PARTICIPATION OF VILLAGE HEALTH VOLUNTEERS IN PHC IN PHUTTAMONTHON DISTRICT, NAKHONPATHOM PROVINCE, THAILAND

HADI BAKHSH SAHITO

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FACULTY OF GRADUATE STUDIES
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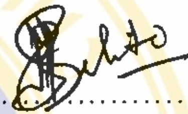

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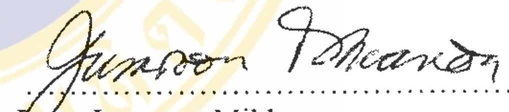

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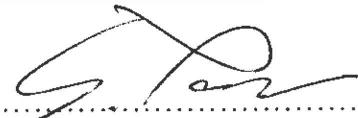

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Dr. Hadi Bakhsh Sahito

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ABSTRACT

A cross-sectional descriptive study was conducted on participation of village heath volunteers in PHC in Putthamonthon district, Nokhonpathom Province Thailand.The objectives of study was to find out socio – demographic characteristics, income, and attitude towards PHC, social support and participation activities of VHVs in PHC in Phutthamonthom district and to identify the factors affecting participation of VHVs in PHC and their association in Phutthamonthon district.

All 3 Sub-districts Salaya, Klongyoung and Mahasawat of Phutthamonthon district were purposively chosen. Total sample for whole population of VHVs was selected in which 132 VHVs can be located out of 143 of total. Questionnaire was designed to include socio-demographic factors, psychosocial factors, working factors and participation of VHVs in PHC. The data was analysis by using percentage, mean, SD, Min, Max for descriptive and for association or statistically significance chi-squire and p-value were used by using cross tabulation.

The analysis showed that VHVs had high participation in Phutthamonthon district particularly, the activities related to health prevention and promotion especially in provision of sanitation improvement, safe drinking water and prevention of food contamination or poisoning.

Factors affecting the participation the participation are attitude, emotional, instrumental, and informational supports from relatives, neighbors, group/committee in community, religious priest and local govt. are significantly associated with participation (p-value< 0.05). In working factors, distance of health centers and VHVs house, relationship with health staff, visit of health officer, happiness to become a VHVs, gaining respect from community or good relationship with their community, wanting to help their community, and also wanting to gain popularity to become headman were identified statistically significant (p-value<0.05).

KEY WORDS: PARTICIPATION OF VILLAGE HEALTH VOLUNTEER/
PRIMARY HEALTH CARE

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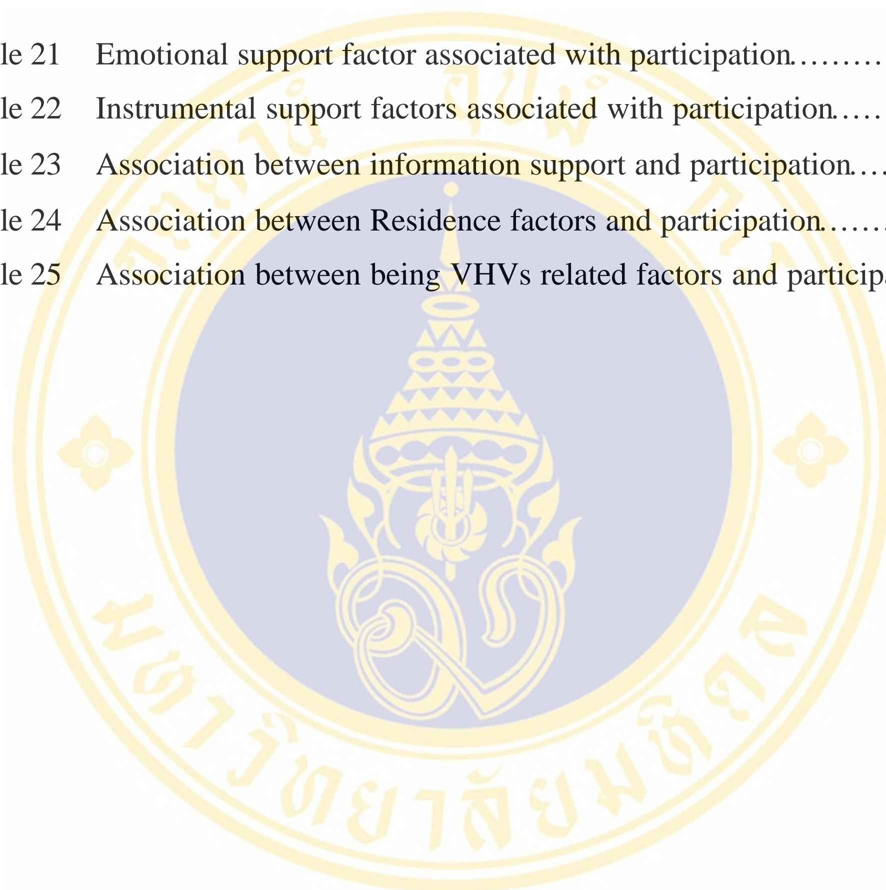

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LIST OF ABBREVIATIONS

ANC	=	Ante-Natal Care
AIDS	=	Acquired Immune-deficiency Syndrome
BMN	=	Basic Minimum Needs
CAH	=	Community Action for Health
CBO	=	Community Based Organization
CBR	=	Community Based Rehabilitation
CPHCC	=	Community Primary Health Care Center
CIH	=	Community Involving in Health
HCP	=	Health Card Project
HFA	=	Health For All
MCH	=	Maternal and Child Health
MOH	=	Ministry Of Health
MOPH	=	Ministry Of Public Health
NGO	=	Non- Government Organization
ORS	=	Oral Rehydration Salt
PHC	=	Primary Health Care
PCU	=	Primary Care Unit
TBA	=	Traditional Birth Attendance
TCDV	=	Technical Co-operation and Developing Villages
UCHIP	=	Universal Coverage Health Insurance Programme
VHV	=	Village Health Volunteer
WHO	=	World Health Organization

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CHAPTER 1
INTRODUCTION

1.1 Rationale and Justification

The constitution of World Health Organization was adapted in 1949 by the member states. The constitution proclaimed that "the enjoyment of the highest attainable standard of health" was "one of the fundamental human right of every human being without regard to race, religion, political belief, economic or social condition". The constitution also noted that " the health of all people is fundamental right in the attainment of peace and security and is dependent upon the fullest cooperation of individual and state".

1.1.1 Declaration of Alma-Ata

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

1. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

2. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

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3. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

4. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

5. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

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

7. Primary health cares: a) Reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and

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is based on the application of the relevant results of social, biomedical and health services research and public health experience.

a) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
b) includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
c) involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
d) requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
e) should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
g) Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

8. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary

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to exercise political will, to mobilize the country's resources and to use available external resources rationally.

9. All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

10. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share. The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

The concept of primary health care for rural populations can be traced back to 1937 when the League of Nations Health Organization convened an Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene in Banding, Indonesia. The recommendations made at the conference foreshadowed

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those made at the International Conference on Primary Health Care at Alma-Ata nearly 40 years later.

The concept of primary health care was at first essentially an expansion of the ideas contained in the concept of basic health services. But it was the Alma-Ata Conference that broadened this concept to encompass a philosophy which went beyond the provision of the first-contact health services. It also provided a political dimension to primary health care. The principles of the PHC philosophy are equity, community involvement, appropriate technology and a multisectoral approach.

1.1.2 Charter for health development

The Southeast Asian Charter for Health Development was endorsed at the Thirty-first session of the Regional Committee for Southeast Asia in 1978. The Charter was a declaration of the principles and an expression of the need of the Member States to mobilize adequate internal and external resources. The countries committed themselves to optimize the use of available resources for dealing with common health problems of high priority. They were also committed to promoting intercountry consultation and collaboration within the framework of national and global development policies.

1.1.3 The challenge of health development

Today we are in a very challenging phase of health development. There are many roads to success. The possibilities of change are open to all people but no standard method or prescription is applicable to them all. Human ingenuity knows no frontiers and thus, if the issues and problems can be analyzed in relation to the strengths, it should be possible to assure equitable development within the bounds of a sound ecosystem and thus leave the future generation a better world than the present one.

1.1.4 Global strategy for HFA/2000

Four years after setting the social target of Health for All by the year 2000, following the preparation of national and regional strategies, the World Health

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Assembly, in 1981, adopted a global strategy for achieving the target. It was an ambitious strategy signifying a new model of development, with health progress promoting overall socioeconomic development.

With a view to accelerating the attainment of the goal of Health for All in the countries of the Region, the Regional Committee urged Member States to initiate and pursue efforts for the development of HFA leadership with a clear understanding of the value system implicit in the strategy for Health for All and its principles. A commitment to social equity and justice, a comprehension of the intersectoral nature of health development and the willingness and capability to convert them into opportunities, and a capacity to motivate other were emphasized.

Since the Alma – Ata declaration in 1978 is widely considered to be a concise statement of the principles of PHC. There has been widespread recognition of the importance of HEALTH FOR ALL BY THE YEAR 2000. Consequently, primary health care (PHC) has become recognized world –wide as a major approach to "HEALTH FOR ALL," especially for developing countries.

The PHC concept is a community development strategy designed to enable people at the grassroots level to solve their own basic health problems and change their health behavior. Therefore, the people must recognize and understand the problem of their community and cooperate. In finding the simple technology and techniques to tackle the problems, such techniques must be appropriate, economical and flexible to be implemented by grassroots people.

Many governments, especially governments of developing countries can not provide enough health service to their people due to lack of adequate budget and it was found impossible to post qualified medical staff in rural and remote areas where few qualified medical staff wanted to work.

Primary health care is system that complements the existing government health care delivery system at the grassroots level through active community participation and it aims at the development of community self reliance in taking care of their own

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health problems, Primary health care approach focuses on people's participation and maximization of use of locally available resources.

Village health volunteer, who are community served, become main vehicle for promoting PHC approach. It is well recognized that people are able to take care of their basic health problems, if they are properly trained. VHVs are given a modest amount of training and perform a variety of preventive, promotive and some time curative work. (Berman and scholl 1985).

In 1960s, China produced millions of "Barefoot Doctor"(village doctors) to meet basic health needs in rural areas where more than 80% of population in China lived,"Barefoot Doctors"(village doctor) were indigenous and got some reimbursement from the community they served. Those Chines "Barefoot doctor" used to a lot of problems in their performance. As the social and economic system changed afterwards and village cooperative funds reduced, especially no or less payment for them, many of them could not perform well and most of them dropped out or practiced private healing. So they hardly involved in primary health care later and some people called it good lesson for grassroots health workers.

1.2 Kopanong declaration on primary health care 26 august 2003

We, community members, academics, members of NGOs and CBOs, representatives of government, officials and guests meeting at Benoni, Gauteng on the eve of the 25th anniversary of the signing of the Alma Ata Declaration in the former USSR, having assessed South Africa's achievements and challenges in implementing primary health care using the primary health care approach, noting,

The progress made in implementing primary health care nationally; and the challenges that remain. Hereby resolve that the key focus of the agenda for strengthening primary health care over the next five years will include:

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1. Concrete strategies and processes, with clear targets, to reduce inequities in the allocation of resources for primary health care with a focus on both horizontal and vertical equity over the next 10 years.
2. Committed funding and budgets for sustaining community involvement in health through inter alia regular area summits leading to provincial summits.
3. Strengthening the health system by focusing investment of resources on priority health programs and by accelerating the implementation of the DHS including its various components.
4. Develop, implement and monitor the implementation of coherent human resource plans at district, provincial and national levels based on national guidelines including the strengthening of recruitment and retention strategies.
5. Re-invigorated committed to the principles of the PHC approach by all partners with effective national and provincial leadership.
6. Strengthening of PHC through the development of intersectoral forums at every level but especially at the facility and district levels.

We will use the performance management system of government and the accountability mechanisms in each municipality, province and nationally to assess and report on progress each year on the six areas listed above.

Thailand began at first as Lampang Development project (1974-1981) Development and evaluation of an integrated health delivery system project for Thailand proved to be turning point experience for PHC movement and rough idea of VHV was formed at that time.

The function of government is to provide support that will enable the community to analyze and solve its own problem. PHC in Thailand was established during the fourth National five-year Economic and Social Developments Plan (1977-1981) and continue to be well nurtured by the government and the people. From the 4th to 6th Five-year Economic and Social Development Plan, the Ministry of Public Health (MOPH) established the Health Volunteer system as a primary strategy for the PHC activities. These volunteers were selected and trained to be the Village Health

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Volunteers (VHVs) and Village Health Communicators, at present, every village has its own group of volunteers. From the database of PHC information in the year 2000 taken from whole country there are 796 districts 69,942 Community Primary Health Care Centers (CPHCC) and 714,072 VHVs in Thailand. The MOPH started the policy to establish CPHCC and "Heath for All" pilot project in 1992, the beginning of the Seventh Health Development Plan (1992-1996), the government adjusted the PHC strategy to address the situation at the time of improving the quality and the potential of VHVs. It also sought to promote self-care and community- based care from the experience gained in term of following aspect. (1)

1. Management due to inadequacy of management and community such as management of drug, sanitation and nutrition funds which were situated in different places and difficult to follow-up.
2. Community planning. Was due to a lack of information as a resource to identify community problems. VHV were concerned with the discontinuation of VHV training.
3. Supportive material: This was due to lack of medical equipment support.

General information of target area:

In **Nakhonpathon province**, the total population is 733,878. It has 7 district, 106 sub-district and 889 villages. Total population of **Putthamonthon district** is 23648. It has 3 sub-district and 17 villages. Sub-districts are (1-Salaya population 13,172 people (2-Klongyoung population 6,124 people (3-Mahasawat population 4,352 people. Total no: of VHVs in whole province Nakhonpathon is 1,148, as shown in table 1

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Table 1 Number of VHVs in Phutthamonthon District in the year 2001. Health managerial Summary of Putthamonthon District Health Office.

No.	Sub-district Names	Health Centers	Responsible Villages.	No. of houses	No of VHVs
1	Klong Yong	Klong Yong 1	1, 5, 6	542	25
		Klong Yong 2	2, 3, 4, 7	590	24
2	Mahasawas	Mahasawas	1, 2, 3, 4	784	36
3	Salaya	Bansalawan	5, 6	1,876	25
		Watsuwan	1, 2	413	15
		Phutthammonthon Hospital	3, 4	331	18
Total	3.Sub-district	5 Health centers and 1 District Hospital	17 Villages	4,536 Houses	143 VHVs

Source: Annual Phutthamonthon District Health Report of the year 2001

A health survey of rural people in the northern and northeastern part of Thailand revealed that 84%were familiar with CPHCC, while 77% of southern people and 66% of central people reported the same. In terms of utilizing CPHCC services, people in the northern region used CPHCC services more than other region (50%) and (49%) respectively. The lowest utilization occurred in the Central region. Opinion regarding CPHCC Central region had less proportion than other region.(3)

Based on the report of human development and the Primary health care sector in 2000(4)

It was shown some VHVs were unable to perform their tasks effectively due to:

- Lack of knowledge
- Lack of confidant to disseminate health education.
- Lack of skill to perform their tasks.
- Lack of budget and tools

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- Lack of refresher training and
- Lack of supervision from health personnel etc.

Therefore this research is intended to assess the participation of VHVs for PHC in Phuttamonthon district of Nakhonpathom province of Thailand.

1.3 Community participation in primary health care.

The advantages of a community participation approach in primary health care (PHC) are as follows: a community participation approach is a cost effective way to extend a health care system to the geographical and social periphery of a country; communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures; communities that invest labor, time, money, and materials in health promoting activities are more committed to the use and maintenance of the things they produce, such as water supplies; health education is most effective in the context of village activities; and community health workers, if they are well chosen, have the confidence of the people. An error made in early efforts at community participation was to assume that villages were uniformly free from internal exploitation. Some are cohesive moral communities. Villages may be divided by caste or ethnic origin. Political organization of villages may be democratic or they may be governed in an authoritarian manner. In politically unstable countries where the central government has a rather tenuous control over the rural periphery, genuine community initiatives may be viewed as threatening and may not receive official encouragement. Social groups within communities may be tremendous assets. In planning the community participation aspects of primary health care, the collaboration of an anthropologist or rural sociologist with field experience is recommended. Promoting community participation is a skill, which must be taught to community health workers, and backed up with support services. The genuine commitment of medical staff to community self help is crucial to the motivation process. Motivation within the community quickly breaks down if materials, expertise, and salaries fail to arrive when promised. Community activities are most successfully promoted with reference

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to the people's own ideas of purity/pollution, cleanliness/dirtiness, and health/illness. Guidelines for successful community participation include: projects undertaken should be ones that the community has identified as a priority; demonstrations and activities to promote health might be linked with agricultural initiatives, adult literacy campaigns, or programs from other sectors; and it is necessary to make sure the community fully understands all the costs in labor, time, money, and materials. If projects or long term community health programs fail, a quick, simple analysis should be made of constraints that may be operating. Some points to be covered are suggested.

1.4 Objectives

1.4.1 General objective.

This research aim to study the participation of VHVs in PHC in Phutthamonthon District, Nakhonpathom Province, Thailand.

1.4.2 Specific objectives

1. To find out socio – demographic characteristics, income, and attitude towards PHC, social support and participation activities of VHVs in PHC in Phutthamonthon district.
2. To examine the relation of the factors affecting participation of VHVs in PHC in Phutthamonthon district.

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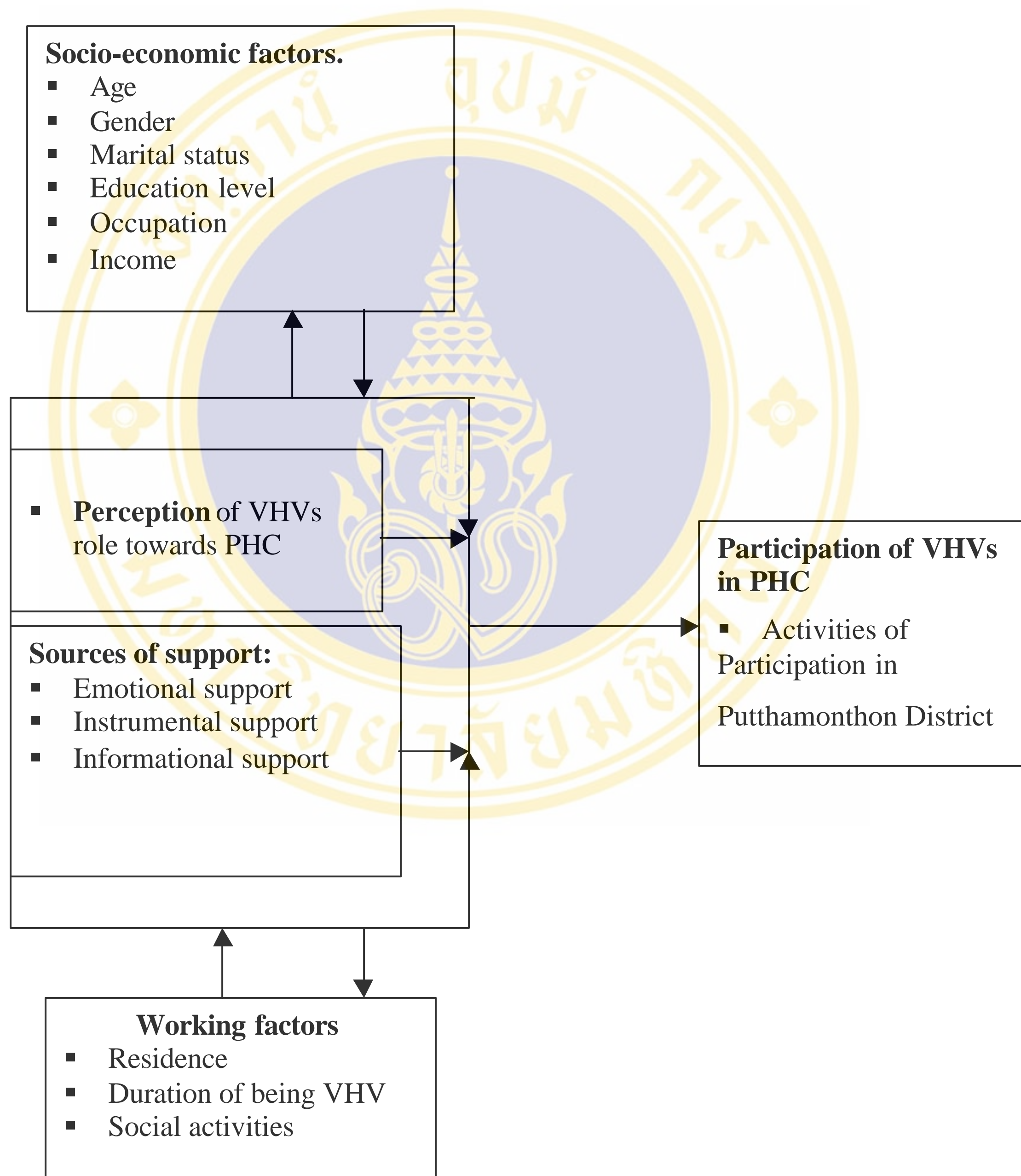
1.5 Conceptual framework



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1.6 Operational Definition

Participation of VHVs in PHC: Refers to activities of VHVs at PCU and in their villages, these will be Prevention activities, health promotion activities, screening and treatment. Home visits, rehabilitation activities and local wisdom conservation activities. etc.

Village Health Volunteer (VHV): is person/villagers in community who registered And trained in primary health care and related to health for to inform and help their area, Located to them, about 12-15 houses in same community.

Household members: Number of the members in the VHVs house.

Marital status: categorized into single, married, divorce, widow and separation.

Educational level: In this study education refers to primary school, secondary school and High school and college/university.

Occupation: In this study refers to the main job that VHVs spend time for earning income. It is categorized as farmer, merchant, government officer, laborer and others.

Duration of being VHV: is number of years he/she has been served to the community as a VHV.

VHV selection process: is the method that VHVs are selected can be classified into community vote, by village headman, health personnel and by self-nominating, etc.

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Characteristics of villages of district

Special project in villages: Any special projects in villages, which are Self – managed PHC, self-preventive development village.

Perception: Defied as refraction of feeling or thoughts, of VHVs on opinion and beliefs and information gained towards PHC in Putthamonthon district.

Social Activities: Referred to involvement in group activities or being a member of social gathering group in community, including group of cooperative, agriculture, house wife, economize, elderly, volunteer scout, Thai Asa, school committee, village health volunteer, religious or tampon administrative organization and others.

Source of Support: Referred to assistance or encouragement rendered to the village health volunteer by relative members, health personal in the CPHCC team, local organization, neighbors, religious priests. This support was characterized as emotional support, instrumental support and information support.

Working Hours: Referred to time of actual labor in usually day of VHVs work.

Residence of VHV: Refers to a regular place where VHV is currently living for at least 3 months in the community.

1.7 Scope and Limitation of the Study

This study tries to assess the participation of VHV's in Phuttamonthon district, Nakhonpathom province, Thailand. Because of limitation of time the participation is lower than report because the study will start to collect data between February 7 until 20th 2005th. Phutthomonthon district is place of study, This district was purposely

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chosen because there never study regarding the VHVs participation in PHC was performed before.

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CHAPTER 2
LITERATURE REVIEW

The objective of this study is to define participation VHVs in PHC in Phuttamonthon district, Nakhonpathom, Province in Thailand. The discussion is as follow:

2.1 Primary Health Care in Thailand

The concept and principles of primary health care are really not new in Thailand. The first seminar on PHC was conducted in Thailand after Alma-Ata conference. This show that Thailand has enough experience in developing primary health care (5). The concept of PHC was adopted as national strategy to reach Health for All (FHA) by the year 2000 after the Alma-Ata declaration in 1978; this concept was based on redundant recognition of modern care system. In the mean time, it aims to promote the empowerment of people

Though democratic participation. Therefore, PHC in Thailand can hardly be conceived as primary care but should rather be interpreted as a health and social development strategy. As for health development, it is the strategy to promote basic medical services through PHC approaches and PHC activities.

Main components or elements of PHC in Thailand are: Health education, Endemic disease control, Expanded Program on Immunization, MCH, family planning, Sanitation and safe water supply, nutrition, essential drug provision, treatment of common diseases, dental health, mental health, NCDC, consumer protection, AIDS prevention and control and environmental health. For PHC and basic health promotion four approaches are applied as.

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1. Community participation: Is most important element of PHC activities.
2. Appropriate technology: economically affordable and socially and culturally acceptable to community.
3. Maximization of locally available Resources; Utilization of natural social and human resources in the community.
4. Inter-sectoral Collaboration; As health and disease result from multiple factors, it was necessary to involves not only the health sectors but also other sectors as well to promote health development.

The fourteen element of PHC and 4 approaches of PHC have been supposed To actual activities at community level in 2 major type of activities, they are village health volunteers training and revolving funds. Moreover, several innovations in health and social development to achieve health for all (HFA) by the year 2000 were also initiated. These are: promotion of basic minimum need (BMN), technical co-operation among developing villages (TCDV), promotion of use herbal medicine in community and hospital promotion of PHC self- reliance villages and strengthening of basic health service and referral systems. (6), (7)

In the Seventh National Health Development Plan (1992-1996), although health infrastructure was extended to cover the country evenly, an indicator of health status provides intensity of health problems in rural areas.

The Major causes are lacking sufficient strengthening of prevention and promotion of the quality of care at the health center. The emphasis of PHC should shift from community to family and individual. The term self care has now become the main theme for PHC. Support of NGOs in development of appropriate health technology at the community and district level, integration of control of some communicable diseases and non communicable diseases to PHC program is now deemed more critical, CPHCC was established as a center for operation and exchange of knowledge of village health volunteers.

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The role of individual, volunteers and community should be clearly identified. Moreover, appropriate technology for diagnosis and treatment at the community, health center, community hospital and provincial hospital should be developed. Lastly, two ways communication of referral system among health centers, community hospital and provincial or regional hospital have strongly recommended (3).

2.2 Universal Coverage Health Insurance Scheme in Thailand

In Thailand first health card project (HCP) was initiated in 1983, was supported maternal and child health care (MCH) program only in rural area. In 1990 the new health card scheme was started named, voluntary health card scheme, and extended to urban area. Since 1993, the government has allocated an annual matching fund from tax revenue for HCP. It was a hope that the HCP will be made universal coverage of the country (8,9,10)

2.3 Thirty Baht Health Care Scheme

It was implemented to solve almost 20 million of Thai people who are without health insurance. Then, "Thirty Baht Health Care Scheme" was arranged for universal health coverage of whole health care reform. On the next steps, government will merge all various health insurance funds for unity. The main objective this scheme was to develop the country's primary health care system, and to encourage people to visit any health care units nearest to their home (11)

2.4 Village Health Volunteer (VHV).

Thailand has had enough experience about VHVs. They started as village volunteer in malaria control, continued to VHV formation and finally in 1978, the Ministry of public Health established VHVs in whole country (12) MOPH formulate identification and selection, criteria, roles and function, responsibilities of VHVs mainly on the 14 elements of PHC.

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2.4.1 Criteria for Selection of VHVs

Following six criteria are set for selection

To show regular willingness in helping others and enough free time for public

VHVs must live and work in village

The villagers must trust VHVs.

VHVs must have own occupation and ability to have own living

VHVs must live in house easily accessible to villagers.

VHVs should not be government official or village headman.

2.4.2 Roles and Functions of VHVs

Roles and functions are defined as below,

Provide health information to villagers in his/her respective areas.

Collect data from villagers regarding health related matters.

Disseminate knowledge, advise and stimulate his/her neighbors to utilize the government basic health care services.

Coordinate public health and other activities in village.

2.4.3 Responsibilities of VHVs

Below are the 14 main elements of the responsibility of PHC.

- Health education
- Locally endemic disease control
- Environmental sanitation and supply of safe water
- Immunization against communicable diseases.
- Nutrition
- Maternal child health care and family planning
- Treatment of common injuries and minor aliment
- Supply essential drugs for village use
- Dental health
- Mental health
- AIDS prevention and control
- Prevention and control of accidents, disaster and non-communicable diseases.

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1) Consumer protection for food and drug control program.
2) Pollution and environmental hazards prevention and control.

2.5 Participation

Community participation has long been recognized as an effective means of helping rural and urban people focus energy and mobilize resources to solve their health, environmental, and economic problems. When people from the community organize, plan, share tasks with professionals, contribute financially to projects or programs, and help make decisions about activities that affect their lives, programs are more likely to achieve their objectives.

Several countries have created ways for communities to participate in PHC programs. They have found that individuals make better choices about solving their health problems when they participate in the different activities in their villages or urban neighborhoods.

PHC-Amsterdam advocates strengthening managerial capacity in health at the lowest level possible; this implies in many cases that health centers/posts and NGO's can assist community health workers in implementing MCH, essential drugs distribution through community pharmacies, water and sanitation, health education strategies and so forth.

PHC has developed several tools, taking advantage of previous experiences. In terms of comprehensive primary health care they form together a community system, which enables its members to deal with health problems, and which at the same time relates efficiently to the formal system of the Ministry of Health or any private organization.

The tools include participate community assessments, means of visualization of problem analysis (charts, chance and risk mapping), training and supervision models for community health workers (VHWs, TBAs, and others), standards for provision of

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equipment and essential drugs packages to community pharmacies, guidance for home based care for the elderly and/or handicapped, health surveillance systems which link into the MOH information system, integrated community water and sanitation with construction of small infrastructure and hygiene education. An additional component is the community-based rehabilitation (CBR), which promotes the involvement of the handicapped, not only in their care, but in all aspects of everyday life.

Virtually lots of efforts, both intellectual and practical, have been made to devise strategies to improve the lives of the millions of disadvantaged people in the world in past decades. In these effort an important concept is the central importance of the people themselves participating in decision, and in the implementation and management of development programs and project. Participation has been widely recognized as both basic right of people and central importance to the success of development efforts. In most countries, the formal health service is supposed to look after. Community participation has therefore, come to be seen as a way of rapidly improving the health service available for the majority of the worlds people (13)

2.5.1 The meaning of people participation

Taecharin (1984) said that community participation is the process of promotion, leading, and support and creation opportunity for people and community in the form of individual, group of people, clubs, association , foundation and volunteer organization etc. to participation in any matter in order to achieve the objectives and designated development policy(14)

Hongwiwat(1984) define the community participation as people or community developed their abilities in management and and control resource distribution and input for the benefits in their economic living and society according to necessity with diginity as the member of society. The participation has developed knowledge and intelligence of people, which showed by the decision making for their life(15)

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Jamrik(1987) suggested the definition of organization participation as the learning process of each other and it may be the stable fundamental for evolution to self-government of local area at the end. He also talked about the beginning of organization that it began the participation in the activities, which have benefit for the whole. It was the activities, which have relation with problems and the needs of community (16)

Wuthimethee (1984) defined as the meeting of people's participation as opening the opportunity for people to participate in creation, decision making, perform and responsible in any matter which would effect to them. The leader should accept the rural development philosophy that all human desire to live with other people happily and had got fair treatment and had accepted by the people, ready to devote themselves for community activities. At the same time we should accept the reality that human could develop if they had chance and had got the right recommendation (17)

Rapeephat (1987) suggested the meaning of community participation that should let people find problems and does everything not determine by us. Every matter should be the idea of people (18)

2.5.2 Concept of people's participation

In people-centered approach participation has become an umbrella term for to development intervention. Participation as collaboration, participation as specific targeting of project benefits, participation as employment have been identified (19)

1) Participation as Collaboration

In this interpretation, people in less developed countries voluntarily, or as a result of some persuasion or incentive, agree to collaborate with an externally determined development project, often by contributing their labor and other resources in return for some expected benefit. An external agency, either the government or some other form of development agency sponsors people's participation, and in many instances this participation is programmed as project input.

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2) Participation as specific targeting of project benefit

One aim of people's participation increasingly has been to include that previously exclude groups, such as small farmers, landless people or the urban poor, in development activities by targeting benefits directly at them- the "project beneficiaries". As a reaction, however, to a rather " participation = benefit " interpretation, emphasis is often put on direct involvement in different stages of project practice.

3) Participation as empowerment

Increasingly participation as an exercise in empowering people has gained widespread public support, and the term has entered the development vocabulary. However, empowerment is a term, which is difficult to define. Some see it as the development of skills and abilities to enable people to manage existing development delivery system better and have say in what is done. Other sees it as more fundamentally people to decide upon and undertake the actions that they believe are essential to their own development.

2.5.3 Concept of community participation and health development in Thailand.

For the community participation in health care delivery: In the past the concepts about community participation in public health system emphasized the importance on primary public health concept; it rather focused on health promotion and disease prevention. It was the right direction because it was the activity, which had high cost-effectiveness, especially when compared with treatment activity. However it could not deny the demands of treatment service was the primary need of people because it related to illness which people had faced. When government public heath system still had not coverd all country and enough quality the participation of people in health service at community level phenomena had happened in different form. The objectives of community participation in heath service are not only for solving government health services. The reasons were that service and health service system had technical details to involve. Medical and public health officer had only considered about techniques so, it was the impediment for people to participate in decision making. The health personnel thought that people didn't have knowledge and lack of

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enough technique. As the result the concept which let people to participation in health service in order to respond to the need of people was the main issue which have to consider with solving services problems (19)

Maleehom (2002) studied participation and factors associated with community participation in government hospital service at Thauung hospital. She found that people's participation in hospital based health care has decrease. However it was also noticed that people had higher participation in level 1 i.e. participation in the benefit which have got from hospital level 2 participation in hospital development activities and level 5 participation in hospital project planning(19)

2.5.4 Community action for health

Community involving in health (CIH) derives its conceptual strength from the emerging trend towards "peoples participation" in the 1970 and 1980s. A more recent evolution of the concept has been termed "community action for health "(CAH). This stresses the notion of "action"and suggests a more proactive and direct involvement of people in health development at a local level.

CAH must be understood as a complete and sustainable process in which community – social, geographical or professional. CAH is involved as a full partner at all stages of the health care process; identification of needs, selection of priorities, planning, implementation and evaluation of activities occur in close cooperation with the formal health sector, as well as with other sector concerned. It is at the same time a basic concept and an essential part of the public health programme. CAH therefore implied partnership between health service and communities, a proactive role for the community and, consequently, the "obligation of formal sector to share power rather than merely to foster cooperation. In context of the community action for health the community is an agent for health and development, rather than a passive beneficiary of health and development programmes".

CAH is a concept, which has been debated in WHO over a long period of time. As follows,

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1) Community of purpose: between the formal health service and the local population in a health development partnership. In this respect it is important to consider what measure will be needed to establish this community.

2) Sharing of knowledge: both the community and formal health structure will have knowledge to contribute to the common purpose of health development and this knowledge must be shared and respected by both sides.

3) Goals and objectives: agreeing on common goals and objectives, which are intelligible on both sides. They must be realistic and allow the partnership to make up at least some achievement from an early stage.

4) Training: the recognition that the training of health workers, particularly on district level, in the skill necessary to promote partnership and community involvement " will ultimately be as important as preparing staff for other technical and administrative responsibilities".

5) Political support: particularly within the health sector and aqt the district level. Political support is the source of policy and the decision and resources necessary to support a process of CAH (20)

2.5.5 Characteristics and type of participation

Taecharin (1984) had mention the stage of participation for achieving the objective and development policy as (14), participate in studying, searching the problems and cause of problem, which happened to community including the need of community. Participate in developing and creating development method, solving and reducing community problems for create new thing, which benefit to community or responding to the needs of community. Participate in laying out policy or plan project or activity in order to abolish and solve problem and responding to needs of community. Participate in decision making on using limited resources for the benefit of all. Participate in handling or improving development management system to have effective and efficiency. Participate in project investment according to the capacity of

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themselves and organization development. Participate in policy, plan, project, and activity implementation in order to achieve the goal. Participate in controlling; follow up, evaluationing and maintaining the project and activity which setting by private and government sector to make use of them forever

2.5.6 Factors affect on the people participation

Readers (1980) summarized factors affect on the people participation as follow.

According to a basic belief that is person or group of people seem to choose practices in according to their basic belief. According to standard, person or group of person seems to practice in his or her own standard.Target, person or group of people seems to enhance, protect and save their own targets.

The unusual experience, individual and group of people's behavior, sometimes come form a basic unusual experience. Expectation, both individual and group of people would practice as they expect that they must behave according to such situation. They also fond of practices to any people in a manner of their expectation from other people. Self-introverts, most people would like to do something that they should do compulsory, people or individual should do what they feel that they forced to do.

Habit and tradition, they should do with a feeling to their habit and tradition. Opportunity of such people or individual usually dealt with them in terms of social practice especially concerning them in such participation. Ability that belongs to each individual or people may play the important role in the participation. They usually take part in such activity according to their ability. Good support could play a major role when individual or people receive such a good support to participate in the activity (21).

2.5.7 Advantage of participation

The following are among the more substantive arguments for the participation of the public in development projects (22).

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Coverage

Most government, and many agency-directed or agency-supported, development projects reach only a limited, and usually privileged, number of people. Delivery services often have contact with only a small fraction of the population. Participation will extend this coverage, in that it will bring more people under the direct influence of development activities. Participation will increase the number of potential beneficiaries of development and could attract more public support for health and similar services.

Efficiency

With willing participation by all those concerned in planning, implementation, monitoring, and evaluation, there should be greater coordination of resources, activities and efforts. This should reduce duplication of efforts and resources as well concentrate the action on fewer areas of work at any time.

Effectiveness

After there is agree about priorities, those interested in working specifically in the relevant areas can pool efforts to determine goals, objectives, plan and strategies for action and give local efforts the benefit of their knowledge, skills and resources.

Equity

By participating in development projects, community members can promote equity through sharing of responsibility, solidarity, serving those with the greatest need and at the greatest risk, and seeking to promote better health for the hundreds of million of people who will do not enjoy access to the necessary resources and services.

Self-reliance

Participation promotes self awareness and confidence and cause people to examine their problem and to think positively about solutions. Participation at community level increase people’s sense of control over issues that affects there lives,

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help them to learn how to plan and implement activities, and on a broader front, prepare them for participation at regional or even national level.

2.5.8 The participation measurement

Kasperson and Breibat (1985) suggested the 3 participation measurements as follows:

Action have been done by the individual not by in-group in the participation process would indicate to the social value or acceptance and behavior of each individual. That was the action of participation referred to the action that individual performed in directly response to such action.

The frequency of action by the frequency participation, a long duration of activity of the connection and incentives to the action.

The quality of participation in the examination resulted and effected on the primary action such as responsibility, decision making, ability of acceptance, opinion of acceptance, and evaluation (21).

From the concept and literature review, the researcher had summarized the activities and level of participation in the universal coverage health insurance program as follows:

The activities of participation in the universal coverage health insurance program will be developed from Nakhon Rachasima's primary care unit services pattern. There are activities that VHVs could participate as follows:

1) The dissemination of information and working for 30 bath health care scheme
2) Recording of family folders
3) Identifying of the problem and in the planning
4) Prevention activities
5) Health promotion activities

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6) Screening and treatment
7) Home visit and rehabilitation
8) Local wisdom conservation activities

2.6 Attitude

Attitudes are describable as learned predisposition to respond in consistently favorable manner with respect to a given object (23).

Downie et.at (1996) concluded that attitudes have several dimensions. They are positive, negative or neutral. We can now develop this characterization by adding further dimension, beginning with extremeness and strength. Extremeness refers to the extent of direction, to how positive or negative the attitude is. Strength can be regarded as an indication of the stability of an attitude, of its resistance to change. It is product of extremeness together with the length of time for which the attitude has been held and like extremeness it is also affected by the individual's own personality, the attitudes of the reference groups to which the subject belongs and the degree of integration of this attitude with his or her other attitudes. A fourth dimension of attitude, the degree to which it is related to and integrated with other attitudes, is known as the isolation of the attitude. The less isolated and attitude, the resistant it is change (24).

There are many measurement judgments of attitudes. One popular and acceptable method is the Likert method or Likert scale (1976). In a Likert scale, a series of attitude statement (including extreme statement clearly favorable and unfavorable) is presented, and respondent are asked to indicate their strength of agreement or disagreement with each statement. A graded scale is provided, which is balanced around a neutral point and has the same number of positive and negative symbols. Usually a five-point scale is used, ranging from 'strong agree' to 'strong disagree'. An attitude score is computed by totaling respondent's answers to different items.

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Likert described that the personal attitude to objects, situation and other people have three components (25).

1) Cognitive or belief and idea
2) Affective or evaluation
3) Cognitive, which included behavior tendencies or intentions.

The attitude towards participation as: Reader had explained (1974) about reason in doing something of people that it depended on many factors which so called believe or unbelief. It had not limited by expressed the form of idea or attitude differently according to the idea of people towards the thing so that it depend on experience and knowledge they had got (19). Suwan (1997) said that attitude of people was the thing that had effect to the performance or activity of people (26).

Singh (1976) said that attitude about participation was the thing that fixed the level of participation (19).

Lertwilai (1997) studied the factors, which had effect to the level of participation of community leader in community hospital implementation in Ayudhaya province, and found that community leader had attitude towards hospital director and officer in hospital implementation with positive relationship with community participation in hospital health services.

Maleehom (2002) shown that most of respondents had positive attitude towards the participation in health and hospital development (19)

2.7 Social activity

Virtually in developing community involving in health, leadership plays a critical role. It may be inside or out side the community. Both traditional and external agent will have a role to play but external agent should never be the dominant force. The gradual deprofessionalization of health services and health care will help establish condition in which community involving in health can function as a useful partnership between the different categories involved in health development (13).

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Weber (1976) thought that value, tradition, culture had a share to fix or as the factors in social activity of people. The participation in any social activity of people or group of people was the matter of mind, which they wanted to participate in such activities in order to achieve there or group of people goal (19).

Rakchat (2001) studied factors affecting the participation in local development of TAO committee in Chonburi province. She found that half of the sample group is voluntary scout. The reason is voluntary scout is a social member of country, and this group is in every area in Thailand. The sample group was being a social member at middle level. Also there is 83.5% of sample tending to more involve in social member (27)

From study of related researches, they concluded people with high social member had more than people participation without social member (28)

2.8 Social support sources

2.8.1 Social support

The social support will be defined as in different ways. Cobb (1979)

Defined as information leading one to believe that he or she belongs to one or more the following three classes: cared for or esteemed, loved or valued, and belonging to a net work communication and mutual obligation (29).

House (1981) defined Social support functional concept of relationship that can be categorized along four broad type of supportive behavior or acts. Emotional support involves the provision or empathy, love, trust and caring and has the strongest, most consistent relationship to health status. Instrumental support involves the tangible aid provision and services that directly assist a person in need. Information support is the provision of advice, suggestions and information that is useful for self-evaluation purposes, that is, feedback, affirmation, and social comparison (30).

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2.8.2 Support mechanism for participation

It is a vast agreement that involvement in health development (CIH) can not be instituted and developed without the support of appropriate mechanisms as different levels. Such mechanism can exist and operate at both national and community levels and is indispensable for the process of CIH has begun to develop, it has done so with assistance of a variety of support mechanisms. The following is a composite list of the factors considered to be of critical importance if a support mechanism for CIH is to succeed: political commitment, Reorientation of bureaucracy, development of capacity for self-management, and minimum basic health structure and coverage.

1) Political commitment to CIH.The most fundamental support for the CIH process determined the decentralization mechanism. It is a process of participation, is indispensable for creating the conditions favorable to increasing involvement. In political commitment, community development will be flourish and also deliberately hindered.

2) Reorientation of the bureaucracy in support of CIH. When the government bureaucracy is reoriented to support process, the administrative support for effective CIH will be materialized. Because bureaucracies have to designed to pass down policy and information. Otherwise it may be inflexible and CIH will never flourished until bureaucratic structure radically reoriented their procedure and behavior.

3) Development of capacity for self-management. Local people skill is very important for build up the organization and management abilities for CIH, therefore, it is necessity to develop local ability to assume full responsibility for health care.

4) Minimum basic health structure and coverage. CIH can not be implemented unless there is at least a minimum health care infrastructure, fairly widespread access to health services, and national and local financial resources to support those services.

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2.8.3 Measurement of support

The most important distinction between social networks and the functional aspects of support is that the quality and type of the support provided by network member. Social network referred to the social contacts of a group of persons. Such contacts can be described in terms of number contacts and frequency of contacts. These measures can be further refines by separating them into the number of contact from the primary group or group of persons to whom the subject is most attached, and from more distant contacts, less likely to provide meaningful support. Other useful measures include density of the network, where it is estimated how much each net work member is in contact with each other- this gives some idea of integrated members. Such measures are also probably less susceptible to reporting socially desirable responses. These measures can provide an index of social integration, how much the individual is part of community of mutual obligation and exchange- thus linking the need of the individual with those of wider society.

In general, type of support may be divided into 'emotional' and 'practical' or 'instrumental' support. In some studies other aspect of support have been identified which may be allied to emotional support. These include 'information' support where support sources provide information, which may be helping the respondent in problem solving. Further important components of emotional support to self- appraisal, providing support that boost self esteem and encourages positive self- appraisal. Practical support is manifest in many forms, including practical help and financial support.

In conclusion, social support is a basic human need. It is considered to be person-environmental interaction that decreases the occurrence of stress. It is a reciprocal process and an interactive resource that provide comfort, assistance, encouragement, and information. The amount and sources of social support needed vary across the life span and across in a given situation (31).

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2.9 Socio-demographic correlated participation of VHVs

From the study of related researches, they showed factors of socio-demographic correlated with participation such as; sex, age, education, and occupation. About gender they concluded men had more participation than women. Many researchers concluded that older people had more participation than younger people. The people have higher education had more participation than low education. In term of occupation, many researchers concluded that occupation influenced people to take part (28).

2.10 The Precede Proceed Model

The Precede model is a framework for process of systematic development and evaluation of health education program. An underlying premise of this model is that health education is dependent on voluntary cooperation and participation of the client in a process, which allows personal determination of behavioral practices. It also states that the degree of active participation of the client. Therefore, in this model, appropriate health education is considered to be the intervention for a properly diagnosed problem in a target population. The comprehensive nature of PRECEDE allows for application in variety of settings such as school health education, patient health education, community health education and direct patient care settings.

Proceed was added to the model in the late 1980s based on L. Green's experience with Marshal Krueter in various positions with the federal government and the Kaiser Family Foundation. Its addition to the framework was in recognition of the emergence and need for health promotion interventions that go beyond traditional educational approaches to changing unhealthy behaviors. The administrative diagnosis is the final planning step to " |precede" implementation. From there "proceed" to promote the plan or policy, regulate the environment and organize the resources and services, as required by the plan or policy.

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The purpose of PRECEDE/PROCEDE model is to direct initial attention to outcome rather than inputs. This forces planner to begin the planning from outcome point of view. In other words, program planners begin with desired outcome and work backward to determine what cause it (what precede the outcome). Intervention is targeted at the preceding factors that result in the outcome.

2.10.1 Description of the model

Precede-the first 5 phases.

Phase 1- Social Diagnosis

Phase 2- Epidemiological Diagnosis.

Phase 3-Behavioral and Environmental Diagnosis

Phase 4 –Education and organizational Diagnosis

Phase 5-Administrative and Policy Diagnosis

Proceed-the second 4 phases

Phase 6-implementation

Phase 7-Process Evaluation

Phase8-Impact Evaluation

Phase 9-Outcome Evaluation

Phase 1-Social diagnosis

The focus of this phase is to identify and evaluate the social problems that impact the quality of life of a target population. Methods used for social diagnosis may be one or more of the followings:

Community Forums

Nominal Groups

Focus Groups

Surveys

Interviews

Central location intercept

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Phase 2-Epidemkiological diagnosis

It helps to determine health issues associated with the quality of life. The focus of this phase is to identify specific health problem and non-health factors, which are associated with a poor quality of life. Examples of Epidemiological data are vital statistics, years of potential life loss, disability, prevalence, morbidity, incidences, and mortality

Phase 3- Behavioral and environmental diagnosis

Behavioral Diagnosis is the analysis of behavioral links to the goals or problems that are identified in the epidemiological or social diagnosis.

Environmental Diagnosis is a parallel analysis of factors in the social and physical environment other than specific actions that could be linked to behaviors.

Phase 4-Educational diagnosis

Three kinds of causes are identified

Predisposing factors such as knowledge, beliefs, values, and attitudes.

Enablers such as accessibility, availability, skills, laws (local, state, and federal) Reinforces such as family, peers, teacher.

Phase 5- Administrative and policy diagnosis

Administrative Diagnosis is the analysis of policies, resources and circumstances prevailing organizational situations that could hinder or facilitate the development of the health program.

Policy Diagnosis is to assess the compatibility of your program goals and objectives with those of the organization and its administration; does it fit into the mission statements, rules and regulations.

Phase 6- Implementation of the program

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Phase 7- Process evaluation

It is used to evaluate the process by which the program is being implemented.

Phase 8- Impact evaluation

Measures the program effectiveness in terms of intermediate objectives and changes in predisposing, enabling, and reinforcing factors.

Phase 9- Outcome evaluation

Measures change in terms of overall objectives and changes in health and social benefits or the quality of life. It takes a very long time to get results and it may take years before an actual change in the quality of life is seen.

2.10.2 Key Terms

PROCEED is an acronym for Predisposing, Reinforcing, Enabling, Causes in Educational Diagnosis and Evaluation.

PROCEED is an acronym for policy, Regulatory, Organizational constructs in Educational and Environmental Development.

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CHAPTER 3
RESEARCH METHODOLOGY

3.1 Study Design

This research is a cross –sectional descriptive study. The dependent variable is the participation of the VHV in PHC activities in Phutthamonthon, Nakhonpathom, Thailand. The primary health care activities, which VHVs involved, may be measure in frequencies and classified in 3 levels of participation. The independent variables include VHV's socio-demographic characteristics, a member psychosocial factor and working factor towards participation of VHV's activities

3.2 Study Population

The target populations in this research are VHVS who have registered, carried out PHC activities and lived in area under responsibilities of District Phutthamonthon.

3.3 Sample Size

Whole population of 143 VHVs in district was sample size, 132 were respondents overall 92.3% response rate.

3.4 Methods of Data Collection

3.4.1 Research Instrument

The instruments in data collection are required, structured questionnaires that consists of 4 parts.

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Part 1: Socio-economic factors

Consisted of age, gender, marital status, education, occupation and family income.

Part 2: Psycho-social Factors

(A) Attitude

Positive and negative attitude will be observed.

(B) Social support

emotional, instrumental and information supports were analyzed.

Part 3 working factors.

Family, villagers, local leaders, and health officers for participating in the PHC activities in the village. A 4 pints response format will be used through choice of response, high, moderate, low and no support.

Part 4: Participation of VHVs in their work place

VHVs will be asked the question about the PHC activities in the district.

3.4.2 Pretest of Questionnaire.

Prior to data collection, a pre-test with 30 VHVs will be carried out in the Near by district.

Thereafter, the reliability and validity of questionnaire among attitude towards PHC will be carried out

3.4.3 Data Analysis

Data will be analyzed by using computer software, mini-tab version 14. Descriptive analysis will be done to describe the socio-economic characteristic psychosocial factors and working factors and participation of VHVs in PHC, descriptive statistics using frequency, mean, median, standard deviation, minimum and maximum.

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Using chi-square statistical technique to determine the significance association between dependant and independent variables will be done bivariate analysis. The critical significance level of chi-square test at 0.05.Testing value used, compare between VHVs PCU and out side work is measured.

The result will be presented by two statistical methods, first by frequency distribution for Socio-economic characteristics, and psychosocial factors working factors and participation of VHV in PHC. Mean and standard deviation will be computed for total score of the factors and participation of VHVs in PHC.

Second inferential statistics will be used to present the results. The analysis of association between participation of VHVs in PHC and socio-economic characteristics, psychosocial factors and working factors will also be analyzed and will be elaborated by Chi-square and p-value. The critical significance level of all statistical tests will be set at alpha equal to 0.05.

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CHAPTER 4
RESULTS

This research is aimed to study the participation of VHVs in PHC in Phutthamonthon District, Nakhonpathom Province Thailand. The data was collected from132 VHVs whom had been working in different health centers in whole district. Researcher carried out pre-test on sample of 30 VHVs an near by district for to assess the reliability and validity of research instrument prior to data collection. The presentation of results in this chapter is divided into following parts.

Characteristics of sample

4.1 Socio-demographic factors
4.2 Psychosocial factors
4.3 Working factors
4.4 Participatory factor
4.5 Association between all factors with participation

4.1 Socio-demographic factors

Total number of 132 VHVs interviewed, most of them 70.5 were female, and many of them were aged more than 46years (48.1%) with mean 46.35 years with st.dev.11.898, min=16,max=76years, majority 70.5 of VHVs were married, 73.5% of VHVs completed their basic requirement primary education and 26.5% got secondary education higher and vocational. It is observed that main occupation 43.9%of VHVs were agriculture, 25% were employee and 15.9% were merchant, majorities of them have enough income with saving 50% and enough income but not savings 42.4% as shown in table 2.

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Table 2 Number and percentage distribution of VHVs by socio-demographic Characteristics.

Characteristics		Number	Percentage
Gender	Male	39	29.5
	Female	93	70.5
Age	16-25	5	3.8
	26-35	15	11.5
	36-45	48	36.4
	≥ 46	63	47.7
mean = 46.35 SD = 11.89 min. = 16 max. = 76			
Marital status	Single	19	14.7
	Married	91	70.5
	Widow	16	12.4
	Divorce/separate	3	2.3
Education level	Primary school	97	73.5
	Secondry school	24	18.2
	Vocational	2	1.5
	Bachelor/higher	9	6.8
	Others(specify)	0	0
Occupation	Agriculture	58	43.9
	Merchant	21	15.9
	Employee	33	25
	House wife	9	6.8
	Not working	6	4.5
	Others	5	3.8
Family income	Enough and some saving	66	50
	Enough but no saving	56	42.4
	Not enough but no debts	8	6.1
	Not enough and has debts	2	1.5

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4.2 Psycho-social Factor

4.2.1 Attitude

In this study, level of attitude in PHC of the VHVs was divided into 2 groups as positive and negative attitude. Of the total score of 39, average attitude score was 37.6. Therefore, VHVs who had more than or equal to 38 was categorized as positive attitude and VHVs who had total score equal to or less than 37 was categorized as negative attitude. There were 68 VHVs (64.8%) got positive attitude level and the rest (35.5%) got negative attitude level. (Table 3)

Table 3 Number and percentage of VHVs classified by attitude level

Level of attitude	N = 127 n	Percentage
Positive	68	64.8
Negative	37	35.2

4.3 Social factor

Source of emotional support VHV

Table 4 analyzing the emotional source of support in which researcher has divided it in to four parts, no, low, moderate and high, the results showed that health personal is major source of support (68.2) and local government is second source (13.6). In moderate support relatives 51.5%, neighbors 56.1% and group/committee supports the VHVs in emotionally.

Source of instrumental support VHV

Table 5 showed source of instrumental support and health personnel is main Source of high support with it 68.2% and here also local government is second source of high level of Support with 16.7%, and in moderate level of support 42% group/committee is main source of support.

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Source of information support for VHV

Table 6 analyze the source of information support which showed that health personnel is main source of high information support with 78% and local government is on second number 20.5% and in moderate support group/committee has major share 48% and neighbor 46.2%.

Table 4 Number and percentage of respondents classified by level of emotional support

Person/group	N	Number (Percentage)			
		No	Low	Moderate	High
Relative	132	12 (9.1)	39 (29.5)	68 (51.5)	13 (9.8)
Health personnel	132	1 (0,8)	3 (2.3)	45 (34.4)	90 (68.2)
Neighbor	132	5 (3.8)	44 (33.3)	74 (56.1)	9 (6.8)
Group /committee in community	132	5 (3.8)	50 (39.9)	64 (49.2)	12 (9.1)
Religious priest	130	30 (23.1)	46 (35.4)	43 (33.1)	11 (8.5)
Local government	132	12 (9.1)	51 (38.6)	51 (38.6)	18 (13.6)
Other	9	1 (11.1)	1 (11.1)	3 (33.3)	4 (44.4)

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Table 5 Number and percentage of respondents classified by level of instrumental Support

Person/group	N	Number (Percentage)			
		No	Low	Moderate	High
Relative	130	37 (28.5)	46 (35.4)	41 (31.5)	6 (4.6)
Health personnel	132	0	2 (1.5)	40 (30.3)	90 (68.2)
Neighbor	131	29 (22.1)	46 (35.1)	52 (39.7)	4 (3.1)
Group /committee in community	131	3 (11.5)	52 (39.7)	55 (42.0)	9 (6.9)
Religious priest	131	51 (38.9)	41 (31.3)	33 (25.2)	6 (4.6)
Local government	132	18 (13.6)	51 (38.6)	41 (31.1)	22 (16.7)
Other	8	1 (12.5)	1 (12.5)	2 (25)	4 (50)

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Table 6 Number and percentage of respondents classified by level of information Support

Person/group	N	Number (Percentage)			
		No	Low	Moderate	High
Relative	130	22 (16.9)	42 (32.3)	54 (41.5)	12 (9.2)
Health personnel	131	1 (0.8)	1 (0.8)	27 (20.6)	102 (77.9)
Neighbor	130	12 (9.2)	45 (34.6)	60 (46.2)	13 (10.0)
Group /committee in community	131	10 (7.6)	44 (33.6)	63 (48.1)	14 (10.7)
Religious priest	131	46 (35.1)	34 (26.0)	39 (29.8)	12 (9.2)
Local government	132	17 (12.9)	47 (35.6)	41 (31.1)	27 (20.5)
Other	7	1 (14.3)	3 (42.9)	0	3 (42.9)

4.2.3 Social activities

It was found that many of the VHVs are involving in other social activities, as VHVs society 84.1%, health promotion club 75.7%, agriculture group71.6%, economic group 71% and cooperative group 58.9% as well as elderly group 56.2% and also in other group as mention in table 7 in Appendix A.

4.3 Working factors

4.3.1 Duration of living in village

Table 7 show that respondent living in village are more from 41-50 years (29.5%), >50years are 20.5% with Min.2years to Max.76 years.

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Table 7 Number and percentage of VHVs duration of living in village.

Duration of living in village	N	Percentage
1-10 Years	11	8.3
11-20 Years	21	15.9
21-30 Years	14	10.6
31-40 Years	20	15.2
41-50 Years	39	29.5
>50 Years	27	20.5

Mean = 37.27, Median = 40, Standard Deviation = 17.84, Minimum = 2 and Maximum = 76

4.3.2 Distance in kilometers of nearest health center

Nearest house of VHVs were on only 20 meters, farthest was on7 km with mean=2.28, median =2.0 and SD=1.58, Minimum = 0.02 and Maximum = 7

4.3.3 Familiarity with village of VHV

This Table 8 indicates that majority of VHVs (56.2%) are familiar with almost all of villages and 39.2% are familiar with around half of villages in their district.

Table 8 shows how many villages familiar with (130)

Familiarity with villages	N	Percentage
Most of them	73	56.2
Around half	51	39.2
Less than half	6	4.6

4.3.4 Number of house holds in a village

Smallest number is 27 houses in village of VHVs and largest number is 2352 household, with Mean = 447, Standard deviation = 641, Minimum = 27 and maximum = 2352.

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4.3.5 Need of VHV in situation of villages

As mention in table 9, (76.0%) respondents has responds that VHVs are needed in situation of villages and 21% of VHVs feel urgent need of VHVs in situation of their villages and only 4(3%) answered in negative.

Table 9 Level of need

Level of Need	No.	Percentage
Urgent Need	27	20.9
Needed	98	76.0
Not Needed	4	3.1

4.3.6 Duration in years registered as a VHVs

The main purpose of researcher is to identify the duration of being as VHVs results shows that they are working as volunteers from one year to 40 years with Mean = 8.37, Median = 6.0, Standard Deviation = 8.13, Min = 1 and Max = 40

4.3.7 How often plays a role as a VHV

In table 10 VHVs responded that majority of them 86% play role as VHVs once a week, 7.8% play role twice a week and 6.2% were not playing any role as VHVs in their community.

Table 10 Role as VHV

No of visiting times / week	N	Percentage
Not at all	8	6.2
Once a week	111	86.0
Twice a week	10	7.8

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4.3.8 Difference before and after 1998 work as a VHV

The researcher wants to know for any difference in work of VHVs before and after crises of 1998, result shows that there are 67% VHVs whom feel that there is difference in their work before and after crises of 1998.

Table 11 Difference of work as VHVs before and after 1998

Work difference	N	Percentage
Yes	84	66.7
No	42	33.3

4.3.9 Personal relationship with health staff

Table 12 shows that majority of VHVs 64.7% have good relationship with health staff and 34% of them have fair relation.

Table 12 Personal relationship with health staff

Relationship	N	Percentage
Good	84	64.7
Fair	44	33.8
Poor	2	1.5

4.3.10 Average visit of health officer

Result of analysis shows that average of visit of health officer is 2 per month that is varying from 0 to 12 times with median 1 and SD: 2.41

(Mean = 2.06, Median = 1.0, Standard Deviation = 2.41, Min = 0 and Max = 12)

4.3.11 How did you become VHV

Table 13 shows that 54% were self- nominated and 31% appointed by headman/health officer and 12% are elected by villagers.

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Table 13 The way become VHV

How become VHV	N	Percentage
Self nominated	71	54.2
Elected by villagers	15	11.5
Appointed by head man / health officer	45	34.4

4.3.12 Are you happy now or at first time becoming VHVs?

Results shows that 63.8% VHVs are happy to become VHVs as compare with 31.5 are same or no difference in becoming VHVs now and when they become VHVs first time (Table 14).

Table 14 Happiness to become VHVs

Happiness	N	Percentage
More	81	63.8
Less	6	4.7
Same	40	31.5

4.3.13 Why did you want / accept as a VHV?

Majority 58% VHVs wants to do some thing for helping of their community and some 26% want respect or good relations, as shown in Table 15

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Table 15 Number and % of reason of becoming VHV.

Reason	N	Percentage
Free Medical care	16	12.2
Respect or good relations	34	26
Do something for helping community	76	58.0
More suitable for me	5	3.8

4.3.14 After becoming VHV has got popularity to be elected as a village headman

Table 16 shows that 38% have no any opinion on popularity to become village headman and 32% disagree to become headman only 29.5% agree that they want to become popular as to become headman.

Table 16 Number and % of VHVs want popularity as head man

Popularity	N	Percentage
Agree	36	29.5
No opinion	47	38.5
Disagree	39	32.0

4.4 Participation towards PHC activities.

These results indicate that majority of VHV have only one activity as show in table 18 and table 17 shows that most of them 111(84.1%) participate their activities at health centers and 35% plays their role only in one place of work (Tick=participating, no tick not participating).

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Table 17 Number and % of participation at places of work.

Places of work	N	Percentage
PCU	32	24.2
Health center	111	84.1
PHCC	53	40.2
Mobile clinic	21	15.9
Home visit	40	30.3

Frequency as more than one activities.(0-6 activities)

Table 18 Number and % of participation of VHVs more than one place.

Number of work places	N	Percentage
0	16	12
1	46	34.8
2	27	20.5
3	20	15.5
4	16	12
5	6	4.5
6	1	0.8

4.4.1 Participation of VHVs in PHC

The result indicated that most of VHV had some participation in PHC (Table19 in Appendix A) some of VHVs 0.8 –41.2% had never participated in all activities at different level of participation some of these activities are like, principle physical examination for patient 24.4%, The use of remedies or other medicines as recommended by MOPH (28.2 %) weighting under5 year old children for nutrition 30.5 % providing of family profile 31.8%. Compiling the problems about use of 30 Baht care 40.5% and registration of qualified villages to use 30 Baht card etc. in these activities 41.2%.

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Over all, most of activities such as, motivating the people to participate in health projects 44.7%, campaigning for cleaning a community 46.5%, persuading villagers for exercise 53%, provisions of sanitation improvement and safe drinking water 45%, prevention of contamination of food or poisoning 37.7 had better participation as most often and every time activities at their villages.

4.5 Factors affecting the participation of VHV in PHC.

4.5.1 Association between socio-demographic factors and participation.

The scores of participation were made association with socio-demographic characteristics age, gender marital status, education, occupation and family income. The characteristics of age gender marital status, education, occupation and family income were not significantly associated with participation (see table 19) P-value> 0.05.

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Table 19 Association between socio-demographic factor and participation.

Socio-economic factors	Level of participation					
Factor	Low n (%)	Moderate n (%)	High n (%)	χ^2	df	P-value
Age				1.586	2	0.453
<=40	5 (12.5)	29 (72.5)	6 (15.0)			
>40	10 (14.3)	43 (61.4)	17 (24.3)			
Marital status				.593	2	.743
married	10 (13.5)	47 (63.5)	17 (23.0)			
Others	5 (13.9)	25 (69.49)	6 (16.7)			
Education				5.854	2	0.054
Primary school	9 (11.4)	49 (62.0)	21 (26.6)			
others	7 (11.9)	41 (69.5)	11 (18.6)			
Occupation				.922	2	.631
Agriculture	8 (15.7)	31 (60.8)	12 (23.5)			
others	7 (11.9)	41 (69.5)	11 (18.6)			
Family income				4.895	2	.086
Enough and save	7 (12.5)	33 (59.0)	16(28.)			
Enogh but no save	8 (17.4)	33 (71.7)	5 (10.99)			

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4.5.2 Association between psycho-social factors and participation

Association between attitude factors and level of participation

The results of table 20 bellow that VHVs who have positive attitude were more likely participating in PHC activities. Results are statistically significant (P-value=0.04). It shows association between attitude and participation.

Table 20 Association between attitude and Participation

Attitude	Level of participation			c^2	df	P-value
	Low n (%)	Moderate n (%)	High n (%)			
				6.441	2	0.040
Positive	8 (11.6)	41 (59.4)	20 (19.0)			
Negative	7 (18.9)	27 (73.0)	3 (8.1)			

4.5.3 Association between support factors and participation

Association between emotional support and participation

As mention in table 21 about emotional support it shows that relatives (P-Value 0.001), neighbor (p-vaue0.004), group/committee in community (p-value 0.004), religious priest (p-value <0.001) and local government (p-value =0.003) are significantly associated with participation of VHV in PHC only health personal has no association with participation (p-value.429).

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Table 21 Emotional support factor associated with participation

Emotional support factors	Level of participation			c^2	df	P-value
	Low n (%)	Moderate n (%)	High n (%)			
Relatives				20.926	2	<.001
No or low	10(23.3)	33 (76.7)	0			
Mod or high	5 (7.5)	39 (58.2)	23(34.3)			
Health personnel				1.691	2	0.429
Moderate	5 (14.3)	25 (71.4)	5(14.3)			
High	9 (12.7)	44 (62.0)	18(25.4)			
Neighbor				11.127	2	.004
No or low	8 (19.0)	32 (76.2)	2 (4.8)			
Mod or high	7 (10.3)	40 (58.8)	21(30.9)			
Grpou/Committee in community				11.085	2	0.004
No or low	8 (16.7)	37 (77.1)	3 (6.3)			
Mod or high	7 (11.3)	35 (56.5)	20 (32.3)			
Religious piest				22.744	2	0.000
No or low	11(16.7)	51 (77.3)	4 (6.1)			
Mod or high	4 (9.3)	20 (46.5)	19 (44.2)			
Local govt.				11.817	2	.003
No or low	8 (14.8)	42 (77.8)	4 (7.4)			
Mod or high	7 (12.5)	30 (53.6)	19 (33.6)			

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4.5.4 Association between instrumental support and participation

In case of instrumental support table 22 shows that neighbors, group/committee religious priest and local govt. are significantly associated with participation in PHC with P-value < 0.05 and relatives and health personnel are not associated with Participation of VHVs in PHC,P-vaue>0.05.

4.5.5 Association between information support and participation

In information support that relative, neighbors, group/committee Religious priest and local government are significantly associated with participation of VHV in PHC P-value less than 0.05 and health personnel is not associated with participation of VHVs in PHC activities P-value 0.268 (Table23).

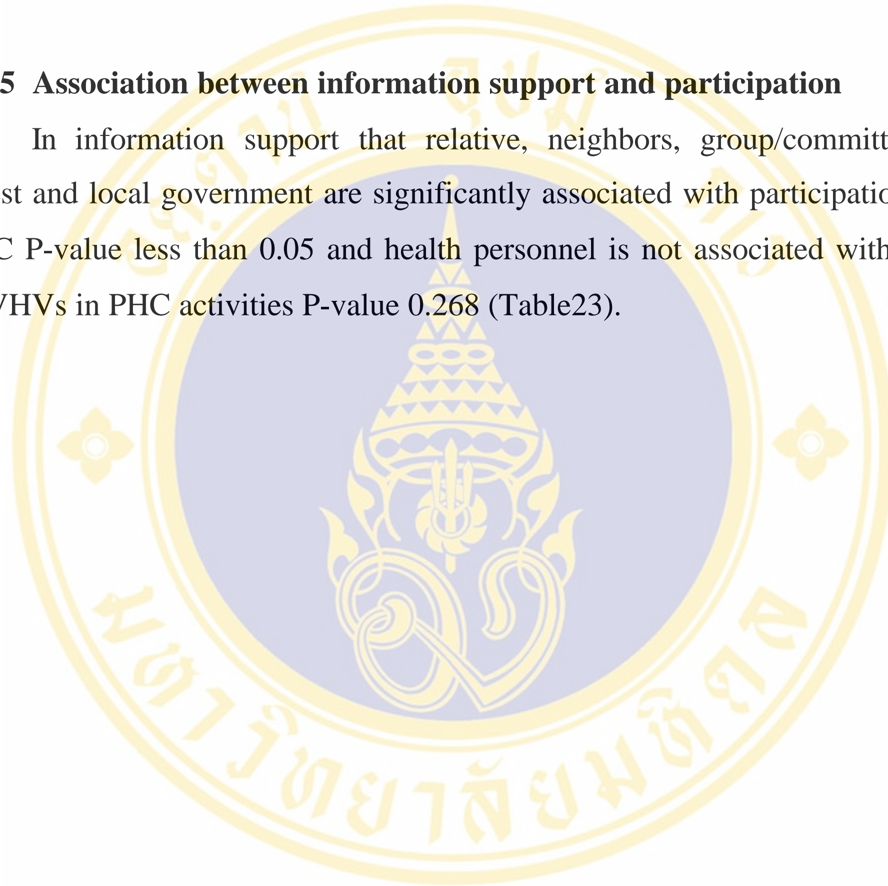

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Table 22 Instrumental support factors associated with participation

Instrumental support factors	Level of participation			c^2	df	P-value
	Low n (%)	Moderate n (%)	High n (%)			
Relatives				1.075	2	.584
No or low	13 (19.4)	50 (74.6)	4 (6.0)			
Mod or high	2 (4.8)	21 (50.0)	19(45.2)			
Health personnel				2.392	2	.302
Moderate	5 (15.2)	24 (72.7)	4 (12.1)			
High	10 (13.3)	46 (61.3)	19 (25.3)			
Neighbor				15.334	2	.000
No or low	11 (17.5)	47(74.6)	5 (7.9)			
Mod or high	4 (8.5)	25 (53.2)	18 (38.3)			
Grpou/Committee in community				13.811	2	.001
No or low	9 (15.8)	44 (77.2)	4 (7.0)			
Mod or high	6 (11.3)	28 (52.8)	19 (35.8)			
Religious piest				32.319	2	<0.001
No or low	12 (15.6)	60 (77.9)	5 (6.5)			
Mod or high	3 (9.1)	12 (36.4)	18 (54.5)			
Local govt.				17.543	2	<.001
No or low	9 (15.8)	45 (78.9)	3 (5.3)			
Mod or high	6 (11.3)	27 (50.9)	20 (37.7)			

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Table 23 Association between information support and participation.

Informational support factors	Level of participation			c^2	df	P-value
	Low n (%)	Moderate n (%)	High n (%)			
Relatives				16.965	2	<0.001
No or low	11 (20.4)	40 (74.1)	3 (5.6)			
Mod or high	4 (7.3)	31 (56.4)	20 (36.4)			
Health personnel				2.832	2	.268
Moderate	3 (13.0)	18 (78.3)	2 (8.7)			
High	11 (13.1)	53 (63.3)	20 (23.8)			
Neighbor				8.114	2	0.017
No or low	10 (20.4)	34 (69.4)	5 (10.2)			
Mod or high	5 (8.3)	37 (61.7)	18 (30.0)			
Grpou/Committee in community				9.923	2	0.007
No or low	11 (22.4)	33 (67.3)	5 (10.2)			
Mod or high	4 (6.6)	39 (63.9)	18 (29.5)			
Religious piest				14.889	2	0.001
No or low	11 (16.4)	50 (74.6)	6 (9.0)			
Mod or high	4 (9.3)	22 (51.2)	17 (39.5)			
Local govt.				10.104	2	0.006
No or low	8 (14.3)	43 (76.8)	5 (8.9)			
Mod or high	7 (13.0)	29 (53.7)	5 (8.9)			

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4.5.6 Association of Working factors with participation of VHVs in PHC.

Residence

Table 24 shows that there is no association between duration of living in villages and participation of VHVs in PHC (P-Value 0.158). Distance from health center to village health volunteer house is significantly associated with participation of VHV in primary health care (P-Value < 0.001). Familiarity with all villages is also associated with participation (P-Value 0.001). Number of household in villages is significantly associated with the participation of VHV in PHC (P-value 0.038).

Duration being a VHV

Table 25 shows that there is no significant relation between duration being a VHV (p-value 0.506), role as a VHV with participation of VHVs in PHC.(P-value 0.254). But there is significant association between difference in work before and after 1998 (p-value0.002), personal relationship with health staff (p-value<0.001), visit of health officer (p-value 0.015) and happiness as VHVs (p-value <0.001) with participation of VHVs in PHC and Acceptance as VHV (p-value < 0.001) and popularity to become village headman (P-value < 0.001)are also significantly associated with participation of VHVs in PHC activities.

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Table 24 Association between Residence factors and participation

Resident factors	Level of participation			c^2	df	P-value
	Low n (%)	**Moderate** n (%)	**High** n (%)			
Duration of residence in villages of VHVs				0.158	2	0.158
≤ 40 years	8(15.1)	38(71.7)	7(13.2)			
> 40 years	7(13.2)	31(58.5)	15(28.3)			
Distance from nearest health center				23.137	2	< 0.001
≤ 2 km	11(16.4)	52(77.6)	4(6.0)			
> 2 km	4(9.4)	20(46.5)	19(44.2)			
Familiar with village				13.461	2	0.001
Most of them	6(10.3)	32(55.2)	20(34.5)			
Half & less than half	9(17.6)	39(76.5)	3(5.9)			
Household in VHVS village				6.707	2	0.038
≤ 600	4(7)	37(64.9)	16(28.1)			
> 600	11(20.8)	35(66)	7(13.2)			

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Table 25 Association between being VHVs related factors and participation

Being VHVs related factors	**Level of participation**			c^2	**df**	**P-value**
	Low n (%)	**Moderate n (%)**	**High n (%)**			
Duration as VHVs				1.364	2	0.506
≤10yaers	12(14.8)	54(66.7)	15(18.5)			
>10years	3(10.7)	17(60.7)	8(26.6)			
Role as VHV				2.743	2	0.254
Not at all	2 (25)	6(75)	0			
Once or more	13(12.9)	65(64.4)	23(22.8)			
Difference in work before and after 1998				12.671	2	0.002
yes	5(7)	44(62.01)	22(31.0)			
no	7(20.6)	26(76.5)	1(2.9)			
Personal relationship with health staff				16.805	2	<0.001
Good	6(8.1)	45(60.8)	23(31.1)			
Fair or poor	9(26.5)	25(73.5)	0(0)			
Average visit of health office				8..421	2	0.015
≤1visit	13(22)	33(55.9)	13(22)			
>1visit	2(3.9)	39(76.5)	10(19.6)			

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Table 25 Association between being VHVs related factors and participation (cont.)

Being VHVs related factors	Level of participation			c^2	df	P-value
	Low n (%)	Moderate n (%)	High n (%)			
How became VHVs				16.29	2	0.443
Self appointed	10(17.2)	35(60.3)	13(24.4)			
Elected or appointed	5(9.8)	36(70.6)	10(19.6)			
Happiness of becoming VHVs or before				17.122	2	<0.001
More happy	3(4.3)	49(71)	17(24.6)			
Same or less	11(30.6)	23(63.9)	2(5.6)			
Why did accept as VHV				30.660	2	<0.001
Respect/good relationship	3(10.0)	11(36.7)	16(53.3)			
Free medical and others	3(4.3)	49(71)	17(24.6)			
Popularity to become head man				25.883	2	<0.001
Agree	1(3.1)	14(43.8)	17(53.1)			
Disagree/no opinion	12(17.1)	52(74.3)	6(8.6)			

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CHAPTER 5
DISCUSSION AND CONCLUSION

The main purpose of the study was:

1. To explore the level and participation activities of VHV in primary health care in Putthamonthon district.
2. To investigate the factors affecting participation of VHV in PHC at district.
3. To compare association of participation and other factors.

In this study one hundreds and thirty-two (132) VHVs interviewed by using constructed questionnaire, which was pre-tested and corrected, before collecting data. The questionnaire was designed by addressing socio-economic factors, psychosocial factors, VHVs working factors and participation of VHVs in PHC. The analysis results would be conducted and discussed in to 4 parts as following.

5.1 Participation of VHVs in PHC

The result indicated that most of VHV had good participation in PHC (Table19 in appendix). In all activities 0.8 –41.2% of VHVs never participated in activities most of them are principle physical examination, The use of remedies or other medicines as recommended by MOPH, weighting under 5 year old children for nutrition, providing of family profile, Compiling the problems about use of 30 Baht card, and registration of qualified villages to use 30 Baht card etc.

Over all, most of activities such as, motivating the people to participate in health projects, campaigning for cleaning a community, persuading villagers for exercise, provisions of sanitation improvement and safe drinking water, prevention of contamination of food or poisoning had better participation than others.

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The researcher examine the level of participation; low, moderate, high and combine the often and every time activities as high activities as in Table 19 (Appendix). Over all participation was high, especially in preventive and health promotion activities. Moderate in dissemination of information, identifying problem. Local wisdom conservation and planning to solve problem .etc.

The findings are consists with provision study by lablertlob (32). She found that responsibility of VHVs in Nonthaburi province on PHC is high competence regarding, environmental sanitation, immunization against communicable diseases, mental health, health education respectively was more than half of all activities.

In contrast to previous research Jitsangonsuk (33) VHVs in Saraburi province had no active participation in every process, many seems to follow health officers in their PHC activities.

5.2 Socio-demographic factors and its relation to participation in PHC:

The researchers divide level of participation into three groups Low = (mean - SD, Moderate =Mean +- SD, High = mean + SD and compare this standards for association with all factors, like socio-demographic and other.

Age = The age of respondents more than 46 years (48 %) with mean 46.35, SD 11.898, Min = 16, Max = 76 years – from previous research, they conclude that people having high age had more participation than those with younger age (28). However, this study found that age was not related to participation. This may be due to the high average of VHV in this study.

Gender = most of the respondents are female 70.5 % and did not show any significant relationship between gender of respondent and participation in PHC. This study is consistent with previous study by Chan- Amrang (28).

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Marital Status = Regarding marital status 70.5 % of respondent were married. The statistics shows that marital status has no effect on participation in PHC as shown in Sompoch Ratioran VHVs participation in UCHIP.

Education attainment: The result of survey shows that 73.5 % respondents had completed their primary school education, has no significant difference so this study is contrast previous study (28). Which conclude that people who received high education had more participation than those obtaining lower education., otherwise , they usually take participation in such activities according to the ability.

Occupation: In occupation of the VHV, agriculture was main occupation 43.9 %. The statistics examination shows that occupation has no effect on participation in PHC. It is probable that participation activities in PHC are not necessary to do every day but they could have activities during compaign or in weekend.

5.3 Psycho-Social Factors and its relation to participation.

Attitude toward PHC: The result shows that the attitude had positive relationship with participation in PHC (P –Value = (0.04). This finding agrees with previous studies by Lert Wilai (19). Which found that community leaders had attitude towards hospital directors and health personal in hospital implementation which was positively related to community participation in hospital health services and also Sampoch Patrorn study on village health volunteer participation in the universal coverage health insurance programme (UCHIP) in Nonthaburi province. Shows that the attitude towards UCHIP had positive relationship with participation in UCHIP (P –value = 0.10), (34).

Source of support: The result shows that most of, the sources of emotional, source of instrumental and source of information support were form health Personnel 68.2 5%, 77.9%, respondent indicated, health personnel as the first priority for the support. The statistical result shows that significant association between participation and emotional, and information support from relative, neighbor, group/ committee in

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community, religious priest and local government and instrumental support is associated with support from neighbor, group/ committee in community, religious priest and local government to participation in PHC.

In conclusion, social support is basic human need. It is considered to be person-environmental in interaction. That disease the occurrence of stress. It is reciprocal process and interactive resource that provide comfort, assistance, encouragement and social support needed vary across the life span and across in a given situation (31).

5.4 Working factors and their relationship to participation in PHC

1. Residence

Distance of HC from VHVs house table 24 show that distance is associated with participation of VHV in PHC units with p –value less then 0.001, less distance more participation and more distance less participation. This study was revealed that the distance was one factor that affected social participation as same as the result from previous investigation by Lertwai. The study indicated that distance had negative relationship with the community leader participation. . Also the study of Maleehom (19) showed that the distance from home to hospital had negative relationship with people's participation in benefit of hospital implementation and also study of Sompoch Patroran. Show that the respondents who live in PCU area had relationship with participation in UCHIP.

Relationship with participation in PHC and other working factors.

The statistics as shown in Tables 24 and 25 of other working factors like relationship with health staff, visit of health officer, happiness of VHV, respect and good relationship with community and popularity to become headman shows significant association with participation in primary health care activities, conclusion is that multiple factors like above are also affecting VHVs participation in PHC in district.

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CHAPTER 6
RECOMMENDATION

The results of study clearly reflect the potentialities of VHVs participation in PHC. VHV who shows high level of participation could directly affect the higher level of people's health and quality of life status and also could save the government budget for health services.

6.1 Some of the useful recommendations with regard to finding are as following.

The VHVs participation of the high level was in prevention activities and health promotion. So in every health program which related to these activities could involve VHVs for implementation. In addition health personnel and local government are key resources for support to VHVs in all domains in order that VHVs work be more effective and suitable for their communities, should be supported in direction of information, material, budget and also study shows that majority of VHVs should wanting their respect, honor, good relationship with villagers at their villages this behavior of VHVs shows their leadership skills so they may be encouraged by giving them more responsibilities which may increase their dignity and morality.

The attitude has powerful positive effect on the level of participation of VHVs in PHC mean that VHVs with more positive attitude have more participation than VHVs with negative attitude. So health administrator or health worker should promote such positive attitude by encouraging them with good response and honor for it and giving such examples to others by counseling.

Residence of VHVs: distance of VHVs is more significantly associated with participation in PHC activities. This means that VHVs residing near to heath center have more participation than living far. The health administrator should encourage VHVs who are living far from health center to live nearer to it.

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6.2 Recommendations for to implement.

- Multiple positions should be appreciated for VHVs
- Budget for PHC activities should be sanctioned to VHVs
- For increasing participation other responsibilities could support VHVs activities
- for example as village committee member.
- Regular support, supervision, monitoring and evolution of the VHVs need to
- be continued.

6.3 Recommendations for future study.

- Qualitative studies should be done in future, such as direct observation of VHVs participation in the villages.
- It is recommended that appropriate frequency of supervisions should be study in future.
- PCU management research should be suggested in order to create technique for health management like-how to use material in community as PHCC being profitable.
- This data did not reflect the total picture in the community and the health team, to gain more understanding, health personnel team, PCU-team, and people in community should be included in the process of participation.

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APPENDIX

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APPENDIX
QUESTIONNAIRE

Participation of VHV in PHC at Phutthumanthon district. Nokhon Pathom province, Thailand.

This questionnaire is prepared for thesis writing for MPHM course at the ASEAN Institute For Health Development, Mahidol University. Your answers will be kept in secret and not to exposed to any other purpose.

Part 1. Socio-economic Factors (please put the mark Ö in [ ] you agree

1.Gender: 1. [ ] Male 2. [ ] Female

2.Age: ---------------(in years)

3.Marital status

1. [ ] Single 2.[ ]Married 3.[ ]Widow 4.[ ]Divorce/separated.

4.Highest education attainment

1. [ ] Primary School
2. [ ] Secondary School
3. [ ] Vocation
4. [ ] Bachelor or higher
5. [ ] Others (specify) _____________

5.What is your occupation?

1. [ ] Agriculture(Rice farmer, Vegetable crop farmer, live stock)
2. [ ] Merchant
3. [ ] Employee
4. [ ] Retired government official
5. [ ] House wife
6. [ ] Not-working
7. [ ] Others(specify)

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6. What is your family economic status?

1. [ ] Enough for living and have some saving
2. [ ] Enough for living but have no saving
3. [ ] Not enough for living but no dept
4. [ ] Not Enough for living and have dept

Part 2 psycho-social factors

(A) Attitude of VHVs towards PHC

Introduction: please check (√) in the correct column

1. 3= Agree
2. 2=uncertain/not sure
3. 1= disagree

STATEMENT	3	2	1
1. PHC concept is community development strategies to help the People to solve their own problem by themselves.	……	…….	……
2. The VHV is the first level health resource for villager………	……	…….	……
3.People in your village believe what your information ……	……	…….	……
2. The community should mobilize their own resources for Peoples health ………………………………………………………	……	…….	……
5. Children under 2 years who receive completed immunization ar Protected from vaccine preventable diseases ……………….. …..	……	…….	…….
6. Pregnant women who attend ANC regularly have better chance to deliver healthy baby………………………………………..	……	…….	……
7. Drinking boiled water is necessary for health safety reasons….	……	…….	……
8. ORS can be applied to treat diarrhea………………	……	…….	……
9. Malaria is a fatal disease ………………………………………	……	…….	……
10. Malnutrition increase the vulnerability to infections………..…	……	…….	……
11. Defecation in latrine can prevent transmission of diseases …..	……	…….	……
12. Hand washing is required every time after using the toilet……	……	…….	……
13. A healthy couple should not have more than two children……	……	…….	……

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(B) Social Support

1.Source of emotional supports VHV.

Person/group	no	low	moderate	high
▪ Relatives				
▪ Health personnel				
▪ Neighbor				
▪ Group/Committee in community				
▪ Religious priest				
▪ Local government				
▪ Other……………………………………………				

2.Source of instrumental support VHV

Person/group	no	low	moderate	high
▪ Relatives				
▪ Health personnel				
▪ Neighbor				
▪ Group/committee in community				
▪ Religious priest				
▪ Local government				
▪ Others…………………………………………				

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3.Source of information support VHV

Person/group	no	low	moderate	high
▪ Relatives				
▪ Health personnel				
▪ Neighbor				
▪ Group/committee in community				
▪ Religious priest				
▪ Local government				
▪ Other………………………………………				

Part 3 Working factors.

▪ **Residence**

1. How long have you lived in the village …..years……months

2. How many kilometers is the most nearest health center from your house?……kilometers

3. How many villages you are familiar with?

1. [ ] Most of them 2.[ ] around half 3.[ ] less than half

4. How many household in your village? …………………

5. In situation of village, VHV is.

1. [ ]urgent needed 2.[ ]needed 3.[ ]not needed

▪ **Duration of being VHV**

1. How long do you registered as village health volunteer …..Years…..Months

2. How often do you playing role of VHV in your community (in week, months)

[ ] not at all [ ] once a week [ ] twice a week or [ ]………..

3.Before and after year 1998, have any differce in your work as VHV?

[ ] yes [ ] no

4. How about your personal relationship with health center staff. ……………………….

1. [ ] Good 2.[ ] Fair 3.[ ]Poor 4.[ ]can't judge

5. By average how many time did health officer visit you per month?………..times

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6. How did you become VHV? 1. [ ]nominated my self 2.[ ]villagers elect me 3. [ ]Headman/health officer appoint me.

7. Are you happy now or when you become VHV at first time 1. [ ]more 2.[ ]less 3.[ ]same

8. Why did you want /accept to be a VHV. 1. [ ] Can get free medical care 2.[ ]get respect /Good relationship 3.[ ] Do something/ help for my community 4.[ ]more suitable for me

9. To become a VHV for some years, you will have been gained popularity to be elected as village Head man. 1. [ ]Agree 2.[ ]Disagree 3.[ ]No opinion

- **Membership in other group/ committee/Social activities**

Group/committee	Participation	
	Yes	No
1. Cooperative group		
2. Agriculture group		
3. Economized group or "Oomsub group"/Co-operative group.		
4. Elderly group		
5. Voluntary scout		
6. Thai volunteer		
7. School committee		
8. Religious committee		
9. Tambon administration organization		
10. Village health volunteer society		
11. Sport club		
12. Health promotion club		
13. Income Generating club		
14. Other…………………………………………………		

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Part 4 Participation to wards PHC activities

1. Where did your participation activities (more than one answer).

1. [ ]PCU 2.[ ] Health center 3.[ ] PHCC 4.[ ] Mobile clinic

5.[ ] Home visit 6.[ ]Others

2.Participation activities

Activities	Participation			
	None	Sometime	Often	every
1. Identifying health problems in the community.				
2. Planning to solve the problems in the community.				
3. Participating the community for problem solving.				
3. Introducing health problem to THO or health person in the community.				
5. Motivate the people to participate in health projects.				
6. Publicizing information of disease situation through t Media in the community.				
7.Compaigning for cleaning a community.				
8.Councelling for villagers.				
9.Survey for mosquito larva in community.				
10.Helping health personnel in giving vaccination for Children in community				
11.weighing under 5 years old children for nutrition.				
12.Health local wisdom conservation in community.				
13.Organizing exercise group in community.				
14.Persuading villagers for exercise.				
15.Home visit for health education				
16.Searching for the risk group such as elderly group or Malnutrition group.				
17. home visit for rehabilitation				
18. First aid for all emergencies				
19. Principle physical examination for patients				

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Activities	Participation			
	None	Sometime	Often	every
20.Recording of family profile				
21.Registration of qualified villagers to use the 30 Baht card				
21.compiling the problems about use of the 30 Baht car				
23.The use of remedies or other medicine as recommen MOPH				
24.The use of traditional medicine				
25. Control and prevention communicable diseases by Immunization.				
26. First aid treatment of injuries, fractures, burn, etc….				
27. Provision of Mother and child health care including growth monitoring				
28. Provision of sanitation improvement and safe drinki Water, garbage disposal, and latrine construction. Insect and rodent control, etc………………………..				
29. Prevention of contamination of food or poisoning.				
30. personal hygiene				

Please give any suggestion that you want.

1.………………………………………………………………………………………

2. ………………………………………………………………………………………

3.………………………………………………………………………………………

4.………………………………………………………………………………………

Thank you very much for cooperation

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APPENDIX B
SUPPORTING DATA

Attitude	Percentage		
	Agree	Not sure	disagre
PHC concept is community development strategies to help the People to solve their own problem by themselves	88.6	10.6	0.8
The VHV is the first level health resource for villagers	88.6	8.3	3.0
People in your village believe what your information	84	16	0
The community should mobilize their own resources for peoples health.	85.6	8.3	3.8
Children under 2 years who receive completed immunization are Protected from vaccine preventable diseases	97.0	2.3	0.8
Pregnant women who attend ANC regularly have better chance to deliver healthy baby	93.9	3.8	0.8
Drinking boiled water is necessary for health safety reasons	85.6	14.4	0
ORS can be applied to treat diarrhea	88.6	8.3	3.0
Malaria is a fatal disease	89.4	8.3	1.5
Malnutrition increase the vulnerability to infection	90.2	8.3	0.8
Defecation in latrine can prevent transmission of diseases	96.2	2.3	0.8
Hand washing is required every time after using the toilet	94.7	3.8	1.5
A healthy couple should not have more than two children	90.9	4.5	3.8

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Table 2 Percentage distribution of membership status in social groups / committees.

No	Group/Committee	Participation			
	Total Number = 132	Yes	%	No	%
1	Cooperative group (95)	56	58.9	39	41.1
2	Agriculture group (109)	78	71.6	31	28.4
3	Economized group or	76	71.0	31	29.0
4	"Oomsub group"/Co-operative group(107)	50	56.2	39	43.8
5	Elderly group (89)	28	33.3	56	66.7
6	Voluntary scout (84)	20	26.0	57	74.0
7	Thai volunteer (77)	29	36.7	50	63.3
8	School committee (79)	25	32.5	52	67.5
9	Religious committee (77)	26	33.8	51	66.2
10	Tampon administration organization (77)	106	84.1	20	15.9
11	Village health volunteer society (126)	35	40.7	51	59.3
12	Sport club (86)	87	75.7	28	24.3
13	Health promotion club (115)	41	43.6	53	56.4
14	Income Generating club (94)	5	55.6	4	44.4
	Others (9)				

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Table 19 Percentage of participation activities of VHVs in PHC in Putthumonthom district.(N=132)

Activities	Participation			
	None	Sometime	Often	every time
1. Identifying health problems in the community.	9 (6.9)	80 (61.1)	35 (26.7)	7 (5.3)
2. Planning to solve the problems in the community.	8 (6.1)	79 (60.3)	40 (30.5)	4 (3.1)
3. Participating the community for problem solving.	6 (4.6)	70 (53.8)	45 (34.6)	9 (6.9)
4.Introducing health problem to THO or health personnel in the community.	9 (7)	74 (57.4)	41 (31.8)	5 (3.9)
5. Motivate the people to participate in health projects.	7 (5.3)	66 (50)	53 (40.2)	6 (4.5)
6. Publicizing information of disease situation through the Media in the community.	12 (9.4)	67 (52.8)	40 (31.5)	8 (6.3)
7.Compaigning for cleaning a community.	1 (0.8)	69 (52.7)	56 (42.7)	5 (3.8)
8.Councelling for villagers.	3 (2.3)	68 (52.3)	49 (37.1)	11 (8.3)
9.Survey for mosquito larva in community.	1 (0.8)	52 (39.7)	50 (38.2)	28 (21.4)
10.Helping health personnel in giving vaccination for Children in community	20 (15.3)	67 (51.1)	35 (26.7)	9 (6.9)
11.weighing under 5 years old children for nutrition.	40 (30.5)	51 (38.9)	31 (23.7)	9 (6.9)

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Table 19 Percentage of participation activities of VHVs in PHC in Putthumonthom district.(N=132) (cont.)

Activities	Participation			
	None	Sometime	Often	every time
12.Health local wisdom conservation in community.	12 (9.1)	76 (57.6)	37 (28)	7 (5.3)
13.Organizing exercise group in community.	2 (1.5)	64 (48.9)	49 (37.4)	16 (12.2)
14.Persuading villagers for exercise.	4 (3)	58 (43.9)	54 (40.9)	16 (12.1)
15.Home visit for health education	11 (8.3)	73 (55.3)	43 (32.6)	5 (3.8)
16.Searching for the risk group such as elderly group or Malnutrition group.	20 (15.2)	67 (50.8)	35 (26.5)	10 (7.6)
17. home visit for rehabilitation	20 (15.5)	68 (52.7)	35 (27.1)	6 (4.7)
18. First aid for all emergencies	13 (9.8)	73 (55.3)	35 (26.5)	11 (8.3)
19. Principle physical examination for patients	33 (25.4)	60 (46.2)	30 (23.1)	7 (5.4)
20.Recording of family profile	42 (31.8)	55 (41.7)	26 (19.7)	9 (6.8)
21.Registration of qualified villagers to use the 30 Baht card	54 (41.2)	56 (42.7)	17 (13)	4 (3.1)
22.compiling the problems about use of the 30 Baht card.	53 (40.5)	54 (41.2)	20 (15.3)	4 (3.1)
23.The use of remedies or other medicine as recommended by MOPH	37 (28.2)	65 (49.6)	22 (16.8)	7 (5.3)

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Table 19 Percentage of participation activities of VHVs in PHC in Putthumonthom district.(N=132) (cont.)

Activities	Participation			
	None	Sometime	Often	every time
24.The use of traditional medicine	19 (15)	71 (55.9)	33 (26)	4 (3.1)
25. Control and prevention communicable diseases by Immunization.	20 (15.4)	71 (54.6)	32 (24.6)	7 (5.4)
26. First aid treatment of injuries, fractures, burn, etc…….,	35 (26.7)	68 (51.9)	24 (18.3)	4 (3.1)
27. Provision of Mother and child health care including growth monitoring	29 (22.5)	64 (49.6)	35 (27.1)	1 (0.8)
28. Provision of sanitation improvement and safe drinking etc.	12 (9.3)	59 (44.7)	43 (33.3)	15 (11.6)
29. Prevention of contamination of food or poisoning.	15 (11.5)	66 (50.8)	35 (26.9)	14 (10.8)
30. personal hygiene	27 (21.1)	59 (46.1)	27 (21.1)	15 (11.7)

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BIOGRAPHY

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