UNDERSTANDING HEALTHY AGING IN ISAN-THAI CULTURE

Pornpun Manasatchakun

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Akademisk avhandling

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Fakultetsopponent: Professor Gunilla Strandberg, Umeå University
Abstract

The older population in Thailand is growing, and the number of older people who suffer from health problems is increasing as well. The health situation of the older population challenges healthcare providers to care for older people. Healthy aging is key to promoting the health of older people and sustaining their well-being. However, little is known about healthy aging in Thailand, especially in northeastern Thailand, or the Isan region, where the number of older people is increasing. Thus, this thesis aims to understand the factors associated with perceived health and healthy aging and how older people and their relatives in the Isan region conceptualize healthy aging. This thesis also focuses on how community nurses experience the meaning and promotion of healthy aging in this region.

This thesis includes four studies. The first is a quantitative cross-sectional study with 453 participants aged 60 years or older. The second and third studies are qualitative with a phenomenographic approach that is based on lifeworld theory. Participants in the second and third studies include 17 older people and 14 relatives who are responsible for caring for older people, respectively. The fourth study is a qualitative study that involves focus group interviews with 36 community nurses who work with older people in the Isan region.

The findings of the first study show a variance (24.3%) in perceived health and healthy aging based on residential area, marital status and disability status. The meaning of healthy aging, which was derived from the second, third and fourth studies, was divided into three domains: being interconnected; being able to do something good and feeling strong; and thinking beyond the capacity and functions of body and mind. The promotion of healthy aging was described as “providing health assessments”, “sharing knowledge”, and “having limited resources”.

The findings of the first study revealed the key factors that will help healthcare providers promote healthy aging. The findings of the second, third and fourth studies revealed that older people, their children and grandchildren, and community nurses attach different meanings to healthy aging. The finding regarding promotion of healthy aging emphasizes that the person-centredness should be integrated in practice when promoting healthy aging. The results of this thesis will be useful to policymakers, who can apply this enhanced understanding of healthy aging to develop healthcare practices that promote healthy aging.
"...Things that we do not plan may well happen. Things that we do plan may well meet with disaster. Wealth will not come to anybody by just dreaming about it."

(His Majesty King Bhumibol Adulyadej, The story of Mahajanaka, p. 115)
Abstract

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**Keywords:** cross-sectional study, focus group interviews, healthy aging, life-world theory, nursing, person-centred care, phenomenography, relatives, Thai nurses
List of papers

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals (I–IV):


IV. Manasatchakun, P., Choowattanapakorn, T., Roxberg, Å., & Asp, M. (in press). Community nurses’ experiences regarding the meaning and promotion of healthy aging in northeastern Thailand. *Journal of Holistic Nursing*

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<table>
<thead>
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<tbody>
<tr>
<td>CSMBS</td>
<td>Civil Servant Medical Benefit Scheme</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
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<td>GPF</td>
<td>Government Pension Fund</td>
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<td>HAI</td>
<td>Healthy aging instrument</td>
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<td>MoPH</td>
<td>Ministry of Public Health, Thailand</td>
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<td>QOL</td>
<td>Quality of life</td>
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<td>SSF</td>
<td>Social Security Fund</td>
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<tr>
<td>SSS</td>
<td>Social Security Scheme</td>
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<tr>
<td>TAT Udon Thani</td>
<td>Tourism Authority of Udon Thani</td>
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<td>UCS</td>
<td>Universal Coverage Scheme</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNFPA</td>
<td>United Nations Family Planning Association</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHOQOL</td>
<td>World Health Organization Quality of Life</td>
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<td>WHO SEARO</td>
<td>World Health Organization in South-East Asia</td>
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1 Introduction

The overall aim of this thesis is to describe from multiple perspectives how healthy aging is experienced and perceived in northeastern Thailand. This thesis considers the perspectives of older people, their relatives, and community nurses who work with older people.

Previous research inspired me to study the concept of healthy aging in northeastern Thailand (Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, & Steckler, 2009; Hung, Kempen, & De Vries, 2010; Rattanapun, Fongkeaw, Chontawan, Panuthai, & Wesumperuma, 2009). Moreover, my experience as a registered nurse in a medical ward and as an instructor at a nursing college has led me to consider the care that older people receive. Older people are common in areas of the healthcare system such as hospitals, and I often met older people in the ward when I worked as a nurse ten years ago. I realized that I usually viewed nursing only practices in terms of the curing disease without being aware of the importance of promoting health and preventing illness. However, a nurse’s role includes not only healing or treating patients based on physician recommendations but also taking responsibility for improving people’s health. After working for three years as an instructor at a nursing college in the northeastern region of Thailand, I found that preparing nursing students to promote the health of older people in the community was important. As in the rest of the world, the growing population of older people is an important issue in Thai society. The demographic change and the expanding older population have increased the dependency ratio. Older people are living longer because of better healthcare systems. For people who reach very old age, the aging process may lead to a decline in functional independence. Some older people may be at greater risk for chronic illness and disability. For these the cost of long-term care for older people may increase. Chronic diseases and impairment may have an impact on older people’s lives. Therefore, healthcare providers should focus not only on prolonging life but also on maintaining older people’s health and quality of life (QOL).

Healthy aging is a concept that has been applied to promote health in older people. It describes a process of optimizing opportunities for physical, social and mental health to enable older people to play an active role in society without facing discrimination and to enjoy independent and satisfying lives. The World Health Organization [WHO] (2016a) is committed to promoting healthy aging in every country. In Thailand, this concept has been part of the
national agenda to improve the older population’s health. Implementing this plan to promote health for older people poses a great challenge for nurses. Nurses compose the largest group of healthcare professionals in Thailand. Thus, the concept of healthy aging should be investigated to develop a deeper understanding of this concept. Many studies have been conducted about healthy aging in both Western and non-Western countries. However, the concept of healthy aging has not been studied in northeastern Thailand, also called the Isan region, where the number of people aged 60 years or older is growing rapidly.

I am especially interested in the factors associated with healthy aging. I also focus on how older people and the people who surround them—the latter of which generally influence the former—define healthy aging based on their experiences. The meaning of healthy aging may be conceptualized differently or similarly by various perspectives. Perceptions of healthy aging may reveal individual characteristics that indicate the different roles people play. To promote healthy aging, the healthcare provider should properly understand the perceptions of older people and their relatives. These different perceptions allow us to observe the healthy aging-related experiences of older people and those who surround them. Furthermore, understanding how community nurses experience the meaning and promotion of healthy aging may help policymakers and related parties to develop nursing practices that promote healthy aging.

The findings of this thesis may highlight the key dimensions that influence healthy aging in the northeastern region of Thailand. The knowledge from this thesis may increase our understanding of healthy aging, which will facilitate the development of strategies to promote health in older people. Moreover, the findings may be suitable for application to nursing practices to support, promote and improve healthy aging among the older population in Thailand. The findings of this thesis may also be applied when teaching nursing students about community practices that will enhance the promotion of health and care for older people, especially those who live in northeastern Thailand.
2 Background

This section provides the background for the thesis. First, the aging situation in Thailand, theories of aging, and definitions of old age will be described, followed by an exploration of the concepts of health and healthy aging. Next, previous studies on healthy aging and several concepts related to healthy aging will be reviewed. Then, the culture of the Isan region, which is linked to older people’s way of life, will be explained. A discussion about the informal care of older people follows. Finally, the entire picture of social welfare and the healthcare system that is relevant to older people in Thailand will be presented.

2.1 Thailand and its aging situation

Thailand, an upper-middle-income country (Sasat & Bowers, 2013), is the oldest in Southeast Asia (Choowattanapakorn, 1999), with an area of 513,120 km². Thailand is divided into 76 provinces and four regions: the central region (which includes the Bangkok Metropolitan Region), the north region, the south region and the northeast region, or Isan region (UN Thailand, 2016). These regions differ in terms of natural features; topography and drainage; economic, social and ecological factors; and cultural patterns. Thailand’s official language is Thai. Nearly 95 percent of the Thai population are Theravada Buddhist; the remainder are Muslim or Christian. The nation’s development has been based on agricultural production (Singhapreecha, 2014). Gross domestic product (GDP) at market prices (in current USD) was 404.8 billion in 2014. The total population of the country in 2014 was reported to be 67.7 million (World Bank, 2016a).

The aging population is increasing throughout the world. The percentage of older people in the world increased from 9.2 percent in 1990 to 11.7 percent in 2013 (United Nations [UN], 2013). The aging population is estimated to account for 21.1 percent of the global population by 2050 (UN, 2013). The report indicates that 60 percent of the world’s older population lives in Asia (Sasat & Bowers, 2013). The number of older people in Thailand is growing faster than in other Southeast Asian countries. Thailand has the second highest population of older people in Southeast Asia, following Singapore (Sasat & Bowers, 2013). In 2015, the older population in Thailand numbered 10.7 million, representing 16 percent of the total population (Knodel, Teerawichitchainan, Prachuabmoh, & Pothisiri, 2015). The number of Thai senior citizens is
expected to reach approximately 14.9 million by 2025 (National Committee on the Elderly, 2009), which is double the 2009 population of senior citizens. This significant increase will greatly impact socio-economic issues, with major health social and cultural implications (Knodel & Chayovan, 2008). Furthermore, this increase, especially for people older than 80 years of age, is partly due to the development of medical and healthcare services, which has contributed to longer lives. In 2015, life expectancy at birth was 72 years for men and 78 years for women (WHO, 2015a). In 2050, life expectancy in Thailand will be 77 years for men and 82 years for women (UN, 2002). These long periods of life after the age of 60 provides an opportunity to promote health for older people. In a society that includes increasing numbers of senior citizens, the burden of caring for older people clearly falls on younger generations, who are apparently becoming a lesser proportion of the community. In 2015, the number of dependents per 100 working-age individuals was 39 (World Bank, 2016b). In general, an aging person is likely to face greater risks that will eventually lead to chronic disease and even disability (Knodel & Chayovan, 2008). This eventuality, combined with the changing population structure (Sasat & Bowers, 2013), may have critical implications for the Thai population. Therefore, policymakers and healthcare providers must ask themselves how to contribute to and stabilize the health of older people in Thai society to provide them with better standards of living and suitable support.

2.2 Aging and old age

The phenomenon of aging is quite complex (Meiner, 2015). To understand the concept, theories of aging and definitions of old age must be reviewed.

2.2.1 Theories of aging

Several theories explores aging and aging process. Aging is defined objectively and subjectively by gerontologists (Miller, 2004). Objectively, aging begins at birth, and age is defined as the length of time that has passed since one’s birth. Subjectively, aging is associated with being old and senior adulthood and is defined in terms of people’s individual meanings and experiences (Miller, 2004). Aging can also be described in terms of chronological age, biological age, and psychological age (Touhy & Jett, 2010). Chronological age is measured by the number of years lived. Biological theories describe the process of aging as a function of genetics, human deterioration, and physiological status (Touhy & Jett, 2010). In biological gerontology, aging can be defined as a complex, cumulative, time-related process of psychobiological deterioration that occurs during the post-development phase of life. Biological
theories of aging attempt to characterize aging as a physiological process and to describe types of age-related changes (Miller, 2004).

Psychosocial theories of aging examine the mental processes, behaviors, and feelings of a person throughout his/her lifetime, along with the challenges that he/she faces in old age (Eliopoulos, 2010). Developmental theories are included in this area. Erikson’s theory of development describes the developmental stages from early childhood to old age. Erikson posits that human life follows a cycle of eight stages, or a task model (Erikson, 1993; Redfern & Ross, 2006) and highlights the basic advantages of each stage of development. The last stage of life is described as the period in which an individual looks back at oneself and life as it has been lived with a sense of completeness or a sense of despair (Erikson, 1993).

Sociological theories of aging (Touhy & Jett, 2010) describe the changes in people’s roles and relationships in middle and later life. For example, disengagement theory (Coleman & O’Hanlon, 2004; Hochschild, 1975) explains the measures of disengagement, based on age, work, and decreasing interest or investment in social concerns. Disengagement theory can be explained through an aging person and through others in the society to which the aging person belongs. The process of disengagement means that individuals withdraw from society and vice versa. Disengagement theory emphasizes a natural process during a person’s lifetime in which he/she disengages from his/her roles in and relationships with society. Another theory of aging, which focuses on development in later life, is the Tornstam’s theory of gerotranscendence (Tornstam, 1989, 1997). The theory of gerotranscendence is viewed as a reformulation of the disengagement theory (Jewell, 2014; Tornstam, 1989, 1997). Gerotranscendence also relates to disengagement from society but the reason for disengagement differs from that of disengagement theory. In gerotranscendence, old persons focus on what makes sense in life and the things to be valued in life. Furthermore, the theory of gerotranscendence is explained as a development theory of positive aging (Tornstam, 1989, 1997). The period of gerotranscendence is described as a development process, and the final developmental stage is called the natural progression (Wadensten, 2007). According to this theory, gerotranscendence views the development of man as a life-long process and as a natural developmental process (Wadensten, 2007). The outcome of gerotranscendent aging is the individual’s acceptance of him/herself and others. The dimensions of gerotranscendence are presented as three levels: cosmic, self, and relationships (Coleman & O’Hanlon, 2004). The first level refers to the redefinition of time, which describes the transcendence
between past and present. This level focuses on connections with earlier generations and a decreasing fear of death. The second level is the dimension of self, which is also called ego transcendence (Wadensten, 2007). The development of self relates to the discovery of hidden aspects of one’s personality and decreasing self-centeredness. The last level of the gerotranscendence theory focuses on social and personal relationships. This level describes the importance of social contacts during the different phases of life. Moreover, social and personal relationships emphasize the importance of growth from innocence to maturity, reduced interest in material assets and everyday wisdom. Wadensten (2007) states that human aging is characterized by a general potential to achieve gerotranscendence. However, not everyone achieves a high degree of gerotranscendence.

Theories of aging also includes symbolic interaction theories (Gubrium, 1973), which note that the kind of aging process people experience is “a result of interaction between the environment, the individual and the meaning the person attributes to his/her activities” (Touhy & Jett, 2010, p. 87).

Clearly, no one theory explains all aspects of aging (Meiner, 2015). Human aging is viewed as a comprehensive process that is influenced by an amalgam of functional, biological, psychological, sociological and spiritual factors (Meiner, 2015). Therefore, the understanding of aging via various aspects of different aging theories may provide a deeper understanding of the concept of healthy aging.

2.2.2 The definitions of old age

Older people are not merely defined according to chronological criteria, rather, by the acquisition of physiological and psychosocial characteristics. These characteristics include the deceleration of physiological processes, a decline in the potential for wisdom and creativity, and the potential for an advanced level of personal and spiritual growth (Miller, 2009). Many documents released by the World Health Organization (WHO) define “older people” as those of 60 years of age or older (Euro Health Net, 2012). However, most developed countries have defined older people as those who have reached the chronological age of 65 years (WHO, 2016b). In the United States, psychologists have classified older people into three groups: the “young-old” (aged 65–74 years), the “middle-old” (aged 75–84 years), and the “old-old” (older than 85 years) (Touhy & Jett, 2010). In Africa, people older than 50 years are considered older people (WHO, 2016b). At this time, the UN has not presented a standard numerical criterion but agrees that people
who are 60 years old or older constitute the older population (WHO, 2016b). Some definitions of older people relate to the age at which an individual can begin to receive pension benefits (WHO, 2016b). In Thailand, people retire at 60 years old; it is at this age that the state and society define them as old. Thai senior citizenship can thus be defined as anyone who is 60 years of age or older (National Committee on the Elderly, 2009). Accordingly, in this thesis, the term “older people” is defined as those who are 60 years of age or older. This definition relates to retirement from paid employment, and this age range most commonly describes older people in Thailand (Knodel et al., 2015).

2.3 Health and healthy aging

2.3.1 Health

Theories about health relate both to individuals and groups on both organizational and social levels. The definitions of health constantly vary and are influenced by culture and by one’s position on the life span (Touhy & Jett, 2010). Moreover, health is a positive concept that emphasizes social resources, personal resources and physical ability (WHO, 2009). There are various definitions of the concept of health. According to the Oxford Advanced Learner’s Dictionary (Hornby et al., 2010, p. 693), health is “the state of being physically and mentally healthy” and “the condition of a person’s body or mind”. The Cambridge Advanced Learner's Dictionary describes health as “the condition of the body and the degree to which it is free from illness, or the state of being well” (Walter, 2008, p. 666). The WHO offers one of the most frequently quoted definitions of health: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2014, p. 1). Health is viewed in a positive way. The definitions of health can be linked to other concepts, such as well-being (Easthope & White, 2006), which is defined as the ability to reach one’s vital goals given standard or acceptable circumstances and as a dynamic state of physical or mental well-being that satisfies the demands of life commensurate with age, culture and personal responsibility (Nordenfelt, 1995). Nordenfelt’s (2007) theory of health is as follows: “A is completely healthy if and only if A has the ability, given standard circumstances, to reach all of his or her vital goals” (p. 7). Pender (2002) stated that health is considered an expansive phenomenon with multiple biopsychosocial, spiritual, biological, environmental, and cultural dimensions. Saylor (2004) observed that the American Journal of Health Promotion presented health as a multidimensional concept that represented the physical, mental, emotional, social, and spiritual aspects of health and that each health component was considered separately.
In summary, the concept of health has generated many definitions and has been viewed as a state of well-being that includes freedom from disease and infirmity. This thesis falls into the area of caring science, which focuses on maintaining each individual’s optimal health. Therefore, in accordance with the aims of this thesis, the concept of health based on the caring science perspective was adopted. As described by Eriksson, the concept of health is defined in terms of a person as a sense of being whole including body, soul, and spirit (Lindström, Lindholm Nyström, & Zetterlund, 2014). Health describes the state of an individual who is characterized by wholeness (Herberts & Eriksson, 1995). Another example of health is provided by Berg and Sarvimäki (2003), who analyzed the concept of health from a holistic existential perspective. The concept of health was related to health promotion, with a focus on nursing. One example explored by Berg and Sarvimäki (2003) was Watson’s view of the health concept. Watson (1999) stated that “health refers to unity and harmony within the mind, body, and soul” (p. 48). Health is also linked to the degree of congruence between the self as perceived and the self as experienced (Watson, 1999). According to the holistic existential perspective, the individual’s being in the world and experiences of one’s life are in focus (Berg & Sarvimäki, 2003).

2.3.2 Healthy aging

Healthy aging is a combination of two words: health and aging. The concept of healthy aging has been defined ambiguously (Hansen-Kyle, 2005) and considered from various perspectives in both Western and non-Western countries (Hansen-Kyle, 2005; Hung et al., 2010). Moreover, according to the literature review of the concept of healthy aging, healthy aging is influenced by many factors, including physiological, psychological, environmental and cultural factors (Danyuthasilpe et al., 2009; Peel, Bartlett, & McClure, 2004; Thiamwong et al., 2008; Touhy & Jett, 2010). The Western definition of healthy aging is the absence of major life-threatening illness, the maintenance of particular physical and mental functions, and a complex process of adaptation to physical and social changes over a person’s life (Peel et al., 2004; Reed et al., 1998). The European view describes healthy aging as "optimizing opportunities for good health so that older people can play an active role in society and enjoy an independent and high quality of life" (Swedish National Institute of Public Health, 2006, p. 8). Furthermore, the meaning of healthy aging that emerges from academic and professional perspectives focuses on the scope of physical, mental, and social functions (Hansen-Kyle, 2005). Healthy aging is also viewed in terms of the body and mind in relation to activities of daily
living and life enjoyment (Vaillant & Western, 2001). Some studies of healthy aging include freedom from chronic illness and functional impairment in the meaning of healthy aging (Burke et al., 2001). The ability to maintain autonomy also contributes to the value of healthy aging (Hansen-Kyle, 2005).

In Asian countries, healthy aging is described in terms of physical well-being, freedom from chronic illness, happiness, and good relationships with family members. The description of healthy aging is also linked to an active lifestyle, having the financial resources to support one’s lifestyle, and spirituality (Lee & Fan, 2008; Tohit, Browning, & Radermacher, 2012). In Thailand, healthy aging has become increasingly important for the Thai government. Since Thailand announced that healthy aging was part of the national agenda in the Second National Plan for Older Persons (2001–2021), healthy aging has been considered from a Thai cultural perspective. Previous studies show that healthy aging has been studied quite frequently in many regions of Thailand (Danyuthasilpe et al., 2009; Thanakwang & Soonthorndhada, 2011; Thanakwank, Soonthorndhada, & Mongkolprasoet, 2012; Thiamwong et al., 2008). Healthy aging focuses primarily on the perspectives of older people. Thanakwang et al. (2012) revealed that Thailand’s older people describe healthy aging as the sum of multiple components that relate to physical, mental, and social well-being. Healthy aging is the outcome of a continual and reciprocal interaction between individual behaviors and physical and social environments. Factors that are considered to contribute to healthy aging include activities that promote physical health and active engagement in social activities. In northern Thailand, Danyuthasilpe et al. (2009) explored how these factors influence healthy aging and found that healthy aging was influenced by traditions, cultural beliefs, and family practices. All informants considered health to be interconnected with their lifestyles and closely related to their cultural roots. In southern Thailand, Thiamwong, McManus, and Suwanno (2013) developed a model of healthy aging from the Thai perspective. This model included three themes: normality, nature and dharma. Normality was described as the state of being a normal person who continues to be active. Nature was described as natural living and interactions between an older person and those who surround him/her. Dharma was included because Buddhist practices affect beliefs, which in turn influence behavioral strategies. Dharma is a Buddhist term that means a state of nature. Accordingly, the concept of healthy aging is described in similar ways in different regions of Thailand. It combines various aspects of physical, mental, and social well-being. The main aspect of healthy aging relates to activities in daily life. Spirituality has also been recognized as an aspect of healthy aging.
In summary, previous studies on healthy aging (Danyuthasilpe et al., 2009; Hansen-Kyle, 2005; Hung et al., 2010; Lee & Fan, 2008; Peel et al., 2004; Reed et al., 1998; Thanakwang & Soonthorndhada, 2011; Thanakwank et al., 2012; Thiamwong et al., 2008) show that the concept of healthy aging in both Western and non-Western countries encompasses not only functions of the body and mind but also socioeconomic aspects. When comparing the concept of healthy aging in international and national (Thai) studies, differences and similarities become evident. Both Western and non-Western parts view healthy aging as the state of being in which individuals are free from chronic diseases and infirmity. However, independence and the ability to perform daily activities dominate the Western perspective. In contrast, studies of healthy aging in Asian countries emphasize the relationships between older people and their family and friends as a key determinant of healthy aging. Spirituality is also considered a key aspect of the concept of healthy aging, especially in Asian countries (Danyuthasilpe et al., 2009; Thiamwong et al., 2008; Tohit et al., 2012). Furthermore, this literature review indicates that although healthy aging has been widely studied, no previous study on healthy aging has focused specifically on the Isan region. Therefore, healthy aging in this region have to be explored.

2.4 Other concepts related to healthy aging

Many concepts are viewed as positive outcomes in old age and are linked to the state of well-being among older people (Hung et al., 2010). The concepts of QOL, successful aging, and active aging are sometimes related to the concept of healthy aging. These concepts will be briefly described in this section.

2.4.1 Quality of life (QOL)

QOL has been defined in various ways. The World Health Organization Quality of Life (WHOQOL) group defines QOL as “an individual’s perception of his/her position in life in the context of the culture and value systems in which he/she lives and in relation to his/her goals, expectations, standards and concerns” (WHOQOL group, 1998, p. 551). This definition takes a broad view of well-being that encompasses a person’s satisfaction with his/her social, environmental, psychological, spiritual, and health status. Moreover, objective or functional QOL has been defined as the functional effect of an illness and its consequences (Schipper, Clinch, & Olweny, 1996). Objective QOL indicators include income, housing, and physical function. Psychological (subjective) QOL focuses on individuals’ perceptions and experiences of their lives.
2.4.2 Successful aging

Successful aging has been widely studied. This concept is defined as the state of overall functioning (von Faber et al., 2001) and includes having little or no disease or disability, having high cognitive abilities, and leading an active life (Bowling & Dieppe, 2005; Foster & Walker, 2014; Rowe & Kahn, 1997). From the biomedical perspective, successful aging is the optimization of life expectancy and the absence of disease (Bowling & Dieppe, 2005). This concept focuses on good health and concerns physical and mental functioning (Jeste, Depp, & Vahia, 2010). Moreover, the importance of independent living, life satisfaction and QOL have been included in the meaning of successful aging (Bowling & Dieppe, 2005). This concept was described by von Faber et al. (2001) as a process of continuous adaptation. Furthermore, Lewis (2011) maintained that successful aging can be explained as an individual’s attainment of a respected role in the community.

2.4.3 Active aging

Active aging is defined as “the process of optimizing opportunities for health, participation and security to enhance quality of life as people age” (WHO, 2002, p. 12). Active aging concerns the rights of older people to remain healthy and maintain their QOL (Foster & Walker, 2014). This concept focuses on maintaining autonomy and independence to enjoy life (Walker, 2002). The concept of active aging emphasizes the influence of older people’s competence and knowledge on their participation in society. Older people’s participation in society includes their participation in the labor force, community, and other events.

The literature review sought to examine how the concepts of QOL, successful aging, and active aging relate to healthy aging. Given the meanings of healthy aging, successful aging, and active aging, these concepts may contribute to QOL. Nygren (2006) viewed the concepts of healthy aging, successful aging, and active aging as representative of the multidimensional aspects of life, including the physical, psychological, social, and spiritual domains. Furthermore, these concepts may be linked to a person’s inner strength (Nygren, 2006). Hung et al. (2010) stated that healthy aging is a broad concept that is more widely understood than successful aging. Hansen-Kyle (2005) viewed successful aging as a consequence of healthy aging. Like successful aging, active aging is linked to healthy aging. The term “active aging” clearly focuses on the process of maintaining a healthy lifestyle. Walker (2002) maintained that active aging is the key to successful aging. Moreover, Hung et al. (2010)
argued that the concept of healthy aging can help harmonize the overlapping notions of successful aging and active aging.

2.5 The Isan region

The Thai people use the term Isan to refer to the region of northeastern Thailand (Bennett, 1999; Somnasang & Moreno-Black, 2000). The name “Isan” has a Pali-Sanskrit origin (McCargo & Hongladarom, 2004). With 20 provinces, the Isan region is the largest region in Thailand, covering a land area of 160,000 km² (Piayura & Ayuwat, 2012). It borders Laos at the Mekong River and features the Khorat Plateau, which extends south and east toward the Thai border with Cambodia. Isan is also bound by the lower part of the northern region of Thailand to the west. Northeastern Thailand is the most populous region of Thailand, with a population of approximately 18.8 million (National Statistical Office Thailand, 2010), which is approximately one-third of the nation’s total population. In 2014, the older population in the Isan region was approximately 3.2 million (National Statistical Office Thailand, 2014). Fujioka and Thangphet (2009) estimated that the proportion of older people in the Isan region compared with the total population would be approximately 14.7% in 2015. By 2050, this number is expected to be 21.4% of the total population (Fujioka & Thangphet, 2009). Agriculture continues to dominate the economy of the Isan region, although the Isan economic structure has evolved and the non-agricultural sector is growing rapidly (Intarachai, 2003). However, natural resources, such as soil and water, are poor in the Isan region, causing agricultural problems that impact agricultural productivity (Ekasingh, Sungkapitux, Kitchaicharoen, & Suebpongsang, 2007). Therefore, this region still experiences poverty (World Bank, 2005, 2016a), with the lowest income of all regions in Thailand. The poverty rate among older people in the Isan region is especially pronounced.

2.5.1 Isan cultural values and ways of life

Culture is defined as “the fabric of meaning in terms of which human beings interpret their experiences and guide their actions” (Geertz, 1957, p. 33). Cultural values determine one’s thinking and beliefs (Miller, 1991). Certain cultural elements, such as language, religion, and morals (Baligh, 1994), can be described as Isan cultural values and ways of life. A previous study shows that certain Isan people believe that they have their own unique culture that is adapted from Lao and Khmer (McCargo & Hongladarom, 2004). Most people in this region speak “phasa Isan” (the Isan language), which is very similar to the Lao language (McCargo & Hongladarom, 2004; Moulton, 2008). The
Khmer is a minority ethnic group that lives in the southern part of the Isan region and speaks a language that is very similar to the Cambodian language (Denes, 2012). As in other regions of Thailand, Buddhism is the predominant religion in the Isan region (Knodel et al., 2015; National Statistical Office Thailand, 2011). Theravada Buddhism influences people’s lives from early childhood to old age (Parnwell & Seeger, 2008). In Thailand, Theravada Buddhism has two sects: the Thammayuth and the Mahanikai (Sucharitkul, 1998). Monks are key actors in the preservation of the teachings of the Buddha, spreading the Buddha’s teachings to lay people. Buddhism largely concerns virtue and wisdom in daily life, and Thai culture clings tightly to the Buddhism framework. Buddhists believe in karma and punishment for sins; rewards for acts of merit; and the search for nirvana through the accumulation of merit-making (Payuto, 1997). Merit-making is a key concept in Buddhist thought and refers to undertaking good deeds, rituals and ceremonies. People also practice particular doctrines and meditate. Buddhism clearly has a significant influence on the people of the Isan region, especially older people. Most of older people practice Buddhism, which may include offering food to the monks and praying. Older people also believe that if they make merit, they will have a better future life. In this case, a better life means a life characterized by power, wealth or good health (Choowattanapakorn, 1999). Furthermore, Isan’s customs are viewed through a unique tradition called “Heet Sib Sorng - Klong Sib See”, or “Heet 12 and Klong 14” (Wanlu, Chantachon, & Rachote, 2009). Heet Sib Sorng includes customs that are celebrated every month (Wanlu et al., 2009) and is influenced by Buddhist teachings and beliefs. Klong Sib See refers to the traditional way of life and moral standards that maintain the unity of communities and the warmth of families (Prammanee, 2014). It includes the notion that older people should act as venerable people (RakSutee, 2001). Moreover, children should be grateful to their parents, which relates to the debt that children owe their parents according to the Buddha's teaching. The tradition of “Heet Sib Sorng - Klong Sib See” may reflect the importance of religion as cultural norms of the Isan region.

2.5.2 The family unit and the informal care of older people in the Isan region

Policymakers and politicians view family as informal caregivers (Gilbert & Powell, 2005). The family has many functions, including providing love between the family members as well as socialization. Family members and relatives constitute a special type of social support (Hollander, Chappell, Prince, & Shapiro, 2007). Relationships within a family are natural relationships.
Older people often receive many things from their families to fulfill their social needs. Moreover, the family system supports older people’s physical, emotional and mental needs. Hence, the relatives of older people may assist them by taking care of their physical needs and by providing emotional and economic support for their daily living.

Regarding Thai cultural values, people usually respect their parents and older people (Choowattanapakorn, 1999). As described previously, according to traditional Isan cultural norms, children are expected to assume full responsibility for taking care of their parents (Knodel & Chayovan, 2008). The society expects that children will handle most of their parents’ care at home. If a child fulfills this duty, he/she is considered a “good son” or a “good daughter”. Daughters in particular have traditionally been assigned the role of being caregiver. “Katanyukatavedi” is the respect and gratitude that children show their parents; this concept relates to Buddhist principles for parental care (Phratteprattanasutee, 2014). The youngest daughter is expected to bring her husband to live with and provide care for her parents until the end of their lives (Caffrey, 1992). However, certain changes have occurred because globalization and societal changes have altered the traditional Isan lifestyle. For example, the younger generation has a higher educational levels and participates in the labor market. Isan people tend to leave their hometowns, relocating to urban areas to take advantage of modern culture. These changes may limit their ability to live with and care for their parents. People who live in poor areas move to rich areas for work, participating in the labor force in the capital city or in developed countries to earn money, and send some of the income to their parents. Moreover, societal changes include developments related to family relationships and family structure due to successful family planning policies in Thailand (UNFPA, 2006), which has led to changes in the family structure. Specifically, the Thai family has become smaller, with fewer children. Some families have only one child and some older people are single. Older people are left alone, and some of them feel abandoned (Sudnongbua, LaGrow, & Boddy, 2010). Therefore, this situation may affect the health of older people in the Isan region.

In this thesis, the terms “family member” and “relative” are defined as children or grandchildren of older people who live with and care for them in the Isan region.
2.6 The healthcare system and social welfare for older people in Thailand

To enhance understanding of the overall system of governance related to healthcare and social welfare for older people, the healthcare service system and human resources dedicated to care for these people will be described. Then, national responses to support the older population will be explored.

2.6.1 Healthcare services and human resources dedicated to healthcare

Healthcare services in Thailand are provided by the public and private sectors (Sakunphanit, 2006; WHO, 2015b). The public healthcare sector is mainly financed by the Thai government. The Ministry of Public Health (MoPH) acts as the leading agency in health system performance and is responsible for two-thirds of all hospitals and beds across the country (Kespichayawattana & Jitapunkul, 2008). University and state enterprises also provide healthcare services (Kespichayawattana & Jitapunkul, 2008). Other healthcare services are provided by the private sector (i.e., private hospitals, clinics, and specialized hospitals), which accounts for one-third of the total hospitals and beds in Thailand (Kespichayawattana & Jitapunkul, 2008). Under the MoPH, the three levels of healthcare provision are primary healthcare, secondary care, and tertiary care. Primary healthcare includes healthcare centers and certain healthcare services that fall under the supervision of community hospitals. Secondary care refers to community (10–120 beds) and general hospitals. The role of this care level is to provide comprehensive services. Secondary care includes the district hospitals (120–500 beds), which emphasize the provision of healthcare services and the support of government service programs. Tertiary care refers to health services that are provided by medical and health staff with various degrees of specialization, general or regional hospitals, and university hospitals. General hospitals focus on providing medical and health services through health personnel in various health units, which may include provincial hospitals (501–1000 beds). Tertiary care may include large referral hospitals in the capital and major cities (WHO, 2012). One report shows that Thailand has 9765 sub-district health centers, 725 district hospitals, and 95 regional or general hospitals that cover all provinces in Thailand (Pagaiya & Noree, 2009). All healthcare center levels have healthcare providers that support healthcare services. Healthcare providers, such as physicians, dentists, pharmacists, nurses and public health professionals, provide the healthcare services at each level (Thailand Health Profile, 2000). Primary care and secondary care units, such as healthcare centers, community hospitals, and the health promotion unit at provincial hospitals, promote the health of older people. Accordingly, these units provide the setting for the studies in this project.
2.6.2 Community nurses and care for older people

Participation by healthcare providers is crucial for encouraging older people to improve their health. Nurses constitute the largest human resource in healthcare services (WHO SEARO, 2010). The main activities of nursing and midwifery in Thailand focus on improving the quality of healthcare services at all levels of the healthcare system (WHO SEARO, 2000). In primary healthcare centers, community nurses play a key role in improving health outcomes for the Thai population. Nurses who work in communities have endeavored to develop effective community healthcare (Nuntaboot, 2006). The scope of their activities includes establishing and maintaining a healthy community; following up patients through home care; evaluating health problems; preventing disease and illness; providing healthcare programs to reduce risk factors; and cooperating with other resources (Nuntaboot, 2006).

2.6.3 Policies and plans for the older population

The Thai government has been concerned about aging and has designed national plans to address the issue. One example is that the National Council on Aging and Older People in Thailand was established. The Thai government initiated activities directed at older people by establishing the National Elderly Council in 1982 (Jitapunkul & Wivatvanit, 2008) in response to the UN’s emphasis on the rights, care, involvement, self-satisfaction and self-esteem of older people. Furthermore, the Thai government was aware of the law concerning older people. Specifically, the Elderly Act was enacted in January 2004 (Jitapunkul & Wivatvanit, 2008). According to this act, older people in Thailand receive services and benefits. One example is that older people are provided the right to receive protection, support, as well as medical and healthcare services.

To address concerns about the health of the older population, the 11th National Health Development under the 11th National Economic and Social Development Plan (2012–2016) was adopted. This plan aims to ensure that all Thai people are healthy and to create a health system that provides sufficient and equitable care and equal access to healthcare, which leads to social well-being (Ministry of Public Health Thailand, 2012). According to this plan, the main strategies are to emphasize the important roles of people, communities, and health networks and to use Thai wisdom to promote health and prevent disease. Moreover, this plan focuses on the importance of developing a proactive health system by effectively promoting the health of the Thai people (Ministry of Public Health Thailand, 2012).
The national plan for older people is the key strategic plan for the older population (National Committee on the Elderly, 2009). This plan was devised by the Thai government in the early 1980s (Knodel & Chayovan, 2008). The national plan for older people followed the UN World Assembly on Aging in Vienna and was implemented from 1986 to 2001. This plan encouraged older people to not become dependent on family support and care. Then, the Second National Plan for older people was proposed to cover 2002–2021. This plan includes the stimulation of physical and psychological health in older citizens, as well as the government supports, optimized facilities, and social security necessary to allow older people to spend their lives comfortably in their communities (National Committee on the Elderly, 2009). Moreover, the Thai government’s role has evolved. Today, its ambition is to raise national awareness of older people and is concerned about the value of the older population. The Second National Plan for the older population (2002–2021) serves older people and seeks to enhance their well-being (National Committee on the Elderly, 2009).

Long-Term Care is the action plan approved by the National Elderly Committee in 2009 (WHO, 2004). This plan focuses on older people’s QOL and emphasizes assistance from a combination of families and community healthcare systems to care for older people, especially older people with chronic illnesses (Knodel et al., 2015). Sasat and Bowers (2013) stated that long-term care in Thailand is characterized by two models. The first model focuses on older people who need social care and minimal assistance, whereas the second focuses on older people who need continuous skilled nursing care.

2.6.4 Welfare state

Thailand’s welfare system is managed by social security, which includes four areas: social services, social assistance, social security and popular sector assistance (Ministry of Public Health Thailand, 2012). Social security was outlined in the 11th National Economic and Social Development Plan (2011–2016) (Suwanrada & Wesumperuma, 2012). With respect to aging, the government has provided policies to enhance health security, including free universal healthcare, health promotion, and disease prevention. Moreover, provisions for older people have been established. The old-age allowance system presents another challenge. To explain the system that supports the well-being of older people in Thailand, a description of health insurance schemes is provided first. Then, the financial security of the older population will be explored.
Thai health insurance schemes include three health insurance programs (Ministry of Public Health Thailand, 2012): the Civil Servant Medical Benefit Scheme (CSMBS) and state enterprise benefits; the Social Security Scheme (SSS); and the Universal Coverage Scheme (UCS). The CSMBS is financed through general taxation and state enterprise benefits (MoPH & Ministry of Social Development and Human Security Thailand, 2007). The CSMBS and state enterprise benefits are supported by the Ministry of Finance, which assumes responsibility for employees’ medical bills. The SSS is funded by contributions from employers, employees, and the government. This scheme covers employees in the private sector. The SSS requires that each employee pay three percent of his/her salary into the fund; the government then contributes an amount equal to two percent of the employee’s salary to the social security fund. This fund is managed by the Ministry of Labor. The last health insurance scheme is the UCS, which is funded through general taxation. This program was established to cover the uninsured and others who do not benefit from the CSMBS and SSS (Sasat & Bowers, 2013). The UCS generally supports the poor and cares for the older population (Limwattananon, Tangcharoensathien, Tisayaticom, Boonyapaisarncharoen, & Prakongsai, 2012; Sasat & Bowers, 2013).

Financial security for older people is provided through an old-age allowance system in Thailand. Thailand has formal and informal social protection schemes (Suwanrada & Wesumperuma, 2012). These schemes differ in terms of benefit value, public financing method, and target group. Social protection schemes may target specific groups, including public officials, employees of private businesses, the self-employed, and the rest of the working population. The Public Officials’ Pension Scheme is the original pension scheme for retired government officials and people who choose to take part in the Government Pension Fund (GPF), which encourages people to save through the government. Benefits are calculated by “averaging sixty months of salary before retirement, multiplied by years of service, divided by fifty” (Sasat & Bowers, 2013, p. 714). Old-age benefits under the Social Security Fund (SSF) support the working population in the private sector and informal systems (Suwanrada & Wesumperuma, 2012). The last financial security scheme is the old-age allowance system, which was established in 1993 (Suwanrada, 2008). Through this system, which is called “Bia Yung Cheep” in Thai, the government supports older people who do not receive benefits from Public Officials’ Pension Scheme. The allowances increase as recipients age (Sasat & Bowers, 2013). The monthly allowances are 600 baht (USD 18), 700 baht (USD 21), 800 baht (USD 24), and 1,000 baht (USD 30) for people aged 60–69 years, 70–79 years, and 80 years or older.
80–89 years, and 90 years or older, respectively (Suwanrada, 2014). Sasat and Bowers (2013) argued that these pensions are inadequate for older people, and poverty among the older population has been highlighted as a major issue in Thailand (Khiewrord, 2011). Furthermore, the WHO (2016c) emphasizes that poverty can affect people’s health. Thus, the aging population have the attention of healthcare providers to improve their health.
3 Rationale for the study

The aging situation in Thailand has stimulated health promotion efforts, such as the promotion of general health and illness prevention. These health promotion efforts help older people to live healthy lives and to enjoy their lives in the future. Healthy aging has clearly become a key factor in promoting the health of older people in Thailand.

The northeastern region of Thailand, called “Isan”, currently has a high amount of old people, and this figure continues to rise. Isan is known as the poorest region in the country (Knodel & Chayovan, 2008). Normally, adults take care of the older people in their families. This practice is influenced by Buddhist principles and Isan culture, which guide the lives of those who live in the region. Due to modernization and poverty problems, ways of life in the Isan region have changed. The older population feels abandoned because younger generations have moved to large cities (Sudnongbua et al., 2010). Such feelings of abandonment affect an individual’s self-esteem (Sudnongbua et al., 2010), which in turn can impact his/her psychological health (Sedikides, Rudich, Gregg, Kumashiro, & Rusbult, 2004). Therefore, healthcare providers should work to raise awareness regarding the health of older people in the Isan region.

Although healthy aging is one of the goals of promoting older peoples’ health, few studies have been conducted in the Isan region. Moreover, healthy aging has received little attention. One previous study showed that cultural differences influence the definitions of healthy aging (Hung et al., 2010). Therefore, understanding how older people in the Isan region, as well as those who surround them, perceive the concept of healthy aging is important. This thesis seeks to assess the conditions of healthy aging to determine the situation of older people in the Isan region and to describe healthy aging from the perspectives of older people and their close relatives. Furthermore, community nurses’ experiences of the meaning and promotion of healthy aging are explored upon their role in caring for and supporting older people.

The outcomes of this thesis are expected to be used to improve practices to promote healthy aging among the older population and to support their relatives in northeastern Thailand.
4 The overall aim of the thesis and the specific aims of the included papers

The overall aim of this thesis was to describe healthy aging as experienced and perceived in northeastern Thailand.

Specific aims of the papers:

Study I aimed to describe the factors associated with perceived health and healthy aging among older people in northeastern Thailand.

Study II aimed to describe older persons’ qualitatively different conceptions of healthy aging in Isan-Thai culture.

Study III aimed to describe the conceptions of healthy aging held by children and grandchildren caring for older people in northeastern Thailand.

Study IV aimed to describe community nurses’ experiences regarding the meaning and promotion of healthy aging in northeastern Thailand.
5 Theoretical perspectives

The thesis takes an epistemological perspective from lifeworld phenomenology. To understand the experiences of promoting healthy aging, “person-centredness” could help explain how community nurses promote healthy aging in the Isan region. In Thailand, this concept has been used to ensure universal coverage for people who are in the healthcare system to achieve the goal of health promotion (WHO, 2016d). Therefore, the concept of “person-centredness” could be the core competence of nurses who seek to promote healthy aging.

5.1 The phenomenological concept of the lifeworld

Lifeworld theory is central to this thesis, which focuses on the phenomenon of interest as the point of departure for an inductive approach. Thus, the second and third studies use the lifeworld perspective as an epistemological approach—which is inspired by Ashworth and Lucas (1998, 2000)—to understand the meaning of healthy aging. Ashworth and Lucas (1998, 2000) stated that the conception of the world must be grounded in the lived experience of the research participants (Ashworth & Lucas, 1998, 2000). Therefore, lifeworld theory is relevant to this thesis, which aimed to understand individuals’ conceptions of healthy aging based on their lived experience. Lifeworld theory was developed by phenomenologists Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, and Hans-Georg Gadamer (Dahlberg, Dahlberg, & Nyström, 2008). The lifeworld lies between the subjective and objective worlds (Bengtsson, 2013). Dahlberg et al. (2008) referred to Merleau-Ponty, who described “the idea of lifeworld as our being to the world” (Dahlberg et al., 2008, p. 37). Lifeworld ontology is characterized as the interdependence between life and the world (Bengtsson, 2013). The human being lives his/her life with other people; this relationship is described as intersubjectivity (Dahlberg et al., 2008). Human beings can learn through experience. To see reality, “both” should be viewed, instead of “either/or” (Bengtsson, 2013). Dahlberg et al. (2008) emphasized the importance of the notion of “flesh” to an understanding of the lifeworld, which can be described as “understanding an ontological connectedness and mutuality” (p.39). Merleau-Ponty stated that “all of my thoughts, your thoughts, and the thoughts of others are caught up in the fabric of one sole being” (Merleau-Ponty, 1968/1964, p. 110). The concept of “flesh of the world” is the foundation for understanding the phenomenological notion of humans as lived bodies (Dahlberg et al., 2008; Merleau-Ponty,
2002/1945). This explanation can be described as the unity of body and mind (Bengtsson, 2013). Therefore, human beings and their existence can be viewed as a living whole (Dahlberg et al., 2008).

5.2 Person-centredness

Person-centredness is described as “an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, older people and others significant to them in their lives. It is underpinned by values of respect for persons, the individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development” (McCormack et al., 2010, p. 13). This concept is becoming increasingly important for approaches that describe standards of care and guiding principles in healthcare policy (McCormack, Karlsson, Dewing, & Lerdal, 2010). Person-centredness is described in relation to nursing and patient care (McCance, McKenna, & Boore, 1999; McCormack, 2003). McCormack (2003) described person-centredness in terms of its implications for nursing practices, linking it to professional competence. Nursing practices, which contribute to person-centredness care, include the attitudes, knowledge, and skills of nurses who provide holistic care (McCormack & McCance, 2011). In practice, person-centredness care can be explained through a framework of person-centredness nursing, which comprises four constructs (McCormack & McCance, 2006). The first construct concerns prerequisites that focus on “the attributes of the nurses and include professional competence, developed interpersonal skills, commitment to the job, an ability to demonstrate clarity of beliefs and value, and knowledge of the self” (McCormack & McCance, 2006, p. 475). The second construct concerns the care environment, with an emphasis on the appropriate mix of skills, the shared decision-making system, effective staff relationships, and power sharing. This construct includes the potential for innovation and risk tasking. The third construct is the person-centredness process, which focuses on working with a client’s beliefs and values, engaging him or her, sharing the decision making, having a sympathetic presence, and tending to physical needs. This element clearly focuses on the provision of holistic care (McCormack & McCance, 2006; McCormark et al., 2015). The last construct concerns the outcome, which is central to the framework. This construct focuses on the results of effective person-centredness nursing, involvement in care, feelings of wellbeing, and the creation of a therapeutic culture (McCormack & McCance, 2006). McCormack and McCance (2006) stated that the
framework of person-centredness nursing can be described as a mid-range theory. They also explained that the theoretical underpinnings of the person-centredness nursing framework are consistent with Jean Watson, who emphasized the importance of holism and the relationship between the person and others (McCormack & McCance, 2006). The person-centredness nursing framework clearly focuses on the individual, who is seen as the main expert on his/her life situation.
6 Methods

6.1 The setting

Udon Thani province, which is located in the northeastern region of Thailand, was the setting for the studies conducted for this thesis. This province was purposively selected because it ranks among the top ten provinces in the northeastern region of Thailand with the largest aging population (Institute for Population and Social Research Mahidol University, 2014). Older people account for more than 10 percent of the total population of Udon Thani province. This province has witnessed rapid urban growth, as well as lifestyle changes caused by urbanization (Phuttharak & Dhiravisit, 2014). In addition, Udon Thani province is characterized by both rural and urban areas. Udon Thani province covers an area of 11,730 km², with its provincial capital located slightly more than 560 km northeast of Bangkok. Geographically, this province lies in the Northern Korat plateau and consists of flat lowlands. Udon Thani’s administration is divided into 20 amphoe (districts). The provincial capital is a bustling market center for the surrounding agricultural areas and a transport hub for travel to other provinces in northeastern Thailand (TAT Udon Thani, 2010). In 2014, provincial statistics reported that the population of Udon Thani province had reached 1,567,010 (18% of the inhabitants were < 15 years; 70% were 15–59; and 12% were 60 years of age or older). In the same year, the older population in the province numbered 189,471 (Udon Thani Provincial Health Office, 2016).

Figure 1. Map of Udon Thani province showing the provincial districts
6.2 Study design

The thesis comprises four studies with both quantitative (Study I) and qualitative approaches (Study II, III, IV). The four studies have descriptive designs. The first study focuses on the factors associated with healthy aging among older persons. The second and third studies describe conceptions of healthy aging from the perspectives of older people and their relatives, respectively. The last study focuses on community nurses’ experiences regarding the meaning and promotion of healthy aging.

Table 1: Overview of study type, participants, methods of data collection, and analytical methods of each study

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of study</th>
<th>Participants</th>
<th>Data collection</th>
<th>Analytical methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Quantitative research Cross-sectional study</td>
<td>453 older people Men (n) = 149 Women (n) = 304</td>
<td>Healthy Aging Instrument (HAI)</td>
<td>Descriptive statistics Multiple regression analysis</td>
</tr>
<tr>
<td>II</td>
<td>Qualitative research Phenomenographic approach based on lifeworld theory</td>
<td>17 older people Men (n) = 3 Women (n) = 14</td>
<td>In-depth, semi-structured interviews</td>
<td>Phenomenographic analysis</td>
</tr>
<tr>
<td>III</td>
<td>Qualitative research Phenomenographic approach based on lifeworld theory</td>
<td>14 children and grandchildren of the older people in the second study Men (n) = 3 Women (n) = 11</td>
<td>In-depth, semi-structured interviews</td>
<td>Phenomenographic analysis</td>
</tr>
<tr>
<td>IV</td>
<td>Qualitative research Focus group methodology</td>
<td>36 participants (5 groups of 4–9 community nurses who worked with older people) Men (n) = 1 Women (n) = 35</td>
<td>Interview guide Focus group interviews</td>
<td>Latent content analysis</td>
</tr>
</tbody>
</table>
6.2.1 Study I

Study I had a descriptive, cross-sectional design. The Healthy Aging Instrument (HAI), which was developed by Thiamwong et al. (2008), was used. The HAI is a multidimensional instrument that evaluates healthy aging in Thailand (Thiamwong et al., 2008). Thiamwong described a healthily aging person as “an older Thai adult who describes himself or herself as healthy, but not necessarily free from chronic diseases or disability” (Thiamwong, 2008, p. 7). This description of the HAI refers to subjective perceptions of health. This descriptive study determined the relationship between independent variables and the HAI, i.e., the dependent variable. The independent variables in this study were selected in accordance with previous studies regarding determinants of self-perceived health. Variables included area of residence, gender, education level, income level, age, marital status, underlying disease or disability, social support from family and healthcare providers, and perceived meaningfulness in life (Benyamini, Idler, Leventhal, & Leventhal, 2000; Çapik & Bahar, 2008; Cott, Gignac, & Badley, 1999; Faresjö & Rahmqvist, 2010; Molarius & Janson, 2002; Ren, 1997; Singh, Arokiasamy, Singh, & Rai, 2013; Skrabski, Kopp, Rózsa, Réthelyi, & Rahe, 2005; Thanakwang, 2009; Wen, Hawkley, & Cacioppo, 2006; Zunzunegui et al., 2004).

6.2.2 Studies II and III

A descriptive, qualitative design with a phenomenographic approach was used for Studies II and III. Based on lifeworld theory—as recommended by Ashworth and Lucas (1998, 2000)—a phenomenographic approach was used to identify and describe variations in ways of experiencing healthy aging. The most important requirement for phenomenography is an awareness of the individuality of conceptions of the world (Ashworth & Lucas, 1998, 2002). Moreover, the world “must be grounded in the lived experience of its research participants” (Ashworth & Lucas, 1998, p. 417). Therefore, the purpose of the second and third studies was to gain a deeper insight into varying conceptions of healthy aging from the lifeworld of older people and their relatives. The lifeworld perspective (Dahlberg et al., 2008) involves the world as it is experienced and perceived by humans. A phenomenographic approach, which was developed by Ference Marton and colleagues at the University of Gothenburg in Sweden, is a qualitative research approach that helps identify and describe varied conceptions that encompass the phenomena of human experience in the world.
Marton and Booth (1997) explained that phenomenography aims to reveal the nature of human experience and awareness. This approach emphasizes the importance of a second-order perspective and the identification of conceptions. The term conception encompasses the central means of understanding or experiencing something and is often used in the phenomenographic approach (Sandberg, 1997). The term is used to refer to ways of experiencing a specific aspect of reality (Sandberg, 1997). Whereas a first-order perspective focuses on how something really is, a second-order perspective focuses on how people experience and perceive a phenomenon.

The outcomes of such analyses are explained in terms of various understandings from a perspective that views any number of ways of experiencing phenomena (Barnard, McCosker, & Gerber, 1999) and that represents a number of qualitatively different meanings of experiencing the aforementioned phenomena (Åkerlind, 2012).

6.2.3 Study IV

Study IV used a qualitative approach and a descriptive design. Data from focus group interviews with community nurses were used. Focus group interviews were chosen to explore the participants’ views through discussions of the meaning of healthy aging and to examine participants’ experiences with the promotion of healthy aging. This method seeks to allow participants to ask one another questions and to use group dynamics to explore participants’ different perspectives (Barbour & Kitzinger, 1999; Krueger & Casey, 2015). This method was useful in uncovering the participants’ perspectives and to illustrate their understanding of healthy aging based on their experiences.

6.3 Participants and recruitment procedures

6.3.1 Study I

The participants were required to be 60 years of age or older and to speak Thai. All participants who had psychiatric diagnoses that could interfere with memory or judgment were excluded. The community health nurse determined the recruitment process based on the family folder. This study used a six-stage sampling method. First, 20 districts were divided into five groups based on the level of districts (first, second, third, fourth and fifth levels) using the cluster method. Next, one district per level was selected by simple random sampling. Five of the 20 districts were selected in the first sampling stage. Each district was then separated into municipal and non-municipal areas based on their administrative classification. Generally, the term municipality refers to an area
comprising communes and a town. Classification of municipal and non-municipal areas depends on population and local financial resources. Municipalities can be referred to as urban areas, whereas non-municipalities can be referred to as rural areas (ESCAP, 2013). Next, five municipalities and five non-municipalities were selected using simple random sampling. Finally, a list of all residents aged 60 years or older in each selected municipal and non-municipal area was obtained, and these people were selected using stratified systematic sampling. Ultimately, 453 of 460 older people living in Udon Thani province in northeastern Thailand agreed to participate the project (for a response rate of 98.5%).

6.3.2 Study II

A purposive sampling technique was used to select the participants based on the recommendations of public healthcare professionals, community nurses and the older people’s leader. Participants had to be 60 years of age or older and able to speak Thai. Potential participants were excluded if they suffered from a psychiatric disorder that could interfere with their ability to communicate; the participants in Study I were also excluded. Participants comprised 17 older people (14 women and three men) aged 60 years or older. Ten participants had no education and seven had an elementary education or university degree. Eleven were married and living with their partner or their children and grandchildren. Five were widowed and living with their children or grandchildren. One participant was widowed and living alone. Ten participants resided in urban areas and seven resided in rural areas (i.e., non-municipalities).

6.3.3 Study III

A purposive sampling technique was used to select the participants for Study III. The selected participants were relatives who lived with and took care of the older people who participated in Study II. The participants in Study III were 14 children and grandchildren of the participants in Study II. These participants included 11 women and three men who differed in terms of age (16–56 years), education, and relationship to the older person in Study II. Twelve participants were the children of the older person, and two participants were grandchildren. Eight participants were married, and six participants were single. Five participants had completed an elementary education, six participants had a high school education, one participant had a bachelor’s degree, and two had master’s degrees.
6.3.4 Study IV

A purposive sampling procedure was used to recruit participants in Study IV. The inclusion criteria were as follows: (a) having experience working as a community nurse; (b) working in the full-time promotion of health services and (c) no limitations in Thai-language communication. A health promotion officer recommended a list of potential participants. In total, 36 community nurses (35 women and one man) participated. These participants have different backgrounds in terms of their years of experience in caring for older people, gender, age, education level, and marital status. The mean age of the 36 participants was 39 years old, and their ages ranged from 23 to 52 years. All participants were classified into five groups according to their work location. Group size varied from four to nine community nurses.

6.4 Data collection and data analysis

6.4.1 Study I

The researcher contacted three research assistants who were village health volunteers. However, these volunteers did not serve in the areas researched to ensure that the participants did not depend on them for care. Volunteers were trained in how to collect data. The community healthcare providers were then asked to visit older people in their communities. The questionnaire took approximately 25 minutes to complete. The research assistants helped participants understand and interpret the questionnaire items if they were unable to read or write. In this case, participants also received assistance from the research assistants to complete the questionnaire. The completed questionnaires were sent to the researcher.

6.4.1.1 Instruments

This study used two research tools. The first part of the questionnaire addressed the following: sociodemographic factors, health status and perceived meaningfulness in life. The second part was the HAI, which comprised 35 items.

Sociodemographic factors included gender, age, marital status, area of residence, education level, income level, and social support, which included care from family members and contact with healthcare providers at least once per month. Family members were defined as spouses, children and other relatives. Healthcare providers were defined as physicians, dentists, pharmacists, and registered nurses. Care from family members was measured by the question...
“Do you receive any care from your family?” Contact with healthcare providers was measured by the question “Do you have any contact with healthcare providers?” Both questions could be answered “Yes” or “No”. Health status included both disease and disability. Disease was defined as an underlying condition that had been diagnosed by a physician. Disease was a dichotomous variable coded “Yes” or “No” and was measured by the question “Do you have any underlying diseases?” Participants could then select the type of disease, such as diabetes, hypertension, gout, and others. Disability was defined as impairment and measured as a dichotomous variable coded “Yes” or “No”, using the question “Do you have any disabilities?” Types of disability limiting activities of daily living were hearing impairment, vision impairment, physical disability, and other. Perceived meaningfulness in life was measured using the question “Do you feel that your life is meaningful?” Responses were given on a 5-point Likert scale ranging from 1 (not at all) to 5 (to a very high degree).

For the HAI instrument, responses were given on a 5-point Likert scale, which is used to indicate the extent to which participants agree with certain statements (i.e., 1 = definitely not, 2 = less likely, 3 = not sure, 4 = more likely, and 5 = definitely yes). Total HAI scores range from 35 to 175, with higher scores indicating healthier aging persons (Thiamwong, 2008). The HAI includes 9 factors: self-sufficiency and living simply (e.g., “Everything I have is sufficient”); acceptance of aging (e.g., “I accept that I am not able to do things that I used to be able to do”); stress management (e.g., “I do not worry without reason”); having social relationships and support (e.g., “My neighbors and I help each other”); making merit and good deeds (e.g., “I always do good deeds”); practicing self-care and self-awareness (e.g., “I am not worried that I am older”); staying physically active (e.g., “I feel weak if I do not do anything”); staying cognitively active (e.g., “I stay mentally active to prevent forgetfulness”); and participating socially (e.g., “I participate in community activities”). Five experts evaluated the validity of the HAI and agreed that it was appropriate to use to ascertain the health self-perceptions of older people in Thailand. The internal consistency for a sample of older people in south Thailand was acceptable: Cronbach’s alpha = 0.88 (Thiamwong et al., 2008). The Thai language was used to collect data. The questionnaire’s validity was tested by a team of experts before it was used to collect data. The internal consistency was then tested using Cronbach’s alpha with 30 older people from the Udon Thani province. In this study, the internal consistency for the sample was high: Cronbach’s alpha = 0.96.
6.4.1.2 Statistical methods of analysis

Descriptive data are presented as numbers and percentages. All calculations were made using SPSS version 17.0 (Statistical Package of the Social Sciences, 2007). With regard to the total HAI score, two subgroups (which were created based on participants’ area of residence, gender, age, and health status) were compared using the Mann-Whitney U test. Education level, marital status, income level and amount of perceived meaningfulness in life were compared using the Kruskal-Wallis test. The significance level was set at \( p \leq 0.05 \). Then, variables in bivariate analyses and multivariate analyses of the subgroups were selected to test individual predictors using a multiple regression model. Several independent variables were recoded as dummy variables. A backward-selection multiple regression analysis was conducted to test the model because it explained the remaining predictors for all independent variables. The significance level of the multiple regression analysis was set at \( p \leq 0.05 \).

6.4.2 Studies II and III

Interviews are one of the most widely used methods of data collection to encourage dialogue among participants around a particular phenomenon (Marton, 1986). Interviews explore the lived experience of the participants and are normally used in phenomenographic research (Marton & Both, 1997). Interviews are often tape-recorded. The interview is a conversation in which knowledge is generated through interactions between a researcher and participants (Liamputtong, 2009). Participants in these studies were able to explore their own thoughts during the interviews (Holloway & Wheeler, 2010). A pilot interview was conducted to test the interview questions (Green, 2005). Based on the pilot study, the interview guide was not changed. The result of the pilot study was not included in the data. The first researcher performed all interviews. The opening questions were followed by questions about the participants’ conceptions of healthy aging, for example “What do you think about healthy aging?”, “In your opinion, what is meant by healthy aging?” and “Could you tell me about healthy aging?” As explained by Åkerlind (2005), follow-up questions were asked to prompt participants to reflect on the conceptual meanings of the phrases used in their expressions and thoughts. Follow-up questions were also used to follow up and expand on the answers given. For instance, follow-up questions included “Could you please explain that further?” and “Why do you think that way?” The length of the interview depended on the participant and ranged from 45 to 60 minutes. A recorder was used to record the interviews for verbatim transcription and detailed analysis.
Field notes were taken to document the situations, observations, and critical insights during the interviews.

6.4.2.1 Phenomenographic analysis

Before starting the analysis, all transcripts were translated from Thai into English by a licensed professional Thai-English translator (Thai), who reviewed the transcripts to confirm their accuracy (Regmi, Naidoo, & Pilkington, 2010). The analysis involved the identification of meanings or variations in meanings across the set of transcripts. The analyses of study II and study III were performed according to the seven-step process of phenomenographic analysis of Dahlgren and Fallsberg (1991). First, during the familiarization step, the researcher reads the transcripts several times to obtain an overview of participants’ conceptions. Second, the condensation step involves condensing participants’ conceptions and reducing each participant’s answers to find the central elements of the answers or the entire dialogue. Third, the comparison step involves collecting all of the participants’ answers and identifying the most significant elements in each participant’s answers. Fourth, the grouping step involves classifying similar answers into preliminary categories. Fifth, the articulating step is conducted to determine the preliminary categories and to establish borders between categories. The sixth step is labelling, which involves naming the categories to emphasize their essence. The final step is contrasting. In the contrasting step, the researcher considers the differences and similarities between categories and describes each category’s unique characteristics.

The phenomenographic findings were reported as an outcome space that described the categories of qualitatively different conceptions of the phenomenon. The outcome space is an interpretation of a phenomenon that represents the relationship between the descriptive categories found (Kaminsky, Rosenqvist, & Holmström, 2009).

The data analysis of the second study (Study II) was completed by all researchers from the third step forward. For the third study (Study III), all researchers participated from the first to the final steps. Like in Study II, the data of Study III were collected in the Thai language. However, the researchers used the English-language transcriptions throughout the analysis process. The researcher could recheck the transcripts and consult the professional translator during the analysis process if discrepancies were found.
6.4.3 Study IV

Focus group interviews were performed to directly engage the community nurses in discussions about their experiences related to the meaning and promotion of healthy aging. An interview guide with semi-structured questions was created. A pilot study with five community nurses who work outside the selected setting was conducted to test the interview guide for appropriateness. The questionnaire contained open-ended questions that asked the community nurses to share their experiences related to the meaning of healthy aging and the ways in which they promoted healthy aging. Each focus group interview took approximately 60-90 minutes and was conducted in the Thai language. The data were audio recorded and transcribed verbatim in Thai. Before analyzing the data, the transcriptions were read and re-read by the researcher and co-researcher (both of whom are Thai). Although a large amount of data was received, the answers of six participants regarding their experiences of promoting healthy aging required further explanation. Therefore, follow-up interviews via telephone with these six participants from different groups were conducted to obtain detailed descriptions of their experiences in promoting healthy aging. Follow-up questions (Holloway & Wheeler, 2010) included “Could you please tell me more about ways to promote healthy aging?” and “Can you give me an example of that?” The follow-up interviews lasted approximately 30 minutes. Data from interviews were audio-recorded, transcribed, and then sent by email to each participant to confirm the accuracy of the data. These data, which were obtained from individual interviews, were added to the transcripts of the focus group interviews.

6.4.3.1 Qualitative content analysis

In Study IV, the data were analyzed through a latent content analysis (Graneheim & Lundman, 2004). The pilot study was not included when analyzing these data because it was conducted with community nurses who work outside the selected setting. First, the researcher and co-researcher read and re-read the Thai transcripts several times to obtain a comprehensive sense of all of the interviews. Then, the content areas regarding the meaning of healthy aging and the nurses’ experiences of the promotion of healthy aging were each condensed, and the condensed meaning units were labelled with codes. The different codes were compared for similarities and differences. Next, the codes were grouped into categories and sub-categories, which constituted the manifest contents. The themes were then arranged according to the meanings of the categories and were interpreted by all researchers. The researcher and co-researcher discussed emerging findings throughout the data analysis. If their
views of the data differed, all researchers discussed and clarified the data until a consensus was reached. An analysis was conducted in Thai to reduce any potential language barriers (Squires, 2008). In the next step, all transcripts were translated from Thai into English by a Thai expert translator. Finally, the findings in English were discussed and agreed upon by all researchers. The meaning of healthy aging and the experiences of the promotion of healthy aging were described independently. The categories and then the themes were organized, along with the content area of meaning and the promotion of healthy aging. The meaning of healthy aging will be reported first, followed by the nurses’ experiences of the promotion of healthy aging.
7 Ethical considerations

The research project was approved by the Board Committee of the Udon Thani Provincial Public Health Office of Thailand and the Registered Research Ethical Review Board of Uppsala, Sweden regarding the designated ethical considerations (Dnr 2013/019). Because the studies conducted for this thesis involved human beings, the research project followed the principles outlined in the Declaration of Helsinki, which protects participants’ health and rights (WMA, 2013). All participants received both written and verbal information about the purposes and procedures of the studies. If participants experienced physical discomfort or fatigue when completing questionnaires or answering questions, data collection was halted. A team of community healthcare providers could be contacted to closely monitor and care for older people who had health problems. The participants signed an informed consent form and were free to withdraw from the study at any time. The participants were identified by number codes to ensure their privacy. Identifying information was excluded when the interviews were transcribed. The researchers explained the reason for recording the interviews and discussions, and the participants agreed to have their conversations recorded. One researcher kept the instrument, recordings, and transcriptions in a locked office at Mälardalen University, and only that researcher had access to the identification lists. The data will be destroyed in 10 years.
8 Findings

The findings are synthesized and described in three main parts: factors associated with healthy aging, the meaning of healthy aging from multiple perspectives, and the promotion of healthy aging by community nurses.

8.1 Factors associated with healthy aging (Study I)

Study I aimed to describe the factors associated with perceived health and healthy aging among older people in northeastern Thailand. The main findings of this study were divided into four topics: characteristics of the study sample; HAI score; differences between the subgroups related to perceived health and healthy aging and to HAI scores; and factors associated with perceived health and healthy aging.

8.1.1 Characteristics of the study sample

The characteristics of the study sample are presented in Table 2. A majority of the participants were female, married, lived outside the central city of the province, were between 60 and 75 years old, and had a primary education. Just 3.5 percent of the sample had a high monthly income. More than one-half of the participants had an underlying disease; hypertension was reported most frequently, followed by diabetes. Some participants reported a disability; physical disability was reported most frequently. More than three-quarters of the participants lived with their children or spouse, whereas 22.7 percent lived alone. Eighty-one percent of the participants were cared for by a family member (e.g., their children), and the majority of the participant sample had contact with a healthcare provider. More than three-quarters of the participants felt that their life was meaningful to a high or very high degree.

8.1.2 The HAI score

The minimum and maximum HAI scores were 50 and 175, respectively. The mean HAI score was 145.3 (SD = 20), and the scores were normally distributed. Due to the small sizes of the compared subgroups, nonparametric statistics were used. Therefore, the median HAI score was calculated. The median HAI score was 148.8, with an interquartile range of 134-161.
8.1.3 The differences between the subgroups with regard to perceived health and healthy aging and to HAI scores

The results highlighted the differences between the subgroups with regard to perceived health and healthy aging (Tables 3 and 4). For example, out of the 11 factors, HAI scores differed significantly across subgroups based on area of residence, marital status, income level, disability, and perceived meaningfulness in life. Participants who lived in the central city had significantly lower HAI scores. Participants who had a disability and single participants had the lowest HAI scores; these scores were significantly lower among participants who lacked an income. Participants who reported having very high levels of meaningfulness in life had the highest HAI scores.

8.1.4 Factors associated with perceived health and healthy aging

Five factors—area of residence, marital status, disability, income level and perceived meaningfulness in life—were selected as predictors to test their association with perceived health and healthy aging in the model. Because no participant responded “not at all” to the perceived meaningfulness in life factor, the scores for this factor were dichotomized as 1 = less to moderate and 2 = high to very high meaningfulness in life. Healthy aging, as measured by the HAI, was the dependent variable. According to Field (2009), the minimum sample size for a multiple regression model should be $50 \pm 8k$, where $k$ is the number of predictors. Thus, the minimum sample size in this study should be 90 participants. Therefore, the final number of participants was adequate. The key findings showed that area of residence, marital status, and disability were associated with perceived health and healthy aging at $p \leq 0.05$. The final model explained 24.3% of the variance in healthy aging (Table 5).
Table 2
Sample characteristics (n = 453)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area of residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inside the central city</td>
<td>100</td>
<td>22.10</td>
</tr>
<tr>
<td>Outside the central city</td>
<td>353</td>
<td>77.90</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>304</td>
<td>67.10</td>
</tr>
<tr>
<td>Male</td>
<td>149</td>
<td>32.90</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-75</td>
<td>357</td>
<td>78.80</td>
</tr>
<tr>
<td>&gt; 75</td>
<td>96</td>
<td>21.20</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>255</td>
<td>56.29</td>
</tr>
<tr>
<td>Divorced/widowed</td>
<td>188</td>
<td>41.50</td>
</tr>
<tr>
<td>Unmarried</td>
<td>10</td>
<td>2.21</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>39</td>
<td>8.60</td>
</tr>
<tr>
<td>Primary education</td>
<td>401</td>
<td>88.50</td>
</tr>
<tr>
<td>Secondary education</td>
<td>13</td>
<td>2.90</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>17</td>
<td>3.75</td>
</tr>
<tr>
<td>Farmer</td>
<td>267</td>
<td>58.94</td>
</tr>
<tr>
<td>Former employed</td>
<td>147</td>
<td>32.45</td>
</tr>
<tr>
<td>Self-employed</td>
<td>22</td>
<td>4.86</td>
</tr>
<tr>
<td><strong>Income</strong></td>
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<td></td>
</tr>
<tr>
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<td>33</td>
<td>7.30</td>
</tr>
<tr>
<td>≤ $167</td>
<td>285</td>
<td>62.90</td>
</tr>
<tr>
<td>$168-334</td>
<td>119</td>
<td>26.30</td>
</tr>
<tr>
<td>≥ $335</td>
<td>16</td>
<td>3.50</td>
</tr>
<tr>
<td><strong>Underlying disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>215</td>
<td>47.50</td>
</tr>
<tr>
<td>Yes</td>
<td>238</td>
<td>52.50</td>
</tr>
<tr>
<td><strong>Type of disease</strong>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>139</td>
<td>42.38</td>
</tr>
<tr>
<td>Hypertension</td>
<td>169</td>
<td>51.52</td>
</tr>
<tr>
<td>Other (gout and kidney disease)</td>
<td>20</td>
<td>6.10</td>
</tr>
</tbody>
</table>

*Note.** Participants could select more than one item
Table 2 (continued)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>410</td>
<td>90.50</td>
</tr>
<tr>
<td>Yes</td>
<td>43</td>
<td>9.50</td>
</tr>
<tr>
<td><strong>Type of disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>16</td>
<td>37.21</td>
</tr>
<tr>
<td>Vision impairment</td>
<td>8</td>
<td>18.60</td>
</tr>
<tr>
<td>Physical disability</td>
<td>19</td>
<td>44.19</td>
</tr>
<tr>
<td><strong>Living condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>103</td>
<td>22.74</td>
</tr>
<tr>
<td>With children/spouse</td>
<td>350</td>
<td>77.26</td>
</tr>
<tr>
<td><strong>Care from a family member</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>84</td>
<td>18.54</td>
</tr>
<tr>
<td>Yes</td>
<td>369</td>
<td>81.46</td>
</tr>
<tr>
<td><strong>Contact with healthcare provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>0.83</td>
</tr>
<tr>
<td>Yes</td>
<td>449</td>
<td>99.17</td>
</tr>
<tr>
<td><strong>Amount of perceived meaningfulness in life</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less to moderate</td>
<td>82</td>
<td>18.10</td>
</tr>
<tr>
<td>High to very high</td>
<td>371</td>
<td>81.90</td>
</tr>
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</table>
Table 3
Subgroup HAI scores compared using the Mann-Whitney U test (n = 453)

<table>
<thead>
<tr>
<th>Factor</th>
<th>n</th>
<th>Interquartile Range (25th, 75th percentile)</th>
<th>U</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HAI score</strong></td>
<td></td>
<td>(134, 161)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area of residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inside the central city</td>
<td>100</td>
<td>(114, 141.75)</td>
<td>6721.50</td>
<td>0.00*</td>
</tr>
<tr>
<td>Outside the central city</td>
<td>353</td>
<td>(142, 162)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>304</td>
<td>(134.25, 159)</td>
<td>21768.50</td>
<td>0.50</td>
</tr>
<tr>
<td>Male</td>
<td>149</td>
<td>(134, 162)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>60-75</td>
<td>357</td>
<td>(135, 159)</td>
<td>16518.50</td>
<td>0.58</td>
</tr>
<tr>
<td>&gt; 75</td>
<td>96</td>
<td>(129.75, 163.75)</td>
<td></td>
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</tr>
<tr>
<td>Underlying disease</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>215</td>
<td>(135, 161)</td>
<td>24145.00</td>
<td>0.30</td>
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<tr>
<td>Yes</td>
<td>238</td>
<td>(133, 160.25)</td>
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</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>410</td>
<td>(137, 161)</td>
<td>4347.50</td>
<td>0.00*</td>
</tr>
<tr>
<td>Yes</td>
<td>43</td>
<td>(111, 144)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care from a family member</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>84</td>
<td>(138.75, 156)</td>
<td>14805</td>
<td>0.71</td>
</tr>
<tr>
<td>Yes</td>
<td>369</td>
<td>(137, 161)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact with a healthcare provider</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>(128.25, 155)</td>
<td>842</td>
<td>0.83</td>
</tr>
<tr>
<td>Yes</td>
<td>449</td>
<td>(137, 161)</td>
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</tr>
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<td>Amount of perceived meaningfulness in life</td>
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<td></td>
<td>12,036.00</td>
<td>0.03*</td>
</tr>
<tr>
<td>Less to moderate</td>
<td>82</td>
<td>(123.50, 158.25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High to very high</td>
<td>371</td>
<td>(137, 161)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *P ≤ 0.05.
Table 4
Subgroup HAI scores compared using the Kruskal-Wallis test and post hoc analysis (n = 453)

<table>
<thead>
<tr>
<th>Factor</th>
<th>N</th>
<th>Interquartile range (25th, 75th percentile)</th>
<th>P-value</th>
<th>Post hoc analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education Level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>39</td>
<td>(132, 162)</td>
<td>0.19</td>
<td></td>
</tr>
<tr>
<td>Primary education</td>
<td>401</td>
<td>(135, 160)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary education</td>
<td>13</td>
<td>(122, 166.50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td>0.04*</td>
<td>Divorced/widowed†</td>
</tr>
<tr>
<td>Married</td>
<td>255</td>
<td>(138, 161)</td>
<td>228.23, 213.56†</td>
<td>135.18, 77.30†</td>
</tr>
<tr>
<td>Divorced/widowed</td>
<td>188</td>
<td>(131.25, 160.75)</td>
<td>(p = 0.23)</td>
<td>(p = 0.02*)</td>
</tr>
<tr>
<td>Unmarried</td>
<td>10</td>
<td>(104.75, 152.75)</td>
<td>101.48, 62.30†</td>
<td>(p = 0.04**)</td>
</tr>
<tr>
<td><strong>Income level</strong></td>
<td></td>
<td></td>
<td>0.00*</td>
<td>≤ $167†</td>
</tr>
<tr>
<td>None</td>
<td>33</td>
<td>(108, 154)</td>
<td>85.12, 168.11†</td>
<td>19.79, 35.75†</td>
</tr>
<tr>
<td>≤ $167</td>
<td>285</td>
<td>(139, 161)</td>
<td>(p = 0.00*)</td>
<td>(p = 0.00*)</td>
</tr>
<tr>
<td>$168-$334</td>
<td>119</td>
<td>(132, 157)</td>
<td>214.73, 173.20†</td>
<td>149.32, 180.91†</td>
</tr>
<tr>
<td>≥ $335</td>
<td>16</td>
<td>(138, 167.75)</td>
<td>(p = 0.001*)</td>
<td>64.94, 90.78†</td>
</tr>
<tr>
<td>$168-$334</td>
<td>119</td>
<td>(132, 157)</td>
<td>(p = 0.001*)</td>
<td>64.94, 90.78†</td>
</tr>
<tr>
<td>≥ $335</td>
<td>16</td>
<td>(138, 167.75)</td>
<td>(p = 0.001*)</td>
<td></td>
</tr>
</tbody>
</table>

Note: *P ≤ 0.05. †Subgroup description.
### Table 5
Multiple regression analysis with HAI score as the dependent variable (n = 453)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of residence</td>
<td>16.06*</td>
<td>2.24</td>
</tr>
<tr>
<td>Marital status(^b)</td>
<td>3.80*</td>
<td>1.70</td>
</tr>
<tr>
<td>Disability</td>
<td>-12.87*</td>
<td>3.01</td>
</tr>
<tr>
<td>Income(^c)</td>
<td>6.43</td>
<td>3.46</td>
</tr>
<tr>
<td>Perceived meaningfulness in life</td>
<td>2.16</td>
<td>1.15</td>
</tr>
</tbody>
</table>

**Model summary**

<table>
<thead>
<tr>
<th>Model F</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.65</td>
<td>452</td>
</tr>
</tbody>
</table>

R\(^2\) 0.243

*Note.* *P* ≤ 0.05.

\(^a\) B is the unstandardized regression coefficient.

\(^b\) Unmarried/divorced/widowed = 0 and married = 1.

\(^c\) No income = 0, and income = 1.
8.2 The meaning of healthy aging in the Isan region (Studies II–IV)

The meaning of healthy aging was synthesized from the results of Studies II, III and IV. A description of the findings was created to provide a comprehensive picture of the results. Based on the perspectives of older people, the children and grandchildren of older people, and community nurses, the meaning of healthy aging is developed in three dimensions: being interconnected; being able to do something good and feeling strong; and thinking beyond the capacity and functions of the body and mind.

8.2.1 Being interconnected

From the perspective of older people (Study II), the children and grandchildren of older people (Study III), and community nurses (Study IV), the meaning of healthy aging was linked to being interconnected. Healthy aging was described as “being independent in dependence” (Study II), “being a giver and receiver” (Study III), and “being a supporter and feeling supported” (Study IV). The meaning of healthy aging is related to the relationships between older people and those who surrounded them. Healthy aging reflects the ways that older people are interconnected with their environment, especially the society in which they live. Older people live very close to family members and others in their community. Family members and others are supposed to provide care for older people. Healthy aging was perceived as being able to contribute something to society or to family members. Healthy aging is reinforced by giving and receiving support to and from others. Furthermore, healthy aging means that a person is able to perform different activities on his/her own without support or help from family members, friends, healthcare providers or others. Healthy aging was also linked to the provision of support to family members as an act of kindness, including the expression of positive feelings (e.g., feeling happy or feeling warmth) when receiving support from others. Many different types of support emerged from the findings. From the perspectives of older people and their relatives, support referred to socioeconomic, emotional, and instrumental support. From the perspectives of healthcare providers and older people, support meant receiving information or suggestions regarding an older person’s health. These findings show that that healthy aging is viewed not only as being independent but also as being dependent.

8.2.2 Being able to do something good and feeling strong

Based on the perspectives of the children and grandchildren of older people (Study III) and community nurses (Study IV), healthy aging means being able to do something good and feeling strong; it means to continue existing. In this context, being able to do something good and feeling strong includes: “being independent” (Study III), “not being afflicted by diseases or illnesses” (Study III), “being wise” (Study III), and “being strong” (Study IV). These qualities
refer to an individual’s ability to perform bodily and mental functions. Those who age in a healthy manner are able to live independently and to be autonomous. The meaning of healthy aging highlights a person’s ability to maintain the functions of body and mind, which in turn reflects his/her ability to maintain daily living activities without asking others for help. This meaning relates to having good physical and mental health, i.e., having both physical and mental strength. For instance, having a good memory and a very strong body for one’s age reflects mental and physical strength, respectively. The maintenance of organ functions such as cognitive function, the muscular system, psychosocial function and digestive function is also important for healthy aging. Healthy aging also relates to control over the complications of disease and illness, which is linked to a person’s ability to live with disease and to control complications of chronic diseases that may affect bodily functions. Furthermore, healthy aging also means freedom from suffering when living with disease. Participants emphasized that healthy aging means not depending on others and having authority over oneself. Those who age in a healthy manner would not seek attention from family members and others, would have a strong heart, and would face problems as they arose. Healthy aging means freedom and the ability to perform activities in everyday life. Participants also explained that healthy aging means having experience that could help an individual make decisions, such as experience addressing problems, which was linked to intelligence and the ability to adjust to stressful events. Individuals who age healthily are also able to keep their minds strong. Healthy aging means enjoying life and preparing for old age. It relates to regular practices that were beneficial for older people’s health when they were young, such as exercising, consuming all essential nutrients, and maintaining good hygiene. Moreover, healthy aging was described as receiving respect from others. This meaning is linked to a person’s ability to share wisdom and to hold an important position in society.

8.2.3 Thinking beyond the capacity and functions of body and mind

Older people conceived healthy aging as “being at peace” and “being a valuable person” (Study II). According to older people, healthy aging involves not only to the functions of body and mind, which relate to one’s ability to perform activities by oneself, but also to one’s ability to live a peaceful life with a peaceful mind. It means having positive emotions, an absence of stress, and a sense of calmness. It means understanding the meaning of life. Healthy aging means that a person is able to maintain a balance in life. This finding emphasizes the importance of balance between both body and mind. Older people also described healthy aging as the acceptance of death, i.e., accepting approaching death and understanding of life as uncertain. Moreover, healthy aging means being helpful, being a good role model and being a good person in society. It was also characterized as doing good deeds for others, including
living for the community, i.e., being generous. Healthy aging means maintaining virtue to enhance one’s life and being useful to others, especially to family members and society. To age in a healthy manner, one should dedicate oneself to Buddhist beliefs. Healthy aging involves being accepted by others. These meanings of healthy aging clearly relate to feeling proud.

8.3 Experiences of promoting healthy aging (Study IV)

Community nurses reported their experiences with the promotion of healthy aging as follows: “providing health assessments”, “sharing knowledge”, and “having limited resources”. Community nurses were concerned about older people and their surroundings, including the community where older people lived and the work situation of community nurses. Providing health assessments was described by community nurses as routine work, i.e., the process of evaluating older people’s health status. This process identifies each older person’s needs, as well as the health determinants that contribute to healthy aging. Sharing knowledge was described as promoting healthy aging by focusing on the values and wisdom of older people. Community nurses listen to each older person and to others who influence his/her life. They learn how older people share their methods of taking care of their health, which includes having the chance to discuss what older people thought and what they learned from each other. The community nurses referred to their network and believe that they could not work alone. They explained that community nurses cannot stay with older people at all times. They also noted that the family members of older people, people in the community in which the older people lived, health volunteers, and monks were crucial to assist nurses in promoting healthy aging. Furthermore, the community nurses described using folk customs and folk medicine to promote healthy aging. Having limited resources affects many aspects of their work. The community nurses explained that the promotion of healthy aging was influenced by limited resource when new projects were developed to improve healthy aging. They cited limited resources, including a limited budget, limited support, and the growing workload as the major obstacle to their work in the community.
9 Discussion

This thesis reveals the factors associated with healthy aging from the perspective of older people (Study I); the meaning of healthy aging from the perspectives of older people, the children and grandchildren of older people, and community nurses (Studies II–IV); and the promotion of healthy aging by community nurses in the Isan region (Study IV). The following section will discuss these findings in relation to previous empirical studies and explore the implications for healthcare and social welfare dedicated to the improvement of healthy aging in the Isan region of Thailand. Then, the methodological considerations will be presented.

9.1 Understanding healthy aging: challenges in supporting and caring for older people to promote healthy aging in the Isan region

9.1.1 Understanding the key factors associated with healthy aging

Regarding the factors associated with healthy aging (Study I), the results of multiple regression analyses revealed that area of residence, disability, and marital status were associated with perceived health and healthy aging. When considering the factors and HAI scores, differences among subgroups for area of residence, disability, marital status, income level, and perceived meaningfulness in life are notable.

Regarding differences in selected factors and HAI scores among the subgroups, older people who lived in the capital district had significantly lower HAI scores. This finding contrasts with that of Thanakwang (2009), who reported that people living in urban areas had high levels of perceived health. Healthcare providers should consider the differences between residential areas, which may contribute to rural/urban disparities in older people’s health. When improving health promotion programs, older people who live in the capital district should be targeted. Healthcare programs should provide appropriate support in order to promote healthy aging to older people who live in the central city of the province.

Older people with disabilities had significantly lower HAI scores compared with older people without disabilities. Due to impairments affecting vision, hearing, mobility, communication, cognition, emotion, behavior, intellect, or learning, those with disabilities are restricted in terms of daily task performance or participation in social activities. When a person with a disability
experiences a health problem, it can exacerbate the impact of the disability on his/her life. This finding is in line with that of a previous study (Cott et al., 1999) in which disabilities were associated with poor health. For policymakers and healthcare providers it is particularly challenging to promote healthy aging among older people with disabilities. People with disabilities in Thailand have less opportunities to access healthcare services (Bualar, 2015; Viripiromgool, Ksarntikul, Thammaapipol, Suthisukhon, & Peltzer, 2014). Moreover, Thailand has limited facilities for the disabled (Suttajit et al., 2010). This claim is supported by the WHO (2016e), which has noted that health promotion and prevention activities rarely focus on disabled people. Health promotion based on human rights emphasizes available, accessible, acceptable and quality healthcare services (Backman, 2012; United Nations, 2000). Older people’s right to healthcare entails an integrated approach that combines elements of preventive, curative, and rehabilitative care to promote physical and psychological health (United Nations, 2000). However, people with disabilities may struggle to receive appropriate care and health promotion services. Therefore, this group of people should be the highest priority when promoting healthy aging. Ensuring that older people with disabilities have access to healthcare services and health promotion programs is important. Furthermore, social welfare services should extend to older people with disabilities because these people have very low incomes, as well as restrictions that hamper their participation in life situations (Viripiromgool et al., 2014). Therefore, policymakers and healthcare providers should target this group when promoting healthy aging to reduce health disparities.

This project found differences in HAI scores based on marital status, which is consistent with the finding of Palner and Mittelmark (2002) that married people have higher levels of perceived mental health than unmarried people. Healthcare providers and policymakers should focus on older people who are single or live alone when promoting healthy aging. In particular, healthcare providers should design interventions that promote healthy aging among older people who are unmarried or have no children. Another suggestion relates to social welfare and the healthcare system. Although the Thai government provides social welfare care for older people who have been abandoned, are poor, or have no caregivers (Suwanrada et al., 2014), long-term care for middle-class older people remains lacking.

The findings revealed that older people with the highest monthly incomes had significantly higher levels of perceived health and healthy aging. This finding
accords with previous findings that the well-being of older people relates to their economic status (Çapik & Bahar, 2008). The results of this thesis also show that older people who reported having a high degree of perceived meaningfulness in their lives had high HAI scores. One explanation for this result is that the level of perceived meaningfulness in one’s life is associated with positive physical and psychological functioning (Stillman et al., 2009). Thus, the findings indicate that income level and perceived meaningfulness of life should be considered. Moreover, older people who reported low to moderate perceived meaningfulness should be given special attention to improve healthy aging. Differences in perceived health and healthy aging were also found based on income level; specifically older people with low monthly incomes had significantly lower HAI scores. Older people with limited incomes might feel that they are financially dependent on others and may have fewer opportunities to access quality resources and health services. Although Thailand has a welfare system that provide social assistance and social security to the older population (Ministry of Public Health Thailand, 2012), this system may not cover all necessary expenses for older people. Insufficient coverage may affect the perceived health of older people. Therefore, policymakers should focus on providing older people with adequate financial support. For instance, they could support the development of other sources of income for older people who are unable to work.

In light of these findings, this discussion focuses on the importance of particular factors in improving healthy aging. The exploratory study (Study I) revealed the relationship between these factors and healthy aging in the Isan region. In particular, to promote health and care for older people, one must consider older people who live in the capital city, have disabilities, or are single. Understanding each factor may be useful in developing health promotion programs to improve healthy aging. This additional information may guide healthcare providers in their work with older people, help families care for their loved ones, and assist policymakers in designing interventions or programs that are appropriate for each group of older people.

9.1.2 Understanding the meaning of healthy aging

The descriptions of the meaning of healthy aging are the main findings of this thesis. These findings revealed three dimensions: being interconnected; being able to do something good and feeling strong; and thinking beyond the capacity and functions of body and mind.
9.1.2.1 Being interconnected and intersubjectivity

From multiple perspectives, the importance of interconnectedness shows the value of interactions between older people and the significant others in their lives. Being interconnected means “being independent in dependence” (Study II), “being a giver and a receiver” (Study III), and “being a supporter and feeling supported” (Study IV). This finding supports the findings of previous studies (Danyuthasilpe et al., 2009; Thiamwong et al., 2013) that describe healthy aging as being interdependent and mention interactions between an older person and those who surround him/her (Thiamwong et al., 2013).

According to the findings of this thesis, being interconnected can be linked to the theory of intersubjectivity (Dahlberg et al., 2008), which explains human relationships as one human being living his/her life together with other human beings. Human beings are in an intersubjective world. They are with and are influenced by other human beings. Human beings should be viewed through the individual and society. Human beings cannot be separated from their environment. Dahlberg et al. (2008) presented the interlinked relationships between humans and the world as described by Merleau-Ponty as being in the world (Dahlberg et al., 2008). Older people rely upon the people who surround them, which highlights the importance of the relationship between the older person and others. This relationship may be related to Dahlberg et al. (2008), who explained the importance of interconnectedness and mutuality from the lifeworld perspective.

Being interconnected relates to cultural beliefs, with a focus on the relationships between the older person, his/her children, and people in the community. In the Isan region, older people live very close to family members and to others in the community, especially the Buddhist community. The perception of healthy aging as “being interconnected” is related to the impact of the Buddhist way of life that is embraced by those in the Isan region. Thus, this finding suggests the importance of interdependence, which seems to be a cultural value among the Isan-Thai, especially with regard to older people who are dependent on their children. Family responsibility for older people may relate to Isan-Thai traditions and Buddhist principles, which dictate that children should show gratitude to their parents (Phrateprattanasutee, 2014). This view can be linked to the concept of “Katanyukatavedi” in Buddhist teachings and emphasizes the importance of showing respect to older people (Phrateprattanasutee, 2014). Children must pay back the debt of gratitude to their parents by taking care of them when they get old. Children and other family members
must support the older people in their family in accordance with the Buddhist principle. Moreover, according to Thai culture, people in society should show respect for older people because older people are valued in Thai society. The Thai people believe that older people are wealthy in terms of skills and experience. This is reflected in the roles played by older people, who are important components of their family and society. This tradition means that other people might rely on older people. Therefore, the description of healthy aging as being interconnected indicates that healthy aging includes not only being dependent on others but also being independent. For example, older people support their children and help take care of their grandchildren. They participate in activities to support their community and Buddhist practices. Older people interact with each other and with others. The findings of this thesis can be related to other studies. For example, in a study in Hong Kong (Lee & Fan, 2008), participants strongly emphasized family connections and the relationships between older people and their family members when considering healthy aging.

9.1.2.2 Being able to do something good and feeling strong in the aging process

From the perspectives of the children and grandchildren of older people and the community nurses (Studies III- IV), healthy aging was described as “being able to do something good and feeling strong”. This dimension includes: “being independent” (Study III), “not being afflicted by disease or illness” (Study III), “being wise” (Study III), and “being strong” (Study IV). The children and grandchildren of older people and community nurses emphasized the importance of independence in healthy aging and associated healthy aging with the ability to do something well, which is consistent with Western ideas about healthy aging (Hansen-Kyle, 2005; Swedish National Institute of Public Health, 2006). Moreover, the ability to do something well includes not only “being independent” but also “not being afflicted by disease or illness”, “being wise”, and “being strong”. These meanings clearly refer to an individual’s ability to maintain bodily and mental functions; they also refer to living independently and being autonomous. These meanings of healthy aging focus on a person’s ability to maintain their bodily and mental functions, their engagement in daily living activities and the extent to which they can avoid asking others for help. This explanation is in line with a previous study on healthy aging in Thailand (Thanakwang et al., 2012), which focused on functional in-
dependence. These findings are also consistent with medical and nursing definitions of healthy aging (Hansen-Kyle, 2005; Peel et al., 2004), which emphasize good functional status and the absence of chronic disease. These definitions may reflect the burden on relatives or healthcare providers to care for older people. The meaning of healthy aging was also influenced by healthy living. This finding is consistent with Hansen-Kyle (2005), who stated that healthy aging is influenced by nutrition, individual lifestyle, and exercise. When exploring the details of being wise and being strong, participants emphasized that healthy aging is linked to wisdom, receiving respect from others, and the aging process, especially the sociological process of aging (Touhy & Jett, 2010). The children and grandchildren of older people and community nurses experienced the meaning of healthy aging, which relates to the development of older people during their lifetimes. The children and grandchildren of older people maintained that healthy aging can be viewed as the life experience of growing old and an ability to attain wisdom. The children and grandchildren of older people and community nurses focused on the aging process and behaviors of older people throughout their old age. These findings are consistent with previous studies in which healthy aging was based on role expectations and cultural ideas (Hansen-Kyle, 2005). The children and grandchildren of older people and community nurses also emphasized maturity, which may lead to wisdom.

9.1.2.3 Healthy aging, the lived body and the goal of Buddhism

Healthy aging is described by older people (Study II) as “thinking beyond the capacity and functions of body and mind”. This dimension includes “being at peace” and “being a valuable person”. According to older people, healthy aging involves not only to the functions of body and mind, which affect one’s ability to perform activities independently, but also to the ability to live a peaceful life with a peaceful mind. These findings also provide insights into healthy aging by focusing on thoughts beyond the capacity and functions of body and mind. Older people conceived healthy aging as “being at peace” and “being a valuable person”. Being at peace relates to the ability to lead a peaceful life with a peaceful mind, which involves positive emotions, an absence of stress, and a sense of calmness. Being at peace can be considered in terms of emotional and spiritual aspects. From the perspective of older people, the meaning of healthy aging goes beyond the functions of body and mind. Indeed, the emotional and spiritual aspects of healthy aging cannot be separated
from the body and mind. The body, mind, and spiritual aspects of healthy aging are understood as lived. The conception of healthy aging as “thinking beyond the capacity and functions of body and mind” can be explained through the concept of “flesh of the world” (Dahlberg et al., 2008; Merleau-Ponty, 2002/1945), which emphasizes the human body as an indivisible unity. Furthermore, the findings of this thesis show that according to older people, religion and spirituality play an important role in healthy aging. As explained earlier, Buddhism is the most common religion in Thailand and strongly influences people’s beliefs (Choowattanapakorn, 1999). Thai people respect Buddhist doctrines. Peace is the key concept in Buddhism (Yeh, 2006). In addition, Buddhists believe in karma, which describes a kind of spiritual cause and effect. A characteristic of Nibbāna, which is the aim of Buddhism, is the achievement of a state of peace (Yeh, 2006). Buddhism seems to play an important role in creating meaning in one’s life and thereby contributes to healthy aging. Furthermore, healthy aging can be explained through the theory of gerotranscendence (Tornstam, 1989). Being at peace is related to the acceptance of death. Healthy aging means viewing death as a natural occurrence and accepting one’s impending death. According to this explanation, the meaning of healthy aging can be explained by the theory of gerotranscendence (Tornstam, 1989), which emphasizes decreased self-centeredness and diminished fear of death. Moreover, the meaning of healthy aging can be described in terms of psychological theories (Eliopoulos, 2010), especially Erikson’s theory of development, which emphasizes the development of wisdom and ego integrity in late life (Erikson, 1993). Perceiving healthy aging as being at peace relates to the developmental stage when an older individual reaches a fundamental acceptance of his or her life. As described, healthy aging equates to the ability to control situations. Older persons do not worry about death. They feel satisfied with their lives. This satisfaction may be linked with the wisdom of understanding death as something that should not be feared. According to this description, healthy aging can be viewed as the ability to reach the eighth stage of ego integrity (Erikson, 1993). Healthy aging may be linked to the concept of inner strength, which considers dying to be a part of life (Nygren, Norberg, & Lundman, 2007). Being at peace entails living a balanced life, that is, finding a balance between being active and being passive, which is a component of the concept of inner strength (Nygren et al., 2007). Thus, healthy aging clearly can be related to inner strength.

Healthy aging was described as being a valuable person, being helpful, and being a good role model for society. It includes doing good deeds for others
and being useful to others. The perception of being valuable to society may link to the theory of gerotranscendence Healthy aging is not only the ability to do things; it goes beyond the capacity of body and mind. Thus, according to this description, being a valuable person relates to a high level of human development and a sense of good personal development (Tornstam, 1989, 1997). Moreover, being a valuable person may relate to a sense of meaning in life (Jonsén, Norberg, & Lundman, 2015). Jonsén et al. (2015) described a sense of meaning in life as a person’s connection with others and with nature. Healthy aging may be considered in terms of the development of one’s life and one’s relationships with others. The findings of this thesis can help healthcare providers proactively design and integrate religion and Buddhist teachings into the promotion of healthy aging. The findings also suggest that the meaning of healthy aging relates to being a good role model and an upstanding member of society. This role is linked to generosity and being useful to others. Therefore, to promote healthy aging, the social dimensions and skills of older people should be considered.

9.1.2.4 Different perspectives on healthy aging: facing new challenges in planning and caring to promote healthy aging

Regarding the complete description of the meaning of healthy aging, the participants’ responses in Studies II–IV imply a holistic understanding of the concept. Healthy aging involves physiological, psychological, social, and spiritual aspects that contribute to overall health. These aspects are interlinked, and the participants view the totality of healthy aging as a harmony among its various aspects. Healthy aging is experienced and perceived as a whole. These findings are consistent with lifeworld theory, which emphasizes the unity of body and mind (Bengtsson, 2013; Dahlberg et al., 2008). A person cannot be separated from his/her lived world (Hörberg, Ozolins, & Ekebergh, 2011). With respect to the lived body, a person is described as a physical, mental, spiritual, social, and cultural being, and these dimensions form an indivisible unit (Hörberg et al., 2011; Merleau-Ponty, 2002/1945). Moreover, the individual and society cannot be separated from each other. Therefore, healthy aging is not merely a disaggregated group of physical, mental, social, spiritual or cultural aspects. Rather, these parts represent the unity of healthy aging. Therefore, healthcare providers should consider the holistic meaning of healthy aging when promoting the concept. Furthermore, policy makers should create effective strategies to promote healthy aging based on the holistic view. When promoting healthy aging, healthcare providers should focus
on all aspects of the older person’s life, not merely on health problems, symptoms, diseases or bodily and mind functions. Healthcare providers should consider older people’s lifestyles; problems in their lives and potential solutions to those problems; their personal development process; and previous life experiences. Moreover, religion has an impact on the meaning of healthy aging and thus should also be considered when promoting the concept. Considering all aspects of an older person’s life may help healthcare providers understand their clients and to care for them as whole persons. Therefore, the holistic perspective allows healthcare professionals to attend to various aspects of healthy aging by considering social and spiritual dimensions in addition to aspects of the body and mind and the absence of disease and illness.

Healthy aging has different meanings for older people, the children and grandchildren of older people and community nurses. For older people, being interconnected is the key descriptor in the meaning of healthy aging. The importance of interconnectedness means that although being independent is important to healthy aging, being dependent is also essential. Moreover, older people mentioned being at peace and being a valuable person as aspects of healthy aging. Older people focused on the harmony of emotional and spiritual aspects within the concept of healthy aging. In contrast, the children and grandchildren of older people and community nurses emphasized independence in their descriptions of healthy aging. The children and grandchildren of older people and community nurses clearly consider the ability to conduct activities in daily living and physical and mental functionality to constitute the meaning of healthy aging. As described earlier, Isan norms and life values obligate children to take care of their parents. Thus, parental care is a predominant role for children in the Isan region. Children must care for their parents until their parents’ deaths. However, social changes have affected the Isan lifestyle. The number of people in the Isan region with high education levels has grown. In addition, people participate in the labor market, with some of them immigrating from their hometowns to cities to take advantage of modern culture. Changes in Isan lifestyles may limit the ability of children and grandchildren to live with and care for their parents or grandparents. Although independence was the focus of the meaning of healthy aging for the children and grandchildren of older people, these older people still need to be cared for and supported by their children and grandchildren. Given the various perspectives on the meaning of healthy aging, healthcare providers and policy makers must consider how to integrate these different meanings when encouraging older people and working with their relatives to promote healthy aging.
The three different perspectives on healthy aging and the diverse meanings attached to the concept create a challenge for those who hope to promote healthy aging in the Isan region. The findings of this thesis may help healthcare providers understand the different meanings of healthy aging. In particular, the findings suggest that healthcare providers should consider the meaning of healthy aging from various perspectives when developing programs to promote healthy aging in the future. Policy makers should carefully create a strategy that appropriately accounts for recent social changes. Moreover, the shape of the family unit in Thailand has obviously changed (Sasat & Bowers, 2013). In particular, some older people have no children. Thus, policy makers should also focus on older people who live alone and those who have no family support.

9.1.3. How to promote healthy aging

This section explores how community nurses in the Isan region can promote healthy aging (Study IV). Community nurses characterized their experiences in the promotion of healthy aging in terms of providing health assessments, sharing knowledge, and having limited resources. All of these experiences are ostensibly linked to the work situations of community nurses, their networks, older people, the relatives of older people, and members of the community. These linkages highlight the principle of the person-centred framework, especially the notion of person-centred processes, which is consistent with the findings of this study (McCormack & McCance, 2006). Person-centred processes focus on one’s beliefs and individual values. Furthermore, this framework emphasizes the need for engagement, a sympathetic presence, shared decision making, and the provision of holistic care (McCormack & McCance, 2006). According to this thesis, holistic care refers to the consideration of the complete person—physical, psychological, social, and spiritual—when caring for older people. Therefore, the principle of the person-centred framework should be considered. The findings provide a basis for ideas about how healthy aging can be promoted in ways that support older people, the relatives of those people, and the community. This study may inspire better healthcare that focuses on person-centredness to improve organizations that aim to enhance health promotion. Moreover, these findings can be related to the development of a holistic-existential approach to health promotion (Berg & Sarvimäki, 2003) that considers the needs of the individual and the interaction between clients and nurses. The findings of this thesis suggest that healthcare providers must have confidence in the potential of older people and those who surround
them. The use of person-centredness as a strategy to promote healthy aging may be time-consuming but could facilitate the sustainable and equitable promotion of healthy aging because the greatest improvements in older people’s health result from their own necessary actions. Older people and their communities have the right and obligation to be involved in the decisions that affect their daily lives. They know what works best for them. Healthcare professionals must listen to and learn from these people and communities. In addition, policymakers must be made aware of the barriers encountered by community nurses in their efforts to develop a proactive work environment based on a person-centred framework.

9.2 Methodological considerations

Because of the different data collection methods used, this thesis had to grapple with methodological considerations regarding both quantitative and qualitative research (Polit & Beck, 2012).

9.2.1 Study I

One concern was the internal validity of the HAI that was used to measure perceived health and healthy aging. The internal consistency was acceptable when the instrument was used previously. The instrument’s reliability was tested before collecting the data (N = 30). The respondents were asked for feedback on each part of the questionnaire, and no problems or misunderstandings arose. The study’s internal consistency was tested and found to be high. The data collection process yielded a high response rate (98.5%). However, the data collection process confirmed the quality of the data. Specifically, the research assistants were trained by the first researcher about the ethical issues presented by the research, the process of data collection and how to use the questionnaires. In particular, all research assistants were trained to help participants who could not read or write. To reduce response bias, all participants were asked and agreed to participate in the study. Research assistants were not allowed to force respondents to answer the questionnaires. After participants answered all of the questions, the questionnaires were sent back to the research assistants. Then, all questionnaires were sent to the first researcher. This study has certain limitations. First, the number of districts included in the study limits the generalizability of the results. The area of investigation was limited to Udon Thani province in northeastern Thailand, and small subgroups limited the multiple regression analyses. Although the study was set in a single province in the region, external validity was considered. The findings can be gen-
eralized to other settings that have similar backgrounds (e.g., in terms of religion, traditions, and region). In addition, several questionnaire items had only “Yes” or “No” as response options (e.g., receiving care from a family member). Dichotomous items were perhaps not fully considered and may have led to insufficient participant details. Disability should be measured by appropriate instruments to assess disability level. Moreover, the questionnaire should contain additional detail, such as the types of care provided by family members, friends, and healthcare providers. Furthermore, the questionnaire items about care provided by friends should be made into another item. Older people who had psychiatric diagnoses were excluded. Therefore, the findings did not pertain to this group of older people.

9.2.2 Studies II–III

Trustworthiness within a phenomenographic study focuses on the truth value of the findings and a description of a phenomenon, which corresponds to participants’ experiences of that phenomenon (Åkerlind, 2012). Each part of the research was described previously. The interview guides used to cover all of the issues were evaluated by the research team and tested in a pilot study. The questions were asked and evaluated by the research team. The data were examined by the researchers. Before the analysis, all data were transcribed verbatim in Thai and the transcriptions were read and reread, line by line, several times by the first researcher. The data were then translated from Thai into English by a professional Thai-English translator to confirm the accuracy of the transcripts (Regmi et al., 2010). The rigor of the data analysis process of Studies II and III was a concern. All researchers were involved in analyzing the data, and all transcriptions were verified by the researchers. The relationship between the data and the categories that described how people experience healthy aging were explained. The design of the research process and the evaluation of its effectiveness were described. Furthermore, the findings and interpretations regarding the participants were checked and confirmed by all researchers. The findings were reflected through the categories of expanding awareness. A phenomenographic approach was suitable for describing the conceptions of healthy aging held by older people and their relatives. This study included a group of older people from a single province in the Isan region of Thailand and thus the transferability of this study is limited. However, the findings of these studies may be transferable to other provinces in northeastern Thailand. Seventeen older people participated in the second study, and 14 children and grandchildren of older people participated in the third study.
Therefore, the number of participants was considered adequate to allow for the emergence of variations in conceptions of healthy aging. However, the diversity of participants was limited in terms of sex. Fewer men than women were interviewed in both the second and third studies. Thus, men’s conceptions of healthy aging may not be fully represented. In addition, older people who had psychiatric diagnoses were excluded. Consequently, their conceptions of healthy aging were not considered.

9.2.3 Study IV

According to Graneheim and Lundman (2004), trustworthiness is a major concern in a qualitative study. In this study, trustworthiness concerns focused on credibility, dependability, and transferability. Focus group discussions were conducted with heterogeneous groups. All participants were chosen based on criteria that allowed for variation in terms of caring experience, age, and education level to provide a variety of data sources. Although seniority is respected in Thai society and potentially influences group discussions, the researcher encouraged the participants to freely discuss each topic. The assistant researcher acted as the observer and took notes. This process aimed to address power relations (between the researcher and participants or among the participants themselves) while conducting the research. This process was helpful when analyzing the data and enhanced the trustworthiness of the findings. All data could be checked through the data analysis process by all researchers. Using focus group discussions and follow-up interviews may enhance the trustworthiness of the findings. Because only one male nurse was interviewed, the healthy aging content for men may not be fully represented; thus, the transferability of this study may be limited. However, the findings of this study can be transferred to similar contexts in the Isan region.

Another concern is the similarity of the participants’ backgrounds. In particular, all participants were Buddhists. This religious background may have influenced the findings because the participants’ belief system was grounded in Buddhism. This aspect can be viewed as both a strength and a limitation of the thesis. Although Buddhism is the main religion in Thailand, the country is characterized by diverse religious beliefs. Therefore, conceptions of healthy aging and experiences related to the meaning and promotion of healthy aging might have differed if the study had included participants from different religious backgrounds. However, the findings of this thesis can be transferred to most regions in Thailand because Buddhism is the country’s official religion.
10 Conclusions, clinical implications, and future research

10.1 Conclusions

The findings of this thesis contribute to the understanding of how factors such as area of residence, disability status and marital status are associated with perceived health and healthy aging in the Isan region. Another key finding is the meaning of healthy aging, which comprises three dimensions: being interconnected; being able to do something good and feeling strong; and thinking beyond the capacity and functions of the body and mind. In addition, the findings of this thesis increase the understanding of how community nurses promote healthy aging. The promotion of healthy aging can be divided into three themes: providing health assessments, sharing knowledge, and having limited resources.

10.1.1 Suggestion for policy makers to foster healthcare and welfare systems that promote healthy aging

The findings of the first study reveal the effects of socio-demographic factors, health status, and perceived meaningfulness on perceived health and healthy aging. Policy makers should consider the importance of area of residence, disability status and marital status when developing plans to promote healthy aging. Regarding area of residence, government policy should provide an appropriate environment to support older people living in the city, for example, by providing space for community engagement, parks or greenspaces. This environment may help support healthy aging. Regarding older people who live alone and have no family support, the government should consider the creation of support services to assist those people. Because disability status is also one of the key factors associated with perceived health and healthy aging, disability status should be a primary concern. Gaining an understanding of this factor should be a starting point for the Thai government, especially the Ministry of Public Health and Ministry of Social Development and Human Security (MSDHS), to collaborate on the provision of support to older people with disabilities and thereby promote healthy aging in the Isan region. The national plan for older people should address older people with disabilities, older people who live alone or those who live without any support.

The findings of the second, third and fourth studies shed light on the meaning of healthy aging from different perspectives. The main suggestion to policy
makers is that they should consider all perspectives when promoting healthy aging. The holistic view of healthy aging should be integrated into programs designed to support older people and their relatives. In short, the strategy to promote healthy aging should not merely create improvements but also address all aspects of healthy aging.

The findings of the fourth study, which considered the experiences of community nurses in promoting healthy aging, highlight the importance of person-centred care in the promotion of healthy aging. Therefore, policy makers should carefully consider their plans and support person-centred care in the community. To increase the effectiveness of person-centred care, policy makers should implement a bottom-up organizational strategy. This strategy would require policy makers to learn the demands and limitations of employees and staff. Based on the findings of the fourth study, community nurses have explored the limitations that they face when promoting healthy aging in the Isan region, such as limited financial support and a limited workforce. Therefore, these issues should be considered by policy makers.

10.1.2 Clinical implications and suggestions for nursing practice

The findings of the first study reveal that area of residence, disability status and marital status are key factors associated with perceived health and healthy aging. This knowledge indicates that healthcare providers should establish these factors as the highest priority when promoting healthy aging. Moreover, healthcare providers should consider the differences in HAI scores among subgroups based on income level and the level of perceived meaningfulness in life.

The findings of the second, third and fourth studies indicate that from an Isan-Thai cultural perspective, healthy aging relates to the older individuals, their family members, socioeconomic status, culture, healthcare providers and Buddhism. The elements of healthy aging should be viewed holistically when promoting healthy aging in this region. Healthcare providers must work with older people, their children and grandchildren, and their communities. Variations in the meaning of healthy aging based on different perspectives should be considered, which may help community nurses learn how to care for older people and to interact with people who have different views of the meaning of healthy aging. This knowledge regarding different backgrounds and different perspectives is important for community nurses providing care to clients. Thus, variations in views of healthy aging should be considered when implementing programs to promote healthy aging. Person-centred care should be
applied in all areas of community care to promote healthy aging. These suggestions may guide community nurses who work with older people and the people who influence them.

10.1.3 Suggestion for nursing education to improve care for older people through healthy aging

This suggestion focuses on nursing education, especially with respect to nursing students who will work in the Isan region. The knowledge from this thesis may help instructors at universities or nursing colleges apply the findings when teaching students in the Isan region. Instructors may use knowledge of the factors associated with healthy aging and explain the holistic approach to healthy aging to nursing students in the bachelor’s program. The findings reveal that healthy aging must be understood from a cultural perspective. To support healthy aging, nursing students should be viewed as important people who will assume the responsibility to work with and care for older people. They are a part of the younger generation and should be prepared for the aging situation in Thailand. Thus, nursing students should be prepared to work with older people and their relatives. They should understand the concept of healthy aging to advocate for older people, support their relatives, and properly prepare themselves. According to the findings of this thesis, understanding the factors associated with perceived health and healthy aging and the holistic meaning of healthy aging may be useful to nursing students. These findings may help nursing students prepare to collaborate with older people and the people who surround them. The findings may also enhance the holistic nature of the healthcare system when these nursing students graduate and begin working as nurses. Moreover, some nursing students may have grown up in the Isan region and may stay with their grandparents. Therefore, understanding healthy aging may be useful for these students to prepare themselves to care for their family members.
10.2 Future research

Other provinces in the Isan region should be included in future research to increase the generalizability of the results. A longitudinal study should be conducted to reveal additional information regarding relationships between variables (e.g., area of residence, disability, and marital status) and perceived health and healthy aging. When conducting experiments, future studies should integrate the factors that are significantly associated with perceived health and healthy aging. Implementation research should be conducted to test each factor associated with perceived health and healthy aging. Participatory research and action research could be used to apply the findings of this thesis (i.e., the meaning of healthy aging from multiple perspectives and the factors associated with healthy aging) to create a healthily aging society in the Isan region. Participatory research could be used to collaborate with older people, those who surround them, and their key networks. People's participation in the creation of a healthily aging society, which should be organized by older people and their communities, may be a sustainable development goal to promote the health of older people in the Isan region.
11 Summary in Swedish

Sammanfattning

Thailands befolkning består av en ökande andel äldre människor, över 60 år. Ökningen medför att allt fler äldre drabbas av hälsoproblem, vilket är en utmaning att förebygga för samhället och hälsovården. Enligt internationell och nationell policy är hälsosamt åldrande en nyckelfaktor för att främja äldres hälsa och bibehålla välbefinnande. Emellertid saknas kunskaper om vad som kännetecknar hälsosamt åldrande i Thailand och särskilt i den nordöstra delen, Isan regionen, där ökningen av andelen äldre i befolkningen är stor. Det övergripande syftet med avhandlingen var att beskriva faktorer som associerar med upplevd hälsa och hälsosamt åldrande, samt beskriva hur äldre människor och deras anhöriga och uppfattar hälsosamt åldrande. Vidare syftade avhandlingen till att beskriva hur kommunsjuksköterskor i regionen beskriver hälsosamt åldrande och hur de främjar ett sådant.


Resultaten från den första studien visade en varians (24,3%) i upplevd hälsa och hälsosamt åldrande baserad på bostadsområde, civilstånd och funktionsförmåga. Uppfattningar av hälsosamt åldrande har syntetiserats från den andra och tredje studiernas resultat och beskriver uppfattningar av hälsosamt åldrande i tre dimensioner: vara ömsesidigt förenade, vara i stånd att göra gott och känna sig stark, tänka bortom kroppliga och mentala funktioner. Kommunsjuksköterskornas erfarenheter av att främja hälsosamt åldrande bestod av att genomföra hälsokontroller och utbyta kunskaper mellan äldre, hälsopersonal och anhöriga, dock med begränsade resurser.

De faktorer som har betydelse för upplevd hälsa behöver beaktas när hälsofrämjande strategier ska planeras och genomföras. Resultaten visar att de äldre, deras anhöriga och kommunsjuksköterskorna har olika uppfattningar av vad hälsosamt åldrande innebär. Det indikerar att person-centrerad vård behöver integreras i praxis för att främja hälsa hos de äldre och deras anhöriga.
Avhandlingens resultat kan vara en del av ett kunskapsunderlag för att planera strategier för hälsosamt åldrande.

**Nyckelord**: anhöriga, caring, fenomenografi, focusgruppsintervju, hälsosamt åldrande, livsvärldsteori, omvårdnad, personcentrerad vård, Thai sjuksköterskor, tvärsnittsstudie
12 Summary in Thai

 населенияไทย

ประชากรไทยมีสัดส่วนประชากรสูงอายุ (60 ปีขึ้นไป) เพิ่มขึ้นไปกว่า 1 ใน 4 และมีผู้สูงอายุสูงสุดมีความ เสี่ยงในการประสบปัญหาด้านสุขภาพ สถานการณ์ผู้สูงอายุไทยจึงเป็นความท้าทายของเจ้าหน้าที่ ผู้ดูแลด้านสุขภาพ “ผู้สูงอายุสุขภาพดี” ถือเป็นกลุ่มสำคัญที่ใช้ในการสนับสนุน ส่งเสริมสุขภาพ ผู้สูงอายุ รวมทั้งยังเป็นหนึ่งในนโยบายของประเทศเพื่อมุ่งเน้นให้ผู้สูงอายุมีสุขภาพที่ดีในการ ดูแลชีวิตในวัยสูงอายุ ถือว่า “ผู้สูงอายุสุขภาพดี” ถือเป็นเป้าประสงค์ในการส่งเสริมสุขภาพของ ผู้สูงอายุไทยเพื่อทำให้ขึ้นสู่การตัดสินใจมีการศึกษาเรื่องของผู้สูงอายุสุขภาพดีใน ภาคตะวันออกเฉียงเหนือ หรือ ที่เรียกว่า ภาคอิสานของประเทศไทย เท่านั้นที่มีการเพิ่มขึ้นของ ประชากรผู้สูงอายุ ดังนั้นวิทยานิพนธ์ฉบับนี้จึงมีวัตถุประสงค์หลัก เพื่อศึกษาและรับรู้ถึง ประสบการณ์ และการรับรู้ที่เกี่ยวกับ ผู้สูงอายุสุขภาพดี การศึกษาแยกย่อยเป็น 4 วัตถุประสงค์เฉพาะ ซึ่งแยกตามลำดับการศึกษา ที่ 1 ถึง 4

การศึกษาที่ 1 เป็นการศึกษาเชิงวิเคราะห์แบบ ภาคตัดขวาง (Cross-sectional Study) โดยศึกษาใน กลุ่มตัวอย่างผู้สูงอายุ อายุ 60 ปีขึ้นไปที่อาศัยอยู่ในภาคตะวันออกเฉียงเหนือ ประเทศไทย จำนวน 453 คน การศึกษาที่ 2 และ 3 เป็นการศึกษาเชิงคุณภาพ การวิจัยปรากฏการณ์ภาพ (Phenomenographic approach) โดยใช้ฐานของ ทฤษฎีโลกแห่งชีวิต (Lifeworld theory) เพื่อศึกษาการรับรู้ที่เกี่ยวกับผู้สูงอายุ สุขภาพดี โดยศึกษาในผู้สูงอายุ จำนวน 17 คน สำหรับการศึกษาที่ 2 และ 3 ปรับจำนวนที่รับมือจบ ในการศึกษาผู้สูงอายุจำนวน 14 คน สำหรับการศึกษาที่ 3 การศึกษาที่ 4 เพื่อศึกษา ความหมายของ ผู้สูงอายุสุขภาพดีและการส่งเสริมสุขภาพผู้สูงอายุ เพื่อให้มีสุขภาพดี โดยศึกษาผู้โบราณชุมชน จำนวน 36 คน

ผลการศึกษาที่ 1 พบความสัมพันธ์ระหว่าง พื้นที่อยู่อาศัย, สถานะภาค, ภาวะพยาบาล, ทัศนคติการรับรู้สุขภาพและผู้สูงอายุสุขภาพดี อย่างมีนัยสำคัญทางสถิติ (24.3%, p < 0.05) ผลการศึกษาที่ 2, 3 และ 4 ในเรื่องความหมายของ “ผู้สูงอายุสุขภาพดี” แบ่งเป็น 3 คำอธิบาย ได้แก่ การดูแลจริงใจ ,ความสวยงามในการทำให้ฝ่ายหนึ่งมีกิจกรรมและความรู้สึกที่เข้มแข็ง, ความคิดและวิจารณญาณความสามารถของการทำงานของร่างกายและจิตใจ ผลการศึกษาที่ 4 อธิบายประสบการณ์ในการ ส่งเสริมผู้สูงอายุสุขภาพดี ว่า การเตรียมการประเมินสุขภาพ, การแบ่งปันความรู้ และการมี ทรัพยากรที่จำเป็น
จากผลการศึกษาที่ 1 ของวิทยานิพนธ์ฉบับนี้นำไปสู่ความเข้าใจที่ดีขึ้นเกี่ยวกับปัจจัยที่เกี่ยวข้องกับผู้สูงอายุสุขภาพดี นอกจากนี้ผลการศึกษาที่ 2, 3 และ 4 ในเรื่องความหมายของผู้สูงอายุสุขภาพดีพบว่า มีความแตกต่างกัน จากความต่างของมุมมองของผู้สูงอายุญาติ และพยาบาลชุมชน ผลการศึกษาที่ 4 เกี่ยวกับการส่งเสริมสุขภาพผู้สูงอายุเพื่อให้มีสุขภาพที่ดี เน้นถึงว่า ควรจะมีการนำแนวคิดการดูแลโดยมีคนเป็นศูนย์กลาง ปรับใช้ในการส่งเสริมสุขภาพผู้สูงอายุสุขภาพดีผู้วิจัยคาดว่าผลการศึกษาของวิทยานิพนธ์ฉบับนี้จะเป็นประโยชน์ต่อผู้กำหนดนโยบายในการส่งเสริมสุขภาพผู้สูงอายุเพื่อเป็นผู้สูงอายุที่สุขภาพดีต่อไป

คำสำคัญ: การดูแลโดยมีคนเป็นศูนย์กลาง, การพยาบาล, การวิจัยปรากฏการณ์ภาพ, การศึกษาภาคตัดขวาง, การสนทนากลุ่ม, ญาติ, ทฤษฎีโลกแห่งชีวิต, ผู้สูงอายุสุขภาพดี
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