Chapter 10
Popular Health Sector and Health System Development

The popular health sector can be presented from various social perspectives; anthropologically, it is a large health care system with several levels from the individual to family, group and social network, including the knowledge, beliefs and activities related to health. And largely it has a cultural element; thus, it exists in various forms depending on local ecology and has been an integral part of people's livelihood that is always dynamic.

In connection with the health system, the popular health sector is associated with the professional sector and folk or indigenous sector at the individual and structural level. In the beginning phase of the implementation of the primary health care strategy, in the late 20th century, the government gave a high priority to the popular health sector, supporting the people to be actively involved in the health system essentially having village health volunteers (VHVs) in all villages across the country play a key role in community health development.

At present, there are 791,383 VHVs[1] nationwide and they have become part of the health workforce, representing the civic sector and playing a significant role in the Thai health system. The concept of voluntarism began when the primary health care strategy was initially implemented in the 20th century, with evolution according to the socio-political conditions and health situation in each period. With the rising number of VHVs and the expansion of their role, which is well-known and recognized by the state and the people, it can be said that thirty years of the Thai health development have seen health volunteers[2] or VHVs playing a significant role in such efforts and helping community health activities effectively. Such development efforts could not have been successful if only state health officials had acted without people's involvement.

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[1] Records of Health Volunteers Profile as of 30 April 2006. Primary Health Care Division, MoPH.

[2] Generally, "village health volunteers" are called "health volunteers" as they have assumed an increased role.

The Health Volunteers' Capacity and Development Strategy Assessment Project,[3] in 2006, conducted quantitative[4] and qualitative analyses of the changing role and capacity of health volunteers as well as a review of concepts and health/social situations in the areas of operations together with their networks. The project has found the development of social capital with potential for further improvement that is beneficial and valuable for the public and the Thai health system as follows:

1. The Process of Health Voluntarism and Increasing Number of Female VHVs

It was found that, overall more and more females are selected as VHVs rather than males in every region; the proportion being 2.33 females to 1 male and; among new VHVs there are more females and males. According to the VHVs profile database, there are 236,833 male VHVs (29.93%) and 551,299 female VHVs (69.66%); 3,251 (0.41%) with gender unidentified, as shown in Table 10.1 and Figure 10.1.

Table 10.1 Proportion of female VHVs to one male VHV, 1993-2006

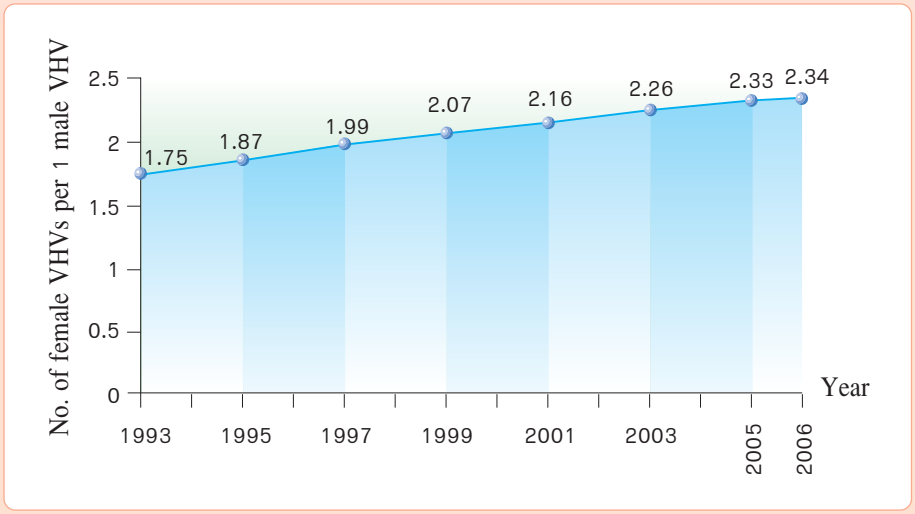
Year	Female VHVs per 1 male VHV
1993	1.7553
1994	1.8144
1995	1.8729
1996	1.9233
1997	1.9994
1998	2.0378
1999	2.0786
2000	2.1203
2001	2.1618
2002	2.1953
2003	2.2656
2004	2.3112
2005	2.3340
2006	2.3410

Source: Saengtien Ajjimangkul et al. Report on Assessment of VHVs Capacity and Their Changing Roles. In: Health Volunteers' Capacity and Development Strategy Assessment Project, 2006.

[3] Komatra Chuengsatiansup et al. (2006). Health Volunteers' Capacity and Development Strategy Assessment Project, supported by the Health Systems Research Institute and the Bureau of Policy and Strategy, MoPH.

[4] Saengtien Ajjimangkul et al. (2006). Report on Assessment of VHVs Capacity and their Changing Roles. In: Health Volunteers' Capacity and Development Strategy Assessment Project.

Figure 10.1 Proportion of female VHVs to one male VHV, 1993-2006



Source: Saengtien Ajjimangkul et al. Report on Assessment of VHVs Capacity and Their Changing Roles. In: Health Volunteers' Capacity and Development Strategy Assessment Project, 2006.

2. The Role of VHVs

An analysis of VHVs' role in the primary health care programme revealed that mostly VHVs were active in disseminating health information to villagers (96.4%), followed by health survey, health leadership, knowledge dissemination, and health service provision (91.5%, 81.3%, 78.6% and 74.5%, respectively). Their roles were less active in referring patients to the health centre, community-based disease surveillance, and people's right protection (54.6%, 48.5% and 48.5%, respectively) as detailed in Table 10.2.

Table 10.2 Percentage of VHVs under study with their roles in primary health care activities and specific actions in descending order

Role of VHVs	No action(%)	Action (%)
1. Dissemination of health information to villagers (Specific action: health examination/screening for hypertension, diabetes, breast cancer and cervical cancer; avian influenza surveillance; Aedes mosquito control; advice on health cards; mobile medical units; drug abuse; vaccination; and welfare services for the elderly and disabled.)	3.6	96.4
2. Health survey (Specific action: surveys on basic minimum needs or BMN, health situation, population, migrant (unregistered) population, poultry raising, Aedes mosquito breeding places, child population and vaccination coverage, elderly people, pregnant women, and eligible persons under social security and universal health care schemes.)	8.5	91.5
3. Health leadership (Specific action: promotion of exercise; advice on food hygiene; encouraging villagers to take part in epidemic disease surveillance; avian influenza surveillance; house-to-house survey on dengue haemorrhagic fever and leprosy; zoonotic and communicable disease surveillance; and anti-mosquito fogging campaign.)	18.7	81.3
4. Provision of knowledge to villagers (using the person-to-person method or through the media such as the village public address system or community radio.)	21.4	78.6
5. Health service provision (Examples: testing/measuring blood sugar levels, blood pressure, height and weight of children, pregnant women and the elderly; first-aid and preliminary medication services; and wound dressing.)	25.5	74.5
6. Referrals of patients to health centres (Method: using a motorcycle to take a patient to the health centre; assistance to disaster victims; taking patients to health centres or community hospital; basic medical care; and calling for an ambulance.)	45.4	54.6
7. Disease surveillance in communities (Examples: surveillance on avian influenza, dengue haemorrhagic fever and diarrhoea; inspection of grocery stores and food hygiene; cleaning of households; health care for community members; and management of solid waste and wastewater.)	51.5	48.5
8. Rights protection (Examples: setting up a checkpoint to inspect food vending vehicles for consumer protection purposes; giving advice on people's eligibility under the universal health care scheme; inspecting grocery shops including the FDA logo on food package labels; giving advice on registration of disabled persons, checking product labels, and health cards; managing food system, wastewater and solid waste.)	51.5	48.5

Source: Saengtien Ajjimangkul et al. Report on Assessment of VHVs Capacity and Their Changing Roles. In: Health Volunteers' Capacity and Development Strategy Assessment Project, 2006.

Even though VHVs play an active role in several primary health care activities, their role in other aspects of social welfare is rather limited. Only 161 VHVs (39.1%) were found to play such a role in serving as:

- Folk or indigenous healers (30 VHVs or 18.6%);
- Experts on plant growing or use of medicinal plants (61 VHVs or 37.9%);
- Experts on organic agriculture, compost, and liquid compost (29 VHVs or 18.0%);
- Hosts of radio programmes and village public address systems and public relations workers (37 VHVs or 23%);
- Resource persons or moderators on panel discussions (33 VHVs or 20.5%);
- Others such as members of local election committees and members of technology transfer committees; members of food processing groups and occupational promotion groups; village livestock volunteers; masters of ceremonies on various occasions; and leaders of exercise and recreational activities (42 VHVs or 26.1%).

3. Capacity of Provincial VHVs Clubs

According to MoPH's policy, provincial VHVs clubs were established in 1992 and it was found that, based on their 14 years of operation, a rather large number of them are managed by VHVs (29 clubs or 65.9%) and are able to effectively carry out joint activities with other networks/partners (31 clubs or 81.8%). However, during the past few years, the MoPH did not allocate any budget for supporting the VHVs clubs, so their operation is dependent on their own capability and support from provincial health officials concerned.

4. Strengths of VHVs

The survey on the VHVs' role in primary health care activities reveals a clear tendency that existing VHVs are capable of undertaking activities that can be accomplished within a short period of time such as dissemination of knowledge or information to villagers, conducting community surveys (basic minimum needs, health conditions, population, poultry, vaccination, etc.), campaigns on disease control such as seasonal occurrence of avian influenza and dengue haemorrhegic fever. The efficiency in carrying out these activities, however, is dependent on their age and occupation as more than 61.4% of VHVs have to earn a living to support their children's schooling and unemployed ones; 44.4% of VHVs are farmers and 25.4% are employees or daily wage workers. As they are family's breadwinners, their achievements in health activities cannot be highly expected; there should be no expectations to have them spend their time regularly on health as detailed in Table 10.3.

However their strengths are the process of health voluntarism with a high level of community's recognition and a broader role in health as well as the tendency to have more and more young people as volunteers.

Most VHVs (over 70%) have their own group-work process, particularly for activities related to information dissemination, surveys, health service provision and disease surveillance in the community.

- Working in collaboration with state officials: most of them (approx. 60%) participate in disease surveillance, health services and eligibility protection.
- Working by each individual: very few VHVs work on their own except for taking patients to the health centre; 51.1% did that on their motorcycles.

Table 10. 3 Percentage of VHVs under the study with a role in primary health care

VHVs' role	Working process (multiple answers)				
	By oneself	With others	With state official	With VHVs	With leaders or other groups
1. Disease surveillance in community (n = 335)	10.7	91.9	66.9	81.5	40.9
2. Surveys (n = 377)	18.8	89.7	40.1	78.2	32.4
3. Information dissemination (n = 397)	15.5	88.8	53.2	77.4	53.2
4. Health services (n = 307)	12.1	93.5	73.9	70.0	12.7
5. Leadership in health (n = 301)	26.6	79.1	40.2	59.8	35.2
6. Eligibility protection (n = 200)	20.5	83.0	61.0	58.0	25.0
7. Knowledge for villagers (n = 324)	30.9	79.0	33.6	57.1	38.0
8. Patient referrals to health centres (n=225)	51.1	55.1	15.6	39.6	16.4

Source: Saengtien Ajjimangkul et al. Report on Assessment of VHVs Capacity and Their Changing Roles. In: Health Volunteers' Capacity and Development Strategy Assessment Project, 2006.

5. Numerous Models of Health Voluntarism in Communities

The trends in the occurrence of numerous models of health voluntarism in communities take place simultaneously corresponding to political changes, resulting in a wide scale of social participation. At the same time, activities of nongovernmental organizations working for public benefits have provided a linkage for some VHVs to have different roles in society, from participatory learning as well as social movements and other forms of voluntarism within and outside the health system, such as friends help friends volunteers, To Be Number One, Jit Ahsa (voluntarism) network, doing good deeds for His Majesty the King volunteers, hospital services volunteers, orphans massage volunteers, friendship therapy volunteers, disabled persons care volunteers and elders care volunteers. Moreover, there are a lot of foreign volunteers working in Thailand, particularly after the occurrence of tsunami; their voluntary spirit has triggered awareness of other volunteers especially young people to help the victims. Then the process and networks of voluntarism have been more clearly initiated. New social situations have resulted in the creation of several forms of voluntarism; and VHVs as a community organization have played a more active role in the learning and implementing development activities.

6. The Worth of VHVs in Community Health Development

The assessment of the satisfaction of community leaders and Tambon or subdistrict administration organization (TAO) officials with the VHVs' role at present revealed that most of them (81 respondents or 86.2%) were satisfied and only a small number (13 respondents or 13.8%) were unsatisfied.

Regarding their opinions on the acceptance and performance of VHVs, the respondents indicated that the people highly accepted VHVs (95.5%), VHVs were a mechanism that had to be continued in the village (80.7%), VHVs were capable of cooperating with health officials effectively (95.5%), and VHVs were able to design a plan to seek budget from the TAO (69.3%) (Table 10.4).

Table 10. 4 Opinions about acceptance and performance of VHVs in communities (n = 88)

Role of VHVs in communities	Disagree		Agree	
	Totally disagree	Rather disagree	Rather agree	Totally agree
1. Villagers highly accept VHVs	1.1	3.4	43.2	52.3
2. Villagers receive a lot of information on health care from VHVs	1.1	9.1	52.3	37.5
3. VHVs are able to effectively coordinate with health officials	0	4.5	37.5	58.0
4. VHVs are able to effectively develop a plan to seek budget from TAO	5.7	25.0	45.4	23.9
5. At present, health officials can provide health services and resolve community health problems on a wide scale; so there is no need to have VHVs in the village	62.5	18.2	10.2	9.1

Source: Saengtien Ajjimangkul et al. Report on Assessment of VHVs Capacity and Their Changing Roles. In: Health Volunteers' Capacity and Development Strategy Assessment Project, 2006.

The respondents opined that VHVs had a rather extensive role in social and health development, mostly in disease surveillance (88.8%), followed by village surveys (74.5%), eligibility protection (56.7%), and health leadership (54.4%).

7. Constraints in VHVs' Operations

Among the VHVs under the study, their major problems and obstacles in performing their duties include: villagers not recognizing the importance of their role (27.4%), working with more difficulties due to lack of community's cooperation (26.8%), lack of incentives for VHVs (25.5%), and most VHVs lacking the skills for their operation (21.4%).

However, VHVs' minor problems are: lack of knowledge in implementing health activities (56.0%), having inadequate time for community (46.0%), and VHVs not recognizing the value of their role (33.6%).

VHVs' obstacles in community health actions include: non-recognition by other agencies (55.8%), inadequate budget and spending difficulties (43.1%), community not participating in the activity (37.3%), and no TAO's policy on VHV development (15.0%).

8. Conclusion

In general the role of health volunteers or VHVs is quite related to the policy context of the government. New policies initiated/launched during the past decade, such as health decentralization and universal healthcare, have resulted in the restructuring and revision of roles in the health system, which affect the VHVs' missions in the development of popular health sector.

The findings of the VHVs' capacity and development strategy assessment project, which can be used for an analysis of the strategy for supporting VHVs in accordance with the rapidly changing social and health situations, can be summarized in seven major points as follows:

1) As the concept and models of actions related to health volunteers are a product of historical developments, with changes in political and health situations during the past two decades, it is necessary to revise such a concept and models according to such changes.

2) There are now approximately 800,000 VHVs, who are extremely valuable assets; and most of them, either selected or volunteering, are the people who have the intention to devote themselves to work for a better health status of their communities.

3) Among the existing VHVs, as many as 70% of them are females and 35% of them are of the new generation having been volunteers for less than five years.

4) Most of existing VHVs are capable of accomplishing short-term tasks, such as community surveys and disease prevention campaigns, since they have got a lot of work to do but with constraints in performing long-term tasks such as chronic patient care.

5) Most of existing VHV's do not have so high educational and economic background; how can a larger number of people with better quality and economic status be drawn into the health voluntarism process?

6) That the support system has changed according to the decentralization policy has affected the relationship between VHVs, local authorities and the MoPH, despite the establishment of a coordinating mechanism at all levels, very little are the VHVs involved in the coordinating mechanism higher than the provincial level.

Another observation is that, when the support for VHVs comes from various sources, they have to work in response to the intention or agenda of supporting agencies which normally have different expectations or goals of themselves. Then VHVs have to adjust themselves according to such expectations. So the challenge is that if the VHVs cannot integrate all the tasks required by different agencies (with different agendas) into the local agenda, the development efforts will lack the integration, resulting in VHVs not belonging to the community. This is because outside agencies have more influence on the work direction and, thus, there has been a call for VHVs to belong to the community, which is consistent with the direction of decentralization and health civil society promotion. The aim is to have VHVs become a local organization working on strengthening the popular health sector in the future.