

**THE MARGINALITY OF ORAL HEALTH PROMOTION AND
PREVENTION: LEARNING THROUGH LIFE AND WORK OF
DENTAL AUXILIARIES**

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**THE MARGINALITY OF ORAL HEALTH PROMOTION AND PREVENTION:
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THESIS ADVISORY COMMITTEE : LUECHAI SRINGERNYUANG, Ph.D., NATTHANI
MEEMON, Ph.D., SONGVUTH TUONGRATANAPHAN, Ph.D.**ABSTRACT**

The purpose of this thesis was to study the situation of oral health promotion and prevention through studying the role, experience, and work life of dental personnel; in particular, the dental auxiliaries who are defined as the main mechanism of oral health promotion and prevention. The methods for data collection were interviews and entering into the world of dental personnel by ethnographic techniques for nine months.

This study attempts to understand the meanings and values of oral health promotion and prevention through dental personnel working in the provincial health office, hospitals, and sub-district health promotion hospitals in a small province of Central Thailand. The study suggests that oral health promotion and prevention as the work life is endowed with negative values and meanings. It did not reflect the dental professional identity.

The social meaning of work in oral health promotion and prevention could be viewed as a marginality. Dental personnel think that oral health promotion and prevention uses not only less knowledge and less potential but also a loss of dental professional identity. Moreover, the employee earned lower income than those doing treatment work. Therefore, the responsibilities of this work were assigned to the dental auxiliaries as the para medical personnel. However, the dental auxiliary group began less power and authority but more responsibility in their work, and they became the only group of dental personnel who were left out by the governmental system regarding advancement and security in their careers. They also lacked support and had no rights to participate in thinking and decision making regarding work-related issues.

The ineffectiveness of oral health promotion and prevention were a reflection the marginality of oral health promotion and prevention in the public health system. This study sheds light on the fact that the performance of oral health promotion and prevention are complex health problems that require a paradigm shift in understanding in order to solve the problem.

**KEY WORDS: DENTAL AUXILIARIES / BIOMEDICINE / MARGINALITY / ORAL
HEALTH PROMOTION / ORAL DISEASE PREVENTION**

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สถานะชายขอบของงานส่งเสริมและป้องกันด้านทันตสุขภาพ : บทเรียนผ่านชีวิตและการทำงานของทันตภิบาล
 THE MARGINALITY OF ORAL HEALTH PROMOTION AND PREVENTION: LEARNING THROUGH
 LIFE AND WORK OF DENTAL AUXILIARIES

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บทคัดย่อ

การศึกษานี้ มีวัตถุประสงค์เพื่อทำความเข้าใจถึงสถานะของงานส่งเสริมและป้องกันด้านทันตสาธารณสุขผ่านการศึกษาบทบาทในการทำงาน ประสบการณ์ และชีวิตของทันตบุคลากร โดยเฉพาะในกลุ่มทันตภิบาลซึ่งถูกวางให้เป็นกลไกสำคัญในการทำงานเหล่านี้ โดยการศึกษานี้เป็นการศึกษาแบบชาติพันธุ์วรรณาในกลุ่มตัวอย่างที่เป็นทันตบุคลากรที่ปฏิบัติงานอยู่ในสำนักงานสาธารณสุขจังหวัด โรงพยาบาล และโรงพยาบาลส่งเสริมสุขภาพตำบล ในพื้นที่จังหวัดขนาดเล็กแห่งหนึ่งในเขตภาคกลาง โดยมีระยะเวลาในการศึกษานาน 9 เดือน

ผลการศึกษาพบว่า ทันตบุคลากรทั้งทันตแพทย์และทันตภิบาลต่างให้ความหมายและคุณค่ากับงานด้านการส่งเสริมและป้องกันทันตสาธารณสุขไปในเชิงลบว่าเป็นงานที่ใช้ความรู้และความสามารถในการทำงานน้อย ไม่แสดงถึงศักยภาพ ไม่ทำให้เกิดตัวตนในสายตาของประชาชน และเป็นงานที่ทำรายได้ก็น้อยเมื่อเปรียบเทียบกับงานด้านการรักษา ทำให้ทันตบุคลากรต่างให้ความสำคัญกับการทำงานในด้านนี้น้อย บทบาทและหน้าที่จึงตกไปเป็นของทันตภิบาลซึ่งเป็นบุคลากรในสายสนับสนุน แต่อย่างไรก็ตามทันตภิบาลกลับเป็นกลุ่มที่มีอำนาจในการทำงานน้อย เป็นบุคลากรที่ถูกระบบราชการทอดทิ้งให้ไม่มีความก้าวหน้าและความมั่นคง ขาดแคลนทรัพยากรต่างๆ และไม่มีสิทธิ์ร่วมคิด ร่วมตัดสินใจในการทำงาน ซึ่งลักษณะเหล่านี้ส่งผลให้ทันตภิบาลตกอยู่ในสถานะของชายขอบ รับรู้ถึงอำนาจในการทำงานของตนเองที่ต่ำ ทำงานได้ไม่เต็มประสิทธิภาพ ขาดขวัญและกำลังใจในการทำงาน สิ่งเหล่านี้สะท้อนให้เห็นว่าการที่งานด้านการส่งเสริมและป้องกันทันตสาธารณสุขต้องตกอยู่ในสถานะที่เป็นชายขอบของระบบสาธารณสุขเป็นผลมาจากกระบวนการทัศน์แบบชีวการแพทย์ที่เป็นรากฐานที่สำคัญ แนวคิดแบบผู้เชี่ยวชาญ รวมถึงวิถีคิดในเรื่องของระบบทุนที่ให้คุณค่ากับงานด้านการรักษาและโอกาสทางเศรษฐกิจทำให้กลไกด้านกองทุนทันตกรรมที่เกิดขึ้นไม่สามารถแก้ปัญหาเหล่านี้ได้

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CHAPTER I

INTRODUCTION

1.1 Statement of the problem

The dental public health are comprised of 4 major parts, which are health promotion, disease prevention, treatment, and rehabilitation as same as other general primary health care. The oral health promotion and oral disease prevention are considered very important as they are sorts of operational works that help removing and reducing the health problems or the cause of illness and death. (Zarkowski, 2006) They help reducing diseases as well as the severity of the diseases, which reflect the better quality of life of the people. Moreover, they are lower investment cost compared with the treatment of the diseases. (Penkhae Labying, 2006) In addition, they consume lesser time and fewer numbers of personnel since the health promotion and disease prevention can be conducted with plenty people at the same time. Whereas the treatment must be done for an individual so it needs numbers of personnel, the promotion and prevention are the way to save the whole system cost or the individual cost. For example, the lifetime cost of water fluoridation per head (1 person) is lesser than one tooth fillings cost (Jenkins, et al., 2005) or the cost of pit and fissure sealant for preventing the dental caries in children by the government dental personnel which costs 128-177 Baht per one tooth (depends on the wage rate of the dental personnel) (Penkhae Labying, et al., 2007) which is lower than general fillings cost.

The persons who play an important role in all 4 services providing to the people are dentists and dental auxiliaries (which had a role model from dental nurses in New Zealand, but in the Dental Auxiliary Association called themselves as the dental auxiliaries). Almost all dentists under the Ministry of Public Health will work in the district hospitals and the provincial hospitals which are the secondary and tertiary care units. But the dental auxiliaries are working closer to the people in the primary care unit system. They could be found in vary levels from the sub-district health promotion hospitals, the district hospitals to the provincial hospitals. While the

dentists are able to complete all 4 aspects of work as they have more knowledge with 6 years-Bachelor degree in the university, the dental auxiliaries can complete only the first 3 aspects of work. They cannot do the rehabilitation work as they have been trained for 2 years-Diploma of Public Health Program from the college of Public Health only. The major roles and responsibilities of the dental auxiliaries are perceived that they have to focus on oral health promotion and disease prevention. This study will emphasize on this group of dental auxiliaries.

For the oral health promotion and disease prevention works, the major target group which has been continuously worked with for a long term is the primary students since they are easy to be approached as they enter the school system. In addition, these children are having the first permanent tooth in their oral cavity when they became 6 years old and later ones would appear one after another until 28 teeth when they are between 12-13 years old. Also, this period of child's life is the most suitable time for forming good habits in oral health care and preventing dental caries. (Nathe (2005), Waraporn Jirapongsa, et al. (2004) and Penkhae Labying (2006)). This study, therefore, selected the case study concerning the oral health promotion and disease prevention in primary students as a sample case in clarification.

Recently, it has been found that the operation guideline in oral health promotion and disease prevention works in Thailand has been changed and developed periodically. From the project called "Incremental dental care" during 1972-1987 which organized the dental auxiliaries to work in the community hospital (the district hospital) and they were providers of comprehensive care for the first primary students individually as a complete case that included promotion, prevention and treatment works. Then, the consistence monitoring would be provided until the students are in primary level 6. Moreover, the Fourth National Economics and Social Development Plan in 1977-1981 had started the policy on dental health stated that it had to extend the service providing to the population in order to reduce the prevalence of diseases. Having the children in school as the target of the incremental dental care about 10% of the whole country students (The office of the National Economics and Social Development Commissions, 2008) However, the result of the project found the problem was the service had covered very low numbers of the primary students only

0.9% and 0.7% of the schools nationwide since there were insufficient dental personnel. (Piyada Prasertsom, et al., 2009)

Later, the policy had been changed to “Dental Health Surveillance and Promotion for Primary school students” since 1988 in the cooperation between Ministry of Public Health and Ministry of Education in order to expand the role of dental health promotion in school for the teachers. The training has been provided for teachers to be able to screen and take the students with dental problem to the health care service units. Including, the trained teachers to be able to oversee the activity that students must brush their teeth after lunch and do the fluoride mouth rinse. Then the dental auxiliaries have changed their roles into the supporters, monitors, and dental treatment providers. For the surveillance results in 1993, it is found that the oral examination by the teachers could cover 75.6%, the tooth brushing after lunch was 83.7%, the fluoride mouth rinse every two weeks was 74.4% and the dental care received (filling and extraction) covered 20.3 % (Waraporn Jirapongsa, et al., 2004) The schools could complete several activities following the policy about 70%, also they were successful in making habits of tooth brushing after lunch for the students. However, there were higher numbers of students with decayed tooth since lacking of systematically food consumption care and taking sweets or snacks that risk for decayed tooth (Piyada Prasertsom, et al., 2009, already referred)

In 1999, the work plan had been changed to be conducted under the concept “Health Promoting School Initiative” in order to be coherent with World Health Organization (WHO) plan to support the concept of WHO’s Global School Health Initiative since 1995. The purpose was to strengthen the health initiative and health education in schools by emphasizing the circumstances and environments for the healthy setting that was suitable for living, learning and working (WHO, n.d.a and Anuwat Suppachutikul, 1998) The oral health operation was integrated into the umbrella project of health promoting school initiative e.g. developing the learning curriculum of Ministry of Education together with the overseeing and controlling of food consumption of children through the healthy setting in school such as avoid selling sweets, toffee, soft drinks in school and encourage tooth brushing after lunch. Moreover, there was the adjustment of oral health care system to cooperate and support the operation of oral health promoting in children (Office of Health

Promotion, Department of Health, 2005) The concept for implementing the health promotion school initiative was to fulfill the surveillance project as it focused on the environmental factor that supported the individual factor in the previous project.

Once there was a health system reform by raising the policy of universal coverage “30 baht for curing every disease” scheme which was tested in 2001 and was effective over the country a year later in 2002 (Sa-nguan Nittayarumpong, 2005) This change had created a new organization which has an authority to form the policy to control several works of health care service and personnel. That organization was known as National Health Security Office (NHSO) which was established according to the National Health Security Act 2002. It has responsible for managing the fund for the highest effectiveness, as well as improving the health care system for people to be able to access the quality standard services (National Health Security Office, n.d.) The changes have caused the NHSO became the budget controlled organization as a purchaser. So it has the authority to define the pattern of needed services, while the roles of Ministry of Public Health as a policy maker and activity operators have been reduced.

NHSO had chosen the way to allocate the budgets to the hospitals or the Contracting Unit for Primary Care (CUP) by using the capitation payment according to the numbers of people who hold the golden card in one particular area. With this payment, it helps (the government) saving and being able to control the expenditure of the whole system. On the other hand, it had pushed the negative impacts to the hospitals in both aspects of the budget management and the services providing. So the hospitals have to take responsibility on the financial risks. As the more people came for the services or getting for the high cost treatment, the higher chances for the hospitals to get lost. However, if the hospitals could possibly control their expenditure until they had budget left over, they would get benefits. Thus, this way seems to have its own weakness in creating the problem of service’s quality or reducing the services in order to cut their costs. (Saowakhon Rattanavichitrasilp, 2005)

In the same way, the result of assessment rate of oral health care service after the project of “30 baht for curing every disease” has been operated, at the beginning the amount of work in dental care services in the health care units were increasing obviously about 15-30%. As the service receiver groups were mostly adults

and elderly, while the young children group became lesser. In addition, most of the regional service units at all levels had decreased their active roles of promotion and prevention. Especially, the private sectors' health care service units (hospitals) as they all were aware of that active works cost higher expenditure. While the general hospitals and regional hospitals where the most personnel were specialty dentists or general dentists would focus more on the treatment as their main duty. They have not emphasized continuously on the protection. This had affected to the reduction of the oral health promotion and prevention services for nursery, pre-school age, and primary school children. From the assessment in 2004, it was found that the promotion and prevention works were occupied only 14% of all services. (Sunee Wongkongkathep, 2006: 74)

When the NHSO had realized that the reduced numbers of services on the children oral health promotion and protection in all organizations, including the results of the national oral health survey of the year 2001 which shown that there were only 5.3% of the 12 years old children had the permanent first molar sealant, although the oral examination and sealant have been included in the privilege rights in this program. In the fiscal year 2005, NHSO had solved the problem of the service coverage by organizing the vertical program called "Yimsodsai Dekthaifundee" (which is the oral health promotion and prevention services in school) as the project had separated supporting budget and management. The project's budget was 193 million baths for the three years period. The objectives were to allocate the specific budgets for the promotion and prevention service system clearly in the way that the budget allocated purposely for the targets and results. (Sunee Wongkongkathep, 2006: 67-68) By doing so, the record of oral health examination of Primary level 1 and Primary level 3 students would be taken into the database in order to be able to organize the sealant service for Primary 1 students and to organize the teeth brushing activity after lunch daily in Primary schools (Bureau of Dental Health, Department of Health, 2009)

Base on the evaluation of the project "Yimsodsai Dekthaifundee" found that in the academic year of 2007 the dental personnel were able to do the students' oral exam according the target. The Primary level 1 students have received sealant service increasing 35.92%-48.82% and the schools could organize the teeth brushing

activity after lunch almost 80%. In addition, the evaluation of impacts in reducing the decayed teeth in the two years period after the project, it was found that the Primary level 3 students who had been received sealant service for two years had the rate of decayed tooth only 33.09% in comparison with the other children who had not received the service. The occurrence rate of the decayed first permanent molar was 66.91% (Waraporn Jirapongsa and Piyada Prasertsom, 2008)

Although there have been the attempts to implement the activities and adjust the ways of oral health promotion and prevention in the primary students for more than 40 years, when considering the dental caries situation in this group of children it was found that it had been increased dramatically. From the six times of the national oral health surveys done by Bureau of Dental Health, Department of Health (2008a), there was no a good trend of the decayed teeth. The results had shown that the 12 years old children group had 45.8% of children with decayed tooth in the year 1984 and became 53.9% in the year 1994 and finally became 56.87% during the years 2006-2007 (Whereas the Bureau of Dental Health had set up the target and the indicator of the oral health promotion in primary children should not be exceeded 55% (referred in Khanit Rattanaungsima and Piyada Prasertsom, 2009) However, the average DMFT (decayed, missing and filled permanent teeth) was rather stable from 1.5 in 1984 and became 1.6 in 1994 and 1.55 during 2006-2007 (as in Table 1)

The data showed that there were the changes in rate of diseases occurrence and the severity of specific disease only in the beginning which was about 1977 to 1984. After that, the dental health status of Thai children almost has no changed or improved in the better way. Comparing to the Fourth German Oral Health Study, it was found that in the year 1997 the group of 12 years old children had 58.2% of decayed tooth and average DMFT was 1.7 which were similar to Thailand. However, Germany could possible reduce the percentage and the severity of caries disease obviously in 2005 or within eight years later, the percentage of decayed tooth became 29.9 and average DMFT became 0.7 (Schiffner, et al., 2009)

Table 1.1: Showing the caries prevalence in 12 years old children in overall Thailand

	Surveyed year					
	1977	1984	1989	1994	2000-01	2006-07
Percentage of children with the decayed permanent tooth	66.7	45.8	49.2	53.9	57.3	56.87
DMFT (teeth per person)	2.9	1.5	1.5	1.6	1.6	1.55

Remark: Data in the year 1977 was taken from the subject content of Dental Public Health for Rajabhat University students (n.d.)

In 2010, NHSO had established the “Dental Fund” (first operated in the fiscal year 2011) since it realized that very few people could access the dental service, especially the rural people while the numbers of oral disease occurrences were increasing. According to the data from the Department of Service Support, Ministry of Public Health in year 2008, it was found that was only 15% of population used the dental service in the Universal Coverage (UC) health security system. Therefore, to have more people access to the service, especially the oral health promotion and prevention service, NHSO has set up 4 target groups of this work, who are pregnancy women, pre-school age children, school age children and elderly people age over 60 years old. However, the school age group was emphasized by NHSO since the indicators for achievement were: 1) Not less than 70% of Primary level 1 students in each area have been received oral health examination, 2) not lesser than 20% of Primary level 1 students who had been examined should be received the complete treatment including prevention and treatment works. While the other Primary levels students have not been identified the indicators, they have been able to receive necessary services following to their rights as same as the Primary level 1 students have. (National Health Security Office, 2010 and Dentist Wirat Euangpoolsawas (Interview))

Dental Fund, then, was the cause of enormous changes in oral health promotion and prevention works for several age groups since NHSO allocated budget to CUP (Contracting Unit for Primary Care) for 37 Baht per person. So that each hospital that is a CUP can define the concrete operation guideline and be unity in policy (Wirat Euangpoolsawas, et al., 2010 and National Health Security Office, 2010) Therefore, each hospital has received budget from hundred thousand to millions digits in order to operate the oral health promotion and prevention which increased from ten to hundred thousand digits baht only in the past.

In the previous time, although Ministry of Public Health and NHSO have implemented following the policy continuously and there were specific personnel, the operation pattern, working method and successful works in each area might have been different. So this study needs to find the answer that why the oral health promotion and prevention was small and unimportant as since the past there was only the attempts to allocate man power and resources. At present, there is the allocation of Dental Fund budget from NHSO to the hospitals (CUP). Therefore, I, as a researcher, would like to study that how this financial change, which was the chosen mechanism by NHSO, would impact to the dental personnel to give more or less significance the oral health promotion and prevention, and how it would affect to the works status?

This study has tried to propose a new vision to look at this phenomenon by considering the situation of oral health promotion and prevention works through role, experience and life of the dental personnel, in particular, the dental auxiliaries who defined as the main mechanism of this work. The study then tries to point out that the problems in oral health promotion and prevention works as well as the problems in dental auxiliaries are the reflection of the power structure in solving the health issues under the medical science conceptual framework or biomedicine that focuses on treatment rather than health promotion and disease prevention. In addition, it emphasizes on using of the expensive technology rather than fixing the behavior problems or promoting the community participatory. All aspects forced the oral health promotion and protection works fall into the edge (margin) or become at the last priority, which in this study called the situation as marginal status.

1.2 Research objectives

This study focused on creating the understanding of situation of oral health promotion and prevention through studying roles in the works, experiences and life of the dental auxiliaries. The study was based on the assumption that the problem state and working status of dental auxiliaries on the oral health promotion and prevention was the reflection of marginality of this oral health promotion and prevention that relying on the contextual conditions which were the biomedicine paradigm and the structure of service system that defined concept and working style of oral health works.

1.3 Research questions

1.3.1 Main question

How was the working status of oral health promotion and prevention for the primary students group?

1.3.2 Sub questions

1. How was the way of thinking, meaning, and valuing to oral health promotion and prevention of the dental personnel?
2. What were problems and obstacles of oral health promotion and prevention works?
3. What were the pattern of work on oral health promotion and prevention of the dental personnel?

1.4 Expected benefits

This research study would help to create the understanding of the situation of oral health promotion and prevention in the area contexts. The results would also be applied for guidance in the development planning or adjusting the administrative

policy and for suitable management of the oral health promotion and prevention in primary students later on.

CHAPTER II

LITERATURE REVIEW

The remedy of pain from gingivitis and oral diseases of the people had been happened since when or where, there was no document evidence. However, the first oral health service provided by the government sector was happened around 1891 when the American Physician named George B. McFarland who was graduated bachelor's degree in Doctor of Medical and Doctor of Dental Surgery from The United States of America and came to work in Siriraj Hospital as a doctor. He also opened his own clinic after official hours (cited in Dental Division, Royal Thai Army Medical Department, n.d.). For the dental health service providing in King Chulalongkorn Memorial Hospital occurred in the year 1914 by having foreign dentists as the service providers as well. Later, in the year 1919, the government had clearly managed the oral health service providing through Health Department, Ministry of Interior. It had established the dental section in Vajira Hospital in order to provide services of dental diagnosis and treatment for the general people. While the oral health service for student group were depending on the health pavilion of Chaokhun Pra Prayoonwongsa and the health pavilion of Bangrak, then the service extended to the students group in nearby areas under the cooperation of Medical Sanitary School division, Ministry of Public Instruction (School Health Division, in the later). Then, in the year 1937, the School Health Division had set up Dental Section to take care of student's oral health in particular. (Waraphon Jirapongsa, et al., 2004)

In the period before 1947, the service providing management was rather independent, so the services were fixed in Bangkok and the big city only. After the policy to establish the hospitals in every province during 1947 until 1956, the dental health section had been established in the provincial hospitals and this was the beginning of oral health service in regions. For the oral health service in the district level, it was happened in 1970 when there was the appointment of dental auxiliaries who graduated from Public Health College, Chonburi for the first academic batch, to

work in the First class Health Stations where later were changed to District Hospital. They were assigned to provide the service called “Incremental Dental Care: IDC” to the primary students which was the comprehensive care integrated all promotion, prevention and treatment works altogether (Waraphon Jirapongsa, et al., 2004). That was considered the beginning of the oral health promotion and prevention works in the primary student group. So at first, oral health promotion and prevention was operated by the dental auxiliaries since the dentists at that time did not prefer to work in provinces or even worse in cases of the districts that far away. In 1976, there were only nine dentists working in the district hospital nationwide (cited in Waraphon Jirapongsa, et. al., 2004). Therefore, most of the oral health care works for students and general people were belong to the dental auxiliaries who had limited roles at work. Then after 1989, there was the regulation that the new graduated dentists must repay the scholarship by working outside the city in the community hospitals (district hospitals) in order to provide the oral health care services of treatment, rehabilitation, as well as oral health promotion and prevention.

To understand the status of oral health promotion and prevention, I (as the researcher) had reviewed the concepts explaining the status and operation of the oral health promotion and prevention in the governmental hospitals which there were 3 concepts as following; (1) the concept concerning the professional aspect, medical paradigm and the capitalism, (2) the concept on disease prevention and health promotion and (3) the concept about the state of marginality. These concepts were considered as this research framework as the following details.

2.1 Professional, Medical Paradigm, and the Capitalism

The physician is the occupation that has been accepted by people since the past time as it has been established as the profession. Such professional occupations are often separated themselves from others by claiming that they have to use their scientific knowledge which is abstract, complex, and specialist knowledge in providing service for other people. This profession is limited among a few people, thus, the work of profession often monopolizes. The professional knowledge would be related to the educational background in the university as it could present that they had

passed the trainings and held the certificates or the degrees as guarantee. So this knowledge became powerful and created autonomy and authority existing in the expertise. Thus, the physicians could use their knowledge in controlling and ordering people under their care and patients treatment (Daniel (1990), Freidson (2001) and Cruess, et al (n.d.))

The claim of scientific knowledge was the significant thing promoted the growth of medical science throughout the 19th and 20th century. As the efficacy of practice and validity of the knowledge, therefore, the medical has been accepted from people. The medical service had been controlled and standardized by the Professional Association. The profession itself had supported by the government so the authority of profession had been trusted then the autonomy had occurred (Daniel, 1990)

Although there was a claim on codes of ethics which controlled behaviors and works of professional (Cruess, et al, n.d.) and also a claim on being neutral and value free of scientific knowledge, we must not forget that the science and technology was also a part of forces of production (Navarro, 1986) as under the concept of Bourgeois who were the group of Dominant class that often were the owners or managers of medium sizes business including all kinds of professional such as lawyer, architect, physician, dentist, as well as the middle class level civil servants (Miliband, 1987). They believed that science and technology was a force for development as well as it could define nature and what going on in the society. Therefore, the scientific knowledge was not neutral but it was full of social relations of production. Under this capitalism, the dominant ideology of bourgeois was occurred in every institution including in the manufacture, medical and scientific institution such as hospital. These institutions became not neutral as they supported the power relations existing in the society in order to specify how the works in the institutions should be done, by whom, what kinds of instruments, and how much they cost which would be benefit to their own group.

Medical profession is being accepted as the highest income generating professional occupation in Thailand at least during the past 3-4 decades. So this professional occupation became the most popular and required the highest scores in the university entrance examination. The fact that physicians have high income might come from many reasons, but the most important reason is the inelastic demand of

treatment. Because treatment is necessity that the patients have to pay rather than other consumption products. Thus, the service providers have fully rights to collect the remedy costs up to the affordability of the patients. Moreover, the fact that Thailand still has limited on medical doctor production so the ratio of a doctor per people is considered low. Insufficient numbers of doctors causes the existing doctors have more chances for higher income generating, and they do not need to compete with each other in the market as other occupations (Pitiporn Chantaratat Na Ayuthaya and Wanee Pinpratheep, 2003) These are the causes that physicians and other health personnel having chances to seek for profits through the induce demand since they were monopoly on the medical knowledge and treatment.

Since the modern medicine has grown up together with the advancement of science and technology as well as the growing of capitalism system that focuses on creating high profits. So the medical system was strongly laying the foundation and people believe, keep their faith, and surrender to the constructing knowledge of the modern medicine. The monopoly of such knowledge made the medical professions search profits from their works. In the following parts, the important paradigms of medical knowledge would be explained as follows;

2.1.1 Looking at the relations among several parts as mechanism and reductionism so that there was a need for specific expertise

Medical knowledge had related closely to the biological knowledge which had the important foundation from the view of Descartes that the body of living things were just like a machine which was compiling of many parts that worked separately. So we could understand the living things from reduction and studying those small parts that combined to a whole unit. Such a way of thinking called mechanistic. Many scientists tried to conduct researches in order to develop knowledge about health and sickness by dividing it into several disciplines. (Fritjof Capra, 2003 and Marcum, 2008) This was coherent with the scientific facts which were developed mechanically; there was the production of knowledge, tools, and new technology widely until the physicians were able to study the body system through the deepening view into the level of organ, cell, or even molecule as genetic codes. The physicians could also separate the body regulators or body systems that working independently. The smaller

parts the physicians were studying, the more understanding and easier to cure. They could see which organs were damaged and they could manage to fix or cure those organs properly, without considering the complicated relations among organs, systems, or other major factors. So this was the subdivided work in order to remedy specific organs according to specialty skills of physicians. (Prawese Wasi, 1987)

When facing with the illness, the physicians would try to inquire into the causes of the abnormality whether it caused from the degeneration or the abnormality of any organs or even take a depth look into the disorders of any chromosome line. Then the physicians would manage to cure specifically at the problem organ or system in order to be a mechanism for the body to return to the normal same as a machine without paying attention at the patient as a whole body or relations to the other contexts as a Holistic. Such a situation context was an attempt to reduction of non-physical disciplinary terms and theories into the terms and theories of physical sciences, or so called Reductionism (Marcum, 2008). Most doctors often did not realize that causes of the diseases came from other factors or surrounding states which created stress, pressure, and the patients must struggle more and more. Also, the causes of the diseases might come from the economic system and capitalism that expanded all over; these social diseases were generalized into the physical diseases which had biological factors in 3 aspects: defects, deformities, and disabilities only. (Evan Elish, 1989 and Komart Junsatiensup, 2005)

This mechanistic paradigm was consistent with the works of capitalism that needed to divide into small tasks according to each specialization. Both business owners and controllers had to control properly so that the specialty happened, increasing works speed and productions as well as adding value to the products. Moreover, this paradigm created the hierarchicalized administration form in order to create the differences so it would be possible to control and oppress among various different positions. (Navarro, 1986)

Conforming with the medical system where the knowledge was divided into small branches automatically, there was a division of labor called specialization in accordant with specific body's organ such as cardiologists, nephrologists, etc. (Navarro, 1986). The higher studying the physicians committed the more they looked at the separate organs in depth, so it was difficult for them to know the human beings

and view the holistic things. The general practitioners physicians were considered less capable than the specialists ones (Sor. Sivaraksa,1989). So the physicians paid more attention to further their specialty study in order to increase their expertise, skills, and bring back that knowledge to work and generate more income for themselves. The more they became specialist, the more they were needed and the more they could increase their capacity in controlling human lives and bodies. Same goes to the dentists who have specific duty to take care of the oral health but still there are separated into several oral diseases remedies and specializations of dentists. In Thailand, there are 10 branches of dental specialists such as Oral and Maxillofacial Surgery, Periodontology, Pediatric Dentistry, Orthodontics, Prosthodontics, Dental Public health, Endodontics, Operative dentistry, Oral Diagnostic Sciences, and General dentistry (The Royal College of Dental Surgeons of Thailand, 2012). Specialized working is increased knowledge and expertise skills for dentists to work in that particular field and they could claim for the rightness to collect higher costs from the patients as they are specialists. Therefore, the bachelor degree graduated in dentistry are fond of taking the exams to be selected to further their study in the specialty fields.

Moreover, the public health systems in Thailand are still consisting of other field personnel more than 40 fields such as physician, dentist, pharmacist, registered nurse, technical nurse, midwifery, medical technologist, physiotherapist, radiographer, dental auxiliary, dental assistant, patient care giver (aid) and others. Each professional occupations/ occupation might have different responsibilities and duties. There are rules, regulations to control or authorize in administration each other clearly, and to prevent working out of the framework. This is the obvious character of hierarchicalization such as the nurses have to work under command of physicians or the dental auxiliaries have to work under control of dentists. Although the production of these personnel was aimed to help reducing the works but they had to be controlled strictly which Friedson (2001) mentioned that this legitimatizing hierarchy would be depended on specialized knowledge and skill through the careers in higher level. These higher level career were having specialized knowledge and skill that was important as the central target of production. Therefore, it was not surprised that the professional group as “physician” would act as they were center of all knowledge

about the physical body and sickness. The physicians were in the high position, status, and having highest authority to control human beings' health. Therefore, once the physicians stepped into the capitalism, their remedy of people's sickness would not be for better health but for arranging suitable profits from different class, gender, and their own ethnic. (Navarro, 1986)

2.1.2 Being “biomedical model” that emphasizes on “disease-oriented medicine”

Since 17th Century, advanced technology and sciences had improved the biological education along with the modern medical system such as the study of cell and molecule, finding of relations between bacteria and occurrence of disease, discovery of antibiotics and vaccines, the study of endocrinology and hormones, including the advancement in degraded organs transplant operation. So the medical profession could produce medicines, vaccines, and extract some hormones to fight with the infection diseases and control working system of human (Fritjof Capra, 2003).

This was in line with the view that human body was mechanism and reductionism which made physicians looked at disease and sickness as states of abnormality of organ that obstructed the mechanical work of biology. Therefore, the physicians must intervene in order to cure the patients through the focusing on micro-causality of the diseases. The scientific investigation had improved to search for the biological causes e.g. bacteria, parasite, virus, toxin, and even the abnormality of chromosome that affected to body and sickness. The physicians paid attention only on physical axis phenomenon, they would define who had disease and need remedy through diagnosis of sickness or signs of disease through looking, listening, knocking, radiograph, biopsy, or even inspection of chemical level but there was no attention paid to mental states or power relations in society that might be concerned. Therefore, the treatment mechanism was the attempts to get rid of causes of diseases and sickness such as giving of anti-infective medicines, replacing hormones, or operation, etc. (Prawese Wasi, 2004 and Navarro, 1986) Mechanical thinking in the scientific way made physicians became the important person in providing treatment since they were controller of all knowledge. Physicians took the role of explorer who could judge who

was sick and who was not, and also decide the treatment methods. This mentioned view made the health became the individual sake for self-care taking before become sick, but once they were sick it was a matter of health profession only who would explain and cure the sickness. (Evan Elish, 1989 and Komart Junsatiensup, 2005) This was also in line with this study which found that the oral health service providing focused on treatment e.g. tooth extraction, filling, scaling, rather than the oral health promotion and prevention in every level of service providing. (Sunee Wongkongkathep, 2006).

Results of Biomedicine paradigm forced the medical system falling into the state of passive defensiveness as the physicians would wait until people become sick, then they would put highly efforts on individual curative treatment by eliminating the causes of the sickness. Therefore, the medical system had to receive more and more patients. In coherent with the work of capitalism that needed to increase the numbers of consumers/ service receivers. If we considered it as the state government medical services, this paradigm had increased number of patients without necessity as well as employing the expensive technology in treatment. So the expenditures in this service system were higher, and this health system was entering the crisis. Then the physicians themselves would be unable to handle the responsibilities while the patients would never get the good services (Prawese Wasi, 2004).

2.1.3 High dependency on advanced technology

Bio-medical paradigm had focused on searching for the causes of diseases, so the patients had to rely on physicians and enter to the diagnosis and treatment process of using technology. Since the advancement of sciences, chemistry, physics, biology, and electronic sciences had invented tools and equipments for diagnosis including laboratory tests, biopsy, radiograph inspection, and magnetic resonance imaging so that the physicians could know the causes and pathologies of the sickness. Then, the complicated treatment with modern technology would be provided by the physicians such as using kidney dialysis machine, ventricular cardiac pacemaker, and radiotherapy while the patients had to consent through there was no confirmation of the effectiveness of these devices (Prawese Wasi, 2004 and Fritjof Capra, 2003)

The more complicated technology that the treatment was depend on, the more catalyst of the specialists system to control such technology. The physicians tended to pay more and more attention to specific part of the body and seemed to ignore the individual person as holistic. This system also changed the physicians' behaviors to be the human body controller more whereas the people almost had no choices and not necessary to have the role to take care themselves. The people could only follow the instruction of the physicians to change their behaviors without paying attentions to other factors (Marcum, 2008 and Fritjof Capra, 1996)

The fact that the specialists had been employing the complicated technology was coherent with the works of capitalism system that using technology in surplus value of the products. As the technology could replace and reduce the biological limits in human beings. Since the capitalist needed to increase their products to create more profits, the labour had to work even harder through increase their working hours or put more intensity on works which meant they had to work faster and longer. As the results, the labour had also increased their stress, weariness, and deteriorated body. Comparing with the technological tools and equipments which could be easily replaced, continued, effective, accuracy, and less mistakes than human labour. Therefore, the capitalism turned to use the technology tools and equipments that had more working capacity than human and low investment too. (Navarro, 1986)

Base on the historical study of dental works (Ring, 1985) shown that the evolution of dental works had developed techniques and modern tools more and more. In the past, the human beings in Primitive era only coated their teeth with gum resin, chewing tobacco leaf to clean their teeth, decorating their teeth with jade or gold, including using a similar technique to teeth transplant by putting the nonorganic to attach with alveolar bone. In Classic era, there was a finding of forceps from many places in Greece. Until late middle ages (13-16 Century) there was the evidence found of surgery by the barber and surgeons. In that era the barbers could extend their work scope to surgery e.g. operation of cataract and bladder calculi, releasing pus, blood puncture, and tooth extraction. The surgery works had been developed continuously until Renaissance era when there were gathering and competing among the surgeons and barbers. Until 20th century, there were the development of 8 specialists in dentistry

in the US while in Thailand there were 10 fields of dentistry specialists (The Royal College of Dental Surgeons of Thailand, 2012) as mentioned above.

The more numbers of specialists there are the more necessity to use technology for treatment in order to increase efficiency, accuracy, and fastness of works. As in the present, there is the airtors, prompt action anaesthetic, advanced dental materials, higher techniques to make artificial denture in several forms, bone graft techniques, or tooth transplantation. All these presented the development and advancement of technology. The more technology and specialty is needed, the more people have to rely on the dentists as they could not take care of themselves. Both physicians and dentists could make the remedy become the products that people needed.

The main medical paradigm is relying on all mentioned scientific concept, it has established the personnel in medical profession to be important persons as they hold knowledge and special technique in controlling technology, life, and body of people. If we looked at capitalism, all these things help promoting mechanism of market system as the monopoly products and services must create more profits to the business owners. The more people become sick without self-prevention, the medical service will be more needed. Also the higher advanced technology used, the more they could claim its high effective and efficiency and gain more profits. At present, many physicians, dentists and other health professions have opened or applied to work in many private clinics in order to get more income and respond to the capitalism. This was coherent with the study of Komes Wichchawut (1998) which found that the dentists resigned from the government system after they had worked for a while and based on the data, more than half of dentists work in the private sector. This was considered the highest ration compared to all health professions (Nongluck Pakaiya and Pennapa Hongthong, 2011). This affected to the dentists who still kept working in the government system to receive more and more responsibilities.

Therefore, if we would consider the health issue and development of service system to define the life quality and happiness of the people. The scientific paradigm would look at relations among parts as mechanism and give significance to bio-medical concept that relying on high technology, and specialists had limitation. As biomedical model would be good in some contexts only such as to provide remedy to

infection diseases, accidents, and emergency cases. Such a phenomenon made physicians could help to reduce illness and uncomfortable, or saving life of people incredibly. However, it seemed like the health caring of people is not quite successful as this paradigm forced the modern medical system facing with the service providing. Since the 4 important characters of the biomedical system were; (1) the modern medical system has focused on providing treatment to people when they were ill through investigating of specific cause and then provide treatment according to the symptoms to eliminate those causes. They tended to forget that the disease and illness were the results of everything surrounding the patients (human beings). So the physicians rarely pay attention to health promotion and could not stop or prevent the diseases for the people when they are still not ill. Thus, the medical system seemed to be in the inactive or passive situation though the remedies have been provided to many people, still there have been more numbers of other people became ill. (2) The modern medical system had emphasized working with individual patients rather than public sector as they focused on diagnosis, analysis, classifying the specific causes and providing treatment case by case while the physicians become the center of all process but excluding the participatory process with the public sector. So there are no changes in social factors that might be the cause of the sickness. (3) The modern medicine are high expenditures in the service system since it is focusing on treatment and relying on the expensive technology. (4) The unfairness has been created in the modern medical service system. People with good economics status would access to more services and expensive technology than the poor and one who living in the remote areas.

At present in Thailand, there are arrangements of health service systems in the concept of government social welfare as it is believed that such services are necessary and complicated than the people could gain enough knowledge and information to make decision on choosing the service by themselves. Thus, the state government has to manage and control the service through the universal health insurance so that every people no matter how their economics status is, must be able to access the primary service fairly. However, the weakness of this system is the government has to spend more budgets to take care of the people health equally. Thus, the government must have format of administrative management and have effective financial system to oversee the expenditures in this system. Thai government chose the

method in allocating budget to each hospital so called Contracting Unit for Primary Care: CUP though the capitation payment per one person per a year. The total numbers of people are according to the numbers of people who hold the golden cards in one particular area. This method could save budget for the government and able to control the overall expenditures in the system (Saowakon Rattanavijitsilp, 2005). At the same time, the health service providing units (hospitals) have to try to create responsibility in self-health caring to the people suitably and focus more on health promotion and prevention in primary level in order to reduce the expenditure of the treatment which costs higher, otherwise the hospitals might face with the loss.

The concept of state government's welfare in Thailand then seems to be contradiction to the bio-medicine paradigm since it emphasizes on saving budget and encourage people to be able to take care their health. While the bio-medicine paradigm emphasizes on the treatment process in order to conquer diseases by relying on many medicines and high technology, so the expenditures in this system is rather high. Therefore, this study would like to know that how much the dental personnel pay attention to the oral health promotion and disease prevention as well as how do they think about these works.

2.2 The concept on health promotion and disease prevention

Although the main medical paradigm as mentioned before had tended to allow most physicians to focus on treatment after diagnosis the symptoms, when the medical system had related to capital and market mechanism, it turned to be that the physicians were even more emphasizing on providing treatment for better payment. In particular, the specialist would have higher income. However, the cooperation between the government sector and medical system in Thailand history had shown that physicians and public health personnel could not ignore the disease prevention completely. The reason was that the government has emphasized on populations health status as groups who maintain and develop the country as well as have duty to health care taking of their children to be healthy, non-diseases, and not disability. When there were more knowledge about diseases and fearfulness of the diseases, especially infections, and infected patients, the more people gazed themselves and watched over

their bodies strictly base on the medical system requirement in caretaking and managing (Davisakd Puaksom, 2000).

Modern medical system that based on bio-medicine views everything in mechanistic, reductionistic, and focused on diseases and illness. Therefore, the endeavor in making people live without diseases had focused on the specific cause that significant to the diseases and illness such as hygiene or communicated diseases control, etc. Especially, after Louise Pasteur had found Germ theory of disease, the medical system had more tendency to emphasis on the specific cause that from the micro-organism more and more. The works then was focusing on prescribing medicines and vaccines to prevent and eliminate the germ only which in the narrow view. It was the concept of disease prevention. Although before this theory found there were many researches on the physical, social, and economic such as developed world, education, poverty, working conditions, living areas conditions, and freedom that related with the diseases, illness and premature death (Terris, 1992 and Fritjof Capra, 2003).

Base on the study of Health Promotion development which had further concepts than the disease prevention, it was found that in 1945 Henry E. Sigerist was the first person who used the term “Health Promotion” which he claimed 4 important missions of medicine: (1) the promotion of health (2) the prevention of illness (3) The restoration of the sick and (4) Rehabilitation (Terris, 1992 and MacDonald, 1998). This represented that the health promotion and disease prevention in the medical system would have been different kinds of works. However, in the meanings of Sigerist “health would be promoted through management of suitable living conditions including working, education, culture, relaxation and recreation”. Such an idea or concept was wider than considering only about the germ that cause illness but he still viewed that health promotion would be a method to prevent illness. So according to this idea the prevention of illness must be focused on both general cause and specific cause which was the wider perspective anyway.

Later in 1974 Marc Lalonde, the Minister of Health Ministry of Canada, stated that 4 factors of Health field concepts were Human biology, Environment, Lifestyle and Health Care Organization. Lalonde emphasized on lifestyle factor as the powerful determinant of health, which was considered wider viewed than biological

causes and it was more holistic view of health since this concept was emphasized on the social contexts which related to individual. However, it still gave significance to individual and biological determinants of health only, without paying attention to the other factors beyond controlling of individual. Later, in 1986 Jake Epp, the Minister of National Health and Welfare of Canada, had announced the healthful states which were both personal and societal responsibility. Therefore, the emphasis on individual according to health field concept of Lalonde would create the "victim blaming" as the understanding that health and illness was resulted from behaviors and health care taking of that person even though the actual reason was that there were many factors beyond the individual controlling. Therefore, the health for all must be (1) reducing inequalities, (2) increasing prevention, and (3) enhancing coping too, which Epp had focused on the truth that people had unequal opportunities to get the healthful states since health issues often related to the factors beyond individual controlling. Epp's conceptual framework was proposed to the International Health Promotion Conference in Ottawa for the first time in 1986. It was well known as the Ottawa Charter, that was viewed as the guideline for works towards the Health for All in 2000 (MacDonald, 1998)

The concept of "Health" had more meanings than the absence of disease but it was the complete state of physical, mental, social, and spiritual well-being combining together. Having good health, then, was related to several contexts as a holistic context including those able and unable to control by individual person. This was coherent with the concept of Brown (1985 cited in Sasithorn Chairasit, 2001) that separated the levels of health promotion and disease prevention works clearly. (as in the Figure 2.1) The purpose of health promotion would be achieved the suitable states of health, while the purpose of prevention meant reducing diseases that had different ways of work.

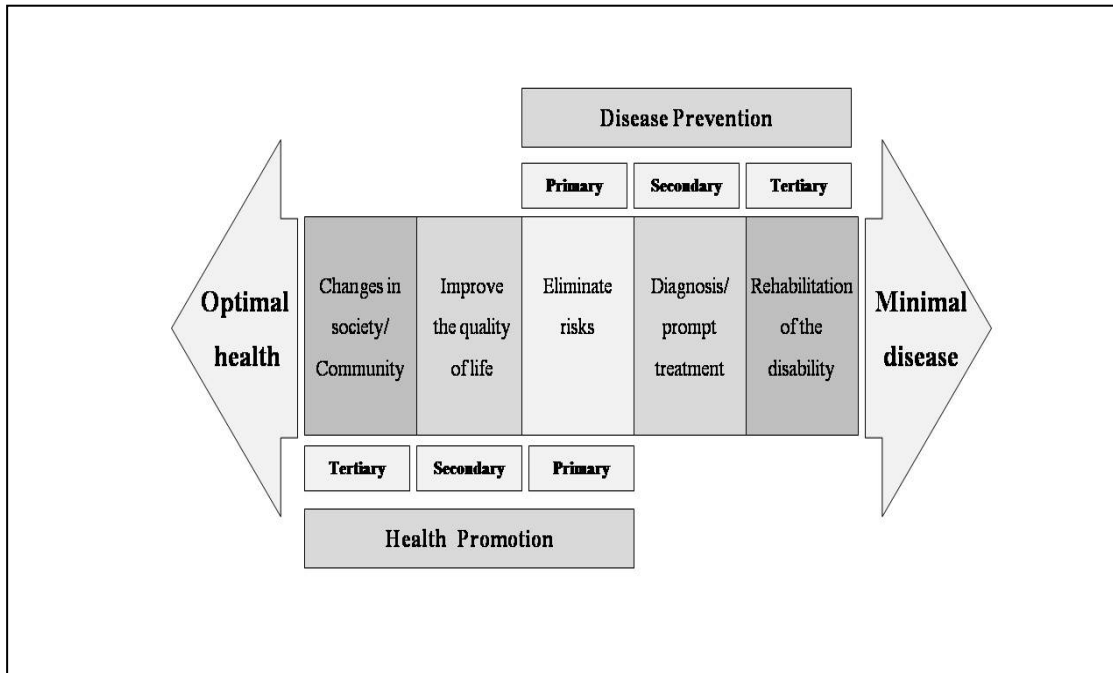


Figure 2.1: Showing the concept of health promotion and disease prevention (according to Brown’s concept)

From the International Conference on Health Promotion in 1986 in Canada, there was a statement that health promotion works must emphasize on Specific and General-cause oriented approaches to health promotion. This meant that health promotion had to consider both conditions and resources which were basically to health such as peace, residence, education, food, income, economic security, justice, and social equality. So health promotion had more meanings than only the eliminating factors which were causes of the disease, and it was rather concerned with changes of lifestyle. Also, it was not just only the responsibility or duty of individual. Health promotion had wider meanings covered “the process enabling people to increase control over, and to improve, their health” (Terris, 1992).

The Ottawa Charter stated the important strategies in health promotion works; (1) to create social advocate in health so that everyone should have realized that health is the significant resource for all dimensions including social, economic, and personal development, which were all related to promotion of better life quality.

Thus, health promotion needed to make the factors concerning economic, social, politic, culture, environment, and relevant behaviors to health that supported better health, (2) to enable people to get equal opportunities in health care services, and reduce the differences in health status as well as to have health potential fully such as being in the safe environment, able to access the right information, have life experience and skill, and have alternatives in health matters since people could not have fully health potential until they could control factors that define the good health, (3) to mediate among several sectors which focused on health including government sector, social and economic organizations, voluntary agents, industry, and media, etc. (WHO, n.d.b) Therefore, health promotion had become common responsibility to all sectors to determine and control health factors together without depending on specific individual or health organization only.

Arnstein (1969) proposed that people should have participated in the government works in every level as she had realized that “Citizen Participation is Citizen Power”. Arnstein had divided participation into 8 levels so called “the eight-rung ladder” (as in the figure 2.2) Starting from the below part which was (1) Manipulation and (2) Therapy, which these two steps of the ladder considered the levels of “non-participation”. Since the purposes of the works did not need the people participation in planning or implementing, people could only gain education or being cured at these steps. In the later steps which were levels of “tokenism” where people could listen and have rights to vote, these steps were (3) Informing and (4) Consultation. However, in these circumstances people still lacked of power and there was nothing to ensure their desires to be considered exactly. Thus, it was no assurance of changing the status quo in these steps. Then, the step (5) Placation which was a higher level of tokenism where people could have rights to give consultation and advise but the decision making power was still up to the higher power holders. For the highest level was the levels of “citizen power” which in these steps the decision making power had been authorized to the people as in the step (6) Partnership where people could more participate in decision making. They could negotiate and engage in trade-offs with traditional power holders. In the step (7) Delegated Power and (8) Citizen Control where people had highest authority/power in making decisions, which meant that in any government implementing works if the government had authorized

people to participate in planning, decision making, implementing and evaluating the activities or projects, those works would be successful and responded to the actual problem and way of life of people truly. Moreover, it might be possibility of continuation and sustainability of those activities since the people realized the effective results and benefits they had gained. So they would be willing to continue them.

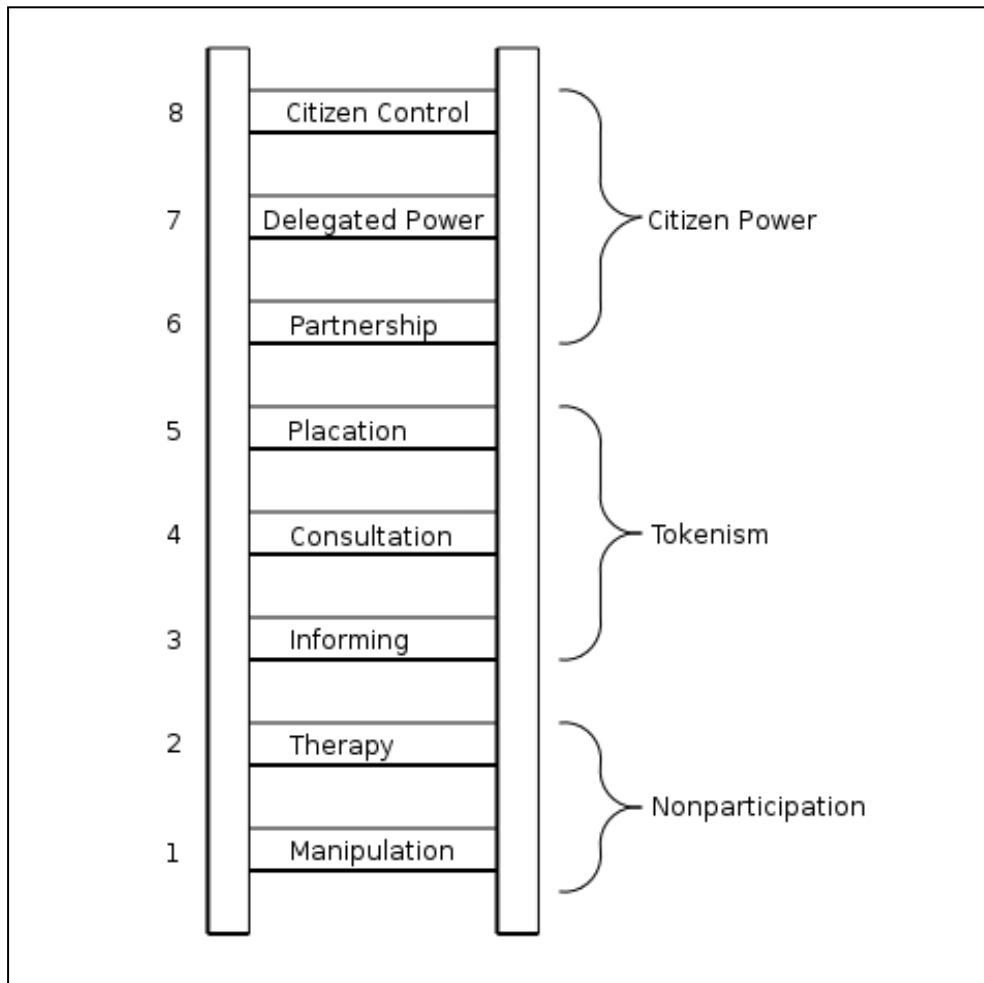


Figure 2.2: Showing Eight Rungs on a Ladder of Citizen Participation (Arnstein, 1969)

Compared with the concept of modern medicine system which had a view of reductionism and mechanism which made the health personnel tended to look over (or unable to realize that) various duties system must work in cooperate with each

others as a whole. So they looked at health and illness as the responsibility of the individual. They focused on health education so that people would be aware and adjust their behaviors for disease prevention. They ignored the other factors that might affect to the individual health. Such an idea or concept was rather narrow and it should have been called the medical model of disease prevention and of health education. While the concept of health promotion in the Ottawa Charter rather focused on the holistic concepts of the individual and refused to provide health education in the same way where the people could only passively participated in the activity that having the medical doctor as the center. Health promotion concept had emphasized on the active role of public as “people could not have complete healthy if they could not control things that affected their own health. Besides, it was important to focus on strengthening community action in order to empowerment of communities. Since the empowerment was a procedure to encourage individual to be autonomy and having enough self-esteem to present their own health agendas so they could be the owner of their lives and destinies rather than being a person who was told to do what others thought it was suitable. Moreover, the concept of health promotion must also emphasize on creating equity on health as well as allowing communities and other sectors to participate in health promotion works too in order to increase one’s state of health where as the concept of disease prevention would be only maintaining a status qua (MacDonald, 1998 and Terris, 1992).

If we believed that the Bio-medical model paradigm would make medical personnel had less interested in health promotion and disease prevention than treatment work, it was contradiction to the mechanism of payment (budget allocation) of NHSO which based on capitation payment (per person per year). Such a payment had forced the medical personnel to emphasize on the health promotion and disease prevention in order to save the expenditure of the system. The most interesting things to be studied were the thinking method of the policy makers concerning the oral health promotion and prevention works in children group as well as the opinions of dental personnel who are working in the field that how they think about this policy, and what was their practice guideline whether they employed health promotion (wide concept) or disease prevention (narrow concept) in their works. Also, it was interesting to know that when the oral health promotion and prevention works have more budget support

from the Dental Fund, whether it encouraged dental personnel to pay more or less attention to these works.

In the social science theory, we could apply the concepts to explain the meanings that the person or social groups were pushed away from the center of power in decision making or having other social roles as “marginality” which would be discussed in details later on.

2.3 The marginality and oral health promotion and prevention

The concept of Marginality was often used to explain and analyze in socio-culture, politics, and economics about the areas of disadvantaged people who have to fight for being allocated resources and participating fully to live in society. In other word, they might be called as “marginalized people” which meant people who were ignored in terms of social, economic, politic, or legal, they were excluded or neglected and being vulnerable to the changes in lives (Gurung and Kollmair, 2005). The studies about the marginality in the beginning era would be the studies in terms of geography which referred to the remote area that far away from the developing center, where was lacking of resources and infrastructure. The marginal people in this sense were often moved from their original areas for some reasons such as nature, economic, politic, and socio-culture to the new areas and have new livelihoods, or have new way of life which needed to adapt, struggle, and fight for accessing to limited resources. The marginal people would definitely be excluded and taken advantages from the majority of people who originally lived there before them. With this reason, the marginal people become minority in the new society. The migration created integration and cultural merging. Some people who might not be able to adapt themselves would be ambiguous and felt like they were not unity with their original culture as it became unaccepted sub-culture or discriminated from people in the mainstream. At the same time, they were ambiguous and being discriminated and strangers in the new society too (Surichai Wankaew, 2003 and Davis, 1997).

In the next era, the marginality was given a new definition without related to the aspect of physical area anymore, but it was established newly in the aspect of complicated power relations in changing society. The society that was not equal

between center and margin, where the center had more power and resources so it could create the truth and present or create image of lower status for the margin (Paritta Chalernpao Ko-anantakul, editor, n.d.) Therefore, the marginality could happen all the time and in every social level from the single social to the highest developed social. In the developed society, the marginality was happened socially rather than geographically (spatially) whereas in the less developed society, the marginality often happened in both terms (Gurung and Kollmair, 2005)

Socially marginality was often affected from being exclusion from the mainstream in various aspects including economic, politic, socio-culture, and environment (Gurung and Kollmair, 2005). However, in this study the only two major aspects were discussed which were political economic aspect and postmodernism aspect that believed “knowledge and the truth” was created through various discourses of the authority (powerful) people.

Considering the marginality in term of political economic aspect, the marginalized people referred to the powerless people who were the subordinate of majority and the have-not people who were having no opportunity, nor chance to benefit from resources or capital, lacking of skills and opportunities. Besides, the marginality might happened from the power structure of Welfare States that provided resources supports which seemed to be for the poor people such as education, job training, labour force market conditioning, or providing resident, etc. However, the states itself became a major cause of existing of social levels that created inequality and marginality (Wacquant, 1999). Finally, the marginalized people often lacked of opportunities to raise their level up and even worse if they were minority ethnic group, small group, less power gender, and having no-position in society or in general these groups of people were having “the other” status in society. They were even fallen into the situation of multiple exclusions or multiple marginalities that almost have no human being dignity left. (Surichai Wankaew, 2003) The case study of marginalized people in this aspect was obviously shown in the study of the Homeless' World by Boonlert Wisetpreecha (2003) including lives and experiences of garbage people and old stuff buying people by Siriporn Somboonburana (n.d.) Even though these groups of people living in the city where was the center of development, they were excluded to the marginality by their poor economic status, or some were having no jobs, some

were live from hand to mouth so they were looked as dangerous people, who might become thieves or unlawful livelihood whom normal people should have stayed away.

Through this discrimination and classification of people based on their capacity to work, find money, and possess resources in the capitalism system, so people who were good at work, or specialists often expected to gain more income than others. Also, these people were looked “being existed” while at the same time the other types of people were excluded as their less capacity or having no knowledge in specific work and finally they become “valueless” as social definition such as elderly people were defined as the marginalized people as they were non-productive groups in terms of economic, they also have signs of illness, and become social burden who needed expensive expenditure in caretaking, needed more special cares. Besides, the elderly were looked as social problem and led to the mutual belief in the society that the elderly were old aged people, physical degradation, and dependent to others. (Somrak Chaisighnanon, n.d.)

Based on the meaning of being marginality in political economic aspect, if we considered the accessibility to limited resources, less production, creating low profits as the conditions of being marginality, the fact that oral health promotion and prevention was being allocated lower budget than other medical branches, including its higher investment in equipments and materials but generating less income for the hospitals. So whether it was possible to consider the oral health promotion and prevention was in marginality or not, and how?

Another aspect of marginality was postmodernism which believed that “the truth” was construction through various discourses. Therefore, to identify that who or which group was normal/abnormal, that which behavior or moral should be accepted/which should not, that what should be valued and what should not, that which was good and which was bad or even that which was right/not right, all these identifications were created from power/authority people in the society. Creation of marginality was exclusion from the center based on the belief, valuing, or a set of discourses which was explained by a group of power people or who were at the center of social structure. It might happened from some social bias which looked at the marginalized people were far from the center, strangeness from the norms, rules or

morals, so it led to unfair and unequal relations or even the feelings of reduction of human dignity. (Anant Kanjanapan, 2006 and Gurung and Kollmair, 2005)

Complicated way of life was compiling of vary diversity groups of people and each group had their own way or standard way of their group. So we might often found that social groups with diversity were well known, understood, and accepted in various different levels as they were identified with value system in moral standard and different ways of life. When the marginality was social construction, the social then also created “the otherness” together all the time to people who had different way of life or traditions that different from majority mainstream in society. “The otherness” had rather wide definitions/meanings depended on it was being consideration based on which matter’s standard or value. Staszak (2008) stated that “the otherness was resulted from discursive process which in-group of speakers created for the out-groups to stigmatize the difference both in reality or imagined in order to deny the identity and stimulate the discrimination”. The otherness was happened from the criterion that could easily separate people into two groups which one group was on the norm and was valued while another group was explained as faults, no value and discrimination. Mostly, people who were in dominant group were persons who could identify matters of the group through stigmatizing at the others. For example, the Westerners looked at the domestic people under their colonial as the others by calling them Barbarians, Savages, or People of Color and pushed them away to margin of humanity. Therefore, “the others meant members of dominated out-group, who were not in-group of speakers and often were prescribed as lacking and discrimination by the in-group”. The out-groups had to fall into the situation of the others since they were classified and acted over from the in-group and since they could not prescribe their own norm. However, the ability in classifying groups was not depending on the discourse power only but also depending on political, social, and economical power.

It might be stated that the otherness was happened from the feelings of discrimination, group dividing with the sense of looked down, entrusted, or hatred from the dominant group. The person who was looked as the other was often stigmatized or labeled in negative way or being treated unfair” If we considered the same humanity as “the others” it would be easy to lead to the violence, taking advantages, and extortion without realized ourselves since we might not pay attention

nor feel anything towards the same human fates or we might see them were being treated unfair or squeeze without any feelings at all. (Phu Chiangdao, 2007) such as the imaging that the Hmong hill tribe people as people who destroyed the forests (Anant Kanjanapan, 2006) or looking at the homosexual as people who had wrong or unsuitable behavior, and were out of standard as they had different behaviors from the heterosexual (Pichet Saipan, n.d.) which according to this meaning of “the otherness” so it was similar to marginality.

Since the marginality could be considered in various aspects and each aspect was not totally separated, the political economic might be overlapped with the social contexts of postmodernism that created marginality through the discourses. Therefore, the center position might included either one of power, resource, and value which were all various and complex, or conflict. They were not unity and might not have only one center. The feelings of being excluded of marginalized people might be happened from many reasons at the same time. Thus, even they were in the same geographical center, they might be possibly pushed away to the marginality as well. (Paritta Chalermkao Ko-anantakul, n.d)

The marginalized people have one or more mutual characters which were often a minority group of people, might be migrated to the new place, have limitation on accessibility to the resources, less accessibility to the health services, have bad economical status, as well as lacking of supporting factors in terms of economic. They had strangeness, differences, not in groups, low education, lacking of skills and craftsmanship in works which all these qualifications were imaged to surrounding people of abnormality, dirtiness, entrusted, ugliness, and lacking of capacity. The representative images which surrounding people in the society created had resulted in exclusion of these people in pushed them to the powerless social position, no opportunities as well as limited rights and votes in politics. They were lacking of tools to access the power, so they lacked of negotiation power and they were often taken advantages and being discriminated with biases.

At present, the medical system had been developed, there were productions of knowledge and new technologies to use thoroughly. Especially, the western medical system that look at the body as mechanism or machine-like when the body was in good condition and be able to work well but when it become degraded or

illness so it needed to be fixed or cured until it was back to normal so that the body could be able to make money or added value. Such a logical reason of science and a view of body system as a mechanism like this still had affected to the western medical system looking at the death as undesirable thing. The present medical knowledge could possible to extend life time of the patients to be survived from the death in many cases from the outbreak diseases caused by infection, death from baby delivery of mother and baby, or saving lives of people from many accidents. Therefore, the human beings at present have longer life when compared with the previous time, when people do not desire death or sickness or even refuse the natural aging, the western medical had established its dominant, and coverage all human life time from the day they were born until die. So the medical doctors become the important persons who established themselves as the center, control power in every life aspects while the other professions in the health system including dentist, pharmacist, nurse, medical technician, or others have been looked as the secondary group next to the centered group who were staying away from the center level by level until being at the marginality at finally. They always have been accepted by people and recognized their own organization in the reducing level in orderly. Even the physicians who were in different fields were being recognized and valued differently such as the specialist physicians would be more accepted and respected by people than the general practitioners. So the other personnel besides the physicians were always lacking of opportunities to be grown up in their careers. The lower level they were, the more they become treated unfair. (Sor. Siwarak, 1898)

Bryan Turner (1986 cited in Daniel, 1990) state that within the health system itself there were conflicts and feeling of enemy between doctors, nurses and para-medicals personnel too. Daniel gave the sample cases of the nurses who were in the closest position to the doctors and gained the professional status since the changes in the education from the practical training in hospital to study in the university system, in order to emphasize on theory study and receiving the certificated specialist training program. However, the nurses still had autonomy and authority not different from the same days. They still had not fully autonomy and could only control the areas of work in hospital only little and still in the subordinated status within the hospital structure.

Same goes to the study on “the sub-district health station officers (หมออนามัย, literal meaning)” or the the public health officers in Thailand which found that the public health officers was the profession that was looked over from the states government since the national health policy was relied on the concept of bio-medicine that valued the medical knowledge and technology in treatment rather than taking a look at health in other aspects. The public health officers were assigned to screen the patients at the basis before sending the patients to the service systems with modern tools and specialists. Such a paradigm made the physicians in hospitals become powerful person and being accepted by people while the public health officers were pushed away to the marginality of the health service system (Ratree Pinkaew, 2005)

The differences between these professionals made the health personnel have been accepted by people and recognized by their own organizations in the different degree. Some works might have been interested to follow up, support, control, assess, or investigate by the authority persons rather than the other works. Thus, this study would like to search for the answer that at which level the oral health promotion and prevention have been recognized or whether it was fallen into the marginality and how?

Moreover, in the context of dental health work itself was compiling of both dentists and dental auxiliaries who both could provide the oral services for people, so it should have been reviewed and find out that how both groups have related to each other in the good way or not, whether anyone have been excluded and pushed away to the marginality and why?

2.3.1 Marginalization

The marginalization was referred to status or processes that persons or group of people were refused to promote to important positions and were the symbols in economic, religious, political power in any society. (Surichai Wankaew, 2003)

The most 3 important social conditions and contexts of the marginalization were (1) the context of state-nation creation which was related to history of self creation and being Thai nation (2) the capitalism and globalization currents including the modernization of the nation, and (3) the matter of selfness of various people

groups during the social transitions (Surichai Wankaew, 2007 and Anant Kanjanapan, 2006)

For the context of states-nation creation, it would be related to the marginality in the aspect of geographical areas mostly (which was not mentioned in this study) while the capitalism and globalization currents including national development, especially the development that focused on modernization, economic growth, trade competition or New Industrial Countries (NICs), they were all emphasized on highest benefits and economic profits as the main targets. This context was considered important to the changes of people life since the development paid more attention to people with power and economic status but tended to ignore the voices or rights of less power people, especially, the marginalized people. So they have not only participated in identifying the policy and strategy of economics development but they also have very few channels to access the resources and benefit shares from the economic development process.

For example, the case of the traditional medical system was pushed to the marginality in the knowledge scope and there was the establishment of western medicine knowledge to be the mainstream medical system. This was happened in the period after the change of governed system to democracy 1932 when the governed/dominant class in the country had the policy to create nation in order to develop the country to modernized society. But the problem was there were insufficient personnel to develop the country since at that time though there was high birth rate but the survival rate of the baby was still low. Then, the modern medical and health system was began to take the crucial roles in order to reduce the fetal death rate, get rid of the communicated disease, and strengthen health of people. There was the establishment of Health Education Division to extend knowledge to general people. So the people accepted the modern medical discourses through various media such as document, leaflet, radio spots, and health education movies in order to present the healthy body nationwide according to the government desired. At the same time, there was the legal issued to enforce people to obey. (Chatchai Mooksong, 2005 and Nalinee Makarasaen and Pensri Kerdnak, 2006) And one of the issued law to control the public health and medical system which affected to the Thai traditional culture of illness management from the past was the Medical Practice License Act, 1936 which

defined that the traditional doctors who using the local and traditional treatments had to take the tests in order to be registered for the license for practice traditional medicine by having the high educated personnel from the centered office as the test controller and using the standard knowledge in the royal medicine bible as the main prescription. Such the testing method, it made none of the traditional local healers passed the exams though they had been expertise on the traditional treatment since the past since they had different knowledge. Many traditional local doctors who could not pass the exams and be registered, then became “illegal doctors” as the label that the government gave them. Also, at that time, the modern medicine with the scientific paradigm began to expand in this country and took the crucial roles as mentioned, so the traditional local medicine system was not accepted and became the marginality later on. (Yongsak Tantipitok, 2005)

For the matter of self and identity of various groups of people, it was found that the present society had often created the fix image of many groups of people and it became the cage of identity such as the case of “Gay or homosexual” group who were looked as the abnormal sex and had the negative image of abnormal sexual behaviors, slush, often change their mates. These different identities from other groups might made them looked like being in the marginality of society. So these marginalized people have to stand up and show their identity to have their own standing point and have different images for their groups. Moreover, they tried to define new meanings to their ways of life with different views in order to free themselves from detrainning so they could have flow images (Paritta Chalermkao Ko-anantakul, n.d and Anant Kanjanapan, 2006)

However, in the present situation we could not definitely identify that the marginality had happened to a group by the condition in which particular context since all three contexts were overlapped each other and crawling in every aspect and area. For example, in the study of discourse about “alienation” that became to “the others” of migrated "Tai Yai" minority group by Oamsin Boonlert (2008), it was found that the Tai Yai group was fallen into the marginality which resulted from the state government policy to strengthen the national security with the mechanism control, limitation of border passing, walking through in and out, or with the permission period of other nationalities to live in Thailand. At the same time, the capitalism was

becoming stronger, so there were the needs of cheap labour to work in some field that Thai people did not want to do, together with various discourses had been produced through media that created the feelings that these foreign labour groups had cruel minds, fierce, and taken away the jobs from Thai, also they brought bad diseases and they were dangerous to the national security. These were new identities or self-image of the foreign labour group and forced them to become “the others”. They were labeled, excluded and pushed away to be like the materials that needed to be inspected.

2.3.2 Struggle and resistance of the marginalized people

Since the marginalized people were often acted over, reduced rights and power, limited resources, and deducted human dignity. They felt hurt, valueless, not being accepted, unsecured, and unclear with their present status. However, they often not let themselves for being acted over alone, they tried to improve themselves and develop the relationships in terms of power among various groups in order to struggle, and seek for area and resources, and time. They tried to present their own selfness and return their human dignity to show their knowledge, security, identity and social roles which were complex and flowing without actual meanings. So they could possible response and negotiate with the coverage power over them. We often have seen that these people had particular character and had ability to adapt themselves quickly to the changes of social and culture (Paritta Chalermphao Ko-anantakul, n.d, Anant Kanjanapan, 2006 and Stonequist cited in Davis, 1997) This was harmonized with the concept of Foucault, although in the beginning of his studies, he did not pay attention to the individual person as he thought that person was not free and could not define and control their own lives as they were under the discourse or truth that they had to accept. Later, the studies of Foucault began to pay attention to the identity as he had an idea that every human being had subjectivity and rights to create or negotiate their own identity or self without depending on any discourses (Anant Kanjanapan, 2008:94-95, 111-114)

While Scott (1985:28-47) stated that the resistance to reduce violence of power and the refusing to be dominated of the lower class and group of farmers towards the capitalist class and land owners were the presentation to resist the advantages taking from the dominant class which was not necessary to be a violent

protest and an obvious revolution or a publicly confrontation with the higher power class. Such a reaction could be done informally, gradually and unrevealingly (secretly done) without the fix format, no advanced planning, it was the prompt reaction and could happen everyday form of resistance by symbolic way. Scott called this kind of resistance as "the weapon of the weak" since the hidden resistance like this helped them avoided the confrontation with the power and higher class. The forms of this resistance which often found were such as slowly working, gossiping, analyzing, pretending that they knew nothing, not coordinating, not obeying, lazy working, pretending to be sick, stealing, creating non-peaceful situations, destroying property, telling a lie, and resisting to the orders, etc. Although, these kinds of resistance were not aimed for opening up the area to get acceptance from the higher class, the researcher had the opinion that it was the way that the lower class, powerless group, or less resources people group would use this method to reduce the violence and refuse to be dominated such as being controlled, democratically unfair paid wages-taxes-land rental fare, etc. So that they would not be threatened one side only, they had to react. However, we would understand such a resistance when we could understand the symbolic system, meanings given, value, willingness, languages, and conditions related to the reactors before.

The attempts to open up the space of the marginalized people were appeared clearly in many cases study such as the study of Yongsak Tantipitok (2005) in the issue concerning social area construction for the networks of local herbal doctors in the Northern Thailand which at that time they were excluded to be in the marginality of the medical system. The study found that the group of local herbal doctors took the opportunity during the outbreaks of HIV/AIDS and the modern medical system could not cure the patients or take care of this disease satisfactory, they set up the network called "The project for local herbal doctors for HIV/AIDS patients care of the community capacity development foundation (North Net)" and cooperated with the community health organizations. So the northern local herbal doctors got the supports to participate in caretaking, health examining, and giving advice to the patients. Moreover, they set up groups to exchange knowledge, traditional medicine formula, or herbs among each groups. They also gave advice and transfer patients among the groups too. More importantly, during the health system

reform, the North Net had participated in the meeting on “The Development of Alternative Medical Health System in Thailand” which the main propose was to open the social area for the traditional medicine and create the legal rightness of traditional medicine doctor in Thailand health system. Their suggestions were presented to many academicians and gained rather high supports in every region. So this was considered the opening up social area for the traditional local doctors and other alternative medicine doctors to be appeared to the social public.

The study of Ratre Pinkaew (2005) found that the public health officers in the sub-district health station (หมออนามัย, literal meaning) tried to create their identities and meanings for their group as the health personnel who worked closely to the people. Then, they knew the community details, including traditions, culture of the community. They were more understanding of human being and able to take care of the local patient in holistic way. Although, there was a mechanism of government system to follow up and monitor their works, some public health officers reflected and resisted to such power as the reason that they could not follow the order until it had been adjusted to the local context so that the work would be successful.

In this point of view, if the oral health promotion and prevention was considered the marginality in the health system, the dental health personnel would have to struggle, fight to open the area for themselves or not, and how would they do? Also, if in the dental health personnel group, there were group of people who were looked as “the others”, how would they have struggle, resist or negotiate in order to find their own space to show their identity?

Therefore, this study had three concepts to explain the status and operation of oral health promotion and prevention in the government hospitals which were firstly, the concept on professional occupation, medical paradigm and capitalism. Secondly, the concept about disease prevention and health promotion and lastly, the concept of marginality. It aimed to conduct the study through life, work, and experience of dental health personnel, especially, the group of dental auxiliary who were the important operators of oral health promotion and prevention work in order to point out the problems that dental auxiliary were facing. These problems were resulted from the structure of relations in professions, biomedical system and capitalism as a supporting mechanism behind.

CHAPTER III

METHODOLOGY

This research study applied an ethnographic approach to search for the explanation of the situation for the oral health promotion and prevention through the studying on life, experiences and works of dental personnel, especially, the group of dental auxiliaries. The study also focused on their works' target group who were the primary students. Since this target group had been emphasized and included in the guideline of the government sector's works for 40 years up to the present time.

The anthropological study could possibly be used in explaining a policy through creating an understanding of thinking method, ideology, and behavior of relevant person. Including those affected to policy making and resulting of the policy within the context of organizational culture or the culture of government system. Anthropology of policy would focus on the study of interactions and disjunctions between individual person in the different sites or levels in policy processes. Also, it must emphasize on the study of policy document in order to comprehend and reflect the background of the concepts (Shore and Wright, 1997). Thus, this study has chosen the ethnographic approach.

In addition, the qualitative study may help us seeing the complex phenomenon and gaining the in-depth information (Perecman and Curran, 2006). Since "the truth" is not a universal thing as the objective one but it is related to surrounding contexts (Savin-Baden and Major, 2010). We could not possibly understand such a phenomenon by applying the quantitative study, which believed that there was the existing of one and only truth with value free and independent from the researchers who perceived. (Chai Podhisita, 2004 and Nisa Chooto, 2002) The study of the oral health promotion and prevention works under the policy of Dental Fund, must put the emphasizes on the surrounding contexts as well as the relationships among the relevant people groups who are the conditional factors in identifying the situation, the way to go and the significance of works.

3.1 Research setting

Since this study would like to vision the image of oral health promotion and prevention works including the image of the relationship between dentist and dental auxiliaries in depth situation. I have an intention to select the area of the study in a small province where there are government hospitals with permanent dentists working. Also, there are the dental auxiliaries both in the hospitals and in the sub-district health promotion hospital (the former Health Center at the sub-district level) under supervision of these dentists.

Before selecting the studied area, I had a chance to discuss and consult with the director and dentists who work in Bureau of Dental Health, Department of Health, and Ministry of Public Health about the strategy and works of oral health promotion and prevention in the past. Moreover, I had consult them about the study area selection for data collecting which I had an intention to select the province with the remarkable work results. The director had mentioned many provinces that capable to respond to the work plan and operate the activities initiated from the concept of Bureau of Dental Health continuously as a guideline for my decision making.

From the suggestion, I decided to select a province in the central region of Thailand as the research setting by co-consideration with the possibility in field data collecting. Since it was a small province with small society and the area was not too wide, it was suitable for the qualitative study. I had to put myself into the studied area for learning, understanding the contexts as well as relating with several groups of relevant people in order to create good relations and acquaintance. Moreover, this province was the place where I was born, raised and lived until I finished high school. I also have some graduated friends who now work in the health division in this province. Thus, these might help me understand the socio-cultural contexts and reach the informants at ease.

In this province, there are 6 hospitals under the Ministry of Public Health. Two of them are considered the big scale hospital (general hospitals) which are Muang Hospital, the provincial hospital and Ingfa Hospital. Other four hospitals are the small scale hospitals (community hospitals) which are Bannkai Hospital, Bannpoon Hospital, Sriburi Hospital, and Chiangtai Hospital (all the name of the hospitals are pseudo names). Each hospital has the dental health division (community hospital

level) or the dental health working group (general hospital level). The study found that there are about 1-8 dentists working full time in the hospital, and about 1-3 dental auxiliaries (depends on the size of the hospital and the request for further study leave of the dental personnel). Also, each hospital has its own working network about 3-17 sub-district health promotion hospitals. While the whole province, there are 47 sub-district health promotion hospitals and one municipality hospital. Some rather big sub-district health promotion hospitals have the full time dental auxiliaries working under supervised of the dentists in that hospital. Whereas some hospitals have no dental auxiliaries but there are general staff taking care of dental health works instead.

Originally, I planned to select two hospitals for this study which are Muang Hospital, the general hospital and Bannpoo Hospital, the community hospital, respectively, in order to see the different image of working in the two levels. Since, the general hospitals normally focus on the treatment in the secondary and tertiary care units, and the dentists working in the general hospitals are specialists. So they may transfer the patterns of work in oral health promotion and prevention in the different manners to the community hospital. Moreover, the selection of a few numbers of hospitals may help me, as a researcher; reach the data deeply as I would be able to follow up the implementation and interaction between dental personnel works related up to provincial level and down to the community level easily. However, when I started the data collecting, and found that it was not easy as I thought, even the informants were in the same field as I was, especially, the dental auxiliary group. Since being questioned about their works often made them felt worried like being inspected as well as the opinion expression about working situation and relations with co-workers might affect to the relation between the dentists and dental auxiliaries in the same area. Once the in-depth information was difficult to gain, I had to expand the data collecting areas in order to gain the in-width (wider) information instead.

Therefore, I had expanded the interview and observation to Ingfa Hospital as well. Although, this hospital has the working structure and operation pattern as a general hospital, it still has several aspects similar to the community hospital too. For example, the qualification of dentists is incapable to receive patients transferred from other hospitals, and its location is less civilized as a city-like than Muang Hospital. So in this study, there are three hospitals as the major studied units which are 2 general

hospital and 1 community hospital, named Muang Hospital, Ingfa Hospital and Bannpoon Hospital, respectively. However, the rest 3 hospitals I had visited and talked to the dental personnel and gained some information at a certain level. I could realize the variety of information and able to compare the similarities and differences of works status and relations.

I started entering the studied area through visiting and talking with “dentist Dream” a dentist in Bannkai Hospital and “Odd” the dental auxiliaries in Fajaem sub-district hospital in Ingfa district (all the name of the informants in this research are pseudo names). Both of them are acquaintance with me very well before, so I asked to them take me to the head of dental health working group (section) in the Provincial Health Office including the other dental personnel in order to introduce myself and inform them about my study objectives. In addition, I had requested for a permission to get into the studied area unofficially. After that I submitted the official letter to request for data collecting permission in the area which issued by Faculty of Social Sciences and Humanities to them later on. I had received very kind cooperation from them very well.

3.2 Key Informants

To gain the in-depth information, I has selected the informants through purposive sampling by identified the qualifications that s/he must be related to the whole works to the planning for oral health promotion and prevention in that area in order to get the information and details in the rich information. These informants are dentists, dental health officers (dental auxiliaries), who are working in the hospitals or sub-district health promotion hospitals, and the staff who are responsible for dental works in the sub-district hospitals that there is no the dental auxiliaries. The informant are Including the dental personnel who are involved with policy making and working guidelines defining, both in the provincial level which is the Provincial Health Office, and the national level which is National Health Security Office (NHSO) and the Bureau of Dental Health. So that, I could see the ways of thinking, meanings defines, and valuing from these different informants which led to the policy making, as well as ways of working designing and the relationships among the dental personnel in the

area. All this information could reflect the working status of dental health promotion and prevention.

During May, 2012, I had commenced the data collecting in the field, and it was found that each hospital had different kinds of work for dental personnel. In Muang Hospital and Ingfa Hospital, which are the big scale ones, have responsibility to receive the transferred patients from the small scale hospitals with less capacity. The big scale hospitals have a high numbers of dental personnel about 7-8 persons (as in Table 3.1). However, it was found that dentists in both hospitals who are 3 specialists and 1 specialist, respectively. The rest are general practice (GP) dentists who graduated a bachelor degree. Whereas the numbers of dentists in the community hospital are only 1-2 persons, depends on the numbers of leave taking for further their study, Bannpoon Hospital have 2 full time dentists but both of them have not taken a leave for further specialty study.

For the numbers of dental auxiliaries working in the studied area hospitals, they were not much different in the general hospitals and community hospital including the sub-district health promotion hospital in their service network. Although in that particular district, there are higher numbers of population and numbers of sub-district hospitals than of other districts (as in Table 3.1). The numbers of dental auxiliaries are 3-5 persons in each district. From observation, it found that though Ingfa district is a big district with the numbers of population are close to Muang district and there are the highest numbers of sub-district hospitals compared to the other districts, there are only 3 dental auxiliaries.

Table 3.1: Showing the data on numbers of dental personnel within the province (by May, 2012)

Organization	Level	Numbers of Dental personnel		Numbers of sub-district hospitals (+municipality) in the network	Numbers of sub-district hospitals (+municipality) with full time dental auxiliaries
		Dentists	Dental auxiliaries		
Muang Hospital	Gen.	8	2	9 (+1)	2 (+1)
Ingfa Hospital	Gen.	7	1	17	2
Bannpoon Hospital	Com.	2	3	5	1
Bannkai Hospital	Com.	1	2	7	2
Sriburi Hospital	Com.	2	3	3	1
Chaingtai Hospital	Com.	2	2	6	2
Provincial Health Office	-	3	3	-	-
Total	-	25	16	47 (+1)	10 (+1)

While the Provincial Health Office has 3 dentists and 3 dental auxiliaries working full time, it is considered higher numbers than other provinces. As there is a policy to merge the dental health working group with the other sections, so some provincial office have only 1 dentist or 1 dental auxiliary. I have learnt that a dentist named “dentist Proud” who is the head of dental health working group in this provincial office could possibly negotiate to have this working group still existed. As she has been working here since 1995 until present, and made so many visible successful works for Bureau of Dental Health Office in Department of Health. So her works have been recognized by the higher level both from the provincial and central office, which enabled her to make the negotiation to keep the dental health working group.

I have chosen to collect data from the dental personnel who are expected to be involved with the oral health promotion and prevention from all sections. Especially, the head of the dental health working group/division in every hospital in

the studied area. The informants are including “dentist Krit” from Muang Hospital, “dentist Bow” from Ingfa Hospital and “dentist Kay” from Bannpoon Hospital as well as the staff responsible for works with the primary students and all dental auxiliaries in the studied area. However, at the end of field data collecting period, I have focused rather on the dental auxiliary group as they are directly responsible for the oral health promotion and prevention works in the area.

3.3 Duration of the study

Prior the actual field data collecting, I had a chance to discuss and interview several dental personnel in the studied area for many months. I gained the sufficient information for defining a draft conceptual framework for this research. After passing the dissertation outline defending process, submitting a proposal, and receiving certify from Institutional Review Board, I have collected field data from May, 2012 until January 2013, total 9 months period.

In May, I commenced the field data collecting which was considered the suitable time since it was new semester started. So it was the beginning of the mission that the dental personnel in several hospitals would work with the schools. I had a chance to accompany them in the oral examination process. Therefore, I had vision several patterns of work in each area. Although, it was shifted from the work plan of the surveillance and promotion of the primary students’ dental health project to the work plan of Dental Fund operation, the working pattern was not changed from the past.

Around June to August, it was the appointment time for primary students to get the service according to the disease prevention and treatment after the examination. Both Ingfa Hospital and Bannpoon Hospital used the same way of making the appointment in their service zone of the hospital and of the sub-district health promotion hospitals where there was no dental auxiliaries to come to Ingfa Hospital and Bannpoon Hospital in the district. At the same time, the dental auxiliaries in the sub-district hospitals were responsible for providing service to the students in their responsible area. For the pattern of service providing of Muang Hospital, there was an arrangement for 5 schools in its service zone (three of five schools were big

scale schools with more than 1,000 students) that the students from these five schools have to travel to the hospital in order to get the service. While the students who live outside the service zone, there would be the mobile units to provide the service at the closest sub-district health promotion hospitals. In each mobile team, there are compiled of 1 dentist, 2 dental auxiliaries, 2 dental assistants and 1 worker (staff), together with 2 mobile dental chairs. For the sub-districts where there are dental auxiliaries, the operation process is the same as in other sub-districts.

In August, 2012 before the end of the fiscal year, the Provincial Health Office organized a meeting of all dental personnel including the staff who are responsible for oral health works in the sub-district hospitals all over the province. The objectives of this meeting were to have the implementation reports and the strategic plan for working with various age groups of people for the next coming fiscal year. Each district was requested to make a work plan at the district level, the planning process was led by the dentist who is the head of working group in that district.

In October, the beginning of the new fiscal year, but it was the semester brake of the school students. So all health care units have to stop service providing for the students following during the semester brake according to the educational system. Therefore, all kinds of work from the Dental Fund which have to work with the primary students should have been complete by September, which was the last month of the fiscal year, 2012 in order to submit the report to the Provincial Health Office and the representative of supervision team from NHSO. Moreover, there was a meeting for monitoring and evaluation of works organized by the evaluators from NHSO.

In November, I found that Muang Hospital organized the meeting for all personnel who were responsible for oral health promotion and prevention. It called for the meeting of dental auxiliaries in CUP all over Muang district in order to inform the sub-district health promotion hospitals to participate in writing the project proposals for their activities in the fiscal year, 2013. While the other hospitals in the studied area did not have such a persuasive movement to the sub-district hospitals to participate in writing the proposal as Muang Hospital did.

January 2013, the Provincial Health Office called for the meeting again in order to follow up the progress of works in the Dental Fund work plan of each hospital. The meeting participants were the dentist that heads of the dental health working groups, dental auxiliaries in the sub-district health promotion hospitals, and the staff responsible for oral health in the district health offices. The purposes of the meeting included to clarify and encourage each CUP hospital to open up for the dental auxiliaries in the sub-district hospitals to participate in project propose and activities organizing in the sub-district level that belongs to their responsible service zone. This event was considered a new concept that the dental health working group in Provincial Health Office has attempted to define the guideline for arranging and encouraging the sub-district hospitals to participate in the activity operation work plan in their own area. The result found that some hospitals such as Ingfa Hospital did not have a project proposal from the sub-district level at all. So, the budget allocation and activity plan had to be revised in order to be ready for the next academic year.

Since the beginning of the second semester or approximately about the beginning of October, I have found that the activities implementation and service providing on the oral health promotion and prevention for primary students were very few, especially, Muang Hospital and Ingfa Hospital. As most of the works according to the indicators of Dental Fund have been finished in the first semester, the second one almost there were none of activities to be implemented with the primary students. However, Bannpoon Hospital and Fajaem sub-district hospital in Ingfa district, the dental personnel still called the students to receive the services as necessary according to the dental health assessment report (รายงาน ทส., literal meaning) from the teachers in the dental health surveillance and promotion in the school project.

Although, the beginning of the field data collecting was not the beginning of operational works according to the fiscal year which I had expected to witness the working process from the beginning of planning, implementing or operating, following up and evaluating the whole process. However, I had discussed and questioned about the pattern and plan of work to the dental personnel in the area, and I made a comparison with what happened in the fiscal year 2013 (since October, 2012). Thus, I could see almost the whole process of work in each fiscal year as the

characters of the oral health promotion and prevention works were same under the conditions of Dental Fund.

Being in the studied area for a long time and participating periodically in several kinds of activities together with the key informants, e.g. assisting in recording the data of oral health examination, participating in the meetings, joining in creating the project of "Less Sweets in Secondary School" and other activities, made me even closer and gained trusts from them even more. From the beginning that the younger dental auxiliaries felt uncomfortable and did not fully express their opinions and feelings, later for a while they talked to me in more friendly and familiar way. So that I could feel and touch their daily life and works as well as see the contexts that related and linked each other complicatedly. Also, I could witness the phenomena under situations and contexts that went by naturally. However, it was not possible claimed that I could reach and understand all process truly as I was the insider.

3.4 Data Collection

In the Ethnographic study, the researcher is the most important tool in order to gain the benefit data for understanding of the phenomenon. Thus, I, as a researcher, had participated closely in several activities those key informants do. So that I could observe and learn about various contexts related to the informants in terms of their status, way of thinking, belief as well as their inter-personal groups relations in order to absorb and understand their ways of life.

I started entering the field and meeting with the informants by introducing through "dentist Dream", the junior dentist, who works as the head of dental health division in Bannkai Hospital, as well as through "Odd" a friend who works as a dental auxiliary in Fajaem sub-district health promotion hospital in Ingfa district. Dentist Dream took me to join the meeting for monitoring the works of the Dental Fund at the Provincial Health Office. So I had a chance to know other dentists from this meeting. While, Odd could introduce me to the dentists and dental auxiliaries who work in the other hospitals as she has been working in this area for more than 15 years so she has been well known and respected from the younger staff. She took me to meet with the head of dental health working group in the Provincial Health Office, the head of dental

health working groups/sections in hospitals, dentists and dental auxiliaries who work in the hospitals and sub-district health promotion hospitals, so I took a chance to ask for permission for data collecting and following up their works.

Data collecting through participation of the researcher, in case of this study, had variety levels from the participatory observations in the informants' works and meetings only to actual participating in their activities such as assisting them in keeping a record of the students' oral health examinations, or taking a lecture role in giving the knowledge about oral health. By doing so, I would consider the suitability of each event, and available chances, e.g. in case that the dental personnel went alone in the activity I would help by assisting and reducing the works and saving the time. In some cases that there were many personnel in the team as in the mobile service units of Muang Hospital, I would be only an observer and asked some questions when the time allowed.

For data collecting from the dentist group, it was rather difficult since the characters of their works which mostly about managing or treatment providing in the service units. Their working places are normally small, and closed room where they are with patients and dental assistants, so I could not observe their works closely. Moreover, the knowledge of dentist is rather specific as it is a professional knowledge which was the status of dislike being inspected, monitored, or evaluated. Thus, it was hard to observe their works as it was a closed space which was in line with the study done by Justice (cited in Pimwan Boonmonkol, 2012) which mentioned that the study in the form of "study up" especially in the government system or an organization often has the obstacles since the executives or the government officers in the organization would not like being the sample in the case study. In addition, they were often unavailable, too busy and having no time to be interviewed. Thus, the unofficial data collecting and by unfamiliar people is hardly possible to be happened. I could make an appointment for a short meeting, interviewing and exchanging only. I might have chances to join them in some special activities e.g. the training of health care teachers in schools, or in the organization of the project called "Less Sweets in Secondary School". These were the only chances that they would step out of the clinics and let me discussing with them. Otherwise, I had to make the appointment in advance to meet them, or sometimes I had to wait until they finished their service with people.

However, when they had the time to talk and discuss with me, the data gaining from this group became rather easy, especially, from the junior dentists who graduated after me. It was even easier if they graduated from the same institution of mine, the conversation happened easier, and they could express their opinions and even their feelings in almost every matter since we could share some mutual experiences together. They could talk and exchanged opinions without hesitate and walk away.

When comparing to the dental auxiliary group, though I could easily reach out and meet them, in the other way round, they often felt uncomfortable and stress when we talked. Observing from their answers to the questions, avoiding eyes contact or walking away in the situations that there were other members around, this “the gap between the professional dentist and dental auxiliary” seemed to be the main issue in this situation. Even Odd who took me in to the field often chose to walk away from the conversation group if the one she took me to visit was a dentist. However, when she took me to the group of dental auxiliaries, she often joined the conversation by talking, creating non-stressful way and answering some questions too. Although, I had tried to reduce such a professional gap by talking naturally in the most friendly way as much as possible, and using a lower status pronoun to refer to myself as “noo” to the older ones and called myself “pii” which means a sister to the younger ones that I talked to. However, they still called me as “mor” (means “dentist” here) or called me as “ajarn” (means “professor”).

Therefore, though that I had many characters and there are several contexts which helped me having the similar character of the insider but there was still “a gap” in terms of power relations existed. So it was not possible to claim that what I have perceived from the informants were all truth because the truth was not exist with value free but it was depended on the contexts and the researchers who perceived. This is the important focal point in epistemology of the qualitative study.

My participation in the field definitely affected to the occurrence of phenomenon which was not different from throwing a rock into the water that caused the vibration of phenomenon more or less. I have perceived all the time during the data collecting that in the beginning the dental auxiliaries felt uncomfortable, and insecure that I happened to join them in the events, e.g. the first time that I followed and

observed the school visitation for oral health examination of the students with “Pim”, the dental auxiliary in Bannpoon hospital. On that day, I observed that she held the basket which there was a teeth model and a tooth brush for giving oral health education. Once we arrived the school, she asked me that “*Normally, when “pii” (means you as an older sister) went out for inspection, do you teach about how to brush the teeth?*” So, I told her that at the university, whether it would be taught or not depended on the work plan of the students at that particular time. On that day, I did not see Pim give the health education, and later on she did not even bring that teaching basket with her at all. At that time, she asked me to examine the oral health of the students instead of her. I thought that she might feel anxiety and afraid of making mistake in examining. Also I did not know the diagnosis index for decision making on the oral status and not familiar with the symbols use in the recording form so I refused to do but volunteered to be an assistant in recording data instead.

The data collecting in the beginning period of interaction like this, I might have had the fault or different information from normal situation. Thus, being waited for things to turn to normal situation is important issue I needed to concern. As if Pim did not ask and used her prepared materials to provide oral health education for the students, I would have recorded and interpreted something that was not right to the facts.

I solved these problems by explain them more details of work as I realized that they felt uncomfortable and insecure to give the information. Previously, I often introduced myself only that I was now conducting a research study on the works of oral health in this area and asked for permission to discuss and follow up their works for some times only. Later, I had to clarify more that my study did not have a purpose to inspect or evaluate their works, but to have a look at how things are working as they are at present, whether there are any problems or obstacles and how. At the same time, I had insisted them that in the research writing, their names and work places would be confidential, and I would handle the given information confidentially, so that there would not affected them as the informants. Then, they felt more released. In the mean time, I also informed them that although I was a lecturer, I had not got experiences working in the hospital before. So I rarely had known any image or experiences of working in the governmental health care units. Therefore, the data gained from this

study was not only benefit to the dissertation writing and propagation in the academic only, but also helping me to visualize the picture of field works and relations among the dental personnel in Ministry of Public Health better, which would be benefits to teaching and learning in order to produce the suitable dental personnel in the future.

Within the organization, I have found more or less gap between dentists and dental auxiliaries who are colleagues in the same organization. Therefore, another important issue to be concerned in data collecting was “choosing the right time” for interviewing and data collecting. Besides, making the observation at the right time to be able to see the phenomenon, I must be waiting for the time that the informants would be free from their works and duties so that I could have a conversation with them. The new discovery about time, and another issue affected to the constructed “the truth” was the suitable time schedule to collect the data from the dental auxiliary group. It was the time that the dentists or their heads were not there. Since when they were talking about works with different views or opinions against their heads that had “power’ might have the effects to the status and relations among each others.

Odd often warned me about having a conversation with dental auxiliaries who were responsible for works towards different ages target groups of the Provincial Health Office, should be at the time when their working group’s head was away. *“If the dentist or the head was there, no one dares to speak out”* They were afraid that their head might have heard the conversation between the dental auxiliaries and I, then their head might disagree. Later, she might blame the dental auxiliaries that *“How did you say that, it caused damages”*. Although what the dental auxiliaries said might be personal thinking and feeling only.

There was once that I had a chance to accompany Odd to contact her works at the Provincial Health Office, she took me to greet the senior dental auxiliary who was working in the dental room. When there was a chance, I then talked to "Pii Kan" who is considered the first generation of dental auxiliary working in this province. Once we had talked for a while, her head came back to the office. Odd immediately gave me a signal to go back. "Pii Jan" (another dental auxiliary) who was sitting in that room rushed out, while Pii Kan told me to have discuss with “the head” first. So I had to introduce myself and informed the head about what I had discussed with Pii Kan in order to reduce her wondering.

However, the data collecting from the group of people who have the same professional and cultural background as well as the way of thinking form can cause the limitations. Since the close relationship until creating shared understanding might make the informants thought that the researcher understands what they are talking about. So they tend to look over the important things in their story though the researcher needs to know that how the informants think about the particular situation. (Darlington and Scott, 2002) In the same way, often that I, as the researchers, might miss the important questions to ask because having thought that I have already understood the structure or the phenomena. Therefore, the gained information was only my opinions to be interpreted not from the informants. Moreover, the familiar with works characters and with the studied area might make me blind to the structure and some important characters for analysis of the phenomena. Thus, I ignored to questions towards such a thing. So, I must be careful and give significance to these limitations.

Besides collecting the data from the sampling groups, I had done the documentary review in order to keep as the additional data. So I could see the policy and the process of oral health promotion and prevention from the past in order to compile with the information from the interview with the key informants in the field. Moreover, there are the data collecting from the social network of the group “Thailand’s dental auxiliaries” in www.facebook.com, at that time there were about five thousand members in the group. And since it was the data collection through the observation of the conversation content among the dental auxiliaries in this social network, I had received the information concerning their thinking, feelings, and exchanging experiences in works of the dental auxiliaries in other areas besides the studied areas. Therefore, I had seen the similarities and differences as well as the additional information from the field. This information would be benefit in the triangulation data checking as well.

While I was trying to act as “insider” who lives in the field for a long time in order to make understanding to the phenomena, I was also taking a role of “outsider” to be able to analyze, interpret and linkage all factors found and learnt from the field together. Moreover, I had to aware of not attached to the good relations in the field until ignorance of the researcher’s roles. Every day after data collecting, I would

take a field note in order to be benefit in writing the results by keeping the details record of the events, e.g. person, scene, activity, story and feelings. These records would be used in analysis, review and thinking reflection. In addition, I might review the documents or discussion, arguing, defending with the advisors and other academic professors through the viewing of “the outsider” in discussing the phenomena that were found.

3.5 Data explanation and analysis

While I was collecting data, I would have a notebook with me to keep record of the event and the interview results. Then after completed data collecting each day, I would keep the data record on the field note every day by created data files in the computer in order to review the happened events as well as to remind myself of the important issues so that I would not forget them. If any days I had the special interview such as the interview of dental personnel from the central office or the interview with the heads of work groups/divisions in the hospitals with the interviewed voice recording, I would immediately write down the tape recorded interview day by day. So there would be not much data left over as word by word recording from the tape was quite time consuming.

Thinking and analysis of data had been happened all the time since the beginning of the field data compiling until the completion of the data collecting and left the field. The beginning period, the revision of the contents and issues from the individual interview and observation had been done for the completeness according to the guide line questions. If there was any missing or incomplete information I would make a correction by collecting more data for completeness. After that, I had tried to categorize the data in group e.g. personal details data, provincial overview data, and the same meaning individual data such as meaning and valuing the oral health promotion and prevention by the dental personnel. After grouping, the coding was put in order to classify the data group for the ease of analysis.

Until the time had been passed for a while after I collected the certain amount of data from several people and places which was enough to see some structure such as the characters of promotion and prevention works which mostly was

fallen into the dental auxiliaries' responsibilities. These dental auxiliaries were excluded and limited in almost every aspects of life. While the dentists often work on the treatment in the hospitals. There were not any groups of dental personnel preferred the promotion works but all were fond of the treatment works. I had brought the data to be analyzed and compared with the biomedical model, concerning the concept of health promotion and the concept of marginality. Also, I would use these concepts in explanation, discussion on the received data as well as use the concepts in identifying the guidance for further data collecting in order to explain the phenomenon deeply.

Participating I had been in the phenomena through talking, having a conversation and questioning as well as observing how things were being or going on until I was certain sure that I have learnt that interesting matter well. All these methods helped enabling me to interpret and understand the particular phenomenon as much as the key informant does. Since "the truth" had the subjective character, so it was constructed under the context bound and being as the needs or objectives of human beings. (Bishop, 2007, Perelman and Curran, 2006 and Chai Podhisita, 2004)

3.6 Ethical considerations

Prior the research conducted, I had passed the training of humanity research and proposed the research outline in order to get certified on ethnic aspect for conducting humanity research from MU-IRB.

When I had started collecting data, I had submitted the official document issued by Faculty of Social Sciences and Humanities, Mahidol University in order to get the permission from the heads of organization who were the directors of relevant hospital, and provincial public health doctors. Moreover, I asked for permission to collect data from every informant by informing them verbally as well as handed the clarification document. So they would know the objectives, expected benefits as well as the important conditions that the key informants should have known for making decisions. Whenever the informants had a question about the research, I would welcome their questions until they had truly understood. Therefore, their participating decisions were independent, no forced or controlled to join the study at all. If any key

informants felt uncomfortable or reluctant during the study, they could inform to discontinue studying process at any time.

During the process of data collecting and compiling, I had acted towards the informants politely, with honor and I had never threaten their rights either in front of them or behind their backs. In addition, I had reassured the informants the I would take the confidentiality of their data as the first priority, there would be no revealed of their real names and work places in order to prevent the direct and indirect impacts to their lives and works. Therefore, this research study had used the alias of both persons and places instead of the real names.

This data collecting, there were sometimes voice recording and photo taking of the informants, I would ask for their permission before doing so and after complete the research study process, I informed them that all documents, pictures, and recorded voices would be destroyed completely.

CHAPTER IV

RESULTS

In this Chapter, I would like to present the overall information for more understanding of complicated phenomena concerning the works on oral health promotion and prevention in the primary students group. All contents would be divided into 3 crucial parts, as following;

1. Work context within the province
2. History and the works of dental auxiliaries who were the main mechanism in this work, and
3. Implementation of dental personnel in the context of policy and relationships among professional occupations / inter-professional groups.

The overall information I have gained from the key informants who were the dental personnel in the studied area including the dental personnel in the central offices. Some parts of the information were based in the literature review and some from the social network of “Thailand’s dental auxiliaries” facebook (www.facebook.com). As the following details;

4.1 Work context within the province

The province I have chosen for this study is a small one in the central part of Thailand. There are 6 hospitals under the Ministry of Public Health, which are Muang Hospital, Ingfa Hospital, Bannkai Hospital, Bannpoon Hospital, Sriburi Hospital, and Chiangtai Hospital (pseudo names). The first two hospitals are general hospital and the other four are community hospital. The general hospital has a dental health working group whereas the community hospital has a dental health division, which takes care and provides service on oral public health for the people in this area. Both of them work for the oral health promotion and prevention within the direction,

guidance and control of the dental health working group in the provincial health office. This was the common working structure same as in other provinces.

In this provincial health office, there are 3 dentists and 3 dental auxiliaries working in the dental health work group. Compared with other same sized provinces or the bigger ones, this provincial office is considered having a high numbers of dental personnel. As general, there are only 1-2 dentists working with dental auxiliaries in each provincial health office. Some provinces, there is no dentist and only one dental auxiliary. Some provinces, the dental health work group is even merged with other work groups in the same provincial office. Therefore, the dental health working group in this provincial health office is considered crucial and has authority in making negotiation with the higher level bosses or commanders.

The head of dental health work group in this province is “dentist Proud” who transferred to this organization for almost 18 years. She is the group head who has crucial roles in the oral health promotion and prevention of the province. Since she has not only worked as her roles and duties according to the organization structure but she also voluntary works in the projects or activities which are initiated by Bureau of Dental Health (the former Dental Health Division). These projects and activities are often pilot operated in this province through the head’s attempts with the hope for mutual benefits to the people.

Since dentist Proud has rather emphasized on oral health promotion and prevention works in this province, so there are three dental auxiliaries; Pii Pin, Pii Kan and Pii Jan. (*Pii is the Thai term used for calling a person who is older than the speaker*) They all are working together in the same organization as dentist Proud, so they have to follow her and be active all the time. These three dental auxiliaries will be assigned tasks to responsible and handle the activities for several age groups of people within this province. The provincial health office must have order, control and monitor the works in district level by organizing the regular meetings such as the monthly meeting of dentists who are the division heads or the heads of dental group in each hospital. The objectives of the meeting are to coordinate, follow up the operations, and listen to the problems and obstacles encountered by the working team so that the activities will be operated smoothly and effectively.

In the district level, there are the heads of dental division or the heads of dental working group in the hospital. In theory, these people will identify the directions and the work plan of dental health in their responsible district. However, in the practice they have received the policy and work plan from the provincial level before handing to the district level. The heads will oversee and control the works of dental personnel in all level, including dentists and dental auxiliaries in hospital and sub-district health promotion hospital, as well as the staff responsible for dental health works in the sub-district hospitals where there are not dental auxiliaries. Generally, the transferring of the work plans from district hospital to sub-district health care hospitals will be in the meeting together. However, there are many times that the hospital makes a phone call to give an order instead of making face to face order.

For the works with primary students, this province has continuous tasks including (1) the main project works that every province has to operate such as the project for surveillance and oral health promotion for the primary students, the project of oral health promotion and prevention services in school, named "Yimsodsai Dekthaifundee", (2) the pilot project which Bureau of Dental Health created and initiated the new project such as the "Sweet Enough Network (เครือข่ายเด็กไทยไม่กินหวาน, literal meaning)" (only 20 provinces as the pilot), the Learning process for Young Researcher project (โครงการเรียนรู้คู่วิจัย, literal meaning), and the Dental School Buddy project (โครงการโรงเรียนคู่หู, literal meaning). This province has always received "all kinds" of works and "achieves all targets" of the indicators. Therefore, when I have been visiting and asking personnel in the Bureau of Dental Health, everyone will say that "*dentist Proud is really good at work, there are many kinds of activities for children and elderly..*" while the reflection from the dental personnel within the province is that "*the dentist is too serious and she wants to pass all criteria indicators*"

As after receiving the works from the central office no matters they are routine projects or pilot projects, dentist Proud would make the appointment for dental personnel meetings at least twice or more depends on the importance of the work. In the first round meeting, it would be held for the heads level or the representatives in order to clarify the activities, goals as well as to discuss about the implementation plan. Also, In case that the works do not identify the numeric quantitative targets set,

the participants would identify the targets together. In the following meetings, the participants would be discussed in depth about the operation. Therefore, there will be the calls for further meetings so that the dentists and dental auxiliaries will be perceived and assigned tasks for implementation. The working system in this province seems to be the order system where the tasks will be assigned from the top to the lower position or so called top-down system. This also reflects the working system in each district in the same direction as the provincial health office.

Due to the working system that relies mainly on the top level order, when dentist Proud received the tasks from the central office, the heads of each district working group would have no choice or could not make any negotiations. Sometimes, they could only make complain that it is too difficult to do in their responsible area, but they could not refuse it. Moreover, they have to operate to achieve the targets too. For the cases of long term projects, the first year of the operation might be only requesting for the coordination from each district, in order to find out which districts are interested in and ready to take the project to be implemented. After that, the meeting will be organized to exchanged experiences, and then expand the project to the rest of the districts. In the same way, if the tasks would not be assigned from the provincial health office directly to the dental auxiliaries, the dentists who are the heads of the working group would hand in the tasks to the dental auxiliaries, which in both cases the dental auxiliaries would not have a chance to express their opinions or to make any negotiations at all.

Therefore, when asking the dentists or the dental auxiliaries who have to receive the tasks to implement in their responsible areas, it was found that all dental personnel felt that their responsibilities were too much as their regular works were fully occupied. Moreover, they had to receive extra tasks which mostly were the pilot projects that the provincial health office had received. When compared with the dental personnel from other provinces, many said that receiving the extra tasks to add up to the regular jobs which sometimes were still incomplete, often caused the extra tasks inefficiency and ineffective as expected. Since the numbers of dental personnel are limited while they have to accept the undeniable orders.

“Working with the dentist (Proud), there would be plenty of works. She does not think for the implementers that it would be more or less works, she only orders ... when she ordered without considering whether it was possible in the practice or not. We have too many works already so we could not do as she ordered” (Odd, the dental auxiliary in Fajaem sub-district health promotion hospital)

“It should have been fewer indicators in order to be close to the reality since the present indicators were too high and beyond the reality. Dentist (Proud) is too idealism, she does not know that in fact all these are untrue. She always thinks of new projects over and over again. Although the old projects are still incomplete the new ones come in...” (Dentist Dream, Head of dental health division, Bannkai Hospital)

Mentioned about the practice patterns and activities in the project for oral health promotion and prevention in the primary students which have been important from the past to present, it was found that before the Dental Fund around the year 2011, this province had worked with the primary students continuously. Through the discussion with the senior dental auxiliaries who graduated as the first group of this province (started working in 1983 -1987) at that time there were very few dentists working in this area. Through the documents reviews, it has been known that the period of time was during the Incremental Dental Care project, which most of their missions with the primary students were organizing medical mobile units to provide services e.g. oral health education, fluoride mouth rinse provision, oral health examination and tooth extraction for the students, while other operative treatment which was complicated works would not be included since there were insufficient materials and equipments to provide such services.

Later in the year 1988, the senior dental auxiliaries mentioned that there was a change in practice model of the project for oral health promotion and prevention in schools by holding “the project for surveillance and dental health promotion”

nationwide. In this project, there were activities for training the health care teachers and classroom teachers to be able to assist in oral health examination including gums and teeth of the students. Then, the teachers had to submit the report on the students' oral health to the dental personnel in order to make an appointment with the students who needed urgent treatments. This could help reducing the works of dental personnel and solving the problem of insufficient staff to provide services to cover all population.

The operation of the project for surveillance in this province has been continued until present although the other provinces have been discontinued after there were other projects in replaced. However, this provincial health office still keeps the oral health report format 002 and 003 (นร.002 and นร.003, literal meaning, a summary of oral health examination of the students in each class of that particular school and a summary of oral health examination of the students in each school in the responsible areas of the health care institutes, respectively.) At present, the practice form of the sub-district health care hospital have been adjusted such as the dentist in the hospital will assign dental auxiliaries or the staff who responsible for oral health to reach out and inspect the students instead of the teachers so that they could keep this report formats to submit to the provincial health office since the teachers did not submit the report or some teachers claimed that they did not have knowledge to carry out the oral health check for the students, while some schools are still able to do the activity and submit the report to the sub-district health care hospital. After the dental personnel received the reports from the teachers, 001report (นร.001, literal meaning, results of oral health examination of the individual student), some hospitals / sub-district hospitals still make appointment with the students to provide them treatments while others do not since this matter is not defined as the significant target or indicator to be reported further.

In December, 2002, there was a mutual agreement made at the country level among the multi-disciplinary professional group including physicians, dentists, nutritionists, and communication strategists in the name of "Sweet Enough Network". This group had realized that the health problems in Thai children were caused by their behaviors of over consuming sweets. So they started the campaign and found out the

solution to reduce the risk factors, together they had supported the policy until the food administrative committee agreed to revise the national announcement to prohibit adding sugar in the powdered milk formula in January, 2005.

In the same year, the three years dental operation work plan to campaign for “Sweet Enough Network” had been implemented from 2005 to 2007. The operation were to create trends and practicing guidance to reduce consuming of sweet, the policy of schools with no soft drinks had been pushed by the Office of the Basic Education Commission of Thailand through submitting official letter to all schools to ask for cooperation in stop selling soft drinks in the school area (Bureau of Dental Health, Health Department, Ministry of Public Health, 2008.) In the area where I have carried out the research, all primary schools had been passed the evaluation and became schools with no soft drinks all over the province. The schools had been received a sign of “School without soft drinks (โรงเรียนปลอดน้ำอัดลม, literal meaning) in order to put this sign at each school to support the activities under the concept of “Health Promoting School Initiative” of Health Department. Moreover, the province had joined the project of “Sweet Enough Network”, phase 2 as a pilot province in the year 2009 too. Therefore, there were many activities e.g. training of the students’ leaders, holding the competition of the Dental School Buddy project, and creating network of Thai children with healthy teeth (เครือข่ายเด็กไทยฟันดี, literal meaning).

During 2005-2006, “The project of Learning process for Young Researcher : Food and Dental Health” was brought up to be a pilot testing in 14 provinces including this studied province. The concept of the project were to create a process in oral health taking care to integrated with schools so that the learning would be continued and coherent with learning management in schools. It emphasized on working as a team and allowing freedom to think as well as organizing activities to encourage learning through surveying process so the students would know the situation, seriousness of the problems, and prioritizing the problems and solution making. The students would work with their advisors and Bureau of Dental Health as their coaches in academic way. In the first year, there were three hospitals in the province adopted this project to implement, and then later in the second year the rest 3 hospitals had been followed.

Another important event which affected the nation health service system was an application of the policy for universal health care coverage through “30 baht for curing every disease scheme”. This policy had been implemented throughout the country in 2002 which made more than 49 million of Thai people who had no any insurances could possibly reach the service equally. (Sa-nguan Nittayarumpong, 2005) So there were obviously higher numbers of people who lined up for the oral health care services which mostly were adults and elderly people, while the group of children became lower. Most of the service providing institutes had to reduce their active roles since the numbers of people who waited for the services were increasing. Moreover, they could decrease the expenditure from avoiding the active role activity of oral health promotion and prevention. Based on the evaluation in 2004, it was found that the oral health promotion and prevention services were considered only 14 percent out of all kinds of services. (Referred in Sunee Wongkongkathep, 2006)

With the mentioned reasons, during 2005-2007 National Health Security Office (NHSO) together with Bureau of Dental Health, Health Department had requested all provinces to operate the activity of "Yimsodsai Dekthaifundee" project (oral health promotion and prevention services in school) in the way of vertical program by organizing the full mouth examination and keeping record of Primary 1 and Primary 3 students in the database to cover all 100 percent. Then, there was a service providing of sealant service at the first permanent molar for Primary 1 students about 50 percent of all students or average 2.5 teeth per person. There was including the activity of daily teeth brushing after lunch in Primary school students to cover about 100 percent of all schools. (Bureau of Dental Health, Health Department, 2009) These activities had become the guidance for service providing for Primary 1 students since then. There was a claim that at least it should be considered to provide sealant service at the first permanent molar for Primary 1 students in order to prevent the decayed tooth in the future.

All mentioned activities are considered important activities in the province level in operating the oral health promotion and prevention for primary students in the previous years. For the activity that is a pilot project, Bureau of Dental Health might

have some supporting budget but for those routine projects, the provinces or hospitals have to defend with the executives for supporting budgets for conducting the activities.

Based on the interview with the informants, it was found that the hospital itself might not have much support to these activities. Although NHSO had allocated the budget for promotion and prevention works (so called PP budget), it was only the budget for overall activities of the hospital. To use this budget, each work group in the hospital has to propose the activity proposals to request for the budget. So far, the dental health section has often received a small supporting budget or sometimes it did not receive budget at all. Since the hospital committee often sees that the promotion and prevention works are small and less important. The budget request proposal composing for ten to twenty thousand baht seems to be the hardest thing to do, especially, when the proposal is not belong to any dentists. To receive a small amount budget is considered fortunate thing as it is known that the oral health promotion and prevention works seem to be at last priority of the hospital's works list. As the information gained from dental personnel which was shared with me that;

“In the past (before the Dental Fund) we could not request for budget in time, we were all in small positions without power. I used to get budget once and then no more again at all....” (Rose, a dental auxiliary in Muang Hospital)

“To pass the proposals before the Dental Fund was very difficult as we (had to) fight with other sections. Even worse if any hospitals did not have the head of dental work group who was really fight for that proposal, no matter it was written by a dentist or a dental auxiliary, it would never been approved.” (dentist Dream, Head of dental health division, Bannkai Hospital)

“In the past before the Dental Fund, when we had to defend for budget requests with other sections, we often lost, in particular to

the Ministry works projects e.g. "Bonds of Family Love Project" which was the specific ordered project that handed to us with the success indicators. In case that the oral works were attached to such a project, so we could do the task" (dentist View, Head of dental health division, Sriburi Hospital)

After the clarification of the guideline and communication in the areas where the activities would be operated, the provincial health office would follow up, request / ask for results, and evaluate the results through the next monthly meetings or until the head of dental work group was monitored or requested for results by the central office once again. The working system in the way that the work was "thrown" away down step by step from the top to the bottom level while the implementer could not express their opinions at all, so the work sometimes had been roughly done just to fill up the orders. As the implementers felt that their routine works were already too much, some had worked with sufferings for both themselves and target people in the area e.g. teachers and students, all had to force themselves to do the activities according to the orders of "the bosses".

"They were the health care teachers who were forced to be in this position, while we were also forced to do the activity from the top level. If the teachers refused to do, we had to do ourselves.... The picture that came out might look beautiful but deep down inside it was not as they (the students) gained. They (the bosses) did not know what problems were. To do this activity every side including teachers, students, and the dental personnel must be ready" (dentist View, Head of dental health division, Sriburi Hospital)

Until the fiscal year 2011, National Health Security Office (NHSO) had adjusted the budget allocation to the oral health promotion and prevention works by allocating the budget through "Dental Fund" which was separated clearly from the budget for promotion and prevention works (or PP budget). The reason for setting up

this separated fund as it was found that there were very few Thai people reached to the oral health care services especially in the remote rural areas. So NHSO has allocated the budget of 37 Baht/ per head of population to each CUP to operate the oral health promotion and prevention with the 4 major target groups which are pregnancy women, pre-school age children, school age children and elderly people age over 60 years old. The primary students group is considered the important target of the works still. NHSO has opened up wider for the activity types to be operated by allowing the NHSO at the provincial level and the regional level to take care, oversee, monitor and evaluate the activity operation by themselves. This became the significant change in operational budget in every province throughout the country. Therefore, each hospital in this studied province has received the budget of 200,000-700,000 Baht (depends on the numbers of population in each district) for operation of oral health promotion in vary target groups. Compared to the previous time when each hospital might receive 20,000-30,000 Baht for each project activities or not even received in some years, all hospitals at the present have the actual budget for oral health promotion and prevention per head clearly. Thus, the problems concerning budget for activity operation and activity designed to solve the problem status in each area would seem to be released.

At this state, the provincial health office which is led by “dentist Proud” still has an important role in defying the directions, planning the work plan, considering the context, numbers and ratio of budget for each target group including the monitoring and evaluation of the results in each hospital in this province as usual. Moreover, the office is also responsible for the follow up the evaluation and budget spent by the regional evaluators together with the NHSO evaluators. The NHSO has particular emphasized on the primary students, especially the Primary 1 students, as it could be observed that the outcome indicators were set for only the Primary 1 group that: 1) Not less than 70% of Primary level 1 students in each area have been received oral health examination, 2) not lesser than 20% of Primary level 1 students, who had been examined, have been received the complete treatment. While the other Primary levels students have been able to receive necessary services following to their rights. With the hope that this Primary level 1 students and later on would have better oral

health. (National Health Security Office, 2010 and Dentist Wirat Euangpoolsawas, Interview) Moreover, the provincial health office has identified the addition indicator as that not less than 50% of the Primary 1 students have sealant service.

After each hospital had knew the amount of allocated budget, they had to compose the proposals to request for that amount by the work plan of each hospital might be designed by the dentist or the dental auxiliary. Then, after there would be many meetings for the committee in the district, province and region level to consider the proposals and provide the suggestions in terms of activities, content, and budget.

For the activity of the project to be done with the primary students in the year 2012 which was the second year of the Dental Fund when it was the period of time that I had collected the field data, it was found that most of projects from the hospitals in all 3 studied areas were composed and revised from the dentists in those hospitals. In some hospitals, the dental auxiliaries had not participated in designing or decision making at all while in some hospitals there was consultation and discussion among them. However, it had been observed that the dental auxiliaries who are working in the sub-district health promotion hospitals in the area of CUP would have not been joined in the decision making concerning the content of the project at all. Some dental auxiliaries told me in the way that *“We have never known what CUP wrote in the projects, how many budget spent and how it was spent, but when they wanted us to work on some things, the dentist would tell us time by time.”*

When considering the details of the project, it was found that both Muang Hospital and Ingfa Hospital which are the general hospitals, would emphasize on the service providing such as tooth examination, sealant, filling or scaling for the Primary 1 students only in order to achieve the targets and the indicators of the Dental Fund. But for Bannpoon Hospital not only emphasized on the service providing but also organizing the school competition for oral health promotion in the district. There were activities of training the students' leaders, training of the health care teachers to be able to assist in full mouth examination for the students, as well as there were the committees to evaluate the operation in the representative schools in the sub-districts. However, Nong Pim (*Nong is the Thai term used for calling a person who is younger than the speaker*) who was a dental auxiliary responsible for the school age target

group in Bannpoon Hospital gave the reason for the school competition that it was the preparation in case that there might be the competition in the provincial level or regional level as in the past so that the hospital would not waste the time to find out the best school and with this competition it helped school to prepare themselves in other way too.

From the above information, the dental health working group in this provincial health office was rather strong and had been recognized its importance from the provincial health medical physicians. This could be seen from the high numbers of dental personnel in this working group as well as the ability to maintain the existence of dental health working group without being merged with the other sections as happened in many other provinces. However, the pattern of oral health promotion and prevention works in this province health office was still relying on receiving the policy and projects from the central office and used the power to give the orders to the hospitals to implement accordingly which was not different from the other provinces' working processes.

In the next part, I would explain the important characteristics of the oral health promotion and prevention works with the primary students in this studied area, which might be categorized into 4 issues; (1) dental personnel including dentists and dental auxiliaries all focused on the treatment works rather than promotion and prevention works, (2) the oral health promotion and disease prevention works were mainly belonging to the dental auxiliaries' responsibility, (3) the significance given to the goal in terms of quantitative numbers and implementing the works to keep their good images, and (4) the significance given to the works under the concept of "disease prevention" rather than "health promotion". All these characters would be presenting the concepts and works valuing of the dental personnel as well as showing the status of oral health promotion and prevention and showing the outcome of the operation.

4.1.1 Dental personnel all focused on the treatment works rather than promotion and prevention works

Based on the observation on the implementation of dentists and dental auxiliaries in the general hospital level, community hospital, and sub-district health

promotion hospital, it was found that the dental personnel were emphasizing and spending most of the time with the treatment work. Their regular routine work during the morning session, they would provide treatment service for general patients and then in the afternoon, they would do the service with the appointed patients. Whereas the oral health promotion and prevention would have been designed for special occasions only which were not often, so these dental personnel had viewed towards the promotion and prevention works as the second priority when compared to the treatment. For the service provided to the primary students who were the main target group would be done only 2 or 3 days per week in the afternoon by the general hospitals would provide the services only on the first semester only while the community hospitals and sub-district health promotion hospitals would provide both semesters. However, the service provided for the students including the treatment and the oral health promotion and prevention works was considered only 20 percentage rate of overall working time per week. Therefore, if considered only the rate of oral health promotion and prevention work, it would be less than that. Moreover, both dentists and dental auxiliaries in the areas were trained for specialty and expertise in treatments including filling, tooth extraction, or scaling. Even though the dental auxiliaries who graduated later on and they trained by the college to focus the oral health promotion and prevention works rather than the previous graduated, when they entered the work, they were forced by the dental personnel in the areas to be keen on the treatment work.

I have met “Kat”, a dental auxiliary who was just graduated from Sirindhorn College of Public Health and started working at a sub-district health promotion hospital in 2011. At the beginning after her graduation, her work place at the sub-district hospital still had insufficient equipments and materials for work. As this hospital had never worked on dental care services before, she had not much work to do. The head of dental group in Muang Hospital had persuaded her to get the training at Muang Hospital where most of the works were treatment works “*I had trained all the clinic works such as tooth extraction, scaling*”. While the oral health promotion and prevention works at her first sub-district hospital had not much work as there was not any schools in its responsible area. There was only one school that

Muang Hospital asked this hospital to help taking care of this school. For other ages target groups were not assigned to do, her daily work context has instructed her to focus on the treatment works rather than the others.

Moreover, the ability in treatment service providing becomes the indicator of working capacity of the dental personnel. Most of the personnel who were good at the oral health promotion and prevention works or the document works were not truly accepted. Working in the service clinics become the capacity indicators for dental personnel including both dentists and dental auxiliaries.

“I think my capacity is much more than that” said Pii Jan, the dental auxiliary who just transferred from the provincial health office to work at the sub-district health promotion hospital. In the past, she had responsible on the mother and baby target group, her duties were to control and oversee the works concerning this target group through giving the policy of work to the health service institutes by telling them what kinds of works they had to do, and then follow up and monitor the overall works. However, she felt all the time that she was not keen on this work as she had to deal with too many documents which she had to read through the documents, revise them and provide suggestions to the proposals which the hospitals submit to the provincial health office. *“So I informed the dentist that I would like to work on treatment rather than the documents”* that was the reason she requested to transfer to the sub-district health promotion hospital after working in the provincial office for more than 4 years.

Same as Odd, the dental auxiliary in Fajaem sub-district health promotion hospital who thought that to provide treatment service adds her self-value and being existence in the people’s eyes

“If I worked in the sub-district health promotion hospital but I could not provide treatment, how the villagers would think about me? They came to me because they wanted me to pull out their teeth rather than to teach them how to brush their teeth”.

So she thought that it was not possible to have the dental auxiliaries responsible for the oral promotion and prevention works only since the treatment works helped releasing the sufferings from people was what they expected. Also, the treatment works created value and identity of the dental auxiliaries as the oral health promotion and prevention works seemed to be less value and less important than other works.

For the promotion and prevention works with the primary students, especially Primary 1 who are very young, become undesirable things for almost every dental personnel because of its difficulty. The young children often resist and negotiate, so the service providers have to manage the situation by explaining and persuading them until they cooperate well. Besides, the children themselves were hardly control their own oral health conditions, as well as the fear feelings make them produce a lot of saliva which cause them vomit easily. All these are the obstacles for all services especially pit and fissure sealant for this target group as in case that the service providers could not control the moisture on the teeth, sealant would be failed as the material that filled in the tooth would fall off or unbound easily. In the case that they have to work alone without dental assistants to hand in the materials and equipment as well as saliva sucking, the dental auxiliaries are even worse.

To work with children is very annoyed, it is better to do the difficult work like tooth extraction” (Wun, a dental auxiliary in Bannkai Hospital)

“I don’t really like to teach the children. There are many limitations, and when I do sealant for the Primary 1 students, they would vomit easily and they have too much saliva, soon the sealant is fall off. If they are older in Primary 3-4, they become ready for this service, but their teeth might already be decayed. ... I have no idea. Perhaps, what they assessed it might be good for children in the city. But for the Primary 1 students here, they know nothing, they don’t even know how old they are and what their nicknames are. They

don't understand us.....but it is our duty we have to do anyway."

(Odd, a dental auxiliary in Fajaem sub-district hospital)

To work on the oral health promotion and prevention in the primary students, especially Primary 1 who are the main target group is the target group that the dental personnel considered more difficult when compared to other target groups e.g. adults, teenagers, or elderly which are easy to control and manage.

For the dentists, they are more emphasizing on the treatment works rather than the oral health promotion and prevention because on one side they have been trained to be expertise in curing the diseases and healing the suffers. While the oral health promotion and prevention works are so boring and not suitable for their potential and capacity. I have talked to dentist Krit and dentist Bow, heads of the dental groups in Muang Hospital and Ingfa Hospital (respectively), it was found that the dentists who work in hospitals preferred treatment works, especially when they worked in the general hospitals which are the secondary level hospitals, they even believed that it was necessary and more suitable to emphasize on the complex treatment. Moreover, they would have more choices of works both in government sector and private sector which had higher payment. Therefore, if there were assignments or pressures to work on the oral health promotion and prevention, they would choose to resign and work in private dental clinics instead.

"Actually, the original concept was good which was the general hospitals should develop for the highest capacity to be a tertiary care so that they would be ready for a patient refer from the community hospitals in 6 districts. Any district could not cure the patients, they would be sent to the provincial hospital. This was a good concept and the in-depth work. While the promotion and prevention works, I knew that some (general hospitals) do not have the dental auxiliaries, so they could not do these works. And if we ordered the dentists to go out and do these works, some of them who do not like this kind of work, they will resign... Here, I already

checked with the dentists, all of them do not want to do these works at all. However, there was only one who happened to transfer from the other provincial health office, when he knew that he was assigned for these works here, he accepted it. Simply that the dentists in central hospitals and general hospitals, nobody likes the promotion and prevention works. Although they could do it, they do not like it and do not keen on it. These works become partly reasons that the dentists felt bored with the working system and decided to quit the job. The salary of ten thousand-something, it seems very tiny for them” (dentist Krit, Head of dental work group in Muang Hospital)

For Ing Fa Hospital, although it is a general hospital level, it is located in a district. There is too often rotating of dentists. At present, almost of the dentists who working in this hospital are very young (except the head of dental work group). They have not pursued their further study in order to be the specialist dentists. When the dentists are in the same age, the work assignments and cooperation in works seem to be harder than those in Muang Hospital where the head of the dental work group is very senior and nearly retired. Therefore, the head could not assign any tasks to the co-workers, the head, who is the only one the specialist dentist, has to accept all missions undeniably.

“The dentists here, when they were asked to go out and work in the community, or to teach the children, nobody wanted to. They prefer doing treatment works... that is because of their professional. We chose to learn for this profession since we wanted to cure the patients but the community works need communicative ability in order to contact with many people, and these works need to do document works too. Recently, I went out for the dental education in the school, I asked the other junior dentists if they would like to come, at first there were some interested in but when I told them that

they had to prepare power point presentation, and draft the speech (opening speech) everyone refused to go. So I had to go as usual”
(dentist Bow, the head of dental work group in Ingfa Hospital)

As the dentists focus on treatment works, it is partly because of the long term value instructed from the university, including the studying curricula and units that emphasized the students to give the significance to treatment. This is a biomedical paradigm. Comparing the units of the community dentistry subjects which focused on the student ability in individual and community promotion and prevention works with others subject, it was only 6 percentage of all (15 from 246 units). The rest would be “general education subjects” and “specific subjects” in other fields which all focused on medical sciences and clinical practice in other fields in order to be profession (Faculty of Dentistry, Naresuan University, 2011) this was in line with the study of Tuongratanaphan (2004) in Chiang Mai University. Thus, it was not surprised that most of the dentists prefer the treatment works in clinics. They love to fight with the diseases. Also, the modern technology is produced to attack and response to the disease curing and restoring the oral health conditions, so all dentists need to struggle for further studying to be a specialist dentist. Then, they would come back to tackle with the diseases and other impairments in order to improve their treatment works. Some furthered their study in order to gain more knowledge for opening or working in the private dental clinics to give treatment to the patients although they all realized that the oral health promotion and prevention is the important works.

“The dentist in general hospitals and central hospitals do not like promotion works as firstly we graduated to be a dentist so we want to provide treatment, and want to work in clinics to do filling, extraction, or surgical tooth removal as all these works make more money. Secondly, we had never been trained to do promotion works. But I am not sure that the new curriculum has the subject about this more or less. ... Thirdly, the university produces dentists for treatment service works rather than promotion works. Many dentists

could not even write a proposal” (dentist Krit, Head of dental work group in Muang Hospital)

“The dentists here (in this province) often work for a short time, when they graduated as the specialists they moved to work in the clinics mostly. ... There was a young dentist in Bannkai Hospital, for example, she was studying on orthodontics, I met her when she made a request for extension her study period. I guess she would not continue working there when she graduated. ... At present, there are the study centers supporting for orthodontics course studying about 500,000 Baht per course, it might be worth investment. ... the most needed branch is the cosmetic dentistry e.g. endodontics and operative dentistry, so all these dentists often resign” (dentist Kay, the head of dental health division in Bannpoon Hospital)

It is obviously that both dentists and dental auxiliaries prefer and give significance to the oral treatment rather than the oral health promotion and disease prevention. Based on the education conditions of the dentists that focus on specialty in treatment as well as the practice training condition of the dental auxiliaries, the meaning and valuing of treatment works became higher capacity and potential works. Moreover, it made the treatment service providers become having more value and identity in all services receivers' eyes. More importantly, it made more income for the service providers. If possible to choose, all dentists prefer to choose for passive action of waiting for the patients at the clinics rather than going out for promotion and prevention works. In addition, there was an additional factor concerning insufficient budget for promotion and prevention works in the past, which caused the dental personnel lack of interests in these works. However, in case that they could not choose, such as they were forced by the targets and indicators of their works, the dental auxiliaries would be assigned to complete these works.

4.1.2 The oral health promotion and disease prevention works were mainly belonging to the dental auxiliaries' responsibility

When the promotion and prevention are the tough works which nobody wants to do, but it does not mean that they are challenge works, as in the reality these works are identified as indicators achievements. They are necessary to be implemented. There are the monitoring and evaluation periodically as the more allocated budget the more monitoring conducted. However, the implementers are not dentists but the dental auxiliaries.

Before the universal health care coverage concept, in the general hospitals there were almost no works concerning the oral health promotion and prevention at all as they were considered large hospitals should only have the duty to receive the patients referring from the district hospitals. Therefore, they were emphasizing on the treatment of complex diseases. Besides, Muang Hospital had never had the positions of dental auxiliaries before, so the promotion and prevention works have been done by the dental personnel in the provincial health office. Once there was the new budget allocated per population head to the CUP, the provincial health office had no budget to do these works, so it had to reduce its roles.

When every hospital had to responsible for oral health promotion and prevention in all age target groups, Muang Hospital was no exception. However, all dentists did not want to do these works, dentist Krit told me that *“The dentists in general hospitals and central hospitals do not like promotion works. If we pressured them to do, they would choose to resign”*. The hospital then had to hire the new dental auxiliary students in the “casual worker” position to responsible for this job in particularly.

“During the period of gold card (at the beginning of UC), it was necessary to receive the dental auxiliaries to do these works. If we did not provide for dental auxiliaries, the promotion works would be incomplete as nobody did it. As the CUP Muang in the city had wide responsible areas and high numbers of students as including the students from outside the city who came to study in town. We did not

get the expenditure base on these students per head, but we had to do the works to cover all. We had to responsible for almost a thousand students while other districts had only one or two hundred.” (dentist Krit, Head of dental work group in Muang Hospital)

“Rose” had worked as the first dental auxiliary and the only one in Muang Hospital since 2006. She took responsibility on the oral health promotion and prevention since the beginning. For the first year, she went out to work with the medical section but there were more works to do including full mouth examination for the patients, so her works were often finished later than other sections. Others had to wait for her in order to come back to the hospital together. Later, Rose requested for a dental assistant and went out to work in the community alone without any sections at the same time.

Later in the year 2008, the dental section of Muang Hospital had hired one more dental auxiliary to help on the dental health promotion and prevention works. During that time was the period of project called "Yimsodsai Dekthaifundee" (oral health promotion and prevention services in school) This project aimed to provide sealant service for the Primary 1 and 6 students in the responsible areas. Although there were only 5 schools in the responsible area of Muang Hospital, but they were large scale schools where included students from other districts. When there were 2 dental auxiliaries to work together, it was better and more convenience.

Although in 2012 when I went to collect the data and found that the active activity of mobile unit of Muang Hospital, a dentist had been assigned to go out and work with the two dental auxiliaries. However, it was a rotation of 8 dentists in this work group as there were only 5 dental chairs, while the two dental auxiliaries were fixed to do this work every time. The process was started from oral examination of Primary 1 students in the beginning of the first semester, all thousands students had to be oral examined from the dental auxiliaries and dentists together through the health mobile units. After that there would be planning for sealant services and

comprehensive care in the responsible area and the areas where there were no any dental auxiliary in the sub-district hospital to take care.

“They (the oral health promotion and prevention works) are new for us but if you asked that actually a dentist could do this, with the capacity of a dentist of course they can do, but it is not worth enough. At present, the dentists plan to go out to the sub-district health promotion hospital outside. To have the periodontist going out for services like tooth extraction for children and people, I think it is not worth. If they were here in the hospital, they were specialists. So the persons who should go out with the mobile units should be those general practice dentists (the new graduated dentists who have not further the specialist study). I think that is okay, right? Only the dental auxiliaries are enough” (dentist Krit, Head of dental work group in Muang Hospital)

Unlike the work in Ingfa Hospital which is a general hospital as same as Muang Hospital, there is only one dental auxiliary in the hospital. In addition, with its current financial status is not possible to hire more dental auxiliary. So “Kwang”, the dental auxiliary, has to responsible for many kinds of work e.g. the oral health promotion and prevention with pregnancy women and well baby clinic. For the primary students group, she has to assist the dentists in making appointment and cooperating with the schools as well as coordinating the vehicle for the work. For the duty of examination, the dentist and dental auxiliary will take turn to do it. The students group was not all her responsibility, but she also has to accompany and coordinate with several sections to facilitate this work. Although, she has to responsible for many tasks, the dentist who is the head of work group thought that she should have ability to help with more works.

“This kind of work should rather be done by the dental auxiliaries. Some community hospitals have many dental auxiliaries, and they

even have equal roles to the dentists. However, the dental auxiliaries here are not quite good as in other hospitals, they could not draft the activity proposals. I have to do it and let them type. ... Normally, I have worked with the dental auxiliaries who had more ability. The dental auxiliaries in other hospitals would know that the dentists soon would be moved, but they had to work for a long time, they tried to learn all and knew what they had to do and how. But in case of Pii Kwang here, she would claim that she was not good at these tasks so the former dentist did all these things. She could not conduct the trainings, but she could find some information or the total numbers of something, that would be okay for her. I remembered that the former hospital I worked, the dental auxiliaries wrote the proposals by themselves.” (dentist Bow, the head of dental work group in Ingfa Hospital)

Since there are 43 primary schools in the responsible area of Ingfa Hospital, which is the highest numbers when compared with other hospitals in this province (in this amount, there are 9 schools in the responsible of the sub-district health care hospital with the dental auxiliaries working there). The dentists have to help the dental auxiliaries working in order to achieve the target indicators. “Dentist Prink” had expressed her opinion towards this issue as follows;

“Actually, the general hospital will not have the promotion works. For example, Muang Hospital had deleted the promotion works from the dentist’s job description, but the dental auxiliaries would take responsible on it. However, our hospital has only one dental auxiliary to responsible for 45 schools (primary and secondary schools) which considered very loaded. So the dentists have to help, also the dental auxiliaries in the sub-district hospital are very few, only at Fajaem and Sanamchai. ... So my hospital has to take care all schools, but Muang Hospital has fewer numbers of schools.” (dentist Prink, the dentist in Ingfa Hospital)

When I asked what her opinion is about the concept that the dental auxiliary has to responsible for all oral health promotion and prevention works, she replied that

“I think to tell them that they should take all these works so that we (as dentist) would do only our specific works but when I looked at both ANC and WBC, the dental auxiliary would have only Monday and Friday, which they could not receive all” (dentist Prink, the dentist in Ingfa Hospital)

This was coherent with the idea of “dentist Kay” the head of dental health division, Bannpoon Hospital that it was suitable to have the dental auxiliary works on the oral health promotion and prevention work. And the hospital has 3 dental auxiliaries so all the oral health promotion and prevention works in Bannpoon district were belonging to the dental auxiliaries.

“It is suitable as they have competency to do the works. The dental auxiliaries have to work under the dentists, and the promotion works are not complicated and done before the disease occurred. So the works are considered fit to the knowledge, and experience of the dental auxiliaries. Some treatment works the dental auxiliaries could not do, so the dentists had to remain at the hospital” (dentist Kay, the head of dental health division in Bannpoon Hospital)

Oral health promotion and prevention works in the area are often assigned to the dental auxiliaries since the dentists all emphasized rather on the treatment works. Except the dental auxiliaries could not complete works in time and to make the overall of the hospital works to pass the indicators, so in that case the dentists would come and help working.

“The promotion works are the works of the dental auxiliaries since the dentists refused to do it. ... For me, I think it should be done together. By the way, there are many other works that the dentists have to do such as curing the patients. But if they have free time, some dentists help on the promotion works while others don’t.” (Pii Jan, the dental auxiliary in the provincial health office, shared her former experience when she was working in Muang Hospital in one province.)

“The dentists rarely worked on the promotion and prevention work as they thought that it was the duty of the dental auxiliaries. So for, dentists had never helped examining the oral health of children, but they had been speakers in the activity sometimes” (Pim, the dental auxiliary in Bannpoon Hospital)

“If we looked at these works as the division’s works, everybody would help working together, but if they thought that it was the dental auxiliaries’ works, so we would be exhausted” (Wun, the dental auxiliary in Bann Kai Hospital)

The oral health promotion and prevention works in this province are often assigned to the dental auxiliaries to responsible. By claiming that the dentists have higher education and have more capacity, so they should rather work in the hospitals’ clinics to provide treatment. While the knowledge and ability of the dental auxiliaries is more suitable with the promotion and prevention works in the fields. So many times, it often found that the dentist did not pay attention or care to know about the oral health promotion and prevention at all, and they let alone the dental auxiliaries to do the works.

4.1.3 The significance given to the indicators in terms of quantitative numbers and implemented the works for goals achievement in order to keep their good images

It has been seen obviously that the oral health promotion and prevention works in this province had the target indicators for activities / projects in quantitative numbers as well as the other works of Dental Fund in the primary students which have been set up by NHSO and the provincial health office as mentioned earlier.

As such a situation, the monitoring and evaluation of the control units, therefore, gave the significance to the numeric targets as whether or not each person had achieved the targets set. To achieve the target became the indicators which were representing the work efficiency, and helped promoting the better image of the person and the organization. Every dental personnel must try to achieve the targets. If anyone could not do it, not only he/she would be blamed in the meeting but also affected to the organization's support budget continuously, including they would not be considered for promotion to the higher level.

Given the significance to achievement of the quantitative indicators had affected to the pattern of work and oral health service providing in at least 4 aspects, which were (1) there was the inequity in service providing, (2) there was the ignorance to the emotions and feelings of an individual, (3) there was a culture of making a fake data to be their own sake, and (4) there was a blocking of the ideas and other new working models.

I had a chance to participate in the monitoring and evaluation with the representative evaluators to this province in the year 2011 which was the first year of the Dental Fund operation. In that year, the dental personnel in several levels had worried about the new target indicators which were set by NHSO. Especially, the case of indicator stated that there must be at least 20 percents of the students who had been examined should have received the comprehensive care. Since the oral health problems of the children in this area were rather high, most of children needed several kinds of services, including filling all decayed teeth, extraction all decayed teeth that could not be cured, and some children also needed to be scaling at the same time too. Thus, one student had to receive many services in many different times until complete

the case. Therefore, everyone had worried that they would be unable to achieve the targets. In the meeting, there were discussions and exchanges opinions about the problems and obstacles which they have confronted such as time limitations, and any other limitations from schools as many times the schools were not convenient to take the students to get the services. Another problem was on the students' parents did not allow the students to get the oral services. So the regional evaluators suggested that they should select the students with less oral health problems to get the comprehensive care service before the others who had too much problems such as the students with no decayed tooth or a few decayed teeth to get the sealant service or filling a few teeth so that they could count as a complete case. The evaluators had given the reasons that *“In the first year, we would like everyone to help working for passing the indicators before, in order to save the Dental Fund to be survived for the next coming years”*

To provide services according to the indicators set, thus, it was not focused truly on “health” and the problems that occurred with the people. As the dental personnel tend to forget “the way of thinking” accompanied all activities that to increase the opportunities for people to access to the oral health services. They only thought that how or in what way they could do to achieve the target indicators that were set from the above level. Therefore, the selected students to get the services were no or less oral problems students or even the ones who could take a good care for their oral health. As well as the students who had abilities or opportunities to access the services from other sources such as the children with good socio-economic whose parents took them to regular oral examination and treatment. While the children with less opportunities and having many oral problems which needed to be cured were refused to the services. Since the dental personnel thought that to provide services to the latter group of students would make them fail to achieve the targets as indicators set, and then they and their organization would be blamed as imperfect working from the above level commanders / bosses. This way of thinking had reproduced the inequity to the students as the service receivers.

Concerning the issue of “Provincial image”, it was very sensitive issue in this area as every times that I had talked with the dental auxiliaries in the provincial health office, especially the time that their head of work group, “dentist Proud”, was

sitting around or nearby. Odd often stopped me from asking the questions with the reason that they would not reply or expressing their opinions as their head would be dissatisfied with their answers that might reflect “negative image”. In case that they had spoken out something in that way, they would be blamed from their head that “*How did you say that, it caused damages*”.

“The image of this province must be A plus only, and so far (before dentist Proud being a head) this provincial image had been good all the time. When we had a meeting, my friends in another province would ask curiously that was it really good or you just pretended. ... This meant that this province had so beautiful works results and too surreal data or information” (Pii Kan, the dental auxiliary in the provincial health office)

When the works had focused on the target or quantitative indicators, the duty of the monitoring team was only emphasis and requesting for the numbers of operation results “*Could you do it? How many did you do?*” They rather ignored to listen to the real problems, obstacles, feelings or even to encourage and support the dental personnel to work properly, especially the dental auxiliary group.

Moreover, giving the significance to the target indicators in order to show other people or other organizations that one had work efficiency was actually affected to the actual numeric data. Since the reported numbers at that time might not the real numbers of the work results. However, the reporters had to create the numbers or made the fake numbers to show that the works had been done and complete in time of the reporting period though there were actually many problems and obstacles in their operation, so that they or their organizations would not be looked down as inefficiency or incapability.

I had followed up and asked the questions about the Dental Fund in the primary students concerning the target indicators of NHSO from “Rose” who was a dental auxiliary in Muang Hospital. She told me that the numbers of students in the responsible area of Muang Hospital were very high since there were the children from

other districts preferred to study in the city or in town (Muang, literal maning). Thus, the numbers of target students for the services in Muang district became higher than others. Therefore, only 4 months period of the operation started from health examination in May, and providing services in June to August. The target works might not be achieved completely as indicators.

“We must submit the report stated we had completed the target before, and then we would do it (providing services) later. If we did not do this it meant that we had incomplete work” (Rose, the dental auxiliary in Muang Hospital)

Therefore, making a fake data had been done with this reason.

When the organizations that had a duty to oversee work received the report from “under organization/staff” had done and completed the tasks, they often assumed that the works they had ordered were in the range of the staff’s capacity. Therefore, for the next coming years planning of the work plan, they would base on the reported data as a basis of what the staff could do. Sometimes they even adjusted the numbers to be higher than that what reported, though they were made up numbers. In the worst case, when they followed up or asked for the work results from under controlled staff/organizations but the staff had not done or had not finished no matters what the reason was or any limitations were, such as some materials had not been ordered or delivered, or there was flood in the area. The monitor team or the followers from the higher level might say directly themselves that *“Just made up the report and submitted it”* or *“Make the report first, then do the works”*

Such a phenomenon indicated that working by giving the significance to the target quantitative indicators was affected to “the data of the operation results” very much. Everyone had learnt that “To play safe for their own sake and their organization sake, they should first have reported as they had completed all works” Therefore, although this province had accepted that they had done “accuracy data” concerning the results of works as the target, if considering deeply inside, it was seen that there were so many problems happened during the period of bringing policy down

to the field implementation. Once the data had been reported completely as the target, several problems and obstacles in work then had been omitted, and never been given the significance for solving, as well as left the problems with the implementers to learn and solve problems by themselves.

Moreover, the significance given to the target indicators also prevented the new working models of oral health promotion and prevention which response to the field problems. As in the fiscal year 2013, the provincial health office has expanded the opportunity for the dental auxiliaries in the sub-district health care hospitals which were the primary care units (PCU) of the province to participate in writing a proposal plan to request for the budget from the Dental Fund too (previous years, all the projects proposals were submitted by CUP). In this case, "Pii Jaem", the dental auxiliary in Thabo sub-district health promotion hospital, in Muang district had prepared several project proposals to work with new target groups such as the chronic patients, elderly and disability groups. Her planned activities were in the active way by going out visiting these target groups at their home. However, in the final approval stage, all the project proposals of Pii Jaem had been deleted with the reason that there was insufficient budget and they were not accompanied with the indicators of NHSO. The approved project proposals from sub-district health care hospital were in the old model of working that is organizing the service for primary students. It has just been separated from the budget of CUP hospitals. As a result, the Muang Hospital's activities for different age target group have been still in the same pattern that based on the significance given to the indicators while the new activities focusing on responsive to the problem conditions in the area had been rejected.

This might be said that the oral health promotion and prevention works that focused on the indicators had caused the working model which the dental personnel must give the significance to the target indicators rather than the health or the equity in the social. The high ranking officers have focused following up, forcing for the quantitative results that achieved without paying any attention to the problems, obstacles, emotions and feelings of the implementers. There were attempts to making up fake data to complete the report in order to pass the quantitative target indicators as

well as blocking the new models of working that could step over beyond the indicators set.

4.1.4 The significance given to the works under the concept of “disease prevention” rather than “health promotion”

It might be able to mention that the works operation according to the activity or guideline for the primary students was identified from the central office since the past to present time. This was the working model that emphasized on the concept of “disease prevention” rather than “health promotion” (although these works were called together in general as “the oral health promotion and prevention”.) Since most of activities all were focusing on the prevention and elimination the causes of diseases including decayed tooth diseases, and gingivitis in the target group.

Since the starting from the service provision following the "Incremental Dental Care Project" which it was the beginning era of the first graduated dental auxiliaries to work in this province. The works in that period would rather be emphasized on going out to the target group to provide them the full mouth examination, oral health education, and fluoride mouth rinse including tooth extraction service. Therefore, these works focused on knowledge-giving, disease diagnosis and treatment, as well as the prevention of dental caries by using fluoride. All kinds of work had been fallen into the dental personnel' s responsibility alone as service providers and there were students as the service receivers. The problem on this activity organizing way was the insufficient numbers of dental personnel to provide services.

The following era, the works were oral health surveillance and promotion, though there were changes by having teachers to participate in the activity. There were teacher trainings so the teachers could assist in full mouth examination for the students in every class instead of the dental personnel. And then the teachers would submit the list of students who had oral health problems such as urgent needed treatment of gingivitis (เหงือกอักเสบระดับ จ., literal meaning) or the students with the decayed tooth that needed to be extraction or filling, the teachers could submit their names to the health care units to get the services. Until the present, this province still asked the teachers to submit the report on the students' oral health condition. Based on the concept of the

dental personnel in the provincial health office that at least the teachers should know the students' problem, but the dental personnel did not strictly provide service since these days every hospital gave the significance on working as in the Dental Fund's indicators. As it may be seen from the Muang Hospital and Ingfa Hospital that they have not received the other levels students who needed the dental services according to the report (นร.002, literal meaning), so the work of the dental personnel in this period was still related to the treatment as well as to sharing their role and responsibility with the teachers who were closer to the students.

In the period of the project for health promoting schools initiatives, this project was adopted by the provincial health office to pilot as same as other projects e.g. the Dental School Buddy project, the network of Thai children with healthy teeth, the project for Sweet Enough Network, including the project of Learning process for Young Researcher. It was found that the working pattern had been expanded from the service providing in dental clinics by the dental personnel only (although, they were still kept operating the project for surveillance and promotion as usual.) This time, they gave significance to empower or encourage the community people to take part on the activities, such as the teacher trainings to increase abilities in several aspects e.g. making less sweets herbal drinks for students. Also, there was the activity to support learning of the students through conducting small researches, the training for students' leaders and the activity of tooth brushing after lunch, as examples. Moreover, all initiatives emphasized on adjusting the environments for oral healthy setting for the students such as the measurement on reducing and avoiding soft drinks and sweets products selling in schools, the activity to encourage tooth brushing after lunch to control plaque, etc.

However, all these initiatives were still initiated and planned from the central office by the dental personnel, so the working pattern was not fully of the community participation. Since the operation was still in the way of assignment and requesting for cooperation from schools to join such activities. Although the activities in this period were stepped outside the concept of services providing by the dental personnel themselves, these activities' operation were considered giving chances for

the community participation and taking responsible as well as learning through the oral health just as never been happened before.

While in the year 2005, the three years project of "Yimsodsai Dekthaifundee" (oral health promotion and prevention services in school) had forced the dental personnel back to work on oral health service providing once again and having the students as service receivers. As this project had the following indicators; (1) there must be 100 percent of examination and recording the data of oral health condition of the Primary 1 and Primary 3 students in the database, (2) 50 percent of the Primary 1 students must have received sealant services, and (3) there must be 100 percent of activity for tooth brushing after lunch at school. These activities had reduced all community participations as all activities had been designed from the central office for the dental personnel to do to achieve the target indicators.

Until the present, there is the working operation according to the concept of the "Dental Fund" which National Health Security Office (NHSO) had defined the guidance for working through the procedure indicators e.g. (1) there must be the following up meetings for monitoring and evaluation at least twice a year, and (2) there must be a District Health Coordinating Committee (DSCC) which comprising of multi-sectors such as dental personnel, local representatives, and civil society. This commission must have the meetings at least 3 times per year in order to consider and follow up the oral health operation plans which were consisting of oral health promotion works, oral disease prevention, and treatment for the main target group in the area. This was considered that NHSO had foreseen the significance of the participatory working with all sectors too.

However, though the NHSO had the targets for work planning, monitoring and evaluating of the oral health works by the assigned committee from several sectors in the area level, in the practice the work plan and project details were often written by the dental health work group whereas the other sectors or even the dental auxiliaries in the area had no participation in sharing ideas or comments. This was because the committee members often thought that all activities, created by dentists, were already good and suitable.

“In my part, I have not expressed much opinion as in the meetings the dentists would present that how much budget our CUP has received, and what projects we would do. I personally thought that what the dentists presented were things that we could do, and the sub-district health promotion hospitals would get benefits too. So in the meeting there was scarcely disagreement to the dentists as we were not keen on these things as they were” (Pii Nate, the director of Plaengna sub-district health promotion hospital, the Commission on DSCC, Ingfa district)

When things turned out this way, all activities were identified by the dental health work group of the hospital which was the same concept of working as previous, although the NHSO was opening up for all activities operation. It was still found that the dental personnel all focused on the quantitative target indicators which were identified 2 items of indicators in the primary students. They were full mouth examination and complete treatment for the Primary 1 students as mentioned. The two hospitals in this studied area were both Muang Hospital and Ingfa Hospital intended to do only these service activities for this target group. So this was considered the way of working that returned back to the pattern of work in the Incremental Dental Care era.

When asking about the operation concept from one dentist in the NHSO who was taken the major roles in controlling and overseeing the Dental Fund, the answer was found that NHSO would follow up and monitor all projects' operation according to the indicators set as they believed that the more dental personnel worked (achieved the target indicators) the better oral health of the children became. But to consider carefully, it was found that these indicators would rather be focusing on service providing through the full mouth examination, and treatment as necessary including the prevention of decayed tooth by sealant because NHSO would like to increase the accessibility of people in the area.

“The Dental Fund focused on Prevention and Promotion as the most important and the selected worthy target group which was children

as the adults were too difficult to cure. But in the children group, sometimes prevention and promotion were too late as our children maybe age 9-10 months the new teeth were already decayed. So it was impossible to do only the prevention and promotion in the children, in this case treatment needed to be done too. So we designed the core package that the children must receive the comprehensive care. Thus, we have to give the significance to these main target groups. But the reserved budget to work with children was almost not enough as there are more than 10 million children with rotten decayed teeth in their mouths, so we have to select the level of primary students which was Primary 1. We did not want to spend all for nothing” (A dentist in NHSO)

Therefore, the Dental Fund although was assumed as the oral health promotion and prevention works, it was found when considered closely that the service provision for the students in these activities (the full mouth examination and comprehensive care) were still emphasizing on the treatment and disease prevention by eliminated the factors which was rather specific to disease. The reason for this was because they gave significance to the examining, diagnosis, and treatment according to the disease, together with sealant service only.

The operation on oral health promotion and prevention in this area were still related on the vision of Bio-medicine. This vision was focusing on the works of dental personnel concerning treatment, prevention and elimination of disease causes only without giving significance to the process that made people having more ability in control and promote their health in order to achieve the healthy physical, mental and social statement. That was the definition of the true health promotion though the strength of community participatory process from all sectors by having the confidence in capacity of community people, as well as having clear understanding about problems and learning to solve the problems by themselves as the best. Therefore, it was necessary to promote the community participation in thinking, analyzing and planning for defining the possibility for their health.

Since the most of oral health promotion and prevention works were fallen into the dental auxiliaries' roles and responsibilities, the following part would be concerned about the history and the works of dental auxiliaries which have been identified by the working structure and what I have found truly in the area context.

4.2 History and the works of dental auxiliaries

Although the dental health service system in Thailand would consist of three groups of dental personnel who could provide the service to people e.g. dentist, dental auxiliary and dental therapist. The last group was very small numbers in the governmental system at present (since there was no more producing the new graduated in this branch since 1973). However, at present the oral health promotion and prevention works are belonging to the dental auxiliaries mostly, in this part I would review their history and works.

Production of dental auxiliaries in Thailand was happened in the year 1968 after the government had produced two dental personnel groups which were dentist and dental therapist for many years (in 1940 and 1944, respectively) (Faculty of Dentistry, Chulalongkorn University, 2009a, 2009b) Based on the reason that in the year 1960, the Consultancy on dental health of World Health Organization (WHO), Thailand proposed that the government should set up the committee on dental consultancy in the Ministry of Public Health, and the appointed committee suggested that the government should emphasize on oral health care in children for being part of general health promotion and preventing the expansion of decayed tooth disease which had an effect to the overall economics of the country. The committee then proposed to set up the dental clinics in schools and agreed to have the existed dental therapists take responsibility in taking care of child 's oral health in the schools under the overseeing of the dentists. Moreover, the committee also proposed to prepare the personnel structure and produce more dental personnel too.

Later, in 1963 the government appointed the new committee according to the suggestion of WHO consultancy that the oral diseases were important to people health conditions and the management of oral diseases in people needed to be done

including promotion, prevention and treatment in cooperation from the government sectors both inside and outside the Ministry of Public Health to work together. On the other side, the committee had considered on the trainings of the dental auxiliary according to the Department of Health project in the same year, and summarized as following; (1) it should be 2 years curriculum and received 50 students each year, (2) the students must be female and have background knowledge at least Mattayom 5 (High school grade 11), and (3) after training, it is not necessary for them to have the license to practice, as they have to work in the schools to provide the service on oral health care for the students under supervision of the dentists. However, there were no more training of the dental auxiliaries until the year 1966 when Department of Health had issued the plan to train the dental auxiliaries once again. This time the trainings had changed and added more criteria that the training would take only one and a half year and when graduated they would be appointed to work at the first class health station (สถานีอนามัยชั้น 1, literal meaning, later became the district hospital) and have the duty to prevention and treatment of oral diseases for students and general patients. However, they had not started training at that time since there were insufficient equipments and places and it was during awaited of assistances from WHO.

In year 1967, Department of Health had assigned the Education and Training Division to establish the School of Dental Nurse and there was Dr. G.H. Leslie, the WHO Consultant and the Director of Health Department, New Zealand at that time, as school director. He had been assisting in establishment and operation of the school for 6 months. There was a recruitment of 5 dentists to be the trainers and a request for budget from Eastern Development Plan of 1 million Baht in order to construct the dental nurse building, which was completed in 1968.

The first school of dental nurse was opened in July, 1968 at the Central Health Training Center, Chonburi province (later it was changed to Sirindhorn College of Public Health, Chonburi). Since it was received the assistance from Dr. Leslie in operation, the dental nurse in Thailand had the principle in work similar to the dental nurse in New Zealand. (Dental Auxiliary Association in Thailand, 2010a) Later, in the year 1978 there was one more college; Northeastern College of Public Health, Khonkaen province, and since 1984 there had been 5 colleges in Phitsanulok, Yala,

Trang, Ubonratchathani, and Suphanburi provinces. All colleges together had opened for receiving about 300 students per year. (Dental Auxiliary Association in Thailand, 2010b)

Although, in the beginning of students production or even in these days, these personnel might have been called “dental nurse”, at the present according to the agreement of the (dental auxiliary) association, they rather preferred to call themselves as dental auxiliary. So in this study, they were called the dental auxiliaries too.

For the roles and responsibilities of the dental auxiliary in the beginning, they were assigned to take care of oral health of pre-schools students and the primary students aged not over 14 years old, within the dental clinics of Department of Health, Ministry of Public Health. Their scope of works as follows; (Dental Auxiliary Association in Thailand, 2010a and 2010b)

1. To examine and keep recording of the abnormal oral status
2. To clean the teeth
3. To do permanent and temporary teeth filling
4. To extract the permanent and deciduous teeth by using local anesthetics
5. To apply fluoride for prevention
6. To consider taking children with occlusion problems or other impairments which besides their duties to get treatment from the dentists
7. To provide oral health education

When completed the training, the dental auxiliaries would be appointed in the position of “Dental Health Officer Level 2” (Dental Auxiliary Association in Thailand, 2010a and b).The dental auxiliaries in the beginning era were often assigned to work at The first class health station or at the provincial health office. Then, since the operation of the Decade of Health Station Development Project in 1993, there was the assignment for the dental auxiliary to work at the big health station to provide service to people too. So the dental auxiliaries had been distributed and provided services to more people both in the community hospitals and in the health stations.

However, although there was a limitation for service providing for children aged not over 14, in practice the dental auxiliaries had to work over their scope of works all the time. Since there were the patients needed the dental treatment,

while the numbers of the government dentists, especially, in the rural provinces were insufficient. Therefore, the dental auxiliaries had to take the duty on the basic oral health service providing to all groups of people. Until 1996, there was the regulation of Ministry of Public Health to extend the working scope of dental auxiliary wider including the prevention, emergency treatment, oral treatment and gingivitis treatment by scaling. Moreover, this extension of work was also covering all ages target groups. The dental auxiliaries were then become legally working under this regulation. At the same time, the guideline of dental auxiliary work had been changed to more treatment service. (Sunee Wongkongkathap (2006), Pisak Ongsirimongkol and et al. (2008) and Dental Auxiliary Association in Thailand, (2010b))

Comparing with the working scopes between the dental auxiliary group and the dentist group, it would be found that there were the overlapped fundamental working capacities e.g. examination, diagnosis, tooth extraction, filling, scaling, and the service on oral health promotion and prevention to the population. Certainly that the dentists had the same capacity of works but in more difficulty and complicated works since they were bachelor degree graduated and spent 6 years of studying in the university, While the dental auxiliary spent only 2 academic years in Sirindhorn College of Public Health and received the dental auxiliary Certificate or Diploma in Dental Health.

“Dental auxiliary” was considered the second class of the dental personnel who were produced to assist and help the dentist works since there were insufficient distributions of the dentists to take care of oral health of people over the country. So they have not been treated as important as the dentists. However, since there was a good plan to produce the dental auxiliaries as they were scholarship students from the rural provinces when they graduated and worked in their own provinces, the transferring requested from these dental auxiliaries were very few. Most of them would work in their provinces for a long time while the dentists often transferred to other places and often changed the work places (Waraporn Jirapongsa and et al., 2004) Majority of dentists choose to work in the capital city like Bangkok and other big provinces. Thus, the numbers of dentists in other provinces, especially in north east becomes seriously insufficient. Although, since the year 1989 the new graduated

dentists had to be firstly positioned in the rural provinces in order to repay their scholarships. However, from the information there were only half of the dentists distributed in the rural provinces, and another half were still together in Bangkok. (Komes Witchawut, 2008) Therefore, the dental auxiliary group was the only group of dental personnel who attached to the local areas and had been acquainted with local people and knew several information of the community.

For the studied province, there are 27 dental auxiliaries who are classified into 3 groups by areas and kinds of responsible tasks as follows; (1) a group 3 dental auxiliaries who are working in the provincial health office, (2) a group of 13 dental auxiliaries who are working in the hospitals both the general hospital and community hospitals, and (3) group of 11 dental auxiliaries who are working in the sub-district health promotion hospitals and the municipality health station. The first group of dental auxiliary has main duty in control, follow up and direct the oral health works of dental personnel both in hospitals and sub-district hospitals within the province. This studied province, the provincial health office has rather focused on oral health promotion and prevention more than other provinces. The dental auxiliaries in group 2 and group 3 have duty to provide services to all groups of people in both treatment and oral health promotion and prevention works, but the amount of works in each area were different.

Although then dental auxiliaries in group 2 and group 3 would have similar duty but the difference is the structure of their work places. That meant, all sub-district hospital has only one dental auxiliary working while in each general or community hospital has many dental personnel working in division or work group which there are included dentists and dental assistants working in the section. To implement work, the dental auxiliary in sub-district hospitals has been working alone without the dental assistant while providing services to the people, and there is no one to help thinking or decisions making. On the other hand, they have more freedom in works as no ones to control or direct them closely. In addition, every dental auxiliary in sub-district hospitals has to spend their time to take responsible for other tasks which are not oral health since there are very few personnel in each sub-district hospital such as documents receiving –sending, overseeing the stock of materials and

equipments, planning and evaluating, health insurances, patients visiting at homes, and including the general treatment such as preparing medicines as prescribing, wound dressing, and children vaccinating, etc.

Considering the promoted opportunity and security in the career path of dental auxiliaries, it was found that this career has less opportunity to be promoted since the education background is the only 2 years Diploma (in Dental Health). So the chances to change positions or salary promoted seem to be lesser than other careers with 4 years bachelor degree background. When compared to other types of health personnel who had the same education background, the dental auxiliary almost had never been promoted or supported for better positions or higher salary though they would further their studies until bachelor degree or even master degree.

Here, I would like to explain the two important characters of dental auxiliary which are the promotion's opportunity in the career path and the security in the career.

4.2.1 "Other positions have been gone so far, but our bosses rarely push us up"

In the past, when completed the dental nurse training curriculum, the new graduated dental auxiliaries would become the civil servants in the position of "Dental Health Officer level 2" in the organizations under Ministry of Public Health or other governmental organizations only such as Bangkok Metropolitan, Provincial Administration Organization, or municipality. Since they have not got the dental license so they have to work under the supervision and control of the officers who have the license of dental professionals (means a dentist) in the health institutes which belonging to the government only.

Dental auxiliary will work and be promoted step by step until complete level 6 which is the last level means "dead end". Since the new graduated dental auxiliaries could work and produce academic written works for promotion within 9 years or a bit more they would reach level 6. When their salary base has been increased until hitting the ceiling of the highest level, their salary could not be increased anymore. Many of them had to find the other ways such as further studying

to complete bachelor degree or higher, in case that they could use their new educational background to adjust their positions or increasing their salary rates. However, until present the dental auxiliaries with the bachelor degree still could not use their additional education and their increased capability to adjust their positions and increasing their salary according to the regulation of the Office of Civil Service Commission (OCSC).

Although later there was a change in OCSC regulation concerning the salary level adjustment in October, 2009 by changing the “common level system” to “broadbanding system”. The government civil servants have been divided into 4 career bands which are management, administration, academic and general band in order to separate the types of salary accounts from each others. The salary rates were considered according to the knowledge and ability of civil servants in each type (band). With this new system, it was believed that there would be more flexibility in adjustment of the salary in accordance with the work market and management of work results so that the governmental system would be efficient and attractive as well as it could keep the high quality civil servants in the system and they would not resign. (Preecha Watcharapai, n.d.) However, this concept has increased benefit to the group of high knowledge and ability civil servants whom are needed by the private sector only, but has not been benefit to the low level groups. Thus, the broadbanding system has not made any differences from the former system.

Base on the broadbanding system, the dental auxiliary have been categorized into the “general” band as to work in this position not necessary to graduate the bachelor degree. While the positions which have been adjusted to “academic” band need person with academic background in several kinds of degree according to the OCSC specified for each position (The Office of Civil Service Commission, n.d.a) However, the same problems had been still existed though the dental auxiliaries had furthered their study in bachelor degree. They could not change their band except they changed their works or quit the job.

In the general band, although there are divided into 4 levels; operational level, experienced level, senior level, and special skilled level, the dental auxiliary position was still limited to the operational and experienced level. There has been an

attempt to request for “senior” level but it was still not happened because of limitation in the position criteria by OCSC. (The Office of Civil Service Commission, n.d.b) At present, the experienced level dental auxiliary has the highest salary ceiling of 35,220 Baht but the salary base is lower than those in the academic group (bachelor degree holding group) so that when there was salary adjustment, the dental auxiliary still has smaller ratio. This has become a reason that some dental auxiliaries who furthered their study in bachelor degree decided to change work types / lines such as they took the exam to be public health technical officer, public health administrator, or policy and plan analyst. The worst case was they quit from the health organizations to outside organizations.

I had a chance to meet “Pii Sao” who had changed from a dental auxiliary in a community hospital in the province to be a general administration officer in Sub-district Administration Organization (SAO) in 2010. She had furthered study until she completed a master degree, then she transferred to be a head of the secretariat office as well as having a duty as a community health officer. She talked about the major reason to change the job because of the opportunity for advancement in career

“Since my former job at the hospital was dead end, no more chances to progress although I graduated master degree, my salary was not increased either. My position was not changed which meant the chance for dental auxiliary to reach common level 7 was very difficult and almost none. ... Being dental auxiliary, it was very hard to adjust from experienced level across to the academic block but at the SAO it could be done as the salary was not came from Comptroller General’s Department”.

When mentioned about reward for working and bonus, she said that this year the SAO gave her bonus about 40,000 Baht. Therefore, concerning the rewards, it was another reason that she felt glad to change the job.

“At the hospital, the salary would be increased according to the level of promotion. I always promoted a half or one level only when compared to my own salary rate which was very low, I would get very small increased salary. But at the SAO my salary would be more increased according to the band’s salary rate”

Compared the dental auxiliary with the other career which is quite similar such as the technical nurse who graduated two year program from Boromarajonani College of Nursing, it was found that although the latter group had the same education background of 2 years college, but they had more opportunity of advancement in their career than the dental auxiliaries. Since the technical nurses have been supported to take the continuation program of another 2 years to complete bachelor degree in order to receive a Bachelor of Nursing Science, then they could change the position as well as the band for more advancement in their career path. They could have higher salary base and be able to take the test to get the license of nursing practicing. Once they have the license they could choose to work with the government sector or the provide sector in health organizations. Whereas the dental auxiliary have not been given the significance from the government, a key informant who worked as a dental auxiliary in a sub-district health promotion hospital told me that;

“Compared with Tiew (her friend who is a nurse), she was very lucky as when she was appointed to work at a sub-district health station not so long, there was a project to encourage further studying so she took a long leave for study. She hadn’t worked but still got salary and after studying she would be promoted. Then, there was another project that the health station must have a license nurse, so Tiew was assigned to be a licensed nurse even before her senior (the technical nurses who worked before Tiew). For another while she was sent to attend the training of practical medicine for 3 or 4 months, everything for free, and she got the accommodation repayment as well as her salary during the training. After the training, she had got extra wages. Can you see? From the same

beginning of 2 years study, Tiew could go farther than others. Even we all got salary increase of 3% but the amount of money was far different since we are in the different band now. From the similar past as a technical nurse to present, we become so obviously differences.”

This is not different from the unreleased feelings of “Som” the first dental auxiliary of this province who could have a chance to further her study in Bachelor of Public Health Program (Dental Health) which transferred 2 years. She was in the first generation of the program which was opened at the end of November, 2009. Som graduated in October, 2011 she expected that she would be adjusted the position to be “Public Health Technical Officer (Dental Health)” which was in the Academic band as discussion in the academic field before she made a decision to further the study. Although, she already graduated a bachelor degree in other field, she decided to continue the 2 years study in order to get the bachelor degree that was “direct field to the career” as much as possible. However, after she graduated and worked in the same position for one year, there was still the same, nothing was change, she still took the same roles and duties although the Minister of the Ministry of Public Health at that time used to agree with the development of the dental health officers to be able to have the position of public health technical officer (dental health) by using the same official position number since August, 2010 (Dental Auxiliary Association in Thailand, 2010c). The dental auxiliaries had never been supported seriously from the government sector. Som mentioned that

“Right now, only I could pass a test to be a public health technical officer (general) I would be willing to accept it. I won’t wait for the public health technical officer (dental health) position as it is not clear yet. At present, my position was already dead end, there was no any progress”.

After that, in August, 2013 Som requested to change her position to be a public health technical officer (general) instead.

The movement of dental auxiliaries to request for the justice and advancement in their career has the important leader Khun Ratchanee Limsawat, a former dental auxiliary who used to work in Bureau of Dental Health, Ministry of Public Health. At present, she resigned from the government work in order to lead the movement and operate the issues concerning the advancement in career path in 2 aspects, which are (1) operation in identifying the position of “dental health technical officer” and (2) allowing the dental auxiliaries who are in the general band could be able to adjust to “senior level”. However, at present there has not been changed much about these issues. I often heard Khun Ratchanee complained in the group of dental auxiliary that *“Other positions have been gone so far, but our bosses (means dentists) rarely push us up”*

Moreover, based on the following up the facebook of “Thailand’s dental auxiliaries” which is the channel to communicate and gathering together clearly among the dental auxiliaries nationwide, they could talk, exchange, communicate as well as report the situations and progress in work of Khun Ratchanee Limsawat’s group. In the facebook page, I observed that there are messages posted to request for fairness, there are from times to times the messages showed their self-sympathy on unfortunate being in this career. Especially, when they heard that other careers/positions in the same health works field had been promoted or level up their significance, but their own career, which already had attempts to make a movement to require those things, has never been response or receiving any attentions from the higher authority levels. However, there are also messages posted to encourage each other too.

For example, during the protest of registered nurses in front the government house in 2012 in order to request for being appointed the registered nurses who were in the casual worker to be the government officers or civil servants. At that time, the dental auxiliaries who graduated after 2002 were also become the casual staff, they posted the messages showing their sad and hurt feelings and they become bored that they had never got attention from the higher level as those registered nurses.

“Today I went to the meeting and felt irksome and weak as I heard the inside news that since the protest, there would be 2 new professional positions to be appointed as civil servants. One was the nurse (who works in the sub-district health promotion hospitals) and the 4 years studied of Thai Traditional Medical Program. I felt down inside my mind, and thought the if the dental auxiliary in such sub-district hospitals were not important like this, when there were dental problem patients, just let them got on the massage beds instead.” (Ying Daw Dek Dent (alias), 2012)

Besides the feeling that their career was not progressed as others when compared with the same level positions, in the year 2008, OCSC (The Office of Civil Service Commission, n.d.c) also had issued the regulation concerning the criteria in categorize the position types and position level 2008. This regulation affected that the civil servants in the group of specific technical work group, the implementer in dental health work including dental auxiliary and dental assistant were all in the same position of “dental health officer”. This also affected that “dental assistant” who graduated the certificate program of dental assistant was adjusted to be a civil servant in the position of “dental health officer”, which was in the same position the dental auxiliary. This event made the dental auxiliary group in the area even felt worse as not only they felt of unfair allocated when compared to other career, but also they felt of down grading to people in the position that had less responsibility than themselves.

The information from the studied area, it was found that some of dental assistants agreed to take leave for further their study as the dental auxiliary students in order to be appointed in the position of “dental health officer”. But once they completed their study, and found that the other dental assistants who did not further their study were also be appointed in the same position as they were. Whereas the work operations of both careers were absolutely different as the dental auxiliary must be a service provider as same as a dentist, but the dental assistant only prepared equipments and provided assisting to dentists next to the dental chairs.

“If I knew that after the study I would get the results same as others who did not, I would not do that. Since when we could do more work, we would be more tried but we got the same paid” (Kwang, a dental auxiliary in Ingfa Hospital)

That was the reflection of “Kwang” the only dental auxiliary in Ingfa Hospital who decided to take a leave for further her study in hope that she would come back with the better position. Such a feeling was not different from the feeling of the other dental auxiliaries as they felt that the dental auxiliary and the dental assistant had different duty and different responsibility, so they should not be adjusted into the same position and being promoted by the same salary level.

4.2.2 “We have always been being kicked away from one place to another”

From the information of Thailand’s dental auxiliary association (2010c) indentified that the graduated dental auxiliaries since 2002 would not be appointed as civil servants as before since there were no more positions available. So they had to work in the position of “casual worker” belonging to that health service providing institutions. Based on the information in this area, it was found that there were 5 dental auxiliaries out of 27 had been appointed as casual worker, but only 3 of them just have been appointed as civil servants in 2011. It was because there were dental auxiliaries and dental assistants (which were in the same position of “dental health officer”) resigned from the government system, so there were available positions to replace those who resigned. In 2012, there were 2 dental auxiliaries who had not still appointed as civil servants, they had to be casual worker for another while without knowing their future.

Since the dental auxiliary career in Thailand is not allowed to have the license to medical practice, so they could not bring their knowledge to work independently. They have to work under the supervision of the dentists who have such a license, and they have to work in the government health institutions only. Once at

present, the available positions of civil servants seem to be insufficient for being appointed as the dental health officers. So they have to accept the position of casual staff which is not secured and certain in life as they have no rights in social welfares or other benefits to support them as their senior dental auxiliaries who were already civil servants.

“Kat” the newly graduated from Sirindhorn College of Public Health, she is the latest dental auxiliary in this province. In 2011, she started working in Kokwha sub-district health promotion hospital, but while she had worked only one year and a few months, the hospital had not received dental tools and equipments. Then, there was a senior dental auxiliary who was a civil servant transferred to work in this hospital instead, so she was discontinued getting hired as a temporary. She had to move to other places since every hospital needs the civil servants to work rather than the casual staff. As the salary of the civil servants would be allocated from the central government whereas the salary of the casual has to be deducted from the supporting budget to that particular organization.

At first, the provincial office had the agreement that Muang Hospital would hire Kat to work there, but finally there was a summary that she had to move to Bangmai sub-district health promotion hospital as Bangmai sub-district had a plan to support a dental auxiliary student to study according to the urgently producing of dental auxiliary project and SAO has agreed to support the budget for procurement of materials and equipments for dental services for the hospital. While waiting for that student to complete her study and back to work in the hospital, Kat was sent to work there although at that time, there were no dental chair, equipments and other dental tools for works at all.

To move the work place at this time was not as Kat desired, but she had no right to choose. Even though “Pii Tar” who was her senior working in Bangmai sub-district health promotion hospital felt sympathetic on her situation. As the situation like this, it made her felt like “being let go alone on the ship and drifted away” and Kat was “being kicked away from one place to another” according to the order of higher authority. Pii Tar also mentioned about the following problem that when that student

graduated around May in 2014, Kat might be transferred to another places. Kat has reflected to me that

“at first I left sorry and pity, but later when it happened all the time, I get used to it. If the student graduated and came here, I might have to be moved again. Even my mother said that why I have to flow away from place to place it seems like a spirit without a house to live” (Kat, the casual dental auxiliary in Kokwha sub-district health promotion hospital)

Compared with the similar situation happened in 2000 when there was adjusted the civil servants numbers, at that time the government had policy not to appointed the scholarship students in many branches such as physician, dentist, pharmacist, and nurse to be civil servants in the Ministry of Public Health. All positions had been changed status from civil servant to “government officer” instead. That event was a co-factor affecting the increased numbers of resignation from the organization such as the dentists’ resigned numbers from 71 to 62, 111, 178, 187 and 142 in the year 1999 to 2004 respectively. (When compared to the average numbers of allocated positions about 300 people per year) While the medical doctors’ resignation rate from the Ministry of Public Health from 2.07 percent to 2.74, 6.39, 8.53 and 4.97 percent in the year 2000 to 2004 respectively. This was observed that both medical doctor and dentist had the highest in the year 2003 (The Office of Research and Development of Health Personnel, 2011) which was the first year of “government officer” had repaid their scholarship for 3 years. This event might be part of stimulation to the government to back to appointed medical doctors, dentists and pharmacists as civil servants as before in 2004, by they had no need to protest. Moreover, in the fiscal year of 2009 there was increased wages through Compensation expenses allowances to a few careers in health personnel which the government realized as the important positions such as medical doctor, dentist, pharmacist, registered nurse, Medical Technologist and clinical psychologist. This extra payment in hope that it would attract these personnel to work in the government system while

the other health personnel including dental auxiliary who supported and assisted works of dentists had not been supported at all.

The event occurred to the health personnel as mentioned above, it has shown that the government gave significance to specific positions and some professional careers only through providing rights social welfare and various benefits. Since the government realized that these components would help attracting the important personnel and keep them in the government system, including appointing to being civil servants for specific positions, changing of common level system to the boardbanding system, providing extra allowances to specific groups only. All these measures have created differences and separated between the careers more and more.

Such a situation, it made dental auxiliaries became another health personnel group who had no secure and certain in their career as it seemed like they were limited in all aspects. Ranging from not being appointed as a civil servant but to be “casual staff” instead, including there was no license to support the career’s working. Therefore, if they chose to continue being dental auxiliary, they had to accept the position of “casual worker” of the health organization. They could not resign to work in the private health organizations like the medical doctors, dentists, or even the nurses. So they were forced to be in the situation of temporary staff only and had to encounter with the risks of being unemployed from the employer’s decision at any time as they were in annual contract to be renew year by year. Whenever that the health organization had a better choice such as there was a civil servant transferred to, the casual dental auxiliary would be a choice to be cut in order to save their budget. If any dental auxiliaries decided to quit from the government system works, they had to change their career or jobs completely.

4.3 Practice of dental personnel in the context of policy and relationships among the inter-professional groups

As above mentioned, the oral health promotion and prevention in the primary students group in this province are mostly the duties of dental auxiliary group. In this part, I would like to mention about the roles, status, life, experience and the

works of dental auxiliaries in the context of policy and relations among the careers in order to show the status and the marginality of dental auxiliaries in the level that affected to lives and works of oral health promotion and prevention.

4.3.1 Dental auxiliary works: as it was seen and as it was being

As mentioned in the previous parts that the curriculum of dentistry and dental auxiliary had 4 years different time of study. They were trained in the different curriculum so they received knowledge, skills, and ability in diagnosis and service providing in the different level. However, to mention about the ability in work and providing in the basic practice which was needed by general patients such as diagnosis, oral health education for several ages group, and providing services e.g. filling, tooth extraction, and scaling, the both careers might be able to provide such services responding to the needs of people in the similar level.

Although, the people who received the service might not know the differences between these two groups of personnel as they called both service providers with a common word as “a doctor” means who could release their oral suffering and uncomfortable. However, in the Hierarchy working system, there are government system rules and regulations to control and oversee life and status in work. So the health personnel like the dental auxiliaries are fallen into the inferior level and having unfortunate future. All these things have affected to the duty, work, life, and daily experiences of the dental auxiliaries as follows; (A) tough work, hard work, but less paid, (B) lack of several resources and supports which encouraging to work, (C) having no rights to share opinions or make decision only act as implementers working according to the order and policy, (D) being deprived and discriminated until they felt like being the other, and (E) have to responsible for other works which are not the oral health works.

A. Tough work, tired work, but less paid

Compared the works between dentists and dental auxiliaries, their works are quite similar in many parts but the dentists have the positions with higher responsibilities such as the position of head of work group or dental health division

which have to responsible to diagnosis and treatment for the complex and complicate diseases than the dental auxiliaries do. Meanwhile, the dental auxiliaries often do the basic examination and oral health promotion and prevention, which the government sector considered that this is suitable to their knowledge and ability according to the original purpose of dental auxiliary production of serving the primary students group aged not over 14 years old. The dental auxiliary's works focused on the "active role" but their scope of works in each organization is not clearly identified, they have to do every work depends on the assignment of their supervisors.

To consider the work with primary students, most works happen during the first semester starts that the dental auxiliaries would visit the schools and do the students' oral examination. Moreover, they have to provide services according to the national and provincial policy in that particular year whether it would be in which direction. Some years' policy, for example, the extraction of the inflammation teeth had been focused in order to reduce disease and suffering, while some years the policy focused on sealant of the first and the second permanent molar in order to prevent decayed teeth. At present, during the Dental Fund has emphasized on the comprehensive care service according to the Dental Fund's policy. This is considered the "active works" and belonging to the dental auxiliaries. Almost every hospital assigned dental auxiliaries to do the full mouth examination in the schools. There was only Ingfa Hospital assigned both dentists and dental auxiliaries to visit schools to do this work together as there was only one dental auxiliary in this hospital. In each time of school visit, the dental auxiliaries have to prepare all equipments for the work.

Compared with the other public health works, such as the diagnosis of the medical doctors or nurses, it was found that the oral health works needed to prepare many tools and equipments in providing services whereas medical doctors and nurses used the stethoscope as the only tool in examining, diagnosis, and prescribing the medicine. While the oral health works are often involving with manual works using set by set of equipments separately as the works might need sterilization to prevent infection too. So the oral health works need numbers of equipments and materials as many as the numbers of the patients who received the service. Moreover, most of the dental instruments and equipments are made of metal which are rather heavy. Besides,

there are also mobile dental unit, mobile dental cabinets, and handpiece which the dental auxiliaries have to carry and move by themselves.

Each time of service providing outside on the mobile unit is considered tough work, if they could choose nobody wants to do these. Some service providing outside the studied area where I used to see that there were some extra allowances for the dental personnel who volunteered to go and provide mobile services since there were many service receivers under the hot weather and they had to prepare all equipments, transfer and install the equipment themselves. I used to join the mobile service providing to the community with “Rose” and “Prief” who were the dental auxiliaries in Muang Hospital. Fortunately, Muang Hospital’s mobile unit was rather big as besides the two dental auxiliaries there was a male worker so there were three persons as main staff in each mobile service plus one dentist and two dental assistants took turn to join the services. I found that in the first semester, there were mobile services providing almost every week. The whole team had to help each other carrying the equipment, some heavy ones had to be carried by 4 people and the dental auxiliaries were main staff who carried them. Whereas one of the original qualifications of the dental auxiliary students must be female, though there were male dental auxiliary students in 1998, but almost of dental auxiliaries were still women. So some hard labour works seemed to be too hard for them.

This was coherent with the information that I found in the facebook page, there were some posted messages concerning the mobile service providing to the students in the area that

“Dental auxiliaries or the labour, I wonder? Mobile unit, dental chair, air pumper machine, lamp bags, tool box, etc. Everything is not just one piece and we had to carry forth and back. Moreover, we had to do sealant for children, almost forty to fifty students per day. I was going to be crazy” (Ung-ing, a mad person, outcast dental auxiliary (Alias)), 2012)

Later, there were some other dental auxiliaries posted messages to respond the post such as *“Life of minor wife’s child as they compared seems to be true with ours ...”*, *“Oh..very hard work, where is it?”*, and *“Born to be Thai dental auxiliaries ... all the hard work wherever you are, fight and fight.”*

Moreover, the oral health service providing works are mostly operative work which time consuming in providing the services to the patients, they are not only diagnosis and prescribe the medicine for the patient and let them go home. Each kind of dental works need complicated skill, and using many types of equipments such as sealant service took 15 minutes per one tooth (quoted in Penkhae Lapying, et al., 2009) and the works were even more difficult when children did not get used to dental service at all.

The picture of a little child in Primary 1 was opening his mouth, straightening his body and closing his eyes tightly happened to me when I walked to Odd in the dental room as our appointment. Odd was doing sealant for children according to the Dental Fund, when I stepped to look closer I saw his small mouth was full of saliva suction and two cotton rolls which the child tried to push out by his tongue. Odd told me that the children had too much saliva, if we did not put the cotton roll to protect the sealant it would not be success. Some children when we put the saliva suction they would vomit, or if they were too scared they would close their mouth and cry. At the time, I heard Odd was encouraging the child all the time *“Open your mouth wider”*. In the period of 3 hours there were 8-10 students receiving services, it was rather stressful atmosphere as the service provider had to be quick and need high cooperation from children. The reason was most of the Primary 1 children who received the service in the sub-district health promotion hospitals were never been done their dental treatment before, they might only be used fluoride vanish by applying fluoride on their teeth but never been got into the dental room before.

In the situation like this, the service providing for the target group students inside and outside the clinics was not easy to control but the outside mobile service providing was more difficult because the equipments and tools were not ready as inside clinic services. I used to have experience joining the mobile units with the team

of Muang Hospital and I found that the children cried all around since before they got into the dental room. The new graduated dentist even refused by saying to the dental auxiliaries that came together in the mobile unit that *“I don’t want this crying child”* and gave away that child case to the dental auxiliaries to take care.

In the present context that there is the Dental Fund, the service providing for the 1st primary students is the major policy to be implemented. Since the National Health Security Office (NHSO) has set up the key performance indicators by focusing on the 1st primary students to be examine and receive comprehensive care. As it had been seen, the most of works are fallen into dental auxiliaries from oral examination, making appointment to receive the further treatment, contacting the schools, and organizing the mobile services. Moreover, if any hospitals had to conduct the mobile unit, the dental auxiliaries had to work even harder.

To consider that the oral health promotion and prevention is the work of dental auxiliaries because it use less skill. The belief that it does not need complicate knowledge, especially the work with children aged not over 14 years old and it used to be duty of dental auxiliaries. This might be partly true but not all. In the past the oral health promotion and prevention often focused on oral health education, teaching to brush, or prevention of decayed tooth with fluoride mouth rinse, as these works were non-complex works and they were using the fix or unchanged knowledge only. However, in the present, these works’ patterns have been changed from focusing on the service providing at the community level to the individual level more and more. To control and manage the children behaviors are needed to be learnt, and the service providers must use more skills as well as be patience in working. Even the dentists who claimed that they have more knowledge as they spent more time studying, but they could not manage this work well. The words claimed that *“the oral health promotion is the work of dental auxiliary”* seem not to be right, because it has been known that the oral health promotion and prevention is very tough and tired works. The works must exert and need inner strength to do the work. While the dental auxiliaries have to take responsible this work but their wage becomes so much different from the dentists including their less opportunity, advancement and security in career.

B. Lack of several resources and supports which encouraging to work

Since the purpose of dental auxiliary production in Thailand was to assist and help lightening the workloads of the dentists, the dental auxiliaries thus were classified as the second class to the dentists and not often got supports enough necessary materials, equipments and tools for the service providing even though these things were necessary for the primarily services. This might be the reason that the dental equipments were high prices, so the allocation of the equipments was often to the dentist first and then other personnel in the hospitals. In case that the equipments for the dental auxiliary work, it was often in the last priority and delayed. Sometimes they were insufficient and did not respond to the needs, especially for the dental auxiliaries who were working in the sub-district health promotion hospitals.

I had met with Pii Jan who was just transferred from the provincial health office to Kokwha sub-district health promotion hospital in September, 2012 and it has just started dental services for approximately one year. Pii Jan told me that she made a request for the necessary materials and equipment for dental auxiliary's work to the CUP, Muang Hospital, since at present this sub-district hospital has only extraction and scaling works only. There is no equipment for filling service at all, except the old Amalgamator, so this hospital could not provide filling service although the dental auxiliaries have ability to serve people. After that the dentists of the Muang Hospital informed her that what she had requested spent to high budget and asked her to reduce numbers of things to be procured.

"I made the request for everything e.g. composite, GI, Amalgam (all materials for filling, the researcher) light curing machine, and many other materials. When my requests had been considered in the meeting, they said that what I requested in total about one hundred seventy thousand, could I reduce it? For the light curing machine, they suggested me to fix the old one and use it. For the set of filling materials, they gave me only 2 sets. One doctor asked me is it possible to use alcohol to clean the filling equipments as they don't

too much dirty and no blood stain. So I said no, I could not." (Pii Jan, the dental auxiliary in Kokwha sub-district health promotion hospital)

While "Kat" transferred from Kokwha sub-district health promotion hospital to be the first dental auxiliary in the position of "casual staff" in Bangmai sub-district health promotion hospital. In this hospital, they had never operated the dental works before, so Kat had nothing much to do except helping other works which were not concerning with oral health works such as document sending, or transferring the medicine form the CUP hospital. Until the time past for five months, she was then suggested to be trained working in Muang Hospital while waiting for equipments since this sub-district hospital did not have dental unit, tools and other materials for service.

For the case of Kat, she has to encounter with the problem of lack of equipments and tools for work again and again, including her former hospital which was Kokwha sub-district health promotion hospital and her new hospital. Since in the former hospital there was not enough equipment at the first time she was worked there, she had to borrow the equipments from other sub-district hospital. The borrowed equipments were often old such as the dental unit and sometimes they were almost out of date. While the dental equipment have many complicated technology, the new worker and had no experience as Kat often faced with the problems such as no water flow out, obstructed salivary suction, broken electric wire or wind tube. Some problems could be corrected but some needed the mechanic from the company to repair, while some could not be fixed at all but had to be changed. When Kat moved to work at the new hospital, there were no equipments for dental health service once again. The new graduated dental auxiliary like her, who were ready and eager to work, felt discourage and bored,

"It should have equipments ready, not just that I had to make a request for everything. When there were not equipments for new graduated, at first it was comfortable but for a long time it was boring. ... Scaler, forceps, and dental unit of the hospital that gave

were quite old, when I used it with patient and found out that no water or obstructed suction, then I could not do anything. When I was studying every equipments and dental units were new, I was so frustrated. But in this new hospital, I would get the new I felt happy as they no need to repair.” (Kat, the dental auxiliary in Bangmai sub-district health promotion hospital)

Not only the sub-district health promotion hospitals where just started the new dental health services would lack of materials and equipments but also the ones that provided this service for long time, their equipment and material were still insufficient for fully fundamental service of dental auxiliaries. That was because of the supervisors did not realized the significant of oral health service such the case of Odd who worked in Fajaem sub-district health promotion hospital for more than 17 years, she shared her experience that she just got the approval to buy light curing machine after she worked for 6 years so she just was be able to provide composite filling and light cured sealant.

At present, the budget allocation according to the universal health care coverage policy made the CUP hospital had the duty to support the services of sub-district hospitals (as primary care unit: PCU). So the CUP has to support necessary materials and equipments for dental work, but in the real practice, it was found that the sub-district hospitals' dental auxiliaries rarely got enough supports. When they made a request to the CUP hospitals, they might not receive any response as they often claimed that they did not see “the requests”. So the dental auxiliaries have to make frequently following up and asking for the progress of each request. “Ping” was one of them, she told me that when she worked in Banndan sub-district health promotion hospital in Ingfa district, at that time her hospital just started the oral health service providing, and the evaluators from the provincial health office came to visit and suggested that she should solve the problem of insufficient equipments. So she made a request for equipment purchasing to Ingfa Hospital, but she had never been responded.

“I had made a request to borrow and prepared purchasing issue to submit to Ingfa Hospital, but the dentists did not approve and said that they did not see my original request. If we sent the request and did not follow, it would be lost, so we have to follow up regularly. This morning, there were five patients which all need upper teeth extraction, but there were only three sets of equipments for upper teeth and three sets for lower teeth, so I had to use what I had.”
(Ping)

Same as “Pii Jaem”, who was working in Thabo sub-district health promotion hospital in the network of Muang Hospital, shared her similar experience that

“The dentists often said that if I wanted anything I should make a request, but when I did I had got nothing. They often said that my request letter was lost” (Pii Jaem)

Besides, having not received the necessary materials and equipment support for services providing, to implement the work it often lacks of assistants who were trained to be “the dental assistant” to help during operating to increase work efficiency. And the similar events happened in the sub-district health promotion hospital as there was only one dental auxiliary as the only dental personnel in the organization while in every hospital has permanent dental assistants. So I had seen the dental auxiliaries in sub-district hospital had to do every work by themselves from preparing necessary equipments need to be used in the service, putting the saliva suction, treating by light cured machine, and finally cleaning up all equipments without any assistants working beside them.

The similar event might happen with the dental auxiliaries who work in the hospitals, although there are numbers of dental assistants working, but the numbers are still not enough for the numbers of operators. So the dental auxiliaries must often work all alone anyway. Even the time of going out with mobile units to complete the key

performance indicators, since the dental assistants are insufficient they often are assigned to assist the dentists in the clinics. Thus the dental auxiliaries would be sent out with the mobile unit have to do all works by themselves.

Being considered by the government sector that the dental auxiliaries are group of dental personnel who least important or having limited capacity that affected to the insufficient allocation of resources for serving people. Such a thinking method, it was contradiction to the objectives of the government itself in distribution of dental auxiliaries to work in the sub-district health promotion hospitals by claimed that it would be covering and fair in service providing. There was an attempt to distribute the dental auxiliaries to the sub-district level, but there were not supporting resources for the services. It would not possible to be fully benefits to the people.

In the works of oral health promotion and prevention in primary students group, besides the dental auxiliaries in the hospitals and sub-district hospitals are the main responsible person, the health personnel in other position are appointed to do the works in case that sub-district hospital has no dental auxiliary. It depends on each sub-district hospital to appoint whom to be responsible person for the works such as a nurse, public health officer, or public health technical officer, etc. All these appointed staff would help the works of oral health promotion and prevention in every target group.

Based on the field data, it was found that the responsible person for oral health works need to have ability to conduct the full mouth examination and give knowledge on basic oral health education. Moreover, they have to be able to assess the patients to further suitable treatment either in the sub-district hospitals or the hospitals where there are dental personnel. For the work with primary students group, they were assigned to collect all 001 and 002 reports that the teachers had checked the students' oral health status in each school in order to further report to the district health office (where in this office, there would be assigned staff to take responsible on oral health works as well). In some cases that the health teachers could not do the students' full mouth examination, these assigned staff have to do the works instead. Moreover, they have to follow up and stimulate the activities such tooth brushing after lunch. Some hospitals also assigned them to apply erythrocin and record plaque index for giving

oral health education, as well as they might be assigned to do other works by the provincial health office, the district health office or CUP hospitals.

In Ingfa District, I had some chances to talk with Pii Somjit, Pii Da, Pii Napa, Pii Jom and Ruj and I have found that many staff who took responsible on the dental health had no actual knowledge and clearly understand about their work, especially, the works that need specific knowledge such as identifying the deciduous and permanent teeth, applying fluoride vanish, etc. It was because they were assigned to do the oral health work which needs specific knowledge but they did not have been clarified or trained to have necessity skills and ability to do the works. When there were the assignments from the provincial health office, the district health office or CUP hospital to do the works out off their knowledge and ability, they had to ask from friends who were dental personnel that what and how they had to do. Mostly the people they asked for information and suggestion were dental auxiliaries rather than the dentists.

“I can check the decayed tooth, identify which are deciduous and which are permanent teeth, but sometime I have to guess because I have never been trained before. For primary 1st -6th students, normally their teachers would check their oral health, but in my working area the teachers told me that they need to be trained as they were trained for 5-6 years ago and there were no more trainings” (Pii Napa)

“They (the responsible dental auxiliary in the provincial health office) gave the order message through Pii Somjit to inform but there would be no teaching or training how to apply fluoride vanish, so I have to ask from Pii Odd by myself” (Ruj)

All these reflections from the personnel who were assigned to take responsibility on the oral health works, which shown that there was only assignment but other supports concerning the actual and suitable knowledge were still insufficient.

So it could be presumed that the work results might not be effectively. Moreover, being “order” through the assignments step by step, while there were no trainings or continuous trainings to the operators in the working structure. So “the oral health promotion and prevention work in the sub-district hospitals (where there is not a dental auxiliary working there)” is often the work that thrown from one to another, and the finally receiver of the work was often unable to deny it.

Besides, lacking of knowledge and skills in works the dental health work responsible personnel were still lacking of material supports to work too. From a conversation with Pii Da, the public health technical officer, who took responsible on the dental health for every age group in the sub-district health promotion hospital including the three schools of primary students in her responsible areas; two were government schools and one is the private school. However, the teachers in private school were often changed, and the new teacher had no knowledge on full mouth examination since they had never been trained. Therefore, Pii Da decided to do the full mouth examination herself. Moreover, Pii Da was assigned to do the plaque record and evaluate the tooth brushing after lunch activity once a month. But the problem was that there were no supported materials which were necessary from the provincial health offices. Since the assignment was not related to her duty directly, and no necessary materials or equipments, so her work became “do only as it could do”

“The dentists only gave orders, but they never supported the equipments or materials. When I informed them that there was not enough erythrocin, they said “could you buy food coloring agents to mix with water? Because it was not too expensive” or they (the dental provincial health officer) called me and said “hello, Is the Jombang? (name of the sub-district hospital), there were no reports from October to December, can you backward the reports? So I think Ummm..October there was a flood on my home (most area of the district was flooded) and no fluoride vanish for me, I just got it in February (next year) so how can I report that. But okay, I will make fake numbers reports if you’d like. For fluoride, I would get when

*they distributed everywhere only, but I sent the reports all the time.
If you asked that whether the provincial health officer knew or not
that I have made the numbers, they knew it as they ordered me to
make the backward reports, right?*

Lacking of the necessary knowledge and the materials supported to the works of dental auxiliaries and the responsible staffs on the dental works was not only forced the people in the remote areas to the district hospital to get less service when compared to other people in the central district. It was also reflected that the official data that focused on the indicators only was inaccurate and far away from the truth too.

C. Having no rights to share opinions or making decision only act as implementers working according to the order and policy

Working under the government system in general is often being controlled and instructed following the hierarchy ranking from the head level to the implementer level. It is in the same atmosphere of the working in this province that the head of dental health work group in the provincial level will be controlling, managing, coordinating and following up the progress of every government health service institutes in all level from sub-district health promotion hospitals, district health office, community hospital and provincial hospitals, so the same key performance indicators have been set for all.

After having received the policy and assignment from the central office, “dentist Proud” the head of dental health work group in the provincial health office would call for a meeting in order to clarify all received works and projects to inform and assign these works to dental personnel in this province. From the observation in the provincial meetings, it was found that the meetings would be organized in several levels and types e.g. (1) the meeting for the dentists who were the heads of section or the representatives of the hospitals (2) the meeting for both dentist and dental auxiliaries together and (3) the meeting for dentists, dental auxiliaries and the

responsible staff for dental work in district level and sub-district hospitals all together. Each meeting had different purposes.

The first type or level of meeting would happen regularly almost every month in order to inform the target of policy and the mobilization in the dental health society both in the regional and national levels. Sometimes the purpose of the meeting was to consult or plan the work plan together among the dentists in the province. The second type of meetings which there were dental auxiliaries participated in the meeting too were often organized after the planning meeting the first type already. The second type meetings aimed to clarify and inform the work plan that what to do and how to do within which time frame. Sometimes the meetings might be held to follow up and evaluate the works progress to see the overview of the province. Both types of the meetings were obviously different, as the first type the meeting's participants were dentists who have right and power to propose and express their opinions in work equally while the second type meeting had dental auxiliaries participated in the meeting to instruct and assign the dental personnel to work according to the work plan. According to dentist Proud said that "*The meeting with dentist, we would inform about the work target, but the dental auxiliaries would be implementers.*"

The third type of the meeting where there were many dental health works relevant personnel participated in this meeting including the dental work responsible staff in the district health office level and in the sub-district health promotion hospitals. This type of meeting had not been held regularly, as I could witness this meeting organized during the end of the year or the beginning of the fiscal year for one or two meetings. That period of time was that the provincial health office had to summarize the annual work results or to inform the work policy for the coming fiscal year to the dental personnel and other responsible personnel to be acknowledged over all. However, during the mid of fiscal year, there were no such a meeting organized, the responsible personnel in the district level might be invited to the second type meeting instead for sometimes. While many responsible personnel in the sub-district hospitals where there were no dental auxiliaries had never been invited to join the meetings.

Since the meetings to clarify the information and listen to the opinions of the relevant personnel in this province were in these forms, so the dental auxiliaries and the dental work responsible staff had not many chances to express their opinions. Therefore, they had often become listeners and actor according to the instruction at the end. Some districts, the dentists, heads of work group, might bring the issues to discuss at the district level which meant that those districts had been working in more participatory manner than other districts. However, in general the dental auxiliaries often had no participation at all, their voices often not loud and no power enough to make any decisions. A friend of mine, Odd, told me about 1- 2 years ago that there used to be the meetings for the dental auxiliaries only in the provincial health office but later the meeting had been canceled since the dental auxiliaries who were the representatives of heads of dental health sections in the hospitals could not make any decisions such as they could not decide that their district would take responsible in which works, how many works, etc. So the meeting with only dental auxiliaries was cancelled finally.

For the atmosphere in the meetings, I had chances to join a meeting to clarify, follow up, and monitor in the provincial and regional levels many times. In each meeting I observed that the dentist representatives often sat inside ring near dentist Proud who was the chairperson of the meeting, while the dental auxiliaries would sit outside ring. Although they were the dentists and dental auxiliaries from the same hospital, or same district, they did not sit together as a group. But they chose to sit separately in 2 levels or rings as mentioned. During the meeting, when there were a request for opinions, mostly the dentists did express their opinions whereas the dental auxiliaries spoke very few or almost not having any chance to speak. The stimulation to get the opinions from the dental auxiliaries was also very few. Sometimes there were some dental auxiliaries tried to speak out their opinions but they would often be stopped by dissuading them to present their opinions. So the dental auxiliaries felt like they did not have any participation in the meetings.

“To join the meeting in the provincial health office, I felt like we had no roles. It seemed like the dentists were talking among

themselves. They just only wanted us to acknowledge since we were the implementers. Once we did we had to report the CUP. Actually, everyone (both dentists and dental auxiliaries) was assigned to work, but when they wanted to ask for opinions they rather asked from the dentists. Some works or projects they received were very difficult to do such as a project of implantation which needed 80 cases, but in the field it could not be done as the target. Still dentist said it must be possible to do (emphasized voice)” (Ping, while she was a dental auxiliary in the sub-district health promotion hospital)

The feeling of having no participation like this was still happened with the dental work responsible personnel in the sub-district hospitals, even worse when they did not study in the dental health field directly, the more they felt like they were excluded from the meetings. As Pii Da had told me her feelings in the meetings with the dental health work group that the atmosphere in the meeting did not give the significance to the meeting participants, though she used to express her opinion and suggest the obstacles in works, but there was not any responses or mutual solve the problems.

“When I went to the meeting in the provincial health office, I felt like I was the outsider who had nothing involved with the meeting. It seemed like I went to sit there and listen to they talked, or just only to get the document, the rest of the meeting they were talking to each other. I felt like I had useless mouth as an ass that could not speak. When I spoke they did not listen, they would have argument all the time. They always insisted that everything could do. Some projects or some works were not necessary to do such as plaque staining or tooth brushing, but they did not listen, so what? Then tomorrow we had to do it again for every student. The dentist told us to check every month on the 16th, but they never supported the materials.” (Pii

Da, the responsible staff in the sub-district health promotion hospital)

The meeting pattern that was giving significance to dentists and ignoring the opinions of dental auxiliaries including the dental health responsible personnel, it made them felt in the negative ways. They felt discouraged to express their opinions and feelings which had never been responded. So they learnt to sit silently and ignored the meeting process.

During the field data collecting, the oral health promotion and prevention had major changed since there was “a Dental Fund” which opened for all dental personnel to join thinking, planning, and decision making in oral health promotion to the people in their area for suitability to the problem conditions and context. The Dental Fund has supported the budget per person, so each district in this province has received the different budget range from 200,000-700,000 Baht including the allocated budget to the provincial health office too.

To operate the fund, there were many calls for meetings both national, regional and provincial levels since the beginning of the fiscal year in 2011 in order to clarify and identify the guideline as well as to create the understanding with the implementers. The NHSO had created the structure of work by appointed the committee to develop dental (oral) health system in the provincial level. This committee has the duty to take care and oversee the work plan at the district level and there is also the mechanism at each district called the District Health Coordinating Committee (DSCC). The committee members are dental personnel, local representatives, and people so that all sectors would have seen the budget and also they can plan the work plan together to achieve the purpose of people’s accessibility to the dental health better and equity. (Santi Siriwattanapaisal, interview)

In the implementing level, it should have been managing, planning, and decision making of the relevant personnel from all sectors. Actually, this has never happened. Started from the discussion in the provincial level in the short period the relevant personnel have no chance to prepare themselves to do the work plan. This happened near the beginning of the new fiscal year (15 August, 2012) when dentist

Proud called for the meeting in the provincial level to summary the operation the fiscal year of 2012, and prepare the strategy plan for the 2013 fiscal year. That meeting, dentist Proud invited the health committee in the district level, dentist representatives, and dental auxiliaries from the hospitals and the sub-district hospital as well as the dental work responsible personnel from the sub-district hospitals to the meeting. However, that meeting had not many participants since it was on the same day as the vaccinating day for children that the province had identified the day on every third Wednesday of the month, so some responsible personnel from the sub-district could not join the meeting. Moreover, that meeting was not informed in advanced, many had known about the meeting the day before the meeting. The provincial health officer, the meeting organizer, only made apologize and said that they could not find the other day for the meeting, so it had to be that day.

On that day, there were the operation summary reports from every district, each district informed that what projects and works had been done, for how many and what ratio calculated towards the indicators. After that dentist Proud requested the participants to form the groups to discuss and plan the work plan for the 2013 fiscal year. Odd told me that in CUP Ingfa Hospital, there were 8 vacancies of dental personnel to take care of the dental health works in total 17 sub-district hospital. All work plan were the old plan to do with the same target group as everyone knows that the decision making power was at the head of dental health work group in the hospital. Odd told me that *“it was just only thinking for no purpose, when CUP made the proposals it was depending on their selection”*

The character of works that seemed not to realize or emphasize on the voices of less authority personnel was always seen over and over again in this working system. Although in the first year of the Dental Fund operation (fiscal year 2011) the dental auxiliaries like Odd, Game, and Ping who working in the sub-district health promotion hospitals in Ingfa district, had been assigned from the district health office to join thinking and composing the proposals according to the budget from Dental Fund for the district. But it was only thinking and writing alone without the dentists or heads of the working group to plan or decide together. So after the proposals were sent to the heads and they had never told them about the progress, and finally when they

proposed in the provincial level, they were unsure that the dentists who are the heads of work group had compose the proposals as they proposed or not because they had never seen the details of the proposals at all *“We had prepared two or three proposals, I could not remember but I never seen that they were not used or merged with other proposals. I have no idea.”*

This was coherent with the story of Pii Jaem, who was working in Thabo sub-district health promotion hospital under the supervision of Muang Hospital, that in the first fiscal year 2011 of the Dental Fund she was called for the meeting in order to draw the work plan, but finally she had not known what the approved work plan looked like

“Last year, they called me for help writing work plan, and putting the detail of the project at what should we do towards each target group. So I used the information from my routine works to draft the plan and proposals, but I did not see what would be done for each group. ... They should have allowed the dental auxiliaries to know that too as we were the implementers. I used to ask for the file of the proposals from the dentists, but I still had not got it.” (Pii Jaem)

Pii Jaem told me that until now (19 July, 2012) she still had not known the details and progress that how much budget allocated to CUP and when was the budget arrived, *“It was strange, unlike Bannkai Hospital and Sriburi Hospital. ... I felt uncomfortable to work under a large CUP as they had not got used to the community works”*.

Ignorance of the significance of dental auxiliaries was not happened only in the step of writing or defining the details of the project proposals such as how much CUP had received the budget, how much budget set for each target group, and how were the activities and details for each target group only. But in the step of operation, they only receive the orders from the responsible dentists to assign them to do. Sometimes the orders had been done on the telephone in order to instruct the dental

auxiliaries what to do with no need to see each other faces, and the implementers did not know the purpose of the works or which project to be done. For the dental health responsible personnel, who were in the sub-district hospitals where there were no dental auxiliaries, were even worse because they were lacking of participatory in identifying scope of work, setting up purpose, and applying working method.

“In everyday working, they had never told us they only ordered. While what to do, how to do, and for what, we never known anything. Actually, it should be a meeting to talk about these, but there is no such a meeting. So we did not know. If you asked Pii Da whether she known about the Dental Fund, I was sure she would say no. The dentist should call staff to discuss in the meeting, everything would be better than this” (Odd, a dental auxiliary in Fajaem sub-district health promotion hospital)

Operation of the activities and projects of oral health works in this province, the dental personnel would have less participation in expressing their opinions and making decision. The dental auxiliaries and other responsible personnel became only the orders receivers and implementers according to the higher commanders. There assigned works were not served the needs of people in the area neither the needs of the implementers. Mentioning about the needs of dental auxiliaries who have to respond to the works, they rather preferred to initiate the project and manage the project's budget by themselves.

“This Dental Fund, if the budget was in our hands we would feel more positively. But in fact, we had never seen the money and when we worked, it had never been as we expected. We had to wait for the provincial health office and CUP to tell that what to do and then follow their needs. Even though they asked for our ideas to write the plan, but finally the project proposal composed by the hospital and

CUP controlled the money. But the only good thing was we had received the free gift sets, but it would be a lot better if we could use it fully. But Ingfa distric was not like that, here we had difficulty to deal with budget, we had to fight for it. It was really boring” (Odd, a dental auxiliary in Fajaem sub-district hospital)

The operation following the Dental Fund’s target should have been more effective and efficiency as well as more worth budget allocated to the health service institutes. If all relevant personnel to the dental health works from dentists, dental auxiliaries and other responsible personnel including all stakeholders had acknowledged and more participated in works by thinking and managing the projects, things would be better. However, what happened in this province was that even the dental auxiliaries, who were considered the closet person to the works, did not know what were going on. So it was useless to ask the responsible personnel as some of them not even know the Dental Fund. *“What was the Dental Fund, who did set it up, they did not know.”*

D. Being deprived and discriminated until they felt like being the other

Dentists and dental auxiliaries are all health personnel who need to work together in many aspects including treatment, planning, oral health promotion and prevention as well as other works as assignments from the first level commanders. Of course, to consider position, status, and education background, they are fairy differences so the dental auxiliaries would feel considerate, respect, and not dare to express opinions that contrasted to that of dentists. Although, they sometimes have more experiences working in the field than the dentists, they often feel uncomfortable to express their opinions or give suggestions about the works to the dentists. Until sometimes I felt that “the dentists were personnel who were un-touchable for the dental auxiliaries”, especially to express their wonders or unclear about the decision of the dentists which seems to be impossible, though sometimes they were in the right status to discuss about it, or to ask or even inspect it. For example, in operation of the

Dental Fund, many dental auxiliaries would like to know that how much their CUP had allocated the budget, what kinds of project activity they were going to do and how, but it seemed like nobody were courage enough to ask the head of the work group. As the result, every dental auxiliary had to undeniable accepted the orders of the dentists. Therefore, it is obviously that there is a big gap between the dentists and the dental auxiliary.

From working experiences of dental auxiliaries, they reflected that the dentists often work with their high “ego”, they rarely listen to others. Therefore, whatever the dental auxiliaries’ opinions are, they are often ignored and not get any attentions from the dentists. Sometimes, the dentists even said something discredited the dental auxiliaries among the meetings after they expressed their opinions such as “that was not a good idea at all” or in some cases were even worse when the dental auxiliaries’ words were interpreted wrongly from their attentions such as their intention to give suggestions but the dentists understood that they gave “order” to the dentists. Therefore, the dental auxiliaries are learnt and choose to stay quiet in order to prevent the conflicts feelings.

“If we look at the career, the dentists are acting more like a controller as they are in the supervisor level, so they have to use their power to control others and they become self-centered, not listen to others as they are the bosses. Their style would be dictatorship” (Odd, a dental auxiliary)

Such an idea might be happened as the general personnel in the public health work who had lower status when they had to contact with the physicians or dentists. When I had a chance to talk with Pii Noi who was the health personnel working in the district health office in a province in the western region. Pii Noi shared the unclear matter in her mind about the management of the Dental Fund too, her district had received 900,000 Baht budget when compared to the general health promotion and prevention (PP) budget of 1.2 million Baht. Although at that time she had wondered about the management and organization of dentists’ projects in CUP but

she could not ask or express her opinions much about the projects as she would like to know how much money was spent to do, what activity and what were the results whether it was worth the investment budget. She could not ask about these as she knew it was sensitive matter.

“Since there has been the Dental Fund, it was more like a secret village. What they were doing? Such as in the past when they conducted the oral health survey on children and elderly, we had never known the results but it was even worse when the Dental Fund came as it seemed like they were in the closed town with the resources available inside already (making her hand like a circle) where we could not see anything, or enter inside. We had not participated at all as when we asked them (the dentists in the hospital), they would said that it was the order from the central office so we could not get involved. It seemed like mystery. I had no idea what kinds of work they were doing in the dental works, we could not ask as it was sensitive. Sometimes when we asked, they would call to the provincial office said that I asked this and that. So it is quite sensitive, right? Later I choose not to get involve with this matter at all.” (Pii Noi, the health personnel working in the district health office in a province in the western region)

In the case of Pii Noi, the Dental Fund became the “secret money” that the other personnel could not get involved except the dentists and the authority staff who have power in allocating budget. This was in the same way as the opinions of the dental auxiliaries in this province as there was a hierarchy relations where the lower positions have to speak less in the sensitive matters though they had right to do so.

Moreover, in the routine working both dentists and other personnel in other work lines often act and speak in the way that emphasized the discrimination, detachment, and repletion of the lower status of dental auxiliaries, so they feel like they are deducted their dignity and rights. Although they have the feelings that their

work loads are not lesser than those of the dentists, the works are only the different. Their works are often given less significant. Things that made the dental auxiliaries felt of being discriminated and excluded were obviously seen from (a) the speaking words and acting and (b) being watched over and controlled by the strict rules. These mentioned characters might be presented clearly or sometimes not very clear and by unaware. However, the dental auxiliaries could feel and acknowledge that clearly.

a. The expression through speaking and acting of detachment and discriminated

The actual fact that the dentists had more knowledge than the dental auxiliaries, when they graduated and worked in the higher positions and have power as commanders, many dentists felt they were in different group to the dental auxiliaries. This attitude had affected to the action and behaviors through speaking, acting and other expressions which were created the feeling of being detached and discriminated to the dental auxiliaries.

“Kwang” a dental auxiliary in Ingfa Hospital talked about the new graduated dentists who just had came to work at this hospital for 2 years that *“They keep certain distances which far away from others as they are dentists... in the section they rarely speaks to others as they work separately”*. Therefore, when Kwang had a problem in work she would not dare to consult with them as they were quite unfriendly even with the dentist’s assistants who work with them. The dentist would not try to be close but would only speak about works.

“For example if the assistants picked up the phone while working, the dentist would blame them by saying that are you going to work or talking on phones?” (Kwang, a dental auxiliary in Ingfa Hospital)

Same as the case of “Rose”, a dental auxiliary in Muang Hospital had told me about her feelings toward the dentists who are her co-worker that she felt being detached and differentiated which was hard to explain as sometimes it

was not in the form of wording or acting of the dentists that presented to the dental auxiliary directly but by expressing by ironic speaking.

“(feeling) as sometimes....(quiet)....how could I say....I could not speak...I could feel it but what could I say...for some dentists only....(quiet)....for example when we were going out together in the mobile units some sub-district health officers would not take care us, they (dentists) would ask me that why there is nobody takes care us, by serving drinking water to her, while others would not get as well. Actually I would not feel anything, if she did not say that “she is a dentist”. Is it meant that they are different from us, right? But when they confronted with problem case, they would say “I would not do it”why?.. the moment ago she said she was a dentist, but when the children criedshe said she would not cure them. The dental auxiliaries should say that not the dentists.” (Rose, a dental auxiliary in Muang Hospital)

Whereas “Som” the dental auxiliary in Bannpoon Hospital, who is in the same age as Odd and me, has reflected the words that comparing behaviors of others (which were Pii Pui and Pii Duean who working as dental assistants) that acted towards her and me as the dentists that in the first time when the assistants met me, they thought that I was a dental auxiliary as Odd and Som but later when Pii Pui and Pii Duean knew that I was a dentist, their behaviors towards me had changed.

“Can you think about it, Odd? We had been working there for a year, we had never been served coffee while Tha (the researcher) went there only once, they served both coffee and water. Pii Pui serves coffee too but with

us they had never done that. At first time they did not know who Tha was, they thought Tha was our friend, Odd's friend. Later, they called me to ask that who Tha were. When they knew, the next time you came, they serve with coffee. To ask is it different, sometimes I could feel obviously” (Som, the dental auxiliary in Bannpoon Hospital)

Oad also added up that *“if you go there as our friends, it would not like this, but when you introduced yourself as a dentist, it turned out to be another way”*. In this case, the two friends of mine felt like they were detached and discriminated very much because we were compared by “the position” in works, while both dental assistants did not know me before.

Same as the case of Pii Pin and Pii Kan (the dental auxiliaries who are working in the provincial health office and taking care of the students and elderly target group, respectively). Although, both of them were older than many dentists but they used to be blamed by the dentists in front of the younger dental auxiliaries in the provincial meeting as well. Odd told me that

“Dentist Proud often blamed Pii Pin and Pii Kan in the meeting. I think if I were them I would feel dissatisfied and ashamed as when she blamed she used rather strong words. We had never seen her blamed the dentists as she felt more concern about the dentists than us” (Odd)

This opinion was similar to the story from Pii Kan who often told me with feeling of unfair that

“dentist Proud chose to give us a blame only, to dentist Por, dentist Pan, she had never blamed them as they were dentists together but for us we were only dental

auxiliaries. She used to blamed Pii Pin until she cried”

(Pii Kan)

b. Being watched over to be strict to the rules and regulations more than others

Although in the government system there are rules and regulations that used to control every civil servant in every position, all have to obey the rules as the same norm seriously. For example, the defining of period of working time from start to finish, the identification of duty and responsibility to respond to the needs of people. However, in the practice there are exceptional for the higher positions while the lower positions under the commander like dental auxiliaries have to obey the rules and regulations seriously and strictly.

Such the phenomenon was often seen that the dental auxiliaries were expected from the colleague both dentists and dental assistants that they should have been able to accept the people's need of more services. So the dental auxiliaries have to work early in the morning and must be a person who are “frontiers” to meet with the service receivers, especially the dental auxiliary groups who are working in the hospitals.

Pii Jan told me that before she transferred to work in this province where was her hometown she used to work in Muang Hospital in another province. At that time, she had to drive from her home every in the morning in order to be on time at 8.30 a.m. every day because if the official hour started but if nobody called the patients in, they would make a complain. *“We had to arrive the office before dentists and started serving the patients otherwise they would complain, so we had to start on time”* The dental auxiliaries had to be strictly on time, we had to start early although the dentists would come to work later. Although Pii Jan transferred to work here in this province, her works had been changed from service providing in the general hospital to the provincial office work, she felt uncomfortable with the rules and regulations that are very strict especially about the time from their heads which is different standard to the dentists group.

Not different from “Rose”, the dental auxiliary working in Muang Hospital, told me that the dental auxiliary had to stand by to provide services to the patients alone according to the orders of the head of work group. In the normal period, she would have the duty to work on the mobile service units for the patients in the sub-district health promotion hospital but some periods when many dentists took vocations, the dental auxiliaries had to stop mobile unit in order to stay in the hospital to provide services instead. For example, during the academic meeting of dental association, many dentists left for the meeting, so Rose had to turn to the service work again although her duty was to work in the mobile service units. *“Numbers of dentists were not enough, they took a leave, so we had to work replacing them. Also, this week the dentist asked if I could be their assistants. I must said yes.”* So, no matters what the works are, the dental auxiliaries have to be available to do according to their dentists’ orders.

It could not be denied that the thing happened to the dental auxiliaries had made them felt of the double standard treating. When the personnel in the same system though they had different works, duties, and responsibility, they should have not been treated with the different rules. However, it already happened to the dental auxiliaries and made them felt the different and being discriminated that led to the feeling of detachment and discrimination.

However, although the dental auxiliaries would be detached or discriminated until they felt different from the group. But the dental auxiliaries did not stay still and wait to be acted over only. They would show their defense, negotiate, or struggle to the power acted over them such as when they were assigned from the dentists to work on the things that were not their direct duty, they pretended to be silent in order to refuse to do or if they felt more pressure from some actions they could not response, they might showing defense through gossip behind the scene, etc.

E. Have to responsible for other works which are not the oral health works (especially the dental auxiliary in the sub-district health promotion hospital)

“There are so many works in Health Station, only the purchasing work that we have to make procurement process, including inspection, and registration of the materials, are taking so much time than our main works. Especially, this period the large amount of budget would be allocated, so we have to make many requested issues as part of procurement. Then, there are the works of health insurance, the village insecticide works. So the dental works could only be done in the morning. Sometimes if there were no staff, I had to help in prescribing works too.” (Game, the dental auxiliary in Sanamchai sub-district health promotion hospital)

This was the responsible works of “Game”, a dental auxiliary who was working in Sanamchai sub-district health promotion hospital on the day that I had followed Odd to the Ingfa district health office which there was the inspection process of computers for two big sub-district hospitals. These equipments had been procured under the budget of the Strong Thailand Project, so on that day there were so many health personnel there including the computer company staff. Ruj and another person whom I did not know had also helped the district health office in the inspection process. Game was the representative of Sanachai sub-district health promotion hospital and Oad with her friend were from Fajaem sub-district health promotion hospital that they came for receiving the computers too.

While I was accompanying Odd closely, I have seen her way of works in details. Odd would provide the oral health service for the patients in the morning session every day. She would accept 10 patients per a day, but for the student group services which would receive only 8 students per a day according to the appointment made with the school. Since service providing for the students was more variety such as sealant, filling, tooth extraction, and scaling while the general patients only need

tooth extraction service which spent less time. In the afternoon session, I often saw Odd working on the other kinds of work e.g. planning, the health insurance work, compiling a report on numbers of all patients of the hospital, cleaning and maintaining the dental equipments, and going out to submit the report to the district health office and contact other issues. She even drove her own car to get the medicine from the CUP hospital in order to use in the sub-district hospital. However, I had found that there were several dental auxiliaries who used to work in the sub-district hospitals often did not like to take responsibility on the other works so they always made the request to be transferred to work in the community hospitals instead.

In the sub-district hospitals there would be less health personnel than the community hospital while the responsible numbers of work groups were not different. Therefore, one personnel must take responsibility on many and vary works. Each dental health officer (dental auxiliary) had to take responsible for the dental health work as the main task, and had to do all kinds of work as assignment from the directors such as diagnosis and treatment of general patients, supply, financing, health insurance works as well as the village visiting works. I have seen that some dental auxiliaries have to do other works more than doing the dental works. One reason perhaps that there were insufficient dental materials and equipments in the sub-district hospitals, some pieces of equipments were out off services and having no budget to fix them. Another reason might be that at some sub-district hospitals there were very few patients to get the services, so they had to help on the other works in the hospital instead. Comparing to the dental auxiliaries in the community or general hospitals, it was obviously seen that the dental auxiliaries working in the sub-district hospitals had more variety and numbers of works rather than dental health works only.

Other jobs are also considered important not less than the dental health works since to consider the relations among the personnel in the workplace which are not many, helping each other works are necessary. Moreover, considering the advancement in the career path through the performance they have to arrange their time for other works in their organization too as their bosses have authority to propose or consider the rewards for their performance. The persons who have this authority are all the other health personnel not the dental health officer, so they often do not

understand the nature of the dental health, neither realizes its importance. Therefore, in the state that the dental health is not so prominent or being interested by the bosses, the dental auxiliaries have to implement other tasks in order to be realized of their being and their responsibility has not been less than others. To implement other works in order to be “caught in sight by the boss” becomes an important issue for the dental auxiliaries in the sub-district health promotion hospitals to be promoted. For them, the career advancement was depended “the bosses”, who have full authority in giving orders, controlling, and providing the rewards, are the hospital director and the head of the district health officer, respectively.

Odd told me that once in the birthday anniversary of the head of district health officer, while he was talking in front of the party in the way that

“In my eyes, I could see that who works and who doesn’t. For example, in the case Odd though her boss told me this and that all the time, but I did not believe as I could see by eyes that Odd is one of the hard working personnel”. (Odd referred to the words of the head of district health officer)

That was the reason that Odd claimed that she could not do only dental work *“we have to do many things, many kinds of works, so they will see that we really do the works”*

With the characters and structure of the work like this, it even increased the limitations of the oral health promotion and prevention works. Since in the past there were the definitions of responsibility for dental auxiliaries mainly in the oral health promotion and prevention, but when the dental auxiliaries in the sub-district hospitals have to responsible in the other works as well besides their main responsibility, and the other works are even considered more important for their career and advancement rather than their main works. This fact is the significant issue made the dental health promotion and prevention works had been less interested.

4.3.2 Effective performance of the dental auxiliaries that was missing

In this part, I would describe the limitations of the works in these circumstances without blaming that the dental auxiliaries have less capacity in this work. Although the performance of oral health promotion and prevention with the primary students during the past 50 years had been low as the oral health problems had never been reduced. Moreover, the budget had been spent highly. The limitation of the works with the primary students group would be got rid of or be lessen if we could understand, and turn to work together more. And if we were not leaving the responsibility to the dental auxiliaries alone or letting it be as what happened to the dental auxiliaries at the present, all limitations would be reduced. The things that happened to the career of dental auxiliary (as explained in Item 4.3.1 A-E above) had affected them in the three important characters as follows; (A) Having no authority/power in administration and management (B) Working with non fully functional and (C) Lacking of encouragement in works. As the following details:

A. Having no authority in administration and management

As mentioned above, the dental auxiliaries have to work under the control of the dentists and they also lack of the opportunity to join in the thinking and decision making process of all activities they have to do. Besides, they have no opportunity for their career advancement. All these made them perceived the less authority of themselves, especially, when they made contacts with several organizations for organizing the oral health promotion and prevention activity in schools. They had to make a request for cooperation from the schools including to get permission for students' full mouth examination and to cooperate with the teachers to take the students to hospital for treatment. Sometimes, in this province, they had to organize the extra activities as the orders from the bosses.

Since the way of work was mainly in the "command" to work so there often were the extra works that dentist Proud received from the central office and order the personnel in the area to do. The received works were always "urgent" things to do in the schools, so it turned to be the dental auxiliaries had to go out to the field and contact the schools. Many of them felt that such works had increased the

workloads for the teachers as the teachers had to co-working in order to achieve the target of the provincial health office.

Odd told me that “the Project of less sweet” was operated in 2011, the provincial office had ordered the responsible hospital in the area to contact two schools to join the project. For the responsible area of the CUP hospital, the dentists assigned dental auxiliaries to cooperate the schools but for the sub-district hospitals, it would be the duty of dental auxiliaries directly. So Odd had to contact the schools to find the 2 schools to join the project with no matters they would be willing to or not, as it was the undeniable order from the head so she had to get them. Odd felt that these kinds of work if the provincial health office or the dentists direct contacted the schools, it would be better and more suitable.

“I worked alone, so contacting the schools was my duty too. They just only thought and forced us to do. Just like the project of less sweet last year, they ordered that we had to find two schools, and how could I force the school to join the project, right? If I informed the schools and they agreed with it, it was good. But sometimes the schools claimed that they had already been busy and there were many works they have to do. Then what? Could we force them to do our works? Also, many projects of dentist Proud were too much requests, once the schools accepted to do, then they had to think what activities they would do, they had to create the information board, to do the presentation, and so on. So I wondered which schools would do that if they had many works to do. By the way, of the provincial health office contacted the provincial education office in that level first, then the education office made order to the schools and I did only cooperate with those schools, it would be easier, right? But at the CUP hospital, like Pii Ploy (a dental auxiliary) and dentist View to talk with the teachers in schools, you think which one would be more listened to?” (Odd, the dental auxiliary in Fajeam sub-district hospital)

Same as the other works in general, the dental health division has to ask for cooperation or nearly force the schools to participate in the activities which the dental auxiliaries felt that “all works would be a lot easier than the existence if the person who made a contact with schools were the dentists”. Since all the dental auxiliaries knew that they had less power such as the case of “Pii Jib”, a dental auxiliary who works in the municipality health station that

“the dental auxiliaries work on health promotion and prevention was good but the dentists were better as the people tend to listen to the dentists more. So it would be better if they should contact the schools, they could get more cooperation than the dental auxiliaries could” and “If the dentists lead, the dental auxiliaries assist, the cooperation would be than this, the listeners would intend to listen as the dentists had more power”. (Pii Jib, the dental auxiliary in municipality health station)

As in Pii Jib’s opinion, the people do not realize the significance of the oral health care as the other diseases are more important since the dental disease did not cause the death. If they did not brush their teeth and then became dental caries, they could be cured. Therefore, to talk about the issue that people have not realized its significance by the less power people (whose voice unheard), the issue even become less important to not important at all.

Not different from the feeling of “Pii Kan” who took responsible on the elderly target group which last year there was the cooperation with private sector in producing complete denture for the old people. She told me that she was not the main person who took responsibility on this project but only the coordinator to make contacts with the private sectors in the province to join the project

“when I contacted them, I could not do much. They only knew me because I have been working here for long time. But if the dentists

contacted them, it would be better as the dentist had more power in making decisions and others. We were only the dental auxiliaries who studied only 2 years, even we could graduate the master degree, and we were still unequal with the dentists” (Pii Kan, a dental auxiliary in provincial health office)

And when there was an evaluation from the central office, she could not do much as she was only the coordinator not the person who was responsible for the project. During the past 2 years, there was much budget allocated (almost two million Baht) but Pii Kan complained that she felt stress and sometimes she even wanted to resign, *They should protect us in work, not just thrown the hot potatoes and push us to front line like this”*

While “Kwang” who was the only one dental auxiliary in Ingfa general hospital had to confront with the difficulty in making a contact with the administration section of the hospital in order to get materials for activities operation the project of "Less Sweets in Secondary School" which was the project that the provincial health office organized within the Dental Fund. When the provincial health office transferred the budget to CUP hospital where she worked, the head of the section assigned her to cooperate with the administration section in order to get an approval for activity operation. Kwang and Odd mentioned that her hospital had the expense over the revenue, so the coordination would be uneasy. It was even worse when the dentists assigned her (who has less power) to coordinate this work because the administration section staff asked that “why your heads did not come to talk by themselves” and when was the provincial meeting, Odd informed this problem to the provincial level, perhaps they had some solutions as the hospitals with the same financial problems as when the budget came in as “revenue budget”, it was hard to get this budget to use. Odd had informed about this issue to “dentist Bow” (the head of work group) as the reason that it might be more reliable if the dentist informed the meeting by herself. But dentist Bow just said nothing much except that “*at first, there was a problem but later it could be solved*”. This made Odd felt angry with the dentist as she had never helped clarifying the problem which might happen again in the future.

The feeling of “no authority” in work of the dental auxiliaries was not able to say that it came from one factor or another definitely but such the feeling happened from the structure of governmental system of hierarchy. Being frozen in the general band system so the dental auxiliaries had very few opportunities to be grown up and promoted in their career, and they were treated as being the other in system. Moreover, the hierarchy system provided them very few chances to perceive and participate in thinking and decision making process such as the Dental Fund which had a lot of budget but the group of the dental auxiliaries in this province had a few roles only, they rarely knew what happening in the fund, etc. They became only the implementers who acting as the orders. Also the individual perception and experiences they had to face, including their lower education background, not getting interested or being responded, having no right or voice, all these situations made them felt and fallen into the no power state, they also lost confident and encouragement to go on working.

B. Working with non fully functional

As mentioned before that the dental auxiliaries had to work under the circumstances of lacking of the tools, equipments, materials, and assistants as in one side they were considered as if they had limited capacity, so they were limited the support resources. As the result, their works were not fully efficient such as providing the dental service without the equipment set for filling so they could not provide this service to the people although they had ability to do so. For another example, the dental auxiliaries had to provide the dental service without any dental assistant; they had to do everything alone. Therefore, their service became inconvenient and time consuming, especially to provide sealant for the 1st primary students which was the target indicator of the province because the small children gave less cooperation so the service providers had to prevent the moisture in the children’s mouth very well. The sealant service for children was very difficult task and many times they were found that the sealant substances were not fixed well to the teeth and often failed especially on the the buccal surface. Both Som and Odd complained that this was a difficult work though Som worked in the hospital where there was an dental assistant. However, the

assistants rather helped the dentists than the dental auxiliaries. Often Som had to work alone just like Odd

“to work with (the children), it was hard to prevent their saliva, no matter we did the sealant materials always went off. And about 80-90 percent of the buccal surface was easily fallen off. Dentist Proud used to ask me and I had to tell her frankly that it was fallen off.”

(Odd)

Therefore, no matter how much effort in terms of labour force and budget to be put in the work, the results were still not fully efficiency.

Moreover, the coordination and command line between the CUP hospital and the sub-district hospital were not in the same command line directly but the budget allocated from NHSO to the main network CUP hospital. The CUP hospital has the duty to take care of people in its responsible area including the people in the responsible area of sub-district hospital, so they have to support each other work in terms of academic and operation support. However, the CUP hospital has no authority to order the personnel in sub-district hospital directly as these personnel are under commands of the district health office and the provincial health office. Therefore, Physicians or dentists would be able to request for cooperation from nurses and dental auxiliaries in sub-district hospital whenever their policies were going together in the same way. However, in the contexts of the district health office has not given significance to the dental health works, so the dental auxiliaries in the sub-district hospital have to cooperate in other kinds of work and reduce their role in oral health works too. Thus, although with the order or request for cooperation in dental health works from the main hospital, the dental auxiliaries might not respond fully to those works.

Dentist Krish, the head of dental work group in Muang Hospital, had reflected the working system in this issue that the dental auxiliaries in the sub-district hospitals were not under command of the CUP hospital directly had created the problems in management because the hospital could not order them to work as the hospital needed which was not coherent with the working system.

“In term of management, it would be the problem. Although the dental auxiliaries in the sub-district hospital are under the CUP Muang Hospital, they receive the salary from the provincial health office. So we would order them to do anything but if they did not do it, we have no right to control them. Are you understand this?... They depended on the provincial health office, but we have to supervise their works, we ordered them to do. When they need the work performance results they relied on us but when they were considered the rewards, it was not up to us. So it was not good in the command line, we could not order them to do anything, just only ask for cooperation or assistances to do the work. And if there was a budget support to the activity, they would be okay, but sometimes if not, they will be told us they could not do, or they had no time. So for the management, it should be going together.”.... “but for the dental auxiliaries who are working with us in the CUP hospital like Rose and Prieu, it would be easy, when we have time we just talk. Every day we talk about the problems, the policy and so on. Once they got the order, they draft the plan. But the dental auxiliaries in sub-district hospital we could not force them to do anything if they did not want to do. Naïve stubborn, they said yes..but they did not do.”
(dentist Krit)

Therefore, both lacking of several resources and the command system that was not coherent with the duty of the dental auxiliaries were another reason that made the dental auxiliaries did not work fully effective as their own capacity.

C. Lacking of encouragement in works

Last but not least, as this issue was considered important to the implementation of dental auxiliary. Since the dental auxiliary career was considered not having much support neither advancement in the career path and in particular, the

recent graduated dental auxiliaries were appointed as the casual worker only. This was emphasizing the insecurity in this career. Base on the information of Ratchanee Limsawat (n.d.) who was the resigned dental auxiliary from the government system in order to mobilize the advancement for dental auxiliary, it found that in 2011 all over the country there were less than ten thousand dental auxiliaries and 917 of them admitted to change their work line and 59 decided to resign. From this provincial data, there was 1 dental auxiliary changed their work to public health technical officer, and another one resigned to work in the sub-district administrative organization as the case of Pii Sao.

The work with less opportunity to get advancement in the career, and it also seemed less significant for the supervisors. Because the dental work in sub-district hospital was unknown to the people. The dental auxiliary were also discriminated as the other. So it was no wonder that all these reason made the dental auxiliaries felt lost confident and encouragement to work. They tend to do their duty with no purpose, they did what they could but they did not try harder for anything. Whatever works that needed labor force and ideas, they felt bored with them because they saw no point to do it. As whatever they did, they would not get promotion or praised, the work performance were not belonging to them so it just wasted their time. That was the reason why they turned to the other works that would make the bosses realized their significance as it was creating and promoting their capital for themselves.

One dental auxiliary told me that when she was newly graduated, she worked very hard and contributed to work a lot. One year she was sent to the competition of oral health works and became the winner of the regional level championship. There was a letter circulated around the district health office to let everyone know about her work. That year she expected to she would be considered to be salary promoted since it was hard to get such a promotion in the sub-district hospital as there were many personnel and the one who get promoted must have prominent works in that particular year. As the result, in the first round her name was in the list of “prominent” work results, but finally there was no her name in the final list of the person who get salary promotions. But instead there was a name of the wife

of a staff who worked in the district health office who had not prominent work results. In that year, she was very upset and sad. About 2-3 years later, her name was in the list of “prominent” group again though she had not done anything significantly. This was confirmed her thought that *“if things turned out like this, it was better to keep regular daily works, no need to be exhausted working hard as it did not matter anyway.”*

Such the way of thinking might happen with many dental auxiliaries because the work that did not even created their proud as it was pressed and almost had no value to the society. So the dental auxiliaries learnt to keep only their routine works. They work less, and lost creativity in their works as the message in the facebook page of Thailand’s dental auxiliary association that

“working in the position of casual staff like me, the salary was a few thousand, OT allowances and other allowances I never had. The professional license I had nothing, so please do not expect works or anything from me. I was resignation ... I could do only what I got paid by you” (Momotaro Kung (Alias), 2012)

If the dental auxiliaries in the field have such idea, it was rather pity for their working capacity. Therefore, instead of being focused on producing numbers of dental auxiliaries only, why not we turn to pay attention and find solution to adjust the rules and regulations as well as deconstruct the old structure which was the obstructing or preventing the capacity building for dental auxiliaries? so that the old dental auxiliaries could still be in the system while the new ones became happy to continue working.

CHAPTER V

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Base on the academic sources, the oral health promotion and disease prevention is considered worth investing work since it is a guideline to help controlling and reducing risks of oral diseases. It is also increasing quality of life of a person. To consider deeply, the oral health promotion work also helps enhancing individual's capacity in controlling every factor that might affect their own health (Jenkins, et al.(2005), Zarkowski (2006), WHO (n.d.b), Penkhae Lapying, (2006), Penkhae Lapying and et al. (2007))

However, the study results in Chapter 4 shown that the oral health promotion and prevention became less important works in the health field. Considered from the period before the Dental Fund, it was found that these activities had not been supported in terms of the operational budget as the health promotion and prevention implementers had to defense their budget against the other sections in a hospital. However, the dental health working group rarely received the budget, or received only few budgets. Moreover, the dental personnel hardly preferred these kinds of work. Although at the provincial health office, the dental work group was strong and led by dentist Proud, the major leader in this province.

5.1 Summary

The following parts, I would like to summarize the study results through the explanation of various issues found in the studied area according to the order of 3 research questions as follow;

1. How was the way of thinking, meaning, and valuing to oral health promotion and prevention of the dental personnel?
2. What were problems and obstacles of oral health promotion and prevention works?

3. What were the pattern of work on oral health promotion and prevention of the dental personnel?

5.1.1 The way of thinking, meaning, and valuing to oral health promotion and prevention of the dental personnel

Almost of the dental personnel in this province have defined the meanings and value of the oral health promotion and disease prevention in the negative way, as follows;

5.1.1.1 oral health promotion and prevention was the work that used less knowledge and less potential to do, so the implementers could not show their abilities as they did not need to use any skills or expertise in work compared to other oral treatment. From the literature reviews, whenever mentioned about the roles of oral health promotion and prevention works, either in strategy planning, in the manpower situation reviewing for allocating personnel, or in the opinions of the dentists who are responsible for planning and managing the oral health promotion and prevention works, the roles of these works mostly were assigned to the dental auxiliaries. For the reason, they claimed about “the Myth” which believed that the knowledge, skills, and expertise of dentists were higher and they should be fit into more difficulty and complicated works. Thus, the dentists should responsible for the specialist works. Such an idea happened to the dentists both community hospitals and general hospitals in the study area, it has reflected the professional paradigm and Bio-medical concept that focused mainly on the disease-oriented.

While the target of dental auxiliary production in the beginning period was aimed to assist the service providing for primary students aged not over 14 years old. However all dental auxiliaries knew that all these works belong to them, they did not have any different views from the dentists. Many dental auxiliaries looked at the oral health promotion and prevention as the works which did not allow them to show their potentials as much as the oral diagnosis and treatment works that responded to the needs of people. They also preferred doing the treatment works.

5.1.1.2 Oral health promotion and prevention have not created any value since all dental personnel perceived that people still highly needed treatment service as the saying that

“(dental auxiliaries) graduated and worked at health station, if we could not provide treatment at all, how the villagers would think about us? They came to us because they wanted us to extraction their teeth rather than teaching them how to brush their teeth”.

So the personnel who worked on oral health promotion and prevention, in particular, the oral health education seemed to be invisible in the eye of the people. It was even worse if the position of dental auxiliary emphasized on the oral health promotion and prevention, it would even reduced their “identity” as “a doctor” in people’s eyes. This would reduce status and value of themselves even more when compared with “public health officer (หมออนามัย, literal meaning)” who can curing the people and were in the same situation and context. So it was not difficult to make the dental auxiliaries felt inferior even more if they could not show their ability in providing treatment. As Ellemers, et al. (2002) stated that the surrounding context had affected to social identity that they looked at themselves and others looked at them as who they were, and how were their abilities, how they were different than others when compared with their group and between groups.

Such an idea of dental auxiliaries in the study area was similar to the opinion of the dental auxiliary in Trang province that “the treatment works of dental auxiliaries convince the people to trust and believe in their potentials”. As they viewed that the trust and faith in treatment would be the opening tool to attract people to join the oral health promotion activities easily (Nimmanorradee Nancha, 2005)

5.1.1.3 Oral health promotion and prevention are the less paid work when compared to the oral health treatments, such a meaning occurred in specific group of dentists who had a professional license that allows them to work outside the official hours or leave the government works to work for private sector. So they choose to continue their study in specialty to increase their knowledge and skills in treatment works. In particular, those dentists who have more capacity would choose to study in the branches that were popular such as orthodontics and other esthetic branches e.g. prosthetic and operative dentistry (as dentist Kay mentioned) in order to prepare themselves to work in private sector. Therefore, it was found that the dentists

who work for government sectors after they graduated their higher degrees and came to work only for a while before they left to work with private sector. The specialty ability in treatment became the ability in increasing more incomes from work for dentists. This was coherent with the words of dentist Krit, the head of dental working group, Muang hospital. Besides, there was no any dentists at all in the study area stated that the oral health promotion and prevention could help increasing their income.

From the meanings and value of oral health promotion and prevention in the above 3 meanings shown that both dentists and dental auxiliaries did not like and not realize the significance of these works. All groups of dental personnel preferred the passive work of waiting for patients to provide treatment for them. This was coherent with the report of Sunee Wongkongkathep (2006) that the service in health care units in all level, firstly was tooth extraction, secondly was filling, scaling and treatment by prescription, whereas the oral health promotion and prevention in the area seemed to be the next priority, and it had to be done in order to respond to the indicators from the central only. So they have to do these works according to the target so it was considered mission success.

5.1.2 The problems and obstacles of oral health promotion and prevention works

Since duty and responsibility in oral health promotion and prevention was assigned to the dental auxiliaries as the information on field found that they have less authority in work, they were left out in the health system. This can be seen from the non advancement in career path of the dental auxiliary. Although they had furthered their study and increased their knowledge in work they could not promote their positions. Even worse for the new graduated dental auxiliaries, they had insecurity in their career as the government positions had been reduced for government system reform. They had forced to be casual staff in the government system, which might be changed and transferred at anytime. They also could not work for the private sectors or others besides being the government temporary employed staff since they did not have a professional license. This reflected that the government system had not given enough significance to the dental auxiliaries as much as the dentists.

Moreover, the characters and duty of the dental auxiliaries were lacking of promotion and support in several aspects which affected the dental auxiliaries' works as follows (1) more hard work, more exhausted but less paid since their education background was only the diploma in public health (dental health) so the dental auxiliary was classified in the "general" band which less paid than "academic" band which must hold bachelor degree (2) lacking of resources and supports in terms of materials, tools, equipments, and assistants to support their work effectively (3) having no rights to share their opinions and decision making in their works. They could only be implementers who follow the orders and policy. When analyzed the level of participation in works of dental auxiliaries in this province by using a ladder of citizen participation of Arnstein (1969), it was found that the dental auxiliaries had participated in thinking process, designing, and joining in the degrees of tokenism in the step of informing or the highest level was consultation only. Since their voice might be heard from some powerful people but they still did not get attentions enough. The dentists, the leaders of working group who have power in planning and giving orders to the dental auxiliaries to follow (4) the dental auxiliaries were excluded and discriminated from the dentists so they felt like being "the other" from both verbally and behaviorally of looking down, discriminating them so they were gazed from strict rules and regulations. Anand Kanjanaphan (2006) stated that looking at other groups who were not in the same side as ours as "the other" and created the marginality. Once we looked at them as the others, we would not pay attention at them. We would not care whether they were treated cruelly or taken their benefits unequally and (5) the dental auxiliaries have to take responsible for other works in their organizations, besides their dental health. Especially, the dental auxiliaries in the sub-district hospitals where there are very few personnel in the organization, so the organization could not work fully on dental health. This was in line with the study on dental auxiliaries of Nimmannorradee Nancha (2005) in Trang province and Saowaluck Choobangbo (2006) in Trad province.

With the characters and roles of dental auxiliary career as mentioned, they were forced to be in the situation of "marginalized people" since the marginalized people meant people who were ignored in terms of economics, social, politic or legal including they were excluded from accessing to the resources. They also became the

subordinate of the major group or being neglected so they were vulnerable in living their life (Gurung and Kollmair, 2005 and Surichai Wankaew, 2003). So the dental auxiliaries have not only been marginalized people in the group of dental personnel but also they have been in the lower status and less advancement in their career when compared to other health personnel such as technical nurse, or public health officer.

Being marginalized people of the dental auxiliaries, who were the main personnel in oral health promotion and prevention, then have affected to their status, lives, and works in particular the oral health promotion and prevention that we expected from them. Therefore, as the results (1) the dental auxiliaries have less perceived their authority in work since they got used to the government culture of work that relied on command system. So they have rarely chances to think and making decision. When they have to contact with the other government officers such as the teachers in schools, they felt that it was difficult to make any negotiation or requesting for cooperation from schools (2) the dental auxiliaries could not work with their full capacity since there were lacking of resources and supports including materials, equipments, tools, and dental assistants. As one dental auxiliary stated that in the past she had to do sealant for the students by using the self curing pit and fissure sealant, since the sub-district hospital did not get approval to buy the dental curing light. Her works became very slow and less effective. Even though they have the ability to perform the fundamental services but they were limited with supporting resources. The resources would be distributed to the hospitals or to the dentists before them. and (3) all mentioned characters had affected to the self and encouragement in work of the dental auxiliaries since they were excluded, until they felt less authority, and being the other. Even worse, they have not gained any supports in terms of suitable equipments for works and their wages or allowances.

The attempts to struggle and fight back in order to be free from the marginality of the dental auxiliaries were same as the other marginalized people groups in the society (Paritta Chalermphao Ko-anantakul, n.d. Anand Kanjanaphan, 2006 and Stonequist cited in Davis, 1997). They have tried to improve themselves by rushing to further their study in order to get higher degrees as bachelor or master degrees as well as adjusting the power relations inter groups such as colleagues in the sub-district hospitals who have similar status or with the people who came for service.

The dental auxiliaries have to fight in order to struggle, find their own areas, and present their identity as the example I have found during the study. I found that the dental auxiliaries turned to focus on the treatment work as this kind of work could respond to the local people needed. So it would help very much in creating their self and identity in the working area. However, they could not free from the marginality. So many dental auxiliaries felt bored with government system, some might choose to continue working while others chose the other careers (as in the case of Pii Sao). This was in line with the study of Saowaluck Choopangpo (2006) in Trad province which found that the dental auxiliaries were the group of dental personnel who had the highest rate of transfer in order to change their professional line to be the public health technical officer or the general administrative officer.

Same goes to the information in Facebook of the dental auxiliary group in Thailand, where I have found the information showing the movements in making negotiation for the dental auxiliaries to get better status, to have the professional license and to have more advancement in career path. However, all these movements have not been achieved. The Office of the Civil Service Commission (OCSC) had the letter to inform the Minister of Ministry of Public Health in October, 2013 that there was not the permission to appoint the civil servants to positions of general work in senior level in the position of dental public health officer. Moreover, the OCSC did not allow the adjustment of qualification of dental public health officer (general band) to the public health technical officer who works on dental health (academic band) as per requested (The Office of Civil Servants Commission, 2013). Things that I have found in the study area and on the Facebook page were only complaining, gossiping, ignoring to the orders, or not cooperating when they felt dissatisfaction or disagree. These were all symbolic expression of resistance from the lower status group which Scott (1985) called as “weapons of the weak” as such resistances were done secretly to avoid them from confrontation with the dominant power or the higher class group

5.1.3 The pattern of work on oral health promotion and prevention of the dental personnel

Considering the pattern of operation that was called roughly as “oral health promotion and prevention” which was the assigned policy from the central office since

the past, it was found that it was the work in the concept of disease prevention rather than health promotion. This was coherent with the growth of scientific knowledge that the oral disease prevention believed in diagnosis, providing oral health education, and prevention of the diseases before they happened. These could help controlling the occurrence of diseases and maintaining good conditions of oral cavity. (Garcia and Sohn, 2012)

Starting from the work in the period of Incremental Dental Care program and program of dental health surveillance and promotion before 1999 including the program of "Yimsodsai Dekthaifundee" (oral health promotion and prevention services in school) which were vertical programs started in the fiscal year of 2005. All programs focused on the diagnosis of dental caries and periodontitis. Then, the dental personnel would make appointments with the students to get treatment services together with the dental caries prevention by fluoride application and sealant. Moreover, the emphasis was on changing behaviors of the students in teeth cleaning and food consumption through the dental education providing. All these services had the dental personnel as the center they focused their services on eliminating the risk factors for oral diseases. Since the dental personnel who had the duty to give command from the center including NHSO and Bureau of Dental Health, all believed that the more dental personnel in the field (achieved the target indicators) it should affect the better oral health of the students more. So the duty of the students as service receivers was only waiting for the services provision.

Until the year 1999 to present, it was the period of the program for Health Promoting School Initiative which focused on changing policy of school to strengthen activities of health promotion and education in schools. The activities emphasized on controlling of context and environments in schools to be the healthy setting for living, learning and working (WHO, n.d.a, Anuwat Suppachuthikul, 1998). The activities had been done by integrated the oral health promotion to the component of criteria indicators to select the health promotion schools. By arrange the oral health teaching into the curriculum of Ministry of Education together with the measures of students' consuming control through the arranging of school healthy setting e.g. prohibition of selling sweets, desserts, soft drinks and promoting the teeth brushing after lunch activity.

For other activities in the same period of the Health Promoting School Initiative program were that the provincial office had received the pilot activities from the Bureau of Dental Health under the same concept such as the Dental School Buddy project, the network of Thai children with healthy teeth, the program of Sweet Enough Network, and the program of Learning process for Young Researcher. These programs had the idea to urge for community participation with teachers and students in conducting activities in order to promote knowledge and adjust the surroundings for more suitability. Concerning this matter, Piyada Prasertsom and et al. (2009) stated that if we divided the operation of oral health promotion and prevention into 3 significant period which were the program of Incremental Dental Care, the program of dental health surveillance and promotion, and the program of Health Promoting School Initiative. It was considered that the Health Promoting School Initiatives program had the highest level of community participation promotion in the previous time. This community participatory working like this helped created activities that responded to the local problems truly since they were based on brainstorming, analysis, and operation of people who were the owners of their own health, so the people should gain the highest benefits from the activities.

From the operation of the health promoting school initiative program in this study area, it was found that various contents of the activities still have been designed and guided by the central health organizations as well as having set the clear target indicators rather than the activities designed by the schools. The dental personnel had to request the schools to participate in the program so that the target would be achieved. So all activities were still belonging to the roles and duties of the dental personnel, for example, the case that the provincial health office received the program of Learning process for Young Researcher to be pilot in the area, dentist View (of Sriburi Hospital) shared her experiences that this activity was receiving to do while the schools were not ready, but the provincial organization needed the work results. So she had to do it by herself through training students to observe the food labels and able to compare the amount of sugar in each food, which was an idea to adjust consuming behaviors of the students. This activity asked both teachers and students to join, it was not initiated or forecasted to solve the problem from the owners of the health. Thus, both teachers and students had role as coordinators in planning or

in the programs that set up by the government only. When analyzed the participatory level according to Arnstein (1969) it was in the level of tokenism in the step of consultation and placation only since the schools still lacked of power in managing, specifying the activity guidance, as well as they still could not change the status of student's health or no assurance of changing the status quo.

With this reason, although the concept of health promoting school initiative program needed community participation in thinking and analyzing their own problem or so called community-based activities in order to change the schools to be the healthy setting for living of every personnel in schools as well as create the sustainability of the activities. However, from the collected field data from interviewing and observing the activities in the area, it was found that many activities used to be done before had been reduced or stopped as there was no sustainability of the activities. The reason was the dental personnel had to do the other works which responded to the targets and other indicators from the central office. This was in line with the study of Siripen Arunpraphan and et al. (2007) that randomly selected sample groups to assess the situation of the operation of health promotion in schools in the educational year 2003 and found that although the schools still had activities concerning the oral health promotion, but the coverage of the activities became lesser.

Until the fiscal year 2011-2013, there were the operations in forms of the Dental Fund which had increased the budget on oral health promotion and prevention obviously, each service organization (CUP) would receive the operational budget from 2-7 hundred thousand Baht when compared to the former budget of a few ten thousands only. Moreover, the Dental Fund had provided the opportunities for all partnerships organizations to be able to draw a project for several aged groups to solve the problems in each area. The Dental Fund might be the important transition to trigger the strengthening of oral health promotion and prevention since all health personnel paid attention and interested to share the resources through integration their works together. However, in the first year of the Dental Fund, there were many reflections especially from the dental personnel complained that this support budget was like "the suffering luck" as they thought that NHSO used this budget to exchange with their harder works to achieve the target set by NHSO. However, after the first year, during the second year when I had collected the data in the field, the dental

personnel in the area all knew that the targets for achievement were not more or less than the original targets they had to achieve anyway. Many of them said that their works were even reduced than before as in the past they had to inspect and provide services for three levels of primary students: Primary 1, Primary 3 and Primary 6 but now they had only one level (Primary 1) only as the target group in the program of "Yimsodsai Dekthaifundee"

Considered the operational work concept of the Dental Fund, it was found that the basic concept of the dental personnel in NHSO, in the Bureau of Dental Health, including within the province itself, they were still relied on the individual disease prevention paradigm that focused on specific cause rather than health promotion work. The central organizations emphasized on the target indicators of oral health examination and complete treatment service. They hoped that the results would be as the same as in the period of Incremental Dental Care that gradually expanded the services from Primary 1 to the other primary levels in the following years. While the dental personnel in the area, especially the dentists who had the duty on writing and designing the project in the study area still relied on the working patterns of the old prevention work together with treatment services through the activities of diagnosis, organizing services, and preventing of dental caries by sealant technique. So the dental personnel were the major implementers of these activities. For the activities that focused on changing behaviors, adjusting lifestyle, and adapting the environmental settings in the schools became less intensive, in particular, the schools in the responsible areas of general hospitals. Although, Bannpoon hospital which was the community hospital had organized the competition of the best oral health promoting school in the district by organized teachers and core students training, campaigning the teeth brushing after lunch activity, the objective of these activities claimed by the dental personnel who responsible for the activities was only to prepare the schools to be ready for the competition in case that there was a call for provincial or regional competitions as in the past.

Large amount of budget had been increased into the service system became only the lubricant material for smoothly flowing works, but it could not change the way of thinking and the pattern of works of the dental personnel. Though the NHSO would identify the guideline of work by setting the indicators of working

process that needs participatory from several sectors. Those indicators were as following: (1) there must be the follow up and monitoring meetings of the operational area in the province by the provincial committee of oral health service system development at least twice a year, and (2) there must be the District Health Coordinating Committee (DSCC) which comprising of several sectors and there must be the committee meetings at least 3 times / a year in order to consider and follow up the work plan on dental health of the CUP. However, in the practice, the work plan and details of projects still had been determined by the dental health working group without participation from any sectors including the dental auxiliaries who working in the area. They did not even have participated in thinking and planning process at all. All works were designed and operated by the dental personnel as the center of the service as before and people had only the role of person who waited for the service in the levels of “non-participation” within the manipulation or therapy only. Since the people would get only education or cure from the government sector without having any participatory in planning, decision making, and any operating at all (Arnstein, 1969). This participatory level of the people like this was considered lower than the period of the program for health promoting school initiatives. Therefore, to have people, who are the owners of the health had skills and competency in taking care and managing several factors that affected their own health, participated more in the activities which considered the true meanings of health promotion works seemed to be the concept that was far to reach.

Such a work that focused on the concept of disease prevention like this had been grown and merged in the working policy for a long time within the medical and dental public health system in Thailand. Therefore, we might find that the works relied on guideline of oral disease prevention in many provinces such as in the study of Songvuth Tuongratanaphan, et al.(2003) and Tuongratanaphan (2004) in Chiangmai, Nan, Khon Kaen, Bureeram, Bangkok, Pratumthanee, Songkla, and Pattalung provinces, and in the study of Nimmannorradee Nancha (2005) in Trang province, as well as the study of Saowaluck Choopangpo (2006) in Trad province, and the study of Natthida Chaiyawan in Lampang province (2013). The information had shown that all dental personnel had focused on disease and the risk groups only. Their works, then, emphasized on the services of full mouth examination, sealant, fluoride coating and

oral health education to change the behavior and maintain a status quo rather than the health promotion works which meant “the process enabling people to increase control over, and to improve their health”.

5.2 Discussion

The value of treatment works and the negative meanings towards the oral health promotion and prevention of the dental personnel have all been affected from Biomedical paradigm that was formed in themselves since they were trained in the educational institutes. From the study results of Tuongratanaphan (2004) in the Faculty of Dentistry, Chiang Mai University found that the most of subjects that dental students had to attend would be in the groups of basic sciences, biomedical science, and dental science which all had fundamental and developed from Biology. In the first year, all subjects would be basic sciences, then the second and third year were per-clinic stage which the students had to learn the theory and then practice the dental works in the labs. After that in the fourth to sixth year, that would be clinical stage where the students would be trained for dental skills especially clinical skills including the oral diagnosis, dental roentgenology, oral and maxillofacial surgery, periodontic, dental restoration, prosthodontic, pedodontic, community dentistry, and comprehensive dentistry. Most of subjects enabled the students to have competency in providing treatments rather than the patient’s care which Tuongratanaphan stated that biomedical science discourse is constructed in dental education.

Once the Biomedical paradigm became the fundamental of the way of thinking of dental personnel as well as the modern medicine that made them especially the group of dentists had the view of mechanism and reductionism. The dentists would pay deep attention into the characters and compositions of teeth, periodontium, and all tissues in the oral cavity. They studied the occurrence of disease, diseases process, and the treatment that fit to each stage of the disease, etc. Once they found the disease or the abnormality in the oral cavity, the dentists would diagnose and provide treatments separately part by part or for each particular tooth without concerning the relations with other organs in the body. This was coherent with the idea of Decartes which believed that the human body works like a machine where each parts working

separately and freely from each others. Once any parts became disordered that particular part should be repaired and then the whole body would be work properly again. (Fritjof Capra, 2003) Disease and symptoms happened in the oral cavity of people could be released and eliminated by the dental personnel. In Thailand, there are the classifications of specialty dentists into 10 branches (The Royal College of Dental Surgeons of Thailand, 2012) which each branch works differently and sub-divided into small branches.

Nine in ten branches of dental public health, which are Oral and Maxillofacial Surgery, Periodontology, Pediatric Dentistry, Orthodontics, Prosthodontics, Oral Diagnostic Sciences, Endodontics, Operative dentistry, and General dentistry, all defined works after the disease had found or after the abnormality happened in the oral cavity. There is only one branch that is Dental public health focuses on the prevention of the disease or abnormality. Therefore, it could be stated that the dental knowledge are the disease-oriented which is not different from other medical works (Navarro, 1986 and Prawese Wasi, 2004)

At present, there are many developed materials, equipments, and advanced techniques in the treatment of oral diseases and abnormality rapidly. So the dental personnel could diagnose and cure accurately, high safety, and truly respond to the needs of patients including in terms of beauty, strong, and long lasting material used. The more they used new materials to create more beauty and biocompatibility with the tissue in oral cavity, the more they could claim for higher service charges from the service receivers. This would be reflected in the selected branch for further study of the dentists which were more related to the beauty purpose and it could make higher income for them such as orthodontics and prothodontics. There were highly competitive to enter the study in these two branches.

With the biomedical paradigm that had characters of mechanism, reductionism, and disease-oriented, when the dental personnel needed to do the oral health promotion and prevention works, they would focus on disease prevention through searching for risk factors, limiting specific causes, and adjusting the person's behaviors. For example, the case of dental caries there would be 3 factors according to Keye's circles which were host or susceptible tooth surface, microorganisms or cariogenic plaque, and substrate or cariogenic diet. (Hiermath, 2007) Therefore, the

mechanism for prevention was coordination between dental personnel and individual person to avoid these three factors to meet up and create the disease. So the dentists would help strengthening the teeth by added fluoride, sealing pit and fissure in order to reduce the chances of collected pieces of food and germs by sealant, and then giving the oral health education to make people have suitable behaviors. Then, the rest were the duties of the individual person to take care of their own teeth by avoiding the sweet diet, avoiding the frequently eating between meals, and often brushing their teeth to get rids of pieces of food and germs in their mouths. Once the dental personnel focused on causes of disease only, when the disease happened the dental personnel would provide treatment for return the good oral health. For these reasons, the dental personnel often do the victim blaming to the patients that the patients did not take care of their own dental health. This was coherent with Health field concept of Lalone that focused on lifestyle of individual as one factor of healthy defining (MacDonald, 1998).

This pattern of oral health promotion and prevention works have been still existing with the dental personnel as the center of services. Most of the dentists and dental auxiliaries focused on prevention and controlling the specific causes of the diseases and still ignored the empowerment of an individual person. Also, there was the neglect of the participatory working process by both the service provider who was the dental auxiliaries and the people who were the owners of the health to have rights to participate thinking, decision making, operating, and receiving the results of those activities. In addition, the present working pattern has not emphasized on the others surrounding contexts that might affect the health in order to be enabling people to increase control over, and to improve their health which was a wider view than disease prevention only. Health promotion could also increase one's state of health rather than being able to maintain a status qua. (MacDonald, 1998 and Terris, 1992)

Since the Biomedical paradigm has focused in disease and had the concept of mechanism and reductionism so it affected to the treatment service and made it became more important and in the center of attention. Therefore, several budgets in the national level and provincial level have been dumped into the treatment works while the oral health promotion and prevention works was pushed away to the marginality and did not gain any attention at all. So the oral health promotion and prevention gained very little budget support. All dental personnel gave meanings and

value the work as less competency work and did not reflect any identity or selfness of implementers. Also, the employee earned lower income than those doing treatment work. Therefore, the responsibilities of this work were assigned to the dental auxiliaries as the para medical personnel, small group, and have not gained any supports or significance. The dental auxiliaries then has no rights, not voice, no power to make any decisions in their works.

The conflict and the opposition between the medical and para-medicals personnel have always been found in the public health works (Turner 1986 cited in Danial, 1990) as well as the professional dentists and the para-dental personnel in the study of Adams (2004) in Ontario, Canada which found that the dentists and the dental hygienists who had roles in preventive or primary health care had the conflict in taking care and curing the people. The dental hygienists requested that they should have worked freely without permission or being under the commands of the dentists since they had skills and expertise enough to provide safety services. Also, they claimed that if they could work freely they would increase the access to the services of people. As they demanded that the dentists had resisted the autonomy of the dental hygienists since the dentists concerned about maintaining of their income, and the gender issues rather than the reasons about health and safety. While the dentists argued and gave reasons that the dental hygienists have been less trained and not expertise enough to make decisions in all cases which might cause harmful to the treatment, especially the case of high risk patients. The dentists claimed that the opposite standing points were not relied on the issue of high income but on the facts that they were more expertise.

In Thailand, even though the conflict situation was not serious, the Thai dental auxiliaries have tried to request for professional license permission as it was seen in the messages on Facebook of Thailand dental auxiliaries. Moreover, in the study of Nimmannorradee Nancha (2005) found that the dental auxiliaries needed the license for three reasons which were (1) to implement their works on the rightness of government regulations (2) to be accepted in their implementation and (3) to be able to work in the private sectors since the dental auxiliaries income was not suitable with the economic situation at the present time. However, their demands still have not been responded as the present the Dental Council has dominant power in identifying the qualifications of dental practicing license which was not covered the qualifications of

dental auxiliaries. So the dental auxiliaries still have unclear status, which supported the concept of profession which were monopolized by the specialist knowledge including the establishment of professional association to protect themselves and maintain the benefits for their members (Cruess, et.al. n.d.)

When the oral health promotion and prevention work was classified as the marginality that did not get any attention. And this work had been assigned to the dental auxiliaries who already were marginalized people in the system to take responsibility. It was even reduced the significant of this work more and more in the health system. Including the dominant power person in the provincial or ministry level lacked of the interests to take care as it was seen from one case of a dental auxiliary who worked in the provincial health office in the western part of Thailand. The dental health working group in that province was merged with the health promotion group as she was working alone in the dental health work group in the provincial office. There had been no dentists working in the group for many years. So the dental health work group in this province had no power to make negotiation for the budgets among other working groups compared to the duration that there were dentists working in. With this reason, though she was rather senior than others, herself had only the position of dental auxiliary with no power to fight for the oral health promotion and prevention, so it seemed to be even degraded.

Although the concept of marginalized people, there have been the endeavors shown in fighting, negotiating, and adjusting the relations among the groups in order to free themselves from the marginality or express their own self and identity that was complex and flown to negotiate with all dominated issues (Paritta Chalernpao Ko-anuntakul, n.d.a, Anuns Kajanaphan, 2006, and Stonequist cited in Davis, 1997). However, the context of oral health promotion and prevention had fallen into the marginality but there was nobody tried to struggle, fight back, and negotiate for this kind of work to gain more significant and become the center of the interest.

Dentists at all levels, no matter they are in a group of center of the country which have power to define the policy or in a group of implementers in the field, are satisfied with the continuation of classification of this work in the marginality. So they would have time for treatment as the main work, and have some times for additional works in private sectors. While the oral health promotion and prevention work, though

it might be the work that helped them have identity in their commanders' eyes but it was not the main work so they could do only to pass the indicators or just to make other people knew that they still had this kind of work. Because if they thought to work largely or to exceeding works it would be wasted of budget more and more exhausted. As the statements of a dentist in the Bureau of Dental Health that working on dental health promotion and prevention which was promoted as a national big campaign during the data collecting period that

“working in the campaign like this, we have not got increasing budget. This meant that we had to have the money available but the politician would know that, the executives would also perceive that. It was like propagating work to let others knew about our works. Sometimes we had to propose as the ministry agenda of monitoring and following up tasks but to think bigger like that, when it became a policy and we were not ready we would almost die and have to take all the blames” (Dentist in the Bureau of Dental Health)

Even the dental auxiliary group, who has main responsibility on the oral health promotion and prevention work, has not given the significance or had the attempts to push up the work to gain attention or to be at the center of services, they turned to focus rather on the treatment as it could respond to the needs of the people in the area. So it could help creating identity and selfness for them. While oral health promotion has never gained attention or significance as even the dentists who worked in the same working place, had more authority, and might be as a role model for dental auxiliaries, still did not pay attention to the works.

These situations found conflicted with the concept of marginality which the marginalized people should have struggled to be free from the status since the dental personnel both the dentists and dental auxiliaries were all choosing to be at the edge of circle to maintain their freedom in doing other works that had higher authority, and not being controlled or followed up too much from the center office. They (in particular, the dentists) so could work on private sectors to increase their own income.

When the oral health promotion and prevention was fallen in to the marginality because of biomedical paradigm, the concept of mechanism and reductionism, the concept of expertise as well as the way of thinking in the matters of capitalism that emphasized and valued the treatment and economic opportunities. All these affected that most of dental personnel gave significance or favorable to oral health promotion and prevention works. Therefore, the mechanism of NHSO, that created the Dental Fund in order to be financial incentive to the CUP and hope to stimulate the dental personnel to increase working on the oral health promotion and prevention, seemed to be unsuccessful. Since all the dental personnel still gave the negative meanings to this work. Although, the dental personnel in all level would give significance to the target indicators that NSHO had set up, they just did it only “enough to be passed” the criteria as they all claimed that they did not like the works and were not interested in this work. The period of marginality of oral health promotion and prevention work like this was not happened from the insufficiency in terms of economic aspects but happened from that the dental personnel did not create meanings and discourse for the work. Thus, many increased budget did not help changing the contents or contexts of the work at all.

5.3 Recommendations

What happened in the dental public health service system, in particular, in the government sector that forced this work into the marginality by the dental personnel did not pay attention or give significance to this work as they should. This was reflected the problem in terms of the medical system structure that related to the biomedical paradigm, capitalism, and the relations between the professional: dentists and dental auxiliary career. All these affected the dental auxiliary who are the paramedicine personnel became the responsible person and had the duty to provide these services while the dentists rather provided the treatment service.

However, the assignment to the dental auxiliaries to take the duty on oral health promotion and prevention was not come with the power decentralization and resources allocation for them properly. Since the authority people in the system which was the dentists tried to maintain the resources to respond their own works only by

claiming their scope of works that they could do more variety and coverage more complex works.

Therefore, the solution guidance to make the oral health promotion and prevention gain more significance and be the center of attention of all dental personnel became difficult since it was the structural problems. Although there were the attempts to solve the problem in order to have more amount of works and people would access more to the services by increasing the production of dental personnel, or using the way of financial incentive from the Dental Fund, they were all still unable to solve the problem. The dental personnel still work on curative tasks as usual. Moreover, the produced dentists were flowing out of the government system to the private sectors in order to do specialized works (mostly were curative works), while the dental auxiliaries felt bored with the current system so they chose to work as they could or change their career to do other works at all. So the solution of the problem was to try to understand this issue in the paradigm aspect.

The fact that the oral health promotion and prevention was fallen into the marginality, as the result, fewer people could access these services. The study of Sunee Wongkongkathep (2006) found that after the campaign “30 baht for curing every disease” in the beginning period shown that the amount of dental services in the institutions were increasing about 15-30 percentage, in particular, the groups of adults and elderly, while the children group had received the service became less. Also, the service providing institutions at regional level all reduced the active approached works. As the same results, this study found that the dental personnel at all levels focused on the treatment works, while the oral health promotion and prevention works have been done only to pass the target indicators. To emphasize the quantitative target indicators like this had affected in the discrimination to some people groups as they directed to the numbered target without paying attention that the digit numbers were done with whom, or which groups, whether it was the truly opportunity to access the service or not. For example, the case of NHSO identified that there must be complete treatment for the Primary 1st students about 20 % of all students received the diagnosis. I found that the dental personnel selected the students as the target group from the large schools in the city area which mostly the parents already were in interested in taking the good care of their oral health. So the dental personnel provided

the sealant service only which was considered the complete treatment as the indicators stated. For the students in schools outside the city area had rather bad oral condition, had many dental caries, they would receive only examination services according to the indicator but there might not be the follow up appointment to get the further treatment. This character of work affected to the fairness of dental service receiving of the people as the people who already had good oral health status which often related to their good economic status had a chance to receive the service in the campaign while the less opportunity students did not receive the necessary services that led to the good health and reduced disease. Such a method/process was creating unfair rights to access the health service for the people.

When the dental personnel did not give the significance to the oral health promotion and prevention work fully, on the other side, the government sector should have done empowerment for the people so that they could take care of their own oral health. Moreover, the government sector should have decentralized the power to the people so they have participated strongly to manage the resources and budgets that came from their own tax to serve their own problems and fit to the capacity of the community. The people should have participated in all level ranging from the strategy designing, planning, operating and evaluating the activity results of oral health promotion and prevention as they were the owners of their health.

Moreover, while the oral health promotion and prevention work of the government sector was not gained any attention and fallen into the marginality, the private sector's oral health promotion and prevention became the big market opportunity. For example, from the data in 2009 it was found that the market value of oral care products e.g. toothpaste, toothbrush, and mouthwash, was totally about 8,000 million baths which divided into 5,000 million baths, 2,200 million baths, and 1,400 million baths, respectively (War of the mouth. Hot! "Colgate" ready to take the chair of oral care, 2009). Each brand had put plenty amount of budget from ten millions to hundred millions for the commercials and promotions to take the market shares (Editorial, Thansethakij, 2012, Bio-safety accepted their growth of 50% marching to the oral care market and hidden big surprised at the end of 2012, Twins lotus big rebrand invested 100 million baths opening the premium products, 2013). Therefore, if the content of oral health promotion and prevention work was created to have benefit

and profit in relations in order to stimulate the business profits as well as the treatment work, it would be more attractive and persuasive to do the works and the works would be more significant too.

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