

Potential Mechanism Development of Local Health Security Funds and Graduate Volunteers on Health Management

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Abstract—Thailand has been faced the challenge to solve alcohol, tobacco, and drugs for decades. Many government sectors, especially ministry of public health, and non-government organizations, have critical roles in control and prevention. However, the other mechanisms are graduate volunteers and local health insurance funds that have not been yet cleared for their roles in these management. This study aimed to explore and develop the capacity of both mechanisms in generating plans and projects for fixing these health risk problems in community level. The study was conducted during June 2017-December 2018 by a participatory action approach in 27 pilot provinces of 12 health regions, Thailand. The 578 participants consisting of 100 graduate volunteers, 306 local health security fund committee and 172 provincial coaching teams that were trained to create plans and projects through a specific website. The findings revealed that both mechanisms actioned in developing 843 plans for alcohol, tobacco, and drugs equally 276, 276, and 291, respectively. The 1,053 projects were approved to be done inside the community for alcohol, tobacco, and the drugs that were 325, 386, and 342, respectively. The strategic approaches in those plans and projected were categorized into 8 items: (1) New case prevention (2) Reducing an access (3) Quitting services (4) Alternative rehabilitation (5) Increasing social measures (6) Health protection for all (7) Increasing health risk communication (8) Personal role models and learning centers. These indicated that both mechanisms could be used for health risk solutions at the community level in all parts of Thailand

Keywords— Local health Insurance funds, Graduate volunteers, Health risk management; Alcohol, Tobacco, Drugs.

1. Introduction

Alcohol consumption, smoking, and drug use are frequently co-occurring in worldwide [1]. People who drink alcohol often also smoke and illicit drug use or vice versa, leading to health threatening for mortality, the burden of diseases and injuries [2]. Global patterns of health risk exposure are often developed during adolescence and these habits tend to define individuals' lifestyles later in life. In Thailand, these problems have been major concerned of the public health and justice

systems at individual, family, societal, and national levels. Since the prevalence of health-risk behaviors among Thai people especially in the adolescence can be found at an early age in recent years [3]. These problems contribute to attempt in the management of alcohol, tobacco and other drug-related issues for demand, supply, and harm reduction strategy.

The synergistic mechanisms among the government sectors, private sectors, non-government organizations, civil society and health movement volunteers are powerful for a health partners and networks to deal with behavioral risk factors. For example, Thai Health Promotion Foundation (ThaiHealth), National Health Security Office (NHSO), Ministry of Public Health (MOH) present critical role in health risk solutions in health promotion and prevention. The principles collaboration of health and law enforcement in leading the implementation of the three pillars of harm minimization. For these efforts, the smoking rate decreased from 22.5% in 2001 to 18.2% in 2014 and alcohol drinking decreased from 8.1 liters of pure alcohol in 2005 to 6.9 liters in 2014 [4]. In addition, prevention programs can be organized on a large scale and address in several settings in Thailand.

According to health risk factors have negative consequences on the health, economy, productivity, and social aspects of communities. The other mechanisms are involved particularly in community level such as graduate volunteers and local health security funds (LHSFs). The former mechanism is supported by Southern Border Provinces Administrative Centre (SBPAC) for developing village strategic plans in 5 provinces, Deep South of Thailand. The latter mechanism is supported by the NHSO and local governments in co-matched funding on promotion and prevention activity at sub-district level [5]. These mechanisms are receiving increasing attention in community-based approaches for the prevention and control the health risk problems.

For decades, the most implementation strategies have been focused on secondary and tertiary prevention in Thailand. These are directed towards people who have a higher or specific risk of suffering health risk problems and people with an existing disease, disability, or medical condition to overcome it, or to improve their quality of life. In contrast, primary prevention is a crucial step that protects people from developing health risk factors-related problem or experiencing an accident or injury. In addition, the other mechanisms are graduate volunteers and local health insurance funds that have not been yet cleared for their roles in these management. Thus, this study aimed to explore and develop the capacity of both mechanisms in generating plans and projects for fixing these health risk problems in community level to achieve a sustained improvement in health outcomes in all part of Thailand.

2. Literature Reviews

1) Local Health Security Funds (LHSFs) have critical roles in community-driven activities based on Ottawa Charter to promote health and prevent diseases such as noncommunicable diseases (NCDs). This initiative is funded by the Universal Health Coverage of NHSO and Local Governments [6].

2) Health promotion and prevention financing mechanisms in Thailand consist of three agencies [7]:

- local governments share major funding roles for health promotion and prevention services
- the Ministry of Public Health (MOPH)
- the National Health Security Office
- the Thai Health Promotion Foundation
- Local (Tambon) Health Insurance Funds.

3) The total expenditure on prevention and public health in 2010 was 10.8% of the total health expenditure, greater than many middle-income countries that average 7.0–9.2%. MOPH was the largest contributor at 32.9%, the Universal Coverage scheme (NHSO) was the second at 23.1%, followed by the local governments and Thai Health Promotion Foundation at 22.8 and 7.3%, respectively [8].

4) Graduate volunteers play effective roles as agents of change and the main force in community development.

Nowadays, there are thousands of graduate volunteers in 5 southern border provinces that are playing great roles in the health promotion in the community level.

5) The SBPAC works as the main coordinator promoting developments in the southern border provinces with the role of a total of 2,249 graduate volunteers from those provinces.

3. Methodology

Study design: This study was carried out during June 2017-December 2018 by using a participatory action research approach to strengthen and enhancing

continuity role of the graduate volunteers and local health security funds for developing plans and projected based on health risk management in community level.

Participants and Setting: 578 participants were purposively selected from a pool of stakeholders who were actively involved in the health regional projects at provincial, district and sub-district levels. These consisted of 100 graduate volunteers, 307 local health security fund committee and 172 provincial coaching teams in 27 pilot provinces of 12 health regions of Thailand.

PAR Study Phase: Research organization was conducted in 5 phases as follows:

Phase One: Preparation and situation analysis.

Training needs analysis (TNA) is the crucial starting point to identify the existing gaps or to meet the need of a new skill acquisition. This step was performed with core teams from all 12 health regions to determine about training need assessments for participant skills of plan and project improvement. Since health risk management requires mechanisms to be skilled in performing complex tasks in an efficient, cost-effective, and actionable plans. The objectives of the need analysis were to:

- 1) Identify problem and needs in both mechanisms.
- 2) Determine and design for workshop and training required to fill the gap in both mechanisms.

Phase Two: Planning framework.

This was the first step of the training management cycle. As training is a performance improvement tool for health risk management, it is needed when both mechanisms are not performing up to a certain standard or at an expected level of performance. The difference between actual the actual level of job performance and the expected level of job performance indicates a need for training. The identification of training needs is the next step in a uniform method of instructional design. This step enabled an academic team to anticipate and meet training need in a timely and cost-effective manner as follows:

1) Performance gap analysis identified performance gaps by comparing the current and desired operational results for both mechanisms performance. The discrepancy between the desired performance of plan and project development and their actual baseline performance was used as a performance gap for this study.

2) Root cause analysis determined the possible causes of performance gaps. It helped an academic team to figure out the possible causes of the performance issue such as lack of skills, capacity and motivation. Once the root cause was determined, it become easy to outline and map the appropriate solution to bridge the gap for this study.

Phase Three: Action-the proposed solutions.

The previous step represented the performance of both mechanisms that was an unsolved issue or capacity needs as follows:

- Inadequate knowledge or skill deficiency in health risk management.
- Lack of basic skills for plan and project development in health risk management.
- Inadequate knowledge of new technologies to create a new plan and project.
- Population need requirement for new methods or services to solve health risk behaviors.
- Lack of coaching on higher performance standards in each pilot province.
- Lack of motivation for new tasks in both mechanisms.

These brought to consider that a workshop and short course training might be necessary to strengthen in both mechanisms. This step also contributed to develop courses for health risk management, plan and project manuals and mappings including training action plans for each region of Thailand (North, Northeast, Central and Southern). Program implementation plans finally included the scheduling of training activities and organization of any related resources. In addition, a specific website was developed for this training and evaluation (<https://localfund.happynetwork.org/>)

Phase Four: Workshop training-strategy and delivery.

Through the participatory action research, where participants of this study can be able to share knowledge, participate in meetings and workshops. This process contributed their own experiences in defining and developing the plan and project elements leading to building not only capacity but also ownership of their tasks.

The training procedures were done in 5 steps as follows:

- 1) Define: Explored baseline capacity of the participants from each region.
- 2) Outline: Determined the main topics and subtopics for learners in each region.
- 3) Build: Created a short course and content production/slide presentation for the training workshop.
- 4) Engage: Developed a website and manuals to understand the contents of the training. This helped our target learner understand why it is valuable to them and increase value for their works.
- 5) Measure: Constructed to measure the effectiveness of the training workshop in 4 regions.

Phase Five: Post-training evaluation and learning.

This step was a critical part of the training program that gave an academic team an idea of what the participants thought of the course and valuable insight into the training program from both mechanisms' perspective. Thus, in every session, the participants' s

feedback regarding the training program was one of the measures of how successful it was, at the end of the day.

Data Collection: The project duration was approximately 21 months after the protocol was accepted and became financially supported in June 2017. Data were collected through documentary research, a constructed-website—web-based applications improving the effectiveness of plan and project development (localfund.happynetwork.org/), and group discussions with semi-structured open ended question.

Data Analysis: Quantitative data were descriptively analyzed using descriptive statistics, and qualitative data were content-analyzed.

Ethical Approval: The study protocol was approved by the Ethics Committee from Health System Management Institute, Prince of Songkla University (Ref.no 60-0010) prior to initiating the study. All participants gave their written informed consent.

4. Results

Demographic Data of Participants

Demographic characteristics of participants in this study was presented in Table 1.

Table 1 Demographic Data of Participants

Participants	Health Region	Province	Number (person)
Graduate volunteer	12 only	5	100
Health Regional Coaching Team	1-12	27 (pilot)	14
Provincial Coaching Team	1-2	4	29
	3-6	8	42
	7-10	8	41
	11-12	7	46
Local health security fund committee	1-12		306
Total	12	Pilot 27	578

Current Outcomes

Number of health risk management plans and projects-derived from this study was demonstrated in Table 2.

Table 2 Number of health risk management plans and projects-derived from this study

Alcohol		Tobacco		Drugs		Total
Plan	Project	Plan	Project	Plan	Project	Plan
276	325	308	386	291	342	875

Evaluating Capacity Development Results

Mapping the Capacity Development Results Chain

The key principle strategic approaches-derived from plans and projects

The key principle strategic approaches in those plans and projected addressing its three pillars of supply

reduction, demand reduction and harmreduction that were categorized into 8 items:

(1) New case prevention

Because health risk factors—use of alcohol, tobacco, and drugs commonly begins in adolescence. These substance use associated with a wide range of negative impacts on children and youth's mental and physical health as well as on their wellbeing over the short and long term.

(2) Reducing an access to supply sources

Young people's use of tobacco, alcohol, and other drugs caused major concern in this study. This strategy was rigorously controlled by law enforcement and social measures for them to difficult to access in price (tax policy), place, and time.

(3) Quitting services

Several plans and projects provided the target groups considering enrolling in a treatment program for drug or alcohol addiction and smoke cessation.

(4) Alternative rehabilitation

Some were introduced an alternative rehabilitation in many channels such as online, phone, and other support for quitting smoke, drugs, and alcohol.

(5) Increasing social measures

One potential approach to reducing the use of these health risk factors was using the social measures and peer pressures such as the restricted the sale of tobacco and alcohol inside the community. The community rules were announced that no alcohol drinking in every community ceremony.

(6) Health protection for all

This program run in the communities to prevent all people to be victims of these substances such as secondhand smoke exposure.

(7) Increasing health risk communication

Health communication played a role in the prevention of alcohol, tobacco, and drug use through community forum and community meeting.

(8) Personal role models and learning centers

These strategic methods were major resources to learn how people can avoid health risk factor trapping or get rid of their struggling.

Process of Capacity Building and Lessons Learned

1) The participation and ownership of program development was a crucial step to achieve the mission of strengthening in both mechanisms for community-driven roles.

2) Participant feedback should be obtained from all stakeholders that involved in this study to determine program and instructor effectiveness, knowledge and skill acquisition. Analyzing this feedback could be allowed the core team and academic team to identify any weaknesses in the training program.

3). Partnerships (core team, academic team and coaching team) in this study was a fundamental component of an effective capacity building strategy because of their central role in establishing

ownership, support, and sustainability of capacity building interventions in their roles.

5. Discussion

Use of alcohol, tobacco, and drugs is associated with a wide range of negative health consequences worldwide. Like these health risks harm place a high burden on the Thai community. For example, tobacco smoking is the top risk factors for non-communicable chronic diseases (NCDs), including various types of cancer, respiratory disease, and ischemic heart disease. Similarly, illegal drugs can not only have dangerous physical and mental health impacts but are a significant contributor to criminal cases. Other alcohol-related harms include its toxicity, road safety, and other accidents, domestic and public violence, crime, NCDs, unsafe sex, unintended teenage pregnancy, birth defects and disability, family breakdown, and broader social dysfunction etc. The purpose of this study was that to explore and develop the capacity of local health security fund committee and graduate volunteer mechanisms in developing plans and projects to solve these health risk problems in community level.

The process of study using PAR approach presented the capacity development rather than capacity building because the process was driven from the inside and starts from their existing capacity assets more than supporting only the initial stages of building. For the levels of capacity, this study focused on both individual level—skills, experience and knowledge that are vested in both mechanisms, and organizational level—the internal policies, arrangements, procedures, and frameworks, except enabling environment. However, this study emphasized the use of knowledge and learning in empowering local health security funds and graduate volunteers to advance change the health risk behavior of people through their plans and project that occupied with alcohol, tobacco, and drugs. Furthermore, the role of book manual, mapping, and website program acted as a project tool providing the context and rationale to improve the plan and project development towards both mechanisms.

The findings indicated that it is possible to integrate PAR research into alcohol, tobacco, and drugs prevention programs running by the partnership between the researchers and the coaching teams. In addition, this study enhanced the capacity of both mechanisms to prevent and minimize alcohol, tobacco, and other drug-related harm across the domains of supply, demand, and harm reduction activities in the community level. This contributed to the local governments responding to these of alcohol, tobacco and drugs prevention plans and projects in their areas.

6. Conclusion

This study was conducted using PAR approach to explore and develop the potential of local health security fund committee and graduate volunteer

mechanism for health risk management due to alcohol, tobacco, and drug use at community level in 27 pilot provinces, 12 health regions of Thailand. The findings revealed that 843 plans and 1,053 projects for alcohol, tobacco, and drug use management were developed. These indicated that both mechanisms could be used for health risk solutions at the community level in all parts of Thailand.

Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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