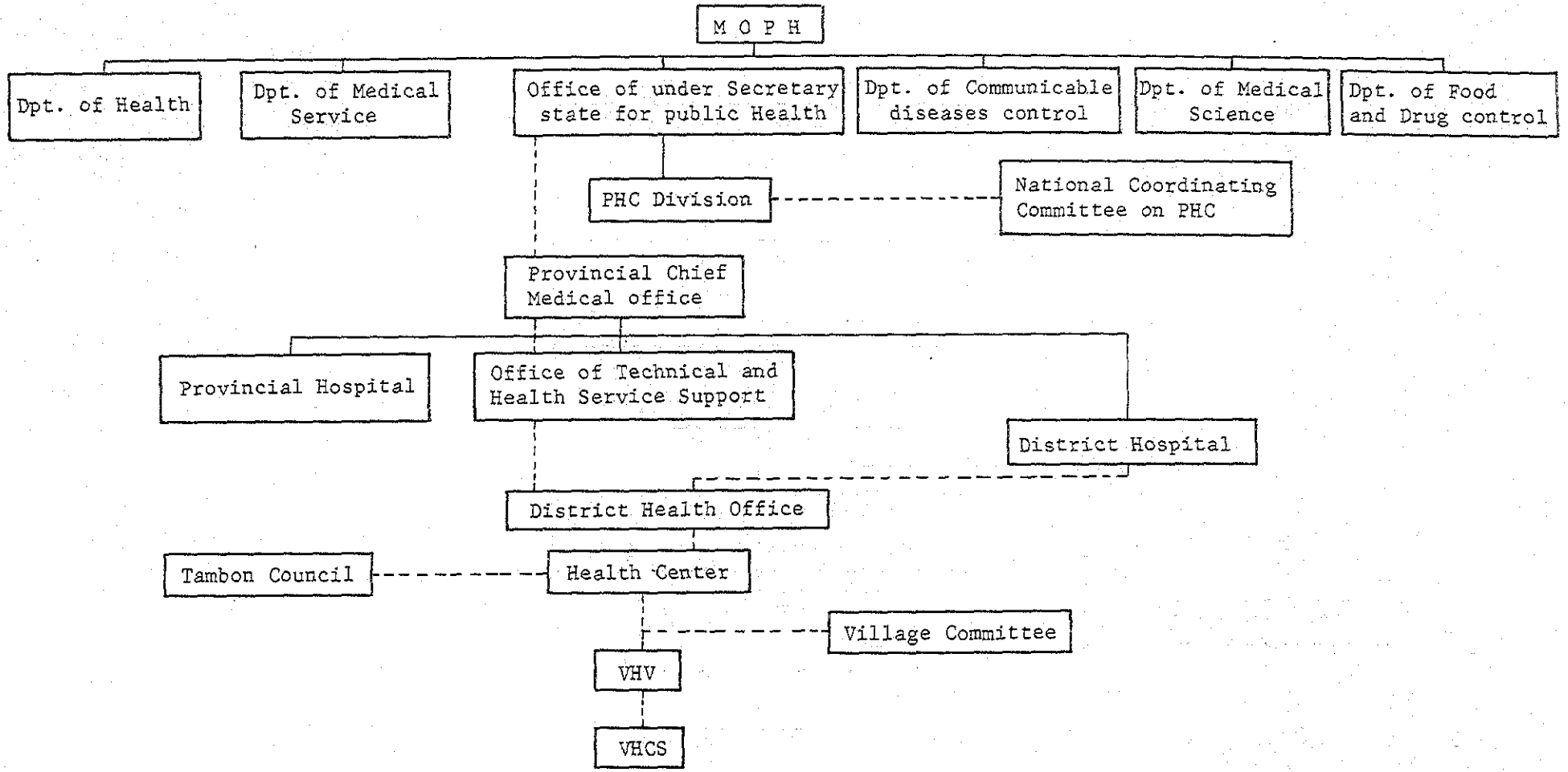
9.2 The supervision will help the implementation of planning the aim of training, recruitment, orientation for VHC/VHV and continuous training more correct and efficient.

9.3 To support materials and other things which are necessary for the implementation of VHC/VHV and use the existing resources in community to solve health problem.

Supervision organisation chart



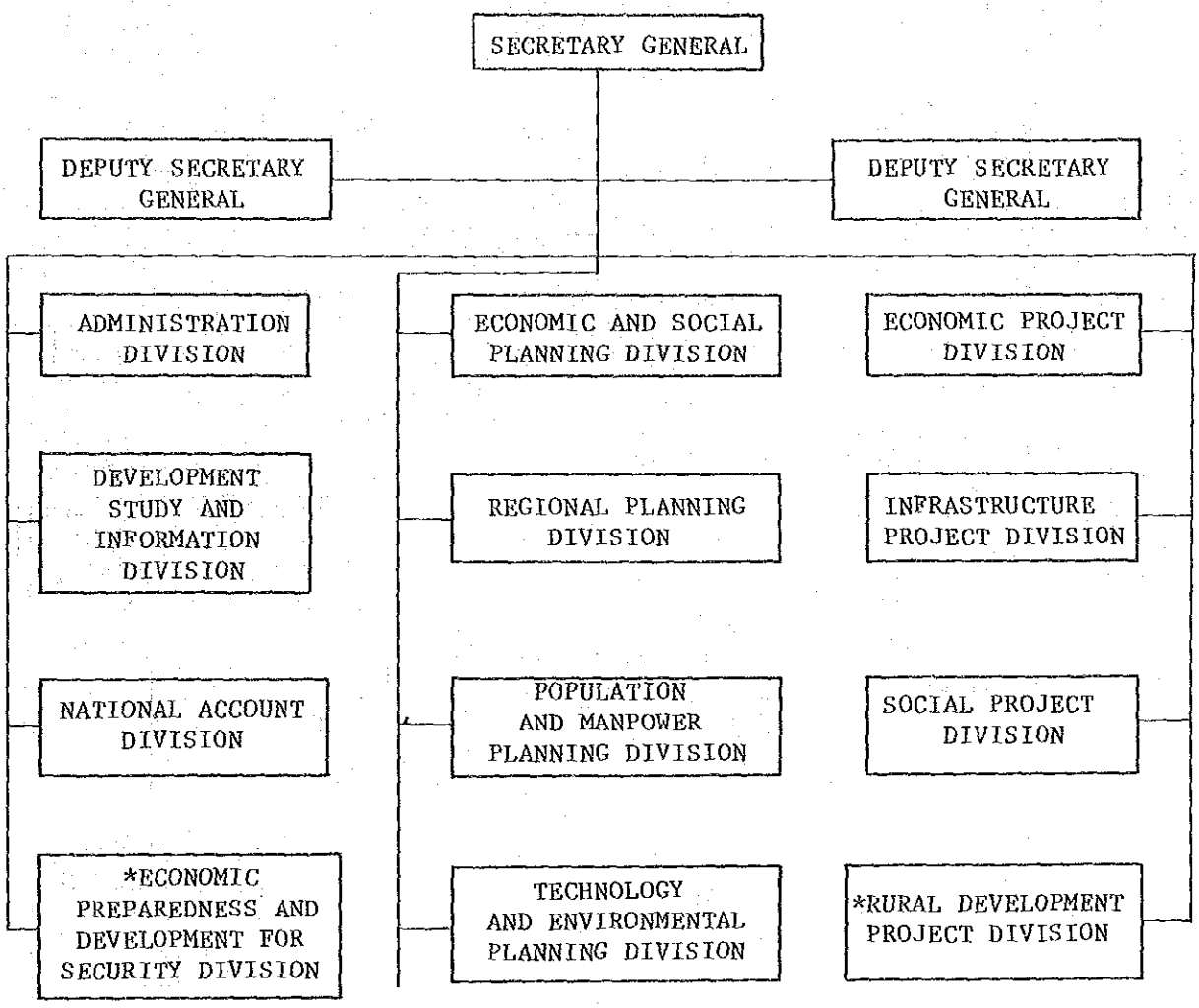
Organization chart



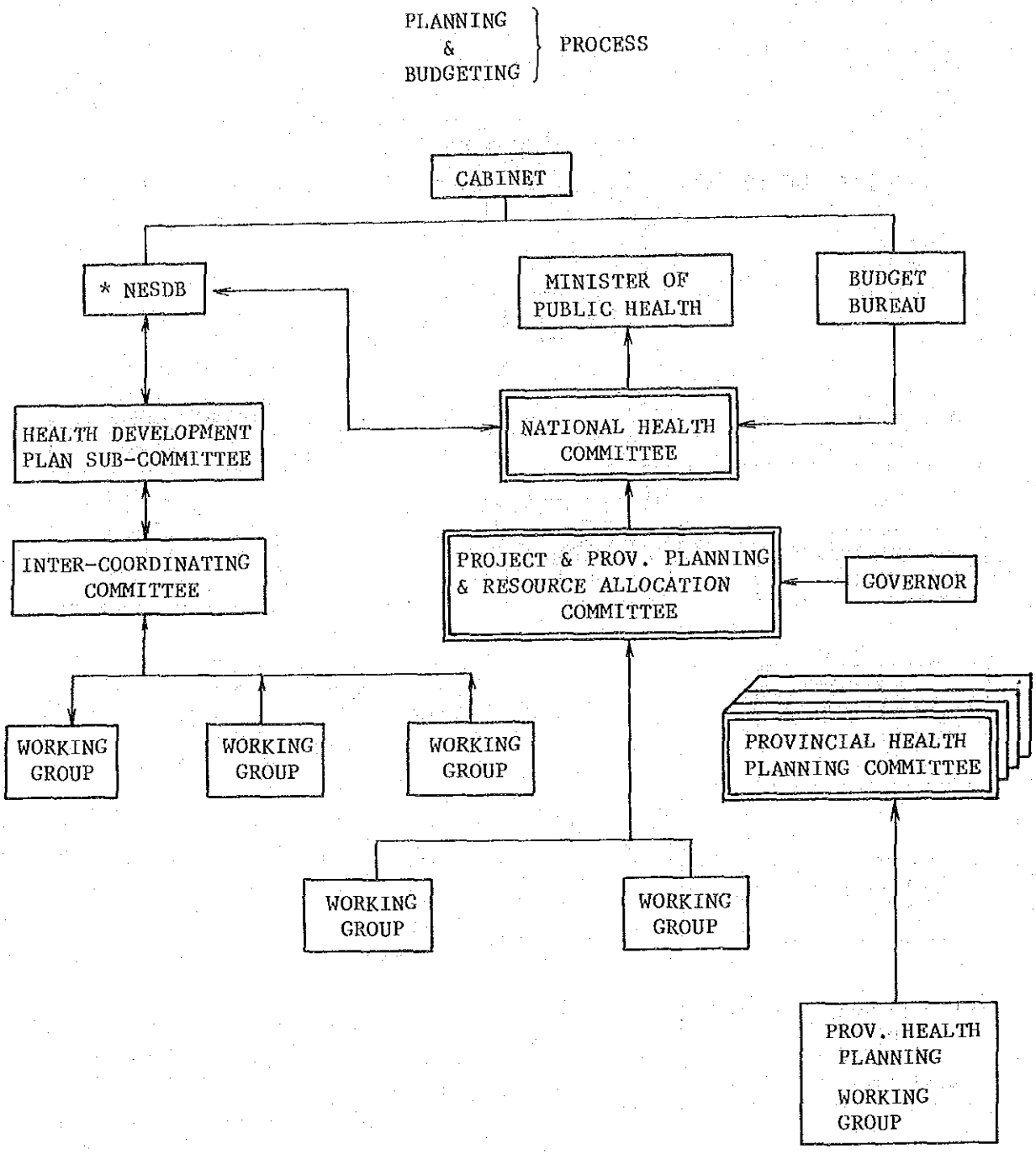
2. 関係機関組織図

(1) NESDB

ORGANIZATION CHART OF
OFFICE OF THE NATIONAL ECONOMIC AND SOCIAL DEVELOPMENT BOARD



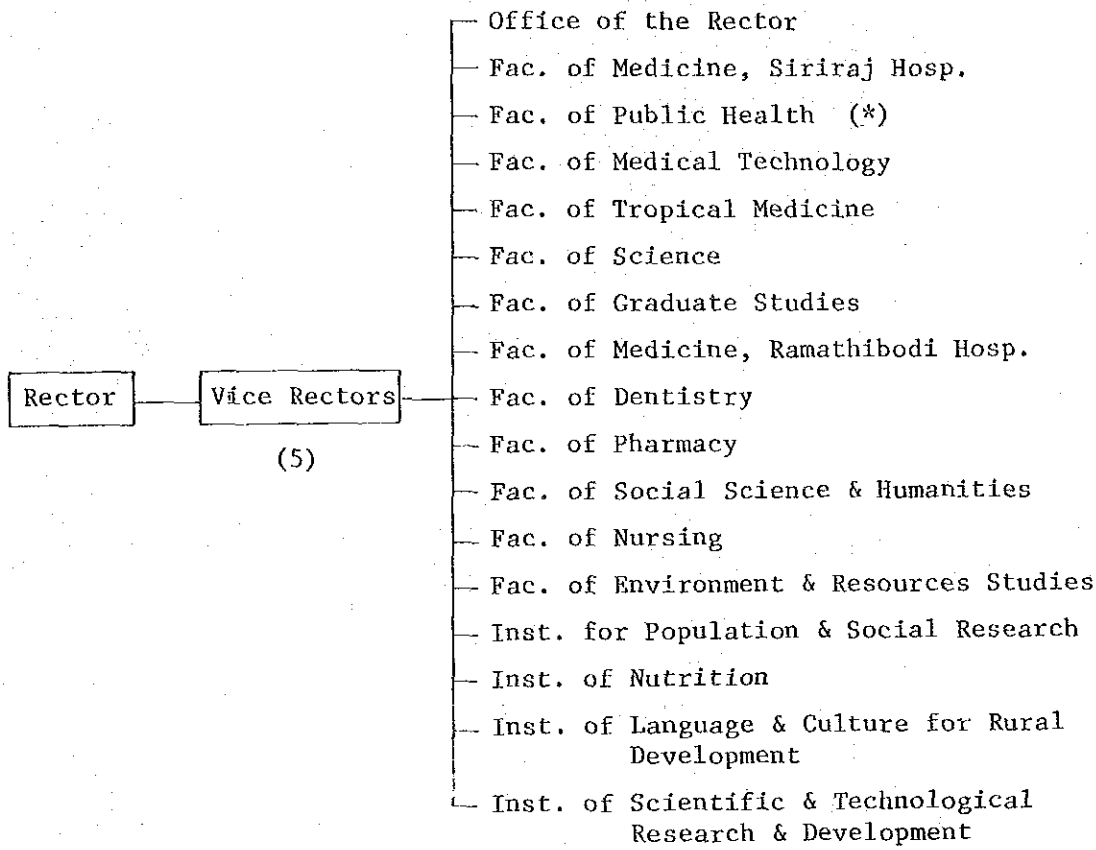

*DIVISIONS ARE UNDER CONSIDERATION



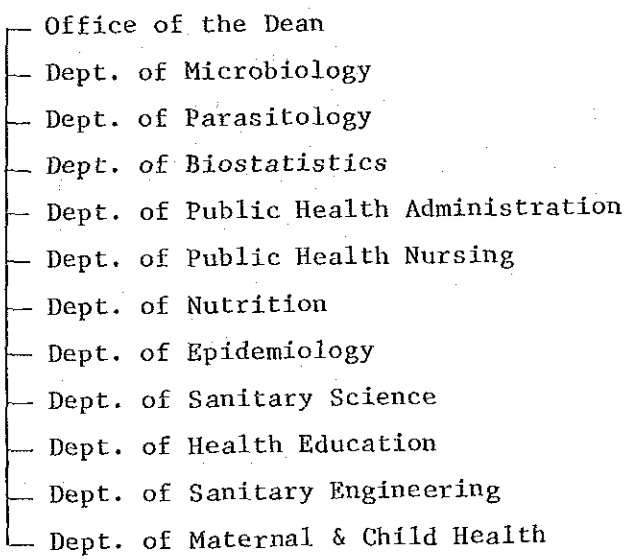

* NESDB = NATIONAL ECONOMIC & SOCIAL DEVELOPMENT BOARD

(2) 国立マヒドン大学

MAHIDOL UNIVERSITY ORGANIZATION

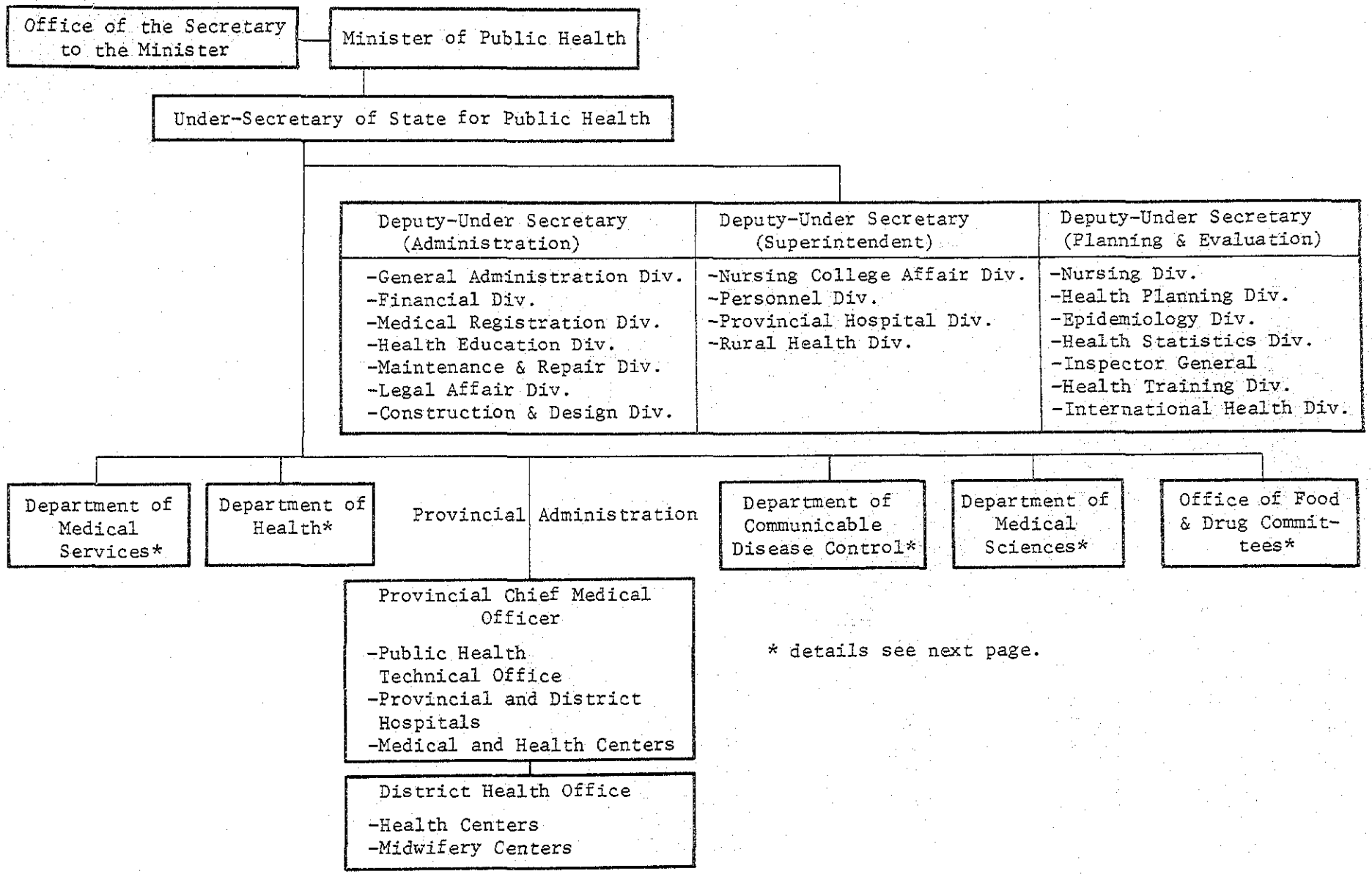



* Faculty of Public Health



(3) 公衆衛生省

ORGANIZATION OF THE MINISTRY OF PUBLIC HEALTH



| Department of Medical Services | Department of Health | Department of Communicable Disease Control | Department of Medical Sciences | Office of Food and Drug Committees |
|---|---|---|---|---|
| -Office of the Secretary<br>-Financial Div.<br>-Personnel Div.<br>-Technical Div.<br>-Mental Health Div.<br>-Children's Hospital<br>-Thanyarak Hospital<br>-Prasart Neurological Hospital and Institute<br>-Mental Deficiency Hospital<br>-Lerd Sin Hospital<br>-Srithanya Hospital<br>-Buddhist Monk's Hospital<br>-Somdej Chaophraya Hospital<br>-Women's Hospital<br>-Institute of Pathology Pathology<br>-National Cancer Institute<br>-Institute of Dermatology | -Office of the Secretary<br>-Financial Div.<br>-Personnel Div.<br>-Dental Health Div.<br>-Rural Water Supply Div.<br>-Nutrition Div.<br>-Sanitation Div.<br>-Family Health Div.<br>-School Health Div.<br>-Environmental Health Div.<br>-Occupational Health Div. | -Office of the Secretary<br>-Financial Div.<br>-Personnel Div.<br>-V.D. Control Div.<br>-Malaria Eradication Div.<br>-General C.D.C. Div.<br>-Filariasis Control Div.<br>-Leprosy Control Div.<br>-T.B. Control Div.<br>-Bamrasnaradura I.D. Hospital<br>-Leprosy Hospital<br>-Chest Hospital | -Office of the Secretary<br>-Entomology Div.<br>-National Health Laboratories Project Div.<br>-Radiation Protection Service Div.<br>-Clinical Pathology Div.<br>-Toxicology Div.<br>-Drug Analysis Div.<br>-Food & Beverage Analysis Div.<br>-Medical Research Div.<br>-Virus Research Institute | -Office of the Secretary<br>-Public Relation and Advertisement Control Div.<br>-Cosmetic Control Div.<br>-Drugs Control Div.<br>-Psychotromic Substance Control Div.<br>-Food & Beverage Control Div.<br>-Technical Div.<br>-Inspector Div. |

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3) Dr. Pricha Deesawadi, Director of PHC Office
4) Mr. Chairat, Health Planning Division

(注) プロジェクト実施機関のみに限定した。