Cultural Care among Homebound Older People to Maintain Holistic Health: A Focused Ethnographic Study

Supussajee Detthippornpong

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

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Prince of Songkla University

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I hereby certify that this work has not been accepted in substance for any degree, and is not being currently submitted in candidature for any degree.

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ชื่อหัวข้อวิทยานิพนธ์ การดูแลเชิงวัฒนธรรมสำหรับผู้สูงอายุกลุ่มติดบ้านเพื่อคงไว้ซึ่งภาวะสุขภาพแบบองค์รวม: การศึกษาเชิงชาติพันธุ์วรรณา

ผู้เขียน นางสุพัสจี เดชทิพย์พรพงศ์

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ปีการศึกษา 2563

บทคัดย่อ

การศึกษาเชิงชาติพันธ์วรรณา มีวัตถุประสงค์เพื่อศึกษาวิถีชีวิตที่ดำรงไว้ซึ่งภาวะสุขภาพแบบองค์รวมของผู้สูงอายุกลุ่มติดบ้าน รวมทั้งเพื่ออธิบายปัจจัยทางสังคม วัฒนธรรมที่ช่วยส่งเสริมภาวะสุขภาพแบบองค์รวมของผู้สูงอายุกลุ่มดังกล่าว ผู้ให้ข้อมูลหลักได้แก่ ผู้สูงอายุกลุ่มติดบ้านจำนวน 16 คน ซึ่งได้มาโดยการเลือกแบบเจาะจง และผู้ให้ข้อมูลทั่วไปที่เข้าร่วมอีก จำนวน 23 คน ประกอบด้วยผู้ดูแลในครอบครัว ผู้ให้บริการด้านสุขภาพ อาสาสมัครสาธารณสุขชุมชน ผู้นำชุมชน และหมอพื้นบ้าน การศึกษาครั้งนี้เก็บข้อมูลโดยการสังเกต สัมภาษณ์ และ สนทนากลุ่ม และวิเคราะห์ข้อมูลด้วยวิธีการวิเคราะห์เชิงเนื้อหาตามวิธีการ 4 ขั้นตอนของไลนิงเกอร์

ผลการศึกษาพบว่า ผู้ให้ข้อมูลรับรู้ถึง ภาวะสุขภาพแบบองค์รวมว่าความสัมพันธ์กับวิถีชีวิตตามแบบวัฒนธรรมพื้นบ้านไทย โดยผู้ให้ข้อมูลอธิบายความหมายของภาวะสุขภาพแบบองค์รวมคือ “ ฉันมีชีวิตปกติสุขตามอายุของฉัน” อธิบายประเด็นสำคัญ 3 ประการเกี่ยวกับ การมีสภาวะสุขภาพแบบองค์รวม คือ 1) การมีความสามารถในการดูแลตนเอง 2) ความสามารถในการควบคุมภาวะแทรกซ้อนจากโรคเรื้อรัง และ 3) ความสามารถในการปรับตัวกับการเปลี่ยนแปลงรอบ ๆ ตัวที่ทำให้มีความสนุกสนานในชีวิต การปฏิบัติตัวเพื่อการมีภาวะสุขภาพแบบองค์รวมใน 2 มิติ ได้แก่ 1) การดูแลตนเองเพื่อการคงไว้ซึ่งสุขภาพดี และ 2) มีปฏิสัมพันธ์กับสมาชิกในครอบครัว เครือญาติ

และเพื่อน ๆ การศึกษาครั้งนี้ยังพบว่ามี ระบบบริการด้านสุขภาพ การบริการทางสังคมและการดูแลแบบตนเองแบบพื้นบ้านในชุมชน ที่ช่วยส่งเสริมการคงไว้ซึ่งภาวะสุขภาพแบบองค์รวมของผู้สูงอายุกลุ่มติดบ้าน ส่วนปัจจัยด้านอื่น ๆ ที่สนับสนุนให้ข้อมูลคงไว้ซึ่งมีภาวะสุขภาพแบบองค์รวมได้แก่ ความเข้มแข็งของชุมชน การมีเครือข่ายสนับสนุนจากครอบครัวและภูมิปัญญาท้องถิ่นในการดูแลผู้สูงอายุ

ผลการศึกษายังให้ข้อเสนอแนะต่อพยาบาลผู้ปฏิบัติงานในชุมชนในการพัฒนาโปรแกรมการดูแลผู้สูงอายุกลุ่มติดบ้าน โดยบูรณาการความหมายของภาวะสุขภาพแบบองค์รวม ความเชื่อ คุณค่า บริบททางสังคม วัฒนธรรม นอกจากนั้น ควรส่งเสริมทรัพยากรในชุมชนชน การสนับสนุนของครอบครัว ในการดูแลผู้สูงอายุกลุ่มติดบ้านให้คงไว้ซึ่งภาวะสุขภาพแบบองค์รวม ดังนั้น การออกแบบและจัดการระบบการดูแลที่เหมาสมกับวัฒนธรรม เพื่อเพิ่มภาวะสุขภาพแบบองค์รวมของผู้สูงอายุในชุมชนภาคใต้ เป็นสิ่งจำเป็น

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ABSTRACT

This focused ethnographic study aims to explore ways of life to maintain holistic health of homebound older people and describe socio-cultural factors that could promote their holistic health. Sixteen homebound adults were purposive selected to be key informants and twenty-three associated informants (family caregivers, health professionals, caregivers, folk doctor, health village volunteer, and community leader) were participated. Data were collected through participant observation, semi-structure interview, and focus group discussion. The content analysis was used to analyze the data following four steps of Leininger.

The results showed that all informants perceived holistic health as interrelated with their lifestyles surrounding Thai folk culture. The meaning of holistic health was reflected as “I am alive with good health in my age” which included three sub-themes; 1) “I assume a self-support function, so I am healthy”, 2) “I am in good health because I am able to control my conditions”, 3) I can adapt my living to the changes around me and then I enjoy in my life”. Two main practices to maintain holistic health were; 1) “always taking care of myself to stay healthy”, 2) “keeping contact with family and friends as usual”. Existing health, social care services, and folk care for

promoting holistic health were described. Factors that facilitated holistic health maintenance of the homebound older people included 1) “strong family network”, 2) “supportive family network”, and 3) “local wisdom of older people care”.

The findings suggested that nurses who work in the community should consider program development for homebound older by integrating meanings of holistic health, beliefs, values, socio-cultural context of care. In addition, some community resource and family support should be encouraged to maintain older people holistic health. Therefore, it is necessary to design and accommodate culturally appropriate care system to improve holistic health of homebound older in southern Thai community.

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CHAPTER 1

INTRODUCTION

Background of the Study

An aging population is rapidly increasing. According to a report by the United Nations (2015), the 21st century will be marked by older people worldwide. A recent report by the UN (2020) claims that in 2019 there were 703 million people at the age of 65 or older around the world. The number of older people is projected to double to 1.5 million by 2050. Globally, the number of people aged 65 or older increased from 6 percent in 1990 to 9 percent in 2019, with even higher increase (11 percent) in Eastern and South-Eastern Asia. The proportion is projected to rise to 16 percent by 2050. According to the World Health Organization (WHO), 80 percent of older people will be living in low and middle-income countries by 2050 (WHO, 2020). Thailand is a country with the fourth highest number of older people in Asia and the second highest number in the ASEAN (UN, 2020). Since 2005, Thailand has been an ageing society. It is estimated to become a complete aged society in 2021 and super complete aged society by 2035 (The Foundation of Thai Gerontology Research and Development Institute (TGRI), 2018). In 2020, the number of older people in Thailand reached 10 million, with 15 percent of socially bound people, 20 percent of homebound, and 1 percent of bedridden older people (Health Data Center, Ministry of Public Health, 2020).

Since the global population pyramid has changed, the number of dependent people has doubled in every country (Ritchine and Roster, 2019; UN, 2020). Moreover, older adults are faced with common health conditions associated with an

ageing society—hearing loss, cataracts and refractive errors, back and neck pain, osteoarthritis, and diabetes—so they are more likely to experience several conditions at the same time (WHO, 2020). The experience of older people in Thailand is similar. Their ability to perform activities of daily living has decreased due to their old age, and most of them have been prone to chronic illnesses such as stroke, heart diseases, gout, and depression (Institute for Population and Social Research, Mahidol University, 2020).

Homebound older people are considered as a middle group between being in very poor health (bedridden older people) and in good health (socially bound older people) (TGRI, 2015). Previous studies about the health status of the homebound older people have reported that they are at high risk of mental health problems, traumatic accidents, mortality, decreased mobility, and dying (Cohen-Mansfield et al., 2012; Herr et al., 2013; Omestein et al., 2015; Vu et al, 2013). Other studies have reported several health issues of the population, such as difficulty in carrying out activities of daily living (ADL), chronic diseases, functional decline, osteoarthritis, and geriatric syndromes. In this regard, the homebound older people can have a reduced quality of life and can easily become bedridden in the future (Husebo & Storm, 2014; National Statistical Office, 2014; Stall et al., 2014). The deterioration of physical function due to aging and chronic illnesses are the major causes of the decreased quality of life in older individuals, including the homebound older people. Therefore, this group of older people is highly vulnerable, and the society should prevent the deterioration of their health. Those health risks and impacts should be delayed or reduced through effective health care services specific to homebound older people.

Currently, there are many healthcare services in Asia designed to improve the quality of life of homebound older people with long-term-care systems proposed by the World Health Organization (World Health Organization, 2014). Several Asian countries (including Thailand) have applied those systems to support older people by integrating other health care services such as home visits and home health care for the socially bound, homebound, and bedridden older people (Nation Security Health Office (NSHO), 2016; TGRI, 2015). Some studies have reported clear evidence that health care programs improve the quality of life in older people, increasing their functional ability and decreasing the care burden of the family caregivers (Chou et al., 2012; Gine-Garriga et al., 2014; Gori, 2012; Labra et al., 2015; Nu et al., 2015; Stanton and Reaburn, 2014; Wollscheid et al., 2013). Other studies have established specific health care programs that fit with specific health issues of the population, such as fall prevention, sarcopenia, and heart failure (Bauer et al., 2015; Kitzman et al, 2016; Langlois et al., 2013; Sherrington et al., 2017). However, few studies focus on specific health problems of the homebound older people.

Moreover, existing knowledge and healthcare programs have been designed to support homebound older people in real situations. These healthcare services have been integrated with discharge planning, home healthcare, and long-term-care services. Discharge planning has been implemented to provide the continuing care for patients who must receive long-term care such as surviving stroke patients, patients with chronic diseases, and patients with decreased functional abilities (Phemphul et al., 2011). The discharge preparedness often takes place during the transition from the hospital to the patients' home and provides continuing care such as rehabilitation activities at their home (Nursing Division, 2015). Likewise, health professionals,

health village volunteers, and other stakeholders can provide home health care. The purpose of the care activities, envisaged in the discharge planning, is to guide the carers in providing effective care together with rehabilitation for those patients (Nursing Division, 2015). The long-term-care services have been implemented to support general older people (Ministry of Public Health, 2016). Moreover, many rehabilitation programs have been established to improve physical function and quality of life for the older people who must receive long-term care at their home (Rodsup & Suwintharahorn, 2013; Yodrach & Choowattanapakorn, 2014). However, the services may be limited or inappropriate due to different individual needs and concerns regarding beliefs and values of the population, including homebound older people.

Generally, older people have a different lifestyle based on their beliefs, values, and sociocultural context that relate to the meanings of health and self-care. Cultural background, language, religious beliefs, and awareness could impact the daily care of older people. Moreover, the population of each country has different health conditions (WHO, 2020). Some independent older people are more likely to gather in groups and carry out social activities, communicate with each other, help each other, make merit together at the local temple and use religious principles as their anchor. Meanwhile, older people in urban areas are likely to live in single dwellings or condominiums, mostly with their children and grandchildren, often tending their grandchildren while their parents are at work (TGRI, 2015). Having received at least a primary school education or higher, most of them have a moderate income either from their pensions or savings. In addition, the interrelationship with their families is at a moderate level partly because of little contact with their neighbors. Few of them become involved in

social groups, although some older people living in a city may meet others at senior citizen clubs (Sukanun et al., 2014). As a result of those issues, dependent older people can become socially isolated. Even though there are differences in their socio-cultural context, ways of life, and living conditions, each of them has specific health problems and needs healthcare services related to those issues, so that they can solve the problems and promote their health. However, few studies or healthcare services focus on beliefs and values which promote the holistic health of the population.

Holistic health is therefore an important concern among homebound older people because it can maintain the well-being of the population who need long-term care. the holistic health can be used to guide health care providers to develop the health care program which covers several dimensions of care (Dossey & Keegan, 2016). In terms of the holistic approach, health should be balanced and integrate all factors in a person's life that are usually separated (Light, 1997). WHO (2017) also describes the concept of care for older people as a holistic approach that focuses on physical, mental, and social well-being of individuals. Therefore, the holistic health approach can be used to guide several disciplines in developing appropriated healthcare model to support their population. For example, the holistic view can be used to develop health assessment tools such as environmental indicators to assess the factors influencing the quality of life and health status indicators among patients with chronic illness (Kryzanowski & McIntyre, 2011; Vigano & Morais, 2015). Moreover, the approach can help in designing care activities within a health care system that promote a balance among the body, mind, and spirit to create wellness rather than emphasize treating specific physical diseases (Dossey & Keegan, 2016).

Previous studies have integrated holistic care with other concepts to provide beneficial care for an older person as a whole; one study has integrated with Buddhist ethics for older people and another one applied traditional Thai wisdom. The results of the studies revealed that a holistic health approach was suitable to develop the appropriate care model and provided beneficial health outcomes to the participants including physical, mental, spiritual, and social dimensions (Pongbariboon, 2014; Prodbumrung & Thongpan, 2016; StraBner et al., 2019). Therefore, holistic health has attracted greater attention in several health care services and is integrated in health care systems for older people. The approach can encourage people to achieve well-being by focusing on the whole person, which includes their socio-cultural context and several factors that influence their ways of life. Therefore, holistic health and ways of life need to be explored since they could help in developing healthcare services for the homebound older people.

To gain more beneficial knowledge about the worldview and ways of life of the homebound older people who are still healthy and able to maintain their holistic health, a comprehensive study has been conducted. It is based on the theory of cultural care diversity and universality, proposed by Leininger, that focuses on interdependence of care within similarities and differences of cultures and obtains knowledge of care and cultural constructs of all informants (Leininger, 2006). Using this theory, we explored the holistic view of the homebound older people. Within the theory, transcultural nursing has been defined as a discipline that focuses on promoting and maintaining the cultural care needs of a human being (Leininger, 2006). Transcultural nursing is based on the patterns, expressions, values, beliefs, and ways of life of the people in the cultures. It suggests that nurses could discover

holistic dimensions based on the Sunrise Model, that is the socio-cultural context, ethnohistory, genetics, religion, spirituality, ethics, language, environment, politics, and family structures that influence human care (Leininger, 2002. According to Leininger (2002), the researcher should start from the individuals and their families, and move on to communities and other dimensions; however, it should explore all dimensions or components in the Sunrise model.

Moreover, Leininger's theory proposes that ethnographic study is an appropriate way to access the cultural information related to human beings (Leininger, 2006). To explore the ways of life of the homebound older people who are still healthy, we conducted a focused ethnography which is considered a classic ethnography with a narrower topic or a micro-ethnography (Higginbottom, Pillay, and Boadu, 2013). It applies the ethnographic method to capture specific data from individuals (Spider & Wood, 2010). Following the research method of focused ethnography (Higginbottom, 2013., the researcher collected data from individual participants to gain knowledge on their perception of holistic health, their ways of life to maintain holistic health, specific health and social services, and factors related to promoting holistic health. In focused ethnography**,** multiple methods are employed such as participant observation and in-depth interview methods to explore the perception, beliefs, culture, values, and practice in the participants' daily lives.

Purpose of the Study

The purpose of this study was to explore the ways of life among rural homebound older people to maintain holistic health.

Research Questions

1. What are the ways of life of rural homebound older people which help them maintain holistic health?

2. What are the social and cultural factors which influence the ways of life of rural homebound older people in maintaining holistic health?

3. How do rural homebound older people take action to maintain holistic health in their daily life?

4. What are the specific services and supports related to maintaining holistic health for the rural homebound older people?

Conceptual Framework

Holistic health is a broad, human-centered perspective which introduces the idea of positive health and well-being, and includes the concepts of physical, mental, social well-being, and spiritual needs of people (Ventegodt and Ervin, 2016). The term holistic is used in several disciplines including nursing. Holistic care stems from Integral Nursing theory established by Florence Nightingale, the first philosopher of modern nursing care who was concerned about the basic needs of human beings including the environment that influences nursing practice and global mission of health and healing for humanity to achieve well-being (Dossey & Keegan, 2016). In holism, healing is valued as the desired outcome, acknowledging human experience as a complex, dynamic relationship of health, illness, disease, and wellness. According to the holistic nursing concept, every human is a unity, a totality which is connected to everyone and everything (body, mind, emotion, spirit, sexuality, environment, society, culture, belief systems, relationships, and context). Human

beings are considered unique and inherently good. They can find meaning and present their story of life, and they can solve problems regarding their health (Dossey & Keegan, 2016). Therefore, holistic health is a concept of balance, integrating physical, mental, emotional, and spiritual aspects to establish healthy way of life and promote wellness by including individuals in making decisions on their health and healing process.

The theory describes that people are born, live, become ill, and die within a particular cultural belief and practice system based on human care for growth and survival. The theory emphasizes the cultural base of the individual or group related to their health, illness, and well-being. The theory can guide nurses to understand and adapt health care delivery to diverse and specific cultural contexts. The Sunrise Model is another element of this theory that describes various dimensions of culture and social structure, including technology, religion and philosophy, kinship and social relationships, cultural beliefs, values, lifestyles, political and legal aspects, economy, education, environmental context, language, and ethnohistory. All those factors influence the experience of human reality, which prompts one to understand the meaning of relationships and cultural influences in the care provided to individuals, families, and community. This model also explains the nursing care practices regarding the folk care and professional care system. Both care systems are significant in helping nurses make decisions based on three modes of culturally congruent nursing care: culture care preservation or maintenance, accommodation or negotiation, and re-patterning or restructuring.

Cultural issues are among several factors that influence health care action in patients including older people (Zagaria, 2013). To increase the potential efficacy of

nursing care, it is highly beneficial to develop an in-depth understanding of the participants' cultural and social contexts. Ethnography has been developed in anthropology and its ontology is based on considering the world as culturally based, where cultural groups have various cultural perspectives, differences, patterns of beliefs and behaviors (Chesnay, 2015). These assumptions define the nature of social reality in terms of existing relations between individuals and through their interactions within groups. The epistemology of ethnography is based on knowing by exploring the symbols, rituals, and traditions of a particular cultural group (Parse, 2001). Based on this epistemology, ethnography in nursing is a way of discovering, knowing, and determining the knowledge of people to maintain their health status (Leininger, 2002).

Therefore, ethnography is an appropriate research method to study the participant's way of life regarding their holistic health. It emphasizes the participants' culture in understanding the meaning of phenomena seen through the people's ways of life (Spradley, 1979) and the meaning of actions in the people's context. The main methods of data collection aimed to understand meanings in a context and included participant observation, interviews, and a focus group (Spradley, 1980). Focused ethnography is usually used to describe specific phenomena rather than a broad culture (Richards and Morse, 2013). The duration of data collection in a focused ethnography is usually shorter than in traditional ethnography; however, the research findings can be employed to describe the whole culture through several instances of data collection. Using the focused ethnography method, the researcher will be able to ask questions and observe actions related to the research questions and purpose of the study in the specific context of the specific phenomena within the specific time (Chesnay, 2015).

Definition of Terms

Culture is defined as the broadest, most comprehensive, holistic, and universal feature of human beings (Leininger, 2006). Cultural care of homebound older people refers to their perceptions, beliefs, values, and practice related to maintaining their holistic health among homebound older people. It includes perceptions and meanings of holistic health, self-care activities of the homebound older people to maintain holistic health and well-being, care support provided by health professionals such as nurses and non-health professional or folk caregivers such as health villages volunteers, caregivers, local government officials, and private sector personnel. Holistic health refers to the ability of homebound older people to balance the four components of life: body, mind, social, and spirit to achieve the well-being.

Significance of the Study

The findings of this study provide a foundation to develop a cultural care model to maintain holistic health for the homebound older people. Cultural care services specific to the cultural context of the population could be modified to accommodate those who have complicated health problems while considering their context. This study also contributes to the understanding of a holistic view in cultural care of homebound older people. We hope that a culturally appropriate understanding related to the socio-cultural context of homebound older people can be used to offer appropriated care services to the older people population in the future.

CHARPTER 2

LITERATURE REVIEW

The literature review will be presented as follows: 1) health care system for older people in the Thai context, 2) cultural care among older people in Thailand and the Southern Thai context, 3) sufficient economic discipline, 4) existing support program for homebound older people, 5) holistic health, 6) cultural care theory, 7) nurses' role in cultural care, 8) ethnographic study, and 9) strategies to involve the informants.

Health Care System for Older People in the Thai Context

In Thailand, free health care, home-based care services and community-based care services were established to support older people. In 2016, the Ministry of Public proposed the budget for improving health care system of Thai older people through Nation Security Health Office (NSHO). NSHO and a local government organization then reached a mutual agreement on developing the Long-term Care System (LTC) for older people in Thailand. To implement the LTC system, health professional in the community were trained—within a special course in caring for older people—to be the care managers (CM) of the care system. CM then invited volunteers in the community to attend another special course to take care of older people in the community (Care manager; CG). The older people's health was assessed by CM and CG. After that, CM and CG devised an action plan for development and implementation depending on older people's health problems. NSHO supported the budget for older people in LTC system through a local government organization in the

community (NSHO, 2016). In 2017, the Department of Older People (DOP) established four strategies for supporting older people in Thailand: 1) encouraging and integrating policies, mechanisms, and innovations for older people into practices; 2) improving older people's capacities and preparing every age to support the aging society within stakeholders; 3) developing protection system for the rights of the elderly; and 4) encouraging innovation for older people (DOP, 2017).

Currently, all public health organizations in Thailand established their health policy to support older people using the LTC system. The Region 11 Public Health conducted the Blueprint of Health Service and Human Resource 2020 – 2027, based on the Sriwichai Declaration. The policy determined that the health care of the aging population was a key focus of the health care system and was included in a Primary Care Cluster (PCC). The aging population's health care was developed to support older people using SALE model, which refers to health screening, aging health club, long-term care, and the end of life care (Region 11 Public Health, 2019). The majority within the health care system agreed to implement this trend in older people's care in the community. Thus, the ways of life and socio-cultural context of the population should be recognized so that they could provide care that fits the situation on the ground.

Cultural Care among Older People in Thailand and the Southern Thai Context

Nowadays, people are living longer across the world, which is the consequence of the aging society. The previous studies have reported that the perspectives of aging in each country are different depending on their culture (Ariff and Beng, 2006; Aw et al., 2017; Institute on Aging, 2014). Moreover, In Asian

countries including Thailand, older people are treated with more respect than others. To understand the cultural care for older people, the researcher decided to focus on the Asian countries with a large number of older people and several ethnics groups. A few studies have analyzed the cultural care for older people, including homebound older adults. Due to Thailand's multicultural population, as in other Asian country, cultural and religious beliefs may have similarities or differences which people have exchanged and learned together. For example, Chinese older adults with cardiovascular diseases, lung diseases, cancer, prostatitis, and nervous system diseases still believe and use Chinese traditional medicines to support their health (Xin et al., 2020). The majority of Chinese older adults often exercise based on their belief that physical activity could prevent bones and joints from deteriorating and stimulate their internal organs, bringing benefits to the whole body, lowering blood pressure and improving blood circulation (Tai Chi, walking) (Liu, Shaun, and Beaver, 2012). The majority of Chinese older people with heart failure focus on dietary management, especially Taoists and Buddhists. Given that Chinese tea culture has a long history, Chinese people believe that tea helps them maintain their health (Rong et al., 2016).

Cultural care among older people in the Thai context

Thailand is the country with diverse ethnic groups. Thailand is divided into four regions—Northern, Northeastern, Central, and Southern—where people differ based on their way of life, beliefs, values, and socio-cultural context. Hence, health care is different depending on those factors. Bubpa and Nultaboot (2017a; 2017b) claim that the ways of life and diet of older people in Northern Thailand promote their health and wellness. The findings have revealed that the older people are happy to

cook local dishes which are easy to find in their community. Moreover, they value self-reliance (they grow vegetables, raise small animals, and cook by themselves), help others in their families, have their own health conditions regularly screened by health professionals, support other older people as much as possible, visit temples and take walks in the countryside, join social activities, make merit, and get help when they are in need.

Buddhist doctrine has been used to develop health care programs in support of older people, such as vipassana meditation and other Buddhist activities. The findings have shown that older people who follow the Buddhist doctrine have improved their spiritual well-being and health conditions (Sasiwongsroj et al., 2015; Stewart et al., 2014; Wiriyasombat, 2011). Another study has revealed that older people in an Isan cultural society still use three main types of local wisdom to care for their mental health: Phuk Siew ritual, Yao ritual, and Bai Sri Su Khwan ritual. It helps create social immunity, builds social support source and consultant, and engages older people in therapeutic ceremony performed for the cure of their souls. It relieves stress, reduces anxiety and depression symptoms, creates the feeling of security, stabilizes heart, gives hope, and provides energy (Wongkwanklom, 2018).

In summary, the majority of healthcare services in Thailand have been developed to support older people using the WHO's guideline, namely LTC. The health care services have applied the LTC to fit their own context and maintain the quality of life for their older people. The LTC services have been developed and implemented based on each country's economic status. In developed countries, the older people have received various modes of support including physical function, meals, medications, and allowance. On the other hand, in developing countries, the

older people still have limited access to healthcare services. Moreover, the healthcare services focus on improving physical and mental health of older people. A few healthcare systems have emphasised socio-cultural background and other factors that affect holistic health, illness, and death within a population.

Cultural care among older people in the Southern Thai context

A few studies analyze cultural care for older people specific to the Southern Thai context. Studies have explored the quality of life, factors that promote the quality of life, and the relation between quality of life and health of older people. It has been found that factors which promote their quality of life are housing, participation in religious activities, happiness about their life, participation in the community, living in a good environment, comfortable and safe life, the main occupation before retiring, and relationship with the family (Noknoi and Boripunt, 2017). Other studies report that health status and quality of life are interrelated. The findings also suggest that health care services to support the population should be accommodated to their specific cultural and religious contexts, such as praying, meditation, candle cycling at the temple (nine temples, per year) study tours and mind development, birthday celebrations and holidays for older people (Kittipunyo, Boorit, and Nilkarn, 2018; Tongdee, Rongmuang, and Nokchatree, 2013). Therefore, pursuing their own ways of life and performing their daily activities based on their beliefs and values, the older people are able to maintain their quality of life.

The studies which explore the perception of physical function among the older people in Southern Thailand's rural communities have found that physical activities provide many benefits that they integrate into their daily work and make their body move. They have analyzed agricultural activities such as growing

vegetables, plants and seeds around their houses, and intensive farming. According to the research, older people, particularly Muslims, stretched peripheral organs and nerves 30 minutes a day, which helped them relax. Both Buddhists and Muslims regularly performed physical activities to maintain their health (Suwankhong et al., 2020). Other studies have developed and evaluated healthcare services to support older people in the Southern Thai context. Thiamwong, McManus, and Suwanno (2012) have developed the Thai healthy aging model using grounded theory. The model consists of the theme of dharma that refers to living simply and economically. The dharma theme encompasses the subthemes of enjoyment through helping one's family, participating in community activities, and helping other people without expecting a reward.

In brief, religious and cultural beliefs strongly relate to the quality of life and well-being of older people in the Southern Thai context. Therefore, the ways of life which promote their health need to be explored so that we could develop specific healthcare services that fit with the older people in each setting.

Sufficient Economic Discipline

The sufficient economic discipline focuses on having enough and promotes a middle path in life. In 1997, when the economic crisis affected all people in Thailand, the sufficient economic discipline of the Majesty King Bhumibol (King Rama 9) of Thailand was established. The King Rama 9 proposed a new theory of agriculture—firstly called sufficiency economy and later renamed The Philosophy of Sufficiency Economy (PSE)—to guide Thai people through the economic crisis and globalization. The sufficient economic discipline is based on the Buddhist doctrine

and science that focused on sufficiency in life and the middle path. The core of sufficiency is enough to live one's life, that is to say, a reasonably comfortable life, without excess or overindulgence (Dhirathiti, 2017). The concept of the sufficient economy consists of four statements: 1) sufficient economy is an approach for people to live at every level—individual, family, and community; 2) the discipline focuses on the middle path or balanced life; 3) the discipline consists of three interlocking principles (moderation, reasonableness, and self-immunity) that people can apply to their own life; 4) two conditions (appropriate knowledge together with ethics and virtues) of the discipline also suggest that knowledge, integrity, and honesty should be used to design a good plan and decide on its implementation.

The three interlocking principles (moderation, reasonableness, self-immunity and the two conditions (appropriate knowledge and ethics and virtues) have been presented by the Office of the Royal Development Project Broad (ORDPB); 1) moderation is referred to as adequacy that is neither too scant nor too much, 2) reasonableness is presented as sufficiency that should be carried out based on the reason and whose results should be predicted, and 3) self-immunity is described as a quality that should prepare people to face with changes that will occur in the future. Similar descriptions have been given for the two conditions that people should recognize to support their decisions; 1) appropriate knowledge is referred to as ability to integrate knowledge of each discipline and carefully conduct the action plan; and 2) ethics and virtues have been described as a set of qualities that emphasize morality, integrity, patience, and effort (ORDPB, 2020). Therefore, the constructs of the discipline guide people to live with a balanced approach that can be applied to on all levels and in all fields.

The sufficient economy has been applied to healthcare services to support older people. The term “sufficient health” underpins sufficient economy. Two previous studies have revealed the perspectives on sufficient health among Thai villagers who wanted to stay healthy, undergo regular check-ups, have ability to support themselves, live sufficiently and avoid health risks (Arpanantikul, 2018; Phuphaibul, Arpanantikul, and Khuwatsumrit, 2017). Moreover, the sufficient economic discipline has been used to develop and indicate sufficient health index on all levels—individual, family, and community (Arpanantikul et al., 2011). Another study claims that sufficient economic discipline is significant and able to integrate the WHO’s quality of life indicators to gain information about older people’s perception of life based on sufficient economy (Ngamsri, 2018). Consequently, the concept of sufficient economic discipline can provide the meanings of healthy and health indicators.

Several studies have been developed using sufficient economic discipline to support older people. The study by Gunlawong et al. (2016), and Silapanan (2019) explored the self-reliance and quality of life in older people who applied sufficient economic discipline to strengthen their community. Their findings showed that people from several organizations, both within one community and in other communities, had participated in the community activities such as provision of healthcare services for bedridden older people and full services for older people. Another study by Pholprasert and Witayatha (2016) applied sufficient economic discipline to develop a program to improve quality of life of older people using group process. It was found that after the program had been implemented, the quality of life of the experimental group was higher than before the program and higher than in the control group.

In addition, sufficient economic discipline has been used to develop healthcare program and care activities to improve older people's quality of life. Healthcare models and guidelines to support older people have been developed using sufficient economic discipline. The results reveal that the principle is helpful to enhance the self-care ability of the population and community participation in healthcare services (Rodjarkpai et al, 2018; Sirikitsthian et al., 2017). Another study (Sirikitsthian et al., 2018) has designed activities to improve quality of life of older people through action research and by following sufficient economic discipline. The care activities consisted of making the herbal ball, making Plai oil, and basic massage for older people, which the older people can integrate in their daily activities. In summary, the sufficient economic discipline not only applies to the agricultural sector but to the healthcare system, which can guide both the individuals and community to improve their quality of life.

Knowledge on Support Programs for Homebound Older People

The literature indicates various types of support programs for older people including the homebound older people.

Exercise program

Several exercise programs have been implemented to improve the mobility and function of older people with functional decline. Gymnastics exercise was applied to improve functional ability for older people with limited physical function from 6 weeks to 6 months. After the program had finished, the findings revealed that during the first two weeks of the first month, the lower limb deep venous thrombosis (DVT) intervention group had performed better than control group. However, during the first

and third months, there was no significant difference on the time points of the first month between the two groups (Yang et al., 2016). Another study (Iamchaimongkol et al., 2017), beguine dance was performed to improve the strength and balance in older people. The programs were implemented in two to three sections per week, with an hour per section from six to eight weeks. After the participants were trained to practice the beguine dance at home, they were evaluated at the hospital or rehabilitation clinic in the first and second weeks, and six to eight months after the program was implemented. The findings presented the score of the Timed up and go test (TUG), Berge balance scale, and Single Leg Stance Test left and Right. for the participants after he program during the first and second weeks, after six to eight months, the mobility, balance, and postural control of participants was significantly better than before the program had been implemented.

In another study (Britten et al., 2017), a dance session program was performed for eight weeks and was delivered by dance choreographers in the local community. The session comprised a warm-up, individual active and passive movements of all joints, basic low impact aerobics movements such as walking on the spot or while seated, and cooling down by taking deep breaths and passive and active stretching. The results revealed significant increase in moderate and vigorous physical activity, while the fear of falling and TUG decreased significantly. Another study (Kumar, 2017) compared the functional outcomes of older people. Both Tai Chi and balance exercises were implemented in each group five days per week for eight weeks. The Tai Chi consisted of curving back arms, stepping sideways, moving arms and hands, diagonal strides, standing on one leg, and stepping and pushing. The total exercise session involved a 10-min warm-up, 30 minutes of practicing, and 5 minutes cooling

off. The balance and strength training comprised strength exercises (sit-to-stand-progression and variety; cross arms across chest and changing the nature of the surface) and balance exercises (standing with decrease base progression; feet together and level, semi-tandem stance, tandem stance, and standing on one leg). The findings presented that fear of falling had significantly decreased in both groups, and the balance and functional mobility significantly improved in both groups. Also, the Tai Chi training had better effect in fear of falling, balance, and functional mobility than the balance training.

In another study (Mesquita et al., 2015), proprioceptive neuromuscular facilitation (PNF) and Pilates exercise (the name coined by Joseph Pilates) were implemented for improving the strength and balance in older women for a month. The PNF group started on the upper limbs in a bilaterally symmetrical agonist pattern, external flexion-abduction-rotation and internal extension-adduction-rotation, and external flexion-abduction-rotation. The Pilates exercise comprised of motion and strength of the upper limbs, trunk, and lower limbs. The results reported that the women in both PNF and Pilates group had significantly decreased in their time up and go score, Berge Balance scale, and increased their functionality more than the control group, although there was no significant difference between the PNF and Pilates groups. Therefore, both programs were able to use to improve functional ability of older women and other.

Moreover, home rehabilitation programs which focused on long-term rehabilitation have been performed at patients' home and studied (Sled et al., 2010). The programs always included health educations and focused on client-centered, interdisciplinary helping and assistive rehabilitation devices, and home-based

exercise. Hip abductor program was conducted to strengthen the joints, muscles, and physical function of older people with knee osteoarthritis. The program comprised the side-lying resistive exercises for the hip abductor muscles, with progression to resistance bands; standing single-leg stabilization exercise, with progression to standing hip abduction using resistance bands placed just proximal to the ankles; and single-leg standing exercise off the side of a 10 cm step. The activities were carried out three to four times per week for eight weeks. Over the eight-week period, a physical therapist paid a home visit twice, whereas every 2 weeks there was a telephone follow-up. The results revealed that the program had significantly improved the hip abductor strength, even though it was not significant in knee abduction.

In another study (Karlsson et al., 2016), multidisciplinary health workers were invited to carry out a home rehabilitation program for walking ability of older persons with hip fracture. The program focused on walking ability indoors and outdoors, functional strength, and balance training. Physiotherapist paid special attention to independence in personal and instrumental ADLs, trying out assistive devices and helping participants to modify safety home environment. Moreover, nurses and geriatrician were invited to work collaboratively regarding medical issues, to evaluate pain using pain score, to provide nursing care the operation wound, etc. All team members worked together to improve the health outcomes of the participants within ten weeks. After intervention, the results revealed no significant difference in walking ability and gait speed during the third and twelfth months.

In Latham et al. (2014) study, a home-based exercise program has been developed to improve physical function for older people after hip fracture. They exercised at home three times per week for six months, which included Thera-Bands

for resistance, standing exercise with steps of varying height, and weighted vest used to overload. The therapist encouraged the participants by showing a DVD about the benefits of exercise and overcoming fear of falling, goals setting, and self-monitoring progress by using an exercise calendar. The findings revealed that the intervention group had significantly improved in short physical performance battery (SPPB), activity measure for post-acute care (AM-PAC), mobility, and ADL comparing to the baseline and control groups, but there was no significant difference between two group for nine months.

The Elastic Band exercises and health promotion program were conducted to maintain static balance and functional mobility in older people (Asawakosinchai et al., 2011). The program comprised a 5-minute warm-up (shoulders, joints, hip, and knees movement), 30-40 minutes for Elastic Band exercise, and 10 minutes for cool-down in 2 sessions per day, 3 times per week for 8 weeks. After the program had been implemented within 16 weels, the Elastic Band Exercise (BBS) scale improved significantly as compared to the baseline, but there was no significant improvement for TUG.

A weight vests and patient education program was implemented to increase muscle strength, dynamic balance, and quality of life among older women with osteopenia and previous wrist facture (Hakestad et al., 2015). The program included strength, balance, coordination, and core stability exercises with weight vests. The patient education component provided the meaning of osteoporosis, risk factors, nutrition for bone health, fall prevention, and general exercise guideline. The program was implemented in the intervention group for six months. The results revealed no significant difference in the improvement of anthropometry, dynamic balance,

walking capacity, physical activity level, and quality of life between the intervention group and the control group, including the baseline during the over one-year follow-up.

Another type of exercise, a set of exergames, consisted of pigeon express game-sit-to-stand exercise, river gems game-side steps exercise, panda peak game-marching exercise, horse hurdles game-knee bends exercise, and virtual physiotherapist exercise (Uzor & Baillie, 2014). Each game was performed to improve the muscle strength, balance, and body functions. The programs lasted for 12 weeks and included 38 sessions. The findings presented the improvement of adherence and effective rates to exercise program in the intervention group afterwards; however, there was no significant difference in the outcomes measurements between the intervention group and control group for 12 weeks.

In summary, the majority of rehabilitation programs were exercise programs, implemented as clinical-based and home-based. The exercise programs focused on improving physical function of the participants. They were trained during the physiotherapy at the hospital, and upon their release, they had to continue exercising by themselves. The exercise programs comprised muscle strength, standing, walking, balance, coordination, range of motion, strength of the upper limbs, trunk, and lower limbs. Booklets, a manual, and a DVD for guidance were supplied. All participants were valuated during the follow-up at the physiotherapy clinic or at the evaluation time such as 1st, 2nd, 3rd times, and at the end of the intervention. The content of the programs did not specify how to encourage the participants to continue exercising at home. Meanwhile, home-based rehabilitation programs included exercise, health education, home visits (by nurses, physiotherapists, and other health professionals),

telephone follow-ups, exercise calendars, and they were also client-centered. The programs were implemented during 8 weeks to 6 months, with the frequency of 2-3 time per week, 20-30 minutes per sessions. The measurements were performed during the intervention, immediately after the intervention, and after one or two-year follow-up.

The outcomes of the interventions measured were muscle strength, physical function, muscle mass, walking ability, balance, and ADL. The tools used to measure the outcomes included TUG, BBS, ADL index score, and a questionnaire. The findings of both exercise programs and home-based rehabilitation programs indicated that the interventions had been both significant and insignificant, with the significant outcomes found during the short-term period of the interventions, immediately after the programs had ended (four to eight weeks). There was no significant difference between the interventions group and the control group in the measurement outcomes during the long-term follow-up from 9 months to 2 years.

Most of the studies in the literature review reported no positive change in the long term, which may owe to limitation in sample size, inadequate evaluation, and follow-up. One such question refers to how and in what way the older people maintain the effects of rehabilitation or exercise if they are not supported within their own home. Likewise, home rehabilitation may be influenced by the customs, values, and beliefs of the older people. Therefore, it is essential to consider the cultural context so as to encourage participation from individuals within their home environment and communities.

Home health care programs

The majority of care programs developed for older people with specific health problems were implemented in the short term. A few studies analyzed health care services which support older people at their home in the long term. Nagaire Kerse et al. (2010) have developed home-based activity program to support older people suffering from depression. The program included individual physical activity (Otago Exercise Program). The participants were visited seven times during six months. The control group received a social visit without physical activity. The findings indicated that there was no difference between the physical activity and social visit on the effect on physical function, quality of life, and mood. Another study (Lewin, G. and Vandermeulen, S. 2010), has compared the health outcomes of older people who underwent Home Independent Program and received usual home care services. The outcomes were examined at three months and one year. The findings showed that the intervention group had significantly improved functional dependency, confidence in performing activities of daily living without falling and functional mobility comparing to the older people who received usual home care services (control group). Therefore, older people should receive specific health care services related to their health issues at their home.

Parsons, J., Sheridan, N., Rouse, P., Robinson, E., and Connolly, M. (2013) have conducted a study about based home care on physical function and support among older people. The intervention consisted of 5 steps that involved allocation of primary care practices and were implemented with the intervention group. The findings revealed that there had been significant improvement in physical function within the intervention group as compared to the control group. Another study (Lee,

T. W., Yim, E. S., Lee, H., S., Ko, Y. K., Kim, B. N., Kim, S., 2015) has compared activities of daily living in nursing home care and home care setting for physically dependent older people in Korea during a 1-year cohort study. The results showed that the older people who had received home care had less deterioration than the older people who had received nursing home care after one year. The activities of daily living were different based on the type of long-term care they received. Home care resulted in better maintenance of daily living than nursing home care. Another study (Barnay, T. and Juin, S., 2016) evaluated the effects of both informal and formal home care on depression and mental health in France. The results found that informal homecare had reduced the risk of depression among the older people while formal homecare increased their general mental health.

In summary, there were limitations in home health care programs implemented to support older people including homebound older people, although they needed a long-term care support at home. The majority of health care programs focused on specific health problems and did not emphasize beliefs, values, and life ways related to their holistic health.

Holistic Health

The holistic health is a broad medical perspective which introduces the idea of positive health and comprises four components: mind, body, spirit, and emotion. It focuses on life rather than illness or specific parts of the body. In other words, this ancient approach to health takes the whole person into consideration and the ways in which individuals interact with their environment (Haynes, 2009). Moreover, the holistic health emphasizes the connection among the mind, body, and spirit, aiming to

achieve maximum well-being. Everything that relates to individuals should be included in care activities for the purpose of well-being (American Holistic Nurses Association (AHNA), 2007).

Holistic health has been applied to yield positive health outcomes. Using holistic approach, Teranut et al. (2009) have developed continuing care model for the elderly with chronic illness. They conducted four phases of participatory action research. The results of the evaluation phases showed that the new care model had been implemented to continue holistic care for older people. Moreover, the holistic health healing was designed to provide effective care for patients as well. The hospital was re-designed through participatory action research which was based on the interaction among body, mind, social life, and environment (Assawabunydej, 2013). Additionally, holistic health was used to improve the health status of the United Methodist clergy through focus group discussions. The health care model comprised five socioecological levels that directly and indirectly influenced the clergy's health via two mediators: self-care and coping (physical, mental, and spiritual health practices) and stress. Both mediators were affected by many conditions and also by each other. Stress, in turn, impacted self-care, coping, and well-being. The final health outcomes consisted of physical health, mental health, quality of life, and spiritual well-being (Proeschold-Bell, 2011).

Moreover, holistic health approach was used to develop a memory intervention program with the aim of improving attention and working memory for older adults. The holistic training program included mindfulness, exercise, stress reduction, socialization, diet, and values/identity techniques. The findings of the study revealed that holistic health program had significantly reduced the risk of cognitive

problems among older adults (Hyer et al., 2014). Besides, DeGrezia and Scrandis, (2015) conducted a qualitative study based on hermeneutic method to explore how older adults in an urban, community-dwelling (n=40) coped with HIV infection, comorbidities, and related stressors. They found three main themes which related to holistic health: assessing support, helping oneself and helping others, and increasing spirituality.

In summary, holistic health approach has been applied to maintain the health status of patients including older people. All studies have reported positive health outcomes after the intervention. However, the previous studies were conducted among general patients and older people. They were still limited to homebound elderly who had complicated health problems. Therefore, specific health care which would maintain holistic health for homebound elderly needs to be explored.

Cultural Care Theory

Cultural care has been included in nursing knowledge for a long time. Leininger was the first theorist to emphasize transcultural care nursing. One of the most well-known cultural care theories was cultural care diversity and universality developed by Leininger (Leininger, 2006) that highlighted cultural care. Following this theory, nurses should deeply understand cultural background of an individual in order to provide suitable care for culturally diverse people through decision-making, planning, implementation, and evaluation between nurses and clients. The cultural care diversity and universality was developed based on the concepts of holistic nursing and anthropology. Leininger believed that human perceptions and practices were different based on their socio-cultural context (Leininger, 2006).

Leininger has proposed four major tenets of the theory: 1) Cultural care expressions, meaning, pattern, and practices are differing, sharing commonality and universality; 2) The worldview that consists of multiple social factors, ethnohistory, environmental context, language, and generic and professional care directly influence cultural care patterns that could be used in the contexts of health, well-being, illness, healing and methods people overcome disabilities, and death; 3) Generic (folk) and etic (professional) health factors within different contexts significantly influence health and illness. 4) Three majors action modes—cultural care preservation and/or maintenance, cultural care accommodation and/or negotiation, and culture care repatterning and/or restructuring—were used to support culturally congruent care for health, well-being and dying (McFarland and Wehbe-Alamb, 2015).

The central constructs in the theory of cultural care diversity and universality were designed to encourage researchers or nurses to gain new qualitative knowledge that differs from quantitative definitions. Leininger describes the meaning of care as actions, attitudes, and practices to support people in order to encourage wellbeing, presented in the “Sunrise Model”. Leininger claims that culture consists of beliefs, values, norms, and lifeways of people in their common setting. Emic is described as the view of people in the community, whereas etic usually comes from professionals’ view. The cultural and social structure factors consist of religion, kinship, politics, legal issues, education, economics, technology, political factors, philosophy of life, cultural beliefs and values, and lifeways, which directly influence health and wellbeing. Ethnohistory is defined as the history of each setting that consists of events and experiences of people in the community that can be used to explain past and current lifeways in culture care influencers of health, wellbeing, and death.

Environment context refers to situations or experiences of people that explore meanings, actions, interpretations, and social interactions within the cultural and social structure factors described above. Worldview is defined as a broad perspective that makes people understand and value various things around them. As described in the tenets of the theory, three action modes provide cultural care for people in terms of their health, well-being, and dying. Culturally congruent care refers to knowledge about cultural care that focuses on beliefs, values, and ways of life related to people's health and wellbeing. Moreover, it is also used to explore people's perspective on illness, disability, and death. Care diversity refers to character of care that respects beliefs, values, ways of life, patterns, and symbols to provide good care to culturally diverse people. Lastly, cultural care universality is defined as the phenomena of human being presented through patterns, beliefs, values, ways of life, and symbols, based on which caregivers can support people in improving their health (Leininger, 2006).

The theoretical assumptions of the theory have been established as follows (Leininger, 2006): 1) Leininger describes care as both abstract and concrete phenomenon, stating that it is assistive, supportive, and essential in nursing; 2) both humanistic and scientific approaches are significant for human wellbeing, health, survival, death, and disabilities; 3) caring refers to actions, attitudes, and practices to support people's health; 4) culture care consists of two major constructs (cultural and social structure) that a researcher can use to explain health, wellbeing, care expression, and other conditions; 5) cultural care expression, meaning, patterns, processes, and structures are usually found between cultures; 6) cultural care values are influenced by the worldview, social structure, ethnohistory, and environmental

context; 7) every culture has generic (emic) and professional (etic) need to be discovered for culturally congruent care practices; 8) culturally congruent and therapeutic care could be found when cultural values, beliefs, expressions, and patterns are used for people within diverse and similar cultures; 9) three action modes are used to help people within a diverse culture; 10) the qualitative research method is the way to discover knowledge and practices related to cultural care; 11) transcultural nursing is a discipline with a body of knowledge and practices that guide a researcher in meeting their goals and culturally congruent care for health and wellbeing.

Leininger developed the transcultural care nursing theory in the 1950s to recognize the diversities of a culture as a discipline and practice field. The purpose of the theory is to promote and maintain patient care in the context of an individual patient's culture. The theory enables nurses to provide beneficial care to patients in all settings, focusing on comparative human care within their beliefs, values, lifeways similarities and differences in order to give them culturally congruent, meaningful, and beneficial care (Lininger, 2002). Moreover, Leininger claims that specific transcultural training in nursing concepts and principles, along with the discussion on research findings, can support nurses in acquiring effective cultural awareness. Accordingly, to improve nursing cultural knowledge regarding the quality of care, cultural care diversity and universality programs have been developed to focus on human care and cultural relationships.

Therefore, to provide appropriated nursing care and at the same time respect one's cultures, beliefs, and values, a nurse needs to understand the ideas of cultural care nursing; 1) one should be aware of the similarities and differences of an individual culture in their environment and real-life situation so as to provide

appropriate care, 2) a culture in the community has been transferred from old generations and still influences their beliefs, values, and practices related to healthcare, 3) transcultural-specific and comparative knowledge is beneficial for nurses so that they could provide care which focuses on the similarities and differences of each culture, 4) nurses need to learn about cultural care continuingly so they could clearly understand the culture care phenomena in each setting, 5) nurses need to follow well-proven methods to provide cultural care appropriately (Leininger, 2002).

In summary, cultural care diversity and universality is an appropriate theory to guide nurses in providing cultural care to their clients. Nurses can use transcultural nursing to understand the real context in which people live. It can also be a mediator between folk care and professional care.

Nurses' Role in Cultural Care

According to Leininger's (2002) transcultural care nursing theory, cultural care and care are interacted. Moreover, transcultural care nursing focuses on understanding individuals' situation in the real-world, including health-illness practices, beliefs, and values. Nurses comprise the largest number of healthcare professionals who are in the front line between patients, family members, and other healthcare professional. They also have the greatest opportunity to provide effective care to patients. Nurses play role as mediators between patients, their family members, and other healthcare providers. Salmela, Koshinen, and Eriksson (2017) claim that the participants in their study view nurse as managers of ethically sustainable caring cultures. Murcia and Lopez (2016) have analyzed the experience of

nurses who provide care to culturally diverse families. The findings show that nurses take responsibility and ethical commitment in patient care within external and internal barriers of family care. However, nurses sometimes help the family, assisting them in communication, patient safety, and support for the patient. Another study has analyzed the experiences of nurses caring for older people with dementia. The findings have revealed that nurses tend to communicate bearing in mind the patient's native language and cultural oriented activities to support them (Soderman and Rosengahl, 2016).

Other studies propose that nurses are key informants in the cultural care. Khalaf et al. (2014) have conducted a qualitative study to explore nurses' views and experiences while caring for malnourished patients in Saudi Arabia. The results reveal that nurses have high potential to provide appropriate health education to the patients. Moreover, in the cultural care, nurses must be sensitive to their patients' values, beliefs, lifestyles. They might seek information that may impact a patient's health and deal with patients from diverse cultures (Bee & Chipps, 2014).

Several studies have analyzed the role of Thai nurses in providing care within a culturally diverse community. Prasertsri and Tirapaiwong (2013) have proposed that culture influences the expression of pain in each person; thus, they have several patterns of expressing pain such as salience and crying. They also claim that some pain assessments in healthcare services developed in Eastern culture may not fit with Thai and Asian culture. Hence, it is necessary for nurses to deeply understand cultural diversity that influences the experience and expression of pain in order to provide adequate health care.

Songwathana (2014) suggests that individual care is emphasized within a multicultural society and guides healthcare professionals who focus on diversity of individual and ethnic groups. Given that nurses have priority in cultural care for each person, their role within cultural diversity should be improved and they also need to preserve traditional culture of their clients. Another study reveals the cultural competency of nurses working in Thailand's southern provinces. The findings show that overall cultural competency, cultural knowledge, and cultural skills of nurses are at a moderate level. The findings also highlight that cultural competency of Thai nurses aim to decrease stress and conflict, and enables them to adapt to working in a multicultural setting (Songwathana and Siriphan, 2015). Other studies reveal various factors related to transcultural nursing competence. The findings indicate that nurses have competence of transcultural nursing at a moderate level (Chonjaroen, Kongvarrananon, & Thongbi, 2018). Cross-cultural experiences and attitude have direct effect on the cultural competence of nurses (Khongsamai and Intarakamhang, 2020). Both studies suggest that nurses should improve their knowledge and awareness of giving care to patients within cultural diversity.

Different multicultural and religious perspectives often cause misunderstandings of behaviors related to health problems or health beliefs, especially in older people with complex health issues. If health professionals, including nurses, lack basic knowledge and skills to communicate with their clients with differing cultural perspectives, it may bring harm to the patients. Hence, cultural competency is necessary for nurses (Julawong et al., 2019). Understanding one's socio-cultural context is essential for nurses, so that they could provide care to homebound older people and promote their holistic health based on their beliefs, values, and cultural factors.

Ethnographic Study

More research is needed to identify how older people perceive and participate in cultural care. Although many health care programs have been developed and implemented to prevent falls among older people, the majority of the studies report no statistically significant long-term outcomes. The interventions implemented in real-life situations might not fit with the lifestyle of the participants in their socio-cultural context; thus, they might not continue the activities after the researchers finish their work.

Regarding Leininger's (2006) concept of cultural care, qualitative research methods must be performed to gain cultural information of the research setting. The philosophic underpinning of ethnography is interpretivist, as described by Schwandt (1994). The interpretivist approach through psychological or cultural sciences is different than in natural sciences. The interpretivist approach focuses on the meaning of social phenomena. Humans try to understand the real world where they live and work and develop subjective meaning through language and actions (Creswell, 2007). The interpretive and descriptive approach is derived from human sciences and Greek social anthropology which has documented how to understand people from their cultures (Holloway & Wheeler, 2010). Social scientists conduct their studies in the real world—which is more or less an abstract representation—and explore the relationships between the world views and context of humans (Porta & Keating, 2008).

The ontology of ethnographic study has been developed as a field of anthropology which describes cultural groups to determine cultural perspectives, cultural differences, and to identify cultural patterns of beliefs and behaviors. The

assumptions are proposed based on the nature of social reality in terms of relationships between individuals and through interactions of groups. Ontological assumptions are concerned with what we believe and what constitutes social reality (Chesnay, 2015). This can be applied to a cultural perspective of fall prevention and home rehabilitation of the homebound elderly. The epistemology of ethnography is a way of knowing through exploring the symbols, rituals and traditions of a particular culture or group (Parse, 2001). Ethnography is the meaning that individuals apply to their way of life or patterns through groups. Leininger describes ethnography as a way of discovering, knowing, and determining knowledge of people in order to maintain their health status.

There are four major types of ethnographic studies: 1) classical ethnography, 2) systematic ethnography, 3) interpretive or hermeneutic ethnography, and 4) critical ethnography (Speziale & Carpenter, 2003). The research designs in anthropology have been adopted by sociologists, educators, nurses, and others who are interested in culture and social interactions of groups. Focused ethnography, one of classical ethnography's approaches, aims to describe a problem focusing on a specific context study. Focused ethnography is a way to assess and answer a researcher's questions rapidly and intently. Research questions will be used to delimitate an investigation and understanding of background knowledge of the study. Participants in the study are knowledgeable and experienced about the matters which the researcher would like to learn (Higginbottom, 2013). According to Speziale and Carpenter (2003), ethnography is categorized into two main types: macro-ethnography, which is developed to study broad cultural questions, and micro-ethnography, also known as focused ethnography, which is concerned about narrow cultural facets in order to gain

a better understanding of the experiences of a sub-culture in a specific setting so as to describe the culture by learning from individuals' ways of life and being (Higginbottom, 2013). Therefore, focused ethnography is a time-limited method for nurses to understand their patients through their culture and social construct with their specific health issues (Spider, 2010).

Focused ethnography is applied to carry out research projects in order to understand the social and cultural meanings of a particular, rather than a general area (Knoblauch, 2005). Graham and Connelly (2013) have developed their study in order to understand values, beliefs, and behaviors related to exercise as self-care among older adults in rural communities. Through focused ethnography, researchers have gained rich information from their informants that helped them understand the beliefs, values, and behaviors of older adults in rural areas. The findings of the study based on focused ethnography provided a contextual example of why physiotherapists must understand what self-care activities older clients enjoy and have done previously and how these specific outcomes could be applied to develop the appropriate exercise programs for the population. Older adults' perceptions regarding falls were revealed through focused ethnography. The research project was developed within the family context. The study focused on three main themes: risk-free daily living, common sense, and other-focused risk reduction advice related to falls within a family context that could also be generated in broader ways (Kilian et al., 2008).

Focused ethnography is also used to explore the social context and culture of key informants who are involved with care of older people. Gustafsson et al. (2013) explored nurses' experiences of case manager's work in the daily care of older people. Through focused ethnography, the experiences and work of ten case managers (CM)

for older people with multi-morbidity were explored by several methods of data collection: participant observation with field notes, group interviews, and individual interviews. It was found that the case managers experienced daily challenges to their current professional identity. These outcomes could encourage the development of case manager interventions that fit with older patients who have complex health needs. Nurses' experience of caring for older people in the emergency department was studied through focused ethnography (n=7). The information from the participants helped researchers understand the culture of the emergency and nurses provided beneficial information between the elderly patient and the emergency department. Specific outcomes revealed both appropriate and inappropriate situations in the emergency department. These outcomes could guide health professionals to manage the emergency department more effectively (Taylor, Rush, and Robinson., 2015).

Kilian et al. (2008) used the focused ethnographic method to examine how older adults and their adult children perceived the risk of falling. Three main themes were: 1) participants claimed the risk of falls never occurred in their daily living, as they did everything they could do to prevent it; 2) participants claimed that common sense could decrease the risk of falls in daily living; 3) participants claimed that external factors caused them to fall and they were not to blame. Another study based on the ethnographic method explored beliefs, values, and behavior related to exercise as self-care of older adults in rural community-dwellings. A total of 17 participants stated that exercise was movement and not self-care behavior. Through focused ethnography, the older people's perception regarding fall and fall prevention were shown. Thus, further study must explore the data further.

A focused ethnographic approach will be used to carry out this research project. Following this method, the researchers will focus on the specific context of the homebound older people. This is an interpretive approach which allows in-depth, exploratory capture of data from both the emic and etic view of the informants and researchers (Chesnay, 2015; Holloway & Galvin, 2017; Higginbottom et al., 2013; Knoblauch, 2005). Therefore, the specific data of the homebound elderly living in a rural community will be captured through multiple methods of data collection such as participant observation with cultural immersion, semi-structured interviews, and documentary analysis.

Strategies to Involve the Informants

Gaining access to the informants is one of the concerns that an ethnographer might have. Two studies have explored strategies to involve the informants for qualitative study. Sheton and Hayter (2004) highlighted two problems in accessing the informants; 1) securing entry into the organizations, and 2) persuading individual informants. To access individual informants, researchers may seek for known people or gatekeepers able to introduce the researcher to the informants. The researcher then prolongs engagement in the field and seeks to immerse himself or herself in the community. The researchers try to ensure that there are no discrepancies with the informant's culture and prolonged engagement to gain acceptance. Researcher may secure in advance any data collection by wearing appropriate clothing, sharing the informants' interests and conversation, listening to their stories, using suitable language when in contact with them and discussing experiences and problems related to their lives. Other studies (Archibald, 2015; Holloway & Galvin, 2017) proposed

few benchmarks to estimate the number of informants in a study and strategies to involve them:

1. Initial informants screening, identifying eligible informants, and researcher identifying the inclusion criteria to recruit the informants.

2. Prolonged engagement: Spending time with the informants (e.g. individuals, their families, and their communities) and having a long-term engagement in the setting is necessary to gain more successful recruitment and to increase the quality of data. The consultation with their major advisors and health professionals before immersing themselves in the community is essential. Also, researchers will prepare their appearance, speech, and behavior in ways highly acceptable to the informants. They should also listen patiently and non-judgmentally to the participants' stories and use suitable language when discussing the stories that have relevance to the participants' lives.

3. Informed consent: the researcher will clearly describe important information to the informants, such as the aims of the study, the process of data collection and data analysis, the protection of the informants, and the informants' rights. All important information should be included in the informed consent form.

4. Determining the informant sample: sampling strategies will be developed; purposive sampling will be used to guide the researcher on how to recruit the key informants by using incursion criteria. Homebound older people who meet the incursion criteria will be invited to participate voluntarily. Since potential key informants with complex health problems such as chronic diseases, physical functional decline, geriatric syndrome might consist of newcomers, associate informants may be able to introduce them to the researchers.

In summary

As the older population is growing, the incidence of falls, chronic diseases, and other health problems in the elderly is increasing. The homebound elders are the second largest population group and most of them have physical function limitations, chronic diseases, and difficulty to carry out activities in daily living. The consequences of chronic diseases, such as a stroke, impact their quality of life and can lead to permanent disability and the state of being bedridden. Cultural care services related to their way of life need to be implemented so as to balance the body, mind, social life, and spirituality in the elderly population to achieve maximum well-being. Cultural Care Theory is an appropriate way to guide nurses and other health professionals in developing suitable care programs related to the culture of the specific population. The Leininger's Sunrise Model (2006) provides guidance to help researchers apply the cultural care theory into their research. Focused ethnography will be further developed to generate the knowledge.

CHAPTER 3

METHODOLOGY

This chapter describes the research methodology that was used for this study. The topics of the methodological components are as follows: research design, research setting and context, preliminary study, informants, ethical considerations, data collection instruments, data collection processes, data collection methods, data analysis processes, and trustworthiness of the results.

Research Design

To understand the context of the homebound older people, a focused ethnography was conducted to obtain the data in a specific social milieu and gain a fuller understanding of the context. As part of classical ethnography, the focused ethnography approach is appropriate to capture the data of cultural and social constructs of focused participants and their families, and thus to understand their context within the broader culture. Through the focused ethnography, researchers are able to understand the specific phenomena of a specific group in the field (Daach-Hirsch and Gamboa, 2010; Higginbottom, 2013; Kilian et al., 2008). In order to explore emic views of the homebound older people regarding the cultural care which could maintain their holistic health, the researcher used focused ethnography to explore, analyze, and explain the ways of life of the homebound older people in terms of maintaining holistic health from their viewpoint, cultural beliefs, social behavior, and practice. Through a focused ethnographic study (Higginbottom, 2013), the researcher was able to gain insight as to how the homebound older people perceived

cultural care within the research setting. The homebound older people were observed and interviewed, as well as their family members.

Research Setting and Context

This ethnographic study was carried out in the Khiriratnikhom district of the Surattani province in Southern Thailand. Covering the area of about 812.3 square kilometers, Khiriratnikhom is located to the west of the Surattani town and approximately 660 kilometers from Bangkok. Khiriratnikhom consists of 8 sub-districts: Takhanon, Banyang, Namhak, Kapea, Takradan, Yanyaw, Tamsingkhorn, and Bantamnuitb, with a total of 84 villages (Figure 1). The population stands at 41,840 inhabitants with 20,971 males and 20,839 females. In 2016, the population of older people was 6,020 inhabitants, with 175 homebound and 70 bedridden inhabitants (Khiriratnikhom hospital, 2017).

Khiriratnikhom was an appropriate area for this study because it received two awards for aging care from the Department of Medicine Services, Ministry of Public Health, Thailand, in 2015 and 2016. However, at that time, the health care services focused on socially restricted older people with dementia who received care packages in accordance with the long-term care policy of the Thai government. The long-term care services consisted of home health care and home visits. Home health care was performed by care managers and care givers who had been trained for that purpose; moreover, in specific cases, physiotherapists and other health professionals had been invited to provide health care. The Department of Medical Services supported the health care services for older people at Khiriratnikhom by providing financial, material, and academic support. Since the number of homebound older

people had sharply increased to 145 in 2010 and 195 in 2017, a rehabilitation medicine center was set up in 2010 to provide effective health care services to older people. However, the health care services were implemented for general older people and did not focus on homebound older people. To bridge the gap and extend the role of nursing, we should explore the cultural care whose aim is to maintain holistic health in this setting.

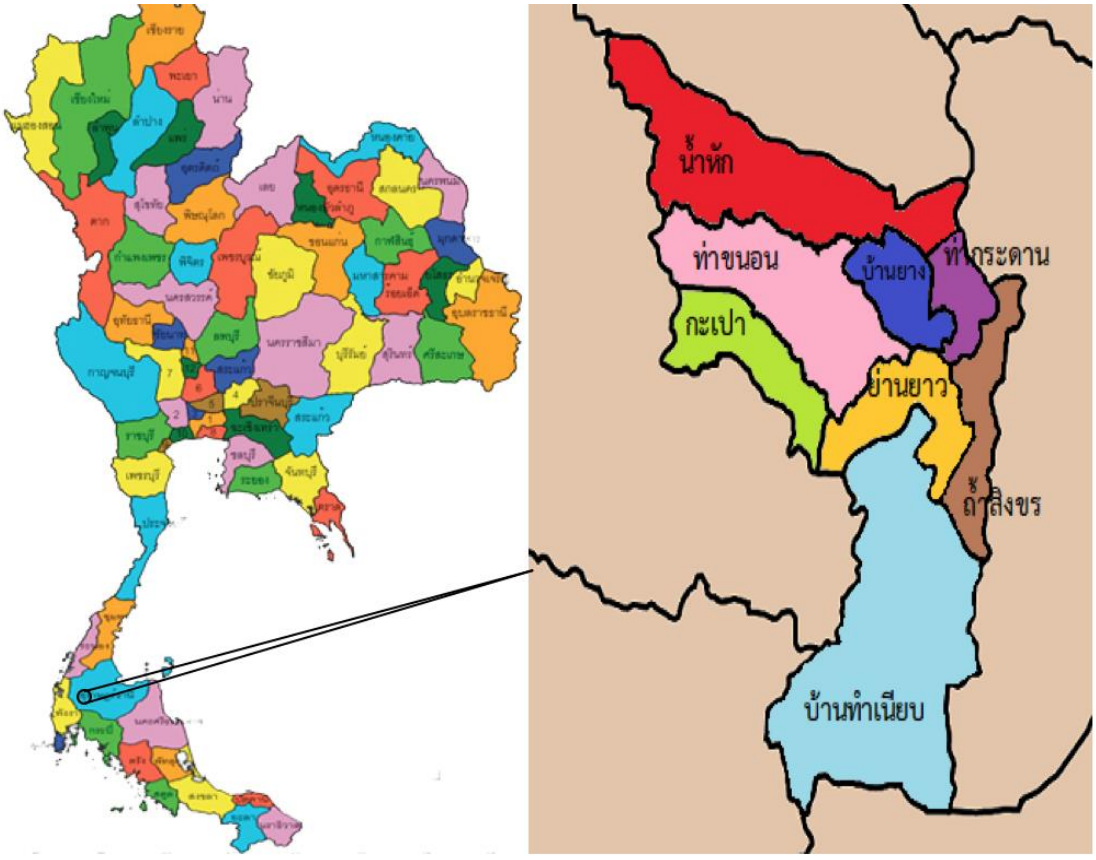

Figure 1 Map of Thailand and Khiriratnikhom district

(Source: https://sites.google.com/site/thailand1548145533/prathesthiy-77-canghwad)

Preliminary Study

In February 2017, the researcher conducted a preliminary study at Tamsingkhorn sub-district of the Khiriratnikhom district, using multiple methods to collect and analyze the data such as semi-structured interview guidelines, observation guidelines, and field notes. The dual purpose of the preliminary study was to develop a situation analysis and provide knowledge on conducting interviews based on the semi-structured interview guidelines, observation guidelines, and field notes including data analysis. Before conducting the semi-structured interview, the researcher submitted the semi-structured interview guidelines to the major advisor and revised them according to the major advisor's suggestions. The researcher then trained herself by reading and re-reading the semi-structured interview guidelines to understand the wording and follow the guidelines questions. The researcher conducted the preliminary study by interviewing a homebound older male and his wife.

The setting was selected based on the aims of this preliminary study. Firstly, Khiriratnikhom district, as one of the largest areas in the Suratthani province, has a physical medicine and rehabilitation center for aging, set up with community participation. Multidisciplinary health professionals—nurses, physiotherapists, and Thai traditional medicine practitioners—have been working together to provide effective care to older individuals in the community. Moreover, health village volunteers and local government personnel participate in the health care services in this locality. A fall clinic is set up every Tuesday morning to support older people who are at the risk of falling. Secondly, the researcher had a chance to practice an in-depth interview and observation that helped her improve her skills in data collection and analysis. During the interview, the researcher conducted the semi-structured

interview without the relevant guideline. However, the researcher read the semi-structured interview guideline before completing the interview to ensure that she had asked all the questions properly. Having finished the semi-structured interview and observation, the researcher went back home and immediately wrote down her field notes. The data from this semi-structured interview was transcribed and the researcher read the transcription line by line and listened to it many times. The researcher then started the data analysis which included four steps recommended by Leininger (2006).

The steps were as follows: 1) collecting, describing, and documenting; 2) identification and categorization of descriptors and components; 3) pattern and contextual analysis; and 4) the major themes, research findings, and theoretical formulations. Moreover, the semi-structured interview guidelines, observation guidelines, and field notes helped the researcher in the methodological triangulation of this study.

Informants

The informants invited to participate in the study consisted of key informants and associated informants. According to Leininger (2006), key informants are the major sources of information in data collection, while associated informants refer to people who usually join the care activities of the key informants. Initially, the key informants were selected based on purposive sampling and assessed based on a Barthel Index score, as defined by the National Health Security Office (NHSO) (2016) to identify performance in activities of daily living. Those were the homebound older people who had a Bethel index score between 5-11. They were recruited according to the following inclusion criteria: 1) being healthy based on their

latest health record and having no complex health problems such as chronic diseases or geriatric syndrome; 2) having been treated and having their current health problems under control; and 3) being able to speak and understand Thai or southern Thai. Finally, sixteen homebound older people were invited to participate in the study.

The majority of the associated informants were family caregivers recommended by or referred to by the key informants. Healthcare providers, community leaders, health village volunteers, and a folk doctor were also recruited as associated informants with a snowball sampling from the key informants and family caregivers. Twenty-three associated informants were invited to participated in the study.

All informants (Sixteen key informants and twenty three associated informants) were invited to attend a briefing which explained the purpose of the study. The number of key and associate informants was determined by data saturation (Lincoln & Guba, 1985). The data was considered as saturated when no new information had been gained.

Ethical Consideration

Before conducting the study, the researcher had obtained permission for the involvement of participants from the Institutional Research Board Committee, Faculty of Nursing, Prince of Songkla University. The participants received a complete explanation and written description of the study's objectives, research methods, and potential risks and benefits for the participants. Most of them participated in the study until the data collection, data analysis, and trustworthiness phase were completed. Both verbal and written informed consents were obtained from each informant before

the interviews. The informants with limited literacy were asked to stamp their thumb instead of signing. Initially, the researcher asked for written informed consent from key and associated informants (see Appendix J). Most of those with limited writing ability were asked to use a fingerprint instead. As the researcher had lived in the research setting until becoming a community member, only a verbal informed consent was obtained from some informants who had limited writing capacity and preferred giving their verbal consent as a result of trust and familiarity between the researcher and informants. The majority of the informants participating in the study gave a verbal consent.

Data Collection Instruments

Several instruments were used in this study: the researcher, interview guide, observation guide, focused group discussion guide, field-note taking form, camera, audiotape recorder, and researcher diary.

The researcher

The researcher is the most important research tool in a focused ethnographic study. The researcher's self-awareness was essential not only for developing a schedule of data collection but also for determining the data to be obtained and the best way to do so. The researcher recognized several times that both verbal and non-verbal contexts of informants should be recorded. Through social interaction, the researcher had the chance to learn people's culture, observe their behavior, listen to their comments, ask questions, collect artifacts, and document the data. By this cultural immersion over an extended period of time, together with the data analysis

and writing the story (Hollway & Galvin, 2017S; peziale & Carpenter, 2003), the researcher could gain substantial information about the culture.

Based on the researcher's background—she was born and raised in Southern Thai culture in the Surattani province—the researcher was familiar with the setting and language used by the informants. Also, the researcher was a community nurse who had been working in the community for a long time, which was helpful in establishing good relationships with all informants. However, to reduce the researcher's bias of familiarity in terms of health care services for older people and long-term care services, the researcher was trained to look for, listen to, and learn about activities, processes, stakeholders, and community participation. The researcher faced with the high expectations of the key informants and their family members who always asked for a nurse's advice related to their health. The researcher tried to avoid answering their questions and asked them to describe their health or reflect instead. Moreover, the researcher had been studying the process of ethnographic study from textbooks, related articles, experts, and direct experience, to improve her personal skills of applied ethnography. The researcher was also involved in the participatory action research developed by the Research Center at the Faculty of Nursing, Prince of Songkla University, whose goal was to establish a care system for Thai elderly population. The research project aimed at developing a care model to support the aged population in Hat Yai city. In this case, the researcher directly practiced several aspects of the study methodology: interview, observation, field notes in data collection, data analysis, and report of the findings. Having gained experience in qualitative methods, the researcher felt more confident and was able to apply her skill in a focused ethnographic study.

Interview guide

A sociodemographic information form was included in the interview guide for the purpose of gaining primary information about the participants' characteristics. The researchers developed a semi-structured interview guide based on the literature review and Leininger's cultural care theory (Leininger, 2006). The question examples were: "What is the meaning or understanding of holistic health?" or "What is your opinion about holistic health at your age?" (see Appendix C, D). Initially, the information about holistic health was difficult to get from the informants. The researcher asked the informants to describe what holistic health meant for them; they still could not understand. The researcher then looked for the local term in the Southern Thai language related to holistic health. The local equivalent of holistic health "Bai Lod" was elicited from the community members. From then on, the researcher used the term "Bai Lod" to ask the informants to describe the meaning of holistic health. As the interview guideline was conducted, the researcher added open-ended questions in the local language to the guide in order to gain the informants' viewpoints. Moreover, the researcher was aware of the complexity of medical terms when asking the interview questions and thus she always looked for simple sentences so that the informants could easily understand her questions.

Observation guide

Three types of observations were conducted to gain the information from the informants: descriptive observation, focused observation, and selective observation (Spradley, 1980); for example, "activities of daily living or other activities such as exercises performed to maintain holistic health of homebound older people" or "frequency of each activity performed to maintain holistic health in the daily lives of

the homebound older people" (see Appendix E). In the initial stage the study, descriptive observation was used to gain general data about the situation. Focused observation was used to collect the data about a particular issue that may come up in the data analysis. For example, what activities do the key informants perform during the day to maintain their holistic health? The researcher used selective observation (see more detail in data collection process) after part of the data analysis had gained more data, so that she could broaden her understanding of the particular situation or important issues in a particular phenomenon. For example, the researcher observed what activities of daily living the key informants performed from the morning until they went to bed in the evening. The researcher asked for their permission to stay in their home overnight and gain more profound information. Moreover, the researcher joined them while they exercised, had breakfast, and worked at the vegetable farm near their home.

Focused group discussion guide

The focused group discussion guide related to the purpose of the study and research questions also followed Leininger's theory (Leininger, 2006). The questions were similar to the semi-structured interview guide. For example: "What do you think about holistic care?" or "How do you provide holistic care for the homebound older people in your community?" or "What is your opinion about cultural care?" (see Appendix F)

Field note-taking form

A field note-taking form (see Appendix G, H) was developed to capture the data about the informants, including what the researcher heard, saw, thought, and experienced in particular situations. Moreover, the researchers reflected on the ideas

related to a particular situation and wrote them down immediately or soon after leaving the setting. The researcher took field notes every day and often used them when she could not take a photo. For example, the researcher described the details of each activity the key informants performed during the day and night, and reflected on them by asking herself: Why did they do it in that way? What beliefs and values led them to perform the activities? The researcher then continued the observation and conducted the semi-structured interview to gain the answers.

Camera

A camera was used to capture the informants' homes, events they attended, exercises, activities related to maintaining their holistic health, general environment, and objects which provide meaningful data such as the furniture layout. The researcher took pictures only with the informants' permission. In this study, the informants did not allow taking photos while they performed their daily routines (bathing, dressing, and eating) and during exercises when they were unable to walk smoothly. However, they allowed taking photos when they felt good (talking with their friends and others, working at their farms, and making merit).

Audiotape recorder

An audiotape recorder was used with the informants' permission to record interviews in order to capture the data completely and accurately. The researcher asked for permission from the informants to use the audiotape recorder before performing semi-structured interview. Most informants allowed using the recorder.

Researcher diary

The researcher developed a diary to record the personal ideas, self-preparation, planning of data collection day by day, and mistake and further improvement during data collection, etc.

Data Collection Processes

The data collection consisted of three phases: 1) getting access to the informants, 2) exposing researcher values, and 3) leaving the field as described below:

Getting access to the informants

To enter the research setting and informants, the researcher participated in specific unit of older people and long-term care services of the Kiriratnikhom hospital. In this step, the researcher became familiar with the clients and took care of homebound older people who came from the Bantamnuitb subdistrict and talked with their family caregivers. Moreover, the researcher joined the long-term care services of the hospital. In this regard, the case manager (nurse) introduced the researcher to a nurse and health village volunteers at the Bantamnuitb subdistrict health promotion hospital. The researcher then joined the long-term care services of the healthcare center in order to understand general context and the situation related to older people care. During this step, the researcher studied the secondary data of the older people from electronic health data of the subdistrict health promotion hospital (JSCIS) and Health data center (HDC). The researcher accompanied the nurse and health village volunteers during a visit to the community (one such example being a visit to a temple) and community leaders to become familiar with the people in the specific

research setting. A mutual trust was developed among the researcher, key informants, and other people in the community.

The homebound older people who met the inclusion criteria were invited to participate in the research project. The researcher started with the homebound older people who had been introduced by a nurse working at the health promotion hospital. The researcher continued developing the relationship with the key informant and their family members by staying with them days and nights or attending some events with them as part of prolonged engagement. Other key informants and associated informants were referred by the homebound older people. The researcher had a long-term engagement for seven months in the setting to secure a more successful recruitment and increase the quality of the data. The researcher always had discussions with the major advisor during the data collection. The researcher also prepared her appearance, speech, and behavior so as to be acceptable to the informants. She listened patiently and non-judgmentally to the participants' stories and used the Thai southern language when discussed the stories that had relevance to the informants' lives.

Exposing researcher values

Throughout the duration of this study, the researcher always evaluated her self-expectations and personal opinions that may have influenced the data from the field. For example, as the researcher was familiar with the long-term care services of the Thai government, she could have ignored important details of the long-term care services that the homebound older people received from the health professionals and health village volunteers from the community. The researcher empathized with the informants and was occasionally biased towards the healthcare providers. Having

recognized such thoughts, the researcher reflected on these preconceptions and discussed them with her advisor several times. During the data collection and data analysis, the researcher met her advisor twice a month to report on both processes and receive feedback.

Leaving the field

Gradually, the researcher initiated the process of leaving the field. The researcher informed all informants in advance when sufficient data was reached or when the researcher had to stop the data collection. However, the researcher stayed in contact with the informants via the internet, phone, and Facebook to clarify any unclear data. Likewise, the informants could consult the researcher about their health and illness. The relationship between the researcher and informants continued after the researcher had left the field.

Data collection Methods

The researcher used four methods of data collection: 1) observation (participant and non-participant); 2) semi-structured interviews; 3) field note-taking; 4) focus group discussion.

1. Observation

1.1 Non-participant observation

Non-participant observation was used to capture general information from the key and associated informants. The researcher had conducted a non-participant observation at the beginning of the data collection before participant observation was implemented and during the data collection concurrent with the interview.

1.2 Participant observation

Participant observation is one of the main methods of data collection in an ethnography. Participant observation was used during the in-depth interviews (Holloway and Galvin, 2017). Three types of participant observation were completed: a) descriptive, b) focused, and c) selective observation (Spradley, 1980).

a) The researcher performed descriptive observation upon entering the research setting. She stayed at the informants' homes to observe their daily activities and also to participate in them. She joined the family activities of the key informants in order to capture the common experiences of the homebound older people and other informants. The researcher also participated in several events with the key informants and their family members to capture what occurred in their context, focusing on the place, actors, and activities. The researcher also joined the activities that the key informants always performed to maintain their holistic health, such as exercises, rehabilitation, making merit, and working at their farms. The researcher took photos and field notes.

b) The researcher conducted focused observation to gain information about the cultural issues related to the key informants' way of life and their efforts to maintaining holistic health. The issues came up especially during the data analysis of the descriptive observation. The researcher returned to the field to capture the required data and revisited the informants when they participated in the relevant activities.

c) After the data analysis and repeated observation, the researcher conducted selective observation to gain more data related to the situations that seemed particularly important. The researcher visited the informants again to participate in the

activities with them and gain more data, so that she could understand the phenomena from study such as, exercising early in the morning and relationship with others during the exercise, visiting friends and relatives, and working at farms.

2. Semi-structured interviews

Semi-structured interviews were conducted when the researcher and informants knew each other better and established mutual trust and camaraderie. The key informants and associated informants were interviewed using the interview guide developed from the literature review. Having established a good relationship with the informants, the researcher conducted the first interview. The informants were allowed to choose convenient time and place, and the interviews were recorded. Most interviews at home lasted 30-45 minutes. The interviews resembled a friendly conversation, with the guide being used to prevent missing important aspects. A folk healer living in a nearby community was also invited to participate in the interview, as he was recommended by a key informant. The oldest key informant (K6, 96 years old) with a hearing limitation was invited to join the semi-structured interview. The researcher asked her daughter-in-law to repeat some words or questions that the key informants and the researcher could not understand.

3. Field note-taking

Field notes were taken during participant observation and semi-structured interviews. The researcher used field notes to record the environmental factors, nonverbal communication, and interaction between the homebound older people and others. Additionally, the researcher recorded her key observations with explanations after leaving the field, as recommended by Spradley (Spradley, 1980).

4. Focus group discussions

A focus group was held at Kiriratnikhom hospital. Three health professionals were invited to participate in the activities—a nurse, a Thai traditional healer, and a physiotherapist—as they had no more time to participate in semi-structured interviews. All health professionals were invited to join the focused group discussion, which was held three times, each one lasting 45-60 minutes. An audiotape recorder was used to record the conversation. The researcher asked the other health workers to take photos during the focus group.

Data Analysis Processes

The researcher undertook the four steps of data analysis recommended by Leininger (2006) to analyze the qualitative data from the field:

First phase

Collecting, describing, and documenting raw data

In this phase, the participants' comments were transcribed verbatim immediately after the semi-structured interviews and focused group discussion. The researcher re-read the transcripts line by line and listened to the recording many times. The researcher then developed a template for data analysis which included a memo sheet and coding units using Excel software. All the data from several sources (i.e., field notes and observation recording forms, and verbatim transcription of semi-structured interview and focus group discussions) were incorporated into the coding units of the template. The researcher read the data several times to make sure that it completely retained the perspectives of the informants considering the research questions and objectives of the study.

Second phase

Identification and categorization of descriptors and components

The researcher developed open coding by staying close to the data. The researcher coded the data based on the research questions and objectives of the study. She removed the redundant codes, while the ones relevant to the research questions were retained. The codes were then compared according to their similarities and differences. The relevant verbatim transcripts and data from the field notes and observation record were translated from Thai to English, which was hard and time-consuming, as the local Thai language was region-specific. To verify the accuracy and context of the terms or phases, the researcher asked the major advisor (who was a Southern Thai person) and a proofreader (who was a Southern Thai English teacher) to translate many transcripts from Southern Thai to English.

Third phase

Pattern and contextual analysis

In this phase, all data were considered to reach the saturation of ideas and identify recurrent patterns of similar or different meanings, expressions, structural forms, interpretation, and explanation of the data related to the cultural care for homebound older people whose aim was to maintain holistic health. The data were examined to present the patterning with respect to the context. The researcher confirmed the preliminary results with the informants to ensure that the results deriving from the interpretation represented their views. The researcher developed contextual meanings by describing the data from the observations that occurred during the data collection, which included the meanings of the data.

Fourth phase (Last phase)

The major themes, research findings, theoretical formulations

In the latest phase of data analysis, the researcher developed synthesis and interpretation. The researcher abstracted, identified, and presented the main themes from the patterns emerging from the data related to the cultural care which maintained holistic health among homebound older people, including the meanings of holistic health, holistic practices among homebound older people, together with specific health services and factors related to promoting holistic health of homebound older people.

Trustworthiness of the Results.

The rigor of the study was ensured following the trustworthiness criteria developed by Lincoln and Guba (1985), including credibility, confirmability, and transferability.

Credibility

The researcher achieved credibility by prolong engagement in the field for seven months and member checking, clarifying the research findings with the informants. In addition, the researcher used method triangulation based on three different methods of data collection (i.e., semi-structured interview, focus group discussion, and observation) and data triangulation with three types of participants (i.e., key informant homebound older people, family caregivers, and health professionals) to ensure the credibility of the results.

Confirmability and dependability

In order to maintain confirmability and dependability, the researcher kept the audit trail. For this process, the researcher clearly described the methodological processes of the study. Raw data were systematically recorded and noted. Audiotape recordings, transcripts, and data analysis products were arranged and sorted. The field notes and researcher reflection were recorded on regular basis. The research supervisors verified all steps of the data collection and data analysis.

Transferability

Transferability was presented with the clear description of the similar views, experiences and beliefs of the older people on holistic health along with their context, culture, and the situation. Reflexivity was also maintained using the research diary. Finally, every step of the research process, questions, commentaries, and stories were documented for the purpose of understanding the findings further.

In summary

The focused ethnographic method was employed throughout the entire process. The data were collected from the homebound older people at the research setting by using multiple methods. The purposive sampling method was employed to include several informants such as homebound older people, family caregivers, healers, and nurses. The research instruments included a researcher, an interview guide, an observation guide, and a field note-taking form. An audiotape recorder and a camera were also used during the data collection. The analysis and trustworthiness were performed in the field to gain the rich findings, which are presented in the next chapter.

CHAPTER 4

FINDINGS AND DISCUSSION

This chapter presents the research findings and discussion related to the ways of life of the homebound older people in which they can maintain holistic health. The findings are divided into three parts; 1) general context of the older people who live in a rural community setting; 2) demographics of informants; 3) ways of life in maintaining holistic health of homebound older people which included the meanings of holistic health, holistic health practices, health, and social care services for promoting holistic health of the homebound older people, and factors related to promoting holistic health of the homebound older people.

1. General Context of the Older People who Lived in Rural Community Setting

The research setting of this study was a small sub-district in the West of Kiriratnikom district, Suratthani province, and in the South of Thailand. The Khiratnihkom consisted of eight sub-districts: Tha Khanon, Ban Yang, Nam Hak, Kapao, Tha Kradan, Yan Yao, Tham Singkhon, and Ban Thamnaip. In the past, it was difficult to go to Khiratnihkom because it did not have a public transportation system and people had difficulties communicating with other people at other places. More than half of the population of Khiratnihkom had immigrated from other provinces such as Nakhonsrithammarat and Pathalung. Although the population of the community consisted of people from multicultural backgrounds, the majority of them were Buddhist.

Most people in the community came from other provinces; however, they were in unity. Since 1975, the people from Nakhonsrithammarat and Pathalung migrated to live in the community because they would like to look for arable land. They heard about the fertile terrain of the community that suitable for agriculture; since then, they came to live in the community. At that time, several places in Thailand faced political problems because of the infiltration of the Communist Party of Thailand in the Kiriratnikom district. Moreover, the Kiriratnikom district was surrounded by the forest and mutants that caused difficulty of communication and transportation. Because of those difficulties, those immigrants were united, had closed relationship, and support each other. They lived together as a big family and relative and on community development. They cooperated in community activities, by donating their arable land to build some local streets for their transportation. Moreover, some places were built for community development such as temples and schools.

After that, the community had good transportation and communication, the majority of people in the community encouraged their children to study outside the community in order to bring new knowledge back to develop their home. Most of them had learned how to improve community plans and further development and shift their thought to focus on human development. Because of the idea, there were a lot of new generations of community members graduated with higher levels of education, such as bachelor, master, and doctoral degrees and they came back to develop their own community, such as establish new farm using new technology for better agriculture product. This helped the improvement of the quality of life of their parents. Older people often considered themselves that their land and information

were proved to be helpful for the younger generation and the young also brought some new technology to help as a shared contribution. This is the strength of the community that different from many places and led to community development and community strengthening.

The Khiratnihkom was surrounded by an abundance of nature, including forests, mountains, and beautiful traveling destinations. The majority of community people worked on rubber farms, palm oil farms, and fruit farms. Most of them had a good economic status and completed primary school while the new generations were able to obtain a Bachelor degree and or higher. At the Ban Thamnaip sub-district, the topography and climate were the same as in another sub-district of Khiratnihkom. There were 5,000 people: 1,399 were older people, including 1,353 socials bound, 34 homebound, and 12 bedridden older people. The number of elders in the Ban Thamnaip sub-district accounted for 15% of those who belonged to the aging society. The majority of people, including the older people community, had always lived with their children or close to them. They usually exercised on the street in their communities, which most of the locals used as a sports ground because there were not many places for exercising. Every morning, many people did several types of exercise such as running, riding a bicycle, and walking. They also did group exercises such as Ram Mai Plong (traditional or local exercise) and aerobic in community-supported places with sports equipment.

Surrounded by nature, they exercised on the streets of their local communities. While exercising, they could also talk and share their experiences with each other, forming close and friendly relationships. As for the homebound older people, they could not join others on the street; however, they still exercised by walking in front of

their homes and talked with other people on the street. In addition, having finished exercising, people gathered together at tea houses and soft-boiled rice shops. There they could eat together, drink tea or coffee and talk to each other. Some homebound older people were also able to do these activities at tea shops, which helped them connect with people in their community.

In the research setting, people had a close and friendly relationship. Not only they lived in the same area or in groups, but they also did several activities in their community and supported each other. Their houses were surrounded by rubber farms, palm oil farms, fruit farms, and vegetable farms. In this regard, the people's lifestyle can be categorized into three types based on their living patterns:1) family members lived together in the same house as a large family which included several generations (extended family); 2) the elderly (parents) lived with their spouses, whereas their children lived nearby (living in a couple); and 3) the homebound older people lived alone after their spouse's death (living alone), but received support from their relatives who lived nearby.

In the community, the sub-district health promotion hospital had a leading role in providing health care services to patients with chronic diseases and people who were at risk of falling ill. For patients with chronic diseases, health professionals provided home healthcare services to prevent complications and control the diseases through health assessment, health care depending on health problems, and health information. Meanwhile, people and the older people who were in chronic disease risk groups with a chronic disease received health behavior modification and health information. Thus, they could be protected from the disease. The health care services influenced the health behavior, beliefs, and values of the homebound older people

regarding chronic illnesses. Therefore, most of the people, including the homebound elderly, were informed about diseases and the control of health conditions. In case of emergency, people could access emergency services by dialing the emergency number 1669.

The older people often relied on the principles of sufficiency economy which guided them in daily life. They owned arable land, separated into several sections, covering rubber farms, palm oil farms, fruit farms, vegetable farms, and the living areas. The farms were major sources of their income. The products of their farms provide them a secured and stable income. Surrounded by vegetable farms, they planted a lot of vegetables so as to secure their meals. If they could not eat them all, they sold the vegetables at the local flea markets and other markets in Phuket or Phangnga Provinces. Moreover, most of the people in the community were able to support themselves — they could see a doctor for a follow-up on time, exercise, and rehabilitate at their home, depending on their health status. The biggest strength of the community that we have chosen for our research setting was their ability to support themselves, the ability also known as the “Community strengthening”.

The community also encouraged its members to produce agricultural products without chemicals from their farms — One Tambon One Product (OTOP) to share in their community and to sell so as to promote their local tourism as well. They used organic fertilizers that they had fermented themselves to fertilize their vegetables and trees. Such lifestyles were passed on from generation to generation, resulting in the community living well without debt. Most elders in the setting had their own income and savings from their own farms. The heritage farms and savings would transfer to the main family caregiver after they died.

2. Demographics of Informants

2.1 Demographics of key informants (K1 to K16)

Sixteen homebound older people who met the inclusion criteria were invited to be the key informants for this study. Six of them were male and ten were female. All of them were Buddhists homebound older people who were still healthy and able to control health conditions. Their ages ranged from 76 to 99 years old with the mean age of 84.38 (SD= 6.10). All of them were married. Nine of them still lived in couples and seven were widows and widowers. Eight key informants (equal number of males and females) had a formal education at grade 4, while eight of them (six females and two males) were uneducated. Eight of them had hypertension, seven of which were stroke survivals. Five of them had other chronic diseases, such as gallstone, heart disease, asthma, osteoarthritis, and gout. Three of them did not have any chronic disease. Nine of them lived with their children and three of them lived at their home as a couple and four lived alone.

Although some of them lived alone, their children were living nearby. Their children usually came to visit and support them by encouraging them to perform their daily activities, such as making their homes a safe environment by adding handrails inside, cooking, and taking them to doctor appointments. Moreover, their children supported them by taking them to social gatherings, such as making merit at local temples, meeting for exercise, visiting at a tea shop every morning, and visiting relatives. All of them earned income from their farms. They lived based on sufficient economic disciplines and self-reliance. They taught their children to manage resources by maximizing the benefits, such as consuming products from their own

farms, dividing arable land into two parts to grow main and secondary crops, and consuming self-produced agricultural products without chemical contamination.

Prior to living in homebound older people conditions, all key informants had been social-bound older people. The majority of them worked hard at their farms and performed several social and religious activities. The key informants had their own farms that were a major source of their income. They prepared themselves for being old by saving money to support themselves. Despite giving a lot of farms to their children, they still kept some of their farms as personal; so, they could earn money and support themselves. In terms of health status, the majority of key informants always kept moving. So, they can work and exercise to maintain their functional ability. Moreover, the key informants performed social activities to maintain their relationship with their friends and relatives. The key informants also attended religious ceremonies to take care of their mental health. The majority of key informants had prepared themselves before becoming the homebound older people while a lot of them had not prepared themselves before entering homebound older people, especially in terms of their own income and health status. However, they were able to adapt themselves to the changes around them and live a happy life.

2.2 Demographics of associated informants (A1-A16, P, T, N, CM, CG, HV, CL, FD)

The associated informants who participated in the study were approached after key informants mentioned their names to the researcher. All associated informants were stakeholders who were engaged in the community's support for older people. These included fourteen family caregivers, four health professionals, two caregivers, a folk doctor, a health village volunteers, and a community leader. The majority of

family caregivers were female and were married, five were single and three were widowed or widowers. The health care professionals and others lived with their families alone. Eight of them had graduated from high school, seven graduated from primary school, and five had higher education. Most of the family members were agriculturists, whereas the health professionals were government employees. The family members earned income from their farms. The ages of associated informants ranged from 25 to 62 with the mean age of 48.57 (SD= 13.14).

The majority of associated informants who were family caregivers lived on the basis of sufficient economic disciplines as followed by their parents. They consumed the products from their own farm. They also focused on taking care of themselves and their family without a social burden. The family caregivers lived close to their parents and shared the responsibility to support them. In general, they did not ask for community support regarding health care services, public transport, and other social welfare because they were capable of supporting themselves and their families.

2.3 Key informants' family and living conditions

The personal and family background of the key informants could be categorized into three groups, depending on their living conditions: 1) extended family, 2) living in a couple, and 3) living alone (Observation: Field note extract) as described below:

2.3.1 Extended family

The term "extended family" referred to the family whose several generations lived together — parents and their children's families with grandchildren. In the research setting, nine key informants lived with their families. They had at least three generations of their family members living together — parents, their children

and a spouse, and a grandchild. The parents were respected by their family as the family head. The family members supported their parents in all aspects of their lives—physical, emotional, social, and spiritual. They tried to encourage the homebound older people to live a normal life, inspiring them to perform their daily activities themselves. The family members believed that everyone, including the homebound older people, would like to do personal activities and thus increase their self-esteem. Nine key informants lived in the extended family (in case K1, K2, K5, K6, K9, K10, K12, and K13) as described below:

K1

K1 was a 78-year-old homebound older person who was a stroke survivor. He lived at his home with his wife and two daughters. His son lived in Bangkok with his family — his wife with a daughter and a son. His son chatted with his mother and father on Line application every day and also came to stay with K1 every summer. K1 and other family members were happy to chat and stay with their grandchildren. His home was surrounded by fruit and rubber farms, and it was very close to his relatives' home. K1 lived with limited physical functions, as he could not walk by himself, perform daily activities, and work at the nearby vegetable farm smoothly. He had been a healthy person who had always worked hard at his rubber farms, palm oil farms, and fruit farms with his wife till he had a stroke in 2009.

At that time, his family tried to help K1 to improve his functional ability. They took him to see a doctor at several private clinics and a private hospital. Finally, thinking that he had not improved as he still had limited functions, they stopped seeking modern medicines to support K1. However, they still tried to look for ways to improve his functional ability in order to manage his daily activities. Using a walker,

he grew vegetables and herbs, and removed the grass. His family members helped him by modifying their home for the K1; they refurbished the bathroom, kitchen, and private retreat for that purpose. Both K1 and his family members believed that everyone would like to be a normal person and able to do things independently. Although K1 still had a limited physical function, he was still a healthy homebound older because he can take care of himself as much as he could. By doing this, he improved both his physical function and mental health.

According to his original belief and knowledge about herbs, he started to seriously learn which herbs were able to help him improve physical function and how herbs were able to help him. He sought information about herbs from his friends, neighborhoods, and relatives. Moreover, K1 could surf the internet on his smartphone in order to gain information on herbs, and every day he ate the herbs he had planted. Likewise, surfing the internet, he also gained information about exercise and rehabilitation that could help him improve his physical function. He followed the information regarding rehabilitation from the internet. Every day, he woke up early in the morning, exercised on his bed for around 1 hour, drank herbal drinks such as ginger juice, Bai-ya-nang juice, and bamboo juice, etc. He then showered and watched TV at a private retreat till 8.00 a.m. His daughter made breakfast for him. He always performed his daily activities, exercised, and ate on time because he believed that it was good for his health. By using a walker, he got the food from the kitchen, which was not far. He planted a lot of herbs around his home, he always ate and used herbs because he believed that herbs benefited his health. In the afternoon, he exercised again using a stretcher trolley although his wife, daughter, and a village

health volunteer wanted him to use the walker. However, he was happy to use the stretcher trolley because he was familiar with it.

Using Line application, K1 still maintained the relationship with others in the community, his old friends and relatives, and they came to visit him at home. He did not perform any community activities like when he had been young because of his limited physical function. He always communicated with others via Line application, and his old friend, the community members, and relatives always came to see him at his home, which made him happy. Moreover, health professionals also came to visit him for monitoring his health and giving him advice on rehabilitation. He and his daughter believed that herbs and modern medicine could be integrated to treat himself. Thus, he used both ways to maintain his health.

K2

K2 was a 93-year-old homebound older person who was a stroke survivor and lived with her family — her son, daughter-in-law, and grandchild. Her daughter's home was next to hers, together with her relatives' house and a rubber farm. Her daughter was her major caregiver and her son also took care of her. They shared responsibility. Since her husband, a member of the Communist party of Siam, was hiding in the forest for a long time. So, she was a single mom who took care of her six children alone. Thus, she was a strong woman who was able to work hard as a man till she had a stroke in 2008. Her son and her daughter took her to the hospital. At that time, her physiotherapist taught her how to improve her physical function. K2 always closely followed the doctor's advice and applied other health professional's suggestions as well. Finally, she was able to walk, work, and take care of herself independently. However, when the researcher went to see her, she was 93 years old.

She had difficulty doing things alone; she needed to use a walker or ask for any assistants from her daughter, her son, and her grandchild. However, she was still healthy. Her family members facilitated her to perform her daily activities such as showering, eating, and taking medicines. From her early age up to recently, K2 had always done things in her daily life on time because she believed that daily activities could help her maintain her health and be mentally stable. She woke up early in the morning to take a bath, have breakfast, and take medicines. She never forgot to do those things because she strictly followed her schedule. She always ate vegetables planted near home together with local foods. She believed that the vegetables bought from the market, including pork and beef, were contaminated with harmful chemicals. Moreover, she ate fish instead of pork or beef because she believed that fish was healthier than pork or beef. She then walked around her home using a walker and drank a cup of milk.

K2 went to see the doctor regularly in order to continue treatment for hypertension and stroke recurrent prevention. Her daughter did not believe in herbs because she a health professional had told her to be careful with herbs because they might be combined with steroids. Thus, her daughter and K2 believed in modern medicines only. K2 always asked for medicines when she had health problems such as headaches, insomnia, and ache because she wanted to eliminate those symptoms immediately. K2 believed that she was an older woman with a dangerous chronic disease; thus, she had to be careful in her daily life. She wanted to protect herself from the stroke. K2 stated that older people should live without any illnesses and could support themselves (manage their own daily routines and not be a burden to anyone).

K2 also maintained her mental health by making merit. She went to a temple, even if she was unable to spend a lot of time there. Due to her limited functionality, her daughter and son took K2 to the temple to make merit. Moreover, her children took her to visit a younger daughter in Weangsa district and she frequently stayed with the younger daughter. Meanwhile, other children normally came to visit her. The K2 was never alone because around her home were small restaurants and grocery stores; thus, a lot of people came to see her.

K5

K5 was an 83-year-old homebound older person who was a stroke survivor. She lived with her family — a daughter, a son, a grandmother, and her husband — in two houses. During the day, they lived at her daughter's home nearby. Her daughter had been divorced for 3 years and she had a daughter. Her son was a diabetic and chronic kidney disease patient who had peritoneal dialysis. Her husband was still healthy and played the role of the family head. Early morning, K5 woke up and, with an assistant from her home, walked to her daughter's house to stay with her granddaughter and cook for her because her daughter went to work on her rubber farm. After they went to school, following her physiotherapist's suggestions, K5 exercised for around an hour and helped her daughter do business at a small grocer's shop till her daughter came back from the rubber farm. K5 perceived that a healthy homebound older person should have a good physical function. Although she had a physical impairment, she was recovering and able to take care of both herself and her family members. K5 cooked for her family members, as they stayed at her daughter's home all day long. They ate and spent time together, and in the evening, they went back to another home nearby to sleep. During the day, K5 and her daughter supported

each other, working at the small grocer's shop, cleaning the house, and taking care of her son who had chronic kidney disease.

Meanwhile, all of the family members worked at home, whereas her husband went to the rubber and palm oil farms. He played the role of a householder who was able to support family members in the same way as K5, who always supported her family members, cooked for them, took care of her granddaughter and son. However, K5 had another daughter who worked as a nurse in another district. The daughter came to visit her twice a month. She taught her how to exercise and control her diet because of her hypertension; moreover, she took K5 to make merit at a temple nearby. K5 always kept the relationship with relatives and other community members, especially the relationship with her older sister, who often visited her at her home; they talked, had meals together, and took care of each other. Since her daughter's home was a small grocer's shop, a lot of people came to buy household goods and talked with K5 intimately. However, K5 did not like to leave home. She just wanted to support her son, daughter, and granddaughter. K5 received health care services from health professionals at home: health assessment, health education, and rehabilitation. K5 always followed suggestions from health professionals and her daughter, who was also a nurse. She never used any herbs or folk medicines to take care of herself. Meanwhile, her husband had diabetes and took medicines regularly; however, he also drank herbal juice to control his diabetes.

K6

K6 was a 93-year-old homebound older person who was still healthy and looked good. She lived with her family including her son, daughter-in-law, and two grandchildren. Their home was surrounded by a fruit farm. Next to K6'home was her

daughter's house. K6 had diagnosed with Gout around 5 years ago and regularly received treatment at the hospital. She was also supported by her daughter, who was a government employee. K6 was able to slowly perform her daily activities using a walker for showering, dressing, and eating. Her family members helped her perform those activities; the bedroom was very close to the bathroom and kitchen, and the handrails were added in the bathroom, with the refrigerator being put next to her bed. Thus, she could eat and drank anytime she needed. Every morning, her son and daughter-in-law went to the rubber and fruit farms while her grandchild went to school. K6 woke up and drank a cup of milk, soft-boiled rice, and took medicines. She then walked near her house in order to exercise and relax. After her son and daughter-in-law came back from the farm, they gave her breakfast and helped her taking a bath in order to prevent K6 from falling.

K6 was still able to take care of herself at home, even if it took time for her to do her usual activities. K6 and her family members believed that older people would like to manage their daily routines by themselves. Moreover, the ability to take care of her own health was a proof that she was still healthy. During the day, K6 stayed in her bed and watched TV. Sometimes, she was in the living room and talked with her relatives and others who came to visit her. Likewise, K6 often asked her daughter-in-law to take her to visit her friends at their home. She brought her friends fruits and snacks and talked with them all day long. Three or four times per year, her son took her to visit her older sister, relatives and made merit at Phattalung province, and she also brought them fruits and snacks. Moreover, K6 asked her son to invite monks, her friends, and relatives to her home so they could make merit together. All relatives, friends, and other community members were pleased to join the activities as they had

always respected K6 as a venerable person of the community. K6 was happy and so proud of herself and her family members who supported her. Her son and daughter-in-law taught their children to respect K6 as a center of their family.

In the evening, all family members always had dinner together. The daughter-in-law cooked food for K6 following the health professional advice about appropriate food for Gout patients. Moreover, other children always brought K6's favorite food and had dinner with her. After finishing the meal, all family members stayed with her until her bedtime. They often asked K6 to tell her story in the past, and this made her happy. She was proud of herself who was able to overcome several obstacles in their life and worked hard in order to increase their income. Moreover, she and her husband were able to get a lot of arable lands, where they planted rubbers, palm oils, and fruits that increased their income. K6 and her husband left many farms to their children, so the children were able to earn their living from the farms. Some of them slept near her bed during the whole night and her son's bedroom was very close to hers, so they never left K6 alone.

K9 and K10

K9 was an 84-year-old homebound older person and K10 was an 86-year-old homebound older person, they were a couple living in a large family which included two daughters, a son-in-law, and a grandchild. The older daughter had osteoporosis and had undergone left foot surgery, so she used a wheelchair. Her younger daughter was not able to support K9 and K10 too much because she always worked hard. She had to take care of her son and her husband who had a low-back pain. However, she tried to support her parents by cooking, working at home, and taking them to doctor appointments. K9 was an 84-year-old homebound older person who had osteoarthritis

in both knees and had been operated two years before. Thus, she had functional limitations in her knees that affected her confidence to leave home. K9 lived with her older daughter and her husband (K10), in a house surrounded by fruit farms. Next to the fruit farm were rubber farms and behind her home was her younger daughter's home. Her husband was a homebound older person who had heart disease and still played a role as a householder, while her older daughter was a disabled person suffering from osteoporosis. K9 and her older daughter shared responsibility: both of them cooked, cleaned the house, and did other housework. Meanwhile, K10 still tried to work on the rubber and also helped K9 and her daughter to work at home. Her younger daughter lived with her husband and her son, their homes being in close proximity. Her younger daughter sometimes helped them do house works such as cooking; nonetheless, she had no more time to help because her husband also had low-back pain. Thus, she spent almost her entire time supporting her family.

Early in the morning, K10 woke up at 4 a.m. to cook rice and clean outside his home. He believed it was a more effective exercise than running or riding a bicycle. After that, K9 and her daughter woke up to cook and clean the house. Every morning, K9 and K10 gave alms to a Buddhist monk at home. They then had breakfast together before K10 went to the rubber farm. K10 thought that work was the best exercise; thus, he believed that every day he had to engage in some physical activities. Both K9 and K10 were worried about their older daughter's health problems. They wanted her health to improve and be able to walk again. Meanwhile, her older daughter still tried to support her mother and her father. She did not want them to worry too much because she was still healthy and was able to support them. Likewise, K10 was worried about his family's economic issues because their rubber threes were too old,

having been cut down already; thus, K10 was worried that their income may not be enough to support their family.

K9 and her older daughter tried to maintain their life because they did not want K10 to worry too much. They always told K10 that they had enough savings; however, they had to budget their life in order to save money. In reality, both K9 and her daughter did not want K10 to work on the rubber farm because they wanted him to rest rather than work hard; however, they reluctantly allowed him to work in order to release his stress through working. By the way, they believed that working on the farm helped K10 continue his exercise. The three of them seemed to have tried to support each other in order to maintain their holistic health. All of them went to see the doctor and took medicines regularly. They received home health care from a health professional in terms of health basic assessment, health education, and other health problems.

K9 had osteoarthritis, while K10 had heart disease. Both of them were able to manage their own daily routines and support each other. They tried to maintain their functional ability and stay strong. They believed that healthy older people had good physical functional ability. Although they had chronic diseases, they were able to live without any complications.

K11

K11 was an 81-year-old homebound older person who had a history of Gallstones. She refused to undergo surgery from the doctor, thinking that the surgery might be harmful to her. She wanted to maintain her health without surgery. Luckily for her, she was able to maintain her health without any complications from the disease for several years. She lived with her son, a daughter who had diabetes, and

grandchildren. K11 had her own fruit and rubber farms like other families in the research setting. K11 always followed the doctor's suggestions in order to control her conditions, working near home and thus going outside her house. She also monitored the symptoms of the gallstones exacerbation by herself. She had learned about its abnormal symptoms such as flatulence, abdominal pain, and vertigo, and she also learned how to manage the illness during the outbreaks, when she felt uncomfortable. She took medicines and rest; however, if the symptoms were persistent, she asked her daughter to take her to the doctor's. When she was diagnosed with gallstone, she went to see the doctor at a local hospital, where she refused surgery and was prescribed the medicines by the doctor. In order to continue the treatment, she went to a pharmacy to buy the medicines, showing the medicines she had gotten from the doctor because she did not want to wait at the hospital. By the way, she did not want to burden her son and her daughter to take her to the hospital, as they did not have a personal car. They had to use public transport, which took time to wait; thus, she decided to get the medicines from the pharmacy, which was not too far from her home.

K11 have never thought that she would recover from the gallstone; she just wanted to live happily for the rest of her life. She woke up in the morning to do personal routine and take medicines on time and then walked near her house to exercise. Since she had been diagnosed with gallstone, K11 never worked hard because she wanted to control the disease by herself. Her son and daughter had to monitor the work of employees at the rubber farms. During the day, if K11 felt good, she always helped her daughter clean the yard. However, if she felt bad, she would go to bed for the rest whole day. Besides, her daughter, son, and grandchild did not allow her to do more. K11 did not go far any place from home. She had a chance to make

merit at home and sometimes at the temple arranged by her daughter. Besides, K11 did not like to go outside because she was worried about the disease. She just wanted to be a normal person, able to control the disease. She was not afraid of death except pain; thus, K11 focused on disease control and pain relief.

K12

K12 was an 87-year-old homebound older person who had suffered a stroke a year before. He lived with his daughter and his wife, who was a bedridden older person. Before he had a stroke, he had lived with his wife at their house. He took care of his wife as a major caregiver because his daughter lived in another province far from them; however, his sons still lived very close to him. K12's home was surrounded by fruit and rubber farms like others in the community. When he had a stroke, his daughter came to stay with him; also, his sons renovated his home so that K12 could manage his daily activities. K12 was a positive thinking person and did not worry about the stroke. He always followed the health professional's suggestions that he should improve his functional ability several times a day. K12 did not like to use any assistants or ask for his children's help. He tried to do things in daily life by himself because he wanted to improve fast. He performed daily activities such as working on the rubber farm near home. K12 believed that he could improve his health and live as a normal person for the rest of his life.

Every morning, K12 woke up early to do exercise, have breakfast, and take medicines. His daughter cooked for him and help him do his daily activities. During the day, K12 also exercised as a part of his rehabilitation. K12 felt good because he improved so fast and was able to help his daughter do a bit of housework such as drying clothes in the sun, washing dishes, and cooking rice. Moreover, K12 still tried

to take care of his wife who was a bedridden, as he wanted to support and decrease his daughter's burden. K12 received home health care services from health professionals regarding basic health assessment, health information, and rehabilitation. K12 was particularly committed to rehabilitation because he believed that it helped him improve fast. In general, as K12 liked to make merit, he donated money, fruits, and vegetables to his friends, relatives, and others in their community. He often supported the people he knew under the belief. He believed in a Buddhist doctrine that if he did good things for others, he would receive the good things back.

K13

K13 was a 76-year-old homebound older person who had Asthma. He lived with his wife who was a social bound older person and the family of his grandchildren including her husband and her little daughter. His family had several problems, including economic issues, lack of a major caregiver, and environmental issues. His wife played a role of a householder. She still worked hard to earn money and support her family. Surrounded by a few fruit trees and rubber trees, his home was far from the community. Moreover, there was a landslide close to his home, threatening to destroy it. K13 and his wife tried to contact the municipality and ask for their help several times; however, nobody responded to their calls. However, K13 asked his son who lived in another province to come back home and contact the municipality again. He believed that the problem would be solved soon. In the meantime, his wife still worked hard. Every morning, she went to work on her vegetable farm far from home. K13 wanted to help his wife; however, he couldn't because of his disease.

K13 felt bad because he thought that he took a burden for his wife. However, his wife always supported and said that he just followed the doctor's advice in order

to control the disease. She did not want him to exacerbate his asthma because it would be a burden for both of them. K13 also agreed with his wife to control and prevent himself from an asthma exacerbation and reduce hospital readmission. If he was admitted to the hospital, his wife would be more burden in taking care of him and has to stop working on the vegetable farm. Thus, K13 focused on disease control so he could decrease his wife's burden. Moreover, K13 tried to exercise, as he had been advised by his health professional so that he could improve his health. K13 believed that a healthy older person should have a good physical function and be able to manage their daily activities no matter if they had a chronic disease or not.

K13 and his wife did not have a lot of saving money; however, they adhered to the principles of sufficient economy in managing their later life. They spent money economically, usually eating the vegetables they had planted and eating eggs from their small farm. They never wanted to earn more money; they just wanted to have a happy life. They received health care services from a health professional at home. The couple also made merit like other Buddhists. They gave alms to a Buddhist monk at home and went to the temple on a holy day. They supported each other. When his wife brought vegetables from the farm to sell them at the market, K13 helped her prepare the vegetables, cooked rice, and cleaned the house every day. They did not worry too much about their life, as they believed that they were older people who wanted to be happy together in later life. They almost always stayed at home and disliked participating in social gatherings, except when their community had important activities, such as funerals of their friends or relatives, religious ceremonies, and community meetings.

2.3.2 Living in a couple

Three of the key informants lived with their spouse in their own house. They supported each other and performed several activities together: they planted vegetables, exercised, and made merit. As described before, most of the older people in the research setting received good support from their children. Although living in their own house, they always took care of their parents—they cooked for them, did the housework, and took them to doctor appointments. Their children's homes were very close to their parent's. Every day they met, talked, and supported each other. It looked like they lived at the same home. The lifestyle of each key informant was described below:

K4

K4 was an 84-year-old homebound older person who suffered from lower back and leg pain. She did not have other chronic diseases and was still healthy until her illnesses two months before. Her daughter and her son took her to see the doctor in Bangkok and her health improved. K4 lived with her husband in their house surrounded by a Durian farm, vegetable farm, and their children's house. Her husband was a social bound older person who was able to do farm work and go outside without any assistance. Both K4 and her husband supported each other. Her husband usually helped K4 plant vegetables and harvested their farm products for sale. Moreover, her husband helped her relieve pain by giving her a massage. K4 and her husband spent most of their time together. While her daughter and her son renovated the bedroom for K4, a bathroom, an air conditioner, a big bed, and a wardrobe were included in the room. Her husband was a social bound older person who was still healthy and was able to go outside by himself. He took care of K4 and all the time. Using a walker, K4

was able to perform her daily activities such as cooking and planting vegetables. K4 woke up early in the morning to exercise for around one hour, then she drank a cup of warm lemon juice because her daughter suggested that it was good for her health. She believed her daughter and followed her advice. After that, K4 cooked rice and went to her vegetable farm to plant and take care of the vegetables, without any chemicals, until it was too hot whereupon she came back home to cook; however, her daughter also cooked for her. They usually used their own vegetables which were chemical-free.

K4 believed that older people should keep in good physical and mental health in order to support themselves. Despite her health problems, she tried to handle them by following health professional's advice. K4 stated that she was a healthy older person because she was able to control her conditions and be in good health while living at home. K4 ate fresh garlic during her meals in order to control lipids in her blood vessel, as her daughter had advised her at a village volunteer's suggestion. During the day, K4 and her husband rested at home. Their daughters and sons always came to stay with them. Moreover, neighbors also came to visit them. They were very close, so they brought foods, vegetables, and fruits to share with each other. Besides, her husband was a huntsman who knew a lot about the forests and mountains here; thus, a lot of people came to see him in order to invite him to worship a relic in the forest. K4 also joined other people in the community through an illegal lottery group. Every 1st and 6th of each month, her daughter invited the members of the illegal lottery group to a meeting. They paid for the lottery and talked to each other. In the afternoon, K4 and her husband went to the vegetable farm again to water and harvest them. Her daughter took the vegetables to sell them at the community market and

gave K4 money. Having finished her work on the farm, K4 exercised following the suggestions from a health professional and she had dinner with her family. K4 made merit by giving alms to a Buddhist monk at home and went to a temple on the Buddhist Sabbath. Moreover, her children usually took her to visit her relatives and travel to various places. They shared responsibility for their parent in terms of daily activities such as cooking and mental health care.

K14 and K15

K14 was an 80-year-old homebound older person who did not have any chronic disease. She lived with her husband who was an 82-year-old homebound older person (K15). K15 had suffered from hypertension six years before. Both of them were rich. They had a lot of fruit farms, palm oil farms, and rubber farms. Their home was surrounded by their children's home and their farms. Both of them liked to make merit; they donated money to the temple every year and did other types of charity. Before they turned into a homebound older person, they had performed social activities, such as charity events, exercise, and an older people club. After they became a homebound older person, they were still supported by the society. Moreover, they also informed themselves about exercise, care for older people, and disease control. K14 and K15 supported each other and spent most of their time together, never leaving one another alone. During the day, they often gave a massage to each other in order to relax their muscles.

Every morning, K14 exercised by walking near his house while K15 walked to a nearby farm, covering the distance of 1.5 kilometers in 2 rounds and 2 times per day—in the morning and in the afternoon. In the morning, after finishing their work on the farm, they gave alms to a Buddhist monk who came to receive food offerings

in front of their home. Then they had breakfast with their daughter. During the day, K14 and K15 stayed at a little hut close to their home to rest and talk with their children, their relatives, and friends who came to visit them. Their children always stayed with K14 and K15 and shared the responsibility to take care of their parents. They took K14 and K15 to travel, make merit, and visit relatives. Moreover, K14 and K15 had a very close relationship with health professionals, so they often came to visit them and talked with them. K14 and K15 were still supported by the health care center provided that they asked for help. K14 did not have any chronic disease; thus, she was happy and focused on keeping herself in good condition. While K15 had hypertension, he was able to control blood pressure to be normal (between 128/68 to 138/78 mmHg). K15 also believed that he was healthy because he was able to control the disease and be stable.

In the evening, K14 and K15 stayed at home. They did not ask their children to stay with them because they were able to take care of themselves, performing daily activities, taking medicines, and maintaining personal routine. Although K14 and K15 lived in their own house, their children, including granddaughter and grandson, were very close to them. The children also shared responsibility to support K14 and 15, by taking K15 to see the doctor on time. In the same way as other families in the community that respected the authority of older people, K14 and K15 were as a spiritual center for their children. It made the older people proud of themselves, which was the best way to take care of the mental health of an older person. K14 and K15 were friendly people; thus, they had a lot of old friends, relatives, and others in the community who came to visit them at home. They still kept a close relationship with others.

2.3.3 Living alone

Four key informants lived alone after their spouses had already died. They decided to stay at home alone because they wanted to have some privacy. They spent most of their time at their home; however, they still needed care and support from their children. Due to, the concern of safety from fall and faint, their children did not allow them to stay at their own home at night. Moreover, their children encouraged the key informants to join in the family's activities—cooking, house working, and working on far, depending on their health status. The lifestyle of each key informant who lived alone was described below:

K3

K3 was a 79-year-old homebound older people who had had a stroke and living alone at her home which was very close to her daughter's home. She lived there before she had a stroke. After she had been discharged from the hospital due to the stroke, her daughter did not allow her to live alone at nighttime, although both homes were very close. However, K3 always stayed at her home during the day. Their home was surrounded by a fruit farm where they grew durian, rambutan, mangosteen, and other fruit. Next to the fruit farm was a rubber farm. Moreover, the children's house was close to the K3's home, so they always came to visit her. K3 had a stroke in 2017, and her children took her to the hospital. After she was discharged from the hospital, she still had problems with functional ability in her left hand and leg. Her children encouraged her to continue rehabilitation at home. They supported her by building for her an overhead pulley, handrail, wrist sandbag, and ankle sandbag. Moreover, her children adapted to her home so that she could easily perform her daily activities, modifying the bathroom, kitchen, and a little hut close to the house. Her

children believed that if K3 followed health professional suggestions, she would get well soon. Therefore, they always encouraged K3 to perform rehabilitation activities regularly and on time.

At night, K3 lived at her daughter's home, as her daughter did not allow her to stay alone at her house overnight, worrying that she might have another stroke, fall, and faint. K3 woke up early in the morning walk near her house, using a cane. In front of her home, several people exercised on the street, running, riding a bicycle, and walking. While exercising, the people always greeted K3, and some of them even stopped by to talk with her. In the past, K3 had also exercised with them on the road; unfortunately, after her physical function had been limited due to the stroke, she could not join them anymore. However, she still exercised because she believed that exercise was good for her health and improved physical function. After the exercise, she would go to her own home to take a bath, have breakfast, and take medicines, using a walker or a cane. She cooked rice, cleaned dishes, and waited for her children to bring other foods to her little hut close to the house. She would spend the whole day in that little hut, eating, rehabilitating, and meeting with others. It was close to her house and looked like a living room or a reception room, and rehabilitation room. The hut was also her rehabilitation room, as it contained an overhead pulley, handrail, wrist sandbag, and ankle sandbag, so she was able to do rehabilitation whenever she needed. Moreover, during the day, her children came to stay with her there, and also her old friends, relatives, and other people came to visit her, so she was never alone.

Her children believed that if their mother followed the health professional's suggestion, she would improve soon. They took her to see the doctor on time, made sure she took medicines on time, and encouraged her to do exercise and rehabilitation.

They supported their mother physically, emotionally, and socially, so that she could live like a normal person with good physical function. They believed that good physical function came from good mental health, whereas her good mental health came from several aspects of her life such as social relationships, self-esteem, and good care from her children. They encouraged K3 to take part in group activities at the hospital. Moreover, when K3 went to see her doctor, they invited her friends to join them, and they told the doctor to make an appointment with all of them at the same time. They shared responsibility with the family of K3's friends by switching among each other to take their mother to see the doctor. They took K3 to visit her other children and make merit at a local temple. All this made K3 and her friends were happy.

K3 received home health care from a health professional at the Khiratnihkom hospital and Ban Thamnaip sub-district health promotion hospital. They came to visit her, gave her basic health assessment by checking BP, and evaluated her other health problems, gave her health information and health education, and taught her how to rehabilitate. She also received an allowance from the Thai government like other older people in Thailand.

K3 used to get worried about her conditions, as she expected to walk, participate in social activities, and religious ceremonies at a temple after she had a stroke. K3 believed that older people should have a good physical function to manage their life. She initially tried to continue rehabilitation to improve her physical function and wanted to walk smoothly. Overtime, she accepted the fact that she could not walk as comfortably as before the stroke and changed her attitude. K3 continued

rehabilitation to maintain her health and to prevent herself from staying a bedridden older person.

K7

K7 was an 82-year-old homebound older person who was K5's older sister. K7 lived at her home which was very close to her daughter's home. K7's lifestyle was similar to the one of K3 as she stayed at home during the day. She did all her daily activities at home such as showering, eating, and relaxing. Her daughter cooked for her, while her son and another daughter brought her favorite food. Early in the morning, K7 woke up to drink a cup of milk and exercise by walking without any assistant. She walked from her home to the street and talked with others who were jogging, riding a bicycle, and walking. They exercised together and shared their stories. Having finished exercising, K7 went back home to take a bath, have breakfast, and take medicines. K7 spent most of her time with her younger sister and her son in their house. She would ask her daughter to take her to their home because she wanted to keep a close relationship with them and to take care of her mental health, as they had a chance to support each other. In the afternoon, her son and nephew took her back home. K7 strictly performed her daily activities because she did not want to lose anything in her life.

At night, K7 stayed at her daughter's home nearby, because she was worried about dizziness, vertigo, and fainting. Her daughter then went to the rubber farm with her husband, while K7 and the grandchild slept at home until the morning. When her daughter came back from the farm, she cooked for her daughter and K7, then took her daughter to school and dropped K7 at her sister's or her son's home. In general, K7 did not like to travel because she believed that older people should stay at home. If

older people always traveled, they might end up exhausted. However, her children encouraged K4 to make merit at home and the temple. K7 believed that older people had worked hard when they were adults, so they should not work anymore in their old age; instead, they should spend their time resting, seeking happiness, and doing what they liked without burdening anyone. In order not to burden any other person, K7 valued an ability to take care of herself and perform her daily activities. K7 was happy, as she had neither complex health problems, nor economic issues, nor any conflicts among her family members.

Although K7 was a hypertension patient, she was able to control her blood pressure at a normal level (between 131/79-135/82 mmHg) without any complications. K7 was happy with her conditions and ability to manage her own daily routines. K7 believed that she had a good health bearing in mind her old age.

K8

K8 was an 83-year-old homebound older person who had survived a stroke a year before. He lived in his house alone because his wife had died two years before and K8 still thought about her. However, his children's homes were close to his, and next to their home were fruit and rubber farms. K8's two daughters were his major caregivers, as they shared responsibility to take care of their father, cooking, cleaning the house, and helping him do his daily activities using a cane and walker. Other daughters and sons came to visit him every day. During the day, they spent most of their time with K8 at his home. They talked and had meals together until bedtime when they went back to their home. However, if K8 felt bad, the children stayed with him all the time, sharing responsibility to take care of their father.

His children encouraged K8 to perform his daily activities by himself. They adapted his home, modifying the bedroom, bathroom, and kitchen to facilitate his life. K8 cooked rice and heated up the food his children would bring him. Early in the morning, K8 woke up, did his personal daily routine, and paid his respect to the spirit and the God at home. K8 really believed that the spirit and God influenced his health. He survived a stroke because his daughter helped him to pay respect to the spirit and God, as she invited a Savant from another place to his home. Not only did he pay his respect to the spirit and God K8 but he also asked his children to take him to the temple so that he could make merit. He also regularly gave alms to a Buddhist monk at home. After that, he walked to his older daughter's cafeteria nearby to have breakfast and talk with other customers. They ate, discussed daily issues, and shared their stories.

K8 tried to take care of himself by performing his daily activities himself, that is, exercising every morning and during the day and taking medicines on time because he did not want to burden his children too much. Moreover, K8 did not receive home healthcare and health professionals because he had just become a homebound older person a year before. However, his children regularly took him to see a doctor at the hospital. Furthermore, K8 did not have other complex health problems or any other issues. He had his own money from his rubber farm and his relatives, friends, and other community members always visited him. K8 tried to take care of himself and control his conditions to protect himself from another stroke. Although he had suffered from hypertension after the stroke, he could be a strong person by maintaining his health— he could control his blood pressure, protect himself from stroke recurrent, and keep good mental health.

K16

K16 was a 99-year-old homebound older person who was still healthy, as she did not have any health problems including chronic diseases. She lived alone in a small house which was right next to her children's home. They did not have any fruit or rubber farm, because they were workers. However, they were happy with their life based on their age, especially K16, who had positive thinking and never worried about anything. She thought that every problem could be solved. K6 took care of herself. She performed daily activities, cooked rice, and grew betel nut near her house. She was happy to stay at home because her children never left her alone, but always supported her with food, and helped her do her daily activities, and maintain family relationships.

K16 tried to do things by herself, as she did not want to burden her family members. During the day, she stayed at home and waited for her daughters, sons, and granddaughter came back home after they finished their work. They usually ate together in a big group, being a big family. K16 was happy to join them in many activities, such as drinking, singing, and dancing. Their favorite food included vegetables, fish, clams, and other food they picked from the forest. They did not want to spend a lot of money on food from the market. Also, they thought that the vegetables and other foods from the market were contaminated with chemicals which could cause various diseases.

K16 wanted to be happy every day of her life because she was an older person and did not have a lot of time left. The family members treated her as a spiritual center and respected her authority. Although relatives from another province never came to visit her, they often called her and respected her. K16 received home health

care services from a health professional like other older people, such as basic health assessment and health information. K16 was really proud of herself because she was able to live without any health problems and chronic diseases. She had never asked for any assistance from the health professionals and community support.

3. Ways of Life in Maintaining Holistic Health of Homebound Older Person

Holistic health is determined to be related to the well-being of older people. The qualitative data from the field was analyzed to describe ways of life of the key informants in maintaining holistic health during the period of being a homebound older person. Four main parts emerged describing daily life experiences of the homebound older persons in holistic health: 1) the meaning of holistic health; 2) holistic health practices to maintain holistic health of the homebound older people, 3) health and social services for promoting holistic health of homebound older people, and 4) factors related to promoting holistic health of homebound older people.

3.1 The meaning of holistic health

Ways of life of the homebound older people came from their beliefs and values which contributed to the meanings of holistic health. The majority of informants perceived their holistic health as living in self-sufficiency and feeling satisfied with their health status. They were able to perform daily activities independently and did not burden their family members. Some informants reflected that holistic health meant not only being able to take care of themselves but also to support their family members. Due to physical impairment and deteriorated health because of their old age and chronic diseases, most of them performed their daily activities as much as they could. For example, the stroke survivals tried to improve

their functional ability as much as they could in order to keep their capacity to manage daily routines and protect themselves from stroke recurrent. Similarly, the key informants who had other chronic diseases committed themselves to follow health information so they could control their diseases and reduce suffering. Although the key informants who have any chronic diseases faced with declined health based on their old age, they tried to take care of themselves by managing their own daily routines.

Seven key informants were stroke survivors, eight had chronic diseases, and three did not have any chronic diseases. Most of them had emphasized on maintaining their physical and mental health. The holistic health came from their cultural beliefs and values of harmony in their age, ability to manage their own daily routines and support their family members, and their opinion that they should not burden their family members and the community. They meant that healthy older people could live with those personal properties. The holistic health sprang from their cultural beliefs and values of harmony in their age under the main theme "I am alive with good health in my age," as it is described below:

3.1.1 I am alive with good health at my age

The informants lived at home and spent a lot of time working on their farms or surrounding their home. They grew vegetables for cooking, not for selling. Some of them worked or exercised on the nearby fruit farm close to their house. The majority of key informants were able to perform their daily activities without any assistants, while some required assistants such as a walker, a cane, or a help from family caregivers. Other key informants had chronic diseases, but they were able to take care of themselves and control their conditions—they took medicines and went to

see the doctor regularly (strictly on time) (Observation: Field note extract). They valued themselves according to their ability to take care of themselves and have good health status, which is illustrated by three sub-themes; 1) “I assume a self-support function, so I am healthy,” 2) “I am in good health because I am able to control my conditions,” and 3) “I can adapt my living to the changes around me and then I enjoy in my life.”

3.1.1.1 I assume a self-support function, so I am healthy.

When they were young, the majority of key informants had worked hard and spent a lot of time on their farms, and had earned a lot of money from the farm, so they believed in their own ability to maintain physical functions. They perceived that holistic health was related to good physical function and ability to take care of themselves, as evidenced in performing daily activities and walking smoothly. They stated that older people should be in good physical function because they must still be able to do things in their life. If some homebound older people had a limitation in their physical function, he was not considered healthy; so, healthy persons should walk well and be able to work near home. Two sub-categories described their self-support function as their health; 1) ability to perform daily activities and take care of their own health, and 2) ability to work on their farms independently, as it is described below:

1) Ability to perform activities of daily living and take care of their own health

All key informants in this study focused on self-care ability regarding their capacity to perform daily activities independently. They stated that daily routines were important activities a healthy person should do. Therefore, the

key informants tried to perform their daily activities by themselves every time they needed in order to confirm that they were still healthy. K7 was a hypertension patient and stayed alone at home. K7 performed her daily routine, eating, rice cooking, bathing, and dressing by herself on time strictly. Although those activities were carried out based on her physical ability that deteriorated following her age, K7 slowly and carefully implemented the personal routines step by step of each activity until finished. She stated that older people who were unable to take care of themselves were bedridden. She did not consider herself a bedridden older people because she was able to manage her daily routine herself as K7 said:

> *"I think I am healthy because I am able to take care of myself. I think everyone should take care of themselves. A person who is unable to take care of themselves is a bedridden older person. Like me, I can cook rice, eat, take a bath, get dressed, and do everything I need. My daughter cooks for me because I don't like to cook. Moreover, my son and another daughter bring their food for me, so I have a lot of food every day" (K7(living alone), Line 16).*

Moreover, the key informants who had a limited physical function due to a stroke or old age (K1, K2, K3, K6, K8, and K12) stated that they were able to take care of themselves, although they faced with decreasing functional ability. All of them slowly and carefully performed their daily routines on time strictly. They asked their family members for help or used assistant equipment or both. They understood that it was normal for everyone to face with health problems depending on their age and

health status; however, they thought they should improve to live a normal life and be able to take care of themselves. Therefore, they were still healthy because they were able to keep their ability to perform daily activities. K1 always did his activities of daily living using a walker. He could not live without his walker. He used it during walking, bathing, and put it nearby all the time, as K1 said:

> *"Yes, I always perform my daily actives by myself, such as eating, showering, dressing, and other similar things. I also work at my farm near my house, where I mow, plant, and water my plants." (K1(extended family), Line 25)*
>
> *"I am happy with my health but it will be better if I can walk or do things smoothly without a walker. So, I always exercise, work, and do things by myself. If I cannot do things by myself, I will be bedridden someday" (K1(extended family), Line 27).*

Similarly, K6 was a very old homebound older person who had limited functionality because of her age. She was still to do her daily routines by oneself using a walker and a cane. She usually used a walker when she walked inside her home or went to the restroom because the walker was easy to use on the smooth floor and used a cane on the rough floor when she walked outside her home nearby. She was able to do each activity of her life quite smoothly although, it was very slow because of the limitation of her physical function as K6 said:

“I felt good with my ability to take care of my own health. I am the oldest in the community but I was maintaining my life by myself. It was enough for me” (K6(extended family), Line 25).

2) Ability to work at farms near home independently

The majority of key informants emphasized working on their farms. They believed that their farms were their life, as they had gained money from them to sustain their life and support their family. The key informants stated that if they were able to work on their vegetable farms, fruit farms, and rubber farms near home, it meant that they were healthy. K10 believed that working was the best way to exercise; thus, he was able to gain two benefits from one daily activity. He happily took care of his rubber trees—pruning, adding fertilizer, and mowing grass. By doing this, K10 was both happy and healthy with his age, as he explained:

"I just want to work on the farm near home and walk smoothly. I would like to be healthy; so, I should work on the farm, and if I stop working, I will end up bedridden. Also, I am very happy when I have a chance to take care of my rubber trees. In contrast, if I just stay at home, hold still, I will be stressed out"(K10(Living in a couple), lines 49-54).

3.1.1.2 I am in good health because I am able to control my conditions.

The majority of key informants (n=15) had a physical impairment and declined health caused by chronic diseases and their age. More than half of key informants (n=8) had chronic diseases that they were able to control to be stable. Another half of the key informants (n=6) were stroke survivals and had a limited physical function and the condition of a homebound older person. Only a small number of key informants (n=2) did not have chronic diseases. They turned into homebound older people because of their old age. Moreover, a small number of key informants (n=3) were stressed out because of economic issues; however, they were able to maintain their mental health. They lived by using economic sufficient to guide them in their daily life. They had their own vegetables, fishes, eggs from their farms to consume so, they did not spend a lot of money to buy their foods. Despite the health issues, all key informants believed that it was normal for older people to encounter health problems and decreased physical abilities, especially when they had a chronic disease such as diabetes or hypertension. However, they were able to live without any complications or health problems because they had learned about the diseases from their neighbors who had a stroke and became bedridden as the consequence of the diseases. Moreover, key informants who were stroke survivors had learned how to improve their health, prevent bedridden conditions and stroke recurrent, and live a stable, normal life. Within the sub-theme, three subcategories emerged: 1) ability to control chronic illnesses, 2) try to be independent and 3) keeping mind and body together to accommodate the changes following diseases as described below:

1) Ability to control chronic illnesses

Most of the key informants of this study had chronic diseases. More than half of the key informants experienced complications of the diseases, whereas the other half were stroke survivals. After they survived and improved, they emphasized how they could control the diseases and prevent themselves from related complications. This is because they had learned about disadvantages coming from not being able to control the disease. The informants were able to learn new information related to their conditions and also applied that information in order to maintain their health. K8 stated that he was still healthy with the normal blood sugar level (rang of blood sugar before meal between 78-122 mg% and HbA1C $\leq$ 7mg%) and he was satisfied with his health status (Observation: Field note extract). In other words, he was still healthy within the normal health status, although he was still a diabetes patient:

> *"I am improving, I can control my blood sugar to be stable. The doctor already reduced my dose of medications because I had a normal blood sugar. Also, I am not sick. I can walk better than before" (K8 (Lived alone), lines, 74-76).*

2) Try to be independent

The key informants emphasized having a good physical function. They stated that the good physical function contributed to good health of both body and mind. Living with good functional ability allowed them to take care of themselves or perform daily activities such as eating, showering, and other types of personal routine. Besides, they were able to exercise, stay outside during the day,

work, and meet with their friends and relatives. K10 perceived that working was an exercise. He saw people in his community exercise on the street, walking, running, and riding a bicycle. Having finished the exercise, they weary sweaty and exhausted. It was the same when he worked, as he felt tired and sweaty as well. Thus, he continued to work, thinking that exercise was good for him because he was able to take care of his rubber trees:

> *"I think it is the same. I see several people run, walk, and ride a bicycle on the street. They just use their energy, and working can do that as well; so, I think, I exercise by working at my rubber farm. My rubber trees will be good and I am so happy because I have a chance to take care of them every day" (K10 (Living in a couple), Line 16).*

While K8 always walked from his home to the soft-boiled rice and tea shops in front of his home to have breakfast and talk with other people. He did not allow his daughter to make him breakfast at home. He wanted to take it himself because he was able to walk everyday:

> *" After I feel better, I am able to do things by myself, such as exercise, walk to my daughter's soft-boiled rice shop nearby to have breakfast, and talk with other customers. My daughter does not bring it to me at home like before because I can walk to the shop. I think it is better because at least I have a chance to exercise every morning "(K8 (Living in a couple), line 48).*

K3, K7, K8, and K16 decided to live alone at home, while, K4, K9 and K10, K13, and K14 and K15 lived in a couple supported by their family members because they wanted to have their private life. They believed that the lifestyle of older people was different from the young if they lived within a big family that included several generations. It might create conflicts in the family because of the generation gap. In this regard, the key informants were able to do things as much as they would like, even if they asked their family members for support in certain activities, such as cooking, house cleaning, and seeing a doctor, as the K7 explained:

> *"I live at my home during the day, cook rice by myself, but my daughter cooks other food for me. I can eat immediately, I don't want to wait for anyone. I sleep at my daughter's home at night time but I do everything at my home. My daughter washes my clothes for me. I am very happy because I am free to do things as I would like to do. When I am hungry, I can eat immediately. I am an older person, and sometimes I am hungry while the young ones are not. So, I can eat immediately because I need to take medicines on time as well. My daughter and her husband always eat after they finish their work at the rubber farms. Our schedules are different. My grandchild just stays in her private room the whole day long. Sometimes, I think she should stay outside her room but I try to understand the adolescent's lifestyle. So, I never blame her. However, my children and their family always respected me, they never blame me. I just stay with their family at night time and I come back home in the morning. I am so happy in my life every time" (K7(Living alone), Lines, 21-37).*

3) Keeping mind and body together to accommodate the changes after a disease

"Mind is Boss, body is servant" is the Thai idiom that most people who emphasized mental health care are usually mentioned. The informants believed that having good mental health impacted everyone's well-being. The key informants who focused on good mental health (K1, K4, K7, K10, and K13) stated that the mind was the master of the body. If they were not in control of their mind, they were not in control of their actions. It referred to the ability to do things without stress and maintain their health. K4 believed that working was good for her health so she was able to exercise while working. She was happy to consume the vegetables from her own farm. At the same time, she was able to earn money from the products of her farm. Furthermore, living with good mental health helped the key informants to keep a relationship with their family members, old friends, relatives, and others. K1 always shared his goodwill and happiness with his friends and relatives via Line application (Observation: Field note extract). While K7 believed that the mind was able to control the body, her mind had power over her body:

> *"I am happy, I have good mental health, so, I am appetizing and sleep well. I think it is enough for an older person. If we have good mental health, everything in life will be good, such as appetizing, sleep well, rest well. So, good health will be achieved. For the limitation of physical function because of my old aged, I think that it is normal for older people, I understand and let it be" (K7 (Living alone), lines 147-151).*

3.1.1.3 I can adapt my living to the changes around me so I enjoy my life

The majority of key informants were happy with the changes in their life, including their health. They believed that their health status could deteriorate based on their age, and several health problems will occur (chronic diseases, pain and aches, anorexia, flatulence, and insomnia). They had prepared themselves to deal with those issues consciously. The key informants who had limited functions tried to improve themselves in order to perform their daily activities and take care of themselves. Also, they did not want to burden their family members. The key informants who had chronic diseases focused on disease control as much as they could. The key informants were proud of their ability to overcome health issues (Observation: Field note extract). Within the statement of the qualitative data, two sub-categories appeared; 1) living without imposing care burden on their family members, and 2) accepting the limits of old age, and 3) being able to adapt life to a new reality as described below.

1) Living without imposing care burden on their family members

As self-esteem is a spiritual matter for older people, the majority of key informants focused on their personal ability to take care of themselves, not imposing any burden on anyone. The key informants stated that if they asked their family members to help them in their daily activities such as going to the toilet, eating rice, and getting dressed, their humanity decreased. K2 stated that she heard about bedridden older people who asked their family members to help them perform daily activities. It burdened their family members so much and she did not

want to be like them. She perceived it as a decrease in self-respect. Therefore, she was happy with their own ability to do ordinary things. K12 stated that living without imposing a burden to anyone was directly linked to the well-being of an older person. He was happy with his ability to take care of himself by performing daily activities without assistants. Although he still had limited physical function; he always tended to improve his functional ability and decrease the care burden.

> *"I feel good that I don't burden my children too much. Thus, they are able to work smoothly and don't need to worry about me. My wife has been bedridden for more than 10 years, and my children must take care of her, so I must take care of myself in order to decrease their burden" (K12 (extended family), line 17).*

2) Accepting the limits of old age

Most of the key informants perceived that they were older people, but they wanted to live like any older person who was still healthy. Sometimes, they faced with a functional decline or felt discomforts such as insomnia, pains and aches, anorexia, and chronic diseases. However, they were able to overcome the challenges and maintain their life by adapting themselves and solving those problems as much as they could. They tried to walk, perform routine activities independently carefully, and slowly without burdening their family members. They accepted help and several types of supports from their family members if needed in order to prevent themselves from falling, other accidents, and health issues (Observation: Field note extract). K14 lived in a couple at her home with her husband. She accepted the limitation of her old age as she said:

"I never worry about my health. I am an older person. It is normal to face with illness and limitation of physical function because of my old aged that could not compare with the youngers. I understand that my functional ability is declining based on my old aged. I just live with happiness every day. If I get sick, my children usually take me to see a doctor and take care of me. It is enough for me". (K14 (living in a couple), Lines 82-85)

The majority of key informants seemed to be focused on their physical function regarding the ability to take care of themselves, regardless of whether they were homebound older people because of their old age or chronic diseases (stroke, osteoarthritis, asthma, and gallstone). Therefore, most of them performed their daily activities and took care of themselves based on their personal capacity (Observation: Field note extract).

3) Being able to adapt life to a new reality

The key informants believed that adapting to the changes in their health deteriorated because of their age, and adapting to the changes in their social environment were the best ways to maintain holistic health. They perceived that it was normal for them to have health problems such as chronic diseases, insomnia, anorexia, and aches. K13 lived in an extended family which included his wife, grandchildren, and her family (her husband and a little daughter). K13 was a householder before he became a homebound older person K13 and his wife took care of themselves and never asked for help from their grandchildren and her husband. K13 and his wife did not have a lot of money and did not have a lot of farms; so, they had an economic problem. However, they were able to solve the

problem using economic sufficient in their daily life. His wife planted vegetables to consume and to sell them at the local market and earn income. They did not spend much so, money was not most necessary for them, they just wanted to live together and support each other until they die. K13 also had asthma; however, he adapted himself to those issues by keeping his ability to take care of himself, followed health professional' suggestions in order to control his conditions and decrease his wife's care burden, as K13 explained:

> *"If we can help each other, it is very good. We have been living together for a long time, so we must take care of each other as much as we can. I have asthma. I cannot work a lot but I still try to work as much as I can. Also, I try to take care of myself as the doctor suggested, so I could prevent my pangs of asthma. If I have severe asthma outbreaks, my wife will stay with me at the hospital, so it is a big burden for her. It is very bad for her. She will be tired and will not be able to work and earn income. Many problems will come up and we will suffer" (K13 (extended family), Line 47).*

Meanwhile, K9 and K10 believed that they were facing economic problems because their rubber trees had been cut to plant new trees. Therefore, their income decreased. K10 was worried about it; however, K9 tried to calm down K10 and managed their life by using sufficient economic principles—they reduced spending on unnecessary things and increased ability to access health care services supported by the government:

" I told him (her husband), we have savings for the three of us but we will not spend too much, just for food, water bill, and electric bill. We don't need to travel anywhere, we just make merit a little bit. Also, for our daughter's treatment, we don't need to pay a lot because the government will pay for us. So, I think, it is good for us" (K9 (extended family), line 52).

3.2 Health practices to maintain holistic health of homebound older people

All key informants in this study had been the social bound older people before they became homebound older people. Living as a social bound older person, the key informants reflected their ability to work hard on their farms, which were the major source of their income and savings. Furthermore, the key informants usually participated in social activities of their community, such as volunteers, folk shows, religious ceremonies, and local folk products (One Tambon, One Product (OTOP)). After that, they turned into homebound older people because of their age, health status, and chronic diseases. The key informants transferred their work to their children to continue their business. They also overcame their health problems by following a Buddhist way, under the thought and accepting that "all things are impermanent and naturally decaying". They took care of themselves as much as they could, including both their body and mind, in order to maintain their health. However, they were not worried too much; they just wanted to take care of themselves without imposing any burden on their family members.

The key informants believed that burdening everyone around them would make them suffer. They thought that they should take care of themselves as much as

possible. They always improved their physical function through exercises and rehabilitation. The key informants who had chronic diseases followed health professional suggestions to control the diseases. They also performed daily activities themselves every day, regardless of whether they lived in the extended family, in a couple, or alone. All of them tried to do their daily routines in order to support themselves as much as they could (Observation: Field note extract).

The key informants did not only perform daily activities but also work on their farms near home. They consumed farm products without chemicals because they believed such products were good for their health. Moreover, within their work, they could exercise, decrease expenses, and increase their income if they sold the products. On the other hand, they tried to overcome their health problems by seeking health information related to their health from health professionals, trusted people, and the internet. They calmed down their emotion and released stress in order to take care of their mental health. Moreover, the key informants who lived in an extended family supported their family members as much as possible, depending on their ability, such as taking care of their grandchild (Observation: Field note extract). Two broad main themes arose from the qualitative data: 1) always taking care of myself to stay healthy, and 2) keeping contact with family and friends, as described below:

3.2.1 Always taking care of myself to stay healthy

The majority of informants stated that most people, including the older people, would like to keep the ability to perform daily activities. Especially, they were deeply concerned about the ability to take care of themselves. The informants performed several activities in order to maintain their holistic health such as their daily routines, active learning and seeking new information regarding their health issues, understanding the nature of life that could decay, and always improving their health. Although most of them had limitation of physical function because of stroke and their old age, they tried to take care of themselves to reduce the care burden of their family member, such as K1, K2, K3, K4, K6, K7, K8, K11, K12, K14, K15and K16. In comparison, K5, K9, K10, K13 valued the ability to support their family members (Observation: Field note extract).

Moreover, the pattern of self-care activities of the homebound older people was similar although some differences in living patterns. K1, K2, K5, K6, K9, K10, K12, K13 lived in the extended family. K1, K2, and K6 focused on taking care of themselves without burdening their family member. Their children facilitated them by modifying their home to fit with the homebound older person, such as a handrail and a bath mat. Moreover, the children also prepared clothing, other personal use, and meals for their parents before they went to their farm. Thus, the homebound older person easily to perform their activities. K2 was unable to do her daily routines alone. She asked her daughter to stay with her nearby because she worried about falls. K1 and K6 were able to perform their daily routines themselves using a walker while K12 refused to use any assistant including his daughter. K9, K10, and K13 lived in the extended family; K9 and K10, a couple who were able to take care of themselves,

worked at their farm nearby, and also supported each other in their family. K10 still played a role as a householder; thus, he always supported his family members as much as he could. K13 lived with his wife who was a social bound older people and their grandchild's family. His wife played a role as a householder who always supported their family members. K13 had asthma; however, he was able to take care of himself and supported his wife by doing some household work (Observation: Field note extract).

The health practice of key informants who lived as a couple (K4, K14, K15) was often like a buddy. For example, K4 lived with her husband who was a social bound older people and always supported her. K4 also supported her husband, such as cooking and serving his favorite food. Her children usually supported her and her husband by offering a meal and facilitating K4 to perform her daily routines and work at vegetable farms nearby. In comparison, K14 and K15 was a couple who lived at their home that surrounded by their fruit farms and their children's homes. Their children encouraged and facilitated them to take care of themselves. Thus, K14 and K15 were able to take care of themselves without any assistance except that their children brought their meals, cleaned the house, and took them to see a doctor as scheduled. Their children also facilitated them to work at their fruit farms as exercise near home. Besides, their children always spent time at K4, K14, and K15's home to provide support to their parents, took a break from their work, and also kept their family relationship. The homebound older people's homes were a center of the family meeting (Observation: Field note extract).

Similar health practice was also observed in those living alone (K3, K7, K8, and K16) at their home which surrounded by their children's homes. Their children

were often concerned about the safety issue. During day time, the homebound older people were allowed to stay at their home as they were happy with their private life. They took care of themselves under their children's support. For example, the house was modified to fit with older people (with handrails, bathmat, and smoothing floor). Their children did not allow the homebound older people to stay at their home at night time. The family support was also the main resource similar to the homebound older people who lived as a couple (Observation: Field note extract).

Accordingly, several ways they did to take care of themselves depending on the socio-cultural context at the community, beliefs, and values of each person. From the qualitative data related to the broad theme, five sub-themes were found: 1) performing daily activities with and without assistants, 2) eating local food and healthy foods, 3) living happily every day, 4) continuing exercises and rehabilitations, and 5) seeking information related to their health issues as described below:

3.2.1.1 Performing daily activities with and without assistants

The majority of key informants believed that a healthy older person should have the ability to perform daily activities by themselves. Therefore, every day, it was important for them to do their daily routine —eat, take a shower, get dressed, and exercise. Most of them were able to perform those daily activities by themselves. More than half of them were able to perform daily activities without any assistant (K7, K9, K10, K11, K12, K13, K14, K15, and K16). K12 lived in an extended family; he woke up early morning to carry out his daily routines such as showering, dressing, having breakfast, taking medicines, and resting without any assistant. Every day, he tried to walk and perform rehabilitation himself following a physiotherapist’s advice. He never asked his daughter to help him and never used a

walker or cane although he had both. He believed that, if he always used a walker and cane, he would not able to improve his functional ability and might have to rely on the assistant equipment forever (Observation: Field note extract). He stated that he did not want to live in this way:

> *"I am not using them, but I have both a cane and a walker. Look at them, they have been there for a long time (he pointed at his cane and walker). I don't want to use any of those assistants. I try to walk and exercise without them. When I walk, I used to feel I could climb the wall and tables. Finally, I can walk independently. I think, if I always used the cane and walker, I would use them forever, which I don't like, so I try to live without them both" (K12 (Extended family), lines, 79-81).*

Meanwhile, K14 and K15 lived in couple at home which was very close to their children's homes. Both of them were able to perform their daily routines by themselves and sometimes they helped each other. They exercised and worked at the farm near home as exercise every morning and afternoon. Their daughter brought them breakfast and helped with the household chores, and others as necessary. K14 swept the courtyard and K15 went to the fruit farm nearby to water the plants with sprinklers. Both K14 and K15 carefully performing those activities, they never asked for any assistants to support them (Observation: Field note extract), as K14 explained:

> *"I am able to do things without any assistants such as taking a shower and eating. In reality, I am able to cook but my children don't allow me to cook*

because my daughter already cooks at her rice curry shop. I just tell her about my favorite foods and she gives me immediately. Also, I don't like to cook, as I cooked a lot when I was younger. Now, I am old and tired of cooking. I have many things to do: clean the house and take care of my plants every day" (K14(Living in a couple), Lines 25-32).

K11 and K13 lived in an extended family. K11 and K13 did not have a lot of savings. K11 had her rubber and fruit farms to support her family but it was not much. However, K11 never worried about the issues, stating that it was enough for her family. She never needed a lot of money, but only good health. As she had gallstone, she just wanted to live without any complications. K11 was able to perform daily activities without any assistants. She did her daily routine carefully in order to prevent affecting gallstones in her gallbladder. She walked, showered, and dressed slowly. During the day, she slowly swept the courtyard, which was a mode of exercising. K13 had asthma, but he also performed daily activities without any assistants. His family living with three generations consisted of K13 and his wife, grandmother and grandfather, and a grandchild's family which consisted of her husband and her son. His wife played a role as a householder. Thus, it was good for him if he could help her and supported each other. He valued on not burdening his wife and also helped her. He cooked rice for their meal; while his wife cooked other foods. They supported each other in terms of several activities in their daily life. K13 followed the doctor's suggestions to prevent asthma exacerbation—living in the fresh air, exercising her lungs by both inhaling and exhaling, and walking slowly (Observation: Field note

extract). He stated he could not help his wife more; however, he should not burden her as K13 said:

> *"I take care of myself following the doctor's advice to prevent asthma. If I have a simple asthma, I can use my medicines (inhaler) but if I have more asthma, I will be admitted to the hospital. It will burden my wife because she must take care of me at the hospital. She will be tired and cannot work. I can take care of myself because I don't want to burden her and also help my wife to cook rice and wash the dishes. I would like to help her" (K13 (extended family), Lines 19-25).*

Meanwhile, there were key informants K1, K2, K3, K4, K5, K6, and K8 who were able to perform daily activities using assistants. The informants believed that performing everyday activities by themselves was the best way to maintain their health and to prevent themselves from becoming bedridden. K1, K4, and K5 performed their daily activities and worked near home using a walker, which was a substitute for exercising. K1 and K5 lived in an extended family, while K4 lived in a couple. They wanted to improve their physical function as much as possible, stating that even if their physical function could not be improved, at least they were able to keep their condition stable. They woke up early morning and performed their daily routines using a walker. Moreover, handrails and other convenient equipment were put for them in the bathroom by their children. They then were able to do the activities anytime they needed. Thus, they were able to live without imposing much burden on their family members. Moreover, both K1 and K4 always exercised using a

walker also. Not only did she used a walker to perform her daily but K5 also supported her family members although her physical functions were limited. While her daughter worked on a rubber farm, she cooked and cared for her grandchild using a walker. She was happy with her capacity (Observation: Field note extract) as K5 said:

> *"Yes, so, I am very happy I have a chance to help my daughter. My daughter and her husband were separated two years ago; that's why I need to help her. She is a single mum. Also, my sister always comes to my home" (K5 (Extended family), Line 31).*

K2, K3, K6, and K8 had more limited physical function than the key informants described above. Therefore, they focused only on performing daily activities. K3 and K8 lived alone, while K2 and K6 lived in an extended family. They used a walker and cane to support themselves when walking, taking a bath, and exercising. However, they still tried to do it as much as they could. Their family members helped them do those activities without falling— they had installed a handrail and a bathmat. K2 used a walker to walk and shower, and she also asked her daughter to stay with her while she was taking a bath in case she was dizzy (Observation: Field note extract). K3 stated that, although she usually asked for assistants to support her, she was proud of her ability to take care of herself because she was not a bedridden older people:

"I am able to walk quite smoothly and do a little bit of work such as housework, cooking, and washing dishes. I do things by myself, I am not a bedridden person; so, I should do things myself. In the afternoon, I always walk to exercise" (K3 (Living alone), Line,8).

3.2.1.2 Eating local foods and healthy foods

The majority of people in the community, including the key informants, believed that daily foods they consumed were contaminated with chemicals. Thus, they tried to reduce food consumption from markets or supermarkets. They kept following the principle of living with sufficient economy as "eat everything that is planted and plant everything that you eat"; thus, they usually consumed local vegetables they planted themselves until it became their routine dining. The homebound older people asked their children to cook for them using vegetables at their farms near home. If they needed to buy other foods from the market, it should be local fishes. Surrounded their home were vegetable farms. Most homebound older people had their own vegetable farms near home for their meals and sales. Thus, their children always cooked for them using local products from their own farms (Observation: Field note extract). K2 who strongly believed in local foods was very strict with her foods. She believed that local foods at her home were good for health and also economical. K2 stated that she had been able to live until then because they ate products from their own farm without chemicals, as K2 explained:

"I heard that vegetables from the market were contaminated with chemicals. I grew vegetables by myself, so I don't want to buy them at the market. Also, I have a pig farm and a chicken farm, so my family has their own food, and we never bought food from anyone. I have never got sick and had any chronic diseases. I just had a stroke when I was old" (K2 (extended family), lines 303-316).

The key informants who were stroke survivals and had hypertension (K1, K2, K3, K5, K6, K8, and K12) perceived that eating healthy foods with low salt, sugar, and fat was good for health and they were able to stabilize their diseases as they received health information from healthcare providers and the internet by using a smartphone. Moreover, the key informants also used supplementary foods to support their health. K2, K3, K5, K6, K8, and K12 drank milk with high calcium and low fat to nourish their body as suggested by health professionals, family members, and their own beliefs. K1 usually ate fresh herbs and drank herb juice as a supplementary food. He planted a lot of herbs around his home (Observation: Field note extract). K1 believed that herbs were good for health, as they helped him control blood pressure, nourished the body, and increased his appetite. He had used several types of herbs to support his health since he was young; herbs then became supplementary food in his daily life as K1 said:

"I know that herbs are good for your health. Some kinds of herbs are well known for their properties such as golden bush. Also, I have searched the internet to learn about other herbs and selected the herbs that have properties

to nourish my body so I could be healthy" (K1 (extended family), Lines, 133-143).

3.2.1.3 Living happily every day

The informants believed that good physical health could be linked to good mental health. They believed that body and mind were related and that the mind had power over the body. Therefore, the majority of key informants focused on taking care of their mental health. Whether they lived in an extended family, in a couple, or alone, they were happy with their later life with their positive mind. They were proud of their ability to support their children to gain a successful life. Thus, they thought that it was the time to rest and be happy with their later life. The homebound older people in this study lived without stress although living alone. K7 lived alone at her home; she understood that real life could continually deteriorate with time. K7 stated that she had already worked hard when she was young. She gave her children a lot of farms to support them and now they were happy. They were able to earn their own income from the farms. It was enough for her to have a mother's role. Therefore, she wanted to be happy as older people should be; her motto was: "let it go, let it be, and accept the aging of your body." She usually did everything that made her happy; she stayed with her sister and her son the whole day, and lived alone without stress at home, meeting old friends every morning while she kept exercising regularly, as K7 explained:

"In our community, most people like to exercise. When I was a social bound older person, I went to exercise at the older people club in our community. Also, you see, early in the morning, a lot of people exercise, walking or riding

a bicycle, and running. It is normal to exercise in our community because most of us exercise. It is not only an exercise for us, as we also talk and share our stories. We have a lot of fun during our exercises" (K7(Living alone), Line ,123).

K4, K10, and K15 were happy to stay at their farm, as it was their spiritual hub. They liked to plant and support their trees themselves because when they saw the trees grow, they were really happy. K4 felt happy to live within her vegetable farm near home, which she and her husband planted by themselves. Every morning, they did exercise and had breakfast, before spending time with the vegetable farm as their relaxing time. In the afternoon, both of them went to the vegetable farm to water them (Observation: Field note extract). By doing this, they had a chance to exercise again. Therefore, they perceived that working at their farm provided many benefits to them (relaxing the mind and exercising the body). While, K10 stated that when he got stressed out because of his family's problems, he went to his farm to care for his rubber trees and stayed at the farm until he felt good:

"When I am at my rubber farm, I am happy and forget everything. Also, I always make merit by giving food offerings to a Buddhist monk every morning in front of my home" (K10 (Extended family), Line, 26).

Another key informant (K1) surfed the internet during the day. He was happy with his ability to access the internet and several applications on his smartphone. He sought new information related to his health issues and was happy to apply the

information he had gotten from the internet (Observation: Field note extract). K1 stated that he had never experienced any stress or bad emotion. He was happy every day of his life although he had suffered a stroke and had limited functionality. He saw others who had a stroke and lived in a bedridden condition with TV and the internet. He thought he was lucky to have survived and was still able to take care of himself, as K1 explained:

> *"I could not suggest this for everyone, but I would like to say that I am a stroke survivor, and I am able to live and take care of myself. I should be happy in my life. There are a lot of stroke survivors who have become bedridden and rely on several assistants to support them in their daily activities" (K1 (Extended family), Lines, 381-384).*

Since all key informants were Buddhist, they valued on religious activities and making merit. K4, K9, K10, K14, K15 always offer food to the monks every morning at their home. For those who could not do the activities, they tried to go to the temple on the Buddhist Holydays although they could not stay at the temple for a long time until the ritual activities finished. K6 asked her children to invite the monks to their homes to receive food because she could not join religious activities at the temple because of her health. Meanwhile, K14 and K15 were proud of themselves as they were able to be a Host Kathina (donating a lot of money to support the temple) once a year as K15 said:

"Once a year, I would be a Host Kathina and join the vegetarian festival to giving the merit to our King Rama IX. I donated money ten thousand to the temple and will do it every year until I die. I am so happy with this" (K15(Living in a couple), Lines, 59-63).

3.2.1.4 Continuing exercises and rehabilitations

In the community, most people exercised every morning and early evening, jogging, riding a bicycle, and walking until it became a part of life for community members. During the exercises, they could talk and share their experiences to each other. Therefore, exercise and rehabilitation were included in the daily activities of the majority of key informants (Observation: Field note extract). All key informants believed that the activities helped them maintain and improve their functional ability. The key informants performed exercise and rehabilitation regularly and on time. They performed their exercise based on their functional ability although they could not join with others on the street or sport field in their neighborhood. However, they continued the exercises as stickily as scheduled. Moreover, other people who exercised on the street always talked with homebound older persons who exercised nearby. Therefore, exercises were included in activities in the daily life of some homebound people, accounted as their way of life. K1 stated that he could exercise and do rehabilitation every day, especially while watching TV, relaxing with family members, and working near home, as K1said:

"I exercise using several methods that I have seen on YouTube while looking for the way to fit with me because I found that the old methods were not good; so, I wanted to look for a new way. Now, I can find the way that is suitable for

me. I do it the whole day while watching TV, talking with other people. I always exercise" (K1(Extended family), Lines, 484-489).

K3 and K7 woke up early in the morning every day to exercise by walking in front of their home. They walked from their homes to the street, where other people exercised (running, walking, and riding a bicycle), and they talked with them (Observation: Field note extract). They stated that they felt improved every day because of the exercise and rehabilitations they had performed. By doing this, they were able to maintain and improve their functional ability every day, as K3 said:

"I feel better than before since I am able to walk and clean my home. In the afternoon, I always exercise. In reality, I am so lazy. However, I must do it well in order to improve my physical function and to prevent myself from the stiff joint" (K3(Living alone), Lines 26-32).

3.2.1.5 Seeking health information related to their health issues

The majority of key informants had health problems and functional limitations because of stroke, old age, and chronic diseases. Most of them wanted to maintain and improve their physical function, and control their chronic diseases. They continue to follow health professional's suggestions; however, some of them thought that it was not enough for them to achieve the goals. Community people including homebound older person could access new information and technology. Also, they were able to learn, choose, and gain information via technology to support

their healthy life. This was observed that the majority of people encouraged their children to study at high levels and their children then could bring the new knowledge and technology back to their hometown as part of community development projects, such as the upskill of learning internet Wi-Fi, a new technology of agriculture, and good health information. Therefore, the homebound older persons in the community were able to access new health information and apply it to their life and health (Observation: Field note extract). K1 had functional limitations because of the stroke, and he wanted to walk better than now. Due to his ability to access the internet via smartphone, he always looked for new information so that he could improve his physical function and he applied the methods he had found. Moreover, K1 also believed that he should increase his physical strength; therefore, he sought for supplementary foods to support his health. By surfing the internet, he got new information about herbs and used them to maintain his health, as K1 said:

> *"Of course, I will be able to walk without a walker someday. Thus, I still try to search for new knowledge about herbs in order to improve my functional ability. I like YouTube because I can gain a lot of information including information about herbs. After I learn about their medicinal properties, I will plant them on my farm. I have to learn from YouTube and my neighbors" (K1 (Extended family), Lines 9-11).*

Meanwhile, other informants had learned from health professionals how to take care of themselves and maintain their conditions. K3 joined a self-help group of older persons at an older people clinic of Kiriratnikom hospital. In the group, older

people who came to see the doctor were allowed to share their stories about taking care of themselves, health problems solving, and improving their health status. K3 had learned from both the ones who failed to improve and the ones who actually improved. The group's members suggested that K3 should walk between two handrails without touching them and increase the walking distance every day (Observation: Field note extract). By doing this, K3 had improved very fast, as the K3 said:

> *"I met other people at the hospital. They had a limited functional ability like me. Not only do I face this problem but also a lot of people do. I don't know why a lot of people have a stroke. It looks like a communicable disease. At the hospital, a nurse asked the patients with limited physical function to gather to discuss and share experiences to one another. During the group discussion, I have learned several ways to take care of myself. This handrail also, my daughter got the idea from a patient at the hospital who suggested that I walk between two handrails and put coconut shells in the ground to massage my feet" (K3 (Extended family), Lines 141-148).*

3.2.2 Keeping contact with family and friends as usual

The key informants of this study still kept a close relationship with their family members and interact with their old friends. They participated in several activities organized by their family and community, such as having meals together, attending religious ceremonies, and doing exercise. By doing this, they were able to take care of their mental health and support each other among friends and their family

members. Owing to social networks, the informants of this study were able to use smartphones to communicate with one another easily. They also have their private group in several applications such as Line. They could chat with their friends, relatives, and others via Line application every day. Therefore, it helps them stay in their own network and they never feel lonely. Whether key informants lived in an extended family, a couple, or lived alone, they still had a social relationship (Observation: Field note extract). Within the theme, two sub-themes emerged: 1) sharing stories with old friends and relatives, 2) sharing obligations with family members, as described below:

3.2.2.1. Sharing stories with old friends and relatives

Within the socio-cultural context of Thai rural area of the research setting, people had close relationships. They met and talked every morning while exercising and having breakfast at soft boiled rice or tea shops. Likewise, the majority of key informants were able to use a smartphone to communicate with others via Line application, and they were invited to join several groups in the application. Using the application, K1 chatted, messaged, and shared his experiences to others. While K6 and K7 often met their old friends and relatives at home. They did not use any smartphones but asked their family members to take them to see their friends and relatives at home. They spent a whole day staying together and talked about their health status, their children and grandchild, and collective of their merit. They also talked about their previous life when they met. Moreover, some also participated in social activities by accompanying their family as much as possible. Moreover, they were happy to tell their old stories in their life to their children, especially the story related to how difficult of daily living in the past that they were able to handle or

overcome with the pride of themselves (Observation: Field note extract). K7 stated that she never felt lonely because she still had friends and relatives:

> *"It makes me feel good that my friends never let me be lonely. Also, my cousins always come to visit me; so, I feel good, I am never alone. It allows me to share my story to others, and I have a chance to relieve stress. To take care of ourselves, we must see a doctor on time, talk with each other to share our stories or consult with a person we trust" (K7 (Living alone), Lines, 60-64).*

K5 lived in the extended family. She still kept a close relationship with her sister (K7) who often came to visit her and stayed with her every day. Both K5 and K7 could share their experiences and support each other, as K5 explained:

> *"I have my sister, she always comes to stay with me during the day. Her daughter drops her at my home, and we have a chance to talk and laugh together" (K5 (Extended family), Lines 81-85).*

Furthermore, K6 was very old and unable to use a smartphone to communicate with her relatives. However, she still kept a close relationship with her former family. During the fruit season, she asked her children to take her to her relatives in another province far from her home and she picked a lot of fruit from her farm for the relatives. A6 who was a family caregiver of K6 stated that she and her husband

recognized automatically when the fruit season had come. Of course, K6 asked them to take her to visit their cousins in another province, as A6 said:

> *"She understands that we are very busy. Sometimes, she thinks of her sister but if she knows I am busy, she can wait. So, I have never broken a promise with her. When I have time, I take her to visit her relatives immediately. She has an older sister and younger brother in Pattalung Province. We bring them a lot of fruit from our farm; rambutans, durians, mangosteens" (A6 (Family caregiver), lines, 25-32).*

3.2.2.2 Sharing obligations with family members

In the research setting, people still kept a close relationship in their family and supported each other. They believed that good relationships in the family influenced mental health that was related to good health. K9 lived in an extended family. He still played a role of the householder and cared for his family members. They lived with several generations in a big family—K9 and K10, the oldest daughter, a younger daughter, and her family (her son and her husband). They supported each other. K9 and K10 were able to take care of their grandchild, do housework, and cook. K5 lived in an extended family as well, but she supported her daughter and her daughter took her to see the doctor on schedule, make merit at temple, and visit her relatives. K14 and K15 lived in a couple at their home although their children supported them. The children shared responsibility to take care of their parents as their homes were close to their parents. Therefore, their children were able to support them every time they needed. The children cooked, cleaned the house, and

took them to see a doctor. They also encouraged their parents to participate in several activities of their big family (Observation: Field note extract), as K14 explained:

> *"I have a good support from my children. I really love them. Once I told them I had a problem with my glasses and three of them brought new glasses for me. They made me laugh. They discussed among each other that they should share responsibility to take care of me and my husband. Moreover, my husband really understands me, so we never had a conflict. I am so happy with my family" (K14 (Living in a couple), lines, 55-71).*

3.3 Health and social services for promoting holistic health of the homebound older people

Caring for older people in the research setting was proposed by family members, health professionals, and the community. Due to beliefs, values, family support, and the ability to take care of themselves, social services were not much needed for them. Most key informants and their family members were able to live independently. However, existing health care and social services were available in the research setting.

3.3.1 Health care services

Specific health care services for homebound older people were included in the long-term care system of Thai government. All key informants received home health care from health care services. Nurses and health village volunteers performed a health assessment for homebound older people at their houses in order to know the need for health care in the population. Nurses, as the care

managers (CM), composed a care plan by inviting multidisciplinary experts to join the health care system, such as physiotherapists, pharmacists, and proponents of traditional Thai medicine. The care plans were proposed to the Municipality to get the budget for the health care services through the National health security local fund of each sub-district. The multidisciplinary team of the long-term care services included health professionals, health village volunteers (CG), and community leaders. CM and CG were trained in a special course to support older people, including the homebound older people. CM and CG then invited the multidisciplinary team and other stakeholders in the community to join the health care system. Through the health care services, key informants received home health care activities which included basic health assessment, rehabilitation, health education, mental health support, and other services depending on the health problems of each key informant (Observation: Field note extract).

Moreover, key informants who had chronic diseases received specific health care services for each disease at home from health professionals. K12 received home health care services from the home health care center at Kiriratnikom hospital. The care activities were the same as the long-term care which included a multidisciplinary team that took care of the patients based on their health problems, especially in terms of the rehabilitation to improve their functional ability (Observation: Field note extract).

Although the health care services have been implemented to support older people at home, the care activities were unable to support all older people in the community because the budget was not enough. Therefore, home health care services also focused on encouraging family members to take care of their parents in specific

ways related to the health problems: rehabilitation at home, health control by diet control and exercises, and regular follow-up with the doctor. K12 stated that it was good for him to improve physical function because the health professional often encouraged him to practice:

> *"I have improved so fast. I am able to walk well. Please, take a look, I'm gonna show you (he walks). I went to see the doctor at the hospital, and he told me that I will improve if I practice every day. He also said that I must be patient and just practice. Moreover, health professionals came to visit me at home and taught me how to walk and exercise. I follow their suggestions strictly" (K12(Extended family), Lines, 191-194, 202-205).*

At the same time, health care services homebound older people and other older people were developed at hospitals and health care centers, such as sub-district health promotion hospitals. An older people clinic was opened and a multidisciplinary team was invited to provide health care activities through One-Stop Services of the specific clinic at the hospital. The specific health care services included doctor treatment, self-help group discussion, rehabilitation, and health education. Moreover, the data on the health issues of each person was transferred from the hospital to the health promotion sub-district hospital for continual care at home. The health promotion sub-district hospital then included the health issues in the care plan for home health care services (Observation: Field note extract).

3.3.2 Social services

In the community, homebound older persons received allowance supported by Thai government according to their age. Key informants who had their own income (K1, K3, K4, K5, K6, K7, K8, K9, K10, K11, K12, K14, K15) never spent the allowances, but they saved them in their bank account together with their own savings. As K2, K13, and K16 did not have their own income, the allowance was necessary for them, so they asked their children or relatives to withdraw the money from the bank. However, the allowance was not enough for them, they worked on their vegetable farm to support themselves (Observation: Field note extract).

Besides, the community also had a sports field, audio equipment, and sports equipment supported by the municipality, to encourage the community members to exercise. Likewise, the municipality encouraged older people to do group activities, such as folk shows like Manohra. The Manohra was applied to be Nohrabic as an exercise method. It could inspire older people in the community to continue exercising, keep relationships with their friends, and it also promoted harmony among people (Observation: Field note extract). Even if the key informants had limitations to join the activities, the social services could inspire them to continue exercising. K9 was the leader of a Manohra group (a kind of local Southern Thai traditional show) when she was in good physical condition, although she still exercised at her home and followed the prescribed methods:

> *"I exercise by walking near my home based on my condition. I just want to prevent myself from ankylosis and muscle atrophy. The doctor also suggested*

that I continue exercising. I follow all the basic steps I used when I did not have a functional limitation. I am not able to follow advanced steps because it may hurt me. I improved so much after my knee surgery because I always exercise" (K9 (Extended family), Lines, 46-57).

3.3.3 Folk care services

There were some folk care which may relate to health practice of the homebound older people and others in the community. On the main street of the community was found a big tree called Ton Ngiu (Bombax ceiba) growing on the middle of the street. All people in the community were respected and always made offerings to the tree to protect them from several bad things, such as illness. The tree was a central of mind of people in the community under the belief that there was a Nymph lived on the tree to support them including homebound older people. The homebound older people also respected the three and believed that the three help them to stay healthy and improve their health conditions as an associated informant said:

"In our community, we have a big tree growing on the middle of the main street. We respected and believed that a Nymph lived at the tree to support us from danger. If we don't have anyone to support us, we will respect and tell the Nymph" (A12 (Family caregiver), Lines, 76-77).

Moreover, K8 also believed that he had a spirit of Feng Shui Master who always protect him from illness. He got a stroke and he had improved because of the spirit of Feng Shui Master that help him to improve his functional ability. Every day,

he woke up early morning to respect the Feng Shui Master by offering foods, fruits, and a cup of tea for the Feng Shui Master. If he did not respect the spirit of Feng Shui Master, he will be harmed by the spirit of Feng Shui Master. Furthermore, he and his daughter had worship big ceremony for the spirit of Feng Shui Master every year. They believed that K8 got stroke because they never had worship ceremony for the spirit of Feng Shui Master; however, after they respect the spirit of Feng Shui Master, K8 has improved continuingly as A8 said:

> *"My father got a stroke around 8 months ago, I took him to see the doctor at the hospital. He was transferred to Suratthani hospital to continue treatment. We stayed at the hospital for 7 days. My father then was transferred back to Kiriratnikhom hospital again. We received continuing treatment from the doctor and a physiotherapist. They taught me and my father to exercise to improve his physical function. After that, we went back home. My father always exercised followed the physiotherapist's advice; however, he had slowly improved. I then think of a folk healer who lived at another subdistrict. I went to see him and told him about my father. He told me that I should respect the spirit of Feng Shui Master in order to help my father to more improving. I picked up the folk healer to my home to respect the spirit of Feng Shui Master. Absolutely amazing, my father had improved so fast. From then onwards, we established respect ceremony to the spirit of Feng Shui Master once a year" (A8(Family caregiver), Lines, 159-172).*

Meanwhile, a folk healer who lived in another community nearby and a lot of people including people from the research setting went to see him when they got bad things, such as illness. The folk healer treated their clients by several methods based on their health problems, such as herbals decoction, and worship holy things (Observation: Field note extract). However, the clients including older people will come to see him if they did not improve after they went to see a doctor at the hospitals and the folk healer became a last resort for them as a folk healer said:

> *"There are a lot of people come to see me with their problems; especially, their health problems. They usually went to see doctors at several hospitals and they did not get well, so they come to see me. I treat them as follows my knowledge and the angel, Nymph, and others because I am able to communicate with them and They told me how to treat them. In general, I suggested them to establish a respected ceremony. As followed me, they had improved" (F, Lines, 79-86).*

Moreover, many people in the community including homebound older people always integrated folk care and modern medicine to support themselves. They used herbs as a food supplement in their daily living. K1 used herbs to support his health for a long time; however, he still received modern medicines to support his health also. He believed that folk care and modern medicines could be integrated. Moreover, his family members also encouraged and facilitated K1 to use herbs as folk treatment (Observation: Field note extract). They stated that modern medicine was a major

source of treatment in the present; however, herbs were the major source of treatment of people in the past and it was still useful until now as A1 said:

> *"I think, herbs and modern medicines can be used together. My father had used herbs when he was young to support his health and for us. In the past, our community was surrounded by forest and mountain, when we got sick, we could not go to see the doctor at the hospital. My mother and my father treat us with herbs they got from the forest and we had improved. Thus, our family believed in herbs" (A1(Family caregiver), Lines, 88-103).*

Health professionals also believed that folk care and modern medicine can be integrated to support holistic health for homebound older people if it was not harmful and did not disturb the treatment processes of the doctor. Their role was a facilitator and coordinator of both care by offering alternatives in order to gain the best benefits to the homebound older people and to decrease conflicts between doctor and the homebound older people as a nurse said:

> *"For me, I accept folk care if it is not disturbing the treatment plant of our doctor. I usually allow the patients to practices by following their beliefs. I also communicated with the doctor for them. For example, they would like to meditate and take a funeral robe at the hospital. I allowed them to do" (N, Lines, 12-15).*

3.4 Factors related to promoting holistic health of homebound older people

There were several socio-cultural factors related to promote holistic health of the homebound older people. Relative and family network was a significant factor that directly influenced the holistic health of the homebound older people. Moreover, the family had some beliefs, values, and lifeways that related to the care pattern of family members that support their parent and also related to promote holistic health of the older people. All older people in this study had enough income that led them to access health care services both government and non-government services, so the economic status seems to promote holistic health of the homebound older people. They had never asked for their family member to support their income. Moreover, with a good economic status, the key informants could encourage their children to study at a higher level of education. Their children then brought new knowledge and technology back home to support their parents. By observation, the key informants were able to use the internet via smartphone and computer to gain new information related to their health issues and were able to improve and maintain their health. Therefore, the homebound older persons could support themselves surrounding a supportive family network and live in a strong community.

Accordingly, because of those factors, all key informants lived in an extended family either living as a couple, alone, or having some chronic diseases, they were able to maintain their holistic health and stay healthy at their home (Observation: Field note extract). From the qualitative data, three main themes were emerged: 1) strong community, 2) supportive family network, and 3) local wisdom of eldercare.

3.4.1 Strong community

Culture and ways of life focused on the self-reliance of the community members of the community encouraged strong community leading to quality of life of people including homebound older people. The majority of community people emphasized on living independently without burdening others. This value was instilled by their parent when they were young until became their life's way. Therefore, the strong community was built with a supportive family unit and the families were able to support themselves—enough family income, no dept, no gambling, and happy families. As a result, families viewed themselves to be contributors to their family and encouraged a strong community which also enhanced the quality of life of people including homebound older people. Moreover, the ways of life of people in the community were quite the same—sufficient, independent, harmonious, and respect older people. The community members often supported their parents as part of their culture, helped each other before asking for other support. Moreover, the community also support each other in their community until became a strong community network. Therefore, homebound older people were happy to live in their community with love and respect from their family and community members (Observation: Field note extract). This is one of the socio-cultural factors that influenced care pattern and care practices that related to promoting holistic health of the homebound older people.

3.4.2 Supportive family network

In general, the majority of people usually emphasized their grandma and grandpa as the venerable person of their family. They respected the authority of the older persons and gratefully supported them. Even if, the key

informants lived in the large family (extended family, although in some families, parents lived together at their house (living in a couple) and others lived alone at their home (living alone), the majority of key informants received good support from their family. Their family members prepared their meals for the homebound older person before other family members. All family members believed that parents were regarded as monks in their house that need to be respected. They always cooked the favorite foods of their parents and brought the foods to the homebound older person at their home and treated them as the highest authority person in their life.

The family members always supported their parents by encouraging them to perform daily activities, facilitating them to exercise, and taking them to see a doctor. Moreover, the family members provided a good mental health support related to maintaining the holistic health of the homebound older people, such as making merit, relaxing, and encouraging them to keep relationship with others. Most of the key informants in this study focused on improving their functional ability. They always exercised and rehabilitated by including such activities in their daily routine. Their family members encouraged them to perform those activities through rehabilitation equipment and always inspired their parents. This factor may be directly related to holistic health and interrelated to the cultural values, beliefs, and lifeways of the key informants (Observation: Field note extract). As a family caregiver who believed that performing daily activities also improved the physical function of the key informants, she encouraged her mother to perform activities of daily living by herself as the following excerpts:

> *"I would like to encourage her to perform activities of daily living by herself because I don't want her to be bedridden. If she can do it by herself, she will*

be happy. Thus, I renovated her bedroom to do her daily activities easily; the toilet was built in the bedroom and her personal belongings were kept in the bedroom as well. I often stayed with her in this room the whole night, my brother also. Our homes are very close, it is like we are in the same house" (A4(Family caregiver), Lines, 51-54).

Both key informants and associated informants believed that mind and body were related. Therefore, family members also provided a good mental health care to key informants. A1 supported her father through in ways, looking for herbs for K1, teaching K1 to use a smartphone and access the internet, and taking their grandchildren who lived at another province to stay with K1 during summer as A1 said:

"My father saw that we (me and my sister) always surf the internet, so he wanted to do it also and asked me to teach him. So, I bought a new smartphone for him and taught him how to use it and surf the internet. He asked my brother, my sister, and others who came to my home to teach him how to surf the internet. He learned fast and was very happy with it. Now he uses the smartphone throughout the whole day—he surfs the internet, chats via Line application, and watches TV. After he learned how to use the smartphone, I installed the home internet for him, and we are very happy to see him happy. We have never had any problems among the family members, as we have always discussed any issues. I think my father is happy with the harmony in our family also" (A1 (Extended family), Lines, 328-336).

According to family members valued on the relationship between body and mind, they believed that everyone would like to stay in their old social group which supported the mental health of the older people as well. They encouraged their parents to keep a close relationship with old friends, cousins, and other community members. According to the culture of the community in the rural area, the community members had a very close relationship. The family members usually took their parents to gather with others from the community at soft-boiled rice shops and tea shops. At the shop, they were able to share their stories about taking care of themselves, health problems regarding geriatric syndromes, and some of them were happy to talk about politics. Moreover, their family members encouraged them to use smartphones to communicate with one another (Observation: Field note extract). A6 supported her mother-in-law by taking her to visit their cousin in another province where she was born:

> *"I think I am able to be healthy because of my children since they take a good care of me and take me to see a doctor. If I want to see my friends, they always take me there. Every year, my children take me to Pathalung province to visit my sister. I bring a lot of fruits to my cousins" (K6 (Extended family), Line, 86).*

Meanwhile, other informants (K5 and K9) were able to support their family members by taking care of their grandchild when the daughter went to the rubber farms. They also supported each other by cooking, caring for grandchildren of other

family members, and working at farms. In this way, the key informants were happy and had a good mental health, relying on their own ability to support their family members, as K5 explained:

> *"My granddaughter is very naughty but I understand, she is a girl. I still help my daughter to take care of her. I never think of her as a burden. I don't work too much at the shop. I am so happy to help her. I feel good. I just help my granddaughter prepare herself for school and work at the shop until my daughter comes back from the rubber farm. By the way, my daughter also helps me take care of my son (her brother)" (K5(Extended family), Lines, 133-144).*

3.4.3 Local wisdom of older people care

The research setting had specific socio-cultural factors that were unique and different from others. The people of the community were able to manage their life by following local wisdom that had been transferred from generation to generation. The key informants who were parents taught their children to create plans for their life in terms of both their financial situation and lifestyle. They followed the principles of sufficient economic discipline—do not own superfluous things, live sufficiently, do not have debt, save money, do not gamble, and do not steal. Therefore, they lived without family conflicts and social problems that led them to enjoy their life. Their family members had more time to take care of the key informants. Both key informants and their family members had a high potential to take care of themselves and their families without needing to wait for government or other support (Observation: Field note extract). Three sub-categories emerged to

describe the sub-theme; 1) learning society, and 2) generosity society, and 3) spiritual center as described below:

3.4.3.1 Learning society

The research setting was a learning and modern society. People of the research setting always copied the living behavior of those whom they considered good for their own health. The key informants were supported by their children in the same direction depending on their living conditions (extended family, living in a couple, and living alone at home). In general, people of the community were able to access health information in several ways: through the internet, TV, and health professionals. The majority of the third generation of community members (grandchild of key informants) graduated with a bachelor's degree or higher. They were taught by their parents to take care of their grandma and grandpa. Even if they studied or worked at other places, they recognized that they should return home to take care of the older people in their families and develop their own motherland and support their grandma or grandpa. Their grandchild always used new technology to support their grandma or grandpa. They taught them how to use a smartphone to communicate with relatives and get new information about their health. Family members were taught to take care of their parentage from generation to generation. The new generation of family members was able to learn and follow the health information and practice until it became a part of their daily life. The educational factor had interrelated to the ability to use new technologies and the ability to access new health information that helped to promote holistic health of the homebound older persons as an associated informant said:

"In our community, most people emphasized self-care ability and learning. They were able to access good information on health and apply until it became a part of our culture. We recognized that we need to take care of our parents and they also perceived that they should keep the ability to take care of themselves and not burden their family members. Meanwhile, all family members were taught to take care of their parents. They had their own intellect and were able to learn and follow each other until it became normal for them. It occurred naturally. I cannot describe what it is, I just know that, if they know that someone does a good thing, another one will follow (C1, lines, 47-55).

They support their parents in the same way. Please notice, the parent's house and their children's house were close; even if older people lived at their own house, they were still very close to their children. It was just the name of living alone at home. In reality, their children did everything for them, such as cooking, cleaning the house, traveling, and making merit at a temple. This is because they had time to support their parents, and they had never gambled or used drugs. As I said, they were taught and followed each other, so they usually practiced the same way. If they knew that someone did good, another one followed, and then another, and finally, everyone practiced the same thing, including taking care of older people" (C1, lines, 58-63).

3.4.3.2 Generosity society

The majority of people in the community recognizes that our society is aging. They believed that older people should receive good support from their family, both physical and mental care, in order to keep their ability to take

care of themselves. The community members focused on older people who should receive sufficient support and were respected. Moreover, the community leaders also encouraged older people in the community to join the community's activities as much as they could do, such as religious activities at the temple and cultural ceremonies. The community leaders offered the services by picking up the elders from home to join the activities. Moreover, older people were also arranged as the first priority to be supported when they were faced with disasters, such as flooding. By doing this, key informants were proud of themselves and received good care from their family and community. There were not abandoned by the community, as an associated informant said:

> *"I think, aging society is not a problem of the community because young generations learn from their parents how to support older people in their family and that behavior will be transferred from generation to generation" (C2, lines, 54-59).*
>
> *"We always supported each other in our community. Especially, older people, we supported them a lot, we join the health care services of the Sub-district health promotion hospital in our community to facilitate and support our older people. We also encourage the older people to join our activities, such as Buddhist Holy days, Songkran Day (a cultural activity). If their family members could not take them to join, I and other community leaders will pick them up by ourselves because we would like to support their mental health and we considered that mind is the most important to support" (C2, lines, 73-91).*

3.4.3.3 Spiritual center

Key informants considered themselves as the key contributors of their families and community. The homebound older persons were respected by family and the community members. In family, the homebound older persons were arranged at the first priority of their family that all family members need to support and emphasize as a venerable person of their family. For example, the family members prepared their meals for the homebound older people before others because they believed that their parents were monks in the house (the older person was the first to be served). Moreover, the homebound older persons were considered as knowledgeable persons who typically provided good recommendations to their family members for working at their farms, couple life, and social life, etc. Furthermore, in the community, older people including homebound older persons were considered as a center of the mind of community members. In priority, all older people were respected and received good support. The community leaders always informed older people to participate in the decision making of several activities in the community, such as cultural activities, religious activities, and other community development activities. The homebound older people lived as valuable and knowledgeable persons in their community (Observation: Field note extract) as an associated informant said:

> *"We are Thai, in general, we usually respect older people as a venerable person and knowledgeable person. They are the first person who needs to receive good support and respect. We start at the family and expand to our community. We inform them to participate in serval activities in our*

community and ask them to give good recommendations and take decision making about community activities and development" (C1, Lines 62-79).

Summary of Findings

The informants of this study revealed their beliefs and values relevant to the meanings of holistic health which led to practices in order to maintain holistic health in their daily life. They perform their daily activities based on their own ability to support themselves and some key informants were able to support their family members. Several socio-cultural factors had interrelated between each other and also directly related to promoting holistic health of the key informants. The informants proposed meanings of holistic health as: "being alive with good health in their age". Within the broad meaning of holistic health, the informants gave three main reasons to support their document as: 1) they were self-support function so, they were healthy. Of this, they were still healthy because they were able to perform activities of daily living and take care of their own health and were able to work on their farm near home independently. 2) They were still healthy because they were able to control their conditions. In order to support this idea, the informants described that they could control chronic diseases they faced, having regular physical activities such as exercises, and they also were able to keep mind and body together to accommodate the changes after a disease. 3) They were able to adapt their living to the change around them so they were enjoyed their life. This point was supported by three ideas as they lived without imposing care burden on their family members, by accepting the limits of old age, and by being able to adapt life to a new reality.

Based on the meaning of holistic health which sprang from their believes and values, the key informants took action to maintain their holistic health as: 1) always taking care of themselves to stay healthy. Because of this, they were able to perform their activities of daily living with and without assistance, eating local and healthy foods, living with happiness every day, continuing exercises and rehabilitations, and seeking for health information related to health issues. 2) Keeping contact with family and friends as usual, the key informants shared stories of their life with friends and relatives and they also shared obligations with their family members.

Health and social services for promoting holistic health of homebound older people were available. The long-term care services of Thai government were implemented in the research setting extensively. The key informants received the care services at home based on their health issues. Moreover, nursing care services were implemented to support homebound older people by providing health education and home visit. Social services were available in the form of the research setting; eating local foods produced from their farms without chemicals, sports field, audio equipment, and sports equipment supported by the municipality. Factors related to promoting the holistic health of the key informants were also found such as being a learning society, generosity society, and spiritual center of their family members and community.

Socio-cultural factors and environment context particularly local wisdom had interrelated and directly influenced care expression, pattern, and practice that promoted the holistic health of the homebound older people. The overall summary of the findings is described in Figure 2.

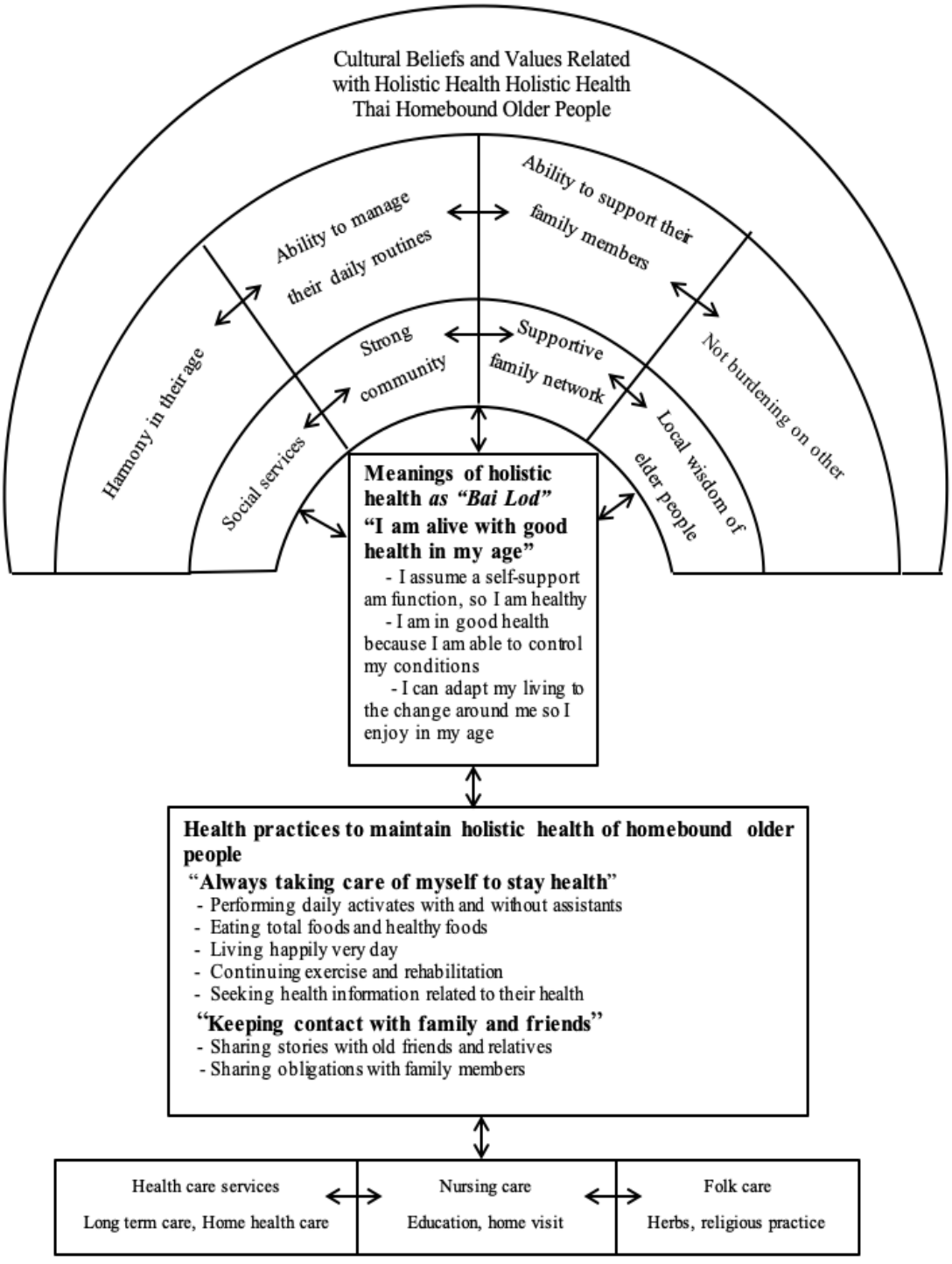

Figure 2 Model of cultural beliefs and values related to holistic health among southern Thai homebound older people

Discussion

The findings of this study provided insights about the holistic health from the perspectives of homebound older people and their health practice in the southern Thai socio-cultural context of older people care. The informants valued on their personal properties that were derived from their cultural beliefs. Health care practices were performed to support their health followed their own beliefs and values. Healthcare, social

older people are presented in Figure 2. The Leininger's Sunrise Model (Leininger, 2006) was used to guide to develop the model. Leininger suggested that the worldview, cultural and social structure, and environmental context influence care expressions, patterns, and practices and related to the holistic health of people.

Meanings of holistic health

The beliefs and values about their personal properties were able to support themselves without burdening on others and also still kept their ability to support others. Being with a good health in their old aged or "Bai Lod" in southern Thai local term was considered that they were still healthy.

"Self-supporting or taking care of themselves," was referred to the ability to perform their daily routines themselves and work as before with or without assistive equipment and their family members' support. To relieve the burden on their family member, all informants stated that performing their daily routines and working at the farms could prevent them from a bedridden condition and confirmed that they were still healthy. Some assumed that working at the farms was similar to do exercise, some engaged in exercise regularly as a part of their rehabilitation which helps them feel strong and maintain health. Many studies also stated that exercising in older

people promotes a healthy and longevity lifestyle (Asawakosinchai, Sanhpetch, and Rungsai, 2011; Huzmeli, Yildirim, and Kilinc, 2017).

In our study, the key informants also perceived that "having the ability to control health conditions" considered as they were still healthy. The homebound older people accepted the natural decline of the human body. They understood that several health problems will come up because of their age; however, if they could handle their health that meant they were healthy. This belief was influenced by a Buddhist doctrine in Thai culture which indicated that: "the mind is a boss, the body is a servant". The benefit for older people's health was that the mind's power was over the body. If you have a good mental health, they will overcome many physical issues and stay healthy (Tassanasri, 2014). This finding is in accordance with the previous studies that described how mind's power manage health issues in chronic diseases successfully (Manasatchakun, Roxberg, and Asp, 2018; Thanakwang et al., 2012; Tkatch et al., 2017). However, those studies mostly presented the ability to control the physical aspect of health conditions. Our findings had given the clear influence of perceptions of participants that the ability in controlling their health condition also came from having good mental health, which led to the holistic health.

Moreover, the greater capability to control one's health condition, the better good self-management was mentioned. They were able to do the activities at any time as their needs and desires independently which also meant that they were healthy. It also found from the previous studies proposed that the ability to manage their personal health provided a good influence on blood pressure and increased good physical and mental health of older people (Camp, Fox, Skrainer, Antenucci, & Haberman, 2015; Girdler et al., 2010). This means that living independently is related

to the meanings of the holistic health of homebound older people. Moreover, the results of this study also revealed that a powerful mental health allowed the homebound elders to develop their self-esteem and proud of themselves. This related to the study of Rojpaisarnkit (2016) that described that physical activities and mental-social-spiritual health are directly related to each other. Such that, the interdependence of those dimensions emphasizes the meanings of holistic health from the perspective of homebound elders.

Living without burdening their family and being happy in old age as “valuing being proud to be a healthy older adult”. The key informants understood and accepted several changes and were able to overcome those changes in both health and illness. However, they believed that strong family relationships and community can be linked through religious and social activities. This allowed them to stay healthy. Thus, they lived without burdening on their family members and they were happy in their life. Moreover, there are four importance in their daily lives - valuing gratitude, responding to people’s needs, practicing dhamma, and making merit. Moreover, they had self-respect when they are responsible for their children’s successes and their children also respected the key informants as people who encouraged them to be a successful person. This finding reflects that being proud of oneself is related to self-esteem, which is related to spiritual health. In other words, it could say that both self-esteem and spiritual health are linked to the holistic health of homebound elders. Therefore, being interdependence and family ties are essential resources for olders, as found in previous studies in Thailand, especially in the northern Isan communities (Manasatchkun, Roxberg, & Asp, 2018; Thanakwang, Isaramalai, & Hatthakit, 2014). Similar findings were also presented that cultural values and beliefs influenced the

holistic health of the homebound older people as explained by the Leininger's Sunrise Model (Leininger, 2006).

Health practices to maintain holistic health of homebound older people

All informants performed several activities in daily living to promote their holistic health. Most health practices are derived from their own beliefs, values, and cultural background. Since daily routines were considered as basic activities that everyone should perform by themselves (Nosraty et al., 2015), having the ability to do the activities at home was believed that they were healthy as a homebound older person. The pattern of activities of daily living of the homebound older people in the community was quite similar although the activities they do with or without assistive equipment. The key informants also believe in the relation between body, mental, and spiritual health. Thus, maintaining good physical function was related to maintaining their mental health. Moreover, their ability to take care of themselves decreased the care burden of their family members and help them to keep their ability to support their family members that increased their self-esteem that related to their spiritual. This was congruent with the policy of Thai government which emphasized people to live independently under their own context and encourage sustainable self-reliance in all aspects, such as economic, social, and health (Office of the National Economic and Social Development Council, 2020).

Regarding physical activity, it was considered as the most important aspect of daily living. Thus, increasing body strength was considered to be the main focus of homebound older people. Although the health conditions of older people can deteriorate because of aging (Park and Yeo,2013), there are several ways to maintain and improve health conditions in order to slow down aging, such as eating healthy

food, caring for their mental health, and continued exercises and rehabilitation. The findings of our study showed that the homebound older people, both those who lived with and without chronic diseases maintained their health by performing daily activities by themselves. The ability to perform activities of daily living by themselves had benefits for taking care of both physical and mental health (Atallah et al., 2018; Thanakwang et al., 2014). Besides, eating local and healthy food and exercise were major concerns of homebound older people which were relevant since it is considered to prevent and control non-communication chronic diseases (NCDs) (Bubpa and Nuntaboot, 2017a).

Besides, all informants continue taking care of their mental health by adhering to the doctrine of Buddhism. They engaged in religious and spiritual activities every day to increase their happiness, such as being optimistic, living in the present, and accept the way of the world, and being willing to serve others (V. Vajiramedhi, 2020). The homebound older people then took care of their physical health by continuing doing exercise and rehabilitation based on their condition. Although, they were limited by their physical function; they were able to adapt themselves by doing passive exercises or using an assistive device. They were able to exercise every time and any place as their needs. Limitation of health was not an obstacle to the exercise for them. This reflected that they were living with real-life living in the present follow the Buddhist doctrine as described above.

Moreover, the self-sufficient lifestyle of people in the community lets them live without a burden on others. The homebound older people, in particular, emphasized their wish to be independent - whether they lived with their extended family, as a couple, or alone. The way they cook and consumed related to natural

foods or fresh from their farms was appropriate with their age to stay healthy. More local herbs and vegetables were used among those who had a chronic illness. This also was found in other parts of Thailand (Manasatchakun, Roxberg, and Asp, 2018). Some of the informants believed that using modern medicines as well as traditional or folk care (recommended by a healer) could maintain their good health. This was similar to a previous study (Peltzer and Pengpid, 2019) that both herbs and modern medicine (following health professionals' suggestions) were more likely to use in those who had chronic diseases to promote their health. In this study, most older people with chronic diseases used the traditional self-healing practices by using local materials or plants from their farms. It was used based on their own experiences which transferred from the previous generations that helps to maintain both physical and mental health (Peltzer and Pengpid, 2019; Sumngern, et al., 2011).

Therefore, the finding of this study was related to Leininger's Sunrise Model (2006) that described that beliefs and cultural values influence care expression, pattern, and practices and also related to holistic health.

Health and social services for promoting holistic health of homebound older people

Health services for promoting holistic health of homebound older people were found. the comprehensive healthcare services were implemented in the community following the government's criteria (NSHO, 2016). The majority of the key informants stated that the healthcare services were adequate for them partly because they were able to take care of themselves. This has strengthened the community when activities were implemented by their local municipality and Thai government. In this study, it was found that the community was currently able to

support themselves without government supports in terms of care services for homebound older people. It was partly due to the small number of homebound older people but the system might need development because of the continuing aging society.

Moreover, in order to promote the health of people in the community, the municipality supported a sports field, audio equipment, and other sport equipment. However, our findings were found that people in the community exercised according to the social trend, such as cycling; while, homebound older people exercised at their home. However, the community leaders supported the homebound older people by giving praise and encouraging them to continue exercise at home. The community leaders supported and encouraged every good and beneficial activity promoted by people in their community performed. This reflects the strength and vision of community leadership to improve the quality of life of people, including homebound older people.

Moreover, folk care services were also found in the community. Some of the key informants believed in their local wisdom that herbs supported their health since they were young until today. The fact most community members lived in their community was encouraged to use herbs and local products from their farm through OTOP that they were able to consume in their family and to sell. Besides, the healthcare professionals also accepted folk care, beliefs, and values of the homebound older people. Many nurses in the community played the role as a mediator between folk care and modern medicine in order to maintain both care services to meet the need of the homebound older persons. This finding really related to the Leininger's theory that described that nursing care practices were able to bridge the gaps between

folk care and professional care followed the three action-decision care mods (cultural care preservation and -or maintenance, culture care accommodation and -or negotiation, and culture care repatterning and -or restructuring) (Leininger, 2006). Although folk healers were not found in the community, the homebound older people who believed in the folk care, they would go to see the folk healer in another community when they felt that their illness was not improved by using modern medicines only. The folk care seemed to be used as well as other care. This is because the new generations of the community members brought new knowledge and technology to develop their hometown. Therefore, the local and modern medicine was combined to use and they were more likely to acknowledge the importance of a self-sufficient lifestyle and their local wisdom.

Factors related to promoting holistic health of homebound older people

In this study, there are several factors related to promoting holistic health of the homebound older people. The ways of life with the nature of the older people was also enhanced good environment around them. Surrounded by mountains and forests leading to fresh air and a good atmosphere. The integrity of natural resources was also suitable for occupation in agriculture that led them to have good economic status. They learned to live and rely on the nature around them and gained a lot of benefits from the nature. The people also used sufficient economic discipline to guide their way of life. They had main cash crops, such as rubber trees, palm oil trees, and fruits, and secondary economic crops as vegetables that promote their income stability. Thus, the social problems (thief, gambling, and drugs) was less likely found. Closed relationships between community members, their harmony, and conservation of natural resources and local culture were considered of the strength of this community.

Moreover, the difficulty of living in the past also encouraged harmony of people in the community because they were close relationship and support each other although they came from different places.

The remarkable living conditions of the homebound older people in the community were significant factors promoting their holistic health. Three patterns of living conditions (lived in an extended family, lived in a couple, and lived alone) were designed by themselves based on their beliefs, values, and culture of care for older people in the community. Whichever one of those, three living conditions; however, they were closed to their children that were available to support each other. The homebound older people who lived with their extended family were treated as the highest authority person that influenced decision processes of their family members in term of farming, wedding, and dealing with problems that they faced in their families. Their children cooperated to support their parents and the homebound older persons were at the center of the mind of their children and facilitate the family relationship. Interdependence care was found to be the main source of social interaction among homebound older people. The closed family relationship was also observed and found by the fact that parents' or homebound older' homes were surrounded by children's homes that were designed to make it easy to take care of the older people and encouraged family ties. The patterns of living and interdependence care were also found in other regions, such as northern Thai village (Danyuthasilpe, 2009). This way of life may be found in different and difficult to find in the urban areas where most family members live apart from their parents or older people.

The majority of the key informants who lived in the extended family and lived in a couple valued on living without burdening on their family members. They

focused on their daily routines and maintain their chronic diseases to be under control. The belief in independent care was explained which is similar to the previous study as shown in Isan culture (Manasatchkun, Roxberg, & Asp, 2018). Another study also proposed that living by relying on others for basic life activities was considered by older people as a loss of their power of persons (Nosraty et al., 2015). However, interdependence care was also significant as mentioned earlier. The support and share responsibility in a couple for their activities in daily living could bring happiness in life. This reflects that living as a couple in their later life was able to promote their holistic health. This finding is coherent with previous studies that proposed that the spiritual well-being of older people was associated with marital status (Jafaripoor et al., 2018; Jing et al., 2016).

Likewise, based on Thai traditional care that respects their parent and valued on gratitude, family members always supported and encourage the key informants to live dependently with and without their assistance under their support. The family members who had a better understanding of the real needs of their parents were able to support them correctly. This reflected that understanding older people live as a family member was a significant source of holistic health. This is relevant to a previous study described that family relationship was related to promoting the holistic health of older people (Manasatchakun, 2018). Therefore, homebound older people performed their physical activities and emphasized their social interaction with the family to maintain holistic health. Not only the traditional care but also the availability of nursing care and support for homebound older people remained important particularly for those with dependence and having a chronic illness. Most homebound in the study received health information and home care services as part of

long-term care services including a home visit. However, they expressed their needs to have more encouragement of local practice and acknowledge their respect of older people as a contributor to family and community harmony as found in other parts of Thailand.

In the culture care in Thai society, adhere to social interaction and being with others is necessary for people in every life span. People in rural areas, in particular, maintain very closed relationships with their friends, relatives, and community members. They usually join several activities in the community together and provide help and support both physical and mental health. Due to social and economic changes, it could impact the ways of life of people in both rural and urban areas. The decreased number of family members and the migration of youth to study or work far away home could affect the daily living of homebound older people (Phillips, 2015). However, our key informants were able to keep their relationship with their family members, relatives, and others. They learned to use new communication technology to contact each other in order to maintain their social status. The social interaction with others in their community and their previous social network, although they just stayed at home could support mental health in later life. This corresponds to the results from the previous study that reported that social support and social interaction had a significant correlation with the quality of life of older people (Long and Sudnongbua, 2017). Also, most of our informants played a significant role as the main supporter for their family members in terms of farming, good recommendations, and spiritual center. The ability to support each other between family members and their parents was valuable for homebound older people.

Moreover, the growing use of communication technology influenced the way of life of people worldwide including homebound older people. Health information is easier to access which was encouraged the homebound older person to look for suitable methods regarding their needs in order to take care of themselves. The key informants felt accepted the new information that was good for their health and they were ready to adapt themselves to the new things to improve their health. This finding is coherent with a previous study that older people need to know new health information to support their health (Punyathorn, 2014). By accepting changes in life without sticking to old ways, it contributed to support their mental health. This practice is coherent with the Buddhist doctrine that proposed that all things happen upon other things, name and form, six senses, contact, feeling, desire, attachment, existence, birth, and all suffering (Dhammadanasuanmok, 2011). Some key informants also expressed the importance of attending temple and religious activities within the community, as a way to maintain mental health and a sense of spiritual health in later life. Thus, if ignorance is extinguished, all the other causes of suffering are also extinguished (Harirakthanrong and Taruno, 2017).

The findings of our study revealed that living in a strong community also helps to promote the holistic health of homebound older people. The key informants lived in a community that encouraged the community members to live based on self-reliance both economic and health care. Therefore, the majority of people including homebound older people focused on taking care of themselves while not rely on others. Our finding is related to the Leininger's theory that beliefs, values, and ways of life of people influence the pattern and practice of the people (Leininger, 2006).

Moreover, the community members also valued on gratitude and respect of the older people.

Another factor is strong family ties are significant to promote holistic health of homebound older people. All family members emphasized and encouraged their parents to keep their ability to take care of themselves with their support and the cooperation between each other in their family members. The key informants were considered as venerable persons who were put on the center of mind and spirit of their families and family members need to respect and practice followed their doctrine. This corroborates a previous study proposed that described that the family is the smallest unit of the society that is important for everyone from birth to death and also help to promote holistic health for older people (Prazeres and Santiago, 2016; Silverstein and Giarrusso, 2010).

In general, most people in the Southern Thai had a good economic status; thus, it was unnecessary for the young generation to go far away from their home to work. They just went to work in order to gain more experiences in their life. Finally, they would return home to stay with their family and supported them. Although socio-cultural and economic changes have influence families' structure, the extended families in a southern Thai area have remained that supported the closed relationship and availability of support between family members (Abas, 2013). Especially, in the research setting, most of the young generations were still at home. Some of them who worked in an urban area eventually returned home and were able to improve their farms by using new knowledge and technology.

All key informants always received support from their extended family which included three generations of family members. Much supports from their families

helped homebound older people maintain a warm and close relationship and raise their mental and spiritual health. Besides, the homebound older people were also accepted and regarded as key persons in the family by supporting their family members, such as taking care of their grandchildren, helping in household work, and providing advice. Therefore, a strong family network was a significant factor for promoting the holistic health of homebound older persons in southern Thai community.

Moreover, our findings showed that the cultural care of holistic health (Bai Lod) practice was adopted by their learning. A learning society and a generous society can lead to a strong community and self-reliance of people in the community. Most people, including older people, accepted and learned new knowledge, new technology, and integrated them with their traditional practice that they considered good for their life through regular exercise, farming, and eating local foods. Moreover, the lifestyle of the community members was translated, transferred, and learned from one generation to another generation and also applied to current practice. This could be sustained as part of cultural care for older people in the southern Thai community.

Likewise, the community based on a generous society could lead to community well-being. This is partly because most people in the community spend their life way to respect each other as relatives and had a closed relationship. The focus of the Thai Traditional care on older people in the study was related to respect and love which is always given the first priority. In addition, the community leaders acknowledged older people in their community as the resources of local wisdom. The community leaders also played the role as facilitators to support older people to join

several activities in the community. For example, an older person was invited to be a prayer leader in religious activities. This finding reflects the Buddhist doctrine that teaches all living with benevolence for others leads to happiness in life (Ariyabuddhiphongs, 2016; Setwong and Suporn, 2020; Somsri and Supasorn, 2017). So, the shared beliefs and values in the community contribute to the health promotion of homebound older people in order to achieve holistic health.

In summary, our findings reflected the relation and interrelation between cultural, social structure dimensions and environmental context, and community history have influence care patterns and practices in the holistic health of people. Cultural practice to maintain holistic health reflect the universality of care pattern that influenced by several factors in the specific phenomena. Diversity of care could be indicated by beliefs, values, and socio-cultural background of the homebound older people. For example, belief in self-care ability, valued on not burdening on others, the homebound older persons can perform their daily routine themselves. As a result, they considered holistic health practice as a way of life at their age.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the conclusions and recommendations for nursing practices, nursing education, and further research.

Conclusions

The increasing number of older people has caused a major concern for public health worldwide. Health care services to support this population, improve their quality of life, and decrease care burden have been developed. However, there are still limitations in care services. Health care services are limited when it comes to cultural care for a specific group of older people implemented in the real situation, especially for homebound older people who are neither in good nor in poor health and who require specific services to support their health. These homebound older people are still healthy enough and can maintain their life. This qualitative, focused ethnographic study aims to explore the ways of life in homebound older people to maintain their holistic health. It covers the meaning of holistic health (beliefs and values), practice to maintain holistic health, health and social care services related to promoting holistic health, and factors related to promoting holistic health.

This study has been guided by Leininger's theory of cultural care diversity and universality, which provided pathways to gaining the emic view regarding the holistic health of the informants. This theory describes different factors that influence cultural care related to the holistic health of older people. The researcher has used focused ethnographic study method to achieve this goal. Sixteen key informants and twenty-

four associated informants were invited to participate in this study. The researcher collected the data employing several methods such as participant and non-participant observation, semi-structured interview, and focus group discussion. Field notes and observation taking forms were used to record data in the field. The interviews were tape-recorded, transcribed, and paralleled with the data analysis. The researcher used four steps of data analysis recommended by Leininger to analyze the data. The findings have indicated that beliefs, values, lifeways, and socio-cultural context have relevance to the meanings of holistic health and practices in daily living to maintain holistic health. The study has also suggested appropriate health and social care services, including factors related to promoting holistic health of the homebound older people.

Holistic health in this study has been perceived as a concept of good health (Bai Lod) which unites body and mind, integrating both social and spiritual aspects. Physical health was the first domain of holistic health emphasized by both key and associated informants due to their belief that having good physical health allowed them to perform their daily routines. The older people in this study considered holistic health as the ability to support themselves, control their health condition, and adapt themselves life changes so that they could have good mental health or positive mind. Likewise, they considered the ability to support their family members and work at farms near their homes as having holistic health. The key informants also claimed that living without burdening their family members and others made them proud of themselves, which encouraged their mental health and spirituality. Therefore, body, mind, and spirituality have been interrelated and cultivated in their lifestyles.

Holistic practices were described related to the meanings of holistic health which included the informants' beliefs, values, and lifeways. Depending on their beliefs and values, and their ability to take care of themselves, support each other in their families, and work at the farm near their homes, the homebound older people took care of themselves and stayed healthy. They performed activities of daily living with and without an assistant, focusing on decreasing the burden on their family members and supporting each other. Eating local and healthy food was considered to benefit their own health and promote holistic health. Healthy food meant the food with low fat, sugar, and sodium. Local food was comprised of vegetables planted by the informants and the vegetables they could easily find in their community. Neither healthy nor local food was contaminated with chemicals.

Furthermore, based on their beliefs on the interrelation between body and mind, the key informants often took care of their physical and mental health together. They tried to be happy every day in order to maintain their mental health and continued their exercise and rehabilitation to maintain physical health. Furthermore, the homebound older people still kept in touch with their family and relatives and performed activities to maintain mental health and spiritual well-being. Moreover, to maintain their holistic health, the homebound older people always sought health information related to their health issues in order to gain new knowledge and ensure its practice.

Both health and social services were at their disposal, and they were performed by health professionals and communities. However, the majority of the key informants and their family members took care of themselves. They did not need any support from health professionals. Significant factors in promoting holistic health

were a strong family network and local wisdom inherited from their ancestors and transferred from generation to generation.

Factors that promoted holistic health of the homebound older people were related to Leininger's theory. The local wisdom that included beliefs and values on their ability to support themselves without burdening others influenced their practices and promoted their holistic health. Other factors in promoting holistic health were economic status, social factors, education factors, and technological factors. The key informants had their own income, so they supported themselves and their children. In addition, they lived in a community where people had always supported each other and respected older people.

Recommendations

The findings have shown rich data based on ethnography. The study indicates that socio-cultural background, beliefs, and values have shaped the perception of the holistic health among the key informants. It has been found that health practices to promote their holistic health were influenced by cultural, social, and environmental factors. The cultural care of homebound older people demonstrates the importance of integrating cultural beliefs and practices into nursing practices and nursing education.

Nursing practice

The meanings of holistic health from the perspective of homebound older people would help nurses consider the most important care activities to support homebound older people at their home and adapt those activities to improve both physical function and mental health. Moreover, the beliefs and values of homebound older people towards holistic health should be integrated into existing health care and

social services. The cultural appropriated model should be developed by fostering beliefs, values, and cultural background to enhance holistic health in later life of homebound older people.

Nursing education

The Thai homebound older people had their own beliefs and values related to maintaining their health. Nursing educators should encourage nursing students to recognize the meanings of holistic health in the subculture of older people. Cultural care practices should be acknowledged and integrated into nursing assessment subject to design appropriate care for each community.

Further research needed

The findings of this study have presented the essential components of holistic health of homebound older people. Further research should develop healthcare or learning packages for nurses in order to access, design, and evaluate holistic health and implement the holistic care program that fits with the real need of homebound older people. The specific cultural values, beliefs, and lifeways are different in each culture and subculture; therefore, further research is needed to explore the perceptions of Muslim older people.

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APPENDIXES

APPENDIX: A

Demographic Information Form (Key informants)

Interview codes

number……

Date of interview……

1. Address……..

2. Gender ☐ Male ☐ Female

3. Age……..years

4. Marital status ☐ Single ☐ Married ☐ Discovered/widowed

5. Number of persons in family……

6. The highest level of education ☐ Under Grade 6th ☐ Grade 6th

☐ High school ☐ Bachelor

☐ Graduate

7.Occupation……

8. Religion preference ☐ Buddhist ☐ Islam

☐ Christian ☐ Others (specify)……

APPENDIX: B

Demographic information form (Associate informants)

Interview codes number……

Date of interview……

1. Address…….

2. Gender ☐ Male ☐ Female

3. Age……..years

4. Marital status ☐ Single ☐ Married ☐ Discovered/widowed

5. Number of persons in family……

6. The highest level of education ☐ Under Grade 6th ☐ Grade 6th

☐ High school ☐ Bachelor

☐ Graduate

7. Occupation……

8. Religion preference ☐ .Buddhist ☐ Islam

☐ Christian ☐ Others (specify)……

9. Relationship to key informants……

10. Duration of time closing to key informant……

APPENDIX: C

Interview guide for key informants

The following open-end questions related to daily life rehabilitation for improving physical function and falls prevention will be explored with key informants. However, the interview may modify or add some important questions along the process of interview if needed.

1. What is the meaning of holistic health?
2. What are your opinion about holistic health?
3. What are the cultural issues regarding holistic health?
4. What are the meaning of holistic health?
5. What are factors influence holistic health?
6. How do you carry out your daily activities to maintain holistic health?
7. What are health care services that you received regarding holistic health at your home?
8. What kinds of supportive services that you received regarding holistic health at your home?
9. What are the supportive services that you received from other accept health care services regarding holistic health at your home?
10. Who are your supporter regarding holistic health at your home at your home?

APPENDIX: D

Interview guide for associate informants

Family member

1. How long you stay with the homebound elder?

2. What are the activities related to holistic health that the homebound elderly performs in daily living?

3. What do you think about holistic health at home?

4. What are factors influence holistic health at home?

5. What are the factors influence holistic health of the homebound elderly at home?

6. Who are the key supporters for encouraging cultural care to maintain holistic health among homebound elderly?

Health professionals and other stakeholders in community

1. How long you stay here?

2. What do you think about cultural to maintain holistic health at home?

3. What kinds of health services that you provide for supporting holistic health for the homebound elderly?

4. What are the factors influence cultural care to maintain holistic health of the homebound elderly at home?

5. How do you encourage homebound elderly in order to perform cultural care to maintain holistic health?

APPENDIX: E

Observation guideline

1. Activities performing regarding cultural care in daily living of homebound elderly

2. Frequency of each activities performing regarding cultural care in daily living of homebound elderly

3. Integrated activities regarding cultural care to maintain holistic health in daily living of homebound elderly

4. Other services related to cultural care that homebound elderly received

APPENDIX: F

Focused group discussion guideline

1. How long you stay here?

2. What do you think about cultural to maintain holistic health at home?

3. What kinds of health services that you provide for supporting holistic health for the homebound elderly?

4. What are the factors influence cultural care to maintain holistic health of the homebound elderly at home?

5. How do you encourage homebound elderly in order to perform cultural care to maintain holistic health?

APPENDIX: G

Field Note Taking Form 1

The following of field note taking form will be used in the semi-structure interview

Informants……

Date……Time……

Place……

Semi-structure interview guideline	Informants' behavior and environment	Researcher's reflection

Conclusion……

……..

Problems……...

……..

Next plan……..

……..

APPENDIX: H

Field Note Taking Form 2

The following of field note taking form will be used in the observation

Informants……

Date…….Time…….

Place……..……...

Plan……...

Observation guideline	Expanded accounts	Researcher's reflection

Conclusion……

……..

Problems……...

……..

Next plan……..

……..

APPENDIX: I

Informed Consent Form for Key Informants

Thesis Title: Cultural Care among Homebound Elderly to Maintain Holistic Health: A Focused Ethnographic Study

My name is Supussajee Detthippornpon. I am a PhD student of the Faculty of Nursing, Prince of Songkla University, Thailand. I am conducting this study as a research project for a doctoral degree. The objective of this study is to gain knowledge and more understanding of the way of life among the homebound elderly in order to maintain their holistic health. Information gained from this study will be valuable and important as it will provide data for developing a model of care for the homebound elderly related to their individual cultural and social context.

I would like to encourage you to join in this study, which will be conducted using participation, observations, interviews, focus group discussion, and reflections and involve me visiting you at home a number of times over a period of months. Both interviews and discussions will take place during my visits or at any time and any place that you prefer. If you do agree to participate in this study, you will be interviewed, which will take around 90 to 120 minutes and will be tape-recorded. During the interview, you may decline to answer any question and demand that the tape record be turned off. No names will be shown in the transcriptions of the interviews. All information from your answers will be used only for the purpose of this research project. There is no risk to participate in this study. Your participation is voluntary in nature; you may withdraw from this study at any time even after the start of the interview process. There will be no public indication of having signed this consent and participation form. However, if there are any questions or concerns regarding this study, please do not hesitate to contact me.

Moreover, if you are not treated as specified in this statement, please contact Miss Chayanit Putpong, Center for Social and Behavioral Sciences Institutional Review Board, Prince of Songkla University (SBSIRB-PSU),
Tell: 0-7428-6475

Signature…….. Supussajee Detthipornpong
Name…… Phraseang Hospital, Phraseang
District, Date……Surattani Province, Thailand, 84210
E-mail:ganhealth@gmail.com; Phone: 0843078309

APPENDIX: I-1

ขอเรียนเชิญเข้าร่วมโครงการวิจัย

โครงการวิจัยเรื่อง การดูแลเชิงวัฒนธรรมในผู้สูงอายุติดบ้านเพื่อการคงไว้ซึ่งสุขภาพแบบองค์รวม: การศึกษาแบบชาติพันธุ์วรรณา

เรียน ผู้เข้าร่วมโครงการวิจัยทุกท่าน

ดิฉัน นางสุพัสจี เดชทิพย์พรพงศ์ นักศึกษาปริญญาเอก คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ วิทยาเขตหาดใหญ่ มีความสนใจที่จะศึกษาถึง วิถีชีวิตของผู้สูงอายุกลุ่มติดบ้านว่ามีการปฏิบัติอย่างไรในการดูแลสุขภาพ เพื่อคงไว้ซึ่งการมีสุขภาพที่สมบูรณ์ ทั้งร่างกายและจิตใจ อารมณ์ สังคม และจิตวิญญาณ หรือที่เรียกว่าการมีภาวะสุขภาพแบบองค์รวม มีอะไรเป็นปัจจัยส่งเสริมหรือสนับสนุนให้ท่านสามารถดำเนินการได้อย่างต่อเนื่อง หรือว่ามีปัญหาและอุปสรรคใด ๆ ที่ทำให้ท่านไม่สามารถปฏิบัติกิจกรรมดังกล่าวได้ ข้อมูลของท่านจะเป็นประโยชน์ในการพัฒนาระบบการดูแลผู้สูงอายุติดบ้านให้สอดคล้องกับวิถีชีวิต สังคมและวัฒนธรรม สามารถปฏิบัติได้อย่างต่อเนื่อง ทั้งยังเป็นประโยชน์ต่อการขยายผลและพัฒนาระบบการดูแลดังกล่าวในพื้นที่อื่นต่อไป ถ้าท่านตัดสินเข้าร่วมโครงการนี้ จะมีขั้นตอนของการศึกษาเกี่ยวข้องกับตัวท่านคือ จะมีเวลาสัมภาษณ์ 90-120 นาที การสังเกตการณ์รูปแบบการดำรงชีวิตที่สอดคล้องกับคงไว้ซึ่งภาวะสุขภาพแบบองค์รวมในชีวิตประจำวันของท่าน ในโครงการนี้จะมีการบันทึกทึกเสียงของการสัมภาษณ์และการถ่ายภาพกิจกรรมการฟื้นฟูสภาพที่บ้านของท่าน รายละเอียดของของข้อมูลที่ได้จากท่านจะถูกเก็บไว้เป็นความลับ การนำเสนอข้อมูลในรายงานวิจัยจะเสนอภาพรวมของกลุ่มผู้เข้าร่วมวิจัยทั้งหมด การเข้าร่วมโครงการวิจัยครั้งนี้ขึ้นอยู่กับความสมัครใจของท่านและเมื่อท่านเข้าร่วมโครงการนี้แล้ว ท่านมีสิทธิ์ที่จะยกเลิกหรือถอนตัวออกจากการวิจัยไม่ว่ากรณีใด ๆ ถ้าท่านมีคำถามใด ๆ ก่อนจะตัดสินใจเข้าร่วมโครงการนี้โปรดซักถามดิฉันได้อย่างเต็มที่

หากผู้เข้าร่วมการวิจัยได้รับการปฏิบัติไม่ตรงตามที่ระบุไว้ในเอกสารชี้แจงนี้ สามารถขอรับคำปรึกษาร้องเรียน ได้ที่ นางสาวชญานิศ ผุดผ่อง ศูนย์จริยธรรมการวิจัยในมนุษย์ สาขา/แจ้งเรื่อง/สังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์ โทรศัพท์ หรือ 6475-7428-0 ทางจดหมายอิเล็กทรอนิกส์chayanit.p@psu.ac.th”

..... ขอขอบคุณอย่างสูง

(.....) นางสุพัสจี เดชทิพย์พรพงศ์

ผู้เข้าร่วมวิจัย โทร. 0843078309 หรือ e-mail ganhealth@gmail.com

APPENDIX: J

Informed Consent Form for Associate Informants

Thesis Title: Cultural Care among Homebound Elderly to Maintain Holistic Health: A Focused Ethnographic Study

My name is Supussajee Detthippornpon. I am a PhD student of the Faculty of Nursing, Prince of Songkla University, Thailand. I am conducting this study as a research project for a doctoral degree. The objective of this study is to gain knowledge and more understanding of the way of life among the homebound elderly in order to maintain their holistic health. Information gained from this study will be valuable and be important as it will provide data for developing a model of care for the homebound elderly related to their individual cultural and social context.

I would like to encourage you to join in this study because you area person who is involved in the health care of the homebound elderly. Your information will help me to better understand the way of life of the homebound elderly in order to maintain their holistic health. Data collection will be conducted using participation, observations, interviews, focus group discussion, and reflections. This will involve me visiting you at home a number of times over a period of months. Both interviews and discussions will take place during my visits or at any time and any place that you prefer. If you do agree to participate in this study, you will be interviewed, which will take around 90 to 120 minutes and will be tape-recorded. During the interview, you may decline to answer any question and demand that the tape record be turned off. No names will be shown in the transcriptions of the interviews. All information from your answers will be used only for purpose of this research project. There is no risk to participate in this study. Your participation is voluntary in nature; you may withdraw from this study at any time even after the start of the interview process. There will be no public indication of having signed this consent and participation form. However, if there are any questions or concerns regarding this study, please do not hesitate to contact me.

Moreover, if you are not treated as specified in this statement, please contact Miss Chayanit Putpong, Center for Social and Behavioral Sciences Institutional Review Board, Prince of Songkla University (SBSIRB-PSU), Tell: 0-7428-6475

Signature…… Supussajee Detthipornpon

Name…… Phrasean Hospital, Phraseang District,

Date……. Surattani Province, Thailand, 84210

E-mail:ganhealth@gmail.com; Phone: 0843078309

APPENDIX: J-1

ขอเรียนเชิญเข้าร่วมโครงการวิจัย

โครงการวิจัยเรื่อง การดูแลเชิงวัฒนธรรมในผู้สูงอายุติดบ้านเพื่อการคงไว้ซึ่งสุขภาพแบบองค์รวม: การศึกษาแบบชาติพันธุ์วรรณา

เรียน ผู้เข้าร่วมโครงการวิจัยทุกท่าน

ดิฉัน นางสุพัสจี เดชทิพย์พรพงศ์ นักศึกษาปริญญาเอก คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ วิทยาเขตหาดใหญ่ มีความสนใจที่จะศึกษาถึง วิถีชีวิตของผู้สูงอายุกลุ่มติดบ้านว่ามีการปฏิบัติอย่างไรในการดูแลสุขภาพ เพื่อคงไว้ซึ่งการมีสุขภาพที่สมบูรณ์ ทั้งร่างกายและจิตใจ อารมณ์ สังคม และจิตวิญญาณ หรือที่เรียกว่าการมีภาวะสุขภาพแบบองค์รวม มีอะไรเป็นปัจจัยส่งเสริมหรือสนับสนุนให้ท่านสามารถดำเนินการได้อย่างต่อเนื่อง หรือว่ามีปัญหาและอุปสรรคใด ๆ ที่ทำให้ท่านไม่สามารถปฏิบัติกิจกรรมดังกล่าวได้ ข้อมูลของท่านจะเป็นประโยชน์ในการพัฒนาระบบการดูแลผู้สูงอายุติดบ้านให้สอดคล้องกับวิถีชีวิต สังคมและวัฒนธรรม สามารถปฏิบัติได้อย่างต่อเนื่อง ทั้งยังเป็นประโยชน์ต่อการขยายผลและพัฒนาระบบการดูแลดังกล่าวในพื้นที่อื่นต่อไป ดิฉันใคร่ขอเรียนเชิญท่านมาร่วมมาให้ข้อมูลในการศึกษาครั้งนี้ในฐานะผู้มีส่วนเกี่ยวข้องในการดูแลสุขภาพผู้สูงอายุกลุ่มติดบ้าน ข้อมูลจากท่านจะช่วยให้ผู้วิจัยเข้าใจวิถีชีวิตที่เกี่ยวข้องกับการดูแลสุขภาพเพื่อคงไว้ซึ่งสุขภาพแบบองค์รวม ถ้าท่านตัดสินเข้าร่วมโครงการนี้ จะมีขั้นตอนของการศึกษาเกี่ยวข้องกับตัวท่านคือ จะมีเวลาสัมภาษณ์ 90-120 นาที การสังเกตการณ์รูปแบบให้การดูแล ช่วยเหลือ หรือสนับสนุนการปฏิบัติกิจวัตรประจำวันของผู้สูงอายุติดบ้านที่สอดคล้องกับคงไว้ซึ่งภาวะสุขภาพแบบองค์รวม ในโครงการนี้จะมีการบันทึกเสียงของการสัมภาษณ์และการถ่ายภาพกิจกรรมการฟื้นฟูสภาพที่บ้านของท่าน รายละเอียดของของข้อมูลที่ได้จากท่านจะถูกเก็บไว้เป็นความลับ การนำเสนอข้อมูลในรายงานวิจัยจะเสนอภาพรวมของกลุ่มผู้เข้าร่วมวิจัยทั้งหมด การเข้าร่วมโครงการวิจัยครั้งนี้ขึ้นอยู่กับความสมัครใจของท่านและเมื่อท่านเข้าร่วมโครงการนี้แล้ว ท่านมีสิทธิ์ที่จะยกเลิกหรือถอนตัวออกจากการวิจัยไม่ว่ากรณีใด ๆ ถ้าท่านมีคำถามใด ๆ ก่อนจะตัดสินใจเข้าร่วมโครงการนี้โปรดซักถามดิฉันได้อย่างเต็มที่

หากผู้เข้าร่วมการวิจัยได้รับการปฏิบัติไม่ตรงตามที่ระบุไว้ในเอกสารชี้แจงนี้ สามารถขอรับคำปรึกษาร้องเรียน ได้ที่ นางสาวชญานิศ ผุด/แจ้งเรื่อง/ผ่อง ศูนย์จริยธรรมการวิจัยในมนุษย์ สาขาสังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์ โทรศัพท์ หรือทาง 6475-7428-0 จดหมายอิเล็กทรอนิกส์chayanit.p@psu.ac.th”

..... ขอขอบคุณอย่างสูง

(.....) นางสุพัสจี เดชทิพย์พรพงศ์

ผู้เข้าร่วมวิจัย. โทร. 0843078309 หรือ e-mail ganhealth@gmail.com

APPENDIX: K

Informed Consent Form for Community Leader

Thesis Title: Cultural Care among Homebound Elderly to Maintain Holistic Health: A Focused Ethnographic Study

My name is Supussajee Detthippornpon. I am a PhD student of the Faculty of Nursing Prince of Songkla University, Thailand. I am conducting this study as a research project for a doctoral degree. The objective of this study is to gain knowledge and more understanding of the way of life among the homebound elderly in order to maintain their holistic health. Information gained from this study will be valuable and important as it will provide data for developing a model of care for the homebound elderly related to their individual cultural and social context.

I would like to encourage you to join in this study because you are a community leader who is involved in the health care of the homebound elderly. Your information about the health care system in the community and the support of the homebound elderly will help me to gain more information of the influence of culture in the care for the homebound elderly. Data collection will be conducted using participation, observations, interviews, focus group discussion, and reflections. This will involve me visiting you at home a number of times over a period of months. Both interviews and discussions will take place during my visits or at any time and any place that you prefer. If you do agree to participate in this study, you will be interviewed, which will take around 90 to 120 minutes and will be tape-recorded. During the interview, you may decline to answer any questions and demand that the tape record be turned off. No names will be shown in the transcriptions of the interviews. All information from your answers will be used only for purpose of this research project. There is no risk to participate in this study. Your participation is voluntary in nature; you may withdraw from this study at any time even after the start of the interview process. There will be no public indication of having signed this consent and participation form. However, if there are any questions or concerns regarding to this study, please do not hesitate to contact me.

Moreover, if you are not treated as specified in this statement, please contact Miss Chayanit Putpong, Center for Social and Behavioral Sciences Institutional Review Board, Prince of Songkla University (SBSIRB-PSU), Tell: 0-7428-6475

Signature…….. Supussajee Detthipornpong
Name…… Phrasean Hospital, Phraseang
District, Date……. .. Surattani Province, Thailand, 84210
E-mail:ganhealth@gmail.com; Phone: 0843078309

APPENDIX: K-1

ขอเรียนเชิญเข้าร่วมโครงการวิจัย

โครงการวิจัยเรื่อง การดูแลเชิงวัฒนธรรมในผู้สูงอายุติดบ้านเพื่อการคงไว้ซึ่งสุขภาพแบบองค์รวม: การศึกษาแบบชาติพันธุ์วรรณา

เรียน ผู้เข้าร่วมโครงการวิจัยทุกท่าน

ดิฉัน นางสุพัสจี เดชทิพย์พรพงศ์ นักศึกษาปริญญาเอก คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ วิทยาเขตหาดใหญ่ มีความสนใจที่จะศึกษาถึง วิถีชีวิตของผู้สูงอายุกลุ่มติดบ้านว่ามีการปฏิบัติอย่างไรในการดูแลสุขภาพ เพื่อคงไว้ซึ่งการมีสุขภาพที่สมบูรณ์ ทั้งร่างกายและจิตใจ อารมณ์ สังคม และจิตวิญญาณ หรือที่เรียกว่าการมีภาวะสุขภาพแบบองค์รวม มีอะไรเป็นปัจจัยส่งเสริมหรือสนับสนุนให้ท่านสามารถดำเนินการได้อย่างต่อเนื่อง หรือว่ามีปัญหาและอุปสรรคใด ๆ ที่ทำให้ท่านไม่สามารถปฏิบัติกิจกรรมดังกล่าวได้ ข้อมูลของท่านจะเป็นประโยชน์ในการพัฒนาระบบการดูแลผู้สูงอายุติดบ้านให้สอดคล้องกับวิถีชีวิต สังคมและวัฒนธรรม สามารถปฏิบัติได้อย่างต่อเนื่อง ทั้งยังเป็นประโยชน์ต่อการขยายผลและพัฒนาระบบการดูแลดังกล่าวในพื้นที่อื่นต่อไป ดิฉันใคร่ขอเรียนเชิญท่านมาร่วมมาให้ข้อมูลในการศึกษาครั้งนี้ในฐานะผู้นำชุมชนที่มีส่วนสนับสนุน การดูแลสุขภาพผู้สูงอายุกลุ่มติดบ้านในชุมชน ข้อมูลจากท่านจะช่วยให้ผู้วิจัยเข้าใจระบบสนับสนุนในชุมชน หรือข้อมูลอื่นๆที่เกี่ยวข้องกับการดูแลสุขภาพผู้สูงอายุกลุ่มติดบ้านเพื่อคงไว้ซึ่งสุขภาพแบบองค์รวมของกลุ่มผู้สูงอายุดังกล่าว ถ้าท่านตัดสินเข้าร่วมโครงการนี้ จะมีขั้นตอนของการศึกษาเกี่ยวข้องกับตัวท่านคือ จะมีเวลาสัมภาษณ์ 90-120 นาที การสังเกตการณ์รูปแบบให้การดูแล ช่วยเหลือ หรือสนับสนุนการปฏิบัติกิจวัตรประจำวันของผู้สูงอายุติดบ้านที่สอดคล้องกับคงไว้ซึ่งภาวะสุขภาพแบบองค์รวม ในโครงการนี้จะมีการบันทึกทึกเสียงของการสัมภาษณ์และการถ่ายภาพกิจกรรมการฟื้นฟูสภาพที่บ้านของท่าน รายละเอียดของของข้อมูลที่ได้จากท่านจะถูกเก็บไว้เป็นความลับ การนำเสนอข้อมูลในรายงานวิจัยจะเสนอภาพรวมของกลุ่มผู้เข้าร่วมวิจัยทั้งหมด การเข้าร่วมโครงการวิจัยครั้งนี้ขึ้นอยู่กับความสมัครใจของท่านและเมื่อท่านเข้าร่วมโครงการนี้แล้ว ท่านมีสิทธิ์ที่จะยกเลิกหรือถอนตัวออกจากการวิจัยไม่ว่ากรณีใด ๆ ถ้าท่านมีคำถามใด ๆ ก่อนจะตัดสินใจเข้าร่วมโครงการนี้โปรดซักถามดิฉันได้อย่างเต็มที่

หากผู้เข้าร่วมการวิจัยได้รับการปฏิบัติไม่ตรงตามที่ระบุไว้ในเอกสารชี้แจงนี้ สามารถขอรับคำปรึกษาร้องเรียน ได้ที่ นางสาวชญานิศ ผุดผ่อง ศูนย์จริยธรรมการวิจัยในมนุษย์ สาขา/แจ้งเรื่อง/สังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์ โทรศัพท์ หรื 6475-7428-0อทางจดหมายอิเล็กทรอนิกส์ chayanit.p@psu.ac.th”

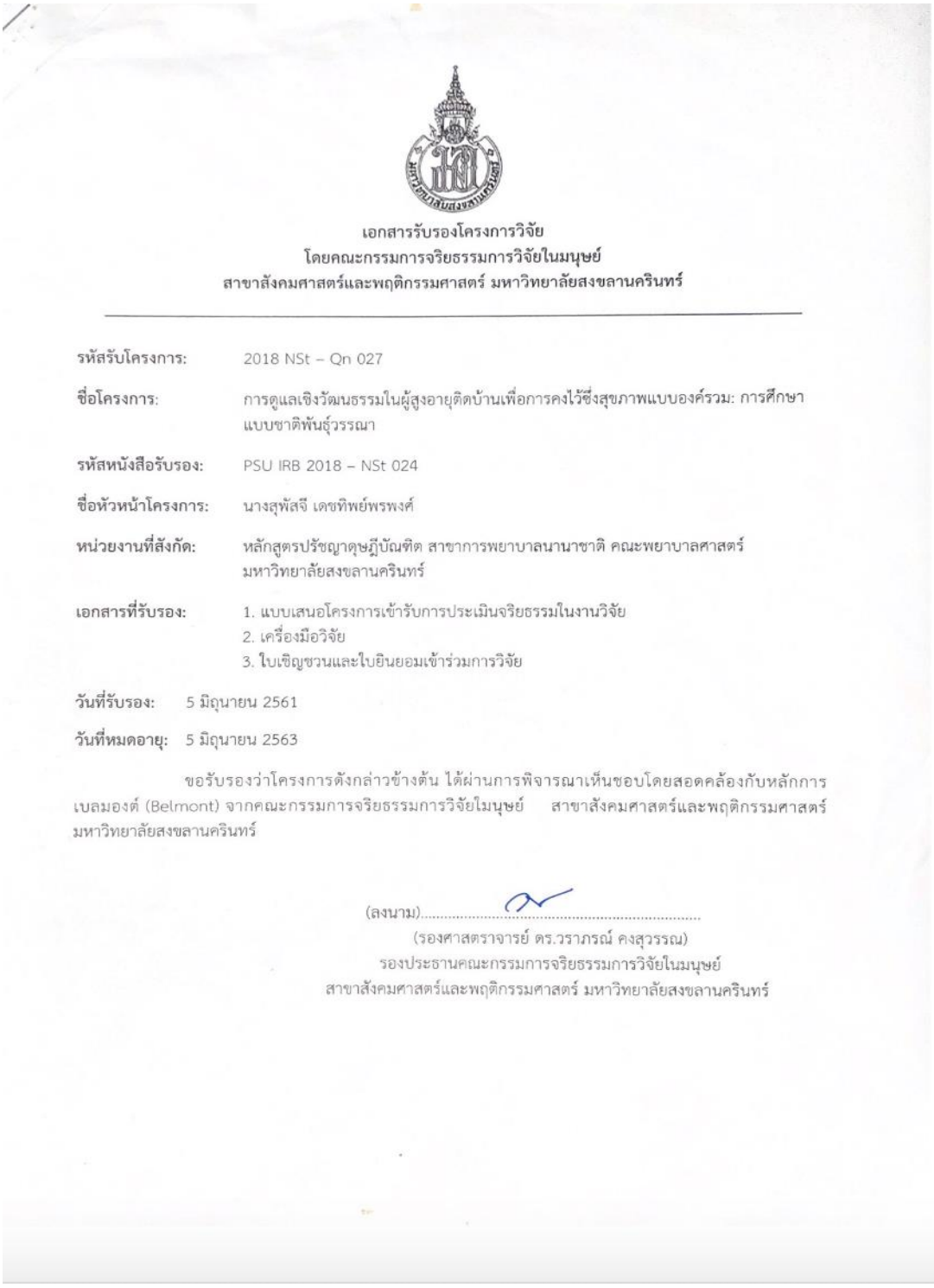
..... ขอขอบคุณอย่างสูง

(.....) นางสุพัสจี เดชทิพย์พรพงศ์

ผู้เข้าร่วมวิจัย โทร. 0843078309 หรือ e-mail ganhealth@gmail.com

APPENDIX: L

Ethics Committee Approval



เอกสารรับรองโครงการวิจัย
โดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์
สาขาสังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์

รหัสรับโครงการ: 2018 NSt – Qn 027

ชื่อโครงการ: การดูแลเชิงวัฒนธรรมในผู้สูงอายุติดบ้านเพื่อการคงไว้ซึ่งสุขภาพแบบองค์รวม: การศึกษาแบบชาติพันธุ์วรรณา

รหัสหนังสือรับรอง: PSU IRB 2018 – NSt 024

ชื่อหัวหน้าโครงการ: นางสุพัสจี เดชทิพย์พรพงศ์

หน่วยงานที่สังกัด: หลักสูตรปรัชญาดุษฎีบัณฑิต สาขาการพยาบาลนานาชาติ คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์

เอกสารที่รับรอง:
1. แบบเสนอโครงการเข้ารับการประเมินจริยธรรมในงานวิจัย
2. เครื่องมือวิจัย
3. ใบเชิญชวนและใบยินยอมเข้าร่วมการวิจัย

วันที่รับรอง: 5 มิถุนายน 2561

วันที่หมดอายุ: 5 มิถุนายน 2563

ขอรับรองว่าโครงการดังกล่าวข้างต้น ได้ผ่านการพิจารณาเห็นชอบโดยสอดคล้องกับหลักการเบลมองต์ (Belmont) จากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ สาขาสังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์

(ลงนาม).....
(รองศาสตราจารย์ ดร.วราภรณ์ คงสุวรรณ)
รองประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์
สาขาสังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์

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The dissertation grant, the Faculty of Nursing, Prince of Songkla University

Education HUB grant, Prince of Songkla University

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List of Publication and Proceeding

Detthippornpong, S., Songwatthana, P, & Bourbonnais, A. (2020). "Bai Lod" Holistic health experienced by homebound older people in the southern Thai community. *International Journal of Older People Nursing*, 16(1), 1-9. doi: 10.1111/.12364