Chapter 6

Capacity Building for Resilient Long-term Care in Thailand

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Chapter 6

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1. Introduction

The novel coronavirus disease (COVID-19) pandemic brings challenges to both government and private sectors in order to ensure adequate care for elder citizens and persons with disabilities. Both long-term care workers and those that they care for have revealed vulnerability or resiliency, depending upon certain factors. This study of Thailand explored the knowledge, attitudes, and practices (KAP) amongst caregivers and village health volunteers (VHVs) and investigated the catalysing factors leading to vulnerability or resiliency regarding the COVID-19 pandemic. Recommendations are also formulated based on evidence found from this study.

1.1. COVID-19 and Older People in Thailand

Thailand transitioned to an aged society in 2020, with approximately 12 million people that are aged, about 19.2% of Thailand's population (NSO, 2017). One report (UNFPA, 2021) has mentioned that almost one out of every five people is aged over 60 years and one out of 10 people is aged over 80 years. While almost 2 million older persons are not in good physical health, with some 250,000 being in extremely poor condition, more than 80% of them are still active and productive in some way. However, Thai society itself is going through a significant transition, moving away from a traditional, nuclear family-oriented pattern. The family structure now seems to be fragmented, with physical and psychological distances amongst its members. Further, there are more older persons today that are poor, many of whom live alone and lack family and other socioeconomic support, and that was the picture before the COVID-19 pandemic in Thailand.

When the COVID-19 pandemic occurred in China and other countries in the region in 2019, Thailand was attacked by the disease beginning in 2020, and the crisis became more serious in 2021 during the third wave of the pandemic. In the early days of the pandemic, the Thai government gave serious attention to controlling the pandemic situation. A state of emergency was declared on 26 March 2020, right after new COVID-19 cases spiked to 111 in one day. This was followed by curfews and various public health measures to contain the spread of the virus. These measures have proven successful; the death toll as of the 23 April 2020 was 50, and the total number of confirmed COVID-19 cases amongst Thai citizens was 2,521, of which 10.1% were older persons aged 60 years and over (Department of Disease Control, 2021). However, during this third wave of the COVID-19 pandemic, a new high rate appeared in early May of 2021, and that made people frightened and stressed.

Daily reports find that many new cases are older persons that are living with their family, some are living as couples, and some are in age-care facilities. Therefore, this shines light on the fact that older persons need special attention, as their infections are more serious than other age groups; the mortality rate amongst them is also higher. Not only have serious problems emerged in terms of their physical health, but also in terms of their mental health and economic problems. One report

mentioned that almost 90% of the weak elderly in Thailand do not have a caregiver. They must take care of themselves and therefore the risks to them during the COVID-19 pandemic are obvious.

A survey in Thailand exploring the impact of COVID-19 on older persons was conducted in July 2020 by the College of Population Studies, commissioned by the United Nations Population Fund (UNFPA, 2020). It was the very first COVID-19 survey directly focusing on older persons aged 60 years and over. The survey explored information on economic status, living arrangements, and the physical and psychological health of the respondents before and during the COVID-19 outbreak. It was found from the report that overall, 80% of the participants indicated that their health was about the same as before COVID-19, and about one-fifth felt that their health was worse than before. This proportion was higher in urban than in rural areas. Only small percentages (4% to 8%) reported that their health problems became worse during the COVID-19 pandemic; their income was either sometimes or always inadequate before the COVID-19 outbreak. In terms of living arrangements, 67% co-resided with at least one child, whereas 5.5% lived alone and 12% lived with their spouse only. One-quarter of older persons experienced one of the selected psychological symptoms, either sometimes or always during the COVID-19 pandemic. The most common symptom was feeling worried, loss of appetite, loneliness, and unhappiness. The percentages varied little by gender but were significantly higher in urban areas than in rural areas. Older persons living alone were more likely to feel lonely than those in other living arrangements. However, very little was mentioned about the elderly in long-term care (LTC) facilities, which seems to be a worse situation than those living with family members. In early 2022, severe COVID-19 infections seemed to have decreased because of high vaccination rates in Thailand. However, the Omicron variant has begun to spread around the country in the middle of 2022 and decreased in late 2022. Since then, most of the infected persons have been asymptomatic or have had only mild symptoms.

1.2. Long-term Care in Thailand and the COVID-19 Pandemic

The World Health Organization (WHO) defined long-term care as 'services to ensure that people with, or at risk of, significant loss of physical and mental capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedom, and human dignity' (WHO, 2020, p.9). In Thailand, there are about 800 LTC facilities, and most of them are small and medium sized. There are only 40 large LTC facilities within central Thailand and in some large cities. With regard to the definition of LTC by the WHO (2020, p.9) 'long-term care facilities vary by country. Nursing homes, skilled nursing facilities, assisted living facilities, residential facilities, and residential long-term care facilities are collectively known as long-term care facilities that provide a variety of services, including medical and assistive care to people that are unable to live independently in the community'. However, this study focuses on long-term care facilities that include only nursing homes and community care facilities organised by the private and public sectors in Thailand.

It has been mentioned in many reports that COVID-19 has disproportionately affected long-term care facilities. Evidence shows that what is needed is to mitigate the impact across all aspects of long-term care, including institutional-based and community-based care, given that most users and providers of care are vulnerable to severe COVID-19. The Thai government therefore is paying attention to and is concerned about long-term care both in the community and in the institutional sector. Guidelines for COVID-19 prevention developed by the Ministry of Public Health in Thailand have been distributed to LTC facilities. Many social media and announcements concerning COVID-19 have been distributed.

At present, long-term care facilities such as private nursing homes receive support from the Health and Elderly Establishment Confederation (HEC) in terms of a range of information related to government programmes, training, and advocacy. Those facilities are encouraged to be a member of the HEC. At present, the HEC covers more than 50 % of LTC facilities in Thailand (HEC, n.d.). During the COVID-19 pandemic, the HEC has played important roles in assisting the facilities by providing knowledge and skills to prevent COVID-19. High coverage of COVID vaccines amongst the elderly in facilities were also supported by the HEC.

1.3. Volunteering in Thailand

In the context of community-based LTC, the essential support has come from the Local Administrative Organization, public health centres, and hospitals and local networks. VHVs have been cited as key persons providing proactive support and have successfully managed COVID-19 outbreak control by playing a huge role. There are approximately 1,055,000 active VHVs in Thailand (Department of Protocol, Thailand, 2020) and each province contains around 104,000.

VHVs have been recognised as valuable assets for the primary healthcare system in Thailand for many decades, and they have begun to play an important role in line with the concept of community participation since 1977 (Chuengsatiansup and Suksuth, 2007). This group of people come from a variety of careers and backgrounds; however, most of them are females with low and middle incomes. Their roles in primary care services have been accepted and are trustworthy, and they perform very well on short-term tasks such as taking ad hoc health surveys, collecting periodic data, and conducting disease prevention campaigns by collaborating with health personal.

At the beginning phase of health volunteering, VHVs are very involved with maternal and child health, family planning, and infectious disease control. Recently, as Thailand has approached an aged society, areas of work are needed with long-term, continuous dedication, such as caring for chronically ill patients and dependent elderly. Further, health issues have become more complicated, and digital literacy is needed, and therefore VHVs have been equipped by the Ministry of Public Health and other sectors, such as the local administrative organisation that runs many training programmes for VHVs. During the time of COVID-19, VHVs have been very active and have provided a lot of support to the people in their villages.

According to the changing contexts in Thai society, the relevance of the conventional model of VHVs has been called into question. The Ministry of Public Health (MoPH) currently therefore has launched new mechanisms for primary healthcare services that increase the roles of VHVs called 'three doctors for primary health care'. The VHV is so called the 'first doctor' in the village and works collaboratively with the second doctor, who is a member of the public health personnel or nurse practitioners at the local health centres; and the third doctor is the family physician. VHVs are expected to communicate more with their villagers, use basic tools for health assessment, and then report the results to the second doctors. This strongly indicates that health volunteering has been progressively more accepted and plays an increasing role in Thai society.

1.4. Capacity Building of the Long-term Care Team for COVID-19 Prevention in Thailand

The unique challenges that have affected the ability of long-term care systems to respond to the COVID-19 pandemic are currently presented by the WHO (2020). The 11 key actions for addressing

these challenges in the short and longer term seem to be beneficial to LTC if all stakeholders are collaboratively implementing these key actions. This study focuses on three of the 11 key actions as follows: (i) ensuring that infection prevention and control standards are implemented and adhered to in all long-term care settings to prevent and safely manage COVID-19 cases, (ii) providing support for family and voluntary caregivers, and (iii) prioritising the psychosocial well-being of people receiving and providing long-term care services.

In early 2021, the Thai Health Foundation granted funding to an academic group to carry out a project for the infection prevention of COVID-19 for LTC facilities across the country. Fifteen facilities have been included in the training programme, and it is expected that acceptable guidelines will be produced through learning and sharing across settings. However, significant factors relevant to the effectiveness of the programme have not been explored yet. Regarding the statement, 'truly leave no one behind in the response to COVID-19, Thailand needs to do more in terms of prevention, preparation, and response to the COVID-19 pandemic', and to mitigate its impact across long-term care services, including care providers.

Recently the MoPH in Thailand launched new regulations for private LTC facilities to monitor and supervise services. Private LTC facilities in Thailand have been informed to register with the MoPH and have to follow the new regulations; for example, caregivers must be trained by certified institutions with a total of 420 hours and a completed self-assessment report submitted to the MoPH, along with an application form. The MoPH will then send auditor teams to visit the LTC facilities to ensure that adequate quality standards are met and that licenses of owners and care workers are recorded.

In conjunction with the LTC network, the researchers of this study continued to utilise the existing programme and used evidence gained from previous studies to make refinements and to ensure the effectiveness of the training programme and recommendations.

2. Objectives of the Study

- To explore the situations and factors related to the prevention of COVID-19 in institutional and community LTC for the elderly during the COVID-19 pandemic.
- To develop a model for a training programme for the caregivers in nursing homes, family caregivers, and village health volunteers using existing evidence and media.
- To utilise the training programme and collect feedback about on COVID-19 prevention in institutional and community care settings.

3. Research Procedures

3.1. Field Survey (observational study)

Bangkok and Patum-Tani Province were selected as field survey settings. The situations and factors related to the prevention of COVID-19 in institutional and community care for the elderly were explored in December 2021. A KAP survey and resilience quotient questionnaire were applied in order to obtain the factors related to the prevention of COVID-19 infection. The essential documents, such as business continuity plans (BCPs), and infectious disease control manuals used in LTC facilities during the COVID-19 pandemic were also explored.

3.2. Development of a Model for a Training Programme (meetings and consultation activities)

The results from the KAP survey and the existing programme used for LTC capacity building developed by the Thai Health Foundation were brought together, analysed, and synthesised. The redesigned model for training emerged from a research team meeting and consultations with the LTC facility leaders and the chair of the VHVs. The model is presented in Figure 6.1. The researchers selected existing media for the training and applied them to the training programme (the media used are shown in Appendix 3).

The research team carried out focus group discussions with home nursing staff and VHVs in order to explore the details of the developed model and to extract the essence of each factor, and then used this information in the workshop on capacity building for LTC facilities. At this stage the model has been refined and adjusted to suit each type of LTC. Lastly, we obtained two models, as shown in Figures 6.2 and 6.3.

3.3. Implementation of the Model and Collecting Feedback

The workshops to implement the model of capacity building for resilient LTC were carried out in the middle of June 2022 and approximately 30 VHVs and 10 caregivers participated. Online group discussions and individual interviews were carried out after the implementation of the programme to collect feedback on the programme in terms of satisfaction with it, and self-efficacy amongst the care workers and caregivers in terms of the prevention of infection and the impacts on resident care.

4. Results of the Survey

A cross-sectional survey was carried out in December 2021 at the time of the pandemic crisis in Thailand. Online responses were obtained through google form application with 126 participants that were involved in LTC activities. The study areas were Pathum-Thani Province and Bangkok, as indicated above. The data for this study were collected using a KAP survey questionnaire and a resilience quotient scale and were analysed by adopting descriptive statistics: percentage, mean, and standard deviation. In addition, two focus group discussions were carried out from January to February in 2022 in order to collect qualitative data illustrating the situation of LTC and the factors related to COVID-19 prevention. The first group of participants were LTC facility staff and the owners, and the second group participants were VHVs and community leaders working with community-based LTC in Pathum-Thani Province.

4.1. The Knowledge, Attitudes, and Practice (KAP) Survey

The KAP survey obtained 126 participants with the response rate of 85%. The results were divided into four parts: (1) the demographic characteristics of the participants, (2) the knowledge of the participants, (3) the practice of the participants, and (4) the resilience quotient, which reflected attitudes towards their life during the pandemic.

Demographic Characteristics of the Respondents

Table 6.1 shows the characteristics of the respondents; the majority were female (88.10%), the average age was 64.65, the value of the standard deviation (SD) was 8.42, the maximum age was 79 years, and the minimum age was 48 years. Half of them had one to two family members that were over or equal to 60 years of age (including the respondents), one person (32.54%), and two people (29.37%). Most of them did not have COVID-19 patients (92.86%) or a bed-ridden person (95.24%) in their family.

Table 6.1. Demographic Characteristics of the Respondents

Demographic characteristics	Frequency (n = 126)	Percentage (%)	Average	SD	Max.	Min.
1. Gender						
Male	15	11.90				
Female	111	88.10				
2. Age (years)			64.65	8.42	79.00	48.00
3. The number of family members that were over or equal to 60 years of age. (Including the respondents)						
0 persons	30	23.81				
1 person	41	32.54				
2 people	37	29.37				
3 people	8	6.35				
4 people	5	3.97				
5 people	3	2.38				
6 people	1	0.79				
8 people	1	0.79				
4. COVID-19 patients in family						
Yes	9	7.14				
No	117	92.86				
5. Bed-ridden person in family						
Yes	6	4.76				
No	120	95.24				

SD = standard deviation.

Source: Developed by researchers.

Knowledge of the Respondents

After the data collection and analysis, the participants that were VHVs and caregivers in LTC facilities were found to have relatively high KAP scores, as shown in Table 6.2. The participants seemed to have clear knowledge about COVID-19. Some unclear knowledge was related for example to how long the coronavirus can survive on a surface and in the air and frequently-touched areas (do not know=18.25% and 9.52%, respectively), the duration of the infection (do not know=7.94%), and

asymptomatic pathogen holders (do not know=11.11%). These four points were discussed and explained in greater detail with the participants in the capacity-building training session.

Table 6.2. Knowledge of the Participants (n=126)

Statements	Answer	
	No n (%)	Yes n (%)
1. I know that infection with COVID-19 causes fever, respiratory symptoms (cough, sore throat, nasal discharge, nasal closing, etc.), headache, malaise, etc.	2 (1.59)	124 (98.41)
2. I know that COVID-19 has similar initial symptoms to influenza and colds.	7 (5.56)	119 (94.44)
3. I know that COVID-19 make people lose sense of taste and smell.	4 (3.17)	122 (96.83)
4. I know that COVID-19 was initially thought to spread with contact or droplet infections, but has now been proven to spread with aerosol infections.	1 (0.79)	125 (99.21)
5. I know that the underlying diseases (chronic respiratory diseases, diabetes, cardiovascular disease, etc.) are high-risk factors for COVID-19.	1 (0.79)	125 (99.21)
6. I know that the COVID-19 virus remains in the air for about 3 hours in aerosol form, about 72 hours on plastic and stainless steel surfaces, about 24 hours on cardboard surfaces, and 4 hours on copper surfaces.	23 (18.25)	103 (81.75)
7. I know that the COVID-19 virus is more attached to patients' pillows, telephone answering machines, TV remote controls, doorknob and toilet environments.	12 (9.52)	114 (90.48)
8. I know that most COVID-19 patients are the sources of infection transmission.	9 (7.14)	117 (92.86)
9. I know that COVID-19 is transmitted before onset (2 days before onset) or from asymptomatic patients.	6 (4.76)	120 (95.24)
10. I know that COVID -19 is most infectious before and after the onset.	11 (7.94)	115 (92.06)
11. I know that COVID-19 causes aerosol infections in enclosed spaces.	4 (3.17)	122 (96.83)

Statements	Answer	
	No n (%)	Yes n (%)
12. I know how COVID-19 becomes more severe with symptoms associated with pneumonia and respiratory failure.	9 (6.35)	117 (93.65)
13. I know that in COVID-19 severe cases, the progression after pneumonia progresses quickly and the condition deteriorates rapidly, so careful observation and quick response are required.	6 (3.97)	120 (96.03)
14. I know that the close contact person is one who comes into contact with the COVID patients between 2 days before a term from the onset.	4 (3.17)	122 (96.83)
15. I know that the patients here include 'asymptomatic pathogen holders'.	14 (11.11)	112 (88.89)

Source: Developed by researchers.

Practice of the Respondents

Table 6.3 shows the practice of the respondents divided into two parts: the first part was COVID-19 preventive behaviour for themselves, and the second part was COVID-19 preventive behaviour for the elderly in the household, community, or nursing home. The results of the first part show that the majority would wear a mask when going out (97.62%), wash their hands before and after meals, coughing, and using the toilet (95.24%), and having a hot meal or just cooked food (95.24%). However, wearing a mask in their own house when doing things with the family was the lowest level of practice.

The results of the second part show that the majority would stop contacting the elderly when they have a fever, cough, or sore throat (85.71%), wash their hands with soap or alcohol gel before and after touching the elderly (83.33%), and wear a mask anytime they were taking care of the elderly (79.37%). While the behaviour that the participants practiced for themselves was appropriate, one item that was found at a moderate level was having a meal with the elderly during the pandemic. Almost 50% did not apply this recommendation to their daily life.

This might be because of the strong Thai culture to have meals at the same time and to share meals in the family, even if they know that this might cause the spread of the virus from one to another.

Table 6.3. Practice of the Participants (n=126)

Statements	Level of practice		
	Rarely/never n (%)	Sometimes n (%)	Almost always n (%)
COVID-19 preventive behaviour for yourself			
1. I wash my hands before and after meals, coughing, and using the toilet.	1 (0.79)	5 (3.97)	120 (95.24)
2. While having a chat with others, I create a 1 to 2 metre distance.	2 (1.59)	33 (26.19)	91(72.22)
3. I do not use any personal items with others such as bath towel, dishes, glasses, spoons.	5 (3.97)	13 (10.32)	108 (85.71)
4. I avoid doing things in crowded places.	4 (3.17)	19 (15.08)	103 (81.75)
5. I wear a mask in my house when I do things with family members.	19 (15.08)	48 (38.89)	58 (46.03)
6. I wear a mask when I go out.	0 (0.00)	3 (2.38)	123 (97.62)
7. I have a hot meal or just cooked food.	2 (1.59)	4 (3.17)	120 (95.24)
8. I follow up on the news about COVID-19 and avoid going to places where there are COVID patients.	1 (0.79)	13 (10.32)	112 (88.89)
9. I do exercise at home during the COVID pandemic.	8 (6.35)	46 (36.51)	72 (57.14)
10. I try not to travel or visit any places or activities if not necessary.	4 (3.17)	46 (32.54)	72 (64.29)
COVID-19 preventive behaviour for the elderly in the household/community/nursing home			
1. When I return home, I change my clothes and have a shower before I see the elderly.	14 (11.11)	24 (19.05)	88 (69.84)
2. I wash my hands with soap or alcohol gel before and after I touch the elderly.	11 (8.73)	10 (7.94)	105 (83.33)
3. I wear a mask anytime I take care of the elderly.	14 (11.11)	12 (9.52)	100 (79.37)
4. I wear gloves anytime I take care of the elderly.	24 (19.05)	24 (19.05)	78 (61.90)
5. If I have a fever, cough, or sore throat I stop contacting the elderly.	15 (11.90)	3 (2.38)	108 (85.71)
6. I avoid close contact with the elderly for example by hugging or kissing.	15 (11.90)	12 (9.52)	99 (78.57)
7. I avoid having meals with the elderly.	21 (16.67)	36 (28.57)	69 (54.76)
8. If it is not urgent, I avoid taking the elderly to the hospital. I postpone the appointment with the doctor for them.	20 (15.87)	27 (21.43)	79 (62.70)

Source: Developed by researchers.

Resilience Quotient of the Respondents

Resilience has been defined as the ability to plan and prepare for, absorb, recover from, and adapt to adverse events (Chavapattanakul, Wongkumsin, and Kongkasuwan, 2020). In addition, the resilience quotient is the capability of a person to adjust or adapt oneself and recover when facing crises. Some articles have proposed that resilience comprises the coping capacity of the individual. Resilient individuals seem to have optimistic attitudes and positive emotions, which can be protective factors during the COVID-19 crisis. This study applied a set of questions from the Department of Mental Health in Thailand (2009), which covers three elements: emotional stability, hope and morale, and problem management. The definitions of three element are as follows:

- **Emotional stability** refers to being emotional stable, and not easy to be stressed in pressure situations and having techniques to manage one's emotions to be peaceful and to become emotionally stable.
- **Hope and morale** refer to having a determined mind to achieve one's goals and to be undaunted and having a consultant when facing hardships or perturbations.
- **Problem management** refers to having positive thinking, not wanting to escape one's problems, and finding information and having techniques to solve the problems.

Table 6.4 shows the results of the resilience quotient of the respondents, where the average score was 46.76 from the total of 60, and the value of the standard deviation was 8.24. The results of each element show a high level of resilience quotient, which means that they have flexibility in their lives and can adapt themselves and handle problems during crises. The ability to manage and cope with problems, crises, and pressure would help them to be productive caregivers working in LTC. Whilst the resilience quotient was shown to be at a good level, the problem management element was the lowest amongst these three. This result needs to be responded to as LTC facility owners, caregivers, and volunteers play an important role in protecting the vulnerable elderly people, especially those needing long-term care from COVID-19 infection. It was also evident during the pandemic that the older a person is and the presence of co-morbidities were the key risk factors that require proper management, especially infectious disease control in facilities, enough space, clean physical environment, and sufficient workforce in LTC facilities. The key limiting factors in LTC at the early stage of the pandemic in Thailand were the lack of support and appropriate communication between private LTC facilities and responsible organisations, and the lack of BCPs, which leads to insufficient care workers when infected staff have to quarantine. It is a fact that there are some inter-related reasons why the elderly in long-term care facilities and communities are vulnerable in COVID-19 pandemic situations. At the basic level, the high and close-contact nature of care leads to frequent opportunities for infection (Florek, 2021). This nature requires appropriate attitudes and positive concerns amongst the staff and volunteers working in this area.

Table 6.4. Resilience Quotient

Resilience Quotient	Total scores	Mean	S.D.
Overall	**60**	**46.76**	**8.24**
• Emotional stability	30	23.39	4.65
• Hope and morale	15	12.83	2.57
• Problem management	15	10.55	2.54

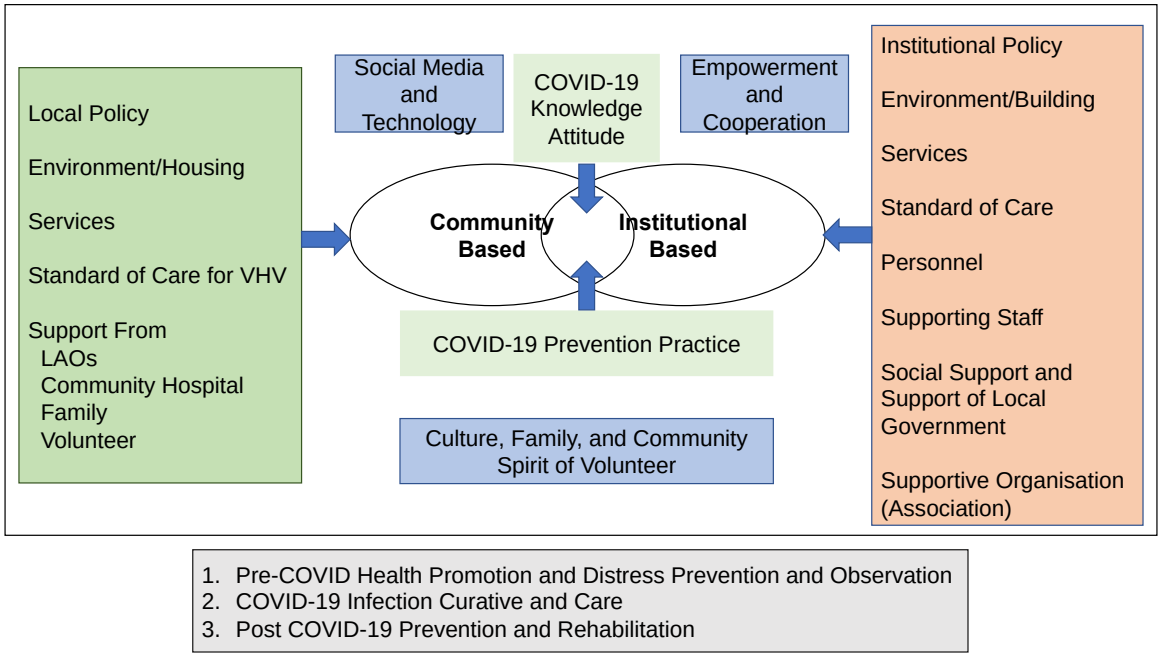
Source: Developed by researchers.

4.2. Model for COVID-19 Prevention and Resilience in LTC

The focus group discussions revealed that the pandemic has brought with it physical and emotional burdens for care workers. Many of them lack time to take care of themselves and their family, or even provide the basic care for residents. Some care workers mentioned that their work relies heavily on moral commitment. These combined effects have led to widespread fear, hopelessness, and depression amongst care workers for those that work in institutional care. In contrast, the VHVs in LTC services seem to obtain strong support from local networks, families, and charity organisations, which helps them to work effectively and to be acknowledged.

Because closing nursing homes to families and other visitors was the most common emergency measure carried out to limit the risk of infection, care workers were also separated from their families and outer society in order to prevent the transmission of the virus to the facilities. At one nursing home where many care workers were infected with COVID-19 during the crisis, it was expressed that because of the owner's kindness and leadership, they were able to cope with their stress and symptoms. They were provided with food, material, emotional, and financial support. The leadership of the LTC owners was therefore mentioned as a significant factor relevant to coping with the stress and resiliency amongst the care workers. After collecting both quantitative and qualitative data, the researchers had a brainstorming meeting to extract solid results that could answer the research questions concerning what factors influence LTC in terms of vulnerability and resiliency. A model for COVID-19 prevention and resilience for LTC was proposed (Figure 6.1). This model was then utilised in a workshop as capacity building for LTC facilities.

Figure 6.1. Model for COVID-19 Prevention and Resilience in Long-term Care, Thailand



LTC = long-term care, LAOs = local administrative organisations, VHV = village health volunteer.
Source: Developed by researchers.

4.3. Resilient Long-term Care Beyond Vulnerability: Institutional-based and Community-based LTC

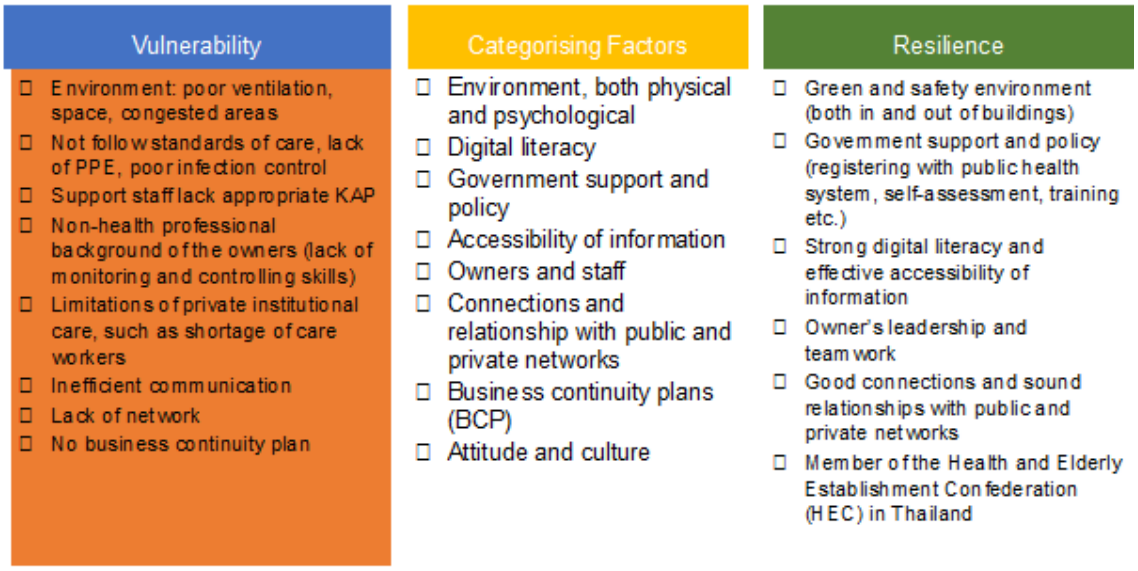
Focusing on institutional-based LTCs (Figure 6.2), which were private nursing homes, it was revealed that the catalysing factors leading to vulnerable or resilient LTC were (i) the environment, (ii) networking, (iii) KAP, (iv) digital literacy, and (v) business continuity plan (BCP). All were significant factors derived from the interviews and discussions. In this report, clear pictures and details are described.

Due to the closure of nursing homes to families and visitors, researchers were unable to conduct site visits; however, the environment both in and outside the building were explained by the facility owners. As most private nursing homes in Thailand are small and medium size with 30 to 50 beds, some facilities are in small buildings and are crowded, without green areas surrounding the facilities. Ventilation was therefore of concern. This would lead to vulnerability when one is infected, and it is therefore difficult to do zoning or to retain social distancing. In addition, if nursing homes are not cohorting patients, where the staff are caring for both infected and uninfected residents, this presents a risk of outbreak. It was found in one nursing home where researchers conducted an interview, that a group of caregivers and residents were infected with mild symptoms.

The manager decided and applied a guideline for COVID-19 management of those requiring LTC by setting up an isolation room for this group. This decision seemed to help them get through the crisis, and the family members of the residents were satisfied as they preferred not to have their parents in hospital. However, this needs to be revised and well prepared in order to prevent complications that

may occur; especially care workers may suffer with physical and emotional breakdowns in their own health.

Figure 6.2. Resilient Care beyond Vulnerability: Institutional-based Long-term Care



KAP = knowledge, attitudes, and practices, LTC = long-term care, PPE = personal protective equipment.
Source: Compiled by researchers.

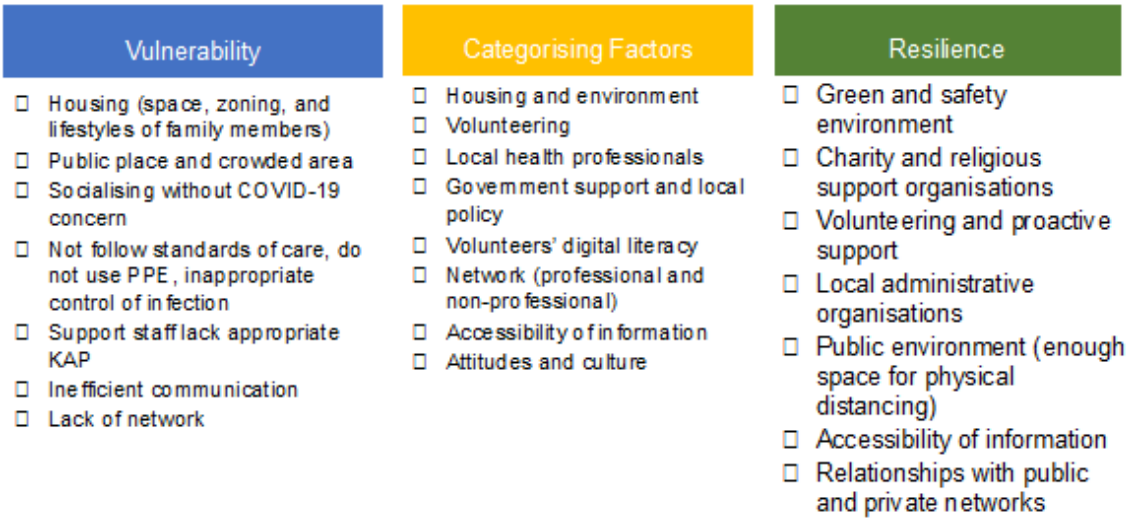
The network of the private nursing home was revealed as a resilient factor. The Health and Elderly Establishment Confederation (HEC) is one of the most important sources of support for private nursing homes in Thailand. Its mission is the commitment to elevating the healthcare and ageing business to the international level with creativity, innovation, and the highest quality management for mutual success with healthcare business sectors and elders. Whilst the crisis of COVID-19 was ongoing in Thailand, the HEC provided material, information, and emotional support to members such as COVID vaccine distribution to cover most members. Another activity which is relevant to the HEC mission is to prepare members to meet the new regulations of the Thai government. The roles of the HEC and its activities are a resilient factor in providing positive impacts for institutional LTC.

One more factor relevant to vulnerability is the BCP. Without a BCP, this sector would be in difficulty as some owners mentioned that they faced staff shortages and the remaining workers increased their work hours, creating unsafe conditions for staff and residents. BCPs have been developed in Thailand but are not used by private nursing homes.

Special mention needs to be made of community-based LTC (Figure 6.3). The results from the survey and focus group discussions show that the catalysing factors leading to vulnerable or resilient LTC were as follows: (i) housing and the environment, (ii) government and local authority organisations, (iii) the spirit of volunteering, local wisdom, and the attitudes and culture amongst the volunteers and family, (iv) digital literacy and accessibility of information, and (v) private and public networks, such as charity organisations and the business sector. In this summary, the most important factors to help community LTC gain resiliency were strong volunteering work and community support. In

Thailand, health volunteers are recognised as an important sector to drive public health services for local people. The stronger the volunteering work in the community, the more resilient the elder care can be found. Health volunteers are familiar with the local people in the catchment areas (one volunteer takes care of 10–15 families). This creates effective support by the health volunteers for the dependent elderly and their families during the pandemic crisis. Local wisdom, such as Thai herbs and traditional therapy, were widely used by the volunteers. Some charity organisations received donations and transferred those materials and money to the community assisted by VHVs. Most VHVs expressed the idea that they were motivated to do volunteer work and found benefits returned to them and their families in terms of recognition, privilege, and health benefits. However, a few VHVs contracted COVID-19 infection, but they were able to access treatment and care easily as they are accepted as a member of public health team.

Figure 6.3. Resilient Care beyond Vulnerability: Community-based Long-term Care



KAP = knowledge, attitudes, and practices, PPE = personal protective equipment.
Source: Compiled by researchers.

5. Conclusions

To conclude, the WHO proposed key actions to address the challenges of COVID-19 in the LTC sector. This study discussed three key actions in this regard: (i) ensure that infection prevention and control standards are implemented and adhered to in all long-term care settings to prevent and safely manage COVID-19 cases, (ii) provide support for family and voluntary caregivers, and (iii) prioritise the psychosocial well-being of people receiving and providing long-term care services. These three key actions were demonstrated through the research activities. The survey revealed that KAP amongst the caregivers both in the community and institutions were satisfactory. They may not have been able to understand some of the points regarding COVID-19, such as the duration of transmission and asymptomatic holders; however, the resilience quotient, which can be referred to as one's attitude towards life, was appropriate. Problem management was re-skilled through the capacity-building workshop, and prevention and protection skills were found to be positive.

However, some practices, such as having meals with the elderly during high rates of infection, were not in compliance with standards due to Thai culture and lifestyle. The study identified the catalysing factors that lead to resilient or vulnerable LTC. It was also found that the vulnerability and resiliency of both types of LTC were different. Community-based LTC seems to be better in terms of resilience than institutional-based LTC: for example, there is less work burden in community settings, as the elderly live with their family. VHVs play important roles in visiting and giving specific care to the elderly with the family support. The volunteers also gave advice by consulting with the community nurses or care managers and received positive support from local organisations and some charity groups in the community. In contrast, caregivers working in private nursing homes seem to face the complicated problems of heavy workloads and high expectations. Private nursing homes, which are members of the HEC, had strong support from this network and seemed to cope with the crisis successfully. The HEC members are deemed to demonstrate resilient LTC in Thailand. In addition, facility owners with health science backgrounds and strong connections with public and private networks demonstrated sound coping skills and resiliency.

6. Lessons Learnt

- Regularly provide and update knowledge and skills regarding COVID-19 to LTC staff and VHVs via an effective route using appropriate technology. Digital literacy amongst caregivers needs to be developed.
- Improve health monitoring in LTC by establishing systems of surveillance to monitor COVID-19 outbreaks in LTC across the country.
- Implement an integrated approach to health and social services in LTC, both institutional based and community based. Charity organisations and the business sector should be encouraged more to support LTC services in general and during the crisis.
- Encourage all private nursing homes to become involved with a strong trade union or confederation so that sharing information, learning from each other, and providing support amongst members will be effectively carried out. The confederations of LTC in Thailand, such as the HEC, provide a variety of support and activities for LTC and work as a bridge to connect to government sectors.
- Improve occupational health and safety in LTC facilities in order to protect all staff working in this area, focusing on holistic health (physical, mental, environmental, and spiritual health).
- Strengthen and upgrade VHVs to become more involved in the area of community-based LTC. Financial mechanisms to support VHVs need to be considered.

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