การมีส่วนร่วมของชุมชนในการดูแลผู้สูงอายุที่ต้องการการพึ่งพาในการทำกิจวัตรประจำวัน

*พิมพวรรณ เรืองพุทธ**
*วรัญญา จิตรบรรทัด ***

บทคัดย่อ

การวิจัยนี้เป็นการวิจัยเชิงปฏิบัติการแบบมีส่วนร่วมมีวัตถุประสงค์ เพื่อศึกษาการมีส่วนร่วมของชุมชนในการดูแลผู้สูงอายุที่ต้องการการพึ่งพาในการทำกิจวัตรประจำวัน ในตำบลนาเคียน อ.เมือง จ.นครศรีธรรมราช มีผู้เข้าร่วมวิจัย จำนวน 57 คน ประกอบด้วย อาสาสมัครสาธารณสุขประจำหมู่บ้าน จำนวน 43 คน ผู้ดูแลผู้สูงอายุที่ต้องการพึ่งพาในการทำกิจวัตรประจำวัน จำนวน 10 คน เจ้าหน้าที่สาธารณสุข จำนวน 3 คน และนักพัฒนาสังคม 1 คน กระบวนการวิจัยอาศัยความร่วมมือประสานกันระหว่างผู้วิจัยและผู้ร่วมวิจัยแบบเป็นหุ้นส่วน (mutual collaborative approach) โดยกระบวนการมีส่วนร่วมในการดูแลตั้งแต่ร่วมคิด ร่วมวางแผน ร่วมกระทำกิจกรรมและร่วมประเมินผล ในระหว่างเดือนมกราคมถึงธันวาคม 2557 เก็บรวบรวมข้อมูลเชิงคุณภาพโดยการสัมภาษณ์เชิงลึก การสังเกตแบบมีส่วนร่วม การสนทนากลุ่ม บันทึกภาพการมีส่วนร่วมในการดูแลผู้สูงอายุที่ต้องการพึ่งพา วิเคราะห์ข้อมูลแบบอุปนัยและจำแนกชนิดของข้อมูล

ผลการวิจัยพบว่ากระบวนการมีส่วนร่วมในการดูแลผู้สูงอายุที่ต้องการการพึ่งพาในการทำกิจวัตรประจำวัน มีปัจจัยหลักของการมีส่วนร่วม คือ 1) การช่วยเหลือและสนับสนุนซึ่งกันและกัน 2) การเรียนรู้จากการกระทำในการแก้ไขปัญหา 3) การแลกเปลี่ยนประสบการณ์การดูแล และ4) การสืบทอดการดูแลต่อเยาวชนรุ่นใหม่ ลักษณะของชุมชนที่ช่วยสนับสนุนการมีส่วนร่วม คือความเข้มแข็งชุมชนการมีผู้นำชุมชนที่เก่งและการมีสัมพันธภาพที่ดีกับคนในชุมชน นอกจากนี้เจ้าหน้าที่สาธารณสุข และองค์กรปกครองส่วนท้องถิ่นต้องเข้ามามีส่วนร่วมในการดูแลผู้สูงอายุที่ต้องการการพึ่งพาในการทำกิจวัตรประจำวัน ส่วนสาเหตุของการไม่มีส่วนร่วมของชุมชนได้แก่ 1) การขาดแหล่งข้อมูลเพื่อการรับรู้ของคนในชุมชน และ 2) การขาดการกระตุ้นติดตาม

จากการดำเนินการวิจัยดังกล่าว เพื่อให้เกิดการมีส่วนร่วมของชุมชนอย่างต่อเนื่องและยั่งยืน ในการดูแลผู้สูงอายุที่ต้องการการพึ่งพาในการทำกิจวัตรประจำวันผู้ที่มีส่วนเกี่ยวข้องควรดำเนินการคือ 1) การเตรียมผู้ดูแลในการดูแลผู้สูงอายุ 2) การจัดตั้งระบบการดูแลผู้สูงอายุ 3) การสนับสนุนงบประมาณในการดูแลผู้สูงอายุ และ 4) การจัดทำหลักสูตรการดูแลผู้สูงอายุสำหรับอาสาสมัครสาธารณสุขประจำหมู่บ้าน

คำสำคัญ: การมีส่วนร่วม ชุมชน ผู้สูงอายุ ความต้องการการพึ่งพาในการทำกิจวัตรประจำวัน

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* พยาบาลวิชาชีพชำนาญการพิเศษ วิทยาลัยพยาบาลบรมราชชนนี นครศรีธรรมราช
** พยาบาลวิชาชีพชำนาญการ วิทยาลัยพยาบาลบรมราชชนนี นครศรีธรรมราช

Community Participation toward Health Care among Dependent Older Adults

*PimpawanRueangphut M.N.S**
*WaranyaJidbantad M.Sc.***

Abstract

The older adult population in Thailand is increasing rapidly. Support from the community is even more important for older adult patients to maintain their home-based life, particularly for those with extensive care needs and family caregivers are engaged in providing care almost all day long. The purpose of this research is to explore the community participation toward health care among dependent older adults in Nakean district, Maung, Nakhon Si Thammarat, Thailand. Fifty seven volunteers from this community were selected after meeting certain criterion. Participants comprised 43 village health care volunteers, 10 caregivers, 3 community health care officers and 1 social development worker. The process was based on participation in thinking, planning, acting and evaluating elderly illnesses pattern. The study was implemented between January and December 2014. Data was collected by means of in-depth interviews, observation of focus group discussion, writing field notes, taking photographs and participating with dependent older adultsin community. Data analysis was carried out through mean of induction and typological analysis.

The finding revealed that there were generally 4 types of processes in older adultscare . They are: 1) helping and supporting each other. 2) learningto cope with appropriate problem. 3) exchanging experience in caring. 4)maintaining culture of caring. The supportive community was characterised by strong community support, strong leadership and friendliness among people in the village, public health and local organization. The reasons for non-participation in dependent older adults care in this community were 1) insufficient source toward caring to older adults information. 2) lack of stimuli and follow up care.

To go on the processfordependent older adultswould involve; 1) preparingcaregivers to care for dependent older adults, 2) establishing health care system, 3) allocation of budget for caring dependent older adults, and 4) creating curriculum for health volunteers to care for dependentolder adults.

Keywords: Community, Participation, Dependence, Older adults

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* Registered Nurse, Senior Professional Level, Boromarajonani College of Nursing, Nakhon Si Thammarat
** Registered Nurse, Professional Level, Boromarajonani College of Nursing, Nakhon Si Thammarat

Introduction

The older adult population in Thailand is increasing rapidly. This demographic change is a direct result of the success of socio-economic development that has led to declines in mortality rates at all ages and reductions in infertility (Pramote, 2014). An increase in health care needs is expected to accompany this increase in older adult population. In Thai culture, the elderly live at home even during illness, rather than in a health care facility. Support from the community is even more important for older adult patients to maintain their home-based life, particularly for those with extensive care needs and family caregivers are engaged in providing care almost all day long (Sasipat, 2009).Therefore, making best use of the limited resources available for health care will require an emphasis in training of professional staff and volunteers. Integration of health care for older adults with established health services will be necessary, particularly with the existing primary health care systems. The Ministry of Social Development and Human Security laid down the principles for the rehabilitation of older adults to strengthen the quality of lifewithinthe community, with emphasis on participation of all citizens, family and community to care for older adults. Rehabilitation is an integral part in improving the lives of older adults, by allowing relatives and people within community to provide the support.

The goal of National Health Security Organizationis to ensure people have access to health services with focus on personal care, family and community. Therefore, participation of village health carevolunteers and leaders of community, together with the involvement of individuals, communities, public health and Sub district Administration Organizationare important to service the older adults. That is the duty of everyone in society. The public participation is key to developing a process that is promoted and supported by the state, so that the community hasa chance to participate in their community affairs to establish developmental objectives and policies. As a result, all related groups in the community take part in planning and decision making for a good mutual understanding for any project implementation there. These people are also able to form acceptance and responsibility as community members. This participation could arouse a feeling of ownership in community projects and pride in activities that theyhad participated. Furthermore, they arrange various activities in a village smoothly, efficiently, and successfully (Cohen&Uphoff, 1981; Nattaporn, 2011).

The Nakean subdistrict is located inthe Maung of Nakhon Si Thammarat province in the southern part of Thailand. There are 2 Tambon Health Promoting Hospital, for a population of 11,303, including 1,034 older adults and 53 dependentolder adults. (Nakean Sub-district Administrative Organization, 2014). Nakean subdistrict is a community with bothcity and rural environment. Community families are both extended and single ones. Most older adults have some abnormal health conditions. Most frequently found diseases included

high blood pressure, heart attack, diabetes, chronic disease and disability (Tambon Health Promoting Hospital of Banmaunghuotalang, 2014). The older adultswould be cared for by anyone whom they live with. Most local people were agriculturists and their economic status is fair. The caregivers of these older adults have other work outside the family. The community plays an important role in helping any families loaded by the caring of older adults who need continual assistance in every day life. The Boromarajonani College of Nursing Nakhon Si Thammarat joined Nakean Sub-district Administrative Organization (SAO) and Tambon Health Promoting Hospital of Banmaunghuotalang and Tambon Health Promoting Hospital of Bantungnod training Health Volunteers and caregivers to promote and support health care for the older adults in the community. We believe it is important that the community stay physically and mentally fit, which can be quantified with a community appraisal so that it is crucial to study participation of community care for dependentolder adults, and the lessons learned to improve and promote the quality of life for the older adults.

Method

Design: The study used participatory action research, the research process was based on mutual collaborative approach to participate in thinking, planning, acting, and evaluating (Kemmis & Mc Taggart, 1988). The study was implemented from January 2014 - December 2014, in 9 villages of Nakean district, Maung, Nakhon Si Thammarat, undertaken within 4 phases. In phase I, studying the community and finding people to participate in the project. Phase II, preparing teams by volunteering and organizing a workshop on dependent older adult care. Phase III, organizing the virtual family and assessing the dependent older adults' performance and way to rehabilitate them individually and preparing a family folder to record the visits. Phase IV, visiting the dependent older adults in the community once a month to share problems, needs, and readiness confidence among older adults in the villages and summarizing lessons learnt.

Participants: The participant in this study comprised of 57 persons with43 village health care volunteers who voluntarily provided care for patients in the community and had received a training course in disabled patients care.Ten caregivers had cared for dependentolder adults with illness, 3 community health care officers, and 1 social development worker.

Instruments: the dependent older adults in Nakean community were selected by using Barthel index of Activities of Daily Living for distinguished level of older adult activities (Collin et al., 1988). Theolder adults who were selected fulfilled the survey items based on 10 items and20 score. The older adults who were partial dependence (5-11 score) and complete dependence (0-4 score) were selected into group 2 and group 3 respectively.

Approval for research involving human subjects was obtained from Boromarajonani College of Nursing Nakhon Si Thammarat Thailand, prior to data collection.

Data collection process: Survey data was obtained from January 2014 through February 2014, while interview data was obtained between April and November 2014. The procedure for obtaining data consisted of two parts. Part I: The primary researcher requested permission, by way of a formal letter to the Director of the Public Health Office, to collect data. After approval was granted, the coordinator of each public health office was visitedto build relationship, to explain objectives of the study and process, and request assistance in collecting data. Part II: The researcher had prepared training program for volunteers, and joined their local activities, i.e., visitsick dependent older adults every 2 week, exchange experience on caring every month.The researcher builtan ongoing relationship with each volunteer until they feel trust. Then, the researcher conducted focus group and the in-depth interviews, critical reflection, observed their behaviors and collected data from their diaries which the community health officerhad provided to them.

Data analysis: the content analysis was used to analyze the in-depth interviews, focus group and the observation information of this study which had started since the early stage of data collection. The researcher used triangulation methods, including the observation, the critical reflection, and the individual interviews for checking and confirming the accuracy.

Results

Outline of participants: Table 1outlines participant characteristics. There were 57 person who have been participated, Most of them were females (84.2%, n=48), age ranges from 28 to 65 year old, 23 were Buddhist and 34 Muslim. More than half of the subjects were married (65.0%). Nearly 43.8 percent of subjects had completed Secondary school. Regarding occupation, about 88.7 percent were still working. Nearly 8.8 percent of subjects (n=5) have high income. And most of them (77.2%, n=44) have good health.

Table 1 outlines participant characteristics (N=57)

Characteristic	Number	Percentage	Characteristic	Number	Percentage
Sex			**Religion**		
Male	9	15.8	Buddhist	23	40.4
Female	48	84.2	Muslim	34	59.6

Table 1 outlines participant characteristics (N=57)

Characteristic	Number	Percentage	Characteristic	Number	Percentage
Marital Status			**Health Status**		
Single	17	29.7	Good health	44	77.2
Married	37	65.0	Have disease/	1	22.8
Widowed/Divorce	3	5.3	(HT, DM, Gout)		
Age (years)			**Occupational**		
≤ 30	7	12.3	Trader	13	22.8
31-40	18	31.6	Employee	21	36.8
41-50	22	38.6	Agriculturist	11	19.3
51-60	6	10.5	Officer	5	8.8
>60	4	7.0	House wife	7	12.3
Education level			**Income per month**		
Primary school	21	36.8	≤5,000	25	43.8
Secondary School	25	43.8	5,001-10,000	27	47.4
Bachelor of Arts	8	14.0	> 10,000	5	8.8
Master of Arts	3	5.4			

Community participation: The community participation including the Sub-district Administrative Organization (SAO), the community health care officers, health care volunteers, and caregivers, were mostly management. The SAO has been involved in the management process as part of health activities. They are awareof roles and duties in health care to a statement that "I have attended the meeting, training and I assigned the community health care to attend it". The SAO has been supportive of training in arranging the activity, and older adult remuneration.

The health care volunteers involved in caring for older adults, were commissioned by community health care workers care for all people who were in their responsibility including the older adults, pregnant women and children. The health care volunteers seem to get more knowledge, making them more efficient to care for the older adult with pride. He explained that "I was born in the village.I saw the older adults and disabled patients were left alone in the day, I wanted to help them because we live together in the same village. After

I take care of him, he was smiling and was feeling better. I feel happy and proud".

The Health Promoting Hospitalset down all organized measures to prevent disease, promote health, and prolong life among the population as a whole. The three main public health functions are 1) assessment and monitoring of the health of communities and populations at risk, to identify health problems and prioritise 2) formulation of public policies designed to solve identified local and national health problems and priorities 3) to assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services. The community health care officers provide management, including planning, controlling and directing, and set up to assist older adults health services.

Most staff has understood roles and duties of health teamin the community in volunteering health services. They were give advice, training, consultation to stimulate health care volunteers to take part in controlling, directing and evaluating the services. Most of caregivers were daughters who were married but still live together withtheir parents, and some caregivers were daughters in law. The members of family have divided functions and roles to take care of the dependent older adults as the primary caregiver and as the secondary caregiver. In fact, primary caregiver have direct physical and mental care of the older adults and second caregiver provided economic support. The community participation divided by activities of participants as show in table 2.

Table 2 Community's Participation

Sub-district Administrative Organization	**Health care volunteers**	**Community health care officers**	**Caregivers**
- Thinking	- Thinking	- Thinking- Planning	- Thinking
- Planning	- Planning	- Supporting - Acting	- Planning
- Supporting Budget	- Training	- Advising- Consulting	- Training
- Evaluating	- Acting	- Simulating- Reflecting	- Acting
	- Reflecting	- Evaluating	- Reflecting
	- Evaluating		- Evaluating

Process of community participants: The community participants set up planning, working, sharing, and evaluating activities for dependent older adults. They understood and were aware of participation in any decision-making process, undertaken within the 4 phases. In phase 1, studying the community and finding people to participate in the project. Cooperation of people in community was used as referendum. Phase II, preparing teams with volunteers and organizing workshop on dependent older adult care. In this phase the subjects were assignedroles of their own, getting training onsituation and effects to the older adults, older adults related diseases and caringfor them, promoting health in the older adults. The level of evaluation and competency of training was high.

Phase III, organizing the virtual family and assessing dependent older adults's performance and ways to rehabilitate them individually and preparing a family folder to record the visits. Phase IV, visiting dependent older adults in the community, similar to sharing problems, needs, readiness confidence and exchange among older adults in work in the villages once a month and summarizing lessons learn, as illustration 1.

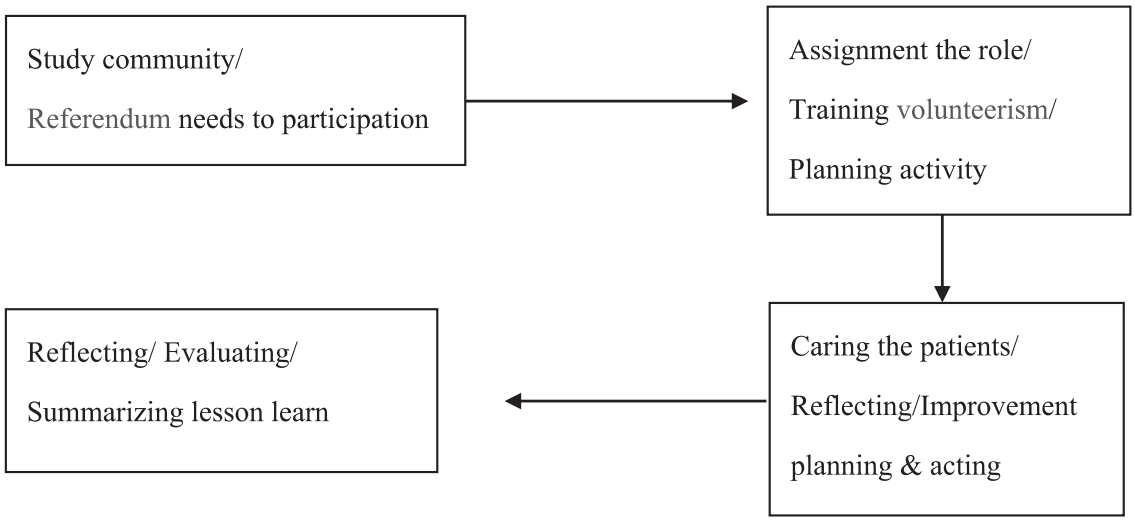

Illustration1. The process of community's participants

The finding: The finding revealed 4 processes of participatory learning in older adults care, as follow;

1. Helping and supporting each other.

Most health care volunteers have their own occupation. Theyused theirfree time to care for patients, which differ from person to each person. Sometimes volunteers were unable to carefor their patients, they had toaskother volunteers to take care for them.

"People in the village are fraternal neighbors. We have to help each other because we want him to be healthy like a normal person".

"I felt compassion for her, She lived alone in day and cannot help herself. When I visited her, talk to her, change her side and massage, she smiled and I am glad she was happy. When I was young, she had given some food to me and let me watch TV at her home so when she is old and sick, I must take care her".

"we took care patient together but sometime we had to switch if someone can't go, another one will do".

2. Learning by doing for appropriated problem.

The participants visited dependent older adults every 3 day per weeks. They had schedule to visit patients and record performance, after taking careof patients they will record performance of what they had done, if the patients have problems and they can't manage it, they will report the data to the community nurse.

"some of the patient's problems, I did not know how to do it, so I report to the community nurse, she advised me what should I do, after which I apply to another patients",

"I tried help the patient to sit on the bed in various ways. And finally I found that good fabric helped patients to get the best seats. It helps to reduce the stress and patients can sit longer".

3.Exchanging experience incaring.

The participants were sharing and reflecting their experienceon caring each month, they were exchanging and learning scopes for dependent older adults.

"I had learn transferring patient from her, she told me how to move patient from the bed to wheelchair".

"That was good to share our patient's care experience, I learn more things, and usethem on my patient".

4. Maintaining culture of caring.

Culture within the same society.Vertical culture is inherited from one generation to another generation. Learning is a process that is a common practice in the community. The community characteristic that supported participation was community strength, strong leadership and friendliness among people in the village, public health and local organization.

"We must maintained a culture of caring, the younger will learn it".

"We live and help each other regardless of religion, whether Buddhist or Muslim.That is the culture of our villages, so we were the example for the young".

The causes for non-participation in dependent older adultsin this community, is as follow; 1) The source forcaring to older adults informationwas not enough. 2) Lack of stimulation and follow up.

"The information of older adults care have less, we have not pamphlet or information transmitter".

"Some volunteers seldom visited patient because lack of simulating from community health care officer.

The target group were perceived to the dependentolder adult situation. Then, they have recognized and participate in planning, acting, reflecting, and evaluating to dependent older adults. The process were contribute to the community.

The satisfaction of community participants:

The participants were satisfy to activities care for dependent older adults in high level (4.34)

Table 3 The satisfaction of participants

Items	M	S.D.	Level
1. The activities have raised-participants awareness of dependent older adults problems	4.33	0.71	High
2. The activities property to this community	4.34	0.69	High
3. The activities benefit to dependent older adult	4.39	0.59	High
4. The activities should be continuous	4.37	0.62	High
5. The activities supported community self-reliance	4.32	0.72	High
6. The satisfy of participants to the activities	4.34	0.69	High

Discussion

The community was participated in all process of dependent older adults care. According to concept of health service supply, need of service users must be served. The previous study revealed that, if any communities were not involved in planning, making decision, and evaluating, the service user's satisfaction would not be met (Nattaporn, 2011). In the community participation's process found that the Sub-district Administrative Organization (SAO) has participated support budget for training volunteers, conference room and meal costs. The SAO have been slightly involved in the management process in the part of health services. They have less received advice or training about roles and duties of public health, and they lacked the staff to manage on health services. Our results are consistent with several studies (Lek, 2009; Nattaporn, 2011; Sarawut, 2008; Sasipat et al., 2009).

All the participation process of health care volunteers were high level. This can be explained that they recognized the importance of health, most

of them has a plan for helping dependent older adults and informal sharing including arrange exercise activities, measure blood pressure, and massage. Therefore they gave financial and equipment support. However, some activities, health care volunteers were not be able to help dependent older adults because they lack of knowledge and practice which is relevant to several studies that reporting the Health Promoting Hospital were compliance, which, improving the structure, service, and management emphasized to promoting, preventing, policing, rehabilitating, training volunteers for older adults care, cooperating network to provide care for older adults. Service covering all segment of older adults, managed care, access to services, including manual of practice guideline and standard service for older adults. (Chanatda, 2006; Nitaya, 2006; Prapa, 2004; Prasert,2012; Wanapa&Ladda, 2010; Worachart, 2010).

Conclusion

The community participation care to dependent older adults at high level. To improve the community participation ongoing and sustainable, there should be the action plans; 1) The community should encouraged to learn and understand their role, duties and expected benefits. The community should take a part in the health services, preparation of supervision by establishing a team of community volunteers in providing care for older adults at least three times per weeks. 2) Health Promoting Hospital should preparedness caregivers for caring dependent older adults and establishing care system. 3) Sub-district Administrative Organization allocate budget for caring dependent older adults, there should be meeting to indicate about roles, mission and scope of health personnel work.4) Educational institutions should develop older adult's curriculum for support health care volunteers.

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