

Factors Predicting Self–Management Behavior among Thai Older Monks with Type 2 Diabetes: A Cross–Sectional Study

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Abstract: Self-management is important for people with diabetes, including older monks whose lifestyles must conform to religious practice. This cross-sectional study aimed to describe self-management and its predictive factors among older Thai monks with type 2 diabetes. The sample consisted of 196 older monks who received services at two monastic hospitals from September to December 2023. Data were collected using questionnaires regarding general information and illness information, self-management behavior, health literacy, perceived self-efficacy, and social support. Stepwise multiple regression analysis and descriptive statistics were used to analyze the data.

The findings indicated that the older monks exhibited moderate self-management and health literacy levels, with high perceived self-efficacy and social support. Collectively, these factors significantly predicted self-management by 35.4%. Health literacy emerged as the most influential predictive factor for self-management, followed by self-efficacy and social support. Nurses can use this finding to develop and test the effectiveness of an intervention program that emphasizes increasing health literacy, self-efficacy, and social support to enhance self-management behaviors integrated with new technology.

Keywords: Health literacy, Monks, Self-efficacy, Self-management, Social support, Type 2 diabetes

Received 11 June 2024; Revised 5 November 2024;
Accepted 7 November 2024

Author contributions:

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Introduction

Diabetes is a chronic condition that worsens with age and poses a significant public health concern. In 2021, the percentage of the global population aged

20 to 79 with diabetes was 10.5%. In the same year, it was found that 24% of those aged 75 to 79 had diabetes, which was predicted to rise to 24.7% in 2045.¹ In Thailand, diabetes also becomes more common as people age.² The data from the health data center of the Ministry of Public Health of Thailand in 2024 revealed that the prevalence of diabetes in older adults was 22.17%.³ Regarding the prevalence of diabetes in Buddhist monks, the studies show that monks have a high prevalence of diabetes.⁴⁻⁶ Reported data from the Ministry of Public Health of Thailand show that 15.4% of older monks have diabetes, which is the second top cause of illness among older monks.^{7,8} Additionally, diabetes results in complications in both acute and chronic conditions, such as hypoglycemia, high blood sugar levels with diabetes ketoacidosis (DKA), hyperglycemic hyperosmolar nonketotic syndrome (HHNS), diabetic nephropathy, diabetic retinopathy, diabetic neuropathy, and diabetes foot ulcer.⁹

The high prevalence of diabetes among older monks might be their difficulties managing their diabetes. Monks are devoted to attaining spiritual enlightenment, which involves giving up the five aggregates—physical contact, feeling, memory, emotion, and numerous embellishments. They typically only eat one meal a day and receive cooked food as alms without always being able to consider the food's composition, resulting in an incapacity to control current diseases and possibly even exacerbating them.¹⁰ Because of these issues, the National Constitution of Monks' Health 2017 was declared to address these difficulties and promote clarity by emphasizing the need for monks suffering from chronic diseases to modify their behavior and adhere to monastic discipline in their daily routines. This involves ensuring an adequate and well-balanced diet, the flexibility to choose appropriate food types, and the ability to take prescribed medication at specified times. Engaging in aerobic exercises through almsgiving or temple ground sweeping is encouraged. Monks are also encouraged to utilize various assistive devices and seek support

from their community to enhance their physical and mental well-being.¹¹ Nonetheless, the modified behavior for achieving the treatment and control of diabetes criteria lies with older monks to manage themselves. They must practice adequate self-management to regulate their blood sugar levels and avoid the various possible consequences by incorporating themselves into their life plan.¹¹ However, the review of self-management among older monks with diabetes shows that it was at moderate levels.¹² Thus, this study seeks to understand self-management and its predictive factors among older monks with type 2 diabetes (OMW-T2DM), which will be beneficial in developing interventions to improve their self-management behavior (SMB).

Conceptual Framework and Literature Review

To achieve the goal of diabetes control, the Diabetes Association of Thailand's 2023 clinical practice guidelines and pharmaceutical and non-pharmacological therapies are available for managing diabetes.⁹ The goal of medication treatment for older adults with type 2 diabetes who do not have any comorbidities is to keep their blood sugar levels within the target range, which is their hemoglobin A1C (HbA1C) levels below 7%. In contrast, older people with comorbidities should control hemoglobin A1C levels between 7 and 7.5%.⁹ Older monks with diabetes are also treated based on these principles.^{13,14} Furthermore, the initial phase of non-pharmacological treatment for type 2 diabetes often entails adjustments to an individual's lifestyle. Medical treatment, such as medications, may be recommended when blood glucose levels remain uncontrolled.^{9,14} Therefore, to achieve the goal of diabetes treatment, older monks must practice medication use and change their lifestyle, which must be integrated into their lives to achieve self-management.

This research used the concept of self-management developed by Hibbard et al.,¹⁵ which defines the SM

concept as the role of patients who must be experts in managing various complex situations and adhering to treatment to the fullest. Self-management is divided into four aspects, which are explained in more depth. Firstly, the role aspect believes that caring for health diligently is the patient's responsibility. Older monks should adjust their roles to be consistent between the roles of monks and patients.¹¹ Secondly, in terms of knowledge, having confidence and expertise in medical or behavioral treatments is crucial. Older monks possessing the assurance and knowledge necessary for appropriate practices are more likely to undergo behavioral changes through the monks' routine, following the tenets of monastic discipline.¹¹ Thirdly, the action aspect involves adeptness in skillful practice and negotiation when receiving diverse types of health services. Older monks can modify their behavior to align with the routine dictated by monastic discipline.¹¹ Lastly, regarding stress, effectively handling emotions during lifestyle changes and moments of stress is paramount. Older monks are encouraged to acknowledge that illnesses may arise as a part of nature. They can meditate and stay attuned to their present emotions to manage the mind.¹¹

Based on the review, the exploration of self-management among older monks with diabetes revealed a moderate level of self-management.¹² While many exhibited active exercise behaviors through almsgiving or temple ground sweeping, their ability to choose their food was a notable constraint. This limitation stems from the monks' commitment to maintaining a state of samadhi, a state of deep concentration and mindfulness, to garner respect from those observing them. Therefore, to understand and adjust self-management in this group, studying the factors that can predict self-management is necessary. From the literature review, the study identified factors influencing self-management, encompassing personal aspects. Firstly, there were factors deemed unalterable, such as (1) age,¹⁶ (2) education level,¹⁶ and (3) duration of illness.¹⁶ Secondly, factors amenable to change were identified, including

(1) self-efficacy,¹⁷ (2) social support,¹⁸ and (3) health literacy.¹²

Health literacy is a personal skill crucial for accessing, understanding, and applying information to promote and maintain good health.¹⁹ It is categorized into three levels: (1) primary or functional health literacy, involving skills such as reading, writing, understanding vocabulary, translating meanings, and calculating numbers; (2) communicative or interactive health literacy, which entails effective communication with others to exchange information and make decisions for behavioral change; and (3) critical health literacy, utilizing intellectual and social skills to analyze, synthesize, establish connections, compare, process received information, and exert control over events or situations.¹⁹ A study focused on the older population in Groningen province, the Netherlands, and demonstrated that health literacy significantly predicted self-management.²⁰ Precisely, a lower level of health literacy corresponded with diminished self-management capabilities. This underscores the critical role of health literacy in anticipating and influencing the effectiveness of self-management among older adults.

Self-efficacy refers to an individual's perception and confidence in their ability to perform a particular task or make decisions independently.²¹ The variation in individuals' abilities stems from differing perceptions of self-efficacy. A positive perception of self-efficacy is associated with effective self-management.²² The patient's perception of self-efficacy plays a pivotal role in influencing decision-making skills, enabling confident choices regarding health, including decisions to alter behavior for enhanced self-management. In addition, it also promotes patients' confidence in practicing the skills to achieve effective self-management. In a study focusing on factors associated with self-management in older people with type 2 diabetes, self-efficacy emerged as the most influential predictor of independent diabetes management behavior.²³

Social support is being cared for, loved, accepted, valued, and recognized as part of an interpersonal network.²⁴

It comprises three key aspects: (1) emotional support, (2) support for acceptance and appreciation, and (3) support for being a part of a network of shared responsibilities.²⁴ Furthermore, according to Schaefer et al.,²⁵ social support involves receiving help from various sources, including family and the community. This support comes in three forms: emotional, informational, and material.²⁵ It provides encouragement, assistance, and valuable information, enabling patients to make informed decisions in their self-management journey.²³ Social support results in effective self-management by providing help or benefit. It is also related to the skills of being a health partner who will help and suggest to patients matters of self-management. A study among older patients with type 2 diabetes found that support from the family had a positive relationship with self-management.¹⁸ The findings suggest that adequate family support correlates with better self-management outcomes; in other words, when there is strong support from the family, the individual's ability to manage their condition will be improved.

The existing literature primarily focuses on predicting self-management factors in adults and older adults with diabetes, with a notable gap in studies involving older monks. This population may face heightened complications due to unique lifestyle routines and practices. Unlike other people with chronic conditions, older monks follow a distinctive routine, engaging in merit activities to attain nirvana with the utmost earnestness as per monastic discipline.²⁶ Self-management involves a complex interplay of multiple factors, and more than one aspect may be required. There remains a need for specific studies addressing the distinctive challenges and requirements of self-management in older monks, considering their distinct lifestyles and spiritual commitments.

Study Aim

This study aimed to describe the level of self-management, health literacy, self-efficacy, and social

support in older monks with type 2 diabetes and determine the predictive power of health literacy, self-efficacy, and social support for self-management in older monks with type 2 diabetes.

Methods

Design: This study used a cross-sectional design. We reported our findings using the STROBE Statement Checklist.

Sample and Setting: This study focused on monks aged 60 years and above who were diagnosed with diabetes and received treatment at the outpatient departments of two hospitals in Thailand's northern and central regions. The sample was purposively recruited according to the following criteria: 1) being diagnosed with diabetes for at least 6 months, 2) being treated with oral blood glucose-lowering drugs, 3) being able to perform daily routines by themselves, assessed using the Barthel ADL Index of the Department of Medical Services, Ministry of Public Health,²⁷ consisting of ten questions, on which the score must be 12 or more, 4) having complete mental awareness, assessed by using the Short Portable Mental Status Questionnaire (SPMSQ) of Pfeiffer,²⁸ the Thai version of the Chiang Mai Provincial Public Health Office,²⁹ consisting of ten questions, on which the score must be eight or more, 5) being able to understand and communicate in Thai, and 6) being willing to give informed consent.

The criteria for exclusion from the sample group were as follows: blood sugar level at the fingertip on the day of data collection of less than 70 milligrams per deciliter or more than 250 milligrams per deciliter because complications of hypo-hyperglycemia may cause them not to answer the questionnaire.

Sample size determination was conducted using the power analysis method, with the power value set at 0.80. The effect size of the variable was calculated based on the factors predicting self-management of elderly patients with hypertension in the study by Phanlek

et al.,³⁰ who reported an R-squared value of 0.283 ($p < 0.001$) with similar characteristics. Subsequently, the effect size of the variable was calculated using the G*Power program and determined to be 0.394. However, this was deemed excessively large and unsuitable for this study. Consequently, a medium-sized effect of 0.15, commonly used in nursing research,³¹ was chosen.

The test family selected the F-test, and the statistical test chosen was linear multiple regression with a fixed model and R^2 deviation from zero. The error value (alpha) was set at 0.01, and the power value was set at 0.95, considering three independent variables. Utilizing the G*Power program, the calculated sample size was 157 individuals. To account for potential data loss, we added 25% to the sample group, resulting in a final sample size of 196 participants.

Ethical Considerations: This research project was approved on 3 August 2023 by the Research Ethics Committee, Faculty of Nursing, Chiang Mai University, No. 082/2566, Project Code 2566-EXP053, and approved by two studied monastic hospitals. Permission to collect data was obtained from the directors of two monastic hospitals. During the research process, participants were provided information about the research's purpose, data collection procedures, benefits, and the right to withdraw. The sample group could withdraw at any time without affecting their treatment or health services. Confidentiality was assured for personal and health-related information, which has only been presented and discussed in an anonymized manner. Finally, participants were required to sign a consent form to participate in the research. All data were treated with the utmost confidentiality and were accessible only to the research team. After data analysis, all documents would be securely destroyed within two years of publication.

Instruments: The tools used for data collection were as follows:

The General Information and Illness Information Questionnaire encompasses personal details such as age, years in the monkhood, secular and religious education levels, temple location, health service, and information

sources. Additionally, it includes illness-related data like the duration of diabetes diagnosis, other existing health conditions, prescribed medications for blood glucose and other purposes, recent blood glucose levels, and any complications resulting from diabetes.

The Self-Management Behavior Assessment Form (SMBA): This instrument was originally developed by Hibbard and colleagues¹⁵ and was translated into Thai by Pidetch et al.³² We modified some items to better fit the older monks with chronic diseases with permission from the developers. The SMBA form consists of 13 items, including two items for roles, such as "You are responsible for taking care of your own illness"; six items for knowledge, such as "You believe that you can prevent and manage symptoms or problems related to your health condition"; three items for practice, such as "You understand the differences in treatment methods of doctors"; and two items for coping with stress such as "You believe that you can handle any problems or stress that may arise." The items are rated on a 4-point scale from 1 = disagree to 4 = strongly agree. The score ranges from 13 to 52, with a higher score reflecting higher self-management behavior. For the cut point, SMB scores 13–35 indicate a low level, 36–39 scores indicate a moderate level, 39–42 scores indicate a high level, and 43–52 scores indicate a very high level. The content validity index (CVI) was validated by six experts, including one geriatrician, three expert nursing professors, and two monks with a high ecclesiastical rank with a CVI of 0.93 and its internal consistency reliability Cronbach's correlation coefficient of 0.84. in the actual study.

The Health Literacy Assessment Form (HLA): This instrument was developed by Ishikawa and colleagues³³ and translated into Thai by Noppakraw et al.³⁴ The Thai version of the health literacy assessment form was modified in some items to better fit the older monk with hypertension by Codrington and colleagues,³⁵ and for this study, we modified the term "hypertension" to "chronic disease" with permission of the developers. The HLA form comprises 14 questions with five negative

items in basic health literacy, such as “You find that the text is too small and not suitable for reading”; five positive items in interactive health literacy, such as “You search for health information from various sources, such as asking experts, printed documents, and the internet”; and four items in critical health literacy, such as “You have considered the health information received to be appropriate.” The items utilize a 4-level rating scale for responses of 1 = never to 4 = often. The five negative items are reverse-scored before the summation of the total score. The scores range from 14 to 46 points, with a higher score indicating higher health literacy. The results are interpreted by calculating class differences, with scores of 14.00–28.00 a low level, 28.01–42.00 a moderate level, and 42.01–56.00 a high level. The same experts validated the content validity (CVI) as in the Self-Management Behavior Form, which was 0.97, and its internal consistency reliability Cronbach’s correlation coefficient of 0.85 in the actual study.

The Perceived Self-Efficacy Assessment Form (PSEA): This instrument was originally developed by Bandura²¹ and was modified into a Thai version by Thatsaeng et al.³⁶ We modified the name and adjusted the content of specific items to better suit the participants with permission from the developers. The PSEA comprises ten positive items, including two items on symptom management techniques, such as “You have confidence that you can manage the symptoms of chronic disease”; two items on exercise, such as “You have confidence that you can choose the type of exercise that is appropriate for your chronic disease”; three items on having a diet, such as “You are confident that you can eat breakfast and lunch as usual”; and one item each on contacting a doctor, using medicine, and emotional management. The items utilize a 10-level rating scale for responses with 1 = no confidence to 10 = confidence. The score ranges from 10 to 100 points, with higher scores indicating higher self-efficacy. The score is also calculated by class differences, with scores of 1.00–3.00 indicating low self-efficacy, 3.01–6.00

moderate self-efficacy, and 6.01–10.00 high self-efficacy. The content validity index (CVI) was validated by the same experts as the other two previous instruments, and it was 0.93, and its internal consistency reliability Cronbach’s correlation coefficient of 0.83 in the actual study.

The Social Support Assessment Form (SSA): This instrument was originally developed by Wongsuwan et al.³⁷ Based on Cobb’s concepts of social support,²⁴ together with Schaefer, Coyne, and Lazarus’s concepts of social support,²⁵ we modified some items to better fit the older monks with chronic diseases with permission from the developers. The SSA consists of 16 items divided into four items on emotional support, such as “You are always taken care of by the people around you”; four items on receiving recognition and appreciation, such as “People around you respect you”; three items on participation and being part of society, such as “People around you always encourage you to participate in temple-related activities and religious activities”; two questions on assistance with material, financial, labor, and health services, such as “When you are sick or have a problem, you know the resources around you for help”; and three questions on information support, such as “You always receive advice on taking care of your health from people around you or health personnel.” The items were rated on a 4-point scale from 1 = disagree to 4 = strongly agree, with scores ranging from 16 to 64, with higher scores indicating higher social support. The cut point is 20–40, indicating low social support; 41–60, indicating moderate social support; and 61–80, indicating high social support. The content validity index (CVI) was validated by the same experts as previous instruments and was 0.91, and its internal consistency reliability Cronbach’s correlation coefficient of 0.81 was in the actual study.

Data Collection: After the IRB committee approved the research proposal and permission from the director of two monastic hospitals, the principal investigator (PI) met with the heads of the outpatient departments of both hospitals to explain the research’s purpose and

the data collection method. In this study, research assistants trained by the PI screened and collected the data for all questionnaires. The data collection process was as follows: 1) the sample group was screened for eligibility according to the inclusion criteria. Then, the study's purpose and benefits were explained, and the participants signed the consent form; 2) The participants answered all the questionnaires for about 30 minutes in a private area near the outpatient department.

Data Analysis: Descriptive statistics were used to analyze personal and illness data. All dependent and independent variables and data characteristics were tested for compliance with the preliminary assumptions in the regression analysis. The results met the criteria, enabling the examination of the predictive power of health literacy, self-efficacy perception, and social support on self-management behavior through stepwise multiple regression analysis, with a significance level set at 0.05.

Table 1. Demographic characteristics of the sample (n = 196)

Demographic characteristics	Frequency	%
Age (years) (mean = 71.17, SD = 11.24)		
60–69	95	48.5
70–79	64	32.6
> 79	37	18.9
Seniority level		
Novice monk 1–5 years	10	5.1
Machima monk 6–10 years	14	7.1
Thera monk 11–20 years	65	33.2
Mahathera monk > 20 years	107	54.6
Level of formal education		
No education	8	4.1
Primary education	54	27.6
Secondary education	83	42.3
Bachelor's degree or equivalent	36	18.4
Higher than bachelor's degree	15	7.7
Dharma department studies		
No dharma scholar bachelor	45	23.0
Dharma scholar advanced level	151	77.0
Location of the temple		
District area	44	22.4
Outside district area	152	77.6

Results

Characteristics of participants

The sample group in this study had an average age of 71.17 years. Approximately half of the participants were younger elderly, aged between 60 and 69, and more than half identified as monks. Most had graduated from the Dhamma Department, while over half completed their secular education at the primary and secondary levels. Most of the sample group resided in temples outside the city district and predominantly sought health services from the university hospital. A substantial portion of the participants had been diagnosed with diabetes for 1–5 years. However, a notable observation was that the majority still struggled to control their blood sugar levels, as detailed in **Table 1**. As shown in **Table 2**, the participants had moderate self-management and health literacy, whereas self-efficacy and social support were high.

Table 1. Demographic characteristics of the sample (n = 196) (Cont.)

Demographic characteristics	Frequency	%
Health service sources		
Subdistrict health promoting hospital	29	14.8
Community hospital	27	13.8
University hospital	140	71.4
Receiving information from a medical person		
Received	196	100.0
Duration of diagnosis (years) (Mean = 7.02, SD = 5.16)		
1–5	116	59.2
6–10	54	27.6
> 10	26	13.3
Blood glucose control from HbA1C level		
Controlled	68	34.7
Uncontrolled	128	65.3

Table 2. Score range, mean, standard deviation, and level of self-management, health literacy, perceived self-efficacy, and social support (n = 196)

Variable	Min–Max	Mean (M)/SD	Level
Self-management	22–48	M = 35.19/SD = 6.78	Moderate
Health literacy	17–50	M = 35.83/SD = 7.04	Moderate
Self-efficacy	41–100	M = 70.28/SD = 13.17	High
Social support	38–62	M = 51.59/SD = 5.27	High

Factors predicting self-management

The preliminary data agreement checks of the statistics found that all variables had a linear relationship and a normal curve. The linear correlation test between all independent variables did not find that they had a high correlation with each other (multicollinearity). Therefore, the data could be used to calculate stepwise

multiple regression statistics. As shown in **Table 3**, it was found that health literacy, self-efficacy perception, and social support together explained self-management by 35.4 percent ($R^2 = 0.354$, $F = 6.92$, $p < 0.01$), with health literacy could predict self-management behavior the most ($\beta = 0.371$, $p < 0.01$).

Table 3. Predictors of self-management among elderly monks with diabetes (n = 196)

Variable	b	Std. Error	β	t	p-value
Health literacy	0.358	0.057	0.371	6.236	< 0.001
Self-efficacy	0.157	0.032	0.304	4.865	< 0.001
Social support	0.208	0.079	0.162	2.631	0.009

Note. $R^2 = 0.354$, $F = 6.92$

Discussion

This study found that participants had self-management behavior and health literacy at a moderate level and self-efficacy and social support at a high level. Furthermore, health literacy, self-efficacy, and social support were significant predictors and explained that 35.4% of self-management behavior with health literacy is the strongest.

In this study, self-management and health literacy among older monks with type 2 diabetes were moderate because nearly half of the participants were younger older monks. These older monks exhibited robust physical health, lacked diabetes-related complications, and demonstrated a notable capacity to manage themselves. Moreover, over half of the sample group had completed secular education at the primary and secondary levels. They can demonstrate proficiency in interacting with others to exchange health-related information, including discussing diseases and treatments with medical personnel. Still, they may have limitations in sharing information at a discretionary level. Previous studies support this study in that self-management in a sample group of younger elderly ages was at moderate levels,¹⁷ whereas in older adults with poorly controlled type 2 diabetes mellitus was at a high level.³⁸ For health literacy, it was found that most of the sample completed fundamental school,³⁰ and older adults with poorly controlled type 2 diabetes mellitus were at a moderate level.^{38,39} This is potentially influenced by following diabetes treatment. Older adults with type 2 diabetes continued following up with healthcare providers and exchanging health information with other diabetes patients. In contrast, older monks could not do it because of conflicts with monastic discipline.

In our study, the perceived self-efficacy and social support among older monks with type 2 diabetes were high because most of the sample comprised senior monks, with over half having graduated from the Dhamma Department. As monks, they were respected by the public and received ample help and support. They always

receive consistent assistance from various individuals, such as emotional support, information sharing, and material support. They also receive support on health services, as shown by the fact that most participants received health services from the university hospital. Additionally, more than half of the sample had been diagnosed with diabetes for 1–5 years, a period during which they received substantial advice from health personnel and demonstrated the intention to apply their knowledge to deal with their disease. This resulted in their ability to manage their diabetes independently, effectively aligning their activity patterns with healthcare practices and monastic discipline. This finding corresponds with a previous study of older people with type 2 diabetes that reported an overall high level of social support.³⁰ However, the self-efficacy among older monks in this study was different from a study finding that explored older people having a moderate level of overall self-efficacy perception.³⁰

Health literacy, self-efficacy perception, and social support collectively predicted self-management. Notably, health literacy emerged as the most significant predictor. These findings underscore that effective self-management in older monks with type 2 diabetes is contingent on possessing good health literacy. This entails essential listening, speaking, reading, and writing skills, enabling them to access and comprehend health information. Additionally, engaging in social interactions for information exchange with health personnel proved beneficial. Analytical thinking and judgment further facilitated proficient self-management regarding roles, knowledge, practice, and stress coping that correlate with self-care behaviors. Moreover, self-efficacy perception emerged as a secondary yet significant factor in predicting self-management.⁵ In this context, when older monks receive information from health personnel, instilling confidence in their ability to enact change becomes crucial. This confidence leads them to make decisions aligning their health behavior with monastic principles, ultimately contributing to comprehensive and effective self-management. This

result is consistent with previous studies in older people with type 2 diabetes that identified self-efficacy perception and social support as jointly predicting self-management.³⁰ Similarly, another study¹⁷ demonstrated that variables such as social support, self-efficacy perception, self-regulation, and diabetes knowledge all together predicted self-management with self-efficacy perception emerging as the most influential predictor. Moreover, the result was consistent with the research on poorly controlled type 2 diabetes mellitus,³⁸ which found that health literacy could positively predict diabetes self-management. Thus, promoting self-management in older monks with type 2 diabetes necessitates attention to crucial factors, such as health literacy, self-efficacy perception, and social support.

Limitations

This study has some limitations. First, purposive sampling was used to select the participants in two hospitals in the northern and central regions of Thailand, so the results cannot be generalized to other settings and populations. Second, all three factors could explain only 35.4% of the variance in SMB, so further study with adding other variables, such as knowledge and personal factors, is needed.

Conclusions and Implications for

Nursing Practice

This study found that health literacy and self-efficacy perception were factors that could predict self-management. Nurses can use this finding to develop and test the effectiveness of an intervention program that emphasizes increasing health literacy, self-efficacy, and social support to enhance self-management behaviors. The program needs to be integrated with new technology, such as telenursing for education and artificial intelligence to design individual programs.

Acknowledgments

This study was supported by the Faculty of Nursing budget for the fiscal year 2023, under the category of new researcher fund, Faculty of Nursing, Chiang Mai University. We are grateful to all participants.

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ปัจจัยทำนายพฤติกรรมการจัดการตนเองในพระสงฆ์สูงอายุไทยที่เป็นโรคเบาหวานชนิดที่ 2: การศึกษาภาคตัดขวาง

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บทคัดย่อ: การจัดการตนเองมีความสำคัญต่อผู้ป่วยโรคเบาหวาน รวมถึงพระสงฆ์สูงอายุที่มีวิถีการดำเนินชีวิตตามแนวทางปฏิบัติทางศาสนา การศึกษาแบบตัดขวางนี้มีวัตถุประสงค์เพื่ออธิบายการจัดการตนเอง และปัจจัยทำนายการจัดการตนเองในพระสงฆ์สูงอายุไทยที่เป็นโรคเบาหวานชนิดที่ 2 กลุ่มตัวอย่างประกอบด้วยพระสงฆ์สูงอายุ 196 รูปที่เข้ารับบริการในโรงพยาบาลสงฆ์ 2 แห่งตั้งแต่เดือนกันยายนถึงธันวาคม พ.ศ. 2566 รวบรวมข้อมูลด้วยแบบสอบถามข้อมูลทั่วไปและข้อมูลการเจ็บป่วยแบบสอบถามพฤติกรรมการจัดการตนเอง แบบสอบถามความรู้ด้านสุขภาพ แบบสอบถามการรับรู้สมรรถนะแห่งตน และแบบสอบถามการสนับสนุนทางสังคม ใช้การวิเคราะห์การถดถอยเชิงพหุคูณแบบขั้นตอนและสถิติเชิงพรรณนาในการวิเคราะห์ข้อมูล

ผลการวิจัยพบว่า พระสงฆ์สูงอายุมีการจัดการตนเองและความรอบรู้ด้านสุขภาพอยู่ในระดับปานกลาง การรับรู้สมรรถนะแห่งตนและการสนับสนุนทางสังคมอยู่ในระดับสูง ปัจจัยความรอบรู้ด้านสุขภาพ การรับรู้สมรรถนะแห่งตน และการสนับสนุนทางสังคม สามารถร่วมกันทำนายการจัดการตนเองได้อย่างมีนัยสำคัญร้อยละ 35.4 โดยความรู้ด้านสุขภาพเป็นปัจจัยทำนายการจัดการตนเองที่มีอิทธิพลมากที่สุด รองลงมาคือการรับรู้สมรรถนะแห่งตน และการสนับสนุนทางสังคม พยาบาลสามารถใช้ผลการศึกษานี้ในการพัฒนาและทดสอบโปรแกรมเพื่อส่งเสริมการจัดการตนเอง โดยเน้นการเพิ่มความรู้ด้านสุขภาพ การรับรู้สมรรถนะแห่งตน และการสนับสนุนทางสังคม โดยการบูรณาการร่วมกับเทคโนโลยีสมัยใหม่

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