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**COMMUNITY PARTICIPATION IN
HEALTH DEVELOPMENT IN THAILAND**

**A thesis presented in fulfillment of the requirement
for the degree of Doctor of Philosophy
in Nursing at
Massey University**

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ABSTRACT

This thesis is a chronicle of research into the implementation of community participation in health development in Thailand. Community participation is recognised as the key concept of primary health care. Participation in this study has been conceptualised as power. Therefore, to participate is to achieve power, and participation is a process of empowerment. The research participants were health workers employed at the subdistrict health centre, and village health volunteers. These participant groups were chosen because the researcher perceived that they were groups with relatively little power in the Thai health service.

The research involved the participants in a two stage process. The first stage was an examination of the concept of participation in relation to the community's experience with development projects. During this stage it became apparent to the researcher that the original concept of community participation was poorly understood by both participant groups. The second stage involved the use of participatory research to achieve community empowerment by supporting the participants in an analysis-action-reflection process. Dialogue, with equal respect between the researcher and participants, was the key method to encourage analysis of their existing situation in order to raise their awareness, the most important step of empowerment. Simultaneously, action research was also utilised to solve a selected health problem, dengue fever control. A comparison between the results of the implementation of action research processes and that of the participatory research processes utilised in this study revealed that participatory research better ensured community participation in health development.

The findings provide an understanding of the theoretical concept of community participation in health development, and its enaction by the use of an empowerment process. The utilisation of a new primary health care approach, whereby the community is empowered to be self reliant and solve its own health problems, would depend on the acceptance and application of the empowerment approach by health workers. The empowerment approach would need to be pivotal in the work of all health personnel, including the implementation of policies and routine practice.

Specifically, the empowerment approach has much to offer community health nursing and its adoption would support the World Health Organisation's recommendation that a problem-solving, process-oriented and community-based curriculum is necessary to adequately prepare these practitioners. The adoption of this approach would require expansion of the present curriculum to include not only public health science and nursing science concepts, but also those related to community development. The new curriculum would uniquely equip nurses to work in communities and this in turn would provide specialised knowledge for community health nursing, allowing it to be differentiated from other nursing specialties.

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ABBREVIATIONS

APHA	American Public Health Association
AR	Action research
BMN	Basic Minimum Needs
CIH	Community involvement in health development
CP	Community participation
CPHC	Comprehensive primary health care
CPHCC	Community primary health care centre
CPT	Communist Party of Thailand
FAO	Food and Agriculture Organisation of the United Nations
IBRD	International Bank for Reconstruction and Development
ILO	International Labour Office
MOPH	Ministry of Public Health
NESDB	National Economic and Social Development Board
NGO	Non-government organisation
PAHO	Pan America Health Organisation
PAR	Participatory action research
PR	Participatory research
PHC	Primary health care
SPHC	Selective primary health care
UNICEF	United Nations International Children's Emergency Fund
UNRISD	United Nations Research Institute for Social Development
VHC	Village health communicators
VHV	Village health volunteers
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION AND CONTEXT OF THE STUDY

RATIONALE FOR THE STUDY

The idea of this study arose from concerns I experienced as an instructor in community health nursing at Khon Kaen University, in the Northeast of Thailand. For me, the longer primary health care (PHC) was implemented in Thailand the more confusing and mysterious it became, even though I had been working in the area of community health for over twenty years. I had a feeling that PHC in Thailand did not work. Many new words were introduced without the provision of enough fundamental information about their concepts and their implementation in practice. Insufficient understanding of these concepts contributed to difficulties in implementation of PHC programmes in a way that was consistent with the fundamental concepts of PHC as outlined by the World Health Organisation (WHO) in 1978.

In 1988 I participated in a research team to evaluate the end of the decade of PHC in Thailand. It was a national project and the team was assigned to evaluate the village health volunteer scheme. Instead of evaluating it as an activity which was based on the concept of community participation (a foundation concept of PHC), the evaluation was mainly focused upon the knowledge and performance of the village health volunteers (VHV) in roles such as giving health education, and providing medication as suggested by the Ministry of Public Health (MOPH).

My suspicion that PHC did not work in Thailand was confirmed by Justice (1987) who acted as a social science consultant for the WHO in South and Southeast Asia to help the health ministries of each country to design and set up research to indicate how team work in PHC could be strengthened since many PHC programmes were ineffective. The reason for the failure of effective implementation of PHC programmes, in her opinion, was largely because PHC was interpreted differently by bureaucrats, and the translation of the concept into practice was adapted to bureaucratic needs rather than adapted to community culture and conditions. She writes: "In Thailand the government was very sophisticated in conducting research studies, but the Thai government's definition of

PHC did not coincide with WHO's. Here primary health care referred only to the voluntary workers who were active in distributing medicines" (Justice, 1987, p.1305).

As a result of my concerns about difficulties in the successful implementation of PHC in Thailand, this study was undertaken with the broad aims of examining why PHC did not work in Thailand, and how to make it work. It has been suggested that the rationale for the limited progress in implementing PHC is because the key concept of community participation has not yet been successfully translated into practice (Morgan, 1993; Oakley, 1989; Rifkin, 1987; Tarimo & Creese, 1990; Ugalde, 1985).

Community participation is accepted as the key to PHC by many authors (Ahmed, 1978; Annett & Nickson, 1991; Axelbank, 1986; Hollnsteiner, 1982; Rifkin, 1990; White, 1982). The argument which is advanced to support its significance is as follows. If a community can participate in decision-making, it is likely that a community itself could decide the appropriate technologies which are effective, culturally acceptable, affordable and manageable, to solve its own problems. As a consequence of that involvement, services would be accepted by and made accessible to the majority. That would increase the service coverage as well as the equity of access. The situation would enable a community to focus on community-based problems and activities. This in turn would provide an opportunity for intersectoral cooperation, since by nature, community problems are complex and their solution requires multidisciplinary strategies and cooperation from other sectors.

The research question this study sought to address was: *what are the strategies by which to implement community participation in health development in Thailand.*

The study was conducted in the context of the Thai health system. The study area was in the Northeast region. At the outset, information about the country and the region is provided to introduce the reader to the general context of the study.

THAILAND

The kingdom of Thailand (formerly known as Siam) covers an area of approximately 514,000 square kilometres, about the size of France, lying within the northern tropical zone in the centre of the Indochinese Peninsula. It is bordered by Malaysia to the south, Laos to the north and north-east, Myanmar to the west, and Kampuchea to the east (figure 1).

The country is divided into four regions. The Central region, which is a great fertile plain alongside the Chao Phraya River, comprises about 30% of the total area of the country. The Southern region, a peninsula, is a narrow mountainous strip running down the west side of the Gulf of Siam to Malaysia. It is a land of rubber plantations and tin mines. The mountainous region of the North is covered with forests which yield valued teak and various resins. The Northeast region, the largest land area, is a low altitude plateau tilted to the north and east toward the Mekong River. Its semi-arid climate, limited water supply, and low soil fertility limit its agricultural production, and thereby the region's contribution to the national income.

In 1990, the population of Thailand was 56.3 million, with a growth rate of approximately 1.4% per annum. The trend in population distribution indicates that the country is growing more urbanised: 12.5% in 1960 to 18.7% in 1990, and it is forecasted to be 20.5% in the year 2,000 (Health Education and Health Planning Division, 1991). The largest city is Bangkok metropolitan area with a registered 1990 population of 5.5 million, 10% of the total population. The next largest cities are the regional capitals of Chiang Mai in the North and Hat Yai in the South. The largest city in the Northeast is Nakorn Ratchasima with the population of 2.4 million (Vongsoebchart, Chiampoempoon & Narayoongtong, 1994).

THE NORTHEAST REGION

The Northeast covers 170,000 square kilometres, which is 33% of the total area of the country. It is rimmed on the south by the Phanom Dongrak Range, a chain of hills rising to between 300-750 metres above sea level on the Kampuchean border, and on the west by the Phetchabun Mountains, which have a maximum altitude of 1,200 metres. The Phetchabun Mountains rim has been an impediment to communication

with the Central region in the past. The region is drained by the single river Mun and its northern tributary, the Chi, which unite near the town of Ubon and flow east to the Mekong river (Moore, 1974).

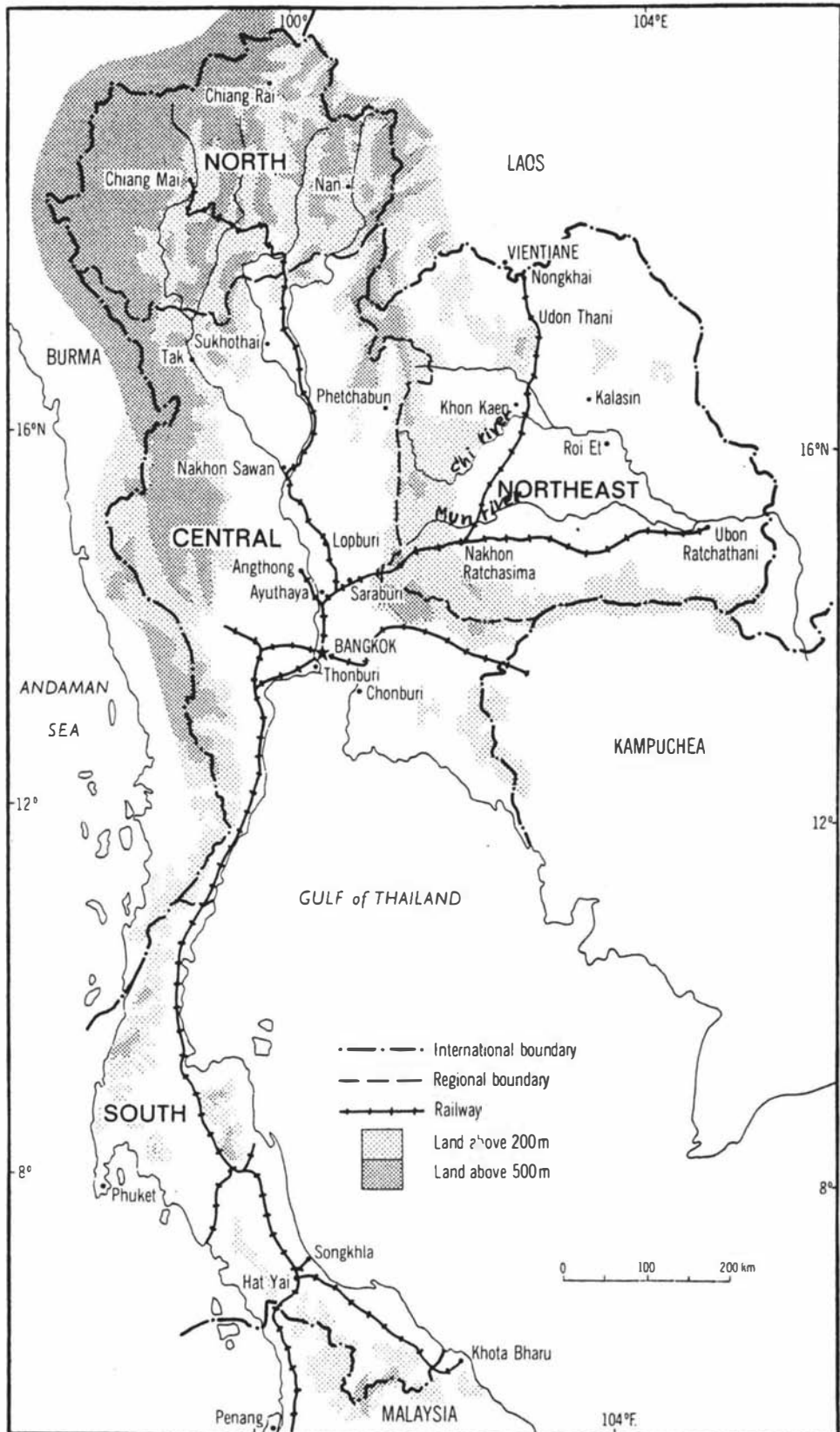
Its long dry season and relatively scarce rainfall make it the least favoured region in the country, and the least developed. The soils for the most part are fine, sandy loams and deficient of plant nutrients. Drought is now a regular feature of the area with less than half of the region receiving sufficient rain for agriculture. As a result, the Northeast does not contribute to the national income through exports. The principal crop is glutinous rice in accordance with local preferences, but the production is mainly used for household consumption.

The region's population in 1990 was 19.8 million, which was approximately 36% of Thailand's population. Relative isolation from the rest of the country makes it culturally close to its neighbours, Laos and Kampuchea. The dialect is *Thai Isaan*, which is similar to Laotian, and differentiates the Northeast people from the rest of the country. The combination of lack of water and poor soil cause people's living standards and per capita productivity to be lower than those of other regions. Thus "Bangkok people looked down on the people of the Northeast calling them Lao. They were said to be lazy and dirty" (Rabibhadana, 1993, p.22).

The Northeast is considered the poorest region in the country, with the lowest annual per capita income. In 1990, the average income in the Northeast was estimated at 42,348 *baht*¹ (NZ\$ 2,491) compared with 140,688 *baht* (NZ\$ 8,276) in Bangkok, or with the country average of 67,500 *baht* (NZ\$ 3,970) (National Statistical Office, The Office of the Prime Minister, 1993). Conditions of poverty prevail throughout much of the Northeast because of its physical and natural limitations which are not suitable for rain-fed rice farming, as well as the limited technological change in production. Therefore people go to work in factories in town or in agricultural work in other regions. In some villages there are seasonal migrations for sugar cane planting and harvesting. At present Northeasterners constitute the largest percentage of the workforce in factories in the country.

¹ During the fieldwork period in 1994-1995, one NZ dollar was equivalent to approximately 17 *baht*.

Fig. 1 Map of Thailand



HEALTH SERVICES

Health services in Thailand can be categorised into two systems, government and non-government. The majority of the services, particularly in rural areas, are government services under the responsibility of the MOPH. The government services are the main focus of this study. The non-government services include those operated by private and charitable organisations.

The MOPH provides comprehensive care which includes curative care, preventive care, health promotion and rehabilitation. Curative care is divided into three levels: tertiary, secondary, and primary medical care. The tertiary level is the most sophisticated service. Each level is expected to serve as a referral unit, and provide technical support for any lower levels in the system. The levels of health service correlate with the Ministry of Interior's geopolitical structure. This structure is divided into region, province, district, subdistrict, and village. The related curative services are regional or provincial hospitals, district hospitals and health centres at the subdistrict level. Each service provides comprehensive care within a set area for which it is responsible, but the ratio of different types of care and PHC activities are different. In the provincial level, the ratio of curative care to preventive care and PHC activities is much higher, whereas this ratio is the opposite at the subdistrict or at the village level. In addition, in each province and district there are provincial health offices and district health offices, which are responsible for administering and supporting all types of care including health reports and statistics in that particular area (see chart 1).

In the Northeast region there are 2,798 health centres in 2,620 subdistricts (28,140 villages). This made the MOPH the only ministry supplying officials to cover the subdistrict level throughout the country. Health personnel working in the health centres are junior sanitarians and midwives; both will be categorised in this study as health workers. Both types of personnel have one and a half years of training after intermediate education. The origin of the midwifery training was a provisional special curriculum to prepare health personnel to work in rural areas to combat the infant mortality rate which was as high as 62 per 1,000 births after World War II (Moore, 1974).

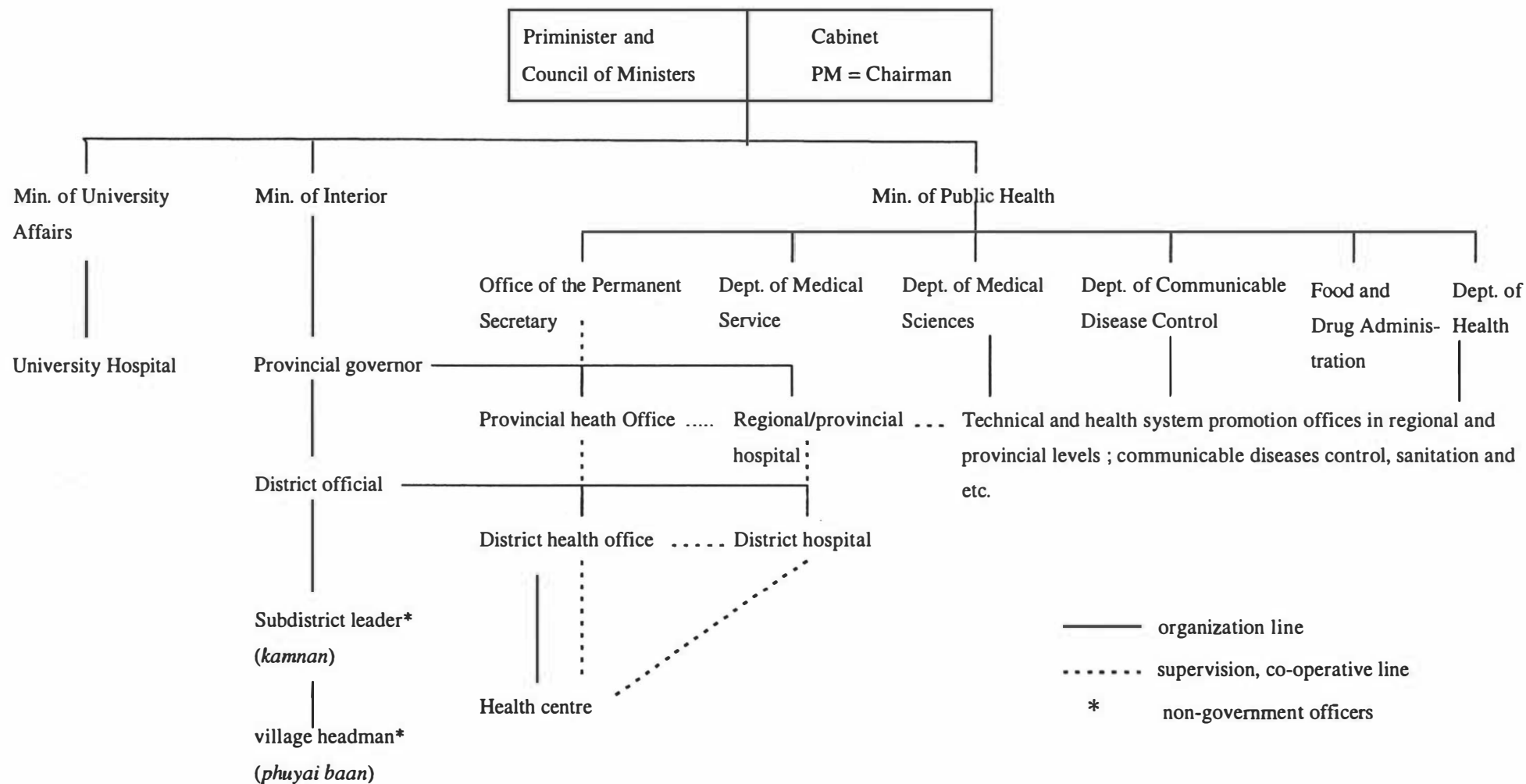
The health centre is the most peripheral service where all policy and plans are translated into practice and it is the level at which there is most direct contact between health personnel and the people. These clients are a relatively disadvantaged group, and PHC is the focus of the service.

NURSES' ROLE IN PHC

Although the majority of nurses work in hospitals there are positions available for those who are interested in community health service. Positions in the health promotion section of a district hospital, the community medicine department of a provincial hospital, or a provincial health office are open for personnel who have at least a bachelors degree in public health or in nursing. Nurses can further their career preparation by doing a masters degree in a variety of areas of public health science, such as family health, communicable disease control, or community health nursing.

Nurses who are employed in such positions are directly involved in PHC in two ways. First, they are part of the supervision and consulting team for health workers who practice PHC at a village level. This team consists of personnel in the hospitals and the health offices either at the district or provincial level. Second, those who work in the health promotion section of the district hospitals or community medicine department in the provincial hospitals have to provide preventive care and health promotion services to people within the area in which the hospitals are located. These services are similar to those provided by a health centre.

Chart 1 The Government Organization of Thailand



Source : Health Education and Health Planning Division, MOPH. 1991, supplement page.

OVERVIEW OF THE RESEARCH

This empirical research aimed to identify strategies by which to implement the concept of community participation in health development in Thailand. In this study, participation was conceived as power, therefore to participate means to be empowered or liberated. The empowerment process was engendered by using participatory research to work with the health workers and the VHV in village health centres at the lowest level of the health care delivery system. Within this approach, attempts were made to implement the concept of community participation in the health system infrastructure utilising a comprehensive primary health care approach (CPHC) which is consistent with traditional approaches to PHC as outlined by WHO in 1978. Following the implementation of this first approach action research methodology was employed to attempt to elicit community participation in selected health problem, utilising a selective primary health care approach (SPHC). The comparison of both types of approach enabled me to draw conclusions about the suitability of strategies for implementing the concept of community participation in the Thai context. The implications of the findings for the nursing profession and for the reorientation of public health policy implementation and practice will be discussed.

ORGANISATION OF THE THESIS

This thesis is organised to document the exploration undertaken by the researcher in order to answer the research question. Chapter one outlined the problems of PHC implementation in Thailand and provides a rationale for the study. As a general context for the study an overview of Thailand and the Northeast region is provided and the health service in Thailand, and nurses' roles in a PHC approach is discussed.

Chapter two traces the emergence of PHC and its implementation and evaluation in both Thailand and other countries in South and South East Asia. Parallels with development theory are identified. Responses to difficulties in the implementation of PHC including moves away from a comprehensive approach to the implementation of PHC and toward targeting key problems (the SPHC approach) are described.

Chapter three focuses on community participation in health as the key to successful implementation of PHC in Thailand. Changing definitions of the concept within the

context of literature on PHC are identified. Thai conceptualisations of participation and the Thai ethos of anti-participation are explored in depth. A review is undertaken of programmes in Thailand and other countries which have attempted to achieve community participation in health related projects.

Chapter four explores possible research methods which may be utilised to introduce and evaluate change in order to answer the research question. The theoretical and philosophical underpinnings of action research and participatory research methodologies are examined and compared. Participatory research methodology was selected by the researcher to work with the health workers and the VHV in the village health centres utilising a CPHC approach, and action research is selected for a SPHC approach to a specific health problem. Self understanding is discussed since it is a significant tool for conducting these types of research.

Chapter five discusses the details of the twelve month fieldwork experience, extending from obtaining access to the study community, through how the fieldwork situation was handled, until the end of the study. Ethical issues are discussed.

Chapter six provides an indepth picture of the study village from its settlement, tracing changes from traditional subsistence farming to a wage-earning livelihood for its peoples, and reviewing factors influencing these changes. In addition, the social systems are discussed to provide the local context which is critical to understanding participation in the study community.

Chapter seven presents the results of examining community participation in the study community. The data is presented in three sets. First, participation of the community in the previous development programmes such as village road building, tap water supply and the drug revolving fund. Second, the perceptions of community participation concepts among relevant groups, including the health workers, village leaders, VHV and the villagers themselves. Third, the attempt to encourage participation of the health workers and VHV in decision making about health issues by employing participatory research methods to raise their awareness.

Chapter eight describes action research applied to selected health problems. A dengue fever control project was used as a case study to test the SPHC approach, and to test the interpretation of participation as access to knowledge and information, and the possibility of implementing the community participation concept by applying action research.

Chapter nine concludes with the findings of this study, discussion of the implications of the findings and the contributions of this study from an insider's point of view.

CHAPTER TWO

PRIMARY HEALTH CARE

PHC is an alternative approach to health service delivery which was developed to overcome the situation of unequal access to health services. PHC is defined as follows:

Primary health care is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

(WHO, 1978, pp.3-4)

THE EMERGENCE OF PHC

The emergence of PHC can be traced back to the 1950s, as Djukanovic and Mach (1975, p.7) state:

Despite great efforts by governments and international organizations, the basic health needs of vast numbers of the world's people remain unsatisfied. In 1951, when efforts of many developing countries were centered on specialized mass campaigns for the eradication of diseases, the Director-General of WHO pointed out that these efforts would have only temporary results if these were not followed by the establishment of permanent health services in rural areas to deal with the day to day work in the control and prevention of diseases and the promotion of health.

By 1970, WHO had started to ask serious questions about the effectiveness of the traditional health care system because the situation had not changed much since 1951. Less than 15% of the rural population and other underprivileged groups had access to health services. These groups made up about 80% of the population in the Third World countries (Djukanovic & Mach, 1975). As a result, a joint UNICEF/WHO study was carried out to examine systems of health care delivery within various political, economic, and administrative frameworks in order to identify the key factors in their successes.

The information was gathered from a wide range of sources, and the study sites selected were Bangladesh, Cuba, India, Niger, Nigeria, Tanzania, Venezuela, China and Yugoslavia. The results of the study were reported in 1975 by Djukanovic and Mach. This study in turn became the baseline information for the adoption of “Health for All by the Year 2000” (HFA), which later was proposed as the goal of PHC in the Alma-Ata Declaration in 1978 (WHO, 1978).

PHC was a new approach which was expected to avoid the identified limitations of the conventional medical approach. These limitations were that the conventional medical approach was an ambulatory service or a “come-and-get-it” approach that was available only for those who could reach the service, whilst the majority who could not access it were left without care. This approach was criticised as being too narrowly technological and highly professionalised thus creating professional dependency. It was also too costly for poor countries, resulting in inequitable distribution of health care. Furthermore, it was argued that this disease-oriented medical care was inadequate to solve health problems which by their nature are of complex causation. In addition, it was realised that many improvements in health were the result of improved socio-economic conditions, improved nutrition, better housing, adequate supply of water and an efficient sewage system. Actually, it could be argued that health services have made a limited contribution to health. This is particularly the case when disease patterns are changing from communicable diseases to chronic, incurable and behavioural-caused or related diseases which sophisticated medical technology alone cannot cure (Ebrahim & Ranken, 1988; Fendal, 1985; McEwen, Martini & Wilkins, 1983).

PHC offered an alternative approach which differed from the conventional medical approach in terms of the following characteristics. Firstly, primary health care implied much more than a concern for the clinical treatment of the ill in a hospital-based service; rather, a comprehensive, community-based service was the focus. Secondly, health was no longer limited to the absence of diseases as viewed within a medical paradigm. Rather, in a PHC approach “Health is a fundamental human right and a world-wide social goal” (WHO, 1978, p.34). Thus the goal of the health service was health development. It was expected that different countries would strive to improve the health of their people to keep up with their social and economic capacities. In this social

paradigm of health, people were not viewed just as consumers of health care, but rather as able to provide it for themselves. The phrase “health by the people” was coined (Gish, 1982; Mandl, 1978; Rifkin, 1985). This approach emphasised the importance of self-reliance as an expression of human dignity and development. As a result it was proposed that the professional-client relationship should be changed from a provider-client relationship to an equal partnership. The redistribution of responsibility in the health system was said to call for community participation in planning, resource allocation and decentralisation in health system management.

Thirdly, it was recognised that health was not a separate entity, but that there was a close relationship and interdependence of health, social and economic development. WHO stressed that “primary health care is an integral part of the socio-economic development process. Activities of the health sector must be co-ordinated at national, intermediate, and community or local levels with those of other social and economic sectors” (WHO, 1978, p.17). Thus PHC could be a lever for increasing social awareness and interest, initiative, and innovation.

In summary, five concepts were concluded to be the fundamental concepts of primary health care. First, universal coverage of the population, with care provided according to need. Second, although services should provide integration of promotive, preventive, curative and rehabilitative services, the PHC approach stressed preventive, community-based care designed to meet the needs of the majority of the people. Third, services should be effective, culturally acceptable, affordable and manageable (appropriate technology). Fourth, the community should be involved in the development of services so as to promote self-reliance and reduce dependence (community participation). And fifth, approaches to health should be related to other sectors of development (intersectoral cooperation) (WHO, 1988b).

It is accepted that the emergence of PHC has been influenced by current development theories and paradigms wherein people participation is the core concept. The changes of those theories provided fundamental understanding as to the reasons why community participation became the core concept of PHC and how it played an important role in the health sector at the international level.

PARALLELS BETWEEN DEVELOPMENT THEORY AND PHC

At the time of first recognition of the need for PHC in the 1950s “modernisation theory” was the dominant development theory. Modernisation theory reflected the work of economists in the Western World where economic growth and industrialisation were central to the planning and control of the distribution of resources. In the 1960s “dependency theory”, which inverted many assumptions of modernisation theory, was introduced. It critiqued economic development as inevitably increasing dichotomies and engendering the enrichment of a few at the expense of many. Economic development was credited with creating ruling elites who were interested in serving their own and foreign interests, rather than the interests of the majorities. The link with international capital was viewed as obstructing independent development and creating inequity and dependency. An unequal trade encouraged the transfer of surpluses out of the country, and thereby stunting the development process. Therefore, an alternative was proposed in both the industrial and agricultural sectors, although the focus was on agriculture and the rural areas where dependent associations with the international economy might be most easily avoided. The goal of development was then focused on self-reliance and equity, creating interesting parallels with changes in the health sector.

The early 1970s, during which WHO was focusing on the inadequacies of the traditional health system to meet the needs of the majority of people in developing countries, became an era of dependency theory. It has gone through various stages of elaboration, refinement and consolidation, resulting in wide differences in approaches within dependency theory. Among them, growth with equity has brought two approaches: basic human needs and human resource development. These differing approaches were the result of an increased awareness that development should concern people not things, like roads or dams; it should be “development for people” not “people for development”. It was the time when a social dimension, the human factor in particular, was brought in to the strategies for development.

The basic human needs approach argued that meeting human needs and improving quality of life should be seen as the main goal of development rather than building the economic wealth of the nation. Economic growth should be treated as a subordinate or intermediate goal in order to provide better health, better welfare, a better environment

and a fairer way of life for the people, rather than an ultimate goal. This approach then established a wide range of goals, not only health and economic growth, to suit the context of each individual country. Basic human needs and quality of life also became goals in the health sector during the last decade.

The human resource development approach was grounded in the theoretical argument that the poor were not adequately absorbed into remunerated jobs because they lacked physical strength, skills and education. These deficiencies were to be overcome through social investment programmes to develop the nation's resource into employable commodities.

Nonetheless, both approaches had problems. Both the basic need approach and the human resource development approach placed economic growth first and equity second. Secondly, people were seen only as a resource or a means to achieve an end rather than as an end in itself. Hence people serve the economy rather than the economy serving the people. Thirdly, both strategies required outside aid - basic needs as being identified by others, human resource development programmes needed funding - which seemed to do little to alleviate dependency or poverty.

By the late 1980s it had become clear that the implementation of First World economic development models had reached an impasse. Growth-centred development reflected a narrow conceptual basis of professional top-down processes rather than being based on the analysis of the complex and diverse reality of most rural life in the Third World. The failure of this strand of development in the Third World was because governments found the need to direct production and control economic and power structures centrally so that a loss of local autonomy was inevitable. Therefore, an alternative paradigm was proposed in which people and communities participated in self-directed development thereby ensuring equitable distribution and sustainable development (Bauzon, 1992; Burkey, 1993; Chambers & Conway, 1992; Gsanger, 1994; Ife, 1995; Kleymeyer, 1994; Korten, 1992; Leys, 1996; Oakley & Marsden, 1984; Rogers, 1992).

The current development paradigm holds the issue of participation as central and it is primarily associated with the rural poor who are not only the most disadvantaged within

society, but also relatively neglected by previous development strategies. It has been argued that they are deliberately excluded from power by those who have it (Oakley & Marsden, 1984). This paradigm no longer views the people who are at the bottom of the system as obstacles for development, backward, deprived, ignorant, and needy; rather, they are viewed in positive terms as marginalised potential participants (Rogers, 1992). According to this approach people at the bottom, the grassroots, the disadvantaged group - who were hitherto excluded, are encouraged to participate in decision making and organise themselves to overcome the obstacles to their social and economic well-being. Therefore the approach is often called people-centred development, grassroots development or participatory development. In this type of development participation is pivotal and a bottom-up process is essential.

Participation, from Oakley and Marsden's point of view, is not only the goal of development but also "a fundamental pre-condition for and a tool of any successful developmental strategies. The failure of past development strategies is fundamentally linked to the absence of this missing ingredient - participation" (Oakley & Marsden, 1984, p.10). They also conclude "There seems to be a general agreement that participation is essential for development. Some would argue that development in fact is participation" (p.85, emphases deleted).

Clearly there are marked parallels between changes in development theory and the consequent changes in approaches to development within industrial and agricultural sectors, and the changes being implemented in the health sector, particularly in relation to provision of health services for the rural villages in developing countries. The next section details the implementation and evaluation of primary health care in Thailand.

PRIMARY HEALTH CARE IN THAILAND

The concept of PHC was first introduced in the north of Thailand in a pilot project called the Saraphi project which was initiated by the WHO in 1969. The concept of community participation in responsibility for its own health through the introduction of community volunteers was implemented. In 1979, a year after the Alma Ata Declaration, PHC was accepted as the national health care policy for Thailand. The National Primary Health Care Plan was included in the Fourth Five-year National Economic and Social

Development Plan (1977-1981). The following discussion details early PHC development in Thailand, illustrating how the PHC approach has been implemented in this country, as well as how programmes have been evaluated.

1. The Village Volunteer Scheme

PHC was initially implemented by launching a village volunteer scheme which was adapted from the Saraphi project. The volunteer scheme was viewed as the key to organising village communities to participate in primary health care services which were socially and culturally acceptable. There were two kinds of volunteers, VHV and the village health communicators (VHC). Consistent with a human resource approach to development, the volunteers were regarded as untapped invaluable resources the mobilisation of which would make possible the most cost-effective health system. The aims of the volunteer scheme were to get community participation in the health care delivery system and to increase the service coverage (MOPH, 1980; 1986). This was one of the main thrusts of the PHC approach in the country.

Each VHC was responsible for 8-15 households and his/her function was mainly focused on prevention and promotion aspects; for instance to disseminate health information, give health education, and collaborate with health workers in the village. The VHV were elected by and from amongst VHC in that village to have further training to be able to give simple treatments for common diseases, and to keep the basic village census. The volunteers were supposed to be selected by using a sociometric technique which involved mapping out the social relationships within each village and identifying the person who was the most popular. However the actual practice was for volunteers to be identified by authorities such as health workers or village leaders. By the end of the Fourth Plan, the aim was to implement the volunteer scheme in at least 50% of the total number of villages. Nation-wide coverage was anticipated by the end of the Fifth Plan (1982-1986) (MOPH, 1998).

One evaluation of the volunteer scheme was done by Hongvivatana, Sri-ngernyuang, Chuengsatiansup and Dejkhumwong (1988) who conducted a study which aimed to identify the volunteers' performance using a nation-wide representative sample. A multi-stage random sampling technique was used to get a sample size of 10% of all villages. In

the first stage, questionnaires were mailed to subdistrict health workers to ask their opinion about volunteers' performance and after that, field visits were made to selected provinces in different regions. The purpose of the field visit was not only to confirm and supplement the survey data, but also to hold discussions with those subdistrict health workers in order to explore some alternative models to encourage better performance of the volunteers. The health personnel were asked to assess volunteers' performance in terms of how they conducted their assigned tasks. The assessors were asked to judge and classify the volunteers' performance as highly active, moderately active, and non-active.

The results of the study showed that only 24% of the volunteers were highly active, or were enthusiastic and able to direct themselves and work independently. About 62% of the volunteers had already dropped out, either from the programme or from active service. The volunteer attrition rate was notably high (42%) even in villages implementing the volunteer scheme for the first year. The attrition rose sharply (to about 60%) during the second and third years, and then stabilised at the same level afterwards. The causes of attrition were categorised into three groups. First, volunteers' personal characteristics; those with good intentions, who were devoted, and were recognised for their work tended to enjoy the volunteer job and worked longer. Second, their socio-economic status, since the job required a commitment of time which was not suited to the poor who had to struggle for their income. And third, implementation variables, such as how health personnel dealt with the community and volunteers, their understanding and orientation to primary health care and community participation.

The researchers of this study questioned the appropriateness of some aspects of the volunteer structure within the existing health service system: for instance, recruitment of the volunteers; expected roles and functions, particularly the number of households for which they were responsible, which in turn determined the number of volunteers in each village; the supervision and evaluation system. Two issues were criticised. First, in the researchers' opinion, the structured roles of the volunteer within the existing bureaucratic system tended to be less effective in promoting active participation. It was suggested that a more flexible and bottom-up approach to allow volunteers to work independently to solve their community health problems would be more appropriate.

Secondly, encouragement of community participation required health personnel to have community development skills. The skills required were too much to be expected from subdistrict health workers. Actually, these personnel had very limited knowledge in the areas of management, planning and community development skills. Not enough appropriate training was made available for them. Even personnel at the provincial level were not capable of such tasks, as the researchers described: “(M)any provincial health officers are simply working as postmen delivering to lower levels whatever orders, goals, services, targets set by the Ministry. Planning for health services adapted to local situations rarely occurred” (Hongvivatana, Sri-ngernyung, Chuengsatiansup & Dejkhumwong, 2988, p.96).

The questions raised by the above study remain unanswered. In other words, the situation of the volunteer scheme has not changed much, except the role of VHC was abandoned. Every volunteer was called a VHV and was expected to perform VHV roles.

2. The Drug Revolving Fund Programme

Another PHC approach was the development of a drug revolving fund programme, which was initiated in 1979. After training each VHV received free household medicines worth about 500 *baht* to create a drug revolving fund in one’s own village. The fundamental idea was to create a financial resource for each village to be able to mobilise its own funds, and to make essential drugs available in each village to use for curative services. After that, another set of medicines valued at 1,000 *baht* (about NZ\$ 70) was given as a commencement fund. To further expand the fund, each volunteer was asked to persuade villagers to buy shares of drug revolving funds (about 10 *baht* or NZ\$ 0.70 per share). The main objectives of the programme were to improve people’s behaviour in using medication, to reduce the rate of unnecessary drug usage, and to encourage people to get involved in providing essential drugs for their own community.

Evaluations of the drug revolving fund were conducted by different organisations. The Primary Health Care Office (1993a) conducted a nation-wide evaluation, the result of which showed that 23% of the funds had been operated successfully. The funds were judged to be successful if a fund had been developed further to be a multipurpose fund,

or had been combined with other funds to expand its functions. About half were judged as doing “just right”, for which the three criteria were that at least 10% of the households became members, there were at least 10 clients per month, and there was a committee responsible for its operation. Certainly those criteria were also criticised for their reliability and validity. Another 25%, which failed to achieve the above criteria, were determined as failures.

However, evaluations from other studies provided the unanimous finding of enormous problems in managing village drug revolving funds. The problems stemmed from the initiation of the funds since the idea for the fund was suggested by outsiders. Villagers perceived it as a bureaucratic policy or a government project which required some kind of participation from them, otherwise they would not get help from the government officials. From the perspective of subdistrict health workers, once the funds had been set up it meant the job had been accomplished. There was not enough information provided for villagers to understand the principle and objectives of the fund, and not enough supervision to facilitate fund management (Hongvivatana, Sri-ngernyuang, Chuengsatiansup & Dejkhumwong, 1988; Khumtong, 1986; Pridasawadi & Kan-ornsri, 1984; Pridasawadi & Pradabmuk, 1984; Pridasawadi & Rittipakdi, 1984; Supajanya, 1984).

The report of four separate case studies, conducted in one village in Northern Thailand and three villages in North-eastern Thailand, confirmed that genuine community participation in this programme was not able to be initiated by the bureaucracy. Most of the programmes introduced to the villages were outside the villagers’ interest, nor did they fit with community problems. On the contrary, one case study showed how hard the community had to work to balance between cooperating with the bureaucrats on the one hand, and maintaining its own dignity on the other. In this village, the village leader was a well-respected person who was very much concerned with community problems, and there was a strong cohesion among people due to their close kinship. Those two important factors contributed to an effective community organisation. Undoubtedly, people in this village had a voice in decision-making in managing village problems by participating in village meetings (Pridasawadi & Pradabmuk, 1984).

The concordant results of all case studies suggested that health personnel, particularly those who worked at the practical level, were the most important factor affecting the success of primary health care initiatives. In the health personnel's view, community participation meant obtaining help from volunteers in order to assist them to accomplish the policy goals, or to diminish their burdens in delivering a primary health care service.

This misinterpretation of the concept of community participation led to its ineffective translation into practice. Besides, health personnel were not capable of performing the facilitators' tasks since they themselves did not have enough training or supervision to prepare them for these new roles. They performed their tasks according to their basic understanding. The situation was aggravated by the highly centralised bureaucracy where projects and activities were designed as policy by central government, regional or provincial authorities. Usually, policies changed very frequently or whenever the administrators or policy makers were changed. Therefore, there was not enough time for the health personnel to perform their tasks efficiently, or even to scrutinise their performance or the tasks so as to improve it.

The drug revolving fund programme was seen as crucial for the following step of the PHC approach, creating community self-reliance. The drug revolving fund was expected to be expanded to provide multipurpose village development funds and a cooperative store. It was seen as the basic step to lay down the following three foundations for a PHC approach; building community organisations to act on solving community problems, training or strengthening leadership skills by selecting and forming a critical mass at different levels, and mobilising resources in terms of a wide range of village revolving funds. The next step was the launching of the Self-Managed Primary Health Care Villages Programme.

3. The Self-Managed Primary Health Care Villages Programme

The programme was implemented in 12 villages in 1982 as a pilot project. The basic concept of this programme was to create community self-reliance in resource mobilisation, organisation, management, and social development. The strategy started by setting up model villages. The selected villages were supported by the MOPH in terms of financial support to build up appropriate technologies. For example, village craftsmen

were trained to build commonly used sanitation parts, such as latrine parts and big water jars. This technical knowledge encouraged village production of goods for everyday use as well as providing cheaper good for villagers, and also creating other financial resources for communities. Afterwards, some revolving funds were set up which would enable the poor to pay by instalments. A few other funds were developed, such as the sanitation fund and the water tank fund. If possible, these single purpose funds would be also expanded to be a multipurpose fund for other social development purposes. Subsequently, these model villages were expected to develop their own networks and transfer their technical knowledge to those satellite villages (Technical Cooperation among Developing Villages = TCDV) for nationwide coverage of the programme.

The evaluation of the Self-Managed Primary Health Care Villages Programme showed that the practical results varied widely dependent upon the backgrounds and contexts of each village. One evaluation of this programme undertaken by the Research and Development Institute at Khon Kaen University, suggested that the success of the programme varied greatly with the potential of local leaders, in terms of being respected and having leadership skill, and community cohesion rather than with the initiative of the government officials (Rabibhadana, Sriharattana, Thongyou, Choungcham & Techa-atik, 1986).

A further step was the introduction of another foundation building community organisation to act on solving community health problems. To help in problem identification communities were encouraged to examine their own problems.

4. The Basic Minimum Needs Form

In 1983, a Basic Minimum Needs (BMN) form was introduced to use in the self-managed model villages in order to provide social development indicators to assess the quality of life of Thai people. The BMN survey form was developed through the cooperation of four Ministries: Education, Agriculture, Interior, and Public Health with the support of the National Economic and Social Development Board (NESDB). The BMN form was also expected to be a tool for villagers to identify village problems and to solve them.

The process of BMN assessment began with the village committee who were responsible for conducting a household survey on form 1 (BMN-1). Then the household information was summarised to provide the data of the village (BMN-2). The BMN-2 form provided basic demographic data of the village and also village problem issues. Any problem issues that were not able to be solved at a village level would be put forward to the subdistrict council and considered to be subdistrict problems and documented on form 3 (BMN-3).

5. The Health Card Fund Programme

In 1983, a Health Card Fund Programme was set up in eight subdistricts. The concept was to set up a voluntary prepaid health insurance scheme for rural villagers to assure their accessibility to the health service and to create financial resources for communities to mobilise their own resources. The card cost 300 *baht*, although recently the price was increased to 500 *baht*. The card holders were entitled to get free health care services or hospitalisation six times per year per family. A health card which cost about one-third of the family card price was also available for pregnant women to attain maternal and child care services. The service for health card holders was not confined to that available in the village, but the clients could be referred to other levels of care according to their conditions. In the same year, as a result of this health card initiative the MOPH launched a scheme to improve basic health care services and the referral system.

6. The Extended Outpatient Department Programme

This scheme consisted of strategies used to strengthen the basic service at the health centre level by personnel inservice training and supervision through an Extended Outpatient Department Programme, and by improving the referral system. This programme was a service conducted by having physicians on rotation from a district hospital seeing clients in each health centre one day each week. The aims of the program were to improve the service at the health centre level as well as to help health workers learn new skills. In addition, a consultant team at district level was formed by cooperation between the district hospital and the district health office to supervise health workers working in health centres.

The Sixth Plan (1987-1991) was mainly the continuation of the strategies of the former Plans, except more activities were added to PHC elements, making a total of ten activities to be focused on. These were health education, nutrition surveillance, maternal and child care, water supply and basic sanitation, immunisation, prevention and control of locally endemic diseases, basic treatment, provision of essential drugs, promotion of oral hygiene and dental care, and community mental health care. As well, the PHC approach and activities were expanded to urban areas.

7. Establishing Community PHC Centres in Villages

In the Seventh Plan (1992-1996), the two major activities were to develop practical guidelines to improve the health centre service, and to establish community PHC centres (CPHCC) in villages. The former was to strengthen the service offered at the health centre level by reducing the ratio of population per health centre to 3,000. At the time the plan was initiated the average population under a health centre's responsibility was 5,781 and there were 1,312 centres which were responsible for a population of more than 7,000. The standing strategy was to build more health centres, and to provide more equipment such as a microscope, an autoclave, or a car in each health centre (Division of Rural Health, 1992). The aim of the latter activity was to provide an office for VHV to perform their tasks, a place to be a centre for other PHC activities, such as a meeting place, a place to keep the records and utensils, and to display community baseline data.

The CPHCC was expected to be a focal place to facilitate various PHC activities in villages. The MOPH supplied some equipment at the outset such as microscopes, a sphygmomanometer and some essential drugs. In those villages where CPHCC had been set up, health personnel were required to supervise and give training to the volunteers and other community leaders once a month. The implication of setting up the CPHCC meant that those villages had achieved the self-reliance goal. Setting up the centre was also used as an indicator to evaluate the success of community participation (Primary Health Care Office, 1993b).

The MOPH undertook evaluation research on the CPHCC programme, and recommended that this activity should be continued to expand the coverage. This recommendation was despite the finding that 21% of subdistrict health workers, who

were directly involved complained that they did not understand the principle of CPHCC. Also they did not agree with a rapid expansion of the programme. The study showed only 38% of villagers used this service. This percentage was lower in the village where a health centre was situated, or in the village which was close to town (Primary Health Care Office, 1994).

In summary, at the outset PHC implementation in Thailand seemed to be going in the right direction where three foundation concepts were laid to promote community self-reliance: building community organisation, strengthening leadership skills by selecting and forming critical masses, and encouraging resource mobilisation. Furthermore, the MOPH had succeeded in pushing PHC into national development policy, in which the health sector was ready to be the pivot for inter-sectoral development. However, the strategy of setting up model villages, then expanding the activities on a wider scale, reflected an unrealistic expectation of village change. Besides, too rapid an expansion of implementation resulted in a quantitative outcome orientation rather than a qualitative one. Also it was argued that the seven years of action (1979-1986) were not enough to assist health personnel at different levels to develop their confidence in PHC concepts. After the retirement of the Permanent Secretary of State of MOPH over that time period, the original concept of PHC has faded out, and the strategies and activities in the later stages tended to be more guided and material-orientated rather than focusing on the development of self-reliance.

THE DIFFICULTIES OF PHC IMPLEMENTATION

The difficulties experienced in PHC implementation in Thailand are not unique. In a WHO evaluation report of PHC implementation in fifteen countries, the authors summarised: "It is sobering to recall that the main problems discussed at Alma-Ata still feature prominently in the country reports, and clearly there are no simple solutions to such ingrained problems" (Tarimo & Creese, 1990, p.262). In Latin America, Ugalde comments "(W)e should not be surprised to discover that in spite of the promotional efforts made by international agencies there are no success stories of community participation in Latin American health programmes" (Ugalde, 1985, p.44). Morgan (1993) depicts a similar result in her study in Costa Rica.

The limited success of the PHC approach has resulted in a number of questions such as that of Ugalde: “Why this outburst with its crescendo as the decade progresses for community participation? Were international health policy makers unaware of the meagre results of community participation programmes in other sectors? Or had perhaps the early attempts in the health sector been successful enough to warrant replication?” (1985, p.44). Foster (1987, p.1044) quoted Wolfgang Bichmann’s writing: “There are surprising analogies between the PHC and CD [community development] approach Generally speaking, CD did not yield the expected results on a nation-wide scale Why then should PHC produce a better outcome than CD?”

The criticism of the concept of community participation in PHC is that it paints too rosy a picture. It fails to distinguish sufficiently between broad policies and narrow implementation, big talk and little action, radical declarations and conservative intentions. Some questions which have been raised are as follow: Is participation just rhetoric verse? Is this concept necessary to improve the health of a nation? (De Kadt, 1982; Heggenhougen, 1984; Mburu, 1980; Ugalde, 1985).

One consequence of the limited progress in implementing the PHC approach was an argument that the integrated, or CPHC approach, as suggested by WHO was too ideal to practise. An alternative approach to the provision of appropriate health services in poor countries, namely SPHC, was introduced in the late 1970s. The reason for proposing SPHC was based on the observation that the PHC approach was too idealistic, costly and difficult to implement effectively. It was viewed as more realistic to spend scarce resources to control specific diseases which caused the highest mortality and morbidity, particularly where low-cost technologies for prevention and treatment were available. However, WHO (1988,b, p.44) urged maintenance of its standpoint by stating: “The position we take here is that health must be seen as part of overall development, that community must be involved in that development process . . . “. The following review discusses the detail of this debate.

THE DEBATE OF CPHC AND SPHC APPROACHES

In 1979, Walsh and Warren criticised the goal of primary health care and found that it was too ideal to practise. According to their opinion “the rhetorical goal pledged at the

Alma Ata conference - a socially and economically productive life for all attained through comprehensive primary health care - may not come to pass in the near future” (Walsh & Warren, 1980, p.146). Walsh and Warren drew upon the results of a World Bank report, which demonstrated that the PHC approach supported by WHO was costly. The report concluded that the investment cost for training health workers would be in the range of many billions of US dollars (Walsh & Warren, 1980; Phillips, 1990). In addition, little was known about the effectiveness of the health workers in the system, particularly how many opportunities they would have to apply such preventive measures. It was argued that whilst many developing countries have faced endemic diseases, health services should be directed towards controlling those diseases which produced the largest amount of death and disability. Therefore, a *selective* attack on the most severe public health problems should be considered to have greatest chance of improving health as an interim strategy for developing countries. The process of implementing SPHC was suggested to begin with ranking problems in terms of the annual death and disability rates, causes of illness, and feasibility of various control measures. The next step was to devise an intervention programme of reasonable cost and practicability.

Walsh and Warren claimed that a selective approach suggested the most cost-effective form of medical intervention which was “based on the analysis of cost-effectiveness on the indicators of changes in mortality or deaths averted” (1980, p.152). They also added that this approach has often led to improvement in people’s living conditions, and also to allowing health workers to obtain training or more education. The SPHC approach was supported by several donor agencies; for instance the Rockefeller Foundation (Halstead, Walsh & Warren, 1985) and UNICEF. Later on UNICEF launched the Child Survival and Development Revolution Programme which aimed to combat specific problems, and was known as GOBI-FF (growth monitoring, oral rehydration therapy, breast feeding, immunisation, female education, and family spacing).

The debate opposing the implementation of SPHC accused its proponents of misinterpretation of the primary health care concept, suggesting that SPHC was likely to undermine the social basis of PHC. It was argued that the goal of PHC was not merely change in health service delivery, nor did it equate to a health programme. Rather, PHC was a strategy for health development which was expected to affect the range of social,

political, and economic factors which ultimately influence the improvement of health status. When critiqued, SPHC was seen to differ from the concept of PHC in several points.

Firstly, there was a difference in the definition of “health”. SPHC tended to view “health” as the absence of disease. Its measures for health improvement were the reduction of diseases which were the most harmful and feasible to control. The adequacy of cost-effective evaluation was also questioned, in that it was a too simplistic technical criterion to measure complex-caused health problems (Berman, 1982; Chen, 1986). In contrast, PHC has broadened the meaning of health from that of the absence of disease and has focused on a state of well being. Secondly, allocating health resources only to people with priority diseases, leaving the rest to suffer, meant that SPHC failed to address the issue of equity which was one pillar on which PHC rested. Thirdly, the SPHC approach, as such, did not recognise or solicit the help of other sectors nor non-professionals in defining or making decisions about those problems. The basic principles of SPHC did not coincide at all with the PHC concept of intersectoral cooperation. Moreover, it consolidated health provision in the hands of the professionals and gave high credence to the importance of medical technology. Lastly, PHC was community based, but SPHC had no concern with enabling people to determine and to be involved in solving their own problems: it negated the concept of community participation (Newell, 1988; Rifkin & Walt, 1986). In addition to that, there was evidence in practice that effective GOBI-FF activities were not easily implemented. In the actual setting, health workers did not have enough time and did not realise it was necessary to talk to mothers about their children’s problems, and the purpose of the programmes as well as any tangible benefits for them. Therefore, there was a tendency to exclude mothers from full participation in the monitoring process. Critics suggested that SPHC could create only a climate of short-term expediency instead of long term and sustainable change (Fendal, 1987; Unger & Killingsworth, 1986; Wisner, 1988).

Other authors proposed a “middle way” in which SPHC could be integrated so as to improve health of the populace: an evolutionary process within a revolutionary concept. Taylor and Jolly (1988) suggested that the debate of selective versus comprehensive approach was only a “self-satisfying war”, because both approaches were reconcilable,

“Just as Alma-Ata recognised the need to be both comprehensive in goals and strategies, and somewhat selective in choosing tactics and specific programme interventions” (p.972). In their opinion, such debate was only the beginning of misleading polarisation, which was dangerous, because both selective and comprehensive approaches were necessary for health development. Technology development was also seen as important and effective, and needing to be more widely promoted. It was stated that promotion of technological approaches has often substantively helped to accelerate the PHC infrastructure. Mosley (1988) also supported the idea of integration. In his opinion, SPHC should be acceptable as long as the programme is problem-based and population-based. Because the implementation of SPHC is not simply technology oriented, it provides a chance for the population and health workers to be educated or trained and all resources to be re-allocated or mobilised (Mosley, 1988). It is claimed that both concepts are reconcilable as SPHC has never claimed to be more than an interim strategy of the broad concept of PHC (Warren, 1988; Walsh, 1988). The following discussion illustrates the implementation of SPHC approach in dengue control projects.

IMPLEMENTATION OF A SPHC APPROACH

Dengue fever is a viral infectious disease transmitted to humans by the mosquito vector genus *Aedes*. Dengue viral infection may be characterised in various forms of clinical manifestation from the mild febrile illness of dengue fever (DF), hemorrhagic diathesis which is called dengue hemorrhagic fever (DHF), to the most serious form which is called dengue shock syndrome (DSS) in which death may ensue. The disease is more common among children in the age group 5-14 years.

The species of the vector is *Aedes aegypti*. It is a domestic mosquito that lives around human habitats. Its breeding places are man made water reservoirs in and around the house such as collected water in old tyres, old bottles and cans left around houses, or water containers in the houses. There are two ways to control the vector. Firstly to kill adult mosquitoes. The method commonly used is chemical substance spraying, either from various devices and vehicles or from aeroplanes. Secondly, to control mosquito larvae by different control measures such as putting ABATE (sand granules covered with chemical pesticides for larvicide) into breeding places, reducing breeding places by

improving household sanitation, or bio-control by putting larvovorous fish or Copepods in water reservoirs.

However, the second method is recommended because the control of adult mosquitoes has proved to be inefficient. Chemical substance spraying reduces the mosquito population for only a few days, after which time the number of mosquitoes increases again. More often than not, the time of spraying is too late to affect the disease outbreak. In addition, the control of adult mosquitoes by chemical spraying to cover all infested areas requires much more resources in terms of time, money and manpower. Insufficient resources and implementation would not lead to changes in the epidemic profile of the disease. It was recognised this problem was one which may benefit from a SPHC approach and that the control strategies needed to be changed from “top-down” activities to a “bottom-up-approach” to encourage people to realise that they themselves have to do this job. Community participation therefore became the core strategy to control and prevent dengue fever (Halstead & Gomez-Dantes, 1992; Yoon, 1986).

Though the importance of community participation was recognised, its implementation was not fully achieved. The report of the First International Conference on Dengue and *Aedes aegypti* Community-Based Control held in Mexico suggests that community participation was conceptualised differently in different programmes. Only one out of 38 programmes clearly stated that community participation meant communities shared the goal of the programme from the beginning and took part in the programme organisation, implementation, and evaluation. Participation, as interpreted in this one project, meant a deep and adequate knowledge of the problems being worked with, to allow communities to work with total awareness of what they were doing. The programme started by contacting the local leaders, to whom the programme was explained. After that an ethnographic study was conducted to identify problems. Then three methodological approaches were defined: getting the community to participate in identifying knowledge about disease problems, using problem-oriented education in the participative research process and to educate the community, and identifying the appropriate way to communicate best with the community such as plays, songs and stories. However the results of the programme were not available because it had not been finished at the time of reporting (Alonso, Arceo, Cruz, Lopez, Minon & Perez, 1992).

The rest of the programmes which were reported on at the conference, interpreted the word “community-based”, the theme of the conference, differently. Many programmes did not state clearly what the concept meant and how it was translated into practice. The activities undertaken by the majority of the programmes were forms of health education. The target groups were either school children, housewives or the mass population. The subject content was designed by health personnel prior to the activity. Another popular activity was a campaign to reduce the breeding places by involving groups of volunteers, such as boy scouts, housewives, or school children. One project expected to build community awareness of the need to improve the domestic hygiene of the house surroundings, but the activities were mainly undertaken via the traditional health education (Clark, 1992).

The majority of the activities reported at the conference were traditional top-down approaches in which all activities were decided upon and conducted by government personnel. This reflected how this concept was perceived by the authorities. As one project recommended:

It is not feasible to leave community problems entirely in the hands of the community. The purely bottom-up dengue control approach is unlikely to work in suburban/rural Thailand. Therefore, an effective community-based programme in Thailand should be a blend of bottom-up and top-down approaches.

(Kittayapong & Strickman, 1992, p.172)

This perception was also reflected in the evaluative indicators selected for the programmes. Almost all of the programmes used entomological indices, but the concept of community participation was not yet evaluated, as suggested by social scientists:

There are new concepts being brought into the study; what it is that needs to be measured, it is not just numbers of mosquitoes, numbers of larvae, density, and those kinds of issues but rather human conceptions of what should be done with the containers. That is obviously a new language, unfamiliar and uncomfortable to many, perceived as necessary by others.

(Klein, Trostle & Pederson, 1992, p.323)

CONCLUSION

This chapter has traced the emergence of PHC and its implementation and subsequent evaluation in Thailand and in other countries in South and Southeast Asia. Parallels between the emergence of PHC and development theory were identified.

It is clear, particularly from the detailed description of the implementation and evaluation of PHC programmes in Thailand to date, that a key unresolved issue is to establish how to gain community participation in health care. The following chapter explores in more depth the concept of community participation which is viewed as the pivot of the PHC approach.

CHAPTER THREE

COMMUNITY PARTICIPATION IN HEALTH

The notion of community participation in the health sector as the core concept of PHC has been influenced by the current development paradigm (Oakley & Marsden, 1984; Rifkin, 1985). Community participation is significant as a basic human right and it is of central importance to sustainable development. This chapter traces the ambiguities in interpretation of the concept over time. The Thai conceptualisation of participation and the Thai ethos of antiparticipation are detailed to identify sociocultural factors which work against the implementation of community participation in Thailand. The experiences of other countries in implementing community participation are reviewed to identify commonalities with Thailand.

THE CONCEPT OF COMMUNITY PARTICIPATION

The concept of community participation was first introduced in the health literature as a fundamental concept of PHC in 1978. It was defined as:

(T)he process by which individuals and families assume responsibility for their own health and welfare and those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid. They therefore need to realize that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable. They have to acquire the capacity to appraise a situation, weigh the various possibilities and estimate what their own contribution can be. While the community must be willing to learn, the health system is responsible for explaining and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative costs.

(WHO, 1978, p.51)

The broad aim of the above definition, however, provided limited guidance as to what it really meant, and particularly how it would be achieved. Thus it is not surprising that interpretation of the concept of community participation ranges from people's contribution to public programmes, to self-help groups to community development

(Brown, 1994; McEwen, Martini & Wilkins, 1983; Robinson, 1980). The ambiguity of interpretation of the concept over time can be seen from the following discussions.

In January 1979, The Executive Board of WHO invited member states to consider using the PHC principles as a basis for formulating their own national policies, strategies and plans of action, and collectively as a basis for formulating regional and global strategies for attaining PHC goals. The strategies suggested for each government to encourage community participation read:

Measures have to be taken to ensure free and enlightened community participation, Governments, institutions, members of the health professions as well as agencies involved in health and development, will therefore have to *enlighten* the public in health matters so as to ensure that people can participate individually and collectively, as part of their right and duty, in the planning, implementation and control of activities for their health and related social development.

(WHO, 1979, p.17, emphasis added)

In 1981, global strategies were formulated based on the collection of individual national policies, strategies and plans of action. This report mentioned some of the measures, linked with strategies involved in mobilising human resources which were considered to promote community involvement (WHO, 1981b).

Later the term empowerment was introduced by WHO in relation to the implementation of the concept of community participation. It was suggested that “empowering should be done by providing information, technical support and decision-making possibilities, so as to enable them to share in opportunities and responsibilities for action in the interest of their own health” (WHO, 1988b, p.137).

In 1981, WHO suggested the term community involvement should be used in preference to community participation. The stated reason was “because it is not sufficient merely to participate, which may be a simply passive response; there should be mechanisms and processes to enable people to become actively involved and to take responsibility for some decisions and activities jointly with health professionals” (WHO, 1981a, p.21). It has been suggested that the term “involvement” was preferred in the health sector because it was perceived to have deeper implications (Oakley, 1989).

In 1985, WHO held an inter-regional meeting in Yugoslavia, where experts from other sectors were invited to participate in order to gain a wider view of thoughts on and interpretations of the concept. From that meeting a new term - community involvement in health development (CIH) was introduced. It was defined as:

Community involvement [in health development] is a process by which partnership is established between the government and local communities in the planning, implementation and utilization of health activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of primary health care.

(Oakley, 1989, p.13)

From that meeting, it was suggested that the above definition implies two broad but distinct interpretations of the *practice* of CIH: firstly, CIH as *awareness* and *understanding* of health and health problems; secondly, CIH as *access* to information and knowledge about health service programmes and projects (Oakley, 1989). For the first interpretation, the strategy is to build up communities' awareness and understanding of the issues of health development and the causes of poor health as the basis of their future active involvement. The purpose of this strategy is to develop and strengthen the capability of rural people to take development initiatives. The programmes in this strategy may not have predetermined measurable objectives or even a direction beforehand. In this approach, participation is regarded as an *end* in itself. Emphasis is then laid on participation as a process in which confidence and solidarity among rural people are built up. Such development is likely to be permanent because it encourages communities to play active roles in development.

In the second interpretation, the strategy is to facilitate communities' direct access to information and health service programmes as a precondition for participation. The programmes are normally designed and implemented by external health professionals. In this approach participation is a *means* to achieve some predetermined goals or objectives. Frequently, it is used as a means to improve the project delivery that professionals want to implement. In these cases participation is a short term exercise, there is direct involvement in the task but the participation evaporates when the programme is finished. It also is considered as a passive form of participation (Oakley, 1989; Oakley & Marsden, 1984).

In some health literature the terms community participation, community involvement and CIH are used interchangeably. In this study, the term community participation is preferred in order to make linkages with other relevant literature. In the section which follows, Thai understandings of participation are explored.

THAI CONCEPTUALISATION OF PARTICIPATION

In Thai, “participation” has been translated as “*kaan mii suan ruam*”¹ which simply means taking part or sharing. With increasing popularity of this concept, there are more metaphorical uses such as, *ruam mue* (hands) which suggests cooperation, or *ruam chai* (heart) which means to come together with a common purpose, or *ruam kamlang* (strength, force) which means joining forces, or *ruam klum* (group) which means to join or to form a group. Thus the verb *ruam* “is used with a human object which implies the gathering together, mobilising, rallying, concentration, even uniting of people by others without reference to subjective or voluntary participation” (Turton, 1987, p.10).

Hirsch (1990) critiqued the Thai conceptualisation of participation and found that it has long been influenced by the World Bank in its orientation of the Thai development strategy since 1960. The Bank has promoted economic growth and traditional economic indicators were used to reflect the success of development. By the end of the 1970s, the negative side of such a strategy became more apparent in steadily increasing inequalities between urban and rural areas, between regions and between social groups. Thus the Bank turned towards participation in development, where the issues of redistribution of resources resulting from economic growth have been stressed (IBRD, 1980).

A contrasting conceptualisation of participation appeared in the UNRISD project which involved a group of Thai academics, NGO development workers, government officials in the study areas, and the poor themselves in an attempt to assess their achievements and potential effort to enhance their livelihood and social power, together with their

¹ The transcription of Thai words or names or local dialect in this study is usually written in English either as it is pronounced or is transiterated for the Thai. Generally, they have been made to use a common-sense approach by using the spelling that appear to be widely accepted. The “ph” and “th” are pronounced as “p” and “t”, and the vowel “aa” is usually meant to be pronounced a long sound as in “farm”.

obstacles and limitations. In this project participation was linked with power, consequently popular participation was defined as “the organized efforts to increase control over resources and regulative institutions in given social situations, on the part of groups and movements of those hitherto excluded from such control” (Turton, 1987, p.3).

In February 1984, there was a conference about participation in Thai development which involved Thai civil servants, academics, and NGO development workers. The resulting publication by Hongvivatana (1984) reflected the variety of interpretations of participatory development held among different groups.

Among civil servants there was a heavy emphasis on official designated institutions. This was because most of them were senior officials who were not directly involved at a practical level. Their statements reflected the rhetoric of participation but not necessarily the local practice. Participation was defined by the Director of the Community Development Department, Ministry of Interior as:

(T)he process by which the government promotes, persuades, supports and provides the opportunities for people in the community, whether they be individuals, groups, clubs, associations, foundations, or voluntary organizations, to take part in carrying out any piece(s) of work . . . in order to fulfill stipulated development objectives and policy.

(Hirsch, 1990, p.190)

Hirsch interpreted the statement as “participation is something sponsored by outsiders, and its aim is to encourage local involvement in achieving objectives that are stipulated elsewhere” (Hirsch, 1990, p.190). He also criticised the emphasis on the government framework, where the subdistrict council has been identified as the core organisation for community development (Hirsch, 1990; Hongvivatana, 1984).

The academic contributors to that conference were critical of the project orientation and the emphasis on official channels as the medium for participation. Thawithong Hongvivatana criticised the ambiguity of the Fifth Plan in terms of the implementation of popular participation which was stated in development policy. Furthermore, he

considered that there was a misinterpretation of the concept among officials. He states (Hirsch translation):

The (official) meaning of participation tends to be used as a means to get people to co-operate in activities or projects that the State or its officials have stipulated Most state officials think that participation is a new instrument or technique for getting villagers to accept the activities already laid out by those officials.

(Hirsch, 1990, pp.190-191)

This approach led to the forcing of villagers into numerous activities that increased their burden and also their dependence on outsiders. Saneh Jamrik, a retired academician, criticised the government approach to community participation in that the idea and forms of implementation were initiated from outside and ignored the peasant potential. Saneh defined participation as developing and using local people's full potential, starting with what was already there. Chai-anan Samudavanija, a prominent Thai political scientist, defined participation as involving issues of power and broader structural aspects of the social transformation. Participation was concerned with the devolution of power from bureaucrats who have exploited it for a century to those who did not have it (Hirsch, 1990; Hongvivatana, 1984).

The majority of the rural poor were probably not familiar with the concept of participation as identified in the UNRISD project:

In reality the rural poor have a very concrete experience of their lack of control of both resources and regulative institutions. They may not be altogether aware of the reasons for this lack of control or of possible remedies, or even of their own potential to change things. At the same time, the language, perceptions and prejudices of outsiders may prevent them from being aware of or appreciating the potential of the rural poor.

(Turton, 1987, p.10)

THE THAI ETHOS OF ANTI-PARTICIPATION

Thailand has been described as a country which has no history of large-scale social movements of peasant and workers in recent decades (Turton, 1987). A study of farmer self-help organisations confirmed that during a period of 80 years of development in Thailand, no long-term successes have been reported (Heim, 1990). On the contrary, state development programmes have been accused of contributing to widening the gap between the rich and the poor in rural areas (Rabibhadana, 1982). Turton described the

situation before the UNRISD started the “Popular Participation Programme” in 1981 as follows:

(T)here was, in Thailand far less experience of local organization by political parties and, more recently, ‘non-party’ political groupings, and there was less legal support for such organization. Also, there had been no major attempts by the states, at the time the Thailand project was conducted, to introduce social development policies which directly emphasized ‘popular participation’. Thailand seemed to be a case where an authoritarian state and society were organized on ‘anti-participatory’ lines insofar as the rural poor were concerned.

(Turton, 1987, pp.3-4)

It is worthwhile exploring what are these “anti-participation” characteristics among the Thai, including how and why they have developed. The following characteristics are derived from the study of farmer self-help organisations and the UNRISD project, within which people participation was the major concern.

1. The Belief in Kamma

The basic problem for farmer self-help group organisations found in Central Thailand is described as follows:

Because of the belief in re-incarnation and the karmic law Thai people accept personal differences in wealth and power as natural. Thus a person is born into, or gains wealth and power because one has accumulated merit or good deeds (*bun*) in the past and/or present lives. Similarly, a person is born into poverty or loses one’s wealth and power because of one’s bad deeds (*baap*) in the past and/or present lives.

(Heim, 1990, p.11)

This belief is also strongly held among people in the Northeast region (Tambiah, 1970). In fact, it is popular Buddhism: laypersons’ beliefs and values according to their interpretation of Buddhist doctrines of *nirvana*, kamma, and re-incarnation.

The *nirvana* (*nibbana* in Pali, *niphan* in Thai) is the ultimate goal in Theravada Buddhism. It is an abstract religious goal (Kirsch, 1977); the state of absolute fulfillment “free of desire for, and cleaving to sensuous objects, and free of the accompaniments of sorrow and pain” (Tambiah, 1970, p.49). Being aware that to achieve this state is far beyond the ability of human beings, even of normal monks, Thai people aspire to a more proximate version of the ultimate goal. Thus, “most Thai are linked to Buddhism

through popular beliefs about merit (*bun*) and the pervasive ritual system connected to these beliefs, merit-making (*tambun*)” (Kirsch, 1977, p.246). *Bun*, as defined in popular thought and action is attained through liberal gifts to the monks and the temple (Tambiah, 1970).

The theory of kamma (karma in Sanskrit), of moral action with moral consequences, is the core in Theravada Buddhist doctrine. It is described as:

The Buddha posits the ultimate cause of suffering as ‘craving’ or ‘desire’ (*tanha*). *Tanha* in turn, leads one to act, and these actions (*kamma*) have their consequences (*vipaka*; *phala*), whose character depends upon whether the act itself was morally positive (*punna*, *bun* in Thai) or morally negative (*papa*, *baap* in Thai) The Buddha analyzed *tanha* as being of two types: the first, caused by ignorance (*moha*), conduces to bad kamma; the second, the desire for existence, conduces to good kamma . . . (K)ammic theory provides the basis for action. If one acts in ignorance - giving vent to one’s passions of greed (*lobha*), lust (*raga*), and anger (*dosa*) - one will commit immoral acts and will suffer negative consequences. If, on the other hand, one acts with awareness, suppressing the impurities (*kilesa*) of one’s nature and following the desire to reduce or eliminate suffering, one will perform moral acts and experience positive consequences.

(Keyes, 1983, pp.261-262)

Instead of such esoteric doctrines of kamma, a simple formula is accepted among the Thai, as in saying: *tham di dai di, tham chua dai chua* (do good, receive good; do evil, receive evil). Combining these three concepts in a materialistic sense, Thai people believe one has merit (*mii bun*) such as having wealth and power, because one has a certain store of merit from one’s past kamma. There is nothing much one can do to change the status quo. Besides, everyone is capable of accumulating *bun* in this life to ensure a rebirth blessed with happiness, prosperity and wealth (Tambiah, 1970).

2. Patron-Client Relationship

Another hindrance to farmer self-help organisations was a social relationship in Thai society, which was identified as the “patron-client relationship”. It is characterised as: senior-junior (*lukphi-luknong*), or superior-inferior (*phuyai-phunoi*). This type of relationship was based on ways in which groups which have been called “entourage” were organised. An entourage was “an hierarchically organized group in which a

number of subordinates support a leader who holds their allegiance by successfully advancing their interests” (Heim, 1990, p.11). The model of the “entourage” was the family or the extended family, with the underlying assumption that the leader was head of the family who protected and distributed benefit to his children. Members of the entourage were like young children, respectful and obedient.

The patron-client relationship has had a long history in Thai society. Historically Thai society has been characterised by a two-class division into nobles and common people (*nai* and *phrai*). The former group were princes and semi-hereditary officials, who were given a ranking expressed in terms of rice-lands (*sakdina*). This ranking was obtained initially by royal patronage, and by hereditary process, and the ranking declined with each succeeding generation. Such a traditional administrative arrangement enabled the control of labour which was vital to maintain or expand power; to extract wealth, and to assure prestige and status for the ruling class. The latter group were common people (*phrai*) and slaves who had sold themselves into debt-bondage. In the mid-nineteen century they were estimated to number at least one-third of the population (Girling, 1981; Hirsch, 1990).

Everyone among the *phrai*, from the fourteenth century onward, had to be registered under a leader, for the *phrai* as such had no legal status, and therefore no legal protection, except through their leaders.

(Girling, 1981, p.26)

Despite the modernising reforms of the state and the abolition of slavery the two-class system has continued in Thai society, but the criterion for class division has shifted from power attached to official positions to accumulated wealth, such as of merchants (Heim, 1990).

As society increasingly urbanized and westernized, the elite or upper class was referred to less frequently in terms of its landed status (*nai*, *sakdina*) and more often in terms of *phuudii* (approximately to ‘gentlefolk’) and *panyaachon* (educated) . . . for most rural dwellers there are two classes of Thai: villager (*chaobaan*) and official (*khaaraachakaan* - literally, royal servant) . . . Officials and others of higher status are often addressed as *nai*, reflecting the persistence of traditional categories in social discourse.

(Hirsch, 1990, p.19)

Within the administration in this type of relationship has always been a hidden element of exploitation. The process of administration is highly centralised and characterised by top-down orders, often without sufficient explanation of the reasons behind the orders. It is a relationship which is based upon unequal exchanges of benefits in economic, political and social terms. As a result, the current situation is described as:

Eventually, the attitude of inferior persons, including low-ranked officials as well as farmers, is that personal advancement or success is dependent on finding an effective patron or entourage leader who can further one's case. One cannot find success through one's own work alone, or in cooperation with one's equal.

(Heim, 1990, p.13)

3. *Krengchai*

Krengchai is a word which describes a typical characteristic of the Thai. It is defined as "fear to displease or disturb another person" (Rabibhadana, 1982, p.31). The term indicates mutual respect, the basis of most social relationships in the society. It is closely connected with the value of avoidance of open hostilities or embarrassing others. Kulick and Wilson (1992, p.71) explained "(It is) to protect the self-respect of other person, knowing that they will protect his". Moore viewed this characteristic as related to the Chinese concept of saving face. He commented:

It involves the desire to be self-effacing, respectful, humble, and extremely considerate, as well as the wish to avoid embarrassing other people (and oneself), intruding upon them, and causing them to extend or trouble themselves. Since a Thai abhors being considered weak, cowardly, or afraid, the concept of *krengchai* can rationalize weaknesses where they exist.

(Moore, 1974, pp.181-182)

Kulick and Wilson gave an example as:

At a faculty meeting junior lecturers will voluntarily abstain from opposing the department head's proposals, however silly - though if it seems important enough, they might later beard him privately to argue with him. It is not that they are timid or frightened, but rather that damaging his self-respect in front of the others would name him and the department, as well as opening themselves to his retaliation and the others' condemnation for what would be considered insolent bad manners.

(Kulick & Wilson, 1992, p.71)

Another example of *krengchai* given by Rabibhadana (1982) described how the members of a farmer self-help organisation handled the election of their chairman who also would

be the manager of the cooperative shop set up by the organisation to sell pig food. The former corrupt chairman was nominated by his followers. No one in the meeting proposed any other person to compete nor did anyone express any objection. Thus he was reelected. This surprised the fieldworkers because before the election day almost every member of this cooperative had come individually to the fieldworkers and told them about the chairman's corrupt practices and stated they did not want him to be elected again. But interestingly, after this chairman was reelected none of the members participated in any activities of the cooperative store. Therefore it had to be closed down because of lack of customers. Afterwards, this group was able to form a small informal group. This illegal small group opened up the store after the cooperative one was closed. The composition of membership was changed to the new group membership. A new chairman was elected and the store was reopened and was soon operating a profit.

Krengchai keeps the Thai from confrontation, or at least from face to face discussion, particularly when dealing with hostile issues. Without discussion there is little likelihood that participation will be achieved. Another consequence of *krengchai* is the doubt about the appropriateness of voting as a mechanism to control management in Thai society. The following incident illustrates well the influence of *krengchai* on an election when cooperative members control a farmer self-help organisation.

Thai people do not show their satisfaction or dissatisfaction by using their rights to elect those whom they want, but rather tend to show their satisfaction or dissatisfaction by participation and cooperation, or refusing to do so. Elections, which are one of the most important mechanisms of control in Western cooperative movements, would thus seem to have limited meaning in Thai cooperative organizations.

(Rabibhadana, 1993, p.30)

This limitation relates to the issue of the weakening of village management.

4. The Weakening of Villages

In earlier times when there were no highways and road networks, the villages were not easily accessible, and most were left to live on their own. They were self-sufficient and associations of entire communities existed for themselves, for their own social production.

They included external, or horizontal inter-village relations, as well as inter-household networks based on kinship and neighbourhood. They involved various forms of reciprocal and redistributive exchanges (for example, labour for agricultural and domestic production tasks, pooling labour for communal religious, social and irrigation tasks) and collective decision-making and action.

(Turton, 1987, p.80)

At that time people selected village elders as their leaders for their virtue and morals. The villages in the North region used to have two leaders; the one who looked after the affairs of the lay population was called *kae baan*, and another who looked after the affairs of the monks was called *kae wat* (Rabibhadana, 1993).

Until 1897 when the positions of *phuyai baan* (village headman), and *kamnan* (subdistrict leader) were set up by the government, these leaders were elected by villagers. The procedure of the election, however, was carried out rather flexibly, and not formally. The formality lay only in the recognition given to the elected person by the central government (Rabibhadana, 1993). In 1943, there was a major change regarding eligibility, when, to be eligible, the candidate had to be able to read and write. It also stated that persons who served in the army or the police force were to be preferred. This condition was relaxed in 1946 when the clause giving preference to ex-soldiers or policemen was taken out. In 1971, the level of educational qualifications was raised, requiring that the eligible candidate was over 25 years of age, and had completed the compulsory elementary education. Once elected, a headman remained in his position for life, or as later occurred, until 60 years of age (Rabibhadana, 1993).

The requirement for formal education removed the eligibility of all village elders to take up the positions as none of them had had a chance to go to school, or could read or write. "We must note that with both formal education as well as the training for soldiers and policemen organized by the central government, it was policy to make village headman and subdistrict leader staff of the central bureaucracy" (Rabibhadana, 1993, p.9).

The dismissal of both the village headman and subdistrict leader occurred if more than half of the village inhabitants who were eligible to vote, petitioned for their dismissals. Then the act of dismissal was performed by provincial governor, who used his power

through the district official, when he deemed the headmen unfit for the position because of their behaviour or lack of ability. Rabibhadana provided a critique of this and stated “a little power over the headmen was given to the village, the overwhelming power, very much discretionary, was given to the governor, and district official . . . who are officials of Ministry of Interior appointed directly from Bangkok” (Rabibhadana, 1993, p.9).

The role of the village headman was as follows. On one hand, he should be the spokesman of the village, responsible for villagers’ welfare, and make requests and demands to the government on their behalf. On the other hand, he takes the role of being the registrar, collects taxes, and keeps the peace within this village. He is the eyes and ears (*pen hu pen taa*) of the government. Such dual roles made the job of a headman more difficult, particularly after 1950 when the threat of communism was first felt and the development policy was closely linked with the state security. Then the First National Development Plan was drawn up in 1961, in which infrastructure, buildings and road networks were proposed. “Only one year after the outbreak of fighting with insurgents, the Office of Accelerated Development was set up to construct roads to villages, even remote ones” (Rabibhadana, 1993, p.11).

The penetration of the state was soon accelerated by the highways and road networks, and many more government officials of various departments were posted to work at district and village levels.

(This made) the job of a headman became more difficult since he had to please so many different officials, the officers of different departments with different programmes, at the same time he had to try to please his villagers. The job however became attractive to a certain types of people because with all these development projects, there were gains and benefits which unscrupulous headmen could capture with the corrupt officials.

(Rabibhadana, 1993, p.11)

These positions became the most attractive for those ambitious people who wanted to use the positions as instruments to invest or to facilitate their businesses. Usually, they were the well-off in the village, and the village committee were people in the same social status. There are numerous cases of corruption by local leaders and officials in rural development projects. They colluded with contractors and government officials for private benefit. The latest activity in which the local leaders have been engaged is the

role of middlemen in selling land, since in some villages the land has been in great demand for housing estates, tourist resorts, golf courses and factories (Rabibhadana, 1993; Turton, 1987).

Eventually, the consequences of the process of change resulted in the weakening of villages, particularly of the local leader institution. Village headmen no longer belonged to, or worked for the benefit of the inhabitants but rather for the government or for their own benefit.

5. Thai Bureaucracy

Thai society has been described as a bureaucratic polity in which the bureaucrats lay down policy and govern the country and the people (Rabibhadana, 1993). It is the consequence of a great transformation beginning in 1880 to escape the intervention of the West. Although Siam (now Thailand) escaped colonial rule, foreign experts were employed to advise and direct in the highest levels of the administration in many departments and ministries. The use of foreign advisors and other means by King Chulalongkorn spanned the most intensive period of transformation in a Western manner. Thus the Thai polity was organised in the pattern of colonial administration, in which the monarch took the place of the colonial governor. "This 'indirect colonization' resulted in the centralizing policy which is largely responsible for the subsequent stunted or distorted political growth of present-day Thailand" (Girling, 1981, p.47).

According to the structure and the personnel of the new bureaucracy, functional ministries - salaried, professional bureaucrats in the Western style - have replaced the old semi-hereditary ruling families. These bureaucrats are subjected to periodic transfer throughout the country to avoid local officials establishing a power base, and the transfer is ordered centrally. Centralisation is reinforced by the promotion structure and status accorded by transfer from district to provincial level, and from provincial level to Bangkok. This has also resulted in vertical rather than horizontal communication, since bureaucratic relationships are still largely based on a patronage attitude: local-level officials gain merit points by following orders from the next rank up the administrative ladder rather than by knowledge of, or skill in dealing with local affairs. Therefore, each

department or ministry has an entity, in which accountability and promotion are still largely internal, though inter-sectoral actions are expected.

The effect of this entrenchment of vertical linkages at the expense of horizontal linkages is to inhibit co-ordination between the state's local-level developers. Each department with each ministry runs its own projects with its own budget, and duplication is rife. Furthermore, it is in each department's interest to expand its role at the expense of others in order to secure larger budget allocations.

(Hirsch, 1990, p.22)

The system does not encourage either the people to participate in government projects that concern them, or the lower-ranking officials who have to implement the projects, to participate and provide information upwards. Development policy is mostly decided in supra-local level. The administration system contradicts the concept of participation.

Another consequence of the bureaucracy reforms is the rise of "new men" who are educated, recruited and trained to manage the powerful bureaucracy. The education system is also centralised and biased in favour of certain social classes and regions over others. In 1972-4 more than 74 percent of university students came from families of businessmen or government officials and only 6 percent from agricultural family backgrounds. The Thai attitude toward education is reflected in the phrase, *rian sung sung cha dai pen chao khon nai khon* (higher education to be master over others). The words *nai* and *chao* mean the members of noble class and princes who ruled or governed a number of the ordinary people in the past. Since the patronage attitude has persisted these officials do govern or rule in the true sense of giving orders (Rabibhadana, 1982; 1993; Turton, 1987).

The "state controlled" education system determined that "all children throughout the country would study the same national language (standard Thai), study the same national history (one that accentuated the role of the Siamese Monarch and de-emphasized the roles of local lords and rulers), and learn the same national songs" (Rabibhadana, 1993, p.21). The effect of the dominant educational system is described as:

(T)o ignore or dismiss as irrelevant, at least to discredit, many pre-existing traditional and popular forms of knowledge and skills and with them, powers of decision-making and responsibility. Much official 'development' thinking and training starts with a baseline notion of rural

ignorance. Such values can be internalized, thus giving rise to a sense of inherent ignorance or lack of ability.

(Turton, 1987, p.107)

It is clear therefore that there are socio-cultural factors which work against community participation in PHC in Thailand. The following section examines the experiences of other countries in attempting to implement community participation in PHC programmes and identifies the commonalties with those of Thailand.

THE EXPERIENCES OF OTHER COUNTRIES

In other Asian countries there is limited success reported in attempts to achieve community participation in health care, although success has been claimed in increasing coverage and equity of service delivery at a low cost compared with alternative modes of service organisation. Consistent with Thai studies, research in Nepal revealed that the implementation of community participation in the PHC approach reflected the perspectives and needs of the health bureaucracies involved rather than those of local village interests. Similarly, the work in other South and Southeast Asian countries showed that the concept of community participation was interpreted differently in different bureaucratic settings and adapted to bureaucratic needs, and there was a failure to appreciate and integrate the cultural factors (Justice, 1986; Stone, 1986; 1989).

In African countries, there were some successful cases reported by Bugnicourt (1982) who described some concrete examples of community participation; for instance in the provision of a piped water supply for a squatter settlement in one district in Central Africa, the people decided to break the costs down by offering to do a large part of the work themselves. People who lived along the loop of the Niger River gave priority in “making books in their own tongue”. They used a silk screen technique, as advised by the NGO worker, to produce collections of texts to which everyone contributed, such as proverbs, legends, riddles, history, linguistics, and even traditional medical knowledge, instead of remaining passive and waiting for information from elsewhere.

However, Bugnicourt also identified socio-cultural factors which created barriers to participation which were similar to those identified in Thailand and other Asian

countries. He reported different interpretations of the concept of community participation in different situations to suit local socio-economic structures and related to the local political regime. Government-organised participation reflected a centralised administrative system and desire for standardisation. An hierarchical attitude and bureaucratic tendencies led to a preference for written paper work over direct contact with village people. There was insufficient personal commitment on the part of public servants. Those factors contributed to the officials viewing themselves as specialists and situating themselves in the hierarchical system of *modern* society. The majority of government agents showed little appreciation of the experience and knowledge of the people, and had little ability to examine their behaviour in relation to the majority of the population in the town or country. Moreover, they had serious doubts as to the ability of grass-root groups to understand the situation and to solve the problem. As Bugnicourt concluded: "a certain scorn subsists in regard to *traditional* knowledge and the colonial prejudice against the *savages* encountered in the bush still lives on" (Bugnicourt, 1982, p.72, emphasis original). He concluded that this was a consequence of the education system, the system inculcated to lay the foundation for future people. It was a system of competition, not cooperation, in which those who were gifted, lucky and worked hard kept the results for themselves, and the rest were left behind. It was far from the spirit of solidarity of peer groups (Freyens, Mbakuliyemo & Martin, 1993; Shoo, 1991).

Nickson (1991) reported a successful case in Zaire, where the community was encouraged to identify its own health needs, and to be involved in making decisions to solve the problems. The villagers determined the meaning of *health*, as perceived by the community. Then a survey was undertaken to measure the extent to which health was present. From the survey, the community decided what their health priorities were, and what strategies would be needed to meet their needs. This example showed how indigenous structures were applied in local initiatives in problem-solving and decision-making. Afterwards, a school was built in the village as the chosen strategy to solve the nutrition problem in the village. In Nickson's opinion, a vertical approach tended to be incompatible with community participation, and may even be destructive to the process of group formation and self organisation in development. Community involvement could only become a reality where health authorities were prepared to discuss the ideas and

concepts of the community, and to try to participate and collaborate with the community according to its needs. Since those authorities were key intermediaries between the bodies influencing health policy and the target population, they were the point at which instructions or suggestions were blocked or passed on (Nickson, 1991).

Welsch (1986) indicated that the Papua New Guinea health care system had been unable to promote effective community participation and local self-determination. The centralised bureaucracy and the top-down flow of information within the system were the underlying causes of the limitation of communication between levels. There was a general lack of communication from villagers to health workers about how communities defined and understood their health problems. But equally important, planners never fully understood how rural health workers perceived their own working conditions and the health services they were going to provide. Besides, rural health workers were expected to give health education to villagers, who were assumed to be backward and to lack knowledge about health matters. This encouraged them to feel that they possessed superior health knowledge. There was little interest in the knowledge, beliefs, and ideas that villagers had about illness and its treatment. He concluded:

(T)his pattern is anticipated at each level of the health service. At every level, higher personnel act authoritatively, as if they have some private esoteric health knowledge, and deal with lower ranking staff as passive *acceptors* of this wisdom. Thus, health information and policy decisions flow from more sophisticated centres to what is assumed to be unknowledgeable periphery.

(Welsch, 1986, p.107, emphasis original)

In Latin America, the Pan America Health Organisation (PAHO) realised that its member countries were encountering serious problems in trying to implement the concept of community participation, particularly within large-scale national health programmes. Thus the organisation decided to conduct research to answer the questions: why, when, and in what ways community members voluntarily participated, and what sustained this participation over time. The conclusion of the study found there were inherent contradictions between the orientation and structure of most government health systems and conditions necessary for community participation. Most health systems were based on the medical concept of treating patients and curing diseases, which assumed a paternalistic doctor-patient relationship; whereas a participatory system implied a

preventive approach, considering environmental and social conditions, group action, and a partner relationship between health personnel and communities. Therefore, the major recommendation from the study was about changes and re-organisation of the bureaucratic system, such as changes in health policy and philosophy, and personnel training systems in order to encourage community participation in that particular national health system. In addition, it was suggested that action research on primary health care be undertaken to help develop a systems approach to community participation (PAHO, 1984).

Ugalde also concluded that the promotion of community participation in Latin American countries, in spite of promotion efforts by international agencies, had not succeeded. In contrast to the PAHO report, he viewed the failure of PHC as due to the unrealistic and unimplementable nature of its principle. Community participation, in his view, was not necessary for the success of primary health care. Instead, the failure of primary health care delivery was because of incompetence, corruption, and mismanagement by civil servants; the Cuban situation was raised as an example (Ugalde, 1985).

The examples outlined above demonstrate the difficulties experienced across a range of developing countries in their attempts to implement community participation in CPHC as originally conceived by WHO. The conclusion drawn by the PAHO was that the inherent contradictions between the orientation and structure of most government health systems and conditions necessary for community participation could be generalised to most developing countries.

Although the notion of participation has been widely accepted by health policy makers and planners success, in its implementation is still very limited (Cohen & Uphoff, 1980; Oakley & Marsden, 1984). Nevertheless, within the context of particular projects community participation has been demonstrated, and the conditions for successful implementation of community participation have been further explicated, as will be described in the following section.

IMPLEMENTING COMMUNITY PARTICIPATION

Success in achieving community participation in water supply and sanitation projects has been demonstrated. One example was a programme in Mexico described by Elmendorf (1982). The concept of community participation used in the project was that of learning by doing, and using a dialogic approach to solve problems. The process of getting the local population involved was carried out through a series of steps. In the first step, a survey was conducted by trained young women in the community to interview village leaders and families. From the survey the villagers were able to define their resources and their needs, of which safe drinking water was the first priority. In the second step, the villagers, particularly women, were encouraged to talk face-to-face with the outsiders about their own environmental health problems, their attitudes and roles toward water and sanitation. Ultimately, joint analysis led to greater understanding of needs, resources, and alternative solutions. In the third and most significant step, the actual application of the alternative solution was implemented and evaluated. In this case, the village people raised money and set up a special bank account which proved sufficient to cover local costs for the water pipe and gasoline for the drilling rig. The amount of money raised was not important, but the process of managing the money was. The community also offered home hospitality to the well-drillers. This hospitality, like the village survey and the fund management, were the integral parts of village awareness, orientation, and education for effective participation.

Paul and Demarest described the course of a community participation project event in Guatemala where an initiative by the mayor attracted funds to build a clinic, hire a doctor and attract an American health educator to direct the project. Contrary to plan, the director's insistence on creating a representative community committee discouraged rather than increased participation. The case chronicled the interplay of interests and strategies and pointed toward potentially more productive approaches to issues of leadership, factionalism and public participation. The authors offered the following advice for professionals who were involved in community participation projects:

First, if a community's need is already represented by competent leadership, accept their form of leadership; do not impose your own concept of proper representation. Second, think twice before trying to create a community-wide committee, especially in the case of a politically polarized community. Third, if a community committee is charged with

decision making, serve as its consultant, not its director. Fourth, if you are really the director with ultimate authority, make your position clear at the outset; do not build up false expectation about community self-determination. Finally, and more generally, community development specialists would do well to spend more time learning how the community is organized and less time trying to organize it.

(Paul & Demarest, 1984, p.192)

One author has undertaken extensive research focused on the concept of community participation in health in Southeast Asian countries. Rifkin (1985) reported on a study of three community health programmes launched by a Christian Church during 1970-1975 in Hong Kong, Indonesia and the Philippines. The programmes were extensions of hospital-based services aimed to “bring people to be involved in decisions about matters which affect their own daily life” (Rifkin, 1985, p.x). The most interesting case study was in the Philippines where the programmes aimed to encourage rural people to gain awareness of the causes of their deprivations in order to act upon their problems. Programmes were set up to train and deploy community health workers who would carry out actions such as treating the sick, referring patients, and dispensing medicine. The training of these workers was intended to be based on Freire’s concept and the dialogical technique was the method of teaching (Rifkin, 1985).

In those three case studies, the programme origins, their development, their problems and potentials were investigated. The programme planners were interviewed about how they perceived the idea of community participation and their attempts to implement the idea in those programmes. Although the programmes differed according to the background of socio-political systems and of the planners (mainly health professionals), the results of the study were that there was a wide gap between the principle of community participation and the realities which emerged. The author states “Given this situation and the context of the programme, it is, perhaps, unrealistic to believe that true self-reliance was possible” (Rifkin, 1985, p.149).

The reasons for the gap given by Rifkin were the following. First, the planners’ differing perceptions of the community and of participation were reflected in differing actions to implement the concept. Where the situation was perceived as a lack of health services for the poor and rural people, the aim was to provide some types of medical care and

technology. Another group viewed the community as a local resource to be mobilised to meet the existing health needs and to develop self-reliance. Whereas another group's perception was that lay people needed to be taught how to carry out simple medical tasks in order to become independent of the oppressive medical hierarchy and to be able to take control of decisions and resources that affected their own lives.

Secondly, planners had little information about people's views and expectations. The people themselves did not see health as a priority need as they did housing or income generation. Besides, they perceived that health services were a government responsibility provided by people with long training and special skills. Thus they had little idea of how they could be involved in a community health programme.

Thirdly, the domination of the health service system, which was common, easily led to the erosion of attempts to develop community participation in the programme by ignoring those realities mentioned above. Furthermore, to encourage community participation two broad tasks were required. The first was to help lay people to realise that one of the reasons for the existing health inequalities was because the health system was dominated by doctors and medical technology. The lay people had to be educated to realise that health depended more on individual action and control of resources than on medical technology. The second task for medical professionals was to create a new role focussed on developing and supporting the task of community development. Those professionals, in the midst of change, were not able to provide a model or direction for these tasks.

Fourthly, to encourage community participation meant to conscientise people about their situations in order to bring about a radical change. In reality, translating this role into practice was not easy because it related to power. In the existing health care and social systems, there was a great difficulty in developing community participation and community control which guaranteed power to people.

Rifkin's suggestion to bridge the gap between the principles of community participation and its implementation was for the planners to pursue a community development

approach to community health programmes. This approach, which stressed process over product, would encourage them to see community participation as a strategy for, rather than a component of, improved health care. Rather than seeing community participation as an additional resource for the health care system the emphasis would be shifted from providing medical science and technology to improve health, to developing human efforts. (Rifkin, 1983; 1985).

Another study by Rifkin (1987) concluded that to implement community participation is to mobilise a community to take action. She recommended that the action took place around specific issues or around specific health interventions to provide communities with an opportunity to assess their felt needs. This probably could be done through the interest of specific groups, or by charismatic leaders who were able to inspire vision and were able to obtain commitment from a large group of people for community activities. She also suggested that if PHC had a chance of success all services must be integrated, planning and management mechanisms must be developed, agency work must be coordinated, and finally, planners must have flexible responses to programmes.

In 1990, Rifkin reported on a review of community participation in several hundred maternal and child health, and family planning programmes in developing countries. The purpose of the review was to illustrate the factors and conditions that encourage effective community participation. Only fifteen programmes, on which the analysis was based, were identified as demonstrating community participation. To analyse whether the programmes demonstrated community participation, Rifkin posed the following questions: Who participates? And how do people participate? In her analysis community participation activities were classified into five separate levels:

- participation in planning the programme
- participation in benefits of the programme
- participation in programme activities
- participation in implementing the programme
- participation in monitoring and in evaluating the programme.

Within each level of participation, an attempt was made to define factors which determined community participation in the programmes.

Rifkin classified factors that determined community participation characteristics in the programmes into two distinctive groups. The first group called “descriptive factors” included cultural, socio-economic and political systems, historical factors, government policy, decentralisation of administration, local level organisation, and communication systems between the core and periphery. These factors acted as background circumstances on which health planners and agencies could have little impact. The authorities may succeed, to some extent, in changing government attitudes or removing special bureaucratic obstacles, but they would have little influence on cultural and historical factors. On the contrary, they have to accept these factors and recognise their importance in developing and defining programme objectives.

Another set of factors Rifkin called “action factors”. These factors could be acted upon by the programme planners in order to achieve the set objectives. These action factors determined how community needs were assessed, how community organisations were developed, how programmes were managed, how financial and human resources were mobilised, and how leadership was developed. These determinants contributed to activities of community participation in the programmes. Later, these factors were modified to become indicators to measure community participation in health projects (Rifkin, Muller & Bichmann, 1988).

PARTICIPATION AS POWER

Parallel discussion to that outlined in the above sections with respect to community participation in the health sector, is found in the development literature. The extensive review of people participation in rural development by Oakley and Marsden (1984) showed a wide range of interpretations of the concept. These ranged from a voluntary contribution by people to public programmes, involvement in decision making processes, to the ability to have control over resources of the programme. A wide range of terms were used such as self-help, self-reliance, co-operation or local-level autonomy. The review concerned with how to bring about meaningful people involvement in rural development. Therefore, participation in their opinion was “seen as the means for a widening and redistribution of opportunities to take part in society decision-making, in contributing to development and in benefiting from its fruits” (p.18). The changing of

the focus to people who were at the bottom, the majority of whom had not participated in the benefits of those programmes, and achieving some kind of base from which these benefits could be challenged. This enabled them to conclude that “we are left in no doubt that meaningful participation is concerned with achieving power: that is the power to influence the decision that affects one’s livelihood” (p.88).

There are other supportive ideas that view participation as power. In the field of participatory research, where people are encouraged to solve their own problems and to build up their own knowledge, these processes are seen to be concerned with power (Hall, 1981; Tandon, 1981). In the health sector, Werner suggests that in the world today the biggest obstacles to “health for all” are not technical, but rather social and political. The causes of hunger and poor health are not scarcity of resources but the unfair distribution of land, resources, knowledge and power. Thus he states firmly that it is necessary to give power to the people to participate in their struggle on their terms for greater control over their lives. The people must work together to increase control over events that determine their lives (Werner, 1988).

It is clear that community participation means something different to different people, depending on who defines it, when and for what purpose. Consistent with the work of Oakley and Marsden (1984), Rifkin (1985) and Werner (1988), in this study participation has been conceived of as power.

At present, with the exception of Rifkin’s work, there has been very little documented about the implementation of the concept of community participation in the health sector using the concept of participation as power. There are few who could argue with Oakley’s comment:

To date, an impressive amount of research has been done into CIH, although in many instances it has failed to study the details of how CIH works in the field . . . in the health field there has been less research on the concept of CIH itself. A distinct impression is also obtained that many of the publications are not based on empirical research on CIH in the field but tend rather to be exercises in integrating some notion of participation into existing practice. Certainly in the last five years or so health publications have become increasingly influenced by the concept of participation, but the feeling persists that it is a literary exercise. If

CIH is not widely practised, it will be difficult to produce material on it that is supported by empirical evidence.

(Oakley, 1989, p.66)

In summary, the health sector lacks the knowledge of how to practise the concept of community participation, particularly knowledge that is derived from empirical data. This becomes the primary question this research asks - what are the strategies by which to implement community participation in health development in Thailand?

CONCLUSION

This chapter discussed the significance of the concept of community participation in the health sector. The change of terminology from community participation to CIH signifies the difficulties experienced in implementing community participation. In Thailand, where there is no history of large-scale social movements of peasants in recent decades, this difficulty is anticipated. The Thai interpretation of community participation and the Thai ethos which are believed to hinder the implementation of community participation were reviewed. The experiences of other countries were also examined in order to identify commonalities with the Thai experience of attempts to implement community participation in health. Parallels with the development literature were again identified and the definition of participation as power in this study was delineated.

To answer the research question - what are the strategies by which to implement community participation in health development in Thailand? - research methods for empowerment are explored in the next chapter.

CHAPTER FOUR

REVIEW OF RESEARCH METHODOLOGY

The review of literature in the previous chapter indicated that implementation of the concept of community participation in health development is still largely underdeveloped, and a few successful cases are exceptions rather than the rule. It has been suggested that the health sector, as a late comer to the efforts of promoting community participation, should learn the “new strategy” which has been adopted by other sectors (Ugalde, 1985; Oakley, 1989); in particular, the strategy of implementing the concept of participation as empowerment. This chapter explores potential research methods which could be used to achieve the process of getting people to participate in health sector development in the Thai context in particular.

EXPLORING RESEARCH METHODS

The exploration of possible research methods stemmed from two current ideas; the definition and the interpretation of the concept of community participation used in this study, and the review of research methodologies, which have been suggested in the literature from the health and other sectors, in relation to the enactment of the empowerment approach.

The definition of community participation used in this study was based on the definition of CIH suggested in the WHO inter-regional meeting in Brioni, Yugoslavia in 1985 and outlined in the previous chapter. CIH was defined as a partnership process between government and local communities to increase their self-reliance and social control over resources to improve communities' health status. According to this definition, there were two distinctive interpretations for practice suggested; participation as *awareness* and *understanding* of health and health problems, and participation as *access* to information and knowledge about health service programmes and projects (Oakley, 1989).

The first interpretation stresses building up communities' awareness and understanding of the issues of health development and the causes of poor health as the basis for their

future active involvement. In this interpretation, participation is a process for people development and the process itself is determined as the outcome of participation. In other words, participation, here, is regarded as an *end* in itself. Whereas, the second interpretation emphasises that communities must have direct access to specific information and knowledge about health service programmes and projects as a pre-condition for becoming involved in health activities designed and directed by others. In this interpretation, participation is described as a state or an input into a development programme to achieve certain objectives. Participation then becomes a *means* to achieve some predetermined goals or objectives designed by outsiders (Oakley, 1989; Oakley & Marsden, 1984). These two distinctive interpretations imply different types of practice.

A review of the literature showed that there are different methods mentioned as potential implementation strategies for the concept of community participation. *Action research* is one of the research methods recommended by WHO (1988a). *Participatory research* is also claimed to be another appropriate method to raise peoples' awareness and as Oakley suggests "in view of the nature of CIH, research into it should be conducted in a participatory manner" (Oakley, 1989, pp.66-67). Some literature suggests broad characteristics of the appropriate methodology. For instance, Ahmed (1978, p.92) suggests that it has to be a "learning-by-doing" process; or that the CIH approach must be based on one fundamental principle, the people of the community itself need to be involved in real decision-making at every stage - identification of problems, study of feasibility, planning, implementation and evaluation (Axelbank, 1986).

At least three terms need to be taken into consideration; action research, participatory research, and another term which lies in between - participatory action research. Only the first two terms are investigated further, because the latter one is used confusedly by both groups; action researchers use this word when they want to stress the participatory dimension of their research (Chesler, 1991; Greenwood, Whyte & Harkavy, 1993; Whyte, 1991), or when action is stressed in the works of participatory researchers (Burkey, 1993; Fals-Borda & Rahman, 1991; Rahman, 1993).

UNDERSTANDING THE METHODS

1. Action Research (AR)

Action research was introduced by Kurt Lewin in 1946 to denote a pioneering approach towards social science research which led to social action. It combines generation of theory with changing the social system through the researcher acting on or in the social system. He proposed a cycle of three steps involving planning, action, and reconnaissance. The first step is to plan a constructive action to improve what is already happening. By its definition, it must be prospective to action, thus it must be recognized as highly flexible and open to change according to altering circumstances since all social science action is to some degree unpredictable. This step ends up with the setting of goals and plans to shed light on the means available and to serve as a blueprint for action to bring about change.

The second step, action, is a careful and thoughtful variation of practice. Action is guided by planning, but is not completely controlled by plans. It takes place in real time and encounters real political and resource constraints. As a result, action is used as a platform for planning the further development of later action in order to achieve the goal.

Reconnaissance, the last step, is the evaluation of each step of the actions taken to determine its effect before the next step will be accepted. It shows whether what has been achieved is above or below expectation. This fact-finding step not only serves as a basis for correct planning for the next step, but also gives the planners a chance to learn about the strengths and weaknesses of certain techniques of each action. This information, in turn, serves as a basis for modifying the overall plans (Chein, Cook & Harding, 1948; Kemmis & McTaggart, 1981; Lewin, 1946; 1947). The following definition of action research is perhaps the most frequently quoted in contemporary literature:

Action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to be the goals of social science by joint collaboration within a mutually acceptable framework.
(Rapoport, 1970, p.499)

This definition emphasises the importance of both the scientific contribution and problem solutions. The stress is placed on the equal relationship and dialogue between researcher/outsider and client/insider. Action research has been applied to study business firms in United States (Whyte, Greenwood & Lazes, 1989) and in Scandinavia (Elden, 1983; Whyte, 1991); in educational organisations (Carr & Kemmis, 1983; Kemmis & McTaggart, 1981) and in other practice disciplines such as nursing and organisational science (Greenwood, 1994; Holter & Schwartz-Barcott, 1993; Susman & Evered, 1978).

2. Participatory Research (PR)

The underlying assumption of participatory research (PR) is that there is a political nature to what all people do; all of the work has implications for the distribution of power in society. Participatory research begins with the premise that knowledge has become the primary basis of power and control. It is argued that knowledge creation is a monopolised industry among experts while ordinary people are rarely knowledgeable, even capable of knowing, about their own reality. They are excluded from meaningful participation in the knowledge creation process. Oppressed and ordinary people are subjected to a process which treats them as objects and things; it is an alienating and dehumanising process. Thus participatory research offers an alternative paradigm approach to social science by learning through doing to strengthen people's awareness of, and belief in their abilities and resources for organising (Brown & Tandon, 1983; Fals-Borda, 1982; Hall, 1981; Maguire, 1987; Reason, 1994; Tandon, 1981; 1988; Vio Grossi, 1981).

There are divergent views on the emergence of participatory research. One opinion claimed that the traditional PR approach emerged from work with oppressed peoples in the Third World, and later variants were developed independently in many settings; for instance, Paulo Freire's dialogue approach in adult education (Brown & Tandon, 1983). Hall (1981) suggested that the history of PR could be traced back to the late 1950s and early 1960s, when the dominant paradigm for social science research was based on empiricism and positivism. PR is an alternative research method which is based on cultural difference rather than objectivity and scientific credibility. The dominant

development paradigm was altering from a focus on economic dependency to people-centred development. As a consequence of these developments PR is seen as an alternative social science research method to find ways that work better in societies where interpretation of reality must be taken into consideration before changing that reality. The practical experiences of this approach have been explored in other parts of the world and eventually become known as participatory research.

Maguire (1987) concluded that participatory research has emerged from, and has been influenced by, the following three movements which share a vision of society without domination:

- 1) Radical and reformist reconceptualisations of international economic development assistance in a way to bring the poor more rapidly into full participation in development decisions, process, and benefits.
- 2) The reframing of adult education as an empowering alternative to traditional educational approaches. Among this group, Paulo Freire has had a strong influence as he emphasised the importance of critical awareness or conscientisation for social change. Another influence was the bringing of knowledge about participatory research practices into adult education, since the traditional research methods were considered inconsistent with the principles of adult education, and
- 3) an ongoing debate within the social sciences, challenging the dominant social science paradigm, which was based on empiricism and positivism and characterised by an attention to instrument construction and rigour defined by statistical precision and replicability.

The development of the theory and practice of participatory research has been a collective process of the creative and thoughtful work of hundreds of people worldwide. It has gradually become recognised and defined as a research process in which a community participates in the analysis of its own reality in order to promote social transformation for the benefit of the participants, who are the oppressed (Vio Grossi, 1981). In 1978, an international network of participatory researchers was formed under the support of the International Council for Adult Education which has continually expanded and has contributed to enriching the discussion.

The characteristics of participatory research are summarised as follows:

Participatory research is . . . an integrated activity that combines social investigation, educational work and action . . . some characteristics of the process include (the following):

- The problem originates in the community or workplace itself.
- The ultimate goal . . . is fundamental structural transformation and the improvement of lives of those involved
- (The) workplace or the community (is involved) in the control of the entire process
- (The) awareness in people of their own abilities and resources (is strengthened) and mobilizing or organizing (is supported).
- The term “researcher” can refer to both the community or work-place persons involved as well as those with specialized training.
- (Outside researchers) are committed participants and learners in a process that leads to militancy rather than detachment.

(Brown & Tandon, 1983, p.279)

Though action research and participatory research share common characteristics in terms of offering an alternative system of knowledge production and an emphasis on social transformation, the researchers of the two schools do not engage in a lively and mutually enriching exchange of information and experience. Such mutual ignorance is outlined by Brown and Tandon as follows:

A recent bibliography of participatory research readings (Participatory Research Network, 1981) does not mention major action researchers (e.g. Lewin, Argyris, Trist). And recent reviews of action research literature (e.g. Susman & Evered, 1978; Pasmore & Friedlander, 1982) do not cite the writings of influential participatory researchers (e.g. Freire, Hall, Swantz). The authors learned about the action research tradition in United States graduate schools, but did not discover the participatory research perspective until they become involved in rural development in India.

(Brown & Tandon, 1983, p.282)

However, there are differences and similarities of both inquiries explained by Brown and Tandon’s analysis as detailed below.

3. Similarities and Differences Between Action and Participatory Research

3.1 Values

Both inquiries share many common *values*, where *values* are defined as “preferences for courses of action and outcomes; relevant values shape choices among perceived alternative actions” (Brown & Tandon, 1983, p.280). The values are expressed in the definition and in the examples of previous work. It is suggested that action researchers place a high value on useful knowledge and development change. Similarly, participatory researchers emphasise the value of useful knowledge and dismiss the abstractions and irrelevancies of traditional social science. Action research seeks to make social systems more efficient and effective, to promote the fulfillment of human potential, to solve the problems of individuals and institutions, whilst participatory research focuses on encouraging the poor and the oppressed to generate their own knowledge, control their knowledge, control the means of knowledge production and use the knowledge to improve their lives. Recurring value themes in participatory research include equitable distribution of resources, empowering oppressed groups, increasing self-reliance, and transforming social structures into more equitable societies. However, this analysis suggests that the major differences among these two inquiries lie in the *ideology* and *political economy*.

3.2 Ideology

Ideology is defined as “sets of beliefs that explain the world, bind together their adherents, and suggest desirable activities and outcomes. Ideologies link values and realities, suggesting cause-and-effect linkages that make purposeful action possible” (Brown & Tandon, 1983, p.280). Ideological differences between action and participating research produce different perspectives of research clients and situations. The two traditions focus on different levels of analysis, use conceptual tools from different disciplines, hold fundamentally different assumptions about the nature of society, and attend to different central problems (Brown & Tandon, 1983; Chisholm & Elden, 1993; Hall, 1981).

Action research has developed in the context of the industrialised countries, and action researchers are often trained in clinical and social psychology and management theory.

They often share ideological perspectives that emphasise *individual, interpersonal, and group levels of analysis* in problem solving. Their training and cultural context encourages them to emphasise interpersonal and group explanations, and to plan change strategies that assume *societal consensus* about desirable outcomes (Brown & Tandon, 1983). In other words, the ideological stance of action researchers emphasises problem solving and development of knowledge, and they believe that enhanced efficiency and effectiveness will improve the situation of the system.

Participatory researchers are often adult educators and community organisers and they tend to analyse problems in terms of *community and social structures*. They draw on the intellectual traditions of sociology, political science, and economics as well as on individual and group theory. They have also been influenced by the cultural contexts of work with poor people in the Third World, and so conceive problems in terms of resource inequities, dependence, and oppression. They particularly emphasise research implications that enable oppressed groups to improve their lives. In brief, they conceive the world in terms of *conflict theories of society* that emphasise fundamental differences of interest among social groups and the dynamics of oppression and change. Their ideology also emphasises large-scale structural forces, conflict of interest, inequities, and changes that reduce oppression (Brown & Tandon, 1983; Greenwood, Whyte & Harkavy, 1993).

Table 1 Values and Ideologies in Action Research and Participatory Research

	<i>Action Research</i>	<i>Participatory Research</i>
<i>Values</i>	Useful Knowledge (e.g., means to control dengue fever) Developmental Change (e.g., community participation in dengue fever control)	Useful Knowledge (e.g., power system) Developmental Change (e.g., awareness of problems)
<i>Ideology</i>	Individual/Group Analysis Consensus Social Theory Efficiency/growth problems are central	Societal Analysis Conflict Social Theory Equity/self-reliance/oppression problems are central

Derived from Brown & Tandon, 1983, p.283

3.3 Political Economy

Political economy is defined as “(T)he study of interaction of political factors (e.g., distributions of authority and power) and economic factors (e.g., allocations and uses of resources) that affect decision making” (Brown & Tandon, 1983, pp.283-284). The political economy of inquiry influences decisions made on at least three critical sets of choices in the process of social science inquiry: the definition of research problems, the collection and analysis of data, and the utilisation of results. The detail of each process is discussed below.

3.3.1 The definition of problems

The definition of research problems fundamentally shapes and constrains the results of inquiry. It influences the data collected, the results apprehended, and the solutions proposed. Problem definition in both AR and PR is influenced by the tradition’s commitment to “real” problems, but the difference between the two groups may be affected by research results.

Since action research has been carried out within organisations, action researchers must respond in part to problem definitions posed by these in authority within the organisation. Other groups with different interests might have defined “the problem” in different terms. Authorities and researchers together define the research problems, with the former providing organisational authority and financial resources, and researchers offering information and expertise (Brown & Tandon, 1983; Hall, 1981; Vio Grossi, 1981).

Participatory researchers start with the assumption that oppression is a central problem, so their immediate clients are defined as “a wide range of exploited or oppressed groups” (Hall, 1981, p.7). This perspective has at least three implications: (1) participatory research will define problems differently from dominant groups, (2) authority and resources will be controlled largely by other interest groups and (3) dominant interest groups can be expected to resist or attack problem definitions that threaten their positions. Participatory researchers generally ally themselves with oppressed groups and

opponents of established authorities and so find resource and authoritative support set up against them (Brown & Tandon, 1983; Hall, 1981; Tandon, 1981).

3.3.2 Data collection and analysis

This process, which includes choice of methods, the types of data, and data collection and analysis procedures, is influenced by interested actors and the distribution of authority and resources in that system. Traditional social science research emphasises data collection and analysis methodologies that require specially trained researchers and complex data processing techniques. Those methodologies allow researchers to control data even when other actors finance the research.

Action researchers seek joint collaboration within a mutually acceptable ethical framework, and so encourage active client involvement in data collection and analysis. Common interests between researchers and clients make mutual trust and the sharing of valid information possible. In other words, action researchers collaborate in data collection and analysis with organisations on the basis of common goals and use sanctions and resources provided by cooperative authorities. They emphasise mutual trust and iterative data collection and analysis to develop shared diagnosis. Participatory researchers use collaborative data collection and analysis strategies with participants, much like action researchers, but they emphasise collaboration and consciousness raising to mobilise and educate oppressed groups and to build close links to those clients (Brown & Tandon, 1983; Tandon, 1988).

3.3.3 Use of results

The political economy perspective also directs attention to actors interested in result utilisation, distribution of authority and resources among them, and the cost benefit of utilisation decisions. Access to control over findings, and choices of how to link results to implementation are important issues for researchers.

Action researchers seek new knowledge to focus on problem solutions. They seek solutions that can be supported by consensus among relevant actors. Ideally, the use of action research benefits all interested actors, at least within the system. But participatory

researchers seek fundamental transformations of societies. They call for improving the oppressed groups, and seek research outcomes that will change the status quo. Therefore, at least three sets of actors have an interest in research outcomes as a result of their conflicting interests; the researchers, their clients, and their opponents. Participatory researchers explicitly join one set of actors in a social system fragmented by conflicting interest. Their choice is very expensive, for the opponents often have more access to authority and resources (Brown & Tandon, 1983).

Table 2 Political Economies of Action Research and Participatory Research

	<i>Action Research</i>	<i>Participatory Research</i>
<i>Actors</i>	Researchers Client Systems	Researchers Client Groups Established Authorities Third-Party Funders
<i>Resources and Authority</i>	Researchers Provide research expertise Client Systems Provide sanction insights information	Researchers provide research expertise political awareness Client Systems Provide information energy insights Established Authorities Provide sanction power funds and rewards Third-Party Funders Provide funds protection
<i>Impacts on Phases</i>		
1. Problem Definition	Shared by researchers and client system Benefits provided to whole system Resources and sanction from system leaders	Controlled by client group Benefits provided to client group Resources received from clients or extracted from system
2. Data Collection and Analysis	Collaborative with whole system Iteration to system-wide shared diagnosis	Collaborative with clients; adversarial with authorities Iteration to educate and mobilize client groups
3. Uses of Results	Systematic consensus on goals of intervention Problem solving with systemic benefits	Client consensus on goals of intervention Negotiation to improve client situation

Source: Brown & Tandon, 1983, p.288

In sum, the differences in political economy encourage choices that produce the differences in research analyses and problem solutions between the two inquiries. Brown and Tandon conclude:

The political economy of action research emphasizes interdependence between researchers and client systems and thus encourages inquiry in which researchers and client leaders cooperate to define problems, collect and analyze data, and develop intervention and problem solutions designed to be accepted across the system. The political economy of participatory research, in contrast, allies researchers with oppressed clients in opposition to existing authorities and resource holders. Action researchers work *with* 'the system'; participatory researchers often work *against* it.

(Brown & Tandon, 1983, pp. 287-288, emphasis original)

The most critical part of the analysis is its implication - when each type of inquiry is appropriate. The analysts propose that action research strategies would be appropriately employed when distribution of resources and authority are accepted as legitimate, when the relevant parties accept researchers as credible, and when rewards are available for integrating problem solving and research. Participatory strategies would be appropriately employed when the legitimacy of power and resource distribution is questioned, when client groups are aware and mobilised to influence their situation, and when researchers are ideologically committed to social transformation (Brown & Tandon, 1983; Hall, 1981; Tandon, 1981).

The question then arises as to which research approach is appropriate for this study, and why? It seems the practice of community participation has been on the horns of a dilemma. There is always a choice to be made between two approaches: the two interpretations for practice - community participation as awareness raising or as access to knowledge or information; participation as a means or an end; SPHC versus CPHC approaches; action research or participatory research. Since community participation is conceived as power in this study, it is inevitable that participation would be interpreted as an end in itself. As Oakley and Marsden (1984, p.28) comment that:

The state of achieving power and of meaningfully participating in the development process is in fact the objective of the exercise. There is no necessary notion of fixed quantifiable development goals, although these often accompany the process, but the major effort is concentrated upon the empowering process.

Therefore, participatory research was selected at the outset as the method of choice in implementing community participation in this study.

SELECTED RESEARCH METHOD: PARTICIPATORY RESEARCH

A literature review suggested that participatory research was congruent with the empowerment process, because it strengthens the system of knowledge production by the people for the purpose of daily survival in that circumstance (Tandon, 1988). Hall (1981), who defined participatory research as the process of mobilising people for their collective creation of new knowledge about themselves and their own reality, concluded “Participatory research differs significantly from more traditional kinds of research in its commitment to the empowerment of learning for all those engaged in the process (T)he idea is not very far removed from what many adult educators mean by ‘the empowerment of people through learning’”(p. 11). Burkey (1993) stressed the similarity of the key concept of the process of human resource development and PR. “The role of PR is to strengthen people’s awareness: the awareness of their own abilities, resources and its support to mobilizing or organizing” (p.58). Werner (1988, p.6) states “People . . . feel powerless because they temporarily lack awareness, confidence and competence to take action leading to change”.

In reviewing the literature on participatory research methods it became clear that there are numerous models for conducting participatory research. As Werner (1988, p.6) comments “There is no fixed formula for empowerment”. Burkey (1993, p.59) describes participatory research as “a complicated process with no clear-cut guidelines and no straight pathways to success”. Each model is usually presented as one possible approach among many, carefully avoiding the claim that there is or should be only one way to do participatory research (Maguire, 1987). As Oakley (1989, p.20) comments, “the concept and practice of CIH are so broad and varied in nature that it is impossible to suggest a model of CIH that would be applicable to health care in all contexts”. This is because the process varies with the nature of the problem faced and is highly flexible according to each particular context.

The two decades of alleviating poverty in the Third World enabled the FAO to suggest a guideline called a “process approach”. This approach was designed to benefit disadvantaged groups in rural areas. Although the following guideline could be seen as a

top-down approach, it does focus on the understanding of existing reality of a community under study.

- (i) Determine the broad parameters for the project through discussions with senior government and donor.
- (ii) Review and assess existing documentation.
- (iii) Conduct a field investigation in the localities (or a representative sample of localities) in which the project will operate or intends to provide benefits.
- (iv) Identify and analyse the supporting requirements necessary for project implementation and for sustaining the development benefits from the project.
- (v) Determine the management and organizational arrangements for the project.
- (vi) Prepare an outline of the project design for review and discussion with responsible government and donor officials.
- (vii) Develop the project's implementation plan.
- (viii) Design the project's monitoring and evaluation system.
- (ix) Prepare and secure in-country government and donor approval for the final project design.

(FAO, 1986, pp.xiii-xiv)

Maguire (1987) proposed five phases of conducting participatory research to empower battered women. The initial phase includes the organisation of the project and knowledge of the working area, to understand about the research area and about the central problems faced by people. This phase includes establishing relationships with community organisations, leaders, and institutions. The key guideline is that the research problem should originate in the community. The second phase, definition of problems, is to identify and understand participants' perceptions of their most significant problems. Dialogue is the method for continuing problem-posing to help both researcher and participants to a deeper and more thorough understanding of the reality. The third phase attempts to link participants' individual interpretations of problems to the broader context, including the structural conditions of social reality. In this phase collective educational activities can be important to help participants further examine their interpretation of causes of their problems. In the fourth phase the researcher and participants develop their own theories and solutions to problems. The final phase revolves around the decision making process of what actions to take to address the problems that they have collectively defined and investigated. The balance between the social investigation, educational and action components of participatory research was

considered. Maguire stressed that “These phases did not occur in a linear, sequential fashion” (1987, p.158).

Rees (1991) suggested the following steps could be used in employing participatory research for empowerment in social work. The first step is that of understanding themes which depict experiences of power and powerlessness in the community. The practitioner encourages people to tell a story to begin to gain confidence from knowing that one is being listened to and to create a chance for an exchange regarding the possible link between personal and social issues. The underlying process is one of evaluating self-image and knowledge to revive people’s confidence and self-respect by addressing their disparaging view of themselves, a self-imposed burden which is additional to their difficulties. The exchange of information about current knowledge and ways of addressing problems helps people to assess their self-image, and it generates ideas and creates hope. As a consequence, peoples’ awareness is raised, because people develop awareness of policies, uncover the influence of policies on cultural and social problems in which they struggle to effect some control over their lives. Discussing how policies and services affect their lives not only enables them to know that services and other resources exist to which they are entitled, but demystifies what policy is about and becomes part of an overall educational and political process.

The following stage is to encourage people to specify their own problems, rather than the traditional approach whereby their problems were defined for them. The art of conceptualising problems and sorting one from another carries with it the seeds of self-learning, and some skills in analysing the relationship between themselves and the society.

The development of the notion of choice and ability to choose follows. To be able to choose from among a range of people, services and ideas usually reflects a self-image which incorporates the feeling of knowing and the assumption that it is appropriate to have some control over one’s circumstances. To be able to choose involves assertiveness and a familiarity with the importance of choice. It requires moving from

the assumption that there is no alternative, to deliberation over what might be possible. It is an indication of some element of power being exercised and achieved.

The last step is experiencing solidarity with others and this step brings together people experiencing the same predicament to reveal a common grievance and to share ways to respond to such problems. From the sharing comes confidence, trust and a sense of solidarity. Through this process people develop interactive and political skills to encourage groups taking action, and reflection-on-action on their behalf. Being in groups brings some pleasure and value in reflecting on what has been learned from such experiences. Afterwards, and as a group, an evaluation is undertaken to test whether the theme with which this process began has been redefined in conducting their lives (Rees, 1991).

Although the method or stages of conducting participatory research or an empowerment process is not clearly defined, there is a common language that describes its nature which lays the foundation for its practice. The following characteristics are summarised from the review of the methodologies of a number of projects which claimed to bring about effective participation or empowerment (Burkey, 1993; Fals-Borda & Rahman, 1991; FAO, 1986; Hall, 1981; Lee, 1994; Maguire, 1987; Oakley & Marsden, 1984; Rahman, 1993; Rees, 1991; Tandon, 1981; Vio Grossi, 1981).

THE CHARACTERISTICS OF PARTICIPATORY RESEARCH

Participatory research is a process of knowing and acting. People engaged in this process simultaneously enhance their understanding and knowledge of a particular situation as well as experiencing action taken to change it for their benefit. To that extent, knowing is linked to a concrete action which is the consequence of direct involvement in a particular action, rather than a directive, imposed knowledge and ideas. It is an alternative for knowledge creation that comes from the people which it serves and is understood by the common people.

Small projects are important as a means of encouraging direct experience to help people learn. Positive experiences and small successes promote and reinforce their self-

confidence and increase problem solving skills, since they will become aware of their own ability to change the situation. As Rogers states “One can not learn about freedom without experiencing it in the learning process itself, one can not learn about participation without participating” (Rogers, 1992, p. 114). The projects must be initiated in the context of the actual reality to help participants to understand their present situation and the possibility that the results of the projects could be used.

Participatory research involves a continuous cycle of analysis-action-reflection, beginning with an analysis of the situation in order to raise people’s awareness or conscientisation, and to help them mobilise their own existing resources in order to initiate action. When the action has been taken, the results are reflected upon, these reflections lead to a new circle of analysis and to new actions.

A dialogical process, which provides discussion and reflection, is essential. The dialogue should be carried out with equal respect in which both researcher and participants become jointly responsible for this growing process.

The participatory process seldom begins spontaneously. Generally, the process is initiated by outsiders whose vision is external to the perception and aspirations of the people concerned. Even if it begins with an external push the analysis of reality must be undertaken by the people who can decide what their needs are, not by experts.

The significance of collective behavior, as an outcome of the above characteristics of participatory research, has been the creation of organisations among participants. Actually the oppressed are unorganised and isolated. The process of participatory research is designed to bring them together, with collective sharing, analysis and action generating strong connections between them. Over a period of time, these connections can grow into organisations of the oppressed to back up and support them. Maintaining people’s power requires that the poor retain genuine control over their own organisations.

IMPLEMENTING THE RESEARCH PROCESS

In this study, participatory research was used at the outset of the research. The manner in which it was implemented is outlined in the following chapter. However, it became obvious that conducting participatory research in the above sense, and in the Thai context, was difficult, if not impossible. It was unrealistic to expect to achieve an empowerment goal in such an “anti-participation” climate of the Thai structural and cultural systems (as outlined in chapter three) and within the limited time frame for the research. In addition to that, as described in chapter seven, the understanding of the concept of participation among the health personnel was very limited, a factor which would not facilitate the chance for empowerment to occur. Rather than waiting for the success of the empowerment process to be achieved I decided to join the dengue control project which was already underway in the village, and in which I had been involved prior to undertaking this study. In the dengue control project the problem was selected and imposed by outsiders, and the methodology was that of action research focussing upon a specific health problem (an example of the SPCH approach).

ACTION RESEARCH FOR SELECTED PROBLEMS

The most distinctive difference between participatory research and action research is that in participatory research problems have to be identified by people themselves because the fundamental belief is to avoid a process of “indoctrination”, and not to detach people from their own cultural elements. The process of participatory research encourages people to investigate their situation so as to decide what their problems are and their consequent actions, whereas in action research problems are usually selected by outsiders such as researchers and organisation authorities. Rather than empowering the oppressed, action research aims to generate theories to solve particular problems. The dengue control project is then considered in applying action research according to the Brown and Tandon analysis which has been presented earlier.

However, both types of research require participation of subjects to some extent in the control of the entire research process. Participatory research emphasises the system of producing knowledge for the purposes of the daily survival of the poor and deprived people; action research stresses the production of knowledge to guide practice. The

subjects in both types of research, therefore, are research participants. The following discussion describes the determination of who is the community in the term “community participation” and who are research participants.

RESEARCH PARTICIPANTS

According to the definition used in this study, community participation is the collaborative process between government and local communities (Oakley, 1989). The government side is represented by the health workers who are government paid personnel working in a health centre at the subdistrict level. They represent bureaucracy, and work according to MOPH guidelines. It is at this level, the most peripheral level of the health care system in Thailand, where health policies are directly translated into practice. It is the level where most PHC activities are carried out and also where most direct contact between health personnel and the people takes place.

The local community is represented by the VHV who act as community leaders in the issues relating to health by forming themselves into a group to work out village health problems on a volunteer basis. They are expected to work alongside health workers to improve health in their own village. Their roles are to help in information distribution, encourage people to cooperate, and give treatment for some simple diseases. However, among the two groups of participants, the health workers are the primary focus since it is admitted that health personnel are still the key factor in encouraging community participation, according to the above definition. It is unrealistic to expect them to encourage the community to participate without they themselves participating.

Both health workers and the VHV are at the lowest rank of the national health service. To some extent, according to my perspectives, both groups lack power. Usually, both of them have to undertake or join activities although they may not be interested in the activities or determine them as their problems. This is because health workers' career promotion depend on outcome performances relevant to national policy or the quantitative evaluation of programmes translated from policy designed by higher authorities. This is the same for the volunteers, who perceive their task is only to help and cooperate in carrying out all the activities. In my belief, this is a type of oppression.

One of the difficulties is that both types of research, action research and participatory research, make great demands on a researcher. Their high degree of flexibility and use of a variety of methods of investigation result in the need for an experienced investigator. In addition, action researchers' and participatory researchers' roles are expanded to include both educator and activist roles, in which the researcher is expected to demonstrate the required skills. To complete participatory research, commitment, teaching skills, and ability to set up a project structure and processes to transfer organisational, technical, and analytical skills to participants, are required (Greenwood, 1994; Maguire, 1987). Thus the major burden has been put on the researcher. In addition these research processes employ qualitative data collection techniques in which the researcher is an important tool. The following discussion concerns the researcher's need to understand oneself in order to perform this role.

THE RESEARCHER: UNDERSTANDING "SELF"

When conducting social science research it is necessary for a researcher to understand "self". This is because "self" is used as the instrument for studying human systems, particularly in these types of research. It is "self" which contributes to the creation of the research relationship between the researcher and the social system being studied. This relationship, in turn, is an extremely powerful determinant of the quality of the data. In other words, the data about a person, group, or social system cannot exist without this relationship. Simultaneously, it is the sensitivity of the researcher's "self" which captures useful data. Therefore, it is necessary to undertake as an intense scrutiny of "self" as the systematic analysis of methodological issues in other research methods (Berg & Smith, 1988).

Another reason for this scrutiny is that self-understanding helps a researcher to have insight into the influences of the researcher's involvement and activity as well as the dynamics of the individual or social system being studied. Self understanding is a process of developing self-awareness which provides the knowledge of how one looks at oneself as well as how one is looked at from the outside. This capacity enables one to coordinate one's actions so as to make decisions, to interpret actions and decisions, and to plan for the future, as well as develop the same understanding of others, particularly

where conducting action research and participatory research where direct involvement with human beings or social systems is required (Maguire, 1987). The value of understanding “self” is twofold, as Berg and Smith explain:

First, it can help develop both an intellectual and emotional understanding of the dynamics inherent in a human system’s struggle to learn about itself, especially those involved in confronting weaknesses, *imperfections, failures and problems*. Second, self-scrutiny can help uncover valuable information. The scrutiny may be directed at the researchers themselves or at their relationship with the social system. Since all research is approached with some intellectual presuppositions and a variety of emotional predispositions (sometimes called *biases*) it is absurd to act as if this were not the case.

(Berg & Smith, 1988, p.30, emphases original)

In brief, understanding “self” is central to conducting these types of research. There are different terms mentioned in the literature, such as: self-scrutiny, self-reflecting (Berg & Smith, 1988); self-awareness, self consciousness, self analysis (Agar, 1980); self-criticism (Burkey, 1993). The more the researcher understands oneself, the better one can interpret what has been discovered. This complex process requires both commitment and skill. To help in this process researchers are encouraged to scrutinise themselves by answering the following questions: Who am I to do this research? Why do I do it? How do I create knowledge? and How does this research process change me? (Agar, 1980; Berg & Smith, 1988).

My early training and experience was in quantitative research. However, I also had opportunities to attend two one-month formal courses in qualitative research, and one of them required the fulfillment of field practice and report writing. In addition, my personal interest is in the teaching-learning process which I have found is the basic requirement for my career. I was involved in problem-based learning, which is based on the concept of adult education, and had a chance to observe this process in a nursing school which fully applied this concept, before applying it myself. These experiences provided me with an understanding of the principles of adult education and the facilitator’s role which is a great advantage for conducting these types of research.

CONCLUSION

This chapter discussed the process of identifying appropriate research methodologies to be adopted to implement the concept of community participation in the Thai context. The process begins with the analysis of the concept and an examination of the methods suggested in relevant literature. A literature review suggested there are two research methods: action research and participatory research. Both methods have been explored in terms of their origins, foundation concepts, processes and epistemologies. Participatory research became the method of choice when community participation was conceptualised as power. Conducting this type of research however was considered extremely difficult in the Thai context because of the cultural factors as mentioned in the previous chapter. Therefore action research was incorporated into the study in relation to an externally designed project.

The following chapters provide details of the application of these methodologies in the study village. The results of the empowerment approach through participatory research are described in chapter seven and the results of employing action research in the externally designed dengue control project are outlined in chapter eight. The next chapter discusses the details of the fieldwork.

CHAPTER FIVE

FIELDWORK

The selected research method was participatory research (as mentioned in the previous chapter). Conducting participatory research in this study was based on the characteristics described on pages 75-76 in this thesis. Since participatory research is undertaken with people in their existing environment and encourages the production of knowledge that suits existing situations, it is suggested that the understanding of actual realities is essential. Therefore, this study was conducted in two stages. The first stage aimed to understand the community reality, especially in the aspects which I believed to be critical to participation. In this stage the data about the village, how villagers perceived participation, how they participated in government development projects and in solving community problems, both in the health and in other sectors were explored. Three community development programmes launched in the community were selected to study. Those were village road cutting, tap water system and the drug revolving fund. The data were obtained from key informants who were involved at the time when the selected projects were initiated.

The second stage was the implementation of participatory research in order to identify strategies by which to implement community participation. In this stage I also participated in an externally designed action research process.

The details of conducting a 12-month period of fieldwork, from November 1994 to October 1995, are discussed in this chapter. The discussion begins with how the study community was selected. The steps of community approach are presented in detail to show how the relationship between the researcher and the community was built, what problems were faced and how the researcher handled the fieldwork.

SITE SELECTION

The study village was a community on the outskirts of the Khon Kaen township. The site was purposively selected for two major reasons. First, I was particularly interested to study a suburban rather than a rural community. The number of suburban

communities have been increasing in Thailand because of increased urbanisation. In such communities, problems are more complex, particularly in relation to community participation, than in their rural counterparts. To work with this specific type of community needed a different kind of knowledge and a different approach to that which health personnel were familiar with using in rural villages.

The second reason was to save time as I was aware that the data collection period was rather tight in respect to the issues to be studied. The study village selected was a village where I had been involved in research previously. I was familiar with the village and the health workers, and it was accessible from Khon Kaen. I reasoned that my prior knowledge of the village would save time in the beginning phases of the research, such as village selection, gaining access and establishing rapport.

GAINING ACCESS

Being aware that personal contact was necessary, I started direct informal contacts with the relevant authorities: the provincial health officer, the district health officer and the district governor, as soon as the data collection period began. I outlined to them the nature and the process of the study to them and asked for permission to go and start the research before the formal letter from my Dean arrived.

Actually, there was no problem at all in getting access because I personally knew all of those authorities beforehand. The provincial health officer was my husband's classmate in medical school. Two years previously, he had cooperated in conducting research in child immunisation before he was promoted to take this provincial position.

I had known the district health officer for ten years, both personally and formally, as my brother-in-law used to be the governor of this district, and my sister, who was a nurse, also worked in this district health office. In addition, I used to join the District Outreach Service once a month to provide comprehensive services to remote rural areas in this district for five years. Besides, in 1989, I had voluntarily worked in a health centre in this district helping to improve immunisation service and record systems. This probably was the reason he introduced me to a meeting of VHV inservice training as "a person who is interested in community health and always gives me a hand".

In summary, the process of gaining access began with informal contact and personal relationships. I received good support from the authorities. Probably in their opinion, the process of supporting me was just to help someone they knew and could trust. It was my responsibility to commit myself to the work and to be honest. I was aware that this type of approach might have some drawbacks, therefore I planned to use it only in the first stage just to shorten the time used in the beginning period. Because of such politics, I was able to start the research within the second week of approaching the authorities for approval. Then I had permission to go to the village to meet the health workers and start my research.

Introducing myself to the health workers was not a problem because we had already met a few years earlier when I was involved in research for a dengue fever control project. There were three health workers working at this centre at the start of this study. Two of them knew me, the third was a junior staff member who had worked at the health centre for just six months. I told them that this time I came back to do research for my degree. My study focused on community participation; I wanted to know how the community participated in solving its own problems.

I asked a health worker to introduce me to both village headmen. The village was large so it was divided into two administrative villages¹ (hereafter referred to as villages A and B). Introducing myself to the headmen, I told them about myself, the purpose and the process of the study. The explanation, that I was a university staff member who wanted to do research about how the community participated in solving its own problems, was also provided in written form. I requested them to make an announcement via the village broadcast system to inform the people so they would not wonder when seeing me around. Also occasionally, I probably would need some cooperation from them. I also informed the headmen that the official letter from my boss would follow shortly. I sincerely apologised for having taken a “short cut” since I was worried about the limited time available for the study.

¹According to the Act of Local Administrative Legislation, the area can be called a “village” with a collection of more than 200 people.

I went to the village during working hours. I usually went wearing slacks and a top which made me look like health personnel, but it was quite difficult to identify exactly which organisation I belonged to. Villagers used the word *maw* for addressing health personnel in general, though the meaning of the word itself referred to “doctor”. They called the health workers, including me *maw*, but health workers called me *ajarn* which meant teacher. While in the village I usually had lunch with the health workers at the centre. Normally, we bought cooked food in the village, sometimes we brought our lunch from home and shared with each other.

ESTABLISHING RAPPORT

I asked the health workers for permission to accompany them at any time they visited villagers for any purposes. They were willing, but only when they went to give treatments which they usually performed as a private business. They gave medication, bought from their own pocket money, and charged for the service. I was sympathetic and understood that their low salary meant this situation was widely practised among health workers, and I accepted it. I would not interfere in this business. The only reason I asked to accompany them was because I wanted to contact villagers as much as possible. Fortunately, during that period there was a project requested by the MOPH to make a list of traditional healers in the village. It was the best time for me to get to know those traditional healers and villagers. My regular transportation in the village was by motorcycle. I could not ride it myself, so I always travelled on the back seat. It was a very good way to present myself around the village day after day.

I found the village map, which was available in the health centre, very useful in terms of familiarising myself with the village and bringing me into discussion with the villagers. I took it to get a magnified photocopy. From that map I could locate the houses of all the village committee, the former village leaders, and the VHV, as well as locating how the clusters of households were divided, the location of the houses of the chairpersons of the clusters, and where the relatively poor of the village lived. All of them were the target groups for the first stage of my study.

By the third week I was no longer attached to the health workers. Instead, I went directly to the specific target groups I had in my mind. The first group to be approached

was the formal community leaders. I went to introduce myself in a sense of paying respect and giving recognition to them as the important persons in the village and I was a stranger entering their place. Another important group was the 24 VHV. I visited them individually at their houses after the introduction by the health workers. As well as chatting about how they became VHV, what were their jobs, what were their attitudes towards being VHV and about problems in doing this job and other problems, I asked them to show me the area they were responsible for, but found it was not well established. Sometimes, if they had time available, some VHV went with me to check the map, to ascertain whether the houses in their area were correct or not.

From that point I could continue to approach villagers at household level. I would come with the map and ask whose houses were here and there, who was the relative of whom and how and so on. Whenever I walked along village roads with the map in my hand it would attract people to come to me and wonder what I was doing, or whether their houses were on the map.

When approaching households, I introduced myself as I did to other groups, but added that I used to work in the same group with the entomology workers. I knew that those workers were excellent in gaining rapport, because they were from a similar background and it was a major part of their job. Some of them got permission to go into the houses when the owners were absent. Some were even told where the house keys were hidden in case they came and found the houses locked. Making reference to this group accredited me and raised some topics for discussion. In addition, whenever entomology workers did their survey, I usually joined them visiting from house to house. It was the only chance that I had to get to see the whole house.

I occasionally joined some social activities in the village. For instance, I went to offer food for Buddhist monks on some holy days, when numbers of people were gathering. Consequently, I could introduce myself both to the community and to the abbot, who was one of the important leaders in the village.

Afterwards, I went to the village spirit's shrine (*saan pu ta*), in order to observe people going there and to pay respect as a new-comer to the village. The ceremony was set up

every Wednesday morning. The villagers believed that the village spirit protected them and helped them to solve some problems. Those who prayed for special help or protection had to bring gifts to offer. The gifts included a bottle of local whiskey, one whole steamed chicken, a pair of flowers, a cigarette, a mouthful of *mhaak* (essential items for betel nut chewing), and a five-*baht* coin. The communication with the spirit was done by a person who was selected specifically for this job. His major role was to communicate with the village spirit and ask when someone wanted its help. He asked the village spirit to protect me and bless me for the luck of my research.

In December, the village committee planned to organise grand New Year activities, such as parades, sports, and some entertainment. Every cluster had to organise itself to join the activities and prepare for the competition. People were excited about this special occasion, and lots of meetings and preparations were undertaken. It was another good chance for me to present myself to each cluster meeting. I attended five cluster meetings. Usually, the meetings were arranged around 8 pm. because people were busy in the day time.

During this rapport building process, I began to join the routine VHV meetings which were held for VHV in villages A and B once a month. The meeting took place in the health centre. The health workers conducted the meeting and the focus of the meeting was mainly the announcement of government projects relayed from what they had heard at the monthly meeting at the district health office. Furthermore, I also asked for permission to attend subdistrict council meetings from the subdistrict headmen (*kamnan*).

In December the new health worker who was appointed to be in charge of the health centre started her work there. It was hard to believe that she was a junior midwife whom I met in 1973 when she started her career and I started my instructor role and I accompanied my students to work in that village. The personal relationship facilitated my research work.

SELECTING KEY INFORMANTS

The key informants for the first stage of the project were identified according to the development projects selected. For instance the former village headman during the time the road was built, the village health volunteer who was responsible for selling drugs, and the former abbot who convinced the villagers to donate money to get the tap water system project started. Fortunately, all of them were still living the village. There were no problems in getting access to those key informants after rapport was established.

The identification of the research participants in the second stage was more complicated and I was more cautious because I realised that research participants played an important role in these types of research. This stage required active involvement of the participants which would determine the success or otherwise of the implementation. These criteria, in turn, were the key for research participant selection. The question was which group should I approach: the whole community, or the community leaders because they were people who decided about all the community affairs, or the poor because they were the voiceless people in the community. To answer this question each group was taken into consideration to trace its interest, its sharing in community health problems, and its potential and possibility to be involved in the research process.

SELECTING RESEARCH PARTICIPANTS

The first group that I had in my mind was the whole community. I tried to randomly visit each household and ask what, in their opinion, the health problems were in their community and families. Afterwards, I realised that the selection of this approach was due to my lack of knowledge, as I had an idea that problem identification in participatory research had to come from a community itself, but I did not have experience of how to do it, and the only kinds of problems I could think of were health problems.

After spending about one month visiting each household I came to the conclusion that I could not approach the whole community. Every household that I talked to said there were only mild illnesses in their family, like common cold and diarrhoea. They could not tell exactly what the major health problems in the community were, or even major problems in their families. In fact, it was very difficult to come to a consensus by this approach.

Their response to the question as to what participation meant to them was that in their opinion “participation” equaled the word “*home*” in the local dialect, which meant to collect together. There was a similarity to the verb “*ruam*” defined by Turton (1987, p.10) (stated on page 37). “*Home*” implied collection in every aspect, labour to accomplish a job, getting together for a meeting, donation for the monastery or community affairs or collecting essentials like money or glutinous rice for their neighbours in the event of special occasions such as wedding or funeral ceremonies.

Then I tried meeting with the poor in the community who were identified by the location of their residences. There were about ten families belonging to this group. About half of them built their houses on land which was village property. A few of them earned their living by gambling. The major problems of this group were gambling, drinking and unemployment. I realised that to deal with these problems enormous time and effort were needed which was not possible given my constraints at the time.

Another group was the community leaders which included formal and informal ones. One of the formal groups was the village headman (*phuyai baan*) and subdistrict head (*kamnan*). After approaching them I came to a conclusion that they were interested only in projects that were to their benefit rather than solving community problems. One of the VHV told me; “The village leader (in village A) does not pay attention to what we have done. We wanted him to make an announcement about what we have found but he would not. Sometimes we asked for his help in solving village problems but he was not interested. He occasionally asked us to do surveys, but that is all, he never did a tangible summary of the results that we reported” (Fieldnotes, November 29, 1994).

The second group of formal community leaders that I approached was the chairmen of the household clusters. The idea of household clustering came from the provincial administration office as an attempt to decentralise management. This project was launched in village B as a pilot project before expanding it to other villages in the province. Houses in village B were grouped into six clusters by the village committee as well as assigned cluster chairs. This year each cluster received 4,500 *baht* from the pond re-digging company to spend on cluster development projects. No one questioned the

leader in village A, where the clustering has not yet been launched, as to how the same amount - a total of 30,000 *baht* - had been spent.

At the outset, I thought it would be easier to get information about health problems from the cluster level than collecting it from a household level. I was optimistic because in January 1996, there were two forms of surveys which each village had to complete: the Basic Minimum Needs Survey and a Social Welfare Survey. These two surveys were somewhat overlapping in terms of demographic information, family problems related to health and social conditions, and the process of identifying problems from household level to village level and then to subdistrict level. I had a high expectation that via these surveys I could have an opportunity to get through the process of problem identification. I even offered the village committee, with the agreement of the health workers, that we, the health team, would help them to complete these jobs. Eventually, none of these surveys were completed.

Later on, I tried to approach each cluster chair individually to identify the problems within each cluster. Almost all of them could be described by a Thai term *choei*, which meant aloof or indifferent. A person who is *choei* is part of the general Thai value of a kind of person who possesses equanimity or *chai yen* (cool heart). The Thai consider it highly desirable to avoid direct expressions of aggression, anger or hatred. A person who is *choei* is never caught unaware and never permits himself to be found in an embarrassing situation. I found almost all of the cluster chairs fell into this category. In responding to my question as to how the cluster development fund was spent, four out of six clusters stated that they had spent the money putting fluorescent lamps along the road in their neighbourhoods to make enough light for those who went to work on a night shift. In one cluster, the members contributed another 2,000 *baht* to set up a cluster reserve fund (Fieldnotes, January 8, 1995).

I came to the conclusion that the cluster chairs could not be the research participants after I approached the chair of a cluster which was situated near the market place, a man in his late forties who was friendly and helpful. I was impressed by the recognition he received from the cluster members. After the market hours there was lots of garbage in this area especially plastic bags which was really nasty on a windy day. I discussed with

him how he managed this problem. He himself admitted this was really the problem for this cluster. The only thing he could do was to sweep the road in front of his house and his backyard then burn the garbage collected. He asked the others to do the same. In response to my question about alternative ways to manage with this problem he mentioned a village where villagers managed to have a rubbish bin for each house and hired a pick-up truck driver to dump it in the municipality dumping area. I asked whether such a situation could occur in his cluster as I was sure there was enough input to supply rubbish bins. I asked him whether it was possible to bring this topic for discussion at the next cluster meeting and stated that I would like to attend. He himself felt this problem was not his responsibility, it should be the formal village leaders. I shared with him my opinion that each cluster should be independent in solving its own problems by using available resources which was the reason of clustering. Two months later he informed me that his cluster had raised 17,700 *baht* (NZ \$ 1,039) to buy musical instruments to form a band. The main part of the fund, 8,500 *baht*, came from a family who earned a big income from a land sale; 3,500 *baht* was donated by the cluster members; and 5,800 *baht* was the contribution of the musicians in the band. They expected to earn some money from performing apart from entertaining themselves at social gatherings (Fieldnotes, February 5, 1995).

The abbot was another informal leader that I approached, but this too had some limitations. Firstly, was the limitation in his ability to reach people. Though he was a significant spiritual leader of the village he could reach only certain groups of people, particularly those who came to the monastery or those who were included within this specific communication network, usually the elderly. Besides, the monastery broadcast could not reach even half of village B. Secondly, some villagers criticised him for spending the money which was raised on each holy day in that he has never made it clear how the money was spent. Some comments were made about his decision to have his place of residence rebuilt despite the fact that the old one was still in good condition.

Another important set of community leaders were school teachers, but the problems were similar to those of the abbot. In traditional rural villages, school teachers were the real community leaders because they were the only educated people in a village and they usually resided in the village and that made them become part of a community. This was

the reason for the core community tri-partite group for rural development in Thailand, *baan, wat and rongrien* (village, monastery and school). At the time, the MOPH launched a few co-operative programmes with the Ministry of Education to manage village health problems. However, the actual situation in this village was different; there were only a few school teachers who lived in the village. The relationship between the school teachers and the villagers was distant. Many villagers criticised the corrupt behaviour of the principal and there were many teachers who were not serious about their jobs (Fieldnotes, December 16, 1994; January 25, 1995).

The selected participant groups were the health workers and the VHV. The reason was that both groups took direct responsibility for the health issues in the village in the existing system. In my opinion, it was worth trying with established groups instead of trying to start something else. Each village health volunteer was expected to be responsible for 10-15 households in his or her own neighbourhood. This enabled VHV to establish an effective communication network because people in the same neighbourhood were close kin. This assumption was based on the kinship system or close neighbour relationship.

In summary, identifying the research participants was an important step in encouraging community participation. This process took time and required skill as well as good understanding of the circumstances under study. It was important to identify all possible target groups so as to be able to compare their ability to conduct the task in terms of their responsibility, interest, potential, and their willingness to give their time to become involved. After the participant groups were selected the implementation step then followed.

IMPLEMENTING PARTICIPATORY RESEARCH

The implementation of participatory research was the second stage which followed the study of community reality. The aim of this stage was to develop participants' critical awareness so as to lead to the fundamental transformation. The implementation was based on the process of analysis-action-reflection process and dialogue was the key method. The participants were encouraged to analyse their own situation and problems whenever possible while doing routine work. Dialogue between the researcher and

participants was encouraged in a sense of sharing ideas: how they thought of each particular situation, causes of problems and how they thought they could make it better. The different opinions between each group and each individual were encouraged and compared. If possible, actions were initiated by the researcher to ensure that there were opportunities for any alternative actions. Nevertheless, the empowerment process via participatory research was not successful, as discussed in chapter seven.

My first intention was that after the stage of studying community reality I should be able to identify problem issues in order to start the intervention stage. Four months passed and I could not identify a single problem. Though I tried very hard to approach different groups such as household cluster chairs, VHV, community leaders and even health workers, I was not successful. I was very disappointed and worried about not being able to fulfill my research. Then I started seeking help. I went to the North East Rural Development Association (NERDA), where I was sure to meet development workers who worked for non-government organisations (NGO). They were the only people employing participatory research in Thailand. I brought my plan to discuss with them.

In their opinion, before starting participatory research a community must be aware of its own problems. In other words, conscientisation was essential. This particular point was their greatest concern. For them, conscientisation was an enlightenment, an internal process, although it could be learned, but it was impossible to tell how long the process would take. The readiness of the subject was the most important factor and the outcome was unpredictable. They advised that participatory research would not be able to start without conscientisation or raising awareness.

Instead of waiting for the success of awareness raising or conscientisation, I decided to change my focus and join the dengue control project. In my opinion, this was a SPHC approach which utilise the second interpretation of CIH: participation as access to knowledge or information. According to this interpretation, a community was encouraged to have direct access to specific information and knowledge as a pre-condition for becoming involved in health activities designed and directed by others (Oakley, 1989). This was when action research, according to the analysis of Brown and

Tandon, was applied. This decision, in turn, enabled me to confirm the empowerment process afterwards. The detail of this process is discussed in chapter eight.

DATA COLLECTION

The different stages of the study required different methods of data collection and target groups. The study of the community reality in the first stage required a general picture of the village, such as village history, village changes, peoples' perception of participation, and the villagers' past experiences participating in previous development projects. In contrast, the data in the second stage were focused on the observation of the process of participation of research participants.

The data about village history and village changes were obtained from my discussion with villagers, the hand-written village history by the late village headman and other documents (Cumpirapakorn, 1977; Smutkupt et al., 1993).

Data about the participation in the previous projects were obtained from three key informants. They were requested to discuss how the project began, how the community took part in the project initiation and management and in solving problems that occurred. The selected key informants were approached directly for an individual interview which was conducted at the respondents' houses.

The three health workers at the health centre were involved in formal group discussion at the beginning of the study to discuss what community participation meant to them (as detailed on pages 133-134). In the following months the discussion tended to be very informal, most of the discussions were conducted during the lunch break, or in the afternoon when they were not busy with clients, or while they were completing records and reports. In addition their behaviour while completing the daily routine were also observed to ascertain whether or not it was based on the concept of community participation.

The four formal village leaders were interviewed to assess to what extent they were interested in health problems. Some issues were brought for discussion such as: to what extent, to their belief, the community could solve its own problems; in their opinion what

were the problems of this village, and how to solve them; how to make this village to be developed (*pattanaa* in Thai). The data were validated with the related data obtained from other sources.

Twenty four VHV were approached directly for an individual interview, which most of the time was done in the respondents' houses. They were asked to share their opinion about the reason for being volunteers, how they perceived their roles and what problems they found in carrying out this role. These data were compared with those I observed during the meetings.

Information about people's understanding and perception about community participation in health was considered necessary to complete the picture of the community realities. The information about villagers' perception of community participation was derived from my discussions with villagers during the twelve months of data collection period. I visited about sixty households, including ten poor families who built their houses on the village land. When I visited each household I talked with them and asked questions such as; What were health problems in their families or in their community? What did they do to solve those problems? Did they usually use the service of an injection man? How could they make their family members healthy? Did they think the village can solve its own problems? What did the word participation (*karn mee suan ruam*) mean to them? In some visits I had lunch with them at their houses. The villagers' behaviours were observed when they visited the health centre to validate the interview data.

Almost all of the interviews and discussion involved asking open-ended questions in a conversational manner, and over a short period of time. The majority of the interviews were carried out at the respondents' houses, with less interference because less people stayed home during the day.

In the second stage, while dialogue was the key method, direct observation was the main method of data collection. Data collected during the observation of each event included its context as well as my personal feelings and opinion towards it. Actually, my observation was not merely passive. Rather, it was conducted during dialogue or discussion processes.

During the data collection period a tape recorder was used occasionally, for example in the interview about village road making, in which I expected there would be years and names mentioned and it would probably be difficult to remember or inconvenient to jot those down; besides, I did not want note-taking to interrupt the conversation. Group discussion was another occasion when the tape recorder was found to be useful. However, it was used only after asking permission from the respondents or the group.

DATA PROCESSING

During the fieldwork I recorded short notes whenever possible. Every evening, after coming back from the village, I rewrote the fieldnotes from my pencilled notes. Going to the village during regular working hours allowed me to be able to rewrite these almost every day and then the data were typed in Thai and stored in a personal computer, which was accessible only to me. Data were retrieved, examined, categorised and analysed frequently.

DATA ANALYSIS

The analysis of data was influenced by choices of methods, types of data and data collection methods. In the first stage, the purpose of the analysis was to determine whether there was community participation in its original meaning. In other words, it was to assess whether the community had power to decide and manage. The purpose of the analysis in the second stage depended on the research ideology. Participatory research aimed to raise awareness in order to mobilise and educate the oppressed groups, whereas action research aimed to undertake collaborative data collection and analysis between researchers and participants in order to develop the answer for the proposed questions. As a result, different frameworks for the analysis were required in this stage.

In assessing community participation, a problem occurred because the participation concept itself was rather new. It emerged in the mid-1970s; its evaluation was an even more recent phenomenon. It was admitted that the practice of its evaluation was still in its "infancy" (Oakley et al., 1991, p.239) or at the "trial-and-error" stage (Oakley, 1989, p.65). There were a series of conceptual and methodological problems which have not yet been subjected to systematic evaluation (Oakley, 1989).

The problems of evaluating participation resulted from the diversity of interpretations of the concept, which not only caused difficulties in characterising it, but also difficulties at the beginning as to how to predict its outcome. Unpredictable outcomes again led to difficulties in identifying indicators for evaluation. In addition, it was agreed that quantitative evaluation techniques for measuring the material or linear, single-directional changes were inadequate, particularly when participation was conceptualised as a qualitative change process. This type of change process brought with it certain other results, both quantitative and qualitative, apart from its goals or objectives, which were measured by quantitative indicators.

The quantitative outcomes of participation were defined in terms of direct contributions of a project. In this respect, participation was seen as a tangible objective which could be measured as an outcome at the time of project evaluation. The quantitative measure was usually applied to assess whether programmes achieved goals which were set beforehand by using quantitative indicators and methods. But the qualitative outcomes were beyond the targets or primary objectives of programmes and sometimes were called “unforeseen outcomes or impacts which were defined as effects a programme had on a community in general” (Rogers, 1992, p.217). The evaluation of the qualitative aspects of participation demanded different indicators, different methods of data collection and different analysis. The major problem was the limitation of availability of substantial literature, especially when participation was interpreted as an abstract concept and composed of many potential dimensions. In addition to that, since participation was a qualitative process, the evaluation needed to identify the key phenomena throughout the process rather than following a predetermined direction, and to measure simply by a single “snap-shot” in a certain point of time. Indeed some authors have questioned whether it was at all possible to think of developing an analytical framework to evaluate “participation” in development projects (Oakley et al, 1991, p.239).

In this study, each stage required different indicators for analysis. In the first stage the framework used to assess community participation was the instrument introduced by Rifkin, Muller and Bichmann (1988) to measure participation in PHC activities. The instrument was developed by the analyses of over a hundred maternal and child health and family planning programmes to define indicators for participation in those health care

programmes. Five factors believed to influence community participation were needs assessment, leadership, organisation, resource mobilisation and management. The process indicators for each factor were developed on a continuum from narrow participation at one end to broad participation on the other end. For example, in the needs assessment factor, narrow participation was described as activities imposed from outside with a medical or professional point of view, while broad participation on the opposite end was characterised when community members, in general, were actively involved in needs assessment. By plotting a mark on the continuum for each factor and connecting it with all other marks in a spoke arrangement, it was possible to describe how wide participation was. This served as baseline data for participation in any specific health programme. This baseline could be used to compare the same programme at a different point of time, and/or to compare observations by different evaluators, and/or to compare perceptions of different groups of participants in the same programmes, rather than to assess in an absolute term.

In the second stage, the framework to measure the success of conducting participatory research was centred on the measurement of awareness raising or consciousness raising which was suggested as the first and most important step of the process. Again problems arose due to the reasons mentioned previously. The following discussion describes how the indicator for this evaluation was derived.

A review provided few examples of participation evaluation. Maguire (1987) used participatory research as an alternative paradigm research approach to empower women who had suffered from family violence by forming a Battered Women's Support Group. The project aimed at three types of change: development of critical consciousness of both researcher and participants, improvement of the lives of those involved in the research process, and transformation of the fundamental societal structure and relationships. After individual case studies the Former Battered Women's Support Group was developed for collective problem sharing, to provide information about the problems women faced after leaving the shelter and to assess a support group as one mechanism for dealing with those problems. Success was claimed as the group was formed and began to challenge the oppression of isolation and silence. In the group self-assessment session most members participated in the discussion and indicated the group

accomplished its initial purpose of providing an opportunity for collective problem sharing and solving. They also identified other benefits from project participation such as learning that they were not alone in their struggle. This resulted in increased self-confidence; increased self-awareness and increased understanding of their problems; increased appreciation for women's strength, courage, mutual support; and help with current relationships.

Rees (1991) proposed a new model which explained key concepts about empowerment for social work. His view was that empowerment should contribute to social justice which was defined as "equality in basic liberties, equality of opportunity for advancement, and positive discrimination in favour of the underprivileged to ensure equity" (Rees, 1991, p.65). The process of empowerment addressed two related objectives: the achievement of a more equitable distribution of resources and non-exploitative relationships between people, and the enabling of people to achieve a creative sense of power through enhanced self-respect, confidence, knowledge and skills. Through the process of enabling people to think and act for themselves or to become confident participants in addressing those social issues which affected them were linked to social justice generally (Rees, 1991).

Rees stresses the importance of language in reflecting an essential feature of self development. Command over vocabulary contributed to people's capacity for reflective thought and should sharpen their awareness of themselves in relation to others. This process could have an empowering effect on individuals if it enabled them to anticipate the responses of others, to play new roles and respond to the political cues in the world around them. Therefore, the language expressed was considered to be a tool to evaluate empowerment, and the reason stated was "language is not merely a tool to communicate but also a means of creating social relationships and realizing the self involved in those relationships" (Rees, 1991, p.95). Language expresses power such as "I want to make my own choices", "We now know that there are alternative ways of thinking about this matter, or resists a return to powerlessness, or what might be in their best interests if they were able to make the choices" (p.95).

The review of literature as well as my personal discussion with Mrs. Sue Watson, a staff member of the Department of Human Development Studies, Massey University, who has been working with adult education for transformation, enabled me to identify indicators to measure awareness for this study. The verbal responses of the participants to the following questions determined their awareness or expression of power - Why did they behave in the way they did? How could they have done better in their situation? What might be in their best interests if they were able to make choices? The criterion for interpretation of the answers was the indication that they had choice or power to change the status quo. This analytical framework was employed to assess awareness in the following stages.

The indicators to evaluate action research implementation were derived from the content of the project itself. In the dengue control project both quantitative and qualitative indicators were necessary. Quantitative indicators were the measure of the direct contribution of the project, which were assessed via the entomological indexes, such as whether mosquito breeding sites were reduced, whereas qualitative measurements were concerned with whether community participation had occurred.

ETHICAL CONSIDERATIONS

It has been suggested that the researcher does not need to worry about ethical problems in fieldwork because it is a study of natural phenomena and everyday life circumstances which are publicly accountable (Jorgensen, 1989). Cassell (1980) proposes two issues for ethical consideration of fieldwork; these are moral dilemmas and the different possibilities of harm and benefit between investigators and subjects. The situation of this study is analysed in accordance with Cassell's model.

Firstly she suggests "investigators must examine the moral dilemmas particular to this type of research, discover the appropriate ethical principles, and learn how best to apply them"(Cassell, 1980, p. 38). Here the questions I asked myself were - What is my right to do this research ? Who am I ? Who will benefit from this research ? What benefit or harm may come to participants by being involved in this research ? The explications are the next issues of discussion. I considered myself to be a member of the system under study and that this study would help to improve the health system in Thailand.

Secondly, harm and benefit in this model are concerned with harm caused by violating the principles of autonomy. Autonomy was defined as authenticity plus independence. Autonomy was threatened due to the difference between subject and investigator in terms of who controlled the setting of the research, and the direction of interaction. It was necessary that the autonomy of the subject was respected or else they could be treated as “means” for research.

In this study, the main aim was to help those subjects (in this study they were research participants) gain power. Actually, it tried to increase participants’ autonomy. Although I could do some things to shape the context of interaction by my definitions of the study, in relative terms, I did not have more power than the participants to control the situation. Instead, it was the participants themselves who decided changes and direction of change. To this extent, participants were treated as an “end” of the development process. In fact, this was an ideal relationship between investigator and subjects in Cassell’s model (Cassell, 1980, p.37).

As research ethics have not been of much concern in Thailand, particularly among villagers, it was necessary for the investigator to assume full responsibility. The most concern in this study was being aware that individual’s attitudes, beliefs, and behaviour were private and confidential. During the stage of implementation, avoidance of deception and exploitation by the researcher were the issues concerned (Jorgensen, 1989; Punch, 1994). One way of doing this was that the investigator had to be conscious and clear about her values, roles and relationship with the participants. Another was to present a detailed report of the activities for readers to examine. Besides, this research was taken under supervision of the academic advisors and the research proposal was approved by the Human Ethics Committee of Massey University.

An overt strategy was employed for the method of approach. Information about the investigator was presented. The community was informed of the purpose and process of the research. Informed consent was considered methodologically and culturally unjustified. Instead, the investigator needed to be aware of, and alert to, verbal and non-verbal consent. Asking for permission before any interview or direct observation, or before using a tape recorder and taking photographs was necessary. The investigator

also had to be sensitive to any signs of embarrassment or difficulties shown by verbal and non-verbal responses.

The fieldnote data were accessible only to the investigator. There was a typist, but she was asked to sign a confidentiality contract and asked to treat the data confidentially.

The data within the thesis are anonymous for institutional and personal identity protection to ensure that participants would not suffer, be harmed or embarrassed as a consequence of the research.

CONCLUSION

This chapter has discussed details of the 12-month period of fieldwork, starting from site selection, and tracing the steps of doing fieldwork from getting access to the study village until exit. Problems experienced during the fieldwork were identified and ways the researcher handled the situations, as well as identifying factors which facilitated or hindered working in the field were described. During the stage of gaining access and establishing a relationship with the community, personal factors and informal contact were considered useful. In the stage of implementation of participatory research and action research understanding of the context and the experience of the researcher facilitated this process. The steps of conducting this study were described from the selection of key informants and research participants, implementing participatory and action research, data collection, data processing, to data analysis. Ethical considerations were also discussed. The next chapter presents the baseline information about the study village.

CHAPTER SIX

THE VILLAGE: A CHANGING COMMUNITY

Prior to outlining the research findings in chapters seven and eight, information about the study village is provided in this chapter to supply a detailed description of the local context of the study. The village settlement, and the influence of the macro-level changes that affect villagers' livelihoods and life styles and which are critical for community participation, are the focus of the discussion. The information in this chapter is derived from my own participant observation in the village both prior to this study when I was a member of a research team undertaking the dengue project in this village and during the present study. Information from available documents such as research reports, a thesis and the writing of the village history, was also utilised. The most significant written source was the anthropological study of the dengue project which is cited frequently in this study (Smutkupt, Kitti-asa, Phutta, Pholmart & Tee-kantikul, 1993), and with which I was involved.

LOCATION

The village was located by the side of the main Northeast highway approximately eight kilometres to the south of Khon Kaen township. Next to the highway was the main Northeast railway and *Baan* (in *Isaan* dialect means village) Don Bom, which was on the eastern border of the village. To the south there were two natural water resources; one was the Chi river, one of the few important rivers of the Northeast region, in which water ran all year long. Very close to the south of the village was an elongated 25 *rai*¹ pond which was an old river bed where both ends had shallowed making it into a big pond, and which was described in the local dialect as *khud*. The latter was important for villagers' lives in terms of water resources for cultivation, household use and food resource, thus the village was named after it. Approximately three kilometres to the west was another village, *Baan Sa Aad* and a huge 6,000 *rai* (2,400 acre) pond described as *kaeng*. Both villages shared the water for cultivation purposes.

¹ *Rai* is the Thai unit of land measurement. One *rai* is approximately 1,600 square metres or two-fifths of an acre.

The houses were in a nucleated settlement, the common traditional village settlement in this region. Houses were built close to each other and formed clusters surrounded by paddy fields. The school and the health centre, the only two government offices in the village, and the monastery were at the south end of the village. Village property was one *rai* of land where the village spirit shrine (*saan pu taa*) was situated (see figure 2).

The area slightly sloped to the east and to the south, which caused the drainage of domestic sewage water to run down and contaminate the pond in the south. To the east it created a big swamp area, about one kilometre in length, along the main highway. Some people staked out their claims there and grew reeds to make mats, though the land within 15 metres of the road was the legal property of the Department of State Highway. Mat weaving was a year long activity and an important additional income for some families.

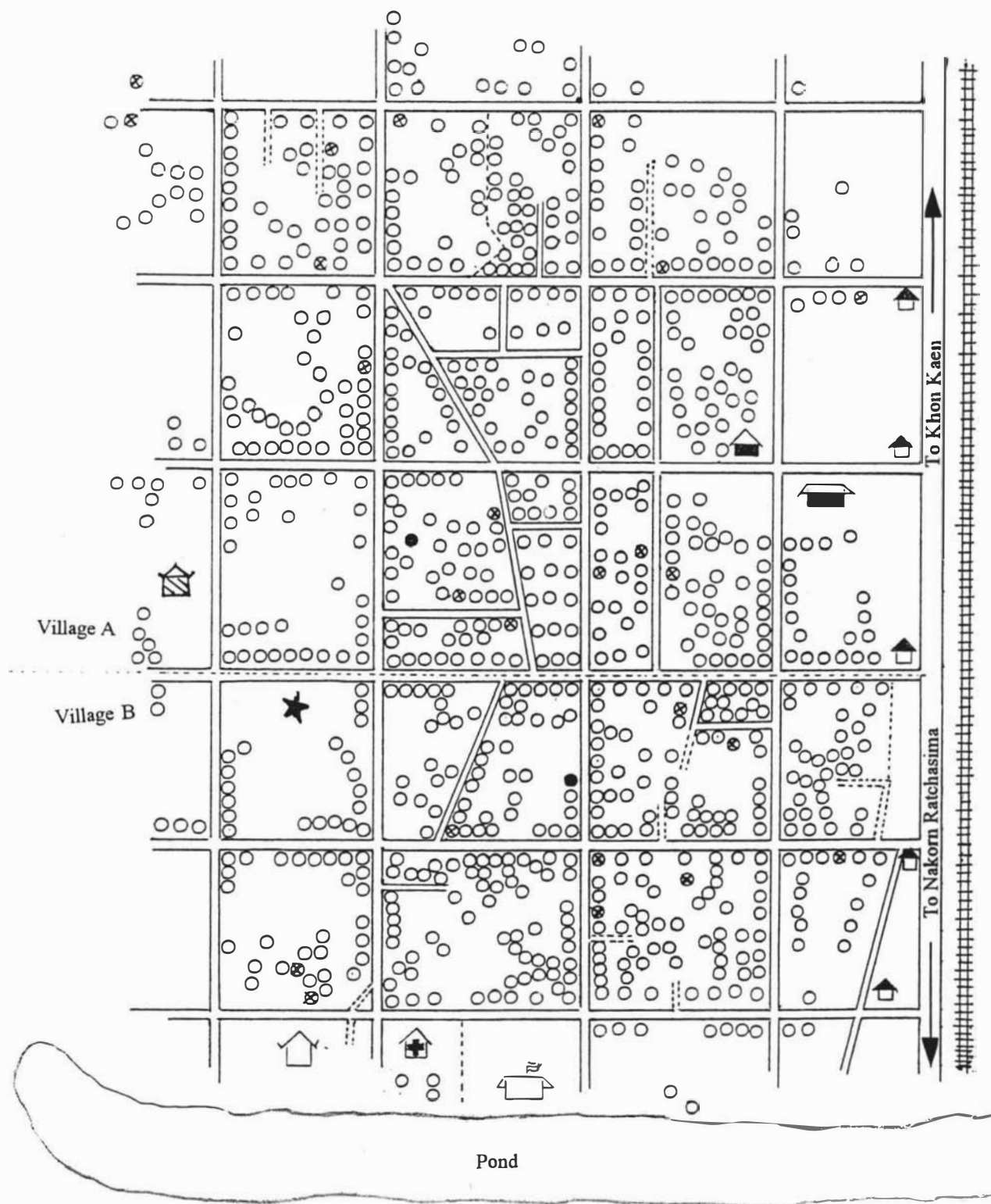
The soil was sandy and unfertile, which was typical of this region, and not aided by improper land usage. Actually, the majority of land around the village had not been cultivated for some years because it no longer belonged to the villagers having been sold to businessmen in the town.

Only 103 out of 735 households owned the land and engage in rice farming, growing glutinous rice. The rest were labourers in the nearby factories and only a few were tenant farmers. Because of the high price the land was sold to businessmen whose aim was either to make profits or to build business plants.

(Smutkupt et al., 1993, p.62)

Money from land sales was spent on building large and modern houses, and buying items such as cars, pick-up trucks, motorcycles, televisions, and refrigerators, except for some who spent it to purchase cheaper land in other villages. Thus it was common to see big two-storey concrete houses like the houses in town, overwhelm the traditional-style houses in the village. The traditional houses were raised about two metres above the ground to leave open ground underneath to provide a cool area during the heat of the day. Houses in this village were built very close to each other, and because of the high value of the land, only a few families could afford to keep their courtyards.

Fig. 2 Village Settlement Outline



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Derived from The Entomological Study, Dengue Control Project, Khon Kaen University.

The study village was divided into two administrative villages in 1974, due to the increasing population. In this study they were called village A and village B. However, people of the two villages still maintained their cohesion and communication by kin relationships. They shared the same school, health centre, water resources, and the virtue of the monastery (*wat*). Although some families in village A preferred to go to another monastery called *wat paa* (forest temple), which was about 1.5 kilometres to the south of the village, the relationship between the two religious institutions was very positive. Occasionally, on important events, such as New Year or Thai New Year (*Songkraan*), the monks from the forest temple were invited to participate in the ritual ceremony at the monastery. People from both villages participated in a seven day Buddhist retreat held in the forest temple once a year.

VILLAGE SETTLEMENT

The age of the village was rather ambiguous. In Cumpirapakorn's study she estimated the village was approximately 110 years old, based on her interview of one of the former village leaders in 1976. The interview read: "This village was about 90 years old [it was established approximately in 1886]. People moved from *Baan Ped*, *Baan Nong Koi* and *Baan Don Bom*. The leader who first came was Phra Dhamasangworn from *Baan Don Bom* to build the monastery" (Cumpirapakorn, 1977, p.419). However, the anthropological team of the dengue project disagreed with the above statement. They referred to the same document which further states "Phra Dhamasangworn was the abbot in this monastery during 1887-1899" (p.419). In their opinion, the village settlement should have been dated much earlier for two reasons.

First, usually villages in this region started with a collection of people and households, until a community was established, then it was time for thinking about a religious building to serve the people's spiritual needs. Actually, building a monastery required great efforts on the part of the community, not only in material resources but also in maintaining harmony in the community to complete its common goal, as well as strong leadership and management skills. It demanded all kinds of community resources such as manpower, food for labour, money and cooperation to a certain extent. The success of monastery building implied that the community had already been settled long beforehand.

Thus it was suggested that the actual village settlement should be dated many decades earlier (Smutkupt et al., 1993).

Second, they were convinced that this village already existed before the establishment of Khon Kaen township during 1837-1867, as did its neighbouring villages. In addition, historical and monastery buildings in the study village and the nearby villages showed they were of the same age. A few of the villages within three to five kilometres of the study village were chosen to be the place for Khon Kaen township. Since the Khon Kaen settlement took almost thirty years to develop and had to be moved five times due to drought in the selected areas, these findings confirmed that the study village must have been settled earlier than 1886 (Smutkupt et al., 1993).

The early settlers came from nearby villages, particularly from *Baan Don Bom*, to expand their cultivated land. One of the key informants in the anthropological study, who was born in the village in 1913, stated:

My parents came from *Baan Don Bom* to extend their farmland and to look for pasture to feed cattle. The waterside plain was excellent and there was an abundance of food. At that time the area was covered with forest, big trees and wild animals, tiger and wild boar in particular. Some families moved from Ubon Province in order to find fertile land for their livelihood. Later on the population increased dramatically, when I was 7-8 years old [1920-1921] there were only 30 households in this village. Five years later [1925-1926] the number was increased up to 70-80. In 1959, when I was vice-subdistrict head (*saarawat kamnian*) there were already 300.

(Smutkupt et al., 1993 , p.55)

POPULATION

The village was relatively large compared to other villages in the same subdistrict, with a total of 824 households: 464 in village A and 360 in village B; and a total population of 3,938: 2,437 in village A, and 1,501 in village B (data from the village survey done by health workers in July, 1995). The age and sex distribution of the population is shown below.

Table 1 Population by Age and Sex Distribution

Age	Village A		Village B		Total
	Male	Female	Male	Female	
Under 1 yr.	30	22	6	11	69
1-2 yr.	45	35	32	35	147
3-4 yr.	32	26	20	21	99
5-9 yr.	96	106	47	35	284
10-14 yr.	120	125	74	68	387
15-19 yr.	108	115	79	66	368
20-29 yr.	269	281	139	185	874
30-39 yr.	213	190	132	131	666
40-49 yr.	122	117	87	107	433
50-59 yr.	91	88	69	48	296
60-69 yr.	58	72	28	35	173
70* yr.	40	36	17	29	122
Total	1,224	1,213	730	771	3,938

Source: Health Centre Annual Report, 1995, p.2

A CHANGING COMMUNITY

During the last thirty years Khon Kaen has been through remarkable changes. Not only was it expected to be the centre for the business and government sectors of the Northeast region but also to be the gateway through which socio-economic relations to other countries in the Indochina Peninsula, such as Laos, Kampuchea and Vietnam would be extended. Various types of industries and private businesses have been built up, including five star hotels, national network supermarkets, private hospitals, as well as government offices. This has resulted in changes to the livelihoods of villagers in the surrounding communities in which the study community was included.

As a consequence of the macro-level development, the study village has been changing from traditional subsistence farming to a wage-earning life style. The most influential factor was the change in land ownership. The increasing demand for land for business and industries fueled rising prices, particularly for the land in the study village because it was very close to town. Therefore, people tended to sell land and engage in labouring work. The land price has increased incredibly during the last five to ten years, as the

anthropologists document: “Seven years ago [1982] I sold my paddy field 14 *rai* for 600,000 *baht*.² Recently the real estate company from Bangkok bought the nearby land 30 *rai* for 26,000,000 *baht*” (Smutkupt et al., 1993, p.63).

Consequently, the village has been surrounded by a variety of businesses such as export fishing net factories, and a ploughing machine factory. Another rapidly expanding business was that of real estate since the village was very close to town. The village paddy fields seemed to be a perfect site for the housing estate business. There were a numbers of local companies and at least three big ones from Bangkok. The nearby natural water resources provided a peaceful atmosphere and pleasant breezes. In 1995, during my data collection period, 400 square metres of land, which was enough to build a moderate-sized house in the housing estate area, cost about 1.5 million *baht*. Recently, the village has been surrounded by modern style houses belonging to the middle and upper class people from the town, whilst the study village itself provided cheap rental rooms for people migrating from rural areas to find jobs in the province.

The causes of such changing circumstances, as analysed by Smutkupt et al. (1993), were three crucial events. Firstly, the railway was built to connect the Northeast region with the Central region during 1927-1933. The Bangkok-Nakhon Ratchasima railway was extended to Khon Kaen and Nong Khai near the Laos border. During the construction of the railway some workers married village women and settled here, while others moved in as families. It was the first time the village was opened to the outside world. The railway facilitated transportation of essential goods and people which consequently provided economic and population growth in the village.

Secondly, the construction of the *Mitraphaab* (friendship) highway, which was sponsored by the USA government as part of the policy of linking national development to state security under Field Marshall Sarit’s government during 1958-1963. The government proposed major building of infrastructure, including dams and networks of roads and highways in order to solve what was called at that time the “Northeast region problems”. They were defined as poverty, invasion by the Communist Party of Thailand

² During the field period in 1994-5, one NZ dollar was approximately equivalent to 17 *baht*.

(CPT), and the physical isolation from the central region. Construction of the main highway accelerated the process of village growth.

The most significant factor was the policy to make Khon Kaen the centre of the Northeast region. This policy was initiated after Field Marshall Sarit came to power, and the policy was carried on after his death in 1963. A new town plan was developed to support the construction of government offices, the extension of administrative units of various ministries in Bangkok. Radio broadcast and television stations were set up to encourage communication with the Central region. Khon Kaen University was established and functioned from 1962. A new airport was built to serve the growing socio-economic structures as a consequence of the growth in industry and businesses. More bypass road networks have been created.

As a result, life in the study village has changed to a predominance of wage-earning livelihoods, with villagers going out to work early in the morning and coming back exhausted in the late afternoon. During the day mainly the aged and some mothers with small children are at home. In some families grandmothers looked after children while the mothers go to work. This life style has diminished individual and social contact between villagers, as the former abbot told me: "People in this village are individualistic, they are interested only in their own business. It is very hard to expect them to cooperate in any development programmes" (Fieldnotes, January 12, 1995).

One of the village health volunteers told me:

Well, people in this village, it is very hard to say, they are somewhere in between, not really urban and not exactly rural. Rural people are very close to each other and helpful. While the urban people understand things easily, are knowledgeable, and they are able to take care of themselves, and make reasonable decisions. But people in this village are neither of the above.

(Fieldnotes, January 5, 1995)

One way to describe the community is to present the social systems in that society, as outlined in the following section.

SOCIAL SYSTEMS

1. Family and Kinship System

In rural North and Northeast Thailand it was common that the households in the same cluster were close kin such as families of married daughters who resided near their parents' houses. This was the consequence of traditional practice as Potter describes:

After marriage, Chiangmai Village couples go to live in the bride's parents' house. If the bride is the youngest daughter who will inherit the parental house, the couple will reside there permanently; if not, they usually live a year or two with the bride's parents and then reside permanently nearby, often in the same courtyard.

(1976, p.118)

This matrilineal residence characteristic was identified by anthropologists as "matrilocal extended family", "uxori-parentilocal extended families", or "multihousehold compound" (Potter, 1976, p.157-158). Those families were the closest relatives outside each one's immediate family, with whom they shared respect, affection, mutual support and cooperation in everyday life and at any life crises. Thus it was common during the day for women in each cluster to get together in a place, bring their children to play, or work together. The work they could do to earn additional income whilst taking care their young children at home was repairing factory-made fishing nets or mat weaving. When together they would chat about everything, such as television programmes, gossiping, telling jokes, and teasing each other. In other words, each cluster was a small communication network in the village.

Another important social characteristic in this region was that the status of women was rather high because of the inheritance practice which was described as follows:

If a man marries a young women who is to inherit her parents' house and compound, he continues to live in her house with her parents and gradually assumes more authority as his father-in-law ages When father-in-law retires or dies, the resident son-in-law succeeds to his position as male head of the family.

(Potter, 1976, p.126)

In a system like this, the authority was passed from man to man, from father-in-law to son-in-law, but only by virtue of relationships to a line of women. This meant the woman was in the most important position since her husband's status in the family was conferred by her. A woman had an important voice in the management of family life (Potter, 1977).

Though the man was regarded as the head of the family, children were supposed to treat their parents with a special sort of intimate deference. The family relationship was very strong, particularly between mother and daughters. Parents gave support for their offspring in every sense that they could afford, materially and emotionally, sometimes even after they were married. Therefore, the essence of the relationship lay in the concept of *bunghun*. *Bunghun* is a Thai word defined as "the fervour or benefit which has been bestowed, and for which one is obligated to do something in return" (Rabibhadana, 1993 p.3).

The Thai kinship system was bilateral in nature. The kinship group was composed of the descendents of maternal and paternal grandparents. "This group, the members of whom are called '*pii nong kan*', includes all one's uncles and aunts and their children (first cousins) through both his mother and father, on both sides of the family, males and females" (Potter, 1976, p.136), though the maternal kin were usually closer than the paternal ones due to the residence practice. Kinship terminology emphasised the differences in generation and age, implying that seniority occupied an important place in the behaviour of kin. Even in the same generation seniority was considered rather than sex. Older siblings were respectfully addressed as *pii* (older brother or older sister), along with their names. Younger siblings were addressed by their names only, and the word *nong* was the general word for younger brother or sister. To put it simply, respect for elders is a very important element in the Thai social structure.

2. Leadership and the Political System

The political organisation at village level was called the village committee. The committee consisted of three types of membership: the village headman (*phuyai baan*) who was elected by villagers and acted as the chairperson of the committee, the

administrative team formed by the village headman, and one expert or qualified person (*phusongkhunawut*), who was also elected by villagers specifically for this position to act as the committee consultant.

There were twelve village committee members in each administrative village involved in this study. Both groups got along quite well because they considered themselves as people of the same village and shared common resources. Some of them were next of kin. It was important to note that the headman of village A was also the subdistrict head (*kamnan*), who was elected by and from among the village headmen of each administrative village in the subdistrict. The subdistrict council office was also situated in village A. It was the place where the subdistrict council (*saphaa tambon*) meeting was held on the eighth of every month.

Actually, the subdistrict council meeting was controlled by the *kamnan* and little discussion took place in this meeting. Most of the time in each meeting was used for official announcements from district government officers from the different Ministries of the Interior, Education, Agriculture and Health. This practice was not consistent with the national policy of establishing subdistrict councils to emphasise decentralisation and empower village communities.

In the meeting on March 8, 1995, the district administrative official announced that the Parliament had recently approved a bill to support a new organisational structure for subdistrict councils. According to the new law, those councils that earned enough annual income (more than 100,000 *baht* per year) would be released to independently manage themselves with a lump sum support from the central government of 2,000,000 *baht* per village per year. This drastic move was an attempt to strengthen the capacity of subdistrict councils and popular participation.

According to the new organisational structure each village must arrange for the election of village consultants (*phusongkhunawut*), which were increased to two persons from each village instead of one as in the former structure. Seven members of the administrative team would be elected by and from subdistrict council members to

manage the subdistrict development plan similar to the government at the national level. The remainder would act as the members of the parliament to control the work of the first group. The council then would become a jurisdictional organisation under the new title “Subdistrict Administrative Organisation” (*Ongkhaan Borihaan suan Tambon*). With respect to this criterion, the subdistrict in which the study village was included was required to adopt the new organisational structure.

A few months before my entering the field, there was an election for the headman in village B, because of the resignation of the current incumbent. There were two candidates; one was the consultant of the village committee, the former police sergeant in his late fifties who had been elected to the consultant position several times, the other candidate was a thirty-eight-year man and a novice for this task. Both of them were well-to-do and had many relatives to vote for them. The result was the latter one was elected because “people don’t like the former one, he is aggressive and he is not so clean, although the latter is young, inexperienced, and cannot fluently read and write because he only finished primary level of education” (Fieldnotes, January 3, 1995).

The former candidate, to whom the result was very disappointing, told me

I am intending to contribute to the village and I am sure I can do, while those people who take the position cannot. I am the one who made the contact with the businessman in town to redig the pond. Recently, the real estate company from Bangkok, who invested in this village, offered me 10,000 *baht* salary to be the company consultant

(Fieldnotes, February 2, 1995)

However, he was elected as a village consultant of the new subdistrict organisation structure in the election on April 1995. Moreover, it was most likely that he would be elected to be one of the administrative team, a position to which every member aspired. The reason was that two of his brothers were members of the subdistrict administrative organisation; one was the headman of another village, and the other one was the former subdistrict headman of this village and was elected to be the consultant of village A in the new election.

Few villagers understood the new subdistrict council organisation, its significant roles, and how the organisation related to their livelihood. This information was probably also new to the village headmen, thus little information about the organisation was announced to the people. Despite lack of this information, there was a big election campaign. Consequently, while I was observing in the voting tent a lady came in and asked me what was the voting for and how many candidates she voted for, and the elderly asked me to explain to them how the new organisation worked.

In my opinion, the formal village leaders neither intended, nor were competent, to solve community problems despite the fact that there were opportunities for them to do so. The tasks performed by these leaders tended to be the 'eyes and ears of the government' rather than working for community problems or people's welfare. The villagers themselves did not trust their leaders. In their opinion:

The village leaders are not seriously working for the community. They are interested only in benefits to them. If you ask them to do something for you, like birth registration and asking for birth certificate or something else, they will ask for money from you.

(a woman in early forties, Fieldnotes, December 19, 1994)

The subdistrict head and school principal are corrupt, everytime there is fund raising they've never been able to produce the list who donates how much. They just tell people the total amount raised.

(one of the VHV, Fieldnotes, December 12, 1994)

There are lots of problems in this village: solvent inhalation among school children, gambling, and this village has the highest alcohol consumption in the whole province. Let's take the most common problem, garbage. None of them pay any attention. I told them the people keep on dumping in this area and it smells. They told me to record the name of the person who did that. How come! It is not my business. How dare I, those people will be angry. In fact, it is difficult to know to whom that garbage belongs, because they always ask children to do it and pay them. It is the leader's business. He just announced it in the village broadcast for few days, and that's all.

(a woman from a poor family, Fieldnotes, February 6, 1995)

During the year of my data collection there were two types of survey for which the village committee was responsible, the Basic Minimum Needs Survey and the Social

Welfare and Family Survey, but neither of them was completed. However, in *Baan Sa Aad*, the nearby village, both surveys were completed and I offered the village headman, whom I met in a subdistrict council meeting, to work with them in tallying the results.

3. Economic System

As previously stated the village life has been changing from traditional agriculture to a wage-earning community. Only 30% of households still engaged in farming, and farming was not the source of major family income any more (Smutkupt et al., 1993). It is changing to a cash economy community, as a man in his mid sixties told me:

Life is changing here, people have less contact with each other. When I was a lad if someone got fish from the pond we shared with our neighbours, but now, if we catch some we sell them. Nowadays money is a necessity, and we have just kept on spending it like time. It reminds me of the old words "*ngern kham wao painaa, pu plaa wao kuen lang*" (money is the issue for the future, crab and fish were the olden day issue)
(Fieldnotes, January 23, 1995)

The majority of people were engaged in wage-earning livelihoods, though there were no exact data available because the community leader had never managed to complete any surveys to provide baseline information for the village. For villagers it was not difficult to find work as there were a number of jobs available in nearby factories including the Coca-Cola factory, Pepsi factory, three export fishing net factories, locally made ploughing machine plant and lots of service jobs in town. The fishing net factories also created middlemen who brought the defective nets to the village to have them repaired and returned them. Net mending was popular with the women because they could work at home and spend time doing other housework. Though the wage was very low, it did provide additional income for the family. In addition to that, the estate companies also offered many jobs for both skilled and unskilled labourers. There were about 10-15 families engaged in mat weaving. Since only women did this work, they considered it as additional family income.

A consequence of changing life style, with villagers rushing out to work early in the morning and returning exhausted from work in the late afternoon, was the emergence of a market in the village. It was very unusual to have a market because in a traditional village people gathered foods from their rice field or a village forest and cooked their

own meals. The anthropologists interpreted the market as a symbol of a cash economy community.

The market started in late 1963, beginning with a few village dwellers who brought their cooked food for sale. Since then it has become more popular and has grown since it is suited to the changing life styles of the people. During the period of my fieldwork, the market opened twice a day, early in the morning about 6 am., and 4 pm. until dusk, to serve the need of workers. Varieties of goods were brought from town to sell, clothes, cooked food, meat, and vegetables. Frequently people from other villages also came to trade here. There were about 30-50 goods stalls, where goods were displayed on wooden platforms. The market was located on the boundary road between village A and village B, thus it was the trading centre for people from both villages.

The market created an income of 60-100 *baht* per day as a result of traders paying space rental fees. A few traders in the village organised among themselves to assign someone to collect and keep this money, as well as to decide when to use it. None of the community leaders got involved, except when they wanted to ask for some money.

Another village input was the income from redigging the pond, which should be done every 2-3 years because of the erosion of its banks. Actually, the majority of this money went into the broker's pocket; only a small amount was given to the village. During my data collection, the redigging was done for an area of 20 metres width, 2,000 metres length, and 3 metres depth which resulted in 120,000 cubic metres of soil being taken from the pond. The digging company made a good profit from selling the soil at 26-50 *baht* per cubic metre depending on the distance it had to be transported. The broker got 2 *baht* per cubic metre, which made him a total of 240,000 *baht*. The villages, which were supposed to be satisfied with a free redigging to provide a natural water resource available for their people, got a gift of 30,000 *baht* each, as well as some soil to put on the road which was damaged during heavy trucking.

4. Buddhism and Cultural Practices

Although the community was changing, Buddhism was still the centre of Thai rural life. Buddhism in the village, was symbolised by *wat* (the monastery), which has two significant roles: providing emotional security and spiritual needs for villagers, and facilitating community unity. In respect to the first role, it was the residence for monks who were involved in the daily life events of village people, such as preaching, house blessings, weddings, or funeral ceremonies. For villagers the monks were mediators or a vehicle for merit-making (*tam bun*). Listening to the chant and sermon or offering food and secular necessities for the monks were ways the people gained merit; it showed the dependence of the villagers on the monks' religious role.

Every morning villagers, particularly senior people, offered food to the monks when they came along the village street at dawn. On the holy days many of them went to the monastery to offer food to the monks, chanting and listening to sermons in the morning, and chanting and taking the Eight Precepts in the evening. Such activities were believed to be merit-making (*tam bun*). The motivation for accumulation of merit was the gaining of happiness, security, safety and prosperity in this life and the next.

Ordination was still practised in the village though the duration of being a monk was somewhat shorter, probably only two weeks or one month instead of three months through the *wasa* (during lenten period). It was the popular belief that becoming a monk was a great merit. This sort of merit was also able to be transferred to all those who released a man from his social obligations to become a monk, particularly for one's mother, who could not herself be ordained. A son who became a monk (*bhikkhu*) or novice (*samanera*) was believed to acquire the merit of helping his parents to go to heaven or to decrease their demerit (*baap*) when they died.

For its second role, the monastery was the most important place where various kinds of community rituals were carried out. Particularly in the Northeast region, there were community rituals to be carried on throughout the year which were called *heet sib song* (twelve rituals). Thus it was the place where villagers came together and expressed their sense of membership of the community through shared norms and common participation

in these rituals. The role of the monastery in social gatherings or being the core of village unity was based on the relationship between villagers and the monastery. In this village the relationship was intimate and interdependent. The monks depended wholly on the material support given by the villagers and the villagers relied on the monks' spiritual guidance.

Another important reason that motivated people in this village to participate in various community rituals conducted in the monastery was the abbot himself who had prestige and was respected by villagers. He was born in this village and became a monk when he was twenty-one. Almost thirty years of his monkhood had been spent in this village, in which many of his relatives resided. He was one of the significant community leaders. In accord with his position he performed his religious functions to benefit villagers' spiritual needs. Recently, he succeeded in getting the sacred hall built for the monks (the *bot*) valued 3,000,000 *baht*. He was also the joint chairman, together with village headmen, for organising the feeding ceremony for the village ancestor spirit which was held on April 15 every year.

This ceremony was performed for the whole village to remind them that they all were from the same ancestor, and also to recognise the benefits the ancestor had brought to the village. It was a special social occasion in which different generations and every household participated. During this ceremony, the villagers also transferred merit for their own ancestor spirits. On that day, about 10 am., when the drum signalled, villagers, particularly women, brought food and some secular essentials to offer to the monks. The idea was that the food being visibly consumed by the monks was feeding their dead relatives. Afterwards, they shared food, chatted, and had a good time in this social gathering. Those young people who gone to work in other places took this opportunity to visit their homes once a year, and they looked forward to it.

The abbot also performed secular roles. He was interested in village problems and cooperated in village development projects. When I went to talk with him about my research he complained about the ignorance of the formal leaders, and stated that he himself was willing to cooperate in conveying messages via his preaching or his

broadcast amplifier. During the fund raising to build the fence for the health centre in December 1994, he decided to have the activity organised in the monastery instead of in the village hall as usual. Thus this fund raising was not controlled by the village committee, and it made the highest amount ever, a total of more than 30,000 *baht*. In addition, he occasionally attended the subdistrict council meeting.

The monastery itself created its own networks. There were two types of organised groups to support the monastery activities: monastery support groups (*klum sangha thaan*), and the novice support group (*klum mae ok kam*). For the first type of group, 6-15 households in the same cluster would form a group to encourage villagers to join in the monastery activities. The groups gave the monastery support in terms of labour and financial support. There were twenty-two such groups in both village A and B during my data collection. This type of organised group was successful in encouraging community cooperation and communication within the group. This was because the group organisation was based both on kinship or close neighbour relationships and on their strong belief in Buddhism (Smutkupt et al., 1993, p.137).

The second group was organised to provide food for the novices. Since the study village was close to town where there was a Buddhist College for monks and novices to study, about 20-30 of the novices stayed in the monastery every year. Those novices were the boys of poor families who could not afford to go to normal school. Entering into the monkhood was a channel for those ambitious, talented, but poor young men to get better education, where material support and opportunities for further education were available. Therefore, the abbot with villagers who were helping in monastery activities, assigned laywomen called “*mae ok kam*” to look after the secular needs of these novices. *Mae ok* in Northeast dialect means laywoman who helps in the monastery activities, and *kam* means support.

Actually, *mae ok kam* were women who could afford and had agreement from their families to undertake such a responsibility. The responsibility was to support one novice with at least two meals a day, and some other additional support such as necessities for living, and money for transportation if necessary. Their relationship was similar to

mother and son. The woman could admonish the novice, in that case he was expected to respect her and support her and her family whenever he could. The reason of being *mae ok kam* was that “the continuance of the Dhamma (the teaching of the Buddha) depends on the *Sangha* (the monkhood society), whose members practice, realize and propagate it” (Suksamran, 1977, p.4). Therefore, people who supported ordination were believed to gain great merit.

5. Education System

There was one primary school in the village which was built in 1920. In previous times education in the village was attached to religion. The teaching was conducted in the monastery sermon hall by Buddhist monks, and was accessible only to boys. In 1913, according to the national development policy, a village school was launched. However, the school was not able to be built until a family in the village donated the 23 *rai* 87 *tarang wa* (approximately 9 acres) of land, on which the school is presently situated.

In 1984, schooling was extended from the fourth grade up to the sixth grade consistent with the compulsory education policy. During this period the success of the family planning programme was reflected in a low birth rate and the number of children entering the primary school system diminished. Thus the school opened the pre-compulsory service with the support of the national education policy and admitted five year old children to kindergarten classes, before they reached their seventh year and then entered compulsory education. In 1995, to postpone the age of entering labour markets, the government launched a scheme of nine years of compulsory education. The school in the village was involved in this pilot project, thus the classes were extended a further three years in the intermediate level.

In 1993 there was a total of 604 school children. Of those, 126 children were in kindergarten, 334 children in the primary level, and 144 children were in the intermediate level. The percentage of children entering intermediate level education was 64 % in 1993 (School Annual Report, 1993). This figure was relatively high compared to other villages.

However, children of the well-off families usually went to schools in town, particularly at kindergarten and intermediate levels. The reasons parents gave for not taking their children to the village school were:

Teachers are not seriously doing their job. After finishing primary level in the village our kids could not pass the competitive exam to enter the good intermediate schools in the province. The headmaster is interested only money matters, he does not pay any attention to improving the school.

(a woman in early forties, Fieldnotes, December 5, 1994)

School buses ran to the village or covered pick-up trucks were arranged for transportation. After they had finished their primary level in the village many children went to town for their intermediate education then continued at vocational colleges or universities of which there were a number of both private and government institutions available in the province. As a consequence the educational level of the villagers was high in comparison to other villages.

The problem with the village school arose because a number of teachers were the wives of high and middle rank government officers in the province who transferred to this school because of family reasons. Since the village was very close to town, few teachers lived in the village. Ideally, school teachers should reside in the village and be part of the community. This was the idea of forming the tripartite for village development which included the village committee, the Buddhist monks and the school teachers. The situation in the study village resulted in a distant relationship between school teachers and the villagers.

The relationship between the school and the health centre was rather more positive due to the location and their mutual benefits. The school teachers received convenient services, and they also provided satisfactory cooperation with the health centre. School children received a free health care service, according to the state policy, and they could easily go to the health centre whenever they needed help. In addition, the policy of cooperation between the MOPH and the Ministry of Education facilitated such a relationship, particularly in the dengue prevention project.

6. Health Service

The health centre in the village was opened to the public on April 1, 1986. It was situated at the south end of the village, between the school and the monastery, which was close to village B. The establishment of the health centre was initiated by the provincial health officer, and the village cooperated by providing the land. The community leaders, at that time, decided to have it built on the school land which belonged to the government, since the health centre was also a government office which made the land request much easier.

The area of responsibility of the health centre covered five villages and a population of 6,106 (Health Centre Annual Report, 1995). It did not cover the whole area in this subdistrict because there was another centre in *Baan Don Bom*. The service was operated by health workers who were government employees. In October 1994, when I started the study, there were three midwives³ working in the health centre. In December, another health worker, a midwife, was assigned to be the person-in-charge, which made four health workers working there. In July 1995 one health worker was shifted to work in the district health office, which left three of them working in the health centre; this number was rather high compared to elsewhere. Usually, the country average was about 2-3 personnel per centre responsible for the whole subdistrict area (Division of Rural Health, MOPH, 1992). In the case of *Baan Don Bom*, which had similar area of responsibility, the health centre was run by two health workers. The higher number of personnel was an advantage because their work load was minimised; on the other hand, it was a disadvantage, since their opportunity to get special promotion was reduced.

Their actual workload, however, was rather heavy even for three health workers. The existing situation allowed them only to complete the routine tasks that they were required to do, rather than initiate action to address community problems. There was a joke among health personnel that the job of health workers in the health centre was to be the MOPH at the village level, because the health workers were required to implement activities for every Department in the Ministry.

³ Health personnel who completed a two year training course after twelve years of formal education. It is the provisional health manpower plan to alleviate high infant mortality rate. The course started in 1839 by training traditional birth attendants or auxiliary midwives to work in rural health centres.

The health centre provided a comprehensive service. This meant one health worker had to be available for the curative service whenever a client arrived. At the same time preventive services were also offered. There were twelve basic essential preventive services: nutrition surveillance in children, maternal and child health and family planning, immunisation, safe water supply and basic sanitation, prevention and control of locally endemic diseases, provision of essential basic drugs, oral hygiene and dental care, community mental health care, accident and non-communicable disease prevention, consumers' right protection, AIDS prevention, and community environmental control. According to the above basic services, health workers have to give health education to villagers and supervise the VHV too. In addition, health workers had to participate in inter-sector activities carried out in the community and provide community baseline data as well as health census data.

Another task was to carry out the PHC programme. According to the concept of the MOPH, PHC was the collaboration between health workers and a community to provide the twelve basic preventive services mentioned above plus health education, plus curative services. A community was represented by VHV who were requested by the health workers to help in health matters. In this village, the majority of VHV participated in whatever the health workers asked them to do. For instance, VHV were asked to help weigh children under five years of age in the nutrition surveillance programme, or to remind mothers to bring their children on that day. If someone was missing, VHV would be asked to do the weighing to complete the record. The tasks mainly performed by VHV in this village were to give information and to collect data requested by the health workers, such as the number of pregnant women and the number of newborn babies in each month.

Moreover, the health workers had to take turns to provide an after hours standby service available for emergency cases according to the policy of the MOPH. They took turns to sleep in a vacant house near the health centre. Frequently, their family moved to spend the nights there, or their husbands accompanied them for safety reasons. The allowance for this after hours service came from 80% of the income each centre earned from selling drugs which was supported by the district health office.

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Apart from that, health workers had to join the special programmes initiated from other sectors and the provincial health authority, such as special activities on the King's Birthday, and Buddhist holidays. Mostly those projects were designed by different divisions in the provincial health office. For instance, March-September was the campaign period for non-communicable diseases control. The health education division of the provincial health office designed a project which aimed at case finding, health education and prevention of three diseases: diabetes, hypertension and cervical cancer. In the case finding for the first two diseases, a urine test and blood pressure had to be taken from villagers who were over forty years and those who were obese. Yet the criteria for obesity was not given. To diagnose cervical cancer papanicolaou smears had to be done. The target group was married woman age 15-44 years. The specimens were taken and sent to the provincial hospital for microscopy test by the end of the day. Cervical specimen smears required specially trained personnel and not every health centre could manage by itself. Besides, it was a lot of work preparing equipment and solutions to keep the specimens in before transferring them to be examined at the provincial level. Therefore, they pooled health workers from the nearby health centres in the same zone to help each other. It took about two weeks to complete this project.

During May-June every health centre had to complete the new form of family folder census, a project which came from the MOPH. The objective was to include the birth date and education level of each family member in order to provide the exact data. This project resulted in health workers having to resurvey the whole family folder census in every village which was under their responsibility so as to complete the survey in the assigned timeframe, rather than updating the folders within the regular process.

At the end of each month the health centre had to present a report and statistics about the tasks performed. Actually, on the 25th of the month health workers started compiling the data. This was a time consuming job to count the number of clients sorted to fourteen different categories, and to count the number of medicines left in stock each

month. Afterwards, this report was sent to the district health office, to be compiled into provincial data before being reported to the Division of Public Health Statistics, MOPH in Bangkok.

In this district the cluster health centres were grouped in the same “zone”. The idea was to let centres in the same zone sort out any problems that may arise. In this zone there were six member centres, and the health worker who was in charge in the study village was elected as a zone head. Being in this position she had to sit in on the subdistrict council meeting every month, and be a chairperson of the zone meeting, apart from the routine monthly meeting of every health centre held in the district health office.

The health centre provided services for 200-300 clients each month and the majority of services were curative. However, the well-to-do families preferred to go to town where there was a variety of choices available including two tertiary care government hospitals, six private hospitals, more than one hundred and sixty private medical clinics, and forty dental clinics. The reasons given were that “there you get better and stronger medicine, and you see the real doctors who are competent, not just the health workers” (Fieldnotes, December 6, 1994). Those who used the health centre services were particularly the people who bought health cards and who could get free services from the health centre. The reasons given were that it was more convenient and cheaper. They did not have to pay for transportation cost and food. Besides, there was always a long queue in the government hospitals. The health workers at the centre were friendly and understanding.

CONCLUSION

This chapter provides information on the local context of the study village. It depicts the transition of the village life within the last thirty years from subsistence farming to a wage-earning community. The transition, inevitably, has created factors which do not seem to facilitate community participation. These factors included wage-earning, clock-hour working life styles, a cash economy encouraging individualism and diminishing discussion and sharing among people, and the formal leaders who lacked leadership skills and good intentions to work for the people's welfare.

There are some factors which are considered to influence the likelihood of community participation in the village. For instance, the abbot, who in general is the most important spiritual leader and is interested in village problems, and the monastery communication network. Another is the health service where the volunteer scheme is based on the kinship system and the potential of women, particularly in this specific community where the status of women is high compare to other cultures or other regions. The next chapter presents the application of participatory research.

CHAPTER SEVEN

PARTICIPATORY RESEARCH FOR EMPOWERMENT

Participatory research starts from the principle that it is not possible to separate facts from values and social relations, therefore, problems must be viewed in a social and historical context. It starts from what is already there. This starting point is not only necessary for the people themselves to participate in the analysis of their own reality, but also for the outsider to understand community participation and to depict the exercise of power in a community. The first stage is to understand the community reality. Such understanding provides a picture of problems, causes of these problems as well as available resources specific to that community. The more understanding of the specific context the more likely a project is to succeed.

My former experience of working in this particular area provided an understanding of the situation and the specific cultural characteristics. However, other useful information came from two research activities designed in the early stages of the study; an investigation of how the community participated in former development projects (village road cutting, the tap water system, and the drug revolving fund), and an exploration of villagers' perceptions of participation.

Following these activities existing health situations and tasks in their day to day work were discussed with both health workers and VHV in an attempt to raise their awareness of the possibility of community participation in health.

PARTICIPATION IN FORMER DEVELOPMENT PROJECTS

1. Village Road Cutting

In earlier times the village road was narrow and winding. Many years ago there were attempts to get agreement to straighten the road for the convenience of traffic and to make the village look tidy. These proposals failed because the affected land owners were unwilling to give concessions for use of their land. In 1962, the project was brought up again by the district community development officer (*phattanakorn amphoe*). He proposed this idea to the village headman and some other leaders. This time the project

was successful although the road passed 61 houses and 23 rice barns. Significantly, the cost for this project was only 5,000 *baht* (NZ\$ 295) for the demolition work.

The main reason for the success of this project, from the perspective of the former headman who was in charge of the project, was because it was a coup d'etat period. The headman announced to the affected villagers that he would report to higher officials if there was any opposition.

Another important reason, in his opinion, was during 1962-1964 the extended provincial office of the Department of Land tried to issue land title deeds. The title deed was issued in substitution for *Sor Kor 1*, the temporary one, which was unable to be used as collateral security and did not identify a definite boundary. The headman took this opportunity to declare that no title deeds would be issued to villagers who were not willing to cooperate with the road realignment project. A piece of land without a title deed could then be claimed as a state asset. The deed issuing process involved undertaking cadastral surveying, and staking to show the confirmed boundary. This process needed to be certified by a village headman. Because the state policy was to issue the title deeds throughout the country, but there were limited numbers of cadastral survey officers, each village was assigned a specific period of time to complete this process. If it was not done in that specific time, the survey officers would move away to other villages.

The headman collected land owners who wanted the title deeds and made contact with the cadastral survey officers. This process enabled him to earn a commission from the land owners. He told me:

Others envied me so they wanted me to resign. I did not mind. What did I care for the village headman salary? It was nothing. I had regular income from the commission of collecting electricity bills in the village, apart from the income of being a land broker.¹

(Fieldnotes, December 2, 1994)

¹ This village headman resigned in 1987. He told me that his assistant advised him to resign because the villagers did not trust him any more. The accusation was of his corruption in issuing title deeds of the land around the huge pond, the *Kaeng*.

One villager told me that this headman cheated. Because of the uncertain boundary of the *Sor Kor I*, a piece of land which once belonged to her family was taken to sell to a businessman after getting the title deed. She quarrelled with him and did not respect him after that (Fieldnotes, December 13, 1994).

Another development project was the introduction of a tap water system in the village. One of the major problems for the Northeast was lack of water both for domestic use and cultivation. In traditional village life styles a tap water system was a dream. However, in this village, few natural water resources existed.

2. The Tap Water System

In 1968, a village tap water system project was proposed by provincial health office personnel; the project was initiated in order to implement the state policy to provide clean water in rural areas. The system would work by pumping water from the pond to a high tank, after which treated water would be sent house to house via a pipe line system. To launch this project the villagers had to contribute 50,000 *baht* (NZ\$ 3,000) to add to the state budget.

The key informant was the former abbot who, after leaving the monkhood, married a widow in the village. He told me that the village headman at that time could not manage to convince villagers to make such a contribution. He, as the abbot, took this responsibility and he achieved agreement, which made tap water available in the village.

The tap water system was managed by a selected group of villagers. A water fee was set by this group to run the system. The major expense was the electricity fee for water pumping, which cost the customers about 3-4 *baht* per cubic metre per month on average. In 1992 the system was transferred to the local waterworks organisation (*Kaan Prapaa suan Phumiphaak*).

In 1995, during my data collection, the water supply was transferred again to the municipal waterworks system. In this system the villagers paid 8 *baht* per cubic metre of water per month, the same rate as people in the town. Under the new system, a new main line system had to be launched at the expense of the villagers. The key informant told me “It was the failure of the village tap water system because no one wanted to take responsibility. It was also the failure of management, and inadequate control systems” (Fieldnotes, December 4, 1994).²

The last selected programme was the drug revolving fund. The basic concept of the programme was to establish a community financial resource and to make essential drugs available in the village as outlined in chapter two. It was organised through the health volunteer scheme.

3. The Drug Revolving Fund

In 1982, the volunteer scheme policy was first launched in this village. Ten village health communicators (VHC) were selected by health workers who worked in a health centre in a nearby village. Later on, a village health volunteer was selected by and among VHC as the group leader. The key informant was the village health volunteer who was responsible for the drug revolving fund and the drug depot was set up in her own house. She told me:

After the training the health worker told us to try to set up a drug revolving fund as in other villages. All of us helped to inform and persuade people to buy a 10-*baht* share. I collected all the money and did all the management, such as keeping accounts, buying medicines, arranging volunteers to take turns selling drugs. Two years later it had completely collapsed. There was no income since hardly anyone came to buy drugs. Some drugs were expired and thrown away. Afterwards I resigned because my only daughter died of dengue hemorrhagic fever.

(Fieldnotes, January 12, 1995)

² Compare this village with *Baan Sa Aad*, a neighbouring village three kilometres to the west, where the tap water system was started in the same period, which was able to set up the fund and had accumulated 300,000 *baht*. The system was totally managed by villagers. The water fee was 4 *baht* per cubic metre per month. The key person was a well-to-do and a respected person in the village who held the chair of the waterworks committee. The committee were selected by villagers. Among them, one was assigned to record the amount of water used by each household every month and write down the bills. Another was assigned to be a bill collector, both of them received a commission for doing these jobs.

I asked her opinion as to the reason for the collapse. She responded:

This village was very close to town, when people get sick the well-to-do go to see doctors in town, either in hospitals or private clinics. Only the poor go to the health centre. There they can see health personnel who are trained, knowledgeable. But for us, the volunteers, people thought we know as much as they do. Only short-course training won't make any difference. People do not trust the volunteers. In fact, it is the nature of people in this village that they do not appreciate others, especially those who were working for them.

(Fieldnotes, January 12, 1995)

An analysis of these three case studies of former development projects in the study village was undertaken to assess whether there was any history of community participation. The evaluation was based on the criteria and the instrument proposed by Rifkin, Muller and Bichmann previously described in chapter five. They identified five factors which contribute to community participation: needs assessment, leadership, organisation, resource mobilisation, and management (Rifkin, Muller & Bichmann, 1988).

The result of the analysis showed that the village community did not participate, in a genuine sense, in the former development projects. With respect to the first factor, needs assessment, all of the projects were imposed by the authorities rather than by the community itself. The second factor was leadership structure in that community; whether the structure of community leadership was represented by some specific groups, such as community elites or it was opened for all socioeconomic groups. Two out of three of the projects under study showed the leadership structure in the village was confined to the well-off. This limited the projects' prospects for wider participation which in turn limited the benefits to the majority of villagers or for the poor. The third factor was organisation. Ideally, organisations should be created by members of the community to deal with a health problem they themselves have identified as being of prime importance. The example of the drug revolving fund demonstrated that it was not based on the community need which made it very difficult to implement successfully. With respect to the factor of resource mobilisation, there were some successes in mobilising resources for particular development programmes but these were in response to government programmes rather than directed to solving the community's problems. Thus, the consequences were that there was no shared commitment of community

resources; money, manpower, materials, and also a lack of flexibility which could be exercised in deciding how these resources could be used. With respect to the last factor, management, the failure of the drug revolving fund and the village tap water system programme indicated the limitation of community potential to self-manage and be responsible for the projects which had been implemented.

Further understanding of the existing situation came from an exploration of how the concept of community participation was perceived among different groups of people - what this word meant to them. The groups selected to be studied were the formal village leaders, the health workers, the VHV and villagers.

PERCEPTIONS OF COMMUNITY PARTICIPATION IN HEALTH

1. Village Leaders

The exploration of the village leaders' perceptions was derived from informal individual discussion and observation. The formal village leaders thought health problems were none of their business, but saw them as the responsibility of the health workers and VHV. During my observation at one of the subdistrict council meetings a policy to encourage decentralisation was announced; a community could propose its own project to get financial support from the provincial administrative office. It was stated clearly that any projects that dealt with improvement of the community environment, such as garbage disposal management, would be prioritised. However, none of members of the council were interested in this type of activity.

2. Health Workers

The health workers' perception was obtained from discussion both in informal talking and in formal meetings. Their behaviour was also observed to validate their perception.

In the beginning of my data collection the health workers proposed that they wanted to join with my research. I responded that they were welcome to join. In fact, it was necessary for them to join because they knew the situation better than I did. However, I understood clearly that the underlying reason for their request was that they needed to be involved in research work to achieve special promotion rather than that they had an inherent interest in the research itself. Research work has been identified as a key

criterion for the evaluation and reward system for personnel promotion. I took this opportunity to inform them that my topic was about community participation in health. Therefore, at the outset I had to know what was their perception of this concept. We set an afternoon session once a week, when the clinic was less busy, for this discussion.

Community participation, in their opinion, meant that villagers cooperate in all activities. From their perspectives, the VHV scheme had nothing to do with the concept of community participation, rather they believed it was set up to help the health workers with their work. They believed that the VHV should take full responsibility for primary health care in the village but admitted they did not know how to make this happen. Thus the major problem they mentioned was that VHV did not help or participate in health activities as much as they expected. The health workers stated:

The VHV think all the jobs are our responsibility. But we want them to realise that the jobs, particularly the PHC, is their job not ours. But we don't know how to make this happen. However, we do not quite agree with everything the MOPH has said: not all PHC activities should be left for the VHV. Some are too difficult for them to handle, such as management and presentation of the village background information, or updating such data.

(Fieldnotes, December 29, 1994)

The health workers concentrated more on curative services rather than health promotion or encouraging community participation since they realised that their own credibility, status and prestige rested directly on their ability to dispense medicines and offer treatment.

3. Village Health Volunteers

The perceptions of the VHV about community participation were derived from individual interviews, group discussion and observation. Their responses to the questions as to how they perceived their roles and the reason for being a volunteer were unanimous - that they were there to help the health workers.

None of the VHV had any idea about community participation; they perceived that the role of volunteers was to help health workers with their work. They did whatever the health workers told them to do. It was not surprising in the meeting with VHV in village

A on July 9, 1995, that they told me they should receive allowances for this helping task, apart from getting free medical service for their families. One of them said “what do we get from being volunteers, those who receive a salary use us to do the job for them”. I suggested to them that volunteers were the community leaders who voluntarily worked to help people in the village, not to help the health workers. They were village representatives to negotiate with, or to propose the village problems to the health workers. But this attitude would take time to be changed.

The attitude that the VHV were there to help the health workers arose from the original approach by the health workers. The concept of community participation in health was not clear for them and the intervention strategy was far beyond their understanding and experiences. Therefore, most tasks assigned to the VHV were only to help in the routine activities, such as reporting pregnancies and births, and weighing the children in the nutrition surveillance programme, rather than encouraging the VHV to analyse the problems by themselves. Another example was updating the village census; every time there was a request from MOPH the VHV were asked to do the survey. Most of the surveys undertaken were not continuously kept and used in a meaningful way to show the village picture or problem. Once the survey was conducted, the VHV handed it to health workers and the task was finished. From an empowerment perspective the VHV should be the ones who kept the record and should be taught to use it properly, for example, as baseline information for problem analysis, or for updating instead of undertaking a resurvey when data was next required.

The VHV response to my question as to their reasons for being a volunteer were because they wanted to have more knowledge, and to go out for social activities; although in the health workers' opinion, the major reason was to get free health care service for themselves and for their families.

4. The Villagers

The information about the villagers' perception of participation in health was gathered through informal interviews. During my occasional visits the interviewee was asked questions such as what this word meant to them, how they managed illness in their families, how often they used the service of an injection man, and what caused good health? In addition, observation of the patients' behaviour at the health centre clinic was another source of information. I came to the conclusion that the villagers were very dependent on the health care system and medicine, injectable medications in particular, as illustrated by the following examples.

On the morning of April 17, 1995, while I was observing in the health centre, four out of sixteen clients who turned up asked for intravenous fluid infusions and injections. The first client was a man in his early fifties, a worker in a nearby plant, who told the health worker he did not have any health problems, only he wanted an infusion to make him feel strong. He also asked for intravenous protein but the health worker replied there was none of this type of protein available in the health centre. The health worker explained to him that the intravenous fluid would not help, instead he himself should eat nutritious foods and get enough rest. He insisted he wanted it and said that he used to feel "strong" after an infusion.

The second client was 62 year-old woman whose complaint was dizziness and weakness, she too wanted an infusion. The health worker explained the same thing to her, but she insisted every time the symptom occurred it was cured by infusion. The health worker came up with 500 millilitre 5% Dextrose Solution bottle, but she asked for a 1000 millilitre one. That same evening her daughter came to pick her up from the health centre and remonstrated with the health worker as she had not added any vitamins to the infusion fluid.

The third client was a woman over seventy years of age who was accidentally hit by her son when she tried to stop him quarrelling with his wife a few days previously. She had bruising in her left cheek. She had already been to see the subdistrict doctor and been given some medicines. She thought that oral medicine was not strong enough and delayed relief of her symptoms, so she wanted an infusion. After she left, the health

worker explained to me that villagers always come and ask for infusions in the health centre because those who are under 12 and over 60 years of age could get the service free of charge. The fourth client was a thin postnatal mother, who came with the symptom of dizziness. The health worker gave her a tri-vitamin B injection.

The villagers also used other sources for medicine. There were a few private services available in the village: a *tambon* (subdistrict) doctor and a few injection men. Actually, the position of *tambon* doctor was usually offered to a villager who performed a certain type of healing practice to help people in villages where there were no health centres. The position of *Tambon* doctor entitled the incumbent to be a member of the subdistrict council, and to get regular payment from the district administrative office. The *tambon* doctor in the study village was nominated by the subdistrict headman (*kamnan*) before the health centre was established. The reason of being selection given by health workers and villagers was: "because he is *kamnan's* relative, he does nothing for us, except for his income. Besides, he is a drunkard" (Fieldnotes, December 18, 1994).

There were some "injection men" (*maw cheedya*) who usually travelled to this village. The most popular one was a man in his mid sixties who received field army medical care training and had served in the army for some time. He lived in a nearby village and always visited the study village about once a month. He had regular clients, one of whom said: "I always have an injection once a month to make me strong" (Fieldnotes, December 22, 1994). In addition to that, the health workers themselves also carried out home visits to provide a variety of medicines to supplement their income. This practice was common in most rural areas. The most popular practice was administration of a nourishing injection for postnatal women. In the villagers' opinion, it was a must for every woman after giving birth, to facilitate the recovery period.

The anthropological study of the dengue fever project found that the villagers perceived that illness prevention activities were government officials' responsibility, not theirs. They thought that the health workers who got a regular salary from the government should do this job. According to the team's opinion, this expectation stemmed from government initiated intervention in the past, such as ABATE distribution, and chemical spraying, which did not encourage the community to participate (Smutkupt, et al. 1993).

In summary, the villagers in the study village were very dependent on others for their health needs. The dependence is the consequence of the development of the state health care delivery system in Thailand, wherein the state law did not certify traditional healers. Curing of diseases became the monopoly of the medical profession. The medical education system itself was also dependent on Western culture in terms of technologies, instruments and medicines (Nartsupha, 1992). Eventually, people forgot their rights and abilities to participate in solving their own health problems; if they were sick they had to see doctors to cure diseases.

I decided that the health workers were the key to the translation of community participation in health at the practice level, however it appeared that they did not understand the genuine theoretical and practice concept of community participation. All of the programmes or activities implemented by the health workers were conducted according to the directives of the provincial health office rather than aiming to solve village issues or their own problems. I decided to work with the health workers to see if I could assist them realise that they could involve the community more in health issues in the study village.

PARTICIPATORY RESEARCH PROCESS

Participatory research was employed by talking with the health workers and the VHV as they carried out their daily routine work, or whenever I found it was applicable, in order to encourage health workers and VHV to think about their problems, to identify causes of the problems, and ways to handle the problems. The aim of this approach was to raise their awareness. The following section outlines a series of interventions in health activities for which the health workers were responsible during the 12 month period of fieldwork.

1. Latrine Coverage

The policy of latrine coverage was launched in the First National Health Plan and continued to the present plan in order to diminish enteric endemic and parasitic diseases. Various types of incentives were presented to the district or province to attain 100% coverage. But in Khon Kaen Province the goal was still far from being reached.

In December 1994, the provincial health office developed a goal to achieve 100% coverage of latrines for every household in every village in the *Muang* District, where the study village was located. There were seven households in village A and only one in village B without latrines. The reasons for not having latrines in village A were that two families were too poor to afford them, while in the remaining five households the houses were temporary and the owners planned to build new ones.

The only household without a latrine in village B was the house of a 73 year old woman. The house was in a very poor condition, and was built on somebody else's land who kindly allowed her to live there and when she died the land would be taken back. The block was very small, only enough for the house. The house was raised up about two-metres high from the ground, where she could keep some chickens underneath. Being by herself without regular income meant her life was very difficult. All food was given to her by the well-off neighbour, who also paid her electricity bill and allowed her to use the latrine. She could not afford to build a latrine, even though there was a subsidy from the health centre, however the health workers tried to force her. In my opinion, the most important criterion should be that every individual had access to a latrine. But in their opinion, each numbered household must have a latrine of its own. The one household without a latrine meant they were unable to claim total coverage for this village.

In March, we were able to claim the total coverage of latrines in village B after we found there was an alternative criterion: that the ratio of people per latrine was 6:1. In this case, the coverage was achieved because there were four members in the neighbouring family. Note that the focus throughout this exercise was on the meeting of government goals, rather than on finding community solutions to community health problems.

2. Mumps

During January 1995 there were a few first grade school children who came to the health centre with mumps. Within one week the number of infected cases had increased and spread to other classes. By the end of the month those infected included mothers, other siblings and relatives who lived in the same households. A mother with a little baby came in and asked whether she should isolate her school-aged child with her mother in an attempt to prevent the baby getting measles. Many more questions were asked.

I talked to the health workers and proposed that we should consider the disease incidence was an epidemic. I suggested we should do something to handle the situation, rather than just keeping records and routinely reporting to the district health office at the end of every month. We could use the data, not only collect them. I discussed with them what I thought we could do to handle the situation.

I reviewed the basic information about mumps, such as the incubation period, the early signs and symptoms, how to take care of oneself when infected, disease transmission, as well as who was at risk. This information was distributed to different sources including the school teachers to announce to every class, and both village headmen to announce via the village broadcasts. One copy was posted at the health centre for whoever dropped by to read. I insisted it was the way that they could make use of their own information and do something to solve community problems. But the health workers just listened.

Three months later, the district health office announced there was a mumps epidemic in the study village, but by that time the actual situation was already relieved. From my understanding, the health workers were reluctant to take any initiatives for three reasons. Firstly, this type of action was new for them. Normally, announcing a disease epidemic was the responsibility of the district health office; the health workers' task was just to collect and report the figures. Secondly, any intervention in the actual situation, could only be done after the authority had approved. They were accustomed to a system in which activities were designed for them. And thirdly, announcing a disease epidemic implied there was problem out of control in the area under their responsibility and therefore reflected badly on them.

3. Preparation for Being Supervised

At the monthly meeting at the district health office in February 1995, the health worker in charge was informed that five health centres would be selected to be supervised. However, every centre had to get ready because the selection would be done randomly and the selected centres would be notified only a few days before the actual supervision took place. The supervision team were personnel from the district and provincial health offices. Therefore, this supervision implied two things; it was a routine annual evaluation

for promotion, and a competition among health centres in the province. It was important for the health workers to give as good an impression to the team as possible.

Preparation included preparing a pamphlet to summarise what they had done during the past year. The resume included records about the provision of basic health services, such as immunisation, the coverage of the maternal and child health service, nutritional surveillance, and others. Display boards to show baseline information and the Basic Minimum Needs Survey of the village were also necessary, as the health workers had learned from a one-day visit to the health centre which won the competition last year. The time schedule was very tight since they had only few weeks to prepare all the data and the displays. Thus, I offered to help by summarising the immunisation data as I had experience doing research on this subject.

Being aware that there were some practical considerations about reporting immunisation coverage, I talked to them about which criteria I would use. First, complete immunisation for a child meant an individual child was followed up to make sure he or she received the following immunisations according to the state recommendation scheme during the first year of life: one dose of BCG vaccine; three shots of diphtheria, pertussis and tetanus vaccine and three doses of oral polio vaccine (DPT & OPV); one shot of measles vaccine; and three shots of vaccine for viral hepatitis B. Second, the target children were those who resided in the particular village. If any child who resided in the village received immunisation elsewhere, the record must be kept up to date to make sure each child had a complete vaccination. Third, the target group was children born last year; children age 1-2 years at the time of report; not children under one year or born in that year. This would help to justify the “completeness” of vaccination received. Besides, “year” meant the Thai fiscal year - from October 1 to September 30 of the following year rather than the calendar year or calculating by using a child’s birthdate. The reason for this timeframe was to make this report accord with the other routine systems so as to be able to make comparisons. And fourth, the denominator for calculating coverage was the number of children actually resident in the village at the moment of the report summary. If any children had moved out of the village they had to be discharged from the target list. On the other hand, those who had moved in had to be included and their immunisation record must be kept up to date.

I found that in the 1993 fiscal year at least 97% of children in village A and B had received complete immunisation. The immunisation with the lowest compliance was the third shot of hepatitis B vaccine, and the trend was upward during the last three years as shown in table 2 below.

Table 4 Children Immunisation Coverage in Village A and B

Time	Total born	BCG	Measles	DPT & OPV			Hepatitis B			Remarks
				1 st	2 nd	3 rd	1 st	2 nd	3 rd	
Fiscal year 1991 (Oct.1991-Sept.1992)	137	137/137 100%	96/105 91.4%	133/135 98.5%	133/135 98.5%	100/105 95.2%	132/135 97.8%	128/135 94.8%	96/105 91.4%	- 4 moved out - 28 were discharged due to the new health centre was built
Fiscal year 1992 (Oct.1992-Sept.1993)	98	98/98 100%	92/95 96.1%	98/98 100%	93/95 97.8%	93/95 97.8%	98/98 100%	93/95 97.8%	93/95 97.8%	- 3 moved out
Fiscal year 1993 (Oct.1993-Sept.1994)	111	111/111 100%	111/111 100%	111/111 100%	111/111 100%	108/108 100%	111/111 100%	110/111 99.1%	105/108 97.2%	- 3 moved out

This finding was in contrast to the figure of 75% coverage calculated for these two villages by the district health office. This was because the district health office used the expected target group as a denominator. The number of the target group was calculated from multiplying the total village population by a national birth rate.

Unbelievably (from my perspective), they asked me to put 75% in the pamphlet though I discussed with them that my data could be traced back for reliability. I assured them that they had done their best. They had every right to claim this credit instead of being labelled with such a low productivity rate. Besides, knowing the real situation would help them to plan their activities appropriately. The high immunisation coverage indicated people understood the need and brought their children for immunisation, thus this activity should be left for systemic routine monitoring and they could concentrate their efforts to work out other problems.

I also suggested that the annual plan of health centre activities was not used properly. The plan showed routine activities rather than being used to guide the actual activities and for evaluation as it should be. For instance, activities for communicable disease control were put under the general term "communicable disease control" and activities were expected all year round, instead of prioritising what diseases were endemic and

what specific activities should be identified accordingly. For example, if dengue fever was determined as a priority problem, then distributing ABATE would be required every three months. However, my suggestions were not accepted and no change was made. No reason was given, they told me “never mind, just leave it like that”.

4. CPHCC Activities

The policy of establishing Community Primary Health Care Centres (CPHCC) was launched in 1992 to provide an office for the VHV and a centre for other PHC activities. Criteria for setting up CPHCC were that there was a place available, the centre must carry out some PHC activities, and the health workers had to supervise to the VHV at least once a month.

In villages A and B, two CPHCC were set up in the houses of the VHV heads in each village and the only activity was as a drug depot. Drugs supplied by the health centre were put in the drug depots, in spite of the failure of the drug revolving fund some years ago. The result was as expected; villagers hardly used the drug depot service. After establishing good relationships with them, I asked the health workers why they had not discontinued the drug depot. I had already checked with the supervision team and the answer was confirmed that a wide range of activities were possible to fit community needs and problems. To my question, the health workers answered “Just leave it there, it is already set up and won't be good to give up”. I understood very well that once it was established it was counted as a quantitative success although it did not work. The VHV themselves did not agree with setting up drug depots, but their response to my question was “it was the health workers who wanted us to do it”.

The required monthly supervision was recorded to demonstrate that it had been done regularly, and the VHV in villages A and B signed on the form that they received supervision. But in fact it was just a monthly meeting held at the health centre and it was just a repetition of what the health workers heard in their monthly meeting in the district health office.

5. The Non-Communicable Disease Control Programme

In May 1995, the health centre was informed that the provincial health office had set up a Non-Communicable Disease Control Programme. The programme focused on three major diseases: diabetes, hypertension, and cervical cancer. This programme was to be carried out during March-September 1995. The stated aims of the programme were case finding, health education and disease prevention. A problem arose because each disease had its own target group; for the first two diseases the target groups were people over forty and obese, or those who had family history of such diseases, whilst the target group for the latter was married women aged 15-44 years (see also chapter six).

This programme created extra work for the health workers who were already overburdened. The screening and health education activities for diabetes and hypertension were carried out by arranging mobile services for one day in each village. The villagers were informed via the village broadcast system a few days before the mobile team moved to that specific village. For cervical cancer screening, they had to pool health workers in the same zone rotating to help in each health centre to do cervical smears. Then the number of clients examined were summarised and reported to the district health office.

I shared with them my opinion of some aspects of this programme. First, such a report was not adequate to give a real picture of disease prevalence in each village, since it covered only those who turned up on those days, but not about the rest who did present. Besides, it reported the absolute number of clients being screened rather than disease prevalence which would enable them to make comparisons between times, villages and diseases. The disease prevalence was calculated as the percentage of people who had the disease out of the total target population. My point was that the target population for each group was essential background information; it was necessary to set up a system of keeping and updating this data. But this was beyond their ability to decide, and perhaps too difficult for them to handle, both to think about this issue or establishing the updated system.

Second, for me this project could actually provide only case finding rather than health education or disease prevention as was stated in the proposal. I questioned the

appropriateness of the latter two activities at this stage when clients did not yet have a confirmed diagnosis. In addition, health workers would rather spend time case finding from which they could benefit when being evaluated.

Practically, these types of activities could possibly be integrated into routine work with much less time and manpower spent. For instance in detecting cases of diabetes and hypertension, the most important information which should be provided was clear criteria for each disease for the health workers. With these criteria it would be easy for them to monitor, and give health education to, the at risk groups. The health worker or VHV knew all the villagers very well, including those who had a family history of the disease, or who were at risk according to the criteria. Furthermore, integrating screening and health education into a routine work basis would enable them to start compiling a list of the at risk group, which could guide follow up services rather than doing snap-shot activities.

6. Family Folder Census and Working with Village Health Volunteers.

In mid June, the Ministry of Public Health wanted to revise the family folder record; the birthdate of each member was to be added in order to know their exact age. This meant health workers had to do another household survey, and it was required to be finished by the end of June. I asked the health workers what their plan was. They planned to complete it by themselves. In my opinion, the family folder survey would provide very useful baseline data, if only it could be updated regularly. Updating it was a big burden for health workers. On a contrary, it was an easy task for the VHV, since they knew very well what was going on in the area they were responsible for, who was married, pregnant, died or had a baby, and so on. I suggested asking the VHV to do this job and taking this opportunity to inform them how important it was and how to handle it. We discussed it, and my idea was supported. Later on the task was explained to the VHV, and they were willing to help.

I started by deciding on a definite area for which each VHV was responsible and communicated this to them. After that a copy of the village map with the area coloured for which each VHV was responsible was handed to each of them. After two weeks the health worker who was responsible for village A and I followed up the VHV and

discussed problems with them. Two out of fifteen VHV in village A, who could not read and write, paid someone to do the task for them, one resigned because she did not have time to carry out the work.

All the family folders were taken back to the health centre, but in my opinion the VHV should keep their original forms; the forms belonged to them and from this record they should be trained to understand the significance and how to update them.

At the end of June the health worker who was responsible for village A had to shift to the district health office. I offered to take her place to work with VHV in village A. I took this opportunity to call a meeting. Hereby I learned how they felt, their attitudes about their roles and responsibilities, and much more.

During the second meeting with VHV in village A, they told me that there was an encephalitis patient in the village who was admitted to the hospital. Consequently, it was suggested that children under 14 years old in the village be vaccinated. Since this vaccine was not in the national immunisation policy, parents had to pay for it. Children were taken to be vaccinated at the hospital in town which was inconvenient for parents. Finally, we were able to give the vaccine at the health centre, which was more convenient for parents and saved time and money for travelling. I assured the VHV that they performed their role perfectly.

In the same meeting they complained about illiteracy. A few of them admitted that they could not read and write, although they knew the alphabet. I contacted the organisation responsible, but it was not possible to get this service in the village, thus I decided to do it by myself. The class was held at the health centre, starting from the beginning of July. There was only one student who regularly came to my class, but I still continued doing it. It took a few months for her to learn to read and write the basics, then I told her that she could continue practising herself.

ANALYSIS OF THE SITUATION

In my opinion, dealing with VHV was beyond the understanding of the health workers. This was due to inadequate and inappropriate training, as well as the lack of examples to

guide their practice. They lacked the skills necessary to communicate, monitor, supervise and evaluate the work of VHV. Implementation of community participation was far beyond the expected role for health workers to fulfill. In other words, they could not be expected to facilitate VHV participation when they themselves were not expected to participate in decision-making about health issues in the community. The situation was maintained by the existing bureaucratic system, as demonstrated in the following section.

First, the beliefs of the village health workers were consistent with those of health personnel in every level: it was the way they were socialised into the system. My discussion with personnel in the health planning section in the provincial health office revealed their belief that it was impossible to expect communities, or even health workers to solve their own problems since both groups were not competent to do such a job. It was my opinion that the perception of higher level personnel at the central level, MOPH, would be consistent with that of the personnel in the provincial office. A review of numerous MOPH guidelines and publications for PHC showed that these did not reflect the concept of participation as set out in the WHO definition (cited in chapter three). For example, the Decade of Health Centre Development Programme, and the Community Primary Health Care Centre (CPHCC) Programme which aimed to build more health centres, were based on an assumption that if the ratio of population per health centre met the criteria of 3,000 per centre, then the quality of the health centre would be improved (Division of Rural Health, MOPH, 1992).

Secondly, the situation has been developed in accordance with the paternalistic and centralised bureaucratic system which was reflected in the type of supervision, evaluation, and reward practices for health workers. The system was set up to reward conformity to top-down directives and guidelines rather than to promote diversity of actions according to each context.

I concluded the health workers were not yet aware that they themselves could change the situation. This was reflected in the silence after our discussions, somewhat *krengchai*, not embarrassing me by disagreeing with me and their expression of “never

mind, just leave it like that". These reflections persisted even after the follow up assessment, one year after the fieldwork.

My discussion with VHV took place both in the role of the researcher and as a health worker. I was optimistic for this group, since there was some behaviour that showed that they were aware that they could have input into changing their situation, particularly in the last few meetings. This assessment was drawn from their complaints about illiteracy problems, asking for encephalitis vaccinations to be given at the health centre instead of taking their children to the hospital in town, and talking more about what they wanted. Though this was not exactly what Freire called "critical awareness" it was a positive sign of awareness. The most important factor, in my opinion, was that they learned to participate in the discussion because they felt they were welcome and their opinions listened to.

People's awareness is assessed by their ability to express an understanding of their own problems, increasing self-confidence for problem sharing and solving (Maguire, 1987), or resisting a return to powerlessness, understanding what might be in their best interests if they were able to make choices (Rees, 1991); or expressions that indicated they have choices or power to change the status quo, such as how they could have done better in relation to the specific situation. The crucial consequence of awareness is that it leads to problem identification; once people are aware of their situation then they are able to know what their problems are about. This is an inherent process that must be undertaken by the people themselves who can decide what their problems are, not by experts or by a process being imposed from outside (Burkey, 1993). Awareness precedes problem identification, and in the timeframe of this study it was not possible to move further than has been described in undertaking participatory research.

SELF REFLECTION

The significance of self reflection at this stage in the study is for me to understand the dynamics of my relationship with the social system under study. It helps me to understand my bias or what Berg and Smith (1988, p. 30) called "my intellectual presuppositions and emotional predispositions". This understanding helps me learn about myself, especially when involved in confronting weaknesses, failures and problems.

In other words, it is the process that enables me to develop self-awareness, which, in turn, helps me understand other-awareness. As Markova describes:

One can become aware of oneself only in so far as one becomes aware of other people. We perceive, interpret and act on the basis of our understanding of each others' thoughts, abilities, emotions, intentions and actions, and at the same time we are aware that others can perceive, interpret and act on the basis of their understanding of our abilities. This mutuality of awareness between our own and other selves leads to more complex forms of interaction involving, *the self, the other person, social groups and social establishment*

(Markova, 1987, p. 10, emphases original)

Although I was born in this culture I am somewhat different from the villagers and the health workers with whom I worked. The differences began with my family background as an urban dweller, and both the education and professionalisation processes have influenced my thoughts and actions. An opportunity to explore the concept of community participation in depth resulted in my conceptualisation being different from other health personnel. Accordingly, the conceptual framework and strategy to implement it were proposed. As an academic, a professional and a researcher, I tried to convince the community to work out my conceptualisation of community participation by using a strategy I proposed, and expected to gain the pre-planned outcomes.

I considered myself as an insider in terms of a health professional and a Northeasterner. Nevertheless, the health workers were not of the same mind. They saw me as an outsider of their group. My ideas and my suggestions were not applicable to them. They told me:

We know that your idea is good but we can not do it. In a real situation there are many problems you have to think about if you do not do it in the way it is expected. There are lots of things to be done, we have to shuffle to get things done according to each set date. We are not like you. For you, you can think whatever you like because in the University you don't have bosses. But if you are involved in the real practice like us you will know it is impossible.

(Fieldnotes, May 15, 1995)

I understand that the background training and socialisation of the health workers in their careers have influenced their mechanical behaviour. The majority of them were from a rural background before they entered the midwifery schools. The content orientated training concentrates on how to do the job rather than stressing why the job should be done. Such a curriculum has been grounded in the need to accelerate health manpower

development to alleviate the high infant mortality rate since World War II. After graduation, they are socialised to this specific career environment, how to behave and how to run their lives. In addition the patron-client relationship and highly top-down bureaucracy gradually influences them to conform to the group norms otherwise their future careers would be affected.

One day the health worker who was in charge of the health centre told me that the provincial chief medical officer called her into his office. He said she should adjust the reports according to what I had suggested. She did not have to worry because he had already told the district health officer to exclude this health centre out of the routine reporting system during my study. I had to make myself clear to both of them, the health worker and the district health officer, that they did not have to agree with everything I said. In fact, I wanted to know what their ideas and what their problems were. It was significant for us to discuss, and for them to decide themselves what they should do (Fieldnotes, March 7, 1995).

A literature review of indigenous psychology provided me with a profound understanding of the health workers' behaviour. Ho (1993) proposed a relational orientation as the conceptual framework to explain what it means to be human throughout an individual's life time for an Asian. This conceptualisation recognises the primary importance of the relational contexts within which social behaviour takes place and, as such, derives its meaning only from the co-existence of other individuals. Without others, the very notion of identity loses meaning. In this sense, Asian conceptualisations of social existence are relationship centred, in contrast to Western conceptualisations, which tend to be individual centred. In Asian cultures, social behaviour is characterised by a high degree of other directedness pervading a wider domain of social interactions and actions in diverse situations, primary social sanctions, and avoidance of social disapproval. If the main concern is to be socially accepted, the imperative is to avoid being disapproved of. That means that one must be sensitive to social norms and act cautiously so as not to violate them. The normative pattern of social interaction is the maintenance of harmony and smoothness and the avoidance of open conflict. To this extent, the self is not an individualistic self, but is group-orientated, which is characterised by conformity not self-assertion (Ho, 1993).

CONCLUSION

This chapter has outlined the exploratory process of empowerment through participatory research undertaken in this study. The process started by examining the history of community participation in previous development projects in the study village and the perception of selected groups towards community participation in health. The results showed that participant groups did not understand the genuine concept of participation. Nor were they aware of their power to change the status quo; this was particularly so for the health workers, though the VHV group showed some positive signs of awareness of the possibility of change.

The results shown in this chapter illustrate the influence of sociocultural factors on people's perception and practice of community participation. The patron-client relationship, centralised bureaucracy, weakened formal community leaders and the individualism resulted from changing to wage-earning livelihood were the factors discouraging participation in the study village.

As awareness precedes problem identification in participatory research, it was not possible to move further than has been described in the timeframe of this study. This chapter concluded with an analysis and reflection on my own role in the study.

The following chapter describes my concurrent involvement in the dengue fever control project in the study village, a process which used action research applied to a specific health problem which was identified by outsiders rather than by the villagers themselves.

CHAPTER EIGHT

ACTION RESEARCH TO SOLVE A SELECTED HEALTH PROBLEM

The application of participatory research methods using an empowerment approach as described in the previous chapter did not seem promising. Prior to entering the field, I had expected problem issues to be identified after the first stage of the study. After applying participatory research methodology I came to realise that this expectation was unrealistic within the timeframe of 12 months fieldwork, given the history of the study village with respect to community participation in health and development projects and the lack of readiness of the study participants to envisage other ways of working to achieve community participation in health. I therefore decided to work with the dengue fever control project which was already implemented in that particular village and with which I had been involved prior to undertaking this study. Involvement in the dengue project took place concurrently with my other work in the study village during the second half of my year of fieldwork.

I considered that the approach used in the dengue fever control project was the application of action research. The reasons were that the project was designed by the researchers, and the ideology was centred on solving problems and enhancing peoples' understanding rather than dealing with social equity or oppression (as indicated in chapter four). This project was a SPHC approach because the problem was specified beforehand and by the outsiders (as detailed in the discussion of the SPHC approach indicated in chapter two). According to Oakley's interpretation of CIH practice this approach provided the community with access to information and knowledge of health projects (as indicated in chapter three). This chapter describes the details of project intervention during March - August 1995.

THE DENGUE FEVER CONTROL PROJECT

There has been growing recognition of the significance of community participation to control mosquito breeding places in dengue fever control (see chapter two). However, strategies for achieving community participation have not yet been identified, particularly

in Thailand where the control activities to date have mainly used a “top-down” approach. Therefore, this project aimed to develop models to encourage community participation in controlling dengue fever. The research team members were from different disciplines and included entomologists, anthropologists, a community health nurse (myself), public health personnel and a physician. The project was supported by the Thailand Health Research Institute, a non-government funded organisation. The project started in January 1993, when an entomological study was carried out to provide baseline information about mosquito breeding places. Later on, an anthropological study was started to understand the community’s perception and practice about the disease. The intervention stage to identify models to generate community participation was planned to follow the first two stages once the information from those studies was available. At the outset I was a member of this research team and was allocated responsibility for the intervention activities, however I went to New Zealand to commence my own doctoral study in 1994.

ACTION RESEARCH PROCESS

According to Brown and Tandon’s analysis the dengue control project would be classified as utilising action research methodology rather than participatory research methods, for the following reasons. The ideological perspective of this project was to solve the problem of dengue outbreak. The project was designed by authorities, the researchers and the chief of the communicable disease control section in the provincial health office. The purpose of this project was to identify a model of control which would enable the community to participate in the control measures. This was because there was increasing recognition of the importance of the concept of community participation and the bottom-up approach to control mosquito larvae. The researchers believed that if the villagers were supplied with appropriate and sufficient information they would participate with this project so as to protect their children from this disease.

The implementation phase of the dengue control project was first introduced in a routine VHV monthly meeting in March 1995. It was a regular meeting for volunteers in villages A and B, which was held on the second Monday of the month. The principal investigator of the dengue project, who was a paediatrician from Khon Kaen University (hereafter referred as the researcher), presented the results of the entomological survey.

He showed various mosquito breeding places found in the village. The differences between *Aedes aegypti* and other types of mosquito in terms of breeding places, biting behaviour, and their role as vectors of different diseases, were clarified. The aim of the presentation was to encourage discussion in order to identify appropriate and acceptable control measures. The discussion was a lot of fun because the VHV could recognise the locations of the places shown in the slides.

From the discussion, it was agreed that ABATE seemed to be the best way, because it was introduced more than ten years ago and was believed to be widely accepted by the villagers. But the health workers complained that they could not get sufficient quantities of ABATE for distribution. They got one 25 kilogram drum from the district health office every three months to distribute in the five villages under their responsibility, whereas they estimated about three drums were needed just for villages A and B.

After that meeting a health worker, the researcher and I went to see the teacher who was responsible for health programmes in the school to inquire what control activities had been carried out. In Thailand dengue control programmes involve collaboration between the MOPH and the Ministry of Education to get school children to help. School children may be asked to survey mosquito breeding places in their houses, join a campaign to destroy breeding places, and distribute ABATE. The teachers told us that nothing was done at that time because it was not the rainy season. The researcher reminded her about placing ABATE in open water containers in school bathrooms which needed to be done regularly even when it was not the rainy season.

In the second meeting the researcher asked whether there were any problems with distributing ABATE during the last month or any other problems. No one mentioned any problems. Then I raised the problem of how much of ABATE should be placed in a plastic bag if it was to be used economically. Normally, ABATE came in a 25-kg drum. Small plastic bags had to be filled, then sealed, and the bag needed before placing it in water containers to let water seep through and let the chemical substance disperse. I observed that there was no standard as to how much ABATE should be placed in a bag.

Actually, there was a recommendation by the MOPH, but that was not consulted. Eventually we reached agreement that each bag had to be filled with 20 grams of ABATE (about 2-teaspoons full) and placed in a standard container (about 100 litres) and it would last for 3-4 months.

A health worker mentioned the use of plastic mosquito nets to cover drinking water jars which was widely practised in other villages. This type of jar was very big (about 400-800 litres), so it was called a jumbo jar. Almost every household owned this type of container because it was funded from the village water tank fund, and was used for collecting rain water for drinking. Usually, villagers did not like to place ABATE in their drinking water, because they tried to avoid taking chemical substances. Mosquito net was a perfect measure for this type of container, since the jar had a faucet at its bottom to let water out without opening the lid. In addition, the net could prevent leaves and small lizards from falling into the jars. We agreed that each VHV should ask each household in his or her area of responsibility whether it was needed, and I would find out a way to get it at the cheapest price.

At the third meeting in May, the researcher brought three drums of ABATE, which was supplied by the research project. He still was not sure whether this amount would be enough. He insisted it was necessary to know the exact number of water containers in the village, thus he asked each VHV to do a survey in their own area, to find out how many water containers each household had. During this meeting, I reported on three items. First the net survey, only 7 VHV out of a total of 24 had reported the number of mosquito nets wanted, and all of them were from village B. I needed more information.

Second, there was a mosquito net factory 10 kilometres from the village, where we could get it at a cheaper price, but we had to buy it in multiples of ten 25-yard rolls. Purchasing the net in this way, the average price per metre would be 8 *baht*, compared to 15 *baht* if bought from a shop in town.

Third, I also reported what I had found while accompanying entomological workers conducting a larval site survey in the end of previous month. There were a number of

households which did not have ABATE in their water containers. We needed to know exactly what the reasons were; was ABATE unacceptable or unattainable, and why.

During the lunch time of that meeting day, I had a discussion with the health workers. I thought it might be a distribution problem which contributed to a low rate of ABATE use, because only VHV who joined the meeting were given ABATE to be distributed, while those who did not attend the meeting and did not come to the centre would not get it. I proposed the idea of allowing villagers to get it directly from the centre, but the health workers did not agree. Their reasons were that it would create the same problems for those villagers who did not contact the centre, besides, the current system of distribution created pride and prestige for the VHV and also minimised the workload of the centre. I agreed with their idea, but still we had to find a way to achieve a better distribution.

At the fourth meeting in June, I reported there were 279 pieces (1x1.2 metre) of nylon net sold. Most of them were taken by VHV in village B. There was only one village health volunteer in village A who ordered 84 pieces. Later I found out that the VHV leader in village A did not bother asking. He was afraid of being criticised that we were doing business or gaining advantage from these sales, apart from which he did not want to get involved in collecting money. I told them that there was no profit made from this activity; I could show the bill. Instead, we did this because it was our job to prevent the children from getting the disease, and it was for the benefit of the people.

In July, the fifth meeting, I reported that a total of 629 pieces of nylon net had been sold. I reminded them that I had only a few responses about the water container survey; 5 out of 15 from village A, and 8 of 9 from village B. I also reminded them that this information was important to estimate the amount of ABATE needed, and to be used as baseline data for ABATE distribution.

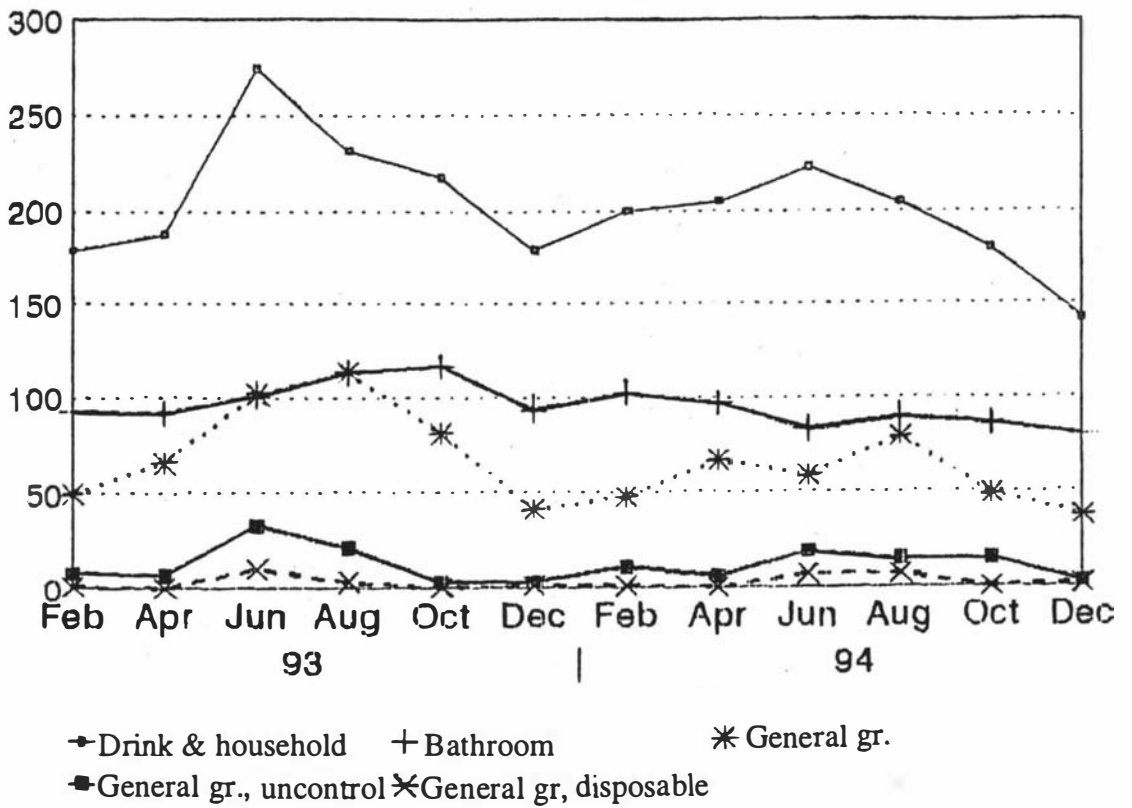
From the survey data available, I calculated the average number of water containers per household was 5.39. The total number of containers was estimated from multiplying the total number of households by the average number of containers per household (5.39 x 900); it was about 4,860 containers. If we could make 1,250 bags of ABATE from one

drum, (25 kgs. at 20 gm./bag), then we probably needed 4 drums of ABATE each time. This amount was for villages A and B only. It was not possible to get this amount from the regular system. My question was - how we were going to manage after the dengue project was withdrawn? Then the researcher had an idea that the water container survey should specify how many containers were already covered, then we could save on the amount of ABATE used. He asked the VHV to resurvey these data.

Later on, I showed them the graph prepared by the entomologists as shown in figure 3 below. The graph showed that the rate of ABATE used in bathroom containers had not changed much despite the fact that it seemed that the village acceptance of ABATE for this category of container was high. The research team proposed that if the index of positive bathroom containers was brought down it could possibly improve the overall entomological indexes. The possibility of success in lowering this index was rather high because of high acceptance of ABATE for this type of container. In fact, ABATE was the best control measure for this type of container which was a concrete tub attached to the bathroom wall so it was not possible to find a proper lid to cover it. Besides, it was not practical to cover it because water was taken from it very frequently. We came to a conclusion that we would give priority to encouraging the use of ABATE in bathroom containers.

The sixth meeting was held in August, however only 5 VHV from village A attended; the VHV in village B informed the health workers beforehand that they would not be available on that day. Afterwards, I found out that the most important reason for them not coming to the meeting was because they were upset. They came on the regular meeting day but then realised that the meeting was cancelled without notice, because the health workers were busy. Those who came on that day were asked to help with the physical screening of school children instead.

Fig.3 Breteau Index by Types of Containers in the Study Village (1993-1994)



There were no important discussions in this meeting because it was the last month of the intervention. At the end I summarised what we had done so far. I informed them that this was the last meeting for me, because my time in the village was running out, but the entomological study would be continued for one year. The next month's meeting would be cancelled since it was the end of the fiscal year; the health workers would be busy completing all the records and reports. I thanked them all for their co-operation and said I hoped I could come back to the village again.

After I left the project to return to New Zealand the researcher carried on providing ABATE and following up. The routine prevention activities were left for the health workers to integrate into their routine work. The entomological study was carried on for one year after the intervention finished for the purpose of evaluation.

EVALUATION

There were two types of evaluation in this project. First, to assess whether the primary objective or goal of the project was obtained, and second, to assess whether the community had participated according to the purpose of the project. The following sections discuss the details of the evaluation.

1. Programme Goal Evaluation

The primary goal of the dengue project was to reduce mosquito breeding places in order to reduce outbreaks of disease. An entomological study was undertaken in February 1993, a year before the project started, in order to formulate baseline data for comparison. Specific indexes selected were the house index, container index, Breteau index, landing index and biting index¹. The survey was conducted every two months by the same field workers in each area. They walked around each house and spotted whether there were any containers in which water was collected and then examined whether there were mosquito larvae or pupae in each container, both inside and outside each house. Due to the limitations of money and manpower, only households in village B were systematically selected for entomological study. The total number of households under study was 150.

The survey was continued regularly for one year following the intervention stage. The data showed the number of positive larval sites decreased from the beginning of the project, and from the intervention period (during March-August 1995), as shown in figure 4. Nevertheless, when compared with the control village (figure 5), it was found

¹The followings are indexes for detecting or monitoring larval and adult mosquito populations. The basic sampling unit is the house or premises, which is systematically searched for water-holding containers. These containers are examined for the presence of mosquito larvae and pupae. All containers in each sample houses are examined.

House (premises) index: percentage of houses infested with larvae and/or pupae.

HI=Infested houses/Houses inspected x 100

Container index: percentage of water-holding containers infested with larvae and/or pupae.

CI=Containers positive/Containers inspected x 100

Breteau index: number of positive containers per 100 household inspected.

BI=Number of positive containers/Houses inspected x 100

Landing and biting indexes are landing/biting collections on humans which are sensitive means of detecting low level infestations, but are very labour intensive. Both male and female *A. aegypti* are attracted to humans. Because adults, especially males, have low dispersal rates, their presence can be a reliable indicator of close proximity to hidden larval habitats. Rates of capture, typically using hand nets or land on the collectors, are usually expressed in terms of landing-biting counts per hour (PAHO, 1994, pp.29-30).

that the pattern of decrease for each village was similar, especially, the Breteau index which is shown in figure 6. The control village was a nearby suburban village which was similar in size, having a tap water system and similar villagers' life styles. It was selected as the control from the beginning of the project and an entomological study was conducted parallel to the study village. Therefore, the research team concluded the pattern of decrease was natural, and the dengue project failed to achieve its objectives.

Fig. 4 Breteau Index by Types of Containers in the Study Village (1993-1996)

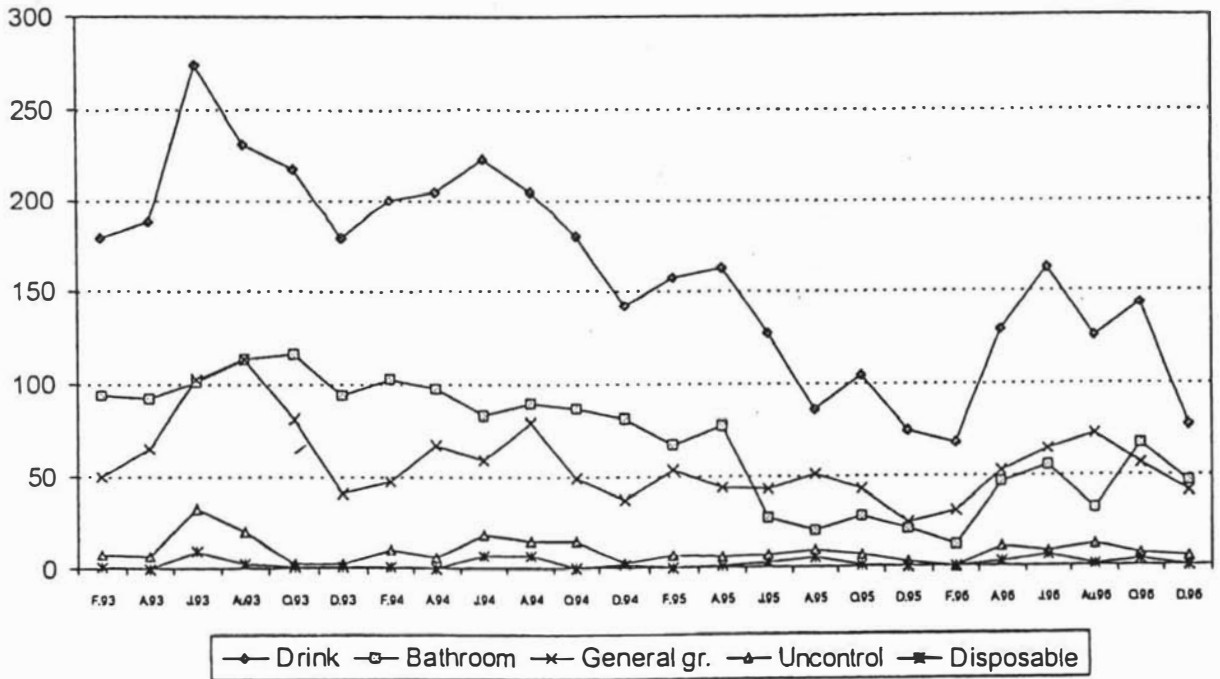


Fig. 5 Breteau Index by Types of Containers in the Control Village

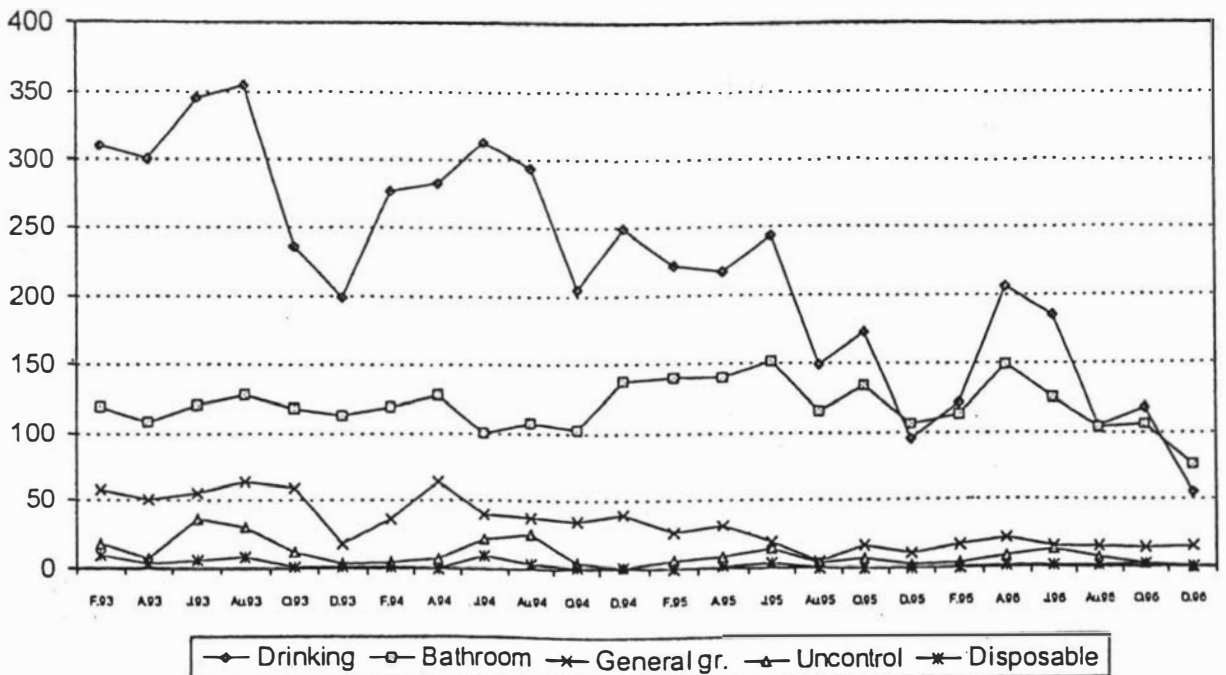
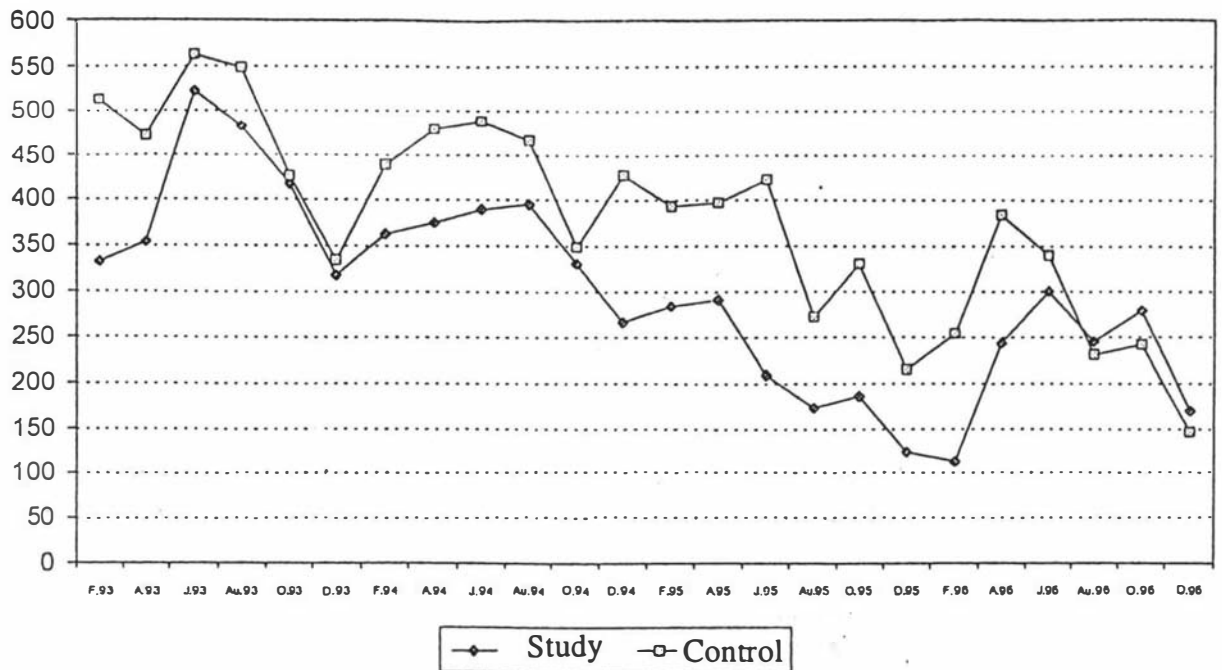


Fig. 6 *Aedes aegypti* Breteau Index Pattern

2. Evaluation of the Impact: Awareness Assessment

Since the main purpose of the dengue fever control project was to develop a model to encourage community participation, the evaluation of its impact was focused on assessing to what extent the community participated. The verbal expression to assess participants' awareness used in PR was also applied in this project. This is because participation of research participants is also a primary requirement and dialogue is the key method of AR as in PR methodology. Fuller participation is expected so as to integrate the strength of local knowledge and understanding in planning and adapting the research process. Participation, therefore, is a key process that must be generated in AR, particularly in the "open" action research process which is described as:

A highly open AR process rests on a belief that AR depends upon discovering the nature of the target system, what aspects and dimensions are relevant to study, and how to examine identified dimensions as an integral part of the research process itself.

(Chisholm & Elden, 1993, p.282)

2.1 Health workers' awareness

When asked how routine control activities for dengue were conducted the senior health worker who had worked in this village longer than the other staff responded:

The control activities will be carried out only when there is an order from the district health office. Then the result can be reported. Without an order we would rather not to do anything, because we are usually caught up with a lot of routine work. Sometimes, we forget about conducting regular control activities until there are some suspected cases. Then it reminds us it is the time to be aware of the endemic disease. So we have to be careful when seeing patients, and that's all.

Usually, the activities for dengue control are suggested by MOPH. Those are health education, a campaign for household sanitation improvement and ABATE distribution. Mainly health education is done via the village broadcast system. We give the headmen tapes, leaflets and posters which are sent from the Department of Communicable Disease Control, MOPH, in Bangkok through the provincial and district offices, and ask them to run the tapes, read messages from the leaflets. But the village broadcast system does not seem to work very well. Actually, the headmen always forget, we have to remind them from time to time. The villagers complain about the repetition of the message, and the sound is not clear enough to understand.

The campaigns to improve household sanitation are usually done with the school's co-operation. It is too much for us to do this job by ourselves. School children help in collecting trash and garbage around houses and on the street and placing ABATE in water containers.

If there are many suspected cases and we are not sure that there is endemic disease we can go and ask for DDT spray from the district health office and sometimes they will come and do the spraying.

(Fieldnotes, June 19, 1995)

I asked her how the health centre would manage if the dengue research was withdrawn; whether it would be possible to maintain the control activities as at present without waiting for orders, and with the regular amount of ABATE supplied. Her response was it was possible if they could get help from the VHV; it would be too much for the health workers to do this job by themselves. In her opinion, this job should be the VHV responsibility, the same as other primary health care activities, particularly

the health promotion activities such as a survey of pregnant women, new-born babies, and weighing children. ABATE distribution should be done at the same time when they perform these PHC tasks, such as weighing children under five in nutritional surveillance programmes. The problem for the health workers was that they did not know how to make this known to the VHV (Fieldnotes, December 29, 1994; June 19, 1995).

2.2 Village health volunteers' awareness

The VHV perception of their role was different to that of the health workers. They were overwhelmed by the belief that they were just volunteers. Their task was only to be helpers or supporters, not the ones who had direct responsibility because they were not on salaries. For them, the routine control measures were the responsibility of the health workers, and the research was the researcher's responsibility. Each group held different opinions about each other's roles. When the VHV were asked to do the water container survey, I had the feeling that they thought it was nonsense and tedious whilst the researcher took it seriously as the basis to estimate the amount of ABATE needed and as a checklist to evaluate ABATE distribution.

The second factor that determined VHV awareness of the problem was their personal characteristics and capabilities, which varied from person to person. Those who were competent and had leadership skills could demonstrate their concern about problems in their neighbourhood. The more concern they felt, the more they spent time working with people in their own neighbourhood. This resulted in feelings of competency, self-confidence and credibility or acceptance by the villagers. On the contrary, some of the volunteers had no credibility in the villagers' eyes. "This person is a volunteer! She cannot and will not do anything. Being a volunteer just to enjoy herself" (Fieldnotes, February 27, 1995).

The above factors determined the success of the VHV. Joining with the entomological team I observed there were lots of water containers without ABATE. The majority of villagers used ABATE only in the bathroom water containers but not for water for other uses such as water for pets and for cooking. A few families totally refused to use ABATE and also refused VHV suggestions. They told me the reason was because they were afraid of chemical substances. After discussion with me they told me they had a

better understanding of the issues. My conclusion was that ABATE was accepted but the level of acceptance was not enough to change the overall entomological indexes. The important point to be worked out was how to increase people's acceptance. The expectation that the VHV would educate villagers in the area they were responsible for, and distribute ABATE was based on the assumption that the VHV were aware of the problems, competent and had a good relationship with people in the neighbourhood, thus being able to talk to them. Actually, this was not always true. Therefore, it was often found that villagers did not receive ABATE, they did not know how to use it, and did not know how long it would last.

The third factor influencing the VHV awareness was their attitude about dengue fever and mosquitoes. VHV were peasants, they were the product of the specific culture within which their attitudes were formed. They shared the same attitudes and beliefs with the other villagers which will be discussed in the following section.

2.3 Villagers' awareness

The occurrence of dengue fever during the previous thirty years was a nightmare. An outbreak of the disease was reported in 1958 in Bangkok metropolitan area with 2,500 cases. In the same year there were cases reported in 40 out of a total of 71 provinces which were closely connected to Bangkok. In later years there were cases reported throughout the country. During the first outbreak the case fatality rate (number of deaths per 100 diagnosed patients) was higher than 10% because of the lack of knowledge of appropriate treatment. The record during 1958-1987 showed the average incidence (number of cases per 100,000 population) was 10, 23 and 54 at the end of each decade. The number of cases had increased, although the case fatality rate had dropped to 2, 3 and 0.7%, respectively. At the end of 1987, there were 177,630 cases and 896 deaths reported for the whole country (Ungchusak & Kunasol, 1988).

The study undertaken by the anthropological team indicated people in this village knew about dengue fever around 1968. They estimated about 40-50 % of the families interviewed had experienced at least one child suffering from this disease. From this study they concluded that:

Though villagers know dengue fever is dangerous for their children's lives it is not serious enough to follow control measures such as reducing mosquito breeding places. Some villagers viewed disease prevention and controlling as the job of the government or health personnel, not peasants. They did not take the control measures seriously unless there was a family member suffering from the disease.

(Smutkupt et al., 1993, p. 106)

The abbot shared a somewhat similar opinion as he told the anthropologist:

People have enough knowledge about the disease but they do not realise the importance of disease prevention. They do not have serious intention to carry out preventative measures, when their children get sick they just seek treatment. They always claim they are too busy working, do not have enough time for this thing. I always told them to sleep in mosquito nets, take care of their own sanitation around ones' houses, destroying breeding places, but everything is still the same.

(Smutkupt et al., 1993, p. 135)

The anthropological study described the villagers' belief about mosquitoes. This was that human beings could not overcome the mosquitoes. They probed the convergence of at least three traditional legends about mosquitoes told by villagers *Sangsilpchai*, *Karakade* and *Ramayana*. They explained:

In these legends, giant and human beings were enemies. At the end of the story human beings won, giants were killed by human gods. When the giants were killed their blood poured to the earth and then became mosquitoes to mark the destruction of human beings forever.

(Smutkupt et al., 1993, pp. 99-100)

The researcher stressed the importance of *Aedes aegypti* which is the specific vector for dengue fever and its specific breeding places in order to use ABATE effectively. However from the villagers' perspective all types of mosquito were the same, all of them could bite and caused itching. They would use ABATE anywhere they found mosquito larvae. This belief and practice disturbed the effective use of ABATE.

ANALYSIS OF THE SITUATION

The lessons I learned from the failure of the dengue project are the following. First, the direction of the dialogue was focused on decisions about means to reduce mosquito breeding places rather than on raising research participants' awareness about the problem. This issue was critical because the dengue research was imposed by the researchers and the provincial health official. The health workers and the VHV were expected to cooperate although their perception of the problem might be different. The differences of interest between the researchers and participants were revealed while the project was going on: for example their different attitude about the water container survey, or the researchers' interest to control the outbreaks of the disease versus the peasants' interest to control the mosquito population.

Second, the assumption for choosing the VHV was that they were respected community leaders who could help villagers with health problems. They were also expected to develop a communication network within their own neighbourhood. However, the above assumption was not true for all cases.

And third, there was not enough specific information related to the issue available. For instance the information as to what extent ABATE was accepted and used by the villagers, or what the reasons were for not using it. The above information could have been gathered by the anthropologist rather than obtained from the dialogue with research participants.

CONCLUSION

The intervention of the dengue fever control project described in this chapter differs from the participatory approach illustrated in the previous chapter in the way that the problem was identified by outsiders and the collaboration within the whole system was anticipated. This intervention was considered as a project which was; a SPHC approach, application of action research approach and interpretation of participation as access to knowledge and information of health projects. The result showed that this project could not contribute changes of entomological indexes. The index changes were summarised as natural decline when compared with the data of the control case. The project was also unsuccessful in developing community participation. However, the application of

action research enabled me not only to compare the interventions of both methodologies, but also to further explore the paradox of the implementation of the concept of community participation in health development which is the focus of the next chapter.

CHAPTER NINE

SUMMARY AND DISCUSSION

The situation of the PHC approach in Thailand has been appraised from the viewpoint of an insider. The primary focus of the study has been on the concept of community participation in health which is accepted as the key to the PHC approach. To date, it is the most difficult and least understood principle which is reflected in the ways in which the concept has been put into practice. The pitfall of implementing community participation is that the concept itself has been defined in narrow terms. It has been treated like a missing ingredient which is to be added into existing services or to be regarded as a means of technology transference. These interpretations are different from those initially intended when the concept was first introduced (WHO, 1978). It would appear to be a radical reorientation of the existing system for people-centred development, or the notion of transferring power and authority to lay people to facilitate their self-reliance. This study, therefore, has attempted to pursue strategies to implement the original concept of participation in Thailand; in particular to enhance "little actions" instead of critique "big talk". The discussion in this concluding chapter begins with a summary of the findings.

SUMMARY OF THE FINDINGS

The empirical data of this study enabled me to conclude that the empowerment process is able to be achieved through the process of participatory research. This conclusion is drawn from the beginning positive trends shown while working with the VHV group (outlined in chapter seven) and it is confirmed by literature. Although the study does not explicitly demonstrate changed practices by VHV and health workers as a result of the empowerment process, such results are unlikely to be demonstrable within the time limitations of the study. To understand the empowerment process, therefore, is to understand the concept and the process of participatory research.

The basic assumption of participatory research is a belief in peasants' potential to produce their own knowledge which suits their livelihood. The process of participatory research is to encourage people to participate in analysing their situation, decision-

making about actions, and evaluating the actions taken. Their participation in the analysis-action-reflection activities of their existing situation helps them to understand problems and how they could make the situation better. Dialogue with equal respect between researcher and research participants is significant for the whole process - from analysis to reflection on the results of actions taken. A direct experience in this process makes those who are involved learn, and small successes eventually create participants' self-confidence. In this study, the success of the VHV in asking for encephalitis immunisations to be provided in the village was a small confirmation of the idea that they could do something to solve their problems. Another reflection of this process was their increased participation in discussion during meetings when they felt that they were listened to.

The above findings lead to the following issues or questions for discussion to further our understanding of the empowerment process. First, since the empirical data did not show the explicit result of the empowerment process, did this imply that empowerment did not occur in this study, and if it did occur why could it not be observed? Second, according to this study, participation is interpreted as power; can the conceptualisation as such be justified? The third issue concerns the implementation stage. If empowerment is expected to happen, how can the process be started and who is the one to initiate it ?

DISCUSSION

The difference between the two research approaches used in this study is that participatory research allows participants to analyse their own situation, whilst action research, as carried out in the dengue control project, represents the traditional approach of the health sector, whereby people are expected to participate in the project designed by outsiders. The situation analysis in participatory research is believed to provide opportunities for local people to look at themselves in relation to the social systems that effect and control their lives. Situation analysis and exchanging information of current knowledge via a process of dialogue help people to assess their own self-image, examine

what factors influence their lives and then to be able to address their own difficulties and problems. This is believed to be the process of raising people's awareness. The following discussion provides a theoretical explanation for the questions: What is awareness? How is awareness raised? And why is it important for the empowerment process?

1. The Importance of Awareness Raising

Awareness or consciousness raising is based on the conscientisation concept of Paulo Freire, a Brazilian educator. Freire used literacy training for the "voiceless" people in the slums of Brazil, in order to encourage them to understand their political and economic situation, to understand how the system oppressed them, and to take appropriate collaborative actions to transform the system. This process made people become conscious of their problems which eventually would lead towards liberation. The product of this process he called conscientisation. In other words, conscientisation was a degree of consciousness in which individuals were able to see the social system critically. Freire used the term "critical consciousness" for the most preferable type of consciousness. The term was described as; "They are able to understand the resultant contradictions in their own lives, to generalize those contradictions to others around them and to transform society creatively with others" (Smith, 1976, p.2). To be critically conscious requires a depth of interpretation of problems towards the issue of the unjust system rather than the oppression of certain individuals and the participation of their collective actions (Freire, 1972; 1973; Smith, 1976).

Consequently, Freire proposed a new pedagogy to help people understand their present situations. Usually these problems were related to socio-political conditions of the individuals involved which required the task of liberation. Liberation means the creation of new norms, rules, procedures and policies; it is the transformation of the existing system. Thus this pedagogy is called the pedagogy for the oppressed. This pedagogy focuses on awareness raising by encouraging people to analyse and solve their own problems. Sometimes, it is called problem-posing education. This pedagogy is summarised as:

(It) is a co-operative search for the answers to unsolved problems faced by a group of people. For this reason, there is no 'expert' who knows the answers and whose job is to transmit those answers. Individuals come together with equally valid, but different, perspectives sharing problems which have yet to be defined, seeking answers which have yet to be formulated. Participation is not a convenient pedagogical tool, it is the heart of the pedagogical process. *Conscientizacao* is not a simple goal to reach; it is the ultimate goal of the pedagogy of the oppressed.

(Smith, 1976, pp. 3-4)

The issue of how awareness is raised is explained by Markova's model which was introduced in chapter seven. In this model, the awareness raising process is a developmental interaction process between an individual and one's environment and the situation involved; it is an evolution process in the social development of human beings. The awareness development process arises from comparison of oneself with others through observation, communication and learning. In the process of social interaction one learns to accept the attitudes of others toward oneself and to evaluate oneself in terms of the adopted social criteria. Markova explains people's awareness as:

(C)apacity for self- and other-awareness enables people to co-ordinate their actions and to make decisions, to reinterpret their actions and decisions, and to understand the intentions of others and to plan for their own and others' future. Indeed, all human activities and psychological process involve a capacity for awareness in one way or another.

(Markova, 1987, p.10)

The crucial consequence of awareness is that it leads to problem identification; once people are aware of their situation then they are able to know what their problems are. This is an inherent process that must be undertaken by people themselves, who can decide what their problems are, rather than being imposed from outside or by experts. Problem identification then leads to decisions about actions to be taken to change the situation. Awareness is crucial for the human development process since its greatest contribution is to help people regain their confidence in themselves and their ability to find their own ways to solve problems or change the status quo. Experience in doing things for oneself and making independent decisions makes people believe in their own efforts; it is how self-confidence develops (Burkey, 1993; Lee, 1994).

The importance of awareness in community development is explained by a model proposed by Rogers (1992). In this model, development is continuous, with progressive

changes which are rooted in and spring out of previous situations. It is not a change which is natural. Rather, development is a desired change arising from within a community itself based on the existing situation - it is "the situation developing". Therefore, development is defined as a process of planned change which consists of two basic elements, planning and action. "Planning is a purpose or an intention to direct and push the process of natural change towards a specified objective Action is an integration, an activity which is hoped will achieve this purpose, lead towards this objective" (Rogers, 1992, p.84).

This model emerged from an integration of community development and adult education for development. Its focus is upon the importance of education and training of adults in the process of development. The goal of development, therefore, is self-direction of change, to end outsider-led education and training, and to encourage learners to take control of their own planned learning process and development. In this model, the basic route for effective change or "development" consists of four stages, 1) understanding of the existing state of condition, 2) development of critical awareness, 3) developing a solid basis of knowledge, skills and understanding, and 4) engaging in a programme of social action.

However, awareness raising is considered the most important stage. Rogers states that "Awareness-raising of the issue to be addressed or opportunity to be realized comes first in almost all Development programmes" (Rogers, 1992, p.124). In his opinion, awareness raising is a matter of attitudes, it is a provision for the promotion of positive attitudes among the participant groups, especially, the development of confidence and a focus on motivation. Awareness has to come first because:

As awareness rises and insights develop, so the demand for new knowledge, new skills and new understandings will often grow; and as knowledge, skills and understanding grow, so the picture of the possible range of actions and of the goal will change.

(Rogers, 1992, p.125)

Behaviour changes because people decide to act in a desired way, if they are confident and motivated that the action is going to work. It is the sense of power that people have that makes them decide to take action. This is the reason why awareness is considered the first stage and the pivot of the empowerment process.

The empowerment process is involved with the process of awareness raising which is a time-consuming and unpredictable process. Therefore, in answer to the questions raised earlier, it is unrealistic to expect people's awareness to be raised in such a short period of time as in this study. If it did occur, the changes were probably too subtle to be recognised.

The empowerment approach stems from conceptualisation of participation as power. The following discussion provides a theoretical explanation about models of power, and examines whether this conceptualisation of participation as power is suited to the study situation.

2. Models of Power

Power is a term which is often used in sociological theory to explain social integration or social order. "The term is used without fear of danger of unresolved complexity, both in everyday life and in the more causal practices of social science" (Waters, 1994, p.127).

A number of questions have been raised by Lukes and summarised by Waters as follows:

Is power a property or a relationship? Is it potential or actual, a capacity or the exercise of a capacity? By whom, or what, is it possessed or exercised: by agents (individual or collective?) or structure or system? What *kind* of outcome does it produce?

(Waters, 1994, p.217, emphases original)

There are different ways to look at power in a society, for example Waters (1994) grouped modern theories of power into four groups: critical structuralism, functionalism and constructionism, utilitarianism, and polymorphic power. But the discussion here is based on a model proposed by Nelson and Wright (1995) which is considered appropriate to explain the power system at the micro-level or in a community. For them, power is both experienced in encounters in everyday life and as part of systems. An example is that even within a family, individual relationships are in some ways subject to

intervention and control by culture and social systems. They summarise that “how people stand in relation to each other in these systems is described as power. Power is a description of a relation, not a thing which people can have” (Nelson & Wright, 1995, p.8). The authors distinguish between “power over” and “power to” models which are discussed in the following section.

In the “power over” model, power is perceived as a “thing” of which there is a finite amount in a closed system. Power is viewed as a zero-sum concept, if one party gained more power, it would be at the expense of others. The degree of domination which one class has is exactly balanced by an equal degree of subordination for the others, which when added together totals zero. This model views power relations as coercive, centred in institutions of government, although spilling over into wider structures of society. (Nelson & Wright, 1995; Waters, 1994).

This model, according to Nelson and Wright, includes three types of power. First, a one-dimensional view of power, the concrete decision is made on issues over which there is an observable conflict of interest. It is metaphorically phrased as “A has power over B” (p.9). Second, a two-dimensional view of power: here power is being exercised when one party establishes barriers which prevent others from voicing their interests. The result is “non decision-making” on key issues, and conflict is not visible. This is phrased as “A affects B in a manner contrary to B’s interests” (p.9). Third, a three-dimensional view of power: where the interests of the dominant party are taken to be natural or god-given, so that no alternative to the status quo can be imagined. The metaphor is: “A exercises power over B . . . by influencing, shaping or determining his very wants. As a result B accepts his (sic) role in the existing order of things and no conflict arises” (p.9). This type of power may not be attributable to a particular individual’s behaviour, nor is it confined to decision-making within institutions rather it is distributed in society through relations of gender, race and class, imbued with ideology (Nelson & Wright, 1995; Rees, 1991; Waters, 1994).

In contrast, the aim of empowerment is generally explained by the model of “power to”. In this view, power is like human abilities, it can grow infinitely if one works with it, and “growth” of one person does not necessarily negatively affect another. This model is

based on Parsons' proposal that we can perceive power as an infinitely expandable resource, similar to an economic resource. The basis for this view is an observation that as societies become more complex, there is a clear increase in the level of transformative capacity, the ability to alter the physical and social world; power can therefore be understood as a transformative capacity (Nelson & Wright, 1995; Waters, 1994).

The power models outlined above support the conceptualisation of participation as power in this study, because the circumstances under examination exemplify all three types of power. The health workers and the VHV have had power exercised over them by the authorities who decided for them what should be done and how and when. Most of the programme activities carried out by health workers were designed either from the provincial or the central level. More often than not, the health workers conformed to the assigned plans to avoid any problems that may occur. They realised that having troubles with authorities would not benefit their careers. Gradually, they were socialised within a patron-client social relationship and highly centralised bureaucracy which is consistent with the third type of power in the "power over" model.

The findings in this study would suggest that the above circumstance is the major hindrance to successful implementation of community participation in the health sector in Thailand. This finding supports Oakley's opinion that health personnel are the crucial factor for community involvement in health (CIH). He comments that the very real obstacle to developing CIH is "health personnel who have become generally entrenched in their professionalism and their adherence to well-proven methods of practice" (Oakley, 1989, p. 61). Similarly Chambers (1993) states: "The problem is not 'them' (the poor), but 'us' (the not poor) The basic issue is power. Those with power - 'us' - do not easily give it up" (pp. 13-14). The discussion which follows explores why the professionals are important, and if there is to be a reorientation of power, how much the professionals can rely on community potential so as to hand over this power. In other words, is it possible to empower communities?

3. Professionals: the Major Obstacle

Professionalism refers to the thinking, values, methods and behaviour dominant in a profession or discipline. Traditionally, professionals have been characterised as being unique because their positions require relatively high levels of formal education and the mastery of extensive knowledge. They also emphasise autonomy and control over their work activities to sustain power. Working within top-down development models, professionals are the most knowledgeable and believe that the product of their professional expertise will trickle down and eventually benefit the people as a whole. As illustrated throughout this thesis, the prevailing situation of health service delivery in Thailand is one of professional dominance, combined with a highly centralised, top-down bureaucratic system underpinned by patron-client social relationships.

The alternative development paradigm challenges and redefines the roles of professionals who are engaged in development activities from helping to rectify to encouraging the lay to be involved more fully in development activities. The redefinition of professional roles implies two important points. First, the emphasis is placed on professionals understanding the complexities of the social, cultural, organisational, economic and political context in which development projects are to be carried out, since development does not occur in a vacuum. Second, it calls for attention to the fact that development is not imposed. Rather, development professionals seek increased input and commitment from lay beneficiaries in people-centred development (Chambers, 1993; Mennerick & Najafizadeh, 1992).

4. The Potential for Community Change

I have been gradually convinced that communities themselves are not major hindrances to the implementation of community participation in health, if only they are approached in an appropriate way by health professionals. In the history of Thailand when there was no road system, most villages were isolated and experienced little interference from the outside world. The villages were independent and self-reliant in terms of crop production and solving their own problems based on kinship and moral community leaders (Rabibhadana, 1993; Turton, 1987). From my experience in this study there were positive signs which showed that community participation could be initiated, particularly when I worked with VHV in the role of health personnel during the last few

meetings with the VHV group. They were able to propose their own problems, such as illiteracy and asking for encephalitis immunisation to be provided at the health centre in the village instead of taking their children to the hospital in town. They talked more about what they thought and participated more in the discussion when they felt their expressions were listened to and welcomed. The following examples from Thailand and from other developing countries support this conclusion.

A study by Panya (1995) in Khon Kaen province (a retrospective analysis of rural people adjusting to a rapidly changing world to improve their livelihood), indicated villagers were literate and active agents of change. They were neither just passive recipients of change nor were they trapped in a culture of poverty when they were affected by a dramatic change at macro-level. Rather, they engaged themselves in diverse activities centred around those which gave the highest cash return.

Another study in the same province was conducted by staff of Khon Kaen University. Three villages were encouraged to analyse their own history, how people in the past survived and coped with problems. Historical analysis helped the villagers to regain pride in their culture, their history and their own potential. The villagers came to the conclusion that the conventional type of "development" had pushed them into a dead end, thus they had to search for an alternative development by themselves. It was agreed that an alternative model of development should aim towards more balanced development, wherein people were the master of change rather than the object, and community self-reliance should be strengthened. The village economy should be reorganised, from the market-oriented economy, in which people were totally dependent on one or two crops, to an integrated natural agriculture so as to revive the ecological balance and to increase their bargaining power. They realised that traditional knowledge and practices in self-care should be revived. Group activities, village cooperation and the like should be strengthened. All these activities should be based on values rather than expecting benefits with the traditional social and social relationships based on virtue, mutual respect and collaboration being introduced (Samosorn, Thongyou & Thongyou, 1989).

Stone (1989), in a watershed development project in Nepal, identified a gap between villagers' and officials' perceptions of the notion of development and community participation. For villagers, development referred to concrete, visible structures such as schools, a health post or electricity which were obtained from outside, whereas the meaning to officials was behavioural changes. After an anthropological study, this project arranged village-level development workshops followed by village council workshops. Attending the workshop were project staff, teachers, selected farmers, and village representatives from other organisations such as agricultural extension services, and women's organisations. During the workshop the participants shared their perspectives and shifted and adjusted their views about "development and community participation". Afterwards, some villagers began to consider that they should look to themselves and their own individual or community resources as a basis for action, rather than merely blaming the government or a project for their area's lack of "development". In the follow-up investigations, some villagers explicitly claimed that they valued the "workshops" as a new kind of opportunity for them to come together to assess their situation.

Nickson (1991) suggests if PHC is expected to be a success professionals must see the promotion of health care in totality, and there must be a clear definition of the role of community as client wherein the community is a decision maker. To this extent, the initiative and the decision for programme implementation must come from a community within an existing indigenous structure. By this approach action is more likely to be taken because the leaders and villagers are convinced of the need. To this extent, it is a "problem" such as general hygiene, potable water, which is dealt with rather than a "programme", so it is likely that more than one issue is involved in taking action (Nickson, 1991).

He explicated a case study in Boga, North-Eastern Zaire, where village leaders and interested members of the health team began to ponder together the paradox of children dying from malnutrition in an area with an apparently well-established PHC programme. It was found that a mother of a dead child thought her child "was not sick", she had attended pre-school clinic regularly and it was ensured that her child was fully immunised. She commented that her child ". . . just miserable. Doctors at the hospital

can cure sickness, but not misery” (Nickson, 1991, p.76). Then the local concept of “health” was explored. It was found that children with malnutrition were usually associated with families where the mother was illiterate. The community decided to deal with the illiteracy rather than the immediate problem of malnutrition. A school in the village was built, an area of forest was cleared to plant coffee. The reason for choosing coffee was that it was an export product, the price of which increased with inflation, at about the same rate as a teacher’s salary.

IMPLICATIONS OF THE STUDY

There are two implications in relation to the identification of strategies to implement community participation in health which can be drawn from the above discussion. First, the study clarifies whether to use participatory research or action research; a SPHC approach versus a CPHC approach; and in particular highlights the importance of the interpretation of participation as awareness and empowerment versus the more traditional approach to participation as accessibility to information and knowledge.

It is concluded that an empowerment approach is the preferred strategy to implement the concept of community participation in health. The empowerment process emphasises the necessity of awareness raising as the first and pivotal step. However, the empirical data from this study shows that action research utilising a SPHC approach does not support the process of awareness raising. The interventions carried out within the case study of the dengue control project demonstrated that accessibility to information and knowledge alone does not encourage participation. The control activities by the community ceased after the project was withdrawn. Therefore, it is concluded that an SPHC approach based on the interpretation of participation as access to information or knowledge is not considered to be an effective approach to support the implementation of community participation in health.

Second, the importance of the role of health professional highlights the necessity to improve health personnel qualifications and challenge the content and structure of the curriculum in order that health professionals are better prepared to encourage community participation. The following discussion is focused on community health

nursing education, which is my primary concern. In addition to that, the implications for the public health policy implementation and practice will be discussed.

IMPLICATIONS FOR THE NURSING PROFESSION

The important role of nursing personnel in attaining PHC goals is widely accepted. In most countries, nurses are the most important group of health personnel in terms of numbers, closeness to prevailing health problems, and understanding of community needs (WHO, 1984). Cost effectiveness is another reason for focusing on nurses; “nurses cost less to train, and they receive lower salaries. They are easier to attract to rural areas and usually communicate more effectively with their clients” (World Bank, 1993, p.9). Those nurses who are involved in community health need to be better prepared to work effectively within the new approach of the health system. It is suggested that a reorientation of the system of nursing education is necessary.

1. Community Health Nursing Education

Community health nursing is a nursing specialisation which has struggled to identify its specialty. Hitherto, it has been suggested that community health nursing is the synthesis of public health science and nursing science (APHA, 1982; Hanchett & Clarke, 1988). This is because working in a community requires knowledge and skill to deal with the different levels of clients, individuals, families, aggregates and the community as a whole. Nevertheless, there are gaps in the knowledge provided by these two disciplines. Nursing science is mainly focused on individuals, which limits the possibilities of its application to multi-level client groups in community work; whilst epidemiology, the core concept of public health science, is a disease-oriented concept which cannot cover the area of health promotion. Therefore, it is suggested that these two disciplines are not enough to prepare community health nurses for the new role, and knowledge of social sciences should be integrated (William, 1988; Cooney, 1994). To date there has not been enough explanation of what kind of social science it should be and how the integration should be done.

In October 1984, a WHO Expert Committee on the Education and Training of Nurse Teachers and Managers with Special Regard to Primary Health Care met in Geneva. From that meeting it was suggested that:

If nurses are to be equipped to meet the real health needs and demands of people, a reorientation of all educational programmes is required at both basic and post-basic levels. The aim of such programmes must be to produce graduates capable of functioning effectively at all levels within health systems based on the primary health care approach.

(WHO, 1984, p.18)

However, post-basic education was focussed upon because it was at that level that preparation for specialisation took place. The basic programme provided general professional education. Besides that post-basic schools were assuming a leadership role in the process of professional development.

The suggestion for a reorientation of educational programmes was based on a report of a survey undertaken in 43 countries by WHO of post-basic training programmes for nurse teachers and administrators, which showed that a wide gap existed between the concepts and approaches in the real situation. The situation was described as follows:

It is clear that the majority of programmes preparing nurse teachers and managers were not directly relevant to the main social and health needs of the countries covered in the survey. In general, curricula continued to relate to the curative model, focusing on the teaching and management of nursing care in the hospital setting. Most post-basic schools were linked, directly or indirectly, to hospitals and most teachers in these schools were not aware of the goal of health for all by the year 2000 or of the principles of primary health care.

(WHO, 1984, p.19)

In that meeting, the Committee was convinced of the need for urgent action to bring about radical changes in the philosophy and conceptual frame of reference of post-basic educational programmes, although it was admitted that there was no blue print for an ideal system that could be universally applied. The changes recommended included attitudinal change; a new way of thinking about health and health care provision.

The health professions have a key role to play in promoting this change, but first they must themselves have a clear understanding of, and a commitment to, primary health care in the context of the health care system prevailing in their individual countries.

(WHO, 1984, p.25)

Orientation towards a primary health care approach involves a whole change in relationships between professions and communities. The relationship of care provider and recipients of care will no longer be the same; all will be in the system on a basis of

partnership. This altered conceptual frame of reference must be reflected in the post-basic education for nursing personnel. The role of the teacher must change to the facilitator of the learning. In addition to that, health personnel must be aware of the need for cooperative action between the health sector and other sectors; practical approaches and strategies must be evolved for intersectoral cooperation. Therefore, the Committee recommended that “problem-based, practice-oriented and team-focused educational process should be developed for nursing students that are multiprofessional and multisectoral” (WHO, 1984, p.44).

The empirical data from this study provide support for the above recommendation. This study clarifies the expected roles of health professions with regard to a primary health care approach. The exploration of an empowerment approach to initiating community participation in health in this study has highlighted the need for community development concepts and strategies to be integrated in the community health nursing curriculum. The concept of community development, which aims to encourage community self-reliance, is similar to the notion of community participation, the key concept of PHC.

The process of empowerment shown in this study exemplifies how the integration of social sciences knowledge and a problem-based, action-oriented and process-oriented curriculum could be put into practice. It is clear from observing the practice of health workers in this study that nursing students need to be empowered through the education system. Within an empowerment approach the curriculum utilises a process-oriented rather than a content-oriented approach; the focus is on preparing people to ‘learn how to learn’. This approach is required because community problems are varied, complex and multi-causal in their nature. It is unrealistic to design a competency-based curriculum to prepare graduates to be able to solve every community health problem. Rather, it is necessary to prepare nurses to help communities to help themselves. Use of a process-oriented approach in nursing education will enable nurses to better understand the facilitator role and ways to encourage community participation in health.

2. Community Health Nursing Practice

The concept of community participation is foundational for community health nursing practice in a similar way to PHC. This is not only because the nursing profession lends

itself to human changes towards health and illness, like changes in belief and behaviour, but also clients of community health nursing are not sick. The services are mainly for health promotion and disease prevention. Thus clients have, in the majority of situations, to act and make decisions themselves, and the relationship between the professional and the client is an equal partnership, not care provider and care receiver.

It is acknowledged that role reorientation is necessary in community health nursing practice as well as in education. The significance of community participation in this process is mentioned in the literature, however it has not been made clear enough to guide the practice to support this change. Take the example of community diagnosis or the assessment process to identify community problems, the starting point for intervention. Almost all community health nursing textbooks mention the community diagnosis process which is based on surveys and interviews to assess community parameters. As it is described, the process is conducted under a professional framework; professionals are the authorities and control the whole process (Anderson & McFarlane, 1988; Archer & Fleshman, 1985; Cooney, 1994; Fromer, 1979; Goepfing & Chuster III, 1988).

I have been sceptical as to the possibilities of getting the community involved in the community diagnosis process. From my own experience, I usually called for a community meeting to discuss the problems that existed. In doing this, I wondered who were the people who joined the meeting and who did not? Who spoke out? Were the problems the genuine community problems? I wondered if it was realistic to expect people who were uneducated, like many of the villagers in the study village, to diagnose community problems; if yes, how. This study ascertained the answers for the above questions. I am now convinced a popular wisdom does exist. The problem is my own limitation, as a health professional, to draw that wisdom out. Villagers can make a community diagnosis though it will not be expressed in professional terminology.

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

Usually, public health policy in Thailand is implemented by translating government policy into programme activities at the central level or the provincial level. More often than not, the programme activities have been launched without enough provision of basic

principles and foundational concepts for personnel at the practice level to understand and be able to effectively implement the programmes. The majority of programmes are started by setting up a successful model and then expanding the programmes countrywide.

This method of policy implementation contradicts the concept of community participation itself. Gradually, health personnel are socialised into this system of working. Emphasis is put on perfunctory jobs and numerical outcomes. The health workers usually have to carry out programmes that they do not understand or even are not sure how to action. They are caught up with these jobs and have no time to think and scrutinise their situations and activities.

The findings of this study suggest that the genuine concept of community participation is not yet understood among health personnel. This implies that clear and concrete theoretical and practical knowledge needs to be disseminated among health personnel at every level. It requires a reorientation to the new approach and the new roles which substantially differ from the conventional ones. The emerging empowerment approach can be built-in to health personnel's everyday work; encouraging them to analyse the situation and identify what their problem is. Through this process three consequences are produced: research, action and education. Those who are involved in the process will be involved in action taken to find answers for posed questions, then the search for the answer is fulfilled. At the same time people who engage will learn.

It is recognised that the proposed reorientation can not be implemented or developed without the support of appropriate mechanisms at different levels to create a favourable environment. The following supportive mechanisms are considered to be of critical importance. Political commitment to community participation is the most fundamental support since it will lead to the success of the other important mechanisms such as decentralisation and reorientation of the bureaucracy. Decentralisation of decision making and resource mobilisation is required to build up the management abilities of people. The patron-client, centralised bureaucratic system must be reoriented, as well as the reward and evaluation systems. Without changing these factors the practice of community participation will remain extremely limited. The above recommendations for

change are suggested despite the limitations of this study which are discussed in the following section.

LIMITATIONS OF THE STUDY

The discussion of the limitations of the study is focused on two points, limitations of generalisation and limitations which will effect the credibility and usefulness of the results. With respect to the issue of generalisability of the results, it must be made clear that as previously stated, there is no fixed formula for both the empowerment process and the participatory research process. Rather, both of these are highly flexible and context-bound processes. The results of this study, therefore, are generated using only one possible empowerment approach among many, and the application of this knowledge can only be claimed to be applicable to the situation of Northeast Thailand where the study was based.

Factors that might affect the credibility and usefulness of the results include the time limitations of the study that influenced the conclusions which could be drawn from the study, the limitations caused by the diversity of concept interpretations, and the limitations of the researcher.

First, it is acknowledged that conclusions about the empowerment process were derived from anticipated results which were based upon the positive signs and clues observed in the VHV group rather than the actual result of awareness raising or empowerment outcomes from the research participant groups. It could be argued that the positive signs claimed in this study might not end up with positive results as anticipated. Nevertheless the constraint of a fixed timeframe of one year for fieldwork was out of my control. Despite the use of strategies to shorten the time required for site selection and gaining access, establishing rapport and the first stage of studying community realities took time. Hence there was only approximately six months left for intervention. Given the lack of a history of success in participation in former health and development projects within the study community (outlined in chapter seven), a six month period was too short even for the initial stage of awareness raising. This meant time was a crucial and limiting factor for conducting participatory research using an empowerment approach in the selected village.

Many studies have identified time factors as a major hindrance in meeting participatory goals of conscientisation and empowerment. Conducting participatory research demands both considerable time commitment from the researcher and participants, and time available to allow the process of change. An example was a programme in Brazil, which aimed to develop fisherwomen's awareness and ability to assess critically their own situation, organise themselves as a powerful group and creatively work to change society towards building up a new world. The programme started in 1975, and it took more than six years to get 50 fisherwomen to join the group compared to 16 at the beginning (Oakley, 1980). Galjart, as quoted by Oakley et al., concludes:

The implementation of participation is a protracted, step-by-step affair which can spread over a period of six to ten years; it is not an event but a series of unfolding stages. One of the examples is the programme named Community Involvement in Health Development: Caranavi District, Bolivia. In this programme the government tried to encourage popular mobilization as a strategy of building up a political base for more democratic way. The mobilization was based upon community education programme. The programme took about three years.

(Oakley et al., 1991, pp.145-157)

Secondly, the identified limitations relate to the diversity of interpretations of concepts used in the study. There are many concepts in this study that can be interpreted differently, and different interpretations certainly lead to differences in implementation. For instance, in this study the concept of community participation is conceptualised as power, which lead to the choice of an empowerment approach as the implementation strategy. An empowerment approach conducted through participatory research is a process with no clear-cut guidelines and no straight pathways to success, which again can be interpreted differently. Similarly with respect to action research, in this study action research was defined according to the analysis of Brown and Tandon. However, it is accepted that the process of conducting action research is also varied, and in some instances there may be a blurring of boundaries between action research and participatory research. For example, Rapoport suggests that the initiation of problem should come from a community.

The service-oriented action research conception places the initiative with the client who states, conventionally, that he has a problem that needs solution and approaches the social scientist who then responds by undertaking such studies as seem required to help to solve the problem.

(Rapoport, 1970, p.508)

The concept of community is also subject to diverse interpretation, in particular, how “community” in the concept of community participation is defined. There are a number of ways to define a community as illustrated in chapter five.

Thirdly, in this type of study the researcher plays a significant role in creating the relationship between themselves and the social system being studied which affects the quality of the data obtained. The following section identifies drawbacks in my performance which might have had some effects on this study.

This is my first experience of conducting participatory research. Though I have studied its theoretical concepts I recognise that my skill in doing this type of research is still very rudimentary. In this type of research where intergroup relationships with research participants during the whole process is necessary, a deep respect for research participants is required. Though I myself might think I did not have a problem I felt that I was not accepted as an equal partner, or as an insider especially when there were conflicts of interest between myself and participants. For instance when they told me “you tell us what we should do, or what you want us to do”. During the dengue project intervention, I knew that the researcher requested the VHV to survey and resurvey household water containers because he thought these data were necessary to estimate the amount of ABATE needed and to construct a list for its distribution. In my opinion, the VHV perceived the situation differently. To them that was the researcher’s problem, not theirs.

Since the empowerment process involves awareness raising, which is an inherent process, and it is necessary to consider participants’ or community interest, it requires a high tolerance of uncertainty on the part of the researcher and an ability to let go when appropriate. In this type of research where a researcher has very little control over events it requires a high degree of flexibility and various types of investigatory skill in a researcher. This was very difficult for me because my training and experiences are quantitative research orientated (Greenwood, 1994).

Sometimes, I faced the conflict of being shuffled between different roles as a researcher, a student and a community nurse. As a researcher, I must perform a facilitator role and

should wait for spontaneous conscientisation, which was against the customary role of a nurse educator, and a student. As a nurse educator I thought I knew better and should have given information, or educated them. But as a student I really wanted to finish my thesis and wanted to see the results of performing participatory research.

Most important of all, are the limitations identified to putting this approach into practical reality in the Thai context because this approach stands in contradiction to the existing socio-political system. This approach requires reorientation and reorganisation of the bureaucratic system and the social system. These processes will not be easy and will not happen in the near future. Some even argue that an empowerment approach is impossible for Thailand; it is just more rhetoric.

SUGGESTION FOR FURTHER STUDY

The following suggestions are based on my optimistic assumption that an empowerment approach is possible in Thailand. Although many factors lead to an ethos of anti-participation in Thailand as outlined in chapter three, on the other side of the coin there are also advantages. My optimistic view comes from factors within the existing system which have been identified in this study. The belief in kamma engenders feelings of sympathy for and acceptance of others; treat others the way you would like to be treated. Another factor is that the Thai are not strict on rules and regulations resulting in their characteristics of high flexibility which, in combination with the main teachings of the Lord Buddha that negate the notion of a permanent and unchanging soul (*anatta*) and stress the notion of the impermanence of things (*anicca* in Pali, *anijja* in Thai), make Thai people accept uncertainty and changes. As a result, in Thailand there is no situation of professional conflict or rivalry, like in some places where there is rarely support or even open hostility among professionals (La Forgia, 1985, p.61).

Another important factor is the “zone” system when the health workers in the nearby health centres are grouped together to help each other. In my opinion, it is an open opportunity for discussion and collective activities within the existing system.

In addition to that, the trend of national development policy is directed towards decentralisation. The Eighth National Social and Economic Development Plan (1997-

2001), launched in October 1996, has emphasised that people are the centre of development; and that people will determine the success of development. The two identified strategies are developing cooperation between people and bureaucracies by encouraging people participation and focussing on community-based activities. Secondly, it is stated that there is an urgent need to reorganise the existing bureaucratic system in order to effectively translate the policy into practice. For instance, rearranging the financial and personnel management system to be in accordance with community-based activities, and developing a monitoring and evaluation system to serve the new system (National Economic and Social Development Board, 1995).

The suggestions for further study evolve from the identified limitations and my experience of conducting this study. The following are unanswered questions and limitations which needed further investigation.

First, it would be interesting to see whether it is possible to fully implement an empowerment approach in the Thai context. If the time factor was excluded, this type of study could be continued and expanded to the “zone”, rather than concentrated in one health centre. This approach would provide opportunities for the health workers to speak out as a collective voice. It would not only show the health workers that there are alternatives, but also demonstrate to the authorities how they have exercised their power.

It would also be interesting to trial the empowerment approach at a different level of health personnel. The health workers in this study were junior midwives and junior sanitarians who have less training and skill compared to other types of personnel which meant they had less power. Do the personnel in different levels have the same problem or need different types of approach? The framework of this study could also be applied with different groups of personnel, such as community health nurses. Certainly, the study at any level would have to be built-in to routine work processes and without time limitation in order to see whether the empowerment approach would work or not. An approach at different levels would provide an understanding on how to work with different levels of health personnel to support the practice of community participation in the field.

Since there are different interpretations of the concepts under study as previously stated, another suggestion is that further research could be conducted based on different interpretations of the concept of community participation, and different definitions as to who is the community; such studies would therefore involve different types of target groups.

CONCLUSION

The aim of this study was to explore strategies to implement the concept of community participation in health in Northeast Thailand. The continuous deductive-inductive processes of this study enable me to conclude that community participation is the key concept of the PHC approach, and the effect of its implementation determines the success of PHC. The concept of participation was linked with power to make decisions to solve ones own problems. In other words, to participate means to achieve power, or empowerment. Since encouraging community participation in health is still the responsibility of health personnel, the major focus of this study was to attempt to empower the health workers and village health volunteers in the study village, who are oppressed groups in the existing health system in Thailand, to take responsibility for initiating problem solving with respect to health problems in the study community.

In this empowerment process, awareness or consciousness raising is the first step and pivot. The awareness raising process is conducted through participatory research to help the participants to analyse their situations and solve their own problems. The situation analysis enables them to understand the resultant contradictions in their own lives, or to see the social system critically. This is how awareness develops. This process requires dialogue in-depth interpretations and to share those contradictions with others around them.

The main contributions of this study are; first, community participation has not yet been understood among health personnel. The concrete theoretical concept and practical knowledge needs to be disseminated at every level of health professional. It is necessary to empower health personnel during policy implementation and training. Second, the bureaucratic system needs to be reoriented to create a favourable environment for community participation in health, such as decentralisation and review of evaluation

systems. Third, the knowledge gained in this study provides guidance for practice in communities and identifies the required knowledge base of the community health nursing specialty.

In order to successfully implement primary health care it is necessary to empower health personnel so that they can be self-reliant. This, in turn, will enable them to encourage the self-reliance of local communities - the ultimate goal to be achieved.

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