CHAPTER III

PROPOSAL: COMMUNITY HEALTH DEVELOPMENT THROUGH STRENGTHENING HEALTH PARTNERSHIPS: A PILOT STUDY IN KIENG SUB-DISTRICT, MUANG DISTRICT, MAHA SARAKHAM, THAILAND

3.1 Introduction

"We have learned that successful development programs are more likely in a sound policy environment. We have learned that the quality of policies in a developing country is influenced by the political processes by which decisions are made, and that the decision making process, in turn, is influenced by the capacity of the people and institution, not only to formulate decisions but also to carry out on a sustained basis. We also know that capacity means more than technical competence. It extends to the capacity to sustain a dynamic and productive interaction among political leaders, the institutions of government and civil society" (OECD, 1996).

It is becoming increasingly apparent that Thailand has been a successful innovator in many areas of health promotion practice by developing a "Master Plan for Social Development" which aims to financial decentralization and the empowerment of community organizations for local development (Hasroh, Mhankham, and Khamsiriruk, 1999). However, the nation's tremendous investment in medical care and the rapid expansion of its health systems, has led to a plethora of disconnected agencies, programs, and initiatives; most of which focus on particular diseases, risk factors, or services, rather than on the *integrated needs* of people and communities (Buasai, 1997).

That is because the conventional politics have not given voice to some groups or promoted the broad and open discourse that is needed to understand and solve complex health problems. In addition, participation by the population has assumed adherence to the program's aims and directions. with *less* influence on priorities and choices of action areas (Nilson and Kraft, 1997).

In many communities, partnerships between community-based organizations are helping to create supports that enable the community to learn and succeed to expand community health development. For example, the American Stop Smoking Intervention Study (ASSIST) (Michigan ASSIST Project, 1996) is a partnership of national, state, and local organizations concerned with reducing the incidence of tobacco-related cancers. The programs objectives, which are directed toward both smokers and the general public, include policy changes, media advocacy, and prevention activities at the community level. The ASSIST program reflected the partnership aspects of the principles of community participation. That is, when a community affected by change is involved in initiating and promoting the development of that change there is an increased probably that the change will be successful and permanent. This involvement includes participation by the community representatives in defining the problem, planning and instituting steps to resolve the problem.

Another example of a successful statewide partnership effort is the Tobacco-Free Oklahoma Coalition or TFOC (Available at http://www.health.state.ok.us/partners/part2.html). The partnership efforts have had a positive impact on public health through reducing tobacco addition, increasing the utilization of breast cancer screening services, reducing childhood injuries,

or decreasing teen pregnant rates. Moreover, Partners in Health 1999 and Beyond, a strategic partnership between Department of Health and Human Services (DHHS) and the Faculty of Health Science (FHS), University of Tasmania (1999) has shown the value and importance of health partnership to improve health improvement by encouraging the community in health decision-making and improving community participation in health promotion, health protection, and disease prevention programs as well as stated that partnership is the *catalysts* for change in community health development. That is, twenty-five additional communities have existed and requested technical assistance to shift towards population-based public health activities.

3.2 Statement of problems and rationale

Since decentralization with the passage of 1997 constitution that are associated traditionally with participation and empowerment in local development has been implemented throughout Thailand, intersectoral collaboration among private and public sectors was issued resulting in several community health groups or civil society have been established throughout the country, including Maha Sarakham, in order to address health issues. However, the failure in development cooperation to produce sustainable results (Hasroh, 2000; Wibulpoolprasert et al., 2000). In addition to the review of literatures and the problems experienced by the researcher, the problems of collaboration occurred due to the projects have been prepared in an expert, "top-down" manner, with minimal local participation at the onset. Although there are the right kind of experts to design the technical framework for the program, there may be the wrong

kind to undertake collaborative decision-making with local people (Yangkrathok, 2000). As a result, many people will be wary of becoming involved in programs where they feel out of place with other people who are perceived as being more capable and successful.

Additionally, WHO (1993), pointed out that it is the most important to call for collaborated efforts from all the sectors/agencies in attaining and maintaining a state of good health. In Thailand, it can be seen that since health care decentralization and 30-baht universal health coverage scheme have been implemented, community health development is seen to be in the face of diminishing external funding and limited internal budgets for maintaining various health activities (Wibulpoolprasert, 2000; Wongkhomthong, 2001; Yangkrathok, 2000; and Hasroh, 2000), calls for judicious utilization of resources are potentially needed.

Therefore, it can be said that partnerships are becoming an increasingly prevalent way to address complex health issues and many have great strengths. However, they encounter difficulties and many are struggling to realize the full advantage of collaboration and attain their goals (Wagner et al., 1997; Chrislip and Larson, 1994; Kreuter, Lezin, and Young, 2000; Wandersmand, Goodman and Butterfoss, 1997). Additionally, they failed to involve non-health sector inputs to deal with health problems. On the other hand, creating a successful local health partnership is a complex, challenging, and time-consuming task. Therefore, to gain maximum benefit in community health development, stakeholders must participate as a full and equal partner in setting project aims and specifying outputs (WHO, 1997, Niyomwan, 1997). In other words, the collaboration of all local health partnerships among educational and

research institutions, local health sector, local governmental unit as well as community-based organizations which cannot afford to be isolated from the profound changes under way in the health sector is needed. This stresses the importance of participation by all people in identification of problems, plan cohesive interventions, implementation and evaluation in community health development.

Furthermore, regarding the complexity and magnitude of health problems, partnerships can, for example, facilitate the definition of important health issues and concerns, the development of measurement instruments that are culturally appropriate, and the establishment of trust that will enrich the value of the community health development. Additionally, in order to break down these barriers, integrated collaboration through health partnership can act as triggers partners to embark on a community participation will be the study approach to promote community participation instead of the rather broad-bush methods that have been employed until now. This is because health could not proceed alone without exchanges with economic and social activities. Therefore, to overcome such this problem, one unique characteristic is effectiveness partnerships between individuals, communities and all sectors: private, public, professional and voluntary, are essential for addressing their own problems, defining the tasks and roles of various players, selecting intervention options, creating and sustaining effective health interventions and programs. In order to improve such collaboration among health partnerships, Health Team Problem Solving (HTPS) - an interactive learning through action developed by Nan Provincial Public Health Office (2000) by applying District Team Problem Solving (DTPS) strategies developed by WHO (1997) will be used throughout this study. This HTPS aims to improve collaborative relationships with communities experiencing these problems.

It is hoped that this characteristic of a true collaboration among stakeholders would lend themselves to sustainable community development favorable for improvement in health, quality of life and other challenges.

There are four phases throughout this proposed project: baseline investigation; intervention implementation, post-intervention evaluation of short-term impact; and follow-up evaluation of long-term effect. The participatory approach will be used with the full participation of participants at every stage of the project.

3.3 Study question

Can improvement of collaborative health partnerships through HTPS result in changes in community health development, increases people's health and quality of life?

3.4 Objectives

The objectives are divided into two groups; general and specific objectives as described below:

3.4.1 General Objectives

To improve collaboration among health partners through Health Team Problem Solving (HTPS) for community development in Kieng sub-district, Maung district, Maha Sarakham, Thailand.

3.4.2 Specific objectives

1. To identify inputs and the impacts of health programs by partners.

2. To examine attitudes and perceptions of people towards the programs by partners.

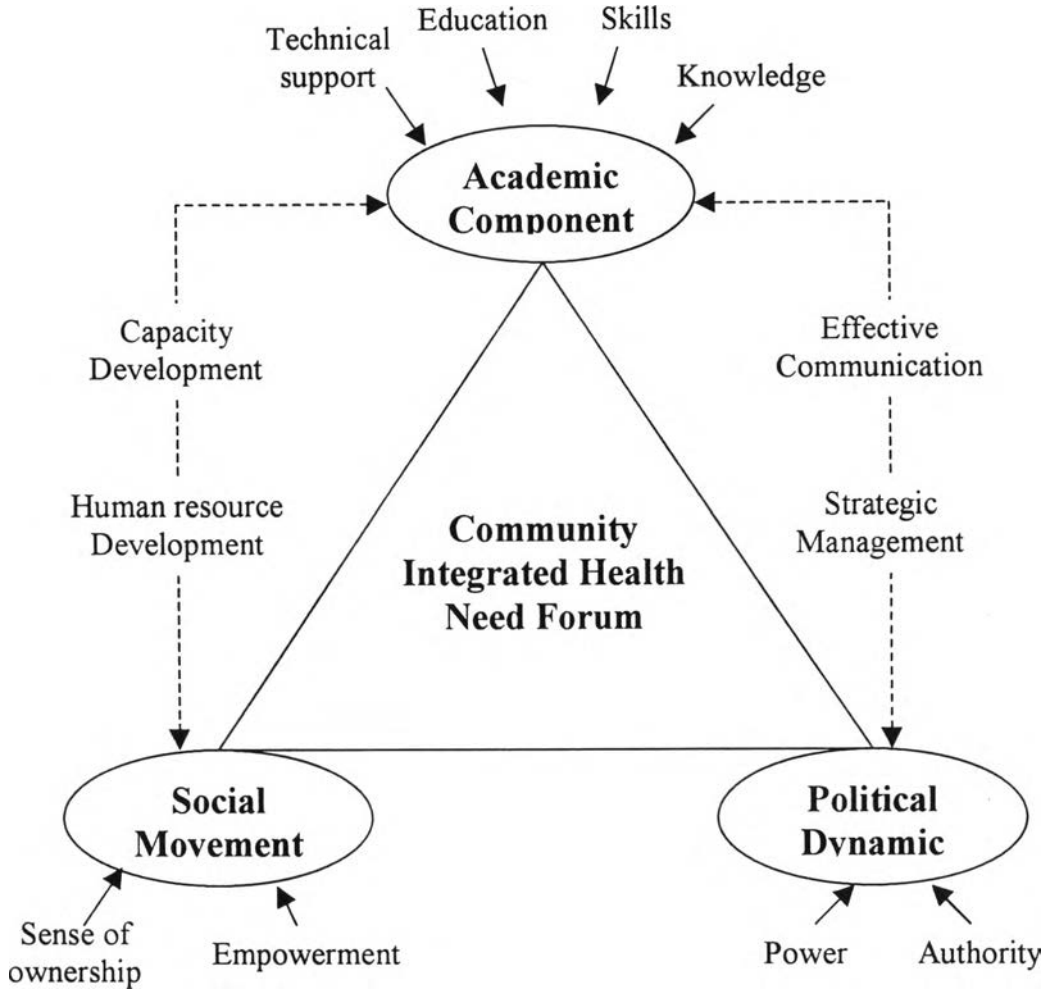
3. To identify success rates of health intervention by various partners.

4. To find out the trend of government financial inputs in Muang District. Maha Sarakham, Thailand.

3.5 Conceptual framework

A broad conceptual framework of this study presented in Figure 3.1 is designed based on the concept of "Samliam Kha Yuain Phu Khao" or "Triangular Mountain-driven" suggested by Professor Praves Wasee (cited in Wibulpoolprasert et al., 2000). What make partnerships unique is their power to combine the perspectives, knowledge. and skills of a group of people and organizations. This unique combining power is then called partnership synergy (Weiss, Miller, and Lasker and the Committee on Medicine and Public Health, 1997; and Karl, 2000). However, to be effective, partnerships need to participate in a thoughtful process to define a vision and clear goals. Partnerships need to have effective governance and management structures to ensure that programs operate efficiently and the partnership is responsive to community needs. Health partnerships also need to draw from a broad range of perspectives and expertise-from outside community as well as community-based organizations and individuals within the community. In addition, health partnerships need to connect, coordinate, and leverage resources from a variety of sources to support and continue their work.

Figure 3.1: Conceptual framework of collaborative health partnerships in establishing community forums.



Source: Adapted from Praves Wasee , cited in Wibulpoolparesert et al., 1990 Towards Health System Reforms, Health System Research Institute, Thailand.

The above figure explains how collaborative health partnership efforts that the related sectors programs will be packaged based upon community needs in such a way that they are implemented effectively, with minimal duplications. Thus, making proper use of limited resources for the community development thereby raising the quality of life. It can be said that combining the perspectives, knowledge, and skills of diverse

partners in the community: academic, social, and political movement in a way that enables the partnership to think in new ways about how it can achieve its goals; plan more comprehensive, integrated programs; and strengthen its relationship to the broader community, partnership synergy will established. In such case, partners do more than exchange resources; they create something new and valuable – a whole that is greater than the sum of its plan. In addition, partnership can accomplish objectives that no one partner could accomplish alone (Lasker and the Committee on Medicine and Public Health, 1997) and will broader community participation in community heath development as an element leading to the establishment of community forum based on integrated health needs. Therefore, through this collaborative partnership, there is more likely to be a shared responsibility and genuine buy-in from all segments of the community.

3.6 Study Methodology

3.6.1 Study area

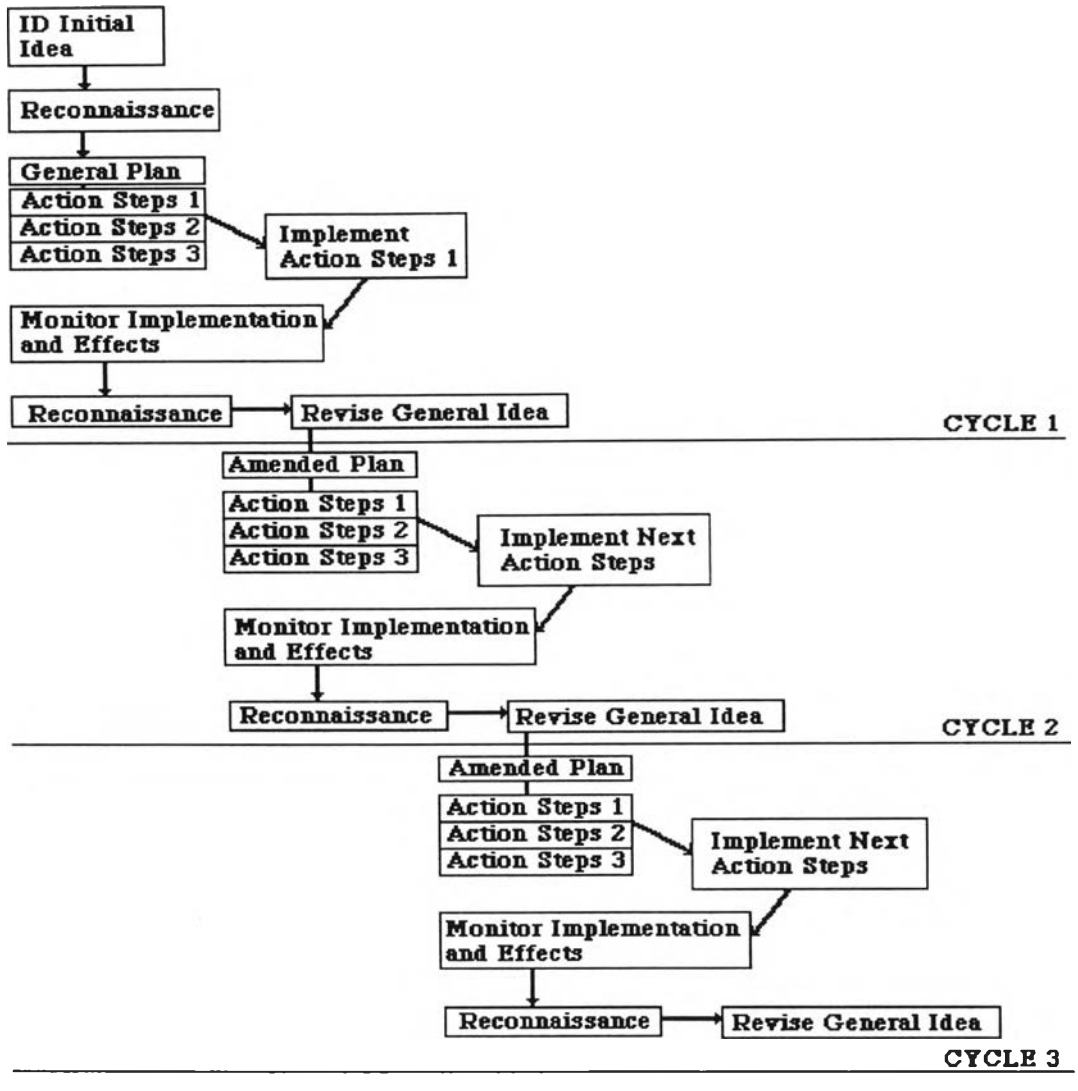
Kieng sub-district, Muang district, Maha Sarakham is purposively chosen based on the assurance of cooperation. In addition, Maha Sarakham was one of ten pilot provinces that have capacity building of Area Health Broad (AHB) in 1999.

3.6.2 Study design

This study is a Community-based Participatory Action Research (CBPAR) to broader health partnership in community health development; helping community to assess the health problems and assets of a community; setting health priorities to tackle, and taking action to address identified concerns and evaluate the program as they move

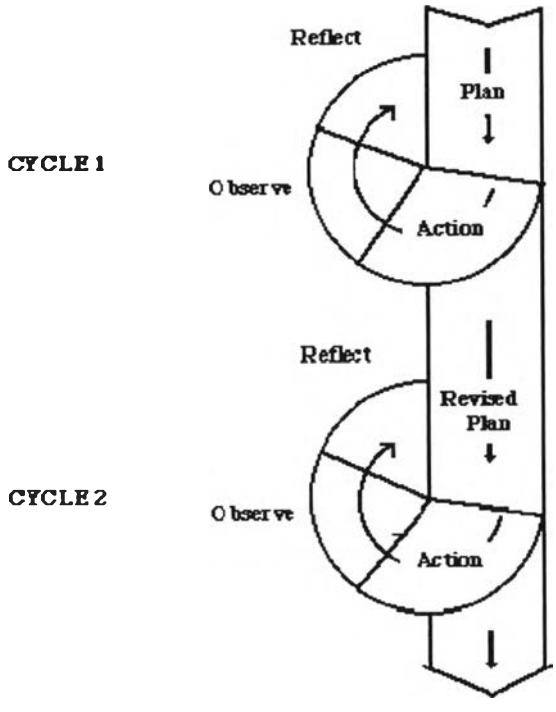
from one phase to the next in developing their projects. This proposed project will be conducted in a manner that reinforce collaboration among stakeholders, community members and research institution. Moreover, this study is designed to be culturally appropriate, for example, due consideration is given to the social, economic, and cultural conditions that influence health status. Identifying and incorporating unique cultural factors into intervention strategies which will result in increased acceptability, use, and adherence. Owing to 97% of people in the pilot site are Buddhist (Chujaruporn, 2001). This proposed study will applied the principle of the Buddhist Noble Truth called 'Ariya Saj 4' along with the principle of cyclical process of PAR. Ariya Saj 4 is the Dharma preaching about four truth factors of life: 'Took' (problems), 'Samhuthai' (causes of problems), 'Niroth' (solutions), and 'Marck' (means or ways to carry out solution. It can be said that these two principles are iterative process which are similar to one another. That is the process begins with identifying problems, analyzing their causes, making hypotheses, testing hypotheses and applying the result of the test, as can be seen in the figure of PAR and Ariya Saj 4 bellow.

Figure 3.2: The cyclical process of PAR



Source: *Narayan, D. (1995) Toward Participatory Research, World Bank Technical Paper, No. 307, Washington, D.C. and Wadsworth,Y. (1998).* ***What is Participatory Action Research?*** *http://www.ncrel.org/sdrs/pathway.htm*

Figure 3.3: The Cyclical process of Buddhist Noble Trust-Ariya Saj 4



Source: Wibulpoolprasert et al., 1990 Towards Health System Reforms, Health System Research Institute, Thailand.

In each cycle of PAR and Ariya Saj 4 are highly flexible and iterative that likely to go through the four phases: plan, act, observe and reflect. That is, a problem is identified and data is collected for a more detailed diagnosis. This is followed by a collective postulation of several possible solutions, from which a single plan of action emerges and is implemented. Data on the results of the intervention are collected and analyzed, and the findings are interpreted in light of how successful the action has been. At this point, the problem is re-assessed and the process begins another cycle. This process continues until the problem is resolved. Therefore this CBPAR that seeks

to expand knowledge and understanding of the potential causes and remedies of community health development, while at the same time enhancing the capacity of the community to participate in the processes that shape research approaches and intervention strategies.

3.6.3 Intervention approach

There are three approaches for this intervention to be committed which are described in the following pages.

1. **Beliefs**: This intervention is committed based on the beliefs of *academies without walls* (Palm, 2001). It is committed to the belief that learning may not existed only at academic institutes but also from community stakeholders working together as a partnership. That is, when collaborative action takes place, it brings together people with different voices and visions to learn from each other through issues and problems, establishing techniques/strategies, action plan, and then use it to shape ongoing decisions and actions.

2. **Fallacies:** According to the study of Steven Polgar (cited in Wibulpoolprasert et al., 2000) on the review and analysis of national health plans of various countries, he pointed out that there are four fallacies in planning and implementing health programs. These four fallacies must be avoid when designing the program for the community are:

2.1 The fallacy of empty vessel: The assumption of policy-makers or health professionals in planning health program is that they always think that the community or people in the community are the person who have no knowledge, skills, techniques or social strategies to manage their problems. Instead, they will wait for policy or health

professionals to solve their problems. Community capacity is, therefore, left behind or unforeseen.

2.2 The fallacy of single pyramid: Community organization or structure cannot build their own organizations unless the government or health professionals establish it for them only. Therefore, the policy made is always official policy process that limited alternative ways to solve problems in the communities. This is because each community is unique. Some strategies that established or useful in one community may fruitless in another community. In other words, this fallacy is limited people to think or use their skills to solve problem.

2.3 The fallacy of separate capsule: In health plans always made in the accordance that health problem is not related to other factors such as economic, social and political factors. Therefore, health problems are partly solved and lack of holistic approach.

2.4 The fallacy of interchangeable face: The policy makers or health professionals always believe that if one program or project has been successfully implemented in one particular area, then it can be reproduced in other places with the same strategies. As a result, misleading to health decision-making that will further lead to the failure of the program.

3. Government policies.

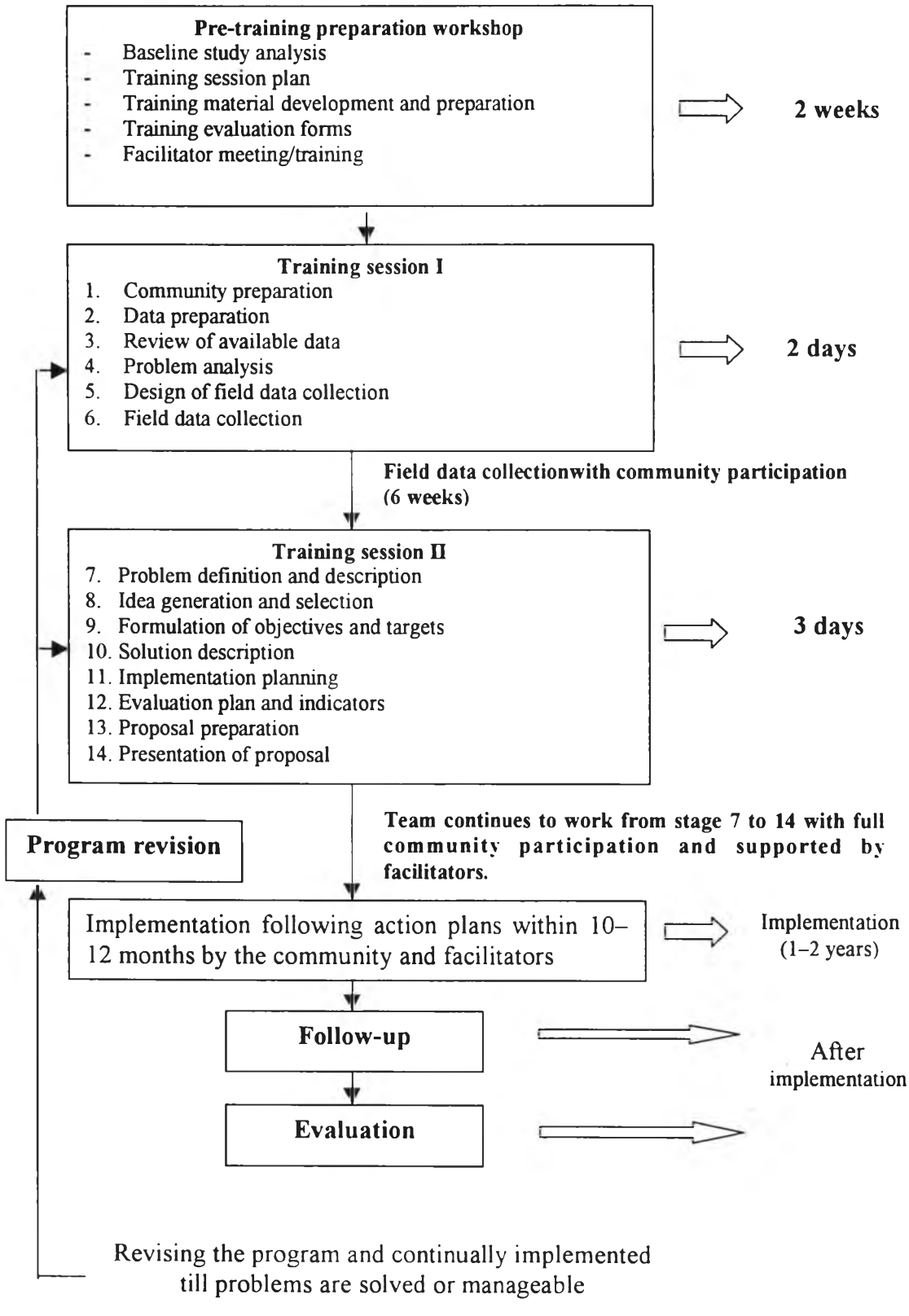
3.1 Decentralization of Health Care Act of 1999 Section 78 (Health System Reform Organization, 2001; and Hasroh, 2001) points toward the decentralization of health services, greater accountability and transparency in the conduct of government and encourage the people's participation and community involvement.

3.2 The Eighth National Economic and Social Development Plan for 1997 – 2001 (Ministry of Public Health, 2000) charts a more human-centred development strategy. It addresses the plan favours reforming the system of public administration to allow more decentralized decision-making as well as an emphasis on intersectoral collaboration between public and private sectors.

3.6.3.1 Description of the intervention

This proposed program is a joint program among Maha Sarakham Provincial Public Health Office (MK PPHO), Maha Sarakham Provincial Government Office (MK PGO) and Maha Sarakham University (MSU). It is proposed to improve collaborative health partnerships through the Health Team Problem Solving (HTPS) process. That is, HTPS at provincial level will oversee activities of the HTPS at district which will be further supported various village development committee which will in turn implement and monitor the activities at the grassroots level depending upon their needs. MK PPHO, MK PGO and MSU will act as a technical facilitating body to set up HTPS. The members of this team come form various organizations both public and private as well as community-based organizations. The activities for improvement are assigned as a following figure:

Figure 3.4: Model of HTPS intervention approach applying CBPAR process



Phase I: Preparation There are three stages in preparation phase.

Stage 1: Staff preparation

Before this proposed project is being undertaken, it would have to start by bringing together key stakeholders from government, academia, the NGO, and other community-based organizations to share their experiences in working together and to get their ideas on how this study should proceed. This process gives opportunity to personnel of every level to participate in the development and decrease the role of leadership and give equality to everyone in expressing view, making decision and eventually proceeding according the group's agreement. This event will mark the beginning of the preparation process for the study. It is also the start point ofa long and involved effort to build consensus for collaboration at all levels in the community. To do this, a one-day workshop will be organized as follow:

a. Collaboration commitment

The concept of the need for involvement of all stakeholders in promoting community health development in Maha Sarakham province will present through a series of the meetings hosted by the Governor of Maha Sarakham province. The meeting will be attended by the provincial representatives of the six crucial ministries such as Agriculture, Education, Animal Husbandry, Engineering, Administration and Account, Health, the private sectors, and the research team. The objectives of this first workshop are to determine priority areas and to discuss community's perception of their own development, and to discuss more about cooperating toward a common goal. Here,

the clearance, vision, mission, supporting forces i.e. financial, human, and technological resources, and meeting regulation will be discussed and established during formal occasion or in during informal sessions. However, commitment will finally be in the contract form.

b. **Provision of ongoing supports:** The systems of training, incentives, social, and political supports will be made widen support for the pursuit of the beliefs and vision among all members of the community.

c. **Fostering innovation and flexibility:** The district develops a policy environment and a management system that foster flexibility and rapid response; that encourage innovative use of time, technology, and space; that encourage novel and improved staffing patterns; and that create integrated need forum that will be responsive to the needs of community.

Stage 2: Targeted area preparation

A pilot site, Kieng sub-district, is purposively selected for HTPS implementation. Prior to the training session, some related health information are prepared which may include:

- General/situation information about the selected area such as causes of disease, health services utilization, community participation. This information will be later compared to with the program outcomes after program is ended.

- Related information that indicates the magnitude of the problem. This will be used as the criteria for problem prioritization.

Stage 3: Facilitators preparation

The interactive learning through action of HTPS process consists of 14 steps.

Step 1: Data preparation

Step 2: Review of available data

Step 3: Problem analysis

Step 4: Design of field data collection

Step 5: Field data collection

Step 6: Analysis of field data

Step 7: Problem definition and description

Step 8: Idea generation and selection

Step 9: Formulation of objectives and targets

Step 10: Solution description

Step 11: Implementation planning

Step 12: Evaluation plan and indicators

Step 13: Proposal preparation

Step 14: Presentation of proposal

a. HTPS training procedure

The characteristics of team need for HTPS training should include:

1. Be willing to participate.
2. Have never been trained about HTPS.
3. Team members are able to carry out the program from the beginning through end.
4. Team must expand the effectiveness of the programs to solve other problems in the future.

b. Components of team: Should include all stakeholder representatives:

1. Head of district health office	1
2. Director of district hospital	1
3. Health academic personnel from district health office	1
4. Municipal councilor	1
5. Promotion health personnel	1
6. Director of district school or representative	1
7. District inspector	1
8. Other academician in the area	1
9. Head of health center	1
10. The presidents of TAO	1
11. Sub-district leader (Kamnan)	1
12. Head of village	1

The training is; therefore, divided into 2 sessions as follow:

Training I: During this session, a two-days workshop will cover stage 1–6 include:

Step 1: Data preparation

Step 2: Review of available data

Step 3: Problem analysis

Step 4: Design of field data collection

Step 5: Field data collection

Step 6: Analysis of field data (6 weeks)

Training II: Analysis the gathered data from step 6 (Training I) before furthering through step 7 – 14. This workshop will set up for 3 days.

Step 7: Problem definition and description

Step 8: Idea generation and selection

Step 9: Formulation of objectives and targets

Step 10: Solution description

Step 11: Implementation planning

Step 12: Evaluation plan and indicators

Step 13: Proposal preparation

Step 14: Presentation of proposal

c. Training techniques

The training session will be interactive learning through action, the strategies and techniques used will include, group discussion, brain storming, seminar and plenary.

Action-planning workshops will be set to facilitate the project. During the workshop, training the participants in the techniques used in the project and worked collaboratively with the facilitators to refine the methodology and begin planning for imminent pilot tests. The workshop will introduce to innovative approaches to participatory stakeholder participation and generate a great deal of enthusiasm for promoting and implementing the program. Furthermore, the workshop will provide an ideal tool for participants to promote equity and excellence, and to be full partners in process. To do this, participants need skills and knowledge about the content and pedagogy of the partnership, as well as facility working through learning-by-doing

approach. At the same time, efforts need models and tools for including participants in significant roles for creative change and sustaining ongoing, systemic improvement.

The attempts of workshop provision are to:

- Help participants to be collaborators, by raising the level of knowledge, and support.
- Enable community to create receptive environments to support positive changes.
- Assist communities to collect, analyze and report the data regarding effectiveness of their learning.

Therefore, the model will be workshop-based decision-making, namely, Health Team Problem Solving (HTPS) that will use Appreciate Influence Control (AIC), Objectives-Oriented Project Planning (ZOPP), and Team up techniques.

Appreciation Influence Control (AIC) is a workshop-based decision-making techniques that encourages stakeholders to consider the social, political and cultural factors along with technical and economic aspects that influence a given project or policy (William, 1991). AIC helps workshop participants identify a common purpose, encourages to recognize the range of stakeholders relevant to that purpose, and creates an enabling forum for stakeholders to pursue that purpose collaboratively. Activities focus on building appreciation through listening, influence through dialogue, and control through action.

Objectives Oriented Project Planning or ZOPP (cited in Nickson, 1993) is a project planning and management method that encourages participatory planning and analysis throughout the project cycle with a series of stakeholder workshops. The

technique requires stakeholders to come together in a series of workshops to set priorities and plan for implementation and monitoring. The purpose of ZOPP is to undertake participatory, objectives-oriented planning that spans the life of project or policy work to build stakeholder team commitment and capacity with a series of workshops. Five distinct ZOPP phases, which run alongside the project cycle, can lead to a sound strategic project plan and the earnest efforts to plan collaboratively prior to implementation increase the likelihood of smooth implementation and the degree of stakeholder ownership and readiness to work toward sustainability.

Team up builds on ZOPP but emphasizes team building through team-oriented research, project design, planning, implementation, and evaluation. It enables team to undertake participatory, objectives-oriented planning and action, while fostering a *learning-by-doing* atmosphere.

Phase II: Mobilize community support and development of intervention plans (3 months)

There are seven stages throughout this phase.

Stage 1: Problem identification and management with the community involvement: A village focus group discussion is set to clarify the objectives of the study as well as to open for communities to identify their community health problems. The management strategies will be integrated with the existing management structures of the village. The management of the village is accomplished by village committees, including administration; law and law enforcement; social welfare; education; religion; culture; promotion of occupation such as finance; and woman committees. However, there are many special groups, such as village health volunteers, village

health communicators, animal husbandry, and various youth groups that will be involved. A broad array of people and organizations involvement in ongoing basis efforts to define and assess community health, prioritize health issues, and take collective action to address community health priorities aims at enhancing and fundamentally transforming, the way these basic community health activities are carried out.

"Power is in our Hands" will be a strategic slogan used to promote the participation from community-based organizations, both health and non-health sectors and to involve people in the major activities. The idea of the slogan aims to:

1. Emphasis on the people problems and using them as the focus activities.
2. Integration of activities of the government, the private sectors and the people with the belief that the private sector and the people have a lot to contribute.
3. Continuity of involvement particularly on the part of the people who are key to sustainability.
4. Implementation in a format which allows an objective evaluation.
5. Mobilization of resources from within and outside the community.
6. Provision of opportunities for everyone to learn from common activities.

All of above principles are though to be the key components that could start a process leading towards a high level of community integrated health needs through self-reliance within the constraints of the current society. That is, all community health programs should encourage people to participate in both individual and collective actions actively according to their needs. Thus, the outcome of this step will be the

documentation of the community baseline data, community basic needs, and potential resources for further possible action plan and interventions. Moreover, the methodologies of community involvement will also be documented.

Stage 2: Community study and issues identification

The Participatory Rapid Appraisal (PRA) will be carried out initially to meet the local authorities and bring them on board and explain the purpose to come to do and ask for their cooperation. This is because gaining their support from the beginning will ultimately ensure the work to progress smoothly. Moreover, it can be clearly said that without their support, change would be impossible. In doing PRA, the objective is to bring together members of the community in an open dialogue to generate learning and spark innovative thinking on a wide variety of issues. Techniques that will be used including open-ended interviewing, focus group discussions, matrix ranking, mapping, and seasonal and historical diagramming to bring out the rich experiences and local knowledge of the community. This is a highly interactive process in which the participants will be able to modify their views as the PRA go along-adding to the previous models or maps, shifting priorities, rethinking their strategies, and intervening new options-as they begin to view and discuss their problems, constraints, and opportunities in new ways. The process is iterative and continuous.

Stage 3: Development of instruments

The next step is to choose the right technique. It is believed that community members are probably the best experts around when it comes to knowing what they need and what they are or are not willing to do to bring about the desired changes their

communities. To do this, an approach needed would not only provide the way to talk with people about what is important to them but go beyond this to involve them actively participate in a whole process. By doing so, the second community meeting will be held to discuss the specifics of undertaking participatory fieldwork and the possibility of using CBPAR. The basic principle of CBPAR will be introduced and explained how it could be used to contribute to the study. The main outcome will be the general consensus on giving this study a try.

Stage 4: Development of indicators for community health plans through CBPAR approach involving all stakeholders

Once the prioritization of the problems is being made using certain criteria, including the magnitude of the problems and the feasibility for control considering the resources availability and constraints, the community-based organizations and research team will be participated in the subsequent meeting arrangement in the constructions of the questionnaire. The new questionnaires will be tested for clarity and the reliability. The validity of each component of the new questionnaire will be verified through qualitative research methods, including in-depth interviews, case analysis and participant observation in selected area. Then, the people will collect their own data that will later be used for identifying community problems, baseline basic minimum needs, potential resources planning, and involvement of all parties. Hence, the indicators for community health plans will be made.

Stage 5: Development of strategies for strengthening community collaboration and interaction

Group organization: A village will consider as a catchment area to develop and strengthen the community participation in community health programs. Therefore, they will manage their own organization. By doing so, it will help in developing structures for continuity, the provision of stability in leadership, structure, and culture over time, including support for innovative efforts that produce desired results. Here, the community development committee will be forms.

Stage 6: Development of action plan

Community plans will be developed through partnership between agencies involved in providing and in consultation with local people. The plans will address strategic objectives set out in this document but will allow local priorities to be identified and addressed in order to:

- Increase communities' involvement in community health development programs by strengthening partnerships between community-based organizations so that resources will be used to best effect and barriers of participation will remove.

- Build the capacity of community by improving both individual and collective participation in the community through social action, voluntary work, social justice and other methods of improving the quality of life.

Stage 7: Development and implementation of intervention

Implementation and interventions will planed according to the problem identified by the community, and then the alternative intervention will be carried out by all stakeholders. The step will include:

a. Community task forces establishment: Governmental sectors, the private sectors and the community will be involved to develop strategic and operation plans based on community problem-oriented. A project that addresses the health issues identified by a community. It starts with a locally driven effort of concerned citizens working on common goals to improve the overall health and well-being of their community.

b. Potential resources pooling and allocation: In order to support the implementation of the operation plans, both external and internal resources are essential. Therefore, the municipality, PPHO, MSU and all community–based organizations are expected to collaboratively allocate budgets to support implementation plans as well as a follow-up on capacity strengthening. By doing so, proposed plans or programs developed through the HTPS process must present and be approved by those supporting fund committees. Furthermore, according to the needs to implement the various aspects of the operation plans, making questionnaires, data collection, priority setting and development of operation plans, technical inputs and capacity strengthening activities will be provided.

Phase III: Program implementation with a full participation of the people, community-based organizations and the research team (1 - 2 years)

This is the third step in the cycle, once actions have planed and agreed upon, the action plans will be implemented with the full participation of community. Therefore, representatives of community-based organizations, public health agencies, health care organizations and educational institutions are involved as appropriate in all major activities of the research process. Some activities that will be arranged are:

1. **Meeting:** The meeting will be organized between the community-based organizations, stakeholders, and the researcher to design operation plans and to identify responsible parties. The strength of the community organizations and participation will be the key to sustainable development.

2. Delegation of roles and responsibilities: The main objective is to ensure inclusiveness of participation in various aspects of the operations such as sharing of manpower, resources, program implementation, and evaluation throughout the project.

3. Prime movers: The prime for specific tasks will also be arranged. This is because, some interventions might require sophisticated technology and will be developed by technical experts from the Ministry of Public Health. They will be charged with the responsibilities to coordinate inputs with the municipality technical officials, MSU staff, and the community.

4. Presentation of the proposed program: The proposed programs will present and be approved by local government and all stakeholders for ongoing of the program.

5. Implementation (1): The implementation will be carried out following the proposed plans with the facilitator supports.

6. Periodic feedback: Feedback along the program, is another critical component of program implementation. Regarding CRISP principle (Campbell, 1997), feedback should be:

Constructive:	presented with feasible recommendations
Relevant:	comments made about achievements and problems seen
Immediate:	every report is fed back immediately after analysis
Selective:	not every detail is fed back to all levels
Presentable:	set out in a form understandable by everyone.

Therefore, the periodic feedback will be obtained and presented to all potential stakeholders in the community during program implementation to modify the interventions according to changing needs using quarterly meeting as the key mechanism. This is because some difficulties may be seen during the implementation stage. The progress or problems occur will be monitored regularly during this phase. Staff meetings will also consult each other to deal with problems.

7. Post-intervention monitoring of short-term impact: Developing structures for results-oriented decision making will also be provided. That is, results-oriented management system and a quality-focused decision-making process that are consistent with the beliefs that guide the system and that ensure that measures of quality conform with the requirements will also be made. The results, recommendations, and lessons learned will be valuable inputs for further development of intervention for the next step.

8. Implementation (2): This phase will include reflection, evaluation and problem re-identification.

9. Follow-up (long-term effect): Throughout this stage, writing up a report, arranging workshops at provincial level to discuss and disseminate findings and recommendations as described in the following phase.

Phase IV: Monitoring and evaluation

The measurement and indicators will be assigned base on the identified problems and proposed program by the full participation of the community and the stakeholders. The monitoring and valuation will be conducted jointly by the stakeholders according to the indicators in the proposed program and to ensure that the program is going on the right track. Although the implementation is divided into various steps, there are considerable overlaps between each other. However, the steps identified only serve as general guidelines to follow. The actual running of the program dictated a going back and forth between the various steps based on the cyclical process of PAR basis.

The program results as well as the process of organizational strengthening will be the guiding principle of program implementation. In addition to evaluation elaborated in the process, all baseline parameters identified by the new questionnaire will measure at the end of this 3 years after the program implementation. Northeastern Primary Health Care Training and Development Center (NEPHCTDC), Khon Kaen, and Khon Kaen University (KKU) will help in evaluation and give technical inputs and undertake capacity strengthening efforts, such as strengthening the capacity of the people in problem analysis, priority setting and the development of a cohesive plan.

Nevertheless, in order to know whether the project is successful or not, this study applied the evaluation pattern of Scriven (cited in Abnot and Guijt, 1998). This evaluation pattern focuses on each phase of the project which can be divided into two stages as follows.

Stage 1: Formative evaluation

The formative evaluation focuses on the methodology of the project in order to follow its progress and give monitoring. The research team will evaluate each of four phases of the intervention program which focuses on the project progress of the strengthening health partnerships through HTPS in order to know whether the project has been continuously worked or not. It is fully recognized that systematic monitoring and evaluation of progress on implementing the strategy and subsequences action plans will have to be carried out. The action plan includes the performance indicators that will be used to measure progress.

To conduct an evaluation to provide information for future modification and management for those continuing to be involved with this project, including community-based organizations which have supported the project by provision of resources and staff participation at the project meetings and events, and community members who have been active participants in the project; thus this evaluation has two functions. First, a formative evaluation providing information for ongoing program improvement. Second, an impact evaluation determining the results and effects of the program to date. Correspondingly, this evaluation is an assessment of both the processes employed during the project and the outcomes.

Stage 2: Summative evaluation

This kind of evaluation focuses on the implementation of work. The research team will make the summative evaluation when the project had been completed using following questions.

- What will be the input factors of this project?
- What is the process resulted from the research?
- Does the work achieve the defined objectives?
- What are the results of this project?
- What are the impacts of the project?
- How is the effectiveness of the project?
- Etc.

Choosing the most useful process for assessing the outcomes of a project is largely determined by the extent to which outcomes have been specified as clear, identifiable, and measurable goals. In the case of this project the clearly identifiable goals have been simply (1) the establishment of a multi-stakeholder group, and (2) the production of a community-based organizations' problem management strategy. This is because to restrict this evaluation to the achievement or non-achievement of these goals would not satisfy the requirements to provide useful information to the project participants and to those involved in future initiatives. Broader project outcomes (see objectives in section 3.4) include to improve collaboration among health partners for community health development, and to improve health and quality of life of the people. In this situation a goal-free or needs-based evaluation is a more suitable process for evaluating the project.

Goal-free evaluation attempts to document the actual affects of the project on the target participants or addresses the extent to which actual participant needs are being met by the project (Abnot, and Guijt, 1998). A goal-free evaluation requires a substantial input from the participants since the focus is on what they are experiencing rather than what *should* have happened. Therefore, as PAR approach is used for this study, the process used in this evaluation has been primarily a participatory one which in keeping with the project's basic principles of citizen participation.

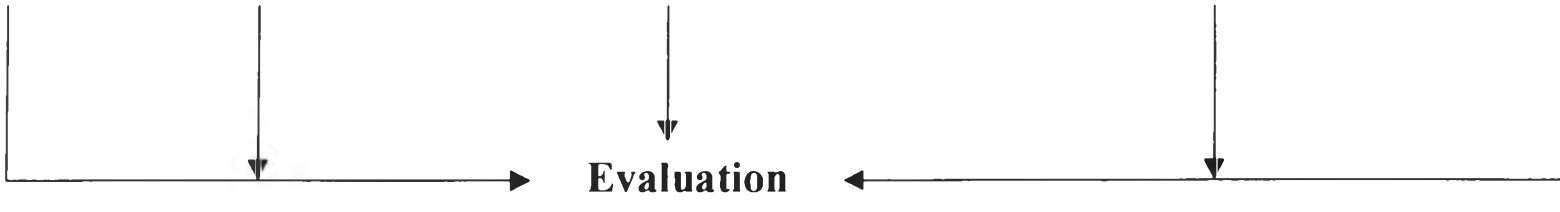
Along with the meetings, review on the action - plan progress including what worked and what did not work will be probed. Under this circumstance, a revision of the action plan will be done. Moreover, the strategy needs for follow-up, assessment and information-gathering activities will be agreed upon, which will further lead to step one again. Therefore, the cycle of PAR will then continue after the evaluation has shown whether the program is actually taken place as planed or not. Therefore, the outcomes are generally expected to be seen in following areas.

- Positive changes in community participation performance. That is, by the end of study period, high percentage (80% or above) of community participation in community development will be seen.

- Gap between the actual practice and the ideal practice would have minimized through better collaborative management among health partners.

Figure 3.5: Evaluation design

nput	Process	Output	Results	Impa
n resource: Team Solving g ne study	-Learning-by-doing process to strengthen partnership - Learning-by-doing process	- Feedback - Partnership functioning - Health - Human resources - Funding - Health information - Resolved health problems - Community participation/community capacity - Established HTPS and its network - Community health forums both private and public sectors, at community and higher levels. - New mechanism in thinking and working through health problems from community through provincial level. - New financial management.	- There is a network system of HTPS - There is a manual of HTPS - Improve in people's health and quality of life	- Health status - Achieving heal - Community ca - There is a goo of working am - Partners arc their work



Evaluation plan

Table 3.1 shows the timeframe and work plan throughout the proposed project. The evaluation of the intervention implementation will be done on a regular basis during routine activities as designed by the participants. However, apart from being continuous during each phase, monitoring will do following on a regular basis:

- Provide guidance and support to complete task.
- Readjustment of unrealistic timeline
- Exploring together with staff alternative root causes and solution to the problem
- Rethink a solution that has turn out not feasible.

Additionally, the team will come together to review the action plan, assess progress made on the implementation, and decide on the follow up steps. It will be done in the following manner,

- During routine staff meeting
- Action plan development quarterly meeting
- Annual review meeting.

3.7 Time frame

The proposed project will be carried out for three years. It is planned to start from July 2003 to June 2006 (Table 3.1).

Table 3.1: Timeframe and work plan of a proposed three-years pilot project.

Activities	1st year (July 2003 – June 2004)				2nd Year (July 2004 – June 2005)				3rd Year (July 2005 – June 2006				Responsible
	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	
Analyzing existing documents and health promotion programs													RT
Project proposal discussion with all stakeholders													RT, CC
Draft project proposal protocol and obtain approval													RT, CC
HTPS training													RT, CC
Community mobilization													HTPS, RT
Analyze data for interpretation													HTPS, CS
Defining indicators													HTPS, CS, RT
Developing questionnaires & conducting data collection training													HTPS, Cs
Development of action plan													CS
Implementation of plan													HTPS, CS
Conducting data													HTPS, CS, RT
Analyzing data													HTPS, CS, RT
Annually review													HTPS, CS, RT
Overall evaluation													NEPHCRDC-KK, KKU
Developing guidelines and publishing													

RT = Research Team, NEPHCTDC-KK = Northeastern Primary Health Care Training and Development Center, Khon Kaen, KKU = Khon Kaen University,

3.8 Data collection

3.8.1 Quantitative data

3.8.1.1 Instruments

- **Primary data:** The instruments both questionnaire and evaluation forms for data collection will be designed base on problems or programs identified by the community.

- **Secondary data:**

  - The results from the partnership level assessment (Chapter IV) will also be used.

  - Financial records from district and the community levels

  - Disease profile

  - General community development plans

3.8.1.2 Data collection plan

a. Preparation

1. Inform all community-based organizations such as Maha Sarakham Provincial Health Office, Muang district health office, TAOs, Health center at the sub district level and the village head man of the sample villages.

2. Training for data collection (using WHO data collection guidelines provides in Chapter IV).

b. Action

1. The interviewer-administered will be carried out following the items in the questionnaire guideline and will take approximately 30 minutes to complete.

2. While interviewing, strict confidentiality will be maintained by not recording the name of the participants.

c. Evaluation

1. The gathered date will be checked and decoded in the field. If the questionnaire is not complete, it's needed to be interviewed again.

2. The gathered data will be entered into a program and checked by double entry technique using SPSS.

3.8.2 Qualitative Data

3.8.2.1 Focus group discussion (FGD)

One of the objectives of the study is to explore the perception of the community on the key factors affecting partnership synergy in Maha Sarakham. The FGD will be done first in the during phase to identify health issues or problems by full participation of the stakeholders and the community.

The Focus Group Discussion (FGD) planning

The FGD methods, strategies and guidelines will be made during the stakeholders meeting as well as the necessary equipment will also consider.

3.8.2.2 In-dept interview

In-depth interview will be included in this study; however, the guidelines will be developed by the research team and .

3.9 Data analysis

3.9.1 Quantitative data

1. Survey data will be checked and processed using SPSS for Window.

2. Both survey and secondary data will be analyzed using descriptive statistics in terms of *frequency, mean*, and *standard deviation*.

3. The results of survey will be triangulated with the findings in the in-depth interviews, focus group discussions, and observation.

3.9.2 Qualitative Data

Interview, focus group discussion, and observation data will be transcribed in narrative forms using summative and verbatim quotes

3.10 Expected Outcomes

The expected outcomes of the project are:

1. Improvement in collaborative health partnership through HTPS in provincial, district, sub-district and village level resulting in establishing continuous HTPS network.

2. Increased health programs with full community participation and collaboration among health partners that will lead the community resolve their own problems systematically.

3. Increased community capacity in problem-managing and solving continuously.

4. The success of the program will be generalized to the whole district.

5. The local derived strategies will constitute useful recommendations to guide the future work for health policy, research and decision making on important aspect of health and social services.

3.11 Utilization of results

If successful, the enhanced program will not only be used as a guideline for the selected area but also for enhancing other public health programs in communities throughout Thailand. This is because participation has not only generated interest, ownership and collaboration among different government agencies, NGOs, and research institutions, but, more important, it has opened up a realm of possibilities for involving local people in their own development.

3.12 Ethical consideration

Because research is carried out in real-world circumstances, and involves close and open communication among the people involved, The study will be approved by the Ethical Committee of the North-eastern Research Institute, Maha Sarakham University before undertaking. The relevant persons, committees and authorities will be consulted, and that the principles guiding the work are accepted in advance by all.

3.13 Estimation of budgets

As this proposed project is a joint program between three main stakeholders, MK PPHO, MK PGO and MSU, the major sources of fund for this proposed project will be approved by these three organizations The budget is designed accordingly only for the major activities as the following table.

Table 3.2: Estimation expenditure for program activities

Budget category	1st Year	2nd Year	3rd Year	Total
Notification to relevant authorities of the purpose and methods of the study; visit each sample site prior to promote active cooperation; logistical preparation and administrative procedure				**5,000**
- Stationery	2,000			
- Transportation –fuel	3,000			
Establish coordination committee: Two-weeks workshop to develop				**5,000**
- Consultant	2,000			
- Refreshment & stationaries	3,000			
HTPS workshop				**74,000**
- Resource persons				
4 persons x 5 days x 1,800 baht	36,000			**36,000**
- Workshop materials				
20 persons x 5 days x 100 baht	10,000			**10,000**
- Stationery				
20 persons x 5 days x 40 baht	4,000			**4,000**
- Communication: phone, fax etc.	1,000			**1,000**
- Food & refreshment				
30 persons x 5 days x 100 baht	15,000			**15,000**
- Transportation –fuel (non-local)				
4 persons x 2,000 baht	8,000			**8,000**

Budget category	1st Year	2nd Year	3rd Year	Total
Data collection procedure				**83,000**
- Food & refreshment				
30 persons x 6 weeks x 50 baht/day	52,500			**52,500**
- Transportation –fuel				
6 weeks x 500 baht	17,500	5,000	5,000	**18,500**
- Questionnaire				
200 x 10 baht	2,000	2,000	2,000	**6,000**
- Communication: phone, fax etc.	1, 000	1, 000	1, 000	**3,000**
Data analysis				
- Stationary	1,000	1,000	1,000	**3,000**
Implementation **# Establish village development committee & meeting** - Prepare village plans - Review plans & monitoring every meeting	Budget as approved by all stakeholders	Budget as approved by all stakeholders	Budget as approved by all stakeholders	
Monitoring and evaluation procedures				**86,500**
1. Personnel				
- Consultant (2 persons x 3 days x 500 baht	3,000	3,000	3,000	**9,000**
2. Quarterly monitoring	10,000	10,000	10,000	**30,000**
3. Annual review	4,000	4,000	4,000	**12,000**
4. Project evaluation by KKU and NEPCRD-KK	10,000	10,000	10,000	**30,000**
5. Report				
- 50 copies x 50 baht			2,500	**2,500**
- Photocopy	1,000	1,000	1,000	**3,000**
Transport & Materials				**74,950**
- Local	5,000	5,000	5,000	**25,000**
- Non-local	10,000	10,000	10,000	**30,000**
- Filed trip	5,000	5,000	5,000	**15,000**
- Paper	1,000	1,000	1,000	**3,000**
- Diskette	250	250	250	**750**
- Tape cassettes	200	200	200	**600**
- Writing materials	200	200	200	**600**
Miscellaneous & supplies				**21,550**
Total (Baht)				**350,000**

REFERENCES

Buasai, S. (1997). An Organized Approach to Setting up a Health Promotion Organization in Thailand. *Health Promotion Matters;* 1 (3): 18-20.

Butterfoss, F.D., Goodman, R.M., and Wandersman, A. (1997). Community Coalition for Prevention and Health Promotion: Factors Predicting Satisfaction, Participation, and Planning, *Health Education Quarterly*; 23: 65-79.

Boelen, C., (2000). *Towards Unity for Health: Challenges and opportunities for Partnership in Health Development; A Working Paper*, Geneva: WHO.

Bracht, H., (1999). Health Promotion at the Community Level 2: New Advances, London: SAGE Publications, London.

Campbell, M. (1995). *The Challenges of Conducting Cross-Disability, Cross-Cohort Survey, Research in a PAR Environment*, Annual Conference of the National Association of Rehabilitation Research and Training Centers.

Chrislip, D.D., and Larson, C.E. (1994) Working Together: A Profile of Collaboration, in *The National Study of Partnership Functioning*, Weiss, E., Miller, R., and Lasker, R., The Center for the Advancement of Collaborative Strategies in Health, Division of Public Health: New York, New York Academy of Medicine, http://www.cacsh.org.

Chujaruporn M. (2001). *Tambon Administration Organization versus Primary Health Care*, The Journal of Primary Health Care; 2 (1), January – March: 7–10.

Hasroh, J. (2000). *Decentralization of Primary Health Care Process to Tambon Administration Organizations*, Primary Health Care Journal: Northeastern Edition; 16(3), February – March: 38 – 46.

Hasroh, J., Mhankham, K., and Khamsisriruk, P. (1999). *Public Health Civil Society: Case Study of Donwan, Mung District, Maha Sarakham, Thailand,* Khon Kaen: Northeast Primary Health Care Training and Development.

Health System Reform Office, (1999). *Health Care Reform Project in Thailand,* Thailand: Ministry of Public Health (MOPH).

Health System Reform Office, (2001). *Conceptual Framework of National Health System (draft)*, Thailand: Ministry of Public Health (MOPH).

Kachondham, Y. (1993). *Rapid Assessment and Analysis Procedures, In: Qualitative Research in a Development World: Applications for Population and Health Issues*, Institute for Population and Social Research, Mahidol University, Thailand.

Karl, M. (2000). *Monitoring and Evaluating Stakeholder Participation in Agriculture and Rural Development Project: A Literature Review*, Sustainable Development Department (SD), Food and Agriculture Organization of the United Nations (FAO), http://www.fao.org/Ppdirect/Ppre0074.htm

Kreuter, M.W., Lezin, N.A., and Young, L.A. (2000). Evaluating Community-Based Collaborative Mechanisms: Implications for Practitioners, *Health Promotion Practice*; 1: 49-63.

Lasker, R.D. and the Committee on Medicine and Public Health (1997). *Medicine and Public Health: The Power of Collaboration*, Chicago: Health Administration Press.

Michigan ASSIST Project (1996). *Michigan ASSIST Project: Annual Action Plan.* Michigan Department of Public Health.

Ministry of Public Health (2000). *The Eighth National Economic and Social Development Plan (1997 – 2001)*, Office of the Prime Minister, Bangkok, Thailand.

Nan Provincial Public Health Office (2000). *Report of Health Team Problem Solving Process*, Nan: Provincial Public Health Office.

Narayan, D. (1995). *Toward Participatory Research*, World Bank Technical Paper, No. 307, Washington, D.C.: The World Bank.

National Association of County and City Health Officials (NACCHO). (1991). *Assessment Protocol for Excellence in Public Health (APEX/PH)*. Washington; http://www.naccho.org

Niyomwan A. (2001). *Civil Society versus Health System Reform*, The Journal of Primary Health Care; 2 (1), January – March: 57 – 67.

Palm, L. (2001). *Tunring Point State Priorities for Change*, A National Program Supported by The Robert Wood Johnson & te W.K. Kellong Foundations: http://www.turningpointprogram.org.

Scriven, L. (1973). "Monitoring and Evaluation Social Development Project", in Abbot, J., and Guijt, I. (1998). *Changing Views on Change: Participatory Approaches to Monitoring the Environment*, SARL Discussion Paper No., 2, London: International Institute for Environment and Development (IIED).

Wadsworth, Y. (1998). *What is Participatory Action Research?* http://www.ncrel.org/sdrs/pathwayg.htm

Wiboolpolprasert, S., Poolcharoen, W., Chunharas, S., Juengsatiansup, G., and Sriratanabuln, J., (2000). *Towards Health System Reform*, Thailand: Health System Research Institute.

Weiss, E.S., Miller, R., and Lasker, R.D. (2001). Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage, *The Milbank Quarterly*; 79 (2): 179-205: http://www.cacsh.org

Williams, R.M. (1990). The Kaiser Foundation's Grassroots Approach Enables Communities to Set Their Own Health Priorities; The Technique Works and It's Become Contagious. *Foundation News* 1990:24-29.

Wongkhomthong, S. (2001). *Health Problems in Developing Countries and Basic Concepts for Soling Them*, The Journal of Primary Health Care, 2 (1), January – March: 73 – 85.

World Health Organization (1993). *Implementation of Global Strategy for Health for All by the Year 2000*, Second Evaluation, Eight report on world health situation, Vol. 4, Regional Officer for South-East Asia: New Delphi.

World Health Organization (1997). *Improving the Performance of Health Centers in District Health Systems*, Report of a WHO Study Group, Geneva.

Yangkrathok, S. (2000) *How can Health Care be Transformed to Tambon Administration Organization?: Experience from Nakornrachasrima Province*, Journal of Mohanamai; 10 (1): 41 – 48.