The Four-Decade Development of Primary Health Care in Thailand
1978 - 2014
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Advisor:
Squ. Ldr. Boonruang Triruangwarawat, Director General of The Department of Health Service Support
Dr. Phattarapol Jungsomjateprisal, Assistant Director of General of The Department of Health Service Support
Mrs. Untiga Chatchawalyangkool, Director of The Primary Health Care Division

Editorial department:
Mrs. Amornsri Yortkham, The Primary Health Care Division
Miss Monwadee Prakairunthong, The Primary Health Care Division
Mr. Viroj Lengrugsa, The Primary Health Care Division
Miss Chutisuda Netikul, The Primary Health Care Division
Mrs. Aungpai Assawasri-anun, The Primary Health Care Division

Created by:
The Primary Health Care Division, The Department of Health Service Support
Tiwanon Road Amphoe Mueang Nonthaburi, Nonthaburi Province 11000
Tel. 02 590 1545 Fax : 02 590 1530
www.phc.moph.go.th

Publication Date: September 2014
Publisher:
The War Veterans Organization of Thailand
Under Royal Patronage of His Majesty The King (Office of Printing Mill)

Edition: 500 copies
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Primary Health Care Division
Department of Health Service Support
Forwards

The 1978 Alma-Ata Declaration, raised after The 1978 International Conference on Primary Health Care, held in Alma-Ata, USSR (Almaty at the present, Republic of Kazakhstan), predicted its ultimate goal “Health for All by the Year 2000”, and recommended primary health care, was the only effective tool to achieving that goal. In 1981, Thailand as a WHO member signed to commit “Charter for Health Development”, using in the development of national health system, this was the beginning of primary health care legend of the country.

The cabinet approved the exclusion of main issues of “Charter for Health Development” in the 4th National Economic and Social Development Plan (NESDP, 1977 – 1981), and the National Primary Health Care committee. Subsequently, Office of the Primary Health Care Committee, a division level within the Office of the Permanent Secretary, “Ministry of Public Health”, were formed to carry out primary health care mission, under national health care plan, within the 4th – 10th NESDP (1978 – 2003). Then, primary health care projects have been processed to develop, generating it networks covering the whole country.

Due to socio-economic changes, and government’s policy to reform Thai bureaucratic system, “Primary Health Care Division” was setup to replace “Office of Primary Health Care Committee”, as ceased after the declaration of “Health for All” in 2000. Precise mission with holistic administration has been conducted following the concept; “Health is People’s Right and Duty”, and the motto; “Take Health Promoting First, Get Health Repairing Later”.

Over a phase of 37-year legend, primary health care plays role as a solid basis for national health system, contributing in every village of the entire country. Village health volunteers of more than 1.04 million as well as multilevels of village health volunteer networks, have to “take-in-charge” their responsibility, to strengthen health care system. People aware themselves in health care as individual, family and community.

Primary Health Care Division, as its authority to respond for primary health care of the country, wishes to publish a book of “The Four-Decade Development of Primary Health Care in Thailand”. It would present context, scope, and the process of primary health care development, step by step. Problems, struggles, strength and weakness, have been analyzed, as well as trend and direction of primary health care in the future. On behave of primary health care authority, we gratefully thank primary health care leaders and personnel, related authorities and personnel, whom devoted themselves to support primary health care works, to be strengthened, sustainable, and progressed up to the present.
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Reference
Predicting the ultimate goal of "Health for All by the Year 2000", and selecting primary health care (PHC) for use as strategic roadmap to achieving that goal, according to "The 1978 Alma – Ata Declaration on Primary Health Care", held in Alma – Ata, USSR, and an official agreement to "The Charter for Health Development", to be implied as national health plan (held in Bangkok, Thailand in 1981), was the first step of primary health care development in Thailand. Under the national health care plan, "The National Committee of Primary Health Care" and "Office of the Primary Health Care Committee", were formed to serve primary health care’s mission as follows. Firstly, PHC context with 4 principles of 1) equitable distribution of health care 2) community participation 3) use of appropriate technology and 4) multisectoral approach, became as main context for PHC development in Thailand. Secondly, to conclude an idea to formulate PHC developmental theory, which then assigned as "The Trigonal Theory": comprising 1) committee, referred to villager’s representatives 2) fund, referred to money resource as administered by community’s committee, and 3) manpower, referred to villagers that would able to be handled PHC mission in their village. In addition to the manpower, village health communicators (VHCs) and village health volunteers (VHVs), the typical model of community health worker of Thailand, were processed to multiply their numbers, prior to meet national coverage of PHC project implemented in rural and urban village, in 1981.

Conclusion
For Executive Administrators
During the first half of the 1st decade of PHC development (1977 – 1986), it was engaged with the management of 8 PHC essential elements in each village (education on health problems, development of effective food supply and proper nutrition, maternal and child healthcare, adequate and safe water supply and basic sanitation, immunization against major infectious diseases, local endemic diseases control, appropriate treatment of common diseases and injuries, and provision of essential basic medication). Health care officers had been recruited and well trained to be "Trainers", which were further appointed to train villagers, to become VHCs and VHV. Then, VHCs and VHVs would be assign to "take-in-charge" as "Community Health Workers" within their village. Six essential elements (dental health, environmental health, consumer protection, accident and non-communicable disease control, prevention and control of AIDS, and environmental health) were later added in 1987 and 1991. Whereas the second half of the 1st decade, several provisional funds and the process of minimum need, had been processed to develop as quality approach.

Golden age of PHC development was observed in the 2nd decade (1987 – 1996), in which, community’s PHC center was formed as well as satisfied progress of village development fund and health card fund. All VHCs were upgraded to be VHV, and multi-level VHV clubs were also founded in this meantime. During the first half of the 3rd decade (1997 – 2006), was mentioned as an accelerated developmental phase, due to achieving the goal of "Health for All". VHV played role as "Community Health Workers", whereas academic support and advices to the VHV had been conveyed from bureaucratic officers. The out-comes were valuable, helpful and needed by the people such as solving public health problems, e.g. transmitted diseases, malnutrition, sanitation, environment, maternal and child, and basic medical treatment. This lead to the massive improvement of people health and life quality.
PHC was insisted as the only effective tool to achieving goal "Health for All by the Year 2000".

Second half of the 3rd decade, was named as the era of change, in accordance to the effect of 1997 constitution and government’s policy to reform bureaucratic system in 2003. In 2003, "Primary Health Care Division" was formed to replace "Office of the Primary Health Care Committee", to carry out PHC mission. The PHC works deserved as a part of public health works, and its new context needed collaborative administration from related sectors. PHC developmental direction focused on "Village Health Management" and change "VHVs responsibility" from village health worker to be community health manager.

In the 4th decade (2007 – 2014), main theme of PHC development emphasized in administrating, managing, community empowering, network forming and collaborating such as improvement of VHVs potential to be community health manager, use of strategic route map as a tool for PHC administration, development of "Village of Health Management" and "Tambon of Health Management", and strengthening PHC works to connect with "Tambon health promoting hospital" and "district hospital".

Again, a great change in PHC context would be occurred in the aseanization era. It’s necessary to get well planning for our readiness such as 1) to reconsider policies and strategic plan in relate with PHC works, 2) to integrate PHC works with health service system in every level 3) to conserve and develop PHC works and VHVs. 4) to improve VHVs potential to become community health manager, 5) to manage PHC database from the past up to the present 6) to arrange PHC knowledge and innovations and 7) to support and promote PHC research.

In conclusion, primary health care is a universal health principle, valuable, useful, and existed as a solid basis of Thailand health system. It is deserved to support its continuous development, to provide sustainable "Health for All Thai People", as long as possible.
Chapter 1
Introduction, Definition and Principle of Primary Health Care

Introduction

The beginning of primary health care (PHC) as global distribution, was addressed eventually "the 1978 International Conference on Primary Health Care", sponsored by World Health Organization (WHO) and United Nations Children’s Fund (UNICEF), held in Alma – Ata, USSR (Almaty at the present, Republic of Kazakhstan). This lead to the formation of "Charter for Health Development", which aimed to provide "Health for All by the Year 2000". Emphasizing in this health bible’s context, it comprises a set of guiding values for health development, a set of principle for the organization of health services, and a range of approaches for addressing either primary health care needs and the fundamental determinants of health.  

As PHC launched its implementation through worldwide and progressed consequently for 35 years, representatives from 134 countries around the world (WHO members), including representatives from Thailand, had invited to share their experiences in “The 35th Anniversary of Alma-Ata


In a case of Thailand, PHC was introduced to be applied as strategic roadmap for health development since 1978. It took a wide range of experiences, including successes, struggles and problems, year by year, which have been varied following socio-economic-political changes, up till now. In order to predict PHC mission’s trend and direction through the next decade, it’s necessary to address and reconsider our four-decade lessons, comparing to the 35th Anniversary of Alma-Ata Declaration’s context. These are herein:

**Definition of Primary Health Care**

A classic definition of PHC, concluded after "The 1978 International Conference on Primary Health Care", defined as:

"Essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. In addition, it must be fully integrated within health service system of the country, as the main economic-political mechanism of community that being accessible to people at their household and office as well as possible."

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*Declaration*, held in Almaty, Republic of Kazakhstan, in November 6 – 7, 2013. The book of "Almaty within the Context of the New Millennium of Human Evolution", edited by Professor Dr. Toregeldy Sharmanov (former minister of public health, Republic of Kazakhstan, acknowledged as a key organizer for the 1978 Alma–Ata Declaration on PHC), was officially published and distributed across worldwide. This book is likely the great reference in PHC development, acknowledged by WHO and UNICEF.

In a case of Thailand, PHC was introduced to be applied as strategic roadmap for health development since 1978. It took a wide range of experiences, including successes, struggles and problems, year by year, which have been varied following socio-economic-political changes, up till now. In order to predict PHC mission’s trend and direction through the next decade, it’s necessary to address and reconsider our four-decade lessons, comparing to the 35th Anniversary of Alma-Ata Declaration’s context. These are herein:
“The state of complete physical, mental and social well-being”, has been an official meaning of "Health", proposed by WHO since 1946. This strategic definition reflexes an idea to discover possible roadmaps to achieving the well-being status of physical, mental and social well-being."

Dr. Amorn Nondhasutta, the former Permanent-Secretary of the Ministry of Public Health, one of key persons in Thailand PHC’s legend, simplified the meaning of PHC as;

“Additional health services extended from state’s health service system, that mainly establish to serve people at rural area, as village or Tambon level, and need deep collaboration from community and its local people. Governmental health officers have been assigned to support the community for problem analyzing, planning, and counseling to promote necessary activities. PHC works would adapt themselves to integrate with other community’s development projects, and closely connect to governmental health service system.”

Dr. Margaret Chan, WHO Director-General (2006 – present), insisted the significance of primary health care as follows; PHC is the best way to achieve universal access and achieve sustainable results in health care, and guarantee equitable access to health. More and more countries are turning again to the value of primary health care as the basis for strengthening their health systems.

The recent meaning of PHC, officially promoted by WHO and UNICEF, realized after the 2013 Almaty Declaration, defined as;

“A necessary fundamental support of the health system as a complex principle of comprehensive health care, performs as integral function in the national health care system, is the core of the system, and integral part of the global social development of human society.”
Principle and Goal of Primary Health Care

The ultimate goal of PHC has aimed to achieve the target "Health for All by the Year 2000". In order to launch and sustain PHC as a part of a comprehensive health system and in coordination with other sectors, the 1978 Alma Ata Declaration insisted that national policies must be formulated to its country agenda, as follows:

1) Equitable distribution of health care—The opportunity of PHC and other services to meet main health problems via the community, must be provided equally to all individuals, irrespective of their gender, age, caste, color, urban/rural location and social class.

2) Community participation—Community participation has considered to be sustainable, due to its grass roots nature and emphasis on self-sufficiency, as opposed to targeted approaches dependent on international development. It would lead to make the fullest use of local, national and other available resources.

3) Health workforce development—Comprehensive health care relies on adequate number and distribution of trained physicians, nurses, allied health professions, community health workers and others working as a health team and supported at the local and referral levels.

4) Use of appropriate technology—Medical technology should be provided that is accessible, affordable, feasible and culturally acceptable to community.

5) Multi-Sectoral approach—Health cannot be improved by intervention within just the formal health sector. Other sectors are equally important in promoting the health and self-reliance of communities, including agriculture, education, communication, housing, public works, rural development, industry and community organization.

Essential Elements of Primary Health Care

In accordance to the 1978 Alma-Ata Declaration, PHC context had been divided into five integral frameworks, comprising prevention of the disease, health promotion, health...
treatment, and health rehabilitation. PHC components play role as the heart of PHC, generally known as “Essential Elements of PHC”, are:

1. Education on health problems and how to prevent and control them.
2. Development of effective food supply and proper nutrition.
3. Maternal and child healthcare, including family planning.
4. Adequate and safe water supply and basic sanitation.
5. Immunization against major infectious diseases.
6. Local endemic diseases control.
7. Appropriate treatment of common diseases and injuries.
8. Provision of essential basic medication.

In Thailand, the project used to implement primary health care in 1980, was the WHO typical pattern with 8 PHC essential elements. Due to dental and mental incidences among Thai people, the other two elements of dental health and environmental health, were later added in 1987. In addition, four elements of consumer protection, accident and non-communicable disease control, prevention and control of AIDS, and environmental health, were subsequently added in 1991.3-4.

Progression after the 1978 Alma-Ata Declaration

Due to socio-economic changes over a phase of 30-year PHC implementation, strategic roadmap of PHC among south-east Asia countries had been arranged by the conference; “Technical Discussions on Revitalizing Primary Health Care held in Jakarta, Indonesia from 6 – 8 August 2008”.

Recommendations to member countries were concluded as follows:

1) Reaffirm political commitment to revitalizing PHC as an effective approach to strengthen health systems, to address national health needs.
2) Review health financing and expenditure.
3) Strengthen human resources and service delivery system to support effective health systems through revitalizing PHC.
4) Develop a strategy for improving health information systems that can better support PHC.
5) Establish mechanisms as well as strengthen capacity for health system research and ensure its linkage with health policy and program implementation.

6) Empower communities, especially women, to take an active role in insuring responsiveness and accountability in PHC.

7) Strengthen the capacity of ministries of health vis-à-vis their governance, leadership and stewardship responsibility to coordinate all health and health–related sectors and stakeholders.

*Meeting of the South–East Asia Primary Health Care Innovations Network (SEAPIN)* held in Chiang Mai, Thailand in 2010, represented an advanced step of PHC among south–east Asia countries. Main issues conducted from the meeting were to promote the discovery and use of innovations as tools to strengthen PHC works. In Thailand, health innovations using folk know–how, have been continuously promoted and accepted among village health volunteers (VHVs), as a massive scale.

In summary, The 1978 Alma Ata Conference on Primary Health Care, has been acclaimed as the event that changed direction of world health care through worldwide, including Thailand. In reality, strategic roadmap used to implement "The Charter of Health Development" as realistic approach in each country, had been flexible and adaptable, due to its socio–economic–politic variation. However, all countries’ goal still to be the same, to achieving "Health for All by the Year 2000". PHC is believed as the only effective tool to achieving that goal by these centuries.
Primary Health Care (PHC) : Definition

Primary Health Care (PHC), is defined as "Additional health services extended from state's health service system, that mainly establish to serve people at rural area, as village or Tambon level, comprising with prevention of the disease, health promotion, health treatment, and health rehabilitation. It needs deep collaboration from community and local people for planning, processing and evaluating, as well as the support from governmental health care authorities to provide knowledge, health information, training activities, referral system, and necessary instruments. This would initiate the beginning of community development with strengthening the community to solve their own problems, as well as managing their health care projects in collaboration with other sectors, e.g. agriculture, education, etc."

Principle of Primary Health Care, Formulated to Implement in Thailand.

1) Community Participation (C.I.). People must share their collaborative activities through health care service, appoint themselves as owners of community’s problems and village projects, and share their activities to solve the problems as well.

2) Appropriate Technology (A.T.). Common techniques or methods to be used and applied in PHC works must be simple, suitable and appropriate according to resources and people potential.

3) Basic Health Service (B.H.S.). PHC works in every village must be approached to make connection with available governmental health service system, and set up effective referral system.

4) Intersectoral Collaboration (I.C.). PHC works must be carried out following extensive collaboration with authorities and officials from the Ministries of Public Health, Interiors, Education, and Agriculture and Cooperatives, and other governmental and private sectors.
Community Funds/Tambon health securities fund Process mechanism, participation, local authorities, networks in community Village Health Volunteers/leaders, local organizations, community networks
Chapter 2: Evolution of Primary Health Care in Thailand

Status of Thailand’s Primary Health Care, Before 1977

As the first hospital founded at Petchaburi in 1828, this was the beginning of western medicine as hospitalized scale in the Kingdom of Siam. Eventually Cholera struck Bangkok and vicinity in 1881, western healthcare system had begun to establish across the country such as; 48 hospitals for cholera treatment (1881), Siriraj Hospital (1887), King Chulalongkorn Memorial Hospital (1914), Chulalongkorn University (1899) and Ministry of Public Health (1942).

When the 1st National Economic and Social Development Plan (NESDP) had been applied via bureaucratic administration of the country, administrative capability led by the government raised to be more systemically effective. Health care development during the 1st – 3rd NESDP (1963 – 1975), emphasized mostly infrastructure establishment, e.g. provincial hospital, district hospital and Tambon health station. During these periods, some pilot projects that aimed to develop a health service delivery system through rural communities, were carried out under the support of WHO, UNICEF and USAID. Malaria was mentioned as an important public health problem, in which malaria...
volunteers" were probably a role model for "village health volunteers and village health communicators" in the next few years.12.

One of public health problem at community level, "less amount of people came to use Tambon health station's service", was firstly raised by Dr. Somboon Watcharothai in 1966. This lead to the initiation of a pilot study, namely Wat Bothi project, Phitsanulok province. In this meantime, three key persons of Thailand’s PHC legend, comprising Dr. Somboon Watcharothai, Dr. Amorn Nondhasutta and Dr. Piroj Ningsanonta, launched a community-based primary health care project at Sarapee district, Chiang Mai (Sarapee project).12. Village health volunteers (VHVs) and village health communicators (VHCs), were firstly formed to “take-in-charge” for their assigned function as "community health workers". The successfulness of Sarapee project enabled its extension to other districts of Chiang Mai province (Samoeng project), and got further trials at different regions, e.g. Nakhon Ratchasima province (None Thai project) and Khon Kaen province (Baan Phai project). The operation project aimed to systemic PHC development as provincial scale in the 4th National Economic and Social Development Plan (NESDP, 1978 – 1981), on April 12, 1979. To this approval, the National Primary Health Care Committee was formed to serve PHC project’s coordination as well. Then, Office of the Primary Health Care Committee, a division level, was setup unofficially within the Ministry of Public Health (MoPH), to carry out its responsibility to serve PHC mission that be proposed to launch officially in the short future (1 year before official agreement to “Charter for Health Development”).

Thailand, as WHO member, had been invited to participate and attend "The Alma-Ata International Conference on Primary Health Care", between 6 – 12 September 1978, and its representatives had signed to adopt "The 1978 Alma-Ata Declaration". Subsequently, the cabinet approved the inclusion of the PHC project was held in Lampang province (Lampang project) between 1980 – 1985.12.
The First Decade (1977 - 1986)

PHC Development During the 1st Decade (1977 - 1986)


1) To implement PHC project as a national policy and public health plan.
2) To discover and recruit village health volunteers (VHVs) and village health communicators (VHCs), and train them to be leaders of change.
3) To incorporate 8 PHC essential elements into PHC village.
4) To contribute PHC principle and supervision toward all levels of community health workers, and insist the significance of people and community’s participation.
5) To form village drug fund.

The 5th Public Health Plan (1982 – 1986)
1) To multiply VHVs and VHCs numbers to meet rural community coverage, and initiate PHC in urban area.
2) To integrate PHC with other community development projects, as village development fund project through intersectoral collaboration.
3) To extend additional PHC essential elements to be 10 by the end of the 5th plan.
4) To formulate community based projects e.g. developing the quality of life by using the basic minimum need (BMN) process and indicators, project for the people’s quality of life campaign 1985 – 1987, PHC self-cared village project, and health card project.
Thailand’s Socio–Economic–Political Situation During 1977–1986; In accordance to Indochina’s post–cold war, it affected directly to Thailand’s governmental policies that focused mainly on military, political and economic campaigns. Whereas, a wide range of public health problems affecting to people life quality, such as poorness, health service system, malnutrition, undelveloped sanitation, and people’s capability to access health information, were still appeared over the country, especially rural community.

The Frist Decade (1977 - 1986); Establishment of Infrastructure of Primary Health Care.

Thus, the beginning of PHC development in Thailand started officially, when Thailand government (signed by General Kriangsak Chamanan, Prime Minister, and Dr. Boonsorn Matin, Minister of Public Health), signed to commit “Charter for Health Development”, to be implemented in the country on February 11, 1980 (WHO officials signed by Dr. H.T. Mahler, WHO Director–General (1973–1988) and V.T. Harat Gunaratha, Regional WHO Director of South–East Asia3).
Emblem of Primary Health Care and Its Meaning

People hold hand-to-hand refer to people, families and communities.

Nine people hold hand-to-hand as a circle refer to intersectoral collaboration of governmental authorities, private sector, business organization and people, to promote and support health care among people, families and communities.

Red color refers to the soul of primary health care, which being supported people’s health.

Blue color refer to great vision and strength.
The Project of Primary Health Care in 1981

According to WHO recommendation, it should process to recruit local people and train them to be Community Health Workers (CHWs), and then appointed them to work in their community. In case of Thailand, a volunteer model of Village Health Volunteers (VHVs) and Village Health Communicators (VHCs), was used instead of WHO’s Community Health Workers (1 VH and 10 VHCs per village, recruited by sociogram method). In addition to the PHC project implied, "The Trigonal Theory; man, fund and committee", as well as village drug fund and training program, were also introduced to process in this operation project4-6,12.

Establishment of Infrastructure and Multi-Level-Bureaucratic System to Support PHC Development

National Level; The National Health Care Committee comprised with representatives from the Ministry of Public Health, Interiors, Education and Agriculture and Cooperatives, and assigned experts, was authorized to be responsible over the national health plan. Whereas, The National Primary Health Care Committee, approved by the cabinet in 1979, comprised with MoPH’s permanent secretary (as president), and other director – generals and directors from related MoPH’s authorities (as committee), was assigned to handle on PHC planning4-8.
Central Level; After the government signed to commit "Charter for Health Development" on February 11, 1980, the cabinet approved to establish Office of Primary Health Care Committee, to be functioned as secretary of The National Primary Health Care Committee. Its responsibility also dealt with policy, plan, resource and budget, academic and technology support, and research and assessment toward the process of PHC development across the country.4-8

ASEAN Training Center for Primary Health Care Development (ATC/PHC), Mahidol University, was established in 1986, as a human resource development to support PHC development among ASEAN countries, as sponsored by Japanese government. It was later upgraded to be ASEAN Institute for Public Health Development on July 9, 1986, and finally transformed to be ASEAN Institute for Health Development (AIHD), on May 20, 2009.13

Regional Level; In 1984, 4 Regional Training Centers for Primary Health Care Development had been founded at Khon Kaen (north - eastern region), Nakhon Si Thammarat (southern region), Nakhon Sawan (northern region) and Chon Buri (central region). In addition, Regional Training Center for Primary Health Care Development at Southern Border Region, was later founded at Yala in 1997. The center’s responsibility dealt with academic support and coordinating the PHC works as regional level. All centers became to be Regional Training Center for People Health Care System, in 2003.4-8

Provincial Level; The Unit of PHC work was formed as a provisional part within Personnel Development Division of Provincial Public Health Office. Its function was to coordinating the PHC works between central headquarter and District Public Health Office.4-8
District Level; District Public Health Office was also founded in every district, serving PHC coordination between Provincial Public Health Office and Tambon Health Officials, providing drug and medical supplies to VHV's, and supporting referral system⁴-⁸.

Tambon Level; Tambon health officials were assigned to "take-in-charge" for discovering, recruiting and training VHCs and VHV's, following up and orientating to VHCs and VHV's, and handling referral system⁴-⁸.

Village Level; VHCs and VHV's, recruited from local people via sociogram method, and well trained following training schedules, were then assigned to "take-in-charge" for PHC works as village health workers in their community⁴-⁸.

Village Health Communicators (VHCs) and Village Health Volunteers (VHV's)

Recruitment; VHC candidates recruited from local villagers by Tambon health officials using a sociogram technique, were assigned to attend a 5-day orientation course. Subsequently within a 6-month period, a refresher course had been applied to follow up. On a regular scheme, VHV's were selected among active VHCs after a working period of 3 – 4 months. Qualification criteria were; devoted mind to serve community, had enough time, be literate, be trusted by the villagers, be good health and well economic status. VHV candidates would attend a 15-day orientation course, and would be followed by a refresher course within the next three months. In addition, either VHV's and VHCs were expected to attend continuous training through regular training courses, as supervised by Tambon Health Officials⁴-⁸,¹².

Responsibilities; To each village with average size of 100 households, 10 VHCs and 1 VHV were assigned to "take-in-charge" for their function(1 VHC for every 8 – 15 households and 1 VHV for 100
households). Each VHV also deserved himself/herself as a leader for the other VHCs. Since VHCs and VHVAs played role in the contribution of PHC project toward target villages by mean of community-based administration, thus the 4th and 5th plan focused predominantly on training activity for VHCs and VHVAs. Enough numbers of VHCs and VHVAs with accepted performance, was a key to get successfulness of PHC project during the 1st decade.4,12.

Curriculum; Training courses designated to VHCs included elements of basic health and medical knowledge e.g. first aid, communicable disease control, sanitation and environmental health, personal hygiene and family health (family planning, maternal health and child care), and care for minor ailments. Topics on community health problem analysis and group-work techniques were also enlisted as well. In addition to VHCs, VHVAs had expected for following up patients referred to them by health facilities, taking blood samples for malaria detection, dispensing condoms and contraceptive pills, and to be team leaders of other VHCs.4,12.

PHC Project’s Out-Comes; The First Decade (1977 - 1986).

1) PHC Project Implemented Across the Country; At the end of 1981, a half rural villages across the country (24,000 villages from 4,800 Tambons, 620 districts, 68 provinces), accounted as 18.5 million of Thai population, were initially applied with PHC project of 8 essential elements. And at the end of the 1st decade (1986), 87% of rural and urban villages of the country were successfully implemented with this typical PHC project.4-8,12,14.

2) VHCs and VHVAs; At the end of 1986, total numbers of VHCs and VHVAs were reported to be 510,286 and 53,498, respectively. During the first decade, average attrition rates for VHVAs and VHCs were estimated to be 62.4% (47,033 from 75,351) and 25.0%, respectively. More seriously, average number of active VHCs per village was observed to be 4 – 5, regardless of village size. In case of VHVAs, their performance seemed to be problematic.4-8,12,14.
3) Village Drug Fund; Beginning from the 4th plan to the 5th plan, village drug funds were formed as a 800 Baht support by the government, comprising 63 items of household drugs, which were provided by the Government Pharmaceutical Organization (GPO). The fund was held following joined administration by VHV's and VHCs. At the end of 1981, 1984 and 1987, numbers of village drug fund of 2,000, 2,200 and 26,977 were reported to formed\textsuperscript{4,12,14}.

4) Health Card Project; The project initiated in 1983, and aimed to expand in every Tambon within 1987. Unfortunately, the project ceased, due to its uncontinuous processing\textsuperscript{4,12,14}.

5) Community Development Fund; Since the beginning of 5th plan (1982), several provisional funds were performed in PHC villages. To the results as reported in 1995, 22,000 nutrition funds and 11,952 sanitation funds, were shown. In 1986, all provisional funds, including village drug fund had been consolidated to be “Community Development Fund”, contributing in 53 provinces. Administration to the fund, was joined by its village committee such as sub-district headman, village headmen, villagers’ representatives, VHCs and VHV's. The fund was also co–supported by means of intersectional collaboration from the Ministries of Public Health, Interiors, Education, and Agriculture and Cooperatives\textsuperscript{4-8,12}.

6) The Process of Basic Minimum Need; The process of basic minimum need was mentioned as the MoPH innovation, to become the project for the people’s quality of life, using the basic minimum need (BMN) process and indicators (8 groups of job, and 32 indicators). Its initiation began in 1987, co–supported as intersectional collaboration by the Ministries of Public Health, Interiors, Education, and Agriculture and Cooperatives. The responsibility was later taken by Department of Community Development, Ministry of Interiors. In 1987–1987, a campaign to promote the project for the people’s quality of life had been launched. Then, the project was later processed in every PHC village, which was joint–administered by village’s committee, as well\textsuperscript{4-8,12,14}. 
The Four-Decade Development of Primary Health Care in Thailand: 1978 - 2014

Chapter 2: Evolution of Primary Health Care in Thailand


**1977**

Evolution of Primary Health Care

**1st Decade : 1977 - 1986**

- 1974 Pilot project at Lampang, Samoeng, None Thai
- 1978 Used PHC as health development strategy

**2nd Decade : 1987 - 1996**

- 1980 Office of PHC committee founded
- 1981 VHVs VHCs
- 1984 A year for PHC campaign/BMN implied
- 1984 Village development fund founded
- 1985 - 7 Project of people’s life quality campaign
- 1994 Upgraded all VHVs to be VHCs
- 1991 Community Centre

**Abbreviations:**

- PHC: Primary Health Care
- ATC/PHC: ASEAN Training Center for PHC Development
- VHVs: Village Health Volunteers
- VHCs: Village Health Cooperatives
- LLO: Local Legislative Office
- SRM: Strategic Route Map

Beginning from Communicable Disease’s Problems, Changed to

**Chapter 2: Evolution of Primary Health Care in Thailand**
Be Problems of Non-Communicable Diseases and Accidents


PHC Development during the 2nd Decade (1987 - 1996)


1) To strengthen PHC village by mean of “Man – Fund – Committee” concept.
2) To try out self-care project for individual, family and community approach.
3) To try out “4 – elements PHC” as a trial project.
4) To convince and support private sectors to share their activity among PCH villages.

The 7th Public Health Plan (1992 - 1997)
1) To form community’s primary health care center using the "Man – Fund – Committee" concept, and set up information system within the community’s primary health care center.
2) To support private sectors to share their activity among PCH villages.
3) To plus 4 additional PHC essential elements for PHC project.
4) To develop effective process and mechanism used for knowledge transferring among PHC works.
5) To initiate self-care project as family approach.

The Continuity of Life Quality Development

The Second Decade (1987 - 1996); The Continuity of Life Quality Development. Socio-Economic-Political Situation during 1987-1996

Eastern Seaboard was the big step of Thailand economic development, resulting in enhanced economic growth rates, increased people incomes, and enabled great change among societies. Interactive participation to
global society, lead to the upcoming of AIDS, which later affected to overall health care system and PHC context.

Problematic issues on VHCs and VHVs, had been conducted to analyze, prior to solving as systemic processing. More incidences of non-transmitted diseases such as diabetes mellitus and hypertension, as well as other problems, e.g. environments, accidents and natural disaster, were new issues to be considered and handled. "Health for All by the Year 2000", was an ideal goal to achieving in the next 10 years, whereas PHC system was not in readiness, in neither individual village performance nor nationwide PHC system. Of course, PHC mission of the 2nd decade was really challenged to carry out.

Trend of public health problems shifted from infectious diseases to non-communicable diseases. These were reasonable for the foundation of Community’s Primary Health Care Center4-8,12.

Community’s Primary Health Care Center was likely an operation center to provide basic health care service among villagers such as weighing, heightening, blood pressure measuring, and providing of household drug. It was usually used as a meeting or coordinating center for VHCs, VHVs and villagers. In addition, it was a health care’s information center in the community. At the end of the 2nd decade, foundation of 67,682 Community’s Primary Health Care Centers, was reported4-8,12.

PHC Project’s Out-Comes; The Second Decade (1987 - 1996)

1) Community’s Primary Health Care Center; Problematic issues of VHCs and VHVs performance from the 1st decade, were analyzed by The Office of Primary Health Care Committee. It was due to lack of precise working schedules and enough orientation.
2) VHVs Club, Health Care Volunteer’s Day, and Upgrading VHCs to Be VHVs; An idea to form VHCs and VHVs club in their provinces as cremation purpose, was raised by some VHCs and VHVs (from the total number of 700,000). Subsequently, meetings between Regional Training Center for Primary Health Care Development and VHCs and VHVs’ representatives, were set up, and finally concluded to the formation of regional VHCs and VHVs club. During this meantime, the governmental campaign, “Health for All by the Year 2000” needed a great support from PHC networks, which then the cabinet approved “The Health Care Volunteer’s Day (March 20, 1994)”, and upgrading all VHCs to be VHVs.4

The Office of Primary Health Care and Regional Training Center for Primary Health Care Development, supported the foundation of VHVs club as Tambon, district, province, region, up to national level. Objectives were; 1) to support, coordinate and promote unity among people, 2) to promote and contribute PHC works, 3) to be used as knowledge and experience transferring center, 4) to provide social welfare among VHVs members and 5) to consolidate spiritual mind among VHVs members. In reality, the foundation of multi-level VHVs clubs, was held by means of the bureaucratic system.
**The Third Decade (1997 - 2006)**

**PHC Development during the 3rd Decade (1997 - 2006)**


The 8th Public Health Plan (1997 – 2001)
1) To emphasize in human resource development, especially family health leaders.
2) To provide new budget policy (changed from budget per activity to budget per village, and focused on human resource development for its approach in community’s PHC center)
3) To declare health for all by the year 2000.

1) To provide a PHC budget of 7,500 Baht per village to local administrative authorities, and raise up to be 10,000 Baht per village.
2) To form "Primary Health Care Division" for carrying out PHC mission instead of "The Committee of Primary Health Care".
3) To contribute PHC frameworks toward people health sector, and address the significance of collaboration and intersectional coordination.
4) To support "health managed village" for sustainable and strengthened development.

"Human" as the Center of Development

**The Third Decade (1997 - 2006); Human as the Center of Development. Socio-Economic-Political Situation during 1997 - 2006**

In accordance to the 1997 Constitution, it enabled a wide range of changes through the society. Due to "The Office of Primary Health Care Committee" terminated its mission, "Primary Health Care Division", 
was formed to carry out PHC mission. To the bureaucratic reform act, several health authorities were established to achieving properly assigned mission to its authority under a new health system’s structure. Local legislative authorities and people sectors have also played role in their collaborative administration such as PHC works in village, governmental declaration for the health for all year 2000, and Korat Commitment for sustainable health for all year 2000 – 2010. Enabling of strong distort effects through the society was addressed, after the government launched its health coverage policy, in 2002. This was an era of information technology (I.T.), consolidating into people life styles, bureaucratic system and business sector. Incidence of bird flu, was the situation to contest health system’s performance and VHVs networks covering the entire country.

PHC Project’s Out-Comes; The 3rd Decade (1997 - 2006).

1) Declaration of Health for All by the Year 2000; During the readiness arranging phase to declare Health for All year 2000, the government asked each province to attend and take actions, if necessary, to accelerate all developing projects (with measuring indicators) that being operated among village or community. On October 23, 2000, nationwide-scale evaluation was conducted among village and community for their readiness, operated by the Ministry of Public Health. Criteria used in this evaluation were; 1) the basic minimum need (BMN) process and indicators 2) self-care capability and 3) accessibility to health care service. It was shown that the readiness scores of 97.45 and 92.32 were reported for rural villages (65,855 villages) and urban villages (1,791 villages), respectively.

The Ministry of Public Health setup the meeting at Nakhorn Ratchasima (Korat) on November, 29 – 30, 2000. Then, “Korat Agreement for Sustainable Health for All, 2000 – 2010”, was adopted to public as follows:

1.1) The Health for All by the Year 2000, will be the permanent process, performed consistently within a range of 10 years. It must be focused for more coverage on poor people, to improve their life quality by mean of primary health care.
1.2) To convince VHVs to play role as
VHVs for social, in which they have to
perform additional activities such as operator
in economics, education, and environment.
VHVs networks must be strengthened up,
as well as their ideology and independent
service mind.

1.3) To coordinate other volunteers
such as school health volunteers,
monastery health volunteers, family health
leaders, and village veterinary volunteers
to share their collaborative activity. Expected
out-comes will be ensured in health coverage,
and reproduced good health behaviors
to people.

1.4) Other local authorities such as
Tambon legislative office and other
urban legislative offices should declare
their policies or guidance to support
“The Sustainable Health for All”, and
adopt to public as well.

1.5) To support consortium as village,
Tambon, district and provincial level,
to monitor, control, follow up, evaluate, and
suggest all other activities/projects/works that
related to “The Sustainable Health for All”.

2) The Support of New Budget
Agenda; Due to the decentralized act,
PHC budget from central authority was further
assigned to Tambon legislative office in 2008.
The budget increased from 7,500 Baht per
village to 10,000 Baht per village, would be
provided; 1) to support human resource
development to serve PHC works, 2) to solve
PHV problems in the community, and
3) to support community’s PHC center
service4,6-7.

Three significantly problematic issues
arose from the 2000 report were due to;
1) misunderstanding of community’s
leaders and Tambon legislative officials to PHC
works, 2) problem of budget disbursement,
and 3) Tambon legislative health officials
usually performed their own custom, taking
their activity on PHC works instead of advisory action.4,6-7

3) Primary Health Care Division; Bureaucratic reform actenabled it effect to ceased "The Office of Primary Health Care Committee", and formulated "Primary Health Care Division" to carry out PHC works in 2003. Its administration has been conducted via a new concept of "Health Is People's Right and Duty", and new strategic frameworks to promote the strength of community and local legislative office, to support and collaborate intersectoral coordination, and to carry out knowledge and information transferring management.4,6-7

4) Village of Health Management; Village of health management has been purposed as a role model for self-solving problem via community’s capability, under necessary support from health officers. It designation engaged with the concept of "Man, Fund and Knowledge", that aimed to be sustainable and strengthened community, as supported by Primary Health Care Division. There are 5 indicators used to evaluate village of health management, comprising 1) responsible authorities, 2) fund, 3) developing plan, 4) health activity, and 5) knowledge transferring activity. At the end of the 3rd decade (2007), 60% of villages were examined to be *acceptable status* of village of health management.4,15

5) PHC, VHV and Health Coverage Policy; Unexpected distortion through nationwide society following the launch of health coverage policy in 2002, was the beginning of government’s health promoting campaign (aerobic dances). Leaders from health promoting clubs, and a large number of VHV displayed their activity to convince people, to get aerobic exercises.4,14

The significance of PHC and VHV, were also integrated to support the *MoPH's Thailand Strength Project* in 2004. Its objectives focused on Thai people to be strengthened in terms of social, economics, politics and security. Intersectoral collaboration with several ministers was approached within 23 indicators, emphasizing in body, mind,
social and economics, wisdom and spirit. The MoPH was assigned to handle 6 topics, including exercises, safe food, environmental sanitation, emotion, disease-free status, and debris advices, as administered following PHC and VHV's mechanism as follows:

5.1) Strengthened VHV's to provide knowledge transferring to people continuously.

5.2) Strengthened health promoting clubs with continuous activities.

5.3) Community’s PHC center, ready to serve villagers regularly.

5.4) Community health service center with standard quality, good service and effectiveness.

5.5) All people have Health card.

5.6) Usual participation of people to health development and repair, especially exercises, good quality foods, control and prevent diseases such as mental health, cancer, hypertension, diabetes, and heart diseases.

5.7) Continuous access to essential information

5.8) Well behaviors and good status of health.

6) VHV’s and Bird Flu; The epidemiological incidence of bird flu in 2003, VHV’s deserved themselves in preventing, monitoring and reporting the situations following VHV’s networks covering the entire country. VHV’s also played role in the exercise of operating plan against bird flu in 2006.

VHV’s career had been addressed to be dominant in monitoring of local transmitted diseases such as dengue hemorrhagic disease, reporting the incidence of ill and dead poultry, etc, as analyzed by the Office of Strategy and Policies. They were lack of potentials in the analysis of health problems, editing of frameworks, horizontal vision, and working with intersectoral collaboration.
Thai society has moved toward globalization era, in which information technology is widely contributed and consolidated into people life styles, business sectors and bureaucratic system. The new era of public health works, was closely engaged with the national health act and the 2007 constitution, focusing on power decentralizing, and empowering participation from local administrative office, community sectors, private sectors, multi-level VHVs sectors and people to share their opinions in public health administration, arranging from community to national level.

To a new era of community works’ administration, VHVs had expected to be "Village Health Manager". Whereas, Primary Health Care Division still played role...
in PHC mission such as using strategic route map as a tool for PHC administration, village of health management, Tambon of health management, subjective development of VHVs, and promotion of multi-level winning awards for VHVs works.

PHC Project’s Out-Comes; The 4th Decade (2008 - 2014).

1) Use of strategic route map as a tool for PHC administration; In accordance to 2007 health insurance act, section 47, “The Office of National Health Insurance” must proceed its mission to guarantee people under Tambon health insurance fund by using strategic route map as a tool for PHC administration. People feeling to belong community health system, and sharing their opinion to community, must be concerned.

2) Subjective development of VHVs; Regardless of medical treatment welfare and other welfares as predicted in 1990, the government launched its subjective development campaign to VHVs, to receive a slavery of 600 Baht monthly since 2009. Trend of VHVs’ function has shifted to be “Village Health Manager” and “Leaders to Change Health Behavior”. Improvement of VHVs potential have been proceeded following an expert VHVs curriculum and a refresher curriculum for VHVs.

3) Support of Essential Materials for VHVs Operation in Community; In 2013 - 2014, essential materials needed for VHVs operation in community such as blood pressure, measuring machine and blood collecting instrument, were provided to them, as a purchase of 1,500 Baht per village.

4) Development of Village of Health Management; Self-Assessment protocol with 6 indicators such as collaborating, health planning, budget managing, developed activity, assessing, and out-come achieving, had been applied for the development of
village of health management, as academic and advisory supported by "Primary Health Care Division". At the end of 2013, 75% of village of health management, were approved\(^7\).

5) Development of Tambon of Health Management; Based on the village of health management, the project of "Tambon of health management" had been carried out, as the process of systemic administration in 2008. The trigonal administrative model, comprising bureaucratic sector (Tambon health promoting hospital), local legislative officials (sub-district headman/village headman, Tambon legislative office), and people sector (VHVs, representatives from housewife, women, and people), was introduced for joint-administration\(^6\).

Self-Assessment protocol for Tambon of health management, has been achieved via 5 multi-level scheme, consisting of basic (Tambon health team), developing (Tambon health plan), good (Tambon health plan in advance to real operation), very good (continuous managing activity) and excellent level (a role model for Tambon of health management). At the end of 2013, the number of 788 from 1756 Tambon, had been approved to be "good or very good" or excellent "Tambon of health management". Networking connected between Tambon of health management and district health system, have been developed to achievement as the target by the next step, "District Health Level"\(^16\).
Schematic Relationship of People Collaboration in Community Health Promotion

**District Level**
- District Health System (DHS)

**Tambon Level**
- Good Tambon of Health Management Sustainable Community and Enterprises

**Village Level**
- Village of Health Management
  - Self-Assessment with 6 Criteria
    1. Collaborative activities
    2. Arranging community health plan
    3. Arranging budget plan
    4. Arranging activities for development
    5. Assessment
    6. Outcomes

**Individual Level**
- To be developed as community health manager
- Expert VHVs

**Five Key-Point Principle**
- Unity district health team
- Appreciation
- Process Sharing
- Development
- Community Participation

**District Health System (DHS)**
- Each province has to predict its goals: DHS

**Tambon Health Plan**
- To pass every item of assessing criteria
- To pass at least “best level”

**Good Tambon of Health Management Sustainable Community and Enterprises**
- Self-Assessment with 5-level Criteria
  - Basic Level: Formation of Tambon health team
  - Developmental Level: Progress development of Tambon health plan
  - Good Level: Realistic driving of Tambon health plan
  - Best Level: Continuous management of Tambon health plan
  - Out-Standing Level: Prototype of Tambon of health management

**Village of Health Management**
- To arrange community project
- To handle appropriate activities for solving community health problems
- To be developed as community health manager
- Expert VHVs

**30,000 VHVs as Community Health Manager**
- 200,000 Expert VHVs

**Self-Assessment with 5-level Criteria**
- To arrange community project
- To handle appropriate activities for solving community health problems

**Self-Assessment with 6 Criteria**
- To arrange community project
- To handle appropriate activities for solving community health problems
Chapter 3
Lessons from the Four Decade Development of Primary Health Care

Conclusion of Primary Health Care

Conclusion; PHC Development During the 1st - 2nd Decade

The primary health care, is universal principle, valuable, useful and helpful, which can be practically approached to achieving its goal, and provided out–comes properly to people needed. Integration of VHCs and VHVs into the PHC project prior to implementation via Thailand’s villages, was an exclusive model fitted to its socio–economic situation, enabling pride to Thai PHC personnel and society. This typical Thailand model of primary health care and village health volunteers, had been acknowledged by Dr.H.T. Mahler (WHO Secretary-General, 1973–1988), as the exceptional PHC characteristic of the world18.

One of key successive points in PHC development of Thailand, was due to an attempt of the government. Highlighting the PHC by declaring as national policy, and establishing bureaucratic system covering from national level to village level, were performed successfully within a few years. The another key point was Thailand health care personnel, whom got a wide range
of health care experiences from tried out projects dealt and supported by WHO, UNICEF and USAID, since 1963\textsuperscript{4–5}. Some interested points emphasizing in key leaders of Thai PHC personnel, e.g. their expertise as international recognition, willing to serve PHC, and opened mind to accept unexpected problems (which then processed to be corrected systemically), are deserved to be addressed here. One great thing to be mentioned, they believed in people and community participation, problems might occur anytime during PHC developing process, and participation needed time to get sustainable development\textsuperscript{4}.

The first stage of PHC development following the 4\textsuperscript{th} plan (1977 – 1981), was likely "An Introduction of PHC Lesson to Thai People and Community", aiming on quantitative approach to meet national coverage of PHC project applied. According to strategic plan, the only PHC protocol was processed to implement in each village following bureaucratic system. This had been carried out following the "Top–Down Culture", with no respect to local variation of culture, custom, believe, folk know–how, and local life styles\textsuperscript{19}.

After a massive PHC project applied to meet nearly national coverage at the end of 1981, several projects emphasizing in the participating approach from villagers and community such as village development fund and the project for life quality development, were launched continuously from the 5\textsuperscript{th} plan (1982 – 1986) to the 6\textsuperscript{th} – 7\textsuperscript{th} plan (1987 – 1996). In addition, these two projects represented intersectional collaborative activity from Ministries of Public Health, Education, Interiors, and Agriculture and Co–Operatives, and aimed to achieving goal, "Health for All by the Year 2000" by the next 10 years\textsuperscript{4–8}.

In term of quantitative approach, the top–down bureaucratic scheme exhibited its high potential during the early stage of PHC implementation. Almost budget spent and operation done, were due to VHCs and VHVs recruitment and training activity. It was therefore, however, incidences of unexpected problems such as villager and community’s participation, and inappropriate performance of VHCs and VHVs, were also observed. The high drop–out rate (62.4%) and inactivity for the majority of VHCs (average 4 – 5 VHCs per village) during the 4\textsuperscript{th} – 5\textsuperscript{th} plan, were concluded by Dr.Thavitong Hongvivatana. These were due to Tambon health officials, or sometimes, the community leaders, did not
ask or inform villagers to be recruited, and some VHC candidates were lack of willing mind to serve community12.

Tambon health officials, were a key connecting point in VHCs and VHVs recruitment and training. A 5-day training course was not enough to ensure VHCs quality. Average 1 – 3 health officials per Tambon, and limited budget to provide their transportation were also mentioned as the real problems15. In order to carry out PHC mission by using VHCs and VHVs as a key of the PHC project’s mechanism, it was necessary to increase their potential as well as the process needed to empower them to be proud themselves, and making unity12.

During the 7th plan, foundation of public health volunteers’ clubs was done, supporting by bureaucratic system. This was the beginning of multi-level networks of public health volunteers that being flexible to coordinate, organize and administer in the future. Subsequently, the cabinet approved March 27, 1994 as a public health volunteer’s day, and upgraded all VHCs to be VHVs. In 1995, the national VHVs winning awards has been arranged and processed continuously and shared their opportunity as stakeholders. The community’s PHC center founded during the 6th plan, was really a VHCs and VHVs operation center. It was usually used as a meeting center for villagers and community’s leaders to share their opinion, collaborative, coordinating, and administrative activity4,18.

Thailand also displayed its potential to conduct PHC researches in collaboration with WHO support, achieved in the research topics of strengthening of primary health
care in the community in Thailand" and "health team for primary health care development in Thailand". Final conclusion from the researches re-approved 1) the administrative concept of "Man, Fund and Committee" was fittable to Thailand PHC development’s situation which expected to generate the further out-come of PHC activity, and 2) PHC principle with 8 essential elements realized from "The 1978 Alma – Ata Declaration", comprising equitable distribution of health care, community collaboration, use of appropriate technology, and multi-sectoral approach, was the right and suitable principle to be applied, forming of effective PHC teams, and providing PHC out-comes, as usefully needed by the people⁴,¹⁸.

Conclusion; PHC Development During the 3rd - 4th Decades

Thailand’s declaration on "Health for All by the Year 2000", reflected the 37 - year processing of PHC development since 1981, that enabled its expected out-comes, represented by three key indicators of 1) the basic minimum need (BMN) process and indicators, 2) self-care capability, and 3) accessibility to health care service. It had been confirmed again that PHC was an only strategic roadmap to achieving goal "Health for All by the Year 2000". According to the health assurance act, it enabled the process to guarantee health service’s accessibility to the people, provided by the government, and fulfilled the completion of "Health for All by the Year 2000"¹¹⁻³⁻³.

The 2007 constitution, enabled its post-effects to reform health system’s structure, and reduce the PHC context as a part of public health sector that needed extensive collaboration from local administrative sector (Tambon Legislative Office), people sector (VHVs and people’s representatives), and bureaucratic sector (Tambon health promoting hospital). In central level, "Office of Primary Health Care Committee" ceased, and "Primary Health Care Division" was formed instead, carrying out PHC mission following academic and advisory support through community as well as other health care works⁴.
VHVs had been convinced to support the government’s health promoting campaign (aerobic dances), in association with other leaders from health promoting clubs. This was expected to decrease the unexpected distortion following the health coverage policy in 2002. Again, VHVs exhibited their potential in the preventing, monitoring and reporting of bird flu incidence in 2003. However, almost VHVs are lack of performance to “take-in-charge” as “Village Health Manager” and “Leader to Change Health Behavior”. At community level, neither local administrative sector (Tambon Legislative Office, sub-district headman, and village headman) nor people sector (villagers’ representatives), did not consider for their administrative authorities and collaborative activities through “Village of Health Management” and “Tambon of Health Management”. All these problems have affected directly to PHC movement, up to the present.  

More convenient in transportation, accessibility to information technology and health card availability, enable people’s opportunity to visit Tambon health promoting hospital or district hospital or other hospitals, as well. Comparing to PHC status during the 1st – 2nd decade, it significance in the community was subsequently decreased after 2002. There is no report to confirm the availability of active community’s PHC center across the country.  

Final Conclusion

Primary Health Care was the core of the 37 – year primary health care developing process across the country. VHVs, the heart of PHC works, have played role as “Community Health Workers”, in which academic support and advices to them, have been conveyed from bureaucratic officers. Its out – comes were valuable, useful, helpful and needed by the people such as solving public health problems, e.g. transmitted diseases, malnutrition, sanitation, environment, maternal and child, and basic medical treatment. This lead to the massive improvement of people health and life quality. PHC had been addressed as the only effective tool to achieving goal “Health for All by the Year 2000”.

PHC context had been changed according to socio – economic situation, as shown its great change in 2002. In the further period up to the present, its development requires multi-sectoral collaboration, and VHVs responsibility has changed to be “Village Health Manager” and “Leader to Change Health Behavior”. It would purpose that PHC context would be changed again as affected from the ASEAN COMMUNITY. Of course, PHC is always important as the solid basis for health system of the country, so long.
Suggestion

December 31, 2015, has been scheduled as an official timeline for grand opening of ASEAN Community. It’s the sign of change via socio – economics of the region, in which health situation will be affected extensively. Primary Health Care Division would reconsider to its plan for the preparation of readiness, in advance, to serve and handle the primary health care mission and relates during Aseanization era. Guidelines to Primary Health Care Division, are presented herein;

1) To reconsider policies and strategic plans, in relates with primary health care and people sector health. The upcoming situation via socio – economic change is the key factor to be concerned, and needed precise evaluation.

2) Policies, strategic plans or projects that being currently operated or able to be planned in the future, would introduce primary health care works/principle to integrate with health care/health service system, especially service plan, district health system and networking development.

3) To maintain primary health care and enlighten village health volunteers as a significant part of health care system. Community’s PHC center will be handled to bring back as the village’s operation center, supporting and strengthening health care activity to serve community, family and individual.

4) To improve VHVs potential (through training of skill, vision, knowledge, and anything if required, e.g. information technology.), which would approach them as community health manager.

5) To arrange and manage PHC databases as systemic achievement (from the past to present), and get ready to use or access that public health officers and people would able access via information technology. This will be useful for the development of research, education, health care management, etc.

6) To address the significance of PHC out-comes such acknowledge, innovations and VHVs works as systemic achievement, and contribute to public via information technology.

7) To support and promote PHC research, emphasizing in knowledge, innovations, successive procedure, administration, etc. Collaboration in advance with academic institutes, research institutes and NGOs, is a possible choice to carry out.
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