

# A Community Capacity Enhancement Model for Care of the Elderly

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**Abstract:** This two-phased, community-based, participatory action research sought to develop a community health care model for providing care for elderly northeastern Thais. Participants included, over a 12 month period, 140 elders (60 years and older), 20 elders' family members, 11 community leaders, 5 nurses, 10 health care volunteers and 5 local government officials from a community in northeastern Thailand. Phase I involved data gathering, via interview, participatory observation, focus groups and review of related documents, regarding the needs of the elderly. Development of an appropriate community health care model for the elderly occurred in Phase II, and represented the ideas, procedures, constraints and roles of all participants involved in data generation during Phase I.

Data regarding the elders' abilities to perform activities of daily living were obtained via the Barthel ADL index, participant observation, in-depth interviews and focus group discussions. Descriptive statistics were used to analyze the quantitative data, while content analysis was performed on the qualitative data.

Findings revealed the elders could be categorized as either: independent; semi-independent or dependent. Elders were found to have difficulties performing activities of daily living when without illnesses, as well as when ill. In addition, most of them expressed a: need for financial stability; desire to stay with family members, including children and grandchildren; and, chance to be part of the community.

The proposed Community Capacity Model for providing care for the elderly was found to: be a workable partnership model with horizontal relationships; be based on the resources and capabilities of the community; reinforce community involvement within the social and cultural context; and, focus on the role of family and community as main entities for providing care, for elders, through support of the local health care unit and administration, and the community and family network. Thus, the model was seen as: supportive of elders; encouraging of elders staying with family and maintaining health as semi-independent community members; and, encouraging establishment of senior associations and financial cooperatives to provide assistance in the care and welfare of elders.

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**Key Words:** Elderly Thais; Health Care Model; Community Care; Community Partnerships

## Background

Concerns have been raised regarding the effects and burdens the changing Thai population structure poses on the county, as well as on the elderly. Currently, more than 10% of Thailand's population is 65 years of age or older and the number of dependent elders is expected to double by

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2025.<sup>1</sup> However, the number of workers supporting the Thai society has decreased from 19 million in 1960, to 11 million in 2000, and is projected to decrease to 6 million in 2020.<sup>2</sup>

Historically, Thailand has been a rural, agrarian, society with the extended family and Buddhism as its roots and elders being respected by those younger. However, Thai society predominantly has become an urban society, wherein the government has taken on the responsibilities of the family unit, with changes occurring in old traditions, norms and beliefs regarding the elderly.<sup>3</sup> Currently, the family unit primarily consists of members of the nuclear family, with approximately 30% being 60 years of age or older. These changes have led elders to experience health care difficulties and financial instability.<sup>2</sup>

The Thai government currently gives, to each elder for living expenses, 500 Baht (\$15 USD) a month, as well as provides economical healthcare insurance for elderly government officials and business employees. Maintenance of the health and welfare of elders, especially those who are handicapped and dependent, has become an economic and resource burden on their families, communities and nation.<sup>4, 5</sup>

In compliance with the 2<sup>nd</sup> National Plan for Older Persons (2002-2021),<sup>6</sup> communities, local governments and organizations, throughout Thailand, are being forced to assume key roles regarding involvement in and support of healthcare for the elderly. The national committee, under the auspices of the Prime Minister, has recognized the need for elders to engage, when able, in self-care (i.e. be independent) prior to relying on, for care and support, family members and relatives, as well as community and national resources.<sup>6, 7, 8</sup>

Although a government policy to improve the quality of life of Thai elders has been implemented, there is a limit to the amount of care that can be provided by families of elders. Community-based

health care, with limited assistance from the national health care system,<sup>8</sup> has been proposed as a way to support elders in performance of self-care. However, research has not been conducted regarding how the policy actually would enhance and utilize the health care system, with respect to delivery of care to elders in the community. Thus, this study sought to determine if a Community Capacity Model would be an appropriate model for providing care for elderly Thais in a community in northeastern Thailand.

## **Method**

**Design and Sample:** This two-phased, community-based, participatory action research included, over a 12 month period, 140 elders (60 years and older),<sup>6</sup> 20 elders' family members, 11 community leaders, 5 nurses, 10 health care volunteers and 5 local government officials from a community in northeastern Thailand. The elders served as the major informants, while the family members, community leaders, nurses and government officials served as secondary informants. The elders, who had an average age of 71.2 years, primarily were: female (n = 81; 57.8%); Buddhist (n = 140; 100%); married (n = 94; 67.1%); farmers (n = 75; 53.5%); and, educated at the primary school level (n = 117; 83.5%). Their monthly household income ranged from 10,000 Baht [\$330 USD] (n=18; 12.8%) to more than 30,000 Baht [\$1,000 USD] (n = 5; 3.5%), with an average of 12,000 Baht [\$400 USD].

The majority of the family members were daughters (n = 15; 75%) who: received an income from agriculture (n = 12; 60%); were educated at the 9<sup>th</sup> grade of primary school (n = 13; 65.0%); and, had an average age of 31.9 years. All family member participants lived with their respective elders.

The community leaders had an average age of 51.9 years, and included: one (9%) village chief; two (18%) assistant village chiefs; one (9%) village patrolman; two (18%) village administrators; and, five (46%) village committee members. Four (36%) of the community leaders held a primary school education; the others (n = 7; 64%) had a secondary school education.

Four of the five local health care center nurses, who provided care for elders, held a baccalaureate degree in nursing; the other nurse had a master's degree in community health care. The nurses, on average, were 46.2 years of age and had 11.2 years of work experience.

The ten health care volunteers, who had an average age of 53 years, primarily were: female (n = 8; 80%); educated at the primary school level (n = 7; 70%); and, farmers (n = 7; 70%). The leader of the volunteers had 21 years of experience as a volunteer.

The five local government officials had an average age of 53.6 years and consisted of: one (20%) chief local administrator; two (40%) deputy chiefs; one (20%) assistant deputy chief; and, one (20%) director of the local Health and Environmental Department. All of the government officials were college educated males.

The community was selected because the primary investigator (PI), as an instructor, had brought nursing students to there for 15 years. Thus, she was trusted and respected by the members of the community, community leaders and local government officials. As a result, the PI was able to easily engage and work with all study participants.

**Ethical Considerations:** Permission to conduct the study was granted by the PI's university ethical committee on human research, and the leaders of the selected community. All study participants were informed about: the purpose of the study; what their particular involvement would entail; confidentiality and anonymity being

maintained; and the fact they could withdraw, at any time, without repercussions. All participants signed a consent form.

**Procedure:** The procedure consisted to two parts: Phase I and Phase II. Phase I involved gathering data about the needs of the elderly via interview, participatory observation, focus group discussions and review of documents. Informants were elders and their family members, health care volunteers, nurses, community leaders and local government officials. Phase II involved development of an appropriate community health care model for providing care for the elderly, which represented the ideas, procedures, constraints and roles of participants involved in data generation during Phase I. Phase II participants included purposively selected individuals from each of the Phase I informant groups.

**Phase I: Data Gathering Regarding the Needs of the Elderly:** Prior to providing the PI with the names and addresses of 150 elders in the community, the community leaders, community health care center officials and heads of the health care centers were informed about the purpose and details of the research. The PI then sent a letter to each elder inviting him/her to participate in the study. The letter indicated: the purpose of the research; what would be involved as a participant; a description of all ethical considerations; and, if interested in participating in the study, he/she should come to the local community center on the stated date and time. Those who came had the study explained again and were asked to sign consent forms. The signed consent forms were retrieved at a predetermined time, by two trained research assistants, at the home of each elder. Since some of the elders could not read or sign the form themselves, a family member signed the form on their behalf. A total of 140 elders consented to take part in the study.

After receiving an elder's consent to participate, the PI telephonically contacted him/her and arranged a date and time to meet in his/her home to: obtain demographic information; evaluate his/her physical capabilities; and, conduct an in-depth interview. Using a demographic data sheet, the PI sought information about each elder's: age, gender, religion, educational level, family income and relationship with family members living with him/her.

Assessment of each elder's physical capabilities was conducted via a modified version of the Barthel Activities of Daily Living (ADL) Index because it had been found to be suitable for use with Thai elders.<sup>9</sup> The instrument consisted of 10 items that assessed each elder's capabilities, during the past 24-48 hours, related to: eating, bathing, grooming, dressing, bowel control, bladder control, transferring from bed to chair and back, being mobile on a level surface and using stairs. Depending upon the activity and level of independence each person had regarding a specific activity, the items had possible responses (i.e. unable, independent, need major help, need some help, immobile) that were scored from 0 to 1, 0 to 2, or 0 to 3. The response values were summed across items to obtain a total score which could range from 0 to 20. A score of 0-8 was categorized as having low physical capabilities (i.e. dependent group), while a score of 9-11 was recognized as having some level of independence (i.e. semi-dependent group) and a score of 12 or greater was indicative of being able to care for one's self (i.e. independent group).

Once demographic information and an evaluation of the respective elder's physical capabilities were accomplished, an in-depth, tape-recorded interview was conducted. Each elder gave verbal consent to have the semi-structured interview, which focused on the problems, needs and expectations of the elders related to their

economical/social problems and health care, tape-recorded. Examples of questions or statements posed to the elders included: "What do you do to take care of yourself?"; "How do your family members assist you?"; "What things would you like for your family members to do to assist you?"; "How can the community help you?"; "What needs do you have that you do not think are being met?"; and, "Exactly what do nurses in the community health care center do to assist you?" Probing questions and statements also were posed to obtain more in-depth data and clarify understanding of each elder's comments. Examples of probing statements used included: "Tell me more about how your daughter/son help you with your nutritional needs."; "Please tell me more about what nurses at the community health care center can do to assist you."; and, "In case your daughter/son cannot take you to see your doctor, who takes you?". During each interview, the PI also engaged in observation of the respective elder's non-verbal behavior, interactions of family members with the elder and activities of the care providers (i.e. family members and nurses from the community health care center). Field notes of all observations were recorded. The data gathering process (obtaining demographic data, assessing physical capabilities and conducting in-depth interview) lasted approximately 1 to 1.5 hours.

During the 12 months the PI gathered data from the 140 elders, four separate focus groups were conducted, by the two trained research assistants with the help of the PI, for family members, health care volunteers, community leaders, nurses and local government officials. Participants were contacted so as to set up a common location and date for each focus group. The focus groups for the family members, health care volunteers and community leaders were held at a local community center, while the focus group for the nurses and local government officials was held in a conference room at the community health care

center. After the participants gave permission, each focus group was tape-recorded and lasted approximately 1.5 to 2 hours.

During the focus groups, the PI and research assistants recorded observations of the group process, by way of field notes, and used an interview guide that addressed questions geared toward the purpose of the specific focus group. The questions posed to each focus group were validated, prior to use in the study, for relevant content by five experts (one physician with expertise in gerontology, two nurse educators who specialized in nursing and community health care, and two registered nurses who delivered health care to elders in the community).

Two of the focus groups, consisting of 10 participants each, were held with family members. Questions posed for each group included: "What roles do you have, as family members, in the provision of care for your respective elders?"; "What are the physical conditions of your respective elders?" and, "What are the needs of your families related to services the community and local government can provide?" A third focus group was held with 10 health care volunteers and 11 community leaders. The specific questions posed to this group were: "What is the best way to use community resources to help with care of elders?" and, "What type of activities and support should the community provide to elders and their families?" The fourth focus group included 5 nurses from the community health care center and 5 local government officials. Questions posed to this group included: "What activities do your organizations provide for elder care in the community?" and, "What roles do you and your respective organizations play when family members are unable to provide care for their respective elders?"

*Phase II: Development of a Model for Elderly care:* Phase II consisted of two stages: a) data verification from primary informants and

members of each focus group; and, b) brainstorming with select study participants regarding development of a relevant community model for care of the elderly. Data verification consisted of the PI validating interpretation of data, gathered during Phase I, with the participants. The elders examined the accuracy of their respective: demographic data; physical capabilities; and, content of the in-depth interviews. Members of each focus group were given the opportunity to review a summary of the interpretation of the data obtained during their respective discussions. The family members' focus group examined data related to the roles family members assumed in care of the elders, the physical condition of the elders, and the family needs related to community and local government services. The health care volunteers and community leaders' focus group examined data related to the community resources and types of community activities/support that should be provided to elders and their families, while the nurses and local government officials' focus group examined data on the activities and roles of the individual participants' organizations in delivery of care to the elders.

Brainstorming, the second stage of Phase II, involved input from 58 purposively selected study participants who met for the purpose of developing, based on data gathered and analyzed during Phase I a community model for care of the elderly. Ten participants were selected from elders assessed as independent and six were selected from elders assessed as semi-dependent. A total of fifteen family members of elders (5 from the dependent elder group, 5 from the semi-dependent elder group and 5 from the dependent elder group), as well as 10 health care volunteers, 7 community leaders, 5 nurses and 5 local government officials were selected. These participants met, as a group with the PI and two research assistants, for a brainstorming session at a designated time and place.

The brainstorming session began with the PI presenting a 30 minute summary of the analysis of data gathered during Phase I. The participants then were divided into two groups. One group consisted of the elders, family members, health care volunteers and community leaders. The other group was comprised of the registered nurses and local government officials. Each session was moderated by one of the research assistants familiar with conducting a brainstorming session. The PI went between the groups to assure the purpose of the brainstorming sessions was being accomplished. Each of the brainstorming sessions lasted approximately two hours. Upon conclusion of the brainstorming sessions, a representative from each group presented their group's proposed model for community care of the elderly to the other groups. Each presentation lasted about one hour.

The PI and researcher assistants then summarized the groups' proposed models and integrated them into a community model. One week later, the PI described the integrated community model to the focus group participants and asked for their comments and suggestions. All concurred with the integration of their models into the final community model (See **Figure 1: A Community Capacity Enhancement Model for Care of the Elderly**).

**Data Analysis:** Both quantitative and qualitative data were collected. The quantitative data were analyzed via descriptive statistics. The qualitative data were analyzed through use of data organization and thematic, time-line and comparative analyses.

Data organization was used to identify and categorize topics from the collected data. Thematic analysis was utilized to classify the theme of the data in order to identify an appropriate model for each group of elders. Time-line analysis was conducted as a means of the time occurrence of events within each group, so as to provide understanding of the

elders' daily lives, needs and care. Comparative analysis was performed to note the similarities and differences in behaviors and relationships among the elders.<sup>10, 11</sup>

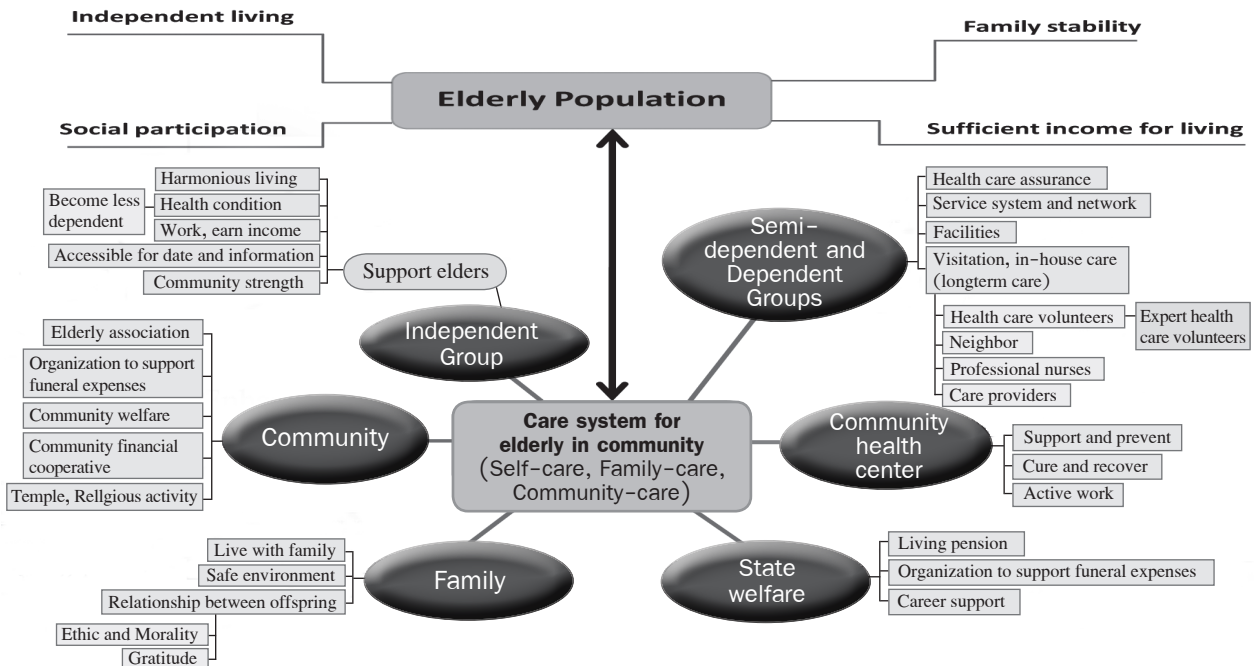
**Trustworthiness:** To ensure trustworthiness of the study, criteria for developing effective evaluation of a qualitative study was employed.<sup>10, 11</sup> Prolonged contact with the informants, triangulation of data obtained from multiple sources at different points in time and validation of data with informants helped to establish credibility of the study. Transferability of the findings, to other contexts, was established by providing a data base with sufficient information and detailed descriptions about how the data were obtained. Finally, dependability and conformability were accomplished by providing sufficient, in-depth, information.

## **Results and Discussion**

Based upon the findings of the qualitative data obtained from the elder interviews and the four focus group sessions, with family members, health care volunteers, community leaders, nurses and local government officials, "A Community Capacity Enhancement Model for Care of the Elderly" was developed (See **Figure 1**). The purpose of the model was to serve as a guide for community leaders, health care volunteers, nurses and local government officials to use as they developed and implemented a comprehensive care program for providing care for elders in the community. The data identified key factors important to the elders (the target population), including: family stability; sufficient income for living; independent living; and, social participation. The following overview and interpretation of the qualitative findings shows how these data supported formulation of the model.

**In-depth Interviews of Elders:** Through use of the modified version of the Barthel Activities of





**Figure I** “A Community Capacity Enhancement Model for Care of the Elderly”

Daily Living (ADL) Index,<sup>9</sup> three categories of the elders’ physical capabilities were determined: independent elders; semi-independent elders; and, dependent elders. Summarization of the qualitative content data analysis from the interviews with, and observations of, the 140 elders follows.

**Independent Elderly Residents:** Elders found, at times, to be independent were heads of household and served as the main source of income or support for the family. The men and women in this category often were rice farmers or hired laborers on another family’s farm. After the rice farming season ended, independent elders often would grow garden vegetables and catch fish/shrimp to sell or cook. Some of these elders would stay with their adult children or grandchildren, or live alone. It was not uncommon for them to volunteer within the community and serve: in official or unofficial community leadership roles; as the chairman of health care volunteers who

monitored health care services for village residents; or, as leaders in religious activities. Some of the females in this group, who were not welcome in the homes of their adult step-children after their spouses’ death, lived in temples, as nuns, and cleaned temple rooms in return for food. A number of them assumed a major role raising their pre- or primary school grandchildren. This finding is similar to prior findings regarding childrearing in Thailand,<sup>12, 13, 14</sup> and occurred when the elders’ adult children had to work a distance from home (i.e. Bangkok), as well as when the elders retired and their adult children took over the family business. In such cases, the elders took responsibility for their grandchildren’s’: food, health care when ill, and progress in school. During times of family illnesses, these elders served as health care providers and often took ill family members to the physician, as well as helped with the family’s ADL.

**Semi-dependent Elders:** As individuals age, it is not unusual for them to encounter health problems and a decline in physical capabilities, especially if they have a chronic illness (i.e. diabetes mellitus, hypertension and/or arthritis). The semi-dependent elders were found to rely partially on others (i.e. family members) to help them with their ADL and health care needs. For example, an adult child or grandchild may have to take the elder to the physician, provide food and medications, and monitor illness symptoms and medication side effects. Some semi-dependent elders were able to assist with limited household chores and/or provide care for their grandchildren. However, they were found, at times, to be undependable regarding family activities and functions. Because the semi-dependent elders, to some degree, were able to care for themselves, they did not require constant monitoring and assistance.

**Dependent Elders:** Because of health care advances, improved life styles and better self-care practices, Thais are living longer. However, an increased incidence of chronic illnesses comes with advanced age.<sup>5, 9</sup> Thus, many of the most aged elders, in the study, were found to be unable to provide care for themselves and, thus, had to rely on others for total, or nearly total, physical and mental health care. Their required care often included, but was not limited to: bathing; dressing; feeding; obtaining food, clothing and housing; providing transportation to the physician or hospital; and, administering medications and other health care therapies. Such demands were found to be taxing for family members who served as their care providers, since these elders often were in need of assistance from the community and local health care center.

**All Three Elder Groups' Expressed Concerns about Their Needs and Desires:** The elders generally preferred to be as independent as possible, but realized they, at times, needed assistance and care from others, especially their

family members. The fact most of them lived with family members was supported by prior findings regarding intergenerational relationships.<sup>13, 15</sup> Elders in the semi-dependent and dependent groups desired to have assurance that: a) they would receive health care, by way of a service system and network; b) adequate health care facilities would be available; and, c) if long term care was needed, home care visitation, via expert health care volunteers, neighbors, professional nurses, and family care providers, would take place. All of them wanted to remain contributing members of their family unit and community, because they viewed themselves as having knowledge and experiences, due to their extended years of life, which others may not have. The independent, as well as some of the semi-dependent, elders continued to work outside and/or inside their homes. Elders, from all three groups, felt they had information that may prove helpful to members of the younger generation. As a result, they often considered themselves to be major contributors to their respective family's and community's harmony.

Due to social changes, some of the elders indicated they often were left alone and ignored by others and, as a result, experienced loneliness. Thus, they expressed a need for an active community center where they could meet with others for support, interaction and involvement in activities. If they had a well functioning community center, with an active elder association, the elders felt they could be made aware of each other's needs and, subsequently, become involved in assisting each other. Such assistance could include running errands for, or making a hospital and/or home visit, when one of them became ill. The elders also expressed the importance of attending temple and religious activities, within the community, as a way for them to maintain a sense of spiritual well-being.

**Focus Groups:** A summarization of the qualitative content analysis of the data from the four focus groups follows.



**Family Members' Focus Group:** Two focus groups, of 10 family members each, were held to identify what they believed were the: needs of their elders; roles they assumed in providing care of their elders; and, type of assistance they required when providing care for their elders. A number of them expressed that, within the Thai culture, elders expect, and often need, especially when they are ill and/or dependent upon others for care, to spend their later years with their family. Within the Thai culture, it is traditional for adult children to believe they have an ethical and moral obligation to their parents to provide for their care and safety.<sup>12, 13, 15, 16</sup> The adult children, in this study, felt, by providing care for their elderly parents, they were able to express their personal gratitude for what their parents had done for them. Of interest, however, was the fact that regardless of how independent or dependent the elders were, they continued to want to contribute, in some way, to the functioning of their respective family.

Family members stated their elders conditions often deteriorated quickly, and they had slow recovery, when they became ill. Since elders often had insufficient funds to provide for their living and health care needs, illness often posed problems for their family because the burden of paying for needed medical treatments often fell on the family members. Thus, it was apparent that the elders often relied, for financial assistance, on their family members, especially their adult children. However, the family members indicated their elders expected to receive elder welfare (a government mandate) to help pay for their everyday needs.

**Health Care Volunteers'/Community Leader' and Nurses'/Local Government Officials' Focus Groups:** The focus group comprised of the health care volunteers and community leaders dealt with the best way to use community resources to provide care for the elders, as well as the type of activities and support the community needed to

provide the elders and their families. On the other hand, the focus group of nurses and local government officials dealt with activities the organizations provided for care of the elderly in the community, and the roles each participant and their respective organizations played when family members were unable to provide care for their elders. Many of the ideas expressed by members of the focus groups were similar to what had been expressed by the elders during their interviews, and by family members during the focus groups. For example, both groups stated a need for community services that would assist elders to remain independent, as long as possible, as well as a need for an active community center.

However, several unique aspects of information were noted during the focus group sessions. For example, members of the focus groups pointed out the importance of elders within the Thai culture, and the need for local practices, functions and activities to be sensitive to and respectful of elders. In addition, the local government officials and community leaders pointed out, to help support the cost of funeral ceremonies for elders when family members are unable to bear the expense, the need for the community and provincial government to develop a community financial cooperative, wherein each family would pay 100 Baht (\$3 USD) when one of the cooperative members dies. In addition, in accord with Buddhist practices, they saw such action as a demonstration of good merit.

The community leaders also recognized the need to encourage residents to save 100 Baht (\$3 USD) each month so as to develop a financial cooperative where community members could seek low interest loans. They envisioned the financial cooperative profits being divided among all share holders or used to strengthen relationships within the community via the purchase of gifts for hospitalized community members. In addition, since the elderly typically have lower, or no, income, they believed

workers should be encouraged to become members of the financial cooperative.

Policies that would mandate appropriate accommodations for the elderly, as well as functional partnerships between elders, their family members, the community services and health care center also were noted as being essential. These findings are similar to those of prior research regarding development of a successful model for delivery of services to members of the community.<sup>15, 17, 18, 19, 20, 21</sup> The nurses and health care volunteers indicated elders in the community had chronic health care problems that required intermittent and continuous home health services, and emotional support.

Thus, the identified needs for services for the elders and their families, focused on: emotional support; prevention; cure; recovery; and, activity at an appropriate level for each respective individual. Such services needed to include, but not be limited to: educational programs regarding appropriate diet and exercise; the effects of poor health practices (i.e. smoking, substance abuse, lack of cleanliness); stress management; and, safety.

The community leaders and local government officials identified programs that needed to be available, at both the local and provincial level. These programs included: a living pension for elders; career support for elders who are actively working; and, a data base (for future planning) that would track information related to the needs of elders' within the community. They recognized such programs potentially would encourage and facilitate elders, in the community, to remain independent as long as possible.

## **Conclusions**

Evolution of the model demonstrated input from all relevant parties (elders, family, health care volunteers, community leaders, nurses and local government officials) concerned with the development of a comprehensive care system for the elderly within one community in northeastern Thailand. Multiple needs of the elders were addressed, along with which parties should be held accountable for meeting those needs. The process of developing the model was similar to prior research,<sup>18, 19</sup> and demonstrated the importance of fostering partnerships among the various parties involved in providing care for elderly in the community.

## **Limitation and Recommendations for**

### **Future Research**

Because cultural practices and beliefs may differ from one community to another, the "Community Capacity Enhancement Model for Care of the Elderly" may not be applicable to communities different from the one used in this study (i.e. large urban communities and communities in other geographic areas). In addition, one has to assume all parties involved in this study were honest in their comments and did not say things they thought would please the PI.

Finally, future research is needed to develop, in other areas of Thailand, similar models of elder care, as well as studies related to the effect of each of the components identified in the model. Such research could assist in determining whether the components of the model are effective in bringing about comprehensive, community-based care of the elderly.

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## รูปแบบการส่งเสริมศักยภาพการดูแลผู้สูงอายุโดยชุมชน

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**บทคัดย่อ :** การวิจัยครั้งนี้ใช้กระบวนการวิจัยแบบมีส่วนร่วมโดยชุมชนเป็นฐาน ในชุมชนชนบทแห่งหนึ่งในภาคตะวันออกเฉียงเหนือของไทย โดยมีวัตถุประสงค์เพื่อหารูปแบบที่เหมาะสมในการดูแลผู้สูงอายุในชุมชน ใช้เวลาในการศึกษาในพื้นที่เป็นเวลา 12 เดือน ผู้เข้าร่วมวิจัยประกอบด้วยผู้ให้ข้อมูล ได้แก่ ผู้สูงอายุ 140 คน สมาชิกครอบครัวผู้สูงอายุ 20 คน ผู้นำชุมชน 11 คน พยาบาลวิชาชีพประจำศูนย์สุขภาพชุมชน 5 คน อาสาสมัครสาธารณสุข 10 คน และบุคลากรองค์กรปกครองส่วนท้องถิ่น 5 คน การศึกษาวิจัยแบ่งเป็น 2 ระยะ การวิจัยระยะที่ 1 เป็นระยะการวิเคราะห์สถานการณ์ความต้องการการดูแลของผู้สูงอายุ เก็บรวบรวมข้อมูลโดยการประเมินความสามารถในการปฏิบัติกิจวัตรประจำวัน (Barthel ADL Index) การสัมภาษณ์เชิงลึก การสังเกตแบบมีส่วนร่วม การสนทนากลุ่ม การวิจัยระยะที่ 2 เป็นการประชุมระดมสมองเพื่อพัฒนารูปแบบการดูแลผู้สูงอายุที่เหมาะสมกับบริบทของชุมชน การวิเคราะห์ข้อมูลเชิงปริมาณนำมาวิเคราะห์ทางสถิติเป็นความถี่และร้อยละ ข้อมูลเชิงคุณภาพนำมาวิเคราะห์เชิงเนื้อหา

ผลการวิจัยสามารถแบ่งกลุ่มผู้สูงอายุได้ 4 กลุ่ม คือ ผู้สูงอายุที่สามารถช่วยเหลือตัวเองได้ ผู้สูงอายุที่ช่วยเหลือตัวเองได้บางส่วนและต้องพึ่งพาผู้อื่นบางส่วน ผู้สูงอายุที่ช่วยเหลือตัวเองไม่ได้ และผู้สูงอายุที่ถูกทอดทิ้งไม่มีผู้ดูแล ด้านปัญหาและความต้องการดูแล ประกอบด้วยความต้องการการดูแลเมื่อเจ็บป่วย ต้องการความมั่นคงด้านการเงิน ต้องการอยู่ในครอบครัวกับลูกหลาน และต้องการการยอมรับจากชุมชน สำหรับข้อเสนอรูปแบบที่เหมาะสมในการดูแลผู้สูงอายุในชุมชนประกอบด้วย 1) การดูแลในลักษณะของภาคีหุ้นส่วนของผู้ที่มีส่วนเกี่ยวข้องในลักษณะของความสัมพันธ์ในแนวราบ 2) อยู่บนฐานของทรัพยากรและศักยภาพของชุมชน 3) การดูแลนี้จะมีส่วนในการสร้างความเข้มแข็งของชุมชนที่สอดคล้องกับบริบทสังคมและวัฒนธรรมของชุมชน และ 4) ครอบครัวและชุมชนเป็นสถาบันหลักในการให้การดูแลผู้สูงอายุ โดยการสนับสนุนช่วยเหลือของศูนย์สุขภาพชุมชน องค์ปกครองส่วนท้องถิ่นและภาคีเครือข่ายที่เกี่ยวข้อง โดยรูปแบบการดูแลที่เหมาะสมประกอบด้วย 1) มีระบบสนับสนุนดูแลช่วยเหลือผู้สูงอายุให้สามารถช่วยเหลือตัวเองได้ 2) ส่งเสริมและสนับสนุนให้ผู้สูงอายุได้อยู่ในครอบครัวกับลูกหลาน และ 3) ดำเนินการให้มีการจัดตั้งชมรมผู้สูงอายุและกองทุนชุมชน เพื่อให้เป็นสวัสดิการในการให้การดูแลช่วยเหลือด้านการเงินและสุขภาพสำหรับผู้สูงอายุ

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**คำสำคัญ :** ผู้สูงอายุไทย รูปแบบการดูแลสุขภาพ การดูแลสุขภาพชุมชน ภาคีหุ้นส่วนชุมชน

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