HEALTH STATUS AND HEALTH SEEKING BEHAVIOURS AMONG THE ELDERLY IN THE DONMUANG SLUM COMMUNITY, BANGKOK, THAILAND

Miss Lalita Sangngern

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การศึกษาสุขภาวะและพฤติกรรมการแสวงหาการรักษาในผู้สูงอายุ ที่อาศัยอยู่ในชุมชนแออัดเขตดอนเมือง กรุงเทพมหานคร ประเทศไทย

นางสาวลลิตา แสงเงิน

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธารณสุขศาสตรมหาบัณฑิต
สาขาวิชาสาธารณสุขศาสตร์
วิทยาลัยวิทยาศาสตร์สาธารณสุข จุฬาลงกรณ์มหาวิทยาลัย
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ลิขสิทธิ์ของจุฬาลงกรณ์มหาวิทยาลัย

Thesis Title	HEALTH STATUS AND HEALTH SEEKING BEHAVIOURS AMONG THE ELDERLY IN THE DONMUANG SLUM COMMUNITY, BANGKOK, THAILAND
By	MISS LALITA SANGNGERN
Field of Study	Public Health
Thesis Advisor	Assistant Professor Naowarat Kanchanakhan, Ph.D.

Accepted by the College of Public Health Sciences, Chulalongkorn University in Partial Fulfillment of the Requirements for the Master's Degree

……Dean of the College of Public Health Sciences

(Professor Surasak Taneepanichskul, M.D.)

THESIS COMMITTEE

……Chairman

(Associate Professor Ratana Somrongthong, Ph.D.)

……Thesis Advisor

(Assistant Professor Naowarat Kanchanakhan, Ph.D.)

…… Examiner

(Tepanata Pumpaibool, Ph.D.)

……External Examiner

(Associate Professor Ong-arj Viputsiri, M.D., Dr. P.H.)

ลลิตา แสงเงิน : การศึกษาสุขภาวะและพฤติกรรมการแสวงหาการรักษาผู้สูงอายุที่อาศัยอยู่ในชุมชนแออัดดอนเมือง กรุงเทพมหานคร ประเทศไทย (HEALTH STATUS AND HEALTH SEEKING BEHAVIOURS AMONG THE ELDERLY IN THE DONMUANG SLUM COMMUNITY, BANGKOK, THAILAND) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: (ผศ.ดร. เนาวรัตน์ กาญจนาคาร, 110 หน้า)

การศึกษานี้มีขึ้นเพื่อศึกษาสุขภาวะและพฤติกรรมการแสวงหาการรักษาในผู้สูงอายุที่อาศัยอยู่ในชุมชนแออัด เขตดอนเมือง กรุงเทพมหานคร ประเทศไทย โดยใช้การเก็บข้อมูลแบบสัมภาษณ์จากแบบสอบถามกับกลุ่มผู้สูงอายุในชุมชนแออัดจำนวน 287 คน ระหว่างเดือนมีนาคม - เมษายน 2556

ประชากรที่ศึกษามีอายุระหว่าง 60 ถึง 99 ปี โดย 2 ใน 3 เป็นเพศหญิง และผู้สูงอายุส่วนใหญ่มีการศึกษาระดับประถมศึกษา คิดเป็น 66.9 % สามารถอ่านและเขียนภาษาไทยได้เล็กน้อย (43.6 %) ผู้สูงอายุมีรายได้ต่อเดือนโดยเฉลี่ยน้อยกว่า 2,500 บาทต่อเดือน 77.9 % ไม่ได้ประกอบอาชีพ โดยเฉลี่ยผู้สูงอายุจะอาศัยอยู่กับครอบครัวโดยมีสมาชิกในบ้าน 1 – 5 คน โดยส่วนมากผู้สูงอายุจะอาศัยร่วมกับบุตรสาวและคู่สมรส บ้านที่พักอาศัยเป็นบ้านของตนเอง โดยห้องนอนจะอาศัยอยู่ที่ชั้นหนึ่งของบ้าน สถานที่นอนจะนอนบนเตียงและใช้ส้วมแบบชักโครก

การรับรู้สุขภาวะของผู้สูงอายุอยู่ในเกณฑ์ดี 52.9 % สุขภาวะพอใช้ 28.2% และสุขภาวะไม่ดี 18.8 % 78 % มีโรคประจำตัวที่ได้รับการวินิจฉัยโดยแพทย์ 71.4% ของผู้สูงอายุใช้สิทธิการรักษาประกันสุขภาพถ้วนหน้า ปัญหาสุขภาพที่สำคัญ ได้แก่ ภาวะความดันโลหิตสูง 74.1% โรคเบาหวาน 40% และโรคไขมันในเลือดสูง 34.4% ภาวะความเจ็บป่วยเล็กน้อยที่พบบ่อยได้แก่ ปวดศีรษะ (53.1%) ปวดเมื่อยกล้ามเนื้อ (19.8%) และมีไข้ (10.3 %) เมื่อมีอาการเจ็บป่วยเล็กน้อย ผู้สูงอายุจะเลือกยารับประทานเองเป็นส่วนใหญ่ และเมื่อเจ็บป่วยมากขึ้นหรือเป็นโรคเรื้อรังจะเข้ารับการรักษาที่สถานพยาบาลของรัฐบาลและเอกชนตามลำดับ

การไปรับบริการที่ศูนย์บริการสาธารณสุข ส่วนใหญ่เดินทางโดยใช้รถยนต์ส่วนตัวและรถจักรยานยนต์ ใช้เวลารอรับการรักษาที่ศูนย์บริการสาธารณสุขประมาณ 15 – 30 นาที ผู้สูงอายุส่วนใหญ่พึงพอใจต่อการให้บริการที่ศูนย์บริการสาธารณสุขในท้องถิ่น

ปัจจัยที่มีผลต่อสุขภาวะอย่างมีนัยสำคัญทางสถิติ คือ ระดับการศึกษา ความสามารถในการอ่านและเขียน ปัญหาสุขภาพและ ความสัมพันธ์ในครอบครัว และปัจจัยที่มีผลต่อการแสวงหาการรักษาของผู้สูงอายุอย่างมีนัยสำคัญทางสถิติ คือความพึงพอใจต่อการให้บริการของศูนย์บริการสาธารณสุข

สาขาวิชา สาธารณสุขศาสตร์ ลายมือชื่อนิสิต.....

ปีการศึกษา 2556 ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์หลัก.....

5578813753 : MAJOR REPRODUCTIVE AND COMMUNITY HEALTH
KEY WORDS : HEALTH STATUS/ HEALTH SEEKING BEHAVIOURS/ THE ELDERLY/ THE DONMUANG SLUM COMMUNITY/ BANGKOK
LALITA SANGNGERN : HEALTH STATUS AND HEALTH SEEKING BEHAVIOURS AMONG THE ELDERLY IN THE DONMUANG SLUM COMMUNITY, BANGKOK, THAILAND. ADVISOR : ASSIST. PROF. NAOWARAT KANCHANAKHAN, Ph.D. 110 pp

Most of the study population aged 60 to 96 years, two third of them were women and the majority of the elderly achieved primary education 66.9% and 43.6 % could read and write a little. The average monthly income of elderly was less than 2,500 baht per month, 77.9% did not work. The average life arrangement of elderly lived with 1 – 5 family member. Most of the accommodation were their owner. The bedrooms of the elderly was on the ground floor of the house. Besides, most of them sleep on the bed and use a flush toilet.

Perception of health status was good 52.9%, fair 28.2 % and not good 18.8%. Elderly have underlying diagnosed by physician (78%) and 71.4% under universal coverage. Major health problems mainly found were hypertension (57.8%), diabetes (31.0%) and dyslipidemia (31.0%) . Minor illness included headache (23.3%), muscle pain (19.8%), and fever (10.3%). When getting a minor illness, the elderly choose their own medicine byself and when the illness was treated. They got to government hospitals and private sectors, respectively.

Assessibility to health center, most of them transportation was personal car and motorcycle. Elderly use time between 15 – 30 minutes to waiting at health center. For overall satisfaction was satisfied.

Factors affecting the health status of statistical significance were the level of education. The ability to read and write, health problems and family relationship. Factor affecting health seeking behaviours of statistical significance was satisfaction of health center.

Field of Study : Public Health ..... Student's Signature……...……...

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LIST OF ABBREVIATIONS

MOPH	:	MINISTRY OF PUBLIC HEALTH
WHO	:	WORLD HEALTH ORGANIZATION
NHES	:	NATIONAL HEALTH EXAMINATION SURVEY
HBM	:	HEALTH BELIEF MODEL
NCD	:	NON - COMMUNICABLE DISEASE

CHAPTER 1

INTRODUCTION

1.1 Background and Rationale

Nowadays the number of senior people aged 60 years and older is growing rapidly worldwide. The world's population aged 80 years and older is anticipated to increase between 2008 and 2040 by 233% (Lutala, 2010). Sixty seven percent of aging of the world will be in developing countries, especially in Asia (MOPH, 2007). Most of people are living longer than ever before which settled down both high and low income regions. In addition, both fertility and mortality rate tend to decline while the average of life expectancy has increased and created a new set of challenges in today's society (Biswas, 2006). As a result, implication of the aging population in the global is gigantic and pervades every aspect of human development (Abdullah, 2009).

According to the data of United nations, Thailand changed into the period of "the aging society" since in 2005. The number of elderly people is anticipated to rise significantly over the next 25 years. Moreover, an important issue for Thailand is a very lofty rate of growth of its aging population. Since in 1960 the proportion of people who have aged 65 and over was 2.9% (0.77 million), and this tented to increase to 6% (5.3 million) in 2000. The proportion of the aged population will increase to 15%, at which time they will come to more than seven million by the year 2030 (MOPH, 2007).

Consequently, the elder has become a most important people of public health concern as they are alive with health in all aspects, physical, mental and psychosocial (Chamroonsawasdi et al, 2010).

Quality of life can change over the life span. Therefore, health becomes one of the major concerns about older age for both individuals and society. In addition, evaluation of functioning capacity assessed by activities of daily life providing a social. Definition of health in terms of variation from normal role functions with reduced ability to make resources. Health status of elderly people will be affected because they lack basic needs. Moreover, attribution of poorly health workers towards

the care of them are some of the parts associated with an interruption in seeking health care (Waweru, 2003).

Uzma (1999) mentioned that "health seeking behavior is not just a one of isolated event. It is part and package of a person's, a family's or a community's characteristic which leading to evolving a combination of social, personal, cultural and pragmatic factors. The process of responding to 'illnesses or seeking care involves several steps and can be hardly translated into a simple one of choice or perform, or be explained by a specific model of health seeking behavior" (Uzma, 1999).

Unavailability and inaccessibility of health care services and limited affordability of poor people have been concerned by the Thai government launching the universal coverage program. Health care seeking is a principal issue in all kinds of morbidity, since the duration of symptoms increases the probability of severe morbidity and harmful sequelae (Grover, A et al, 2006). Understanding of health seeking behaviors could manage delay diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts (MacKian, 2003).

In spite of such concerns, studies on the specific of health status and health seeking behaviors of the elderly in slum communities. There is an important vulnerable group in the community. The importance of understanding constraints of health care seeking behavior of older people is of fundamental importance, if a responsive and efficient health care system is to emerge (Biswas, 2006).

Donmuang district located in the upland of the Bangkok which is the Capital city of Thailand. The Donmuang districts are sub-divided into 3 sub-districts (1) Si kahn (2) Donmuang (3) Sanam Bin. There are 60 village communities, 15 slum communities and 3 suburban communities, and 2 urban communities. Total population is 166,882 (Donmuang district office, 2012). The important place in Donmuang is the Donmuang International Airport.

Focused on Elderly population in Donmuang district. The elderly people is 11 % of the total population. There are about 18,213 elderly people in this community and about 1,014 elderly people living in slum areas (Donmuang district office, 2012).

There is no study about health status and health seeking behaviors and also access to health service among elderly people in this district. The activity to support the elderly people have only the MOPH policy implemented such as elderly clinic, home visit, health education health promotion, prevention and disease control. The increasing number of elderly people leads to many problems in this community. In the nearly future, they might be tended to increase the severity of the situation.

For the reason above, the researcher is interested in studying the health status and health seeking behaviors among the elderly in the Donmuang slum community. The findings from this study will provide more beneficial for elderly people. Moreover, the results can be a baseline data and used as a guideline to improve the health care service system for the elderly in the Donmuang slum community, Bangkok.

1.2 Research questions

1. What are the health statuses among the elderly in the Donmuang slum community, Bangkok?
2. How are the healths seeking behaviours among the elderly in the Donmuang slum, Bangkok?
3. What are the personal profiles of the elderly under different scheme in the Donmuang slum community, Bangkok?
4. What are the relationship between (1) personal profile (2) utilization of health services with both health status and health seeking behaviours for the perceived minor and major illness of the elderly?

1.3 Research objectives

General objective

To find out the health status and health seeking behaviours including factors related to health seeking behaviors among elderly who lives in the Donmuang slum community, Bangkok**.**

Specific objective

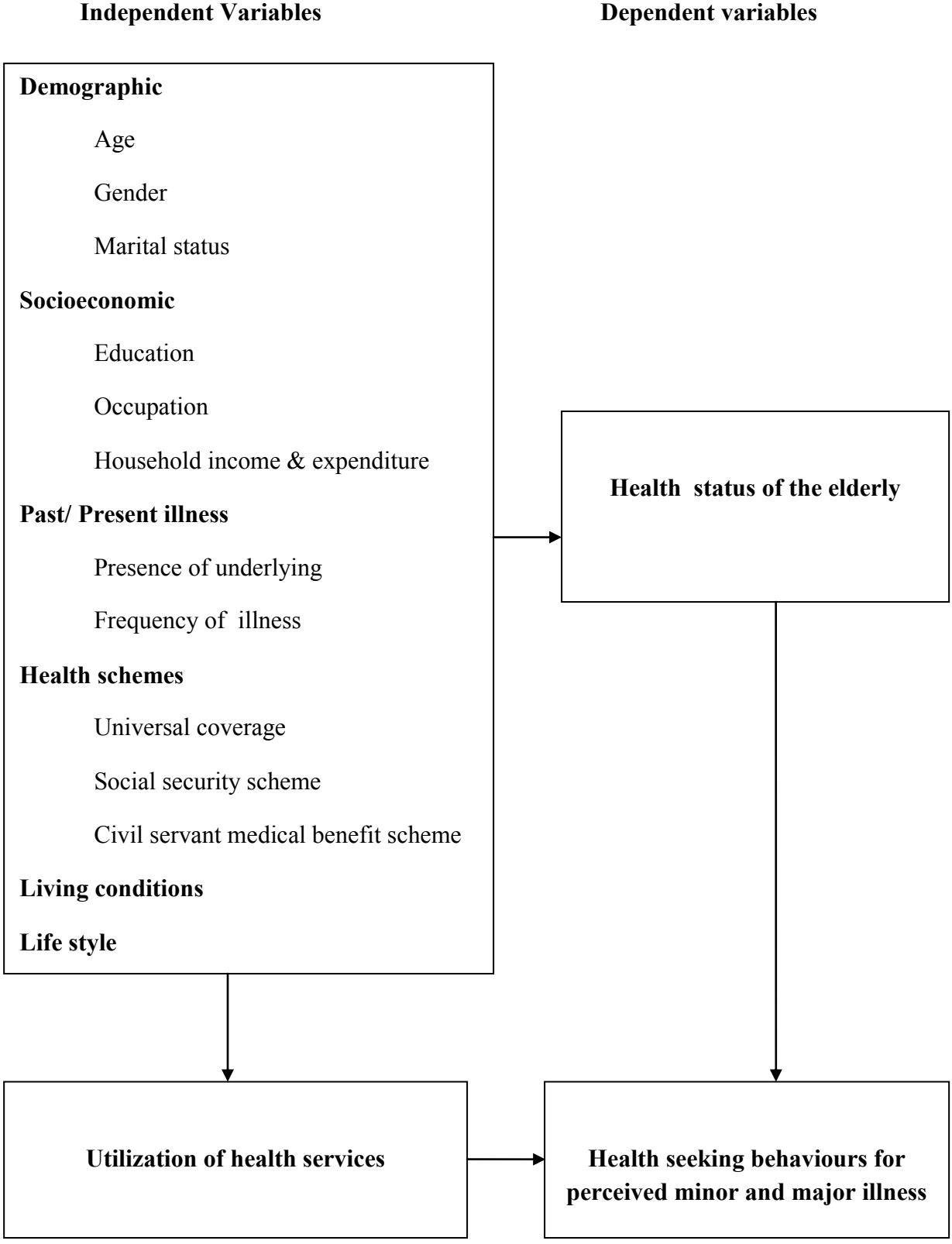
The study has the following objectives:

1. To determine the health status among elderly in the Donmuang slum community.
2. To describe the health seeking behaviors for perceived minor and major illness.
3. To determine personal profile of the elderly under different scheme.
4. To determine the relationship between (1) personal profile (2) utilization of health services with both health status and health seeking behaviours for the perceived minor and major illness of the elderly.

1.4 Knowledge Gap

There has been several study focused on the health seeking behaviours in vulnerable groups such as migrants who live in Thailand. Elderly focused on specific disease in the rural areas but base on my knowledge there is few study conducted on slum communities in aspect of both health status and health seeking behaviours in elderly people who live in urban areas.

1.5 Conceptual Framework



1.6 Operational Definitions

Health status is defined as the physical health situation of the elderly during three months prior to the survey including, social health status will asssesd through living arrangement interaction pattern, member to social group and performing family and society roles. Psychological health status will assessd through perception of one health feeling of being wanted and satisfaction with the current way of life.

Health seeking bahaviour in this study will assessed how the elderly managed their health problems. The actions are organized into 6 groups namely (1) Self medication, (2) Buy medication/ Consult at drug store, (3) Visit public health agencies, (4) Visit private health agencies, (5) Traditional healer/ Traditional treatment, (6) Do nothing/ignoring.

Personal profile in this study in Demographic; age, gender, marital status. Socioeconomic; education, occupation, household income and expenditure. Past/ present illness; presence of underlying, frequency of illness. Health schemes; universal coverage, social security scheme, civil servant medical benefit scheme, living conditions, life style.

Utilization of health services in this study focused on accessibility to health care services refers to the ability of using the health care services in terms of presence of health insurance, opening time, closing time at the local health center. traveling time to go to the health center, privacy of the treatment room, hospitality of the health care personnel and number of the health care provider at the health care center and efficiency refers to waiting time to use at the health center.

Elderly is defined as both male and female persons who have sixty years and above

Donmuang slum community is defined as informal and illegal sattlements at Donmuang district office determines at a slum area.

CHAPTER II

LITERATURE REVIEWS

The study is cross-sectional study focused on health status and elderly's health seeking behaviours. In order to give some background information, this chapter will provide concepts, theories and literature reviews that related to the study of health status and health seeking behaviours; in the following areas:

2.1 Concepts and theories of the elderly

2.1.1 Definition of Aging

2.1.2 The changes in the aging process

2.1.3 Theories of aging

2.2 Concepts and theories of health status

2.2.1 Definition of health status

2.2.2 Health problem of the elderly

2.2.3 Assessment of the health status

2.3 Concepts and theories of health seeking behaviours

2.3.1 Definition of health seeking behaviours

2.3.2 Health seeking behaviours model

2.3.3 Concepts and relavant of health seeking behaviours

2.4 Concepts and theories of utilization of health services

2.5 Relevant research

2.1 Concepts and theories of the elderly

2.1.1 Definition of Aging

Aging defined as " the process of progressive change in the biological, psychological and social structure of individuals" (Stein and Moritz, 1999).

"Aging is associated with the progressive decline in homeostatic control and the ability to respond to stress and /or change"(Ferri, 2007).

Most developed countries have accepted elderly population age of 65 years, but not accepted well in Africa region, While aging definition is "many times associated with the age at which one can begin to receive pension benefits". At the moment, the UN agreed cut off is 60+ years to refer to elderly population (WHO, 2012).

In this study, elderly means the people who are 60 or more than 60 years old and both sex; male or female.

2.1.2 The changes in the aging process

Aging and change

Changes that occur with aging fall into three categories: physical, psychological, and social. As changes begin to happen in one area of a person's life, most likely the other two will be affected as well. (Smith and Gove, 2005).

The changes occurred upon the elders as follows: Physical aging

This concept focus on change that aging process normally and are not concern for disease. There are five part focused on; sensory changes, bone and muscle, digestion, circulation and sexuality.

Sensory changes

Hearing

- Hearing impairment will occur with people who have aged over 60 years. About 30% of people hearing loss will occur with aging 75 to 84 years and about 33% of aging people who have aged over 85 years will have a hearing loss about 50%.
- Aging people have problems with hearing high pitched tones and ability to talk can effect from hearing loss.

Vision

- Vision of aging reduce from the flexibility of the eye decrease and also peripheral vision.
- Degeneration of eye muscles.
- Increase clouding of the lens.

Taste and Smell

- There are a smaller amount saliva and other lubricating fluids.
- A decrease in the sensations of taste and smell.

Touch

- A decline in sweat gland activity.
- A decline of maintain a body temperature from poor circulation in the body.
- Skin easy to tears and breaks, high risk of injury and infection on skin.

Changes in bones and muscles

- A decline in density and bone strength.
- A decline of muscle strength and coordinating.
- A loss of elasticity between ligaments and bones.

Teeth and mouth

- The aging has a problem with loose teeth and gum.

Digestion

- A decrease of bowel movements, mostly occur constipation in aging.
- A decrease sense of thirst and decline capacity to conserve water.
- A decline acid production in stomach.

Circulation

- A decreased ability to pump blood through the whole body.
- A decrease of blood flow in the body.
- The aging with poor circulation may experience of numbness of the hands and feet.
- High risk to develop "little strokes", Transient Ischemic Attack (TIAs) than when the age is younger.

Sexuality

- Sexual hormones and sexual functioning decrease.
- A decline of interest in sex may be caused by emotional cause, drug used and disease.

Biological theories of aging are "concerned with answering basic questions regarding the physiologic processes that occur in all living organisms as they chronologically age" (Meiner, 2011).

There are many theories that related to physical change follow as:

- Genetic theory, human cells maintain their own seed of destruction at the level of the chromosomes.
- Connective tissue or cross-linking theory hypothesizes that with age some proteins become increasingly cross-linked or enmeshed and many impede metabolic processes by obstructing the passage of nutrients and wastes between the intracellular and extracellular compartments.

- Free-radical theory, it is based on free products of fundamental metabolic activities within the body. Chemical reactions of the cells product free radicals, these free radicals cause the cells of the body break down. As times pass, more cell dies or lose the ability to function, and the body soon causes to function as a whole.
- Immunological theory, the immune system is a network of specialized cells, tissues, and organ that provides the body with protection against invading organism. Its primary role is to differentiate self from non self, thereby protecting the organism from attack by pathogens. It has been found that as a person ages, the immune system functions less effectively, the term " immunosenescene" has been given to this age- related decrease in function.

Psychological aging

Psychological aging is characterized primarily by cognitive and personality change.

Intelligence

- Intelligence is often asymptomatic until quite late in the life span.

  Decrements that do appear seem to be more a factor of motivation, vocabulary, contemporary skills, and speed than they are a factor of age-related loss.

Learning and Memory

Andrew E Scharlach and Barrie Robinson reveals that "most persons experience a modest increase in memory problems as they get older, particularly with regards to ability to remember relatively recent experiences. Decrements are found both in the ability to accumulate new information and in the ability to retrieve existing information from memory storage, although there is a little decline in the ability to store new information once it is learned".

2.1.3 Theories of aging

Psycho-sociological Theories

Vicki Notes stated that

- "Psychosocial aging can be described as a result of the disuse of previously acquired skills, random wear & tear, a change in the ability to adapt due environmental variables, loss of internal & external resources, genetic influences over the life span.
- Social scientists agree that genetics (heredity) are a major factor in determining the length of human life, although environment plays an important role in modifying the expected life span.
- The bottom line of Psychosocial Theory: As people grow older, their behavior changes, their social interactions change, and the activities in which they engage change".

There are four Psychosocial Theories important are

- Disengagement theory
- Activity theory
- Life-course theory
- Continuity theory

2.1.3.1 Disengagement theory

The disengagement theory, which states that society and the older person withdraw from one another simultaneously and satisfactorily as the older person aged. This theory emerged in 1960 in a study commonly referred to as the Kantus city study of Adult life. In addition complete bibliography on disengagement theory by Hochschild (1975).

The four premises of the theory are:

- Disengagement is a gradual process.
- Disengagement is inevitable.
- Disengagement is a mutually satisfying process for both the society and the individual.
- Disengagement is the norm.

2.1.3.2 Activity Theory

The activity uses to describe normal aging. This theory advances the idea that the individual needs to develop a high level of physical, mental, and social activities. Thus if younger roles in society are given up by older adults, for example working then new role must be found to take their place. The major criticism of this activity theory is that activities may not ensure high morale. Not all older people want high activity and enjoy a more relax schedule. There have been relatively few empirical attempts to test activity theory (Marshall, 1999).

2.1.3.3 Life - course theories

One theory we are all very familiar with is Erikson's developmental stages, which here approaches maturity as a process. Within each stage the person faces a crisis or dilemma that the person must resolve to move forward to the next stage, or not resolve which results in incomplete development.

Hanighurst (in Vicki Notes, 2003) stated that "for older people to progress they must meet the following tasks:

- Adjust to declining health & physical strength
- Adjust to retirement & reduced income
- Adjust to the death of a spouse or family members
- Adjust to living arrangements different from what they are accustomed
- Adjust to pleasures of aging i.e. increased leisure & playing with grandchildren "

2.1.3.4 Continuity Theory

This theory purpose that people became more of themselves as they age, Consequently, activity in late life should fit with life long personalities for people to age successfully, therefor, a bank president wishing to remain active content in later life might volunteer as the leader for community projects and accomplishing a gold would lead to his particular happiness (Haight et al, 2005).

Vicki Notes state that Continuity theory are:

- "Older adults try to preserve & maintain internal & external structures by using strategies that maintain continuity. Meaning that older people may seek to use familiar strategies in familiar areas of life.
- In later life, adults tend to use continuity as an adaptive strategy to deal with changes that occur during normal aging. Continuity theory has excellent potential for explaining how people adapt to their own aging.
- Changes come about as a result of the aging person's reflecting upon past experience & setting goals for the future".

2.2 Concepts and theories of health status

2.2.1 Definitions of health status

Unipan, J (2000) defined “ health as a state or condition that enables the individual to adapt to the environment”.

Newman (Pender, R., 1996) defined the health status as a condition in which all subsystems phychological, psychological and socio-cultural are in balance and in harmony with the hole man.

2.2.2 Health problem of the elderly

Health problems of the elderly result from poor health promoting behaviors (Palank, 1991) which may lead to chronic diseases and non-communicable disease such as cardiovascular disease, diabetes mellitus and mental health problems. A national survey on elderly's health promoting behaviors and lifestyles in 2007 found that 28% of them had daily exercise, 13% had regular smoking, 3% had regular

drinking alcohol, 63% ate fruits and vegetables daily and 74.1% had an annual physical checkup.

About mortality rate, common cause of death in both sexes of aging are heart failure and cerebrovascular disease. Among elderly men; accident and cancer were common causes of death, whereas diabetes mellitus, hypertention and septicemia are a common cause of death among elderly woman (MOPH, 2009).

2.2.3 Assessment of the elderly health status

The scope of assessment of the elderly health status was health valuation and other conditions, such as a physical health, functional ability, psychological health, and social functioning. The methods used in assessing this status may be different and different tools or test may be used. However, the tests that may be used should be examined or developed appropriately.

Thai elderly health status

Elderly people perceive themselves as having good health status. The 4th National Health Examination Survey (NHES) 2008 - 2009 which assessed the health of 9,195 elderly people, 48.4% evaluated themselves as having “medium” health while 38.1% gave themselves a “good” (32.6%) or “very good” health.

The proportion of the elderly in this survey who assess themselves as having ‘not good’ or ‘not good at all’ health was 12.5% and 1.0% respectively. When considering gender, elderly men evaluated themselves as having ‘medium’ or better health more than their female counterparts, while it was the elderly women who self-assessed themselves as having ‘not good’ health or worse more than elderly men (TGRI, 2009).

Health care services for elderly

The Ministry of Public Health Thailand started a free health care program for Thai elderly in public hospitals and health centers in 1992 but until now there was no long-term hospital care for the elderly in Thailand. However, it has has operations in some private hospitals in Bangkok. In all regional hospitals / clinics in Thailand. There are counseling caregiver of the elderly.

According to the universal coverage policy, it free services for all people. Available from primary to secondary or tertiary health center. A very important role in the care of older people in the community is village health volunteers who trained from health staffs (MOPH, 2007)

2.3 Concepts and theories of health seeking behaviours

2.3.1 Definition of health seeking behaviours

Health seeking behavior is a topic which has received considerable attention in recent years. Health seeking behaviors, "it explains health-seeking behavior by describing the relationships among individual, interpersonal and environmental factors" (Grace et al , 2012). Health-seeking behavior " has been conceptualized as the act of using health services" (Andersen and Newman, 1973).

Health seeking behaviors is part of a wider concept, health behaviors. While little has been written specifically on health behavior ” there is an extensive literature on health behaviors in general. Health behavior includes all those behaviors associated with establishing and retaining a healthy state, plus aspects of dealing with any departure from that state.

" illness behavior" a term which includes attention to pain and symptomatology, the processes by which symptoms are defined, accorded significance and socially labelled, to extent of seeking help, and the change in life regimen as a result.The health seeking behavior is only a small part of a wider concept" (Mechanic, 1978).

2.3.2 Health seeking behaviors model

2.3.2.1 The Health Belief Model (HBM)

In 1950, Sheeran and Abraham developed one of the oldest model in social psychology, well known in public health (Susanna et al, 2003). That is “the health belief model" which can perform by following :

1. Beliefs about the happening of diseases or critical conditions which rely on:

- Perceived susceptibility, or the acceptances about how sensitive a people thinks himrself in relation to health problem
- Perceived severity of health problems and its effects

2. Health motivation, or preparedness to take care about health matters. This part has been contained in the HBM, in 1970 .

3. Beliefs about the effects of health performs. The behavioral appraisal relies on:

- Perceived benefits of the practices to reduce risk of impact.
- perceived barriers, both concrete and psychological costs of health performances.

4. Cues to action, which provide how to promote awareness by using proper systems and health resources (family, friends, health care provider, etc.).

5. Beliefs and health motivation are limited by several factors including socio-demographic data and the psychological aspects of the interviewee (individual, peer group support etc).

2.3.2.2 The Theory of Reasoned Action and the Theory of Planned Behaviour

The TPB is determined by:

- "Attitudes towards behaviour, determined by the belief that a specific behaviour will have a concrete consequence and the evaluation or valorisation of this consequence.
- Subjective norms, or the belief in whether other relevant persons will approve one’s behaviour, plus the personal motivation to fulfil with the expectations of others.
- Perceived behavioural control, determined by the belief about access to the resources needed in order to act successfully, plus the perceived success of these resources (information, abilities, skills, dependence or independence from others, barriers, opportunities etc).

- Socio-demographic variables and personality traits which condition attitudes, subjective norms and perceived behavioural control. These are the same as in the HBM".

The advantages of this theory are clearly the taking into account of motivational dimensions of controlling disease or illness.

2.3.2.3 Pathway models

Janzen (1978) suggested that "Significant others are part of the ‘therapy managing group which is key to understanding the decision making in therapeutic processes. This idea challenges the strong emphasis on the individual and stresses the pivotal role of extended groups of relatives and friends in illness negotiation and management. In the course of the illness episode, the involvement of support groups in illness management can successively change. Pathway models acknowledge these dynamics of illness and decision-making".

The strength of this models is that illustrating about health seeking as a dynamic method.

2.3.2.4 The Health Care Utilization Model

Andersen & Newman (1973) noted that the socio-behavioural model was definitely improved to explore the use of biomedical health services included other health care divisions, for instance traditional medicine and domestic treatments.

The categories of the Health Care Utilization Model are composed of " this examples like this :

- Predisposing factors: age, gender, religion, global health assessment, prior experiences with illness, formal education, general attitudes towards health services, knowledge about the illness etc.
- Enabling factors: availability of services, financial resources to purchase services, health insurance, social network support etc.
- Need factors: perception of severity, total number of sick days for a reported illness, total number of days in bed, days missed from work or school, help from outside for caring etc.

- Treatment actions: home remedies (herbal, pharmaceuticals), pharmacy, over the counter drugs from shops, injectionists, traditional healers, private medical facilities, public health services etc" .

The model focused on treatment selection. It includes material and structural factors. Moreover, this model has also been applied for improving indication on the different parts for health service approach.

2.3.2.5. Kroger ‘s model

Kroeger (1983) developed this model from Andersen's model based on an extensive and well-detailed literature rewriting, descriptive variables, all of them influenced on perceived morbidity. This model is comprised of this ways :

- “An individual’s trait or predisposing factors: age, sex, marital status, status in the household, household size, ethnic group, degree of cultural adaptation, formal education, occupation, assets (land, livestock, cash, income), social network interactions.
- Characteristics of the disorder and their perception: chronic or acute, severe or trivial, etiological model, expected benefits or treatment (modern versus traditional), psychosomatic versus somatic disorders.
- Characteristics of the service (health service system factors and enabling factors): accessibility, appeal (opinions and attitudes towards traditional and modern healers), acceptability, quality, communication, costs".

2.4 Concepts and theories of access to health services

Many factors have a powerful influence on the elderly people's approach to health care services include socioeconomic conditions, sociodemographic components and the kind of insurance coverage. In addition, poverty is the most important obstacle blocking the elderly people's approach to health care.

Smith (2012) suggested that "The ethical issues related to these hindering factors involve the principles of social justice and beneficence. The ability of the elderly to access quality health care will continue to become more difficult with the rising cost of these services, the increasing complexity of the healthcare system, and the decline in the number of primary-care providers, coupled with the growing number of older individuals. It is important for NPs and other health care providers to be aware of identifiable factors that have a powerful effect on an elderly person's ability to access health care and the ethical principles that play a role in assuring adequate access to this care" (Smith, 2009).

2.5 Relevant Research

Wongyala studied about health seeking behavior of the elderly with osteoarthritis of knee in Ratchaburi province by using a qualitative study. A grounded theory approach was used to generate a substantive theory. Population of this study was the elderly who have knee osteoarthritis with knee diagnosed by a physician in the orthopedic outpatient department at Ratchaburi hospital. This study was conducted between October 1,1998 - September 30, 1999. Twelve participants were in-depth interviews, observation, recording and note taking during collected data. Researchers separated the results into two parts: Part 1 Basic Information on the sample and the second the content (Substantive Theory) samples, the majority were male (7 participants) are located in the age group 60 years to 70 years (7 participants) most are Thai and 10 participants had senior critizen card for receiving health care services. Time for participants been osteoarthritis was 6-10 years and 11 participants was pain. Moreover this study founded that elderly who had osteoarthritis with knee faced pain and affected to both mental health and social life. The use of modern medicine and the traditional treatment was the way to help relieve the pain and important factors

affected health seeking behavior was social support from family of elders (Wongyala, 2001)

Nadee conducted a study entitled “Health seeking behavior of the elderly receiving first service at King Mongkut Prachomklao Hospital, Petchaburi”. The objective of the study was to describe the illness, health seeking behavior of the elderly receiving the first time service at King Mongkut Prachomklao Hospital, Petchaburi. The study try to identify factors associated with the use of health services of the elderly. Sixty participants were in-depth interviews. Participants described that the illness depends on the social context of the individual person the culture. The severity of the illness caused the distress to the elderly. They managed their illness by take care of themselves before seeking services from other sources, including the medical profession and the medical folk or health care system. Factors associated with the use of health services, including: 1) the health care system, 2) the service provider, and 3) the user (Nadee, 1998).

Ammarittagul conducted a study on health status and factors related to health status of the elderly in Payayom district, Patthalung Province. The aim of the study were to determine the health status of the elderly, health behaviors, social support and accessibility to health services. The study population were selected by stratified-two stage methods. The interviewed was reformed by using a questionnaire created with the expert, conbart alpha was good. The results showed that the study sample were male more than female. In the age group 60-69 years, mostly finished primary school. Most of them were agricultural occupation. A common disease of the elderly were hypertension, diabetes mellitus and heart disease. Females' s health status were better than males. Elderly perceived themselves that they were healthy 47.1%, average 31.4% and weak 21.4%. Social support for the elderly found at high level. The common problem in this studied were problems in sighing 47.7%, in chewing 44.9% sleeping pattern and in hearing. Regarding to accessibility of health services, they chose state hospital 74.7% and time for traveling to the hospitals took less than 30 minutes and satisfaction from services was good (Ammarittagul, 2004)

Waweru et al studied “Health status and health seeking behavior of the elderly person in Dogoretti division, Narobi”. This study was a descriptive cross-sectional study. Four hundred non – institutionals elderly persons were recruited. Multiple stage

sampling was applied to for choosing the sample and in each cluster was randomly selected with table of random numbers. Data were collected from self- reported and focus groups. The finding indicated that there were females more than males. 79.5 % were suffered musculo-skeletal condition, 67.8 % were respiratory condition. Results from focus groups indicated that morbidity as a major determinant of health and function dependency. 40.3 % were satisfied with their current way of life while 63 % perceived themselves as a healthy. About health seeking behavior, 73% of participants lack of money hindered health care access. Most of the participants chose to buy drug by themselves when they get sick(Waweru et al, 2003).

CHAPTER III

RESEARCH METHODOLOGY

The purpose of this chapter was to describe the methodology of the study, study area, sample selection, measurement instruments and method for data analysis. This chapter explain how to conduct the research on health status and health seeking behaviour of the elderly in the Donmuang slum community.

3.1 Research design

A cross-sectional study design was to assess health status and health seeking behaviours among the elderly in the Donmuang slum community.

3.2 Study area

This research was conduct in Suburb areas, slum communities, Donmuang district, Bangkok. The total population in the Donmuang district was 166,882 people, total population who lives in a slum community is 9,216 people. Focused on elderly in the Donmuang slum community, the estimated elderly in slum about 1,014 people (Donmuang district office, 2012).

3.3 Study population

The population in this study was both male and female elderly persons who live more than one year in Suburb areas of the Donmuang slum community, Bangkok, Thailand.

3.4 Sample size

The sample size was calculated by using (Yamane, 1967) formula

Sample size ,

$$n = \frac{N}{1 + N (e)^2}$$

Where n = the sample size

N = the size of population

e = the error of 5 percent points

$$n = \frac{1{,}014}{1 + 1{,}014\ (0.05)^2}$$

$$= 286.8$$

$$= 287$$

Sample size = 287 subjects

3.5 Sampling Technique

There are fifteen slum communities in Donmuang district. All elderly aged 60 years and above was selected by household survey random sampling until the required sample size is obtained. Incase of there are elderly more than one people live together in house. Simple random samping was apply to choose only one elderly per house.

Inclusion criteria

Thai elderly people both male and female

Who are aged 60 years and above

Who are able to speak Thai language

Who are living in the Donmuang slum more than 1 years

Who are willing to participate in this study

Exclusion criteria

Who are affected by a condition which impairs communication such as psychiatric disorders, mental impairments, severe hearing or speech.

3.6 Measurement instruments

The measurement instrument which was used in this study is a questionnaire that generates from literature reviews, journals and research that divided by 4 parts

Part 1 Sociodemographic

Part 2 Health status

Part 3 Local health provision

Part 4 Health seeking behaviours.

3.7 Validity

Face validity and content validity of the health seeking behaviours survey questionnaire was assessd by three experts. Validation of the instrument including testing survey questionnaire. IOC = 0.79

3.8 Reliability

Pilot testing of 'Health status and health seeking behaviours among elderly" questionnaire was conducted with elderly who lives in small slum community in Donmuang district (Na-ta-argard-sa-yarn dan tai) before doing a real survey. The purpose of pilot study was to assess the clearness of the questionnaire, wordings in the questionnaire will modify as suggest by feedback from the volunteers, Conbach's alpha = 0.81

3.9 Data collection

The research assistants were trained to understand the purpose of the study. Data was collected by a face to face interview with the respondents by the researcher and four research assistants. The data collecting time will be about 30 minutes for each person. The data was collected everyday at 8.00 am. to 4.00 pm, during the work day until obtaining the sample size. All the data was checked before performing the statistical analysis.

3.10 Data analysis

All data was collected and analyzed using the Software Package for Social Studies (SPSS) version 16.

Data analysis was conducted to answer the specific objectives of the study which are

Specific Objective 1: To determine the health status among elderly in physical health status, social health status, psychological health status

Specific Objective 2: To describe health seeking behaviors for perceived minor and major health problems

Specific Objective 3: To determine the personal profile of the elderly under different scheme.

Descriptive statistics in frequency, percentage, mean and standard deviation will be used for analysis

Specific Objective 4: To determine the relationship between (1) personal profile (2) utilization of health services and both health status and health seeking behaviors for the perceived major health problem of the elderly

Pearson's Chi – square test will be used to identify the relationships.

3.11 Ethical consideration purposes of the study

The research was approved by the Ethics Review Committee for Research involving Human Research Subjects, Chulalongkorn University before it begins. Moreover, the purposes and procedures of the study was clearly explained to the participants, Finally, the elderly was sign the informed consent form containing the agreements relating to confidentiality, free participation, freedom to withdraw from the research, and no use of the information for other purposes.

3.12 Limitations of the study

The study was conducted in only one district in suburb area, therefore, the results cannot be generalized to the whole of the elderly in the other slum communities.

The study show the health seeking behaviours of elderly in general. However, the results cannot be exactly the same with health seeking patterns for other specific disease.

As this study was a cross-sectional and conduct in a short time period, therefore it cannot summation the changes among the elderly population after a while.

3.13 Expected Benefits and Applications of the study

The results from study can be a baseline of the health status and health seeking bahaviours of the elderly in Donmuang community. The results of this study would be useful for the government or healthcare team planning for improving the accessibility to critical health care services.

CHAPTER IV

RESULTS

This chapter describes the results of the study in 4 parts. The first part presents personal profile including living conditions and life style. The second part presents health status of the elderly. The health seeking behaviors for perceived minor and major illness are describes in the third part. The forth part focuses on the relationship between (1) personal profile and perception of health status (2) utilization of health services and perception of health status (3) personal profile and health seeking behaviours (4) utilization of health services and health seeking behaviours for the elderly.

4.1 Personal profile of the elderly

Personal profile were described in table 4.1. A total of 287 elderly in the Donmuang slum community were interviewed. Age of the elderly ranged from 60 to 96 years. 69.7 % were females and 30.3 % were males. Most of the elderly were Buddhist with 99.3 %. Only few of them were Christian (0.3 %) and Islam (0.3 %). Half of the elderly (52.6 %) were married. 39.7 % were widowed and those who single, divorced and separated were 4.5 %, 1.7 % and 1.4 % respectively.

Table 4.1: Personal profile of the elderly

Variables	Frequency	Percentage
Total	**287**	**100**
1. Gender		
Female	200	69.7
Male	87	30.3
2. Age		
60 to 69 years	140	48.8
70 to 79 years	93	32.4
80 to 89 years	49	17.1
0ver 90	5	1.7
Range = 60 – 96 years		
Mean = 71.03, SD = 8.024		
3. Religions		
Buddhist	285	99.3
Christian	1	0.3
Islam	1	0.3
4. Marital status		
Married	151	52.6
Widowed	114	39.7
Single	13	4.5
Divorce	5	1.7
Separated	4	1.4

Table 4.1: Personal profile of the elderly (continued)

Variables	Frequency	Percentage
Total	**287**	**100**
5. Educational status		
No formal education	49	17.1
Primary school	192	66.9
Secondary school	32	11.1
Vocational education	12	4.2
Bachelor's Degree or higher	2	0.7
6. Reading and writing ability		
Can read and write	86	30.0
Can read and write a little	125	43.6
Can read but cannot write	17	5.9
Cannot read and write	59	20.5
7. Occupations		
Not working	221	77.0
Laborer	35	12.2
Self employed	27	9.4
Government or State Enterprise	3	1.0
Employee private company	1	0.3

Regarding to the educational status, two thirds of the elderly got primary school education (66.9 %). Another 17.1 % never go to school, 11.1 % reached to secondary school. 4.2 % of the elderly got vocational education and 0.7 % got bachelor's degree or higher. Most of the elderly in this community had the ability to read and write (30% of them can read and write, 43.6% can read and write a little and 5.9% of them can read only), while 20.5% of these elderly had no ability to read and write.

From the study in economic status, it was found that the majority of the elderly (77 %) are not working, 12.2 % are laborer, 9.4 % are self employed, 1 % are working in government or state enterprise and 0.3 % are employee in private company.

Table 4.1 : Personal profile of the elderly (continued)

Variables	Frequency	Percentage
Total	**287**	**100**
8. Average net elderly income per month		
Less than 2,500 baht	184	64.1
2,500 to 5,000 baht	70	24.4
More than 5,000 baht	33	11.5
Range = 0 – 50,000 baht		
Median = 2,838.65, SD = 3,935		
9. Average net elderly expenditure per month		
Less than 2,500 baht	189	65.9
2,500 to 5,000 baht	65	22.6
More than 5,000 baht	33	11.5
Range = 0 – 45,000 baht		
Medan = 2,680.51, SD = 3,559		

Expenditure ranged from 0 – 45,000 baht. Average net elderly income were less than 2,500 baht per month for 64.1 %, Income ranged from 0 – 50,000 baht and average net elderly expenditure were less than 2,500 baht per month for 65.9 %.

Table 4.1: Health insurance of the elderly (continued)

Variables	Frequency	Percentage
10. Health insurance (n = 287)		
Universal coverage	205	71.4
Civil Servant Medical Benefit Scheme	44	15.3
Social Security Scheme	17	5.9
Others	21	7.3

Table 4.1: Personal profile of the elderly (continued)

Variables	Frequency	Percentage
11. Whom do you live with (Multiple response)		
Daughter	141	49.1
Grandchildren	123	42.9
Husband/ wife	118	41.1
Son	112	39.0
Cousins	26	9.1
Alone	8	2.8
12. Number of people staying together in the house (n = 287)		
1 to 5 people	220	76.6
6 to 10 people	63	22.0
More than 10 people	4	1.4
Range = 0 – 17 people		
Mean = 4.40, SD = 2.487		

Personal profile of the elderly in table 4.1 are shown. 49.1 % of the elderly lived with daughter, 42.9 % lived with grandchildren and 41.1 % lived with husband/ wife. Only 2.8 % of the elderly lived alone.

76.6 % of the elderly staying with 1 to 5 family members and 94.8 % of the elderly have good relationship with family.

Table 4.1: Personal profile of the elderly (continued)

Variables	Frequency	Percentage
13. Relationship within family (n = 287)		
Live happily together	272	94.8
Live together but have a problem	11	3.8
Live together but not associate	2	0.7
Others	2	0.7

Table 4.2: Living conditions of the elderly

Variables	Frequency	Percentage
Total	**287**	**100**
1. Home		
Own home	279	97.2
Rent home	3	1.0
Others	5	1.7
2. Location of bedroom		
First floor	208	72.5
Second floor	79	27.5
3. Place to sleep		
Lying on the bed	178	62.0
Lying on the floor	109	38.0

Table 4.2: (continued) Living conditions of the elderly

Variables	Frequency	Percentage
Total	**287**	**100**
4. Type of toilet		
Flush toilet	186	64.8
Water pouring toilet	91	31.7
Others	10	3.5
5. A source of drinking water		
Water pass with strainer	227	79.1
Tap water	30	10.5
Underground water/ water in the pond	2	0.7
Others	28	9.8

Living conditions of the elderly were shown in table 4.2. 97.2 % of the elderly staying in their own home. Location of the bed room was at the first floor and 62 % of the elderly lying on the bed. Most of toilet type was flush toilet (64.8 %). A source of drinking water was water pass strainer with 79.1 %.

For a smoking habit, 72.1 % of the elderly do not smoking, 15.7 % ever smoke but now they stop smoking and 12.2 % had a smoking habit. Regarding alcohol drinking habit, 64.5 % do not drink and 15 % had a drinking habit.

Table 4.3: Life style of the eldelrly

Variables	Frequency	Percentage
1.Smoking habit (n = 287)		
Do not smoke	207	72.1
Ever smoke	45	15.7
Smoke	35	12.2
Number of cigarette per day (n = 35)		
Less than 4	8	2.8
4 to 8	11	3.8
More than 8	16	5.6
Range 2 – 20		
Mean = 1.1498, SD = 0.489		
2.Alcohol drinking habit (n = 287)		
Do not drink	185	64.5
Ever drink	59	20.6
Drink	43	15.0
Frequency of alcohol drinking (n = 43)		
less than 2 time/ month	14	4.9
2 -3 times/ month	16	5.6
1- 5 days / week	5	1.7
6 -7 days /week	8	2.8

4.1.1 Personal profile of the elderly under different health scheme

Table 4.4: Personal profile of the elderly under different scheme

Personal profile	Health insurance			
	Universal coverage N (%)	Social Security Scheme N (%)	Civil Servant Medical Benefit N (%)	Others N (%)
Gender				
Male	59 (67.8)	9 (10.3)	11 (12.6)	8 (9.2)
Female	146 (73.0)	8 (4.0)	33 (16.5)	13 (6.5)
Age				
60 to 69 years	105 (75.0)	16 (11.4)	13 (9.3)	6 (4.3)
70 to 79 years	65 (70.2)	1 (1.1)	16 (17.0)	11 (11.7)
80 to 89 years	31 (62.5)	0 (0)	15 (31.2)	3 (6.2)
Over 90 years	4 (80.0)	0 (0)	0 (0)	1 (20.0)
Religion				
Buddhist	203 (71.2)	17 (6.0)	44 (15.4)	21 (7.4)
Christian	1 (100)	0 (0)	0 (0)	0 (0)
Islam	1 (100)	0 (0)	0 (0)	0 (0)
Marital Status				
Single	11 (84.6)	0 (0)	0 (0)	2 (15.4)
Married	96 (63.6)	12 (7.9)	31 (20.5)	12 (7.9)
Separated	3 (75.0)	1 (25.0)	0 (0)	0 (0)
Widowed	91 (79.8)	3 (2.6)	13 (11.4)	7 (6.1)
Divorce	4 (80.0)	1 (20.0)	0 (0)	0 (0)

Table 4.4: (continued) Personal profile of the elderly under different scheme

Personal profile	Health insurance			
	Universal coverage	Social Security Scheme	Civil Servant Medical Benefit	Others
	N (%)	N (%)	N (%)	N (%)
Education				
No formal education	32 (65.3)	4 (8.2)	8 (16.3)	5 (10.2)
Primary school	142 (74.0)	9 (4.7)	26 (13.5)	15 (7.8)
Secondary school	21 (65.6)	4 (12.5)	6 (18.8)	1 (3.1)
Vocational education	8 (66.7)	0 (0)	4 (33.3)	0 (0)
Bachelor's Degree	2 (100)	0 (0)	0 (0)	0 (0)
Occupations				
Laborer	26 (74.3)	9 (25.7)	0 (0)	0 (0)
Self employed	22 (81.5)	2 (7.4)	3 (11.1)	0 (0)
Employee private	0 (0)	1 (100)	0 (0)	0 (0)
Government	1 (33.3)	1 (33.3)	1 (33.3)	0 (0)
Not working	156 (70.6)	4 (1.8)	40 (18.1)	21 (9.5)
Reading and writing ability				
Can read and write all	71 (82.6)	2 (2.3)	9 (10.5)	4 (4.7)
Can read and write a little	82 (65.6)	10 (8.0)	22 (17.6)	11 (8.8)
Can read and cannot write	12 (70.6)	2 (11.8)	3 (17.6)	0 (0)
Cannot read or write	40 (67.8)	3 (5.1)	10 (16.9)	6 (10.2)

The data from table 4.4 showed that more than half of male elderly were under universal coverage scheme (67.8%). Some of them used civil servant medical benefit scheme (12.6%) and social security scheme (10.3%). Similarly to female participants, 73% of them used universal coverage scheme, 16.5% were under civil servant medical benefit scheme and only 6.5% used others scheme. The results from this study revealed that most of the elderly both male and female were more likely to used

universal coverage scheme when compared to the others scheme. Focusing on the population in age range 60-69, the data showed that they prefer to choose social security scheme more than others.

In regard to marital status, the data showed that most of the elderly in every marital status prefer to used universal coverage scheme. However, the married elderly have selected the civil servant medical benefit scheme more slightly than the others scheme. In the issue of educational level, the universal coverage scheme is the most popular followed by civil servant medical benefit scheme and social security scheme, respectively. Interestingly, this study found that the elderly who finished primary school were more likely to use the others scheme than social security scheme.

Concerning the occupation, the results revealed that most of the elderly in every occupation prefer to use universal coverage scheme. Some of the elderly in the labor group chose social security scheme. The results also showed that most of the elderly who can read and write well prefer to used universal coverage scheme followed by civil servant medical benefit scheme and others, respectively.

Table 4.4 : (continued) Personal profile of the elderly under different scheme

Health problems	**Health insurance**			
	Universal coverage	**Social Security Scheme**	**Civil Servant Medical Benefit**	**Others**
	N (%)	**N (%)**	**N (%)**	**N (%)**
No	48 (76.2)	2 (3.2)	5 (8.0)	8 (12.7)
Yes	157 (70.0)	15 (6.7)	39(17.4)	13(5.8)

Elderly under universal coverage have health problem diagnosed by physician high at 70.0 %, Civil Servant Medical Benefit 17.4 %, Others scheme 5.8 % and Social Security Scheme at 6.7 % respectively.

4.2 Health status of the elderly

Table 4.5 : Health problem diagnosed by physician

Variables	Frequency	Percentage
Health problem diagnosed by physician (n = 287)		
No	63	22.0
Yes	224	78.0

The study found that most of the elderly have health problem diagnosed by physician for 78.0 %

Table 4.6 : Type of health problem of the elderly

Variables	Frequency	Percentage
Type of health problem diagnosed by physician (Multiple response) N = 224		
Hypertension	166	74.1
Diabetes	89	40.0
Dyslipidemia	77	34.4
Heart and vascular disease	41	18.3
Orthopedic diseases	38	17.0
Others	28	12.5
Cancer	5	2.2

From table 4.6 shows that most of health problem of the elderly was hypertension for 74.1 %, diabetes and dyslipidemia for 40 % and 34.4 % respectively.

Table 4.7 : Health problem in last three months

Variables	Frequency	Percentage
Health problem in last three months (n = 287)		
Never	191	66.6
Less than 5 times	87	30.3
5 times or more	9	3.1

Health problem in last three months in table 4.7, 66.6 % of the elderly was never have health problem, 30.3 % have health problem less than 5 times in last three months and 3.1 % have health problem 5 times or more.

Table 4.8: Perception of health status

Variables	Frequency	Percentage
Perception of health status (n = 287)		
Good	152	52.9
Fair	81	28.2
Not good	54	18.8

The study was found that perception of health status of the elderly was good 52.9 %, fair 28.2 % and bad 18.8 %.

Table 4.9: A physical examination

Variables	Frequency	Percentage
A physical examination (Multiple response)		
An annual physical examination (last one year)	218	76.0
Vision test	78	27.2
Hearing test	50	17.4
Oral cavity	34	11.8

An annual physical examination in last one year revealed that 76 % of the elderly have an annual examination. Vision test 27.2%, Hearing test 17.4 % and oral cavity 11.8 %.

Table 4.10: Admit in the hospital

Variables	Frequency	Percentage
Admit in hospital (n = 45)		
No	242	84.3
Yes	45	15.7
Cause of admit		
Infections	14	4.9
Hypertension	10	3.5
Asthma	8	2.8
Electrolyte imbalance	5	1.7
Diabetes	3	1.0
Gut obstruction	3	1.0
Kidney disease	2	0.9
Admit day in hospital		
Less than 4 days	30	10.5
4 to 10 days	13	4.5
More than 10 days	2	0.7

The study found that 15.7 % of the elderly admit in the hospital in last six months. 10.5 % admitted less than 4 days and the cause of admitted was infections at 4.9 %, hypertension at 3.5 % and asthma at 2.8 %.

Table 4.11: Vision and hearing problem

Variables	Frequency	Percentage
Vision problem (n = 287)		
No	134	46.7
Yes	153	53.3
Hearing problem (n = 287)		
No	231	80.5
Yes	56	19.5

From the study half of elderly have problems with vision problem and 19.5 % have hearing problem.

Table 4.12: Problem of urination

Variables	Frequency	Percentage
Problem of urination (n = 287)		
No	232	80.8
Yes	55	19.2
Type of urination problem		
Urination at night	29	10.1
Dysuria	14	4.9
Incontinence	12	4.2
Decrease urinary stream	5	1.7
Hurts when urinate	1	0.3
Slow and hard to urinate	1	0.3

Table 4.12 shows problem of urination of the elderly. Most of elderly have no urination problems. Type of urination problem was urination at night 10.1 %, dysuria 4.9 % and incontinence 4.2 %.

Table 4.13: Problem of defection

Variables	Frequency	Percentage
Defection (n = 287)		
No	178	62.0
Yes	109	38.0
Problem of defection		
Constipation	102	35.5
Diarrhea	6	2.1
Change of defecation (Have a constipation and break into diarrhea)	1	0.3

Respondents have problem with defection 38 % and 35.5% faced with constipation, 2.1 % have a diarrhea.

Table 4.14: Activity daily living

Variables	Frequency	Percentage
Total	**287**	**100**
Have meal by yourself		
Do without anyone help	278	96.9
Do by someone help	6	2.1
Can not have a meal by yourself	3	1.0
Take off clothes		
Do without anyone help	274	95.5
Do by someone help	9	3.1
Can not do by yourself	4	1.4

Activity daily living of the eldery. Most of the eldery have a meal without anyone help for 96.9 % . Take off clothes do without anyone help at 95.5 %.

Table 4.14: Activity daily living (continued)

Variables	Frequency	Percentage
Total	**287**	**100**
Walk		
Do without anyone or anything help	255	88.9
Do by someone help to walk	27	9.4
Cannot walk at all	5	1.7
Spend money		
Do without anyone help (Self –pay)	271	94.4
Do by someone help	7	2.4
Cannot manage the money	9	3.1
Activity daily living		
Do it all by yourself	263	91.6
Do it by someone help	17	5.9
Do it by yourself but using equipments	2	0.7
Cannot do anything/ need helping form someone	5	1.7

From the study shows 88.9 % of the elderly can walk without anyone help. 94.4 % can spend money without anyone help and 91.6 % can do it all activity daily living by themself.

Table 4.15: Happy life of the elderly

Variables	Frequency	Percentage
Happy life		
No	29	10.1
Yes	258	89.9

89.9 % of the elderly have felt happy in their life.

Table 4.16: Exercise in last three months

Variables	Frequency	Percentage
Exercises (n = 287)		
No	171	59.6
Yes	116	40.4
Type of exercise		
Walking	78	27.2
Movement	33	11.5
Running	5	1.7
Biking	8	2.8
Taichi	2	0.7

The study found that their exercise was 40.4 %, The most type of exercise was walking for 27.2 %, movement for 11.5 % and biking for 2.8 %.

Table 4.17: Social activities in last three months

Variables	Frequency	Percentage
Social activity (n = 287)		
No	208	72.5
Yes	79	27.5
Type of social activities		
Religious activities	50	17.4
Health promotion activities	7	2.4
Field trip	7	2.4
Elderly organization	6	2.1
Public preform activities	4	1.4
Revenue promotion activity	1	0.4
Recreational activities	2	0.7
Others	2	0.7

Most of the elderly people have not social activity 72.5%. Some elderly have social activity 27.5% which type of social activities are religious activities 17.4 %.

4.3 Health seeking behaviours

Table 4.18: Perceived major illness of the elderly

Variables	Frequency	Percentage
Major illness		
No	63	22.0
Yes	224	78.0
Type of major illness		
Hypertension	88	30.7
Vascular and heart disease	41	14.3
Diabetes	24	8.4
Orthopedics disease	19	6.6
Others	19	6.6
Dyslipidemia	15	5.2
Respiratory disease	12	4.2
Cancer	6	2.1

From table 4.18 shows perceived major illness of the elderly. Elderly have disease diagnosed by physician 78 %. Most of major illness was hypertension 30.7%, Vascular and heart disease at 14.3 % and diabetes 8.4 % respectively.

Table 4.19 Health seeking behaviours for perceived major illness

Type of disease		Percentage				
	Number (N)	Self Drug	Buy Drug	Public Health Agencies	Private Health Agencies	Do Nothing
Hypertension	88	3.4	1.1	89.8	2.3	13.3
Vascular and heart disease	41	0	0	87.8	9.8	2.4
Diabetes	24	0	0	95.8	0	4.2
Orthopedics disease	19	5.3	0	73.7	21.1	0
Dyslipidemia	15	0	0	80.0	6.7	13.3
Respiratory disease	12	0	0	91.7	8.3	0
Cancer	6	0	0	83.3	16.7	0
Others	19	0	0	89.5	5.3	5.0

From table 4.19 shows health seeking behaviours of the elderly when perceived major illness. Elderly who have hypertension visit health agencies 89.8 %, do nothing 13.3 % and self medication 3.4% in similar to the elderly who have dyslipidemia. Most elderly who have vascular and heart disease, orthopedics disease, respiratory disease, cancer and others disease visited health agencies, follow by private agencies.

Table 4.20: Health seeking behaviours for perceived minor illness

Variables	Frequency	Percentage
Minor illness		
No	161	56.1
Yes	126	43.9
Type of minor illness		
Headache	67	23.3
Muscle pain	25	8.7
Fever	13	4.5
Common cold	8	2.8
Diarrhea	6	2.1
Nausea and vomit	5	1.7
Rash	2	0.7

From table 4.20 show health seeking behaviours for perceived minor illness .Most of minor illness was headache at 23.3 %, muscle pain at 8.7 % and fever at 4.5 %.

Table 4.21 Health seeking behaviors for perceive minor illness

Type of disease		Percentage					
	Number (N)	Self Drug	Buy Drug	Public Health Agencies	Private Health Agencies	Traditional healer	Do Nothing
Headache	67	67.2	4.5	7.5	1.5	3.0	16.4
Muscle pain	25	36.0	24.0	20.0	4.0	4.0	12
Fever	13	30.8	15.4	15.4	7.7	7.7	23.1
Common cold	8	37.5	12.5	37.5	0	0	12.5
Diarrhea	6	33.3	33.3	16.7	0	0	16.7
Nausea and vomit	5	0	60.0	40.0	0	0	0
Rash	2	0	0	100.0	0	0	0

From table 4.21 shows health seeking behaviours of the elderly when perceived minor illness. Most of the elderly chose self – medication, except elderly who have nausea and vomit symptom buy drug at the medication store and most of elderly who have rash visited public health agencies.

4.4 The relationship between (1) personal profile (2) utilization of health services with perception of health status

Table 4.22: Relationship between personal profile and perception of health status

Personal profile	Perception of health status						x^2	p-value
	Good		Fair		Not good			
	N	%	N	%	N	%		
Sex								
Male	49	(56.3)	19	(21.8)	19	(21.8)	2.67	0.26
Female	103	(51.5)	62	(31.0)	35	(17.5)		
Age								
60 to 69 years	78	(55.7)	38	(27.1)	24	(17.1)	3.73	0.71
70 to 79 years	46	(49.5)	26	(28.0)	21	(22.6)		
Over 79 years	28	(51.9)	17	(31.5)	9	(16.7)		
Marital Status								
Single	5	(38.5)	6	(46.2)	2	(15.4)	5.34	0.72
Married	85	(56.3)	39	(25.8)	27	(17.9)		
Separated/ Widowed	62	(50.4)	36	(29.2)	25	(23.0)		

N less 5 ; p – value = Fisher's exact test

The relationships between the personal factors and perception of elderly's health status of the elderly male had perception of good health better than male and age of 60 – 69 maintain good health status than other age groups. It was not found statistic significant level at 0.05.

Table 4.22: Relationship between personal profile and perception health status (continued)

Personal profile	Perception of health status						x^2	p-value
	Good		Fair		Not good			
	N	%	N	%	N	%		
Education level								
No formal education	26	(53.1)	19	(38.8)	1	(8.2)	16.87	0.031*
Primary school	101	(52.6)	52	(27.1)	39	(20.3)		
Secondary school	17	(53.1)	10	(31.2)	5	(15.6)		
Vocational and above	8	(57.1)	0	(0)	6	(42.9)		
Reading and writing ability								
Can read and write all	36	(41.9)	33	(38.5)	17	(19.8)	22.81	0.001*
Can read and write a little	79	(63.2)	18	(14.4)	28	(22.4)		
Can read and cannot write	9	(52.9)	6	(35.3)	2	(11.8)		
Cannot read or write	28	(47.5)	24	(40.7)	7	(11.9)		

*statistically Significant level 0.05, N less 5 ; p – value = Fisher's exact test

Relationships between the personal factors and perception elderly 's health status, the study found that there was a significant difference between education level and perception of health status (p-value = 0.03). Regarding the literacy, there was a highly significant difference between the ability of reading and writing and perception of health status (p-value = 0.001).

Table 4.22: Relationship between personal profile and perception of health status (continued)

Personal profile	Perception of health status						x^2	p-value
	Good		Fair		Not good			
	N	%	N	%	N	%		
Occupations								
Laborer	26	(74.3)	7	(20.0)	2	(5.7)	13.71	0.090
Self employed	13	(48.1)	6	(22.2)	8	(29.8)		
Employee private	0	(0)	1	(100)	0	(0)		
Goverment	2	(66.7)	0	(0)	1	(33.3)		
Not working	111	(50.2)	67	(30.3)	43	(19.5)		
In view of income level								
Without sufficient income	93	(56.0)	38	(22.9)	35	(21.1)	5.740	0.057
With sufficient income	59	(48.8)	43	(35.5)	19	(15.7)		

N less 5 ; p – value = Fisher's exact test

Relationships between the personal factors and perception elderly's health status, the study found that there was no significant difference between types of occupation and perception of health status . In view of income level, there was no significant association between the income level and perception of health status.

Table 4.22: Relationship between personal profile and perception of health status (continued)

Personal profile	Perception of health status						x^2	p-value
	Good		Fair		Not good			
	N	%	N	%	N	%		
You live with								
Alone	7	(38.9)	4	(22.2)	7	(38.9)	9.832	0.043*
Spouse or children	144	(54.8)	73	(27.8)	46	(17.5)		
Relatives	1	(16.7)	4	(66.7)	1	(16.7)		
Relationship								
Live happily together	149	(54.8)	77	(28.3)	46	(16.9)	15.61	0.016*
Live together but not associate	1	(50.0)	0	(0)	1	(50.0)		
Live together but have a problem	2	(15.4)	4	(30.8)	7	(53.9)		
You need assistance during your daily living								
Do it all by yourself	141	(53.6)	76	(28.9)	46	(17.5)	6.03	0.420
Do it by someone help	7	(41.2)	5	(29.4)	5	(29.4)		
Do it by yourself but using equipments	1	(50.0)	0	(0)	1	(50.0)		
Can not do anything	3	(60.0)	0	(0)	2	(40.0)		

N less 5 ; p – value = Fisher's exact test

Table 4.22 : Relationship between personal profile and perception of health status (continued)

Personal profile	Perception of health status						x^2	p-value
	Good		Fair		Not good			
	N	%	N	%	N	%		
Health problem diagnosed by physician								
No	44	(78.6)	7	(12.5)	5	(8.9)	18.32	0.000*
Yes	108	(46.8)	74	(32.0)	49	(21.2)		

*statistically Significant level 0.05

Relationships between the personal profile and perception elderly's health status, the study found that there was a significant difference between the relationship within family and perception of health status (p-value = 0.01). Regarding living with family member, there was a significant difference between the living with family member and perception of health status (p-value = 0.04). In addition, there was a highly significant difference between the health problem diagnosed by physician and perception of health status ($p < 0.01$). Most of the elderly in the community lived with their spouse and children. Moreover, they had perceived a good health status (50.2%) and they could do their activities by themself (49%). Even though they had health problem diagnosed by physician.

Relationship between utilization of health services and perception health status.

Table 4.23 Relationship between utilization of health services and perception of health status

Utilization of health services	Perception of health status			x^2	p-value
	Good	Fair	Not good		
	N %	N %	N %		
Health insurance					
Universal coverage	106 (51.7)	55 (26.8)	44 (21.5)	9.80	0.133
Social Security	10(58.8)	5 (29.4)	2 (11.8)		
Civil Servant	25 (56.8)	17 (38.6)	2 (4.5)		
Medical Benefit Scheme					
Other	11 (52.4)	4 (19.0)	6 (28.6)		

N less 5 ; p – value = Fisher's exact test

Relationship between personal profile and health seeking behaviours

Table 4.24: Relationship between personal profile and health seeking behaviours (continued)

Personal profile	Choice of health seeking		x^2	p-value
	Do not visit health agencies	Visit health agencies		
	N %	N %		
Sex				
Male	4 (6.5)	58 (93.5)	0.203	0.653
Female	8 (4.9)	154 (95.1)		

N less 5 ; p – value = Fisher's exact test

Table 4.24 : Relationship between personal profile and health seeking behaviours (continued)

Personal profile	Choice of health seeking				x^2	p-value
	Do not visit health agencies		Visit health agencies			
	N	%	N	%		
Age						
60 to 69 years	6 (5.9)		96 (94.1)		1.134	0.769
70 to 79 years	5 (2.2)		72 (32.1)			
80 to 89 years	1 (0.4)		43 (19.2)			
Over 90 years	0 (0)		1 (0.4)			
Marital Status						
Single	0 (0)		6 (2.7)		3.509	0.477
Married	6 (2.7)		110 (49.1)			
Seperated/ Widowed	8 (6.7)		94 (78.3)			

N less 5 ; p – value = Fisher's exact test

Relationship between personal profile and health seeking behaviours of the elderly the results showed that gender, age and marital status, there were no statistically significant between personal profile and health seeking behavior (p =0.05).

Table 4.24: Relationship between personal profile and health seeking behaviours (continued)

Personal profile	Choice of health seeking		x^2	p-value
	Do not visit health agencies	Visit health agencies		
	N %	N %		
Education status				
No formal education	1 (0.4)	38 (17.0)	1.511	0.680
Primary school	9 (4.0)	141 (62.9)		
Secondary school	2 (0.9)	24 (10.7)		
Vocational education	0 (0)	9 (4.0)		
Reading and writing ability				
Can read and write all	5 (2.2)	57 (25.4)	2.996	0.392
Can read and write a little	6 (2.7)	91 (40.6)		
Can read and cannot write	0 (0)	16 (7.1)		
Cannot read or write	1 (0.4)	48 (21.4)		
Occupations				
Laborer	2 (1.3)	17 (7.6)	4.217	0.377
Self employed	1 (0.4)	16 (7.1)		
Employee private company	0 (0)	1 (0.4)		
Goverment	0 (0)	2 (0.9)		
Not working	8 (3.6)	176 (78.6)		

N less 5 ; p – value = Fisher's exact test

Table 4.24 : Relationship between personal profile and health seeking behaviours (continued)

Personal profile	Choice of health seeking				x^2	p-value
	Do not visit health agencies		Visit health agencies			
	N	%	N	%		
In view of income level						
enough	7 (3.1)		118 (52.7)		0.033	0.856
not enough	5 (2.2)		94 (42.0)			

Relationships between the personal factors and health seeking behaviours of the elderly, the study found that there was no significant difference between types of occupation jobs and health seeking . In view of income level**,** there was no significant association between the income level and health seeking behaviours. However, the elderly who visiting health agencies, more than haft of them had not enough income.

Table 4.24: Relationship between personal profile and health seeking behaviours (continued)

Personal profile	Choice of health seeking				x^2	p-value
	Do not visit health agencies		Visit health agencies			
	N	%	N	%		
You live with						
Alone	1 (0.4)		10 (4.5)		1.929	0.381
Spouse or children	10 (4.5)		197 (87.9)			
Relatives	1 (0.4)		5 (2.2)			
Relationship						
Live happily together	12 (5.4)		202 (90.2)		0.592	0.898
Live together but not associate	0 (0)		2 (0.9)			
Live together but have a problem	0 (0)		8 (3.5)			
You need assistance during your daily living						
Do it all by yourself	12 (5.4)		191 (85.3)		1.312	0.726
Do it by someone help	0 (0)		16 (7.1)			
Do it by yourself but using equipments	0 (0)		2 (0.9)			
Cannot do anything	0 (0)		3 (1.3)			

N less 5 ; p – value = Fisher's exact test

The relationships between the personal profile and health seeking behaviours of the elderly, the study found that there was no significant association between the relationship within family and health seeking behaviours. Regarding living with family member, there was no significant difference between the living with family member and health seeking behaviours. However, the elderly who visited health agencies, most of them could do all activities by themselves .

Table 4.24: Relationship between utilization of health service and health seeking behaviours of the elderly (continued)

Utilization of health service	Choice of health seeking		x^2	p-value
	Do not visit health agencies		Visit health agencies	
	N	%	N	%		
Health insurance						
Universal coverage	10	(4.5)	150	(67.0)	2.480	0.479
Social Security Scheme	1	(0.4)	14	(6.2)		
Civil Servant	0	(0)	36	(16.1)		
Medical Benefit Scheme						
Other	1	(0.4)	12	(5.4)		

N less 5 ; p – value = Fisher's exact test

Table 4.25: Relationship between utilization of health service and health seeking behaviours of the elderly (continued)

Utilization of health service	Choice of health seeking		x^2	p-value
	Do not visit health agencies		Visit health agencies	
	N %	N %		
Cost of transportation				
No	5 (2.2)	60 (26.8)	0.985	0.321
Yes	7 (3.1)	152 (67.9)		
Cost of charge				
No	3 (1.3)	51 (22.8)	0.006	0.941
Yes	9 (4.0)	161 (71.9)		
Closing time of the health center				
No	1 (0.4)	10 (4.5)	0.318	0.573
Yes	11 (4.9)	202 (90.2)		
Opening time of the health center				
No	0 (0)	11 (4.9)	0.655	0.418
Yes	12 (5.4)	201 (89.7)		
Traveling time to health center				
Less than 15 minutes	5 (2.2)	43 (19.2)	3.591	0.139
15-30 minutes count	6 (2.7)	112 (50.0)		
More than 30 minutes	1 (0.4)	57 (25.4)		

N less 5 ; p – value = Fisher's exact test

Table 4.25: Relationship between utilization of health service and health seeking behaviours of the elderly (continued)

Utilization of health service	Choice of health seeking		x^2	p-value
	Do not visit health agencies		Visit health agencies	
	N	%	N	%		
Health center crowed or not						
Every time	1 (0.4)		21 (9.4)		1.833	0.608
Sometimes	2 (0.9)		33 (14.7)			
Often	7 (3.1)		87 (38.8)			
Never	2 (0.9)		71 (31.7)			
Hospitality of health care personel						
No	0 (0)		3 (1.3)		0.172	0.678
Yes	12 (5.4)		209 (93.3)			
Time to talk about health problem with physician						
No	0 (0)		4 (1.8)		0.231	0.631
Yes	12(5.4)		208 (92.9)			
Number of facilitator enough						
No	0 (0)		2 (0.9)		0.114	0.735
Yes	12 (5.4)		210 (93.8)			

N less 5 ; p – value = Fisher's exact test

Table 4.25 : Relationship between utilization of health service and health seeking behaviours of the elderly (continued)

Utilization of health service	Choice of health seeking		x^2	p-value
	Do not visit health agencies	Visit health agencies		
	N %	N %		
Privacy of the treatment				
No	0 (0)	3 (1.3)	0.172	0.678
Yes	12 (5.4)	209 (93.3)		
Overall satisfaction of health center				
Strongly Satisfied	1 (0.4)	23 (10.3)	12.71	0.005*
Satisfied	8 (3.6)	177 (79.0)		
Dissatified	3 (1.3)	7 (3.1)		
Strongly dissatisfied	0 (0)	5 (2.2)		
Waiting time of the health center				
Less than 15 minutes	4 (1.8)	41 (18.3)	1.435	0.488
15-30 minutes	4 (1.8)	93 (41.5)		
More than 30 minutes	4 (1.8)	78 (34.8)		

N less 5 ; p – value = Fisher's exact test

In regarding to the relationship between utilization of health service and health seeking behaviours of the elderly, the results showed that found that there was no significant difference between traveling time to heath center and health seeking behaviours. There was no significant difference between time duration to talk about health problem with physician and health seeking behaviours. 41% of the elderly who visited health agencies spent time for travelling to health center for 15-30 minutes.

CHAPTER V

DISCUSSION

Discussion

5.1 Personal profile

From the collected data, The ratio of male to female was about 1 : 2. The majority of the respondents were elderly with in age of 60 to 69 years old. Most of them were Buddhists. Half of the elderly was married. The education level of majority was in primary school and ability to read and write a little. Most elderly who live in this slum come from other provinces since they were teenage. They had varity of occupations such as laboror and trade. A slum community settle near the Donmuang airport.

Most of the elderly did not working. This was consistent with the study of (Nimnoy, 1999) and (Nadee, 1998), but some elderly were working due to economic conditions. The most popular occupations were employees and trade. The incomes of them were uncertainty.

Regading the income of the elderly. The average monthly income was about 2,836 bahts. A regular income come from family support and allowances. Average expenditure per month was 2,680 Bahts. This is consistency with the study of (The 4th National health examination survey, 2009) They reported that the elderly have income more than poverty line (1,443 baht).

From this study found that elderly lived with their daughter grandchildren and spouse. Number of members living in the same house were 1 -5 people and had good relationships within their family.

This results were in line with Ammarittikul, 2004 which found that most of the elderly live with spouse or children more than live alone and had good relationship with their family.

Concerning the living condition of the elderly, their house was a little wooden house with a small living area. The house were their own. Located near Prem Prachakorn canal. The bedrooms were on the ground floor and most of them lying on

the bed because of to protect animals such as insects, snake. The door of their house are always close because of noisy from the traffic. Most elderly used manual flush toilet. Drinking water was of the water pass from the strainer.

These results were in line with the health status of the elderly in Bangkok, reserch of institute of geriatric medicine.

5.2 Health status

The study found that most of the elderly have health problem diagnosed by physician for 78 %. The most founded of health problem of the elderly was hypertension for 74.1 %, diabetes and dyslipidemia for 40 % and 34.4 % respectively.

The research was in line with data from (Health center 60, 2012). The top five disease in Donmuang district were hypertension, diabetes mellitus, cardio vascular disease, dyslipidemia and allergy respectively.

The research was in line with (National statistic office, 2003). Three - fourths of the elderly have chronic health problems such as cardiovascular disease, hypertensive disorder, diabetes mellitus and consistent with The 4th National Health Eamination Survey, 2009) the burden of disease in the elderly is high blood pressure, diabetes, high blood cholesterol level, strokes, ischemic heart disease, chronic obstructive pulmonary disease. Cancer invarious organs and renal disease.

Non-communicable diseases such as heart disease, cancer, diabetes and lung disease are no longer only a problem for wealthy countries and NCDs on people ages 60 and older in low - and middle – income countries is much greater than for people in high – income countries(Population Reference Bereau, 2012).

The study was found that perception of health status of the elderly was good 52.9 %, perception was fair at 28.2 % and perception was not good at 18.8 %. Because most of the participant over the elderly at age 60 – 60 years. The data were mostly collected from the early stage of the elderly groups and all of elderly can have activity daily living by themself. Perception of the health status was high.

It was consistency with (Ammaritagul, 2004), he also found that most of elderly in age group of 60 – 69 years, perceived themselves in good healthy.

It wsa different from the study of (Nimnoy, 1999) he found that the perception of the elderly was fair 63.3%, while 23.3% gave themselves a " not good" and only 13.3% gave themselves "good".

It also was different from the study " the exploration and study health status of the elderly 4 the sectors of Thailand" (Institute of Geriatric Medicine, 2006), elderly assess themselves as having " fair " or " good" was 41.8% and 30.5%, very good was 36.6% , not good was 21.7% and not good at all was 2.5%

An annual physical examination in last six months, the results of the study found that 76 % of the elderly have an annual examination.

The study consistency with (Ministry of public health, 2009) they found that 74.1 % of the elderly had annual physical check up. They are always do the follow up checking with physician and can get physical examination when they go to the health center and at least they was checked for vital sign and blood sugar level.

The study was inconsistency with (Tuanwong, 1997), they found that elderly who lives in bangkok more than 49.3 % never have an annual physical examination. The results from elderly in this study found their had several chronic disease. This study also found that 15.7 % of the elderly were admited in the hospital in last six months. 10.5 % admitted less than 4 days and the caused of admitted was infections at 6.3 %, hypertension at 4.5 % and asthma at 3.6 %.

The study consistent with (Institute of Geriatric Medicine, 2006) found that elderly 20 % of the elderly ever admit in the hospital in last six months.

From this study half of elderly have problems with vision problem and 19.5 % have hearing problem. These figures were nearly the same as the data from the Institute of Geriatric Medicine, 2006. As for these problems, they were related with degeneration of the physical health which occurs when the people getting older and also lack of good care for their health.

Concerning with the problem of urination of the elderly. Most of elderly have no urination problems and 10.1 % have urination at night. The elderly who had diabetes mellitus, they have to faced with urinate more often at night. Moreovere,38 % of respondents have problem with defection and 35.5% of them faced with

constipation. Due to the movement of abdomen and intestines becoming less effeicient, the constipation could easily occur. The finding was in line with the study " Health status and factors related to health status of the elderly in Payayom district, Putthalung province.

Focusing on the activity daily living of the eldery. Most of the eldery have a meal without anyone help at 96.9 % . They could take off clothes by themselves at 95.5 %. From the study shows 88.9 % of the elderly can walk without anyone help. 94.4 % can spend money without anyone help and 91.6 % can do it all activity daily living byself. The results of the study consistent with (Institute of Geriatric Medicine, 2006).

5.3 Utilization of health services

Most of the elderly were underd universal coverage when they go to the health center 71.4%, 15.3% were undered civil servant benefit scheme. Only 5.9% under social security and others scheme 7.3%. Some elderly have no identification card then there were no any scheme. In this study showed no elderly who was under private health insurance. When focus on age and health insurance, in age 60 – 69 years, most of them were under universal coverage and social security scheme. At age 70 – 79 year and age more than 80 years, most of them were under universal coverage and under civil servant medical benefit scheme. The study was in line with Thailand health situation (Akajumpa and wattanamano, 2010)

The benefit obtatined by the elderly who were under universal coverage was that they could visit the government hospitals under free of charge.

The results showed that 66 % of the elderly had follow up their health with physician. 47.4 % of elderly took time between 15 – 30 minutes for waiting at health center. Transportation was personal car and motorcycle. Cost of tranportation and cost of charge did not expensive for the elderly. Regarding to closing and opening time of the health center, it was convenient for the elderly at 95.5% perceptions health center often crowed 44.6 %. Hospitality of health care provider, time to talk with physician about problem, privacy of the treatment room and number of facility enough was high at more than 98 %. For overall satisfaction of health center was satisfied. Scragg &

Maitra, 2005 stated that the most asian people were very satisfied with their primary care doctor at their last visit.

The study was in line with Ammarittagul in 2004, this study found that the most popular medical welfare which the elder utilized were gold card 73.6 %. The accessibility to the services was in the form of hires vehicles and take time less than 30 minutes. Satisfaction was up to satisfied up to 96.9%

5.4 Health seeking behaviours

From this study major illness of the elderly were hypertension, vascular, heart disease and diabetes, health seeking behavior those elderly perceived were visiting the public health agencies follow by visiting private health agencies. More than two thirds of the elderly in this study have underlying and most of them were under universal coverage. The elderly satisfied with overall services of health facility, accessibility was convenience and health center was not so far from their home. They can go to health center alone by using motorcycle service. Even though the elderly in this study have low income but health services are free of charge. They can get services easily. Regard to the minor illness in this study, there were headache, muscle pain, and fever. Elderly choose self medication, do nothing and visit health agencies for minor illness.

The results of this research was in line with (Tuanwong, 1997) when elderly get major illness, they chose to meet health providers at the health center and when elderly get minor illness, first choice for management the symptoms was using self medication rather than met health providers. Choice of health seeking behaviours depend on severity of the illness.

As for acute illness of elderly in Kenya. The elderly started with self medication. 62% from study were buying over the counter drugs when they felt a need while seeing traditional healers accounted for 2% (Waweru, 2003).

The study " Health problems and treatment seeking behaviours among elderly in India found that majority of them were taking allopathic treatment, 4.9% were used both allopathic and ayuravedic treatment. The most common reason for non – compliance was the perception of patient needlessness of medicine, followed by non availability of medicine and high cost of treatment (Shalika et al, 2012).

Relationships between age groups of elderly and health status

The study in the relationship between age groups of elderly and health status in term of the statistically, the result showed statistically significant at P value 0.05. The elderly with age groups between 60 – 69 years had better health status than the elderly with age groups between 70 -79 years and over 80 years respectively. The study was in line with the study (Ammarittagul, 2004) when people reach 30 years of age, their physical functions become less efficient at slow gradual speed. The degeneration of the organs in each system was at different stage at different age. The overall health status of the elderly become worse and worse gradually.

Relationships between education and ability in reading/ writing with health status

This study found that education and ability in reading/ writing related with health status in term of the statistically significant at P value 0.005. The elderly with high education would have better health than the ones with low education. This was due to the knowledge, attitude and better taking care of themselves (Ammarittagul, 2004). The elderly with low education were less patient to seek knowledge or to take care of themselves to prevent themselves from disease and promote their health.

Relationships between occupations with health status

The study found that occupations were not related with health status in term of the statistically significant with P value 0.005 which was different from the study of Treamvisit and Augpiroj in 1997. The elderly with jobs would have better income than elderly without jobs. Jobs in agriculture required the elderly to use more strength and that made them stronger than the elderly in other occupations.

Relationships between care assistants and health status

The study found that care assisstants and relationship of family related with health status in term of the statistically with P value 0.005, The study was in line with the study of (Ammaritagul, 2004) meaning that the social support were posiltively related to the health behaviours and helath status.

Relationships between present of health problems and health status

The study found that health problems related to the health status in term of the statistically significant with P value 0.05. The study was in line with the study of (Sirirasamee and Liewprapai, 1998) and Ammaritagul, 2004.

Relationships between personal profile and health seeking behaviours

There is no statistically significant with P value 0.005 between personal profile and health seeking behaviours. The results from this study did not consistency with (Wongraya, 2004) he found that social support, received from their family memebers was the important factors in health seeking behaviours among the elderly population.

Relationships between utilization of health services and health seeking behaviours

This study found that overall of satisfaction related with health seeking behaveiours in term of the statistically significant with P value 0.05. The study was not consistency with the study of Nadee, he founded that factors influence health seeking behaviours include health care system, health team members and client factors (Nadee, 1998).

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study was conducted in Donmuang slum community, Bangkok, Thailand. A total of 287 elderly who lives in Donmuang slum community more than 1 year participated in the study. Data was collected by using questionnaire during March - April 2013.

The main objective of the study was to find out health status and health seeking behaviours among the elderly in the Donmuang slum community, Bangkok, Thailand. The specific objectives were determine the health status of the elderly and health seeking behaviours for perceived minor and major illness. To determine personal profile of the elderly under different scheme. To determine the relationship between (1) personal profile (2) utillzation of health services with both health status and health seeking behaviours of the elderly.

SPSS software was used for data analysis. Chi-square test was used to identify relationship between independent variables with both health status and health seeking behaviours.

Age of the respondents ranged from 60 to 99 years but the majority were 60 to 69 years. Around two thirds were females. Most of them were Buddhist. Around half of them were married. The majority of elderly attained primary school. 43.6 % can read and write a little. 64.1 % of the respondents have income and expenditure less than 2,500 bahts. More than two thirds of the respondents were not working. 71.4 % of the elderly used universal coverage scheme when go to the health center. As regard to the life style, 12.2 % and 15 % of the elderly had smoking and drinking habits within 3 months before the survey.

All of the respondents stayed in their own home. The elderly had 1 -5 people staying together in their home. Location of the bed room was at the first floor. Place to sleep was lying on the bed. Two thirds of the respondents use flush toilet and a source of drinking water was water pass with strainer.

Regarding to the health status, 78 % of the elderly have health problem diagnosed by physician and it was found that 52.9 % of the elderly have good perception of health status. 76% have an annual physical examination. 15.7% of the elderly ever admitted in hospital in last 6 months. Most problem were relating to urinations 19.2%, defections for 38%, sight problems for 53.3% and hearing problems 19.5%.

For health seeking behaviours, it was found that major illness were hypertension, heart and vascular disease and diabetes. First choice to health seeking behavior for major illness were visit public health agencies 69%, visit private health agencies 4.9%. Minor illness of the elderly were headache 23.3 %, muscle pain 8.7 % and fever for 4.5%. Health seeking behaviours for minor illness were self medication 22%, visit public health agencies 7.0% and do nothing 6.6%.

As for utilization of health services, time for travelling to health center took

15 – 30 minutes. They went by personal care and motorcycle. Cost of transportation and cost of charge did not expensive for them. The elderly were satisfied for the overall services of health center.

For the study of relationships, it was found that personal factor relating to the relationship with health status of the elderly in Donmuang slum community in term of the statistically significant value at 0.05 were ability in reading and writing, education status, health problems, family care taker and relationship with in family.

Regarding to personal profile relating to health seeking behaviours, visit health agencies, there are not statistically significant value at 0.05.

6.2 Recommendations

6.2.1 Health problems

The major health problem of the elderly in the Donmuang slum community were non-communicable diseases related to the elderly and poor health promoting behaviours, high number of non-communicable diseases such as hypension, diabetes mellitus, cardioandvascular diseases. From the researcher experiences when working at the hospital, Most of the elderly people were suffered from non - communicable disease rather than communicable disease. Non – communicable disease are a result of genetic and lack of knowledge in healthy life style, nutrition, and lack of exercise. Awareness to take care their health are low. Moreover elderly in slum community have a chance to face with poor quality of environment. Then a well establishment of health education since young of people should be done. Young people should learn health education and practice and adults people should to know how to be quality elderly. This way will prevent the health problems that may occur in the future. However, the solutions for the problems should be :

6.2.1.1 Promotion of health education in the community by encouraging concerns for good health, In this study, elderly have risk behavior in smoking and alcohol drinking. All sectors should promote awareness of good health care such as exercise, consuming foods that are healthy. Moreover reduce or stop drinking alcohol and smoking of the elderly. Drinking alcohol and smoking affect the health of elderly, both directly and indirectly. The effects can occur with the organs such as gastrointestinal tract, liver, brain, heart and blood vessels. Alcohol consumption and smoking are the pathogenesis of chronic diseases. Therefore, there is a need to established a group or support experts to assist in stop of smoking and alcohol drinking.

6.2.1.2 Increase collaborating with multi-organizations in community to prevention of health problems of the elderly such as local administration, private sector and sustained benefit project for the elderly are urgently recommended.

6.2.2 Self medication and training the drug stores

6.2.2.1 Control self medication of the elderly

The promotion of health education such as how to take or use the medicine effect and possible side – effects of the medical possible interaction, duration of use and properly seek for the professional advice relating to the most disease that elderly use medicine byself e.g. headache and pain.

6.2.2.2 The drug stores can be used as focal places to distribute the information, education and communication materials. These are the places that elderly start to use medicines. Monitering the drug stores to sell quality medicine to the consumers.

6.2.3 Problem of low health check-up or physical examination

Many chronic diseases are associated with disability and quality of life of the elderly, Eventhough the percentages annual health check up for elderly was quite high in this study (76 percent), but it will be better if we can increase the percentage of health check-up activity. Diagnose the disease in early stage it can help reduce severity of disease and disability. Reduce complex treatment and expensive cost. The solutions for the problems should be :

6.2.3.1 Promotion of the health education and encouraging the concerns of check up and follow up on time. As indicated in the Health Develpoment Policy, it is important for people of all ages to have a health check-up at least once a year. Health staff should provide health education to the people in this issue especially the group of people who do not have underlying diseases.

6.2.3.2 Increase roles of relatives and caregiver. Well being of the elderly related to the attention of relatives and caregiver. The relatives and caregivers for the plays an important role especially elderly who do activity daily living by someone help.

6.2.4 Health care units

The government should reconseder health care policies in terms of universal coverage scheme special for the elderly, every treatment should be free of charge. There are still some problems in many areas such as people do not understand the universal coverage scheme and they do not know how to access to the health services. It is important to improve the policies in some part of services. There are some factors that influence the quality of the services including the issues below:

6.2.4.1 Personal training of the health staffs

Health care providers should increase their expertise in term of the elderly health care services because the elderly are the age of change and special care for them need to be concerned.

6.2.4.2 Waiting time

The elderly responded that they spend time at the health center around 15 minutes to more than 30 minutes. Most of them had a problems with sitting for a long time. Then a special line for the elderly should be provided at all health center.

6.2.4.3 Health center crowed

A special elderly space or comfortable space for elderly should be provided. This study found that the elderly considered that health center was too crowed at the time they visited. Most of them feel not comfortable when stay in the health center, Therefore.

6.2.5 Problems of low income

The study shows low economic status of the elderly in the Donmuang slum community. Elderly have main income from allowance for the elderly from the government.

6.2.5.1 Promotion revenue activity in the community

The study found that revenue promotion activity was low persented. Job creation for older people should be increased or created specifically for elderly group to make them more income and also encouraging the elderly to do part time job which was appropriate for their needs and their potential.

6.2.5.2 Fair in allowance elderly systems. The study found that one part of income elderly's come from elderly allowance. Elderly should to get fair elderly allowance and adults who are stepping into elderly and poor should to know how to proceed in order to get the right help.

Recommendation for further study

1. Conducted study on health seeking behaviours of the elderly in specific disease.
2. Qualitative study should be conducted to explain the reasons for the elderly seeking behaviours.

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Appendices

APPENDIX A

แบบสัมภาษณ์

เรื่อง " การศึกษาสุขภาวะและพฤติกรรมการแสวงหาการรักษาในผู้สูงอายุที่อาศัยอยู่ในชุมชนแออัดเขตดอนเมือง กรุงเทพมหานคร ประเทศไทย "

แบบสัมภาษณ์เลขที่..... **ผู้สัมภาษณ์.....**

วันที่...../...../.....

คำชี้แจง **โปรดทำเครื่องหมาย / ลงในหรือ เติมข้อความลงในช่องว่างตามความเป็นจริง**

ส่วนที่ 1 **แบบสัมภาษณ์ข้อมูลประชากร สังคม เศรษฐกิจจำนวน 30 ข้อ**

1.1 เพศ 1. ( ) ชาย 2. ( ) หญิง

1.2 อายุ.....ปี (จำนวนปีเต็ม)

1.3 ศาสนา 1. ( ) พุทธ 2. ( ) คริสต์
3. ( ) อิสลาม 4. ( ) อื่น ๆ โปรดระบุ.....

1.4 สถานภาพสมรส 1. ( ) โสด 2. ( ) สมรส 3. ( ) แยกกันอยู่
4. ( ) หม่าย 5. ( ) หย่า
6. ( ) อื่น ๆ โปรดระบุ.....

1.5 วุฒิการศึกษาสูงสุด
1. ( ) ไม่เคยศึกษา 2. ( ) ประถมศึกษา
3. ( ) มัธยมศึกษา 4. ( ) อาชีวศึกษา
5. ( ) อุดมศึกษาหรือเทียบเท่า 6. ( ) อื่น ๆ โปรดระบุ.....

1.6 ความสามารถในการอ่าน – เขียนภาษาไทย
1. ( ) อ่านออก – เขียนได้ 2. ( ) พออ่านออก – เขียนได้บ้าง
3. ( ) อ่านออก – เขียนไม่ได้ 4. ( ) อ่านไม่ออก – เขียนไม่ได้

1.7 อาชีพปัจจุบันของท่าน

1. ( ) เกษตรกร/ ประมง
2. ( ) ผู้ใช้แรงงาน/ รับจ้าง
3. ( ) ธุรกิจส่วนตัว
4. ( ) ลูกจ้างเอกชน
5. ( ) ภาครัฐ/ รัฐวิสาหกิจ
6. ( ) ไม่ได้ทำงาน
6. ( ) อื่น ๆ โปรดระบุ.....

1.8 รายได้เฉลี่ยต่อเดือนของท่าน

.....(บาท)

1.9 รายจ่ายเฉลี่ยต่อเดือนของท่าน

.....(บาท)

1.10 สิทธิการรักษาของท่านเป็นอย่างไร

1. ( ) ประกันสุขภาพถ้วนหน้า
2. ( ) สิทธิประกันสังคม
3. ( ) บัตรข้าราชการ/ บัตรจ่ายตรง
4. ( ) อื่น ๆ โปรดระบุ.....

1.11 ท่านอาศัยอยู่กับใคร (ตอบได้มากกว่าหนึ่งข้อ)

1. ( ) ลำพังคนเดียว
2. ( ) คู่สมรส
3. ( ) หลาน
4. ( ) ลูกสาว
5. ( ) ลูกชาย
6. ( ) ญาติ
7. ( ) อื่น ๆ โปรดระบุ.....

1.12 ความสัมพันธ์ในครอบครัวของท่านเป็นอย่างไร

1. ( ) รักใคร่กันดี
2. ( ) ต่างคนต่างอยู่
3. ( ) มีความขัดแย้งกันในครอบครัว

1.13 ท่านทำงานกี่ชั่วโมงต่อวัน (ตอบได้มากกว่าหนึ่งข้อ)

( ) ทำงานบ้าน.....ชั่วโมง

( ) ทำงานที่ทำงาน.....ชั่วโมง

1.14 ท่านทำงานกี่วันต่อสัปดาห์ (ตอบได้มากกว่าหนึ่งข้อ)

( ) ทำงานบ้าน.....วัน

( ) ทำงานที่ทำงาน.....วัน

1.15 สภาพบ้านที่พักอาศัยของท่านเป็นอย่างไร

1. ( ) บ้านพักของตัวเอง
2. ( ) บ้านเช่า
3. ( ) อื่น ๆ โปรดระบุ.....

1.16 ผู้ที่พักอาศัยบ้านเดียวกับท่านมีกี่คน.....(คน)

1.17 ตำแหน่งของห้องนอน

1. ( ) ชั้นหนึ่งของบ้าน 2. ( ) ชั้นสองของบ้าน

1.18 ลักษณะเตียงนอน

1. ( ) นอนบนเตียง 2. ( ) นอนบนพื้น

1.19 ลักษณะส้วม

1. ( ) ส้วมนั่งชักโครก/ ราดน้ำ 2. ( ) ส้วมซึมราดน้ำ (นั่งยองๆ)
3. ( ) ส้วมหลุม 4. ( ) อื่น ๆ โปรดระบุ.....

1.30 แหล่งน้ำที่ใช้ดื่ม

1. ( ) น้ำประปา 2. ( ) น้ำบาดาล/น้ำบ่อ
3. ( ) น้ำฝน 4. ( ) อื่น ๆ โปรดระบุ.....

ส่วนที่ 2 สุขภาวะ จำนวน 23 ข้อ

2.1 ปัจจุบันท่านมีปัญหาสุขภาพที่วินิจฉัยโดยแพทย์หรือไม่

1. ( ) ไม่มี
2. ( ) มี, โปรดระบุ (ตอบได้มากกว่าหนึ่งข้อ)

โรคหัวใจและหลอดเลือด

( ) รักษาหายขาดแล้ว ( ) กำลังรักษา ( ) ไม่ได้รักษา

โรคไขมันในเลือดสูง

( ) สามารถควบคุมได้ ( ) ไม่สามารถควบคุมได้ ( ) ไม่ได้รักษา

โรคความดันโลหิตสูง

( ) สามารถควบคุมได้ ( ) ไม่สามารถควบคุมได้ ( ) ไม่ได้รักษา

โรคเบาหวาน

( ) สามารถควบคุมได้ ( ) ไม่สามารถควบคุมได้ ( ) ไม่ได้รักษา

กลุ่มโรคกระดูกและข้อ

( ) รักษาหายขาดแล้ว ( ) กำลังรักษา ( ) ไม่ได้รักษา

อื่น ๆ โปรดระบุ ……..

( ) รักษาหายขาดแล้ว ( ) กำลังรักษา ( ) ไม่ได้รักษา

2.2 เมื่อท่านมีนัดติดตามการรักษากับแพทย์ ท่านไปตามนัดหรือไม่

1. ( ) ไปตามนัดเป็นประจำ
2. ( ) ไปตามนัดเป็นบางครั้ง
3. ( ) ไม่ไปตามนัด
4. ( ) ไม่มีนัดติดตามการรักษา

2.3 ใน 3 เดือนที่ผ่านมา ท่านเจ็บป่วยบ่อยแค่ไหน

1. ( ) ไม่เคยเจ็บป่วย
2. ( ) น้อยกว่า 5 ครั้ง
3. ( ) 5 ครั้งหรือมากกว่า

2.4 ท่านสูบบุหรี่หรือไม่

1. ( ) ไม่เคยสูบเลย
2. ( ) เคยสูบแต่ปัจจุบันเลิกแล้ว เลิกมา.....ปี
3. ( ) ปัจจุบันสูบ (กรณีสูบบุหรี่ตอบคำถามดังต่อไปนี้)
   - ความถี่ในการสูบบุหรี่.....ครั้ง/ วัน
   - จำนวนบุหรี่ที่สูบบุหรี่.....มวน/ วัน

2.5 ท่านดื่มสุราหรือไม่

1. ( ) ไม่เคยดื่มเลย
2. ( ) เคยดื่ม แต่ปัจจุบันเลิกแล้ว เลิกมา.....ปี
3. ( ) ปัจจุบันดื่มสุรา (กรณีดื่มสุราตอบคำถามดังต่อไปนี้)
   - ความถี่ในการดื่มสุรา

   ( ) น้อยกว่า 1 ครั้งต่อเดือน ( ) 2 - 3 ครั้งต่อเดือน

   ( ) 1 - 5 วันต่อสัปดาห์ ( ) 6 - 7 วันต่อสัปดาห์

   - จำนวนสุราที่ดื่ม (250 ml ต่อแก้ว)……..(แก้ว)

2.6 ขณะนี้ท่านรู้สึกว่ามีภาวะสุขภาพเป็นอย่างไร

1. ( ) ดีมาก 2. ( ) ดี
3. ( ) พอใช้ 4. ( ) ไม่ดี
5. ( ) ไม่ดีมาก

2.7 ท่านได้รับการตรวจร่างกายประจำปีโดยบุคลากรทางการแพทย์และสาธารณสุขหรือไม่

1. ( ) ไม่ได้รับการตรวจ
2. ( ) ได้รับการตรวจโปรดระบุ (ตอบได้มากกว่าหนึ่งข้อ)

( ) ด้านช่องปาก ( ) ด้านการเห็น
( ) ด้านการได้ยิน ( ) ด้านระบบหัวใจและหลอดเลือด
( ) ด้านระบบทางเดินหายใจ ( ) ความดันโลหิต
( ) เบาหวาน ( ) ไขมันในเลือด

2.8 ใน 6 เดือนที่ผ่านมาท่านเคยเจ็บป่วยจนต้องอยู่โรงพยาบาลหรือเข้าโรงพยาบาลหรือไม่

1. ( ) ไม่เคย
2. ( ) เคย

ถ้าเคยระบุจำนวน (กี่วัน).....วัน

ท่านเจ็บป่วยเป็นอะไร ระบุอาการ หรือโรค.....

2.9 ท่านมีปัญหาด้านการมองเห็นหรือไม่

1. ( ) ไม่มี
2. ( ) มี โปรดระบุ

( ) มองไม่เห็น ( ) มองเห็นไม่ชัด
( ) มองเห็นภาพซ้อน ( ) อื่น ๆ โปรดระบุ.....

2.10 ท่านมีปัญหาการได้ยินหรือไม่

1. ( ) ไม่มี
2. ( ) มี โปรดระบุ……..

2.11 ในรอบ 6 เดือน ที่ผ่านมาท่านเคยหกล้มหรือไม่

1. ( ) ไม่เคย
2. ( ) เคย ถ้าเคยระบุจำนวนครั้ง.....

ถ้าเคยระบุบริเวณที่หกล้มครั้งสุดท้าย

ในบ้าน ( ) ห้องนอน ( ) ห้องน้ำ
( ) ห้องรับแขก ( ) ห้องครัว
( ) อื่นๆ โปรดระบุ.....

นอกบ้าน ( ) รอบบ้าน ( ) ถนน

( ) ตลาด ( ) วัด

( ) อื่นๆ โปรดระบุ.....

2.12 ในรอบ 1 เดือนที่ผ่านมาท่านมีปัญหาในการปัสสาวะหรือไม่ (ตอบได้มากกว่าหนึ่งข้อ)

1. ( ) ไม่มี
2. ( ) มี ระบุ
   - ( ) ปัสสาวะกลางดึก (ขณะนอน)
   - ( ) รู้สึกเจ็บเวลาปัสสาวะ
   - ( ) ปัสสาวะกระปิดกระปอย
   - ( ) กลั้นปัสสาวะไม่อยู่
   - ( ) ปัสสาวะมีความแรงลดลง/ ไม่พุ่ง
   - ( ) เวลาเริ่มปัสสาวะและหยุดปัสสาวะจะลำบาก

2.13 ท่านมีปัญหาในการขับถ่ายอุจจาระหรือไม่

1. ( ) ไม่มี
2. ( ) มี ระบุ
   - ( ) ท้องผูก
   - ( ) ท้องเสีย
   - ( ) ระบบขับถ่ายอุจจาระเปลี่ยนไปจากเดิม เช่น เคยท้องผูกแล้วมาท้องเสีย
   - ( ) อื่น ๆ ระบุ.....

2.14 ท่านรับประทานอาหารได้เองหรือไม่

1. ( ) ทำได้โดยไม่ต้องมีคนช่วย (สามารถรับประทานอาหารได้เองโดยตลอด)
2. ( ) ทำได้โดยมีคนช่วย (เช่น ช่วยตักอาหารให้)
3. ( ) ไม่สามารถรับประทานอาหารได้เอง

2.15 ท่านสวม/ถอดเสื้อผ้าได้เองหรือไม่

1. ( ) ทำได้โดยไม่ต้องมีคนช่วย
2. ( ) ทำได้แต่ต้องมีคนช่วยบ้าง
3. ( ) แตงตัวเอง/ ถอดเสื้อผ้าเองไม่ได้เลย

2.16 ท่านเดินได้หรือไม่

1. ( ) ทำได้โดยไม่ต้องมีคนหรือสิ่งใดช่วย (ยกเว้นไม้เท้า)
2. ( ) ทำได้โดยต้องมีคนช่วยพยุง หรือใช้เครื่องช่วยพยุง, รถเข็น ฯลฯ
3. ( ) ไม่สามารถเดินได้เลย

2.17 ท่านจัดการเรื่องเงินหรือใช้จ่ายเงินได้หรือไม่

1. ( ) ทำได้โดยไม่ต้องมีคนช่วย (จ่ายเงินสดด้วยตนเอง)
2. ( ) ทำได้โดยต้องมีคนช่วย (สามารถจัดการเรื่องซื้อวันต่อวันได้แต่ต้องมีคนช่วยจัดการเรื่องการชำระเงินให้ท่าน)
3. ( ) ไม่สามารถจัดการเรื่องเงินทองได้เลย

2.18 ท่านสามารถทำกิจวัตรประจำวันได้ด้วยตนเองหรือไม่

1. ( ) ทำด้วยตนเองได้ทั้งหมด
2. ( ) ต้องมีคนช่วยบางส่วน
3. ( ) ทำด้วยตนเองได้แต่ต้องใช้อุปกรณ์ช่วย
4. ( ) ทำเองไม่ได้เลย/ ต้องมีผู้อื่นทำให้ทั้งหมด

2.19 ท่านรับประทานอาหารหลัก (อาหารหลัก 5 หมู่) วันละกี่มื้อ

1. ( ) 1 มื้อ
2. ( ) 2 มื้อ
3. ( ) 3 มื้อ
4. ( ) อื่น ๆ โปรดระบุ.....

2.20 ท่านมีความสุขในชีวิตหรือไม่

1. ( ) ไม่มี
2. ( ) มี

2.21 ท่านออกกำลังกาย/กิจกรรมทางกายอย่างน้อยสัปดาห์ละ 3 วัน และวันละ 30 นาทีหรือไม่

1. ( ) ไม่ออกกำลังกาย
2. ( ) ออกกำลังกาย/กิจกรรมทางกาย ระบุ

( ) วิ่ง ( ) ไทเก็ก

( ) เดิน ( ) บริหารร่างกาย

( ) อื่น ๆ โปรดระบุ.....

2.22 ในรอบปีที่ผ่านมาท่านมีส่วนร่วมในกิจกรรมทางสังคมหรือไม่

1. ( ) ไม่มี
2. ( ) มี (ตอบได้มากกว่าหนึ่งข้อ)

( ) กิจกรรมส่งเสริมสุขภาพ เช่น ออกกำลังกาย ตรวจร่างกายประจำปี

( ) กิจกรรมทางศาสนา

( ) กิจกรรมส่งเสริมรายได้

( ) กิจกรรมบำเพ็ญสาธารณประโยชน์เช่น เป็นอาสาสมัคร

( ) กิจกรรมนันทนาการ

( ) กิจกรรมทัศนศึกษา

( ) เป็นการสมาชิกชมรมหรือองค์กร เช่น ชมรมผู้สูงอายุ

( ) การเยี่ยมเยียนหรือให้ความช่วยเหลือสมาชิกเจ็บป่วย/ญาติมิตร

( ) อื่นๆ โปรดระบุ.....

2.23 เมื่อเจ็บป่วยท่านมีผู้ดูแลหรือไม่

1. ( ) ไม่มี
2. ( ) มี ระบุ

( ) คู่สมรส ( ) บุตรชาย

( ) บุตรสาว ( ) บุตรเขย

( ) บุตรสะใภ้ ( ) ลูกจ้าง

( ) เพื่อนบ้าน/คนรู้จัก/เพื่อน

( ) อื่นๆ โปรดระบุ.....

ส่วนที่ 3 การรับบริการทางด้านสุขภาพจำนวน 15 ข้อ

3.1 ท่านได้รับข้อมูลข่าวสารทางด้านสุขภาพในท้องถิ่นจากแหล่งใดบ้าง (ตอบได้มากกว่าหนึ่งข้อ)

1. ( ) ผู้นำชุมชน 2. ( ) อาสาสมัครสาธารณสุข
3. ( ) แผ่นพับ/ ใบปลิว 4. ( ) โปสเตอร์
5. ( ) วิทยุกระจายเสียง 6. ( ) เมื่อไปสถานบริการสุขภาพ
7. ( ) อื่น ๆ โปรดระบุ.....

3.2 ท่านใช้เวลานานเท่าใดในการเดินทางจากบ้านไปรับบริการที่ศูนย์บริการสุขภาพที่ท่านใช้เป็นประจำ

1. ( ) น้อยกว่า 15 นาที
2. ( ) 15 – 30 นาที
3. ( ) มากกว่า 30 นาที

3.3 ท่านเดินทางไปศูนย์บริการสุขภาพที่ท่านใช้เป็นประจำอย่างไร

1. ( ) การเดิน
2. ( ) รถประจำทาง
3. ( ) รถแท็กซี่
4. ( ) รถจักยานยนต์ / รถยนต์ส่วนตัว

3.4 ท่านไปศูนย์บริการสุขภาพกับใคร

1. ( ) ไปคนเดียว 2. ( ) สามี หรือ ภรรยา
3. ( ) หลาน 4. ( ) ลูกสาว
5. ( ) ลูกชาย 6. ( ) ญาติคนอื่นๆ
7. ( ) อื่นๆโปรดระบุ.....

3.5 ท่านใช้เวลานานเท่าใดในการรอพบแพทย์หรือเจ้าหน้าที่ที่ให้บริการทางด้านสุขภาพที่ศูนย์บริการสุขภาพ

1. ( ) น้อยกว่า 15 นาที
2. ( ) 15 – 30 นาที
3. ( ) มากกว่า 30 นาที

3.6 ท่านรู้สึกว่าค่าใช้จ่ายในการเดินทางไปรับบริการทางด้านสุขภาพแพงเกินไป

1. ( ) ไม่ใช่ 2. ( ) ใช่

3.7 ท่านรู้สึกว่าค่าใช้จ่ายเกี่ยวกับการรับบริการทางด้านสุขภาพแพงเกินไป

1. ( ) ไม่ใช่ 2. ( ) ใช่

3.8 ท่านคิดว่าเวลาการเปิดให้บริการทางด้านสุขภาพของศูนย์สุขภาพทำให้ท่านสะดวกสบายในการมารับบริการ

1. ( ) ไม่ใช่ 2. ( ) ใช่

3.9 ท่านคิดว่าเวลาการปิดให้บริการทางด้านสุขภาพของศูนย์บริการสุขภาพเหมาะสมสำหรับท่านในการมารับบริการ

1. ( ) ไม่ใช่ 2. ( ) ใช่

3.10 ท่านรู้สึกว่าที่ศูนย์บริการสุขภาพแออัดเมื่อท่านไปรับบริการทางด้านสุขภาพ

1. ( ) ทุกครั้งที่ไป 2. ( ) บ่อยๆ

3. ( ) เป็นบางครั้ง 4. ( ) ไม่แออัด

3.11 ท่านได้รับการต้อนรับเป็นอย่างดีจากเจ้าหน้าที่ในทีมสุขภาพ เมื่อท่านมารับบริการด้านสุขภาพ

1. ( ) ไม่ใช่ 2. ( ) ใช่

3.12 ท่านมีโอกาสได้พูดคุยเรื่องความเจ็บป่วยของท่านกับเจ้าหน้าที่ในทีมสุขภาพ เมื่อท่านมารับบริการด้านสุขภาพ

1. ( ) ไม่ใช่ 2. ( ) ใช่

3.13 ศูนย์บริการสุขภาพมีห้องตรวจหรือห้องที่ให้คำปรึกษาทางด้านสุขภาพที่เป็นส่วนตัวสำหรับผู้มารับบริการ

1. ( ) ไม่ใช่ 2. ( ) ใช่

3.14 โดยทั่วไป ท่านรู้สึกพึงพอใจเมื่อมารับบริการทางด้านสุขภาพที่ศูนย์บริการสุขภาพที่ท่านใช้ประจำ

1. ( ) พอใจมาก 2. ( ) พอใจ

3. ( ) ไม่พอใจ 4. ( ) ไม่พอใจมาก

3.15 ศูนย์บริการสุขภาพมีจำนวนเจ้าหน้าที่ที่ให้บริการทางด้านสุขภาพเพียงพอสำหรับผู้มารับบริการ

1. ( ) ไม่ใช่ 2. ( ) ใช่

ส่วนที่ 4 การแสวงหาการรักษาจำนวน 2 ข้อ

4.1 ท่านมีความเจ็บป่วยที่สำคัญ (วินิจฉัยโดยแพทย์) เช่นโรคเบาหวาน ภาวะความดันโลหิตสูงและโรคหัวใจและหลอดเลือด ฯลฯ)

1. ( ) ไม่มี
2. ( ) มี โปรดระบุ

โรคที่ 1 ( ) โรคหัวใจและหลอดเลือด
( ) โรคไขมันในเลือดสูง
( ) โรคความดันโลหิตสูง
( ) โรคเบาหวาน
( ) กลุ่มโรคกระดูกและข้อ
( ) อื่น ๆ โปรดระบุ ……..

ปกติท่านจัดการกับภาวะเมื่อท่านมีความเจ็บป่วยที่สำคัญอย่างไร?

1. ( ) เลือกยาทานด้วยตนเอง
2. ( ) ซื้อยา / ปรึกษาที่ร้านขายยา
3. ( ) รักษาที่หน่วยบริการของรัฐ
4. ( ) รักษาที่โรงพยาบาลเอกชน
5. ( ) รักษาวิธีแพทย์แผนโบราณ / การรักษาแบบดั้งเดิม
6. ( ) ไม่ทำอะไร
7. ( ) อื่น ๆ โปรดระบุ.....

โรคที่ 2 ( ) โรคหัวใจและหลอดเลือด
( ) โรคไขมันในเลือดสูง
( ) โรคความดันโลหิตสูง
( ) โรคเบาหวาน
( ) กลุ่มโรคกระดูกและข้อ
( ) อื่น ๆ โปรดระบุ ……..

ปกติท่านจัดการกับภาวะเมื่อท่านมีความเจ็บป่วยที่สำคัญอย่างไร?

1. ( ) เลือกยาทานด้วยตนเอง
2. ( ) ซื้อยา / ปรึกษาที่ร้านขายยา
3. ( ) รักษาที่หน่วยบริการของรัฐ
4. ( ) รักษาที่โรงพยาบาลเอกชน
5. ( ) รักษาวิธีแพทย์แผนโบราณ / การรักษาแบบดั้งเดิม
6. ( ) ไม่ทำอะไร
7. ( ) อื่น ๆ โปรดระบุ.....

4.2 ใน 2 สองสัปดาห์ที่ผ่านมาท่านมีอาการเจ็บป่วยเล็ก ๆ น้อย ๆ เช่น ปวดศีรษะ ท้องเสียและไข้ ฯลฯ)

1. ( ) ไม่มี
2. ( ) มี โปรดระบุอาการ

( ) ปวดศีรษะ ( ) ท้องเสีย

( ) มีไข้ ( ) คลื่นไส้/ อาเจียน

( ) อื่น ๆ โปรดระบุ.....

ปกติท่านจัดการกับอาการเจ็บป่วยเล็ก ๆ น้อย ๆ ที่เกิดขึ้นอย่างไร?

1. ( ) เลือกยาทานด้วยตนเอง
2. ( ) ซื้อยา / ปรึกษาที่ร้านขายยา
3. ( ) รักษาที่หน่วยบริการของรัฐ
4. ( ) รักษาที่โรงพยาบาลเอกชน
5. ( ) รักษาวิธีแพทย์แผนโบราณ / การรักษาแบบดั้งเดิม
6. ( ) ไม่ทำอะไร
7. ( ) อื่น ๆ โปรดระบุ.....

APPENDIX B

Health Status and Health seeking behaviours among the Elderly in Donmuang slum community , Bangkok, Thailand

Subject Code…….
Interviewer……. **Date……./…..…./…….**

Part 1 Socio-Demographic Information

<u>Explanation</u> : Please mark √ in the proper space ( ) or fill in the correct information as required :

1.1 Gender 1. ( ) Male 2. ( ) Female

1.2 Age.....Year (Complete years)

1.3 Religion 1. ( ) Buddhist 2. ( ) Chistian
3. ( ) Islam 4. ( ) Other (specify).....

1.4 Status 1. ( ) Single 2. ( ) Married 3. ( ) Seperated
4. ( ) Widowed 5. ( ) Divorce
6. ( ) Other (specify).....

1.5 Hightest eduction level completed :

1. ( ) No formal education 2. ( ) Primary school
3. ( ) Secondary school 4. ( ) Vocational school
5. ( ) Bachelor's Degree or higher

1.6 Reading and writing ability

1. ( ) Can read and write all 2. ( ) Can read and write a little

3. ( ) Can read but can not write 4. ( ) Cannot read or write

1.7 Present occupation (Employment) :

1. ( ) Agriculture/Aquaculture 2. ( ) Laborer

3. ( ) Self employed 4. ( ) Employee private company

5. ( ) Goverment or State Enterprise 6. ( ) Not working

7. ( ) Other (specify).....

1.8 Do you currently have an income?

1. ( ) No - Go on to 1.9 2. ( ) Yes - Please answer 1.8.1

1.8.1 If you currently receive an income, what is the resource of that income?

1. ( ) Chidren 2. ( ) Savings

3. ( ) Salary 4. ( ) Spouse

5. ( ) Pension 6. ( ) Other(specify).....

1.9 What is your average monthly household income?

…….(Bahts)

1.10 What is your average monthly household expenditure?

…….(Bahts)

1.11 What kind of insurance do you have?

1. ( ) Universal coverage 2. ( ) Social Security Scheme

3. ( ) Civil Servant Medical Benefit Scheme (CSMBS)

1.12 Do you have past illness which is diagnosed by physician ?

1. ( ) No
2. ( ) Yes, please

1.13 Do you have any present illness which is diagnosed by physician ?

1. ( ) No
2. ( ) Yes, please specify……

1.14 How often do you get illness in the last past three months?

1. ( ) Have not been sick
2. ( ) Less than five times
3. ( ) Five times and more
4. ( ) Always ill

1.15 Whom do you live with?

1. ( ) Alone
2. ( ) Spouse
3. ( ) Grandchildren
4. ( ) Daughter
5. ( ) Son
6. ( ) Cousin
7. ( ) Other relatives…….

1.16 How is your relationship with your family ?

1. ( ) Live happily together
2. ( ) Live together but not associate
3. ( ) Live together but have problems

1.17 Do you smoke?

1. ( ) Yes
2. ( ) No (if no, go to question 1.19)

1.18 How many cigarettes/cigars do you usually smoke per day(amount)?

……

1.19 Do you drink alcohol?

1. ( ) Yes
2. ( ) No (if no, go to question 1.21)

1.20 How many days do you drink a week (amount)?

……

1.21 How many hours do you work per day? ……Hours

1.22 How many days do you work per week? …….Days

1.23 Where do you live?

1. ( ) Own home
2. ( ) Rent home
3. ( ) Others (please specified)……..

1.24 How many people are staying in your house?

…….

1.25 Location of bedroom

1. ( ) First floor
2. ( ) Second floor

1.26 Place to sleep

1. ( ) Lying on the bed
2. ( ) Lying on the floor

1.27 Type of toilet

1. ( ) Flush toilet
2. ( ) Water pouring toilet
3. ( ) Pit toilet

1.28 A source of drinking water

1. ( ) Tap water
2. ( ) Underground water
3. ( ) Rain water
4. ( ) Others……

1.29 How satisfied are you with sound condition in your house environment?

1. ( ) Strongly satisfied
2. ( ) Satisfied
3. ( ) Dissastified
4. ( ) Strongly dissatified

1.30 How satisfied are you with lighting condition in your house environment?

1. ( ) Strongly satisfied
2. ( ) Satisfied
3. ( ) Dissastified
4. ( ) Strongly dissatisfied

1.31 How satisfied are you with ventilation/dust condition in your house environment?

1. ( ) Strongly satisfied
2. ( ) Satisfied
3. ( ) Dissastified
4. ( ) Strongly dissatisfied

1.32 How satisfied are you with smell condition in your house environment?

1. ( ) Strongly satisfied
2. ( ) Satisfied
3. ( ) Dissastified
4. ( ) Strongly dissatisfied

Part 2 Health status

2.1 How about are your health now?

1. ( ) Very good
2. ( ) Good
3 ( ) Fair
4. ( ) Bad
5. ( ) Very bad

2.2 Have you ever been checked an annual physical examination by a health care providers?

1. ( ) No
2. Yes, please specify (you can select more than one choice)

( ) Oral cavity ( ) Vision

( ) Hearing ( ) Cardiovascular system

( ) Respiratory system ( ) Blood pressure

( ) Diabetes ( ) Hypertension

2.3 In the past six month, Did you get sick until you have to admit in hospital?

1. ( ) Never
2. ( ) Yes, specify the number of day……

What are the symtoms of an illness or disease……

2.4 Do you have vision problem?

1. ( ) No
2. ( ) Yes, please answer

( ) Invisible ( ) Blur vision

( ) Diplopia ( ) Specify……

2.5 Do you have hearing problem?

1. ( ) No
2. ( ) Yes, please specify……..

2.6 How many meals do you have per day? (main courses)

1. ( ) 1 meal
2. ( ) 2 meals
3. ( ) 3 meals
4. ( ) Other, specify……..

2.7 In the past six months,Did you have ever fallen?

1. ( ) No
2. ( ) Yes, How many times……..

If yes, identify the area last falling

In door ( ) Home ( ) Bath room

( ) Living room ( ) Kitchen

Out doors ( ) Specify……

2.8 In the past one month, Did you have a problem with urinate?

1. ( ) No
2. ( ) Yes, specify

( ) Urination at night (while sleeping)

( ) Hurts when urinate

( ) Dysuria

( ) Urinary Incontinece

( ) Decrease urinary stream

( ) Slow and hard to urinate

2.9 Do you have a problem of defecation?

1. ( ) No
2. ( ) Yes, please specify

( ) Constipation

( ) Diarrheaa

( ) Change of defecation(Have a constipation and break into diarrhea)

( ) Others, specify……..

2.14 Can you have a meal by yourself?

1. ( ) Do without anyone help
2. ( ) Do by someone help
3. ( ) Can not have a meal by yourself

2.15 Can you wear/ take off clothes by yourself?

1. ( ) Do without anyone help
2. ( ) Do by someone help
3. ( ) Can not do by yourself

2.16 Can you walk?

1. ( ) Do without anyone or anything help(except gait equipment)
2. ( ) Do by someone help to walk or use gait equipment or wheelchair
3. ( ) Can not walk at all

2.17 Can you manage or spend the money?

1. ( ) Do without anyone help (Self –pay)
2. ( ) Do by someone help
3. ( ) Can not manage the money

2.18 Can you do the activity daily living by yourself?

1. ( ) Do it all by yourself
2. ( ) Do it by someone help
3. ( ) Do it by yourself but using equipments
4. ( ) Can not do anything/ need helping form someone

2.27 Do you have an exercise/physical activity at least three days per week and 30 minutes per day?

1. ( ) No
2. ( ) Yes, please identify your activity…….

( ) Running ( ) Tai-chi

( ) Walking ( ) Aerobic dance

( ) Exercise ( ) Play sports such as

Social and religion

2.28 The recent year, Have you ever participated in social activities?

1. ( ) No
2. ( ) Yes, pcisionlease identify

( ) Health promotion activities such as annual physical examination, exercise

( ) Religious activities

( ) Revenue promotion activity

( ) Public perform activities such as volunteer

( ) Recreational activities

( ) Field trip

( ) The club members or organization such as the elderly organization

( ) Visit or help cousins when get ill

( ) Others, specify……

2.31 Do you have a caregiver when you get sick?

1. ( ) Not have
2. ( ) Have,specify

( ) Spouse ( ) Son

( ) Daughter ( ) Son-in law

( ) Daughter in law ( ) Employees

( ) Neighbor/ acquaintance/ friend

( ) Other……..

2.32 Do you have to look after a sick member of your family?

1. ( ) No
2. ( ) Yes

( ) Dementia or Alzheimer's ( ) Cancer

( ) Heart disease ( ) Cerebrovascular disease

( ) Diabetes ( ) Depression

( ) Insomnia

( ) Other, specify……

Part 3 Local health system provision

3.1 Approximately how long do you travel from your home to the health center that you got the health service?

1. ( ) Less than 15 minutes
2. ( ) 15-30 minutes
3. ( ) More than 30 minutes

3.2 Which transportation do you use to go to the health care unit?

1. ( ) Walk
2. ( ) Bus
3. ( ) Hired vehicle (Taxi)
4. ( ) Personal car/ mortorcycle

3.3 Whom do you go to health center with?

1. ( ) Alone
2. ( ) Spouse
3. ( ) Grandchildren
4. ( ) Daughter
5. ( ) Son
6. ( ) Cousin
7. ( ) Other relatives…….

3.4 Is traveling costs for visiting the doctors expensive for you?

1. ( ) No
2. ( ) Yes

3.5 Is the consultative fee expensive for you?

1. ( ) No
2. ( ) Yes

3.6 Is opening time of the health center convenient for you?

1. ( ) Convenient
2. ( ) Inconvenient

3.7 Is closing time of the health center convenient for you?

1. ( ) Convenient
2. ( ) Inconvenient

3.8 Is the health center usually crowded?

1. ( ) Every time
2. ( ) Sometime
3. ( ) Often
4. ( ) Never

3.9 How long do you usually have to wait to meet the physicians at health center after you registerd?

1. ( ) Less than 15 minutes
2. ( ) 15-30 minutes
3. ( ) More than 30 minutes

3.10 When you meet the health personnel, are you welcomed?

1. ( ) No
2. ( ) Yes

3.11 Do you get a chance to talk about your disease? (with a health staff)

1. ( ) No
2. ( ) Yes

3.12 Is the consultating room at the health center provided the privacy room (that people outside can not see in) for patients to be examined?

1. ( ) No
2. ( ) Yes

3.13 In Generally, how satisfied are you with this health center?

1. ( ) Strongly Satisfied
2. ( ) Satisfied
3. ( ) Dissatified
4. ( ) Strongly dissatisfied

3.14 Is the health facilitator more enough for patients to service in the health center?

1. ( ) No
2. ( ) Yes

3.15 When would you visit the health center in case of you have abnormal symptoms of health?

1. ( ) When I realize I have health problem
2. ( ) When this health problem disturbs my daily activities
3. ( ) Only when my health conditions gets worse
4. ( ) Others (please specify)…….

Part 4 Health seeking behaviours

4.1 Did you have any major illness (Diagnosed by physician)? such as diabetes mellitus, hypertention, cardiovascular disease, etc).

1. ( ) No
2. ( ) Yes

If yes, please specify……

4.2 What did you usually manage when you have a major illness?

1. ( ) Self medication
2. ( ) Buy medication/ Consult at drug store
3. ( ) Visit public health agencies
4. ( ) Visit private health agencies
5. ( ) Traditional healer/ Traditional treatment
6. ( ) Do nothing

4.3 Did you have any minor illness in past two weeks? (you considered not serious) such as headache, diarrhea, fever, etc).

1. ( ) No
2. ( ) Yes

If yes, please specify……

4.4 What did you usually manage when you have a minor illness?

1. ( ) Self medication
2. ( ) Buy medication/ Consult at drug store
3. ( ) Visit public health agencies
4. ( ) Visit private health agencies
5. ( ) Traditional healer/ Traditional treatment
6. ( ) Do nothing

3.14 Budget

No.	Activities	Total costs (Thai Baht)
1.	Traveling Expenditure	3,000
2.	Assistant research's salary	30,000
3.	Pre-testing	
	- Photocopy questionnaires	300
	- Stationery	1,000
	- Miscellaneous Expenditure	1,000
4.	Data coolection	
	- Photocopy questionnaires	3,000
	- Stationery	500
	- Miscellaneous Expenditure	2,000
5.	Document Printing	
	- Paper + Printing	3,000
	- Photocopy (exam + final submit)	2,000
	- Stationery	1,200
	- Binding Paper (exam)	1,000
	- Binding Paper (submit)	2,000
	Total	50,000

3.15 Timeline

No	Research process/activity	2012						2013								
		July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1	Research question formulation and literature review	←	—	→												
2	Proposal writing		←	—	—	—	→									
3	Ethical approval							←	—	→						
4	Field work: ask for coorporation and recruit samples									↔						
5	Field work: data collection									←	→					
6	Data analysis											←	—	→		
7	Report writing and presentation												←	—	—	→

VITAE

NAME	Ms. Lalita Sangngern
DATE	13 May 1986
PLACE OF BIRTH	Bangkok, Thailand
INSTITUTE ATTENDED	Mahidol University, 2004-2008
	Bachelor degree of Nursing
	Chulalongkorn University, 2012-2013
	Master degree of Public Health
POSITION & OFFICE	2008- Present
	Registered Nurse
	Division of family medicine and emergency
	Department of nursing,
	Faculty of Medicine, Ramathibodi Hospital
	Mahidol University, Bangkok.