

**THE DEVELOPMENT OF A STRUCTURAL EQUATION
MODEL OF COMMUNICATION FACTORS FOR
HEALTH COMMUNICATION OF COMMUNITY**

Kirati Kachentawa

**A Dissertation Submitted in Partial
Fulfillment of the Requirements for the Degree of
Doctor of Philosophy (Communication Arts and Innovation)
The Graduate School of Communication Arts
and Management Innovation
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ABSTRACT

Title of Dissertation	The Development of a Structural Equation Model of Communication Factors for Health Communication of Community
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This research was meant to study (1) the means of communication based on three paradigms of health in successful communities; (2) to analyze the communication factors that lead to the success stories of communities in health communication; and (3) to develop and validate the congruence of the measurement model and the structural equation model of communication factors for health communication of community with empirical data. Research methodology was mixed method separated into 2 phases the following: Phase I: qualitative research method that employed in-depth interview technique for data collection; for this purpose, researcher selected 20 key informants drawn from almost every facet involved in community health communication obtaining highest scores in 2014's Area and Province-level assessment by Office of Disease Prevention and Control, 1st Area, consisting of (1) Bangyai district, Nonthaburi; (2) Phra Nakhon Si Ayutthaya district, Phra Nakhon Si Ayutthaya; and (3) Nong Sua district, Pathum Thani, and Phase II: quantitative research method that employed close-ended questionnaire for collecting data from 400 respondents who performed in three successful districts. Data analysis conducted by employing Frequency, Percentage, and Standard Deviation in descriptive statistical analysis and Structural Equation Model technique (SEM) in inferential statistical analysis.

Responses revealed that health communication behavior in successful communities still congruently utilized three paradigms of health: Education, Promotion, and Communication. As for communication factors found they corresponded to the Concept of Communication Components consisting of five: (1) public health officers extended their viewpoints toward other sectors to be health communicators and supported participation in health communication operations; (2) variety purposes for exhibiting message conforming to the requirements of locals; (3) integration of various types of media in community; (4) active role of locals in order to be a part of health communicators; and (5) social context based on normal and unusual situations affecting the differences of health behavior expression. In the part of Structural equation model analysis results found: 1) the structural equation model of communication factors in promoting the participatory communication to create health communication behavior of community was in accordance with empirical data according to assumed hypothesis, by passing the determined criteria from 8 indicators, out of 13. The model's fit indicators were accepted the following: (1) Chi-Square/df = 3.99 (< 5.00), (2) Root Mean Square Residual = 0.032 (< 0.05), and (3) Standard Root Mean Square Residual = 0.039 (< 0.05), (4) Normed Fit Index = 0.98 (> 0.95), (5) Non-normed Fit Index = 0.98 (> 0.95), (6) Comparative Fit Index = 0.98 (> 0.95), (7) Incremental Fit Index = 0.98 (> 0.95), (8) Relative Fit Index = 0.97 (> 0.95). Besides, 2) communication factors variable (COMMUNICATION) had no direct effect on health behavior in community variable (HEALTH BEHAVIOR) but had a positive indirect effect on health behavior in community variable (HEALTH BEHAVIOR) through community satisfaction in regards to acquiring health communication information variable (SATISFACTION), role of personal media in order to be health communication leader in community variable (HEALTH LEADER), and participatory communication in community variable (PARTICIPATION).

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CHAPTER 1

INTRODUCTION

1.1 Background of the Study

Having “good health” is desirable. “Health” has been defined by varied and sometimes common dimensions by many scholars. Thapin Patcharanuruk (2003, as cited in Kanjana Kaewthep, Kanittha Nilphueng, & Rattikan Jenjad, 2013, pp. 159-163) has categorized health definitions into five aspects; 1) being without sickness, 2) strength, 3) abilities to perform tasks, 4) balance of elements and other factors, and 5) having good social relationship. Wijit Wongwareethip (2008) has made a notion that “health” should be defined variously and shouldn’t rely on a specific definition.

At present the most legitimate health definition is the one proposed by World Health Organization (WHO). The organization defines good health as the state of being physically and mentally mature as well as wellness of being in the society, not only the state of being free from illnesses or disability. In addition good health is achieved through a holistic approach. Kanjana Kaewthep, Kanittha Nilphueng, Rattikan Jenjad (2013, p. 165) expands the meaning of holistic health that it is the positive standpoint of health, focusing on “continuous well-being of life,” which refers to balance, correlation, harmony, and dependence between mental and soul dimensions.

WHO’s definition of health is in line with the policies of the National Health Development Plan stated in the Eleventh National Economic and Social Development, 2012-2016. Drawing upon the policies, “All citizen should healthy, through collaboration of sufficient health systems, be equitable, leading to a healthy society.” The “sufficient health system” refers to the processes of health development that results in wellness of body, mind, society, and intellect by high quality health services. The services must be standardized, vigilante, adequate, and accessible. Public participation is integral with the aim to empower competency of the public,

communities, localities, alliances, including promote good health and prevent or decrease tenable illnesses that are caused by behaviors. These must be conducted by the employment of Thai local wisdom. In addition participation is required to solve one's health problems or those of the society (Ministry of Public Health, Office of Permanent Secretary, 2012, pp. 23-26; The Presentation Stage of Innovative Health Communication Studies, 2007).

Traditionally, Thai people tended to perceive that healthcare must be exclusively conducted by public health officers. This results to limitation of practices to "healing" instead of "preventing or promoting well-being". Whereas doctors, nurses, or medicine are no use provided that people do not change their behaviors. Besides, numerous Thai people become physically and mentally ill as a result from family violence and disturbing environmental context. Lots of money has been paid for health service costs. As a result the country wastes a large sum on medical fees for the public. The perpetuation of this crisis results in the loss of opportunities to develop healthcare standard. Therefore, the focus should be on protection rather than medication. Participation of communities, localities, government organizations, private sectors, and academic institutes must be promoted for the publics' good health in peaceful harmonious environment (National Health Act, 2007).

According to the government report, "Thai Society during the 4th Quarter Year 2015 (As shown in Table 1.1), the total number of patients from disease surveillance in 2015 was 492,207 or 755.8 per 100 thousands individuals. The figure grew 25.4 percent from 2014. The number constituted of 144,952 patients with hemorrhagic fever, which was 4 times higher from 41,082 in 2014. The disease had spread since the 3rd quarter of 2015 mostly among 15-24 years old people. Besides, there were 216,959 patients with pneumonia, which were 1.5 times higher from 2015 (Office of the National Economic and Social Development Board, 2016, pp. 8-9).

Table 1.1 Patients with Surveillance Diseases in Each Quarter in 2015

Surveillance Diseases	2015 (unit: amount)			
	1 st quarter	1 ^{2nd} quarter	3 rd quarter	4 th quarter
Pneumonia	56,556	42,176	57,754	60,473
Dengue Fever	7,538	24,409	60,768	52,237
Hand Foot Mouth Disease	9,217	7,771	14,594	9,810
Influenza	24,206	10,840	18,397	24,483
Dysentery	1,804	1,956	1,774	1,508
Measles	224	236	276	279
Leptospirosis	283	393	723	752
Encephalitis	164	144	178	146
Cholera	2	2	4	100
Meningococcal Meningitis	4	6	9	6
Rabies	1	1	2	1
Total	99,999	87,934	154,479	149,795
Total figures of all the quarters			492,207	

Source: Office of the National Economic and Social Development Board, 2016, p. 9.

In accordance to the information provided in the table, the figures of non-communicable diseases have been grown especially hypertension, diabetes, ischemic heart disease, stroke, and cancer. These diseases result from unhealthy lifestyle habits such as inadequate exercise, or insufficient consumption of vegetables or fruits. These health hazards can be prevented by exercising, having regular blood pressure and sugar level checkup, eating less sweet or salty food, avoiding smoking, drinking less alcohol as they are not caused by germs. (Office of the National Economic and Social Development Board, 2016, p. 9; Peterson & Lupton, 1996, pp. 89-145).

As a result of the realization of the actual causes of modern health problems, which include stress, social problems, and deteriorated environment, the Department of Disease Control, Ministry of Public Health has realized that only one health organization is inadequate to solve the problems. Therefore, they launched a project known as “The Development of Local Administration Network in Enhancing Disease Prevention” in 2006 targeting more in the local community areas. This is the initiative for “Active District for Long-term Disease Protection” started in 2011 through collaboration with other relevant health organizations and the local administrative units. The policy targeted at monitoring and control diseases as well as spreading health threats, serious infectious illnesses, diseases that seem to escalate (History and Background of the Department of Disease Control, 2011). Consequently, in the fiscal year 2011 the Bureau of Planning, under the supervision of Department of Disease Control launched the “Active District in Long-term Disease Protection.” The active district was defined as “a district with systematically administrative protocols in effectively protecting and controlling health threats in the local community in a timely manner. These processes were made through the collaboration of public health sectors, local people, and the public. In addition, academic support has been provided by the establishments under the administration of Department of Disease Control (2011) for Provincial Public Health Centers for them to convey to the districts, sub-districts, to the communities. The knowledge transfer was conducted by district public health centers, province and district hospitals, health promotion hospitals in sub-districts along with local administrations aiming at enhancing local people to be competent in solving health problems and threats in a timely manner (Department of Disease Control, Bureau of Planning, 2013, pp. 1-3).

Later in 2014 the Bureau of Planning, Department of Disease Control, Ministry of Public Health had developed the administration of “Active District for Long-term Disease Protection” policy and named it as “District Health System: DHS.” The policy defines the district as a baseline unit and every sector in the district as whole units. The sectors are 1) public health sector including provincial public health divisions, provincial public health centers, provincial or district hospitals along with sub-district health promotion hospitals, 2) local administrations such as municipalities, sub district administrations, 3) regional bureaucratic sector, for

example, district chief, 4) private sector including businesses, non-government organizations, clubs, associations, or foundations. 5) public sector such as public health volunteers, community leaders, and 6) other government and private sectors e.g. village headmen, community head, schools, mass media, department of disaster prevention and mitigation, and other organizations in the district or sub-districts, etc. Every sector aims at promoting health by a holistic approach through supporting, protecting, healing, and improving. The ultimate aim of the policy was the occurrence of “healthy district,” or in other words people in the district had better health and were responsible for their health. Collaboration of every division is required in addition to those of public health departments. Moreover, DHS is driving its strategy based on the WHO Vision and National Economic and Social Development Plan No. 11 for 2012-2016 (Department of Disease Control, Bureau of Planning, 2014, pp. 1-5).

In this study, the evaluation criteria of DHS in 2014 by the Department of Disease Control to award the best role model district from all 12 areas in the final round has been employed for research setting selection. The criteria have recently been modified to challenge the participants for them to be more eager to monitor and prevent diseases successfully. By doing so the organization has added more points for the sub-criteria of all major evaluation criteria as follows:

1) The efforts start from the modification of self-evaluation for district judges, which is the first stage of the evaluation. The five evaluation criteria of area level have been employed for each district during 2011-2016. The criteria include; 1) health threat protection and control committee, 2) a well-performing epidemiology team, 3) plans, monitoring, and evaluative protocol, 4) resource gathering and funding from relevant organizations, and 5) successful protection of serious diseases indicated in the policy as well as any current health issues in the area. A district would pass provided that it obtained 80% scores. However, in 2014 the first stage self-evaluation criteria were adjusted. The major change was the employment of different core indicators from those employed in the area level. The variations were; 1) level 1 cooperation among districts, 2) level 2 targeting at both service receivers and providers, 3) level 3 contribution of resources and personnel development, 4) health servicing in required circumstances, and 5) participation of network and communities. It was indicated that any districts would pass the evaluation when exceeded level 3, contribution of resources and personnel development.

- 2) The increase of all 5 core indicator scores from 50 to 100
- 3) The addition of minor indicators to encourage participation from any other sectors except public health profession and local administrations such as schools, foundations, associations, clubs, and etc.
- 4) The inclusion of minor indicators for situation analysis in order to identify problems, prioritize them, and seek for the solutions
- 5) The measurement of disease control and protection achievement according to policies of the Ministry of Public Health, for example, from 1 to 2 illnesses as well as local health issues from 1 to 3 illnesses

As a result, the research setting is the area under the supervision of the Office of Disease Prevention and Control, 1st area, Bangkok in which four provinces are included: 1) Nonthaburi, 2) Pathum Thani, 3) Phra Nakhon Si Ayutthaya, and 4) cooperation with Bangkok in some aspects. The area is selected as it is outstanding for many reasons. To begin with, the administration of this division is different from the others since it deals with big cities, which are complicated and populated. Next, they tend to have a high rate of migration and a large passive population. Besides, people in each of these provinces also have heterogeneous socio-economic status when compared to other areas. Hence, health communication in the setting becomes more difficult, unique, and challenging than others. In addition the Office of Disease Prevention and control, 1st area (2014a), Bangkok cooperates with Bangkok, the capital city of the country, which is governed uniquely as follows:

- 1) The pilot administration of “Active District for Long-term Disease Protection” policy in Bangkok in 2016
- 2) Cooperation with alliances such as health offices, Bangkok Metropolitan Administration, Public Health Service Center 24, Health Center 1 Bangkok, Bang Khen, and Thai Health Promotion Foundation aiming at the development of health promotion for people in big cities who live in condominiums through the campaign, “Healthy Condo Model” taking “One Health” as a baseline concept with the aim to improve healthcare system and evaluate health condition of people in the residence, as well as promote better life and good health, Development and improvement of leprosy services including monitoring in Bangkok including assistance for those disabled from the illness through a campaign, “Leprosy in the

City: Honor and Life Quality of Leprosy Patients who Required Treatments”. This is done in collaboration with the Bangkok Public Health Center, Disease Control Division, and Rat Phracha Samasai Institute in planning the service development for those patients starting from patient identification by public health centers under supervision of Bangkok Municipality to provide prompt treatment that can lessen disability rates, as well as to supply specialist services or the transfer of patients with complications (Thanya Rodsuk, Personal Communication August 5, 2015; Office of Disease Prevention and Control, 1st Area, Bangkok (2014a, pp. 56-57, pp. 61-62).

3) Consequently, the researcher has employed purposive sampling technique to select three research setting areas under the supervision of Office of Disease Prevention and Control 1st area, Bangkok. The research setting where samples are drawn include 1) Phra Nakhon Si Ayutthaya District, Phra Nakhon Si Ayutthaya Province, which was awarded the best “Active District in Long-term Disease Protection” in 2014 by Office of Disease Prevention and Control, 1st area, Bangkok, 2) Bang Yai District, Nonthaburi Province, which obtained the highest scores of all the districts in the province by the same division, and 3) Nong Sua District, Pathum Thani Province, which acquired the highest assessment scores of the province by the division. Moreover, all of the three districts were scored similarly both in the district and province levels (see details of indicators and scores of each district on page 116, Part III of Chapter 3.) Hence, the researcher has to conduct a survey to find out perspectives of those related in health communication in the community as well as successful cases. The survey has found that three health paradigms are employed. In this study the “Health Communication Model” has been adopted to categorize health behavior of community people.

Besides, “health communication” also covers influencing factors on media exposure that feature health content through traditional and new media, as well as satisfaction of those people for the media characteristics, which serves as the channel to transfer healthcare information to the public. In addition, it refers to participatory communication of related sectors together with health behavior of the community that can be classified into two aspects. The first is health behavior in unusual situations where in the researcher has found relationship between two sets of paradigm. They are “health behavior from the standpoint of health education and health promotion.”

Both of the concepts propose that people are required to rely on public health officers in unusual situations. For instance in health crisis such as the incident of epidemic, repeated accidents, new accidents, or when people get serious illnesses. In those contexts, people need to follow the instructions of the officers and cooperate with them, which is congruent to “health education paradigm.” On the other hand, when community people seem to perform unhealthy behavior, a campaign to “protect” instead of to “heal” after an infection by the public health officers will be launched. For instance a mask wearing campaign to prevent airborne infectious diseases, vaccination for diphtheria, tuberculosis, and influenza, as well as screening for diabetes, high blood pressure, breast cancer as indicated in “health promotion paradigm.” Second, the health behavior in normal situations in which people are actively engaged in self-care. People who are already healthy prefer to stay fit by exercising, having healthy food, avoiding sweet, salty, or greasy food according to “health communication paradigm”. These two types of health behavior are still in practice in the community. However, the employment of each health behavior type depends on the situations. Furthermore, the three districts are prototypes for successful cases, which represent the extent in which effective health communication is performed.

In line with the aforementioned part, qualitative data of this present study will assist in the design of the questionnaire and the structural equation model. In addition, the literature review provides knowledge about relevant factors that encourage for health behavior of community. As a result, the model will be holistic and correlated to real contexts of the research settings and could become a prototype for metropolises aiming at generating good health behavior. However, the employment of the proposed structural equation model as a guideline in other settings requires consideration of many factors such as community media or social and cultural factors, which are required to be similar.

1.2 Research Questions

1) How does the communications based from the three paradigms of health lead to successful communities?

2) What communication factors that lead to the success stories of communities in health communication?

3) Were the measurement model and the structural equation model of communication factors for health communication of community congruent with empirical data?

1.3 Research Objectives

1) To study the means of communication based on the three paradigms of health in successful communities.

2) To analyze the communication factors that lead to the success stories of communities in health communication.

3) To develop and validate the congruence between the measurement model and the structural equation model of communication factors for health communication of community with empirical data.

1.4 Hypothesis

The measurement model and the structural equation model of communication factors for health communication of community which researcher developed and validated through this study were found to be congruent with empirical data.

1.5 Scope of the Study

The study, “The Development of a Structural Equation Model of Communication Factors for Health communication of Communities” employs mixed-methods design. The study consists of 2 phases. The first phase uses qualitative method in which an in-depth interview is conducted. The key informants are representatives of all parties relating to health communication in the communities. Those people are 1) public health officers, 2) local administrative officers, and 3) public leaders. To put it simply, the key informants are (1) Officers from Office of Disease Prevention and Control, 1st area, Bangkok, (2) Provincial public health

officers, (3) District public health officers, (4) Central hospital officers, (5) Officers in sub-district hospitals, (6) Municipality officers, (7) Sub-district administration officers, (8) Surveillance and rapid response teams (SRRTs), and (9) Public health volunteers and Community leader. The sampling technique yielded the selection of 20 people from each group. A semi-structured interview was conducted with the underlying rationale that the researcher could be more flexible in adding questions not previously set. Then the qualitative data from the interview along with knowledge from literature review would be synthesized to develop a set of questionnaire items along with the structural equation model of communication factors for health communication of community in the second phase. The practice can examine the consistency between the research model and empirical data. On the other hand, in the 2nd phase the quantitative method is employed. The survey research method was selected and a set of close-ended items developed for the questionnaire was adopted for data collection. The participants included people who are involved with community health communication in 1) Phra Nakhon Si Ayutthaya District, Phra Nakhon Si Ayutthaya Province, 2) Bang Yai District, Nonthaburi Province, and 3) Nong Sua District, Pathum Thani Province. The respondents included (1) district public health officers, (2) central hospital officers, (3) officers in sub-district hospitals, (4) municipality officers, (5) sub-district administrative officers, (6) surveillance and rapid response teams (SRRTs), (7) public health volunteers and community leader, and (8) the public playing their roles in community health communication who obtain healthcare information in the community.

1.6 Operational Definitions

1) Structural Equation Model (SEM) refers to a prototype of causal relationship among structural variables based on theories and previous studies that result in the hypothetical investigation to study the congruence between the research model and empirical data along with the investigation of direct and indirect influences of the variables in the model.

2) Communication Factors include 1) frequencies of exposure to health information from community media of people who are involved with health communication in the community including; (1) Phra Nakhon Si Ayutthaya District, Phra Nakhon Si Ayutthaya Province, (2) Bang Yai District, Nonthaburi Province, and (3) Nong Sua District, Pathum Thani Province through community media. The informants would be drawn from 1) personal media such as public health officers, regional civil servants, local administrators, public health volunteers, community leaders, recovered patients, recovered patients, NGOs' officers members, teachers, students, neighbours, relatives, and the public, 2) special media such as brochures, leaflets, vinyl board, poster, 3Ds media, stickers, calendars, bicycles, and publicity vehicles, 3) community media including local media, wire broadcasting/transition towers, local televisions, local radios, public health meetings, and village cafes, 4) mass media such as televisions, and newspapers, 5) activity media for instance meetings, trainings, plan preparing/projects and health activities, and 6) new media such as websites, search engines including Google/Yahoo and applications such as LINE, Facebook, and You Tube. Secondly, opinions of people relevant to community health communication on qualifications of community media. This would be based on 3 aspects including: 1) skill and knowledge of sender towards health communication, 2) Attitude of sender towards receiver and health communication content, and 3) Sender's consideration of social and cultural context to communicate health issues.

3) Community Satisfaction in the Acquisition of Health Communication Information refers to the gratification of people in relation to community health communication. This would include the population from people in 1) Phra Nakhon Si Ayutthaya District, Phra Nakhon Si Ayutthaya Province, 2) Bang Yai District, Nonthaburi Province, and 3) Nong Sua District, Pathum Thani Province in health information from community media. The information must satisfy the need of community people and can raise their gratification. The satisfaction criteria covers 4 aspects as follows: 1) obtaining information, knowledge and advice related to health promotion, 2) obtaining health information consists with community's taste and needs, 3) seeing a proper model from health senders, 4) two-way communication and participation in health communication.

4) Role of personal media personnel in order to be health communication leader in the community consists of the mission and responsibilities of “personal media personnel” in the community, which include: 1) Phra Nakhon Si Ayutthaya District, Phra Nakhon Si Ayutthaya Province, 2) Bang Yai District, Nonthaburi Province, and 3) Nong Sua District, Pathum Thani Province. The roles are not limited to the public health officers. However, they refer to those of people related to health communication in other sectors including regional civil servants, personnel in local administration organizations, community headmen, community volunteers, people who used to be ill, relatives/ family members who take care of the patient, as well as teachers, students, neighbours, relatives, and the public. Personal media personnel are responsible for providing knowledge, suggestion, protective means and health promotion for people in the community. Qualified personal media personnel are required to achieve 4 assessment criteria: 1) as a role model of health promotion, 2) as a supporting health activities, projects, or networking, 3) as a public hearing post and having public mind to take up health operations, and 4) as an educating and inspiring personnel of health promotion.

5) Participatory Communication in Community Health Communication refers to a facet of communication in which people in 1) Phra Nakhon Si Ayutthaya District, Phra Nakhon Si Ayutthaya Province, 2) Bang Yai District, Nonthaburi Province, and 3) Nong Sua District, Pathum Thani Province are allowed to be both the “senders” and the “receivers” in the entire communication process. The participation assessment criteria include 4 features: 1) 3 levels of participation in health communication with regard to (1) receiver level/exchange of opinions/interaction, (2) local media producer level/presenter and, (3) planning level and methods and policy identification, 2) Health information exchange is beneficial to all stakeholders, 3) equality in health communication from all people and agencies, and 4) decentralization of health content from public health officers to all stakeholders.

6) Health Behavior of Community is defined as the extent to which people are involved with health communication in 1) Phra Nakhon Si Ayutthaya District, Phra Nakhon Si Ayutthaya Province, 2) Bang Yai District, Nonthaburi Province, and 3) Nong Sua District, Pathum Thani Province. They expose themselves to health contents from traditional media, personal media personnel, as well as new media. This

includes the evaluation of personal media qualifications along with the satisfaction from the health information those media provide. Besides, this covers the extent those people perform as leaders of health information including their participation in health communication. These factors are “interrelated”. To put it simply, not only the exposure of community media results in the degree of satisfaction after obtaining the information, the satisfaction generates more exposure or the interest of being a leader in health communication. Similarly, the more people are interested in being health communication leaders, the more participation is activated. Consequently, the more participation results in more interest to become health communication leaders. With regard to community health behavior, two categories are proposed based on different characteristics of each community. First, health behavior in the unusual situation refers to “health behavior based on health education paradigm and health promotion paradigm”. These share a similar principle that people depend on health education professionals in abnormal situations, for example, during health crisis such as the spread of communicable diseases, re-emerging infectious diseases or emerging infectious diseases in the community. Besides, when people have serious diseases they are required to follow instructions from those personnel as stated in “health education paradigm.” Likewise, when there is tendency of occurrence of infectious disease in the community or people are likely to perform health threatening behaviors, those public health officers usually raise awareness of “protection” rather than “cure” after the infection, for example, a mask wearing campaign to prevent breath infectious diseases, vaccination for diphtheria, tuberculosis, and influenza, as well as screening for diabetes, high blood pressure, and breast cancer, etc. following “health promotion paradigm”. Second health behavior in normal situation in which people are active in self-care when they are still healthy and prefer to stay fit by exercising, having healthy food, avoiding sweet, salty, or greasy food, or relying on alternative medical services such as herb application, massage, sauna or massage with hot press, acupuncture, and meditation, etc. This includes the readiness in case of the health crisis incidents based on “health communication paradigm.”

1.7 Significance of the Study

1.7.1 Office of Disease Prevention and Control 1st area, Bangkok and their responsible areas could effectively apply the Structural Equation Model of Communication Factors for Health Communication of Community, which has been developed and investigated empirically. The practice could represent the communication factors that could encourage continuous and sustainable health behavior.

1.7.2 The Structural Equation Model of Communication Factors for Health Communication of Community has been developed based on the qualitative research results as well as concepts, theories, and relevant studies together with the quantitative research results. Consequently, the model could be a prototype for other big cities in which health behavior is promoted. The model could be applied as a baseline practice for health development in each community. However, the application is required to take into account the community media along with social and cultural factors, which must be similar to each other.

1.7.3 Public health officers could appropriately adopt and apply the Structural Equation Model of Communication factors for Health Communication of Community in their own areas.

1.7.4 Researchers, scholars, and people who are related to health communication could further develop the equation model and expand the knowledge of health communication, which will result in its advancement.