Thesis Title A Study of People's Participation Needs and Concordance of Relative Rankings of Primary Health Care Components in Bangkok: A Case Study of Two Communities

Name Doungsamorn Kittisoponphandh

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(Population and Social Research)

Thesis Supervisory Committee
Kritaya Archavanitkul, Ph,D.
Boonlert Leoprapai, Ph,D.
Buppha Sirirasamee, Ph.D.

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Abstract

The objectives of this study were to study: 1) the relationship between population, economic, and social characteristics of people and community leaders and the desire for participation in primary health care activities and 2) the concordance of relative rankings of the thirteen primary health care components by comparing three groups : policy setters, providers of health services (public, private, volunteer), and leaders and members of the community. The purpose was to find out whether people and leaders and civil servants, who provide primary health care services in slums, looked at problems in the same.

Data used in this research is both quantitative and qualitative. Quantitative data is secondary data collected during the "Strategies for the Health Management of the Urban Poor: A Comparative Analysis for Four Cities in the ASEAN Region 1988." The sample population used is divided into three groups: policy setters (27 persons), providers of health services (50 persons), and leaders and members of two slum communities: community A=46 persons, community B=50 persons. They were at least 20 years old and had lived in the community for at least six months. Qualitative data was collected by indept interviews with community leaders, 5 from community A and 2 from community B, one Village Health Volunteer, two members of the community, and two visiting nurses, who work in the two public health centers. In analysis percentages, chi-square, F-ratio, and Kruskal-Wallis Test were used.

It was found that the community members and leaders participation wants in public health activities were not particularly affected by age, sex, education, whether or not they worked, or position in the community. This contradicts the expected results. When the length of stay in the community is introduced, there was still no affects. This means that members and leaders of the community, no matter how long they have been in the community and regardless of economic, social, and population differences, their participation want were not particularly different. However, from the interviews is was

found that community members of both communities, very few actually were involved in primary health care activities.

As for the concordance of relative rankings of the thirteen significant primary health care components between the three groups and four situations (A=would have best affect of health status, B=community had the most interest, C=significance for low-income people in Bangkok, D=community can conduct activities themselves), it was found that the three groups ordered the components in the four situations inconcordantly. So, this study shows that civil servants and members and leaders of communities look at primary health care problems differently. If the civil servants want to have the community to give the same significance to the components that they have, they must spread authority for planning to officers directly responsible and coordinate activities with community members and leaders. It is necessary for community members and leaders to be involved in order to define problems and find methods of solving those problems in their communities, including evaluating work done in the community. This is so the community members and leaders will learn to be responsible for their community. This means they must participate in their community's activities and at the same time civil servants will give support and aid where needed and follow-up activities of the community so that primary health care activities can fulfill their objectives.