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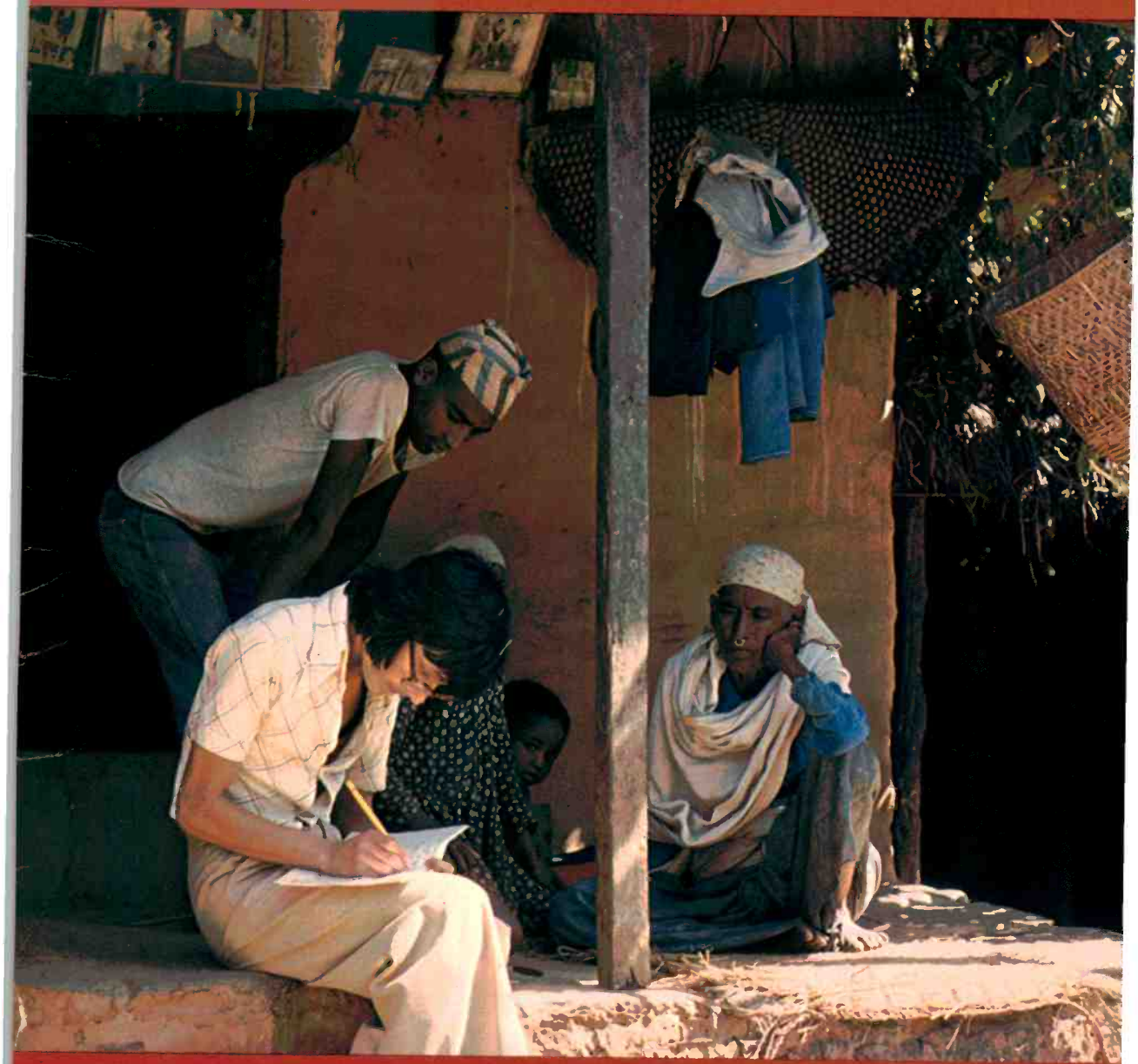

Report of a Seminar held at Pokhara,
October 1977

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Cover: An interviewer with the Nepal Health Manpower Development Research Project questions an elderly woman about her health in a small village in the Pokhara Valley of Nepal.

Credits: All photographs, including cover, by Marilyn Campbell.

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Rural Health Needs

Report of a Seminar held at Pokhara, Nepal, 6-12 October 1977

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Thailand

Population	**44.4 million**
Infant mortality rate	**89/1000**
Crude birthrate	**35/1000**
Crude death rate	**11/1000**
Rate of population growth	**2.4%**
Per capita GNP	**$350**

All figures from 1977 World Population Data Sheet of the Population Reference Bureau, Washington, D.C.

Development of Rural Health Care in the Ramathibodi Community Medicine Project, Mahidol University, Bangkok, Thailand

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Arnuwatra Limsuwan

Thailand has a population of 44 million, of whom 85% live in rural areas where the economic, social, and health conditions are poor. Only 45% of the 556 districts of the country have a medical and health centre and only 75% of these centres have M.D.s; of the 5115 subdistricts or "Tambols," only 57% have secondary health centres, which are operated by one midwife and one junior sanitarian per centre; and of the 50 000 villages only 4% have midwifery centres with one auxiliary midwife per centre. The physician:population ratio is 1:7000, but in the rural areas it is 1:100 000. The existing health services and health manpower are very much underutilized: the average number of visits to the health centres was three to five persons daily, and the utilization rate of the hospital was also very low. Self-treatment in the urban areas was 44.4% and in the rural areas 58.4%.

The overall problem in the country is that the health system fails to provide the basic types of health services needed by the population as a whole. A few segments of the population may be relatively well served, but the majority are poorly served, if at all.

This situation is due to many factors, including the low priority given to health. The health system itself presents problems: the components of the many health systems function, to an excessive extent, in isolation from each other. The result is that the approach to resolving the above problems is grossly fragmented, a factor that leads to policies, plans, and activities that wastefully overlap, conflict with each other, and, in many instances, are redundant. The

health workers available are not efficiently used, bringing into focus the urgent need to define the functions and tasks to be performed and the types of preparation and quantities of manpower needed for the performance of such functions and tasks. This effort calls for the close coordination of the two major components of the health system, i.e., the health care or service component and the health manpower component.

Ramathibodi Community Medicine Project

Ramathibodi Medical School, which is one of the newer (7 years old) medical schools of Mahidol University, has a community medicine program that is involved in a complex rural development program, training all types of health workers for a pilot area of 50 000 inhabitants, including village health workers.

The Ramathibodi Community Medicine project has the long-range objectives of: (1) assisting the Government of Thailand in reaching its goals of improving health care delivery to the rural community through an improved educational program; and (2) fostering educational activities through field research, especially for operational research (how to deliver minimal care to the rural villagers).

The Ramathibodi Community Medicine project has a field training centre in Bang Pa in the district of Aythaya Province, which is about 60 km north of Bangkok. The area is about 500 km^2 with a population of 50 000. There are 18 subdistricts called "Tambols," with one primary and 10 secondary health centres in the district. The primary health centre is staffed by two M.D.s, two nurses, two midwives, one sanitarian, and two junior sanitarians. Each secondary health centre is staffed by one junior sanitarian and one midwife.

The following is a breakdown of the functions and services provided by the Ramathibodi Community Medicine project:

Health Services: peripheral health care; primary health care; social action.

Innovations: health posts; volunteers; communicator.

Functions of Communicator: collecting information from a "cluster" of homes; dissemination of information through these clusters; implementation of action programs through these clusters.

Education of Health Workers: M.D. 6-year course — 1st and 2nd year, ecology group; 3rd and 4th year, summer survey, baseline data; 5th year, clinical department; 6th year, clinical department and 6 weeks in rural field training.

The Objectives of Field Training: (1) establish a relationship with the community; (2) identify and formulate the community health problems; (3) analyze, solve, and evaluate the health problems; (4) set up and defend priorities before implementing the program; (5) plan and implement the program; (6) evaluate the effectiveness of the program; (7) use diagnostic tools and basic medical surgical skills in the management of patients; (8) know and understand the functions of health teams; (9) know and understand how to mobilize and utilize the resources of the community; (10) encourage willingness to ask for help; (11) promote a commitment to continue self-education.

Activities are provided to help the student to meet these objectives: (*a*) medical service — introduction to a team approach including the health personnel; (*b*) student projects — learning by doing; (c) the Journalism Club; (*d*) case presentation and seminars; (e) responsibility for assigned families; (*f*) area of special interest — nutrition project, infectious disease control.

Nurse and midwife curriculum refresher courses are also available and efforts are made to recruit traditional midwives to integrate them into the health

service system. The communicator network is used to identify, supervise, and evaluate the midwives.

Therefore, within the Ramathibodi Community Medicine project, the overall health problem in the country is discussed. This approach coordinates the health services and health manpower development, an interdepartmental approach. It involves a joint partnership with the Ministry of Health, and exposes students to a realistic setting. It encourages active participation by students using the problem-solving approach with flexibility and feedback. The program is dynamic and includes periodic evaluation.

Problems and Constraints Existing in the Program

There are those who are against the health service and manpower development concept, and who want to keep universities far from the community, stressing mainly academic excellence. Private sectors of the health services have been permitted to grow and, at the same time, the public sector continues to overemphasize expensive hospital care, which, although essential to part of the urban population, is to the detriment of the rural population and the urban poor.

However, because university people have not had any experience in providing health care to the overall population, a lot of errors occurred in the pilot project.

To be frank, this was the first time that university people (manpower development) had thought about overall health care problems and about producing graduates according to the health needs of the community (integration of health service and manpower development). There had been little communication between the policymakers and the implementors. Most of the older graduates, who are now provincial chief officers, have not had training like our medical students. Most of the time conflicts occur when introducing new ideas of total health care.

There is no residency training in community health, so the graduates do not have continuing education available.

Initially, our program emphasized the services given by government officers and overlooked the so-called self-help that villagers can provide to help themselves.

Because health is just one part of integrated rural development, the university cannot just improve health without improving education, occupations, agriculture, marketing, etc.; therefore, recently we became involved with an integrated approach to rural development.

The lack of willingness of M.D.s to work in rural areas after their 2-year compulsory period is due to many reasons: living conditions; desire for education of their children; desire for higher education or training for themselves; lack of prestige; and very little incentive.

As well, there is the loss of continuous support from outside agencies, e.g., international agencies.

Mahidol University recently took students from rural areas into their medical program without requiring an entrance examination. These students represented 10% of the class (recently increased to 15%) and were trained completely free of charge with the expectation that they will return to their hometown primary health centres. It is hoped that this will help overcome this problem of sending urban-raised M.D.s to rural areas, and will gradually alleviate the problem of lack of medical services in the rural areas.