ปัจจัยที่มีอิทธิพลต่อกิจกรรมการดูแลผู้ป่วยระยะท้ายของอาสาสมัครสาธารณสุขประจำหมู่บ้านในเขตอำเภอประโคนชัย จังหวัดบุรีรัมย์

Factors Influencing Caring Activities for Patients with End of Life among Village Health Volunteers in Prakhonchai District, Buriram Province, Thailand

นิพนธ์ต้นฉบับ

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Original Article

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บทคัดย่อ

วัตถุประสงค์: เพื่อศึกษาปัจจัยที่มีความอิทธิพลต่อกิจกรรมการดูแลผู้ป่วยระยะท้ายของอาสาสมัครสาธารณสุขประจำหมู่บ้าน **วิธีการ:** การวิจัยเชิงสำรวจมีตัวอย่างเป็นอาสาสมัครสาธารณสุขประจำหมู่บ้าน 257 คนในเขต อ.ประโคนชัย จ.บุรีรัมย์จากการสุ่มแบบหลายขั้นตอน ให้ตอบแบบสอบถาม 1) กิจกรรมการดูแลผู้ป่วยระยะสุดท้าย (ตัวแปรตาม) และ 2) ความรู้ 3) ทัศนคติ 4) การรับรู้บทบาท 5) การได้รับการยอมรับนับถือ และ 6) ความพึงพอใจในการดูแลคนไข้ระยะสุดท้าย (ตัวแปรต้น) ทดสอบความสัมพันธ์ด้วยสมการถดถอยพหุคูณแบบขั้นตอน **ผลการศึกษา:** อาสาสมัครสาธารณสุขประจำหมู่บ้านมีกิจกรรมการดูแลผู้ป่วยระยะท้ายโดยในระดับมาก (*M* = 83.20, *SD* = 0.88) และปัจจัยที่มีอิทธิพลอย่างมีนัยสำคัญทางสถิติ ได้แก่ การรับรู้บทบาท (β = 0.225) การได้รับการยอมรับนับถือและเคารพ (β = 0.250) และทัศนคติ (β = 0.224) โดยสามารถร่วมกันทำนายการทำกิจกรรมได้ร้อยละ 34.4 (R[2] = 0.344, P-value < 0.001) **สรุป:** ปัจจัยด้านการรับรู้บทบาท การได้รับการยอมรับนับถือ และทัศนคติร่วมกันทำนายกิจกรรมการดูแลผู้ป่วยระยะท้ายของอาสาสมัครสาธารณสุขประจำหมู่บ้านได้ สามารถส่งเสริมการทำกิจกรรมได้ด้วยการแลกเปลี่ยน เผยแพร่ความรู้ และประสบการณ์ในบทบาทหน้าที่ตามกิจกรรม

คำสำคัญ: ผู้ป่วยระยะท้าย; กิจกรรมการดูแล, อาสาสมัครสาธารณสุขประจำหมู่บ้าน; ปัจจัย

Abstract

Objective: To identify factors influencing caring activities for patients with end-of-life among village health volunteers. **Methods:** Survey research had 257 village health volunteers in Prakhonchai district, Buriram province using multi-stage sampling. Participants completed the questionnaires of end-of-life care activities (dependent variable), and knowledge, attitude, perceived role, recognition and respect, and satisfaction about care for end-of-life persons (independent variables). Associations were tested using stepwise multiple regression analysis. **Results:** The village health volunteers had a mean score for caring activities for end-of-life patients at a good level (*M* = 83.20, *SD* = 0.88). Significant predictors of caring activities were perceived role of caring (β = 0.225), recognition and respect (β = 0.250), and attitudes towards caring (β = 0.224) with a 34.4% of the variance of caring activities explained (R[2] = 0.344, P-value < 0.001). **Conclusion:** Perceived role of caring, recognition and respect and attitudes towards caring for end-of-life patients predicted care activities by village health volunteers. Care could be promoted through activities for sharing and provision of knowledge and experiences in caring the end-of-life patients.

Keywords: end-of-life patients; care activities; village health volunteers; factors

Introduction

The current health situation is that there are 40 million people worldwide who are end-of-life patients.[1] The principle of palliative care that is widely used today is palliative care. It is predicted that by 2060, the demand for palliative care will double from the present, especially in low- and middle-income countries. It is estimated that the number of people worldwide who need palliative care will reach 56.8 million, and this number will increase by 31.1 million per year, Only 54.2 percent have access to palliative care.[1] The number of end-of-life is divided into 3 groups: adult patients with end-of-life due to cancer, adult patients with end-of-life due to

chronic diseases other than cancer, and pediatric patients with end-of-life[2], which tends to increase every year.

Although there is currently preparation for caring for end-of-life by developing the operating mechanism of the health service system of the Service plan in the palliative care branch[3] The current palliative care and patient care system has a network of care by sending important information on caring for end-of-life from the provincial level to the district level and the primary care unit level. There are additional specialized courses on palliative care for end-of-life patients for health personnel, and home visits by health personnel in the community, but it is still not enough to meet the needs

of patients. As a result, it is not possible to provide comprehensive care in all 4 dimensions: body, mind, society, and spirit. Therefore, a course on end-of-life care for public health volunteers has been added to play an important role in taking part in caring for palliative patients or end-of-life at home to reduce the gap in accessing health services 24 and develop a comprehensive palliative care health care system in the community.

As for the role of public health volunteers in activities caring for end-of-life patients, in Thailand, there is no specific role as compared to England, which has clear activities and roles.[27] There is only the competency standards of public health volunteers by the Division of Community Health Support, Department of Health Service Support, Ministry of Public Health in 2006, which broadly proposed the role of volunteers related to caring for end-of-life patients and their families in the curriculum for training community public health volunteers and the user manual. This includes creating and managing a network for caring for end-of-life patients and their families in partnership, campaigning to drive communities and society to participate in supporting home care for end-of-life and their families and preparing a network in the community for managing home care for end-of-life and their families both before and after death.[5] The researcher therefore compared the role of caring for end-of-life according to the palliative care guidelines of the Department of Thai Traditional and Alternative Medicine.[6] The palliative care guidelines were developed to connect multidisciplinary palliative care networks with village health volunteers in the community. Seven steps were set for jointly caring for end-of-life: 1) searching for end-of-life in the community, 2) diagnosing and assessing patients for palliative care, 3) holistic assessment of end-of-life 4) continuous follow-up care, 5) caring for end-of-life in the community, 6) post-mortem care, and 7) developing and improving the end-of-life care system.[6] To provide comprehensive and effective care that better meets the needs of patients.

The Buriram Provincial Public Health Office has divided the care of end-of-life into 4 groups: 1) end-of-life cancer patients (Cancer stage 4) 2) patients whose vital organs have permanently lost function, such as chronic kidney failure who refuse renal replacement therapy, patients with severe cerebrovascular disease, etc. 3) accident patients with severe brain injuries (Severe head injury) 4) children

with multiple congenital anomalies (Multiple congenital anomalies), children with cerebral palsy. From the results of the follow-up report of end-of-life receiving palliative care by the Buriram Provincial Public Health Office, it was found that there were a total of 7,538 terminal patients, and in Prakhon Chai District, there were the highest number of terminal patients, totaling 538, and the highest number of patients who were readmitted to the hospital with complications. This is due to the workload of the caregivers, which leads to a lack of comprehensive and continuous care, coupled with the lack of health personnel with sufficient knowledge of palliative care in the area.[4]

From a systematic review of the literature and research documents on factors related to end-of-life care activities in Thailand, it was found that factors related to end-of-life care are personal factors including knowledge [7,8,9] Perception[8,9,10,12] Attitude[10,11,13] Training[13,28] Experience in caring for end-of-life patients[13,14] Age Duration of work[15] And the factors that are related to the performance of village health volunteers are personal factors, consisting of knowledge[15], role and duty[11,15], experience[16], length of time as a village health volunteer[16], motivational factors[17,25] consisting of being respected[17], and support factors consisting of compensation and welfare[17].

In addition, there was a study of factors related to the role of volunteers in caring for different patient groups, such as the dementia patient group, consisting of role perception factors, motivation factors and support factors[18], and the disabled sample group, consisting of role perception factors, role support factors, and attitudes toward care. Health status of village health volunteers and knowledge about care.[19] However, the current literature review found relatively few studies on factors directly influencing the end-of-life care activities of village health volunteers. Most of the studies were on factors related to end-of-life care by medical personnel to be able to care for end-of-life patients and on factors related to the performance of village health volunteers to achieve their goals and be more efficient, including studies on factors related to the role of volunteers in caring for other patient groups. It can be seen that studies specifically on end-of-life patients have not covered factors related to end-of-life care activities by village health volunteers.

The researcher, as a community nurse, plays a role in promoting, planning, caring for, and developing the potential

of the community. Therefore, he is interested in studying the factors that influence the activities of caring for end-of-life patients by village health volunteers. The factors studied in this study were derived from a literature review and the application of Herzberg's two-factor theory[20] to create motivation for village health volunteers to work. They consisted of personal factors, such as experience, knowledge, attitude, and role perception; motivating factors, such as being respected; and supporting factors, such as satisfaction with compensation and welfare. Village health volunteers play an important role in caring for end-of-life patients and their families. This is to ensure that patients receive good care, have a better quality of life, and reduce obstacles in caring for end-of-life patients. This is a guideline for developing the potential of village health volunteers, which will result in a comprehensive care system that is easily accessible and can comprehensively respond to end-of-life patients in the future.

Specifically, this study aimed to examine the end-of-life care activities of village health volunteers, and its influencing factors 1) personal factors (e.g., experience, knowledge, attitude, and perception), 2) motivational factors (e.g., recognition and respect), and 3) supporting factors (e.g., : satisfaction with compensation and benefits for the end-of-life care activities). Accordingly, we hypothesized that experience, knowledge, attitude, role perception, recognition and respect, and satisfaction with compensation and benefits influenced the end-of-life care activities of village health volunteers.

Methods

This research is a predictive correlational study to study the activities of caring for end-of-life patients by village health volunteers and to study the factors that influence the activities of caring for end-of-life patients of village health volunteers. The sample group in this research is 257 village health volunteers working in Prakhon Chai District, Buriram Province. The sample selection criteria are: 1) aged between 20-59 years, 2) having experience working as a village health volunteer for at least 6 months, 3) being a village health volunteer who has worked in the area continuously for at least 6 months, 4) having a smartphone that can use the Line Application system. The method of obtaining the sample group is as follows: 1) specifying the area for data collection, which is a total of 16 sub-districts, using the simple random sampling method without imputing 50 percent of the total number of sub-districts, resulting in 8 sub-districts, which have village health volunteers who meet the criteria. A total of 1,268 people 2) Calculate the sample group according to the proportion of the population of each sub-district, all 8 sub-districts, resulting in a sample group of each sub-district, a total of 257 people. 3) Carry out random sampling using simple random sampling without replacement from the list of names of village health volunteers of each subdistrict according to the proportion of the sample group calculated until all 8 sub-districts, a total of 257 people, using a total data collection time of 1 month. The sample group size in this research was calculated from the sample group size using the G*Power program to find predicting factors for 6 independent variables Taking into account the control of Type I error and Type II error By setting statistical significance (Alpha) =.05, power of test =0.80 and setting the effect size. From the past research of Sasivimon Panurach[14], studying the factors related to nurses' caring behavior in caring for end-of-life, it was found that the knowledge factor is related to nurses' caring behavior in caring for end-of-life (r =.244) and calculating the effect size using the formula $f2 = r2/(1-r2)$[21] equal to.06. After that, the sample size was calculated using the G*Power program. The sample group was 234 people. The researcher prevented incomplete responses to the questionnaires and prevented data loss. Therefore, an additional sample of 10%[21], or 23 people, was added to the sample group for this study, totaling 257 people. From the actual data collection, it was found that 6 people had incomplete questionnaires. Therefore, the remaining sample group for this research was only 251 people or 97.67%.

Measurement instruments

The research instrument used to collect data in this study was a questionnaire consisting of 7 parts as follows:

Part 1 Personal Data Questionnaire consists of general information, including gender, age, marital status, religion, education level, length of employment, area of responsibility, history of training related to end-of-life care, and experience in end-of-life care.

Part 2: Questionnaire on knowledge in caring for end-of-life. The researcher requested permission to use the knowledge assessment form of Saengwan Tangsangsakun et al.[9]. The instrument has been examined for its reliability

using Cronbach's alpha coefficient, which is .89, and has been retested for reliability before data collection using the Kuder-Richardson 20 (KR- 20) with a reliability of .90. It is a 20-item multiple-choice questionnaire with 3-choice answers: yes, no, don't know. The scoring criteria are: correct answer is 1 point, incorrect answer or don't know is 0 points, with a maximum total score of 20 points and a minimum score of 0 points. High scores mean good knowledge of caring for end-of-life patients.

Part 3: Attitude questionnaire on end-of-life care. The researcher adapted and developed the questions from the attitude assessment on end-of-life care by Saengwan Tangsaengsakul et al.[9]. The instrument was tested for content validity, with a CVI of .80, and the reliability of the instrument was tested using Cronbach's alpha coefficient of .88. The questionnaire is a closed-ended form with 10 items: 6 positive questions (items 1,2,3,4,5,10) and 4 negative questions (items 6,7,8,9). The answers are on a 5-point rating scale, from strongly agree to strongly disagree. Starting from 1, having a poor attitude towards caring for end-of-life patients, to 5, having a good attitude towards caring for end-of-life patients, the total score for this section is between 10-50 points.

Part 4: Questionnaire on the perception of the role of caring for end-of-life patients. The researcher adapted and developed the questions from the attitude measurement form of caregivers towards the role of caring for end-of-life before and after the training of Pornpattra Saenlao[11]. The instrument has been examined for content validity, with a CVI value of .90, and the reliability of the instrument was examined using Cronbach's alpha coefficient method, which was .95. The questionnaire is a closed-ended form with 10 items. The answers are on a 5-point rating scale, from most agree to least agree. Starting from 1, there is a low perception of the role in caring for the patient at the end-of-life, to 5, there is a high perception of the role in caring for the patient at the end-of-life. The total score of this section is between 10-50 points.

Part 5: Recognition Questionnaire The researcher requested permission to use the questionnaire on motivating factors that influence the recognition practices of Phiranya Champasri et al.[18] The instrument was tested for reliability using Cronbach's alpha coefficient, which was .89. The questionnaire was a closed-ended questionnaire with 3 items. The answers were on a 5-point rating scale, ranging from most agree to least agree. The total score for this section ranges from 1, low acceptance, to 5, high acceptance. The total score for this section ranges from 3 to 15 points.

Part 6: Questionnaire on satisfaction with compensation and welfare in the work of village health volunteers. The researcher asked for permission to use the questionnaire on supporting factors that influence the performance of satisfaction with compensation and welfare by Phiranya Champasri et al.[18] The tool was tested for reliability using Cronbach's alpha coefficient method, which was .88. The questionnaire was a closed-ended form with 4 items. The answers were on a 5-point rating scale, from most agree to least agree. Starting from 1, little satisfaction with compensation and benefits, to 5, very satisfied with compensation and benefits. The total score for this section is between 4-20 points.

Part 7 End-of-life care activities questionnaire The researcher created and developed a tool based on the definition of terms and the literature review on the activities of the end-of-life care of village health volunteers, both those who directly performed the activities and those who participated in the activities according to the guidelines for palliative care in the community of the Department of Thai Traditional and Alternative Medicine[6]. 7 steps as follows: 1) Searching for end-of-life patients in the community 2) Diagnosing and assessing patients for palliative care 3) Holistic assessment of end-of-life patients 4) Continuous monitoring and care 5) Caring for end-of-life patients in the community 6) post-death care and 7) Joint development and improvement of the end-of-life care system. The questionnaire was a 20-item closed-ended questionnaire. The answers were on a 5-point rating scale, ranging from most practice to least practice. Starting from 1, the least practiced, to 5, the most practiced. The total score for this section is between 20-100 points.

Instrument quality assurance

For the quality control of the End-of-Life Care Activity Questionnaire, the researcher presented it to 5 experts: 3 lecturers from the Faculty of Nursing, 1 family medicine physician, and 1 community nurse. The instrument was checked for content validity and obtained a CVI of .90. The End-of-Life Care Activity Questionnaire was tested with a similar sample of 30 patients. The reliability was analyzed

using the Cronbach's alpha coefficient method, which was .99.

Participant ethical protection

The researcher explained the details of the research, the research methodology, the data collection process, and the protection of the participants' rights in detail, giving them the opportunity to ask questions and decide to participate in the research freely. Data collection will not specify the names and surnames of the sample group, only the code in the questionnaire will be used. The data will be saved in a personal computer system that has a password set before each use. After the research results have been published and disseminated, all data will be destroyed. This research has been reviewed by the Human Research Ethics Committee of Burapha University and has been approved under the research project code G-HS102/2565(E1) on January 20, 2023.

Data collection procedure

1. The researcher submitted a letter to the Buriram Provincial Public Health Office to request permission to collect data in the area of the sub-district health promotion hospital under his jurisdiction and coordinated with the director of each sub-district health promotion hospital to request permission to collect data in the area.

2. The researcher coordinated with the staff of the sub-district health promotion hospital responsible for the work of village health volunteers and met with the sample group to explain the objectives, protect the rights of the sample group, give the sample group time to decide to join the research and make an appointment for a date and time to answer the questionnaire again via the Line Application system after the sample group and the staff responsible for the work of village health volunteers have joined the Line group by scanning the QR code separated by sub-district. However, the researcher asks for cooperation to join the Line group within 1 week.

3. The researcher collected data from village health volunteers by requesting the cooperation of the sub-district health promotion hospital staff who were responsible for the work of village health volunteers to be research assistants in the study area. There was training and explanation of the data collection process for the sample group from the beginning of the questionnaire until the completion. On the appointed day and time in each sub-district, the research assistant explained the information and instructions to the sample group about the questionnaire on factors influencing the activities of the village health volunteers in caring for end-of-life patients. After the sample group arrived at the sub-district health promotion hospital in the area and the sample group agreed to participate in this research, the research assistant began to administer the questionnaire.

4. The participants can answer the online questionnaire about factors influencing the end-of-life care activities of public health volunteers by scanning the QR code or the link (Link) that the researcher sent via the Line Application system on the appointed day and time. The questionnaire is in the form of a Google Form. The questionnaire data can be accessed in 2 ways: with and without email lock. The researcher is the account owner. No other sample groups can access the data. The sample group is given time to answer the questionnaire by themselves, which takes about 30-45 minutes. The research assistant supervised the questionnaire this time and the researcher reminded them of the period. After completing the questionnaire, the researcher checked the accuracy and completeness of all data and analyzed the data using statistical methods.

Data analysis

The researcher recorded and analyzed the data using a ready-made program (IBM SPSS Statistics 26) by analyzing the personal data of the sample group and the end-of-life care activities of village health volunteers using descriptive statistics, including frequency distribution, percentage, mean, and standard deviation. The predictive power of the factors influencing the end-of-life care activities of village health volunteers was analyzed using stepwise multiple linear regression. All assumptions of multiple linear regression were met.[29]

Results

1. Personal data The sample group of 251 people found that the majority of the sample group was female (84.5 percent), mostly between 50-59 years old (59 percent), most of them were Buddhists (100 percent) and were married (80.9 percent). The study found that most of them had completed secondary school (50.6 percent) and had worked as village health volunteers for 5 years, 1 month - 10 years (29.5 percent), followed by 15 years, 1 month - 20 years

(18.8 percent), had a history of training in caring for end-of-life patients (52.2 percent), had direct experience in caring for end-of-life patients in the community, most of whom had been in the range of less than 1 year - 5 years (43.0 percent), followed by 5 years, 1 month - 10 years (8.4 percent), and had experience in caring for end-of-life patients in the community (43.8 percent).

2. Level of knowledge, attitude, role perception in caring for end-of-life patients, being respected, satisfaction with compensation and welfare, and activities of caring for end-of-life patients. From the study, it was found that the sample group had a good level of knowledge in caring for end-of-life patients, with an average score of 17.76 (SD = 3.54), a maximum score of 20, and a minimum of 5. Attitude in caring for end-of-life patients was good, with an average score of 37.99 (SD = 3.57), with a maximum score of 48 and a minimum of 26. Perception of the role of caring for end-of-life patients was high, with an average score of 42.02 (SD = 5.30), with a maximum score of 50 and a minimum of 19. Recognition was high, with an average score of 12.61 (SD = 1.56), with a maximum score of 15 and a minimum of 7. Satisfaction with compensation and welfare was moderate, with an average score of 12.60 (SD = 1.81), with a maximum score of 20 and a minimum of 9. Activities of caring for end-of-life patients. It was at a good level with an average score of 78.03 (SD = 14.91), with a maximum score of 100 and a minimum score of 43 (Table 3).

Table 3 Score range, mean score, standard deviation, and level of knowledge, attitude, perception, role, respect, satisfaction with compensation and benefits, and activities of end-of-life care (n = 251).

variable	Score range		M	SD	level
	Possible Score	Score obtained			
knowledge	0-20	5-20	17.76	3.54	good
attitude	10-50	26-48	37.99	3.57	good
Role Awareness	10-50	19-50	42.02	5.30	high
Recognition	3-15	7-15	12.61	1.56	high
Satisfaction with compensation and benefits	4-20	9-20	12.60	1.81	moderate
End-of-life care activities	20-100	43-100	78.03	14.91	good

3. Factors influencing the end-of-life care activities of village health volunteers The stepwise multiple regression analysis of the factors influencing the end-of-life care activities of village health volunteers revealed that there were 3 factors that influenced and could jointly predict the end-of-life care activities

of village health volunteers: role perception, esteem, and attitude. They could jointly predict the end-of-life care activities of village health volunteers by 34.4 percent (R^2 =.344, p<.001). The first factor selected to be included in the prediction equation was role perception, which could predict the end-of-life care activities of village health volunteers by 25.8 percent (R^2 =.258, p =.002). The second factor selected to be added to the prediction equation was esteem. The third factor selected to be added to the prediction equation was attitude, which was able to predict the end-of-life care activities of village health volunteers by another 5.4 percent (R^2 change = .054) to 31.1 percent (R^2 = .311, p<.001) and the third factor selected to be added to the prediction equation was attitude, which was able to predict the end-of-life care activities of village health volunteers by another 3.2 percent (R^2 change=.032) to 34.4 percent (R^2 =.344, p = .001) (Table 4).

Table 4 Stepwise multiple regression analysis of factors influencing end-of-life care activities of village health volunteers (N = 251).

Predictive variables	R^2	b	SE(b)	Beta	t	p
Role Awareness	.258	.609	.194	.225	3.139	.002
Recognition	.311	2.306	.609	.250	3.787	<.001
attitude	.344	.905	.259	.224	3.488	.001
Constant = -5.911, R^2=.344, $Adj.R^2$=.336. , $F_{(3.124)}$ = 43.117, p < .001						

Discussions and Conclusion

The researchers discussed the research results according to the study objectives as follows:

1. The research results found that the sample group of village health volunteers had activities to care for end-of-life patients at a high level overall (*M* = 83.20, *SD* =.88) because they had experience in caring for end-of-life patients, both direct experience and shared experience, consistent with the results of the study by Subramanian S et al.[23] who found that volunteers who had personal experience in caring for end-of-life patients or had experience working in palliative care in nursing homes would have an understanding of the role and activities that had to be performed.

The results of this research can be explained according to the concept of Herzberg's Two Factor Theory [20] and a review of related literature, which is that the sample group of village health volunteers who have experience caring forend-of-life patients ha**s** motivating factors directly related to the nature of the work they do because it is work that matches their abilities and knowledge that they have studied, resulting in a good feeling towards the work,

expertise, and the ability to use the knowledge they have gained to evaluate, analyze situations, and manage problems for end-of-life patients.

It can be seen that the sample group of village health volunteers in Prakhon Chai District, Buriram Province, has activities to care for end-of-life patients at a high level overall. This may be because the number of end-of-life patients in the area of responsibility is large, resulting in widespread participation in end-of-life patient care activities, resulting in experiences that lead to greater understanding, resulting in new concepts and skills that will make the behavioral patterns more effective and can be applied to crystallize ideas for self-development.[27]

2. The research results found that there 3 influential factors could jointly predict the end-of-life care activities of village health volunteers as follows: 1) Role perception was a factor that could predict the end-of-life care activities of village health volunteers by 25.8 percent (R^2 =.258, p = .002) and was the factor with the highest influence on the end-of-life care activities of village health volunteers (b =.225) which WHO It is stated that the perception of appropriate roles will result in the person understanding the assigned tasks for both themselves and others. As a result, the person tries to learn the role until they are ready to care for the patient.[1] Therefore, if the village volunteers understand and are assigned responsibilities, they will be able to work according to their assigned roles with quality. This is consistent with the research study of Phiranya Champasri et al.[18] who found that the perception of roles (β = .38) can jointly predict the rehabilitation practice of the disabled people of the village health volunteers by 40.40 percent. Consistent with the research study of Natrada Haekham et al.,[19] it was found that the factor that had a positive relationship with readiness to care for people with dementia was the perception of the role of care (r = .669, p <.001) and was consistent with the research study of Pornpattra Saenlao.[10] It was found that village health volunteers played an important role in caring for end-of-life patients, while professional nurses played a significant role in supporting and participating in cases with complex care needs (p<.01). 2) Being respected was an influential factor and could jointly predict an increase in end-of-life patients' care activities of village health volunteers by 5.4 percent (R^2change=.054) is 31.1 percent (R^2 =.311, p <.001).

According to the concept of Herzberg's two-factor theory (Herzberg et al.,1959)[20,] it is believed that people or workers will be able to work effectively and efficiently depending on the worker's satisfaction because satisfaction will help increase interest in the work and increase enthusiasm for working. Being recognized and respected is one of the motivating factors that will lead to job satisfaction that makes goals and work productivity higher, consistent with the study and research of Charoonlak Pongcharoen and group [12] It was found that being respected (b=. 260) could significantly predict the motivation to work of VHWs (p<. 01) and was consistent with the study of Penpicha Luandee et al. [22,] It was found that the aspect of acceptance and respect had a statistically significant relationship at a p-value less than 0.001, 3) Attitude was an influential factor and could jointly predict the end-of-life care activities of village health volunteers by increasing by 3.2 percent (R^2 change=.032) is 34.4 percent (R^2 =.344, p =.001) which according to the concept of Herzberg's two-factor theory [20] stated about the motivation factors or factors that stimulate work (Motivation Factors or Motivators) are factors that are directly related to work and are factors that will lead to positive attitudes and true motivation consistent with the study of research by Natrada Haekham et al.[19] It was found that the factors that had a positive relationship with readiness to care for people with dementia were attitudes towards care (r = .344, p <.001) and were consistent with the study and research of Sachi Sanjay Pandya et al.[25] Motivation was found to be the foundation of palliative care, a natural motivator that leads to feelings and attitudes that want to give back to society.

However, the factors that could not predict the end-of-life care activities of village health volunteers were: 1) experience. This may be because all sample groups have previous experiences, whether direct or shared, as they conduct home visits with a multidisciplinary team every year. Consistent with the study and research of Saengwan Tangsangsakun et al.,[9] it was found that the level of education and experience were not significantly different (p<.05). 2) Knowledge. This is because knowledge alone may not be able to lead to the implementation of various activities. Other factors are also required, such as awareness of the role and the correct attitude in caring for end-of-life patients. This is because awareness of the appropriate role and having a positive attitude will be the

driving force for village health volunteers to perform such activities more effectively. Consistent with the study and research of Saengwan Tangsangsakun et al.,[9] It was found that the level of knowledge classified by different levels of education did not show any statistically significant differences (p=.31), 2) and 3) satisfaction with compensation and benefits. This may be because the sample group understands their duties and performs their duties without considering the benefits they will receive, focusing on helping end-of-life patients and their families in terms of physical, mental, emotional, and social aspects, with a human heart, and creating life force.[5] Not consistent with the study of Charoonlak Pongcharoen.[12] It was found that compensation and benefits (b=.220) could significantly predict the motivation of village health volunteers to work (p< 01).

Suggestions for applying research results

The researcher would like to suggest the application of the research results as a guideline for organizing the end-of-life care activities for village health volunteers to community nurses and related health personnel as follows:

1. Role awareness: There should be activities that increase the awareness of the roles of village health volunteers according to their rights and duties according to their status in society, such as exchanging the performance of various roles among village health volunteers, etc., by encouraging the creation and management of networks for caring for end-of-life patients and their families.

2. Recognition should be promoted to support activities to gain recognition in terms of knowledge and abilities from the community, for work or health personnel, such as giving awards, being a representative in disseminating knowledge and experience in caring for end-of-life patients and their families, etc., which creates a sense of self-worth for village health volunteers, which will result in increased success in their work.

3. Attitude: By promoting village health volunteers to have a positive attitude towards caring for t end-of-life patients and their families, accepting, understanding, and seeing the value of end-of-life patients, such as observing successful work on end-of-life patients care in the community, talking and exchanging knowledge with community health volunteers who have cared for end-of-life patients, this can create benefits and be a good example for other public health volunteers.

Suggestions for future research

1. There should be a study on the care of end-of-life patients in health volunteers in urban, rural, and industrial areas, because each society has a different context of health volunteers' lives, to obtain more comprehensive information on the care of end-of-life patients.

2. There should be a specific study on the group of village health volunteers who have experience in caring for end-of-life patients and have received training in caring for end-of-life patients, and then compare the results to be able to use it to develop a standard tool for caring for end-of-life patients, a manual or guidelines for caring for end-of-life patients for village health volunteers. Because this research studied both the group of health volunteers who had direct experience and shared experience, both those who had received training and those who had not received training.

Highlights of research

1. This study was conducted in a sample group of village health volunteers in Buriram Province. There is no research on factors influencing the end-of-life care activities of village health volunteers in the area.

2. From the results of this study, it was found that there are many factors that influence the activities of caring for end-of-life patients. The results of the study can be used to develop an activity model that promotes the competence of village health volunteers.

Limitations of the research

1. This study studied only the sample group of village health volunteers in Prakhon Chai District, Buriram Province, and did not include personal characteristics variables in the analysis, such as gender, age, and religion. Therefore, it cannot refer to village health volunteers in other areas because there may be differences in culture, language, and lifestyle.

2. This study used online questionnaires, resulting in incomplete data, as respondents did not complete the questionnaires and provided unreasonable answers.

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